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State Nutrition Mission in Uttar Pradesh

Pushing the Nutrition Agenda Forward

October 2016

Process documentation of State Nutrition Mission by Results for Development and Amaltas

RESULTS FOR DEVELOPMENT

AMALTAS

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Abbreviations and Acronyms

AAA	AWWs, ASHAs, and ANMs
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BPL	Below Poverty Line
BMGF	Bill and Melinda Gates Foundation
CAAM	Citizen's Alliance Against Malnutrition
CDO	Chief Development Officer
CM	Chief Minister
CS	Chief Secretary
CSR	Corporate Social Responsibility
CSS	Centrally-Sponsored Schemes
DG	Director General
DM	District Magistrate
DNC	District Nutrition Committee
FLW	Frontline Worker
GSDP	Gross State Domestic Product
HMIS	Health Management Information System
ICDS	Integrated Child Development Services
IFA	Iron Folic Acid
IIPS	International Institute of Population Sciences
IMR	Infant Mortality Rate
IYCF	Infant and Young Child Feeding
MCTS	Mother & Child Tracking System
MI	Micronutrient Initiative
MMR	Maternal Mortality Rate
MUAC	Mid Upper Arm Circumference
NFHS	National Family Health Survey
NHM	National Health Mission
NRC	Nutrition Rehabilitation Centre
NRHM	National Rural Health Mission
PIP	Programme Implementation Plan (PIP)
POSHAN	Partnerships and Opportunities to Strengthen and Harmonise Actions for Nutrition in India
RJMCHN	Rajmata Jijau Mother-Child Health and Nutrition Mission
SNM	State Nutrition Mission
SNP	Supplementary Nutrition Programme
SRLM	State Rural Livelihood Mission
SUW	Severely Underweight
TOT	Training of Trainers
UP	Uttar Pradesh
VHND	Village Health and Nutrition Day
VHSNC	Village Health Sanitation and Nutrition Committee
WASH	Water, Sanitation and Hygiene
WCD	Women and Child Development

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Executive Summary

Uttar Pradesh (UP) is the most populous state in India and has some of the highest rates of malnutrition in the world – half of all children under age 5 have stunted linear growth and 10% are wasted.[1] In 2014, the UP State Nutrition Mission (SNM) was instated to help improve child and maternal nutrition in the state. The SNM acts as a multi-sectoral coordinating body within the government with the objective to improve nutrition programming across sectors, especially within Integrated Child Development Services (ICDS) and the National Health Mission (NHM). UNICEF financially supports and is a technical partner of the SNM in UP.

The main objective of this report is to document the evolution of the SNM in UP, its current governance structure, core activities, and successes and challenges. The impact of government-delivered nutrition services on nutrition outcomes was not evaluated. A budget analysis for nutrition was also conducted to assess nutrition-specific and -sensitive budget allocations across departments in UP.

Assessing the Enabling Factors of the Mission and Key Activities

A research team conducted secondary research and key informant interviews at the state level and in three districts that were purposefully selected to capture information pertinent to the Mission's activities and influence. The research team interviewed personnel from SNM staff, state and district government officials, development partners, front line workers, pregnant women and mothers of children below five years, and UNICEF. Core thematic areas were analysed, including critical enabling factors that have led to the success of the Mission and the Mission's key activities.

The key enabling factors and resources that have contributed to the Mission's achievements to date include: high-level political support from the Chief Minister and Chief Secretary, strong programme leadership, including a Director General who provides creative and targeted strategic direction, policy and programme advocacy efforts to raise awareness towards nutrition, including support from the Citizen's Alliance Against Malnutrition at the inception of the Mission and the Mission's continuing efforts to generate population-based demand for improved nutrition programmes, and technical support from UNICEF and other development partners working in the state.

One of the core initiatives of the SNM is the Adopted Village Model, which represents one of the most important adaptive innovations for the Mission. Through the Adopted Village Model, District Magistrates and Chief Development Officers are asked to adopt two village-level Panchayati Raj Institutions, the Gram Sabha, which covers a cluster of 3-4 villages each. Subsequently, each of the district officials are asked to "adopt" two Gram Panchayats, to visit them regularly, and to track their progress. District Nutrition Committees, chaired by District Magistrates, are established to monitor progress. The Adoptive Village Model has multiple objectives as it serves to: 1) sensitise government officials across departments on the core issues of nutrition; 2) instil a sense of personal attachment and commitment to improving nutrition among government officials; and 3) create replicable model within

[1]Rapid Survey on Children (RSOC) 2013-14. (2015) Retrieved June 28, 2016, from the Ministry of Women and Child Development: http://wcd.nic.in/acts/rapid-survey-children-rsoc-2013-14

other districts. Although adopted villages are not targeted to the highest burden districts, the model – which is built on the engagement of government officials – seems to work well in a state like UP where hierarchical systems often defy change. Even though the most vulnerable villages may not yet be the Mission's primary focus, the model has led to movement on the ground and to an increased sense of ownership by government officials.

Overall, the UP SNM has made remarkable progress in a short period of time since its inception in 2014. Some of the salient accomplishments include:

- A village adoption programme, which has increased ownership of the SNM mandate among district officials across departments and the accountability of frontline workers. As described above, adopting Gram Panchayat means assuming responsibility for improved nutrition outcomes.
- Increased convergence with multiple development sectors through increased coordination with multiple departments (especially the departments of Women and Child Development and Health).
- Improved technical capacity of frontline workers to deliver nutrition services through enhanced training.
- Routine monitoring and reporting by SNM of the districts, through a dedicated website which helps with data-driven decision making and planning. The website collects quantitative data on mission activities in the districts on a monthly basis, including, for example, number of district meetings held, number of field visits made by officials adopting villages, quality of outreach session etc. The website lists all identified SUW and tracks their growth. This information is analysed and presented during regular SNM reviews.

Challenges to improved convergence across sectors include lack of accountability for nutrition outcomes, restricted budgets with little flexibility to be used for purposes that were not pre-approved, and transient leadership roles. Given the challenge of restricted budgets, the SNM has made efforts to influence the budget management cycle of ICDS by advocating for the Spot Feeding Scheme, which ultimately received funding approval. A challenge to monitoring and evaluation is timely access to high quality nutrition indicator data. While the SNM collects district-level data that is useful for process monitoring, there is no routine monitoring of district-level outcomes which is important to track progress.

Budget Analysis for Nutrition

A descriptive budget analysis for nutrition was conducted with the SNM and UNICEF to assess nutrition-specific and -sensitive budget allocations across departments. The following departments were considered to have nutrition-specific and sensitive investments: Women and Child Development, Health, Education, Agriculture, Rural Development, and Panchayati Raj Institutions.

In 2015-16, about Rs 5,077 crore (US $819 million) was budgeted for nutrition-specific programmes within ICDS and NHM, most of which was dedicated to the Supplementary Nutrition Programme through ICDS.[2] We compared current budget allocations to projected annual costs for the high-priority India Plus interventions at full coverage, as estimated by POSHAN, and found mixed results.[3] Partnerships and Opportunities to Strengthen and Harmonise Actions for Nutrition in India (POSHAN) mobilises nutrition evidence to support

[2]While the SNP is considered nutrition-speci c by the government in this analysis, the ICDS age range of 0-6 years does not match the recommended 0-2 year target age range for most nutrition-speci c interventions.

[3]Partnerships and Opportunities to Strengthen and Harmonize Actions for Nutrition in India web site. http://poshan.ifpri.info/2015/12/31/estimating-the-cost-of-delivering-direct-nutrition-interventions-at-scale/

policy and is led by the International Food Policy Research Institute (IFPRI), New Delhi. We found that current budget allocations for food supplementation and IFA/iron/vitamin A interventions surpass the estimated total costs to achieve full coverage of the interventions as calculated by POSHAN. However, at the same time, these interventions have low coverage rates, indicating that this resource needs estimation does not tell the whole story: possible explanations for this discrepancy include the use of budget allocations rather than actual expenditures (which may be lower), possible underestimation of scale up costs in UP based on national average costs, or potential misalignment between the estimated cost of interventions and budget line items. We found that maternity benefits make up a large share of total annual resource need (Rs 3,825 crore), but no funding is currently allocated to this intervention. Other core interventions, including infant and young child feeding counselling, zinc and oral rehydration salts (ORS) for treatment of diarrhoea, deworming, and facility-based treatment of severe acute malnutrition, are currently being implemented, but receive only a portion of the estimated resources needed for full scale, with an estimated annual resource gap of about Rs 510 crore (US $82 million) across these interventions. This resource gap is likely a lower bound estimate of what is needed on top of currently budgeted resources, given the findings above concerning budget allocations and coverage levels for other interventions. Additional work is needed to assess costs and financing needs, and, possibly, to assess possible reallocation of current funding to interventions with higher impact.

Nutrition-sensitive budget allocations as a share of total departmental budgets ranged from 6 per cent in Agriculture (Rs 229 crore or US $37 million)[4] to 39 per cent in Rural Development (Rs 3,878 crore or US $765 million) in 2015-16.[5] While this analysis provides a snapshot of nutrition-relevant budgeting across sectors, more work is needed to analyse the nutrition-relevant components within these programmes, and to assess where and how to leverage current budgets to make them more nutrition-sensitive. This is especially true considering the large budgets of many sectors delivering nutrition-sensitive programmes, and the potential to unlock more funding towards better nutrition outcomes. Ultimately, this resource mapping information could help assess how departmental budgets could be leveraged for nutrition (or made more nutrition-sensitive). It could also help build an investment case for nutrition across sectors that will support the SNM's advocacy efforts.

Conclusions

Uttar Pradesh alone makes up about a sixth of India's 1.2 billion population. Its achievements have tremendous influence on the nutritional outcomes of India as a whole. Undernutrition is an issue of such concern in UP that the present efforts by SNM to create synergy between the efforts of government departments to jointly tackle the problem are both welcome and praiseworthy. As the UP SNM continues to develop and work towards its targets, outlined in the Vision Document 2014-2024, it has the opportunity to build on the successes documented in this report and adapt to the challenges highlighted in our analysis.

[4]While the department of health budgeted about 1% towards nutrition-sensitive activities, when nutrition-specific interventions were included this rose to 4%.

[5]Amounts are "unweighted" total activity/programme budgets. See Annex D for a list of programmes included

Chapter 1

Introduction

The Burden of Undernutrition

India is home to about a third of all global cases of chronic undernutrition in children. Almost 40 per cent of the country's children under the age of five exhibit stunted growth.[6] Although, as a whole, India's rates of undernutrition have improved significantly in recent years – rates of stunting declined from 48 to 39 per cent from 2005-06 to 2013-15 – the country still lags behind in terms of achieving the World Health Assembly's targets for stunting.[7] Across India, there is tremendous variability in nutrition outcomes; state-level analyses are critical for understanding the complexities of undernutrition in the country.

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[6]Rapid Survey on Children (RSOC) 2013-14. (2015) Retrieved June 28, 2016, from the Ministry of Women and Child Development: http://wcd.nic.in/acts/rapid-survey-children-rsoc-2013-14

[7]Raykar, Neha and Purnima Menon, Panel 3.3 "State Nutrition Missions in India: Doing Poorly on Target Setting" from Global Nutrition Report 2016, pp 29-30, 2016.

Uttar Pradesh (UP) is the most populous state in India, with a population of 199.5 million and population density of 820 persons/km.[2,8] If it were a country, it would be the fifth most populous in the world. UP is also one of the poorest states in India, with a per capita GDP of US $567, about a third of the national average of US $1,503.[9] According to the 2011 Indian census, overall literacy rate in UP is also low (69.72%) and the female literacy rate is even lower (59.26%). Table 1.1 provides an overview of UP's key demographic indicators and compares them with India's national average.

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In addition to its high poverty rates, UP's undernutrition rates are among the highest in the world; there has been relatively little improvement in the past decade. Between 1998 and 2006, the prevalence of stunting in the state among children under 5 declined by only 9 percentage points (from 61% to 52%), the prevalence of underweight by 6 percentage points (from 48% to 42%), and the prevalence of wasting actually increased by 3 percentage points (from 17% to 20 %).[10]

Figure 1.1 depicts the findings of the second and third National Family Health Surveys (NFHS-2 and NFHS-3), which measure the prevalence of stunting and wasting among children under three years of age in 1998-99 and 2005-06, respectively. The graphic also shows the findings of the more recent Rapid Survey of Children (RSOC), which measured the stunting and wasting rates of children below five years of age in 2013-14. While stunting and wasting rates for children below three and five are not directly comparable, these figures do demonstrate the overall high rates of stunting and wasting in UP and show the need for more rapid improvement.

[8]Uttar Pradesh Population Census data 2011. (n.d.). Retrieved June 28, 2016, from Census 2011: http://www.census2011.co.in/census/state/uttar+pradesh.html

[9]India's top 25 states with highest GDP. (n.d.). Retrieved June 28, 2016, from rediff : http://www.rediff.com/money/slide-show/slide-show-1-top-25-states-with-highest-gdp/20120223.htm - 2

[10]International Institute for Population Sciences (IIPS) and Macro International. (2007). National Family Health Survey (NFHS-3), 2005 06 India: Volume II. Mumbai: IIPS

Table 1.1: Demographic indicators in UP and India

Indicator	UP	India
Population (2011)[a]	199,812,341	1,210,854,977
Rural	78%	69%
Urban	22%	31%
Minority population (2011)[a]		
Scheduled Tribes	0.6% (1,134,273)	8.6% (104,281,034)
Scheduled Castes	21% (19,680,633)	17% (201,378,086)
GSDP (Rupee in crore, 2013-14)[b]	890,265	10,472,807
GDP growth (annual), 2013-14 [c]	13.80%	11.54%
Poverty Headcount Ratio (<$1.25/day PPP)[d]	32.8%	27.5%
Rural	33.4%	28.3%
Urban	30.6%	25.7%
India State Hunger Index[e]	22.13	23.30
IMR (2012)[f]	53	42
MMR (2012) [f]	292	178

[a] Indian Census 2011 (http://www.censusindia.gov.in/2011census/PCA/PCA_Highlights/pca_highlights_ le/India/5Figures_at_glance.pdf, http://www.censusindia.gov.in/2011census/hlo/pca/PCA_pdf/PCA-CRC-2700.pdf)

[b] Gross State Domestic Product (GSDP) at Current Prices (as on 31-10-2014) http://planningcommission.gov.in/data/datatable/data_2312/DatabookDec2014%20156.pdf

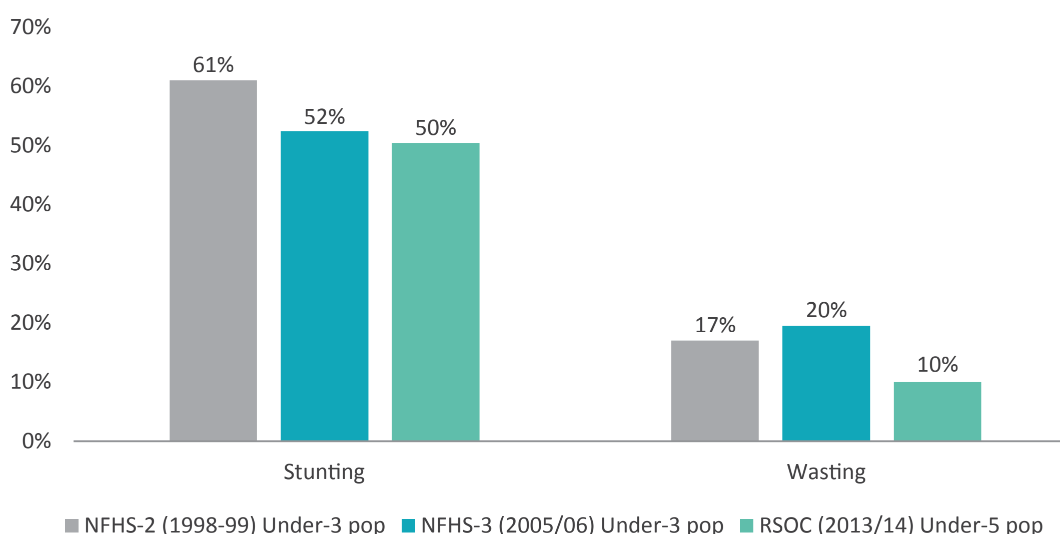
[c] Growth Rate - GSDP % (current prices) as per CSO Data 1997-98 onwards (as on 30-11-2014), Data for Planning Commission, 2014. http://planningcommission.gov.in/data/datatable/data_2312/DatabookDec2014%20163.pdf

[d] Percentage of population below poverty line by states & UTs for 61st (2004-05) rounds, Data for Planning Commission, 2014. http://planningcommission.gov.in/data/datatable/data_2312/DatabookDec2014%20105.pdf

[e] Percentage of population below poverty line by states & UTs for 61st (2004-05) rounds, Data for Planning Commission, 2014. http://planningcommission.gov.in/data/datatable/data_2312/DatabookDec2014%20105.pdf

[f] Infant, Child and Maternal Mortality Rate. Ministry of Health and Family Welfare, Government of India, July 11 2014. http://pib.nic.in/newsite/PrintRelease.aspx?relid=106438

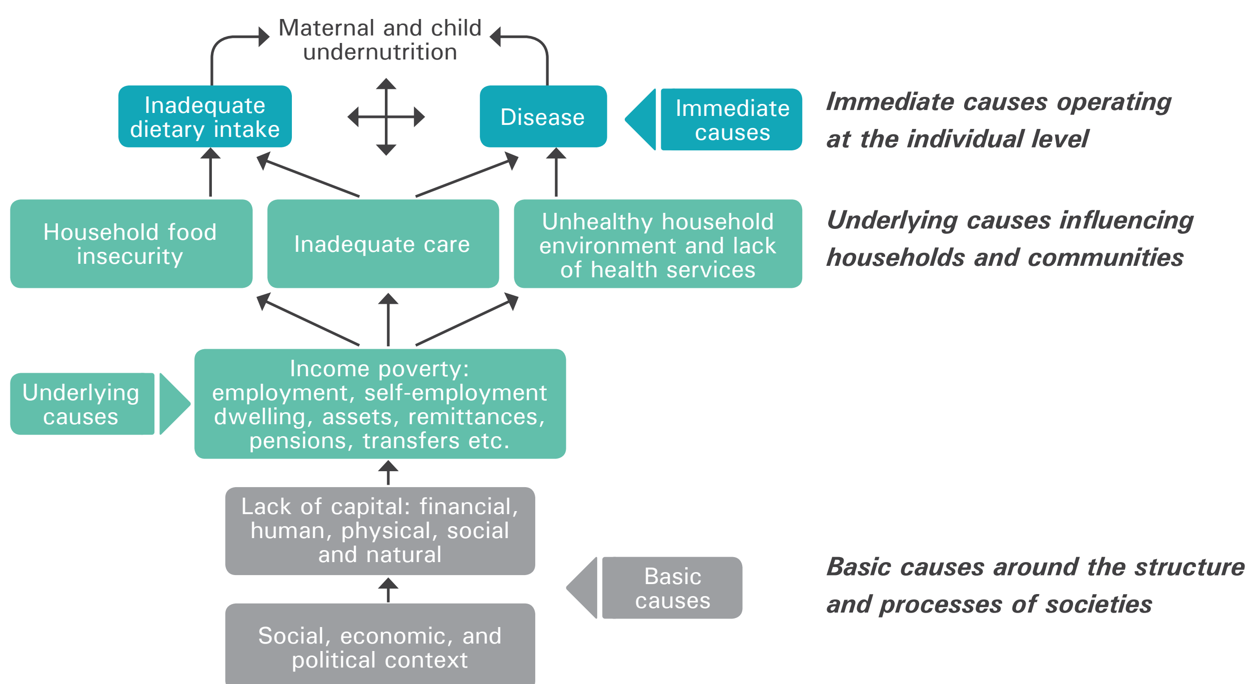
Figure 1.1: Nutrition indicators in UP



Interventions to Address Undernutrition in UP and India

The causes and consequences of undernutrition are multi-faceted and intergenerational. The UNICEF conceptual framework for undernutrition highlights the immediate, underlying, and basic causes of undernutrition (see Figure 1.2).[11] To break the cycle of intergenerational undernutrition, global experts recommend that governments adopt a multi-faceted approach that includes 1) developing a multi-sectoral nutrition plan that includes nutrition-sensitive components, and 2) scaling-up a core package of high impact, evidence-based nutrition-specific interventions.[12,13]

Figure 1.2: UNICEF conceptual framework for undernutrition[14]



A recent study by Aguayo and Menon shows that the major causes of stunting in South Asia include poor diets of pregnant women (which increase the likelihood of their infants being born with low birth weight and subsequently undernourished), inadequate food and nutrient intake of young children, and poor sanitation practices.[15] Improving nutrition, therefore, requires a multitude of interventions, including dietary diversification that ensures greater consumption of nutrient-rich foods by women and adolescents, the timely introduction of nutrient-dense complementary feeding, the provision of nutrient fortified foods, greater access to micronutrient supplementation and better access to improved sanitation.

Recognising that undernutrition is a massive public health and development problem across the country, the Government of India launched several major programmes and policy

[11]Multi-sectoral Approaches to Nutrition: Nutrition-Speci c and Nutrition-Sensitive Interventions to Accelerate Progress. (n.d.). Retrieved June 28, 2016, from UNICEF: http://www.unicef.org/eapro/Brief_Nutrition_Overview.pdf

[12]Ruel, M. T., & Alderman, H. (2013). Nutrition-sensitive interventions and programmes: How can they help to accelerate progress in improving maternal and child nutrition? The Lancet, 382(9891), 536-551. doi:10.1016/s0140-6736(13)60843-0

[13]Bhutta, Z. A., Das, J. K., Rizvi, A., Gaffey, M. F., Walker, N., Horton, S., Black, R. E. (2013). Evidence-based interventions for improvement of maternal and child nutrition: What can be done and at what cost? The Lancet, 382(9890), 452-477. doi:10.1016/s0140-6736(13)60996-4

[14]UNICEF. (2008). UNICEF Conceptual Framework. Retrieved from UNICEF: http://www.unicef.org/nutrition/training/2.5/4.html

[15]Aguayo, Victor and Purnima Menon. (2016). "Stop stunting: improving child feeding, women's nutrition and household sanitation in South Asia." Maternal & Child Nutrition, 12 (Suppl. 1). Pp. 3-11.

initiatives to reduce the alarming rate of undernutrition.[16] Annex A includes a list of key nutrition-specific and nutrition-sensitive interventions, as well as the public ministries, departments, and agencies in India concerned with each intervention.

The Integrated Child Development Services (ICDS) and National Health Mission (NHM) are two centrally sponsored programmes that the central government funds and the states implement (adhering to the 14th Finance Commission involves a change in the cost sharing pattern of centrally sponsored schemes). Both programmes have a broad scope and nutrition is only one of several areas of focus.

ICDS, launched in 1975, is the government's largest maternal, child health and nutrition programme and, arguably, the largest in the world.[17] Run by the Ministry of Women and Child Development (WCD), the programme provides six essential interventions, including immunisation, supplementary nutrition, health check-ups, referral services, pre-school education, and nutrition and health education.

The National Health Mission (NHM), launched in 2005 as the National Rural Health Mission, is another centrally sponsored scheme housed in the Ministry of Health and Family Welfare. NHM delivers high impact nutrition-specific interventions through the health sector.

Although ICDS was launched more than 40 years ago, and most children live within range of ICDS' Anganwadi Centres (AWC), the percentage of UP children receiving ICDS services remains relatively low. While 76 per cent of the state's children below the age of 6 live within the coverage area of an Anganwadi Centre, only 22 per cent of these children reported receiving any service from the AWC in 2005.[18] According to the more recent RSOC data, 23 per cent of children receive supplementary food from an AWC, only 38 per cent children were weighed at an AWC, and mothers of only 40 per cent of those children received any counselling after their child was weighed.[19]

Coverage rates for basic health and nutrition services across departments also remain low. For instance, the RSOC results indicate that only 27% of children under the age of five received vitamin A supplementation – a vital means of reducing the prevalence and severity of infectious disease – within the 6 months prior to the survey. Similarly, while consumption of iron-folic acid by pregnant women helps protect against anaemia and can improve nutritional outcomes of infants, only 4% of mothers in UP reported receiving the recommended dose during pregnancy.[20] Coverage rates for these and other vital nutrition interventions are presented in Annex B.

State Nutrition Mission: entering "Mission mode" to Improve Multi-sectoral Nutrition

Because of India's limited success in reducing the high rates of undernutrition across the country, several Indian states have formed State Nutrition Missions (SNM) to help reduce

[16]Kapil, Umesh, S. Chaturvedi, and D. Nayar. National Nutrition Supplementation Programmes (1992). Retrieved June 28, 2016 from: http://www.indianpediatrics.net/dec1992/1601.pdf

[17]Ministry of Women and Child Development, Government of India . (n.d.). INTEGRATED CHILD DEVELOPMENT SERVICES (ICDS) SCHEME. Retrieved April 27, 2016, from Ministry of Women and Child Development, Government of India : http://icds-wcd.nic.in/icds/icds.aspx

[18]International Institute for Population Sciences (IIPS) and Macro International. (2007). National Family Health Survey (NFHS-3), 2005 06 India:Volume II. Mumbai: IIPS

[19]Rapid Survey on Children (RSOC) 2013-14. (2015) Retrieved June 28, 2016, from the Ministry of Women and Child Development: http://wcd.nic.in/acts/rapid-survey-children-rsoc-2013-14

[20]Rapid Survey on Children (RSOC) 2013-14. (2015) Retrieved June 28, 2016, from the Ministry of Women and Child Development: http://wcd.nic.in/acts/rapid-survey-children-rsoc-2013-14

undernutrition among women and children. An SNM is a multi-sectoral coordinating body within the government with the objective of improving nutrition programming across sectors, especially for ICDS and NHM.[21] The model is similar to multi-sectoral governance bodies for nutrition that have been used in other countries to help develop a supportive environment for nutrition governance and stewardship.[22,23]

SNMs go beyond departmental activities and the nutrition-specific areas of NHM and ICDS. They elevate the profile and importance of nutrition at the state level and help to endorse nutrition-specific and nutrition-sensitive policies and strategies to reduce undernutrition, using an integrated and multi-sectoral approach. SNMs provide the formal structure needed to prioritise the issue within each sector.

Based on the success of the Rajmata Jijau Mother-Child Health and Nutrition Mission in Maharashtra, the Nutrition Mission in UP was established in 2014 – to strengthen the delivery structures and accelerate the efforts to reduce undernutrition.[24] The Mission does not implement nutrition programmes, but rather aims to review existing ones, assess gaps in implementation, recommend specific improvements, and work with departments to help them implement these improvements.[25] A description of objectives, scope, and core initiatives of the UP State Nutrition Mission are presented in a subsequent chapter.

Purpose of this Report

The establishment of SNMs represents one of the most significant efforts to improve the governance and coordination of nutrition services across sectors in India and in UP. However, there has not yet been documentation of the State Nutrition Mission in UP.

This report fills that gap. It documents the history and trajectory of the SNM in UP. It captures the SNM's evolution, the current governance structure, including coordination between sectors, core activities including its influence on programmatic activity at state and district levels and successes and challenges.

This report does not intend to formally evaluate or assess the success of the SNM. Rather, the qualitative information presented in this documentation exercise is intended to be descriptive and to identify a set of key issues that policy-makers may wish to consider further. This information should be useful to the government as it strengthens the SNM and identifies successful components and/or processes that may be useful in initiating SNMs in other Indian states.

The chapters that follow describe the methods used to document the SNM, provide an overview of the SNM, describe enabling factors that have helped to shape the SNM and some of its key activities and present a budget analysis for nutrition.

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[21]Maharashtra, R. J.-C. (n.d.). FAQs on Setting up a Nutrition Mission in a State - Why and How Retrieved 4 26, 2016, from Maharashtra Health and Nutrition Mission: http://www.mahnm.in/Pdf/Why_Nutrition_Mission.pdf

[22]Levinson, J. and Balarajan, Y. (2013). "Addressing Malnutrition Multisectorally: What have we learned from recent international experience?"

[23]Acosta, A.M. and Fanzo, J. (2012). "Fighting Maternal and Child Malnutrition: Analysing the political and institutional determinants of delivering a national multisectoral response in six countries." IDS Synthesis paper

[24]Government of Uttar Pradesh. (2014-2024). State Nutrition Mission Uttar Pradesh Vision Document. Government of Uttar Pradesh

[25]Ibid

Chapter 2

Methods

Documentation of the State Nutrition Mission

The documentation was conducted by performing secondary research and primary qualitative data collection through key informant interviews. The first step was a desk review of core policy and research documents on child undernutrition to establish the context and to develop a framework for interviews. Following this review, a five-person research team visited UP to conduct key informant interviews and focus group discussions to gather information on the evolution and current conduct of the Mission.[26]

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[26]Interviews took place over a two-week period in May 2016

The research team interviewed stakeholders, including personnel from SNM staff, state and district government officials, UNICEF, development partners, frontline workers, including Anganwadi Workers (AWWs), Accredited Social Health Activists (ASHAs), and Auxiliary Nurse Midwives (ANMs), as well as beneficiaries (see Annex C for a list of key informants). Three districts were purposefully selected based on consultation with UNICEF and the State Nutrition Mission leadership to ensure that the information captured came from a broad and diverse array of sources. The research team conducted field work during a two-week period.

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The research team communicated regularly with UNICEF and SNM staff while it collected data to discuss preliminary findings. The research team generated emergent themes to represent the Mission through an iterative process while consulting with key stakeholders to ensure the accuracy of reporting. The team's process was important because many of the Mission's key events and earlier efforts had not been documented.

In UP, the monumental State Vision Document 2014-2024, written upon the establishment of the SNM, was used as a core reference document. The 6 primary objectives outlined in the SNM strategy were used as a thematic framework to guide interview discussions in order to understand how the State Nutrition Mission works towards each objective. The SNM objectives include:

1. Better coordination among all departments concerned
2. Visibility to the issue
3. Advocacy at the highest level
4. Creating accountability
5. Leveraging resources
6. Strengthening monitoring systems

Qualitative Analysis

The research team analysed the Mission's core themes, including critical enabling factors and resources that have led to the success of the Mission, and the key activities that have contributed to the Mission achieving its objectives. These core aspects of the Mission help improve service delivery across departments that ultimately have an impact on nutrition. An analytical framework was developed to summarise these core themes, as they emerged from key informant interviews, depicted in Figure 2.1.

The five critical enablers and Mission resources required for the SNM to carry out its work consist of (i) political support, (ii) programme leadership, (iii) oversight mechanisms, (iv) policy and programme advocacy, and (v) technical support.

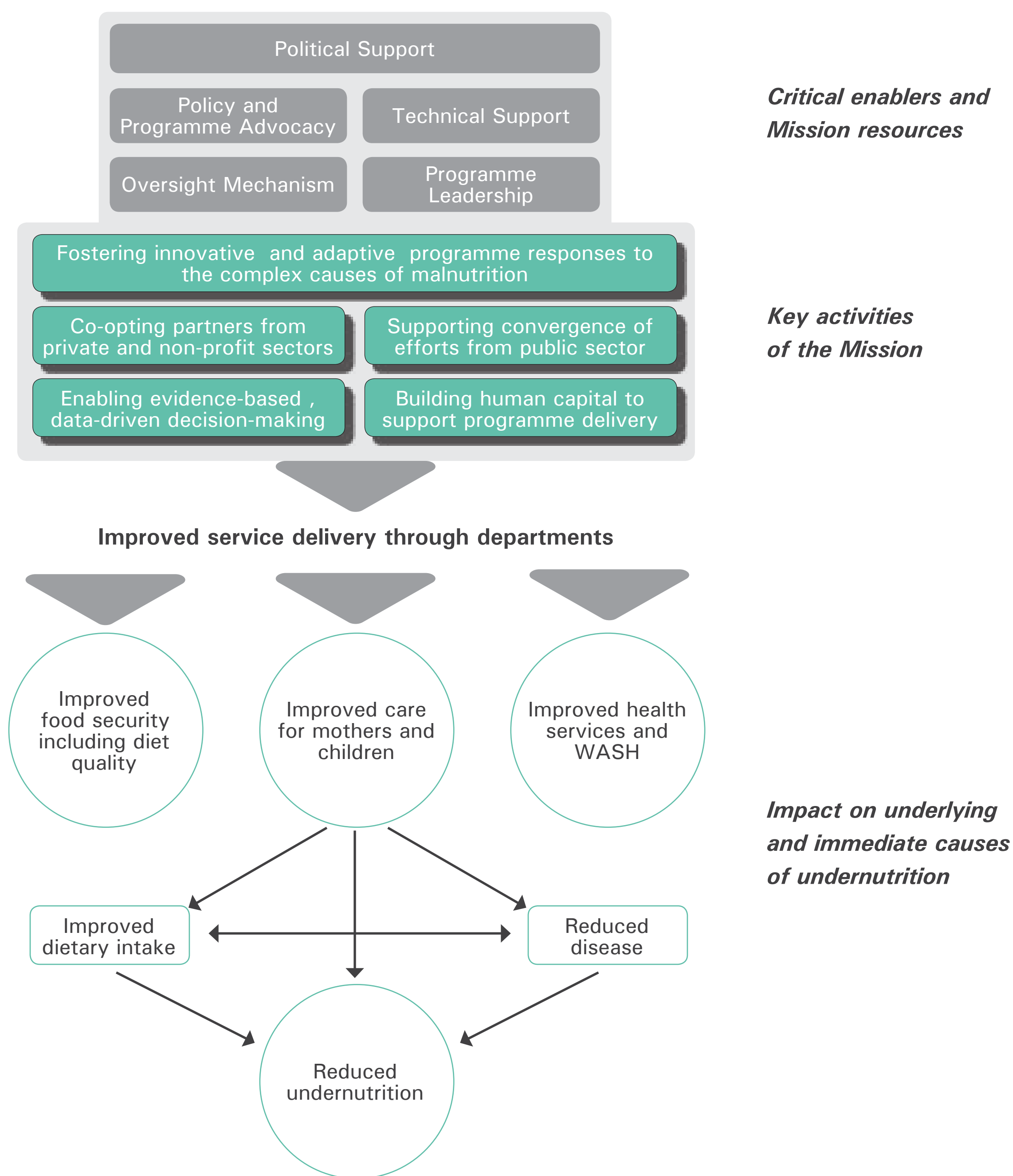
The team also aimed to capture key activities undertaken by the Mission, including (i) innovative thinking, (ii) co-option of partners, (iii) convergence of efforts between public sectors, (iv) evidence-based, data-driven decision making, and (v) building human capital to support programme delivery.

Chapter 4 describes each of these areas, as they relate to the SNM in Uttar Pradesh, based on information from key informant interviews. The impact of government-delivered nutrition services on nutrition outcomes was not evaluated.

Budget Analysis

A descriptive budget analysis for nutrition was conducted with the SNM and UNICEF. For a description of the data and the approach to budget analysis for nutrition across sectors, see Chapter 6.

Figure 2.1: Analytical framework of State Nutrition Mission influence on the delivery of nutrition services across departments[27]



Critical enablers and Mission resources

Key activities of the Mission

Impact on underlying and immediate causes of undernutrition

[27]WASH: Water, sanitation and hygiene; Underlying and immediate causes of undernutrition adapted from UNICEF conceptual framework: UNICEF. (2008). UNICEF Conceptual Framework. Retrieved from http://www.unicef.org/nutrition/training/2.5/4.html

Chapter 3

Overview of the State Nutrition Mission in Uttar Pradesh

3.1. Genesis of the State Nutrition Mission

The inception of the State Nutrition Mission can be linked to a large advocacy and accountability movement starting in 2012, pushing the government to improve nutrition programming. The Citizen's Alliance Against Malnutrition (CAAM), an initiative comprising young parliamentarians, media personalities, and prominent experts, advocated for increased attention and awareness by the government to address undernutrition.

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At this point in time Maharashtra already had its Rajmata Jijau Mother-Child Health and Nutrition (RJMCHN) Mission operating for 7 years, serving as a role model for nutrition governance that could be adapted to fit the UP context. Ms Dimple Yadav – Member of Parliament and a member of CAAM – was one of the leaders who helped advocate for UP to develop its own State Nutrition Mission. The Maharashtra experience demonstrated that an independent, governmental body dedicated to nutrition could influence existing systems and create positive change for nutrition programming.

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UP accordingly decided to establish a Mission modelled after what was done in Maharashtra.[28] The UP State Nutrition Mission was set up and officially launched in November 2014. Mr Kamran Rizvi, who is also the commissioner of Rural Development department in the state, took the lead as the Director General of the Mission.

The stated purpose of the State Nutrition Mission at inception was to converge and coordinate multiple sectors relevant to nutrition, advocate for improved programmes through the use of evidence-based interventions and recommendations and monitor the work of line departments. The aim was to improve the quality of service delivery, increase demand for nutrition services, implement local innovative models, and support line departments with general nutrition-relevant knowledge and materials.[29]

While the UP SNM learned from the experience of Maharashtra, the Mission strategy was structured to fit the specific context of UP, taking its health and demographic context into consideration. Today the SNM is operating in full swing with strong momentum and enthusiasm to enhance nutrition service delivery and outcomes.

[28]Refer to Maharashtra documentation report for further details on the history of the RJMCHN Mission

[29]SNM CDO Presentation, December 2014

3.2. Focus of the SNM: Objectives, Strategy and its Core Initiative

Objectives

Broadly speaking, the Mission's objectives are to improve five nutrition outcomes over a 10-year period: prevalence of underweight, prevalence of wasting, prevalence of stunting, rates of exclusive breastfeeding and anaemia in women of reproductive age. The Mission divided the 10-year period between 2014 and 2024 into three phases and set specific targets to achieve across each nutrition outcome during each phase.[30] The outcomes and phase-specific goals are specified in Table 3.1.

Table 3.1: UP Nutrition Mission Objectives and Phases (2014-2024)

	Short term objectives Phase I (Three years)	Intermediate objectives Phase II (Two years)	Long term objectives Phase III (Five years)
Underweight	Reduce underweight prevalence by 5 percentage points	Reduce underweight prevalence by a further 4 percentage points	Reduce underweight prevalence by a further 10 percentage points
Wasting	Reduce wasting prevalence by 1.5 percentage points	Reduce wasting prevalence by a further 1.5 percentage points	Reduce wasting prevalence by a further 5 percentage points
Stunting	Reduce stunting prevalence by 5 percentage points	Reduce stunting prevalence by a further 5 percentage points	Reduce stunting prevalence by a further 5 percentage points
Exclusive breastfeeding	Increase exclusive breastfeeding rates by 4 percentage points	Increase exclusive breastfeeding rates by a further 3 percentage points	Increase exclusive breastfeeding rates by a further 10 percentage points
Anaemia	Reduce anaemia in women of reproductive age by 7 percentage points	Reduce anaemia in women of reproductive age by a further 5 percentage points	Reduce anaemia in women of reproductive age by a further 15 percentage points

Mission Strategy and Approach

In order to achieve its objectives, the Mission identified a set of 10 Essential Interventions to promote and strengthen in the state. These are listed in the SNM Vision Document and include:

- Early initiation of breastfeeding
- Exclusive breastfeeding for the first 6 months
- Timely introduction of complementary foods after 6 months
- Age-appropriate complementary feeding, adequate in terms of quality, quantity, and frequency

[30]Government of Uttar Pradesh. (2014-2024). State Nutrition Mission Uttar Pradesh Vision Document. Government of Uttar Pradesh

- Adequate feeding during and after illness
- Safe handling of complementary foods and hygienic complementary feeding practices
- Micronutrient supplementation (IFA, Vitamin A, and Zinc-ORS)
- Timely and quality therapeutic feeding and care for all children with severe acute malnutrition
- Improved food and nutrition intake for adolescent girls, particularly to prevent anaemia
- Improved food and nutrient intake for adult women, including during pregnancy and lactation

The Mission began by focusing on improving nutrition programme implementation within ICDS and NHM during the first 1000 days i.e from pregnancy till first two yeas of life. The strategic focus of the Mission was on mothers, neonates, pre-school age children, and adolescents. The initial focus of the Mission's activities was to sensitise its team of core senior district officials on the essentials of nutrition so that they can be better engaged in monitoring the ground situation and identify implementation challenges. The exercise helped the Mission identify following programme gaps: 1) erratic and incorrect weighing and reporting by ICDS, 2) weak health and nutrition service delivery systems, especially at the community level and 3) poor involvement of health department in Mission activities.

To address the programme gaps and support evidence based planning, the Mission initiated a state-wide weighing campaign. It also advocated for Health and ICDS to revamp outreach sessions (also known as Village Health and Nutrition Days) and to improve field referrals to Nutrition Rehabilitation Centres (NRCs), which are district based facilities to treat children with severe acute malnutrition. The Mission also created a website to monitor and track districts' performance.

As a result of these efforts, reporting of children with undernutrition (weight for age less than -2SD) increased, outreach sessions were strengthened especially in terms of availability of nutrition services for pregnant women, – and the number of NRCs increased from 26 to 70 (almost one per district) in a span of 18 months. The Mission also began to focus on the training of nutrition stakeholders – at all levels and across departments – in order to raise awareness not just about undernutrition and its associated factors, but also about how existing service delivery mechanisms could be leveraged to deliver for nutrition.

In the initial stages of the Mission, the leadership discussed targeting geographic areas and selected 50% of the districts; this was later changed to all 75 districts in UP.

A Core Initiative of SNM: The Adopted Village Model

SNM introduced the concept of "undernutrition-free gram sabhas" with the idea that actions taken at the Gram Sabha level would work towards achieving the state-wide nutrition objectives, while also creating a model for districts to learn from and replicate. The Adopted Village Model is a core component of SNM – and a mechanism for increased ownership and monitoring of nutrition actions by government officials.

Through the Adopted Village Model, senior officials in the district – the District Magistrate (DM) and the Chief Development Officer (CDO) – are asked to adopt two village-level Panchayati Raj Institutions, the Gram Sabha which covers a cluster of 3-4 villages each. Subsequently, each of the district officials (who can be from different departments) are asked to "adopt" two Gram Panchayats, to visit them regularly, and to track their progress. Because the district officials are from different departments, this strategy encourages the involvement of all sectors, directly or indirectly, in nutrition.

"Adoption" in this case means assuming responsibility for improved nutrition outcomes. District officials are meant to visit their adopted villages at least once a month, preferably on outreach session days, gather information on any progress, and report on that progress. The Mission initiated the use of a checklist for officials to fill out during village visits to determine whether particular public services are available and utilised. While these checklists do not yet involve the collection of quantitative data on coverage or effectiveness indicators, the Mission has found them useful to determine the extent to which the officials are visiting their adopted villages and in monitoring operational quality of interventions. Thus, the checklists provide information on gaps and areas for increased attention.

At the same time, District Nutrition Committees (DNCs) hold monthly meetings chaired by the DM or CDO to discuss the progress achieved and outstanding issues in need of resolution. DNCs are a platform created in all districts to deliberate in a focussed way on nutrition initiatives in the district. All district officials who have adopted villages are expected to participate in these DNC meetings and to report findings and observations from their village visits. Those who have failed to make the necessary visits are held accountable at these meetings.

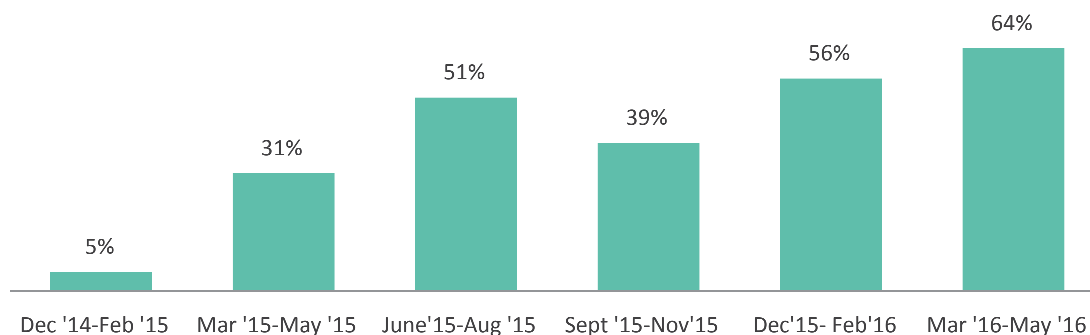
Initially, the Mission required officials to submit only the checklists and reports from adopted village visits. However, the Mission gradually requested that government officials also upload a photographs of themselves while visiting villages. These photographs tagged with GPS location gets uploaded on Mission database using a mobile application created for officials by the Mission.

Progress of the Adopted Village Model

The Mission's Adopted Village Model covers 7,600 Gram Sabhas in the state, which is almost 21,000 villages (10% of the total villages in the state). Under the adopted villages model, district officials of various departments are each required to visit villages under their portfolio in order to supervise activities, as described above. These district officials then discuss the outcomes of their visits at meetings of the District Nutrition Committee.

Since December 2014, the proportion of adopted villages visited per quarter has risen from 5% at the model's inception to 64% in May 2016 (Figure 3.1). The absolute number of villages visited per quarter exceeds 4,680 adopted villages, an over 10-fold increase since the launch of the model. This indicates that SNM is succeeding in its goal to increase the number of visits made by government officials to the local level to help monitor nutrition service delivery and governance.

Figure 3.1: Proportion of adopted villages visited by a government official per quarter[31]



Source: Data was shared with the authors by UNICEF and captures monitoring of VHND through Social Mobilisation network

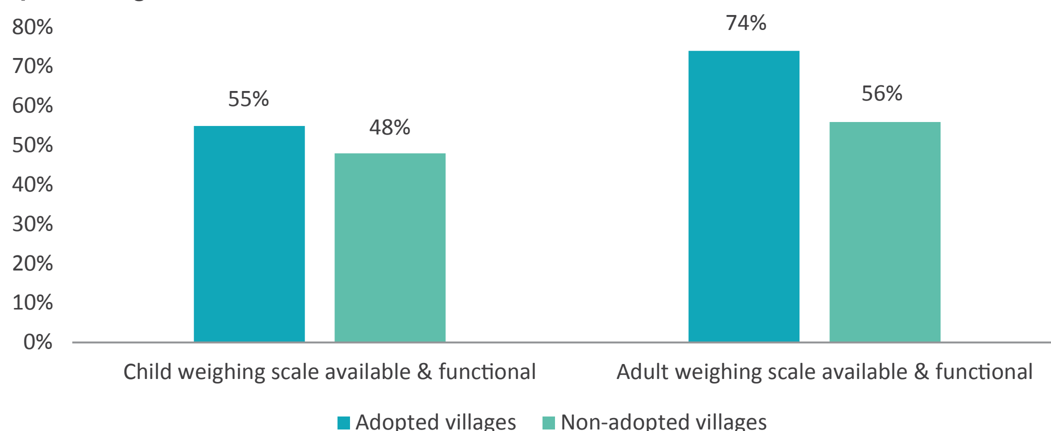
According to Village Health and Nutrition Day (VHND) monitoring data, service delivery capacity varies between adopted and non-adopted villages. For both child and adult weighing, for example, adopted villages were more likely to have available and functional scales than non-adopted villages, which were more likely to have non-functional scales or no weighing machines at all (Figure 3.2).

However, where functional weighing machines were available, adopted and non-adopted villages were equally likely to offer weighing services, suggesting that availability of equipment was the main driver behind variance in service delivery capacity.

Similarly, adopted villages were more likely than non-adopted villages to offer haemoglobin testing (62% of villages compared to 43%); however, both were nearly equally likely to provide iron tablets to anaemic women (87% and 84%, respectively). Small differences were reported in the percentage of adopted and non-adopted villages providing counselling to the parents of children and infants and to pregnant women.

Although data is not available to compare nutrition outcomes between adopted and non-adopted villages, the data presented here describes process indicators important for monitoring progress towards achieving improvements in nutrition. Continued monitoring of data is necessary to assess service delivery and impact moving forward.

Figure 3.2: Availability of functional child and adult weighing scales in adopted and non-adopted villages



Source: Data was shared with the authors by UNICEF

[31] The dip in the number of visits in September 2015 is attributed to the local elections of new Gram Pradhan, the activities for which continued for around 3 months

Chapter 4

Key Factors Influencing UP's State Nutrition Mission

This chapter describes key themes that emerged in interviews and field visits across districts in UP. The findings are categorised into two broad thematic areas: enabling factors that influenced the SNM and its role, and factors that illustrate key activities of the Mission, as outlined in the analytical framework shown in Chapter 2.

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4.1. Assessment of Critical Enablers and Mission Resources

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Political Support

The Office of Chief Minister has helped raise the profile of SNM by including SNM monitoring in its core development agenda. Regular high-level attention through reviews, meetings, and follow-ups, helps to ensure that departments are committed to achieve the goals of the Mission.

The high level of political commitment to nutrition by the current UP government was one of the original drivers for the establishment of SNM. The current Chief Minister (CM) and his wife have "upped the ante" for the nutrition agenda further. The CM's direct involvement has led to nutrition now being accepted (at least in principle) as a priority issue on the state's development agenda and by all relevant departments, itself generating a major incentive for senior officials to participate actively in Mission efforts. The CM's wife, Ms Dimple Yadav, is herself a political figure, and has been instrumental in the initiation of the Mission. Her personal involvement in the Citizen's Alliance Against Malnutrition – a national-level advocacy network – has also helped to elicit visible political and celebrity support, increasing the visibility of both nutrition and SNM at the state and national levels.

After the establishment of the Mission, the Chief Minister signed and sent motivational letters – to all the Pradhans (elected representative of local governance at gram panchayat level), to officials who have adopted villages, to Members of Parliament/Members of the Legislative Assembly and to frontline workers – specifying the importance of SNM and their role in supporting and facilitating its efforts. Departments like Health, Education, PRI have begun sending regular programme directives to the districts asking them to prioritise nutrition actions and give more emphasis to nutrition-related initiatives. In doing so, these departments have assumed significantly greater ownership of nutrition in the state.

Programme Leadership

SNM has benefited from the involvement of the Chief Secretary who has high-level oversight over all departments, making it easier to generate their active support.

The Chief Secretary (CS) heads the SNM Executive Committee and conducts quarterly meetings with the Mission staff. The meetings are used as platforms to discuss progress, plans, budgets, challenges and opportunities for the Mission and have been useful in reaching final decisions and in increasing accountability and ownership for the nutrition

agenda. When departments are unable to make decisions, or the decision-making process becomes stalled within departments, such issues are addressed in these quarterly meetings with the CS for final action.

The Director General's leadership is widely recognised as a positive force in the state, driving Mission objectives forward.

Several stakeholders cited the Director General (DG) as a visionary, insightful, and highly active official who works creatively and constructively with the government departments and with development partners. His additional responsibility as Commissioner of the Rural Development Department has encouraged inter-departmental convergence. Despite this additional charge, the DG continues to be personally involved in the day-to-day working of the Mission and is perceived as "a very accessible officer" in constant touch with the DMs and CDOs on the progress – and challenges – facing their respective districts. The DG personally took the lead in making the village adoption programme and other initiatives to jump start progress in a state traditionally hampered by administrative issues. Recognising the short-run lifespan of many governmental initiatives, the DG has a primary interest and commitment to push for demand creation among the people for better sustainability of the momentum created under his leadership.

Oversight Mechanisms

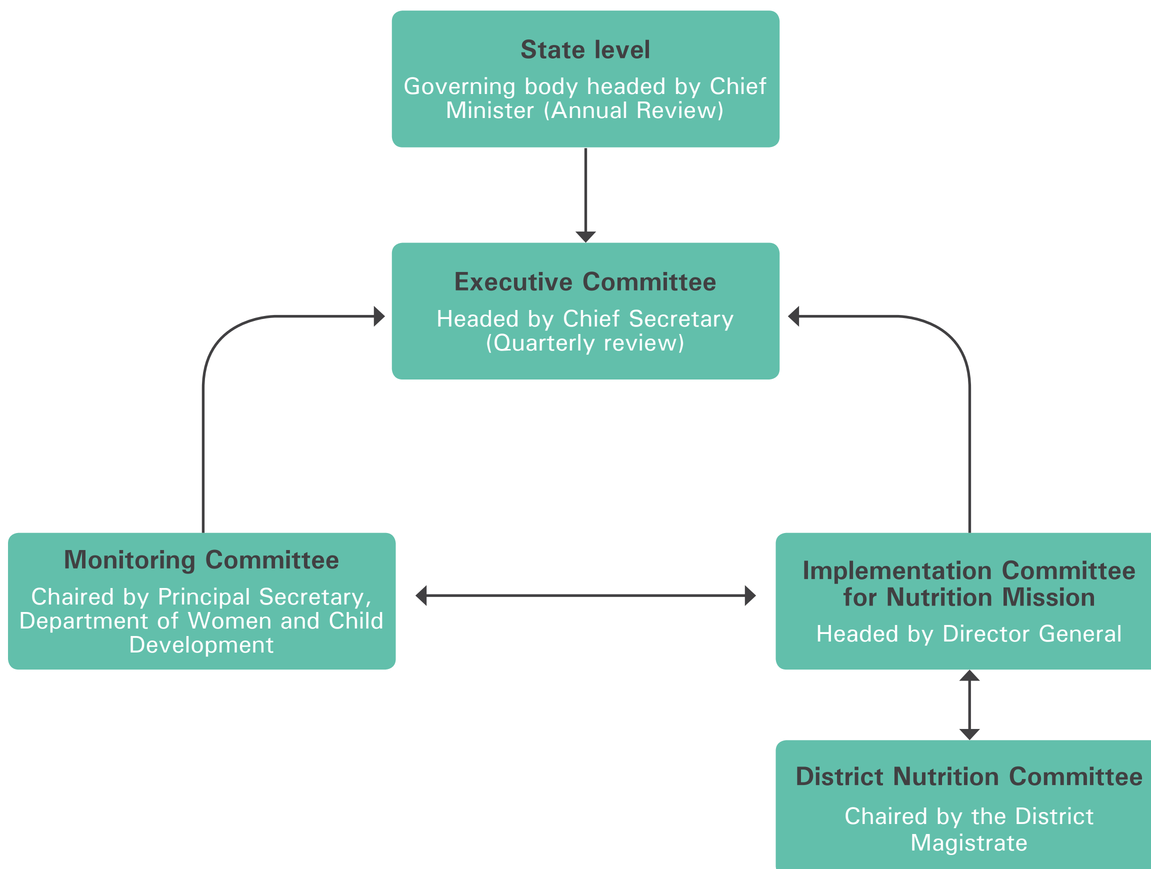
An oversight structure of SNM was established to ensure continuous and timely review of core Mission activities and to execute key decisions when needed.

In Uttar Pradesh, an Executive Committee headed by the Chief Secretary was established consisting of Principal Secretaries from relevant departments to review progress, ensure delivery on the multi-sectoral agenda of nutrition and create accountability within departments. The Executive Committee meets every quarter and is the main body responsible for nutrition-related decision making. A Monitoring Committee, chaired by the Principal Secretary of WCD, meets more frequently to discuss programme implementation and bottlenecks. The Implementation Committee, headed by the DG of the Mission, is an independent group that is responsible for actual dialogue with various departments for their support and in turn reports to the Executive Committee and communicates with the Monitoring Committee regularly. Figure 4.1 illustrates this oversight structure.

At the highest level, the Chief Minister's Office also receives regular updates, ensuring that active progress is being made across the state. The District Nutrition Committee, a multi-sectoral entity in every district chaired by the District Magistrate, is also critical in ensuring that state-wide initiatives are being actively addressed at sub-state levels.

An example of a key decision taken by these oversight structures is the push for rollout of the Spot Feeding cum Counselling Scheme (Hausla Poshan Yojana- HPY) through ICDS, supported by state government budget (discussed below as well). The SNM submitted its plan to support the scheme, including budget requirements, to the Executive Committee, which then approved it. Then the proposal was submitted to the Cabinet and presented to the Chief Minister. Approval at this level was granted, and the finance department was empowered to release the funds required. The actual scheme began in July 2016.

Figure 4.1: Management structure of the State Nutrition Mission[32]



Policy and Programme Advocacy

Advocacy efforts played an important role during inception of SNM by helping to raise awareness on the burden of undernutrition in the state.

Advocacy groups in the state have been a vitally important force, providing initial and now continuing momentum for SNM. These groups helped spread messages throughout the state government on the importance of nutrition and on the urgent necessity of government action. The Citizen's Alliance Against Malnutrition, an advocacy network across India whose members include Parliamentarians, helped encourage the inception of the Mission in UP. The example of the RJMCHN Mission in Maharashtra was used as part of the argument by the Citizen's Alliance to encourage the establishment of a committed Nutrition Mission in UP. RJMCHN too was similarly born, in the 2000s, in part following social activism raising awareness to the high number of undernutrition-related child deaths in Maharashtra.

Generating population-based demand (i.e., community support) for more and improved nutrition services is one of the DG's self-declared top priorities, and a focus of SNM advocacy efforts.

"Demand needs to be created from the community until the community starts demanding it themselves"

[32]Government of Uttar Pradesh. (2014-2024). State Nutrition Mission Uttar Pradesh Vision Document. Government of Uttar Pradesh

SNM has been helping to create awareness about maternal and child undernutrition and to build demand for improved access to quality services through campaigns such as the Weighing Drive (Vajan Diwas) and Maternal Health Week (Matritva Saptah).

Vajan Diwas were two dedicated days when all children across the state were weighed in an election-mode format. While the main objective of Vajan Diwas was to weigh children and identify those severely undernourished, its community-based participatory approach also had an important effect. It raised awareness of nutrition and encouraged mothers to take an active role in ensuring adequate growth of their young children. With the data generated by Vajan Diwas uploaded to the SNM website, the districts have reported a 5-8-fold increase in identified cases of underweight children.[33]

The State Nutrition Mission also helped conduct the Matritva Saptah, a week-long campaign, between 27 January and 5 February 2016, to identify "high risk" pregnant women, especially those with anaemia. The campaign provided iron-folic acid supplementation to pregnant women, carried out weighing, and conducted antenatal examination to determine high risk pregnancies. According to SNM reports, the maternal campaign reached 15 lakh pregnant women with antenatal care services. Of these, more than half were found to be anaemic. Seven per cent of the women were identified as having high-risk pregnancies and have since received follow-up attention. Identification of such high-risk pregnancies for better birth outcomes remains an important focus area for SNM. The maternal campaign will henceforth be organised on a biannual basis in the state, thus ensuring that the efforts are sustained.

Based on key informant interviews, these initiatives have been successful in increasing nutrition knowledge in the local communities visited. In particular, the weighing initiative appears to be successfully countering superstitious beliefs, in some pockets, against child weighing and increasing the awareness of mothers and other family members about its importance in monitoring the nutrition status of the child. During team visits to villages and AWCs, Anganwadi workers indicated repeatedly that mothers now associate weighing with efforts to identify undernutrition and address it; they now increasingly insist that their children be weighed.

The Mission is also attempting to create demand through mass communication. Informative advertisements on nutrition are regularly aired on prime TV news channels and radio stations at frequent intervals. These advertisements seek to inform the audience of the importance of nutrition, the concept of VHNDs and the role of frontline workers for improved child health and nutrition. The Mission, though, has not yet assessed the reach and effect of these advertisements.

The overarching aim of such extensive advertisements in the media is to create broader visibility for the Mission and for nutrition. Efforts are being made to generate ongoing coverage of Mission activities in the media to keep the nutrition issue alive in the public eye.

SNM's focus on population-based demand is a step towards improving health-seeking behaviours. It ultimately seeks to increase and sustain women's, adolescents' and children's use of nutrition services. The SNM has come to understand that improving nutrition services

[33]From CDOs Meeting PowerPoint: 4th Nov 2015

[34]From CDOs Meeting PowerPoint: 20th Feb 2016

[35]Ibid

will generate more demand in the community. It has therefore made efforts to enhance the training of frontline functionaries, like AWWs, ASHAs, ANMs, and Pradhans, with the overarching goal to create demand for nutrition services by improved counselling and information sharing.

Technical Support

UNICEF and other development partners have provided valuable technical support to the UP SNM, using lessons learned from the Maharashtra experience.

UNICEF's advocacy efforts and technical assistance have been major enabling factors in the establishment and functioning of the Mission in the state. Apart from providing technical expertise on nutrition, UNICEF also has been providing hands-on support to the Mission and has encouraged appropriate inputs from other partners. UNICEF works directly with the Mission office and has appointed a group of consultants to help the Mission monitor district-level progress. UNICEF also facilitates Technical Working Groups and Partners' Forums at the state level to maintain support and broad ownership of Mission activities.

Technical support for nutrition is also being provided to the government by the Bill & Melinda Gates Foundation (BMGF) – in 25 high-priority districts – Alive and Thrive, and other development partners (described in the next section under "Co-opting partners from public, private, and non-profit sectors").

4.2. Key Activities of the State Nutrition Mission

Innovative and Adaptive Programme Responses to the Complex Causes of Undernutrition

SNM has recognised that there is no "cut-and-paste" option. Instead, the Mission has evolved according to the changing state landscape and emerging opportunities.

While the UP used the experience of Maharashtra to develop its Nutrition Mission, the government and UNICEF were clear that the strategy and structure of the SNM must fit the UP context; the efforts of one state do not necessarily translate exactly to other states and need to be customised. A prime example of adapting to local reality has been the Adopted Village Model, which recognises the importance of government officials and the respect for hierarchy in a state like UP. This is one of the most important innovations of the UP Nutrition Mission; perhaps it would not work as well in another state.

SNM, jointly with Health and ICDS, co-facilitates an informal Triple-A forum of ANMs, ASHAs and AWWs to encourage grassroots collaboration, communication, and learning amongst these key functionaries.

Since its launch, the Nutrition Mission has been encouraging better dialogue and coordination among ANMs, AWWs and ASHAs – collectively known as AAAs. The Triple-A forum is active in 25 high priority districts, in those blocks where BMGF provides support to NHM. In this informal forum, ANMs convene all AWWs and ASHAs once a month to discuss plans for cross-departmental activities and to discuss uniformity in reporting across AAAs. At the same time, frontline workers informally discuss day-to-day successes and challenges in their work, thus encouraging peer learning. Community level activities, such as planning for VHNDs or VHSNC meetings, are conducted through this platform. Capacity building is promoted through the Triple-A forum.

The Mission has been actively promoting the delivery of quality maternal and child health and nutrition services during VHNDs, the only monthly outreach service delivery platform involving all three frontline workers (AAAs). VHNDs are organised monthly by AAAs in order to deliver a package of health and nutrition services. The Triple A forum was activated across the state by joint efforts of Health department and SNM for strengthening VHNDs. Nutrition Mission has strongly advocated with the Health department to ensure availability of essential medicines and supplies during VHNDs, which have traditionally focussed on immunisation services. By encouraging monitoring by foster officials, who adopted the villages, during VHND days, the quality of services of this outreach platform appears to have improved. The Mission's activities have also led to increased awareness among community members that VHND includes a basket of services, in addition to immunisation.

VHSNC is a committee designed to encourage local-level community action for improved Water, Sanitation and Hygiene (WASH) and nutrition. While NHM has a dedicated budget to support VHSNCs, and while the SNM is supporting them, there is still a long way to go to have them up and running. SNM is working actively with Pradhans to use the funds available in the budget.

The Triple-A forum is innovative and adaptive because it has established a common platform for frontline workers from ICDS and NHM – where nutrition interventions historically have been implemented vertically – to communicate and exchange lessons learned. This enables better planning and problem solving at the grassroots level, leading, in turn, to improved service delivery.

Building Human Capital to Support Programme Delivery

The SNM uses a "training of trainers" (TOT) model to train government officials across departments on the burden of undernutrition, the importance of good nutrition and optimal means of intervening, while at the same time encouraging multi-sectoral leadership.

The SNM, with the technical support from UNICEF, developed a TOT programme to train officials from five different departments on nutrition – Health, Panchayati Raj, ICDS, Education, and Rural Development – serving as message bearers throughout their networks. Through this training programme, government officials across these departments were trained on nutrition specific and sensitive interventions, and the core activities of the SNM for the first time.

The objectives of these trainings have been to: sensitise departments on SNM's vision, strategy and role as a coordinating body, sensitise departments on the multi-sectoral framework of undernutrition and the roles of various departments addressing undernutrition, improve community and facility-based service delivery through strengthened monitoring and feedback. Another objective of these trainings is to ultimately create a district-level pool of master trainers among participants who can share nutrition information with their departments.

Many of the master trainers have been used as resource persons for district level nutrition trainings. For example, block level training of Pradhans was organised under the umbrella of SNM with the support of master trainers trained at the state level. Almost 43,000 gram pradhans were trained on Nutrition, VHND and VHSNC.

TOT was also organised jointly by Health and Nutrition Mission for creating district level trainers on VHND.

The TOT model is helping to build the capacity of frontline workers through a cascading approach in order to ensure they are equipped with strong technical skills.

VHND trainings operate under this TOT cascade model, where: (a) CDOs are responsible for ensuring that all districts have master trainers who completed the programme at the state level, (b) these master trainers train district-level staff, and finally, (c) AAAs are trained (three-day skill training for ASHAs, and one-day joint training for ASHAs and AWWs). Almost 225,000 frontline functionaries were trained.

Interviews with FLWs indicate a positive response to this training. They cited new knowledge about Mid-Upper Arm Circumference (MUAC), the importance of weighing children, and the establishment of new NRCs in nearby District Hospitals for referral. One AWW commented that continuous training acts as “a good refresher” for the services and record keeping she provides.

Key informants explained that some challenges in improving the capabilities of nutrition stakeholders at all levels are the sheer numbers of potential trainees and the frequency of staff turnover – plus the turnover rate of government officials. These human resource challenges can be studied further to ensure adequate training.

Supporting Convergence of Efforts Within the Public Sector

SNM leadership has made serious efforts to increase ownership of nutrition among all relevant departments and sectors, most notably through the Adopted Village Model, which has increased ownership for nutrition among government officials.

The Adopted Village Model may have its shortcomings insofar as the Gram Sabhas and villages that are adopted are not necessarily the most vulnerable to undernutrition (i.e., undernutrition burden is not considered when selecting a Gram Sabha for adoption). However, the model seems to work very well in a state like Uttar Pradesh, where hierarchical systems often defy change. Even though the most vulnerable villages may not yet be the Mission’s primary focus, the model has led to movement on the ground and to an increased sense of ownership by government officials, and has accordingly been successful in getting nutrition in UP “un-stuck” for the first time.

This “ownership” factor appears to be pivotal. Officials regularly visit villages and claim to be significantly more aware of village problems as a result. There have been some unexpected wins in the form of toning up of the system due to frequent visits by officials – including of departments not explicitly targeted. A case in point is the improvement of schools in villages adopted by an official from the education department.

Key informants consistently indicated that the village adoption strategy has been successful in improving the effectiveness of ongoing programmes through regular supervision. “There is better monitoring and supervision in the adopted villages,” commented a district government stakeholder.

The Mission's reporting format (now including photographs) further facilitates this ongoing supervision and helps to assure regularity. Increasingly, the "Best 5" and "Bottom 5" districts are selected by SNM website based on monitoring and data reports – a step which breeds healthy competition amongst districts.[36]

Despite these efforts, there continue to be gaps in monitoring by district officials, even in the adopted village programme. Village-level stakeholders indicated that some officials have not been able to make monthly visits. State-level informants also indicated difficulty in getting timely reports from all districts. According to a state government official, "25-30% of the districts are not reporting on time".

The gaps notwithstanding, these visits to villages have far-reaching effects. District officials come in regular contact with frontline workers and with the parents of severely underweight children in their adopted villages. This provides perspective on their work – adding faces to data points and recommendations. Through this model, government officials themselves acknowledge that as long as officials are making visits to villages under the Mission, they will assume ownership and make special efforts to assess and improve service delivery relating to their own government department.

At the state level, SNM has facilitated horizontal coordination among nutrition-relevant departments and sectors.

Stakeholders from the 6 nodal departments cite convergence as one of the key successes of the Mission. "Inter-departmental coordination has improved a great deal; everyone is working under one umbrella,"said a state government stakeholder. This was further reinforced by non-government stakeholders: "Departments are working together because of the Nutrition Mission, which is facilitating discussion between departments."

Among the accomplishments in improving convergence noted in these interviews are the following:

- The SNM helped support the Spot Feeding Scheme trial, which is largely implemented through ICDS.
- The SNM has been working closely with the ICDS to conduct Vajan Diwas and with Health on the Matritva Saptah.
- The Mission has been working with the Department of Panchayati Raj to enhance the construction and utilisation of toilets especially in the adopted villages.
- The Mission is collaborating with the Department of Food and Civil Supplies to add nutrition messages in ration cards.
- The Nutrition Mission is planning to expand its partnership with the State Rural Livelihood Mission (SRLM) through regular meetings and integrated activities. SRLM has been highly cooperative in working with the Nutrition Mission and in integrating health and nutrition into its activities.
- The SNM has been successful in engaging with the Department of Medical Education. One of the positive outcomes of this high-level engagement is the inclusion of IYCF (Infant and Young Child Feeding) curricula in medical schools.

[36]Ranking is based on visitation rates. SMNet data also ranks best performing (rst two) and low performing (last two) districts based on: availability and use of weighing machines for children and adults, haemoglobin testing and distribution of iron and folic acid tablets at VHND sites, and use of growth monitoring charts

- The Mission has worked with the Education Department to develop school curricula for classes 1-8 to make them more nutrition, health, and sanitation friendly. The curriculum has been sent out for printing by the Education Department.
- Stakeholders also indicated better understanding of the importance of the multi-sectoral approach to tackle undernutrition and to address its underlying determinants. Many have attributed this increased understanding to advocacy and training undertaken by SNM and UNICEF.

SNM helped advocate for the Spot Feeding Cum Counselling Scheme (Hausla Poshan Yojana), implemented through ICDS, and successfully helped leverage US $76 million for ICDS to roll out the Scheme through state government funds.

One of the objectives of the SNM is to promote increased and improved nutrition services through other departments. However, given that departments often have little flexibility to use the budget they have for purposes that were not approved in advance (an issue noted as a particular challenge in key informant interviews), there is a need for advocacy efforts linked with the policy and budget management cycle in order to influence budgetary support for services.

The Spot Feeding cum counselling Scheme (known as Hausla Poshan Yojana) provides additional hot cooked meals to pregnant women and severely underweight children through AWCs and is an opportunity to improve registration and deliver services such as iron and folic acid supplementation. The objective of the scheme as stated by the Mission is to improve nutritional status of pregnant women and children under-five. SNM proposed budget for the scheme in December 2015 (described above under "oversight mechanisms") and the funds were made available by the state government for the financial year 2016-17.

At the district level, District Nutrition Committees with DMs and CDOs help to improve coordination, monitor progress, and build momentum among government officials.

The Mission has successfully engaged with DMs and CDOs – the highest-ranking officials at the district level – by organising District Level Nutrition Committees. These meetings have helped improve coordination among various nutrition-relevant sectors at the district level with DMs and CDOs holding district officials accountable for progress. UNICEF consultants, deputed to the Mission, have assisted with the development of technical presentations during these monthly District Nutrition Meetings. The DM or the CDO chairs these meetings, which ensure participation of all sectors concerned.

These meetings offer a platform for discussion on district-wide issues related to nutrition. Apart from coordination and joint planning, stakeholders indicated that these meetings have also served as platforms for sharing innovations and best practices. "All departments are coming together to discuss one issue (nutrition), which has never happened before for any other topic," commented a district government stakeholder.

In July 2015, the decision was made to appoint CDOs as CEOs of the Mission at the district level. This helped cement their commitment to the Mission and underlined their responsibilities to help improve nutrition.

The Adopted Village Model and monthly District Nutrition Committee meetings help spark healthy competition – or peer pressure – among officials, motivating them to improve nutrition.

The fact that all officers are required to visit their villages, and that it is regularly monitored by the DM, who is the highest officer in the district hierarchy, has led to most officers making the visits. The Mission took a carrot-and-stick" approach by publicly recognising the best efforts among district cadres and frontline workers and also acknowledging those performing below par. In monthly District Nutrition Committee meetings, the DM or CDO have been singling out the best and worst performers of that month. The meetings also discuss best practices and areas of that need improvement.

At the village level, SNM encourages convergence between ICDS and NHM frontline workers through VHNDs and VHSNCs.

VHNDs offer an opportunity for convergence among AAAs. The SNM has devoted considerable energy to activate the VHNDs by providing joint VHND training to AAAs, which several stakeholders stated have helped improved coordination among frontline workers. These trainings, as well as the acknowledgement and reward of good performance by frontline workers, have also contributed to greater motivation among these grassroots workers.

Stakeholders indicated that the Mission played a critical role in activating VHSNCs, which are headed by the Gram Pradhans. The Gram Pradhan has a joint account with the ANM to work on village-level activities. Through this, ANMs are in the position to inform the Pradhan about small items that may be needed, and procure them through these funds, to ensure things go smoothly. These items are usually small ticket items like soap and other such commodities, but are important to promote practices related to hygiene. The training that the Mission provides to Pradhans, sensitising them on the importance of nutrition and how to intervene, enables utilisation of VHSNC funds. Involving the Pradhan is important to build community support for initiatives like VHNDs and VHSNCs, and is another example of a grassroots innovation undertaken by the Mission. Previously, chunks of these funds, available to local committees, went unutilised.

Regular nurturing by state officials helps ensure a high level of motivation to achieve the Mission goals. It is hoped this motivation level continues should there be a change of government after the state elections of 2017. If the succeeding government does not give as much weightage to nutrition as the current government, the efforts, which have only started to yield results, may go in vain, considering that high-level attention is very important to push for things in UP.

Challenges to improved convergence across sectors include lack of accountability for nutrition outcomes and transient leadership roles.

Coordination among different departments has been challenging in UP as in other states because it involves sectors with different mandates, vision and understanding of how these sectors are linked to nutrition outcomes. Some stakeholders noted ownership issues as well: "Health feels that Nutrition is ICDS's job." This reflects a hazy understanding of roles and responsibilities across sectors, something the SNM is actively trying to change (i.e., through TOT trainings).

Several stakeholders interviewed by the documentation team expressed concerned that changes in the leadership of any department act as a barrier for coordination, given that

effective coordination is highly dependent on the motivation of the leaders. "If a proactive leader gets transferred, the string just breaks," commented a state government official.

Co-opting partners from public, private, and non-profit sectors

SNM establishes partnerships with non-governmental organisations –civil society, technical partners, and donors – to improve nutrition service delivery, advocacy, and coordination.

Coordination with non-government organisations (including the private sector, academia, and civil society) is important for the success of nutrition programmes and policies in the state. According to key informants, SNM has opened the line of communication between government sectors, donors, and non-governmental organisations that are working on nutrition and cross-cutting issues.

SNM representatives participate in a number of technical working groups and partners' forums at the state level. Additionally, SNM also holds meetings with non-governmental partners and development partners who are working in nutrition, to facilitate joint planning and coordination.

The Mission collaborates with BMGF through regular meetings and advocacy for nutrition. The Triple-A forum for frontline workers is operational in the 100 blocks of the 25 high-priority districts where BMGF has Technical Support Units. BMGF community resource persons (of which there are 300 across the 25 districts) help mentor frontline workers and build capacity. BMGF has been supporting the government with frontline worker coordination, VHNDs, the development of a counselling booklet for the Spot Feeding Scheme (created jointly with Alive & Thrive) and strengthening data and monitoring systems for nutrition.

The DG indicated that the Mission intends to pass on monitoring responsibilities to BMGF in these districts. Other partners – including Alive and Thrive, the World Bank, and Micronutrient Initiative – have also been actively participating in the coordination meetings. The Micronutrient Initiative is conducting pilots for double fortified salt and working on adolescent anaemia in 10 additional non-BMGF districts and on vitamin A and IFA supplementation. Alive and Thrive[37] has been involved with the Mission since February 2016 on behavioural change communication efforts.

In some districts, the private sector has engaged with SNM by adopting villages. SNM could do more to engage with the private sector in public-private partnerships and with academia for research and capacity building on nutrition.

Enabling Evidence-based, Data-driven Decision-making

SNM partnership with the state's Social Mobilisation Network (SMNet[38]).

At the community level, SNM has partnered with SMNet community mobilisers, supported by the Mission to monitor VHNDs. The SMNet mobilisers monitor indicators to assess core

[37]Alive & Thrive has been working with BMGF Technical Support Units (TSU) as its knowledge partner. It is also involved in advocacy work (advocacy tools for policymakers, preparation and dissemination of toolkits on breastfeeding, complementary nutrition, maternal nutrition, etc.), communication (tools for FLWs, job aids, TSU's community resource personnel providing handholding for FLWs), mass communication, and strategic use of data (community behaviour tracking survey and formative qualitative research)

[38]SMNet was established in UP by UNICEF in 2002, and works in particularly vulnerable blocks. SMNet played an important role earlier in polio eradication in the state

functioning of VHNDs, including: availability of child and adult weighing scales at the VHND site, use of weighing scales at VHND sites for children and pregnant women, haemoglobin testing, distribution of IFA tablets, IYCF counselling, counselling to pregnant women and use of growth monitoring charts.

Monitoring results provided by SMNet are presented during state level meetings and district nutrition committee meetings.

Monitoring and evaluation is a key component of the UP SNM vision. SNM developed a divisional feedback website for officials to report and monitor nutrition progress.

"Whatever you don't monitor doesn't get done." – State Government Stakeholder.

One of the key mandates of the Mission is to act as a monitoring body and track progress on nutrition schemes and interventions.[39] As the Adopted Village Model evolved, SNM developed a website to help officials track progress. The website provides a platform for officials to upload district survey reports, meeting minutes, information of monitored VHNDs from adopted villages and other data.

This website also generates summary reports for the SNM to review. The DG regularly monitors SNM activities and, with technical support from UNICEF, reviews the performance of the districts based on the information uploaded to the website. SNM reviews the performance of districts using such qualitative indicators as the quality of district Nutrition Committee Meetings and the quality of visits by district officials. SNM also tracks quantitative data on the number of severe underweight children identified, indicators on the Spot Feeding Scheme and improvements in their nutritional status, uploading this data on its website (as indicated above, the data is monitored by SMNet).

Though it is yet to roll out, SNM has developed District Report Cards to assess progress, based on predefined parameters, including timely submission of the monthly report, presence of the DM and CDO at the monthly district meetings and adoption of villages by key government officials. The Report Cards will help rank districts as highest performing and worst performing – the latter will be held accountable by SNM.

Several stakeholders reported improvements in ICDS and Health department activities because of SNM. "ICDS activities are closely monitored by the Mission and they are now working better," said a state non-government stakeholder.

The Adopted Village Model encourages district officials to monitor progress within districts, opening up opportunities for improvement.

"Because of competition among districts, DMs and CDOs are actually visiting communities to monitor activities." – State Government Official

[39]Government of Uttar Pradesh. (2014-2024). State Nutrition Mission Uttar Pradesh Vision Document. Government of Uttar Pradesh

Several district-level government officials reported how seriously the DG takes their feedback, and how determined he is to address community-level bottlenecks in a timely manner. AWWs from the adopted villages have been trained by the SNM on accurate reporting of growth monitoring data. They have also been encouraged to maintain a red register for recording and tracking severely underweight children. In order to ensure a robust online data tracking system, SNM has appointed data entry operators in each district to enter growth-monitoring data, reported by AWWs,[40] into the computer. As a result, increased attention is being paid to the trends in key indicators – most importantly, whether or not they are improving.

A challenge to monitoring and evaluation is timely access to high quality nutrition indicator data. While the proposed District Report Cards will be useful for process monitoring, they currently do not include outcome indicators important to measure progress.

As is clear from the above, the primary attention to data – with the exception of growth monitoring data – has been on qualitative indicators (e.g., timely submission of the monthly reports, presence of the DM and CDO at the monthly district meetings, adoption of villages and regular visits by district officials). These also have been the primary indicators on the proposed District Report Card. While this represents a marked improvement from the pre-Mission period, in the longer run it is inadequate to assure well-functioning service delivery.

Additionally, despite considerable efforts by the SNM, there continue to be substantial gaps in data for nutrition and growth monitoring indicators. Stakeholders expressed their concern that getting correct and accurate data is still a major challenge, which points to a larger challenge in data collection within ICDS and NHM. During the district visits, the documentation team heard from some AWWs that data reporting has been overburdening them; one AWW remarked: "I see registers even in my dreams."

In the current national Health Management Information System (HMIS), indicators for the reporting of vitamin A and IFA distribution are inadequate, a problem clearly in need of attention.[41] During the state-level interviews, the documentation team heard of an interest in initiating a UP-specific HMIS although some informants expressed scepticism.

[40]The Anganwadi Workers submit their data to the Anganwadi Supervisors, who submit the data to DCEO of ICDS

[41]The HMIS collects data on (a) the number of IFA tablets received by a pregnant woman during antenatal care (ANC) and (b) the number of Vitamin A doses administered. Far more valuable would be (a) the percentage of women who received at least 100 IFA tablets during their pregnancy, and (b) the percentage of children aged 12-59 months who received vitamin A supplementation within the past six months

Chapter 5

Budget Analysis

A budget analysis was conducted with support from UNICEF in order to provide an overview of nutrition prioritisation – in terms of budgetary allocations – across nutrition-relevant departments in UP. First, the team identified all nutrition-specific and nutrition-sensitive departments to be included in the analysis, as well as the interventions or programmes within departments to be included (a list of nutrition-relevant programmes included in the budget analysis is included in Annex D). Second, with support from UNICEF, the research team analysed government budgets from the fiscal years 2014-15 and 2015-16 to understand current levels of financing for both nutrition-specific and -sensitive programmes in the state. Finally, in a high-level financial gap analysis, current budgetary allocations were compared with the estimated cost to scale up a package of nutrition-specific interventions. This analysis is meant to provide a high-level snapshot on budget allocations for nutrition.

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This budget analysis has not applied percentage allocations – or "weights" as they are commonly referred to in the field of nutrition – to nutrition-sensitive programming.[42] Instead, the full programme activity costs are presented (See Annex D for a list of programmes and activities included). This was done in order to assess the total contributions available for nutrition-sensitive programming. Future analysis is needed to understand the particular components currently aimed at improving nutrition within each nutrition-sensitive programme. This information is necessary in order to advocate for enhanced nutrition-sensitive programming across departments.

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5.1. Nutrition-specific Initiatives and Gap Analysis

Budget Allocations for Nutrition Specific Initiatives

In the fiscal year of 2015-16, the Department of Health budgeted Rs 241 crore (US $39 million)[43] for nutrition-specific interventions, and ICDS budgeted Rs 4,836 crore (US $780 million) for nutrition-specific interventions (most of which is allocated to the Supplementary Nutrition Programme).[44] In total, this amounts to Rs 5,077 crore (US $819 million) for nutrition-specific activities across both departments (Table 5.1). While for ICDS almost the entire budget of the department is directed to nutrition-related activities (73% of the total departmental budget is considered nutrition-specific), the opposite is true for the Department of Health – 3.6% of NHM's Programme Implementation Plan in 2015-16 is directed towards nutrition-specific interventions.

[42]Fracassi, P., & Picanyol, C. (2016). Tracking government investments for nutrition at country level

[43]The conversion rate used by the government was applied for this Chapter (1 US $ = 62 INR)

[44]While SNP is considered nutrition-speci c by the government in this analysis, the ICDS age range of 0-6 years does not match the recommended 0-2 year target age range for most nutrition-speci c interventions to focus on the first 1,000 days

Table 5.1. Nutrition-specific approved budget allocations within Health and ICDS

		2014-15		2015-16	
Department	Thematic Area	Total budget allocation (Rs. Lakh)	Share of departmental budget (%)	Total budget allocation (Rs. Lakh)	Share of departmental budget (%)
Health	Micronutrients	13,118	3.6%	15,863	2.4%
	RBSK	4,428	1.2%	5,906	0.9%
	NRC	838	0.2%	1,473	0.2%
	IDCF	-	-	750	0.1%
	IYCF	269	0.1%	85	0.0%
	Activity under WIFS/MHS/ RBSK	36	0.0%	13	0.0%
	TOTAL nutrition-specific	18,689	5.1%	24,090	3.6%
ICDS	Supplementary Nutrition Programme	469,164	66.3%	465,675	70.1%
	Cooking logistics	11,625	1.6%	-	-
	Training	4,992	0.7%	14,023	2.1%
	Sneh Shivirs	3,202	0.5%	1,462	0.2%
	Infant and Young Child Feeding practice	471	0.1%	2,406	0.4%
	TOTAL nutrition-specific	489,454	69.2%	483,566	72.8%
Total nutrition-specific across ICDS and Health		**508,143**	**NA**	**507,656**	**NA**

Figure 5.1: NHM nutrition-specific budget allocations

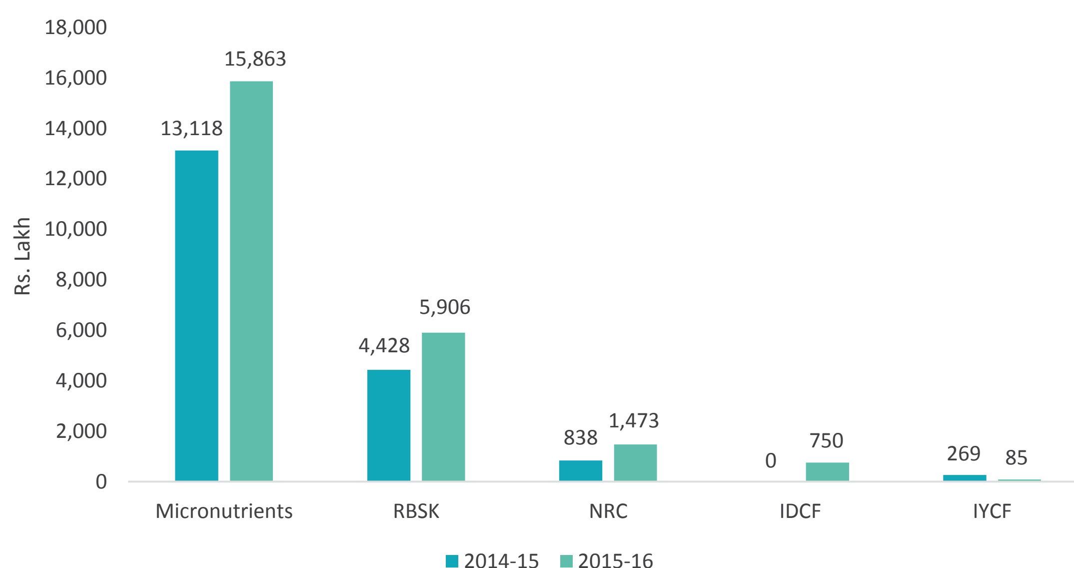


Figure 5.1 shows the budget breakdown for the core nutrition-specific activities delivered through the Health department: micronutrient supplementation (including iron and folic acid for pregnant women, vitamin A for children, zinc and oral rehydration solution for children), Rashtriya Bal Swasthya Karyakram (RBSK), a programme to reduce child mortality that includes micronutrient supplementation and treatment of severe acute malnutrition, Nutrition Rehabilitation Centres (NRCs), Intensified Diarrhoea Control Fortnight (IDCF) and counselling for Infant and Young Child Feeding (IYCF).

Within Health, micronutrient supplementation by far received the largest budget allocation compared with the other interventions. In 2015-16, this category of interventions received Rs 159 crore (US $26 million) in total, or Rs 78 per child under-five. Of this funding, 60% went to IFA supplementation for all women registered under government facilities.

For this first-ever look at UP's nutrition budgeting, trends could not be analysed because there were only two fiscal data points (2014-15 and 2015-16). The allocation for ICDS's nutrition-specific programmes decreased by about 1% (about Rs 59 crore or US $10 million) between the two budget years. Within Health, there was an increase in almost all programmes. Budget allocations for micronutrients, RBSK and NRCs increased by 1.2, 1.3 and 1.8 times, respectively, over the two years (Figure 5.1). More granular analysis must be carried out to assess these changes, especially in the context of larger departmental budgetary processes.

Analysis of Budgets Against Resource Needs

In 2015, POSHAN assessed the annual resource need to scale up a set of 14 high priority nutrition interventions that are relevant for India's policy framework referred to as the India Plus interventions.[45] The interventions within this set include:

- Three food supplementation interventions: complementary food supplements, supplementary food rations (for children and for pregnant and lactating women), and additional food rations for severely malnourished children
- Four micronutrient interventions: Vitamin A supplementation for children, iron supplements for children, iron-folic acid supplements for pregnant and lactating women, oral rehydration salts (ORS) and therapeutic zinc supplements for treatment of diarrhoea
- Deworming for children and adolescents
- Facility-based treatment of severe acute malnutrition
- Three IYCF counselling interventions: counselling during pregnancy, counselling for optimal breastfeeding, counselling for complementary feeding and hand-washing
- Maternity benefits for breastfeeding mothers
- [Not applicable to UP] Insecticide treated nets for pregnant women in malaria-endemic areas

[45] Menon, P., C. M. McDonald, and S. Chakrabarti. 2015. Estimating the cost of delivering direct nutrition interventions at scale: National and subnational-level insights from India. POSHAN Report No 9. International Food Policy Research Institute, New Delhi. http://poshan.ifpri.info/2015/12/31/estimating-the-cost-of-delivering-direct-nutrition-interventions-at-scale/

POSHAN estimated it would cost about Rs 7,219 crore (US $1.2 billion) annually for the India Plus interventions to be delivered at scale across UP. This estimate includes costs to maintain current coverage and programming within the package plus additional costs of scale up.

A subset of these interventions is already funded through ICDS and NHM. Table 5.2 illustrates the estimated costs of the India Plus interventions as compared to the departmental budget available for the costed interventions, as extracted from the budget with the support of UNICEF (see Table 5.1). For purposes of this analysis, some of these interventions have been aggregated, as budget lines are often not available at the fully disaggregated intervention level.

The interventions can be divided into three main groups based on the funding context: 1) interventions that are currently funded by the government that have budget allocations that surpass the cost estimates, 2) interventions that are currently funded by the government but where budget allocations are lower than the total resource need, and 3) maternity benefits, which is the only intervention that is not currently implemented by the government.

First, for food supplementation activities and the IFA/iron/vitamin A interventions, it appears that budget allocations surpass the estimated resource needs (significantly so in the case of supplementation for children). However, when looking at current coverage rates in UP for some of these interventions, such as SNP coverage for children (23%), SNP coverage for

Table 5.2.Total annual costs for India Plus interventions compared with budget available from Health and ICDS

Funding context	Intervention	Total annual cost (Rs. crore)[46]	Total available budget through Public Health and ICDS (Rs. crore)	Difference (Rs. crore)
Funded – budget allocations surpass cost estimate	Food supplementation (children)	1,786	3,309	(1,523)
	Food supplementation (Pregnant and lactating women)	823	1,019	(196)
	Micronutrients: IFA, iron, vitamin A	159	160	(1)
Funded – interventions show a resource gap	Micronutrients: Zinc, ORS for treatment of diarrhoea	80	9	71
	Deworming	26	9	17
	Treatment of severe acute malnutrition	201	74	128
	IYCF Counseling	319	25	294
Currently unfunded	Maternity benefits	3,825	-	3,825

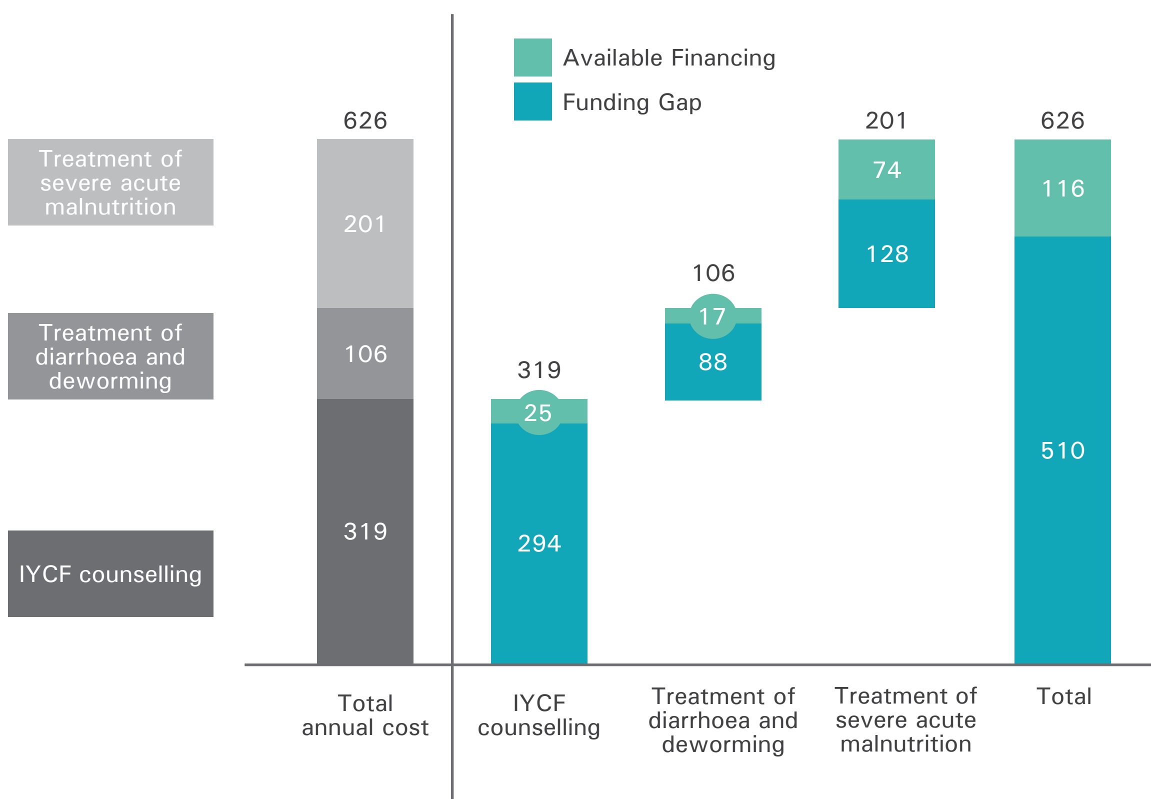
[46]Menon, P., C. M. McDonald, and S. Chakrabarti. 2015. Estimating the cost of delivering direct nutrition interventions at scale: National and subnational-level insights from India. POSHAN Report No 9. International Food Policy Research Institute, New Delhi. http://poshan.ifpri.info/2015/12/31/estimating-the-cost-of-delivering-direct-nutrition-interventions-at-scale/

pregnant and lactating women (24%), vitamin A supplementation (27%), or iron and folic acid supplementation (27%) (Annex B), it is clear that these interventions are not currently reaching all target beneficiaries. The discrepancy between low programme coverage and seemingly adequate funding could be because budget estimates do not indicate actual expenditures (which in practice could be much lower), because current funding is not being used as efficiently as possible, or because the cost estimates to scale up these interventions underestimate what is needed. Further work is needed to assess the alignment between cost and financing estimates, utilisation of budgeted funds, and whether more could be achieved by the programmes with their current budget allocations.

Next, interventions, including the treatment of diarrhoea (through zinc and ORS), IYCF counselling and the treatment of severe acute malnutrition, are currently being implemented to some extent, but are not receiving resources sufficient to meet the estimated resource needs for full scale up. The resource gap to scale up these remaining core interventions is estimated to be Rs 510 crore (US $82 million) annually (Figure 5.3).

Finally, maternity benefits is the only intervention that is currently not being implemented by the government to any extent. The estimated annual resource need is very large (Rs 3,825 crore), representing more than half the estimated total resource need, but no funding has been earmarked in the state budget for this purpose. The size of the current resource gap for this intervention is therefore larger than the nominal surplus in funding for the food supplementation interventions, indicating that additional resources will need to be mobilised if this full package of interventions is to be scaled up.

Figure 5.3: Annual resource gap for three intervention areas in UP based on POSHAN cost estimates (Rs crore)



5.2. Nutrition-sensitive Initiatives

The following departments were considered to have nutrition-sensitive investments (See Annex D for a list of activities included under each department): Health, Education, Agriculture, Rural Development, and Panchayati Raj Institutions. We did not include Rural Livelihood Mission, which houses the self-help group programme, in this assessment of nutrition-sensitive financing. The self-help group programme is not state-wide yet, and the scheme's annual budget[47] could not be broken down into activity-level items needed to categorise funding as nutrition-sensitive.

The UP government budgeted Rs 7,721 crore in 2014-15 (US $1.2 billion) and Rs 9,598 crore in 2015-16 (US $1.5 billion) for nutrition-sensitive programmes across all of these five departments. Figure 5.4 shows total nutrition-sensitive budget allocations by department.

Both years Rural Development contributed the highest absolute amount (Rs 4,743 crore or US $765 million in 2015-16) as well as the highest amount as a share of its total departmental budget (39 per cent in 2015-16). These investments go towards the State Water and Sanitation Mission, the National Rural Drinking Water Programme and the National Rural Employment Guarantee Scheme.

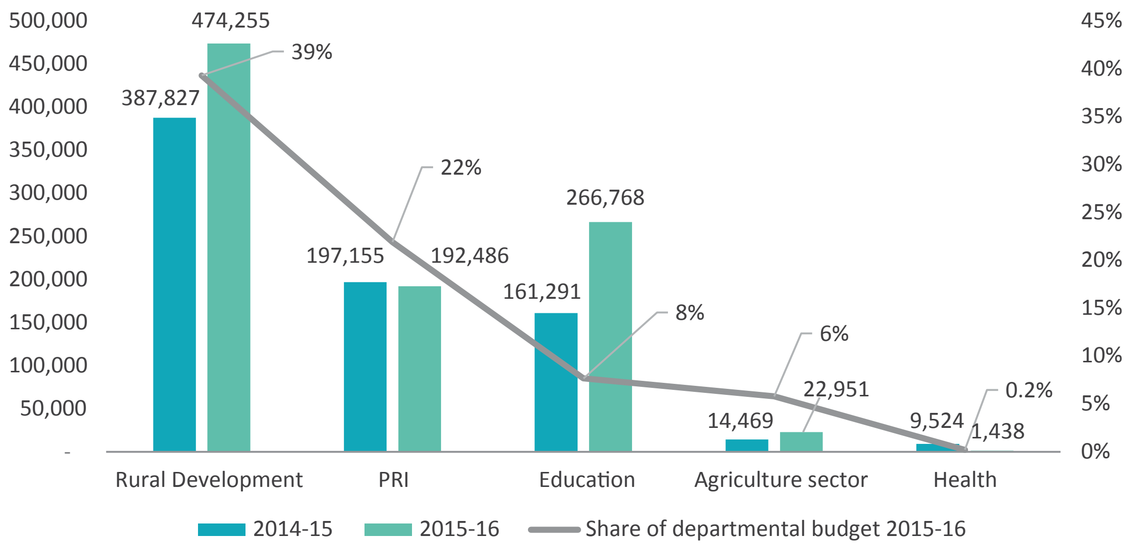
The Mid-Day Meal Scheme, implemented through the Department of Education, represents the next largest nutrition-sensitive investment in 2015-16 – all of the Department of Education's nutrition-sensitive budget allocations go to this programme. While Figure 5.4 shows a steep rise in budget allocations for this programme between the two years (2014-15 and 2015-16), more analysis required to assess whether this reflects a real increase in funds available or an artefact of just two data points.

Note that there is a wide range in how much each department contributes to nutrition-sensitive activities as a share of their total departmental budgets: on the low end, agriculture included 6% of its budget as nutrition-sensitive and Health less than 1%. Notably, most of Health's contributions go towards nutrition-specific interventions which, when combined with nutrition-sensitive investments, make up about 4% of its budget. A deeper look into the agriculture and health programme budgets may be necessary to determine whether some nutrition-sensitive programmes are not being adequately captured.

While this analysis provides a snapshot of nutrition-relevant budgeting across sectors, more work needs to be done to analyse the nutrition-relevant components within these programmes, and to assess where and how to leverage current budgets to make them more nutrition-sensitive.

[47]The Rural Livelihood Mission was budgeted Rs 2,995 lakh in 2014-15 and Rs 8,261 lakh in 2015-16

Figure 5.4: Multi-sectoral nutrition-sensitive budget allocations



Chapter 6

Conclusions

Uttar Pradesh alone makes up about a sixth of India's 1.2 billion population. Its achievements have significant influence on the nutritional outcomes of India as a whole. Undernutrition is an issue of such concern in UP that the present efforts by SNM to create synergy between the efforts of government departments to jointly tackle the problem are both welcome and praiseworthy. The preceding chapters provide an overview of the UP SNM, document enabling factors that have helped to shape the Mission, describe some of its key activities and present a budget analysis for nutrition in the state.

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Overall, the UP SNM has made remarkable progress in a short period of time since its inception in 2014. Some of the salient accomplishments include:

1. A village adoption programme which has increased ownership of the SNM mandate among district officials and the accountability of frontline workers.

   The Adopted Village Model is a cornerstone of the UP Nutrition Mission; it brought in early success by generating attention and resources to the issue of undernutrition in the state. Designed to leverage the existing supervisor-level human resource of the state government, the programme achieves multiple objectives: it ensures that village-level workers are regularly supervised in their work on nutrition, the ICDS and NHM systems work together effectively on the ground, there is awareness of the problem at the district level, officers across the government system are mindful that synergistic action is of utmost importance at the district level.

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   It also ensures that undernutrition becomes hardwired into the consciousness of young administrative service officers as they begin their careers as district-level staff. The active interest of district officials and frontline workers makes them more likely to offer insights and suggestions for improvement.

2. Increased convergence with multiple development sectors

   Convergence lies at the heart of SNM's work. Working off a shoestring budget, the Mission carries out its main work through other departments which have or can be induced to begin nutrition-specific and -sensitive activities. The cooperation between departments has begun with initial emphasis on what each can do to support nutrition-specific activities; for example, by ensuring that the Department of Food and Civil Supplies provides ration cards to families with children who are severely underweight. This helps ensure that these families can overcome the challenge that undernutrition poses in its protracted history. Similarly, SNM has encouraged the Departments of Panchayati Raj and Education to prioritise actions such as building of toilets and modifications to curriculum that could improve nutritional outcomes.

3. Improved capacity of frontline workers

   SNM provided refresher training to frontline workers of both ICDS and NHM which they value a lot. Standardised material with powerful visuals have made the refresher training an effective capacity-building tool. This training has helped frontline workers to carry out their tasks with greater efficiency; at the same time it has also generated more enthusiasm. Now that there is better and more supervision, it also means frontline workers receive on-the-job training and support on an ongoing basis, thus improving their skills and resulting in greater clarity about the centrality of their role in the fight against undernutrition. With the emphasis that is placed on coordination at village-level VHNDs, frontline workers are also clearer about the synergistic nature of their jobs.

4. Significantly improved monitoring and reporting

   The availability of information regarding the situation on the ground has improved significantly the system's ability for corrective actions. Large-scale initiatives, such as Vajan Diwas and Matritva Saptah, have helped improve data availability on the nutritional status of pregnant women and young children in the state. These have served not only to raise awareness of the importance of nutrition during these critical life periods among frontline workers, but also local populations. There is also greater effort made now to complete monitoring data sheets and ensure their transmission to higher levels of the system.

   District Nutrition Committees now meet regularly, with the report mentioning whether or not the meeting was chaired by the District Magistrate. Trip reports of government officers who visit their adopted villages add another layer, thus toning up accountability systems. SNM's website and monitoring data provided by SMNet are important monitoring tools.

5. Creative and passionate leadership by SNM management

   The Mission could have been realised any of the gains without progressive leadership at the helm. This has been amply demonstrated by the management of the complex work that the SNM has been doing over the past two years. UNICEF has played a crucial role in providing staffing and technical support. Other development partners in the state, such as Micronutrient Initiative, Alive & Thrive and Bill and Melinda Gates Foundation, have also contributed to the sum of knowledge and effort that has gone into SNM. Support has been extended by related departments: notably, Medical Education, Civil Supplies, Basic Education and the State Rural Livelihood Mission. With support from the top levels within the government and under the guidance of the Chief Secretary, the DG has walked a challenging road to build a multi-sector response to undernutrition in the state.

Chapter 6 presents an overview of nutrition-specific and nutrition-sensitive funding available across departments. This landscape assessment could be enhanced by analysing the core components within nutrition-relevant programmes that contribute to the programme's impact on nutrition and an assessment of what could be changed or improved across departments to increase the nutrition-sensitivity of programmes. SNM could use this analysis to help with advocacy efforts and leverage funding across departments for nutrition – the budget analysis shows there is an annual resource gap of about Rs 510 crore (US $82 million). Generating data to influence the budget management cycle across departments may be the critical step towards enhancing convergence in the state.

As the UP SNM continues to develop and work towards its targets outlined in the Vision Document 2014-2024, it has the opportunity to build on its successes and learn from challenges as documented here. While recommendations for strategy development of the SNM were beyond the scope of this documentation exercise, Annex E provides some considerations for future SNM strategy and refinement.

The experience and lessons learned from the UP SNM can also be used to inform other states interested in establishing a State Nutrition Mission. The policy brief in this documentation series describes overarching themes and policy recommendations that emerged from documenting the Maharashtra and Uttar Pradesh experiences.[48] These policy recommendations could apply more broadly to states looking to set up a State Nutrition Mission or to strengthen their existing State Nutrition Mission.

[48]R4D. (2016). POLICY BRIEF: Lessons from the State Nutrition Missions of Maharashtra and Uttar Pradesh

Annex A

Nutrition-relevant Public Programmes in India

Table A.1: Key nutrition-specific and nutrition-nensitive nchemes & programmes and associated departments

Scheme/Programme	Acronym	Relevant Department
National Food Security Mission	NFSM	Agriculture and Farmers' Welfare
Public Distribution System	PDS	Consumer Affairs, Food and Public Distribution
Mahatma Gandhi National Rural Employment Guarantee Act	MNREGA, MGNREGA or NREGA	Rural Development
National Health Mission	NHM	Health and Family Welfare
Mid-Day Meal	MDM	Human Resource Development
Swachh Bharat Abhiyan	SBA	Ministry of Drinking Water and Sanitation
Integrated Child Development Services	ICDS	Women and Child Development
Indira Gandhi Matritva Sahyog Yojana	IGMSY	Women and Child Development
Rajiv Gandhi Scheme for Empowerment of Adolescent Girls	RGSEAG – Sabla	Women and Child Development

[a]Mahbub, Rifaiyat et al. (2016). Tracking Nutrition Financing in Rajasthan http://www.r4d.org/sites/resultsfordevelopment.org/ les/v3_R4D_NF%20in%20Rajasthan_ExecSummaryPg.pdf

Annex B

Basic Health and Nutrition Indicators in UP

Table B.1: Health and nutrition programme coverage Indicators

	NFHS 3	RSOC
Vitamin A (NFHS: 9-69 months)	9%	27%
Consumed 100 or more IFA tablets/syrup during pregnancy (90 for NFHS 3)	9%	4%
Institutional births	22%	62%
Mothers who had at least 4 antenatal care visits for their last birth (3 or more for NFHS 3)	27%	28%
Children under 6 months exclusively breastfed	51%	62%
SNP for children	15%	23%
SNP for lactating mothers	7%	24%
SNP for pregnant women	10%	24%
Salt iodisation	36%	48%
Improved drinking water source	94%	98%
Households using improved sanitation	21%	33%

Table B.2: Nutrition indicators

	NFHS 3	RSOC
Stunting	52%	50%
Wasting	20%	10%
Low-birth weight (0-35 months) (birth weight less than 2.5 kg)	25%	22%
Anaemia among pregnant women	52%	NA

NA = not available

Figure B.1: Trends in coverage rates of key nutrition-sensitive and nutrition-specific interventions in Uttar Pradesh

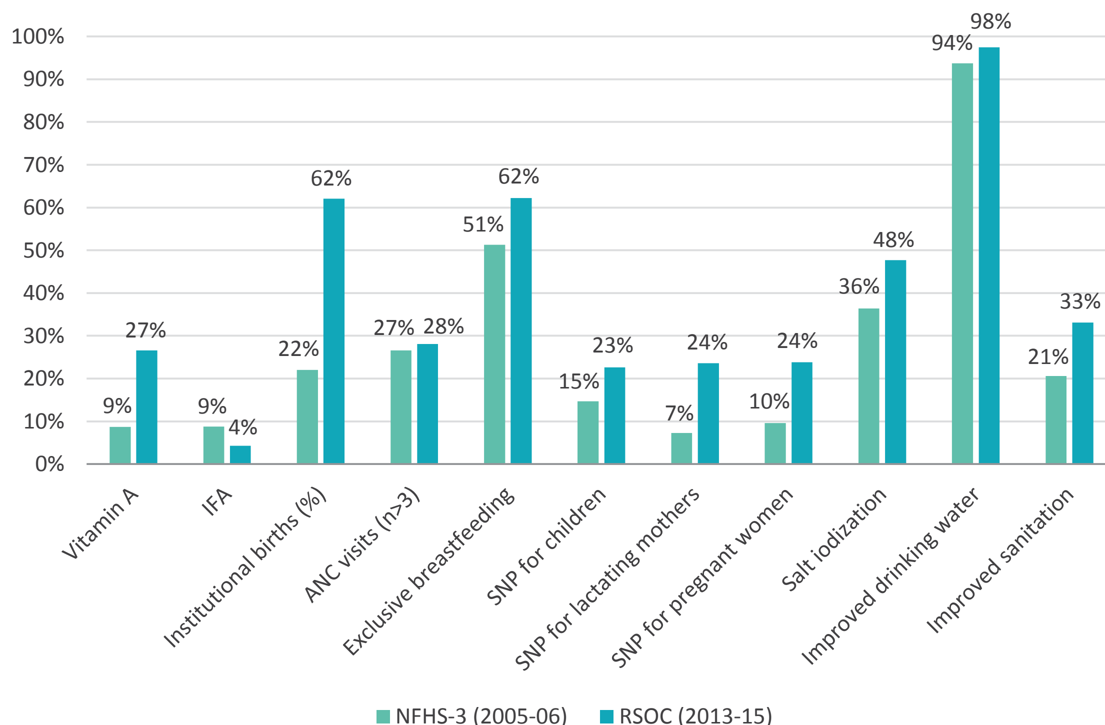
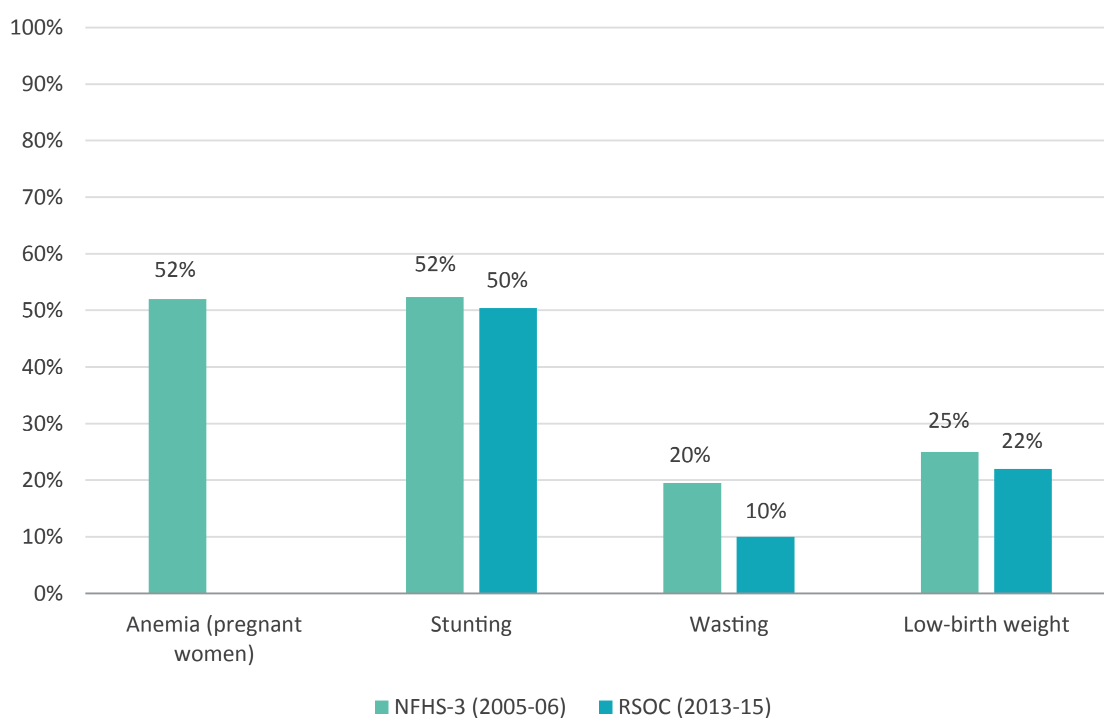


Figure B.2: Trends in nutrition indicators in Uttar Pradesh



Annex C

Key Informant Interviews

Table C.1: List of key informants interviewed in Uttar Pradesh

<table>
<tr><th rowspan="2">Level</th><th rowspan="2">Organisation</th><th colspan="2">Interviewees</th></tr>
<tr><th>Name</th><th>Position</th></tr>
<tr><td rowspan="6">State</td><td rowspan="2">UP State Nutrition Mission</td><td>Kamran Rizvi</td><td>Director General</td></tr>
<tr><td>Amitabh Prakash</td><td>Director</td></tr>
<tr><td rowspan="3">UNICEF UP</td><td>Richa Singh Pandey</td><td>Nutrition Specialist</td></tr>
<tr><td>Shradha Pant</td><td>Consultant</td></tr>
<tr><td>Mustafa Kamal</td><td>Consultant</td></tr>
<tr><td>Rural Development (SRLM)</td><td>Adil Abbas and Gaurav Tiwari</td><td>Thematic Lead and Mission Executive</td></tr>
<tr><td rowspan="5">State partners</td><td>Alive & Thrive</td><td>Shumitro Roy</td><td>Project lead in UP</td></tr>
<tr><td>BMGF
Technical Support Unit</td><td>Dr Sanjiv Kumar and Dr Manish Kumar</td><td>Team Leader, Technical Intervention, Project Director, Nutrition</td></tr>
<tr><td>Tata Trust</td><td>Amita Jain</td><td>Regional Head - UP</td></tr>
<tr><td>World Bank</td><td>Laxmi Durga</td><td></td></tr>
<tr><td>Micronutrient Initiative</td><td>Sunil Kumar</td><td>State Programme Representative</td></tr>
<tr><td>District and village</td><td>3 Districts:
Allahabad
Barabanki
Jaunpur</td><td colspan="2">Interviewees from the districts and villages included:
▪ DM and/or CDO
▪ Education, PRI, Health, and ICDS district officials
▪ AWC supervisors
▪ AAAs
▪ Beneficiaries: pregnant women with young children, adolescent girls
▪ Self-help group participants</td></tr>
</table>

Annex D

Nutrition-relevant Programmes Included in the Budget Analysis

Department	Thematic Area	Activity	Classification
Health	IYCF	Training of IYCF	Specific
		Newborn Care week	Specific
		Breastfeeding week	Specific
		IYCF promotion package	Specific
	Micronutrients	Micronutrients Programme (Cost of activities except cost of procurement of supplements)	Specific
		Zinc & ORS for Childhood diarrhoea	Specific
		Procurement of drug under Child Health (Vit A for BSPM)	Specific
		IFA Syrup (with auto dispenser)	Specific
		Albendazole Tablet (1-19 yr.)	Specific
		IFA CPW	Specific
		IFA tablets (5-19yr.)	Specific
	Activity under WIFS/MHS/ RBSK	WIFS/MHS Meeting	Specific
		RBSK convergence meeting	Specific
	RBSK	Mobility support for mobile health team	Specific
		Anaemia screening for 1 district	Specific
	IDCF	Intensified diarrhoea control fortnight programme	Specific
	NRC	Care of Sick and Severe malnourished children (NRC+CDNCs)	Specific
		NRC HR Cost	Specific
		NRC Software	Specific
		Mid-Upper Arm circumference (MUAC) tape for NRC	Specific
	Strengthening immunisation services		Sensitive
	Preventing and treating pneumonia, diarrhoea and malaria	SNCU, NBSU	Sensitive
	Family planning to prevent too early pregnancy		Sensitive

Department	Thematic Area	Activity	Classification
ICDS, WCD	Supplementary Nutrition Programme	Children 6 months to 3 yrs	Specific
		Children 3 yrs to 6 yrs	Specific
		Pregnant & Lactating women	Specific
		SABLA	Specific
	Training	Training	Specific
		Kishori Shakti Yojana	Specific
		MIS	Specific
		Sabla	Specific
		Requirement at each level (including new staff i.e. additional AWW, link worker etc.)	Specific
	Cooking logistics	Cooking Utensils & Stove or Gas	Specific
	Infant and Young child feeding practice	IYCF Tools-BF Folder	Specific
		IYCF Tools-BF Flip Chart	Specific
		IYCF Training	Specific
	Sneh Shivirs		Specific
WCD	ECCD Day		Sensitive
Education	Mid-Day meal		Sensitive
	Food management		Sensitive
	Cooking cost		Sensitive
Agriculture Sector	Availability and access to diverse nutrients dense foods coming from production	National Food Security Mission	Sensitive
Rural Development	State Water and Sanitation Mission		Sensitive
	National Rural Drinking Water Program		Sensitive
	National Rural Employment Guarantee Scheme		Sensitive
PRI	Rural Sanitation Programme		Sensitive
	Clean India Mission		Sensitive
	Bathroom Building		Sensitive
	Sweeper		Sensitive

Considerations for Future SNM Strategy Development

Although the UP SNM Vision Document sets targets up to 2025, there is a continuous need to reflect on the Mission's core approaches as the state continues to evolve. While providing comprehensive short-, medium-, and long-term strategy recommendations for the SNM requires intensive analysis – outside of the scope of this documentation exercise – here are some suggestions that could be considered in future.

Targeted Focus

Now that nutrition is being given more serious attention in the state, a sharper focus on the first 1,000 days, on vulnerable districts and on below-the-poverty-line (BPL) households is appropriate; this is consistent with international best practices. Doing this would mean targeting the following issues:

- **Child's age:** Focus (and ideally limit) child weighing to young children below 24 months.
- **Household income:** Limit on-site feeding to eligible young children from BPL households. Similarly, limit additional economic benefits (e.g., job cards and connection to the National Rural Livelihood Mission) to the households of eligible children from BPL households.
- **Nutritional status and risk of relapse:** Include as eligible for on-site feeding the growth falterers: young children who have failed to gain weight for two successive months – along with severely underweight children.
- **Pregnant women:** To address currently inadequate attention to pregnancies: Make clear to families – including husband and mother-in-law – that healthy pregnancy practices and antenatal care, leading to adequate pregnancy weight gain and good birth weight, are essential for the child's cognitive and physical development. Failure will mean poorer school performance and lower paying jobs. (This understanding is essential for demand creation, one of the DG's top priorities.)
- **Family members:** The Mission should seek to reach other key family members with its behaviour change communication efforts, including husbands and mothers-in-law, so that they, too, understand the benefits of healthy pregnancy practices, antenatal care, growth monitoring and proper IYCF (Infant and Young Child Feeding) practices.
- **Geography:** The Mission should use available data to identify and target high-burden districts and villages.

- **Adolescent girls:** The Mission should also strengthen its efforts to reach adolescent girls, whether it is through school or adolescent health days. Nutrition counselling before these girls become mothers will assure sustainability of this demand creation.

Attention to High-impact Nutrition-specific Interventions:

- The dangerously low coverage of the most basic nutrition interventions: vitamin A supplementation, iodised salt, and IFA distribution to pregnant women (and weekly to adolescent girls) needs to be addressed in the state as a whole.

Attention to Nutrition-sensitive Interventions:

- While systematic multi-sectoral nutrition convergence may be premature in UP, intensified nutrition inputs, and those from relevant sectors, should be encouraged.
- More intensive attention needs to be given, particularly in vulnerable districts, to the three underlying determinants of undernutrition identified by UNICEF: poor nutritional and health status of women of reproductive age and adolescent girls, poor sanitation and delayed introduction of nutrient-rich complementary food to infants – plus household food insecurity/low dietary diversity.
- Dietary diversity can be rapidly improved through increased women's involvement in homestead gardening and small livestock – carried out in ways which do not compromise women's childcare responsibilities – as well as counselling focused on increasing dal, milk, egg, and fruit intake.
- Convergence with other departments – especially Horticulture, Livelihoods and Agriculture – to promote dietary diversity and household food security in areas where this is a problem.
- Water, Sanitation and Hygiene (WASH) require special attention by the Mission – perhaps a task force responsible for forging the necessary convergence among sectors to rapidly increase both access to latrines and safe water and to increase significantly the percentage of total defecation-free villages in the state. These actions will need to be supported by the necessary monitoring and incentives. Note that WHO now considers poor sanitation responsible for 50% of undernutrition in the world.

Civil Society Engagement:

- An immediate concern is the effect a change of government following state elections in 2017 might have on the SNM. Accordingly, efforts should be launched without delay to mobilise civil society advocacy in the state (using organisations such as Citizens Alliance Against Malnutrition) to organise a systematic advocacy campaign during the election, along the lines of the advocacy carried out in Peru during the presidential election of 2006. A comparable campaign in UP could seek to elicit from each political party a signed commitment to continue and expand the efforts of the SNM, if elected.

Monitoring Progress:

- The Mission should organise a systematic evaluation of the effect on knowledge and practices of its nutrition-related behaviour change communication advertisements being aired on TV and radio. Assistance might be provided by Alive & Thrive.
- The Mission's effect at the village level and specifically on Gram Pradhans should be reviewed since, despite Gram Pradhan training, the Mission appears to be having a minimal effect at the village level. In this regard, the Maharashtra model, and its attention to local governance in promoting the maternal and child health and nutrition agenda, may be useful. This review should also include an examination of Village Health Sanitation and Nutrition and Committees (VHSNCs). Although the UP Mission made efforts to revitalise these committees, their contribution to the nutrition agenda to date remains unclear.

Partnerships:

- Build public-private partnership for nutrition on a larger scale. The private sector can play an important role in leveraging financial support for nutrition activities; the Mission, in turn, can advocate for leveraging Corporate Social Responsibility (CSR) funds from the private sector to support nutrition activities.
- Increase involvement of academic institutions in coordination meetings; academia can support research and can provide technical support.
- The SNM needs a carefully developed and phased plan to expand its training programme in ways that will reach the large number of frontline workers and other potential trainees and that will address the frequency of turnover among staff and more senior officials.
- The SNM should join with similar Missions in other states to seek improvements in the national HMIS regarding its nutrition indicators, including those used for the reporting of vitamin A and IFA coverage.

Monitoring and Evaluation (M&E) Recommendations:

- While the Nutrition Mission has been remarkably creative with process monitoring indicators (e.g., number of meetings held, the chairing of such meetings, timely submission of reports), it is time now to increase quantitative monitoring, with a focus on the most important indicators (see bullets below), and, accordingly, with revised reporting formats and with necessary retraining.
    - The percentage of young children (under 24 months of age) weighed in the past month;
    - The percentage of growth faltering children who have graduated (gained weight for two successive months);
    - The percentage of young children who have received a vitamin A supplement within the past 6 months;
    - The percentage of pregnant women gaining at least 1 kg during the past month;
    - The percentage of women who delivered recently and:
        - consumed at least 100 IFA supplements during their pregnancy
        - delivered an infant of adequate birth weight (2.5 kg or higher).
- This monitoring will require greater attention to denominators– e.g., accurate assessment of the number of children under age two in the coverage areas.
- Over time, the Mission should consider the integration of behavioural indicators in its monitoring and/or evaluation efforts. These could include
    - The percentage of children introduced to nutrient-dense complementary food at 6 or 7 months;
    - The percentage of children receiving ORS and zinc during bouts of diarrhoeal infection while feeding continues;
    - The percentage of pregnant women consuming more food than usual during pregnancy.
- While such monitoring will require increased record keeping by AWWs and their assistants, ASHAs and ANMs, it is important that undue pressure not be placed on these already overworked frontline workers. The SNM, therefore, should consider the utilisation of a full-time external (to the project) M&E entity with responsibility for particular monitoring functions including spot checks on data, facilitation of local utilisation of data, operations research where necessary, and periodic evaluations. This external entity also could be responsible for evaluating the Mission itself.