State Nutrition Policy

(2020-2030)

Department of Women and Child Development

Government of Madhya Pradesh

Chief Minister

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Acknowledgement

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1. Vision 2030

Madhya Pradesh nutrition policy envisions nutrition secure communities, where communities enable every member of the population especially children, adolescents, and women to attain optimal nutrition and health status, thus helping them to achieve good physical growth, development and cognitive potential with dignity.

The Vision is – *"Suposhit Madhya Pradesh" by 2030*

i.e., Freeing Madhya Pradesh from all forms of malnutrition, across intergenerational cycle.

This is detailed as –

***Suposhit* Children –** Reducing all forms of child malnutrition complying with the Sustainable Development Goals (SDGs) targets by 2030 and decreasingUnder-5 Child Mortality Rate (U5CMR) from the existing 56 (base year 2018-SRS) to 25 per 1000 live births" by year 2030 as per SDG target.

***Suposhit* Mothers –** Reducing Maternal Mortality Ratio (MMR) from existing 173 (2016-18) to <70 maternal deaths per 100, 000 live births by year 2030 as per the SDG targets and ensuring safe motherhood (100 percent Ante Natal Care, institutional delivery care by health professional and Post Natal Care).

***Suposhit* Adolescent –** Reducing anemia from existing 53.2 percent (National Health Family Survey -4 [2015-16] (NFHS-4, 2015-16) by half to 26.6 percent by year 2025 as per World Health Assembly (WHA) targets, ensuring gender equality, abolishing child marriage, focusing on skill development and women's economic empowerment.

***Suposhit* Adults –** Promoting better nutritional status and addressing individuals at nutritional risk (undernutrition and obesity).

Through this policy, We, the Government of Madhya Pradesh and the society at large express our commitment towards achieving the Sustainable Development Goals by establishing a "*Suposhit Madhya Pradesh*" through effective community centric-Nutrition Governance (Poshan Sarkar – Sushasit Poshan)

2. Mission Statement

India signed World Declaration on the Survival, Protection and Development of Children during World Summit for Children in 1990 and subsequently also ratified United Nations Convention on the Rights of the Child during December 1992. There is highest level of commitment to promote and protect rights of children which was further evident from the policies enacted thereafter like National Nutrition Policy 1993.

The State has been affected by malnutrition for a long time and it is the need of the hour to draw out a comprehensive strategic action plan to technically assess and address all the underlying causes in order to eliminate them in a timely and effective manner.

On 1st of April 2016, the UN General Assembly proclaimed the United Nations Decade of Action on Nutrition, 2016-2025 with a commitment to undertake ten years of sustained and coherent implementation of policies and programs, following the recommendations and commitments of the ICN2 Framework for Action and the 2030 Agenda for Sustainable Development. The Decade will increase visibility of nutrition action at the highest level and ensure coordination, strengthen multi-sectoral collaboration, create synergies and measure progress towards sustainable food systems and food and nutrition security for all.

Action plan for the Nutrition Decade centers on six cross-cutting, integrative areas for impact, derived from the recommendations of the ICN2 Framework for Action. The six areas are: (1) Sustainable, resilient food systems for healthy diets; (2) Aligned health systems providing universal coverage of essential nutrition actions; (3) Social protection and nutrition education; (4) Trade and investment for improved nutrition; (5) Safe and supportive environments for nutrition at all ages; and (6) Strengthened nutrition governance and accountability. While each of these thematic areas inform and frame action, they were suggested not to be seen as silos; policies and programs will normally be linked to several areas at the same time.

In alignment with global and national priority, it is crucial to address nutrition issues comprehensively in the state of MP. Therefore, Department of Women and Child Development has developed an integrated action plan framework in form of a State Nutrition Policy 2020 with a clear intention to improve nutritional status in the state primarily focusing on children and women to end inter-generational cycle of malnutrition. This policy is developed considering nutrition in a holistic and scientific manner with convergent approach to address the issue by analyzing the underlying determinants of malnutrition and focusing on process and outcome indicators. Thus:

GOVERNMENT of Madhya Pradesh, in collaboration with the COMMUNITY at large commits itself to realize the vision of **"*Suposhit* Madhya Pradesh"** by Year 2030. Towards this end, it seeks to bring about optimal nutritional and healthy wellbeing of all children and women in consonance with the agenda of Sustainable Development Goals. The state acknowledges its obligation to secure rights for optimum nutrition care and support for women and children through:

1. **Establishing Nutrition Governance at the grassroot level** and co ordinating activities at all levels of governance in order to attain goal of ending all forms of malnutrition.
2. **Establishing a strong and vibrant community level nutrition and health management system by ensuring:** a)**Securing community involvement in the decision making and development process, for achieving the cherished goal:** The emerging roles of groups at the community levels and those of the local bodies (Shourya Dals, Vigilance Committees, Village Health, Nutrition Sanitation Committee, Local Bodies) in decision making and implementation, b) **community monitoring and social audit** institutionalized and strengthened. c) **strengthening capacities, morale and motivation of frontline workers (Anganwadi Workers, ASHAs, Sahayikas and ANMs)** to perform their respective, shared and joint roles with continuity and efficiency in bringing about improved performance and d) **Poshan Samvad (Nutrition Dialogues) at the local**

levels e) community ownership of the nutrition challenges and creating an enabling environment for community sharing of food and collaboratively taking solution oriented actions for securing nutrition goals for their space and communities.

3. **Creating a dynamic response and feedback mechanism between the public health services and the community health requirements** while ensuring universal coverage of health services, the community level health management and response system would be aligned with the public health services and infrastructure. The quality and accessibility of health services would be assessed by the communities and they would be empowered to communicate their requirements.
4. **Focusing Multi-Sectoral Convergence** across the development spectrum including health, protection of nutritional ecology, livelihood, drinking water, sanitation, empowerment and social protection, amongst others, by aiming to address immediate, underlying and basic determinants of malnutrition.
5. **Evidence-based, data analytic, informed, results-based, accountable and decentralized planning** across all key departments to scrupulously implement nutrition-specific and nutrition-sensitive interventions on the premises of inclusive, dignified, transparent and accountable performance.
6. **Independent Assessments, Research and Studies** with a view to ensure efficacy of impact of the policy imperatives and concomitant schemes and programs.
7. **Placing special emphasis on effectively safeguarding the nutrition interests and rights of the children,** particularly those belonging to the **vulnerable groups** across informal sector, families of migrant workers, landless laborer, scheduled caste, scheduled tribe and persons with special needs and those who are deprived in terms of social, economic and geographical aspects; with an approach of social equality and dignity.
8. **Securing Transparency, Accountability and Grievance Redressal Mechanism** for addressing the issues pertaining to nutrition rights of the targeted groups, operating at district and state levels in accordance with the stipulations encompassed in the National Food Security Act 2013.
9. **Ensuring nutrition communication** for sustainable change in behaviors, practices and beliefs of the families and the communities. These conversations in form of *Poshan samvad* will deepen awareness, cultivate acceptance and develop new alternatives to find a solution to the current health challenges.
10. **Ensuring Enhanced Financial Outlays** and strengthened spending capacities of the departments to address nutrition issues and to comprehensively implement State Nutrition Policy.

3. Objectives, Indicators and Targets

3.1. Objectives

It is evident from the research that maternal and child undernutrition is the key underlying factor for half of child deaths (Lancet 2013) and that one-fifth of maternal mortality could be averted by addressing maternal malnutrition including iron deficiency anemia (Lancet 2008). The set of prime objectives of this policy seek to address these preventable deaths, end child undernutrition and promote healthy growth among the communities.

Objectives of the State Nutrition Policy are to:

1. Enhance the nutrition and health status of the communities in a sustainable manner with complete ownership of communities.
2. Prevent and reduce all forms of under-nutrition among children, adolescents, and women through a comprehensive approach monitored by the communities. Thus, the policy seeks to create an impact on the inter-generational effects of undernutrition.
3. Develop community resilience to deal with nutrition challenges and create demand for public health services.
4. Strengthen implementation/service delivery of evidence-based nutrition-specific and nutrition-sensitive interventions across the life cycle through a convergent approach.
5. Empower and create awareness in the community with women and adolescent health in the center of the dialogue on nutrition. To put forward the demand for nutrition for themselves and their children to ensure a healthy and diverse diet across the life cycle
6. Strengthen the community health nutrition management system, especially concerning women of reproductive age, pregnant women, nursing mothers and children.

3.2. Outcome indicators and targets

In alignment with the global commitment under SDG, World Health Assembly, and POSHAN Abhiyaan, the policy aims to achieve key indicators by 2030, presented in **Table 3.1**

Table 3.1 : Monitoring Outcome Indicators

SN	Monitorable Outcome Indicators	Existing Status	Source	Targets		
				Short-Term Targets	Mid Term Targets	Long-Term targets
				Poshan Abhiyaan (2022)	WHA 2025	SDG 2030
1	Underweight (Low Weight-for-age) among children Under 5	42.8 percent	NFHS -4 (2015)	36%	25.70%	End all forms of malnutrition by 2030
2	Stunting (Low Height-for-age) among children Under 5	42.0 percent	NFHS -4 (2015)	36%	25.20%	
3	Wasting (Low Weight-for-Height)	25.8 percent	NFHS -4 (2015)		<5%	
4	Anemia					
4	Anemia in Children (6 to 59 months)	68.9 percent	NFHS -4 (2015)	55.00%	34.50%	
4	Anemia in Adolescent Girls	53.2 percent	NFHS -4 (2015)	45.00%	26.60%	
4	Anemia in Women of Reproductive Age (WRA)	52.4 percent	NFHS -4 (2015)		26.20%	
5	Low Birth Weight (LBW)	21.9 percent	NFHS -4 (2015)	16%	15.30%	

6	Under 5 Mortality Rate (U5CMR)[I]	56	(SRS-2018)	25
7	Neonatal Mortality Rate (NMR)[II]	35	(SRS-2018)	12
8	Maternal Mortality Ratio (MMR)[III]	173	(SRS-2018)	<70

1. Under-5 Child Mortality Rate (U5CMR) is defined as Under-five Mortality Rate (U5MR) which measures deaths among children below five years of age, per 1,000 live births.

2. Neonatal Mortality Rate is defined as the number of neonatal deaths (in first 28 days, i.e., 0-27 days) per 1000 live births.

3. Maternal Mortality Ratio (MMR) is defined as the number of maternal deaths during a given time period per 100, 000 live births in the same time period.

**India Newborn Action Plan target single digit NMR by 2030*

3.3. Resolution

With this policy, the state will follow the targets set out under WHA and will endeavor to achieve 40 percent reduction in stunting and underweight among children under 5; reducing and maintaining childhood wasting to less than 5percent and achieve 50percent reduction in anemia amongst children 6-59 months, adolescent girls (15-19 years) and Women of Reproductive Age (15-49 years) by 2025.

The state will especially review the implementation of the policy in 2025 (apart from other planned reviews every two years) and will strive to achieve SDG targets by 2030 in the context of prevailing situations and as per the global scientific and guiding norms and recommendations.

3.4. Contextual background to the targets set

3.4.1. POSHAN Abhiyaan Targets

The POSHAN (Prime Minister's Overarching Scheme for Holistic Nutrition) Abhiyaan or National Nutrition Mission, is Government of India's flagship program to improve nutritional outcomes for children, pregnant women and lactating mothers. Launched by the Prime Minister on the occasion of the International Women's Day on 8 March, 2018 directs the attention of the country towards the problem of malnutrition and address it in a mission-mode.

With the overarching aim to build a people's movement (Jan Andolan) around malnutrition, POSHAN Abhiyaan intends to significantly reduce malnutrition by 2020.

For implementation of POSHAN Abhiyaan the four-point strategy/pillars of the mission are:

- Inter-sectoral convergence for better service delivery
- Use of technology (ICT) for real time growth monitoring and tracking of women and children
- Intensified health and nutrition services for the first 1000 days
- Jan Andolan

3.4.2. World Health Assembly (WHA) Targets

It is notable that in May 2012, the 65th World Health Assembly (WHA) with its member states (including India) had endorsed a Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition (MIYCN) that included six global targets to be achieved by 2025. These Global Nutrition Targets (GNT), as presented in **Table-2.1,** were established to identify priority areas, inspire ambition at country level and develop accountability frameworks.

3.4.3. Sustainable Development Goals (SDG)

SDGs were adopted by all United Nations Member States in year 2015 as a universal call to action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity by 2030.Through the pledge to Leave No One Behind, countries have committed to fast-track progress for those furthest behind first. That is why the SDGs are designed to bring the world to several life-changing 'zeros', including zero poverty, hunger, AIDS and discrimination against women and girls. The 17 SDGs and their

51 targets are all interconnected and in order to leave no one behind, it is important that all of them are duly achieved by 2030.

SDG 2 – Zero Hunger: End hunger, achieve food security and improved nutrition, and promote sustainable agriculture, aims to end all forms of hunger and malnutrition by 2030 (including achieving WHA targets set for 2025), making sure all people, especially children, have enough and nutritious food all-round the year. Since nutrition is a multi-sectoral issue, it is not limited to SDG 2 and cuts across almost all the goals and more specifically the following ones:

1. **SDG 1** (**End poverty** in all its forms everywhere)
2. **SDG 3** (Ensure **healthy lives** and promote well-being for all at all ages)
3. **SDG4(**Ensure inclusive and equitable **quality education** and promote lifelong learning opportunities for all)
4. **SDG 5** (Achieve **gender equality** and empower all women and girls)
5. **SDG 6** (Ensure availability and sustainable management of **water and sanitation** for all)
6. **SDG 10** (**Reduce income inequality** within and among countries)
7. **SDG 11** (Make cities and **human settlements inclusive, safe, resilient, and sustainable**)
8. **SDG 12** (Ensure **sustainable consumption and production** patterns)
9. **SDG 15** (Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and **reverse land degradation and halt biodiversity loss**
10. **SDG16**Promote peaceful and **inclusive societies** for sustainable development, **provide access to justice for all** and build effective, accountable and inclusive institutions at all level
11. **SDG 17** (**Strengthen the means of implementation** and revitalize the global partnership for sustainable development).

3.4.3.1. SDG - Global Targets explanations

1. **All forms of Malnutrition (Underweight, Stunting, Wasting):**
   - As per SDG 2.2 By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons

2. **Maternal, Under-5 and Neonatal Mortality:**
   - As per SDG 3.1: By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.
   - As per SDG 3.2: By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.

4. Understanding Malnutrition through Systems thinking approach

4.1. Malnutrition

Malnutrition is a physical condition resulting either from a faulty or inadequate diet (i.e., a diet that does not supply normal quantities of all nutrients) or from a physical inability to absorb or metabolize nutrients. According to the World Health Organization, malnutrition refers to deficiencies or excesses in nutrient intake, imbalance of essential nutrients or impaired nutrient utilization. Malnutrition consists of both undernutrition and overweight and obesity, as well as diet-related non-communicable diseases (like heart disease, stroke, diabetes and cancer). Undernutrition manifests in four broad forms: wasting (low weight-for-height), stunting (low height-for-age), underweight (low weight-for-age), and micronutrient (vitamins and minerals) deficiencies. Micronutrient deficiencies are a lack of vitamins and minerals that are essential for body functions such as producing enzymes, hormones and other substances needed for growth and development. A child who is underweight may be stunted, wasted or both.

Malnutrition may be the result of several conditions. First, sufficient and proper food may not be available, because of inadequate agricultural processes, imperfect distribution of food, or certain social problems such as poverty or social inequality. In these instances, the cause of malnutrition is most often found to be a diet that is quantitatively inadequate in calories or protein.Malnutrition is a condition which is affected by multiple environmental factors ranging from social, economic, political, geographical to generational ones. It is a condition which can affect individual to communities and society at large. It is important to study the factors affecting the nutritional status of the people through systems thinking i.e., a process of diagnosing and examining a complex problem by observing events and data to identify patterns to surface those factors which cause the problem. Systems thinking is a holistic approach to understand the affecting structures to a problem and find a solution by deconstructing the system into separate elements and then tying them together for optimal results.

4.2. Status of malnutrition in Madhya Pradesh

4.2.1. Nutritional and health indicators for children

Madhya Pradesh's key indicators of child and maternal malnutrition as per NFHS-4 (2015-16) pose a serious public health challenge. Malnutrition among children is become major issue in the state. Stunting is an indicator of chronic undernutrition or prolonged food deprivation and/or disease or illness. In Madhya Pradesh, 42percent children under 5 are stunted. This status is a matter of deep concern. Likewise, wasting is an indicator of acute undernutrition, the result of more recent food deprivation or illness leading to nutritional loss. The status of child wasting in the state is at 25.8 percent which shows that one-fourth children are suffering from this acute malnutrition. This indicator too is of serious concern. Underweight, low weight-for-age is a composite indicator of both acute and undernutrition. It stands at 42.8 percent and that 1 in 5 births are Low Birth Weight (21.9 percent). Further, as many as 68.9 per cent (more than two-third) children suffer from anemia.

4.2.2. Nutritional status of women and adolescent

Maternal and adolescent nutrition is another crucial area of concern to address in-utero stunting. Anemia among women of reproductive age (15-49 years) stands at 52.5 percent defines the critical situation in the state. It is not only in terms of the status of these indicators for the reference year 2015-16 but also in terms of the poor performance in registering improvement over the preceding decade. (**Table 5.1).** According to NFHS-4 (2015-16), 28.4percent of women of reproductive age in MP have low body mass index (<18.5 kg/m^2), 13.6percent are overweight (BMI >=25 kg/m^2) and 52.4 percent women (non-pregnant women) are anemic. Latest data on adolescent nutrition status shows that 45.7 percent adolescent girls 15-19 years in MP have a low Body Mass Index (BMI <18.5 kg/m^2) (**Table 5.1)**

Detailed nutritional status sheet is placed in Annexure I.

4.2.3. Status of child and maternal mortality in Madhya Pradesh

It is well documented that child malnutrition is the chief contributor to infant and child mortality. Inadequate nutrition before conception may lead to maternal mortality due to greater susceptibility to infections and slower recovery from illness.

Low-birth-weight (LBW) is a significant causal factor in infant mortality. Children who survive out of being LBW suffer growth retardation and illness during their childhood, adolescence and adulthood. This results in the vicious cycle of malnutrition. The growth-retarded adolescent girl or woman would give birth to low birth-weight infants and the inter-generational cycle continues. Malnutrition increases the proneness towards infection accentuated by micronutrient deficiencies leading to insufficient growth. Increased susceptibility towards infection, less responsiveness to treatment due to weak immune system may even lead to child mortality.

On the similar grounds, maternal malnutrition increases the risk of poor pregnancy outcomes including obstructed labor, premature or low-birth-weight babies and postpartum hemorrhage. Severe anemia during pregnancy is linked to increased maternal mortality.

4.2.3.1. Under-5 Mortality rate

State of Madhya Pradesh exhibits high under five mortality rates with 56 children per 1000 live births (SRS, Reference Year 2018), which works out to more than 100,000 under five children's deaths every year and global evidence suggests that nearly half of them would have undernutrition as an underlying cause of death. (**Table 5.1)**

4.2.3.2. Neonatal Mortality Rate (NMR)

In terms of Neonatal Mortality Rate (NMR), Madhya Pradesh loses lives of 35 newborns per 1000 live births within 28 days of birth. (**Table 3.1)**

4.2.3.3. Infant Mortality Rate (IMR)

Likewise, in terms of Infant Mortality Rate (IMR), 48 infants die in the state within 1 year of their birth per 1000 live births in year 2018 as per the SRS Bulletin 2020. It also needs to be kept in view that NMR accounts for as much as 71.8percent of the IMR. If the State were to go as per the trends between the decade 2008 to 2017, Madhya Pradesh will achieve the SDG target of NMR (as low as 12) only by year 2033 and that IMR (as low as 18 - a derived value from NMR) by the year 2031. (**Table 5.1)**

4.2.3.4. Maternal Mortality Ratio (MMR)

Madhya Pradesh also raises alarm in respect of high Maternal Mortality Ratio (MMR) – number of deaths of women due to maternal caused per 100, 000 live births. The MMR of the state stands at 173 as per Special Bulletin, SRS 2020, giving estimates of maternal mortality for the period 2016-18. It is notable that the status has remained same from the previous estimates for the period 2014-16, i.e., 173. (**Table 3.1)**

4.3. Areas at Higher Nutritional Risk (Malnutrition) within state

4.3.1. District-wise prevalence of Malnutrition

It is notable that there are inter-district variations across the state for nutritional impact and process indicators. The Government of India has identified 100 poor-performing districts in terms of stunting across the country. Notably, 12 districts from Madhya Pradesh are included in this list. These, with Stunting percent in parenthesis, are Sheopur (52.1), Barwani (52.0), Burhanpur (50.0), Tikamgarh (49.7), Datia (48.9), Sidhi (48.7), Shivpuri (48.6), Khargone (48.3), Shajapur (48.1), Morena (47.7), Bhopal (47.6) and Bhind (47.6).

Table 4.1 presents the Nutrition Profile of Madhya Pradesh across the high burden 12 districts in terms of nutrition and health-related indicators. It shows the range of variation, for example, Child Stunting is lowest in district Balaghat is 32.1 percent whilst it is the highest in district Sheopur at 52.1percent. Accordingly, the district-specific plans are required to drive the requisite efforts in terms of intensity as well as quantum.

As per the National Nutrition Strategy (2017) document, currently, the focus areas/ high priority districts vary as per Ministries and their respective schemes. For example, out of the 184 High Priority Districts chalked out under the National Health Mission (NHM) implemented by the Ministry of Health & Family Welfare and the list of 200 High Burden Districts identified within the ICDS program and 162 Districts covered within the ISSNIP, both implemented by the Ministry of Women and Child Development (MoWCD), only 39 districts are common. This calls for synergy in the efforts made by MoWCD and MoH&FW to address the challenge of undernutrition. Likewise, when other Ministries like Drinking Water and Sanitation, etc. are considered, the number of common high priority districts reduces further. The multidimensional nature of factors affecting nutrition calls for a coordinated and combined effort from all stakeholders to attain optimal outcomes; particularly by formulating and implementing district-specific Integrated Action Plans. (**Table 4.1)**

Table 4.1: Children's Nutritional Status (Under-5 Yrs)

Districts	Stunted	Wasted	Severely Wasted	Underweight	6-59 months - anemic
Madhya Pradesh	**42.0**	**25.8**	**9.2**	**42.8**	**68.9**
Barwani	52.0	28.0	8.7	55.0	82.0
Bhind	47.6	30.6	12.6	49.8	71.8
Bhopal	47.6	21	8.1	39.5	77.3
Burhanpur	50.0	20.1	6.7	46.1	80.2
Datia	48.9	26.2	8.2	46.9	73.2
Khargone	48.3	21.2	5.7	44.7	76.9
Morena	47.7	29.5	12.5	52.2	67.3
Shajapur	48.1	30.0	10.0	48.6	77.5
Sheopur	52.1	28.1	9.0	55.0	77.5
Shivpuri	48.6	25.8	7.7	49.6	62.7
Sidhi	48.7	24.9	8.5	43.9	67.7
Tikamgarh	49.7	19.2	7.6	43.3	67.1

4.3.2. Region-wise prevalence of Malnutrition

Prevalence of malnutrition is more pronounced in rural areas compared to urban areas. It is notable that neonatal, infant and under-5 mortality is skewed disadvantageously for the rural areas with the respective rates being 1.65, 1.11 and 1.54 times those for the urban areas. The children belonging to rural areas have higher stunting rates (43.6) than in urban (37.4); similarly, higher wasting of 27.1 in rural than 22.0 in urbans; underweight with 45.0 is higher in rural than urban with 36.5. This is followed by anemia with higher prevalence in rural with 69.8 compared to 66.2; IMR is 52 in rural compared to 36 in rural and Under-5 mortality is 60 in rural compared to 39 in urban. (**Table 4.2)**

4.3.3. Gender-wise prevalence of Malnutrition

Prevalence of malnutrition is more in males compared to females in all the indicators. Stunting is more in male child (42.6percent) compared to female (41.6percent) likewise, wasting subsides in female child (24.5percent) than male child (27.0percent).Correspondingly the other parameters including anemia, severe anemia, IMR and Under-5 mortality rate are again on higher side in male children compared to female children where percentage of anemia in female is 68.8 percent lower than that of males (69.1percent); IMR in females (46percent) against males (51percent) and Under-5 mortality rate in males is 58percent which is again on higher side than that of females (53percent). (**Table 4.2)**

4.3.4. Social groups at higher nutritional risk

The children belonging to scheduled caste and tribes are at risk largely, wherein the status of nutritional risk of Scheduled Tribe is anytime greater than Scheduled Caste. Stunting rate of ST child with -2 Standard Deviation is 48.2percent which is higher than 47.6percent of Scheduled Caste. Likewise, with wasting at 30.2percent for Scheduled tribe has more prevalence than that of SCs at 25.5percent. On a Similar note, prevalence of underweight is more in ST with 51.5 percent than SC at 45.9 percent. However, the prevalence in both SC and STs is still more than that of entire state at 42.8 percent. Scheduled Tribe even has high prevalence of anemia (76.1percent) than SC (69.3percent) as shown in **Table 4.2**

Table 4.2 : High prevalence of Malnutrition (percent distribution) amongst children across Madhya Pradesh

SN.	Indicator	Male	Female	Rural	Urban	Schedule Caste	Schedule Tribe	Total
1	**Stunting [Moderate Acute Malnutrition (MAM) <-2 SD] (%)**	42.6	41.4	43.6	37.4	47.6	48.2	42.0
2	**Stunting [Severe Acute Malnutrition (SAM) <-3 SD)] (%)**	19.2	18.1	19.6	15.9	22.0	23.5	18.6
3	**Wasting [Moderate Acute Malnutrition (MAM) <-2 SD)] (%)**	27.0	24.5	27.1	22.0	25.5	30.2	25.8
4	**Wasting [Severe Acute Malnutrition (SAM) < -3 SD)] (%)**	10.3	8.0	9.6	8.1	9.9	10.9	9.2
5	**Underweight [Moderate Underweight (M-UW) <-2 SD)] (%)**	43.4	42.1	45.0	36.5	45.9	51.5	42.8
6	**Underweight [Severe Underweight (S-UW) <-3 SD)] (%)**	14.5	14.1	15.6	10.5	15.9	19.5	14.3
7	**Anemia (Total) (%)**	69.1	68.8	69.8	66.2	69.3	76.1	68.9
8	**Severe Anemia (%)**	2.2	1.7	1.9	2.1	2.0	2.4	2.0
9	**Infant Mortality Rate**	51	46	52	36	-	-	48
10	**Under-5 Mortality Rate**	58	53	60	39	-	-	56
Data Source: **SN 1 to 8: National Family Health Survey-4, Year 2015-16, Madhya Pradesh State Report** **SN 9 to 10: SRS Statistical Report (2018), Office of the Registrar General & Census Commissioner, India**								

4.4. Increased Nutritional risk during Covid-19 pandemic

Further, with the recent unfolding corona virus pandemic during 2020in the backdrop, there is need to accord a heightened significance to 'nutritional wellbeing for all', "especially the vulnerable". After all, the undernourished people are highly susceptible to severe illnesses, given their much weaker immunity. Many of these vulnerable people (the poor, women, children and migrants) who have already been suffering from inequalities now are further impacted by the virus and the concomitant containment measures. Whilst it is recognized that good nutrition can go a long way in safeguarding individuals against Covid-19, perpetual undernutrition of the vulnerable threatens worsening of the pandemic apart from being infringing their right to safe, healthy and dignified life.

4.5. Determinants of malnutrition in Madhya Pradesh

According to UNICEF conceptual framework of determinants of undernutrition, causes of malnutrition are broadly divided into three categories – immediate, underlying and basic causes. While immediate causes act at individual level and are shorter term related to dietary intake and diseases; the underlying causes act at family / household level pertaining to food security, practices / behaviors, environment and access to health services; and the basic causes act at community level pertaining to livelihood, resources, socio-cultural, economic and political context. Addressing malnutrition in a sustainable manner entails addressing all these determinants comprehensively.

Failure to address them holistically would result in dire consequences ranging from morbidity (immediate and long term) to reduced physical and cognitive ability and economic productivity to disability and mortality. It is quite evident that the determinants are interlinked in a complex way. In a diverse setting like Madhya Pradesh, there are region and community specific local issues which are quite different in different areas. Govt. of MP intends to consider these issues to derive at context specific local solutions to address the issue.

4.5.1. Immediate (causes) determinants

4.5.1.1. Breastfeeding and IYCN Indicators

Around two-third (65.4 per cent) of newborns are deprived of the first breastmilk. Likewise, rate of exclusive breastfeeding at 58.2percentis quite pitiable. Similarly, only 38.1percent children (age 6-8

months) receive solid or semi-solid food as complementary feeding along with continued breastfeed (**Table 5.2)**

4.5.1.2. Adequate diet for children (6-23 months)

In addition, the situation that only 6.9 per cent children in age group 6-59 months who are breastfed receive the minimum acceptable diet is very alarming. The more concerning fact is that the children who are not breastfed are also not receiving adequate diets except for 4.9 percent. It also brings out clearly that complementary feeding from 6 months onwards needs to be carefully looked into so that early onset of malnutrition is prevented. (**Table 5.2)**

4.5.1.3. Nutritional Deficiencies

Nutritional deficiencies due to poor dietary practices are one of the key factors especially in the etiology of iron deficiency anemia. Below table shows dietary intake of different nutrients that are crucial for prevention of iron deficiency anemia among different categories and age-groups in the state of MP compared with standard recommended daily intake (RDA) for Indians (MP - NNMB 2012) demonstrated in **(Table 4.3)**. Nutritional deficiencies due to poor dietary practices are one of the key factors especially in the etiology of iron deficiency anemia. Below table shows dietary intake of different nutrients that are crucial for prevention of iron deficiency anemia among different categories and age-groups in the state of MP compared with standard recommended daily intake (RDA) for Indians. (MP - NNMB 2012).

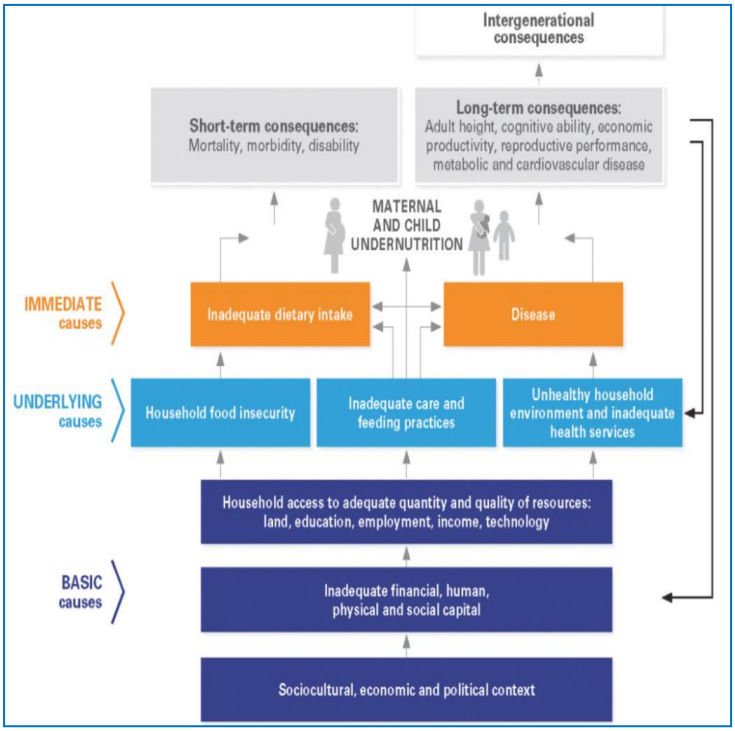

Table 4.3: Recommended Dietary Intake (RDA) for Indians (MP-NNMB 2012)

% of population receiving ≥ 70% of RDA	1-3 years	4-6 years	7-9 years	10-12 years Boys	10-12 years Girls	13-15 years Boys	13-15 years Girls	16-17 years Boys	16-17 years Girls	Non-Pregnant	Pregnant Women	Lactating Women	Man
RDA for Iron (mg/day)	09	13	16	21	27	32	27	28	26	21	35	25	17
Iron	54.2	65	67	54.6	25.5	25.3	51.8	49.5	61.5	43.4	26.9	87.5	90.1
Dietary Folate	55.6	73.4	70.9	71.5	68.3	49.5	62.4	59.3	71.2	63.8	15.4	75	72.6
Vitamin A	7.6	8.1	7.6	10.1	5.8	12.4	8.8	12.1	12.5	10.1	7.7	4.2	11.4
Vitamin C	5.1	13.1	18.8	28	17.3	28.4	25.9	29.7	26.9	31.4	23.1	14.6	36
Protein	83.3	99.3	98.3	94.2	91.8	85.1	90.6	97.9	92.3	92.8	61.5	93.8	94.8

It is evident that the consumption of 70% of the RDA for these nutrients is not very satisfactory and for iron and folate it is around 60% children receive it and for vitamin A and C, it is less than 20% children receive it. For pregnant women, it is further low with approximately 20% pregnant women consume 70% of the RDA for all these micronutrients. Consumption of proteins is better with almost 90% population is receiving 70% of RDA for proteins except pregnant women.

4.5.1.4. Micronutrient supplementation

According to recently released Comprehensive National Nutrition Survey (CNNS – 2018), the prevalence of deficiency of key micro-nutrients in the state of MP is mentioned in Table 4.4. Further vitamin D, B12 and zinc deficiency are emerging issues among children especially adolescents.

Table 4.4: Prevalence of Key micro-nutrient deficiency

% children with deficiency of	Children 1 – 4 years	Children 5 – 9 years	Adolescents 10 – 19 years
Iron (Serum Ferritin)	45.9	25.2	22.1
Folic Acid	57.6	62.4	74.5
Vitamin B12	11.6	22.4	42.0
Vitamin A	-	13.4	13.2
Vitamin D	7.7	19.7	23.0
Zinc	22.3	12.3	19.9

4.5.2. Underlying (causes) determinants

4.5.2.1. Maternal care and Health services

National Family Health Survey-4, 2015 throws a light on the maternal and childcare situation of the state. The ante-natal care during first trimester is confined to 53 percent whereas full Ante-natal checkup care was taken by only 11.4 per cent of women in the state whereas 35.7 percent of women at least had 4 ANC care visits. As many as 54.9 percent nursing mothers had post-natal care visits. There is a substantial raised record as observed in cases of pregnancy registration where 92.2 percent of women were provided with Mother Child protection card and about 89.8 percent of pregnant women had their tetanus vaccination. It is evident that IFA supplementation becomes important to address the scenario. However, IFA was consumed for 100 days by only 23.5 percent pregnant women during their pregnancy. The financial assistance provided under Janani Suraksha Yojana was accessed by only 61.1percent of mothers. Similarly, benefit of tetanus vaccination reached only 61.1 percent women.

4.5.2.2. Childcare and Immunization

About 20.8 percent of the deliveries are either taking place at home or not being reported. Only 2.3 percent deliveries are conducted by health professionals whereas 2.5 percent of children who are delivered at home have received a health check-up by health professionals within 24 hours of birth. Neary half of the children (53.6 percent) have received full immunization; only 60.4 of children received Vitamin A dosages. About one-tenth of the children who became ill with diarrhea and about fifty five percent of children have received Oral Rehydration Salt (ORS) packets.

4.5.2.3. Water and Sanitation

About fifteen percent of households are yet to receive the improved water facilities whereas more than the two-third of the population do not have improved sanitation facilities i.e., only 33.7 of households have better sanitation facilities

4.5.3. Basic/ Structural Causes

4.5.3.1. Sex Ratio

Sex ratio of the total population (females per 1,000 males) is 948 whereas sex ratio at birth for children born in the last five years is recorded as 927 girls per 1000 boys in the state under NFHS-4, 2015

4.5.3.2. Women Empowerment and Gender-Based Violence

About 18 percent women are not involved in decision making process of the household whereas 29.9 percent of the women have been employed in wage and are being paid.

More than one third of the women (33.3percentNCBR 2019) in the state are facing the gender-based violence and about 3.3 percent have experienced the violence during their pregnancy period. This may lead to serious implication on the growing fetus as well as mother. Approximately 43.5percent of women have their share in the lands and 37.3percent of women in the state also have a bank or savings account using for themselves whereas fairly low percent have mobile (28.7percent). Lack of hygiene during menstrual period in 62.4 percent women in the state cost them health issues.

4.5.3.3. Substance Abuse

Substance abuse is seen commonly in adult male and female population in the state which becomes the cause of gender-based violence, ill-treatment of women, empty calories consumption affects the nutritional intake of the women can contribute in malnutrition as it will compromise mother and

childcare further. About one-tenth of female population of the state is consuming tobacco against 1.6 percent of women who consume alcohol. More than half of the male population (59.5 percent) consumes tobacco against 29.6 percent of male population consuming alcohol which is 28 folds more than females

4.5.3.4. Female literacy and Marriage before age of 18 years of girls

The female literacy (59.4percent) of the state is still lower than that of male (81.8percent) impacting on the overall status of women in terms of decision-making, child-caring and rearing practices, self-care and practicing of better health and hygiene. Another important determinant of malnutrition is Total Fertility Rate (TFR). In simple words, it refers to total number of children born or likely to be born to a woman in her lifetime if she were subject to the prevailing rate of age-specific fertility in the population. The TFR of Madhya Pradesh is 3.12 as per NFHS 4 (2015-16). It is much higher as compared to India's TFR at 2.2. Likewise, in Madhya Pradesh, 8.8 percent women have height below 145 cm. It shows that the 8.8 percent shorter women may be potentially at-risk during delivery. However, this indicator for the state is relatively better as compared to that of India at 11.1 percent.

Early childhood marriage is still prevailing and about one of the women (32.4 percent) in the state get married before they turn 18.

4.5.3.5. Landholding and Forest

According to Agriculture Census 2015-16, about 68.45percent of the total holding belong to marginal farmers (below 1 hectare of lands) whereas only 24percent of the total area is operated by the marginal farmers. About 48.3 percent of operational and holding belong to marginal farmers followed by 27.2percentby small farmers

Department of Planning, economics and statistics 2017 suggests the total geographical area of MP as 308245 Km square of which 30.72percent is the total forest area i.e., 94689 km square

5. Progress achieved so far

5.1. Trend Analysis

5.1.1. Improvement in Nutritional Status

Govt of MP has always accorded priority to addressing nutrition issues in the state and achieved significant progress in performance of the state over the preceding years across the nutritional status and various indicators (determinants) pertaining to and influencing malnutrition. Results emanating from the National Family Health Survey – 3 [NFHS - 3 (2005-06)] and NFHS - 4 (2015-16) have been taken into consideration for determining the Total Reduction Achieved thus far and the Annual Rate of Reduction or Improvement (ARR or ARI) in the malnutrition related indicators' rates; over the 10-year period.

Table 5.1 : Nutritional Status

Indicators	2005-06 (NFHS 3)	2015-16 (NFHS 4)	Total percentage point Reduction or Improvement Achieved (2005-06) to (2015-16)
Stunting	50	42	8
Wasting	35	25.8	9.2
Severe Wasting	12.6	9.2	3.4
Underweight	60	42.8	17.2
Infant Mortality Rate	70	51	19
Under-5 Mortality Rate	94	65	29
Low Birth weight (LBW)	23.4	21.9	1.5
Child Anemia	74	68.9	5.1
Anemia in women (15-49 years)	55.9	52.5	3.4
Women's Body Mass Index (BMI) Below 18.5 Kg/M Sq.	41.7	28.4	13.3

The steep decline of 17.2 percentage points has been observed in the status of underweight over the past decade. The wasting status has been improvised with a decline of 9.2 percentage points when compared between both the NFHS surveys. However, severe wasting has not shown much decline (3.4percentage points) even over a decade. The condition remains true for the status of low birth weight and anemia where the decline points are at 1.5 and 5.1 respectively.

5.1.2. Improvement in maternal and child health indicators

Latest data on adolescent nutrition status shows that 45.7 percent of adolescent girls of 15-19 years in MP have a low body mass index (<18.5 kg/m2), which has decreased only by 4 percent over the period of ten years.

The State of Madhya Pradesh has witnessed increase in early initiation of breastfeeding over the past ten years from 14.9 percent to 34.4 percent. However, the achievement of 34.4 percent cannot be considered to be good as it shows that as many as 65.6 percent children remained deprived of essential colostrum feed. It is all the more worrying that this status is there even though institutional deliveries have gone up to 80.8 percent. Similarly, exclusive breast-feeding rates up to 6 months from birth have more than doubled from 21.6 percent to 58.2 percent. The concern, however, pertains to the fact that 41.8 percent infants have remained deprived of the exclusive breastfeeding, thus adversely affecting their immunity and growth. After 6 months, infants must receive complementary feed along with continued breastfeeding well in to and beyond 2 years. Over the decade, the rate of initiation of complementary feeding has declined from 46 percent to 38.1 percent registering a decline of 7.9percent points. Further, children (6 – 23 months) receiving adequate diet as per complementary feeding guidelines is very low at 6.9percent. It goes to show that the state has a formidable task to bring about a sustained and positive improvement in ensuring that all children of 6-23 months duly receive adequate diet.

Table 5.2 : Trend Analysis and Improvement status of determinants of Malnutrition

Indicators	2005-06 (NFHS 3)	2015-16 (NFHS 4)	Total percentage point Reduction/Improvement Achieved (2005-06) to (2015-16)
1. IYCN Indicators			
Early initiation of breastfeeding within one hour of birth	14.9	34.4	19.5
Exclusively breastfeeding (Children under age 6 months)	21.6	58.2	36.6
Complimentary feeding (Children age 6-8 months receiving solid or semi-solid food and breastmilk	46	38.1	-7.9
Newborn Given Pre-lacteal Feed	58.1	12.4	-45.7
2. Adequate Dietary Practices			
Adequate diet for (breastfeeding-children age 6-23 months)	na	6.9	
Adequate diet for (non-breastfeeding-children age 6-23 months)	na	4.9	
Adequate diet for all children (age 6-23 months)	na	6.6	
3. Mother care and health services			
ANC during first trimester	39.3	53	13.7
At least 4 ANC	22.3	35.7	13.4
Recommended Full ANC care	4.7	11.4	6.7
PNC care from health care professional within 2 days of delivery	24.9	54.9	30
Registered pregnancies for which the mother received Mother and Child Protection (MCP) card	na	92.2	
Financial benefits from Janani Suraksha Yojana (JSY)	na	61.1	
Tetanus Vaccination	70.7	89.8	19.1
IFA consumption	7.1	23.5	16.4
4. Childcare and health services			
Institutional deliveries	26.2	80.8	54.6
Home deliveries by skilled professional	6.6	2.3	-4.3
Children born at home who were taken to health facility for check-up within 24 hours of birth	0.2	2.5	2.3
Full Immunization (BCG, measles, and 3 doses each of polio and DPT)	40.3	53.6	13.3
Vitamin A supplementation in last 6 months (children 9-59 months)	12.5	60.4	47.9
Prevalence of diarrhoea	12.1	9.5	-2.6
Children with diarrhoea who received oral rehydration salts (ORS)	29.8	55.2	25.4
5. Water and Sanitation			
Availability of better drinking water sources	74.2	84.7	10.5
Availability of improved sanitation facility	18.7	33.7	15
6. Women's Empowerment and Gender Based Violence (age 15-49 years)			
Women participating in Household decisions	68.5	82.8	14.3
Women on wages/labors	32.8	29.9	-2.9
Domestic violence by husband	45.7	33	-12.7
Domestic violence during pregnancy by husband	NA	3.3	NA
Woman landholding and ownership	NA	43.5	NA
Women having bank accounts	8.9	37.3	28.4
7. Substance Abuse			
Female Consumption of tobacco	16	10.4	-5.6
Male Consumption of tobacco	68.5	59.5	-9
Female consumption of alcohol	2.1	1.6	-0.5
Male consumption of alcohol	30.8	29.6	-1.2
8. Literacy, Sex Ratio and Early Marriage Status			
Female Literacy	44.4	59.4	15
Male Literacy	78.5	81.8	3.3
Female Marriages before age 18 years	57.3	32.4	-24.9
Sex ratio of the total population (females per 1,000 males)	961	948	-13
Sex ratio at birth	960	927	-33
9.Women Hygiene and Fertility aspects			
Women practicing safe hygienic methods during menstrual periods	NA	37.6	NA
Female fertility rate (children per woman)	3.1	2.3	-0.8
Women's Height Percentage Below 145 cm	8.4	8.8	0.4

It is notable that some indicator was not captured under the NFHS until 2015-16. Whilst there has been a significant decline in the infection rates among children, it is observed that there continues to be the practice of feeding the newborn with things like honey, water and Janm Ghutti. This is a wrong practice as it makes the infants susceptible to infections. It is notable that the rate of this pre-lacteal feeding has declined from 58.1 percent to 12.4 percent over the decade between 2005-06 to 2015-16, a huge achievement. The state shall address the challenge of reducing this rate from 12.4 percent to zero so that all infants can be safeguarded against any potential infection. It is observed that consumption of Iron Folic acid (IFA) by pregnant women has increased from 7.1 percent to 23.5 percent, the wide gap persists in reaching all pregnant women so that occurrence of anemia may be prevented amongst them. Likewise, coverage of pregnant women in respect of recommended full ANC is also a major challenge. Notably, coverage of all basic vaccinations (BCG, measles and 3 doses each of DPT and Polio[1]) for children has improved from 40.3 percent to 53.6 percent. However, the challenge is that 46.4 percent children are yet to be covered with all basic vaccinations. Therefore, ensuring that all basic vaccinations are administered to the children remains a formidable but crucial challenge for the state.

5.1.3. Improvement in health service delivery infrastructure

5.1.3.1. Status of Health Centers and Civil Hospitals

Table 5.3: Status of Health centres

Health Centers	2006	2019	Improvement	Percentage
Sub Centre	8874	10226	1352	15.2
PHCs	1192	1199	7	0.6
CHCs	229	309	80	34.9

The comparison between 2006 and 2019 of health centers from Rural Health Statistics shows the 34.9 percent increase in the number of Community Health Centers against 15.2 percent increase of the subcenters whereas with almost negligible (0.6 percent) improvement in the provision of primary health centers establishments.

5.1.3.2. Ratio of Medical and paramedical staff to population

The data from Rural Health statistics show the difference of the positioning of the medical and premedical staffs over the period of 1.5 decades.

Table 5.4 : Availability of medical and paramedical staff

Availability of Medical Staff	Required	In position	Filling position	Required	In position	Filling Position	improvement
	2006			2019			
Doctors at PHCs	1192	839	70.39%	1199	1053	87.82%	17.44%
Surgeons at community health centers(CHCs)	229	12	5.24%	309	27	8.74%	3.50%
Obstetricians and Gynecologists at CHCs	229	13	5.68%	309	30	9.71%	4.03%
Block extension Educators	313	239	76.36%			NA	NA
Pediatricians At community health centers	229	12	5.24%	309	22	7.12%	1.88%
Total Specialists [Surgeons, OB&GY, Physicians &Pediatricians] at CHCs	916	49	5.35%	1236	104	8.41%	3.06%
Radiographers at CHC	229	NA	NA	309	214	69.26%	NA
Physicians at CHC	229	12	5.24%	309	25	8.09%	2.85%
Ayush Doctors at Community Health Centres	NA	NA	NA	309	144	46.60%	NA
Health Assistant Male at PHCs	1192	1168	97.99%	1199	991	82.65%	-15.33%
Health Assistant Female at PHCs	1192	1074	90.10%	1199	786	65.55%	-24.55%

The improvements are shown in the filling of position of doctors at PHCs only by 17.44% which is followed by least improvements of about 1.88 % in filling of pediatric positioning in Community health Centers

[1]Excluding polio vaccine given at birth.

5.1.4. Status of relevant services

5.1.4.1. Swachh Bharat Mission (SBM)

The data suggested by Swachh Bharat Mission states that one hundred percent of the Gram Panchayats are declared Open Defecation Free (ODF) in the year 2019-20 whereas there were only 3.73 percent (of 50228 Gram Panchayats in the State) ODF in year 2015-16. Likewise, 75.1 percent of the total households have got their toilets constructed compared to 25.41 percent in the year 2014-15 **(Table 5.5)**

Table 5.5 : Status of ODF

Gram Panchayat	2015-16	2019-20
Declared Open defecation free	1873	50228
Total number of HH Toilet constructed (2014-15)	295341	6280040
Source: https://sbm.gov.in/sbmdashboard/ODF.aspx		

5.1.4.2. Safe drinking water services

Availability of better drinking water resources of the households has improved over a decade by 10.5 percent from 74.2 percent in year 2015-16 to 84.7 percent in year 2015-16. **(Table 5.2)**

5.1.4.3. Marriage before age of 18-year girls

A steep decline by 43.4 percent (from 57.3 percent to 32.4 percent) in the child marriage (below the age of 18 years) has been observed over a decade when NFHS-4 is compared with NFHS-3. **(Table 5.2)**

5.1.5. Status of agriculture production

The State of Madhya Pradesh has achieved tremendous improvement in regard to agriculture production. Some of the notable highlights for the year 2018-19 are shown in Table 5.6 as (sourced from Agricultural Statistics at A Glance 2019[i]).

The table shows that the production of food grains is not the core issue. On the contrary, it is the question of ensuring food and nutritional security across the board, with a differentiated focus on the vulnerable sections of the population. The emerging measures, therefore, need to comprise the nutrition-sensitive interventions in bringing about coherence with nutrition-specific ones.

Table 5.6 : Agriculture and Horticulture Production in Madhya Pradesh: 2018-19

Agriculture Products	Ranks	Total Area in Million Hectares	Percent of all India	Production	Percent of all India
Pulses	1	6.88 Million Hectares	23.71	7.81 Million Tonnes	33.39
Oil Seeds	1	7.26 Million Hectares	28.49	8.99 Million Tonnes	27.87
Spices	1	640.17 thousand Ha		2961.02 Thousand MT	
Food grains	2	16.41 Million Hectares	13.24	32.80 Million Tonnes	11.51
Wheat	2	5.52 Million Hectares	18.95	15.47 Million Tonnes	15.14
Vegetables	3	897.99 thousand Ha		17773.19 Thousand MT	
Nutri-Cereal	4	2.02 Million Hectares	9.20	5.02 Million Tonnes	11.69
Fruits	5	357 Thousand Ha		7464.97 Thousand MT	
Rice	9	1.98 Million Hectares	4.52	4.50 Million Tonnes	3.86

5.2. Legal and Policy Framework

5.2.1. Policy framework at GoI level

Over the past decade, Government of India updated various policies and programs to address health and nutrition issues in the country. The highlightsare as below:

5.2.1.1. National Health Mission (2005)

National Rural Health Mission (NRHM) was launched in 2005 to provide accessible, affordable and quality health care to the rural population, especially the vulnerable groups. The key features include making the public health delivery system fully functional and accountable to the community, human resources management, community involvement, decentralization, rigorous monitoring & evaluation against standards, the convergence of health and related programs from village level upwards, innovations and flexible financing and also interventions for improving the health indicators. In 2013, urban areas were

also included as a sub-mission under overarching **National Health Mission**. The mission implements some of the key health system-led interventions across the life cycle that are critical for reduction of undernutrition. Hence, it remains a crucial stakeholder for any efforts to reduce under-nutrition.

5.2.1.2. Pradhan Mantri Matra Vandana Yojana, 2017

Ministry of Women and Child Development (MoWCD), as the nodal ministry for holistic development of women and children is administering a number of women and child-centric schemes and programs in the country and has introduced the Indira Gandhi Matrutva Sahyog Yojana (IGMSY) scheme in accordance with the National Food Security Act (NFSA), 2013. The Act makes the provision for maternity cash benefit of a minimum of Rs. 6,000 for every pregnant woman and lactating mother as a justiciable right. This scheme was first introduced as a pilot in 52 districts. It was further rechristened as Pradhan Mantri Matru Vandana Yojana (PMMVY) as was announced by the Prime Minister on 31stDecember 2016 as a pan-India program with a conditional direct cash transfer provision of Rs.6,000 in three instalments for the first live birth. In May 2017, the Cabinet approved the implementation of the PMMVY but with a revised payment of Rs. 5,000, and the remaining amount to be provided under the Janani Suraksha Yojana (JSY). This became applicable from 1st January 2017. All women (pregnant and lactating) who were eligible as beneficiaries under this program as on 1st January 2017 were enrolled. The MoWCD remains responsible at the central level for the implementation of the scheme. The scheme can be led by the WCD and Social Welfare department or by the health department at the state level. PMMVY is a Centrally Sponsored Scheme under which the grant-in aid is being released to States/UTs on cost sharing basis. The PMMVY pursues to deliver a cash incentive of INR 5,000 to Pregnant Women and Lactating Mothers in three installments for the first live child through Direct Benefit Transfer (DBT) and ensures to meet the supplementary nutritional requirements during pregnancy and lactation by providing them with partial compensation for the wage loss in terms of cash incentives so that the women can take adequate rest before and after delivery of the child and thus promotes improved health seeking behavior amongst the vulnerable groups of women and children.

5.2.1.3. National Health Policy, 2017

It aims at attainment of the highest possible level of health and wellbeing for all at all ages, through a preventive and promotive health care orientation in all developmental policies, and universal access to good quality health care services without anyone having to face financial hardship as a consequence. Health goals cannot be achieved without significant investment and improvement in nutrition interventions. The Global Nutrition Report 2015 estimates that for investment in nutrition, there is a benefit cost ratio of 16:1 for the low and middle-income countries.

5.2.1.4. National Nutrition Strategy, 2017

National Nutrition Strategy of government of India was developed by NITI Aayog, based on policy directive by the Prime Minister's Office (PMO), during 2017, through a consultative process. It clearly puts nutrition at the center of the national development agenda recognizing it as an entry point for human development (physical and cognitive), poverty reduction and economic development.

The National Nutrition Strategy is committed to ensure that every child, adolescent girl and woman attains optimal nutritional status- especially those from the most vulnerable communities. The focus is on preventing and reducing undernutrition across the life cycle, as early as possible, especially in the first three years of life. This commitment also builds on the recognition that the first few years of life are forever the foundation for ensuring optimum physical growth, development, cognition and cumulative lifelong learning. The vision being "*Kuposhan Mukt Bharat*", with clearly defined targets is to be realized in a time-bound manner.

5.2.1.5. POSHAN Abhiyaan or National Nutrition Mission, 2018

Poshan Abhiyaan, Government of India under the leadership of Ministry of Women and Child Development was launched under the Prime Minister's Overarching Scheme for Holistic Nutrition or **POSHAN Abhiyaan** or National Nutrition Mission during 2018 with an aim to improve nutritional outcomes for children, pregnant women and lactating mothers in a mission mode. It draws on the national nutrition strategy and the micro-analysis of the issues. It targets to reduce stunting, underweight

and low birth weight by 2% per annum while seeking to reduce anemia amongst children, adolescent and women by 3% per annum.

The strategy is to ensure convergence among the key departments and schemes through a life cycle approach with focus on addressing issues among adolescent girls, pregnant women, lactating mothers and children from 0 to 6 years of age, including strong emphasis on first 1000 days of life. The mission is primarily the monitoring and reviewing body for taking stock of monitorable indicators of nutrition-centric schemes/programs requiring convergent actions for better and effective delivery to the targeted beneficiaries.

The strategy also includes ICT-based Real Time Monitoring system, incentivizing States/UTs for meeting the targets, incentivizing Anganwadi Workers (AWWs) for using IT-based tools, introducing measurement of height of children at the Anganwadi Centers (AWCs), institutionalizing Social Audits, setting-up Nutrition Resource Centers and involving the masses through Jan Andolan.

5.2.1.6. Swachh Bharat Mission (SBM, 2017)

Under SBM, India has made a steady progress towards eliminating open defecation in rural areas through mass scale behavior change, construction of household-owned and community-owned toilets and establishing mechanisms for monitoring toilet construction and usage. It is one of the crucial interventions contributing to reducing undernutrition. The Government of India launched ***Jal Jeevan Mission*** during 2019 with an aim to provide safe and adequate drinking water through individual household tap connections by 2024 to all households in rural India. Safe water too has an important contribution to reduce infections and thus resultant undernutrition.

5.2.1.7. National Education Policy (2020)

National Education Policy, Government of India has recently released (2020) this policy. It places a strong emphasis on early childhood development as a foundation for cognitive development of children. In the context of recent policy changes across different domains of determinants of undernutrition and in view of some of the recent technical evidences as well as field level experiences and the changing scenario of nutrition situation, it is imperative to review the nutrition policy at the state level and update the same in the best interest of children and women. Nutrition remains multi-sectoral issue with interventions cutting across many ministries/departments within the Government of MP. The Department of Women Child Development in Madhya Pradesh shall be the key driver of this policy with responsibility of coordinating amongst different departments to achieve policy objectives, under the overall leadership of the Chief Minister.

5.2.2. Policy Framework at State level

5.2.2.1. Bal Sanjeevni Abhiyaan, 2002

Government of Madhya Pradesh initiated the *Bal Sanjeevani* drive in the year 2001 with support from development partners in the state with an aim to identify children with growth faltering and addressing it through counselling, better service delivery at Anganwadi Centre (AWC) and tracking the children's growth.

5.2.2.2. Bal Shakti Yojana,

To prevent deaths among severely malnourished children identified under the *Bal Sanjeevni* drive, the state government further initiated Nutrition Rehabilitation Centers (NRCs) under the *Bal Shakti Yojana* with support from UNICEF. The objectives of the program is to identify children with severe malnutrition early and provide them appropriate care in order to address mortality and morbidity among the children under 5 years.

5.2.2.3. Atal Bihari Vajpayee Bal Arogya Evam Poshan Mission (ABM), 2010

Madhya Pradesh launched its State Nutrition Mission called as **Atal Bihari Vajpayee Bal Arogya Evam Poshan Mission** in December 2010 to enhance the efforts by the state to address the issue of malnourishment in children. This mission focused on creating convergent mechanism, enabling environment, implementation of innovative schemes such as *Suposhan Abhiyaan, SnehSarokar, Atal Bal Palak, etc.* and ICDS system strengthening.

5.2.2.4. SuPoSHaN Abhiyaan, 2014

ICDS in MP also rolled out the SuPoSHaN program (Supportive Program on Sustaining Health and Nutrition) with in-built components of collaborative action since March 2014. This program aims at reducing severe underweight prevalence and prevention of undernutrition through multi-pronged strategies to address food insecurity, infections, inadequate health access, and poor WASH (water-sanitation-hygiene) practices. Special camps known as 'SnehShivirs' are being held in high burden districts of Madhya Pradesh which are designed on a community-based approach for the prevention and management of moderate and severe under nutrition.

5.2.2.5. Dastak Abhiyaan, 2016

It was further conceptualized to provide comprehensive package of services at the doorstep of the community. It includes 12 services / activities such as active screening of children for severe anemia, severe acute malnutrition, critically sick children and those with pneumonia as per Integrated Management of Childhood Illnesses (IMNCI) along with counseling of Infant Young Child Feeding (IYCF) practices under the Mothers' Absolute Affection (MAA) program of the Government of India, tracking death of children under five, demonstration of hand washing steps and ORS preparation. In addition, to prevent iodine deficiency disorders amongst mother and children, testing of salt for iodine adequacy was also in-built into the Dastak strategy. The Dastak Abhiyaan is a strong example of convergent approach to provide services closest to the community leveraging existing manpower of Health & ICDS without incurring any additional cost.

5.2.2.6. Supplementary Nutrition Programe

Supplementary Nutrition is one of the six services provided under the Integrated Child Development Services (ICDS) Scheme which is primarily designed to bridge the gap between the Recommended Dietary Allowance (RDA) and the Average Daily Intake (ADI). Supplementary Nutrition is given to the children (6 months – 6 years), adolescent girls (11 -14 years school dropout) and pregnant and lactating women under the ICDS Scheme. Under the program, Take Home Ration (6 - 36 months, AG &Pregnant/ Lactating women) and Hot Cooked Meal (3-6 years age) is provided to the beneficiaries. Apart from this with support of Department of Rural development, Fortified Milk (fortified with Vitamin A & D) is also being provided thrice in a week to all 3-years children at AWC. The provision of supplementary nutrition under ICDS Scheme prescribed for various categories of beneficiaries is shown in Table 5.7

Table 5.7: Nutrition and cost norms

Sl. No.	Category	Nutritional norms (per beneficiary per day)		Revised cost norms (per beneficiary per day)
		Calories (K Cal)	Protein (g)	
1.	Children (6-72 months)	500	12-15	Rs.8.00
2.	Severe underweight children (6-72 months)	800	20-25	Rs.12.00
3.	AG & Pregnant/Lactating women	600	18-20	Rs.9.50

5.2.2.7. Mukhya Mantri Shramik Seva (Prasuti Sahayata) Yojana (MMSSPSY), 2018

In April 2018 the Government of Madhya Pradesh launched the Mukhya Mantri Shramik Seva Prasuti Sahayata Yojana (MMSSPSY) for women over 18 years of age from the unorganized sector who are registered as Shramik with the state government or are wives of registered male Shramiks. Various types of laborers including those belonging to the Madhya Pradesh Unorganized Urban/ Rural Workers Welfare Mandal and those who come under the Madhya Pradesh Building Construction and Construction Workers Mandal are covered under the scheme.

The scheme is designed to enable women to take rest before and after the birth of the first two children, and to promote improved health seeking behavior amongst pregnant women and lactating mothers. The health seeking behavior of the targeted women includes early identification of high-risk pregnancies, safe institutional deliveries, and early initiation of breastfeeding and 0 dose of immunization of the newborn. A cash incentive of Rs. 16, 000 to cover partial wage loss is provided under the scheme. The scheme is implemented by the Department of Health & Family Welfare and uses the NHM and Samagra Portals for beneficiary registration and verification.

5.2.3. Legal Frameworks at National and State level

5.2.3.1. Infant Milk Substitution Act, 1992

The Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act, 1992 and amendment act 2003 (IMS act) provides legal framework to protect and promote breastfeeding and to ensure proper use of infant foods and for matters connected therewith or incidental thereto.

Key provisions of IMS Act, 1992 (as amended in 2003)

The Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act, 1992 as Amended in 2003 (IMS Act) says –

An Act to amend the Infant Milk Substitutes, Feeding Bottles and Infants Foods (Regulation of Production, Supply and Distribution) Act, 1992. It provides for the regulation of production, supply and distribution of infant milk substitutes, feeding bottles and infant foods with a view to the protection and promotion of breastfeeding and ensuring the proper use of infant foods and for matters connected therewith or incidental thereto.

Be it enacted by Parliament in the Fifty-fourth Year of the Republic of India as follows –

1. This Act may be called the Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act 1992, as amended in 2003 (IMS Act)
2. It extends to the whole of India.
3. It shall come into force on such date as the Central Government may, by notification in the Official Gazette, appoint.

The act mandates to provide –

1. No person shall advertise or take part in promotion of infant milk substitutes
2. For the purpose of promotion or utilization or sale of infant milk substitutes or feeding bottles or infant foods.
3. The label should focus on the importance of Mother's milk: a statement "mother's milk is best for your baby" in capital letters.
4. No container should contain picture, sentence or graphical representation to increase the sale-ability of infant milk substitutes or infant food
5. The act suggests that the information pertaining to the composition of formula and ingredient along with method of preparation and health hazards if not prepared correctly.
6. Distribution of Infant milk substitutes: No one shall distribute infant milk to the community or gift unless to the orphanages.
7. Inclusion of harmful effects of complete or partial use of infant milk substitutes about effect on health of mother and child.
8. No person shall use any health care system for the display of placards or posters to promote use and sale of infant milk substitute
9. No person or health worker should involve in promotion of infant milk substitutes in term of promotion, preparation and proper use of it.
10. Professional Benefit: No producer or supplier shall create entitlements based on improvement in sales of Infant milk substitutes.
11. If any authorized officer has reason to believe that the provisions of this Act have been or are being contravened, he may seize such substitute.

5.2.3.2. Provisions of The Panchayats Extension to The Scheduled Areas (PESA) Act, 1996

Article 243 M of the Constitution, while exempting the Fifth Schedule areas from Part IX of the Constitution, provides that Parliament may, by law, extend its provisions to the Scheduled and Tribal Areas subject to such exceptions and modifications as may be specified in such law and no such law shall be deemed to be an amendment to the Constitution. On the basis of the report of the Bhuria Committee submitted in 1995, the Parliament enacted the Panchayats (Extension to Scheduled Areas) Act, 1996 (PESA) to extend Part IX of the Constitution with certain modifications and exceptions to the Scheduled V areas.

Be it enacted by Parliament in the Forty-seventh Year of the Republic of India as follows: -

This Act may be called the Provisions of the Panchayats (Extension to the Scheduled Areas) Act, 1996. In this Act, unless the context otherwise requires, "Scheduled Areas" means the Scheduled Areas as referred to in Clause (1) of Article 244 of the Constitution. Extension of part IX of The Constitution. The provision of Part IX of the Constitution relating to Panchayats are hereby extended to the Scheduled Areas subject to exceptions and modifications as are provided in section 4 of Act.

5.2.3.3. Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA, 2005)

MGNREGA 2005 aims at enhancing the livelihood security of people in rural areas by guaranteeing one hundred days of wage-employment in a financial year to a rural household whose adult members volunteer to do unskilled manual work. It is an important government flagship program that attempts to address the livelihood issues for rural population, which has significant impact on household level access and availability of food / nutrition.

5.2.3.4. The Scheduled Tribes and Other Traditional Forest Dwellers (Recognition of Forest Rights) Act, 2006

The act recognizes and vests the forest rights and occupation in forest land for Scheduled Tribes and Other Traditional Forest Dwellers who have been residing in such forests for generations. The act also establishes the responsibilities and authority for sustainable use, conservation of biodiversity and maintenance of ecological balance of forest dwelling tribes. It aims to strengthen the conservation regime of the forests while ensuring livelihood and food security for the tribal.

The act identifies four types of rights:

1. Title rights - to ownership to land farmed by tribal or forest dwellers with ceiling of 4 hectares and only for land cultivated by the concerned family.
2. Use rights – for extracting Minor Forest Produce, grazing areas, to pastoralist routes, etc.
3. Relief and development rights - To rehabilitation in case of illegal eviction or forced displacement and to basic amenities, subject to restrictions for forest protection.
4. Forest management rights - to protect, regenerate or conserve or manage any community forest resource which they have been traditionally protecting and conserving for sustainable use.

5.2.3.5. National Food Security Act (NFSA), 2013

NFSA enacted in 2013aims at providing subsidized food grains to approximately two thirds of India's population. It has led to conversion of all public food security programs into legal entitlements – making it shift from welfare approach to a right based approach.

The preamble to the NFSA 2013 says that it is *"An Act to provide for food and nutritional security in human life cycle approach, by ensuring access to adequate quantity and quality of food at affordable prices to people, to live a life with dignity and for matters connected therewith or incidental thereto."*

Describing the perspective of the Act, it is mentioned in the statement of objectives and reasons that the issue of right to food and nutrition variously refers to the Article 47 of the Constitution, which defines the Indian State's Policy Commitment that *"State shall regard the raising of the level of nutrition and the standards of living of its people and the improvement of public health as among its primary duties".*

The act mandates to provide,

2. Nutrition entitlements for Pregnant Women and Lactating Mothers
3. Special focus on malnourished children and growth monitoring
4. Maternity benefits / entitlements for ALL Pregnant Women and Lactating Mothers
5. Mandate to follow infrastructure norms for Anganwadi Centers
6. Beneficiaries have right to receive food security allowance if entitlements are not delivered.
7. Internal Grievance Redressal Mechanism (within the department)
8. Effective (external) grievance redressal mechanism (DGRO and State Food Commission)
9. Vigilance Committee and Social Audit (for System Strengthening, Transparency and Accountability).
10. Mandate to make specific-effective plans for people living in remote, hilly and tribal areas.
11. Clearly spelt out inter-multi sector linkages (Agriculture, Health care, support to adolescent girls, adequate social security pensions, safe and adequate drinking water and sanitation) call for convergence

5.2.3.6. The Madhya Pradesh Ladli Laxmi (Balika Protsahan) Adhiniyam, 2018

[Received the assent of the Governor on the 16th July 2018; assent first published in the "Madhya Pradesh Gazette (Extra-ordinary)", dated the 31st July 2018.]

This Act was formulated to provide for special rights to female children so as to enable them to realize their potential, create a social environment in which parents and society cherish female child and for matters connected. In order to promote girl child education, the act provides for financial security at various stages of her education and a lump sum grant at the age of 21 years for her future. It aims to create a positive attitude towards the birth, health and education of the girl child and create a balance in the demographic profile of the state.

6. Approach

Nutrition and health are critical pillars for survival, growth and development of every human being and it is evident that nutrition, especially during the early life, plays a key role not only in physical growth but also in neurodevelopment of the child. This is important in helping children to thrive well and to reach their fullest development potential. Public Health Nutrition (PHN), thus, needs to render nutritional resilience in building society's own preparedness to combat the threat. The PHN needs to rise to be equity-centric and equity-focused in delivering nutritional wellbeing across the board. Access to equitable, nutritious, efficient and inclusive food and public health system for all is the key to food and nutritional security, disease prevention and curative services.

Thus, the state policy encompasses the comprehensive approach factoring the determinants of malnutrition, life-cycle approach focusing on the 1000 days, adolescent nutrition, maternal nutrition and intra-uterine nutrition, and Maternal Infant Young Child Nutrition (MIYCN) approach.

The policy has the following major ingredients:

6.1. Comprehensive Approach

The National Nutrition Policy, 1993 traced widespread poverty to chronic and persistent hunger manifesting in undernutrition amongst large sections of the poor, particularly in the women and children. It recognized that the problem of malnutrition ought to be seen as part of a larger set of processes across the food chain. It sought to identify and address the interplay of three subsets, namely, agriculture, food, and nutrition, and thus needed to be addressed from a policy perspective.

The policy focus was on the multi-sectoral strategy across different levels from the community to the state and national levels. The policy laid down thrust on direct interventions (short-term) and indirect interventions (long-term). The direct interventions comprise an array of actions including inter alia, expanding the safety net for the vulnerable populations, triggering behavioral change, ensuring better coverage, control of micronutrient deficiencies, etc., whereas the long term interventions focused on addressing the strategic components including institutional and strategic changes pertaining to food security, rural/urban reforms, improved knowledge and practices, nutrition surveillance and assessments, monitoring, etc. The policy called for comprehensive, intra-and inter-sector convergence and coordination for securing sector-wide efficacy in policy implementation. The base ground of NNP, 1993 is thus taken account into the current State Nutrition Policy 2020-30.

The State Government considers it prudent to institute a "**Madhya Pradesh Nutrition Policy (2020-2030)** with the vision to have the **"State Free from Malnutrition in All Its Forms by Year 2030"**. It may be stated here that year 2015 has been considered as the baseline year for the policy for the purpose of tracking progress across indicators, in view of availability of results from National Family Health Survey 2015-16 (NFHS-2015-16).In addition, it becomes co-terminus with the SDGs. It is also emphasized here that the policy's goals and objectives are in sync with Sustainable Development Goals (SDG) 2030 and the concomitant Global Nutrition Targets (2025) as set out by the World Health Assembly. Further, the policy seeks to stay aligned with the tenets of National **Nutrition Policy 1993**, **National Nutrition Strategy, 2017** and the reinvigorated thrust on nutrition-specific and nutrition-sensitive interventions enshrined under Atal Baal Mission, Madhya Pradesh.

It is notable that the Government of Madhya Pradesh whilst seeking to adopt the mandate for the "**Nutrition Policy (2020-2030)** with the vision to have the **"State Free from Malnutrition in All Its Forms by Year 2030"** has considered it prudent to effectively take forward the tenets of National Food Security Act (NFSA) 2013. In doing so, the State resolves to recognize and deliver nutrition as a matter of right for children and women of reproductive age. The envisaged and intended resolve meets the provisions of the NFSA which include, inter alia, sectoral convergence (agriculture, water, local bodies, health, drinking water, sanitation etc.), differentiated focus on adolescent girls, deliberate and redoubled thrust on breastfeeding, creating a grievance redressal mechanism, making provision for special interventions for

tribal areas and the traditional forest dwellers with stated and scrupulous observance of transparency, accountability and social audits along with community-based vigilance mechanisms.

Madhya Pradesh State is determined to take a giant leap in improving the continuum of intermediate and process indicators vis-à-vis the targeted impact indicators. The State would be bringing a sustained breakthrough both in the content as well as the quality of programmatic interventions across the dimensions of its proactive, responsive, sensitive, and accountable governance. This is very important aspect that needs to be flagged here pertains to earmarking government allocation versus its efficacious spend on programs from the perspective of universal coverage; with the accent on reaching the unreached and underserved populations

It is also notable that the center and the state government are supporting a host of schemes which are being implemented across the country having direct or indirect impact on the health and nutrition status of the people. These include, inter alia, the following:

- POSHAN Abhiyaan (time frame of 3 years from 2018) through a Life Cycle Approach.
- Anganwadi Services under Umbrella of Integrated Child Development Scheme
- Scheme for Adolescent Girls is implemented for out-of-school adolescent girls in the age group of 11-14 years for self-development and empowerment of adolescent girls; improvement of nutritional and health status; to promote awareness about health, hygiene & nutrition.
- Pradhan Mantri Matru Vandana Yojana for Pregnant Women and Lactating Mothers.
- Infant and Young Child Nutrition (IYCN) practices.
- Interventions including Nutrition Rehabilitation Centres (NRCs), Vitamin A Supplementation (VAS), Village Health and Nutrition Days, and Mother and Child Protection Card, Anaemia Mukta Bharat (AMB) Strategy, Home Based New-born Care and Home-Based Care for Young Child Programs, National Deworming Day, Promotion for intake of Iodised Salt, Rashtriya Bal Swasthya Karyakram (RBSK) and Rashtriya Kishore Swasthya Karyakram (RKSK) and Food Fortification.
- National Health Mission
- National Creche Scheme
- ABM - Atal Bihari Bajpayee Bal Arogya evam Poshan Mission (state specific)
- Jal Jeevan Mission providing safe drinking water to the habitations
- State Livelihood Mission/ Urban Livelihood Mission to promote self-employment and micro financing among the economically vulnerable communities with focus on women engagement in form of self-help groups
- Ladli Lakshmi Yojana to promote girl child and increase girl child education (state specific)
- Horticulture Mission
- National Mission for Sustainable Agriculture
- Parampragat Krishi Vikas Yojana
- Mid-Day Meal (MDM)
- Targeted Public Distribution System (TPDS)
- Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA)
- National Rural Livelihood Mission (NRLM) / National Urban Livelihood Mission (NULM)
- Forest community rights
- Integrated Tribal Development Programs (ITDP)
- Sarva Shiksha Abhiyaan

The state policy and programmatic framework will ensure to reflect the integration of various schemes and programs through a concrete convergence action. The State seeks to render this disposition through the prioritized interventions in terms of intermediate, process and policy indicators, with an informed sense of urgency in due accordance with the National Food Security Act 2013.

6.2. Life Cycle Approach across Madhya Pradesh

The life cycle approach focuses on the first 1000 days ranging from conception to the end of the second year of life is crucial for any intervention to ensure adequate nutrition and development that will benefit in the long run throughout the life of the individual. Focusing on this period increases the child's chance of having a healthy and productive life in the future and helps to break the inter-generational cycle of poverty. The maternal nutrition is important as many malnourished children are born to a malnourished mother. This resonates the significance of nutrition for mothers during their child-bearing age. As proved through data various determinants interact with the nutritional status of the mother that is required to be focused during the entire inter-generational cycle period through a systematic life-cycle approach. Thus, this policy seeks to address gender issues, provide better health care and services, promote education and skill development programs, promoting enhanced nutrition practices to break the inter-generational cycle during adolescence by focusing through second windows of opportunity

6.3. Maternal, Infant and Young Child Nutrition (MIYCN)

65thWorld Health Assembly (WHA) resolution urged the Member States to put the MIYCN Plan into practice by including proven nutrition interventions relevant to the country in maternal, child and adolescent health services and care. Interventions carried out should ensure universal access, and establish and engage policies in agriculture, trade, education, social support, environment and other relevant sectors to improve nutrition.

The MIYCN Plan proposes five actions to support the achievement of the global targets. These are:

1 Create a supportive environment for the implementation of comprehensive food and nutrition policies.
2 Include all required effective health interventions with an impact on nutrition in national nutrition and sub-national plans.
3 Stimulate development policies and programs outside the health and nutrition sector that recognize and include nutrition.
4 Provide sufficient human and financial resources for the implementation of nutrition interventions.
5 Monitor and evaluate the implementation of policies and programs through a well-defined framework, which would allow a harmonized and internationally accepted approach to monitoring of progress towards nutrition targets.

Based on the WHA endorsed indicator framework, table below presents the matrix of indicators to monitor progress on policy milestones for the State's Nutrition Policy, Government of Madhya Pradesh is committed to address the complex issue in a comprehensive manner to improve health and nutrition status of population especially children and women in the state.

7. Guiding principles of the policy

While there are global and national evidence and recommendations to strengthen nutrition programs to achieve the desired outcomes, it is also important to consider the local context, customs, cultural patterns, socio-economic and political dynamics. Thus, the policy provides broader framework to design and implement interventions / programs adhering to following principles,

7.1. Nutrition - Key Development Agenda

State accords highest priority for nutrition issues as part of key development agenda and would strive to integrate it in all the policies, missions and programs cutting across different departments (Health, Women and Child Development, Education, Tribal Welfare, PHED, Panchayat & Rural Development, Food & Civil Supplies, Agriculture, Horticulture, Animal Husbandry, Dairy, Fishery, Urban Development, Sports & Youth Welfare, Science & Technology, Food Processing, Finance etc.) to bring about essential synergy. The state is committed to enhance financial investment in the nutrition programming across different sectors, ensuring that due compliance is observed in scrupulous implementation of all laws, regulations, codes and guidelines, i.e. Forest Right Act 2006, NREGA 2005, The Prohibition of Child Marriage Act 2006, PC-PNDT Act 2003, IMS Act 1992 & 2003, The Biological Diversity Act, 200 etc.

7.2. Universalization

State is committed to universalize the service delivery ensuring food and nutrition security to every citizen addressing the inequalities in coverage on account of any kind of vulnerability (due to gender, religion, caste, residence, geography, socio-economic status, etc.).

7.3. Context specific differential planning approach

Policy envisions to undertake comprehensive and convergent nutrition planning by understanding region specific local issues and identifying evidence based specific solutions (using the contextual nutrition profiles, local data and experiences).

7.4. Systems analysis approach for understanding the determinants

State adopts systems approach to address the complex issues which manifest into malnutrition, by involving all the key stakeholders and departments of Government for developing systemic insight for root cause analysis to further devise strategic action plan. System analysis tools will be used to identify high leverage interventions with a strong focus on data to support evaluation against the goals and metrics. Also, the approach will be to integrate multiple interventions into a clear strategy and reinforce the implementation of high leverage interventions with a process of continuous learning and outreach, expanding the resource pool, and scaling up what works the best.

7.5. Flexibility in implementation

Policy provides space for decentralized approaches such as preparation of village to district and state Strategic plan to manage nutrition-specific and sensitive interventions using their relevant data and information, with monitoring and checking indicators, their co-relation and result-based outcomes to ensure nutrition and health status. This will ensure greater flexibility at district and local levels for sustenance of the program and involvement of the community with greater responsibility.

7.6. Inclusive and gender sensitive strategies

Policy seeks to promote the rights of women and children to survival, development, protection and participation – without discrimination. Strategies / programs to ensure social inclusion of marginalized community groups, recognizing that nutritional vulnerability is compounded by multiple deprivations - based on socio economic status, high burden of disease, natural factors such as floods/droughts and/or other conditions such as lack of access to services. Efforts to focus on reaching the most vulnerable and deprived.

7.7. Continuum of care approach across life cycle

High prevalence of chronic form of under-nutrition clearly indicates the presence of inter-generational cycle of malnutrition, which is perpetuating among generations, further complicated by multiple deprivations like poverty, social exclusion, gender discrimination and complex social norms, influencing every stage of life. Hence, it is critical to broaden the scope of this policy to encompass all the stages across life cycle maintaining continuity of essential interventions.

7.8. Early Prevention Action

Recognizing that growth and development deficits that compromise child health and survival and achievement of optimal learning outcomes are cumulative and largely irreversible – there will be emphasis on preventing under nutrition, as early as possible, across the life cycle.

7.9. Community mobilization engagement and ownership

Policy envisions strong community engagement to plan, monitor and evaluate schemes / programs that contribute to nutrition outcomes and to create community driven systems to promote nutrition behaviors and to support the vulnerable families. State shall extend the process of Social Audit for nutrition security as is envisaged under the National Food Security Act 2013

7.10. Involvement and ownership of local self-governance structures

Strengthening the ownership of Panchayati Raj Institutions (PRIs) and Urban Local bodies (ULBs) is a key principle – to ensure that local self-governments own, promote, monitor and sustain nutrition initiatives – effecting convergence of action at the grass roots. This is relevant in view of 73rd and 74th Amendment of the Constitution and the Fourteenth Finance Commission Recommendations.

7.11. Nutrition Governance, Accountability, Review and Monitoring

Inclusive and equity-sensitive nutrition planning and governance architecture starting from the grassroot level by engaging the PRIs and ULBs shall be configured, integrated and streamlined. The policy and its implementation shall be reviewed at the apex steering level regularly for appraising its efficacy and status (on or off-course). Following this, course correction programmatic actions at the executive mechanisms at the state, district, block, gram Panchayat and ward levels shall be duly triggered and acted upon.

7.12. Developing and sharing of nutrition specific information and evidence-based research

Existing Nutrition Information Systems (Monitoring, Assessment, Surveillance) will continue to be developed, and mechanisms to endorse the sharing of Nutrition specific Information and evidence-based research and will be strengthened the evidence-based decision making. Research to be carried out to fill in the gaps in current knowledge base and evidence pool as and whererequired.

7.13. Outcome-oriented, effective and efficient utilization of resources

Policy would promote departments towards operative and competent utilization of available resources, prioritizing and ranking confirmed high-impact-action-interventions and proven high-impact-low-cost-preventative interventions. It is recognized that up-front investment in programs and capacity-building may be required in the short and medium term to achieve greater impact in the longer term.

7.14. Enabling environment for frontline functionaries

Policy hinges on enhancing the working conditions, skills, development pathways and motivation of frontline functionaries comprising of AWW, AWH, ASHA, ASHA Sahyogi and ANM.

7.15. Foster Innovations

When innovation introduced effectively, it has the potential to lower costs, magnify impact and improve the effectiveness or efficiency of the program objective. State recognizes the need and aims to foster

innovations, particularly showing the convergent nutrition action to achieve one or more desirable nutrition results under this policy.

7.16. Partnerships, stakeholder engagement and feedback

Involvement of communities, local governance structures, departmental field functionaries, private sector and development agencies, to create a transparent mechanism for feedback and collaborative actions, would be encouraged. It is needless to mention that development of this policy has also considered and followed these principles.

7.17. Social Behavior Change Communication plan

It is important to design the social behavior change communication plan in local dialects for its acceptability and greater involvement of the community. The messengers and vehicle of change has to be from and within the community. Also, women and adolescent girls to be made the center of discourse on nutrition. The local traditional wisdom and the knowledge of the modern day to be brought together and synthesized to evolve a society with best practices with regard to nutrition intake and reproductive age group women and childcare. Devising the communication tools and plan to be installed at field functionaries' level to mobilize the community with effective communication skills

8. Policy Imperatives/ Intervention

The global evidence suggests a set of interventions that has shown to be effective in addressing under-nutrition issues at the larger level. It is extensively documented that Maternal and Child Undernutrition is the underlying and primary cause of nearly half (45%) of the children's mortality belonging to under five years (LANCET 2013) and that one-fifth of maternal mortality can be forestalled by redressing maternal stunting and iron deficiency anemia (LANCET 2008).

From this perspective, the State Nutrition Policy will, therefore, contribute to significant statewide progress in goals like reducing maternal, infant and young child mortality. In a longer-term standpoint, the policy will also be the intent to progressively lessen all forms of undernutrition by 2030. The emphasis of this policy over the next five years is on averting and dipping child undernutrition. However, since undernutrition marks huge segments of the populace – the policy seeks to accord precedence to the most vulnerable and critical age groups, which also regulate nourishment in future life across the and inter-generational plateau.

The Lancet series on Maternal and Child Nutrition released in 2013 focused on the prevalence of the issues in relevance with stunting, wasting, and deficiencies of essential vitamins and minerals, and recognized the necessity to emphasize on the critical period of first 1000 days with where proper care and nutrition provisions and healthy growth have lasting benefits throughout life.[ii]The Series also stressed on better precedence for nationwide nutrition programs, sturdier integration with health programs, greater intersectoral slants and approaches, and extra attention and harmonization in the worldwide nutrition system of global agencies, contributors, academia, civil society, and the private sector.[iii]

It highlights importance of both nutrition specific (direct) and nutrition sensitive (indirect) interventions.[iv]

1. **Nutrition-specific interventions** highlighted in the recent LANCET series comprise adolescent and maternal nutrition, promotion of optimal breastfeeding and Infant and Young Child Feeding Practices, food and micronutrient supplementation programs for young children and in pregnancy and lactation, prevention and management of severe acute malnutrition and disease prevention and management.
2. **Nutrition-sensitive interventions** reviewed include food security and agriculture, livelihood, social protection and safety nets, early child development, child protection, schooling, women's health, empowerment, mental status, gender equity and access to services of health and family planning, WASH services etc.

In this perspective and in alignment with National Nutrition Strategy, this State Nutrition Policy would focus on these interventions across the life cycle approach, for the protection of nutrition, with focus on coupling effective nutrition-specific interventions with nutrition-sensitive programs, in addressing the immediate as well the underlying causes of undernutrition. This, apart from securing acceleration of progress, will also entail more than bringing these two together. It will rather efficiently compound these two approaches with Nutrition Governance cutting across them and lay special emphasis on addressing vulnerabilities by virtue of gender and social grouping, particularly the tribal. Predominantly, the policy will focus on all the three arms so as to realize synergy in action for accelerating the aspired nutrition progress –

1. Nutrition-Specific Intervention (i.e., Addressing the immediate determinants of nutrition)
2. Nutrition-Sensitive Intervention (i.e., Addressing the underlying and basic determinants of nutrition)
3. Nutrition Governance (i.e., Addressing systemic links with immediate, underlying and basic determinants of nutrition)
4. Focus on Nutrition in Tribal Areas
5. Convergence, Monitoring and Evaluation

8.1. Nutrition-Specific Interventions and their effective delivery

Nutrition-Specific Interventions are the responses in actions or programs focus on redressing the immediate determinants of undernutrition by endorsing the sufficient intake of food and nutrients, feeding and care giving practices and parenting habits, improved community health customs, while dropping the burden of infectious diseases.

State is committed to deliver essential evidence-based nutrition specific interventions to enhance the coverage maintaining continuity, intensity and quality at the community level for addressing immediate determinants in a comprehensive and sustainable manner. The policy-focus follows –

8.1.1. Emphasis on Intergenerational Cycle and first 1000 days

8.1.1.1. Care, Health, Nutrition and Dietary supplementation of women of Reproductive Age (including Pregnant and lactating women):

The State Policy understand the importance of maternal nutrition for the health of mother and children for ensuring healthy fetal growth and development. Meeting the increased nutrient requirements of women during pregnancy and lactation and controlling anemia is critical. The prevention of maternal and child undernutrition is a long-term investment that will benefit the present generation and their children. The determent of both maternal and child under-nutrition is a persistent and abiding contribution to support not only the existing age groups, generation but their offspring and progenies in the longer run as well.

1. The policy commits to ensure the **provision of optimum nutrition to women** in reproductive age through extensive availability and knowledge of prescribed food and supplements across the life cycle combining with efforts to improve maternal nutrition and health by improvement in **comprehensive health services** and community sensitivity and in thereby breaking the intergenerational cycle of malnutrition.
2. Assuring adequate and sufficient nutrition and relevant services to all the pregnant women throughout the gestation period thus **ensuring safe delivery** of healthy new-born having appropriate birth weight.
3. Enabling adequate nutritional intake, **Maternity entitlements** as a holistic approach including rest, incentives, nutrition and diet, and care, while ensuring timely and quality supplementary nutrition (Take-Home Ration).
4. Ensuring early registration of pregnancies and ensuring MCH card issuance, appropriate Antenatal and Post-natal care, identification and management of High-risk pregnancies*(including those due at nutritional risk– young age, short stature, moderate or severe anemia, moderately or severely thin with pre-pregnancy Body Mass Index [BMI] less than 18.5 Kg/M^2 or overweight / obese with pre-pregnancy BMI > than 25Kg/M^2, raised blood sugar levels, inappropriate gestational weight gain - < 1 kg or > 3 kg per month during second and third trimester and signs of other deficiencies like goiter, vitamin A deficiency or fluorosis)*, immunization, deworming, micronutrient supplementation for preventative and curative measure towards addressing anemia and undernutrition, Menstrual Hygiene Management, Ensuring proper weight and growth tracking, etc. Whilst the mother and Child Health (MCH) Card provides for checks on nutritional risks for pregnant women, the policy shall seek to address the strengthening of the role of the ANM in ensuring that these signs of risks are duly attended upon with due diligence.
5. As has been spelt out in section 6.2 on Outcome Indicators and Targets, the State Government seeks to reduce anemia amongst children, adolescent girls and women of reproductive age by 50% to stay aligned with the WHA Targets. This works out to overall reduction of anemia in children by as much as 34.5% (6.9% per year), in adolescent girls by 26.6% (5.32% per year) and women of reproductive age by 26.2% (5.24% per year). Whilst these targets sound very ambitious given poor trends over the preceding decade, the state government commits itself to realize these targets by according an informed impetus, particularly for children and pregnant women so that requisite reductions are duly achieved.

8.1.1.2. Child Care Nutrition and Health (Children Under-5):

The Lancet series recognized the necessity to emphasize on the critical period of first 1000 days, where proper care and nutrition provisions and healthy growth have lasting benefits throughout life. Both mother, infant and young child undernutrition has abiding upshots for cognitive competence, economic efficiency, reproductive and generative efficiency and increased vulnerability to diet related non communicable diseases including metabolic and cardiovascular disorders (Black et al., 2008; Victora et al., 2008). There is evidence -proven efforts and interventions, those when applied efficiently, can intensely diminish the degree of malnutrition (WHO, 2013a).

1. The policy commits to ensure Child Care, Nutrition and Health through promotion of Breastfeeding and Complementary Feeding and laying the healthy foundation for children in their early lifespan, thus establishing better nutrition and childcare practices at child bearer, household and community level focusing on Infant young child nutrition guidelines.
2. Persuade caring household atmosphere, facilities and supervisory social protection and safety nets programs to promote optimal IYCN practice including early initiation of breastfeeding, exclusive breastfeeding for six months and continuation of breastfeeding for 2 years and more with proper complementary feeding practices.
3. Policy would ensure Growth Monitoring and Promotion for children under five using WHO growth standards (2005) and provision of Essential Anganwadi Services including Supplementary Nutrition Program to children under 6 as per Government of India guidelines. Thus, the policy approach for children will be categorized under three segments as under –
    I. **Zero-Six months (0-180 days):** Early initiation and exclusive breastfeeding, Immunization, growth monitoring, health checkups (under HBNC and HBYC programs), Promotion of Mother's Absolute Affection - MAA.
    II. **Seven Months to Three Years (07-36 months):** Complementary feeding along with continued breastfeeding for 07 to 24 months, Immunization, growth monitoring, health checkups (HBYC), Supplementary Nutrition (THR), Promotion of Mother's Absolute Affection - MAA.
    III. **Three Years to Six Years (37 -72 months):** Supplementary Nutrition, Hot-Cooked Meal (HCM), Immunization, growth monitoring, health checkups, Pre-school Education etc.

    The detailed strategic plan is placed in Annexure- II

8.1.1.3. Second Window of Opportunity: Adolescent Care, Health and preconception Nutrition

Adolescence is a period of speedy growth, development and maturation from childhood to adulthood, which comes with both vulnerability and opportunity. The rapid development increases energy and nutrient requirements which is higher at the growth spurt than later stages. Moreover, body enters the biological and physiological changes during puberty causing the increase in the gender-specific nutrient needs particularly in adolescent girls. Anemia is the entry point and key priority at this stage. The adolescent girls along with the rights to health and nutrition have the right to gender equality as well. Thus, their special needs include protection from discriminatory social practice.

1. The policy intends to promote and ensure the provision of recommended nutrition and health services for adolescents and supporting creation of an enabling environment for the physical, mental, and social wellbeing of adolescents through interdepartmental convergence in terms of schemes and entitlements.
2. Ensuring fulfillment of their nutritional needs and provision of health services with a special focus on adequate nutritional intake, food security issues, micronutrient supplementation, Menstrual Hygiene Management, immunization, deworming, preventative and curative measurements towards anemia and undernutrition etc.
3. Ensuring reduced workload, removing child labor and child marriage practices, prioritizing their nutritional status in their families, enabling pro-environment for adolescent care under adolescent schemes, gender sensitization and equality, addressing substance abuse, school enrolment and formal and non-formal education, skills development.

8.1.2. Ensure Micronutrient Supplementation and controlling its deficiencies

Micronutrients include the vitamins and minerals those are cardinal and required for a body to develop healthy, fighting infection and diseases thus desirable for wellbeing. These are required in smaller quantity but are of utmost importance for providing the immunity and enzymes production, which is essential for body's growth and development. Micronutrient deficiencies often co-occur with protein and calorie malnutrition and have autarkical and relating effects on health, development and immunocompetence. Vitamin A deficiency, Iron Deficiency and Iodine Deficiency Disorder are the most common form of micronutrient malnutrition and are public health problems and hence considered important in the policy under holistic approach to promote optimal health and nutrition practices. Focus thusly required on dietary diversification, nutrient (both Macro as well as micronutrients) supplementation, food fortification, public health measures and horticultural interventions

1. The policy intends to promote prevention and control of micronutrient malnutrition and deficiency disorders among the vulnerable population especially children under 5, adolescent and women.
2. Ensure promotion of Micronutrient Supplementation and prevent, reduce, detect and treat Iodine Deficiency Disorders (IDD), Vitamin A Deficiencies (VAD), Iron Deficiency Anemia (IDA), and other micronutrient deficiencies; through an integrated strategy of supplementation, treatment, fortification, education and food-based approaches.

8.1.3. Integrated Management of Acute Malnutrition (IMAM) and Disease's prevention

Severe Acute Malnutrition or severe form of wasting as defined by WHO is a very low weight for height (below -3z scores of the median WHO growth standards), by visible severe wasting, or by the presence of nutritional edema.[v]Provision of appropriate care and support to children with severe acute malnutrition and increasing maternal health proportionate with reduced level of undernutrition can result in reducing thirty-five percent of deaths among children under five caused due undernutrition. Moderate Acute Malnutrition (MAM as defined by WHO is weight-for-height indicator between -3 and -2 z-scores (standard deviations) of the international standard or by a mid-upper arm circumference (MUAC) between 11.5 cm and 12.5 cm.[vi]

The fatal impact of undernutrition will be reduced by ensuring the prevention of acute malnutrition and management of children with MAM and SAM and associated infections and illness following IMAM approach. The provision of apposite services available at the public health system and Anganwadi Services, coupled with strengthened community responses for improved nutrition and care to reduce morbidity and mortality by Integrated Management of Acute Malnourished children (MAM and SAM). The IMAM approach will be securing sustainable prevention and recovery thus ensuring and establishing adequate services for preventing and treating children with Acute Malnutrition where needed. Based on the evidence and pervasiveness of undernutrition in the affected and distressed region, an integrated approach is being used in the public health system

Preventing Acute Malnutrition and associated illness and infections

Infection is one of the major causes of Acute malnutrition which contributes further in morbidity and mortality thus needs to be tackled as an integrated approach thus, IMAM approach will focus on preventing the acute malnutrition by,

1. Essential Nutrition Package (ENP) to Prevent Malnutrition in Women of Reproductive Age and Infants and Young Children by Promoting maternal nutrition, child care and spacing , IYCN, optimal breastfeeding practices, community-based growth monitoring and promotion, with referral to services for treatment of severe and moderate acute malnutrition where services are available , Control of micronutrient deficiencies (promote and provide supplementation, promote dietary diversification), immunization, family nutrition, family discourse of maternal nutrition, optimal hygiene and sanitation
2. Ensuring water and food security by promoting locally available/ diverse/ traditional/ uncultivated food

3. Developing and implementing community-based approach for management of Acute Malnutrition to prevent them slipping into severe forms of malnutrition.
4. Policy commits to undertake focused efforts to reduce incidence and provide prompt treatment of common childhood infections especially diarrhea, respiratory infections, malaria, vaccine preventable disease especially measles and chronic infections like TB.
5. Policy commits to undertake focused efforts to maintaining nutrition, health and diet in diseases including Diarrhea, ARI, EPI targeted diseases, fever, special attention for SAM and MAM, low-birth weight.

A. Management (early identifying and treating) Severe Acute Malnutrition (SAM) and Moderate Acute Malnutrition (MAM) by community-based approach

1. Strengthening the protocols to ensure early identification and timely referral of Severe Acute Malnourished (SAM) children with medical complications. Scaling up of Community-based Management of Severe Acute Malnutrition for children without medical complications.
2. Developing and scaling up of community-based approach for management of children with Moderate Acute Malnutrition to prevent them slipping to severe status.
3. Regularizing the process of growth monitoring for children under 5 Years at Anganwadi and pregnant women during ANC and universalizing the process of growth monitoring and promotion for children under 6, utilizing the Children Growth Standards established by the WHO.
4. Simple Standard Operating Procedures (SOPs) shall be formulated for use by the frontline workers and the community in management of MAM and SAM.

8.1.4. Securing Nutritional Care for the deprived and vulnerable population

1. Improve the care and nutritional status through establishing an effective nutritional care and support system (covering access, quality and coverage) for the deprived and vulnerable groups including socio-economic vulnerability, geographic vulnerability, differently abled, people living with HIVs, sexual orientation and gender identity as transgender, gender-wise, single headed families, single women, and nutritionally vulnerable and migrants
2. Ensure and promote nutritional status and quality of life of people infected and affected by HIV/AIDS and PLHIVs (people living with HIV) by increasing awareness on the relationship between nutrition and HIV/AIDS by providing the nutritional information, care and support to people infected and affected by HIV/AIDS
3. Special focus on differently abled children in child development program (including early detection of development delays) to enable protection, care and health component while increasing their knowledge base and skills, providing them barrier-free communication and physical atmosphere to enable their understanding the rights in terms of their physical, gender and sexual exploitation
4. Access to and availability of interruption-free diet, nutrition, health and educational services for children, adolescent girls and boys and women of reproductive age shall be secured for children and women who migrate out.

8.1.5. Enabling Nutrition and care in Emergency Situations including natural calamities and catastrophic pandemic like Covid-19

1. Prevent, detect and treat forms of malnutrition and nutritional situation occurring in response to emergencies situation through provision of appropriate services through the ICDS and public health system
2. Developing guidelines as an emergency response guideline and ensuring nutrition and care in emergencies, extreme weather conditions, natural disastrous situation, social conflicts

8.1.6. State's Approach

8.1.6.1. Ensuring accessibility of Public Health Services

The state will strengthen the accessibility of the adolescent, maternal and children to public health services through a strong collaboration between community level field functionaries and the community with public health system.

8.1.6.2. Ensuring Quality delivery and outreach of services through improved Monitoring

The system will primarily implement services and enhance access to preventive health services at village level by ensuring quality delivery of services with trained paramedical and Frontline workers. It will ensure and regularize monitoring in all Anganwadi Centers with continued interventions in building the infrastructure of AWCs for ANC PNC. It will make efforts to give complete coverage of RCMNCH+A Services and its outreach to its beneficiaries.

8.1.6.3. Strengthening Anganwadi Centers

Policy further envisages infrastructural strengthening of Anganwadi centers by making them child friendly, safe, and attractive. It will revitalize Anganwadi Centre as a powerhouse and acting as pivot point for all the convergent actions. Revisiting AWC to Nutritional Resource Center to envisage the proposition of Nutri-garden, crèche, knowledge house, counselling center, wellness Centre, convergence center for nutrition, IYC feeding and nutrition practices, information on locally available food, care and health component, WASH practices etc. Thus, enabling and empowering the AWWs as a resource person and facilitator. In urban setup Anganwadi center will reappropriate basis on relocation of urban slums to continue and ensure coverage of services in vulnerable area as per the GoI norms.

8.1.6.4. Capacity building of the frontline functionaries

The state will strengthen its frontline functionaries by institutionalizing capacity development programs (including reduced vacancies, identifying additional need of human resource, reviewing remuneration norms, simplification of administrative processes and technical training) of frontline workers VHSCNCs, PRIs and urban bodies, to form the face for the community while engaging it further with the public health delivery mechanism. The efforts and works of field functionaries will be recognized thus motivating them and involving them in designing actions plans efficiently at village level. Field functionaries will also be capacitated on the effective communication strategies and tools to deliver a greater amount of expressions to influence the community positively.

8.1.6.5. Create sustainable community health system

The policy will focus on systematic approach to create sustainable community health system at different levels to deal not only with nutrition and health issues during first 1000 days ensuring 100% ANC and PNC services, 90% immunization along with tackling other health issues including epidemics / pandemics.

8.1.6.6. Establishing Linkages of Community health System and Public Health Facilities

The policy will establish linkages of Community Health System with Public Health Facilities to ensure responsive system. It ensures dissemination of nutrition health services. These structures would be empowered to develop their service delivery and monitoring plan adhering to principles of equity (reaching the most marginalized and deprived segment) while ensuring the community participation. It will enable Anganwadi Centers and Panchayat to act as service delivery hub for the community health system at village level.

8.1.6.7. Efficient linkage with public health facilities

Community health system would have functional and efficient linkage with public health facilities with an aim to reduce response time for any curative health service need of the communities as well as for the fulfillment of the need for any medical supplies at the community level.

8.1.6.8. Developing and enhancing Social Capital

The state will create and develop social capital encompassing *Sahyogini MatruSamiti*, and community level groups like women's self-help groups and Shourya Dals, and linking them with existing local groups and bodies Vigilance Committee like JFMC, SMC, and Self-help groups to enhance community understanding and acceptance of nutrition knowledge and adopting them in behaviors and practices. The policy also adheres to capacitate the Self-Help Groups on promoting locally available and diverse food in Hot Cooked Meals and to establish decentralized SNP services to ensure quality and timely distribution, and its acceptance in the community.

8.1.6.9. Imparting Nutrition literacy Programs

The policy intends to ensure Nutrition literacy through nutrition communication. Policy further intends to achieve sustainable behavior change at community level to strengthen feeding, care giving practices, parenting habits and improved community health norms / customs. Thus, providing scope for developing

effective nutrition communication plans considering local issues, local languages, traditional media and popular activities. Policy will encourage involvement of local communities to execute the communications plans.

8.1.6.10. Ensuring Social Behavior Change Communication (SBCC) and community mobilization

The policy also contemplates to address Socio-Cultural Beliefs and Social Behavior Change Communication (SBCC) and community mobilization pertaining nutritional wellbeing of women and children. It prompts intended changes in nutritional actions, conduct and practices impacting the nutritional status, communication for changing care behaviors, such as observing community based events addressing key stages of the life cycle, counseling on IYCN, Growth Monitoring and Promotion, better care activities including WASH, IYCN feeding practices, psychosocial, care of adolescent girls women and children; prevention, care and integrated management of SAM and MAM through community-based approach, abolishing mal-practices of child marriages and early pregnancy, practice of identifying "nutrition-champions, practice of including locally available/diverse/cultivated/uncultivated foods, use of iodized and Double Fortified Salt, wherever available in social safety net programs". This will ensure adoption of good nutrition practices while addressing misinformation, myths and taboos about food and nutrition. This will influence markets and food prices. The approach will utilize Participatory Learning and Action (PLA)and Community Nutrition Need Assessment to mobilize the community.

8.1.6.11. Leveraging technology:

It will implement health services by department to ensure monitoring of rural and urban local bodies on real time basis. Specific efforts for capacitating frontline workers will be put in place for using prescribed technologies for monitoring, awareness and grievances redressal.

8.1.6.12. Joint State Level Health Survey

Joint State level survey will be conducted periodically by Women and Child development department and Health department on overall nutritional indicators.

8.2. Nutrition-Sensitive Interventions and their effective delivery

Nutrition-sensitive interventions mentioned in this policy are programs or responsive actions work on redressing the underlying causes of malnutrition - undernutrition including food security; efficient care giving services at all levels including care-giver, family and community; and accessibility towards services of health, WASH, while integrating nutrition explicit actions and goals. These programs lend transport podiums for nutrition-specific interventions, possibly growing their gauge, treatment, and efficacy.

Nutrition-sensitive programs therefore contribute in stabilizing nutrition-specific programs thereby creating the exhilarating atmosphere for mothers, infants and young children to attain their growth and development to the fullest.

Nutrition sensitive interventions are identified based on understanding of the causative factors leading to the malnutrition and deep-rooted linkages to various sectors such as agriculture, education, safe drinking water, health and hygiene, livelihood, social security, environmental factors, genetic factors, susceptibility to vulnerable community diseases and natural disasters, political aspects, engaging multiple stakeholders other than family, society, political and social leaders, civil society organization and government

Under this policy, state commits to strengthen programs for implementation of nutrition sensitive interventions through following approaches:

8.2.1. Contributing to food security and diversity through nutrition-sensitive agriculture

Nutrition-sensitive agriculture is a food-based approach to agricultural development that puts nutritionally rich foods, dietary diversity, and food fortification at the heart of overcoming malnutrition and micronutrient deficiencies. Agriculture remains an important focus for pro-poor and pro-rural nutritional interventions in India. This makes leveraging agriculture to address under-nutrition a key area

of focus. State would integrate nutrition-sensitive strategies into agricultural development policies promoting '**Plant what you need to eat'**.

Six pathways through which agricultural interventions will impact nutrition –

1. *Food access* from own production.
2. *Income* from the sale of commodities produced.
3. food prices and nutrient content from changes in supply and demand in community
4. *Women's social status and empowerment* through increased access to and control over resources.
5. *Women's time* through participation in agriculture, which can be either positive or negative for their own nutrition and that of their children; and
6. *Women's health and nutrition* through engagement in agriculture, which also can have either positive or negative impacts, depending on exposure to toxic agents and the balance between energy intake and expenditure.

State will implement the nutrition-sensitive agricultural through –

1. Increasing availability, affordability and accessibility of food through increased agriculture production to improvise both the health and the economic status of the community.
2. Promoting sustainable production practices like conservation agriculture, water management and integrated pest management, family farming, home gardens and homestead food production making wider variety of crops available at the local level.
3. Encouraging production and self-supporting growth of staple foods – rice, wheat, potato and sweet potato and non-staple foods – pulses, oilseeds (mustard, sesame, soybean, groundnut, and cottonseed) fruits, vegetables, fish, meat and poultry products.
4. Promotion of cultivation and use of millets as nutrition storehouse to develop sustainable local food systems.
5. Focusing on market infrastructure to provide similar access to lower-cost, higher quality foods around the year by ensuring increase production and consumption of biodiverse nutritive foods and utilizing short supply chain chains as a market-based approach. Enabling community to adopt better practices for post-harvest storage and handling to establish marketing linkages
6. Building networks of key players including various of stakeholders in the value chain right from the researchers to institutes, to breeders, market persons, venders and customers to improvise the nutrient contents in a crop
7. Discourage indiscriminate use of chemical fertilizers, insecticides and pesticides, so that residual effects in the harvested crop remain within permissible limit.
8. Raising awareness to community and key players on the stakeholders on the importance of biodiverse foods and nutrients, their role in boosting up the immunity and strength, and preparing base for developing and enhancing nutrition -sensitive agriculture

8.2.2. Promoting nutrition sensitive food system to ensure biodiversity and bio-fortification to encourage nutrient rich food consumption

Assessing biodiversity helps to identify available species and varieties that can address state-specific malnutrition issues in a cost-effective and locally acceptable way. Improved knowledge and appreciation of indigenous and rural peoples' food systems and diets through taking note of their potential strength in terms of nutrition and environmental sustainability, understanding the drivers of disruption, and designing culturally appropriate approaches to conservation and use of indigenous genetic resources and food systems. Bio-fortification puts a solution in the hands of farmers, combining the micronutrient trait with other agronomic and consumption traits that farmers prefer. Thus, is a part of larger portfolio of sustainable, food-based approaches to nutrition. The policy will ensure every member of the community is able to answer and act on - ***"Do you know, how much to eat? And, what to eat?"***

Through this policy, the state will ensure the nutrition-sensitive biodiversity through –

1. Taking Community-level initiatives to build the support to the community and local people like creating seeds banks, village seed-fairs, small enterprise seed entrepreneurs, managing the natural resources, promoting local and forest produce rich in micronutrients, boosting

community local food system, generating resources and empowering tribal and indigenous people.

2. Collecting and analyzing data on food composition, as well as data on yields, for different species and their varieties/cultivars and breeds (including for wild and underutilized foods) is essential to ensure that nutrient content becomes a priority criterion in cultivar promotion and research.
3. Increasing nutrient contents of food through bio-fortification focusing on processing, plant breeding and improved soil fertility
4. Promoting fortified foods available under Social Safety Nets while conducting the technical and feasibility studies on fortified and its usage, and endorsing the national standards leading the fortification of local or regional foods joined with decree of pertinent regulation.
5. Ensuring increase in production and consumption of biodiverse nutritive foods and utilizing short supply chain chains as a regulated market-based approach.
6. Establishing linkages with ecology (mapping of cultivated and uncultivated food, promotion of forest grown foods, poultry, fisheries, knowledge sharing by experienced and senior members of the community, engagement with the making of ecology diversity register etc.)
7. Promoting selection and production of species and varieties based on yields as well as nutrient contents (nutrient productivity), thereby enhancing the macro-micronutrients.
8. Developing bio-diversity register and supervisory and monitoring system to protect the biodiversity and establishing broader policies for tackling ecosystem degradation.
9. Promoting nutri-gardens (home and farm gardens), domestic poultry, farming livestock and fisheries, enabling its ownership (e.g., cattle, chicken and other poultry, small ruminants such as goats and sheep) to promote to dietary diversity, home consumption, income generation, home-based animal husbandry to enhance integrated farming systems. Thus, this will help in developing nutria-smart village.
10. Promoting sustainable fishing, home-based aquaculture, cultivating fishes of high nutrient contents
11. Under the framework of Annapurna Panchayat, the community would be able to ensure food sharing by enabling practice of community *Nutrition Rasoi* and Vyanjan Divas (nutritious recipe day) filled with locally available and diverse foods available from uncultivated/cultivated sources and homestead gardening

8.2.3. Ensuring livelihood programs/schemes and establishing linkages with MNREGA and Forest Right Act for livelihood security and income generation

Livelihood comprises of activities such as agriculture, fishing, rearing animals, collecting daily necessities like water, fodder, food items as well as goods like timber and medicinal plants from surrounding wasteland and forest, agricultural as well as non-agricultural wage work, crafts, etc. and majorly depends on MNREGA or migration (absence of livelihood opportunities). Rural people hinge on additional resources in terms of the livelihoods. A deprived household will raise its food security through growing crops on a small piece of land, rear goats, and migrate to cities as unskilled labor. Thus, promoting livelihood and establishing linkages becomes crucial in enabling and ensuring the marginalized and deprived households generating income, increasing purchasing power and improved nutritional habits, and mitigating malnutrition.

Through this policy, the state will encourage livelihood opportunities by –

1. Ensuring every family especially vulnerable family gets meaningful employment including at-least 200 days employment for families of SAM.
2. Stressing on livelihood securities, appropriate strategies and establishing its linkages with schemes like MNREGA/SRLM/NULM, forest rights and natural resources, forest products, forest food items, strengthening of self-help groups, fisheries, poultry, goat rearing, as livelihood options.
3. Enabling Initiatives of Gram Panchayats, Urban local bodies, State Governments and Civil Society Organizations to connect rural families with livelihood opportunities in rural and urban setup.

4. Targeting those crops which have good market price as well as high nutrient contents including milk and dairy products, fisheries, animal sources etc.

8.2.4. Creating gender-sensitive programs to empower Women

Women's empowerment refers to improving the social, economic, political and legal strength of women so that they gain power and control over their own lives. It is the precondition to achieving gender equality, which refers to women and men having equal rights, opportunities and entitlements in civil and political life. In the food and agriculture sector, gender equality refers to equal participation of women and men as decision-makers in rural institutions and equal access to productive resources, assets, decent employment opportunities, income, goods and services for agricultural development and markets.[vii]
Women empowerment and male involvement are the key measures in the Indian communities to improve nutrition especially for women and children. Research has shown that when women are empowered to make decisions about the household goods, the health of the household improves (Bennett, 1988)[viii].However, it is often the case that decisions are taken either by the male members or women in positions of power.
Women perform productive as well as reproductive roles; therefore, the trade-offs between childcare and agricultural production to be carefully assessed. Time and labor demand to be evaluated to avoid negative impacts on care, health and nutritional status that might result from women's increased workloads. The pathway from women's empowerment to improved nutrition consists of three interrelated components: women's use of income for food and non-food expenditures; women's ability to care for themselves and their families; and women's energy expenditure.[ix] Both women's empowerment and gender equality are at the nexus of the agriculture, nutrition and health sectors.

The policy intends to design and implement gender-sensitive interventions in agricultural and rural development, urban development and the food system by,

1. Addressing unequal gender relations and empower women, are major factors contributing to the success of programs to improve nutrition.
2. Enhancing and imparting knowledge and competencies on role of gender in nutrition, family structure livelihood, agriculture, gender-neutral messages to promote health component alongside making women empowered.
3. Focusing on food crops grown by women and improving women's access to extension, rural advisory and financial services as well as to information and markets.
4. Promoting income-generating opportunities for women and ensuring their equitable access to decent employment and control over earned income are equally important.
5. Involving all the members of the household including male members, as well as community leaders, who often play an important role in household dynamics and decision-making with a special focus on inter-sectional families including single headed families, single mother and father families to encourage male members in participating actively and share responsibilities with mothers and women in caring for their infants and young children, and household chores and work loads
6. Promoting the adoption of labor-saving technologies and practices, water-source construction and rehabilitation to further reduce women's workloads and free up valuable time for childcare, food preparation and women's health and leisure.
7. Designing strategies that can target, and be adapted to, both men and women regarding access to a diversified nutrition rich food, equal livelihood opportunities, increasing purchasing powers by enhancing consumption and selling of kitchen gardens products
8. Equal access to participation and decision making of women in social, political and economic wellbeing of the family and to nutrition and health care by changing societal attitudes and community practices through active participation and involvement of both men and women.

8.2.5. Positive stress on Social Protection and Safety Nets

"Social protection encompasses initiatives that provide cash or in-kind transfers to the poor, protect the vulnerable against risks and enhance the social status and rights of the marginalized – all with the overall

goal of reducing poverty and economic and social vulnerability." (SOFA, 2015). Safety nets and social protection schemes helps in addressing the social and economic determinants of undernutrition and thus improves nutritional status. Additionally, social protection support families increasing their consumption of nutritive food, helping them maintaining their asset base, crucial for supporting decent nourishment in the long run and easing entree to health care and services.

Targeted Public Distribution System – The Targeted Public Distribution System (TPDS) operated by Department of Food, Civil Supplies and Consumer Protection, under the National Food Security Act, 2013 has an important role to play in ensuring family food security and tackling the challenge of undernutrition among women and children.

The policy intends to implement this through,

1. Ensuring timely and proper distribution of HCM and MDM prepared in hygienic conditions using double fortified salt (Iodine and Iron) and locally available food while ensuring attendance.
2. Enabling Local bodies to ensure including locally available food/ uncultivated and cultivated diverse food in the MDM and HCM menus.
3. Promoting local purchase for school meals or food distribution thus enabling and improving nutrition and purchasing power both of the consumers, community and producers
4. Ensuring support in food and transfers from local markets without compromising the nutrient value of the ration
5. Recognize the Right to Food and the Right to Health and to ensure adequate social protection systems as a way to fulfill them.
6. Coordinating with the Department of Food, Civil Supplies and Consumer Protection to take policy initiatives to address food insecurity of identified families with undernutrition and anemia in ensuring their entitlements under NFSA
7. As the supply of food grains for supplementary nutrition programs under the ICDS program is provided through TPDS, it will be ensured that the barriers to conducting supplementary nutrition programs are collectively removed by improving coordination.
8. Making beneficiaries well informed on the buying PDS commodities
9. Also make beneficiaries aware about their rights and entitlements, corruption levels and redressal mechanism etc.

8.2.6. Promoting school health, food and nutrition approach through classroom education

The school food and nutrition approach are the portfolio of activities benefiting the nutrition of school-aged children. It encompasses several elements – from provision of nutritious meals to nutrition education, from school gardens to school environments that support nutrition and health – for addressing the immediate food and nutritional needs of school children, as well as the wider aims of improving the health and nutrition of children beyond the school years.

The policy intends to develop life-long healthy eating habits, and contribute in generating new demand for, and supply of, healthy and nutritious foods by encouraging children, their families and the school community by,

1. Promoting School health interventions including early and supported learning of positive behaviors for healthy and nutritional wellbeing
2. Ensuring School meals (i.e., cooked meals, snacks and take-home rations, as appropriate) comprised of a diversity of foods, including local foods for healthy, traditional diets.
3. Enabling the local procurement for school meals (e.g., Community Grown School Meals) thus offering them opportunities to establish connection with local farmers to raise demands, enhance incomes, endorse their social and monetary inclusion and diminishing poverty.
4. Ensuring hands-on activities, including school gardening, to be leveraged within comprehensive and culturally appropriate nutrition and health awareness programs that provide opportunities to learn about hand-washing, personal hygiene, food safety and physical activity.

8.2.7. Ensuring Safe drinking water and Sanitation

The Sustainable Development Goals (SDGs) have raised the quality standard to safely managed water supply and sanitation. The shift from addressing access to quality, equitable, and sustainable services is

an important enhancement that can improve the child's health and nutrition impacts of WASH services. Poor sanitation and hygiene make children vulnerable to infections, therefore delays their growth and development.

The policy thus envisages to enhance the water quality, sanitation, and hygiene practices in combination with other nutritional interventions through,

- Promoting access to improved water sources and improved sanitation facilities for beneficiary households with children under five
- Improvising the safe drinking water and sanitation facilities at AWCs, CHCs, PHCs, other health care institutions
- Social mobilization to construct and use household toilets, or to construct small-scale community water supply systems to support the ODF status and Swachh Bharat Mission
- Imparting nutrition sensitive WASH behaviors change and practices in field level functionaries on better water, health and sanitation practices through training and capacity building sessions
- Increasing the number of communities in villages and urban area's participating in surveillance system for safe drinking water and enabling households practicing safe disposal of child and animal feces parental counseling and behavior change communication around household sanitation and hygiene
- Promoting “baby WASH” or “child-centered WASH” includes food hygiene, clean play environment, management of animal and child feces, and infant and child handwashing at AWCs

8.3. Nutrition Governance (PoshanSarkar [Sushasit Poshan] towards Suposhit Madhya Pradesh)

State accords highest priority to improve governance of nutrition programs at all levels, as it remains a key to address these multi-sectoral issues that demand collective planning and constant monitoring of various interventions for ensuring coverage, continuity, intensity and quality with transparency, accountability; and further requires proper organization and responsive coordination between different stakeholders, sectors and government.

Nutrition governance Approach in framework of **Poshan Sarkar** follows –

1. Establishing planning, monitoring and effective grievance redressal mechanism by involving committees including local bodies (PRI and urban), VHSNC, SMC, JFMC, Matru Sahyogini Samiti etc.
2. Community Based management of nutrition and health services – Developing community ownership by involving informal groups like Shourya dal, youth and adolescent groups, women groups, Self-Help groups and community mobilizers
3. Result-based reviewing and incentivization of the formal and informal groups

Nutrition Governance emphasizes the importance of numerous programs and approaches, priority lists, evidence-proven activities, multi sectoral interventions for pursuing a combination of nutrition-sensitive interventions like agriculture, health, water and sanitation etc. along with underlying determinants of nutrition that should be addressed (poverty, food security, the existence of access to resources such as health care and clean water, and social inclusion) by involving the local bodies.

Local bodies (urban/rural) are more responsible to assure the progress indicators of Human Development Index but are not recognized and responsive largely despite of being resourceful and acceptable to the community, thus needs to be affirmed as a channel in the ladder of Nutrition governance.

This policy envisages to strengthen nutrition governance at community level by developing community ownership through identifying and capacitating social capital, mapping of locally available resources, enabling environment and community monitoring and Social Audit by strengthening and activating local bodies and PRIs, vigilance committees to ensure their involvement in raising nutrition and health issues and problems pertaining to women, children and community. This approach would involve:

8.3.1. Mapping of Social Capital (Existing Groups)

Mapping and identifying of existing groups at village level i.e., Gram Sabha, Village Health Nutrition and Sanitation Committee, SHGs / CBOs, Shourya Dal, Matru Samiti, Vigilance committee, Joint Forest Management Committees, School Management Committees as Social Capital

8.3.2. Capacity strengthening of groups and members

Sensitizing the identified social group on nutrition specific and sensitive issues and activating programs and approaches inter-related with nutrition directly or indirectly including agriculture, horticulture, MNREGA and National Food Security Act, Forest Rights Act, Social Safety Nets, early childhood development (ensuring IYCN and proper growth monitoring), maternal mental health, adolescent and women's empowerment, water and sanitation and health.

8.3.3. Mapping of locally available resources for its optimum utilization

Prioritizing evidence-proven activities that focus on combination of sectors where nutrition sensitive work can be tracked (agriculture, health, social protection, early child development, education, and water and sanitation)

8.3.4. Engagement of Social capital

Engaging social capital to identify the issues, mobilizing the resources and ensuring its optimal and effective use, encouraging community participation, in addressing the social and cultural behavior related to malnutrition.

8.3.5. Enabling environment

In collaboration with local bodies creating enabling environment for developing village health and nutrition plans, for uptake of improved behaviors and access to key services like antenatal care, immunization, supplementary nutrition, growth monitoring and community-based management of severe acute malnutrition. This ensures Community Based management of Health and Nutrition Services and other related services and schemes. Enabling PRIs and other groups to ensure the convergence as well as sensitizing the community on nutrition sensitive issues like water, sanitation, gender-issues, agriculture, livelihood etc.

Efforts will be made to improvise Nutrition and Allied Schemes Management Information System relating to Nutrition and Nutrition Sensitive Interventions and Programs for ensuring outcome-based planning and review. Under the purview of good practices of Nutritional Governance, panchayat and ward level nutrition profiles will be prepared; data and information of nutrition indicators will be shared and discussed with the Community Groups and PRIs.

8.3.6. Role of local self-governance structures and PRIs

Strengthening of community-based monitoring of all the interventions by appropriate devolution of resources to the PRIs and different community structures / committees operating under the larger governance framework at the community level. Communities would be empowered to take charge of the issues that concern their well-being. PRIs and urban body representatives can play a very active role for Malnutrition-Free-State (*Suposhit Madhya Pradesh*) through the Gram Sabha/Mohalla Samiti where their role can ensure that the women and children in their respective areas should access all opportunities and chances of development. Ensuring role of PRIs as –

1. Developing functional **'Annapurna Panchayat'**and **'Annapurna Ward'**which works on the principle of participative nutrition taking appropriate care of the vulnerable families for their nutrition needs with the support of the community involving all the resources available at the panchayat and urban local bodies level. The policy will encourage leaders of panchayats to take such initiatives at the village level and would recognize, those who take it forward successfully under their panchayat, as **'Poshan Sarkar'.**
2. Inviting the field functionaries of the Anganwadi Centre, Mid-Day Meal, School, Public Distribution System, Health, Sanitation, drinking water, agriculture, horticulture, dairy, and fisheries etc. in such meetings.

3. Bringing up all the groups (formal and non-formal) on common platforms by conducting the regular and periodic meetings with PRIs at Panchayat Samiti/urban ward office on the prescribed date as mentioned by State Government
4. Ensuring Gram Panchayat's agendas to include and prioritize issues of health and nutrition to address malnutrition, anemia, infectious diseases etc. concerning women and children.
5. Ensuring the regular review/assessment of the status of Village/urban wardSanitation, Drinking Water, Anganwadi, Fair Price Shops, Maintenance of School Buildings; Health Centre, gender-sensitive issues, as per their agendas

8.3.7. Social Audit

State emphasizes to institutionalize Social Audit mechanism to ensure transparency and accountability. A social audit is a way of measuring, understanding, reporting and ultimately improving organization's social and ethical performance. It helps to narrow gaps between vision/ goal and reality, between efficiency and effectiveness. State would adopt an extensive community-centric process of nutrition program review and validation with the involvement of community groups, which will be followed by Poshan Sabha, Jan-Sunwai (Public Hearing) on nutrition and health. This would be binding on all the implementing departments to adopt this process for creating accountability at the field level.

Detailed Matrix Nutrition-specific, nutrition-sensitive and nutrition governance is placed in **Annexure IV**

8.4. Focus on Nutrition in Tribal Areas

Madhya Pradesh has the highest population of tribal communities in the country at 20.3% and a high burden of undernutrition. Tribal women and children continue to remain more vulnerable to various deprivations especially nutrition. As per Ministry of Tribal Affairs[x], the food intake and intake of various nutrients have decreased in the last decade amongst the tribal population. The tribal population in state is severely challenged by malnutrition. Tribal children are one and half times more under weight than children from 'other castes'.

It is amongst the tribal communities that individuals have shown up the direct health fallouts. NFHS-4 shows that malnutrition in all of its varied aspects is anytime more amongst Scheduled tribes and Scheduled Caste than any other community. According to NFHS-4 about 51.5 percent of children below 5 years of age in ST communities are underweight as compared to 42.8 percent Madhya Pradesh and 35.8 percent of India In the similar vein, children below 5 years of age in ST communities continue to lag behind in height-for-age (stunting) and weight-for-height (wasting) with 48.2 percent and 30.2 percent as compared to Madhya Pradesh's 42 percent and 25.8 percent respectively. It is evident that if the focus is sharpened on improving nutrition in tribes, it would result in overall improvement in the health and nutrition status of the population in Madhya Pradesh.

The tribal population in the state faces triple burden – malnutrition, rise of communicable diseases and mental illness due to environmental distress and changing lifestyle. To add on there are other severe constraints at all levels including worse socio-economic determinants, especially in education, income, housing, connectivity, quality of health services provided, availability of safe water and sanitation. Thus, restructuring, re-strengthening of the public health and nutrition services in accordance with the need of tribal malnutrition especially in their vulnerable segments with full participation of tribal communities should be the highest priorities.
State policy envisions to address the vulnerability of tribal population by emphasizing on development of region-specific plans through community engagement, enhanced public health service delivery and combining the traditional knowledge of food from the indigenous tribes (Gond, Baiga, Bhil, etc.) with nutrition awareness, local food and tribal heritage.

State will undertake following strategies to assure nutrition in tribal areas by addressing their specific needs nutrition-related issues –

1. The policy commits to assure nutrition sensitive initiatives as per the legal provisions under Panchayats Extension to the Scheduled Area Act, 1996 (PESA) which focuses on providing the tribal community to protect their traditional and customary system
2. Involve traditional and indigenous knowledge of the tribal community developing the policies ensuring the decision-making and choice-making powers on the community, equipped with

nutrition knowledge while uplifting of the tribal women and children to ensure access to food and information

3. Ensure local knowledge at the heart of the information dissemination to food diversity and nutrition security to increase awareness among the target communities.
4. Ensure the access of the tribal community of different public services like Madhya Pradesh NFSA, PDS, ICDS and the specific schemes meant for the tribal population to provide short term and long-term measures to enhance food and nutrition security of tribal population in the district.
5. Policy envisages to ensure fulfilment of community rights as mandated by The Scheduled Tribes and other Traditional Forest Dwellers (Recognition of Forest Rights)Act,2006like extracting Minor Forest Produce, grazing areas, to pastoralist routes etc. and right to cultivate traditional foods and conserve biodiversity. The grant of community rights will be ensured in order to protect the marginalized socio-economic group of people and balance the right to environment with their right to life and livelihood.
6. State would ensure collaboration between tribal communities for traditional tribal wisdom and millets mission to identify and promote cultivation of appropriate millets locally.
7. Review the existing situation of health in tribal areas, suggest interventions, formulate strategic guidelines for states, and make recommendations on the requirement of additional resources
8. Ensure developing a national framework and roadmap to improve the appropriateness, access, content, quality, and utilization of the health services among the tribal population, particularly those living in scheduled areas, collating the data and information, and making action plans considering their local preferences, tastes and traditional wisdom in terms of securing nutrition and food security.
9. Emphasis on Focused areas including malaria control, use of additive substances, reduce malnutrition, child mortality, ensuring safe motherhood and health of women, timely treatment of animal bites and accidents, ensuring positive family planning services, sterility care, redressing anemia, promoting health and nutrition literacy
10. Ensuring Protection to natural based nutrition security systems and focusing on tribal area specific target-based planning.
11. Reducing prevalence of tribal malnutrition by their ensuring their food security issues through nutrition counselling of tribal women and adolescent girls specifically on utilization of locally available food and promoting their long-gone traditional nutrition practices, prevention and treatment of especially in the wake of Covid-19 crisis, emergencies and extreme weather conditions, infections, sickle-cell anemia
12. Enhancing tribal communities in participation in Tribal health advisory councils, district level consultative tribal health council, their involvement in Gram Sabha, VHSNCs, SBCC and community mobilization on health and nutrition issues relevant specifically with tribal population, counseling for mental distress and regaining the lost ecological stature etc.
13. Additional financial outlays to be made for strengthening the reach of the public health delivery system in tribal dominating areas as well as for meeting food and cash needs of the migrants

8.5. Convergence, Monitoring and Evaluation

8.5.1. Multi-stakeholder Convergence

Policy acknowledges the need for effective convergence mechanism for efficiently implementing nutrition sensitive interventions and envisages to establish a strong convergence mechanism to plan, implement and monitor program. This would not only involve intra-government convergence among different departments (especially Health, Education, Tribal Welfare, PHED, Panchayat & Rural Development, Food & Civil Supplies, Agriculture, Horticulture, Veterinary, Urban Development, Sports & Youth Welfare, Science & Technology) and schemes at all levels, but also involves convergence with private sector service providers, corporates, academic institutions, professional bodies and networks, civil society organizations and development partners. In order to make it effective, a systemic approach would be undertaken to establish functional linkages between program and stakeholders.

The state mandates to structure the multi sectoral approach within department as well as Public and private sectors and Civil Society Organizations to work together on nutrition specific and nutrition sensitive interventions. The Nutrition Policy plans to create the space for departments and local bodies taking ownership in relevance to convergence approach in terms of implementation, regulation,

monitoring and evaluation. The Policy further aims to involve and utilize the CSR resources for the platform to address malnutrition within causal framework. This would enable the society to handle their issues for reducing the episodes of malnutrition and sustain the good nutrition behaviors.The convergence action plan will be focused on cross-sectoral convergence to emphasize the multidimensional nature of malnutrition by mapping of various Schemes contributing towards addressing malnutrition.

Convergence needs to be considered from two perspectives – perceptions and approaches, and Programmatic/Schematic. As the SDG and WHA targets are time bound it is important to have the evidence-based data which could rather be difficult looking to the purview of different departments. Utilizing the data to plan the program further and achieve the targeted results it is important to have convergent actions on it.

Through this policy the state will create accountability and transparency in the system by providing the similar grounds for different departments/schemes to act upon by,

1. Convergence within the governmental department and schemes which directly or indirectly developing tools to measure the extent and effectiveness of conference of activities of various departments as well as with the community and civil society
2. Strengthening of the social capital, fixing Monthly Village Health, Sanitation and Nutrition Days/gram Sabha/nutrition dialogues days to constitute the effective platform for convergence of services to the mother and child and a forum for growth promotion and behavioral change counseling.
3. Establishing gap filling to tap the resources in the districts to support infrastructure and services
4. Enabling energetic and participatory atmosphere in the community where they take the ownership to develop the Village Development and Nutrition plan linking it with different schemes and programs while addressing the underlying and immediate determinants of undernutrition.
5. Revitalizing Anganwadi Centre as a powerhouse and acting as pivot point for all the convergent actions.
6. Revisiting AWC to Nutritional Resource Center to envisage the proposition of Nutri-garden, crèche, knowledge house, counselling center, wellness Centre, convergence center for nutrition, IYC feeding and nutrition practices, information on locally available food, care and health component, WASH practices etc. Thus, enabling the capacity building and empowering the AWWs as a resource person and facilitator
7. Strengthening of Community Health Systems and establishing its Linkages with Wellness Centers providing and establishing ways out for convergence and coordination, monitoring, equality, access to services, availability of services according to the norms, transparency, grievances redressal mechanism etc.
8. The triple A platform of AWW (Anganwadi Worker), ASHA shall be extended to include and integrate Agricultural Extension Worker in communicating with and working for the community towards securing its nutritional wellbeing, with particular attention to the children and pregnant women and those from the vulnerable sections.

   Detailed Convergence plan is placed at Annexure-III

8.5.2. Differential planning and implementation

State would undertake differential and decentralized assessment and planning approach to understand local issues and cause-effect relationships of underlying and basic determinants operating in the specific context. This would enable very focused and tailored response to programming in the specific area, thus helping to achieve the desired results. Implementation of these plans would also follow the similar approach with greater involvement of local communities in execution and monitoring of the interventions based on their specific needs. **Detailed design of institutional arrangements for convergence is placed in Annexure-III**

8.5.3. Policy Accountability, Review and Monitoring

Inclusive and equity-sensitive nutrition planning and governance architecture from the village/urban ward level to that of the state government shall be aligned, integrated and streamlined. The policy and its implementation shall be reviewed at the apex level steering committee every two years (2022, 2024, 2026, 2028 and 2030). In addition, the policy shall be especially reviewed in year 2025 also to mark the coinciding with the review of the Global Nutrition Targets. Following this, course correction programmatic actions at the executive mechanisms shall be duly triggered and acted upon.Basedon the

policy directions, respective departments would issue detailed guidelines for implementation of various strategies and to develop comprehensive convergent plans to address nutrition issues. The state, district and village level plans of actions developed and implemented to achieve the policy objectives, would be reviewed at regular frequency (quarterly) at all levels.

The policy envisages the effective planning, monitoring and review through,

8.5.3.1. Nutrition Surveillance/Survey

1. Strengthen institutional capacity at all levels, to efficiently compile, assess, analyses and monitor nutrition and nutrition related situations
2. Establishing a mechanism to endeavor the support in measuring, examining, monitoring and assessing nutrition and nutrition relevant surveillance
3. Incorporation of Nutrition indicators into Early Warning Systems like growth faltering and ensuring growth monitoring and promotion at community level by energized social capital
4. Creating awareness amongst the stakeholders on the significance of Nutrition Information Approach and the tactics to utilize it
5. Conducting Audit on Anganwadi Infrastructure and providing feedbacks on the same and prepare a checklist ensuring on the basic facilities provided at Anganwadi including safe drinking water, provision of proper storage facilities of THR, proper hygiene facilities, provision of toilets and sanitation practices, kitchen gardens, etc.

8.5.3.2. Nutrition Research and intervention assessments

1. Advocate for the strengthening of ethnographic research in the diversification and development of food production, processing and preservation, micronutrient deficiencies, food quality, standard and food safety, diet related status of Food Diversity, Nutritional Practices during Pregnancy and Lactation periods, IYCN practices, myths and taboos prevailing, power structure within the community, effect of Covid19 on nutritional status etc. Infections and prevalence, non-communicable diseases, emergency setouts, local and tribal issues, nutrition and health pertaining problems etc.
2. Ensuring assessment and impact evaluation of specific interventions
3. Utilizing the evidence-based research for further effective planning and establishing the coordination in the program.
4. State Government will synchronize the program planning and implementation with the Community Nutrition and Health Assessment (CNNA).

8.5.3.3. Community Monitoring, Grievance Redressal Mechanism, Transparency and Public Hearings

1. Community processes such as Village Contact Drives, Community weighment sessions and mapping of nutrition status, monitoring through VHSNCs will ensure effective implementation of planned activities, monitoring and evaluation in all development programs.
2. In addition, periodic evaluations are necessary for establishing level of objective achievement. In order to follow up implementation of nutrition programs, data will be collected regularly at the health center and community level. Community-based monitoring process includes preparatory activities, capacity building and training of trainers, community assessment, interface meeting and finally the evaluation.
3. Discourse and sharing, review and future planning will be ensured with Gram Sabha/Mohalla Sabha/ Jan Sunwai or Public Hearing while activating the system of community monitoring as per the provision under Social Audit.
4. At the end of each year, the State Convergence Committee shall assess the impact created by the innovation pilots and select the ones that could be scaled up in the state and highlighted at the national forum. For scaling-up the pilots, additional funds would be allocated by the state or would be arranged through development partners. Local NGOs/CBOs may be involved for scaling-up the intervention across the state.

8.5.3.4. Joint Review Missions

1. Conducting Annual Joint and collective Review Missions by different departments including WCD, Health, Rural Development, Agriculture, etc. on the current status of the implementing schemes and programs to analyze the situation in-depth and preparing entry points for convergence

2. Joint Community Communication for growth monitoring promotion of children to visualize undernutrition
3. Joint Community Monitoring of nutrition status of children under 3 years at Panchayat, village /AWC and health sub centers and in urban models

8.5.3.5. Securing Monitoring System with triangulation model including MIS, POSHAN Tracker and GIS Layer and Report Sharing

1. Establishing GIS layer tracking and real time monitoring to identify the sensitive pockets/ areas/ zones pertaining to any nutrition and health specific problems with checking indicators of malnutrition, IYCN, health, infections, immunization, program interventions, Covid19 situation, extreme weather conditions etc.
2. Ensure MIS of all the strategic, data, monitoring and implementation activities in place
3. Real Time monitoring of the data through mobile applications such as POSHAN Tracker in Poshan Abhiyaan and SAMPARK application by WCD
4. Development and implementation of protocol for Community Nutrition and Health Need Assessment for community and geo-cultural situation linked planning.
5. Preparing reports and compiling data on monitoring and review findings
6. Developing dynamic district dashboard and sharing periodic report card by using data and information across anganwadi level while matching it with annual targets and results focusing on birth and death registration, breastfeeding practices, anemia, undernutrition (underweight, wasting and stunting), sanitation practices, safe drinking water, age of marriage, community participation in growth monitoring, hygienic menstrual practices etc.
7. Utilizing the data on yearly basis as a cross checking tool.
8. Making available the reports including Annual State report/ Social Audit Report/ Assessment reports/ JRM reports/action taken reports etc.in the public domain

Annexure I: Nutritional Indicators of Madhya Pradesh – NFHS-IV 2015-16

Madhya Pradesh State Nutrition Profile (NFHS 4; Year 2015-16)																		
State / District	Children's Nutritional Status (Under-5 Yrs)					Children's Access to Nutrition in Early Ages			Women's Nutritional Status		Factor Indicators linked with Under nutrition and Mortality							
	Stunted	Wasted	Severely Wasted	Underweight	6-59 months - anemic	Children breastfed within one hour of birth	Children under age 6 months exclusively breastfed	Breastfeeding children age 6-23 months receiving an adequate diet	Women whose Body Mass Index is below normal	All women age 15-49 years who are anemic	Women with 10 years or more of schooling	Women age 20-24 years married before age 18 years	Mothers had full antenatal care	Births of birth order 3 or more	Mothers received postnatal checkup within 2 days of delivery	Children received health check within 2 days of birth	Children age 12-23 months fully immunized	Institutional births
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
India	**38**	**21**	**7.5**	**36**	**59**	**41.6**	**54.9**	**8.7**	**22.9**	**53.1**	**35.7**	**26.8**	**21**	**16**	**62.4**	**24.3**	**62**	**49**
Madhya Pradesh	**42**	**26**	**9.2**	**43**	**69**	**34.4**	**58.2**	**6.9**	**28.4**	**52.5**	**23.2**	**32.4**	**11.4**	**28.6**	**54.9**	**17.5**	**53.6**	**81**
Alirajpur	49	33	11	52	75	25.4	58	3.5	35.8	64.4	9.6	37.9	4.8	51	44	16.5	22.6	50
Anuppur	34	30	14	40	68	43.6	61.3	9.1	26.2	62.3	23.2	29.8	15.4	32	53.2	18.4	57.8	77
Ashoknagar	43	31	11	46	60	32.8	30.2	6.4	30.1	42.3	12.3	35.4	5.1	28.9	70	19.8	37.2	82
Balaghat	32	32	8.9	42	69	52.2	67.6	8.2	42.4	68.6	28.2	8.6	16	18.6	52.3	16.6	64.6	84
Barwani	52	28	8.7	55	82	34.8	71.4	3.6	40.8	65.8	16	43.1	7.9	38.4	42.6	18.5	41.8	51
Betul	35	34	11	45	62	49.2	NA	7.3	27.2	54.1	33.4	12.9	14.4	16.1	56.3	30.4	69.1	76
Bhind	48	31	13	50	72	44.1	33.3	2.6	29.6	66	25	33.4	7.5	30.7	45.7	13.1	51	86
Bhopal	48	21	8.1	40	77	18.3	NA	7.1	19.1	47	42.8	14.7	22.3	27.3	58.7	14.9	62.3	92
Burhanpur	50	20	6.7	46	80	42.2	48.7	2.4	28.4	80.2	22.6	26.6	14.2	29.7	58.4	16	43.3	76
Chhatarpur	43	19	7.2	41	66	37.9	68.9	11.6	28.2	48.1	15.3	47.3	4.6	33.3	50	5.6	41.1	81
Chhindwara	34	31	11	41	66	37.4	60.8	11.6	29.1	65.7	28.7	18.1	19.1	14.2	52.7	24	64.3	86
Damoh	43	21	8.8	38	76	46.3	69.6	6.3	27.1	75.7	17.8	40	8.2	24.1	31.5	3.9	55.9	70
Datia	49	26	8.2	47	73	32	63.9	4.4	32.3	60.3	21.6	38.8	5.1	27.7	58.7	10.3	53.2	85
Dewas	42	26	5.5	45	66	25.3	64.7	11.6	28.7	47.8	22.1	37.4	15	30.5	77.9	26.8	60.3	92
Dhar	43	31	11	48	75	20.9	72.1	17.8	30.4	56.2	20.2	32.4	4.1	28.1	70	28	65.6	78
Dindori	46	27	11	47	67	36.8	35.5	1.9	35.8	66.5	13.6	37.2	5.1	23.3	45.1	15.4	49.4	56
Guna	43	33	12	51	67	41	52.5	2.1	34.2	46.2	16.5	36.3	8.4	34.7	57.2	18.1	65.1	90
Gwalior	43	28	11	49	69	26.9	26.4	2.7	22.2	57.4	32.6	21	14.6	27.7	68.9	19.2	52.5	88
Harda	40	25	8.6	41	66	30.3	51.2	0.7	22.3	51.3	17.8	25.8	11.8	23.3	66.2	26.3	48.6	80
Hoshangabad	37	30	11	41	67	36.7	36.5	1.6	23	67.3	28.2	18.3	13.6	24.1	73.7	19.4	49.5	89
Indore	39	18	6.7	31	71	21.9	61.3	12	18.9	46.8	41.4	23.4	27.5	19.2	67.4	13.6	57.8	95
Jabalpur	36	31	11	43	59	49.2	47.7	7	23.3	49.6	37.3	15.3	30.5	19.4	62.1	21.1	67.5	88

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Jhabua	46	24	9	44	72	21	55.8	4.8	30.4	58.8	9.3	54.5	5.3	42	51.1	17.3	25	74
Katni	46	24	12	43	66	47	72	18	27.2	52	23.4	31.1	12.4	28.5	61.3	14.3	46.7	78
Khandwa	44	22	6.6	47	77	30.6	46.1	3	34.7	58.5	16.8	18.7	19.1	23.7	56.1	16.8	58.7	82
Khargone	48	21	5.7	45	77	17.8	62.8	5.7	36.8	57.8	17.2	25.9	11.9	23.8	54.2	15	64.2	74
Mandla	37	34	11	50	70	53	66.5	3.2	34	69.7	18.1	28.9	15.4	30.5	52.1	22.1	55.1	59
Mandsaur	34	22	7.5	31	66	36.4	95.1	2.5	31.1	66.1	17.5	54	7.3	20.8	55.8	20.3	43.5	88
Morena	48	30	13	52	67	38.5	36.6	4.4	27.5	56	21.4	27.9	7.4	36.8	67.2	19	60.6	94
Narsinghpur	38	22	10	35	69	30.9	84.3	10.3	25.1	69.3	26.4	28.9	15.2	16	56.9	17.3	54.2	86
Neemuch	36	25	8.2	39	69	21.4	60.3	7.9	31.1	49.2	19.6	37.6	10.6	21.1	70.1	36.7	47	87
Panna	42	24	10	41	68	32	55.5	13.1	25.8	48.7	20.5	30.6	2.5	31.8	45.4	21.4	26.2	74
Raisen	46	25	7.3	44	68	41.9	52.4	4.5	29.5	50.7	21.9	28.9	13.8	29.6	60.2	23.4	78.5	85
Rajgarh	39	32	9	47	63	35.5	51.4	0	37.5	50.3	17	47.8	5.9	33.3	52.8	15.7	42.7	89
Ratlam	46	22	7.5	42	76	19.1	72.3	11.8	33.8	54.4	17.9	47.8	12.4	24	58.2	21.1	45.2	86
Rewa	40	18	7.4	36	55	44.8	46.3	4.6	23.2	40.9	23.1	37.3	3.6	33.7	53.7	12.4	52.8	82
Sagar	41	17	5.2	31	67	25.4	60.4	5.7	24.1	39.7	22.4	38.1	3.2	25.2	45.3	20.7	52.7	77
Satna	41	27	10	40	70	33	55.7	4.4	22.2	48.8	25	37.4	7.6	39.3	53.9	37.8	52.4	80
Sehore	34	27	13	40	65	31.1	43.1	8.1	26.6	46.9	22.5	37.3	9.2	29.6	67.7	20.8	60	88
Seoni	35	32	13	44	61	46.3	64.6	10.8	32.4	55.3	22.2	17.3	18.7	15.5	54.7	21.7	57.1	86
Shahdol	37	28	11	41	67	56.6	NA	8.3	29.1	60.5	18.7	40.1	7.2	31.6	35.2	4.2	40.3	72
Shajapur	48	30	10	49	78	22.7	53.9	0.8	29.4	52.8	18.8	47.2	18.7	26.2	49.1	9.4	71.7	96
Sheopur	52	28	9	55	78	44	63.5	0.4	43.9	61.6	11.8	37.5	7.2	38.8	27.3	11	48.7	77
Shivpuri	49	26	7.7	50	63	41.9	69.9	6.8	31.4	49	14.3	36.9	7.2	32.8	61.9	19.1	63.1	87
Sidhi	49	25	8.5	44	68	48.9	72.7	8.4	27	50.5	19	44.5	1.7	40	25.1	1.9	34.4	61
Singrauli	33	34	17	38	62	33.5	59.8	11.7	19.4	52.6	20.2	38.4	10.1	33.2	32.4	13	42.2	44
Tikamgarh	50	19	7.6	43	67	32.1	59.8	2.8	30.8	45.8	13.8	49.5	3.2	34.6	43.8	8.9	34.4	81
Ujjain	36	19	6.9	31	69	19	57.6	8	26.4	47.4	20.7	45.5	9.5	24.7	56	16.6	56.8	89
Umaria	41	27	9.4	47	74	37.2	36.9	9	29.3	61.5	16	37	6.5	24.7	64.5	33.4	67.1	85
Vidisha	41	21	6.3	40	70	46.4	71.7	8.8	28	44.2	12.4	45.9	4.5	37.8	32.4	4.3	45.7	73

Annexure II: Strategic Plan for Children (Under-6 years) to ensure their optimal Infant Young Child Nutrition (IYCN) practices

Approach	Zero- Six months (0-180 days)	Seven Months to Three Years (07-36 months)	Three Years to Six Years (37 -72 months)
Ensuring the Nutritional needs	Early initiation and exclusive breastfeeding, ensuring monthly anthropometrical assessment (Growth Monitoring and Promotion), ensuring maternity entitlements by mothers to assure exclusive breastfeeding	Supplementary nutritional support by ensuring THR, ensuring monthly anthropometrical assessment (Growth Monitoring and Promotion), Complementary and continued and prolonged breastfeeding, prompting age-appropriate dietary intake and diversity based on locally available food in the food platter Ensuring supply both in quality and quantity of Hot Cooked Meal and Take-Home Ration as in accordance with the provisions of NFSA 2013	Ensuring Nutritious, healthy and hygienic Hot Cooked Meal, ensuring monthly anthropometrical assessment (Growth Monitoring and Promotion from 37-59 months), prompting age-appropriate dietary intake and diversity based on locally available food in the food platter. Ensuring supply both in quality and quantity of Hot Cooked Meal and Take-Home Ration as in accordance with the provisions of NFSA 2013
Health services	Ensuring timely Immunization as per National Schedule and health checkups (HBNC), Diarrhea and Pneumonia Management, Identifying LBWs and ensuring Kangaroo Mother Care, Promotion of Mother's Absolute Affection (MAA) nationwide program of the Ministry of Health and Family Welfare to bring undiluted focus on promotion of breastfeeding and provision of counseling services for supporting breastfeeding through health systems, Prompt Referral if required, Identification of early Development Delays (4Ds), Management of SAM with medical complications, Child Death review, SAM incidence review	Ensuring timely Immunization as per National Schedule and health checkups (HBYCC) Ensuring timely deworming, Micronutrient-supplementation, Referrals based on the health conditions, Malaria and Measles Management, referral and Management of SAM with medical complications, Identification of early Development Delays (4Ds), Child Death review, SAM incidence review. Promotion of Mother's Absolute Affection (MAA) program well up to 2 years and beyond.	Ensuring timely Immunization as per National Schedule and health checkups, ensuring timely deworming, Micronutrient-supplementation, Referrals based on the health conditions, Malaria and Measles Management, referral and Management of SAM with medical complications, Identification of early Development Delays (4Ds), Child Death review, SAM incidence review

Home care	Ensuring proximity of mother and child, infant and neo-natal care at home, WASH practices, enabling home environment for IYCN behavior	Ensuring proximity of mother and child, infant and neo-natal care at home, WASH practices, enabling home environment for IYCN behavior, promoting locally available food, enabling pro-environment for the families to prioritize the nutrition and food needs including proper consumption of THR	Ensuring proximity of mother and child, infant and neo-natal care at home, WASH practices, enabling home environment for IYCN behavior, promoting locally available food, enabling pro-environment for the families to prioritize the nutrition and food needs including proper consumption of THR
Social health wellbeing	Raising awareness of IYCN and health care practices, Busting the myths pertaining to IYCN, social behavior, health related issue, community practices, access to employment and livelihood and gender equality (care of girlchild, lactating mothers)	Raising awareness of IYCN and health care practices, Busting the myths pertaining to IYCN, social behavior, health related issue, community practices, access to employment and livelihood and gender equality (care of girlchild, lactating mothers) Enhancing society's support to mothers through women support groups for IYCN practices and assisting them for continuous breastfeeding and complimentary	Raising awareness of IYCN and health care practices, Busting the myths pertaining to IYCN, social behavior, health related issue, community practices, access to employment and gender equality (care of girlchild, lactating mothers). Enhancing society's support to mothers through women support groups for IYCN practices and assisting them for adequate dietary practices. Promotion of socially adequate, diverse, acceptable, calorie and protein dense food with micronutrients including Vitamin A, D, and Mineral rich by promoting SHGs using locally available food for cooking HCMs
Convergence	Nutrition and maternity entitlements during lactation, prompt new-natal referral if required, creating an environment for assuring services and practices including MNREGA, FRA, WASH, community support system.	Creating an environment for assuring services and practices including MNREGA, FRA, WASH, community support system. Exploring and implementing the current provisions of establishing Crèches at worksite under MNREGA and Rajiv Gandhi Crèche Scheme[xi] Remodeling Anganwadis to Anganwadi cum crèche and resource centers (Child-Development Centre)	Creating an environment for assuring services and practices including MNREGA, FRA, WASH, community support system. Exploring and implementing the current provisions of establishing Crèche at worksite under MNREGA and Rajiv Gandhi Crèche Scheme[7] Remodeling Anganwadis to Anganwadi cum crèche and resource centers (Child-Development Centre) Ensuring Early Childhood Care and Education (ECCE) Pre-school Education Ensuring the provision of center-based play-school facility at the anganwadi with the workers trained in conducting preschool activities

Annexure-III : Matrix of Intervention Domains and Convergence Plan

1. Nutrition-Specific Interventions Domain			
SN	**Policy Manifestation**	**Line Department**	**Intervention/Programs/Schemes**
1	Reduced anemia amongst the adolescent girls and enable them to be healthy and productive adults.	Department of Public Health & Family Welfare; Women and Child Development Department	Reduction of anemia amongst the adolescent girls, WRA, Focus on Rashtriya Bal SwasthyaKaryakram (National Health Mission - Department of Public Health & Family Welfare)
2	Secured optimum nutrition across the life cycle.	Department of Public Health & Family Welfare; Women and Child Development Department	Ensuring optimum nutrition across the life cycle thereby breaking intergenerational and vicious cycle of malnutrition (Maternal, Care, Health, Nutrition and Dietary supplementation), including Efficacy in implementation of Maternity Entitlement Scheme.
3	Better nutrition and childcare practices established at childcare provider, household and community levels.	Department of Public Health & Family Welfare; Women and Child Development Department	Laying the healthy foundation for children in their early lifespan by ensuring their optimal nutrition and better IYCF practices, promoting early initiation of breastfeeding within 1 hour of birth, exclusive breastfeeding up to 6 months and complementary feeding thereafter well up to 2 years with continued breastfeeding.
4	Secured prevention and control of micronutrient malnutrition among the vulnerable population especially children under five, adolescent and women.	Department of Public Health & Family Welfare; Women and Child Development Department;	Controlling and Preventing Micronutrient Malnutrition and Deficiencies. Focus on Anemia Control Program;
5	Ensure accessibility of sufficient diverse and nutrient rich and quality food by introducing healthy feeding practices and increased consumption of fortified food and its availability under Social Safety Nets and welfare schemes for promoting the upgradation of nutrient quality and ensuring micronutrient supplementation to vulnerable groups.	Department of Public Health & Family Welfare; Women and Child Development Department; School Education Department; Food, Civil Supplies, and Consumer Protection Department, PRIs/Urban Bodies	Promoting and Supporting Dietary Diversification and Food Fortification in PDS, MDM, ICDS schemes; Promoting locally available/traditional/indigenous/diverse/cultivated/un-cultivated food
6	Secured prevention, spotting and treatment of Moderate Acute Malnutrition (MAM) and Severe Acute malnutrition (SAM)	Department of Public Health & Family Welfare ; Women and Child Development Department;	Community-based Management of Moderate Acute malnourished (MAM) and linkages with Facility-based Severe Acute Malnourished (SAM) children through provision of apposite services available at the public health system and ICDS services, community responses and improved nutrition and care to reduce infant morbidity and mortality; Immunization; Health check-ups, referral
7	Enhanced knowledge, awareness and adoption of improved nutrition practices at community level.	Department of Public Health & Family Welfare ; Women and Child Development Department; School Education Department; Food, Civil Supplies, and Consumer Protection Department, PRIs/Urban Bodies;	Addressing Socio-Cultural Beliefs and Social Behavior Change Communication (SBCC) pertaining nutritional wellbeing of women of reproductive age and children in terms of dietary and feeding practices by employing community mobilization, nutrition education and social behavior change communication approaches for promoting and

		Field level functionaries	improving knowledge and nutritional practices at both facilities and community levels through local and general mass media platforms. Ensuring education to all through Sarv Shiksha Abhiyaan
8	Secured prevention and control of infectious diseases in the community.	Department of Public Health & Family Welfare; Women and Child Development Department; Public Health Engineering Department	Management and prevention of infectious diseases, reduced prevalence of diseases related to micronutrient deficiencies among the identified group at risk including women, adolescent and children (pediatric TB) through promoting precise nutrition practices, reduced incidences and prevalence of TB cases in identified group at risk
9	Secured prevention and control of Non-Communicable Diseases in the community.	Department of Public Health & Family Welfare Women and Child Development Department; Public Health Engineering Department	Increasing awareness of the risk factors and major determinants of diet-related NCDs thereby reducing mortality associated with diet-related NCDs Improved health and quality of life of individuals with diet related NCDs.
10	Improved nutritional status and quality of life for persons living with HIV/AIDS.	State AIDS Control Society is functioning under Department of Public Health & Family Welfare, Women and Child Development Department;	Increasing awareness on the relationship between nutrition and HIV/AIDS by providing the nutritional information, care and support to people infected and affected by HIV/AIDS
11	Secured enhanced responsiveness to prevention, detection and treatment of malnutrition and increased immunity for the community.	Department of Public Health & Family Welfare, Women and Child Development Department;	Nutrition and care in emergency situations including natural calamities and catastrophic pandemic like Covid-19 through provision of appropriate services through the ICDS and public health system extreme weather conditions, emergency response
12	Specific health and nutritional needs of the tribals identified and addressed.	Department of Public Health & Family Welfare, Women and Child Development Department; Tribal Department; Forest Department, SRLM, MNREGA (Department of Panchayati Raj and Rural Development)	Bridging the current gap in the health and nutrition status of the tribal people to bring the health coverage and outcome indicators at par with the State's average. Focus on PESA and MGNREGA
13	Ensured sustained nutritional care for the deprived and the vulnerable.	Department of Public Health & Family Welfare; Women and Child Development Department; School Education Department; PRIs/Urban Bodies; Field level functionaries; Tribal Department; Forest Department; SRLM, MNREGA (Department of Panchayati Raj and Rural Development);	Address sustained nutritional and health care for the socio-economically/geographically deprived and nutritionally vulnerable groups through establishing an effective nutritional care and support system.
14	Nutritional care for the differently abled duly addressed.		Undertake child development program to enable protection, nutritional and care healthcare for the differently abled while increasing their knowledge and skills, providing them barrier-free communication and empathetic atmosphere.
15	Secured heightened levels of community mobilization reflected in enhanced community engagement in healthcare and nutrition services.		Promote, facilitate and support community mobilization for improved health and nutrition seeking behavior and practices and generating demand for quality service deliverance.
16	Increased level of services, skills, capabilities of community, nutrition staff and non-nutrition staff working on the direct and underlying causes of malnutrition.		Capacity Building and Field Functionary Empowerment.

17	Ensured outcome-based quality implementation of Supplementary Nutrition Program for enhanced outreach and universal coverage.	Women and Child Development Department	Instituting results-based programming (like Supplementary Nutrition) in service delivery.
18	Secured effective implementation of maternal entitlement schemes to ensure the care, health and nutrition for the pregnant women, lactating mothers and children.	Women and Child Development Department; Labour Department	Effective implementation of Maternity Entitlement Schemes; Conditional cash transfer to Pregnant and lactating mothers by monitoring enrollment of beneficiaries, their access to services and availed benefits Focus on JSY, PMMVY and Mukhya Mantri Shramik Seva Prasuti Sahayata Yojana (MMSSPSY) 2020

2. Nutrition-Sensitive Interventions Domain			
SN	**Policy Manifestation**	**Line Department**	**Intervention/Programs/Schemes**
1	Securing agriculture and food diversity across the State.	Farmer Welfare and Agriculture Development Department; Rural Development Department; State Rural Livelihood Mission; Forest Department; Department of Panchayati Raj and Rural Development; Department of Urban Development and Housing	Promote adoption of diversification approaches to increase availability and affordability of diverse foods and maintaining sustainable intensification through strategies aimed at improving productivity and environmental sustainability, which can be achieved through increasing species diversity in cropping systems or ecosystem-based strategies.
2	Enhanced outputs of vegetables, fruits, eggs, and improved availability of livestock and fisheries.	Farmer Welfare and Agriculture Development Department; Horticulture Department; and Fisherman Welfare and Fisheries Development Department; State Rural Livelihood Mission; Forest Department; Department of Panchayati Raj and Rural Development; Department of Urban Development and Housing	Facilitating access to adequate, nutritious, safe and quality foods (vegetable and fruit home, farm gardens, domestic poultry farming, livestock and fisheries)

3	Positively impacted biodiversity and bio-fortification.	Madhya Pradesh State Biodiversity Board; Forest Department; Department of Panchayati Raj and Rural Development; Department of Urban Development and Housing Food, Civil Supplies, and Consumer Protection Department Department of Public Health & Family Welfare; Women and Child Development Department; FSSAI; Food and Drugs Administration, MP	Assessing biodiversity helps to identify available species and varieties that can address country-specific malnutrition issues in a cost-effective and locally acceptable way. Improved knowledge and appreciation of indigenous peoples' food systems and diets, taking note of their potential strength in terms of nutrition and environmental sustainability, understanding the drivers of disruption, and designing culturally appropriate approaches to conservation and use of indigenous genetic resources and food systems. Ensuring substitute consumption of nutrient-poor varieties with nutrient-rich ones. Thus, is a part of larger portfolio of sustainable, food-based approaches to nutrition. Ensure use of fortified food in ICDS, PDS and MDM
4	Ensuring steady and balanced incomes for families for securing requisite food and nutritional security.	State Rural Livelihood Mission; MNREGA, (Department of Panchayati Raj and Rural Development); Forest Department; Department of Panchayati Raj and Rural Development; Department of Urban Development and Housing	Focusing Income Generation and Livelihood Programs and Schemes from the standpoint of securing food security for the local population in the community.
5	Secure functionality of Social Protection and Safety Nets for the community so that none in the vulnerable are left out from the services.	School Education Department; Women and Child Development Department Department of Public Health & Family Welfare; Food, Civil Supplies, and Consumer Protection Department	Reaching the nutritionally vulnerable group, to integrate overt nutrition aims and pointers thus enhancing and designing approaches that suffice the accessibility of health services by family and community.
6	Secure complete coverage and utilization of Targeted Public Distribution System.	Department of Public Health & Family Welfare; Madhya Pradesh State Civil Supplies Corporation; Food, Civil Supplies, and Consumer Protection Department; School Education Department Women and Child Development Department; Department of Panchayati Raj and Rural Development; Department of Urban Development and Housing	Studying in coordination with the Department of Food, Civil Supplies and Consumer Protection at the level of the Government of Madhya Pradesh to take policy initiatives to address food insecurity of identified families with undernutrition and anemia.
7	Ensuring Food Marketing, Advertising, Regulation, Compliance; and Consumer Awareness and Education.		Design policies and strategies for shaping healthy food environments and leveraging both traditional and modern retail sectors to facilitate consumption of healthy diets.
8	Availability of and access to water and sanitation services universalized.	Public Health Engineering Department; Public Works Department; Water Resource Department; Department of Public Health & Family Welfare; Rural Development Department;	Undertake Water and Sanitation – Infrastructure Development and Maintenance in line with and Community Awareness focused on nutrition. Ensuring Open Defecation Free status and Swachh Bharat Mission

		Swachha Bharat Mission	
9	Status of School Health Program including Mid-Day Meal enhanced to meet health and nutritional needs of all school-going children with provision for covering the dropouts through regular campaigns.	School Education Department; Public Health Engineering Department; Water Resource Department;	Develop life-long healthy eating habits towards contributing to generate new demand for, and supply of, healthy and nutritious foods by encouraging children, their families and the school community. Focusing on Mid-Day Meal Scheme with ensured WASH services
10	Secure women's empowerment across a range of output indicators like household decision making, roles in program design and implementing bodies etc.	Rural Development Department; Urban Development Department; State Rural Livelihood Mission; MNREGA (Department of Panchayati Raj and Rural Development);	Designing and implementing gender-sensitive interventions in agricultural and rural development and the food system, which address unequal gender relations and empower women, are major factors contributing to the success of programs to improve nutrition.
11	Securing linkages between livelihood programs and the community for enhanced family income generation and its sustenance.	Women and Child Development Department; Department of Panchayati Raj and Rural Development; Department of Urban Development and Housing; Field functionaries State Rural Livelihood Mission; MNREGA (Department of Panchayati Raj and Rural Development);	Generating and promoting livelihood options and establishing linkages with MNREGA to ensure and enable the marginalized and deprived households ensuring marginalized generating income, developing assets and extracting benefits out of it.

3. Nutrition-Governance Interventions Domain			
SN	**Policy Manifestation**	**Line Department**	**Intervention/Programs/Schemes**
1	Bring about operational functionality of Community-Based Management of Malnutrition (CBMM), particularly with focus on development of model for Community-based Management of Moderate Acute Malnutrition (MAM), its adaptation/replication across the state.	Women and Child Development Department; Department of Public Health & Family Welfare; Madhya Pradesh State Civil Supplies Corporation; Food, Civil Supplies, and Consumer Protection Department;	Strengthening community groups, health and nutrition committees and encouraging sustainability and ownership of the program and services through involving the community in planning, management and implementation of the CBMM services.
2	Ensuring improvement in health and nutrition of the serviced population, responsiveness to expectations and fairness in financial allocation and use.	School Education Department Panchayat and Gramin Vikas (PRD) Rural Development Department Urban Development Department	Intra-sector Vertical Coherence in terms of quality of performance with responsiveness and sensitivity
3	Focus on meeting the needs and growing demand for food, water and nutritional and healthy wellbeing, strengthened coordination amongst the diverse actors, like joint planning, joint capacity building and reviews, deriving from reflection of	Human Resource Development Department Forest Department; Tribal Department PRIS/Urban Bodies;	Inter-sector Coordination and Convergence with Horizontal Coherence and Integration across the sectors for synergy in progress and optimization of resource utilization

	nutritional and health goals in sector-wide action plans.		
4	Raised community ownership by active participation of community group through their capacity building.		Institutionalize Community Based Mangaement of ICDS.
5	Reach an operative and effectual Nutrition Information Approach to make available all the nutrition-relevant information to the key players and stakeholders to be utilized for well-versed decision making, policy devising and program designing		Institute and conduct Nutritional Surveillance – Community Monitoring, Grievance Redressal, Social Audit and Public Hearings.
6	Nutrition governance established through activated Panchayati Raj Institutions (PRIs) Urban Local Bodies		De-centralized Nutritional Planning and Gram Sabha: Role of PRIs and Urban Local Bodies.
7	Securing consistence between funding and programming within and across the sectors.		Resourcing Nutrition-specific, sensitive and governance domains with consistent budgetary allocations and facilitating their optimum utilization to render Value for Money (VfM) for programmatic infusion.
8	Ensuring that accountability and transparency in the system are brought about by providing a framework of systemic protocol.		Bring the Multi-Sectoral Convergence in heightened action mode.
9	Create the enabling environment for human nutrition research to communicate the research findings to further planning with policy makers, think tanks, and various stakeholders.		Undertake Human Nutrition Research.
10	Achieve Scalable Model of Community Monitoring and Social Audits, along with an effective Grievance Redressal System, duly following the provisions of National Food Security Act, 2013. The emphasis will be laid on the developmental spirit of 'learning lessons for improvement' rather than 'fault finding'; Improve ICDS functioning at village and urban unit level by increasing community participation, building ownership and improving monitoring of ICDS.		Institutionalise modes and mechanisms of Community Monitoring, Grievance Redressal, Social Audit and Public Hearings.

Annexure IV: Institutional Arrangements

(based on the suggested framework provided in National Nutrition Strategy)

Institutional Arrangements/Setup	
State Nutrition Mission	State Nutrition Mission Steering Group/State Program Steering Committee
Chief Minister - Chairperson	Chief Secretary - Chairperson
Chief Secretary - Convener	PS - WCD - Member Secretary
Minister - WCD – Vice Chairperson	PS - PH & FW – Co-Member Secretary
Minister - PH & FW – Co-Vice Chairperson	PS - Tribal Welfare
Minister - Tribal Welfare	ACS/PS - Agriculture
Minister - Agriculture	PS - PHE
Minister - PHE	ACS - Panchayat and Rural Development
Minister - Panchayat and Rural Development	PS - Urban Development and Housing
Minister - Urban Development and Housing	ACS/PS - Forest
Minister - Forest	ACS/PS - Finance
Minister - Finance	PS- Animal Husbandry
Minister - Animal Husbandry Fisheries	PS- Food, Civil Supplies and Consumer Affairs
Minister - Food, CS & CA	PS - Social Justice
Minister - Social Justice	PS - School Education
Minister - School Education	PS - Science and Technology
Minister - Science and Technology	Secretary - State Food Commission
Chairperson - State Food Commission	**Special Invitees**
Principal Secretary, WCD – Member Secretary	Representative, AIIMS, Bhopal
Principal Secretary, PH&FW – Co-Member Secretary	Representatives of Development Partners
Special Invitees	Representatives of CSOs
Minister, WCD, Government of India or Nominee	Representative - Food and Nutrition Board
Minister, PH & FW, Government of India or Nominee	Representative - Biodiversity Board
Vice Chairperson or Nominee, NITI Aayog	Representative - Frontline Workers
Chairperson, ICMR	
Chairpersons, PHFI& National Institute of Nutrition	

Institutional Arrangements/Setup

District Nutrition Mission Committee	Block Nutrition Mission Committee
District Collector - Chairperson	SDM / CEO, Janpad Panchayat- Chairperson
Member of Parliament	MLAs
MLAs	Chairperson, Janpad Panchayats
Chairperson, Jila Panchayat	CDPO, WCD - Member Secretary
Chairperson, Janpad Panchayats	BMO – Co-Member Secretary
CEO, Jila Panchayat	JSO, Food
DPO, WCD - Member Secretary	BEO
CMHO – Co-Member Secretary	PHE
Food Controller / DSO	Social Welfare
DC, Social Welfare	Tribal Welfare
DC, Tribal Welfare	Agriculture, Animal Husbandry Dept.
DC, Agriculture, Animal Husbandry Dept.	Representatives of CSOs
District Education Office	Representative - Frontline Workers
Representatives of CSOs	
Representative - Frontline Workers	

Panchayat/Ward Nutrition Mission Committee	Anganwadi Center level Vigilance Committee
Sarpanch / Elected Urban Ward Member	Matru Sahyogini Samiti and Representatives of the Community, Representatives of Beneficiary Group, Representatives of Women SHG, Woman Elected Representative, CBOs, School Teacher, Representative of SMC, JFMC/Forest Protection Committee/Eco-Development Committee, Representative, WUA etc.
Village Health Sanitation and Nutrition Committee	
Representatives of CSO (if working)	
Chairperson/Representatives of Women SHG	
Representative of Shourya Dal	
Chairperson, Joint Forest Management Committee / Eco-Development Committee	
Chairperson, School Management Committee	
Chairperson/Representative, Water Users Association	
Agriculture Extension Worker	

GLOSSARY

SN	Terms	Definition/Meaning/Reference
1	Absorption	The process by which nutrients pass through the cells of the intestinal tract into the circulatory system to be utilized by the body
2	Acquired Immunodeficiency Syndrome (AIDS)	A disease of the immune system due to infection with HIV, Decreases immunity thus leaving the body vulnerable to life-threatening infections and cancers
3	Adequate Intake	A specific judgment or the amount of some nutrients for which a specific RDA is not known
4	Anaemia	Anaemia is a medical condition in which a person's red blood cell (or, more precisely, haemoglobin) level is less than normal
5	ANC	Antenatal Care is a 'four visits providing evidence based interventions', a package often called antenatal care, containing essential interventions that include identification and management of obstetric complications such as preeclampsia, tetanus toxoid immunisation, intermittent preventive treatment for malaria during pregnancy (IPTp) and identification and management of infections including HIV, syphilis and other sexually transmitted infections (STIs).
6	Anganwadi	The Integrated Child Development Service Scheme of the Indian Government has village level centre to promote health and nutritional status of young children from 0-6 years and provide nutrition for children and pregnant women and lactating mothers.
7	Anganwadi Helper	The supporting hand to AWW helps in running the basic functionaries, maintaining records, assisting AWWs in growth monitoring, providing meals, THR distribution, calling children etc
8	Animal Source	Source that provides all of the essential amino acids and good quality protein and nutrients
9	Anorexia	An eating disorder with symptoms including self-induced starvation and highly distorted body image
10	ASHA	Accredited Social Health Activists, one of the key components of the National Rural Health Mission is to provide every village in the country with a trained female community health activist. ASHA is trained to work as an interface between the community and the public health system
11	AWC	Anganwadi Centre as described in Anganwadi
12	beneficiaries	The person or entity eligible to receive benefits and entitlements from government schemes or programs and are registered
13	Biodiversity	Biodiversity refers to the variety and variability of living organisms on Earth, including plants, animals and micro-organisms like fungi and bacteria.
14	Body Mass Index	A proportion of weight to height
15	BPL	An annual family income has been set as a benchmark (by GOI) and families whose income is below this benchmark are in the 'Below Poverty Line' category (above the benchmark are in 'Above Poverty Line' category). Government schemes and programs are tailor made for this category of families.
16	Calorie	A measurement of heat or energy
17	Cancer	Disease characterized by unrestricted and excessive multiplication of body cells
18	Carbohydrates	Nutrients made up of carbon, hydrogen and oxygen that primarily provide energy to fuel the body
19	Cardiovascular Disease (CVD)	General term that refers to the diseases of the heart and blood vessels
20	Chronic Disease	Degenerative diseases of body organs
21	Communication	The exchange of information by writing, speaking or gestures
22	Communitisation	Communitisation is the process of owning the accountability and responsibility towards any projects/programs furthering by the community further empowering itself to ensure the sustainability of the program through active participation, engagement and mobilization and promotes co-operation, coordination and collaboration between the stakeholders at all levels of program implementation to have result-oriented outcome.

23	Community	Is defined as a group of people living in a definite geographical area, characterized by varied caste, cultural, ethical values and perform various intensive social interaction and categorized as beneficiaries, non-beneficiaries and potential beneficiaries
24	Community-Based Organization (CBO)	A public or private nonprofit organization that is representative of a community or a significant segment of a community and works to meet community needs.
25	Dietary diversity	Dietary diversity (or dietary variety) refers to the variety in the number and type of foods in a person's diet over a reference period.
26	Dietary Supplementation	Approach that is intended to supplement the diet, to increase the total daily intake of a particular substance
27	Double burden of malnutrition	The 'double burden' of malnutrition is a term used to characterize the coexistence of undernutrition (including stunting, wasting, underweight and micronutrient deficiencies) alongside overweight, obesity and other diet-related NCDs. Different forms of malnutrition can coexist (or overlap) at any population level: country, city, community, household and individual. For example, a country can have high levels of both anaemia and obesity, and a child can suffer from both stunting and overweight.
28	Fair price shop	A public distribution shop, also known as fair price shop (FPS), is a part of India's public system established by the Government of India which distributes rations at a subsidized price to the poor.[5] Locally these are known as ration shops and public distribution shops, and chiefly sell wheat, rice and sugar at a price lower than the market price called Issue Price
29	Fair Price Shop owner/ Ration shop owner	The person running or own the FPS at local levels in a community is terms as salesman/ ration shop owner or FPS or PDS owner
30	Food security and insecurity	Food security means that all people, at all times, have access to enough safe and nutritious food for normal growth and development, enabling them to lead an active and healthy life. Food insecurity means the opposite, and can be at the individual, household, national, regional or global level.
31	Food system	A food system gathers all the elements (including environment, people, inputs, processes, infrastructures and institutions) and activities that relate to the production, processing, distribution, preparation and consumption of food, and the outputs of these activities, including socioeconomic and environmental outcomes.
32	Food value chains	The whole economic process of producing food, including farming and processing, and disposal of any waste or packaging.
33	Fortification	Process of adding one or more nutrients added
34	Gram Sabha	The Village Council of voters under Panchayat Raj Institution; under 73rd amendment of the Constitution, the Gramsabha has the powers to decide about the resources in the village and is mandatory to have a specific number of Gramsabha meetings in a financial year. It consists of all the male and female members of the village.
35	Gramsabha	The Village Council of voters under Panchayat Raj Institution; under 73rd amendment of the Constitution, the Gramsabha has the powers to decide about the resources in the village and it is mandatory to have a specific number of Gramsabha meetings in a financial year. It consists of all the male and female members of the village.
36	Human Immunodeficiency Virus	The virus that causes AIDS, which is the most advanced stage of HIV infection. HIV is a retrovirus and is transmitted through direct, contact with HIV-infected body fluids, such as blood, semen, and vaginal fluids, or from a mother who has HIV to her child during pregnancy, labor and delivery, or breastfeeding (through breast milk)
37	Hygiene	is the cooperative effort to bring greater health and prevention of disease to a group of people living near one another?
38	ICDS	The Integrated Child Development Scheme (ICDS) comes under the purview of the Ministry of Women and Child Development (MWCD). ICDS was launched in 1975 and has been working to eliminate hazards to child health and development. The scheme aims at providing an integrated package of services. These services include supplementary nutrition, immunization, medical check-ups, recommendation services, pre-school non-formal education and nutrition & health awareness.
39	IFA	(Iron and Folic Acid) All pregnant women are given a daily intake of one tablet of Iron/Folic Acid which contains 60 mg iron and 400 µg folic acid for six months.

40	Iron Deficiency Anemia	A condition resulting from insufficient dietary iron intake or blood loss
41	Malnutrition	Inadequate intake of protein and/or energy over prolonged periods of time resulting in loss of fat stores and/or muscle wasting including starvation-related malnutrition, chronic disease-related malnutrition and acute disease or injury-related malnutrition
42	Malnutrition Intervention	The implementation of specific actions to address malnutrition outlined in the plan.
43	Malnutrition Screening	The systematic process of identifying an individual who is malnourished or who is at risk for malnutrition to establish whether the patient is in need of a nutrition assessment.
44	MAM	Moderate Acute Malnutrition is defined as weight for height (WHz) score between -2 and-3. This is the stage preceding severe malnutrition
45	Mangal Divas	In order to bring the effectiveness of different schemes programs and activities, currently running by state. Mangal Divas is celebrated in AnganwadiCentres on Tuesdays of every month. Godbharai, Annaprashan, Birthday's, Adolescent Girl's day programs are observed respectively on all the four Tuesdays.
46	Matru Sahyogini Samiti	Matru Sahyogini committees are to be framed at Anganwadi to be constituted with women to monitor the quality and distribution of SNP to monitor the other activities and mobilize the community
47	Menstrual Hygiene Management	Menstrual hygiene management (MHM) refers to management of hygiene associated with the menstrual process. WHO and UNICEF Joint Monitoring Program (JMP) for drinking water, sanitation, and hygiene has used the following definition of MHM: 'Women and adolescent girls are using a clean menstrual management material to absorb or collect menstrual blood, that can be changed in privacy as often as necessary for the duration of a menstrual period, using soap and water for washing the body as required, and having access to safe and convenient facilities to dispose of used menstrual management materials. They understand the basic facts linked to the menstrual cycle and how to manage it with dignity and without discomfort or fear - WHO
48	Message	The primary instructions, actions, and information expressed in a communication with an audience.
49	Micronutrient deficiency	Micronutrient deficiency is caused by inadequate (or insufficient) intake or absorption of one or more vitamins or minerals and leads to suboptimal nutrition status
50	Micronutrients	Dietary components, commonly known as vitamins and minerals. They are critical to health, despite being required in only small amounts. They include minerals such as iron, calcium, sodium, magnesium, zinc and iodine, and vitamins such as A, B group (such as folate), C and D.
51	MNREGS	Mahatma Gandhi National Rural Employment Guarantee Scheme is a special program, designed under Mahatma Gandhi National Rural Employment Act, of the government for providing guaranteed employment in the rural areas.
52	Monitoring and Evaluation	The systematic process to identify the amount of progress made since patient diagnosis and assesses whether outcomes relevant to the malnutrition diagnosis and treatment goals are being met.
53	non-beneficiaries	The person or entity who are not eligible to receive benefits and entitlements from government schemes or programs and are not registered
54	Non-communicable diseases (NCDs) and diet-related NCDs:	NCDs are non-infectious chronic diseases that last a long time, progress slowly, and are caused by a combination of modifiable and non-modifiable risk factors, including lifestyle/behavioral, environmental, physiological and genetic factors
55	NRC	Nutrition Rehabilitation Centres (NRCS) have been set up in various states to address severe under-nutrition and underlying complications. It is a specialized facility that rehabilitates severely malnourished children and strives to restore them to good health and educates their mothers about nutrition andchildcare.
56	Nutrients	Food components that supply the body with energy, promote growth and maintenance of tissues and regulate body processes

57	Nutrition Surveillance	A method of documenting nutrition data with five steps: Nutrition Assessment, Nutrition Diagnosis, Nutrition Intervention, Nutrition Monitoring and Evaluation
58	Nutrition-sensitive actions	Nutrition-sensitive actions are interventions, programs or policies in sectors other than nutrition that address the underlying determinants of fetal and child nutrition and development and incorporate specific nutrition goals and actions. Sectors include agriculture, health, social protection, early child development, education, and water and sanitation.
59	Nutrition-specific actions	Nutrition-specific actions are interventions, programs or policies intended to have a direct impact on immediate determinants of nutrition. Nutrition-specific actions include promotion of adequate food and nutrient intake, feeding, caregiving and parenting practices, and prevention of infectious diseases. Examples are breastfeeding promotion, disease management and treatment of acute malnutrition in emergencies
60	Obesity	Having a BMI of 30 or greater
61	Outcome	Outcome is the end result of work
62	Panchayats	The Village level local governance system: the panchayat is an elected body of members from the village and has executive powers to plan and budget for the village development.
63	PDS	Public Distribution System is a program of the government where in the essential food grains, sugar and kerosene is distributed to the people with differential pricing policy. For the BPL cardholders, there is a subsidized provision of the goods under PDS through 'Fair Price Shops' established under the scheme.
64	potential beneficiaries	The person or entity eligible to receive benefits and entitlements from government schemes or programs and are not registered
65	Quality	A direct correlation between the level of improved health services and the desired health outcomes of individuals and populations
66	Quality Improvement	Systematic activities that are organized and implemented by an organization to monitor, assess, and improve its healthcare with the goal of seeking continuous improvement in the care delivered to the patients the organization serves.
67	Quality Indicator	"Measurable [element] of practice performance for which there is evidence or consensus that it can be used to assess the quality, and hence change in the quality of care provided
68	Risk factor	A risk factor is an attribute or characteristic of a person or something they are exposed to that increases their chance of developing a disease, infection or injury
69	SAM	Severely Acute Malnutrition is a stage of malnutrition where in the person/child is low MUAC or low W/H wasted and susceptible to death.
70	Sanitation	Environmental Sanitation is (a) the promotion of hygiene and, (b) the prevention of disease and other consequences of ill-health, relating to environmental factors
71	SanjhaChulha	SanjhaChulha (Common Kitchen) Scheme for serving hot cooked meal to beneficiaries. Under the Mid-Day meal program of the Panchayat and Rural Development Department school children are served fresh cooked food prepared at school kitchen by the Self-Help Group. Same group also cooks Hot cooked Meal to be served under SNP at Anganwadi Centres
72	SBM	Swachh Bharat Mission includes elimination of open defecation, conversion of unsanitary toilets to pour flush toilets, eradication of manual scavenging, municipal solid waste management and bringing about a behavioral change in people regarding healthy sanitation practices.
73	Screening	Approach to identify potential nutrition, health, mental or physiological problems
74	SHG	Self-help Group is a small group of persons formed as a special interest group. The membership ranges from 10 to 20.
75	Social Audit	It is a process to involve the community and the officials engaged in work with the government to monitor and evaluate the planning and implementation of a scheme or program to narrow gaps between vision/ goal and reality, between efficiency and effectiveness.

76	Stakeholders	They are generally defined as people, groups, organizations or businesses that have interest or concern in the community. Stakeholders can affect or be affected by the community's actions, objectives and policies. Community stakeholders includes women, youth groups, community groups, developers, field functionaries, PRI members, teachers, Community Mobilizers etc
77	Starch	A polysaccharide made up of many molecules of sugar and plant materials that are digestible
78	Stunting	World Health Organization (WHO) defines childhood stunting (moderate and severe) as a length- or height-for-age z-score more than two standard deviations below the median of the WHO Child Growth Standards.
79	Swasth Gram Samiti	The "Swasth Gram Samiti" is an ad-hoc committee of the Gram Sabha duly constituted under the Madhya Pradesh Panchayati Raj Act. This committee has 20 members; at least 50% of whom are women. The members are nominated by the Gram Sabha with representation to the weaker sections. All elected women Panchayat members, ANM, AWW, ASHA, hand pump mechanic, and chairpersons of Matra Sahyogini Samiti &SHG providing mid-day meal are ex-officio members of GSSGTS. Gram Sabha Health Village Ad Hoc Committee is constituted and governed to increase community participation in meeting and take initiatives and efforts in rooting out the basic health and other issues of the village
	Social Capital	This is the effective functional network of different Social groups through interpersonal relationship. They have a shared sense of identity, understanding, norms, values, trust and cooperation to address the issues with most appropriate solution. Social capital as assets plays a very crucial role to established accountable local governance.
80	Take Home Ration	the food supplied through Anganwadi Centre to children and pregnant women/lactating mothers. The THR is supposed to be taken home by the recipient and cooked.
81	Teachers	In community setup, teachers in school villagers, as a driving force in motivating and influencing adolescents and youth in participating in the community based programs and also helps in establishing the monitoring and supervising activities
82	Tumor	Growth of cancerous cells that form a mass
83	Undernutrition	Undernutrition is a diet-related condition resulting from insufficient food intake to meet needs for energy and nutrients. It includes being underweight, too short (stunted) or too thin (wasted) for age or height, or deficient in vitamins and minerals (micronutrients).
84	Underweight	Underweight is a form of undernutrition when body weight, or weight for height, is too low for a person's age
85	Verbal Communication	Communicating thoughts, messages or information by speaking
86	Vigilance Committee	For ensuring transparency and proper functioning of the NFSA programs, the vigilance committees are set up to monitor and supervise the implementation of the scheme and informing the District Grievance Redressal Officer, in writing, of any violation of the provisions of this Act
87	Village Health, Nutrition, and Sanitation Committee	The NRHM conceptualized the Village Health and Sanitation Committee (VHSC) as responsible for village-level health planning and monitoring, formed within the overall framework of the *Gram Panchayat* (village council), in which women, village members from vulnerable groups and minority communities should be adequately represented
88	WASH	The concept of WASH groups together water supply, sanitation, and hygiene because the impact of deficiencies in each area overlap strongly. Addressing these deficiencies together can achieve a strong positive impact on public health.
89	Wasting	Children who are too thin because of undernutrition are 'wasted'. The World Health Organization (WHO) defines childhood wasting a weight-for-length or -height z-score more than two standard deviations below the median of the WHO Child Growth Standards.
90	Women's Groups	The women's groups, mostly small in size and formed and functional for specific purposes. Self Help Group (SHG) is a form of Mahila Mandal.
91	Written Communication	Communicating thoughts, messages or information by writing

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viiihttps://link.springer.com/content/pdf/10.1007%2F978-3-030-14409-8.pdf
ix Understanding the Women's Empowerment Pathway
x Tribal Health in India, https://www.nhm.gov.in/nhm_components/tribal_report/Executive_Summary.pdf
xi MGNREGA reserves the inclusion and empowerment of women by reserving 33 percent of employment, provision of wages equal to males, residence proximity, catering to vulnerable sections including widow, deserted and destitute - https://wcd.nic.in/sites/default/files/Revised%20RGNCSScheme_210515.pdf Making Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) More Care-Responsive