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Non-lending Technical Assistance to Assam: Improving Nutrition and Development Outcomes in Early Years

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Position Paper:
" Improving Maternal Infant Young Child Nutrition (MIYCN) in Assam"

Output submitted to the World Bank by
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SAFANSI

Assam State Nutrition Working Group

A Position Paper on Improving Maternal Infant Young Child Nutrition (MIYCN) in Assam

Facilitated by - The Coalition for Food and Nutrition Security and Centre for SDGs - Assal

Improving Maternal Infant Young Child Nutrition (MIYCN) in Assam

1. Investing in Reducing Child Malnutrition: Imperative to ACT now

Our perception of undernourished children is limited to a child with sunken eyes, emaciated bodies with prominent body bones. Such extremely undernourished children, suffering from acute severe malnutrition (extremely low weight for height) and at a very high risk of mortality are 'visibly' undernourished but are much lower in numbers (7 in 100 under five children) compared to four in 10 children (36 in 100 under-five children) suffering from 'invisible" chronic undernutrition or stunting (low weight for age) with serious consequences (NFHS 4).

Chronic undernutrition or stunting in early child not only contributes to almost 45% mortality but plays a central role in high incidence morbidities, poor cognitive development, high absenteeism, poor concentration and reduced school achievement. In adulthood, the implications of undernutrition are reported to contribute to lower economic productivity in adulthood and poorer maternal reproductive outcomes. In summary, the persistent problem of malnutrition (the term used malnutrition used interchangeably with the term undernutrition) in women and children fundamentally reduces life chances as well as has a negative impact on people's ability to grow optimally physically and mentally (Dewey and Begun, 2011).

In addition deficiencies of specific minerals and vitamins (often clubbed as micronutrients) such as iron, iodine, Folic Acid, Zinc and vitamin A result in lowering of output low birth weight, neurological disorders in newborns, lowering of immune functions in young children, suboptimum brain development, loss of 10-15 IQ points, poor cognitive development in early first two years, poor concentration in school, poor work output etc. Clinical form of these deficiencies have reduced substantially but sub-clinical forms of these micronutrient deficiencies remain a public health problem. Prevalence of deficiencies of vitamin A and iodine has decreased significantly with committed effective public health interventions but sustained efforts are required for preventing any deterioration.

Improving maternal-infant and young child nutrition (MIYCN) therefore is crucial and needs to be viewed in the broader context of its implication on 'GenSMART Assam' with healthy, smart, educated adults. The interrelationship of undernutrition and economic growth is evident. Substantial MIYCN thus contributes in breaking undernutrition-poverty link. Improved MIYCN situation not only improves work output and earning but also reduces the financial burden of avoidable expenditure on health care and medical treatment which often are associated with excessive quantum of loans for medical care resulting in financial loss, monetary insecurity and eventually leading to poverty. In fact, undernutrition in early childhood also increases chances of adult onset chronic diseases such as diabetes, cardio-vascular diseases etc. with substantial drain on finances with excessive health expenditure.

In summary, poor maternal, infant, young child nutrition has serious implications on health, education, productivity and economy of family, community and country. Our efforts for the reduction in absolute poverty and consistent economic growth therefore need to be actively supported and translated in ensuring improved health and nutrition situations of the marginalised populations. The value of addressing undernutrition is evident from the recent assessment that for every dollar invested in scaling up nutrition actions, $16 are realized in return. It is important to recognise that investing in nutrition is means to accelerate economic growth rather than viewing nutrition improvement merely as an outcome of economic growth. Infact improving maternal, infant and young child nutrition (MIYCN) scenario in the state is central to our efforts in achieving the sustainable development goals (SDGs) by 2030.

2. Magnitude of the Problem of Malnutrition in Women and Children

Assam state with 33 districts is home to more than 31 million people of which 72.2 percent are literate. Today, we have district-wise malnutrition information for 27 districts (since the National Health and Family Survey 2016-17 was undertaken using the district boundaries of Census 2011).

As per the survey of 2016-17, 36.4% under five children in Assam are stunted or suffering from chronic undernutrition compared to 46.5% a decade back. Stunting rate in children varies moderately among districts---ranging from 24.6% in Kamrup Metropolitan to 47.4% in Dhubri (Figure1). Stunting rate is higher than 40% in 6 districts (Chirag, Barapeta, Kamrup M, Karimgan, Goalpara and Darrang). Two of these 6 districts (Barapeta and Goalpara) are listed under the 'aspirational districts' while the third aspirational district, Udaiguri, has under 5 child stunting rate of 39.1 %.

The prevalence rate of stunting (height for age indicating chronic undernutrition) increases steadily between the age of 0-24 months and then stabilises. In Assam 19.9% and 21.5% infants are stunted in first 6 and 12 months respectively. By 24 months 47.4% children are stunted while 36.9% stunted at 36 months, 40.0% at 48 months and 39.8 % at 59 months. Similar trend in stunting prevalence rate in the first two years of life is reported nationally and internationally. The significance of such a trend is critically for program planning.

Level of undernutrition is noted worse in tribal region and SC population, rural region, high birth order, and in Muslim children. Unfortunately, along with undernutrition, there is an increasing trend in overweight and obesity in women and children.This is of concern

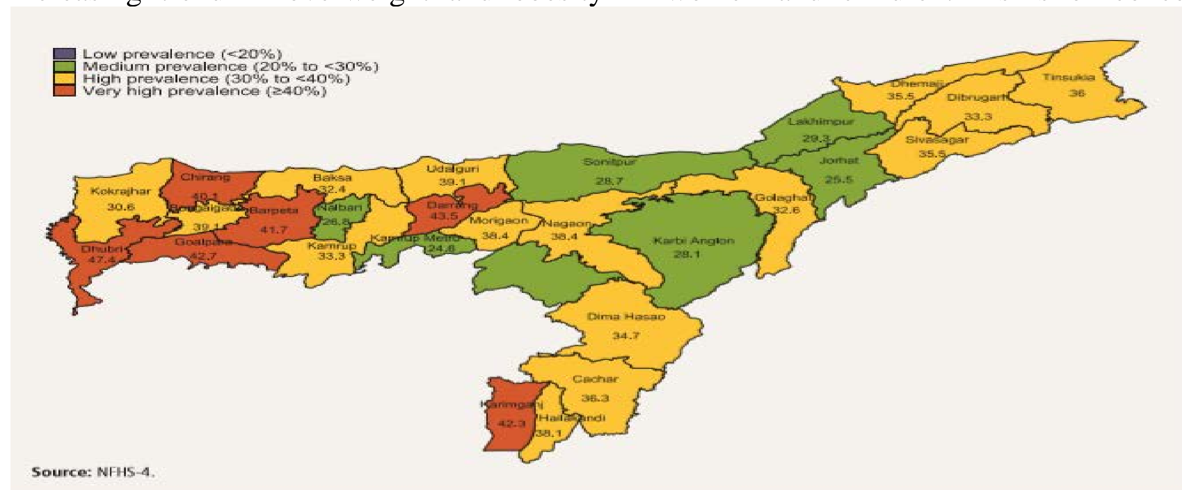


Figure 1: Stunting (among children <5 years) in Assam in 2016, by district (Source: IFPRI)

though currently only two percent children are reported to be overweight (NFHS4).

Acute undernutrition or wasted children in under- fives (measured as low weight for height-2 sd) indicate 15 districts have very high prevalence rare of over 15%. The above referred three aspirational districts have a very high wasting rate over 15% i.e. 16.6%, 18.3% and 22.1%. The prevalence rate of extremely wasted or severe acute malnourished (SAM -measured as weight /height -3sd) children ranges from as low as 0.8 percent in District Dhemaji to as high as 12.7 % in District Bongaigaon. These SAM children have almost seven times higher chances of dying as compared to nourished children. The high IMR (43) and (56.2) reflect poor nutrition situation in the state.

Besides poor child nutrition in Assam state, high prevalence rate of undernutrition in women (BMI <18.5) is evident. A quarter of women are undernourished (25.7 Percent) and almost half of women (46.0%) are anaemic (NFHS 4). Anaemia is reported to be extremely high in adolescent girls who are from families of tea garden workers (Vir, 2011). Undernutrition in women sets up an intergenerational cycle of undernutrition (Figure2). Maternal undernutrition is estimated to account for 20% of childhood stunting (WHO, 2014). Low birth children have higher chances of being stunted. Incidence of low birth weight (<2500 grams) is reported to be 13.6 percent in the state and these children start life undernourished.

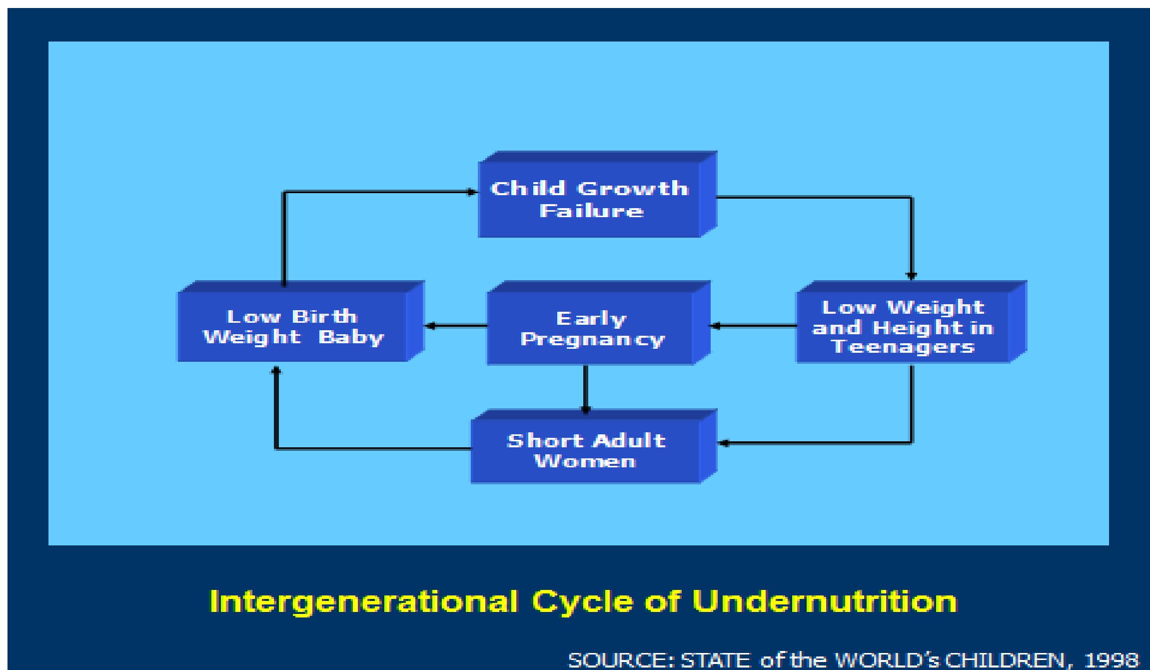


Figure 2 : Intergenerational cycle of Undernutrition

3. Determinants of Malnutrition

Malnutrition or undernutrition is caused by not having enough to eat, not eating enough of the right things, or being unable to utilise the food that one does eat. The immediate determinants of undernutrition in women and children are therefore inadequate dietary intake and frequent illness. Poor diet combined with poor health care, hygiene and sanitation sets up a cycle of poor intake of nutrients, frequent infection and a loss of nutrients with resulting malnutrition. Inadequate dietary intake and frequent illness are the immediate cause of undernutrition (Figure 3).

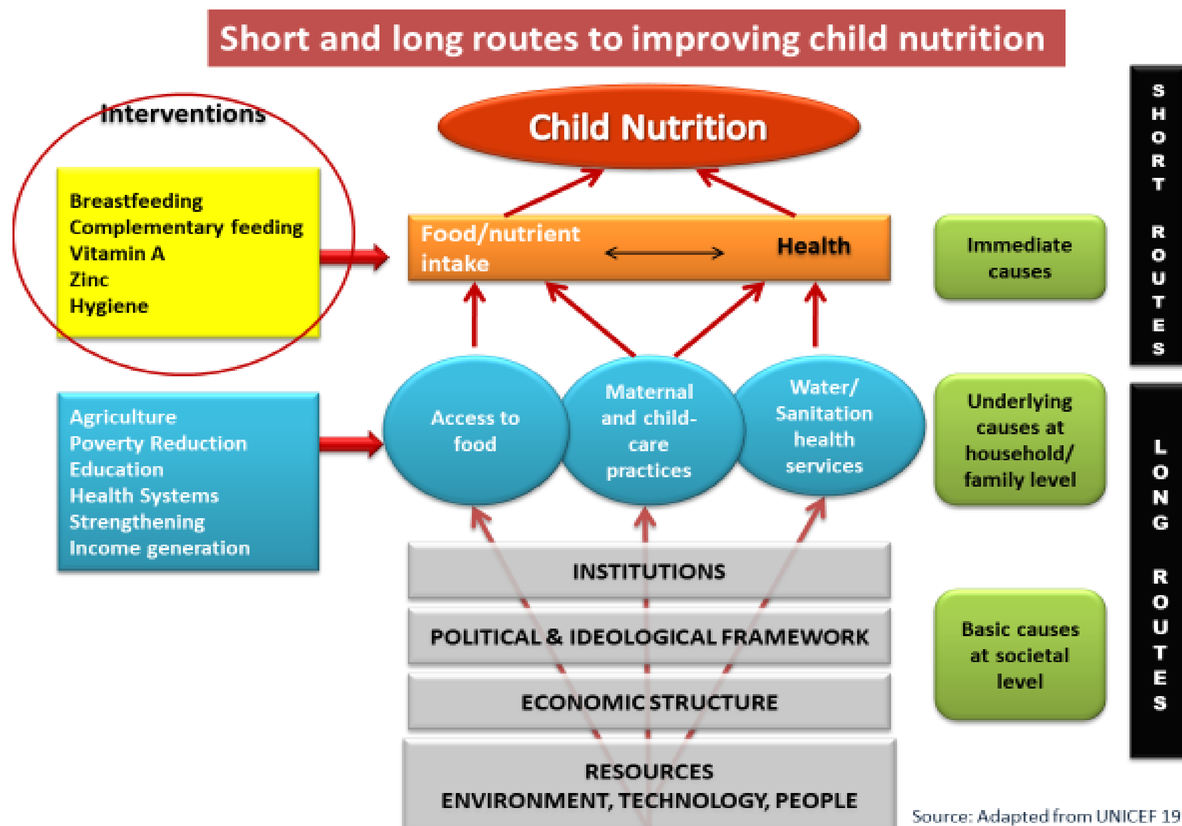


Figure 3: Conceptual framework of undernutrition and routes for improving the situation

Additionally, there are intermediate and underlying factors which influence immediate determinants of undernutrition. The intermediate determinants of undernutrition are household food insecurity, inappropriate maternal and child feeding practices, poor care practices and health services as well as poor water-sanitation and poor environment. The underlying causes are poverty and lack of political support.

The primary reason for poor dietary intake seems to be lack of knowledge regarding appropriate feeding practices as well as socio-economic factors which contribute to poor availability of diverse diet.In case of women, poor nutrition can be attributed to poor food intake in terms of quantity and quality through the life cycle due to low social status and poor purchasing power, inadequate knowledge and decision making power (Figure 3). Besides poor diet, these women have a high chance to be undernourished since they are also involved in day to day tasks associated with excessive physical drudgery and suffer from infection and illness caused due to poor hygiene, water and sanitation. Additionally, other social factors such as early marriage and conception, frequent pregnancies, large families, poor nutrition care during childhood and adolescence domestic violence result in undernutrition (Figure 4). An analysis of current evidence indicates that constraints on women's resources influence immediate determinants of nutrition as well as the other underlying causes. These resources (as shown in Figure 4) encompass not only wealth but education, decision making power, health benefits, access to services such as mobility, maternity benefits, crèches etc. (Vir, 2016).

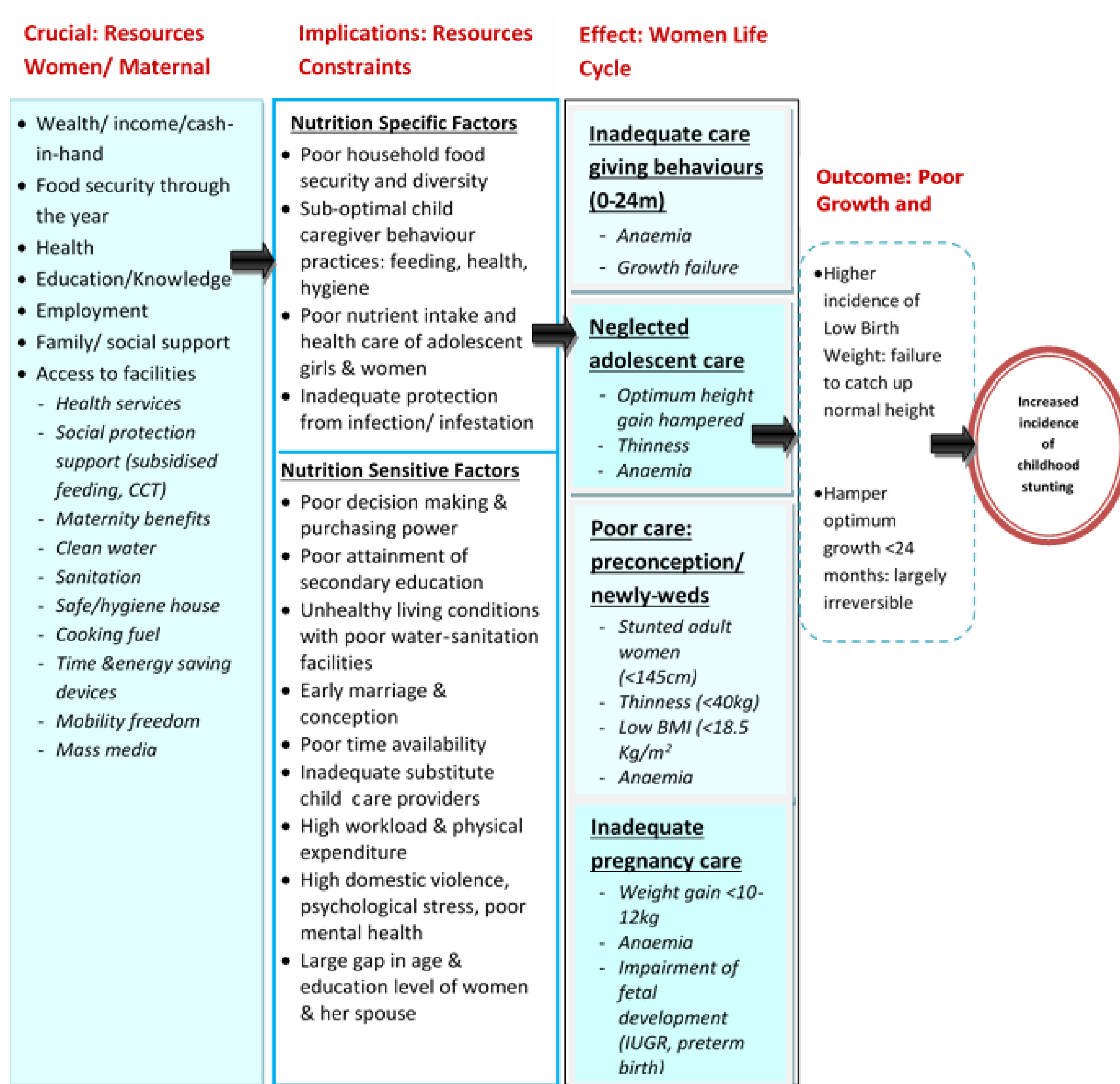


Figure 4: Women Resources: Nutrition specific and nutrition sensitive interventions and MIYCN (Source: Vir, 2016)

4. Risk Factors of Childhood Stunting:

Regression analysis indicate that in India, as in other neighboring South Asia countries, mothers' height, nutrition and education status as well as poor environmental sanitation are important major risk factors contributing to stunting in children (Table 1). Women's nutrition plays a crucial role in optimising pregnancy outcome and influencing maternal, neonatal and child health outcomes.

In the context of Assam, it is important to recognize that early marriage (below 18 years) is rather high. Over a third of the adolescent girls (32.6%) are married. These newly wed adolescent girls are often pregnant within a year of marriage. Such conception in adolescence has adverse implications on achievement of optimum height by these girls in the second and last growth spurt of life. Such women with low height (<145cms) have a higher chance of having undernourished children. Early marriage also deprives a girl from completion of middle and high school education and in being empowered to take a family decision. Such married adolescent girls as well as other newlywed women must be reached and supported to have

attained optimum height and weight as well as provided appropriate timely inputs for being free from anemia.

Table 1 : Highest Risk Factors for Stunting in Young Children: India, Bangladesh and Nepal

Highest Risk Factors Associated with Stunting		
India	Bangladesh	Nepal
No education of mothers	Domestic violence	Maternal Height
Maternal Height	Decision making power	Water
Mothers with no Institutional delivery	Maternal Height	Open defecation
Households with low standard of living	Secondary education	Born in hospital
Households with no toilet facility	Wealth quintile	ANCs visits- or more
--	---	Maternal education

Source: Adhikari et al, 2014; Vir et al, 2013; Heady & Hoddinott, 2013; Bhagowalia et al, 2012

Poor socio-economic status of women not only effect foetal growth and pregnancy outcome but also adversely impacts behavioural practices pertaining to appropriate self and child care which contribute to low BMI in women and stunting in children. Today, there is increasing evidence and recognition among scientific community that it will be difficult to achieve rapid and significant progress in reducing childhood stunting without simultaneously addressing the underlying socio-economic causes which adversely influence nutrition of women. (Smith & Haddad, 2015). In Assam state, urgent action is required to introduce effective measures to retain girls in school for completion of education. There is an urgent need to reach the non-school going adolescent girls with health and nutrition education, family planning services and iron-folic acid supplements and equip them to be healthy,well-nourished ,informed adult women.

5. Essential Facts for Developing Assam State Nutrition Plan

5.1. Evidence Based Interventions for Improving MIYCN Situation: Coupling Nutrition specific and Nutrition Sensitive Measures Imperative

Today, there is increasing evidence and recognition among scientific community that it will be difficult to achieve rapid and significant progress in reducing childhood stunting without simultaneously addressing the underlying socio-economic causes which adversely influence nutrition of women (Smith & Haddad, 2015; Vir, 2016a). Analysis of determinants and the evidence emerging from international and national experiences indicate that direct nutrition specific interventions and essential maternal-child health services will need to be complemented with nutrition sensitive interventions to accelerate improvement in nutrition situation through the life cycle (Figure 5).

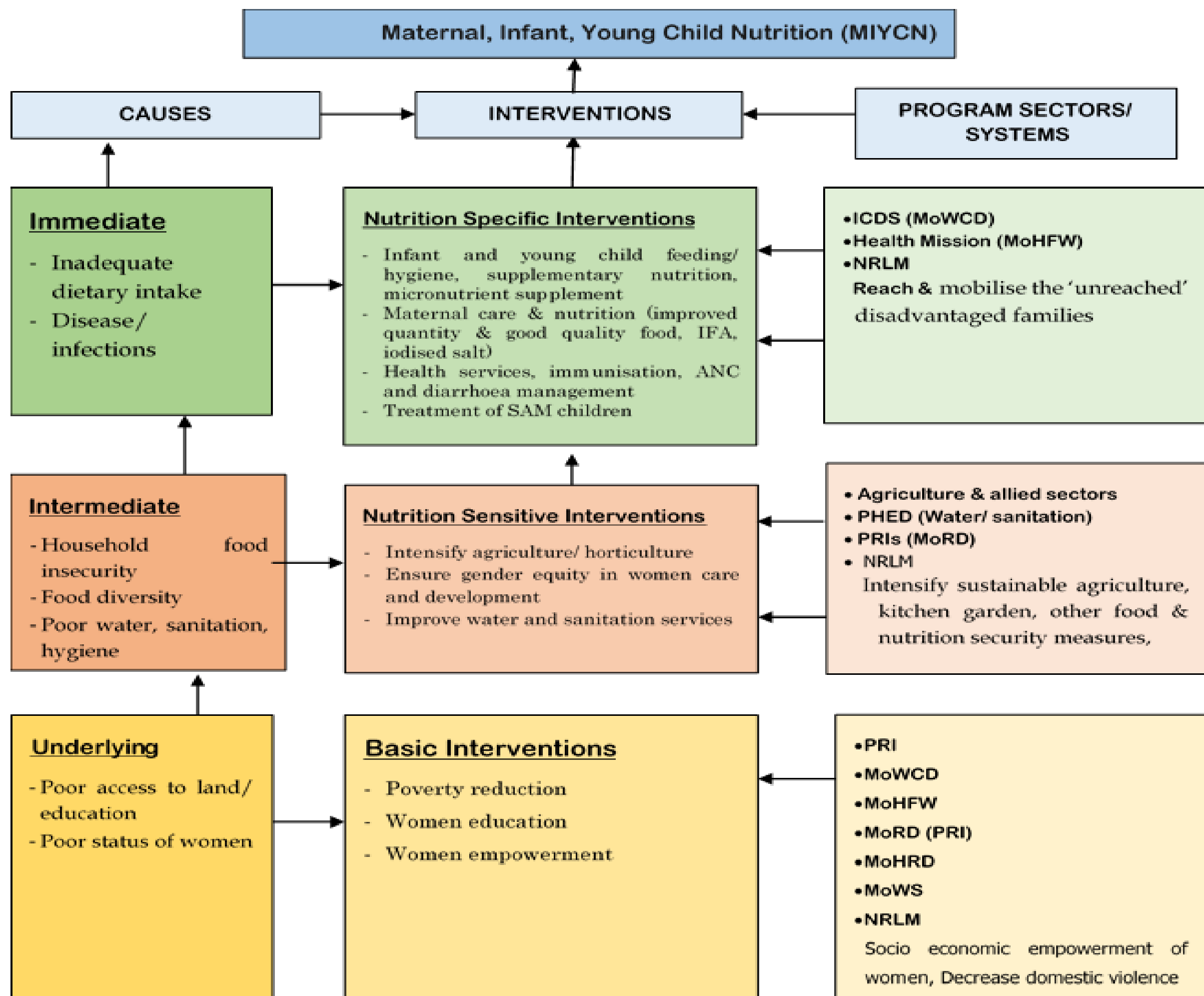


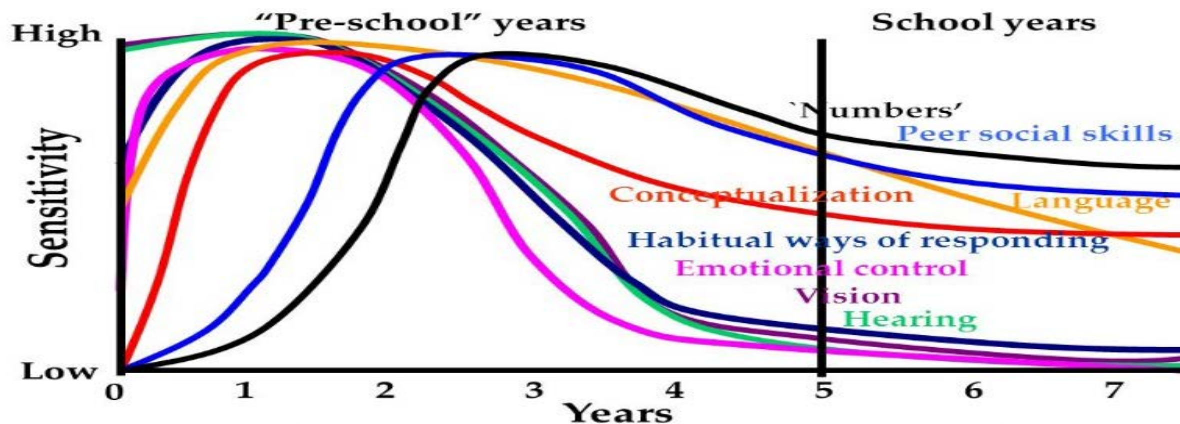
Figure 5: Nutrition Specific and Nutrition Sensitive Interventions (adaptation UNICEF,1998 and Lancet 2013)

The nutrition specific interventions which address immediate and intermediate determinants comprise adoption of appropriate child feeding and maternal feeding practices, consumption of food and pharmaceutical supplements etc. In addition, essential maternal-child health(MCH) is imperative. There are a number of intermediate and underlying causes which are not nutrition or MCH specific but impact nutrition situation of women and children and are therefore referred as 'nutrition sensitive'. The latter include a range of interventions which reduce poverty and purchasing power, improve household food security and diversity such as inputs in agriculture and allied sectors, improve access to water and sanitation facilities, empowerment of women and improve education, social status, and decision making power of women (Figure 5).

5.2. First 1000 Days of Life Critical for Preventing Undernutrition: Needs to be Accorded Highest Priority

The first 1000 days of life, from the onset of conception to 24 months of age of a child , is established to be the most crucial time to take action to prevent childhood stunting. The first 1000 days of life includes 270 days of pregnancy and 730 days of early childhood of 0-24 months and is the "window of opportunity" for addressing undernutrition. Undernutrition (stunting) occurring in the first two years of life is largely irreversible. Moreover, as presented in Figure 6 below, many functions pertaining brain and cognitive developments like language,

peer social skills, habitual ways of responding, etc. develop in a child before the completion of two years of age. It is therefore evident that the period of life from conception to two years of age is the critical period of life that lays the foundation for health, learning and productivity.



Graph developed by **Council for Early Child Development** (ref: Nash, 1997; *Early Years Study*, 1999; Shonkoff, 2000.)

Figure 6: Sensitive periods in early brain development

It is therefore well established that intervention measures for preventing undernutrition must be addressed intensively in the first 1000 days of life i.e. from the onset of conception to 24 months of age. In addition, it is imperative that newly- wed women prior to onset of first conception are provided appropriate nutrition and health care and enter pregnancy healthy, well-nourished and free from anaemia.

5.3 Some Emerging Positive Facts from Assam: Analysis of Situation and Learnings It is considered important to systematically study and analyse the positive scenario reported by NFHS 4 for some indicators from the state of Assam and adopt the contributing best practices. For example, three of the 10 top districts in the country with the lowest prevalence rate of severe wasting is observed to be from Assam state —Dhemaji (0.8%), Morigaon (0.9%) and Dima Hasao (1.3%). Moreover, one of the 10 best nationally performing districts regarding exclusive breastfeeding (EBF) practice is also reported to be from Assam –Tinsukia district with 86.2% infants reported to have been exclusively breastfed up to 6 months. The determinants of malnutrition which show a poor performance in Assam are in reference to complementary feeding practices, early age of marriage, high incidence of malaria and rising rate of overweight in women of reproductive age.

5.4 National POSHAN Abhiyaan (National Nutrition Mission) Guidelines: Opportunity of Building on Enabling Political Support Environment

Government of India is according very high priority to child nutrition situation in the country and launched POSHAN Abhiyaan (also referred as National Nutrition Mission) on 8th March 2018. Under POSHAN Abhiyaan, details of the national nutrition improvement strategy have been elaborated on. These include objectives, roles of ICDS, Health and other sectors, principles for multi-sector planning especially with reference to Jan Andolan/community drive , incremental learning/training, monitoring mechanism including national, state and district committees and emphasis on scaling up the use of computer application software (CAS) Assam state therefore needs to build on these guidelines and take into consideration the state specific details presented in the above sections 1 to 5.3 for the development of Assam State Nutrition Plan of Action 2019-25. The next section presents a framework for the proposed plan.

6. Accelerating Improving Nutrition Situation in Assam: Proposed Framework for Assam State Nutrition Plan of Action (ASNPA) 2019-25

6.1. Target, Coverage and Program Systems

Assam State Nutrition Plan of Action (ASNPA) will have the following targets to be reached by 2025.The proposed targets for anaemia and LBW are based on the WHA and National targets stated under POSHAN Abhiyaan as well the rate of the decadal decline noted in the period 2005-6 to 2015-16.

i. No district in Assam will have a stunting rate exceeding 30 percent and the state stunting rate to be reduced to 26 % or by 10 % in five years.

ii. Anaemia levels in women of reproductive age will be reduced by 12 percent points i.e. from 46 % to 24%.

iii. Rate of Low birth weight will be reduced by 8 percent points i.e. from 13.6 % to 5.6%.

iv. All districts will have an exclusive breastfeeding rate of over 70 percent.

v. All districts with prevalence rate of wasting in under-fives of over 15 % will reduce the rate to between 10 to <15 percent while in the remaining 9 districts with the existing medium prevalence wasting rate between 5% to <10%, wasting rate will be reduced to 5%.

The state plan of five years 2019-25 will cover all the 33 districts. Available district data of NFHS 4 will be used for district planning and will keep in mind that the available data for the period 2015-16 is for 25 districts i.e. based on the Census 2011 district boundaries/data.

In 2019-20, all 33 districts will focus on improving coverage of essential nutrition interventions to 90% (Figure 7).

The two systems which will spearhead the implementation will be the Integrated Child Development Services (ICDS) and health sector (National Health Mission). Health Sector, as per the existing policy, is in-charge of health care of pregnant women and young children and in fact needs to take the lead role for majority of actions in the first 1000 days of life. Additionally, Assam Rural Livelihood Mission (ARLM) will be involved in many actions to contribute to care in first 1000 days. Besides ARLM, PHED, Food and Civil Supplies and Education will be advocated to implement their programs and make a difference in the nutrition situation.

With reference to development and execution of a comprehensive multisector ASNPA, highest priority will be accorded to the following seven districts with stunting rates in under five children of over the state average prevalence rate of 38.4 % i.e. Chirag, Barapeta, Karimgan, Goalpara, Darrang, Bobgaigaon, Udalguri districts. Three of these districts (Barapeta, Goalpara, Udalguri) are also gaining special support as the selected ‘inspirational districts’ and already have specific district level multisector plans for overall development, including some indicators of health and nutrition.

In the 33 districts, primary focus will be on a joint plan by health and ICDS sectors for improving rapid coverage of nutrition specific interventions and maternal child health services to at least 90%. In these districts, parallel investment in nutrition sensitive interventions will include special attention to improving diet diversity through homestead food production and effective implementation of public distribution system as well as measures for improving water-sanitation and hygiene situation. Involvement of the relevant sectors will mainly focus

on sensitisations events such as organising multisector workshops and creating demand for social and infrastructural services through organising community events/Jan Andolans such as rallies on specific themes. The key themes will include WASH, girls' school education and right age of marriage and other selected sectoral entitlements.

6.2. Operational Strategy for ASNPA

Based on the national and global evidence, the ASNPA strategy will accord highest priority to the first 1000 days of life (pregnant women and children 0-24 months) and newly-wed women. The plan recognises nutrition specific interventions and nutrition sensitive interventions are crucial to be implemented simultaneously for improving nutrition status of women and children. However, the focus will be primarily of actions spearheaded by health and Social Welfare(ICDS) sectors.

6.2.1 Coupling Nutrition Specific and MCH Interventions in the First 1000 days of life and Reaching Newly weds

6.2.1.1 Nutrition Specific and Maternal-Child Health Interventions:

For addressing the immediate determinants of MIYCN, intensive effort is required for increasing coverage of the evidence based essential nutrition specific interventions and MCH services.These interventions are being addressed by two sectors -Integrated Child Development Services (ICDS), Ministry of Women and Child Development (MoWCD) and National Health Mission, MoHFW. The interventions essentially comprise the following: promote appropriate infant and young child feeding practices, ensure adequate maternal nutrition and optimum weight gain, regular consumption of food supplied by ICDS, prevention & treatment of anaemia. Additionally, timely and therapeutic feeding and treatment for all children with severe acute malnutrition (SAM) is essential. In addition, improved access to health services (routine immunisation, antenatal care, institutional deliveries ,family planning advice to new couples) is critical. For all these interventions, policies have been issued by the Ministry of Health and Family Welfare.

As presented in Figure 7, there has been a progress in achievement of almost all indicators in the decade between 2005/6 and 2015/16.However, the situation is far from satisfactory. The coverage of children introduced to timely complementary feed (CF) is less than 50% while less than 10 % children are reported to be receiving adequate diet, 47.1% children covered under full immunization and 46.5 % reported having attended the minimum recommended 4 ANC visits (Figure 7). In the next three years, the aim will be to improve coverage of the above referred package of interventions to at least 75% and in the next five years to at least 90%. Health sector is responsible for most of these actions and could spearhead actions in the state with support from ICDS.

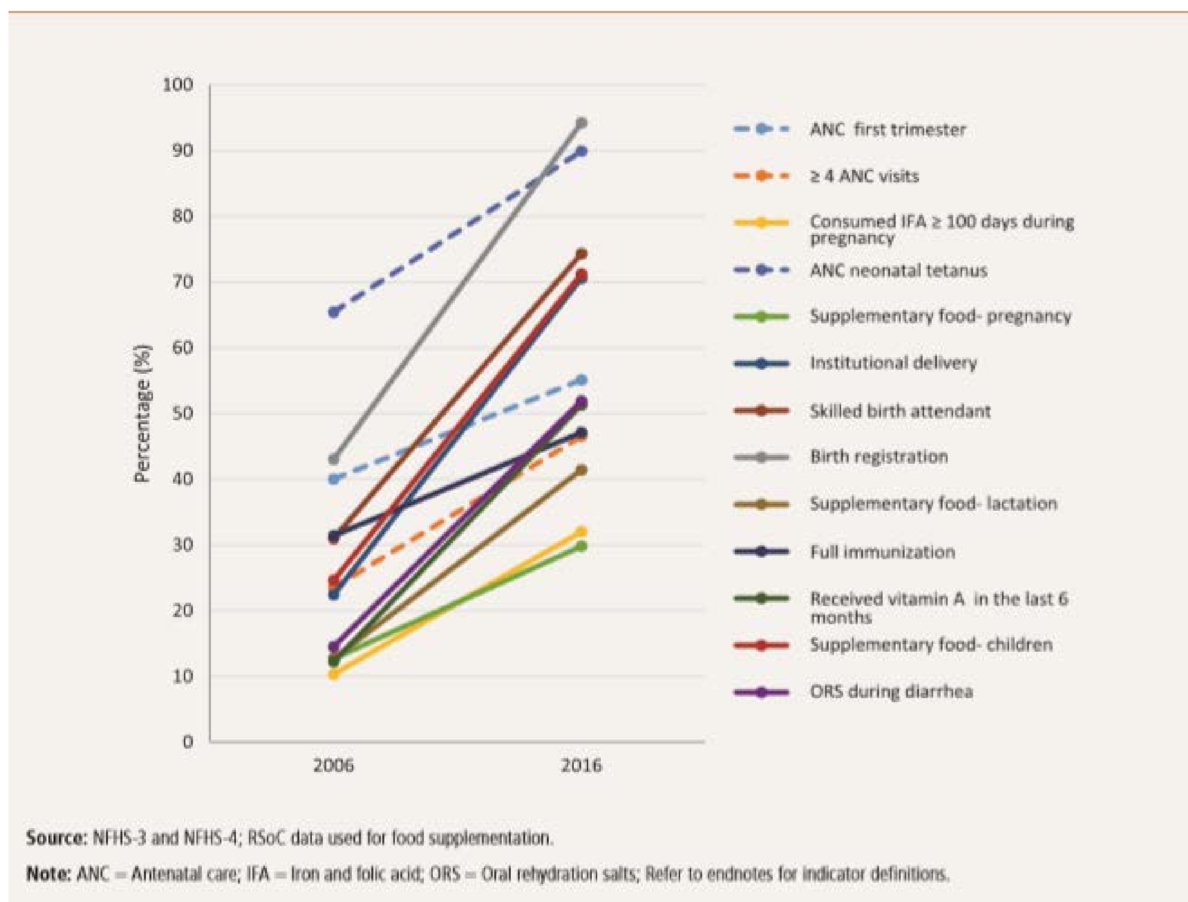


Figure 7: Coverage of Nutrition Specific Interventions in 2006 and 2016 (NFHS 3 and NFHS4)

6.2.1.2 Intensification of Nutrition Sensitive Interventions:

Besides improving the coverage of above stated nutrition specific actions by health and ICDS sectors, there is an urgent need for the intensification of nutrition sensitive interventions .In this context, in the state of Assam, high priority must be placed for introducing measures for elimination of early marriage, improving water-sanitation and hygiene situation, introduction of incentives for completion of high school education and ensuring food security and food diversity through adoption of successful strategies. Assam Rural Livelihood Mission with Self-Help Groups (SHGs) of women must be effectively utilised for a number of actions for improving food security and diversity, reduction of domestic violence, physical drudgery etc. Positive lessons emerging from the National Rural Livelihood Missions (NRLM) could be adopted (CARE, 2016). Additionally, effective implementation of Public Distribution System under the National Food Security Act is crucial. For implementation of these actions, it is important to sensitise the concerned departments of the grave problem of malnutrition, the roles of these sectors which deal with high school education, implementation of the existing legal act of marriage age, water-sanitation, rural development, PDS etc and seeking their support for urgent action in implementing the sctoral programs ,as per the existiond program policies ,goals and design.

6.2.2 District Level Plans of Action: Development and Implementation Strategy

Every district will develop a nutrition plan of action. The district data presented by NFHS 4 will be reviewed and analysed. District plan will focus on identifying and working with families of households "at risk" of malnutrition i.e. households with pregnant women or, a child 0-24 months or a newly- wed women. Focus will be on interventions for ensuring women enter pregnancy at the right age with optimum height and weight gain ,free from anaemia and young children are provided appropriate food, care and timely child health care service. All households of under twos will be mapped by Anganwadi workers with support of ASHAs. Home visits to households will be periodically undertaken by AWWs and ASHAs as per the POSHAN Abhiyaan guidelines as well as and ICDS guidelines and MoHFW policies on AWWs home visit guidelines, Home Based care of New-borns, Home Based Care of young children and Anaemia Mukt Bharat.

As per the above referred policies, women and family members will be mobilised to attend the monthly Village Health Sanitation Nutrition Days (VHSNDs) and weekly counselling sessions at the ICDS linked to specific mother -child events such as 'Anna Prasan' and 'Godh Bharai '.In addition, ICDS,health sectors ,community organisations and other relevant sectors will be encouraged to participate in community education events or 'Jan Andolan' as per the POSHAN Abhiyaan Policy of the Government of India. Using VHNSD platforms, quality health and ICDS services will be provided to "at risk" families. Social Behavioural change communication (SBCC) strategy will be planned for the state by adopting successful experiences from some selected states. Contacts with pregnant women during ANC services, institutional deliveries and with children during immunisation and growth monitoring will be used effectively for improving the following nutrition specific activities - promotion of appropriate feeding practices in children 0-6 months, over 6 -24 months and nutrition care of pregnant women. Newly- wed women will be registered by ASHAs under the Fertility control/Family Planning scheme and she will make home visits for counselling women on usage of contraceptive, weekly dose of iron-folic acid and gaining adequate weight.

In addition, school going adolescent girls and boys will be reached with counselling on healthy eating habits and consumption of weekly IFA tablets. Special effort will be made to reach and mobilise non-school going adolescent girls 13-18 years to form self-care "kitty groups" and involved in activities of families of under twos who are at nutrition risk.

For improving diet diversity in family of "nutrition risk" households, self-help group of women will be involved and provided support for establishment of saag-sabjee bagicha (kitchen garden), poultry keeping, goat rearing and other income generating activities for improving purchasing power with guidance on improving family diet. SHGs as well as caregivers of under twos will be encouraged for production of nutrient dense mix with good shelf life.

For strengthening multi-sector involvement, investment and effective implementation of ongoing sectoral schemes by state government ,as per the program goal and policy, is important. State Nutrition Plan will support advocacy and inclusion of sectoral key themes in Jan Andolan/public or community events .The key themes will focus on for encouraging girls to complete high school education, creating awareness on legal policy guidelines on accepted legal age of marriage, creating demand and ensuring availability of potable water supply and sanitation facilities as well as informing community of the entitlement to subsidized food under the public distribution system (PDS).

6.2.3 Social Behavioural Change Communication (SBCC):

An effective SBCC strategy will be developed. Effort will be directed to influence behavioural change for timely introduction of semisolid feeding along with breastfeeding, nutrient density

and diversity of food, frequency and amount of feed. Successful experiences of Alive and Thrive SBCC strategy will be reviewed and adopted.

6.2.4 Training : As per the POSHAN **Abhiyaan policy, the prescribed incremental learning modules will be adapted for the state and used. In service training will be encouraged. Health sector will also be trained in relevant themes. Implementation of the proposed operational strategy and imparting communication skills will be integral part of capacity building and training.**

6.2.5 Establishing Monitoring Mechanism:

The state data (NFHS 4) reveals that 95% mothers possessed Mother-Child Protection (MCP) card. Use of MCP card is for effective monitoring will be institutionalised. For effective analysis of monitoring data and technical support, a State Nutrition Resource Centre (SNRC) or a Centre of Excellence (described under 6.2.7) needs to be established in a development institute or in a medical college of the institute. As a part of POSHAN mission strategy, use of computer soft application (CAS) needs to be scaled up and experience of other states need to be studied for scaling up CAS.As per POSHAN Abhiyaan guidelines, state,district and block coordinating and monitoring committees could be set up.

6.2.6 Supply Support:

Supply situation of digital weighing machines, infantometer, smart cell phones with the software recommended by POSHAN Abhiyaan (CAS), training manuals and IEC materials in local language, village survey registers needs to be reviewed and supply ensured. A system for procuring such supply items need to established.

6.2.7 Human Resource Support:

For execution the state and district plans of action, it is important that the positions of frontline workers of health and ICDS are not vacant and AWWs and ANMs are in position and trained.

In addition for effective rolling out of the ASNPA, the state requires technical and management support. Besides having a State Nutrition Working Group, an institutional support mechanism is imperative for rolling out district plans of action and monitoring progress. Such a State Nutrition Resource Centre (SNRC) could be considered to be established either in a Development or medical science related institute. SNRC should be responsible for coordinating development of district plans of action, organising training of trainers, state sensitisation workshops, supporting in execution, establishing and conducting monitoring progress and supporting in implementation.

Additionally, in every district, an officer-in-charge of overall implementation of Nutrition Plan of Action will be required to ensure plan of action is developed and implemented. In case of 7 districts with a comprehensive multisector strategy, a block person will need to be made in charge.

6.2.8 Budget Allocation :

Budget situation for rolling out the plan, including cost of supply, additional human resource, needs to be worked out.

Series of Monthly Nutrition Working Group Meetings

Members of nutrition working group met every month from Dec'2018 to July'2019 for a deliberation session on various challenges during "First 1000 Days- the Critical Window of Opportunity" and their potential solutions. Nutrition working group report is the result of these series of meetings. Following sections give details on monthly Nutrition Working Group meetings.

i. First Nutrition Working Group Meeting – 17th Dec, 2018

First nutrition working group meeting was organized on 17th December 2018 at Hotel Lily, Guwahati by CFNS. It was attended was Mr. Jishnu Barua, Additional Chief Secretary, Social Welfare Department, Government of Assam, Dr. Tushan Rane, UNICEF, Dr, Satish B Agnihotri, HoD CTARA (Center for Technology Alternatives for Rural Areas), IIT Bombay, Mr. Arjan De Wagt, UNICEF along with the members of working group including Dr. Santosh MR from Tata Institute of Social Sciences, Dr. Manisha Choudhary from Piramal Foundation, Dr. Melari Nongrum from NESFAS Meghalaya, and Mr. Jiban Phukan from CSDGs Assam.

The group deliberated on the nutritional scenario of Assam, the need to identify aspirational pockets within the district and need for district specific interventions for nutrition. Group members emphasized that instead of focusing and researching on new and innovative methods to curb malnutrition it will be more beneficial if the focus can be brought on doing the basic interventions right- ANC visits for pregnant women, early initiation of breastfeeding, exclusive breastfeeding, timely and optimum complementary feeding and ORS during diarrhoea. The group agreed to finalize the Terms of Reference (ToR) for working group in the next meeting.

ii. Nutrition Working Group Meeting – 28th Feb, 2019

Second nutrition working group meeting was organized on 28th February, 2019 at Assam Administrative Staff College, Khanapara, Guwahati. The group discussed extensively on Terms of Reference and suggested modifications that will enhance the output from the working group. ToR was finalized after incorporating all the suggestions from the members. It was decided in the meeting that date of next month meeting will be decided by the members in the meeting of preceding month.

Since the members of the nutrition working group come from diverse backgrounds including civil society organizations, academia, think tanks etc. it was suggested to delineate the roles and contributions of different members based on their capacities and skill sets.

The working group selected Dr. Sunil Kaul of the ANT organization as nutrition working group chairman and all others present as its members. Besides that the meeting authorized the chairman to opt special invitees for the group from the sectors not represented by the members present.

In this meeting members of working group decided to focus their deliberations on first 1000 days for nutrition and come up with a nutrition working group report for Government of Assam that will provide technical operational guidance to Government on first 1000 Days.

iii. Nutrition Working Group Meeting- 15th March, 2019

Third Nutrition Working Group meeting was organised on 15th March, 2019 at Assam Administrative Staff College, Guwahati. The meeting was attended by The Ant, Piramal foundation, TISS, IIT Guwahati and CFNS and Center for SDGs members. The meeting was chaired by Dr. Sunil Kaul from the ANT organizations.

The group deliberated on wide range of topics that are critical to the child and maternal nutrition in the first 1000 days of life in context of Assam. Members discussed on socio cultural problems that leads to late initiation of complementary feeding among children and ways to address the issue. Members highlighted that there is a need of local community based studies to understand different practices of complementary feeding in different communities especially among vulnerable population- tea garden areas and char areas. Members also discussed about the role of social behaviour change communication in educating the people and creating awareness, and the importance of uniform messages being communicated to the communities from different government departments and outside agencies.

iv. Nutrition Working Group Meeting- 11th April, 2019

Fourth Nutrition working group meeting was organized on 11th April, 2019 at Assam Administrative Staff College, Guwahati. The meeting was attended Piramal Foundation, ANT organization, IIT Guwahati along with CFNS and Center for SDGs members. As a special invitees the meeting was attended by officials from Social welfare department and National Health Mission.

The meeting resumed the discussion on first 1000 days for improving maternal and child nutrition in the state. The discussion was focused on some of the critical schemes for the period like Pradhan Mantri Matru Vandana Yojana (PMMVY), Village Health Sanitation and Nutrition Day (VHSND) and training curriculum for front line workers of ICDS amongst others. This meeting also focussed on mechanisms for generating the nutrition working group report on first 1000 days. It was decided that based on the discussions held so far Dr. Sunil Kaul, the Chairperson of the Nutrition Working Group will prepare the draft report and will share it with all the members of the group before the next meeting on 10th of May.

v. Nutrition Working Group Meeting- 10th May, 2019

Fifth Nutrition working group meeting was organized on 10th May, 2019 at Assam Administrative Staff College, Guwahati. The meeting was chaired by Dr. Rajshree Bedamatta, Associate Professor of Humanities and Social Science. The meeting was attended by officials from Social Welfare, National Institute of Public Cooperation and Child Development (NIPCCD), Indian Academy of Pediatrics, Centre for North East Studies and Piramal Foundation.

On special invitation the meeting was also attended by Dr. Shiela Vir, Director, Public Health Nutrition and Development Center. She shared her views and comments on the working group report and suggested that besides 1000 days period, focus should also be given on newlywed adolescents girls and improving their nutritional status given high prevalence of teenage marriages and pregnancies in Assam. She suggested to include some strategies that state should undertake to ensure healthy pregnancy outcomes and good start in first 1000 days.

All other members present in the meeting also shared their feedback on the report. It was then decided that CFNS will incorporate all the suggestions made by the members so far and will share the updated report with all the members before next working group meeting

vi. Nutrition Working Group Meeting- 7th June, 2019

Sixth Nutrition Working Group meeting was organised on 7th June, 2019 at Assam Administrative Staff College. The meeting was chaired by Sunil Kaul, CEO of the ANT organization. In this meeting the group deliberated on the mechanisms through which the report should be shared with the Government of Assam in the best effective manner.

Conclusion

- The position paper on first 1000 days was shared with heads of all the concerned departments
- Nutrition working group will advocate for incorporating the key recommendations from position paper to be incorporated in District Implementation Plan of Health and Social Welfare Department