Addressing child undernutrition in India: Opportunities and Challenges

Proceedings of a consultation on intersectoral convergence in Chhattisgarh

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Proceedings of the Consultation on intersectoral convergence for Nutrition

held with

Government Departments of Chhattisgarh

as part of the study on

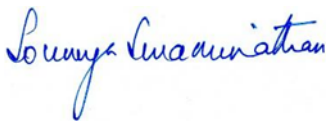
"Assessing the Impact of Poshan Abhiyaan in Addressing Child Undernutrition in Aspirational Districts Across India"

Held on 3rd April 2025 at Raipur, Chhattisgarh

PREFACE

The Integrated Child Development Services (ICDS) Programme is the largest, domestically funded Early Childhood Programme in the world. As early as 1975 when it was introduced, it operationalized taking services right into the community and served as a convergence platform to meet the intersecting needs of women and children. While the core principles continue to remain the same, there have been considerable changes in the programmatic and administrative aspects of service delivery, for improving efficiency and impact. The Poshan Abhiyaan program launched in 2018 aimed to further strengthen convergence and had an ambitious goal of reducing stunting by 2% and undernutrition by 2% per year.

We are thankful to the Ministry of Women and Child Development for having given M S Swaminathan Research Foundation an opportunity to organize a series of consultations with government departments across several states on this subject. It was a very interesting exercise and threw up the heterogeneity of the situation in India across States, and also a lot of insights from a variety of stakeholders. I thank all the government officials of Chhattisgarh who gave their valuable time in participating in the consultation. As those who are implementing the programme and involved in serving the community, their critical inputs and suggestions are key to enhancing service delivery and improving the impact of the program. We hope that the deliberations of this consultation will help WCD in addressing the gaps and leveraging the opportunities to further reduce malnutrition in the country.



Soumya Swaminathan
Chairperson
M S Swaminathan Research Foundation
November 2025

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The M S Swaminathan Research Foundation is deeply thankful to the Ministry of Women and Child Development, Government of India for allowing us to organize a series of consultations across several states to understand the convergence between various government departments to address child undernutrition in India.

We extend our gratitude to all the government officials from Chhattisgarh who participated in this exercises representing the departments of Health, Women and Child Development and Public Health Engineering (Drinking Water and Sanitation).

We thank the Gates Foundation, the Confederation of Indian Industry (CII), and the Karmannya Council for the financial and logistic support extended towards this consultation.

Contents

Background

Malnutrition is a multi-faceted phenomenon requiring concerted efforts from different stakeholders. In India there are several government programmes across life cycle to improve peoples' health and nutrition. These include direct feeding programmes, health interventions, provision of safe drinking water supply, sanitation, agricultural interventions, and livelihood enhancement programmes. While all these have helped in improving health and nutritional outcomes, progress has been slow. Of even more concern is that some states are lagging more than others. In 2018 the Government of India launched the aspirational districts programme, to propel the 112 least developed districts towards prosperity and good health.

The Poshan Abhiyaan or the Prime Minister's overarching scheme for reducing malnutrition among young children, also launched in 2018, is an important milestone in India's journey towards eliminating malnutrition. Poshan Abhiyan aims to improve the nutritional status of pregnant women, lactating mothers, adolescent girls, and children between 0-6 years in a time bound manner by reducing stunting and wasting in children (0-6 years) as well as reduction in anaemia in women, children, and adolescent girls. This program drives its mission for nutrition security through a three-pronged strategy: harnessing innovative technology, fostering convergence among government departments, and mobilizing communities through the Jan Andolan public movement for social and behavioural change.

Recognizing well the importance of convergence between various government departments to tackle the problem of malnutrition holistically, Poshan Abhiyan provides a platform for convergence to realize the goal of 'Suposhit Bharat.' It lists out high impact interventions of 18 ministries/departments especially during the first 1000 days of life since conception Every department formulates a strategic plan for nutrition and aligns it with its current initiatives.

The M. S. Swaminathan Research Foundation (MSSRF) with support from the Ministry of Women and Child Development undertook a study to assess the impact of Poshan Abhiyaan in reducing child undernutrition in select aspirational districts between November 2024 to June 2025. As part of this exercise MSSRF held a series of online and offline consultations with various government departments to understand their role and contributions in addressing

malnutrition. Online consultations were held in the states of Andhra Pradesh, Telangana, and Rajasthan while offline consultations were held in Assam, Chhattisgarh, and Jharkhand.

The current proceedings highlight the initiatives undertaken by government departments and programs in Chhattisgarh to address malnutrition. The challenges and bottlenecks in implementation as well as the recommendations suggested by the participants during the floor discussion have also been documented.

Consultation with Departments of WCD, Health and PHED on April 3, 2025, at Raipur Chhattisgarh

Agenda of the consultation

TIME	TOPICS	DETAILS
09.30 to 10.00 am	Registration	
10.00 to 10.10 am	Welcome Address and purpose of the consultation	Dr. Rama Narayanan – Senior Fellow, MSSRF
10.10 to 10.20 am	Introduction by the participants	
10.20 to 11.00 am	State Nutritional Profile of Children (0-6 years) and Role of Poshan Abhiyaan in addressing child undernutrition	Ms. Shruti Nerkar, Deputy Director – Poshan Abhiyaan, Department of Women and Child Development, Govt of Chhattisgarh
11.00 to 11.40 am	Convergence of Safe Drinking water supply and Sanitation facility to households with children below six years in aspirational versus non aspirational districts and convergence for Behavior Change Communication	Mr. Rajendra K Shukla, Executive Engineer of Jal Jeevan Mission, Public Health Engineering Department, Government of Chhattisgarh
11.40 to 12.30 pm	Low Birth Weight, Immunization and Health status of children (0-6 years) in aspirational districts versus non aspirational districts and convergence with other departments	Dr. V. R. Bhagat, Deputy Director, Child Health, Department of Health and Family Welfare, Chhattisgarh
12.30 to 1.30 pm	Lunch	
01.30 to 2.30 pm	Thematic Discussion by participant in Groups	
02.30 to 3.30 pm	Presentation of the outcome from Discussion	
03.30 to 3.45 pm	Closing Remarks	Dr. Rama Narayanan – Senior Fellow, MSSRF

The consultation commenced with a formal introductory note from Dr. Rama Narayanan, Senior Fellow of the Nutrition and Health Programme Area at the M S Swaminathan Research Foundation. Dr. Narayanan welcomed the participants and set the strategic context for the day's discussions by outlining the primary objectives and desired outcomes of the consultation.

Following this, a round of introductions was conducted, allowing all participants to briefly present themselves and their respective departments to establish a collaborative foundation and thereby enriching the subsequent dialogue.

The first presentation was by Ms. Shruti Nerkar, Deputy Director of Poshan Abhiyaan from the Department of Women and Child Development, Government of Chhattisgarh. Ms. Nerkar provided a comprehensive overview of her department's pivotal role and multi-faceted initiatives in combating undernutrition across the state. Her presentation detailed the on-ground implementation strategies of Poshan Abhiyaan, shedding light on both the challenges encountered and the key achievements in improving nutritional outcomes for women and children in Chhattisgarh. This set a concrete, state-level context for wider discussions to follow.

Role of Women and Child development department in addressing child undernutrition

Presented by Ms. Shruti Nerkar, Deputy Director – Poshan Abhiyaan

The Nutritional status for active children measured between the ages of 0 to 5 years recorded in the Poshan Tracker app are given in the table below. The data revealed concerning trends in nutritional status from September to December 2024. The prevalence of both moderate and severe stunting showed a consistent increase, with moderate stunting rising from 13.52% to 17.41%. Conversely, rates of moderate and severe wasting declined from 1.78% (September) to 1.61% (December). The proportion of severely underweight children remained stable throughout the period. The observation of PT data also highlighted upward trend in childhood overnutrition. The prevalence of overweight children increased steadily from 0.65% to 1.13%, while the rate of obesity rose from 0.38% to 0.69% over the same period. This highlights the emergence of a double burden of malnutrition.

Table 1: Nutritional status of children between 0-5 years

Nutritional Status	September 2024		October 2024		November 2024		December 2024	
	Number	(%)	Number	(%)	Number	(%)	Number	(%)
Total Measured	1922405		1917900		1922261		1910454	
Moderately Stunted	259909	13.52	297090	15.49	311296	16.19	332632	17.41
Severely Stunted	98907	5.14	114830	5.99	127494	6.63	139771	7.32
Moderately Wasted (MAM)	122315	6.36	105029	5.48	100360	5.22	101000	5.29
Severely Wasted (SAM)	34185	1.78	29742	1.55	30471	1.59	30814	1.61
Moderately Underweight	206326	10.73	209424	10.92	209109	10.88	212394	11.12
Severely Underweight	42149	2.19	42033	2.19	41989	2.18	41858	2.19
Overweight	12588	0.65	15225	0.79	17602	0.92	21563	1.13
Obese	7381	0.38	8558	0.45	10867	0.57	13205	0.69

Source: Poshan Tracker Data

Aspirational vs non-aspirational districts:

- Aspirational Districts in Chhattisgarh under Poshan Abhiyaan 2.0 receive additional support, targeted interventions, and more intensive monitoring compared to Non-Aspirational Districts.
- The Poshan Tracker and Anganwadi Services play a key role in ensuring improved nutrition, growth monitoring, and community engagement in both categories, but the focus remains stronger in Aspirational Districts due to their vulnerability

Table 2: Comparative Implementation of Nutrition Programs: Aspirational vs. Non-Aspirational Districts

S No	PARAMETER	ASPIRATIONAL DISTRICTS	NON-ASPIRATIONAL DISTRICTS
1	Priority & Focus	Higher priority due to poor nutritional indicators	Moderate priority, but still covered under the scheme
2	Funding & Resources	Additional central & state support, performance-based funding	Standard allocation as per national guidelines
3	Monitoring & Reporting	Intensive monitoring through Real-Time Data (Poshan Tracker), direct review by NITI Aayog & WCD	Regular monitoring, but lesser direct intervention from NITI Aayog
4	Nutrition & Health Indicators	Higher malnutrition rates, anemia, stunting, and underweight children	Relatively better indicators but still focus on improving nutrition
5	ICDS & Poshan Tracker Implementation	Greater focus on Anganwadi Centers (AWCs), Community-based events, Poshan Vatikas, and beneficiary tracking	Regular implementation but with less direct oversight
6	Capacity Building & Training	More training programs for Anganwadi workers (AWWs), supervisors, and nodal officers	Standardized training under ICDS & Poshan Abhiyaan guidelines
7	Convergence with Other Schemes	Stronger convergence with health, sanitation, and agriculture schemes	Convergence is followed but not as closely monitored

Role of Poshan Tracker in identifying and targeting malnourished children

Poshan Tracker is a real-time based monitoring tool designed to track and monitor nutritional indicators of children, pregnant women, and lactating mothers. It helps in identifying and targeting malnourished children through data-driven decision-making.

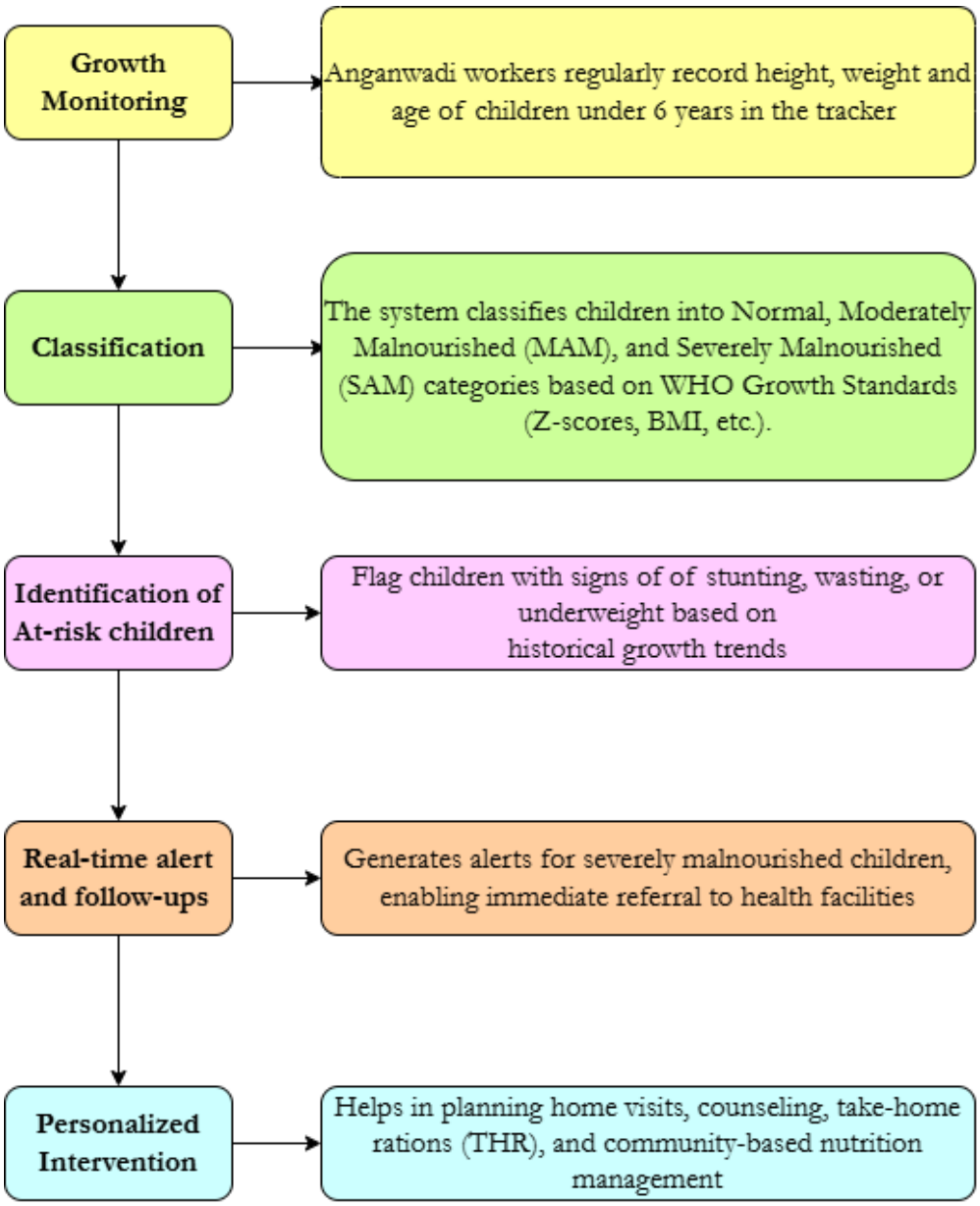


Figure 1: Process of identifying malnourished children in the Poshan Tracker

The Effectiveness of the Poshan Tracker: An Assessment

The Poshan Tracker has demonstrated significant strengths in enhancing the delivery of nutritional services. Its capacity for real-time data and digital tracking enables timely interventions for at-risk children, while its function in enabling targeted nutritional support ensures that rations and supplements reach intended beneficiaries effectively. Furthermore, its integration with broader health and ICDS systems facilitates crucial convergence with immunization and home-visit programs.

However, key challenges persist. While the platform is effective in identifying malnourished children, ensuring their sustained nutritional recovery remains a complex hurdle. Additionally,

operational effectiveness is sometimes hampered by technological barriers, such as network connectivity issues in rural and tribal areas, which can impede real-time data synchronization.

Table 3: Protocol for identifying & addressing Child Malnutrition

S No	PROTOCOLS	METHOD
1	Identification	• Monthly recording weight and height at Anganwadi Centers (AWCs). • Classification based on Growth Monitoring A. Normal B. Moderate Acute Malnutrition (MAM) C. Severe Acute Malnutrition (SAM) • Referrals: Poshan Tracker flags MAM/SAM cases for timely intervention.
2	Intervention	• **MAM (Community-Based Management)** Additional Take-Home Ration (THR), home visits, counseling. Regular monitoring at AWCs, growth tracking every 15 days. • **SAM (Institutional Management at NRCs)** Referral to Nutrition Rehabilitation Centers (NRCs) for medical nutrition therapy, infection treatment, and weight recovery (10-14 days stay). Post-discharge follow-up through Poshan Tracker.
3	Convergence with other departments	• Health (Medical Treatment, Immunization, NRC Support). • ASHA/ANM (Health Check-ups, VHND Sessions).
4	Challenges	• Network issues, referral delays, limited NRC capacity, and community resistance.
5	Conclusion	• MAM cases → Community-based care at AWCs • SAM cases → Institutional care at NRCs with real-time tracking via Poshan Tracker.

Table 4: Convergence of Poshan Abhiyaan with other government agencies in addressing child undernutrition

S NO	Department	Role in addressing undernutrition	Data sharing & integration
1	ICDS (WCD)	Growth monitoring, supplementary nutrition, home visits	Shares malnutrition data with Health, Rural Development, and Drinking Water departments via Poshan Tracker & ICDS
2	Health (NHM, MoHFW)	Immunization, NRC treatment, medical check-ups	Receives SAM/MAM child data from ICDS & integrates it

			with NRC, VHSND, and ASHA records
3	Drinking Water & Sanitation (Jal Jeevan Mission, SBM)	Safe drinking water, hygiene, toilet construction	Shares water quality & sanitation data to correlate with malnutrition cases
4	School Education & Mid-Day Meal (PM Poshan)	Nutritional meals in schools, health check-ups	Data shared on child growth, anemia prevalence
5	Rural Development (MGNREGA, NRLM)	Supports livelihoods, kitchen gardens	Links household economic status with malnutrition trends

Data Sharing and Convergence Mechanisms for Nutrition Security

A multi-platform framework for data sharing and convergence has been established to facilitate a coordinated response to malnutrition. The Poshan Tracker serves as the central pillar, enabling real-time sharing of data on malnutrition, growth trends, and referrals between ICDS, the Health department, and Nutrition Rehabilitation Centres (NRCs). This is complemented by the Anaemia Mukt Bharat Dashboard, which integrates data from ICDS, Health, and Education to monitor anaemia prevalence in women and children. At the community level, Village Health, and Nutrition Days (VHNDs) act as a critical node for joint data sharing and growth monitoring between frontline workers from ICDS and Health, including ASHAs**.**

Furthermore, cross-sectoral convergence is achieved by linking nutritional data with other determinants of health. Reports from the Jal Shakti Abhiyan are utilized to correlate undernutrition hotspots with areas of poor water and sanitation. Finally, specific data on Severe Acute Malnutrition (SAM) and from NRCs is systematically shared between ICDS, Health, and the District Administration to inform targeted intervention planning.

Impact of Poshan Abhiyaan on child malnutrition: achievements & challenges

Achievements:

1. Reduction in Malnutrition Rates
    - Decline in Stunting, Wasting & Underweight Cases (as per NFHS-5).
    - Increased screening & early intervention for MAM & SAM children.
2. Real-time Monitoring via Poshan Tracker
    - Automated growth tracking & alerts for malnourished children.

- Integration with Health & ICDS for better intervention.

3. Improved Supplementary Nutrition
   - Enhanced Take-Home Rations (THR) & Hot Cooked Meals at Anganwadi Centers.
   - Increased fortification of food & micronutrient supplementation (Iron, Vitamin A).
4. Convergence with Health, WASH & Education
   - Better immunization & deworming under Anaemia Mukt Bharat.
   - Improved hygiene & sanitation, reducing infections, and diarrhea.
5. Community Engagement & Awareness
   - Poshan Maah & Poshan Pakhwada drive behavioral changes.
   - VHNDs (Village Health & Nutrition Days) ensure mother-child care awareness.

Challenges:

1. Digital Barriers: Limited internet access in rural & tribal areas affects real-time updates.
2. Behavioural & Cultural Barriers
   - Low dietary diversity & traditional food taboos impact child nutrition.
   - Resistance to institutional care (NRCs) in tribal communities.
3. Limited Capacity & Training of Field Workers
   - Lack of adequate NRCs & healthcare infrastructure in rural areas.
   - Strengthening of AWW Training needed for Accurate Growth Monitoring & Effective Use of Digital Tools
4. Gaps in Inter-Departmental Coordination
   - ICDS, Health, and WASH departments need better synchronization for holistic action.
   - Referral linkages to NRCs are slow, delaying treatment for SAM children.

Floor Discussion:

Following the presentation, participants' insights from the field were shared, highlighting the operational strengths, challenges, and transformative impact of the Poshan Abhiyaan. The key points are summarized below:

1. **Daily Monitoring and Data Management via Poshan Tracker**

   Daily data from Anganwadi Centres is captured and shared with District Programme Officers (DPOs) and Collectors, ensuring continuous monitoring. While data entry itself is consistent, the focus remains on improving data quality. The Poshan Tracker was highlighted as a transformative tool, enabling real-time monitoring and

immediate identification of issues like centre closures or worker vacancies. This is an improvement over the previous manual system, which caused delays of several months. There was a 99% measurement efficiency, attributable to frontline workers for this achievement. The data is reviewed at high-level forums like the Central Zonal Council meetings.

2. Differentiated Strategy for Aspirational Districts

A focused approach is employed in Aspirational Districts and Blocks, which receive higher priority. This includes:

- **Enhanced Monitoring:** Close oversight not only by the WCD department but also by NITI Aayog, which ranks performance based on specific indicators.
- **Special Programs:** Implementation of targeted missions like ' Lalima' in Bastar to combat anemia and the 'Saksham Anganwadi' program. Lalima (Project Name: "Lalima – Loha Le Anemia Se") was launched as a pilot project in May 2019 in specific blocks of the Kanker district (part of the North Bastar region) and aimed to combat anemia through awareness and medical intervention.

3. Impact and Benefits of Digital Transformation

The Poshan Abhiyaan's digital infrastructure has led to significant improvements:

- **Efficiency:** Officials can assess the status of any district or Anganwadi centre with a single click.
- **Problem Identification:** The system allows for quick tracing of issues, such as fluctuations in Take-Home Ration (THR) data or beneficiary numbers.
- **Administrative Planning:** It facilitates the creation of real-time lists of SAM/MAM children, aiding in strategic interventions and capacity building.

4. Community Mobilization and Convergence:

The Jan Andolan (People's Movement) component was appreciated for its role in community outreach through Poshan Thapa which is a Fortnightly community conversation and Poshan Maa programme which is a month-long intensive awareness and activity campaign. Effective convergence with other departments (Health, Education, Jal Shakti, Panchayati Raj) was identified as critical for success. Convergence committees at the state, district, and block levels facilitate this collaboration.

5. Programmatic Gaps and Challenges

The participants outlined several challenges:

- **Systemic Gaps:** The need to extend support to adolescent girls in non-aspirational districts and improve post-rehabilitation care for undernourished children to prevent relapse after they come from NRCs.
- **Infrastructure and Planning:** The location of Anganwadi Centres, often on land provided by Panchayats, can be inaccessible. Integrating centre planning into village infrastructure development is essential.
- **Workforce Challenges:** High workload, burnout among frontline workers, and a critical lack of structured training and capacity-building for Anganwadi Workers.
- **Digital Barriers:** Network connectivity issues and challenges with the mobile devices provided for the Poshan Tracker.
- **A Call for Integration:** A key recommendation was to integrate the Poshan Tracker with other systems (e.g., Health Department's HMIS) to reduce duplication and create a single data source.

6. Discussion on Technological Hardware for Frontline Workers

A key topic of deliberation was the technological hardware issued to frontline workers for data collection. Concerns were raised that the government-provided mobile devices are frequently prone to malfunction, leading many workers to rely on their personal phones for official duties. In response, it was suggested that feedback on device performance be thoroughly verified, as disparities have been observed even between districts using the same hardware models. To address these challenges, two primary solutions were proposed: upgrading the specifications of official handsets or providing tablets for improved usability, and alternatively, adopting a Direct Benefit Transfer (DBT) model that would offer a monetary allowance for workers to procure and maintain their own suitable devices.

Dr. Rama Narayanan acknowledged that similar hardware challenges are reported in other states. She requested that these proposals be thoroughly discussed in the subsequent group discussion to formulate a unified recommendation for the Government of India.

The session concluded with the moderator inviting the next presentation from the Public Health Engineering Department. Mr. Rajendra K Shukla, Executive Engineer of Jal Jeevan Mission delivered a comprehensive presentation on the role of Drinking water department in addressing undernutrition

Role of Drinking Water and Sanitation department in addressing child undernutrition

Presented by Mr. Rajendra K Shukla, Executive Engineer of Jal Jeevan Mission

Jal Jeevan Mission: Water Supply and Governance Framework

The Department of Drinking Water is committed to providing safe and adequate water supply to every household, school, Anganwadi Centre, hostel, Aashram, Panchayat Bhawan, and other public gathering spaces under the Jal Jeevan Mission (JJM). Each household is supplied with 45 litres per capita per day (LPCD) of potable-quality water, adhering to prescribed standards for turbidity, iron, fluoride, nitrates, and other components.

State-Level Coverage and Monitoring

According to data from the Women and Child Development (WCD) Department, 45,731 Anganwadi Centres are operational in the state, of which 41,666 centres currently receive piped tap water. This indicates 96–97% coverage, with running water available in all toilets. Regular monitoring ensures compliance with quality and infrastructure standards.

The state conducts periodic reviews to assess water quality and infrastructure functionality. Corrective measures are implemented in partnership with the Public Health Engineering (PHE) Department to sustain near-universal coverage, particularly in rural and remote blocks.

District-Level Governance and Convergence

At the district level, the District Water and Sanitation Mission (DWSM) play a pivotal role in planning, coordination, and decision-making. Chaired by the District Collector, it includes officials from departments such as Health, PHE, and WCD. The DWSM convenes monthly meetings—and more frequently during urgent situations to review data submitted by WCD and PHE departments, discuss field-level issues, and coordinate timely interventions.

These meetings address a range of operational challenges, including:

- Non-functional hand-pumps and frequent mechanical breakdowns
- Motor failures and water shortages, especially in tribal and hilly terrains
- Logistical bottlenecks in supply to remote Anganwadi Centres

Compared to the state, district-level convergence enables faster problem-solving through regular interaction and dynamic data exchange between departments.

Village-Level Implementation and Support Systems

Each Gram Panchayat, managing at least three villages, has established a Village Water and Sanitation Committee (VWSC). The committee is typically chaired by the Sarpanch or a designated local leader, with strong emphasis on women's participation, recognizing their crucial role in household water management and conservation.

At the grassroots level:

- Operational and financial support is drawn from both district-level budgets and PHE Department resources.
- A cluster-based model is operational wherein one mechanic is assigned to 8–10 villages for immediate maintenance and defect rectification.
- Mechanisms for reporting supply interruptions or contamination are streamlined through the village committees, strengthening accountability at the local level.

Innovative Water Quality Solutions

To mitigate water quality challenges—particularly high iron content in tribal regions like the Bastar belt, which often results in reddish-coloured water—a local innovation termed the "three-bucket system" has been introduced. This system, conceptualized under the supervision of the District Collector, involves a simple yet effective three-tier filtration process.

1. Water poured into the top bucket first passes through a layer of charcoal, followed by a layer of coarse sand in the second bucket.
2. This setup promotes oxidation and sedimentation: soluble ferrous iron converts to ferric iron, which precipitates.
3. Clean, filtered, and iron-free water collects in the bottom bucket, suitable for drinking.

This low-cost, easily maintained solution has been particularly successful in areas where conventional filtration plants are not viable due to terrain or financial constraints.

Infrastructure and Technological Transitions

There was an animated discussion over coverage. A review of infrastructure revealed inconsistencies between the reported 90% coverage and on-ground data. The use of lift-pumps had been discontinued across the state, and no new installations were being carried out. While several Anganwadis continue to use old technologies, a large-scale transition to single-phase 1 HP power pumps is ongoing as confirmed in districts such as Raipur, Dhamtari, Mahasamund, and Balod. Verification in remote districts like Sukma is still pending.

Earlier systems like the force-lift pumps (which used a dual arrangement to fill an overhead tank while enabling manual hand-pump extraction) have been phased out due to issues such as power interruptions and mechanical unreliability.

A major maintenance crisis was reported in Bijapur District, where out of 47 centres with JJM water supply, only 7 remain functional, and 40 were non-operational. The core issue lies in the absence of a clear maintenance protocol, with both the PHE Department and Panchayat authorities claiming it to be the other's responsibility. This jurisdictional ambiguity has resulted in prolonged delay in maintenance and unmanaged asset deterioration.

Financial Framework and Funding Mechanisms

Funding for water supply projects to Anganwadi and schools under JJM is drawn primarily from the 15th Finance Commission, separate from the departmental budget. The approval process for these projects follows a structured multilayer framework:

1. Clearance from the District Water and Sanitation Mission (DWSM)
2. Approval by the State Water and Sanitation Mission (SWSM)
3. Final sanction from the Government of India

At the district level, 3% of JJM funds are reserved for administrative support and can be utilized by the District Collector to strengthen implementing agencies such as PHE, Panchayats, or RES (Rural Engineering Services).

However, financial disbursement issues have emerged. In many locations, completed or ongoing works remain unpaid due to diversion or delay of 15th Finance Commission funds at the Panchayat level. Streamlining this funding mechanism and linking it directly to JJM's operational framework is recommended for Phase 2 planning.

Operation, Maintenance, and Sustainability Challenges

Once installed, all functional assets including hand-pumps, pipelines, overhead tanks, and power pumps are formally transferred to the Gram Panchayat, which then assumes responsibility for operation and maintenance (O&M). Funds for O&M are allocated separately within JJM budgets.

However, a significant challenge emerges in the post-installation maintenance phase. To illustrate, a village may receive a complete water supply system including pipelines, household connections for 400 homes, an overhead tank, pumps, and a power connection—leading to the issuance of a 'Har Ghar Jal' Certificate by the Gram Sabha. This certification is then reported

to the State government and, upon approval, recorded in the JJM's Integrated Management and Information System (IMIS) to reflect physical and financial progress.

Despite this formal closure, system failures often occur months later. Minor repairs, if delayed, lead to system "slip-back," where functional systems become non-functional over time. A typical example is a burned-out starter, a minor repair costing around ₹700 can escalate into a ₹10,000 major overhaul, covering pump extraction, repair, and reinstallation.

Villages with proactive leadership, where the Sarpanch ensures rapid repairs such as fixing pipeline leaks within 24 hours will successfully prevent such cost escalations.

This underscores that sustainability depends not only on infrastructure but also on timely management and strong local governance.

Inter-Departmental Coordination and Institutional Gaps

Inter-departmental coordination, particularly between PHE Departments and Panchayats, continues to pose operational challenges. In districts like Bijapur, centres that were once functional have fallen into disrepair due to unclear post-handover responsibilities. The absence of a unified maintenance protocol leads to overlapping accountability and unresolved service disruptions.

It is recommended that Phase 2 of JJM explicitly define maintenance ownership and response mechanisms, ensuring seamless coordination between implementing agencies, local bodies, and monitoring authorities.

The presentation concluded that the Jal Jeevan Mission has achieved remarkable progress in providing the infrastructure for safe drinking water supply to rural and institutional facilities across the state. However, for long-term sustainability, focus must shift towards timely maintenance and financial accountability; Clear maintenance protocols post-asset transfer; Enhanced coordination between PHE and Panchayats and capacity-building of local governance institutions

Through these measures, the mission can ensure that the vision of *"Har Ghar Jal"*—universal access to safe drinking water—remains sustainable and inclusive in practice.

Floor Discussion:

A central theme of the discussion was the critical link between the efficiency of Poshan Abhiyaan and the reliable provision of safe drinking water, a cornerstone for the health of women and children. The Jal Jeevan Mission (JJM) was highlighted as the key framework for ensuring water access, with a mandate to provide 45 LPCD of potable water through household tap connections to Anganwadis, schools, and other public institutions.

To operationalize this, a multi-level governance structure was described. The District Water and Sanitation Mission (DWSM), chaired by the Collector, facilitates monthly coordination and data sharing between departments like Public Health Engineering (PHE) and Women & Child Development (WCD). At the village level, Village Water and Sanitation Committees (VWSCs), often led by women, are tasked with local management and maintenance, supported by cluster-based mechanics and funds from the Panchayat.

While the state-level data presented indicated near-universal coverage of water connections to Anganwadi, three major challenges in implementation were raised which were

- Accountability Gaps: Persistent confusion between PHE and Panchayat departments regarding responsibility for repairs, leading to non-functional systems.
- Quality and Payment Issues: Instances of poor workmanship and delays in payment to contractors, even after work completion.
- Localized Quality Problems**:** Specific water quality issues, such as high iron content in tribal areas, though local, low-tech filtration solutions were shared as successful interventions.

The discussion concluded that the primary determinant of success is robust monitoring and timely maintenance. It was observed that in districts where the District Collector ensures strict quality control and active VWSCs, outcomes are significantly better. To address the identified gaps, a key recommendation emerged: formally integrating the specific needs of Anganwadi and schools into the planning and funding cycles of JJM's Phase 2 (extended to 2028), with a reinforced focus on clarifying accountability and strengthening local monitoring mechanisms to prevent systemic failures.

The moderator invited the next presenter, Dr. V.R. Bhagat, Deputy Director - Child Health from the department of Health and Family welfare to present the efforts of the department to improve the nutritional and health status of the population.

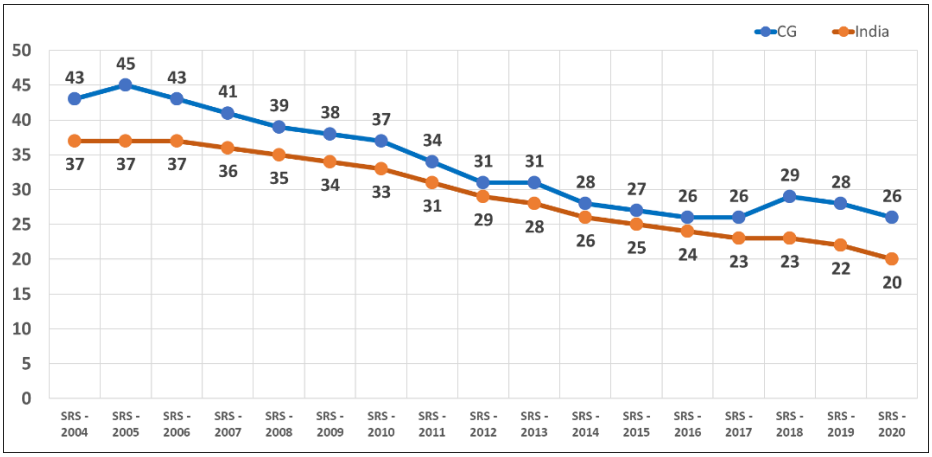
Role of Health and Family Welfare department in addressing child undernutrition

Presented by Dr. V.R. Bhagat, Deputy Director Child Health

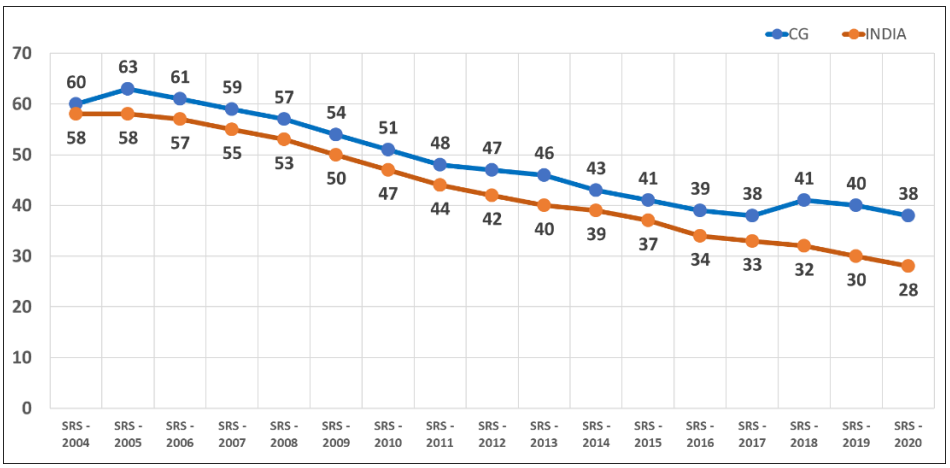
The data from the Sample Registration System (SRS) highlights a significant and sustained reduction in child mortality in Chhattisgarh between 2004 and 2020. The state has recorded a commendable decline, with the child mortality rate falling from 43 percent in 2004 to 26 percent in 2020.

This positive trend is further reflected in key health indicators. The Infant Mortality Rate (IMR) also saw a substantial decrease from 60 to 38 percent, mirroring the improving trend observed at the national level. Similarly, the Under-Five Mortality Rate (U5MR) was nearly halved, dropping from 71% in 2008 to 41% in 2020. However, despite this impressive progress, Chhattisgarh's U5MR remains higher than the national average, indicating a critical area for continued focus and intensified intervention.

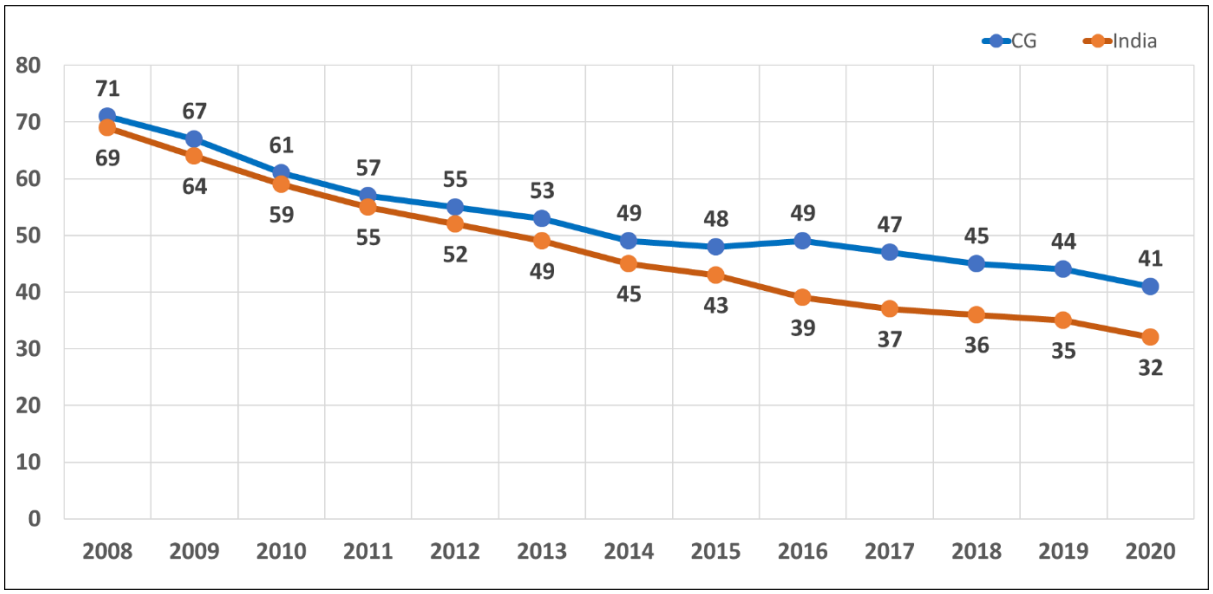
Status of Neonatal Mortality Rate (NMR) in Chhattisgarh (CG) & India



Status of Infant Mortality Rate (IMR) in CG & India



Status of Under 5 Mortality Rate (U5MR) in CG & India



According to NFHS-5, in Chhattisgarh, 79.7% of children aged 12–23 months were fully immunized (BCG, measles, and three doses each of polio and DPT). Among children aged 9–35 months, 84.5% had received a vitamin A dose during the six months preceding the survey.

The reported prevalence of diarrhoea within two weeks prior to the survey was 3.6%. Of those affected, 67.3% received oral rehydration salts (ORS), while 40% were treated with zinc supplements.

Only 32.2% of children under three years were breastfed within the first hour of birth. Exclusive breastfeeding among infants below six months 80.3%, and 41.3% of children aged 6–8 months were given solid or semi-solid food along with breast milk. However, just 9.7% of breastfed children aged 6–23 months received a diet considered nutritionally adequate.

Among children under five, 7.5% were severely wasted (low weight-for-height), and 67.2% of those aged 6–59 months were anaemic (haemoglobin below 11.0 g/dl).

Immunization and Health status of the children between 0-6 years from NFHS data

S. No.	Indicators	Chhattisgarh (NFHS)		
		2005-06	2015-16	2020-21
A	**Child Immunizations and Vitamin A Supplementation**			
01	Children age 12-23 months fully immunized (BCG, measles, and 3 doses each of polio and DPT) (%)	48.7	76.4	**79.7**
02	Children age 9-35 months who received a vitamin A dose in last 6 months (%)	NA	76.7	**84.5**
B	**Treatment of Childhood Diseases (children under age 5 years)**			
03	Prevalence of diarrhoea (reported) in the last 2 weeks preceding the survey (%)	5.2	9.1	**3.6**
04	Children with diarrhoea in the last 2 weeks who received oral rehydration salts (ORS) (%)	40	67.9	**67.3**
05	Children with diarrhoea in the last 2 weeks who received zinc (%)	NA	28.9	**40**
C	**Child Feeding Practices and Nutritional Status of Children**			
06	Children under age 3 years breastfed within one hour of birth (%)	24.6	47.1	**32.2**
07	Children under age 6 months exclusively breastfed (%)	82	77.2	**80.3**
08	Children age 6-8 months receiving solid or semi-solid food and breastmilk (%)	49	53.9	**41.3**
09	Breastfeeding children age 6-23 months receiving an adequate diet (%)	NA	11.1	**9.7**
10	Children under 5 years who are severely wasted (weight-for-height) (%)	5.6	8.4	**7.5**
D	**Anaemia among Children and Adults**			
11	Children age 6-59 months who are anaemic (<11.0 g/dl) (%)	71.2	41.6	**67.2**

Prevalence of low birth weight in Chhattisgarh

According to data from the Health Management and Information System (HMIS) for the period April 2024 to March 2025, 22% of new-borns in Raigarh weighed less than 2,500 grams, the highest proportion among non-aspirational districts. Among the aspirational districts, Bijapur reported the highest incidence of low birth weight at 27%. The proportion of children born weighing below 1,800 grams was 4.4% in Durg, the highest among non-aspirational districts, while Bijapur again recorded the highest rate among aspirational districts at 6.2%.

Rate of Low Birth Weight: Aspirational Vs Non-Aspirational Districts

S.No	District	Live Birth	Number of Newborns having weight less than 2500 gms	% of Newborns having weight less than 2500 gms	Out of the above, number of Newborns having weight less than 1800 gms	% of Newborns having weight less than 1800 gms
Non-Aspirational district- % of Low Birth Weight (As per HMIS April 24 - March 25)						
1	Balod	7620	1584	**21**	161	**2.1**
2	Balodabazar	17372	1737	**10**	116	**0.7**
3	Balrampur	16421	1218	**7**	100	**0.6**
4	Bemetara	10117	975	**10**	133	**1.3**
5	Bilaspur	31812	3988	**13**	885	**2.8**
6	Dhamtari	9946	1446	**15**	241	**2.4**
7	Durg	24225	4132	**17**	1078	**4.4**
8	Gariyaband	7287	981	**13**	102	**1.4**
9	Gaurela Pendra Marwahi	5056	741	**15**	123	**2.4**
10	Janjgir-Champa	15758	2638	**17**	370	**2.3**
11	Jashpur	12412	2179	**18**	204	**1.6**
12	Kabeerdham	15877	1993	**13**	227	**1.4**
13	Khairagarh Chhuikhadan	4125	410	**10**	34	**0.8**

14	Korea	4875	477	**10**	86	**1.8**
15	Manendragarh Chirmiri	4686	482	**10**	35	**0.7**
16	Mohla Manpur	3441	321	**9**	39	**1.1**
17	Mungeli	13594	1406	**10**	74	**0.5**
18	Raigarh	19914	4411	**22**	552	**2.8**
19	Raipur	45784	9140	**20**	1496	**3.3**
20	Sakti	4535	893	**20**	53	**1.2**
21	Sarangarh Bilaigarh	5209	909	**17**	39	**0.7**
22	Surajpur	14500	1671	**12**	210	**1.4**
23	Surguja	21621	3211	**15**	386	**1.8**
Non-Aspirational district		**316187**	**46943**	**15**	**6744**	**2.1**
Aspirational district- % of Low Birth Weight (As per HMIS April 24 - March 25)						
1	Bastar	19165	2338	**12**	648	**3.4**
2	Bijapur	6366	1714	**27**	397	**6.2**
3	Dantewada	5986	1377	**23**	125	**2.1**
4	Kondagaon	10872	2041	**19**	147	**1.4**
5	Korba	17936	1388	**8**	253	**1.4**
6	Mahasamund	15012	1726	**11**	173	**1.2**
7	Narayanpur	3632	692	**19**	93	**2.6**
8	Rajnandgaon	15016	3113	**21**	505	**3.4**
9	Sukma	5939	1526	**26**	176	**3.0**
10	Uttar Bastar Kanker	8988	1207	**13**	159	**1.8**
Aspirational district		**108912**	**17122**	**16**	**2676**	**2.5**

Source: HMIS – April 2024 to March 2025

Rate of Immunization:

The state has successfully immunized over 85% of its target population, demonstrating a robust public health delivery system. The HMIS data between April 2024 to March 2025 reveals strong and equitable immunization performance across Chhattisgarh. Notably, the Aspirational Districts collectively show a slightly higher Full Immunization Coverage (88%) compared to the Non-Aspirational Districts (86%). The maximum coverage was reported in Sukma (100%), Dhamtari (96%), and Mungeli (95%). The percentage of immunization coverage below the state average was reported in Sakti (74%) and Rajnandgaon (80%).

Immunization coverage: Aspirational Vs Non-Aspirational Districts

S.No	District	Target	Fully Immunized Children	Percentage (%)
Non-Aspirational district- % of Full Immunization Coverage				
1	Balod	13000	11056	**85**
2	Balodabazar	23502	20044	**85**
3	Balrampur	23274	21180	**91**
4	Bemetara	17000	15357	**90**
5	Bilaspur	54616	50760	**93**
6	Dhamtari	16362	15739	**96**
7	Durg	38999	33713	**86**
8	Gariyaband	13185	10973	**83**
9	Gaurela Pendra	10220	9089	**89**
10	Janjgir-Champa	26375	21383	**81**
11	Jashpur	19537	17010	**87**
12	Kabeerdham	21065	17871	**85**
13	Khairagarh	8162	6741	**83**
14	Korea	6587	6137	**93**
15	Manendragarh	8442	6740	**80**
16	Mohla Manpur	6380	5259	**82**
17	Mungeli	23736	22466	**95**
18	Raigarh	24291	21458	**88**

19	Raipur	61279	52140	**85**
20	Sakti	16990	12612	**74**
21	Sarangarh Bilaigarh	13362	10690	**80**
22	Surajpur	26060	20776	**80**
23	Surguja	27880	23115	**83**
Non-Aspirational district		**500304**	**432309**	**86**
Aspirational district- % of Full Immunization Coverage				
1	Bastar	21285	19513	**92**
2	Bijapur	7294	6694	**92**
3	Dantewada	8458	7096	**84**
4	Kondagaon	14222	13002	**91**
5	Korba	32768	29284	**89**
6	Mahasamund	22184	19042	**86**
7	Narayanpur	3390	3139	**93**
8	Rajnandgaon	19014	15181	**80**
9	Sukma	7183	7209	**100**
10	Kanker	14138	12224	**86**
Aspirational district		**149936**	**132384**	**88**

Source: HMIS – April 2024 to March 2025

Nutrition Rehabilitation Centre:

The figures on district-wise distribution of Nutritional Rehabilitation Centres (NRCs) reveals a statewide network of 96 centres across all 33 districts. This reflects a significant infrastructural commitment to combating severe acute malnutrition. The distribution is strategically varied, with a higher concentration in regions with a known high burden of malnutrition, such as Bastar (7 NRCs), Balrampur (6), and Kanker (6).

Additionally, State Centre of Excellence for Nutrition Interventions (SCoE4N) at AIIMS Raipur is a specialized unit within the Department of Paediatrics focused on managing and preventing malnutrition, particularly Severe Acute Malnutrition (SAM). The centre includes a Severe Acute Malnutrition Referral & Advance Treatment (SMART) unit for children with

SAM, and its work involves community-based programs, facility-based management, and promoting infant and young child feeding (IYCF) practices.

District wise number of NRC		
S.No	Districts	No. of NRC
1	Balod	2
2	Balodabazar	3
3	Balrampur	6
4	Bastar	7
5	Bemetara	1
6	Bijapur	4
7	Bilaspur	1
8	Dantewada	4
9	Dhamtari	4
10	Durg	2
11	Gariyaband	1
12	GPM	1
13	Janjgir-Champa	1
14	Jashpur	3
15	Kanker	6
16	Kawardha	4
17	Khairgarh-Chhuikhadan	2

District wise number of NRC		
S.No	Districts	No. of NRC
18	Kondagaon	5
19	Korba	5
20	Koriya	1
21	Mahasamund	2
22	Manendragarh	3
23	Mohla-Manpur	2
24	Mungeli	2
25	Narayanpur	5
26	Raigarh	4
27	Raipur	2
28	Rajnandgaon	2
29	Sakti	2
30	Sarangarh-Bilaigarh	1
31	Sukma	3
32	Surajpur	3
33	Surguja	2
Total		96

Bed Occupancy and Cure Rate:

The data on bed occupancy and cure rate across Chhattisgarh districts reveals clear differences between aspirational and non-aspirational areas. Overall, the 23 non-aspirational districts recorded a total of 10,783 admissions with an average bed occupancy rate of 71% and a cure rate of 71%. In contrast, the 10 aspirational districts reported slightly fewer total admissions (9,072) but showed much stronger performance, with an average bed occupancy rate of 87% and a cure rate of 84%. This indicates that aspirational districts are utilizing their health facilities more efficiently and achieving better treatment outcomes.

Within the non-aspirational group, there is considerable variation across districts. Manendragarh (122%) and Gariyaband (115%) reported remarkably high bed occupancy, suggesting overutilization or shortage of beds, while Sakti (42%) and Mohla-Manpur (49%) showed underutilization. Cure rates also varied widely—from high recovery in Balodabazar

(92%) and Sarangarh (91%) to extremely low rates in Mohla-Manpur (22%) and Bilaspur (36%), indicating issues with service quality or case complexity.

In the aspirational districts, performance was more consistent. Most districts-maintained bed occupancy between 80–100% and cure rates between 80–90%. Kondagaon, Korba, and Sukma performed exceptionally well with cure rates above 90%, while Bijapur (73%) and Kanker (75%) lagged slightly behind. While the Aspirational districts program shows remarkable success, the data reveals specific district-level crises that require targeted, urgent intervention to prevent them from becoming major failures.

Rate of Bed occupancy and Cure percentage – Aspirational vs non-aspirational

S.No	Districts	Total Admission	Bed Occupancy Rate (%)	Cure Rate (%)
Non-Aspirational Districts- Bed Occupancy & Cure Rate				
1	Balod	370	74	74
2	Balodabazar	514	81	92
3	Balrampur	1284	85	81
4	Bemetara	224	93	77
5	Bilaspur	695	39	36
6	Dhamtari	715	79	67
7	Durg	276	59	88
8	Gariyaband	287	115	68
9	Gorella Pendra	183	71	78
10	Janjgir-Champa	226	85	81
11	Jashpur	501	82	81
12	Kabeerdham	391	82	80
13	Khairagarh	0	0	0
14	Koriya	207	79	73
15	Manendragarh	626	122	87
16	Mohla-Manpur	258	49	22
17	Mungeli	425	68	85

18	Raigarh	1130	76	78
19	Raipur	497	63	52
20	Sakti	217	42	83
21	Sarangarh	282	56	91
22	Surajpur	1025	75	88
23	Surguja	450	59	84
Non-Aspirational Districts		10783	71	71
Aspirational Districts- Bed Occupancy & Cure Rate				
S.No	**Districts**	**Total Admission**	**Bed Occupancy Rate (%)**	**Cure Rate (%)**
1	Bastar	1644	80	83
2	Bijapur	914	106	73
3	Dantewada	827	84	80
4	Kanker	927	65	75
5	Kondagaon	1098	98	93
6	Korba	1199	96	91
7	Mahasamund	432	86	83
8	Narayanpur	1075	85	90
9	Rajnandgaon	375	85	82
10	Sukma	581	80	91
Aspirational district		**9072**	**87**	**84**

Source: As per NRC MIS Portal April 2024-March 2025

Percentage of Newborns breast fed within 1 hour of birth in non-aspirational district:

The data indicates strong performance in early initiation of breastfeeding across non-aspirational districts, with an aggregate rate of **91.5%** of new-borns being breastfed within the first hour of birth. Top-performing districts like **Sakti (99.3%)** and **Mohla Manpur (98.4%)** demonstrate near-universal adoption of this critical practice. However, the notably lower rates in districts such as **Dhamtari (71.5%)** and **Surguja (80.4%)** highlight specific geographical pockets that require targeted interventions and support to improve this key maternal and child health indicator.

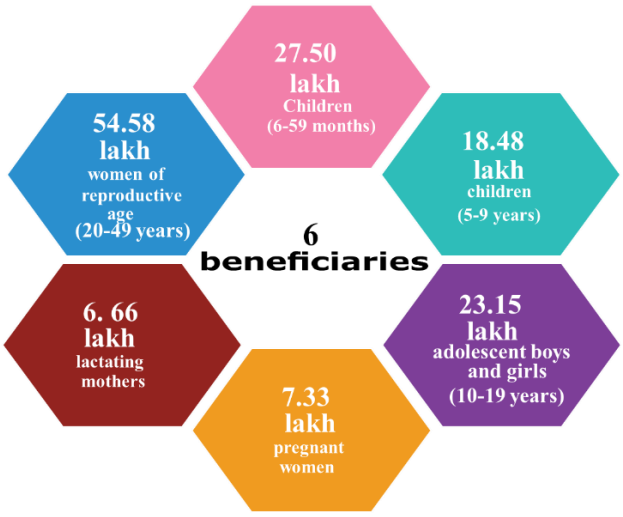
S.No	Districts	Live Birth	Number of Newborns breast fed within 1 hour of birth	% of Newborns breast fed within 1 hour of birth
1	Balod	8034	7498	93.3
2	Balodabazar	17519	17000	97.0
3	Balrampur	16539	16129	97.5
4	Bemetara	10240	10015	97.8
5	Bilaspur	35219	30013	85.2
6	Dhamtari	12095	8653	71.5
7	Durg	24451	23942	97.9
8	Gariyaband	7323	7118	97.2
9	Gaurela Pendra	5110	4834	94.6
10	Janjgir-Champa	15928	13612	85.5
11	Jashpur	12462	12155	97.5
12	Kabeerdham	15956	15641	98.0
13	Khairagarh	4133	4010	97.0
14	Korea	5052	4537	89.8
15	Manendragarh	4704	4618	98.2
16	Mohla Manpur	3459	3403	98.4
17	Mungeli	13842	11836	85.5
18	Raigarh	19914	17020	85.5
19	Raipur	46436	43993	94.7
20	Sakti	4557	4525	99.3
21	Sarangarh Bilaigarh	5210	5073	97.4
22	Surajpur	14520	13870	95.5
23	Surguja	22085	17765	80.4
Non-Aspirational district		**324788**	**297260**	**91.5**

Source: ***As per HMIS April 24 - March 25***

Convergence for addressing anaemia:

In a concerted effort to address the critical issue of anaemia, the Department of Health has strategically converged with the Department of Women and Child Development to implement the Anaemia Mukt Bharat (AMB) initiative. This comprehensive program is structured around a multi-pronged **6x6x6 strategy**. i.e., 6 beneficiaries, 6 interventions and 6 institutional mechanisms.

Six Beneficiaries: the initiative has reached an estimated 137.7 lakh beneficiaries, reaching nearly one-third of the Chhattisgarh population. This includes children (6-59 months and 5-9 years), adolescents (10-19 years), pregnant and lactating women, and women of reproductive age (20-49 years).



Figures on beneficiaries reached through AMB

Six Interventions: 1. Prophylactic iron folic acid supplementation, 2. Periodic deworming of children, adolescents, pregnant women, 3. Intensified year round behaviour change communication campaign (solid body smart mind, delayed cord clamping) 4. Testing of anaemia using digital methods and point of care treatment, 5. Mandatory provision of iron and folic acid fortified foods in public health programmes, 6. Addressing non-nutritional causes of anaemia in endemic pockets with special focus on malaria, hemoglobinopathies and fluorosis.
Six Institutional mechanisms: 1. Intra-Departmental coordination between the divisions of Medicine & Health, Child Health, Adolescent Health, and other relevant units, 2. National Anaemia Mukth Bharat Unit, 3. National centre of Excellence and Advanced research on Anaemia Control, 4. Convergence with other departments (Education, WCD, Drinking Water and Sanitation, Panchayati Raj Institution etc.), 5. Strengthening Supply Chain and Logistics and 6. Anaemia Mukth Bharat Dashboard and digital portal: a one-stop shop for anaemia

Convergence for National Deworming Day:

The National Deworming Day initiative exemplifies a coordinated, multi-departmental effort to administer deworming medication to all children and adolescents aged 1-19 years. The intervention is delivered through a dual-channel approach utilizing the extensive networks of both schools and Anganwadi Centres. This strategy directly targets key determinants of child development, aiming to enhance nutritional status, reduce disease burden, improve school attendance and cognition, and elevate the overall quality of life.

Key Stakeholders & Implementation:

- Lead: Department of Health and Family Welfare (providing technical guidance, supply chain, and drugs).
- Implementation Partners: Department of Education and Department of Women and Child Development (ICDS), whose frontline workers such as teachers and Anganwadi Workers/*Mitanin* directly administer the medication.
- Supporting Departments: Departments of Tribal Development, Panchayati Raj, and Urban & Rural Development, along with the Swachh Bharat Mission, ensure wide reach, community mobilization, and reinforce the link between deworming and improved sanitation.

Convergence for Shishu Sanrakshan Maah (SSM):

The Shishu Sanrakshan Maah (SSM), or Child Protection Month, is a biannual, month-long campaign implemented statewide to consolidate and deliver a package of essential nutrition and health services. The initiative employs a convergent service delivery model to address key determinants of child and maternal well-being.

Scope of Services & Beneficiaries:

The campaign provides a comprehensive suite of interventions, including:

- Vitamin A Supplementation for children aged 9-59 months to prevent deficiency.
- Iron and Folic Acid (IFA) Supplementation for children (6-59 months) and for Pregnant & Lactating Women (PW & LW).
- Systematic Screening for Severe Acute Malnutrition (SAM) in all under-five children, with subsequent referral to Nutritional Rehabilitation Centers (NRCs).
- Integrated Health Services including immunization, antenatal care (ANC) for pregnant women, hemoglobin testing, and age-appropriate nutrition counselling.

Services are delivered with specific protocols: a 1ml dose of Vitamin A for children aged 9-12 months and a 2ml dose for those 1-5 years old, alongside bi-weekly administration of IFA syrup. For the current round, the campaign has ambitious targets, aiming to reach approximately 25.9 lakh children with Vitamin A and 27.5 lakh children with IFA syrup, demonstrating the significant scale and reach of this convergent effort.

Convergence for Mother's Absolute Affection (MAA):

MAA is a nationwide programme of the Ministry of Health and Family Welfare to bring undiluted focus on promotion of breastfeeding and provision of counselling services for supporting breastfeeding through health systems. The programme has been named 'MAA' to signify the support a lactating mother requires from family members and at health facilities to breastfeed successfully.

Goal and objectives of Program: -

- Building an enabling environment & demand generation through Mass media
- Reinforce lactation support service through building capacity of functionaries
- To incentivize & recognize health facilities that show high rate of BF along with process for lactation management

The goal of the 'MAA' Programme is to revitalize efforts towards promotion, protection, and support of breastfeeding practices through health systems to achieve higher breastfeeding rates

CHIRAYU- RBSK

CHIRAYU-RBSK is a National Child Health Program in the state of Chhattisgarh, which implements the Rashtriya Bal Swasthya Karyakram (RBSK), or National Child Health Programme. This government initiative was launched on 15th August 2014 to provide comprehensive child healthcare through screening children from birth to 18 years for early detection and management of 4Ds: Defects at birth, Diseases, Deficiencies, and Developmental delays including disabilities.

The program is funded by the National Health Mission, Government of India, and is executed through a robust network of 342 sanctioned Mobile Health Teams deployed across all 33 districts. These teams conduct systematic screenings for 44 specified health conditions in Government & Government aided Schools once in a year and in AWCs twice in a year by RBSK Mobile Health Teams.

The program has demonstrated extensive reach, covering 41,254 schools (83% of the target) and 49,505 Anganwadi Centres (95% of the target) during the reported period. On an

average, each mobile team conducts approximately 120 outpatient consultations per day, underscoring the program's significant volume of service delivery.

Convergence for National Nutrition Initiatives:

As part of the national POSHAN Abhiyaan, two key annual events are observed to intensify efforts against malnutrition: Poshan Maah (National Nutrition Month) in September and the Poshan Pakhwada (Nutrition Fortnight). These campaigns are dedicated to large-scale awareness generation and service delivery, with a targeted focus on children, pregnant women, and adolescent girls.

Poshan Maah is a month-long observance focused on community mobilization and raising public awareness about critical nutrition issues.

Poshan Pakhwada is an intensive, fortnight-long drive that involves concentrated activities such as health camps, community rallies, and educational workshops to promote essential practices related to nutrition, hygiene, and health.

Objectives:
The collective goal of these initiatives is to drive measurable progress on key national nutrition indicators, specifically to:

1. Prevent and reduce stunting in children (0-6 years).
2. Prevent and reduce underweight prevalence in children (0-6 years).
3. Reduce the prevalence of anaemia among young children (6-59 months).
4. Reduce the prevalence of anaemia among Women and Adolescent Girls (15-49 years).
5. Reduce the incidence of Low Birth Weight (LBW).

Floor Discussion:

The discussion underscored the critical need for inter-departmental convergence, particularly between the Health and Women & Child Development (WCD) departments, to effectively address child malnutrition and anemia. A primary point of contention identified was the operational responsibility for Nutritional Rehabilitation Centres (NRCs). It was clarified that NRCs serve a curative and life-saving function for severely malnourished children, while the WCD department's role is crucial in the community-based screening and referral of these children from Anganwadis. A significant operational hurdle highlighted is the lack of

incentives and support, such as transportation, for Anganwadi workers to facilitate these referrals, unlike the incentives provided to ASHAs.

Regarding anemia control, the challenge of low compliance with iron syrup supplementation—cited as low as 26%—was identified as a major bottleneck. While testing is important, logistical and budgetary constraints make frequent haemoglobin checks for all children under five unfeasible. Instead, the focus has shifted towards strengthening annual health camps, in convergence with the health department, as a more practical model for mass screening and follow-up, with a special emphasis on adolescents and children under five.

On dietary solutions, the use of iron cookware was noted to have limited and conditional efficacy, as iron leaching occurs primarily with acidic foods and its bioavailability is uncertain. The conversation strongly emphasized that promoting dietary diversity and the consumption of iron-rich foods, like green leafy vegetables, as a more sustainable strategy. However, this is challenged by the declining consumption of traditional, nutritious foods and the increasing preference for cheap, ultra-processed snacks among low-income families, even at the Anganwadi level. Practical techniques to enhance iron absorption, such as adding acidic ingredients like lime to meals, and addressing inhibitors like tannins in tea/coffee, were also discussed. The importance of hygiene and deworming as factors influencing anemia outcomes was also acknowledged.

The session concluded with a directive for the WCD, Health, and Public Health Engineering (PHED) departments to collaborate post-lunch on drafting concrete recommendations for the Ministry, with a central focus on creating an actionable framework for convergence.

The three broad themes identified for the group discussion were; Convergence between various line departments; Improving poshan tracker data quality & management; and Infrastructure & capacity building of Anganwadi worker. The outcomes of the discussion were presented by a representative member from each of the three groups.

Group 1 – Convergence between various line departments

Dr. V.R. Bhagat, Deputy Director Child Health from the Department of Health, and Family Welfare and Ms. Shruti Nerkar, Deputy Director – Poshan Abhiyaan, from the Department of Women and Child Development jointly developed action points for interdepartmental convergence at all the three administrative levels.

Key convergence points at State Level

- Jointly quarterly meeting with all line departments under the Chairmanship of Secretary WCD for monitoring of programmes like Saksham Anganwadi & Poshan 2.0, Anaemia Mukt Bharat, Nutrition Rehabilitation Centre, Sampoorna Swasthya Mahila (Comprehensive Health for Women), National Deworming Day (NDD), Stop Diarrhea Campaign, Jal Jeevan Mission, Swachh Bharat Mission, Rashtriya Kishor Swasthya Karyakram (National Adolescent Health Programme), Rashtriya Bal Swasthya Karyakram (National Child Health Programme) etc.
- Programme directive should be issued jointly by the heads of departments
- IEC material should be prepared jointly & interdepartmental sharing of IEC material to be facilitated
- Common BCC strategy should be undertaken
- Joint annual action plan should be prepared to achieve the target/goal of Malnutrition & Anemia free state
- Integration of Poshan Tracker, HMIS, RCH portal & other relevant portal for effective monitoring

Key convergence points at District Level/Block Level

- Joint meetings with line departments under the chairmanship of collector/SDM for reduction of malnutrition & anemia, DWSM
- Joint training with line departments especially with WCD, Health & Education departments
- Joint Campaigns should be organized like Poshan Maah, Poshan Pakhwada, Stop Diarrhea Campaign, NDD, SSM, etc.
- To ensure participation of local body committees for awareness generation campaigns mentioned above

Key convergence Grass Root Level

- Joint training of Anganwadi worker, ANM & ASHA (Mitanin)
- Annual head count survey of beneficiaries
- Common registration system for common beneficiaries
- Sharing of due list for home visit/Immunization/ANC check up
- Joint effort should be taken for Community mobilization & sensitization of local leaders

Discussion on the theme by the participants of Group 1

Group 2 – Improving Poshan Tracker - Data Quality and Management

District Women and Child Development Officers of Mohala, Korba, Bastar and Kondagaon districts worked together and arrived at the following recommendations for improving data quality and management of the Poshan tracker.

Recommendations to Strengthen Technology and Data Systems for Frontline Workers

1. **Provision of Hardware:** Supply new mobile devices or tablets with high-processing capability and ample storage to efficiently run all necessary applications.
2. **Financial Support for Maintenance:** Ensure a dedicated financial provision for the ongoing maintenance, repair, and mobile data recharges for these devices.
3. **Stable Application Environment:** Limit the frequent introduction of new applications to a maximum of one new app per year to ensure stability and user proficiency.
4. **Structured Training and Roll-out:** Conduct standardized Poshan Tracker training for both supervisors and Anganwadi workers every quarter. Mandate comprehensive training and a trial period for any new application before its final implementation.
5. **Dedicated IT Support:** Establish dedicated IT support cells at the Block and District levels to provide immediate technical assistance and manage Poshan Tracker data.
6. **Staffing and Capacity Building:** Fill all vacant supervisory and clerical positions and ensure that these staff members receive essential computer literacy training.
7. **System Performance Optimization:** Improve the backend system of the Poshan Tracker to reduce data synchronization time, aiming for a delay of no more than two hours.
8. **Infrastructure Enhancement:** Improve internet network connectivity, particularly in remote and rural areas, to ensure reliable data entry and submission.
9. **Data Utilization and Analysis:** Establish a research and analysis cell at the district level, staffed with nutritionists, to interpret anthropometric and nutrition data for actionable insights.
10. **Adequate Equipment at Centers:** Provide at least two electronic weighing scales at every Anganwadi centre to ensure accuracy and efficiency during growth monitoring sessions.

Discussion on the theme by the participants of Group 2

Group 3 – Infrastructure and Capacity building of AWW

The District programme officer (DPO) of Sukma & Narayanpur along with Child Development Project Officers (CDPO) of Kanker, Kutru and Mahasamund jointly provided suggestions for improving infrastructure facility and capacity building of the Anganwadi worker.

1.INFRASTRUCTURE:

A) WCD should have authority and oversee Anganwadi building construction. Hence the department should be authorized to recruit one person with an engineering background for construction-related convergence in districts.

B) Construction should be time bound without any compromise in layout.

C) Provision of budgetary allocation for repair of AWCs like electrical, sanitation, and drinking water.

D) The kitchen sheds should be constructed separately.

E) After completion of a building, a third-party evaluation should be done by a district level committee.

F) In case of poor-quality buildings, construction penalties and punishment should be imposed.

G) Modern and Proper tools for measurement of weight and height should be provided to AWWs like electronic salter scale.

2. CAPACITY BUILDING OF AWW:

A) Recruitment of AWW should be made with no compromise on eligibility

B) The scope of the search for AWW, should be widened (ie) applications from GRAM (village) should be broadened to GRAM PANCHAYAT.

C) For the post of AWW computer knowledge should be made compulsory.

D) Effective training and proper budget allocation should be made.

E) Training should be hand-held and in real-time.

F) Refresher training should be done regularly.

G) For tribal belts, AWWs familiar with the local dialect should be preferred.

H) Master trainers should be selected from AWWs group only.

I) Engagement of AWWs in different departments should be limited.

J) Best performing AWWs should be rewarded for better motivation.

Discussion on the theme by the participants of Group 3

List of participants in the consultation

- Dr. V.R. Bhagat, Deputy Director, Child Health, Department of Health and Family Welfare
- Ms. Shruti Nerkar, Deputy Director – Poshan Abhiyaan, Department of WCD
- Mr. Mumtaz Ansari- State Consultant- UNICEF- Health Department
- Mr. Rajendra K Shukla, Executive Engineer of Jal Jeevan Mission
- Mr. Bhanupratap Sahu (CDPO - Kanker), Department of WCD
- Mr. Kanta Meshram (CDPO - Kutru), Department of WCD
- Mr. Lupendra Mahilang (DPO - Narayanpur), Department of WCD
- Mr. A K Biswal, DPO, Kondagon, Department of WCD
- Mr. C S Mishra, DPO, Mohala, Department of WCD
- Mr. Gajendra Dev Singh, DWCDO, Korba, Department of WCD
- Mr. Hemant Sahu, DPO, Bastar, Department of WCD
- Mrs. Manisha Sahu (CDPO - Mahasamund), Department of WCD
- Ms. Bismita Patle (DPO - Sukma), Department of WCD
- Shri R. K Shukla- Executive Engineer- PHE Department
- Shri S. K Soni- Assistant Director- WCD Department
- Dr. DJ Nithya, Scientist, M S Swaminathan Research Foundation
- Dr. Rama Narayanan, Senior Fellow, M S Swaminathan Research Foundation
- Ms. Jeya Rani A, Senior Research Associate, M S Swaminathan Research Foundation