

*Review Article***POSHAN Abhiyaan: Making Nutrition a Jan Andolan**

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The launch of *POSHAN Abhiyaan* has successfully brought back the focus on one of the biggest challenges India currently faces - the burden of malnutrition. The impact of malnutrition on health, well-being, productivity and longevity is well-known. It is estimated that for every \$1 spent on health and nutrition, the returns are as much as \$16.

Despite several programmes targeted towards improving the health and nutrition of women and children, we have not been able to solve this persistent problem. The ICDS programme is our primary intervention in this area. However, despite being implemented for decades now, the results of the programme are sub-optimal at best. One out of every third child under 5 years of age continues to be under-nourished, whereas one in every two women is affected by anaemia. In order to secure the well-being of our children, and to fully realize our growth potential and capitalize on the demographic dividend; we need drastic reductions in the prevalence of malnutrition.

This paper analyses the reasons due to which under-nutrition continues to remain a threat and presents the current strategy of the government to curb it. It argues that without channelizing cross-sectoral interventions towards the first 1000 days, achieving geographic and programmatic convergence and creating a *janandolan*, success in this area is highly unlikely.

**Keywords:** Stunting; Wasting; Under-Weight; Anaemia; POSHAN Abhiyaan

**Introduction**

The sluggish pace of malnutrition reduction despite promising economic growth continues to baffle policy-makers and researchers all across India. The consequences of early stunting and its irreversible impact on longevity, susceptibility to diseases including non-communicable diseases, physical and cognitive growth, performance in school and adult productivity has been extensively documented (Bhutta, 2013; Smith & Haddad, 2015). It is estimated that two-third of the world's stunted children live in ten countries of the world, of which India tops the list with about 48.2 million stunted children (Save the Children, 2017). As we eagerly wait to reap the benefits of India's demographic dividend, the urgency to address malnutrition has never been more potent. It is estimated that about two-third of India's present workforce was stunted in their childhood (Galasso & Wagstaff, 2015). In addition to the loss of human potential, the economic costs of this is unimaginable,

something we can neither repeat nor afford.

The Indian policy landscape is packed with interventions targeted to improve the health and nutrition status of women and children. Unfortunately, their impact can be stated as sub-optimal at best, primarily due to governance and implementation issues. The *POSHAN Abhiyaan* presents a unique opportunity to make a dent in this area. A new strategy, presented here, has been carved out to eradicate under-nutrition from its roots. As it transforms into a *janandolan*, it is essential that the *Abhiyaan* is co-owned by all stakeholders in order to amplify its efforts to reach its final objective of a drastic reduction in under-nutrition levels in India.

**Malnutrition in India: Current Status**

India offers an interesting case in point, where in spite of an impressive economic growth record and innumerable interventions directed to improve maternal and child health and nutrition status, we have

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not been able to make any significant gains. There has been some reduction in the prevalence of stunting and underweight rates for children under 5 years; but the rate of reduction - about 1 percentage point per year for stunting and 0.8 percentage point per year for underweight prevalence- is too slow (NFHS, 2017). Figure 1 shows the status of key child nutrition indicators. It is a matter of concern that ‘wasting’ (low weight-for-height) considered being a chronic form of malnutrition has actually increased over the last decade. Overall, a reduction of 1% is considerably less, especially when compared to countries such as China, Brazil and Peru (Keefe, 2016; Marini and Rokx, 2017; Report on China’s Implementation of MDGs, 2015).

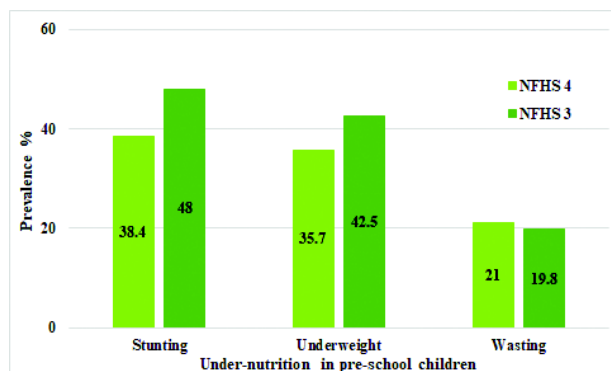


Fig. 1: Key child nutrition indicators

Latin American countries have recorded a rapid decline in stunting rates by simply addressing the underlying causes of malnutrition. Closer home, the case study of Bangladesh which recorded a 1.1 and 1.3 percentage points per annum decline in underweight prevalence and stunting respectively is noteworthy (Headey *et al.*, 2015). Bangladesh has successfully reduced malnutrition and sustained the results without any large-scale nutrition programme, purely on the basis of broad-based economic and social development. Enhanced levels of household wealth and gains in education (especially for girls through secondary school stipends) have been identified as key drivers, complemented with government investments in ensuring availability of health services (which witnessed an enhanced demand) and sanitation facilities.

In the Indian context, there are large inter-state differences in performance. Arunachal Pradesh,

Tripura, Himachal Pradesh, Punjab and Mizoram are the top five States with respect to stunting reduction levels. More than 25% decline has also been witnessed in Chhattisgarh, West Bengal, Nagaland, Maharashtra and Haryana (NFHS, 2017). In fact, the efforts made in States such as Chhattisgarh and Odisha especially stand out. Various community as well as state-led models have emerged out of Chhattisgarh such as the *Fulwaris*, *Vazan Tyohars*, *Annaprasan* and *God Bharai* Celebrations, *Bal Sandarbh Yojana* and *Nava Jatan* Programme- many of which have the potential to be scaled up nationally and replicated across States. Similarly, Odisha stands out in its improvement on the coverage of a range of essential services for health and nutrition. However, on the other end of the spectrum, Jharkhand, Bihar and Uttar Pradesh have made little progress over the decade and currently have more than 45% stunted children.

In women, anaemia and low BMI remains a challenge. Over the decade, the numbers of overweight or obese women have also shot up, for both rural (15%) as well as urban (31.3%) India (NFHS, 2017). Figure 2 presents the nutritional status of women. Anaemia remains the biggest threat towards securing the well-being of women with severe repercussions, not only on the health of women but on the health of her child as well. As evident, little progress has been made in this area.

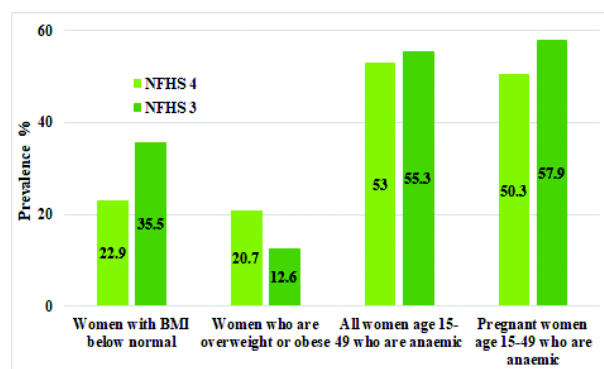


Fig. 2: Key nutrition indicators: women

### Identifying the Challenges

India has a gamut of programmes and schemes targeting maternal and child health and nutrition. Despite that, we have been largely unsuccessful in our efforts to fully eliminate malnutrition. Here, we present the key challenges, clubbing them into three

broad levels- societal, policy and lastly, implementation.

### ***Societal Level***

Babies born to under-nourished mothers face a high risk of restricted foetal growth and death. Those who survive are likely to be stunted with a high probability of transmitting their poor nutrition status to their next generation (Black *et al.*, 2013). The status of girls/women within the household, their agency and decision-making abilities especially with respect to their reproductive rights are important factors which merit a closer look. Despite the Prohibition of Child Marriage Act, 2006 which pegs the legal age of marriage at eighteen for girls, 30% Indian girls are married before the age of 18 years and 8% are already pregnant by the time they are 15-19 years (Census, 2011; NFHS, 2017). Facing intra-household deprivations due to their sex and abject poverty, these young girls often forego necessary nutrition, care and rest during their pregnancy period, delivering low birth weight babies. For these babies, the cycle of malnutrition has already begun.

### ***Policy Level***

While food is an essential component, food-based solutions are not sufficient by themselves. Children may receive a diet which is both adequate in quantity (calories) and quality (nutrients). However, if they are already weakened by ill-health and disease, they will be unable to absorb sufficient nutrients from their food (Nisbett *et al.*, 2014). Unfortunately, our single-handed approach towards addressing under-nutrition has been through food provision. Second, there is enough scientific evidence indicating the importance of the first 1000 days (roughly translating to about 2 years) of a child's life. It is estimated that about 80% of the brain development takes place during this time. However, children start coming to the ICDS centres (our primary intervention in this area) after they are 3 years old. By then, precious time is lost and it is already too late. In fact, there is barely any contact between the child and the system (barring routine immunization by the ANM and visits by the ASHA worker in case the child is visibly sick) till the child attains 3 years of age.

### ***Implementation Level***

Considering the multi-dimensional nature of

malnutrition, convergence is the key. However, an analysis of the three biggest programmes in this area- ICDS, ISSNIP and NHM showed that there were only 39 common high-burden districts among them (NITI Aayog, 2017). The number is likely to be less if we consider the Swatchh Bharat Mission (SBM). Such lack of geographic convergence results in substantial loss of resources as well as sub-optimal results. Convergence and coordination among the frontline workers, especially those delivering health and nutrition services is the key. This, in turn, needs to be supported and supervised by a strong monitoring mechanism. Presently, the monitoring mechanism under the ICDS is particularly weak and often, the scheme is marred by allegations of pilferage, corruption and questionable food quality. Lastly, the capacities of frontline worker to deliver on the field needs to be enhanced. While all the programmes have in-built components of SBCC, counselling and health and nutrition related education, these are generally neglected and receive less priority, mainly due to their intangible nature and limited capacity to deliver them by the workers.

### **Bringing Nutrition Centre-stage**

#### ***Recent Initiatives of the Government***

In September, 2017 a National Nutrition Strategy 'Nourishing India' was released by NITI Aayog. The Strategy presented an in-depth analysis of the 4<sup>th</sup> Round of NFHS and identified the bottlenecks which were hampering the effective delivery of our health and nutrition programmes. It was followed by a series of measures undertaken at the highest levels to set things right. The cost norms under the Supplementary Nutrition Programme (SNP) of the ICDS programme was revised and pegged to inflation rates with an additional allocation of Rs 12,000 crore over the next three years (PIB, 2017). The Pradhan Mantri Matru Vandana Yojana (PMMVY) was launched. It provides cash benefits contingent upon the fulfilment of prefixed conditions (related to increasing health seeking behaviours and inducing behavioural changes) to pregnant women and lactating mothers. Rotavirus and Pneumococcal vaccinations, proved to be successful in reducing stunting, were introduced. And finally, the *POSHAN Abhiyaan* was launched with set targets and financial commitments of roughly Rs 9000 crore for a 3 year period (PIB, 2018).

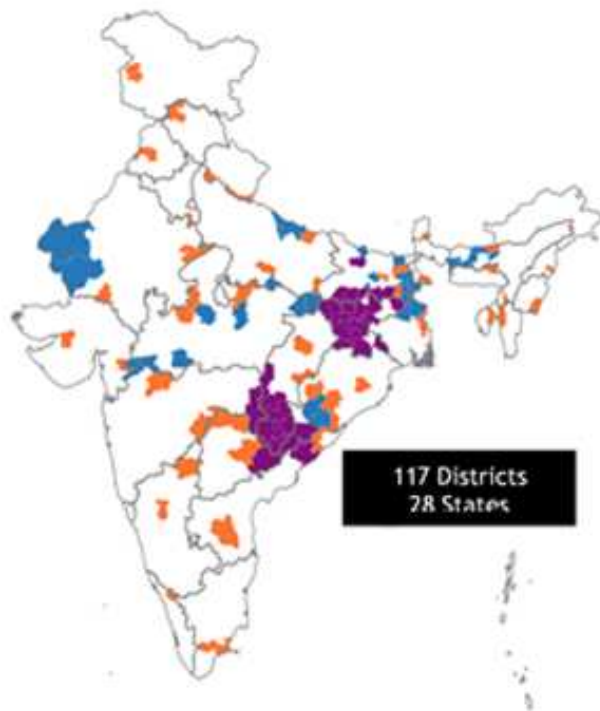


Fig. 3: Aspirational districts of India

### ***Transforming India's Aspirational Districts***

Social indicators, especially those related to health, nutrition and education, feature prominently in the Aspirational District Programme launched in the 117 most challenging districts of the country. The programme is founded upon the principles of convergence, collaboration and competition; and identifies a set of predefined cross-sectoral indicators-improvements over which are to be tracked, measured and verified by 3<sup>rd</sup> party surveys. The underlying principle behind the programme is that transformation of these 117 districts will make significant dents on the overall Human Development Index levels of the country. Health, nutrition and education indicators have been given an overall weightage of about 60% within the programme (NITI Aayog, 2018).

### **The Building Blocks of POSHAN Abhiyaan**

India has both nutrition-specific, as well as nutrition-sensitive interventions, considered to be essential to resolve nutrition related issues (Lancet, 2013). The launch of *POSHAN Abhiyaan* by the Prime Minister is symbolic, reflecting commitments and prioritisation given at the highest levels in eliminating malnutrition from the country. The *Abhiyaan* has been designed



Fig. 4: Pillars of POSHAN Abhiyan

taking into consideration most of the problems stated above.

### ***Resolving Programmatic Issues through a Revised Package of Interventions***

The 1<sup>st</sup> 1000 days provide a unique window of opportunity to intervene and secure the well-being of a child. Figure 5 depicts the comprehensive package of interventions identified within the *POSHAN Abhiyaan* which focus on the first 1000 days of a child's life. Attempts have been made to re-orient the ICDS programme towards this critical time-period, as well as direct programmes implemented by other Ministries in this phase. At the same time, policy gaps have been plugged in. For example, in order to increase the periodicity of contact between the child and frontline workers, the scope of Home-Based Young Child Care Programme has been extended. ASHA workers will now conduct home visits for a period of 15 months, counselling mothers on appropriate feeding practices, energy dense diets and disease management.

Considering that two of the five targets of the *Abhiyaan* are directly linked to the reduction of anaemia, the impact of the new *Anaemia Mukta Bharat Strategy* (I-NIPI) will be critical to the success of the *POSHAN Abhiyaan*. It presents a 6\*6\*6 Strategy targeting 6 different beneficiary groups

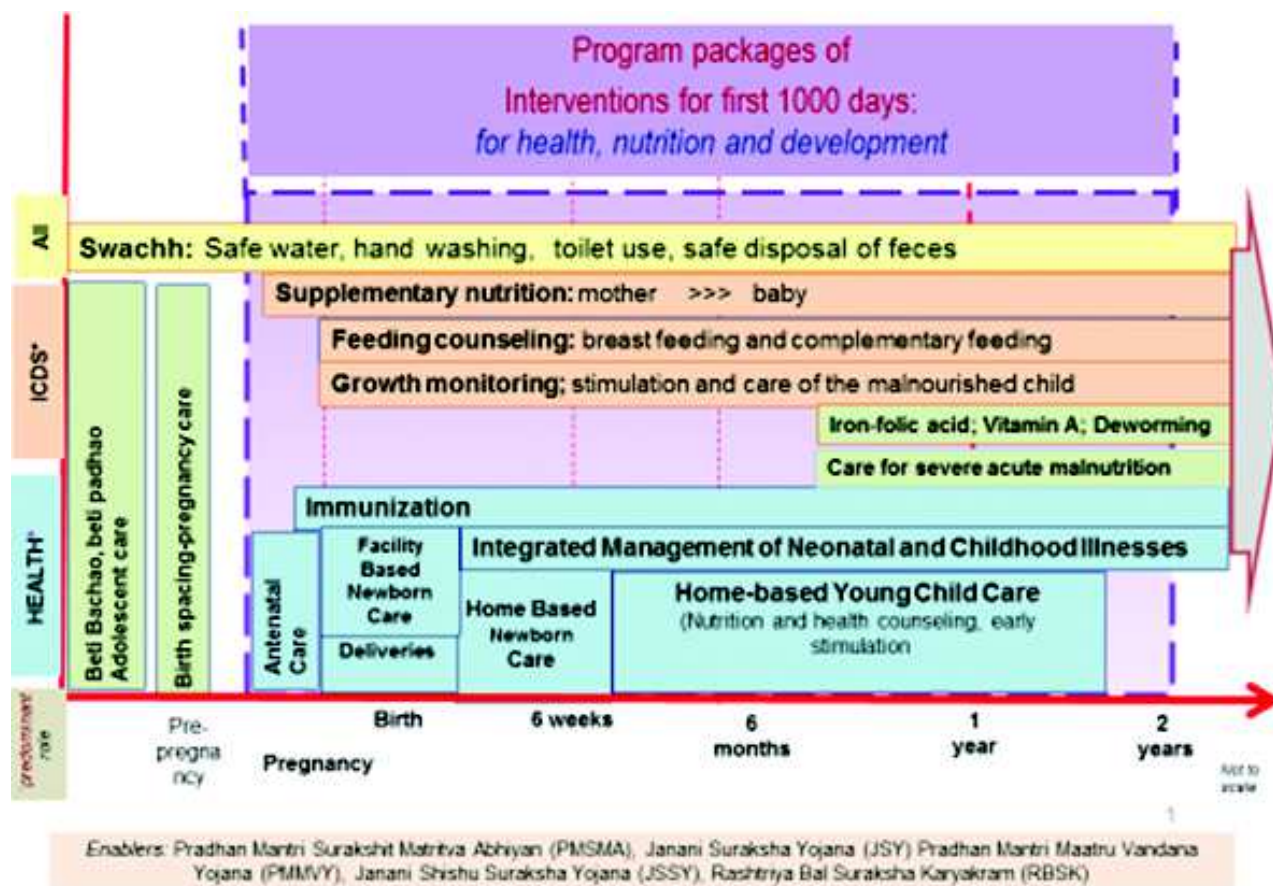


Fig. 5: Revised packages of the current interventions

through 6 different interventions (IFA supplementation, deworming, intensified BCC, testing and treatment at the point of care, mandatory fortification and addressing non-nutritional causes of anaemia) by leveraging 6 re-vamped institutional mechanisms. In addition, the benefits received under the PMMVY will encourage health seeking behaviours of the mother, while Rota Virus and Pneumococcal Vaccinations wherever implemented, will add to the layers of protection.

**Cross Sectoral Convergence**

The *Abhiyaan* calls for cross-sectoral convergence, reflected within the blueprint of its implementation strategy. It decentralizes planning and implementation by creating structures across block, district and state levels. These structures ‘Convergence Committees’ will have representatives from relevant departments/officials and focus on contextualized problems. Their mandate is to devise ‘Convergence Action Plans’ at

different levels and subsequently ensure the implementation of those plans. At the apex, the National Council on India’s Nutrition Challenges has been created to drive the *Abhiyaan*, review its implementation and facilitate convergent action at the highest levels.

At the micro level, the Village Health, Sanitation and Nutrition Days (VHSND) have been identified as the platform for convergent action. All possible efforts are underway to make them dynamic and festive at the local level. A series of activities are being lined up under the Community-Based Events (CBEs) components. These will serve the dual purpose of driving behavioural change and engaging the community at the grassroots level. The VHSNDs are being visualized as the platform for these events. Once they become popular, they can also be used for service delivery (growth monitoring, immunization, distribution of Take Home Rations and Iron and Folic Acid tablets), as well as for IEC and SBCC.

Under the *Abhiyaan*, components of performance linked joint incentives have also been introduced for AAA (ASHA, Anganwadi Worker & ANM). This will further encourage coordination and convergent action.

### **Leveraging Technology**

The biggest innovations under the *POSHAN Abhiyaan*, however, have been through the use of technology for a range of purposes. Record keeping and data management have been the biggest challenges for the anganwadi workers, consuming hours of work and shifting the focus away from the delivery of services such as home visits, counselling and growth monitoring. The ICDS-Common Application Software (ICDS-CAS), preloaded into the mobile devices given to the workers, simplifies and digitizes much of the data management work. Further, it auto-generates, among other things, lists to identify children at-risk and upcoming immunization dates. Interactive videos on appropriate care practices during pregnancy, feeding related information, child care practices, disease management have also been in-built within the software.

The most critical component, however, is the use of technology for strengthening the monitoring mechanism. Monitoring mechanisms will be based on using geo-tagged and date/time stamped photos which will enable keeping a check on the number of visits made by supervisors (for monitoring purposes). Separate institutions have been created at the centre and state level to analyse the data generated within the programme. Processes are being established for a strong feedback mechanism after analysis and for corrective/curative actions at the right time.

### **Building a Jan Andolan**

The impact of the *Abhiyaan* will be optimal if it manages to bring nutrition into the forefront through a *janandolan* encompassing people across class, caste and regions. The scale of malnutrition in India indicates that it is a problem for the majority of Indians and not limited to any specific population subgroups. The challenge is that people are unaware of its onset or its impact in the long run, mainly due to the hidden nature of problem. Hence, there is a need to build a

*janandolan* around malnutrition, which serves multiple purposes; such as raising awareness on under-nutrition, early detection of its symptoms, information around energy dense foods, appropriate feeding practices and disease management.

Community-based events led by anganwadi workers and situated within local festivals, traditions and folklore will provide platforms for Information Education and Communication activities, Behavioral Change Communication drives, including display of the nutritive values of locally grown food crops. Over time, existing institutions such as village organizations, self-help groups, students of the local schools and panchayat institutions need to be subsumed within the *Abhiyaan* to strengthen it at the bottom. At the same time, at the central level, efforts of all the partnering Ministries such as, Ministry of Health and Family Welfare, Human Resource Development, Drinking Water & Sanitation, Rural Development and PRI need to be synergized and scaled up. Ingenious use of platforms such as the national print and television media, social media and radios to catalyse the larger audience will play a critical role.

### **Conclusion**

The *Abhiyaan* has given momentum to an otherwise hidden problem affecting millions of Indians across the various age groups. It is envisaged that the *Abhiyaan* will raise (i) *awareness* on various forms of under-nutrition, early detection, required care and most importantly, the preventive measures (ii) bring about the *social and behavioural change* through which we can prevent further generations from slipping into malnutrition (iii) *build synergies* across implementing agencies and frontline workers binding them with a common purpose and targets (iv) all of which will ultimately lead to an *enhanced demand* for services resulting in (v) an *increased coverage* within key programmes. With sealed political commitments and fund allocations, the stage has been set. It is now up to the implementers, practitioners, experts and civil society organizations to take this *Abhiyaan* forward and convert it into a people's movement by engaging the entire society for a healthier and well-nourished India.

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