Azadi Ka Amrit Mahotsav

MUKHYA MANTRI BAL SUPOSHAN YOJNA

HIMACHAL PRADESH

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन
हिमाचल प्रदेश

POSHAN Abhiyaan
PM's Overarching Scheme for Holistic Nourishment
सही पोषण - देश रोशन

सत्यमेव जयते
नीति आयोग

नए समाज की ओर
Towards a new dawn

मानव सेवा

Jai Ram Thakur
Chief Minister,
Himachal Pradesh

MESSAGE

A healthy mind resides in a healthy body and for physical and mental development, it is necessary that pregnancy, infancy, childhood and adolescence are well nourished. To attain this objective, State Govt.has given the approval for "Mukhya Mantri Bal SuposhanYojna".This scheme would be implemented with the joint efforts of the Centre & State Governments. The Department of Women & Child Development, Health & Family Welfare, Education and National Health Mission, H.P having pivotal role in implementation.

The scheme envisages significant improvement in the nutritional status of mothers and children through intensive interventions involving convergence of various stakeholders. This scheme is based on the seven pillar, SAPT STAMBH approach for which the State Government has done extensive consultation with NITI Aayog.

It will involve planning, implementation and monitoring of the health of children, adolescents, pregnant women and lactating mothers with a focused approach in Jan Andolan mode. With this scheme, Himachal Pradesh will be able to improve upon the parameters of health and nutrition amongst children to desirable levels.

The State Government is fully committed to the health and well-being of the people of Himachal Pradesh particularly children. MMBSY will prove to be a milestone in tackling the problem of malnutrition in children by combating diseases like diarrhea, pneumonia and anemia.

I convey my best wishes for the publication and successful implementation of this scheme document.

(Jai Ram Thakur)

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Annexures:

Abbreviations

AMB	Anaemia Mukt Bharat
ANC	Ante Natal Care
ANM	Auxiliary Nursing Midwifery
ARI	Acute Respiratory Illness
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWH	Anganwadi Helper
AWW	Anganwadi Worker
AV	Audio Visual
BMO	Block Medical Officer
CBE	Community Based Event
CDPO	Child Development Programme Officer
CH	Civil Hospital
CHC	Community Health Centre
CHO	Community Health Officer
CIFF	Children's Investment Fund Foundation
CMO	Chief Medical Officer
DEIC	District Early Intervention Centre
DH	District Hospital
DPO	District Programme Officer
ECD Call Centre	Early Childhood Call Centre
FRU	First Referral Unit
GAM	Global Acute Malnutrition
HBNC	Home Based Newborn Care
HBYC	Home Based Young Child Care
HFW	Health and Family Welfare
HR	Human Resource
HRP	High Risk Pregnancy
HSC	Health Sub Centre
HWC	Health Wellness Centre
ICDS	Integrated Child Development Scheme
IDCF	Intensified Diarrhoea Control Fortnight
IDPCF	Intensified Diarrhoea & Pneumonia Control Fortnight
IEC	Information Education Communication

Abbreviations

IFA	Iron and Folic Acid
ILA	Incremental Learning Approach
IMNCI	Integrated Management of Neonatal & Childhood Illness
IYCF	Infant and Young Child Feeding
JSV	Jal Shakti Vibhag
MAA	Mother's Absolute Affection
MAM	Moderate Acute Malnutrition
MCP Card	Mother Child Protection Card
MMMC	Mukhya Mantri Mobile Clinic
MMU	Medical Mobile Units
MO	Medical Officer
MoHFW	Ministry of Health and Family Welfare
MUAC	Mid Upper Arm Circumference
NC	Nutrition Counsellor
NFHS	National Family Health Survey
NHM	National Health Mission
NRC	Nutrition Rehabilitation Centre
OPD	Out Patient Department
ORS	Oral Rehydration Solution
PCV	Pneumococcal Conjugate vaccine
PHC	Primary Health Centre
PMSMA	Pradhan Mantri Surakshit Matritva Abhiyaan
PNC	Post Natal Care
PPE	Personal Protection Equipment
PRI	Panchayati Raj Institute
PW	Pregnant Woman
RD	Rural Development
RI	Routine Immunization
RMNCH+A	Reproductive Maternal Neonatal Child &Adolescent Health
RBSK	Rashtriya Swasthya Bal Karyakram
SAANS	Social Awareness and Action to Neutralize Pneumonia Successfully
SAM	Severe Acute Malnutrition
SBA	Skilled Birth Attendance
SBCC	Social and Behaviour Change Communication
SD	Standard Deviation

Abbreviations

SHG	Self Help Group
SIA	Special Immunization Activity
SN	Staff Nurse
SNCU	Special Newborn Care Unit
SNP	Supplementary Nutrition Programme
STH	Soil Transmitted Helminths
THR	Take Home Ration
ToTs	Training of Trainers
UNDP	United Nations Development Programme
UNICEF	United Nations International Children's Emergency Fund.
VHSND	Village Health, Sanitation & Nutrition Day
WCD	Women and Child Development
WFH	Weight for height
WIFS	Weekly Iron Folic Acid Supplementation
WHO	World Health Organization

CHAPTER 1 INTRODUCTION

1.1 NUTRITION SITUATION ANALYSIS

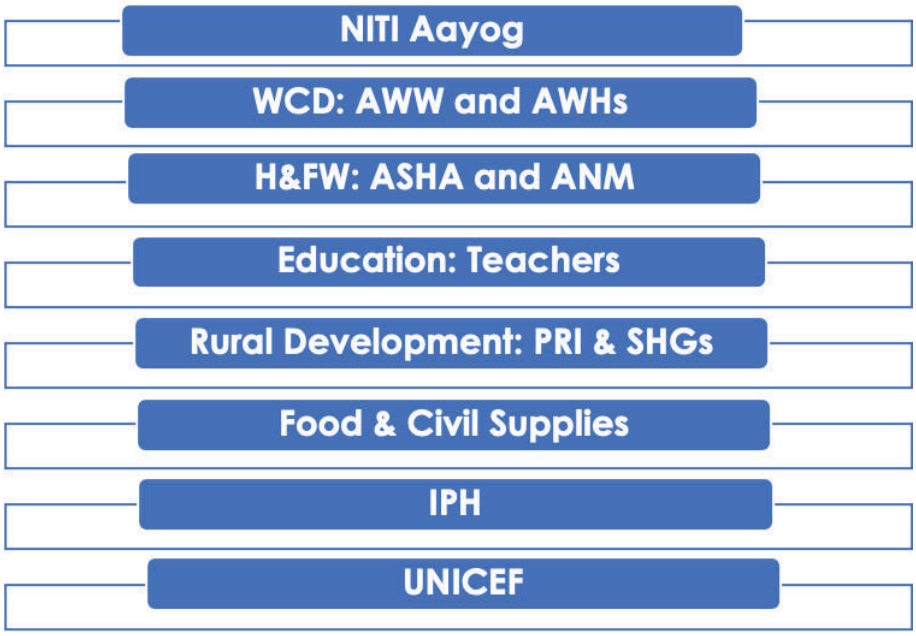
Nutrition is acknowledged as one of the most effective entry points for human development, poverty reduction and economic development, and a policy focus on nutrition has high economic returns. The rationale for investing in nutrition is globally well recognized–both as a critical development imperative, as well as crucial for the fulfilment of human rights- especially of the most vulnerable groups viz. children, adolescent girls and women. Optimum nutrition constitutes the foundation for human development, as it helps reduce susceptibility to infections, related morbidity, disability and mortality burden, enhances cumulative lifelong learning capacities and adult productivity.

As per the Global Nutrition Report 2021, India is currently off course to meet five out of six global maternal, infant and young children nutrition (MIYCN) targets on stunting, wasting, low - birth weight, anaemia and childhood overweight. Poor diets and malnutrition need to be addressed sustainably to ensure a healthy future for people and planet. Investment in nutrition has been conceptualized as a community level strategy for convergent actions for Health, Early Childhood Development, Nutrition and Sanitation. Additional finance is needed to meet a nutrition target which has grown significantly, partly due to the impacts of COVID-19.

The Sustainable Development Goals emphasize the need for various actions through inter-sectoral collaboration. India is committed to achieve the health, nutrition, development and sanitation goals. To achieve these goals various programmes have been launched, namely Ayushman Bharat (with establishment of Health and Wellness Centres), POSHAN Abhiyaan with a strong component of Jan Andolan (people's movement) and Swachh Bharat Mission to enhance sanitation related activities.

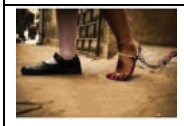
Inter-departmental and inter-sectoral convergence is imperative for combating malnutrition. The targets for reduction in malnutrition and anaemia warrant a comprehensive approach cutting across programmes and schemes to ensure service delivery, monitoring of services and interventions wherever required. Further, synergy and convergence among frontline functionaries like Anganwadi workers (AWWs), Accredited Social Health Activist (ASHA), Auxiliary Nurse Midwifery (ANM), Supervisors and Teacher is crucial. It is also important to note that the role of PRIs (Panchayati Raj Institute) and SHGs (Self Help Groups) is equally important.

The major stakeholders Departments involved in the scheme are National Health Mission, H.P representing Departments of Health and Family Welfare, Social Justice and Empowerment represented by Women and Child Development and Education. Schematic format is depicted below:



There are 10 key themes around eradicating malnutrition. The Department wise responsibilities for each key theme are delineated below. It is, however, important to note that every Department has a role in the materialisation of all the themes.

Key Theme		Department Responsible
	ANC (Ante Natal Care), Institutional delivery and early initiation of breastfeeding	HFW & WCD
	Optimal breastfeeding	HFW & WCD
	Complementary food and feeding	HFW & WCD
	Full Immunization and Vitamin A Supplementation	HFW & WCD
	Growth monitoring and promotion	HFW,WCD & Education

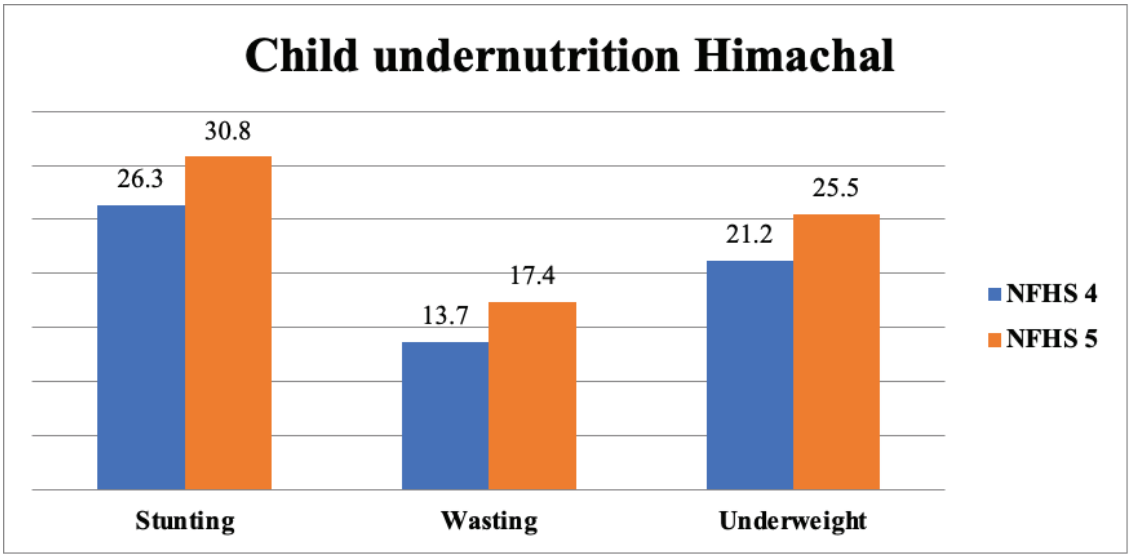
	Anaemia prevention in children, adolescents, and pregnant and lactating women	HFW & WCD
	Food fortification and micronutrients	WCD and Food & civil supplies
	Diarrhoea and pneumonia management	Health and Family Welfare
	Diet and education of the girl child and appropriate age for marriage	WCD, Education and Rural Development (RD)
	Hygiene, sanitation and safe drinking water	WCD, Health and Family Welfare , Education, RD and Jal Shakti Vibhag

1.2 PROBLEM STATEMENT:

India is home to the largest number of children in the world. Nearly every fifth child in the world lives in our country. Studies indicate that a quarter of child malnutrition is attributed to LBW (low birth weight), another quarter due to diseases like diarrhoea and pneumonia and the remaining half is caused by poor/inadequate food intake.

The finding of the National Family Health Survey - 5 (NFHS - 5) indicate stagnation, if not deterioration, in most indicators (especially those pertaining to women and child health) when compared with the fourth round of the survey (NFHS - 4). Though, some States show an improvement, but on the whole in most States, there is a worsening in indicators such as childhood stunting (13 out of 22 States see an increase), wasting (12 out of 22 States see an increase) and underweight (16 out of 22 States see an increase).

Himachal Pradesh is no exception and has registered deterioration in most of nutrition indicators in NFHS - 5 (2019-20) as compared to NFHS - 4 (2015 - 16). As per the NFHS-5 factsheet in Himachal, stunting among the under five category has increased from 26.3 % in NFHS-4 to 30.8 % in NFHS-5; wasting has increased from 13.7 % in NFHS-4 to 17.4 % in NFHS-5; and the percentage of underweight children under 5 years has increased from 21.2 % to 25.6% from NFHS-4 to NFHS-5 respectively.



Hon'ble Chief Minister of Himachal Pradesh, Sh. Jai Ram Thakur, in his budget speech 2022-23 announced an Action Plan under the name 'Mukhya Mantri Bal Suposhan Yojana' (MMBSY) to combat child malnutrition. This scheme is proposed to be run through the joint efforts of the Centre and State Govt. active convergence of Departments of Women and Child Development with Health, and Elementary Education, and shall ensure necessary coordination to implement the scheme.

MMBSY is based on the Seven Pillar Approach *(Sapt Stambh)*

- Components in the form of seven pillars
- *Jan Sahbhagita* through stakeholder participation & convergence
- Intensified monitoring
- Transparent system of last mile service delivery

1.3 GOALS OR OUTCOMES OF THE MMBSY

- Significant improvement in nutritional status of mothers and children through multiple intensified interventions and convergence of various stakeholders.
- Service - delivery and interventions by increase use of technology and behavioural change through convergence.
- To lay down specific targets to be achieved across different monitoring parameters.
- Improved Nutritional status of children & their mothers.
- Increased of technology for transparent and efficient service delivery.
- Behaviour change through increased awareness on causes of malnutrition.

1.4 COMPONENTS OF THE MMBSY- *"SAPT STAMBH"*

The State Govt. has done extensive consultations with NITI Aayog to realize the vision as stated above. It will be achieved through seven pillars-***"SAPT STAMBH"*** of MMBSY which are as follows:

1. Early identification and treatment of Diarrhoea and Pneumonia.
2. Intensified monitoring and care of identified high risk groups.
3. Special Supplementary Nutrition Protein addition of protein rich food for high-risk children and improved feeding practices.
4. Interventions for Anaemia in Children and Adolescent girls.
5. Detection of High-risk pregnancies particularly Hypertension and Anaemia.
6. Treatment and follow up of malnourished children.
7. Social behaviour change communication.

Other components of the Scheme:

- Capacity Building.
- Monitoring and Supervisory mechanism (in convergence mode).

1.5. EXPECTED OUTCOME INDICATORS OF MMBSY

The findings of the National Family Health Survey (NFHS-5) in respect of Himachal Pradesh require deeper analysis. While the State has effectively managed to reduce mortality indicators, the parameters for malnutrition and anaemia prevalence have worsened over NFHS-4.

With the current interventions, in the next 5 years, child & maternal mortality and morbidity indicators are expected to improve to a certain level. However, with the introduction of MMBSY, the State aims at fast tracking the improvement in the health and nutrition indicators.

Through the MMBSY, the State aims at increasing availability of ORS (Oral rehydration solutions and Zinc in children with diarrhoea by 8.4% and increasing health seeking behaviour in cases of fever and ARI by 15.9% by 2026 as compared to that achieved with no additional measures.

With the existing program, the NMR, IMR and U-5MR of the State are expected to decrease by 4, 6.5 and 6.7 percentage respectively in the next five years. However, MMBSY aims at decreasing the NMR by 11.5%, IMR by 13.6% and U-5 MR by 13.9% by 2026, thereby doubling the achievements over the same time period similarly, exclusive breastfeeding practices and complementary feeding practices are aimed to be increased by 7.3% and complementary feeding to be increased by 26.9% than without any additional intervention on current NFHS-5 data.

Similarly, with MMBSY in place, the State aims to decrease the prevalence of SAM/ MAM cases at a faster pace than that achieved with existing interventions. MMBSY aims at decreasing the prevalence of anaemia in children (0-6 years) bringing it down to 30% and in Pregnant Women to 25% by 2026 against NHFS-5 values of 55.4% and 42.2% respectively.

Comparative impact projections of MMBSY

Indicator	NFHS-4	NFHS-5	Reduction by 2026 without MMBSY	Target for 2026 with MMBSY
Children with diarrhoea in the 2 weeks preceding the survey who received oral rehydration salts (ORS) (%)	62.7	73.7	86.6	95.0
Children with diarrhoea in the 2 weeks preceding the survey who received zinc (%)	15	19.5	25.4	95.0
Children with fever or symptoms of ARI in the 2 weeks preceding the survey taken to a health facility or health provider (%)	78.4	76.2	74.1	90.0
NNMR	25.5	20.5	16.5	9.0
IMR	34.3	25.6	19.1	12.0
Under 5 Mortality rate	37.6	28.9	22.2	15.0
Children under age 6 months exclusively breastfed (%)	67.2	69.9	72.7	80.0
Total children aged 6-23 months receiving an adequate diet (%)	10.9	19	33.1	60.0
Children under 5 years who are stunted (height-for- age) (%)	26.3	30.8		20.0
Children Under 5 years who are Wasted (weight-for- height) (%)	13.7	17.4		10.0
Children under Severe Wasted (weight-for-height) (%)	3.9	6.9		3.0
Children under 5 years Underweight (weight-for-age) (%)	21.2	25.5		20.0
Children aged 6-59 months (<11.0 g/dl) (%) who are anaemic	53.7	55.4		30.0
Pregnant women 15 -49 years age who are anaemic (<11.0 g/dl) (%)	50.4	42.2	35.3	25.0

CHAPTER 2

EARLY DETECTION AND TREATMENT OF DIARRHOEA AND PNEUMONIA

2.1. BACKGROUND

Diarrhoeal diseases are the second main cause of death and one of the leading causes of malnutrition in children under five. 19.5% of the children with diarrhoea received Zinc as per NFHS-5 in Himachal Pradesh whereas 73.7% received Oral rehydration solutions (ORS). The same figures in 2015-16 were 15% and 62.7%, respectively, thereby indicating slight improvement over the years Diarrhoea and malnutrition operate in a vicious cycle . Prompt interventions are needed to prevent the child from falling into this cycle.

One of the key measures to treat diarrhoea is rehydration with oral rehydration salts solution (ORS). ORS is absorbed in the small intestine and replenishes water & electrolytes lost in faeces. Zinc supplements reduce the duration of diarrhoeal episode by 25% and are associated with a 30% reduction in stool volume. Rehydration with intravenous fluids is required in severe dehydration and shock. The vicious cycle of malnutrition and diarrhoea can be broken by giving nutrient rich food including breast feeding the children when they are recovered. Integrated Management of Neonatal and Childhood Illness (IMNCI) guidelines can be used to treat diarrhoea at all levels of the health system. Gaps identified in the successful treatment of diarrhoea at the community level include poor knowledge of IMNCI guidelines, failure to detect dehydration early, lag in referral, poor ORS reconstitution and administration, lack in counselling regarding feeding and exclusive breast feeding in children up to 6 months of age.

Pneumonia is caused by a number of infective agents including viruses, bacteria and fungi. Bacterial pneumonia can be treated with antibiotics, but as per NFHS-5, only 14.6% of children with Acute Respiratory Illness (ARI) received antibiotics in Himachal Pradesh, whereas, the figure as per NFHS-4 was 23.5%. Pneumonia contributes to growth lag both during and after the period of disease, thereby contributing to a high load of malnutrition in the community. Pneumonia, as per the IMNCI guidelines, has been classified on the basis of symptoms and observation by the grass root level health worker into three types:

a) Severe Pneumonia or Very Severe Disease (child with history cough or difficulty in breathing with fast breathing and any one or more signs like- inability to feed or breastfeed, repeated vomiting, convulsion, chest in drawing or stridor in a calm child.)
b) Pneumonia - child with history of cough or difficulty in breathing with fast breathing (2 months to 1 year > 50 breaths per minute, 1 year to 5 years>40 breaths per minute)

c) No Pneumonia- Cough and Cold (child with history of cough or difficulty in breathing with no sign of Pneumonia or very severe disease).

These guidelines are simple and can help triage children with pneumonia. If followed diligently, they can prevent progression to severe disease, can diagnose pneumonia affected children requiring prompt referral and can prevent malnutrition & deaths due to pneumonia. The major challenges identified in treatment of pneumonia at the community level are delayed care-seeking, frequent stock outs of antibiotics and l ack of knowledge of IMNCI guidelines and implementation. Hypoxemia is a common occurrence in pneumonia especially in severe & very severe illness and the clinical signs often fail to accurately predict presence or absence of hypoxemia, thereby healthcare workers miss out on potentially very sick children. Pulse oximeters is the only reliable non-invasive method to confirm the presence of hypoxemia. There is a lack of pulse oximeters (paediatric and neonatal pulse oximeters are different from adult oximeters), apprehension and lack of confidence amongst primary healthcare staff in dealing with paediatric patients, especially neonates. Wheezing is associated with Pneumonia and in many cases, bronchodilators are needed before antibiotics. Bronchodilators may even obviate the need for antibiotics. The most appropriate route for administration of bronchodilators is through the inhalation route. Though there has been a general lack of such delivery systems at primary level, but during the course of health infrastructure strengthening during the COVID pandemic, Sub Centres and PHCs were provided with oxygen concentrators with a nebuliser port.

As per the campaign guidelines it will be ensured that essential drugs (including Amoxicillin (tablet / syrup), Injection Gentamycin and Ampicillin) and equipment (including pulse oximeter, oxygen concentrators / cylinders / generation plants, PPEs, hand-sanitizers) are available at the facility and Front-Line Workers level have access to these as and when:

- Pneumonia treatment protocols will be displayed in all health facilities.
- Plan for community awareness generation regarding Pneumonia and Pneumococcal Conjugate Vaccine (PCV) will be put in place.
- Facilities that provide comprehensive Pneumonia care will be mapped out and shared with frontline workers (FLWs), for further dissemination.

2.2 INTENSIFIED DIARRHOEA AND PNEUMONIA FORTNIGHT

To combat common childhood illnesses (Diarrhoea and ARI), the State will be modifying IDCF campaign to IDPCF (inclusion of Pneumonia component) which will be a yearlong effort, and will be supplemented with seasonal campaigns. Special focus will be given to high priority areas like urban slums, flood prone areas, sub centres having no ANM, brick kilns communities and other vulnerable communities such as migrants and streets children etc. This campaign will have three components.

Dedicated Diarrhoea Control Fortnight: 15th June – 30th June

- Upfront Zinc and ORS strategy - 2 ORS packets and 14 Zinc tablets to every family having children under 5 by AWWs and demonstration in every Gram Panchayat and establishment of ORS Corners in the health facilities
- Procurement of drugs and logistics will be done by CMOs and shall be further distributed by ASHA and AWWs.
- Special focus will be given on IEC on 'Red Flag Signs' and early care seeking.
- Demonstration of ORS preparation and Zinc Tablet administration will be done at community level.

Dedicated Pneumonia Control Fortnight: 12th November – 27th November

- Advanced training of Medical officers by the identified pediatricians of the Medical College and District Hospitals on sensitization for identification and management of childhood illness including Pneumonia and Diarrhea. This will be done in the month of July and August.
- Availability of Antibiotics at Sub-Centers, PHCs and (FRU's) First Referral Units.
- Distribution of neonatal pulse oximeters at Sub-centers.

Combined Intensified Diarrhoea and Pneumonia Control Fortnight: 15th March - 28th March

- With the components of Diarrhoea and Pneumonia.

2.3 INTENSIFICATION OF WATER SANITATION AND HYGIENE (WASH) ACTIVITIES:

Water Sanitation and Hygiene practices are known factor in reducing morbidity and mortality caused due to infectious diseases and hence break the illness- malnutrition cycle. These activities will be a part of Intensified Diarrhoea & Pneumonia Control Fortnight (IDPCF) and will be promoted using platforms like RI session, POSHAN days, VHSND, VHSNC etc. All related Departments like Health, WCD, Education, RD, JSV and other line Departments will play a crucial role.

2.4 CAPACITY BUILDING AND STRENGTHENING

Identification and strengthening of facilities for management of diarrhoea and pneumonia shall be done to ease out the case load on the District Hospitals and Medical Colleges. Cascade training methods will be used to train medical officers and para-medical staff in advanced management of complicated/ severe diarrhoea and severe pneumonia

In districts with Medical Colleges, faculty from Department of Paediatrics will be brought on board. For districts without medical college, but paediatrician in place, District ToTs will be developed involving the paediatrician on board, District Programme Officer, Child Health and Medical Officers posted in sub District hospitals (CH/ CHC/ PHC).

The early detection of these diseases is critical in combating malnutrition as well as saving precious lives of children. Special awareness drive for diarrhoea and pneumonia will be conducted with Dedicated IEC plan which would include all red flag signs of diarrhoea and pneumonia. LED screens shall also be installed in health institutions displaying IEC pertaining to combating malnutrition and promoting child health.

CHAPTER 3

INTENSIFIED MONITORING & CARE OF LOW BIRTH RATE AND IDENTIFIED HIGH RISK GROUPS

3.1 IDENTIFICATION OF HIGH RISK GROUPS FOR MALNUTRITION

The provision of coherent Home-Based New-born Care (HBNC) and Home-Based Young Child Care (HBYC) strategy with a robust monitoring mechanism is critical for ensuring quality care of new-borns up to the first 1000 days of life. The objective is to reduce child mortality, morbidity, and improve nutrition status. This can be achieved by monitoring growth and early childhood development of young children through structured, focused, and effective home visits by ASHAs. In the current scenario the home-based visits are as follows:

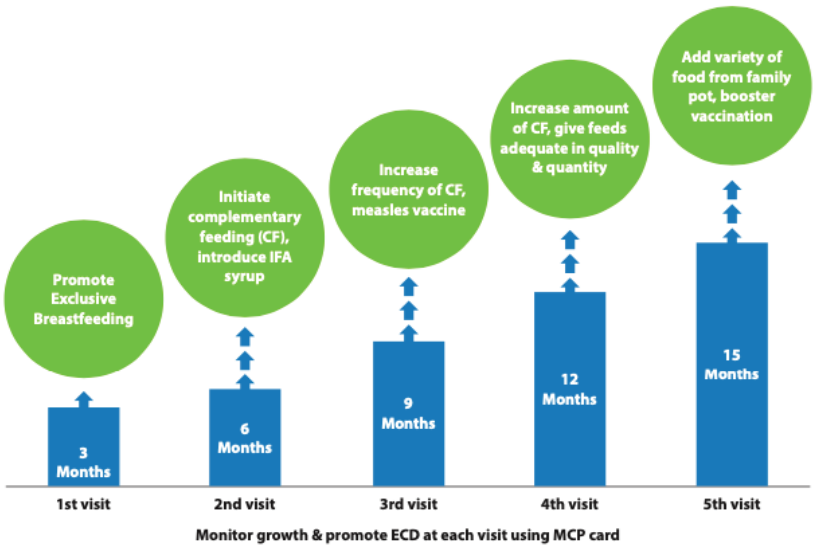
a) Six visits in case of Institutional Deliveries (Days 3, 7, 14, 21, 28 & 42).

b) Seven visits in case of Home Delivery (Day 1, 3, 7, 14, 21, 28 & 42).

c) In case of Special Newborn Care Units (SNCU) discharged babies, day of discharge is counted as day 1 of home visit schedule and the six remaining visits are completed as per schedule.

From 2-3 month onwards under HBYC, ASHAs will provide quarterly home visits (3rd, 6th, 9th, 12th and 15th months).

Figure below depicts the age-appropriate intervention to be promoted during HBYC Visits:



3.2. PROPOSAL OF HOME-BASED VISITS

It has been seen that low birth weight is identified as a causal factor for malnutrition in 25% cases of malnourished children. Similarly, diseases like Pneumonia and Diarrhoea contribute to another 25% of childhood malnutrition. Confounding factors like SNCU admissions also predict development of malnutrition later on in childhood. However, neither HBNC nor HBYC provide for intensified monitoring of these high-risk groups.

Under the MMBSY, the following interventions shall be undertaken for all SAM/MAM/LBW/ SNCU discharged babies:

- Continuum of HBNC and HBYC visits: In addition to the existing visits, the frequency of ASHA visits shall be doubled in case of all the low birth weights, and all the babies who have been discharged from SNCUs or any other medical health facility. These additional visits will be done on Day 11, 18, 35, 49, 60 and 75 of birth. Thereafter, HBYC visits will take over. Incentive shall be paid to ASHA for these additional HBNC visits @ Rs 200/ child (Annexure 3).
- ASHA will also mandatorily contact medical officers through telephone for tele-consultations in case she finds the children in a sick or malnourished condition during her visits.
- AWW shall perform additional home-based visits with ASHA, congruent with additional HBNC visits for LBW and SNCU discharged babies on day 11, 35 and 60. Incentive @ Rs 100/child shall be provided to AWW for these visits.
- Last Saturday of every month shall exclusively be dedicated to cases referred by ASHA from the HBNC visits to the nearest public health facility, which shall run a dedicated clinic that day, designated as Bal Swasthya Clinic.
- Iron drops will be provided for 2 months to under 6 months LBW children on daily basis @ 3-5 mg/kg/day.
- Vitamin D Syrup 400 IU will be given to children up to 1 years of age on daily basis (Annexure 6).
- Procurement will be done through DHS/CMO & distribution will be done through ASHA.
- Special focus will be paid on kangaroo mother care, breastfeeding support, technique of expressed breast feeding, and if needed, massage with coconut oil or sunflower oil.

3.3 TREATMENT AND FOLLOW UP OF LOW BIRTH WEIGHT BABIES

Low Birth Weight is identified as a causal factor for 25% cases of malnutrition. As per the SNCU portal for the year 2021-22, low birth weight babies (1000 gm-2499 gm) are 4.55% out of 10914 admissions.

Early admission of sick newborn shall be ensured at Special Newborn Care Units (SNCU) and Neonatal Stabilization Unit (NBSU) in order to cut delays occurring after labour. Standard operating procedures shall be put in place for this purpose. For ensuring follow up of SNCU graduates as per protocol, mother/ guardian will be provided travel allowance (Annexure 3).

Kangaroo mother care (KMC) binder's availability shall also be ensured at all the delivery points in sufficient quantity. SNCU discharged babies shall be monitored for ensuring continuum of KMC at home during HBNC visits by ASHA, and through timely follow up visits to the hospital.

Mechanism is already in place for communicating the discharge of babies from SNCUs by the SNCU DEO to ASHA. Under MMBSY an additional mechanism will be developed for same communication to AWW also.

CHAPTER 4

SPECIAL SUPPLEMENTARY NUTRITION - ADDITION OF PROTEIN RICH FOOD FOR HIGH RISK CHILDREN AND IMPROVED FEEDING PRACTICES

Supplementary Nutrition is one of the main components of Anganwadi Services Scheme. At present supplementary nutrition is provided to bridge the gap between recommended dietary allowances and actual intake of food of mother and child in the State of Himachal Pradesh. The supplementary nutrition is being provided to the beneficiaries enrolled in the AWC in the age group of 6 months to 3 years, 3 to 6 years and pregnant & lactating mothers.

At present beneficiaries enrolled in the Anganwadi Centres are provided dishes/ nutritional food items containing micronutrients like fortified panjiri, fortified ajwain & oats biscuits, sweet dalia, fortified seviyan, rice khichari, sprouted gram, rice rajma etc. Green leafy & other vegetables etc. are also provided through local procurement. In addition to the supplementary nutrition which is already being provided under Supplementary Nutrition Programme & H.P Bal - Poshahar Top Up Yojana, special supplementary nutrition. ***Purak Aaahar*** in form of quality protein (animal sourced) shall be provided to all target groups defined under MMBSY.

Special supplementary nutrition i.e. ***Purak Aaahar*** under MMBSY will ensure provisioning of protein, calories, and micronutrients enriched food items to SAM/MAM children in the age group of 6 months to 6 years. Proper feeding practices will be inculcated in the mothers and the care givers. Special care and supervised feeding of malnourished children below six years will be ensured and the children who are ill or severely ill shall be referred to nearest health facility. Monitoring of nutritional status of SAM/MAM children will be an important part of this pillar.

4.1. STRATEGIES FOR IMPLEMENTATION

1. Introduction of animal sourced protein in addition to plant protein. Caregivers and Community shall be involved.
2. Growth monitoring (including weight, length/ height and Head Circumference) of children under 6 years shall be done.
3. Community orientation and sensitization on stunting, wasting and underweight parameters shall be done.
4. Health check-ups of those children who have not shown any improvement in one month shall be ensured.

5. Treatment & referral services to the children who have not shown any improvement in three months shall be ensured.
6. Anganwadi level Monitoring & Support Groups (ALMSCs) shall be involved to counsel mother-in-law, mother and father on the importance of Infant and Young Child Feeding (IYCF) practices.

4.2 TARGET GROUPS

a) Children

- 6 months – 12 months
- 1-3 years (12 months- 36 months)
- 3-6 years (36 months -72 months)

b) Pregnant & Lactating mothers

c) High Risk Group:

- SAM and MAM children (6 months to 6 years)
- High Risk Pregnant women (validated by the health department)

4.3 PLAN OF ACTION

A district level Suposhan Task force headed by the Deputy Commissioner of the district shall be responsible for implementation of this scheme in the District. The Task force will decide the quality protein nutrition items to be provided under this programme in consultation with nutrition counsellors as per the regional food preferences of beneficiaries. The Task force may decide to revise the food items on quarterly basis.

Special supplementary nutrition viz. Quality protein products etc shall be provided as per detail given below:

Target group	Rate and Frequency of distribution of quality protein food products	Type of food
a) Children*		
6 months – 12 months	Rs 8.00 twice a week viz. 96 days in a year	Quality animal sourced proteins
1-3 years (12 months- 36 months)	Rs 8.00 twice a week viz. 96 days in a year	Quality animal sourced proteins

3-6 years (36 months -72 months)	Rs 8.00 twice a week viz. 96 days in a year	Quality animal sourced proteins
b) Pregnant & Lactating mothers *	Rs 8.00 twice a week viz. 96 days in a year	Quality animal sourced proteins
IEC campaigns will be held for behavioural changes for supplementary nutrition		
c) **High Risk Group****		
SAM and MAM children (6 months to 6 years) High Risk Pregnant women	Rs 12.00 six days in a week viz.300 days in a year	Quality animal sourced protein. Any other regional food items suggested by DLTF ***Nutritional counsellors and local mothers must be consulted before deciding of food items.**
****Detailed standard guidelines will be issued separately.**		

4.3.1 RELEASE OF FUNDS

Funds from the Directorate of Women and Child Development will be released to the concerned District Programme Officers, (DPO) on quarterly basis for procurement of quality protein (animal sourced) like eggs, milk, paneer etc.
Provisioning of nutrition items shall be made through local SHGs in selected circles of one ICDS project on Pilot basis.

1. The Supervisor, WCD, shall collect monthly demand of funds in advance for procurement of food items from the Anganwadi Workers.
2. The demand shall be floated by the Supervisors to the CDPO.
3. The procurement of quality protein will be done by DPO/CDPO/Supervisor/AWWs as per the decision taken by District level Suposhan Task force.

4.3.2 SOURCE / MODE OF PROCUREMENT

1. The procurement of food items under this programme at District level will be undertaken by DPO after approval of source of procurement from District level Suposhan Task force. DPO will ensure the fulfilment of all codal formalities for procurement as per HPFR.
2. In case of procurement at block level, the concerned CDPO shall get the approval of source of procurement of food items viz. whether from the local shop or any dairy/poultry farm in the adjoining area of the Anganwadi Centre or Supervisor circle from the Suposhan Task force at Block level.

3. The codal formalities required for procurement of the food items at block level shall be done by the concerned CDPO.
4. The list of source of procurement of food items shall be circulated to the Anganwadi Centres.
5. AWWs shall prepare/submit bills/vouchers and submit the same to the concerned Circle-Supervisor. The Supervisor shall send the bill/vouchers to the CDPO after verifying the same.
6. The DPOs (WCD) / CDPOs / Supervisors (WCD) shall ensure quality check of supplementary nutrition being procured at the decentralized level as per already defined in the monthly schedule under ICDS as depicted below:

Officers/Officials	**Monthly schedule**
District Programme Officers (WCD)	Inspection of at least 10 AWCs every month
Child Development Project Officers	At least 15 AWCs of their respective ICDS projects every month on rotation basis.
Supervisor (WCD)	Inspection of all Anganwadi centres under circle at least once in a month

4.3.3 INVOLVEMENT OF COMMUNITY

1. Prior to the start of distribution of these food items in the Anganwadi Centres (AWCs) the community shall be orientated and sensitized to the nutritional aspect of the quality protein whole meal food items like milk, egg etc. to be distributed to the parents of the children. IEC / sensitization shall be planned every two months. Information, Education & Communication (IEC) funds shall be pooled from POSHAN 2.0.
2. Proper guidance on feeding practices shall be provided to the mothers during the home visits by the Anganwadi /ASHA Workers/ANMs/Supervisors.
3. CDPOs and Supervisors shall also conduct home visit for creating awareness amongst the care givers.

4.3.4. SUPERVISION, GROWTH MONITORING AND HEALTH CHECK-UP

1. Development of 'Common Application Software' for monitoring of Take Home Ration (THR).
2. The ASHA workers and ANMs shall be involved in growth monitoring and health check-up at AWCs and Supervisor circle level.
3. AWC social map shall be made by Supervisors indicating the household of moderately & severely malnourished children in the village.
4. A record of these maps shall be maintained and shall be by the Supervisors in her Supervisor circle.
5. Community Based event shall be organized every 2 months in the Anganwadi Centres.
6. The community shall be involved in ***Vazan Tyohaar*** viz. weighing of children on 15th of every month in AWCs. The ASHA workers and ANM will play active role in this event.
7. After every ***'Vazan Tyohaar'***, the Anganwadi Workers shall display the picture of healthy child after taking consent, from the parents/ legal guardian to motivate other parents to compete for making their child healthiest by adopting the advised practices.
8. Annaprashan shall form part of CBE and IEC activities during Poshan Maah, Pakhwada and ***Jan Manch.***
9. Growth Charts/POSHAN tracker shall be used to educate the community on the gravity and scale of the problem.
10. The concerned supervisor shall be responsible for monitoring of MAM and SAM children showing no increase in weight and shall ensure that they are referred to health institutions in the following month in coordination with the ANMs.
11. The check-up profile of SAM & MAM children shall be maintained by Supervisors for the follow-up of the child.
12. The caregivers shall be sensitized by the Supervisors as per the prescription/medical advice of the Medical Specialist.

4.3.5 LIAISON WITH DEPARTMENT OF HEALTH:

1. The concerned CDPOs shall share the list of names of MAM and SAM children with the concerned BMO on monthly basis.
2. The list of MAM and SAM children shall be provided by the District Programme Officer WCD to Chief Medical Officers on monthly basis.

4.3.6 MONITORING BY CDPOS/DPOS (WCD) IN COORDINATION WITH THE HEALTH DEPARTMENT

1. Nutritional status of the children shall be displayed in Panchayat Bhawans and AWCs.
2. The concerned Supervisors shall compile the data of all moderately & severely malnouri shed children along with the reasons of non-recovery in status of moderately malnourished if any.
3. Every month the CDPOs, in coordination with the Block Medical Officers, shall review the status of the malnourished children in their blocks with the Supervisor and shall ensure check-up and follow up of these malnourished children.
4. The District Programme Officer (WCD) shall monitor the status of moderately & severely malnourished children after every 7th day of the month.
5. The Chief Medical Officer shall be involved by the District Programme Officers (Health) in case of non-improvement in the nutritional status of the malnourished child; the same shall be /consulted with the Paediatricians of District Hospital or referred to the Nutritional Rehabilitation Centres (NRCs).

4.4 EXCLUSIVE BREASTFEEDING FOR SIX MONTHS OF LIFE AND PROMOTION OF COMPLEMENTARY FEEDING

Studies indicate that one fifth of child mortality (under 5 years) in India can be prevented by ensuring universal exclusive breastfeeding for the first six months and appropriate complementary feeding practices after 6 months (along with continued breastfeeding till 2 years and beyond) under five mortality can be reduced globally by 13% and in India by 16% through the universal practice of exclusive breastfeeding for the first six months of life, and another 5% through the universal practice of appropriate complementary feeding. (LANCET 2003, India analysis 2004).Special care is needed for those who are preterm/ small/ sick and cannot suckle at breast.

Complementary feeding at the age of six months with age - appropriate nutrient - dense complementary foods with increased quantity, density and frequency as child grows is essential for normal growth of the child. Training of Front line worker (FLWs) on active and responsive feeding by the caregiver under IYCF and Mother's Absolute Affection (MAA) will be taken up on priority.

Incentive @ Rs 100/- for exclusive breastfeeding shall be given to mother and the output indicator shall be doubling of birth weight at specified age (corrected age). Similarly,@ Rs 100/- incentive to mother for starting complementary feeding after 6 months of age along with breast feeding shall be given with Output Indicator as tripling of birth weight at specified age (corrected age) after validation by AWW & ASHA worker.

Similar incentive @ Rs 50/- will be given to ASHA and AWW each for promoting and assisting exclusive breast feeding including Kangaroo Mother Care (KMC) and Expressed breast milk for the first six months of life and @ Rs 50/- will be given to ASHA and AWW each on tripling the birth weight at specified age (corrected age) by initiating and promoting complementary feeding by ensuring consumption of supplementary nutrition from 6 months of age, in addition to breast feed.

CHAPTER 5

INTERVENTIONS FOR ANAEMIA IN CHILDREN AND ADOLESCENT GIRLS

The prevalence of anaemia in children (6-59 months) has increased from 53.7 % in NFHS-4 to 55.4 % in NFHS-5. Similarly anaemia in women (15-19 years) has increased from 52.7 % in NFHS-4 to 53.2 % in NFHS-5. Though prevalence of anaemia has decreased in pregnant women (15-49 years) from 50.4 % in NFHS-4 to 42.2 % in NFHS-5 respectively

5.1 STRATEGIES TO PREVENT ANAEMIA

In community settings, there are high chances of missing anaemia in children, adolescent girls and women, if only clinically assessment is relied upon by health care workers. Further, the traditionally used Sahli's method is a way to determine haemoglobin estimation which is a laborious, subjective and time consuming for screening of anaemia in the community. Hence, the Anaemia Mukt Bharat strategy adopts the following interventions:

a) Prophylactic Iron and Folic Acid supplementation
b) Deworming
c) Intensified year - round Behaviour Change Communication Cam paign focusing on four key behaviours:
    i. Improving compliance to Iron Folic Acid supplementation and deworming
    ii. Appropriate infant and young child feeding practices
    iii. Increase intake of iron-rich food through diet diversity/quantity/ frequency, and / or fortified foods with focus on harnessing locally available resources and
    iv. Ensuring delayed cord clamping (umbilical cord isn't clamped immediately) after delivery by 3 minutes in health facilities.
d) Testing and treatment of anaemia, using digital methods and point of care treatment, with special focus on pregnant women and school-going adolescents
e) Mandatory provision of Iron and Folic Acid fortified foods in Government-funded public health programmes
f) Intensifying awareness, screening and treatment of non-nutritional causes of anaemia in endemic pockets, with special focus on malaria and haemoglobinopathies

In addition to the above interventions, MMBSY shall deploy the following technological & IEC strategies:

a) Digital Hemoglobinometer can be used as rapid, convenient, and accurate method of Haemoglobin estimation. Under MMBSY, it is proposed to use Digital Hemoglobinometer in three age groups:

- Pre School children aged 6 months to 59 months
- Children aged 5-9 years.
- School-going and out of school Adolescent boys and girls aged 10-19 years.

b) Digital Haemoglobinometers shall be provided to Primary Health Centres and RBSK teams. School and AWC enrolled children will be screened by the RBSK mobile teams.

c) Schools should sensitize the students and parents about the planned check-up, and importance of diagnosis and treatment of anaemia in adolescents for improvement of their overall health and performance in schools.

d) A list of the anaemic children will be prepared by the RBSK teams and shall be shared with the class teacher, who can inform the parents as well as the health centre for treatment, follow up and dietary counselling. The details of such children shall be entered in the digital application for follow up.

e) Intensified monitoring of the children detected with anaemia shall be carried out in the school-based programme, Haemoglobin levels shall be monitored every 3 monthly after initiation of treatment, and the progress maintained in the app.

f) Opportunistic screening will be done in health care facilities for all age groups.

g) Individual treatment and follow up of moderate and severe anaemic children shall be taken up.

h) Involvement of Red Cross Societies for monitoring of high risk groups.

5.2 INTENSIFIED ANAEMIA MUKT HIMACHAL CAMPAIGN

This campaign will be organized from 1st to 30th June every year in line with Jan Andolan. The detailed action plan is as follows:

- A joint action plan for screening will be developed at the Block level in collaboration with Department of Elementary Education, Higher Education, Health and WCD for the screening of the children (6 months to 9 years) and Adolescents Girls (10 years to 19 years). Block Elementary Education officer (BEEO), Block Medical officer (BMO), Child Development Project Officer (CDPO) will make the roster for the screening of children.
- During the Anaemia Mukt Himachal campaign Elementary and Higher Education Department will ensure the presence of students in schools and will counsel them on the importance of early identification of anaemia and importance of iron rich nutritious diet. Department of Women and Child Development (WCD) will also ensure optimal attendance of children in Anganwadi Centres (AWCs).

- Comprehensive testing of children of pre-primary, primary and Adolescent Girls of higher and Secondary School will be done. This shall be done by RBSK teams at Anganwadi centres and schools and Medical Officers in PHC's. RBSK team and Medical Officers will use Digital Haemoglobinometers for the screening of anaemia.
- Exclusive IEC through posters on anaemia, radio jingles, and newspaper advertisement will be done.
- Test - Treat and Talk (T3) camps will be organized at District and Block level to create awareness and early detection of anaemia through Health Department.
- Weekly progress of the campaign will be monitored by monitoring teams at District level. The monitoring teams will comprise of Chief Medical Officer (CMO), District Programme Officer-Child Health, DPO, ICDS, Deputy Director, Elementary Education and at Block Level constituting of Child Development Project Officer (CDPO), Block Medical officer and Block Elementary Education Officer (BEEO).
- DPO Child health will submit the campaign report to SPO Child Health, NHM.
- The entire activity will be reviewed after one year and the progress and the intervention done for these children will be analysed for Hb level as per their age.
- Management of anaemia will be done as per guidelines (Annexure 5)

5.3 TREATMENT AND FOLLOW UP AT COMMUNITY LEVEL

In addition to the treatment options, all low-birth weight babies, premature babies, and babies of Anaemic mother will be provided with iron drops. Further as per age specific treatment guidelines for anaemia, treatment shall be initiated by the RBSK teams and Medical Officers. The Anaemic children and adolescent girls shall be followed up after 3 months with testing by the RBSK teams / nearest public health facility.

CHAPTER 6

DETECTION OF HIGH RISK PREGNANCIES PARTICULARLY HYPERTENSION AND ANAEMIA

6.1 EARLY DETECTION OF HIGH RISK PREGNANCIES

A high risk pregnancy (HRP) is one in which the health of the mother, baby or both is in danger before, during or after birth. There are both internal and external factors that put a woman at risk during pregnancy, including existing health conditions, genetic background, age, lifestyle choices, history of pregnancy complications, and conditions that may develop with pregnancy.

In India the exact situation of HRP is unknown. However, it is estimated that about 20 - 30% pregnancies belong to the high - risk category and this is responsible for 75% of perinatal morbidity and mortality. High risk pregnancy conditions include,

- Short stature mother <145 cm
- BMI < 18.5
- Anemia
- Hypertension
- RTI/STI
- Systemic disease: Diabetes Mellitus, Heart disease, epilepsy, TB etc.

High risk pregnancy conditions may contribute adversely to pregnancy outcomes including intrauterine growth retardation, subsequent low birth weight (LBW) and childhood malnutrition. Therefore, appropriate care during pregnancy, early detection and effective management of high risk pregnancy can contribute substantially to reduction of maternal and adverse fetal outcomes.

The MoHFW had launched Pradhan Mantri Surakshit Matritva Abhiyaan in 2016. It aims to improve the quality and coverage of Antenatal Care (ANC), Diagnostics and Counselling services as part of the Reproductive Maternal Neonatal Child and Adolescent Health (RMNCH+A) Strategy. PMSMA day is celebrated on 9th of every month when ASHA is incentivised to mobilise the pregnant mothers to these health days for early detection of any pregnancy related complication. As a matter of routine, IFA tablets with 100 mg elemental Iron are given to the Pregnant Women from second trimester onwards, extending till 6 months post - delivery. In addition, Tablet Albendazole 400 mg single tablet is given on first contact with health services after first trimester of pregnancy and 360 tablets of Calcium Supplements are given before and after delivery, starting from 13 weeks onwards. Four essential ANCs are mandated in routine cases.

6.2 INTENSIFIED AND EFFECTIVE MONITORING OF HIGH RISK PREGNANCY

In case, a beneficiary is categorized as high risk pregnancy, the doctor makes note of the same in red ink on the Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) OPD slip. Record is also maintained in the PMSMA register. HRP is marked on the Mother and Child Protection (MCP) Card. Special seal shall be placed on MCP Card. In addition, ASHA submit the details of the HRP to the respective ANM, who in turn maintains an HRP Line list of her area in the prescribed register and ensures appropriate treatment and follow- up. All high-risk pregnancy cases will be linked with the nearest health institution for ensuring safe delivery after completion of pregnancy and prompt management of complications, if any.

6.3 INCREASED FREQUENCY OF ANTE-NATAL CHECK-UPS IN PREGNANCIES

Presently four ante-natal check-ups are being conducted for all pregnant women. In case of High-Risk Pregnancies as determined during PMSMA clinics or routine ANCs, the PW will be encouraged and incentivized to visit nearest Health Care facility in the last trimester, with visits on week (POG) 30, 34, 36, 38 and 40as per revised WHO ANC model, 2016. These check-ups will be conducted by Medical Officers. ASHAs and AWWs will motivate all such cases. The additional visits as mentioned above shall be documented on MCP Card in addition to traditional four Antenatal Care (ANC) Visits. Pregnant Women will be paid a travel allowance for up to 5 ANC visits @ Rs 200/ visit. Also, to engage family participation in care of high risk pregnant women, incentive of @ Rs 500/- per case shall be paid to the family (husband or guardian) when her haemoglobin reaches level of 10gm/dl or more by gestation age of 30 weeks (Annexure 3).

6.4 TREATMENT OF PREGNANCY RELATED COMPLICATIONS

This is to be done as per medical protocols at the designated hospitals with appropriate HR and other resources. Gap between identification of such facilities and communication of the same to the stake holders for early and timely referral is to be bridged during capacity building sessions. The existing delivery points will be strengthened as per SUMAN guidelines. Arrangement of immediate referral will also be ensured at these delivery points in case of requirement. Timely shift to injectable forms of iron/blood transfusion depending upon the stage of pregnancy and the degree of anaemia shall be promoted.

CHAPTER 7

TREATMENT AND FOLLOW- UP OF MALNOURISHED CHILDREN

The effects of childhood malnutrition can be devastating and permanent. Whether or not babies are well-nourished during the prenatal period can have a profound effect not only on their health status in the first year of life, but also their ability to learn, communicate, socialize, reason, and adapt to their environment.

Weight and height of children under 59 months are used as proxy measures for the general health of the entire population. Weight - for - height (wasting) provides the clearest picture of acute malnutrition in a population at a specific point in time.

7.1 DEFINITIONS

7.1.1. MODERATE ACUTE MALNUTRITION (MAM)

MAM is identified by moderate wasting, i.e. Weight for Height (WFH) between-2 and -3 Z-score (SD) for children 0-59 months and maternal mid-arm circumference (MUAC) between 11 cm to 12.5 cm.

7.1.2. SEVERE ACUTE MALNUTRITION (SAM)

SAM is identified by severe wasting with Weight for Height WFH Z score below-3 SD of the median WHO child growth standards for children 0-59 months, or MUAC <11.5 cm or presence of bilateral pitting oedema.

7.2 MEASURES/ PROGRAMS BEING IMPLEMENTED IN THE STATE TO DIAGNOSE AND TO TREAT MALNUTRITION AMONGST CHILDREN

1. Department of Health and Family Welfare is working in close association with Department of Women and Child Development on Early identification of SAM / MAM children at community level and facilitating timely referral and treatment. For this a Joint Signatory Standard Operating Procedures (SOPs) has been developed and circulated to all the stakeholders.

2. State has established NRCs at district / Zonal Hospital / Medical College with the appointment of district nutritional counsellor / RMNCH + A counsellor. Nutrition counsellors screen most children visiting the paediatric OPD for MAM/SAM. They also play role in promoting early and exclusive breast feeding, and work closely with the paediatrician in diet management of SAM cases admitted in NRC.

7.3. ADDITIONAL MEASURES PROPOSED

In addition to the current measures, additional actions are proposed under the campaign as follows:

1. AWW will mobilize such suspected children to the Medical Officer of nearby health facility for further assessment and examination.
2. Medical Officers at nearest facility shall monitor and examine these suspected SAM/MAM children before 25th of every month subject to the number of children mobilized by AWW and provide necessary treatment management or referral.
3. Medical officers shall do group counselling of parents/guardians when they come along with the SAM/MAM children for examination and tell them about locally available nutritious diet.
4. All the confirmed MAM/SAM children shall be mobilized / referred to higher health facilities in coordination with NRC head/ paediatrician specifying that these children shall be given priority. Mobilization of these referred children shall be done by CDPO though Supervisors/AWW for health camps being organized by HFW or to NRCs and SMOs shall coordinate with paediatrician /NRC facility.
5. The calibration of the equipment in the AWC shall be ensured by WCD Department.
6. The AWW shall monitor the progress or deterioration in health, if any, of SAM and MAM children during home visits twice a month. The ICDS Supervisors at sector level shall review the follow-up status of SAM/MAM with AWWs. ASHA shall monitor follow up discharged SAM children till recovery as per HBNC/HBYC protocol. Growth progress shall be recorded in growth chart/MCP card/POSHAN Tracker app.
7. Nutritional counsellor/RMNCH+A counsellor at NRC shall be responsible for coordination with ASHA for follow up of diet of the identified SAM child at home and up- keep of the records.
8. The mother accompanying the malnourished child shall be incentivized and facilitated. Travel support @ Rs 250 each for two attendants for tentative 8 NRC follow up visits will be provided.
9. Incentive to mother for up to 5 kg gain in weight of SAM/MAM child @ Rs 200 per kg gain shall be given.
10. Incentive to ASHA & AWW for 8 NRC follow up visits @ Rs 150/- per child shall be provided.

7.4 REVIEW AND MONITORING MECHANISM

1. A quarterly meeting of BMO and CDPO along with their Supervisors shall be organized. This meeting should be held every month to ensure the coordination at block level between WCD and HFW department with the following common objectives:

    - To reduce the prevalence of malnutrition amongst children.
    - Line list of suspected SAM / MAM children with recorded anthropometric measurement to be shared by CDPO with BMO at block level for reporting and analysing data at their end.
    - Issues of forward and backward linkages to be sorted out
    - Review the follow up of discharged SAM children and their current status
    - ATRs from previous meetings
    - Any other item deemed fit to achieve the objective.
    - BMO office shall draw the minutes of the meeting.

2. A district level quarterly meeting by the CMO with DPO-CH, DPO-CP and DPO-WCD in presence of NRC head /District Hospital Paediatrician shall be conducted.
3. The data regarding the identification, examination, treatment and follow up of all the SAM/MAM children in the State shall be shared by the Districts with their respective State headquarters on a monthly basis as per format that may be prescribed by the Departments This data shall be shared between the WCD and NHM departments at the State level every quarter for reconciliation and mid-course correction required if any.

The SOP as detailed above shall be operationalized effectively. Existing NRCs shall be strengthened to cater quality care to admitted children.

CHAPTER 8

SOCIAL AND BEHAVIOUR CHANGE COMMUNICATION

The interventions designed to tackle malnutrition need an inherent component of awareness creation, sensitisation and changing behaviours (adoption of healthy behaviours) through holistic, multifaceted & sustained social and behaviour change efforts at individual, family, community and systemic level. The seventh pillar of MMBSY is the behaviour change strategies. Under this scheme, a strategic framework shall be laid down with the following key objectives:

- Increased recognition of the impact of malnutrition across sectors in the State.
- Call to action 'for each sector's contribution to reducing malnutrition.
- Mobilize multiple departments, sectors and communities towards adopting healthy nutrition behaviours with focus on ***'Purak Ahaar'.***
- Build knowledge, attitude and behavioural intent to practice optimal breastfeeding, complementary feeding, protein rich food, maternal nutrition and adolescent, nutrition practices to prevent malnutrition, including SAM, diarrhoea and anaemia.

8.1 APPROACHES OF SOCIAL AND BEHAVIOUR CHANGE COMMUNICATION

Socio - ecological model of social and behaviour change communication, interpersonal communication, group communication, community mobilisation, advocacy, community engagement, partnerships and convergence integrated with nutritional approaches viz., life cycle approach or first 1000 days of life.

8.2 TARGET GROUPS

i) **Primary target group:** caregivers of young children, adolescent girls, pregnant and lactating women.

ii) **Secondary target group:** family members, frontline workers, community stakeholders – PRI members, school authorities and teachers, caste leaders, religious leaders and sanitation volunteers.

iii) **Tertiary target group:** Health facility staff and officials, line department officials, CSOs representatives, VHSNCs, training institute staff, administration officials, health bodies/associations, media, celebrity ambassadors and policy makers.

8.3 THEMES AND MESSAGES FOR SBCC:

Themes and messages for SBCC will be nutrition specific (complementary feeding, vitamin A & zinc supplementation etc.) and nutrition sensitive (maternal health, water sanitation & hygiene, early childhood development etc.) the targeted approach shall be broadly categorized into general and specific measures. General measures will focus on nutrition supplementation and ***'Purak Ahaar'*** of the target beneficiaries. Specific measures will be used for high-risk group beneficiaries (SAM/ MAM or anaemic).

8.4 OPERATIONALIZING THE STRATEGY

State SBCC plan defining the role and responsibilities of functionaries, ensuring community engagement utilizing platforms through localized and contextual SBCC material will be laid down with the help of our strategic partners viz. NITI Aayog and UNICEF. Time bound activities will be undertaken leveraging existing festivals and events at State, district and sub-district levels.

8.4.1 COMMUNITY BASED EVENTS (CBES)

Community Based Events will be organized at Anganwadi level once in two months in which ASHA workers, ANMs, Supervisors, CDPOs, Medical Officers, DPOs etc. will also participate. During these CBE's, PW, lactating mothers and other caregivers including husband, father, mother-in -law & sister- in- law etc will be made aware about:

- **Pregnant Mothers:**
  - Antenatal check-up,
  - Diet of pregnant women,
  - Calcium supplementation,
  - Institutional delivery & early initiation of breastfeeding.
- **Neonates:**
  - Optimal breastfeeding
  - Feeding of small babies (expression of milk, spoon feeding)
  - Kangaroo Mother Care
- **Infants (Complementary feeding):**
  - Protein rich food.
  - What food items / recipes are suitable (suji, dalia, khichari, mashed banana etc.)
  - What consistency (semi-liquid)
  - How often to feed
  - How much to offer each time

- How to ensure feeding sessions for interaction and early childhood stimulation
- Concept of energy density by adding butter / oil
- How to prepare feeds using THR
- Annaprashan

- **Infants and Children:**
  - Full immunization & vitamin A supplementation,
  - Growth monitoring and promotion,
  - Food fortification and micronutrients,
  - Diarrhoea management,
  - Malaria management and prevention,
- **Anaemia:**
  - Anaemia prevention in children, adolescent girls and women– diet, IFA, deworming
- **General:**
  - Quality health services,
  - Food security,
  - Girls' education, diet and right age at marriage,
  - Hygiene, sanitation and safe drinking water.

8.4.2 VHSNDS:

Village Health, Sanitation and Nutrition Days (VHSNDS) are currently being conducted on monthly basis by department of Health and Family Welfare, in coordination with Department of Women and Child Development. Community members are involved and various health topics are discussed. For the next one year, VHSNDs will be synergised and will mandatorily include POSHAN. VHSNDs will be celebrated in addition to Community Based Event (CBE), and preferably in areas that could not be reached through CBE.

The topics to be included are as follows:

a) ***Vyanjan Pradarshani:*** Promotion of nutritious foods from locally available, economically feasible and culturally acceptable methods will be done through a demonstration which will be held every month in every synergised VHND. This will be done with the help of self - help groups with mothers and other ladies and care takers at homes.

- POSHAN Vishay par Charcha: Debates will be held with villagers as participants (preferably pregnant women and Lactating mothers or adolescent girls). Topics pertaining to nutrition like importance of IFA tablets, balanced diet, importance of green vegetables, ill effects of junk food etc will be taken up to create awareness on importance of nutritious food and special focus on Purak Ahaar, myths vs real facts:

  - What food items / recipes are suitable (Suji, dalia, khichari, mashed banana etc.)
  - What consistency (semi-liquid)
  - How often to feed
  - How much to offer each time

- How to ensure feeding sessions for interaction and early childhood stimulation
- Concept of energy density by adding butter / oil
- How to prepare feeds using THR

Department of Education will help department of Health and Family Welfare and WCD in organizing debate competitions.

b) Vyanjan Jhanki: All districts have Medical Mobile Units / MMMC that is equipped with TV/AV aids. CMO will plan the mobilisation of these vans to remote areas/ high priority areas on VHSNDs. Visual content in the form of small videos will be shown to the participants on importance of nutritious diet for pregnant women, lactating mothers and young children, home based cooking of nutritious food, importance of IFA and community - based detection of signs of malnutrition and minor illness. Whatsapp group at block level will be created by ASHA to be in touch with pregnant women and mothers.

c) Vazan Tyohar: The community shall be involved in 'Vazan Tyohar' viz. weighing of children on 15th of every month in AWCs. The ASHA workers and ANM will play active role in this event. After every 'Vazan Tayohar', the Anganwadi Workers shall display the picture of healthy child to motivate other parents to compete for making their child healthiest by adopting the advised practices.

8.4.3 ROUTINE IMMUNIZATION DAYS:

Routine Immunization days are the platforms where beneficiaries, who are also the target population for interventions under MMBSY. Mother Child Protection Card is an essential logistic that is brought along on RI days. MCP Card is a booklet that has provision to record the ANC check-ups, PNC check-ups and Routine Immunization (RI) doses. In addition, these cards have pictorial and linguistic columns on Mother and child-care, including nutrition. These cards may be used as IEC material and mothers made to go through the contents of the card on RI days gatherings.

8.4.4 PRADHAN MANTRI SURAKSHIT MATRITVA ABHIYAAN (PMSMA):

PMSMA shall be celebrated on 9th of every month (or next working day if 9th is a holiday/Sunday) in which all pregnant mothers gather for their routine check-ups at a facility not less than Primary Health Centre where at least a Medical Officer is posted. Focus is kept on early identification of High-Risk pregnancies. ASHA is already given incentive for mobilising the PW for ANC.

Facilities running PMSMA day are proposed to own an LCD monitor, preferably placed in the waiting area of these PW to run videos on care during and after pregnancy, safe delivery methods, promotion and of institutional deliveries/ SBA and importance of birth vaccination doses as early as possible, importance of early initiation of breast feeding and maternal danger signs during pregnancy and post-natal period and neonatal danger signs during early days of life etc. In addition, 'First 1000 days' booklet has been designed by the State that will be distributed to all the pregnant women.

8.4.5 SOCIAL AND ELECTRONIC MEDIA

Social and electronic media platforms will be used for sharing videos and audios specially prepared for mother and child health care including nutrition and early identification and treatment of illnesses. Publicity of such content can be done using ECD call centre and IEC wing of NHM and WCD. Special focus will be given to check and identify the false information being circulated through social platforms.

8.4.6 ECD 104 CALL CENTRE:

Early Childhood call centre (ECD) 104 call centre has been established in Himachal Pradesh. It focuses on importance of the first 1000 days (from pregnancy period till child completes two years of age) and aims at counselling the pregnant women for DO's and DON'Ts during pregnancy and how to bring up the child during first two years of life which form the basis for physical and mental health of the child. Total 14 outbound calls are made during the first 1000 days (270 days during pregnancy + 730 days after birth). Content of calls are as follows:

8.4.6.1. DURING PREGNANCY:

- Importance of first 1000 days
- Concept of flavour bridge (eat leafy vegetables & variety of food so that baby develops the flavour and attachment to that food)
- At six months of intrauterine life the child's hearing sense develops and now parents should start talking to the child that helps in bonding of the child with parents.
- Choose birth companion beforehand of delivery
- Don't opt for caesarean unless advised by doctor

8.4.6.2. AFTER BIRTH OF CHILD:

- Exclusive breastfeeding for 6 months of child.
- Provide support for feeding of low birth weight baby (Expression of milk, spoon feeding)
- Kangaroo mother care for low birth weight babies
- Start complementary feeding after six months of age and breastfeeding to be continued for at least first two years of life.
    - Explaining details about *Purak Ahaar:* What food items / recipes are suitable (suji, dalia, khichari, mashed banana etc.); What consistency (semi-liquid); How often to feed; How much to offer each time; How to ensure feeding sessions for interaction and early childhood stimulation; Concept of energy density by adding butter / oil; How to prepare feeds using THR

- Importance of immunization and to check the status of child's immunization.
- Brief about the childhood milestones and advice to contact health beneficiaries if the child doesn't achieve the age-appropriate childhood moment.
- Don't give violent toys to child instead give creative toys to help child to learn.
- Don't compare the child with other children.
- Don't shame the child in front of others.

The ECD call centre will also function as Nutrition Helpline. Four additional call centre seats will be provided for this. The Call Centre will provide helpline services to all pregnant and lactating mothers regarding breast feeding, complementary feeding, early red flag signs of Diarrhoea and Pneumonia.

8.4.7 RBSK TEAM VISITS IN SCHOOLS

Rashtriya Bal Swasthya Karyakram (RBSK) is run by National Health Mission, which aims at screening and early detection of early childhood diseases, deficiency, defects and disabilities. Mobile teams are in place, consisting of Medical Officers, Pharmacist and an ANM. These teams conduct screening in schools of their areas on annual basis and bi-annual basis in AWCs. These teams are an essential source of IEC and can be strengthened to take up sessions on Nutrition in school assembly and in Anganwadi centres in coordination with the Department of Education and WCD.

Additionally, these teams will be strengthened to supervise the workflow and progress of WIFS in schools and to educate mothers of children under five on importance of administration of bi-weekly IFA syrup.

8.4.8 SPECIAL AWARENESS DRIVE FOR DIARRHOEA AND PNEUMONIA

The early detection of these diseases is essential in combating malnutrition as well as saving precious lives of children. Dedicated IEC plan shall be prepared containing all red flag signs of Diarrhoea and Pneumonia. LED screens shall also be installed in health institutions displaying IEC pertaining to child health and malnutrition.

8.5 SUPPORT FROM DEVELOPMENT PARTNERS

Development partners such as UNICEF etc. shall be providing the necessary support for developing the behaviour change communication strategy, and help in its operationalisation, monitoring, evaluation and documentation of achievements and good practices.

CHAPTER 9

CAPACITY BUILDING

Capacity building is an essential aspect of all fresh initiatives in Government. Trainings of all concerned Departments will be done jointly by Department of Health & Family Welfare and Women and Child Development.

9.1 INDUCTION TRAINING

Under MMBSY, two days induction training will be done in cascade manner to prepare TOTs at District and Block level, who will further train all stakeholders like Anganwadi workers, AWCs, ASHA, school teachers, members of PRI, SHGs. The training will be held on following components (Annexure 1):

1. Institution based anthropometry (technique for measurement of height, weight, head circumference), its recording in growth charts/ available software and reporting for further management, if needed.
2. Screening and referral mechanisms for malnourished children in community
3. Eat Right: Healthy dietary habits for SBCC activities and counselling of beneficiaries in need.
4. Screening of anaemia and community-based management and follow ups
5. Safe Water, Sanitation and Hygiene practices.
6. Importance of early initiation of breast feeding and techniques for breastfeeding.
7. Exclusive breastfeeding for first six months and then complementary feeding.
8. Screening and follow up of high risk pregnancy.
9. Importance of institutional delivery and routine immunization.

Timelines for induction trainings*:

Activity *	End By Date
Development of training modules by UNICEF	20th May 2022
State Training for District ToT's	1st Week June, 2022
District Training for Block ToT's	Mid July, 2022
Field level trainings of AWW, ASHA and School teachers	31st August, 2022`

* Dates subject to approval/ clearance of competent authority.
500 batches with 30-40 participants per batch will be planned for field level trainings.

9.2 REFRESHER TRAINING

Six monthly refresher trainings of one day will be organised at district and block level for the stake holders like Anganwadi workers, ASHA, school teachers, members of PRI, SHGs (Annexure 2).

9.3 ILA-MODULES LEARNING

Module of Incremental Learning Approach (ILA) developed by the Govt. of India is an excellent tool for expanding trainings on 1000 days. Officials of WCD are already trained on these modules. Training on these modules can be extended to ASHA & SHGs through Supervisors in monthly ICDS meeting.

9.4 TRAINING OF MEDICAL OFFICERS

Advanced training of Medical Officers on various skills to tackle Diarrhoea and Pneumonia in the perJSVeral health institution for management and treatment for such sick children. They shall be trained at SAANS skill station under 'Dakshata' and NSSK by specialists.

9.5 SUPPORT FROM DEVELOPMENT PARTNERS

NITI Aayog and development partners like UNICEF will provide capacity building support to the state of Himachal Pradesh, including help with latest technological innovations and global best practices.

UNICEF and partners, including National level resource centres (National Centre of Excellence for SAM management at Kalawati Saran Children's Hospital; National Centre of Excellence and Advanced Research on Anaemia Control at AIIMS New Delhi, Institute of Economic Growth, and others) shall share available tools, materials and resources that have been developed and used in various States across various thematic areas as outlined across the seven pillars of the strategy.

UNICEF and partners shall also support State Govt. Officials to adapt the materials to the state context as appropriate, and support development of a resource pool of trainers to rollout capacity building efforts for frontline functionaries as envisaged in the strategy. The thematic areas for which such materials and tools that shall be provided by development partner UNICEF are:

- Module on addressing Early Growth Failure through intensification of Home-Based New-born Care and Home-Based Young Child Care program
- Algorithms for maternal nutrition and mental health services
- Modules on management of children with SAM and MAM including the 10 steps of management (including audio visual content) etc.

CHAPTER 10

MONITORING AND SUPERVISORY MECHANISM

A key approach under this scheme is the formulation of the Task forces at different levels. The primary objective of these Task forces shall include review of progress, identification of gaps and introduction of effective interventions as required based on specified targets. It is a flagship scheme of the State Govt. which endeavours to improve nutritional outcomes in children, pregnant women and lactating mothers. For close monitoring and periodic evaluations of the scheme, the following four tiers of monitoring system shall be formulated to achieve synergy of all interventions to effectively target malnutrition.

10.1 SUPOSHAN TASK FORCE AT DIFFERENT LEVELS

10.1.1 STATE LEVEL SUPOSHAN TASK FORCE

This task force will be chaired by the Chief Secretary to the Govt of Himachal Pradesh. Secretaries and Head of Departments of line departments like WCD, Health, Education, Rural Development and Panchayati Raj Department etc. will be the members. This task force shall be responsible for:

- Overall quarterly monitoring and review of the health & nutrition indicators shall be done at the State level.
- Bi-annual reviews of the nutritional and health indicator outcomes of the children and mother shall be done by the Suposhan task force at State level.
- Reviewing the identified reasons for the gaps.
- Identifying districts and blocks which need special attention.
- Identifying clear actions to be undertaken to address these gaps.
- Reviewing quarterly and annual targets set by districts & blocks by specifically analysing the proceedings of the meeting of Task force at district level.

10.1.2 DISTRICT LEVEL SUPOSHAN TASK FORCE:

The task force will be constituted under the Chairmanship of the Deputy Commissioner of District with representatives from departments like WCD, Health, Education, Rural Development and Panchayati Raj, Food, Civil Supplies and Consumer Affairs Department, Jal Shakti Vibhag and Directorate of Health Safety and Regulation as members. This task force shall be responsible for:

- Overall monitoring of the 7 pillars of MMBSY at District level on a monthly basis.
- Deciding the quality protein nutrition items to be provided under this programme in consultation with nutrition counsellors as per the regional food preferences of beneficiaries.
- Monitoring the management of funds received by the concerned DPO.
- Developing a transparent mechanism for procurement and distribution of special supplementary nutrition. The Task force will decide the level of procurement of items whether to be done at district/block/supervisor/AWW level.
- Approving the source of procurement of nutrition items if the procurement is done by DPO at district level.
- Quality control of food items
- Data assessment of all the blocks will be collated at this level by line Departments.
- Assessment of the gaps and lagging interventions
- Identifying the blocks which are performing poorly and thereafter, identifying clear actions to be undertaken to address these gaps
- Seeking assistance from the State for redressal of any identified gaps.
- Reviewing the quarterly and annual targets set by Blocks by specifically analysing the proceeding of the meeting at Task force at Block level.

10.1.3 BLOCK LEVEL SUPOSHAN TASK FORCE

The task force shall be constituted under the Chairmanship of the Sub Divisional Magistrate with representatives from the line departments like WCD, Health Department, Education, Rural Development and Panchayati Raj, Jal Shakti Vibhag, Food, Civil Supplies and Consumer Affairs Departments and Directorate of Health Safety and Regulation as members. This task force shall be responsible for:

- The overall monitoring of the 7 pillars of MMBSY at Block level on monthly basis.
- Approving the source of procurement of nutrition items if the procurement is done by CDPO or Supervisor or AWW Block level.
- The overall monitoring of the distribution of the food items at the block level.
- The codal formalities required for procurement of the food items shall be done by the concerned CDPO as per provisions of HPFR.

- Random testing after receipt of stock at the AWC or at the Block level. The CDPO or Supervisor shall draw the samples, as per the prescribed procedure and send the sample for testing to a FSSAI owned / registered / empanelled / NABL accredited laboratory in a quarter.
- Ensuring the quality of food items.
- An assessment of the status of key interventions will be done at the Block level in convergence with the line Departments.
- Identification of the gaps & clear actions to be undertaken.
- Redressal mechanisms.
- Quarterly and annual targets to be achieved shall be formulated at this level.
- Review quarterly and annual targets set by Panchayats by specifically analysing the proceeding of the meeting of task force at Panchayat level.

10.1.4 PANCHAYAT LEVEL SUPOSHAN TASK FORCE

The task force will to be constituted under the Chairpersonship of the Pradhan with Panchayat Secretary / Panchayat Sahayak, parents of AWCs, Primary School Teacher, Ward members of concerned Panchayat, ASHA workers, Anganwadi Workers etc as members. This task force shall be responsible for:

- Monitoring of the distribution of the special supplementary nutrition to the children and mothers in their Panchayat.
- Regular checking of the Anganwadi Centres
- This Task force shall meet on monthly basis to discuss nutritional and health status of children and mothers in their Panchayats.
- Developing Redressal mechanisms
- Seeking assistance from the block for any problem being faced at Panchayat level.

10.2 MONITORING TOOLS

POSHAN Tracker application has been developed by the Ministry of Women and Child Development & is being used by the Directorate of WCD. This tracker records the growth of a child till age of 5 years. However, in the current scenario, not all children under 6 years go to Anganwadi centres (whether enrolled or not). In Himachal Pradesh there is an increasing trend of enrolling child to private schools for pre-primary sections (play schools, nursery and kindergarten). Primary sections in government schools have also started pre-primary classes. These are the children that get missed on routine anthropometry, and hence in early detection of malnutrition. Involvement of Department of Education across all State Govt., Central Government and private schools is needed.

Health Department will play a role in in identifying and training nodal teachers in every school. Provision of growth chart/ development of POSHAN Tracker like app/ extension of POSHAN Tracker app is needed for reporting and follow-up. Linkage between the screening, diagnosis, treatment and follow up through digital platform is advocated. Government of India will be requested for early development of such a platform.

MMBSY will involve development of a simple application which captures the integrated data from the field and allows dynamic updation of the same. This application shall assist monitoring of high risk groups such as high risk pregnancies, low birth weight babies and severe and moderately acute malnourished children and tracking of THR.

Mother Child Protection Cards (MCP Cards) are in practice through Department of Health & Family Welfare. These cards are used as means of verification during NFHS Survey. This MCP Card documents all the services taken by a beneficiary (Mother or her Child). ANC Services and due services, HBNC & HBYC visits along with Syrup IFA implementation and growth monitoring must be filled in by the service provider and will be used for incentive release purpose.

RCH Portal is developed by Ministry of Family & Health Welfare and being currently in use by Deptt. Of HFW where all the services as documented on MCP Cards have to be entered by concerned ANM/HW/BPM so that the services due could be monitored for mother and child. Any future portal replacing RCH portal will be accepted as per the directions of Ministry of H&FW.

10.3 MONITORING AND EVALUATION

- Under the Mukhya Mantri Baal Suposhan Yojana, (MMBSY) program review meetings for 7 pillar based outcomes will be conducted at State, District and Block Level.
- On a quarterly or biannual basis, bottleneck analysis exercises (also called intervention validation exercises) with districts as units will be held. In each round, select (1-2) districts will be chosen for assessments. The findings from such exercises will be used for validation of reported data and to assess the bottlenecks for priority corrective actions.
- UNICEF will provide the technical assistance for carrying out the exercise/survey.

ANNEXURE 1

Agenda for Induction training for ASHA/ AWW/ School Teachers/PRIs and SHGs

Day -1		
S. No.	**Topic**	**Timings**
1	Registration & welcome to participants	10:00 am to 10:30 am
2	ANC schedule and Importance of 1000 days (Early Childhood Development)	10:30 am to 11:30 am
Tea Break		**11.30 am 11.45 pm**
3	Care of new born at Home	11:45 am to 12:30 pm
4	Immunization	12:30 pm to 1:15 pm
Lunch break		**1:15 pm to 2:00 pm**
5	Early initiation of breastfeeding, exclusive breastfeeding up to 6 months of child Positions, attachment, and problem management	2:00 pm to 3:00 pm
6	Hygiene, sanitation, and safe drinking water	3:00 pm to 3:30 pm
Tea Break		**3.30 pm to 3.45 pm**
7	Identification and management of Danger signs of Diarrhoea, timely referral	3:45 pm to 4:15 pm
8	Care of LBW and preterm babies	4:15 pm to 5:00 pm
Day-2		
S. No.	**Topic**	**Timings**
1	Growth Monitoring and anthropometry measurement	10:00 am to 11:15 am
Tea Break		**11:15 am to 11.30 am**
2	Training on MMBSY Software and record keeping	11:30 am to 1:15 pm
Lunch break		**1:15 pm to 2:00 pm**
3	Role of Nutrition and Locally available nutritious food	2:00 pm to 3:15 pm
4	Counselling of mothers on creative cooking and healthy cooking	3:15 pm to 3:45 pm
Tea Break		**3:45 pm to 4:00 pm**
5	Follow-up of SAM/MAM children	4:00 pm to 5:00 pm

ANNEXURE 2

Agenda for One Day Refresher training for ASHA/ AWW/ School Teachers/PRIs and SHGs

S. No.	Topic	Time
1	Registration & welcome to participants	10:00 am to 10:15 am
2	ANC schedule and Importance of 1000 days (Early Childhood Development)	10:15 am to 10:45 am
3	Care of new born at Home, Care of LBW and preterm babies	10:45 am to 11:15 am
Tea Break		11:15 am to 11:45 am
4	Immunization	11:45 am to 12:30 pm
5	Early initiation of breastfeeding, exclusive breastfeeding up to 6 months of child Positions, attachment and problem management	12:30 pm to 1:30 pm
Lunch Break		1:30 pm to 2:00 pm
6	Growth Monitoring and anthropometry measurement	2:00 pm to 2:30 pm
7	Early Identification of danger signs of diarrhoea and Pneumonia and timely referral	2:30 pm to 3:00 pm
Tea Break		3:00 pm to 3:30 pm
8	Software and data keeping	3:30 pm to 4:00 pm
9	Counselling of mothers on creative cooking, role of nutrition and locally available nutritious food	4:00 pm to 4:30 pm
10	Follow up of SAM/MAM children	4:30 pm to 5:00 pm

ANNEXURE 3

Budgetary Heads

S. N.	Pillar	Activity	Incentive/ cost (In Rs)	Unit	Funds Liability	Total amount	Remarks
1	Early detection and treatment of Diarrhoea and Pneumonia	Pulse oximeter	1500	2100	NHM	3150000	For all subcentres
2	Intensified monitoring and care of identified high risk groups	Vitamin D for LBW child up to 1 year of age	60	12000	NHM	5760000	8 bottles per child till the age of 12 months (@ 400 IU/day) per child
3		Travel allowance for up to 2 attendants for every follow up of SNCU graduate @ Rs 100 per head tentative 4 visits	200	10000	State Govt.	8000000	Approximate annual SNCU admissions are 10000. Follow up till 1 year of age (tentative 4 visits)
4		IFA drops for LBW	8	12000	NHM	192000	2 bottles per LBW child up to age six months
5		Incentive for ASHA for additional 6 HBNC visit	200	14000	State Govt.	2800000	For SNCU graduates/LBW /Preterm
6		Incentive to AWW for three additional visits for LBW and SNCU graduates @ Rs 100 per visit per child on day 11, 35 and 60 days of life	100	14000	State Govt.	1400000	These visits will be in addition to the existing 5 visits under AWW mandate within 30 days of life.
7	Special SNP-addition of protein rich food for high-risk children and improved feeding practices	Incentive to mother for exclusive breast feeding and age specified doubling of weight of the child	100	95244	State Govt.	9524400	Output Indicator will be doubling of birth weight at specified age and will be validated by ASHA

8		Incentive to mother for starting Complementary feeding at 6 months age specified tripling of weight of the child	100	95244	State Govt.	9524400	Output Indicator will be increase in three times of birth weight at specified age and will be validated by ASHA
9		Incentive for ASHA& AWW for doubling of age specific weight @ Rs 50/-each	100	95244	State Govt.	9524400	Output Indicator will be doubling of birth weight at specified age
10		Incentive to ASHA & AWW for ensuring age specific tripling of birth weight @ Rs 50/- each	100	95244	State Govt.	9524400	Output Indicator will be increase in three times of birth weight at specified age
11		SNP for 6 months to 6 years	8	396754	State Govt.	304707072	Per child twice in a week viz.96 days in a year
12		SNP for Pregnant women and lactating mother	8	81909	State Govt.	62906112	Per mother (excluding HRP) twice in a week viz.96 days in a year
13		SNP for Severely acute malnourished children (SAM)	12	912	State Govt.	3283200	Per child 6 days in a week viz 300 days in a year
14		SNP for Moderately acute malnourished children (MAM)	12	5169	State Govt.	18608400	Per child 6 days in a week viz 300 days in a year
15		SNP for High Risk Pregnancies (HRP)	12	13335	State Govt.	48006000	Per child 6 days in a week viz 300 days in a year

16	Interventions for Anaemia in children and adolescent girls	Purchase of Haemoglobin ometers	744	15000	NHM	11160000	Cost includes cost of machine and strips. 144 units o be purchased for RBSK and 600 for PHCs
17	Detection of High-risk pregnancies particularly Hypertension and Anaemia	Incentive to PW for increasing Hb equal to or more than 10gm/dl by 30 weeks POG	500	12058	State Govt.	6029000	Incentive to be given to Husband/ Family member to ensure family participation.
18		Transport charges for HRP PW for follow up in health facilities (average 5 visits in 3rd trimester per HRP with approx TA 200 Rs per visit)	200	13335	State Govt.	13335000	14% of pregnant women i.e 13335 falls under High Risk
19	Treatment and Follow-up of malnourished children	Travel allowance for up to 2 attendants for every follow up of SAM case to NRC @ Rs 250 per head	500	912	State Govt.	3648000	Tentative 8 NRC visits
20		Incentive to mother/ guardian for every kg increase in weight of SAM child @ Rs 200 per kg	200	912	State Govt.	912000	Expected MAM/SAM population based on previous records expecting average weight gain of 5 kg per child

21		Incentive to ASHA & AWW for 8 NRC follow ups @Rs 150 per child per follow up	150	912	State Govt.	2188800	Incentive to be given to both AWW and ASHA @ Rs 150 each per child
22	Social and Behaviour change strategies	1000 days booklet for pregnant women	400	95244	NHM	38097600	Printing Cost @ Rs 400 per booklet
23		Development of IEC materials including films and pamphlets for all possible platforms like wards/ OPDs/ MMU/ Health Days/ RI days	1000000	1	NHM	1000000	Purchase of Pen drive, development of IEC material, printing of pamphlets
24		Nutrition helpline 4 seaters	30000	4	NHM	1440000	For additional 4 seats for nutrition helpline at ECD 104 call centre
25		Purchase of LCD Monitors for IEC	50000	100	NHM	5000000	To be purchased for Maternity wards, paediatric wards, Paediatric OPD and maternal OPDs (PMSMA Clinics) where monitors are not available at present (40-55")
26		Printing of growth chart booklets for up to 5 years	200	15000	NHM	3000000	Per booklet 15 pages per ASHA/AWW/ Nodal teacher
27		Purchase of Head circumference measuring tapes @ 40/- per stake holder	40	23000	NHM	920000	Head circumference tape, to be provided to all stake holders

28	Capacity Building	10 days Training for MOs	25	390425	NHM	9760625	10 days training to prepare Master trainers for implementation & sensitization training of field staff
29		Induction trainings for 2 days for ASHA/ AWW/ Nodal Teacher (30-40 participants per batch) including expenditure on resource persons	54400	500	NHM	27200000	Approx500 batches with Rs 54400 expenditure per batch for a total cohort of 20000 participants for 2 days
30		Half Yearly refresher trainings for 1 day for AWW/ ASHA/Nodal teachers (40 participants per batch)	27200	500	NHM	27200000	Rs 150 honorarium +Rs 100 stationary + Rs 200 for lunch +Rs 200 TA per participant = 650*40= Rs 600 per trainer = 27200 per day per batch
31	Monitoring and Supervisory Mechanism	Development of Software	600000	1	NHM	600000	App will use UHIDs already created in POSHAN Tracker app and will have access to users like AWW, ASHA and Nodal Teachers and will have Admin rights for block,
							district, and State level officers
Total						**64,84,01,409/-**	

ANNEXURE 4

Funds Liability Department wise:

Department	Funds Liability (INR):
State Govt.	51,39,21,184/-
National Health Mission	13,44,80,225/-
Total	**64,84,01,409/-**

Expenditure Head	Amount
Department of Health & Family Welfare	20,94,90,625/-
Department of Women and Child Development	43,89,10,784/-

ANNEXURE 5

Treatment protocol of Anaemia in various age groups (AMB Guidelines)

a. Management of anaemia on the basis of Haemoglobin levels in children 6 months – 10 years

Level of Hb	Treatment	Follow up	Referral
Mild Anaemia	3 mg of iron/kg per day for two months	every 14 days, Hb estimation after end of 2 months of treatment to document Hb>11 gm/dl	In case inadequate/ no response to treatment for 2 months refer the child to FRU/ DH
Moderate Anaemia	3 mg of iron/kg per day for two months	every 14 days, Hb estimation after end of 2 months of treatment to document Hb>11 gm/dl	In case inadequate/ no response to treatment for 2 months refer the child to FRU/ DH
Severe Anaemia	Refer urgently to DH/ FRU		

b. Management of anaemia on the basis of Haemoglobin levels in children 10 -19 years

Level of Hb	Treatment	Follow up	Referral
Mild Anaemia	60 mg elemental Iron daily for 3 months	Every month, Hb estimation after end of 3 months of treatment to document Hb>12 gm/dl	In case inadequate/ no response to treatment for 3 months refer the adolescent to FRU/ DH
Moderate Anaemia	60 mg elemental Iron daily for 3 months	Investigate Follow up every 14 days, Hb estimation after end of 3 months of treatment to assess if Hb>12 gm/dl	In case inadequate/ no response to treatment for 3 months refer the adolescent to FRU/ DH
Severe Anaemia	Refer urgently to DH/ FRU		

c. Management of anaemia on basis of haemoglobin levels among pregnant and lactating mothers

Hb level	Level of facility	Therapeutic Regimen
9-11 gm/dl	**Sub Centre** Signs and symptoms (generalised weakness, giddiness, breathlessness, etc.) Clinical Examination (pallor eyelids, tongue, nail beds, palm etc.) Confirmation by Laboratory testing	**Hb level between 9-11 gm/dl** 2 IFA tablets per day (morning-evening) for at least 100 days. Reassess Hb levels at monthly intervals. If on testing Hb has come up to normal level, discontinue the treatment. If not, refer to higher facility
7-9 gm/dl	**PHC/CHC** Signs and symptoms (generalised weakness, giddiness, breathlessness, etc.) Clinical Examination (pallor eyelids, tongue, nail beds, palm etc.) Confirmation by Laboratory testing	**Hb level between 8-9 gm/dl** Before starting treatment assess cause. 2 IFA tablets per day (morning-evening) for at least 100 days. Reassess Hb levels at monthly intervals. If on testing Hb has come up to normal level, discontinue the treatment. If not, refer to higher facility **Hb levels between 7-8 gm/dl** Assess cause before starting treatment. Injectable IM with oral folic acid if IDA is the cause. Repeat Hb after 8 weeks. Discontinue if Hb>11 gm/dl, IFA oral 100 mg BD if between 9-11 gm/dl. If woman comes in third trimester, refer to FRU
<7 gm/dl	**FRU/DH/ MC** Signs and symptoms (generalised weakness, giddiness, breathlessness, etc.) Clinical Examination (pallor eyelids, tongue, nail beds, palm etc.) Confirmation by Laboratory testing	**Hb level between 5-7 gm/dl** Parental iron therapy (IM). Hb testing to be done after 8 weeks. Step down as per Hb levels. **Hb less than 5 gm/dl** Injection IV Iron Sucrose preparation Immediate hospitalization irrespective of period of gestation

ANNEXURE 6

Recommendation for Vitamin D-Prevention and Treatment Protocols (IAP guidelines)

Vitamin D- Prevention and Treatment			
Age	**Prevention**	**Tolerable upper Limit**	**Treatment**
Premature Neonates	400 IU/day	1000 IU/day	1000 IU/day
Neonates	400 IU/day	1000 IU/day	2000 IU/day *
1-12 months	400 IU/day	1000-1500 IU/day	2000 IU/day *
1-18 years	600 IU/day	3000 IU day till 9 years,4000 IU/day from 9-18 years	3000/-6000 IU/day *
At risk groups	400-1000 IU/day	as per age group	as per age group

*For a minimum of 3 months; after treatment, daily maintenance doses need to be given.