MOST IMMEDIATE

No.11-2/2012-ND
Government of India
Ministry of Women & Child Development

New Delhi, dated the 11th December, 2013

To

The Chief Secretaries of Chhattisgarh, Madhya Pradesh, Rajasthan and Delhi

Secretaries incharge of States/UTs dealing with ICDS of Chhattisgarh, Madhya Pradesh, Rajasthan and Delhi

Subject:- Multi-sectoral Nutrition Programme to address the Maternal and Child under-nutrition in 200 High Burden Districts – Centrally Sponsored Scheme under National Nutrition Mission – Approval thereof.

Sir/Madam,

I am directed to state that the issue of under-nutrition which affects survival, development, health, productivity and economic growth has been receiving the attention of the Government. The problem of under-nutritionis a complex and multi-dimensional issue, affected mainly by a number of generic factors including poverty, inadequate food consumption due to access and availability issues, inequitable food distribution, improper maternal infant and child feeding and care practices, inequity and gender imbalances, poor sanitary and environmental conditions; and restricted access to quality health, education and social care services. A number of other factors including economic, environmental, geographical, agricultural, cultural, health and governance issues complement these general factors in causing undernutrition of children.

2. Taking note of the problem of maternal and child undernutrition in the country, the PM's National Council on India's Nutrition Challenges in its meeting chaired by the Hon'ble Prime Minister on 24th November 2010, while making a number of valuable suggestions and recommendation for addressing the nutrition challenges in the country, inter alia decided that: *"A multi-sectoralprogramme to address the maternal and child malnutrition in selected 200 high-burden districts would be prepared….."*. The Ministry of Women & Child Development was given the responsibility of preparing the multi-sectoral programme in consultation with the Planning Commission, Ministry of Health & Family Welfare and other relevant Ministries. Consequent to the above decision and a series of consultations, the proposed framework and design of the Multi-sectoral Nutrition Programme was prepared and processed for approvals.

3. It has since been decided by the Government of India that the Multi-sectoral Nutrition Programme to Address the Maternal and Child Undernutrition will be implemented as a special intervention in 200 High Burden Districts across the country in a phased manner. The first phase will begin in 100 districts during the year 2013-14, while in the second phase, it will be scaled up to cover 200 districts during the year 2014-15. The Scheme Document detailing the various facets of the programme is at **Appendix-I**.

4. Approval of the Government of India is accordingly accorded for –

(i) Implementing the Multi-Sectoral Programme to Address the Maternal and Child Undernutrition in selected 200 High Burden Districts in the 12th Plan as per the Scheme Document at Appendix-I.

(ii) Allocation of Rs.1213.19 crore for the 12th Five Year Plan (2012-17) as a Centrally Sponsored Scheme with a Centre:State cost sharing ratio of 90:10 for all components in NER States and special category States and 75:25 for other States & UTs. Rs.944.39 crore is the Central share and the State share would be Rs.268.80 crore.

(iii) Hiring (Contractual)/outsourcing of personnel numbering a total of 14 at the national level and 5 per district (1000 personnel) at the district level.

(iv) National Mission Steering Group (NMSG) and Empowered Programme Committee (EPC and also referred to as M-EPC) constituted for ICDS Mission to be the highest administrative and technical bodies for ensuring effective planning, implementation, monitoring and supervision.

(v) Powers to approve State and District Nutrition Action Plans as per approved guidelines and overall budget of the Multi-sectoral Nutrition Programme be vested in the M-EPC.

(vi) Ministry of Women & Child Development (MWCD), Government of India would have the powers to carry out any such modifications in operational modalities as may be warranted, from time to time, for effective implementation of the Programme after due consultation and approval of the Ministry of Finance.

4.1 In continuation to this Ministry's letter of even number, dated 25th November, 2013 according approval in respect of 141 districts in all and 56 districts in Phase-I to begin with, approval is hereby also accorded for the balanced 59 districts (including 44 districts in Phase I) in the remaining States/UTs addressed herein. As per the approved scheme, the Multi-sectoral Nutrition Programme would address the maternal and child malnutrition in selected 200 high burden districts by bringing together various national programmes through strong institutional, programmatic and operational convergence at the

National, State, District, Block and Village levels. The scheme would have following objectives:

(i) Ensuring strong nutrition focus through institutional and programmatic convergence by integrating it in the planning, implementation and supervision process in all relevant direct and in-direct interventions / programmes;

(ii) Increasing availability and accessibility of key maternal and child health & nutrition services at all levels through convergence of sectoral programmes;

(iii) Bridging critical gaps in inter-sectoral programmatic and institutional arrangements for addressing maternal and child undernutrition at National, State, District, Block and Village levels leading to harmonized nutrition action plan;

(iv) Enhancing the capacities and skills of service providers, care givers, voluntary action group, mothers' groups and communities; and

(v) Ensuring convergent multi-sectoral actions for empowering families and communities for improved care behaviours such as early and exclusive breastfeeding for the first six months and optimal IYCF, health, hygiene, psychosocial and early learning and care for girls and women.

5. The approach to deal with the nutrition challenges has been two pronged: First is the Multi-sectoral approach for accelerated action on the determinants of malnutrition in targeting nutrition in schemes/programmes of all the sectors. The second approach is the direct and specific interventions targeted towards the vulnerable groups such as children below 6 years, adolescent girls, pregnant and lactating mothers. The Government is implementing several direct and indirect schemes/ programmes of different Ministries/Departments/State Governments/ Union Territory Administrations. An illustrative list of some of these is enlisted in table below para 2.4 of the scheme document.

5.1 This Multi-sectoral Nutrition Programme provides a platform at all levels to facilitate convergence of all the key activities/services and stakeholders for holistically addressing the maternal and child undernutrition. It is necessary that each programme as well as Ministry/ Department outline their multi-sectoral action required to address the given mandate towards improving nutritional impacts. Such an outline will support and complement the multi-sectoral programme to achieve the desired objectives and goals. The programme also envisages Panchayat led model and urban models.

5.2 The Programme brings in strong nutrition focus in various sectoral plans and provides for a limited gap filling support towards key nutrition related interventions. The programme targets to contribute to following outcomes:

(a) Prevention and reduction in child under-nutrition (underweight prevalence in children under 3 years of age); and

(b) Reduction in levels of anaemia among young children, adolescent girls and women.

5.3 Further, this Multi-sectoral Nutrition Programme will specifically work towards the establishment of State& District Nutrition Councils and preparing State & District Nutrition Action Plans with clear linkages to defined results and outcomes at District and State levels.

6. **Programme Components**:The Programme would focus as components on (i) Nutrition Centric Planning, (ii) Nutrition Centric/ Sensitive Sectoral Interventions and (iii) Nutrition Centric/Sensitive Gap Filling Support; besides, having monitoring, Information Education Communication (IEC), training, community mobilisation and technical support made available (*refer sections 2.6 of the Scheme document in* ***Appendix-I***).

6.1 The Multi-sectoral Nutrition programme would concentrate on key focus areas, specific roles, responsibilities and different dimensions of convergences for ensuring a strong coordinated approach for addressing undernutrition at the State, District, Block and Village levels. Specific roles and responsibilities of the major sectors / departments as both direct & indirect interventions have been outlined in the Scheme document (*refer* ***Annexure II & III*** *of the Scheme document*) as illustrative, but not being exhaustive.

6.2 The first priority would be to fill the existing gaps through resources from the sectoral plans / programmes. However, even after this, if a relevant development deficit / gap remains uncovered / unfulfilled through existing sectoral interventions, and are identified through the rapid assessment and planning process, for improving the nutrition related indicators, gap – filling support would be provided under this programme. The interventions under this component are elaborated at **Annexure IV & VI** of the Scheme document.

7. **Scope & Coverage**: Taking into consideration the available resources and also the absence of more updated data on undernutrition& anaemia (which is likely be available by early 2014), it has been decided to roll out the Multi-sectoral Nutrition Programme progressively starting with 100 high-burden districts (to commence during the year 2013-14)as per Districts indicated in **Annexure-I** of the Scheme document. These 100 districts have been selected out of the 200 high burden districts in ICDS mission using under five mortality data from AHS 2011. Remaining 100 districts would be scaled up to cover 200 districts from 2014-15 based on the number of districts capped as in ICDS mission for the 200 high burden districts as per the table given above. However, States are free to select the specific districts/ Blocks based on any available recent nutrition-specific and credible data on undernutrition and anaemia, keeping in mind that the total number of districts does not exceed the total mentioned in the table. In the absence of any data, ICDS data of undernutrition could be used to select districts/ Blocks. Further, due to unavailability of credible models and data at block level as well as available resources, **selectivecoverage approach and methodology** would be employed to intensify the focus on **covering 50% worst affected blocks**(fully or partially) within each district.

Multi-sectoral Districts Summary (Phase-1 &2)#

States/UT	No. of Districts		
	Phase 1*	**Phase 2****	**Total**
Andhra Pradesh	0	3	3
Assam	3	0	3
Bihar	12	5	17
Chhattisgarh	3	6	9
Daman & Diu	0	2	2
Gujarat	0	15	15
Haryana	0	5	5
Himachal Pradesh	0	3	3
Jharkhand	1	5	6
Karnataka	0	4	4
Madhya Pradesh	25	5	30
Maharashtra	0	20	20
Nagaland	0	1	1
Odisha	6	0	6
Punjab	0	6	6
Rajasthan	16	4	20
Uttar Pradesh	32	9	41
Uttarakhand	2	4	6
West Bengal	0	3	3
Total	**100**	**100**	**200**

*List attached in Annexure I

** List to be finalized

Apart from the above, urban models in Delhi (Delhi), Mumbai (Maharashtra), Kolkata (West Bengal) & Chennai (Tamil Nadu) will be included.

7.1 The selection of worst affected blocks within districts would be done by the District Nutrition Council on the basis of the district level data / assessment on relevant indicators concerning maternal and child undernutrition, and duly approved by the State Nutrition Council and the Multi-sectoral Empowered Programme Committee (M-EPC). Any pockets of **high vulnerability** including pockets of high burden of undernutrition, pockets inhabited by STs, SCs, etc. could also be identified and covered through the gap filling support. In addition, priority may also be accorded to areas with high burden of Japanese Encephalitis/ Acute Encephalitis Syndrome (AES) and silicosis. Further, States also have the flexibility to change Blocks during the current programme period. They can also include and exclude areas based on achievement and status of undernutrition. The States also have the flexibility and are encouraged to expand the concept of multi-sectoral convergence in other Blocks / Districts using their own

resources including resources under SC Plan, ST Plan, Border Area Plan / Integrated Action Plan/Additional Central Aid (ACA), etc.

7.2 As per the recommendations of the PM's National Council on India's Nutrition Challenges, the Government has decided that following alternative models for the decentralized implementation would also be piloted under the Multi-sectoral Nutrition Programme. States may suitably present the modalities for implementation of such pilots to the M-EPC.

(a) Urban Model: The Multi-sectoralNutrition Programme also proposes to implement nutrition focused interventions in urban areas. "Urban Models" would be piloted in select urban slums / vulnerable pockets of the mega cities of the country namely Chennai, Delhi, Kolkata and Mumbai. Innovative interventions of addressing maternal and child undernutrition would be supported. Apart from this, intervention may also be undertaken in the urban centres of the selected high burden districts by the District Nutrition Council.

(b) Rural / Panchayat Led Model: The "Panchayat Led Model" of implementation would be piloted in at least one selected block from each of the high – burden districts in which progressive and proactive devolution of fund and functions for implementation, supervision and accountability would rest with the respective PRI institutions. More blocks/ districts can be taken up by the States depending on their resources and the local context, especially where funds, functions and functionaries have been transferred by the States to the PRIs. The interventions proposed by a particular PanchayatSamiti would be reviewed and approved by the District Nutrition Council.

8. Institutional Arrangements: The institutional setup under the Multi-sectoral Nutrition Programme is same as in ICDS mission which includes National Mission Steering Group (NMSG) of ICDS Mission; (Multi-sectoral) Empowered Programme Committee (M-EPC). An Inter-Ministerial Coordination Committee (IMCC) headed by Cabinet Secretary at National level would also be created for coordination at National level. The M-EPC would meet once in 3 months. The Technical Support Unit (TSU) in the Food & Nutrition Board would comprise of 14 personnel and the administration and management of the programme will be vested in JS in-charge of FNB and Nutrition. Similarly, State Mission Steering Group (SMSG) and State Empowered Programme Committee (SEPC) of ICDS Mission will be at State level and District Nutrition Council at District level. The overall institutional arrangements under the programme is given in para 3 and **Annexure-V** of the Scheme Document.

8.1 **At the State Level**, the State Nutrition Council headed by the Chief Minister would be the highest body for providing policy directions

and oversight to the Multi-sectoral Nutrition Programme. The State Nutrition Council would be assisted by an Executive Committee headed by the Chief Secretary of the State and would comprise of Principal Secretaries/ Secretaries of all line departments concerning the Multi-sectoral Nutrition Programme.

8.2 **At the District levels**, District Nutrition Council headed by the concerned District Magistrate/ Collector would coordinate Nutrition Centric Planning, including leading the process of formulation, implementation and supervision of integrated District / Block level nutrition action plans. In every district, District Magistratewould be assisted in the task by District Planning Officer and District Programme Officer of the ICDSwith the technical support of a District Nutrition Cell created under this Multi-sectoralNutrition Programme. Each District Nutrition Cell could hire/ outsource 5 persons (1 Planning and Coordination Specialist, 1 Nutrition Specialist, 1 Monitoring & Evaluation Specialist and 2 Data Entry Operators) as per details given in section 3.2 of the Scheme document.

8.3 **At the Gram Panchayat& Village Level**, the respective Panchayat Samiti/ VHSNC (as may be decided by the concerned State Government) having jurisdiction over the concerned gram panchayat/ village may be made responsible for overall coordination and supervision of the programme. An indicative list of areas for specific action that may be undertaken by the respective Gram Panchayat/ VHSNC has been detailed out at **Annexure-VI** of the Scheme Document.

9. Monitoring and Evaluation: A robust monitoring system would be led by the National Institute of Public Cooperation and Child Development (NIPCCD) to track the progress and achievements during and after the implementation.A list of indicators for monitoring is given at **Annexure VII & VIIA** of the scheme document.

10. Financial Plan & Budget: The Multi-sectoral Nutrition Programme would be implemented during the 12th Five Year Plan as a Centrally Sponsored Scheme under the broad head National Nutrition Mission with a total cost estimates of **Rs. 1213.19 Crore** with Centre:State cost sharing ratio 90:10 for all components in NER States and special category States and 75:25 for other States & UTs. Rs. 944.39 Crore is the Central share and the Stateshare would be Rs. 268.80 Crore. Detailed budget is given at **Annexure VIII** of the Scheme document.

10.1 As per the institutional arrangement, once the State Nutrition Plan is approved by the Multi-sectoral Empowered Committee chaired by the Secretary, Ministry of WCD, the approval and sanction / budget release would be issued by the Ministry of WCD. A copy of sanction / budget release order would be sent to the concerned division for releasing the approved amount from the Consolidated Fund of GoI to the corresponding State/UT Consolidated Funds. In turn, the respective States/UTs would allocate the funds to the District Nutrition Councils

(institutional/ financial arrangement as per ICDS mission) along with the State share.

10.2 At the State / UT level, all financial powers of handling the funds for Multi-sectoral Nutrition Programme would be vested to the concerned Chief Secretary heading the Executive Committee of the State Nutrition Council (SEPC of ICDS).

10.3 At the district level, the District Nutrition Council headed by the District Magistrate/ Collector would be responsible for releasing funds to the concerned panchayats/ implementing agencies on the sanction of a particular intervention in accordance with the prescribed financial norms of the government. The fund flow mechanism has been illustrated in Chart-3 of the scheme document.

10.4 A major portion of budget has been kept for critical gap filling support. Considering the staff requirement for managing and coordinating purposes as well as for preparation of plans, hiring/ outsourcing provision has been provided at National and District levels. At State level, respective line departments may provide the necessary technical staff or a provision of professional support may be provided as per the requirement.

10.5 As per GOI policy for CSS, a flexi fund of 10% has been earmarked under this Scheme. Such a fund may be used for strengthening district level machinery/ infrastructure, engaging technical support (especially in large districts), and any other local need. However, this fund would not be used for administrative purposes.

10.6 States/UTs have flexibility in terms of earmarking this fund for different thematic areas/interventions/activities/tasks as per the requirement of State Nutrition Action Plan. Technical support may be provided for compiling and finalizing the State Nutrition Action Plan. Other activities earmarked in budget at all levels are:

- Monitoring (including supportive supervision, Surveillance system & third party evaluation)
- IEC activities
- Capacity building, training & incentivizing
- Coordination meetings, workshops and orientations for sensitization
- Community mobilization
- Hiring/ Outsourcing of personnel
- Office expenses and TA of hired personnel.

11. Further guidelines on the above components will be issued, whenever required.

12. This has been vetted by the IFD, MWCD vide their Dy.No. 1944/JS&FA/2013, dated 18th November, 2013.

Yours faithfully,

(H.S. Nanda)
Deputy Secretary to the Govt. of India
Tele.23367573

Copy to:

1. Prime Minister's Office, New Delhi
2. Cabinet Secretariat w.r.t. their Note No.CCEA/35/2013(i) dated 4.10.2013.
3. Secretary, Planning Commission, New Delhi
4. Secretary(Expenditure), New Delhi
5. Secretaries of all line Ministries/Departments
6. Sr.Adviser, WCD, Planning Commission, New Delhi
7. Advisor (PAMD), Planning Commission, New Delhi
8. JS & FA, MWCD
9. Directors (ICDS) in all concerned States/UTs
10. District Magistrates/Collectors of all 100 districts selected under Phase I
11. Director (PF-II), D/o Expenditure, New Delhi
12. All Bureau Heads in MWCD
13. Director, NIPCCD, New Delhi
14. All Directors/DSs in MWCD
15. JTA, FNB, New Delhi
16. PAO, MWCD, New Delhi
17. S.O./ Cash Section, MWCD

Copy also to:

1. PS to MOS(IC), MWCD
2. PS to Secretary, MWCD
3. PS to Addl.Secy(RP)
4. PS to Addl.Secy(PS)
5. PS to Sr.EA and MD NMEW
6. DS(IFD), MWCD

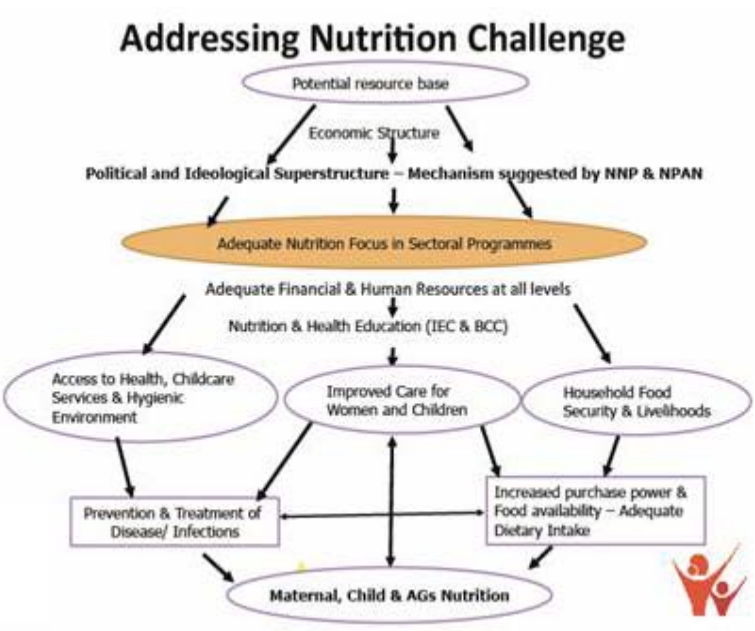
Copy forwarded in continuation to this Ministry's letter of even number, dated 25th November, 2013 for information to Secretaries incharge of States/UTs dealing with ICDS of Andhra Pradesh, Assam, Bihar, Daman & Diu, Gujarat, Haryana, Himachal Pradesh, Jharkhand, Karnataka, Maharashtra, Nagaland, Odisha, Punjab, Tamil Nadu, Uttar Pradesh, Uttarakhand and West Bengal.

APPENDIX-I

MULTI-SECTORAL PROGRAMME TO ADDRESS THE MATERNAL AND CHILD MALNUTRITION IN SELECTED 200 HIGH-BURDEN DISTRICTS

1. Background:

Undernutrition affects survival, development, health, productivity, and economic growth. Undernutrition is a complex and multi-dimensional issue, affected mainly by a number of generic factors including poverty, inadequate food consumption due to access and availability issues, inequitable food distribution, improper maternal infant and child feeding and care practices, inequity and gender imbalances, poor sanitary and environmental conditions; and restricted access to quality health, education and social care services. A number of other factors including economic, environmental, geographical, agricultural, cultural, health and governance issues complement these general factors in causing undernutrition of children.



In order to address the nutrition challenge in India, there is a need for a comprehensive approach that addresses the different sectors and dimensions of the nutrition challenge. It is widely accepted that at the most immediate, under-nutritionis determined by three categories of causal factors namely food intake, care for children and women and environmental health and health services, with factors services, with other factors like income, gender, education underpinning all three. An analysis, done by World Bank for adequacy of these causal factors shows a strong association with undernourishment. Examining the adequacies of feeding, care and environmental health in children from pooled data from Bihar, Madhya Pradesh and Uttar Pradesh (States with high level of malnutrition) compared to data from Tamil Nadu, Kerala, Goa and Punjab (states with relatively low level of malnutrition) has found that proportion of children with adequacy in all dimensions is almost 17 times higher for the group of states with better nutrition levels. Therefore it is critical to ensure that a full package of services reaches every mother & child during the first two years of life.

Taking note of the problem of maternal and child undernutrition in the country, the PM's National Council on India's Nutrition Challenges in its last meeting chaired by the Hon'ble Prime Minister on 24th November 2010, while making a number of valuable suggestions and recommendation for addressing the nutrition challenge in the country, recommended that: *"A multi-sectoralprogramme to address the maternal and child malnutrition in selected 200 high-burden districts would be prepared. This programme will bring together various national programmes through strong institutional and programmatic convergence at the State, District, Block and Village levels. While designing this programme the suggestion made by the Deputy Chairman, Planning Commission about alternate models may be considered."*

2. The Multi-sectoral Nutrition Programme:

The problem of malnutrition is multi-dimensional and inter-generational in nature and the nutritional status of the population is outcome of complex and inter-related set of factors which cannot be addressed by a single sector / intervention alone. Further, the problem of malnutrition being multifaceted in nature needs well-coordinated efforts from different sectors such as agriculture including horticulture, food, health, rural development, biotechnology, water & sanitation, education, information and broadcasting, among others. Both, the National Nutrition Policy and National Plan of Action on Nutrition, have highlighted specific roles and responsibilities of different government Ministries/Departments of the Government of India and State Governments for addressing the challenge of undernutrition in the country. Accordingly, the proposed Multi-sectoralNutrition Programme would address the maternal and child malnutrition in selected 200 high burden districts by bringing together various national programmes through strong institutional, programmatic and operational convergence at the State, District, Block and Village levels.

2.1 Goal

To bring inter-sectoral convergence and coherenceinpolicy, planning and action with core focus on nutrition by including specific pro-nutrition and nutrition sensitive actions in differentprogrammes / schemes through intensified and sustainable direct targeted interventions.

2.2 Outcomes

The 11th Plan targeted to reduce undernutritionandanaemiaby half. National level data to ascertain the achievement against the 11th Plan target in this context is currently unavailable. The 12th Plan in the meanwhile targets to reduce undernutrition amongst children 0 – 3 years of age by half as per NFHS 3 levels and reduce anaemia in women and girls by half. The Multi-sectoralNutritionProgramme by bringing strong nutrition focus in various sectoral plans and providing limited gap filling support towards key nutrition related interventions targets to contribute to the following:

a) Prevention and reduction in child under-nutrition (underweight prevalence in children under 3 years of age; and
b) Reduction in levels of anaemia among young children, adolescent girls and women.

Further, the Multi-sectoralNutritionProgrammewill also specifically work towards the following:

(i) Establishment of State& District Nutrition Councils

(ii) State, District&Block Nutrition Action Plans in place (framework for programmatic convergence)
(iii) Nutrition focus in sectoral programmes
(iv) Gap filling financial support for specific nutrition action

2.3 Objectives

(vi) Ensuring strong nutrition focus through institutional and programmatic convergence by integrating it in the planning, implementation and supervision process in all relevant direct and in-direct interventions / programmes;
(vii) Increasing availability and accessibility of key maternal and child health & nutrition services at all levels through convergence of sectoral programmes;
(viii) Bridging critical gaps in inter-sectoralprogrammatic and institutional arrangements for addressing maternal and child undernutrition at National, State, District, Block and Village levels leading to harmonized nutrition action plan;
(ix) Enhancing the capacities and skills of service providers, care givers, voluntary action group, mothers' groups and communities; and
(x) Ensuring convergent multi-sectoral actions for empowering families and communities for improved care behaviours such as early and exclusive breastfeeding for the first six months and optimal IYCF, health, hygiene, psychosocial and early learning and care for girls and women.

2.4 Key Focus Areas

Considering the fact that the best opportunity to break the vicious inter-generational cycle of undernutritionis by targeting children under two, the Multi-sectoral Nutrition Programme through convergent actions would ensure concentrated efforts on improving the nutrition of infants and young children from conception through the first two years of life. Through multi-sectoral convergent action, the programme would strive to facilitate focused attention to core interventions from amongst the pool of existing programmes, in every habitation of the selected 200 high-burden districts, for reducing maternal and child undernutrition:

(i) Household food security – strengthening food supplementation programmes;
(ii) Augmenting production of locally available nutritional food production, pulses production, vegetables, poultry, fish, meat, milk and milk products, etc.;
(iii) Strengthening livelihoods through MGNREGS, NRLM &National Skill Development Mission etc.;
(iv) Addressing maternal undernutrition and low birth weight;
(v) Improving infant young child nutrition and feeding practices;
(vi) Ensuring proper growth monitoring of all children, addressing growth faltering at its earliest;
(vii) Addressing iron deficiency and anaemia and controlling of Micronutrient Deficiency;
(viii) Strengthening health services, drinking water and sanitation facilities and hygienic interventions and education;
(ix) Strengthening policy, coordination and convergence for improved nutrition outcomes;
(x) Monitoring nutrition interventions and strengthening nutrition surveillance;
(xi) Strengthening training and capacity building; and
(xii) Strengthening nutrition awareness and public education for increased demand, accessibility and utilization of services.

TARGET GROUP	RELATED SCHEMES OF DIFFERENT MINISTRIES	EXPANSION

Pregnant and Lactating Mothers	ICDS, RCH- II, NRHM, JSY, Indira Gandhi MatritvaSahyogYojana (IGMSY) – The CMB Scheme	NRHM (2005-06) JSY (2006-07) ICDS (2008-09)
Children 0 – 3	ICDS, RCH- II, NRHM, Rajiv Gandhi National Crèche Scheme	RGNCS (2005-06) ICDS (2008-09)
Children 3 – 6	ICDS, RCH- II, NRHM, JSSK, Rajiv Gandhi National Creche Scheme, Nirmal Bharat Abhiyan, National Rural Drinking Water Programme (NRDWP)	TSC (2008-09)
School going children 6 – 14	Mid Day Meals (MDM), SarvaShikshaAbhiyan (SSA)	SSA (2002/2005-06) MDM (2008-09)
Adolescent Girls 11 – 18	Rajiv Gandhi Scheme for the Empowerment of Adolescent Girls (RGSEAG), Kishori Shakti Yojana, , Total Sanitation Campaign (TSC), National Rural Drinking Water Programme (NRDWP)	NRDWP (2010) RGSEAG (2010-11)
Adults	MGNREGS, Skill Development Mission, Women Welfare and Support, Programme, Adult Literacy Programme, TPDS, AAY, Old and Infirm Persons Annapurna, RashtriyaKrishiVikasYojana, Food Security Mission, Safe Drinking Water and Sanitation Programmes, National Horticulture Mission, National Iodine Deficiency Disorders ControlProgramme (NIDDCP), Nutrition Education and Extension, Bharat Nirman, RashtriyaSwasthyaBimaYojana, Quality & Clean Milk Production, Assistance to Cooperatives and Dairy Entrepreneurship Development Scheme	NHM (2005-06) MGNREGS (2005-06) NRLM(2010-11) NIDDCP (1992) RSBY (2007) Bharat Nirman (2005)

The above schemes have an overall bearing on nutrition and significantly many of these schemes have been expanded in its coverage in the recent past.Since many of these programmeshave been expanded / universalized in the recent past, the results are likely to be visible after some time. Under the Multi-sectoral Nutrition Programme, these programmes / schemes would be required to integrate nutrition related interventions in their respective APIPs / Annual Plans and allocate required resources both at the State and National levels.

The proposed Multi-sectoral Nutrition Programme would provide a platform at all levels to facilitate convergence of all the key services and stakeholders for holistically addressing the maternal and child undernutrition. The following chart illustrates interventions for mother and child along with the name of major line ministries / departments required to provide services for fulfilling those needs:

TABLE-1: KEY INTERVENTIONS FOR ADDRESSING MATERNAL AND CHILD UNDERNUTRITION

Sl. No.	Interventions	Current Status	Main Responsibilities	Shared With
1.	Care of the adolescent, IFA supplementation, nutrition counseling for adolescent girls, life skill education ensuring right age of marriage;	46.8 % (DLHS-III 2007-08) – Consumption of IFA tablets	MWCD / MoHFW	DEE/ Youth Affairs
2.	Maternal care &nutrition - Universal early registration of pregnancy. ANC, immunization against TT, IFA supplementation &counseling for improved care, diet and rest; monitoring of weight gain. Identification of danger signs during pregnancy, safe delivery,birth planning and spacing	46.8 % (DLHS-III 2007-08)- 3ANC 46.8 % (DLHS-III 2007-08) – Consumption of IFA tablets	MoHFW	MWCD
3.	Care of Newborns and infants Counseling and support for Early initiation and exclusive breastfeeding	40.2 % (DLHS-III 2007-08) – Early Initiation	MoHFW	MWCD

	for the first six months, new born care including special care of low birth weight babies and timely immunization; growth monitoring	46.4 % (DLHS-III 2007-08) – EBF		
4.	Appropriate complementary feeding, after six months of age, along with continued breastfeeding (for two years or beyond);	23.9 % in the age group of 6-9 months (DLHS-III 2007-08) – Complementary feeding 20.7% (NFHS 3, 2005-06) – IYCF	MWCD	MoHFW, MoRD – DoDW&S&MoPR, M/o Food Processing Industries
5.	Timely & complete immunization for under two year old children and Iron & Vitamin A supplementation (and completion of subsequent doses, with de-worming);	55.0 % received during last 6 months (DLHS-III 2007-08) – Vitamin A supplementation 54.1 % for children 12 – 23 months (DLHS-III 2007-08) – Complete immunization 11.9 % for children 6-59 months during last six months (NFHS 3, 2005-06) - Deworming of children 6 to 59 months	MoHFW	MWCD
6.	Improved management of common neonatal & childhood illnesses including:			
	(a) Diarrhoeal diseases (Management with ORS with zinc)	17.8 % for children < 6 months 34.8 % for children 6-11 months 52.3 % for children 12- 23 months (NFHS 3, 2005-06)	MoHFW	MWCD
	(b) Acute Respiratory Infections (ARIs) at home and through AWCs / health facilities;	70.7 % for children < 6 months 76.9 % for children 6-11 months 69 % for children 12- 23 months (NFHS 3, 2005-06)	MoHFW	MWCD
7.	Universal monitoring and promotion of growth and development of young children under three years at ICDS AWCs - using MCP card, with WHO growth standards;		MWCD	MoHFW
8.	Universal access to improved supplementary nutrition at ICDS AWCs for beneficiaries as per new norms;	Not at all to: 81.4% children < 12 months 74.9% children 12-23 months (NFHS 3, 2005-06)	MWCD	M/o Food & PD MoPR
9.	Improved health care and referrals for severely undernourished and/or sick children;	Minimal nutrition therapy	MoHFW	MWCD
10.	Universal consumption of only adequately iodized salt;	47.5% children 6-59 months living in	MoHFW, D/o F&PD MOCI- Salt	MWCD

		households using adequately iodized salt (NFHS 3, 2005-06)	Comm.'s Office	M/o I&B
11.	Universal access to safe drinking water	42 % HH use piped water, 43% HH use hand pump and 12 % use well water (NFHS 3, 2005-06)	MoDWS	MoRD, MoHFW,MoPR, D/o DW&S
12.	Universal access to sanitation with hygiene education including correct hand-washing practices.	74% rural HH& 17% of Urban HH with no toilet facilities (NFHS 3, 2005-06) 52% HH with correct hand-washing practices (NGP Impact Study, DDWS, MoRD, 2011)	MoDWS	MoHFW, MoUD, MWCD, M/o Environment, M/o HUPA
13.	Enhanced Household Food Security including expanded PDS		M/oF&PD& Consumer Affairs	MWCD, MoRD, MoHFW
14.	Strengthened livelihoods and social security		MoRD	M/o Panchayati Raj
15.	Promotion of food production, enhanced availability and consumption of fruits, vegetables, animal protein etc.		M/o Agriculture, NHM, D/o Animal Husbandry, Dairying & Fisheries , ICAR	
16.	Addressing inclusiveness and special circumstances		M/o PRI, MoTA, MoMA	M/o Food,M/o FoodProcessing , Planning Commission
17.	Nutrition education and promotion, IEC and VNAG		MWCD (FNB), M/o I&B, DEE	MoHFW, M/o Youth & Sports
18.	Capacity Building and Training		MWCD (NIPCCD), MoHFW, MoRD	MoPR etc.
19.	Community participation, local action and support		MWCD, MoPR, M/o HUPA, PRIs, ULBs	MoUD, MoHFW, MoRD
20.	Monitoring progress towards desired outcomes & Nutrition Surveillance	Through service by IIPS Mumbai and NNMB	MWCD	Planning Commission
21.	Monitoring progress of actions taken by different Departments/ Ministries	Through divisions of Planning Commission dealing with respective Depts. / Ministries	MWCD	Planning Commission
22.	Periodic review	National Nutrition Council has been constituted	PMO	MWCD, Planning Commission
23.	Monitoring and effective implementation of the IMS Act and Cable TV Act for promotion of foods and food safety.		MWCD /MHFW / FSSAI	M/o I&B

Multi-sectoral Districts Summary (Phase-1 &2)#

States/UT	No. of Districts		
	Phase 1*	**Phase 2** **	**Total**
Andhra Pradesh	0	3	3
Assam	3	0	3
Bihar	12	5	17
Chhattisgarh	3	6	9
Daman & Diu	0	2	2
Gujarat	0	15	15
Haryana	0	5	5
Himachal Pradesh	0	3	3
Jharkhand	1	5	6
Karnataka	0	4	4
Madhya Pradesh	25	5	30
Maharashtra	0	20	20
Nagaland	0	1	1
Odisha	6	0	6
Punjab	0	6	6
Rajasthan	16	4	20
Uttar Pradesh	32	9	41
Uttarakhand	2	4	6
West Bengal	0	3	3
Total	**100**	**100**	**200**

*List attached in Annexure I

** List to be finalized

Apart from the above, urban models in Delhi (Delhi), Mumbai (Maharashtra), Kolkata (West Bengal) & Chennai (Tamil Nadu) will be included.

2.5 Scope & Coverage

The Multi-sectoral Nutrition Programme will be implemented as a

special intervention in 200 high burden districts across the countryin a phased manner. The first phase will begin in 100 districts during the year 2013-14, while in the second phase it will be scaled up to cover 200 districts in the year 2014-15.Districts & Blocks will be the main implementation and supervision points under the programme.

Taking into consideration the resource constraints and also the need for more updated nutrition outcome data by end 2013 (AHS, DLHS 4), it was decided in consultation with the Planning Commission to roll out the Multi-sectoralNutritionprogramme progressively and in phases - starting with 100 high-burden districts **(Annexure-I)**.These 100 districts have been selectedout of the 200 high burden districts,using under five child mortality data from AHS 2011. For the remaining 100 districts, the number of districts in the states has been decided on the basis of data on undernutrition and anaemia (DLHS 2) as approved under the ICDS Mission. However, states are free to select the specific districts/ Blocksbased on any available recent nutrition specific and credible data on undernutrition and anaemia, keeping in mind that the total number of districts does not exceed the total mentioned in the table below.In the absence of any data, ICDS data of undernutritioncould be used to select districts / Blocks.On an average, an amount of about Rs. 5.5 croreper district would be expended during this Plan period.

Further, due to unavailability of credible models and data at block level, **selective coverage approach and methodology** would be employed to intensify the focus on **covering 50% worst affected blocks** within each district.

The selection of worst affected blocks within districts would be done by the District Nutrition Council on the basis of the district level data / assessment on relevant indicators concerning maternal and child undernutrition, and duly approved by the State Nutrition Counciland the Multi-sectoral Empowered Programme Committee (M-EPC). Any pockets of **high vulnerability**including pockets of high burden of undernutrition, pockets inhabited bySTs, SCs, etc. could also be identified and covered through the gap filling support. In addition, priority may also be accorded to areas with high burden of Japanese Encephalitis / Acute Encephalitis Syndrome (AES) and silicosis.Further, States also have the flexibility to change Blocks during the current programme period. They can also include and exclude areas based on achievement and status of undernutrition. The States also have the flexibility and are encouraged to expand the concept of multi-sectoral convergence in other Blocks / Districts using their own resources including resources under SC Plan, ST Plan, Border Area Plan / Integrated Action Plan/Additional Central Aid (ACA), etc.

As per the recommendations of the PM's National Council on India's Nutrition Challenges, the following alternative models for the decentralized implementation would also be piloted under the Multi-sectoral Nutrition Programme. States may suitably present the modalities for implementation of such pilots to the M-EPC.

Urban Model: The Multi-sectoralNutritionProgramme also proposes to implement nutrition focused interventions in urban areas. "Urban Models" would be piloted in select urban slums / vulnerable pocketsof the four mega cities of the country namely Chennai, Kolkata and Mumbai. Innovative interventions of addressing maternal and child undernutrition would be supported. Apart from this, intervention may also be undertaken in the urban centres of the selected high burden districts by the District Council.

Rural / Panchayat Led Model: The "Panchayat Led Model" of implementation would be piloted in at least one selected block from each of the high – burden districts in

which progressive and proactive devolution of fund and functions for implementation, supervision and accountability would rest with the respective PRI institutions. More blocks / districts can be taken up by the States depending on their resources and the local context, especially where funds, functions and functionaries have been transferred by the States to the PRIs. The interventions proposed by a particular PanchayatSamiti would be reviewed and approved by the District Nutrition Council.

2.6 Programme Components

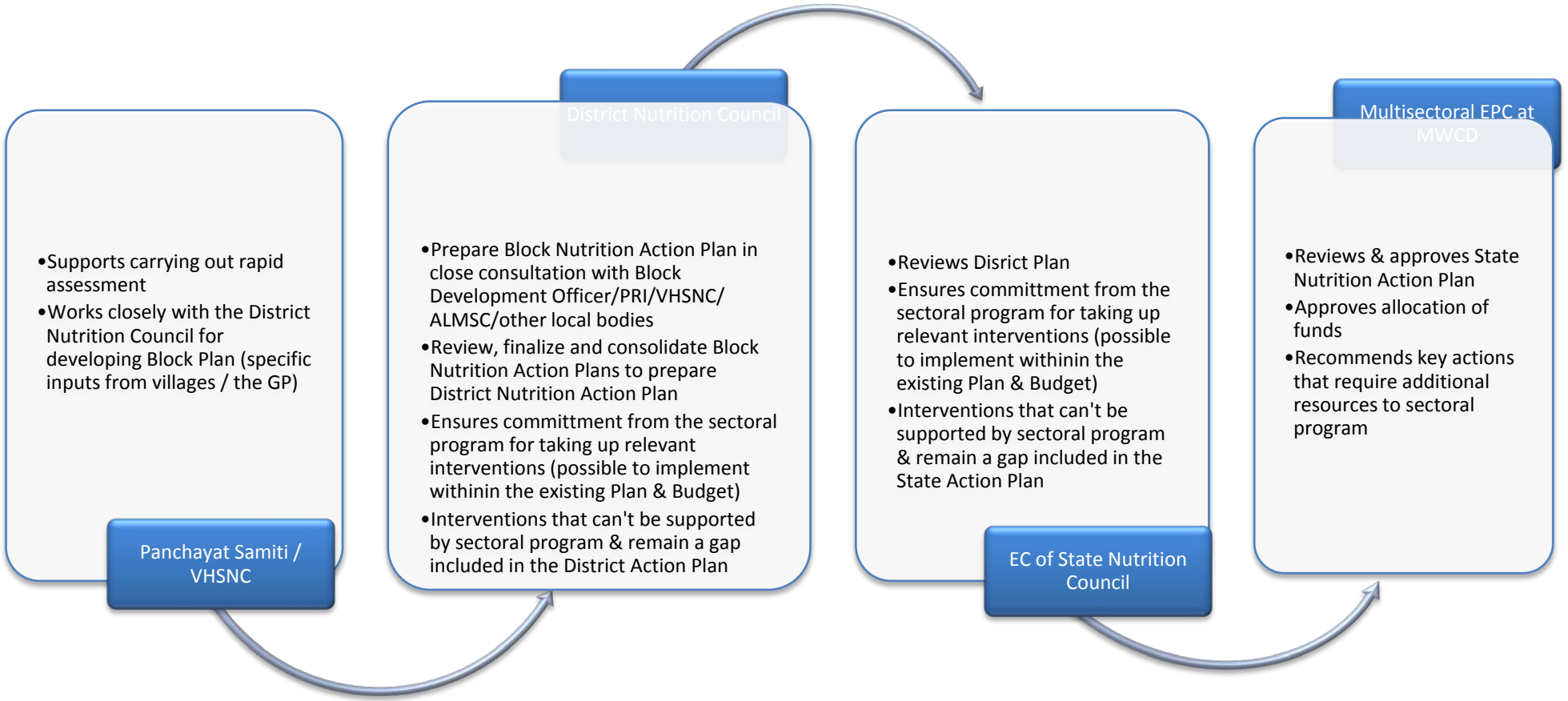
(i) **Nutrition Centric Planning:**The concerned District Nutrition Council headed by the District Magistrate / Collectorin every high – burden district would coordinate Nutrition Centric Planning, including leading the process of formulation, implementation and supervision of District / Block level nutrition plans. The primary thrust will be to ensure planning, operationalization, management and monitoring of integrated nutrition interventions at the district, block and local levels.The multi-sectoral action would commence with each of the selected block, district and state preparing their Nutrition Plans with planning and coordination machinery support.

The nutrition centric plan will be prepared in close consultation with the Gram Panchayat, Village Health & Sanitation Committees (VHSNCs), Anganwadi Level Management & Support Committee (ALMSC) and any other relevant agencies responsible for village to ensure active involvement of local representatives and community members in planning process.

At the district level, under the overall supervision and guidance of the District Magistrate / Collector, the District Planning Officer in each district would be entrusted with the nodal responsibility of coordination and finalization of the Block and District Nutrition Plans with the support of a District Nutrition Cell created under the Multi-sectoralNutritionProgramme.The District Nutrition Cell would act as the technical hub at the district level for all nutrition related interventions and would comprise of 1 Planning & Coordination Specialist, 1 Nutrition Specialist,1 Monitoring & Evaluation Specialistand 2 Data Entry Operators.The team for the District Nutrition Cell would be hiring (contractual) / outsourcing basis.

In order to facilitate development of these nutrition action plans, States would be encouraged to undertake rapid assessments in 200 high – burden districtspertaining to maternal and child undernutrition as well as review of existing sectoral plans and the gaps therein. As part of this process, States would further need to establish and document relevant baseline data from existing sources and prepare district specific results indicators (outputs and outcomes) for the implementation of the Multi-sectoral NutritionProgramme. Based on the local context and need, the District Nutrition Council would have authority to either engage an external agency (academic institutions / government or non – government organizations / firms) to support plan preparation as well as assessments in their respective districts using the budget earmarked. All such procurement of external agencies and / or individuals would be carried out in accordance with the relevant procurement norms of the government.

Chart – 1: Overview of the Planning Process



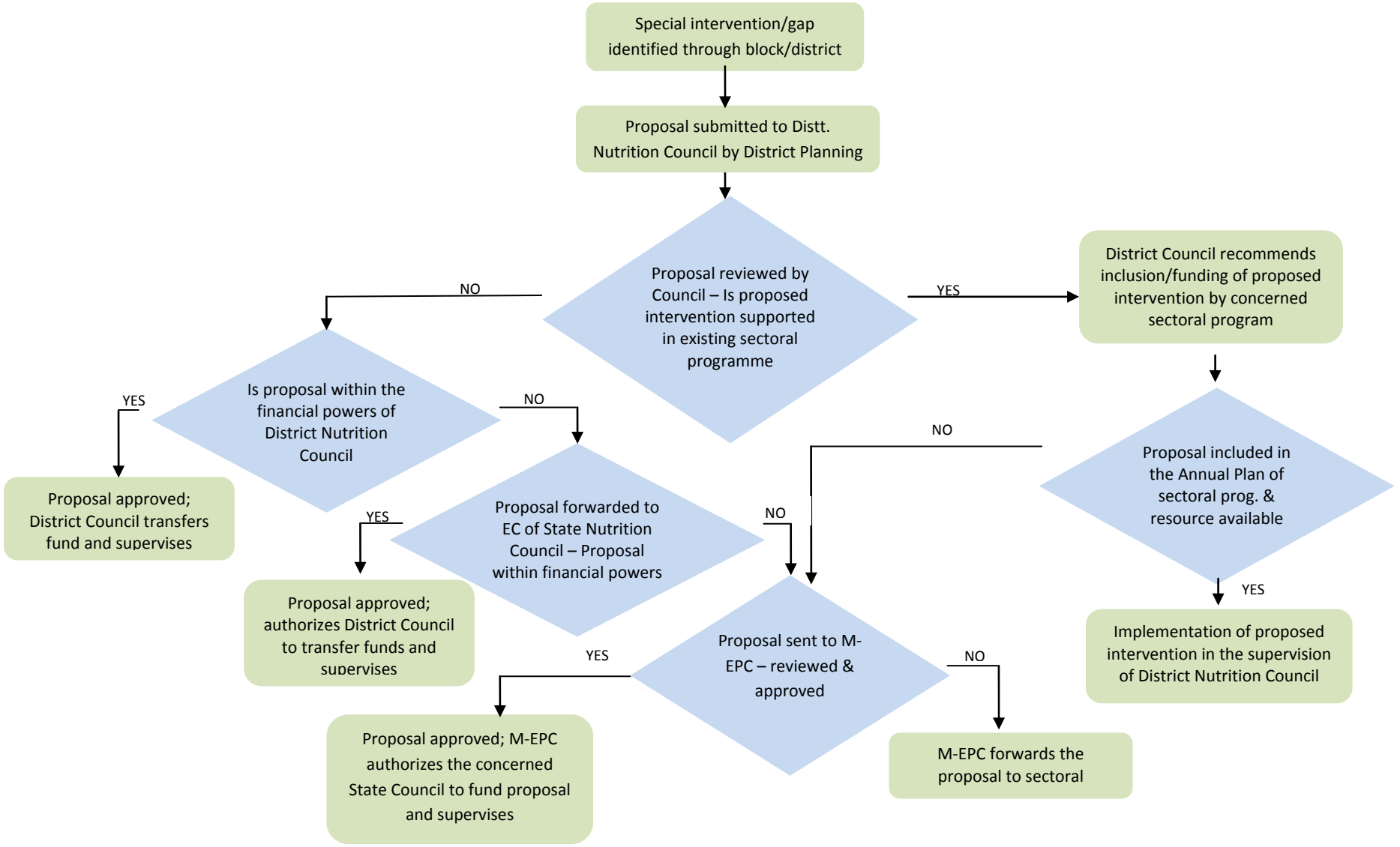
(ii) **Nutrition Centric / SensitiveSectoral Interventions:**In order to tackle the problem of undernutrition both direct and indirect nutrition interventions are essential. Both, the National Nutrition Policy and National Plan of Action on Nutrition, have highlighted specific roles and responsibilities of different government Ministries / Departments (both Central and State) for addressing the challenge of undernutrition. The Multi-sectoralNutritionProgramme would focus on those specific roles and responsibilities for ensuring a strong coordinated approach for addressing undernutrition at the State, District, Block and Village levels. Specific roles and responsibilities of the major sectors / departments have been discussed in the matrix given at **Annexure – II.**

The District Nutrition Council with the support of the District Nutrition Cell in every high burden district would facilitate a well-coordinated convergent action at the grassroots levels by bringing together all these sectoral interventions for addressing the nutrition challenge. The focus would be on ensuring convergence at programmatic, thematic and institutional levels for ensuring improved maternal and child nutrition outcomes.Detail on programmatic, thematic and institutional convergence is given at **Annexure– III.**

(iii) Nutrition Centric / Sensitive Gap Filling Support: The first priority would be to fill the existing gaps through resources from the sectoral plans / programmes.However, even after this, if a relevant development deficit / gap remains uncovered / unfulfilled through existing sectoral interventions,and are identified through the rapid assessment, baseline and planning process, for improving the nutrition related indicators, gap – filling support would be provided under this programme. This allocation would be released on approval of the State Nutrition Action Plan by the M-EPC headed by the Secretary, WCD. The gap – filling support would be made available for meeting the programme objectives and core interventions as well as for evidence based cost effective innovative interventions for improving the nutrition related indicators. The critical actions funded under this component, is not permanent in nature and it is expected that these activities (being critical in nature) after a few years will be mainstreamed and integrated into the respective sectoral programmes and plans. The respective programmes could access funds for this purpose **from their flexi funds**[1]. In addition, as part of the Multi-sectoral NutritionProgramme, provision for a 10% Flexi Fund has been created at the National, State and District levels.The Programme would also provide financial support for temporary tiding over for critical programmatic gaps up to Rs. 5 lakh. For this purpose, financial powers to the District Magistrates for an expenditure uptoRs. 2.5 lakh and District Nutrition Councils for expenditure up to Rs. 5 lakh would be authorized.Any proposal over and above this threshold would require approval of the State Nutrition Council and M – EPC at MWCD.

[1] The report of the Committee on Restructuring of CSS of the Planning Commission has recommended that "To enable State Governments to meettheir special needs, flexibilityin the CSS should be provided in its design. 20% of budget allocationin all the CSS (10% inFlagship Schemes) tobe called 'Flexi Funds'shouldbeearmarked in each scheme for this purpose."

Chart – 2: Process flow for temporary gap – filling support



The Programme would facilitate enhancement and streamlining of nutrition related services of different sectoral interventions through minor gap filling support at the local level that would act as a catalyst. Gap filling support to interventions relating to these key areas that have proven track record of affecting maternal and child undernutrition would be covered under the Multi-sectoral Nutrition Programme**.In general, the gap filling support may have the interventions under this component which will broadly address the following areas:**

- Funds for temporary tiding over critical requirements
- Nutrition promotion specific / sensitive gaps in inputs and processes not covered under the scope of respective programmes
- Nutrition promoting capacity building and IEC
- Promoting mobilization, leadership and champion efforts towards achievement of nutrition outcomes
- Promoting monitoring and surveillance efforts
- Promoting convergence at local level
- Awards, rewards and incentives for community and functionaries at local level not covered under the respective programme.

Further, an illustrative list of activities that can be funded under this programme is given at **AnnexureIV and VI**.

3. Institutional Arrangements

The proposed Multi-sectoralNutritionProgramme to address the maternal and child malnutrition in selected high-burden districts is a special intervention designed to bring together various national programmes through strong institutional and programmatic convergence at State, District, Block& Village levels. This necessitates for a strong institutional mechanism for the implementation and supervision of the programme at all levels. As discussed above, both, the National Nutrition Policy 1993 and National Plan of Action on Nutrition 1995 provides for detailed institutional arrangements for addressing the nutrition challenge in the country. Through this special intervention, those institutional mechanisms would be strengthened and reactivated for taking up the responsibility of monitoring and supervision of the Multi-sectoralNutritionProgramme in the selected districts. Accordingly, the overall institutional arrangements under the Multi-sectoral Nutrition Programme to address the maternal and child malnutrition in selected high-burden districts has been given in **Annexure – V.**Terms of reference for Councils/ Committees included in the Programme would be similar to the Committees/ Councils of ICDS Strengthening and Restructuring and would be notified in the guidelines.

Specifically, the institutional / service delivery mechanism under the Multi-sectoral Nutrition Programme at all level would be as under:

3.1 At the national level, The National Mission Steering Group (NMSG) of ICDS Mission would function and interface as an Executive Committee of the PM's National Council on India's Nutrition Challenges under the Chairpersonship of Minister of State (I/C) WCD. This Committee would have representation of Secretaries of different Ministries, and some State Chief Secretaries on rotation basis, and Member, Planning Commission (In-charge of WCD) as Vice Chairperson. The Executive Committee may contain representatives of State Ministers / Chief Secretaries by rotation.At an operational level, in order to ensure multi-sectoral convergence, a Multi-sectoral Empowered ProgrammeCommittee (M-EPC) headed by the Secretary - MWCD and comprising of representatives from different Ministries will guide the implementation of the Multi-sectoralNutritionProgramme and approve the action plans. This Committee will also ensure convergence at the national level and will report to the PM's Council and Executive Committee on the same. The M-EPC will meet at least once in every 3 months. In order to ensure effective coordination, accountability and ownership amongst various sectoral departments, it is proposed that the Inter-Ministerial Coordination Committee (IMCC) under the Chairpersonship of the Cabinet Secretary may provide coordination

and monitoring leadership at the national level.The IMCC will meet preferably every six months in order to review the programme and will also address convergence related bottlenecks.

3.2 Further, at the national level, the Food & Nutrition Board (FNB) under MWCD would act as the Technical Support Unit with additional Technical human resource to manage and roll out the programme. With the total strength of 14 people at National level, TSU comprises of Programme coordinator, Programme specialist, Programme associate, Data Analysts and Data entry operators engagedon contractual basis at National level.The relevant existing personnel of the FNB would undertake administration, coordination, monitoring and financial management functions of this unit. The administration and management of the programme will be vested in the JS in-charge of FNB and Nutrition.

Particulars – Hiring (Contractual) / Outsourcing	Per Unit	Units	Remuneration per unit per month (Rs)	Total Cost in plan period (Rs in Cr)
National Multi-sectoral Support Unit (MSU)				
National Programme Coordinator	-	1	120000	0.504
Programme Specialists	-	4	80000	1.344
Program Associate	-	5	50000	1.05
Data Analyst	-	2	35000	0.294
Data Entry Operator	-	2	15000	0.126
Sub-total (National)		14		3.318
District Nutrition Cell				
Planning and Coordination Specialist	1	200	35000	27.3
Nutrition Specialist	1	200	35000	27,3
Monitoring & Evaluation Specialist	1	200	35000	27.3
Data Entry Operator	2	400	15000	23.4
Sub-total (District)		1000		105.3
Grand Total		1014		108.618

3.3 At the state level, the State Nutrition Council headed by the Chief Minister would be the highest body for providing policy directions and oversight to the Multi-sectoralNutritionProgramme. The State Nutrition Council would be assisted by an Executive Committee headed by the Chief Secretary of the State and would comprise of Principal Secretaries / Secretaries of all line departments concerning the Multi-sectoralNutritionProgramme. In order ensure sectoral focus, every sectoral department would designate a Director / Additional or Joint Director level officer as the nodal person responsible for multi-sectoral convergent action. In order to collate district level plans and prepare the state plan, the States may hire a suitable agency on a contractual basis for the purpose.

3.4 At the District levels, District Nutrition Council headed by the concerned District Magistrate / Collector would provide all necessary managerial, technical and administrative support in effective implementation, monitoring and supervision of the programme. In order to ensure nutrition focus in sectors, the District Magistrate / Collector would designate a Deputy Director / Joint Director level officer in every sectoral department as the nodal person responsible for multi – sectoral convergent nutrition action in the selected districts. Besides, the District Nutrition Council with the support of the District Nutrition Council and the District Planning Officer along with the District Programme Officer of the ICDS would be responsible for formulation of District Nutrition Action Plan. The personnel in the District Nutrition Cellhas been given in the table above. They would also be responsible for developing and implementing the Block Nutrition Action Plans. Representatives of PRIs/ULBs may also be co-opted in the District Nutrition Council.

3.5 At the Gram Panchayat& Village level, the respective PanchayatSamiti / VHSNC (as may be decided by the concerned State Governments) having jurisdiction over the concerned gram panchayat / village may be responsible for overall coordination and supervision of the Multi-sectoral Nutrition Programme. The respective PanchayatSamiti and / or the VHSNC (which are sub committees of standing committees of Panchayat and have representations from health ICDS, TSC and PRI)maybe responsible for planning convergent actions that impact nutrition outcomes.An indicative list of areas for specific actions thatmay be undertaken by the respective Gram Panchayat / VHSNC has been detailed out at **Annexure–VI.**

4 Implementation Plan

The Multi-sectoral Nutrition Programme would strive to ensure a convergent platform at the State, District and grassroots levels for a coordinated effort for addressing the maternal and child undernutrition. The existing sectoral programmes would continue to carry out their intensive and focused actions as per their existing programme intent/ contentand implementation arrangements. However, the State and District Nutrition Councils would ensure that the relevant nutrition outcomes are not only integrated and intensified into the concerned sectoral plans but appropriate resources are allocated for achieving those outcomes. The funds for local gap filling support would be at the discretion of the District / State Nutrition Council, which would be allocated as per the need identified on the basis of the District / State Nutrition Plans. At the national level, a Multi-sectoralEmpoweredProgramme Committee (M – EPC) headed by the Secretary, Ministry of WCD would be set up for approval and budget release based on the annual State Nutrition Plans submitted by the concerned States / UTs.

Every State / UT selected for the implementation of Multi-sectoral Nutrition Programme would sign a MoU with the M – EPC for affirming their commitments for the implementation of the programmein the selected high-burden districts from their respective State / UTalong with the monitorable targets. A separate Policy Coordination Support Unitmay be set up in the Planning Commission to provide multi-sectoral policy coordination support, linking with the PM's National Council on India's Nutrition Challenges, concerned Ministries / Sectors, and institutional mechanisms established under NNP and NPAN and to provide inputs needs and gaps in respective sectors.

5 Monitoring and Evaluation

As the mandate of the Multi-sectoralNutritionProgramme is to facilitate convergent action at all levels for improved maternal and child nutrition, a robust monitoring system would be required to track the progress and achievements during and after implementation. A list of indicators for monitoring is given at **Annexure VII and VII A**.

The National Institute of Public Cooperation and Child Development (NIPCCD) will lead the monitoring of the programme and will formulate mechanisms for data sourcing and management from various sectors. NIPCCD will also organize time to time reviews, assessments and evaluation. Further, ICDS through NIPCCD will be encouraged to establish a nutrition surveillance system in consultation with NNMB and NIN.

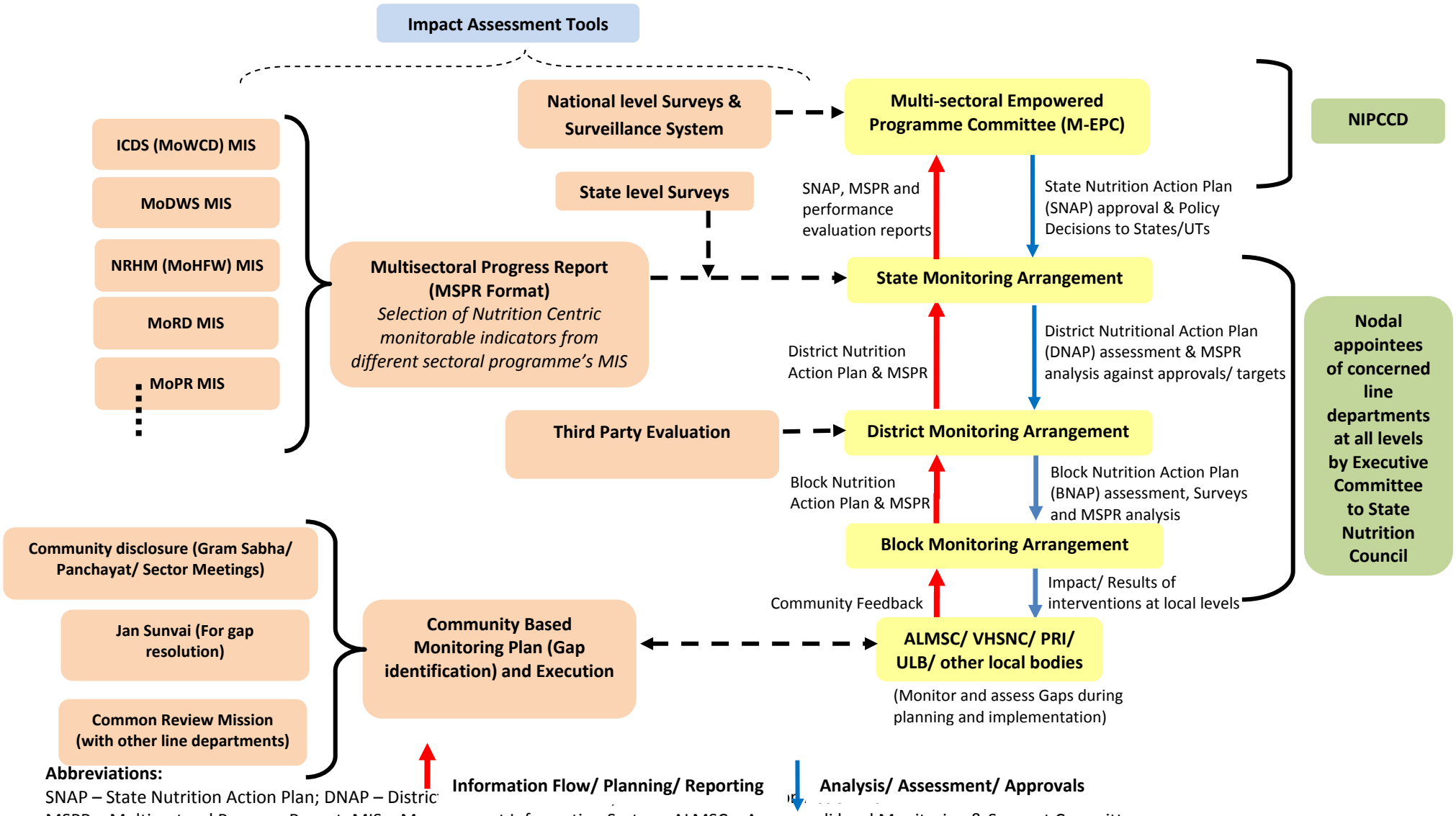
5.1 Monitoring Tools: Different monitoring tools would be utilized to assess the impact of programme on nutrition centric indicators at all levels. The one and most important tool among all would be the Multi-sectoral Progress Report (MSPR) which would draw up information from the existing monitoring / MIS Systems of sectoral programmes and analyze them against the nutrition outcomes. In order to facilitate monitoring of nutrition outcomes, a standardized format (MSPR) having a minimum set of input, output and outcome indicators for evidence based monitoring would be developed by each sectoralprogramme/ scheme and finalized by NIPCCD in close consultation with experts of thematic area/line departments. Data on progress against finalized indicators would be reported from bottom to top initiating from community level to M-EPC at National level. At each level, data being reported by bottom line would be analyzed and collated for feedback to be provided at upper level.

For indicators which are considered to be vital but are not being captured by any of the sectoralprogramme's MIS, M-EPC will facilitate to include such indicators in National level surveys being conducted on regular intervals. Similarly, State Nutrition Council will facilitate the necessary inclusions for State level surveys. Apart from this, a national level surveillance system would be established to provide the necessary information on nutrition with name based tracking system to assess the impact from this programme as well as from other programmes subject to the available resources.Third party evaluation would be done at the end of XII plan at district level to assess the impact made by this programme during its implementation. To improve the public accountability and transparency, consistent with current government initiatives like Citizen's Charters etc., community based monitoring mechanisms like Jan Sunvai, Community disclosures and Common Review Mission would be established.

5.2 Monitoring Arrangements: To deal with the day to day monitoring activities at each level, different monitoring arrangements would be setup at each level with an overall responsibility of NIPCCD at National level. Experts from thematic areas along with TSU would collate and analyze the state level details on monthly basis to provide feedback to M-EPC on progress of the programme as and when desired.

At State level, executive committee to State Nutrition Council will appoint the nodal persons in each of the concerned line departments at State level who would be responsible for providing relevant data/ information on selected indicators for MSPR. Coordination with line departments and collation of data for preparation of MSPR would be done either by the few nominated technical persons from the line departments or by any external support hired by State. Responsibility of preparing MSPR would be of State Nutrition Council. Similar arrangement would be setup at district and block levels wherein nodal appointees will provide relevant data/ information to district/block planning officers who would be responsible for preparation of district/block MSPR with the support of the District Nutrition Cell. At the district level, the Multi-sectoral Nutrition Programme will also develop a system by which achievement on deliverables / outcomes would be recorded in a time bound manner in the selected districts. Keeping the list of indicators given at **Annexure VII and VIIA**, districts would have to formulate specific indicators. The flowchart below is depicting the overall monitoring mechanism of Multi-sectoralNutritionProgramme.

MULTISECTORAL MONITORING MECHANISM



Abbreviations:

SNAP – State Nutrition Action Plan; DNAP – District

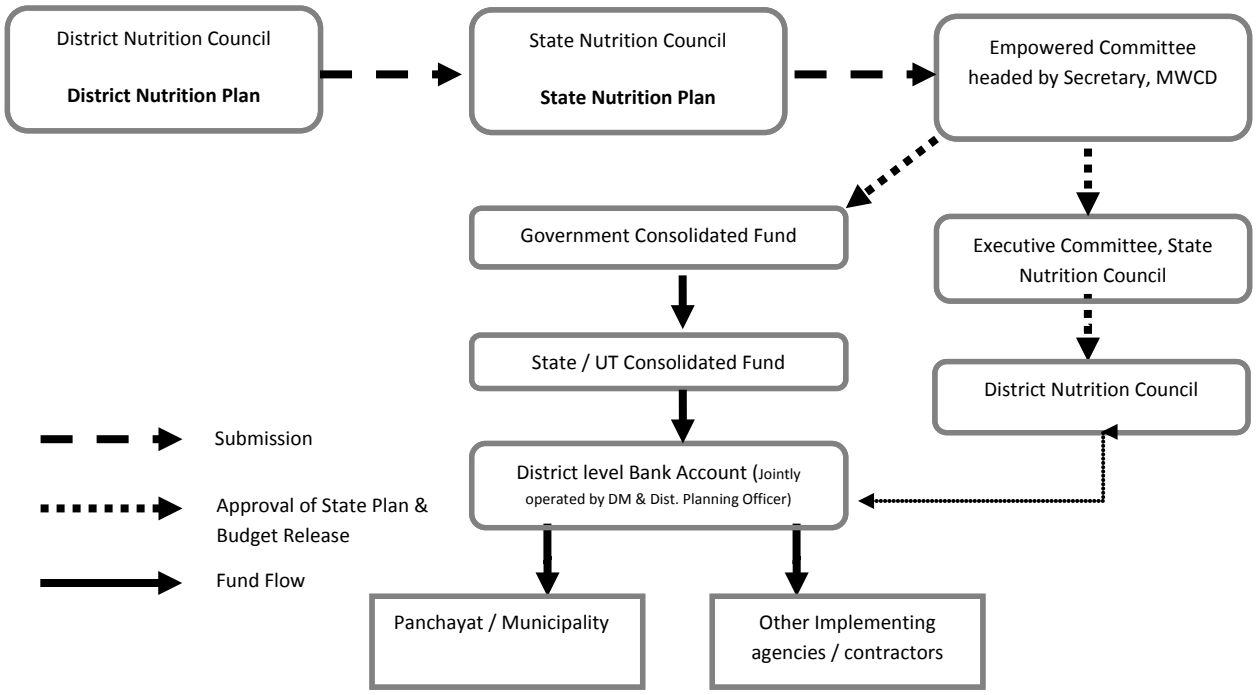
MSPR – Multisectoral Progress Report; MIS – Management Information System; ALMSC – Anganwadi level Monitoring & Support Committee;

6 Financial Plan& Budget

Once the State Nutrition Plan is approved by the Multi-sectoral Empowered Committee chaired by the Secretary, Ministry of WCD, the approval and sanction / budget release would be issued by the Ministry of WCD. A copy of sanction / budget release order would be sent to the concerned division for releasing the approved amount from the Consolidated Fund of GoI to the corresponding State/UT Consolidated Funds. In turn, the respective States /UTs would allocate the funds to the District Nutrition Councilsalong with the State share within the prescribed time limit.

At the State / UT level, all financial powers of handling the funds for Multi-sectoral Nutrition Programme would be vested to the concerned Chief Secretary heading the Executive Committee of the State Nutrition Council. At the district level, the District Nutrition Council headed by the District Magistrate / Collector would be responsible for releasing funds to the concerned panchayats / implementing agencies on the sanction of a particular intervention in accordance with the prescribed financial norms of the government.The proposed fund flow mechanism has been discussed in Chart-3 below:

Chart - 3: Fund Flow Mechanism



After the signing of MoU between centre and respective state governments, to support the planning process at the district level in 100 districts proposed to be covered in the first phase (till financial year 2013-14) of implementation, first instalment of funds not more than 25% of the total annual entitlement for each State would be released by MWCD from Consolidated Fund of GoI. These 100 districts would be required to prepare their block and district nutrition action plans in close consultation with grassroot functionaries like ALMSC/PRI/VHSNC/Community/other local bodies. The concerned State line department (WCD) would coordinate preparation of a State Nutrition Action Plan using the information from the District level Plans submitted to them by the concerned District Nutrition Councils. Once approved by the Executive Committee of the State Nutrition Council, the State Nutrition Action Plans would be submitted to the M – EPC headed by the Secretary, Ministry of WCD for approval and sanction of the second instalment for the implementation of interventions approved in the State Plan of Action.Funds will be released to State/UT Consolidated Fund from where States/UTs will release the funds to district and block level as per the ceiling provided. Respective District Magistrate would be accountable for utilizing the funds at district and below level. If any gap/activity/intervention within a State/UT requires additional funds for

implementation, respective State/UT has the flexibility to re-appropriate the funds earmarked for gap filling support to carry out the respective gap/activity/ intervention.

A major portion of budget has been kept for critical gap filling support. Considering the staff requirement for managing and coordinating purposes as well as for preparation of plans, hiring/ outsourcing provision has been provided at National and District levels. At State level, respective line departments may provide the necessary technical staff or a provision of professional support may be provided as per the requirement.

As per GOI policy for CSS, a flexi fund of 10% has been earmarked under this Scheme. Such a fund may be used for strengthening district level machinery / infrastructure, engaging technical support (especially in large districts), and any other local need. However, this fund would not be used for administrative purposes.

During course of implementing the scheme, the norms of other schemes such as ICDS, NRHM etc., would be followed. This would mean that applicable assistance / subsidy across the different interventions / components under the scheme would be the same as in the case of other ongoing comparable schemes of other Departments / Ministries and MWCD.

At National level, an average provision of Rs.23crore per annum would be made to provide more flexibility in addressing pilots in uncovered urban projects and/or any need-based uncovered gap that emerges during the course of implementation of the Multi-sectoral Nutrition Programme as well as to support the development of National level monitoring & surveillance system and administrative cost of hired technical staff.At the State level, an average of Rs. 1.18 crore per State per annum has been budgeted. Provisions ranging from Rs. 35 lakh to Rs.1.25 crore (depending on the number of districts) per State per annum has been for gap filling support for critical gaps being identified in vulnerable pockets/areas/sectors under finalized State Nutrition Action Plan. Besides, States/UTs have flexibility in terms of earmarking this fund for different thematic areas/interventions/activities/tasks as per the requirement of State Nutrition Action Plan. Technical support may be provided for compiling and finalizing the State Nutrition Action Plan. Other activities earmarked in budget at all levels are:

- Monitoring (including supportive supervision, Surveillance system & third party evaluation)
- IEC activities
- Capacity building, training & incentivizing
- Coordination meetings, workshops and orientations for sensitization
- Community mobilization
- Hiring/ Outsourcing of personnel
- Office expenses and TA

Besides, at district level an average of Rs.1.29 crore per district per annum (includingRs.1crore as gap filling support) would be provided for planning and implementation of programme at district and below level. District Nutrition Councils would be given flexibility to provide funds for utilization at Gram Panchayat/ VHSNC/ALMSC level, if required.

The Multi-sectoral Nutrition Programme would be implemented during the 12thFive Year Plan with a total cost estimates of **Rs. 1213.19 Crore** with Centre:State cost sharing ratio 90:10 for all components in NER States and special category States and 75:25 for other States & UTs. Rs. 944.39 Croreis the Central share and the State share would be Rs. 268.80 Crore. Detailed budget is given at **Annexure VIII**.

Multisectoral Budget Sheet (GoI + State share)						
Level	Particulars	Total Cost - Year wise (Rs. in Cr)				Total Budget (Rs. in Cr)
		PHASE-1	PHASE-2			
		2013-14	2014-15	2015-16	2016-17	
National	Critical gap filling support as per the requirement (incl. urban models) with an upper ceiling of Rs. 20 Crore per annum	10.00	20.00	20.00	20.00	70.00
	Online and offline Monitoring@ Rs. 50 lakh per annum	0.25	0.50	0.50	0.50	1.75
	Orientation Workshops @ Rs. 25 lakh per annum	0.13	0.25	0.25	0.25	0.88
	IEC @Rs. 1.75 crore per annum	0.88	1.75	1.75	1.75	6.13
	Hiring/Outsourcing of personnel, Office Expenses & TA	0.65	1.30	1.30	1.30	4.54
	Flexi Fund (10% of the total National Budget)	1.19	2.38	2.38	2.38	8.33
	SUB TOTAL - National	13.09	26.18	26.18	26.18	91.62
State (Phase-1: 9 states; Phase-2: 19 states in total)	Gap filling support as per the requirement	3.50	13.30	13.30	13.30	43.40
	Monitoring supervision evaluation and review	0.45	1.80	1.80	1.80	5.85
	Capacity building and Training	1.45	5.70	5.70	5.70	18.55
	Technical support for collating district plans to prepare State Nutrition Action Plan	0.45	1.80	1.80	1.80	5.85
	Orientation Workshops & IEC	0.56	2.20	2.20	2.20	7.16
	Token amount @ Rs. 10 lakh per state for preparatory activities	1.00	-	-	-	1.00
	Flexi Fund (10% of the total State Budget)	0.74	2.48	2.48	2.48	8.18
	SUB TOTAL - State	8.15	27.28	27.28	27.28	89.99
District (including Block) (Phase-1: 100 districts; Phase-2: 200 districts in total)	Gap filling support as per the requirement @ Rs. 1 Crore per district per annum	50.00	200.00	200.00	200.00	650.00
	Orientation Workshops & training (engagement of CBOs) @ Rs. 5 lakh per district per annum	2.50	10.00	10.00	10.00	32.50
	IEC @Rs. 4 lakh per district per annum	2.00	8.00	8.00	8.00	26.00
	Monitoring supervision evaluation and review @ Rs. 7 lakh per district per annum (Third party evaluation for impact assessment by any external agency @ Rs. 10 lakh per district in the last year)	3.50	14.00	14.00	34.00	65.50
	District Nutrition Cell establishment	12.60	50.40	50.40	50.40	163.80
	Flexi Fund (10% of the total District Budget)	7.06	28.24	28.24	30.24	93.78
	SUB TOTAL - District	77.66	310.64	310.64	332.64	1031.58
	TOTAL	98.90	364.10	364.10	386.10	1213.19

NOTE: All figures are rounded off to 2 decimal places and all costs for current year has been budgeted for 6 months only.

GANTT CHART – MULITSECTORAL PLANNING & IMPLEMENTATION IN 2 PHASES																				
Sl. No.		Activities	2013-14				2014-15				2015-16				2016-17				Duration
			H1		H2		H1		H2		H1		H2		H1		H2		
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
	1	Establishment of State and District Nutrition Councils																	3 months
	2	Hiring/Outsourcing of support staff at National and district level																	3 months
	3	Orientation workshops/ meetings of States/UTs on the scheme (planning and implementation perspectives)																	3 months
1st PHASE	4	Planning and identification of sectoral gaps/ areas of convergence in 100 HB districts																	6 months
	5	District Nutrition Council with support of District Nutrition Cell would prepares Block Nutrition Action Plan (BNAP) in consultation with BDO/VHSNC/ ALMSC/ ULB/ other local bodies and collate the BNAP to prepare & finalize the District Nutrition Action Plan (DNAP).																	6 months
	6	Respective District Magistrate would present the District Nutrition Action Plan to the Executive Committee at State level.																	3 months
	7	Finalization of State Nutrition Action Plan for 1st phase districts. Executive Committee and State Nutrition Council will prepare the SNAP (collated version of DNAP) with the help of sectoral staff																	3 months
	8	Submission of States Nutrition Action Plan covering 1st phase districts to M-EPC. Evaluation of State Nutrition Action Plans, finalizing approvals in the meeting between M-EPC and States and signing of MoU between Centre & States																	3 months
	9	Resource prioritization and allocation with different line departments and from multi-sectoral budget; inclusion of approved interventions in the sectoral schemes annual plan document																	3 months

	10	Implementation to begin in 100 HB districts with 50% blocks coverage (approx. 450 blocks) as per the approved State/ District Nutrition Action Plans																		2 years
2nd PHASE	11	Identification of additional 100 districts for 2nd phase from AHS data/ any other relevant source at National level.																		1.5 month
	12	Planning and assessment for 2nd phase districts (remaining 100 HB districts) for identifying sectoral gaps																		6 months
	13	Finalizing District Nutrition Action Plans with total coverage of 200 HB districts (addition of phase 2 districts)																		3 months
	14	Submission of State Nutrition Action Plans to M-EPC for approval (additional interventions), its evaluation, finalize approvals and resource allocation																		3 months
	15	Implementation to begin in remaining 100 HB districts with 50% blocks coverage as per the approved State/ District Nutrition Action Plans																		2 years
	16	National level monitoring system to be devised for supervising the entire scheme with the help of hired/outsourced staff at National level as per the directions of M-EPC																		9 months
	17	Third party evaluation/ impact assessment of interventions planned and implemented																		3 months

NOTE: *H1,H2 indicates first half and second half of a year respectively*
Q1,Q2,Q3,Q4 indicated the four consecutive quarters of a year

Annexure-I

INITIAL 100 HIGH BURDEN DISTRICTS – 1ST PHASE

Sl. No.	Common Districts	States
1	Golaghat	Assam
2	Karimganj	Assam
3	Nagaon	Assam
4	Buxar	Bihar
5	Darbhanga	Bihar
6	Jamui	Bihar
7	Madhepura	Bihar
8	Madhubani	Bihar
9	Muzaffarpur	Bihar
10	East Champaran	Bihar
11	Purnia	Bihar
12	Saharsa	Bihar
13	Samastipur	Bihar
14	Sitamarhi	Bihar
15	Supaul	Bihar
16	Jashpur	Chhattisgarh
17	Kawardha	Chhattisgarh
18	Mahasamund	Chhattisgarh
19	West Singhbhum	Jharkhand
20	Barwani	Madhya Pradesh
21	Chhindwara	Madhya Pradesh
22	Damoh	Madhya Pradesh
23	Datia	Madhya Pradesh
24	Dewas	Madhya Pradesh
25	Dindori	Madhya Pradesh
26	Guna	Madhya Pradesh
27	Hoshangabad	Madhya Pradesh
28	Jhabua	Madhya Pradesh
29	Katni	Madhya Pradesh
30	Mandsaur	Madhya Pradesh
31	Neemuch	Madhya Pradesh
32	Panna	Madhya Pradesh
33	Raisen	Madhya Pradesh
34	Rajgarh	Madhya Pradesh
35	Ratlam	Madhya Pradesh
36	Shajapur	Madhya Pradesh
37	Sheopur	Madhya Pradesh
38	Shivpuri	Madhya Pradesh
39	Sidhi	Madhya Pradesh
40	Tikamgarh	Madhya Pradesh
41	Ujjain	Madhya Pradesh
42	Umaria	Madhya Pradesh
43	Vidisha	Madhya Pradesh
44	West Nimar	Madhya Pradesh
45	Baudh	Orissa
46	Dhenkanal	Orissa
47	Gajapati	Orissa
48	Kalahandi	Orissa
49	Koraput	Orissa
50	Malkangiri	Orissa

Sl. No.	Common Districts	States
51	Ajmer	Rajasthan
52	Alwar	Rajasthan
53	Baran	Rajasthan
54	Barmer	Rajasthan
55	Bikaner	Rajasthan
56	Dausa	Rajasthan
57	Dhaulpur	Rajasthan
58	Dungarpur	Rajasthan
59	Jaipur	Rajasthan
60	Jhunjhunu	Rajasthan
61	Karauli	Rajasthan
62	Rajsamand	Rajasthan
63	SawaiMadhopur	Rajasthan
64	Sirohi	Rajasthan
65	Tonk	Rajasthan
66	Udaipur	Rajasthan
67	Kanpur Dehat	Uttar Pradesh
68	Aligarh	Uttar Pradesh
69	Allahabad	Uttar Pradesh
70	JP Nagar	Uttar Pradesh
71	Auraiya	Uttar Pradesh
72	Azamgarh	Uttar Pradesh
73	Baghpat	Uttar Pradesh
74	Banda	Uttar Pradesh
75	Barabanki	Uttar Pradesh
76	SantRavidas Nagar	Uttar Pradesh
77	Bulandshahr	Uttar Pradesh
78	Chandauli	Uttar Pradesh
79	Chitrakoot	Uttar Pradesh
80	Etawah	Uttar Pradesh
81	Faizabad	Uttar Pradesh
82	Farrukhabad	Uttar Pradesh
83	Fatehpur	Uttar Pradesh
84	Ghazipur	Uttar Pradesh
85	Hardoi	Uttar Pradesh
86	Hathras	Uttar Pradesh
87	Kaushambi	Uttar Pradesh
88	SantKabir Nagar	Uttar Pradesh
89	Mainpuri	Uttar Pradesh
90	Moradabad	Uttar Pradesh
91	Muzaffarnagar	Uttar Pradesh
92	Siddharth Nagar	Uttar Pradesh
93	Kushinagar	Uttar Pradesh
94	Pilibhit	Uttar Pradesh
95	Rae Bareli	Uttar Pradesh
96	Rampur	Uttar Pradesh
97	Shahjahanpur	Uttar Pradesh
98	Unnao	Uttar Pradesh
99	Haridwar	Uttaranchal
100	TehriGarhwal	Uttaranchal

Annexure-II

INTERVENTIONS ALONG WITH THE DETAILS OF KEY ACTIONS FOR ADDRESSING MATERNAL AND CHILD UNDERNUTRITION

Sl. No.	Interventions	Current Status	Main Responsibilities	Shared With	Key Actions
1.	Care of the adolescent girls Iron Folic Acid (IFA) supplementation, nutrition counselling for adolescent girls, ensuring right age of marriage;	46.8 % (DLHS-III 2007-08) – Consumption of IFA tablets	Ministry of WCD	Ministry of Health & Family Welfare (MHFW)/ NRHM / Department of Ayush / Department of Elementary Education	• Reach all out of school adolescent girls through RGSEAG, using the ICDS platform. • Reach girls in school by linking with Mid Day Meal. IFA tablets to be distributed during health check up • Ensure availability of IFA supplements and deworming through NRHM • Strengthen life skill education • Counseling and nutrition education • Awareness generation by peer educators • Linkage with menstrual hygiene programme and ARSH
2.	Maternal Care & Nutrition - Universal early registration of pregnancy. Antenatal Care (ANC), immunization against Tetanus Toxoid (TT), IFA supplementation and counseling for improved care, diet and rest;	3 ANC 46.8 % (DLHS-III 2007-08) 46.8 % (DLHS-III 2007-08) – Consumption of IFA tablets	Ministry of Health & Family Welfareincludi ng Department of Ayush	MWCD	• Ensure 4 ANC including early registration • Compliance to IFA supplementation • Counseling on diet, rest, birth preparedness during pregnancy • Ensure provision of Take Home Ration (THR) for facilitating adequate food during pregnancy and lactation • Institutional delivery • Benefits of JSY and IGMSY • Promote birth spacing
3.	Care of newborns and under twos Early and exclusive breastfeeding for the first six months, new born care including special care of low birth weight babies and timely immunization	40.2 % (DLHS-III 2007-08) – Early Initiation 46.4 % (DLHS-III 2007-08) – EBF	Ministry of Health & Family Welfareincludi ng Department of Ayush	Ministry of WCD	• Increased resource allocation for enhancing skilled counseling support for IYCF by ICDS and NRHM • Skilled lactational support at Health institutions / ASHA • Prioritized Home visit by ASHA, for Home based care to newborns • Follow up on low birth weight babies by ASHA • Establish Nutrition Resource Centre in every district • Additional AWW / skilled Nutrition Counselor in 200 high burden districts proposed under ICDS Mission • Increased priority to BCC, IPC and IEC for IYCF counseling • Effective implementation and monitoring of IMS Act • Regular review of IYCF indicators by NRHM & ICDS • Strengthen VHND for full immunization of children by age one
4.	Appropriate complementary feeding, at six months of age, along with continued breastfeeding (upto two years or beyond);	23.9 % in the age group of 6-9 months (DLHS-III 2007-08) – Complementary feeding	Ministry of WCD	Ministry of Health &Family Welfare Ministry of Rural Development – Department of	• Establish Nutrition Resource Centre in every district • Skilled Nutrition Counselor for promotion of appropriate complementary feeding after six months • Increased priority to BCC, Nutrition & IYCF counseling and follow up • Improve compliance and monitoring of IMS Act and Cable TV Act • Prioritized home visiting and counselling by AWW, AWW cum Nutrition counsellor • Implementation of revised and enhanced ICDS nutrition and feeding norms

		20.7% (NFHS 3, 2005-06) – IYCF		Water Supply, PRIs, Ministry of Food Processing Industries	• Promote appropriate feeding behaviors to mothers of severely undernourished children including nutrition care and counselling sessions – SNEHA SHIVIR • Preparation and supervision of locally appropriate foods – mother's committees, women's SHGs, etc. • Promote processing of locally available nutrition foods through training of women's SHGs / Federations • Cater to cluster development for nutritious food promotion
5.	Timely & complete immunization of children under twos and Iron & Vitamin A supplementation (and completion of subsequent doses, with deworming);	55.0 % received during last 6 months (DLHS-III 2007-08) – Vitamin A supplementation 54.1 % for children 12 – 23 months (DLHS-III 2007-08) – Complete immunization 11.9 % for children 6-59 months during last six months (NFHS 3, 2005-06) - Deworming of children 6 to 59 months	Ministry of Health & Family Welfare/ NRHM including Department of Ayush	Ministry of WCD	• Joint village micro planning, sharing of household survey data and enumeration of mothers, children. • Strengthen VHND • Strengthening a basket of services at Biannual health and nutrition promotion months for Vitamin A Supplementation and deworming. • Using Joint MCP Card for both family counseling and child tracking, to identify dropouts, by ICDS, NRHM. • Convergence between AWWs and ASHAs to follow up and ensure high immunization and micronutrient supplementation coverage. • Increased prioritized home visiting and counseling by both AWW, ASHA at critical contact points • Ensure availability of Vaccines, IFA syrups and pediatric tablets, deworming tablets, Vitamin A.
6.	(a) Improved management of common neonatal and childhood illnesses including Diarrhoeal diseases (ORS with zinc)	17.8 % for children < 6 months 34.8 % for children 6-11 months 52.3 % for children 12- 23 months (NFHS 3, 2005-06)	Ministry of Health & Family Welfare/ NRHM	Ministry of WCD	• Strengthening AWCs village level health and nutrition outposts • Ensure availability of ORS, Zinc supplements, and basic medicines at AWCs • Strengthen referral mechanisms.

	(b) Acute Respiratory Infections (ARIs) at home and through AWCs / health facilities;	70.7 % for children < 6 months 76.9 % for children 6-11 months 69 % for children 12- 23 months (NFHS 3, 2005-06)	Ministry of Health & Family Welfare/ NRHM	Ministry of WCD	• Ensure availability of medicines at SHCs . • Strengthen convergent efforts for management of common childhood illnesses including ARI- at community and facility levels. • Strengthen Management of sick newborns and children at health facilities. • Improve referrals and operationalize FRUs and 24x7 PHCs to provide care for sick children.
7.	Universal monitoring and promotion of growth and development of young children under three years at ICDS AWCs, using WHO growth standards and Mother and Child Protection card	ICDS MIS/ Health Surveys	Ministry of Women and Child Development and MoHFW		• Provision of adequate weighing scales and sensitization of field functionaries • Monthly weighing of ALL eligible children 0-3 years and early detection of growth faltering and counseling • Correct weighment and assessment of undernutrition - moderate and severe • Follow up action for severe underweights – SNEHA SHIVIRS • Use of MCPC for counseling and self-monitoring of growth trajectory by care givers/mothers • Referrals as needed for management of severe undernutrition • Introduction of community growth charts and village mapping for sensitization and monitoring of nutritional status by community • Ensure that health surveys provide timely quality national, state and district level data on nutrition status and micronutrient status
8.	Universal access to improved supplementary nutrition at ICDS AWCs for beneficiaries as per new norms;	Not at all to: 81.4% children < 12 months 74.9% children 12-23 months (NFHS 3, 2005-06)	Ministry of WCD	Ministry of Food & Public Distribution PRI and MoHRD	• Universalisation of ICDS completed to cover all habitations • Implementation of revised and enhanced ICDS nutrition and feeding norms • Ensure at least 300 days of SNP to all children under six, P & L mothers • Cost indexation of SNP • Greater involvement of women SHGs, mother's committees and PRIs in monitoring of SNP. • Convergence with other flagships and strengthening AWCs with necessary infrastructure • Strengthen linkages of ICDS with Mid Day Meal • Co-location of schools and AWCs - joint kitchens • Strengthen linkages with NREGA - child care provision • Community / social audits.
9.	Improved health care and referrals for severely undernourished and /or sick children;	Minimal nutrition therapy	Ministry of Health & Family Welfare/ NRHMincludin g Department of Ayush	Ministry of WCD	• Correct assessment of undernutrition - moderate and severe • Identification and referral for those requiring medical attention • Upgrading PHCs, CHCs to cater to severe underweight children, • NRCs & MTCs to be established by NRHM • SNEHA SHIVIRs to be conducted for rehabilitation at community level and link with NRCs • ICDS supervisors/ ANMs to assess children for referrals of severely malnourished children • Enhanced provisions for referrals, transport and stay of children and attendants at NRCs • Strengthening VHNDs for health checkups, referrals and access to care.
10.	Universal consumption of only adequately iodized	47.5% children 6-59 months living in households using adequately iodized	MHFW Dept. Of Food & Public Distribution	Ministry of WCD Ministry of Information	• Availability of adequately iodized salt with improved quality – use in MDM, SNP and other institutional feeding programmes. • Reaching out to rural poor and vulnerable populations - link with TPDS. • Fortification of nutritional supplements including supply of iodized salt

	salt;	salt (NFHS 3, 2005-06)	MOCI- Salt Commissioner's Office	&Broadcasting	• Effective monitoring system, at both production and consumption levels. • Use of VHNDs for salt testing and community mobilization. (MWCD &MoHFW) • Counseling and BCC for promoting use of adequately iodized salt.
11.	Universal access to safe drinking water	42 % HH use piped water, 43% HH use hand pump and 12 % use well water (NFHS 3, 2005-06) In urban areas, as per Census 2011 which is 43.5% households use tap water, 42% households use hand pumps and 11% use well water.	Ministry of Drinking Water and Sanitation	Ministry of Urban Development & Ministry of Housing and Urban Poverty Alleviation	• Progressively ensure provision of safe drinking water supply in all AWCs, SHCs and schools • Training and IEC activities under TSC, NRDWP, NRHM and ICDS to be linked and coordinated, including training of Village Water and Sanitation and Nutrition Committees • VHSNC to ensure and monitor the availability of safe water • Convergent action for more individual connections
12.	Universal access to sanitation with Hygiene Education including correct hand-washing practices.	11.9 % for children < 6 months 13.1 % for children 6-11 months 15.9 % for children 12- 23 months (NFHS 3, 2005-06) 67% rural households without toilets 45% have any toilet facilities 74 % Rural HH without toilets (NFHS 3, 2005-06)	Ministry of Drinking Water and Sanitation	MHFW Ministry of Environment Ministry of Urban Development Ministry of Housing & Urban Poverty Alleviation, Ministry of Youth & Sports Ministry of WCD	• Convergent action for awareness building and ensuring behaviour change for Open Defecation Free Gram Panchayats, toilet usage and hygiene promotion • Provision of toilet facility in all households including child friendly toilets at AWCs and other suitable places • Strengthening AWC as demonstration model for environmental sanitation and hygiene practices • Appropriate IEC for awareness generation and mobilization
13.	Enhanced Household Food Security including expanded PDS		Ministry of Consumer Affairs, Food and Public Distribution		• Enacting of Proposed National Food Security Bill • Expanding TPDS in these districts to have millets, protein, oil, vegetables and iodised salt as well as DFS • Community feeding by PRIs for the destitute, aged and infirm, up to 30 days (per annum, in spells) by PRIs • Endemic hunger, poverty zone, calamity area, conflict zone – full relief measures under National Calamity Fund / Special Relief Fund • Ensure regular availability and access of essential food items through PDS • Effective implementation of TPDS along with reform measures, tools / measures for strengthened monitoring, on an ongoing basis • Support for piloting community grain banks in high burden districts, based on district plans
14.	Strengthened livelihoods		Ministry of	Ministry of	• Ensuring at least 100 days under MGNREGS, wherever there is a shortfall ensure issuance of unemployment

	and social security		Rural Development	Panchayati Raj	allowance • Operationalizing child care provision under MGNREGS, with piloting in remote and tribal areas including hiring of child care worker under MGNREGS • National Rural Livelihood Mission to ensure coverage in 200 districts • Strengthening implementation of provisions for maternity protection and childcare support • Strengthening implementation of RSBY; also use of RSBY cards as an opportunity for nutrition education / IEC for BPL families • Undertake review relating to provisions for special target groups like women and children, seasonal / migrant labour to strengthen nutrition related components • Strengthening convergence of RashtriyaKrishiVikasYojana with other schemes such a MGNREGS, BRGF, SGSY for improving livelihood and food security of nutritionally vulnerable groups
15.	Promotion of production and consumption fruits and vegetables		Ministry of Agriculture, NHM		• Strengthening promotion, production and consumption of fruits and vegetables through National Horticulture Mission • Horticulture mission to provide mini-kits for vegetables and fruits • Support for kitchen gardens in AWCs as village demonstration sites
16.	Addressing inclusiveness and special circumstances		Ministry of Panchayati Raj	Ministry of Food Processing	• Mapping of areas with geographical and social exclusion • Convergent action for availability of services and food to excluded population
17.	Nutrition education and promotion, IEC and VNAG		Ministry of WCD (FNB), Ministry of I&B with other relevant Ministries	MHFW, Ministry of Youth & Sports, Ministry of Drinking Water and Sanitation	• Nationwide IEC Campaign including for Open Defecation Free GPs, for building and for using toilets and sharing of training institutions • Mobilise youth groups for nutrition communication • Strengthen youth groups for supporting malnutrition free panchayats / communities through training / orientation • Creation of network of institution for promotion of good nutrition and improved care practices
18	Capacity Building and Training		Ministry of WCD (NIPCCD)	MHFW, Ministry of Panchayati Raj, Ministry of Rural Development, Ministry of Drinking Water and Sanitation, Ministry of Youth & Sports	• Institutional strengthening of NIPCCD • Revision of training curriculum for ICDS • Emphasis on skill training e.g. IYCF counseling, SNEHA SHIVIRS etc • Setting of Resource centres • Joint training on thematic issues • Sharing of training Institutions • Promotion of Open Defecation Free GPs, for building and for using toilets and sharing of training institutions
19.	Community participation, local action and support		Ministry of WCD, Ministry of Panchayati Raj	MoHFW, Ministry of Rural Development, Ministry of Drinking Water and Sanitation	• Involvement of User groups, SHGs Mothers group and PRIs etc • Identification local motivators, peer educators etc • Involvement of VHSNC for review of nutrition related issues • Involvement of Voluntary action groups • Promotion of Open Defecation Free GPs, for building and for using toilets and sharing of training institutions

20.	Monitoring progress towards desired outcomes	Through service by IIPS Mumbai and NNMB, NIN	Ministry of WCD	Planning Commission; National Nutrition Council	• Strengthening the Routine MIS system under ICDS and linking with HMIS. • Setting of NNMB in every state • Collaboration with Premier Institutes • State wise and district wise nutrition assessments • Ensure Annual Health and Nutrition surveys
21.	Monitoring progress of actions taken by different Departments/ Ministries	Through divisions of Planning Commission dealing with respective Departments/ Ministries	Ministry of WCD	Planning Commission	•
22.	Periodic review	National Nutrition Council has been constituted	PMO	MWCD, Planning Commission	•

Annexure – III

PROGRAMMATIC THEMATIC AND OPERATIONAL CONVERGENCE									
Theme	**Critical Service**	**Activities**	**Primary Responsibility**		**Supportive Responsibility**		**Site of service delivery**	**MOV**	**Associated Programmes/Schemes /interventions**
			Ministry	**Worker**	**Ministry**	**Worker**			
Care of Adolescents	Nutrition education and Life Skill Education	Awareness generation	MWCD	AWW	MoHFW	ANM	AWC	SABLA records	NRHM & ICDS ARSH/ SABLA / WIFS
		Counseling							
		Training							
	Deworming and Anaemia Control	Counseling	MWCD	AWW	MoHFW	ANM	AWC	Kishori card	
		Supervised administration of IFA							
		Twice annual deworming							
Care of Pregnant Women	Early Registration	Registration at SHC	MoHFW	ANM	MWCD	AWW	SHC	ECCR/ MCPC	NRHM &ICDS
		Confirmation of Pregnancy	MoHFW	ANM	MOHFW	ASHA	SHC/ PHC	ECCR	
		History Taking	MoHFW	ANM	MWCD	AWW	SHC	ECCR/MCPC	
		Laboratory examination	MoHFW	ANM	MOHFW	ASHA	SHC/PHC	ECCR	
	Antenatal Care	Measurement of BP	MoHFW	ANM			VHND/ SHC	MCPC	NRHM& ICDS (JSY, IGMSY)
		Weight Recording	MoHFW	ANM	MWCD	AWW	VHND/ SHC	MCPC	
		IFA Supplementation	MoHFW	ANM/ASHA	MWCD	AWW	VHND/AWC/SHC	MCPC	
		TT immunization	MoHFW	ANM			VHND/SHC	MCPC	
		Abdominal Examination	MoHFW	ANM			VHND/SHC	MCPC	
		Check up for oedema& Pallor	MoHFW	ANM	MWCD	AWW	VHND/SHC	MCPC	
		Detection of danger signs and referral	MoHFW	ASHA/ANM	MWCD	AWW	VHND/Home Visit	MCPC/ Records of ANM	
		Counseling on diet, rest, use of iodized salt and SNP	MWCD	AWW	MoHFW	ANM/ASHA	VHND/ AWC/Home visit	AWC records	

	Birth planning	Counseling for birth preparedness	MoHFW	ANM/ASHA	MWCD	AWW	VHND/ Home visit		
	Safe Delivery	Institutional delivery and transportation	MOHFW	ASHA			Health Facility	MCPC	
		Preparation for home delivery only if Institutional delivery not possible	MoHFW	ASHA			Home	MCPC	NRHM & ICDS
	Support for initiation of breastfeeding	Initiation of breast feeding, correct positioning, avoiding prelacteal feeding	MoHFW	ASHA/ Staff Nurse	MWCD	AWW	Place of delivery	Record at the Institution	IYCF
Post Natal Care	Examination of mother	Temperature	MoHFW	ANM			Home Visit	Record of ANM,	NRHM & ICDS
		Identification of complication	MoHFW	ASHA/ ANM			Home Visit	Record of ANM /ASHA	
		Referral	MoHFW	ASHA			Home Visit	Record at Health facility / ANM	
	Lactation and Infant feeding	Counseling for Exclusive breastfeeding, management of lactational failure	MWCD	AWW	MOHFW	ASHA	Home visit	Record of ASHA AWW	IYCF
	Counseling of Lactating mother	Advice on diet and rest	MWCD	AWW	MOHFW	ANM	HV/ VHND	Record of AWW	NRHM & ICDS
		Counseling for family planning and spacing	MOHFW	ANM	MWCD	AWW	HV/VHND	Record of ANM / ASHA	
		Home visits within 6 weeks of delivery	MOHFW	ASHA/ ANM	MWCD	AWW	Home	Record of AWWs	
		Birth Registration	MoRD	Panchayat	MoHFW / MWCD	ASHA, ANM, AWW		Panchayat Records MCPC	
Home based New Born Care	Examination of baby	Birth Weight Recording	MOHFW	Staff Nurse	MWCD	AWW	Place of delivery	Record of Institution / MCPC	NRHM &ICDS (HNBC, JSSK)
		Referral	MoHFW	ASHA	MWCD	AWW	Home Visit	MCPC	
		Care of umbilical cord	MOHFW	ASHA/ANM	MWCD	AWW	Home Visit		
		Management of hypothermia	MoHFW	ASHA	MWCD	AWW	Home Visit		Care of Sick New born
		Care of low birth weight	MOHFW	ASHA	MWCD	AWW	Home Visit / Health Facility	Health facility records	
		Recognition of danger signs	MoHFW	ASHA	MWCD	AWW	Home Visit	Records of home Visit	
Care of infants	Examination of baby	Identification of congenital malformation and disability and referral	MWCD	AWW	MoHFW	ANM	Home Visit	AWWs Records	ICDS&NRHM

		Treatment	MOHFW	ASHA	MWCD	AWW	Health Facility	MCPC / records of Health Facility	NRHM
	Breastfeeding	Counseling for exclusive breast feeding	MWCD	AWW	MoHFW	ASHA	Home Visit	Home Visit records	NRHM &ICDS IYCF
	Immunization Vitamin A Supplementation	Immunization and Vitamin A	MoFHW	ANM	MWCD	AWW	VHND / SHC	MCPC	ICDS & NRHM
	Growth Monitoring	Weighing of children monthly	MWCD	AWW				MCPC / Indl Growth Charts	ICDS
Care of children 1-3	Growth monitoring and development	Monthly Growth Monitoring, identification of growth faltering &counseling	MWCD	AWW			AWC/ VHND	MCPC/ Indl Growth Chart	ICDS
	IYCF	Counseling and follow up for appropriate complementary feeding with continued breastfeeding	MWCD	AWW	MoHFW	ASHA	AWC/VHND / Home Visit	Records of AWW	ICDS (IYCF)
	Rehabilitation of Malnourished children	Referral of severely malnourished children	MWCD	AWW	MOHFW	ASHA/ANM	AWC/ VHND/ Home Visit	Records of AWWs	ICDS&NRHM
		Follow up of severely malnourished children	MWCD	AWW			Home Visit / AWC	Records of AWW	ICDS
		Rehabilitation of Severe malnourished children with medical complication	MoHFW	MO	MOHFW	ANM	Health Facility	Institution records	NRHM /NRCS
		Community based approaches for rehabilitation (SNEHA SHIVIRs)	MWCD	LS AWW	MoHFW	ANM ASHA	AWCs/ village	AWC records	ICDS & NRHM
	Care of sick children	Identification of common childhood illnesses	MOHFW	ANM	MWCD	AWW	Home Visit	Records of ANM/ AWW	NRHM &ICDS (IMNCI)
		Management of childhood illnesses-diarrhoea, ARI, Malaria, fever	MoHFW	ANM	MWCD	AWW	Home visit	Records of ANM/ AWW	
	SNP	THR	MWCD	AWW			AWC	AWWs records	ICDS
	Immunization	Booster doses	MoHFW	ANM	MWCD	AWW	VHND	ANMs records AWW	NRHM
	Micronutrient Supplementation and deworming	Vitamin A (total 5 doses till age three)	MoHFW	ANM	MWCD	AWW	VHND	MCPC / ANMs records	NRHM&ICDS
		IFA syrup	MoHFW	ANM	MWCD	AWW	VHND	ANMs records	
		Deworming twice annually	MoHFW	ANM	MWCD	AWW	VHND/ AWC	Records of ANM/ AWW	
		Counseling for use of Iodized salt	MWCD	AWW					

Care of children 3-6 years	Growth monitoring	Quarterly recording of weight and counselling	MWCD	AWW			AWC	AWCs records	ICDS &NRHM
	Care of sick children	Identification of diarrhoea, ARI, Malaria and fever	MoHFW	ANM	MWCD	AWW	VHND/ Home visit	Records of ANM/ AWW	
		Referral	MWCD	AWW	MoHFW	ASHA	Home Visit	Records of AWW	
Water & Sanitation Facilities	Availability of Water and sanitation	Promotion of Hand washing practices and personal hygiene	MWCD	AWW	MoHFW	ANM	VHND, VED	Survey and Studies	ICDS, NRHM, TSC
		Construction of toilets, Use of toilets, safe disposal of stool	MoDWS	Panchayat	MWCD	AWWs	AWCs,SHCs, Households &Habitation	PHED data	TSC &ICDS, NRHM
		Provision of Safe drinking water	PHED	Junior engineer			AWCs,SHCs, Households &Habitation	Records of Dept of drinking water & sanitation.	NRDWPS, NWM
		House hold waste water disposal	Dept of water Resources	Panchayat			HH level	Survey and Studies	
		Clean surrounding	MoRD	PRI	MoHFW	VHSNC	Village	Disease control records &Panchayat& VHSNC records.	NRHM , ICDS, TSC
Education and awareness generation (Feeding, health, Hygiene psychosocial)	Nutrition, health and hygiene education	Interpersonal Communication (IPC)	MWCD	AWW, LS	MoHFW	ASHA ANM,	Home visit, AWCs, SHCs, VHND, VED	House visit records	ICDS, NRHM,
		Mass media, publicity and dissemination support through Media Units	I&B		MWCD /MHFW		TV,Radio	Survey & studies	ICDS &NRHM
		Information Education Communication (IEC)	MWCD/ MoHFW	AWW/ ANM	I&B, MoRD		AWC, SHC, public places	Survey and studies	ICDS, TSC, NRHM
		Information Communication Technology (ICT)	MWCD		IT		AWCs, VHNDs	Survey and studies	ICDS
		Voluntary Action groups(VAG)	MWCD		Educational Institutions, etc.		AWCs, Village level	VAG report	ICDS
Food security	Household Food Security	Increased crop production and availability of food grains, pulses, cereals, oils iodized salt etc.	M/o Food & Public distribution, M/o Agriculture	PDS worker	Block administration	BDO	PDS shop	PDS shop records	TPDS, NFSM
	Promotion	Provision of mini kits for fruit	M/o	Village	MWCD	AWWs	Panchayat	Record of Agriculture	NHM

	production and consumption of fruits and vegetables	and vegetables and Support for Kitchen gardens	Agriculture D/o Horticulture	agriculture officer	MoRD		Habitation, Household	extension officer	
	Promotion production and consumption of Animal foods	Increased availability of fish, poultry and dairy products	M/o Agriculture, D/o Animal Husbandry & D/o Fisheries	Agriculture Extension officers	MoRD	Panchayat	Panchayat	Record of Agriculture extension officer	Poultry Venture Capital funds Scheme, Dairy Venture Capital Funds Scheme, National Dairy Plan
Livelihoods and Social Security	Strengthened livelihoods and social security	Ensuring at least 100 days work / unemployment allowance under MGNREGS	MoPR	Panchayat	MoRD	MNREGA worker	Panchayat	MNREGA records	MNREGA
		Provision for child care under MGNREGS	MoRD	Panchayat	MoRD	MNREGA worker	Panchayat	Site visit	
		Involvement in welfare schemes	MoRD	Panchayat			Panchayat	Panchayat records	SGSY etc
Community Mobilization	Community Participation	Sensitization of community – rights, duties and entitlements	MWCD, PRI, MoRD	LS, AWWs	MoHFW	LHVs, ANMs, ASHA	Wards Sabha , Gram Sabha VHND, VHSNC meeting	Records of sensitisation	ICDS, NRHM, TSC, NRDWP, etc

Annexure-IV

GUIDELINES FOR PROVIDING GAP FILLING SUPPORT TO INTERVENTIONS FOR AFFECTING MATERNAL AND CHILD UNDERNUTRITION

The Multi-sectoral Nutrition Programme would provide need-based gap filling support for intervention relating to maternal and child undernutrition. As part of gap filling support those critical actions that are not supported by the sectoral plans may be supported under this programme. However, it is expected that budget under this programme is typically for gap filling and sectoral plans over time should be funding critical activities. Innovative activities in specific pockets may also be undertaken under this component with the approval of the M-EPC. Please find below an illustrative list of actions that may be supported under this programme with the approval of the M-EPC.

(a) Enabling Household Food Security and livelihoods: Catalytic support would also be provided for piloting innovative community owned interventions, which would enhance the effectiveness of sectoral interventions. Illustrative examples of gap filling support for piloting / innovation provided under this component could include:

- Community / Village Grain Banks (VGBs) with community contribution;
- Popularization of low cost nutritious food prepared using indigenous and locally available raw materials;
- Facilitation support for common / community kitchen such as SanjhaChulha, SURP;
- Kitchen gardens near / within AWCs, schools and health facilities;
- Extending food supplementation programmes to a second meal per day for highly vulnerable groups;
- Support for convergence and community mobilization for sustaining improvements in household security and livelihoods;
- Support capacity development including demonstration to women's SHGs / mother's groups for promoting local food processing / preparation;
- Incentives to master trainers and champions for promotion of nutritious foods.

(b) Health, Maternal and child care services: Maternal and child undernutrition leads to child growth failure, increased rates of morbidity, increased risks to survival, impaired cognitive development, reduced learning capacity, poor school performance in children, sub-optimal productivity in adults, and reduced economic growth for nations. Key actions envisaged under these services even if planned are unable to address issues related to convergent action. Those programmatic areas requiring convergent action to provide quality maternal and child care services would need gap filling, should be planned for under this programme. This programme would therefore, support interventions that are critical to achievement of nutrition outcomes in different sectors and are not supported under their respective plans, such as:

- Identification and promotion of IYCF practices at local level
- Interventions relating to management of critical illnesses
- Joint training and capacity building
- Promoting home based care of low birth weight
- Joint review and supervision for improving maternal and child care services in selected high-burden districts
- Promotion of locally available vegetables and fruits
- Improvingfamily contact, nutrition counseling and care for pregnant and breastfeeding mothers and children
- Incentivize workers in high endemic areas for nutrition counseling, monitoring and promotion of young child growth and development, using the new joint Mother Child Protection Card
- Interventions pertaining to prevention and treatment of illness at community level
- Availability and accessibility of care of the sick and severely underweight children
- Tracking and rehabilitation of children
- Holding of Village Nutrition Counseling& Child Care Camps

Management and Care for malnutrition amongst children:A seamless care regime is imperative to rehabilitate children with malnutrition. This requires identification of severe and moderate undernutrition by Anganwadi worker who is mandated to conduct monthly growth monitoring of children at Anganwadicentre. ICDS is responsible for providing counseling along with supplementary nutrition. Specialcounseling and care sessions (SnehaShivirs) will be conducted for children not requiring treatment along with supplementary nutrition and follow up.

All children severely underweight identified by ICDS will be further screened by ANM/ ASHA / MO for wasting, stunting, loss of appetite and any other complications. These may be best done at the VHND, health checkups or camps arranged at the AWCs or the village.

Based on the anthropometric measurements and visible signs of complications there may be two lines of treatment and rehabilitation

- Those requiring treatment at NRCS/ MTCs will be referred to district health facility
- Those requiring treatment at community level and follow up at home

The community based management regime, which will be organized between cluster of 8-10 AWCs at the SHC level. The SHC will serve as the therapeutic unit for treatment under the supervision of ANM and with support from nearest or attached AWWs. Subsequently the children will be followed up by respective ASHAs and AWWs in their respective villages through home visit. Tracking of each child, and follow up will be extremely important which will be done jointly by ASHA and AWWs. Children discharged from NRCs will be enrolled in community based management till they are completely rehabilitated. All children discharged from community based management will be followed through the routine activities/ services of ICDS to sustain the rehabilitation and prevent relapse.

(c) Water and Environmental Sanitation: Water supply, sanitation and hygiene, given their direct impact on infectious disease, especially diarrhoea, are important for preventing malnutrition. Universal provision and use of safe drinking water and of toilets and good hygienic practices in households, schools, health centres and AnganwadiCentres are important measures to improve the absorptive capacity of nutrition among children and adults. The Total Sanitation Campaign (TSC) and the National Rural Drinking Water Programme (NRDWP) are two major interventions with the mandate of ensuring safe drinking water, toilets and good hygienic practices in every household, schools, health centres and AWCs among others. Through the State and District Nutrition Councils, the Multi-sectoral Nutrition Programme would facilitate timely implementation and monitoring of all enabling provisions under these programmes. In the event of these programmesunableto deliver the above mandate in selected districts, the proposed Multi-sectoral Nutrition Programme would provide gap-filling support for promoting techno linkages for cost effective water purification and sanitation measures, knowledge and dissemination regarding hygiene promotion among others, promotion of moringa plantation or leaf and any other local herbal measures.

(d) Nutrition Education: Nutrition education is essential for determining the knowledge, attitudes and practices of service providers and caregivers in order to improve the access to health services, water and sanitation, household food security and optimal child care behaviours.

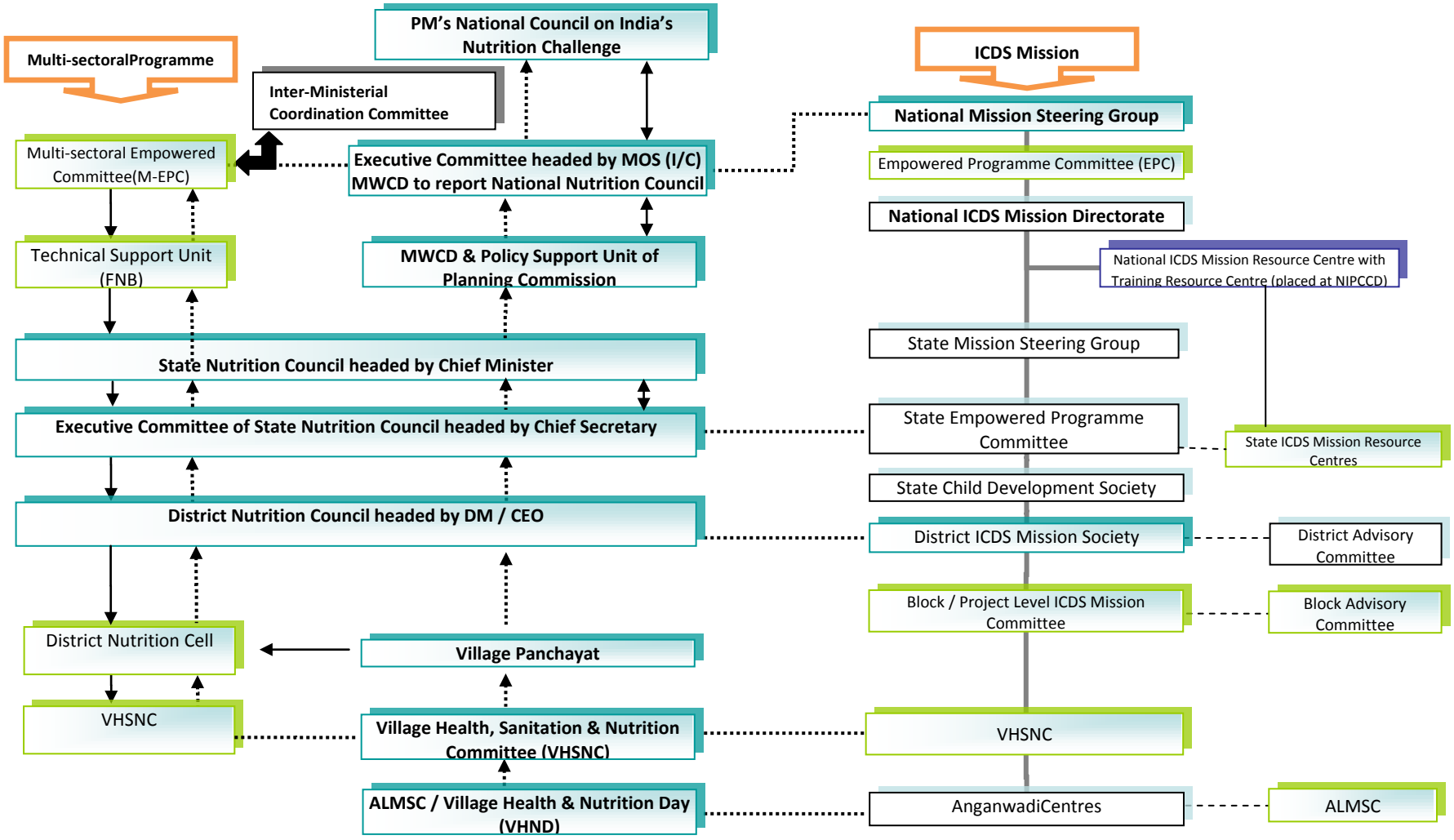
Under the Multi-sectoral Nutrition Programme efforts would be made to include basic health and nutrition education in school curricula (formal & non-formal) as well as incorporate nutrition components in the form of nutrition education and training in all relevant sectoral programmes and their respective plans at State and District levels. The Multi-sectoralNutrition Programme would provide gap-filling support. The level and extent of such gap filling support would be decided with the approval of State Nutrition Council and the M-EPC. The Programme would encourage financial support for organizing community level events such as promotion of community games, local theatre, folklore, or any other creative option for awareness generation and engagement for nutrition education.

The Ministry of Women and Child Development is in the process of setting up a Nutrition Resource Platform (NRP) with an aim to serve a number of ICDS and other stakeholders' need to keep abreast of latest knowledge in the area of maternal & child nutrition on scientific research and learning from the field through practitioners, to interact and learn from each other through exchanges of ideas and discussions and to offer end user-friendly operator services to front-line workers through interactive and mobile service networks. To give it a comprehensive character to reach the general population, the platform will also use various forms of communication namely Internet, telephone, integrated voice response system(IVRS), mobile telephone, data processors, conversion instruments, paper based communication, Internet to mobile services, voice call centre, mobile telephony servers etc. The Food and Nutrition Board (FNB) is proposed as the focal point for this NRP, which will be supported by the National Institute of Public Cooperation and Child Development (NIPPCD) and National Institute of Nutrition (NIN). Under the Multi-sectoral Nutrition Programme States / UTs would be encouraged to set up similar State Resource Platforms in their respective States / UTs by providing financial support.

(e) Rewards and Incentives:The Multi-sectoralNutritionProgramme would include support for constituting rewards and programmes for key community champions as well as grassroots level functionaries (for the purpose of promoting nutrition related cause) for whom there is no other existing provision. These may include community members, members of mothers groups, school teachers, adolescent girls etc. States may propose rewards and incentives in their APIPs and modalities for the same.

Annexure – V

Institutional Arrangements: Linkage with Nutrition Councils at Different Levels



Annexure – VI

SUGGESTED AREAS FOR ACTIONS TO BE UNDERTAKEN BY VHSNC / GRAM PANCHAYAT

1. **Arrange key activities in developing multi sectoral Nutrition Action Plan, such as meeting with different departments, need assessment and plan preparation in the long term.**
   The VHSNC/ Gram Panchayatmayorganize and coordinate convergence meeting with different sectors and facilitate the identification of problems, gaps and map available resources. Based on the findings they can facilitate the process of developing nutrition centric actions for the village / gram Panchayat.

2. **Organize activities for sensitization and awareness generation on Nutrition**
   VHSNC may be made responsible for organizing community meetings and orientation on undernutrition, create visibility of the existing problem and suggest measures for improvement and prevention. VHSNC can ensure participation of opinion leaders, families, adolescent girls and community at large at such meetings.

3. **Promote interventions for supporting nutrition outcomes such as safe disposal of excreta, safe food management etc.**
   Active promotion of nutrition sensitive actions such as improved hygiene and sanitation practices like safe disposal of excreta, use of safe drinking water etc. The VHSNC can take up measures to support these activities.

4. **Promote consumption and production of locally available foods including protein foods**
   The VHSNC may facilitate the availability of seeds for community gardens or kitchen gardens and promote the locally available vegetables. They can also support fish farming in village ponds and tanks and encourage production of eggs and poultry for local consumption.

5. **Holding healthy baby shows, village melas on health and nutrition**
   VHSNC may take lead in organizing village level activities such as village melas, baby shows, competitions etc. to encourage and educate caregivers and community.

6. **Hands on training of mothers / care givers on preparation of nutritious foods**
   With the support of AWWs, VHSNC can organize training of mothers on preparation of low cost nutritious recipes for feeding children especially from the take home ration.

7. **Incentives for local motivators/ champions of nutrition**
   VHSNC may identify local motivators for mobilization and active involvement in pro nutrition activities. Performance based incentives or awards may be given by VHSNC to such individuals or groups.

8. **Any other related area specific action at local level.**

Annexure – VII

A. KEY INDICATORS CONTRIBUTING TO REDUCTION IN MATERNAL AND CHILD UDERNUTRITION			
Impact Indicators	**Current Status (national level)**	**Goals (End 12th plan)**	**MOV**
Undernutrition			
Reduce prevalence of underweight children under 5 years	42.5 %(NFHS-3)	Contribute up to 15percent points in each district	NFHS,AHS, Independent Surveys
Reduce prevalence of underweight children under 3 years	40.4 %(NFHS-3)	Contribute up to 15percent points reduction in each district	NFHS,AHS, Independent Surveys
Reduce severely underweight children under 5 years	16.0 %(NFHS-3)	50 % reduction in all selected districts	NFHS,AHS, Independent Surveys
Reduce low birth weight	22%(NFHS-3)	Decreased by 15%	NFHS 3/ AHS/ Independent surveys
Reduction in anemia in women and children			
Under five	78.9 %(NFHS-3)	25 % in each districts	NFHS/ AHS independent survey
Adolescent girls	56.0 % (NFHS-3) (15-19 years)	30 % in each district	NFHS/AHS/ /NNMB independent survey
Pregnant women	57.9 % (NFHS-3)	30 % in each district	NFHS /AHS/independent survey
Lactating mothers	63.0% (NFHS-3)	25% in each district	NFHS /AHS /independent survey

Annexure VII A

Monitoring Frame work for Multi-sectoral Nutrition Programme

Key Outputs	Intervention/ activity	Indicators	Inputs	Ministries
RESULTS 1: Adequate Care of adolescent Girls				
Every adolescent girl takes a minimum of 52 tablets of IFA in a year Every adolescent timely de-wormed Adolescent girls provided life skill education and raise awareness on delay in marriage and first pregnancy	Supervised administration of IFA weekly	% of adolescent girls consuming 52 tablets of IFA	Training ASHA and AWWS on IFA supplementation Availability of IFA	MoHFW,MWCD&MoHRD
	Biannual de-worming	% of adolescent girls given de-worming tablets every 6 months	Availability of tablets	MoHFW, MOHRD & MWCD
	Counseling and public awareness on delayed age at marriage and first pregnancy	% of adolescent girls received Life skill education and counselling	Training of frontline workers on counseling and life skill education	MoHFW, MOHRD &MWCD
RESULTS 2: Adequate Maternal carefor improved birth outcomes				
Every women takes a minimum of 100 tablets of IFA during pregnancy and after delivery and measures to control anaemia	Active search in communities by ASHA and AWWs to identify women at early stages of pregnancy andrefer them to prenatal consultation	% of women registered by 12 weeks of pregnancy	Training of ASHA and AWWS	MoHFW& MWCD
	Ensure supplementation of 100 IFA tablets through health services	% pregnant& lactating woman receiving micronutrient supplementation	Supply of IFA tablets	MoHFW
	Sensitize pregnant women to	% of pregnant and lactating	Training of ASHA and AWWS	MoHFW& MWCD

Key Outputs	Intervention/ activity	Indicators	Inputs	Ministries
	regularly take IFA	women taking IFA tablets	on counseling for compliance of IFA	
	Distribute mosquito nets treated with long lasting insecticides and promote their utilization	% households supplied insecticide treated Mosquito nets	Supply of mosquito nets	MoHFW
Pregnant and lactating women counseled on Spacing	Provide counselling and contraceptive methods in health units to control spacing between pregnancies, during 2 years after the first delivery	% of ANM providing different contraceptive methods	Supply of contraceptives	MoHFW
Pregnant Women adequately counseled on weight gain and diet and rest during prenatal consultations	Weight gain recording and counselling on diet and rest during pregnancy Supplementary Nutrition for pregnant women	% AWWS trained on counseling on weight gain, rest and diet % pregnant women given supplementary nutrition	Training of AWWs on counseling Provision of energy and protein rich supplementary nutrition	MWCD
Lactating Women counseled on diet during post natal visit	Counselling of lactating women on diet Supplementary Nutrition for lactating women	% AWWS trained on counseling during lactation % lactating women given supplementary nutrition for at least 6 months	Training of AWWs on counselling skills Provision of energy and protein rich supplementary nutrition	MWCD
Maternity benefit and support available for Pregnant and lactating women	Cash benefit available for pregnant women Post -delivery support and benefit for mother	% of pregnant women covered in IGMSY and JSY % women covered JSSK	Schemes rolled out to reach every woman	MoHFW& MWCD
Result 3: Prevention of illnesses and Undernutrition				
ICDS Health functionaries and communities sensitized, equipped and capacitated to	Train ASHA and health staff on how to support early initiation of breastfeeding	% of functionaries trained % of community volunteers trained to promote IYCF	Skilled training of front line workers on IYCF Community sensitization	MWCD &MoHFW

Key Outputs	Intervention/ activity	Indicators	Inputs	Ministries
promote and support IYCF i.e. early initiation of breastfeeding and Exclusive Breastfeeding during the first 6 months and age appropriate complementary feeding along with breastfeeding after 6 months	Train AWWS and ASHAs on how to support a mother to ensure exclusive breastfeeding for 6 months Train AWWs to support Complementary feeding after 6 months	% of Children initiated breastfeeding within one hour of birth % of children exclusively breastfed % of children introduced to complementary feeding after six months		
All children in compliance with standard adequate growth between 0-59 months of age	Strengthen growth monitoring and nutrition counselling including foodpreparation demonstrations basedon the local foods	% of children between 0-59 months of age with severe underweight % of children 0-59 months with Moderate underweight % of children between 0-59 months who received Supplementary nutrition	Training of AWWS Requisites for Growth monitoring in place including MCPC Counseling of mothers/ families of growth faltering children on Age appropriate complementary feeding based on locally available foods during critical contacts points.	MWCD

Key Outputs	Intervention/ activity	Indicators	Inputs	Ministries
All children receive primary immunization by age one and subsequent booster doses All children sick receive appropriate facility/ community based care (IMNCI) All children 6-59 months receive vitamin A , IFA and de-worming	Hold Immunization sessions / VHND monthly Manage sick children providing follow-up support and monitoring at the facility, household and community levels Provide Supplementation through outreach services	% children fully immunized % villages conducting VHND once a month % of sick children received treatment at facility or community % children with diarrhoea who receive ORS with Zn % of children with fever / ARI treated at health facility % Children who received 2 doses of Vitamin A per year % children who receive de-worming twice annually % children who receive IFA syrup twice per week	Supply of vaccines Supervision of VHNDs Counseling of care givers on prevention of common diseases – Diarrhoea, ARI, malaria Availability of medicines , ORS with Zn, for treatment of diarrhoea ARI and Fever at community level Referral- follow up mechanism in place Field level functionaries trained in managing childhood illnesses Supply of Vitamin A, IFA De-worming tablets	MoHFW& MWCD Mo HFW
Result 4: Care and Management of Severe and Moderate Malnutrition				
All Children under six weighed and severe underweight identified All children severely underweight managed and rehabilitated at facility / community level	Growth monitoring followed by next line of action Screening by Health functionaries /officials for wasting, stunting, loss of appetite, presence of complications at AWCs,/ VHND/ health camps	% children severely underweight identified % of children identified with medical complication treated at facility	Requisites for growth monitoring Training of AWWS Facility based treatment available at district level	MWCD MoHFW

Key Outputs	Intervention/ activity	Indicators	Inputs	Ministries
	Referral to facility / community based management Rehabilitation at NRC Management through Community based intervention Follow-up	% of children without medical complication treated at community level intervention % children died	Community based management available at SHC level under the supervision of ANM Referral and follow-up mechanism in place Training of officials and frontline workers	MoHFW and MWCD MoHFW and MWCD MoHFW and MWCD
Children underweight not requiring treatment at facility or community level receive counseling and care at Anganwadi centre	Care and counseling sessions at AWCs (SnehaShivirs) Monitoring of weight gain Extra feeding	% children attending SnehaShivirs	Requisites for SnehaShivir Additional worker / link worker in high burden and JE affected districts	MWCD and MoHFW
Result 5: Food insecurity and nutrition vulnerable households with access to support services to ensure sufficient and diversified food for pregnant and lactating women,adolescents and children aged between 6-24 months				
Food security and nutrition security at the Household level improved	Availability of food grains , pulses oil at subsidized prices Promotion and consumption of locally available fruits and vegetables Supply and consumption of iodized salt Promotion, consumption and production of protein foods	% vulnerable households benefiting through TPDS % Households consuming diversified foods and locally available foods % households consuming iodized salt % of households consuming protein foods	Expansion of Food basket of TPDS Sensitization on local food production and use of vegetables and fruits Availability of and sensitization on use of iodized salt Promotion of animal foods	Mo Agriculture Do Food (TPDS) Do Horticulture & MWCD Do Food (TPDS) /MWCD Do animal husbandry/ Fisheries
Strengthened Livelihood	Ensuring 100 days of	% households employed	Provision of job under	MoRD

Key Outputs	Intervention/ activity	Indicators	Inputs	Ministries
and social security (increased purchasing power of families)	employment specially to vulnerable households Provide social transfers (cash, Food etc) to support livelihoods for the most vulnerable households and communities.	under MNREGS % households receiving social assistance	MNREGA Promote social protection for improved nutrition	 MoRD
Result 6:Ensure basic sanitation and safe drinking water in the poorest households with female teenagers, pregnant women and children under 2 years old				
Increase use of latrines and washing hands after its utilization	Community mobilization for latrine construction and their adequate utilization	% of household with latrines	Financial and technical assistance to support communities in latrine construction	MoRD
Increased knowledge of food handling, hygiene and sanitation	Promotion of good hygiene practices through hygiene and health education	% of households where members wash hands before feeding, after defecation	Hygiene and health education sessions by frontline workers	MoRD/ MWCD
Universal coverage of Safe drinking water	Availability of safe water source in households and habitations	% household with access to safe drinking water	Coverage of households / habitations with safe drinking water	DWS
Result 7: Strengthened and harmonized Institutional framework for Nutrition at all levels				
Multi-sectoral coordination mechanism in place	Nutrition coordinators appointed and assigned responsibilities at all levels Nutrition coordination structure/ committees established at National, State, district and local level	% States with Nutrition coordinators in place % States with Nutrition coordination structures in place	Resource allocation Sensitization	All related sectors
Result 8: Strengthened Human resource capacity to plan, implement and monitor multi-sectoral nutrition programme				
MoUs with relevant State	Finalization and signing of	Number of States that sign	Resources and Technical	MWCD and State

Key Outputs	Intervention/ activity	Indicators	Inputs	Ministries
Governments discussed and signed in the 1st quarter of the programme.	MoUs	MoUs	Support	Governments
State and District Nutrition Councils in all programme States	Notification to constitute State and District Nutrition Councils	Number of States that have constituted State and District Nutrition Councils	Resources and Technical Support	MWCD and State Governments
Hiring/Outsourcing of Personnel	FinalizeToRs for personnel Completion of process of hiring/ outsourcing	Timely hiring/ outsourcing of personnel at National, District and Block levels in all programme States	Resources and Technical Support	MWCD and State Governments
Preparation of Action Plans at Block and District levels	Preparation of plans in consultation with VHSNC/ ALMSC/ ULB/ other local bodies etc.	District and Block Nutrition Action Plans developed in all Blocks and Districts with the prescribed period.	Resources and Technical Support	MWCD and State Governments
Capacity in implementation, surveillance, and M&E strengthened Integrated nutrition M&E system established	Nutrition capacity building plan developed Establish a food and nutrition M&E system for tracking performance of nutrition indicators and timely decision making.	% states / districts with capacity building plan % States / Districts with Nutrition centric plans % states / districts with integrated M&E system	Resources Resources and technical support Resources and technical support	All related Ministries , Academia , IT etc.

Annexure VIII

Multisectoral Budget Sheet (GoI + State share)						
Level	**Particulars**	**Total Cost - Year wise (Rs. in Crore)**				**Total Budget (Rs. in Crore)**
		PHASE-1	**PHASE-2**			
		2013-14	**2014-15**	**2015-16**	**2016-17**	
National	Critical gap filling support as per the requirement (incl. urban models) with an upper ceiling of Rs. 20 Crore per annum	10.00	20.00	20.00	20.00	**70.00**
	Online and offline Monitoring@ Rs. 50 lakh per annum	0.25	0.50	0.50	0.50	**1.75**
	Orientation Workshops @ Rs. 25 lakh per annum	0.13	0.25	0.25	0.25	**0.88**
	IEC @Rs. 1.75 crore per annum	0.88	1.75	1.75	1.75	**6.13**
	Hiring/Outsourcing of personnel, Office Expenses & TA	0.65	1.30	1.30	1.30	**4.54**
	Flexi Fund (10% of the total National Budget)	1.19	2.38	2.38	2.38	**8.33**
	SUB TOTAL - National	**13.09**	**26.18**	**26.18**	**26.18**	**91.62**
State (Phase-1: 9 states; Phase-2: 19 states in total)	Gap filling support as per the requirement	3.50	13.30	13.30	13.30	**43.40**
	Monitoring supervision evaluation and review	0.45	1.80	1.80	1.80	**5.85**
	Capacity building and Training	1.45	5.70	5.70	5.70	**18.55**
	Technical support for collating district plans to prepare State Nutrition Action Plan	0.45	1.80	1.80	1.80	**5.85**
	Orientation Workshops & IEC	0.56	2.20	2.20	2.20	**7.16**
	Token amount @ Rs. 10 lakh per state for preparatory activities	1.00	-	-	-	**1.00**
	Flexi Fund (10% of the total State Budget)	0.74	2.48	2.48	2.48	**8.18**
	SUB TOTAL - State	**8.15**	**27.28**	**27.28**	**27.28**	**89.99**
District (including Block) (Phase-1: 100 districts; Phase-2: 200 districts in total)	Gap filling support as per the requirement @ Rs. 1 Crore per district per annum	50.00	200.00	200.00	200.00	**650.00**
	Orientation Workshops & training (engagement of CBOs) @ Rs. 5 lakh per district per annum	2.50	10.00	10.00	10.00	**32.50**
	IEC @Rs. 4 lakh per district per annum	2.00	8.00	8.00	8.00	**26.00**
	Monitoring supervision evaluation and review @ Rs. 7 lakh per district per annum (Third party evaluation for impact assessment by any external agency @ Rs. 10 lakh per district in the last year)	3.50	14.00	14.00	34.00	**65.50**
	District Nutrition Cell establishment	12.60	50.40	50.40	50.40	**163.80**
	Flexi Fund (10% of the total District Budget)	7.06	28.24	28.24	30.24	**93.78**
	SUB TOTAL - District	**77.66**	**310.64**	**310.64**	**332.64**	**1031.58**
	TOTAL	**98.90**	**364.10**	**364.10**	**386.10**	**1213.19**

NOTE: All figures are rounded off to 2 decimal places and all costs for current year has been budgeted for 6 months only.

Multi-sectoral Budget Sheet (GoI Share)						
Level	**Particulars**	**Total Cost - Year wise (Rs. in Crore)**				**Total Budget (Rs. in Crore)**
		PHASE-1	**PHASE-2**			
		2013-14	**2014-15**	**2015-16**	**2016-17**	
National	Critical gap filling support as per the requirement (incl. urban models) with an upper ceiling of Rs. 20 Crore per annum	10.00	20.00	20.00	20.00	**70.00**
	Online and offline Monitoring@ Rs. 50 lakh per annum	0.25	0.50	0.50	0.50	**1.75**
	Orientation Workshops @ Rs. 25 lakhs per annum	0.13	0.25	0.25	0.25	**0.88**
	IEC @Rs. 1.75 crore per annum	0.88	1.75	1.75	1.75	**6.13**
	Hiring/Outsourcing of personnel, Office Expenses & TA	0.65	1.30	1.30	1.30	**4.54**
	Flexi Fund (10% of the total National Budget)	1.19	2.38	2.38	2.38	**8.33**
	TOTAL - National	**13.09**	**26.18**	**26.18**	**26.18**	**91.62**
State (Phase-1: 9 states; Phase-2: 19 states in total)	Gap filling support as per the requirement	2.68	10.22	10.22	10.22	**33.35**
	Monitoring supervision evaluation and review	0.35	1.39	1.39	1.39	**4.51**
	Capacity building and Training	1.11	4.39	4.39	4.39	**14.27**
	Technical support for collating district plans to prepare State Nutrition Action Plan	0.35	1.39	1.39	1.39	**4.51**
	Orientation Workshops & IEC	0.43	1.69	1.69	1.69	**5.50**
	Token amount @ Rs. 10 lakh per state of Phase-2 for preparatory activities	0.78	-	-	-	**0.78**
	Flexi Fund	0.57	1.91	1.91	1.91	**6.29**
	TOTAL - State	**6.25**	**20.98**	**20.98**	**20.98**	**69.20**
District (Phase-1: 100 districts; Phase-2: 200 districts in total)	Gap filling support as per the requirement @ Rs. 1 Crore per district per annum	37.88	151.95	151.95	151.95	**493.73**
	Orientation Workshops & training (engagement of CBOs) @ Rs. 5 lakh per district per annum	1.89	7.60	7.60	7.60	**24.69**
	IEC @Rs. 4 lakh per district per annum	1.52	6.08	6.08	6.08	**19.75**
	Monitoring supervision evaluation and review @ Rs. 7 lakh per district per annum (Third party evaluation for impact assessment by any external agency @ Rs. 10 lakh per district in the last year)	2.65	10.64	10.64	25.83	**49.76**
	District Nutrition Cell establishment	9.54	38.29	38.29	38.29	**124.42**
	Flexi Fund (10% of the total District Budget)	5.35	21.46	21.46	22.97	**71.23**
	TOTAL - District	**58.83**	**236.01**	**236.01**	**252.72**	**783.57**
	TOTAL	**78.17**	**283.17**	**283.17**	**299.88**	**944.39**

NOTE: All figures are rounded off to 2 decimal places and all costs for current year has been budgeted for 6 months only.

Multi-sectoral Budget Sheet (State Share)						
Level	**Particulars**	**Total Cost - Year wise (Rs. in Cr)**				**Total Budget (Rs. in Cr)**
		PHASE-1	**PHASE-2**			
		2013-14	**2014-15**	**2015-16**	**2016-17**	
National	Critical gap filling support as per the requirement (incl. urban models) with an upper ceiling of Rs. 20 Crore per annum	0.00	0.00	0.00	0.00	**0.00**
	Online and offline Monitoring@ Rs. 50 lakh per annum	0.00	0.00	0.00	0.00	**0.00**
	Orientation Workshops @ Rs. 25 lakhs per annum	0.00	0.00	0.00	0.00	**0.00**
	IEC @Rs. 1.75 crore per annum	0.00	0.00	0.00	0.00	**0.00**
	Hiring/Outsourcing of personnel, Office Expenses & TA	0.00	0.00	0.00	0.00	**0.00**
	Flexi Fund (10% of the total National Budget)	0.00	0.00	0.00	0.00	**0.00**
	TOTAL - National	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
State (Phase-1: 9 states; Phase-2: 19 states in total)	Gap filling support as per the requirement	0.82	3.08	3.08	3.08	**10.06**
	Monitoring supervision evaluation and review	0.11	0.41	0.41	0.41	**1.34**
	Capacity building and Training	0.34	1.31	1.31	1.31	**4.28**
	Technical support for collating district plans to prepare State Nutrition Action Plan	0.11	0.41	0.41	0.41	**1.34**
	Orientation Workshops & IEC	0.13	0.51	0.51	0.51	**1.66**
	Token amount @ Rs. 10 lakh per state of Phase-2 for preparatory activities	0.22	-	-	-	**0.22**
	Flexi Fund	0.17	0.57	0.57	0.57	**1.89**
	TOTAL - State	**1.90**	**6.30**	**6.30**	**6.30**	**20.79**
District (including Block (Phase-1: 100 districts; Phase-2: 200 districts in total)	Gap filling support as per the requirement @ Rs. 1 Crore per district per annum	12.13	48.05	48.05	48.05	**156.28**
	Orientation Workshops & training (engagement of CBOs) @ Rs. 5 lakh per district per annum	0.61	2.40	2.40	2.40	**7.81**
	IEC @Rs. 4 lakh per district per annum	0.49	1.92	1.92	1.92	**6.25**
	Monitoring supervision evaluation and review @ Rs. 7 lakh per district per annum (Third party evaluation for impact assessment by any external agency @ Rs. 10 lakh per district in the last year)	0.85	3.36	3.36	8.17	**15.74**
	District Nutrition Cell establishment	3.06	12.11	12.11	12.11	**39.38**
	Flexi Fund (10% of the total District Budget)	1.71	6.78	6.78	7.27	**22.55**
	TOTAL - District	**18.83**	**74.63**	**74.63**	**79.92**	**248.01**
	TOTAL	**20.73**	**80.93**	**80.93**	**86.21**	**268.80**

NOTE: All figures are rounded off to 2 decimal places and all costs for current year has been budgeted for 6 months only.