

**HARYANA GOVERNMENT
WOMEN AND CHILD DEVELOPMENT DEPARTMENT
NOTIFICATION**

The 8th Feb., 2017

No.158-SW (3)-2017. In supersession of Haryana Government, Women and Child Development Department Notification No 394 SW/2013, dated 17th December, 2013 regarding State Nutrition Policy, the Governor of Haryana is pleased to frame and introduce revised State Nutrition Policy (copy enclosed) for implementation in the State with immediate effect.

Dated, Chandigarh
02-02-2017

P.K Mahapatra
Additional Chief Secretary to Government, Haryana
Women and Child Development Department.

Endst. No 158-SW(3)-2017

Dated 08-02-2017

A copy is forwarded to the following for information and necessary action:-

1. Accountant General (A&E) Audit, Haryana, Chandigarh
2. Director, Women & Child Development Department, Haryana.
3. All members of Haryana State Nutrition Council.
4. All members of Haryana State Executive Committee.

Rajesh Singh

Superintendent (SW)
for Additional Chief Secretary to Government, Haryana
Women and Child Development Department.

Endst. No 158-SW(3)-2017

Dated 08-02-2017

A copy is forwarded to the Controller, Printing & Stationary Haryana, Chandigarh for publishing the notification along with State Nutrition Policy in the Haryana Government Gazette.

Rajesh Singh
Superintendent SW
for Additional Chief Secretary to Government, Haryana
Women and Child Development Department.



STATE NUTRITION POLICY HARYANA

2016

HARYANA

Table of Contents

	Executive Summary	3-4
1	Introduction	5-6
2	Nutrition Scenario	6-18
3	Nutrition Goals	19-24
4	Implementation Structure	24
5	Setting up of State Nutrition Mission	25-27
6	Role of the departments	28-33
7	Community Ownership and Participation	34-36
8	Monitoring	36
9	Funding	36

EXECUTIVE SUMMARY

Malnutrition is a problem of staggering size worldwide and continues to threaten the health and wellbeing of millions in India. The prevalence of malnourished children is highest in the world. High proportion of undernutrition combined with the large population base, had made India the country with the largest number of stunted, underweight and wasted children. Malnutrition is widespread across the country in all states. There is concentration in few states and in those states in few districts.

Haryana is a relatively new state and has achieved all round development. It is one of the prosperous states in India. High economic growth in the state is accompanied by a significant reduction in poverty. Population below poverty line has declined from over 35 percent in the 1970s to 9 percent in 1990s. One of the remarkable achievement in Haryana is the more rapid reduction in rural poverty. The state has also improved human development indicators. Literacy rate has increased from 26 percent in 1971 to 68 percent in 2001. Haryana is one of the largest contributors of food grains to the central pool.

The Human Development Index (HDI) for the country as a whole has improved from 0.302 in 1981 to 0.472 in 2001. The HDI for Haryana has improved from 0.360 in 1981 to 0.509 in 2001. As per HDI, the Haryana was ranked at 15 in 1981, 16 in 1991 and 5 in 2001. Significant steps have been taken to reduce and eliminate the gender inequality in Haryana and its women are much more empowered now than before.

Malnutrition continues to be a development challenge in Haryana. The state has the necessary infrastructure that has been created, it has the financial power and necessary capacity to reduce malnutrition at a much faster rate and rid its society of this scourge.

Investments in health, sanitation, agriculture, women's status, and food and nutrition programmes need to be coordinated because any weak link in the chain will undermine all other investments. Haryana therefore needs draw up its own nutrition policy to fast track achievement of nutrition goals. The state nutrition policy combined with appropriate mechanism for accountable and transparent implementation can rapidly reduce malnutrition in the state.

This document provides a background to the problem of malnutrition globally, in India and in the state of Haryana. Available interventions to reduce and prevent malnutrition in the critical physiological groups so as to arrest the intergenerational transfer of malnutrition by various departments have been included. Overall vision of nutrition policy is to achieve sustainable improvement in the Health and nutrition status of women and children in Haryana with focus on most vulnerable population and families. Nutrition goals aims at reduction in under nutrition and low birth weight in children, anaemia in young children, adolescent girl and women and improvement in immunization which will be achieved through inter-Sectoral convergence.

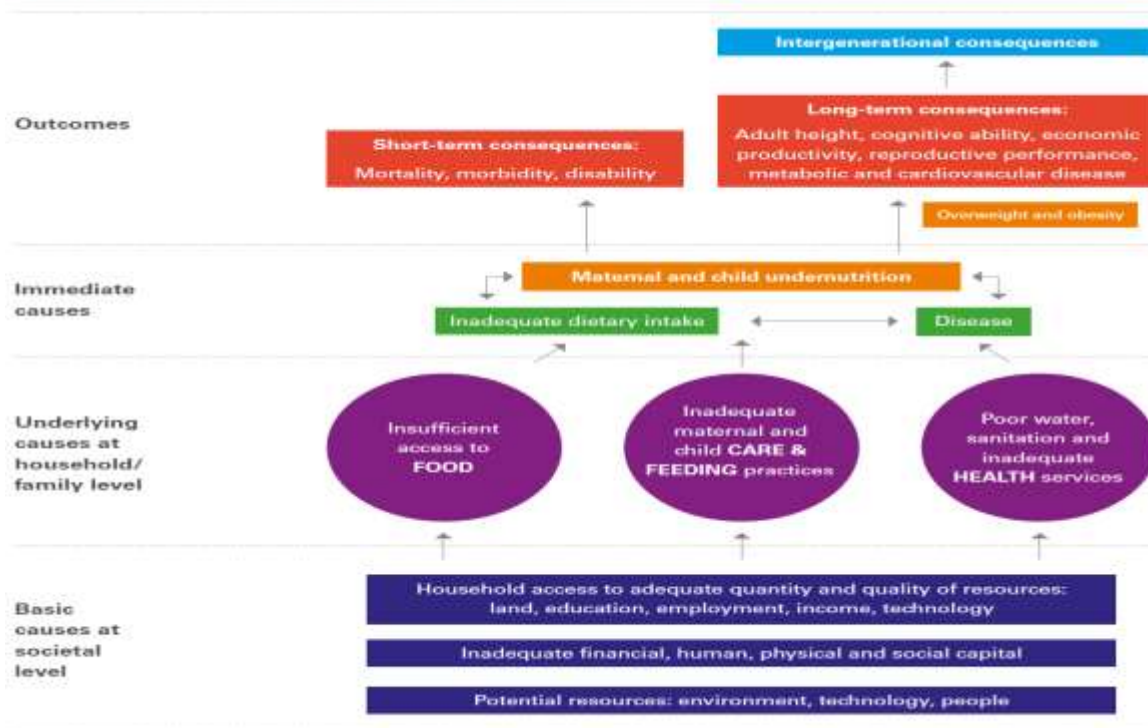
State Nutrition Mission will be established with focus on leadership and accountability, scaling up of nutrition interventions and Multi-Sectoral approach through linkages with key sectors affecting Nutrition. The Mission shall work to bring improvement in the measurable outcomes i.e. Infant and young child care/ health, maternal care and nutrition, adolescent nutrition and control of micronutrients deficiencies.

1. INTRODUCTION

Malnutrition is one of the most concerning health and development issues in India as well as in other parts of the world. It continues to remain one of the greatest development challenges for the world. Malnutrition affects all countries and almost one in three people on the planet. Nearly half of all countries are dealing with more than one type of malnutrition at the same time. And the threat is growing. Despite progress, improvements in nutrition still represent a massive unfinished agenda.

Malnutrition is a largely hidden public health problem and the complex nature of its underlying causes calls for collaborative action from different sectors to work towards its elimination. As the conceptual framework illustrates (Fig-1), preventing child under nutrition requires integrated actions to improve maternal, infant and young child health and nutrition simultaneously, including appropriate infant feeding practices. In fact, the evidence base suggests that the ‘window of opportunity’ for addressing child malnutrition, both under and over nutrition, is from conception to 24 months, which encompasses the period around conception and the periods of pregnancy, breastfeeding and complementary feeding. As the consequences of under nutrition are known to be particularly severe, potentially even irreversible, for infants and children under the age of two, there are strong arguments for focusing interventions on the time between a woman’s pregnancy and her child’s second birthday. This time period has come to be known as first 1,000 days of life.

Figure 1: Conceptual framework for analysing the causes of malnutrition



Ref: Adapted from UNICEF, 2014.

Figure 1- Conceptual framework for malnutrition.
Source: UNICEF

Addressing general deprivation and inequity would result in substantial reductions in undernutrition and should remain a global priority. It should however be remembered that major reductions in malnutrition can be made through programmatic health and nutrition interventions.

Malnutrition takes many forms. It includes stunting, wasting, underweight, and deficiencies of essential vitamins and minerals (micronutrients) together referred to as undernutrition. The other dimension is overweight and obesity that results from overconsumption of specific nutrients.

2. NUTRITION SCENARIO

2.1. Malnutrition

2.1.1. Global Situation

Globally 2 billion people experience micronutrient malnutrition; 1.9 billion adults are overweight or obese; 161 million children under age 5 are too short for their age (stunted), 51 million don't weigh enough for their height (wasted), and 42 million are overweight; none of these children are growing healthily; 794 million people are estimated to be calorie deficient; and 1 in 12 adults worldwide have Type 2 diabetes. In many countries, only a minority of children are growing healthy.

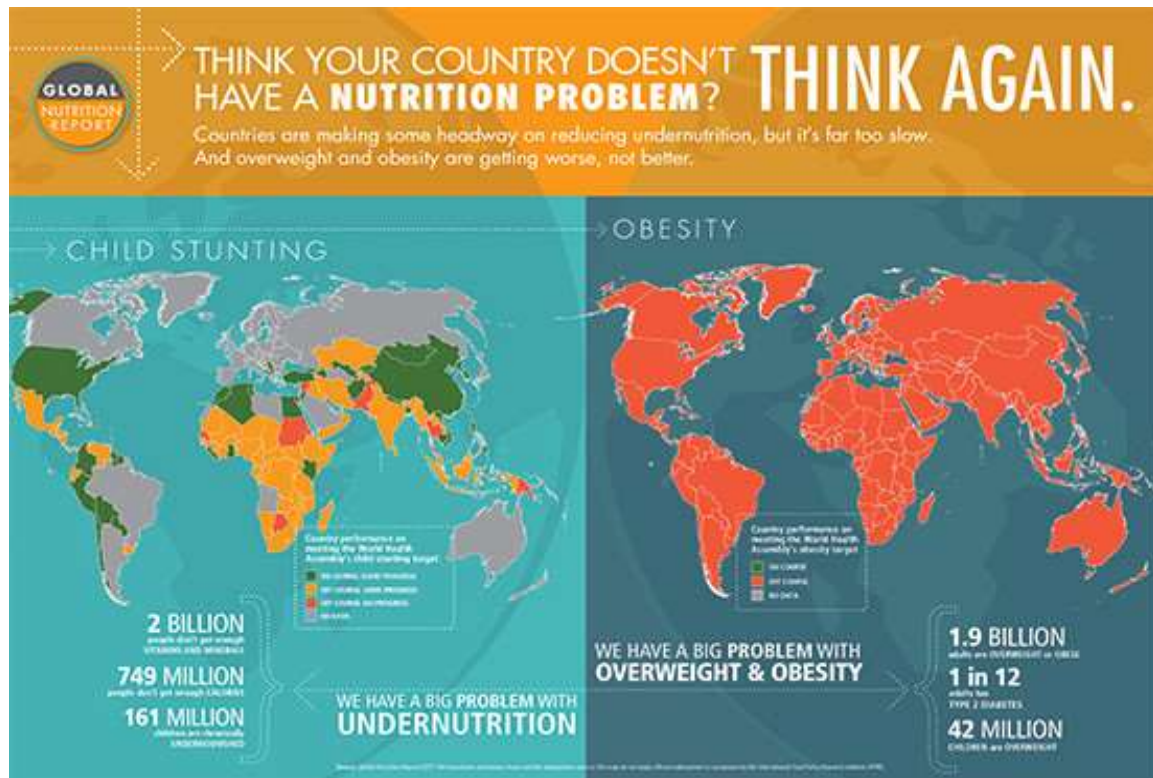


Figure 2- Global Nutrition Report

Stunting is most important and most widely used indicator to measure nutritional status of a community. Stunting is a risk factor for diminished survival, childhood and adult health, learning capacity, and productivity.

It is estimated that globally there are 161 million children who are stunted. This shows a decrease in prevalence from 39.6 percent to 23.8 percent. However, this number has declined between 1990 to 2014 though it indicates that the rate of decline is slow and can happen much faster with available interventions. Global prevalence of wasting stands at 7.5 percent. That is one out of every 13 children is wasted. Nearly a third of all wasted children are severely wasted. Globally there are 50 million children under 5 who are wasted and 16 million of them are severely wasted.

Chronic energy deficiency reflected as low Body Mass Index in women of reproductive age is a useful indicator of maternal nutrition. We know that health of a child is inextricably linked to the health of the mother. Empirical evidence show that the height and weight of mother is closely related to infant birth weight and pregnancy

outcomes such as parental mortality, low birth weight and stunting are often due to chronic malnutrition during pregnancy. Mothers who enter pregnancy with sound nutritional status, and who have not suffered ill health or nutritional deprivation during pregnancy are more likely to have larger healthier infants than those mothers who do not have such advantages. Prevalence of low BMI ($<18.5 \text{ kg/m}^2$) is in the order of 10 percent of all women in reproductive age group. There are wide regional variations. There are 1.2 billion adolescents (aged 10-19 years) in the world. They are the key target group to improve maternal and thus child nutrition in low and middle income countries. Adolescence is the period of rapid growth and However, no global prevalence figures are available for stunting, low BMI for this important target group.

Micronutrient deficiencies are now recognized as an important contributor to the global burden of disease. Iodine deficiency in pregnancy has long been linked to intra-uterine brain damage and possible foetal wastage. It is known that iodine deficiency is the single most important cause of preventable mental retardation in the world. It is also estimated that iodine deficiency is the attributable cause of 0.2 percent of global burden of disease. The strategy of Universal Salt Iodisation has substantially improved iodine nutrition in many countries. Globally 131 countries have USI as a strategy and in only 31 countries iodine deficiency continues as a public health problem.

Vitamin A deficiency harms the eyes and increases childhood and maternal mortality. Globally, 21 percent of children have vitamin A deficiency and suffer increased rates of death from diarrhoea, measles, and malaria. About 800,000 deaths in children and women of reproductive age are attributable to vitamin A deficiency which accounts for 1.8 percent of global burden of disease. Vitamin A supplementation is reaching millions of children and has contributed to reduction in child mortality. Maternal vitamin A deficiency can cause visual impairment and possibly other health consequences. Globally, the prevalence of night blindness in pregnant women is estimated to be 7.8 percent affecting 9.7 million women. Maternal night blindness has been associated with increased low birth weight and infant mortality.

Zinc deficiency is increasingly recognized as an important public health problem throughout the world. Zinc is required for optimal growth in children and for immunity. It is suggested that 17 percent of world's population is at risk of zinc deficiency on the basis of analysis of national diets. It is estimated that about 800,000 child deaths are attributable to zinc deficiency per year and that it contributes 1.9 percent of global burden of disease.

Global prevalence of folate deficiency has not been estimated because of the scarcity of suitable population based data. Nearly half of the neural tube defects are because of folate deficiency around the time of conception. Globally nearly 250,000 children are born with neural tube defects and increasing folate intake in women of reproductive age group can bring this down by more than half.

2.1.2. Indian Situation

Malnutrition in India is a silent emergency. According to NFHS 3, 42.5 per cent of children under the age of five years are underweight (low weight for age), 48 per cent are stunted (low height for age), 19.8 per cent are wasted (low weight for height) (Fig-3). Thirty six percent of adult women have chronic energy deficiency (Body Mass Index <18.5).

In a population with normal growth pattern for children, about 2.3 percent of children under 5 years of age would be underweight. In contrast in India percentage of children who are underweight is 19 times the expected level. The percentage of children who are stunted is 19-21 times as high as would be expected in a well-nourished population and the percentage of children who are wasted is 8-9 times the expected. The nutritional status of Indian children is much worse than the expected and acceptable levels in all indicators.

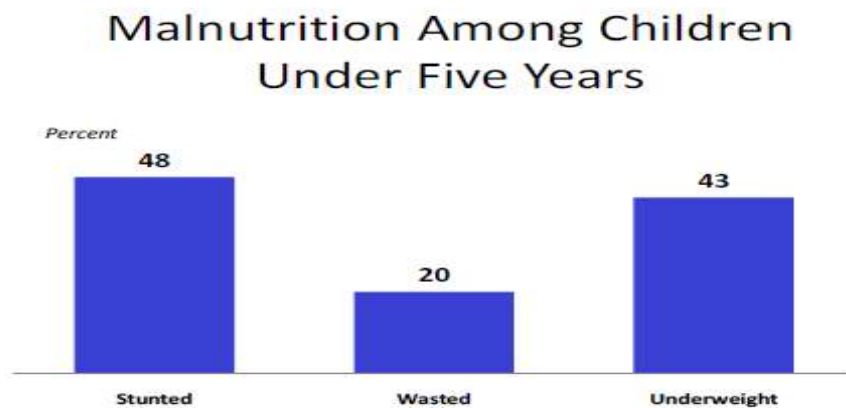


Figure 3 - Malnutrition Among Children Under Five Years.
Source: NFHS-3

Cumulative Distribution of Weight-for-Age Z-scores

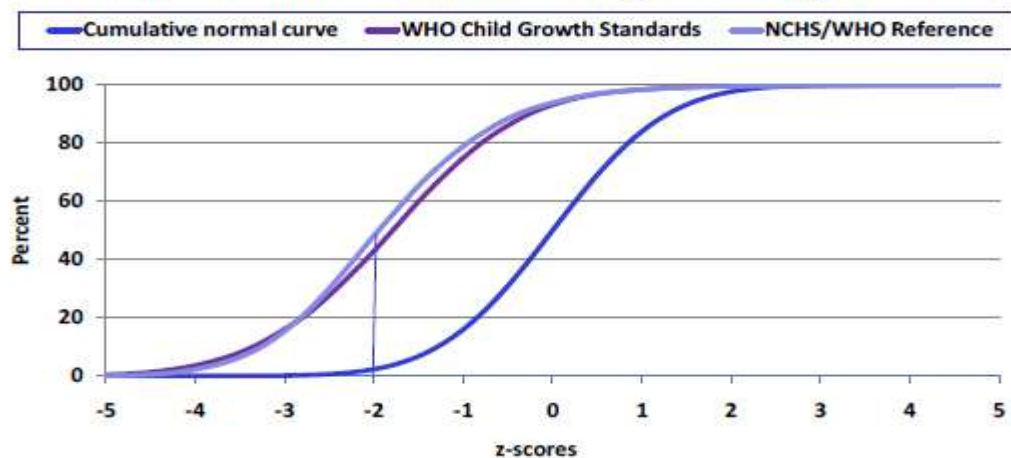


Figure 4 - Cumulative Distribution of Weight -for- Age Z-Scores

India has witnessed impressive economic growth in the recent times and has achieved much in many fronts. However, the progress in reducing malnutrition over the past decades has been modest and much slower than what has been achieved in other countries with comparable socioeconomic indicators. The prevalence of malnutrition varies across states and across socioeconomic status.

Trends in Malnutrition Among Children Under Three Years

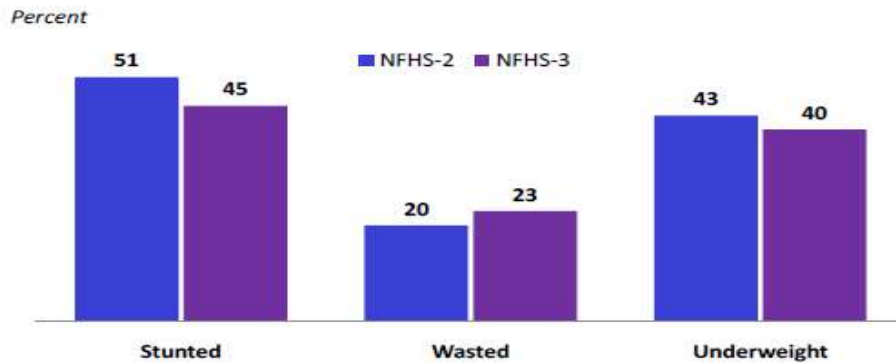


Figure 5-Trends in Malnutrition Among Children Under Three Years.
Source: NFHS-3

Anaemia and iron deficiency anaemia are major public health problem in the country. The level of anaemia is high and has not changed in years. Seventy percent of children below 5 years were found to be anaemic in NFHS 3. And analysis of data from the previous NFHS shows that there is insignificant reduction in anaemia prevalence.(Fig-6)

Trends in Anaemia Among Children Age 6-35 Months

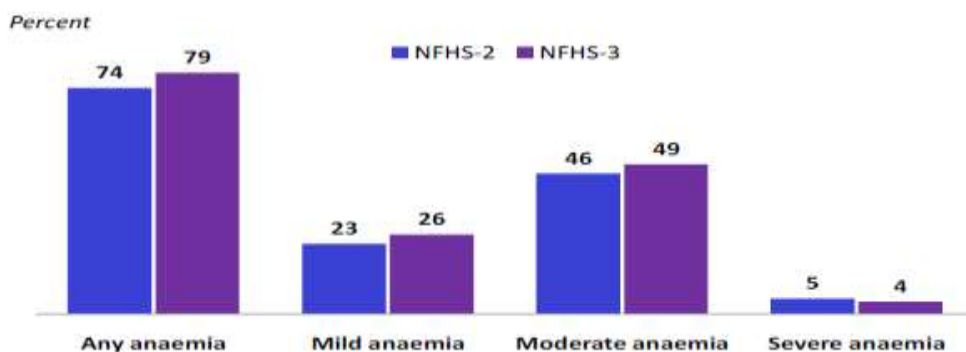


Figure 6-Trends in Anaemia among Children Age 6-35 Months.
Source: NFHS

Breastfeeding is a common practice in India. However, appropriate breastfeeding is not done. Only 46 percent of infants are breastfed exclusively for the first 6 months. When we look at the IYCF indicators as recommended by WHO, only 21 percent of children in the age group of 6-23 months receive all three recommended IYCF practices. This is the most important age group and infant and young child feeding practices are the most important determinant of growth in this age group. Children who falter in their growth during this critical period of growth and development lag behind and don't reach their true intellectual and physical growth potential.

A third of women in reproductive age group are too thin with body mass index less than 18.5. At the same time nearly 15 percent are overweight/obese, a new increasing trend seen even in rural areas. Anaemia prevalence in women is also high. Nearly 56 percent of women of reproductive age group are anaemic. 2 percent have severe anaemia and another 15 percent have moderate anaemia. Anaemia prevalence in women of reproductive age has increased in the NFHS 3 compared to NFHS 2.

Malnutrition and poverty trap

Malnutrition is the underlying cause of death accounting for half of all deaths among children under the age of five. Malnutrition during critical phases of development impairs cognitive development and seriously affects educability. Sound nutrition can change children's lives, improve their physical and mental development, protect their health and lay a firm foundation for future productivity. Malnutrition is both a result and cause of poverty – a 'poverty trap'. Malnutrition has huge economic cost and countries with high prevalence of malnutrition may lose as much as 3 percent of their Gross Domestic Product. Improved nutrition is central to improved income generation, poverty reduction, and more rapid development. "... eliminating hunger and malnutrition have high economic benefits. For instance, in India, research shows that every dollar spent on interventions to reduce stunting is estimated to generate about USD\$34 in economic returns" writes Shenggen Fan, Director General of International Food Policy Research Institute(IFPRI).

2.1.3. Haryana Situation

The State of Haryana, with 21 districts has a population of around 2.54 crores and 13.3 percent of the population are under the age of 6 years. With 65.12 percent of rural (most of whom are engaged in agriculture) Haryana is the second highest contributor of grains to country's central pool and is one of the wealthier States of the country. However, despite its progressive status among other states, Haryana exhibits high rates of undernutrition. The ongoing programmes are making efforts to improve nutrition (Table-1) but anaemia and undernutrition among children and pregnant women are rising alarmingly in Haryana.

Table-1. On Going Programmes to Improve Nutrition

Department	Programmes/Interventions
Women and Child Development	<ul style="list-style-type: none"> • Integrated Child Development Services Scheme (ICDS) through a network of 25450 AWCs and 512 Mini AWCs. • Supplementary Nutrition under ICDS:- Provision of hot cooked food and take home ration to all children under 6 years, pregnant and lactating mothers in compliance to section 4 A, Section 5 A, 5 B and section 6 of the National Food Security Act, 2013. • Kishori Shakti Yojana Scheme (in 15 districts)-for providing Vocational training and supplementary nutrition to adolescent girls. • Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (SABLA) Scheme in 6 districts i.e. Ambala, Rewari, Hissar, Yamunanagar, Kaithal & Rohtak • Indira Gandhi Matritva Sahyog Yojana (pilot in Panchkula)-financial support is being provided to pregnant mother at 3rd trimester and after completion of 6 months age of baby for supporting complementary feeding) • Improving Infant and Young Child Feeding • Best Mother Award • Nutrition Award. • Multi Sectoral Nutrition Programme is proposed for 5 districts.i.e Narnaul, Palwal, Mewat, Kaithal & Fatehabad. • Beti Bachao Beti Padao
Health and Family Welfare	<ul style="list-style-type: none"> • Micronutrient Supplementation Programme (MSP) Vitamin-A, Deworming, Iodine, IFA syrup • Infant And Young Child Feeding • Facility based SAM management • Food fortification Programme • Family Planning • Adolescent Reproductive and Sexual Health (ARSH) and Menstrual Hygiene programme) • Rashtriya Bal Swasthya Karyakram (RBSK)
Department of School Education	<ul style="list-style-type: none"> • Mid-Day Meal Scheme
Development and Panchayat Department	<ul style="list-style-type: none"> • State Incentive Scheme on Sanitation • Mukhaya Mantri Anusuchit Jati Nirmal Bastiyojna • Swachh Bharat Abhiyan • Training of PRIs
Food and Supplies	<ul style="list-style-type: none"> • Public Distribution System • National Food Security Act
Urban Local Bodies	<ul style="list-style-type: none"> • Information, communication and mobilization through urban local bodies • Training of Urban Local Body
Labour Department	<ul style="list-style-type: none"> • Education, Health and Nutrition facilities at brick-kiln and construction sites through crèches

There were 40 percent of children who were underweight, 46 percent stunted and 19 percent wasted as per NFHS-3, 2005-06. There are improvements in the prevalence of underweight children from 40 percent in 2005-06 (NFHS-3) to 29 percent in 2015-16 (NFHS-4) and in stunted children from 46 percent to 34 percent (NFHS-4) but the percent of wasted children has increased from 19.5 percent (NFHS-3) to 21.2 percent (NFHS-4, Fig-7).

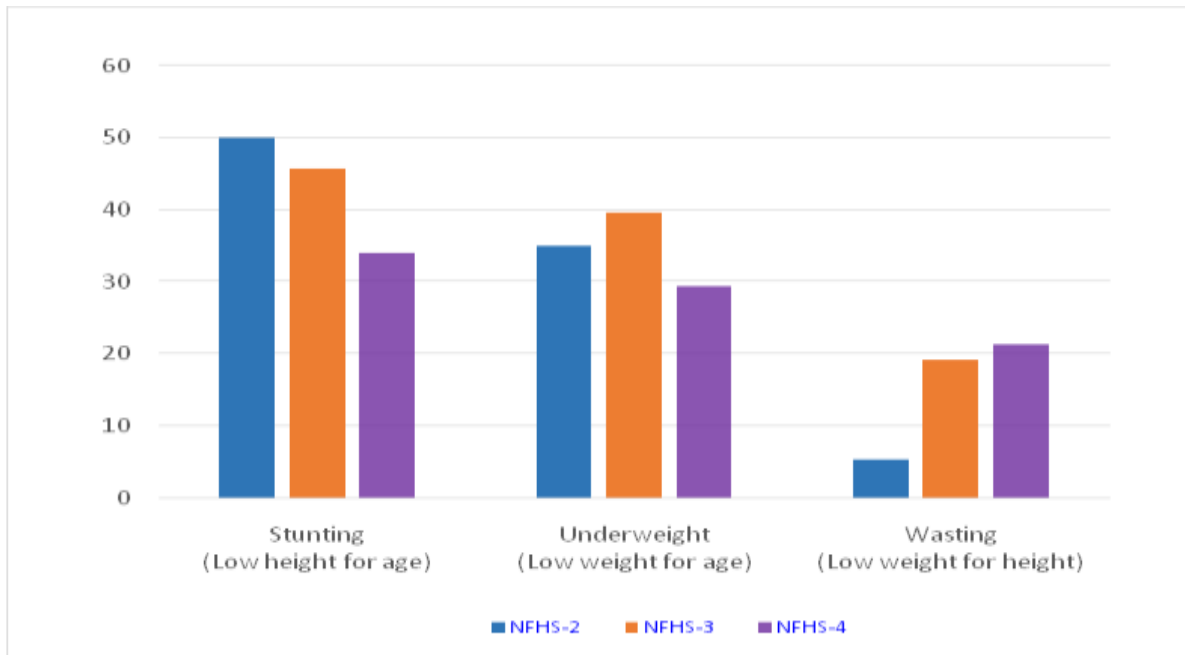


Figure 7- Trends in malnutrition in Haryana (in percent).
Source: NFHS data)

The Post Graduate Institute for Medical Research and Education (PGIMER) 2013, Chandigarh carried out a survey in four districts of Haryana, i.e., Ambala, Karnal, Panchkula and Yamunanagar. Results obtained through these recent PGIMER surveys were similar to that of NFHS-3 and reveal that nothing much has changed in the State since then. Percentage of underweight children in all four districts was more than 35, with Karnal having the highest proportion of underweight children at 40 percent. Stunting was observed maximum in Ambala touching 45 percent while other districts the prevalence was found to be around 40 percent. Wasting or acute malnutrition data was found to be alarming at 17.5 percent in these four districts, with 5 percent severe wasting.

National Institute of Nutrition, Hyderabad was engaged by Women and Child Development Department, Haryana for conducting a survey for assessing the nutrition status of children below 5 years in 2013-14. The survey found that there were 7.97 percent of severely underweight children and 19.88 percent of moderately underweight children in the State. It also found 2.7 percent of children to be severely wasted and 8.29 percent to be wasted; 11.31 percent children were found to be severely stunted with an overall stunting rate of 34.1 percent.

Infant and Young Child Feeding Practices

Infant and young child feeding practices remain far from optimal during 2005-06 indicating early initiation of breast feeding in only 22 percent, exclusive breast feeding in 17 percent and introduction of complementary feeding after 6 month of age is found to be only 43 percent in the state (NFHS-3). NFHS-4, 2015-16 report reveals that some improvements have been observed in IYCF practices indicating the initiation of breastfeeding within one hour in 42.4 percent cases and 6 months of exclusive breastfeeding in 50.3 percent cases. Coverage of essential interventions for infant and young child feeding practices as per NFHS-4 2015-16 has been depicted in Fig-8.

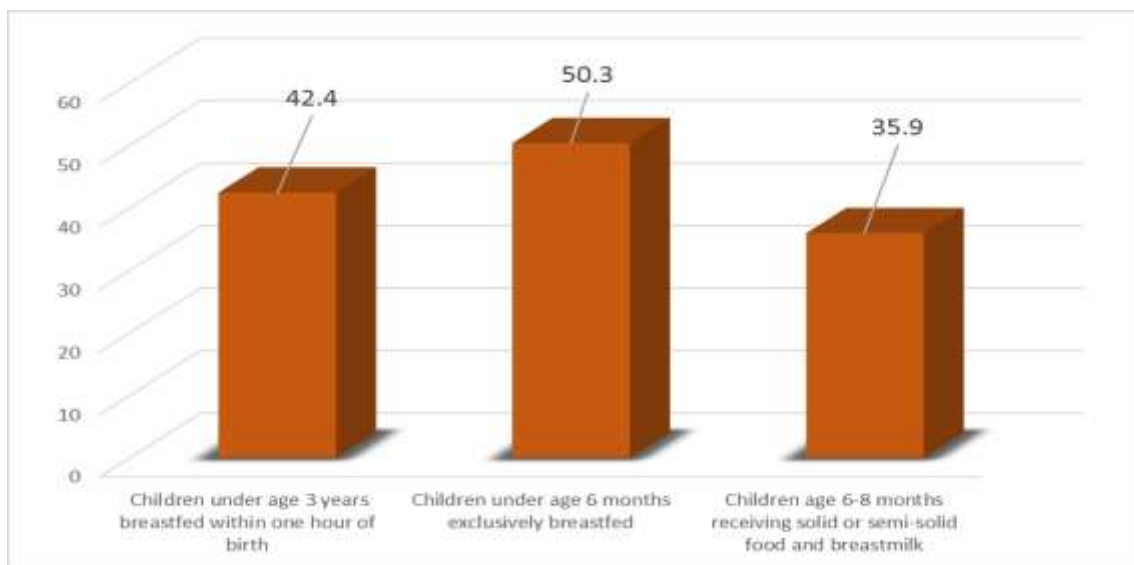


Figure 8 - Coverage of essential interventions for infant and young child feeding practices and care. Source: NFHS-4,2015-16

The NIN survey in 2013 in few districts showed that majority of the mothers (93.4 percent) within 1 hour, while 24 percent initiated 1-3 hours of delivery. This is a significant improvement compared to the NFHS 3. The initiation of breastfeeding within 1 hour of birth was higher in Rohtak division (51.8 percent) and lower in Ambala division (38.2 percent). About 16 percent initiated breast feeding after 24 hours of delivery. Pre-lacteal such as glucose water, cow/buffalo milk, honey, etc. were given to 39 percent of the infants. The use of pre-lacteal was more in Ambala division 47.4 percent and low in Gurgaon division 31.8 percent.

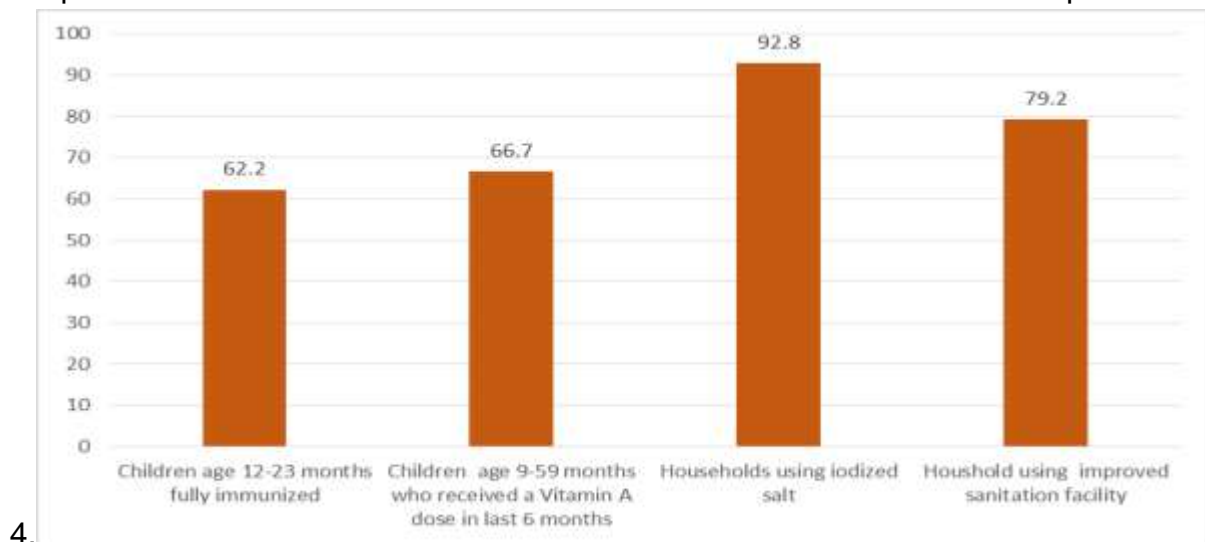
About 79 percent of 6-11 months children received complementary feeding in addition to breast milk, while only 14 percent received the same at 6 months of age, and 58 percent children received after 6 months of age. This is another important and most welcome improvement noticed in the survey compared to the NFHS 3 findings. About 14 percent of infants did not start complementary feeding. The proportion of

children receiving complementary feeding in addition to breast milk was higher in Ambala division 85.9 percent and lower in Gurgaon division 73.8 percent.

Among 6-11 months infants, majority were receiving homemade semisolids/solids (67-70 percent) and cow/buffalo milk 73.4 percent, about 63 percent were receiving such foods at least 3 times a day. Among 12-35 months children, 55 percent children received complementary feeding in addition to breast milk, ranging from a high of 59 percent in Rohtak division to 52 percent in Gurgaon division. Majority 91-96 percent were receiving homemade semisolids/solids and 91 percent were receiving such foods at least 3 times a day.

Maternal and Child Health

As per recent NFHS-4 survey, 62.2 percent of children (age 12-23 months) have been fully immunized for BCG, Measles and 3 doses each of polio and DPT. Coverage of Vitamin A Supplementation in children (9-59 months) has improved from 16 percent as reported in NFHS-3 to 66.7 percent as reported in NFHS-4, 2015-16. Improvement has been observed in percentage of Children with diarrhoea in last 2 weeks who received oral rehydration salts from 24.3 percent in NFHS-3 to 61 percent in NFHS-4. 22 percent children with diarrhoea in last 2 weeks received Zinc as per NFHS-



4. **Figure 9 - Coverage of essential interventions for access to health services.**

Source: NFHS-4, 2015-16

Maternity care has not improved much during the last decade. As per NFHS-4, only 45 percent mothers had at least 4 antenatal care visits. The report also reveals that only 19.5 percent mother had full antenatal care and only 32.5 percent mothers consumed IFA tablets for 100 days or more when they were pregnant. Registered pregnancy for which the mother received MCP card is reported 92 percent. 80.5 percent of institutional births have been reported in NFHS-4. Coverage of essential interventions and care of women during pregnancy is low as depicted in Fig -10.

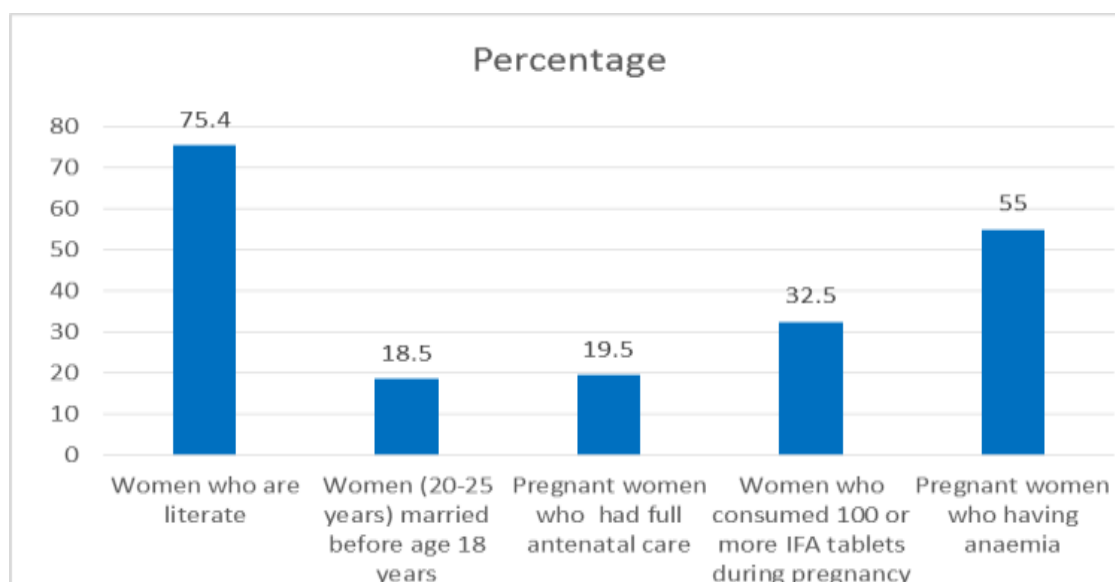


Figure- 10 Coverage of essential interventions for care of women.
Source: NFHS-4,2015-16

Dual Burden

The Double Burden of Malnutrition (DBM) is the coexistence of both undernutrition and over-nutrition in the same population across the life course. “Across the life course” refers to the phenomenon that undernutrition early in life contributes to an increased propensity for over-nutrition in adulthood. The DBM affects all countries, rich and poor, and is a particular concern in countries with high stunting rates. The consequences of the DBM are enormous. NFHS-3 data suggests that India is also witnessing nutrition transition and double burden is real and already there in both rural and urban areas. NFHS-3 has reported that overweight/obesity has affected almost 17 percent of women and 11 percent of men, mostly in urban areas, in wealthier households, and among older adults in Haryana. Prevalence of Obesity has increased to 21 percent in women and 20 percent in men in Haryana (NFHS-4)

Safe Drinking Water, Sanitation and Hygiene

It is generally agreed that there is a bidirectional relationship between diarrhoea and malnutrition. In India with the practice of open defecation by nearly half the population, it is suggested that water, hygiene and sanitation is a significant contributor to child malnutrition. World Health Organization (WHO) estimates that nearly half of malnutrition is associated with repeated diarrhoea or intestinal worm infestation as a result of unsafe water, inadequate sanitation or insufficient hygiene. While there has been considerable progress in ensuring safe drinking water, ensuring universal access to sanitation and improving hygiene practices remains a key challenge.

NFHS-3 reported that 96 percent of households in Haryana use an improved source of drinking water 99 percent of urban households and 94 percent of rural households). The households using improved drinking water source has reduced to

91 percent .The usage is more in rural areas (94.3 percent) than urban areas (88.0 percent) as reported in NFHS-4. Only 40 percent have water piped into their dwelling yard, or plot during 2005-06 which has increased to 79.2 percent in 2015-16.

Out of 6804 villages, 58 villages has been categories as deficient villages where the drinking water supply status is less than 40 litres per capita per day (lpcd). All 79 towns in Haryana are being provided water @110 to 135 lpcd.

As per Census 2011, in India 53.1 percent households did not have latrines as compared to 63.6 households in Census 2001. As per NFHS-3 the stools of 79 percent of children under five years of age were disposed of unsafely. There was hygiene disposal of the stools of only fifth young child. In Haryana 48 percent of household have no toilet facility (NFHS-3). Two third of the rural households 55 percent have no toilet facility as against only 11 percent among urban households.The toilet facility have been improved with 79 .2 percent households using improved sanitation facilities (NFHS-4).

The improvement of hygiene practices such as hand washing and safe disposal of waste remains a challenge, which is now being addressed by Swachh Bharat Abhiyan.

2.2. Other Micronutrients Deficiencies

2.2.1. Iron Deficiency Anaemia

Anaemia is another major health problem in Haryana, like other states of India, especially among women and children. About 58 percent of women in reproductive age group (15-49 years) are anaemic while approximately 6 percent have severe anaemia. Anaemia is particularly high for women who are pregnant or breastfeeding and for women in the lowest wealth quintile. More than half of the pregnant women (59.6 percent) are anaemic, out of which around seven percent suffer from severe anaemia. Anaemia is prevalent in 62.7percent of women in the age group of 15-49 years and 55 percent of pregnant women as per NFHS-4.

Children of mothers who have anaemia are much more likely to be anaemic. Among children between the ages of 6 and 59 months, a large majority (71.7percent) are anaemic (NFHS-4). More than 50 percent females in the age group of 6-19 years are anaemic, which means they are at risk of entering pregnancy with sub-optimal levels of haemoglobin and thus initiating vicious cycle of transmitting malnutrition from generation to generation. The figure-8 highlights the status of anaemia among pregnant and breastfeeding women in Haryana.

Also, here it is important to highlight discrimination against girls which prevails in Haryana. Lower status of women and high discrimination against girl child gets reflected in low nutritional status of female child and women. Under nutrition is more common among female children than male children. For instance, 38 percent of female children compared to 32 percent of male children are underweight and 53 percent of female children compared to 48 percent of male children are stunted.

Evidence shows that an equity-focused approach (reaching the poorest and most disadvantaged) improves returns on investment, averting many more child and maternal deaths and episodes of stunting.

Fig 4: Prevalence of Anaemia in Pregnant & Lactating women as per NFHS-3

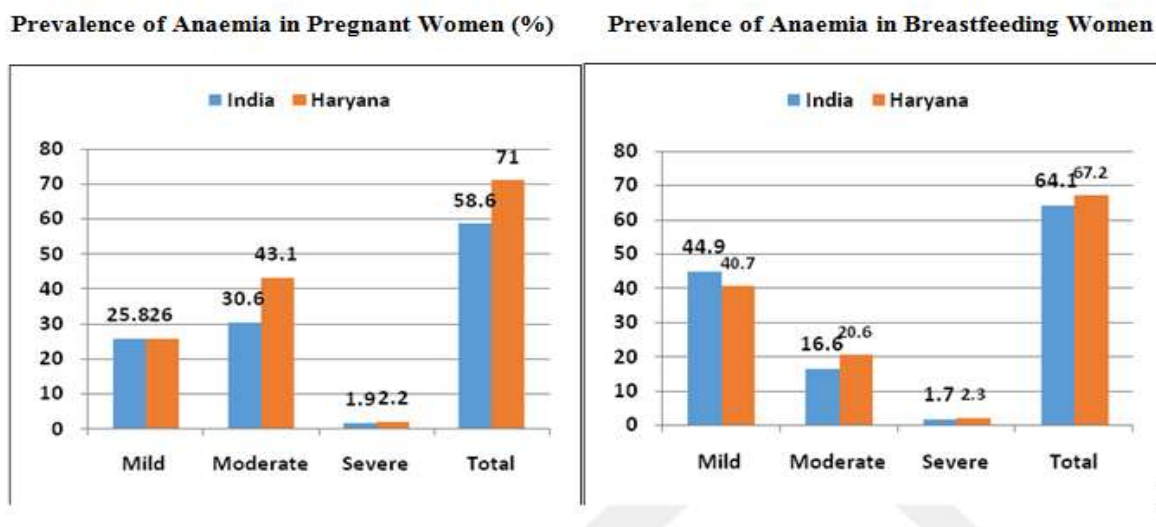


Figure 11- Prevalence of Anaemia in Pregnant & Lactating Women.
Source:- NFHS-3

2.2.2. Iodine Deficiency

Iodine deficiency is endemic in all parts of India. However the Universal Salt Iodisation program has made significant dent in reducing the prevalence of all forms of iodine deficiency disorders. Household coverage of adequately iodised salt in NFHS 3 was 72 percent which has now increased to 93 percent as per NFHS-4. Iodine deficiency is world’s single most important cause of preventable mental retardation.

2.2.3. Vitamin A Deficiency

Vitamin A deficiency is assessed on the basis of conjunctival xerosis and bitot’s spot. As per State Nutrition Profile of Haryana (1998), about 0.25 percent of children (1-5 years) suffer from Bitot’s spot. In the school going children, Corneal Xerosis and Bitot’s spot was found to be prevalent among 0.03 and 0.05 percent of children respectively. As per NFHS-3, only 16 percent of last- born children age 12-35 months were given vitamin-A supplement in the previous 6 months. But this has changed substantially in the next few years and the recently conducted NFHS-4 survey revealed that about 67 percent of 12-59 months children received vitamin A dose in last 6 months. Even mild Vitamin A deficiency probably increases morbidity and mortality in children.

3. NUTRITION GOALS

The ultimate goal of Government is to develop and implement a comprehensive, integrated and multi-sectoral strategy based on an inter-sectoral approach. The State Nutrition Policy, thus developed will be both the guiding force and the framework for implementation of multi-sectoral strategy to achieve the nutrition goals.

World Health Assembly has adopted six nutrition goals to be achieved by 2025 and they are:

1. 40 percent reduction in the number of children under 5 who are stunted
2. 50 percent reduction of anaemia in women of reproductive age
3. 30 percent reduction in low birth weight
4. No increase in childhood overweight
5. Increase the rate of exclusive breastfeeding in the first 6 months up to at least 50 percent
6. Reduce and maintain childhood wasting to less than 5 percent

3.1. Vision

Women of reproductive age and children in Haryana achieve sustainable improvement in their nutrition and health status. There will be special focus on the most vulnerable populations and families.

3.2. Goals

The State Nutrition goals to be reached by 2020 would be as under:-

- Reduction in under nutrition (underweight/wasting/stunting) in 0-6 year's children by one third of NFHS-4.
- Reduction in severely acute malnourished children SAM (0-6 years) by one third of NFHS-4.
- Reduction in incidence of low birth weight by one third of DLHS-4
- Reduction in prevalence of Iron deficiency anemia among young children, adolescent girls, women in reproductive age group (15-49 years) by one third of NFHS-4.
- Increase coverage of Infant and Young Child Feeding Practices to more than 80 percent of eligible children.
- Increase in coverage of vitamin A supplementation and adequately iodized salt to 90 percent or more. Enable and increase coverage of fortification of staple foods such as wheat flour, edible oil, milk, etc.
- Improvement in full immunization coverage of children to reach all eligible children.
- More than 95 percent of deliveries as assisted deliveries with most of them taking place in institutions.

The above to be achieved through a) improved inter-sectoral coordination, b) focus on monitoring, evaluation and learning (MIS, child tracking, etc.), c) mass mobilisation including sustained behaviour change communication, d) capacity building of the frontline workers and functionaries of all line departments, e) partnerships and alliances.

3.2. Objectives

Primary objectives will be to focus on the following to achieve the set targets and goals:

- To ensure optimal Infant and young child care, nutrition and health.
- To ensure improved maternal care, health and nutrition.
- To ensure improved Adolescent Nutrition-especially of girls.
- To ensure the control of Micronutrient Deficiencies or vitamin and mineral deficiencies by addressing vitamin A, iron, iodine, folate and zinc deficiencies.
- To promote Community Nutrition –by ensuring a healthy, hygienic, caring and nutritionally secure environment.

3.3. Effective interventions for reducing undernutrition

Studies suggest that following high-impact interventions at critical junctures of specified opportunity windows can halve the undernourished children and women over the next 10 years (Swaminathan 2009). The various stages and the interventions are prescribed as below.

i) Focus on the blocks/villages with highest levels of child undernutrition

- There are wide disparities in nutrition status across states, districts, blocks and different community groups, and with districts/blocks with very high levels of material and child undernutrition and related mortality. In order to significantly reduce child undernutrition at an aggregate state level at a faster pace-it will be important to have focused interventions for these districts/blocks and community groups, with high levels of child undernutrition. Block/villages with high level of malnutrition will be taken in phased manner.

ii) Infant and Young Child Care and Nutrition

- Initiation of breastfeeding within one hour of birth
- Exclusive breastfeeding during the first six months of life
- The timely introduction of age-appropriate food for children from six months along with continued breastfeeding for two years and beyond (adequate in terms of quality, quantity and frequency).
- Growth Monitoring and promotion of Mother Child Protection Card.
- Access to Infant and Young Child Care (including ICDS, Crèches) with supplementary Nutritional Support.
- Enhance care, improved feeding during and after illness, nutritional support, referral and management of severely malnourished children and / or sick children.
- Hygienic child feeding practices with safe drinking water and basic sanitation

iii) Infant and Young Child Health

- Improved new born care and care of low birth weight baby.
- Timely and complete immunization of Infant.
- Ensuring that young children received micronutrient supplementation i.e. biannual Vitamin A supplementation and IFA supplementation.
- Biannual Deworming and timely feeding of high quality therapeutic feeding and care for all children with Severe Acute Malnutrition (SAM)
- Appropriate and active feeding of children during and after illness, including oral rehydration with zinc supplementation during diarrhoea
- Addressing micronutrient malnutrition in a holistic manner through a food cum fortification of appropriate foods strategy; promoting and improving consumption of iodized salt.

iv) Maternal Care, Health and Nutrition

- Ensuring girl children are born, protected and reasonable delay in marriage, first pregnancy and consequent pregnancies.
- Adequate food, nutrition and support for women (before, during and after pregnancy and lactation) to prevent anaemia, undernutrition and care for those at risk.
- Promotion of enhance maternity protection and institutional delivery.
- Increasing efforts to engage and empower vulnerable communities, particularly women in these communities, to overcome malnutrition, for instance, through Panchayat, Self Help Groups, etc

v) Adolescent Nutrition

- Equal care of the girl child at different stages of the life cycle.
- Improved access to nutritional support through MID Day Meals in schools and through SABLA for out of school girls.
- Universal access of girls in school and girls out of school to IFA supplementation and biannual deworming.
- Girl's education, life skills and female literacy.
- Marriage of young women after the age of 18 years.

vi) Control of Micronutrient Deficiencies

- Coverage of pregnant women screened for severe anaemia
- Coverage of pregnant women receiving treatment for severe anaemia
- Improvement in consumption of iodised salt at House hold level

vii) Community Nutrition

- Coverage of villages where members wash hands
 - before feeding
 - After defecation
- Coverage of villages that are open defecation free
- Coverage of households with access toilets
- Coverage of Anganwadi Centres in Govt./own constructed with access to toilets
- Coverage of schools with access to toilets
- Coverage of households affected to safe drinking water

- Coverage of households by poor water quality (contamination)
- Coverage of Anganwadi Centres in Govt./own constructed with access to safe drinking water
- Coverage of schools with access to safe drinking water

3.4. Measurable outcomes

The current status and target outcome is given below:

Sr. No.	Indicators	Current Status	Target 2020
Infant and Young Child Care and Nutrition			
1	Reduction in incidence of low birth weight	12.6% (DLHS-4)	8%
2	Reduction in percentage of underweight (<2 Standard Deviation) children (0-6years)	29.4% (NFHS-4)	20.00%
3	Reduction in percentage of wasted children (<2 Standard Deviation) children (0-6years)	21.2% (NFHS-4)	14.00%
4	Initiation of breastfeeding within one hour	42.4% (NFHS-4)	90%
5	Exclusive breastfeeding for six month	50.3% (NFHS-4)	95%
6	Initiation of complementary feeding after six month	35.9% (NFHS-4)	90%
7	Percent of children (6month -6 years) receiving SNP for at least 21 days per month	53% (ICDS Report, 2015-16)	75%
Infant and Young Child Health			
8	Reduction in prevalence of anaemia in children (6-59 months)	71.7% (NFHS-4)	50%
9	Reduction in prevalence of anaemia in women and girls (15-49 years)	62.7% (NFHS-4)	42.00%
10	Improvement in coverage of Vitamin -A supplement	66.7% (NFHS-4)	90%
11	Coverage of full immunization of children (12 to 23 month)	62.2% (NFHS-4)	90%
12	Improvement in biannual deworming	83% (Health Deptt. Report ,2015-16)	90%
13	Coverage of children (6m – 59 months) with diarrhoea treated with ORS	60.6% (NFHS-4)	75%
14	Coverage of children (6m – 59 months) with diarrhoea treated with Zinc supplementation	21.9% (NFHS-4)	75%

Maternal Care and Nutrition			
15	Coverage of pregnant women receiving at least 4 ANC check-ups	45.1% (NFHS-4)	75%
16	Coverage of registered pregnant and lactating women receiving supplementary nutrition for at least 21 days.	72% (ICDS Report 2015-16)	100 %
17	Coverage of pregnant women who consumed at least 100 IFA tablets	32.5% (NFHS-4)	75%
18	Coverage of pregnant women receiving maternity support benefits through: <ul style="list-style-type: none"> • Janani Suraksha Yojna (JSY) • Janani Shishu Suraksha Karyakaram (JSSK) 	<ul style="list-style-type: none"> • JSY-134.41% (including ASHA) • JSSK-131.7% (as per FMR FY 2015-16) 	100%
19	Coverage of Women: <ul style="list-style-type: none"> • Who had institutional delivery/Birth • Who received post -natal care 	80.5% 67.3% (NFHS-4)	90% 90%
Adolescent Nutrition			
20	Coverage of out of school adolescent girls receiving supervised weekly IFA supplementation <ul style="list-style-type: none"> • in school – WIFS • out of school 	90% 80% (Health Deptt. Report ,oct 2016)	95% 85%
21	Coverage of adolescent girls receiving nutrition and health education/counselling – through schools, SABLA, ARSH and Any new adolescent drop in community centres etc.	50% At ARSH Clinics (Health department Report September 2016)	60%
22	Coverage of adolescent girls screened through Rashtriya Bal Swasthya Karyakram Coverage of adolescent girls receiving referral care through Rashtriya BAI Swasthya Karyakram	75% 80% (Health department Report,Oct 2016)	80% 85%

Control of Micronutrient Deficiencies			
23	Prevalence of severe anaemia in Pregnant Women	7.9% (DHIS-2)	4%
	Coverage of pregnant women receiving treatment for severe anaemia	60.33% (DHIS-2,Oct 2016)	90%
24	Household using of iodised salt	92.8% (NFHS-4)	100%
Community Nutrition			
25	Coverage of villages where members wash hands: • After defecation	69.47%	100%
26	Coverage of villages that are open defecation free	69.47%	100%
27	Coverage of households with access to toilets	87.34%	100%
28	Coverage of Anganwadi Centres in Govt./own constructed with access to toilets	62%	100%
29	Coverage of schools with access to toilets	100%	100%
30	Coverage of households access to safe drinking water	97.40%	100%
31	Coverage of Anganwadi Centres in Govt./own constructed with access to safe drinking water	51%	100%
32	Coverage of schools with access to safe drinking water	99.9%	100%

4. IMPLEMENTATION STRUCTURE

A State Nutrition Council with Chief Minister as Chairman and Ministers of Departments and experts as members to coordinate, guide and review the implementation of State Nutrition Mission.

A State Executive of State Nutrition Council under Chairmanship of Chief Secretary to coordinate and guide for preparation of State Nutrition Plan and District Nutrition Plan.

State Advisory Committee under the chairmanship of Principal Secretary, Women & Child Development Department will monitor the sectoral plans of the Department.

District Level Nutrition Committees to prepare and implement district action plan.

The measures enumerated have to be administered by various departments and there should be close collaboration between the departments. Concerned Departments should develop their action plan and implement to bring about improvement in the Nutritional Status of Women & Children.

5. SETTING UP OF STATE NUTRITION MISSION

Government of India and state governments has committed considerable resources towards strengthening of planning and budgeting for improving the health, nutritional and social status of women and children in the State. New initiatives are being rolled out across the State by departments responsible for maternal and child health and nutrition. However, the persistent high levels of undernutrition necessitate adopting a Mission approach for accelerating reduction in the levels of undernutrition.

Establishing a Nutrition Mission in Haryana is essential and will help to provide leadership and accountability, to scale up essential nutrition interventions and to catalyse linkage with key sectors affecting nutrition.

There is a need for a dedicated body which can holistically review and monitor nutrition schemes/interventions being implemented for the mothers and children under six years, identify implementation gaps, suggest innovations, coordinate actions and efforts across the departments and make recommendations for achieving results in the area of nutrition.

The Nutrition Mission will be set up in Haryana as an independent body committed to bringing about a reduction in the high levels of maternal and child undernutrition rates in the State. The Mission is expected to play a catalytic role in accelerating efforts directed towards reducing undernutrition amongst children and women by converging and collaborating with nodal departments and ensuring effective and quality implementation of nutrition interventions.

5.1. Scope of work of Nutrition Mission:

- Act as a coordinating body facilitating inter-sectoral collaboration for nutrition action among convergent departments like WCD, Health, Elementary Education, Food and Supplies, Development and Panchayat, Public Health Engineering.
- Perform the role of a monitoring body for effective and quality scaling up of Nutrition Schemes/Interventions.
- Strengthen data management, monitoring and reporting systems of departments linked to their existing MIS for tracking progress and achievements in the area of nutrition.
- Use data and evidence to assist the departments in developing new policies in the area of nutrition.
- Support departments in developing monitoring and evaluation plans as part of their annual programme implementation plans (APIP) and undertaking monitoring and evaluation activities.
- Provide guidance to identify research areas for evidence-based innovations which in turn will help the departments to plan for the innovations in their annual plans.

5.2. Mission's structure and Composition

i. Governing body

For ensuring that maternal and child undernutrition reduction is at the center stage of the State's priorities, the proposed Mission needs to function under Hon'ble Chief Minister. The mandate of the body will include taking policy decisions submitted by executive committee, providing guidance and filling up the funding gap and institutionalizing interdepartmental collaboration.

ii. Executive committee

The executive committee will be chaired by the Chief Secretary. The Executive Committee shall approve the work plan and budget of State Nutrition Mission, appraise the plan performance, guide the programme implementation and sanction the technical, logistical, administrative and financial resources by the State Nutrition Mission for achieving the goals. The power of the executive committee will be as described in the bye- laws of the State Nutrition Mission Society. The Executive Committee shall meet once in three month.

iii. Monitoring & Coordination Committee

As the Mission would be working in close coordination with the Department of Women and Children and Health department. A monitoring committee chaired by Principal Secretary, Women & Child Development will be functional and which will report independently to Executive Committee. The monitoring Committee will review the progress of Mission's workplan and provide separate independent feed back to the Executive Committee.

It will issue necessary instructions & directions to the concerned departments & stakeholders for effective & smooth implementation of Mission's objectives. It will also act as a co-ordinating mechanism to bring about a synergy in the functioning of the various departments related to the work of the Mission.

iv. Implementation Committee

The implementation committee will comprise of the Mission staff and the representatives from the government departments. The Implementation Committee will meet at a regular interval and will review and monitor the progress of the mission activities as per the annual plan prepared by the Mission team. The Mission team will consolidate reports pertaining to the results of programme monitoring and assessment along with resource utilization to the implementation committee for inputs and feedback and for submission and review at higher level committees.

v. District Nutrition Committee

District Nutrition Committee will be formed under the chairmanship of Deputy Commissioner with District Officers of Health, Public Health Engineering, Food & Supplies, Development & Panchayat and Women & Child Development Department as its members. It will play the following key roles: (i) It will implement policy decision approved by Mission body and (ii) It will provide the much-needed data analysis and technical support for nutrition Programmes. The meeting of the committee will be held monthly. Deputy Commissioner will provide guidance and administrative support and filling up the fund gaps wherever necessary.

vi. State Technical Advisory Group

The State Technical Advisory Group will comprise of 6-7 Technical experts chosen from Government Medical Colleges of Haryana and PGI Chandigarh, UN organization (like UNICEF), NGOs, Civil Society or any other body as deemed appropriate by Governing body. The Group's mandate will include providing technical support and guidance to the Mission.

vii. State Nutrition Cell

As present various departments are implementing nutrition interventions but there is no cell/coordinator body for nutrition which can serve as a platform for nutrition data sharing and data use for corrective action. State Nutrition Cell will be set up with 6 persons which will be hired on contractual basis/outourcing as per State Policy. The State Nutrition Cell will have Food technologist -1, Nutritionist cum demonstration Officer - 1, Consultant (Monitoring & Evaluation - 1, Clerk -1, Data Entry Operator -1 and Peon cum Multi-Purpose worker - 1. State Nutrition Cell will function under Director, State Nutrition Mission.

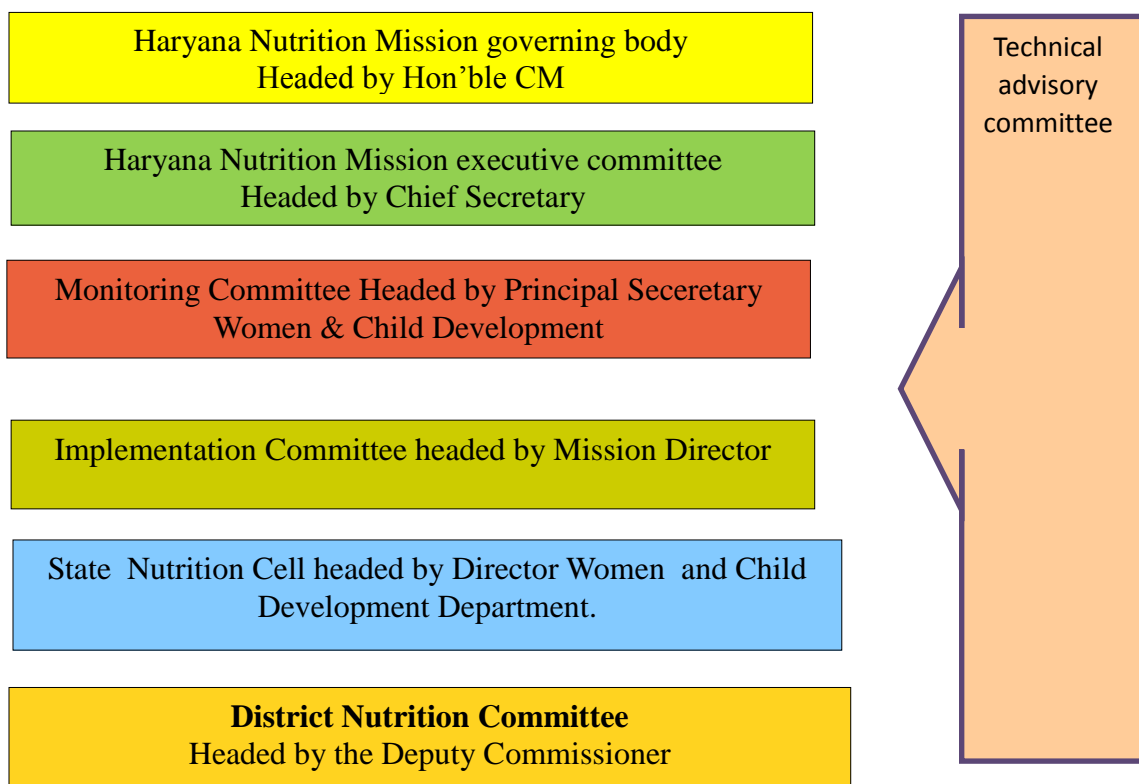


Figure 12- Haryana Nutrition Mission

6. ROLE OF THE DEPARTMENTS

As under-nutrition is a multi-factorial problem, thus one intervention or solution is not enough to tackle the issue. To address the problem, sectors dealing with agriculture, food security, health, women and child development, education, women empowerment, rural development, water and sanitation should come together to develop a common strategy to nail down the problem.

There is an urgent need to create a robust and healthy convergence model where in each department will tune itself to complement each others interventions to improve nutrition outcome. State, will promote meaningful and accountable inter-sectoral/inter-departmental collaboration at each administrative level. The governing and executive committee will provide this platform for this coordination. Each Department will delineate the “extra efforts” they will be putting to universalize the coverage of essential nutrition interventions channeled through their service delivery system and which they will be accountable to. The inter-departmental collaboration will also be used to maximize the resource allocations in flagship programs to avoid duplication of efforts and promote joint action.

Health Department

i. Infant and young Child Feeding Practices

- Counseling of mothers by ASHAs during home visits and VHND/Routine Immunization contact points.
- Provide breastfeeding support and manage lactation problems for mothers delivering at the health facility.

ii. Adequate Feeding during and after illness

- Counseling of mothers by ASHAs during home visits and by ANM and ASHAs during VHND/RI contact points.

iii. Safe handling of complementary foods and hygienic complementary feeding practices.

- Counselling of mothers on safe handling of food during home visits.

iv. Maternal nutrition and prevention of LBW

- Counselling and promotion of ANC visits during pre-conception period.
- Record and monitor BMI of adolescent girls.
- Antenatal care visits should be used to promote optimal nutrition and deliver specific interventions, such as malaria prophylaxis and treatment and deworming.
- Compared to iron-folic acid supplementation alone, supplementation with calcium, multiple micronutrients during pregnancy to reduce low birth weight.

v. Prevention and Treatment of micronutrient deficiencies

- Identification and examination of children with diarrhea and anemia by ASHA.
- Referral of severe cases to sub-centre or health facility.
- Preparing due list and mobilizing target groups for availing supplementation benefits.
- Depot holder and distributor of IFA syrup/ORS packets.
- Supporting ANM in supplementation on VHND/RI days

vi. Prevention and Treatment of SAM

- Identification/screening of SAM children Bi-Annually jointly by ASHA /ANM along with AWW.
- Refer appropriate severely malnourished children.
- Referral for Facility based care of SAM children with complications.
- Training to ICDS officials at state level (Master trainer) and health functionaries on use of MUAC tape, growth monitoring through weight for height method.
- Development of IEC and counselling material for ASHA and ANMs.

vii. Promotion of good sanitation practices and access to safe drinking water

- Frequent testing of water samples by health department.
- Promotion of safe hygiene practices through menstrual hygiene programme.

Viii. Improved food and nutrition intake for adolescent girls, particularly to prevent anaemia

- WIFS roll-out across the state, reaching 10-19 year old with IFA
- Nutrition counselling health education session by schools, health and ICDS functionaries.
- Peer educators for guidance and support.

Women & Child Development Department

i. Infant and young Child Feeding Practices

- Counselling of mothers by AWW through centre-based activities- Take home ration especially during first two years of life.

ii. Adequate Feeding during and after illness

- Counselling of mothers by AWW through centre-based activities- Take home ration contacts especially during first two years of life.

iii. Safe handling of complementary foods and hygienic complementary feeding practices

- Counseling of mothers on safe handling of complementary foods during through centre based take home ration days.
- Organizing Annaprasanna days of feeding demonstration with the involvement of care givers/mothers

iv. Maternal nutrition and prevention of LBW

- Community-based health education and communication interventions to strengthen Anganwadi based Village Health and Nutrition Days and mother's group meetings including involvement of SHGs can support and promote positive care and nutrition behaviour at family and community.
- Use the contact point for distribution of supplementary food as an opportunity for counselling women and families.

v. Prevention and Treatment of micronutrient deficiencies

- AWW- Biannual survey, target group identification and preparation of due list by AWW for MSP (Micronutrient Supplementation Programme of her area.

- Mobilize target groups for availing services on Village health and nutrition day/Routine Immunization /MSP days
- Support ANM and ASHAs in supplementation and monitor compliance
- Referral of severe underweight children to health facilities.
- Provision of fortified food under ICDS Scheme.

vi. Prevention and Treatment of SAM

- Identification/screening of SAM children Bi-annually jointly by AWW along with ASHA/ANM.
- Provision of home based high energy food/therapeutic to SAM children.
- Counselling of caregivers during home visits, VHND and centre based activities.
- Training to ICDS functionaries by WCD master trainers on use of MUAC tape, growth monitoring through weight for height method.
- Development of IEC and counselling material for AWCs.

vii. Promotion of good sanitation practices and access to safe drinking water

- Provisions of safe drinking water in all AWCs with inter departmental convergence.

Viii. Improved food and nutrition intake for adolescent girls, particularly to prevent anaemia

- Biweekly IFA supplementation to out-of-school girls under Sabla Scheme).
- Supplementary nutrition to adolescent girls under Sabla and KSY Scheme.
- Nutrition counselling and Health Education during quarterly Kishori diwas

Education Department

i. Prevention and Treatment of micronutrient deficiencies

- Providing of fortified Mid day meals rich in micronutrients.

ii. Promotion of good sanitation practices and access to safe drinking water

- To promote WASH activities in the school under basic hygiene and sanitation curriculum.

iii. Care of adolescent girls and children for reducing anaemia and improved nutrition education

- Spread awareness about malnutrition and its prevention through formal and informal schools.
- Promote female literacy and girls education (including secondary and higher education) –also linking with Beti Bachao Beti Padhao.

- Use schools as contact point for reaching in school and out of school girl (including linking with SABLA) for-
 - Nutrition and health counselling and check up linking with RBSK.
 - Anaemia control through supervised weekly IFA supplementation (WIFs) and deworming.
 - Second chance/ alternative education for out of school girls.
 - Retaining girls in education and eliminating child marriage.

iii. Child Nutrition

- Improve nutrient value, quality and community based monitoring of Mid-Day Meals in schools and usage of iron fortified iodised salt (double fortified salt).
- Use SSA flexi funds for kitchen gardens in/around school premises – contributing to addition of local/seasonal vegetables and fruits in MDM.
- Strengthen ICDS convergence and linkages with primary schools, synchronization of timings/location of AWCs, where locally needed – releasing girls from the burden of sibling care to participate in education.

Food and Supplies

i. Prevention and Treatment of micronutrient deficiencies

- To undertake fortification of food items like wheat flour, sugar, salt etc.

ii. Enhanced household food security, enforcement of Food Security Act.

- Expanding Targeted Public Distribution System to include Iodised salt/ double fortified salt. Ensure families of undernourished children are registered as beneficiaries under PDS.
- Monitor effective implementation of the National Food Act 2013, including its enabling provisions and formulation of rules by concerned sectors/ states.

Horticulture Department

Prevention and Treatment of micronutrient deficiencies

- Under National Horticulture Mission, area expansion of fruits in clusters which are rich sources of iron and vitamin 'A' & 'C' such as mango, guava and citrus.
- Supply of quality planting material.
- Expansion of quality vegetables which are source of vitamin-A, Iron and vitamin-C such as leafy vegetables, root and tuber vegetables, cucurbits and pod vegetables (Peas etc.).

- Identification and distribution of seeds/saplings and planting material of well-known species rich in iron, vitamin-A, vitamin-C etc. to the household by popularization of kitchen gardens.
- Promotion of organic farming in the state.
- Creation of awareness to reduce the indiscriminate use of chemical/ pesticides etc.

Food and Drug Administration

Quality control of drug and food article.

- To regulate a variety of functions including licensing, inspection of drugs mfg. and sales/distribution channels, quality control of drugs and cosmetics, drug pricing, availability and affordability of drugs in the State.
- To perform statutory functions of sampling of drug, cosmetics & food items and inspections of manufacturing/sale units in the State under various health and nutrition programme being implemented by health, WCD, Education and other related departments.
- Supporting Health Department, WCD department, Education department, Food & Supply Department in advocating food fortification programme through the platform of MDM, ICDS, PDS schemes and at the level of Chakki/flour miller.

Development and Panchayat

Promotion of good sanitation practices and access to safe drinking water

- Provision of toilets and safe drinking water supply in all AWCs, health sub centres, schools and at community and household levels.
- Open defecation Free State.
- Focus on improving hygiene practices – hand washing, safe disposal of child stools and waste etc.
- AWCs, schools and health centres to be strengthened as the hubs for demonstrating and changing hygiene practices.
- Swachhta Doots and community mobilization activities under Swachh Bharat – NHM and ICDS to be linked.
- Act as catalyst for Community mobilisation
- Common core training and communication packages to be developed and widely used.
- Linking with Village Water and Sanitation Committees.
- Mainstream Nutrition in the training of PRIs – for malnutrition free Panchayats, earmarking certain wards to them – especially women members.
- A special Gram Sabha meeting dedicated to Nutrition in every gram sabha every year.
- Recognition and incentivisation of malnutrition free panchayats.

Public Health and Engineering

Promotion of good sanitation practices and access to safe drinking water

- Provision of safe drinking water supply in all AWCs, health sub centres, schools and at community and household levels.
- Awareness generation on safe drinking water and hygiene in convergence with Schools, ICDS, Health Centres, PRIs and SHG groups etc.

Urban Local Bodies

Promotion of good sanitation practices and access to safe drinking water

- Urban local bodies to identify beneficiaries of slum areas/ colonies who need nutritional care for addressing maternal, child & adolescent girl under Nutrition Mission.

7. COMMUNITY OWNERSHIP AND PARTICIPATION

Underweight/malnutrition of children, adolescent girls, pregnant and lactating mothers is not recognized a major health issue till the child becomes extremely ill, severally malnourished or anaemic by mothers/ caretaker, families and communities. Involvement of caretaker community in the process of growth monitoring will have a positive impact on maternal and child malnutrition.

Celebration of joint village health nutrition and sanitation day. VHNS day will be jointly celebrated by line department involving community i.e. SMS member, VLCs member, Panches etc. The following activities will be conducted during the celebration of joint village health nutrition and sanitation (VHNS) day.

- Mapping and weighing of children on fix day i.e. Joint village health nutrition and sanitation day in every village involving Panchayats, Health and ICDS functionaries through community charts.
- Distribution of ready to eat fortified food.
- Distribution of nutrition supplement i.e IFA, vitamin-A, deworming etc.
- Antenatal and postnatal checkup of pregnant and lactating women by health functionaries.
- Counseling on optimal infant and young child feeding, nutrition hygiene and health etc.
- Monitoring and reviewing of activities/data on nutrition in Gram Panchayat Sabhas.

7.1. Malnutrition-free Panchayat

Three best Panchayats in each district will be rewarded a sum of Rs. 1 lac, Rs. 75000 and Rs. 50000 every year on the basis of improvement in the nutrition status of children as per the fixed criteria. The total annual implication will be Rs. 47.25 lac for 21 districts.

7.2. Gap filling support and innovation

Based on the village/block/district nutrition plan some deficits/gap in service delivery may remain uncovered/unfulfilled through existing sectoral interventions, State Nutrition Mission would provide financial gap filling support as flexi funds. The state Nutrition Mission would have provision of innovation funds to support evidence based cost effective innovative intervention for improving nutrition relating indicator. In order to ensure adequate budgetary support & to cover critical area Mewat Development Agency, Shivalik Development Authority, Backward Region Grant Fund, district plan & all other relevant scheme shall be utilized fully in order to meet the objectives of the Mission.

7.3. Partnerships

For improved nutrition outcomes, a momentum for social change calls for strengthened and extended partnership & actions with voluntary agencies, professional bodies & Technical resource institutions. Such partnership will be convened by the Mission at State, District and local levels in alignment with State Nutrition Policy free from conflict of interest and not under mind by commercial influence. Clear memorandum of understanding will be developed open to public scrutiny and with accountability for committed monitorable outcomes.

7.4. Special innovations

i. Community based Management of Acute Malnutrition

Community based management of acute malnutrition will be on state agenda. CMAM programme will include all 4 components namely: Community mobilization, Inpatient treatment, outpatient treatment and Supplementary Nutrition programme for management of acute malnourished children. Severely wasted children, with nine times higher risk of death will be screened using MUAC measurements at community level and will be treated in Nutrition Rehabilitation centres (NRCs); until outpatient programme is established. With full establishment of CMAM package, children without complications will be treated using energy dense therapeutic food (EDTF) at outpatient centre (OTP) and only complicated cases will be admitted to NRCs. Children with MUAC between 115mm <125mm or having weight for height (WHZ) between -3 and -2 z-scores (MAM cases) will be enrolled in SNP programme of ICDS scheme.

ii. Special package for pregnancy and identification of at risk women

Under universal health coverage, special package for pregnant mothers will be developed to identify women at risk. During pregnancy period, ante-natal care services (IFA tablets, TT injection, MUAC, UTI testing, Hb testing and health checkup) will be strengthened and complemented by distribution of iodized salt and calcium tablets to prevent iodine and calcium deficiency. This provision will improve health and nutrition of expecting mother, fetus and eventually will have positive impact on pregnancy outcomes. Successful delivery of this intervention will need convergence of NRHM, Food & Supply Department (PDS) and ICDS (delivery point-Aaganwadi centres).

Also, mothers of SAM children coming to NRC for the treatment of their children will be tested for hemoglobin and nutrition status (BMI, MUAC). In case the mother is identified as undernourished or with any micro-nutrient deficiency; she would also be treated at the facility level.

iii. Promotion of Nutrition and Healthy practices at Schools:-

Nutrition and Health Education (NHE) would be promoted in schools. Healthy practices like hand-washing and hygiene would be encouraged and practiced in schools. Also, kitchen gardening in schools by children and staff would be used as a platform to talk about importance of good nutrition among children. Horticulture department can come forward to promote kitchen gardening among school children and teach them about scientific planting and harvesting methods. Participatory activities involving children would lay foundation of healthy practices.

iv. Collaboration with Home-science Colleges/Medical Colleges:-

Home science colleges and medical colleges will be identified as support units for systems strengthening through field monitoring, supportive supervision and capacity building activities. Home Science colleges can support ICDS for strengthening supplementary feeding and IYCF practices at community level. Medical colleges will support treatment aspect of severe acute malnutrition and will build capacity of medical staff (doctors, nurses, and paramedical staff) on malnutrition, micro-nutrient supplementation and IYCF practices at facility level.

8. MONITORING AND EVALUATION

Assessment, analysis and monitoring are essential elements of any endeavor, directed at improving nutritional well being. Each department would be reviewing and strengthening their information system so as to be able to provide reliable data on various indicators for monitoring goals set in State Nutrition Policy.

9. FUNDING

The funds will be allocated for Institutional and administrative arrangement and for implementing day to day activities to facilitate the smooth functioning of Nutrition Mission from the state budget. A separate budget head would be created to allow flexibility and integration and for convergent actions with wider determinants of maternal and child under nutrition.

Nutrition being a Multi Sectoral issue needs to be tackled at various levels by different department in convergence while synergizing their energies and funds available to them. The departments will allocate funds to the activity related to the Nutrition in their budgets.



Women and Child Development Department Haryana, Panchkula

Bays 15-20, Sector-4, Panchkula

Phone: 0172 2560349

Website: www.wcdhry.gov.in