Republic of India

Mutisectoral Nutrition Action in Bihar

June 9, 2014

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SOUTH ASIA
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Multisectoral Nutrition Actions in Bihar: A Report

May 2014

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# Table of Contents

## Acknowledgements

## Acronyms

## SECTION I: INTRODUCTION AND BACKGROUND

1. Background and Rationale
2. Development Context in Bihar
3. Multisectoral Approach to Nutrition
4. World Bank’s Strategy to Address Malnutrition
5. Background of Multisectoral Nutrition Actions in Bihar
6. Objectives

## SECTION II: METHODOLOGY

7. Two-phased Approach
8. The Analytical Framework:
9. Consultations and design development

## SECTION III: CASE STUDIES

10. Case Study 1: Bihar Rural Livelihoods Project – Jeevika’s Multisectoral Nutrition Convergence Pilot
11. Case Study 2: Bihar Panchayat Strengthening Project
12. Case 3: Rural Water Supply and Sanitation Project in Low Income States (RWSS-LIS)

## SECTION IV: CONCLUSIONS

13. Conclusions

## ANNEXES:

Annex 1: ANALYTICAL FRAMEWORK
Annex 2: SUMMARY OF PROGRAM GUIDANCE NOTE: Improving Nutrition Actions in Rural Livelihoods Projects
Annex 3: SUMMARY OF PROGRAM GUIDANCE NOTE: Improving Nutrition Actions in Programs for Panchayati Raj Institutions (Local Governance Structures)
Annex 4: Statistics on Bihar
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# Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ASHA</td>
<td>Accredited Social Health Activist</td>
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<tr>
<td>ANM</td>
<td>Auxiliary Nurse Midwife</td>
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<tr>
<td>AWW</td>
<td>Anganwadi Worker</td>
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<tr>
<td>BCC</td>
<td>Behavior Change Communication</td>
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<td>BGSYS</td>
<td>Bihar Gram SwarajYojna Society</td>
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<td>BPSP</td>
<td>Bihar Panchayat Strengthening Project</td>
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<td>BPMU</td>
<td>Block Project Management Unit</td>
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<td>BMGF</td>
<td>Bill and Melinda Gates Foundation</td>
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<td>B-TAST</td>
<td>Bihar Technical Assistance Support Team</td>
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<td>BS</td>
<td>Block Samiti</td>
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<td>BRLP</td>
<td>Bihar Rural Livelihood Project</td>
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<td>Bihar Rural Livelihood Promotion Society</td>
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<tr>
<td>BK</td>
<td>Book Keeper</td>
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<td>CHNCCs</td>
<td>Community Health and Nutrition Care Centers</td>
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<td>CPS</td>
<td>Country Partnership Strategy</td>
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<td>Community Mobilizers</td>
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<td>Community Resource Persons</td>
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<td>DfID</td>
<td>Department for International Development</td>
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<td>DPMU</td>
<td>District Project Management Unit</td>
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<td>FGD</td>
<td>Focus Group Discussion</td>
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<td>FSF</td>
<td>Food Security Fund</td>
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<tr>
<td>GOI</td>
<td>Government of India</td>
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<td>GoB</td>
<td>Government of Bihar</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GPs</td>
<td>Gram Panchayats</td>
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<td>HNP</td>
<td>Health, Nutrition Population</td>
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<td>ICDS</td>
<td>Integrated Child Development Scheme</td>
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<td>IFPRI</td>
<td>International Food Policy Research Institute</td>
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<tr>
<td>IQ</td>
<td>Intelligence Quotient</td>
</tr>
<tr>
<td>JS</td>
<td>JeevikaSaheli</td>
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<tr>
<td>MGNREGA</td>
<td>Mahatma Gandhi National Rural Employment Guarantee</td>
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<tr>
<td>MIS</td>
<td>Management Information System</td>
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<tr>
<td>NDCCs</td>
<td>Nutrition Day Care Centers</td>
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<td>National Rural Health Mission</td>
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<td>ODF</td>
<td>Open Defecation Free</td>
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<td>PAD</td>
<td>Project Appraisal Document</td>
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<td>PGN</td>
<td>Program Guidance Note</td>
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<td>PIP</td>
<td>Project Implementation Plan</td>
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NBA  Nirmal Bharat Abhyan
NLTA  Non Lending Technical Assistance
NRDWP  National Rural Drinking Water Program
NRHM  National Rural Health Mission
ODF  Open Defecation free
PCI  Project Concern International
PGN  Program Guidance Note
PIP  Project Implementation Plan
PDS  Public Distribution System
PHED  Public Health Engineering Department
PRI  Panchayati Raj Institution
RAS  Regional Assistance Strategy
RD  Rural Development
RWSP  Rural Water and Sanitation Program
SA  South Asia
SNP  Supplementary Nutrition Program
SHGs  Self Help Groups
SW  Social Welfare
TSC  Total Sanitation Campaign
TTL  Task Team Leader
UNICEF  United Nation Children’s Fund
VO  Village Organization
VRP  Village Resource Person
WDC  Women Development Corporation
WB  World Bank
WSP  Water and Sanitation Program
ZP  Zilla Parishad
SECTION I: INTRODUCTION AND BACKGROUND

1. Background and Rationale

India, currently, has one of the highest malnutrition rates in the world. One-third of its children are born with low birth-weight, 43 percent of children under five are underweight, 48 percent are stunted and 20 percent are wasted. Stunting rates in India are two to seven folds higher than those of other BRICS countries. Micronutrient deficiencies are extremely high with almost 75 percent of the under threes being anemic, 62 percent deficient in vitamin A and over 13 million infants remaining unprotected from iodine deficiency disorders. There are large differentials in the prevalence across states and socio economic groups. Sixty percent of the malnutrition burden exists in low income states: Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan and Uttar Pradesh. The Government’s policy commitment to address malnutrition and the multitude of programs that are being implemented, progress in reducing undernutrition has been slow. It therefore becomes imperative to address the malnutrition challenge and to prevent and reduce maternal and child malnutrition as early as possible across the life cycle especially through pregnancy and in the first two years of life, i.e., in the first 1,000 days of life, and in adolescent girls and women. In order to accelerate improvements across the states, the Government of India (GOI) has made policy commitments to mobilize multisectoral action to address the multiple causes of malnutrition effectively through formulating a multisectoral strategy and a multisectoral program to be implemented in 200 high malnutrition burden districts of the country. The multisectoral strategy also aims to bring a strong nutrition focus in various sectoral plans to address maternal and child malnutrition.

2. Development Context in Bihar

Bihar is one of the largest and poorest states in India. Ninety percent of its population lives in rural areas. It has deep rooted social inequalities especially along gender and caste lines. There is high incidence of malnutrition with 50 percent of children under the age of three being stunted (too short for their age), 55 percent being underweight (too thin for their age) and 33 percent wasted (too thin for their height). Forty three percent of women aged 15 to 49 years suffer from lower than normal body mass index, two thirds of women in this age group and 87 percent of children under the age of three suffer from anemia. Basic access to nutrition, health and sanitation services is poor. Only 24 percent of households have access to toilets. Quality of drinking water is a problem as a result of poor sanitation. There is a plethora of Government programs on health, nutrition and sanitation being implemented in the state such as the Integrated Child Development Scheme (ICDS), National Rural Health Mission (NRHM),
NirmalBharat Abhyan (NBA), Public Distribution System (PDS) and the National Rural Drinking Water Program (NRDWP), besides others. Due to implementation challenges and constraints, they have not been able to bring about the desired improvements in nutrition and health outcomes. Moreover, there is limited or no coordination between these different sectoral programs.

3. **Multisectoral Approach to Nutrition**

The determinants of malnutrition are multisectoral. The immediate causes include inadequate food intake and disease. Underlying these are causes that operate at the household and community levels: household food insecurity, inappropriate maternal and child care practices, lack of access to health services, unavailability of clean water and sanitation, with poverty underpinning these. Gender relations are a key factor which affects women’s access to resources and decision making within the household and community including women and girls entitlement to adequate food and nutrition. Ultimately these factors are determined by the larger political, economic, social and cultural environment. Therefore, in order to address the multiple and interactive causes of malnutrition, it requires a multisectoral approach and action at different levels.

![Multisectoral Approach](image)

4. **World Bank’s Strategy to Address Malnutrition**

The World Bank’s South Asia (SA) Regional Assistance Strategy (RAS) for Nutrition (2010-15) that outlines the region’s vision and approach to improve nutrition is committed to scaling up the Bank’s response to the high rates of malnutrition in the region. One of the key strategic approaches to guide the scale up of nutrition includes adopting multispectral actions by implementing comprehensive programs that integrate nutrition sensitive interventions in different sectors. The strategy also identifies the need to test implementation of nutrition actions in multiple sectors in one geographical area.
The World Bank’s India Country Partnership Strategy (CPS) 2013-17 supports a multisectoral approach both through Government Programs and Bank’s Operations in different sectors. To promote inter-sectoral work in nutrition and to support the WB task teams and their clients and implementing partners to do so, it is important to develop and test approaches that have the potential to affect nutrition outcomes through programs in that sector and to provide them with the necessary programmatic guidance and tools.

5. **Background of Multisectoral Nutrition Actions in Bihar**

The state of Bihar was selected as the geographical area of focus for carrying out initiatives to incorporate nutrition actions within different sectoral operations of the World Bank. Given that Bihar has several WB projects under implementation and new projects that are under preparation, this provided a unique opportunity to explore the feasibility to incorporate nutrition interventions within the various Sectoral Projects. Some of the WB operations in Bihar include the Bihar Rural Livelihoods Project, Bihar Capacity Building Technical Assistance Project, Bihar Kosi Flood Recovery Project, and the Bihar Panchayat Strengthening Project, besides others. Based on the above considerations and consultations with government counterparts, it was decided to undertake the Non Lending Technical Assistance (NLTA) in Bihar with the overall objective to explore, initiate and demonstrate incorporation of nutrition sensitive interventions across multiple sectors and program platforms in order to enhance their food and nutrition security impact.

6. **Objectives**

The purpose of this activity was to incorporate/demonstrate Nutrition actions in at least three World Bank operations in different sectors in Bihar. The expected intermediate outcomes from these initiatives were to: i) Inform and influence nutrition policies and programs based on the experience and effectiveness of the multisectoral nutrition actions ii) informing policies and programs in selected sectors about the effectiveness of incorporating nutrition actions in their respective sectors, and iii) documenting and disseminating knowledge and experience of cross-sectoral nutrition actions.

This report captures the methodology, experience, lessons, opportunities and challenges in incorporating nutrition actions into the design of three World Bank operations in Bihar – the Bihar Rural Livelihoods Project-Jeevika, Bihar Panchayat Strengthening project and the Rural Water and Sanitation in Low Income States project, and includes a case study on each. It also includes (in the Annexes) two Program Guidance Notes, one for Rural Livelihoods programs and the other for programs in the Panchayati Raj Institutions (Local Governance Structures) developed for use in these specific sectors.
SECTION II: METHODOLOGY

7. Two-phased Approach

The operationalization of the Multisectoral Nutrition Action in Bihar has been undertaken in two phases.

Phase 1, Scoping and Design Phase: This component included engaging with Task Teams of WB operations in Bihar, including those under preparation as well as those under implementation to identify key entry points and platforms for incorporating nutrition sensitive interventions in the projects, and to monitor the outputs and outcomes of these interventions through suitable indicators, possibly incorporated into the project results framework. The TTLs of ongoing projects were consulted to explore with them the potential to develop nutrition sensitive approaches and models that could be designed and undertaken by the Project. Further discussions and consultations were held with client teams to work with them to provide technical support to develop the design of the nutrition sensitive interventions. Consultations and discussions with other concerned stakeholders was also part of the design development process. The scoping and design phase also included identifying and design of evaluation of the nutrition actions in the projects selected. Technical support was provided to the identified projects by Consultant/s and through modest staff time.

Phase 2, Implementation Support: This included technical support for the implementation of the designed interventions, monitoring and evaluation, and documentation. This report focuses on documentation of phase I, which has been completed, and phase II activities are ongoing. However, phase II will take time for completion and outcomes can be expected only after implementation over a reasonable period. This report focuses on documenting the process and analytical framework adopted and sharing three Case Studies of incorporating nutrition sensitive interventions in WB projects in three sectors.

8. The Analytical Framework:

An Analytical Framework was developed as a tool to facilitate the identification, analysis and incorporation of nutrition actions within Multisectoral projects of the World Bank. It sets out core principles and adopts the project cycle approach through its various stages namely Identification and Design, Implementation, Monitoring, Learning, Knowledge Management and Evaluation. It is a guide which can be used with the WB Task Team Leaders and other staff and project implementers of counterpart organizations to identify key issues, opportunities and challenges for consideration to explore, inform and influence WB Sectoral projects to incorporate nutrition actions within the Project framework.

Some Core Principles include:
• Facilitate shared understanding amongst key stakeholders (internal and external) of the Multisectoral Projects through advocacy, information sharing, consultations and presentations on the importance of nutrition and its multi-dimensional nature. How nutrition is relevant and has synergy to the concerned Sectoral project so that it is perceived and understood to be mutually beneficial and can add value.
• Important to get a buy in, commitment and ownership from TTLs and other key stakeholders of the Multisectoral project to incorporate nutrition actions through discussions, negotiations, agreements and possibly through incentives, rewards and recognition.
• Identify natural entry points, opportunities and challenges, benefits and risks which would be the basis for incorporating nutrition actions both in new and ongoing Multisectoral projects.
• Engage with project teams and provide ongoing technical support to incorporate nutrition interventions when a new project is being designed or provide technical support in designing the nutrition interventions in the case of ongoing projects.
• Gender to be incorporated in the analysis and actions framework.

A project cycle approach can be used to incorporate nutrition sensitive interventions within the Multisectoral Project framework.

The Analytical Framework details are included as Annex 1 of the Report.

9. Consultations and design development

Using the core principles outlined in the Analytical Framework, consultations were held with the task-teams of key Bank operations in Bihar to explore interest as well as potential opportunities and entry points for incorporating nutrition interventions
within the Sectoral Projects. These included both projects under preparation and projects under implementation. Based on the outcomes of the consultations with the Bank task teams, consultations with the client project teams/project implementing teams, the department of Social Welfare, Government of Bihar, and other stakeholders working on nutrition in Bihar were held. As a result three WB projects in three sectors with the full support of the Bank and client teams were selected to include nutrition actions/strengthen nutrition linkages within their project framework. These include:

i) Bihar Rural Livelihoods Project, Jeevika  
ii) Bihar Panchayat Strengthening Project  
iii) Rural Water Supply and Sanitation Project for Low Income States

Each of these projects varies in size, scope and scale and geographical areas. A brief description of these follows

i) The Bihar Rural Livelihoods Project (BRLP): also known as Jeevika is an ongoing project implemented by the Bihar Rural Livelihoods Promotion Society (BRLPS) set up by the Government of Bihar and supported by the World Bank. This project aims to promote rural livelihoods to enhance the social and economic empowerment of the poorest and most marginalized women on a large scale. It has promoted community institutions and its federations to be set up to give collective voice, space and resources to address their needs and priorities. Initially nutrition actions in this project were started with a view to reduce health expenditures and provide food security to its target group of women. More recently Jeevika has committed to include Health and Nutrition as a component in its project for experimentation and demonstration before it is scaled up. There are various models and approaches of nutrition interventions being implemented by Jeevika using its community institutions and in collaboration with different development organizations and the government. These models adopt different approaches and are of different size and scale operating in different locations and at various stages of preparation and implementation.

Under this grant, Jeevika has been provided technical support through Consultant/s from the World Bank to develop the design of the Multisectoral Nutrition Convergence Pilot and further support by Consultants in the implementation of the pilot during the initial one year period. The pilot has recently moved from design to its implementation. The details of this Case study are described later in the Case Study Section III.

ii) Bihar Panchayat Strengthening Project: This project aims to support the Bihar Government to develop capacity to promote and strengthen responsive and accountable Gram Panchayat (GPs) in six selected districts in Bihar over a period of five years.

The focus of this project is to support Panchayat leadership at the local level to bring about visible changes in the village including village sanitation, improved quality of drinking water, improved nutritional status of women and children and better
management of natural resources. Technical inputs and coordinated support was provided to the client Project team by the TTL Nutrition along with concurrent technical inputs from concerned Sector Specialists in Water and Sanitation right from the outset and during the design and development stage of the Project and thereafter. This project is in its initial stages of implementation.

iii) **Rural Water Supply and Sanitation Project**: This project aims to improve piped water supply and sanitation services for selected rural communities in the target states through decentralized delivery systems. Light touch technical inputs in Nutrition were provided to the project during its design stage. The project is yet to be rolled out for implementation.

**Map of Bihar and districts covered by the Projects is given below:**
Two of the three projects were in their early stages of preparation, thus provided the opportunity for the technical staff in nutrition to engage with the project teams (WB and client teams) to design the incorporation of nutrition actions from the early stages of project preparation, including key results. However, flexibility in terms of the intensity and type of engagement of the nutrition team was important. In the case of the third, the Bihar Rural Livelihoods Project which was already an ongoing project under implementation, the approach adopted was to develop the model of nutrition interventions as a pilot and operationalize prior to mainstreaming it into the project, especially given that other models were being explored alongside. The development of the pilot design, a model that brings about convergence of multiple sectors, was based on extensive consultations with community organizations, project staff, the Water and Sanitation Program (WSP) and staff and officials of relevant government departments and programs and development organizations working in the area.

Thus the entry points and experience for incorporating nutrition interventions were different for each of the three projects which followed different processes of engagement. Details of each are presented as case studies in the section III. Two sector specific Program Guidance Notes (PGNs) have been developed for Rural Livelihoods Projects and for Panchayati Raj Institutions (local Governance Structures) as outputs based on the experience of designing nutrition sensitive interventions within these projects under this Technical Assistance. Summaries of the sector specific PGNs: i) Program Guidance Note on Incorporating Nutrition Actions in Rural Livelihoods Projects; and ii) Program Guidance Note on Incorporating Nutrition in programs for Panchayati Raj Institutions are included in Annex 2 and 3 respectively. The full Program Guidance Notes providing guidance to client and Bank teams on generic guidance and principles on why and how to incorporate nutrition sensitive interventions which can be adapted to their operational context and projects. These sector specific Program Guidance Notes are available on the World Bank website.
SECTION III: CASE STUDIES

10. Case Study 1: Bihar Rural Livelihoods Project – Jeevika’s Multisectoral Nutrition Convergence Pilot

10. Case Study: Development of Multisectoral Nutrition Convergence Pilot with Jeevika:

Overview and Profile

A pilot that incorporates multisectoral nutrition convergence using the Jeevika platform (henceforth referred to as the Jeevika Multisectoral Nutrition Convergence Pilot) was developed to improve nutrition of women and children. The pilot builds on Jeevika’s existing community institutions of Village Organizations (VOs) to interface with multiple local service providers as well as other stakeholders and is informed by extensive consultations with the Jeevika implementation team, particularly at the district and block teams as well as community cadres, the community and officials and staff of government programs in nutrition, health and sanitation, and development organizations working in the area. The pilot has recently begun to be implemented to test its feasibility. It is expected that the pilot will be scaled up after about a year of feasibility testing and refinements. Technical and implementation support by the nutrition team continues as a critical part of this phase by Consultants continues to be provided to support implementation of the pilot during the initial one year feasibility period.

The Target Group includes the poorest and most marginalized women in the community with a focus on pregnant and lactating women and young children below two years (1000 days window of opportunity) and adolescent girls. For some interventions the entire community will be targeted.

The Design framework and approach

The design approach followed included

- A bottom up, community based participatory approach starting small with plans for scale up through learning and adjustment.
- Facilitating interface between demand and service provision of nutrition sensitive interventions through a community based convergence approach
- Leveraging resources, expertise and learning’s of the different stakeholders.
- A multisectoral approach with multiple stakeholders
- Investing in women and their empowerment
The objectives, interventions and expected outcomes

**Objectives, Interventions and Outcomes**

**Outcomes**
- Improved maternal, infant and child nutrition and health practices, personal hygiene and sanitation including use of toilets
- Availability of food throughout the year for impoverished households and improved intake of food by pregnant women and young children
- Increased awareness and utilization of health, nutrition and sanitation services
- Increased capacity of community to participate, monitor and demand services

**Interventions**
- **Behaviour Change Communication on Nutrition, health, hygiene, water and sanitation**
- **Household Food and Nutrition Security**
  - Availability of diverse basket of food to target HHs including 1000 days through food and Nutrition Security Fund
  - Promote kitchen gardens and its universalization
  - Nutrition counseling to pregnant women and women with young children

**Institutionalize coordination and convergence between community and local service providers**
- Village health, nutrition, sanitation coordination committees functioning with community representatives and local service providers
- Block and district coordination established to support local coordination

**Capacity Building**
- For community cadres and project staff

**Monitoring, Learning and Documentation**

**Evaluation**

**Water and Sanitation**
- Demand generated for safe sanitation including toilets
- Construction of toilets
- Potable drinking water available within 1 km
The Nutrition Interventions include:

i) **Behavior Change Communication (BCC)**. The BCC approach will promote awareness and actions related to nutrition, health, water and sanitation. The Jeevika Sahelis (JSs) and other community cadres have received initial training in BCC. The BCC modules will be rolled out every two months. JSs will communicate specific BCC messages at SHG fortnightly meetings with members. Further trainings in BCC are planned and will be implemented to drive change in behaviors on key nutrition, health and sanitation messages. Some of the key messages focus on the window of opportunity and include those related to maternal health, infant and young child feeding and care practices, and those related to health, hygiene and sanitation. These messages are communicated through one-to-one and one-to-many approaches using and leveraging existing appropriate tools, materials and resources developed by different organizations working in the area. The community cadres will support local service providers for BCC during group meetings and community events.

ii) **Household Food and Nutrition Security** The existing Food Security Fund (FSF) will be restructured from a nutrition lens to target the poor, food and income insecure households including those with pregnant women and young children below two years through the micro-planning process and tool. Through the FSF, a basic food basket of cereals, pulses, oil and other food items will be made available to the target households as required at reasonable cost in 3 to 4 tranches through the year. Kitchen gardens will be promoted and universalized to ensure availability of fresh vegetables and seasonal fruits for consumption in the daily diet of targeted households. Emphasis will be on food availability and nutrition counseling for intra-household consumption of food especially by pregnant women and young children. In addition, Jeevika Sahelis will facilitate participation and contributions from mothers with young children (6 to 24 months of age) to encourage them to prepare and feed suitable locally produced nutrient dense foods to their children below two years.

iii) **Convergence and Coordination** between community (comprising VO members) and local service providers for demand generation, improved service delivery and greater mutual accountability. Coordination structures and mechanisms at village, block and district levels will be established to provide support. Village Health, Nutrition and Sanitation Coordination Committees comprising of local service providers (AWWs, ASHAs, ANMs, panchayat reps, school teachers and others) and community (Jeevika Sahelis and VO members) will plan, coordinate and monitor activities related to health, nutrition and sanitation through monthly meetings. Building rapport and trust, confidence and close working relationship between community and service providers will be promoted. Recognition, rewards and incentives would be provided for good work in coordination.

iv) **Water and Sanitation** Community mobilization and motivation of households would be undertaken to stop open defecation (ODF) and create demand for safe
sanitation. Along with the construction of toilets, personal hygiene and sanitation practices will be promoted through individual and collective action and through BCC actions. Technical support will be provided by the Water and Sanitation Program (WSP).

v) Women’s Empowerment will be promoted through their enhanced awareness, capacity, participation, access to resources and services and in decision making so that women are able to meet their nutrition, health and sanitation needs as well as for their families and community.

Scope and Geographical Coverage: The model is being piloted in Saur Bazar Block of Saharsa District in Bihar. The initial feasibility phase will cover three contiguous Gram Panchayats with approximately 35,000 population of which 3/4 of the households are covered by the Jeevika project. Jeevika has 413 Self Help Groups (SHGs) established and functioning with 29 Village Organizations (VOs) which will be part of the pilot.

Each SHG comprises of 10 to 12 women members from the poor and most marginalized communities and 10-15 SHGs are federated to form a Village Organization (VO). The VO is the project’s commonly used community platform to implement the various interventions. The VO comprises of 3 executive members from each SHG committee represented in the VO and has a membership of around 100 to 150 members. The VO meets twice a month and has various sub-committees to oversee the specific activities undertaken by the project.

Implementation Arrangements and Collaboration with External Stakeholders

The pilot will be implemented through the existing institutional structure and arrangements of the Bihar Rural Livelihoods Promotion Society (BRLPS) and relevant external stakeholders related to the Coordination and Convergence component of the model. Implementation of nutrition, health, and sanitation activities will primarily be carried out by community cadres supported by community structures (Village Organisations) as indicated in the organogram below. These community cadres include:

The Jeevika Sahelis (JSs) are the nodal persons to implement the activities at the village level and will be supported by the VO to plan implement and coordinate activities. She will be supported by members of the Health and Nutrition sub-committee and Procurement committee of VOs, and Community Mobilizers (CMs) and Village Resource Persons (VRPs) for specific activities. The roles and responsibilities of these community cadres have been defined related to implementation of the model. Project staff on the ground, which includes an Area Co-ordinator and Community Coordinators, will provide need based support to Village Organizations and community cadres related to the model as required.
The pilot implementation will be managed and supported by the concerned Jeevika District and Block staff under the leadership of the District Project Manager (DPM). The Jeevika Health and Nutrition Manager at the district level, supported by a team of three consultants form the core team to provide oversight, monitor progress, problem solve and address issues and challenges along the way. The Consultants will support the community cadres and project team in implementation, monitoring and documentation of the pilot during the feasibility phase.
Coordination and Collaboration with Multiple Stakeholders

The following figure demonstrates the arrangements proposed to co-ordinate multiple external stakeholders. Periodic planning and review meetings will be held at the community, block, and district level. At the community level, the Jeevika Saheli and members of Health and Nutrition sub-committee of VOs will participate in the Village Health Sanitation and Nutrition Committee as well as other community forums and platforms where local service providers are a part and issues related to nutrition, health and sanitation will be discussed. Clarity of purpose for coordination, roles and responsibilities and accountability mechanisms will be established and regular meetings to motivate community cadres and local service providers to work together including instituting incentives such as recognition, rewards, building their capacity and leadership roles and acknowledging the good work being carried out by them. Actions will be planned at these meetings for implementation and monitoring by the committee which would enhance community participation, build mutual accountability, and assist in generating demand and in strengthening service delivery.

Block and District planning, co-ordination and review meetings will include representatives from the District Administration, District Health Society(DHS), ICDS, Public Health Engineering Department(PHED), Panchayati Raj Institution Department(PRI), Jeevika staff, and development partners operating in the area, e.g., Care India (works with the Health Department as the technical support unit), and Project Concern International(PCI) (works with Jeevika under their Parivartan project on community mobilisation and capacity building on health, nutrition, and sanitation).
Monitoring and Evaluation

A monitoring framework for the model is being developed for the feasibility phase and beyond. This will be used to assess progress with key milestones and bring out issues related to the implementation. Further work on developing the monitoring plan with a list of indicators, processes, outputs and outcomes is under development.

| Promote nutrition, health, water and sanitation awareness and change in practice with a focus on pregnant and lactating women and young children. |
|---|---|---|---|
| Activities | Outputs | Indicators | Results |
| • Develop a framework of key behaviors in nutrition, health, hygiene and sanitation to be targeted | • Behavior Change Communication (BCC) implementation plan and its operation | • No. of community cadres and staff trained to deliver and support delivery of messages | • Improvement in infant and child feeding practices |
| • Review and use identified behavior change communication (BCC) materials developed by stakeholders to be used in the pilot | • Communications materials available | • No. of awareness sessions and events held per month and attendance by members | • Improvement in maternal health and nutrition practices |
| • Plan delivery of messages, methods and materials to be used and capacity building required | • Community cadres and relevant staff trained to deliver BCC | • Community events and VHNS day held and organized by community members and local service providers | • Improved personal hygiene and hand washing practices |
| • Training of trainers | • Community monitoring format developed for village organizations to support and oversee the roll out | • Follow up of households with pregnant women and young children | • Increased households with access to safe sanitation |
| • Training of community cadres | | | • Increased awareness and utilization of services |
| • Implement and support roll out of BCC plan and its review. | | | |

| Improve household food and nutrition security with focus on the 1000 days window of opportunity. |
|---|---|---|---|
| Activities | Outputs | Indicators | Results |
| • Build a consensus to revise the Food Security Fund to include cereals, pulses and oil based on the needs of target households especially 1000 days window of opportunity | • Micro planning includes information and inclusion of pregnant women and young children for FNSF | • Target households access the FNSF to meet maternal and child nutritional needs | • Availability of nutritious food throughout the year for target households including HHs with pregnant women and young |
| • Develop an operational manual for sustained implementation of FNSF. | • Food security fund revised to food and nutrition security Fund with provision of diversified food basket | • Follow up visits by front line workers and community cadres to 1000 | |
| • Technical support for promotion of universal | • Fund operational and utilization cycles initiated and reviewed. | | |
kitchen gardens at household level.
- Implement and support the roll out of the revised FSF and fund and kitchen gardens

- Coverage of kitchen gardens increased to make fresh fruits and vegetables available to all target families at affordable cost
- days window of opportunity households to ensure food consumption
- children.
- Improved infant and child feeding and maternal feeding practices.

### Institutionalize coordination and collaboration between concerned departments related to nutrition, health, sanitation and between community and local service providers to improve quality and utilization of services and making it responsive to the needs of the target group and to improve nutrition outcomes as a common objective

<table>
<thead>
<tr>
<th>Activities</th>
<th>Outputs</th>
<th>Indicators</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation with key stakeholders to agree on coordination structures and mechanisms at village, block and district levels.</td>
<td>Community, block, and district coordination structures and mechanisms in place</td>
<td>Effective participation of community representatives and service providers in community meetings and committees</td>
<td>Greater accountability between community and service providers</td>
</tr>
<tr>
<td>Agreement on roles and responsibilities between community and local service providers for coordination purposes.</td>
<td>Interaction and co-ordination meetings between stakeholders regularly held</td>
<td>Progress on plans and follow up actions from co-ordination meetings</td>
<td>Demand for services increases</td>
</tr>
<tr>
<td>Development of a coordination framework and plan for the community and service providers to interact and co-ordinate</td>
<td>Improved community participation and stronger linkages</td>
<td>Demand and utilization of services</td>
<td>Improved service delivery and its utilization.</td>
</tr>
<tr>
<td>Demand for services generated from the community</td>
<td>Demand for services generated from the community</td>
<td>Demand for services generated from the community</td>
<td>Demand for services generated from the community</td>
</tr>
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</table>

### Develop community and organizational capacity to plan, implement and monitor nutrition sensitive interventions.

<table>
<thead>
<tr>
<th>Activities</th>
<th>Outputs</th>
<th>Indicators</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training needs identified related to the project interventions identified for staff and cadres.</td>
<td>Training sessions held</td>
<td>Systematic plans for implementation are drawn up and executed</td>
<td>A sustainable community based model is built.</td>
</tr>
<tr>
<td>Training and capacity building schedule and calendar drawn up</td>
<td>Organizational and community capacity built</td>
<td>Plan, review and monitor training sessions and events and take follow up actions.</td>
<td>Model is implemented and monitored by the community with support from project staff</td>
</tr>
<tr>
<td>Training modules developed</td>
<td>Staff and cadres better equipped to plan, implement and monitor community nutrition interventions</td>
<td>Need based support provided to community cadres</td>
<td>Enhanced capacity of community cadres and organization to</td>
</tr>
<tr>
<td>Training of trainers</td>
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</tbody>
</table>
carried out.
• Roll out of training to community cadres and staff

    plan, implement and monitor nutrition interventions

after training.
• Application of training by community cadres related to their work.

 External Evaluation
An external impact evaluation is planned for rigorous evaluation of the pilot. Funding from SIEF is likely to be approved soon (seed funding was received to develop the evaluation proposal) and the evaluation will be conducted by the International Food Policy Research Institute (IFPRI) and the Oxford Policy Management (OPM). The impact evaluation design is under finalisation. It will have a treatment group which will receive the intervention package of the multisectoral nutrition convergence model and a control group which will provide the counter factual. Both groups will have the same structure of community based organisations that include women’s self help groups and their federation of village organisations(VOs) thus providing a robust and best possible counter factual. Treatment and control VOs will be randomly selected. Bias due to spill overs could take place. To minimise this, assignment of treatment and control groups will be clustered and specific attention will be given to ensuring that there is adequate space between clusters of both groups. Clustering will also ensure internal validity. A quantitative baseline survey will set base parameters and a subsequent quantitative midline and endline survey on the same sample, with qualitative data collection will be carried out in the interim period. The evaluation period is proposed to be three years.

This evaluation and its results will be extremely useful from a policy and program perspective as there are few initiatives operational on the ground and evidence on their impact is scarce. With established community platforms and infrastructure available, this provides a unique opportunity to test this model and provide evidence on the efficacy and impact of a Multisectoral Approach in Nutrition.

Key Issues and Challenges

• Due to a variety of reasons, there has been a considerable time lag between the design and the implementation phase even though the intervention is to be implemented through an ongoing Bank project. Given that the pilot implementation is to be done through existing project staff, it required reallocation of responsibility and time to support implementation of the pilot. The Jeevika Project team at the district level at that time was over stretched; there was high staff attrition, with increased workloads and competing work demands and timelines. Nutrition interventions were seen by staff as an add-on to their work. There were issues related to ownership and commitment to implementing nutrition interventions. These issues are beginning to be addressed by reallocation of specific responsibilities of selected project staff to support implementation, by providing ongoing orientation and training to staff in nutrition and building their understanding and
perspective on the relevance of nutrition to their project work to help them develop a sense of ownership. This has to be an ongoing process.

- As mentioned above, the implementation of the pilot is primarily the responsibility of the community cadres and community structures to be supported by the concerned project staff. Slow progress was made in establishing community structures and recruiting Jeevika Sahelis, the front line community cadre responsible for implementation of the pilot. In some instances, it was time consuming to find suitable women from the community to fit the requirement of the Jeevika Saheli for which several rounds of selection and recruitment were carried out.
- Besides, the technical and capacity support, oversight, direction provided by the nutrition team at the Bank, in order to overcome the above constraints, at the advice of the Jeevika team, three local Consultants have been placed in Saharsa to support community cadres and staff to implement the pilot through mentoring and capacity building and for monitoring and documentation of the pilot.
- Since nutrition is a new area for the project team, it will require ongoing orientation and support to build a perspective amongst the team on the importance of nutrition as a development priority and its relevance to the work of Jeevika. A capacity building approach will be followed through.

11. Case Study 2: Bihar Panchayat Strengthening Project

11. Bihar Panchayat Strengthening Project

**Background:** The Bihar Panchayat Strengthening Project (BPSP) aims to support the Government of Bihar to develop capacity to promote and strengthen responsive and accountable Gram Panchayats (GPs) in six selected districts of Bihar.

Project beneficiaries include: (i) rural residents in the target PRIs of the six districts, who are more effective in monitoring fulfillment of government obligations and can enjoy better and inclusive government services and undertake effective collective actions to solve local problems; (ii) elected officials and functionaries at the Gram Panchayat level, who can become more capable of taking initiatives to solve the problems of their constituents, resolve local conflicts fairly, and are able to mobilize resources and support for the initiatives.

Nutrition improving actions are nested under the Capacity building for Gram Panchayats component, one of the five project components that aim at institutional strengthening and nurturing development-oriented panchayat leadership and local initiatives. It builds panchayats’ core institutional competencies to empower them to achieve substantive development outcomes. It also engages communities and citizens, through training, mobilization, and media, to participate in local governance and to hold panchayats accountable. The approach is to, on the one hand, raise awareness among local leaders and communities about important behavior changes and local
actions that can improve nutrition, health and livelihood; and on the other hand, to facilitate their access to government program resources to finance community priorities. The project focuses on developing GP’s capacity to plan and implement initiatives that improve results in at least one of the following areas: natural resource management, nutrition status of women and children, quality of drinking water, and village sanitation.

The focus of the project is to develop capacity and to support panchayat leadership to bring about visible changes in the villages including village sanitation, improved quality of drinking water and improved nutritional status of women and young children. This will be done through helping GPs access and effectively use resources provided by the government programs like Total Sanitation Campaign (TCS), National Rural Drinking Water (NRDW), Integrated Child Development Scheme (ICDS) and Mahatma Gandhi National Rural Employment Guarantee (MGNREGA). Moreover, coordination and collaboration will be undertaken with concerned departments such as PHED, ICDS, Rural Development (RD), Social Welfare (SW) and others.

A phased and results based approach will be adopted to raise awareness and build capacity among leaders and local community about the importance of behavior change and local actions that can improve health, nutrition, water and sanitation and to access program resources to meet community needs and priorities. The project will develop the capacity of GPs to plan and implement initiatives that improve results in areas such as nutritional status of women and children, quality of drinking water and village sanitation. Building capacity and leadership of Gram Panchayats will be a motivating factor for them to undertake their role in taking up issues of undernutrition among women and children which otherwise are of low priority and remain invisible and unattended to in most instances.

The nutrition team along with other sector specialists (Water, Sanitation and Natural Resource Management) engaged with the BPSP and the client teams, participating in preparation and appraisal Missions, and the design of each sectoral intervention was jointly developed. This included presentations on nutrition as well as technical inputs in the design of nutrition sensitive interventions including its monitoring and evaluation aspects. There has been a long lag between approval and implementation and project is in early implementation phase now.

**Objective, Approach and Expected Outcomes for Nutrition Interventions**

The following figure demonstrates the objective, approach and expected outcomes of the nutrition, water and sanitation interventions:
Strategy for Nutrition Sensitive Interventions

The proposed strategy and pathway to improve nutrition through Panchayat interventions is as follows:
Key activities supported to improve nutrition

The key activities that the project will fund to improve nutrition include:

i) Capacity Building activities, including:
   - Technical support services to develop training curricula, modules, content, and tools for GPs and community representatives to create awareness about nutrition and promote behavior change;
   - Developing Master Training Teams to provide ongoing training support and monitoring training quality at all levels;
   - Sensitization meetings for senior officials of different departments, training of Block Facilitators, training of all three tiers of PRIs including village Health-Nutrition-Sanitation committees.

ii) Establishment and strengthening of village Health-Nutrition-Sanitation-Water Committees;

iii) Periodic review meetings/joint trainings with line department functionaries at GP, block, district level;

iv) Exposure visits;

v) GP and village level events for social mobilization to create awareness and promote behavior change;

vi) Information, Education and Communication, including nutrition and health content development for mass media, information & communication technology (ICT), wall paintings, community display boards etc.

vii) Learning, documentation and policy-advocacy

viii) Establishing a monitoring system to track nutrition status at the GP level – linked to the project MIS and the MIS for the ICDS.

ix) Rigorous impact evaluation of nutrition-related activities. Documentation – series of papers on successes, lessons learnt.

Geographical Areas of Coverage: The project will cover in a phased manner, six districts and 91 blocks in Bihar over a period of five years.

The Target Groups to be reached will include elected representatives, officials and functionaries at the Gram Panchayat (GP) level whose capacity will be developed to become strong leaders who can listen to their constituents and solve their problems and are able to mobilize resources and take initiatives.

Rural residents especially the disadvantaged in the target PRIs of the six districts will be mobilized to monitor and hold government accountable and can undertake collective actions to solve local problems.

Implementation Arrangements: The implementation and coordination arrangements for the nutrition actions are embedded within the project implementation structures shown in the figure below. Technical expertise, leadership, and facilitation for nutrition will be provided at the project level through a State Nutrition Coordinator, at the
district level through a District Nutrition Coordinator, and at the block level through a Joint Water-Sanitation-Nutrition Coordinator.

Key Issues and Challenges

- It has been easier to incorporate nutrition sensitive interventions for the new project which was in the initial stage of formulating the project design. The engagement of technical experts (in nutrition, water and sanitation) with the project teams, both the Bank task team and the client team, began very early with participation in all preparation Missions and discussions, including in the development of the project results framework, implementation arrangements, monitoring and evaluation arrangements. This enabled the full integration of nutrition interventions in the project, including the Project Appraisal Document and Project Implementation Plan. The nutrition team continues to be engaged in Implementation Support.

- BPSP had a very long preparation period due to a variety of reasons, resulting in significant delay in the start of project implementation, and overall BPSP implementation is somewhat slow.

12. Case 3: Rural Water Supply and Sanitation Project in Low Income States (RWSS-LIS)

12. Rural Water Supply and Sanitation in Low Income States: This case study presents a brief outline of the nutrition interventions and approach agreed upon with the Bank task team and incorporated into the Project Appraisal Document. While the engagement with the project team was initiated during project preparations, given the need for the task-team to meet the appraisal deadlines, and the relatively large number of sectoral competing priorities and the engagement with five entities (the central level and four states), it was agreed that the details and fine-tuning of the proposed approach
and its implementation would be done through participation during implementation Missions.

The RWSS-LIS objective is to improve piped water supply and sanitation services for selected rural communities in the states of Bihar, Jharkhand, Assam and Uttar Pradesh. The project will be implemented over a period of six years. The project takes a decentralized service delivery approach in the participating states with increased participation of local governance structures (Panchayati Raj Institutions) and communities with enhanced accountability at all levels. It adopts a district wide approach where there is low coverage of piped water supply and sanitation services through an integrated approach to water supply and sanitation. It will support household toilets, institutionalized sanitation in schools, anganwadi centers and community/public toilets. It will promote environmental sanitation and solid waste management for village wide cleanliness. This will be supported by Information, Education and Communication (IEC) and Behavior Change Communication (BCC) activities.

**Strengthening water-sanitation-nutrition and health linkages, and testing their impact**

Promoting institutional convergence with relevant sectors and building partnerships as appropriate with the Education, Health and Nutrition sectors for improving rural Water and Sanitation services will be the key thrust of promoting and supporting nutrition sensitive interventions through the RWSS-LIS. While the Nirmal Bharat Abhiyan (NBA), National Rural Drinking Water Programme (NRDWP), NRHM, ICDS – all recognize the strong links between the sectoral programs, outline their commitment for inter-sectoral convergence, and have identified institutional mechanisms to do so, in practice these linkages largely remain weak and the sectoral intents unrealized. The RWSS-LIS project offers the opportunity to strengthen these linkages across the project. Further, ten districts across three states where both RWSS-LIS and the Bank-supported nutrition project, ICDS Systems Strengthening and Nutrition Improvement Project (ISSNIP) overlap3, offers the unique prospect to simultaneously deliver a comprehensive package of water, sanitation, health and nutrition services with community participation and engagement.

Given these opportunities, the project will support:

- Improving community awareness of the importance of improved water, sanitation and hygiene in disease prevention and achieving better health and nutrition, particularly for children. The NBA and NRDWP guidelines speak to this integration,

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3 The ten districts common to both projects across three states are: Kushinagar, Ghazipur and Allahabad in UP; Dumka, Garhwa and Palamau in Jharkhand; and Pashchim Champaran, Muzaffarpur, Munger and Purnia in Bihar.
and by strengthening IEC/BCC strategy, package and training, the project will help operationalize the policy intent of the two programs;

- Enhancing institutional convergence with NRHM and ICDS in two ways. First, at the village level by improving the collaboration between and capacities of the Village Water and Sanitation Committee (VWSC) of the Water and Sanitation programs and the Village Health Sanitation nutrition committee (VHSNC) formed under the NRHM and ICDS for joint IEC/BCC where VHSNCs exist. Where VHSNCs do not exist, the project will build the capacity of the AWW and ASHA, key functionaries of ICDS and the NRHM along with the VWSCs, and engage with NRHM at the district and block levels to catalyze the VHSNCs (Note: the AWW and ASHA are mandated to be VHSNC members and are also identified for IEC and community mobilization activities and training under the NBA and NRDWP). Second, ensure that as mandated under the NRHM, the ASHA fulfills the roles assigned to her related to household level disease data collections, sample collection for testing, sanitary inspection of sources, and corrective action to prevent pollution.

- In the ten districts common to RWSS-LIS and ISSNIP, the two projects will collaborate to ensure that a complete package of health, nutrition, water and sanitation interventions are delivered at the village level with community participation and engagement. In these districts, in addition to the integrated IEC for water, sanitation, hygiene, ISSNIP will support BCC for promoting positive nutrition behaviors such as Infant and Young Child Feeding and Caring practices, along with the water, environmental sanitation and hygiene messages.

**Monitoring and Evaluation**

The Impact Evaluation of the project will design and test the impact of improved water and sanitation on health and nutrition indicators. The overlap with ISSNIP project in several districts offers the opportunity to possibly test the differential impact of water and sanitation interventions, nutrition and health interventions, and nutrition, health, water and sanitation interventions delivered together. Studies to study the impact of improved water and sanitation on morbidity reduction could also be considered.

Suggested indicators for the project to measure progress on the above activities (these might not necessarily be included in the results framework but should be tracked as part of the project MIS):

**Outputs:**

- Number of villages with IEC and community mobilization activities conducted with the participation of ASHA and AWW (at least X sessions over the past year);
- Number of villages conducting joint trainings for VWSC and VHSNC members
Outcomes:

- Increased percentage of women with knowledge of linkages of water, sanitation and health and nutrition;
- Increased percentage of households with improved practices pertaining to: hand-washing with soap before meals, before handling food and after using the toilet; food hygiene (cooking, storing and serving); Infant and young child feeding practices, in addition to hand-washing and food hygiene (in the RWSS-LIS and ISSNIP common areas)

**Implementation Arrangements:** The project will be implemented under the Ministry of Drinking Water and Sanitation and through the State and District Water and Sanitation Missions going down to the village level through the Gram Panchayats. Mechanisms to bring about institutional convergence will be established.

**SECTION IV: CONCLUSIONS**

13. **Conclusions**

The three Case Studies included in this report are in the design and early implementation stage. Therefore it is too early to capture the issues and learning’s related to implementation of the nutrition interventions and the challenges and opportunities that it would pose. These will need to be monitored through the period of implementation to document experiences and evidence it generates for purposes of learning, knowledge management and its dissemination. The evaluation of the nutrition sensitive interventions within each of these projects is also planned.

The experience of incorporating nutrition sensitive interventions to date within each case study has been different. It has been relatively easier to incorporate nutrition actions in the case of new projects through engagement of Nutrition team and other sector specialists (Water and Sanitation) with the respective TTLs and client project teams during the preparatory and formulation stages of the Project Appraisal Document. Moreover suitable provisions and investments were made within the project for implementation, monitoring, evaluation and capacity building support for the nutrition sensitive interventions.

In the case of Multisectoral Nutrition Convergence Pilot of Jeevika, additional and substantive technical inputs and support were provided by the Consultant for developing the design of the pilot and subsequently through recruiting Consultants to support the implementation of the pilot and build capacity of the community cadres and project staff. This technical support was provided to Jeevika since there was no/limited provision for these.
The Jeevika Multisectoral Nutrition Convergence pilot will initially be implemented on a small scale to test and adjust the community based multisectoral convergence approach before it is scaled up. The reason for this is for Jeevika to learn from the experience of working with multiple sectors and stakeholders, adjust and then scale up within Jeevika’s other operational areas and possibly replicate this model in similar types of Rural Livelihood projects.

In the case of Bihar Panchayat Strengthening Project, engagement with the TTL and project team to incorporate nutrition sensitive interventions started at an early stage of project design, and therefore the project could incorporate substantive technical inputs and suggestions on nutrition sensitive interventions into the Project Design and Results Framework.

In the case of Rural Water and Sanitation Project, the technical inputs on Nutrition were light touch.

In all the three Case Studies, there has been a considerable time lag in moving from the design stage to project implementation.

The following issues have emerged based on the experience of the three Case Studies.

a. Key Issues Emerging

• It is well recognized that to mainstream nutrition actions in a Multisectoral project it is important to have nutrition specific objective/s and nutrition sensitive interventions incorporated into the design of the project and to monitor its outputs and outcomes with appropriate indicators which should form a part of the overall monitoring and results framework of the project.

• Incorporating nutrition sensitive interventions within a Multisectoral Project requires appropriate support and investments for it -technical, human and financial. In the case of new projects which incorporate nutrition interventions, these investments can be built into the project design, implementation arrangements and budgets, whereas for ongoing projects that undertake nutrition interventions, these have to be provided for. This was clearly evident in the case of Jeevika Multisectoral Convergence pilot which posed challenges as these provisions were not there within the overall project.

• Technical support in nutrition needs to be provided to the Sectoral project client teams on an ongoing basis especially during the design and early stages of implementation of nutrition interventions along with ongoing capacity building support to the project team and community cadres.

• It is important to develop a perspective and understanding amongst the project team about the importance of nutrition and how it is relevant to their overall project otherwise it will be perceived as an add on
• It is critical to identify within the institutional structure, those responsible for implementing nutrition actions (among project staff and community cadres) with clearly defined roles and responsibilities and mechanisms of accountability otherwise nutrition actions tend to get deprioritised.

• It is important to address issues related to ownership, commitment and workloads of staff for nutrition interventions. Competing priorities and workloads can derail nutrition interventions.

• Suitable Incentives, Rewards and Recognition need to be considered and put into place for undertaking Nutrition actions in Multisectoral projects.

• Strong Leadership and Champions are required within the project/organizations that can provide impetus to nutrition actions.

• Setting up institutional coordination structures and mechanisms to work multisectorally with multiple stakeholders will require organizational commitment, responsibility, resources and time. It is a relatively new area to be tried and tested on how it will work so as to add value for all stakeholders concerned. It would require different ways of working which the implementation of the three case studies will provide evidence on.

b. Way Forward: It is proposed to continue providing technical assistance as appropriate to the three Case Studies that have incorporated nutrition actions within their Sectoral Projects in order to learn from the experience of implementing nutrition interventions within these Projects. These initiatives will offer substantial learning’s which will not only be useful for the project itself but also for wider dissemination.
ANNEXES:

Annex 1: ANALYTICAL FRAMEWORK

This Analytical Framework sets out the core principles and adopts the project cycle approach for analysis and possible actions for incorporating nutrition sensitive interventions within the existing and new World Bank Multisectoral Projects in Bihar.

The Analytical Framework will help to work with Task Team Leaders (TTLs) and other World Bank staff and project implementers to identify key issues, opportunities and challenges for consideration in order to explore, inform and influence the potential to mainstream nutrition interventions within individual Sectoral Projects through the various stages of the project cycle namely: Identification and Design, Implementation, Monitoring, Learning, Knowledge Management and Evaluation.

The Core Principles

- Facilitate a shared understanding amongst key stakeholders (internal and external) of the Multisectoral Projects (through advocacy, presentations, information sharing, and consultations) on the importance of nutrition as a development priority, the multidimensional determinants of nutrition and its synergy with the individual Sectoral Project and platform, so that it is perceived to be mutually beneficial and serves a common purpose.
- Identify natural entry points and opportunities which would be the basis for incorporating Nutrition Actions within the existing project design (Project Appraisal Document) rather than changing the design itself.
- Engage with the Project team to incorporate nutrition interventions when a new project design is being formulated.
- Nutrition Sensitive/Specific interventions to be proposed which have synergy and can add value to the overall project and will contribute to improved nutrition outcomes.
- The target group within the overall project (PAD) to consider and include the most nutritionally vulnerable group especially pregnant women and children up to two years i.e. the 1000 days critical window of opportunity. Besides this group, other nutritionally vulnerable groups and areas, socio-economically vulnerable groups and poor to be included.
- Gender analysis and actions to be mainstreamed within the project cycle framework
- Important to get buy-in, commitment and ownership from Task Team Leaders (TTLs) and other key stakeholders of the project to incorporate nutrition sensitive interventions through discussions, negotiations, agreements and possibly through incentives, rewards and recognition.
- Leadership/Champions for Nutrition to be identified within the individual projects which will be critical to the success of implementing the nutrition sensitive interventions.
In order to mainstream nutrition actions within the Sectoral Project, areas of **synergy, collaboration** (with existing and new external and internal stakeholders) and **convergence** (program and geographical) within individual projects to be assessed and made explicit (through consultations with the project stakeholders).

An analysis (in conjunction with the key project stakeholders) of the Opportunities and Challenges, Benefits and Risks which would influence and inform the selection and decision on whether or not it is feasible to mainstream nutrition interventions within individual Sectoral Projects.

Accountability and Governance issues related to the nutrition interventions should be cross cutting within the project rather than as a stand-alone.

Technical Nutrition support and other capacity building support is critical and needs to identified and provided on a timely basis throughout the project cycle.

Review of lessons learned and good practice on Nutrition Actions in Multisectoral Projects from global and national experience should inform these projects as well as lessons emerging from these projects should be systematically drawn and documented for learning, knowledge management and sharing.

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**Project Framework**

Project PAD and PIP with Nutrition Sensitive Interventions

![Project Framework Diagram]

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THE ANALYTICAL FRAMEWORK

This framework asks a set of key questions for exploring the feasibility and the potential to incorporate and implement nutrition sensitive interventions within the different stages of the project cycle.

**Checklist 1 within Identification and Design: Key Questions**

- What is the nature of nutrition problems and its consequences in the project areas/sectors? Is the information available in the broader project context analysis and whether nutrition analysis can be incorporated/made available to the project?
- Gender analysis should be crosscutting in all aspects of analysis and actions.
- Within individual Sectoral Projects, which project objective/s and its components lend themselves to incorporating nutrition specific/sensitive actions? What is the link between that objective, project component and activities to nutrition action? How would it provide leverage and add value? What are the potential links and pathways of that sector and nutrition?
- What are the likely entry points?
- What would be the likely benefits and risks?( To get perspectives from the TTLs and key stakeholders through consultations)
- What would be the opportunities and challenges to incorporate nutrition into the existing Multisectoral Projects –issues related to stakeholders’ interest, commitment, realism, doability, staff time, issues of capacity, technical support needs, use and deployment of existing and new human and financial resources, existing or new partnerships, issues related to coordination, collaboration and convergence, and any other.
- What would be the nutrition interventions /activities –for whom, what, where and how within the broader project design framework
- Who would be the target groups-women and children, most vulnerable and marginalized groups, who else?
- What nutrition interventions (nutrition specific and sensitive) can be suggested for the different Multisectoral Projects –what is appropriate for different Sectors?
- Geographical focus–which districts, blocks, communities, households, numbers. What would be the scope and scale of operations/activities?
- Which nutrition interventions, and at what levels: household, community, and block, district, state and national?
- Which Stakeholders and Partners to be involved? What is there comparative advantage? Roles and responsibilities and accountability made explicit within the project cycle.
- The above analysis would inform the Implementation plan
Checklist 2 within Project Implementation and Management: Key Questions

- What are the arrangements for Implementation and Management of nutrition interventions within the overall project management?
- Who will provide Leadership? Who will be Champions for the Nutrition Interventions in the Project?
- What will be the Roles, Responsibilities and Accountability for nutrition amongst the structure of the Implementation organization and within the broader Project Management structure?
- What would be the mechanisms of coordination and collaboration amongst different stakeholders operating in different geographical areas and at different levels?
- How would the concerned stakeholders and partners be oriented to nutrition to have shared understanding on the nutrition implementation plan and its expected outcomes within the broader project framework?
- Capacity and Technical support needs in Nutrition to be identified and delivered – what, for whom, when and how?
- What are the opportunities to mainstream relevant nutrition information and action within the existing broader Project Implementation Plans, structures and mechanisms and what would be the challenges to do so? What would be creative/flexible ways to address these?

Checklist 3 within Monitoring, Evaluation and Learning: Key Questions

Monitoring and Evaluation plan for nutrition interventions to be developed and indicators to measure nutrition outcomes to be part of the overall monitoring system and Results Framework for the project.

Key Questions:

- What indicators will be used to measure the progress of nutrition activities and its outputs and outcomes at baseline, mid-term and project completion?
- What indicators would be included in the Monitoring plan to assess progress, identify challenges and constraints and ways to address these?
- Set milestones to measure progress
- Evaluation to be planned and executed
- How to capture the learning’s that will be generated through sharing and reflection amongst the relevant stakeholders and its dissemination.
Annex 2: SUMMARY OF PROGRAM GUIDANCE NOTE: Improving Nutrition Actions in Rural Livelihoods Projects

**Purpose of Program Guidance Note**

**Purpose of the Program Guidance Note-why, what and for whom?**

a. This Program Guidance Note (PGN) is developed to assist the World Bank Task Team Leaders (TTLs), and program implementers of client organizations working in the Rural Livelihoods projects. The purpose is to analyze and design nutrition sensitive interventions within the Rural Livelihoods projects. The PGN is meant to provide generic guidance and is suggestive rather than prescriptive which can be adapted to specific operational and project contexts. It provides the rationale, need, importance and the how of nutrition actions that can be incorporated into the design of new and or ongoing project/s. It sets out the principles for action related to design of nutrition interventions and to work with multiple stakeholders through a project cycle approach.

b. The PGN will be developed in two phases. Phase 1 which is the present Program Guidance Note is related to the development and design of nutrition sensitive interventions within the Rural Livelihoods project drawing on the experience of designing the Multisectoral Convergence Pilot by the Bihar Rural Livelihoods project with technical support from the World Bank. This would be useful and relevant for similar projects within the framework of the National Rural Livelihoods Mission (NRLM) and the National Rural Livelihoods Project (NRLP) supported by the World Bank. Phase 2 PGN will be developed later as a sequel to this Program Guidance Note and will provide guidance on the implementation, monitoring and evaluation aspects.

c. The PGN is structured into three sections. The first section provides basic information and rationale for investing in Nutrition. The second section provides information on the National Rural Livelihoods Mission and Projects and key principles to incorporate nutrition in the design of Nutrition Actions. The last Section draws on from the Case Study of the Jeevika Multisectoral Nutrition Convergence Pilot to develop the design of nutrition sensitive interventions using the project cycle approach.
Nutrition Specific and Nutrition Sensitive Interventions

<table>
<thead>
<tr>
<th>Nutrition Specific Interventions</th>
<th>Nutrition Sensitive Interventions</th>
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<tbody>
<tr>
<td>A term that refers to interventions that directly address inadequate dietary intake or disease which are the immediate causes of malnutrition. These include: promotion of breast feeding, complementary feeding, treatment of malnutrition, micronutrient supplementation and deworming, adolescent and maternal health and nutrition.</td>
<td>These are interventions within sector specific objectives which aim to improve the underlying determinants of nutrition, namely food security, adequate maternal and child care at household and community level, access to health services, hygiene and environmental sanitation, and incorporates specific nutrition objectives and actions. Various actions that would address the determinants of malnutrition are possible in many sectors such as rural livelihoods, agriculture, water and sanitation, education and so on.</td>
</tr>
</tbody>
</table>

Basics in Nutrition

a. **Malnutrition** is poor nutritional status caused by nutritional deficiency (undernutrition) or excess (overnutrition). The focus is on undernutrition which results from inadequate quantity and quality of food, disease and inadequate care and feeding practices that results in underweight (low weight for age), stunting (low height for age) and wasting (low weight for height) and /or micronutrient deficiencies.

Maternal malnutrition: Many children are born undernourished because their mothers are undernourished. The nutritional status of women and girls are affected due to several factors such as limited access to food, traditional and cultural practices where women tend to eat the last and least, early marriage, repeated pregnancies, frequent infections with limited access to health care and sanitation.

b. **Consequences of Undernutrition:**
   - **Single largest cause of child death**
   - **Lost human capital:** Undernourished children have poorer cognitive development, lower school attainment and lower IQ, lower productivity and incomes as adults and are more likely to have undernourished children thereby perpetuating poverty.
   - **Lost economic growth:** It is estimated that undernutrition costs as much as 2-3 percent of GDP in many low income countries.
• **Irreversibly important for the first 1000 days:** Malnutrition experienced during pregnancy and the first two years of life will have severe and irreversible consequences on child development.

• **Nutrition is important throughout the life cycle:** Malnutrition reduces adult workers productivity, exacerbates disease, results in reduced work capacity, and chronic fatigue.

c. **Importance of Nutrition in the First 1,000 Days-Window of Opportunity**

Pregnancy to age 24 months, the first 1,000 days of life is the critical window of opportunity. By the time children reach their second birthday, if undernourished, they could suffer irreversible physical and cognitive damage which could impact their future health, development and well being. The consequences of insufficient nourishment in early childhood can continue into adulthood and be passed on to the next generation as undernourished girls and when women have children of their own. The importance of proper nutrition during this 1000 day period in pregnancy and until 24 months of the child’s life is therefore critical. Effective interventions are known which when provided during the first 1000 days of life can improve undernutrition. These include exclusive breast feeding, appropriate complementary feeding, micronutrient interventions (Vitamin A, iodine and iron), deworming, hand washing and hygiene and food supplementation in food insecure households. It is critical to ensure these interventions reach women and children during the narrow window of opportunity.

**RURAL LIVELIHOODS AND NUTRITION**

**Background of National Rural Livelihood Mission (NRLM)**

The National Rural Livelihoods Mission (NRLM) is perhaps the largest poverty reduction initiative and the largest program for women in the world. The World Bank is supporting this program through its National Rural Livelihoods Project, which is its largest single investment in a poverty reduction program. NRLM will be implemented in 12 states that account for 85 percent of the rural poor households in India.

The NRLM reaches down to the household level to support the formation of institutions of the poor at the community level from Self Help Groups(SHGs) to aggregation of these institutions which are federated at village, cluster, block and district levels. These provide a collective space and voice for the poor especially women to work together to leverage resources and services related to livelihoods. These include savings, building assets, adoption of new livelihoods for themselves and their families. The vast resources enable the institutional platforms to engage with many sectors and interact with many service providers. The program was a wide outreach.
Through the National Rural Livelihoods project, the World Bank provides technical and financial support to improve program delivery. The program which is being rolled out in a phased manner will allow the 12 states that have high poverty rates (Bihar, Andhra Pradesh, Tamil Nadu, Madhya Pradesh, Chhattisgarh, Jharkhand, Karnataka, Maharashtra, Orissa, Rajasthan, Tamil Nadu and Uttar Pradesh) to implement large scale pilots, create demonstration sites and best practice to incorporate lessons learned. It provides an excellent program platform to incorporate Nutrition Actions. An example of the model that has incorporated nutrition interventions under the World Bank supported Andhra Pradesh Poverty Reduction project called Nutrition cum Day Care Centers (NDCCs) is given below.

**Nutrition cum Day Care Centers (NDCCs) in Andhra Pradesh**

This World Bank supported pilot program aims to reduce malnutrition and improve nutritional status of pregnant and lactating women and young children from poor households in the long term. The NDCCs are community driven, community owned and community supervised rather than having a top down approach. They have been built on the social infrastructure of women’s Self Help Groups (SHGs) and their Village Organizations (VOs) and federations that have been established across the state for almost two decades. NDCCs aim to provide complete nutrition to pregnant and lactating and their children below two years with three cooked, well balanced meals a day on site to ensure that the food is consumed by the beneficiaries themselves. The cost of the meal is being recovered through a variety of measures with a view to becoming financially sustainable. These include amongst others, payment by beneficiaries (one third of the cost of the meal), linkages with programs like ICDS and Public Distribution System (PDS) to get food in bulk and at subsidized prices and to use fresh foodstuff from the centers own community gardens. The NDCCs seek to ensure provision of antenatal care for all pregnant women, postnatal care for mothers and immunization for young children, increase awareness and behavior change for maternal, infant and young child health and nutrition practices and repayment for services by the NDCC beneficiaries. Since 2007, through a phased incremental approach around 5000 NDCCs have been established in villages across Andhra Pradesh.

It is recommended that a Review of other Nutrition Sensitive Interventions within Multisectoral Projects that are being implemented especially in the Rural Livelihoods sector be carried out to draw lessons learned on what has worked well and why and what has not worked well so that these can be used to inform future nutrition interventions that can be planned and carried out within the framework of the National Rural Livelihoods Mission and Projects.

**Brief about the Bihar Rural Livelihoods Project (Jeevika)**

The Bihar Rural Livelihoods Promotion Society (BRLPS) is an independent society set up by the Government of Bihar (GoB) and supported by the World Bank. The
GoB has designated BRLPS as the State Rural Livelihoods Mission for implementation of NRLM at the state level. The BRLPS is implementing Jeevika-Bihar Rural Livelihoods Project (BRLP) to promote social and economic empowerment of the rural poor especially women which is being carried out on a large scale in Bihar.

The objectives of the project are to:

i) Create self managed community institutions of participating households,

ii) Enhance income through sustainable livelihoods,

iii) Increase access to social protection including food security by enabling women to have a voice in implementation of such schemes.

The strategy of the project is to build dynamic, self managed social capital comprising of community institutions of women. The strategy promotes savings, credit and livelihood opportunities where community organizations revolve leveraged funds to meet their various needs. The Self Help Groups (SHGs) are the primary level community organizations which are federated at village level into Village Organizations (VOs) as well as at the cluster and block levels. The project is moving towards a saturation approach to cover all the poor households in the geographical areas of its operation. The BRLP intervenes with the community through the following four themes which include: i) Institution and capacity building, ii) Social development, iii) Microfinance and iv) Livelihoods promotion.

Nutrition Actions within BRLPS

More recently, BRLPS has included Health and Nutrition interventions as a fifth theme which is being incorporated within its Project. Initially this was done with a view to reduce health expenditures and provide food security to its target group of women. Jeevika is presently experimenting with different models and approaches of nutrition interventions which are being carried out in different geographical areas and in collaboration with different sectors and organizations. These are being implemented through structures and project infrastructure.

The various models and approaches on Nutrition of the BRLPS include:

i) The Community Health and Nutrition Care Centers (CHNCCs): This pilot was started in 2012 with the objective of setting up community managed Nutrition Care Centers to improve nutrition and health and nutrition seeking behavior among pregnant and lactating women and young children below two years from the poorest and disadvantaged households. It is based on the Andhra Pradesh Nutrition cum Day Care Centers model. The CHNCCs are supported by the Village Organization (VO) structure and targets pregnant and lactating women and for children 13 to 24 months provides them with nutritious on site meals three times a day at the center. It promotes exclusive breast feeding for children from birth to six months and provides weaning foods for children from 7 to 12 months as well as nutrition and
health education, health check up and immunization through monthly check-ups. The beneficiaries are SHG members who pay a subsidized amount for the meals.

ii) **BRLPS administered Supplementary Nutrition Program model for ICDS:** will be piloted in 5 blocks where VOs will administer supplementary feeding program. BRLPS will receive funds from the ICDS which will in turn be transferred to the VOs who will procure food supplies, supervise distribution of take home rations to pregnant and lactating women, prepare and distribute supplementary food to children below six years at the AWCs. This intervention provides the potential to enhance community participation and improve service delivery of the supplementary nutrition component of the ICDS through an open, transparent and accountable process.

iii) **The Gram Varta model:** The purpose of this intervention is to promote positive health, nutrition, water and sanitation practices in the community through the platform of SHGs. Gram Varta is a process of 20 participatory learning and action based meeting cycles delivered through SHGs using participatory methods integrating nutrition, health, water and sanitation messages targeting pregnant women and young children under two years (1000 days window of opportunity). Community meetings by VOs to engage with local service providers in order to seek their participation for improving service delivery. Technical and capacity building support is provided to Jeevika by the Technical Assistance support team (B-TAST) and learning and financial support by the Women Development Corporation (WDC). The first phase will cover 36 Blocks in five districts of Bihar

iv) **Model of collaboration between BRLPS and Project Concern International (PCI) to improve nutrition and health service coverage and outcomes.** The Ananya program is a consortium of development partners funded by the Bill and Melinda Gates Foundation (BMGF) implementing a package of demand and supply side of interventions with a focus to reduce maternal and child mortality and improve health and nutrition outcomes. PCI through its Parivartan program is implementing interventions that aim to catalyze community mobilization and action to bring change in desirable behaviors specifically eight on health and nutrition and four related to water and sanitation through mobilizing and strengthening SHGs.

v) **The Multisectoral Nutrition Convergence Pilot:** Jeevika has developed this pilot with technical support from the World Bank. The pilot has developed a community based convergence approach to bring Village Organisations to interface with local service providers from government programs (ICDS, NRHM, PHED and others) and development organizations working in the area to generate demand, improve quality and utilization of services, enhance mutual accountability and improve nutrition outcomes. The pilot will start small as a feasibility phase with inbuilt mechanisms for learning, monitoring and scale up.

The above nutrition action models/approaches of Jeevika are at different stages of planning, start up, implementation, and are located in different or in some cases same geographical areas. Some of these models have focused on center-based feeding for the nutritionally vulnerable groups mainly pregnant and lactating
women and young children (1000 days window of opportunity) in conjunction with health check-ups and behavior change communication, and in some instances the water and sanitation component has been included. The Jeevika Multisectoral Nutrition Convergence Pilot is a systematic attempt of a community based multisectoral convergence approach of working with key sectors and stakeholders to generate demand and improve service provision for improved nutrition outcomes.

The various models and approaches adopted by Jeevika are of different scope, size and scale. It provides a unique opportunity for BRLPS to learn from them on what and how to implement nutrition sensitive interventions and to assess the effectiveness and outcomes of these different approaches for future scale up.

This Program Guidance Note draws on the experience of developing the design of the Multisectoral Nutrition Convergence Pilot by Jeevika with technical support from the World Bank.

**Nutrition Sensitive Rural Livelihoods**
A large proportion of malnourished persons reside in rural areas and the most affected amongst them are women and children. Rural livelihoods provide a source of income for the poor especially women through savings and livelihood opportunities. Simply increasing women/household incomes and agriculture production are insufficient to improve nutritional status of family and within it women and young children (especially the 1000 days window of opportunity). Many poor and vulnerable households lack nutrition and health information and awareness and often do not avail of existing services. Investing in nutrition especially for women will not only improve nutrition outcomes for their families and community but will also support rural livelihoods and poverty reduction efforts.

Therefore Rural Livelihoods is an important sector and has the potential to address nutrition especially for women and children on a large scale and would further empower poor and disadvantaged women. Nutrition sensitive Rural Livelihoods policy and projects can influence and improve nutrition outcomes for the rural poor especially women and young children by layering nutrition actions related to food and nutrition security, maternal, infant, child and adolescent health and nutrition practices, create demand for services and its utilization by providing appropriate nutrition support through its community platforms.

**Key Principles to incorporate Nutrition in Rural Livelihoods Projects**
Guiding principles can be kept in mind to incorporate nutrition sensitive interventions into the design and implementation of policies, projects and investments within the National Rural Livelihoods Mission/Rural Livelihoods projects. These can be adapted and used to individual contexts.
• **Incorporate nutrition concerns into the design and implementation of Rural Livelihoods projects and to measure nutrition outcomes.** The way to achieve this principle is to include nutrition objective/s and nutrition sensitive interventions explicitly into the project design and to measure nutrition outcomes and results which should be part of the overall Monitoring, Results and Evaluation framework of the project.

• **Target nutritionally vulnerable groups.** In the rural livelihoods project, the population that is being targeted is the poorest and most marginalized women who are being reached. From a nutrition standpoint, the most nutritionally vulnerable groups within this target group which needs to be prioritized and reached is the target group “1000 days window of opportunity” which starts during pregnancy and closes at about 2 years of age which is the critical period for preventing child malnutrition.

• **Increase year round availability of diverse food basket to the income and food deficit households.** The affect of seasonal food shortage and seasonal income deficits (periods when there is no/little work available) can have negative consequences on food and nutrition security of the household especially for the critical 1000 days window of opportunity. To prevent and mitigate this situation and to reduce the impact of food shortage on families and nutritionally vulnerable within it, it is important to provide access to diverse food basket throughout the year. Information related to when food and income shortages occur, who gets most affected by it and for how long and how severe needs to be obtained. By using a nutrition lens, the project can plan and implement (during periods of food scarcity and otherwise)what provisions need to be made through food security fund or alternate income generating activities, what and how much food would be required to meet the food and nutrition needs of the households especially for pregnant women and young children

• **Improve nutrition knowledge among rural households especially women.** Incorporate nutrition awareness and communication to target behavior change especially related to maternal, infant and child health and nutrition, safe hygiene and sanitation practices for the community especially women.

• **Empower women in nutrition and invest in them.** Increase in rural women’s incomes through livelihood opportunities has contributed to women’s economic empowerment. This can be further strengthened by juxtaposing nutrition and health knowledge and awareness and building capacity of women’s collectives and strengthening their role in decision making including how community resources and household incomes are spent. Women who control income have significant positive effect on child nutrition, family food security, health seeking behavior besides other benefits. Given that women play multiple roles within household and community, it will not only benefit them but also their families and community.

• **Promote interface between demand and supply and seek opportunities to work across sectors.** Through community structures and organizations promoted and strengthened by the rural livelihoods programs (NRLM) these can be enabled to
foster linkages and engage with nutrition, health and sanitation programs for mutual accountability. Promote interface between demand and supply through community platforms for convergence with service providers from multiple sectors. This would require multisectoral planning, coordination, geographical overlaps and creating shared structures and commitment for coordination in order to improve nutrition outcomes. Issues around governance and accountability, roles and responsibilities and incentives for coordination will need to be well defined. Actions can be planned taking into account the context, objectives and operating environment.

- **Reaching nutrition to the unreached**: The Rural Livelihoods project primarily targets the most impoverished and vulnerable households which are often missed out by service providers and difficult to reach. Discriminated groups require specific measures to help them overcome obstacles that impede their access to and utilization of nutrition, health and sanitation services and to make these services more responsive and accountable to their needs.

- **Develop understanding and capacity on nutrition as a development priority**: Develop capacity of human resources within the project in nutrition (especially on maternal and child nutrition) at all levels (relevant project staff and community cadres) and to ensure training, capacity building support, mentoring and guidance, motivation and recognition is provided for nutrition work especially for front line workers and community cadres.

**Practical Steps**
- In the case of an ongoing project, review the Project Appraisal Document (PAD) to understand the project objectives, results framework, activities, geographical areas covered, implementation arrangements, project status and key issues. Assess what could be possible opportunities and key entry points for incorporating nutrition interventions. For new projects, engage at the outset during the project preparation and design stage to incorporate nutrition actions within it.

- Get commitment and buy-in from the Task Team Leader (TTL) and other related WB staff and teams from client organizations and continue to engage with them on an ongoing basis in the development of the design of nutrition sensitive interventions for incorporation within the Rural Livelihoods project.

- Project site visits and meetings with the project task teams of counterparts at the state, district and block levels. Consultations with key stakeholders from project (concerned state, district and block project staff, VO members and other community members) as well as external stakeholders- from government programs (such as the ICDS, NRHM, PHED and other development organizations working in the area) to understand the context, programs and issues in the operational area.

- Information and analysis of the context, nutrition problems, opportunities and risks to incorporate nutrition sensitive interventions within the project platform, building on need and what is there.
- Identify key entry points and synergy between the Project and Nutrition Actions identified.
- Provide ongoing technical support in nutrition to the project team in design of the project.
- Develop and build a perspective amongst the team on the importance of nutrition within the project framework.

Sample Checklist that can be used for preparing the design of the Nutrition Sensitive Nutrition Interventions

<table>
<thead>
<tr>
<th>Sample Checklist</th>
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<tbody>
<tr>
<td><strong>1. Analysis of the context and nutrition issues in the operational area</strong></td>
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<tr>
<td><strong>Sample Questions</strong></td>
</tr>
<tr>
<td>- What are the prevalent nutrition problems in the operational area and more widely?</td>
</tr>
<tr>
<td>- Which population and target groups suffer the most?</td>
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<tr>
<td>- What are the existing maternal, infant and child care practices?</td>
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<tr>
<td>- What is the role of women in addressing these problems?</td>
</tr>
<tr>
<td>- How can increased incomes be used to improve food and nutrition security of households?</td>
</tr>
<tr>
<td>- Who are the service providers and development organizations working in nutrition, health, sanitation in the geographical area of operation?</td>
</tr>
<tr>
<td>- What are the opportunities and risks for community structures to work with them?</td>
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</tbody>
</table>

**Tools:** Review existing documents, consultations with key stakeholders, site visits, Focus Group Discussion with SHGs/VOs members.
<table>
<thead>
<tr>
<th>2. Consultation with women from SHGs/Village Organizations</th>
<th>Sample Questions</th>
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<tbody>
<tr>
<td></td>
<td>• Dietary/food consumption patterns</td>
</tr>
<tr>
<td></td>
<td>• Seasonal food availability (households and community) and intra-household food consumption</td>
</tr>
<tr>
<td></td>
<td>• Prevalent practices related to maternal, infant and young child feeding, hygiene and sanitation practices</td>
</tr>
<tr>
<td></td>
<td>• Awareness and use of nutrition and health services</td>
</tr>
<tr>
<td></td>
<td>• Roles and responsibilities of women within household and community and in decision making</td>
</tr>
<tr>
<td><strong>Tools:</strong> Focus Group Discussion with members of SHGs and VOs</td>
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<tr>
<th>3. Consultations with project staff</th>
<th>Sample Questions</th>
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<tbody>
<tr>
<td></td>
<td>• What are the nutrition problems in the area?</td>
</tr>
<tr>
<td></td>
<td>• What, why and how can nutrition activities be incorporated into the project?</td>
</tr>
<tr>
<td></td>
<td>• What are the activities that can be built on and strengthened? E.g. Food Security Fund, kitchen gardens, agriculture/nutrition related livelihoods activities?</td>
</tr>
<tr>
<td></td>
<td>• Need and how to collaborate with government services in the area?</td>
</tr>
<tr>
<td></td>
<td>• What are the potential opportunities and risks and suggestions?</td>
</tr>
<tr>
<td><strong>Tools:</strong> Meetings with staff, one to ones</td>
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</tbody>
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<thead>
<tr>
<th>4. Consultations with external stakeholders (ICDS, Health, PHED, District leadership and development organizations) to explore the potential for collaboration</th>
<th>Sample Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• What is the perception about multisectoral coordination? Who and what (sectors and constituents) to collaborate with and for what purpose?</td>
</tr>
<tr>
<td></td>
<td>• How to facilitate coordination and collaboration between community and service providers in nutrition, health and sanitation? (horizontally and vertically)</td>
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<tr>
<td></td>
<td>• What would be the triggers to work multisectorally?</td>
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<tr>
<td></td>
<td>• How to make coordination and collaboration work over time?</td>
</tr>
<tr>
<td></td>
<td>• What should be the structure, mechanisms, motivation, dynamics and accountability for this coordination? How can it be mutually beneficial?</td>
</tr>
<tr>
<td></td>
<td>• How to develop shared understanding and commitment to coordination?</td>
</tr>
<tr>
<td><strong>Tools:</strong> Consultations with multi-stakeholders, meetings, workshops</td>
<td></td>
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</tbody>
</table>
The Design Framework and Objectives and Results Framework of the Multisectoral Nutrition Convergence Pilot are provided on page 10 of the report.

The Nutrition Sensitive Interventions of the Pilot include:

i) **Behavior Change Communication (BCC)** on nutrition, health, water and sanitation.

![Behavior Change Communication Diagram](image)

- Home visits/group meetings by AWWS and ASHRAs and Jeevika Sahelis
- Village Health and Nutrition Days
- Priority Areas of BCC
  - Antenatal Care
  - Postnatal and New Born Care
  - Promotion of exclusive breastfeeding
  - Promotion of Complementary feeding
  - Routine Immunisation
  - Family Planning
  - Personal hygiene and storage of potable water
  - Use of Toilet and safe disposal of waste
- Community events nakad nataks, fairs, use of folk media

ii) **Household Food and Nutrition Security**

iii) **Institutionalize Convergence and Coordination**

iv) **Water and Sanitation Component**

v) **Promote gender equity and women’s empowerment as a cross cutting aspect.**

Details of the nutrition sensitive interventions are on pages 11 and 12

**Program Impact Pathway:** as in the diagram below
**Design of the Impact Evaluation:** Information on page 17 of the report

**Key Issues, Opportunities and Challenges:**

The Multisectoral Nutrition Convergence Pilot has generated a lot of issues and learning’s based on the design development phase that needs to be taken cognizance of in multisectoral approach to nutrition. There will be a lot more issues that will emerge once the model is implemented. Some of the key issues are as below:

**Key Issues**

- The model has been developed in an ongoing Rural Livelihoods Project, which will be first piloted before it is scaled up.
- The project needs to have appropriate resources—people, financial and technical to undertake nutrition actions.
- Since nutrition is not a core area of the team, technical support in nutrition is required to the client project staff to develop design and to implement the interventions by providing ongoing mentoring and capacity building support.
- Develop perspective and understanding among the project team about the importance of nutrition as a development priority so that they perceive its relevance to the project.
- Identify within institutional structure, those responsible for implementing nutrition actions (among project staff and community cadres). Roles and responsibilities need to be clarified with mechanisms of accountability.
- Address issues related to ownership, commitment and time among staff for nutrition interventions. Competing priorities and workloads can de-prioritize nutrition interventions.
- Provide suitable Incentives, Reward and Recognition for carrying out nutrition actions.
- Leadership and Champions within the organization can provide impetus to nutrition actions.
- Institutional coordination structures and mechanisms should be developed from the community upwards and to learn from evidence how these can be made to function effectively.
Annex 3: SUMMARY OF PROGRAM GUIDANCE NOTE: Improving Nutrition Actions in Programs for Panchayati Raj Institutions (Local Governance Structures)

PURPOSE OF THE PROGRAM GUIDANCE NOTE

Purpose of the Program Guidance Note-why, what and for whom?

a. This Program Guidance Note (PGN) is developed to assist the World Bank Task Team Leaders (TTLs), its project partners and program implementers from client organizations to incorporate Nutrition through strengthening decentralized governance in the Panchayati Raj Institutions (PRIs). It is meant as a generic guidance and is suggestive rather than prescriptive which can be adapted to specific operational and project contexts. It provides principles and actions related to mainstreaming nutrition sensitive interventions within the design of the Project Appraisal Document (PAD) and the Project Implementation Plan (PIP) through a project cycle approach.

b. The PGN is related to the development and design of nutrition actions within the PAD framework to strengthen decentralized governance through Panchayati Raj Institution projects and programs drawing on the experience in incorporating nutrition sensitive interventions within the Bihar Panchayat Strengthening Project. This would have relevance and use for similar and related projects on a wider scale.

c. The PGN is structured in three sections. The first section provides purpose of the PGN; the second section provides background information on the Panchayati Raj Institutions and the key principles to incorporate nutrition in decentralized governance structures. The last section draws on from the Case Study of the Bihar Panchayat Strengthening Project to develop the design of nutrition sensitive interventions using the project cycle approach.

INCORPORATING NUTRITION ACTIONS IN PANCHAYATI RAJ INSTITUTIONS

Brief on the Panchayati Raj Institutions (PRIs):
The PRI is a three tiered system at the state level with elected bodies at the village, block and district level. Panchayats are institutions of self governance vested with powers and functions which varies across the different states. There are Gram Panchayats for a village or a group of villages. These village level democratic structures are set up with the purpose to ensure greater participation of people - women and men and more effective implementation of rural development programs.
Background on Panchayati Raj Institutions in Bihar:

Bihar has had a long history of PRI. However, these have only had legal existence without proper functioning or having funds. In contrast, the PRIs that emerged after the 2006 elections were provided concrete mandate and funds. The role of panchayats were also defined in health and nutrition, water and sanitation, women and child development, education, housing and other areas so that it gave them an opportunity to contribute to local development.

Table Bihar Governance Structure (PRI)

The local gram panchayat members face challenges to execute their responsibilities. These are mainly due to low levels of education, limited and lack of awareness and capacity to implement their responsibilities, poor representation along gender and caste lines and those related to issues of governance, participation and accountability. This holds true for their awareness or lack of it on nutrition, health and sanitation and their understanding of the various dimensions of malnutrition and the important role that they can play to address the nutrition and health challenges at the local level.

To address these challenges, it is important to develop awareness and capacity of local leaders and representatives of the local gram panchayats in nutrition and health so that they are well equipped, positioned and motivated to provide leadership to bring improvements in their community related to nutrition, health and sanitation, especially for women and young children.

Key Principles to Incorporate Nutrition Actions through Decentralized Governance and PRIs
The guiding principles and possible actions that can be kept in mind to incorporate nutrition sensitive interventions into the design and implementation of policies,
projects and investments within the Panchayati Raj Institutions and local governance structures. These can be adapted and used to individual contexts.

- **Incorporate nutrition concerns into the design and implementation of Panchayati Raj Institutions and local governance structures of projects, policies and investments and to measure nutrition outcomes.**

- **Undertake a holistic and bottom up approach to development.** People, both men and women at grassroots level especially the poor and disadvantaged are empowered to participate in local governance structures and take decisions that affect their lives and development including those related to health and nutrition.

- **Build understanding and capacity of local leaders in governance structures about the importance of nutrition.** Through awareness and capacity building approach, develop understanding amongst local leaders in governance structures about undernutrition and their role in promoting nutrition and health of the family (especially women and children) and community.

- **Empower the community to access government resources and programs** of nutrition, health, water and sanitation and other related services.

- **Target the most disadvantaged and vulnerable groups.** In the project, the poorest and most marginalized groups should be targeted. Within that, from a nutrition standpoint, the most nutritionally vulnerable groups would need to be prioritized and reached which is the target group “1000 days window of opportunity” which starts during pregnancy and closes at about 2 years of age and is the most critical period for preventing child undernutrition.

- **Improve nutrition knowledge among rural households and community:** Incorporate awareness and behavior change through communication related to nutrition, health, water and sanitation to improve practices especially related to maternal and child health and nutrition, safe hygiene and sanitation for the families and community.

- **Empower women and invest in them.** Women’s participation and representation in local governance structures needs to be enhanced. Strengthening rural women’s awareness, capacity and role in decision making including how community resources and government programs are used. Given that women play multiple roles within household and community, it will not only benefit them but also their families and community.

- **Promote work across sectors and strengthen decentralized governance and accountability:** Build capacity of local governance structures to facilitate coordination with multiple sectors and stakeholders working in nutrition, health, water and sanitation. This would require multisectoral planning, coordination, and developing capacity, creating shared understanding, commitment and structures for coordination in order to improve nutrition outcomes. Issues around governance and accountability, roles and responsibilities and incentives for coordination will need to be well defined.

- **Develop understanding and capacity on nutrition as a development priority:** Develop capacity of human resources within the project at all levels and to ensure
training, capacity building and mentoring support is provided to PRIs and other multiple stakeholders in relevant sectors.

Case Study of Incorporating Nutrition Actions in the Bihar Panchayat Strengthening Project

Background of the Bihar Panchayat Strengthening Project (BPSP) and Nutrition Actions – Information on this is provided on pages 18 and 19 of the report

Objectives, Focus, Approach and Expected Outcomes of Nutrition Sensitive Interventions within the Bihar Panchayat Strengthening Project: Refer to page 19 and 20

Nutrition Sensitive Interventions:

The focus of the project is on Nutrition, Sanitation and Safe drinking water.

**Nutrition:** The GP leadership will be developed and community action promoted through decentralized governance structures. Community mobilization will be undertaken and households will be supported to adopt appropriate maternal, infant and child health and nutrition practices. Creating awareness and demand for services and to ensure delivery of health and nutrition services and promote convergence of services through interface between demand and supply. A capacity building approach will be adopted and decentralized local structures and mechanisms will be set up to promote nutrition especially for women and children. At the GP level, events like Health melas, Nutrition Health and Sanitation days (with community reps and local service providers working collaboratively) and campaigns will be supported. Monitoring and supportive supervision will be provided to the GP and documentation of key processes will be undertaken.

**Sanitation:** Community led total sanitation campaign will be the entry point intervention to be implemented in a phased manner through community awareness and mobilization to create a need for safe sanitation environment and to stop open defecation. The strategy will be to develop the capacities of GP members and along with them to motivate the community for behavior change. Technical inputs would be provided for toilet construction, facilitating availability of materials and skills and to monitor the sustenance of behavior change. A monitoring system at the GP level will track coverage of toilets and its usage and sustainability linked to the TCS Monitoring Information System (MIS).

**Safe Drinking Water:** A majority of rural households in Bihar rely on private, low cost shallow hand pumps. In most cases, water is highly contaminated due to poor sanitary conditions. The project will provide technical support for improving the
quality of drinking water. Capacity building support and establishing coordination structures and mechanisms with concerned stakeholders will be provided.

**Capacity Building Approach**
There is a strong emphasis on building the capacity of the PRIs at all levels with utmost attention to be given at the GP level. A cascading training model will provide initial and ongoing training and mentoring support to build capacity of GPs, as also other stakeholders at the block and district levels. Development of training modules, manuals, materials and approaches and developing the BCC plan and its roll out would be undertaken.

Given the importance of working in partnership with programs like the ICDS, PHED and RWSP and others, sensitization and capacity support to community organizations, local service providers and officials of these programs will be provided.

**Implementation Arrangements and Coordination with Stakeholders**
Bihar Gram Swaraj Yojna Society (BGSYS) under the Panchayati Raj Department, Government of Bihar is the nodal body for the implementation of the project in six districts. The Society will work in conjunction with other departments including PHED (for water and sanitation) and Social Welfare (ICDS) and development partners such as Water and Sanitation Program (WSP), UNICEF, DfID, and Gates Foundation for the purposes of coordination and collaboration and for technical support to the project. It will work with Support and Training Organizations for providing capacity building support at different levels and to different stakeholders.

**Monitoring and Evaluation**
The outcomes related to the nutrition sensitive interventions are incorporated into the Results Framework and Key Performance Indicators of the project and will be monitored as a part of the ongoing monitoring system by internal and external agencies.

The evaluation will generate evidence of the efficacy of the nutrition sensitive interventions and its impact within the framework of the overall project.

**Key Issues, Opportunities and Challenges**

<table>
<thead>
<tr>
<th>Key Issues Emerging:</th>
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</thead>
<tbody>
<tr>
<td>• It has been experienced that when the engagement and commitment to include nutrition interventions within a Sectoral Project takes place in the initial stages of preparation of the Project Appraisal Document it is easier to incorporate nutrition into the overall project framework rather than in an ongoing project.</td>
</tr>
</tbody>
</table>
- It is important to provide orientation to TTL and the client teams on the importance of nutrition (using tools such as videos and presentations) to develop their understanding and interest as well as for them to see the relevance and added value of the nutrition sensitive interventions from the overall project perspective.

- The suggestions and contributions on nutrition sensitive interventions from the Sectoral Specialists team (Nutrition, Water and Sanitation) who were engaged from the outset and at different stages of the project preparation were taken on board. Their contributions and suggestions were included in the overall project design, implementation arrangements, and capacity building support as well as in monitoring and evaluation of the nutrition outcomes.

- In a new and developing project, it was possible to get coordinated technical inputs from Specialists in Nutrition, Water and Sanitation which would have otherwise not been possible especially in the case of ongoing Projects.

- It is important to be realistic and pragmatic about how much the Sectoral Project can take on of nutrition sensitive interventions keeping in view the expected outcomes and to have selected number of indicators without overwhelming/overloading the project and the team.
Annex 4: Statistics on Bihar

Table on Bihar Statistics

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Bihar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neo-natal mortality rate (NMR) per 1,000 live births</td>
<td>35</td>
</tr>
<tr>
<td>Infant mortality rate (IMR) per 1,000 live births</td>
<td>55</td>
</tr>
<tr>
<td>Under-5 mortality rate per 1,000 live births</td>
<td>77</td>
</tr>
<tr>
<td>Children under 3 years who are underweight (i.e. weight-for-age) (%)</td>
<td>56</td>
</tr>
<tr>
<td>Institutional births (%)</td>
<td>47.7</td>
</tr>
<tr>
<td>Households have access to toilet facility (%)</td>
<td>25.9</td>
</tr>
<tr>
<td>Households used piped or tap drinking water (%)^</td>
<td>4.4</td>
</tr>
<tr>
<td>Total Fertility Rate (TFR)</td>
<td>3.7</td>
</tr>
<tr>
<td>Median Age at first live birth of women aged 15 to 49 years</td>
<td>21.5</td>
</tr>
<tr>
<td>Mothers who received 3 or more antenatal care (%)</td>
<td>34</td>
</tr>
<tr>
<td>Mothers who consumed IFA for 100 days or more (%)</td>
<td>10</td>
</tr>
<tr>
<td>Children with birth weight less than 2.5 kgs (%)</td>
<td>22.4</td>
</tr>
<tr>
<td>Children breastfed within one hour of birth (%)</td>
<td>30.3</td>
</tr>
<tr>
<td>Children (aged 6 to 35 months) exclusively breastfed for at least 6 months</td>
<td>28.5</td>
</tr>
<tr>
<td>Children who received animal or formula milk during first 6 months</td>
<td>61.3</td>
</tr>
<tr>
<td>Total population (million)</td>
<td>104</td>
</tr>
<tr>
<td>Rural population (%)</td>
<td>89</td>
</tr>
</tbody>
</table>

Source: Annual Health Survey 2010-11; #Hungama Survey Report 2010; ^ District Level Household Survey - 3, 2007-08