

Community Managed Nutrition cum Day Care Centers



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Outline of the presentation

- Background
- Innovation
- Processes
 - ✧ Phase1 : Platform establishment to demand entitlements
 - ✧ Phase 2: Focus to bring behaviour change at household level
 - ✧ Phase 3: Community based monitoring and evaluation
- Impacts
- Challenges
- Scale up plan
- Conclusion

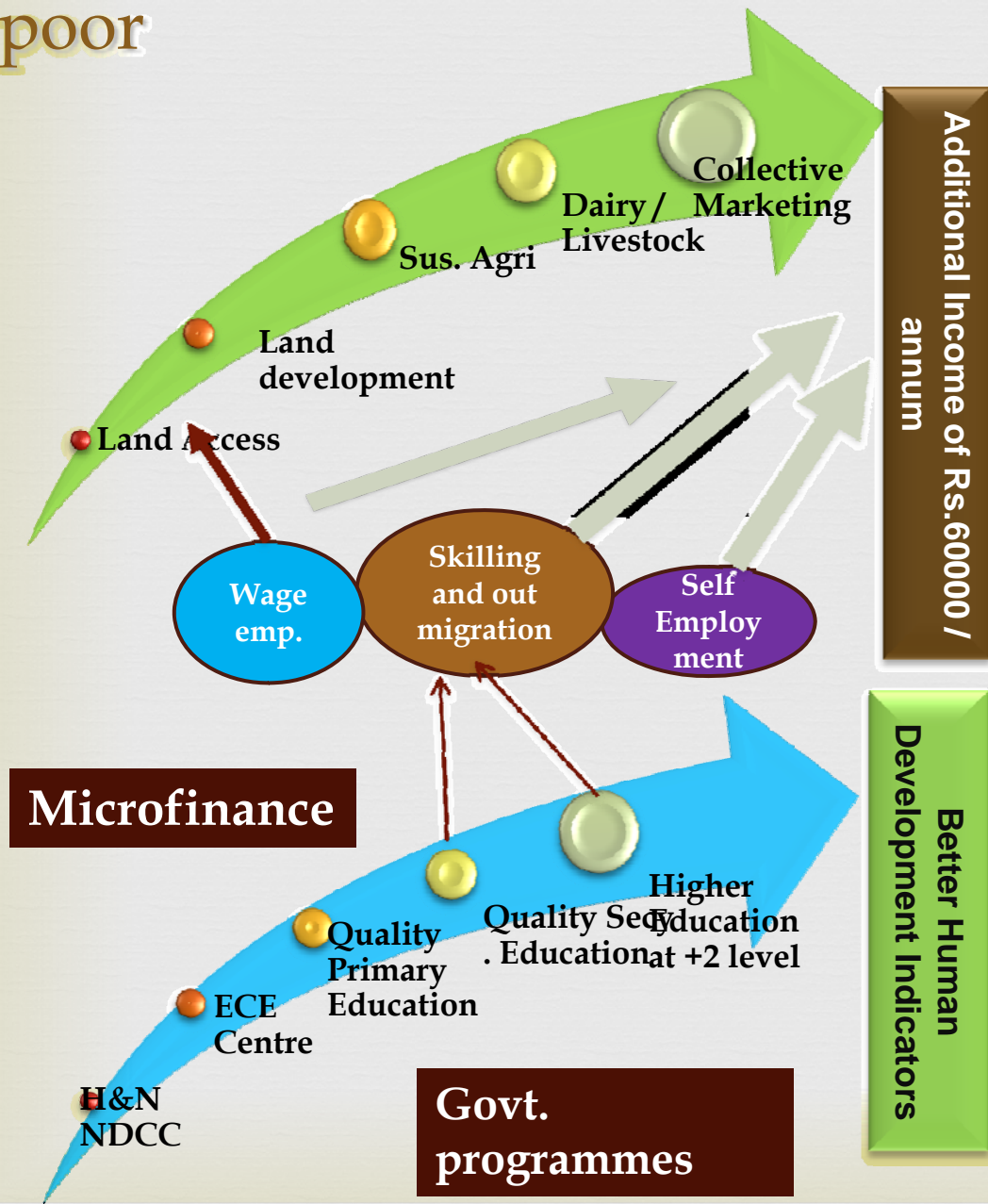
Society for Elimination of Rural Poverty (SERP)



- ❧ Autonomous Society established by Govt of Andhra Pradesh in 2000.
- ❧ Responsible for implementation of AP Poverty reduction project supported by WB & the state Govt.
- ❧ Works with network of Self Help Groups (SHGs) and their federations with women.
- ❧ Works in close coordination with mainstreaming departments



Holistic Development of rural poor



- S.E.R.P
- **Women's organisations :**
plan, and implement
- Village level activists
- **Community best practitioners –**
catalysts, trainers, mentors

Magnitude of the malnutrition

- ❧ 40.4% of children with under weight
- ❧ 37.3% of children are stunted
- ❧ 12.5% of children are wasted
- ❧ 82.7% of children are anemic
- ❧ 37.5% women with BMI < 18.5 Kg/m²
- ❧ 58.2% of women are anemic

Source: NFHS-3

Status of children among poorer sections in India

	Stunted (height-for-age)	Wasted (weight-for-height)	Underweight (weight-for-age)
Scheduled Caste	53.9%	21.0%	47.9%
Scheduled Tribe	53.9%	27.6%	54.5%
Backward Class	48.8%	20.0%	43.2%
Other	40.7%	16.3%	33.7%

Source : NFHS-3

Figures are presented as percent of children who are below 2 standard deviations from the median growth indicator value calculated from the WHO reference population

How far is A.P from MDGs (4 & 5)?

S.No	Name of the state	IMR	MMR	CMR	TFR
1	Andhra Pradesh	49	134	52	1.9
2	Karnataka	49	178	50	2.0
3	Kerala	12	81	14	1.7
4	Tamil Nadu	28	97	33	1.7
5	MDG target set by 2015	28	109	42	2.1

Source : SRS 2007-09

Rationale



- ❧ 56% of the SHG members spent their income on health related issues.
- ❧ Huge net work with Poor health and nutrition indicators
- ❧ No special nutritional care for vulnerable groups
- ❧ Lack of awareness about Govt schemes & low Utilisation
- ❧ Mismatch between the design and implementation of Govt schemes

Community managed health and nutrition interventions to reach MDGs

Universal Interventions (6336 vos) (Common platform to converge for outreach sessions; BCC, support for health emergencies, Anemia reduction)

Fixed
NHDs

Regular
capacity
building of
Stake holders

Health
savings-
HRF-
Sanjeevani

Communit
y Kitchen
Gardens

Intensive Interventions (4200 vos)

Nutrition
cum Day
Care center
(NDCC)

Water and
Sanitation

Health spearhead team strategy

1.
Health
agenda

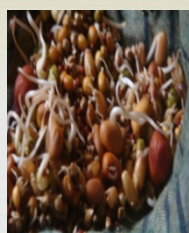
2.
Health
saving
s-HRF

3.
Trainings
at
NDCC/S
HG
members

4.
NDCC

5.
Convergen
ce for
community
health

Key elements of NDCC



Daily use of sprouts



Balanced diet (3 meals)



Daily use of millets



Fixed NH Days



NHED



Growth monitoring



Complementary feeding



Common Interest Group (CIG) activities



Capacity building



Community Garden

The design built in



1. **One-stop-shop** : *Access to nutrition & RCH services*
2. **Ownership** : *Community assisted and supervised feeding centers*
3. **Affordable** : *Member contribution Rs. 10/- per day towards quality diet cost which is less than the home diet*
4. **Sustainable**: *CIGs an opportunity for Pregnant & Lactating mothers to earn an income of > Rs 40-50/day*

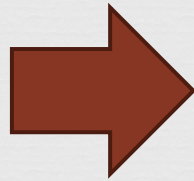
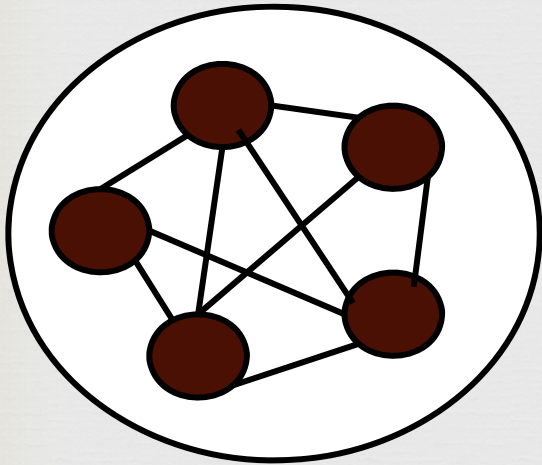
Wight gain – Birth weight

Indicators	NDCC Beneficiaries (N = 234)
Mean weight gain for pregnant women (kg)	9.01 (SD = 0.1557)
Anemia detected during pregnancy (%)	35
Mean Birth Weight (kg)	2.912 (SD = 0.20)
Weight Class (kg)	
2.5 - 2.99	28.7 %
≥ 3.0	56.1 %

- 90% had normal deliveries
- 10% had cesarean section.
- 52% of pregnant women gained 9 -10Kgs weight

Note: study conducted in 8 districts inclusive of mandals in 3 ITDAs.

Revenue generation activities (CIG)



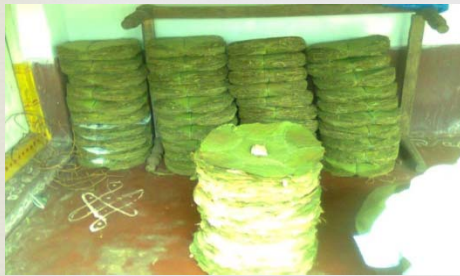
The innovation: Cluster approach



- **Primary CIG: Food basket**
- Collective procurement for cluster of 5-6 VOs
- Profit: Rs. 5000 to 8000 per NDCC per month

Branding exercise: NANYAM

Secondary CIG: Supplementary activities



"It was always my dream.. I had never imagined it would happen so soon. Now my centre is fully sustainable.."

- Satya, CRP, Jogamperta

- Nu
- Ag
- Paper
- Ad
- Curd making
- Garland making
- Cloth business
- Revenue: Rs. 2000- 3000 per month per NDCC

• Feasibility studies conducted by SPJMR & IRMA interns

Revenue from Primary & Secondary CIGs: Rs. 6000- Rs. 10,000 per NDCC per month

Investment for one Village for 5 years: NDCC and AWC



<u>Nutrition cum Day Care Centre</u> (<i><u>one time grant</u></i>)	
	Unit cost (Rs)
Consumption loan corpus for 30 BPL beneficiaries	250,000
Health CRPs resource fee & Health activist incentives	30,000
Non –recurring expenditure	20,000
Total	300,000

<u>Anganwadi Centre</u> (<i><u>Every year</u></i>)	
	Unit cost (Rs)
SNP cost for 80 APL+BPL beneficiaries	360000
Salary component for AWW and AWH	204800
House rent	12000
Total	576000

Note: Additional cost for monthly training at NDCC and induction/ refresher training at AWC

Services provided at NDCC are complementary to AWC and not parallel structures.

S.NO	Particulars	NDCC	AWC
1	Provision of diet	Nutritionally balanced diet	Supplementary nutrition
2	Nutrient supply	2800 Kcals ; 65 gms of protein	500 Kcals ; 15 gms of protein
	Diet cost	Rs 30/day/pregnant Rs 16/day/child	Rs 6/day/pregnant Rs 4/day/child
3	Budget requirement	One time grant (i.e.,Rs 3,00,000/center)	Yearly release (i.e.,Rs 1,69,692/year)
4	Investment	Capacity building	Project mgt
5	Management	Community owned	Functionary driven
6	Nutrition Education	2 members at every SHG to review, educate and encourage to practice at HHs	Weakest components of ICDS
7	Capacity building	Hands on training on regular basis (Fortnightly)	No regular refresher trainings for the functionaries
8	Community based monitoring	Regular social audit to assess the outcomes by external community representatives	Weak accountability to community.

POP pregnant woman diet at Home, AWC and NDCC



S. No	Food group	At home	AWC	NDCC (RDA as per ICMR)
1	Rice & Millets	250	80g	400g
2	Dhal	10g	40g	55g
3	Leafy Vegetables	-	-	150g
4	Other vegetables	50g	-	75g
5	Roots & Tubers	-	-	75g
6	Fruit	-	-	1
7	Egg	-	-	1
8	Jaggary	-	-	20g
9	Oil	10g	10g	30 g
10	Milk		-	250ml
11	Curd	50ml of butter milk	-	50g

Repayment pattern



❧ Diet cost : Rs 30-35/day

❧ Member contribution : Rs 10/day

❧ Income through CIGs : Rs 10/day

❧ Interest thru' internal lending : Rs 5/day

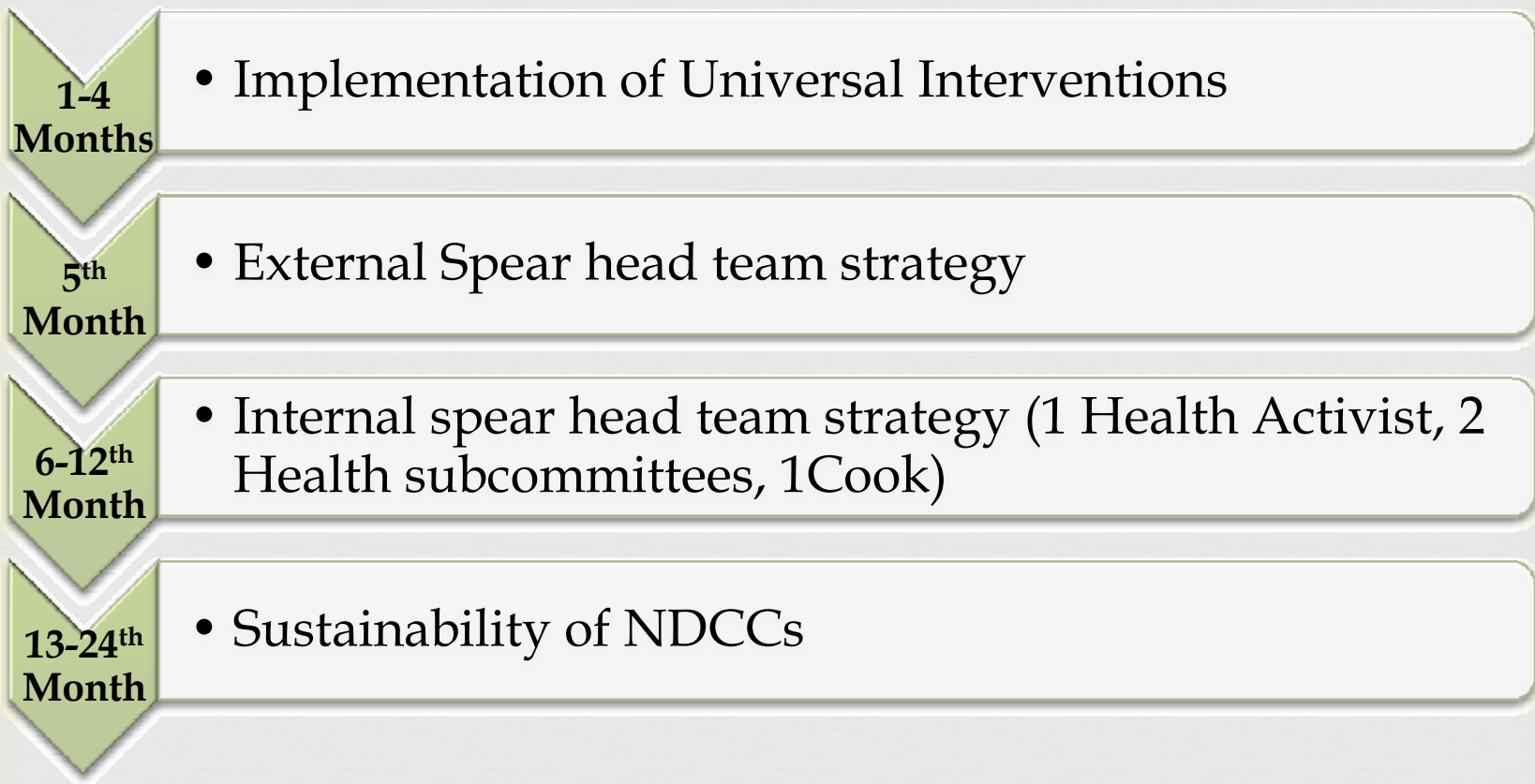
❧ Dovetailing from ICDS : Rs 5/day

❧ VO profits : Rs 5/day

Total : Rs 35/day

❧ For children : Rs 12-15/day

Time line for NDCC establishment

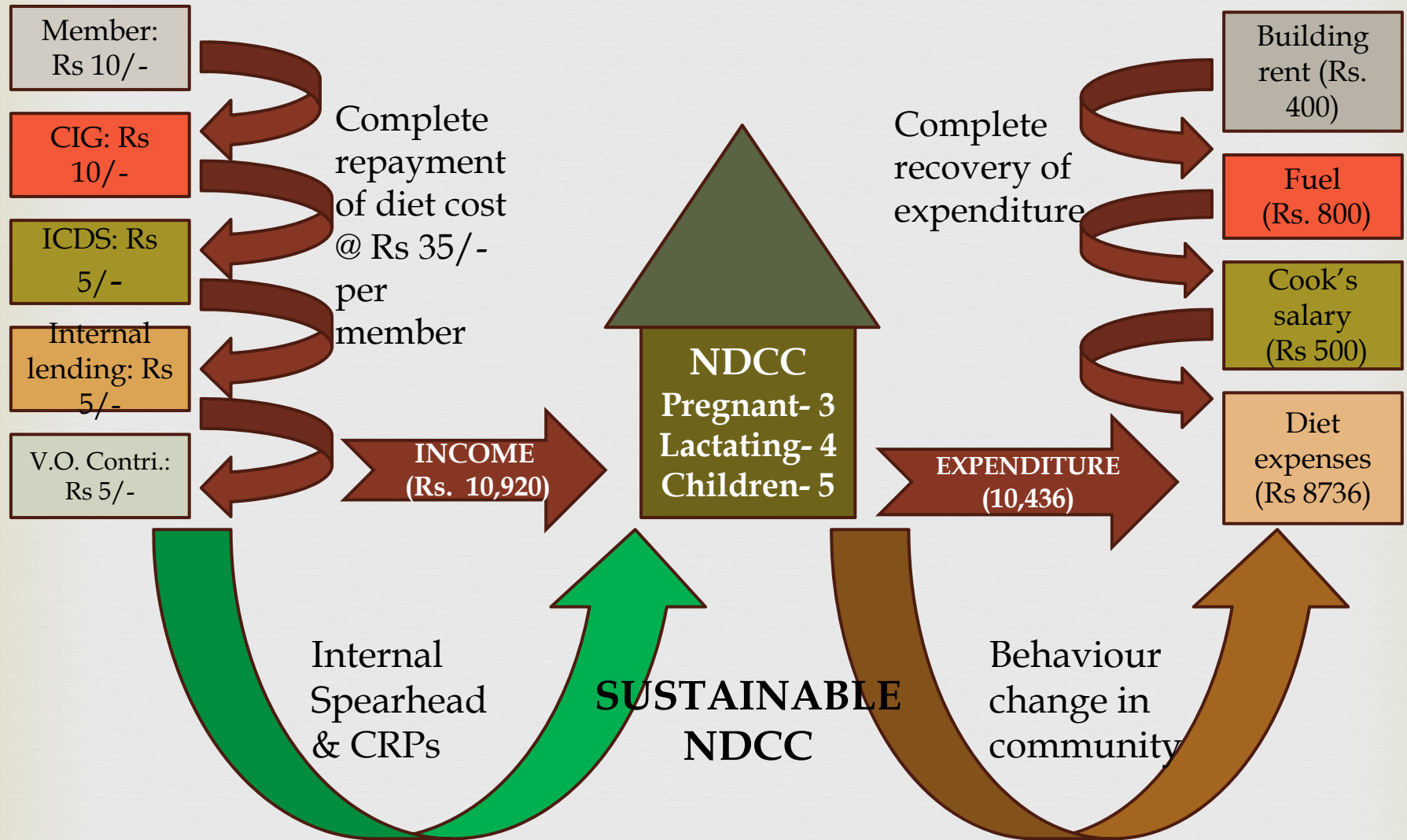


Investment -3 models

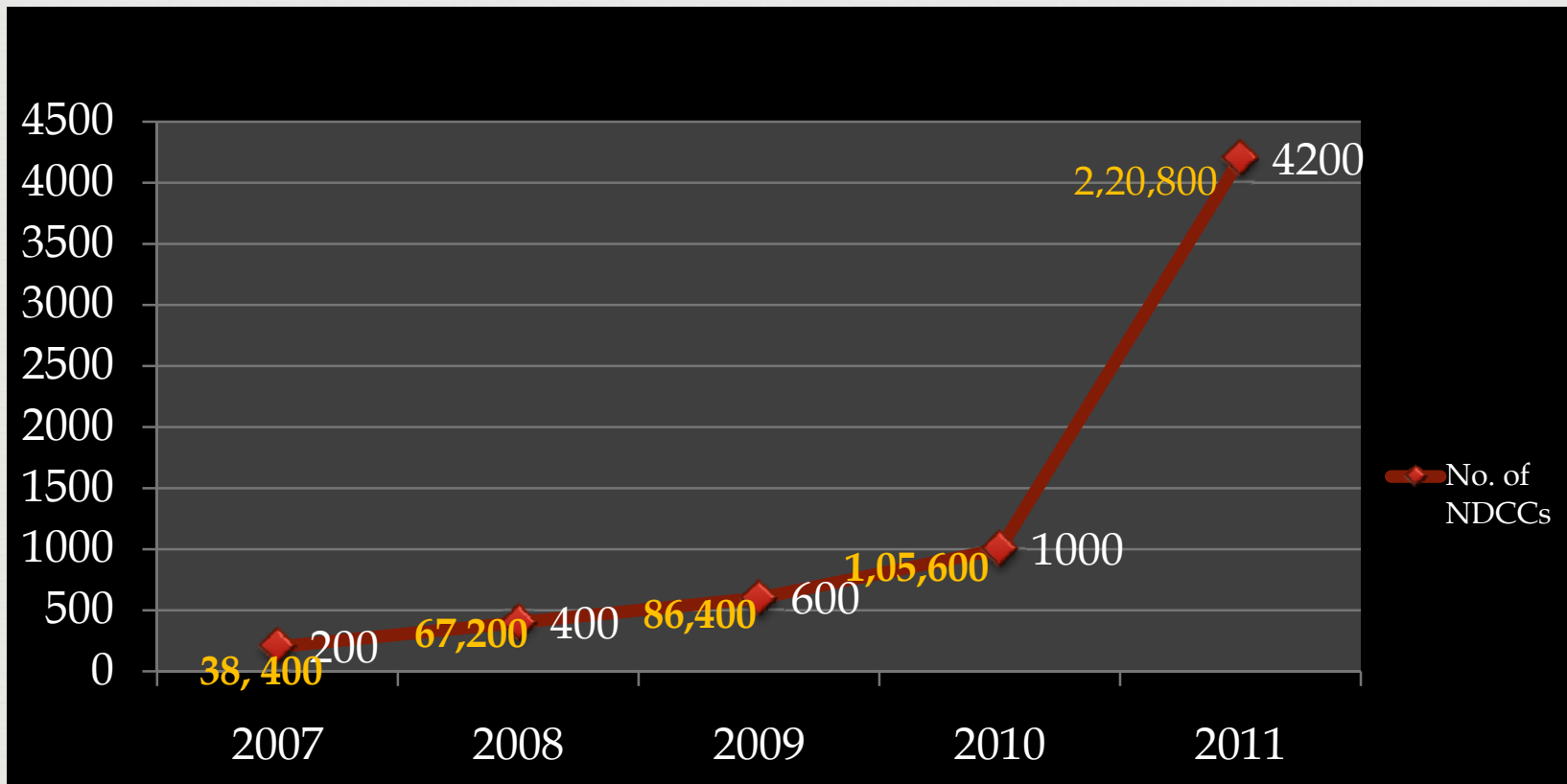


Budget heads	Model 1 (20 beneficiaries) (In Rs)	Model 2 (12 beneficiaries) (In Rs)	Model 3 (5 beneficiaries) (In Rs)
Seed capital	2,50,000	1,75,000	75,000
Equipment cost	20,000	20,000	20,000
CRPs support	30,000	30,000	30,000
Total	3,00,000	2,25,000	125,000

Financial sustainability



Year wise establishment and Coverage of vulnerable groups



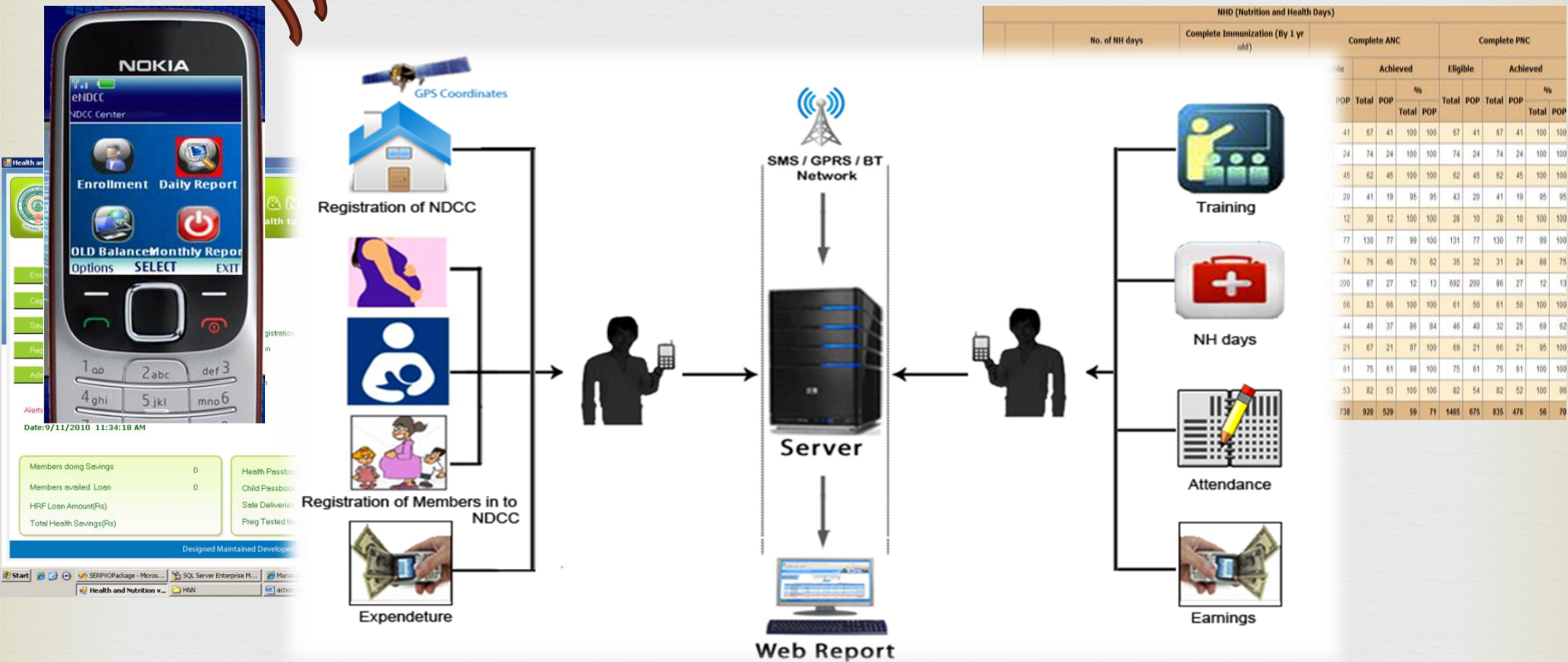
ICT

Bringing technology to health


Mobile Technology

Health Passbook


V O Input sheet




NHD (Nutrition and Health Days)												
		No. of NH days	Complete Immunization (By 1 yr old)		Complete ANC				Complete PNC			
					Achieved		Eligible		Achieved			
POP	Total	POP	Total	POP	Total	POP	Total	POP	Total	POP	Total	
41	67	41	100	100	67	41	67	41	100	100		
24	74	24	100	100	74	24	74	24	100	100		
45	62	45	100	100	62	45	62	45	100	100		
20	41	19	95	95	43	20	41	19	95	95		
12	30	12	100	100	28	10	28	10	100	100		
77	130	77	99	100	131	77	130	77	99	100		
74	76	46	76	62	35	32	31	24	88	75		
200	87	27	12	13	692	200	86	27	12	13		
66	83	66	100	100	61	50	61	50	100	100		
44	48	37	86	84	46	40	32	25	69	62		
21	67	21	97	100	69	21	66	21	95	100		
61	75	61	98	100	75	61	75	61	100	100		
53	82	53	100	100	82	54	82	52	100	96		
738	920	529	59	71	1465	675	835	476	56	70		




Training

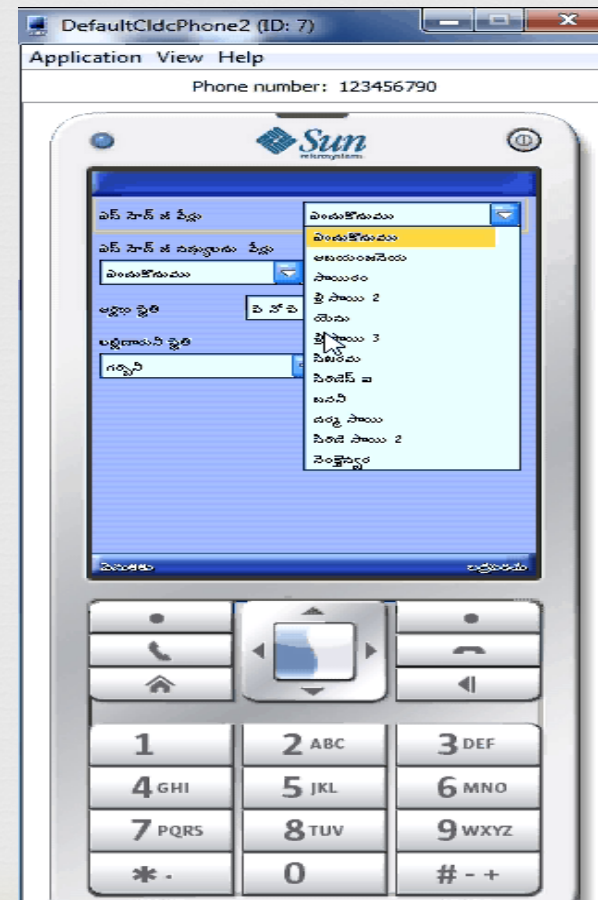


NH days

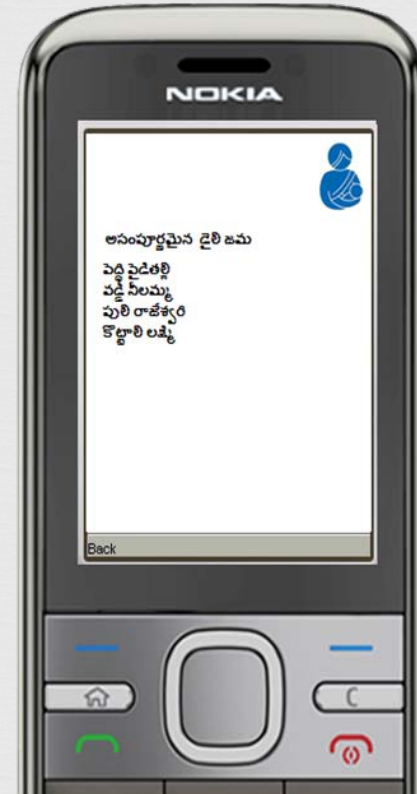
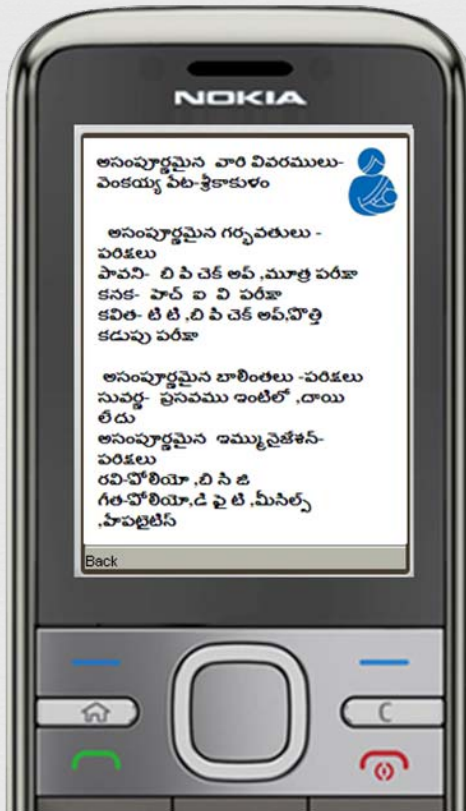




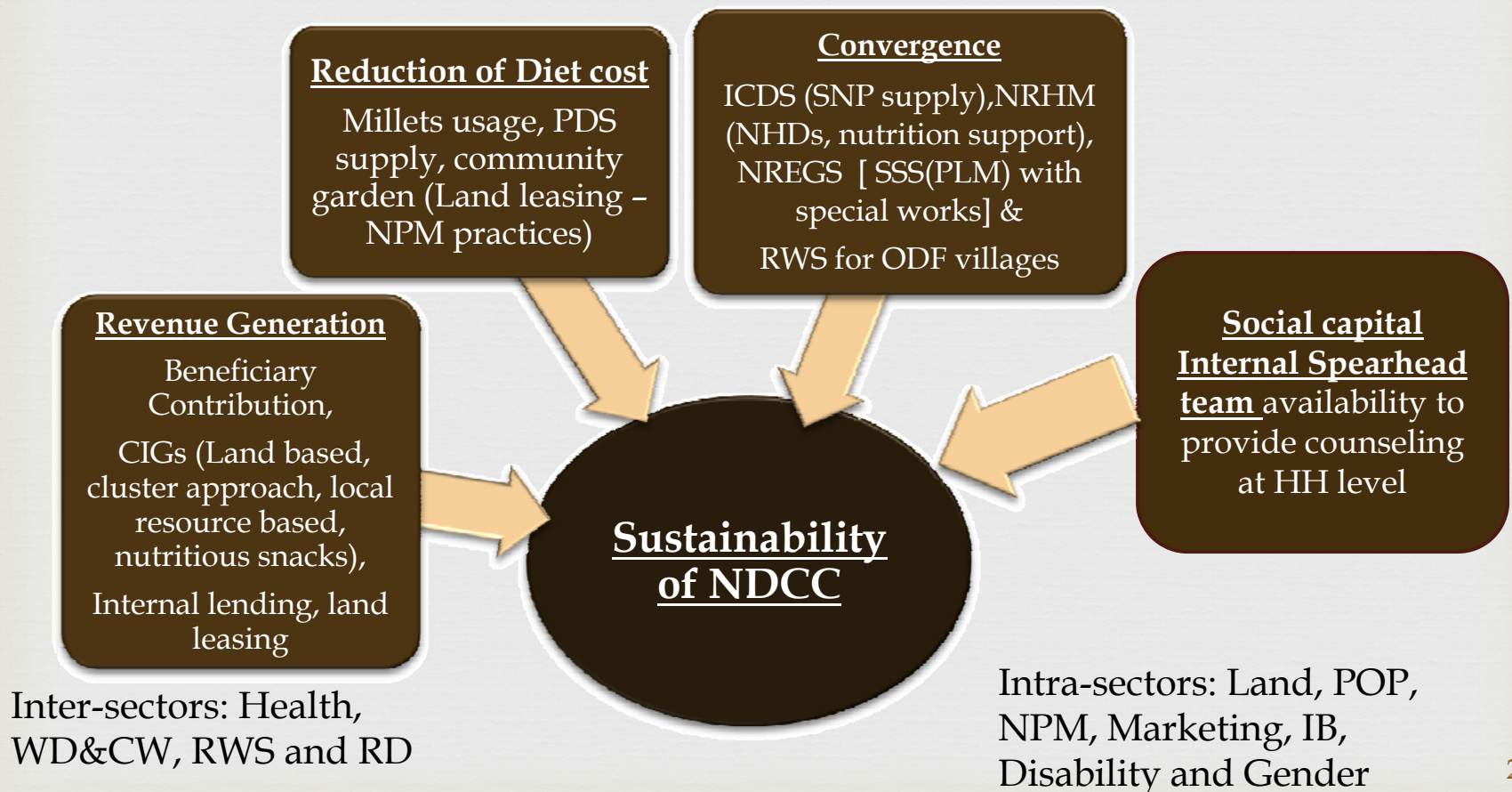
M-NDCC



DSS alerts



NDCC sustainability



Convergence with ICDS, health and rural Development



ICDS

- G.O. Ms No. 55 has been issued for universalization of ICDS with quality by integration of Anganwadi centres, NDCCs and ECEs in backward habitations, Tribal villages, fishermen habitations and SC Localities

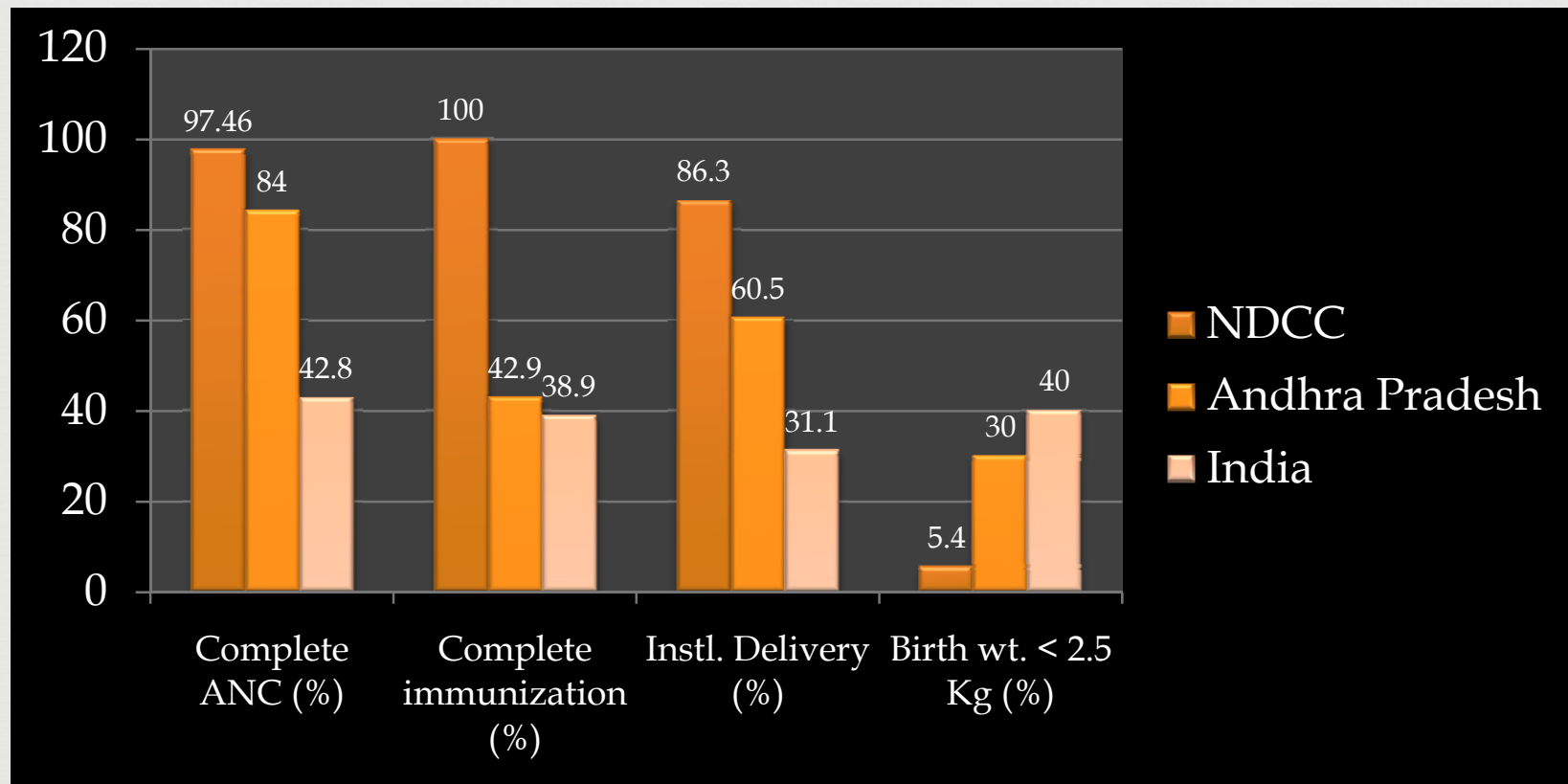
NREGS

- G.O.Ms. No. 4 has been issued for ensuring NDCC sustainability through revenue generation by Land- leasing and development of community kitchen gardens through tie-up with NREGS.

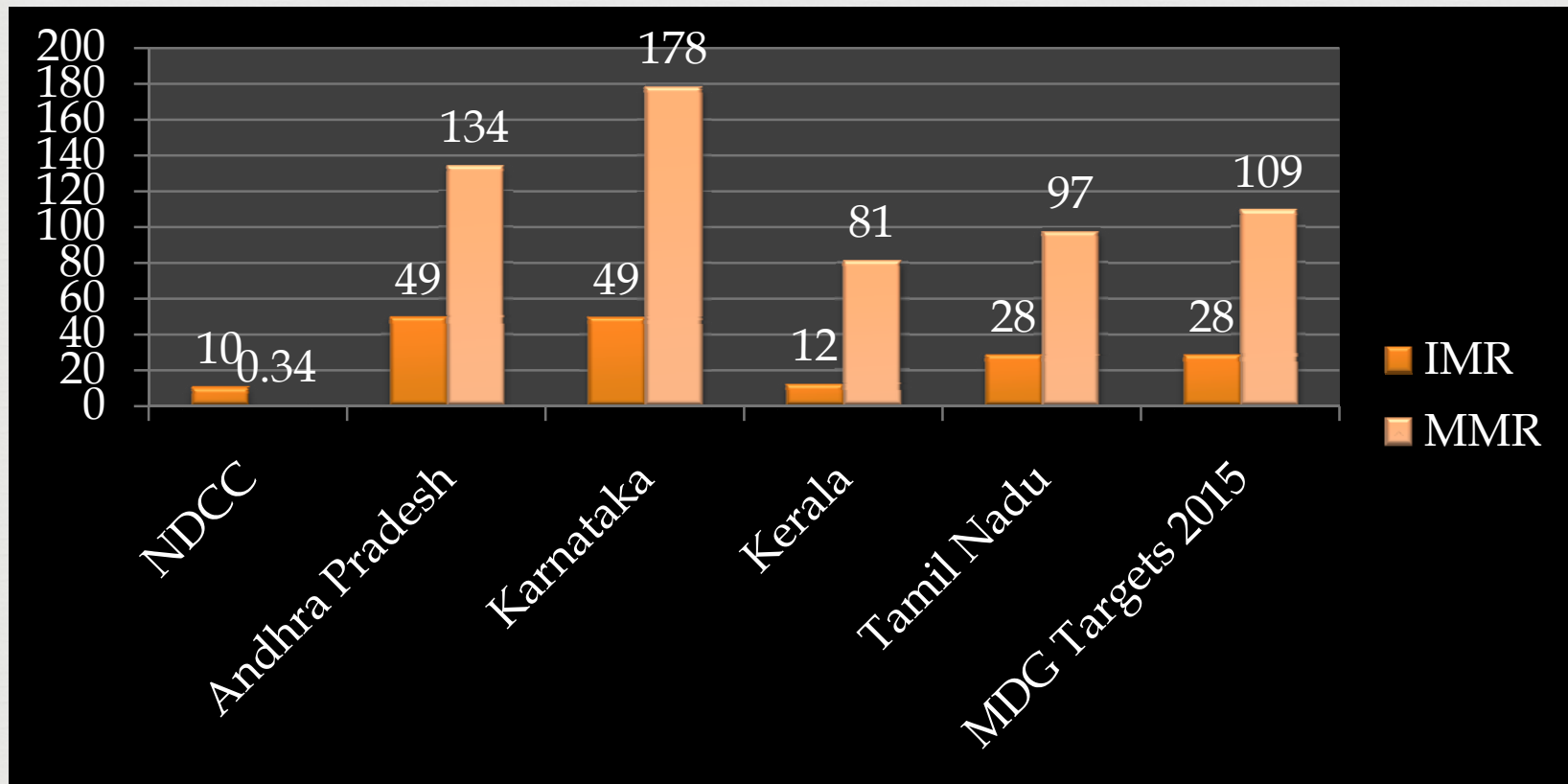
NRHM

- Convergence with NRHM for Fixed NHDs resulting in 100% coverages for immunization, ANC ,PNC and Growth monitoring for children.

Comparison with NFHS 3 (17300 deliveries: 2007- 11)



Reaching the MDGs (17300 deliveries : 2007- 11)



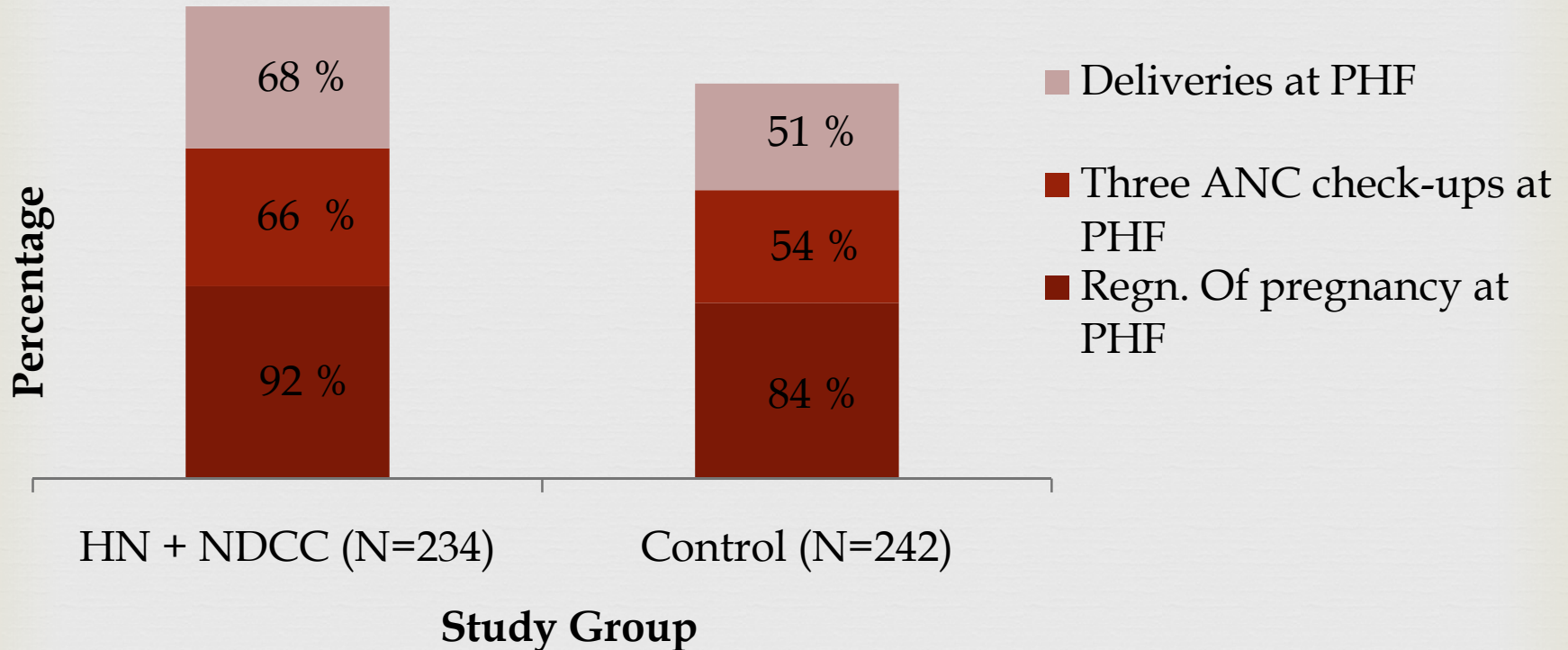
* MMR is measured against 1 lakh deliveries. As our sample is 17,300, MMR shown is as an extrapolation.



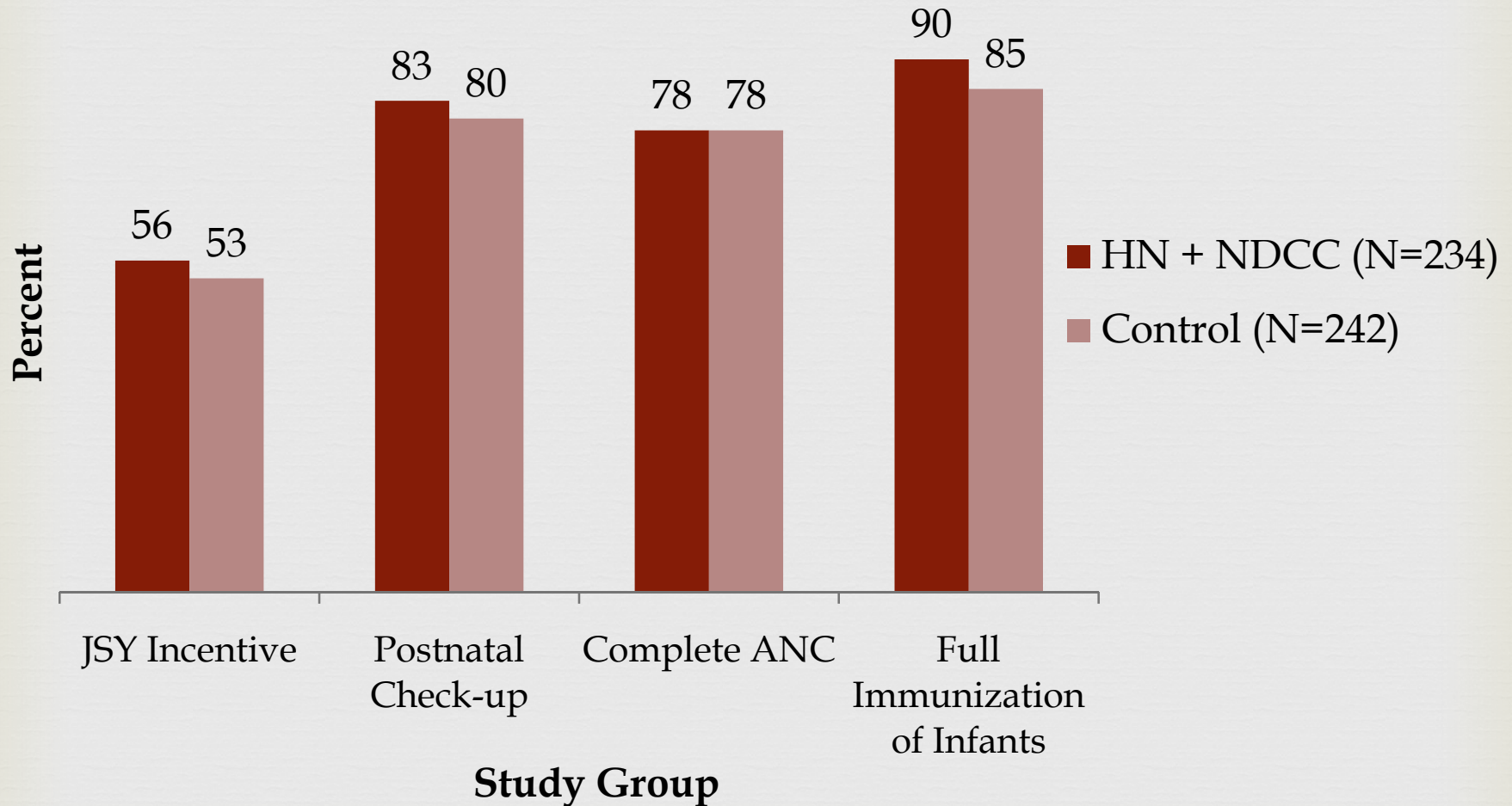
External evaluation study results 2009 and 2011

Phase I: Platform establishment

Utilization of public health facilities



Utilization of 'Provider-Dependent' Services



Wight gain – Birth weight

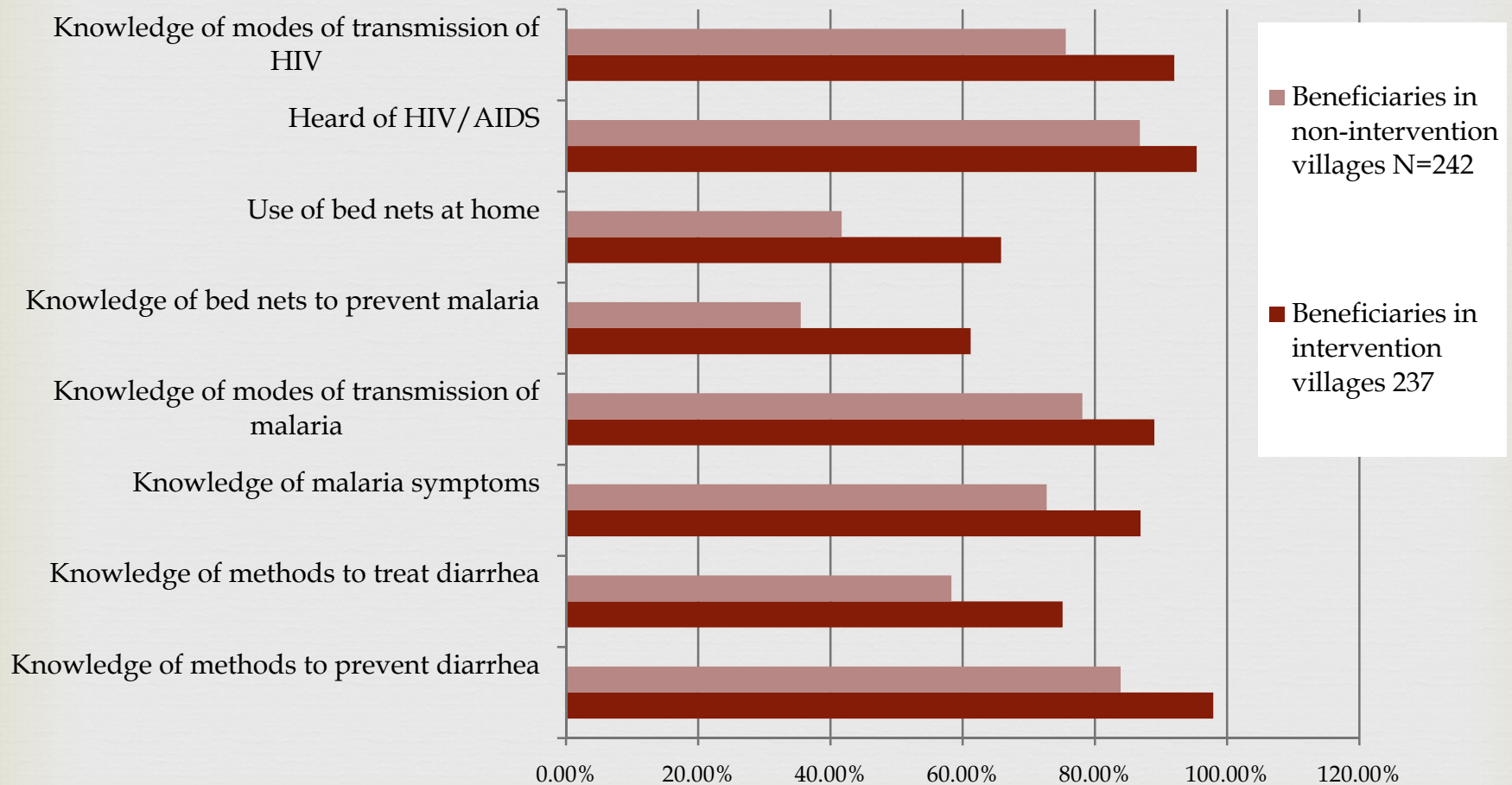
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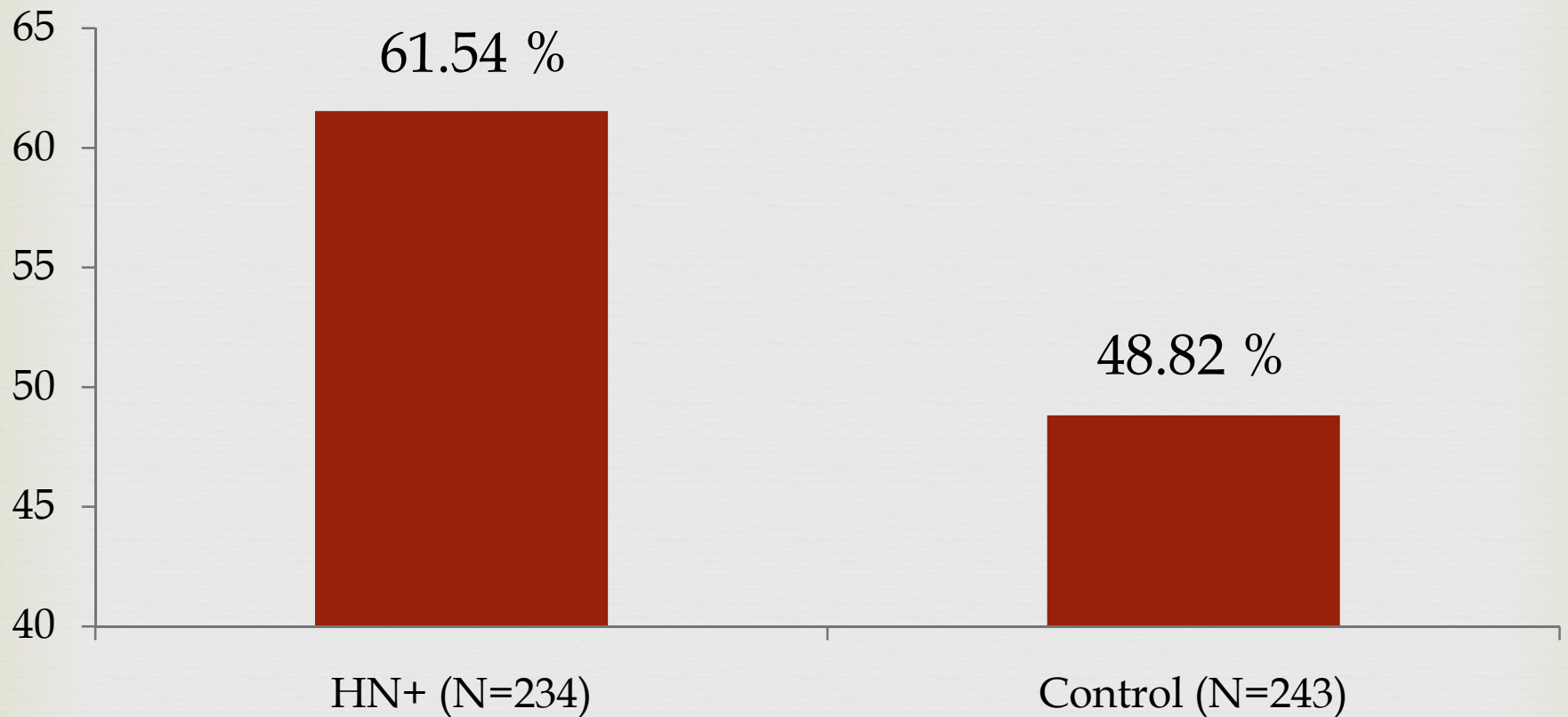
Note: study conducted in 8 districts inclusive of mandals in 3 ITDAs.

Phase II: Health Seeking Behavior Change

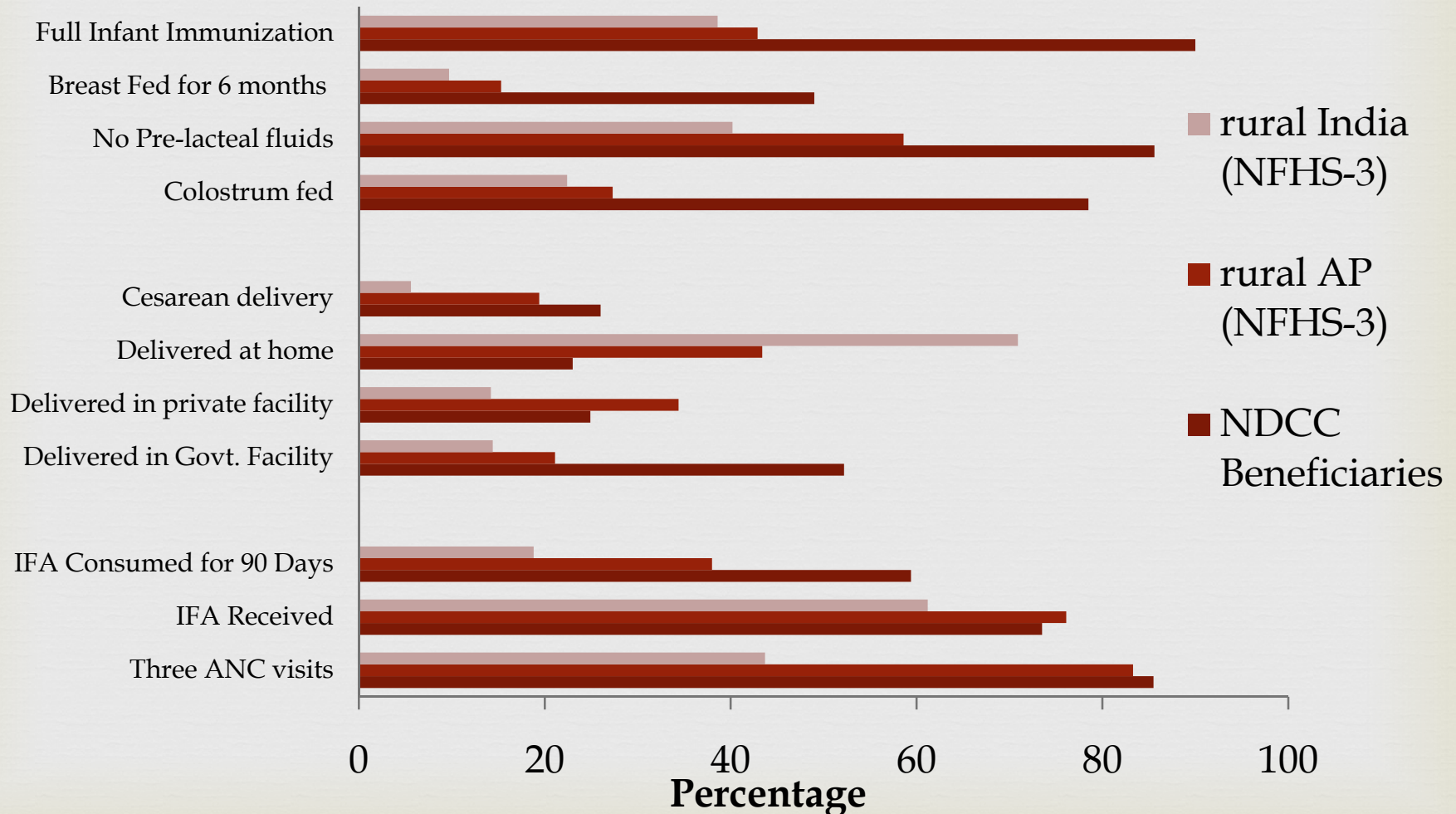
Health Literacy Levels in Mothers



Mean Awareness Score (on Communicable Diseases) between Women in Two Groups (Maximum = 100)



Maternal Health Behaviour Outcomes



Innovation for nutrition





**2009 GRANT
COMPETITION**
SOUTH ASIA
INNOVATE FOR NUTRITION

Together Turning Ideas Into Action



INNOVATE FOR NUTRITION
AUGUST 4-6, 2009
DHAKA, BANGLADESH

WINNER CERTIFICATE

Society for Elimination of Rural Poverty (SERP)

Finalist Organization

"Community-driven" Nutrition Behavior Change Campaign for improved infant and pregnant feeding practices in tribal communities of Andhra Pradesh through "community-managed" Nutrition cum Day Care Centers

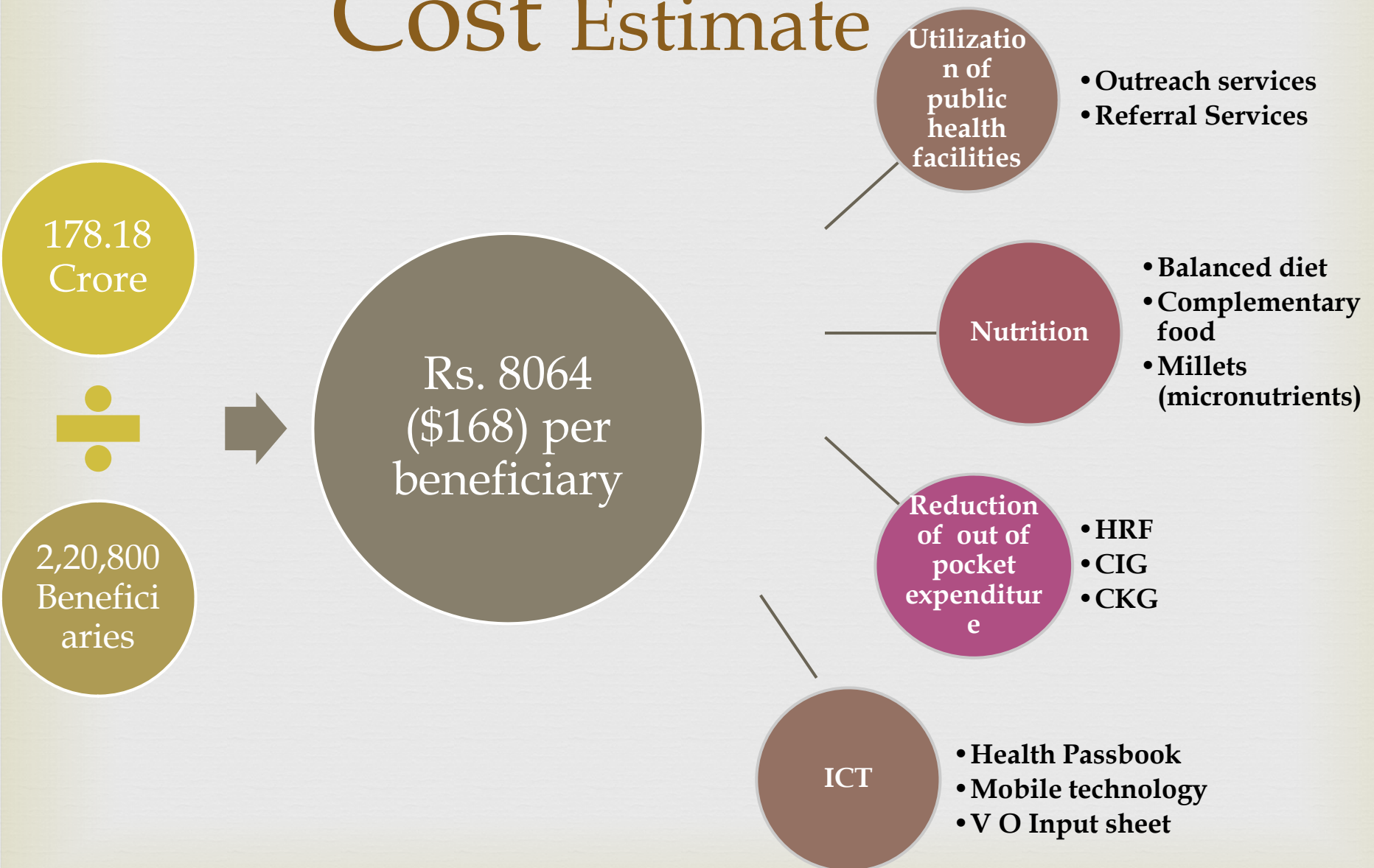
Proposal


Isabel M. Guerrero
Vice President South Asia Region

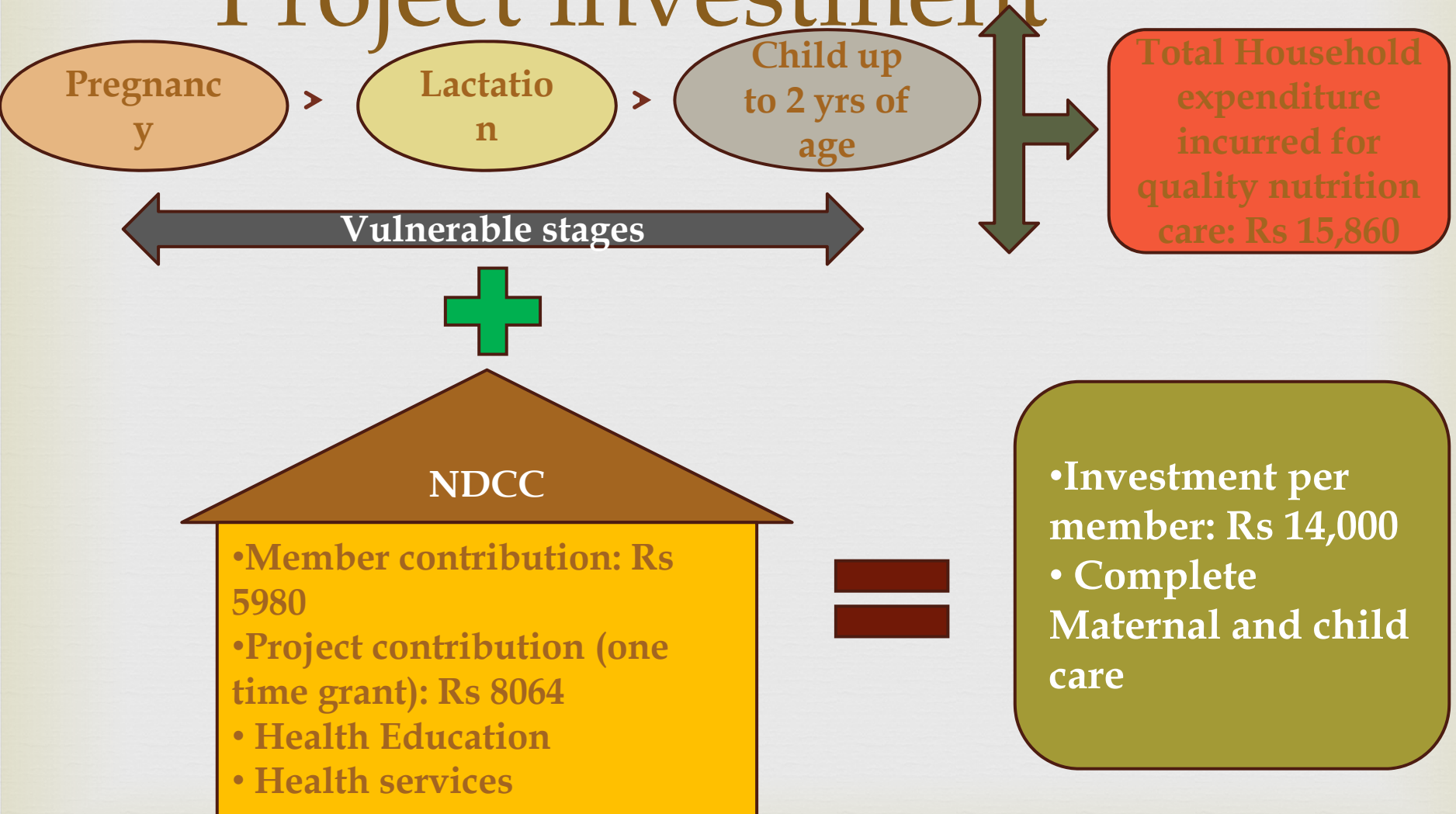


THE WORLD BANK gain COOPERATION gtz Micronutrient Initiative PEPSICO unicef WFP

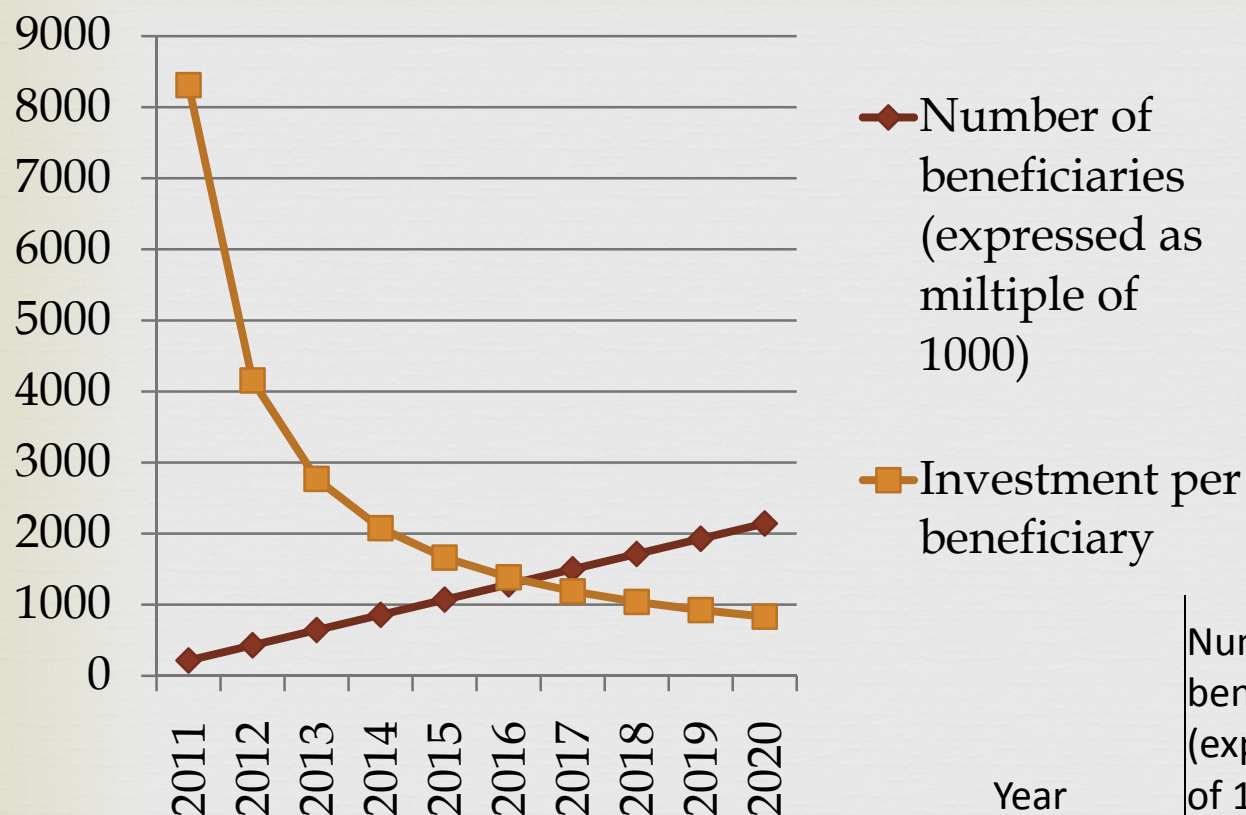
Cost Estimate



Household investment v/s Project investment



Amortization of Investment over next 10 years

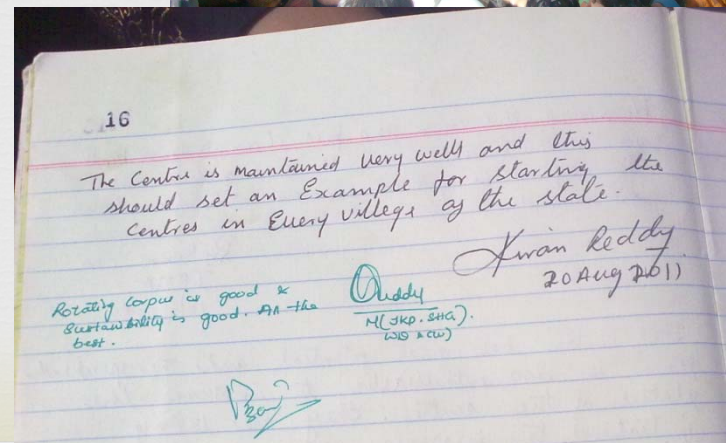


Year	Number of beneficiaries (expressed as multiple of 1000)	Investment per beneficiary
2011	214.2	8309.991
2012	428.4	4154.995
2013	642.6	2769.997
2014	856.8	2077.498
2015	1071	1661.998
2016	1285.2	1384.998
2017	1499.4	1187.142
2018	1713.6	1038.749
2019	1927.8	923.3323
2020	2142	831

Policy influence

C M Announcements
August 20th 2011, Jogampeta, Vishakapatnam

- Rs 5 lakh grant to all NDCCs for building construction
- Rs. 1 lakh as HRF to all SHGs with regular Health Savings
- Expansion from 4200 to 36,000 villages across Andhra Pradesh.



The ecosystem established



- ❧ Institutional architecture to have regular discussions on nutrition and health at SHGs
- ❧ Door step delivery of nutrition and health services
- ❧ Entrepreneur model of delivery
- ❧ Technical inputs through community nutritionist
- ❧ Best practitioners as counselors to influence household behaviors.
- ❧ Community gardens to influence dietary diversification at HH level too.
- ❧ Community based monitoring on nutritional outcomes

Challenges



- ❧ More investment of time in capacitating institutions- Discussions at SHGs and development of sustainable CIGs at NDCCs
- ❧ Long time to appreciate the power of the demand side approaches by the line depts for replication.
- ❧ Lack of baseline data for comparison.

Way forward



- ❧ Reaching 15000 tribal, SC and ST habitations with intensive interventions by 2015
- ❧ Reaching 38000 with universal interventions by 2015
- ❧ External evaluation to measure the outcomes from time to time and make midcourse action
- ❧ Establishment of resource centers to train the social capital for replication

Conclusion



- ❧ Model needs a network/platform for **replication**
- ❧ **For scale up: Constant nurturing** of the network members to plan, implement and monitor the interventions.
- ❧ The whole model can **not be done in one go**. It has phases
 - ❧ *Establishment of platform (1st & 2nd yrs)*
 - ❧ *Focus to bring change in household behaviours (3rd to 4th yrs)*
 - ❧ *Community based monitoring and audit (5th -6th yrs)*
- ❧ Needs to establish **partnership** between the CBOs and line depts.
- ❧ Development of **internal facilitators** from the network for scale up and sustainability.
- ❧ External evaluations to make modifications/ midcourse actions for replication/ scale up.

Conclusion



- ❧ Sustainable
- ❧ Community managed
- ❧ Scalable where SHG network/platform is available

For more details of the innovation



1). <http://go.worldbank.org/305MTTK2Q0>

2). www.serp.ap.gov.in