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Impact Assessment- Ensuring a healthy new life and childhood through 1000 days approach
Action Against Hunger FY 2020-21

SBI Life Insurance Company Limited

June 2023

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List of Abbreviations/Acronyms

AAH	Action Against Hunger	**MAM**	Moderate Acute Malnutrition
AM	Acute Malnutrition	**MCH**	Maternal and Child Health
ANC	Ante Natal Care	**MCHN**	Maternal Child Health and Nutrition
ANM	Auxiliary Nurse Midwifery	**MCPC**	Mother and Child Protection Card
ASHA	Accredited Social Health Activist	**MTC**	Malnutrition Treatment Centre
AWC	Anganwadi Centre	**MUAC**	Mid Upper Arm Circumference
AWW	Anganwadi Worker	**NGO**	Non-Governmental Organization
CAB	Covid-Appropriate Behaviour	**NRC**	Nutrition Rehabilitation Centre
CBE	Community Based Events	**OECD**	Organization for Economic Cooperation and Development
CM	Community Mobilizer	**PMMVY**	Pradhan Mantri Matru Vandana Yojana
C-MAM	Community-based management of Moderate Acute Malnutrition	**PMSMA**	Pradhan Mantri Surakshit Matritv Abhiyan
EBF	Exclusive Breastfeeding	**PNC**	Post Natal Care
FGD	Focused Group Discussion	**PPFP**	Post-partum Family Planning
FLW	Frontline Worker	**PRI**	Panchayati Raj Institution
F-SAM	Facility-based management of Severe Acute Malnutrition	**PW**	Pregnant Women
ICDS	Integrated Child Development Services	**RDA**	Recommended Dietary Allowance
IFA	Iron Folic Acid	**RMNCH+A**	Reproductive, Maternal, Newborn Child plus Adolescent Health
IP	Implementing Partner	**RMNCHA+N**	Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition
IYCF	Infant and Young Child Feeding	**SAM**	Severe Acute Malnutrition
JSSK	Janani Shishu Suraksha Karyakram	**SBCC**	Social and Behaviour Change Communication
JSY	Janani Suraksha Yojana	**THR**	Take Home Ration
KII	Key Informant Interview	**TT**	Tetanus Toxoid
KMC	Kangaroo Mother Care	**VHND**	Village Health and Nutrition Day
KPI	Key Performance Indicator	**VHSNC**	Village Health Sanitation & Nutrition Committee
LW	Lactating Women	**WASH**	Water Sanitation and Hygiene
M&E	Monitoring and Evaluation	**WCD**	Women and Child Department

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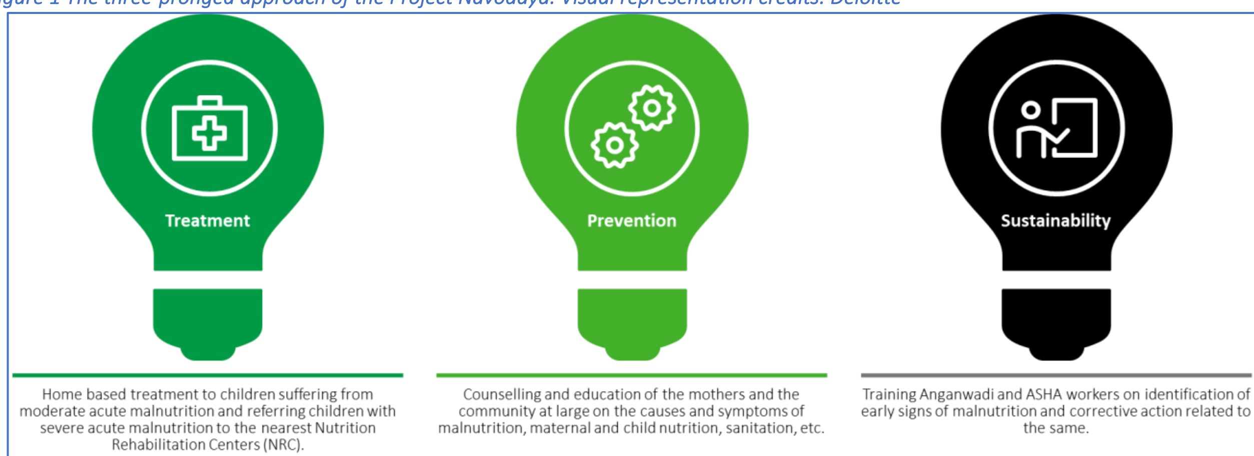
Impact Assessment- Ensuring a healthy new life and childhood through 1000 days approach

SBI Life Insurance ('SBI Life')[1], was incorporated in October 2000 and registered with the Insurance Regulatory and Development Authority of India (IRDAI) in March 2001. In the FY 21, SBI Life has made overall CSR contributions of INR 26.25 Cr largely towards areas of child education, healthcare, disaster relief and environmental projects. In 2021-22, the Company touched over 2 lakh direct beneficiaries through various CSR interventions.

In compliance with the robust governance protocols that govern the decision making and management of CSR portfolio at SBI Life, Deloitte was tasked with conducting the annual Impact Assessment of Project Navodaya/Ayushmaan Bhava[2] (hereafter referred to as Project Navodaya) which aims at addressing community-based malnutrition in the high burden of Baran (Rajasthan) and Dhar (Madhya Pradesh), implemented by Action Against Hunger. The project is funded from CSR grants for the financial year 2020-21 and has an overall reported outlay of INR 20,352,444.00.

The project focusses on the detection, treatment, and in training mothers in the prevention of malnutrition, and follows a 3-pronged approach[3] to address malnutrition challenges.

Figure 1 The three-pronged approach of the Project Navodaya. Visual representation credits: Deloitte



Approach and methodology:

Deloitte used a mix of qualitative and quantitative methods to conduct the impact assessment. A stratified sampling approach was used for identification of the Anganwadi centres for data collection. Additionally, the beneficiary selection for the study was based on purposive approach. The stratified sampling approach[4] accounted for the overall performance classification of the AWCs (High, medium, and low performance)[5]. This was followed by a randomisation among each performance group to arrive at Anganwadis that were selected for the data collection.

[1] **Source:** Web page excerpt- https://www.sbilife.co.in/en/about-us (accessed 22nd December 2022)

[2] Project Navodaya/Ayushman Bhava refer to the Action Against Hunger's malnutrition project at Baran, RJ and Dhar, MP respectively. Later, the projects were both renamed as Project Navodaya and hence referred similarly within the report.

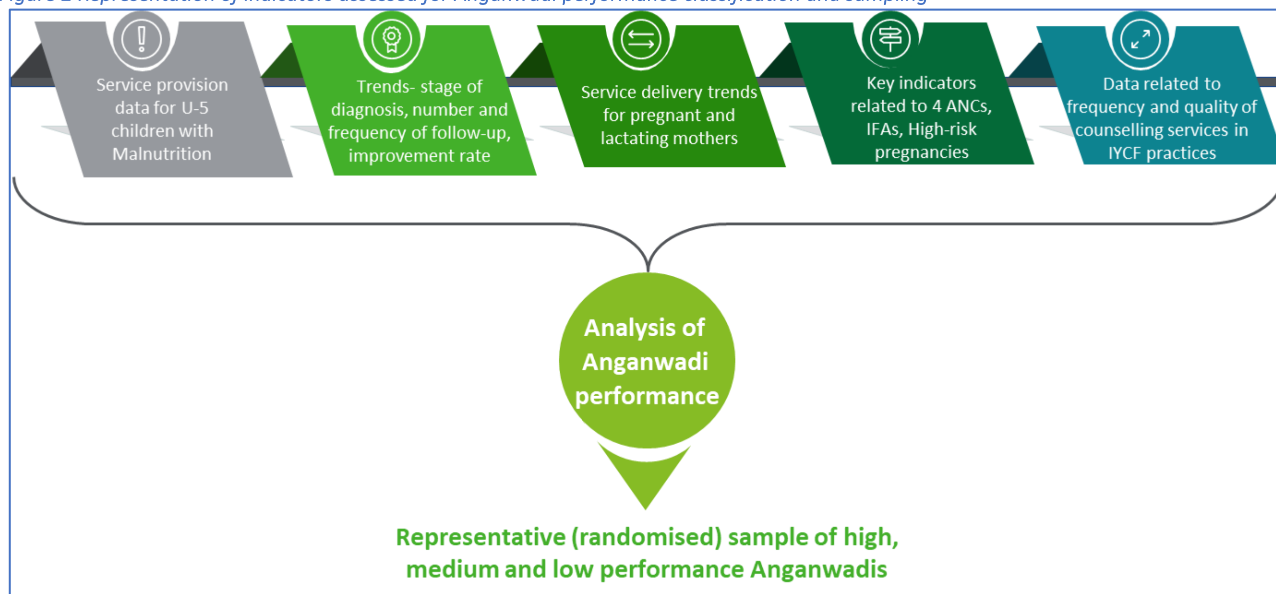
[3] **Source:** Project proposal- "Ensuring a healthy new life and childhood through 1000 days approach" submitted by Action Against Hunger India (registered as Fight Hunger Foundation) to SBI Life CSR committee.

[4] **Further reading:** https://onlinelibrary.wiley.com/doi/abs/10.1002/9781118445112.stat05999.pub2

[5] Detailed methodology of performance classification of Anganwadis is described in chapter 2 on page 15 of the report.

The key parameters on which the performance of the Anganwadis was based on parameters as depicted in the figure 2 below[6].

Figure 2 Representation of indicators assessed for Anganwadi performance classification and sampling



The stratified sampling approach which was based on Anganwadi performance helped capture relevant field insights while also capturing findings from a wider geographical spread of AWCs. The overall number of Anganwadi centres whose data was accessed for this exercise is provided below.

Table a: Number of AWCs for which beneficiary-wise line list was shared by Action Against Hunger

Indicator	Baran	Dhar
Number of AWCs where SAM children were screened (as per last acute malnutrition status)	173	170
Number of AWCs where MAM children were screened (as per last acute malnutrition status)	258	156

Out of the above AWCs, Deloitte identified 41 AWCs (25 Baran, 16 Dhar) considering the data pertaining to the last acute malnutrition (AM) status of the line listed children. These AWCs selected were a mix of good, average and low performing AWCs based on the indicators described in the approach and methodology chapter of the report.

Thus, a final set of **28 AWCs in total (17 Baran, 11 Dhar)** were selected consisting of a mix of good performing and average performing AWCs. While the impact study was planned to be conducted in **25 AWCs (15 Baran, 10 Dhar),** three AWCs were kept as buffer against circumstances which make field work to the locations unfeasible. The field itinerary was finalized in discussion with the IP staff, considering the travel time, availability of front-line workers, beneficiaries and other stakeholders, and overall resources involved in undertaking the field work[7].

Extensive field-based interactions were conducted at the project location at Gandhwani block, Dhar, MP and Kishanganj and Shahabad blocks, Baran, Rajasthan. The final list of 28 AWCs selected for data collection is provided as **Annexure C**.
The following were the enquiry areas for the impact assessment exercise:

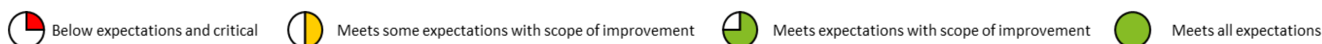
[6] The details of sampling method and the criteria for anganwadi classification are provided in the Approach and methodology chapter (Chapter 2) on Page 15 of the report.
[7] One of the AWCs in Dhar, MP (Schoolpura-10) was de-selected based on IP's suggestion considering it to be a high-risk (of violence) area.

- Are the CSR initiatives either relevant to the community's needs/aspirations or aligned with the developmental priorities of the region?
- What were the intended or planned outcomes of the initiatives? Are the program's results in line with the anticipated outcomes?
- Did the evolving pandemic cause any disruptions to the initial program design, and what were the changes to the overall design to avoid potential program disruption?
- How have the CSR initiatives impacted beneficiaries and other relevant stakeholders? Explore changes in the physical, economic, and socio-cultural environments.
- How do the beneficiaries and other stakeholders perceive the CSR initiatives undertaken?
- Are the activities ensuring long term solutions to the developmental issues of the region? What elements have been built into the project design that will ensure sustainability of results.
- Ascertain any other challenges in implementation of the activities that is impeding optimal results.

The data for the impact assessment was collected by using customized data collection tools through document review, and key stakeholder and sample beneficiary interactions. The primary data was collected through physical site visits during the period of October 2022 to November 2022. The data collection was followed by a phase of analysis and documentation of observations and findings. The details of the approach and methodology followed for the Impact assessment is presented in Chapter 2 of the report.

Summary of findings:

The current report presents a detailed documentation of Deloitte's observations and findings of the impact assessment of **SBI Life's project** that was implemented by **Action Against Hunger**. A summary of the findings is presented in the table below, while the elaborate findings are available in Chapters 4 and 5. Please refer Annexure A for a detailed assessment methodology adopted to define the indicators mentioned in the table below.



SBI Life project	Investment and Project Overview	Outreach
Project Navodaya (Action Against Hunger) • Locations: 380 AWC in Dhar, MP and 391 AWC in Baran, Rajasthan reaching 3,21,939 direct and indirect beneficiaries.	▪ INR 20,352,444.00 grant ▪ Capacity building of Anganwadi workers (AWWs), Accredited Social Health Activists (ASHAs), Auxiliary Nurse and Midwife (ANM) and other Frontline workers (FLWs) on health, nutrition, ante-natal care, and post-natal care through regular quarterly trainings and need based refresher trainings. ▪ Sensitizing and counselling beneficiaries that include Pregnant women (PW), Lactating Women (LW), caretakers of below 2 years children to uptake health- based services with Government health based front-line workers.	▪ Direct beneficiaries: Pregnant women, lactating mothers, caregivers, and children under 2 years of age, FLWs providing services to the community (AWW, ASHA, ANM) ▪ Indirect beneficiaries: families of direct beneficiaries, community members reached through mass media or covid awareness campaigns

Relevance/need for project:	• At each stage during the 1,000-day window, the developing brain is vulnerable to poor nutrition due to absence of key nutrients and/or through the "toxic stress" experienced by a young child whose family has experienced prolonged or acute adversity caused by food

insecurity[8]. First 1000 days movement provided systematic evidence of the problem of early-life undernutrition and its largely irreversible long-term effects, as well as the availability of high-impact and feasible interventions.[9]

- Gender discrimination and reduced reproductive autonomy for women leads to multi-parity which plays an important role in poorer child rearing practices, neglect and undernutrition[10]. This leads to higher rates of infant and childhood disease and malnutrition, and disproportionately affects female infants and children. High parity also leads to increased risk of adverse pregnancy outcomes for mothers and infants[11]. Mother's education and wealth status reduce son preference as well as stunting among both boy and girl children[12]. Hence, high relevance to improve the health and nutrition status of pregnant women, lactating mothers, and new-borns in post-natal period[13].
- Undertrained frontline workers and difficult topography makes the basic health care accessibility beyond reach[14].
- Less productive landholding and seasonal migration leaves the PW, LW and young children highly susceptible to health-based vulnerabilities owing to lack of antenatal and postnatal care.
- Thus, programmes such as 1000 days are critical to address such socio-economic barriers and focus on the overall wellbeing of the mothers and children.

Uptake and usage:

- The frontline health workers including AWWs, ASHAs, ANMs, ICDS and ASHA Supervisors had taken on an average about 6-7 quarterly handholding touchpoints. This led to technical upskilling in provision of extended reproductive and health care-based services with focus on nutrition and IYCF practices.
- Overall, the programme reached 763 Anganwadi workers and 453 ASHAs in 771 AWCs. The AAH staff engaged in training of FLWs on an adhoc basis while on field as a part of the implementation.
- The programme has reached 15,086 children up to the age of 24 months, and 2,365 malnourished children. Additionally, the outreach to pregnant and lactating mothers is reported to be 20,354. 11,251 caregivers have been reached through the programme.
- Overall, the programme reports a direct beneficiary outreach of 54,679 and indirect beneficiary outreach of 2,67,260.

[8] Source: Nutrition in the first 1000 days- a foundation for brain development and learning https://thousanddays.org/wp-content/uploads/1000Days-Nutrition_Brief_Brain-Think_Babies_FINAL.pdf
[9] Source: K. Bezanson, "Scaling Up Nutrition: A framework for action," *Food and Nutrition Bulletin* 31/1 (2010), pp. 178–186.
[10] Source: Associations between contraceptive decision-making and marital contraceptive communication and use in Rural India, https://onlinelibrary.wiley.com/doi/abs/10.1111/sifp.12214
[11] Source: Beyond Reproduction: The "First 1,000 Days" Approach to Nutrition through a Gendered Rights-Based Lens https://www.hhrjournal.org/2020/11/beyond-reproduction-the-first-1000-days-approach-to-nutrition-through-a-gendered-rights-based-lens/
[12] Source: Child Malnutrition and Gender Preference in India: The Role of Culture https://www.academia.edu/73208534/Child_Malnutrition_and_Gender_Preference_in_India_The_Role_of_Culture
[13] Source: Reproductive health, and child health and nutrition in India: meeting the challenge, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3341742/
[14] Source: Planning & designing reproductive health intervention framework for young married couples in India: a systematic review, https://www.researchgate.net/profile/Million-Berhie/publication/334395406_Factors_Related_to_Good_Glycemic_Control_among_Type_2_Diabetic_Patients_at_Jimma_Medical_Center_and_Shanan_Gibe_Hospital_Jimma_Ethiopia/links/623cba4059121d3d1543f7d7/Factors-Related-to-Good-Glycemic-Control-among-Type-2-Diabetic-Patients-at-Jimma-Medical-Center-and-Shanan-Gibe-Hospital-Jimma-Ethiopia.pdf#page=38

Impact created:

The impact findings are based on a record of interactions with stakeholders including primary beneficiaries of the programme, front line workers, government officials from ICDS and health departments, and NGO field staff for conducting the impact assessment at Dhar, Madhya Pradesh and Baran, Rajasthan. The impact was reported on the front-line workers and the pregnant women, lactating women, and children under 2 years of age reached through the programme. **Overall, the programme met its proposed outcome of improved Maternal, Neonatal and Child Health and Nutrition services at the Anganwadi level.** The impact narrative for the programme is as follows:

A) Improved awareness and access to Maternal and child health + Nutrition services during the First 1000 days period

Improved knowledge among women to seek Maternal services

- 100% beneficiaries aware of early registration of pregnancy
- 70% beneficiaries aware of diet diversification through inclusion of suitable food groups
- 10-20% aware of nuanced elements such as weight gain and diet in pregnancy

Improved knowledge among women to seek childcare services

- 80% of caregivers of SAM/MAM children aware of interpretation of color-coded nutrition chart (green-normal, yellow- MAM and red- SAM), 10% surveyed beneficiaries categorized their children in to either red or yellow categories
- 10-20% aware of nuanced elements such as ideal birth weight and kangaroo mother care

Improved access to Maternal and child health services

- 72% (Baran) and 80% (Dhar) accessed UPT kit for pregnancy confirmation, 76% (Baran) and 70% (Dhar) reported early registration of pregnancy
- 70-80% beneficiaries reported access to full ANC services
  - 75% beneficiaries availed minimum 3 ANCs
  - 80% beneficiaries received 1 or 2 TT injections
  - 64% beneficiaries consumed 200 IFA tablets
- 17% (Baran) and 25% (Dhar) women reported severe anemia and received iron sucrose/blood transfusion
- 83% women reported having undergone institutional delivery; majority being normal, public deliveries

Improved access to nutrition services

- 100% respondents availed THR from their respective AWCs
- Access to Double THR by all the malnourished children ensured food security and adequate nutrition to the SAM/MAM children

B) Improved healthcare practices adopted by beneficiaries

Improved diet diversity among PW/LW

- 100% aware of changes in dietary practices for those requiring extra nutrition
- 70-80% reported improved consumption of locally grown vegetables
- 70% participants reported awareness regarding diverse diet and consumption during last pregnancy and lactation, including green vegetables, milk and dairy products, meat, fish

Improved IYCF practices

- 91% (Baran) and 85% (Dhar) women practiced early initiation of breast feeding
- 92% (Baran) and 99% (Dhar) practiced exclusive breastfeeding till 6 months of age (discounted for pre-lacteal feed at the time of birth)
- 81% respondents reported complimentary feeding at 6 months of age, remaining 19% reported delayed or early initiation of complimentary feeding

C) Improved access to public health advice

Provision of counselling on essential services, including covid awareness

- IP line list data depicts that 11% (Dhar) and 13% (Baran) beneficiaries received counseling on essential services* during Q1, which increased to 23% (Dhar), but decreased to 9% (Baran) during Q4
- 43% (Baran) and 36% (Dhar) surveyed pregnant women reported attending at least one counselling session focusing on the benefits and usage of THR services
- Introduction of key concepts on birth preparedness, institutional delivery, post-partum family planning, child immunization closer to delivery due date

Provision of counseling on sanitation practices

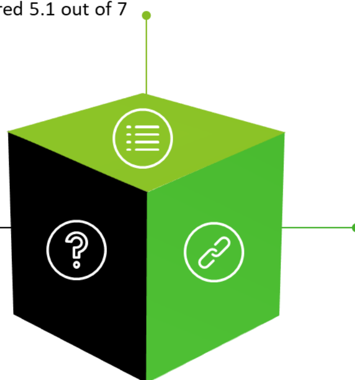
- 78% (Baran) and 70% (Dhar) surveyed women received counselling on handwashing practices
- 40-50% surveyed beneficiaries were able to demonstrate the 5 steps of handwashing
- 100% surveyed participants reported attending counselling sessions on avoiding open defecation; however, 50-60% practiced open defecation

* Essential services provided by FLWs included beneficiary awareness around antenatal check-ups, early pregnancy registration, government schemes, micronutrient supplementation, TT injections, uptake of THR services, WASH, danger signs during pregnancy including awareness about high-risk pregnancies. This are subject to lower rates due to covid-19 pandemic resulting in virtual counselling sessions by IP staff

D) Improved MCHN service provision by frontline workers

Improved knowledge of frontline workers

- **100% Frontline workers demonstrated knowledge** regarding provisioning of key maternal and child health services to target groups
- On knowledge testing, scores revealed high knowledge and retention of nuanced concepts. Anganwadi workers scored 3.2 on an overall composite score of 4, while ASHAs and ANMs scored 5.1 out of 7



Improved awareness about MCHN

- **100% FLWs aware of correct positioning** of mother while breastfeeding
- **100% FLWs** aware of ideal weight gain during pregnancy, ideal birth weight, and diet during pregnancy
- **70% FLWs aware of the benefits of Kangaroo Mother Care**

Improved service provision by FLWs

- **>80% FLWs created linkages with appropriate govt. schemes** and programs entitled for target groups
- **100% FLWs demonstrated ability to provide Full ANC services** (4 ANCs, 1 or 2 TT injections, at least 180 IFA tablets)
- **>90% FLWs demonstrated ability to ensure diet diversity** through counselling, lower awareness regarding methodology and importance of diet diversity score

E) Improved technical capacities of FLWs to provide First 1000-day services

Maternal and Child health services

- 100% FLWs conducted VHNDs and household visits to target beneficiaries
- 80% FLWs accompanied PW to avail access to at least one ANC by a medical doctor on PMSMA day (9th of every month)
- 100% availability of IFA and Calcium micronutrients at AWCs; felt need to monitor adequate consumption of IFA/Ca tablets by PW/LW
- 100% FLWs ensured availability of dry ration (dal/pulses, wheat, rice) to the beneficiaries

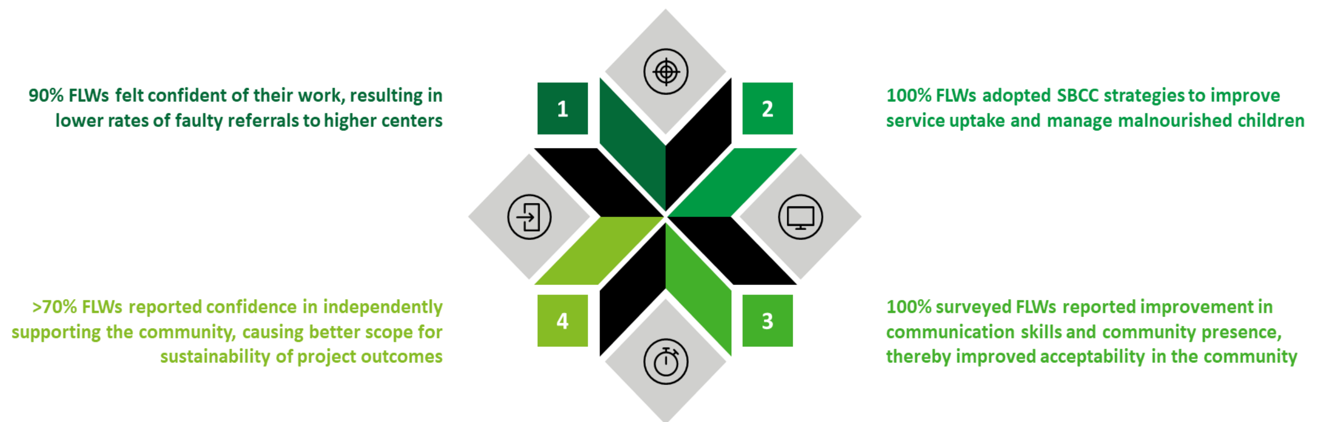
Growth monitoring services

- 100% ANMs and ~80% AWWs/ASHAs reported no challenges in use of measurement tools for height, weight and hemoglobin
- >90% AWWs demonstrated proficiency in the use of growth monitoring charts and measurement tools, and that of MCP cards and Poshan Tracker application
- >90% FLWs aware and regularly counseled beneficiaries for proper diet, IFA and Vitamin A supplementation, deworming, diarrhea management and proper sanitation to address malnutrition

C-MAM and F-SAM services

- Successful recovery/cure of 56% (Baran) and 57% (Dhar) of the total screened SAM children; 80% (Baran) and 71% (Dhar) of total screened MAM children
- 100% villages reported regular services for screening, monitoring and management of identified SAM/MAM children
- Uptake of THR services monitored for >90% MAM children
- 100% referrals based on appropriate measurements of malnutrition by FLWs, treatment denial rate due to wrong referrals at <5%

F) Empowered FLWs to drive social and behavioural change



Sustainability:

- The capacity building of the existing Government structure in ensuring the extended healthcare and nutrition -based services to the beneficiaries can help the system thrive from within.
- The inter-linkage of the program with the Government, bridging its lack of resources, capacity to provide quality training and monitoring the healthcare workers appears to be a critical support to the system making it sustainable.
- The newly added AWWs, ASHAs, ANMs (AAA) might need continued handholding and support to build confidence in absence of Government/AAH assisted trainings.
- The project should include an exit strategy to prevent high dependence on AAH machinery and enable sustainable outcomes through improved capacities of health care providers along with improved community practices.

Recommendations for way forward:

- Replicate cost-effective approaches (applied to SAM/MAM children) of engaging community mobilisers through innovative approaches like cooking demonstrations and kitchen garden promotions.
- Improve the focus of AAH staff on Ayushman Bharat provisions, especially the MCH schemes, comprehensive primary care services and secondary/tertiary referrals. This will support several aspects of the existing programme, such as appropriate referral, ante- and post-natal clinical visits, etc.
- Support through existing, government operated digital monitoring approaches (such as POSHAN Tracker app) in counselling and implementation of IYCF practices within the community.
- Create supportive supervision checklists and framework to ensure structured handholding of FLWs, and to ensure that corrective measures are included within the project delivery.
- Focus on the component of child immunization should also be energized into the project delivery model through already strategized VHND platforms. While this was not observed as a sole activity monitored and provided handholding to FLWs through the AAH staff within the project design, it is an essential component of 1000 days approach to address child morbidity and mortality due to vaccine preventable diseases.
- Increase focus and effort on community- based awareness building related to take-home ration (THR), government schemes and programs such as Pradhan Mantri Surakshit Matritv Abhiyan (PMSMA), Janani Suraksha Yojana (JSY) to improve community-based availability of services and PRI engagement.
- Key water, sanitation and hygiene actions including provision for safe drinking water, handwashing with soap, safe disposal of excreta, avoiding open defecation, and food hygiene are other important parameters to look at while delivering nutrition targeted programs.

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