WFP EVALUATION

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A Pilot Project towards Improving Infant and Young Child Nutrition (IYCN) through the Integrated Child Development Services (ICDS) Scheme in Jaipur District of Rajasthan during 2020-2023

Decentralized Evaluation Baseline Report

Report 1
WFP India Country Office

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India Country Office

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Disclaimer

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Executive Summary

1. The UN World Food Programme India country office (WFP) is supporting the Government of Rajasthan to improve the Integrated Child Development Services (ICDS) scheme in the state by designing and implementing a pilot project that seeks to establish a replicable and demonstrable model for improving infant and young child feeding practices and preventing malnutrition. Under the pilot, a local production unit will be established and women's Self-Help Groups (WSHG) will be trained to produce quality, nutritious and fortified Take Home Rations (THR) for distribution to the ICDS, which targets children aged 6-36 months and pregnant and lactating women. In addition, social and behaviour change communication (SBCC) directed to all sections of the community, is aimed to improve nutritional practices. The pilot will be implemented in five ICDS projects of Jaipur district (Jaipur I, Jaipur II, Jaipur III, Sanganer City and Sanganer Rural) for a duration of 36 months.
2. This cross-sectional evaluation is designed and commissioned by the WFP India Country Office for the proposed pilot in Jaipur, starting from undertaking the baseline evaluation at the stage of initiation of the pilot; and culminating with an endline evaluation towards the end of pilot's implementation (presenting comparative analysis between the baseline and end of pilot/endline stage). The evaluation will cover the period from November 2020 to November 2023. The *baseline evaluation was planned to take place from January 2021 to December 2021, but due to COVID-19 primary data collection was slightly delayed, leading to completion of the baseline in May, 2022. The end line evaluation would be conducted in 2023.* Based on the evidence generated through the evaluation of this pilot, the state government will take the decision to scale up this concept in other districts in the State.
3. The three primary objectives of the baseline evaluation are:
   - To provide an in-depth analysis of the situation and parameters to be targeted through the pilot, especially the current knowledge-attitude-practices regarding IYCF and nutrition, and care during pregnancy; THR demand, availability, uptake, consumption, and acceptability
   - To support in benchmarking of Key Performance Indicators
   - To facilitate operational planning and establishing basis for evaluation on completion of the project.

   Additionally, based on the request of the Government, this evaluation also examined the nutritional status of children (6-36 months) through anthropometric measurements.
4. The sample for baseline evaluation was spread across aforesaid five ICDS projects and consisted of:
   - 77 Anganwadi Centres;
   - 809 lactating women (mothers of children 6-36 months);
   - 379 children (6-36 months) for anthropometric measurement;
   - 152 currently pregnant women;
   - 70 Anganwadi Workers and
   - 70 Accredited Social Health Activists (ASHAs);
   - 65 Auxiliary Nurse and Midwives (ANMs);
   - 3 Child Development Project Officers of ICDS;
   - 1 Deputy Director/District Program Manager of ICDS;
   - 13 Adolescent girls through Focus Group Discussion (FGD); and
   - 20 community representatives through In-depth Interviews (IDIs).
5. Owing to COVID-19 pandemic, case-control design could not be adopted for the baseline; and a pre-post comparison design was adopted (without a control group). The expected users for this Baseline Evaluation include WFP India, Department of Women and Child Development (Rajasthan), the Ministry of Women and Child Development, WFP Regional Bureau and Head Quarters; WFP's Office of Evaluation, and the donor (Cargill India).
6. The evaluation questions are structured around the relevance, coherence, effectiveness, efficiency, impact and sustainability of the pilot (Annex 3) for establishing a replicable, efficient demonstrable and operationally effective model, for nutritious and affordable THR delivery and impacting nutritional knowledge, awareness and behaviours/practices amongst beneficiaries and other stakeholders (Annex 3A).

Key Findings

7. **Knowledge Attitude Practices (KAP) regarding Nutrition and Care during Pregnancy:** In general, the pregnant women have awareness of the importance of good nutrition during pregnancy. However, while adolescent girls are only partly aware, most of the community representatives were aware about these aspects. However, in families of 40% pregnant women, there are misconceptions regarding the food items a pregnant woman should eat or not eat; like consuming papaya or jackfruit may lead to miscarriage; or

consumption of eggs and dairy products will cause the foetus to grow too big, leading to complications during delivery. Thus, despite awareness about nutrition, owing to socio-cultural restrictions in family, many times pregnant women are not able to consume nutritious food items. Almost a third of the pregnant are not aware about the number of days and number of IFA tablets to be consumed during pregnancy. Besides there is a gap in translation of awareness into action among pregnant and lactating women regarding number of days and number of IFA tablets to be consumed during pregnancy. Further, most of the pregnant and lactating women and caregivers, frontline functionaries, and the community representatives are aware about the importance of consuming THR during pregnancy. About 80 percent of the pregnant women have Minimum Dietary Diversity (MDD) in their daily diet.

8. **KAP regarding Importance of Nourishing Diet for Children:** Target groups are aware about the importance of a nutritious diet and about feeding THR to a child 6-36 months. About 45% children 6-12 months, and 69% children 13-36 months, had the MDD in their daily diet.

9. **KAP regarding Breastfeeding:** Almost three-fourth of the pregnant and lactating women (mothers of children 6-36 years) are aware about the correct practices of breastfeeding. However, there are gaps when it comes to translation of this knowledge into practice, especially regarding aspects such as exclusive breastfeeding and duration of continued breastfeeding.

10. **Hygiene and Morbidity:** In 28% households, the caregivers do not wash hands before feeding their child. Further, 14% of children had episodes of diarrhoea (16% girls and 12% boys), 31% had fever (30% girls and 33% boys) and 5% percent had symptoms of ARI in the two weeks prior to the survey).

11. **Nutritional Status of Children:** 15% girl and 24% boys were found to be underweight. Further, 19% girls and 24% boys were found to be stunted. About 10% girls and 21% boys were also found to be wasted. Social category and education-wise, higher proportion of the malnourished children are from marginalized social categories (Scheduled Caste /Tribe and Other Backward Classes (OBC)[1]) and with lactating women with low educational qualifications.

12. **Supply and Distribution of THR from AWCs:** At the time of survey (post-COVID), all Anganwadi workers (AWWs) reported receiving and distributing THR in form of dry ration (wheat, rice, pulses), and all the sample beneficiaries (currently pregnant and lactating women) also affirmed the same. However, only, 72% currently pregnant women and 78% lactating women reported receiving THR from the AWC for themselves. As regards receiving THR for children from AWC, 92% lactating women (mothers of children 6-36 months) reported receiving it for their child.

13. There is high acceptability of THR among beneficiaries and most of them are satisfied with its quality. However, the current THR distribution being in form of dry ration, is also complementing household food requirement, and the same is also being shared with other family members (more than 80 percent of all groups).

Key Conclusions and Lessons/Issues for Consideration

14. As regards the KAP regarding nutrition and care during pregnancy, in general pregnant women are aware of the importance of good nutrition during pregnancy, including the consumption of THR. However, there is a gap when it comes to translation of this knowledge into practice.
15. Regarding the KAP for breastfeeding practices, despite awareness, there is a gap when it comes to translation of this knowledge into practice, especially around the aspects of exclusive breastfeeding and continued breastfeeding.

[1] Scheduled castes are sub-communities within the framework of the Hindu caste system who have historically faced deprivation, oppression, and extreme social isolation in India on account of their perceived 'low status'. Only marginalized Hindu communities can be deemed Scheduled Castes in India, according to The Constitution (Scheduled Castes) Order, 1950. Article 340 of the constitution gives the President of India with the power to constitute a committee to investigate the conditions of backward classes in India and recommend measures for their welfare, upliftment, and development. The Mandal Commission was constituted in 1978 under this article to identify backward communities in India and recommend policy initiatives for their upliftment and welfare; and has listed 11 criteria, falling under social, economic, and educational categories, to identify and classify communities as Backward Classes. Similarly, Article 342 gives the President the power to notify those communities in specific regions that fall under the classification of Scheduled Tribes. There are over 700 Scheduled Tribes in India according to The National Commission for Scheduled Tribes. The National Commission for Scheduled Tribes explains 'Primitiveness, geographical isolation, shyness and social, educational & economic backwardness due to these reasons are the traits that distinguish Scheduled Tribe communities of our country from other communities'.

16. Reportedly there is demand and acceptability among beneficiaries for the THR. However, THR distribution is at times impacted by gaps in supply due to administrative issues. Besides, there is a little bias towards availing THR for male children. Moreover, for a fifth of the children, the THR is not being collected regularly.
17. The status of underweight (20%), stunted (21%) and wasted (16%) children in project areas is less than the national and state averages as per NFHS-5. More boys than girls; more children from ST, SC and OBC families; and more children of women with lower educational qualifications are malnourished. Further, only 57% children have MDD in their diet.
18. The key lessons/issues for consideration emerging from baseline evaluation are presented hereunder:
    - **Lesson 1:** Though most of the pregnant and lactating women have awareness on aspects related to nutrition and IFA consumption during pregnancy, there is a gap when it comes to translation of knowledge into practice. Besides, there is a need to address the beliefs, self-efficacy and social norms regarding nutritional intake. Thus, Awareness generation on aspects related to nutrition and IFA consumption during pregnancy needs to be a focus topic for SBCC under the pilot project.
    - **Lesson 2:** As only about 57% children have the MDD in their daily diet; it is required that under the SBCC component of the pilot project, the lactating women are appropriately made aware, counselled, and motivated to ensure MDD in daily diet of their children as per their age.
    - **Lesson 3:** As almost one-fourth of the currently pregnant and lactating women, and frontline functionaries are not appropriately aware about one or the other aspects related to breastfeeding. Besides, adherence to appropriate breastfeeding practices and nutritional status of children is comparatively lower among social marginalized households and lactating women with lower educational qualifications. Thus, under the SBCC and capacity building components of the pilot project, emphasis should be on awareness generation for pregnant and lactating women, especially from marginalized families and with lower education; and capacity building for the frontline functionaries (who are the first point of contact) on these aspects.
    - **Lesson 4:** Some of the beneficiaries either do not consume the THR or do not consume it regularly, many a times due to its monotonous taste. Thus, activities for enhancing uptake and consumption/uptake of THR by targeted beneficiaries and developing THR recipe with enhanced taste, needs to be a focus area under the proposed pilot.
    - **Lesson 5:** As per the ICDS representatives, at times there have been gaps in supply of THR to AWCs due to administrative issues, impacting its distribution, and thus, consumption. Thus, under the pilot project it needs to be ensured that there are no gaps in the supply of THR to the target AWCs.
    - **Lesson 6:** Overarchingly, in all SBCC activities, there should be engagement/inclusion of husbands/fathers and mother in laws/grandmothers of pregnant and lactating women and children, along with engagement of community influencers for positive social norming. The SBCC should be a combination of interpersonal counselling & individualized skilled support to beneficiaries and their family members, complimented by supportive mid-media & mass media activities for consistent and repeated messaging/communication.
    - **Lesson 7:** Frontline functionaries need to be capacitated and mentored on providing individually contextualized counselling, and for proactively engaging in problem solving and nudging pregnant and lactating women and their family members for adopting optimal behaviour.

1. Introduction

1.1. Evaluation Features

1. The United Nations World Food Programme (UNWFP/WFP) is supporting the State Government of Rajasthan to improve the quality of the Integrated Child Development Services (ICDS) scheme in the state by establishing a replicable and demonstrable model for local production of nutritious supplementary foods (take home rations) and designing and implementing social and behaviour change communication leading to improved infant and young child feeding practices and preventing malnutrition.

2. As part of the pilot, WFP is establishing a local production unit by working with women's Self-Help Groups (WSHGs) to produce quality, nutritious, fortified and age-appropriate Take Home Ration (THR) for distribution to the children and pregnant and lactating women (PLW) under the ICDS scheme. This, along with required social and behaviour change communication (SBCC) being directed to all sections of the community, is aimed to improve nutritional practices. The concept will initially be implemented in pilot mode in Jaipur district. Based on the evidence generated through the evaluation of this pilot, the state government of Rajasthan will take the decision to scale up this concept in other districts in the State.

3. **Evaluation Subject, Commissioner and Timeline:** This evaluation is designed and commissioned by WFP India Country Office (CO) for the proposed pilot project. The evaluation is cross-sectional, starting from undertaking the baseline evaluation at the stage of initiation of the pilot; and will culminate with an endline evaluation towards the end of pilot's implementation. The evaluation covers the tentative period from November 2020 to November 2023. The *baseline evaluation was planned to take place from January 2021 to December 2021, but due to COVID-19 primary data collection was slightly delayed, which led to completion of the baseline in May, 2022. The end line evaluation would be conducted in 2023.*

4. Evaluations in WFP serve the dual and mutually reinforcing objectives of accountability and learning. In view of this, a rigorous and scientific evaluation design has been adopted based on the below mentioned objective of accountability and more emphasis on learning; and using a set of indicators for measuring the results:

   - **Accountability –** Based on the comparison of the baseline and end line evaluation findings, the evaluation would assess and report the performance and results of the Infant and Young child Feeding (IYCF) interventions through the ICDS scheme in the Jaipur district of Rajasthan.
   - **Learning –** The evaluation will determine the reasons why certain results occurred or not; to draw lessons, derive good practices and pointers for learning. The evaluation would also provide evidence-based findings to inform operational and strategic decision-making for future scale-up. The findings of the evaluation will be actively disseminated, and lessons will be incorporated into relevant lesson sharing systems.

5. As the first activity under the overall evaluation of the pilot; the baseline evaluation assessed the situation at the project initiation stage and will act as the benchmark for comparing the situation towards the end of the project (endline). The three primary objectives of the baseline evaluation are:
   - To provide an in-depth analysis of the situation and parameters to be targeted through the project, especially the current knowledge-attitude-practices regarding IYCF and nutrition, and care during pregnancy; THR demand, availability, uptake, consumption and acceptability; and current nutritional status of children (6-36 months);
   - To support in benchmarking of Key Performance Indicators (KPIs)
   - To facilitate operational planning and establishing basis for evaluation on completion of the project.

6. Additionally, based on the request of the Government, this evaluation also examined the nutritional status of children through anthropometric measurement in the target age group (aged 6-36 months).

7. The evaluation team consisted of Aneesh Vijayan (Team Leader and M&E Expert), Ms. Usha Goel (Nutrition Expert), Swapnil Dube (SBCC and Sector Expert), Yuvarajan Subramaniam (Health Expert), Ankit Singh (Field Manager), and Anoop Tiwari (Data Analyst & CAPI Application Developer). *Field enumerators collected the primary data, which took place between October-November 2021. Later, as part of the baseline data collection follow-up visits with the government functionaries were also conducted to collect the data.*

8. This document is the baseline evaluation report which provides analysis of the situation (in terms of current nutrition status of children, IYCF practices, awareness and behaviour, THR consumption, acceptability of THR, on-going practices of WSHGs) in the operational area to support benchmarking of key performance indicators, facilitating operational planning and establishing basis for evaluation on completion of the project; and for providing inputs on issues that may be considered for developing the SBCC strategy and for finetuning the pilot's implementation strategy. The baseline does not present the status on evaluation question (Annex-3); instead sets the benchmarks to compare the performance and impact of the pilot at the endline stage using the evaluation question (Annex-3A). For the purpose, appropriate outputs/outcomes indicators have been covered in the baseline (Annex-4). The endline study will present the outputs/outcomes achievements in comparison with baseline benchmarks/status.

9. **Gender:** To examine the implications of gender on child nutrition, this baseline evaluation has looked at the differences in feeding, care practices and current nutritional status of girls and boys (6-36 months), and between adolescent girls and boys, at the household and community level.

10. The expected users for this Baseline Evaluation Report include WFP India, the Department of Women and Child Development (DWCD) Rajasthan, the Ministry of Women and Child Development, Government of India, WFP Regional Bureau and Head Quarters; WFP's Office of Evaluation; etc. Findings of this evaluation would support the state government in decision making related to the scale-up of the intervention in Rajasthan. Findings of evaluation would provide evidence to the Ministry of Women and Child Development, in taking a policy-level decision at the national-level towards reforming the ICDS scheme. Other government ministries and UN agencies that provide technical guidance or support the programme in other ways will also be interested in the evaluation findings. Besides, the pilot is funded by Cargill India. They have an interest in knowing whether their funds have been spent efficiently and if WFP's work has been effective and contributed to their own strategies and programmes. Further description of the users of the evaluation can be found in Annex 1.

1.2. CONTEXT

11. The ICDS is the key platform through which nutrition and health services are provisioned through the Anganwadi Centres to children, pregnant and lactating women, and adolescent girls. Under the umbrella ICDS scheme, Supplementary Nutrition[2] is provided to children under 6 years of age in the form of THR and Hot Cooked Meals/Food to bridge the gap between the Recommended Dietary Allowances (RDA) and the Average Daily Intake (ADI) as per the provisions of the Schedule-II of National Food Security Act (NFSA), 2013. Severely malnourished children are provided additional nutrition in the form of food supplements providing 800 Kcal of energy and 20-25 gram of protein.

12. **Gender issues:** The overall status of women is poor in Rajasthan, which gets reflected through various gender-related indicators presented in National Family Health Survey Round -5 (2020-21) and Round-4 (2015-16)[3].

- Sex ratio at birth for children born in the last five years (females per 1,000 males) is 891 (increase from 887 at NFHS-4)
- Women aged 20-24 years married before age 18 years stood at 25% (decrease from 36% at NFHS-4)
- Women aged 15-19 years who were already mothers or pregnant at the time of the survey is 4% (decrease from 6% at NFHS-4)
- Mothers who had at least 4 antenatal care visits is 55% (increase from 29 at NFHS-4)
- All women aged 15-49 years who are anaemic (%) is 54% (decrease from 47% at NFHS-4)
- Less women (65%) than men (89%) are literate in the state (NFHS-5)

13. ***The National Policies and Programmes:*** The National Food Security Act 2013 mandates food and nutrition entitlements for children, pregnant and breastfeeding mothers. The National Nutrition Policy 1993, complemented by other policies such as the National Health Policy 2002, the National Policy for Children, 2013 also provides a strong foundation for addressing the underlying determinants of undernutrition. A wide spectrum of national programmes contributes to improved nutrition outcomes. These include the ICDS, National Health Mission, Mid-Day Meals Scheme, Targeted Public Distribution

[2] Hot cooked meals to 3-6 years of children who attend the AWCs, and THR to 6-36 months of children

[3] National Family Health Survey conducted by the Ministry of Health and Family Welfare (MoHFW), Government of India : Round-4 in 2015-16 and Round -5 in 2020-21

System, and National Food Security Mission, Poshan Abhiyan, etc. However, the problem in Rajasthan is the low coverage of these interventions and the consequences of manifest in terms of poor nutrition status of children and women.

14. Situation in Rajasthan and Pilot District Jaipur:

- According to Niti Aayog, 25% of the Population in India are Poor. The poverty rate in Rajasthan is14.71% (2011-12)[4]. The food sector in Rajasthan historically has suffered from various obstacles in local food production. Jaipur, however, is the leading district in terms of food accessibility. Besides, the per capita domestic product of the Jaipur district was 37,601 INR[5].
- The literacy rate in India is 74% (66% for females)[6]. The literacy rate in Rajasthan is 66% (52% for females)[7]. Further, there have been 12,87,957 confirmed cases of COVID-19 in Rajasthan[8].
- Between 2015-16 (NFHS-4) to 2020-21 (NFHS-5), the status of breastfeeding within an hour of birth and exclusive breastfeeding has improved in Rajasthan and is better than the country average. The status of underweight, wasted and stunted children under 5 years in the state is less than the country average. However, on aspects of complimentary feeding for children 6-8 months and receipt of adequate diet by children 6-23 months; the state is lagging behind the country average.

Table 1: Nutritional Outcomes and Feeding Practices in Rajasthan and India (as per NFHS

Indicator	India		Rajasthan		Jaipur	
	2015-16	2020-21	2015-16	2020-21	2015-16	2020-21
Children under age 3 years breastfed within one hour of birth	42%	42%	28%	41%	27%	41%
Children under six months of age are exclusively breastfed	55%	64%	58%	70%	72%	68%
Children aged 6-8 months receiving solid or semi-solid food and breastmilk	43%	46%	30%	38%	42%	-
Children between 6 to 23 months of age received an adequate diet	10%	11%	3%	8%	3%	6%
Children under 5 years of age – Underweight	36%	32%	37%	28%	25%	21%
Children under 5 years of age – Stunted	38%	36%	39%	32%	36%	25%
Children under 5 years of age – Wasted	21%	19%	23%	17%	13%	15%
Women whose BMI is below normal (<18.5 kg/m2)	23%	19%	27%	20%	23%	17%

15. As per Census 2011, 11% of the total population of the state is of children 0-4 years. Further, Rajasthan is among the bottom five states in the country in in terms of the literacy level for SC and among the last six for ST.

16. In the above context, and the WFP has signed a Memorandum of Understanding (MoU) and Letter of Understanding (LoU) for the proposed pilot project with the Government of Rajasthan (GoR).

17. Like the proposed pilot project in Jaipur; the WFP in partnership with the Government of Kerala has also implemented a pilot project of fortification of THR distributed under ICDS and improving the IYCF practices in few panchayats of Wayanad district (January 2017 to December 2018). Based on the success of the pilot, the Government of Kerala has scaled-up the pilot project in the entire state. Similarly in Uttar Pradesh , the WFP has entered into agreement with the and the State Rural Livelihood Mission (SRLM) for setting up over 200 supplementary nutrition production units to support distribution under the ICDS scheme. Till 2023, the initiative is expected to reach nearly 33 lakh beneficiaries in 18 districts of the state; and WFP will set up a single block level automated production unit each in two blocks. Likewise, In Odisha, WFP is partnering with the state government for working on improving household food and nutritional security by strengthening livelihood initiatives, reaching thousands of state-supported Women's Self-Help Groups. The partnership will also be effective till December 2023. Besides, in August 2020, NITI Aayog and

[4] https://www.rbi.org.in/scripts/PublicationsView.aspx?id=18810

[5] https://www.frontiersin.org/articles/10.3389/fsufs.2022.831396/full

[6] https://www.census2011.co.in/literacy.php

[7] https://education.rajasthan.gov.in/content/raj/education/en/school-sec-education/literacy-continuing-education/Literacy_Scenario/Districtwise_Literacy_Rate_of_Rajasthan.html

[8] https://www.mygov.in/covid-19

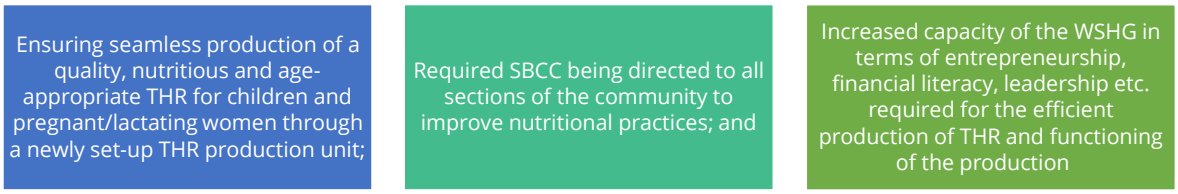
Children's Investment Fund Foundation (CIFF) had commissioned a qualitative study in Rajasthan and Jharkhand aimed to map the processes behind the newly introduced THR production models, uncover and diagnose challenges in implementation and identify opportunities for improvement. The study came out with challenges regarding THR service delivery, their causes, and suggestions to mitigate them.

1.3. SUBJECT BEING EVALUATED

18. Under the proposed pilot, the WFP in partnership with the DWCD will collaborate with a Women Self Help Group (WSHG) to set up a local THR production unit to produce quality, nutritious, fortified and age appropriate THR and its regular supply. The implementation of SBCC strategy under the pilot will be in collaboration with relevant POSHAN Abhiyaan stakeholders and other development partners active in the given space.

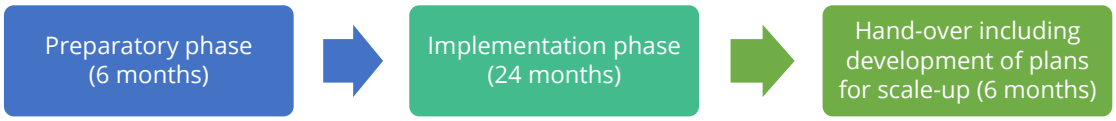
19. The pilot aims to 'Establish a replicable and demonstrable model for improving IYCF practices which could lead to improved child and maternal nutrition'. The hypothesis is that that a consumption of good THR product with the right composition of nutrients can prevent malnutrition in young children. The pilot will be implemented in five ICDS projects of Jaipur district (Jaipur I, Jaipur II, Jaipur III, Sanganer City and Sanganer Rural), which are spread across two blocks (Jaipur and Sanganer). Based on the success of the pilot; the Government of Rajasthan would consider scaling it up in other districts. Under the pilot project, the WFP will work towards achieving the following three core objectives:

Figure 1: Three Core Objectives of the Pilot Project



20. The duration of WFP's pilot project will be three years (36 months) spread across the below-mentioned phases:

Figure 2: Phased Implementation of WFP's Pilot Project



21. Presented below are the three core components of the WFP's pilot project:

A. Improvement in the Quality of THR: As part of this component, WFP will

- Set up a mechanized THR production unit at the sub-district level.
- Make changes in the existing THR recipe to make it age-appropriate and of desirable nutritional quality aligned to global guidance for such products; fortified while being locally acceptable.
- Undertake necessary research and development work around product development, shelf life, acceptability, etc. before the modified superior THR is rolled out for distribution.
- Procure the necessary equipment needed for the production of the THR, supplement the existing pool of funds available with the identified WSHGs as well capacity building for the WSHG members.
- Play an instrumental role in linking the WSHG to ICDS and ensuring that the THR produced by the WSHG is bought by DWCD for distribution to its beneficiaries.

B. Improved Care and Nutrition Practices: Under this component, WFP will:

- Implement a well-planned, coordinated across sectors and thought through, SBCC strategy at district level to ensure appropriate utilization and demand for nutrition services such as THR available through the AWCs and other government platform across sectors in the five pilot blocks.
- Through SBCC, focus on gender equity, which is a key influencer of food intake, by emphasizing the elimination of any discriminatory practices in child feeding and against women and girls in the family.
- Implementation of SBCC strategy :

- Regular dissemination of nutritional messages especially during the first 1000 days of life
- Creating Nutritional Awareness at all levels in the community through linkages with community-based organizations
- Making nutrition a discussion topic for the village, using regional and local radio or TV to air a weekly programme on Nutrition and Health similar to 'Poshan Charcha' and 'Poshan aur Swasthya' and promoting mass media coverage on healthy lifestyles and increasing nutrition counselling skills of frontline functionaries through capacity building.

C. Project Monitoring and Evaluation (M&E): The project will be monitored based on specific indicators at various levels to ensure that project activities are on track and that the envisaged project benefits are reaching the intended beneficiaries.

22. During baseline, appropriate output and outcome level indicators have been measured to establish the benchmarks for comparison at the endline stage). *Further, a Theory of Change (ToC) for the pilot and its scale-up (based on the evaluation findings) is presented at Annex-2 for reference. Besides delineating the required inputs and their related process for the implementation of the pilot, the ToC also presents the expected outputs and outcomes from the implementation of the pilot.* The baseline study provides an analysis of the situation in terms of current nutrition status of children; IYCF practices, awareness and behaviour, THR consumption and acceptability in the project area to support benchmarking of key performance indicators, facilitating operational planning and establishing basis for evaluation on completion of the project. The endline study will present the results, impact, outputs/outcomes achievements of the pilot in comparison with baseline benchmarks/status, including gender and age dis-aggregations. Based on the findings of the end line evaluation, lessons would be drawn towards the learning of WFP, the state government and others; and accordingly, decision on the scale-up of the pilot project would be undertaken.

23. This evaluation is a cross-sectional pilot evaluation including a baseline conducted from January 2021 to April 2022 and an endline evaluation to be conducted in 2023. The following context-specific information has been collected at the baseline:

- ***System Level***
  - On-going practices of the storage and distribution of the THR
  - To identify issues and gap (if any) such as leakages of the THR in the current practices
- ***Community and Individual Level***
  - On-going behaviours, key influencers around exclusive breastfeeding, complementary feeding, and other nutrition-related aspects among the caregivers of children (dis-aggregated by boys and girls), AWWs, and others.
  - Feedback of the beneficiaries about the quality of the THR.
  - Consumption pattern of THR including intra-household consumption pattern, especially between girls and boys, sharing of THR between male and female members.
  - Cooking and eating practices of THR distributed under ICDS to the targeted children (dis-aggregated by boys and girls) and their caregivers.

24. In addition to the above, the following parameters have also been measured during baseline evaluation for children (aged 6-36 months) in the project area-Nutritional Status of Sample Children in the Targeted Age Group through anthropometric data collection (underweight, stunting, underweight); hygiene and Health Practices at the household level; and recent Morbidity among the Sample Children (Diarrhoea, Non-specific Fever (Non COVID), and Acute Respiratory Infection (ARI)[9] among children in in last two weeks (preceding the survey)); disaggregated by sex of the children.

25. The results framework used for the baseline is presented in table-4 below:

[9] ARI is usually coughing accompanied by faster than normal breathing

Table 2: Results Framework along with Study Parameters

OBJECTIVES	ACTIVITIES	OUTPUTS	OUTCOMES
• **Establishing a replicable, efficient demonstrable, and 'Operationally effective[10]' model, that ensures providing nutritious and affordable THR to PLWs, infants, and young children in a sustainable way**	• Up-gradation of existing equipment for the production of a nutritious THR • Capacity building of the staff responsible for the production • Supply chain management • Quality assurance and control • Regular monitoring along with required assessments and studies on shelf life etc before the product is rolled out for consumption by the ICDS beneficiaries.	• Quantity (in kgs) of age-appropriate, nutritious, fortified and diversified THR: (a) produced in the THR production center; (b) supplied to the AWCs; and (c) distributed from the AWCs to the children (aged 6-36 months) and PLWs. • Number of AWCs: (a) supplied with nutritious THR; and (b) distributing nutritious THR • Frequency of monitoring of THR distribution (in a quarter) • Number of quality assurance (QA) mechanisms and standard operating procedures (SOP) on the total production process including fortification in place • Quantity (in kgs) of THR stored appropriately at all levels – production center and AWC level • Number of the state government officials trained for monitoring, procurement, production and distribution of the nutritious THR. • Number of trainings or technical assistance provided to the government officials on monitoring, procurement, production and distribution of the nutritious THR. • Community and Individual Level • Number of WSHGs[11] trained/assisted[12]. • Number of intended beneficiaries receiving and consuming nutritious, diversified and fortified THR - Boys/girls/PLWs	• Systemic Level • Percentage of required age-appropriate, nutritious, fortified and diversified THR regularly produced in the THR production centre • Percentage of AWCs distributing nutritious, diversified and fortified THR to the beneficiaries in a timely manner • Community and Individual Level • Percentage of WSHGs exhibiting improved entrepreneurship, financial literacy, and leadership. • Percentage of intended beneficiaries showing improved consumption and acceptability of the nutritious, diversified and fortified THR - Boys/girls/PLWs
• **Improved nutritional knowledge, awareness and behaviours amongst caregivers, adolescents, PLWs and other stakeholders**	• Developing SBCC materials and pre-testing SBCC materials among target audience segments • Capacity building of staff for effective implementation of SBCC campaign • Implementing the SBCC campaign with partners • Monitoring and improvising	• Community and Individual Level • Number of frontline functionaries trained on nutrition counselling skills • Number of caregivers of children (dis-aggregated by boys and girls), adolescent girls, PLWs, AWWs and community members who received adequate information of exclusive breastfeeding, complementary feeding, anaemia and key nutrition-related behaviours.	• Community and Individual Level • Percentage of individuals exhibiting adequate knowledge of exclusive breastfeeding, complementary feeding, anaemia and key nutrition-related behaviours, by target group.

[10] Operational model will be called workable and replicable if- a) No gap in in the supply of nutritious, diversified and fortified THR to the AWCs, b) no break in the distribution of nutritious, diversified and fortified THR in the AWCs c) quality assurance mechanisms are effectively functional, d) there is acceptability for the nutritious, diversified and fortified THR e) monitoring of THR distribution, and consumption is streamlined, f) Standard operating procedures on fortification adhered to, g) Storage is proper.
A replicable model should have capacities of officials/stakeholders built; government is capable and ready to take over the project; and government's intention to sustain and scale-up the project is strong.

[11] WSHG who would set-up the THR production center

[12] Training or assistance provided to the WSHGs in terms of entrepreneurship, financial literacy, leadership etc. required for the efficient production of THR and functioning of the production unit.

26. **Gender Equality and Equity:** The baseline evaluation incorporates gender analysis to understand the gender differences in nutritional status, feeding and care practices and identify gendered norms or practices that could be targeted by the programme's SBCC strategy to enhance gender equity in the access and consumption of THR by the beneficiaries.

27. Amendments to Initial Design/Limitations:

- Against the original ToR requirement to undertake the evaluation along the lines of the quasi-experimental case-control design, owing to the outbreak of COVID pandemic the baseline evaluation, has been carried-out along the lines of pre-post intervention comparison (baseline-endline) design. Thus, a comparison group of respondents/beneficiaries has not been selected.
- Owing to the outbreak of COVID pandemic, the THR distribution from AWCs to beneficiaries is now in form of dry ration (wheat, rice, pulses)[13]. Thus, in baseline evaluation: probes related to THR (utilization, consumption, demand, storage, preparation, sharing with family members, etc.) have been asked with reference to dry ration)[14]. Further, as no WSHG is currently involved in production and supply of THR (pre-mix) to AWCs; the WSHG members have not been covered for baseline evaluation.
- As part of the baseline evaluation, five Focus Group Discussions (FGDs) were to be organized with the community representatives but , due to the COVID prevention protocols and apprehension of the people to interact in group; they were not willing to assemble in a group for a discussion. Instead, in-depth Interviews were conducted with these respondents.
- The baseline evaluation also entailed interacting with the Chief Medical & Health Officer (CMHO) of Jaipur and the concerned Medical Officer In-charge (MOIC) of the five ICDS projects where the pilot is to be implemented. However, the CMHO and the MOICs did not agree and thus they were not included.

1.4. Evaluation Methodology, Limitations and Ethical Considerations

Evaluation Methodology

28. A quantitative-qualitative mix and independent approach based on pre-post comparison design has been adopted for the baseline evaluation. A cross sectional design has been adopted for the baseline, entailing interactions with different respondents to assess their KAP on same thematic areas. At endline (post intervention stage), the data will be collected and analysed in a manner that the findings are presented in comparison to the baseline (pre intervention stage), to showcase the impacts/results achieved by the project. More details of the methodology adopted for baseline are presented at Annexure-8.

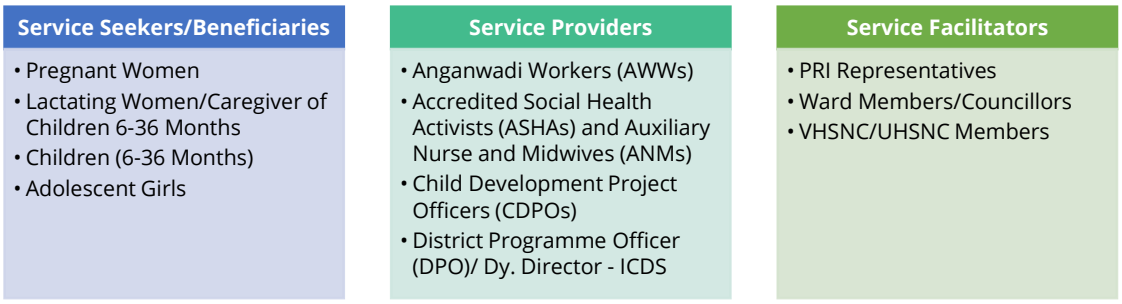
29. The baseline evaluation focused on assessing current KAP of the beneficiaries regarding nutrition, THR demand/uptake/consumption/acceptability, and the nutritional status of children 6-36 months; with a view to support benchmarking of Key Performance Indicators (KPIs). Besides, the evaluation also examined the nutritional status of children (6-36 months) through anthropometric measurements.

30. Along the lines of 360^0 assessment approach, the baseline covered the service seekers, service providers, and service facilitators. The respondents for the baseline evaluation included the following (figure below):

[13] In Rajasthan earlier the THR was being distributed to children between 6-36 months of age and pregnant/lactating women (PLW) in the form of a mix of wheat, soya, gram flour, oil, and sugar; produced under a de-centralized modality. Children and women were provided 750 grams and 930 grams of this mix, respectively, on a weekly basis.

[14] However, to assess earlier practices in this regard; half of the sample AWWs were additionally probed on these aspects.

Figure 3: Respondents for the Baseline Evaluation



31. The baseline evaluation was carried out in five ICDS projects of Jaipur district targeted under the pilot project (Para 19). A two-stage sampling was adopted for the baseline using a mix of Probability Proportional to Size (PPS) and random sampling.

- Stage-1: Sample of 700 lactating women (with children 6-36 months) was distributed across the five blocks using the PPS sampling. The number of caregivers selected from each block have been selected in the proportion of the block's representation in-universe of children 6-36 months.
- Stage-2: Fourteen (14) AWCs from each block (including rural and urban AWCs), households with children 6-26 months and the lactating women, and households with a currently pregnant women were selected randomly in required numbers. Further, from each sample AWC area, up to 2 households with a pregnant woman were randomly selected (a total of up to 140 pregnant women.

32. The actual coverage against the above proposed sample is presented in table below.

Table 3: Sample Spread for the Baseline

Sample AWCs	Lactating Women	Children 6-36 Months for Anthropometric Assessment	Pregnant Women	Anganwadi Workers (AWWs)	Accredited Social Health Activists (ASHAs)	Auxiliary Nurse and Midwives (ANMs*)	Child Development Project Officer (CDPOs)**	District Program Officer (DPO)	Adolescent Girls ***	Other Stakeholders {Village/Urban Health, Sanitation and Nutrition Committee (VHSNC/ UHSNC)/ Panchayati Raj Institution (PRI)/Ward Members} ****
77#	809	379	152	70	70	65	3	1	13	20

#: 7 additional AWCs had to be covered, as in some of the sample AWCS one or the other category of respondent (pregnant & lactating women, children 6-36 months, ASHA/ANM were not available/not posted/not available in required number
**: Five ANMs were common for more than one sample AWCs. Thus, against 70, a total of 65 ANMs have been covered.*
***: At the time of data collection Jaipur-1 and Jaipur-3 projects were being managed by one CDPO. Similarly, Jaipur-2 and Sanganer-Rural projects were being managed by one CDPO. Thus, against 5, a total of 5 CDPOs have been covered.*
****: Total 13 adolescent girls have been covered by organizing one Focus Group Discussion (FGD) in Jaipur-3 project*
*****: Total 20 respondents have been covered through 10 In-depth Interviews (IDIs) and 1 FGD*
##: At the state/district level, the health department was not officially intimated about the baseline evaluation. Thus, the Chief Medical and Health Officer (CMHO) and the Medical Officer In-charges (MOICs) were not willing to interact with the evaluation agency without having an authorization from their department. Owing to this, despite of several attempts requesting them to interact with the evaluation agency, they did not accord the consent for the same. Thus, these officials of the health department could not be covered for the baseline evaluation.

33. Choice of methods for data collection: The data collection on indicators were largely quantitative. However, the qualitative findings/insights have been used to compliment/supplement and corroborate the quantitative findings.

34. Inclusion of Evaluation Questions in Data Collection Instruments: The evaluation questions[15] regarding Relevance, Coherence, Effectiveness, Efficiency, Sustainability, and Impact of the pilot project (presented at Annex-3); have been considered to prepare the evaluation matrix (presented at Annex 3-A) and the TOC (presented at Annex-2). These evaluation questions will be assessed at the time of endline. At large the evaluation questions around the means/mechanism of distributing the THR to pregnant and lactating women and children; level of knowledge, awareness and behaviours/practices amongst pregnant and lactating women, adolescent girls and other stakeholders; nutritional status of children (wasted, stunted and underweight boys and girls); hygiene practices among the mother of children (boys and girls) at the household levels; and status of recent morbidity among children. Indicators for baseline analysis (Annex-4) are based out on the Evaluation Question (Annex 3) and Evaluation Matrix (Annex 3A, with linkage of indicators with evaluation questions). At the endline stage, the same indicators will be used to assess the status of achievement of impact, results, outputs/outcomes of the project in comparison with baseline status.

35. Data Collection Instruments: Simple data collection instruments were developed to aid in appropriately capturing the individual, community, AWW and system level inputs/perceptions/ feedback. These were developed in line with the results framework presented in the evaluation ToR (Annex 5), evaluation matrix, the TOC and in consultation with the WFP representatives, which were translated in Hindi prior to the actual administration in the field. The data collection instruments included:

- Quantitative Semi-structured Interview (SSI) Schedules for interacting with pregnant and lactating women
- Quantitative anthropometric schedule for assessing nutrition status of chikdren (embedded in schedule of lactating women)
- Quantitative semi-structured schedule for interacting with frontline functionaries
- Qualitative discussion guides for In-depth Interviews (IDIs) with ICDS officials and community representatives
- Focus Group Discussion (FGD) guide for interacting with adolescent girls.

36. Locally recruited field teams members were oriented on administering different data collection instruments, who then moved on to the field and interacted with the sample respondents in person in Hindi language. A separate team of local investigators was recruited and oriented for carrying out anthropometric measurements.

37. Choice of methods for data analysis: Quantitative and qualitative data collected for the baseline were separately analysed and interpreted. SPSS was used for generating analytical tables and cross tabulations of quantitative data. Qualitative data was analysed manually using MS Excel. Together, the quantitative and qualitative data/information collected for the baseline and supported by relevant secondary data have been used to present the baseline findings and in generating inputs for the development of SBCC strategy and material under the pilot. The emergent findings have been co-related with parameters like their social-educational background, age-group, etc. (as appropriate and relevant). Besides, the quantitative findings emerging from semi-structed schedules have been supported by qualitative insights, wherever appropriate. Besides the responses of different respondents have been presented in comparison as appropriate. The analysis of quantitative primary data collected through field surveys has been corroborated with the secondary data/information (like NFHS).

38. The field enumerators were specifically oriented to be neutral while interacting with the respondents. Besides, the enumerators were observed and supervised same during the field data collection by the senior evaluation team embers to ensure that there is minimum bias at the level of investigators/enumerators during data collection. As the semi-structured schedules and anthropometric assessment tool were be administered using CAPI, no separate data entry was required. Filled-in CAPI schedules were transferred directly to the data analysis system (secure password protected system). The evaluation team then sanitized the quantitative data using SPSS, to ensure completeness and consistency

[15] The evaluation questions aim at highlighting the key lessons and performance of the intervention in improving infant and young child nutrition, which could inform future strategic and operational decisions

and range. As regards the quantitative data, the evaluation team members used the notes taken at the time of the IDIs/FGDs for generating insights for analysis.

39. The baseline data has been collected by trained enumerators under close supervision of evaluation team members, along the lines of evaluation requirement. The enumerators were monitored and supervised using accompaniments and spot checks. Thereafter it was sanitized by running it through a range of checks. Appropriate revisions (as required) were made in the data through telephonic reconfirmations/checks with respondents. Thus, ensuring its reliability and quality. The baseline data will used as the benchmark for evaluating the outcomes/results at the endline stage, as also will aid the implementation of pilot interventions.

40. Gender Inclusion – During Data Collection: Majority of the field team members deployed for baseline data collection were females. In addition, the children 6-36 months, covered for anthropometric measurement were selected randomly from among the female/male children available in the sample AWC area. During the analysis of baseline data, results were disaggregated by sex, when and where possible.

Ethical Considerations and COVID Protocols

41. ***Ethical Considerations:*** The basic tenants of ethical considerations adopted for the baseline evaluation included: are as follows: taking *informed consent* from respondents for participating in the study; all respondents provided with the *freedom to terminate the interview and not to respond* to questions if they did not feel comfortable; maintain the *privacy and confidentiality* of the respondent's and their responses; and being *respectful of the rights and dignity of all participants.* Besides, all the information collected from respondents was anonymized during analysis and reporting. Along the lines of United Nations Evaluation Group (UNEG) ethical standards, the principles of independence; impartiality; having no conflict of interest; honesty and integrity; competence; accountability; obligations to participants; confidentiality; avoidance of harm; accuracy, completeness and reliability; transparency; were maintained throughout the evaluation.

42. ***COVID Protocol:*** Considering the COVID-19 situation, the prevention protocols adhered during the baseline are:
- The evaluation team ensured that all field team members were healthy and fully vaccinated against COVID and did not have any symptoms related to COVID. They were enquired on a daily basis about any COVID related symptoms, that they may have.
- While being on the field, the field team members wore a face mask, carried hand sanitizers at all times, and washed/sanitized their hands regularly.
- The enumerators for anthropometric measurements also wore a mask at all times. Further, they used gloves while taking measurements and the anthropometric devices were sanitized after each use.

Limitations and their Mitigation Strategies:

43. The evaluation team encountered/faced certain limitations and challenges during baseline data collection and appropriate measures were undertaken to mitigate the same (in consultation with the WFP team). The same are presented in the below:
- As mentioned in para 27, owing to COVID-19 pandemic, case-control design could not be adopted for the baseline. Instead, the baseline has been carried-out along the lines of pre-post intervention comparison (baseline-endline) design (without a control group). Besides, owing to same reason, the THR distribution from AWCs to beneficiaries is in form of dry ration (wheat, rice, pulses). Thus, in baseline evaluation: probes related to THR have been asked with reference to dry ration).
- As no WSHG is currently involved in production and supply of THR (pre-mix) to AWCs; the WSHG members have not been covered for baseline evaluation.

The above aspects will be appropriately addressed at the endline stage, based on situation of COVID-19.

- National and state level statistics/data are not available for all indicates. Wherever, available the baseline data/indicators have been presented in comparison with National Family Health Survey Round 5 (2020-21) data. For other data/indicators, the analysis has been presented using the primary data collected for the baseline.

- To ensure that the field collection team members face no issues on field; the data collection application and CAPI application were revised in consultation with the WFP representatives[16] prior to initiating actual data collection from October 12, 2021. Thereafter, the field teams were provided additional days for data collection, to compensate for the time lost for the respondents not being available because of the festival of Dussehra.

[16] As emerged during the training of data collection teams (organized from October 6-9, 2021)

2. Evaluation findings

44. This chapter presents the brief profile of the respondents and the baseline evaluation findings on the system and community/individual level outcome and output indicators/probes related to the pilot project. Detailed tables/charts for relevant findings are presented at Annex-6 and Annex-7.

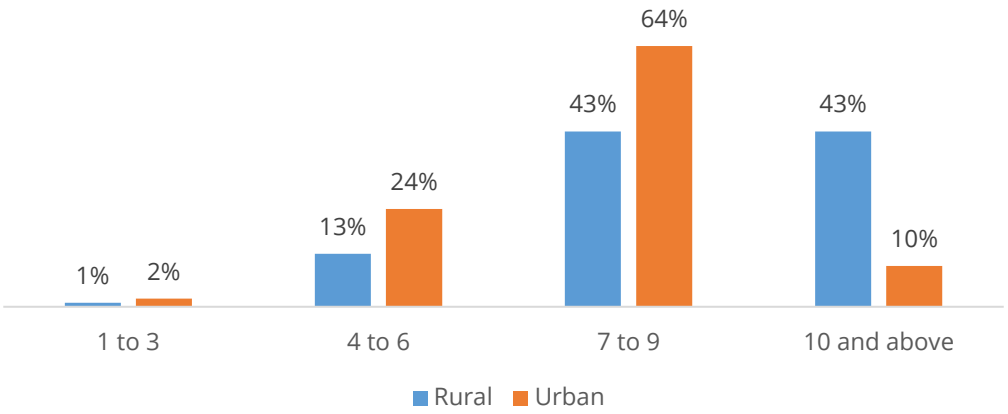
45. Sample Population:

- ***Age Group of the Respondents***: All the sample pregnant women and almost all (99%) the lactating women were in the age group of 18-35 years (Figure 1 at Annex 7). *This indicates that almost all of them are young parents/caregivers and may have more children in future. Thus, an opportunity is available in the project for impacting their Knowledge, Attitude and Practices (KAP) regarding the nutrition and THR consumption for current and future pregnancies.*
- ***Education of the Respondents:*** Among pregnant women, 14% have no education/are illiterate and 30% have passed elementary/high school. Among lactating women, 16% have no education/are illiterate and 38% have passed elementary/high school (Figure 2 at Annex 7). *Considering the low educational level of the pregnant and lactating women, it will be pertinent that while designing the SBCC activities for such beneficiaries under the project; this factor is taken into cognizance.*
- ***Religion and Social Category of the Respondents:*** Majority of the pregnant (76%) and lactating women (75%) follow Hindu religion; and the remaining ones follow Islam (Muslim). Social category-wise, 49% pregnant women and 46% lactating women reportedly belong to Other Backward Classes (OBC) families. Further, 33% pregnant and 32% lactating women belong to either Scheduled Caste (SC) or Scheduled Tribe (ST) category (Figure 3 and 4 at Annex 7). *Since a fourth of the pregnant and lactating women follow Islam; and majority of them belong to the OBC/SC/ST category; it will be pertinent that the local context and culture, norms and practices norms are taken into consideration (without leaving anyone) while designing and implementing interventions and SBCC activities targeting the KAP of these stakeholders regarding nutrition and THR consumption.*
- ***Occupation of the Respondents:*** Reportedly, majority of the pregnant women (88%) and the lactating women (82%) are home makers, that is, as such not engaged in an income generating activity (Figure 5 at Annex 7). *This indicates their dependence upon other family members when it comes to making any expense on their nutrition or healthcare seeking. Given this, the free distribution of good quality and nutritious THR from AWCs needs to be emphasized during the SBCC activities under the project. This will also aid in enhancing uptake of services offered by AWCs and ASHAs, including THR uptake.*
- ***Marital Status:*** Almost all of the pregnant (98%) and lactating women (99%) are reportedly married and living with their spouses (Figure 6 at Annex 7).
- ***Type of Family and Household Size:*** About 84% of the pregnant women and 74% of the lactating women reported their families to be joint families. The remaining ones reportedly were from nuclear families (Figure 7 at Annex 7). *This indicates that most of them are living in households wherein their decision making, especially regarding the nutrition and healthcare is influenced by other family members. Thus, it is suggested that besides the direct beneficiaries, their family members who have a role in influencing their decisions; should also be one of the target groups for the project, especially as part of the SBCC strategy.*
- ***Household size:*** About 47% of the pregnant and 48% lactating women, reported living in households with 4 to 6 members. Further, 39% pregnant and 47% lactating women, reported living in households with 7 or more members (Figure 8 at Annex 7). *Among respondents living in families with 7 or more members, there is a high likelihood of their decisions being influenced by other members of the family. Thus, customised and targeted SBCC for such households would aid in improving the status of nutrition in the project area.*
- ***Availability of Household Assets:*** As a proxy measure of household wealth, the pregnant and lactating women were probed regarding thirteen (13) types of assets17 owned by their household. A higher proportion of the pregnant and lactating women from rural areas (86%)

[17] Thirteen types of assets include - Radio, Telephone/Mobile, Television, Refrigerator, Washing Machine, Coking Stove (Gas), Bed/Sleeping Mats, Table/Chair, Two-Wheeler, Four-Wheeler/Tractor/ Other Vehicle, Electricity Connection, Some Agricultural Land (owned), and Agriculture Equipment.

than those from urban areas (74%) reported having availability of 7 or more of the 13 assets in their household (Figure 9 at Annex 7). Thus, indicating that there are more poor households in urban areas than in rural areas.

Figure 4: Number of Household Assets (%)



46. **Knowledge-Attitude-Practices (KAP) regarding Nutrition during Pregnancy:** During baseline, the knowledge and awareness of the pregnant women was assessed regarding the importance of nourishing diet and good nutrition during pregnancy. Multiple responses were received from 97% of pregnant women in this regard (table below). It must be noted here that over 53% of the pregnant women reported the appropriate importance like 'Child inside the womb grows adequately/healthy', 'Quicker recovery after delivery', and 'For adequate weight gain of pregnant woman'. *This indicates that the in general more than half of the sample pregnant women have appropriate awareness regarding importance of good nutrition during pregnancy. However, there is still scope of improvement in the awareness of pregnant women in this regard, not all pregnant women are aware about all aspects.*

Table 4: Importance of Nourishing Diet and Good Nutrition during Pregnancy (%)- Currently Pregnant Women

Particular	%
Child inside the womb grows adequately/ healthy	71
Quicker recovery after delivery	59
For adequate weight gain of pregnant woman	53
To produce adequate breastmilk	31
For a brainy child with bright future	27
It is a good investment in future	13
To ensure the mother is healthy	10
Extra costs due to doctors and medicine will be saved	7
Do not know	3

47. When asked about how a pregnant woman should eat compared to non-pregnant women, about 73% reported that they should eat 5 variety of foods in addition to roti/rice in her daily diet. Besides, 79% also reported that a pregnant woman should eat yellow/orange vegetables/fruits and dark green leafy vegetables daily. Another 77% also reported taking milk/ milk products daily. *This indicates that as such there is some awareness among the pregnant women about how a woman should eat during her pregnancy, but still a high proportion lack awareness of some of the important aspects.*

Table 5: What Should a Pregnant Woman Eat (%)- Currently Pregnant Women

Particulars	%
Eat dark green leafy vegetables daily	79
Eat yellow/orange vegetables/fruits daily	79
Take milk/ milk products daily	77
Eat 5 variety of foods in addition to roti/rice	73
Take thick dal daily	70
Increase the amount of milk and milk products if you do not consume egg/animal products	22
Take one IFA tablet daily	21
Take two Calcium tablets daily	20
Take nutritious snack daily	19

Particulars	%
Increase amount of food consumed daily	13
Eat egg daily, if acceptable in diet	11
Eat chana (roasted gram)	11
Eat fish/meat daily	7
Eat jaggery	2

48. During their FGD, the adolescent girls (AGs) were also probed to assess their knowledge/awareness regarding importance of nourishing diet and good nutrition during pregnancy. To this, all of them stated that the baby in the womb will receive the nutrition from the food that a pregnant woman consumes and will grow healthier. Besides this, the adolescent girls could not state any specific importance of consuming nourishing diet and good nutrition during pregnancy. *This indicates that the adolescent girls are only partly aware about the aspect.* However, most of the community representatives were aware about the importance of nourishing diet and good nutrition during pregnancy.

49. The pregnant women were also probed about their status of being vegetarian/non-vegetarian; and whether their family discourages them to consume certain foods/drinks during pregnancy. In this regard, reportedly 51% of them were vegetarian, and 49% were non-vegetarian. As regards any restrictions from their family regarding consuming some foods/drinks during pregnancy; 60% reported no such restriction/discouragement from their family. However, the other 40% reported one or more foods/drinks that their family restricts/discourages them to consume. The most reported such food items being 'Papaya', 'jackfruit' and 'Eggs'. The other such reported items being Pineapple, Banana, Ginger/Garlic, Lemon, Radish. There is still a misconception in the community that consuming fruits like Papaya or Jackfruit may lead to miscarriage; that consuming eggs and milks products will make the baby in the womb will grow bigger and lead to complications during delivery. *This indicates that in families of almost 40% pregnant women, there are misconceptions regarding the food items that a pregnant woman should eat or not eat, and owing to such sociocultural family restrictions, many times they are not able to consume nutritious food items. This highlights the need for engagement of mothers-in-laws and husbands as well as community mobilization for positive social norming as the family based restrictions are based on socio-cultural food taboos.*

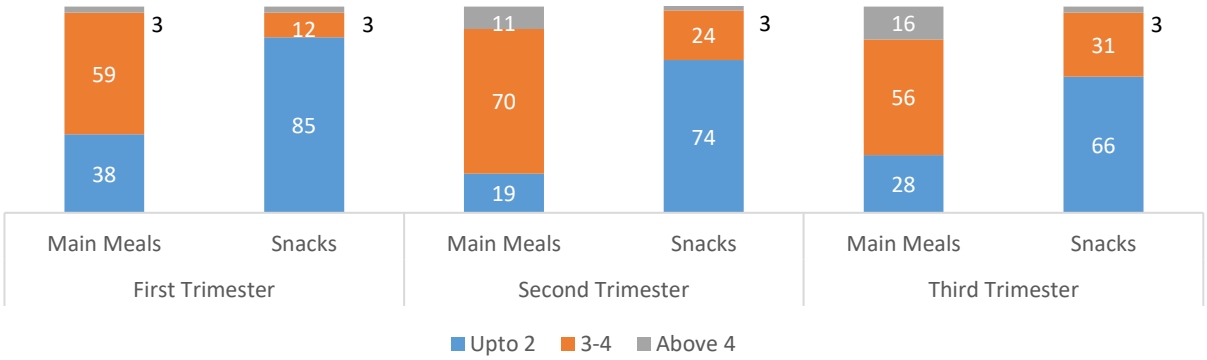
Table 6: Foods/Drinks That are Restricted/Discouraged to be Consumed by Pregnant Women by their Family Members (%) Currently Pregnant Woman

Food Items	%
No food restriction	60
Papaya	38
Jackfruit	9
Meat and poultry (chicken, mutton, lamb, etc.)	5
Eggs	6
Milk and milk products	4
Fish	2
Wheat	**1**
Mango	1
Others	11

50. As per the National Health Mission Guidelines/Booklet for the expecting mothers, a pregnant women should eat one extra meal a day during pregnancy. A well balanced diet consisting of a variety of food helps in the growth of the baby and prevents anaemia[18]. In this context, the pregnant women were also probed about the number of meals a pregnant woman should have in first, second and third trimester of her pregnancy. In this regard, the reported number of meals increase from first trimester to second trimester but decreases from second trimester to third trimester. As for the number of times snacks should be consumed, the reported number keeps increasing from first to second and third semester. *This analysis indicates that as such almost half of the pregnant women are aware about consuming an additional meal during pregnancy and indicates the need of awareness generation among pregnant women their husbands and mother in-laws, to consume an additional meal during pregnancy (as a focus topic for SBCC under the pilot project).*

[18] https://nhm.gov.in/images/pdf/programmes/maternal-health/guidelines/my_safe_motherhood_booklet_english.pdf

Figure 5: Number of Main Meals & Snacks a Woman Should take During Pregnancy (%)- Currently Pregnant Women



51. ***Minimum Dietary Diversity (MDD) for Currently Pregnant Women:*** MDD[19] is a food group diversity indicator that reflects one key dimension of diet quality – micronutrient adequacy. To assess the proportion of pregnant women who have the MDD, they were probed regarding different types of foods consumed by them at different times of the day in last 24 hours. For the purpose of baseline, the grouping of food items was done under nine heads (presented below) and MDD was assessed by checking how many pregnant women have consumed foods from 5 or more of these nine food groups in last 24 Hours:

(i) Grains/cereal, Nuts and Seeds
(ii) Vegetables and Legumes/Beans
(iii) Fruits
(iv) Meat and Poultry
(v) Milk, Butter, Cheese (Clarified Butter), Yoghurt and Dairy Alternatives
(vi) Savoury and Fried Snacks
(vii) Sweets
(viii) Sugar-Sweetened Beverages

52. About 80% of the pregnant women reported consuming food items from 5 or more food groups in the last 24 hours, indicating that have the Minimum Dietary Diversity (MDD). *However, MDD is used as a proxy assessment to describe micronutrient adequacy at the population level, it does not equate to total diet quality. Applying the cut-off of minimum 5 food groups in the daily diet, is only to indicate micronutrient adequacy. Besides, intake of food items from different food groups also varies from season to season. Thus, any SBCC or other activity planned for enhancing the MDD of pregnant women should factors these into consideration.*

Table 7: MDD-Number of Food Groups Consumed in Last 24 Hours - Currently Pregnant Women

Number of Food Groups Consumed in Last 24 Hours	%
Up to 4	20%
5 or More	80%

53. ***Importance of Consuming THR during Pregnancy:*** In this regard, all the pregnant women and the lactating women (when they were pregnant with the reference child) mentioned one or the other reasons for the importance on consuming THR during pregnancy (table below). Almost half or more pregnant and lactating women were aware that 'THR compliments the nutritional requirement during pregnancy' and 'THR helps in appropriate weight gain during pregnancy'.

Table 8: Importance of Consuming THR during Pregnancy (%)

Importance of Consuming THR during Pregnancy	Lactating Women / Caregiver	Pregnant Women
Compliments the nutritional requirement during pregnancy	71	84
For appropriate weight gain during pregnancy	50	49
For healthy birth weight of the child	36	44
For good brain development of the child in womb	24	31
Reduces/prevents the risks of anaemia	20	27

[19] The MDD-W indicator is dichotomous, meaning that it returns the value yes or no. The woman achieves minimum dietary diversity, i.e. yes, if she consumed at least five different food groups during the previous day or night, and no otherwise.

Importance of Consuming THR during Pregnancy	Lactating Women / Caregiver	Pregnant Women
Reduces/prevents other unpleasant pregnancy symptoms such as fatigue and morning sickness	18	16
Can reduce the risk of many birth defects	4	5

54. All the 70 AWWs and 70 ASHAs and 65 ANMs also stated the above reasons for importance of consuming THR during pregnancy. Further, 33% or more of them specifically mentioned 'For good brain development of the child in the womb' as the key importance of consuming THR during pregnancy. Even during the FGDs with adolescent girls, they were found to be aware about the importance of consuming THR during pregnancy. Even during the qualitative interactions with the community representation, almost the same types of reasons were cited by them.

55. The above indicates that, as such, there is awareness among the FLWs, beneficiaries and the community representatives regarding the importance of consuming THR during pregnancy.

56. **Knowledge-Attitude-Practices (KAP) regarding Importance of Nourishing Diet for Children:** The KAP of the lactating women, and the awareness of Frontline Functionaries was assessed in this regard. All the lactating women mentioned one or the other reasons for the importance on consuming nourishing diet by children (table below).

Table 9: Importance of Consuming Nourishing Diet by Children (%)- Lactating women

Particulars	%
For healthy growth	80
For proper weight gain	64
For proper height/length gain	43
For appropriate brain development	41
To develop immunity against illnesses/ diseases	28
For appropriate development of loco-motor skills	11
Do not know	3

57. Besides, all the 70 AWWs and 70 ASHAs and 65 ANMs also stated the above reasons for importance of consuming THR by children, and the most stated reasons by them (30% or more) being:
- Compliments the nutritional requirements
- For appropriate weight gain
- Reduces/prevents the risks of anaemia

58. The above indicates that, there is awareness among the lactating women and frontline functionaries regarding the importance of nourishing diet and feeding THR to a child 6-36 months.

59. **Knowledge and Awareness of Adolescent Girls regarding Nutrition During Adolescence:** During the FGD, the adolescent girls were found to be aware and having appropriate knowledge about importance of nutrition during adolescence. Almost all the adolescent girls in the FGD reported that it is important for them to consume nutritious food for their health, as it will prevent any health complications like anaemia and any issues in pregnancy in future. Besides, they also stated that it will also build their immunity. Some of them also mentioned that it also prevents issues like weakness, fatigue, headaches, etc. The girls also stated that they consume nutritious food 3-4 times a day; and that both boys and girls should consume nutritious food, as both need to stay healthy. The girls did not report any restrictions from their family regarding consuming any specific type of food.

60. **Knowledge-Attitude-Practices (KAP) regarding Breastfeeding:**
Early Initiation of Breastfeeding

61. The pregnant and lactating women and FLWs were probed to assess as to how many of them were aware about early initiation of breastfeeding (immediately after birth/as soon as mother is in position/ within 1 hour of birth). It was also tried to ascertain whether their understanding about initiating the breastfeeding for a female or male child was different. In this regard, 74% pregnant and 83% lactating women were aware about the early initiation of breastfeeding. Whereas all the FLWs were correctly aware about it. Besides, there is no reported difference in the awareness regarding the early initiation of breastfeeding for a female or male child (table below). Further, ICDS project, social category and education-wise also no major deviations were observed in the responses of the pregnant and lactating women. *Among the*

women *not appropriately aware in this regard, most of them were with educational qualifications less than or equal to secondary school (Table 15 and 16 Annex 7). Social category-wise, majority of the* pregnant and lactating women *not appropriately aware in this regard, are from SC, ST and OBC families (Table 17 and 18 Annex 7).*

Table 10: Awareness Regarding Early Initiation of Breastfeeding

Respondents	Correctly Aware about when Breastfeeding should be Initiated	
	For a Male Child	***For a Female Child***
Pregnant women	74%	
Lactating women	83%	83%
AWWs	100%	100%
ASHAs	100%	100%
ANMs	100%	100%

62. The above analysis indicates that 26% pregnant and 17% lactating women are still not correctly aware about when the breastfeeding should be initiated for a new born. *Under the proposed SBCC component of the pilot project, these women, their husbands and mother in-laws need to be counselled about the aspects related to early initiation of breastfeeding.*

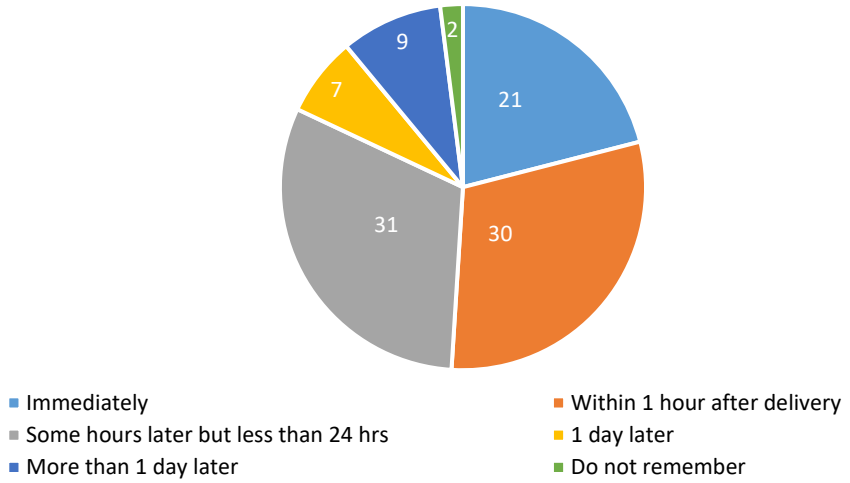
63. When pregnant and lactating women were also probed about what they think about when a baby should start breastfeeding soon after birth, a range of multiple responses were received. The majorly reported reasons being 'Initiating breastfeeding within 1 hour can save baby's life and it is good for baby's health' and 'Colostrum is good for the baby' (table below). *This indicates good understanding and awareness among the respondents about the early initiation of breastfeeding.*

Table 11: Reasons for Why Should a Baby Start Breastfeeding Soon After Birth (%)

Reasons	Pregnant women	Lactating women
Colostrum is good for the baby	51	60
Initiating breastfeeding within 1 hour can save baby's life	39	40
Initiating breastfeeding within 1 hour is good for the child's health	33	31
Initiating breastfeeding within 1 hour can improve breastmilk supply	15	28
Initiating breastfeeding within 1 hour can reduce mothers bleeding	10	-
Don't know	17	7

64. To assess the existing practice, the lactating women were also probed about when they actually initiated breastfeeding to their child. In this regard, while 83% of them were reportedly aware/have knowledge about early initiation of breastfeeding; but only half (51%) reported initiating breastfeeding immediately after birth/as soon as mother is in position/ within 1 hour of birth (figure below). *Thus, indicating the gaps between the knowledge and actual practice. Here also, under the SBCC component of the project; it is required that the women, their husbands and mother in-laws are counselled on aspects related to early initiation of breastfeeding. Besides, the frontline functionaries also need to be capacitated in providing required counselling to the women and their family members in this regard.* As per NFHS-5 data, 42% children under 3 years in India, 41% in Rajasthan and 41% in Jaipur district, are breastfed within one hour of birth. Thus, though the status in sample areas is better than the national, state and district averages, it is not satisfactory.

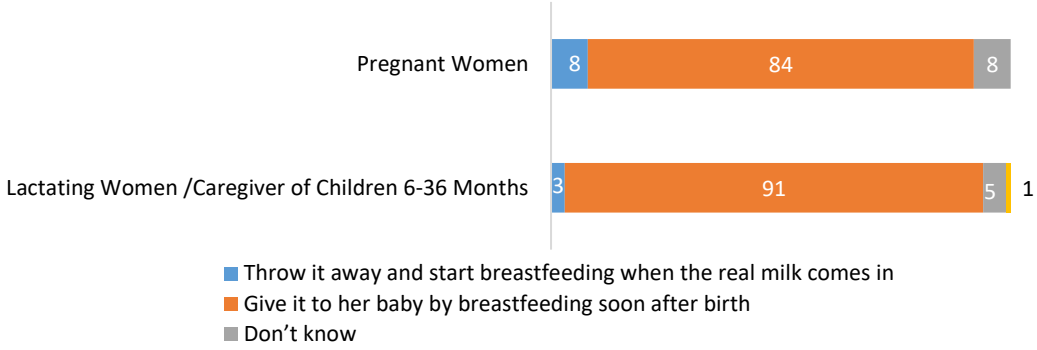
Figure 6: Practice regarding Early Initiation of Breastfeeding (%) : Lactating Women



Colostrum Feeding

65. The pregnant and lactating women and the frontline functionaries were probed to assess as to how many of them were aware about what should be done with colostrum and what is the importance of feeding colostrum to the child. To this, 84% pregnant women and 91% lactating women reported that colostrum should be fed to the child soon after birth. However, 8% pregnant and 3% lactating women also reported that colostrum should be thrown and breastfeeding should be started when the real milk comes in. Besides, 8% and 5% of the pregnant and lactating women, respectively, were reportedly unaware about what should be done with Colostrum. *Most of the pregnant and lactating, who reported that colostrum should be thrown, were either illiterates or had up to elementary school education. This indicates that there are still misconceptions in less educated women about colostrum feeding. Thus, such women along with their husbands and mother in-laws should be a target group on aspects related to colostrum feeding and the SBCC activities/material under the pilot project should be designed/customised appropriately for them.*

Figure 7: What Should be Done with Colostrum "first milk" (%)



66. The pregnant and lactating women, frontline functionaries, adolescent girls and community representatives were also probed about according to them is the importance of feeding colostrum to the new born. Here also a range of multiple responses were received. The majorly reported reasons being 'Colostrum provides good source of nutrition', 'Colostrum is rich in nutrients and is good source of nutrition', and 'Colostrum boosts immunity' (table below). During the FGD/IDIs, the adolescent girls, and the community representatives were also found to be aware about the *importance of feeding colostrum to the new born*, and most of them reported the same reasons as presented in table below. *This indicates good understanding and awareness among the respondents including the* frontline functionaries *about the importance of feeding colostrum to the new born.*

Table 12: Reasons for Why Should a Baby Start Breastfeeding Soon After Birth (%)

Reasons	Pregnant women	Lactating women	AWWs	ANMs	ASHAs
Provide good source of nutrition	65	66	87	89	84
It is rich in protein, fat, and other necessary elements; and is good source of nutrition for the baby	51	53	43	49	49
It is extremely rich in antibodies; and acts as the first immunization of the child	16	28	40	57	41
Providing some protection from inflammation and killing potentially harmful microorganisms /Protects against allergies	12	17	19	22	17
Boosts Immunity	41	42	91	79	85
Having laxative properties that can help baby have the first stool	7	7	11	8	11
Lessens the chance of jaundice	9	7	17	11	20
Don't know	21	12	-	-	-
Others	2	3	-	2	4

67. To assess the existing practice, the lactating women were also probed about did they actually gave colostrum to their child. In this regard, while 89% reported feeding colostrum. *With 91% being aware about the importance, and 89% reporting feeding colostrum to their child, indicates that as such there is no gap between the knowledge and actual practice regarding colostrum feeding.*

Exclusive Breastfeeding for Six Months

68. The pregnant and lactating women, frontline functionaries, adolescent girls and community representatives were probed to assess as to how many of them were aware about the duration of exclusive breastfeeding for a child (for six months from birth). In this regard, 94% pregnant women reported that a child should be exclusively breastfed for six months. Among the lactating women, 96% reported that a male child should be exclusively breastfed for six months; and 95% reported the same for a female child. All the frontline functionaries appropriately also stated the duration to be six months for both, female and male children. Further, majority of the adolescent girls and community representatives were also aware about the same. *This indicates good understanding and awareness among the respondents about the duration of exclusive breastfeeding for a child.*

Table 13: Awareness Regarding Early Initiation of Breastfeeding (%)

Respondents	Correctly Aware about Exclusive Breastfeeding Duration	
	For a Male Child	***For a Female Child***
Pregnant women	94%	
Lactating women	96%	95%
AWWs	100%	100%
ASHAs	100%	100%
ANMs	100%	100%

69. To cross check the awareness/understanding regarding exclusive breastfeeding, the pregnant and lactating and frontline functionaries were probed about what all foods/drinks can be given to a child less than six months of age. In this regard, all the frontline functionaries, 95% pregnant women and significantly lesser[20] proportion of lactating women (89% for a male child and 88% for a female child) correctly reported that a child should only be breastfed for first six months. During qualitative discussions, all the adolescent and community representatives correctly stated that the chid should only be fed mothers milk till 6 months of age. However, about 13% or more of the pregnant and lactating women reported that a child less than six months can be fed other food/drinks besides mothers' milk (table below). Further, 43% pregnant and 12% lactating women also stated that water should be given to a child less than 6 months if the weather is hot. *This indicates that despite high awareness among the pregnant and*

[20] Significant difference at 95% confidence interval (2-tailed)- z score = 2.852225 for male child and z score = 3.070126 for female child

lactating women (table above); there are still a lack of understanding about exclusive breastfeeding; which needs to be focussed upon under SBCC component of the pilot project.

Table 14: What All Foods/Drinks Can be Given To A Child Less Than Six Months of age (%)

Respondent	Breast milk only	Breast milk and water	Breast milk and other liquids	Water if weather is hot	Don't Know	Others
Pregnant women	95	5	8	43	-	-
Lactating women- to a male child	89	6	7	12	1	1*
Lactating women- to a female child	88	6	8	-	1	1*
AWWs- to a male child	100	-	-	-	-	-
AWWs- to a female child	100	-	-	-	-	-
ASHAS- to a male child	100	-	-	-	-	-
ASHAs- to a female child	100	-	-	-	-	-
ANMs- to a male child	100	-	-	-	-	-
ANMs- to a female child	100	-	-	-	-	-
**: Porridge, Khichdi, Mashed Banana, Mashed Biscuit with Milk*						

70. To further assess the awareness and understanding; the pregnant and lactating women were also probed about what according to them is the importance of exclusive breastfeeding. Multiple responses were received in this regard, the most reported ones being 'Protects baby from illness', 'Helps baby grow and develop better' and 'Provides a superior source of nutrients'. *This indicates good understanding and awareness among the respondents about the importance of exclusive breastfeeding.*

Table 15: Importance of Exclusive Breastfeeding (%)

Importance	Pregnant women	Lactating women
	%	%
Protects baby from illness	65%	66%
Helps baby grow and develop better	49%	55%
Provides a superior source of nutrients	40%	41%
Stimulates brain development of the baby	35%	25%
Stimulates breast milk production	24%	29%
Provides adequate water for a baby in the six months	20%	27%
Easy to digest	15%	23%
Increased emotional bonding between mother and child	14%	16%
Good for mother's health (decreases breast & ovarian cancer)	11%	12%
Clean, always ready and of a good temperature	7%	13%
Delays a new pregnancy	5%	8%
Don't know	12%	7%
Others	1%	3%

71. As regards the existing practice, 95% of lactating women reported exclusively breastfeeding their child for 6 months. As per NFHS-5 data, 64% children under 3 years in India, 70% in Rajasthan and 68% in Jaipur are exclusively breastfed for six months. Thus, the status of exclusively breastfeeding for six months in sample areas is better than the national, state and district averages. However, 12% of lactating women are such, who have reported that other food/drinks can be given to a child less than 6 months. Thus, 95% of the lactating women reporting to exclusively breastfeed their child for 6 months, is not certain. *Thereby, indicating that there is a gap between the awareness and understanding among the lactating women about exclusive breastfeeding; which needs to be focussed upon under SBCC component of the pilot project.*

Figure 8: Duration of Exclusive Breastfeeding (%) (Lactating Women)

Initiation of Complementary Feeding after Six Months

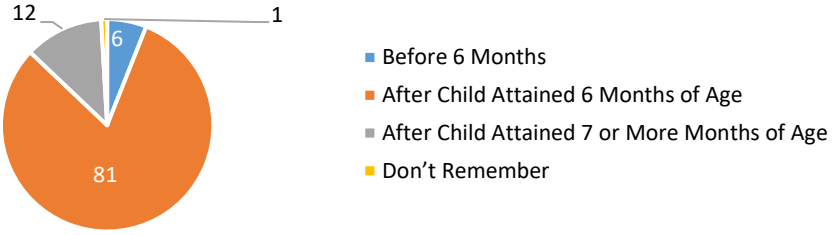
72. The pregnant and lactating women, frontline functionaries, adolescent girls and community representatives were probed to assess as to how many of them were aware about when should the complimentary feeding be initiated for a child. In this regard, 88% pregnant women reported that a complementary feeding a child should be initiated after the child attains 6 months of age. Among lactating women, 81% reported that for both, a male and a female child, complementary feeding should be initiated after 6 months. All the frontline functionaries appropriately also stated the complementary feeding for both, male and female child should be initiated after 6 months. Further, all the adolescent girls and majority of the community representatives were also aware about the same. *This indicates good understanding and awareness among the respondents about the when should the* complementary feeding *be initiated. However, still there is a need to educate and counsel the pregnant and lactating women, and their husbands and mother in-laws; about the importance of initiating* complementary feeding *after the child attains 6 months of age.*

Table 16: Awareness Regarding at Which Age Complimentary Feeding Should be Initiated (%)

Respondents	Respondents Reporting that Complimentary Feeding Should be Initiated After the Child Attains 6 Months of Age	
	For a Male Child	***For a Female Child***
Pregnant women	88%	
Lactating women	81%	81%
AWWs	100%	100%
ASHAs	100%	100%
ANMs	100%	100%

73. As regards the existing practice, 81% of lactating women reported that they had initiated complimentary feeding after their child attained six months of age. However, 6% and 12% also reported that they had initiated complementary feeding before the child attained 6 months and after 7 months or more, respectively. *Thus, indicating a gap between the awareness and actual practice among lactating women regarding the initiation of weaning.* As per NFHS-5 data, 46% children *6-8 months* in India and 38% in Rajasthan *receive solid or semi-solid food and breastmilk*. Thus, the status of initiating the complimentary feeding after the child attains six months of age in sample areas is better than the national and state averages. Besides, *80% lactating women also reported collecting THR regularly from AWC for their child (7% girl and 83% boys).*

Figure 9: Practice regarding Initiation of Complementary Feeding – Age at Which Complementary Feeding was Initiated (%)- Lactating women



74. To further assess the awareness and understanding of the FLWs; they were also probed about what all types of foods/drinks can be given to a child 6-36 months. Multiple responses were received in this regard,

the most reported ones being 'Mothers Milk', 'Mashed Pulses/Dal', 'Mashed Chapati/Roti', 'Mashed Banana' and 'Mashed Potato', etc. (Table 4 at Annex 7). *This indicates that FLWs are largely aware about the foods/drinks that should be provided to a child 6-36 months to meet its growing nutritional requirements.*

Continued Breastfeeding

75. The pregnant and lactating women, frontline functionaries, adolescent girls and community representatives were probed to assess how many of them were aware about till what age a child should be continued to be breastfed. In addition, it was also tried to assess if they felt there was any difference in continuing breastfeeding to a male and a female child. In this regard, only 42% pregnant women reported that a child should be continued to be breastfed till the age of 24 month. With the lactating women, it was also tried to assess as to whether their understanding about continued breastfeeding for a female or male child was different. To this, 46% lactating women reported that in case of both male and female child, they should be continued to be breastfed till the age of 24 months. Among the FLWs, more AWWs (80%) and ASHAs (70%) than the ANMs (45%) reported that male and female child, both should be continued to be breastfed till the age of 24 months of age.

However, all adolescent girls and majority of the community representatives correctly stated that a child should be continued to be breastfed till the age of 24 months or more. *Thus, indicating that there is comparatively higher awareness among the adolescent girls and community representatives regarding continued breast feeding till 24 months of age*

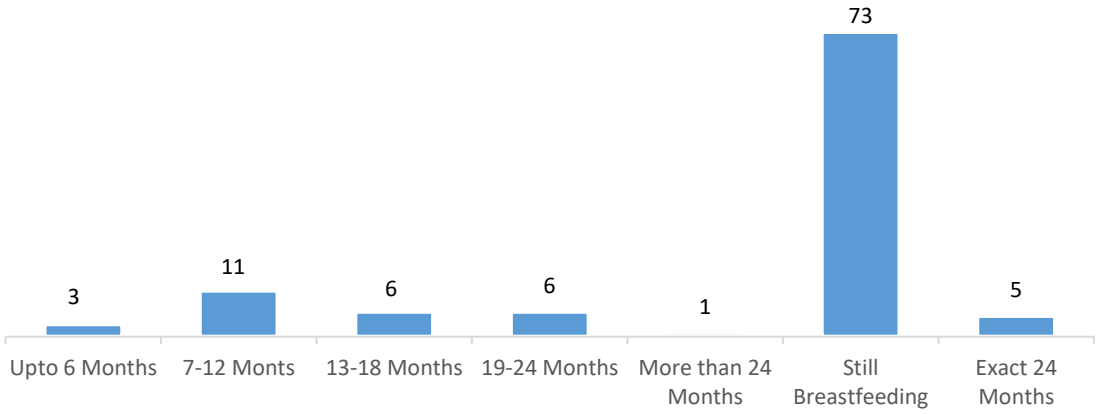
76. The above analysis indicates that over half of the pregnant and lactating women are not aware about the age till which a child should continue to breastfeed. Besides, many frontline functionaries also do not have appropriate knowledge in this regard. *Thus, under the SBCC component of the pilot project; there should be special emphasis on this aspect for both, pregnant and lactating women and the frontline functionaries.*

Table 17: Duration of Continued Breastfeeding (%)

Respondent	6 - 12 Months	13-24 Months	Above 24 Months	Don't Know	24 Months
Pregnant women	37.0	52.0	3.0	8.0	42
Lactating women – for a male child	25.0	60.0	13.0	2.0	46
Lactating women – for a female child	25.0	58.0	15.0	2.0	46
AWWs- to a male child	10.0	86.0	4.0	-	80
AWWs- to a female child	10.0	86.0	4.0	-	80
ASHAS- to a male child	7.0	79.0	14.0	-	70
ASHAs- to a female child	7.0	79.0	14.0	-	70
ANMs- to a male child	23.0	63.0	14.0	-	45
ANMs- to a female child	23.0	63.0	14.0	-	45

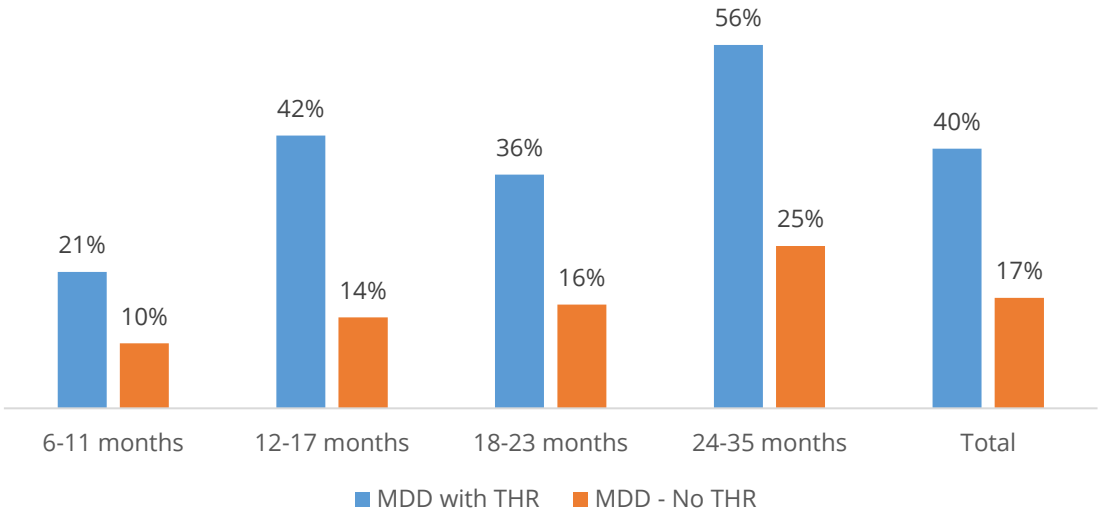
77. To assess the existing practice, the lactating women were also probed about the duration till they continued to breastfeed their child. In this regard, 21% lactating women reported breastfeeding their child for less than 24 months. Exact 24 months were reported by 5% of the lactating women. Whereas 73% of lactating women reported still/currently breastfeeding their child. *Thus, again indicating that owing to the lack of correct knowledge, the* lactating women *are not adhering to the recommend practice of continuing to breastfeed the child till 24 months of age. Thus, there is a need to focus upon this aspect under the SBCC component of the pilot project. Overall, 67% children were reportedly breastfed a day prior to the baseline survey (68% girl and 66% boys).*

Figure 10: Practice regarding Continued Breastfeeding (%)



78. ***Minimum Dietary Diversity (MDD) for Children 6-36 Months:*** Here again, to assess the MDD in daily diet; it was endeavoured to assess how many children have consumed foods from 4 or more of the seven food groups in last 24 Hours (grains, roots and tubers; legumes and nuts; dairy products (milk, yogurt, cheese); flesh foods (meat, fish, poultry); eggs; vitamin A-rich fruits and vegetables; and other fruits and vegetables)[21]. However, the diet of children varies with their age group. Thus, while assessing the MDD for children, they have been categorized into different age groups and as per the status of regularly receiving THR for them. The status of having MDD increase with the increase in the age group. However, it also indicates almost two-third children 6-11 months and almost half in the age group of 18-23 months do not have MDD in their daily diet. *The above analysis indicates that at an aggregate almost 57% children have the MDD in their daily diet. This situation is not very encouraging. It is required that under the SBCC component of the pilot project, the* lactating women and the fathers and grandmothers of the children *are appropriately made aware, counselled, and motivated to ensure MDD in daily diet of their children as per their age.*

Figure 11: MDD-Number of Food Groups Consumed in Last 24 Hours- Children 6-36 Months



79. **Knowledge-Attitude-Practices (KAP) regarding Care and Nutrition During Pregnancy:** In this regard the KAP regarding registration of pregnancy, availing Ante Natal Care (ANC) services, and Iron Folic Acid (IFA) supplementation of the pregnant and lactating women /caregivers of children 6-36 months (when they were pregnant with reference child), was assessed. Besides the knowledge and awareness of the frontline functionaries was also assessed on these aspects.

Registration of Pregnancy

[21] Minimum Dietary Diversity (MDD) indicator as defined by WHO

80. As regards the registration of pregnancy at a facility, all the pregnant and lactating women[22] (99.5%) reported having registered their pregnancy.

81. **Motivator for Pregnancy Registration:** When probed regarding who motivated/helped/supported in registration of pregnancy (Figure 13 at Annex 7);

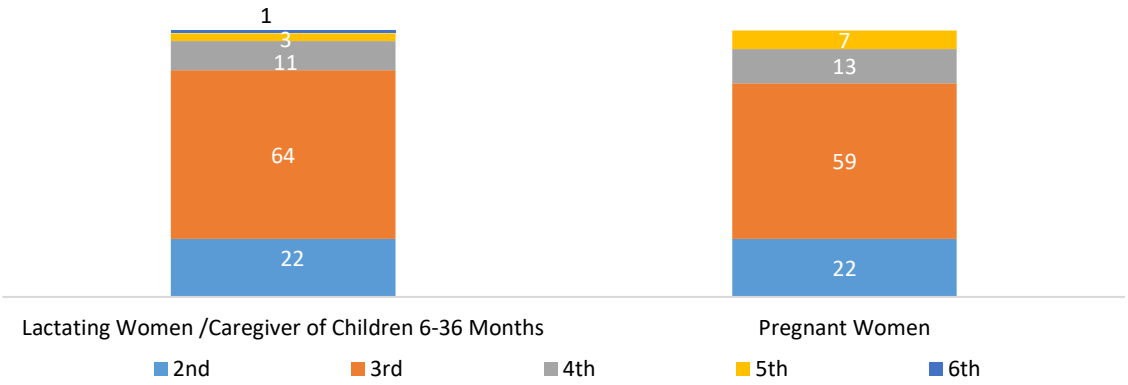
- AWW was reported by 50% pregnant and 57% lactating women
- ASHA was reported by 42% pregnant and 24% lactating women
- Self-motivation was reported by reported by 22% pregnant and 23% lactating women

This indicates that in case of 81% or more pregnant and lactating women, the AWW and ASHA are the key motivators behind pregnancy registration.

82. **Facility/place of Pregnancy Registration:** Almost all the pregnant and lactating women (when they were pregnant with reference child), reported registering their pregnancy at the local AWC. This is followed by 31% and 33% of the pregnant and lactating women, respectively, who, reported, registering at District Hospital (Figure 14 at Annex 7). *This indicates that for both, the pregnant women and the lactating women (when they were pregnant with reference child), AWC is/was the first choice for pregnancy registration. Thus, all these women were/are entitled to receive the THR and other services being provide at the AWCs.*

83. **Registration of Pregnancy In First Trimester:** As regards the month of pregnancy in which the registration was done; 22% of both, the pregnant and lactation women (when they were pregnant with reference child), reported registration of their pregnancy when they were two months pregnant. Further, 59% pregnant and 64% lactating women, reported registration of their pregnancy when they were three months pregnant. *This indicates that 81% pregnant and 86% lactating women (when they were pregnant with reference child), had got their pregnancy registered in first trimester itself. This indeed is an encouraging situation.*

Figure 12: Month of Pregnancy in which the Pregnancy was Registered (%)



Receiving ANC Check-up in First Trimester of Pregnancy

84. When probed regarding the month in which the first ANC service was received, 75% pregnant women and 74% lactating women (when they were pregnant with reference child), reported, receiving it in the first trimester itself (2nd or 3rd month) -Figure 15 at Annex 7. *As per NFHS-5 data, 70% pregnant women in India, 76% in Rajasthan and 81% in Jaipur received ANC in the first trimester. Thus, while the status of receiving ANC in first trimester in sample areas is higher than the national average, it is almost equal to the state average and lower than the district average.*

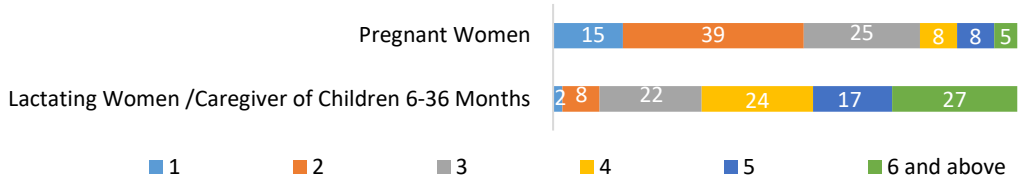
Number of Ante Natal Check-ups Received

85. As regards the number of antenatal check-ups received, 21% pregnant and 68% lactating women (when they were pregnant with reference child), reported, receiving four or more check-ups. As per NFHS-5 data, 58% pregnant women in India, 55% in Rajasthan and 53% in Jaipur received at least four or more antenatal check-ups. *As regards the sample pregnant women, the number of ANC check-ups may change by the time they*

[22] When they were pregnant with the reference child

deliver the child. However, as regards the lactating women (when they were pregnant with reference child), the status of number of receiving four or more check-ups is better than the national, state and district averages.

Figure 13: Number of ANC Check-ups Received During Pregnancy (%)



Knowledge-Attitude-Practice regarding Iron Folic Acid (IFA) Consumption

86. **Awareness regarding Importance of IFA:** The pregnant and lactating women were probed about what according to them is the importance of consuming IFA during pregnancy. To this, multiple responses were received (table below). *Most the lactating women reported more reasons related only to the health of a pregnant women. On the other side, most of the pregnant women stated reasons related to the health of a pregnant women as also those related to the health of the child in the womb. Thus indicating, that comparatively higher awareness among pregnant women than lactating women about the importance of consuming IFA during pregnancy.*

Table 18: Duration Importance of IFA Consumption during Pregnancy

Importance	Pregnant women	Lactating women
To reduce the risk of anaemia for pregnant women	55	66
To reduce risk of anaemia for the child inside womb	49	-
To reduce the risk of low birth weight	28	-
To help improve child's intelligence	42	-
To reduce risk of death from excessive blood loss during/after delivery	23	25
To make mother healthy/strong	52	-
Helps in proper development of the brain, skull, and spinal cord of baby in womb	-	30
Helps the body make healthy red blood cells	-	72
Other	-	5
Don't know	8	-

87. **Awareness regarding initiation of IFA Consumption:** As per the guidelines[23] of the National Health Mission (NHM), Government of India, all pregnant women need to be given one tablet of IFA (100 mg elemental iron and 0.5 mg folic acid) every day for at least 100 days, starting after the first trimester at 14–16 weeks of gestation. In this context, the pregnant women were also probed about from which month of pregnancy should a woman start consuming IFA. To this, 65% pregnant women reported that a pregnant woman should start taking IFA from 3rd or 4th or 5th month (Figure 16 at Annex 7). *This indicates, almost a third of* pregnant women *are such who do not have correct knowledge regrading when the IFA consumption should be initiated during pregnancy. Thus, under the SBCC component of the pilot project, awareness generation about starting of IFA after first trimester of pregnancy should be an emphasis area.*

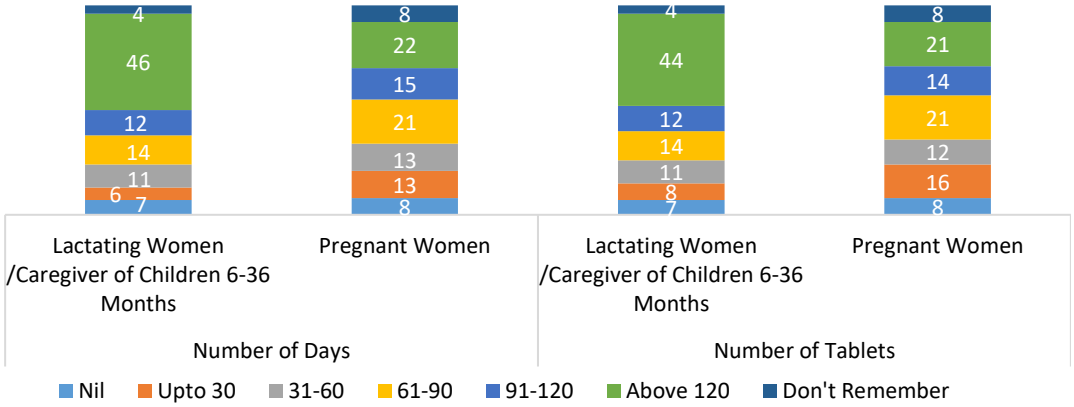
88. **Number of Days and Number IFA Tablets to be Consumed during Pregnancy:** The pregnant women were also probed about for how many days and how many IFA tablets should a pregnant woman consume. To this, 65% stated that a pregnant woman should consume IFA for 91 or more day during pregnancy (6% or 9 of 152 sample pregnant women specifically reported that 100 IFA tablets should be taken during pregnancy). As regards the number of IFA tablets, 63% reported that 91 or more tablets should be consumed during pregnancy (11% or 16 of 152 sample pregnant women specifically reported 100 IFA tablets should be consumed during pregnancy). *This analysis indicates that as almost a third of the pregnant are not aware about the number of days and number of IFA tablets to be consumed during pregnancy.*

89. To assess the practice, the pregnant women and lactating women (when they were pregnant with the reference child) were also probed about for how many days and how many tablets have they/did they consume during their pregnancy. To this, 37% pregnant and 58% lactating women (when they were

[23] https://www.nhm.gov.in/images/pdf/programmes/child-health/guidelines/Control-of-Iron-Deficiency-Anaemia.pdf

pregnant with the reference child) reported consuming IFA tablets for 91 days or more during their pregnancy (31 of 152 pregnant and 3 of 809 lactating reported consuming IFA tablets consumed for exactly 100 days during their pregnancy). As regards the number of IFA tablets consumed, 35% pregnant and 56% lactating (when they were pregnant with the reference child) reported consuming 91 or more IFA tablets during their pregnancy (22 of 152 pregnant and 4 of 809 lactating reported consuming exactly 100 IFA tablets during their pregnancy). As per NFHS-5 data, 44% pregnant women in India, and 34% in Rajasthan and 21% in Jaipur consumed Iron Folic Acid (IFA) for 100 days or more when they were pregnant. *The status of IFA consumption in project areas is as such better for lactating women but lower than the national average for pregnant women. It is, however, higher than the state and district averages. This analysis indicates lack of awareness among pregnant women, as also the lack of the translation of awareness into action among those pregnant and lactating women aware about IFA consumption. Besides, most of the pregnant not appropriately aware in this regard are from OBC and SC families. The reasons behind the same need to be separately probed by having interactions with women in the community in this regard. Based on the emerging reasons, under SBCC special emphasis should be laid on addressing those factors impacting consumption of IFA tablets by women, especially among the pregnant women of marginalized social groups.*

Figure 14: Number of Days and Number of IFA Tablets Consumed During Pregnancy (%)



Awareness/Knowledge of FLWs regarding ANC Related Aspects

90. Almost all the frontline functionaries were found to be aware about registration of pregnancy and availing first ANC in first trimester; and that a pregnant woman should consume one additional meal in day. However, as regards the number of days and tablets to be consumed, not all frontline functionaries are aware about these aspects. A woman should gain 10 to 12 kg during pregnancy[24], in order to elevate the likelihood of giving birth to a healthy baby, with less risk of foetal and maternal complications. In this regard, about half (49%) of the ANMs, 30% ASHAs and 20% AWWs could correctly state the same. *The analysis indicates that the* frontline functionaries *also lack correct knowledge on ANC related aspects like IFA consumption and weight gain during pregnancy. Thus, under the SBCC component of the project, emphasis should be laid on knowledge building of* frontline functionaries *on these aspects.*

Table 19: Awareness of FLWs on ANC Related Aspects (%)

Aspects of Awareness	AWWs	ASHAs	ANMs
Pregnancy registration should be done in first trimester	90	100	100
First ANC should be done in first trimester	84	97	97
A pregnant woman should consume IFA tablets for at least 100 days	69	76	88
A pregnant woman should consume at least 100 IFA tablets	80	84	89
A pregnant woman should gain 10 to 14 kg during pregnancy	20	30	49
A pregnant woman should have 4 meals daily	97	97	99

Beliefs, Self-efficacy and Social Norms

A. Pregnant Women

91. The pregnant women were probed to assess their beliefs, self-efficacy and social norms related to their nutrition, care during pregnancy, nutrition of children, etc. They were presented with situations and were

[24] As per Indian Council for Medical Research (ICMR): https://www.nin.res.in/downloads/DietaryGuidelinesforNINwebsite.pdf

asked to state how much did they agree with it (strongly disagree, disagree, neither agree nor disagree, agree, strongly agree).

92. **Beliefs:** The analysis of the responses of pregnant women regarding their beliefs on the aspects (who stated to agree and strongly agree with the probes) is presented in table below. While the beliefs of 90% or more pregnant women are beneficial to nutrition uptake regarding other practices; the belief of 50% pregnant women regarding exclusive breastfeeding is harmful to nutritional intake. *Thus, there is a need to educate, make aware and counsel the pregnant about the appropriate and correct exclusive breastfeeding practices.*

93. **Self-efficacy:** The analysis of the responses of pregnant women regarding their self-efficacy on various aspects related to nutrition during pregnancy (who stated to agree and strongly agree with the probes) is presented in table below. While self-efficacy regarding other practices of 88% or more pregnant women are beneficial to nutrition intake; 68% pregnant women also stated that recommend food to be consumed during pregnancy is costly. The THR is being distributed free of cost from the AWCs to compliment the recommended nutritional requirements of pregnant women, and 72% pregnant women are also currently availing THR from the AWCs. *Thus, the understanding of pregnant women about recommend food being costly is harmful to nutritional intake. Besides 89% pregnant women have stated that they can follow recommendations of taking IFA every day during pregnancy. However, only* 37% pregnant women reported consuming IFA tablets for 91 days or more during their pregnancy. *Thus, under SBCC component of the pilot project, special emphasis should be laid on addressing these aspects with the pregnant women and their husbands and mother in-laws.*

94. **Social Norms and Practices:** The analysis of the responses of pregnant women regarding the social norms regarding care and nutrition during pregnancy (who stated to agree and strongly agree with the probes) is presented in table below. While the understanding of 88% or more pregnant women regarding other social norms are beneficial to nutritional intake; the social norms regarding number of meals and certain types of foods that a woman should avoid in pregnancy are harmful to nutritional intake in families of 55% of them. As already mentioned, there is lack of awareness among pregnant women regarding the number of meals to be consumed daily during pregnancy; as also misconception in families of 40% pregnant women regarding what all food items should a pregnant woman eat or not eat. *This indicates that despite awareness about nutrition, owing to family restrictions and or social norms (like those mentioned in Para 44), many times pregnant woman are not able to consume nutritious food items or required number of meals daily. These aspects need to be focus topics for SBCC under the pilot project.*

Table 20: Beliefs, Self-efficacy and Social Norms of Currently Pregnant Women (%)- Those Who Agree and Strongly Agree

Beliefs	%
My consuming right types and amount of food during pregnancy is extremely important for my health and my unborn child's health	97
My consuming of IFA every day during pregnancy is important for my health and my unborn child	95
If I breastfeed my infant within 1 hour after giving birth, It'll be good for my health and my child's health	91
My consuming right types and amount of food during pregnancy can save cost due to doctors and medicine	90
My consuming of calcium every day during pregnancy is important for my health and my unborn child	90
If I feed my infant a combination of breast milk and infant formula until s/he completes 6 months, I am giving him/her the BEST possible nutrition.	50
Self-efficacy	
I can follow the recommendations of 5 varieties of food to be consumed along with roti/rice during pregnancy	93
I can follow the recommendations of taking Calcium every day during pregnancy	91
I can follow the recommendations of taking IFA every day during pregnancy	89
I can follow the recommendations of consuming THR during pregnancy	88
It is too costly to obtain the recommended types and amounts of foods for my consumption during pregnancy	68
Social Norms	
Most people who are important to me (e.g. family members, friends…) think that a pregnant woman should take IFA every day during pregnancy	91
Most people who are important to me (e.g. family members, friends…) think that a pregnant woman should consume THR during pregnancy	90
Most people who are important to me (e.g. family members, friends…) think that a pregnant woman should take calcium every day during pregnancy	89

In my family and community we/people expect pregnant women to consume five varieties and larger quantity of food to get enough energy and nutrition during pregnancy	88
Most people who are important to me (e.g. family members, friends…) think that a mother can breastfeed her infant within 1 hour after birth	86
Most people who are important to me (e.g. family members, friends…) think that a pregnant woman should not eat too much to avoid difficult labour due to large baby	55
In my family and community, pregnant women are expected to avoid certain kinds of foods (meat, fish, papaya, jackfruit, milk, etc.) because it will harm the mother and/or baby	72

95. **Sources of Information:** The most reported sources of information of pregnant women regarding care and nutrition during pregnancy and nutrition of infants and young children are the AWW, their Mother-in-law and the ASHA, in decreasing order (Figure 17 at Annex 7)

B. Lactating Women/Caregivers of Children 6-36 Months

96. The lactating women were also probed to assess their beliefs, self-efficacy and social norms related to breastfeeding, nutrition and feeding practices for their children. They were presented with situations and were asked to state how much did they agree with it (strongly disagree, disagree, neither agree nor disagree, agree, strongly agree).

97. **Beliefs:** The analysis of the responses of lactating women regarding their beliefs on the aspects (who stated to agree and strongly agree with the probes) is presented in table below. While the beliefs of 90% or more lactating women are beneficial for nutritional intake regarding other practices; the belief of 66% regarding exclusive breastfeeding is harmful for nutritional intake. *Thus, there is a need to educate, make aware and counsel the lactating women, their husbands and mother in-laws about the appropriate and correct exclusive breastfeeding practices.*

98. **Self-efficacy:** The analysis of the responses of lactating women regarding their self-efficacy on various aspects related to breastfeeding and nutrition of their children (who stated to agree and strongly agree with the probes) is presented in table below. While the belief of 91% or more lactating women are beneficial for nutritional intake regarding other practices; the belief of 68% who reported that recommend food to be consumed by their child to be costly is harmful for nutritional intake. The THR is being distributed free of cost from the AWCs to compliment the recommended nutritional requirements of children, and 92% lactating women are also currently availing THR from the AWCs for their child. *Thus, the understanding of lactating women about recommend food being costly is harmful for nutritional intake. This analysis also indicates that despite having awareness about THR, its importance and availing it for their child; there is a gap in understanding about what types of recommended foods compliment the nutritional requirements of children. Under SBCC component of the pilot project, special emphasis should be laid on addressing these aspects with the pregnant women.*

99. **Social Norms/Practices:** The analysis of the responses of lactating women regarding the social norms regarding care and nutrition during pregnancy (who stated to agree and strongly agree with the probes) is presented in table below. While the understanding of 88% or more lactating women are beneficial to nutritional intake regarding other social norms; the social norms regarding certain types of foods that a child should be avoided to be fed are harmful to nutritional intake in families of 60% of them. *This indicates that despite awareness about nutrition, many times lactating women are not able to feed nutritious food items or to their child. These aspects need to be probed separately and the emerging reasons should be addressed under the SBCC activities of the pilot project.*

Table 21: Beliefs, Self-efficacy and Social Norms of Lactating Women/ Caregivers of Children 6-36 Months (%)- Those Who Agree

Beliefs	%
Feeding first milk/colostrum to prevents the child for infections/diseases and acts as first immunization	95
After six months, giving solid/semi solid food and other liquids should be started for a child	94
Breastfeeding should be initiated immediately /as soon as possible after birth of the child	93
Consuming right types and amount of food helps in in proper growth and health of the child	93
Feeding THR helps in meeting the nutritional requirement for the child	91
Except for breastfeeding, it is not required to give anything else to the child for the first six months after birth	90
Child should be continued to breastfeed till at least 24 months after birth	85

Beliefs	%
Feeding the child with a combination of breast milk and infant formula until s/he completes 6 months, is the BEST possible nutrition	66
Self-Efficacy	**%**
I can follow the recommendations of feeding THR to my child	93
I can follow the recommendations of 5 varieties of food to be to fed/give to my child	91
I can follow the recommendations of breastfeeding to my child	91
It is too costly to obtain the recommended types and amounts of foods for my child	69
Social Norms	**%**
In my family and community, we/people expect that giving solid/semi solid food and other liquids should be started after the child attains 6 months of age	92
In my family and community, we/people expect that the child is exclusively breastfed for first six months after birth	91
Most people who are important to me (e.g. family members, friends…) think that the child should be fed the THR provided by the AWC	91
In my family and community, we/people expect that the child should be fed five varieties of food to get for proper nutrition and growth	90
In my family and community, we/people expect that breastfeeding is initiated immediately /as soon as possible after birth of the child	89
In my family and community, we/people expect the child to be fed the first milk/colostrum	88
In my family and community, we/people expect that the child is continued to be breastfed till 24 months of age	84
Most people who are important to me (e.g. family members, friends…) think that giving certain kinds of foods should be avoided for the child (meat, fish, papaya, jackfruit, milk, etc.) because it will harm the child or hamper the child's growth	60

100. **Sources of Information:** The most reported sources of lactating women for information on care and nutrition during pregnancy, and nutrition of infants and young children are the AWW, their Mother In-law and Other family Members, in decreasing order (Figure 18 at Annex 7).

Vaccination of Children 6-36 Months

101. **Vaccination of Children 6-36 Months:** Under the baseline, to assess the status of vaccination of children, 133 children 6-9 Months and 676 children of age 10 months or more have been covered. Different vaccines are administered to children at different age. Thus, for the purpose, the sample children 6-36 months were categorized in two age groups to assess the vaccination viz. 6-9 Months and 10 months and above; and the status of 22 vaccinations was assessed (Table 5 At Annex 7).

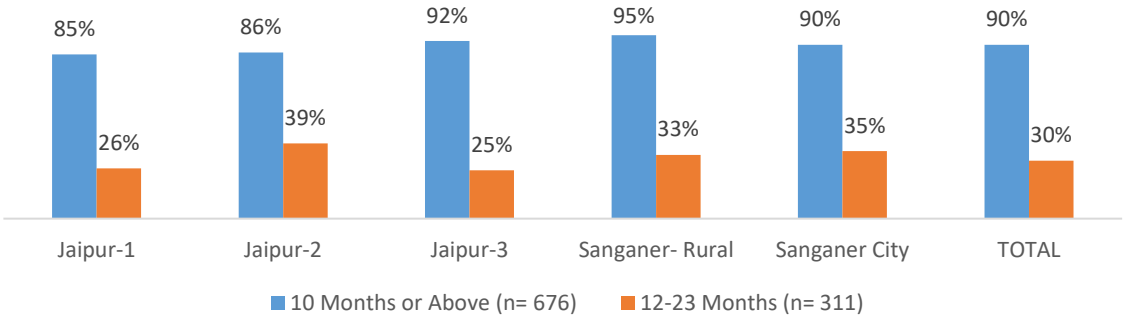
102. The children 6-9 months who have received first 14 vaccines and children 10 or more months who have received all 22 vaccines have been considered as fully vaccinated. Reportedly, all the sample children have received one or the other vaccination (Table 6 at Annex 7). It is noticeable that status of vaccination for vaccines to be administered till 9 months of age, is 97% or more, except for Measles and Vitamin-A First Dose (81% for both). However, as the age progresses (10 months or more), the status of vaccination decreases, and this is across all the five ICDS project areas. The at birth BCG immunization status in sample areas (99%) is better than the NFHS-5 national (95%) and state (96%) averages and is same as the Jaipur district (99%) average. However, as regards Measles 1st Dose, the status in sample areas (80.5%) is lagging behind the NFHS-5 national (88%), state (91%) and Jaipur district (99%) averages.

103. Overall, of the 676 sample children of age 10 months or more 90% (or 611) had received the 14 compulsory vaccinations, which is encouraging to note. *Gender-wise, 88% girls and 93% boys* 10 months or more had received the 14 compulsory vaccinations. ICDS project-wise, highest proportion of such children are from Sanganer Rural (95%) and lowest from Jaipur-1 (85%).

104. However, when it comes to fully vaccinated children 12-23 months; of the 311 sample children, only 30% (or 94) sample children 12-23 months of age have reportedly received all compulsory vaccinations. *Gender-wise, 30% girls and 31% boys* 12-23 months are fully vaccinated. ICDS project-wise, highest proportion of such children are from Jaipur-2 (39%) and lowest from Jaipur-3 (25%). As per the NFHS-5 data, 76% children 12-23 months in India, 80% in Rajasthan and 89% in Jaipur are fully vaccinated. Thus, in this context, the status of fully vaccinated children 12-23 months in sample areas is lagging behind the NFHS-5 national, state and district averages. *While the under-vaccinated children are more prone to be*

malnourished, the children affected by vaccine preventable diseases are prone to be malnourished. Thus, improving this status of under vaccination in project areas needs to be specifically addressed under the SBCC component of the pilot project; as episodes of vaccine preventable diseases have a linkage with the vicious cycle of malnutrition among children.

Figure 15: Status of Fully Vaccinated Children



105. It may be noted here that the lockdown/travel restrictions due to the outbreak of COVID-19 were imposed from March 2020. Since then and till date the AWC services like vaccination of children have been impacted. It is understood that owing to above reason, the status of fully vaccinated children 12-23 months is not encouraging as compared to NFHS-5 findings. It is expected that with roll out of the project and ease in service delivery (after relaxation of COVID restrictions),the situation will witness an improvement.

Hygiene and Health/Morbidity

106. During the baseline, main source of drinking water, availability of a functional toilet, means of disposing child's stool, and instances of hand washing with Soap; in the households of children was assessed by probing on these aspects with lactating women. ICDS project-wise details are presented at Table 7, 8 and 9 at Annex-7.

107. ***Main Source of Drinking Water:*** As per majority (79%) of the lactating women, the main source of drinking water is a Piped Water Supply connection, followed by supplies from Private Water Suppliers through tankers (5%). Thus, indicating that largely the households rely on the government piped water supply, which is apparently considered to be as a safe source of water.

108. ***Availability of a Functional Toilet:*** Reportedly in 99% the households a functional toilet was available.

109. ***Means of Disposing Child's Stool:*** As regards the means of disposal of child's stool, 60% lactating reported disposing it in the household toilet and 11% reported disposing it in drain, which are the correct practices. However, 29% reported disposing the child's stool using means like disposing it along with household waste, disposing it in household bathroom, burying it in ground, etc. *These incorrect practices may lead to instances of Diarrhoea and vector borne diseases in the households and neighbourhood. This indicates a need to sensitize such lactating women about the correct and appropriate means for disposing child's stool; and it can be taken up under the SBCC component of the pilot project.*

110. ***Instances of Hand Washing with Soap:*** As per available information, two major causes accounting for 50% of all deaths at ages 1-59 months are Pneumonia and diarrhoeal diseases[25]. Handwashing with soap could substantially reduce diarrhoea and respiratory infections[26]. In this context, when probed, 93% of the lactating women reported washing hands with soap after using the toilets themselves and after cleaning the child after defecation/ urination (81%). However, 78% or less reported washing hands with soap for all other instances. About 28% lactating women reportedly do not wash hands before feeding their child (Table 10 at Annex 7). *The above analysis indicates that there is a need to sensitize the lactating*

[25] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3042727/
[26] https://www.sciencedirect.com/science/article/pii/S2214109X13701608

women about handwashing with soap at critical times; and this can be taken up under the SBCC component of the pilot project.

111. **Instances of Morbidity Among Children:** A part of the baseline, instances of morbidly among children is last two weeks preceding the survey was assessed for Diarrhoea, Fever (Non Covid), and Acute Respiratory Infection (ARI).

112. ***Episode of Diarrhoea:*** When probed regarding whether their child has suffered from an episode of Diarrhoea in last two weeks preceding the baseline survey; 14% lactating women replied in affirmation (Table 11 of Annex 7), which is higher than national-7.3%, Rajasthan-6.1% and Jaipur district-4.3% averages as per NFHS-5. Gender-wise, 16% girls and 12% boys reportedly suffered from suffered from an episode of Diarrhoea in last two weeks preceding the baseline survey. Sex and age-group-wise, the highest proportion of girls and boys who suffered from Diarrhoea in last two weeks are in the age group of 6-11 months (Figure 19 Annex 7). Of those lactating women whose child reportedly suffered from an episode of Diarrhoea, 97% reported seeking advice/treatment for the same.

113. Among the lactating women, whose child reportedly suffered from an episode of Diarrhoea:
- 87% reported seeking medical advice; higher than national-68% and Rajasthan state-80% averages as per NFHS-5) .
- 71% reported providing ORS to the child, higher than national-61% and Rajasthan state-64% averages as per NFHS-5.
- 55% reported providing Zinc/Zinc Tablets for treatment to the child, higher than the national-31% and Rajasthan state-27% averages as per NFHS-5 data.

114. ***Episode of Fever:*** When probed regarding whether their child has suffered from an episode of Fever (Non Covid) in last two weeks preceding the baseline survey; 31% lactating women replied in affirmation (Table 12 of Annex 7). Gender-wise, 30% girls and 33% boys reportedly suffered from suffered from an episode of fever in last two weeks preceding the baseline survey. Sex and age-group-wise, the highest proportion of girls who suffered from fever in last two weeks are in the age group of 12-23 months (33%). Whereas the highest proportion of boys who suffered from fever in last two weeks are in the age group of 6-11 months, (Figure 20 Annex 7).

115. Among lactating women, whose child reportedly suffered from an episode of fever
- All reported seeking medical advice.
- 98% reported seeking medical consultation on the same day or within 1-2 days of witnessing the fever
- 97% also reported giving medication to the child for treating fever

116. ***Episode/Symptoms of Acute Respiratory Infection:*** To assess whether the child has suffered from ARI in last two weeks preceding the baseline survey; the lactating women were probed whether their chid had illness with cough and had fast, short, rapid breaths or difficulty breathing or had moving ribs. In case the child had both types of symptoms, it has been considered that the child had symptoms of ARI. To this, 25% lactating women replied that their child had cough and 5% replied that their child had fast, short, rapid breaths or difficulty breathing or had moving ribs at least one of the above symptoms (Table 13 and 14 of Annex 7). Overall, 5% (41 of 809 children) had symptoms of ARI.

117. Among the lactating women whose child reportedly had symptoms of ARI:
- 47% reported seeking medical consultation, which is lower than the national-69%, Rajasthan state-71%, and Jaipur district-79% averages as per NFHS-5 data
- 95% reported seeking medical consultation on the same day or within 1-2 days of witnessing the symptoms
- Reportedly, all reported giving medication to the child for treating the symptoms.

Nutritional Status of Children (through Anthropometric Assessment)

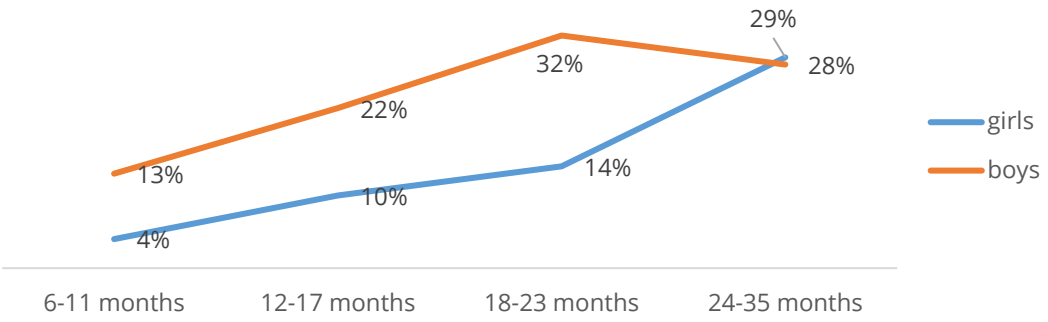
118. The status of stunting[27], wasting[28] and underweight[29] among children 6-36 months was assessed in this baseline. For the purpose, anthropometric indices for weight-for-age, length/height-for-age, and weight-

[27] Stunting: Less height for age
[28] Wasting: Less weight for height
[29] Underweight: Less weight for age

for-length/height z-scores (WAZ, LAZ/HAZ, and WLZ/WHZ, respectively) were calculated. Children with weight for age (WAZ) < -2 SD have been considered to be severely/moderately underweight. Children with height/length for age (LAZ/HAZ) < -2 SD have been considered to be severely/moderately stunted. Children with weight for height (WHZ) < -2 SD have been considered to be severely/moderately wasted.

119. **UNDERWEIGHT:** At an aggregate, 20% of the children were found to be underweight (severely or moderately). This is less than the national-32%, Rajasthan state-28%, and Jaipur district-21% averages as per NHFS-5 data for children under 5 years of age[30]. Gender-wise, a higher proportion of male children (24%) than female children (15%) are underweight. Age group-wise, higher proportion of children in the age group of 18-35 months are underweight.

Figure 16: Gender and Age Group-wise Status of Underweight (%)



120. Social category-wise, the highest proportion of children moderately and severely underweight are from the ST and SC families; indicating that marginalized social groups need to be specially focussed upon in all nutrition and SBCC related interventions under the pilot project.

Table 22: Social Category-wise Status of Underweight (percentage)

Social Category	% of Underweight Children
SC	22
ST	23
OBC	19
Unreserved/General	17
Total	**20**

121. Lactating women's education-wise, the highest proportion of underweight children are of women who are illiterate or have middle school or lesser education (Figure 23 at Annex 6). *Thus, it is required that the* lactating women *with low educational qualifications need to be specially focussed upon in all nutrition and SBCC related interventions under the pilot project.*

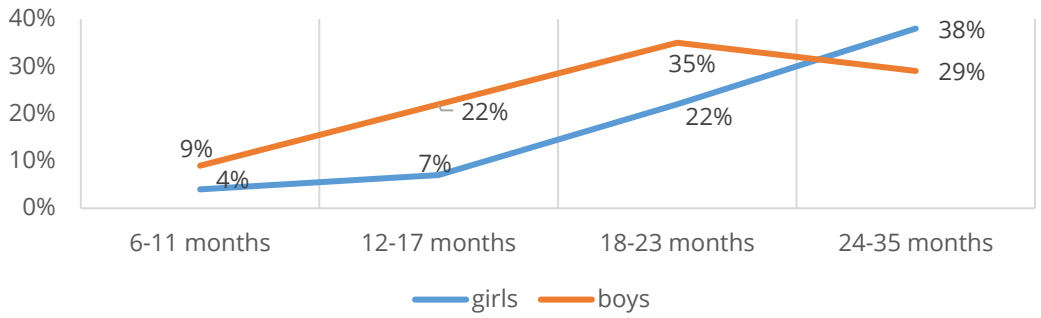
122. Of the 5 children 6-36 months, whose household did not have a functional toilet; 2 were underweight. Similarly, of the 74 children underweight 6-36 months, in whose households' handwashing with soap was practiced for 4 or less critical times; 68% (or 50 of the 74) were underweight. *This analysis establishes that adoption of incorrect/inappropriate WASH practices at the household has a linkage with the status of malnutrition underweight) of children.* Further, out of the 379 children 6-36 months assessed for nutritional status, 48 had suffered from an episode of Diarrhoea in last two weeks preceding the baseline survey, and of these about 31% (or 15 of 48) were underweight. *Thus, here also it is established that episodes of illnesses like Diarrhoea, impact the nutritional status of children.*

123. **STUNTING:** At an aggregate, 21% of the children were found to be stunted (severely or moderately), which is less than the national-36% children, Rajasthan state-32% and Jaipur district-25% averages as per NHFS-5 for children under 5 years of age[31]. Gender-wise, a higher proportion of male children (24%) than

[30] Below -2 standard deviations, based on the WHO standard.
[31] Below -2 standard deviations, based on the WHO standard.

female children (19%) are stunted . Age group-wise, higher proportion of children in the age group of 18-35 months are stunted.

Figure 17: Gender and Age Group-wise Status of Stunting (%)



124. Social category-wise, the highest proportion of children moderately and severely stunted are from the ST, SC and OBC families; indicating that marginalized social groups need to be specially focussed upon in all nutrition and SBCC related interventions under the pilot project.

Table 23: Social Category-wise Status of Stunting (Percentage)

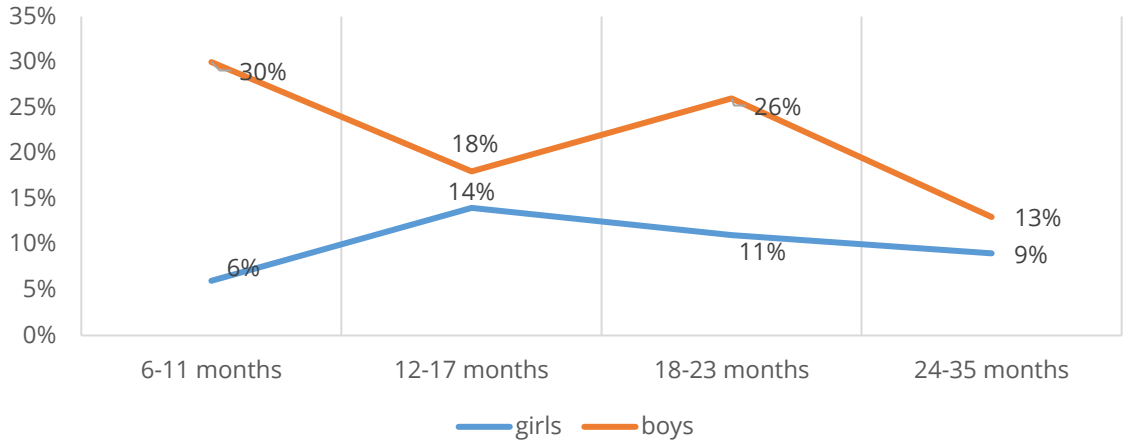
Social Category	% of Stunted Children
SC	27
ST	23
OBC	21
Unreserved/General	14
Total	**21**

125. Lactating women' s education-wise, the highest proportion of stunted children are of women who are illiterate or have middle school or lesser education (Figure 24 at Annex 6). *Thus, emerges a need that lactating women with low educational qualifications need to be specially focussed upon in all nutrition and SBCC related interventions under the pilot project.*

126. **Wasting:** At an aggregate, 16% of the children were found to be wasted (severely or moderately), which is higher than national-19% Rajasthan state-17% and Jaipur district-15% averages as per NHFS-5 data for children under 5 years of age[32]. As per NFHS-5 data, 8% children under 5 years of age in India, 8% in Rajasthan and 4% in Jaipur district are severely wasted[33], indicating that the proportion of severely wasted children (10%) in project areas is also higher than the national, state and district averages. Gender-wise, a higher proportion of male children (21%) than female children (10%) are stunted . Age group-wise, higher proportion of children in the age group of 12-23months are stunted.

[32] Below -2 standard deviations, based on the WHO standard.
[33] Below -3 standard deviations, based on the WHO standard.

Figure 18: Gender and Age Group-wise Status of Wasting



127. Social category-wise, the highest proportion of children wasted are from the SC, ST and OBC families; indicating that marginalized social groups need to be specially focussed upon in all nutrition and SBCC related interventions under the pilot project.

Table 24: Social Category-wise Status of Wasting (percentage)

Social Category	% of Wasted Children
SC	18
ST	15
OBC	15
Unreserved/General	13
Total	**16**

128. Lactating women's education-wise, lowest proportion of children wasted are of women who have graduate or higher qualifications (Figure 25 at Annex 6). *Here again, emerges a need that* lactating women *with lower educational qualifications need to be specially focussed upon in all nutrition and SBCC related interventions under the pilot project.*

129. The overall child nutrition outcomes by age group are presented at Figure 21 at Annex 7.

The age groups of children in the baseline and that used in NFHS are different, thus, as such the findings cannot be compared directly with baseline. However, this comparison has been provided to assess the situation in project areas vis-à-vis that at the district, state, and national level. Moreover, NFHS- 5 fieldwork for Rajasthan was conducted from January to March 2020 prior to the lockdown due to COVID-19 and from December to March 2021 post lockdown. Whereas the data collection for the baseline was carried-out in October 2021; post COVID. Thus, the status presented above in a way also presents the impact of the pandemic on the nutritional status of children. It may be noted here that the lockdown/travel restrictions due to the outbreak of COVID-19 were imposed from March 2020. Since then and till date the AWC services like providing THR, vaccination of children has been affected. Further, owing to the same, the regular growth monitoring of children at AWCs was also impacted. Moreover, owing to COVID-19, the THR is now being distributed in form of dry ration, whereas previously it was distributed in form of ready to eat pre-mix. Thus, even the THR provided from AWC is being shared by other family members of beneficiaries, as it cannot be segregated from the other ration of the household. It is understood that the above factors have also had an impact on the nutritional status of children. It is expected that with roll out of the project and ease in service delivery (lifting off of the restrictions), the situation will witness an improvement.

130. It is understood that the SBCC will be part of project execution at a later stage, as also the trainings of Frontline Functionaries (AWWs/ASHAs/ANMs) will also be part of later stages of project execution. Thus, in baseline evaluation, the following indicators have not been assessed:

- Number of functionaries trained on nutrition and counselling skills

- Number of pregnant and lactating women, adolescent girls and community members who received adequate information of exclusive breastfeeding, complementary feeding, anaemia and key nutrition-related behaviours.
- Number of AWWs who received adequate information of exclusive breastfeeding, complementary feeding, anaemia and key nutrition-related behaviours.

THR Demand/Receipt, Uptake and Acceptance

131. **Number of AWCs - supplied with nutritious THR and Number of AWCs - distributing nutritious THR:** All the sample 70 AWWs reported receiving THR in form of dry ration for being distributed among beneficiaries. Further, all the AWWs also reportedly mentioned distributing the THR further to the beneficiaries. In this regard, all the sample beneficiaries (pregnant and lactating women) also affirmed that the THR is being distributed from the respective AWCs of their area.

132. **Quantity of nutritious THR distributed from the AWC to the Beneficiaries:** As already mentioned, the THR distribution from AWCs to beneficiaries is now in the form of dry ration (*Wheat*, Rice, Pulses)[34].

133. The AWWs were further probed about the quantity of dry ration provided to the beneficiaries.
- ***Wheat:*** 93% AWWs reported the correct quantity (1.50 KG) for pregnant and lactating women (with a child 0-6 months) and 1.25 KG for lactating women (for their child 6-36 months).
- ***Rice:*** 91% AWWs reported the correct quantity (1.50 KG) for pregnant and lactating women (with a child 0-6 months); and 94% reported distributing the correct quantity (1.25 KG) for lactating women (for their child 6-36 months).
- ***Pulses (Daal):*** 96% AWWs reported the correct quantity (3 KG) for pregnant and lactating women (with a child 0-6 months); and 97% reported distributing the correct quantity (2 KG) for lactating women (for their child 6-36 months).

The 7% to 9% AWWs who could not report the correct quantity of food grains, is because of the fact that owing to administrative issues related to procurement; sometimes all three food grains are provided to the AWC for distribution, and sometimes only one or two types of food grains are provided. Besides, owing to the same reasons, the quantity of food grains provided to the AWCs also varies. Thus, as the case may be, the AWWs distribute whatever food grains are provided to them and depending upon the quantity made available. Thus, those AWWs who could not report the correct quantity of food grains being distributed as part of THR, did so, as they had reported what they have been doing for the past 1 to 1.5 years. The CDPOs of the five ICDS projects also affirmed this being the reason.

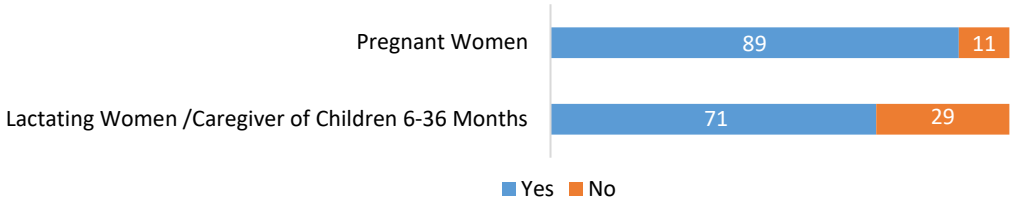
134. **Frequency of THR Distribution:** As regards the frequency of THR, all the 70 sample AWWs reported distributing the THR on a monthly basis. The CDPOs of the five ICDS projects and the sample beneficiary respondents also affirmed the same. Even previously (pre-COVID time) largely the THR was distributed on a monthly basis.

135. **Frequency of Monitoring THR Distribution (in a Quarter):** In this context, CDPOs of the five ICDS projects reported that they monitor the THR distribution on a monthly basis. As and when the dry ration has been supplied to the AWCs, the CDPOs and the concerned Lady Supervisors visit the AWCs of their area to monitor the distribution. Thus, about three visits are made every quarter for monitoring the distribution of THR. However, as per the CDPOs, sometimes the AWCs are provided ration or a particular food grain for more than one month. In such cases, more visits are also planned as per the number of months for which the food grains have been supplied at the AWCs in their area. Thus, at times, they have to make more than one monitoring visits in a month, and at times lesser.

136. **Demand of THR by Beneficiaries from the Local AWC:** About 89% pregnant women and 71% lactating (when they were pregnant with the reference child) reported demanding the THR from AWCs. Social category-wise, the lowest proportion of respondents who demanded the THR from AWC were from the SC category (18% SC Pregnant and 34% SC lactating women).

Figure 19: THR Demanded by Beneficiaries from Local AWC During Pregnancy (%)

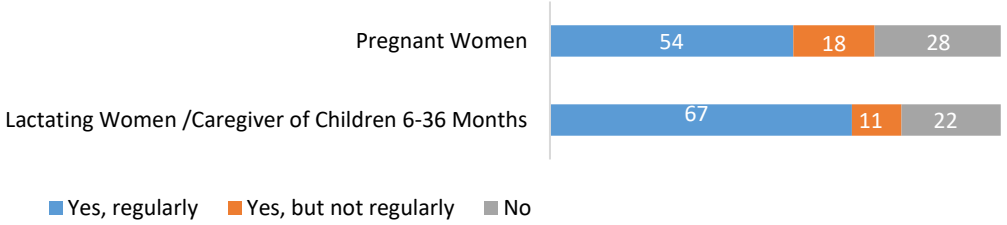
[34] Current norms of THR distribution are presented in Table 1 at Annex-7



137. **Number/Percentage of Beneficiaries receiving THR:** As regards the receipt of THR during their pregnancy; 72% pregnant women and 78% lactating women (when they were pregnant with the reference child) reported in affirmation. Thus, in case of lactating women (when they were pregnant with the reference child), there is a match between the demand (71%) and receipt of THR (78%). However, in case of pregnant women, the receipt of THR has been reported by lesser number of beneficiaries (72%) than those who demanded it (89%). The major reason cited by both the types of women for not receiving or irregularly receiving THR from the AWCs is 'THR not available in AWC for distribution (or not available in required quantity)'- reported by 54% of pregnant and 40% lactating women; of those who reported not receiving or irregularly receiving THR from the AWCs.

As per the CDPOs, in both, the rural and urban areas, there have been breaks in regular supply of THR (food grains) to AWCs. Sometimes, the THR for three months is supplied to AWCs and sometimes the supply is not appropriately adequate for a month. Further, at times one or more food grains are received in lesser quantity, thus, impacting distribution. All these are due to administrative issues related to procurement and supply of food grains; and thus, result in inadequate quantities of food grain to AWCs. Thus, the gap between demand and supply is due to administrative procurement related issues.

Figure 20: THR Received from the Local AWC During Pregnancy (%)



138. Social category-wise, contrary to the demand, the highest proportion of pregnant women and lactating women (when they were pregnant with the reference child) who reportedly are receiving THR were from the SC category (79% SC pregnant women and 83% SC lactating women). In this regard, majority of the AWWs and all CDPOs shared that when the food grains are in short supply; the AWWs distribute the same on a priority basis to the beneficiaries from the reserved categories.

All the 70 sample AWWs reported high demand of THR and acceptability of the THR among the beneficiaries. Even as per the CDPOs, there is demand among the beneficiaries for the THR. However, currently the THR distribution is in form of dry ration. Thus, the THR also actually is complimenting the overall ration requirement of the households, especially among the poor households. This is also one of the reasons behind the THR being in demand among the beneficiaries currently.

One of the CDPOs also stated that in some communities, the pregnant women and their families have a preference for a male child. Thus, they resort to taking guidance from religious and spiritual leaders, who then instruct them to consume certain foods/medicines and give an assuring of having a male child. In such cases, irrespective of they being aware about AWC services, these pregnant women do not avail these services. This because of both, their own personal inclination toward having a male child and familial pressure for the same. Such cases/women/families need to be targeted with focussed SBCC activities with emphasis also on gender equality.

139. **Currently Availing THR for the Reference Child:** As regards currently availing THR from the AWC for their child (6-36 months); 92% lactating women replied in affirmation. Of these, 80% reported regularly availing the THR for their child from the local AWC. Among those who reported not taking or not regularly

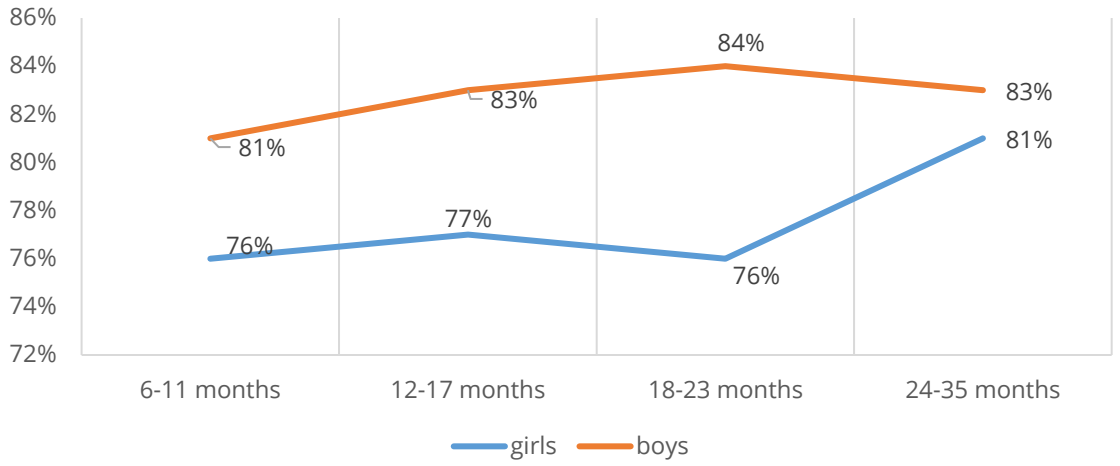
availing THR from AWC; the major reason cited was that 'Sometimes THR is not available at AWC for distribution' (by 57% or 91 of 161 such respondents). ICDS project-wise, highest proportion of respondents who reported not taking or not regularly availing THR from AWC, were from Jaipur-2 (26%) and Jaipur-3 (26%).

Table 25: Currently Availing THR for the Reference Child- ICDS Project-wise (%)

Particular	ICDS Project										Total	
	Jaipur-1		Jaipur-2		Jaipur-3		Sanganer-Rural		Sanganer City		N	%
	N	%	N	%	N	%	N	%	N	%		
Yes, regularly	118	81.9	78	73.6	187	73.3	145	95.4	120	78.9	**648**	**80.1**
Yes, but not regularly	12	8.3	23	21.7	35	13.7	4	2.6	23	15.1	**97**	**12.0**
No	14	9.7	5	4.7	33	12.9	3	2.0	9	5.9	**64**	**7.9**
TOTAL	**144**	**100.0**	**106**	**100.0**	**255**	**100.0**	**152**	**100.0**	**152**	**100.0**	**809**	**100.0**

140. Gender-wise, THR is being more regularly availed for male child, indicating a little gender bias among the caregivers, and requires addressing this aspect among the beneficiaries through targeted SBCC activities. Age group-wise; a THR is being more regularly availed for children in the age groups of 12-17 and 18-23 months.

Figure 21: gender and Age Group-wise Status of Collecting THR for Reference Child



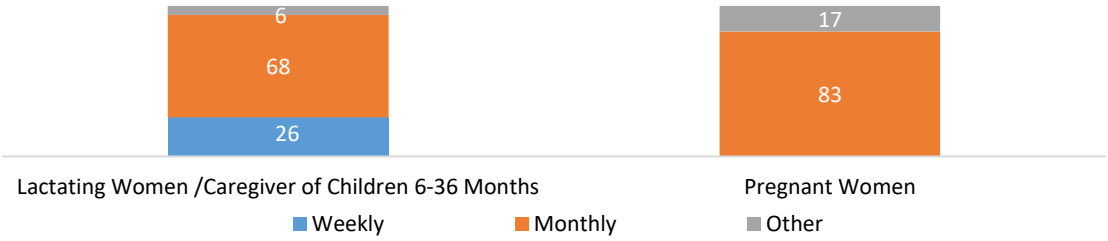
141. Rural-Urban Area-wise; only 5% of rural and significantly higher 23%[35]of urban are lactating women reported not taking or not regularly availing THR for their child (6-36 months) from AWC. *This indicates that there is more demand for THR for children 6-36 months in rural areas. Thus, during the pilot project execution, through focussed SBCC it would be apt to target the lactating women in urban areas to counsel and motivate them to avail/regularly avail THR for their child from the local AWC.*

142. There is awareness among the lactating women regarding the importance of nourishing diet and feeding THR to a child 6-36 months. Besides, the lactating women do demand, avail and feed the THR to their children.

143. **Frequency of Receiving THR During Pregnancy:** About, 83% pregnant women and 68% lactating women (when they were pregnant with the reference child) reported receiving the THR on a monthly basis. *Currently, the THR (dry ration) is being distributed on a monthly basis. Even previously (pre-COVID time), the THR was distributed largely on a monthly basis.*

[35] value of z is -5.2413. The value of p is < .00001. The result is significant at p < .05 (two-tailed).

Figure 22: Frequency of Receiving THR during Pregnancy (%)



144. **Current Frequency of Availing THR for the Reference Child:** 92% of the lactating women who reported receiving the THR for their child (6-36 months); reported receiving it on a monthly basis.

145. **Cooking and Eating Practices of THR:** The respondent pregnant women and lactating women[36] (when they were pregnant with the reference child) gave multiple responses regarding how they prepared the THR making it ready for consumption, with major ones being:

- In form of Porridge(*Dalia*[37]*)* by mixing water/milk in Panjiri (70% pregnant and 83% lactating women)
- By mixing the wheat/pulses flour (prepared from THR) with other flour (62% of pregnant women)
- In form of Halwa (Flummery) by mixing Panjiri with Ghee (clear butter) and sugar (7% lactating women)
- In form of hot cooked meal (39% lactating women when they were pregnant with the reference child)[38].
- Preparing Khichdi by mixing Pulses and Rice and preparing it together by adding salt/condiments and boiling it (24% pregnant women[39])
- Preparing pulses and rice separately by boiling them (and adding salt/condiments as required), and then consuming them together (37% pregnant women[40])

146. **Preparing THR for Consumption Currently for the Reference Child:** As regards what is being done currently to prepare the THR for consumption of their child (6-36 months):

- 91% lactating women reported making Porridge /*Dalia*
- 59% reported mixing the wheat/pulses flour (prepared from THR) with other flour
- 52% also reported other means:
    - Preparing Khichdi by mixing Pulses and Rice, adding salt/condiments and boiling it
    - Boiling the pulses in water and feeding the soup of Pulses boiled in water) to the child
    - Preparing pulses and rice separately by boiling them (and adding salt/condiments as required), and then consuming them together
    - Using the wheat to prepare the flour and then preparing sweet Halwa for consumption (prepared by roasting wheat flour by mixing sugar and Ghee in it)

147. **Duration within which the THR is Consumed after Receipt from AWC:** Almost all the pregnant (98%) and lactating women(97%) (when they were pregnant with the reference child) reported consuming the THR within 7 days from its receipt from the AWC. As regards, the duration within which the THR is utilized for their child (6-36 months) after its receipt from the AWC; all (100%) of the lactating women reported feeding it to their child within 7 days of receipt (Figure 10 at Annex 7).

148. **Sharing of THR by other Family Members:** 89% pregnant and 83% and lactating women (when they were pregnant with the reference child) reported THR provided for them from the AWC, was also shared

[36] 629 out of 809 lactating women who reported receiving THR when they were pregnant with the reference child

[37] Dalia: a thick sticky food made from broken wheat/other grains, cooked in water or milk, at times with sugar added

[38] through the support of Akshay Patra Foundation, in the pre-COVID times hot cooked meals were also being provided to pregnant women and lactating women on a daily basis in Jaipur-1, Jaipur-3 and Sanganer City ICDS projects (as affirmed by the 15 of 35 AWWs covered additionally to assess the earlier (pre COVID) situation)

[39] % of 110 of 152 pregnant covered for baseline

[40] % of 110 of 152 pregnant women covered for baseline

by other family members (Figure 11 at Annex 7). Further, 92% lactating women also reported sharing of THR provided from AWC for their child (6-36 months). *This indicates that owing to the sharing of THR provided for the beneficiary by other family members, the targeted beneficiaries do not benefit from the THR consumption as intended. In the current times, this situation is further aggravated as the THR is being distributed in form of dry ration. Thus, once the THR reaches home, in most of the households is kept and consumed along with other similar dry ration in the home and is shared by all family members. Thus, it is required that the beneficiaries are made aware that the THR provided by the AWC should only be consumed by only the targeted beneficiary. It is only then, the THR would be able to supplement the nutritional requirement of the beneficiary.*

149. **Regular Consumption of THR:** Of those who reported receiving the THR, 59% pregnant women (of 110) and 73% lactating women (629 women when they were pregnant with the reference child) reported consuming the THR regularly (daily or more than 5 days a week). Further, 41% pregnant and 25% lactating women (when they were pregnant with the reference child) reported consuming the THR, but not regularly (up to 3 days a week). However, 2% lactating women also reported not consuming the THR when they were pregnant with the reference child (Figure 12 at Annex 7). When further probed in this regard with such women, THR being provided in less quantity emerged as the highest reported reason for not consuming/not regularly consuming the THR..

Table 26: Reasons for Not Consuming/Not Regularly Consuming the THR (%)

Reason	Pregnant women	Lactating women (when they were pregnant with the reference child)
THR is provided in less quantity	62	42
Do not like the taste of THR provided	38 (for current THR in form of dry ration)	44 (THR that they received when they were pregnant with reference child, including Panjiri)
Do not consider it important to consume THR	30	3
Other family members consume the THR	38	1
THR was not of good quality	-	8
Gave it to others	-	20

150. Of the lactating women who reported receiving the THR for their child from the AWC (745 women), 81% reported feeding the THR regularly to their child (daily or more than 5 days a week). Further, 18% reported feeding the THR to their child, but not regularly (up to 3 days a week). However, another, 1% also reported not feeding the THR to their child (Table 2 at Annex 7).

151. As regards the reasons of not feeding/not regularly feeding the THR to the child (146 such lactating women), the major reported reason is the provision of THR is lesser quantity (48%). The other reported reasons are:

- Other family members consume the THR (34%)
- The child does not like the taste of THR provided (23%)
- THR is not of good quality (8%)
- Do not consider it important for the child (3%)
- Did not feel that it is required to feed THR to the child (3%)

As already mentioned, lesser supply and distribution of THR is an administrative issue and beyond the control of the beneficiaries and AWWs.

Most of the pregnant and lactating women are satisfied with the quality of THR availed by them.
During the FGD with adolescent girls, all the participant girls reported availing THR from the AWC and consuming it regularly. Some of the girls also mentioned that the *Roti* (Chapati) prepared from flour of the wheat provided as part of THR is softer than other wheat flour and is tastier to eat. They also mentioned that THR complements the protein requirement for adolescent girls. However, all of them also stated that the dry ration received as part of THR is not segregated from other ration of the household and is shared by the other family members also.

152. **Meal of the Day in which THR is Consumed:** As presented in table below, majority of the respondents have reported consuming THR as part of their lunch, followed by morning breakfast.

Table 27: Meal in which THR is Consumed

Meal in which THR is Consumed	Pregnant women		Lactating women *(when they were pregnant with the reference child)*		Lactating women *(For their Child 6-36 Months)*	
	N	%	N	%	N	%
Breakfast	36	33	344	56	437	59
Lunch	76	69	421	68	552	75
Evening Snacks	26	24	206	33	305	41
Dinner	47	43	113	18	142	19
Total	**110**	**100**	**616**	**100**	**736**	**100**

153. **Means of Storage of THR at Home and AWCs:** The sample AWWs, pregnant and lactating women were probed regarding means of storing THR currently. Besides, half of the sample AWW (35 of 70; 7 from each of 5 projects) were probed about the earlier THR demand, uptake and consumption by the community and the THR storage practices adopted by them. As presented in table below, the most reported means of storing the THR by pregnant and lactating women are Closed Container (Metallic) or Closed Container (Plastic). Whereas the most reported means of storing the THR at the AWCs by the AWWs are 'plastic sacks (89%)' and 'jute sacks (40%)'. Even in earlier times (pre COVID) majority[41] of the AWWs were reportedly storing the THR in 'plastic sack (Bori)'.

Table 28: Means of Storage of THR at Home and AWCs

Means of Storing THR	Pregnant women		Lactating women *(when they were pregnant with the reference child)*		Lactating women *(For their Child 6-36 Months)*		At AWC	
	N	%	N	%	N	%	N	%
Closed Container/Box (metallic)	45	41	332	54	430	58	2	3
Open Container (metallic)	3	3	6	1	4	1	-	-
Closed Container (plastic)	55	50	239	39	296	40	-	-
Open Container (plastic)	3	3	15	2	16	2	-	-
Plastic bag	10	9	68	11	60	8	-	-
Keep it in an open plate/tray	1	1	8	1	1	0	-	-
Cupboard-Wooden	-	-	-	-	-	-	1	1
Cupboard-Metal	-	-	-	-	-	-	1	1
In Cartons	-	-	-	-	-	-	1	1
In Plastic sacks (Bori)	-	-	-	-	-	-	62	89
In Jute sacks (Bori)	-	-	-	-	-	-	28	40
In open place inside AWC	-	-	-	-	-	-	6	9

154. **Duration of Storage of THR at AWCs:** 59% AWWs reported storing THR for up to 5 days at the AWC before its distribution to the beneficiaries (Table 3 at Annex 7). Currently as the THR is being distributed in form of dry ration from the AWCs. Thus, as soon as it has been supplied at the AWC, the AWWs try and distribute it at the earliest to the beneficiaries. Prior to the current system of THR distribution; even in earlier times (pre COVID) majority of the AWWs[42] reportedly stored the THR for up to 5 days prior to its distribution.

155. As already mentioned, owing to the outbreak of COVID pandemic; the THR distribution from AWCs to beneficiaries is now in form of dry ration. Further, no WSHG is currently involved in production and supply of THR (pre-mix) to AWCs. Thus, in baseline evaluation, the WSHG members have not been covered. Owing to these reasons, the following indicators could not be assessed at the baseline stage. The same will however be covered, at the endline stage using pre-post enquiry method.

- Quantity (in kgs) of age-appropriate, nutritious, fortified, and diversified THR - produced in the THR production center
- Quantity (in kgs) of age-appropriate, nutritious, fortified and diversified THR - supplied to the AWCs

[41] As per the 35 AWWs probed additionally for assessing the situation in pre COVID times
[42] As per the 35 AWWs probed additionally for assessing the situation in pre COVID times

- Number of quality assurance (QA) mechanisms and standard operating procedures (SOP) on the total production process including fortification in place
- Quantity (in kgs) of THR stored appropriately at– production center
- Number of the state government officials trained for monitoring, procurement, production and distribution of the nutritious THR (DPO and CDPOs)
- Number of WSHGs trained/assisted
- Availability of equipment for the production of a nutritious THR with WSHGs
- Number of WSHGs[43] trained/assisted[44] on aspects like Entrepreneurship, Financial literacy, Leadership, Efficient production of THR and Functioning of the Production Unit, etc.
- Number/Percentage of WSHGs exhibiting improved entrepreneurship, financial literacy, and leadership.
- Percentage of required age-appropriate, nutritious, fortified, and diversified THR regularly produced in the THR production centre
- Percentage of intended beneficiaries showing improved consumption and acceptability of the nutritious, diversified and fortified THR

3. Conclusions and lessons/issues for consideration

3.1. Conclusions

156. As regards the KAP regarding nutrition and care during pregnancy, there is awareness among the pregnant women regarding importance of good nutrition during pregnancy and about how a woman should eat during her pregnancy However, there still exist misconceptions regarding what all food items should a pregnant woman eat or not eat; and there is lack of knowledge /awareness about consuming an additional meal during pregnancy. Further, 80% of the pregnant women have MDD. Besides, there is also awareness among the pregnant and lactating women, regarding the importance of consuming THR during pregnancy.

157. The pregnant women and lactating women (when they were pregnant with the reference child and for their child) do demand, avail and consume the THR. Besides, THR is also being availed for most of the male and female children (6-36 months). Most the women are satisfied with quality of THR.

158. As regards the registration of pregnancy and availing ANC services, receipt of first ANC in first trimester of pregnancy and total number of ANCs received; the situation is encouraging. However, there is a gap in translation of knowledge into practice among the pregnant and lactating women, when it comes to IFA consumption during pregnancy. Moreover, not all frontline functionaries have the correct knowledge on ANC related aspects like IFA consumption and weight gain during pregnancy.

159. **Knowledge-Attitude-Practices (KAP) regarding Importance of Nourishing Diet for Children:** There is awareness among the lactating women and frontline functionaries regarding the importance of nourishing diet and feeding THR to a child 6-36 months. About 57% children 6-36 months have the MDD in their daily diet.

160. **Knowledge and Awareness of Adolescent Girls regarding Nutrition During Adolescence:** During the FGD, the adolescent girls were found to be aware and having appropriate knowledge about importance of nutrition during adolescence.

161. **Knowledge-Attitude-Practices (KAP) regarding Breastfeeding:** Majority of the pregnant and lactating women, frontline functionaries, adolescent girls and community representatives are aware about the

[43] WSHG who would set-up the THR production center
[44] Training or assistance provided to the WSHGs in terms of entrepreneurship, financial literacy, leadership etc. required for the efficient production of THR and functioning of the production unit.

breastfeeding related aspects. However, up to one-fourth of pregnant and lactating women and frontline functionaries are not correctly aware about one or the other aspect of breastfeeding. Besides, there are gaps when it comes to translation of knowledge/regrading breastfeeding into practice by lactating women. Most of the pregnant and lactating women not appropriately aware in this regard, have low educational qualifications. Moreover, not all frontline functionaries have the correct knowledge on appropriate and correct practices of breastfeeding.

162. **Beliefs, Self-efficacy and Social Norms- Pregnant Women:** Reportedly, there are misbeliefs/misconceptions when it comes to aspects like exclusive breastfeeding, recommend food to be consumed during pregnancy being costly, number of meals and certain types of foods that a woman should avoid in pregnancy..

163. **Beliefs, Self-efficacy and Social Norms- Lactating Women/Caregivers of Children 6-36 Months:** reportedly, there are misbeliefs/misconceptions when it comes to aspects like exclusive breastfeeding, recommend food to be consumed by their child being costly, and certain types of foods that a child should be avoided to be fed.

164. **Hygiene and Health/Morbidity**: In 29% households, reportedly incorrect means of disposing the child's stool are being followed. Further, in about 28% cases, the caregivers do not wash hands before feeding their child. Such incorrect practices may lead to instances of Diarrhoea and vector borne diseases in the households and neighbourhood. Reportedly, the 14% children suffered from an episode of diarrhoea, 31% suffered from fever and 5% had symptoms of ARI in two weeks preceding the survey. The prevalence of the episodes of these illnesses are however, less than the state and national averages as per NFHS-5.

165. **Nutritional Status of Children:** The status of underweight, stunted and wasted children in project areas is less than the national and state averages as per NFHS-5. Social category and education-wise, the highest proportion of children malnourished children from the ST, SC and OBC families; and of lactating women with lower educational qualifications.

166. **THR- distribution, demand, acceptability:** All the AWWs reported receiving and distributing THR in form of dry ration among beneficiaries on monthly basis. Besides, there is demand and acceptability among beneficiaries for the THR. However, in about one-fifth of the households, the beneficiaries do not consume the THR regularly or do not consume it at all.

167. As per the CDPOs, due to administrative issues related to procurement and supply of food grains; sometimes there are gaps in supply of food grain to AWCs, and these at times, delay the distribution of THR to the beneficiaries, and thus, impacting THR consumption.

168. Strategically, the project implementation will need to cognize socio-cultural norms and practices regrading nutritional intake of pregnant and lactating women and children. Besides, currently the THR is being distributed in form of dry ration, which is also shared between the family members and is also complimenting the household's food requirement. Thus, shifting to ready to eat THR or any other form of THR from the current dry ration, will need to be planned carefully.

169. To provide an enabling environment to bring about the positive change in KAP regarding nutrition; in all SBCC activities, the engagement/inclusion of husbands/fathers and mother in laws/grandmothers of pregnant and lactating women and children, and of community influencers needs to be ensured. Emphasis also needs to be on positive social norming. SBCC activities planned under the pilot should be a combination of interpersonal counselling & individualized skilled support to beneficiaries and their family members, complimented by supportive mid-media & mass media activities for consistent and repeated messaging/communication.

170. The KAP and nutritional indicators are not encouraging among the beneficiaries from marginalized social groups and those with low educational qualifications. Thus, the implementation strategies of the pilot need to be designed /finetuned considering specific requirements of such beneficiaries for impacting social norming and for nudging them towards adoption of appropriate nutrition practices.

3.2. Lessons/issues for consideration

171. The key lessons emerging from the baseline findings are presented below.

Table 29: Key Lessons/Issues for Consideration

#	Lessons/Issues for Consideration	Recommendation grouping (Short/ medium/ long-term)	Responsibility (one lead office/entity)	Other contributing entities (if applicable)	Priority: High/ medium	By when
1	**Lesson 1:** Though most of the pregnant and lactating women have awareness on aspects related to nutrition and IFA consumption during pregnancy, there is a gap when it comes to translation of knowledge into practice. Besides, there is a need to address the beliefs, self-efficacy and social norms regarding nutritional intake. Thus, Awareness generation on aspects related to nutrition and IFA consumption during pregnancy needs to be a focus topic for SBCC under the pilot project.	Medium-term	WFP		High	End of year 2022
2	**Lesson 2:** As only about 57% children have the MDD in their daily diet; it is required that under the SBCC component of the pilot project, the lactating women are appropriately made aware, counselled, and motivated to ensure MDD in daily diet of their children as per their age.	Medium-term	WFP		High	End of year 2022
3	**Lesson 3:** As almost one-fourth of the currently pregnant and lactating women, and frontline functionaries are not appropriately aware about one or the other aspects related to breastfeeding. Besides, adherence to appropriate breastfeeding practices and nutritional status of children is comparatively lower among social marginalized households and lactating women with lower educational qualifications. Thus, under the SBCC and capacity building components of the pilot project, emphasis should be on awareness generation for pregnant and lactating women, especially from marginalized families and with lower education; and capacity building for the frontline functionaries (who are the first point of contact) on these aspects.	Medium-term	WFP	DWCD, GoR	High	End of year 2022
4	**Lesson 4:** As the baseline findings suggest, some of the beneficiaries either do not consume the THR or do not consume it regularly, many a times due to its monotonous taste. Thus, activities for enhancing uptake and consumption/uptake of THR by targeted beneficiaries and developing THR	Medium-term	WFP		High	End of year 2022

	recipe with enhanced taste, needs to be a focus area under the proposed pilot.					
5	**Lesson 5:** As per the ICDS functionaries and officials, at times there have been gaps in supply of THR to AWCs due to administrative issues, impacting its distribution, and thus, consumption. Thus, under the pilot project it needs to be ensured that there are no gaps in the supply of THR to the target AWCs.	Medium-term	WFP		High	End of year 2022
6	**Lesson 6:** Overarchingly, in all SBCC activities, there should be engagement/inclusion of husbands/fathers and mother in laws/grandmothers of pregnant and lactating women and children, along with engagement of community influencers for positive social norming. The SBCC should be a combination of interpersonal counselling & individualized skilled support to beneficiaries and their family members, complimented by supportive mid-media & mass media activities for consistent and repeated messaging/communication.	Short-term	WFP		High	As soon as the production unit has been operationalized
7	**Lesson 7:** Frontline functionaries need to be capacitated and mentored (post training supported by supervisors) on providing individually contextualized counselling, and for proactively engaging in problem solving and nudging pregnant and lactating women and their family members for adopting optimal behaviour.	Short-term	WFP		High	

Annexes

Annexes 1. Users of the Evaluation Report

Several stakeholders have interests in the results of the evaluation. The table below provides a brief analysis of stakeholders, with interest in evaluation and/or would be likely users of evaluation report; and/or will benefit from the implementation of the pilot.

Table 30: Stakeholders Analysis for the Evaluation

INTERNAL STAKEHOLDERS
WFP - Country Office (CO) India: Responsible for the country-level planning and operations implementation, it has a direct stake in the evaluation and an interest in learning from experience to inform decision-making. The findings of the evaluation will aid the CO in decision-making, notably related to programme implementation and/or design, Country Strategy and partnerships towards improving the nutritional status of children and PLW and further, applying the learning to other states.
EXTERNAL STAKEHOLDERS
Beneficiaries: As the ultimate recipients of assistance, ICDS scheme beneficiaries (pregnant and lactating women, adolescent girls, men, boys, and girls), AWWs, and members of WSHGs of this pilot project have a stake in WFP determining whether its assistance is appropriate and effective. Besides, other stakeholders, though with a support role; but will play a critical part in delivering the nutrition-related services from AWC. These include the local ASHAs and ANMs, and the Panchayat Raj Institution (PRI) members. Besides, ascertaining the Knowledge-Attitude-Practices (KAP) of the beneficiaries and AWWs, the evaluation will also entail interacting with these stakeholders and assess their KAP regarding nutrition of women and children, and their role in supporting efficacious delivery of nutrition-related services from the AWC
Government of Rajasthan: Primarily this evaluation is being conducted to inform the Government, to decide on the scale-up and sustainability of the project. The key government department that WFP shall liaison is the Department of Women and Child Development (DWCD) of the Government of Rajasthan. The findings of this evaluation would support the Government of Rajasthan in decision making related to the scale-up of the intervention and towards improving the nutritional status of children and PLWs in Rajasthan.
Government of India: Findings of evaluation would provide evidence to the Ministry of Women and Child Development, Government of India in taking a policy-level decision at the national level towards reforming the ICDS scheme.
Donor - Cargill India: This pilot project of WFP and GoR is funded by Cargill India. They have an interest in knowing whether their funds have been spent efficiently and if WFP's work has been effective and contributed to their strategies and programmes.

Annexes 2. Reconstructed Theory of Change (ToC)

Table 31: Reconstructed Theory of Change

Inputs	Processes	Outputs	Outcomes
Formation of a technical advisory group (TAG) - Support by the Department of Women and Child Development (DWCD), Rajasthan	• The DWCD shall set up a technical advisory group consisting of the relevant departments (Women and Child Development, Human Resource Development, Tribal Area Development, Rural Development, Food, and Public Distribution) from within the Government, subject experts, and WFP to oversee and facilitate the implementation of the project and call for regular bi-annual meetings of the same.	• TAG established and functional	• TAG providing continued support and guidance for the pilot project • TAG providing required guidance and support for the scale-up of the initiative
Access and identification	• The DWCD will facilitate other government partners namely DRD and DTAD to provide access to the existing SHG mechanism involved in providing THR and support the process of identification of existing well-functional SHGs in an alternate geographic location.	• All required information and other access made available to WFP • WSHGs (numbers) to be engaged are identified	• Smooth implementation of the pilot
Timely approvals and facilitatory support	• The DWCD along with other concerned departments of GoR shall be responsible for providing timely approvals to activities envisaged in the project proposal including facilitatory support required to conduct need-based research such as project evaluations, acceptability studies on the THRs. • During the setting up and period of the THR pilot, GoR shall also facilitate, road permits for smooth transportation of the equipment procured for production of the THR from the respective suppliers to the SHG site.	• All required permits/ permissions accorded for the implementation of the pilot	
Resourcing the project	• WFP will ensure the availability of necessary financial resources for the provision of technical assistance to the THR production unit, setting up the THR production unit, as well as SBCC activities in the pilot phase of the project.	• Required financial resources made available for the implementation of the pilot	
Undertake need-based research	• WFP will commission a series of studies such as shelf life, acceptability, economic viability, etc. as a precursor to the roll-out of a quality THR through the unit.	• Required studies commissioned and completed	• The insights/findings from the studies utilized to guide

Inputs	Processes	Outputs	Outcomes
			the implementation of the pilot
Procurement	• WFP will procure the equipment needed for the production of THR through its internal procedures for setting up and running the demonstration unit for the production of fortified blended foods. • During the pilot, WFP will work with the identified SHG/s for procurement of raw material such as wheat, fortification, etc along with packaging needed to produce a quality take-home ration. • To support the implementation of various activities in the project, WFP through its internal procedures may procure the services of other partners.	• All required equipment procured for setting up the THR production unit • The THR production unit established • Required support provided to the SHG(s) managing the THR production unit for procurement of raw material and packaging of THR • Quality THR production unit operationalised	• Production of the age-appropriate, nutritious, fortified, and diversified THR in the production center • Supply of age-appropriate, nutritious, fortified and diversified THR to the AWCs and distribution of nutritious THR from the AWCs to the children (aged 6-36 months) and PLWs.
Provision of technical support and assistance	• WFP will engage regularly with the identified self-help group(s) to strengthen their functioning and expand their coverage. • The role of WFP will be to support the set-up of a quality THR production unit with technical support and input to the SHG in all aspects.	• Required handholding support provided to the WSHGs	• WSHG(s) through THR unit providing quality THR to the AWCs • WSHG(s) managing the THR unit empowered – economically
Development of quality control protocols	• During the period of the THR production demonstration unit, WFP will set up quality control and assurance protocols, both at the production site and through the engagement of the services of an independent laboratory. • Reports of the analysis will be used to undertake corrective action in case so needed.	• Number of quality assurance (QA) mechanisms and standard operating procedures (SOP) on the total production process including fortification in place • Number of WSHGs and other stakeholders trained on QA mechanisms and SOPs	• WSHG(s) managing the THR unit adhering to the quality controls and assurance protocols/ mechanisms and standard operating procedures (SOP) on the total production process including fortification
Procurement of THR from WFP supported self-help groups as well as timely payments	• DWCD shall ensure procurement of the take-home rations regularly from the WFP supported THR production units as well as make timely payments for the THR procured to ensure continuous functioning of the WFP set-up unit.	• THR being produced by the WSHG(s) at the THR production unit being procured regularly by GoR • Quantity (in kgs) of age-appropriate, nutritious, fortified, and diversified THR: (a) produced in the THR production center; (b) supplied to the AWCs; and (c) distributed from the	• A regular supply of quality THR to the AWCs in the catchment of the THR unit • Regular distribution of quality THR to beneficiaries for AWCs

Inputs	Processes	Outputs	Outcomes
		AWCs to the children (aged 6-36 months) and PLWs. • Percentage of AWCs distributing nutritious, diversified, and fortified THR to the beneficiaries promptly • Number of AWCs: (a) supplied with nutritious THR; and (b) distributing nutritious THR • Quantity (in kgs) of THR stored appropriately at all levels – production center and AWC level • Regular payments are being made to the WSHG(s) managing the THR unit for the THR procured from them	• Appropriate storage of THR at all levels – production unit and AWC level • THR unit serving as a viable and profit-making business for the WSHG(s) managing it
Project Coordination and liaison support	• The DWCD will identify a project manager already looking after ICDS/THR production operations in the state for regular dialogue, discussion, and day-to-day follow-up activities. These officers would provide support and would be wholly responsible for project implementation, supervision and coordination and liaise with a designated officer from WFP. • The DWCD through the above-mentioned officer will also provide necessary coordination and liaison support as required with the Department of Rural Development, Tribal development, etc. • For effective coordination, project supervision, and support towards up-scale, WFP will appoint one Project coordinator (Nutrition) based at the district identified for the pilot in Rajasthan. WFP would also designate project focal staff at the Country office in New Delhi, who would provide regular guidance and support to the project coordinator for the day-to-day implementation and problem resolution. • The project coordinator and WFP focal staff would regularly visit the project implementation sites to	• Project manager appointed by DWCD • Project Coordinator appointed by WFP • Regular support for project implementation, supervision, and coordination is provided by DWCD and WFP	• Smooth implementation of the pilot • Progress of pilot's implementation being reported regularly; and required corrective action being taken (as required and appropriate)

Inputs	Processes	Outputs	Outcomes
	monitor the production, quality, and distribution of THR under the ICDS programme. WFP focal staff would also maintain close contact with beneficiaries to assess compliance as well as the relevant state departments to share progress and feedback from time to time.		
Capacity building and awareness creation	• The DWCD will conduct capacity building of the AWWs during the scale-up phase of the social behaviour change communication (SBCC) component of the project; while WFP will support the training of trainers for the rollout. The training and IEC material for the same will be developed in collaboration with WFP. • The DWCD will also support coordination with the Department of Rural Development (DRD) and the Department of Tribal Area Development (DTAD), as appropriate for conducting training of the Raajeevika self-help groups during the scale-up phase on entrepreneurship, management of resources, and THR production including linking with financial institutions for necessary loans. • WFP will support the capacity building of the staff at the THR production unit on systematic production, fortification, quality control, and food handling/safety. • Towards supporting the scale-up of fortification of Nutri-mix, WFP will create a master pool of trainers at the State level who are capacitated on various aspects of THR production and will be able to in turn conduct cascade training for all the women self-help groups engaged in THR production identified in consultation with the government. • WFP will support the development of appropriate training material towards the above. • WFP will also undertake capacity building of AWWs in counselling parents on the consumption of the THR while supporting the development of specially designed information, education and communication material,	• Appropriate training material for the training developed by WFP • IEC material and other communication strategies highlighting the need for and importance of quality complementary foods for young children developed/designed by WFP • Communication strategies and material for sensitizing other members of the community on nutritional requirements at key vulnerable phases of life developed by WFP • A master pool of trainers trained and developed at the State level • Increased capacity of the state government officials trained for monitoring, procurement, production, and distribution of the nutritious THR (Number of officials trained) • Number of master trainers developed • Number of WSHGs capacitated on entrepreneurship, management of resources and THR production; Number of WSHGs linked with financial institutions; Number of WSHGs operating in profits through managing the THR unit; Number of WSHGs trained on production of quality THR; Number of WSHGs adhering to the training	• Increased capacity of the WSHGs in terms of entrepreneurship, financial literacy, leadership, etc. required for the efficient production of THR and functioning of the production unit • Increased acceptability and consumption of the improved, age-appropriate, nutritious, and fortified take-home rations delivered to young children and PLW with aim of preventing and addressing malnutrition. • WSHGs are economically empowered through managing the THR units

Inputs	Processes	Outputs	Outcomes
	and other communication strategies highlighting the need and importance of quality complementary foods for young children. • WFP will also develop communication strategies and material for sensitizing other members of the community on nutritional requirements at key vulnerable phases of life.	learnings on the production of quality THR) • Number of WSHGs exhibiting improved entrepreneurship, financial literacy, and leadership. • Number of master trainers who further provided training to WSHGs/AWWs • Number of AWWs trained/capacitated on SBCC for nutrition/THR • Number of trained AWWs counselling beneficiaries on nutrition, consumption, and importance of THR • Number/Percentage of caregivers of children (boys and girls), adolescent girls, PLWs, AWWs, and community members trained and who received adequate information on exclusive breastfeeding, complementary feeding, THR importance and consumption, anaemia, and key nutrition-related behaviours. • Number/Percentage of caregivers of children (dis-aggregated by boys and girls), adolescent girls, PLWs, AWWs, and community members exhibiting adequate knowledge of exclusive breastfeeding, complementary feeding, THR importance and consumption, anaemia, and key nutrition-related behaviours. • Number of PLWs regularly consuming the THR and feeding it to their children • Number of PLWs aware about and adhering to correct practices of storing and cooking the THR	

Inputs	Processes	Outputs	Outcomes
Project monitoring and reporting	• The DWCD, shall share with WFP, information collected through its regular monitoring mechanisms on the number of beneficiaries reached through the improvised THR, the tonnage of THR produced and distributed, number of units set up for production of THR through the provision of mechanized units, and training of relevant staff during the pilot and scale-up phase of the project every month. • The GoR shall agree to flexibility in the reporting system for any mid-term modification to facilitate WFP in making changes in the reporting format to make these more THR context friendly. WFP may seek other food, nutrition, and health-related reports, which GoR may furnish from time to time. • WFP will intensely monitor the project during the phase of the demonstration unit and report to the government on the quantity of THR produced and distributed etc.	• Frequency of monitoring of THR production and distribution (in a quarter) • Smooth implementation of the pilot and taking appropriate actions, as and when required	• Improvement in the nutritional status amongst the target group - children between 6 to 36 months of age • Improved nutritional knowledge, awareness, and behaviours amongst caregivers, adolescents, PLWs, AWWs, and other stakeholders on exclusive breastfeeding, complementary feeding, anaemia, and key nutrition-related practices.
Support WFP project partnerships	• The DWCD will participate and attend multi-stakeholder platform discussions set up by WFP and its partners. • WFP will work with partners to sensitize and build the capacity of the private sector on nutrition-related issues including setting up multi-stakeholder platforms	• Provision of required technical and other support by the stakeholders in the implementation of the pilot	• Smooth implementation of the pilot and its scale-up in future
Continuation of the purpose of the project (Scale-up)	• The DWCD will continue and scale up the basic purpose of the project i.e., provision of a quality THR for children between 6-36 months of age receiving the same from ICDS at its own cost after assistance from WFP once the demonstration phase is handed over. • WFP will support the self-help groups in the procurement of the fortification, raw materials and mechanized fortification units through technical support and related documentation as need be and appropriate. • WFP will develop a quality control protocol and support instituting systems in place to support GoR in ensuring	• Quality control protocol and support instituting systems established for supporting in ensuring production of safe and good quality fortified blended THR • Locations identified for establishing new THR production units under the scale-up • WSHGs (number) identified for the scale-up of the pilot • WSHGs (number) supported technically and in procurement for establishing new THR production units	• Smooth operations of the new THR production units • Establishing a replicable, efficient demonstrable, and 'Operationally effective' model, that ensures a nutritious and affordable THR to PLWs, infants, and young children in a sustainable way

Inputs	Processes	Outputs	Outcomes
	delivery of safe and good quality fortified blended foods to children between 6-36 months of age. • WFP will also monitor the scale-up phase of THR production through self-help groups at either district/block level to ensure that the government expected activities are on track.	• Number of new THR production units established and operationalized • Number of new WSHG(s) empowered and benefiting economically from the scale-up • Number of WSHG members trained on entrepreneurship, management of resources, THR production, systematic production, fortification, quality control, and food handling/safety, linking with financial institutions for necessary loans. • Regular monitoring of the process and progress of the scale-up	

Annexes 3. Evaluation Questions

Table 32: Evaluation Questions

Criteria	Evaluation Questions
Relevance	1. To what extent the nutritional and SBCC intervention activities, were appropriate to the target population – PLWs, children (boys and girls), AWWs, community members and others? 2. To assess the appropriateness of the initiative in relation to the policies and programs of the governments of India, Rajasthan and local entities in the districts of Jaipur.
Coherence	3. To what extent the nutritional and SBCC intervention activities are compatible with other nutritional interventions for children (dia-agg, PLW, adolescent girls in India, Rajasthan and specifically in Jaipur?
Effectiveness	4. To what extent project activities achieved its objective of establishing a replicable, efficient, demonstrable and 'Operationally effective' model, that ensures a nutritious and affordable THR to PLWs, infants and young children in a sustainable way? Were the same level of improvements achieved among boys, girls, SCs and STs? 5. To what extent intervention led to achieving its objective of improving the nutritional knowledge, awareness and behaviours amongst caregivers, adolescent girls, PLWs and other stakeholders? Were the same level of improvements achieved among SCs and STs? 6. To what extent intervention led to improving the capacities of the WSHGs in terms of entrepreneurship, financial literacy, leadership etc. required for the efficient production of THR and functioning of the production unit and other stakeholders?
Efficiency	7. Were the project interventions cost-effective? 8. To what extent nutritional (production, supply and distribution of improved THR) and SBCC intervention activities were implemented in the timely manner?
Impact	9. To what extent, significant changes (if any) were achieved in the production and distribution of nutritious, diversified and fortified THR to the beneficiaries? 10. To what extent, significant changes (if any) were reached in the consumption and acceptability of the nutritious, diversified and fortified THR ? Were the changes in the consumption and acceptability similar among boys and girls? Explore what factors were responsible for the change. 11. To what extent, significant changes (if any) were attained in the key nutrition awareness, behaviours and practices among the targeted groups? 12. To what extent the intervention activities have aided in improving the nutritional status of children 6-36 months
Sustainability	13. To what extent the intervention activities and benefits are likely to be sustained in the project area? 14. To what extent is the state readiness to sustain and scale-up the intervention in other parts of the state?

Annexes 3-A. Evaluation Matrix

Table 33: Evaluation Matrix

Evaluation question			Criteria
Sub questions/ Indicators	**Data collection methods**	**Sources of data/ information**	**Data analysis methods/ triangulation**
1. **Establishing a replicable, efficient demonstrable and operationally effective model, that ensures a nutritious and affordable THR to PLWs, infants and young children in a sustainable way**			
i) **Quantity (in kgs) of age-appropriate, nutritious, fortified, and diversified THR produced (EQ 3)**	Dyads/Triads	WSHG members	Collation and triangulation of primary and secondary data to draw findings (baseline benchmarks) and insights
ii) **Number/percentage of AWCs distributing THR (EQ 13)**	Semi-structured Interviews	AWWs	
iii) **Frequency of monitoring of THR production (in a quarter)- EQ 3**	IDIs and Dyads/Triads	WSHG Members, and CDPOs/DPO	
iv) **Number of quality assurance (QA) mechanisms and standard operating procedures (SOP) on the total production process including fortification in place (EQ 4, 8, 13)**	IDIs and Dyads/Triads	WSHG Members and CDPOs/DPO	
v) **Quantity (in kgs) of THR stored appropriately at all levels – production center and AWC level (EQ 8)**	Semi-structured Interviews and Dyads/Triads	AWWs and WSHG Members	
vi) **Number of the state government officials trained for monitoring THR production (EQ 4, 13, 14)**	IDIs	CDPOs/DPO	
vii) **Number of WSHGs trained/assisted (EQ 4, 6, 8, 13)**	Dyads/Triads	WSHG Members	
viii) **Availability of equipment for the production of a nutritious THR (EQ 4, 6, 13)**	Dyads/Triads	WSHG Members	
ix) **Number of intended beneficiaries receiving and consuming nutritious, diversified, and fortified THR - Boys/girls/PLWs (EQ 1, 9, 10, 11)**	Structured Interviews	PLWs/Caregivers	
x) **Number/Percentage of WSHGs exhibiting improved entrepreneurship, financial literacy, and leadership. (EQ 6)**	Dyads/Triads	WSHG Members	
xi) **Percentage of intended beneficiaries showing improved consumption and acceptability of the nutritious, diversified, and fortified THR - Boys/girls/PLWs. (EQ 11)**	Structured Interviews	PLWs/Caregivers	
2. **Improved nutritional knowledge, awareness and behaviours/practices amongst caregivers, adolescents, PLWs and other stakeholders**			
xii) **Number/percentage of frontline functionaries trained on nutrition counselling skills (EQ 5, 13, 14)**	Semi-structured Interviews	AWWs and ANMs/ASHAs	Collation and triangulation of primary and secondary

Evaluation question			Criteria
Sub questions/ Indicators	**Data collection methods**	**Sources of data/ information**	**Data analysis methods/ triangulation**
xiii) **Awareness of frontline functionaries on nutrition and related aspects; and THR importance/ uptake (EQ 5, 13, 14)**	Semi-structured Interviews	AWWs and ANMs/ASHAs	data to draw findings (baseline benchmarks) and insights
xiv) **KAP of adolescent girls and VHSNC/UHSNC/PRI members on nutrition and THR uptake/consumption/acceptance (EQ 5)**	FGD	Adolescent Girls and VHSNC/UHSNC/PRI members	
xv) **KAP of PLWs and caregivers of children (boys and girls) on nutrition and THR uptake/consumption/acceptance (EQ 1, 4, 5, 10, 11)**	Semi-structured Interviews	PLWs/Caregivers	
3. **Anthropometric assessment**			
xvi) **Nutritional status of children - Percentage of children who are wasted, stunted and underweight (boys and girls) EQ 4, 10, 12**	Anthropometric Assessment	Lactating Women/Caregivers	Analysis of the anthropometric data using EPI Info and its corelations*
***: The data from the anthropometric assessment will be analysed and looked over parameters like Age of the child, sex of the child, household size, caregiver information, IYCF aspects relate to the child , WASH practices in the households, vaccination of the child, attendance/registration of the child at AWC, use of THR, recent morbidity, how morbidity is treated (at home, clinic, etc.) – wealth and livelihoods of the household (proxy measures). This analysis will aid in having control for these effects on child nutrition status, and thus, at a later stage, will help in assessing the impact of the improved THR (if consumed) on the child's health and nutritional status.**			
4. **Others**			
xvii) **Hygiene and health practices among the caregivers of children (boys and girls) at the household levels (PLWs and caregiver of children 6-36 months) (EW 5, 11)**	Semi-structured Interviews	Lactating Women/Caregivers	Collation and triangulation of primary and secondary data to draw findings (baseline benchmarks) and insights
xviii) **Recent morbidity among children - Percentage of children (boys and girls) who were ill in the last 15 days (before the survey)**	Semi-structured Interviews	Lactating Women/Caregivers	
5. **THR related**			
xix) **On-going practices of the production of the THR (EQ 2, 3, 4, 8, 9 , 13)**	Dyads/Triads	WSHG Members	Collation and triangulation of primary and secondary data to draw findings
xx) **THR storage practices (EQ 4, 13)**	IDIs and Dyads/Triads	WSHG Members, AWWs, and PLWs/Caregivers	

Evaluation question			Criteria
Sub questions/ Indicators	**Data collection methods**	**Sources of data/ information**	**Data analysis methods/ triangulation**
xxi) **Percentage of AWWs and caregivers/PLWs trained on appropriate storage, importance, preparation and consumption of THR (EW 5, 13, 14)**	Semi-structured and Structured Interviews	AWWs, PLWs/Caregivers	(baseline benchmarks) and insights
xxii) **Frequency of receiving THR – by AWW; by beneficiaries from AWW (EQ 4)**	Structured Interviews	AWWs, PLWs/Caregivers	
xxiii) **Consumption of THR by beneficiaries (PLWs, targeted children- boys/girls); consumption by other household members (EQ 4, 5, 9, 10, 11)**	Structured Interviews	PLWs/Caregivers	
xxiv) **Cooking and eating practices of THR distributed under ICDS to the targeted children (boys and girls) and their caregivers, and PLWs. (EQ 10, 11)**	Semi-structured and Structured Interviews	AWWs, ANMs/ASHAs, PLWs/Caregivers,	

Annexes 4. Indicators for Baseline Analysis

Table 34: Indicators for Baseline Analysis

Objective/Indicators	Baseline	Endline
Objective-1: Establishing a replicable, efficient demonstrable, and '*Operationally effective*[45]' model, that ensures providing nutritious and affordable THR to PLWs, infants, and young children in a sustainable way		
(1). Output Indicators- Systemic Level:		
(a) Quantity (in kgs) of age-appropriate, nutritious, fortified, and diversified THR - produced in the THR production center	NA (as the THR is currently being distributed in form of food grains)	√
(b) Quantity (in kgs) of age-appropriate, nutritious, fortified and diversified THR - supplied to the AWCs		√
***(c)* Quantity (in kgs) of age-appropriate, nutritious, fortified and diversified THR - distributed from the AWCs to the children (aged 6-36 months)**	√ (in form of KG of food grains distributed to beneficiaries)	√
(d) Quantity (in kgs) of age-appropriate, nutritious, fortified and diversified THR - distributed from the AWCs to the Women	√ (in form of KG of food grains distributed to beneficiaries)	√
(e) Quantity (in kgs) of age-appropriate, nutritious, fortified and diversified THR - distributed from the AWCs to the Lactating Women (caregivers of children 6-36 months)	√ (in form of KG of food grains distributed to beneficiaries)	√
(f) Number of AWCs - supplied with nutritious THR	√ (in form of food grains)	√
(g) Number of AWCs - distributing nutritious THR		√
(h) Frequency of monitoring of THR distribution (in a quarter)	√ (for monitoring of THR distribution in form of food grains)	√
(i) Number of quality assurance (QA) mechanisms and standard operating procedures (SOP) on the total production process including fortification in place	NA (as the THR is currently being distributed in form of food grains)	√
(j) Quantity (in kgs) of THR stored appropriately at– production center	NA (as the THR is currently being distributed in form of food grains)	√
(k) Quantity (in kgs) of THR stored appropriately at–AWC level	√	√
(l) Number of the state government officials trained for monitoring, procurement, production and distribution of the nutritious THR (DPO and CDPOs)	NA	√

[45] Operational model will be called workable and replicable if- a) No gap in in the supply of nutritious, diversified and fortified THR to the AWCs, b) no break in the distribution of nutritious, diversified and fortified THR in the AWCs c) quality assurance mechanisms are effectively functional, d) there is acceptability for the nutritious, diversified and fortified THR e) monitoring of THR distribution, and consumption is streamlined, f) Standard operating procedures on fortification adhered to, g) Storage is proper.
A replicable model should have capacities of officials/stakeholders built; government is capable and ready to take over the project; and government's intention to sustain and scale-up the project is strong.

Objective/Indicators	Baseline	Endline
(m) Number of trainings or technical assistance provided to the government officials on monitoring, procurement, production and distribution of the nutritious THR (DPO and CDPOs)	√ (for monitoring of THR distribution in form of food grains)	√
(n) Availability of equipment for the production of a nutritious THR with WSHGs	NA (as the THR is currently being distributed in form of food grains)	√
(2). Output Indicators - Community and Individual Level		
Number of WSHGs[46] trained/assisted[47]. • **Entrepreneurship; Financial literacy; Leadership; Efficient production of THR and functioning of the production unit; etc.**	NA (as no WSHGs are involved in production of THR currently)	√
Number of intended beneficiaries receiving nutritious, diversified and fortified THR – Children (6-36 months) Boys and Girls	√ (for THR currently being distributed in form of food grains)	√
Number of intended beneficiaries receiving nutritious, diversified and fortified THR – Pregnant Women		√
Number of intended beneficiaries receiving nutritious, diversified and fortified THR - Lactating Women (caregivers of children 6-36 months)		√
Cooking and eating practices of THR distributed under ICDS for targeted children (boys and girls) 6 months to 3 years Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others), Education, and Area (rural/urban)-wise		√
Cooking and eating practices of THR distributed under ICDS to the Lactating Women (caregivers of children 6-36 months) Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others), Education, and Area (rural/urban)-wise		√
Cooking and eating practices of THR distributed under ICDS to the Pregnant women Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise		√
(3). Outcome Indicators: Systemic Level		
Percentage of required age-appropriate, nutritious, fortified and diversified THR regularly produced in the THR production centre	NA (as the THR is currently being distributed in form of food grains)	√
Percentage of AWCs distributing nutritious, diversified and fortified THR to the beneficiaries in a timely manner	√ (for THR currently being distributed in form of food grains)	√
(4). Outcome Indicators - Community and Individual Level:		
Percentage of WSHGs exhibiting improved entrepreneurship, financial literacy, and leadership.	NA (as no WSHGs are involved in production of THR currently)	√
Percentage of intended beneficiaries showing improved consumption and acceptability of the nutritious, diversified and fortified THR– Children (6-36 months) Boys and Girls Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise	NA (to be assessed at endline)	√

[46] WSHG who would set-up the THR production center

[47] Training or assistance provided to the WSHGs in terms of entrepreneurship, financial literacy, leadership etc. required for the efficient production of THR and functioning of the production unit.

Objective/Indicators	Baseline	Endline
Percentage of intended beneficiaries showing improved consumption and acceptability of the nutritious, diversified and fortified THR– Pregnant Women Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others), Education, and Area (rural/urban)-wise		
Percentage of intended beneficiaries showing improved consumption and acceptability of the nutritious, diversified and fortified THR– Lactating Women (caregivers of children 6-36 months) Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others), Education, and Area (rural/urban)-wise		
Objective-2: Improved nutritional knowledge, awareness and behaviours amongst caregivers, adolescents, PLWs and other stakeholders		
***(1).* Output Indicators- Community and Individual Level**		
Awareness of frontline functionaries on nutrition and related aspects; and THR importance/ uptake- AWWs	√	√
Awareness of frontline functionaries on nutrition and related aspects; and THR importance/ uptake- ASHAs	√	√
Awareness of frontline functionaries on nutrition and related aspects; and THR importance/ uptake- ANMs	√	√
Number of frontline functionaries trained on nutrition counselling skills- AWWs	NA (we understand that the trainings of FLWs will be part of project execution at a later stage)	
Number of frontline functionaries trained on nutrition counselling skills- ASHAs		
Number of frontline functionaries trained on nutrition counselling skills- ANMs		√
KAP regarding nutrition during pregnancy- Pregnant women Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise	√	√
KAP regarding nutrition during pregnancy- Lactating Women (caregivers of children 6-36 months) Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise	√	√
KAP regarding nutrition during pregnancy- Adolescent Girls	√	√
KAP regarding nutrition of children - Pregnant women Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) and Education-wise	√	√
KAP regarding nutrition of children - Lactating Women (caregivers of children 6-36 months) Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise	√	√
KAP regarding nutrition of children - Adolescent Girls	√	√
KAP regarding breastfeeding of new-borns/infants/children - Pregnant women Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise	√	√
KAP regarding breastfeeding of new-borns/infants/children - Lactating Women (caregivers of children 6-36 months) Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise	√	√
KAP of regarding breastfeeding of new-borns/infants/children - Adolescent Girls	√	√
Awareness regarding the age at which weaning should be initiated for children - Pregnant women Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise	√	√
Awareness regarding the age at which weaning should be initiated for children- Lactating Women (caregivers of children 6-36 months) Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise	√	√
Practice regarding the age at which weaning was initiated for the reference child Lactating Women (caregivers of children 6-36 months) Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise	√	√

Objective/Indicators	Baseline	Endline
Awareness regarding the age at which weaning should be initiated for children - Adolescent Girls	√	√
Minimum Dietary Diversity (MDD) in last 24 Hours – Pregnant women Types and Number of Food Groups Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise	√	√
Minimum Dietary Diversity (MDD) in last 24 Hours – for children 6-36 months (girls v/s boys) Types and Number of Food Groups Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise	√	√
Awareness and Perception on Maternal Nutrition and Breastfeeding (Beliefs)- Pregnant Women Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise	√	√
Awareness and Perception on Maternal Nutrition and Breastfeeding (Self-efficacy)- Pregnant Women Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise	√	√
Awareness and Perception on Maternal Nutrition and Breastfeeding (Social Norms)- Pregnant Women Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise	√	√
Sources of Information Counselling on Maternal Nutrition and Breastfeeding- Pregnant Women Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise	√	√
Sources of Information Counselling on Maternal and Child Nutrition and Breastfeeding- Community Representatives	√	√
Awareness and Perception on Child Nutrition and Breastfeeding (Beliefs)- Lactating Women (caregivers of children 6-36 months) Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise	√	√
Awareness and Perception on Child Nutrition and Breastfeeding (Self-efficacy)- Lactating Women (caregivers of children 6-36 months) Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise	√	√
Awareness and Perception on Child Nutrition and Breastfeeding (Social Norms)- Lactating Women (caregivers of children 6-36 months) Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise	√	√
Sources of Information Counselling on Child Nutrition and Breastfeeding- Lactating Women (caregivers of children 6-36 months) Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise	√	√
IFA Consumption during current pregnancy– Pregnant women Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise	√	√
IFA Consumption during pregnancy with reference child– Lactating Women (caregivers of children 6-36 months) Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise	√	√
ANC Registration and Receipt of ANC services during current pregnancy– Pregnant women Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise	√	√
ANC Registration and Receipt of ANC services during pregnancy with reference child– for children 6-36 months (girls v/s boys) Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise	√	√
Knowledge regarding ANC Registration and Number of ANC services for Pregnant Women – AWWs	√	√
Knowledge regarding ANC Registration and Number of ANC services for Pregnant Women – ASHAs	√	√
Knowledge regarding ANC Registration and Number of ANC services for Pregnant Women - ANMs	√	√
KAP regarding THR uptake - Pregnant Women	√	√

Objective/Indicators	Baseline	Endline
Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise		
KAP regarding THR consumption- Pregnant Women **Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise**	√	√
KAP regarding THR acceptance- Pregnant Women **Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise**	√	√
KAP regarding THR uptake for Reference Child (boys v/s girls)- Lactating Women (caregivers of children 6-36 months) **Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise**	√	√
KAP regarding THR consumption for Reference Child (boys v/s girls)- Lactating Women (caregivers of children 6-36 months) **Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise**	√	√
KAP regarding THR acceptance Reference Child (boys v/s girls)- Lactating Women (caregivers of children 6-36 months) **Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise**	√	√
KAP regarding THR uptake – Adolescent Girls	√	√
KAP regarding THR consumption– Adolescent Girls	√	√
KAP regarding THR acceptance– Adolescent Girls	√	√
Awareness regarding Importance of Good Nutrition during Pregnancy– Community Representatives	√	√
Awareness regarding Importance of Good Nutrition during Lactation– Community Representatives	√	√
Perception regarding Importance of THR Consumption during Pregnancy– Community Representatives	√	√
Perception regarding Importance of THR Consumption during Lactation– Community Representatives	√	√
Number of lactating women and caregivers of children (dis-aggregated by boys and girls) who received adequate information of exclusive breastfeeding, complementary feeding, anaemia and key nutrition-related behaviours. **Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise**	NA (we understand that SBCC will be part of project execution at a later stage)	√
Number of pregnant women who received adequate information of exclusive breastfeeding, complementary feeding, anaemia and key nutrition-related behaviours. **Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise**		√
Adolescent girls and community members who received adequate information of exclusive breastfeeding, complementary feeding, anaemia and key nutrition-related behaviours.		√
Number of AWWs who received adequate information of exclusive breastfeeding, complementary feeding, anaemia and key nutrition-related behaviours.		
KAP of adolescent girls on nutrition and THR uptake/consumption/acceptance	√	√
Knowledge & Attitude (KA) of VHSNC/UHSNC/PRI members on nutrition and THR uptake/consumption/acceptance	√	√
***(2).* Output Indicators- Community and Individual Level**		
Percentage of lactating women and caregivers of children (dis-aggregated by boys and girls) exhibiting adequate knowledge of exclusive breastfeeding, complementary feeding, anaemia and key nutrition-related behaviours. **Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise**	√	√
Percentage of pregnant women exhibiting adequate knowledge of exclusive breastfeeding, complementary feeding, anaemia and key nutrition-related behaviours. **Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education, and Area (rural/urban)-wise**	√	√

Objective/Indicators	Baseline	Endline
Percentage of AWWs exhibiting adequate knowledge of exclusive breastfeeding, complementary feeding, anaemia and key nutrition-related behaviours.	√	√
Adolescent girls exhibiting adequate knowledge of exclusive breastfeeding, complementary feeding, anaemia and key nutrition-related behaviours.	√	√
Community members exhibiting adequate knowledge of exclusive breastfeeding, complementary feeding, anaemia and key nutrition-related behaviours.	√	√
Anthropometric & Other Indicators		
Nutritional status of children - Percentage of children who are wasted (boys and girls) (-3 and -2SD) Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education of Caretaker, and Area (rural/urban)-wise	√	√
Nutritional status of children - Percentage of children who are stunted (boys and girls) (-3 and -2SD)	√	√
Nutritional status of children - Percentage of children who are underweight (boys and girls) (-3 and -2SD) Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education of Caretaker, and Area (rural/urban)-wise	√	√
Hygiene and health practices among the caregivers of children (boys and girls) at the household levels (caregiver of children 6-36 months) – Main Source of Drinking Water Social (SCT/ST/OBC/Gen), Education of Caretaker, and Area (rural/urban)-wise	√	√
Hygiene and health practices among the lactating women (caregivers of children 6-36 months); boys and girls) at the household levels – Availability of Toilet Social (SCT/ST/OBC/Gen), Education of Caretaker, and Area (rural/urban)-wise	√	√
Hygiene and health practices among the lactating women (caregivers of children 6-36 months); boys and girls) at the household levels – Means of disposing the stool of reference child Social (SCT/ST/OBC/Gen), Education of Caretaker, and Area (rural/urban)-wise	√	√
Hygiene and health practices among the lactating women (caregivers of children 6-36 months); boys and girls) at the household levels – Handwashing with Soap & Water Social (SCT/ST/OBC/Gen), Education of Caretaker, and Area (rural/urban)-wise	√	√
Hygiene and health practices among the lactating women (caregivers of children 6-36 months); boys and girls) at the household levels – Handwashing times (when are hands washed) Social (SCT/ST/OBC/Gen), Education of Caretaker, and Area (rural/urban)-wise	√	√
Recent morbidity among children (DIARRHOEA) - Percentage of children (boys and girls) (in the last 15 days before the survey) Social (SCT/ST/OBC/Gen), Education of Caretaker, and Area (rural/urban)-wise	√	√
Recent morbidity among children (FEVER) - Percentage of children (boys and girls) (in the last 15 days before the survey) Social (SCT/ST/OBC/Gen), Education of Caretaker, and Area (rural/urban)-wise	√	√
Recent morbidity among children (ARI) - Percentage of children (boys and girls) (in the last 15 days before the survey) Social (SCT/ST/OBC/Gen), Education of Caretaker, and Area (rural/urban)-wise	√	√
Percentage of children (boys and girls) who are fully vaccinated Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education of Caretaker, and Area (rural/urban)-wise	√	√

Objective/Indicators	Baseline	Endline
Percentage of children (boys and girls) who are vaccinated (age-appropriate) Social (SCT/ST/OBC/Gen), Religion (Hindu. Muslim, Sikh, Others) , Education of Caretaker, and Area (rural/urban)-wise	√	√
Number/Percentage of Differently abled – AWWs		
Number/Percentage of Differently abled – ASHAs		
Number/Percentage of Differently abled – ANMs		

Annexes 5. Summary Terms of Reference

1. Context and subject of the Evaluation

Context

1. Adequate nutrition during pregnancy of mother, infancy, and early childhood is essential to ensure the growth, health, and development of children to their full potential. Based on the evidence of the effectiveness of interventions, achievement of universal coverage of optimal breastfeeding could prevent 13 percent of deaths in children less than 5 years of age, while appropriate complementary feeding practices would result in an additional 6 percent reduction in under-five mortality.
2. High levels of maternal and child undernutrition in India have persisted, despite strong Constitutional, legislative policy, plan, and programme commitments. Legislations such as the National Food Security Act 2013 mandating food and nutrition entitlements for children, pregnant, and breastfeeding mothers. The National Nutrition Policy 1993, complemented by other policies such as the National Health Policy 2002, the National Policy for Children, 2013 provides a strong foundation for addressing the immediate and the underlying determinants of undernutrition through both direct interventions and indirect interventions. A wide spectrum of national programmes contributes to improved nutrition outcomes, addressing both the immediate and the underlying determinants of undernutrition through nutrition-specific and nutrition-sensitive interventions. These include the ICDS, National Health Mission, Mid-Day Meals Scheme, Targeted Public Distribution System, and National Food Security Mission. Government of India rolled out Poshan Abhiyaan scheme in 2017-18 to reduce stunting, undernutrition, anaemia (among young children, women, and adolescent girls), and low birth weight by leveraging technology, a targeted approach, and convergence. However, the problem in Rajasthan is the low coverage of these interventions and the consequences of manifest in terms of poor nutrition status of children and women.
3. WFP and the Government of Rajasthan signed a Memorandum of Understanding (MoU) to work together to achieve food security and improved nutrition in the state to make significant progress towards Sustainable Development Goal 2.
4. WFP in partnership with the Government of Kerala has conducted a similar pilot project of fortification of THR distributed under ICDS and improving the IYCF practices in few panchayats of Wayanad district of the state of Kerala. The duration of the pilot project was from January 2017 to December 2018. The government of Kerala has scaled up the pilot project in the entire state.
5. **Background of Rajasthan**: Rajasthan is a state in north-western India, which covers an area of 342,239 square kilometres and has a population of 68.5 million. Rajasthan has 13.48 percent of Scheduled Tribes[48] (STs) and 17.83 percent of Scheduled Castes (SCs). As per Census 2011, Rajasthan's literacy rate is 66 percent. In the state, 79 percent male and 52 percent female are literate, which reflects a huge gender gap in literacy. A low child sex ratio with only 928 girls for every 1000 boys shows how gender inequality impacts girls' survival. As per National Family Health Survey 2015-16 (NFHS-4), there is a huge preference for sons in the state.
6. Regarding the **gender and women issues**, in Rajasthan overall status of women is poor, which gets reflected through various gender-related indicators (NFHS-4). In context to employment, only 29 percent of women were employed, while in the same period, 75 percent of men aged 15-49 years were employed. Concerning the occurrence of domestic violence, almost one-quarter (23 percent) of women in Rajasthan

[48] The STs and SCs are officially designated groups of people in India. The terms are recognised in the Constitution of India. As per available data and literature, they are socially and economically most deprived group. The Constitution lays down the general principles of positive discrimination for SCs and STs.

have experienced physical or sexual violence and the most common perpetrator for ever-married women was the husband (90 percent). Media exposure is higher among men than women in Rajasthan. Men (57 percent) are much more likely than women (22 percent) to read a newspaper or magazine at least once a week.

7. **Status of IYCF and Nutrition in Rajasthan**: According to the NFHS-4, only 6 out of 10 children under six months of age are exclusively breastfed; solid and semi-solid foods were added to the diets of only about 30 percent of children between 6-8 months of age and about 3.4 percent children between 6-23 months of age receive an adequate diet in Rajasthan. Among the children under the age of five, an estimated 23 percent are wasted, 39.1 percent are stunted, and 36.7 percent are underweighting in Rajasthan. There is no significant difference among girls and boys in terms of the prevalence of wasting, stunting, and being underweight. Furthermore, as compared to men (17 percent), a much higher proportion of women (47 percent) aged 15 to 49 years suffer from anaemia; the prevalence being the same even during pregnancy. Twenty-seven percent of women and 23 percent of men in Rajasthan have low BMI (too thin for their height).
8. In Rajasthan, a higher percentage of ST children are anaemic (74 percent), as compared to SC (59 percent), other backward class[49] (58 percent), and others (56 percent). A slightly higher percentage of children residing in a rural area are anaemic (62 percent), as compared to children living in urban areas (56 percent). NFHS-4 results show that with the increase in the mother's years of schooling, the prevalence of anaemia among their children decreases. Mother's anaemia status affects their child's anaemia status50: a lower percentage of children of non-anaemic mothers have anaemia (52 percent), as compared to mothers with severe/moderate anaemia (77 percent) and mild anaemia (65 percent). Through the ICDS in Rajasthan, take-home rations are distributed to children between 6-36 months of age and pregnant/lactating women in the form of a mix of wheat, soya, gram flour, oil, and sugar - both commodities are produced in a de-centralized modality. 750 grams and 930 grams of this mix are distributed to children and women on a weekly basis.

The subject of the evaluation

9. This evaluation of IYCN through the ICDS scheme in Jaipur during 2020-2023 is a pilot evaluation. Baseline evaluation would take place from January 2021 to August 2021 and endline evaluation would be conducted in 2023.
10. Given that improving nutritional practices in the first 1,000 days can prevent the serious and irreparable damage caused by hunger and malnutrition in children even in resource-poor settings, WFP will work towards ensuring seamless delivery of quality, nutritious, and age-appropriate THR to the children and pregnant/lactating women through a newly set-up THR production unit along with required social behaviour change communication - SBCC being directed to all sections of the community to improve nutritional practices and increased capacity of the WSHGs in terms of empowerment, entrepreneurship, financial literacy, leadership, etc. required for the efficient production of THR and functioning of the production unit. The concept will initially be implemented in pilot mode in one district at the sub-district level with scale up to other districts in the State being the overall vision.
11. **Project goal**: The proposed intervention seeks to establish a replicable and demonstrable model for improving infant and young child feeding practices which could help in preventing malnutrition.

[49] Other Backward Classes (OBCs) is a collective term used by the Government of India to classify castes which are educationally or socially disadvantaged.

[50] Existing literature suggest that pregnancy is associated with increased iron demand, and therefore, increase the risk of iron deficiency anaemia among mothers. Anaemia among mothers leads to lowered iron stores in their new-born baby. Hence, it becomes an inter-generational cycle of malnutrition.

12. **Project Outcomes**: The project will lead to the following outcomes:
    i. Establishing a replicable, efficient demonstrable, and '*Operationally effective*' model, that ensures a nutritious and affordable THR to PLWs, infants, and young children in a sustainable way
    ii. Improved nutritional knowledge, awareness, and behaviours amongst caregivers/PLWs, adolescents, and AWWs on importance, consumption, and storage of THR
    iii. Improved nutritional knowledge, awareness, and behaviours amongst caregivers, adolescents, PLWs, AWWs, and other stakeholders on exclusive breastfeeding, complementary feeding, anaemia, and key nutrition-related behaviours.
    iv. Reduction in prevalence of malnutrition in children between 6 to 36 months of age
    v. Enhanced gender equity and empowerment among WSHG member women
13. **Project Outputs:** The project will achieve the following outputs:
    i. Production of the age-appropriate, nutritious, fortified, and diversified THR in the production center
    ii. Supply of age-appropriate, nutritious, fortified and diversified THR to the AWCs and distribution of nutritious THR from the AWCs to the children (aged 6-36 months) and PLWs.
    iii. Adherence to quality assurance mechanisms and standard operating procedures (SOP) on the total production process including fortification.
    iv. Appropriate storage of THR at all levels – production center and AWC level.
    v. Increased capacity of the state government officials trained for monitoring, procurement, production, and distribution of the nutritious THR.
    vi. Increased capacity of the WSHGs in terms of empowerment, entrepreneurship, financial literacy, leadership, etc. required for the efficient production of THR and functioning of the production unit.
    vii. Increased acceptability and consumption of the improved, age-appropriate, nutritious, and fortified take-home rations delivered to young children and PLW with aim of preventing and addressing malnutrition.
14. **Project Components:** The core project components therefore include:
    A. **Supplementary Nutrition:** Under this component, the project partners including the women from the WSHGs will work towards improving the quality of the THR served to children between six to 36 months of age and PLWs.
    B. **Improved Care and Nutrition Practices:** A well-planned, coordinated across sectors and thought through SBCC strategy will be implemented to ensure appropriate utilization and demand for nutrition services and appropriate decisions and behaviours by caregivers and individuals. The SBCC will also focus on gender equity, which is a key influencer of food intake, by emphasising the elimination of any discriminatory practices in child feeding and against women and girls in the family.
15. **Implementation Modalities:** The core components will be implemented via the establishment of THR production unit for the production of quality and nutritionally age-appropriate THR, organization of sensitization workshops, capacity building of grassroots functionaries of various departments including that of DWCD, development of improved supplementary rations, development of training modules and other information, education and communication materials, supply chain management and quality assurance and control as appropriate through need-based hiring of vendors.

16. **Project Location**: In discussions with the GoR, and based on some criteria[51], Jaipur is the choice of the project district for the pilot.
17. According to the NFHS-4, in Jaipur, 72 percent of children under six months of age are exclusively breastfed; solid or semi-solid foods and breastmilk were added to the diets of 42 percent of children between 6-8 months of age, about 2.8 percent of children between 6-23 months of age receive an adequate diet and among the children under the age of five, an estimated 13 percent are wasted, 36 percent are stunted, and 25 percent are underweight. Furthermore, approximately 27 percent of women aged 15 to 49 years suffer from anaemia; the prevalence being 30 percent during pregnancy. Around 23 percent of women are reported to have low BMI (too thin for their height).

    Jaipur is the most populous district of Rajasthan. For administration and development, the district is divided into thirteen sub-divisions. For the implementation of rural development projects/ Schemes under the Panchayati Raj System, the district is divided into the 13 Panchayat Samitis (Blocks). There are 11 statutory towns in Jaipur. **A pilot project would be implemented in five blocks of Jaipur, that is Jaipur I, Jaipur II, Jaipur III, Sanganer City, and Rural Sanganer.**

    Project duration: The project duration will be three years starting from the date of signatures on the memorandum of understanding and letter of agreement between WFP and GoR: (i) Preparatory phase: six months (ii) Implementation phase: 24 months (iii) Hand-over including the development of plans for scale-up: six months.

    Key Project Stakeholders: The key departments of the Government of Rajasthan that WFP shall liaison under the umbrella of this project include the Department of Women and Child Development).

2. Evaluation Approach

Scope

18. This is a decentralized evaluation of the entire pilot project on IYCN through the ICDS scheme in Jaipur District of Rajasthan during 2020-2023. This evaluation is commissioned by WFP India CO and will cover the tentative period from November/2020 to November/2023.
19. In addition to the parameters mentioned in the Result matrix, based on the request from the Government of Rajasthan, the following parameters would also be measured during pre and post-intervention among the children (aged 6-36 months) in the project and comparison area.
    - Anthropometric status of the children in the target age group – Percentage of children who are wasted, stunted, and underweight (dis-aggregated by boys and girls)
    - Hygiene and health practices among the caregivers of children (dis-aggregated by boys and girls) at the household levels, PLWs, adolescent girls, community, and others.
    - Morbidity patterns among the beneficiaries - Percentage of children (dis-aggregated by boys and girls) who were ill in the last 15 days (before the survey)
20. To understand the existing situation, during baseline following context-specific information would be gathered:

    Systemic Level

[51] Jaipur district has high prevalence of malnutrition (stunting, wasting, underweight and micronutrient deficiencies). It also has presence of project partners, other UN agencies and non-governmental organization (NGOs). Availability of existing infrastructure, mechanisms to ensure streamlined roll-out of the project interventions; and pro-active district administration with willingness to make a real change in the nutrition scenario is an added-advantage in Jaipur. Being the state capital, project would have better visibility and eventual scale-up throughout the State. Besides, Jaipur has also been recommended by the DWCD, GoR.

- On-going practices of the production, supply, and distribution of the THR
- To identify issues and gaps (if any) such as leakages of the THR in the current practices

Community and Individual Level

- The ongoing practices by the WSHGs for the production of
- Social context - challenges WSHG members faced in producing THR, whether the pilot has aided in enhancing their self-confidence and sense of empowerment
- Current quality assurance mechanisms – in place and being adhered to by WSHGs involved in preparing the THR
- On-going behaviours, key influencers around exclusive breastfeeding, complementary feeding, and other nutrition-related aspects among the caregivers of children (dis-aggregated by boys and girls), AWWs, and others.
- Feedback of the beneficiaries about the quality of the THR
- Consumption pattern of THR including intra-household consumption pattern, especially between girls and boys, sharing of THR between male and female members,
- Cooking and eating practices of THR are distributed under ICDS to the targeted children (dis-aggregated by boys and girls) and their caregivers.

Methodology

21. A suggestive methodology has been provided in this section. It is expected that the methodology will be further refined by the evaluation team during the inception phase. It should:
    - Employ the relevant evaluation criteria mentioned above Relevance, Coherence, Effectiveness, Efficiency, Impact, and Sustainability.
    - Demonstrate impartiality and lack of biases by relying on a cross-section of information sources (stakeholder groups, including beneficiaries, etc.). The selection of field visit sites will also need to demonstrate impartiality.
    - Using mixed methods (quantitative, qualitative, participatory, etc.) to ensure triangulation of information through a variety of means.
    - Apply an evaluation matrix geared towards addressing the key evaluation questions taking into account the data availability challenges, the budget, and timing constraints.
    - Ensure through the use of mixed methods that women, girls, men, and boys from different stakeholder groups participate and that their different voices are heard and used.
    - Comparison of the findings of the baseline evaluation with the endline evaluation would provide critical insights into the performance of the project.
    - Mainstream gender equality and empowerment of women, as above.
22. The relevant data will be acquired at the appropriate level by using mixed methods (quantitative and qualitative) to ensure the triangulation of information through a variety of means.
23. As part of the evaluation, the hired evaluation team will conduct the following:
    - baseline evaluation towards providing an in-depth analysis of the baseline situation in the operational area to support benchmarking of key performance indicators, facilitating operational planning, and establishing the basis for evaluation on completion of the project.
    - undertake an evaluation of the performance of the project at endline against established benchmarks at baseline, including gender and age dis-aggregations.

A. Desk Review:

24. The agency will review some of the government documents and project-related documents will be done to further the understanding of the pilot, its scope, and objectives. The agency will also need to look at other data sources available such as most recent studies, reports of joint review mission, and other reports provided by the project staff/authorities.
25. Desk review of all the existing SBCC strategies, evidence of key nutrition-related behaviours, communication materials (IPC, mass media, outdoor media) on infant and young child feeding practices would be conducted.

B. Quantitative Survey

a) Caregivers of Children:

26. To measure the change of consumption of nutritious THR on the beneficiary children (boys and girls), children aged 6-36 months (boys and girls) would be identified/selected randomly from the register maintained by AWWs in the project area or birth records and would be examined in terms of their anthropometric measurements.
27. The quantitative survey would be conducted among the caregivers of children (6-36 months) to assess the THR consumption pattern, acceptability, morbidity profile of children, awareness levels, behaviour, decision-making, health services provided at AWC, their beliefs, self-efficacy, and social norms & other determinants of their current behaviours and practices related to complementary feeding and accessing AWC services, etc. Socio-economic characteristics, health, and hygiene practices at the household level would also be collected. To measure changes, which could occur due to project interventions, the sample size should be statistically adequate to identify and measure those changes.
28. From the project and comparison areas, samples would be identified using the Probability Proportional to Size (PPS) methodology, which means Panchayats/Nagar-Palika with a higher number of AWCs would contribute a higher number of samples as compared with panchayats/Nagar-Palika with a lesser number of AWCs. From each sample AWCs, children (boys and girls 6-36 months) would be randomly selected from the registers maintained by the AWWs. Using a semi-structured questionnaire, information would be collected from the caregivers of 700 sample children from the project area.

b) KAP Survey of Women – related to pregnancy, feeding practices, and lactation:

29. To assess the consumption of THR, awareness-levels, women's knowledge, belief, self-efficacy, social norms/determinants of her behaviour, practices, and various other components of SBCC and project-related activities among the pregnant and lactating women, during baseline and endline, women who have given birth in the last 6 months would be investigated from the intervention and comparison areas. The rationale for identifying women who have given birth in the last 6 months is that at the point of endline evaluation, this cohort of women would have exposure to the fortified THR and SBCC components during pregnancy and lactation. Women who have given birth in the last 6 months would be examined during baseline and endline evaluation.

c) Qualitative Survey of AWWs, WSHGs, adolescents, Government officials, community leaders, and other stakeholders:

30. In-Depth Interviews (IDIs) would be conducted among the various stakeholders. IDIs would allow in understanding the knowledge and practices on appropriate complementary feeding and nutrition including anaemia and other micronutrient deficiency disorders and to assess the distribution pattern, acceptability, etc. of THR among the PLWs, targeted children, and their caregivers. Further, IDIs would help in understanding knowledge, belief, self-efficacy, and practices of PLWs, caregivers, adolescents, and others around determinants of their behaviour, practices-enablers, and barriers for service delivery, especially

counselling for triggering the adoption of optimal behaviours in families. An attempt to assess the systems-related determinants would also be made through IDIs. IDIs would be conducted among the members of the WSHG to assess their capacities in terms of financial literacy, entrepreneurship, leadership, decision-making, etc. which are important for the efficient functioning of the THR production center.

C. Anthropometric Assessment of Children:

31. A sample of around 300 children aged 6-36 months (boys and girls) will be drawn randomly and information collected shall include age and sex, feeding practices, recent morbidity, weight in kilograms (to the nearest 1/10 kg), and recumbent length (< 24 months) or height (24-36 months). This information will be used to calculate the following z-scores using Epi-Info: weight-for-height, height-for-age, and weight-for-age. Children with z-scores below -2.00 SD will be classified as being wasted (whz < -2.00 SD), stunted (haz < -2.00 SD) or underweight (< -2.00 SD). The prevalence of child malnutrition in the project areas will be compared to a sample from pre-selected comparison areas to assess the change in nutritional outcomes between baseline and endline evaluation. All child health and nutrition analyses will be presented disaggregated by age and sex.

Annexes 6. Anthropometric Analysis

Malnutrition can manifest itself as either undernutrition (including micronutrient deficiency) or obesity. **Undernutrition** results from a lack of nutritional intake and/or absorption, as well as sickness or disease. Undernutrition increases the risk of sickness and mortality in children under the age of five, with undernutrition accounting for half of all deaths in children under the age of five. This is due to the fact that inadequate diet weakens a person's immune system, making him or her more vulnerable to disease and infection and less likely to recover. Furthermore, undernutrition, particularly early in life, impedes optimal physical growth as well as cognitive, motor, and socio-emotional development, which can have both short- and long-term consequences for learning and productivity. **Acute malnutrition (**wasting and thinness), **chronic undernutrition** (stunting), **underweight** (a composite of stunting and wasting), and micronutrient deficiencies are the four major types of undernutrition that can occur alone or in combination (e.g., deficiencies in vitamin A, iodine, iron, and zinc). Micronutrient deficiencies are evaluated using biochemical and clinical methods rather than anthropometric measurements, and thus are not addressed in this study.

Anthropometrics is a collection of non-invasive, quantitative body measures that are used to monitor growth, development, and health. Anthropometric measures, such as length or height, weight, and head circumference, assist clinicians in determining if a kid is growing normally and can signal when the child's health and well-being are in jeopardy. Anthropometric assessments can aid physicians in determining which treatment choices are best for children and adolescents.

For the baseline, the evaluation agency conducted anthropometric measurements of 379 children 6-36 months with the following objectives: (i) to evaluate the nutritional status of children aged 6 to 36 months; and (b) to identify groups at higher risk to malnutrition based on the age group and sex. The following information regarding techniques for measuring recumbent length, height, and weight has been adapted to meet WHO guidelines.

Recumbent length: The field team used an infant measuring board with a fixed headboard and moveable footboard to measure children aged 6 months to 23 months in completed months and children aged 24 months to 36 months in completed months who could not stand laying down. Before measuring the kid, the field team recommended that the care taker/mother remove any apparel that may interfere with getting exact measures, such as shoes and thick clothing. To get this measurement, two individuals were used: one to position the child's head against the top of the headboard, and the other to straighten the child's body and legs while maintaining the child's feet pointing upward and parallel to the footboard. After that, pressed the footboard into the feet's bottoms. The field team then read the measurement to the nearest 1 cm (1/8 inch) and recorded the precise value.

Height (stature): The field team used a conventional measuring board with a moveable headboard (stadiometer) affixed to a flat wall to measure children aged 24 to 36 months in completing months who can stand. The child was measured in light clothes, without shoes or thick socks, by the field team. The field team also asked the child to gaze front and stand up straight with his buttocks, shoulder blades, and heels contacting the wall or stadiometer during the process. The headboard was then placed perpendicular to the wall and lowered to the height of the child's head. The field team then read the measurement to the closest 1 cm (1/8 inch) and recorded the precise value.

Weight: Children whose age between 6 months to 23 months in completed months: The field team used a calibrated digital child scale to weigh the child without clothing or a diaper. Then I put the infant in the middle of the scale tray and read the weight to the closest 0.1 kg. Children whose age between 24 months to 36 months in completed months: The child was weighed on a calibrated beam balanced floor scale or an electronic floor scale with increments of less than or equal to 0.1 kg by the field team. The child was weighed in minimum indoor attire and without shoes by the field team. The field team then instructed the child to stand in the centre of the scale's platform and remain still until the measurement could be taken. The weight was then measured to the closest 0.1 kg by the field team.

Z-SCORES: A z-score, which is reported in standard deviations, reveals how much and in which direction an individual's anthropometric measurement deviates from the median of the reference population. For example, if a girl's z-score for weight-for-age is -2SD, her weight-for-age is two standard deviations lower than the median weight-for-age of other girls her age.

The table below presents recognized universal cut-offs for determining nutritional status. Z-scores is a regularly used approach for interpreting and classifying anthropometric data. Following WHO guidelines, IDCG adopted and focused on z-scores. Anthropometric z-scores indicate how far and in which direction an individual's measurement differs from the median value of the reference population. The reference population for the WHO Growth Standards is children of the same gender and age (depending on the measure). A nutritional issue is indicated by Z-scores that are outside of the usual range (undernutrition or overweight). The more the score deviates from the typical range, the more serious the nutritional problem becomes.

Table 35: Universal Cut-offs for Determining Nutritional Status

<table>
<tr><th rowspan="2">Anthropometric Indicator</th><th colspan="2">AGE</th><th colspan="6">Z-SCORE</th></tr>
<tr><th>6-23 months</th><th>24-36 months</th><th>< -3</th><th>≥ -3 to < -2</th><th>≥ -2 to < -1</th><th>≥-1 to ≤ +1</th><th>> +1 to ≤ +2</th><th>> +2 to ≤+3</th><th>> +3</th></tr>
<tr><td>Length-for-age Stunting</td><td>√</td><td rowspan="2"></td><td rowspan="2">Severe Stunting</td><td rowspan="2">Moderate Stunting</td><td colspan="4" rowspan="2">Normal</td><td rowspan="2">Extreme tallness is not a nutrition issue</td></tr>
<tr><td>Height-for-age Stunting</td><td></td><td>√</td></tr>
<tr><td>Weight-for-age Underweight</td><td>√</td><td>√</td><td>Severe Underweight</td><td>Moderate Underweight</td><td colspan="5">Normal
Do not use weight-for-age to determine overweight</td></tr>
<tr><td>Weight-for-length Wasting, overweight, obesity</td><td>√</td><td rowspan="2"></td><td rowspan="2">Sever Wasting/ Severe Acute Malnutrition (SAM)</td><td rowspan="2">Moderate Waste / Moderate Acute Malnutrition (MAM)</td><td rowspan="2">Normal</td><td rowspan="2"></td><td rowspan="2">Possible Risk of Overweight</td><td rowspan="2">Overweight</td><td rowspan="2">Obesity</td></tr>
<tr><td>Weight-for-height Wasting, overweight, obesity</td><td></td><td>√</td></tr>
</table>

Figure 23: Lactating Women/Caregivers Education-wise Status of Underweight Children (%)

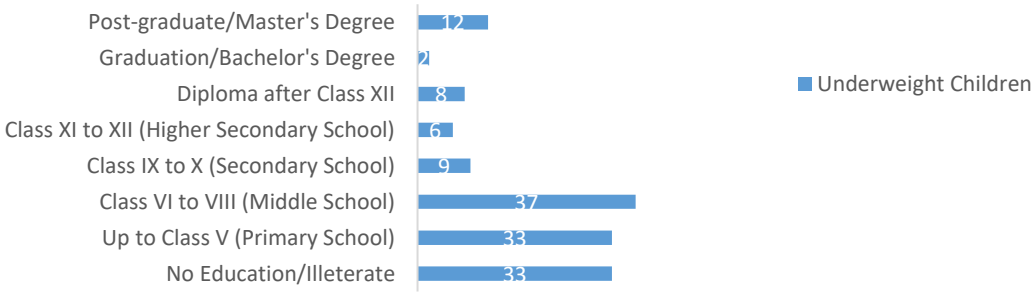


Figure 24: Lactating Women/Caregivers Education-wise Status of Stunted Children (%)

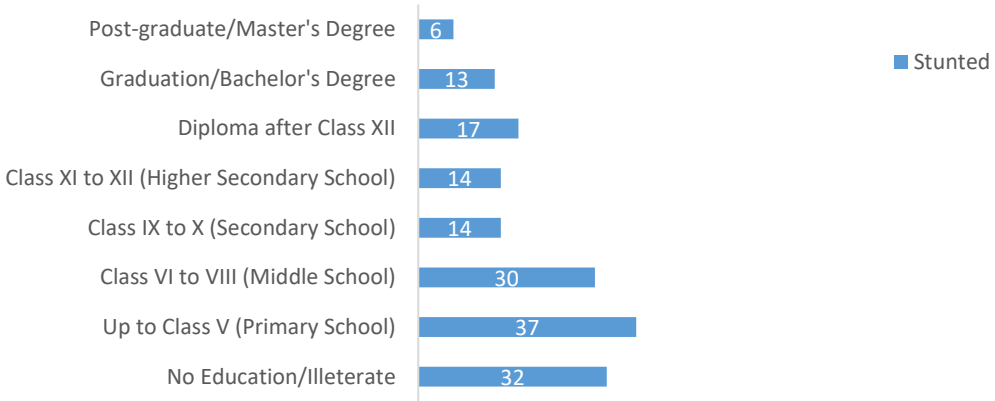
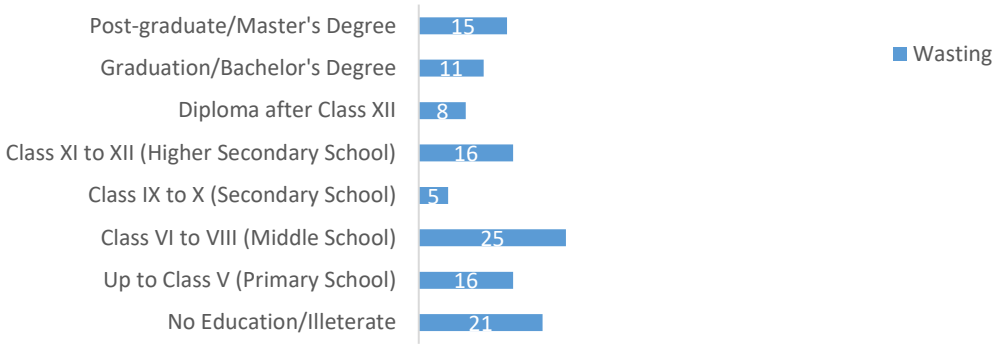


Figure 25: Lactating Women/Caregivers Education-wise Status of Wasting (%)



Annexes 7. Analysis Charts/Tables

Figure 1: Age Category of the Respondents

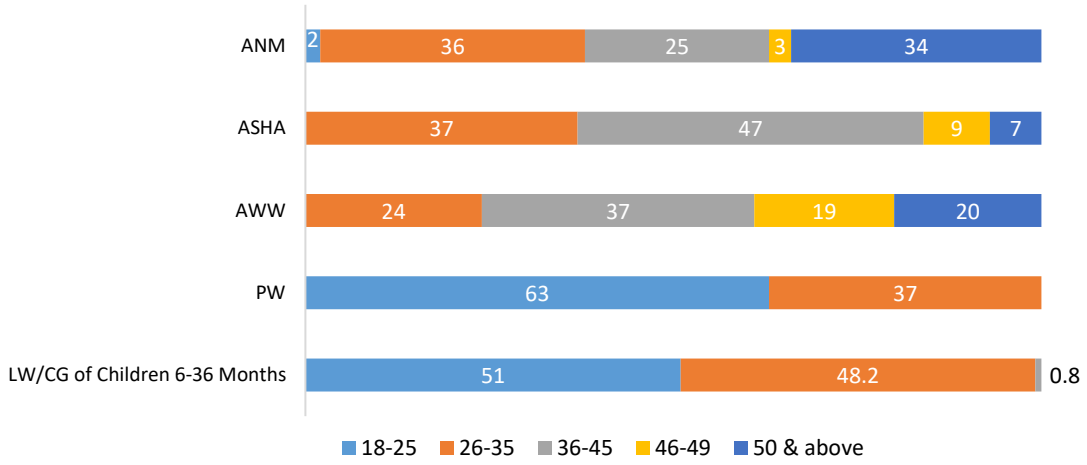


Figure 2: Educational Qualifications of the Respondents (%)

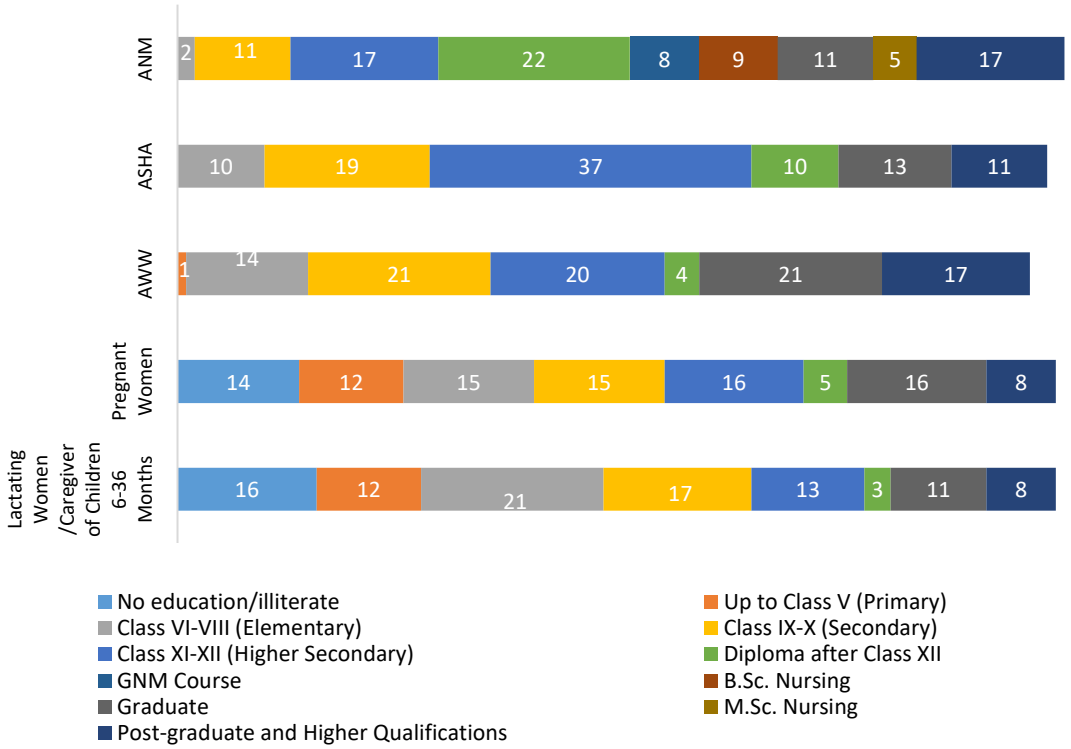


Figure 3: Religion of the Respondents (%)

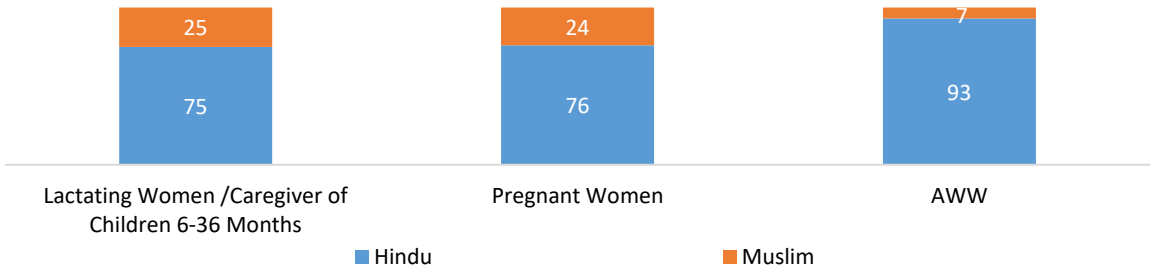


Figure 4: Social Category of the Respondents (%)

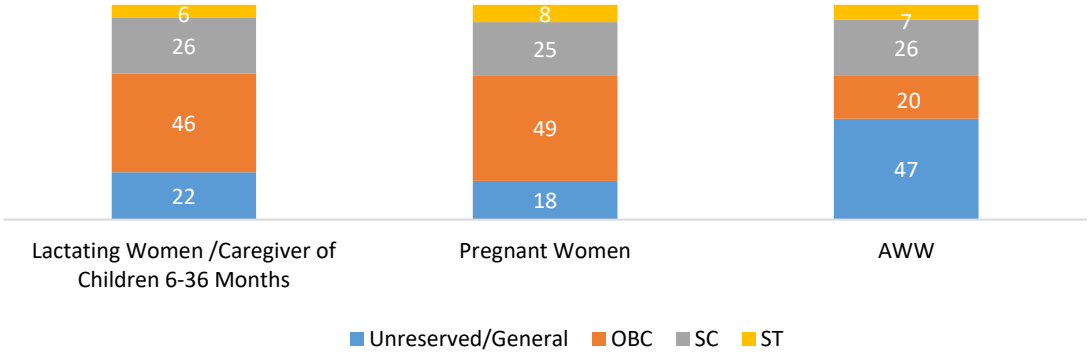


Figure 5: Occupation of the Respondents (%)

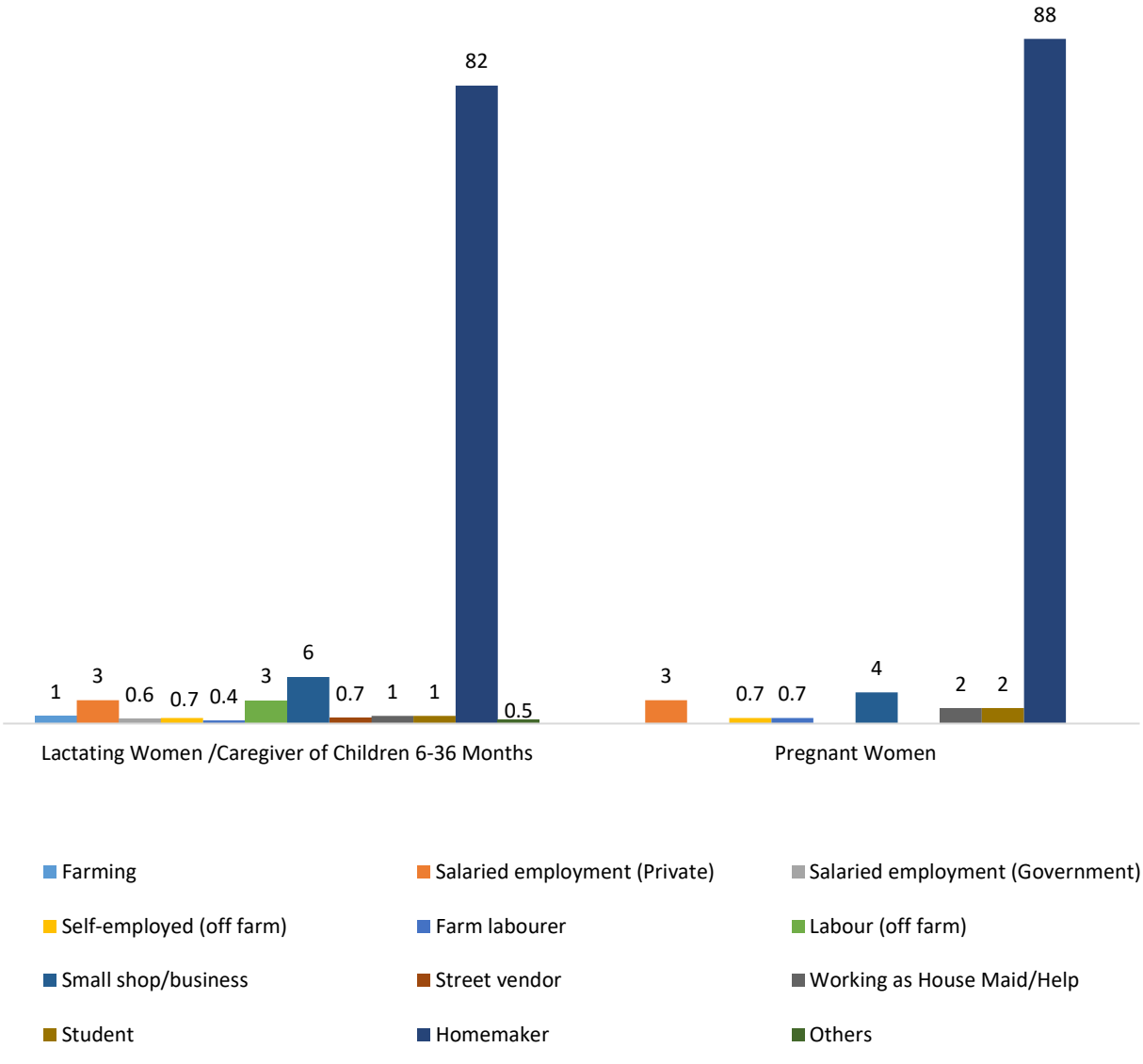


Figure 6: Marital Status of the Respondents (%)

Figure 7: Type of Family of the Respondents (%)

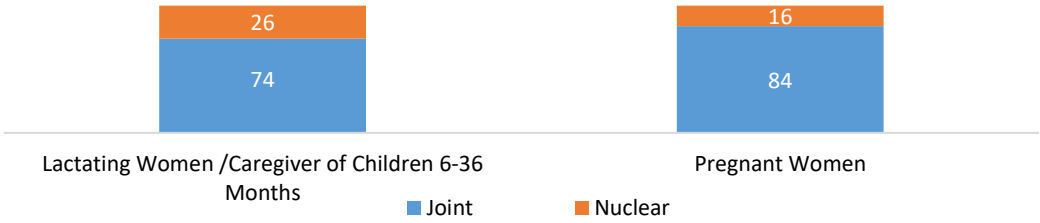


Figure 8: Household Size of Respondents (%)

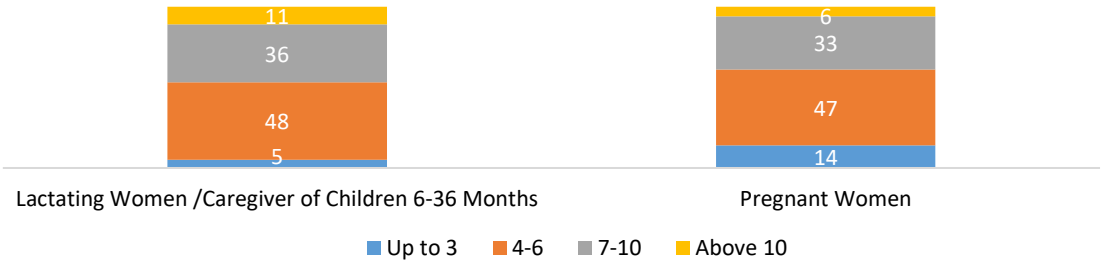


Figure 9: Availability of Household Assets (%)

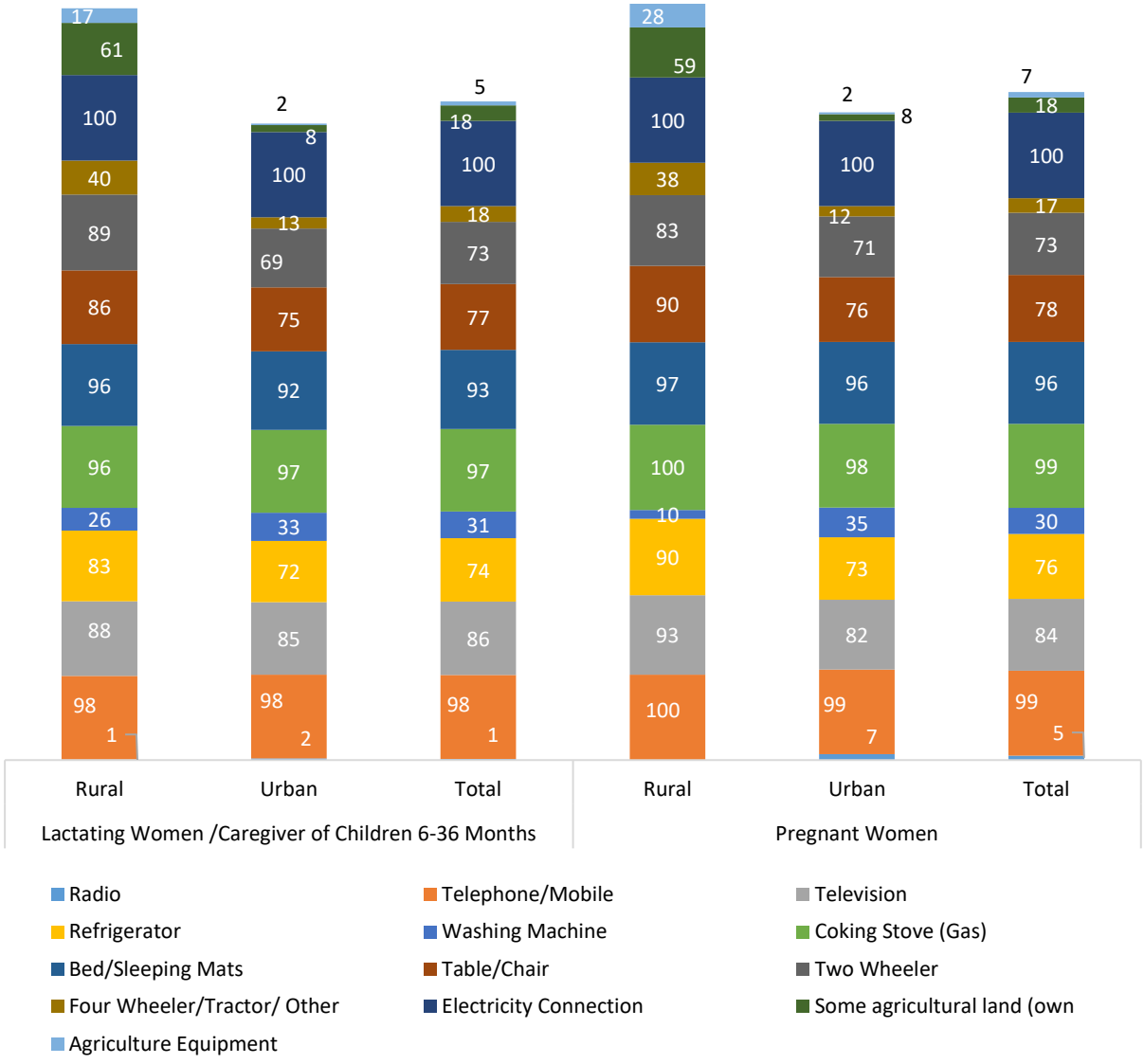


Table 1: Current THR Distribution in Rajasthan

Beneficiary/Ration	Pulses (Daal)	Rice	Wheat
Pregnant Women	3.00 K.G.	1.50 K.G.	1.50 K.G.
Lactating Women (having a child < 6 months)	3.00 K.G.	1.50 K.G.	1.50 K.G.
Children (6 -36 months)	2.00 K.G.	1.25 K.G.	1.25 K.G.

Figure 10: Duration within which the THR is Consumed after Receipt from AWC (%)

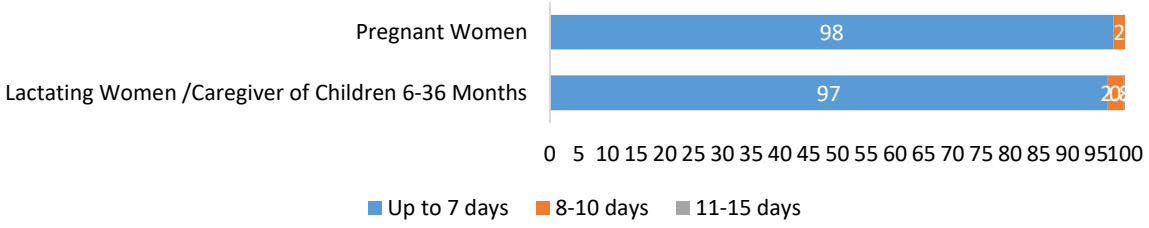


Figure 11: Sharing of THR with Other Family Members (%)

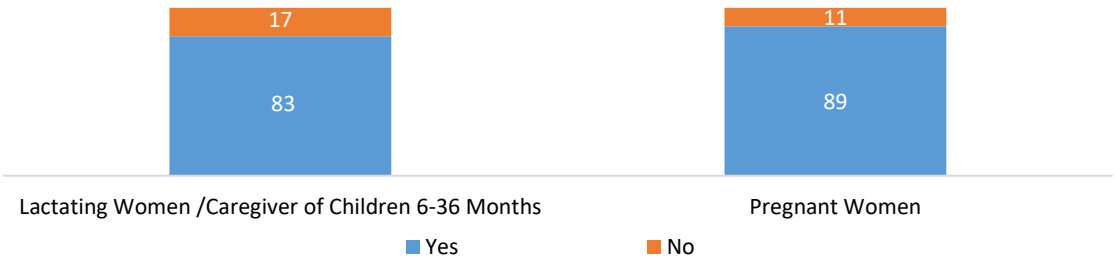


Figure 12: Consumption of THR by Beneficiaries during Pregnancy (%)

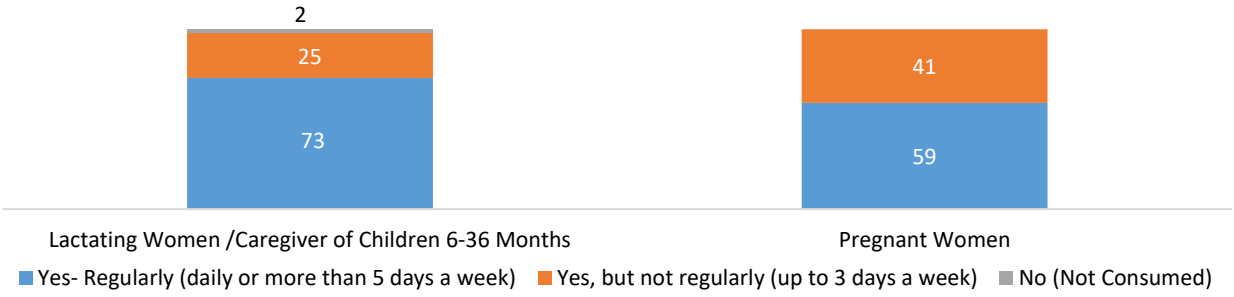


Table 2: Feeding the THR to Children 6-36 Months

Particulars	ICDS Project										Total	
	Jaipur-1		Jaipur-2		Jaipur-3		Sanganer-Rural		Sanganer City		N	%
	N	%	N	%	N	%	N	%	N	%		
Yes- Regularly (daily or more than 5 days a week)	103	79.2	74	73.3	190	85.6	116	77.9	116	81.1	**599**	**80.4**
Yes, but not regularly (up to 3 days a week)	24	18.5	27	26.7	32	14.4	30	20.1	24	16.8	**137**	**18.4**
No (Not Feeding)	3	2.3					3	2.0	3	2.1	**9**	**1.2**
TOTAL	**130**	**100.0**	**101**	**100.0**	**222**	**100.0**	**149**	**100.0**	**143**	**100.0**	**745**	**100.0**

Table 3: Duration of Storage of THR at AWCs

Duration	ICDS Project										Total	
	Jaipur-1		Jaipur-2		Jaipur-3		Sanganer-Rural		Sanganer City		N	%
	N	%	N	%	N	%	N	%	N	%		
Up to 5 days	10	71.4	7	50.0	7	50.0	11	78.6	6	42.9	**41**	**58.6**
Above 5 days	4	28.6	7	50.0	7	50.0	3	21.4	8	57.1	**29**	**41.4**
TOTAL	**14**	**100.0**	**14**	**100.0**	**14**	**100.0**	**14**	**100.0**	**14**	**100.0**	**70**	**100.0**

Table 4: What All Foods/Drinks Can be Given To A Child Less Than Six Months of age (%) - FLWs

Foods/Drinks Can be Given To A Child Less Than Six Months	AWWs	ANMs	ASHAs
Mother's milk	76	69	80.0
Other milk	40	45	48.6
Baby mix	34	25	22.9
Fruit juices	57	63	58.6
Water	36	29	38.6
Honey	4	8	12.9
Gripe water	21	22	17.1
Mashed biscuit	67	66	70.0
Mashed chapati/roti	76	86	82.9
Mashed pulses/dal	91	95	91.4
Mashed potato	73	83	78.6
Mashed banana	83	82	71.4
Other fruits	21	18	24.3
Other vegetables	34	32	35.7
Eggs	23	12	15.7
Meat	7	3	5.7
Others	9	12	4.3

Figure 13: Who Provided Help/Support/Motivation for Registration of Pregnancy (%)

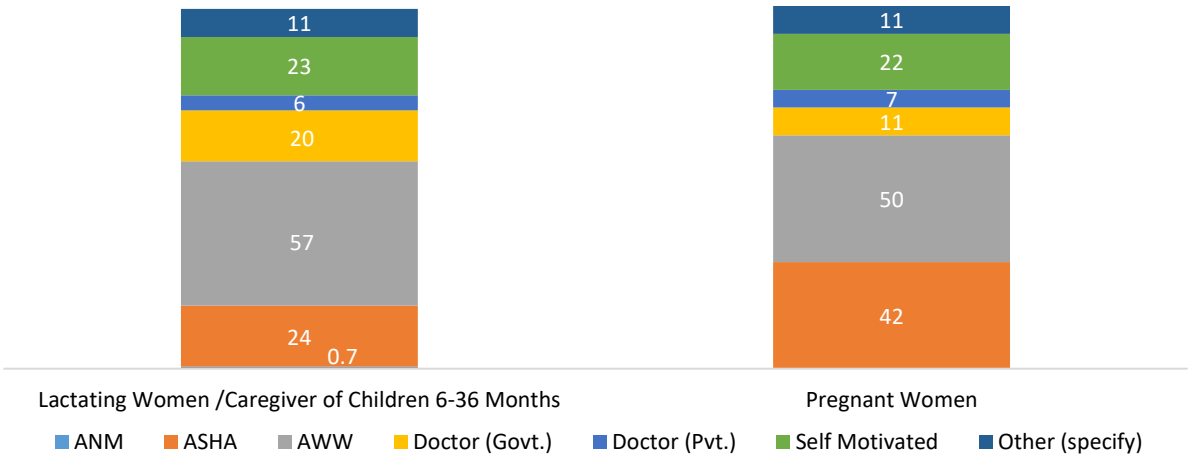


Figure 14: Place of Pregnancy Registration (%)

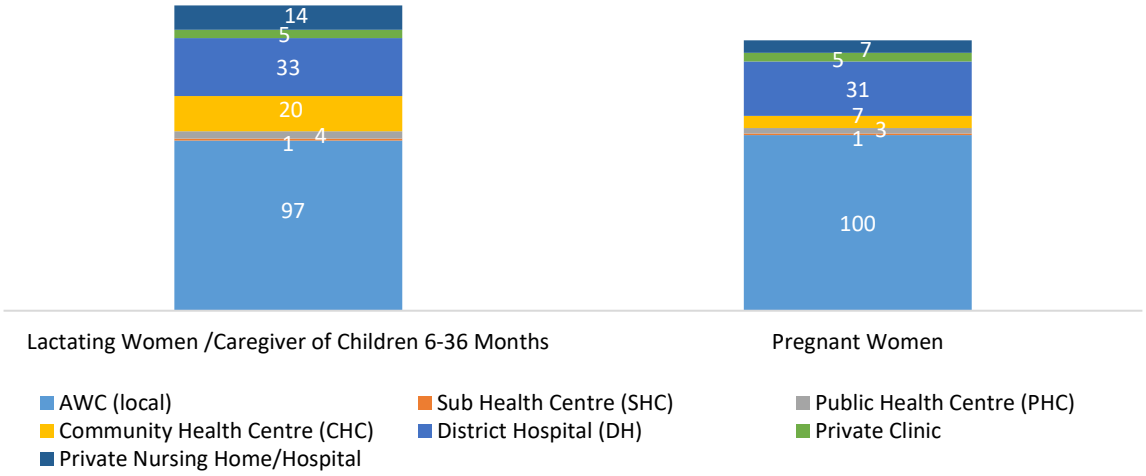


Figure 15: Month of Pregnancy When First ANC was received (%)

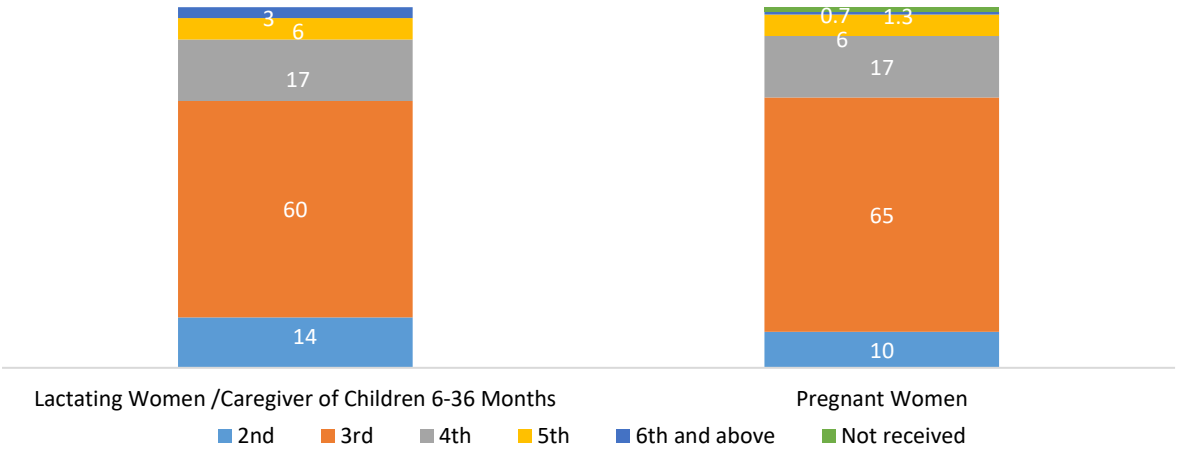


Figure 16: Month of Pregnancy from which a Pregnant Women Should Start Taking IFA Tablets (%)- Currently Pregnant Women

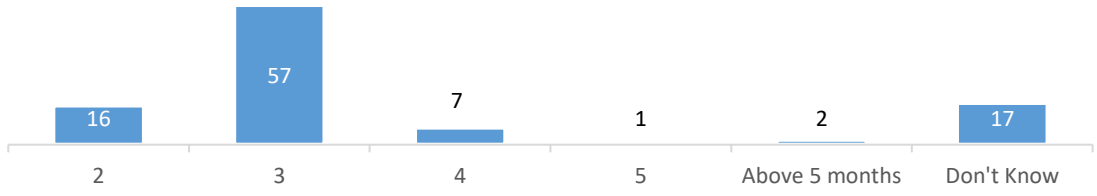


Figure 17: Sources of Information/Counselling of Pregnant Women

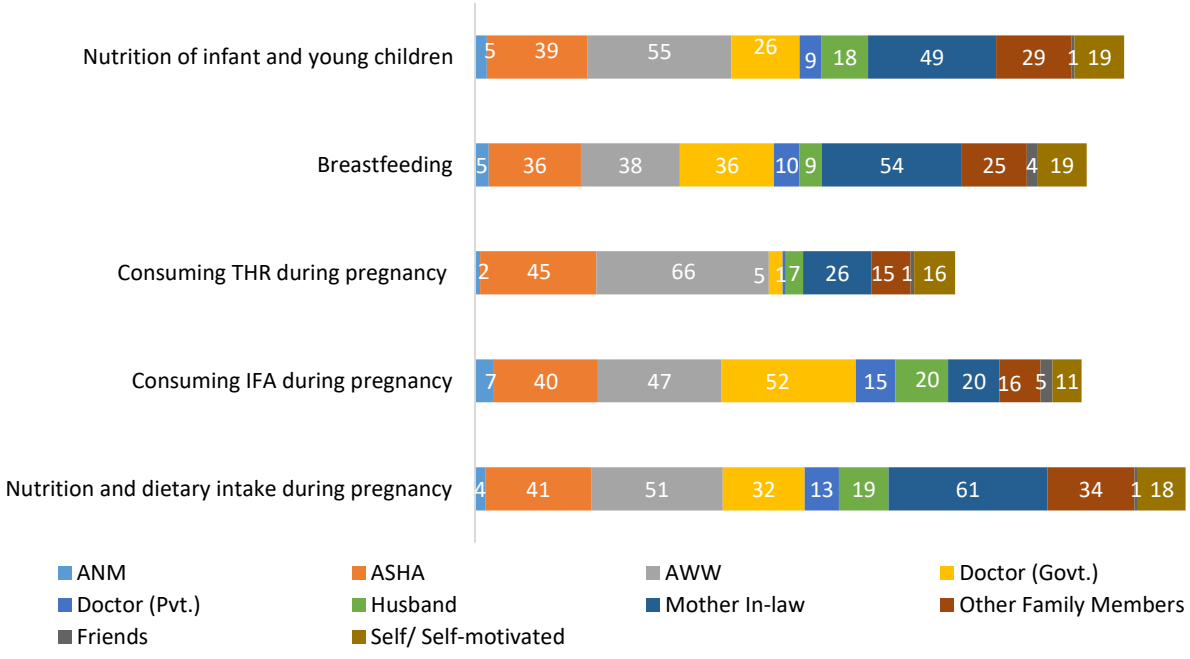


Figure 18: Sources of Information/Counselling of Lactating Women/Caregivers of Children 6-36 Months

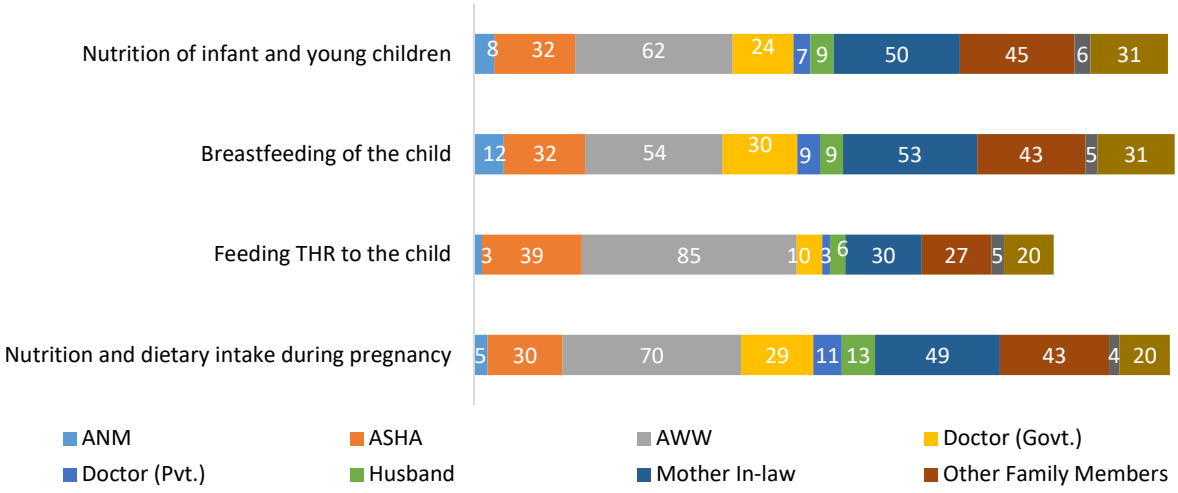


Table 5: Vaccinations Assessed for the Baseline- Child Age Group-wise

#	Vaccination	Age Group of Child	
		6-9 Months	≥ 10 Months
(i)	BCG *(At birth or as early as possible till 1 year of age)*	*	*
(ii)	Hepatitis B Birth dose *(At birth or as early as possible within 24 hours)*	*	*
(iii)	Oral Polio vaccine (OPV) Birth dose *(At birth or as early as possible within the first 15 days)*	*	*
(iv)	Oral Polio vaccine (OPV) 1 *(At 6 weeks)*	*	*
(v)	Oral Polio vaccine (OPV) 2 *(At 10 weeks)*	*	*
(vi)	Oral Polio vaccine (OPV) 3 *(At 14 weeks)*	*	*
(vii)	Pentavalent 1 *(At 6 weeks)*	*	*
(viii)	Pentavalent 2 *(At 10 weeks)*	*	*
(ix)	Pentavalent 3 *(At 14 weeks)*	*	*
(x)	Rota Virus Vaccine-1 *(At 6 weeks)*	*	*
(xi)	Rota Virus Vaccine-2 *(At 10 weeks)*	*	*
(xii)	Rota Virus Vaccine-3 *(At 14 weeks)*	*	*
(xiii)	Measles 1st Dose *(At completion of 9 to 12 months; can be given give up to 5 years if not received at 9-12 months age)*	*	*
(xiv)	Vitamin A, 1st Dose *(At 9 months with measles)*	*	*
(xv)	Oral Polio vaccine (OPV) Booster *(At 16-24 Months)*		*
(xvi)	Measles 2nd dose *(At 16-24 Months)*		*
(xvii)	Fractional dose of Inactivated Polio Vaccine (fIPV)-1 *(At 6 weeks)*		*
(xviii)	Fractional dose of Inactivated Polio Vaccine (fIPV)-2 *(At 14 weeks)*		*
(xix)	Measles & Rubella (MR)-1 *(At 9-12 Months)*		*
(xx)	Measles & Rubella (MR)-2 *(At 16-24 Months)*		*
(xxi)	Diphtheria, Pertussis & Tetanus (DPT)-Booster-1 *(16-24 months)*		*
(xxii)	OPV – Booster *(16-24 months)*		*

Table 6: Vaccinations Received by Sample Children 6-36 Months (%)

Vaccine	ICDS Project										Total	
	Jaipur-1		*Jaipur-2*		*Jaipur-3*		*Sanganer- Rural*		*Sanganer City*		*N*	*%*
	N	*%*	*N*	*%*	*N*	*%*	*N*	*%*	*N*	*%*		
BCG	140	97.2	103	97.2	254	99.6	151	99.3	151	99.3	799	98.8
Hepatitis B Birth dose	141	97.9	105	99.1	255	100.0	152	100.0	152	100.0	805	99.5
Oral Polio Vaccine (OPV) Birth dose	141	97.9	105	99.1	254	99.6	152	100.0	152	100.0	804	99.4
OPV-1	143	99.3	103	97.2	253	99.2	152	100.0	151	99.3	802	99.1
OPV-2	143	99.3	103	97.2	249	97.6	151	99.3	150	98.7	796	98.4
OPV-3	138	95.8	103	97.2	247	96.9	152	100.0	148	97.4	788	97.4
Pentavalent 1	141	97.9	103	97.2	251	98.4	151	99.3	151	99.3	797	98.5
Pentavalent 2	141	97.9	102	96.2	247	96.9	150	98.7	149	98.0	789	97.5
Pentavalent 3	137	95.1	103	97.2	246	96.5	152	100.0	146	96.1	784	96.9
Rota Virus Vaccine-1	131	91.0	102	96.2	250	98.0	152	100.0	148	97.4	783	96.8
Rota Virus Vaccine-2	132	91.7	100	94.3	246	96.5	151	99.3	148	97.4	777	96.0
Rota Virus Vaccine-3	125	86.8	101	95.3	242	94.9	151	99.3	145	95.4	764	94.4
Measles 1st Dose	104	72.2	84	79.2	209	82.0	131	86.2	123	80.9	651	80.5
Vitamin A, 1st Dose	105	72.9	83	78.3	208	81.6	135	88.8	124	81.6	655	81.0
OPV Booster	68	47.2	52	49.1	123	48.2	87	57.2	65	42.8	395	48.8
Measles 2nd dose	58	40.3	47	44.3	109	42.7	81	53.3	64	42.1	359	44.4
Fractional dose of Inactivated Polio Vaccine (fIPV)-1	123	85.4	83	78.3	217	85.1	146	96.1	142	93.4	711	87.9
Fractional dose of Inactivated Polio Vaccine (fIPV)-2	120	83.3	81	76.4	212	83.1	142	93.4	138	90.8	693	85.7
Measles & Rubella (MR)-1	88	61.1	58	54.7	169	66.3	127	83.6	110	72.4	552	68.2
Measles & Rubella (MR)-2	49	34.0	39	36.8	90	35.3	76	50.0	60	39.5	314	38.8
Diphtheria, Pertussis & Tetanus (DPT)-Booster-1	53	36.8	45	42.5	97	38.0	78	51.3	59	38.8	332	41.0
OPV Booster	60	41.7	45	42.5	105	41.2	77	50.7	56	36.8	343	42.4

Table 7: Main Source of Drinking Water in the Households of Children 6-36 Months

Source of Drinking Water	ICCDS Project										Total	
	Jaipur-1		*Jaipur-2*		*Jaipur-3*		*Sanganer- Rural*		*Sanganer City*		N	%
	N	%	N	%	N	%	N	%	N	%		
Covered Well							5	3.3			**5**	**0.6**
Hand Pump	6	4.2	8	7.5	3	1.2	11	7.2	2	1.3	**30**	**3.7**
Piped Water Supply (Connection)	132	91.7	91	85.8	247	96.9	44	28.9	121	79.6	**635**	**78.5**
Public Stand Post			4	3.8			20	13.2			**24**	**3.0**
Supply through Tanker (Govt.)	2	1.4			1	0.4	13	8.6	4	2.6	**20**	**2.5**
Supply through Tanker (Pvt.)	1	0.7			1	0.4	29	19.1	11	7.2	**42**	**5.2**
Buy drinking water cans	2	1.4	3	2.8	2	0.8	18	11.8	6	3.9	**31**	**3.8**
Others	1	0.7			1	0.4	12	7.9	8	5.3	**22**	**2.7**
Total	**144**	**100.0**	**106**	**100.0**	**255**	**100.0**	**152**	**100.0**	**152**	**100.0**	**809**	**100.0**

Table 8: Availability of a Functional Toilet in the Households of Children 6-36 Months

Availability of a Functional Toilet	ICDS Project										Total	
	Jaipur-1		*Jaipur-2*		*Jaipur-3*		*Sanganer- Rural*		*Sanganer City*		*N*	*%*
	N	*%*	*N*	*%*	*N*	*%*	*N*	*%*	*N*	*%*		
Yes	142	98.6	106	100.0	253	99.2	144	94.7	152	100.0	**797**	**98.5**
No	2	1.4			2	0.8	8	5.3			**12**	**1.5**
TOTAL	**144**	**100.0**	**106**	**100.0**	**255**	**100.0**	**152**	**100.0**	**152**	**100.0**	**809**	**100.0**

Table 9: Means of Disposing Child's Stool in the Households of Children 6-36 Months

Means of Disposal	ICDS Project										Total	
	Jaipur-1		Jaipur-2		Jaipur-3		Sanganer- Rural		Sanganer City		N	%
	N	%	N	%	N	%	N	%	N	%		
Dispose into household toilet	90	62.5	64	60.4	138	54.1	94	61.8	100	65.8	486	60.1
Dispose into household bathroom	14	9.7	7	6.6	16	6.3	5	3.3	7	4.6	49	6.1
Dispose into a drain	15	10.4	13	12.3	43	16.9	7	4.6	14	9.2	92	11.4
Dispose it along with other waste/garbage of the household	16	11.1	16	15.1	40	15.7	8	5.3	20	13.2	100	12.4
Throw it in any open ground	8	5.6	6	5.7	16	6.3	33	21.7	11	7.2	74	9.1
Dispose it by burying it in ground					2	0.8	4	2.6			6	0.7
Others	1	0.7					1	0.7			2	0.2
TOTAL	144	100.0	106	100.0	255	100.0	152	100.0	152	100.0	809	100.0

Table 10: Instances of Hand Washing with Soap in the Households of Children 6-36 Months

Instances of Handwashing with Soap	ICDS Project										Total	
	Jaipur-1		*Jaipur-2*		*Jaipur-3*		*Sanganer- Rural*		*Sanganer City*		*N*	*%*
	N	***%***	***N***	***%***	***N***	***%***	***N***	***%***	***N***	***%***		
After using toilet	143	99.3	100	94.3	231	90.6	140	92.1	141	92.8	755	93.3
Before having food	115	79.9	76	71.7	206	80.8	110	72.4	120	78.9	627	77.5
After having food	82	56.9	43	40.6	138	54.1	85	55.9	84	55.3	432	53.4
Before feeding the child	101	70.1	62	58.5	196	76.9	107	70.4	120	78.9	586	72.4
After feeding the child	74	51.4	35	33.0	120	47.1	69	45.4	85	55.9	383	47.3
Before cooking food	105	72.9	59	55.7	190	74.5	110	72.4	124	81.6	588	72.7
After cooking food	67	46.5	35	33.0	128	50.2	77	50.7	79	52.0	386	47.7
After cleaning the child (after defecation/ urination)	119	82.6	72	67.9	209	82.0	133	87.5	122	80.3	655	81.0
Others			2	1.9	2	0.8			1	0.7	5	0.6
TOTAL	144	100.0	106	100.0	255	100.0	152	100.0	152	100.0	809	100.0

Table 11: Reference child had an episode of Diarrhoea any time in the last 2 weeks (ICDS Project-wise)

Particular	Jaipur-1		Jaipur-2		Jaipur-3		Sanganer-Rural		Sanganer City		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
Yes	21	15	15	14	44	17	16	11	19	13	115	14
No	123	85	91	86	211	83	136	89	133	87	694	86
TOTAL	144	100.0	106	100.0	255	100.0	152	100.0	152	100.0	809	100.0

Table 12: Reference child had Fever (non-COVID) at any time in the last 2 weeks (ICDS Project-wise)

Particular	Jaipur-1		Jaipur-2		Jaipur-3		Sanganer-Rural		Sanganer City		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
Yes	36	25	37	35	81	32	50	33	49	32	253	31
No	108	75	69	65	174	68	102	67	103	68	556	69
TOTAL	144	100.0	106	100.0	255	100.0	152	100.0	152	100.0	809	100.0

Table 13: Reference child had an illness with a cough at any time in the last 2 weeks (ICDS Project-wise)

Particular	Jaipur-1		Jaipur-2		Jaipur-3		Sanganer-Rural		Sanganer City		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
Yes	30	20.8	26	24.5	57	22.4	43	28.3	42	27.6	198	24.5
No	114	79.2	80	75.5	198	77.6	109	71.7	110	72.4	611	75.5
TOTAL	144	100.0	106	100.0	255	100.0	152	100.0	152	100.0	809	100.0

Table 14: Reference child had fast, short, rapid breaths or difficulty breathing or had moving ribs, at any time in the last 2 weeks (ICDS Project-wise)

Particular	Jaipur-1		Jaipur-2		Jaipur-3		Sanganer-Rural		Sanganer City		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
Yes	2	1.4	5	4.7	13	5.1	9	5.9	14	9.2	43	5.3
No	142	98.6	101	95.3	242	94.9	143	94.1	138	90.8	766	94.7
TOTAL	144	100.0	106	100.0	255	100.0	152	100.0	152	100.0	809	100.0

Table 15: Knowledge about When should a baby start breastfeeding after birth – Pregnant Women (Education-wise)

When should a baby start breastfeeding after birth	No education/ illiterate		Up to Class V (Primary)		Class VI-VII (Elementary)		Class IX-X (Secondary)		Class XI-XII (Higher Secondary)		Diploma after Class XII		Graduate		Post-graduate and Higher Qualifications	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Immediately	9	42.9	7	38.9	5	21.7	8	34.8	9	37.5			6	25.0	2	16.7
Within 1 hour after delivery	5	23.8	6	33.3	11	47.8	8	34.8	14	58.3	6	85.7	11	45.8	6	50.0
Some hours later but less than 24 hrs	4	19.0	3	16.7	5	21.7	5	21.7	1	4.2	1	14.3	7	29.2	4	33.3
Don't know	3	14.3	2	11.1	2	8.7	2	8.7								
Total	21	100.0	18	100.0	23	100.0	23	100.0	24	100.0	7	100.0	24	100.0	12	100.0

Table 16: Knowledge about When should a baby start breastfeeding after birth – Lactating Women/Caregivers (Education-wise)

When should a baby start breastfeeding after birth	No education/ illiterate		Up to Class V (Primary)		Class VI-VII (Elementary)		Class IX-X (Secondary)		Class XI-XII (Higher Secondary)		Diploma after Class XII		Graduate		Post-graduate and Higher Qualifications	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Immediately	51	40.8	41	41.8	68	40.5	63	47.0	42	38.9	8	38.1	38	41.3	20	31.7
Within 1 hour after delivery	45	36.0	40	40.8	70	41.7	59	44.0	49	45.4	9	42.9	36	39.1	33	52.4
Some hours later but less than 24 hrs	27	21.6	15	15.3	26	15.5	12	9.0	17	15.7	4	19.0	18	19.6	10	15.9
Don't know	2	1.6	2	2.0	4	2.4	0		0		0		0		0	
Total	125	100.0	98	100.0	168	100.0	134	100.0	108	100.0	21	100.0	92	100.0	63	100.0

Table 17: Knowledge about When should a baby start breastfeeding after birth – Pregnant Women (Social category--wise)

When should a baby start breastfeeding after birth	OBC		SC		ST		Unreserved/General	
	N	%	N	%	N	%	N	%
Immediately	23	30.7	12	31.6	5	41.7	6	22.2
Within 1 hour after delivery	33	44.0	16	42.1	5	41.7	13	48.1
Some hours later but less than 24 hrs	16	21.3	6	15.8	2	16.7	6	22.2
Don't know	3	4.0	4	10.5			2	7.4
Total	75	100.0	38	100.0	12	100.0	27	100.0

Table 18: Knowledge about When should a baby start breastfeeding after birth – Lactating Women/Caregivers (Social category--wise)

When should a baby start breastfeeding after birth	OBC		SC		ST		Unreserved/General	
	N	%	N	%	N	%	N	%
Immediately	144	38.9	97	45.3	19	40.4	71	39.9
Within 1 hour after delivery	158	42.7	89	41.6	18	38.3	76	42.7
Some hours later but less than 24 hrs	61	16.5	27	12.6	10	21.3	31	17.4
Don't know	7	1.9	1	0.5				
Total	370	100.0	214	100.0	47	100.0	178	100.0

Table 19: Awareness about Number of Days and Number of IFA Tablets to be Consumed during Pregnancy– Pregnant Women (Social category--wise)

No. of Days/Tablets	OBC		SC		ST		Unreserved/General	
	N	%	N	%	N	%	N	%
No. of Days								
Nil	9	12.0	1	2.6			2	7.4
Up to 30	10	13.3	3	7.9	2	16.7	5	18.5
31-60	10	13.3	7	18.4			3	11.1
61-90	15	20.0	9	23.7	5	41.7	3	11.1
91-120	12	16.0	2	5.3			9	33.3
Above 120	15	20.0	10	26.3	5	41.7	3	11.1
Don't Remember	4	5.3	6	15.8			2	7.4
No. of Tablets								
Nil	9	12.0	1	2.6			2	7.4
Up to 30	12	16.0	3	7.9	4	33.3	5	18.5
31-60	8	10.7	7	18.4			3	11.1
61-90	15	20.0	8	21.1	5	41.7	4	14.8
91-120	11	14.7	3	7.9			7	25.9
Above 120	16	21.3	10	26.3	3	25.0	4	14.8
Don't Remember	4	5.3	6	15.8			2	7.4
Total	75	100.0	38	100.0	12	100.0	27	100.0

Figure 19: Two-week Period Prevalence of Diarrhoea by Sex and Age-group

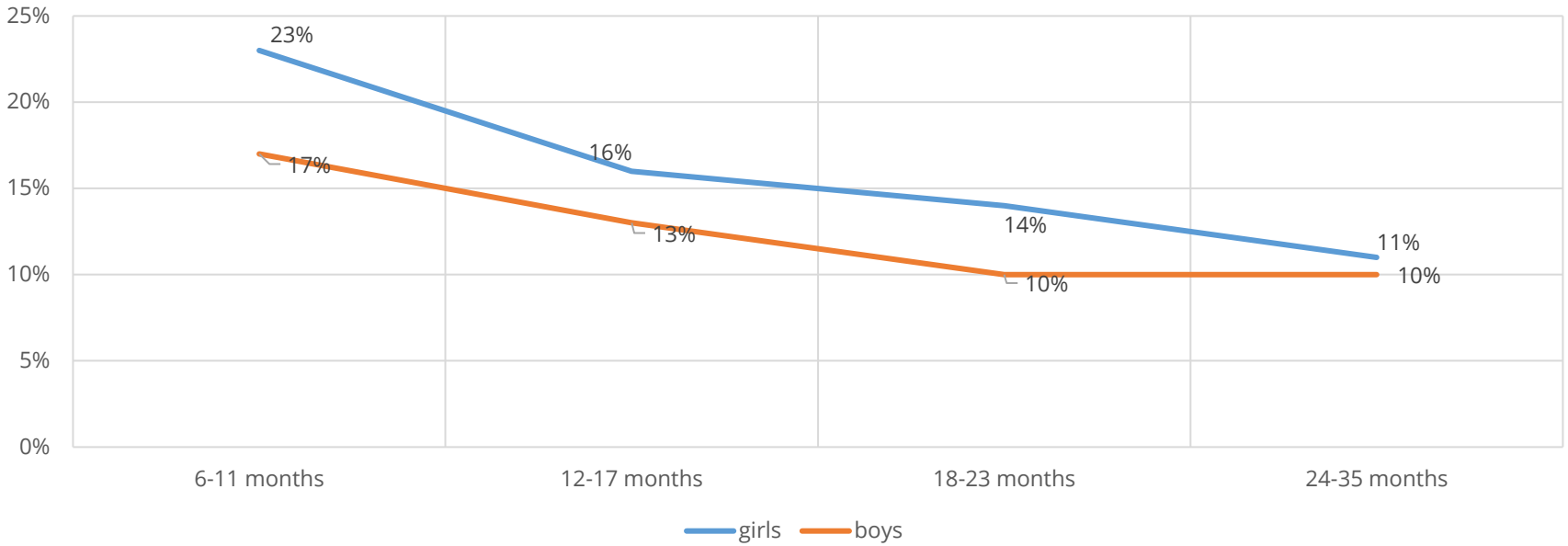


Figure 20: Two-week Period Prevalence of Fever by Sex and Age-group

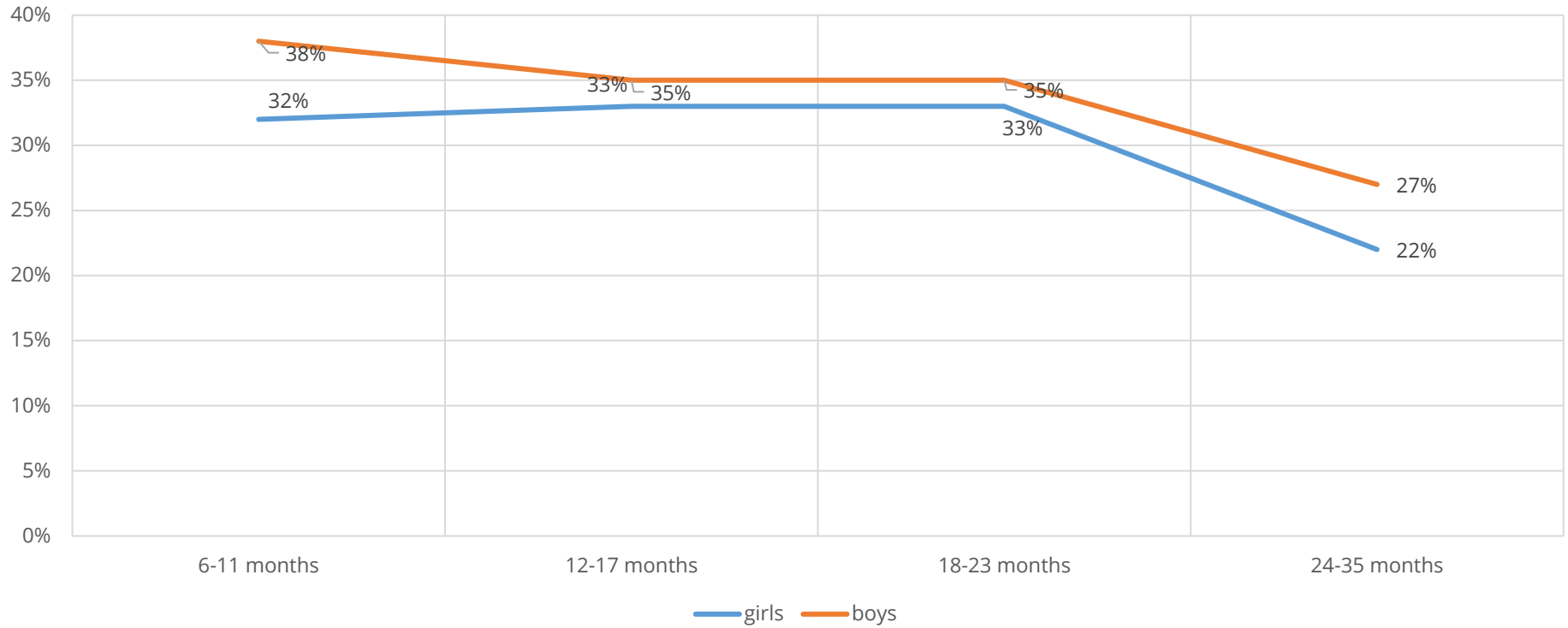
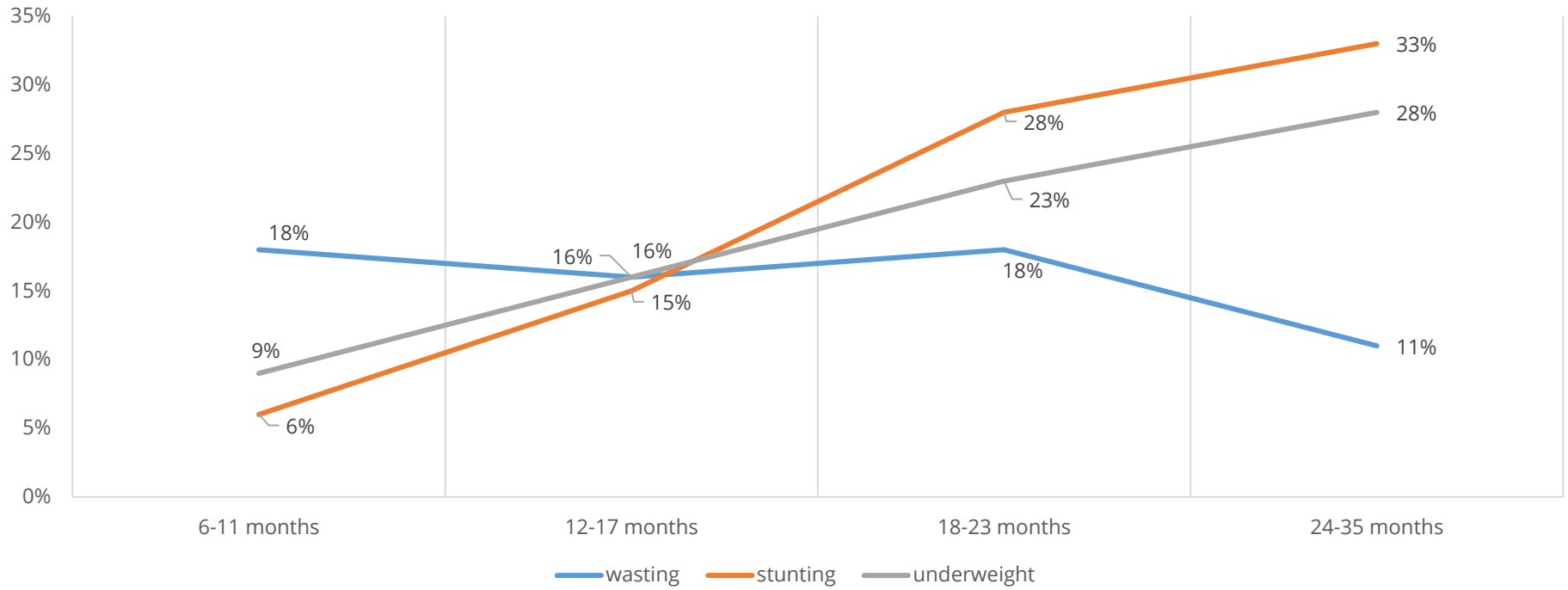


Figure 21: Overall Nutrition Outcomes by Age-group



Annexes 8. Methodology

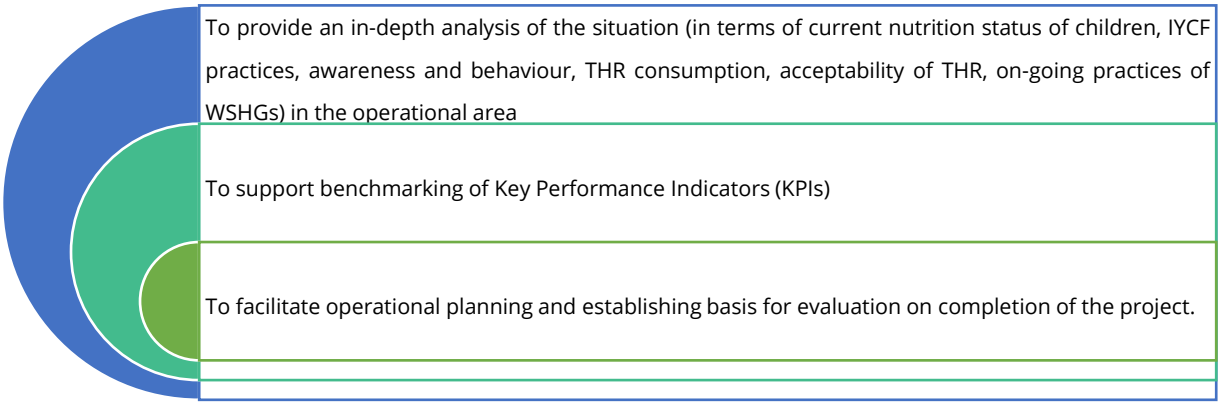
To ascertain the success of the pilot in yielding the desired results, a cross-sectional evaluation along the lines of pre-post intervention design with a comparison between the project initiation stage (baseline) and project closure stage (endline) has been proposed. The evaluation would assess how effectively the pilot project has established a replicable and demonstrable model, that ensures production of nutritious THR, as well as bringing about improvement in infant and young child feeding practices, creating nutritional awareness at all levels in the community; and increasing nutrition counselling skills of frontline functionaries through capacity building. Comparison of the findings of the baseline evaluation with the endline evaluation would provide critical insights into the performance of the pilot project (linking the change/impact with the implementation of the pilot project)

By linking the contribution of the pilot with the changes brought about; it can be deduced whether the intervention yielded the expected outcomes. This will provide inputs and insights to take an evidence-based decision on upscaling/replication of the project.

In view of the above, the cross-sectional baseline-endline evaluation of the pilot has been commissioned by the WFP.

As the first activity under the overall evaluation of the pilot; the proposed baseline will assess the situation at the project initiation stage and will act as the benchmark for comparing the situation towards the end of the project (endline).

The specific objectives of the baseline evaluation are presented in the figure below:



Some studies/data present the Knowledge, Attitude and Practices (KAP) regarding IYCF and its impact on the nutrition and health. However, not much is available, when it comes to the correlation of THR on the nutrition and health of the children and PLWs. In this regard, the baseline evaluation will also focus on assessing current KAP of the beneficiaries regarding nutrition, THR uptake and consumption, and the nutritional status of children 6-36 months. Besides, a core area of assessment will be the existing practices of THR by the WSHG, the challenges faced, and their empowerment. Mechanism/protocols for monitoring the THR production will also be assessed. The WFP will anchor

the pilot and guide the baseline through the evaluation agency. The DWCD (GoR) through its partner departments will offer all requisite support in implementation of the pilot and the baseline. The evaluation agency, guided by the WFP, will be responsible for independently carrying-out the baseline focusing of above-mentioned aspects.
The baseline evaluation of the pilot would provide an in-depth analysis of the current nutrition status of children, IYCF practices, awareness and behaviour regarding THR's importance and consumption, acceptability of THR, on-going practices of WSHGs, etc.; and support benchmarking of Key Performance Indicators (KPIs).

The most critical users of this baseline evaluation would be the DWCD (GoR) and the WFP. Findings of this evaluation would help:

- WFP - To facilitate operational planning and establishing a basis for evaluation on completion of the project.
- DWCD (GoR) - Support in decision-making related towards improving the nutritional status of children and PLWs in Rajasthan to the scale-up of the intervention.

The beneficiary stakeholders include the pregnant and lactating women (PLWs), mothers/caregivers of children 6-36 months; female/male children 6-36 months, adolescent girls; male/female member of the VHSNCs/UHSNCs[52] and PRIs, etc. Thus, there will be an adequate representation of women/girls in the sample for the proposed evaluation. Beneficiary respondents will be randomly selected from the sample AWC area. Furthermore, interacting with a varied group of stakeholders will ensure that their divergent feedbacks/perceptions/KAP are adequately collected for the evaluation. Besides, all child health and nutrition related data will also be analysed and interpreted across age-groups and gender- (male-female child-wise).

The baseline evaluation will cover the five selected ICDS projects in the Jaipur district (Jaipur-1, Jaipur-2, all Jaipur-3, Sanganer-Rural, and Sanganer City). Along the lines of 360^0 assessment approach, the baseline will cover the service seekers, service providers, and service facilitators.

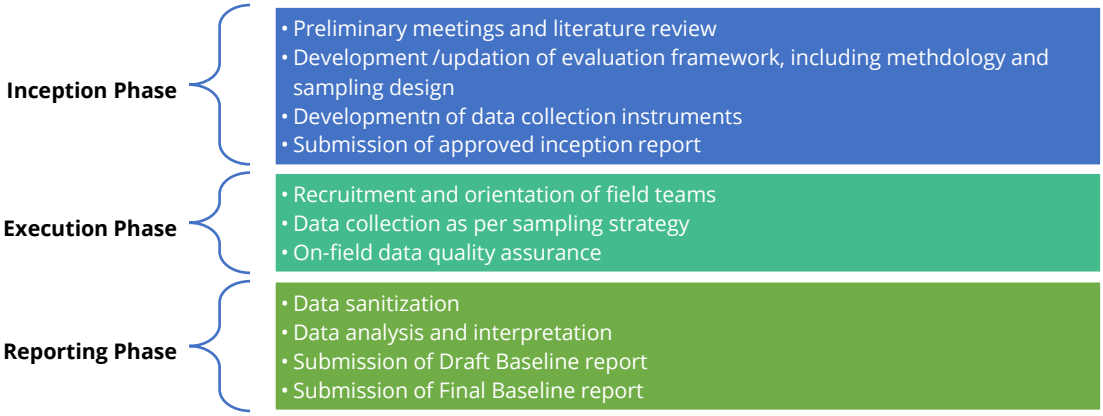
The existing mechanism of THR production through WSHGs, its quality assurance, monitoring, empowerment of WSHG member women, etc. will be specifically assessed in the baseline.
In view of the aforesaid and the objectives and scope of work for the assignment, ***a quantitative-qualitative mix and consultative, but independent approach*** (***based on pre-post comparison design[53])*** has been proposed for the baseline.

The impact and correlation of confounding factors such as literacy, access to information, contamination from TV or radio or other sources of information, etc., on the KAP of the beneficiaries regarding THR consumption, nutrition-related practices, nutritional status; will also be assessed. Thus, aiding in ascertaining that besides the availability of nutritional services, what are the other factors that impact the KAP and ultimately the nutritional outcomes. Thereafter, at the time of endline, these will again be used to assess the situation at that stage with the situation at baseline- thus, aiding in linking the changes/impact to the pilot project.

[52] VHSNC/UHSNC: Village/Urban Health Sanitation and Nutrition Committee

[53] Initially the evaluation was to be carried-out along using quasi-experimental design (Case-Control). However, as discussed during the Inception meeting; the evaluation will now be carried-out along the line of pre-post intervention comparison.

In view of the aforesaid, the proposed approach for undertaking the baseline evaluation of the pilot, can be understood with help of the three intertwined phases presented below:



Choice of Data Collection Instruments: The terms of reference for the decentralized evaluation of the WFP's pilot project[54] presents the Results Framework along with the details of the project's objectives and the expected outputs/outcomes. **In line with the results framework, the evaluation team has designed a set of relevant data collection instruments** to collect information about current THR uptake and consumption pattern, acceptability, recent morbidity of children, awareness levels, behaviour, decision-making, their beliefs, self-efficacy and social norms & other determinants of their current behaviours and practices related to complementary feeding; current systems of THR production by WSHGs, empowerment of WSHG members, etc. A **mix of quantitative and qualitative probing techniques** has been employed to frame questions. The qualitative insights will compliment and corroborate/validate the quantitative findings.

It has been endeavoured to design/develop simple/non-complex data collection instruments, that are culturally appropriate and do not create distress for respondents. It has been ensured that the data collection instruments are developed in a manner that the individual, community, AWW and systemic level inputs/perceptions/feedback are appropriately captured.

Inclusion of Evaluation Questions in Data Collection Instruments: All the data collection instruments have been developed by the evaluation team in line with the results framework presented in the ToR, evaluation matrix, and Theory of Change. The evaluation question[55] regarding Relevance, Coherence, Effectiveness, Efficiency, Sustainability, and Impact of the pilot project; has been considered to prepare the evaluation matrix and TOC. Thus, there will be comparability in parameters/indicators to be evaluated at baseline and endline. All these have been used as the guide to develop the data collection instruments for the baseline evaluation, which include the following:

- **Quantitative Structured Schedule** for interacting with Pregnant Women focussing on Knowledge-Attitude-Practices (KAP)
- **Quantitative Structured Schedule** for interacting with Lactating Women and Mothers/ Caregivers with Children 6-36 months of age (including KAP)
    - ***Anthropometric Data Recording Tool:*** This tool is embedded in the semi-structured schedule for interacting with lactating women/caregivers of children 6-36 months, as the children to be covered for anthropometric assessment will be a subset from the sample of lactating women/caregivers of

[54] Final DE ToR - IYCN through the ICDS scheme in Jaipur, Rajasthan (shared by the WFP)
[55] The evaluation questions aim at highlighting the key lessons and performance of the intervention in improving infant and young child nutrition, which could inform future strategic and operational decisions

children 6-36 months. This schedule will collect and record anthropometric data from children aged 6 to 36 months, including age, height/length, and weight. Thereafter, the data from the anthropometric assessment will be analysed and looked over parameters like Age of the child, sex of the child, household size, knowledge/practices of the caregivers, IYCF aspects, WASH practices in the households, vaccination of the child, attendance/registration of the child at AWC, use of THR, recent morbidity, how morbidity is treated (at home, clinic, etc.) – wealth and livelihoods of the household (proxy measures). This analysis will aid in having control for these effects on child nutrition status, and thus, at a later stage, will help in assessing the impact of the improved THR (if consumed) on the child's health and nutritional status.

- **Qualitative Semi-structured Schedule** for interacting with AWWs (Nutrition service provider) and ASHAs/ANMs (Health service provider)- including KAP
- **Qualitative In-depth Interview (IDI) Guide** for interacting with Child Development Project Officer (CDPO)/District Programme Officer (DPO) of DWCD; Medical Officer In-charge (MOIc)/ Chief Medical Officer (CMO)/Chief Medical & Health Officer (CMHO)
- **Qualitative Focus Group Discussion (FGD) Topic Guide** for interacting with adolescent girls
- **Focus Group Discussion (FGD) Topic Guide** for interacting with Village/Urban Health Sanitation and Nutrition Committee (VHSNC/UHSNC) members, members of Panchayati Raj Institutions (PRIs), the community opinion influencers, and Ward members in urban areas
- **Dyad/Triad Guide** for interacting with the members of Women Self Help Group (WSHG), engaged in production/distribution of THR

Semi-structured schedules: The schedules will combine a pre-determined set of closed ended (with options). A set of relevant questions will be designed to collect information about assessing the THR uptake/consumption/preparation[56]/acceptability, recent morbidity of children, awareness levels, behaviour, decision-making, their beliefs, and social norms & other determinants of their current behaviours and practices related to IYCF, THR uptake/consumption/ acceptance, recent morbidity, WASH practices, etc. *The discussions will be led by a trained enumerator/investigator and will be designed to last up to a maximum of 30-45 minutes.*

In-depth Interview (IDI)/Dyad/Triads: These are an open-ended, discovery-oriented method that is well suited for assessing responses on various issues from the perspective of the target audience or the key stakeholder. IDIs/Dyads/Triads involve not only asking questions, but also the systematic recording and documenting of responses coupled with intense probing for deeper meaning and understanding of the responses. These interactions would allow in understanding views/feedback/perception/practices of respondents regarding nutrition of women and children, breastfeeding, complementary feeding, anaemia, distribution pattern and acceptability of THR, etc. Further, these would also help in understanding knowledge, belief, self-efficacy, and practices of PLWs, caregivers, adolescents, and others around determinants of their behaviour, practices, enablers, and barriers for service delivery, especially counselling for triggering the adoption of optimal behaviours in families, including THR consumption.

During interactions with WSGHs, the guide will focus upon ascertaining aspects like THR as an economic activity, viability and profitability of the activity, their empowerment (confidence, social & economic decision making, recognition, leadership, etc.), capacity building through the activity, challenges faced, quality assurance and THR production SOPs, etc.

[56] THR Preparation and Storage- what meal is THR associated to - breakfast/lunch/dinner/snack; how is the THR stored and for how long; how is the THR prepared, etc.

An attempt to assess the systems-related determinants would also be made through IDIs/Dyads/Triads. *Each IDI will be designed to last up to a maximum of 30-45 minutes.*

Focus Group Discussion (FGD): A FGD is a good way to gather together people from similar backgrounds or experiences to discuss a specific topic of interest. The larger group of participants (as against individuals in an IDI of Dyad/Triad) is guided by a moderator (or group facilitator) who introduces topics for discussion and helps the group to participate in a lively and natural discussion amongst themselves. The strength of FGD relies on allowing the participants to agree or disagree with each other so that it provides an insight into how a group thinks about an issue, about the range of opinion and ideas, and the inconsistencies and variation that exists in a particular community in terms of beliefs and their experiences and practices. In the baseline evaluation, FGDs will be used to explore insights from adolescent girls and VHSNC/UHSNC/PRI members that cannot be explained statistically through other interactions, the range of opinions/views on the nutrition of women & children, and local factors impacting them. The insights emerging from the FGDs will aid in assessing the confounding factors related to the adoption of appropriate and correct nutritional practices, including gender biases (if any), and in societal enablers/barriers in the same. These insights will compliment and validate/corroborate the quantitative findings. *The FGD topic guide will also be designed in a way that the discussion is completed within 45-60 minutes.*

The qualitative insights will also provide inputs to be considered for designing the SBCC strategy and material targeted towards the community.

***Pre-Testing and Translation of Data Collection Instruments*:** All the data collection instruments will be finalized in consultation with the WFP team. The instruments will be finalized after incorporating the project team's inputs/value additions; and will then be translated into Hindi. These instruments will then be pre-tested to assess their efficacy in soliciting the required information. Based on the results of the pre-testing, required modifications/revisions (if any) will be made in the instruments to further refine them. These final instruments will then be translated into Hindi (a commonly used language in Jaipur). The Hindi-translated versions of the data collection instruments will be used for survey administration in the field. The field team members will use the Hindi version of tools for interacting with the respondents. During their training, they will be specifically oriented about administering the instruments in Hindi; in the manner in which they are presented in the data collection instruments.

Interviewing Techniques: The structured and semi-structured schedules ***will be administered using*** tablets through ***Computer Assisted Personal Interview (CAPI)***[57] ***technique***. A CAPI application will be developed for the purpose (***bilingual*** application displaying questions in both ***English and Hindi***). Whereas the ***IDIs/FGDs/Dyads/Triads will be conducted using the standard Pen and Paper Interviewing (PAPI) technique.***

Development of CAPI Application: After the finalization of the data collection instruments; a CAPI version of the semi-structured schedules will be prepared using an open source set of tools that can work on the Android platform (like ODK/SurveyCTO). Automatic skips in questions to be administered based on the response of the respondents, and the logical and consistency checks would be in-built, as part of the CAPI application.

[57] Computer-Assisted Personal Interviews (CAPI) is a face-to-face data collection method in which the interviewer uses a tablet, mobile phone or a computer to record answers given during the interview. Use of CAPI technique, makes quantitative data collection almost paperless.

As already mentioned in the ToR for the evaluation; the pilot initiative will be implemented in two blocks (Jaipur and Sanganer) and five ICDS projects (Jaipur-1; Jaipur-2; Jaipur-3; Sanganer-City and Sanganer Rural) of Jaipur district. Further, the ToR also specifies selecting a sample of 700 caregivers (of children 6-36 months) and 300 children (6-36 months) for anthropometric measurements. In addition, the ToR also specifies adopting a **Probability Proportional to Size** (PPS) for distributing the sample across the five ICDS projects.

Quantitative Sample: In view of the above, it is proposed to adopt a two-stage sampling for the baseline using a mix of PPS and random sampling:

Stage-1:

- **Selection of Blocks and ICDS Projects:** As mentioned above, 2 blocks and 5 ICDS projects have been already identified by the WFP

  Distribution of Sample Across Blocks: The sample of 700 caregivers (with children 6-36 months) is distributed across the five blocks and are selected using the **Probability Proportional to Size** (PPS) sampling. The number of caregivers selected from each block has been selected in the proportion of the block's representation in-universe of children 6-36 months.

Stage-2:

- ***Selection of AWCs/AWWs/ASHAs/ANMs:*** Considering the limited time duration of the assignment and operational factors, it is proposed to ***randomly*** select up to 14 AWCs from each block (using the project-wise list of AWCs made available by the WFP). The sample of a particular block will be distributed ***equally*** among the 14 AWCs. Thus, **a total of up to 70 AWCs will be selected for the baseline**.[58] With random selection of the AWCs, the sample will include both, Rural and urban AWCs. From each AWC, the concerned AWW, ASHA and ANM will be covered (total up to 70 AWWs, 70 ASHAs, and 70 ANMs).
- ***Selection of Households (with a child 6-36 months):*** Households with children 6-36 months will be the target households and will form the base for selecting the sample. In each sample AWC area, the list of households with a child 6-36 months will be obtained from the AWC. Thereafter, using this list, the requisite number of households will be selected ***randomly***. With the random selection, there will be a representation of households of different social and economic groups and female/male children (for anthropometric assessment).

  From the above sample households, the following respondent categories will be covered:

  A. Lactating Women and Mother/Caregiver of the child (6-36 months)- total 700
  B. Children for Anthropometric Assessment (6-36 months)- total 300. This sample of children will be a sub-set of the mother/caregiver of the child – as their youngest child 6-36 months will be covered for Anthropometric Assessment

- ***Selection of Households with a Pregnant Woman:*** Besides above, from each sample AWC area, it is proposed to identify households with a currently pregnant woman. This will also be done in consultation with the AWWs of the sample AWCs. From this list, it is proposed to ***randomly*** select up to 2 households

[58] As per the proposal submitted by the evaluation team; it was proposed to select 6 AWCs from each ICDS project and then select the other respondents from the coverage area of these AWCs. However, as suggested by the WFP, a total of 14 AWCs will now be selected form each of the five ICDS projects.

with a pregnant woman. Thus, from 70 sample AWCs; *a total of up to 140 pregnant women will also be selected for the baseline*[59].

Qualitative Sample: Besides the above quantitative sample, it is also proposed to qualitatively interact with government counterparts and other key stakeholders. These will include the WSHG members, adolescent girls, the block and district level officials of ICDS and health department, and the local VHSC/UHSNC/PRI members/ community leaders. The insights from these qualitative interactions will compliment and validate/corroborate the quantitative findings on aspects like KA of beneficiaries, uptake/consumption of THR, any gender biases in practices, etc. Besides, these interactions will be used to explore insights/aspects, that cannot be explained from quantitative findings. Moreover, these interactions will also aid in assessing the confounding factors related to the adoption of appropriate and correct nutritional practices, including gender biases (if any), sources of information, societal enablers/barriers, etc. The emerging qualitative insights will also provide inputs for the development of the SBCC strategy and material under the pilot.

- **Sample of Adolescent Girls for FGD:** As per the RFP document, only one of the five sample ICDS projects (Jaipur-3) has adolescent girls' beneficiaries. Thus, it is proposed to organize one FGD with adolescent girls in Jaipur-3. It will be endeavoured to interact with adolescent girls from more than one AWCs from Jaipur-3. The AWCs will be selected randomly from amongst the AWCs with enrolled adolescent girl beneficiaries. Thus, the FGD will have 10 adolescent girls from up to 5 AWCs of Jaipur-3.
- **Sample of WSHG Members:** As per the information shared by the WFP's program team, it is understood that members of 3-4 WSHGs will be engaged for operating the THR unit. However, as of now the WSHGs to be engaged in the pilot have not been identified. Thus, as such no sample of the WSHG members can be drawn for qualitative interactions. However, if the WSHGs are identified by WFP by the time field data collection is initiated, it is proposed to organize 5 Dyads/Triads with the WSHG members. Thus, qualitatively interacting with 10-15 WSHG members. The final decision in this regard will be taken in consultation with WFP, at the time of initiation of field data collection.
- **Sample of Government Officials:** It is proposed to interact with the concerned Child Development Project Officer (CDPO) of ICDS and concerned Medical Office In-charge (MOIC) from the five sample ICDS projects. Thus, 5 CDPOs and 5 MOICs will be covered for the baseline (IDIs). Similarly, interactions will also be carried-out with the District Programme Officer (DPO) of ICDS and the Chief Medical Officer (CMO) of Jaipur district. Thus, 2 district-level interactions are also proposed for the baseline (IDIs).
- **Sample of Other Stakeholders (VHSNC/UHSNC/ PRI/Ward Members):** In each of the five sample ICDS projects, it is proposed to organize one FGD with a mixed group of VHSNC/UHSNC/PRI/Ward Members (2-3 members from each category; and about 10 participants in an FGD). Thus, a total of 5 such FGDs are proposed to be organized for the baseline (1 in each of the 5 sample ICDS projects).

The overall proposed sample covered for the baseline[60] against the aforesaid proposed sample can be understood with help of table presented below.

[59] The evaluation team had suggested covering up to 60 pregnant women for the baseline (30 AWCs x 2 pregnant women per AWC). However, in line with the suggestion of WFP to select 70 AWCs; this sample has been increased to 140 (70 AWCs x 2 pregnant women per AWC) .

[60] Revised in line with the suggestion of WFP to select 70 AWCs spread across five ICDS projects

Sample AWCs	Lactating Women / Caregivers of Children 6-36 Months (LW/CGs)	Children 6-36 Months for Anthropometric Assessment	Pregnant Women (PW)	AWWs	ASHAs	ANMs*	Child Development Project Officer (CDPOs)**	District Program Officer (DPO)	Adolescent Girls ***	Other Stakeholders {Village/Urban Health, Sanitation and Nutrition Committee (VHSNC/ UHSNC)/ Panchayati Raj Institution (PRI)/Ward Members}: ****
77#	809	379	152	70	70	65	3	1	13	20

#: 7 additional AWCs had to be covered, as in some of the sample AWCS one or the other category of respondent (pregnant & lactating women, children 6-36 months, ASHA/ANM were not available/not posted/not available in required number
**: Five ANMs were common for more than one sample AWCs. Thus, against 70, a total of 65 ANMs have been covered.*
***: At the time of data collection Jaipur-1 and Jaipur-3 projects were being managed by one CDPO. Similarly, Jaipur-2 and Sanganer-Rural projects were being managed by one CDPO. Thus, against 5, a total of 5 CDPOs have been covered.*
****: Total 13 adolescent girls have been covered by organizing one Focus Group Discussion (FGD) in Jaipur-3 project*
*****: Total 20 respondents have been covered through 10 In-depth Interviews (IDIs) and 1 FGD*
##: At the state/district level, the health department was not officially intimated about the baseline evaluation. Thus, the Chief Medical and Health Officer (CMHO) and the Medical Officer In-charges (MOICs) were not willing to interact with the evaluation agency without having an authorization from their department. Owing to this, despite of several attempts requesting them to interact with the evaluation agency, they did not accord the consent for the same. Thus, these officials of the health department could not be covered for the baseline evaluation.

Details of which data collection instrument will be used to interact with which category of the respondent is presented in the table below:

Sl. No.	Respondent	Data Collection Instrument
1.	Pregnant Women	Quantitative Structured Schedule
2.	Lactating Women/ Caregivers/ Mothers of Children (6-36 months)	Quantitative Structured Schedule, including a separate section on Anthropometric Assessment of Children 6-36 Months
3.	AWWs/ ANMs/ASHAs	Qualitative Semi-structured Schedule
4.	CDPO/DPO- ICDS	IDI Guide
5.	MOIc/CMO/CMHO- Health Department	IDI Guide
6.	Adolescent Girls	FGD Topic Guide
7.	WSHGs engaged in production and distribution of THR	Dyad/Triad Guide
8.	VHSNC /UHSNC members/PRI Members/Community Opinion Influencers	FGD Topic Guide

Anthropometric Measurement: The anthropometric measurement of the children 6-36 months will include the measurement of their weight (children 6-36 months), height (children <24 months), and recumbent length (children 24-36 months).

- **Weight measurement of children using a weighing scale:** The weight will be measured in kilograms (to the nearest 1/10 kg). The child will be made to stand on the weighing scale with his/her head upright and straight, and the weight will be recorded. In the case of infants or children who are unable to stand alone on the scale, first, the weight of the mother/caregiver will be recorded. Thereafter, the child will be handed to the mother/caregiver and their combined weight will be taken. The exact difference between the combined weight and the individual weight of the mother/caregiver will be recorded as the weight of the child.

- **Height measurement of children (24-36 months) using stadiometer:** When measuring height, the child will be made to stand with his/her heels together, feet facing outward at a 60-degree angle, and weight evenly distributed. The positioning of the child will be with the shoulder blades, buttocks, and heels on the stadiometer's vertical backboard; and arms loosely hanging at the sides with palms facing the thighs. If it is not possible to have all three points of contact on the vertical backboard, at least the heels and buttocks must touch the vertical backboard. After this, the horizontal bar of the stadiometer will be lowered until the hair is compressed to the crown of the head. Any objects on the head or hair that obstruct the bar from compressing the hair to the level of the crown of the head, will be removed. Thereafter, the height will be measured and recorded.
- **Recumbent length of the child (24 months) using infantometer:** In the case of infants/children, who cannot stand, their recumbent length will be measured. The child will be made to lie recumbent on the infantometer. One end of the infantometer will touch the crown of the head and the other end will be adjusted to touch the child's heel; while ensuring that the child is lysing evenly and has not folded his/her legs. Thereafter, the recumbent length of the child from the crown of the head to the heels will be measured and recorded.

Minimizing Non-response for Anthropometric Measurement: Moreover, there may be instances, where the mothers/caregivers of children may not allow or be apprehensive about the anthropometric measurement of their child. In case, if such an issue/challenge is encountered; the evaluation team members will convince the mothers/caregivers that this is an exercise like that being conducted regularly at the AWC and will cause no harm to the child. Further, the equipment for anthropometric measurement will be sanitized in front of the caregiver/mother of the child (to build confidence). After each measurement, the equipment will be sanitized again in front of the caregiver/mother of the child. Thus, giving them enough confidence and trust in the activity.

Minimizing Bias: The field team members will be specifically oriented to be neutral while interacting with the respondents. They will be specifically trained to record the responses of the respondents as it is (as the case may be) and as per their interpretation. Besides, the same will be observed regularly during the field data collection by the senior evaluation team. This strategy will ensure that there is minimum bias at the level of investigators/enumerators during data collection.

Data Sanitization

- ***Quantitative Data:*** *As the structured, semi-structured schedules and anthropometric assessment tool would be administered using CAPI, no separate data entry would be required.* Filled-in CAPI schedules would be transferred directly to the data analysis system. Under the close supervision of senior members of the evaluation team, using SPSS, the data will be sanitized by the data analyst to ensure completeness and correctness. Data will also be checked to ascertain that all mandatory fields have a response and are not blank. Besides, checks to assess out-of-range entries for a field like age, weight, height, etc. will also be carried out.
- ***Qualitative Data:*** As all the qualitative interactions would be largely carried out by the senior members of the evaluation team with the support of field supervisors, no separate transcription of the IDIs/FGDs/Dyads/Triads would be required. Senior members of the evaluation team/supervisors will themselves prepare the transcripts, with the help of audio recording and notes of discussions. In cases where the respondents do not permit audio recordings, the notes taken at the time of the

IDIs/FGDs/Dyads/Triads will be used for the preparation of the transcript. Once the transcripts have been prepared; they will be used for analysis.

Data Analysis: Simultaneous with the process of data entry and cleaning, an ***analytical framework and tabulation plan would be prepared***. Data shall be presented as per structured samples covered, which can be agglomerated ICDS project-wise.

- **Quantitative Data:** The clean set of quantitative data will be analysed as per the analysis plan that will be developed by the evaluation team using SPSS. In this software, the numeric data from each participant is recorded in a running format, where the rows denote the respondents, and the columns denote the questions or indicators. The software enables the comparison of percentage scores across indicators. Apart from the standard statistical analysis, the following test would be specially used:
    - ***Statistical Significance (t-Test or z-Test):*** Once sample data has been gathered, statistical inference allows analysts to assess evidence in favour of some claim about the population from which the sample has been drawn. The methods of inference used to support or reject claims based on sample data are known as tests of significance[61]. Using the test of significance will indicate whether or not the difference between two groups' averages (ICDS Projects; or male/female child) reflects a "real" difference. For practical purposes, the statistical significance will help us assess that whether there is a significant difference or not between the situation of beneficiaries in the five ICDS projects**.**
- **Qualitative Data:** The process of content analysis of the qualitative data analysis will be conducted in-house, by the senior team members under the guidance of the team leader. This will entail thematic categorization/distribution of data and its coding.
- ***Anthropometric Data Analysis using EPI-Info:*** The anthropometric data to be collected for children (6-36 months) shall include age, weight in kilogrammes (to the nearest 1/10 kg) and recumbent length (< 24 months) or height (24-36 months). Using Epi-Info , this information will be used to calculate the following z-scores:
    - Weight-for-height z score (WHZ): Children with z-scores below -3.00 SD will be categorized as severely wasted; and those with z-score between -3SD and -2SD will be categorized as moderately wasted.
    - Height-for-age z score (HAZ): Children with z-scores below -3.00 SD will be categorized as severely stunted; and those with z-score between -3SD and -2SD will be categorized as moderately stunted.
    - Weight-for-age z score (WAZ): Children with z-scores below -3.00 SD will be categorized as severely malnourished; and those with z-score between -3SD and -2SD will be categorized as moderately malnourished.
    - All child health and nutrition analyses will be presented disaggregated by age and sex.

  The z-score calculated using Epi-info will be incorporated in the main database, under the variable created on wasting, stunting, and underweight. Thereafter, this data will be analysed and looked over parameters like age of the child, sex of the child, household size, knowledge/practices of caregivers, IYCF aspects, WASH practices in the households, vaccination of the child, attendance of the child at AWC, use of THR, recent morbidity, how morbidity is treated (at home, clinic, etc.), and wealth and livelihoods of the household (proxy measures). This analysis will thus, aid in ascertaining the impact of these aspects on the nutrition status of children. At a later stage (endline), this analysis will help in assessing the impact of the improved THR on the child's health and nutritional status. Besides, the nutritional status and recent

[61] http://www.stat.yale.edu/Courses/1997-98/101/sigtest.htm

morbidity of the children of 6-36 months will also be presented in age and gender-disaggregated way (male-female chid-wise).

The KAP of the PLWs and caregivers regarding nutrition and THR consumption, the recent morbidity will also be assessed across the above-mentioned aspects. Further, while analysing the data from WSHG interactions, the aspects of women empowerment (earning, confidence, social & economic decision making, recognition, leadership, etc.), will also be analysed and presented.

The interactions with the PLWs and anthropometric measurements will yield quantitative findings, while other interactions will yield qualitative insights. The qualitative insights will be used to compliment/supplement and corroborate the quantitative findings. Besides, qualitative insights will also aid in generating inputs for the development of SBCC strategy and material under the pilot. Together, the quantitative and qualitative data/information, and supported by relevant secondary data will be used to present the baseline findings.

The analysis of quantitative primary data collected through field surveys will be **triangulated** and then ***corroborated/validated*** with the secondary data/information (like NFHS[62], ICDS MPRs, etc.). The secondary data/information collected for the assignment will also be used to ***complement*** the field (primary) findings. In case the emergent quantitative findings vary a lot from the secondary data/information; the underlying reasons for the same will be ascertained by digging deeper into the qualitative data.

[62] National Family Health Survey (NFHS)

Annexes 9. Timeline

Table 36: Timelines for Baseline Evaluation

Steps	By whom	Key dates
Inception		
Briefing	WFP	May 7, 2021 May 12, 2021
Submission of draft inception report (IR)	Evaluation Team (IDCG)	May 30,2021
Review of inception report by WFP and providing feedback on the same	WFP	July 9, 2021
Sharing of additional inputs by WFP	WFP	July 22, 2021
Revising the inception report based on the inputs shared by WFP	Evaluation Team (IDCG)	July 29, 2021
Sharing of draft IR with outsourced quality support service (DE QS) and quality assurance of draft IR by EM using the QC	WFP	September 10, 2021
Revise draft IR based on feedback received by DE QS and EM	Evaluation Team (IDCG)	September 21, 2021
Circulate draft IR for review and comments to ERG, RB, and other stakeholders	WFP	September, 2021
Revise draft IR based on stakeholder comments received and submission of final revised IR	Evaluation Team (IDCG)	September 30, 2021
Data collection		
Preparatory work – Recruitment of Field Team, Development of CAPI tool, Anthro machines	Evaluation Team (IDCG)	September 15, 2021
Orientation of field teams	Evaluation Team (IDCG)	Sep, 2021
Fieldwork (data collection and on-field quality assurance)	Evaluation Team (IDCG)	October, 2021
In-country fieldwork debrief	Evaluation Team (IDCG)	October, 2021
Reporting		
Data Sanitization	Evaluation Team (IDCG)	October – 12 November 20, 2021
Preparation and submission of the draft report	Evaluation Team (IDCG)	By November 15 2021
Circulate draft ER for review and comments to CO, ERG, RB, and other stakeholders	WFP	30 November, 2021
Revise draft ER based on stakeholder comments received	Evaluation Team (IDCG)	9 December, 2021
Sharing of draft ER with outsourced quality support service (DE QS) and quality assurance of draft ER by EM using the QC	WFP	Dec 13, 2021

Revise draft ER based on feedback received by DE QS and EM QA	Evaluation Team (IDCG)	Dec 20, 2021
Submission of revised ER based on DEQAS and EM QA		By Dec 29, 2021
Submission of final revised ER to the internal evaluation committee for approval	WFP	4 January, 2022
Dissemination and follow up		
Dissemination of baseline findings	WFP	As suggested by WFP

Annexes 10. Data Collection Tools

Structured Schedule- Pregnant Women

A. General

S. No.	Question	Code
1.	Block (Please put a ✓ mark)	Jaipur ☐ Sanganer ☐
2.	CDPO Project (Please put a ✓ mark)	
	Jaipur-1 ☐ Jaipur-2 ☐ Jaipur-3 ☐ Sanganer-Rural ☐ Sanganer City ☐	
3.	Gram Panchayat (For Rural Areas)	
4.	Village Name (For Rural Areas)	
5.	City/Town (only for urban area)	
6.	Locality (only for urban area)	
7.	Name of the Concerned Anganwadi Centre (AWC)	

B. General information/ Demographic Characteristics

1.	Name of the respondent	
2.	Age of the respondent (completed years)	
3.	Contact Number of Respondent	1. …… 2. No Phone
4.	Marital Status	1. Married living with spouse 2. Married but spouse away 3. Divorced
5.	Education	1. No education/illiterate 2. Up to Class V (Primary) 3. Class VI-VII (Elementary) 4. Class IX-X (Secondary) 5. Class XI-XII (Higher Secondary) 6. Diploma after Class XII 7. Graduate 8. Post-graduate and Higher Qualifications
6.	Occupation (Primary)	1. Farming 2. Livestock rearing 3. Salaried employment (Private) 4. Salaried employment (Government) 5. Self-employed (off farm) 6. Farm labourer 7. Labour (off farm) 8. Small shop/business 9. Street vendor 10. Working as House Maid/Help 11. Student 12. Homemaker 13. Other (specify)……
7.	Social category	1. OBC 2. SC 3. ST

		4. Unreserved/General
8.	Religion	1. Hindu 2. Muslim 3. Others
9.	Household size (Total number of members in the family)	
10	Type of family	1. Joint 2. Nuclear
11	Does your family have a Ration Card and do you take ration from the Government Ration Shop?	1. Yes- Card Available and Take Ration 2. Yes- Card Available and But Do Not Take Ration 3. Card Not Available
12	Are you or any member of your family registered under Mahatma Gandhi Employment Guarantee Scheme (MGNREGS) and have a MGNREGS registration card	1. Yes- Registered and Card 2. Yes- Registered and But Card Not Available 3. Not Registered
13	Details Regarding Household Assets (Yes-1; No-2)	
i)	Radio	
ii)	Telephone/Mobile	
iii)	Television	
iv)	Refrigerator	
v)	Washing Machine	
vi)	Coking Stove (Gas)	
vii)	Bed/Sleeping Mats	
viii)	Table/Chair	
ix)	Two Wheeler	
x)	Four Wheeler/Tractor/ Other Vehicle	
xi)	Electricity Connection	
xii)	Some agricultural land (owned)	
xiii)	Agriculture Equipment	

C. Availing THR During Pregnancy and IFA

S. No.	Questions	Options/Response	
1.	Is this your first pregnancy?	1. Yes 2. No	
2.	If No, how many times have you been pregnant earlier?	___ (Numbers of times)	
3.	How many children do you have?	___ (Numbers of children)	
4.	Have you registered yourself somewhere for availing care during current pregnancy?	1. Yes 2. No	If No, Skip To Q-C-11
5.	Who helped/supported/motivated you to get your current pregnancy registered?	1. ANM 2. ASHA 3. AWW 4. Doctor (Govt.)	5. Doctor (Pvt.) 6. Self-Motivated 7. Others (specify.....)
6.	In which month of the current pregnancy, was the registration done? (no. of month)	.... Month	
7.	Where have you registered your current pregnancy? (Multiple Response)	1. AWC (local) 2. Sub Health Centre (SHC) 3. Public Health Centre (PHC)	6. Private Clinic 7. Private Nursing Home/Hospital

		4. Community Health Centre (CHC) 5. District Hospital (DH)	8. Others (specify)..... .....
8.	In which month of the pregnancy did you receive the first ANC service?	1. ..... Month 2. Not received ANC	If 'Not Received ANC', then skip to Q-C-11
9.	Till date, how many ANC service have you received	..... Number of ANCs	
10.	In which month of the current pregnancy, was the registration done at local AWC? (no. of month)	..... month	
11.	Do you demand the THR for yourself from the local AWW?	1. Yes 2. No	
12.	Have you received Take Home Ration (THR) regularly from the local AWC during your current pregnancy?	1. Yes, regularly 2. Yes, but not regularly 3. No	If Yes (regularly) , then Skip to Q-C-14
13.	If No or Not Regularly, then what are the reasons? (Multiple Response)	1. Anganwadi is non-functional 2. Anganwadi is usually closed/ opens irregularly 3. AWW did not distribute the THR regularly (at least one a month) 4. THR is not available at AWC for distribution 5. Behaviour of AWW not good 6. No need/not required/not interested 7. Others (specify).....	If No in Q-C12, then Skip to Q-C-24
14.	How do you receive the THR from AWC?	1. AWW distributes it by coming to home 2. AWW distributes it from her home 3. AWW distributes it at the AWC 4. AWC distributes it on the MCHN Day/VHSND 5. Others (Specify.....)	
15.	Frequency of receiving THR from AWC (during the current pregnancy)	1. Weekly 2. Fortnightly 3. Monthly 4. Others (specify.....)	
16.	What all food material and average how much quantity do you receive as THR in a month? (Ford material and Quantity in K.G; both options to be recorded)		
	Food Material	Received (Yes-1; No-2)	Quantity Received Per Month (K.G.)
16.a	Pulses (Daal)		
16.b	Rice		
16.c	Wheat		
16.d	Others (Specify .....)		
17.	How do you store the THR in your house?	1. Closed Container (metallic) 2. Open Container (metallic) 3. Closed Container (plastic) 4. Open Container (plastic) 5. Plastic bag 6. Keep it in an open plate/tray 7. Other (Specify.....)	
18.	Do you consume the THR provided from the AWC during your current pregnancy?	1. Yes- Regularly (daily or more than 4 days a week) 2. Yes, but not regularly (up to 3 days a week) 3. No (Not Consuming)	If Yes- Regularly, then Skip to Q-C-20

19.	If Not Regularly or Not Consuming, then what are the reasons? (Multiple Response)	1. THR is not of good quality 2. THR is provided in less quantity 3. Do not like the taste of THR provided 4. Do not consider it important to consume THR	5. THR gets spoilt soon (cannot be stored for longer time) 6. Other family members consume the THR 7. Gave it to others 8. Gave it to the domestic animals 9. Others (Specify.....)	If No in Q-18, then skip to Q-C-25

20.	How do you prepare the THR for consumption?	1. Not required, it is ready to eat 2. Mix with other flour 3. Make porridge 4. Others (Specify.....)			
21.	Usually in how much time after the receipt of THR from AWC, do you consume it?	1. 1-3 days 2. 4-7 days 3. 7-10 days 4. 11-15 days 5. Other (Specify.....)			
22.	Usually, as part of which meal do you consume THR?	1. Breakfast 2. Lunch 3. Evening Snacks 4. Dinner			
23.	Do the other family members also share the THR that is provided for you?	1. Yes 2. No			
24.	How would you rate quality of THR provided to you from the AWC?	1. Very Good 2. Good 3. Neither Good Nor Bad	4. Bad 5. Very Bad		
25.	Are you aware about the importance of consuming THR during pregnancy?	1. Yes 2. No	If No, then Skip to Q-C-26		
26.	According to you what is the importance of consuming THR during pregnancy? (Multiple Response)	1. Compliments the nutritional requirement during pregnancy 2. For appropriate weight gain during pregnancy 3. Reduces/prevents the risks of anaemia 4. Reduces/prevents other unpleasant pregnancy symptoms such as fatigue and morning sickness 5. For good brain development of the child in womb 6. For healthy birth weight of the child 7. Can reduce the risk of many birth defects in the child to be born 8. Others (specify.....)			
27.	Till date for how many days and how many IFA tablets have you consumed in your current pregnancy? (no. of days/tablets)	No. of Days		No. of Tablets	

D. Maternal Nutrition/ Breastfeeding – Knowledge Attitude and Practices

Pregnant Women- Dietary Intake

28.	Are you a vegetarian?	1. Yes 2. No	
29.	During your current pregnancy, does your family discourage you from eating certain foods? (Multiple responses possible)	1. No food restriction 2. Meat and poultry (chicken, mutton, lamb, etc.) 3. Fish 4. Milk and milk products 5. Wheat 6. Rice	7. Eggs 8. Papaya 9. Mango 10. Jackfruit 11. Other (specify.....)

Note for Enumerator:

- First ask if yesterday was a special day, like a celebration or feast day or a fast day where anyone in the HH ate special foods or where they ate more or less than usual or did not eat because they were fasting?
- If yesterday was a special day, then ask the respondent to describe the foods (meals and snacks) consumed the day before yesterday (or the last normal day) during the day and night, whether at home or outside the home

30.	Was yesterday a special day where special kinds of foods were eaten?	1. No 2. Yes, fasting day *3.* Yes, feast day
31.	How many meals did you eat yesterday? *(Latest normal day)*	..... Number of Meals

Instructions:

- *Please apprise the respondent that we will now ask about what all she ate or drank yesterday (or the last normal) during the day or night, at home or anywhere else. We will be asking about what all she ate or drank at different times of the day*
- *There can be multiple responses for what the respondent ate/ drank at different times of the day; record all responses*
- *For each eating episode, after the respondent mentions foods and drinks, probe to ask if she ate or drank anything else. Continue probing until she says "no, nothing else".*
- *Please use the following codes to enter what the respondent ate/ drank at different times of the day*
  1. ***Grains/cereal, Nuts and Seeds:*** Bread (rotis, etc), rice, noodles or other foods made from grains like wheat, millet, sorghum, etc.; Any tree nut, groundnut, peanut or other seeds
  2. ***Vegetables and legumes/beans:*** Mature beans or peas (fresh or dried seed), lentils or bean/pea products); Dark green leafy vegetables (like including spinach, fenugreek, amaranth, mustard leaves wild/foraged leaves); Vitamin A-rich vegetables, roots and tubers (like (Pumpkin, carrots, squash or sweet potatoes that are yellow or orange inside)
  3. ***Fruits:*** Mango, Papaya, Banana, Guava, Others
  4. ***Meat and Poultry:*** Chicken, Goat/Lamb Meat , Fish, Eggs; other meat/poultry alternatives
  5. ***Milk, butter, cheese, yoghurt and dairy alternatives***
  6. ***THR (Given by AWW)***
  7. ***Savoury and fried snacks:*** Chips, crisps, chanachur, French fries and similar items
  8. ***Sweets :*** Sugary foods, such as Indian sweets, chocolates, candies, cookies/sweet biscuits and cake, sweet pastries or ice cream
  9. ***Sugar-sweetened beverages:*** like fruit-flavoured drinks, sports drinks, chocolate and other flavoured milk drinks, malt drinks, 100% fruit juice as well as juice drinks with added sugar or other caloric sweeteners, (packaged in cans, bottles, boxes, sachets, prepared at home, etc.)
  10. ***Did not eat/drink anything***

32.	What did you eat or drink when you woke up?	
33.	What did you eat or drink later in the morning?	
34.	What did you eat or drink at mid-day? If yes, what?	
35.	What did you eat or drink during the afternoon?	
36.	What did you eat or drink in the evening?	
37.	What did you eat or drink in the evening before going to bed or during the night?	

Knowledge about Maternal Nutrition and Breastfeeding

38.	Why are some new-borns very small at birth and others are born healthy in your community? *(Multiple responses possible)*	1. Evil eye 2. Too many children or closely spaced births 3. Mother frail and unhealthy 4. Mother did not eat well during pregnancy 5. Mother did not complete ANC visits	6. Mother did not take IFA or calcium 7. Mother was ill during pregnancy a lot 8. Pre-mature birth 9. Other (specify) 10. Don't know
39.	Why is nourishing diet and good nutrition of pregnant women important? *(Multiple responses possible)*	1. For adequate weight gain of pregnant woman 2. Child inside the womb grows adequately/ healthy 3. For a brainy child with bright future 4. Quicker recovery after delivery 5. Extra costs due to doctors and medicine will be saved	6. It is a good investment in future 7. To produce adequate breastmilk 8. To ensure the mother is healthy 9. Others (specify) 10. Do not know
40.	How should a pregnant woman eat in comparison with a non-pregnant woman to provide good nutrition to her baby and help him grow? (Multiple responses possible)	1. Eat 5 variety of foods in addition to roti/rice 2. Take thick dal daily 3. Take milk/ milk product daily 4. Increase the amount of milk and milk products if you do not consume egg/animal products 5. Eat dark green leafy vegetables daily 6. Eat yellow/orange vegetables/fruits daily 7. Eat fish/meat daily 8. Eat egg daily, if acceptable in diet	9. Take nutritious snack daily 10. Increase amount of food consumed daily 11. Take one IFA tablet daily 12. Take two Calcium tablets daily 13. Eat chana (roasted gram) 14. Eat jaggery 15. Other (specify)
41.	At which month of pregnancy do you think a woman should start taking IFA tablets?	1. .....Month of pregnancy 2. Don't Know	
42.	For how many days do you think a pregnant woman should take IFA?	1. ..... No. of days 2. Don't Know	
43.	How often do you think a pregnant woman should consume IFA?	1. Daily 2. Few times a week 3. Weekly	4. Few times a month 5. Don't know
44.	How many IFA tablets do you think a pregnant woman should take during pregnancy?	1. ..... Number of Tablets 2. Don't Know	
45.	Why do you think a pregnant woman should take IFA tables? (Multiple responses possible)	1. To reduce the risk of anaemia for pregnant women 2. To reduce risk of anaemia for the child inside womb 3. To reduce the risk of low birth weight 4. To help improve child's intelligence	5. To reduce risk of death from excessive blood loss during and after delivery 6. To make mother healthy/strong 7. Other (specify.....) 8. Don't know

46.	How many meals should a pregnant woman have during pregnancy?	A) No of main meals -99 for "Don't know"	(B) No of snacks -99 for "Don't know"
i)	During first trimester of pregnancy		
ii)	During second trimester of pregnancy		
iii)	During third trimester of pregnancy		
47.	How many meals should a lactating woman have?	A) No of main meals -99 for "Don't know"	(B) No of snacks -99 for "Don't know"
48.	When should a baby start breastfeeding after birth?	1. Immediately 2. Within 1 hour after delivery 3. Some hours later but less than 24 hrs 4. 1 day later 5. More than 1 day later 6. Do not think baby should be breastfed 7. Don't know	
49.	Why should a baby start breastfeeding soon after birth? (Multiple responses possible)	1. Initiating breastfeeding within 1 hour can save baby's life 2. Initiating breastfeeding within 1 hour can reduce mothers bleeding 3. Initiating breastfeeding within 1 hour can improve breastmilk supply 4. Colostrum is good for the baby	5. Initiating breastfeeding within 1 hour is good for the child's health 6. Others (specify) 7. Don't know
50.	What should a mother do with the "first milk" or colostrum? (Multiple response possible)	1. Throw it away and start breastfeeding when the real milk comes in 2. Give it to her baby by breastfeeding soon after birth 3. Others (specify) 4. Don't know	
51.	What are benefits of colostrum? (Multiple responses possible)	1. Provide good source of nutrition 2. It is rich in protein, fat, and other necessary elements; and is good source pf nutrition for the baby 3. It is extremely rich in antibodies; and acts as the first immunization of the child 4. Providing some protection from inflammation and killing potentially harmful microorganisms (Protects against allergies and infections)	5. Boosts Immunity 6. Having laxative properties that can help baby have the first stool 7. Lessens the chance of jaundice Others (specify) 8. Others (specify.....) 9. Don't know

52.	What can a baby under the age of 6 months be fed? (Multiple responses possible)	1. Breast milk only 2. Breast milk and water 3. Breast milk and some other liquids 4. Others (specify) 5. Don't know
53.	For how many months should babies be breastfed exclusively (not even water)?	..... Number of Months
54.	What are some benefits of exclusive breastfeeding (only breastmilk, not even water) for infants and mothers? (Multiple response possible)	1. Protects baby from illness 2. Helps baby grow and develop better 3. Provides a superior source of nutrients 4. Easy to digest 5. Provides adequate water for a baby in the six months 6. Clean, always ready and of a good temperature 7. Stimulates brain development of the baby 8. Delays a new pregnancy 9. Stimulates breast milk production 10. Save money 11. Increased emotional bonding between mother and child 12. Good for mother's health (decreases breast & ovarian cancer) 13. Others (specify) 14. Don't know
55.	Do you think that infants under 6 months of age should be given water if the weather is very hot?	1. Yes 2. No 3. Don't Know
56.	At what age should an infant first begin eating soft or semi-solid foods?	1. ..... Number of Months 2. Don't Know
57.	Until about what age should a baby continue to be breastfed in addition to eating soft or semi-solid foods? `	1. ..... Number of Months 2. Don't Know

Awareness and Perception on Maternal Nutrition and Breastfeeding

Please tell me whether you strongly disagree, disagree, neither agree nor disagree, agree or strongly agree with each of the following statements

(Likert Scale: Strongly Disagree-1, Disagree-2, Neither Agree Nor Disagree-3, Agree-4, Strongly Agree-5)

Note: **Five Varieties/Groups of Food are:**

(i) ***Grains/cereal, Nuts and Seeds:*** Bread (rotis, etc), rice, noodles or other foods made from grains like wheat, millet, sorghum, etc.; Any tree nut, groundnut, peanut or other seeds

(ii) ***Vegetables and legumes/beans:*** Mature beans or peas (fresh or dried seed), lentils or bean/pea products); Dark green leafy vegetables (like including spinach, fenugreek, amaranth, mustard leaves wild/foraged leaves); Vitamin A-rich vegetables, roots and tubers (like (Pumpkin, carrots, squash or sweet potatoes that are yellow or orange inside)

(iii) **Fruits:** Mango, Papaya, Banana, Guava, Others

(iv) **Meat and Poultry:** Chicken, Goat/Lamb Meat , Fish, Eggs; other meat/poultry alternatives

(v) **Milk, butter, cheese, yoghurt and dairy alternatives**

Beliefs		
58.	My consuming right types and amount of food during pregnancy is extremely important for my health and my unborn child's health	
59.	My consuming right types and amount of food during pregnancy can save cost due to doctors and medicine	
60.	My consuming of IFA every day during pregnancy is important for my health and my unborn child	
61.	My consuming of calcium every day during pregnancy is important for my health and my unborn child	
62.	If I breastfeed my infant within 1 hour after giving birth, It'll be good for my health and my child's health	
63.	If I feed my infant a combination of breast milk and infant formula until s/he completes 6 months, I am giving him/her the BEST possible nutrition.	
Self-Efficacy		

64.	I can follow the recommendations of 5 varieties of food to be consumed along with roti/rice during pregnancy	
65.	It is too costly to obtain the recommended types and amounts of foods for my consumption during pregnancy	
66.	I can follow the recommendations of taking IFA every day during pregnancy	
67.	I can follow the recommendations of taking Calcium every day during pregnancy	
68.	I can follow the recommendations of consuming THR during pregnancy	
Social Norms		
69.	In my family and community we/people expect pregnant women to consume five varieties and larger quantity of food to get enough energy and nutrition during pregnancy	
70.	Most people who are important to me (e.g. family members, friends…) think that a pregnant woman should not eat too much to avoid difficult labour due to large baby	
71.	In my family and community, pregnant women are expected to avoid certain kinds of foods (meat, fish, papaya, jackfruit, milk, etc.) because it will harm the mother and/or baby	
72.	Most people who are important to me (e.g. family members, friends…) think that a pregnant woman should take IFA every day during pregnancy	
73.	Most people who are important to me (e.g. family members, friends…) think that a pregnant woman should take calcium every day during pregnancy	
74.	Most people who are important to me (e.g. family members, friends…) think that a pregnant woman should consume THR during pregnancy	
75.	Most people who are important to me (e.g. family members, friends…) think that a mother can breastfeed her infant within 1 hour after birth.	
Sources of Information/Counselling		
76.	Who/what are your sources of information/counselling regarding the following? (Multiple Options) (ANM-1; ASHA-2; AWW-3; Doctor (Govt.)-4; Doctor (Pvt.)-5; Husband-6; Mother In-law-7; Other Family Members-8; Friends-9; Self/ Self-motivated-10; Others-Specify-12……)	
(i)	Nutrition and dietary intake during pregnancy	
(ii)	Consuming IFA during pregnancy	
(iii)	Consuming THR during pregnancy (provided from AWC)	
(iv)	Breastfeeding	
(v)	Nutrition of infant and young children	

Structured Schedule- Lactating Women/Caregivers of Children 6-36 Months

A. General

S. No.	Question	Code							
1.	Block (Please put a ✓ mark)	Jaipur		Sanganer					
2.	CDPO Project (Please put a ✓ mark)								
	Jaipur-1		Jaipur-2		Jaipur-3		Sanganer-Rural		Sanganer City	
3.	Gram Panchayat (For Rural Areas)								
4.	Village Name (For Rural Areas)								
5.	City/Town (only for urban area)								
6.	Locality (only for urban area)								
7.	Name of the Concerned Anganwadi Centre (AWC)								

B. General information/ Demographic Characteristics

1.	Name of the respondent		
2.	Age of the respondent (completed years)		
3.	Contact Number of Respondent	1. …… 2. No Phone	
4.	Marital Status	1. Married living with spouse 2. Married but spouse away 3. Divorced	
5.	Education	1. No education/illiterate 2. Up to Class V (Primary) 3. Class VI-VII (Elementary) 4. Class IX-X (Secondary) 5. Class XI-XII (Higher Secondary) 6. Diploma after Class XII 7. Graduate 8. Post-graduate and Higher Qualifications	
6.	Occupation (Primary)	1. Farming 2. Livestock rearing 3. Salaried employment (Private) 4. Salaried employment (Government) 5. Self-employed (off farm) 6. Farm labourer 7. Non-farm Labour	8. Small shop/business 9. Street vendor 10. Working as House Maid/Help 11. Student 12. Homemaker 13. Other (specify)……
7.	Social category	1. OBC 2. SC 3. ST 4. Unreserved/General	
8.	Religion	1. Hindu 2. Muslim	

		3. Others
9.	Household size (Total number of members in the family)	
10.	Type of family	1. Joint 2. Nuclear
11.	Does your family have a Ration Card and do you take ration from the Government Ration Shop?	1. Yes- Card Available and Take Ration 2. Yes- Card Available and But Do Not Take Ration 3. Card Not Available
12.	Are you or any member of your family registered under Mahatma Gandhi Employment Guarantee Scheme (MGNREGS) and have a MGNREGS registration card	1. Yes- Registered and Card 2. Yes- Registered and But Card Not Available 3. Not Registered
13.	Details Regarding Household Assets (Yes-1; No-2)	
i)	Radio	
ii)	Telephone/Mobile	
iii)	Television	
iv)	Refrigerator	
v)	Washing Machine	
vi)	Coking Stove (Gas)	
vii)	Bed/Sleeping Mats	
viii)	Table/Chair	
ix)	Two Wheeler	
x)	Four Wheeler/Tractor/ Other Vehicle	
xi)	Electricity Connection	
xii)	Some agricultural land (owned)	
xiii)	Agriculture Equipment	

C. Particulars of Reference Child

S. No.	Questions	Options/Response				
1.	Name of your youngest child (6-36 months)?	.....Name of the child				
2.	Is the child a baby girl or a baby boy	1. Baby Girl 2. Baby Boy				
3.	Age of the child (in completed months)	Birth Month		Birth Year	Completed Age (Months)	
4.	Child Selected for taking anthropometric measurement	1. Yes 2. No				

D. Registration of Pregnancy with Reference Child, Availing ANC during Pregnancy with Reference Child , Availing THR and IFA Consumption during Pregnancy with Reference Child

**** Reference child name will be auto filled in CAPI***

S. No.	Questions	Options/Response	
1.	Was the pregnancy with ..reference child name... your first pregnancy?	1. Yes 2. No	
2.	If No, how many times have you been pregnant earlier?	___ (Numbers of times)	
3.	How many children do you have?	___ (Numbers of children)	
4.	Have you registered yourself somewhere for availing care during	1. Yes 2. No	If No, Skip To D-11

	your pregnancy with ..reference child name...?		
5.	Who helped/supported/motivated you to get your pregnancy with ..reference child name... registered?	1. ANM 2. ASHA 3. AWW 4. Doctor (Govt.)	5. Doctor (Pvt.) 6. Self-Motivated 7. Others (specify.....)
6.	In which month of the current pregnancy with ..reference child name..., was the registration done? (no. of month)	.... Month	
7.	Where had you registered your pregnancy with ..reference child name...? (Multiple Response)	1. AWC (local) 2. Sub Health Centre (SHC) 3. Public Health Centre (PHC) 4. Community Health Centre (CHC) 5. District Hospital (DH)	6. Private Clinic 7. Private Nursing Home/Hospital 8. Others (specify)..... .....
8.	In which month of the pregnancy with ..reference child name... did you receive the first ANC service?	1. ..... Month 2. Not received ANC	If 'Not Received ANC', then skip to Q-D-11
9.	How many ANC service did you receive when you were pregnant with ..reference child name...?	..... Number of ANCs	
10.	In which month of your pregnancy with ..reference child name..., was the registration done at local AWC? (no. of month)	..... month	
11.	Did you demand the THR for yourself from the local AWW when you were pregnant with ..reference child name...?	1. Yes 2. No	
12.	Did you receive Take Home Ration (THR) from the local AWC during your pregnancy with ..reference child name...?	1. Yes, regularly 2. Yes, but not regularly 3. No	If Yes (regularly) , then Skip to Q-D-14
13.	If No or Not Regularly, then what were the reasons? (Multiple Response)	1. Anganwadi was non-functional 2. Anganwadi was usually closed/ opens irregularly 3. AWW did not distribute the THR regularly (at least one a month) 4. THR was not available at AWC for distribution	5. Behaviour of AWW not good 6. No need/not required/not interested 7. Others (specify)..... ...	If No in Q-D12, then Skip to Q-D-25
14.	How did you receive the THR from AWC when you were pregnant with ..reference child name...?	1. AWW distributed it by coming to home 2. AWW distributed it from her home 3. AWW distributed it at the AWC 4. AWC distributed it on the MCHN Day/VHSND 5. Others (Specify.....)	
15.	At what frequency did you receive the THR from AWC when you were	1. Weekly 2. Fortnightly 3. Monthly	

	pregnant with ..reference child name...?	4. Others (specify.....)	
16.	What all food material and average how much quantity do you receive as THR in a month? (Ford material and Quantity in K.G; both options to be recorded)		
	Food Material	Received (Yes-1; No-2)	Quantity Received Per Month (K.G.)
16.a	Pulses (Daal)		
16.b	Rice		
16.c	Wheat		
16.d	Others (Specify .....)		
17.	How did you prepare the THR for your consumption when you were pregnant with ..reference child name...?	1. Not required, it was ready to eat 2. Mixed with other flour 3. Made porridge 4. Others (Specify.....)	
18.	Did you consume the THR provided from the AWC during pregnancy with ..reference child name...?	1. Yes- Regularly (daily or more than 4 days a week) 2. Yes, but not regularly (up to 3 days a week) 1. No (Not Consumed)	If Yes-Regularly, then Skip to Q-D-20
19.	If Not Regularly or Not Consumed, then what were the reasons? (Multiple Response)	1. THR was not of good quality 2. THR was provided in less quantity 3. Did not like the taste of THR provided 4. Did not consider it important to consume THR 5. Other family members consumed the THR	6. Gave it to others 7. Gave it to the domestic animals 8. Others (Specify.....)
			If No in Q-D-18 , then Skip to Q-D-25
20.	Usually after how much time of the receipt of THR from AWC, did you consume it when you were pregnant with ..reference child name...?	1. 1-3 days 2. 4-7 days 3. 7-10 days 4. 11-15 days 5. Other (Specify.....)	
21.	Usually, as part of which meal did you consume THR when you were pregnant with ..reference child name...?	1. Breakfast 2. Lunch 3. Evening Snacks 4. Dinner	
22.	How did you store the THR in your house that you received from AWC when you were pregnant with the ..reference child name...?	1. Closed Container (metallic) 2. Open Container (metallic) 3. Closed Container (plastic) 4. Open Container (plastic)	5. Plastic bag 6. Keep it in an open plate/tray 7. Other (Specify.....)
23.	Did the other family members also shared the THR that was provided for you when you were pregnant with ..reference child name...?	1. Yes 2. No	
24.	How would you rate quality of THR provided to you from the AWC when you were pregnant with ..reference child name...?	1. Very Good 2. Good 3. Neither Good Nor Bad	4. Bad 5. Very Bad

25.	What according to you what is the importance of consuming THR during pregnancy? (Multiple Response)	1. Compliments the nutritional requirement during pregnancy 2. For appropriate weight gain during pregnancy 3. Reduces/prevents the risks of anaemia 4. Reduces/prevents other unpleasant pregnancy symptoms such as fatigue and morning sickness		5. For good brain development of the child in womb 6. For healthy birth weight of the child 7. Can reduce the risk of many birth defects 8. Others (specify.....)	
26.	During your pregnancy with ..reference child name... , for how many days and how many IFA tablets did you consume? (no. of days/tablets) *(Enter '999' for Don't Remember)*	No. of Days		No. of Tablets	
27.	Do you think it is important to consume IFA during pregnancy?	1. Yes 2. No 3. Don't Know/ Can't Say			If 'No' or 'Don't Know/ Can't say', then Skip to Section-E
28.	According to you what is the importance of consuming IFA during pregnancy? (Multiple Response)	1. Helps the body make healthy red blood cells 2. Reduces/prevents anaemia during pregnancy 3. Helps in proper development of the brain, skull, and spinal cord of the baby in womb 4. Helps in countering the blood loss during delivery 5. Others (specify.....)			

E. Availing and Feeding THR to the reference child

**..reference child name... will be auto filled by CAPI*

29.	Are you currently availing THR for ...reference child name... from the AWC?	1. Yes, regularly 2. Yes, but not regularly 3. No		If Yes (Regularly), then Skip to Q-E-31
30.	If No or Not Regularly, then what are the reasons (Multiple Response)	1. Child not registered at AWC 2. Anganwadi is non-functional 3. Anganwadi is usually closed/ opens irregularly 4. AWW does not distribute the THR regularly (at least one a month) 5. Sometimes THR is not available at AWC for distribution	6. Behaviour of AWW is not good 7. Do not consider it important for the child 8. Did not feel that it is required to feed THR to the child 9. Others (Specify.....)	If No in Q-E-29; then Skip to Section-F
31.	How do you receive the THR from AWC for ...reference child name...?	1. AWW distributes it by coming to home 2. AWW distributes it from her home 3. AWW distributes it at the AWC 4. AWC distributes it on the MCHN Day/VHSND 5. Others (Specify.....)		
32.	For how many days in a month is the THR provided from AWC for ...reference child name...?	..... Number of Days		

33.	Frequency of receiving THR from AWC for ...reference child name...?	1. Weekly 2. Fortnightly 3. Monthly 4. Others (specify.....)		
34.	What all food material and average how much quantity do you receive as THR in a month for ...reference child name...? (Ford material and Quantity in K.G; both options to be recorded)			
	Food Material	Received (Yes-1; No-2)	Quantity Received Per Month (K.G.)	
34.a	Pulses (Daal)			
34.b	Rice			
34.c	Wheat			
34.d	Others (Specify .....)			
35.	Do you feed the THR provided from the AWC to ...reference child name...?	1. Yes- Regularly (daily or more than 4 days a week) 2. Yes, but not regularly (up to 3 days a week) 3. No (Not Feeding)	If Yes-Regularly, then Skip to Q-E-37	
36.	If Not Regularly or Not Feeding the THR to ...reference child name...?, then what are the reasons? (Multiple Response)	1. THR is not of good quality 2. THR is provided in less quantity 3. The child does not like the taste of THR provided 4. Do not consider it important for the child 5. Did not feel that it is required to feed THR to the child	6. THR gets spoilt soon (cannot be stored for longer time) 7. Other family members consume the THR 8. Give the THR to others 9. Feed the THR to domestic animals 10. Others (Specify.....)	If No in Q-E-35, then Skip to Section-F
37.	How do you prepare the THR for feeding to ...reference child name...? (Multiple Response)	1. No required, it is ready to eat 2. Mix with other floor 3. Make porridge 4. Others (Specify.....)		
38.	Usually in how much time after the receipt of THR from AWC, do feed it to the ...reference child name...?	1. 1-3 days 2. 4-7 days 3. 7-10 days 4. 11-15 days 5. Other (Specify.....)		
39.	Usually, as part of which meal do give the THR to ...reference child name...??	1. Breakfast 2. Lunch 3. Evening Snacks 4. Dinner		
40.	How do you store the THR in your home , which is provided from AWC for ...reference child name...?	1. Closed Container (metallic) 2. Open Container (metallic) 3. Closed Container (plastic) 4. Open Container (plastic)	5. Plastic bag 6. Keep it in an open plate/tray 7. Other (Specify.....)	
41.	Do the other family members also share the THR that is provided for ...reference child name...?	1. Yes 2. No		
42.	How would you rate quality of THR provided for ..reference child name... from the AWC?	1. Very Good 2. Good 3. Neither Good Nor Bad	4. Bad 3. Very Bad	

F. Breastfeeding and Nutrition of the Child– Knowledge Attitude and Practices

**..reference child name… will be auto filled by CAPI*

Breastfeeding Practice for the Reference Child			
43.	When did you first breastfeed …reference child name… after birth?	1. Immediately 2. Within 1 hour after delivery 3. Some hours later but less than 24 hrs	4. 1 day later 5. More than 1 day later 6. Do not remember
44.	Did you feed "first milk" or colostrum to …reference child name…?	1. Yes 2. No 3. Do not remember	
45.	Till how many months after birth was …reference child name… exclusively breastfed (did not even gave water)?	1. …. Number of months 2. Do not remember	
46.	Till what age …reference child name.. continued to breastfeed?	1. …… Number of months 2. Still breastfeeding	
47.	At what age (months) of …reference child name.. did you start giving other food/liquids to him/her?	1. …… Number of Months 2. Do not remember	
Reference Child- Dietary Intake			
48.	Is your family vegetarian?	1. Yes 2. No	
49.	How many meals/numbers of times did ..reference child name… eat/was fed yesterday? *(Latest normal day)*	…… Number of Meals/Times Fed	

Instructions:

- *Please apprise the respondent that we will now ask about what all the ..reference child name… ate or drank yesterday (or the last normal) during the day or night, at home or anywhere else. We will be asking about what all the ..reference child name… ate or drank at different times of the day*
- *There can be multiple responses for what the ..reference child name… ate/ drank at different times of the day; record all responses*
- *For each eating episode, after the respondent mentions foods and drinks, probe to ask if ..reference child name…ate or drank anything else. Continue probing until she says "no, nothing else".*
- *Please use the following codes to enter what the ..reference child name… ate/ drank at different times of the day*
  1. ***Grains/cereal, Nuts and Seeds:*** Bread (rotis, etc), rice, noodles or other foods made from grains like wheat, millet, sorghum, etc.; Any tree nut, groundnut, peanut or other seeds
  2. ***Vegetables and legumes/beans:*** Mature beans or peas (fresh or dried seed), lentils or bean/pea products); Dark green leafy vegetables (like including spinach, fenugreek, amaranth, mustard leaves wild/foraged leaves); Vitamin A-rich vegetables, roots and tubers (like (Pumpkin, carrots, squash or sweet potatoes that are yellow or orange inside)
  3. ***Fruits:*** Mango, Papaya, Banana, Guava, Others
  4. ***Meat and Poultry:*** Chicken, Goat/Lamb Meat , Fish, Eggs; other meat/poultry alternatives
  5. ***Milk, butter, cheese, yoghurt and dairy alternatives***
  6. ***Breastmilk***
  7. ***THR (Given by AWW)***
  8. ***Savoury and fried snacks:*** Chips, crisps, chanachur, French fries and similar items
  9. ***Sweets :*** Sugary foods, such as Indian sweets, chocolates, candies, cookies/sweet biscuits and cake, sweet pastries or ice cream
  10. ***Sugar-sweetened beverages:*** like fruit-flavoured drinks, sports drinks, chocolate and other flavoured milk drinks, malt drinks, 100% fruit juice as well as juice drinks with added sugar or other caloric sweeteners, (packaged in cans, bottles, boxes, sachets, prepared at home, etc.)
  11. ***Did not eat/drink anything***

50.	What did the ..reference child name… have to eat or drink when he/she woke?	

51.	What did the ..reference child name... have to eat or drink later in the morning?	
52.	What did the ..reference child name... have to eat or drink at mid-day? If yes, what?	
53.	What did the ..reference child name... have to eat or drink during the afternoon?	
54.	What did the ..reference child name... have to eat or drink in the evening?	
55.	What did the ..reference child name... have to eat or drink in the evening before going to bed or during the night?	
56.	How many times yesterday was the child breastfed yesterday?	1. ..... Number of Times 2. Dd not breastfeed yesterday 3. Breastfeeding discontinued

Knowledge about Child Nutrition and Breastfeeding

57.	Why are some new-borns very small at birth and others are born healthy in your community? (Multiple responses possible)	1. Evil eye 2. Too many children or closely spaced births 3. Mother frail and unhealthy 4. Mother did not eat well during pregnancy 5. Mother did not complete ANC visits	6. Mother did not take IFA or calcium 7. Mother was ill during pregnancy a lot 8. Pre-mature birth 9. Other (specify) 10. Don't know
58.	Why is nourishing diet and good nutrition of children 6-36 months important? *(Multiple responses possible)*	1. For proper weight gain 2. For proper height/length gain 3. For healthy growth 4. For appropriate brain development 5. For appropriate development of loco-motor skills	6. To develop immunity against illnesses/ diseases 7. Others (specify.....) 8. Do not know
59.	What all should be eaten/fed to a child 6-36 months to provide good nutrition to help him/her grow? (Multiple responses possible)	1. Breast milk 2. Five variety of foods in addition to roti/rice 3. Thick dal 4. Milk (other than breastmilk)/ milk product daily 5. Dark green leafy vegetables 6. Yellow/orange vegetables/fruits 7. Fish/meat 8. Egg daily, if acceptable in diet	9. Take nutritious snack daily 10. Increase amount of food consumed daily 11. Take one IFA tablet daily 12. Take two Calcium tablets daily 13. Eat channa (roasted gram) 14. Eat jaggery 15. Other (specify)

	A. Male Child		B. Female Child			
60.	How many meals should a child have in a day?		A) Number of main meals -99 for "Don't know"		(B) Number of snacks -99 for "Don't know"	
i)			i. Male Child	ii. Female Child	i. Male Child	ii. Female Child
ii)	Child 6-12 months					
iii)	Child 13-24 months					
iv)	Child 24-36 months					
61.	When should a baby start breastfeeding after birth?		1. Immediately 2. Within 1 hour after delivery 3. Some hours later but less than 24 hrs 4. 1 day later			

			5. More than 1 day later 6. Do not think baby should be breastfed 7. Don't know	
	i. Male Child		ii. Female Child	
62.	Why should a baby start breastfeeding soon after birth? (Multiple responses possible)	1. Initiating breastfeeding within 1 hour can save baby's life 2. Initiating breastfeeding within 1 hour can reduce mothers bleeding 3. Initiating breastfeeding within 1 hour can improve breastmilk supply 4. Colostrum is good for the baby	5. Initiating breastfeeding within 1 hour is good for the child's health 6. Others (specify) 7. Don't know	
63.	What should a mother do with the "first milk" or colostrum? (Multiple response possible)	1. Throw it away and start breastfeeding when the real milk comes in 2. Give it to her baby by breastfeeding soon after birth 3. Others (specify) 4. Don't know		
64.	What are benefits of colostrum? (Multiple responses possible)	1. Provide good source of nutrition 2. It is rich in protein, fat, and other necessary elements; and is good source pf nutrition for the baby 3. It is extremely rich in antibodies; and acts as the first immunization of the child Providing some protection from inflammation and killing potentially harmful microorganisms (Protects against allergies and infections)	4. Boosts Immunity 5. Having laxative properties that can help baby have the first stool 6. Lessens the chance of jaundice Others (specify) 7. Others (specify.....) 8. Don't know	
65.	What can a baby under the age of 6 months be fed? (Multiple responses possible)		1. Breast milk only 2. Breast milk and water 3. Breast milk and some other liquids	4. Others (specify) 5. Don't know
	i. Male Child		ii. Female Child	
66.	For how many months should babies be breastfed exclusively (not even water)?		A. ..... Number of Months (Male Child) B. ..... Number of Months (Female Child)	
67.	What are some benefits of exclusive breastfeeding (only breastmilk, not even water) for infants and mothers?	1. Protects baby from illness 2. Helps baby grow and develop better 3. Provides a superior source of nutrients 4. Easy to digest	8. Delays a new pregnancy 9. Stimulates breast milk production 10. Save money 11. Increased emotional bonding between mother and child	

	(Multiple response possible)	5. Provides adequate water for a baby in the six months 6. Clean, always ready and of a good temperature 7. Stimulates brain development of the baby	12. Good for mother's health (decreases breast & ovarian cancer) 13. Others (specify) 14. Don't know
68.	Do you think that infants under 6 months of age should be given water if the weather is very hot?	1. Yes 2. No 3. Don't Know	
69.	At what age should an infant first begin eating soft or semi-solid foods?	1. ..... Number of Months (Male Child) 2. ..... Number of Months (Female Child) 3. Don't Know	
70.	Until about what age should a baby continue to be breastfed in addition to eating soft or semi-solid foods? `	1. ..... Number of Months (Male Child) 2. ..... Number of Months (Female Child) 3. Don't Know	
71.	What is the importance of feeding THR to children 6-36 months?	1. Helps in proper growth and development of children 2. Helps in preventing anaemia in children 3. Helps in meeting nutritional needs (calorific/protein) of children	4. Helps in proper brain development of children 5. Prevents malnourishment in children 6. Others (specify.....) 7. Don't Know

Awareness and Perception on Child Nutrition and Breastfeeding

Please tell me whether you strongly disagree, disagree, neither agree nor disagree, agree or strongly agree with each of the following statements

(Likert Scale: Strongly Disagree-1, Disagree-2, Neither Agree Nor Disagree-3, Agree-4, Strongly Agree-5)

Note: **Five Varieties/Groups of Food are:**

(i) ***Grains/cereal, Nuts and Seeds:*** Bread (rotis, etc), rice, noodles or other foods made from grains like wheat, millet, sorghum, etc.; Any tree nut, groundnut, peanut or other seeds

(ii) ***Vegetables and legumes/beans:*** Mature beans or peas (fresh or dried seed), lentils or bean/pea products); Dark green leafy vegetables (like including spinach, fenugreek, amaranth, mustard leaves wild/foraged leaves); Vitamin A-rich vegetables, roots and tubers (like (Pumpkin, carrots, squash or sweet potatoes that are yellow or orange inside)

(iii) **Fruits:** Mango, Papaya, Banana, Guava, Others

(iv) **Meat and Poultry:** Chicken, Goat/Lamb Meat , Fish, Eggs; other meat/poultry alternatives

(v) **Milk, butter, cheese, yoghurt and dairy alternatives**

Beliefs		
72.	Feeding first milk/colostrum to prevents the child for infections/diseases and acts as first immunization	
73.	Breastfeeding should be initiated immediately /as soon as possible after birth of the child	
74.	Except for breastfeeding, it is not required to give anything else to the child for the first six months after birth	
75.	Feed the child with a combination of breast milk and infant formula until s/he completes 6 months, is the BEST possible nutrition	
76.	After six months, giving solid/semi slid food and other liquids should be started for a child	
77.	Child should be continued to breastfeed till at least 24 months after birth	
78.	Consuming right types and amount of food helps in in proper growth and health of the child	
79.	Feeding THR helps in meeting the nutritional requirement for the child	
Self-Efficacy		
80.	I can follow the recommendations of 5 varieties of food to be to fed/give to .... reference child name	
81.	It is too costly to obtain the recommended types and amounts of foods for .... reference child name	
82.	I can follow the recommendations of breastfeeding to .... reference child name	
83.	I can follow the recommendations of feeding THR to .... reference child name	

Social Norms		
84.	In my family and community we/people expect the child to be fed the first milk/colostrum	
85.	In my family and community we/people expect that breastfeeding is initiated immediately /as soon as possible after birth of the child	
86.	In my family and community we/people expect that the child is exclusively breastfed for first six months after birth	
87.	In my family and community we/people expect that giving solid/semi slid food and other liquids should be started after the child attains 6 months of age	
88.	In my family and community we/people expect that the child is continued to be breastfed till 24 months of age	
89.	In my family and community we/people expect that the child should be fed five varieties of food to get for proper nutrition and growth	
90.	Most people who are important to me (e.g. family members, friends...) think that giving certain kinds of foods should be avoided for the child (meat, fish, papaya, jackfruit, milk, etc.) because it will harm the child or hamper the child's growth	
91.	Most people who are important to me (e.g. family members, friends...) think that the chid should be fed the THR provided by the AWC	
Sources of Information/Counselling		
92.	Who/what are your sources of information/counselling regarding the following? (ANM-1; ASHA-2; AWW-3; Doctor (Govt.)-4; Doctor (Pvt.)-5; Husband-6; Mother In-law-7; Other Family Members-8; Friends-9; Self/ Self-motivated-10; Others-Specify-12.....)	
(i)	Nutrition and dietary intake during pregnancy	
(ii)	Feeding THR to the child (provided from AWC)	
(iii)	Breastfeeding of the child	
(iv)	Nutrition of infant and young children	

G. Recent Morbidity and Vaccination of the Reference Child

**: Name of the reference child will be auto filled by CAPI*

Definitions:

Diarrhoea: Diarrhoea is defined as the passage of three or more loose or liquid stools per day (or more frequent passage than is normal for the individual). Frequent passing of formed stools is not diarrhoea, nor is the passing of loose, "pasty" stools by breastfed babies.

Fever: Means fever which is non-specific (not because of any other illness like Malaria, Typhoid) and non-Covid fever

93.	Has the ...reference child name... suffered from an episode of Diarrhoea in last 2 weeks?	1. Yes 2. No	If No, then Skip to Q-G-98
94.	Whether advice/treatment sought for the episode of diarrhoea?	1. Yes 2. No	If No, then Skip to Q-G-96
95.	Whom did you consult/seek treatment from? (Multiple Response)	1. AWW 2. ASHA 3. ANM 4. Government health facility	5. Private health facility 6. Family member/elder 7. Others (specify).....
96.	Did you provide ORS to ...reference child name... during the episode of Diarrhoea?	1. Yes 2. No	
97.	Whether Zinc/ Zinc tablets were given to ...reference child name... during the episode of Diarrhoea?	1. Yes 2. No	

98.	Has the ...reference child name... suffered from an instance of fever in last 2 weeks?	1. Yes 2. No	If No, then Skip to Q-G-103
99.	Whether advice/treatment sought for the episode of fever?	1. Yes 2. No	If No, then Skip to Q-G-102
100.	After how many days of fever was the advice/treatment sought? (no. of days) *(for the reference child 6-36 months)*		
101.	Whom did you consult/seek treatment from? (Multiple Response)	1. AWW 2. ASHA 3. ANM 4. Government health facility	5. Private health facility 6. Family member/elder 7. Others (specify).....
102.	Was ...reference child name... given any medication to treat fever?	1. Yes 2. No	
103.	Has ...reference child name... had an illness with a cough at any time in the last 2 weeks?	1. Yes 2. No	
104.	Has ...reference child name... had fast, short, rapid breaths or difficulty breathing or had moving ribs, at any time in the last 2 weeks?	1. Yes 2. No	If No, then Skip to Q-G-110
105.	Was the fast or difficult breathing due to a problem in the chest or to a blocked or runny nose?	1. Chest only 2. Nose only 3. Both, Chest and Nose 4. Others (specify.....) 5. Don't Know	
106.	Whether advise/treatment sought for this episode of illness (breathing faster than usual with short, rapid breath or have difficulty breathing or had moving ribs)?	1. Yes 2. No	If No, then Skip to Q-G-110
107.	After how many days of the episode of illness, was the advice/ treatment sought (for breathing faster than usual with short, rapid breath or have difficulty breathing or had moving ribs)? (no. of days)		
108.	Whom did you consult/seek treatment from? (Multiple Response)	1. AWW 2. ASHA 3. ANM 4. Government health facility	5. Private health facility 6. Family member/elder 7. Others (specify).....
109.	Was the child given any medication to treat the illness?	1. Yes 2. No	
Vaccination Status of the Reference Child			

110.	Has the ...reference child name.., received any vaccination?	1. Yes 2. No	If No, then skip to Section-H

111.	Record the details of the vaccination of the child till date? (Please refer to the vaccination card, if available) OPV can be given till 5 years of age Pentavalent and Rota Virus vaccine can be given till one year of age Measles/Measles & Rubella vaccine (can be given till 5 years of age)	Received (Yes-1; No-2; Not Applicable as per Child's Age-3)
(i)	BCG *(At birth or as early as possible till 1 year of age)*	
(ii)	Hepatitis B Birth dose *(At birth or as early as possible within 24 hours)*	
(iii)	Oral Polio vaccine (OPV) Birth dose *(At birth or as early as possible within the first 15 days)*	
(iv)	Oral Polio vaccine (OPV) 1 *(At 6 weeks)*	
(v)	Oral Polio vaccine (OPV) 2 *(At 10 weeks)*	
(vi)	Oral Polio vaccine (OPV) 3 *(At 14 weeks)*	
(vii)	Pentavalent 1 *(At 6 weeks)*	
(viii)	Pentavalent 2 *(At 10 weeks)*	
(ix)	Pentavalent 3 *(At 14 weeks)*	
(x)	Rota Virus Vaccine-1 *(At 6 weeks)*	
(xi)	Rota Virus Vaccine-2 *(At 10 weeks)*	
(xii)	Rota Virus Vaccine-3 *(At 14 weeks)*	
(xiii)	Measles 1st Dose *(At completion of 9 to 12 months; can be given give up to 5 years if not received at 9-12 months age)*	
(xiv)	Vitamin A, 1st Dose *(At 9 months with measles)*	
(xv)	Oral Polio vaccine (OPV) Booster *(At 16-24 Months)*	
(xvi)	Measles 2nd dose *(At 16-24 Months)*	
(xvii)	Fractional dose of Inactivated Polio Vaccine (fIPV)-1 *(At 6 weeks)*	
(xviii)	Fractional dose of Inactivated Polio Vaccine (fIPV)-2 *(At 14 weeks)*	
(xix)	Measles & Rubella (MR)-1 *(At 9-12 Months)*	
(xx)	Measles & Rubella (MR)-2 *(At 16-24 Months)*	
(xxi)	Diphtheria, Pertussis & Tetanus (DPT)-Booster-1 *(16-24 months)*	
(xxii)	OPV – Booster *(16-24 months)*	

H. Water Sanitation and Hygiene

**: name of the reference child will be auto filled by CAPI*

112	Main source of drinking water for the household?	1. Open Well 2. Covered Well 3. Hand Pump	6. Supply through Tanker (Govt.) 7. Supply through Tanker (Pvt.) 8. Buy drinking water cans

		4. Piped Water Supply (Connection) 5. Public Stand Post	9. Others (specify.....)
113	Is there a functional toilet in the house?	1. Yes 2. No	
114	What is done to dispose the stool of ...reference child name... in your household?	1. Dispose into household toilet 2. Dispose into household bathroom 3. Dispose into a drain 4. Dispose it along with other waste/garbage of the household	5. Throw it in any open ground 6. Dispose it by burying it in ground 7. Others (specify.....)
115	At what all times do you wash your hands with soap and water? *(Please tick all that apply)*	1. After using toilet 2. Before having food 3. After having food 4. Before feeding the child 5. After feeding the child 6. Before cooking food 7. After cooking food 8. After cleaning the child (after defecation/urination) 9. Others (specify.....)	

I. Anthropometric Measurement of the Child (for the reference child of the respondent between 6-36 months)

This section will only be applicable for the reference child selected in Q-C-4

116.	Height/length of the child (Centimetres- up to one decimal)	Standing Height (for child 25-36 months)	Recumbent Length (for child 6-24 months)
		|___|___|.|___|	|___|___|.|___|
117.	Current weight of the child (lightly clothed) (kilogram – up to the nearest 1/10 kg (or) two decimals)	Kilograms	
		|___|___|.|___||___|	

Semi-structured Schedule-Anganwadi Worker

A. Respondent Particulars

S. No.	Question	Code
1.	Block (Please put a ✓ mark)	Jaipur ☐ Sanganer ☐
2.	CDPO Project (Please put a ✓ mark)	
	Jaipur-1 ☐ Jaipur-2 ☐ Jaipur-3 ☐ Sanganer-Rural ☐ Sanganer City ☐	
3.	Gram Panchayat (For Rural Areas)	
4.	Village Name (For Rural Areas)	
5.	City/Town (only for urban area)	
6.	Locality (only for urban area)	
7.	Name of the Concerned Anganwadi Centre (AWC)	
8.	Name of the Anganwadi Worker	
9.	Age of the respondent (completed years)	
10.	Years since posted at this AWC	
11.	Total experience as AWW	
12.	Education	1. No education/illiterate 2. Up to Class V (Primary) 3. Class VI-VII (Elementary) 4. Class IX-X (Secondary) 5. Class XI-XII (Higher Secondary) 6. Diploma after Class XII 7. Graduate 8. Post-graduate and Higher Qualifications
13.	Religion	1. Hindu 2. Muslim 3. Christian 4. Sikh 5. Buddhist 6. Others (specify)
14.	Social category	1. OBC 2. SC 3. ST 4. Unreserved/General
15.	AWC operating from	1. Department building 2. Rented building 3. School premises 4. Garam Panchayat office premises 5. Other building (specify)
16.	Contact Number of Respondent	1. ..... 2. No Phone
16.a	Is the respondent differently abled (Yes-1; No-2) DO NOT ASK: Please observe and record appropriately	

B. *Take Home Ration (THR)– Importance, Distribution, and View*

S. No.	Questions	Options/Response
1.	What is the importance of consuming THR during pregnancy?	1. Compliments the nutritional requirement during pregnancy 2. For appropriate weight gain during pregnancy 3. Reduces/prevents the risks of anaemia 4. Reduces/prevents other unpleasant pregnancy symptoms such as fatigue and morning sickness 5. For good brain development of the child in womb

		6. For healthy birth weight of the child 7. Can reduce the risk of many birth defects 8. Others (specify.....) 9. Don't Know	
2.	What is the importance of feeding THR to children 6-36 months?	1. Compliments the nutritional requirements 2. For appropriate weight gain 3. Reduces/prevents the risks of anaemia 4. For good brain development of the child 5. Prevents the child from being underweight (less weight for age) 6. Prevents the child from being wasted (less weight for height) 7. Prevents the child from being stunted (less height for age) 8. Others (specify.....) 9. Don't Know	
3.	What is the importance of consuming THR by adolescent girls?	1. Compliments the nutritional requirement during adolescence 2. For appropriate weight gain 3. Reduces/prevents the risks of anaemia 4. Reduces/prevents symptoms like fatigue and weakness 5. Others (specify.....) 6. Don't Know	
4.	Do you provide THR to the Beneficiaries of your AWC	1. Yes 2. No	If No, then skip to Q-11
5.	To which all beneficiaries do you provide THR? (Yes-1; No-2; Not Applicable)		
(i)	Pregnant Women		
(ii)	Lactating Women		
(iii)	Children 6-36 Months		
(iv)	Adolescent Girls		
6.	Frequency of THR Distribution *(Weekly-1; Fortnightly-2; Monthly-3; Others (specify.....)-4)*		
(i)	Pregnant Women		
(ii)	Lactating Women		
(iii)	Children 6-36 Months		
(iv)	Adolescent Girls		
6.a	Whether THR is distributed at AWC or delivered at home?	1. THR is distributed at AWC 2. delivered at home 3. Others (specify)	
7.	What all food items, in how much quantity (KG) and for how many days do you provide THR to the beneficiaries? (record the food items, quantity in KG and number of days) - only one of the option either days or quantity)		

7.A	Pregnant Women	Whether Provided (Yes-1; no-2)	Quantity Provided Per Month (K.G.)	For how many days in a month is the food material provided
7.a.1	Pulses (Daal)			
7.a.2	Rice			
7.a.3	Wheat			
7.a.4	Others (Specify...)			
7.B	Lactating Women	Whether Provided (Yes-1; no-2)	Quantity Provided Per Month (K.G.)	For how many days in a month is the food material provided
7.b.1	Pulses (Daal)			
7.b.2	Rice			
7.b.3	Wheat			
7.b.4	Others (Specify...)			

7.c	Children (6-36 Months)	Whether Provided (Yes-1; no-2)	Quantity Provided Per Month (K.G.)	For how many days in a month is the food material provided
7.c.1	Pulses (Daal)			
7.c.2	Rice			
7.c.3	Wheat			
7.c.4	Others (Specify…)			
7.d	Adolescent Girls	Whether Provided (Yes-1; no-2)	Quantity Provided Per Month (K.G.)	For how many days in a month is the food material provided
7.d.1	Pulses (Daal)			
7.d.2	Rice			
7.d.3	Wheat			
7.d.4	Others (Specify…)			

8.	Average quantity of THR stored at your AWC in a month (K.G.)	
9.	How is the THR stored at your AWC	1. In a cupboard Wooden) 2. In a cupboard (Metal) 3. In a box (Wooden) 4. In a box (Metal) 5. In Cartons 6. In Plastic sacks (*Bori*) 7. In Jute sacks (*Bori*) 8. In open place inside AWC 9. Others (Specify……)
10	For how long (duration) do you store the THR received for a month before its distribution? (No. of Days)	
11	What are your views about the demand and uptake of THR by beneficiaries in your area?	1. High demand 2. Average Demand 3. Very less demand 4. No demand 5. Other (specify……)
12	According to you, is there a demand among the beneficiaries for the THR?	1. Yes, from all beneficiaries 2. Yes, from pregnant women 3. Yes, from lactating women 4. Yes, for children 6-36 months 5. No
13	What according to you are the reasons that the demand/uptake of THR is less among beneficiaries in your area?	
14	According to you, is there an acceptability in the community for the THR?	1. Yes, among all beneficiaries 2. Yes, among pregnant women 3. Yes, among lactating women 4. Yes, for children 6-36 months 5. No 6. Not Sure
15	What according to you are the factors that are impacting the uptake and acceptability of THR by beneficiaries in your area? *(Please record the responses verbatim)*	
16	What are your views about the awareness among beneficiaries about the importance of THR consumption? *(Please record the responses verbatim)*	

C. *Knowledge regarding Nutrition of Pregnant Women and Children, including Breastfeeding*

S. No.	Questions	Options/Response
17	In which month of pregnancy should the pregnant women get their pregnancy registered? (Only one response)	1. … Month of pregnancy 2. As soon as pregnancy is confirmed 3. Don't Know
18	In which month of pregnancy, should a pregnant woman receive first ANC service? *(record the number of month)*	1. … Month of pregnancy 2. Don't Know
19	For how many days during the pregnancy, a pregnant woman should ideally consume IFA tablets? (number of days) *(Enter '999' for Don't Know)*	
20	Ideally how many IFA tablets should a pregnant woman consume during her pregnancy? (number of tablets) *(Enter '999' for Don't Know)*	
21	Ideally how much weight should a normal pregnant woman gain during the entire pregnancy? (record weight in k.g.) *(Enter '99' for Don't Know)*	
22	Ideally how many meals in a day should a pregnant woman consume? (record the number of meals)? *(Enter '99' for Don't Know)*	
23	What all types of food items should be part of the daily diet of pregnant women, children 6-36 months and adolescent girls? (Multiple options allowed) **Code for Five Varieties/Groups of Food are:** 1. ***Grains/cereal, Nuts and Seeds:*** Bread (rotis, etc), rice, noodles or other foods made from grains like wheat, millet, sorghum, etc.; Any tree nut, groundnut, peanut or other seeds 2. ***Vegetables and legumes/beans:*** Mature beans or peas (fresh or dried seed), lentils or bean/pea products); Dark green leafy vegetables (like including spinach, fenugreek, amaranth, mustard leaves wild/foraged leaves); Vitamin A-rich vegetables, roots and tubers (like (Pumpkin, carrots, squash or sweet potatoes that are yellow or orange inside) 3. **Fruits:** Mango, Papaya, Banana, Guava, Others 4. **Meat and Poultry:** Chicken, Goat/Lamb Meat , Fish, Eggs; other meat/poultry alternatives 5. **Milk, butter, cheese, yoghurt and dairy alternatives**	
	Beneficiary	*Food Group*
A	*Pregnant Women*	
B	*Female Children 6-36 Months*	
C	*Male Children 6-36 Months*	

D	*Adolescent Girls*		
24	What is the first food that a new-born baby should receive?	1. Mother's milk only 2. Other milk 3. Fruit juices 4. Water	5. Honey 6. Gripe water 7. Others (specify)…… 8. Don't know
	i. Male Child		ii. Female Child
25	According to you, should a new-born child be fed with the first milk of the mother (colostrum)?	1. Yes 2. No 3. Not Sure/Not Aware	
	i. Male Child		ii. Female Child
26	What is the importance of feeding colostrum to the new-born? (Multiple Response)	1. Provide good source of nutrition 2. It is rich in protein, fat, and other necessary elements; and is good source pf nutrition for the baby 3. It is extremely rich in antibodies; and acts as the first immunization of the child 4. Providing some protection from inflammation and killing potentially harmful microorganisms (Protects against allergies and infections)	5. Boosts Immunity 6. Having laxative properties that can help baby have the first stool 7. Lessens the chance of jaundice Others (specify) 8. Others (specify……) 9. Don't know
27	When should the breastfeeding be initiated for a new-born child?	1. Immediately after birth/as soon as mother is in position to breastfeed 2. Within 3 hours of birth 3. Within 4-5 hours of birth 4. Within 6-12 hours of birth 5. Within 13-24 hours of birth	6. Within 24-48 hours of birth 7. After 48 hours of birth 8. Not aware/Don't Know 9. Others (specify)……
	i. Male Child		ii. Female Child
28	For how many months should a child be exclusively breastfed? (no. of months) *(Enter '999' for Don't Know)*	A. …… Number of Months (Male Child) B. …… Number of Months (Female Child)	
29	What all food/drinks can be given to a child less than 6 months?	1. Mother's milk only 2. Other milk 3. Baby mix	8. Mashed biscuit 9. Mashed chapati/roti 10. Mashed pulses/dal

	(Multiple Response)	4. Fruit juices 5. Water 6. Honey 7. Gripe water	11. Mashed potato 12. Mashed banana 13. Others (specify)..... 14. Don't Know	
	i. Male Child		ii. Female Child	
30	Do you think that breast milk alone is enough for a child less than 6 months of age? (Yes-1: No-2; Not Sure-3)	A. Male Child		
		B. Female Child		
31	A child should continue breastfeeding till what age? (number of months) *(Enter '99' for Don't Know)*	A. Male Child		
		B. Female Child		
32	After how many months, a child should be provided with other food items, apart from breastmilk? – initiation of weaning (no. of months) *(Enter '999' for Don't Know)*	A. Male Child		
		B. Female Child		
33	What all food/drinks can be given to child 6-36 months? (Multiple Response)	1. Mother's milk 2. Other milk 3. Baby mix 4. Fruit juices 5. Water 6. Honey 7. Gripe water 8. Mashed biscuit 9. Mashed chapati/roti	10. Mashed pulses/dal 11. Mashed potato 12. Mashed banana 13. Other fruits 14. Other vegetables 15. Eggs 16. Meat 17. Others (specify)..... 18. Don't Know	

Semi-structured Schedule-ANM/ASHA

A. Respondent Particulars

S. No.	Question	Code
1.	Block (Please put a ✓ mark)	Jaipur ☐ Sanganer ☐
2.	CDPO Project (Please put a ✓ mark)	
	Jaipur-1 ☐ Jaipur-2 ☐ Jaipur-3 ☐ Sanganer-Rural ☐ Sanganer City ☐	
3.	Gram Panchayat (For Rural Areas)	
4.	Village Name (For Rural Areas)	
5.	City/Town (only for urban area)	
6.	Locality (only for urban area)	
7.	Name of the Concerned Anganwadi Centre (AWC)	
8.	Name of Respondent	
9.	Designation	1. ASHA 2. ANM
10.	Age of the respondent (completed years)	
11.	Years since posted at this AWC	
12.	Total experience as ASHA/ANM	
13.	Education	1. No education/illiterate 2. Up to Class V (Primary) 3. Class VI-VII (Elementary) 4. Class IX-X (Secondary) 5. Class XI-XII (Higher Secondary) 6. Diploma after Class XII 7. GNM Course 8. B.Sc. Nursing 9. Other Graduation 10. M.Sc. Nursing 11. Other Post-graduation and Higher Qualifications
14.	Contact Number of Respondent	1. ..... 2. No Phone
15.	Is the respondent differently abled (Yes-1; No-2) DO NOT ASK: Please observed and record appropriately	

B. *Take Home Ration (THR)– Importance and Views*

S. No.	Questions	Options/Response
1.	What is the importance of consuming THR (provided from AWC) during pregnancy?	1. Compliments the nutritional requirement during pregnancy 2. For appropriate weight gain during pregnancy 3. Reduces/prevents the risks of anaemia 4. Reduces/prevents other unpleasant pregnancy symptoms such as fatigue and morning sickness 5. For good brain development of the child in womb 6. For healthy birth weight of the child

		7. Can reduce the risk of many birth defects 8. Others (specify.....) 9. Don't Know
2.	What is the importance of feeding THR (provided from AWC) to children 6-36 months?	1. Compliments the nutritional requirements 2. For appropriate weight gain 3. Reduces/prevents the risks of anaemia 4. For good brain development of the child 5. Prevents the child from being underweight (less weight for age) 6. Prevents the child from being wasted (less weight for height) 7. Prevents the child from being stunted (less height for age) 8. Others (specify.....) 9. Don't Know
3.	What is the importance of consuming THR (provided from AWC) by adolescent girls?	1. Compliments the nutritional requirement during adolescence 2. For appropriate weight gain 3. Reduces/prevents the risks of anaemia 4. Reduces/prevents symptoms like fatigue and weakness 5. Others (specify.....) 6. Don't Know
4.	According to you, is there a demand among the beneficiaries for the THR provided from AWC?	1. Yes, from all beneficiaries 2. Yes, from pregnant women 3. Yes, from lactating women 4. Yes, for children 6-36 months 5. Not Sure 6. Don't Know
5.	What according to you are the reasons that the demand/uptake of THR is less among beneficiaries in the area?	
6.	According to you, is there an acceptability in the community for the THR provided from AWC?	1. Yes, among all beneficiaries 2. Yes, among pregnant women 3. Yes, among lactating women 4. Yes, for children 6-36 months 5. No 6. No Sure 7. Don't Know
7.	What according to you are the factors that are impacting the uptake and acceptability of THR by beneficiaries in area? *(Please record the responses verbatim)*	
8.	What are your views about the awareness among beneficiaries about the importance of THR consumption?*(Please record the responses verbatim)*	

C. *Knowledge regarding Nutrition of Pregnant Women and Children, including Breastfeeding*

S. No.	Questions	Options/Response
9.	In which month of pregnancy should the pregnant women get their pregnancy registered? (Only one response)	1. ... Month of pregnancy 2. As soon as pregnancy is confirmed 3. Don't Know

10	In which month of pregnancy, should a pregnant woman receive first ANC service? *(record the number of month)*	1. … Month of pregnancy 2. Don't Know
11	For how many days during the pregnancy, a pregnant woman should ideally consume IFA tablets? (number of days) *(Enter '999' for Don't Know)*	
12	Ideally how many IFA tablets should a pregnant woman consume during her pregnancy? (number of tablets) *(Enter '999' for Don't Know)*	
13	Ideally how much weight should a normal pregnant woman gain during the entire pregnancy? (record weight in k.g.) *(Enter '99' for Don't Know)*	
14	Ideally how many meals in a day should a pregnant woman consume? (record the number of meals)? *(Enter '99' for Don't Know)*	

15	What all types of food items should be part of the daily diet of pregnant women, children 6-36 months and adolescent girls? (Multiple options allowed) **Code for Five Varieties/Groups of Food are:** 1. ***Grains/cereal, Nuts and Seeds:*** Bread (rotis, etc), rice, noodles or other foods made from grains like wheat, millet, sorghum, etc.; Any tree nut, groundnut, peanut or other seeds 2. ***Vegetables and legumes/beans:*** Mature beans or peas (fresh or dried seed), lentils or bean/pea products); Dark green leafy vegetables (like including spinach, fenugreek, amaranth, mustard leaves wild/foraged leaves); Vitamin A-rich vegetables, roots and tubers (like (Pumpkin, carrots, squash or sweet potatoes that are yellow or orange inside) 3. **Fruits:** Mango, Papaya, Banana, Guava, Others 4. **Meat and Poultry:** Chicken, Goat/Lamb Meat , Fish, Eggs; other meat/poultry alternatives 5. **Milk, butter, cheese, yoghurt and dairy alternatives**	
	Beneficiary	*Food Group*
A	*Pregnant Women*	
B	*Female Children 6-36 Months*	
C	*Male Children 6-36 Months*	
D	*Adolescent Girls*	

16	What is the first food that a new-born baby should receive?	1. Mother's milk only 2. Other milk 3. Fruit juices 4. Water	5. Honey 6. Gripe water 7. Others (specify)…… 8. Don't know
	i. Male Child		ii. Female Child

17	According to you, should a new-born child be fed with the first milk of the mother (colostrum)?		1. Yes 2. No 3. Not Sure/Aware	
	i. Male Child		ii. Female Child	
18	What is the importance of feeding colostrum to the new-born? (Multiple Response)	1. Provide good source of nutrition 2. It is rich in protein, fat, and other necessary elements; and is good source pf nutrition for the baby 3. It is extremely rich in antibodies; and acts as the first immunization of the child 4. Providing some protection from inflammation and killing potentially harmful microorganisms (Protects against allergies and infections)	5. Boosts Immunity 6. Having laxative properties that can help baby have the first stool 7. Lessens the chance of jaundice Others (specify) 8. Others (specify.....) 9. Don't know	
19	When should the breastfeeding be initiated for a new-born child?	1. Immediately after birth/as soon as mother is in position to breastfeed 2. Within 3 hours of birth 3. Within 4-5 hours of birth 4. Within 6-12 hours of birth 5. Within 13-24 hours of birth	6. Within 24-48 hours of birth 7. After 48 hours of birth 8. Not aware/Don't Know 9. Others (specify).....	
	i. Male Child		ii. Female Child	
20	For how many months should a child be exclusively breastfed? (no. of months) *(Enter '99' for Don't Know)*		A. ..... Number of Months (Male Child) B. ..... Number of Months (Female Child)	
21	What all food/drinks can be given to a child less than 6 months? (Multiple Response)	1. Mother's milk only 2. Other milk 3. Baby mix 4. Fruit juices 5. Water 6. Honey 7. Gripe water	8. Mashed biscuit 9. Mashed chapati/roti 10. Mashed pulses/dal 11. Mashed potato 12. Mashed banana 13. Others (specify)..... 14. Don't Know	
	i. Male Child		ii. Female Child	
22			A. Male Child	

	Do you think that breast milk alone is enough for a child less than 6 months of age? (Yes-1: No-2; Not Sure-3)	B. Female Child	
23	A child should continue breastfeeding till what age? (number of months) *(Enter '99' for Don't Know)*	A. Male Child	
		B. Female Child	
24	After how many months, a child should be provided with other food items, apart from breastmilk? – initiation of weaning (no. of months) *(Enter '99' for Don't Know)*	A. Male Child	
		B. Female Child	

25	What all food/drinks can be given to child 6-36 months? (Multiple Response)	1. Mother's milk 2. Other milk 3. Baby mix 4. Fruit juices 5. Water 6. Honey 7. Gripe water 8. Mashed biscuit 9. Mashed chapati/roti	10. Mashed pulses/dal 11. Mashed potato 12. Mashed banana 13. Other fruits 14. Other vegetables 15. Eggs 16. Meat 17. Others (specify)..... 18. Don't Know

IDI Guide- CDPO/DPO (ICDS) or Their Designated Official

A. Respondent Identification and Location Particulars

1. Name of the Respondent:
2. Designation (CDPO, DPO, Other-specify):
3. Date of Interview:
4. Block/District (Jaipur Block, Sanganer Block, Jaipur District):
5. Concerned ICDS Project (Jaipur-1, Jaipur-2, Jaipur-3, Sanganer-Rural, Sanganer-City, Jaipur District):
6. Interviewer Name and contact number

B. Discussion Points Related to Nutrition

S. No	Discussion Point	Response
1.	What all challenges does the department face in providing THR to girl and boys aged 6-36 months, pregnant women, lactating women, and adolescents in the district/project area; and what are your suggestions to mitigate the same ? *(Record verbatim the response in detail- do not prompt or suggest)*	
	Issues/Challenges	
	Suggestions for Mitigation	
2.	How is the THR provided to the AWCs in your district/project area? *(Please record in detail about the current arrangement of making the THR available at the AWCs, process of production, and monitoring)*	
3.	How WSHG are contributing to the THR production?	
4.	How is the THR stored at the AWCs in your area/district? (Please record in detail)	
5.	What problems do the AWCs face owing to inadequate storage and what are your suggestions to mitigate the same?	
	Problem/Issue	
	Mitigation Measure	
6.	How is the THR distributed to the beneficiaries from the AWCs in your area/district?	
7.	What are the reasons of sometimes there being gaps/breaks in the distribution of THR to beneficiaries by the AWCs in your area and what can be done to ensure that there are no such gaps/breaks in future?	
	Issues/Challenges	
	Mitigation Measures	

S. No	Discussion Point	Response
8.	How do you monitor the THR distribution by AWCs in your area? (Mechanism, frequency, etc.)	
9.	What types of training have you received for monitoring the THR distribution by AWCs in your area?	
10.	What are your views about the status of nutrition among the girls and boys (0-6 years, pregnant women, lactating women, and adolescents in the block/project area - in general? *(Is it poor, is it good, does it require any focussed efforts, what are the reasons, factors affecting status of nutrition, etc.)*	
11.	What are your views about the differences in care and nutrition provided to girls and boys 0-6 years in your area? (what are the differences, what are the reasons, etc.)	
12.	What are your views about the differences in care and nutrition provided to adolescent girls and boys in your area? (what are the differences, what are the reasons, etc.)	
13.	What are your views about the demand, uptake, acceptance and consumption of THR by the beneficiaries in your area/district?	
14.	What are your suggestions to increase the demand, uptake, acceptance and consumption of THR by the beneficiaries in your area/district? (Specifically discuss, if changing the composition or type of THR will aid in increasing the demand/uptake of THR)	
15.	As per your views, how are the Knowledge-Attitude-Practices of the community regarding nutrition, impeding factors, that are affecting the THR service uptake and acceptance ; and nutritional outcomes in the district/project area ?	
i.	Knowledge Factors:	
ii.	Attitude Factors:	
iii.	Practice Factors:	

S. No	Discussion Point	Response
16.	As per your views, how are the Knowledge-Attitude-Practices of the frontline workers (AWW/AWH) regarding nutrition, impeding factors that are affecting the THR service uptake and acceptance ; and nutritional outcomes in the district/project area ?	
i.	Knowledge Factors:	
ii.	Attitude Factors:	
iii.	Practice Factors:	
17.	Do you feel that there is a need to strengthen the nutrition related counselling activities organized for the pregnant & lactating women, caregiver of girls and boys 0-6 years and adolescent girls: and what should be done about it? *(please record in detail about the reasons)*	

IDI GUIDE - MoIC/CMO (Health Department) or Their Designated Official

A. Respondent Identification and Location Particulars

1. Name of the Respondent:
2. Designation (MOIC, CMH/CMHO, Other-specify):
3. Date of Interview:
4. Block/District (Jaipur Block, Sanganer Block, Jaipur District):
5. Concerned ICDS Project (Jaipur-1, Jaipur-2, Jaipur-3, Sanganer-Rural, Sanganer-City, Jaipur District):

B. Discussion Points Related to Nutrition

S. No	Discussion Point	Response
1.	What are your views about the status of nutrition among the girls and boys (0-6 years, pregnant women, lactating women, and adolescents in the block/project area - in general? *(Is it poor, is it good, does it require any focussed efforts, what are the reasons, factors affecting status of nutrition, etc.)*	
2.	What are your views about the differences in care and nutrition provided to girls and boys 0-6 years in your area? (what are the differences, what are the reasons, etc.)	
3.	What are your views about the differences in care and nutrition provided to adolescent girls and boys in your area? (what are the differences, what are the reasons, etc.)	
4.	What are your views about the demand, uptake, acceptance and consumption of THR provided from the AWCs to the beneficiaries in your area/district?	
5.	What are your views about the challenges related to the demand, uptake, acceptance and consumption of THR by the beneficiaries in your area/district?	
6.	What are your suggestions to increase the demand, uptake, acceptance and consumption of THR by the beneficiaries in your area/district? (Specifically discuss, if changing the composition or type of THR will aid in increasing the demand/uptake of THR)	
7.	As per your views, how are the Knowledge-Attitude-Practices of the community regarding nutrition, impeding factors, that are affecting the THR service uptake and acceptance; and nutritional outcomes in the district/project area ?	
i.	Knowledge Factors:	

S. No	Discussion Point	Response
ii.	Attitude Factors:	
iii.	Practice Factors:	

FGD Guide - Adolescent Girls

Block:

ICDS Project:

Date:

Group Profile		
S. No.	**Name**	**Age**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Key Instructions:

- *Wherever applicable/relevant; please also record your observations of the discussion to support what the respondents have mentioned*
- *Please use a separate sheet to write down any other observations that you may have or additional inputs received during the discussion, mentioning the relevant question number from the discussion guide*

Discussion Points

1. Why is nourishing diet and good nutrition of adolescent girls important?
2. What all different types of food items should adolescents consume and why? (like grains, pulses, dairy products, fruits, vegetables, eggs, etc)
3. Why should adolescent girls consume different types of food items and why? (what is their importance)
4. Do you consume these food items in your routine meals? (Yes/no, how often in a day, reasons)
5. Do you think the adolescent girls and boys should consume different types of food? (probe for the reasons)
6. Does your family encourage or discourage you from eating certain foods during adolescence? (discuss and record separately for foods for which encouraged and discouraged, and the reasons for the same)
7. Do you think it is important for the adolescent girls to consume THR provided from the AWC? *(record as reported; do not prompt- Why, how it helps, advantages)*
8. How do you like the THR provided from the AWCs (reasons for liking/disliking the THR like its taste, quality, shell life, cooking requirement, etc.)
9. What problems do you face in receiving the THR from the AWC?
10. How do you consume the THR provided from the AWC? (self-consumption, sharing with family members, storing, etc.)
11. Do you think there are differences in feeding and care practices for adolescent girls and boys in your households/community? (what, why)
12. What is the importance of breastfeeding for a child? (probe specifically for colostrum feeding, early initiation of breast feeding)
13. Till what age should a child be exclusively breastfed and why (probe separately for boys and girls and specifically for the age till which the child should be exclusively breastfed and reasons)

14. Do you think that breast milk alone is enough for a child less than 6 months of age? (probe specifically for boys and girls and for reasons)
15. A child should continue breastfeeding till what age? (probe separately for boys and girls and specifically about the age till which the breastfeeding should be continued and why)
16. When should the complementary feeding be initiated for children and why? (probe separately for boys and girls and specifically about the age at which complementary feeding should be initiated and why is it important)
17. What all can be fed to a child less than 6 months and why? (probe about what all food items and why are they important)
18. What all can be fed to a child 6-36 months and why? (probe about what all food items and why are they important)
19. Do you think there are differences in feeding and care practices for girls and boys 6-36 months in your households/community? (what, why)
20. Do you think it is important for a pregnant woman to register her pregnancy at an AWC or at a health facility? (probe for the reasons why they think it is important, what benefits it has, where should the registration be done, etc.)
21. Why is nourishing diet and good nutrition of pregnant women important?
22. What all different types of food items should pregnant women consume and why? (like grains, pulses, dairy products, fruits, vegetables, eggs, etc.; what is their importance)
23. What is the importance of THR consumption by pregnant women?
24. Why is nourishing diet and good nutrition of lactating mothers/women important?
25. What all different types of food items should lactating mothers consume and why? (like grains, pulses, dairy products, fruits, vegetables, eggs, etc.; what is their importance)
26. What is the importance of THR consumption by lactating mothers?
27. Who and what are your sources of information/counselling regarding nutrition? (probe specifically and individually for sources of information/counselling for nutrition of children, adolescent girls, pregnant women and lactating mothers)

FGD GUIDE– VHSC/ /PRI Members/Community Representatives

Block:

ICDS Project:

Date:

Group Profile		
S. No.	***Name***	***Age***
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Key Instructions:

- *Wherever applicable/relevant; please also record your observations of the discussion to support what the respondents have mentioned*
- *Please use a separate sheet to write down any other observations that you may have/additional inputs received during the discussion, mentioning the relevant question number from the discussion schedule*

Discussion Points

1. Why is nourishing diet and good nutrition of adolescents important?
2. What all different types of food items should adolescent consume and why? (like grains, pulses, dairy products, fruits, vegetables, eggs, etc.; what is their importance)
3. Do you think the adolescent girls and boys should consume different types of food? (probe for the reasons)
4. Do you think it is important for the adolescent girls to consume THR provided from the AWC? (record as reported; do not prompt- Why, how it helps, advantages)
5. What is the importance of breastfeeding for a child? (probe specifically for colostrum feeding, early initiation of breast feeding)
6. Till what age should a child be exclusively breastfed and why (probe separately for boys and girls and specifically for the age till which the child should be exclusively breastfed and reasons)
7. Do you think that breast milk alone is enough for a child less than 6 months of age? (probe specifically for boys and girls and for reasons)
8. A child should continue breastfeeding till what age? (probe separately for boys and girls and specifically about the age till which the breastfeeding should be continued and why)
9. When should the complementary feeding be initiated for children and why? (probe separately for boys and girls and specifically about the age at which complementary feeding should be initiated and why is it important)
10. What all can be fed to a child less than 6 months and why? (probe about what all food items and why are they important)

11. What all can be fed to a child 6-36 months and why? (probe about what all food items and why are they important)
12. Why is nourishing diet and good nutrition of pregnant women important?
13. What all different types of food items should pregnant women consume and why? (like grains, pulses, dairy products, fruits, vegetables, eggs, etc.; what is their importance)
14. What is the importance of THR consumption by pregnant women?
15. Why is nourishing diet and good nutrition of lactating mothers/women important?
16. What all different types of food items should lactating mothers consume and why? (like grains, pulses, dairy products, fruits, vegetables, eggs, etc.; what is their importance)
17. What is the importance of THR consumption by lactating mothers?
18. Who and what are your sources of information/counselling regarding nutrition? (probe specifically and individually for sources of information/counselling for nutrition of children, adolescent girls, pregnant women and lactating mothers)
19. Usually who counsels the adolescent girls and pregnant and lactating women, and caregivers of boys and girls 6-36 months regarding their nutrition? (probe specifically and individually for the counsellors of adolescent girls, pregnant women and lactating mothers, and caregivers of boys and girls 6-36 months)
20. What problems do the adolescent girls, pregnant women and lactating mothers, and caregivers of boys and girls 6-36 months face in receiving the THR from the AWC?
21. What are your views about the demand, uptake and consumption of THR by adolescent girls, pregnant women and lactating mothers, and caregivers of boys and girls 6-36 months?
22. What all difference are there in the feeding and care practices for girls and boys 6-36 months in your households/community? (what, why)
23. What all difference are there in the for adolescent girls and boys in your households/community? (what, why)

Dyad/Triad Guide- WSHG Engaged in THR Production

Name of the WSHG:

Location/Address:

Block:

IDCS Project:

Respondent Profile						
S. No.	**Name**	**Age**	**Social category***	**Economic group****	**Mobile Number**	**Signature**
1.						
2.						
3.						

Social category*- 1-Mahadalit, 2-OBC, 3-SC, 4-ST, 5-Unreserved

Economic group* ** 1-APL, 2-BPL, 3-Antyodaya

S. No.	**Probes**	**Response**	
1.	Year since the WSHG is functional (Exact Year-YYYY)		
2.	Total members in the SHG		
3.	Years since the WSHG is engaged in production of THR	*Started From (Exact Year-YYYY)*	*Total Engagement (No. of Years)*
4.	How easy or difficult it was for your WSHG to engage in THR production as an economic activity?		
5.	What challenges did your WSHG face in engaging in THR production activity?		
6.	Where is the THR prepared by the WSHG WSHG Office/campus-1 Separate space owned by WSHG for THR preparation-2 Separate space hired by WSHG for THR preparation-3 In the house of one of the WSHG member-4 Others-5 (Specify.....)		
7.	Do you have enough space for the following (Yes-1; No-2)	i) Preparing the THR	
		ii) Drying	
		iii) Cleaning Equipment/Utensils	
		iv) Grinding of Course Grains/Material	
		v) Packaging of THR	
		vi) Storing THR	

8.	What all is prepared as THR by your WSHG? (Record all the types of THR reported)	i) ii) iii) iv)
9.	What all equipment/machines do you have for preparing the THR? *(Please note all the equipment/machines reported)*	i) ii) iii) iv) v) vi)
10.	Sources of procuring raw material for preparing the THR by your WSHG?	i) Procure/buy from the market ii) Provided by the department (WCD/ICDS) iii) Provided by Panchayat iv) Others (specify).....

11.	What problems/issues do you face in procuring the raw material for preparing the THR; and what are your suggestions for the same?	*Problem/Issue*	*Suggested Mitigation*
		i)	
		ii)	
		iii)	
		iv)	

12.	If working capital availability is not highlighted as a problem by the WSHG members; please probe how do they arrange it, do they face any problems in it; and what are their suggestions to mitigate the problems

	Problem/Issue	*Suggested Mitigation*
i)		
ii)		
iii)		

13.	Are there any quality assurance norms to produce THR	1. Yes 2. No 3. Not Aware	If No or Not Aware, then Skip to Q-58
14.	How many members of your WSHG are aware about these quality assurance norms for the production of THR	1. All 2. Majority 3. Some 4. None	
15.	What all quality assurance norms are adhered in production of THR? *(Record the responses as it is)*	i) ii) iii) iv)	
16.	What all quality assurance norms does your WSHG follows for production of THR?	i) ii) iii)	

		iv)	
		v)	
17.	What all issues/challenges do you face in adhering to the quality assurance norms for production of THR	i)	
		ii)	
		iii)	
		iv)	
		v)	
18.	What are the standard operating procedures (SOP) to be followed for producing the THR? Please explain	i)	
		ii)	
		iii)	
		iv)	
		v)	
19.	What all issues/challenges do you face in adhering to the SOPs for producing the THR? Please explain	i)	
		ii)	
		iii)	
		iv)	
		v)	
20.	What all trainings has your WSHG received for setting-up the center and producing THR? (No. and theme of Trainings)		
21.	What type of technical support/trainings have your received from the department in terms of entrepreneurship, financial literacy, leadership etc. ?	*Support*	*No. of Times Received*
		i)	
		ii)	
		iii)	
		iv)	
		v)	
22.	How does your WSHG maintains the books of accounts for income/expenditure from the THR production activity?		
23.	How is the THR packed?	i) In house by the WSHG	
		ii) Outsourced to other local SHG/Person	
		iii) Others (Specify.....)	
24.	What is the shelf life of the THR produced by your WSHG? (No. of Days)		
25.	Average quantity of THR produced in a Month (K.G.)		
26.	Average quantity of THR supplied to AWCs in a Month (K.G.)		
27.	Average quantity of THR kept stored in a month (K.G.)		
28.	How is the raw material for THR stored by your WSHG?		

29.	How is the produced THR stored by your WSHG?		
30.	What all issues/problems does your WSHG face in storing the raw material and produced THR		
	Problems/Issues in Storing Raw Material	*Problems/Issues in Storing Produced THR*	
i)			
ii)			
iii)			
iv)			
v)			
31.	What problems/issues do you face in preparing the THR; and what are your suggestions for the same?	*Problems/Issues*	*Suggested Mitigation*
		i)	
		ii)	
		iii)	
		iv)	
32.	How does the department (WCD/ICDS) monitor the production of THR by your WSHG?	i)	
		ii)	
		iii)	
		iv)	
		v)	
33.	Average how many times in a quarter does the department (WCD/ICDS) monitors the production of THR by your WSHG?		
34.	From where your WSHG receives the payment for preparing and distributing the THR?	i) From the DPO Office	
		ii) From the CDPO Office	
		iii) From Sector Supervisor	
		iv) From Concerned AWWs	
		v) Others (Specify.....)	
35.	What is the frequency of receiving the payment for preparing and distributing the THR?	i) Weekly	
		ii) Fortnightly	
		iii) Monthly	
		iv) One in Two Months	
		v) Others (Specify.....)	
36.	What problems/issues do you face in receiving the payment; and what are your suggestions for the same?	*Problems/Issues*	*Suggested Mitigation*
		i)	
		ii)	
		iii)	
		iv)	
37.	Is the THR production, a profitable activity for your WSHG?	1. Yes 2. No	If No, then skip to Q-40
38.	Average in a month how much does your WSHG earn from the activity?		

39.	Average in a month how much do the individual members of your WSHG earn from the activity?	
40.	What can be done to make this activity a profitable one?	
41.	How has the engagement with the THR production activity empowered you economically?	
42.	How has the engagement with the THR production activity empowered you socially?	
43.	How has the engagement with the THR production activity enhanced your recognition in your family and community	In Family: In Community:

Please collect the copy of quality assurance mechanism and SOP for THR production from the WSHG

Annexes 11. Fieldwork Agenda

The data collection for the baseline evaluation was carried-out between October and November 2021. A team of 20 female Investigators and 5 Supervisors was deployed for data collection.
The investigators were entrusted with the task to interact with the pregnant and lactating women/caregivers of children (636 months). Of the female investigators, 4 female investigators were trained as health investigators, and were entrusted with the task to take and record the anthropometric assessment of children (6-36 months).
The supervisors were responsible providing supportive supervision to the investigators and for conducting interactions with the frontline functionaries (AWWs/ASHAs/ANMs).
Three members of the senior team of the evaluation agency were present for the entire duration of data collection; to support, supervise and guide the field teams.
The qualitative interactions with CDPOs, Other Stakeholders (VHSNC/UHSNC/ PRI/Ward Members) were conducted by the senior team of the evaluation agency.

On-Field Quality Assurance: The field supervisors and senior team members of the evaluation agency observed each investigator many times throughout the fieldwork. Each investigator was thoroughly observed during the first two days of fieldwork so that any errors made consistently, were caught immediately and rectified by working with the investigators and/or guiding them (as required). Additional observations of each enumerator's performance were regularly made during the rest of the fieldwork. The supervisors/ senior team members of the evaluation agency spent considerable time evaluating and instructing investigators at the start of fieldwork. The following on-field quality checks were specifically employed:

- ***Accompaniments:*** The supervisors/ senior team members of the evaluation agency accompanied the investigators on field and observed how they were conducting the activity, their ease and comfort in administering the data collection instrument, etc. In case an issue was found, the supervisor suggested and oriented the concerned investigator on how to mitigate the same.
- ***Spot check and observations:*** The supervisors/ senior team members of the evaluation agency observed some interviews, to ensure that the investigators are conducting themselves well, asking the questions in the right manner, and interpreting the answers correctly. It was also observed that the investigators were present at the right place at right time and were interviewing the right respondent.
- ***Back Checks:*** These were carried-out are after some interviews have been completed. The supervisors/ senior team members of the evaluation agency randomly contacted some respondents and after ensuring that the respondent has indeed been interviewed, asked a sub-set of critical questions from the questionnaire to ensure correct responses have been coded by the investigator. If any deviations or inconsistencies were noticed in the data recorded and confirmed by the respondent, the same were addressed while the team was there on the field.
- **Filling Data Gaps:** In case there being any inconsistency/gaps in field data; the same were identified and rectified while being on the field itself. It was ensured that the field teams did not move out of the sample area, till the senior evaluation teams confirmed that all requisite sample had been covered.

COVID Protocol: The evaluation team ensured that all field team members were healthy and fully vaccinated and did not have any symptoms related to COVID. While being on the field, at all times the field team members wore a mask, face shield, and gloves. Besides all of them carried hand sanitizers at all times and washed/sanitized their hands

regularly. Daily, the field team members will be enquired if they have developed any symptoms. If such an instance is found, the field team member will be quarantined and will be replaced. In addition, all anthropometric devices were sanitized every time after taking measurement of a child (6-36 months). Besides, all social distancing norms were adhered by the field team members and the member of the evaluation agency while interacting with respondents.

Annexes 12. Findings, Conclusions, Lessons Mapping

Table 37: Findings Conclusions Recommendations Mapping

Lessons/Issues for Consideration [in numerical order]	**Conclusions** [by number(s) of conclusion]	**Findings** [by number of finding]
Lesson 1: Though most of the pregnant and lactating women have awareness on aspects related to nutrition and IFA consumption during pregnancy, there is a gap when it comes to translation of knowledge into practice. Besides, there is a need to address the beliefs, self-efficacy and social norms regarding nutritional intake. Thus, Awareness generation on aspects related to nutrition and IFA consumption during pregnancy needs to be a focus topic for SBCC under the pilot project.	Conclusion at Para No. 156, 157, 158	Findings at Para No. 46, 47, 50, 53, 86, 87, 88, 89
Lesson 2: As only about 57% children have the MDD in their daily diet; it is required that under the SBCC component of the pilot project, the lactating women are appropriately made aware, counselled, and motivated to ensure MDD in daily diet of their children as per their age.	Conclusion at Para No. 159	Findings at Para No. 78
Lesson 3: As almost one-fourth of the currently pregnant and lactating women, and frontline functionaries are not appropriately aware about one or the other aspects related to breastfeeding. Besides, adherence to appropriate breastfeeding practices and nutritional status of children is comparatively lower among social marginalized households and lactating women with lower educational qualifications. Thus, under the SBCC and capacity building components of the pilot project, emphasis should be on awareness generation for pregnant and lactating women, especially from marginalized families and with lower education; and capacity building for the frontline functionaries (who are the first point of contact) on these aspects.	Conclusion at Para No. 161	Findings at Para No. 61 to 77
Lesson 4: As the baseline findings suggest, some of the beneficiaries either do not consume the THR or do not consume it regularly, many a times due to its monotonous taste. Thus, activities for enhancing uptake and consumption/uptake of THR by targeted beneficiaries and developing THR recipe with enhanced taste, needs to be a focus area under the proposed pilot.	Conclusion at Para No. 166	Findings at Para No. 149 to 151
Lesson 5: As per the ICDS functionaries and officials, at times there have been gaps in supply of THR to AWCs due to administrative issues, impacting its distribution, and thus, consumption. Thus, under the pilot project it needs to be ensured that there are no gaps in the supply of THR to the target AWCs.	Conclusion at Para No. 167	Findings at Para No. 137
Lesson 6: Overarchingly, in all SBCC activities, there should be engagement/inclusion of husbands/fathers and mother in laws/grandmothers of pregnant and lactating women and children, along with engagement of community influencers for positive social norming. The SBCC should be a combination of interpersonal counselling & individualized skilled support to beneficiaries and their family members, complimented by supportive mid-media & mass media activities for consistent and repeated messaging/communication.	Conclusion at Para No. 169	Findings at Para No. 49, 50, 62, 64, 65, 72, 73, 93, 97,

Lessons/Issues for Consideration [in numerical order]	Conclusions [by number(s) of conclusion]	Findings [by number of finding]
Lesson 7: Frontline functionaries need to be capacitated and mentored (post training supported by supervisors) on providing individually contextualized counselling, and for proactively engaging in problem solving and nudging pregnant and lactating women and their family members for adopting optimal behaviour.	Conclusion at Para No. 158, 161	Findings at Para No. 64, 90

Annexes 13. List of People Interviewed

Table 38: List of People Interviewed

Sl. No.	Respondent Category	Number Covered/ Interviewed
1.	Lactating Women / Caregivers of Children 6-36 Months	809
2.	Children 6-36 Months for Anthropometric Assessment	379
3.	Pregnant Women	152
4.	AWWs	70
5.	ASHAs	70
6.	ANMs	65
7.	Child Development Project Officers (CDPO) ICDS	3
8.	District Program Officer (DPO) ICDS	1
9.	Adolescent Girls	13
10.	Other Stakeholders (VHSNC/UHSNC/ PRI/Ward Members)	20

Annexes 14. Bibliography

- https://www.unodc.org/documents/evaluation/Guidelines/UNEG_Ethical_Guidelines_for_Evaluation_2020.pdf
- https://www.acog.org/womens-health/faqs/nutrition-during-pregnancy
- https://www.healthline.com/health/pregnancy/healthy-pregnancy#nutrition
- https://www.smilefoundationindia.org/blog/importance-of-nutrition-for-children/
- https://www.who.int/health-topics/breastfeeding#tab=tab_1
- https://www.who.int/elena/titles/early_breastfeeding/en/
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3042727/
- https://www.sciencedirect.com/science/article/pii/S2214109X13701608
- Other performance assessment/review-related documents
  - Improving the Implementation of the Take Home Ration Programme Under ICDS- Findings from Rajasthan and Jharkhand; May 21, 2021
  - A desk review of the IEC/BCC tools developed by Alive & Thrive and TATA Trusts ; May 21, 2021
  - Endline Assessment of Fortification of Mid-Day Meal Programme in Varanasi, Uttar Pradesh; May 21, 2021
- Draft Note: SBCC Strategy in Rajasthan: May 18, 2021
- Project Proposal: Pilot Project Proposal, May 18,2021
- Revised Project Proposal: Revised Pilot Project Proposal: May 18, 2021
- Decentralized Evaluation Terms of Reference (ToR): Final ToR of the DE of the Pilot; May 10, 2021
- Presentation:
  - Inception Meeting - Improving IYCN through the ICDS scheme in Jaipur District; May 18, 2021
  - EA Orientation; May 18, 2021

Annexes 15. Food Groups for Assessing Minimum Dietary Diversity (MDD)

(i) ***Grains/cereal, Nuts and Seeds:*** Bread (rotis, etc), rice, noodles or other foods made from grains like wheat, millet, sorghum, etc.; Any tree nut, groundnut, peanut or other seeds

(ii) ***Vegetables and legumes/beans:*** Mature beans or peas (fresh or dried seed), lentils or bean/pea products); Dark green leafy vegetables (like including spinach, fenugreek, amaranth, mustard leaves wild/foraged leaves); Vitamin A rich vegetables, roots and tubers (like (Pumpkin, carrots, squash or sweet potatoes that are yellow or orange inside)

(iii) ***Fruits:*** Mango, Papaya, Banana, Guava, Others

(iv) ***Meat and Poultry:*** Chicken, Goat/Lamb Meat , Fish, Eggs; other meat/poultry alternatives

(v) ***Milk, butter, cheese, yoghurt and dairy alternatives***

(vi) S***avoury and fried snacks:*** Chips, crisps, chanachur, French fries and similar items

(vii) ***Sweets:*** Sugary foods, such as Indian sweets, chocolates, candies, cookies/sweet biscuits and cake, sweet pastries or ice cream

(viii) ***Sugar-sweetened beverages:*** like fruit-flavoured drinks, sports drinks, chocolate and other flavoured milk drinks, malt drinks, 100% fruit juice as well as juice drinks with added sugar or other caloric sweeteners, (packaged in cans, bottles, boxes, sachets, prepared at home, etc.)

ACRONYMS

ADI	Average Daily Intake
AHS	Annual Health Survey
ANC	Antenatal Care
ANM	Auxiliary Nurse and Midwife
ARI	Acute Respiratory Infection
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWH	Anganwadi Helper
AWW	Anganwadi Worker
CAPI	Computer Assisted Personal Interview
CDPO	Child Development Project Officer
CD/DCD	Country Director/ Deputy Country Director
CMHO	Chief Medical and Health Officer
CMO	Chief Medical Officer
DE	Decentralized Evaluation
DEQAS	Decentralized Evaluation Quality Assurance System
DLHS	District Level Household Survey
DPO	District Program Officer
DWCD	Department of Women & Child Development
EC	Evaluation Committee
ECCD	Early Childhood Care and Development
ERG	Evaluation Reference Group
FGD	Focus Group Discussion
GoR	Government of Rajasthan
HCF	Hot Cooked Food
HQ	Headquarter
ICDS	Integrated Child Development Services
ICO	India Country Office
IDI	In-depth Interview
IFA	Iron Folic Acid
IYCF	Infant and Young Child Feeding
IYCN	Infant and Young Child Nutrition
KAP	Knowledge-Attitudes-Practices
LW/CGS	Lactating Women/Caregivers of Children 6-36 Months
MDD	Minimum Dietary Diversity
MIS	Management Information System
MOIc	Medical Officer In-Charge
NFHS	National Family Health Survey
NGO	Non-governmental Organization
NHED	Nutrition and Health Education
NHM	National Health Mission
OBC	Other Backward Classes

OEV	Office of Evaluation
ORS	Oral Rehydration Solution
PAPI	Pen and Paper Interviewing
PLW	Pregnant & Lactating Women
PPS	Probability Proportional to Size
PRI	Panchayati Raj Institution
PSE	Pre-School Education
PW	Pregnant Women
RB	Regional Bureau
RDA	Recommended Dietary Allowances
RG	Results Group
RSoC	Rapid Survey of Children
SBCC	Social Behaviour Change Communication
SC	Scheduled Caste
SD	Standard Deviation
SOP	Standard Operating Procedures
SRS	Sample Registration System
ST	Scheduled Tribe
TAC/TAG	Technical Advisory Committee/Group
THR	Take Home Ration
TOC	Theory of Change
TT	Tetanus Toxoid
UHSNC	Village Health Sanitation and Nutrition Committee
UNEG	United Nations Evaluation Group
UNWFP	United Nations World Food Program
VHSNC	Village Health Sanitation and Nutrition Committee
WCD	Women and Child Development
WHO	World Health Organization
WSHG	Women Self Help Groups

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