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Impact Practice by CSRBOX

Executive Summary of Impact Assessment of

SuPoshan Programme

South Indian States

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List of Abbreviations

Abbreviations	Details
ANC	Antenatal care
ASHA	Accredited Social Health Activist
ANM	Auxiliary Nurse Midwife
AWC	Anganwadi Centres
AWW	Anganwadi Worker
CAM	Child Anthropometric Measurement
CDPO	Child Development Project Officer
CHC	Community Health Centre
CMTC	Child Malnutrition Treatment Centre
CSR	Corporate Social Responsibility
DD	Diet Diversity
ESG	Environmental, Social and Governance
FGD	Focus Group Discussions
ICDS	Integrated Child Development Services
IDI	In-Depth Interviews
IFA	Iron and Folic Acid
IRECS	Inclusiveness, Relevance, Expectations, Convergence, Service Delivery, Sustainability
IYCF	Infant and Young Child Feeding Practices
KII	Key Informant Interviews
KSY	Kishori Shakti Yojana
MAM	Moderate Acute Malnourished
MCP	Mother and Child Protection
MUAC	Mid Upper Arm Circumference
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
MHM	Menstrual Hygiene Management
NFHS	National Family Health Survey
NHM	National Health Mission
NNACP	National Nutritional Anaemia Control Programme
NRC	Nutrition Rehabilitation Centre
OBC	Other Backward Classes
PHC	Primary Health Centre
PMMVY	Pradhan Mantri Matru Vandana Yojana
PNC	Postnatal care
SAM	Severe Acute Malnutrition
SC	Scheduled Caste
SDG	Sustainable Development Goals
SHG	Self-Help Groups

SNP	Special Nutrition Programme
ST	Scheduled Tribe
TT	Tetanus Toxoid
UW	Underweight
VHN	Village Health Nurse
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organisation

Disclaimer

- This report has been prepared solely for the purpose set out in the Memorandum of Understanding (MoU) signed between Reanalysis Consultants Pvt. Ltd. (CSRBOX) and Adani Foundation to undertake the Impact Assessment of their SuPoshan Programme implemented in Tiruvallur, Mangalore, Vizhinjam, and Nellore across Tamil Nadu, Karnataka, Kerala and Andhra Pradesh, respectively.
- This impact assessment is under the Companies (Corporate Social Responsibility Policy) Amendment Rules 2021, notification dated 22nd January 2021.
- This report shall be disclosed to those authorised in its entirety only without removing the disclaimer. CSRBOX has not performed an audit and does not express an opinion or any other form of assurance. Further, comments in our report are not intended, nor should they be interpreted to be legal advice or opinion.
- This report contains an analysis by CSRBOX considering the publications available from secondary sources and inputs gathered through interactions with the leadership team of Adani Foundation, project beneficiaries, and various knowledge partners. While the information obtained from the public domain has not been verified for authenticity, CSRBOX has taken due care to receive information from sources generally considered to be reliable.
- In preparing this report, CSRBOX has used and relied on data, material gathered through the internet, research reports, and discussions with personnel within CSRBOX, as well as personnel in related industries.

Specific to the Impact Assessment of SuPoshan Programme

CSRBOX has neither conducted an audit and due diligence nor validated the financial statements and projections provided by Adani Foundation

Wherever information was not available in the public domain, suitable assumptions were made to extrapolate values for the same.

- CSRBOX must emphasise that the realisation of the benefits/improvements accruing out of the recommendations set out within this report (based on secondary sources) is dependent on the continuing validity of the assumptions on which it is based. The assumptions will need to be reviewed and revised to reflect such changes in business trends, regulatory requirements, or the direction of the business as further clarity emerges. CSRBOX accepts no responsibility for the realisation of the projected benefits
- The premise of an impact assessment is ‘the objectives’ of the project, along with output and outcome indicators pre-set by the programme design and implementation team. CSRBOX’s impact assessment framework was designed and executed in alignment with those objectives and indicators.

Executive Summary

Executive Summary

Malnutrition continues to pose a significant public health challenge in India, particularly due to its multidimensional and intergenerational nature. Evidence highlights that despite overall progress, undernutrition remains unevenly distributed across states and socio-economic groups, with rural and economically vulnerable populations disproportionately affected. Across the southern intervention areas, **Tiruvallur (Tamil Nadu), Thiruvananthapuram (Kerala), Mangalore (Karnataka), and Nellore (Andhra Pradesh),** these disparities persist, driven by factors such as poverty, migration, limited dietary diversity, and gaps in access to and utilisation of health and nutrition services.[1] Addressing malnutrition in these contexts requires targeted, community-driven approaches that strengthen awareness, service delivery, and behavioural change.

About the Programme

The SuPoshan Programme, an initiative of AWL Agri Business Limited and implemented by Adani Foundation, focuses on addressing malnutrition and anaemia among women, children, and adolescent girls through a community-led model. Central to the programme are SuPoshan Sanginis, who drive household-level engagement through counselling, growth monitoring, cooking demonstrations, and facilitation of access to government services. The programme emphasises behaviour change, improved service utilisation, and women-led community engagement to create sustainable nutrition outcomes.

Methodology

The assessment adopted a quasi-experimental design comparing treatment and control groups across 122 villages. A mixed-methods approach was used, combining household surveys, anthropometric measurements, and qualitative interactions with beneficiaries, frontline workers, and Sanginis to evaluate programme impact across inclusiveness, relevance, effectiveness, convergence, service delivery, and sustainability.

Impact Findings (IRECS Framework)

1. Inclusiveness

- Programme coverage is concentrated among vulnerable groups, with 56% belonging to SC/ST communities and 38% to OBCs.
- Around 70% of households depend on daily wage labour, indicating strong targeting of economically vulnerable populations.

2. Relevance

Prior to the intervention, 35% had not received any nutrition guidance, 45% were unaware of NRCs, and 37% had not utilised Anganwadi services.
Gaps also existed in WASH practices and access barriers, such as distance, awareness, and facility constraints.

3. Effectiveness

Women of Reproductive Age

- 61% of beneficiaries completed at least four ANC visits

[1] Nutrition, POSHAN, and Policy: Analysing the Child Nutrition Trends and Responses of the State in Southern India

- 66% of beneficiaries consumed IFA supplements for at least six months
- 66% of beneficiaries early initiation of breastfeeding
- 95% of beneficiaries reported adequate dietary intake; improved diversity across food groups
- Increased uptake of AWC services across nutrition, health check-ups, and referrals among the beneficiaries.
- WASH practices improved (handwashing: 84%, safe menstrual hygiene: 66%) among the beneficiaries.

Children

- Underweight reduced to 16.1% compared to NFHS-5 (32.1%)
- Wasting reduced to 8.3% compared to NFHS-5 (19.3%)
- Severe wasting reduced to 1.2% compared to NFHS-5 (7.7%)
- Stunting reduced to 26.6% compared to NFHS-5 (35.5%)
- 79% of children had complete up-to-date immunisation coverage
- Perceived improvements in growth (62%), immunity (50%), and digestion (43%)

Adolescent Girls

- 67% of beneficiaries reported improved knowledge of nutrition and menstrual hygiene
- 50% of beneficiaries reported improved dietary habits
- 49% of adolescent girls are actively engaged in physical activity

4. Convergence

- The programme aligns with **Integrated Child Development Services**, **POSHAN Abhiyaan**, and **Anaemia Mukt Bharat**, while contributing to **Sustainable Development Goals**, particularly SDG 2 (Zero Hunger), SDG 3 (Good Health and Well-being), and SDG 5 (Gender Equality).
- Increased utilisation of Anganwadi and health services across maternal, child, and adolescent indicators.
- Improved referrals and stronger linkage with public health systems, supported by Sangini-led mobilisation.

5. Service Delivery

- High outreach intensity with 50% of beneficiary households visited twice a month and 36% weekly.
- Strong satisfaction with sessions: 78–81% of beneficiaries rated nutrition and cooking demonstrations as excellent.
- Regular screening and follow-up contributed to early identification and management of malnutrition.

6. Sustainability

- 68% of beneficiaries continued using and sharing recipes; strong community-level knowledge exchange.
- Kitchen gardens improved dietary diversity (69% of beneficiaries reported increased variety).

- Community support remains positive (54% of beneficiaries are fully supportive), though some variability persists.

Recommendations

- Strengthen structured convergence by integrating Sangini roles within frontline systems, with clear role definition, shared monitoring, and institutional ownership.
- Introduce decentralised, flexible care options for SAM/MAM children to address wage loss and improve accessibility to nutrition services.
- Institutionalise male engagement through existing community platforms to improve shared responsibility in nutrition and health practices.
- Develop targeted strategies for migrant populations using multilingual and visual tools to ensure continuity of service uptake.

Chapter 1

Project Background and Overview

1. Project Background:

1.1. Project Context

Malnutrition, as defined by the World Health Organisation, refers to deficiencies, excesses, or imbalances in a person's intake of energy and/or nutrients. It includes both undernutrition and overnutrition.[2] In a fast-growing country like India, malnutrition remains a critical concern due to its far-reaching impact on socio-economic development. While some progress has been made over the years, findings from the National Family Health Survey (NFHS-5) indicate that underweight prevalence among children remains above 30% in 12 states, stunting exceeds 30% in 22 states, and wasting is above 20% in 10 states, highlighting the continued burden of undernutrition.[3]

Even among the southern states, which generally perform better than their northern counterparts, a closer look at the data reveals an uneven distribution of nutritional gains. In states such as Tamil Nadu and Kerala, NFHS-5 shows an unexpected rise in stunting among the poorest households. In Andhra Pradesh and Karnataka, high levels of undernutrition persist across all wealth groups, with limited progress among poorer populations. Alongside economic disparities, geographical inequities are also evident, with a higher prevalence of malnutrition in rural areas, even within relatively developed states. This underscores the need for interventions that are targeted and responsive to these inequitable outcomes.[4]

Addressing malnutrition is particularly challenging because it does not behave like other diseases that follow a defined course and confer immunity upon recovery. Instead, it is a cumulative condition shaped by a complex interplay of socioeconomic and cultural factors, including poverty and gender disparities. Its effects are intergenerational. Malnourished children, especially girls, are more likely to grow into malnourished women, who in turn are at greater risk of having undernourished children. This creates a self-reinforcing cycle of malnutrition. At the same time, this life-cycle dynamic presents important windows for preventive action, particularly through interventions focused on early childhood (children under five years), adolescent girls, and women's nutrition.[5]

To address these critical stages, the government has implemented several targeted interventions such as Integrated Child Development Services (ICDS), POSHAN Abhiyaan, Anaemia Mukt Bharat, and the Mid-Day Meal Scheme. While these initiatives provide a strong policy foundation, challenges in implementation, such as gaps in infrastructure and limitations in monitoring, continue to affect their effectiveness.[6] Tackling malnutrition in India, therefore, requires a comprehensive and scalable approach that addresses its underlying determinants, including poverty, access to WASH (water, sanitation, and hygiene) facilities, awareness around balanced diets and dietary diversity, and the need for stronger systems of accountability.

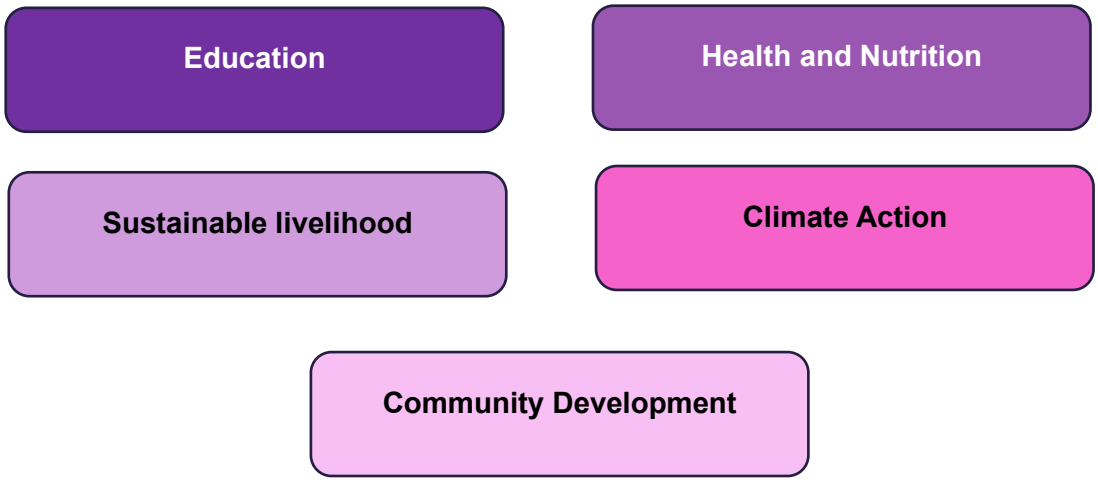
1.2. CSR Activities of the Adani Group:

The Adani Group, through its philanthropic arm, the Adani Foundation, is actively engaged in corporate social responsibility (CSR) initiatives across India. The Foundation currently

[2] Malnutrition: WHO
[3] How is India Doing on Malnutrition and Non-Communicable Diseases? Insights from the National Family Health Surveys (2005-06 to 2019-21)
[4] Nutrition, POSHAN, and Policy: Analysing the Child Nutrition Trends and Responses of the State in Southern India
[5] The Lifecycle of Malnutrition
[6] Nutritional Programmes in India: Ensuring Healthy Growth for Children from Marginalised Communities

operates in 22 states, reaching over 3.6 million people. It is guided by a commitment to fulfilling its social responsibilities towards communities while fostering sustainable and integrated pathways for development.

Its interventions are anchored in the promotion of social and economic well-being, with a focus on inclusive growth and community upliftment. The Foundation's key areas of intervention include:



1.3. Programme Details

The SuPoshan Programme, an initiative of AWL Agri Business Limited and implemented by Adani Foundation, is a flagship initiative aimed at addressing India's critical challenges related to malnutrition and anaemia. The programme focuses on recruiting and training community representatives, known as Sanginis, who serve as educators and advocates for healthy living. They promote awareness of balanced nutrition and facilitate access to existing government schemes designed to improve health outcomes.

In addition, Sanginis play a key role in empowering mothers by providing essential guidance on nutrition, breastfeeding practices, sanitation, and healthy dietary habits. By fostering women-led community engagement, the programme not only contributes to improved public health outcomes but also enhances the financial independence of the women involved. Overall, the initiative adopts a sustainable, community-driven approach to combating malnutrition in vulnerable populations.

1.4. Geographical Coverage

The impact assessment was carried out in the Southern states where the SuPoshan programme has been running for around 4 years. Around 122 villages were covered in the following southern locations-

- Tiruvallur, Tamil Nadu
- Thiruvanthapuram, Kerala
- Mangalore, Karnataka
- Nellore, Andhra Pradesh

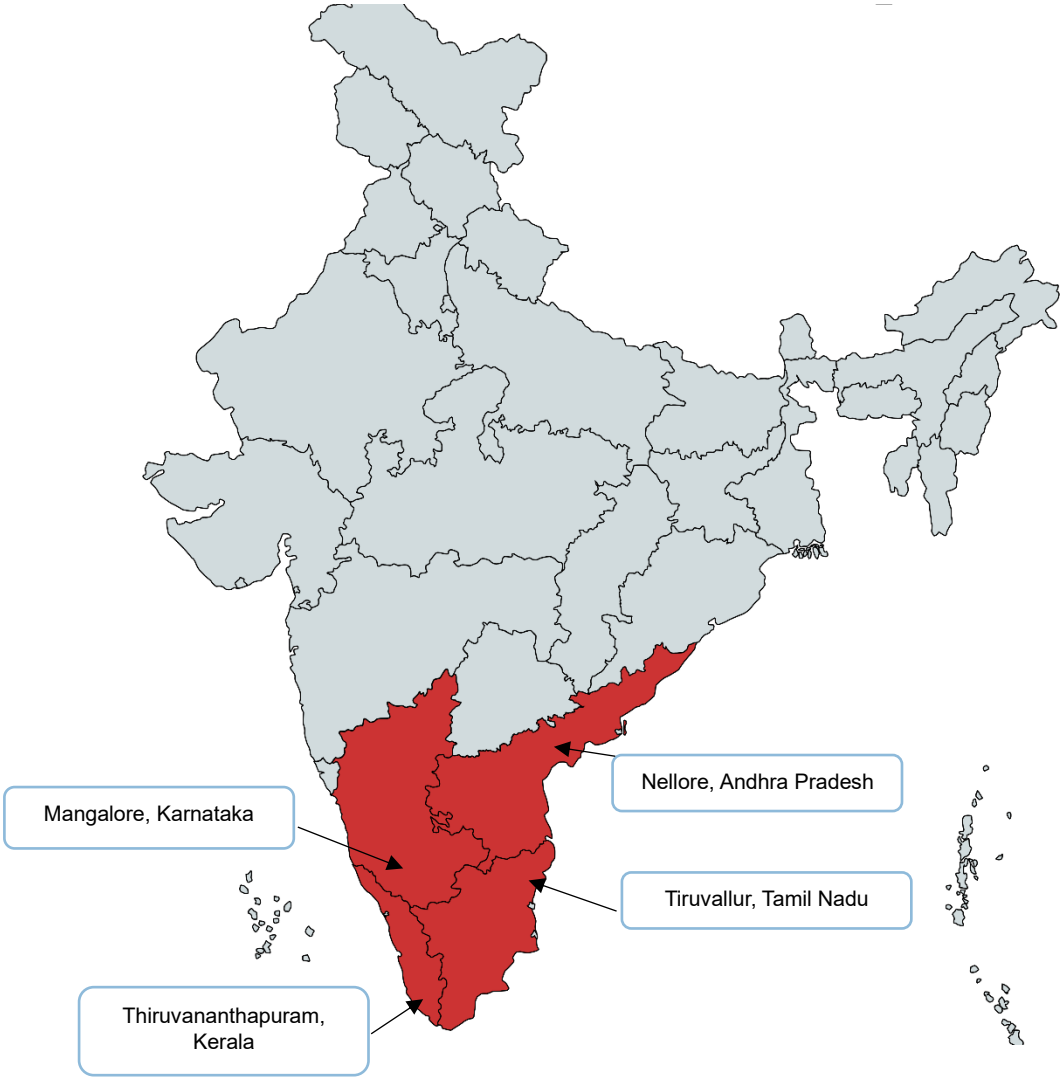


Figure 1: Geographical coverage of the programme

1.5. Alignment with National Policies

Programme	Programme Description	Alignment with SuPoshan
Integrated Child Development Services (ICDS)	Launched in 1975, ICDS is a flagship programme providing an integrated package of services including supplementary nutrition, immunisation, health check-ups, referral services, pre-school education, and nutrition and health education. It targets children under 6 years, pregnant women, and lactating mothers, aiming to break the intergenerational cycle of malnutrition and improve early childhood development outcomes.	**Complete Alignment.** SuPoshan strengthens ICDS by enhancing last-mile delivery through intensive, community-based engagement. By working directly with mothers and caregivers, it improves awareness, uptake, and utilisation of ICDS services, ensuring that service provision translates into sustained behavioural change and improved nutrition outcomes.

Special Nutrition Programme (SNP)	Introduced in 1970–71, SNP aims to improve the nutritional status of vulnerable groups, particularly children under six years and pregnant and lactating women in disadvantaged communities. It provides supplementary nutrition to address calorie and protein deficiencies, especially in high-risk geographies such as urban slums, tribal areas, and drought-prone regions.	**Complete Alignment.** SuPoshan complements SNP by focusing on behaviour change and awareness at the household level. While SNP addresses food supplementation, SuPoshan ensures proper utilisation by promoting appropriate feeding practices, dietary diversity, and nutrition awareness, thereby enhancing programme effectiveness.
Balwadi Nutrition Programme	Initiated in 1970, this programme targets preschool children (3–5 years) through community-based centres, providing supplementary nutrition along with early childhood education. It aims to prevent malnutrition during critical growth years and support holistic child development.	**Complete Alignment.** SuPoshan extends the impact of Balwadi services into households by engaging caregivers on feeding practices and child care. This ensures continuity beyond centre-based interventions and helps sustain improvements in child nutrition and development.
National Nutritional Anaemia Control Programme (NNACP)	This programme focuses on preventing and reducing anaemia among children, pregnant women, and lactating mothers through interventions such as iron and folic acid supplementation and deworming. It addresses one of the most widespread nutritional deficiencies in India, which significantly impacts maternal and child health.	**Complete Alignment.** SuPoshan aligns with NNACP by improving awareness and adherence to anaemia prevention practices. Through community engagement, it promotes consumption of iron-rich foods, supports compliance with supplementation, and addresses misconceptions, thereby improving programme uptake and outcomes.
Kishori Shakti Yojana (KSY)	Launched in 2007, Kishori Shakti Yojana focuses on improving the nutritional and health status of adolescent girls (11–18 years). It also aims to enhance life skills, awareness of health and hygiene, and vocational capabilities, recognising adolescence as a critical stage for intervention.	SuPoshan complements KSY by working directly with adolescent girls to build awareness around nutrition and health. Its community-based approach supports behaviour change, enabling girls to make informed decisions and adopt healthier practices, thereby strengthening long-term nutrition outcomes.
POSHAN Abhiyaan (National Nutrition Mission)	Launched in 2018, POSHAN Abhiyaan is the Government of India's flagship programme aimed at improving nutritional outcomes for children, pregnant women, and lactating mothers. It focuses on	**Complete Alignment.** SuPoshan is strongly aligned with POSHAN Abhiyaan's focus on community-based behaviour change and convergence. By mobilising local women, conducting household-

	convergence across sectors, real-time monitoring, and behaviour change communication, with a strong emphasis on the first 1,000 days of life.	level counselling, and building awareness, SuPoshan directly contributes to POSHAN's goals of improving nutrition outcomes and accelerating the reduction in malnutrition and anaemia.
POSHAN 2.0	POSHAN 2.0 is the consolidated and updated version of India's nutrition strategy, integrating multiple nutrition-related schemes (including ICDS and SNP) into a unified framework. It strengthens supplementary nutrition delivery, improves monitoring through digital tools like the Poshan Tracker, and enhances targeting of beneficiaries, particularly pregnant and lactating women.	**Complete Alignment.** SuPoshan complements POSHAN 2.0 by strengthening last-mile implementation. While POSHAN 2.0 improves systems, delivery, and monitoring, SuPoshan ensures community-level engagement and behaviour change, bridging the gap between service provision and actual adoption of nutrition practices.
Pradhan Mantri Matru Vandana Yojana (PMMVY)	PMMVY is a maternity benefit scheme that provides conditional cash transfers to pregnant and lactating women to support adequate nutrition, rest, and health-seeking behaviour during pregnancy and early childcare. It aims to partially compensate for wage loss and promote institutional care.	**Complete Alignment.** SuPoshan is partially aligned with the programme, enhancing the impact of PMMVY by ensuring that financial support translates into improved nutrition practices. Through awareness and counselling, it guides beneficiaries on how to utilise resources effectively for better maternal and child nutrition, thereby strengthening programme outcomes.

Table 1: Alignment with National Policies

1.6. Alignment with SDGs

The Sustainable Development Goals (SDGs) are a set of 17 global goals adopted by the United Nations in 2015 as a universal framework to address key development challenges such as poverty, inequality, health, education, and climate change. They aim to guide countries and stakeholders towards achieving inclusive and sustainable development by 2030.

SDG Goal	SDG Target	Alignment with the Project
SDG 2: Zero Hunger 	Target **2.1** By 2030, end hunger and ensure access by all people, in particular the poor and people in vulnerable situations, including infants, to safe,	**Complete Alignment**. SuPoshan programme, by improving access to safe, nutritious, and sufficient food through community-based interventions and awareness-building. Addressing malnutrition and anaemia

End hunger, achieve food security, improve **nutrition and promote sustainable agriculture**	nutritious and sufficient food all year round Target **2.2** By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons	among children, adolescent girls, and pregnant and lactating women, it contributes to reducing stunting, wasting, and nutritional deficiencies, supporting the goal of ending all forms of malnutrition.
SDG 3: Good Health and Well-Being  Ensure healthy lives and promote well-being for all at all ages	Target **3.1** By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births Target **3.2** By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least 12 per 1,000 live births and under-5 mortality to at least 25 per 1,000 live births	**Complete alignment.** By strengthening maternal and child health through improved nutrition, awareness, and health-seeking behaviours. By focusing on pregnant and lactating women, promoting appropriate antenatal care, and encouraging optimal infant and young child feeding practices, the programme contributes to better birth outcomes and reduces risks associated with maternal and child mortality. Its community-based approach further supports early identification and prevention of health and nutrition-related issues, thereby improving the survival and overall well-being of mothers and young children.
SGD 5: Gender Equality	Target **5.1** End all forms of discrimination against all women and girls everywhere Target **5.5**	**Complete alignment**. By empowering women as community change agents (e.g., SuPoshan Sanginis), improving awareness around nutrition and maternal health, and engaging

 **Achieve gender equality and empower all women and girls**	Ensure women's full and effective participation and equal opportunities for leadership at all levels of decision-making in political, economic and public life Target **5.6** Ensure universal access to sexual and reproductive health and reproductive rights	women in decision-making at the household and community level, the programme promotes gender equality and strengthens women's agency. Its focus on adolescent girls and maternal health also supports informed choices around health and nutrition, aligning with reproductive health and rights.
SDG 8: Decent work and Economic growth  Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all	Target **8.5** By 2030, achieve full and productive employment and decent work for all women and men, including young people and persons with disabilities, and equal pay for work of equal value	**Partial Alignment.** Through the engagement and training of community-level workers (such as SuPoshan Sanginis), the programme creates local livelihood opportunities and builds skills among women. This contributes to economic participation and empowerment at the grassroots level

Table 2: Alignment with Sustainable Development Goals

1.7. Alignment with CSR Policy

Schedule VII under Section 135 of the Companies Act, 2013, outlines the range of permissible activities that companies can undertake as part of their Corporate Social Responsibility (CSR) initiatives. The table below presents how the SuPoshan programme aligns with these approved CSR activities, highlighting its relevance within the prescribed regulatory framework.

Sub Section	**Activities as per Schedule VII**	**Level of Alignment**
i) Promoting healthcare	Eradicating hunger, poverty and malnutrition, 2	**Complete Alignment**.

	[promoting health care, including preventive health] and sanitation 3 [Including contribution to the Swachh Bharat Kosh set-up by the Central Government for the promotion of sanitation] and making available safe drinking water;	The SuPoshan programme contributes to promoting healthcare by addressing malnutrition and improving overall health outcomes among children, pregnant and lactating women, and adolescent girls. Through community-based awareness, behaviour change communication, and nutrition counselling, the programme supports preventive healthcare by encouraging appropriate feeding practices, maternal care, and early identification of nutritional risks. Its focus on improving dietary practices and strengthening linkages with existing health services contributes to better community-level health and well-being.
ii) Reducing inequalities	Measures for promoting gender equality, empowering women and reducing inequalities faced by socially and economically backward groups	**Complete Alignment.** The SuPoshan programme actively works towards reducing inequalities by targeting vulnerable and underserved populations, particularly women, children, and adolescent girls in rural and marginalised communities. By improving access to nutrition knowledge, empowering women as key decision-makers, and addressing intra-household disparities in food and care practices, the programme helps bridge gaps in nutrition and health outcomes. Its inclusive, community-driven approach contributes to more equitable access to information,

		resources, and services, thereby reducing social and economic disparities.

Table 3: Alignment with CSR Policy

1.8. Alignment with ESG Principles

The programme's intervention also aligns with the ESG principles.

Principle 8

Businesses should promote inclusive growth and equitable development

Chapter 2

Impact Study Design and Approach

2. Impact Assessment Design and Approach

2.1. Objectives of the Impact Assessment

The primary aim of this impact assessment is to conduct a structured, evidence-based review of the **SuPoshan programme** for the FY 2023–24. The evaluation seeks to assess how effectively the programme has improved nutrition awareness, practices, and outcomes among children, pregnant and lactating women, and adolescent girls in the target communities. The specific objectives of the assessment are as follows:

Figure 2: Objectives of the Impact Assessment

2.2. Theory of Change

Programme Component	Key Activities	Outputs[7]	Outcomes	Impact
Early Identification &	• Anthropometric assessment	• 8748 children	• Early detection	• Reduction in child

[7] Number of beneficiaries, as provided by the Adani Team

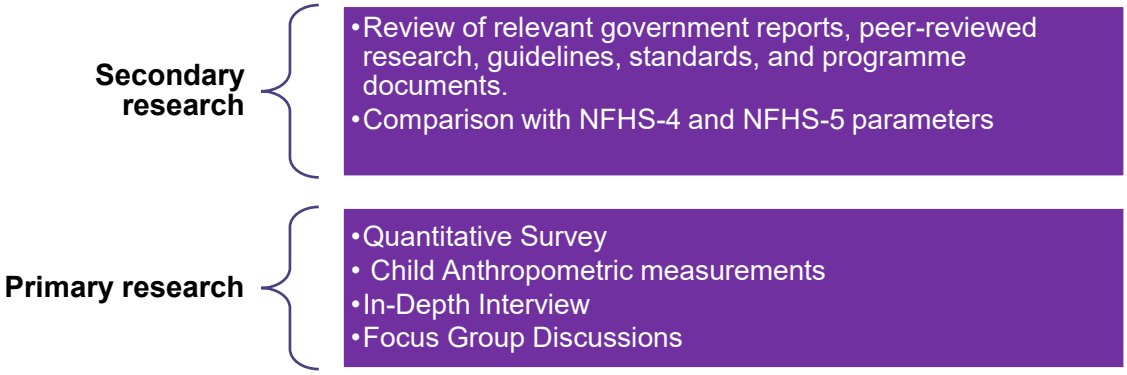
Management of Child Malnutrition	(weight, height, MUAC) • Counselling on IYCF practices • Referral to NRC/CMTC • Follow-up of SAM/MAM children • Home-based nutrition and sanitation counselling	screened for nutritional status • Regular follow-ups conducted	and management of malnutrition • Improved caregiver awareness and feeding practices • Increased utilisation of NRC services	malnutrition (wasting, underweight, stunting) • Improved child growth and reduced morbidity and mortality
Improving Nutrition among Women & Adolescent Girls	• Family counselling and group sessions • Nutrition and anaemia awareness • Cooking demonstrations • Promotion of Poshan Vatika (kitchen gardens) • Screening of women and adolescent girls • Referral support for ANC and institutional delivery	• Community trainings and counselling sessions conducted • Women and adolescent girls screened • Kitchen gardens established	• Improved dietary diversity and nutrition practices • Increased awareness of maternal and adolescent health • Improved health-seeking behaviour (ANC, institutional care)	• Enhanced maternal and adolescent health outcomes • Reduction in anaemia and nutrition deficiencies • Improved household-level nutrition and hygiene practices
Community Capacity Building through SuPoshan Sanginis	• Identification and training of Sanginis - Capacity building on nutrition, IYCF, WASH • Household surveys and community mobilisation • Strengthening linkages with ICDS and health systems - Supporting referrals and follow-ups	• Trained cadre of community nutrition workers • Household outreach and engagement • Strengthened community-institution linkages	• Increased community awareness and participation • Improved access to government services (ICDS, NRC, AWC) • Sustained behaviour change at the household level	• Community ownership and sustainability of nutrition practices • Long-term improvement in health and nutrition outcomes • Women's empowerment and local leadership development

Table 4: Theory of Change

2.3. Approach and Methodology

For the SuPoshan programme, the impact assessment follows a dual approach to data collection and analysis to develop a comprehensive understanding of nutrition practices, health behaviours, and hygiene conditions across the project locations. By integrating both qualitative and quantitative methods, the approach strengthens the robustness of findings and supports evidence-based insights for programme evaluation, learning, and improvement.

The impact assessment adopts a mixed-method research design, wherein qualitative and quantitative tools are used concurrently to capture both measurable outcomes and community-level experiences. This approach enables a holistic assessment of the programme's effectiveness in improving nutrition, health awareness, and behaviour change among target beneficiaries across the intervention areas.



A **case-control study approach** was adopted, wherein the case group comprised communities directly benefiting from the SuPoshan programme across the project intervention areas.

2.4. Sampling

Since the study followed a mixed methods approach, including both quantitative and qualitative methods to ensure a comprehensive understanding of the impact, separate sampling methods were employed for each method of data collection.

Quantitative Sampling

The quantitative sampling followed a purposive sampling approach, wherein villages with the highest number of programme beneficiaries were selected from the list of intervention villages across Tiruvallur, Thiruvananthapuram, Mangalore, and Nellore. This approach was adopted to maximise respondent availability and ensure adequate representation of key beneficiary groups. Within the selected villages, respondents were covered across target categories to capture programme-level outcomes. The number of respondents across each location was calculated at a 95% Confidence Interval at a margin of error of 5%.

Primary Stakeholders	Sample Size (Treatment group)	Sample Size (Control group)	Mode of Data Collection
Children below 5 years	241[8]	67	CAM

*18 entries of the Tiruvallur location were secondary data and were not procured during field data collection

Women of Reproductive Age	220	64	On-field Survey
Adolescent Girls	109	46	On-field Survey
SuPoshan Sanginis	38		On-field Survey
Total Sample Covered	593	177	

Table 5: Quantitative Sampling

Qualitative Sampling

The qualitative sampling followed a purposive sampling approach, wherein key stakeholders were intentionally selected based on their relevance to programme implementation and community engagement across the intervention locations. This included frontline workers, service providers, community representatives, and programme staff to capture diverse perspectives. The approach ensured in-depth insights into programme processes, challenges, and perceived outcomes through IDIs and KIIs.

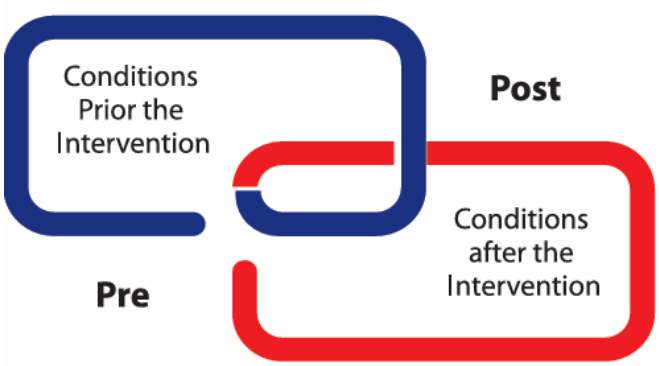
Stakeholder	Sample Covered	Mode Of Data Collection
Men (Married)	4	IDI
ASHA Workers	9	IDI
PHC Doctors	5	IDI
Panchayat Members	7	IDI
Anganwadi Workers (AWW)	12	IDI
Block Development Officer /CDPO	2	KII
NRC Team	2	IDI
Adani Foundation Team	5	KII
Total	46	

Table 6: Qualitative Sampling

2.5. Evaluation framework and Indicators

In line with the study's objectives and key areas of investigation, the evaluation's design prioritised learning as its primary goal. This section outlines our strategy for developing and implementing a robust, dynamic and outcome-focused evaluation framework/design. To gauge the impact, the study proposes a pre-post programme evaluation approach that relies on respondents' recall capacity. Under this method, beneficiaries are surveyed about their conditions before and after the programme intervention. Analysing the difference helps to discern the programme's contribution to enhancing the intended condition of the beneficiary. While this approach can effectively comment on the programme's role in improving living standards, it may not entirely attribute all changes to the programme.

For the programme assessment, a two-pronged approach to data collection and review has been employed, including secondary data sources and literature, as well as primary data collected through qualitative methods. The figure below illustrates the study approach used in data collection and review. The secondary study involved a review of government reports and of other studies and research by renowned organisations available in the public domain to draw insights.



2.5.1. IRECS Framework

The evaluation adopted the IRECS(S) framework to assess key dimensions such as inclusiveness, relevance, expectations, convergence, service delivery, and sustainability of the programme. Anchored in a logic model approach, the framework provided a structured basis to evaluate effectiveness, efficiency, impact, and overall programme value. It enabled a comprehensive assessment of contributions and outcomes while accounting for external factors influencing results.

Inclusiveness

- The extent to which communities equitably access the benefits of the programme.

Relevance

- The extent to which the programme effectively addressess the actual needs of the community.

Expectations

- The extent to which the programme achieved its desired outputs and goals

Convergence

- The extent to which the programme aligns with other existing initiatives.

Service Delivery

- The extent to which efficient methods and processes were used to achieve results.

Framework Dimension	Key Indicators	Data Sources / Methods
Inclusiveness	• Participation of marginalised groups (SC/ST/OBC/minorities) • Coverage of underserved and hard-to-reach areas • Inclusion of low-income households • Access to NRC services for SAM children	• Quantitative beneficiary surveys • Beneficiary surveys • Anthropometric measurements (CAM)

	• Women's participation in nutrition-related decision-making • Coverage of high-risk groups (pregnant/lactating women, children under five, anaemic individuals)	• KIIs with stakeholders and programme teams • IDIs with frontline workers and other stakeholders • Secondary review of programme documents and research • Programme documentation review • Comparative analysis with NFHS data • Field observations and field insights
Relevance	• Alignment with local nutrition challenges (anaemia, stunting, malnutrition) • Contextualisation to local food habits and cultural practices • Perceived improvements in nutrition and health by beneficiaries • Integration of traditional dietary practices • Relevance of capacity-building for Sanginis and frontline workers	
Expectations	• Reduction in malnutrition (SAM/MAM, stunting, wasting) • Improvement in child growth indicators (HAZ, WAZ, MUAC) • Improved IYCF practices (early initiation, exclusive breastfeeding, complementary feeding) • Increased ANC/PNC uptake among women • Improved dietary diversity and hygiene practices • Behavioural change due to counselling interventions	
Convergence	• Alignment with national programmes (POSHAN Abhiyaan, ICDS, NHM, Anaemia Mukt Bharat) • Increased utilisation of government services (AWCs, NRCs, immunisation, institutional delivery) • Coordination with frontline workers (AWWs, ASHAs, ANMs) • Partnerships with SHGs, NGOs, and local institutions	
Service Delivery	• Availability and accessibility of nutrition services • Regular growth monitoring, counselling, and health outreach • Reduction in access barriers (distance, awareness, cost) • Quality and frequency of home visits by Sanginis • Effectiveness of training and capacity building - Monitoring systems and feedback mechanisms	
Sustainability	• Adoption of sustainable nutrition and hygiene practices (e.g., Poshan Vatika, WASH behaviours) • Continued community engagement and ownership.	

	• Retention and capacity of SuPoshan Sanginis • Integration with existing government systems (ICDS, health services) • Emergence of local leadership and long-term behaviour change	

Table 7: Framework and Key Indicators

2.6. Challenges and mitigation measures adapted

Challenges faced	Mitigation measures adapted
Limited availability of pregnant women, recently delivered mothers, and children aged 6 months to 2 years was observed in certain locations. This was primarily because many women temporarily relocate to their maternal homes during pregnancy and the postnatal period, which are often in different villages or districts, making them unavailable at the project sites during data collection	To address this, the sample for these categories was proportionately increased in other locations where access was higher. Additionally, in locations where these respondents remained limited, the sample size for other relevant groups, such as mothers of children under five and women of reproductive age, was expanded to ensure adequate coverage and maintain the overall robustness of the dataset.

2.7. Ethical Practices

Informed Consent:

All participants were informed about the purpose, scope, and voluntary nature of the SuPoshan impact assessment prior to participation. Clear explanations were provided regarding the type of information being collected, including nutrition, health, and household practices, and its intended use. Verbal consent was obtained before conducting surveys and interviews, and participants were informed of their right to withdraw at any stage without any consequences. Verbal consent was also taken before clicking pictures of respondents as well.

Confidentiality and Data Protection:

Strict measures were followed to ensure the privacy and confidentiality of participants. Personal identifiers were excluded from all documentation and reporting to maintain anonymity. All data collected during the assessment was used solely for evaluation purposes and stored securely, with access restricted to the assessment team.

Voluntary Participation and Non-Maleficence:

Participation in the assessment was entirely voluntary, with no coercion or undue influence. Special care was taken while engaging with women, children, and adolescent girls to ensure that discussions around nutrition, health, and personal practices were conducted sensitively. The assessment process was designed to avoid any harm, discomfort, or disruption to beneficiaries and ongoing community or health services.

Chapter 3

Key Findings of the Impact Assessment

3. Key findings from the Impact Assessment

This chapter outlines the major impact findings of the SuPoshan programme across the project locations. The findings on nutritional outcomes of women of reproductive age, adolescent girls and children under 5 years are reported here. To provide a comprehensive evaluation of the programme's outcomes on aspects such as nutrition, behaviour change, WASH practices, and cooking demonstration, the IRECS framework has been employed. Wherever applicable, comparison has been made between the treatment and the control group.

3.1. Women of Reproductive Age

3.1.1. Inclusiveness

75% of respondents were between 20 and 29 years of age

60% of particpants had not completed higher secondary level education

56% of the participants belonged to the SC/ST categories and 38% belonged to OBC category

33% of households reported to have an annual income of upto 25,000

Coverage across maternal lifecycle: Pregnant women (36%), lactating mothers (23%), recently delivered mothers (18%), mothers of children 2–5 years (23%)

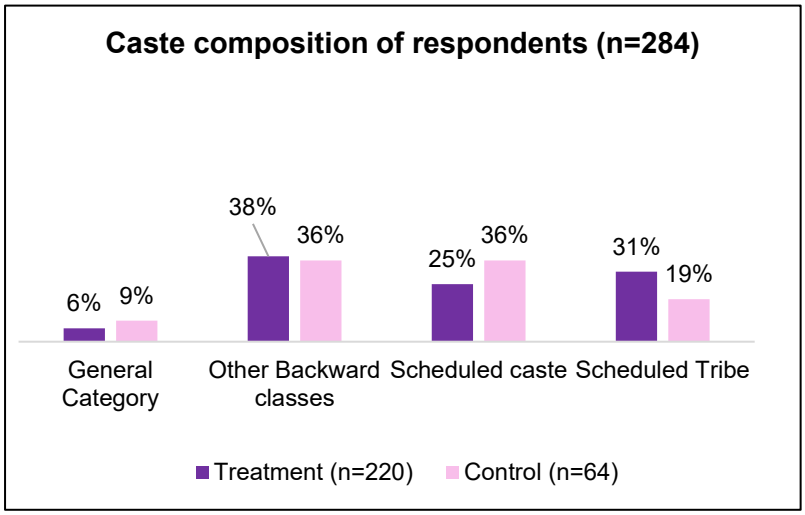


Figure 3: Caste composition of respondents (n=284)

The graph depicts the caste-based distribution of women in both treatment and control villages. The social composition of both groups is broadly comparable, with **Other Backward Classes (OBCs) and Scheduled Castes (SCs) forming a substantial share in both treatment and control groups**. However, the treatment group has a **higher proportion of Scheduled Tribes** (31% vs. 19%), while the control group has a

relatively higher share of the general category (9% vs. 6%) and a slightly higher representation of SCs. This distribution showcases that, across locations, the SuPoshan programme catered to a predominantly vulnerable population. Their coverage is particularly noteworthy as studies have found that **members belonging to SC and ST categories are highly susceptible to malnutrition due to various economic and cultural barriers**.[9]

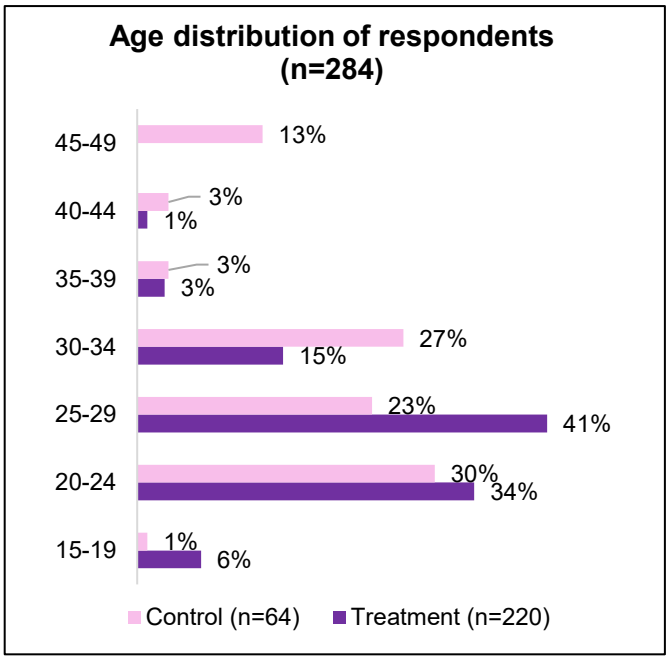


Figure 4: Age Distribution of Respondents (n=284)

The age distribution shows a clear concentration of younger respondents in the treatment group compared to the control group. In the **treatment group, the majority fall within the 20–29 age range (75%), with the highest proportion in the 25–29 category (41%)**, indicating a predominantly younger cohort of women in the prime reproductive years. This is consistent with the programme's focus on women in their reproductive years, whose nutritional needs are explicitly targeted by the intervention.

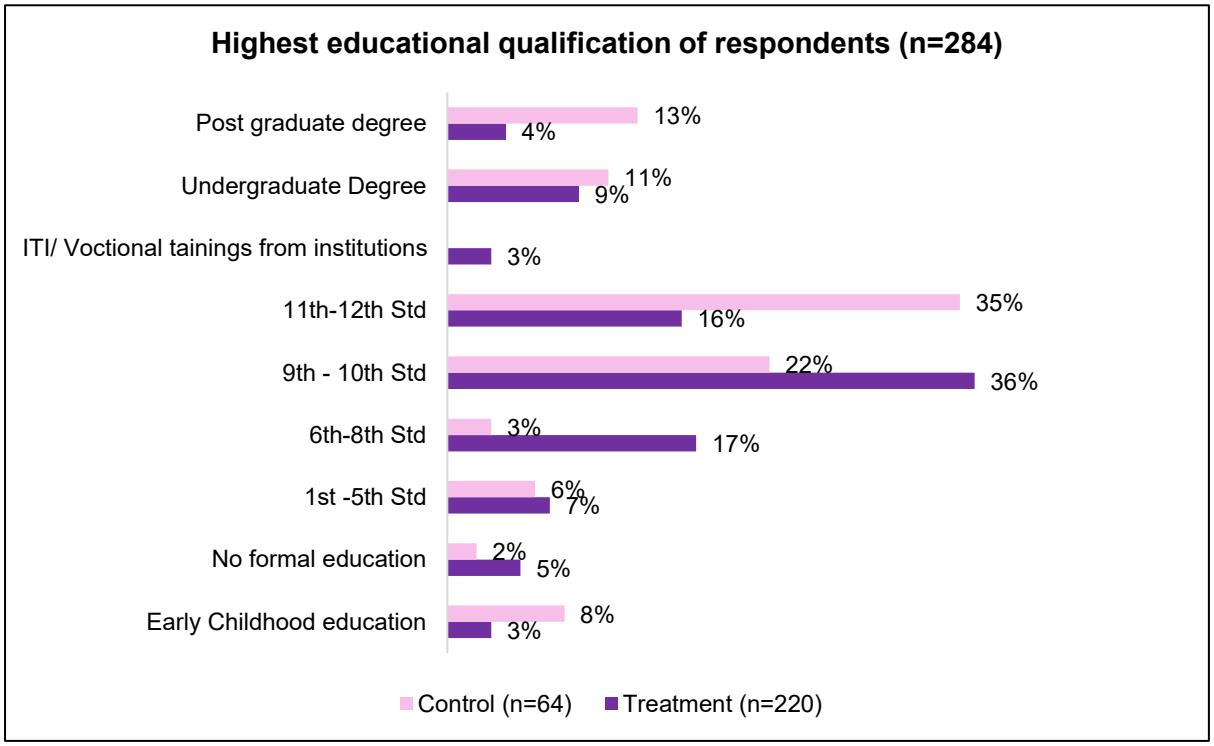


Figure 5: Highest educational qualification of respondents

[9] Decomposing malnutrition inequalities between Scheduled Castes and Tribes and the remaining Indian population

The educational profile indicates notable differences between the treatment and control groups. The treatment group is more concentrated in middle levels of schooling, particularly **9th–10th standard (36%) and 6th- 8th standard (17%), suggesting a predominantly moderate level of educational attainment**. In contrast, the control group shows a relatively higher proportion of individuals with higher secondary (11th- 12th: 35%) and postgraduate education (13%), indicating a comparatively more educated cohort overall. At the same time, **the treatment group has a slightly higher share of respondents with no formal education and vocational training**. Overall, this suggests that the treatment group is skewed toward lower to mid-level educational attainment, whereas the control group reflects relatively higher educational attainment. This is highly relevant for nutritional outcomes, as children of educated mothers have positive survival and nutritional outcomes, especially in resource-poor developing nations.[10]

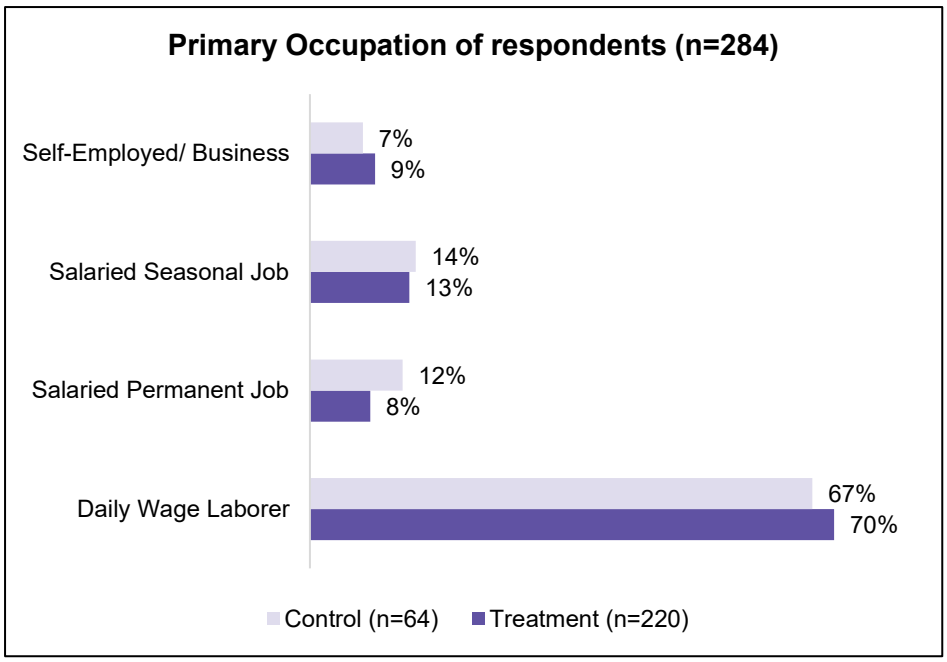


Figure 6: Primary source of income (n=284)

The livelihood profile of women across both the treatment and control groups indicates a strong dependence on informal and unstable sources of income at the household level**. A majority of families in both groups rely on daily wage labour** (70% in the treatment group and 67% in the control group), highlighting the prevalence of low-income, irregular employment. Only a small proportion of households have access to stable salaried employment, **with 8% in the treatment group and 12% in the control group engaged in permanent jobs**, while **seasonal salaried work accounts for 13% and 14% respectively**. Self-employment and small business activities remain limited (9% in treatment and 7% in control), suggesting constrained opportunities for independent income generation. Field observations further reinforce these findings, indicating that women themselves are often not primary earners but contribute through informal or supplementary work when possible. The nature of these seasonal jobs varies across the 4 intervention areas. In Tiruvallur, fishing remains the most common job, whereas in Mangalore, agricultural work in cashew farms and chocolate making are more predominant. Vizhinjam has more people enrolled in the MGNREGA scheme for employment.

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[10] The Importance Of Women's Status For Child Nutrition In Developing Countries. Smith Lisa, Usha Ramakrishnan

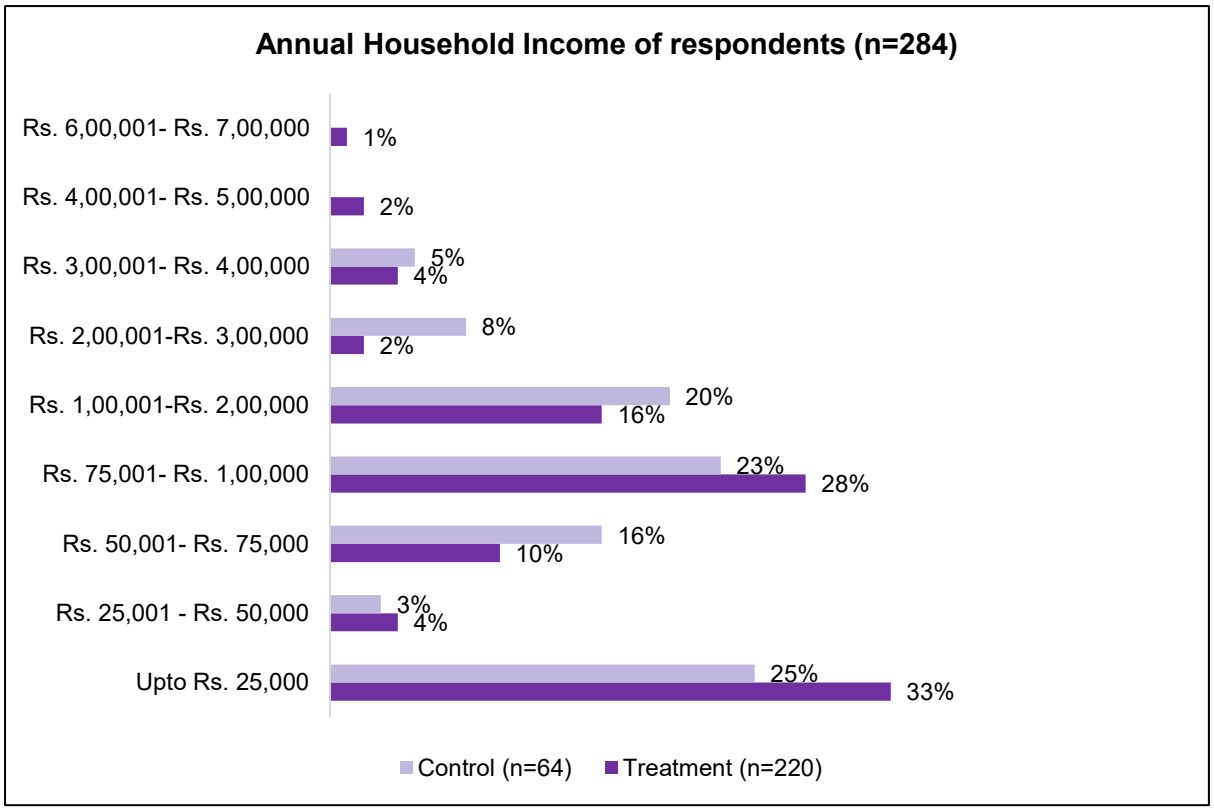


Figure 7: Annual Household Income of respondents (n=284)

The income distribution indicates that both groups are largely concentrated in lower- to middle-income brackets. **In the treatment group, a higher proportion falls in the lowest income category (up to Rs. 25,000: 33% vs. 25%)**, while the control group has relatively greater representation in higher income brackets, particularly between Rs. 1,00,001 and Rs. 3,00,000. The higher proportion of low-income households in the treatment section **reflects existing job and financial insecurity in the population**. The data reflect that the programme is effectively targeted to address the nutritional needs of vulnerable populations from economically disadvantaged parts of the district in each of the 4 states.

Across both groups, **pregnant women constitute the largest share of respondents (Treatment: 36%; Control: 40%)**. The treatment group has a more balanced distribution, with equal representation of lactating mothers and mothers of children aged 2–5 years (23% each), whereas the control group is more concentrated among mothers of children aged 2–5 years (35%). Lactating and recently delivered mothers have relatively lower representation in the control group compared to the treatment group. Overall, while both groups capture key maternal categories, the treatment group reflects a more even spread across stages.

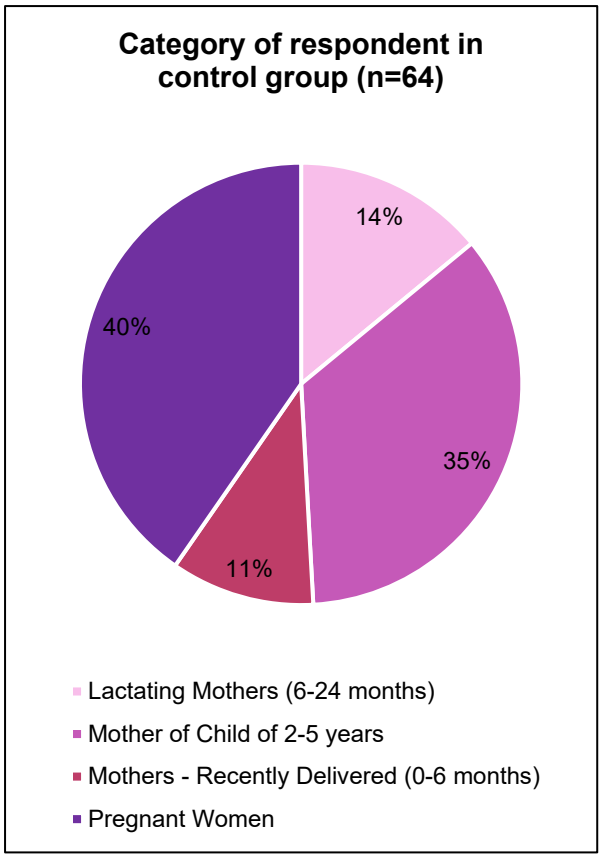


Figure 9: Category of respondents in the control group

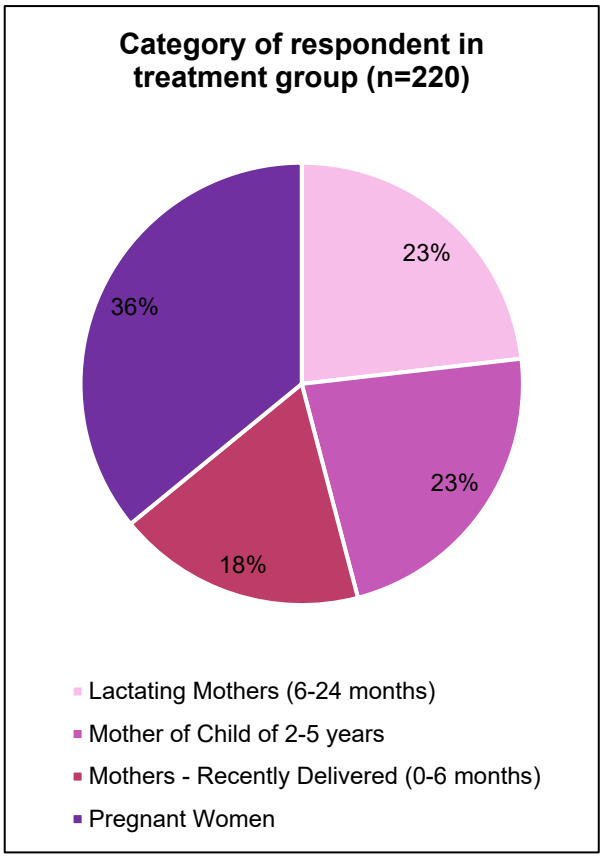


Figure 8: Category of respondents in the treatment group

3.1.2. Relevance

This section covers the extent to which the training programme effectively addresses the actual needs of the community.

45% of respondents were unaware of NRC before intervention

35% of women did not receive any guidance on nutrition; 32% received guidance from informal networks

Gaps in WASH practices: 30% open defecation; only 45% boiled water before drinking

27% of women were not utilising AWC services despite being aware

a) Prior Knowledge on Nutrition

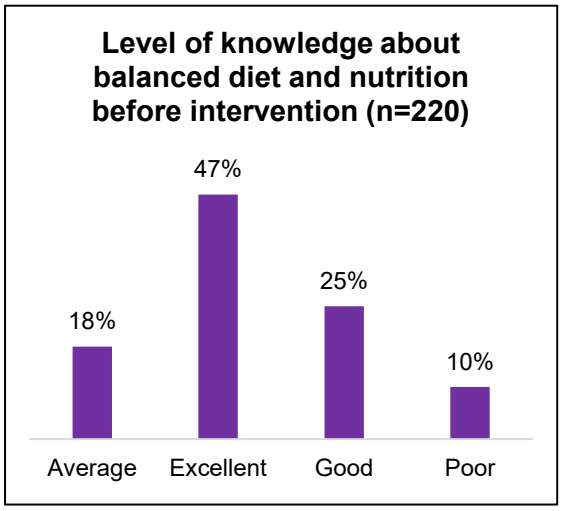


Figure 10: Level of knowledge about balanced diet and nutrition before intervention

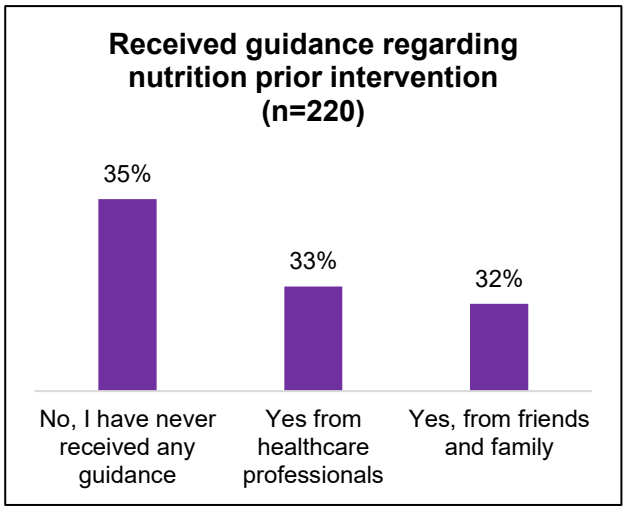


Figure 11: Received guidance regarding nutrition prior to intervention

The graphs depict the participants' self-reported knowledge on nutrition before the intervention. The findings suggest that while a majority of respondents perceived their knowledge of maternal nutrition as good to excellent, a substantial proportion had limited or no exposure to formal guidance. Over one-third had never received any information, and another significant share relied on informal sources such as friends and family, indicating gaps in access to reliable, institutional counselling. **The relatively low proportion receiving guidance from healthcare professionals (33%) highlights a disconnect between perceived knowledge levels and formal information channels, pointing to the need for strengthening structured nutrition education**. Additionally, 47% of participants have cited a lack of clarity on nutritional information of food to be the major hindrance for long-term nutrition maintenance.

b) Prior knowledge of NRCs

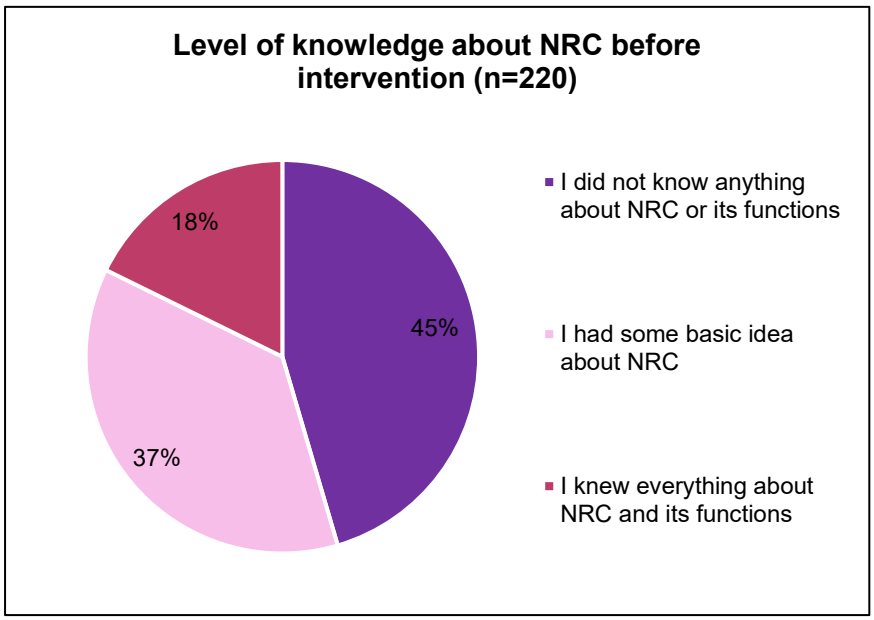


Figure 12: Extent of knowledge about NRC prior to intervention

The findings indicate limited awareness of Nutrition Rehabilitation Centres (NRCs) before the intervention. **Nearly half of the respondents (45%) did not know NRCs or their functions, while 37% reported only a basic understanding. Only a small proportion (18%) were fully aware**, highlighting a significant gap in awareness and the need for improved information dissemination on available nutrition services. These low levels of awareness could be attributed to the lack of proximity to the

villages. This is true in the case of Tiruvallur, where the NRC is 40-50 kms away from the villages. Additionally, it is not readily proposed by the ASHAs or VHNs as they're aware that the uptake would be minimal, due to the residential nature of treatment in the NRCs.

c) *Prior knowledge and uptake of ANC/PNC services*

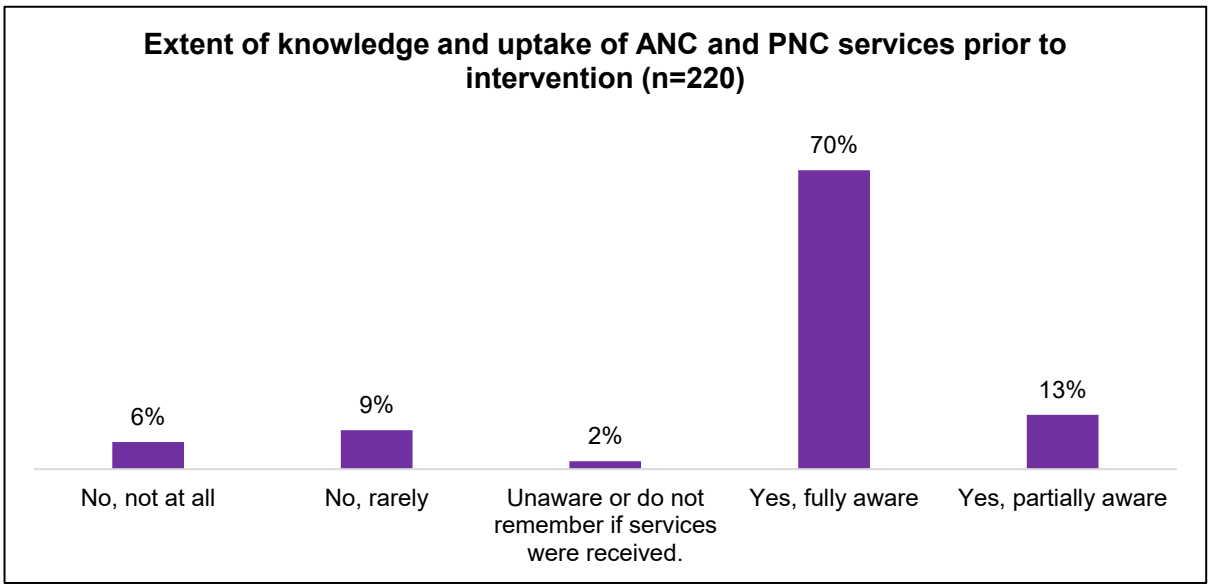


Figure 13: Prior knowledge and uptake of ANC/PNC services before intervention

Even prior to the intervention, **a majority of participants (70%) were fully aware of antenatal and postnatal care (ANC/PNC) services and had fully availed them, while 13% demonstrated partial awareness and uptake. However, 15% remained unaware of these services, and 2% were unable to recall their utilisation**. Despite relatively high overall awareness and uptake, the programme focused on addressing existing gaps by strengthening last-mile delivery through Sanginis, particularly targeting populations with lower access and utilisation.

d) *Prior Knowledge of AWC Services*

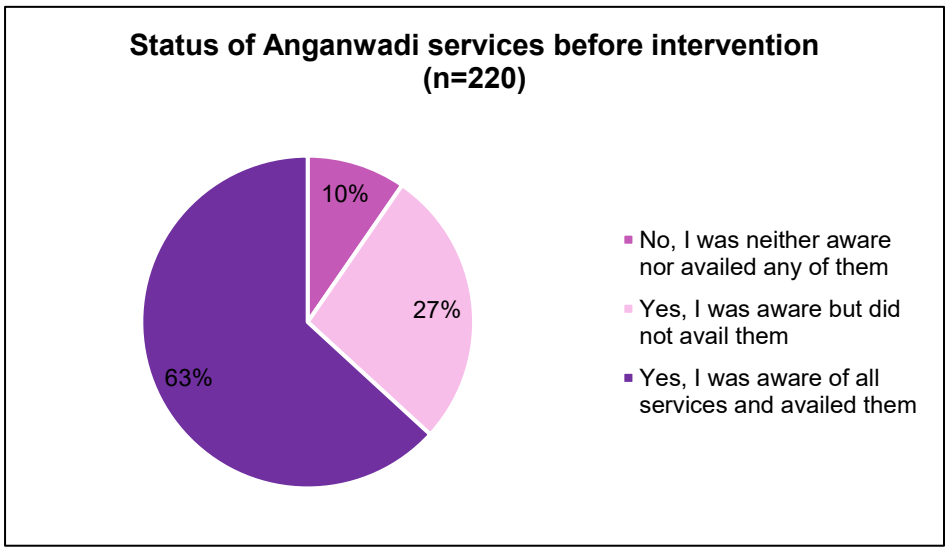


Figure 14: Extent of awareness and uptake of AWC services

The findings indicate moderate awareness but relatively strong uptake of Anganwadi Centre (AWC) services prior to the intervention. While **a majority of women (63%) were both aware of and had availed the services, a notable proportion (27%) were aware but had not utilised them, suggesting barriers to access or utilisation despite awareness. Additionally, 10% of respondents were neither aware of nor had availed of AWC services**, highlighting gaps

in outreach and information dissemination. Overall, the data points to the need for strengthening both awareness and conversion of awareness into actual service uptake.

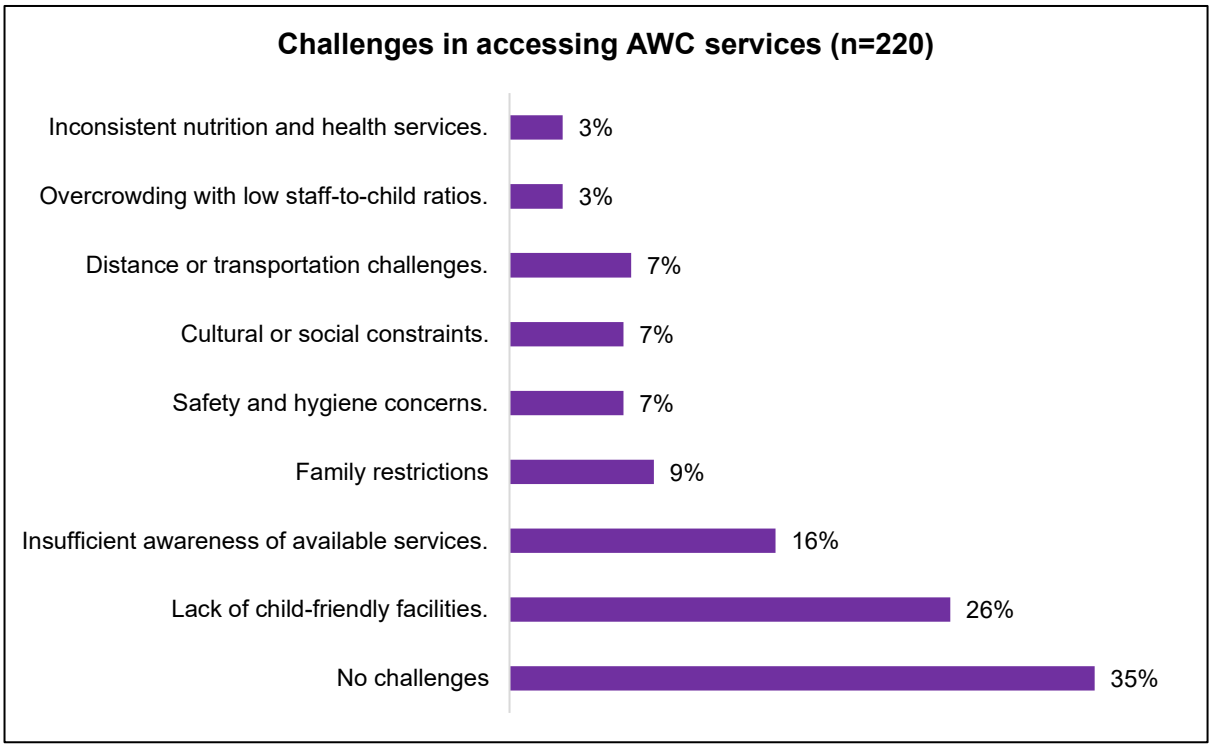


Figure 15: Challenges in accessing AWC services prior to intervention

The findings indicate that while over o**ne-third of respondents (35%) reported no challenges in accessing services**, a majority experienced at least one barrier. The most prominent issue was **the lack of child-friendly facilities (26%), followed by insufficient awareness of available services (16%). Other challenges included family restrictions (9%), and concerns related to safety, hygiene, cultural norms, and distance (7% each**), along with overcrowding and inconsistent service delivery (3% each). The SuPoshan programme seeks to address these gaps by strengthening last-mile service delivery, with the help of Sanginis, thus improving awareness through community-level engagement and utilisation of AWC services.

e) WASH practices prior to intervention

The findings suggest that while basic WASH practices were followed to some extent prior to the intervention, adherence was uneven across behaviours. High compliance was reported for practices such as **regular handwashing with water only (77%), use of toilets (67%), and routine household cleaning (61%)**. However, critical hygiene practices such as **washing fruits and vegetables (50%), boiling water before drinking (45%), and washing clothes and bedding regularly (39%) were less consistently followed**. Notably, **30% of respondents still practised open defecation**, indicating significant gaps in sanitation behaviour. Overall, the data reflect partial adoption of WASH practices, with clear scope for improvement in safe hygiene and sanitation behaviours. Qualitative interactions suggest that

participants, especially pregnant women, used to struggle due to a lack of toilets and practising open defecation; handwashing with soap was also infrequent before the intervention.

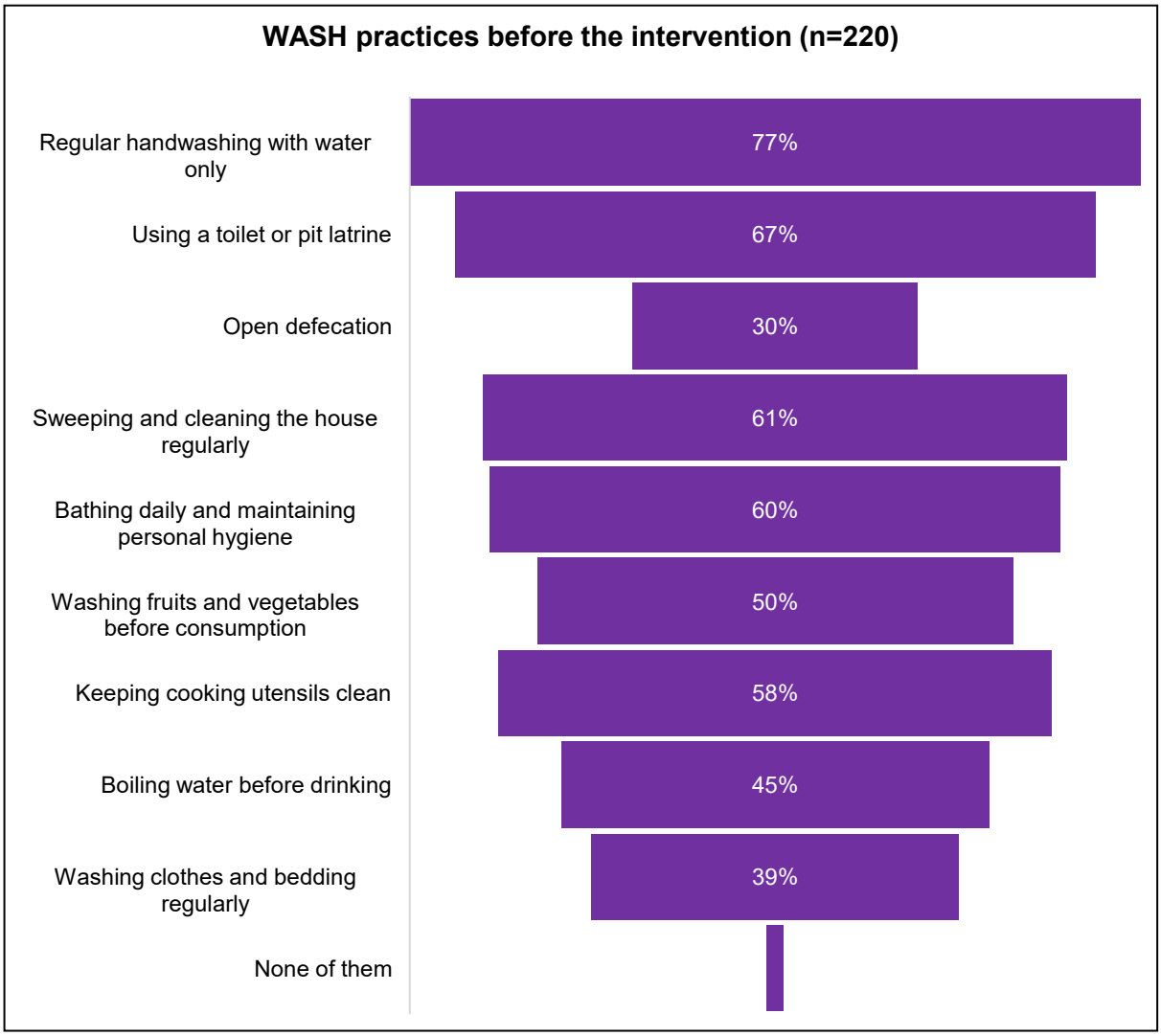


Figure 16: WASH practices followed prior to intervention

3.1.3. Expectations

84% of women reported practising handwashing with soap, reflecting strong adoption of hygiene behaviours

72% of households adopted kitchen gardens, supporting access to fresh and nutritious food

70% of women reported full understanding of NRC and its purpose in treatment areas

67% of mothers of malnourished children have taken their child to an NRC

66% of women reported consumption of IFA tablets, indicating improved awareness on anaemia prevention.

61% of women completed at least four ANC check-ups, showing strong improvement in maternal healthcare practices

This section deals with the extent to which the programme has achieved its desired outputs and goals. It also captures the positive changes experienced by the beneficiaries.

a) Understanding of NRC Post-Intervention

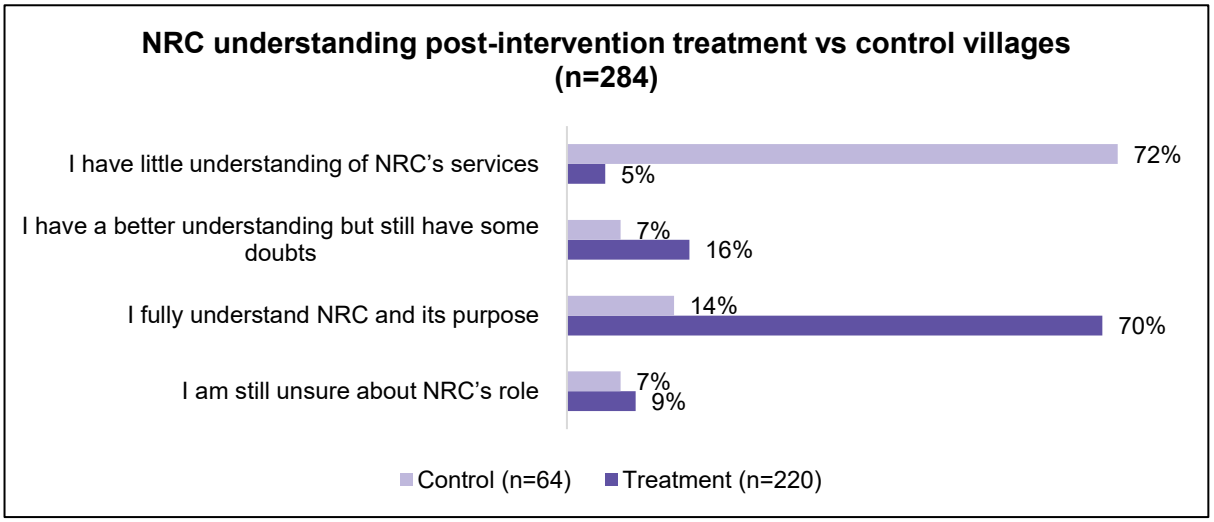


Figure 17: NRC understanding post intervention treatment Vs Control villages

There is a clear difference between the treatment and control groups in terms of understanding of NRCs**. Women in the treatment group largely demonstrate a strong awareness and clarity about the role and purpose of NRCs, with only a small proportion expressing uncertainty.**

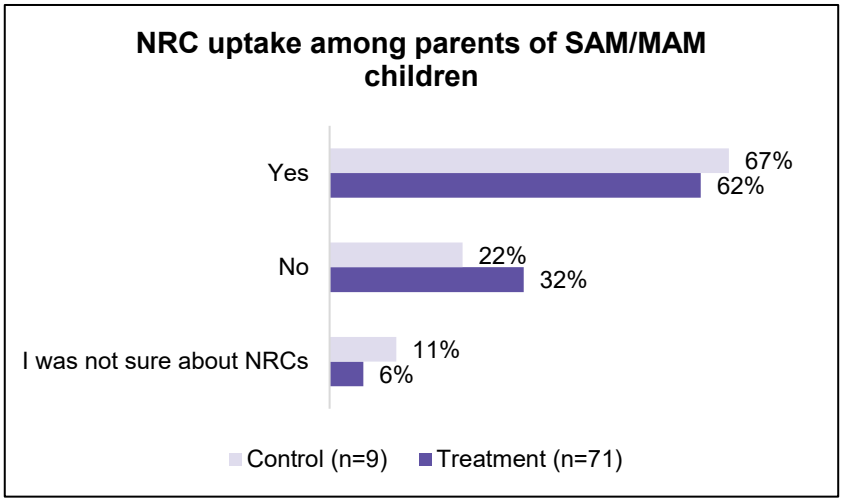


Figure 18: NRC uptake among parents of SAM/MAM children

In contrast, most women in the control group have a very limited understanding, with only a few showing clear awareness. This highlights a significant gap in awareness in non-intervention areas.

Among those eligible for NRC services, uptake appears reasonably high in both treatment and control groups, with most respondents indicating willingness to seek care. In the treatment group, this is supported by relatively higher awareness and clarity around NRCs, with fewer women reporting uncertainty.

In the control group, while many respondents expressed willingness to take their child to an NRC, this intent does not necessarily translate into informed decision-making. Field interactions revealed that a majority of these women were not aware of whether their child falls under the MAM or SAM categories, indicating a limited understanding of malnutrition and when NRC services are required. This suggests that **despite stated willingness, actual uptake in control areas may be constrained by low awareness and identification gaps.**

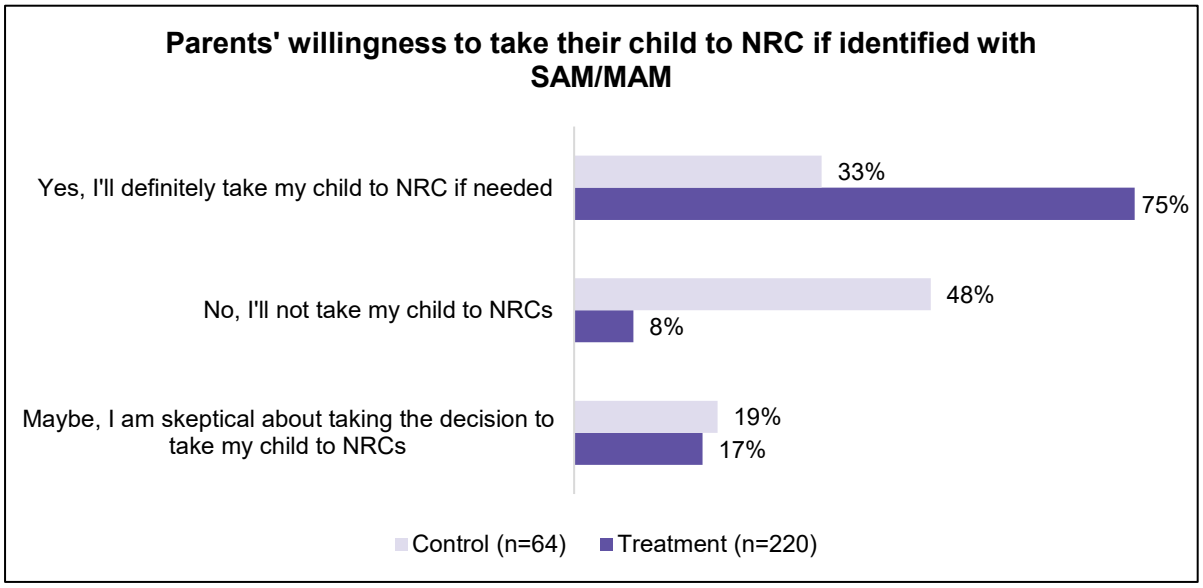


Figure 19: Parent's willingness to take their child to NRC if identified with SAM/MAM

There is a clear difference in willingness to use NRC services between the two groups. In the treatment group, **most parents said they would take their child to an NRC if needed, with only a small proportion expressing hesitation or refusal**. This higher level of acceptance can be linked to the Suposhan programme, which appears to have improved awareness, counselling, and confidence among caregivers regarding malnutrition and the role of NRCs. However, this improvement is not uniform across all four southern locations. In Mangalore, the NRC doctor noted that uptake is relatively satisfactory for children under two years of age. However, parents are more reluctant to admit older children, as it requires them to stay at the facility and to forgo daily wages. In Tiruvallur district, uptake remains low despite the intervention. The NRC is located at a distance of around 40–50 km, making access and stay difficult. In addition, cultural factors further discourage families from admitting their children, limiting the utilisation of services.

In the control group, willingness is much lower. While some parents are open to taking their child, a large share are either hesitant or unwilling to do so. Field observations suggest that this hesitation is driven by limited awareness of MAM/SAM and a lack of clarity on when and why NRC services are needed, which affects decision-making.

b) Status of ANC Services Post Intervention

The findings indicate notable improvements in maternal healthcare practices in the intervention areas. **Consumption of IFA supplementation for at least six months is substantially higher in the treatment group (66%) compared to the NFHS-5 baseline (26%), and is also slightly higher than the control group (63%),** reflecting improved awareness and adherence. Similarly, **the proportion of women undertaking at least four antenatal check-ups (61%) is higher than both NFHS-5 (58%) and significantly better than the control group (38%),** suggesting stronger engagement with maternal health services.

However, the **uptake of TT injections (71%) is lower than the NFHS-5 benchmark (92%), although it remains considerably higher than the control group (50%)**. This decline compared to NFHS-5 may be due to challenges in continuity of care. Field observations highlight migration as a major factor in these regions, with women frequently moving during pregnancy, leading to missed doses and interruptions in immunisation schedules. Overall, while there are clear positive gains in IFA consumption and antenatal check-ups, continuity-related challenges such as migration continue to impact certain services like TT immunisation.

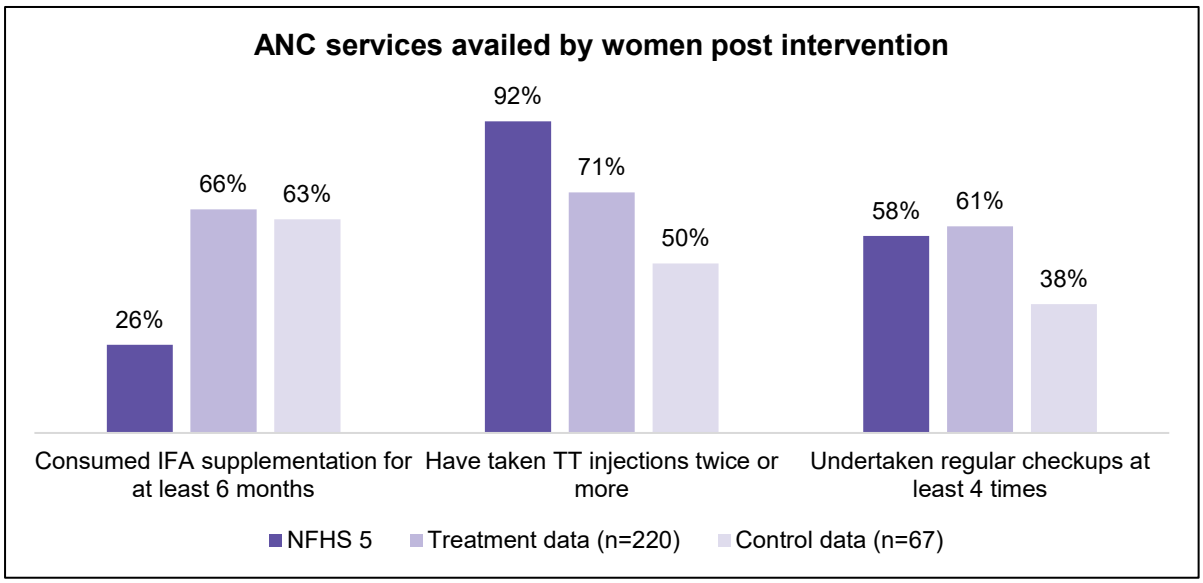


Figure 20: ANC services availed by women post intervention

> ***"The services have reached a majority of women. But still, there are some populations to whom there is a gap in reach. Particularly, migrant workers who come from northern and northeastern states are not covered extensively. There is limitations in their awareness, language barriers that prevent them fro accessing services. We should expand our awareness efforts to them with targeted approach, so that they don't get left behind."***
>
> *- PHC Doctor, Tiruvallur*

c) Status of PNC services and IYCF Practices post-intervention

The findings show mixed trends across key maternal and child health practices, with some clear improvements in the intervention areas. Early initiation of breastfeeding has improved significantly**, with 66% of children breastfed within one hour of birth compared to 42% in NFHS-5 and 38% in the control group.** This positive change can be linked to Sangini's sessions on breastfeeding practices and nutrition, which appear to have strengthened awareness and behaviour among mothers. **Exclusive breastfeeding up to six months, while lower than the NFHS-5 level (56% vs. 64%), is notably higher than the control group (34%**), indicating a positive shift compared to non-intervention areas. Postnatal care (PNC) within two days of delivery is slightly lower than the NFHS-5 benchmark (70% vs. 78%) and also marginally lower than the control group (72%), suggesting gaps in timely post-delivery care.

Overall, while interventions like Sangini have contributed to improvements in early initiation and relatively better exclusive breastfeeding practices compared to control areas, challenges remain in ensuring timely PNC and sustaining recommended practices over time

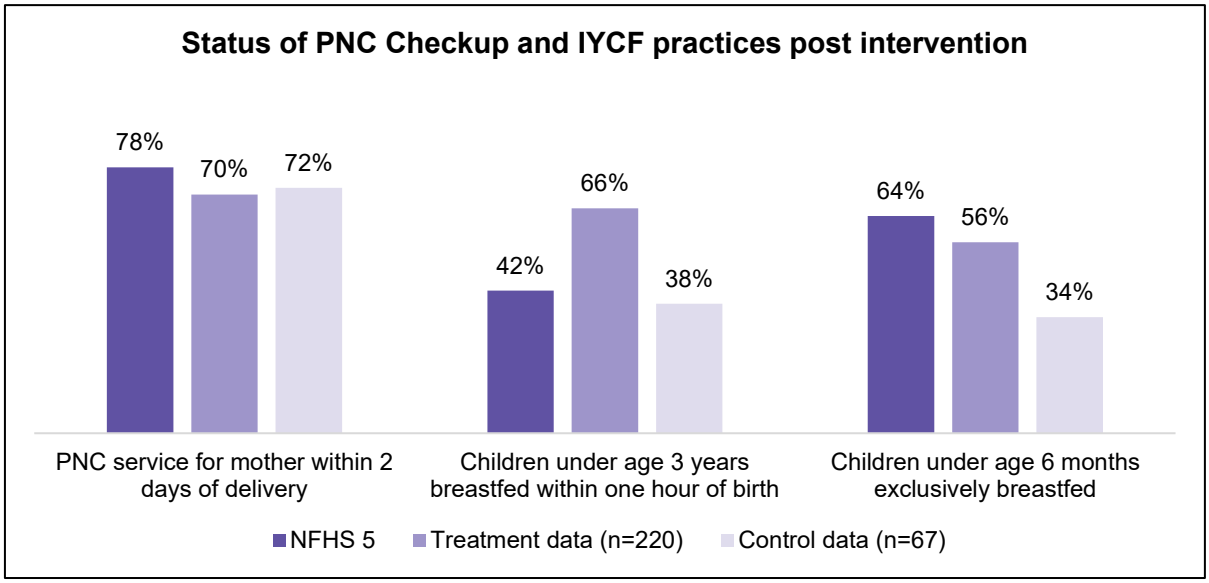


Figure 21: Status of PNC services and IYCF practices post-intervention

d) Uptake of AWC services

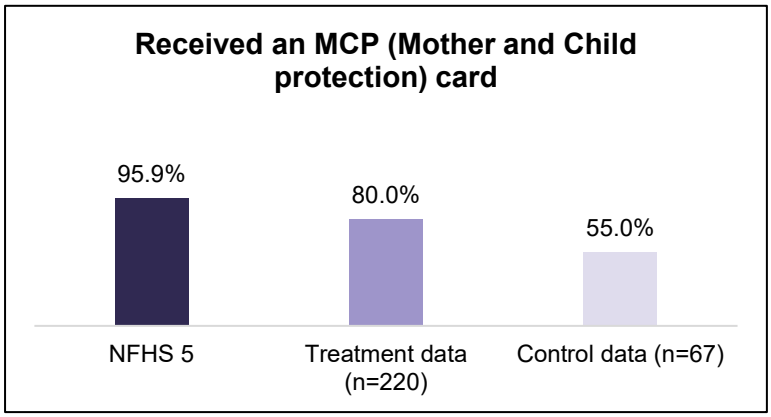


Figure 22: Proportion of women who received an MCP card

Pregnancy registration with **MCP card issuance is lower in the intervention areas (80%) compared to the NFHS-5 benchmark (95.9%), indicating a gap in universal coverage. However, it is significantly higher than the control group (55%),** suggesting improved access and registration in programme areas. Field insights indicate that migration and movement of pregnant women often disrupt timely registration and documentation, affecting overall coverage.

"We ensure that all women are provided with the MCP card. Even though they go to their mothers' house for delivery, I will make sure that I inform the VHN there to keep track of them and make sure that all vaccinations and supplementation are provided to them on time."

- Village Health Nurse, Tiruvallur

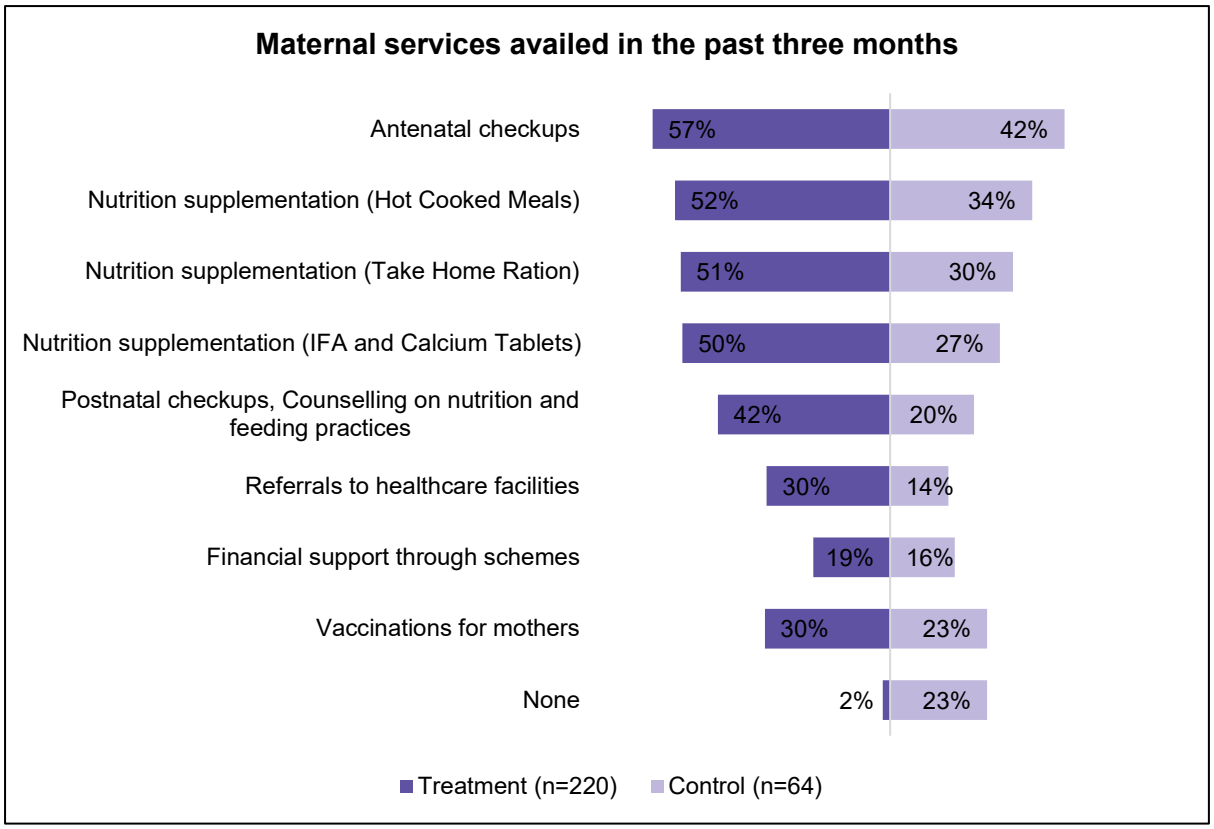


Figure 23: Maternal services availed in the last 3 months

The findings show that **utilisation of Anganwadi services is consistently higher in the treatment group across most components**. A greater proportion of women reported accessing antenatal check-ups, nutritional supplementation (including hot cooked meals, take-home rations, and IFA/calcium tablets), and postnatal care and counselling than in the control group, indicating stronger service uptake in intervention areas. Referrals to healthcare facilities and vaccinations for mothers are also higher in the treatment group, suggesting better linkage with the broader health system.

Financial support through schemes shows a smaller difference between the two groups, indicating that access to such benefits may be influenced by external administrative processes beyond programme support. Notably, very few respondents in the treatment group reported not accessing any services, whereas a significant share in the control group reported no utilisation at all. This highlights a clear gap in service reach and awareness in non-intervention areas.

The data shows a clear difference in utilisation of child-focused Anganwadi services between the treatment and control groups. A significantly higher proportion of children in the treatment group are accessing essential services such as health check-ups, nutritional screenings, and immunisation, indicating better coverage and regular engagement with the system. Nutrition supplementation through hot-cooked meals and take-home rations is also notably higher in the treatment group, suggesting improved access to supplementary nutrition. Participation in

pre-school education and activities at the Anganwadi Centre is considerably higher as well, pointing to greater awareness and utilisation of early childhood services.

Referrals to NRCs/CMTC are slightly higher in the treatment group, indicating some improvement in identification and linkage of malnourished children, though overall referral levels remain low. Importantly, only a small proportion of respondents in the treatment group reported not accessing any services, compared to a much larger share in the control group. This highlights a significant gap in outreach and utilisation in non-intervention areas, while also reflecting the positive role of the programme in improving service uptake.

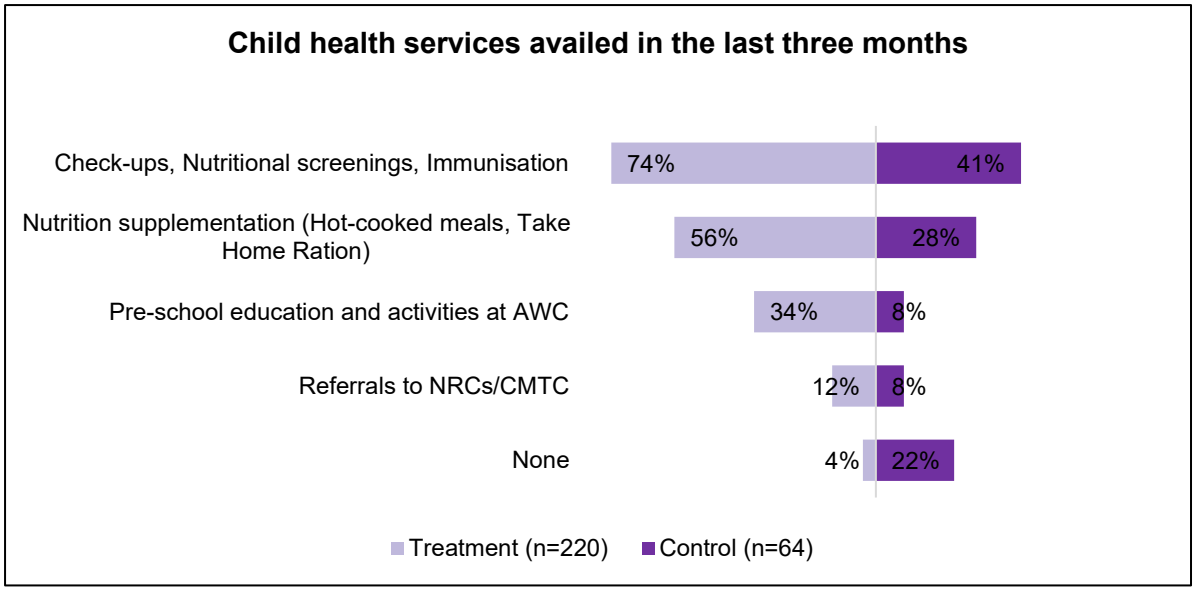


Figure 24: Child health services availed in the last three months

e) Cooking demonstrations

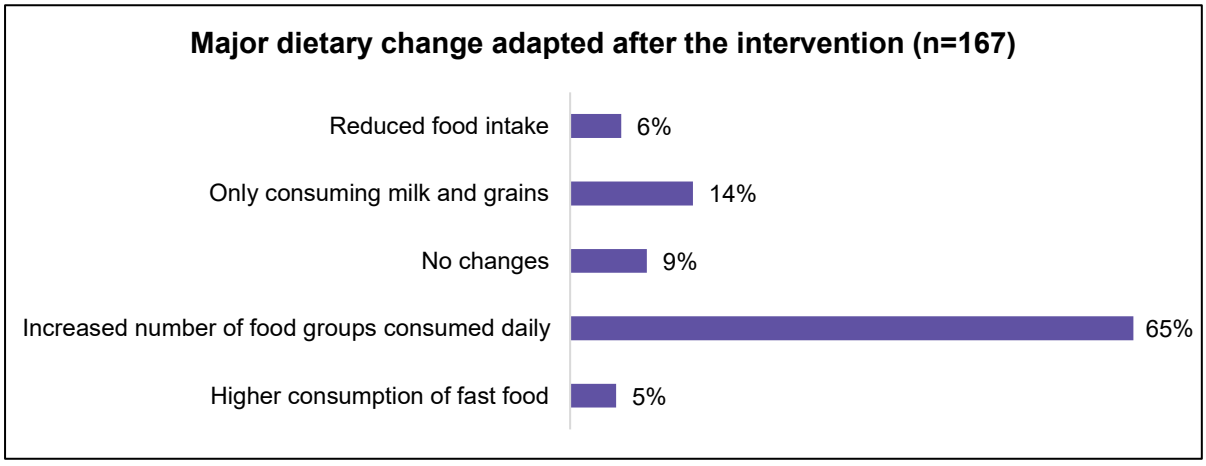


Figure 25: Major dietary changes adapted after the intervention

The results indicate a largely positive dietary shift after the intervention. A majority (**65%**) reported **increased consumption of different food groups**, reflecting improved dietary diversity. However, some adverse or limited patterns persist, including **14% consuming only milk and grains**, **6% reporting reduced food intake**, and **5% increasing fast food consumption**. A small share (**9%**) reported no change. Overall, while the intervention appears effective

in improving diet diversity, gaps remain in sustaining balanced and adequate diets for all households.

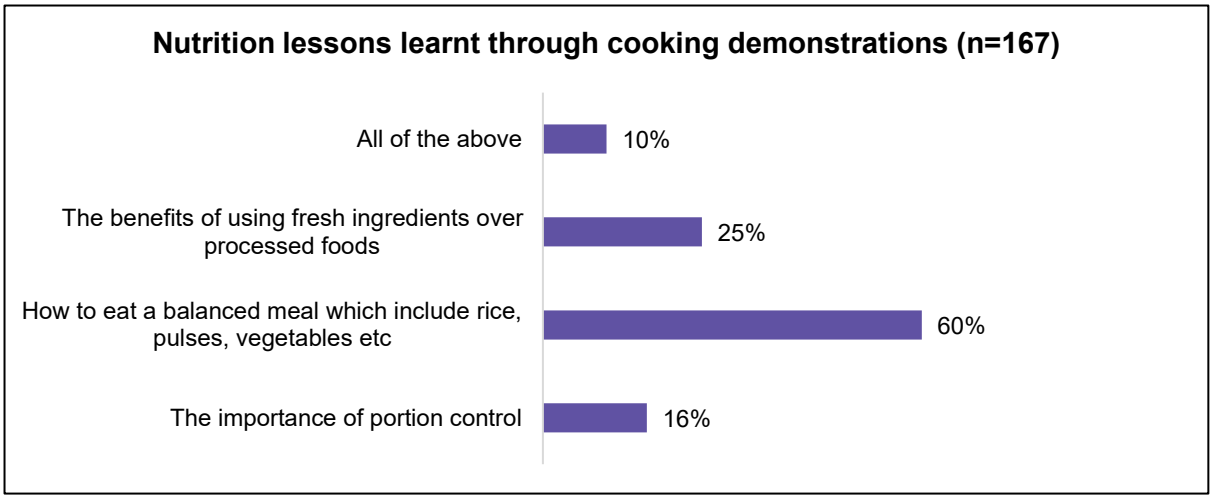


Figure 26: Nutrition lessons learnt through cooking demonstrations

Additionally, **25%** learned the benefits of using **fresh ingredients over processed foods**, while **16%** reported learning about **portion control**, which had relatively lower recall. Only **10%** reported learning **all aspects together**. Overall, the sessions were most impactful in promoting dietary balance, with partial but meaningful uptake of other nutrition messages The findings show a clear improvement in healthier cooking and consumption practices after the intervention. A majority of respondents reported **reducing the use of oil, salt, or sugar (53%)**, indicating better awareness of dietary risks. Nearly half (**50%**) also began **including more vegetables in their meals**, reflecting improved diet quality and nutrient intake. Additionally, **42% adopted healthier cooking methods such as steaming**, suggesting a shift towards better food preparation practices. A small proportion (**5%**) reported adopting **all of these**

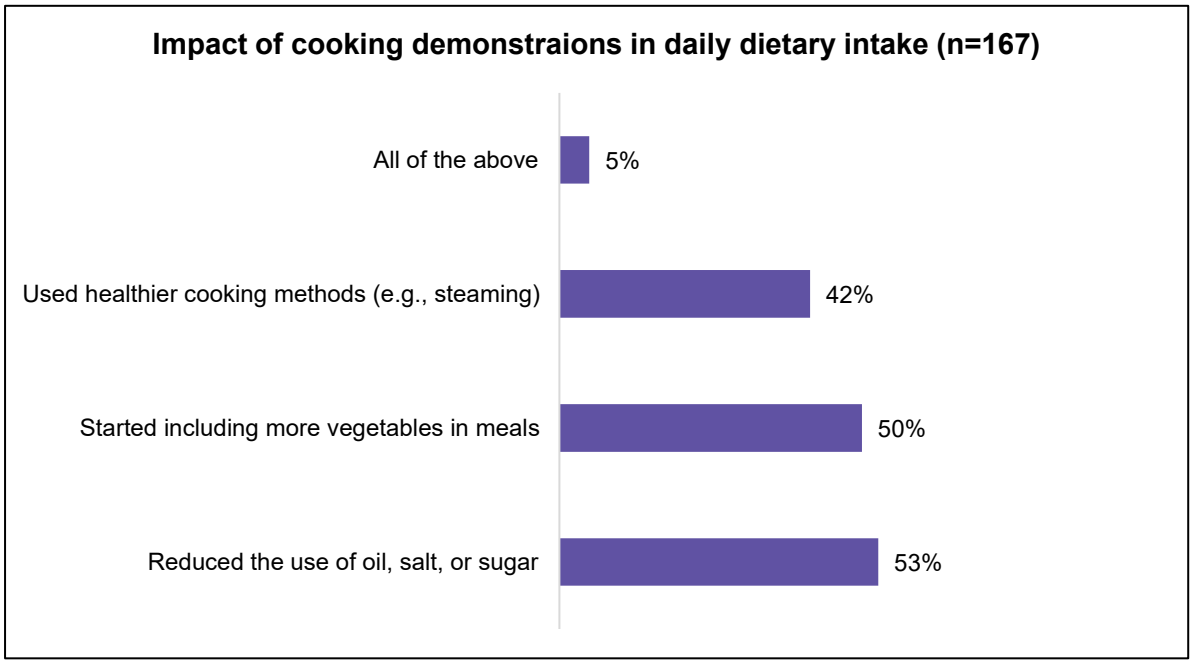


Figure 27: Impact of cooking demonstrations on daily dietary intake

healthy practices together, indicating full behavioural uptake among the beneficiaries. The findings show that cooking demonstrations were most effective in improving understanding of

balanced meals, with **60%** learning how to include rice, pulses, vegetables, and other food groups in their diet. An important reason for this is the usage of local ingredients and interactive demonstrations conducted by the Sanginis. Qualitative interactions suggest that while there have been improvements in nutrition outcomes and practices, men's involvement in sustaining these changes remains limited. Their role is largely confined to ensuring that food is available and rarely extends to decisions around what is cooked or how to prepare healthy meals. Many men are aware of the programme, largely due to the presence of Sanginis, but acknowledge that they are not actively part of discussions on nutrition. This limited engagement is often linked to deeply rooted gender norms that shape roles within the household.

f) Status of Nutri Gardens Post Intervention

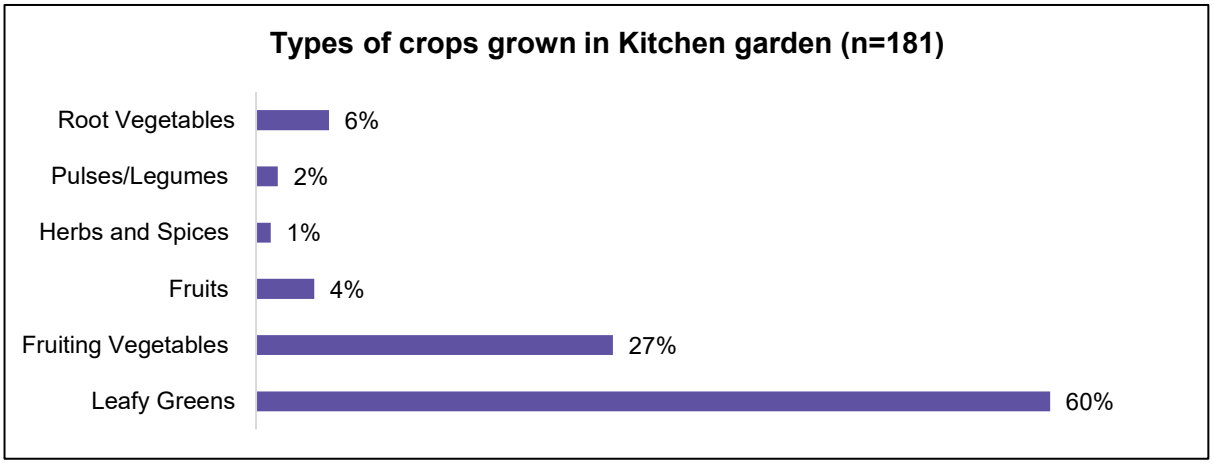


Figure 28: Types of crops grown in Kitchen gardens

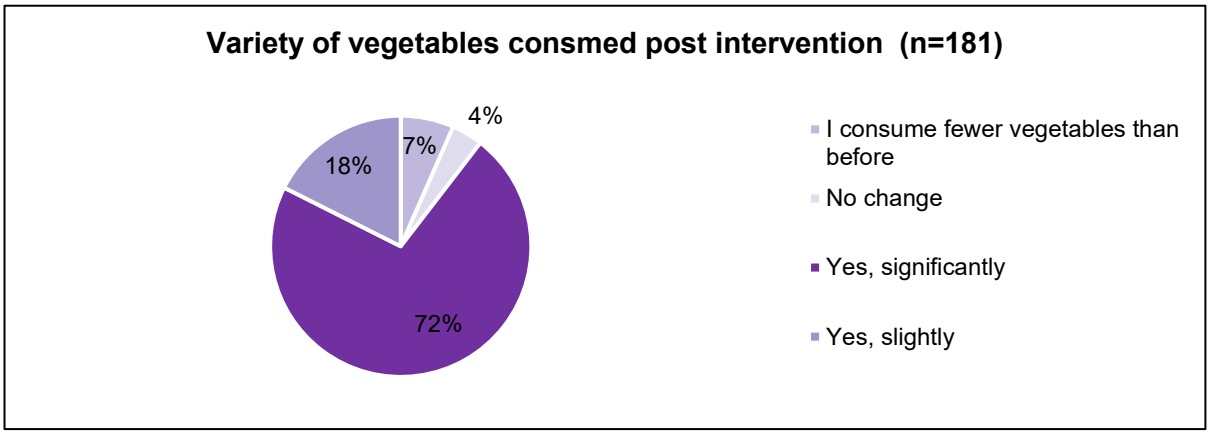


Figure 29: Variety of vegetables consumed post intervention

Kitchen gardens in households are mainly focused on **leafy greens (60%)**, showing a preference for easy-to-grow, daily-use vegetables. This is followed by **fruiting vegetables (27%)**, adding some variety to diets. Smaller proportions include **root vegetables (6%)**, fruits (4%), and **pulses/legumes (2%)**, while **herbs and spices (1%)** are rarely grown.

The findings indicate a strong positive impact of kitchen gardens on dietary diversity. A majority (**72%**) reported that the **variety of vegetables in their diet has increased significantly**, while another **18%** noted a **slight increase**, showing widespread improvement in vegetable consumption.

A small proportion reported **no change (4%)**, suggesting limited impact for a few households, while **6%** stated they now consume fewer vegetables than before, which may reflect inconsistent production or access issues.

Qualitative insights suggest that kitchen gardens were already an established practice in certain intervention areas, which was further strengthened through the establishment of gardens in Anganwadi centres. These gardens are maintained by Anganwadi workers and staff, who cultivate locally suitable greens and vegetables that are also used in daily cooking.

Under the SuPoshan programme, seeds were provided to support and enhance these kitchen garden activities. However, some beneficiaries noted that the timing of seed distribution was not always aligned with optimal growing conditions, particularly when provided during the summer season. They suggested that distribution just before the monsoon would be more effective in ensuring better germination and yield.

g) Status of WASH Practices Post Intervention

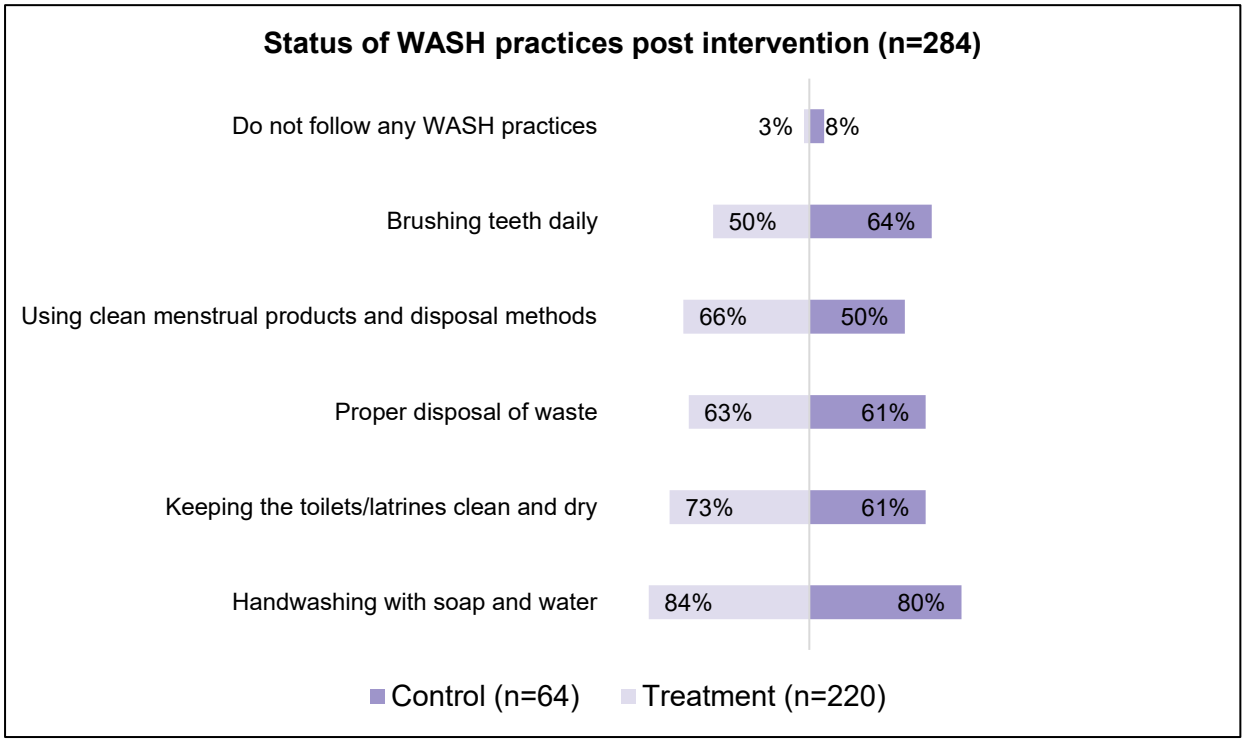


Figure 30: Status of WASH practices post intervention

The results show generally better WASH practices in the treatment group compared to the control group across most indicators. **Handwashing with soap (84% vs 80%)**, **clean toilets (73% vs 61%)**, **proper waste disposal (63% vs 61%)**, and **safe menstrual hygiene practices (66% vs 50%)** are all higher in intervention areas, indicating positive program influence. The proportion of people not following any WASH practices is lower in the treatment group (3% vs 8%), reflecting overall better hygiene adherence. The comparatively better adoption of hygiene practices may indicate that they are well- inculcated into people's daily routine.

h) Status of Menstrual Hygiene Practices followed by Women Post Intervention

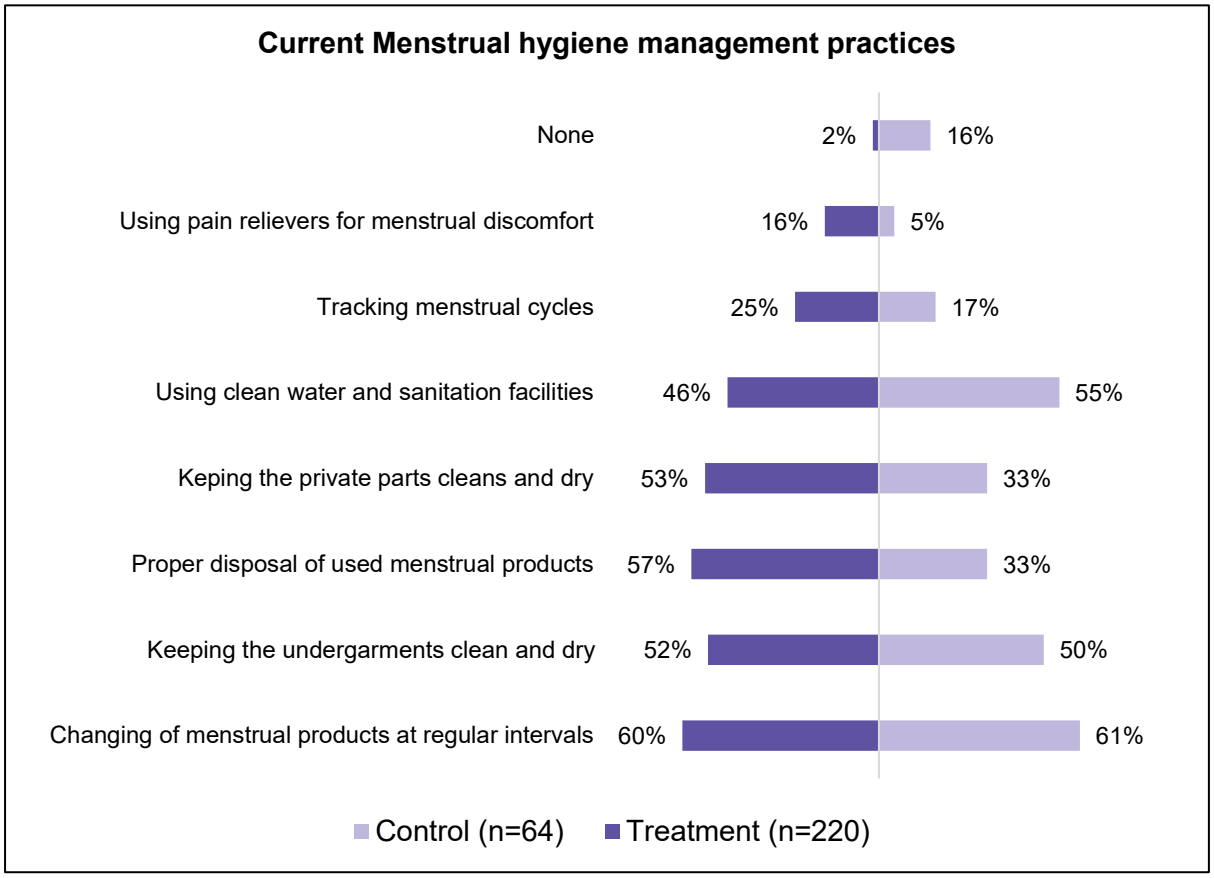


Figure 31: Current Menstrual Hygiene Management practices

The findings show overall better menstrual hygiene practices in the treatment group compared to the control group. **Women in the intervention areas demonstrated improved behaviours such as regular changing and proper disposal of menstrual products, better genital and personal hygiene, and greater self-management practices like cycle tracking and use of pain relief when needed**. Although use of clean water and sanitation facilities was slightly higher in the control group, the treatment group had a much lower proportion of respondents reporting no menstrual hygiene practices at all, indicating stronger overall adoption of safe and hygienic menstrual practices after the intervention.

This positive shift can be attributed to the consistent presence of Sanginis in the community and in the schools. **Their presence and guidance have helped adolescent girls and women to discuss menstruation and its effective management measures more freely without the stigma. Menstrual hygiene is also promoted by the free distribution of pads in the schools. In Vizhinjam, it was noted that menstrual cups are also distributed by AWW and ASHAs, which ensures a more sustainable management of menstrual hygiene**.

i) Sustained Health and Nutrition Outcomes from the Suposhan Sangini Programme

The findings indicate a strong positive impact of the intervention on community well-being, particularly in **maternal and child health (75%)**, which emerges as the most significant outcome. This improvement is closely linked to enhanced nutrition practices, better awareness, and strengthened service delivery at the community level. Half of the respondents also reported **reduced malnutrition (50%)**, reflecting improved dietary intake and behaviour change.

Gains in **diet diversification and health awareness (32% each)** further suggest that sustained behaviour change messaging has begun translating into everyday practices.

Additional impacts such as **women's empowerment, improved access to healthcare, and sustainable nutrition practices** highlight broader systemic and behavioural shifts enabled by community engagement and programme convergence. Though less pronounced, **strengthened community bonds (11%)** indicate some social cohesion effects.

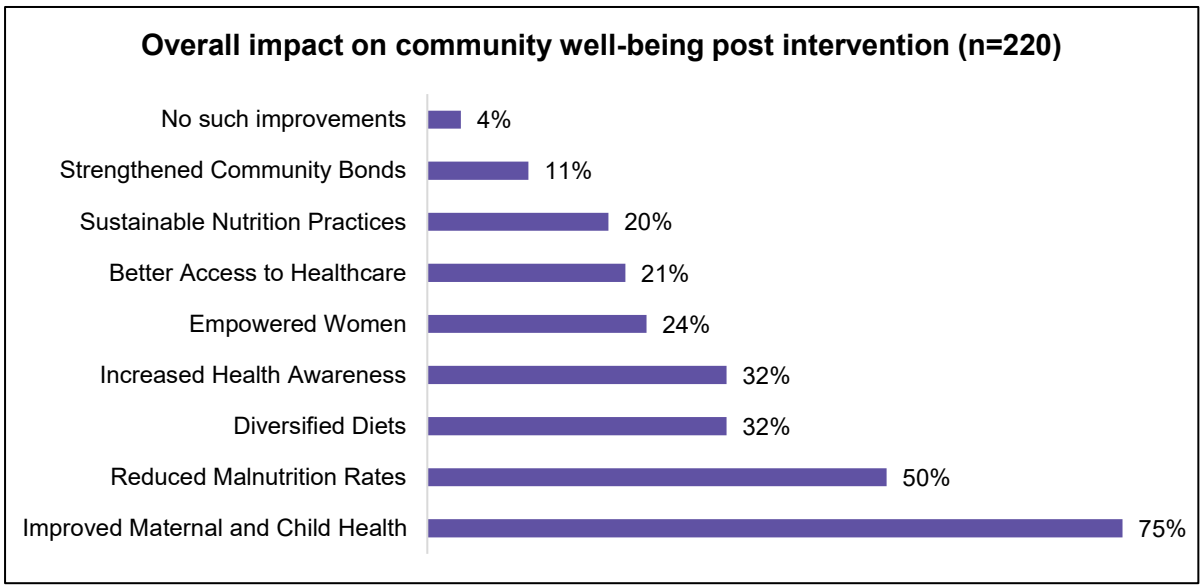


Figure 32: Overall impact on community well-being post intervention

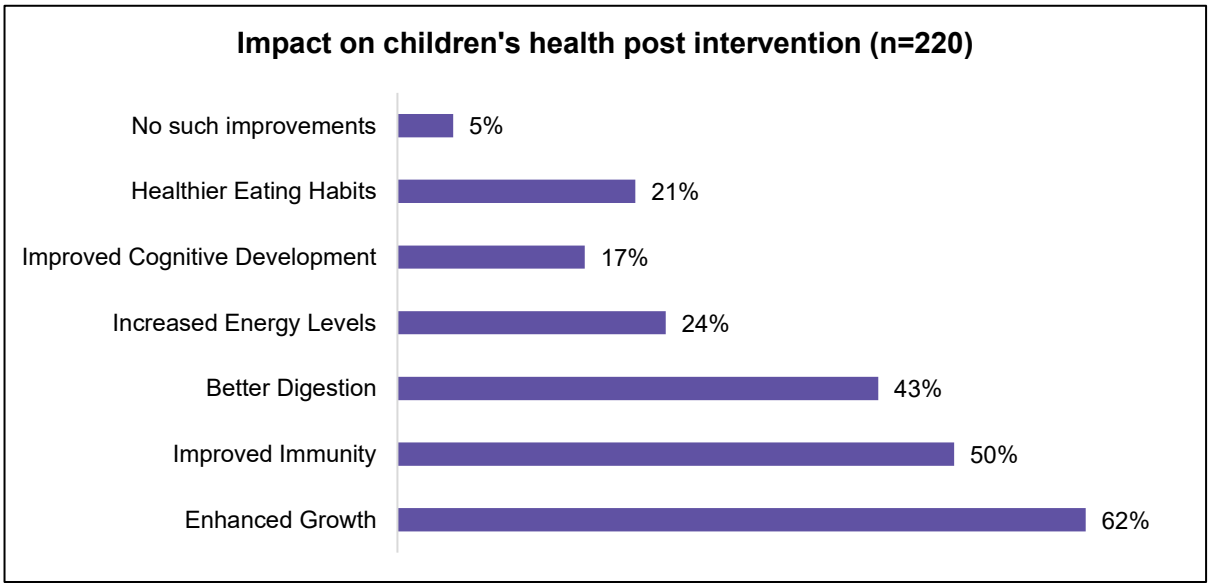


Figure 33: Perceived impact on children's health post intervention

The findings show a strong perceived improvement in child health and development outcomes following the intervention. The most prominent benefit reported is **enhanced growth (62%)**, indicating better overall nutritional status among children. This is followed by **improved immunity (50%)** and **better digestion (43%)**, suggesting that improved dietary intake and feeding practices have contributed to stronger health outcomes. Around one-fourth reported **increased energy levels (24%)** and **healthier eating habits (21%)**, reflecting positive changes in daily nutrition and activity. Additionally, **improved cognitive development (17%)** highlights early but important gains in developmental outcomes linked to better nutrition.

j) Diet Diversity of Women

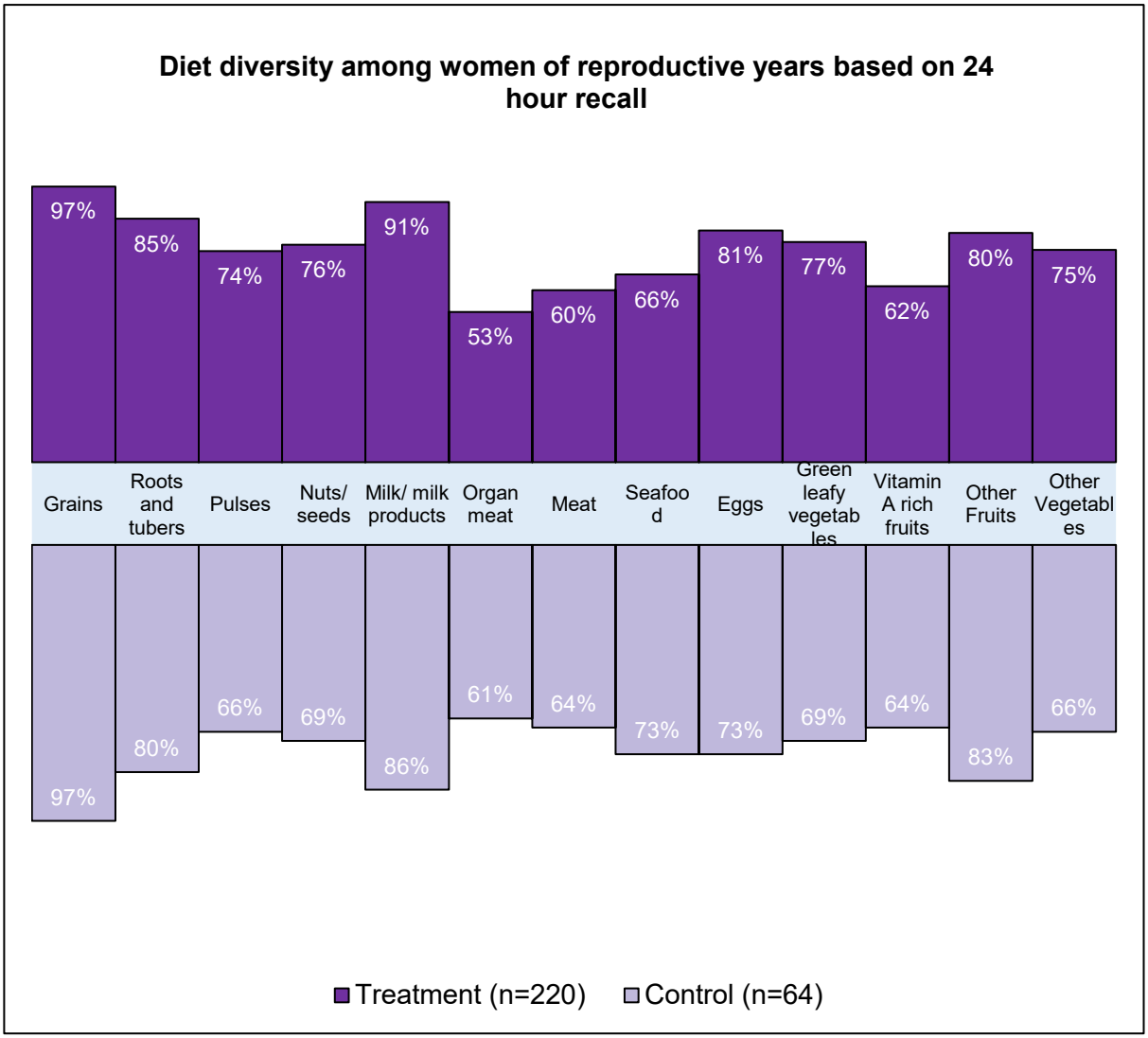


Figure 34: Diet diversity among women of reproductive age based on 24-hour recall

The findings from the 24-hour dietary recall indicate better dietary adequacy among women in the treatment group compared to the control group. A higher proportion of women in the intervention areas reported consuming an **adequate diet (95%)**, while only a small share had **inadequate intake (5%)**.

In comparison, although a majority in the control group also reported adequate diets, the proportion with **inadequate intake (17%)** is notably higher. This

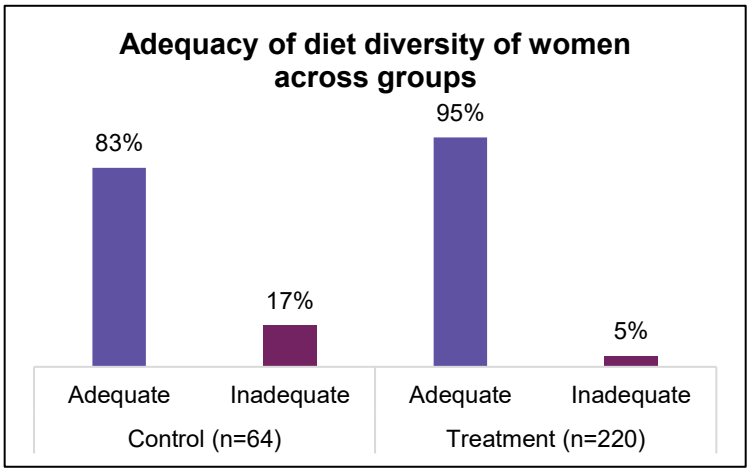


Figure 35: Percentage of women receiving an adequate diet based on 24-hour recall

suggests that the intervention has contributed to improving dietary quality and reducing nutritional gaps among women.

The findings indicate that women in the **treatment group show consistently higher dietary diversity** compared to the control group across most food groups. A greater proportion of women in the intervention areas consume a wider range of nutrient-rich foods, including pulses, animal-source foods, fruits, and vegetables, reflecting improved diet quality and better food choices.

Overall, the results suggest that the intervention has been effective in **promoting dietary diversification and improving nutritional adequacy**, likely driven by increased awareness and behaviour change perpetuated by consistent efforts of the Sanginis.

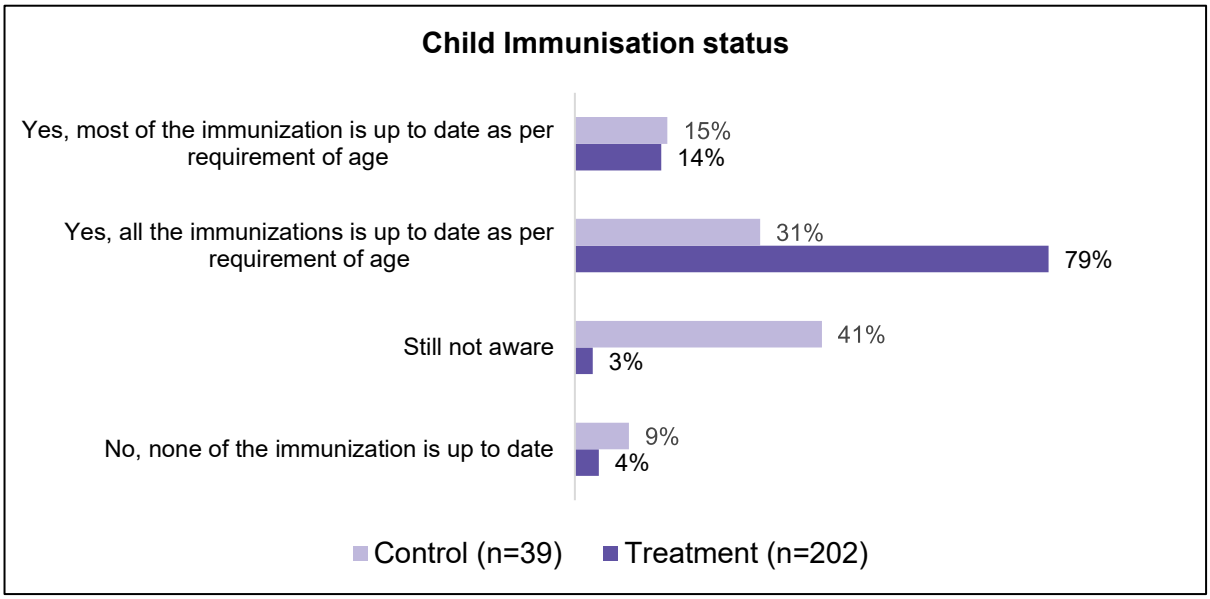


Figure 36: Child immunisation status across treatment and control groups

The findings indicate significantly better immunisation coverage in the treatment group, where most children are **fully immunised as per age (79%)**, compared to the control group (31%). Awareness is also much higher in the intervention areas, while the control group shows a large proportion of respondents who are still unaware of immunisation requirements. Overall, the intervention appears to have strengthened awareness among caregivers and translated it into higher completion of age-appropriate immunisation schedules, resulting in markedly improved full immunisation coverage in the treatment group compared to the control group.

Child Anthropometric measurements

Anthropometric measurements, such as height, weight, and mid-upper arm circumference (MUAC), are key indicators used to assess the nutritional status of children. For this Impact Assessment, these measurements were used to evaluate parameters including wasting, stunting, and underweight, which provide critical insights into the overall health and nutrition status of the population. In addition, the analysis also captures the presence of multiple anthropometric deficiencies among children. The table below presents the proportion of boys and girls aged 6–24 months who are moderately and severely underweight, wasted, and stunted. These

estimates have been calculated and presented in accordance with the WHO 2006 growth standards.

6m-2 years						
Category	**Boys**		**Girls**		**Total**	
	Treatment (n=55)	Control (n=11)	Treatment (n=56)	Control (n=14)	Treatment (n= 111)	Control (n=25)
Underweight						
Moderate	12.7%	18.2%	14.3%	0.0%	13.5%	8.0%
Severe	3.6%	9.1%	0.0%	7.1%	1.8%	8.0%
	WAZ				**-0.89±1.08**	**-1.07±1.01**
Stunting						
Moderate	18.2%	0.0%	14.3%	7.1%	16.2%	4.0%
Severe	18.2%	27.3%	12.5%	0.0%	15.3%	12.0%
	HAZ				**-1.08±1.78**	**-0.74±2.00**
Wasting						
Moderate	9.3%	0.0%	3.7%	14.3%	9.1%	8.0%
Severe	3.7%	0.0%	0.0%	7.1%	1.8%	4.0%
	WHZ				**-0.43±1.33**	**-0.74±2.00**

Table 8: CAM Measurements 6 months to 2-year-old children

In this particular age group, the prevalence of undernutrition shows mixed trends between treatment and control groups. Underweight levels are slightly higher in the treatment group overall, but severe underweight is notably lower compared to the control group, indicating some improvement in more critical cases.

Stunting remains a concern in both groups, with the treatment group showing higher moderate stunting but slightly lower severe stunting compared to the control, suggesting partial gains but persistent chronic undernutrition.

Wasting levels are broadly comparable, though severe wasting is lower in the treatment group.

Gender-wise, boys tend to show higher levels of severe forms of malnutrition, particularly stunting and underweight, while girls generally fare slightly better, though gaps are not very wide. Overall, the treatment group reflects some reduction in severity, even where prevalence remains similar or higher.

The table below presents the proportion of boys and girls aged 2-5 years who are moderately and severely underweight, wasted, and stunted. These estimates have been calculated and presented in accordance with the WHO 2006 growth standards.

2-5 years						
Category	**Boys**		**Girls**		**Total**	
	Treatment (n=49)	Control (n=22)	Treatment (n=82)	Control (n=20)	Treatment (n= 131)	Control (n=42)
Underweight						
Moderate	12.2%	4.5%	14.6%	20.0%	13.7%	11.9%
Severe	6.1%	0.0%	1.2%	5.0%	3.1%	2.4%

	WAZ				**-0.48±1.47**	**-0.43±1.49**
Stunting						
Moderate	12.2%	4.5%	17.3%	10.5%	15.4%	7.3%
Severe	16.3%	4.5%	1.2%	5.3%	6.9%	4.9%
	HAZ				**-0.69±1.70**	**-0.57±1.32**
Wasting						
Moderate	6.1%	0.0%	4.9%	5.0%	5.3%	2.4%
Severe	0.0%	0.0%	1.2%	5.0%	0.8%	2.4%
	WHZ				**-0.17±1.26**	**-0.04±1.21**

Table 9: CAM Measurement of 2-5 year-old children

For children aged 2–5 years, undernutrition patterns remain mixed between treatment and control groups. Underweight prevalence is broadly similar overall, though the treatment group shows slightly higher moderate cases, and comparable levels of severe underweight.

Stunting is higher in the treatment group, particularly moderate stunting, though severe stunting is only slightly higher overall, indicating continued challenges with chronic undernutrition.

Wasting levels are relatively low in both groups, with the treatment group showing slightly higher moderate wasting but lower severe wasting compared to the control.

Gender-wise, boys tend to have higher severe forms of malnutrition, especially stunting and underweight, while girls show relatively higher moderate undernutrition in some categories.

Compared to the 6 months–2 years age group, the severity of malnutrition appears to reduce slightly in older children, particularly for severe underweight and wasting. However, stunting continues to persist across both age groups, indicating long-term nutritional deficits that are not being fully addressed.

Multiple Anthropometric Deficits

6 months- 2years[11]						
Category	**Boys**		**Girls**		**Total**	
	Treatment (n=55)	Control (n=11)	Treatment (n=56)	Control (n=14)	Treatment (n= 111)	Control (n=25)
S+UW+W	0%	0%	0%	7%	0%	4%
S+UW-W	11%	18%	9%	0%	10%	8%
S+W-UW	0%	0%	0%	0%	0%	0%
W+UW-S	5%	0%	5%	0%	5%	0%
2-5 years						
Category	**Boys**		**Girls**		**Total**	
	Treatment (n=49)	Control (n=22)	Treatment (n=82)	Control (n=20)	Treatment (n= 131)	Control (n=42)
S+UW+W	6%	0%	0%	0%	2%	0%
S+UW-W	8%	5%	10%	15%	9%	10%
S+W-UW	0%	0%	0%	0%	0%	0%
W+UW-S	0%	0%	5%	5%	3%	2%

Table 10: Multiple Anthropometric deficits in children under 5 years

[11] S= Stunting
W= Wasting
UW= Underweight

For 6 months to 2 years, multiple deficiencies are relatively low overall. The most common combination is stunting with underweight (S+UW), seen in both groups, while the most severe combination (S+UW+W) is minimal and absent in the treatment group. Wasting with underweight (W+UW) appears only in the treatment group at low levels.

For 2–5 years, multiple deficiencies remain low but show a slight increase in combined forms within the treatment group. S+UW continues to be the most prevalent combination across both groups, while the most severe form (S+UW+W) is observed only in the treatment group at low levels.

Across both age groups, severe multiple deficiencies are limited, with a slight shift towards combined forms in older children. Gender differences are minimal, though girls show slightly higher combined deficiencies in some categories.

The graph illustrates a comparative analysis of child nutritional indicators in treatment areas against NFHS-4 & 5 data, highlighting progress across key dimensions of malnutrition.

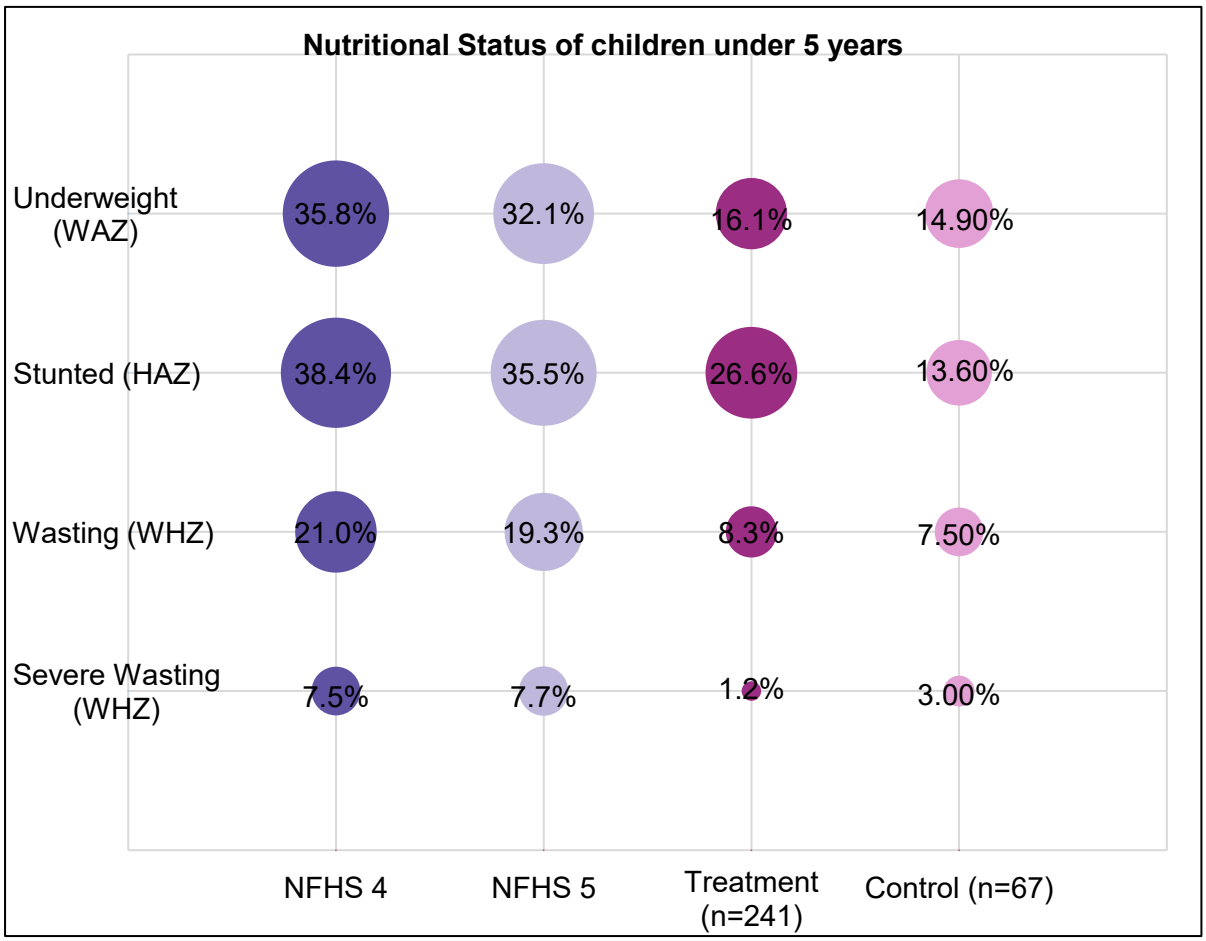


Figure 37: Comparative analysis of nutritional status of Children under 5 years with NFHS-5,4 and Control data

Indicator	NFHS-5 vs Treatment
Under-weight (WAZ)	Underweight prevalence is substantially lower in the treatment group (16.1%) compared to NFHS-5 (32.1%), indicating improved overall nutritional status, likely supported by better feeding practices and nutrition counselling.

Wasting (WHZ)	Wasting is significantly lower in the treatment group (8.3%) compared to NFHS-5 (19.3%), reflecting improvements in acute malnutrition, possibly due to timely identification, referrals, and nutrition support.
Severe Wasting (WHZ)	Severe wasting shows a sharp decline in the treatment group (1.2%) compared to NFHS-5 (7.7%), suggesting better management of critical cases through strengthened service linkages and awareness.
Stunting (HAZ)	Stunting has reduced in the treatment group (26.6%) compared to NFHS-5 (35.5%). This improvement may be attributed to sustained interventions such as IYCF sessions, improved infant and young child feeding practices, and counselling on nutrition and balanced diets, though it remains an area of concern due to its long-term nature.

Table 11: Comparison of NFHS 5 metrics with the treatment group

Image 1: Height measurement of a 2-5-year-old child

Image 2: Measurement of Mid-Upper Arm Circumference

Image 3: Length measurement of a 6-month- 2-year-old baby

Image 4: Weight measurement of a 2-5-year-old child in Vizhinjam

Image 5: Routine measurement of Height and weight of children in Tiruvallur (Image shared by Adani Team)

" We take the CAM measurements of children under 5 years, monthly. If the child has MAM/SAM, we take measurements twice a month. Since we go house-to-house every time, the AWW also gets the measurement details from us whenever they're busy with other work.

- SuPoshan Sangini, Nellore

3.1.4. Convergence

This section examines the level of coordination and collaboration with government systems and other stakeholders. It highlights the effectiveness of partnerships in enhancing programme reach and impact.

National Priorities:

PM POSHAN

NATIONAL FOOD SECURITY
My Ration - My Right

Integrated Child Development Services

SDG Alignment:

"The programme aligns well with existing government nutrition and child welfare schemes, as it complements ongoing efforts and supports similar objectives related to maternal and child health. The collaboration efforts of Sanginis and AWW are more practical than structural. It would be better if was more structured with defined roles."

- CDPO, Athiyannur Block, Vizhinjam

"The SuPoshan Sangini programme is not just aligned with government schemes but strongly supports implementation at the grassroots level. It has helped Anganwadi centres improve awareness among women, children, and even men. Regular monitoring through weekly visits ensures proper tracking, and we are seeing positive changes in participation and nutrition awareness. The programme has strengthened our existing system and made community engagement more effective."

- CDPO, Mangalore

Convergence with Anganwadi Services (ICDS):

The programme complements Anganwadi services by enhancing awareness among beneficiaries and strengthening the utilisation of available nutrition and maternal health services.

Convergence with PHCs/CHCs:

Strong linkages with public health systems enabled timely referrals and increased access to antenatal and maternal healthcare services.

Convergence with NRCs:

Improved coordination with NRCs facilitated early identification and referral of malnourished children, supporting better recovery outcomes.

3.1.5. Service Delivery

This section examines how well the programme's implementation processes function, with a focus on the timeliness, quality, and cost-effectiveness of service delivery.

50% of respondents stated that sanginis visit their household twice a month

78% of women reported the session on nutrion and balanced diet as excellent and highly informative

79% of women stated the session on IYCF practices as "excellent and highly informative

71% of women reported that their child has been screened for one-three times and 22% stated that they were screeened more than thrice in last three months

a) House visits by Sanginis

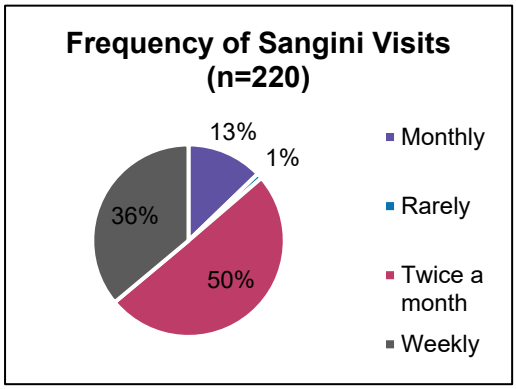
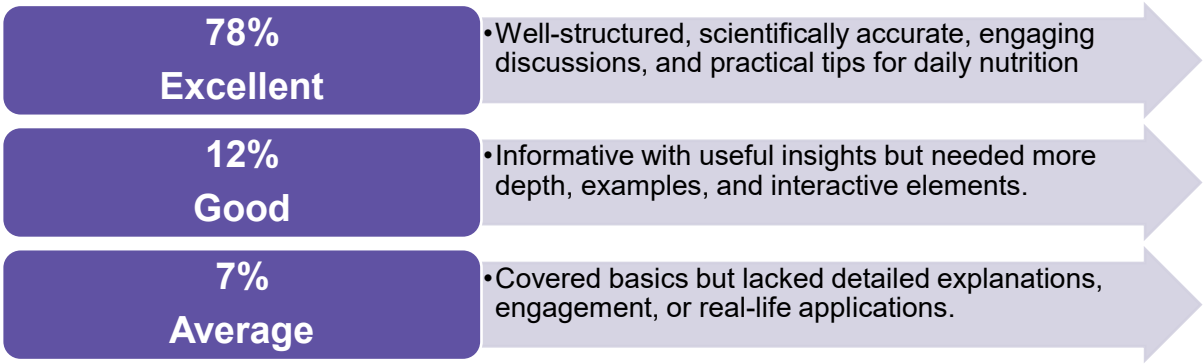


Figure 38: Frequency of Sangini visits

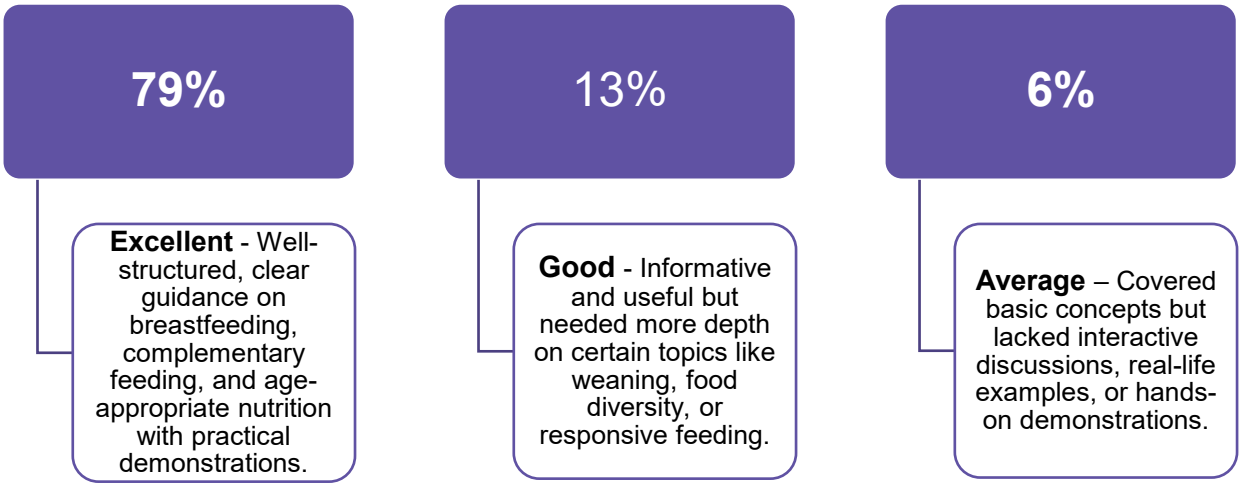
Most respondents reported regular engagement with Sangini, with **visits primarily occurring twice a month (50%) or weekly (36%), while only a very small proportion mentioned that visits were rare (1%),** indicating consistent programme outreach.

b) Women's Rating Session on Nutrition and Balanced Diet



The feedback indicates a high level of satisfaction with the nutrition and balanced diet sessions, with a large majority rating them **as excellent (78%) and a smaller share as good (12%).** This suggests that the sessions are perceived as clear, practical, and easy to apply in daily life. A limited proportion rated them as average or below, indicating some scope for making sessions more interactive or detailed. Overall, the strong positive feedback reflects the effectiveness of Sanginis in improving nutrition awareness and enabling women to adopt better dietary practices.

c) Rating of Sessions on IYCF Practices



The feedback indicates high satisfaction with IYCF (Infant and Young Child Feeding) sessions, with a large majority rating them as excellent (79%) and a smaller share as good (13%). This suggests that the sessions are clear, well-structured, and provide practical guidance on key practices such as breastfeeding and complementary feeding. Only a small proportion rated them as average or below, indicating limited areas for improvement.

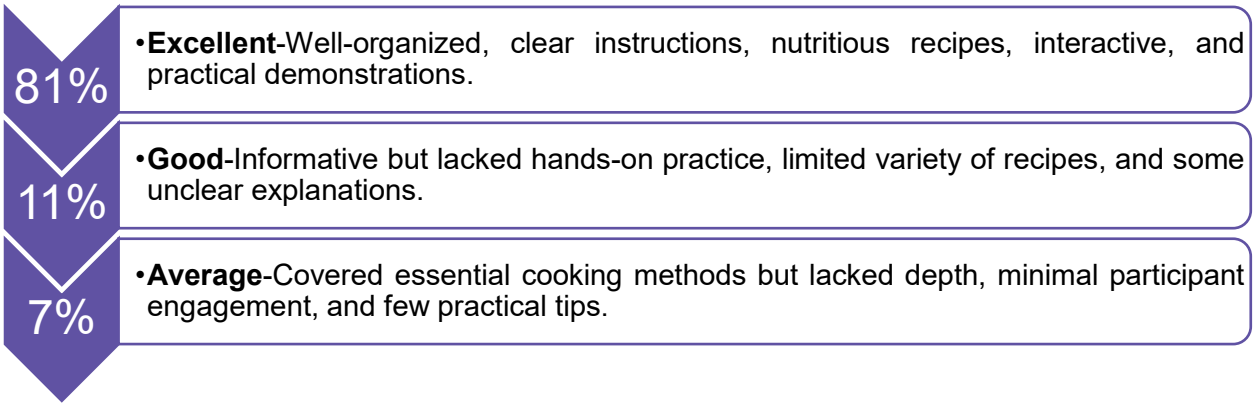
This shows that the sessions appear to be delivered effectively, with Sanginis able to communicate key messages in a way that supports understanding and real-life application.

d) Frequency of Screening by Sanginis

These findings show that Sanginis are actively supporting regular growth monitoring of children. Most children have been screened between one and three times in recent months, with a notable share screened more frequently, indicating that caregivers are aware of the importance of tracking indicators like height, weight, MUAC, and oedema to assess nutritional status.

This regular screening points to the role of Sanginis in encouraging early identification of malnutrition. Their follow-up support through counselling and referrals also seems to be helping in improving child health and nutrition outcomes at the community level.

e) Women Rating Cooking Demonstrations by Sanginis



The feedback shows strong satisfaction with the cooking demonstrations, with most respondents rating them as excellent and engaging (81%), and a smaller share as good but with scope to improve (11%). Only a very small proportion rated them as average or below, indicating that the sessions are generally well received.

Women shared that the demonstrations are easy to follow and useful for preparing nutritious meals using locally available ingredients. Many have started applying these practices at home, though some expressed a need for more hands-on practice and a wider variety of recipes to make the sessions more engaging.

> ***"Before the demonstration, I had no idea that millets can be used to make so many nutritional foods. They taught us a lot of recipes that we could make easily for our children, and they are healthy too."***
>
> ***- 34-year-old beneficiary of cooking demonstration classes***

3.1.6. Sustainability

This section assesses the sustainability of the programme by assessing the likelihood of benefits continuing beyond the intervention period. It focuses on aspects such as community ownership, capacity building, and the extent to which positive practices can be sustained over time.

68% of women reported following the recipes learned during demonstrations regularly and sharing them with others

54% of women stated that the programme and the Sanginis are actively supported in the community with 16% stating growing support.

a) Sustainability of Recipes taught during Cooking Demonstrations

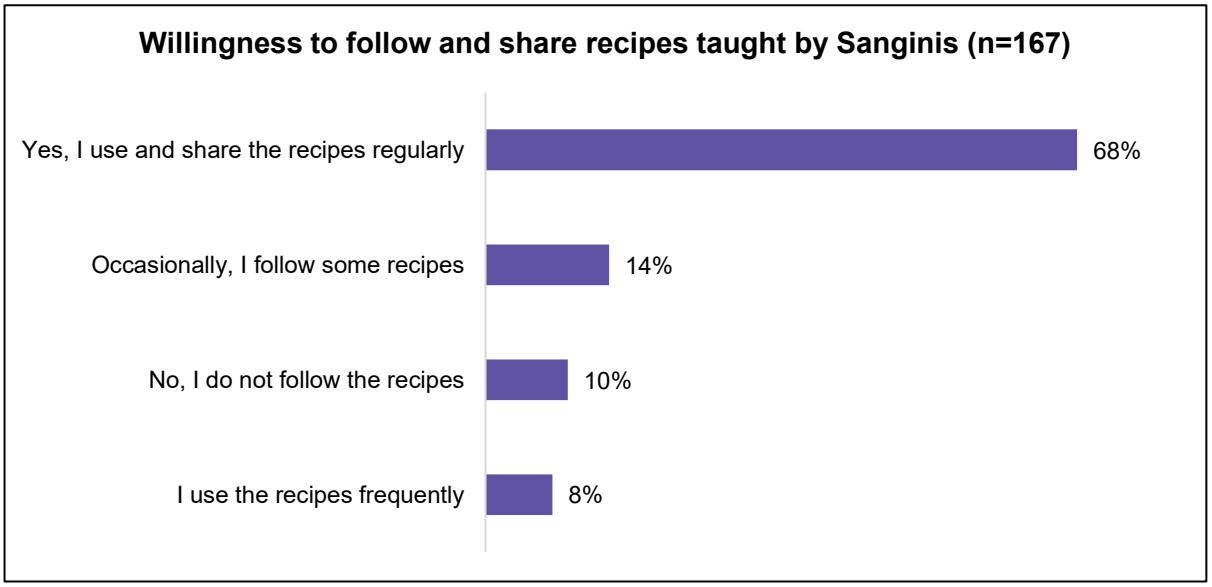


Figure 39: Willingness to share and follow recipes taught by Sanginis

The findings show a strong level of adoption of the recipes taught during cooking demonstrations, with a majority of women (68%) reporting that they regularly use and share them within their households and communities. A smaller proportion follow them occasionally (14%), while 10% do not adopt them at all, and a small share use them frequently but not consistently (8%).

This continued use can be linked to how the demonstrations were delivered; most women had rated them as highly engaging and practical (81%), which made the recipes easy to understand and replicate. Women also highlighted that the use of locally available ingredients makes it convenient to incorporate these practices into daily cooking. At the same time, some felt that adding more variety and hands-on practice could further strengthen long-term adoption.

b) Sharing of knowledge and seeds for the kitchen garden

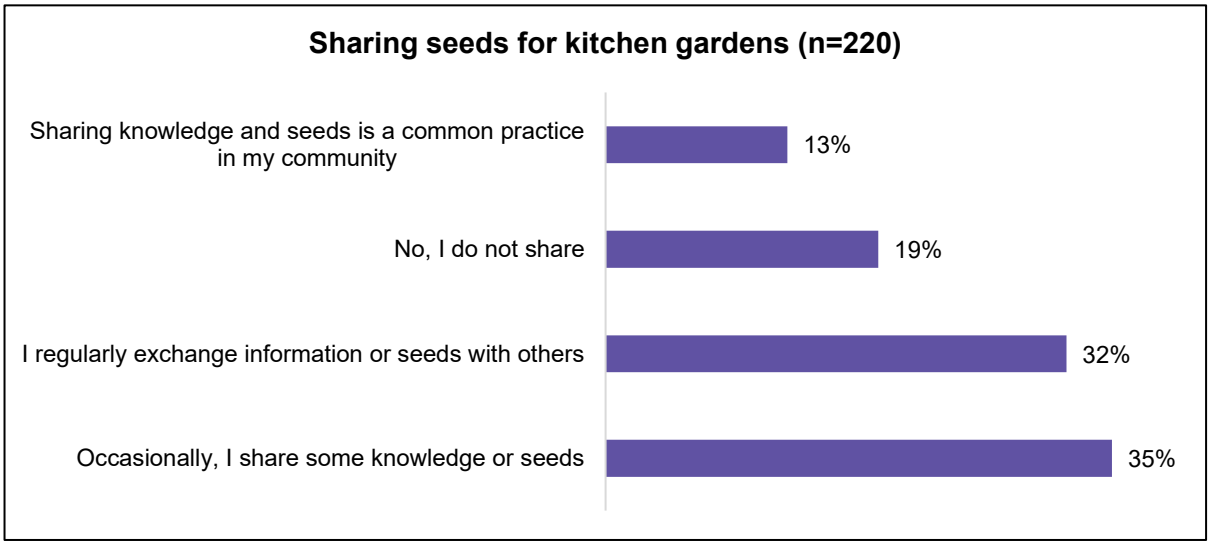


Figure 40: Sharing seeds and knowledge to improve kitchen garden

The findings show positive sharing practices around kitchen gardens, with a majority of respondents either occasionally or regularly sharing seeds and knowledge. A smaller share reported no sharing, while some already consider it a common community practice.

Qualitative insights further reinforce this trend, with respondents mentioning that they often **share surplus fruits and vegetables from their kitchen gardens with neighbours and other households**, strengthening informal support systems. Overall, the results highlight growing collaboration and community-level knowledge sharing that supports the sustainability of kitchen gardening practices.

Image 6: Kitchen Garden installed in Anganwadi Centres in Tiruvallur

"If not for the soil, we would regularly grow our own vegetables. The soil is too salty, and new plants do not grow that easily. Despite that, if we have an excess of some vegetables or fruits in our garden, we do share them with our neighbours."

- 60-year-old resident of a village about the kitchen garden

c) *Extent of Community Support to the Interventions*

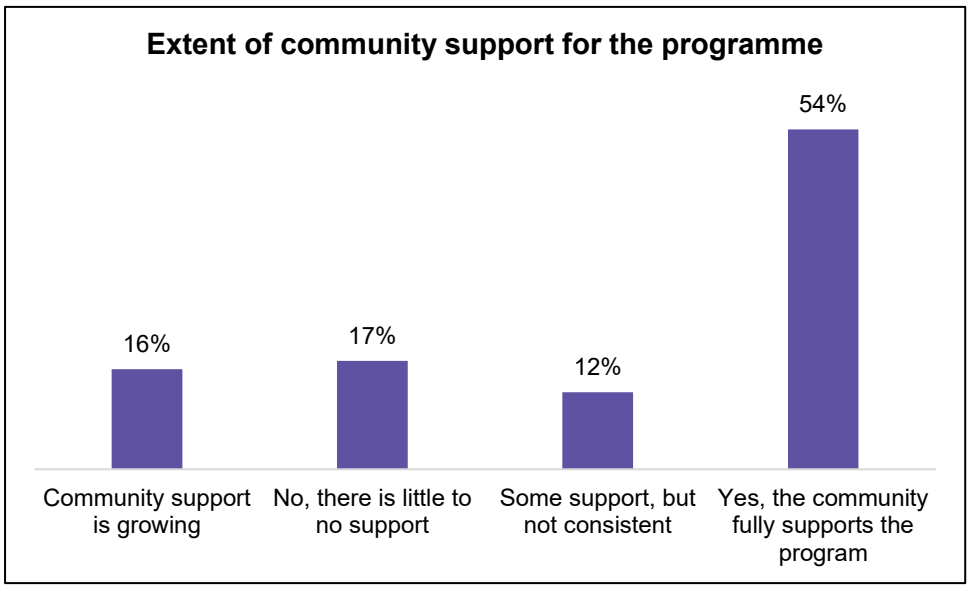


Figure 41: Extent of community support for the programme

The findings indicate a generally positive level of community support**, with 54% of respondents stating that the community fully supports the programme and 16% noting that support is growing. However, 12% reported that support is inconsistent, and 17% felt there is little to no support**.

This overall positive trend can be attributed to the regular presence of Sanginis in the community and their continued engagement with beneficiaries. Their coordination with existing community structures has also helped improve access to services, contributing to stronger acceptance and support over time.

Image 7: Field Interaction with AWW and VHN

3.2. Adolescents

3.2.1. Inclusiveness

Daily wage labour is the primary occupation for 80% **of respondent households**

60% of the adoloscent girls are from OBC Category, 21% from SC and 14% from St categories

40% of adoloscent girls are between 14-16 years age

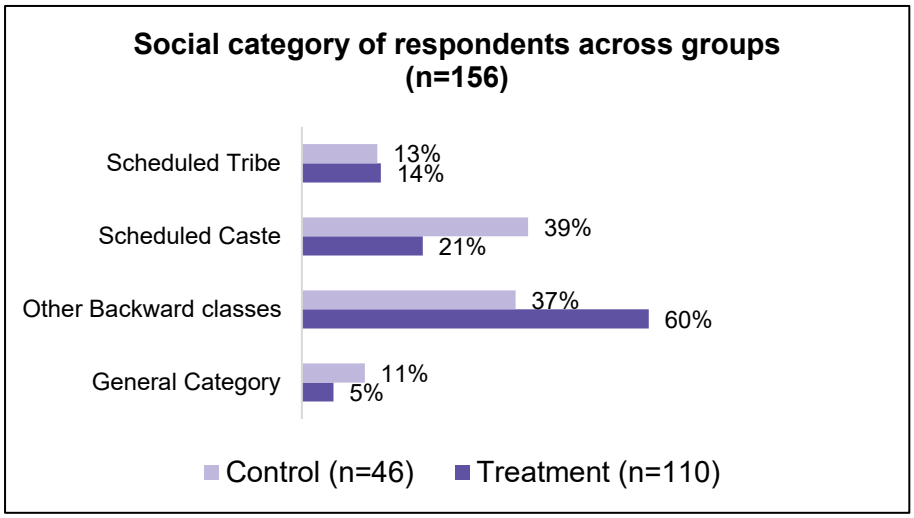


Figure 42: Social category of respondents across groups

The social category distribution shows that a majority of adolescent girls in the treatment group belong to **Other Backwards Classes (60%), followed by Scheduled Castes (21%) and Scheduled Tribes (14%)**, with a smaller share from the General category (5%).

In the control group, the distribution is more skewed towards Scheduled Castes (39%) and Other Backwards Classes (37%), with a slightly higher representation from the General category (11%) and similar representation of Scheduled Tribes (13%). These findings suggest that the programme appears to have strong reach among socially disadvantaged groups, particularly OBC and SC communities, indicating its focus on vulnerable populations.

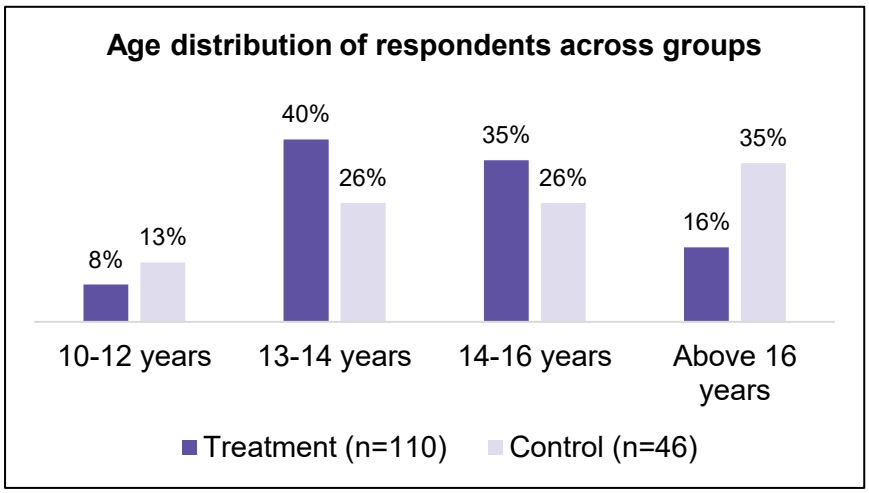


Figure 43: Age distribution of respondents across treatment and control villages

Most adolescent girls in the treatment group fall in the 13–16 years age range, who are the key target for health and nutrition projects, while the control group has a higher share of older adolescents (above 16 years). Younger ages

are represented in both groups.

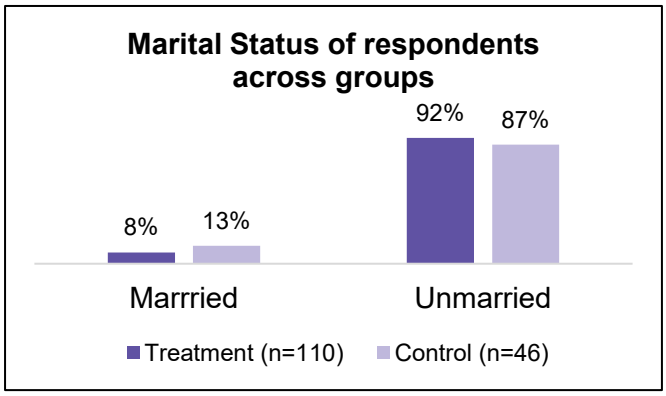


Figure 44: Marital Status of adolescent girls

Most adolescent girls in both groups are unmarried (92% in treatment and 87% in control), with a small proportion already married. The presence of **early marriages, though limited, reflects local socio-economic realities**. Field observations suggest that in some areas, despite job insecurity and vulnerability, young people elope and get married at an early age. This compounded vulnerability often means that girls enter pregnancy while already malnourished, which in turn increases the risk of poor nutritional outcomes for their children as well.

The findings show that a large majority of adolescent girls are currently **attending school (85%), indicating good levels of continued education. A small proportion have completed their education (9%), while only 7% are not attending school**.

This suggests relatively strong school retention among girls, though the presence of dropouts and early completion highlights the need to address factors that may limit continued education.

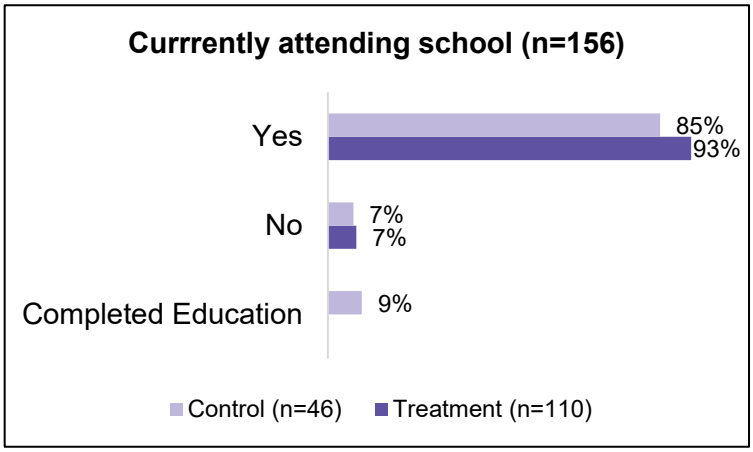


Figure 45: Currently attending school

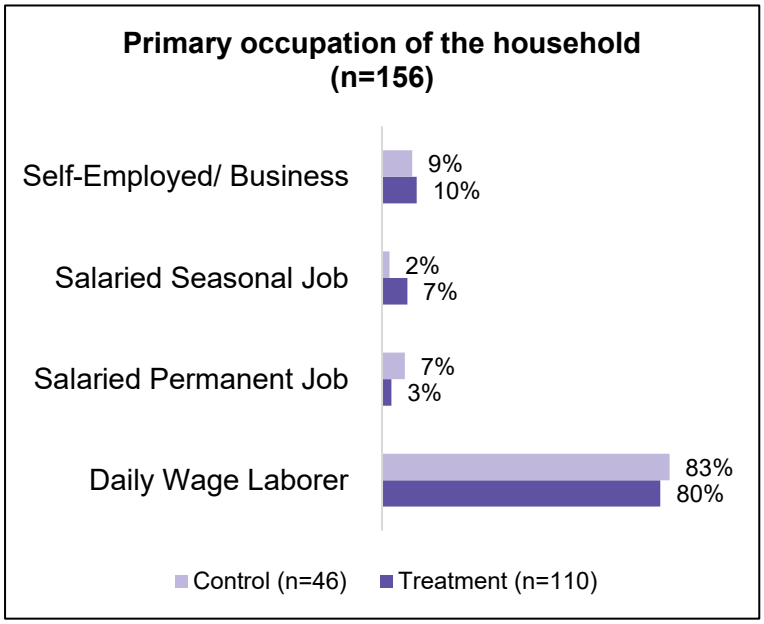


Figure 46: Primary occupation of the households

Most households in both groups rely on daily wage labour (80% in treatment and 83% in control), indicating a high dependence on informal and unstable income sources. Other forms of employment, such as salaried jobs and self-employment, remain limited across both groups.

3.2.2. Relevance

Around 44% of respondents had only moderate knowledge about nutrition

For many adolescent girls, menstruation was not well understood before their first experience, reflecting gaps in early awareness

a) Prior knowledge of Nutrition and Balanced Diet

The findings suggest that prior knowledge about nutrition among respondents is generally mixed, with **a large proportion reporting only moderate understanding. While a small segment reflects good to very good awareness**, a significant share also reports poor or very poor prior knowledge, indicating substantial gaps in baseline nutrition awareness. This highlights that many adolescent girls entered the programme with a limited or uneven understanding of nutrition. This reinforces how the SuPoshan intervention is helping to address these foundational knowledge gaps through structured awareness and education sessions delivered by Sanginis.

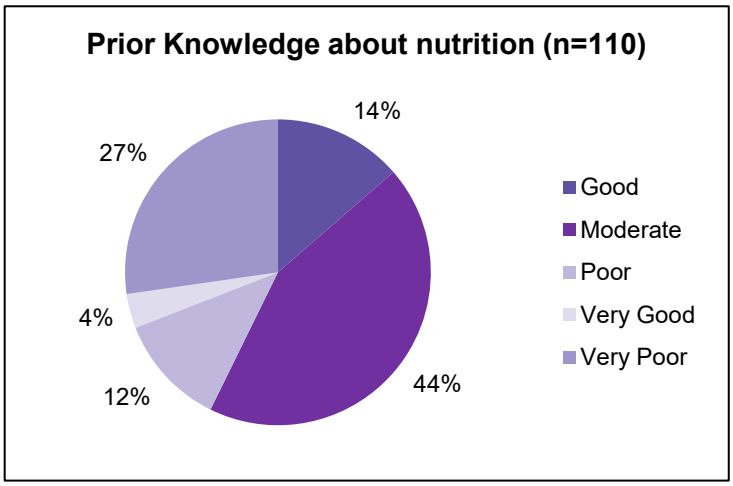


Figure 47: Prior knowledge about nutrition

The findings indicate that prior to the intervention, **half of the adolescent girls had not received any nutritional guidance, reflecting a significant gap in formal awareness of healthy eating practices**. Among those who had received information, guidance was more commonly informal, primarily from friends and family, while a smaller proportion had access to advice from healthcare professionals.

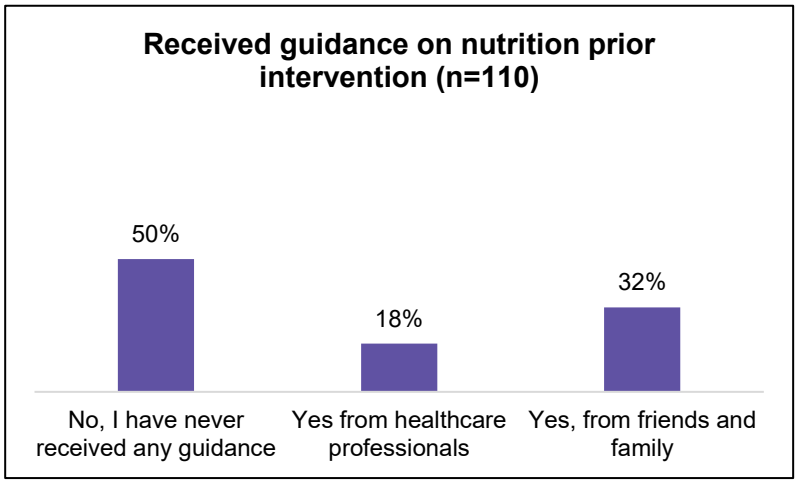


Figure 48: Received nutritional guidance prior to intervention

b) Knowledge and Awareness about Menstruation Pre-Intervention

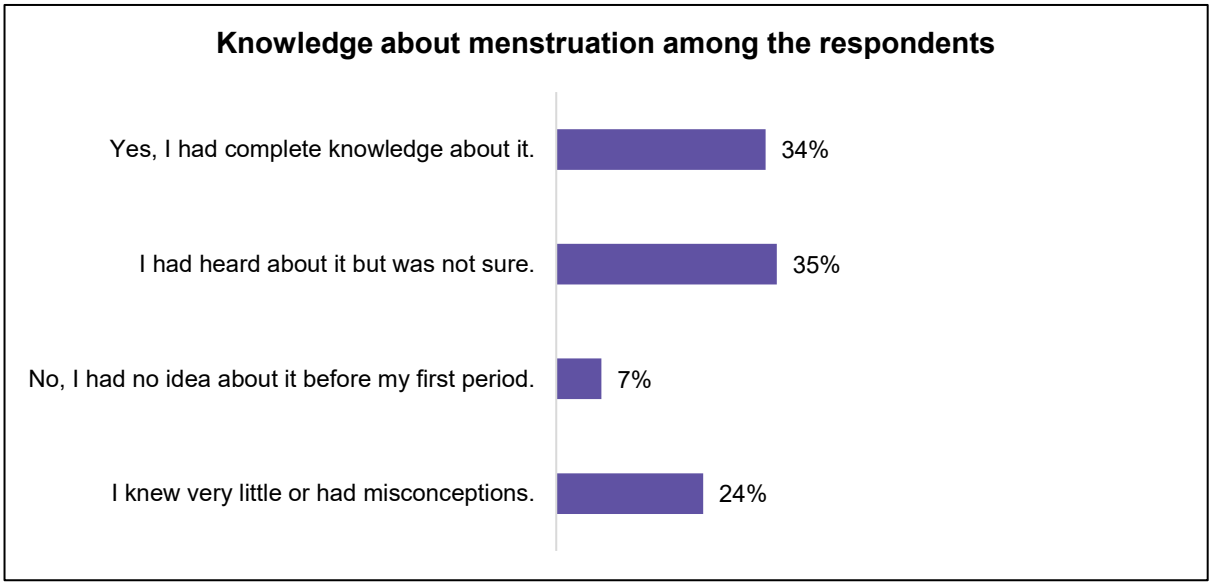


Figure 49: Knowledge about menstruation pre-intervention

The findings show that prior to the intervention, knowledge about menstruation among adolescent girls was uneven. **While a portion reported having complete awareness (34%), a similar proportion had only partial understanding or uncertainty (35%), and some had very limited knowledge (7%) or misconceptions before menarche (24%)**. This reflects that many girls entered adolescence without adequate or accurate information on menstruation, highlighting the importance of early awareness-building.

3.2.3. Effectiveness

74% of adolescent girls reported accessing services including iron and folic acid (IFA) supplementation

70% of girls reported practice of changing menstrual products at regular intervals

67% of respondents demonstrated improved awareness of healthy dietary practices as well as menstrual hygiene management practices

49% of adolescent girls are regularly involved in physical activities, indicating improved adoption of healthy lifestyle practices

a) Services Availed for Adolescent Wellbeing Post Intervention

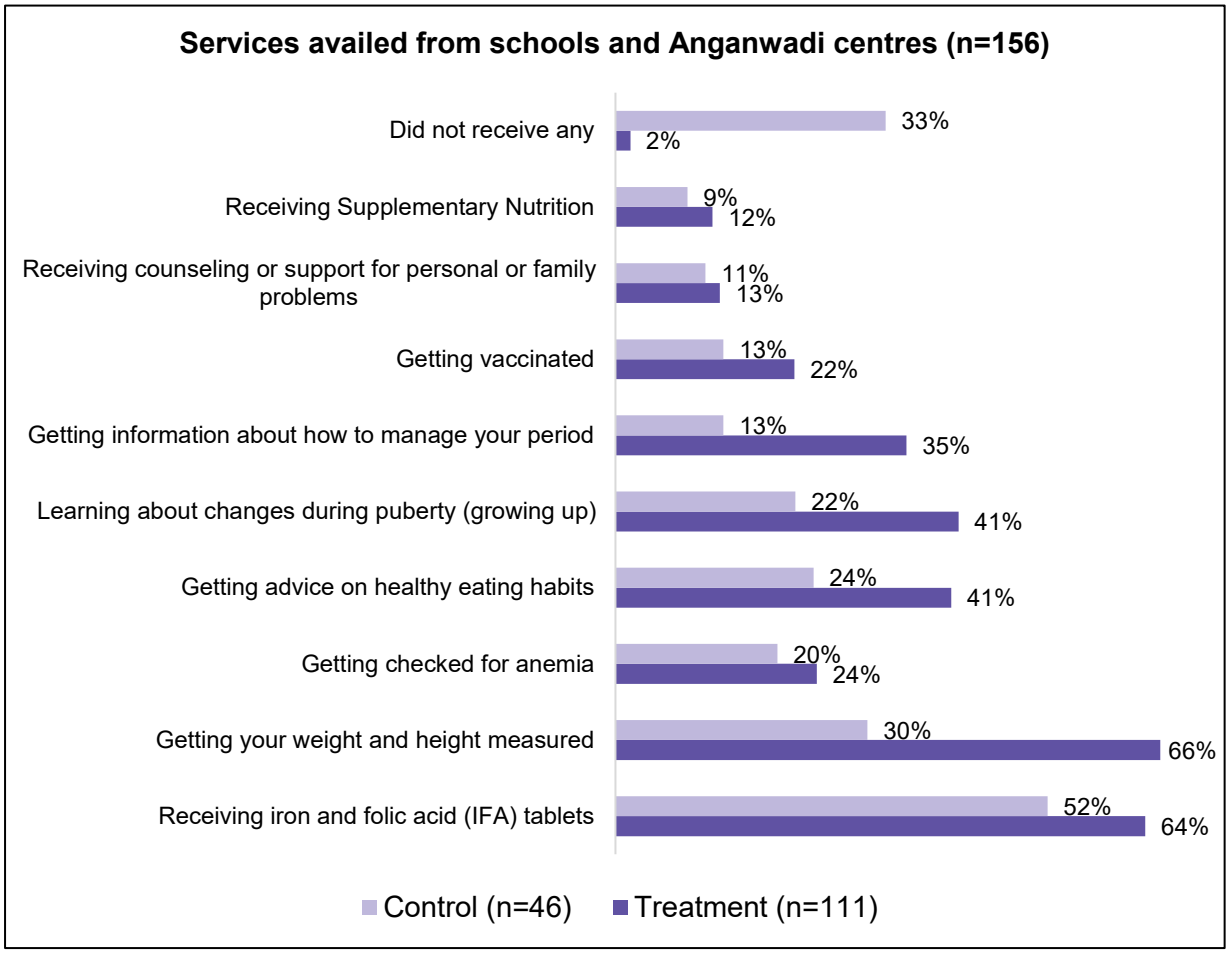


Figure 50: Services availed from schools and Anganwadi centres

Utilisation of Anganwadi services is consistently higher in the treatment group across most indicators, especially for IFA distribution (64% vs. 52%) and growth monitoring (66% vs. 30%). Awareness-related services such as nutrition advice, puberty, and menstrual health education are also notably higher.

This improved uptake can be linked to Sangini's efforts in the intervention areas, which have strengthened awareness and encouraged adolescents to access available services. In contrast, a significant share in the control group reported not receiving any services (33% vs. 2%), highlighting gaps in outreach.

b) Menstrual Hygiene Practice Followed Post Intervention

The findings show relatively strong adoption of basic menstrual hygiene practices among the treatment group, with **70% reporting regular changing of menstrual products,** 59% proper disposal, 58% clean and dry undergarments, and 53% use of clean water and sanitation facilities. However, more advanced practices remain limited, such as tracking menstrual cycles (32%) and use of pain relief methods (6%), with only 3% following all recommended practices.

The observed improvements in basic hygiene behaviours can be attributed to the awareness and educational sessions conducted under the SuPoshan programme. Regular engagement by SuPoshan Sanginis helped strengthen knowledge, address misconceptions, and promote practical adoption of key menstrual hygiene practices at the household and community level.

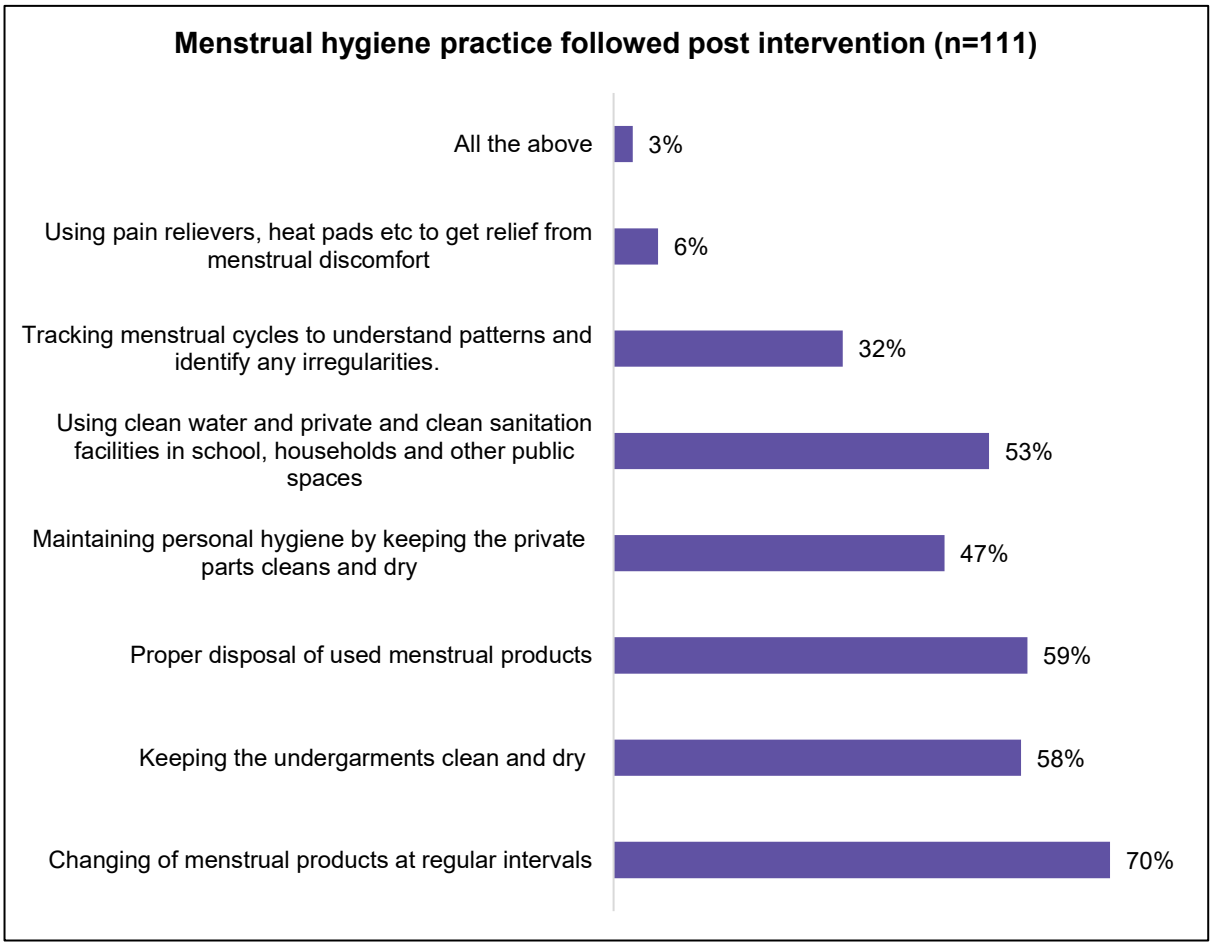


Figure 51: Menstrual Hygiene practices followed post-intervention

c) Extent of Engagement in Physical Activities

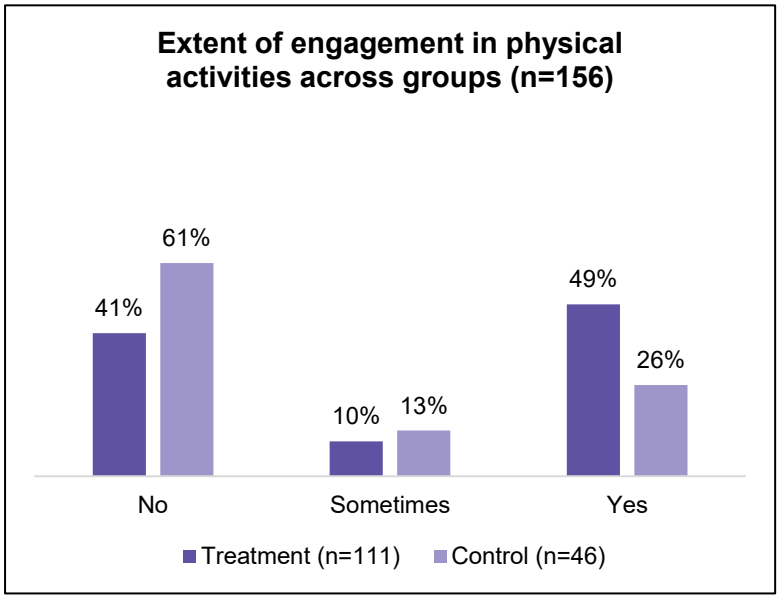


Figure 52: Extent of engagement in physical activities across groups

Among adolescent girls, the treatment group shows higher engagement in physical activities compared to the control group, **with 49% reporting regular participation**. In contrast, **non-engagement is notably higher in the control group (61%) than in the treatment group (41%), while occasional participation remains similar across both groups**. This suggests improved self-awareness and a positive shift towards healthier behaviours among adolescent girls in the treatment areas. The gains can be attributed to the SuPoshan programme's

sustained awareness sessions and regular engagement by SuPoshan Sanginis, which have encouraged girls to be more conscious of their health and actively participate in physical activities as part of a healthier lifestyle.

> ***"Whenever we conduct classes for adolescent girls, we advise them about the importance of physical activity and not to eat too much junk food. They have changed a little. Since the majority of them have irregular periods, it becomes important to teach them the importance of a healthy diet and exercise"***
>
> ***- 36-year-old Sangini Tlruvallur***

d) Impact on Personal Life of Adolescent Girls after the intervention

The findings indicate a strong perceived impact of the SuPoshan programme among adolescent girls, particularly in **improved knowledge about healthy eating and nutrition (67%) and menstrual hygiene management (67%).** Half of the respondents (50%) also reported improved dietary habits, while 41% noted increased awareness about anaemia and its prevention. Lower but meaningful proportions reported greater confidence in health-related decision-making (32%), awareness of physical activity (23%), and understanding of maternal and child health (17%). Only a very small proportion (2%) reported no noticeable changes.

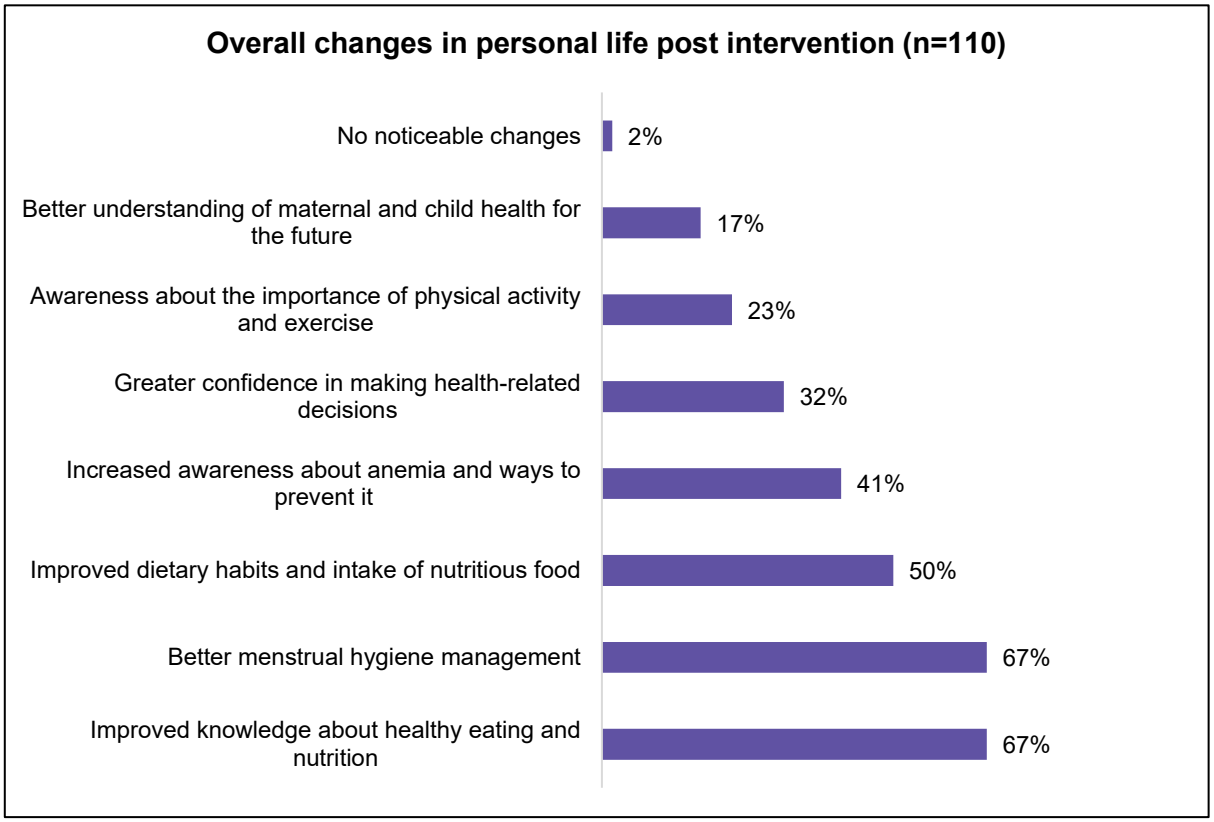


Figure 53: Overall changes in personal life post-intervention

These outcomes reflect the positive influence of sustained awareness and behaviour change interventions under the SuPoshan programme.

3.2.4. Convergence

This section examines the level of coordination and collaboration with government systems and other stakeholders. It highlights the effectiveness of partnerships in enhancing programme reach and impact.

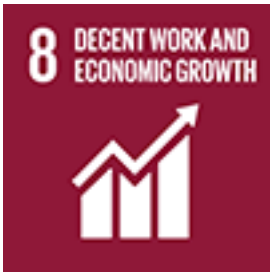
National Priorities:

PM POSHAN

NATIONAL FOOD SECURITY – My Ration - My Right

Integrated Child Development Services

SDG Alignment:



Collaboration with ICDS	Sanginis worked closely with Anganwadi Centres to support outreach and engagement of adolescent girls and women. During sessions and community events, Anganwadi workers played an active role in mobilising beneficiaries, facilitating participation, and strengthening access to nutrition and health services.
Collaboration with PHCs/CHCs	•In cases of health concerns such as anaemia and menstrual health issues, Sanginis guided beneficiaries to nearby health facilities for timely check-ups and treatment. Health professionals also supported awareness sessions on adolescent health, reproductive health, and nutrition, ensuring improved access to essential healthcare services.

3.2.5. Service Delivery

69% of adolescent girls rated sessions on balanced diet and nutrition as excellent or good, highlighting them as highly informative	**43% of respondents** reported that Sanginis visit their households weekly	Girls shared that the sessions helped them better understand balanced diets and encouraged healthier daily food choices

a) Frequency of Household Visits

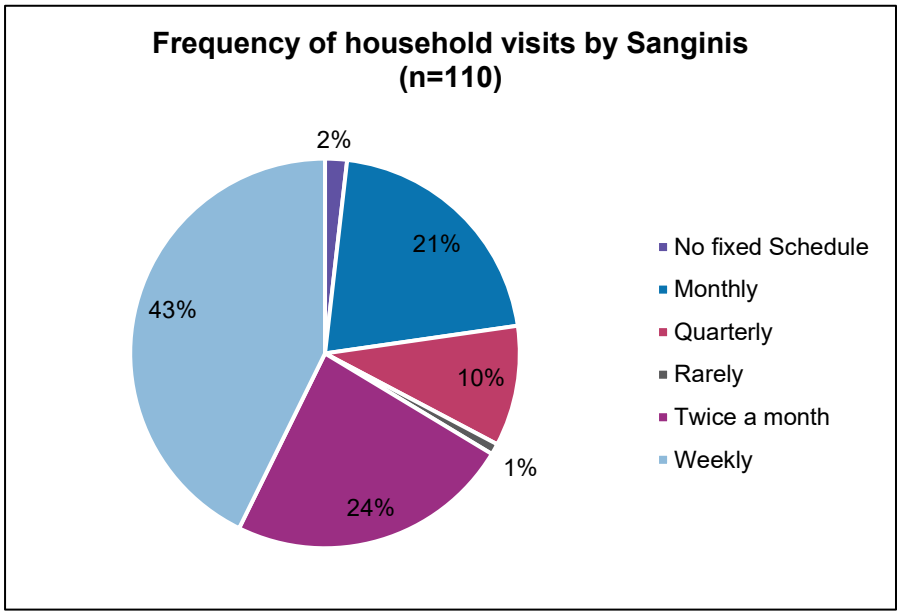


Figure 54: Frequency of household visits by Sanginis

The data shows that Sanginis maintain regular engagement with households, with the highest proportion of visits **occurring weekly (43%) and twice a month (24%),** indicating strong on-ground presence. **Monthly visits account for 21% and quarterly visits for 10%,** while only a very small proportion report no fixed schedule (2%) or rare visits (1%). This reflects a well-structured and frequent outreach mechanism under the SuPoshan programme, ensuring continuous interaction with beneficiaries and consistent reinforcement of key health and nutrition messages at the household level

b) Rating of Sessions on Nutrition and Balanced Diet

69%

Excellent – Well-structured, scientifically accurate, engaging discussions, and practical tips for daily nutrition.

11%

Good – Informative with useful insights but needed more depth, examples, and interactive elements.

The nutrition sessions were overall well-received by beneficiaries, with most reporting a positive and engaging learning experience. The sessions were viewed as well-structured, informative, and useful in improving understanding of key nutrition concepts and their application in

daily life. Only a small proportion felt that the sessions lacked depth or clarity. This indicates that the SuPoshan nutrition sessions were effective in delivering relevant and practical nutrition education, with strong participant satisfaction.

3.2.6. Sustainability

69% of adolescent girls reported actively following and sharing menstrual hygiene management practices

21% of adolescent girls reported full community support for Sanginis' initiatives, while **33% observed that support is steadily increasing**

a) Willingness to Sustain Menstrual Hygiene Practices Among Women -Post-Intervention

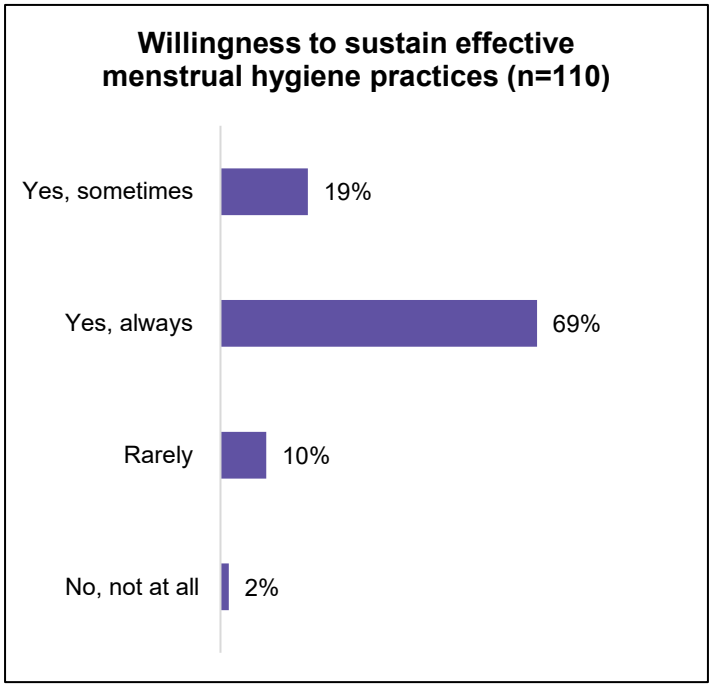


Figure 55: Willingness to sustain effective MHM practice

Most respondents show a clear willingness to continue following good menstrual hygiene practices, with many indicating they would maintain these habits consistently. Only a small group expressed low or no intention to continue. This suggests that the practices promoted under the SuPoshan programme have been well understood and accepted, with many adolescent girls feeling confident and comfortable in continuing them in their daily lives.

"The Sanginis conduct classes every two months in our school. Since they are from our village, we are very familiar with them and feel comfortable sharing our concerns with them. We are now able to talk about periods amongst ourselves more openly, and we know how to manage symptoms better."

- an adolescent girl from 11th grade.

b) Extent of community support

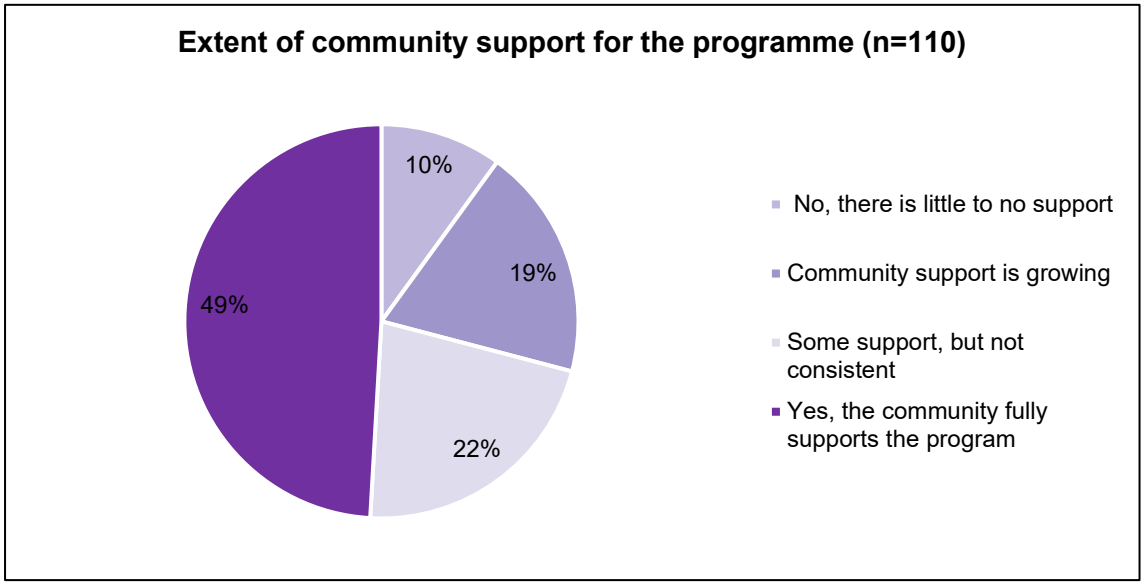


Figure 56: Extent of community support for the programme

The findings indicate a generally positive level of community support for the SuPoshan programme, with nearly half of respondents reporting full support and another segment noting that support is gradually growing. This reflects increasing acceptance of Sanginis' work and a shift towards greater community ownership of adolescent health and nutrition issues.

At the same time, the presence of partial or inconsistent support among some respondents suggests that engagement is still evolving in certain pockets. This highlights the need for continued community dialogue and trust-building to strengthen collective ownership. Overall, the trend points towards improving the sustainability of the programme, supported by gradually deepening community recognition of its relevance and impact.

3.3. Sanginis

a) Socio-demographic profile

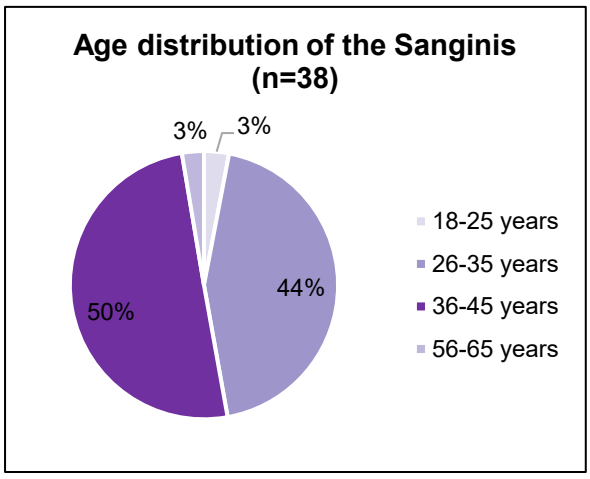


Figure 57: Age distribution of the Sanginis

The age distribution of Sanginis shows that the **majority fall within the 26–45 years age group, indicating a strong presence of individuals in their active and experienced working years**. A very small proportion belongs to the younger (18–25 years) and older (56–65 years) age groups. Additionally**, 100% of the Sanginis are married and mostly are mothers themselves.** They often feel that what they learned while training for the programme was also personally helpful for them.

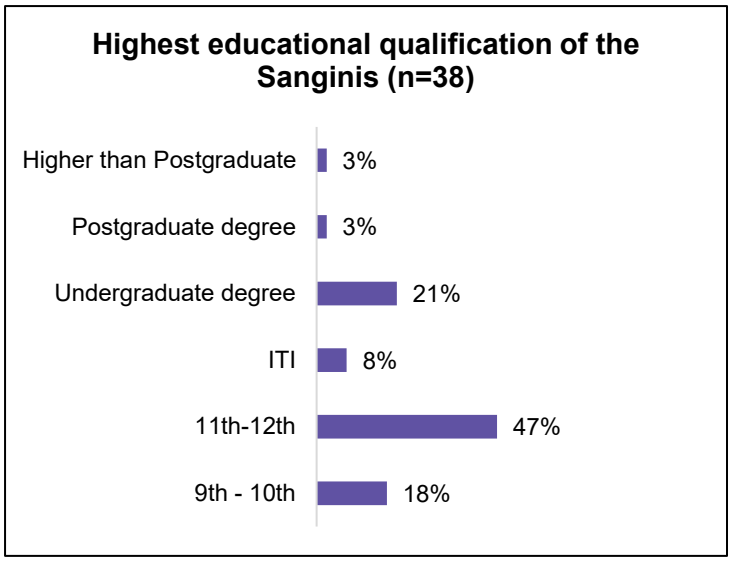


Figure 58: Educational qualification of the Sanginis

The educational profile of Sanginis shows that **most have completed higher secondary education, with a considerable proportion also holding undergraduate qualifications. A smaller share has technical (ITI)** or postgraduate education, while only a very limited number have education beyond postgraduation.

This indicates a moderately well-educated cadre of Sanginis, with sufficient foundational and higher-level education to effectively deliver awareness and counselling activities.

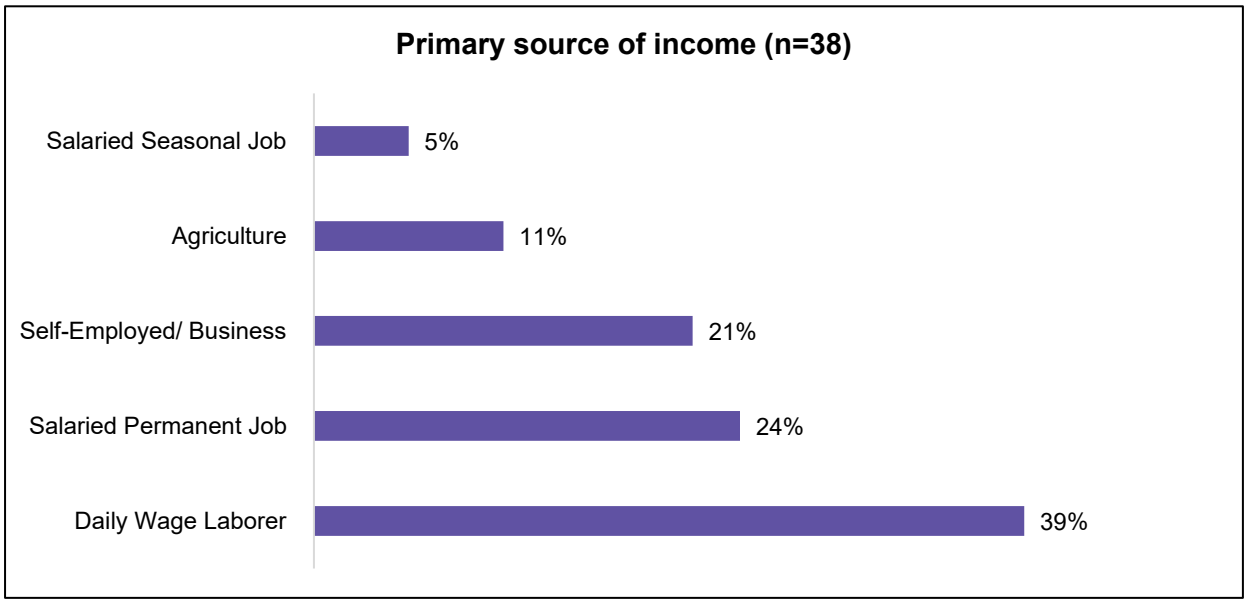


Figure 59: Primary source of income for Sanginis' households

The findings indicate that most Sangini households **depend on informal and less stable sources of income, with daily wage labour being the primary livelihood. A smaller share of households is engaged in salaried permanent jobs and self-employment, while agriculture and seasonal salaried work account for a relatively limited proportion**.

This reliance on daily wage labour also serves as an initial motivation for women to participate in the workforce, as economic necessity drives their engagement in income-generating activities alongside their roles as Sanginis.

b) *Motivation to join the programme*

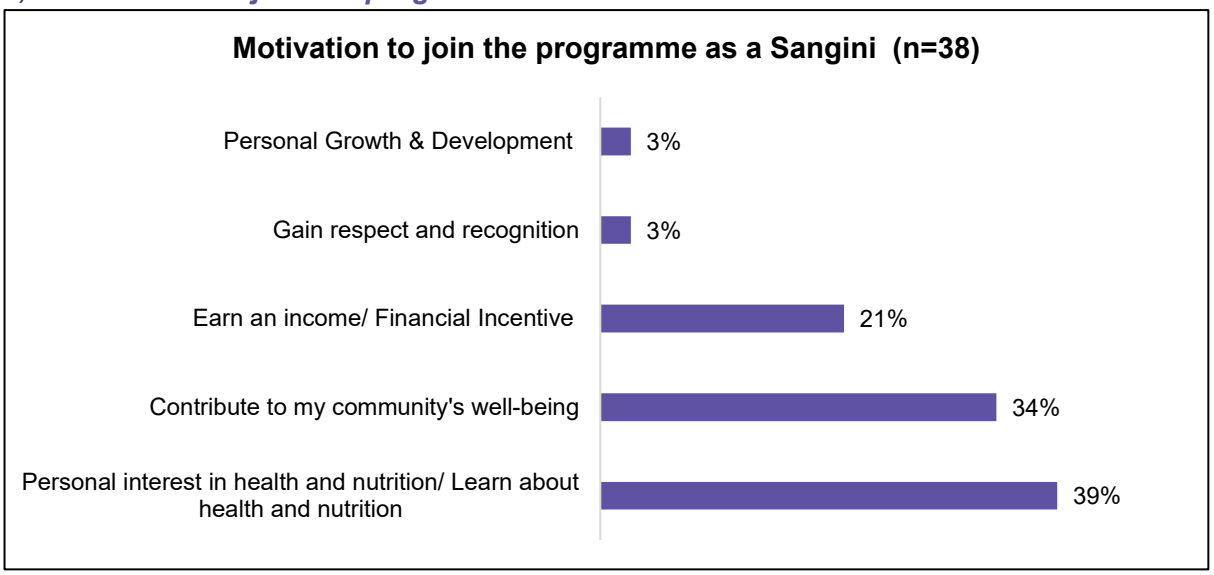


Figure 60: Motivation to join the programme as a Sanginis

The findings show that Sanginis were mainly motivated by intrinsic and community-driven reasons for joining the programme. **Personal interest in health and nutrition was the most common motivation (39%), followed by the desire to contribute to community well-being (34%). Financial incentive was cited by 21% of respondents, while only a small proportion were motivated by gaining respect and recognition (3%) or personal growth and development (3%).**

The Sanginis who participated in the survey had been associated with the programme for more than two years. While many initially joined with financial motivation as a key driver, their experience over time led to a shift in perspective. As they engaged more deeply with communities and witnessed the impact of their work, their motivation evolved into a genuine interest in health and nutrition. They expressed a sense of satisfaction and fulfilment in supporting people, particularly in improving awareness and access to health-related information. This indicates that the programme is largely driven by strong personal interest and a sense of social responsibility, with financial motivation playing a secondary role. This balance of intrinsic and practical motivations supports the sustained engagement of Sanginis in programme activities.

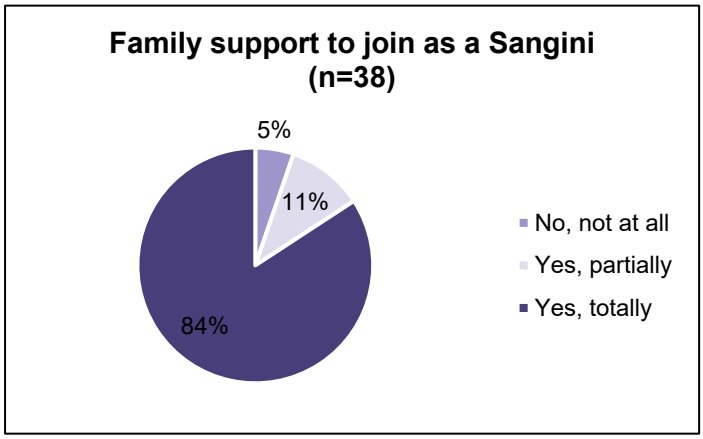


Figure 61: Support from family to join as Sangini

The findings show very strong family support for Sanginis joining the programme, with **the majority reporting full support (84%). Only a small proportion received partial (11%) or no support (5%) from their families.**

These results show that becoming a Sangini is largely accepted and encouraged at the household level, which likely facilitates their continued participation and active engagement in programme activities

c) *Awareness and Knowledge Gain Post Intervention*

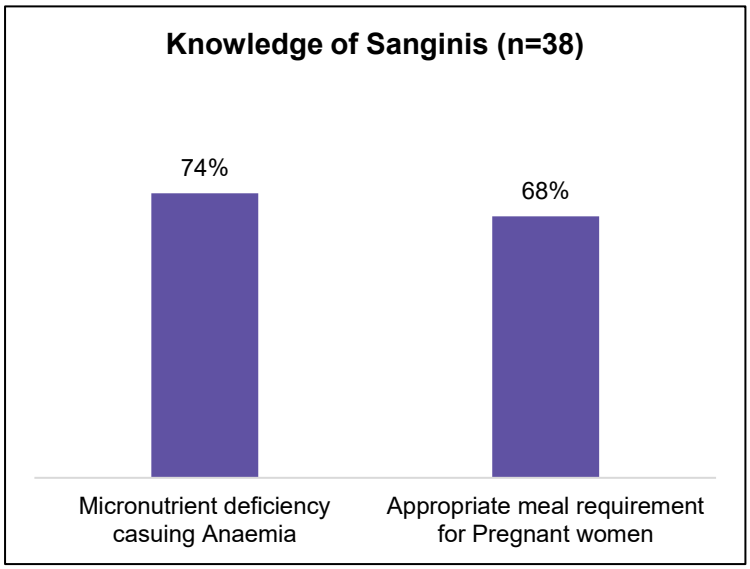


Figure 62: Knowledge gained by Sanginis

A substantial proportion of Sanginis demonstrated correct knowledge on key nutrition concepts, **particularly micronutrient deficiency causing anaemia (74%) and appropriate meal requirements for pregnant women (68%)**. This reflects a strong understanding of core maternal nutrition topics that are critical for addressing anaemia and improving dietary practices during pregnancy.

These findings suggest that the programme has effectively strengthened Sanginis' knowledge base, enabling them to serve as reliable sources of nutrition information. Their improved understanding supports more effective counselling at the household level and reinforces their role in promoting healthier dietary behaviours within the community.

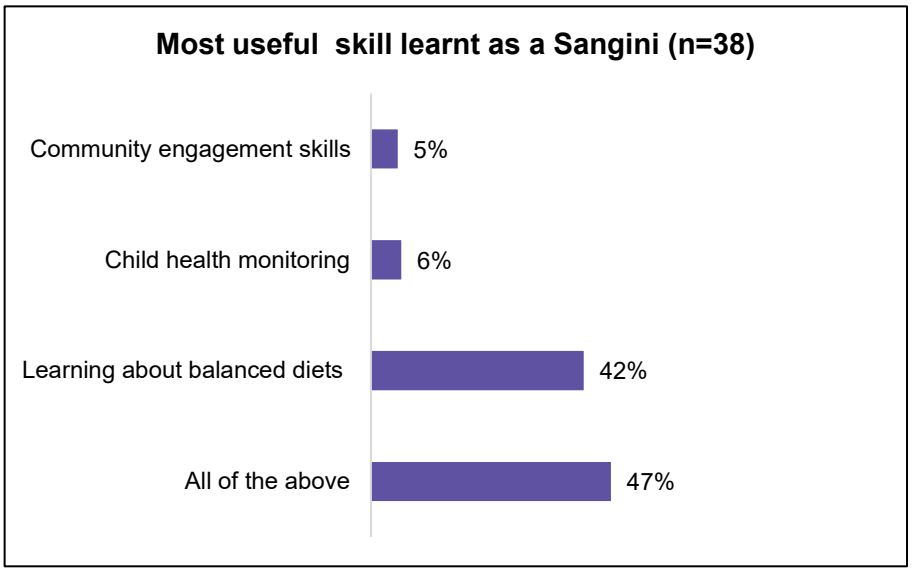


Figure 63: Most useful skill learnt as a Sangini

Nearly half of the Sanginis **(47%) reported that they gained value from all aspects of their training, indicating that the overall package of skills was useful and well-integrated. A significant proportion (42%) specifically highlighted learning about balanced diets as the most useful skill,** while smaller shares pointed to child health monitoring (6%) and community engagement skills (5%).

These responses show that the training has been broadly effective, with a strong emphasis on practical nutrition knowledge. The focus on balanced diets, in particular, reflects strengthened capacity among Sanginis to guide households on everyday nutrition and improve dietary practices at the community level.

d) *Perceived Status of Nutrition in the Community and Its Impact*

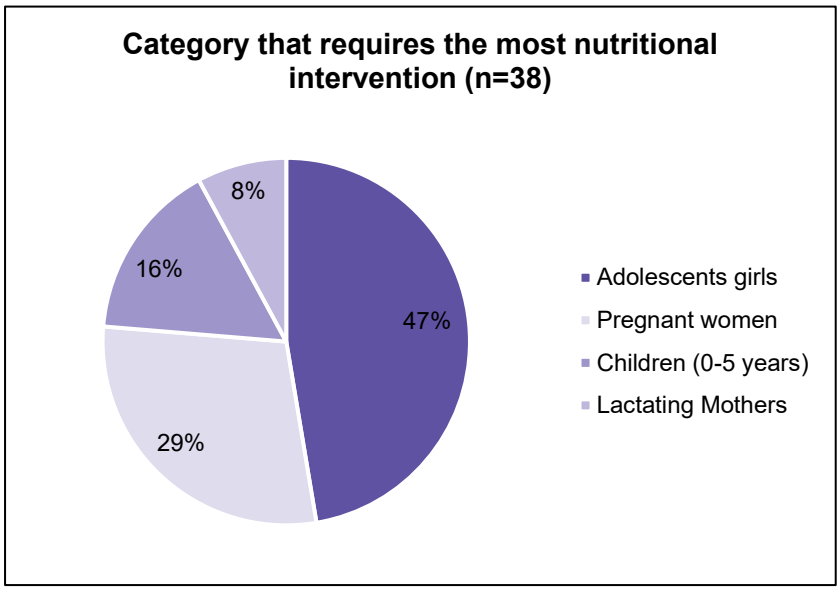


Figure 64: Category that requires the most nutritional intervention

Sanginis identified adolescent girls **(47%) as the group requiring the most nutritional intervention, followed by pregnant women (29%), children aged 0–5 years (16%), and lactating mothers (8%).** This distribution reflects a clear understanding of the different stages of nutritional vulnerability within the community.

Their responses indicate strong awareness of where nutritional gaps are most critical, particularly among adolescent girls, who are often at risk of anaemia and poor dietary intake. The prioritisation of pregnant women and young children further shows their recognition of high-risk life stages where nutrition has long-term implications for health outcomes. This suggests that Sanginis have developed an informed understanding of community nutritional needs, enabling them to better target their awareness and counselling efforts.

Sanginis reported a perceived reduction in malnutrition cases, **with a majority noting significant improvement (66%) and the remaining reporting some improvement (34%).** No respondents indicated a lack of improvement These perceptions reflect their close engagement with households and their ability to observe changes in nutritional status over time. It also suggests that the awareness, counselling, and follow-up efforts under the SuPoshan programme are associated with visible improvements in community nutrition outcomes

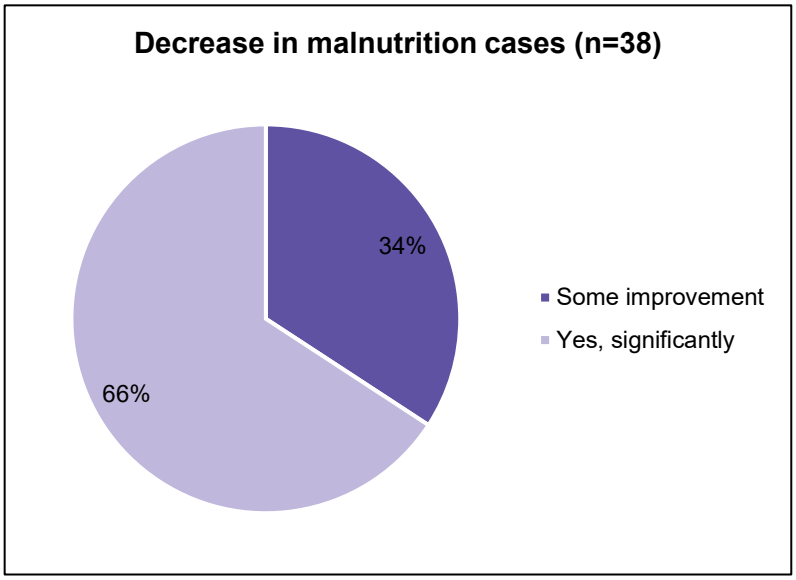


Figure 65: Perceived decrease in malnutrition cases

Qualitative insights

- *Sanginis took active personal responsibility for children identified with SAM/MAM, conducting bi-monthly household visits to monitor and document their progress.*
- *They expressed a sense of empowerment in applying their knowledge to support children's nutritional recovery.*
- *Provided households with homemade calcium-rich supplements such as moringa leaf powder to improve dietary intake.*
- *Regularly counselled adolescent girls to reduce menstrual stigma and promote healthy dietary and hygiene practices.*
- *Conducted cooking demonstrations showcasing nutritious recipes using millets and locally available ingredients to encourage affordable healthy diets.*

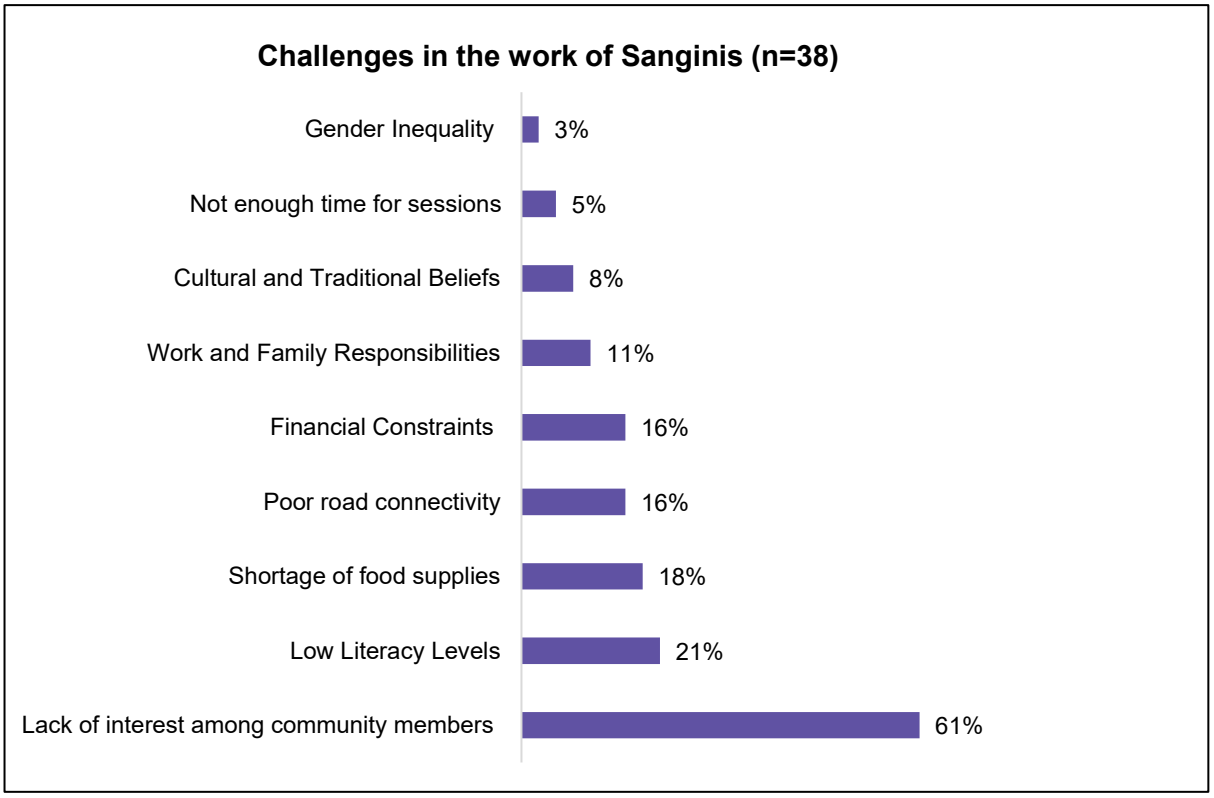


Figure 66: Challenges in the work of Sanginis

The barriers to participation and effective engagement highlight a mix of demand-side, socio-economic, and logistical challenges within the community**. The most prominent constraint is a lack of interest among community members (61%),** indicating behavioural and awareness-related gaps that limit engagement. **Low literacy levels (21%)** further affect comprehension and uptake of information delivered during sessions.

Resource and access-related constraints, **such as a shortage of food supplies (18%), financial limitations (16%), and poor road connectivity (16%),** also hinder consistent participation and adoption of recommended practices. Time constraints due to **work and household responsibilities (11%) add another layer of difficulty**, while cultural and traditional beliefs (8%) influence openness to behaviour change. A small proportion also cited lack of time for sessions (5%) and gender-related barriers (3%).

e) Impact on Financial Independence and Empowerment Gained Post-Intervention

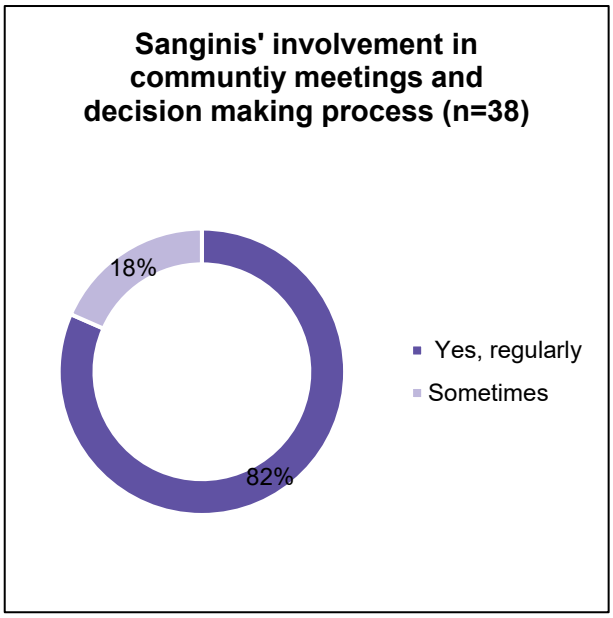


Figure 68: Sangini's involvement in community meetings and decision-making process

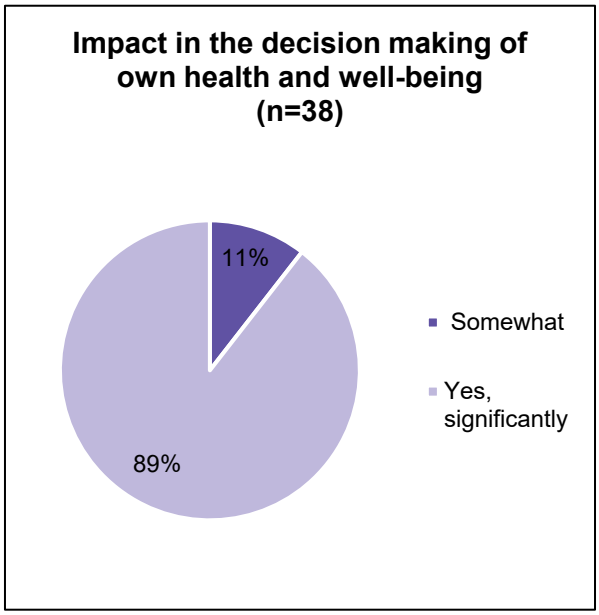


Figure 67: Impact in the decision making of one's health and well-being

Most **Sanginis (89%) reported a significant improvement in their ability to make decisions regarding their own health and well-being**, while a smaller proportion (11%) experienced some improvement. This highlights a strong sense of personal empowerment, with Sanginis becoming more confident and informed in managing their health, likely influenced by their exposure, training, and active role in the programme. A majority of Sanginis reported **regular participation in community meetings and decision-making processes (82%), while the remaining 18% participate occasionally**. This reflects strong engagement of Sanginis at the community level, indicating that they are increasingly being included in local discussions and are actively contributing to collective decisions related to health and nutrition.

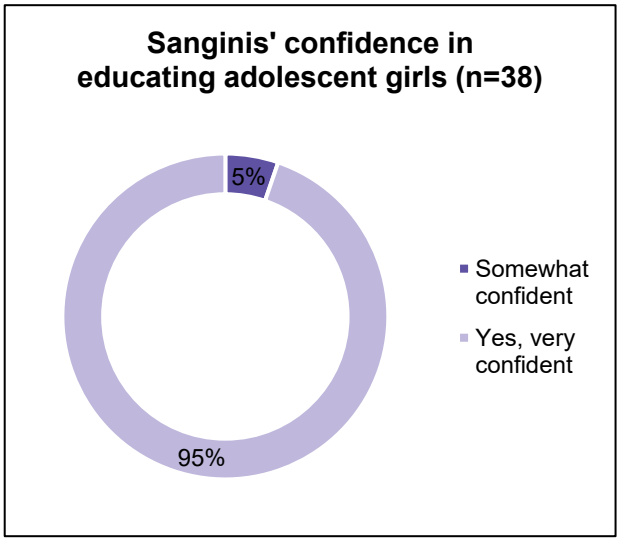


Figure 69: Sangini's confidence in educating adolescent girls

The findings also show a very high level of confidence among Sanginis in educating adolescent girls, with the vast majority (95%) reporting that they are very confident and only a small proportion (5%) feeling somewhat confident. This reflects strong

capacity-building through the SuPoshan programme, where training and field experience have equipped Sanginis with the knowledge and communication skills needed to effectively engage with adolescent girls.

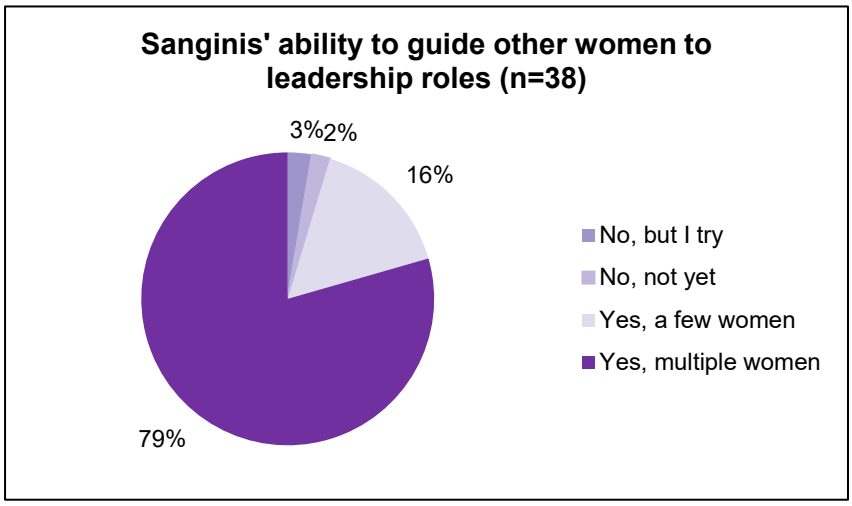


Figure 70: Sangini's ability to guide other women to leadership roles

In addition to helping the beneficiaries to improve their nutrition and health, Sanginis also strive to empower other women. Most Sanginis reported strong progress in encouraging and guiding other women towards leadership roles, with a **majority stating that they have supported multiple women (79%). A smaller proportion indicated that they have guided a few women (16%), while only a very limited number are either trying but not yet successful (2%) or have not yet begun this process (3%).**

These findings reflect the growing leadership influence of Sanginis within their communities. Their ability to mentor and encourage other women suggests that the programme is not only building individual capacity but also creating a ripple effect of empowerment, where Sanginis are actively fostering leadership and participation among other women. Sanginis initially entered the programme primarily with financial aspirations, aiming to improve their household income and support their children's education and prospects. Over time, however, their role expanded well beyond this initial motivation. With continued engagement, they have become trusted figures within their communities, gradually evolving into important connectors between households and local institutions.

They now play a key role in linking community members with frontline systems such as Panchayat representatives and Anganwadi workers, often acting as the first point of contact for health and nutrition-related concerns. This growing trust and accessibility have positioned Sanginis as dependable community intermediaries, strengthening communication between service providers and beneficiaries. In the process, their work has shifted from being incentive-driven to being rooted in responsibility, recognition and a sense of belonging in the community ecosystem.

Chapter 4

Recommendations and Way Forward

4. Recommendations

This chapter draws from the key findings of the Impact assessment and proposes action plans for addressing key gaps in utilisation, service delivery and an effective exit strategy.

Current Scenario	Recommendations
• Awareness of NRCs has improved; however, utilisation remains hindered due to distance, social constraints, and loss of daily wages during facility stay	• Introduce decentralised and community-based models of care for acute malnutrition, including **day-care or outpatient approaches**, to improve accessibility and continuity of treatment for vulnerable children.
• Migration disrupts continuity of maternal and child health services, particularly follow-up care such as immunisation and antenatal services	• Strengthen **continuum of care mechanisms** by enabling frontline workers to facilitate service linkages across locations and orient beneficiaries on accessing entitlements at destination areas
• Migrant populations often face language barriers in the intervention regions, which limit effective communication and access to services	• Introduce **multilingual and non-verbal communication strategies**, including pictorial counselling tools, visual job aids, and identification of **peer facilitators or interpreters within migrant communities**, along with basic cross-lingual orientation for frontline workers
• Kitchen gardens are contributing to improved food access, but are affected by seasonality and irregular input availability	• Establish **community-managed resource systems**, such as seed banks and shared nurseries, and align input distribution with local production cycles to ensure continuity
• Improvements in WASH practices are evident, but critical behaviours such as safe water handling are not consistently followed	• Shift from awareness to **practice-based reinforcement**, including demonstrations, habit formation approaches, and community-level monitoring
• Men remain largely excluded from maternal and child nutrition discussions despite their role in decision-making and resource allocation	• Introduce **targeted male engagement strategies** that position men as co-responsible caregivers, including couple-based counselling, male peer groups, and integration within livelihood and community platforms
• Persistent stunting indicates long-term nutritional deficits despite improvements in other indicators	• Strengthen focus on the **first 1,000 days approach**, with sustained engagement on maternal nutrition, early breastfeeding, and age-appropriate complementary feeding practices

Table 12: Recommendations

Exit Strategy

A well-planned exit strategy should enable a transition from programme-led implementation to locally sustained systems, ensuring that capacities, behaviours, and institutional linkages continue to function effectively beyond the project lifecycle.

1. *Transition Sanginis into Community Nutrition Resource Roles*

Sanginis can be repositioned as **community-based nutrition resource persons** linked with SHGs or local service delivery platforms, enabling continued counselling, facilitation, and community mobilisation while creating pathways for livelihood convergence and sustained engagement. This prevents the loss of human capital and skills, while also ensuring the sustenance of benefits through local champions. [12]

2. *Embed Key Practices within Existing Community Institutions*

Nutrition and health practices should be integrated into **routine platforms such as SHG meetings, Anganwadi activities, and school-based forums**, ensuring that behaviours are reinforced through existing social structures rather than programme-dependent mechanisms. Occasional technical support, such as providing equipment for carrying out anthropometric measurements, and support through manpower can be provided to maintain the benefits.

3. *Strengthen Convergence through Defined Roles and Joint Accountability*

Transition towards a structured convergence model with clearly defined roles, shared indicators, and periodic review mechanisms across frontline workers and local institutions, ensuring institutional ownership of programme outcomes. Given that Sanginis have been functioning in a complementary capacity without formal role demarcation, their responsibilities can be systematically transferred to Anganwadi Workers (AWWs), ASHAs, and other frontline functionaries, with Sanginis repositioned to provide periodic technical support and community-level facilitation as required, so as not to burden the frontline workers.

Image 8: Field interaction with Sangini

4. *Build Community-Led Reinforcement Systems*

Promote **peer-led monitoring, community champions, and group-based reinforcement mechanisms** so that key behaviours are sustained through social norms and collective accountability.[13]

5. *Enable Service Continuity for Migrant Populations through System Navigation*

Strengthen **beneficiary capacity to navigate services across locations**, with frontline workers

[12] Exit strategies for health interventions in low- and middle-income countries: a systematic review
[13] Sustaining Development: Results from a Study of Sustainability and Exit Strategies among Development Food Assistance Projects–India Country Study

facilitating awareness of entitlements and access points, ensuring continuity of care in high-mobility contexts.

Chapter 5

Case studies

5. Case Studies

Ongoing Care at Home: Supporting Lydia's Growth

Lydia, a two-and-a-half-year-old, is an active and energetic child who "never sits in one place," according to her mother. Earlier, a doctor had reassured the family that there was no issue, so her mother did not suspect any concern. It was during a routine household visit by the Sanginis that Lydia was identified as moderately acutely malnourished (MAM). Since then, they have been visiting regularly, twice a month, to monitor her growth and guide her mother on improving her diet. While Lydia has shown some improvement and has grown a little, feeding remains a challenge as she often refuses to eat and tends to fall sick frequently.

The Sanginis also informed the family about the Nutrition Rehabilitation Centre (NRC), but accessing it is difficult as it is located nearly 50 km away. As a homemaker, her mother is unable to stay there for several days due to household responsibilities. Despite these constraints, she continues to follow the guidance provided and is making efforts to improve Lydia's nutrition at home, with ongoing support from the Sanginis.

Turning Initiative into Impact: Dakshayani's Efforts in Community Nutrition

Dakshayani, a graduate, was previously working as a data entry operator, when she witnessed a neighbour's child struggling with severe acute malnutrition. At the time, she felt the need to help but did not have the knowledge or means to do so. When the opportunity to become a Sangini arose, she chose to take it up, motivated by the desire to support children in her community and ensure that such situations could be addressed more effectively.

Image 9: Sangini Dakshayini is distributing the drumstick leaves powder to households

Since then, she has been actively working across coastal villages, identifying cases of moderate and severe acute malnutrition and supporting families through regular monitoring and counselling. Known for her sincerity and initiative, Dakshayani introduced a practical solution when she realised that families found it difficult to regularly include drumstick leaves in their diets despite their availability. She began preparing drumstick leaf powder and distributing it free of cost, making it easier for households to incorporate nutrient-rich food into daily meals. Through her consistent efforts, several children have shown improvement, moving from severe to moderate malnutrition, reflecting the impact of sustained, community-driven support.

Small Changes, Stronger Habits

Anitha, a 15-year-old from a coastal village, had little awareness about nutrition and health before the programme. Like many girls her age, her meals were irregular, and she often skipped food or relied on whatever was available at home. She also experienced frequent fatigue but did not think much of it.

Through regular sessions conducted by the Sanginis, Anitha was introduced to simple and practical ways to improve her diet using locally available foods. She learned about the

importance of balanced meals, iron-rich foods, and menstrual hygiene. Over time, she began making small changes, eating more regularly, including greens in her meals, and being more mindful of her health. She also started sharing what she learned with her friends and younger siblings. Today, Anitha feels more energetic and confident, and her improved habits reflect how consistent guidance and awareness can positively influence adolescent health.

Annexures

Annexure

The following table provides a comparative analysis of the major impact findings from the survey with the national level NFHS 5 data of India with the treatment and Control Villages.

Indicator	NFHS 5	Treatment data	Control data
Child Feeding Practices and Nutritional Status			
Children under age 3 years were breastfed within one hour of birth	41.8%	66.0%	38.0%
Children under age 6 months are exclusively breastfed	63.7%	56.0%	34.0%
Children under 5 years who are stunted (height-for-age)	35.5%	26.6%	13.6%
Children under 5 years who are wasted (weight-for-height)	19.3%	8.3%	7.5%
Children under 5 years who are underweight (weight-for-age)	32.10%	16.10%	14.90%
Maternal and Child Health			
Mothers who consumed iron folic acid for 100 days or more when they were pregnant (%)	26.0%	66.0%	63.0%
Mothers whose last birth was protected against neonatal tetanus	92.0%	71.0%	50.0%
Mothers who had at least 4 antenatal care visits (%)	58.1%	61.0%	38.0%
Mothers who received postnatal care from a doctor/nurse/LHV/ANM/Midwife, /Other health personnel member within 2 days of delivery	78.00%	70.00%	72.00%
Registered pregnancies for which the mothers have received an MCP (Mother and Child Protection) card	95.9%	80.0%	55.0%

Diet Diversity

Women of Reproductive Age: Consumption of 5 or more food groups from the items given below in last 24 hours signifies adequate diet for a woman of reproductive

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