Intervention Package

A. Rationale

This integrated intervention package has been designed to achieve three overarching aims towards improving infant and young child feeding (IYCF) and care practices that in turn will contribute to reduction in under-nutrition particularly in the 0-24 month age group:

1. *Improved breastfeeding practices from first hour of childbirth to 6 months of the child.* This aim has two targets that India needs to meet by 2025: (i) 80% mothers to initiate breastfeeding within an hour, and (ii) 70% children exclusively breastfed for the first six months of life.
2. *Increased consumption of Minimum Acceptable Diet for children aged 6-24 months*. This aim has two targets for India: (i) 80% mothers introduce complementary feeding to infants between 6-8 months, and (ii) 60% of children are fed minimum acceptable diet at 6-23 months.
3. *Enhanced child care practices associated with growth and development of the children below 24 months.*

The Setting Approach for Health Promotion was adopted; this decision was based on consensus arrived at between the study team and the Technical Advisory Board (TAB), London

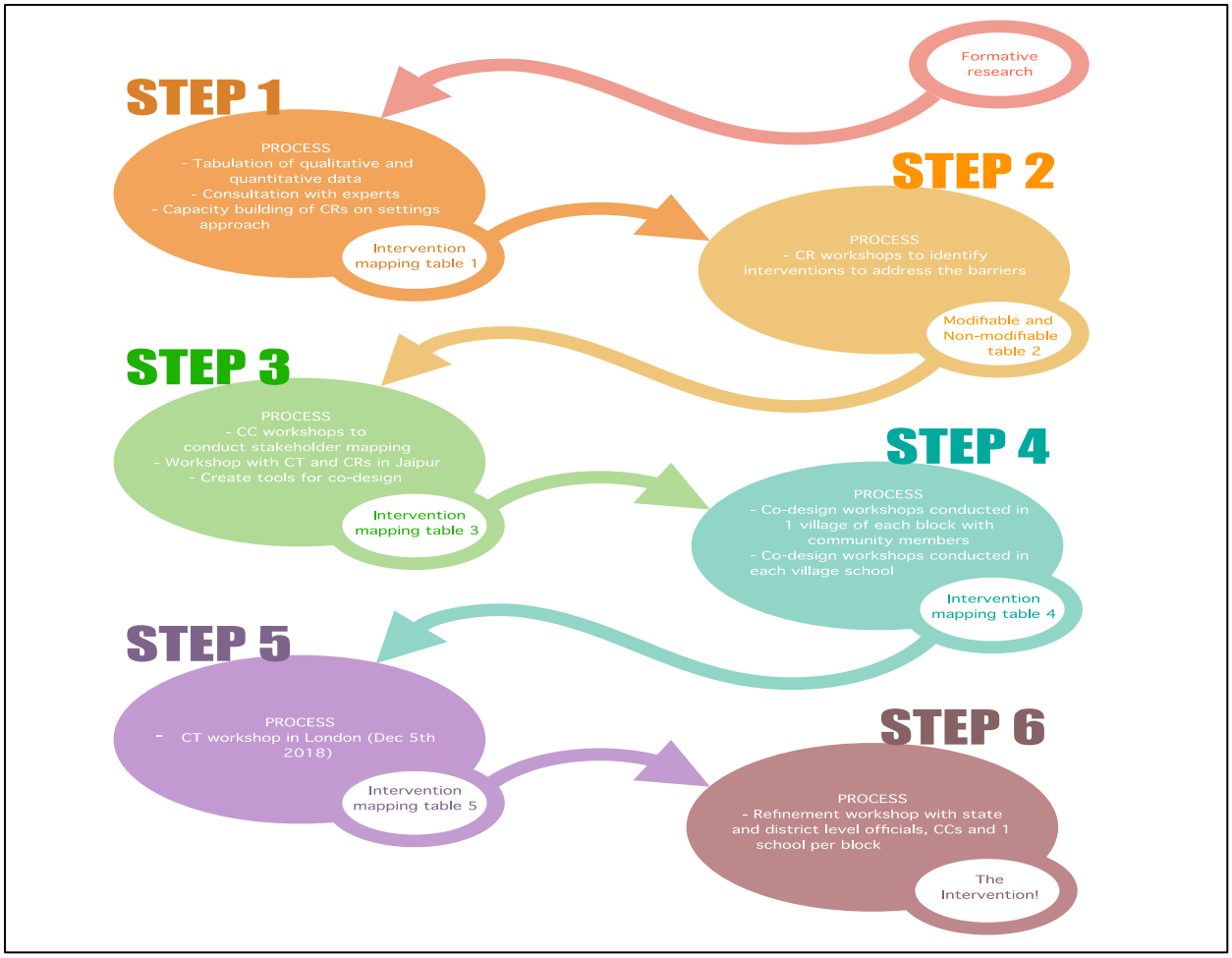
B. Process

This syncretic model was constructed through synthesis of four interlinked processes. These are the four arms of the co-designing of the intervention: (i) discussion with the community, (ii) collation of local partner's experience, (iii) review of Government of India programmes and policies as well as international evidence and (iv) Expert advice. Four categories of participants were engaged in the co-designing process – Core Team (CT), Community Researchers (CR), Community Champions (CC) and Community Members (CM). The CT comprised of the PI and Co-PIs of the project assisted by other team members at the National and Rajasthan State Office of Save the Children India. The CR was also a part of the project team who were not only based at Banswara (study district) but also belonged to that area thus holding deeper

understanding of the field realities. The Community Champions are volunteers selected from the respective study villages and trained by the CT and CR. They acted as a crucial link between the community and the project team and facilitated interactions with community members. The most important participants were the Community Members which included mothers, paternal grandmothers, fathers/ male members of the household, elected representatives from the village, frontline health workers (FHWs) viz. Auxiliary Nurse Midwives (ANM), Anganwadi Workers (AWW) and Accredited Social Health Activists (ASHA) and teachers of schools that were located in the village.

These processes were designed in a cascaded manner with output of one stage being the input for the next (Figure 1).

Figure 1: Cascade Approach to Co-designing of Intervention



Step 1 was the analysis of the formative research which captured the current practices, its facilitators and barriers. While the data collection in the formative phase was conducted jointly by CR and CT, the analysis of the data was done by the CT. The output of this step was

an emergent model comprising various factors that are associated with infant and child feeding and care practices in the community. Step 2 was dedicated to creating a joint understanding of CT and CR about the Settings Approach to Health Promotion. A two day workshop was organised at Jaipur in June 2018 to appraise the CR about the theory and practice of health promotion. Based on this workshop, the CR classified the factors into modifiable and non-modifiable across four levels – Household, Community, Organization and Government. In Step 3 this framework was shared with the CCs to record their views about modifiability of these factors and also map the community stakeholders who would be appropriate for engagement in co-designing. Once the stakeholders were mapped one village from each block was selected and an intensive field exercise undertaken for the co-designing process in Step 4. In-depth discussions were held with CM in these villages. Beside these villages, meetings were also conducted with School Teachers of the remaining 7 study villages to gather views regarding potential role of school in promoting IYCF. Step 5 included mapping the responses of the community as well as experiences of the partners and evidences from national and global programmes to arrive at a consolidated package of possible interventions. This package was constructed through an iterative exercise among key CT. The final Step 6 in this co-designing exercise was a series of refinement workshops with CC and CM, facilitated by CT and CR as well as interviews with heads of relevant departments as per the conceptual model at District and State Officials by CT. The final draft of this Integrated Intervention Package was the output of this step.

C. Output

The structure of package for each aim is as follows:

a. Objectives
b. Current situation (Facilitators and Barriers)
c. Components of Intervention Package

Aim 1: Improve breastfeeding practices from first hour of childbirth to 6 months of the child

a. Objectives:

- Initiate breastfeeding within 1 hour of birth : 80% of mothers to initiate breastfeeding within an hour
- Always give colostrum - including during home births
- Exclusive Breast Feeding for first 6 months

b. Current Situation:

Stakeholders	Facilitators	Barriers
Household (Mothers+ Grandmothers)	1. Mothers mostly deliver at institution, so they start breastfeeding within 1 hour. 2. Tradition of giving pre-lacteals as first food is not common. 3. Majority of mothers feed colostrum as the childbirth is in hospitals. 4. Mothers come back every 2 hours to feed the child or when the child cries (feeding of cue) 5. Grandmothers in Ghatol are aware about colostrum feeding and also abide by the instructions given by the staff of health facilities where the child is born.	1. Knowledge of early initiation of breastfeeding is poor, they do it because they are asked to do so by doctors and nurses at the institutions 1. Mostly women start agricultural work after 3- 4 months of childbirth – time constraints 2. Water introduced in the first six months. Animal milk is also introduced if mother goes to work further from home 3. Mothers are aware of breastfeeding, but not about exclusive breastfeeding 4. Grandmothers in Kushalgarh are reluctant to give colostrum, especially in case of homebirth; misconception about colostrum as “dirty milk”
Frontline Health Workers	1. Aware of the importance of Colostrum 2. Keenness to ensure breastfeeding, even to those	1. Recommend giving water in summer months. 2. FHWs unaware of mothers giving animal milk before 6 months.

Stakeholders	Facilitators	Barriers
Frontline Health Workers	women who are delivering at home 3. Aware of the importance of exclusive breastfeeding.	

c. Components of Intervention Package

Target recipient	Function	Content	Channel
Mother	Building knowledge	1. Importance of colostrum 2. Benefits of EBF for adequate nutrition in first 6 months 3. Correct Breastfeeding practices starting from 1st hour of childbirth till 6 months of the child. 4. Care practices include hand-washing during breastfeeding 5. Expression of breast-milk – skills/techniques for expression, storage of expressed milk 6. Sterilization of utensils (for feeding and storing of expressed milk) 7. Water treatment for feeding water (in instances where EBF is not practiced)	1. Organize mothers meetings in community 2. Video shows at school on sterilization of feeding utensils, water treatment 3. Picture cards 4. Group or one-on-one sessions by FHW
	Demonstration and practice	1. Breastfeeding techniques 2. Addressing complications and difficulties faced by mothers in latching	1. ASHA, ANM at the community as well as at the facility of childbirth using picture cards and audio visual medium in hospitals 2. Household visits

Target recipient	Function	Content	Channel
			3. Group demonstration
	Routine planning	1. Supporting a routine or timetable that facilitates and prioritizes EBF under time pressures. 2. Developing a timetable for feeding and expression of milk where appropriate	1. ASHA and ANM during household visits
	Role modelling/ Positive Deviance[1]	1. All mothers to demonstrate good breastfeeding practices to identify and establish herself as the role model for other mothers- EBF champions 2. Hand-holding (support) for mothers to keep exclusively breastfeeding	1. Mother peer educators supporting other new mothers (group) ● household visits for new mother by identified EBF champions along with FHW ● organise small group meetings 2. Pairing up mothers to support each other
Household [Fathers and Grandmothers]	Task shifting (from the mother)	1. Importance of breastmilk in child's brain development 2. Planning with extended family and husbands to task shift agriculture	1. ASHA, AWW during household visit 2. Teachers and elected

[1] An approach to behavioural and social change based on the observation that in any community there are people whose uncommon but successful behaviours or strategies enable them to find better solutions to a problem than their peers, despite facing similar challenges and having no extra resources

Target recipient	Function	Content	Channel
		duties as well as household related chores like fetching water and cooking during EBF phase	panchyat representatives (communicating to fathers)
Community (VHSNC, Elected Representatives, School Management Committee)	Creating enabling environment	1. Information about importance of breastfeeding 2. Encouragement to set up support networks that help share agriculture duties during times of EBF 3. Building semi-formal structures (mobile creche) near the agricultural fields where the mothers can keep their babies while they are working.	1. Through Mass Media created under the Mothers Absolute Affection (MAA) Programme 2. Self-help or women's groups 3. Mothers with older children, 4. Elected Panchayat representatives
	Generate demand for Maternity Benefit Scheme and Programmes	1. information about provisions of schemes and programmes that support exclusive breastfeeding till 6 months of the child - (to be discussed if any such schemes exist with the district and state officials)	1. FHW at the school meetings as well as Gram Sabha platforms.
Frontline Health workers	Demonstration of behaviour	1. Training on how to demonstrate breastfeeding after delivery	1. 'Training of the trainer' at district level 2. Video 3. Supportive supervision and monitoring of delivery by female Health Visitors
	Counselling skills to support	■ Good Breastfeeding practices - introduction of colostrum,	'Training of the trainer'

Target recipient	Function	Content	Channel
	breastfeeding mothers	feeding on cue, personal hygiene, expressing and storage of mothers milk , sterilization of utensils used to feed expressed breast milk ■ Common difficulties in breastfeeding - latching, dealing with mastitis ■ Correcting the myths and misconceptions - giving water, animal milk and biscuits	Training sessions at district level or similar Picture cards Monitoring of delivery Supportive supervision by ANM?
State and District Level	Supply side strengthening	● Improving the implementation of the schemes and programmes ● Addressing issues concerning frontline health workers role ○ existing bottleneck ○ scope for new role ● Operationalising Comprehensive Lactation Management Centres (CLMC) at the facilities where institutional delivery is conducted. ● Mechanism for service guarantee and redressal.	Advocacy by NGOs

Aim 2: Increase Minimum Acceptable Diet for children aged 6-24 months

a. Objectives:

- Introduce complementary food after 6 months of the child
- Ensure Minimum Acceptable Diet for all children above 6 months
- Appropriate Minimum Meal Frequency and age appropriate portion sizes
- Adequate Dietary Diversity:
  - Higher dairy intake between 6-24 months
  - Increased infant intake of Vitamin A and Iron rich foods
  - Caregivers do not provide biscuits as a complementary food
  - Caregivers practice optimal preparation, frequency and quantity of THR
- Improve quality of services for promoting proper IYCF services - Counselling

b. Current Situation:

Stakeholders	Facilitators	Barriers
Household (Mothers, Grandmothers and Fathers) Household (Mothers, Grandmothers and Fathers)	1. Mothers are primary decision makers related to child feeding. 2. Take Home Ration (THR) collected from Anganwadi Centre (AWC) regularly 3. Mothers and family members are aware that animal milk is necessary for health of the child 4. Breastfeeding is continued for 2 years of the child by majority mothers in Ghatol 5. Young (18-20 years) and informed mother provide more time for childcare 6. Awareness of importance about intake of fruits and vegetables 7. Some houses have kitchen garden in Kushalgarh, more common in Ghatol	1. No separate cooking for children 2. Child fed only when he/she demands food. Only 1 hour dedicated to child care; no time devoted for feeding child. 3. Children less than 5 months receive more and over 12 months receive less un-divided time 4. In Kushalgarh mothers have to migrate with their husbands leaving the child with the grandmothers; breastfeeding till 2 years is less 5. Mothers give biscuits during illness as the child does not want to eat anything. 6. Packets of supplementary nutrition collected from AWC not given regularly as mothers are not aware of how to cook it 7. Child mostly eats roti and tea. 8. Milk not given because of lack of

Stakeholders	Facilitators	Barriers
	8. Pulses are available to the household 9. Green leafy vegetables are grown in Ghatol. 10. Awareness of importance about intake of fruits and vegetables	availability; given in form of tea 9. Children staying with grandmothers are mostly given packaged foods like biscuits 10. Fathers are not involved in child feeding 11. Vegetables available in Ghatol village are not usually given to children 12. Intake of pulses is less for children; respondents said that they did not like it. 13. Low intake of minimum acceptable diet among illiterate women.
Community	1. Some families in the village have animals that produce milk 2. Vegetables are cultivated by some families who have water available for agriculture. 3. Crops like Wheat, Maize, Jawar (oats) and Rice are grown in Ghatol. 4. No families with food insecurity. 5. At least one member of the family engagement in MNREGA which ensure minimum purchasing capacity 6. Access to market is better in Ghatol, so there is more access to fruits and vegetables. Intake of fruits and vegetables is more in Ghatol 7. Soyabean is grown in the villages of Kushalgarh	1. Milk in the villages were mostly used to make ghee. Very few households were milk produced in large quantity sell it outside the village. 2. Most village shops sell biscuits. 3. No work available in Kushalgarh, so families migrate to adjoining cities in Gujarat and Madhya Pradesh 4. Numbers of livestock are dwindling due to lack of family members to take care of them 5. Village Health Sanitation and Nutrition Committees are non-functional 6. Vegetables are not grown less in Kushalgarh due to inadequate irrigation facilities 7. Market is located far from most villages in Kushalgarh and public transport is also limited, so less access to fruits and vegetables 8. Eating non-vegetarian food is discouraged due to religious reasons in both blocks, more in practice in Ghatol 9. No involvement of Ward Panch/ Sarpanch in this issue of under-nutrition

Stakeholders	Facilitators	Barriers
Frontline Health Workers	1. Supply of THR regular at Anganwadi Centre 2. Pukar meeting is held regularly, once a week 3. Teachers are aware of importance of adequate diet. 4. Regular supply of wheat in Public Distribution System.	1. Little counseling by FHW on CF. Mothers are mostly informed about the age of introducing CF and what kind of CF, not about frequency and quantity 2. FHWs do not train mothers on how to cook THR received from AWC 3. FHWs also recommend giving biscuits during illness

c. Components of Intervention Package:

Target recipient	Function	Content	Channel
Mother	Building knowledge	1. The importance of timely introduction of solid and semi-solid foods at 6 months for adequate nutrition 2. The risks of late introduction at 7-12 months. 3. Information on adequacy ○ Age appropriate minimum meal frequency ○ age appropriate portion sizes 4. Information of minimum dietary diversity ○ dairy intake between 6-24 months ○ Vitamin A and Iron rich foods - nutritional benefits and local sources ○ continued breastfeeding till 24	1. Organize meetings in all the hamlets by Frontline Health workers 2. Video shows in the schools 3. Wall paintings of different food groups for children Women's groups / self-help groups? Posters Picture cards Home visits by FHWs

Target recipient	Function	Content	Channel
		months ○ Calorie density 5. Information about suboptimal feeding practices ○ High consumption of packaged food like biscuits and wafers ○ Introduction of powder milk 6. Choice of cooking fuels ○ Harmful effects of indoor air-pollution due to cooking with wood and cow patty - ○ Alternative for different kind of cook stove ○ Benefits of LPG as cooking fuel 7. Importance of Take Home Ration and including it in the regular feeding routine 8. Recognizing feeding cues 9. Role of other fathers and family members in optimal feeding practices 10. Personal hygiene and food hygiene (washing of ingredients prior to cooking, washing of utensils, if drying using clean cloth) and water hygiene (purification of water before giving to the child)	

Target recipient	Function	Content	Channel
	Demonstration and Practice	1. Modelling optimal portion sizes and preparation of age-appropriate meals 2. Different ways of preparing Take Home Ration, 3. Preparing diverse meals with locally available Vitamin A and Iron Rich foods as well as pulses 4. Demonstrating cooking with alternative fuels or alternative cooking stoves 5. Healthy and easily prepared snacks as an alternative to packaged foods 6. Positive feeding behaviour of the mothers	1. Develop a pictoral community recipe book 2. Organize cooking classes in the school by the FHWs with oversight of the school teachers
	Routine planning	1. Age appropriate diet chart with type of foods, frequency of feeding, portion sizes and breastfeeding	1. Mothers meetings in different hamlets by FHWs 2. Home visit by FHWs to follow up
	Role modeling/ Positive Deviance[2]	1. Demonstrating good child feeding practices to identify and establish herself as the role model for other mothers- Mother Champions 2. Hand-holding (support) for mothers to give minimum acceptable diet to their children	1. Mother peer educators supporting other new mothers (group) ● household visits for new mother by identified Champions Mothers along with FHW ● organise small group meetings 2. Pairing up mothers to support each

[2] Please see footnote page no. 7

Target recipient	Function	Content	Channel
			other (Mother to Mother communication)
Household [Fathers and grandmother]	Awareness generation	1. Appropriate feeding for children above 6 months 2. Importance of Vitamin A and Iron rich foods 3. Hygiene issues before feeding the child 4. Harmful effects of packaged food	1. Meetings of the Gram Sabha and grandmothers by FHWs
	Role modelling/ Positive Deviance	1. Encouraging fathers and grandmothers to see themselves as role models to support mothers in adopting good complementary feeding practices	1. Father/ grandmother peer educators supporting other fathers (group) through organise small group meetings
	Restructuring physical environment	1. Water treatment and storage 2. Cook with fuels other than firewood or cow dung cakes 3. Use of reduced smoke cook stoves 4. Kitchen garden projects	1. Posters and mass media campaign 2. Through other NGOs 3. Through schools
Community (VHSNC, Elected Representatives,	Role modelling for milk	1. Designing approaches for selling or exchanging milk locally 2. Valuing milk in the community	1. SHG members 2. Gram Panchayat representative

Target recipient	Function	Content	Channel
School Management Committee)	sharing	3. Promoting consumption of animal milk amongst children above 6 months	
	Health awareness campaigns	1. On various IYCF topics	1. In school premises by FHWs and other Champions
Frontline Health workers	Training and supportive supervision for quality and frequent IYCF counselling	1. Promoting optimal IYCF practices 2. New ways to measure growth where equipment is lacking 3. Monitoring routine and age appropriate IYCF 4. Demonstrating effective growth monitoring and development with limited resources 5. On the job training on effective counselling for IYCF topics (MMF, MDD)	1. Food chart for child's food, 2. Age appropriate recipes including THR recipes 3. Picture cards and audio-videos aids 4. IYCF training manual 5. Portion size bowls 6. By FHW supervisors, e.g. Lady Health Visitor for ANM and ASHA and Lady Supervisors for AWW

Aim 3: Enhanced child care practices associated with growth and development of the children below 24 month

a. Objectives:

- Introduce age appropriate active play methods for development of cognitive and motor skills.
- Improve quality of routine growth monitoring services
- Build infant and young child feeding and care friendly networks
    - Gram panchayat's involvement in VHSNC
    - Schools engagement with the Anganwadi Centres
- Encourage uptake of deworming services
- Reduce risk of intervention
    - Optimal treatment of drinking water
    - Safe toilet construction
    - Improving toilet usage and (No more open defecation)
    - Reduce waterlogging
    - Hand washing with soap
    - Alternative cooking methods
    - Improve access to nutritious food through vegetable gardens
- Optimise water management
- Encourage health seeking behaviours from Public health institutions amongst caregivers

b. Current Situation:

Stakeholders	Facilitators	Barriers
Household (Mothers, Grandmothers and Fathers)	1. Mothers and grandmothers aware of importance of play. Mostly grandmother engages the children using toys like balls, toy cars and also other locally made materials. 2. Mothers and grandmothers aware of importance of play. Mostly grandmother engages the children using toys like balls, toy cars and also	1. Mothers do not have time to engage in play activities 2. Grandmothers do not know different methods of active play 3. Fathers do not engage in active play 4. Mothers not aware of importance of regular growth monitoring 5. Family not aware of signs of under-nutrition

Stakeholders	Facilitators	Barriers
	other locally made materials. 3. Younger siblings also play with the child 4. All mothers are aware of importance of vaccination and it is done regularly. 5. In Ghatol, mostly fathers and in Kushalgarh, mothers take part in meetings at school. 6. Mothers mostly supervise child's homework. 7. All households have access to drinking water from hand pumps close to the house or on own dwelling 8. Women aware about importance of handwashing 9. More houses in Ghatol have built toilets 10. Gas connections are available in many houses in Ghatol and Kushagarh	6. In Ghatol private sector is preferred while in Kushalgarh public healthcare are mostly used 7. Diseases mostly arise during rainy seasons 8. Knowledge about deworming is low 9. Parents participation is school meetings is very less. 10. Filtration of drinking water using cloth, practiced only in Kushalgarh 11. Women spend disproportionate amount of time in fetching water in Ghatol 12. Hand is washed mostly after defecation or else when they perceive that the hand is dirty. 13. Use of soap is only after defecation, rest of the times ash, soil and detergent are used as soap is perceived to be expensive 14. Very few houses specific place for hand washing 15. Less houses have built toilets in Kushalgarh due to paucity of funds 16. Culture of open defecation still prevalent, mostly among men 17. People not aware about ill effects of open defecation 18. Most houses use firewood for cooking as it is cheap source as well as they find the taste of food better 19. High upfront costs for gas connections
Community	1. School teachers realize the importance of growth monitoring 2. School Management committees are formed and meet once in a month	1. Water logging resulting in breeding of mosquitoes 2. Literacy rates are low, especially among women.

Stakeholders	Facilitators	Barriers
	3. Most teachers are staying in the village or closer to the village. 4. Health camps are organised at school once a year by the ANM 5. Handpumps are main source of drinking water and is available to all social groups. 6. No water crises in Ghatol due to canal 7. In Kushalgarh some villages have a Solar water treatment plant 8. Soap is easily available in the village and is also not too expensive 9. Schools promote handwashing practices to children and organize special programmes on Diarrhea Prevention 10. Schools to start a vegetable garden project	3. Language barriers between school teachers and parents 4. Teachers generally prefer speaking to fathers or male members 5. Water crises in Kushalgarh during summer months. 6. Water from the Solar Water Treatment plant is used mainly by the families staying close to the plant. 7. No maintenance of ponds and some handpumps are non-functional 8. Toilets built in Kushalgarh are non-functional due to water shortage 9. Condition of toilets in school is poor and also not enough toilets for staff and students. 10. Incentives to start growing a vegetable garden, need to identify low maintenance crops.
Frontline Health Workers and Gram Panchayat	1. FHWs are aware of importance of play. 2. Teachers are aware of importance of play 3. Vaccination days (MCHN) are organized every month, mothers with eligible children are informed about the vaccination day in advance 4. In Ghatol, mostly fathers and in Kushalgarh, mothers take part in meetings at school. 5. Mothers mostly supervise child's homework	1. No counselling done regarding play methods by FHWs 2. Anganwadi workers do not weigh the child regularly due to non-availability / non-functional weighing machine, instead they use MUAC tapes 3. Measurement with MUAC tapes is done only on vaccination days, so limited to children who come for vaccination 4. No regular growth monitoring of school going children, only done during Annual Health Camps 5. FHWs' knowledge about under

Stakeholders	Facilitators	Barriers
		nutrition and its markers is inadequate 6. No regular monitoring of FHWs, especially AWW by block level staff 7. Toilets built in Kushalgarh are non-functional due to water shortage. 8. No government body is responsible for ensuring gas connection. It is being managed by the private gas company who provides gas connection to those who can pay with an added barrier of high upfront costs

c. Components of Intervention Package:

Target recipient	Function	Content	Channel
Care givers/ Household Members	Awareness generation	1. The benefits of play for motor and cognitive development and knowledge of types of activities 2. Indicators for good growth and development of the child	Schools as a venue for community mobilisation
		1. Importance of hygiene, safe water and sanitation 2. Benefits of rainwater harvesting maybe through a pilot demonstration	1. Thorough school – (i) School going children (i) Schools as a venue for community mobilisation
		3. Common risk factors for various illnesses from un-	Through Women's groups for peer

Target recipient	Function	Content	Channel
Care givers/ Household Members		treated water, open defecation and disposal of child faeces, open drains, mosquito breeding, 4. Benefits of health services available in public health institutions 5. Through vegetable gardens in schools	education (i) Schools as a venue for community mobilisation
		6. Alternative Cooking fuel and indoor air pollution	Through Women's groups for peer education
	Demonstration and practice	1. Hand-washing with soap 2. Safe drinking water at household - treatment at source, storage and during use 3. Cooking with alternative stoves and cooking fuels 4. Rainwater harvesting 5. Enabling interpretation of growth monitoring charts 6. Age appropriate play activities 7. Use of Solar power in schools	1. Through Women's groups for peer education 2. Schools as a venue for community mobilisation 3. FHWs to reinforce caregiver's capability to make these changes 4. Involve NGOs who are designing gas stoves 5. Advocacy with officials
	Routine planning	Plan ways to build playtime into their day	FHW counselling
	Role modelling/	1. Demonstrating good	FHWS to reinforce

Target recipient	Function	Content	Channel
Care givers/ Household Members	Positive Deviance	practices related to a. Play and development of child b. Personal Hygiene c. Water treatment at household level d. Rainwater harvesting in schools e. Cooking with alternative stoves or fuels f. Toilet usage 2. Support for above mentioned services	caregiver's capability to make these changes
	Education and literacy classes	1. Literacy classes for mothers 2. Motivating for change	Through Peer educators in schools after school hours
	Encourage health-seeking behaviours amongst caregivers	1. Providing information and treatment about parasitic infection 2. Public health services for deworming, iron supplementation and other services	FHW household visits Picture cards Small group meetings
Community	Awareness generation	1. Reinforcing messages on : • Handwashing • Toilet Use • Kitchen garden	1. School Teachers 2. Props such as soap, picture cards 3. Games 4. Community score cards 5. Demonstration pilot in schools
	Demonstration and Practice	1. Kitchen gardens 2. Model for low cost toilets	1. School as training centre for community

Target recipient	Function	Content	Channel
		3. Supporting teacher to mentor AWCs 4. Channelising open water 5. Treatment of drinking water 6. Reduce water logging 7. Use of solar panels 8. Milk Banks – human and animal	2. Training package around how to take care of kitchen garden / how to compost 3. Cooking for AWW children in schools
Frontline Health workers	Awareness	1. Recognising signs and symptoms on the need for deworming	Training on need for deworming
	Demonstration and practice	1. Demonstrating on how to deworm 2. Prevention of mosquito breeding and practices to reduce risk of malaria 3. Regular growth monitoring	Training on biannual deworming, malaria prevention and growth monitoring
District and state Officials		1. Access to deworming tablets 2. Model for low cost toilets and demonstration of water treatment plants in schools 3. Equipment for growth monitoring 4. Regularise payment for toilet construction	Advocacy and engagement with policy makers in the District