



dasra

Society for Nutrition, Education and Health Action (SNEHA)

Dasra Giving Circle: End of Project Report

October 2016



Executive Summary

Synopsis of the SNEHA End of Project Report



Program Execution

- Between 2012 and 2015, Aahar scaled to 10 Beats in Dharavi reaching out over 31,000 children and 6,000 pregnant women.
- The Aahar program pivoted from a day care centre model that was dependent on physical infrastructure to a more light weight, scalable community based model of intervention.
- SNEHA also additionally developed two distinct implementation strategies of varying intensities to simultaneously tackle malnutrition in the community and ensure that the program could be sustained by government health providers.



Impact Assessment

- Achieved an 28% overall reduction and a 23% net reduction (directly attributable to the SNEHA) in wasting levels for the 5 Full Intervention (high intensity) beats.
- Aahar recorded significant increases in coverage of government services in Dharavi across the intervention period.
- Recorded marginal improvements in IYCF indicators with the largest being a 37% increase in Exclusive Breastfeeding practices.



Program Financials

- The Aahar program had a cumulative program budget of INR 9.8 crore and achieved a total utilization of 78% over the 4 years. 100 % of DGC funding has been utilized for SNEHA's program implementation and subsequent impact assessment and program exit activities.
- The Aahar model has been found to be a very cost effective model means of averting diseases as compared to malnutrition programs implemented in Zambia, Malawi and Bangladesh.



SNEHA stands today as an extremely capable organization, with strong leadership, execution ability and a clear vision for its future. It has a rich central corpus and a diverse funder base with funding available for its programmatic and organizational development. SNEHA will continue to deepen its research capabilities and sector expertise. It will look to serve as a nodal technical & training partner and scale its impact by collaborating with other implementation agencies across India.

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SNEHA Aahar – Tackling Child Malnutrition



Recapping the Dasra Giving Circle funded project to reduce the levels of malnutrition in Dharavi, Mumbai

- SNEHA's malnutrition program operated in Dharavi, one of India's largest slums with the aim of addressing acute malnutrition amongst children between 0-3 years.
- In November 2011, SNEHA was selected by the Dasra Giving Circle (DGC) to be funded through Dasra's research report ***Nourishing Our Future: Tackling Child Malnutrition in Urban Slums***. The report featured SNEHA's 'Aahar' malnutrition program which looked to cover all of Dharavi, **covering 300 anganwadi (creche) centres** (divided into a total of 10 beats – administrative units) and **reducing acute malnutrition by 25%** amongst 0-3 year olds.
- As March 2016 marked the end of more than **4 years of Dasra support to SNEHA**, this report seeks to consolidate the overall achievements and outcomes of the Aahar program, provide the DGC with program insights and learnings, and highlight SNEHA's organizational evolution.

Existing Malnutrition Prevalence

In Mumbai:

- **40%** of children under 3 are stunted*
- **1 in 3 children** under 3 are underweight*
- Prevalence of Acute Malnutrition is found to be **13%-20%**

In Dharavi, **over 30% of children** under 3 years are **stunted** and **nearly 30%** of them are **underweight**.**

*Source: National Family Health Survey, 2005-2006

**Source: SNEHA evaluation data

Aahar Program Model

- SNEHA's Aahar program uses a two pronged strategy to tackle malnutrition: (a) **working with communities** to improve care seeking behavior and increase access to health services, and (b) **working with local government** stakeholders and functionaries to ensure that high quality care is delivered.
- The program is delivered at the community level by SNEHA's field staff, known as Community Organizers (CO), and focuses on **early screening & treatment** of children and **behavior change communication** for pregnant women and mothers.
- Screening of children is done at each *anganwadi* centre on a monthly basis, using World Health Organization (WHO) guidelines and the metric, **weight for height ('wasting')** to determine nutritional status. The program targets the **most vulnerable children** who are suffering from either Severe Acute Malnutrition (SAM) or Moderate Acute Malnutrition (MAM). **Referrals** for children who require medical attention, are made to either a pediatrician, the **local government municipal hospital**, or the Nutrition Rehabilitation and Research Centre (NRRC) located at Chota Sion Hospital, Dharavi.
- **Frequent home visits** to SAM and MAM children are made by SNEHA COs who educate mothers on hygiene, health seeking practices and **monitor the progress** of malnourished children. Additionally, SAM children also receive Medical Nutrition Therapy (MNT), which are ready to use therapeutic foods, and focused care at **SNEHA's day care centres (DCCs)** located in the community.
- **Pregnant women** are also monitored and provided with crucial information to improve their chances of safe deliveries and raising healthy children.
- A key facet of the Aahar program is that it **collaborates with and closely mirrors the structure of existing government programs**, namely the ICDS, a national women and child welfare program, specifically its key components, the *anganwadi* (creche) and the *anganwadi* front line worker, the *sevika*. SNEHA not only involves the government field staff in its activities but it also conducts ongoing trainings for *sevikas* to equip them with the required growth monitoring and critical response skills required to tackle malnutrition.
- This alignment allows the *Aahar* model to provide the government with a replicable intervention model with valuable insights into the resources and activities required to improve nutrition levels in the community.
- An innovative mobile based data collection system allows the **monitoring of key malnutrition indicators** for each household and the **regular tracking** of children by SNEHA's COs.

Program Achievements

Scaling the program to all of Dharavi covering over 100,000 households

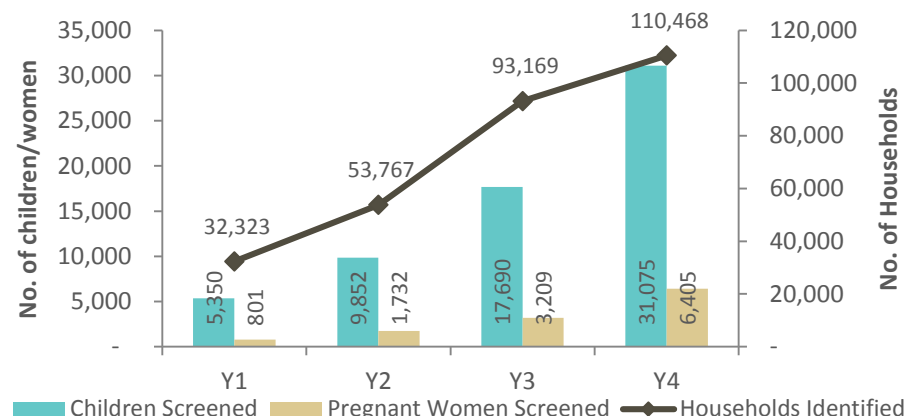


By July 2014, SNEHA successfully met its target of scaling up to all 10 beats of Dharavi. Over the 4 years of implementation, Aahar directly served **37,480 children and pregnant women across 110,468 households in Dharavi.**

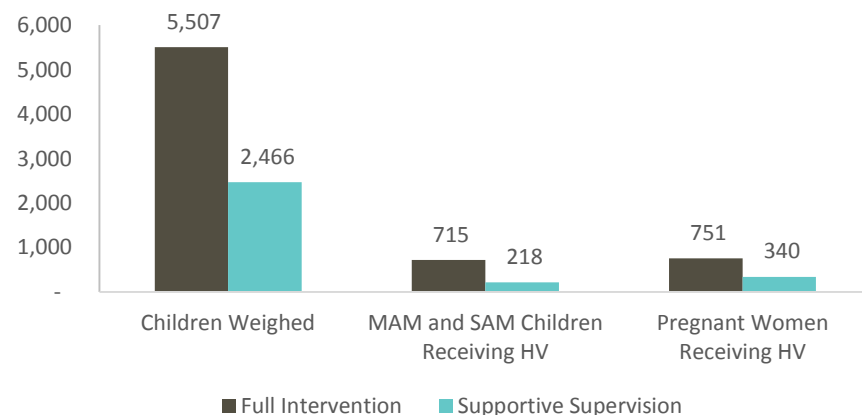
Outreach

- Over the four years, SNEHA screened a cumulative of 31,075 children and 6,405 pregnant women. Of its core beneficiary group (children), 83% were children below the age of 3.
- Cumulatively, by the end of 2015, 14 % of the 31,075 children it monitored across all 10 beats, were either MAM or SAM. SNEHA COs also actively monitored 1,331 pregnant women during that time.
- SNEHA has trained more than 300 *anganwadi sevikas*, and 30 ICDS Supervisors & CDPOs (Child Development Project Officer) through almost a 100 training sessions in various thematic areas.
- In 2015 itself, SNEHA conducted over 500 community awareness campaigns, over 200 health camps and 3,000 group meetings mobilizing over 16,000 participants.

Program Outreach



Monthly Activities



Program Coverage

The graph alongside charts the different levels of coverage under the FI & SS protocols highlighting the 2 distinct strategies deployed. SNEHA's COs prioritized their time and efforts as required by the differing levels of rigor.

- Monthly weighing of children:** Under the FI protocol, an average 72% of children in SNEHA's database were weighed on a monthly basis compared to 34% in the SS beats.
- Home Visits to MAM & SAM children:** 89% of MAM & SAM children received monthly home visits under FI protocols compared to 30% who received them under SS protocols.
- Home visits to Pregnant women:** 90% pregnant women received home visits in FI Beats compared to 58% in SS Beats.

The above graph displays the average values from July-Sept'15

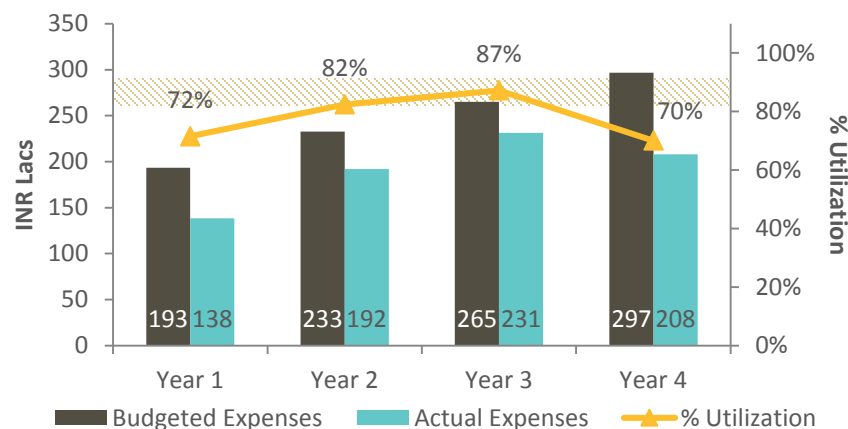
Overall financial utilization of 78% with significant investments made to develop SNEHA's institutional capacity

Highlights

Over the 4 year period, the Aahar program had a cumulative budget of INR 9.8 Crore with the budget growing by an average of 15% year on year. **DGC funding accounted for 26% of the entire program budget.**

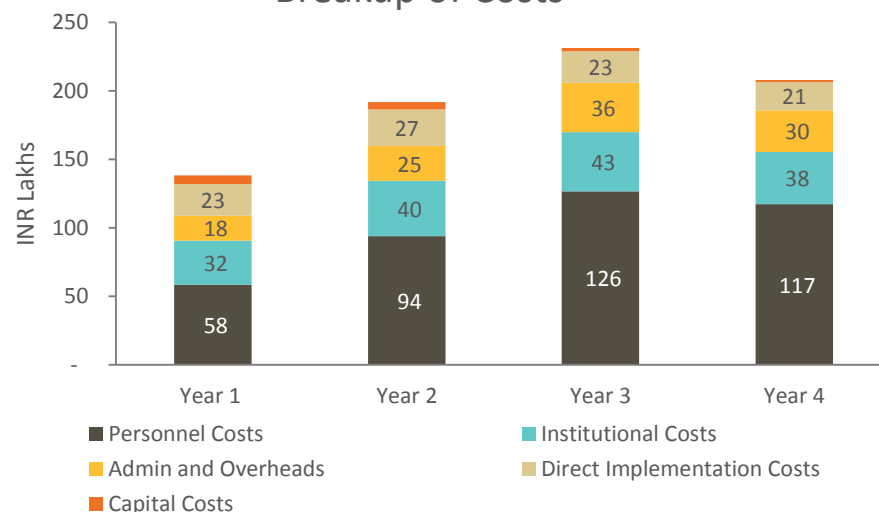
- **Average annual budget utilization of 78% over the 4 years.** The highest utilization figures were recorded in Year 2 (2013) and Year 3 (2014), as SNEHA rolled out its intervention in all 10 beats in Dharavi. As of April 2016, all DGC funds have been utilized by SNEHA for its impact assessment and program exit activities.
- SNEHA recorded a direct implementation utilization of 51%, due to the use of the cost effective CMAM model over the resource intensive DCC model.
- SNEHA invested a significant percentage of the funding in senior management staff as well as recruiting strong talent for support functions like finance, human resources and fundraising. Building out its institution has allowed SNEHA to free up management bandwidth to focus on strategic and organization level matters. It has also allowed the recruitment of dedicated personnel who have core research expertise leading to more rigorous evaluations, research and program learnings.
- Unrestricted DGC funding has allowed SNEHA to grow its marketing capabilities and increase its donor outreach, resulting in greater funding for Aahar and other SNEHA programs. This has also indirectly led to lower utilization, as SNEHA has raised funds for Aahar faster than it has been able to spend them. This has allowed SNEHA greater flexibility in its program planning & execution and build the organizations central corpus.
- SNEHA's institutional strengths and high governance standards will continue to be a differentiator for the organization, as it seeks to compete for funds in a crowded NGO marketplace.

Program Utilization



The shaded band represents 80%-90% budget utilization, which is the preferred region for Aahar to operate within

Breakup of Costs



Assessing Aahar's Impact



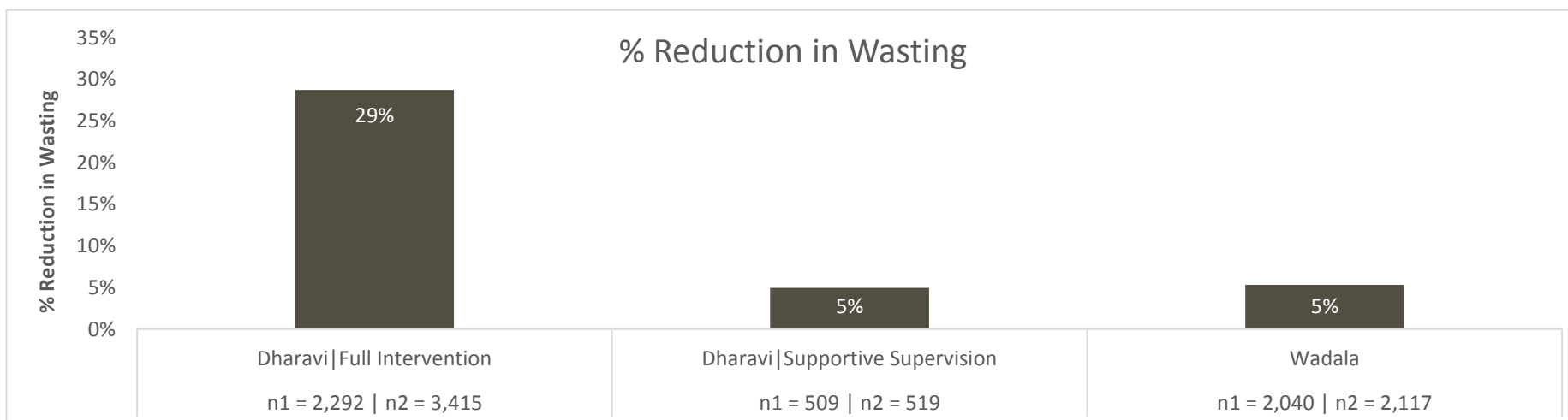
Aahar reduced wasting in Dharavi by 29%, exceeding its Private Philanthropy Memorandum target set at 25%

Impact on Malnutrition

The primary outcome for the 2014-15 Aahar impact assessment study was the measurement of wasting levels in Full Intervention (FI) communities, which comprised of 5 beats in Dharavi. These beats received Aahar's FI protocol for approximately 16 to 18 months.

SNEHA was able to reduce prevalence levels **of wasting from 18% to 13%, achieving an overall 28% reduction** from baseline to endline in the FI beats. The Wadala comparison area recorded a reduction of 5% in levels of wasting in the same duration. By adjusting the % reduction in wasting in Dharavi with the % reduction seen in Wadala, **SNEHA achieved a net reduction of 23 % in wasting levels** through its Full Intervention model.

SNEHA's engagement with ICDS in the 5 Supportive Supervision beats did not lead to the rigorous implementation of SNEHA's CMAM program by the ICDS. As a result, the reduction in wasting in the SS beats was marginal and could perhaps be explained by other macroscopic factors affecting Mumbai.



The above graph shows the percentage reduction in wasting. | n1 and n2 – denotes the baseline and endline sample sizes respectively

SNEHA conducted quantitative assessments of the Aahar program through a series of baselines and endlines in all 10 beats of Dharavi (*Please refer to Appendix D for details*). The primary objective of the assessment was to measure whether the Aahar program contributed to a reduction in the prevalence of wasting (weight for height) in Dharavi, between 2014 and 2015. A comparison area, Wadala, was also evaluated to understand to what extent the outcomes were possibly affected by secular trends.

In summary, over the 16-18 month implementation period evaluated, SNEHA recorded significant positive reductions in the levels of wasting in the community as well as increased coverage and uptake of services provided by ICDS and the Mumbai Municipal Corporation (MCGM) in Dharavi.

Assessing Aahar's Impact

Increased coverage from government service providers and improved breastfeeding practices in the community



Collaborating with Government

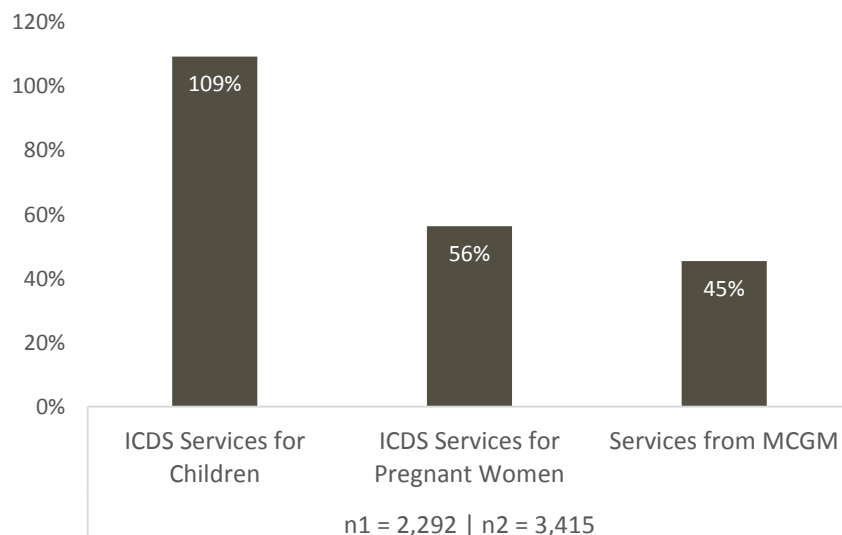
A core component of the Aahar program is collaborating with the ICDS and MCGM to increase coverage of public health services in Dharavi.

SNEHA saw a significant increase in the coverage of government services in Dharavi, headlined by a **109% increase in ICDS services received by children.**

Of all the ICDS mandated services, growth monitoring (weighing) and the provision of nutritional supplements saw the biggest increases.

SNEHA's deeper integration with ICDS and MCGM is demonstrated clearly by the endline data. Greater convergence between SNEHA, ICDS and MCGM also forms one of the pillars of Aahar's future.

% Increase in services provided



The above graph shows the percentage improvement in government services in the Dharavi Full Intervention beats.

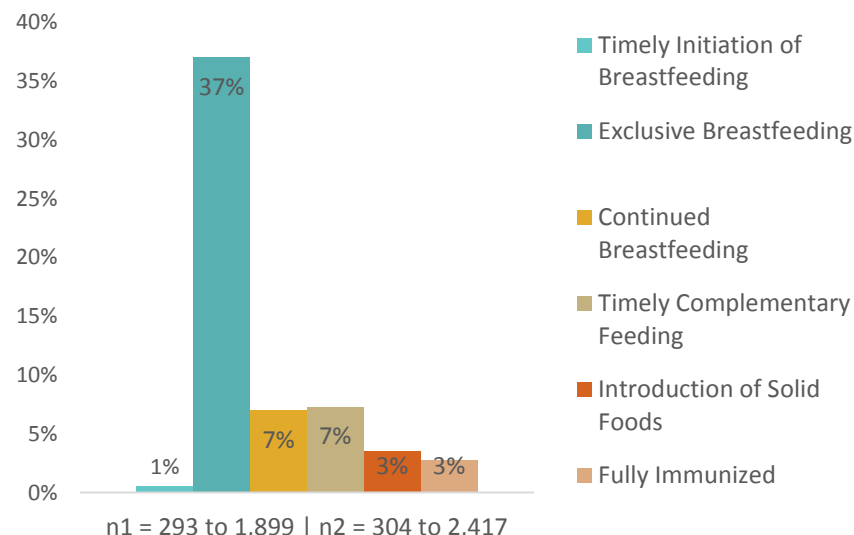
Influencing the Community

To bring down the levels of malnutrition in a preemptive and sustained manner, improving Infant and Young Child Feeding (IYCF) practices through home based counseling and events in the community is crucial.

IYCF practices ensure the reduction of child mortality and morbidity through the optimal feeding of infants and young children.

As Aahar focused on identifying and treating cases of malnutrition it was not intensive enough to affect caregiver practices greatly. This is evidenced by single digit increases in most IYCF indicators, apart from **Exclusive Breastfeeding where all mothers of children under the age of 6 months received home based counselling from the COs.**

% Increase in IYCF practices



The above graph shows the percentage improvement in IYCF practices in the Dharavi Full intervention beats.

Assessing Aahar's Impact

A service delivery model with proven impact, high replicability and frugality



Aahar's impact assessment study looked to evaluate multiple aspects of the implementation of the Aahar program. Apart from understanding how effective SNEHA's community based approach to Manage Acute Malnutrition (CMAM) model was in reducing malnutrition, one of the most important aspects of the assessment was to understand how viably could the model be scaled across geographies. With this in mind, the major takeaways from the assessment relating to the efficacy of the program, its cost effectiveness and its ease of replication by the government are presented below.

Efficacy and Replicability of Aahar

Generating evidence on the feasibility and efficacy of the CMAM model and collaborating with ICDS, MCGM and the community has been one of the major success of the Aahar program.

Through its impact assessment studies, SNEHA has been able to prove that a well implemented CMAM model can reduce malnutrition prevalence rates in an urban slum setting in a time bound and cost effective manner.

SNEHA has generated crucial operational and process data on the implementation of a community based model versus a facility (physical structure) based model of intervention, understanding the strengths and pitfalls of both approaches.

By mirroring the organization and field staff structure of the ICDS and collaborating with existing public health institutions, SNEHA has demonstrated that the Aahar model can be replicated and scaled across the country by the other government agencies.

Since there is a scarcity of existing literature on the implementation and impact of the CMAM program in urban settings, Aahar's impact assessment study contributes crucial evidence and learnings for other institutions who might look to implement similar programs.

Cost Effectiveness of Aahar

The cost effectiveness of SNEHA's CMAM implementation was studied by Sophie Goudet from Loughborough University. In her study, it was found that SNEHA's CMAM program recorded an estimated cost of **USD 23 per DALY averted**.

A DALY or disability adjusted life year, is a measure of the overall disease burden, expressed as the number of years lost due to ill-health, disability or early death. 1 DALY refers to 1 year of productive life lost. Averting 1 DALY would mean 1 year of productive life regained (which might have otherwise been lost to poor health).

The cost of a DALY averted through the CMAM program compares favorably against inpatient care cost (treatment in a medical facility). SNEHA also found that the cost borne by the parents (of a malnourished child) were lower through the CMAM approach.

Aahar's cost per DALY can be very competitively benchmarked against other CMAM programs in Zambia and Malawi which cost USD 58 (2015) and USD 43 (2015) per DALY averted respectively. A study was also conducted in Bangladesh, where the CMAM program was delivered by community health workers. The cost per DALY averted in this case was USD 27 (2015) which once again compares favorably to SNEHA's implementation cost.

In the study, the Aahar program was found to have averted 14,653 DALYs over a program coverage area consisting of approximately 8,600 children.

Assessing Aahar's Impact



Effective delivery of the program made possible due to the excellent performance of SNEHA's front-line staff

The Aahar program made use of multiple methods of engagement with community and government stakeholders. These varied strategies provided SNEHA with crucial learnings about the implementation of a large scale community based program to reduce malnutrition. SNEHA's successes and challenges experienced over the last 4 years will inform future models of implementation.

Program Successes

The performance of SNEHA's field staff was one of the major factors behind Aahar's success. The CMAM model requires the diligent execution of frequent, sequential tasks over an extended duration of time. SNEHA's COs maintained a high ethic despite receiving little support from the ICDS and Dharavi's cramped, unfavorable conditions. Their highly inclusive and positive attitude towards the ICDS *sevikas* laid the foundation for SNEHA to build a strong relationship and pursue its advocacy efforts.

Building and strengthening the partnership with ICDS over the 4 year program period allowed SNEHA to expand its focus in the area of child health and nutrition. SNEHA engaged with ICDS through regular processes reviews, vision building workshops, and motivation and felicitation sessions, creating a high level of buy-in with ICDS. In the future, SNEHA could potentially leverage ICDS' reach, a national program, to replicate the Aahar model in multiple geographies.

Conducting real-time analyses of data provided SNEHA with the ability to rapidly modify its implementation protocols to respond to the changing needs on the ground. SNEHA's data collection rigor, the use of mobile devices and strong backend processes cut down lead times and allowed it to generate crucial insights on a regular basis. SNEHA is currently investing in a centralized Management Information System to consolidate its programmatic data at an organization-wide level.

Effective management of individual cases of malnutrition by SNEHA proved that the CMAM model is effective in providing care to the most vulnerable children and prevent malnutrition deaths. SNEHA's COs closely monitored the health of children with severe malnutrition and provided behavior change communication at a household level to these families.

Program Learnings

Identifying key competency gaps among government stakeholders is essential in understanding their ability to deliver services. In the Supportive Supervision beats, the ICDS possessed neither the training, nor the equipment and motivation to conduct growth monitoring and follow-up activities. SNEHA now understands the critical need to provide experiential (practical) training to ICDS staff to help them practice and implement the theoretical training they have traditionally received.

Empowering the community to take action is critical to ensuring the sustainability of the gains made by the Aahar program. SNEHA has learnt the importance of not only providing access to government services, but also the need to educate and empower the community to demand high quality services from ICDS and MCGM and hold them accountable for their delivery.

Coordinating efforts between government agencies is crucial to tackle a highly complex issue like malnutrition which is affected by interlinked issues like immunization, ante-natal care, post-natal care, family planning, maternal and child morbidity. A convergence approach between ICDS, MCGM and SNEHA, to coordinate activities and resources, is important to tackle a wide ranging issue like malnutrition.

The multiple iterations of the implementation protocols added to the complexity of their implementation. SNEHA's field staff required constant field level support, feedback sessions, sharing of best practices and specific guidance in difficult cases to effectively implement the different models in the community.

Aahar – The Future



Greater involvement of the government and community for joint action against malnutrition

Post the culmination of the Aahar program in March 2016, SNEHA will continue working with the most vulnerable populations through the “Aahar 2.0” program. Aahar 2.0 will build on SNEHA’s learnings from the previous 4 years and leverage its relationships with ICDS and MCGM. The program will be rolled out in 3 beats of Dharavi and in 2 beats in Wadala, a neighboring community with a higher wasting prevalence than Dharavi.

The major strategic focus of the future Aahar program will shift away from direct implementation in the community, where the majority of the community intervention activities like weighing and home visits were performed by SNEHA field staff. SNEHA will work with the ICDS and MCGM to develop their ownership of these critical activities that positively affect the health and nutrition of children in the community. SNEHA will also build the communities’ ownership towards government service providers and empower them to demand services and accountability from the ICDS and MCGM.

Key Intervention Strategies

SNEHA’s Aahar protocols focused on providing curative care to children suffering from acute malnutrition through intensive home based care. However, the results of the Supportive Supervision beats suggest that these protocols are unable to influence crucial caregiver practices. There is a need to focus on the preventive aspect of malnutrition, so that children do not become malnourished in the first place, and on ensuring that this preventive care is provided by the ICDS and MCGM.

Key features of the new Aahar model include:

- **Focusing on implementation through the ICDS and MCGM:** SNEHA’s COs will no longer directly conduct home visits or measuring and weighing activities in the community. These responsibilities, will be taken up by the *anganwadi sevikas*, with SNEHA staff providing visibility to the supervisors on whether all the ICDS mandated activities are being executed or not. A team of full time investigators, hired by SNEHA, will conduct sample surveys on an ongoing basis to confirm the accuracy of ICDS data on malnutrition prevalence levels and generate feedback to review and strengthen the ICDS’s processes.
- **Inclusion of ‘Underweight’ as the primary parameter for malnutrition:** Over the past 4 years SNEHA has advocated, with limited success for the ICDS to adopt wasting (weight for height) as its malnutrition indicator. Wasting is an indicator recommended by the WHO as an accurate measure of malnutrition. While the ICDS drafted an initial circular on the matter, it has not yet adopted wasting as an indicator to measure malnutrition. SNEHA will thus have to align itself with ICDS’s current mandate, which would involve using underweight (weight for age) as the indicator for malnutrition. SNEHA however, will still train the ICDS (in Dharavi) to measure and calculate wasting, as this is required by the Nutrition Rehabilitation Research Centre (NRRC) to diagnose and prescribe nutritional supplements to malnourished children.
- **Deeper community engagement:** As mentioned earlier, SNEHA realizes the need to expand the scope of its community engagement to empower communities and facilitate greater interaction with the ICDS. SNEHA will look to activate women's groups and volunteers in the community who would promote individual and joint action. SNEHA will also look to identify champions in the community who can engage Dharavi’s large migratory population and help them access services in the community.

Aahar – The Future

Key facets of SNEHA's Aahar 2.0 program



The change in the Aahar's strategic priorities can be well represented in the outcome indicators Aahar 2.0 will be measured against. These include:

Working with ICDS

- Improved coverage and accuracy of weighing
- Improved distribution of supplementary nutrition
- Improved coverage of pregnant and lactating mothers
- Appropriate awareness, referral and follow up of children and mothers

Working with the Community

- Access and uptake of ICDS services
- Participation in meetings with ICDS
- Self referral and self monitoring by mothers
- Formation of community groups, volunteer training and action

Aahar 2.0		
	Direct Beneficiaries	Indirect Beneficiaries
Program Duration: April 2016 – March 2019	150 <i>anganwadis</i>	10,000 children
Area of Coverage: Dharavi and Wadala	500 children	30,000 families
Program Budget: INR 1.86 Crore	2,000 pregnant and lactating women	
Current Funding: 85% Funded (INR 1.59 Crore)	100 community groups	
	100 volunteers	

Convergence with the ICDS and the Mumbai Municipal Corporation

In April 2016, SNEHA signed a Memorandum of Understanding (MoU) with the ICDS Commissionerate and the Mumbai Municipal Corporation (MCGM) to form the **Mumbai Child Health and Nutrition Committee (MCHNC)** with a mandate to *“improve the health and nutrition of women and children in informal urban settlements of Mumbai.”*

The MoU will allow SNEHA, ICDS and MCGM to jointly tackle the issue of malnutrition by coordinating the deployment of resources, manpower and data, to service Mumbai's most vulnerable areas.

Dasra Support to SNEHA



Dasra has provided SNEHA 291 days of hands on support and has helped raise INR 14.5 crore of funding over 4 years

Over the past 4 years, Dasra has worked closely with multiple levels of SNEHA’s program and organization staff to provide support in the implementation of the Aahar program as well as provide SNEHA’s management team with inputs to help build out its fundraising capabilities, implement an effective organization structure and reflect on its long term future and strategic priorities.

Some of the highlights of Dasra’s Capacity Building efforts towards SNEHA include:

Fundraising

Dasra has effectively leveraged its network to help SNEHA develop a diverse funder base that consists of foundations, corporates and individual philanthropists. Dasra showcased SNEHA at Dasra events like the Dasra Philanthropy Week, the Dasra Philanthropy Forum and made introductions to funders with aligned values and visions.

Dasra also provided SNEHA’s funding and communications team with perspective on the qualitative and quantitative data that funders look at, as they evaluate organizations they wish to fund. Dasra worked closely with SNEHA to create and refine pitch decks and funding proposals.

Operations and Strategy

Dasra spent a lot of time with SNEHA to develop a detailed understanding of the organization’s program models and operations. It supported SNEHA to scale the Aahar program in a phased manner to all 10 beats in Dharavi, exploring various scenarios for scale and understanding SNEHA’s institutional and financial capacity to execute these scenarios.

Neera Nundy sits on SNEHA’s advisory board and engages with SNEHA’s senior management to discuss the organization’s institutional needs and provide input on the organization's growth plans.

Finance

Dasra worked closely SNEHA’s Director of Finance to formalize its backend financial processes to streamline financial reporting, track fund inflow and utilization. This allowed SNEHA to monitor and report its financials accurately to a large donor base.

These efforts have served SNEHA well and have led to a high degree of sophistication in the organization’s financial management practices, to provide funders with transparency and accountability.

This strength is more relevant today than ever, with complex guidelines and restrictions accompanying today’s funding environment due to the Corporate Social Responsibility act (CSR) and the Foreign Contribution Regulation Act (FCRA).

Monitoring and Evaluation

In the 1st year of funding, Dasra and SNEHA worked to review and consolidate SNEHA’s Monitoring and Evaluation processes (M&E). SNEHA, keen to streamline and digitize its data collection, worked with Dasra to evaluate various technology vendors.

Dasra facilitated conversations with Dimagi to create customized software for smart phones which allowed SNEHA to record data on the nutritional status of mothers and children and track their progress through the intervention. SNEHA worked with Dimagi to develop a nutrition calculator for use on the mobile platform.

SNEHA’s use of technology to increase programmatic efficiencies and community engagement has underpinned multiple programs since.

Dasra Support to SNEHA

Dasra to broaden its scope of engagement with SNEHA



Dasra will formally continue to engage with SNEHA through the following engagements:

Program	Duration	Funder
Child Health and Nutrition (Aahar)	January 2016 – December 2019	Philips India
	March 2016 – April 2017	Comic Relief
Prevention of Violence against Women and Children	January 2015 – December 2018	Azim Premji Philanthropic Initiatives
SNEHA – Ekjut Gender Based Violence Pilot	January 2016 – July 2018	USAID
Sexual and Reproductive Health	March 2016 – April 2017	Comic Relief
Maternal and New Born Health	January 2016 – December 2019	Philips India

In addition to leveraging further funding for SNEHA, Dasra will also look to broaden its engagement with SNEHA and provide support to the Maternal and Newborn Health program and the Prevention of Violence against Women and Children program.

Dasra is currently conducting a needs assessment with the various program teams to identify the areas in which Dasra could either directly support SNEHA or provide access to those who could.

Some of the areas of support that have been identified thus far include:

- Help develop and disseminate SNEHA's impact assessment briefs
- Support SNEHA to create operating manuals to drive partnerships and collaborations
- Provide field staff with perspective on funder reporting requirements
- Create 5 year vision documents and provide needs based strategic support
- Help develop a Management Information System to consolidate program data

Another major area of institutional support requested by SNEHA is to conduct active donor management of SNEHA's growing base of funders. SNEHA believes that Dasra's perspective towards organization centric funding is crucial to creating a cohort of enlightened funders who are willing to work together to realize greater impact. Dasra will also support SNEHA to potentially develop a common reporting format for all its funders which would decrease the reporting burden on SNEHA's program teams.

Dasra is currently unfunded for its future capacity building support to SNEHA and will be looking to raise funds for the same.

Impact

SNEHA's Aahar program has proven to be effective in reducing the prevalence of malnutrition at a community level. SNEHA's Community Management of Malnutrition (CMAM) approach to tackling individual cases of malnutrition does not require investments in physical infrastructure. This is important in a congested urban environment. The program however, does require investments in a large number of highly trained and motivated field staff to carry out the intervention.

The CMAM model is well suited to affect the critical levels of malnutrition prevalent in India in a resource effective manner. By ensuring that its intervention model and program structure is similar to existing government infrastructure and resources, the Aahar model is well positioned to be executed and scaled by the ICDS and other public health departments in the country.

Scalability of Model

The Aahar model is very scalable, with the biggest resource inputs being human capital and technical training. Aahar's independence of cost intensive physical infrastructure, alignment with government service providers and strong Impact Assessment and Monitoring means that it can be readily adopted by other NGOs who are working in areas with critical levels of malnutrition.

SNEHA has also shown an ability to contextualize and iterate the model as ground realities make themselves known. This suggests that an implementing organization could also contextualize the model as required for their specific needs.

The program is also well aligned to SNEHA's organizational growth plans. SNEHA could replicate the Aahar program across geographies, working through other partner NGOs, developing and delivering intensive training modules and providing them with hands-on support through the implementation.

Alignment with Public Health Services

The intensive nature of the Full Intervention protocol brings with it the risk that, the ICDS and the MCGM might become too dependent on an NGO to implement the basic services they are responsible for. The program needs to ensure that it is not doing the government's job for them but is providing the government with the tools and approach to help them best deliver these services.

One of the setbacks that the Aahar program faced was ICDS' reluctance to adopt wasting (weight for height) as an indicator of malnutrition, preferring the indicator, underweight (weight for age) instead. Wasting, a WHO developed indicator has been universally acknowledged as the better indicator of malnutrition but has failed thus far to gain the traction SNEHA expected. This could potentially affect the adoption of SNEHA's model by any other public health service providers as SNEHA's impact is measured in reducing wasting levels and not levels of underweight children.

It is however important to note that wasting as an indicator of malnutrition has been adopted by other key government bodies like the National Rural Health Mission, the Nutrition Rehabilitation Research Centre at Chota Sion Hospital as well as other large scale CMAM programs being implemented across the country.

Leadership

SNEHA is led by its Chief Executive Office, Vanessa D'Souza. Dr. Armida Fernandez, the founder of the organization, supports SNEHA in a non-executive role. SNEHA is one of the few NGOs in the sector, that has integrated business professionals into leadership positions in the organization. As a former Director at the Citibank Group, Vanessa has brought with her the commercial business acumen and the managerial ability required to run a large organization like SNEHA.

Vanessa is supported by SNEHA's executive director Dr. Shanti Pantvaidya, a hugely experienced public health professional, and a strong second line of Program Directors who are well qualified in their respective fields. Dr. Shanti along with SNEHA's Program Directors provides the organization with a strong technical backbone to drive its program development and execution. This has allowed Vanessa to build out SNEHA's support functions like fundraising, finance and human resources, as well as chart out the organizations strategic priorities and growth trajectory.

SNEHA's transfer of executive leadership from Dr. Fernandez to Vanessa is considered by Dasra as an industry best practice. With a large number of founder driven organizations reaching a point that requires professional managerial capability, Dasra has documented SNEHA's approach to succession planning as one of the ways organizations can address their management deficit. Dasra has documented and disseminated these learnings through case studies, executive education (through Dasra's Leadership Program) and an e-learning module on leadership.

Organization Structure

SNEHA is a modern, sophisticated organization with well defined organizational roles and responsibilities. It has been able to attract and retain qualified professionals for both the its programmatic and support functions. SNEHA's organization structure has been continuously adapted to suit the organizations growing requirements.

As SNEHA has increased the scope of its operations and entered into partnerships with other NGOs (Gender Based Violence pilot with Ekjut in Jharkhand) and government departments (National Urban Health Mission), it has delegated operational responsibilities to its second line program staff (Associate Program Directors). SNEHA's Program Directors are now expected to focus on matters like advocacy, developing partnerships and seeking out opportunities to scale their programs.

Impact Assessment and Advocacy

A traditional SNEHA strength has been its extremely robust M&E and IA processes. It has used detailed impact frameworks and has strong monitoring processes to track its advances in an accurate and time bound manner. SNEHA has also demonstrated an ability to act on the intelligence it gathers in the field to make swift and far reaching changes to its implementation processes.

While keeping its data driven fundamentals intact, SNEHA needs to ensure that it is best able to leverage all the evidence it has generated into tangible advocacy efforts. SNEHA's advocacy activities have thus far been limited to interactions with city and state level government officials. It has been a slow process but SNEHA is finally seeing results with the convergence between ICDS and MCGM in Mumbai, and its appointment as the technical training partner for the National Urban Health Mission to form 10,000 women's health committees across 95 urban sites in Maharashtra.

SNEHA's evidence generation approach is crucial for the organization to be able to successfully advocate with government public health departments. Over the years it has actively raised funds for its dedicated research vertical, published multiple peer review papers and has disseminated its findings at conferences worldwide. These activities not only help SNEHA ensure that its research reaches a large audience but also builds their visibility in the sector and allows them to position SNEHA as a highly credible organization.

SNEHA's recent restructuring of the program teams also indicates its commitment to evidence generation. Program teams now have decentralized Impact Assessment teams which will continuously monitor and document SNEHA's programmatic implementation and its near term and long term outcomes. It has also budgeted considerable amounts of money to hire evaluators to generate field data on an ongoing basis to add further nuance to their monitoring process and focus on tracking progress and deviations from the expected outcomes of the program.

SNEHA has made it clear that it will be looking to focus on undertaking more qualitative research, to more deeply understand the context of both communities and the public services that are set up to serve these communities. It will also need to invest further resources in personnel with experience in advocating successfully with the government. It will also consider the steps it needs to take to expand its sphere of influence beyond Mumbai and Maharashtra to a national level.

Finance and Regulatory

As previously mentioned in the report, SNEHA has an extremely robust finance and compliance team sharply focused on ensuring that SNEHA complies with FCRA regulations or any other legal and financial requirements. This is an organizational strength which can not be understated in today's highly scrutinized and tightly regulated development sector environment. Dasra is of the opinion SNEHA is well equipped to receive large amounts of domestic and foreign funding and has all the right controls in place to ensure fair and proper utilization of these funds.

Growth Potential

Dasra believes that SNEHA possesses all the required capabilities to scale exponentially across geographies and grow to the same size as a sector leaders. However, SNEHA does not see scaling through program implementation and expanding directly to new geographies as its path to success. Instead, it sees itself becoming a resource and training partner for other implementation NGOs in the sector. SNEHA wishes to focus on perfecting its implementation protocols, building evidence and creating training modules to transfer these capabilities to other partners.

Dasra sees strong merit in this approach. At a certain tipping point, the resources and effort required to internally manage a large organization outstrips the resources and efforts that go into working with the community. This is a scenario that SNEHA wants to avoid. The development sector in India requires organizations that focus on deepening their sectoral expertise, invest in research and impact assessment and facilitate collaborations in the sector.

SNEHA is already collaborating with the Setco Foundation to replicate the Aahar model with 25 *anganwadis* in Baroda, Gujarat. It is also working with Ekjut, a Jharkhand based NGO on Gender Based Violence. These collaborations not only allow SNEHA to scale its model but also provides them with the opportunity to build valuable knowledge on how to manage multi partner collaborations and create impact at the sectoral level.

Appendices

Appendix A

Glossary of abbreviations and terms used in the report



Abbreviation	Full Form	Abbreviation	Full Form
ICDS	Integrated Child Development Services	DCC	Day Care Center
MCGM	Municipal Corporation of Greater Mumbai	CMAM	Community Based Management of Malnutrition
SAM	Severe Acute Malnutrition	SS	Supportive Supervision
MAM	Moderate Acute Malnutrition	FI	Full Intervention
SUW	Severely Underweight	IYCF	Infant and Young Child Feeding
Wasting	Measuring a child's weight against his/her height to determine the nutrition status	MCHNC	Mumbai Child Health and Nutrition Committee
Underweight	Measuring a child's weight against his/her age to determine the nutrition status	M&E	Monitoring and Evaluation
WHO	World Health Organization	IA	Impact Assessment
NRRC	Nutrition Rehabilitation and Research Center	NGOs	Non Governmental Organizations
CO	SNEHA's Community Organizer also known as <i>Sakhis</i>	MUAC	Mid Upper Arm Circumference
<i>Sevikas</i>	The <i>anganwadi</i> frontline worker	MNT	Medical Nutrition Therapy
<i>Beat</i>	A beat is a geographical unit which consists approximately of 600 households and 30,000 residents. Each beat is serviced by 30 <i>anganwadis</i> that cater to the needs of approximately 1,500 children under the age of 3.		
<i>Mahila Arogya Samiti</i>	Community based women's groups that are formed by the National Urban Health Mission		

Appendix B – The Problem of Malnutrition



Scale and Extent of Malnutrition, and its long-term consequences

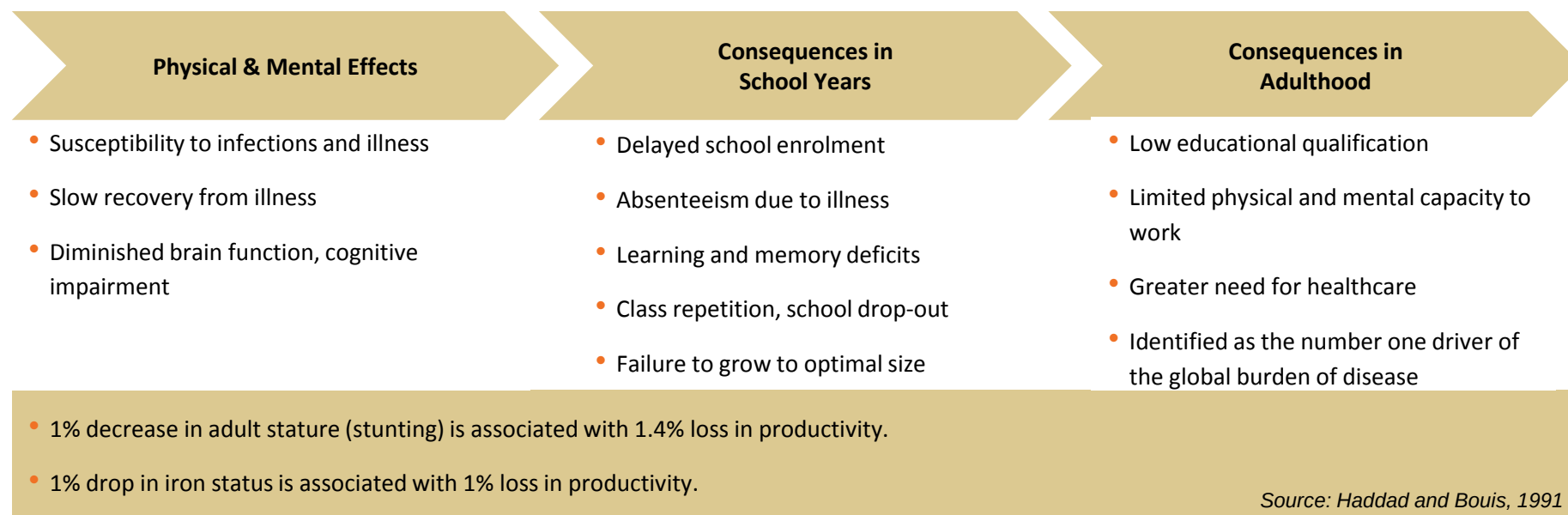
Malnutrition in the world

- Child malnutrition contributes to 3.5 million deaths worldwide annually.
- Approximately one in every three malnourished child in the world lives in India.
- Millennium Development Goal by 2015 was to halve the population which is underweight – but we are far from achieving this.

Malnutrition status across major Mumbai slums

Health Indicators	Mankhurd Govandi (M/E Ward)	Kandivali (R/S Ward)	Dharavi (G/N Ward)
Underweight	40%	40%	27%
Stunting	47%	48%	45%
Wasting	17%	19%	16%

Malnutrition has serious long term consequences:



Appendix B – The Problem of Malnutrition



Diagnosing Acute Malnutrition

The most common way to assess malnutrition in children is through body measurements. It is usually diagnosed in one of three ways:

Measuring Weight for Height (Wasting)

An indicator known as weight-for-height is used to determine whether a child is acutely malnourished. The child’s weight is compared to the ‘normal’ weight for that height. Normal weights for children are determined by studies that have weighed thousands of healthy children globally. Based on this information, the World Health Organization (WHO) has developed charts known as international standards for expected growth. If a child’s weight falls within the range considered normal for his/her height, the child is found to be well-nourished. If the weight is much less than the international standards, the child is considered acutely malnourished or wasted. WHO has created cut-off points to indicate the severity of the malnutrition.

Measuring mid-upper arm circumference (MUAC)

Another measurement used to determine a child’s nutritional status is the mid-upper arm circumference (MUAC) measurement. Because MUAC measurements require a simple, color-coded measuring band rather than weighing scales and height boards, they are often used during crisis situations. Measuring MUAC is appropriate for children between six months and five years of age.

Testing for Oedema

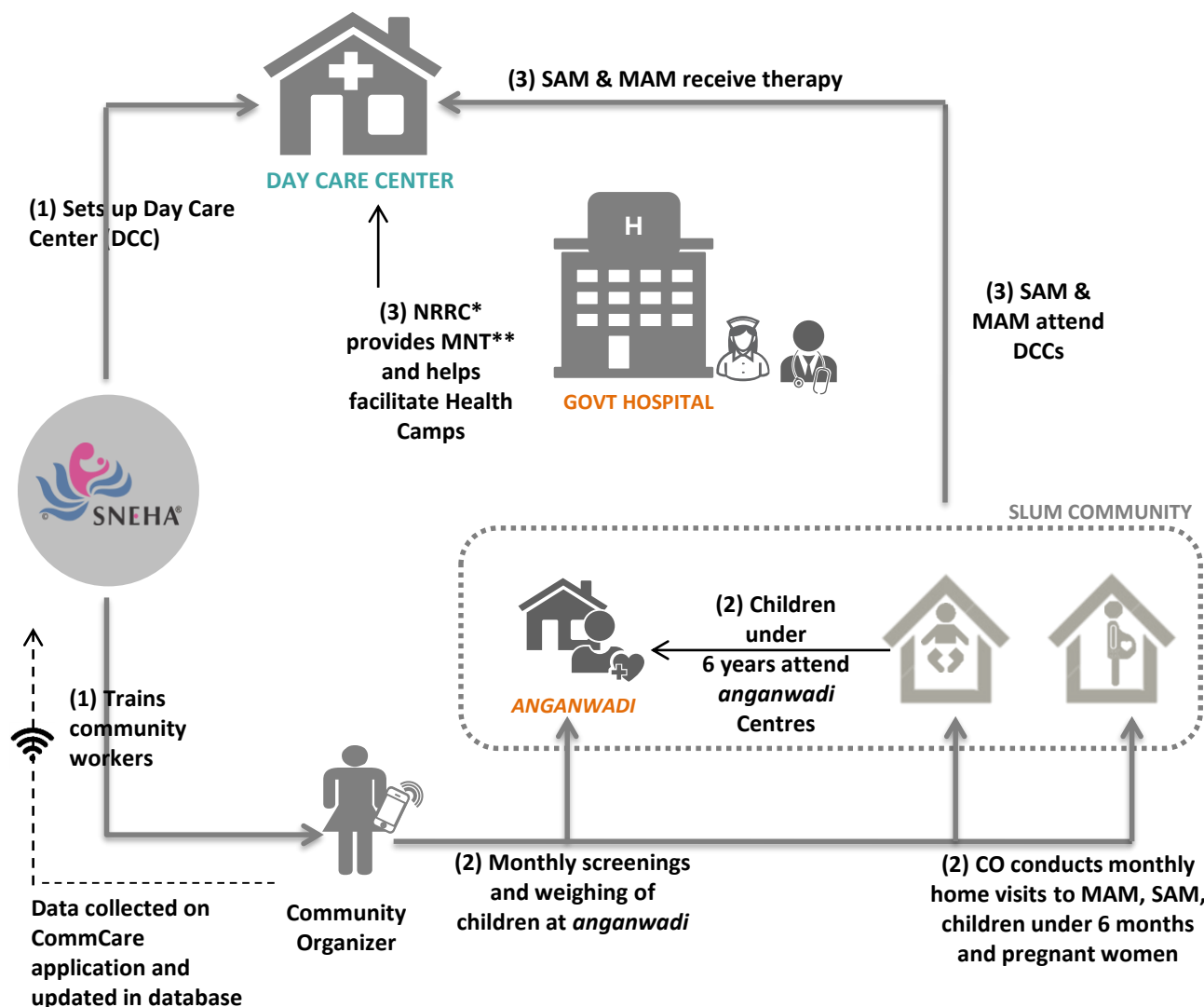
A third way of diagnosing acute malnutrition is by testing for the presence of Oedema. Oedema affects a child’s appearance, giving him or her a puffy, swollen look in either lower limbs and feet or face. It can be detected by small pits or indentations remaining in the child’s lower ankles or feet, after pressing lightly with the thumbs.

Based on the above measures, children are classified as either MAM or SAM as follows:

	Moderate Acute Malnutrition	Severe Acute Malnutrition
1. Measuring weight/height	Weight-for-height is less than minus 2 Z-scores (or standard deviations) of normal children	Weight-for-height is less than minus 3 Z-scores (standard deviations) of normal children
2. Measuring mid-upper arm circumference	MUAC measurement < 12.5 cm	MUAC measurement < 11.5 cm
3. Testing for oedema	Oedema affects a child’s appearance, giving him or her a puffy, swollen look in either lower limbs and feet or face.	Presence of oedema in both feet and lower legs is always considered a sign of severe acute malnutrition.

Appendix C – Aahar Model

Graphical Representation of the original Aahar program (as communicated in the PPM)



- 1. Training community women** and embedding the process within the community is the first step.
- 2. Delivering the program at the doorstep is next.** This involves:
 - On-going screening
 - Monthly anthropometry at *anganwadi*
 - Weekly, bi-weekly and monthly home visits
 - Home based counselling for behaviour change communication and promoting health seeking behaviours
 - MNT provision at doorstep
- 3. Day Care Centres** set up within the communities by SNEHA provide intensive care to the most vulnerable children.
 - 1 Teacher and 1 helper
 - SAM or MAM children <15 months <=3 years
 - 20 children per DCC
 - 10AM to 5PM, 5 days per week
 - Daily provision of THR and 2 meals
 - Daily provision of MNT
 - Weekly health checkups and anthropometry
 - Comprehensive case management
 - Play activities

*NRRC – Nutritional Rehabilitation and Research Centre

**MNT – Medical Nutrition Therapy

Appendix C – Aahar Model

Comparative analysis of the Full Intervention and Supportive Supervision models



Description	Full Intervention	Supportive Supervision
Beats:	Beats: 5, 7, 8, 9 and 10	Beats: 1, 2, 3, 4 and 6
Staffing per beat	1 Program Officer (PO) per beat 10 Community Officers (CO) per beat	1 Program Officer (PO) per beat 3- 5 Community Officers (CO) per beat
Monthly Anthropometry	Expected Coverage: 100% ICDS to assist in conducting anthropometry. ICDS to be introduced to height scales (to measure height for weight).	Expected Coverage: 50% each month, 100% over 2 months ICDS to conduct anthropometry using only weight scales. SNEHA to assist every alternate month. Regular records to be maintained at <i>anganwadis</i> , to be checked by SNEHA to measure coverage or any under reporting of weights.
Home Visits	SNEHA CO conduct daily home visits to SAM children and children under 6 months, weekly visits to MAM children and pregnant mothers. No home visits by <i>sevikas</i>	<i>Sevikas</i> to conduct home visits to only SUW (includes severely underweight MAM) children. SNEHA COs to accompany <i>sevikas</i> on home visits on predefined schedules.
Referrals to Nutritional Rehabilitation and Research Centre (NRRC)	SNEHA to accompany mothers to conduct visits to the NRRC. Appetite tests administered to SAM children by SNEHA or the NRRC. SNEHA to supervises the MNT consumption.	<i>Sevikas</i> to accompany mothers to conduct visits to the NRRC. SAM and SUW were referred to NRRC who provided them with nutritional counselling and medication if required after examination by Pediatrician.
Community Events	SNEHA to organize all community events in conjunction with the <i>anganwadi sevikas</i>	SNEHA to organize all community events in conjunction with the <i>anganwadi sevikas</i> .

Appendix C – Aahar Model



Rational behind the shift from the DCC model to the CMAM model

While SNEHA’s strategy to deal with malnutrition centered around a community based management of malnutrition, for a short period of time, it also set up Day Care Centres (DCCs). These were spaces within the community which aimed to serve SAM and MAM children with immediate health risks.

A DCC would be staffed by a trained full-time teacher and assistant. It would provide around 20 at-risk children with a safe environment, 3 to 4 nutritious meals a day, medical nutritional therapy (MNT) packets and supplemental support like physical checkups and play-group activities to help the child develop his/her cognitive and motor skills. DCC monitoring data would be entered by DCC teachers into ledgers and then Data Entry Operators would enter this information into computers. **An analysis of the DCC data suggested the following:**

- The average number of children attending the DCCs was 12 as compared to the planned 20. The SNEHA team learnt that physical distance of the DCC to many homes along with population migration challenges meant that children would drop out of DCCs frequently.
- 75% of the MNT packets being given to malnourished children were delivered at the door-step by COs, instead of being given in the DCCs. This observation implied that the DCC was failing at reaching a large portion of the malnourished children who were in need of the MNT therapy to recover.
- SNEHA soon realized that the DCC was not meeting its intended purpose. The mothers in the community would treat it as a creche, dropping their child off at the DCC regardless of whether the child required urgent nourishment and care. The organization also tasked an external risk auditor, KPMG, to conduct a risk audit which revealed that SNEHA assumed great liability on its part by providing full day custodial care for at-risk malnourished children.

Cost per Beneficiary Analysis | Indicative Only

DCC Cost Per Beneficiary (Amounts in INR)	
Number of beneficiaries	20
Brokerage	353
Setup Cost	1,146
Monthly Rental and Overhead	12,320
DCC Teacher Salary	6,325
Food for children	9,600
Total	33,359
Cost per beneficiary	1,668

CMAM Cost Per Beneficiary (Amounts in INR)	
Number of beneficiaries	100
Community Organizer Salary	6,325
Equipment Cost	9,545
Overheads	715
Total	16,585
Time devoted to MNT distribution	~ 50%
Cost per beneficiary	83

Appendix D – Impact Assessment

Overview of Impact Assessment and Implementation Schedule



The following table provides a chronological view of the implementation of the Aahar program and the various Impact Assessment activities in Dharavi.

Phase No.	Beat No.	Q1 2014	Q2 2014	Q3 2014	Q4 2014	Q1 2015	Q2 2015	Q3 2015	Q4 2015	
1	#2	FIEA	19 months of Supportive Supervision						Endline Conducted	
	#3	FIEA								
	#6	FIEA								
2	#1				FIEA	9 Months of Supportive Supervision				
	#4				FIEA					
3	#5	BA	17 months of Full Intervention							
	#7	BA								
4	#8		BA	16 months of Full Intervention						
	#9		BA							
	#10		BA							

Notes:

BA: Baseline Assessment

FIEA: Full Intervention Exit Assessment which served as a baseline for the Supportive Supervision Beats

Quarters relate to calendar year quarters starting January every year

Endline Methodology:

- For the program endline, SNEHA conducted a cross-sectional study that involved the analysis of data collected from a population, or a representative subset, at one specific point in time. The survey was carried out by SNEHA's community workers, shuffled across beats to ensure impartiality, along with external evaluators (compensated by SNEHA). These surveyors were supervised by SNEHA's program officers to ensure that a high level of rigor was maintained and that the surveyors kept to their allotted areas.
- SNEHA also conducted a baseline and endline comparative assessment in Wadala, a neighboring community, among families from similar socio-economic backgrounds to identify secular trends in malnutrition. The differences between Wadala baseline and endline results were compared to the differences in Full Intervention Aahar baseline and endline results.
- Full Intervention Baseline:** Final samples for the Aahar phase 3 and 4 intervention areas were 2,579 respondents at baseline and 3,455 respondents at endline. For the Wadala comparison area, 2,093 were collected at baseline and 2,122 at endline.
- Supportive Supervision:** Sample sizes for the supportive supervision areas were designed to estimate phase-wise prevalence levels with a total sample of 540 respondents per phase. For Phase 1 each *anganwadi* was sampled to reach a target of six respondents and in Phase 2 each *anganwadi* was sampled to reach a target of nine respondents.

Thank You