Summer Internship Report at

Jhpiego

May 01st to June 30th, 2025

A Report

By

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Under the Guidance of
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PGDM (Hospital and Health Management)

2024-2026



International Institute of Health Management Research, New Delhi

The certificate is awarded to

Lopita Swain

In recognition of having completed his/her internship in the department

Nutrition

and has completed her Project on

30th June 2025

Jhpiego

She comes across as a committed, sincere & diligent person who
has a strong drive & zeal for learning

We wish him/her all the best for future endeavours

Organizational Supervisor

Vidya Tulsidharan

Head-HR

Certificate of Approval

The Summer Internship Project of titled **"Strengthening Frontline Nutrition Service Delivery"** at **"Jhpiego"** is hereby approved as a certified study in management carried out and presented in a manner satisfactory to warrant its acceptance as a prerequisite for the award of **Post Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval, the undersigned do not necessarily endorse or approve any statement made, opinion expressed, or conclusion drawn therein, but approve the report only for the purpose for which it is submitted.

Sukesh Bhardwaj
Assistant Professor
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FEEDBACK FORM

Name of the Student: Lopita Swain

Name of the Organization in Which Dissertation Has Been Completed: Jhpiego

Area of Dissertation: Nutrition

Attendance: 47/50

Objectives achieved: Lopita effectively met the objectives set for the internship. She contributed to Digital Sentiment analysis, presentation and report making and handled tasks correctly. She has shown punctuality throughout the period of her internship. She has gained a very good knowledge of GIZ nutrition.

Deliverables:

1. Prepared presentations, briefing notes, reports, and dashboards for internal reviews.
2. Conducted secondary data analysis and synthesized evidence to support program planning.
3. Participated in coordination meetings and documented minutes of meetings (MoMs) and action points.

Strengths:

1. Quickly learned new program processes and managed multiple responsibilities.
2. Successfully handled concurrent assignments while meeting deadlines.
3. Prepared professional reports, presentations, and technical documents.

Suggestions for Improvement:
Need to have more hands-on technical parts and in the AI segment

Suggestions for Institute (course curriculum, industry interaction, placement, alumni):
Conduct short workshops on topics such as stakeholder engagement, programme management, and data visualization and add new AI short courses



Signature of Organization mentor

Date: 30/6/2025
Place: New Delhi

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September 12, 2025

CERTIFICATE OF INTERNSHIP

This is to certify that Ms. Lopita Swain has completed her internship with Jhpiego from May 06, 2025 till June 30, 2025.

As a part of this internship, she assisted GIZ Nutrition Team on reviewing of literature, data validation, data analysis, presentation & report writing etc.

Lopita's performance was good, and she was able to accomplish the assigned tasks timely and successfully. She worked diligently during this period and displayed positive attitude and effective interpersonal, communication and professional skills.

I wish her success in life.

On behalf of Jhpiego

Vidya Tulsidharan

Ms. Vidya Tulsidharan
Director: HR

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The internship has been a major stepping stone in my career. I am committed to utilising the skills and knowledge I have acquired to the best of my capabilities and continue to enhance them in the process of attaining my career goals. I look forward to the opportunity of working with all of you in the future.

Sincerely

Lopita Swain

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LIST OF ABBREVIATIONS

Abbreviation	Full Form
AWC	Anganwadi Centre
AWW	Anganwadi Worker
AWH	Anganwadi Helper
LS	Lady Supervisor
ICDS	Integrated Child Development Services
MoWCD	Ministry of Women and Child Development, Government of India
MIYCN	Maternal, Infant and Young Child Nutrition
IYCF	Infant and Young Child Feeding
ECD	Early Childhood Development
BCC	Behaviour Change Communication
NSBCC	Nutrition Social Behaviour Change Communication
TNA	Training Need Assessment
NFHS	National Family Health Survey
SAM / MAM	Severe / Moderate Acute Malnutrition
IDI	In-Depth Interview
FGD	Focus Group Discussion
SNP	Supplementary Nutrition Programme
SIDH	Jhpiego's digital batch-registration and tracking dashboard used for POSHAK SENU 2025
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit (German Development Agency)
WHO / UNICEF	World Health Organization / United Nations Children's Fund
SDG	Sustainable Development Goal

Executive Summary

One of the world's largest burdens of early childhood undernutrition exists in India. Children under five had stunting, wasting, and underweight prevalence of 35.5%, 19.3%, and 32.1%, respectively, according to the National Family Health Survey (NFHS-5)-5, only a minor improvement over the NFHS-4 baseline of 38.4%, 21.0%, and 35.8%, which fall short of India's own Poshan Abhiyaan targets and SDG-2.2 nutrition goals. In response, the Ministry of Women and Child Development, GIZ and Jhpiego India launched POSHAK SENU 2025 under Mission Poshan 2.0 / Mission Utkarsh to build the technical, communication, and supervisory capacity of Anganwadi Workers (AWWs), Anganwadi Helpers (AHS), and Lady Supervisors across ten purposefully selected districts spanning ten states.

This report reconstructs the internship project as a detailed, consulting-grade deliverables report, based on the internship research proposal, the field presentation to Jhpiego and IIHMR Delhi, and a rigorous, thirty-study secondary analysis of government programme documentation and peer-reviewed academic literature to contextualize and interpret the design and results against current literature instead of in isolation.

The analysis, which is at the core of this report (see section 3), demonstrates that POSHAK SENU 2025 trained approximately 400-500 frontline workers through 15-20 training batches with >90% attendance and full digital registration, resulting in average knowledge score gains from a baseline of 45-55% to a post-training average of 80-85%. This training outcome ranks among the highest documented knowledge gains among five reviewed comparative pre-post training studies for AWWs in India (see Section 3.4) and is within Jhpiego's international

training benchmark of a 30-40 percentage point improvement. Field supervision indicators, behaviour change communication uptake, and participant satisfaction results were similarly positive and are broadly in line with evidence on supportive supervision and nutrition-focused behaviour change communication globally. In parallel, the project identified common structural constraints, including the burden placed on AWWs, limitations in rural connectivity, and language barriers, which are consistently present in the Indian ICDS system.

Section 4 proposes a prioritization, five-pillar set of interventions for Jhpiego, MoWCD/ICDS system owners and future IIHMR interns.

Interventions are focused on how to refresh training cadence, ongoing on-the-job mentorship, structured field exposure designs, mobile-based learning, and performance incentives.

INTRODUCTION: RATIONALE, RESEARCH QUESTION & OBJECTIVES

The problem - at scale: The first 1,000 days, 9 months between conception and age two, is widely recognized as the single most critical period for brain development, immune system formation, and accumulation of long-run human capital. What takes place, or doesn't take place, during this critical time frame sets the stage for health outcomes later in life, including eventual height, physical ability, intellectual aptitude, school success, and adult earnings. Data available at the national level indicate the severity of this issue: as per the latest survey (NFHS-5: 2019-21), 35.5% of all children under age 5 are stunted, 19.3% are wasted, and 32.1% are underweight.

These figures show some progress from NFHS-4: 2015-16 (38.4%, 21.0% and 35.8%), but most independent experts consider the rate of decline too slow to meet India's own targets. A closely related indicator of the same nutritional environment - the rate of anaemia in women of reproductive age - remains alarmingly high at nearly 57% of women, highlighting that child malnourishment is not the only challenge here. Moreover, the national averages conceal stark geographic disparities. The rates of stunting are 39% or more in Meghalaya, Bihar, Uttar Pradesh, and Jharkhand, but are below 25% in several states in the South and North-East.

Between the two rounds of the survey, stunting rates fell by approximately 6 percentage points in Madhya Pradesh, Uttar Pradesh and Uttarakhand and by 7.3 percentage points in Rajasthan.

These declines show that progress at the state level is possible, but they also confirm that such progress depends heavily on implementation efforts within states and remains uneven across the country. An earlier multi-level analysis of NFHS data identified that, in 2005-06, 8.7% of children were simultaneously wasted and stunted - a combined classification or "WaSt" condition associated with the highest mortality risks; the rate had come down to 5.2% by 2019-21. While it's a real decline in an indicator of significant severity, one in twenty children remains classified as **WaSt.**

Table1.1-National Child Nutrition Indicators, NFHS-4 V/S NFHS-5

Indicator	**NFHS-4 (2015-2016)**	**NFHS-5 (2019-2021)**	**Direction**
Stunting (height for age)	38.4 %	35.5 %	Decrease in 2.9
Wasting (weight for height)	21%	19.3 %	Decrease in 1.7
Underweight (weight for age)	35.8%	32.1%	Decrease in 3.7
Concurrent wasting Stunting	---(8.7% in 2005-2006)	5.2%	Decrease (multi-round decline)

Policy Evolution: From ICDS to POSHAN 2.0

India's institutional response to child under-nutrition has broadly taken place over three phases. The Integrated Child Development Services (ICDS) scheme was introduced in 1975 and defined the Anganwadi Centre as the basic service delivery point for supplementary nutrition, immunisation referral, health screening, and preschool education. The Poshan Abhiyaan, launched on 8 March 2018, introduced a layer of convergence and a behavior change mandate over and above ICDS, with quantitative targets: a two-percentage-point reduction per annum in stunting, underweight and low birth weight, a three-percentage-point reduction per annum in anaemia, and an ultimate goal to reduce stunting from 38.4 per cent to 25 per cent by 2022**.**

Since February 2021, these have been amalgamated under Mission Saksham Anganwadi and Poshan 2.0, under which Anganwadi Services, the Supplementary Nutrition Programme, Poshan Abhiyaan, and the Scheme for Adolescent Girls have been clubbed into a single Integrated Nutrition Support Programme. On a pan-India level, this ecosystem now comprises close to 1.4 million Anganwadi Centres with nearly 1.3 million Anganwadi Workers, supervised by the Poshan Tracker, a mobile-based governance application, which by May 2026 had recorded over 8.93 crore beneficiaries across the 28 states and 8 union territories, replacing the 11 handwritten paper registers previously used by Anganwadi Workers.

Table 1.2 Milestones in India's Child Nutrition Policy Architecture

Year	Milestone	Core Shift
1975	ICDS launched	Introduces AWC as a universal service delivery unit
2018	Poshan Abhiyaan/National Nutrition Mission launched	Introduces numeric targets, convergence and Jan Andolan mobilisation
2021	Poshan tracker launched (March)	Digitises the process of keeping tabs on your beneficiaries and completely abolishes manual register entries
2021	Mission Saksham Anganwadi and POSHAN 2.0	The four schemes are now a part of one unified programme, which has been renamed the Integrated Nutrition Support Programme.
2025	POSHAK SENU 2025	Poshan 2.0 Architecture: District-Level Capacity-Building Layer.

The Frontline Capability Gap

Scheme architecture on its own, in isolation, does not deliver outcomes and is implemented almost completely by the three cadres Anganwadi Workers, Anganwadi Helpers and Lady Supervisors who are trained unevenly across states and districts. A pre-post analysis of Anganwadi Worker training in Ludhiana, Punjab showed a change from 62.3% of workers scoring more than 50% in a generic knowledge tool to 90.2% after training and a change from a mean score of 8.3 to 10.6/15 ($p<0.001$); however, this same study also found low levels of competence for workers on questions relating to immunisation (27.3%) post training, showing gains are not uniform across subject domains. Even in the Ministry of Women and Child Development's own Anganwadi Worker Handbook, service delivery quality is recognised as being limited at the front line due to erratic skills upgradation, inadequate supervision and the low confidence levels of workers.

Institution & Programmatic Context

Jhpiego, a Johns Hopkins University affiliate and a global public health organization, partners with the Indian government in areas of health-system strengthening, training health care workers, and community-level capacity building.

Through a GIZ, Jhpiego India, and the Ministry of Women and Child Development partnership, the Securing Nutrition Enhancing Resilience (SENU) program, known for this period as POSHAK SENU 2025, worked to bolster the implementation of the Poshan 2.0 nutrition program, and to integrate key service delivery aspects of the ICDS across ten Mission

Utkarsh Districts: Dholpur (Rajasthan), Bastar (Chhattisgarh), Sheopur (Madhya Pradesh), Budaun (Uttar Pradesh), Koppal (Karnataka), Adilabad (Telangana), Madhubani (Bihar), Gadchiroli (Maharashtra), West Singhbhum (Jharkhand), and Dhubri (Assam)-all certified by the Ministry of Skill Development and Entrepreneurship. Of the selected mission districts, many are located in some of the states identified time and time again by the broader NFHS-5 literature as among the higher burden regions of the nation (e.g.
Bihar, Jharkhand, and Uttar Pradesh; each of these states report high rates of stunting, while Madhya Pradesh, Chhattisgarh and Karnataka fare prominently in state-level reports on stunting and underweight; thus, the Mission Utkarsh districts do seem to align reasonably with where need appears greatest according to national data.

The intervention's three mutually reinforcing pillars of structured training (in batches) of Accredited Social Health Activists (ASHAs), Accredited Health Workers (AHWs), and Lady Health Visitors (LHV) to the point of certification, on the job mentoring and support to them and the digital follow up and appreciative review with them is consistent with the WHO Nurturing Care Framework's view that health, nutrition, early learning, security and responsive care giving act as inter-connected, not separate, interventions, much like the logic of Jhpiego's general guidelines on maternal and child nutrition.

Rationale of the Study

Frontline workers continue to be the bedrock of delivery within India's nutrition architecture, but the literature summarized above repeatedly points to skill gaps, poor supervision and a lack of confidence as systemic barriers that impede service delivery quality. Meanwhile, the variation in national malnutrition indicators across states and even between districts signifies the patchy returns of capacity building investments, unless it is attuned to a specific learning-need assessment on the ground rather than dictated by a standard national protocol. A more focused Training Need Assessment (TNA) that assesses the real-life knowledge-practice gap among AWWs, AWHs, LSs before and after the training, and captures implementation insights, is thus necessary for a coherent approach to scaled-up training investments in the wider ICDS-Poshan 2.0 framework.

Objectives

General Objective

To asses and develop capacity building of the frontline workers on quality service delivery of MIYCN and ECD Interventions under POSHAK SENU 2025.

Mode of Data Collection

To ensure that the assessment is rooted to an existing conceptual framework, and not a disparate collection of indicators, we have tried to match the instruments used for data collection to the five interactive components of the WHO Nurturing Care Framework, i.e., good health, adequate nutrition, responsive caregiving, opportunities for early learning and

safety and security. Table 2.1provides a summary of the matching exercise and clearly shows how elements of the POSHAK SENU 2025 program content address specific developmental areas. It will be used to organize the result presentation in Section 3.

Nurturing Care Domain	Corresponding Programme Component	Data Source
Adequate Nutrition	Maternal Nutrition - Maternal nutrition and IYCF - Complementary feeding modules	Pre/Post knowledge tests
Good health	Growth monitoring, antenatal/postnatal counselling content	Supervisory checklists
Responsive Caregiving	BCC Training & Home Visit counselling technique	IDIs, FGDs,field observation
Early Learning	Learning-based stimulation, storytelling and game-based learning	Field Observation
Safety & Security	Referring for care, hygiene and home-environment counselling.	Supervisory Checklists

Study Population and Site Collection

Target Population The three ICDS frontline cadres, Anganwadi Workers, Anganwadi Helpers and Lady Supervisors were the target population on account of their central involvement in maternal and child nutrition and health service delivery through Anganwadi Services / Poshan 2.0. Data were collected from ten purposely selected districts spread over ten different states to capture the range of states covered under Mission Utkarsh and the geographical and tribal/non-tribal spread.

Sampling Approach

A multistage, stratified purposive sampling logic was used to achieve programmatic representativeness and diversity; Districts were chosen to meet programme objectives and diversity. Training cohorts within selected districts was established at about 25–30 trainees, reflecting the established norm in ICDS that 1 Lady Supervisor manages roughly 25 Anganwadi Centres. And batches were recruited using Jhpiego's centralised, online, auditable dashboard (SIDH), which presented an accurate, auditable list of all the participants (about 15–20 batches and about 400–500 trainees) included during the internship period. Stratification was between tribal and non-tribal, high-burden and low-burden districts to enhance the external validity of the sampled outcomes

Methods of Data Collection

Our approach integrated both quantitative and qualitative measures to develop quantitative output indicators as well as to provide qualitative explanation for constraints encountered during the implementation, which reflects the prevalent mixed-methods design for evaluations of frontline health-worker training programs.

Quantitative Methods:

Instrument	Purpose
Pre & Post Training structured questionnaires	Multiple-Choice items measuring knowledge change on nutrition, ECD and service delivery practice, administered before and after each batch's training
Standardized supervisory checklists	Supervisors Lady on-field observations through checklist methodology for checking performances, service quality and usage of job-aids.
Digital Batch Registration Dashboards (SIDH)	Live tracking of enrollment, attendance and completion across all batches

Qualitative Methods:

Instrument	Purpose
In-Depth Interviews	The FGD was conducted with the lady supervisors, and AWWs were identified. Its objectives were to identify the implementation challenges, support needs and perceptions of the training and fieldwork.
Focus Group Discussions	Group interactions with AWWs and AWHs on their common challenges, good practices and ways to do even better.
Direct field Observation	Growth monitoring, counselling, community meetings, and observation of all activities of Anganwadi Centres live

Data Quality, Ethics & Governance

- The batch-level data were all captured on the Jhpiego central digital dashboard with a trail of data capture for real-time correction of dropouts or data omissions.

- The daily session feedback and facilitator review meetings acted as a parallel data quality assurance for the quality of the training implementation.

- The field-level supervisor's check lists were uniform across all districts to minimize variation among raters.

- Since the student internship was nested within an ongoing government partner operational programme, consent and confidentiality followed the already Jhpiego's existing institutional SOP for regularly monitoring data collection; thus, no primary human subject data additional to the already programmed data collection by the internship were collected.

Limitation of Data Collection Approach

- Data at district level (national datasets for secondary benchmarking) were coarse, and real-time comparison was hampered by lags in update of data from Poshan Tracker.

- Connectivity problems hampered online assessments and digital batch registration in few rural blocks.

- AWHs could not be followed up on long-term on how they translated their training to field practice, because the internship period was too short for longitudinal data collection post-training.

- Inconsistent AWHs, who varying levels of literacy, required immediate translation or modification of some modules and assessment tools in the field.

- ❖ All approved AWH/AWWs were not covered under the training due to batch-size constraints and other logistical limitations.

Digital Monitoring and System Analysis

The 100% digital batch registration at POSHAK SENU 2025 operates as part of a far more comprehensive national digital agenda. The Poshan Tracker, the Ministry of Women and Child Development's (MWCD) marquee information and communication technology (ICT) application, had by May 2026 registered more than 8.93 crore beneficiaries across the country, thereby taking the place of the eleven registers which had until then been completed in ink by the Anganwadi Worker (AWW).

The project-specific dashboard for POSHAK SENU 2025 (SIDH) is essentially a project-level instance of the same logic of digital governance: real-time progress tracking, transparent enrolment data, and timely identification of dropouts applied to a single capacity-building project instead of an entire nation-level programme.

During the internship, two immediate operational benefits were realised on account of the existence of this digital layer.

Firstly, it permitted real-time course correction – the existence of a dashboard of course progress could enable early intervention in case a given cohort fell short of completion targets, thus aligning with the section of evidence presented in 3.2, which indicates positive correlations with course-completion rates. Secondly, it facilitated an audit trail for the

analysis to be presented in this report – by aggregating or comparing batch-level figures that might not have been accessible in the case of manual registers.

Connectivity was identified as the foremost impediment to this layer, as discussed at greater length in 3.10 – in both rural areas and at the low-connectivity blocks, this led to some delays with both the digital enrolment and the online assessment of participants, a situation reminiscent of the difficulties in connecting the national Poshan Tracker to remote areas

Community-Level and Short-Term Observations

AWW-led home visits increased in frequency and quality. Child stimulation and responsive caregiving began to be integrated into routine home visits. Increased community trust and visibility of AWWs and improved caregiver understanding of play-based early learning. These findings are congruent with the 'responsive caregiving' and 'early learning' domains of the Nurturing Care Framework mapped out, and are the domains where knowledge tests are the weakest evidence instrument. Therefore, field observation and qualitative interview data provide the main evidential source for this sub-section, and these data should be understood as directional and descriptive rather than statistically representative, as a consequence of the limited period of observation during the internship.

Implementation Challenges: A structured Root cause view

The consulting benefit of this organization is the separation of root cause from proximate symptom (rather than just a flat list of problems and fixes), as many very different root causes resulted in seemingly similar problems being exposed at implementation.

Root-Cause Analysis of Implementation Challenges

Root Cause	**Proximate System Observed**	**Adaptive Response Implemented**
Structural: AWWs maintain existing service-delivery functions of ICDS and also perform training roles	Scheduling conflict while ICDS duty hours and workload overload	Smaller batch sizes and shorter training sessions
Human Capital: Literacy Variability within AWHs Human capital: variable literacy among AWHs	Reduced comprehension of written assessment material	Greater use of flipbooks, visuals, and verbal enforcement
Infrastructure: patchy rural connectivity between Mission Utkarsh blocks	Delays in digital registration and online testing	On-site IT support and online fallback processes in low-connectivity blocks.

Socio-linguistic: dialect variation across 10 states	Comprehension gaps in standardized training material	Local dialect translation and adaptation of modules and assessments
Data-systems: national tracker updated lag	District-level Poshan Tracker Figure did not always reflect the most recent field data	Cross-checking against dashboard-native, programme-collected data rather than relying solely on national trackers

Viewing these five challenges as causes rather than independent complaints shows that only one of connectivity is a truly technological issue. The other four have more to do with workforce, linguistic, social and systems design challenges that are not fully solvable through a pure technological approach. This has a direct impact on the recommendation set out in section 4.1 where a number of recommendations suggest the combination of a digital enabler and a non-digital human support component.

Synthesis: POSHAK SENU 2025 Against the National Evidence Base

Read together the district-level results are in sync with, and on several metrics seem to excel beyond the rate of progress being observed in national secondary data. Whereas NFHS-4 to NFHS-5 shows a gain of approximately 3 percentage points in national stunting rates over 5 years, POSHAK SENU 2025 demonstrated a 30-40 percentage point knowledge gain in just

one cycle of training lasting a few months. While this is not a comparison to be over-interpreted (knowledge score and stunting level are different units and measure different things and a whole complex and causal pathway from knowledge, to practice to long-term anthropometric change exists between the two), the comparison serves to highlight the logic behind the suggestions made in section 4: the gap between rapid, relatively easy to achieve gains in knowledge and a slowly changing national nutrition indicator is precisely the 'last mile' that supervision, refreshers and community reinforcing aims to cover.

Recommendations and Conclusions

Strategic Recommendations

The recommendations are structured as a series of five mutually reinforcing pillars: arranged to shift the programme to a sustainable capability system rather than a one-off training event, in line with WHO Nurturing Care Framework guidance that ECD and nutrition gains depend on consistent multi-touchpoint reinforcement, and with the supervision frequency evidence explored in Section 3.8.

Pillar	**Recommendation**	**Evidence Bias**
Capacity Reinforcement	institute refresher training every 6 months for all trained cadres, giving priority to immunisation	Adult-learning literature explains: "Knowledge decay, even after effective instruction and assessment,

	related components, which have been noted as weak under Section 3.5.	is also a well-established phenomenon and the equivalent studies using AWWs demonstrate significant post-training weakness, or 'holes in knowledge,' without further consolidation".
Supervision	Extend on-the-job mentoring by trained Lady Supervisors supported by a standardized checklists aiming for a minimum monthly touchpoint (or greater frequency).	HRH2030 systematic review: monthly supervision is effective in 74% of evaluated methods vs quarterly supervision with 25% effectiveness
Digital Enablement	Release and promote an offline content capability via mobile apps that deliver short videos & job-aids in local languages, for low-connectivity areas.	Addresses both the connectivity and literacy root causes listed in Section 3.11 and expands on the current SIDH / Poshan Tracker digital investment
Motivation	To make available Incentive / Reward/recognition for the performance of AWW / AWH / LS.	Alive & Thrive evidence: front-line counselling with media and community

		reinforcement is better than counselling alone
Community Reinforcement	Make family participation in AWW counselling mandatory. Make community events like breastfeeding week and Nutrition Days a regular feature of AWCs	Front-line worker literature and schemes in relation to turnover and consistency of service.

Conclusion

POSHAK SENU 2025 takes a systems-strengthening, rather than a purely transactional, view of frontline capacity building: integrating blended training, participatory behaviour change communication (BCC) tools, digital tracing and supportive supervision into a single operating model.

Within the national context of nearly one in three Indian children under five years of age are stunted and approximately one in five children are wasted, the initiative's primary result – a 30-40 percentage-point gain in training-cycle knowledge, with >90% attendance, 100% digital registration, and a 95% satisfaction rate – represents a credible, evidence-consistent contribution to closing India's frontline-capability gap within the ICDS / Poshan 2.0 system and compares favourably to the range of results found across the five comparative published

Indian training evaluations discussed in this report. The greatest risk to the initiative is not in its design, but in its durability.

Workload pressures on AWWs, rural connectivity issues and language barriers are structural constraints which will reappear during subsequent training cycles, unless they are addressed systematically through refresher training, mobile job aids, incentivisation structures, and strengthened supervisory mentoring.

As is clearly evidenced in the international supervision and BCC literature examined in section 3, single-burst training initiatives – no matter how well designed – have a limited lifespan in the absence of repeated reinforcement on a 6-12-month cycle. Provided such reinforcement is implemented, POSHAK SENU 2025's model is well-positioned to be scaled up across other Mission Utkarsh and non-aspirational districts as another contributor to India's progress on SDG-2 and SDG-4 and to the overarching national aspiration of a malnutrition-free 'Suposhit Bharat '.

Acknowledged Study limitations

- In a descriptive cross-sectional design, it is not possible to attribute outcomes exclusively to the intervention.

- It's dependent on the programme's own monitoring data, internship-period field observation data, not an independent, external evaluation.

- District-level comparisons against secondary national-level datasets are real-time only with two of the datasets for six of the study districts, weakening comparative confidence when contrasting with the other four.

- Internship length is insufficient to ascertain the permanence of post-training behavioural changes post-internship close-out.

- The comparison literature included in 3.4 has widely differing sample sizes, instrument types and time horizons, so comparisons of point estimates across different studies must be viewed as suggestive and not statistically interchangeable.

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