



CHAPTER 17

25 Years of Scaling Up

Nutrition and Health Interventions in Odisha, India

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ODISHA, A STATE of 42 million people in eastern India, is one of the poorest in the country. It has faced many development challenges over the years, including insurgent movements, large pockets of extreme deprivation among scheduled tribe communities,¹ social disparities, and natural disasters, as well as a relatively late fiscal turnaround (in 2004–2005) in comparison with other states. Yet Odisha has made significant progress in reducing child undernutrition—less than India as a whole, but more than many other richer states. How has it achieved this progress?

Data from three rounds of India's National Family Health Survey (NFHS) and the Rapid Survey on Children (RSOC)² show that, in Odisha, the proportion of stunted children younger than 3 years of age fell from 49 percent to 44 percent between 1998–1999 and 2005–2006 (compared with an all-India decline from 51 percent to 45 percent during the same period). Between 2006 and 2014, stunting among children younger than 5 years in Odisha fell from 45 percent to 38 percent (compared with an all-India decline

of 48 percent to 39 percent). The rate of stunting decline in Odisha has accelerated from 1.8 percent a year to 2.1 percent a year in the past 10 years, but it remains slower than the all-India rate of decline. This lag is unsurprising, given the challenging conditions in Odisha. Nevertheless, Odisha's rate of decline in childhood stunting is at least three times the rate of decline in other similarly poor states, such as Bihar.³ Not all nutrition indicators showed such advances: anemia rates among children and pregnant women increased or remained stagnant in Odisha between the early 1990s and the mid-2000s, hovering between 60 and 70 percent.

In 2005–2006, Odisha's undernutrition levels were close to those of the state of Gujarat, which is richer and better endowed. That same year, Odisha's performance on delivering health services and Integrated Child Development Services (ICDS) interventions was among the best in India, ranking below only one other state.⁴ More recently, data from 2014–2015 showed that Odisha had outpaced richer states, such as Gujarat, Madhya Pradesh, and Uttar Pradesh, in



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A mother reads the latest advice on how to feed children from the health information wall in her village.

several areas. Odisha had better nutrition outcomes, such as stunting levels. It performed better in terms of immediate determinants, such as infants 6–8 months old receiving solid, semisolid, or soft foods and minimum dietary diversity during complementary feeding. And it had greater coverage of nutrition-specific interventions, such as mothers of children younger than 3 years old who received three or more antenatal care checkups and children 12–23 months old who were fully immunized.⁵ A recent analysis of nutrition progress across states in India explicitly recognized Odisha as a leading state for nutrition-relevant social sector programs, including those targeting health, nutrition, and food security. The authors of that paper called Odisha a “positive deviant in nutrition policy-making” in areas related to nutrition.⁶ Given the unusual emphasis on nutrition policy making for

a poor state such as Odisha, we sought to conduct a Stories of Change study there to understand the drivers of success in establishing supportive social policies and scaling up effective programs for health and nutrition.

This chapter seeks to explain how changes in the delivery of nutrition-specific programs (specifically the ICDS) and the National Rural Health Mission (NRHM) came about over time in Odisha. We also aim to identify the policy and programmatic factors that enabled the changes in these important programs over time, drawing on diverse sources of data, including interviews with present and former officials and stakeholders involved in designing and implementing nutrition and child health policies and interventions.⁷ While we argue in this chapter that the continuity of key actors in Odisha—rather unique in India—is an asset, we

recognize that relying on such sources for assessing performance potentially entails a conflict of interest. Thus, we used a recent framework for scaling up the impact on nutrition to ground our analysis of these factors.⁸ Because child-level data on the nutritional status of children in 2014–2015 are still not available for analysis for Odisha—or indeed, for any other state in India—we restricted our use of quantitative data to reporting statistics rather than performing an empirical econometric analysis.

Nutrition-Specific Interventions, Programs, and Policies in Odisha That Target Children's First 1,000 Days

Nutrition and health services in Odisha have been delivered primarily through the nationwide ICDS program and the health system. Our review of available data shows that, during the 25-year period from 1991 to 2015, coverage of antenatal care, institutional deliveries and assisted births, immunization, vitamin A supplementation, and the use of key ICDS services all went up in Odisha ([Table 17.1](#)). For some of these services, improvements in coverage were substantial. Despite variability across the state in these improvements and the continuing challenges of providing services in tribal areas, evidence also suggests that intervention coverage became more equitable.⁹

Trends in the Focus and Shape of Health and Nutrition Policies and Programs over Time

HEALTH INTERVENTIONS (1990–2015)

Odisha started health sector reforms in the early 1990s, with support from key development partners. As early as 1995, India launched National Immunization Days to address polio in particular; Odisha also carried out “Pulse Polio” days—specific campaign days only for polio vaccination. These efforts expanded into a national initiative called

the Reproductive and Child Health Programme in 1997, which aimed to deliver an integrated package of health and nutrition services for pregnant and lactating women, children, and adolescents. In 2001, the state launched the Infant Mortality Rate (IMR) Mission, ramping up efforts to reduce the IMR.¹⁰ As part of this effort, Odisha emphasized implementation of antenatal care and newborn care.¹¹ In addition to strengthening the implementation of existing interventions, the mission introduced interventions to prevent malaria among pregnant women and incentives to promote institutional deliveries.¹² The state government also developed a vision document for health in the early 2000s.

Over the past decade, especially between 2004 and 2015, the state health delivery system experienced major enhancements with the launch of the State Health Mission in 2005 under the NRHM. Under the NRHM, the budgetary outlays for public health increased, a new cadre of health workers including accredited social health activists was appointed, a conditional cash transfer scheme (Janani Suraksha Yojana) to incentivize institutional deliveries was introduced, and nutrition rehabilitation centers for facility-based treatment of severely acutely malnourished children were launched in 2005–2006.¹³ The goal of the mission was to reduce the IMR, the maternal mortality rate (MMR), and the total fertility rate by strengthening reproductive and child health services.

Odisha also strengthened the delivery of its immunization program, rolled out a vitamin A supplementation campaign during 2005–2010¹⁴ and adapted the national guidelines for Village Health and Nutrition Days, renaming it the Mamata Diwas—a single platform for delivering multiple maternal and child nutrition interventions. In addition, guidelines were released for screening and identifying severely malnourished children under age 5 for treatment at rehabilitation centers

TABLE 17.1 Changes in nutrition and health outcomes, immediate determinants, and interventions in Odisha state and India, various periods, 1990 to 2015

Outcome indicator	Study timeline								
	1990–1995		1995–2000		2000–2005	2005–2010		2010–2015	
	Survey data periods								
	1992–1993 ^a		1998–1999 ^b			2005–2006 ^c		2013–2014 ^d	
	India	Odisha	India	Odisha		India	Odisha	India	Odisha
Stunting (%) ^e	NA	51	51	49	NA	45 (48)	44 (45)	(39)	(38)
Wasting (%) ^e	NA	28	20	30	NA	23 (20)	24 (20)	(15)	(18)
Infant mortality rate	79 ^f	112 ^f	68 ^f	81 ^f	NA	57 ^f	65 ^f	NA	56 ^g
Maternal mortality rate	437 ^h	NA	540	NA	NA	NA	NA	178 ⁱ	230 ^g
Women with body mass index < 18.5 kg/m2	NA	NA	36	48	NA	36	41	NA	30 ⁱ
Women aged 15–49 yrs. with anemia (%)	NA	NA	52	63	NA	56	63	NA	77 ⁱ
Children (aged 6–35 mos.) with any anemia (%)	NA	NA	74	72	NA	79	74	NA	NA
Children (< 3 yrs.) breastfed within 1 hr. of birth (%) ^k	10	18	16	25	NA	24	54	45 ^k	73 ^k
Children (< 6 mos.) exclusively breast-fed (%)	NA	NA	NA	NA	NA	46	50	65	69
Children receiving solid/semi-solid food and breast milk (%)	31	30	34	30	NA	56	68	51 ^l	56 ^l
Children (0–59 mos.) with diarrhea in the past 2 weeks (%)	10 ^m	21 ^m	NA	NA	NA	9	12	7	9
Children (< 5 yrs.) with diarrhea in the past 2 weeks who received ORS (%)	18 ⁿ	17 ⁿ	27 ⁿ	35 ⁿ	NA	26 ⁿ	41 ⁿ	54	71
Women received/bought iron–folic acid supplements during pregnancy (%)	51	50	58 ^o	68 ^o	NA	65	83	31 ^p	45 ^p
Mothers who had ≥ 3 antenatal care visits for previous birth (%)	44	35	44	48	NA	52	62	63	75
Receipt and use of ICDS supplementary nutrition during pregnancy (%)	NA	NA	NA	NA	NA	21	45	41	61
Births in a health facility (based on past 2 births in the 3 yrs. prior to survey) (%)	26	14	34	23	NA	41	39	79	81
Receipt and use of ICDS supplementary nutrition during lactation (6 mos. after birth) (%)	NA	NA	NA	NA	NA	17	40	42	77
Children (12–23 mos.) fully immunized (%)	36	36	42	44	NA	44	52	65	62

(Table 17.1 continued)

Outcome indicator	Study timeline								
	1990–1995		1995–2000		2000–2005	2005–2010		2010–2015	
	Survey data periods								
	1992–1993 ^a		1998–1999 ^b			2005–2006 ^c		2013–2014 ^d	
	India	Odisha	India	Odisha		India	Odisha	India	Odisha
Children (12–35 mos.) who received vitamin A dose in the past 6 mos. (%)	NA	NA	17	26	NA	25	30	46 ^q	57 ^q
Receipt and use of ICDS supplementary nutrition for children (%)	NA	NA	NA	NA	NA	26 ^r	53 ^r	49 ^s 44 ^t	89 ^s 67 ^t

Sources: National Family Health Survey (I, II, III), India, reports and fact sheets (<http://rchiips.org/nfhs/>); Rapid Survey on Children 2013–14 (<http://wcd.nic.in/Acts/rapid-survey-children-rscc-2013-14>); Annual Health Survey 2012–13 Fact Sheet (http://www.censusindia.gov.in/vital_statistics/AHSBulletins/AHS_Factsheets_2012-13/FACTSHEET-Odisha.pdf); and Special Bulletin on Maternal Mortality in India 2010–12 (http://www.censusindia.gov.in/vital_statistics/SRS_Bulletins/MMR_Bulletin-2010-12.pdf).

Notes: Percentages have been rounded to whole numbers; NA = not available; ORS = oral rehydration salts; ICDS = Integrated Child Development Services; ^a National Family Health Survey – I (1992–1993); length/height data were not collected for five states; hence, India average data are not available; ^b National Family Health Survey – II (1998–1999); ^c National Family Health Survey – III (2005–2006); ^d Rapid Survey on Children (2013–2014); ^e Indicator calculated for children < 3 years old; figures in parentheses are for children < 5 years old; ^f Per 1,000 live births for the 5 years preceding the survey; ^g Annual Health Survey 2012–13 Fact Sheet; ^h Per 1,000,000 live births for the 2 years preceding the survey; ⁱ Special Bulletin on Maternal Mortality in India 2010–12; ^j Clinical, Anthropometry and Biometry Census Survey (2014); ^k Indicator calculated for children aged 0–23 months; ^l Indicator calculated for children aged 6–8 months; ^m Indicator calculated for children aged < 4 years; ⁿ Indicator calculated for children aged < 3 years; ^o Includes tablets and syrup; ^p Indicator specifies 100 or more tablets; ^q Indicator calculated for children aged 6–59 months; ^r Indicators calculated for children aged < 6 years; ^s Indicator calculated for children aged < 3 years; ^t Indicator calculated for children aged > 3 years.

on a designated day in a month (Pustikar Diwas). Between 2011 and 2013, the state launched three nationally driven initiatives that included free transportation for institutional delivery (the Janani Express);¹⁵ medical care and other facilities for pregnant women and sick newborns (Janani Shishu Suraksha Kayakaram); and early detection and treatment of physical problems in children younger than 18 years.¹⁶

Taken together, all these state-level initiatives over the years have built on national health initiatives. They have summed up to create an overall set of services to support better maternal and child health, mostly with a focus on reducing mortality.

ICDS INTERVENTIONS (1990–2015)

The ICDS program, which began in October 1975, was designed to deliver services to pregnant and lactating women, children younger than 6 years old, and adolescent girls through the *anganwadi* centers

(AWCs). The services include supplementary nutrition, health education, immunization, health checkups, and referrals, all delivered by *anganwadi* workers; most of these services are delivered in coordination with the health program (see Chapter 2).

In Odisha, the ICDS program was started in 85 AWCs in the Subdega block of the Sundargarh district.¹⁷ Over the past two decades, it has evolved and expanded, largely following national guidelines but also experimenting and enlarging its set of services. Odisha laid a strong foundation for the ICDS program in the early 1990s by building the capacity of the program staff and facilitating coordination with the health department. The ICDS projects and the AWCs continued to grow from the early 1990s until 2014, with major expansions occurring in 2004, then in 2009, and again between 2010 and 2014. These expansions were largely the result of the state government's adherence to the Supreme Court of India's order to increase the number of

AWCs, as part of the national public interest litigation case on the Right to Food.¹⁸

In the late 1990s and early 2000s, the ICDS focused on identifying and providing solutions for moderately and severely malnourished children (*Ami bhi paribu*—“We too can,” a positive deviance initiative) and investing in medical referral for chronic cases. To comply with the Supreme Court of India’s 2006 judgment, the Department of Women and Child Development (DWCD) implemented decentralization, in which the existing self-help groups under “Mission Shakti” took charge of procuring and preparing food supplements.¹⁹ Mothers’ committees were set up in 2006 and rejuvenated in 2012 to monitor the ICDS services. The Government of Odisha, along with its development partners, made significant efforts to identify key barriers to ICDS service provision and use and in the late 2000s established a Nutrition Operational Plan.²⁰

Factors Contributing to Policy and Program Changes in Odisha

An analysis of state-level stakeholder interviews and documents points to a confluence of factors that facilitated changes in the health and ICDS programs. We examine these factors next using the recent framework for scaling up impact on nutrition.²¹

A Vision for Impact

Odisha’s work on scaling up key health and nutrition interventions was stimulated by its poor ranking within India on IMR and high levels of infant and maternal mortality, so changing both of these was a driving goal. The state’s goals were to accelerate reductions in the IMR, MMR, and total fertility rate by strengthening reproductive and child health services. As evidence, mostly global, emerged on the links between poor nutrition and mortality

outcomes, during the past two decades Odisha broadened its agenda to include nutrition as well.

Delivering Interventions through Multiple Operational Platforms

Over time the government implemented interventions through both the health and ICDS programs in order to capitalize on both platforms, and it supported cross-platform convergence on the common goal of mortality reduction in several ways,²² which likely had positive implications for scaling up interventions. Over the years, the types of interventions delivered through the ICDS steadily evolved and expanded. The mortality-reduction goal led to the use of the ICDS platform to identify and rehabilitate severely malnourished children who were at the greatest risk of dying. When the NRHM came into being in 2004, Odisha, after a somewhat slow start, began rolling out key mortality-reduction interventions, such as antenatal care and immunizations, whose rapid scale-up was likely facilitated by the existing state government goal of reducing mortality. Early government orders and a culture of working together across two operational platforms—the health department and the ICDS—continued to support the use of both platforms to deliver interventions that worked toward the overarching mortality-reduction goal. Finally, Odisha’s investment in establishing the *Mission Shakti* women’s self-help group within the same department that ran the ICDS program enabled the state to respond rapidly to guidelines that stipulated decentralized production of food supplements by the self-help groups.

Catalysts, Champions, and Ownership

Catalysts for action against malnutrition in Odisha included the state’s poor national ranking on infant mortality (which spurred internal reflection and action planning) and intense human rights commission monitoring of starvation and other deaths in tribal districts in the state. The choice of Odisha

for sector support from the UK's Department for International Development (DFID) technical assistance program likely also contributed to an infusion of resources and support to strengthen the area's systems.

Several individuals across the two government departments were named, along with the chief minister, as key leaders for health and nutrition in the state. The Odisha political leadership had consistently appointed well-qualified and motivated bureaucrats to manage social sector programs; these individuals took ownership of the vision for improving mortality rates and realizing the programs' potential.

Several observers mentioned the notion of "political/policy intent," which conveyed the goals' focus, as well as the existence of "bureaucratic space" that enabled operations, innovation, and learning. Individual commitment and leadership influenced both policy support and implementation of programmatic changes. For example, at the state level, the chief minister's interest in women's empowerment, and the potential political gains from supporting women, led to initiatives such as the Mission Shakti self-help groups in 2001. These later provided an operational framework for scaling up the decentralized production of supplementary food. The chief minister was also credited with providing "enabling leadership"—that is, clearly stating policy intent but staying removed from operational details.

Several dynamic and committed secretaries and directors of the health department and the DWCD were acknowledged to have provided leadership in moving the agenda forward in the state and to have taken ownership for state goals. Longer tenures by leaders than in other states were also thought to have led to a combination of problem and solution ownership, as well as accountability for results. There was said to have been a sense of responsibility and collegiality among the bureaucrats of the

health department and the DWCD and a desire to effectively implement the programs that facilitated coordinated action: "Odisha is a special case in that coordination is ensured from the highest level. Joint letters were sent to the district collectors to ensure that the ICDS and health departments work together from the district level below. This is rarely done," remarked one bureaucrat who worked at the state level during the mid-2000s, when nutrition was beginning to take center stage.

Diverse Pathways for Scaling Up

Our analysis and interviews showed that scaling up took different pathways in Odisha. Expansion of child care centers and frontline workers in the ICDS, the frontline workforce in the NRHM, and the number of women's self-help groups all led to delivery platforms' becoming available for interventions as well as innovative operations. Once these basic structures and functions were replicated statewide, the scaling up of interventions followed a more functional pathway, and new interventions or operational strategies to achieve coverage could be added to available platforms. For example, eggs were added to the ICDS and midday meal scheme across the state, special child nutrition days (Pushtikar Diwas) were added to improve coverage of weighing and screening for severe malnutrition,²³ and self-help groups were used to produce foods for the ICDS.²⁴ However, limited evidence exists on the impacts of these specific innovations.

Gradually Building Up Strategic and Operational Capacities

Scaling up these interventions was enabled by strengthening both strategic and operational capacities. Over time, a diverse set of capabilities had been built statewide. It is unclear how many of these were intended from the start, but it is apparent that the combination of investments clearly paid off for the state.

From a strategic capacity perspective, the chief minister appointed high-caliber bureaucrats to the social sector departments, including health and ICDS. This move clearly signaled the strategic importance of the social sector across a bureaucracy that typically deprioritizes it by not appointing high-caliber individuals to these positions. Several of Odisha's bureaucrats were well trained for their sector: two senior bureaucrats had mid-career degrees from top public health universities in the United States, and the lead of the NRHM state unit was a doctor with significant public health experience.

From an operational capacity perspective, several years of supporting and strengthening the system readied it to respond. Strengthening measures

included establishing training arrangements, transparently recruiting frontline workers and supervisors, and reducing the capture of frontline positions by local elites. It is possible that the state policy ensuring that all ICDS frontline and supervisory staff were women led to greater motivation within a sector that focused on women and children. District collectors, relatively junior in the bureaucratic hierarchy, were noted to have good communication with secretaries, who were more senior, and to have invested in ensuring robust program implementation. Because of high-level support of social sector programs, district collectors routinely included social sector programs in their monthly district reviews. And at the grassroots level, administrative changes were made in how frontline



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From 1991 to 2015, coverage of antenatal care, institutional deliveries, immunizations, and other interventions all went up in Odisha.

workers were selected. “[Frontline workers] continue to be at the heart of [our] success in health and nutrition,” remarked one senior bureaucrat in our stakeholder interviews.

Finally, several development partners (UNICEF, DFID, the United Nations Office of Project Services [UNOPS], the World Food Programme, CARE, and the World Bank) were said in interviews to have played significant roles in supporting the operations of the health and ICDS programs. Over the years, UNICEF, DFID, and UNOPS helped implement health programs by giving technical and financial assistance and by working in alignment with Odisha’s state goals. The World Bank supported the expansion of ICDS projects in the 1990s, and CARE invested in strengthening delivery systems through its Integrated Nutrition and Health Program (1996–2001 and 2001–2005), which was implemented in collaboration with the ICDS and health programs. And from the mid-2000s, the DFID-supported technical support team invested in systems for strengthening data gathering and documentation. UNICEF was a fairly constant development partner for nutrition throughout the two decades.

Adequate, Stable, and Flexible Financing

For several years, creating the fiscal space for social sector programs in Odisha was a challenge. In 2004–2005, however, space opened up owing to increased national financing for social sector programs, state-level financial restructuring, and significant technical support and direct state budget support to Odisha from DFID. Financial restructuring under the government of Chief Minister Naveen Patnaik was credited with turning around a nearly bankrupt state to reach financial stability, which allowed for investments in social programs and state infrastructure development. Financial restructuring included (1) undertaking fiscal consolidation; (2) reforming tax policy and

administration (for example, introducing a value-added tax); (3) restructuring expenditures (such as reducing public-sector employment); and (4) restructuring debt (swapping high-cost debts for low-cost ones).²⁵ These measures brought together diverse sources of funding to implement national programs, deploy state-level initiatives and innovations, and bring more technical support to the health and nutrition program landscape in Odisha.

Creating an Enabling Policy Environment

Three major elements appear to have contributed to an enabling policy environment for scaling up health and nutrition interventions in Odisha: high-level policy and political backing of social support programs, political and bureaucratic stability, and the emergence of a supportive policy and fiscal framework at the national level. First, Chief Minister Patnaik provided leadership on development issues in the state by sending clear signals of interest in the social sector programs, which were featured in all state reviews and to which he appointed strong bureaucrats. He is said to have established a clear policy intent to deliver on social sector programs and then to have given bureaucrats autonomy to function without political interference. He also signaled a low tolerance for corruption in social sector programs, which limited graft in the systems. Second, an unusual degree of electoral stability for the political party in power enabled several reforms in health and nutrition programs to continue uninterrupted. Coupled with political stability, bureaucrats were assured adequate tenure in their positions to allow them to amass knowledge on health, nutrition, and social programs and to experiment with, learn from, and take credit for innovations in program implementation. Third, overarching policy support—coming from new socially focused policies, programs, and associated financing at the national level—allowed Odisha to expand and experiment in health and

nutrition programs. Indeed, this expansion was especially important both for the scale-up and roll-out of the NRHM and for the expansion of the ICDS. In the case of the ICDS, expansion was mandated by the Supreme Court's ruling on the Right to Food.

Measurement, Learning, and Accountability

Data were used to support decisions in different ways as the programs evolved. In the early years, this data-for-action approach focused on “weighing efficiency”—that is, ensuring that all children were weighed monthly to identify the most malnourished. In later years, investments in concurrent monitoring surveys by the DFID-supported technical support unit, and the use and discussion of these data with officials, facilitated the use of third-party data. Odisha also hosted important research studies that informed state-level programming; for example, Odisha is home to Ekjut, a nongovernmental organization involved in major experiments on the use of women's groups for achieving health and mortality outcomes. Overall, a culture of constructive use of data appears to be in place, though it is not without its challenges. For example, multiple sources of state-level data have created some confusion, data are not always available below the district level, the monitoring systems do not capture all necessary indicators, and the state still depends on monitoring systems established by national programs.

Conclusions and Challenges Ahead

Our study reveals Odisha as a state that, over time, steadily managed to chip away at several system-level challenges to scale up, strengthen, and deliver a set of effective health and nutrition interventions. Rather than identifying a single forward-looking strategic master plan, our analysis highlights the convergence of several

actors, along with several operational and financial resource pools, which in turn enabled the state to respond positively to major national policy changes and to use national fiscal commitments to health and nutrition to provide better services inside its borders. The key success factors in Odisha included high-level political support for health and nutrition programs, fiscal and policy space to operate, and useful collaborations with committed development partners. In addition, notwithstanding continuing challenges of diversity in levels of undernutrition and progress in program delivery and outcomes across the state, a cadre of committed and technically capable bureaucrats enabled programmatic action despite the challenges of a state that is predominantly poor, rural, and tribal. The common goal of reducing IMRs in the mid-1990s and 2000s contributed significantly to several key actions (antenatal care, immunizations, a focus on severe malnutrition, and others) that were scaled up to successfully reduce mortality.

Several lessons from Odisha's experience may be transferable to other states of India—and possibly even to contexts outside of India. These lessons include the importance of (1) setting goals; (2) ensuring bureaucratic stability, capacity, and motivation to deliver on the goals; and (3) creating an enabling environment with little to no political interference, adequate financing from diverse sources (to ensure flexibility and agility), and adequate technical support. Several states in India now have financial stability, the availability of technical support, and additional resources, as well as highly capable bureaucrats who are keen to make a difference. However, long-term political stability, political commitment to development goals for all, and lack of political interference in social sector programs are not always easy to come by. Could this set of drivers of change in Odisha be replicated, in a more rapid and focused way, in other states? And can Odisha

itself succeed in capitalizing on its enabling environment to continue to innovate, expand, and deliver results in areas within the state that are still lagging?

As Odisha looks ahead to improving nutrition further, it becomes crucially important to create similar targets in this area, build on existing technical and system capacities, and capitalize on existing high-level support for such initiatives. The state still faces geographic disparities, which largely reflect challenges in delivering services to the state's tribal populations and in addressing their broader development needs. Therefore, actions will need to engage other government departments, such as

the education sector, water, sanitation, and hygiene, and the Rural Development Department, to ensure that some of the known social determinants are tackled on an urgent basis.

Reducing undernutrition in Odisha is an imperative for the state's further development. Can Odisha become a shining beacon of hope, not just for scaling up nutrition and health interventions and reducing mortality but also for bringing together cross-sectoral interventions to more rapidly improve nutrition in one of India's poorest states? Perhaps the time is ripe for Odisha to take the next big leap for nutrition.

