Integrated Community Based Management of Malnutrition - A Primer

Integrated Community Based Management of Malnutrition

Vikas Samvad

Fourth

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Integrated Community Based Management of Malnutrition

-A Primer

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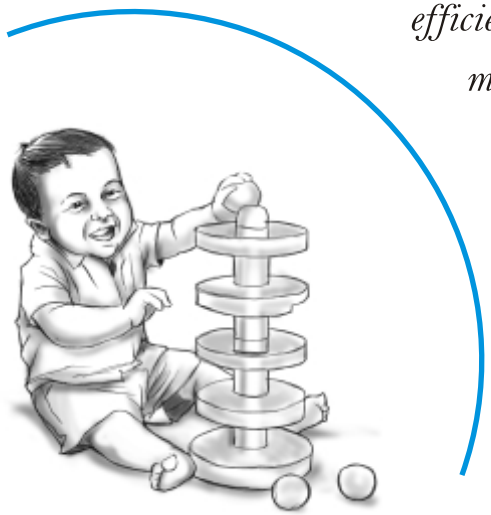
Perspective

Nutrition Security : *It's about access to adequate nutrition and food, It's about feeding practices , It's about water, It's about responsibility, It's about access to basic services, It is about taking right steps in the right direction for dietary intake, and so on...*

Absence of all these causes leads to the emergence of ***"Malnutrition"***

Community Based Management of Malnutrition : *It is about finding ways and means in the community and the institutions, and ensuring that systems are in place and efficient. It's also about our resolution both as a society and State, together to make sure that no child lives with hunger;*



Ultimately our Goal and intervention is ensuring and securing ***Social Justice!!***

The Preface

Malnutrition has been in the news and continues to remain a hot topic for discussion and debate. It is rather evident that the problem of malnutrition is a formidable one, with situation and circumstances marked by persistent disquiet. It increasingly poses an image of crisis. The question is about its remedy, given that the issue is widely acknowledged as an unacceptable menace. Some have advocated for strengthening the institutional measures, implying the suggestion to take the malnourished children to the hospitals. Some have called for having the supplementary food produced in industry or bought from the market for feeding the children. Questions have been raised whether such measures can help eliminate the malnutrition. The natural answer is in the negative! Apparently, these strategies are not the best ones for doing away with the menace of malnutrition.

We would need to make a very robust strategy to address the causative factors that have led to the menace of malnutrition to such a huge proportion. Not every child can be taken to the hospital or to the Nutrition Rehabilitation Centre. And, even if those children who are moved to these facilities for a curative care, they will eventually come back to their homes in the same village or city where hunger and neglect in child care persist. Consequently, the moot question is as to how the child will be tended there. It is a known fact that medical treatment for illnesses could be rendered by the hospitals. On the other hand, remedy for malnutrition calls for a host of measures, including inter alia, access to adequate food and nutrition, safe drinking water, sanitation and hygiene, education, caring attention and basic health services. It needs to be seen that these resources are strewn around us. What is necessary is the modus operandi for ensuring and securing their sustained availability.

We do not agree that people, parents or members of the community are not able to take care or are negligent with regard to behaviors associated with food and nutrition and feeding practices. However, this is also true that the meaning of development has meant a change in behavior of the people, including that pertaining to food and individual disposition towards it. Further, poverty has made this web of malnutrition more complex and incomprehensible. This has led to the dilemma whether there lies a single attributable and identifiable cause for malnutrition or not. Certainly, the menace of malnutrition has to be dealt with across multiple fronts propped by a host of causative factors.

There are a few structural factors related with malnutrition- for example, the dwindling or diminution of livelihood resources, shift from natural resources-based food security to market economy directed system, plunging the poor and the marginalized in to the web of perpetuating hunger. Likewise, there are some direct and immediate causes of malnutrition too: for example, if the children suffer from repeated bouts of illnesses, they will be pushed in to malnourishment. If there is a lack of safe drinking water and personal hygiene, the prevalence of infection-induced illness is bound to rise and beset the edifice of malnutrition. There is a large section in our society that has to confront both of these factors of malnutrition and gets caught in the deep and vicious circle. It is rather evident that only the hospitals, Nutrition Rehabilitation Centres and Anganwadi Centres alone cannot address the menace of malnutrition. We need to broaden our initiatives and interventions.

The Anganwadi Centre does become the primary unit of our initiative as it can keep a tab on the children and can trigger an immediate response to an observed and felt need of the children. We believe that this centre should be viewed as a community child development and protection entity. One must repel the assumption that some outside force will help eradicate the menace of malnutrition. In fact, we rather advocate that programmes on 'growth monitoring' and 'immunisation' should be celebrated as community's festivals.

We believe that there cannot be a universal solution to address the problem of malnutrition. With diverse cultures, practices, differing means and resources being prevalent, malnutrition too does not have a unified cause and cure. We would need to identify the local factors and devise appropriate architecture of response and management. No solution can be successful driven solely by the market forces or being dependent on experts. The solution has to be people-centric where the community, the Panchayat and the people take on a direct role.

We are in the midst of giving shape to a community-based response. In order to drive home this concept, this document can be referred as a primer by the community workers, civil society representatives and planners under the ICDS Mission. We do not believe that it can serve as the only outline for community-based management of malnutrition. Rather, every outline of every initiative requires to be context-specific, in terms of its location, time and situation with regard to the analytics pertaining to the factors and causes of malnutrition. Accordingly, one may seek to dismiss some sections or all of this primer. Nevertheless, this journey shall tread on the path imbibed from this learning.

What you would find in this document? Below is a snapshot of the content as to what you would find sequentially in the document:

The first chapter describes the scope, context and description of malnutrition; we haven't gone in detail as the first book in the series on malnutrition is entirely focused on the fundamentals of malnutrition. The second chapter elaborates on the connotations of community based management of malnutrition. The third chapter throws light on the strategic aspects, the four systemic points being underlined as vital. The fourth chapter of this primer sets the tone by underlying the fourteen factors that contextualize the community based management- consensus, community, child-friendly Anganwadi, nutrition rehabilitation in the community, root-causes (connections with the hidden factors), crèche, community health, parameters of cognitive development, training, roles of local institutions, grievance compliance system, underline the target group and, a summary.

In the fifth chapter, how the community can monitor the Anganwadi is specified. The fifth chapter also provides a perspective framework of monitoring the Anganwadi by the community. As malnutrition is the manifestation of multidimensional factors such as food availability and access, nutritious foods, forest produce, safe and clean drinking water, immunisation, health care etc., it transpires that different government departments; the community and the local institutions play a role. Chapter six brings clarity to the distinctive roles and responsibilities of various stakeholders. Malnutrition can be addressed through nutrition supplements, their sources and information on these is contained in seventh chapter. From eighth to eleventh, a few practical issues have been referred and described. The eighth chapter elucidates about the notoriety of occasional health camps, especially organised during epidemics, and how these camps cannot and are not a panacea for malnutrition. Whether there is epidemic or not, it has to be ensured that the children and women need to be examined regularly and provided care and treatment. Likewise, you'll find concise instructions about growth monitoring in the ninth chapter. It should be kept in mind that the growth monitoring of the children has to take place every month and accordingly the children should be provided care and treatment facilities. Instead of merely making a provision of services to a group of children, we must provide protection to every child, i.e. the protection should be inclusive and not selective. If the family is under the threat of hunger with limited access to adequate food the roots of malnutrition will remain firmly entrenched. So it becomes a prerequisite for community based management of malnutrition to know the status of food security of the community. In the tenth chapter, a study has been discussed in detail. After all this, the first step towards this should be a robust and tangible programme. So to assess the preparation, in the eleventh chapter, we have identified a few basic questions. These questions are introspective and we need to ask ourselves whether we have taken enough steps as a precursor towards the programme to address malnutrition.

Vandana Prasad (member, National Child Rights Protection Commission), Radha Holla (Breastfeeding Promotion Network, Devika Singh (Mobile Crèches), Biraj Patnaik, Dipa Sinha, Ramani Atkuri, Prasanna Saligram (Centre for Public Health), Seema and Prakash (Spandan, Khandwa), Amin Charles (community Development Centre, Balaghat) and Chinmay Mishra gave valuable suggestions and shaped this primer on community based malnutrition management to the present form.

Dr.Sheela Bhambal, Dr. Rashmi Dwiwedi, Dr. Jagmit Kour Chawla and Dr. Madhuri Chandra provided training inputs to Vikas Samvad. During this time, we acquired clarity on a few aspects and got doubts cleared. Without these all, the document would not have been a possibility. We have had a series of discussions with Dr. Manohar Agnani and Dr. Sheela Bhambal, Dr. Rashmi Dwiwedi, Dr. Jagmit Kour Chawla and Dr. Madhuri Chandra imparted training to the team of Vikas Samvad. During this time, we acquired clarity in to many aspects and got answers to our queries. Without them, the document would not have been possible. Further, we have had a series of consultations with Dr. Manohar Agnani and Dr. Steve Collins in last two years and this helped us immensely.

This is a small beginning. We expect your companionship in the endeavor and have no qualms that we will reach our destination with your support and camaraderie. We do believe that all of you are with us to further the dialogue along the stated perspective.

Vikas Samvad Team

Foreword

Community Based Management of Malnutrition

Nothing could be timelier; a document, a primer, systematically arguing for the 'Community based Management of Malnutrition'. A country like India that is blessed with surface areas of 3,287 thousand sq. km and population density of 373 is blessed with total cropland 169,700 thousand hectares i.e 171 Hectares of cropland per 1,000 populations is available. Similarly, arable and permanent cropland as a percent of total land area is 51.6% against world availability of just 11.3%. Thus, nothing justifies the low human development index on the percentage of population especially children suffering with malnutrition/hunger. Thus, the issue is more of an outcome of poor-management than lack of food availability.

The approach to reduce malnutrition at the International fora for Human Centered Development has listed the obligation of the State in acronym PANTHER i.e. Participation, Accountability, Non-Discrimination, Transparency, Human Dignity, Empowerment and Rule of Law. However, there is no mention of obligation of the Community. India is PANTHER compliant to a considerable extent. We have active Judiciary, Civil Societies and Government that have enough laws, programs and schemes to ensure food-security. India has a robust democracy with its institutions like Supreme Court, National Human Rights Commission, Constitutional framework emphasizing the rights approach with strong legal framework, Active media, Civil society and Policies and supplementing programs in place. The writ petitions and the Public Interest Litigations have paved a long way to flag the accountability of the State for execution of Right to Food. Government of India has signed and ratified the international convention on Economic Social and Cultural Rights (ESCR) and also ratified the UN Convention on the Rights of the Child, appropriate legislative and administrative measures are being taken for implementing the Convention Treaties by the concerned Ministries/Departments. Interventions through number of programs and schemes for supplementary diet have been long experimented but the results have never been sustainable. In fact there is a program right from pre-birth to old age to ensure food security. Adolescent care in terms of iron tablets etc, marriage age being advocated for women as 18, supplementary diet during pregnancy, institutional delivery, supplementary diet to lactating mother, health care for infants, supplementary diet to under 6 and SAM children, mid-day meal and overarching subsidized food grains are the major components of the programatic thrust. The health care is subsidized and livelihood opportunities have their own plethora of programs. Thus, there is definitely no lack of State intervention to ensure food security. The problem therefore lies in non-active participation of the community to ensure timely, qualitative delivery to the entitled individuals and groups.

The challenge is now three fold: one, in India hunger and malnutrition are not due to lack of food but lack of access to available food, inter alia because of poverty. 24 % of India's 1.2 billion population is listed as Below the Poverty Line and makes a major vulnerable

segment of world's population. It is therefore important to recognize the fundamental difference between the 'availability' (is there food around?) to that of access (can you make a claim on that food?). Thus the major challenge is to identify the vulnerable and develop mechanisms for ensuring access to food. Who can do it better than community?

Second, is to ensure circumstances and sustainability for long-term availability of and accessibility to food. Community can ensure quality delivery of Government interventions.

Last but not the least is to create enabling conditions to ensure the availability and access by maintaining the dignity of the individual. The Right to Food is not a 'charity' concept but the obligation of the State. The availability of cheap food grains is being misconceived as ensuring food-security and thus a mechanism to ensure nutritious diet that would enable to attack high percentage of nutrition deficiencies is the call of the day. The answer lies in involvement of Community in not just bringing awareness but also in ensuring HABIT change among the vulnerable groups in the society.

Unfortunately, there is no direct, one stroke, one time intervention remedy for the malnutrition. The interventions in terms of supplementary medicines or diet have to be incorporated in the normal food intake practices. The food intake itself has to ensure the balanced diet. Number of interventions that are now being advocated to ensure food security in terms of subsidized food grain, iodized salt, medical facilities and even supplementary diet are just instruments to make vulnerable group aware of their status of malnutrition and educate them about the healthy diet practices. I recollect in the year 1999 visit to 'Tribhuvan Das Foundation' at Anand, Gujrat. The foundation was focusing on working out menu within the budget the poor family spends on food intake and then teaches the housewife to cook the same in a manner that gives the family sufficient nutrition. Such intervention resulted in incorporating the changes that remain permanent and therefore sustainable.

Thus, I compliment Vikas Samvad team and the authors who have underlined the importance of Community taking the onus to attack the issue of mal-nutrition. The community based response is more outcome oriented that is sustainable in nature. This primer to community workers will enable to open up the obligation of Community to reduce the factors resulting in malnutrition and malnutrition itself.

Dr. Aruna Sharma
Additional Chief Secretary (IAS)
Rural Development, Panchayat & Social Justice
Government of Madhya Pradesh

Understanding the genesis and rationale of this primer.....

- Malnutrition is a manifestation of food and nutrition insecurity and related practices and behaviors pertaining to child feeding and care.
- Poverty, social discrimination and gender disparity and irrational policies in development are at the root of this problem.
- The problem is not confined to any limited sphere. Rather, it is a widely spread crisis for the society.
- Its solution is not feasible unless the community intervenes.
- Malnutrition has to be combated by considering each child as a complete unit.
- The community has the answer to this problem but nobody bothers to consult it.
- The need is to have every centre and every institution embedded within the community.
- In order to tackle the problem, community, comprising both the families whose children are malnourished and the families whose children are not, will need to perform certain roles. The community will have to be informed that resources for combating the malnutrition can be available within the household. Further, the government will have to demonstrate the evidence that it is taking the right steps to provide food security for the community.
- This will help the social workers and the government functionaries to be able to develop an enabling operational framework.
- We have to ensure that the services of the Anganwadi Centres, Nutrition Rehabilitation Centres and the health institutions/hospitals become community-centric and community-embedded.
- Believing that caste-based division of the society and gender disparity are amongst the root factors of malnutrition, people will have to take the initiative to bring an end to the inequality and discrimination, whatever be their own dispensation in terms of caste, creed and gender. This task can be better undertaken by people from within the society and that it is this endeavor that will bring about a lasting change.
- The community needs to be empowered to be able to deliver its role in securing an accountable government system.

What is Malnutrition?

- When a person is not having access to adequate and enough food, malnutrition is just around the corner. Disease is often a factor, either as a result or contributing cause. Even if people get enough to eat, they will become malnourished if the food they eat does not provide the adequate amounts of micronutrients - vitamins and minerals - to meet daily nutritional requirements.

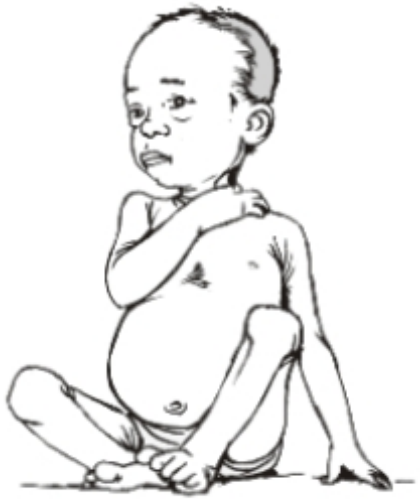
- Malnutrition is the largest single contributor to disease, according to the UN's Standing Committee on Nutrition (SCN).

- Malnutrition at an early age leads to reduced physical and mental development during childhood. Stunting, for example, affects more than 147 million pre-school going children in developing countries, according to SCN's World Nutrition Situation 5th report. Iodine deficiency, the same report shows, is the world's greatest single cause of mental retardation and brain damage.

- Undernutrition affects school performance and studies have shown it often leads to a lower income as an adult. It also causes women to give birth to low birth-weight babies.

And the impact is:

- A malnourished person finds his body has difficulty doing normal things such as growing and resisting disease. Physical work becomes problematic and even learning abilities can be diminished. In case of women they may develop risks in pregnancy.



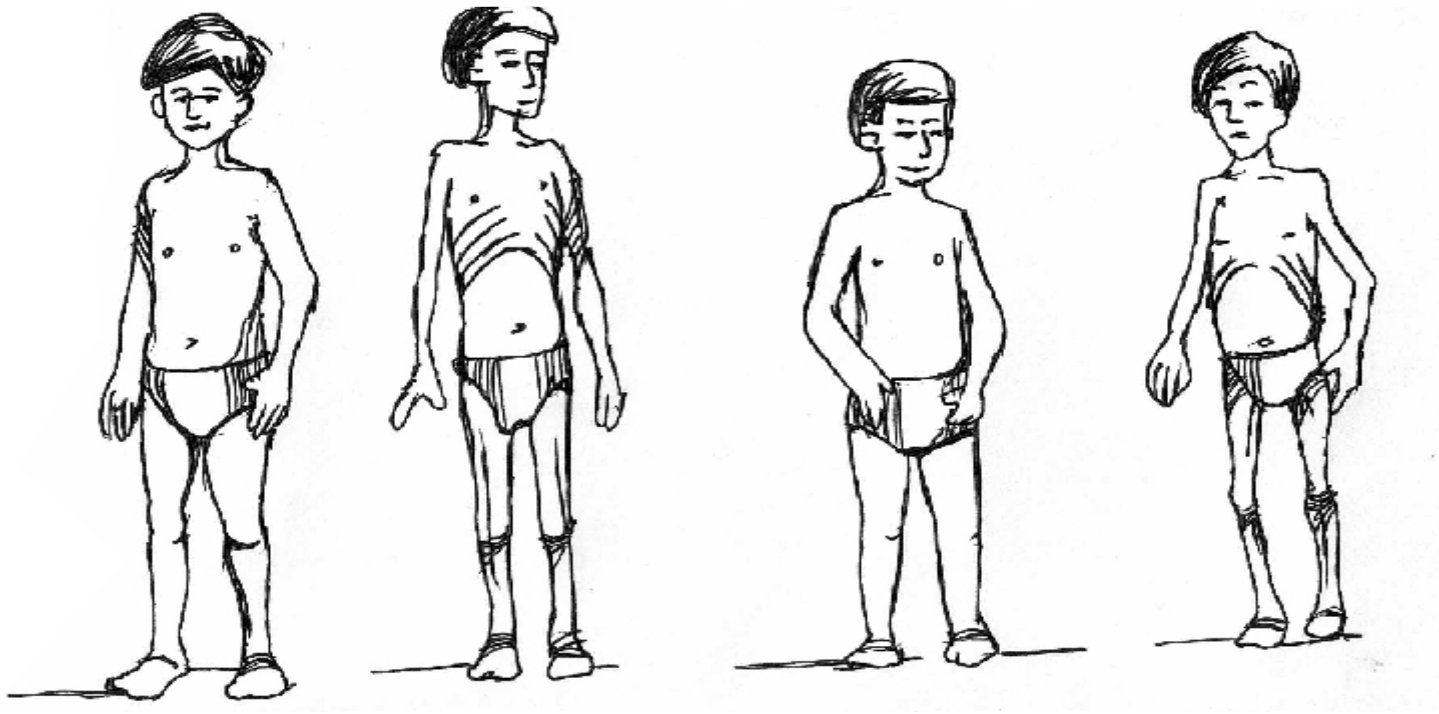
{Source - World Food Program / accessed from http://www.wfp.org/hunger/malnutrition}

Malnutrition is manifestation of the situation arising due to inadequate intake of nutritious diet. When children do not get adequate food, they succumb to the state of malnutrition. It is not necessary that eating of stomach full of food would give adequate quality of essential nutrients also. At times, children may get lots of food grains but may lack the intake of pulses, fruits, vegetables, eggs, milk, edible oil or butter or ghee, beet root or fibrous food. These all ingredients are essential as they provide essential vitamins, minerals, proteins, fats, calcium, carbohydrates, iron and other micronutrients. These nutrients help in making children's bones strong, develop ligaments and muscles, make their brains sharper and lead to develop the body.

When the children do not get these nutrients, they become weak and their physical and mental development is retarded. They become weak and their scholastic performance in the school is adversely affected. It is the lack of nutritious food that makes them vulnerable to diseases as their ability to cope up with the onslaught of foreign bodies is compromised. This is known as weakened immune system which leads to repeated bouts of illnesses for the children. It aggravates their malnutrition status to critical proportions and the vicious cycle of malnutrition-illness-malnutrition takes the children in its grip. This dreaded cycle could become fatal as well.

Whilst anyone can fall prey to malnutrition but children need to be protected as malnutrition can have longer term adverse effect on them such that they are never able to recover from it in their entire lifetime. Malnutrition can make them chronically weak, cause disability and damage their vital organs like kidneys and liver.

It is also imperative to maintain child-specific attention and care as the needs for growth and development are different from child to child. Immediately after the birth, the child should be exclusively breastfed for six months; nothing else, only mother's milk. After six months, along with mother's milk, it becomes necessary that the child gets nutrient dense complimentary foods which are soft and easy to digest. The children cannot eat a full meal to meet their needs for a day. Hence they should be fed 5 to 6 times a day so that they are able to digest the food and ingest the requisite nutrients.



Normal | Weaker than normal | Stunted | Weaker and Stunted

The malnutrition can set in right from stage of being the foetus. If the pregnant woman does not get adequate nutrition and care, the foetus development is impaired and the newborn can be underweight. In India, three out of ten newborns are low birth weight babies. If these low birth weight babies are not taken care of, they may become severely malnourished making their condition precarious.

Malnutrition is assessed measuring the anthropometric data, including weight, height and age. Every child has to have an age appropriate standard weight and height. If the weight and height of the child is less than the standard, the child is classified as malnourished. If the weight and height is very low as compared to the standard weight and height, the child will be considered underweight and/or stunted.

What is Community Based Management of Malnutrition?

- Perhaps, community based management of malnutrition is a new terminology in vogue. Essentially, it connotes taking recourse to such basic and local steps for combating and preventing malnutrition where dependence of the community on external resources is minimal. It means that the causes and remedies should be looked for in the local surroundings.

- What does it mean in practical parlance? That, children have access to nutrient dense foods; children and women get immediate treatment for their illnesses. It means availability and access to safe and clean drinking water. It means that we look for the food stuff available in our village environment-in the agriculture fields, in the forest, in rivers or tanks and make use of them to eradicate malnutrition.

- It also means that the children get good health and nutrition services under the monitoring of the community; that the growth monitoring becomes a shared responsibility of the community and enough resources are allocated for it.

- Community exercises its surveillance on service deliverance and obligates the government for a responsive action on its complaints.

- This work must not be construed merely as a technical one. What we need to determine is whether we really need to be dependent upon the external support.

- Finally, it means creation of a system capable of treating the illnesses and prevention of malnutrition.

Community Based Management of Malnutrition : The Purpose

Malnutrition is a manifestation of food and nutrition insecurity and related practices and behaviors pertaining to child feeding and care. In order to tackle the problem, the community, comprising both the families whose children are malnourished and the families whose children are not, will need to perform certain roles.

The community will have to be informed that resources for combating the malnutrition can be available within the household. Further, the government will have to demonstrate the evidence that it is taking the right steps to provide food security for the community.

Believing that caste-based division of the society and gender disparity are amongst the root factors of malnutrition, people will have to take the initiative to bring an end to the inequality and discrimination, whatever be their own dispensation in terms of caste, creed and gender. This task can be better undertaken by people from within the society and that it is this endeavor that will bring about a lasting change.

The first six years in the child's life are of utmost importance as this is the formative period which affects its life profoundly and shapes it into what it is going to be like in the years to come. These six years starting from the child birth impart direction and pace to the physical and mental development of the child and lay shape to the ensuing quality of life. The first 2 years amongst these 6 years constitute the most sensitive part of the formative years of the human life.

The provisions made during this time towards the health care, nutrition, education, care and development are the basic tenements responsible for the child's good health ushering towards a strong and energetic life. As a first step towards an operational strategy for sound health and good nutrition, interventions can be designed for the following four phases from conception until the child is six years old:

- From conception to birth: Care of pregnant women, i.e. their health and nutrition security- the 1000 days

- Birth to 6 months: Entailing the norm of exclusive breast feeding for the infants.

- 6 to 24 months: The norm is to introduce nutrient-dense foods (semi-solids and solids) in addition to mothers' breast milk as complementary food, whilst the breast feeding for the child is continued well in to the second year.

- Above 2 to 6 years (the pre-school age): It has to be ensured that the child gets the pre-school education opportunity for 1 year prior to getting admission to Standard I.

Under the Integrated Child Development Services (ICDS) Scheme, however, the target group of children up to the age of 6 years is kept in two parts, those below 3 years and those from 3 to 6 years age (commonly referred as the 'pre-school education' period). However, recognising the significance of initial 2 years within the first 3 years, the programme's scrupulous and differentiated implementation needs to accord special focused attention to child's nutritional and healthy wellbeing up to the age of 2 years which is considered to be the most vulnerable period for an early onset of malnutrition.

Presently, majority of the health and nutrition services are being given in villages and hamlets either by the Anganwadi Worker (AWW) or by the ASHA Worker under aegis of various programmes. In a few cases, both are designated as the joint service providers and are accountable for the same. Services, such as immunisation and ante natal checkup (ANC) which require technical skills are rendered by the Auxiliary Nurse Midwife (ANM). ASHA and Anganwadi workers are expected to do advocacy with the community so that an enabling environment is nurtured at the village level for accessing the ANC and immunisation services. There is a provision for organising a Village Health and Nutrition Day (VHND) on a pre-scheduled day every month in each village under the National Rural Health Mission (NRHM). The event helps create a regular platform for coordination between the ANM of the health department and the AWW under the Integrated Child Development Services (ICDS) project. It is the responsibility of

the State Government to develop capacities of these workers and equip them with the necessary resources. The community has the responsibility to avail of their services, value them and accord respect to these service providers.

People, NGOs and institutions devoted to working for child nutrition and development have for long been advocating for a policy decision to augment the Anganwadi Centre with an additional worker. This will help promote services like pre-school education, nutrition, sanitation and hygiene within the community with an accent on continuity.

At the village level, there is a need for bringing clarity in the roles and responsibilities of ASHA and Anganwadi workers so as to distinguish the same in terms of accountability. In some of the states, ASHA has been entrusted with the work of providing nutritional advice, monitoring and consultation and that nutrition has been included as an important subject in their training modules.

At present, a lot of efforts are on in the arena of child health and nutrition. What is needed is to highlight a perspective that malnutrition has to be combated at the roots of its causes and not just attend to its superfluous aspects. These efforts must not remain single-tracked and that they should not be contradictory in their disposition. Whether the efforts are of the state government or of the non-government organisations or are those of the community-based organisations, any contradictions amongst them would not be in the best interests of the children. We also need to be clear that children or the community are not the subject of laboratory research. We need to be accountable towards them and must bear this clarity that it is our prime responsibility to improve their lot and that their deprivation is not aggravated.

Anganwadi is not merely a physical development programme for the children. The programme caters to the age-group specific needs of the children in giving a shape to their personality and attitude. What would the child be like? Is s/he going to be arrogant and violent or would have a positive attitude? These questions are best explained and depend on the early childhood development. We are concerned and talk of stopping violence

against women and strive to change the present situation. At this juncture, we need to remind ourselves that the home environment has a profound impact in shaping up children's life. If there is an environment of violence and stress in the house, the child is going to suffer. It is naive to think children cannot get stressed.

Children too get depressed and stressed. The new research tells us that today's children are more stressed and depressed than before. The children who get stressed are not able to express it and may become malnourished. Whilst they may be eating their food but their tension and distress may not allow them to ingest nutrition in their diet Likewise, the children learn about communalism and caste-based division of the society from their environmental setting. Accordingly, it is crucial to design the community-based programmes in pre-school education and personality development of the children so as to lay the early foundation for a broader outlook for them.

Women's health and empowerment of adolescent girls has to be an important feature of our intervention. Our society forbids any discussions on their health and, as the girls are on the threshold of puberty, a host of prohibitions are loaded against them. Due to the social taboos, beliefs and practices, 6 out of 10 women are vulnerable to be anemic. We have to ponder and ask ourselves: are the live of men and women of co-existence or mutual exclusion? It is seen that right from the birth to adolescence and pregnancy to motherhood, women take no hold on their food likings and intake. It is all decided by the society.

We need to open up a front for an informed discussion on reproductive health and wade through an objective process. Every woman is a working woman whether she works in the house or outside-it is work! But we do believe, fallaciously, that work is only that which earns money and rest is not. A worker is one who expends her/his energy at work, has some regularity in it and others' conveniences are associated with the output of the work. When we believe that work is only what earns money, we tend to negate the significance of work done by the women at and for home. And when the woman after the domestic work attends to outside work as a labour in agricultural field, or goes for a job or does a business, then she bears the dual burden of work. For such situations, were women are working, there is a need to provide arrangements within the community for looking after the younger children. Therefore, it is necessary that the Anganwadi should be linked with the needs of the women also while addressing the needs of the children.

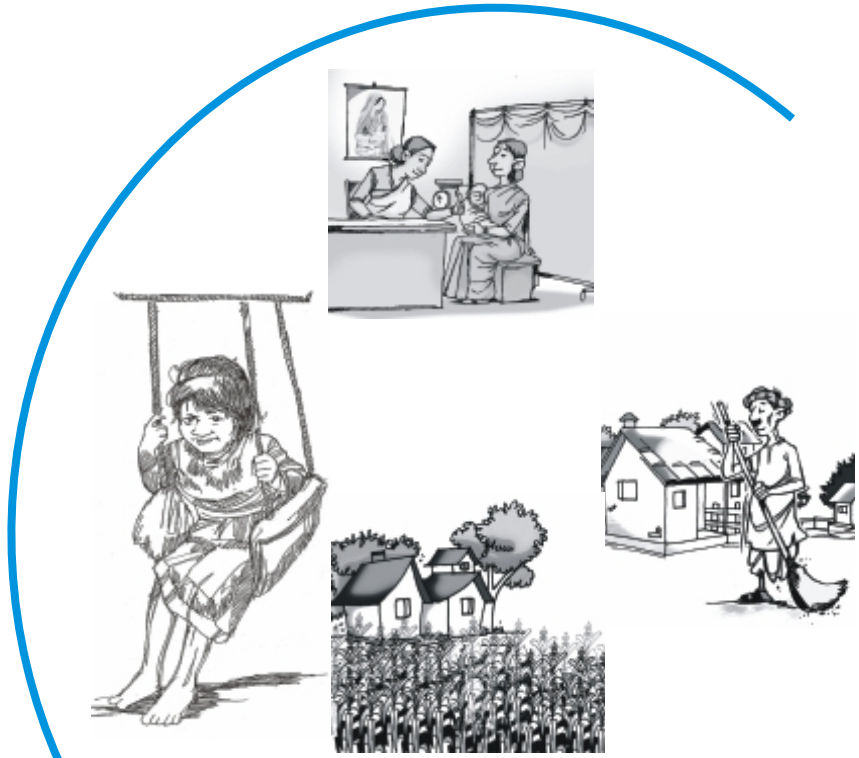
Community Based Management of Malnutrition - Strategic Aspects

- **A system for children's right to nutrition:** To ensure that every child has access to adequate food with appropriate nutrients every day. Further, it is not just the adequate quantity of the food that is important, but due care should also be accorded to social acceptance of the food, its variety, quality and human dignity.

- **A system for child care:** Skilled institutional care for the child should complement the care of the family and mother. It needs to be emphasised here that the men too must also take responsibility of looking after the children. Training, development of infrastructure, safe and clean drinking water provision etc are some of the areas that form the key ingredients of the programme.

- **A health care system:** to keep an eye on the health situation, about the nature of the health issues, to address these at local level or in the immediate surroundings and to ensure that the quality of services are not compromised with. This step is essential for the malnutrition management and its eradication.

- **To intervene on the aspects related to malnutrition:** the food and nutrition security of the family and the community is dependent on the employment guarantee and livelihood security; these two should be considered as the remedial intervention that can affect the sustainability and solutions to malnutrition. At the same time, the government initiatives need to be made functional with due accountability and responsibility. It is expected that the community and the government would accept their mutual responsibilities in management of malnutrition.



The move to take Integrated Child Development Services scheme forward in a mission mode at the national level is an important policy decision. We should ensure that the new policy perspective defines the need for child nutrition as a right and is reckoned as an indicator of development. At present, children's nutrition and health programmes are grappling with various institutional and systemic shortcomings. These shortcomings should be addressed in a time-bound manner.

The Madhya Pradesh Government has constituted Atal Bihari Vajpayee Child Health and Nutrition Mission (ABM). The central government too has reiterated that Integrated Child Development Scheme would be implemented in a mission

Amongst the targeted children up to the age 6 years, those bracketed within the first 3 years are considered to be highly vulnerable because an early onset of malnutrition can have telling effect upon child's growth and development. Further, amongst these children, children under 24 months of age (comprising exclusively breast-fed for first 6 months after birth and those from 6 months to 24 months who should be on continued breastfeed along with introduction of complementary feed, both semi-solid and solid, at 6 months age) constitute the critical window of opportunity in securing a sustained well-nourished status for the child.

And let's underline this. The type of food required to be fed to these children is not being provided with. A vast majority of the children go to sleep on empty stomachs. As we don't understand their language and body indications, they deteriorate into malnutrition minefield. This is the age that makes them vulnerable for illnesses and as such, not getting timely health care services is potentially endangering.

In this intervention, the grass root organisations and community based organisations have a vital role to play, as they are better placed to strike a dialogue with the community whilst sensitizing and mobilizing them. Besides, these organisations are capable of rendering an unbiased monitoring. We, the voluntary organisations, have been discussing issues like agriculture, production, drinking water, employment, migration, displacement, minor forest produce, environment etc. We also discuss malnutrition and health, but if we don't take action; the debate will end at the threshold of Anganwadi.

mode. It becomes imperative that this mission helps overcome the policy flaws and operational inadequacies. The mission arising from a political will has a number of challenges. Whilst on the one hand, the allocation of resources is limited and the systems lack in accountability, there persists a sense of neglect for child care and discrimination within the community, on the other.

Under the Mission, various groups have been formed at the state and the district level. So, it is essential to know their assigned responsibilities. It would be apt that the committees and groups formed under this Mission are reviewed for their performance in a given time frame.

Community based intervention means that the community understands the causes of malnutrition and takes its own decisions on the possible remedial actions. Presently, the government, experts and to a certain extent, NGOs have some insight about the problem of malnutrition. However, the community remains distant within which this problem lies. One may go past an Anganwadi Centre every day but may be completely indifferent as to what goes on there! What is important is that the community takes on the central role in regard to the issue of tackling the malnutrition. The society is not just an abstract entity. It is a key stakeholder and it must recognise that without its role no change is possible. The community has its role both in terms of setting the direction for change as well as that of traversing and reviewing it. This document seeks to examine the contextual roles of both the community and the government.

The Village Panchayat / or Urban body should bear the first line

of responsibility over the situation- the food insecurity, livelihood resources and wage employment; it should have tangible plans to fill in the gaps in the wage employment, livelihood and food and nutrition security of the families with malnourished children. The Panchayat would be deemed to be accentuating the malnutrition when an employment is denied under MNREGA or wages are not paid out. It is when the Panchayat ensures a scrupulous implementation of programmes and schemes like MNREGA that it helps in lessening the severity of malnutrition.

We must accept the proposition that malnutrition is the manifestation of multiple factors. Consequently, any singular tracked initiative would only be superficial and isolated incapable of bringing an end to the menace of malnutrition.

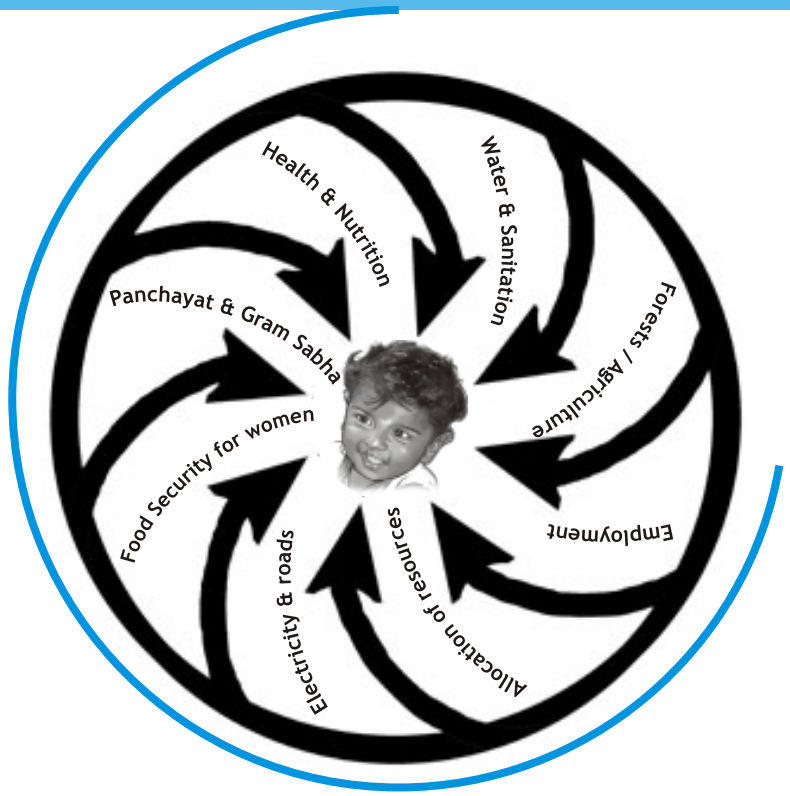
Intervention Framework

Panchayat and Village Health Committees have important roles to play in this work. This part of the primer is important in shaping our outlook and as such we are going to delve in detail on following aspects :

- Synergy, harmony and coordination
- Anganwadi, the complete development centre for the children
- The Community
- Dynamic and pleasing community Anganwadi Centres
- Nutrition rehabilitation centre of the community
- Whom to search?
- Crèche or day-long Anganwadi
- Community health and the children
- Cognitive development at a glance
- Training and capacity development
- Roles of local institutions
- Grievance redressal system
- Whom is this intervention for? (adolescent girls, pregnant women and lactating mothers, children 0-6 months, 6 months to 2 years and 2 years to 5 years age groups)
- To conclude

Synergy, harmony and coordination

In the present context, hunger deaths and malnutrition pose the greatest challenge to development. The challenge is significant not due to mere number of malnourished children but it is its higher level that goes to show that the process of our development carries forward whilst ignoring the rights of children's nutrition and health. Hitherto it was assumed that Women and Child Development Department would free the nation from the evil of malnutrition via provisioning of supplementary nutrition through the network of Centres known as Anganwadis. However, it was not to be. It has now become very clear that there is need for a host of other endeavors that can and must complement the provision of the supplementary nutrition food provision. A single department and an ill-managed Anganwadi centre will not bring about the intended change. Beginning with the family's right to employment and livelihood for its food security, there is a need for synchronising the availability of a host of concurrent measures including health services, safe and clean drinking water, sanitation and hygiene, outreach of health services, elimination of social discrimination and counselling services. The issue should not be considered just to be the remit of the department of Women and Child Development and domain of supplementary nutrition. It calls for an active coordination and mutual commitment amongst the government institutions and the community. In this booklet, under this section, first of all we are trying to find out the meaning of synergy, harmony and coordination in the context of malnutrition.



It is often said that there should be a coordination amongst the different governmental departments so that the campaign to eradicate malnutrition gears up in right earnest and direction. Unless we identify and establish their domains and mandates as are contextual with malnutrition, the talk of inter-sector coordination and convergence would be meaningless and futile. It cannot be forced down by sweeping government orders.

Let's be clear in our mind that the effective implementation of public distribution system (PDS) has a direct bearing on children's access to food and nutrition. If there is no transparency and the scheme is mired in corruption, children will not have adequate access to food at home. A few agricultural issues are also directly linked in this regard. As the cash crops are increasing, the production of nutritious food grain is dwindling and people are not getting cereals. Consequently, the nutrition crisis is bound to get aggravated. Let's ponder. If the people have enhanced their income due to cash crops, why are children malnourished and women anemic? Likewise, the increased use of chemical fertilizers has adversely affected the immune system of children resulting in rise in infectious diseases, increase in cases of bronchitis/asthma etc. Therefore, it is imperative that a comprehensive approach on malnutrition and health of children underlines the role and linkage of the department of agriculture.

In Guna district, it was decided to augment the Anganwadi supply of supplementary nutrition to the underweight children as this alone was not considered enough to mitigate the extent of malnutrition. So the big issue was how to deliver the extra food at the doorstep? So some members of the community came forward and contributed for purchase of 1300 tiffin boxes. The women's self-help group from the village prepares the food and it is distributed through the carry home boxes as the third meal right to the door-step of children's homes. This is one example of the positive community initiative.

At present, more than half of the Anganwadis do not have provision of safe drinking water. As the sources of water are far off or not available in the villages, rural communities have to get water from the unsafe sources and the same becomes the cause for many water-borne diseases for the children. This aspect lays down the significance of the role of the department of Public Health Engineering. In the same vein, the department of labour also has to be made accountable. When a nursing mother goes for work with her 4 month old infant, she needs to be afforded full opportunity to breastfeed the baby. This can be ensured only when their work load is lightened with the needed flexibility, as compared to other workers.

Rural Development Department undertakes the work of road and tanks for water. It is also responsible for the implementation of Mahatma Gandhi Rural Employment Guarantee Scheme. If 80 per cent people do not get employment under MNREGS and/or do not get wages of the work done for months, how will the children's malnutrition get mitigated? If this department feels that it has a role to play in the campaign to end malnutrition, it should be committed towards effective implementation of MNREGS. Though the scheme says it will provide one hundred days of employment to a family per year, wouldn't it like to consider granting more of employment to such families which have malnourished children, as they may so ask for? Does it do so? Freedom from malnutrition is not feasible by adhering to unrealistic and rigid rules and regulations under the programme. Panchayats should be empowered to allocate additional wage employment to such families.

Now, the National Livelihood Mission has been established. It

would be better to ensure that this mission is not turned in to an instrument for wealth accumulation for big traders and industrialists. Instead, it should create trustworthiness by ensuring that small and marginal farmers and tribal and other forest dwellers dependent upon minor forest produce for their livelihood would not be pushed in to oblivion in the market. The mission should promote minor millets and coarse grains like Ragi, Kodo, Kutki, jowar, bajra etc. that give good yields in low rain-fed fields and can withstand extreme vagaries of nature. Can there be a better synergy than this? Also these cereals provide more nutrients, rich in iron, calcium and are high in protein.

Tribal and dalits are the two communities most adversely affected by malnutrition in Madhya Pradesh. Traditionally, tribal communities have been traditionally sourcing different types of food grains, fruits, vegetables and tubers from the forests to meet their needs for nutrients. In the last few years, they have been distanced from these sources. The forest department is well aware that the community's nutrition needs could be met from forest resources and they should not be deprived of their right to harness the forest resources for meeting their needs. The sad part is that the policies are made but are not implemented. The Government of India enacted the Forest Rights Act 2006 to vest the community forest rights. However, contrary to this, everything seems to be done in order to deprive the tribal community of its rights of primacy over the forest and its produce. Under these circumstances, is it possible to eradicate malnutrition?

Malnutrition is not a stand-alone issue. It is the amalgamation of various issues, some small and some big ones which cannot be addressed through the Anganwadi alone. Earlier, Baiga and Gond tribal from Dindori, Mandla, Balaghat, Sidhi and Seoni used to collect twenty five types of mushrooms, five types of honey, twenty eight types of tubers and forty five types of vegetables which provided them food and nutrition security and protected them from ill health. In order to redeem the same status, the government will have to take effective steps to prevent the destruction of forests. It raises the question whether the government is willing to ban the deforestation. It is not merely these foodstuff which will feed the tribals. Rather, the forest produce provides them with items including Aanwla,

medicinal plants, tamarind, Chironji, Harra-Behada, tendu, mahua which can render them a solid base for their livelihood as well. There are many examples: Thirty years ago, in Mahakoshal region, people counted fifty six types of grains that were sown; only twenty four are left now. Of twenty eight types of tubers, only thirteen are known; in the same manner only twenty one fruits out of forty five and twenty seven out of the fifty four vegetables are now known. Baigas, whom the government often terms as backward primitive tribe, used to have as many as two hundred and sixty two different types of food stuff twenty five years ago!

The development paradigm being in vogue today, the path it is treading on has dismantled and ruined the basic livelihood system of the tribal communities. It is precisely due to this hoax of development that the tribal communities are the biggest victims of hunger and social insecurity. The situation has deteriorated so much that the air is pregnant about the expanding social unrest. Madhya Pradesh has 37 per cent of its agriculture land under irrigation. In tribal areas which are marked by undulating and hilly regions, a mere 10 per cent land is under irrigation. This is the development divide the government policies have ushered in.

The efforts should be made to study/assess the availability and use of ingredients in the foods available at community level. We should find out the nutritional content of the food commodities and develop some recipes that could be used by the community.

Ragi, Kodo, Kutki, Sawa etc are termed as “coarse millets”. Possibly those who term these grains as coarse have never seen them as these are rather finer! Whilst over the years, the production of these grains has sharply declined; the State still gets 90 per cent of these millets from the tribal areas. A lot of talk has been there for irrigation in the name of livelihood generation. However, why is it not seen that there has been a tradition of nutritious food, dietary practices and economy even in the low rain-fed tribal areas as well? Regrettably, the State has not extended the required support in protecting these crops and neglected such areas.

Rice and wheat are conspicuously in vogue today. It has been promoted through government machinery and government run

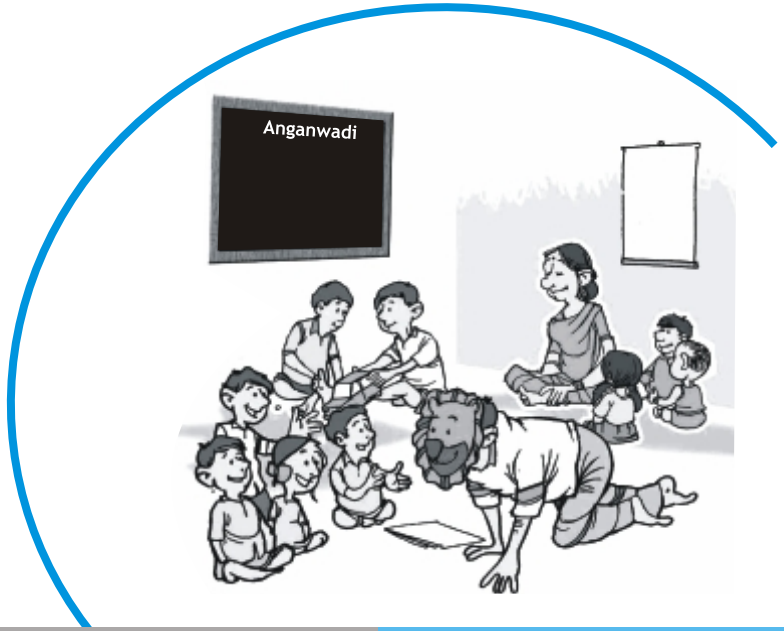
and supported agricultural universities and institutions. 100 gram of rice contains 6.8 gram protein and 0.7 gram iron while 100 gm bajra, the millet, contains 10.6 gm protein and 16.9 milligram iron. Wheat has 11 mg calcium while ragi contains 344 mg calcium. Sawa, which has been notoriously equated with grass by the urban media ('tribal communities survive on eating grass,' are the loud headlines of the print media) contains more proteins and iron per 100 gm than wheat. And besides, the most important aspect is that these millets assist the fight against the climate change while other popular grains cultivation like rice cause climate change by emitting gases aggravating the climate change process!

It is time that we promote the production and use of local produce, especially the millets and other grains that were in use not long ago and start cultivating these. We should also ensure that the production of these millets helps improve the lot of the tribal population. It will be better that the principle of convergence is made central to the context of malnutrition. We need to establish the understanding that malnutrition, its emergence and its solution, is not attributed to the functionality of the Anganwadi Centre alone. Even if the Anganwadi centre is made effective and efficient, malnutrition may not be eradicated. In this context, all government departments have to acknowledge the truth, work together and take some tough decisions. This process will have to simultaneously move from the state to village and from the village to state. Every community has its own food security and livelihood system. It needs to be resurrected. Vegetables, cereals and nutritious food grains have to be integrated in dietary practices.

Anganwadi : Complete and Comprehensive Child Development Centre

To strengthen and build the capacities of the Anganwadi system and in order to ensure the effective and quality delivery of all services, activate the Gram Sabha and the functionality of Village Health Committees under the Panchayati Raj Institutions

Till now we have talked about some broad aspects. Now in order to bring the change in the existing situation, the question arises as to where to initiate it from? Without any iota of doubt, the



answer is, 'from the Anganwadi Centre'!!! The success of the process will invariably be linked to the indicator, whether the Anganwadi centre could be accepted by the children to be perceived as their second home in the village? This centre is expected to provide all those basic services that are necessary for children up to the age of 6 years. The services include health care, immunization, growth monitoring, early childhood development, nutrition and pre-school education. Like a school or a hospital which portrays a complete picture the moment we pronounce this word, the moment the word "Anganwadi" is pronounced a picture has to emerge in the collective psyche of the community as that of children playing around, moving freely and thriving-throbbing, where discrimination is not practiced and taught, where not only the body grows but also young minds are developed. In other words, the Centre should give an impression of a dynamic and vibrant activity where the small children enjoy and learn around without a sense of burden or fright. Needless to state that such an Anganwadi centre has to have at least 2 Anganwadi workers so as to be able to perform all designated roles and activities with a responsible attention to every child and her/his needs.

Anganwadi centre should not be cramped with children. Cleanliness should be its defining parameter with openness of space for the children. It should be a safe place for the children where they can freely move, run and play around. Further, their toys should be available to them instead of being locked in boxes. The Centre should have a mirror, cross ventilation of air, safe drinking water and a well maintained toilet.

We all know as to how the children form their perceptions about their country and society. What they see they believe and form their outlook. The kind of Anganwadi Centre that we portray to them would shape their thoughts about the sensitivity in regard to the government. Their mindset and attitude take the shape as they perceive the institutions around them. After all, what we give to the person in his childhood, s/he returns it back on attaining the adulthood. The Anganwadi Centre is lot more than being merely a centre for distribution of Dalia or supplementary nutrition. Anganwadi centre is not merely a Dalia (fibrous and coarse flour) or nutrition distribution centre; it is much more than that. Just think for a moment, are we not putting a weak foundation for development by not allocating enough resources for Anganwadi, not paying attention to the building and infrastructure and, not making adequate provisions for training and capacity development?

The community

Community means, families that have malnourished children or pregnant women or lactating mothers, self-help groups, members of the Gram Sabha, or any group or families of the village.

No one wishes to starve and go to bed empty stomach. It is a fact that the term 'malnutrition' today has been reduced to an expression for an institutional and technical connotation. Today, we have a number of words and slogans for water crisis and illiteracy. Let's ponder. What instruments do we have to strike on child hunger? The term, malnutrition, is not traced to any society or community's vocabulary. It is rather a creation of

experts. People describe the malnutrition thus: 'the child has gone weak, the ribs are showing up'. In some tribal communities, it is called "sukhi maili" whilst others call it by the term, 'shiti', amongst others. We appear to be using an alien term, malnutrition so as to relate the community with its crisis being confronted by its more than half the children. Malnutrition is not instigated by any bacteria or virus; it is the stage being arrived at and constantly pushed towards precarious end by perpetual hunger-starvation, inadequate food and food devoid of nutrients. A child also succumbs to malnutrition from repeated bouts of illnesses. When one out of every two children is found to be malnourished, we need to appreciate that the problem cannot be resolved through institutional care and treatment. Its roots lie within the community which can be turned over only through policy and behavioral change initiatives.

An innovative experiment was carried out in Shajapur district. The discussions were on to provide children jaggery-grams-groundnuts so as to get the necessary nutrition. The district administration accepted this suggestion and decided to feed the children with grams and groundnuts. If this was to be done through Anganwadi, the children would get small quantity just once in a day. The other option was to provide the whole quantity through a single packet which was discarded. At last, it was decided to provide the children with continuous supplement of groundnuts and grams: the short-pants of the children were stitched with deep pockets which were filled with the stuff immediately after they ate at the Anganwadi. So whenever the children felt hungry, they reached their pockets and ate small quantities of groundnuts and grams. This experiment is effectively working on the unseen hunger of the children to an extent.

Universalisation with quality of Integrated Child Development Services is a very crucial step. But this would deliver only when the process of community based management for malnutrition is established. It calls for an appraisal of the traditional system of food security for every village and every community. It is a foregone conclusion that every geographic, situational and socio-economic-political environment contextualizes the food and nutritional security system. Communities living in or nearby forests have their systems tuned to forest while those living on the coastal lines have their system synchronized with the sea resources. Malnutrition has a direct link with food insecurity which in turn is affected by the availability of local resources and their access to the community.

Even today, all emphasis is placed on providing better supplementary nutrition to the children at the Anganwadi Centres. Do we have any studies telling us about what children eat besides the food supplements from the Anganwadi? What is the source of the food they eat? Is it appropriate for a healthy living? Do the children get enough food at home? Does the community accord an equal status to its women members? Is that community entrenched in the web of discrimination? Answers to such questions lead us to the root causes of malnutrition.

Community based intervention becomes inevitable as even today half of the children are not breastfed within half an hour

of the birth. Whereas the infants should exclusively receive mothers' breastfeed up to 6 months after the birth, we find that they are being fed things like honey and water. These feeds drive the child towards illness and malnutrition. The food that should be given to the children up to two years of age has to be understood, determined and ensured by the community. It could be a good idea to continually develop the capacities of a few women from the village itself to work as change agents in this direction.

The elementary understanding that needs to be cultivated is that the food available in the homes and villages and sourced from the immediate surroundings can fulfill all the nutritional needs of the child. Seasonal vegetables, tubers, fruits and all the other variety of grains full of nutritional contents can be used not only for mitigating malnutrition but also to wipe out the problem altogether. Groundnuts, grams, milk, bananas, eggs, edible oil, pulses sattu etc. are some of the things that could be easily available. Feed the children with this kind of food daily and be assured that malnutrition will be checked!

When we refer to community based programmes, it means working on community food practices that can ensure that there would not be any shortage of nutritional food. In today's context, it is apparent that this situation is not limited to economically or resource- poor families. There are communities whose food practices are such that they do not provide adequate dietary intake of nutrition. We will have to involve the farmers and local grocery shopkeepers so that they help promote the cultivation of nutritious local foods.

This matter is to be taken to the community in its own language. They have to be informed that malnutrition makes their children weaker, puts their children out of the school education resulting in lesser or no opportunities for employment. Malnutrition could also lead to disability. The first and foremost step in the eradication of malnutrition is to monitor the growth of the children. At present, this work is being carried out within the boundary of four walls of the Anganwadi. This has to be taken to the peoples' door-steps. The communities need to be informed and educated about the required age-specific weight of their children and what it is. What is meant by underweight and stunting? The information about every child should be shared with the family, the community and the Panchayat. This step would help us to locate and assess the malnutrition and its gravity in time. A major reason for today's crisis is that the

information about the severity of malnutrition is received only when it has assumed critical proportions.

In growth monitoring system, it is necessary to observe carefully for identifying those children who are normal in weight for age, those whose growth is faltering or those whose weight is static. The children who are moderately underweight are vulnerable and can decline to severe underweight. They need special attention and care. We need to take care of their health within the community's crèche. It is also important to take care of these children with adequate nutrition and health intervention to bring them to normal level. Those who are suffering from severe underweight, their health check should be carried out to determine whether they should be shifted to Nutrition Rehabilitation Centre or it is possible to improve their condition at home itself through nutritious food and care.

The children who are assessed to be severely underweight should be subjected to appetite test so as to find out whether the child is able to eat or not. It has to be found out whether there is any swelling, respiratory infection, fever, cough, diarrhoea etc. If the child is not able to eat or has swelling or is suffering from any of the illnesses, s/he should be taken immediately to the hospital or the Nutrition Rehabilitation Centre.

The children who are sent to the Nutrition Rehabilitation Centre will be back in their families and village after receiving proper treatment and care. These children need special attention. The community should be enabled to take effective steps so that these children do not relapse in to severe acute stage. For this, it should be ensured that the children are regularly monitored every week and the services are rendered accordingly. Nutritious food supplement is an important component of Anganwadi programme. The best option would be to prepare food supplement in the village itself from locally available foods. For this, a resource mapping of the village should be done to portray as to what is produced and what could be produced in the village and what do the people eat. Which fruits, vegetables and tubers are available? This can help determine what hot cooked food can be fed to the children. The recipes should be contextualized in keeping with the present day eating preferences, taste, interest and variety.

- Self-help groups take the responsibility of preparing nutritious food for the children;
- Panchayat representatives-especially women members and village health committee take the responsibility of monitoring the Anganwadi;
- Review the functioning of the Anganwadi and health programmes in the Gram Sabha meetings and take appropriate decision;
- District administration and state government take cognizance of and act on the village panchayat reports;
- A dialogue should be maintained with the children and pregnant women;
- Regular review be done by involving adolescent girls;

Keeping the situation of malnutrition and inadequacy of nutrition in perspective, it becomes imperative that the malnourished children are identified in time so as to bring about the required changes. It calls for working on aspects including local resources like indigenous food, safe and clean drinking water, sanitation, hygiene and care.

- Growth monitoring and immunisation to be done in the midst of the community;

Child Friendly Community Anganwadi

To establish the relevance of the malnutrition and nutritional practices while working with the community, to create and foster participatory approaches using local communication and media tools for continuing dialogue-education-training and review.

- The importance of community based endeavor is to accord child-friendly practices instead of burdening them with mere technicalities so that the children can feel a sense of homeliness. We should not forget that three to six years old children go to the Anganwadi and that the younger ones are accompanied by their nursing mothers. We expect these

children to spend a considerable time in these centres. So it becomes vital that the children find the Anganwadi centres homely where they are eager to spend time and enjoy longer being there. It should be splashed with colours, have openness and evoke a sense of belongingness.

- The centres should be free from such unsafe things and areas like sharp edges/corners as may be dangerous and cause injury to the children. Cleanliness and an aura of fresh air is a must. There should be provision for safe and clean drinking water and if the same are not available, the Panchayat and the Gram Sabha should take the lead responsibility for its provisioning.

Children have threat to their life from tetanus, diphtheria, small pox, hepatitis B, polio, tonsils etc. children can be saved from these diseases and vaccination can save their life. Yes, complete immunisation is a must to save the children from life threatening diseases.

- Play-material, toys and child-friendly practices connect the children with Anganwadi. The behavioral practices should be like those of their friends and kin, being sensitive towards their age appropriate needs. Without becoming their friends, it would not be possible to retain the children in the Anganwadi. Until now, it was assumed that food supplement will attract the children to the Anganwadi irrespective of the behavioral disposition towards them. We should do away with this outlook. We must remember that the security and protection of the children is our important responsibility.

- The children are bored of rote learning and dry lessons; what they need are stories, songs and opportunities to chirp, dance and play freely.

- It is likely that they would not keep the toys properly, perhaps they are curious to break open the toys and explore them. The children continue to play with broken toys for a considerable time and we should be aware of and accept this habit.

- The open and free environment at Anganwadi will also encourage the parents and evoke confidence in them that their children are safe there.

- The community should constantly monitor the maintenance and upkeep of the centre. Toys and games are sent to the centres but they lie unused tightly packed in their boxes. The workers are given strict warning that the toys should be intact, should not be broken and as such they feel that the best available option for them is to stow away the toys in their boxes.

- The children should be provided food with dignity and warmth. The community should monitor to see that it is practiced. They should not have to bring the utensils from home nor should they be asked to wash them. We must ensure that the utensils used to prepare the food and serve are clean.

- There should not be discrimination between boys and girls and, between different caste groups; the community has to keep a tight vigil to ensure that the non-discriminatory practices are ingrained in the Anganwadi culture.

- The centre should be equipped with essential documentation and equipments for growth monitoring. The community has to ensure that the weighing equipments are in working condition, that the mid upper arm circumference (MUAC) measuring tapes are available and are not twisted, torn or damaged. The centres should have a growth monitoring register and it has to be ensured that the information about all the children is regularly entered in the register. The centre should also have enough stock of Vitamin A and de-worming medicines.

- The information dissemination posters should not be tucked in such places that they are out of sight for the children and the women.

- The centre should have information display boards and posters covering content like care of children below six years of age, the services available in the centre, the immunisation schedule and where and how a complaint can be made in case of any perceived problem and information as to how people can associated with the functioning of the Anganwadi Centre. It will be better if monthly meetings of the parents are held with the Anganwadi Worker, as is the practice of parent-teacher association (PTA) meetings are held for the school going children.

Community Nutrition Rehabilitation Centre

- It is estimated that 15 per cent of the total malnourished children belong to severe acute malnutrition category. We can deduce that on an average 8 children per village suffer from severe acute malnutrition. All of these children need not be taken to the Nutrition Rehabilitation Centre (NRC). Only 2 children out of these 8 children may need the institutional service of a hospital and/or nutritional rehabilitation centre. First of all, we need to identify these children so that they could be sent to the NRC. Rest of the children are to be treated at home to take them out of the critical stage. These children need special monitoring and it has to be ensured that not a single child being looked after at home falls ill. Along with this, the condition of children who are shifted to the nutrition rehabilitation centre will improve and they will return to their homes after recovery. All these children also need special monitoring and care in the community.

- This does mean that we will have to develop a community based nutritional rehabilitation centre in the village itself. We need to develop and work on this concept where the children in need of special care get the required protection. This centre needs to be at the village level. A worker drawn from the same village trained and equipped with the required skills should be entrusted with this responsibility. In this centre, along with the care for the children, parents and guardians should also be informed about nutrition. Children will be under the care and surveillance of these community-based nutrition rehabilitation centres. We will have to ensure that the centre is coordinated and run with sincerity of purpose, sensitivity, responsibility and ownership and accountability. This centre will also render special cover to those children whose parents or family members go out for work.

Whom to search?

We have to endeavor to create and foster an enabling environment so that disability is identified in time. The disabled children should be fully accepted in the society and efforts must be made to ensure that neglect and wrong social practices are avoided so as to prevent the occurrence of disability.

With regard to malnutrition, we will have to accept the basic notion that a child in itself is an independent entity, a whole personality. In the ongoing programmes, the children are seen

as a collective entity, a group and are treated accordingly. This outlook results in entrenching the children into the cesspool of malnutrition and some of the children never ever come out of this state. This should not be merely a formality, a technical acceptance that the child be considered an independent entity in our community based programmes. The perspective warrants that we get to know each and every child, be aware about its personal health, the family status which can inform us about the familial, social and economic factors that are becoming the cause for child-specific malnutrition. Based on this, we can decide as to what type of protection does the child need? We also need to address at the family and community levels with regard to employment, land and water rights, access to PDS and health care services etc. so that the process for protection of rights is activated on an ongoing basis.

By adopting this approach, we would be able to find out as to which children are accessing the services and those who are left out and what are the causes for the same? Children are pushed out of the reach of health care and nutrition provision due to a number of reasons like migration for employment, distant location of the Anganwadi, children without adult guardians at home or social boycott etc. As our system is based on the assumption that it does not matter even if some of the children are out of the services -net. However, this outlook portrays apathy and shows that we do not mind to compromise with their lives. It is a reality that the children or the communities which get out of the sight of the institutions and government end up becoming the major victims of malnutrition. In a sense, our endeavor should be to search those children and families in every village, every hamlet, and every settlement who are outside this perspective of access to services. Disability is another issue on which we need to work on. As many as 8 out of every 100 people are affected by some kind of disability. Some of the disabilities are overt while some are covert. It is much more difficult to identify children with disabilities. This condition of the disability is not just limited to that after birth. Most of the disabilities occur and take roots during the pregnancy.

Illness and weakness of women and some of the social beliefs on observing fast also lead to disability. It means that disability is not a natural phenomenon. In fact, it is built in through practices. On one end, discrimination and differential treatment to women gives birth to this condition, while on the other, there is a lack of education for the society to be able to identify the disability. The result is that the children suffering with disability are prejudiced against and no efforts are made to correct their disability for capacitating them and that they face social exclusion. These children have every right to be part of the larger society but are informally excluded by the society from the mainstream of life.

Crèche / Day Long Anganwadi / Day Care Centre

Every woman is a working woman. Either the women work in the home or outside. In this situation, children need a system which takes care of their needs and provide security. Families, whether working on MNREGS or at construction sites or in the agriculture fields, they have to carry their children to the workplace. Despite many efforts and a slew of promises, the children do not get enough cover for care, treatment and

security. In a few cases, mostly confined to the organised sector, some of these services are entitled to the women and children but they are deprived of these facilities in the unorganised sector.

It is the need of the hour that Anganwadi centres should be converted into an institution which runs for a full day: providing security and protection to the children, quality food, safe drinking water, play time and infrastructure, leisure, basic health care and first aid, open spaces and opportunities to learn and develop. The institutional set-up for such an endeavor would not be possible without training and additional support staff. Without this institutional set-up and development, children belonging to unorganised sector working families and to be precise, children of the 90 percent of the country's population would not have access to the mandatory security, protection and rights.

It is often the case when all the adult members of the family go out to work, the elder siblings are assigned the responsibility of looking after their younger siblings. This leads to violation of rights of these elder siblings as well. Most of the studies and experiential knowledge point out that the children need care and fostering of the adult care givers so that situation-specific care of the children can be ensured. So the children's care and fostering should be linked to Anganwadi centre as malnutrition is directly linked to children's development, growth monitoring and protection rights of the children. It is a foregone conclusion that we would need additional resources for this work. A beginning could be done by identifying the select Anganwadi Centres in such a programme.

Community Health and Children

The children are most vulnerable to the life threatening diseases such as diarrhoea, measles, malaria, cough, acute respiratory infection and pneumonia. If enough precautions are taken and if basic primary health care is available to the children, these diseases by themselves are not fatal and are preventable. It is utmost necessary to ensure good sanitation and hygiene practices and availability of safe drinking water. By keeping villages clean and sanitized, these diseases can be kept at bay. Even today, in the age of widespread development rhetoric and economic power, 70 per cent of the population defecates in the

open (Census 2011). There are a host of reasons for this situation. One of these is not having toilets in the homes. However, lack of availability of water is also a major reason for this situation. There is no common ground of understanding between the community and the government on this issue. Schemes and programmes have been designed but not keeping in view the needs of the community and its limitations. As such, it is imperative that the initiative should be taken at the level of the community.

- Lack of access to safe and clean water invite diarrhoea and other infections. Besides the curative treatment, it is necessary that preventive measures should be initiated. Anganwadi worker, ASHA worker and village community groups or women's groups could make a collective proactive intervention on this issue.
- An analysis needs to be carried out so as to find out the diseases and health issues faced by the children and other people.
- What are the causes of these problems?
- Why is the village or the hamlet's surroundings filthy? Are there any spots or the area where the water logging occurs or filth accumulates?
- What are the sources of our drinking water? Are these sources of water providing safe and clean drinking water?
- If not, what are the alternatives for safe and clean drinking water?
- What are the basic (primary health care) services available in the village along with trained workers, necessary medicines etc.?
- Which seasons are prone to rampant diseases? Why so? What are the preparations and precautions that should be put in place for such seasonal outbreaks of diseases?
- What is the attitude of ANM and other functionaries at the health centres?
- What is the status of means of transportation in the village?
- Discussion, analysis and preparation of an action plan through the Gram Sabha and Panchayat.
- To initiate a 'rights based communication and dialogue' with the government so as to make public health care services functional.

Attention to Cognitive Development

At one level, it becomes imperative that primacy should be given to cognitive development under Integrated Child Development Services scheme and Child Health Care Programme. Nutrition and care cater to children's immediate and long term needs. It helps in personality and cognitive development of the children. We will have to accept the notion that the children think and act differently from the adults. They also discern and are sensitive towards fear, joy, security, insecurity, and a sense of homeliness, feeling alien etc.

Development has been classified in to four parts under cognitive development:

- Birth to 2 years of age: in this age children begin to develop abilities to sense they run around, can kick ball, begins to play with blocks and bricks. They gain bowel and bladder control. They start throwing temper tantrums, build possessiveness and resentment of new baby and try to do opposite of what they are told. They start repeating words, respond through smiles and become curious.

- From 2 to 7 years of age: In this age children have mature and coordinated motor control. They can skip, broad jump, try to dress themselves. They can talk clearly, make use of adult speech, master basic grammar, can relate a story. They feel responsible and also exhibit guilt and feel pride in an accomplishment. They love to play with other children and become competitive.

- From 7 to 11 years of age: They become physicaly stronger. They learn how to talk children learn to socialize and interact and they spend their time simply getting acquainted to the world and all its complexes. After gaining their basic skills they start recognizing more emotional struggles, like being a part of a group, maintaining a certain status at school, and avoiding embarrassing situations.

- From 11 years onwards: Faculties of reasoning and analysis develop.

The fact is that the faculties of memory and concentration in children develop at an early age. At the age of two years, if the child is seized by fear and anxiety, it becomes the child's lifelong characteristics. As such, it becomes necessary to develop the temperament and practice in the community with regard to comprehensive development of the children.

Difference between growth and development: Growth relates to increase in size of the body and the brain; while development relates to enhancement in the capacities and creativity levels. We become ready to fulfil the goals of life and develop capacities to face its complexities. We have observed that some

of the children have growth and development constraints below the age of 5 years. The reasons are as below:

- Lack of adequate nutrition as mandated by age and or need;
- Due to some discordant social practices
- Not able to apprehend and assess the problems and issues of the children and lack of care and treatment;
- Non-availability of health care services or denial of health care services.
- Genetic issues? Disability/deformity at birth?

We need to ensure that appropriate development of the children takes place regularly and, if there is any barrier or some issue in the development, the solution should be applied immediately. A mother understands her child's developmental condition easily and if, for any reason, there is a stunted growth or development, she is in a better position to comprehend the situation and understands that there is a need for special care and treatment for her child. As such, it becomes imperative that we endeavor to build capacities of the adolescent girls, pregnant women, lactating mothers and other mothers towards developing an understanding of the impediments in the growth and development of the child so that they can take steps and or care and secure treatment to be provided.

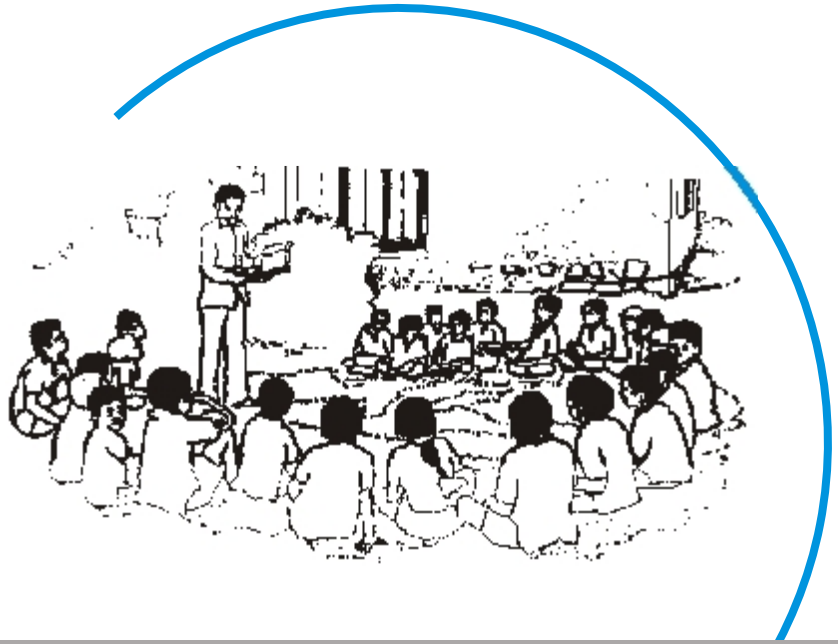
Training and Capacity Development

To develop information and reading material on different aspects of the child's life-from womb to 3 years of age, related to nutrition, health and practices and, this to be used by community groups, local workers and all those people who wish to be stakeholders in mitigation of malnutrition;

A policy for training and capacity development has to be put in place in accordance with the local situation, community and prospects. At present, no age-appropriate training material, methodology and reading material are available in local languages or if available, the same are out of reach. What are the major aspects and causes of malnutrition? How can the situation be improved by use of appropriate practices and care? Charts depicting which local materials can meet the needs of

nutrition, range of services provided by the Anganwadi Centre and a consolidation of their parameters should be publicly displayed. It will be better if both the Anganwadi worker and the ASHA worker are involved in giving a practical shape to the design of the training material. They should be provided such reference material as can be put to direct use whilst taking the initiative in the community. Further, this training material should also incorporate the highlighted information about certain sensitive issues like ill-effects of packaged food for the younger children and the remit of law in vogue.

When it is said that the crèche or the fully-operational Anganwadi concept should be implemented, it also requires tangible and intensive training programme. A crèche is a sensitive initiative and it must be implemented with due diligence. Experience tells us that all the programmes related to growth monitoring, strategy for communication with community, studies on local food and its different recipes, sanitation and social practices (regarding social discrimination) call for intensive training and visioning perspective.



The Role of Local Institutions

To connect the child health and malnutrition monitoring system with the local institutions, with the gram panchayat systems: to train Panchayats, Gram Sabhas, Village Health Committees, Integrated Child Development Scheme (ICDS), youth and women groups from the villages and workers associated with health department towards community based-localised management of malnutrition and, to create and foster a robust monitoring system and to carry on a continuous communication and dialogue process;

The campaign against malnutrition requires not just a token participation of Panchayats and Gram Sabhas but mandates pitch-forking them into leadership role. It has to be ensured that the campaign is placed on the agenda for discussion in every Panchayat and Gram Sabha meeting. Every village should discuss and analyse the status of the children below 6 years of age, pregnant women and lactating mothers in the annual meeting of the local institutions. All the information regarding the issues, and especially list of malnourished children and the

changes in their status should be displayed in public places. It would be far better to transfer the responsibility of remitting remuneration for Anganwadi Worker, Anganwadi Assistant and ASHA worker to Panchayat or Village Development Committee or Village Health Committee.

We cannot, and should not overlook the role of Panchayat, Village Health Committee and active members of the Gram Sabha. As such, it requires that training be provided to all these stakeholders at least once a year. An open dialogue and discussion on the health and nutrition status in every Panchayat or to make Panchayats activated on this issue is a desired step. Similarly, efforts of this nature at the supervisory and monitoring level also become necessary.

Local institutions have to ensure that every family gets employment opportunities under MNREGS and wages are paid on time. It is the responsibility of the local institutions that steps are taken to develop livelihood resources within the village so that people do not have to migrate in distress. Continuing in the same vein, practice of open defecation should be banished with and construction of toilets should be taken up on priority. If the Panchayats take a firm stand, not a single child will be left without having been immunised.

Grievance Redressal System

To make the groups and institutions at the village-community level accountable on the issue of malnutrition;

It is often said that community participation in the system should be ensured. Then it is of utmost importance that we must listen to the community as to what it has to say with regard to any complaints or suggestions and there should be a mechanism for the time-bound redressal of grievances. So far, the community has been making complaints and raising the issues. However, the grievances were hardly resolved. Consequently, the community has distanced itself from the system which remains fraught with corruption and negligence. To begin with, the first step in this direction is that the Panchayat and Village Health Committee should be empowered to hear the grievance and take decision on the same. Following this, it will be better that a grievance redressal mechanism is instituted at the block level which has the authority to hear and

act on the grievance. Whatever be the grievance or problem, its investigation and redressal must be made in a time-bound manner.

Whom is this intervention meant for?

Malnutrition is a vicious circle: Hunger Negligence Discrimination Poverty Disease Exclusion Non access to resources and some more

This cycle may start from anywhere. Non-access to food, not getting adequate nutrition, to fall into the trap of chronic illnesses, and denial of rights pertaining to health, employment and constitutional safeguards towards nutrition are the factors that push children into this vicious circle. Every three out of ten children in India are born with Low Birth Weight. This indicates that the pregnant woman, due to the discrimination and denial of necessary services, succumb to malnutrition and as a consequence, the children too. The women have to face discrimination and neglect at every level in their life in view of society's unequal treatment meted out to them. Likewise, the adolescent girls too do not get the necessary protection. Whilst it is an accepted fact that the newborn should be given breastfeed within the first hour of birth, the infants are deprived of this right in the wake of superstitions and lack of counselling services. It boils down to this requirement that we need to acknowledge the children, specially the under twos, pregnant women and lactating mothers and adolescent girls as the target group for the intervention. It is the life of this group which has to change for the better.

a. Adolescent Girls

Gender discrimination relegates women to the second citizenry position in our society in comparison to the men. In every facet of life, gender becomes the instrument for discrimination. It brings down their health and nutrition status and their physical, mental, social and economic development is adversely affected. If discrimination in the society, child malnutrition, higher child mortality have to be brought down, it will be imperative to empower the girls. Under this programme, it will be crucial to connect with them on all such aspects which can free them from the slavery and subjugation. They need to be connected across the spectrum of physiology to society and development perspective. This intervention could also be taken up under "Sabla" scheme. Alongside, we shall gather information pertaining to their social and health status so that a person-centric approach can be pursued. These adolescent girls from the village and hamlets can perform important roles as society's associates in taking effective steps under the programme ranging from monitoring the status of pregnant women to the rights for safe motherhood and breastfeeding immediately after child birth.

b. Pregnant women and lactating mothers

The "Janani Suraksha Yojana", programme for safe motherhood focuses its entire attention on institutional deliveries. Besides this, what is needed is a comprehensive system encompassing regular examination and care of pregnant women during entire span of pregnancy (and not just limited to delivery period), vaccinations, nutritional supplementation, care and a close

monitoring on the entire process. We'll have to make this intervention at the family, community and institutional (Anganwadi, Sub Health Centre and Primary Health Centre upwards) levels. This does mean that community monitoring work should be a continuous endeavor. In the organised sector, there are enough provisions, programmes and financial assistance for pregnant women and lactating mothers. But such an enabling environment is lacking for the unorganised sector. To mitigate the discrimination against women from unorganised sector, policy initiatives should be brought in force for according rights to maternity entitlements-a minimum nine months (three months during pregnancy and six months post-delivery) maternity leave with full wages equivalent to, at least, minimum wages. Additionally, free health care and nutritional food supplement should be provided.

c. Children from birth to 6 months of age

- Assistance in breastfeeding and quality counselling services; this service to be provided by ASHA worker to the women at their door-steps and by health workers and ANM at health centres. To ensure the functionality of this service, we'll have to work with the community at the institutional levels.

- To sincerely implement Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Amendment Act, 2003 prohibiting feeding of packaged/tinned food and bottled milk to the infants.

- Children's Vaccination/immunisation: this is primarily the responsibility of the ANM while it is the responsibility of the Anganwadi worker, ASHA and the Village Health Committee to mobilise/educate community (and children) for immunisation readiness.

- To carry out monthly growth monitoring of each child, to monitor its health, to identify the malnourished children, to categorise children based on level of malnutrition and provide related treatment and care according to their status. This is primarily the responsibility of Anganwadi worker while ASHA worker can help in mobilizing community for participation in this task.

- Identifying ailing children and taking them to health centres for treatment and care-the primary and principal responsibility lies with ASHA worker;

- Ensuring access to maternity entitlements: it has to be ensured that women resume work only after 6 months of delivery, infants are protected and are breasted. They must not be deprived of any wages. Therefore, incentive amount equivalent to minimum wages for the period should be given to them as part of their maternity entitlement.

- Crèches at work-places: provision of crèches at the work-places should be done so that working mothers can breastfeed their children and take rest as and when needed. There should be flexibility in their working hours so that working mothers can expend their energies appropriately.

We will have to ensure that the provisions ,made under Mahatma Gandhi National Employment Guarantee Scheme (or Act) for establishing crèches at the work-places is implemented in essence and true spirit. We'll also have to ensure that this does not become a mere formality but to be used regularly and the use is promoted.

- At a larger level, establishment of crèches could be accomplished through Integrated Child Development Project (ICDS Mission). This should also provide services to the children who are more than 6 months old. Under exceptional circumstances, where the mother has to go for work before elapse of 6 months after delivery, there should be an option of availability of care services for the young children. This intervention could be effectively implemented with the active support of Village Panchayats and local community. Also, there is a legal provision in MNREGS to establish crèches for children. It needs to be effectively implemented.

d. Children from six months to 2 years of age or above

Around this age, the children are provided with complementary nutritious foods along with continued breastfeeding. This is the most critical stage as with the complementary food and water, there are possibilities and dangers of infections or diseases for the children. As such, community, family and mothers need the right counselling and guidance. It should not be dismissed as an insignificant requirement. In 2010, more than 600,000 children in India died due to infections of diarrhoea, pneumonia etc. This infection can be addressed by changes in familial practices, availability of safe and clean drinking water and availability of primary health care. Anganwadi and ASHA worker, both have to play an important role in this endeavor.

- ANM is responsible for regular immunisation while ASHA is responsible for mobilizing community and children and instil a sense of readiness in them.

- ANM will also provide support and guidance to Anganwadi worker for prescribing essential medicines to the severely acute malnourished children within the village.

- To carry out growth monitoring every month, to monitor their health status, identifying malnourished children, finding out which of these need special care and providing care and treatment to these children. All the above responsibilities belong to Anganwadi worker while ASHA worker can help in mobilizing the community in this work.

- This is the period along with breastfeeding to start the complementary feeding for the children. Counselling services, as to what, when and how to feed the children, should be provided to the community.

- During this period children are prone to infections. They should be immediately attended on falling ill and the treatment and health care should be provided without delay.

- Complete nutritious food: this is the period when the children should get adequate nutrition and nutrient dense foods. Such a supplementary nutrition enriched food

should be culturally acceptable to the community and, at the same time, if it is locally sourced, bringing about changes in the status of malnutrition could be sustainable. Besides, it has to be cooked in the community itself. In the present circumstances, the children should be given "take home food" and it is the responsibility of the Anganwadi worker and our worker (development worker/NGO local partner) to ensure that the child is being fed by the family with properly cooked food.

- Anganwadi in the form of crèche: for the children whose family/parents go to work and who have no adequate provision to provide foster care at home during the day time. For such children, a day long centre equipped with all the services (nutrition enriched food, leisure, safe water, sanitation and hygiene, play-area, safety, primary health/first-aid kit etc). It is immaterial whether one calls it a day-long Anganwadi or a crèche. We cannot, and should not, retract from this as it is the urgent need of the families in whose living conditions we intend to bring about a positive change. An additional worker would be needed for this work.

e. Children from two to five years of age

- Pre-school education: children in this age group need institutional pre-school education. We will have to ensure that children get qualitative pre-school education.

- Anganwadi should be equipped with appropriate instruments, toys and other necessary material. At the same

time, it has to be ensured that the children have the freedom to use and play with these toys and material. This is an important task and as such the process of appointing an additional worker in Anganwadi has to begin.

- From among the community we need to identify and recruit community volunteers, especially adolescent girls and young women.

- Twice a day, freshly cooked nutritionally enriched food should be served with dignity. The community should be apportioned an appropriate role in the whole affair.

- Health services: to make available drugs and medicine for de-worming, vitamin A and basic/primary health care. To carry out growth monitoring and ensuring that the development of the children is leading in the right direction.

To Conclude

- We generally observe that children end up being the beneficiaries of one or the other schemes. When are we going to recognise them as a complete individual entity of being a human being and a citizen? Is it not strange that a majority stakeholder group in our society is not entitled to speak, have a say or participate in the decisions pertaining to them? A large group of our society lives surrounded by abundance of natural resources and still is a victim of malnourishment while at the other end another group is marginalised due to caste and gender discrimination.

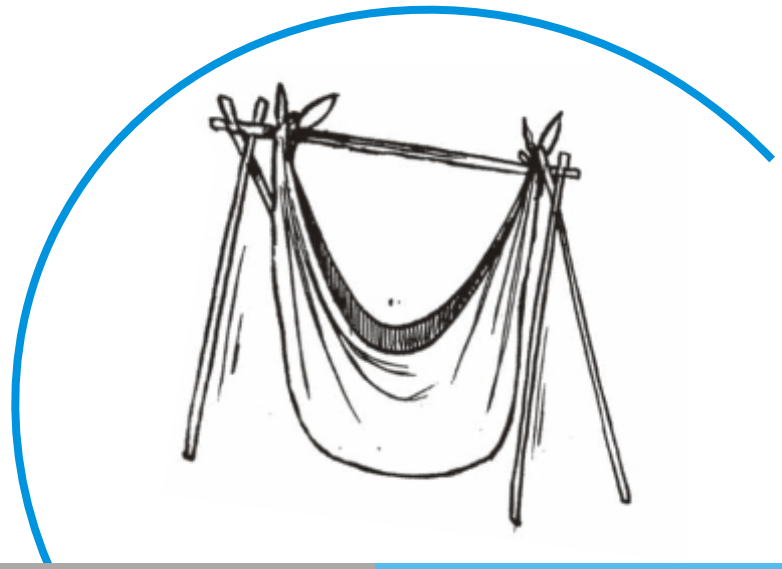
- Not getting nutritionally enriched food on time, day in and day out, leads to malnutrition. This means that children are not getting adequate nutrition. The government does not provide direct employment and protective mechanism to all workers from unorganised sector constitute 93 percent of the total workforce population.This group of population is dependent on its own resources; but, of late, these resources-their own resources are stolen and or seized or forcibly exploited by others to the extent of extinction. Certainly, a lot has changed in last few years, but nobody could take away their knowledge, skills and a determination to struggle and survive from these people. We believe that community' means and resources must be made instruments to combat child malnutrition. They should not gaze intently at the road expecting that somebody from somewhere will come over and drop food on their platter. What would be served on their platter, how much, the time of serving etc., if all this has to be decided by the government, then this is inhuman and disgraceful.

The welfare, care and treatment of children are the responsibility of the society. So the community has to take decisions as to how the government would be accountable; not a government that teaches the children to live without self-esteem and dignity. If the governments assume and believe that they are obliging or are doing charity by running the Anganwadi and hospital, the community has to define its role and remind the government that it is rather its bounden responsibility as a welfare State. It is also not prudent at our end to abdicate our own responsibility towards the children and leave them at the mercy of the strangers. However, now we have to take on our responsibility.

Vision for the community is also vital so that people can analyse and trace the causes of malnutrition to their roots. In fact, the roots of malnourishment are hidden behind our perspective of development. If the crisis is to be prevented from further magnifying, we have to bring about a fundamental change in our perspective of development.

Checklist for an Ideal Anganwadi Centre

- Is the Anganwadi functioning regularly (efficiently and effectively)?
- The total number of children from birth to 6 years of age, number of pregnant women, number of lactating mothers (mothers of six month old children) and adolescent girls in an area serviced by Anganwadi and the total number being enrolled
- The number of enrolled (in the Anganwadi) children (from 6 months to 6 years of age), pregnant women, lactating mothers (mothers of zero to six month old babies), adolescent girls for nutrition supplements and the number (of these) availing these services.
- The number of children from 3 to 6 years of age and the number of children availing pre-school education.
- The percentage of the children who have been weighed and data filled in charts (per month) against the total (number of) children from birth to 5 years of age (per month).
- The centre is functional and availability of weighing machine;
- (The number of) children whose weight has been static or decreased for last three months.
- Moderate to severe malnourished children and children with complications.
- The steps taken to mitigate the above condition.
- (The number of) children with (diagnosed) complications and severe malnutrition. (The number of) children (of these)



sent to Nutrition Rehabilitation Centre. (The number of) children came back with appropriate attention and treatment from Nutrition Rehabilitation Centre. To pay enough attention on their eating and health.

- Mangal Divas being observed or not.
- (The number of) sessions done on health and nutrition education of women from 15 to 45 years of age; the thematic areas/subjects discussed in these sessions; (the number of) women participated in these sessions.
- (Do) the children come to centre neat and clean (and their number)?
- (Is there) first aid box in the centre; (are there) enough medicines in the box/centre; knowledge of worker (has or not) about the medicine use (for illnesses); (is there) any medicine with expiry date over.
- (Do) all the children undergo immunisation on time (or not).
- (Is there/availability of) games and play material for activity based education for children.
- (Is there any/undue stress on) teaching children alphabets/ABCD (it should not be).
- (Availability of) monitoring register in the centre (or not) and (assess whether) the supervisor and other government officers visit (regularly) for monitoring.
- (Availability of) soap in Anganwadi centre.
- (What is) the source of safe drinking water in the Anganwadi (is there a source or not);
- (Availability of) birth and death register at the centre;
- (Do) the children and women get nutritional supplement regularly (or not);
- (Are there any discrimination in) the practices at the Centre.
- How involved is the community in the running of the Anganwadi
- Is there a mother's committee? How often are meetings held?
- Are the Anganwadi records available for public scrutiny?
- Do the gram panchayat sarpanch/members visit the AWC?
- How frequently does supervisory staff visit the centre?
- Is the food supplied regularly?

Roles : Who should be doing what?

The Government

- Let the people say what the problem/s is/are. Wait and see whether they are suggesting any remedy/recourse. Give them ample time and trust their knowledge and instincts. What is needed is the readiness when they suggest options/recourse, the government has a role to play in that solution/s and the government should work on that.

- Constraints in resource allocations (especially building of Anganwadi centres, nutrition supplements, training, remuneration and health care services) should be removed.

- Let them have the right to take decisions. Don't assume and believe that Panchayat, Gram Sabha or Self Help Groups are only to meekly follow the government notifications. These institutions should have the right to take decisions. Let the people-the community decide about the Anganwadi operations-when the centre will open and what and when the children will get to eat in the centre.

- Madhya Pradesh has 80,000 Anganwadi centres which will increase to 100,000. Is it possible for a staff of 500 to monitor so many centres? If the state believes it is possible, go ahead, and do it and keep the system centralised. Let the capital and the district headquarters decide everything.

- If not, just give a thought to the idea that 10 people from one panchayat can take care-run efficiently and effectively five Anganwadis. Do you think they are not concerned about their children? They are, and they are eager to change the situation. Break their shackles, tell them about malnutrition and look for yourself, they won't shy away, they will come forward proactively. So, the community participation will be a good initiative. However, the government must ensure the sufficient staff to monitor all the activities and programmes at each level .

- Develop policies that endow community with rights to protect, conserve and use the resources.

- The village or the community which can move towards self-sustenance of food security, do promote them with encouraging incentives.

- There should be discussions on every child-specific subject in Panchayats and Gram Sabhas and the decisions should be taken in the best interests of the children.

- Make it mandatory to provide all the services of Integrated Child Development Scheme Project in the unorganised sector-at all the sites.

- This intervention seeks equal and proactive role of different

government departments like agriculture, irrigation, forest, social justice, health, women and child welfare / development, tribal development, school education, human resource development, finance etc; so initiate a joint endeavor with a common framework of operation and action programme.

The Community

- We have to find out the number of small children/infants in the village and their status;
- The number of children (from among these) who fell ill, the type of illness and the causes of the illnesses.
- (Which are the) most marginalised families in the village or those who are poor or we consider to be poor.
- What is the status of children in these families? Who should shoulder the responsibility of these children?
- As human beings/as humanity, it is our responsibility to free the children laden with the burden of starvation-hunger.
- The families of these children should also be free of hunger, should get wage employment as and when needed and they are entitled for livelihood resources.
- Scan for children with disabilities and also for girl children. We think they are directly under our care and love. But this is an illusion and these children are far removed from our sight.
- Sanitation and hygiene should be placed ethically in our value system and culture. Panchayat and Gramsabha have to be firm to end open defecation in a time-bound manner. Believe it, this work cannot be done only by the government.
- Look for those produce or product resources that can eradicate malnutrition. How many of these do we produce in the village? How many of these can we produce in the village?
- What is the mechanism for cleanliness of village roads, open grounds, drain lines etc.? Is anybody aware of it or not? The reality is there is no system, at present, to look after all these village resources. When this issue is broached, a single community within the village is expected and made responsible for scavenging work. We'll have to change the practices and mindsets. In fact, the panchayat has to include this in its agenda and prepare a plan of action on this issue. We all would have to put our minds and hands together to work on the issue.
- To monitor the health and nutrition programme. To proactively participate in social audits.
- Review the status of each and every child individually. Record and investigate every child death. Follow up with every malnourished child until he/she is normal.

Gram Sabha and Panchayat

It is true that for all the work in the villages, however small or big it awaits the government notifications and orders. Is it necessary? If we abide by the Constitution of India, it is a dark reality that despite being endowed with so many rights, we have failed to be self-dependent. The Eleventh Schedule of the Constitution tells us that, as Gram Sabha members, the right to take initiative rests with people. As per the Eleventh Schedule, following tasks have to be carried out by the Panchayats and, for this, the Panchayats need not wait for any notifications or orders or permission from any quarters. These tasks are:

- To plan and execute programmes for women and child welfare.
- To implement and make drinking water system.
- To implement poverty alleviation programme;
- To make a system for health and cleanliness;
- Effective endeavors for people with disabilities;
- To plan and implement agriculture schemes;
- To manage and use of minor forest produce available from the forest.

Let's pause and think again; what we can and should do

i. **Scan the village and see that every child is enrolled in the Anganwadi Centre and receives the services without any discrimination. If there is any shortcoming, it should be acted upon rightfully.**
ii. **Ensure that all the children with growth faltering are duly identified in terms of different grades of malnutrition.**
iii. **This list should be made public and their status be monitored regularly.**
iv. **Safe drinking water should be available in the Anganwadi and its provision should be properly maintained.**
v. **The families of the malnourished children should immediately be ensured access to food, social security, employment and livelihood schemes.**
vi. **Children should have access to proper toilet facilities in order to maintain hygiene and senitation.**
vii. **Gram Sabha should review the children's status and take appropriate decisions for systemic changes.**
viii. **Identify the migrating families and efforts should be made so as to stop distress migration.**
ix. **A social audit on children's health and nutrition should be done.**
x. **Taking into consideration all the aspects of malnutrition, an annual plan on children's health and nutrition should be prepared.**

Nutrition requirements and sources of various nutrients

Calories

Source - Cereals (bajra, wheat, roasted grams, rice etc), pulses (small amount), fish, jaggery, root and tubers, edible oil and ghee, sugar, groundnuts and almost all the substances those are taken as food, provide calories. In the cereals, Ragi, fullfills almost all our needs in terms of high quality proteins, calcium and minerals. Similarly Kangani is better than wheat

Carbohydrates

Source - Cereals, dates, mango, bail fruit, bananas, mahua (local/indigenous tree flowers used by tribal), naseberry, sugar, jaggery, potato, sago/sabudana, tubers or root vegetables.

Protein

Source - Groundnut, pulses, gram, fish, soybean, paneer (milk product), eggs, meat (proteins procured from grains is found to be inferior/substandard quality; animal source proteins are superior)

Calcium

Source - Milk, bajra (millet), high granule wheat flour, whole gram (with skin), udad (kidney bean), mung (green gram), moth (chickling or dunpeas), rajma (beans), coconut, fish, mava (milk product), milk powder, edible betel-leaf, surjana vegetables, choulai bhaji (greens of a creeper), fenugreek, soybean, gram green-leaves, fenugreek grains, yams, carrots, beans, rohu fish and buffalo milk.

Fats

Source - Edible oil, ghee, groundnuts, meat, eggs, butter etc.

Folic acid

Source - Pulses, ladyfinger, pigeon-pea, sesame

Vitamin C

Source - Cabbage, drumstick beans and leaves beet, amvla (Indian gooseberry) and guava.

Zinc

Source - Choola gram (indigenous), rajma (beans), lentils, onion beans, sesame, drumstick leaves;

Vitamin A

Source - Grams, bathua (whilte goose foot) vegetable, yams, drumsticks, fenugreek, mustard, carrot, spinach, carrot, mango, papaya, mahua;

Iron

Source - Leafy vegetable of mustard, jaggery, samai (kutki) roasted grams, gram with flattened-pounded rice/poha, watermelon, bajra (millet), ragi (millet)

Continuous and Comprehensive Monitoring of Health and Nutrition Status

These days when the illnesses spread and take epidemic proportion, we (the community as well as the service delivery system, both included) run for curative action. This does mean that our attention is pulled towards those illnesses whose symptoms are easily discernible. There could be many illnesses whose symptoms are generic or are not discernible easily. But the illness could be dangerous or serious in nature. For example, the continuous cough is treated as common cold or cough but in reality the children as well as the adults should be subjected to thorough examination for diagnosis of tuberculosis in these circumstances. A continuous or chronic fever is an indicator of serious illness but it is also brushed off with generic treatment. In these circumstances, in our context, why is the treatment of disease alone considered health care? Why we don't take the onus of creating an enabling, conducive healthy environment where the children do not fall prey to chronic illnesses?

It becomes necessary that we devise a programme wherein all the people from villages and urban slums, especially women and children undergo regular health check up every six months. Such an examination should not be just limited to identifying and treating illnesses but should include a close investigation of the surrounding environment and individual household's

way of living and personal hygiene and sanitation. This health and nutrition check-up should contain:

- Children's health and immunisation card (this is called

mother-child protection card) has been prepared or not? It is necessary to look into this aspect as, as of now, only one card is being maintained for health, growth monitoring and immunisation from pregnancy to five years of age (of the child). To give proper direction to the health and development of the child, its history and the information about the surrounding environment helps immensely.

- We will also look for symptoms of any illness in the child. The investigation or the assessment should look for sources of water-its distance, adequacy and purity of water; what is the status of sanitation and hygiene? Has the child been injected the required vaccination or not? Do the infants get mothers' milk? Are the children provided additional food besides breastfeeding at six months of age? Which of the children, women and adolescent girls are suffering from anemia? are they being given iron supplementation? Are they being taken care of? What is the status of de-worming? Is it being administered whenever required? Do the children get Vitamin A? Are there any cases of skin infections in the village? Those who are found to be having skin diseases, are they being provided treatment? What is the status of malaria in the village? We will have to collect information on these and other equally important parameters, ensure that the illnesses are being treated and the environment giving birth to these illnesses is attended to.

- It is necessary to know whether the family has any means to ensure food security. In this situation, the rights based programmes of the government become much more necessary. This monitoring will ensure and help in preparing a broad programme for the village.

Let's keep in mind, the health-nutrition assessment and investigation should be done through a collective initiative of village health committee-panchayat-nutrition groups.

Community Health Assessment and Monitoring format

(The following information should be taken under the civil society intervention on community based management of malnutrition by the trained community worker during the six-monthly health assessment of the child/this is a sheet of health assessment of a child)

Name of the child		Village		Sex	
Mother's Name		Father's Name		Social Group	

Period	Jan	Jun	Dec	June	Dec	Jun	Dec	Jun	Dec
Age (in years and months)									
Does the Child/mother have "Mother-child protection card"? Is it filled in? (Y/N)									
Weight (in kilogram and grams)									
Height and Length (in centimeters)									
Is the child malnourished by WH_Z criteria? (Y/N)									
Is the child malnourished by height for age criteria?(Y/N)									
If Yes; mention category here?									
MUAC measurement taken – (Y/N)									
If MUAC measurement taken; what is the value?									

Period	Jan	Jun	Dec	June	Dec	Jun	Dec	Jun	Dec
Normal or Underweight (N- Normal / U- Underweight)									
Is there any illness? Or any symptoms of illness? (Y/N)									
If yes, from when?									
Indicate name of the illnesses here>									
Is the child being provided treatment? (Y/N)									
If yes, where?									
Anemia: (Y/N)									
Vitamin A given (Y/N)									
De-worming done (Y/N)									
IFA syrup given? (Y/N)									
Total immuisation done (Y/N)									
Food security of the family: A: Are the means of food secured? (Y/N)									
B: Is the food available in adequate quantity (Y/N)									

Period	Jan	Jun	Dec	June	Dec	Jun	Dec	Jun	Dec
Has the family migrated? If yes, the number of months.									
Is there a toilet in the household? (Y/N)									
If yes, does the family use the toilet? (Y/N)									
What is the source of drinking water?									
Is the source (of drinking water) safe? (Y/N)									
If the child is small/infant, did it get the mother's milk (breastfeeding) regularly?									
Is the child given complementary feeding on the right time (after six months of age)?									
Does the family have a ration card? (Y/N)									
Is the family getting ration every month? (Y/N)									
Has the family got any work under NREGA? (Y/N)									
Were the wages paid? (Y/N)									

Growth Monitoring: There is no alternative to this

Basics

Growth means continuing increase in weight and height of the child with age;

If there is no increase in the weight and height, it means there is some issue with the child and hence its development is not taking place. If the weight is stagnant, the child is moving in the direction of malnutrition and ill health. The child needs urgent attention and care.

It is quite possible that the child succumbs to illness or becomes critically ill or malnutrition makes irreversible changes in the physical-mental capacities of the child.

Growth monitoring means continuously observing whether the weight and height of the child is increasing adequately or not.

When we talk about malnutrition and say that it impacts the physical and mental development of the child, the growth monitoring gives immediate information about the status.

If the growth monitoring is not taking place in the village, if the child is not being weighed every month and the symptoms are overlooked, we'll come to know of the problem only when the child's condition becomes critical.

The growth monitoring is considered important in Integrated Child Development Services and Child health programme. In the 1980s, growth monitoring was one of the important factors that contributed to the survival of a number of children and these children living with dignity. It is considered an important and regular task in the nutrition programme.

What do we mean by Growth Monitoring?

To elaborate further, growth monitoring consists of four important components:

- To weigh the child regularly: it is mandatory to weigh children in Anganwadi programme every month;
- To record and place the noted weight in a chart that shows whether the weight of the child has increased or decreased or remained static in comparison to the preceding months and in relation to child's age so that any anomalies are noted.
- When the growth monitoring reveals that the growth of the child is not taking place as desired or as deemed normal, the Anganwadi workers, ASHA worker and ANM collectively take the responsibility of providing care and treatment to the child;
- The care and treatment thus provided helps to improve the health and nutrition condition of the child. A mechanism is put in place so that the child gets the care and treatment in the family, community or health centre as per the need.

Mechanisms for growth monitoring

Growth monitoring is a fundamental and necessary service under Integrated Child Development Services scheme. It is necessary that each child's weight is being taken and entered in the register/monitoring chart every month at the Anganwadi centre.

This means that every centre should have a weighing machine. For children below 2 years of age, the weighing machine should consist of a basket at the end of the holder and the child is placed in the basket for weighing. For children above 2 years of age, hanging weighing machines are mandatory. It is our responsibility to ensure that every centre has these machines in working condition.

For pregnant women and adolescent girls, weighing machines on which one can stand are required.

Weight as shown in the weighing machine is recorded and registered in the growth chart. One folio/page is dedicated to one child with provision for noting down weight every month till the age of five. In the chart a point is marked according to the weight and after two-three months, when the points are connected with a line, we come to know whether the line is constant, declining or rising. If the graph is ascending, it means there is weight gain; if the line is moving constant, it means there is neither weight gain nor loss; when the line declines, it tells you that there is a weight loss and there is some problem with the growth (for details please refer, "Malnutrition: a few basic things", published by Vikas Samvad).

Along with this, under the national health programme, a "mother-child protection card" is allotted to the pregnant women. This card contains information about timelines for examinations during pregnancy, timelines for vaccination during pregnancy and advice/precautions to be taken during this time. What was the weight of the child at birth? The records of vaccinations of the child are also to be maintained through this card. One folio is earmarked for growth monitoring chart (the same as displayed or to be displayed in the Anganwadi centre) so that the information about the weight of the child be recorded in the card and, very important aspect, the information accessible to ANM, doctor or members of the village health committee. If the child falls ill, this information turns out to be of utmost importance during examination.

Why is the growth monitoring not done properly?

Despite being part of health and nutrition programme, we experience that growth monitoring does not take place as desired. A few reasons are:

- The training of Anganwadi and ASHA workers is not adequate. These workers have not been provided quality training and due to this they are unable to explain the importance of these services to the community or they may lack self-confidence.
- Most of the places and most of the time, growth monitoring does not take place and whenever it takes place, it is conducted within the four walls of the Anganwadi centre without any information to the community.
- Participation of village health committee is not ensured in this process. This work also does not take place on village health and sanitation/cleanliness day.
- Anganwadi centres are not provided with weighing machines. Weighing machines are not in working conditions where these have been provided. In places where the machines are provided, there is no mechanism for skilled maintenance and repairs.
- There are no growth monitoring charts/ folios available.

- It is also being told by the workers that they are not being educated or informed about the linkage of 'growth monitoring' with 'growth'. The Anganwadi worker records the weight but has no idea whether it is declining or rising and if it is declining what has to be done at the community level.

The growth monitoring mechanism and its use in giving impetus to growth

- To ensure that all pregnant women get "mother-child protection card" on time;
- To inform and educate the woman and her family about the card and its importance;
- To assess/review, after some time, whether the pregnant woman and her family have internalised the information and importance of the card.
- To connect the card with services, for example, to register the information, and make it mandatory, say information about immunisation, to enter it immediately in the card.
- To add the name of the child immediately after the birth. If the delivery has taken place in the hospital, the name will be written there immediately. If the delivery has taken place at home, the Anganwadi worker will visit the home within 48 hours of the delivery, weigh the child and register the weight in the card.
- It is mandatory to weigh all the children every month.
- Children below 3 years of age should be weighed on the village health and sanitation day or on the day when "take home ration" is being distributed.
- Children from 3 to 6 years of age should be weighed on a pre-decided day in the Anganwadi precincts.
- The Anganwadi worker should visit the house of those children who are irregular in the centre and find out the reasons for irregularity.

- We all know that regular home visit responsibility has been laid down under Integrated Child Development Programme. It has to be ensured that home visits take place, family and woman counselled and informed about growth monitoring. We have to share the knowledge with the family: "what does it mean or indicate when the child loses weight" and "the threat to its life".

- Growth monitoring becomes meaningful when practiced in true sense and spirit. When we realise about the child's weight loss or inadequate, we have to make provisions for nutrition supplement. If the child falls ill, health care should be provided to the child along with nutrition supplement.It would then make the community aware of the importance of growth monitoring.

What do the outcomes of growth monitoring indicate?

When the growth line of the child declines or becomes static/constant (instead of going up), it connotes:

- The child is not getting complete nutrition and adequate care or;

- The child is suffering from some illness or is likely to fall ill. If the growth falls acutely, an immediate investigation has to be done and the causes found out.

What to do then?

In such a situation, two measures become imminent:

- The child be taken to health centre or nutrition rehabilitation centre;

- A visit to the family for counselling on care and information about the food to be given to the child.

After the child has been identified as malnourished

If the growth monitoring indicates that the child is underweight, or if growth is faltering (not increasing at all or increasing at a very slow pace) three things to be done are:

- Take the child immediately to the health centre if severely underweight and/or ill;

- If the situation is not so critical, visit the home of the family (of the malnourished child) for counselling on care;

- Along with the supplementary nutrition making provisions to feed the child with additional nutrition.

To take decisions as per the growth monitoring information:

The basic premise is that the weight of the child should increase every month. It is very important to understand Growth

Faltering, Steady Weight, Increase and Decline in weight in a period of 3 months. If there is massive weight loss, situation must be handled as emergency in the context of particular child.

- Adequate growth increase: if the graph on the growth chart moves upwards;
- Weight loss starting phase but no illness: if the graph on the growth chart moves down;
- Continuous growth decline: if the weight is not increasing but decreasing or remains static for three months continuously
- Severe underweight: decreasing weight

What should we do?

- To ensure that all the pregnant women have "mother-child protection card" and along with tests during pregnancy, to have vaccinations;
- To have a provision/mechanism for growth monitoring in the Anganwadi: availability of growth chart and weighing machine in working condition;
- Whenever necessary, to provide full cooperation and help to Anganwadi worker and, along with capacity development, to boost her confidence;
- To initiate the growth monitoring process in the midst of the village groups and the community so that they realise the status of the children;

- To place the data and initiate discussion on growth monitoring in Gramsabha, Panchayat and village health committee;
- To create and foster an enabling environment in the village towards malnutrition and care of malnourished children;

If for any reasons children have moved out of the village-have gone to the town, migrated or have fallen ill, we will have to ensure that their growth monitoring takes place as early as possible.

Growth Monitoring : What to do and when?

Parameter	Nature of dialogue and actions with family and community	Counseling points	Practices to be fostered
Adequate growth increase is taking place	Congratulate and shower praise on the family and the community for good growth and; Find out the factors that have contributed to the situation.	Counseling to be done to continue breastfeeding in accordance with the age; As the child turn six month old, start feeding soft and easy to digest food. As the child turns one year old, start feeding the child with the same food which the adults eat; In this age, the children should be fed five times a day.	Tell the family as to when the next date on which the weight would be taken.
Initial volatility in the weight status Growth Faltering	◆ When the graph in the growth chart tapers off after moving in a straight line, explain "what does it mean" to the family of the child. They need to be explained that the child needs better feeding; ◆ Check for any worms It is also necessary to examine to find out whether the child is ill or has fallen ill.	◆ The infants should continue to be breast fed more frequently ◆ The children should be given nutrient dense complementary foods ◆ As the children are unable to eat in one go, feed them in small quantities during the entire day.	◆ To explain the families about the next weight measurement schedule for growth monitoring; ◆ Explain the symptoms of worms and relevant illness ◆ The children should get quality food at home and must refer to health centre or ANM
Weight static for considerable period or going down continuously Growth Faltering	◆ To explain the families that declining weight is a serious matter. To discuss and analyse the food and feeding practices of the child and the family; ◆ To find out whether there is any illness or infection; ◆ If so (yes), then trying to locate the causes. If the status is not clear, refer the child immediately to the health centre for examination.	◆ The infants should continue to be breast fed more frequently The children should be given nutrient dense complementary foods ◆ Children are unable to eat at one go, so feed them more frequently as many times as possible; ◆ To attend the child with love and care (to eat and not harsh words or insensitive behavior).	◆ The child to be taken to the nearest health centre. ◆ ASHA and the Anganwadi workers visit the family at least once a week and take the weight of the child

We will have to bear in mind that weight increase, weight loss and static weight may be caused by some factors. Of these some of the factors can be related to food, hygiene, feeding practices, in-access to basic services and illnesses. Until the causes and the reasons are found out, giving momentum to growth monitoring may not be an easy task.

To ensure growth monitoring of the children

Total number of children enrolled in the Anganwadi	
The average attendance of children in the Anganwadi	
Is there a weighing machine in the Anganwadi?	
Is the available weighing machine (in the Anganwadi) in working condition?	
What is the schedule of registering weights in the Anganwadi?	
How many children are being weighed (below 3 years of age)?	
How many children are being weighed (3 to 6 years of age)?	
How many children with static weight and losing weight (below 3 years of age)? (Essential – Analyse from GENDER perspective)	
How many children with static weight and losing weight (from 3 to 6 years of age)? (Essential – Analyse from GENDER perspective)	

What steps were taken for children with static weight and losing weight?	
How many children are severely malnourished? (On the basis of Weight for Height criteria)	
How many children are severely underweight? (On the basis of Weight for age criteria)	
How many malnourished or underweight children have been referred to ANM or health centre?	
How many children are getting double rations under ICDS?	
Is the growth monitoring carried out in the community? In other words, are the people aware and informed about the growth monitoring and are the people present while growth monitoring is being carried out?	
Has the Anganwadi worker visited the family to tell them about the growth monitoring?	
Is the anganwadi worker aware of what protocols to follow for growth monitoring and follow-up action?	
Do the children above 3 years of age get hot cooked meals regularly?	

Do the children below 3 years of age get “take home ration” regularly?	
What the views of the community on the quality and quantity are of “take home ration”?	
Are the newborn breastfed immediately after birth in the community?	
Are the children breastfed till 24 months old?	
Do the Anganwadi and ASHA worker give information about breastfeeding in the Anganwadi and during home visits?	
Have all children/mothers been given the mother-child protection card?	
Generally, what are common illnesses of the children in the village? What are the common symptoms?	
Does the village celebrate health and nutrition day?	
Do the pregnant and lactating women and adolescent girls participate in this celebration?	
Do the children wash their hands with soap before and after eating? And after defecation?	
Analysis	

Community Assessment of Food Security Situation

To begin with, the community should become informed : With regard to malnutrition, we need to find out in the present day context, whether the community gets food or not. Only after that, an assessment should be done whether they get adequate nutrition as per their requirements or not. This assessment will be to find out whether the community has access to adequate food in meeting the requirements of children and the community. Is it adequate in quantity and quality? Our food should contain six food groups. All food groups should be available in our daily diet:

- Cereals: wheat, rice, bajra (millet), ragi(millet), maize, jowar (sorghum) etc;
- Pulses and beans: like gram dal, pigeon-pea, green gram, rajma (beans), chawla (greens of a creeper) etc.;
- Seasonal fruits: mango, papaya, guava, orange, watermelons, muskmelons, bananas, custard-apple etc.;
- Milk and meat products: milk, curd, paneer (milk product similar to cheese), chicken, fish, eggs, meat etc.;
- Green vegetables (inclusive of leafy and green vegetables): spinach, fenugreek, red-leafy vegetable, mustard, leaves of grams; other vegetables: tomato, brinjal, ladyfinger, pumpkin, capsicum, beans, other beans, onion, cabbage, cauliflower, gourd, gilki etc.
- Fat and sugar: edible oil, ghee, butter, sugar, jaggery etc.

The assessment will find out the constituents from the above food groups being available and consumed by the community on daily basis.

Household food consumption pattern analysis (availability and consumption)

(for a study of the family wherein all the members participate)

Food Groups	Never or just once in a month	1 to 3 times a month	Once a week	2 to 4 times a week	Once daily	2 to 3 times a day	Quantity consumed per person
Cereals : for example, wheat, rice, bajra, ragi, maize, jowar etc.							
Pulses and beans: grams, pigeon-pea, mung, rajma, chawala etc							
Milk and meat products: milk, curd, paneer, chicken, fish, eggs, meat etc.							
Fruits/any of the seasonal fruits: mango, papaya, guava, orange, watermelon, muskmelon, banana, custard-apple etc.							

Vegetables (green and leafy vegetables): spinach, fenugreek, mustard, red-leafy vegetable, leaves of grams etc.							
Other vegetables: tomato, brinjal, ladyfinger, pumpkin, capsicum, beans, other beans, onions, cabbage, cauliflower, gourd, gilki etc.							
Fats and Sugar: any one from edible oil, ghee and butter and, any one from sugar or jaggery.							

- The items available and consumed for number of days have to be entered into the respective cells with a sign of (✓).
- This study has to be done with participation of the community in the beginning of the year.
- Analysis/findings of the study- the outcomes and its effects - are to be discussed in the community, women's groups and local groups.
- We also have to find out the sources of the food available and consumed e.g. from their own sources, and or purchased from the market.
- This analysis to be undertaken with every single household we are targeting.

Children's Food Consumption Pattern Analysis (Availability and Consumption)

(Food consumed by the children in the family)

Food Groups	Details/particulars
If the age of the child is less than six months, how many times the child was breastfed in last 24 hours?	
If the age of the child is between 6 and 24 months, how many times the child was breastfed in the last 24 hours?	
If the age of the child is between 6 and 24 months, what complementary foods are being given to the child along with breastfeeding? What is the quantity of complementary foods How many times a day, complementary food is given to the child?	

Information to be collected for the children above 6 months of age

Food groups	Consumed once and Quantity per person	Never consumed or only once in a month	1 to 3 times a month	Once a week	2 to 4 times a week	Once a day	2 to 3 times a day
Cereals wheat, rice, bajra, ragi, maize, jowar etc.							
Pulses and beans/pods: gram, pigeon-pea, mung, rajma, chawla etc.							
Milk and meat products: milk, curd, paneer, chicken, fish, eggs, meat etc							
Fruits-any seasonal fruits: mango, papaya, guava, orange, watermelon, muskmelon, banana, custard-apple etc.							
Vegetables (green and leafy vegetables): spinach, fenugreek, mustard, red-leafy vegetable, leaves of grams etc.							

Other vegetables: tomato, brinjal, ladyfinger, pumpkin, capsicum, pods and beans, onions, cabbage, cauliflower, gourd and gilki etc							
Fats and Sugar: anyone from edible oil, ghee or butter and, anyone from sugar or jaggery.							

- Foods consumed for number of days are entered in the respective column by putting a sign of (✓)
- This assessment needs to be carried out at the beginning of every year in participation with the community;
- We'll have to keep in mind that a child of about one year of age requires half the quantity as consumed by the adult. In other words, whatever has been served in an adult's plate, half the quantity has to be served for the children. In case of a few nutrients, like calcium, children need the same quantity as that of the adults and children need 75 to 80 per cent of fat quantity as consumed by the adults.
- The analysis of this study should be shared with the community, women's groups and local groups.
- It is also to be explored as to the sources of the food available and consumed e.g. from their own sources, and or purchased from the market.

Establishment of Crèche Services

An important aspect of the community based management endeavor is crèche or a day care centre. When we talk of such a centre, we intend and believe that children get a minimum 8 hours of services. This centre will cater to the children of working women and at the same time provide protection to all those children whose family members go out for work. Working at/from home and working in agriculture field does belong to the category of work. The objective of establishing a centre is not to minimise the importance of family as an institution but to provide immediate relief and protection to children and women. With this intervention, we endeavor to take care of the children, monitor their health and bring about changes in the nutrition related practices. There is no doubt that the present status of malnutrition is quite dreadful and the condition of the children below 3 years of age makes this situation much more apprehensive. We need to initiate a tangible institutional process for these children. Crèche is one of the important constituent of this endeavor.

Why do we need Crèche?

- Children below the age of six years need special care. As most of the adults in the family are engaged in wage earning or other work, these children need alternative provision or a mechanism for care and protection. A crèche fulfils this need.

- Crèche becomes much more imminent so that children of five years of age do not have to take care of their younger siblings.
- Crèche is needed so that the children get complete meals.
- These children get caught up in a vicious cycle-the cycle of illness- less appetite/less food intake-malnutrition-increase in the intensity of the illness-chronic problem.
- As the families are from the impoverished backgrounds, the onus falls on the state and other actors to provide for food-care-treatment of the children.

The purpose

- To ensure that every child gets adequate complete food daily to take care of its necessities.
- Get a protective environment where he/she feels secured and at home;
- Experiential teaching-learning that the children above 6 months of age are able to eat and digest the food. At this age, merely breastfeeding would not suffice to meet their requirements. Children of one year of age and above need half the quantity of food as required by the adults.
- To develop a system for prevention and cure of illnesses and malnutrition.
- This system will ensure that the elder children do not have to look after their younger siblings and in the process forego their school education, as is the case when parents go out to work.
- This system will ensure that the children will have their right to food; most of the times, in the impoverished environments, the quantity of food meant for the children are shared among other members of the family.

- It needs to ensure that this centre takes care of the three-fourth part of the food requirement of the child.
- Ensure growth monitoring.

What will we be doing?

- To provide the children with food made from locally available grains, pulses, vegetables, tubers, fruits, eggs, oilseeds etc.;
- Regular health check-ups and vaccinations;
- To feed them three to four times in the eight hour span. Perhaps, and it is more likely, that the children will not eat on their own. The worker will have to feed the children.
- To inculcate the habits of washing hands before and after eating and, after defecation.
- To develop and regularise growth monitoring system;
- Generally, the children suffer from cough, fever, skin ailments, eye sores, worms in the intestines, and diarrhoea. To identify the children with illnesses, investigate, treat and if felt necessary, take the children to the hospital.
- To identity the problems and issues faced by children and women in the village and to try to find the causes of the problems.
- To initiate dialogue with adolescent girls and women from the village on nutrition, health and, sanitation and hygiene;
- To augment the nutritional needs promote vegetable and tubers cultivation;
- We will have to work continuously on the cleanliness among the children. They will go to the toilet and we will have to attend to them and see that they are properly washed and cleaned.
- Protection, dignity, sensitivity and a sense of belonging need to be fostered. We will have to eradicate discrimination.
- To ensure early identification and follow up of malnutrition. To observe children's growth each month and initiate remedial action as soon as any growth faltering is noticed.

How this will be carried out?

- Communication/dialogue and participatory appraisal (health, nutrition, sanitation-hygiene situation): to develop women's and adolescent groups;
- Intensive training of women's group and the workers; training to take place regularly.
- To conduct meetings with regular frequency on malnutrition, illnesses, anemia etc. to disseminate the information to the entire village;

- To activate village health committee;
- To recruit a worker per 10 children;
- To initiate dialogue on crèche in Gram Sabhas and Panchayats;
- The schedule/time of the meetings will be decided by the villagers/community.

What will be fed?

- Sattu (flour of mixed grains), grains, pulses, jaggery and oil mix (60 to 70 gms);
- Khichadi (boiled mix of)-rice, pulses, oil (100 gm.);
- Eggs (at least one every alternate day);
- In this manner, we'll have to give about 750 to 1000 calories enriched food as per the need and age appropriate;
- To give Vitamin A and de-worming medicines and iron syrup for anaemic kids

The system

- To form and develop a system fully adaptable to the needs of the community. Community participation in the running of crèche is important and as such should be mandatory;

- To make provisions for leisure, sleeping, toilet, safe drinking water, toys and open spaces;
- The crèche should be airy with a lot of open, clean, safe and attractive space;

Analyzing Readiness : Are we really prepared?

What is our purpose? At one end, nutrition insecurity and malnutrition shows a clear and direct link with the food insecurity and lack of nutrition. At the other end, the crisis is ever escalated by livelihood insecurity, lack of health care services, violence, discrimination and social boycott. So, it should be the figment of one's imagination, a classic fantasy, that the ills of malnutrition can be cured by sending children to Anganwadi, nutrition rehabilitation centre and hospitals. At one level, our intervention should endeavor to ensure that the children, families and the community get adequate food. At the other, we will have to strive to make our government accountable for Anganwadi, health care services, drinking water, employment and right to livelihood-an enabling environment in which, a just socio-economic culture, the people live in dignity. We have discussed, more than sufficient, about the management of malnutrition at community level. Now we need to move to the next logical step: is it possible for us to design an appropriate policy and an effective and relevant programme?

These are the questions!	What are the answers?
What is our purpose?	
What does malnutrition (issue) mean?	
Is it possible to eradicate malnutrition completely by merely distributing nutritious food through Anganwadi or some other programme?	
Who gets affected directly first and foremost by this (situation)? And why?	
What are the main factors contributing and aggravating the situation?	
What do we mean by community based malnutrition management?	
Why is “community based management” the best possible strategy to address malnutrition?	

These are the questions!	What are the answers?
Would there be any role for the government and its programmes in community based management of malnutrition? If yes, how?	
Which are the groups within the community that need to be identified and scouted for effective implementation of community based management of malnutrition	
What sequential steps to be taken when to initiate this process within the village?	
Is it necessary to send each malnourished child to nutrition rehabilitation centre or hospital?	
How would we find about the regular food/meal of the children in the family/house?	
If all the members of the family use the supplementary nutritious food supplied by government schemes meant for children, pregnant women and lactating women, would you object and stop the practice?	
If you want to explain the meaning and impact of malnutrition to one of the groups in the village, how would you do that? What would be the probable obstacles in this process?	

These are the questions!	What are the answers?
What do you mean by growth monitoring and if growth monitoring is to be done within the community, how would you do that?	
Would we be planning all our programmes completely focussing our attention on children's needs? Or would we tune our programmes to the needs of the specific groups? If special programmes catering to individual groups have to be planned, which groups we would focus most on? And why this particular group?	
What would be the challenges faced while working on malnutrition? And how would you overcome these challenges?	
In this regard, the state has a major role to play; what are the issues and areas (thematic) that the state (government) has a role to play? What should the community do to make the state (government) accountable on these responsibilities? How to build community's capacities towards this?	
Would the community be in a position to make the state accountable for its responsibilities?	
If our food consists of only cereals/grains, would that help in eradicating the malnutrition?	

These are the questions!	What are the answers?
What should constitute our food that will help to mitigate malnutrition?	
In the management of the malnutrition, which stakeholders would be with us (from family to the state level)? Would all the stakeholders come together?	
In the management of the malnutrition, which of the stakeholders (constituents) would not work with us or work against us (from the family to the state level)? Is there a possibility of any of these being antagonistic to our efforts? And if yes, who and why?	
While working on malnutrition, would there be stakeholders who would keep away from our efforts (from the family to the state level)? Would some of these be indifferent to our efforts?	
What steps would you take to ensure equal participation/partnership (as a stakeholder) of the dalit families?	
What steps would you take to ensure participation/partnership of people with disabilities and widow-single women?	

These are the questions!	What are the answers?
Our work will run from family to the state (government level). In this initiative do you expect men at the family and the community level to participate in our efforts? Or do we need to make extra efforts to ensure that?	
In our initiative of malnutrition management, what do we mean by the community?	
What do we mean by community participation in this process? What are the merits of this participation?	
What are the different stages of community participation? What is the stage or the level of participation do we expect or visualise to attain?	
What would be the parameters to measure community participation and what would be the indicators that would tell us that the community has participated (to the optimum level) in this process?	
How to make Anganwadi centre attractive and interesting? Would that make any difference to the attendance of the children in the Anganwadi?	

These are the questions!	What are the answers?
What do we envisage as the role of Panchayat and the Gram Sabha in this intervention? What steps should be taken to ensure their participation and activation on this issue?	
Severely acute malnourished children could be taken care of by the family in the village itself. Is it possible?	
Is there a direct connect between irrigation, Mahatma Gandhi Rural Employment Guarantee Scheme, public distribution system or the ration shop, electricity and forest act with the malnutrition?	
What are the one-to-one relationship between illnesses and malnutrition? Do we find any examples to illustrate such a relationship?	
Is it possible to end malnutrition without making positive interventions in women's health and secured and safe motherhood? Or is it possible to end malnutrition without changing the existing status of women's health and motherhood?	
What is the present status of food security of the community?	
Is it possible to create and foster a sustainable food security system?	

Malnutrition and Disability

Malnutrition and disabled children

Malnutrition and disability are intimately interlinked. Malnutrition can closely cause disability and vice-versa. The relationship is two-way interaction and is toned when pregnant and lactating women are deprived of proper and adequate nutrition that may lead to permanent childhood impairment. Also, early life malnutrition can ground disability in later stages of life due to it's impinge on health and development. Similarly, disability also causes malnutrition. A malnourished child (whether disabled or not) develops increase risk of growing further devastating disease, delayed development and disability or multifaceted by further disability. Hence, efforts are required to focus on improving both maternal and child nutrition to thwart and tone down disability.

Recognizing malnutrition in disabled children

Do we have an authentic record of how many children under the age of 6 years are there with any kind of disability? Perhaps NO; the system opens its eyes, when children are admitted into schools. We must recognize that the biggest challenge exists even before they reach the school-going age. Early detection of disability in children can play a very significant role, both in

prevention of disability as well as in its timely rehabilitative management.

Children with severe developmental disabilities frequently have nutrition and growth problems that may range from moderate and severe. Because of lowered growth expectations from disabled children, parents and medical practitioner fail to notice gradual deterioration in nutritional status before severe complications occur. Disabled children who have growth parameters below age norms require regular assessment and monitoring. Facilities for screening, vaccinations, regular check-ups and nutrition package need to be well in place along with planned and organised efforts for ensuring an early

detection of disability in children. An initial assessment includes measurement of length or height, weight, triceps, dietary and feeding history, review of medical history and biochemical testing. Consequently, preventive and corrective medical care can be provided so as to rehabilitate the disabled children. It would greatly help in ensuring enrolment of those children in schools who happen stay away due to disability.

Inclusion of Disabled children

It is essential to know that disabled children are most marginalized and excluded group experiencing pervasive violation of their privileges. We observe that the children with disabilities are often obscured out of the mainstream life, first within the family itself and later in community. The discrimination against disabled children can deny them access to education and health care, opportunities for play and cultural family life, protection from violence and adequate standard of living. Our aim should necessarily be to make people understand that these children too have unequivocal right to full life and opportunities. It needs to be realised that after a certain time, it does not remain an issue of disability.

Ensuring disability inclusion in child development program

Exclusion of disabled children from the rest of the children in leading a normal life leads to persistent social perceptions whereby distancing from the disabled children becomes so acute that even those who are afflicted with temporary disability (better described as 'differently-abled'), they also find themselves vulnerable and isolated. We need to appreciate that disability does not mean incapability. Rather, their life can also be full of possibilities. The differently-abled would not be helplessly dependent on others provided we accept, respect and admire them with an inclusive disposition. They don't need sympathy and special treatment. They need friendly environment! This can be done

- Disabled children experience high physical and sexual abuse and are often neglected in all developmental setting. Their rights need to understood and addressed both in practice and at policy level.
- Factors responsible for children living in poverty such as inadequate child health services and poor nutrition and sanitation facilities need to be checked.
- Family member with a disability needs to be considered on all requirement and facilities.
- Generating child-friendly development activities in order to bring awareness of their rights.
- Drawing attention of parents, care-givers/takers, schools, broader communities towards child rights.
- Encouraging disability inclusion and awareness in schooling and other child-focused programs so as to sensitize all children to disability.
- Disabled children and their families must be encouraged to participate in knowledge giving courses, programs, sessions, meetings counting disability specific programs.

Ensuring protection of disabled children in Development Programs

Special Project for Assistance, Rehabilitation & Strengthening of Handicapped (SPARSH) under the Social Justice Department of Government of India provides for the detection of disability in different age groups including those in the 0 to 6 years age group through a campaign mode. It is done in coordination with the Departments of Public Health & Family Welfare and Women & Child Development, amongst others. Ensuring access of children with disabilities is a prime objective of Integrated Management of Community based Management of Malnutrition.

Intervention for Malnutrition and disability

Intervention can be made in the following ways :

- Intervention for root causes will reduce both malnutrition and disability.
- Intervention to prevent Malnutrition will prevent disability due to malnutrition.
- Intervention to treat malnutrition will reduce reverse disability.
- Intervention for disability may improve growth.
- Combined interventions are most effective.

We, under this programme, will discuss lessons and knowledge regarding early identification of disabilities among children from the very early stages. We learn from the experiences that mothers usually are able to identify any disability of her child, but gender bias against her keeps out the sharing of observations with other family members. These issues, thus, will be integral tothe consultations with the community.

Integrated Child Development Services programme will be discerningly mobilized towards the differently abled children.

There will be a need to engage with other family members too in the early detection exercise, so that in case of any need for institutional care, it is made available. Our primary duty under this intervention will be to LEARN and SPEAK for THEM!

The frontline workers always play a key role, during the consultation session on Early Child Care and Development. We will make sure that knowledge relating to early detection and sustained inclusion of children with physical disability is ensured. The non-negotiable characteristics of this initiative are 'respect for the individuality' and 'dignity'. Let's put our heads together and list out the action points.

Nutrition interventions

It can be done in two ways:

1. Preventive Nutrition Intervention
    a. Food to pregnant and lactating women and infants to improve infant birth weight, infant growth and prevent stunting.

b. Supplementation of macro/micro nutrient to be made.

c. Knowledge imparting education programs to be conducted covering breastfeeding/complementary; hygiene and sanitation; disease and prevention sessions.

d. Approaches to be formulated for checking root causes including poverty alleviations, exclusion, family planning and food security

2. Curative Nutrition Interventions

a. Treatment of malnutrition especially SAM

b. Supplementation to cover up the growth for stunting.

c. Micronutrients supplementation of Vit. A, iron, folic acid, iodine etc to catch up the deficiency level.

d. Stimulation improves development outcome and recovers development in stunting and wasting.

Monitoring and Rehabilitation

There is a need for rehabilitation of such disabled children to improve their access to nutrition services providing care to pregnant and breast feeding mothers.

For these children, specific services including professional specialty and Community- Based Rehabilitation are required. Professionals as well as trainers of health should be trained.

Monitoring of children is to be considered on top while intervening and its frequency may vary from weekly or fortnightly depends on age, severity of condition and response to treatment.

A potential checklist

- Children with Disability - Preparing to make intervention
- Let us ask ourselves: Questions unto ourselves
- Do we know as to which children in the community have disabilities(by name, age, family, and type of disability child-specific dossier)?
- How do we keep a vigilant eye so that the disabled children are actively included in the programme?
- Are we prepared to address stigma towards children with disabilities with a comprehensive and thoughtful approach?
- How will our institutions and the responsible persons therein respond towards them with a sense of accountability?
- Will we make this section an integral part of community monitoring system and social audit?
- Shouldn't we have a trained team of resource persons at the community level to ensure efficacy in primary intervention and the concomitant?

Glossary

Anganwadi : The Integrated Child Development Service Scheme of the Indian Government has village level centre to promote health and nutritional status of young children from 0-6 years and provide nutrition for children and pregnant women and lactating mothers.

ANC: Antenatal Care is a 'four visits providing evidence based interventions', a package often called antenatal care, containing essential interventions that include identification and management of obstetric complications such as preeclampsia, tetanus toxoid immunisation, intermittent preventive treatment for malaria during pregnancy (IPTp) and identification and management of infections including HIV, syphilis and other sexually transmitted infections (STIs).

ASHA : Accredited Social Health Activists, one of the key components of the National Rural Health Mission is to provide every village in the country with a trained female community health activist. ASHA is trained to work as an interface between the community and the public health system

AWW: Anganwadi Workers have the main role to perform in Anganwadi system. AWWs are health workers and are chosen from the community itself and given training on health, nutrition and child-care. According to a order by the Supreme Court of India, there should an Anganwadi Centre for every 40 children.

ANM : Auxiliary Nurse Midwives (ANMs) are key workers at the interface of health services and the community under NRHM. They are considered to look the needs of maternal and child care in any village. Their services are considered essential to provide safe and effective care and as a vital resource to achieve the health-related targets.

Gramsabha : The Village Council of voters under Panchayat Raj Institution; under 73rd amendment of the Constitution, the Gramsabha has the powers to decide about the resources in the village and it is mandatory to have a specific number of Gramsabha meetings in a financial year. It consists of all the male and female members of the village.

ICDS : The Integrated Child Development Scheme (ICDS) comes under the purview of the Ministry of Women and Child Development (MWCD). ICDS was launched in 1975 and has been working to eliminate hazards to child health and development. The scheme aims at providing an integrated package of services. These services include supplementary nutrition, immunization, medical check-ups, recommendation services, pre-school non-formal education and nutrition & health awareness.

Mangal Divas : In order to bring the effectiveness of different schemes programmes and activities, currently running by state, Mangal Divas is celebrated in Anaganwadi Centres on Tuesdays of every month. Godbharai, Annapraashan, Birthday's, Adolescent Girl's day programmes are observed respectively on all the four Tuesdays.

MNREGS : Mahatma Gandhi National Rural Employment Guarantee Scheme is a special programme, designed under Mahatma Gandhi National Rural Employment Act, of the government for providing guaranteed employment for 100 days in the rural areas. According to this law employment is a right of the people.

MUAC: Mid-upper arm circumference (MUAC) measures the muscle mass of the upper arm. A flexible measuring tape is wrapped around the mid-upper arm (between the shoulder and elbow) to measure its circumference. MUAC should be measured to the nearest 0.1cm. MUAC is a rapid and effective predictor of risk of death in children aged 6 to 59 months and is also used to assess adult nutritional status.

NRC : Nutrition Rehabilitation Centres (NRCs) have been set up in various states to address severe under-nutrition and underlying complications. It is a specialized facility that rehabilitates severely malnourished children and strives to restore them to good health and educates their mothers about nutrition and child care.

NRHM : National Rural Health Mission (NRHM) was launched to provide accessible, affordable and quality health care to the rural population, especially the vulnerable groups. The thrust of the mission is on establishing a fully functional, community owned, decentralized health delivery system with inter-sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health such as water, sanitation, education, nutrition, social and gender equality.

Panchayats : The Village level local governance system; the Panchayat is an elected body of members from the village and has executive powers to plan and budget for the village development.

WH_z : Weight-for-height is a nutrition index which is a calculation of two measures- weight and height- into a single value so that children of different ages can be compared. There are several nutrition indices. Weight-for-height specifically assesses wasting, one form of acute malnutrition. The Z-score is used to describe how far a measurement is from the median, or average. A WFH Z-score calculated for an individual tells us how an individual's weight compares to the average weight of an individual of the same height in the WHO Growth Standard (GS). A positive WFH Z-score means that the individual's measurement is higher than the median weight value of an individual of the same height in the WHO GS, while a negative WFH-Z score means that the individual's weight is lower than the average weight of an individual of the same height in the WHO GS.

About us

Vikas Samvad undertakes various activities such as participatory studies, reviews, analysis, advocacy and dialogue on various issues concerning the masses with a rights-based and pro-people perspective. We believe that every individual's issues (be it food, nutrition, forest rights, environment, social exclusion, gender, child rights infrastructure development or displacement) are important and must be taken into consideration at first place. Intervention is required at every step through the perspectives of conflicts and creations. But, children's rights should be at the centre of any initiative. Nevertheless they are individual and complete unit in themselves, still are the responsibility of the larger society. To know more about us, you can log on to www.mediaforrights.org.

About CBMM

We herald a collective intervention for Community Based Management of Malnutrition with a belief that malnutrition can only be combated effectively at the community level. By this we meant strengthening the facilities being provided under various programmes and also focusing on nutrition security issues including food insecurity, livelihood crisis, social disparity and inequality, gender discrimination and development imbalance decisively. It will have to be ensured that the system necessarily provides the essential services to the children and the women with due sensitivity and accountability. We conceive the thought that the children under two years are most shaping and sensitive age group that demands comprehend and maximum attention for care and protection. Along with this, adolescent girls, pregnant women and lactating mothers constitute other vulnerable group in the community to be taken care of. Towards establishing such system, the community will have to take the lead role so that the system does not become chaotic and remains on course, and as therefore we are focusing on it and in the process we also are including local institutions, Village Health Committees, Gram Sabha, Youth Organisations and Women's Groups to work with local organizations in order to bring up the practical and functional competent community based institution dedicated to work on nutrition and health.

Tuk..tuk...tuk…..knock on my doors
Hunger knocks and
Like an uninvited guest
Occupies my house.
I didn't open the doors to let her in
It seeped in through the slits
Of the walls that have begun to crumble
Under the weight of thin air
In the surrounding environment
Disabled by God knows what!
Hunger has trickled in
And formed a cesspool
Starvation, illness and darkness
Lifting me in her limbs
Caressing me to deep sleep
Forever sleep
Unless bread
From somewhere
Comes knocking down on my door,
tuk...tuk..tuk...tuk....tuk

Vikas Samvad

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