Nutrition and Health Profile: Rewa

Detailed Nutrition and Health Profile of District Rewa
July 2020

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1. INTRODUCTION

1.1. BACKGROUND

CASE SNIPPETS

KHUSHBOO DEVI KOL, DHURKUCH, REWA

Khushboo Devi Kol stays with her husband and two daughters, she is observing her 3rd pregnancy for 8 months and is facing discomfort for her husband continuous efforts to feed them out of hard labors which is their only support. Being expectant and little work around, Khushboo is able to fetch the desirable rest but fails to have nutritious food on her plate to meet the additional requirements of her growing fetus.
Khushboo is pregnant mother with the pressing need on nutrition and diet with little ration in hand to survive a month. Insufficient grains, lentils, vegetables causing food deprivation to the growing children as well as fetus on all the grounds.

MALTI YADAV, DHURKUCH, REWA

Malti Yadav now barely feeds her three daughters Chapati with salt. Her husband migrated to Surat few days back to earn his luck. Unfortunately, Corona-Covid 19 pandemic abrupt shutdown never gave him the opportunity to returned back to his family. Malti's youngest daughter is Severely Acute Malnourished and needs nutrition apart from food to sustain her life.

PINTU DEVI KOL, NONAARI, REWA

Pintu is a pregnant mother presently is facing nutrition and food security issues due to insufficiency of grains, lentils and vegetables which soon will be exhausted. This stressed her out and is showing negative impact on her health.
Pintu weighs 42 Kg and is anemic with 11.2 Hb at present with reduced diet. Pintu got herself registered in Anganwadi centre and was getting THR and counselling on constantly till the lockdown was imposed. Pintu had dal roti and some vegetables from her kitchen garden including tomatoes and brinjals for now. Both of the family members (Pintu and her husband) need 25-30 Kg of ration as per their basic requirement in a month which is somehow reduced to one-third and if she is not sufficiently provided with nutrition rich food, it may impact the growth of foetus.

These are case snippets from District Rewa during Covid-19 where more families like Malti's, Pintu and Khusboo Kol's are striving for their daily breads. As stated by NFHS-4, four out of every ten children are affected by malnutrition in Madhya Pradesh. The infant mortality rate is striking at 47. More than half of the women and about two-thirds of adolescent girls are anemic. Amidst already crucial health condition in the state, the outbreak of Covid-19 has largely affected more than 3 crore persons of unorganized and agriculture sectors. Around five lakh workers have herded back to their villages as almost all employment opportunities in construction, industry, and retail sectors have either been shut down or are severely curtailed to fewer ones in the wake of the pandemic. With the onset of this pandemic, serious concern is raised on nutritional wellbeing of pregnant women, lactating mothers and 15000 children of these returning migrant families. Unfortunately, they are bound to feed on salt with chapati or rice to meet their basic hunger needs. Undoubtably, the pandemic has also had an adverse impact on the implementation of schemes for their nutritional wellbeing and food security.

1.2. SITUATION ANALYSIS

The increasing poverty, food insecurity, has caused the world to face malnutrition with its varied forms encompassing deficiencies or excesses of macro and micronutrients further inducing disorders affecting more than 2 billion people across the world and are more prevailing in developing countries like India. Global hunger Index, 2016, ranks India at 97 amongst 118 countries, wherein vitamins and mineral deficiencies continue to be throbbing problems and are budding as quiet crisis. Consumption of daily needs of iron, folate, Vitamin A and B complex, and zinc across any age group is merely 50 percent by more than half the population of the country. Despite of various supplementation programme, the score is comparatively low when it comes to trim down and address the crucial nutrient deficiencies like iron folic acid and vitamins. Iron deficiency is widespread across all the age groups affecting the hemoglobin level and has become the root cause for anemia in India

1.2.1. NUTRITIONAL STATUS IN INDIA

As stated by WHO (2009), more than one fourth of the world's Vitamin A deficient children suffering from subclinical Vitamin A deficiency belong to India. Global Nutrition report states that the condition of wasting is critical in the country1. NFHS-4 says that in India, 58.4 percent of children in the ages of 6 to 59 months are anemic, 38.4 percent are stunted (Low Height-for-Age) 35.7 percent of all the children are under-weight (Low Weight-for-Age) and 21.0 percent are wasted (Low Weight-for-Height)1. With a strikingly high Maternal Mortality Rate (MMR) at 130 per 100, 000 live births, Infant Mortality Rate (IMR) at 32 per 1000 live births and Under5 Child Mortality Rate (U5CMR) at 30 per 1000 live births, India is still striving hard to secure its nutritional equilibrium.

1.2.2. NUTRITIONAL STATUS IN MADHYA PRADESH

With a total population of 8.70 crores spread across 52 districts1, the Madhya Pradesh state reflects no different condition than the entire county. The state of Madhya Pradesh (MP) endowed with rich natural, human capital reels under poverty, and backward tag despite numerous attractive features, MP, the state of Central India, has not done much improvement in its health and nutrition indicators. According to National Family Health Survey -4 (NFHS-4), 42.8 percent of children are underweight, and 42.0 percent are stunted in Madhya Pradesh.

Only 37.4 percent women between the ages of 15 and 24 years are adopting safe hygienic methods during menstruation whereas only 11.4 percent women receive full antenatal services. It is also notable that only 34.4 percent of the children are initiated early breastfeeding within one hour of birth, while 58.2 percent of the children receive Exclusive Breastfeeding for 6 months. It means that the rest of the 41.2 percent infants receive complementary feed as well along with the breast feed, within the first six months of life, which is a grossly inappropriate practice. Going by the facts and figures, more than half of the women and about two-thirds of adolescent girls are anemic.1 Anemia stances a foremost danger to maternal and child survival and is indirectly responsible for a high Maternal Mortality Ratio (221/lakh live birth)2, Infant Mortality Rate (47/1000 live birth)3 and lived with disabilities for both sexes in the disease burden of the state. It was rated as number 6 (in 2016) compared with number 12 (in 1990)4 and Under 5 Mortality Rate (40/1000 live births)5..At any given point of time, malnutrition is worse and has its own adverse implication on human body and the results are even shocking when it comes to tribal population as they devoid of consuming nutritious rich in particular.

1.2.3. Nutritional Status in the Tribal

If malnutrition is stated to be one of the most stagnating and adverse conditions affecting the health of people of India, then it is also creating a spectrum of diseases, more across all the tribal belts of the country. It is amongst these communities; individuals have shown up the direst health fallouts. shows us that malnutrition in all of its varied aspect is anytime more in Scheduled tribes and Scheduled Caste than any other community. For instance, approximately 51.5 percent of children below 5 years of age in ST communities are underweight as compared to 42.5 percent Madhya Pradesh and 38.4 percent of India. In the similar vein, children below 5 years of age in ST communities continue to lag behind in height-for-age (Stunting) and weight-for-height (wasting) with 47.6 percent and 25.5 percent as compared to Madhya Pradesh's 42 percent and 25 percent respectively. In view of this, there is an urgent need to redress malnutrition in children. To accomplish this, the Integrated Child Development Services (ICDS) programme, is under implementation as the most important government intervention for reducing maternal and childhood malnutrition. It has emerged as the world's largest programme of its kind. This scheme has expanded remarkably in its scope and coverage providing a well-integrated package of services through a network of community level Anganwadi Centres (AWCs).

1 Government of India, Ministry of Health and family Welfare, National Family Health Survey-4 2015-16
2 Office of the Registrar Government of India, NITI Aayog, 2015
3 Government of India, Government of India, NITI Aayog, 2015
4 India Council of Medical Research, Public Health Foundation of India, and Institute for Health Metrics and Evaluation. India: Health of the Nation's States. The India State-level Disease Burden Initiative. New Delhi, India. ICMR, PHFI and IHME, 2017.
5 Government of India, NITI Aayog, 2015

1.3. Outbreak of Covid 19

1.3.1. Impact of Covid 19

The outbreak of coronavirus disease 2019 (COVID-19) has caused a worldwide wellbeing crisis. In a continued effort to curb the spread of coronavirus disease 2019 (COVID-19), states have been tightening borders and putting travel restrictions in place. These actions have affected migrants and marginalized nationwide. COVID-19 crisis has established an unparalleled calamity leaving all the nations in dismay in the wake of catastrophic pandemic. India announced a 21-days lockdown to avert the pandemic spread of the virus in Phase-I, followed by complete lockdown for a period of another 19 days in phase-II and 15 days in phase-III and 17 days in Phase-IV. The situation is even more concerning in the village premises where the natives are robbing out of any livelihood, health and medical and food services leaving them at the verge of falling prey to death. Lacking jobs and money, and with public transportation shut down, hundreds of thousands of poor families and migrants who have no job security or protection are at stake pf food and nutrition insecurity. Immediate concerns faced by such families hailing from tribal belts and marginalized sections relate to food, shelter, healthcare, fear of getting infected or spreading the infection, loss of wages, concerns about the family, anxiety, and fear and are in acute need of psycho-social support. Outbreak of pandemic outbreak impose reversing impact on health of women and children in the longer rung

Girls and Women

Disease outbreaks increase adolescents and young women's duties caring for elderly and ill family members, as well as for siblings who are out of school. Adolescents, especially those from marginalized communities and with disabilities, may be particularly affected by the secondary impacts of the outbreak. Economic stress on families due to the outbreak can put children, and in particular girls, at greater risk of exploitation, child labor and gender-based violence.

Health Services

Evidence from past epidemics indicates resources are often diverted from routine health services. This further reduces the already limited access of many girls and young women to sexual and reproductive health services, as well as maternal, new-born and child health services.

Economic Wellbeing

Economic challenges during the outbreak pose a serious threat to families and women's work and occupational activities thus exposing them to increased risk of exploitation or abuse. Families, migrants, women, and adolescents facing severe financial shocks are more likely to take on high-risk work for their economic survival.

2. PROBLEM STATEMENT

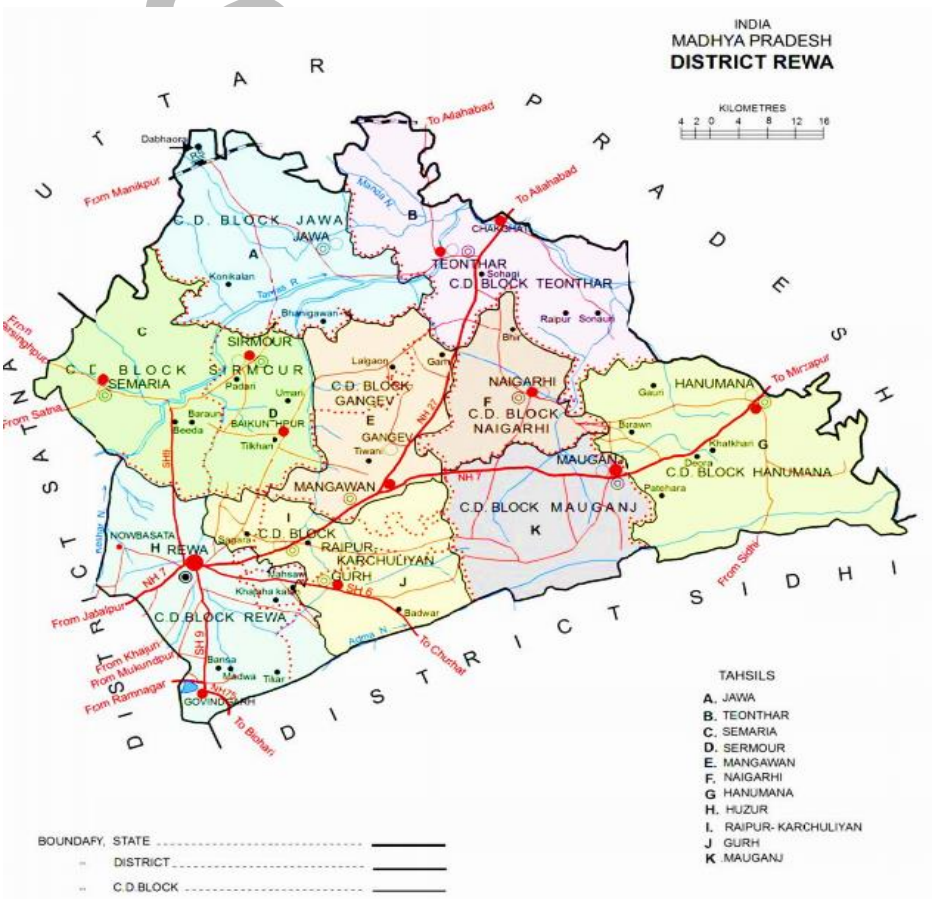
2.1. About the district: Rewa, Madhya Pradesh

2.1.1. Geography

Rewa is a district and division located in the eastern part of the state of Madhya Pradesh, India, which is known as Baghelkhand. Rewa is basically a plateau which decreases in height from the south to the north. In the south, the height of Kaimur Range is more than 450 meters, whereas the height of alluvial plain of Teonthor is just 100 meters. The physical structure of Rewa district is one of the earliest forms. The surface structure of this area is the result of the collective effects of various internal and external movements on the geologic structure there. The surface structure is low and heterogeneous. The temperature in the region is around 18 degrees in January and 45 degrees in May. Tons, Behar, Bichhiya and other smaller rivers provide water to the land, the water flow of these rivers leads to flood conditions in the rain, while they dry up in the summer. Rainfall in these areas varies from 100 to 125 cm the area of the district is 2509 sq. mi.

2.1.2. Historical Background

Rewa was the capital of Vindhya Pradesh after independence and was later merged into Madhya Pradesh in 1956 at the time of the reorganization of Madhya Pradesh. The world ' s first white lion was captured and reared by the Baghel Kings, and all the white lions in the world are the product of this. The former Rewa state was established in about 1400 AD by the Baghel Rajputs. Rewa became important after the demolition of Bandhavgarh Nagar by Mughal Emperor Akbar and was elected as the capital of the former Rewa state in 1597 AD. In 1812 AD, the local ruler compromised British power and handed over his sovereignty to the British. The city was also the capital of the British Bagakhand agency.



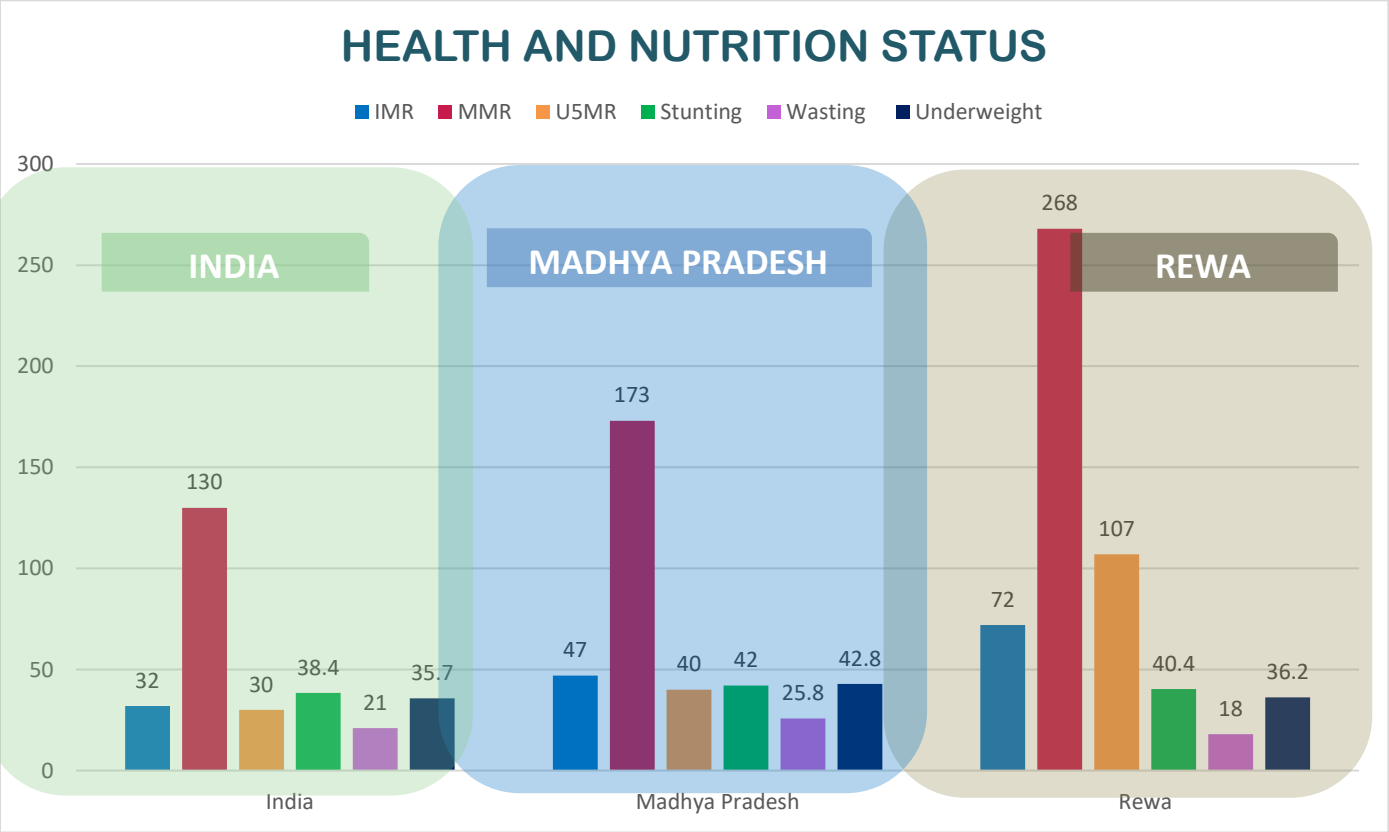
2.1.3. Demography

According to Census 2011, the total numbers of villages are 2719, out of which 2408 villages inhabited and 311 uninhabited. of the district is mainly dependent on agriculture and the district is famous for white tiger. In 2011, Rewa had population of 2,365,106 of which male and female were 1,225,100 and 1,140,006, respectively. The mass density in Rewa district is 375 people per kilometer category whereas in 2001 the rate was 313 persons per kilometer. The sex ratio was 926 in 2011 and that of the literacy ration was recorded as 71.62.

2.2. Health and Nutritional Status: Overview

As clear from the Graph 1, the status of Rewa both in terms of health and nutrition is on declining side when compared to India and Madhya Pradesh. Maternal Mortality rate is higher with 268 than both from the state and the Nation.

On the similar note, Rewa has strikingly high rates of U5MR with 107 against 40 that of MP and 30 that of India. Underweight status is seemingly better than MP with 36.2 but on higher side than country (35.7)



GRAPH 1: Comparative health and nutritional Status of Rewa with India and MP

2.3. REASONS BEHIND: CAUSAL FRAMEWORK

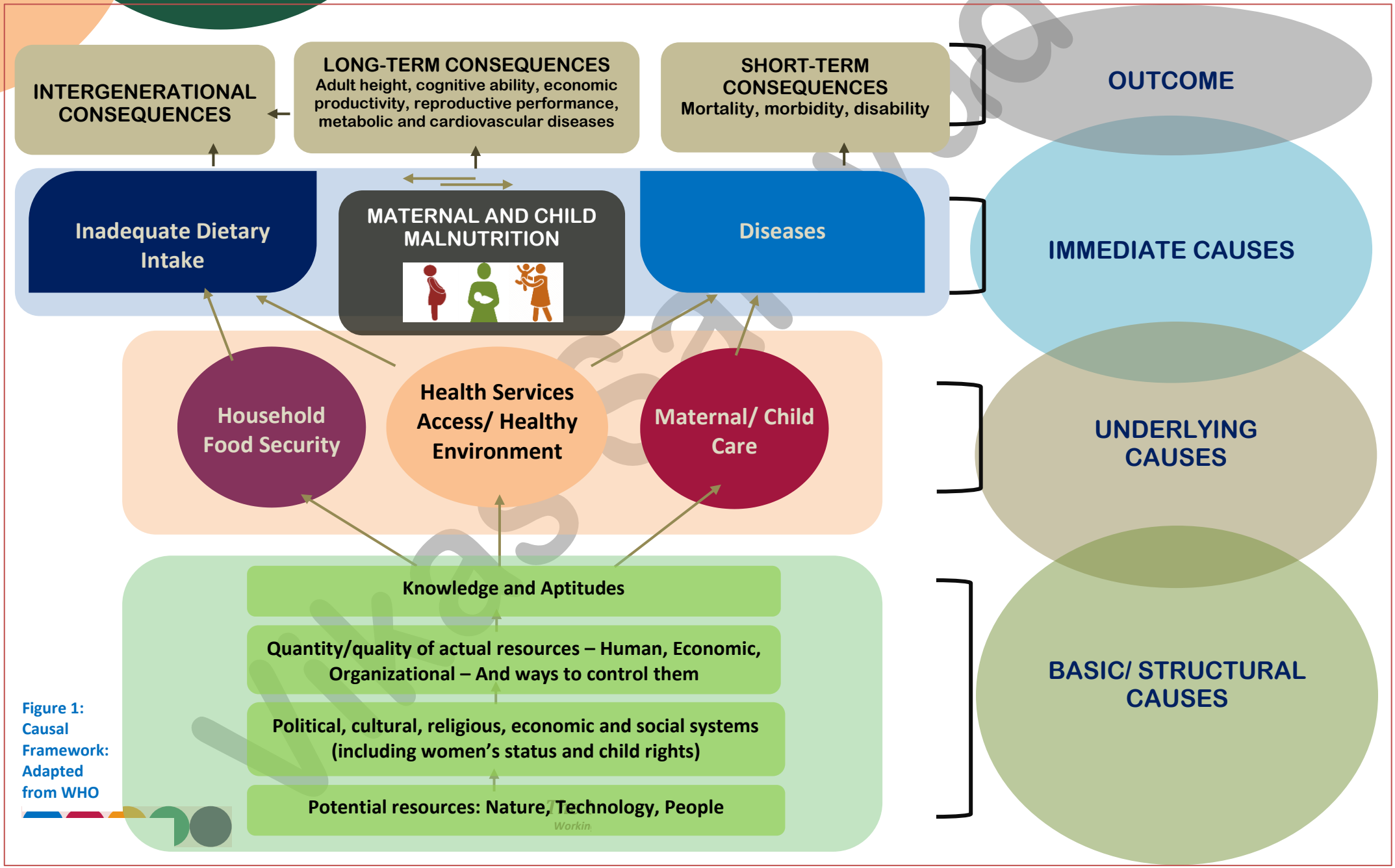


Figure 1: Causal Framework: Adapted from WHO

2.4. In purview of REWA

As explained through causal framework (adapted from WHO) in Figure 1, there are plenty of causes which are solely or collectively responsible to alter Maternal and Child Malnutrition. These causes in relevance to Rewa are –

2.4.1. Basic Causes:

2.4.1.1. Potential resources: Nature, Technology, People

1. Nature/ Resources

Kol and Gond live in hilly areas where there is a plethora of forests that produce lacs, wood and provided with wild animals. The main yield of the district is Paddy/Rice. The people in the far away villages between the mountains have to struggle for their daily breads, as employment, drinking water facilities, health facilities are major problems here.

2.4.1.2. Political, cultural, religious, economic and social systems (including women's status and child rights)

1. Social/Cultural/Political Systems

People from diverse communities reside in different parts of Rewa. The inhabitants include Brahmins, Yadav, Kachi, Manjhi, Sahu, Vishkarma, Rajput, Meena, Gurjar, Lodhi, Muslim, Bohra, Valmiki, Mali, Gond and Kohl etc. Bagheli language is spoken mainly in Rewa district. The district has a strong establishment of brahmin community all in terms of socially, economically and politically advancements.

The border area of Rewa district in Uttar Pradesh has been fraught with criminal incidents where incidents of kidnapping, dacoity and theft have been in abundance, though the incidents of kidnapping and dacoity have decreased significantly in the last few years, despite the incidents of theft, etc., which are still seen in some areas and has created the fear.

2. Status of Women

The status of women in Rewa district is more or less the same in all communities where, women face many social bondages and possess no rights to lead an equal life as their male counterparts. Comparatively, women have more freedom and equal status in the society which is seen lacking in the tribal communities residing in Rewa. In some cases, exceptions are visible like there is no discrimination on the birth of male or female child however the later will then be suppressed in holding the similar rights as the boys or males in terms of social, educational and other opportunities.

No choices of freedom are given for marriages also, women's decision is suppressed if the family agrees. In both tribal and non-tribal communities, the status of women is not fair in terms of the rights and privileges. The conditions are seemingly underprivileged especially due to poverty.

Inequality is also seen on the Household's work sharing. The burden is mostly on women's shoulder. Apart from household chores women have to fix outside works including rearing, farming, going on wages, etc. They have to work during pregnancy till the childbirth. They are not supposed to rest for longer and have to go for their wages soon after 40 days are over. In most of the cases, they take rest as low as lesser than a week. Women's participation in family decisions is restricted to their suggestions only whereas the decision makers are mostly males. They though however are free to decide their nature of job and moving out of the house but are interfered by their husbands or other male members of the families. Socially also, women are not allowed to participate in the community decision not even in attending the Panchayats. Female representatives elected as PRIs are also considered of lower opinion in decision making power.

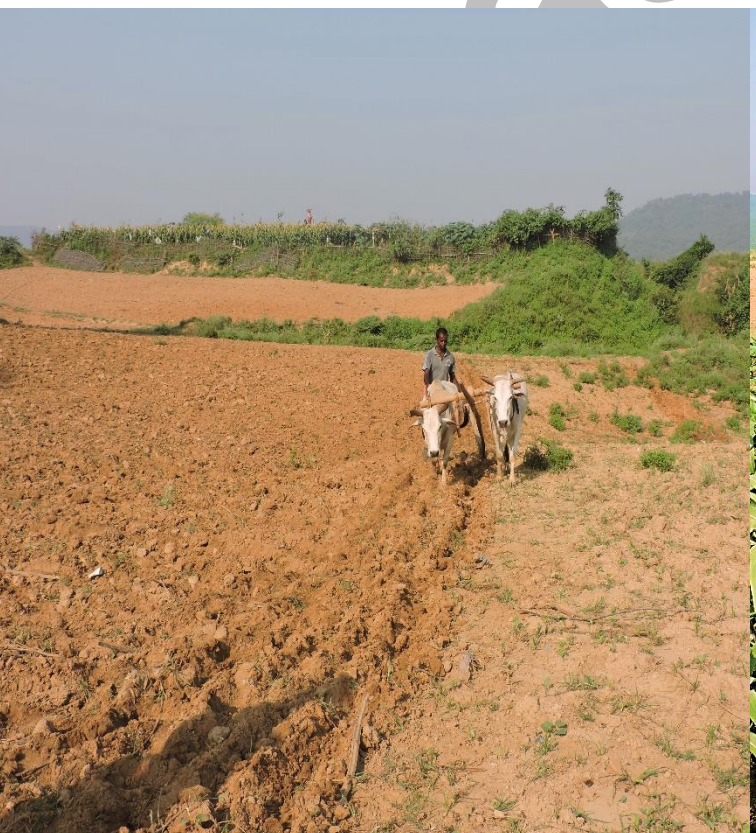
2.4.1.3. Quantity/quality of actual resources – Human, Economic Organizational – And ways to control them

1. **Status of Resources of Communities residing in Rewa**

The district primarily inhabited by Kol tribe that has its own lifestyle and cultural demarcation. This culture not only affects their socio-economic system but also forms a basis for food security, but now the community has been struggling to thrive through. The jungle-based community is striving through economic crisis. Their lives are affected largely because of the changing habitat and climatic conditions. The only source of water is river and smaller ponds around due to rainfall water loss because of sloppy terrains, which otherwise had been responsible for flourishing their cultural and socio-economic circumstances which is largely impressed.

2. **Status of Economy and Agriculture**

In the absence of geographical compatibility in these areas, the economy is influenced by political factors. The majority of the district is of uneven land and low thick soil, which has afflicted the agriculture and livelihood and thus primarily affecting the food security largely and has pivotal role in determining the social and economic system. Clearly, the physical structure and the climate have played the major role in the arbitrating the livelihood, lifestyle and health conditions that directly and indirectly affect the well-being of the community and individual.



The compatibility and adversity of the same structure has transformed the entire economy of the region. There is market pressure in this changing economy and the certainty of food security is getting disrupted. The agriculture methods suited this structure has been rattled and are no longer effective in supporting the food security. Lack of employment opportunities and inefficiency of MGNREGA Scheme has cause the double burden on the system. The job cards do not ensure the guarantee for the services rendered under MGNREGA. In many villages, people were not even given the 50 days of work or wages for the same.

3. Infrastructure and other development conditions

Some basic means of development have been reached out to remote areas in some villages from the district but are not fully functional for promoting livelihood and resources supporting food security of the people, like irrigation facilities, self-employment schemes for the people, water prevention and orchards under MGNREGA etc. Although approaching roads have been constructed in many areas, there are still no roads or means of transport available in the hilly terrains.

Transport plays a crucial role in case of emergency of child birth or serious medical condition either of pregnant, lactating mothers or new born and other community members. Delay of facility are seen fatal, most of the time.

2.4.1.4. Knowledge and Aptitudes

1. Lack of awareness among the beneficiaries and community members have been the issue largely.
2. Untouchability is still seen as common practices in some of the communities.
3. Lack of sanitation causing spread of infectious diseases

Thus, to sum up, issues including Landlessness, Food security, Migration, Issues of Violence against women, feudalism, gender, caste, employment and livelihood, corruption as seen in Schemes like ICDS, PDS, MNREGA, lack of empowerment – lack of leadership and awareness, caste discrimination, political movements, migration etc are altogether play a crucial role in determining the health and nutritional status of women and children.

2.4.2. Underlying Causes:

Resulting from the changing social, climatic and atmospheric structure, their livelihood and economy is now confined to farming and agriculture sources only. Their agriculture methods are traditional and limited to few, which are barely enough to meet their food needs as they are provided with limited irrigated lands whereas smaller farmers are unable to meet the required monthly food demands and thus opt for migrating out. Crops which are grown are however are only grounded to paddy, maize, jowar etc. on the non-irrigated lands whereas wheat, peas, lentils, chana etc. are also grown on irrigated lands.

A study was conducted by Vikas Samvad in September-November 2019 to document the local/traditional food and nutrition system of community within their rural settings in respect to their socio-cultural system covering 500 sample size in 10 villages of 5 districts including Niwari, Satna, Panna, Umaria and **Rewa.**

The study concludes the conditions of Food security, Health Services, Maternal and Child care, Inadequate dietary intake in Rewa.

2.4.2.1. Household Food Security

Four elements build the framework of food and nutrition security: availability, access, use and utilization, and stability. harvesting is done in four major food groups including cereals and grains, pulses and legumes, millets, roots and tubers, GLVs to certain extent through kitchen garden or conventional farming practices.

1. **Food Availability**

The total household consumption that comes from purchase is 123.7 kilograms of food including all the food groups like cereals, millets, vegetables, milk and milk products, pulses legumes etc. against the total quantity that is consumed from the production of about 75.8 kilograms and that from collection is 54 kilograms in winter making the total consumption of 253.5 kgs per household per month.

2. **Food Access**

Rewa comes second, where 48 items are harvested, 83 are purchased and 39 are collected.

3. **Food Distribution**

- Similarly, plenitudes of factors responsible for Household food distribution that includes, wealth, food security, occupation, land ownership, household size, religion/ ethnicity / caste, education, and nutrition knowledge.
- On an average household size of 4.9, the potion of a plate for a household, on full meal day basis, comes 10% from cereals; 6% from vegetables; 8% from millets; 5% from fish 4% from tubers and 3% each from eggs, poultry and meat, NTFPs, shrubs, weeds and fruits.
- Cereals including rice and wheat along with green leafy vegetables and millets (regions wherever available) are consumed on daily basis, whereas roots and tubers, herbs, green leafy vegetables and seasonal vegetables are consumed thrice a week. Potato remains exception in all the regions and is consumed 4-6 times in a week. However all the non-vegetarian consumes are eaten once a week provided the availability and budget.

4. **Food Consumption**

- The monthly consumption of all the food groups is accounted to 225 Kilograms, in which major chunk of 23% is contributed by cereals of about 53 kgs; 21 kgs each are contributed from roots and tubers and other vegetables (9%); 13% is made from Pulses for those who have been growing this crop for others landless farmers it is almost negligible; 10% is contributed by GLVs and 8% each is contributed by millet and oils.. Fish meat, poultry are once in a while products and are consumed as low as 2-3 % however comparatively eggs are consumed for about 7%. Sugar and fruits are lesser contributors to the HH consumption for about 2% only
- The total quantity consumed in a day is computed as 1.5 kgs provided all the food groups on a plate wherein, the total cereal consumption of a day is computed as 358 grams and GLVs, root and tubers and other vegetables as 142 grams others are consumed as lesser a 50 grams. Except for pulses, which on a normal healthy pulse day is consumable upto 193 grams.
- The total cost for consuming 1.5 kgs of food on a healthy day, the cost is computed as 89 rupees and 70 paisa only for a whole day diet, whereas on a monthly basis,
  the total cost incurred by an individual is 2690 INR.

2.4.2.2. Health Services Access/ Healthy Environment

1. **Visit to Anganwadi Centers**

- Study has demonstrated that fairly low percentage (64%) of PLA visits Anganwadi centers in Rewa

2. **Institutional Delivery Status**

- Study interprets, of 100 samples (50 infants and 50 children participated in the study), 92% had institutional deliveries. Amongst the districts, Rewa recorded lowest institutional delivery rates compared to other districts with 80%.

2.4.2.3. Maternal/ Child Care

1. **IFA Status**

- Status of IFA consumption is seen limited to 74% amongst total PLA group. IFA tablets are consumed only by 28% of pregnant and lactating mothers and 16% of adolescent girls.
- 26% of the total population surveyed does not consume IFA at all, those who have been consuming are consuming as per their choices and not because of roper dosage they are advised to.

2. **Meal and Rest Pattern amongst**

- It is evident that half of the population consumes meals only twice a day out of which 72% are pregnant and lactating and 28% are adolescent. Amongst the districts, the maximum percentage recorded for Satna and Panna of about 44% each of their total population who consume food only twice or thrice a week.
- About 41% of the population consume food around 4-5 times amongst which, 84% of pregnant and lactating women and 16% of adolescent are consuming 4-5 times meal a day. A very few percentages of about 8% are consuming means more than 6 times.
- In totality, of all pregnant women 54% are consuming 2-3 times a day against 4% those are consuming more than 5 meals a day. This same trend is seen for lactating mothers also. However, the number of lactating mothers those are consuming more than 5 meals are more (8 out of 50) i.e. 16% of total population.
- Adolescent girls on the other hand are consuming more than 5 meals a day (52%) against 4 % those who have been consuming more than 5 meals

3. **Infant Young Child Nutrition**

- It avows that only 48% of infant and children were breastfed within an hour (Early initiation of breastfeeding). Contrary to which 19% were breastfed between 1-2 hours against 33% of infant and children who were breastfed after 4-5 hours. Rewa reported 50% of breastfeeding more than MP 34.6%
- Rewa reported to have the second highest colostrum feeding in the sampled household with 85%
- Exclusive breastfeeding is attained by only 50% lower than that of entire state (54%)
- Complimentary feeding is attained by 45% which is more than MP (35%)

2.4.3. Immediate Causes

2.4.3.1. Inadequate Dietary Intake

- Study suggested that 70% of total families have been providing the solid foods only where as 52% are providing the semi-solid food in the forms of fruits and vegetables and 68% are giving only liquids in the forms of pulses.
- Except for cereals, all other food groups are consumed by the children lower by 20-30% than Recommended Dietary Allowance

- On an average a child consumes 7-8 biscuit a day provided from any local or popular brand including parle-g, Monaco, goodday, 50-50. This counts to about 40-45 grams a day.
- Similarly, Kurkure or other processed packets are consumed largely by the children on an average about 40-50 grams where 1 packet is 30 grams that means 1.5 packet a day. In Rewa, 30-40 grams a day is consumed on an average
- Similarly, the cereals and grains consumption are average out for pregnant women to 370 grams, the lowest trend was recorded for Rewa.

2.4.3.2. Diseases

In most of the samples recorded under Pregnant, Lactating and Adolescent girls, about 40-60% are reported to have been deficient in Protien, energy, Vitamin A and other micronutrient important for the growth and survival.

Thereby causing the following consequence on the community or individual (especially those who belong to vulnerable section)

1. **Short-Term Consequences:**

Mortality, morbidity, disability

2. **Long-term consequence:**

Adult height, cognitive ability, economic productivity, reproductive performance, metabolic and cardiovascular diseases

3. **Intergenerational Consequences**

This has long run consequence on the community where malnutrition penetrates deep down to the generation causing the stunting and reduced height over long duration primarily unnoticeable

3. APPROACH

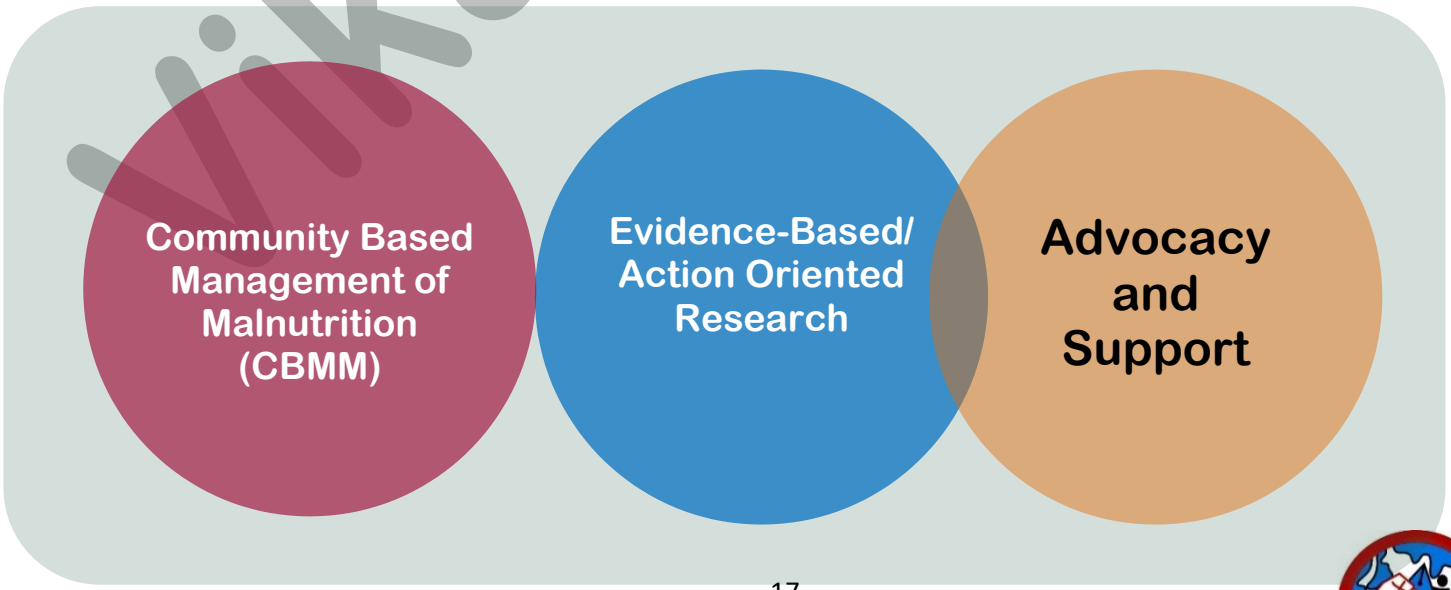
3.1. ABOUT ORGANIZATION – VIKAS SAMVAD

With the strategic idea to capacitate the CSOs and the Media Personnel in light of facts, evidences and developing a sense of empathy, the foundation of Vikas Samvad Samiti was laid to render a platform for the Civil Society Organizations (CSOs) as well as the Media Personnel to work on core issues of the society with a political-economic lens while generating facts, data and evidences to be taken forward in a concerted manner. VSS has established itself as a research, documentation, capacity building and support organization to bring together the socially sensitive individuals, communicators and organized groups with a child-centric perspective. It also works for building the capacities of voluntary organizations to work in a research-based mode.

Vikas Samvad works as a rights-based research, capacity building and advocacy organization. Primarily, it focuses on advocacy and capacity building of a wide network of organizations engaged on thematic issues, including inter alia, child rights (especially nutrition, health, protection and inclusion), with a special focus on food security, poverty and empowerment of women and children. It also has been playing the supportive roles for various people's organizations by endowing them with the requisite advocacy support and building their capacities on process documentation, publication, planning and coordination while also taking forward their constructive advocacy actions. Since the Year 2015, VSS has set itself up as the implementation organization and thereof successfully implementing programs on food and nutrition security. Currently, VSS is identified as a Resource Organization on the issues of Child Rights and Food-Nutrition Security.

3.2. Our roles across the community care continuum

Food insecurity and malnutrition are multidimensional in nature and require a multi-sectorial approach. While immediate factors such as inadequate food intake, inappropriate feeding practices, disease prevalence can be tackled through various public-sector interventions, the underlying factors need a much more holistic approach and broad set of interventions.



The underlying factors that affect food and nutrition security of the community are (i) incomes and livelihoods, (ii) social inequality (iii) status of health infrastructure and agricultural practices (iv) performance of social safety net schemes and are needed to be tackled. Vikas Samvad thus establishes in planning, implementation and developing monitoring framework to achieve the comprehensive and food security approach through community-led intervention.

3.3. Nutrition-specific interventions

- The Lancet series identified 10 high-impact, nutrition-specific interventions that, if taken as a package to 90 percent coverage, could reduce wasting by 60 percent and stunting by 20 percent. These 10 interventions are shown in Figure 2

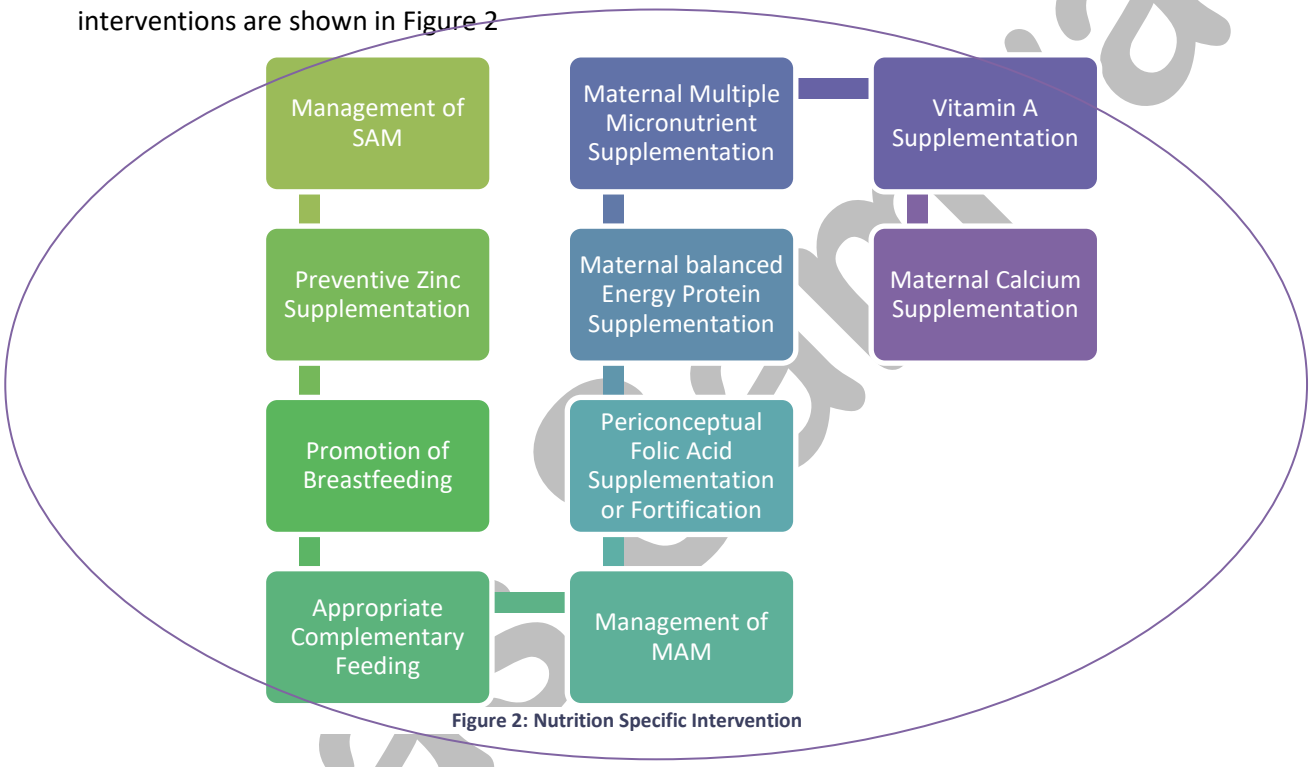


Figure 2: Nutrition Specific Intervention

- If improved access is linked to nutrition-sensitive approaches—i.e., women's empowerment, agriculture, food systems, education, employment, social protection, and safety nets—they can greatly accelerate progress in countries with the highest burden of maternal and child undernutrition and mortality.
- Iron and calcium deficiencies contribute substantially to maternal deaths.
- Maternal iron deficiency is associated with babies with low weight (<2500 g) at birth.
- Maternal and child undernutrition, and unstimulating household environments, contribute to deficits in children's development and health and productivity in adulthood.
- Fetal growth restriction is associated with maternal short stature and underweight and causes 12% of child deaths.
- Suboptimum breastfeeding results in more than 800 000 child deaths annually.
- Undernutrition during pregnancy, affecting fetal growth, and the first 2 years of life is a major determinant of both stunting of linear growth and subsequent obesity and non-communicable diseases in adulthood.

3.4. Approach Adopted/Needed

3.4.1. Components of CBMM

The CBMM approach is comprised of five components:

CBMM Approach may involve:

- Community-based health workers screen children for acute malnutrition using mid-upper arm circumference tapes and refer those identified with SAM or MAM to the nearest health centre.
- If a child is identified as acutely malnourished, the caretaker takes the child to the health centre where the health worker conducts further screening and diagnosis according to the established protocol. The health worker takes anthropometric measurements and checks for nutritional edema, appetite, and other medical complications. At the health centre, the staff also screens other children that have come for paediatric visits.
- If the child has SAM and medical complications or no appetite, the child is admitted to inpatient treatment using therapeutic milks until the complications have stabilized and the child can be transitioned to outpatient care.
- If the child has SAM, no medical complications, and an appetite, the child is treated on an outpatient basis with RUTF.
- If the child has MAM, the child might receive a specialized food product, such as ready-to-use supplementary food (RUSF) or fortified blended food (FBF).
- Once home, the child receives visits from the community-based health worker to check on his/her status and receive counselling, education, and possibly referrals to complementary programs. The child stays in the program until he/she reaches exit criteria, though defaulting (not completing the full course of treatment) is a challenge that most programs face.

Acute Malnutrition

According to the Technical Guidance Brief on Community-Based Management of Acute Malnutrition (last updated on January 28, 2016) of the USAID under its Multi-Sectoral Nutrition Strategy (2014-2025), worldwide in year 2016, amongst children under 5, 156 million children and 50 million children suffered from stunting1 and wasting1 respectively. The phenomenon has severe implications: a child with Severe Acute Malnutrition (SAM) is 11.6 times more likely to die, and a child with Moderate Acute Malnutrition (MAM) is 3 times more likely to die than a well-nourished1 child. Acute Malnutrition is characterized by rapid weight loss and/or nutritional edema1 caused by illness and/or inadequate food intake, such as a sudden change in the quality and/or quantity of food or poor infant feeding practices.

3.4.2. Elements of Quality Programming

- The community component should be strong enough to mobilize, screen, refer, and follow up cases, in addition to providing nutrition education and counseling and other activities aimed at managing and preventing malnutrition.
- To utilize services, people need to have physical access to the health centers, be motivated enough to go to the first visit, continue to go to subsequent visits, and follow the regimen at home until the person has been discharged and, ideally, referred to complementary programs such as those that address the conditions that led to malnutrition.
- Programming should also be sensitive to gender, ensuring that roles and responsibilities for managing and preventing malnutrition are encouraged equally for girls and boys.

3.4.3. Multi-sectoral Linkages with CBMM

Linking CBMM with complementary services and programs – such as those promoting maternal, infant, and young child nutrition; micronutrient supplementation; water, sanitation, and hygiene (WASH); early childhood development (ECD); and livelihoods, agriculture, and food security – have the potential to expand coverage and effectiveness.

Children attending growth monitoring and promotion services, for example, may be screened and referred for acute malnutrition. Community-based workers and mobilizers may be trained to support recommended infant and young child feeding (IYCF) practices with caregivers at key contact points; and IYCF counsellors may be trained to screen, refer, and follow up children with acute malnutrition. Caretakers of malnourished children may also be referred to social safety net programs aimed at improving the household's livelihood and food security status.

3.4.3.1. Entitlements

It is to be mentioned that Government of India has enacted National Food Security Act (NFSA-2013), which aims to provide subsidized food grain for 67% population of the country under Targeted Public Distribution System. It also includes Integrated Child Development Services (Supplementary Nutrition, Immunization, Growth Monitoring, Referral Services, Health and Nutrition Education and Pre-School Education), Mid-Day Meals (food in schools) and Maternity Entitlements. The NFSA-2013 makes provisions for grievance redressal, transparency, social audit and community participation; but as per field experiences these provisions are not implemented at the grass roots. In our program, we intend to inform, aware, empower and organize community to ensure proper implementation of this Act. We also intend to invest our energy on the proper implementation of the Mahatma Gandhi National Rural Employment Guarantee Scheme and the Forest Rights Act.

4. PURPOSE OF CBMM PROGRAM

Working towards the new goals on development agenda in 2015, new targets have been set out in terms of SDGs (Sustainable Development Goals). The proposed targets of SDG 3 focus on improving the health of millions of people suffering any form of morbidity, increasing life expectancy, reducing maternal and child mortality and reducing the prevalence of communicable diseases. However, the world is stalling back in terms of achieving the goals for many reasons those have been occurring lately including the child mortality, infant and neo-natal mortality for instances.

4.1. AIM/GOAL

Create a Malnutrition free environment with Community Based convergence framework, where every woman, man and, child live a healthy life free from hunger and poverty (REF: SDG – Agenda 2030).

Recognizing that working together puts collaborative in the best position to improve child care, CBMM practices, outcomes and pathways, by improvising the services settings. There is no "one size fits all" approach – instead, promoting flexible approaches to meet the communities' specific needs are the only way out.

Driven by community needs, collectively this Community- Based Intervention aims to:

1. Contribute in achieving food and nutritional security and end malnutrition plus hunger in the district Rewa, Madhya Pradesh in India (SDG-2) by strengthening Community Nutrition Education, Community Leadership and Community Monitoring, and developing a model framework for Community Based Management of Malnutrition (CBMM).
2. Ensure developing an evidence-based framework for monitoring SDG-II at the community/state and national level is established and promotion of sustainable community-based management of malnutrition
3. Develop an operational framework for Community Based Management of Under-nutrition.
4. Strengthen the capacities of village level institutions in 25 villages to monitor and assess the government food security programmes.
5. 2000 children, 1000 adolescent Girls and 500 pregnant/lactating mothers in 25 target villages have improved access to government health, nutrition and maternal care services.
6. 3600 households in 25 villages of Rewa are prepared to produce diverse and sufficient food so as to overcome any dependency on the external food supply.

4.2. UTILITY

4.2.1. Functionality

It has been observed that the currently prevailing approaches and strategies are devoid of policy imperatives and program protocols on Community Based Management of Malnutrition (CBMM). The government programmes are already in place with huge investment both on financial and human resource part which is somehow not able to reach out to the beneficiaries at par. Thus, Vikas Samvad believes that there is a dire need to work on the significant areas of socio-economic sustainability thus covering agriculture, kitchen, gardens, employment, traditional practices, water and forests etc. Besides, the various departments should work in accordance and collaboration to establish the accountability and transparency in the system while maintaining the gender inequality and caste discrimination.

Focal points: The causal framework describing the structural, underlying and immediate causes for malnutrition should be the central driving force in bringing the community-led model to control the basic causes ranging from human, economic, natural resources, gender, inequality, political, cultural and social systems, to underlying causes household food securities, health services and maternal and child care and immediate causes including inadequate food and diseases. **Thus, Vikas Samvad proposes the following focal points to establish CBMM Model –**

- Establishing connection between community women and youth to develop their leadership quality and thus promoting the decision-making power amongst them.
- Severely Acute Malnourished Children with no complexities to be cured at the community level while also ensuring that normal or Moderate Acute Malnourished children should not fall in the category of SAM anymore.
- Promoting proper nutrition in the children thus preventing malnutrition and anemia.
- Ensuring the participation of food security and developing nutrition resources within the community
- Strengthening the units of local governance for establishing the monitoring and social audit by the community on the health, nutrition and related issues.

4.2.2. Utilization

It is also thus important to understand whether the services provided to the community and beneficiaries are in place and utilized for the development of the individual in terms of its growth and health. For Instance:

4.2.2.1. PMMVY Financial Inclusion

In the study conducted by Vikas Samvad in the month of September on PMMVY beneficiaries , it is interpreted that maximum amount is utilized either by husband or other family members or being spent in buying provisions for about 20 percent in most of the cases[4]. About 12 percent is consumed either in medication or buying jewelry or is utilized in other household usages. A fairly low percent is saved and spent on clothing for about 10 percent and 6 percent respectively. Shockingly a very minimal amount is spent by the women on her nutritious what it is meant for.

4.2.2.2. Open Defecation Free Status

As per the CFTRM study conducted by Vikas Samvad in September 2019, only 3% of households have toilets, those can be flushed to septic tanks and 5% of those can be flushed to pit toilets. Functionality of these toilets is altogether a different issue. The toilets are basically used for keeping hay and fodder for cattle stock or used for something else but not for the very purpose, this should serve.

Only 5% of the total households, having toilets, i.e. 47 households, use toilets for defecation AAs seen in the villages, the toilet constructed for the purpose. The open defecation free status as shown in figure 7.3 clearly states that only 23% of the total households have attained ODF status.

4.2.2.3. Take Home Ration

The study conducted by Vikas Samvad during Covid -19 Outbreak to determine the status of Health and Nutrition of women and children during April and May 2020, estimated that THR received by the women is averaged out to 2000 g for three weeks which 2500 g lesser than the recommended allowance i.e. 4500 g. Also, per day THR grains intake is computed as 19 g which is only 8 percent of recommended value of 250 g a day. However, though the THR packets are meant for pregnant women or the lactating mothers, it is observed that the THR grains are consumed by all the family members in one or two meals. This is a general practice obtaining in the community. The practice is a pointer to an already a pitiable situation in the community with regard to the inadequacy of availability of food grains to the poor and vulnerable families. Consequently, the actual intake of dietary allowance for the pregnant woman is further cut down to 19 g for pregnant woman [(with an average family size of 5.4), which is just the 8 percent of the recommended THR Allowance i.e. 250 g a day]. This severely impacts her own nutritional wellbeing apart from that of the fetus.

Therefore, it is evident that utilization of the benefits provided to the community should be taken care with utmost priority also and thus it should be included in the intervention

4.2.3. Monitoring

After ensuring the proper utilization of the services, it is important to bring it down to the community to establish the transparency in the system and also making them aware and strengthen on the monitoring part. Thus establishing Community Monitoring followed by Social Audit so that –

1. Strengthening transparency in the Schemes
2. Building Accountability
3. Focusing on grievance redressal mechanism
4. Development of legitimacy and credibility of the schemes and cut down corruption in the TPDS.

5. INTERVENTION

5.1. Strategies Adopted by VSS

Components	Strategies
PLA	• Facilitating in conducting PLA (Participatory Learning and Action) with women, youth and members of standing committee on nutrition, food security, governance and entrepreneurial components
Developing /improvising local resources for Nutrition	• Intervention for security and stability of the Ecology and Environment, Forests, Kitchen Garden, Fisheries, poultry, horticulture etc • Establishing kitchen gardens and connecting community • Generating awareness towards the local and available source of nutrition. • Awareness has been brought about in 3289 households for use of un-promoted food
Taking corrective measures for bringing positive change in community behavior (positivity, equality, gender, race etc.)	• Promoting right to play • Mapping of local food • Practice of equal food behavior through PLA and community surveillance • Strengthening the system and community on IYCN, Family Health Management, Management of Severe Acute Malnutrition, Adolescent Health through Participatory Learning and Action
Organizing / training / Mobilizing the women and youth groups	• Continuous orientation of community with focus on developing leadership amongst women, youth and children • Participatory activities based on nutrition, food security, governance and entrepreneurial components
Social Audit and Community Monitoring	• Establishing the community empowerment and participation • Developing community monitoring on social behavior, traditional behavior and state-provided services - particularly Anganwadi services, Mid-Day Meal, maternity benefits, maternal and child health services and Public Distribution System
Water security for Nutrition and Health Protection	• Reviving/ reinstating/ repairing water structures • Ensuring better accessibility to drinking water
Intervention for improvising ecological system /resources	• Seed ball activities with children for plantation • Collection and conservation of indigenous seeds • Interaction for relationships between health and ecology. • Documentation, mapping and promotion of local sources and resources for nutrition
Early detection of diseases and severe malnutrition	• Creating awareness in the community regarding the various services on the facilities and care, symptoms and systems of malnutrition etc.

VIKAS SAMVAD

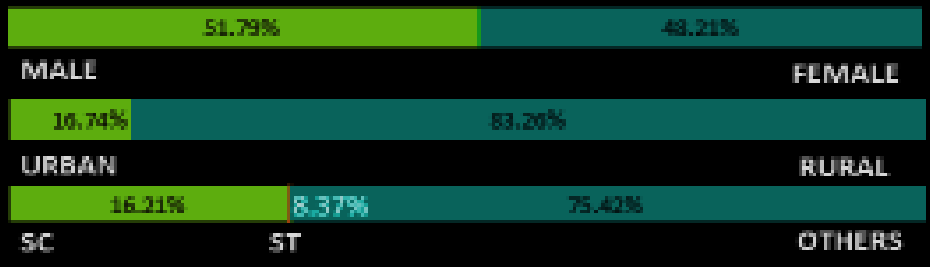
DISTRICT NUTRITION PROFILE

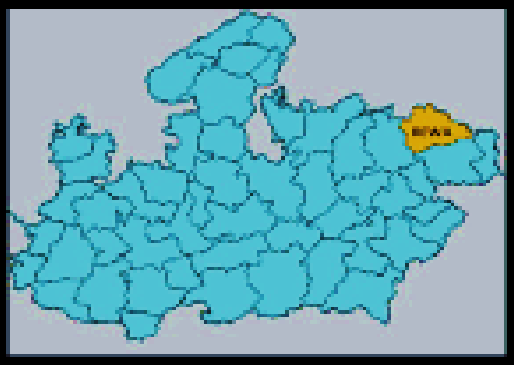
NUTRITION SERIES

Rewa, Madhya Pradesh

DISTRICT DEMOGRAPHY

Total Population 2365106





Rewa ranks 527 in India
(District Development Index)

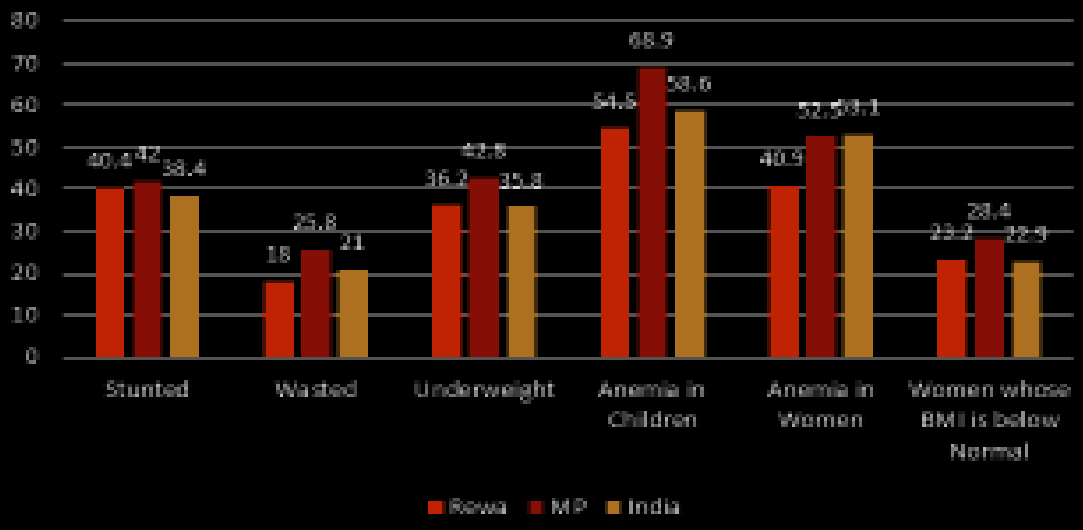
THE STATE OF NUTRITION IN REWA

40.4% CHILDREN STUNTED[1]

18% CHILDREN WASTED[1]

36.2% CHILDREN UNDERWEIGHT[11]

NUTRITIONAL STATUS



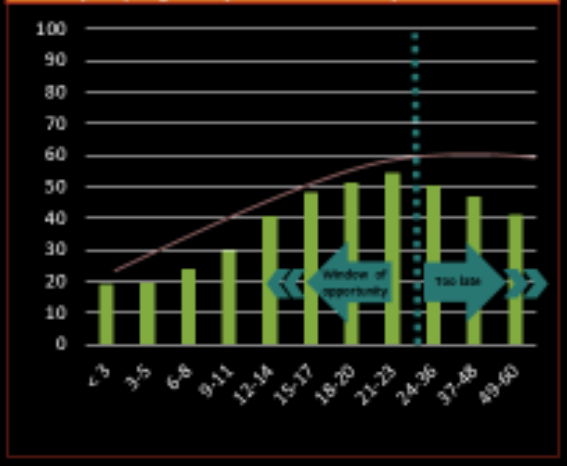
CHANGES OVER TIME

THE PREVALENCE OF UNDERWEIGHT HAS **DECREASED** IN THE STATE BETWEEN 2006

	Madhya Pradesh (Children aged <5 years)		Rewa (Children aged < 5 years)	
	2005-06 (NFHS-3)	2015-16 (NFHS-4)	2005-06 (NFHS-3)	2015-16 (NFHS-4)
Stunting	50%	42%	No data	40.4%
Wasting	35%	25.8%	No data	18%

HOW CAN NUTRITION IMPROVE?

The most crucial period for child nutrition is from pre-pregnancy to the second year of life[2]



WHAT FACTORS CAUSE UNDERNUTRITION?[6]

Optimum fetal and child nutrition and development

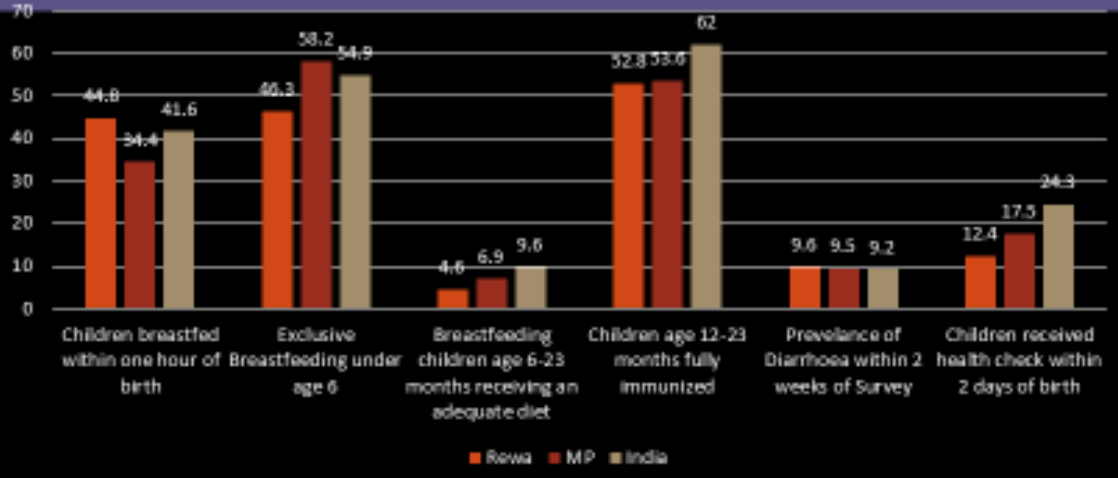
IMMEDIATE CAUSES
Breastfeeding, nutrient rich foods, and eating routine
Feeding and caregiving practices, parenting stimulation
Low burden of infectious diseases

UNDERLYING CAUSES
Food security: availability, economic access and use of food
Feeding and caregiving resources (maternal, household and community level)
Access to and use of health services, a safe and hygienic environment

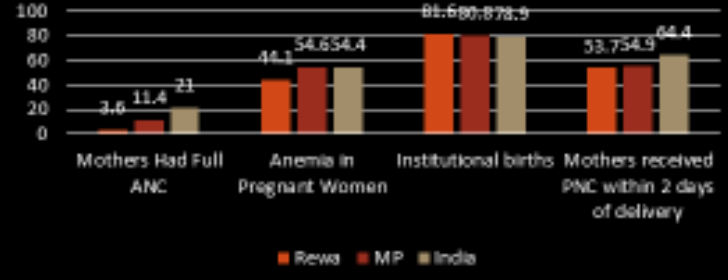
STRUCTURAL CAUSES
Knowledge and evidence
Politics and governance
Leadership, capacity and financial resources
Social, economic, political, and environmental context (national and global)

Child undernutrition is caused by inadequacies in **food**, **health** and **care** for infants and young children, especially in the first two years of life ***(immediate causes)***. Inadequate food, health and care arise from food insecurity, unsanitary living conditions, low status of women, and poor health care ***(underlying causes)***. These are, in turn, caused by social inequity, economic challenges, poor political will and leadership to address these causes ***(basic causes)***. Interventions to address undernutrition must address these multiple causes of undernutrition and do so in an equitable manner.

IMMEDIATE CAUSES OF UNDERNUTRITION



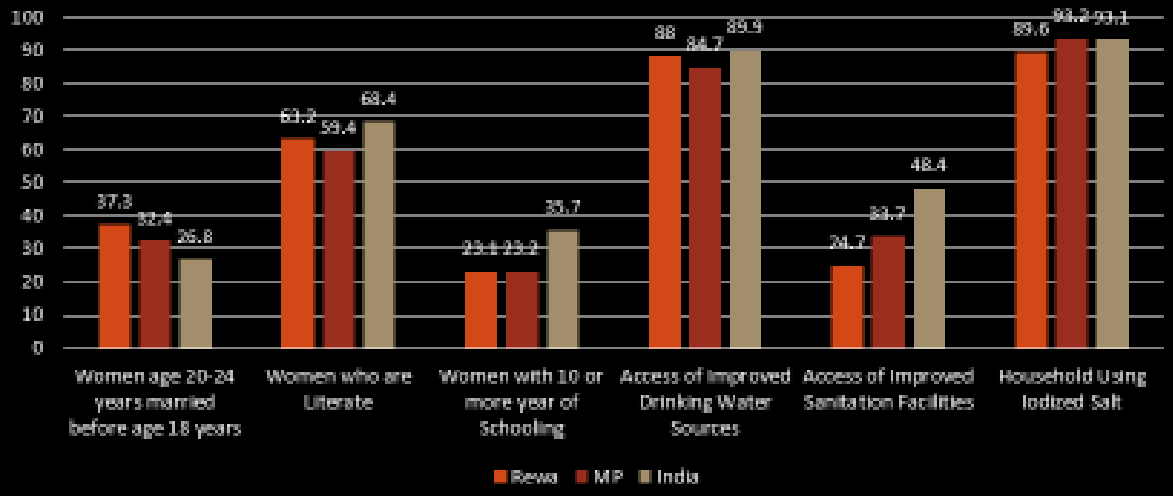
MATERNAL HEALTH



Areas for action:

- Exclusive Breastfeeding up to 6 months
- Semi-Solid after 6 months
- Full Coverage of Immunization
- Essential Health Checkup for Children
- Breastfeeding with in one hour of birth

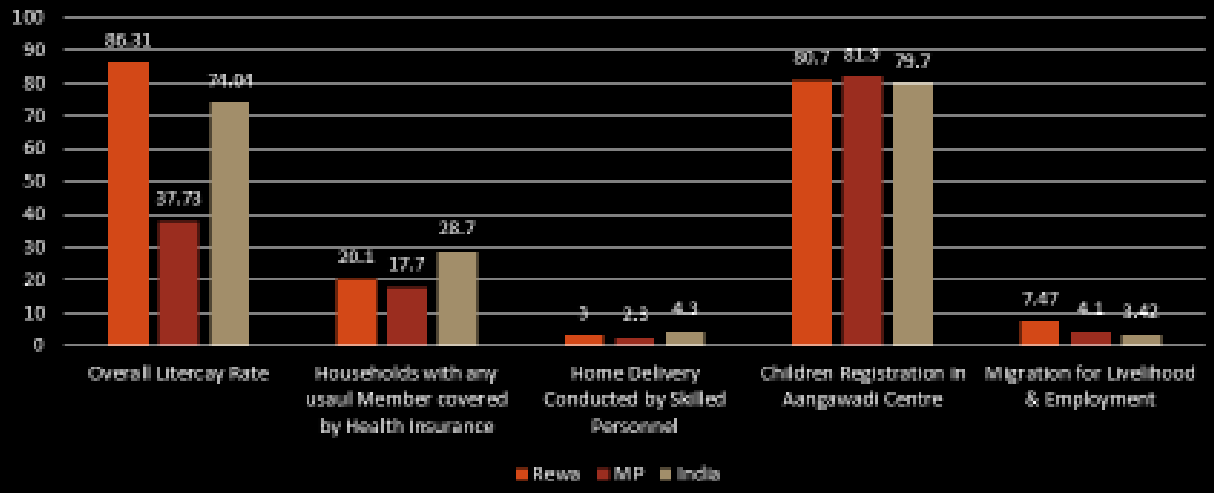
UNDERLYING CAUSES OF UNDERNUTRITION



Areas for immediate action:

- Focus to reduce Girl Child Marriage
- Promoting Community Women Literacy
- Proper Drinking Water arrangements in the Community
- Ensure the proper use of Toilets or any Sanitation Facility

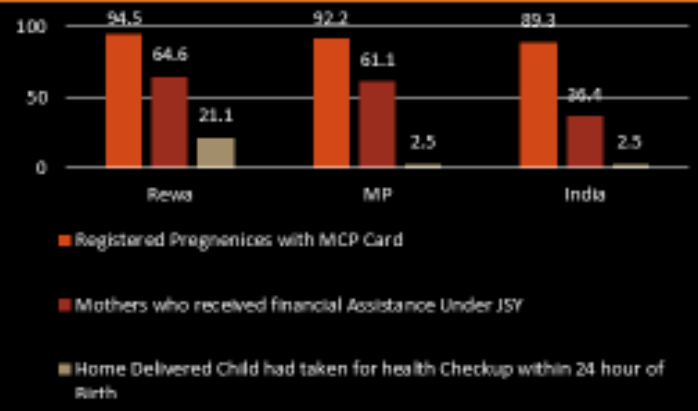
STRUCTURAL CAUSES OF UNDERNUTRITION



Areas for immediate action:

- Strengthening School Education System in Community
- Enabling & Ensuring Health Insurance by Government
- Institutional Delivery Facility needs to be Improved
- Access to all service delivery can be Improved
- Employment Availability at Local Level

EVALUATION OF HEALTH AND NUTRITION SCHEMES



Areas for immediate action:

- MCP Card needs to be Functional
- Janani Suraksha Yojna (JSY) has 3 Delay level which needs to be addressed & improved
- After delivery at home, the newborn should have health checkup at health center.

STATUS OF SICK NEW BORN CARE UNIT AND INFANT DEATHS

Year 2019-20	Infant Deaths	SNCU Admissions	SNCU Deaths	Death Percentage
Rewa	501	585	23	4
MP	31586	99475	12123	12
India	226754	1243578	83372	7

- A total of 501 infants died in Rewa in the year 2019-20 whereas 31586 infants died in Madhya Pradesh during same period
- A total of 585 SNCU Admissions took place in Rewa during 2019-20 in Which 4 percent death indicates the bad service delivery of SNCU in Rewa
- Similarly in Madhya Pradesh & India the Death percentage were 12 & 7.

Data sources

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2. Rewa ranks in India – District Development Index A report by US-IndiaPolicy Institute accessed at 01.01.2020
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12. SNCU & Infant Deaths- HMIS, Health Department Government of India.

This Detailed District Profile is developed by Farhat Nasheen, Vikas Samvad
The Statistical Profile is developed by Arvind Mishra, Vikas Samvad.

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