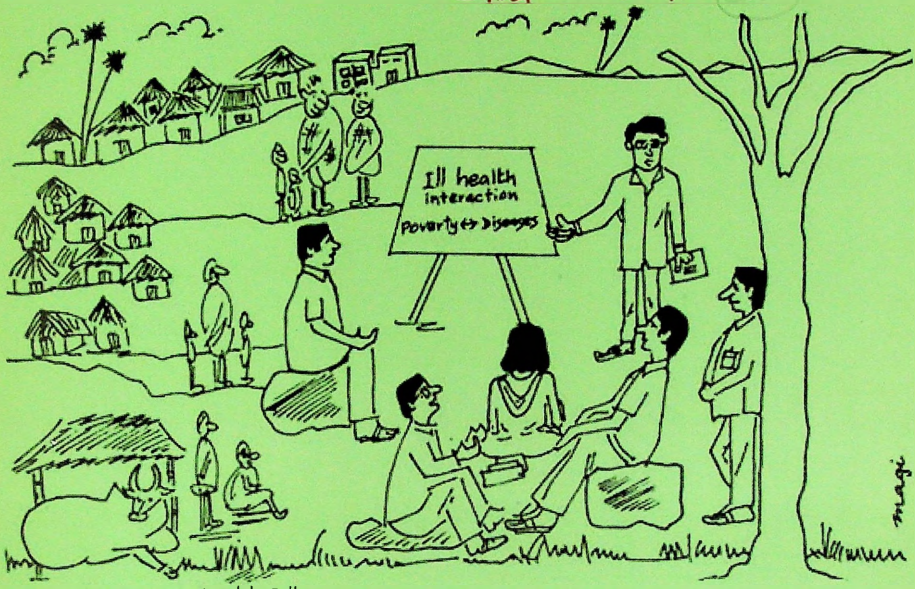
Community Health Learning Programme 2009



Source: Community Health Cell

A Report on the Community Health Learning Experience

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COMMUNITY HEALTH CELL

Community Health Learning Programme
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"Understanding Community Health to improve Nutrition"

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1. Why did I join CHLP?

In India, child malnutrition is a serious problem with almost every second child is suffering from its life time impact on their health and development outcomes. Optimal infant feeding practices are critical for nutrition, health and survival of newborn and infant (with almost 20% reduction in Under-5 mortality). Thus, I assessed the infant feeding practices and mother-child health and nutritional status in rural areas of Rajasthan, for my Doctorate degree in Nutrition. I came to know that socio-economic and demographic factors are closely related with health and nutrition status of any community.

While working with Breastfeeding Promotion Network of India (BPNI), an NGO working on infant feeding issues in India, I got involved in advocacy, training and research on infant feeding issues and found that and there is international and national interest to optimize it. However, proper implementation of this intervention to enable women to do so is a challenge, as there seems a lack of commitment in the form of defined strategy, plan of action and budget. I realized that infant feeding still need to find its place in overall child and maternal health programmes. To understand broader maternal and child health issues, I joined Solution Exchange-Maternal and Child Health Community, a knowledge sharing platform for maternal and child health practitioners.

I started my CHLP fellowship, to deepen my understanding on community health and related issues, to find ways of improving nutrition situation of the communities.

2. My first learning on Community Health during Orientation

During, CHLP orientation reflection time gave enough opportunity for personal learning while laboratory and role-play made me part of the system and helped in realizing the situation. As I started learning the concept "Health as a Human Right," I found that it requires enough resources from the society to reach individual potential, in a dignified way. Here mere "Availability" of resources is not enough, "Accessibility" and "Capability" to utilize these resources are also important.

"Monsoon game" helped in understanding the Web of causation through social, economic, political and cultural (SEPC) analysis and the hard realities of farmers' life, the caste system, difficulties in loan repayment and other socio-economic factors affecting their life. We understood the abstractness of "Society," where it is a stratified group of people, who have power dynamics (intellectual, financial, natural and physical), determining use of resources (ownership, access and control).

For community work, remember "Chinese Proverb":

1. Go to the people
2. Live with them
3. Learn from Them
4. Plan with them
5. work with them
6. Start with what they know
7. Build on what they have
8. Teach by showing, learn by doing
9. Not a showcase, but a pattern
10. Not piecemeal, but integrated
11. Not odds & ends, but a system
12. Not to conform, but to transform
13. Not relief, but release

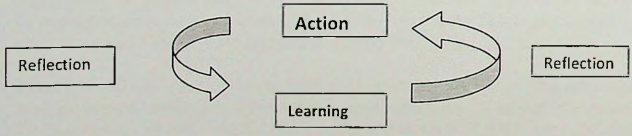
-Yen Tangchu

In the course of discovering how gender affects women's health, it was a realization that so many factors work simultaneously and every factor is interlinked. The factors identified include: Poverty, Last priority in terms of Health, Societal Control, Woman's own Empowerment, Within Family Discrimination, Religious & Cultural Factors, Restricted Mobility, Violence, Overwork, Stress etc. I also got to know that how various factors make women more susceptible for few diseases i.e. Sex/biology, gender norms and Values, activities, access to and control of resources and often policy and programmes seems gender blind /gender neutral.

I understood the concepts of 'equity' and 'equality' and "why equity is more important than equality while allocating resources in a community setting".

Feeling comfortable with negative emotions and using them to bring change by 'engaging' with the system and working towards "what we can do" rather than 'confrontation', was a revelation for me. The role play on "Alternative Paradigm in Community Health- a CHC perspective" helped in realizing how 'individual specific care' works on social model and recognizes patient as people (more humane) and enable them at every step to move from disease to health.

While reflecting back on my learning, many questions were coming to my mind on how to go forward and how to deal with the multidimensionality and complexity of health, here I found this phrase "Research and Learning is, when you ask a question and find another thousand questions in reply", really comforting. This helped me in engaging in "practice cycle," where action and learning was a continuous process of reflection.



I learnt that Community Health is a broader concept and to understand it one need to get deeply involved in the process and evolve his/her own understanding and way forward.

The session on globalization gave two concepts: 1) "Processes," like structural adjustment and privatization and 2) "Ideologies," like Neo-liberalization. Essentially it's a process of increasing interdependence by reducing boundaries, advocating self regulation by making prices free to market correction and increasing freedom to choose. But in real world, freedom to choose and full knowledge is not available with people, so it doesn't work. Role of GATT- General Agreement on Trade & Tariff (1947), WTO- World Trade Organization (1995), TRIPS- Trade Related Intellectual Property Rights (1995), Doha Round & Declaration; and pros and cons of process and product patenting, compulsory licensing, ever-greening of patenting, Exclusive Marketing Rights and profiteering, all helped me in understanding commercialization of Health care. I also came to know how "Targeted Intervention" approaches devoid many people from their basic rights. Besides, in the process of implementing targeted interventions NGOs become implementing agencies, devoting the energy into creating "Safety Nets" rather than working towards "Universal Access and Social Security".

The session on "Whatever happened to Health for All by 2000 AD?- The story from Alma Ata to the present time," explained how historically concept of primary health care came in and then forgotten with pressure of economic downturn, as health was seen as an expenditure (rather than investment) emphasizing Disability Adjusted Years (DALYS) and promoting vertical programme approach. Recognizing the need people's groups came together for People's Health Assembly and later formed People Health Movement (PHM). Worldwide also, there is a renewed commitment from WHO, with its World Health Report-2008 "Primary Health Care-Now more than ever." **People's Health Movement response to globalization made me realized the importance of challenging broader economic and political policies for ensuring equitable, ecological sustainable, non-violent, participatory and humane approach of development.**

The session on "National Rural Health Mission-A nation's effort to strengthening of health systems and improve people's health," highlighted some structural problems of health sector i.e. financing, infrastructure, manpower, logistics, management and evaluation, and lack of responsiveness to address equity. NRHM is envisaged to address these by community involvement in planning and monitoring, capacity building, flexible financing, human resource management and monitoring against agreed milestones. It addresses four major components of comprehensive care: water, food, sanitation and gender to cater universal health care. **Organizing self help groups and creating awareness of entitlements is one way to ensure community participation and enable them to take initiative. Here civil society's role is to facilitate this process to redress the field realities by working towards health of the health system.**

The 3-day field visit to Raichur, among one of the 5 districts having lowest score in terms of Human Development Index (HDI), made me realize that sensitivity to people's need and maintaining the human touch with all ideological constraints is important. Before starting work in any community there is a need to identify the roots of the people and build a community first. (See Annexure-1 for detailed experience of field visit)

I also realized that spirit of human potential has infinite energy and **capacity building is a two-way process, basically it's a mutual resource enhancement in any engagement.** The session on "Alternative System" was another paradigm shift, as AYUSH is not substandard in any way, just that mainstream (Allopathy- "ALLOS"-the other) has dominance in policy and budget. The "PANCH KOSHA" concept: Annamaya, pranamaya, manomaya, gyanmaya and ananadmaya"

was useful in understanding hierarchy in development i.e. physical, emotion, intellectual, social and spiritual. I learnt that process of building consensus should be such that it brings in the smallest voice, reaches nearer to the truth and consider alternatives. Finally as we all work at feeling level we should consciously work on PRO-ACTIVE part and control our RE-ACTIVE one.

3. How I built my learning objectives around my understanding of Community Health

Before joining CHLP, I was constantly challenged by this thought that government is running so many direct and indirect nutrition related programs, still the prevalence of malnutrition in India is amongst the highest in the world. Some of the direct and indirect nutrition interventions are given in Table-1:

Table-1 Nutrition Related Programmes in India

Direct Nutrition Interventions	Indirect Nutrition Interventions
Ministry of Women and Child Development- ⊡ Integrated Child Development Services(ICDS) Scheme. ⊡ Nutrition Programme for Adolescent Girls (NPAG)	**Food and Public Distribution** ⊡ Targeted Public Distribution System ⊡ Antodaya Anna Yojana ⊡ Annapurna Scheme
Ministry of Health and Family Welfare- ⊡ Iron & Folic Acid Supplementation of pregnant women ⊡ Vitamin A supplementation of children of 9-36 months age group. ⊡ National Iodine Deficiency Disorders Control Programme	**Rural and Urban Development** ⊡ Food for Work Programme ⊡ Poverty Alleviation Programmes ⊡ Safe Drinking Water and Sanitation ⊡ National Rural Employment Guarantee Scheme
Department of Elementary Education and Literacy- ⊡ Mid Day Meal for primary school children	**Ministry of Health & Family Welfare** ⊡ National Rural Health Mission ⊡ Integrated Management of Neonatal and Childhood Illnesses (IMNCI)
Department of Agriculture and Cooperation ⊡ Increased Food Production ⊡ Horticultural Interventions	

With my understanding of community health during orientation and realization of various socio-economic and political factors playing role at community level, I planned my learning objectives to analyse the status of implementation of various nutrition related programmes in a broader socio-economic and political framework. I framed my objectives to look at the challenges faced by service providers and experience of the community with these programmes in this broader framework.

Learning Objectives:

Broad Objective:
To understand how to improve nutrition status at community level

Specific Objectives:

1. To explore the status of various schemes and programs addressing nutrition at community level
   - To find out the systemic structure at district level for managing these schemes and programmes
   - To find out the challenges faced by service providers in implementing these programmes and ways to improve nutrition
   - To find out communities' experiences with these programmes and their perspective on how to improve nutrition
2. To understand civil society's perspective and work for improving nutrition at community level

4. My micro-study in M.P. on implementation of Nutrition related programmes in broader socio-economic and political framework

According to the specific objectives the action plan was made for this micro-study in M.P. (Table-2). Sehore District, in M.P. was chosen with the help of local organization, SAMARTHAN.

Table-2 Action Plan for micro-study in M.P.:

Objective	How		Where
To find out the systemic structure/organogram for implementation of these programmes at district level	Preliminary meeting and discussion with DPO, CDPO Person responsible for Vit A, IFA, IDD, PDS, MDM, NREGA		Sehore district
To explore the status of implementation of these programmes at village level	Visiting and observing service delivery and appreciative inquiry with key informants	Supervisor ANM	One village in Sehore district
		AWW	Sehore Block (NRC)
		ASHA	
To find out communities' experiences with these programmes and understand communities' perspective and views on how to improve nutrition	Doing FGDs with: Mother's group, Adolescent girls, Elderly women, PRI members		One village in Sehore district
To understand civil society's perspective and experience with these programmes & and MP State Nutrition Policy and how they are working to improve nutrition at community level.	Doing informal discussion with various civil society members working on health and development issues		Bhopal, MP

After identification of the programme implementers at district and block level, one village (with representative population of SC and ST) was chosen to observe service delivery and interact with service providers.

At village level 5 FGDs were conducted with mothers group, elderly women, PRI members, adolescent boys and adolescent girls, to know their experience with these programmes and views on how to improve nutrition. (See Annexure-2 for tools used for different groups)

The identified important stakeholders for these programmes at district, block and village level are as follows:

	ICDS	Health	MDM	PDS	NREGA	Safe Drinking Water & Sanitation-
District	DPO	CMHO,	DPM, Task Manager, 2 Quality	DPM,	DPM, Janpad Panchayats	District Coordinators

			monitors			
Block	CDPO	BMOs,		Co-operative societies,	Gram Panchayats	Block Coordinators & NGOs
Section	Supervisors	Medical Officers & Supervisors				
Village	AWWs, Helpers	ANMs, MPWs	Panchayat Sarpanchs, SHGs	Fair Price Shop Owners	Sarpanchs	

The major observations and findings from this study are provided under following three heads i.e. programme policies, programme implementation and communities' experience. (See Annexure-3 for detailed observation during field visit to various nutrition related programmes in M.P.)

1. Programme Policies:

- Malnutrition is seen as responsibility of the Dept. of Women and Child Development (WCD), even though other departments are equally responsible for betterment of malnutrition situation.
- Policies don't facilitate change at grassroots as little consideration is given on the participation of community members during policy making:
  - **Integrated Child Development Services (ICDS):** In ICDS too much focus is given on Supplementary Nutrition Programme (SNP), which is one among the 5 interventions (Nutrition and Health Education (NHED), Health check-up and referral, Immunization, Pre-school Education (PSE) and Supplementary Nutrition (SNP). Policies often take 3-6 yrs old into consideration while the malnutrition sets in between 6 month to 18 months of age. The Anganwadi Centre (AWC) is open till 2 pm however mothers going for agriculture work return in the evening therefore they prefer to leave children at home with older siblings or elderly people. Kitchen garden in every household is a sustainable system but the government is facilitating short-term approaches by introducing different food items under ICDS and MDM.
  - **Health:** Programs focus more on Ante-natal Care (ANC) than on Post-natal Care (PNC), resulting in less support and assistance given to the mother to practice optimal infant feeding. Also lactating women's increased (500 calories) requirements are often ignored, this is even greater than requirements (300 calories) during pregnancy.
  - **MDM:** Fund allotment of Rs 2.08 per day+ grains per child, is not enough to follow 6 days menu with feast on Saturdays & National holidays. Here at some places SHGs are taking care of preparation of hot cooked mid-day meal at school. However, SHGs have a mandate to save 500 Rs/month, when fund is not enough to provide quality food running MDM through SHGs has its own constraints.
  - **PDS:** It's targeted towards BPL families. There are issues with identification of all BPL families. It also considers family as the unit. This is not optimal, as some families have fewer members and some have more.

- **Nutrition Rehabilitation Centre (NRC), Sehore**: Severe Acute Malnourished (SAM) children are admitted for 14 days with their mothers in the NRC. Families find it difficult to manage other children at home in absence of their mothers. At NRC SAM children get 7-8 times meals (with 6-7 tonics to treat micronutrient and protein deficiencies) and mothers get training on child care and feeding. Mothers get 65/- Rs per day for food and compensation of labour and 300/- Rs as Transport cost. At every follow-up visit (every 15 days in 2 months) mothers get syrups and 265/-Rs. AWWs also get 100/-Rs on referral and at every follow-up visit. However, follow-up is weak and often children fall into the same malnutrition trap after reaching their home.

Nutrition Rehabilitation Center (NRC), Sehore:

- **NREGA:** Wages are given according to work. However criteria is not according to unemployed, disadvantaged population groups and their capacities

2. Programme Implementation:

- **Socio-economic, political and cultural (SEPC) factors** limit access of communities to services and also build constraints to service providers i.e.
  - **Caste dynamics:** Sometime caste of AWW and helper comes in between service provisions and their utilization. If AWW is from upper caste, she is least accountable to the SC and ST population, however if AWW is from lower caste upper caste community members don't allow their children to eat the SNP provided by them. As the SNP is the main motivation, this caste dynamics actually effects utilization of other programme components as well.
  - **Power Play:** It works both in positive and negative terms. In one case ANM was not staying at village and saying that chief minister is her relative. The District Collector's role was found highly influential in improving "Immunization" coverage and taking initiative for treatment of malnourished children at home by providing "1 egg and 250ml milk" through village Panchayat.
  - **Gender discrimination:** Often gender plays role in a very intricate way where girl's education is not the priority adding to that limited mobility further reduces chances of getting information and utilization of services available. Adolescent girls find mothers-in-law restricting young mothers to get SNP from AWC, as the aim behind providing SNP to pregnant and lactating mothers is not clear. Gendered construction of resources allocation and intra-household food distribution in families, first to males and then to female, if at all, adds to this problem. Pregnant women don't eat more to fulfil their additional requirements and carry their work as before, making them prone to deliver LBW children leading to intergenerational cycle.

- **Systemic Constraints:**
  1. **Human Resource:**
     - **Lack of supportive supervision:** There is lack of supportive supervision to deal with the day to day challenges and implement the intended services in best possible way. For AWWs supportive supervision by immediate supervisors is the missing link, where AWWs find that their concerns are not listened to and in the long run get de-motivated to perform assigned duties.
     - **Capacity building and motivation:** Capacity building and simultaneous motivation are necessary to get desired outputs. However, often it seems that capacity building issues are least thought of before assigning the duties for example to Sarpanch on

how to handle NREGA work and submit proposal; to SHGs on how to manage MDM and savings; and to AWWs on Behaviour Change Communication (BCC) and how to link Nutrition and Health Education (NHED) with Growth monitoring.

- **Too much administrative work:** Often lengthy administrative work takes up most of the time, leaving little time to contribute to actual implementation of the intervention. ANMs and AWWs are supposed to manage 20 registers besides their well defined duties at the centre and during outreach. As system puts pressure on reporting through monitoring, the actual work in the fields get neglected.

2. **Infrastructure related:** Most AWCs don't have independent building and run from Panchayat and school buildings. Lack of proper lighting, ventilation and other basic necessities don't encourage communities to send their children.
3. **Lack of planned systemic structure:** A clear cut strategy with setting goals to ensure accountability in the end is missing. There is no means to ensure that if this much input is given certain output is expected.

- **Inter-sectoral Coordination:** ANM, ASHA and AWW are supposed to work together at village level, however, there is complete lack of joint planning, implementation & monitoring at the higher levels.

3. **Communities Experiences:**
   - **Lack of awareness on entitlements and available services:** In the communities all 6 interventions of ICDS were not known, though it is running from 1975. There is lack of focus on Behaviour Change Communication (BCC), where Block Extension Educator (BEE) post is more or less becoming redundant with no new recruitments. Though home visits are included in CDPOs, Supervisors and AWWs job but still it seems more on papers with little focus on capacity building on Nutrition and Health Education (NHED) component.
   - **General lack of interest in health and food** as health is seen as "absence of disease" and not as state of physical, social and emotional wellbeing
   - **Inappropriate Infant Feeding and Caring Practices:** Optimal infant feeding practices i.e. exclusive breastfeeding for 6 months and timely and adequate weaning is crucial to reduce child malnutrition. Mostly children don't get appropriate quality and quantity of soft food at 6 months of age, to fulfil their nutritional requirements. Consequently malnutrition sets in between 6-18 months age period. Adding to this faulty feeding practices lead to diarrhoea (at least 10 times annually) and during these episodes child is almost on nil diet for 5-7 days. Adolescent girls look after the younger children and can't provide proper care and treatment, especially when child is ill and his appetite is poor. Anaemia and weak resistance further make them prone to malnutrition-infection cycle.
   - **Population:** There is a large unmet need for contraception. So birth spacing is not proper and people have too many children at very short intervals.
   - **Effect of Globalization:** With globalization many changes have come at the grassroots level like:
     - **Displacement of tribal**, disrupting their livelihood. Migration causes pressure on families, these families have greater work load and reduced access to their traditional food sources.
     - **Loss of traditional knowledge and adoption of faulty feeding practices:** Aggressive marketing of packaged food items like biscuits. This has now become the common weaning food even in rural areas
     - **Cash cropping/ contract farming** and increasing food prices has reduced food diversity and availability in rural households
     - **Global warming and climate change** with increasing drought and less water availability rural people grow vegetables only in rainy seasons

Meeting with people from Civil Society Organizations

I also got an opportunity to interact with many people from civil society organizations in Bhopal, who provided their insights into the malnutrition scenario in M.P. I visited the following civil society organizations:

- Madhya Pradesh Vigyan Sabha (MPVS), Bhopal
- DFID- Madhya Pradesh Technical Assistance Support Team (MPTAST), Bhopal
- UNICEF, Bhopal
- ActionAid, Bhopal
- Indian Institute of Development Management (IIDM), Bhopal
- Micronutrient Initiative, Bhopal
- The Hunger Project (THP-India), Bhopal
- Vikas Samvad, Bhopal
- Jan Swasthya Abhiyan (JSA), Bhopal
- Initiatives Women in Development (IWID), Bhopal

I also visited few organizations (CIVIC, Belaku Trust, ILID, IIM) in Bangalore, where I interacted with them to understand their work and their views on how to improve nutrition. (See details of these discussions in Annexure-4). The main points from these discussions are:

1. Civil society has a definite role to suggest constructive and practical alternatives in the current situation, what changes are needed and how.
2. Through nutrition related programmes locally available nutritious food items and optimal infant feeding need to be encouraged. SHGs, school/colleges and co-operative societies should be made part of this awareness campaign.
3. There is a need to ensure optimal Infant and Young Child Feeding (IYCF) practices, by providing Crèche facilities at the work place and appropriate Information, Education and Communication (IEC) to the communities.
4. All delivery centres of government run programmes should have "Citizen Charter" stating the rights of citizens/beneficiaries.
5. ICDS, MDM, PDS are providing grains, which provide 40% of the nutritional requirements. To fulfil other requirements pulses, edible oil, milk, vegetables, eggs need to be included.
6. In ICDS infrastructure is a problem, AWC are not providing child friendly, enabling environment and also lack storage space for SNP.
7. Often SNP is not according to local dietary habits and fund allocation doesn't provide double money to fulfil the principally agreed double ration for Severe Acute Malnourished (SAM) children.
8. There is a need of working out district and block level model with field level innovations
9. Larger livestock and agriculture policies contribute to under-nutrition as they ignore vitamin and mineral requirements in human diet. Pulse production has reduced to only 25% of the 1960s production.
10. These are especially important as nutrition related programs can be a supplement but not a substitute to household food security. Working for self-sufficiency at village level is the only answer.

5. Way Forward: How to improve nutrition?

During interactions with programme managers and civil society members they highlighted various socioeconomic and political issues playing role at community level while addressing nutrition and food security. They discussed the impact of these factors on status of implementation of various Direct & Indirect Nutrition Interventions by Government and suggested several actions at various levels to improve nutrition situation in India.

Policy makers:

- An interdisciplinary high power committee with proper budget allocation is required to take up issues like safe water, transportation, supportive prices to farmers, proper store house and procurement mechanism. Here division of responsibilities and financing for inter-sectoral coordination and convergence need to be clearly defined.
- Building bridges between policy makers and grassroots communities so that their interests and voices get heard while planning policies and placing accountability for results at both community and at top levels.
- Entitlements need to be revisited with allocation of budget according to needs rather than deciding budget first and then allotting it to various heads. BPL criteria also need to be revisited and revised.
- Ensuring appropriate follow-up or withdrawal strategies while planning any programme
- Policy makers need to ensure:
  - Food affordability
  - Provision of nutrition education in school/colleges
  - Day long Crèches at work places
  - Safe Drinking water (Piped Supply)
  - Sanitation

Service Providers:

- **ICDS**
  - Regular training of AWWs on BCC so that they prioritize home visits and provide NHED to families on proper infant and young child feeding, care during illness and need of SNP and regular growth monitoring
  - Streamlining the reporting and monitoring process with appropriate monitoring indicators
  - Providing supportive supervision and motivation to AWWs
  - Rewarding ICDS/SHGs who are able to bring down malnutrition
- **Health**
  - NRCs need to be strengthened further but there is a greater need for putting in place community based management of SAM first
  - Organising "Muskan Shivir" (for health check-up) monthly/regularly in every section through some untied fund available at sector level
  - Ensuring proper and timely supply and distribution of IFA and Vit A supplements with regular counselling on locally available food items rich in these micronutrients.
- Building capacity of SHGs' and PRI members under MDM and NREGA
- Strengthening the IEC department from state to village level to create awareness on what is malnutrition and its after effects, how to maintain good nutritional status with low cost

foods and also what are the provisions available by govt. under different schemes and how to access them.

Civil Society:

- Working for equitable access to services provided under nutrition related programmes by engaging with all stakeholders like local governance, activists, media, relevant line departments, political leadership and quasi judicial bodies in implementation.
- By Mapping malnutrition involving multiple stakeholders and suggesting constructive and practical alternatives in the current situation, what changes are needed and how

Communities:

- Creating awareness about entitlements and services under different schemes/programmes among community using every forum VHSC, Mahila mandals, Mother support groups, youth forums
- Bringing empowerment and ensuring services through local participation and community involvement
- Including locally available nutritious food into daily diets.

6. My experience of attending International People's Health University (IPHU Bangalore; 1-9 September, 2009)

The "Health and Equity" Course, conducted by IPHU helped me to understand health and equity issues at global level. It was part of CHLP alumni workshop and attended by participants from 10 countries and 18 Indian states. There is so much disparity in health, and globalization has widened this gap. Countries grow to export rather than securing food security to the citizens. For example in agriculture traditional wisdom of the farmers and fisher men are not valued and trade unions are not bothered with occupational health issues.

I came to know that in India, where proportional expenditure in public health system is low, promotive, preventive and rehabilitative care basically depend on voluntary sector and more of household care. Health system is also a social determinant of health, where access to health care has challenges like gender, social exclusion, ability to pay, political choice and negotiations. The main reasons for inequities come outside the health sector and for community level action we need to unravel the "causes of causes."

Primary Health Care (PHC), the alternate vision- towards a people centred PHC that empowers communities, enhances participation and advocates for inter-sectoral action. We realized that as a model of care it is more of a philosophy with utopian vision, which requires new economic order but it is inspirational to work towards better health care.
To realize the "Right to health" of people the state has the obligation and duty to respect- put no obstacles; protect- against violation by third parties; and fulfil- create enabling conditions through legislation, policies and allotting budget.

Dr Darshan Shankar, the founder of Foundation for Research in Local Health Traditions (FRLHT) suggested the biggest challenge is of giving health education to communities on good health practices. He also said that reason behind recent epidemics is often changing culture and mental health of the community and health should looked into the mental and cultural determinants also.

In our group work first we explored the area of interest of different participants like: right to information, community awareness of services and entitlements, demand generation, accountability at government and community level, optimal resource utilization for preventive measures and building civil society movement. Further to this, the group agreed to look at these issues by working on how PHM should take Food Security agenda at global and national level. We thought the structures, resources, slogans/actions and program of action for this. We analyzed the situation by discussing trade policies, transport, accountability and price rise issues. In this way we identified some aspects that need to be looked into like service design, policy advocacy, research, dissemination, training, lobbying, and networking/dialogue and technology development. Finally we presented the Concept Plan for "PHM and Food security" and draft email to be sent to IPHU Alumni to contribute to this plan. (See PHM & Food Security Plan Proposal in Annexure-7)

While preparing this concept plan I realized how Food Security (Sovereignty) is an integral component to achieve "Health for All" and how right of peoples to define their own food and agricultural system eventually leads to the economic self-dependence of the society. The preparation of concept plan further clarified the process by making different strategies to address various stakeholders and planning campaign activities and action at various levels. It helped me visualize how understanding issues at local level can facilitate strategies at regional, national and global level.

7. Looking Forward: Improving Nutrition Situation of the Communities

Along with broadening my understanding on the broader socio-economic and political factors working in the communities, my micro-study in M.P. really helped me understand the perspective of different stakeholders on widespread malnutrition in the communities. The various measures suggested by them to tackle malnutrition basically deal with three major issues in implementation of nutrition related programmes: lack of grassroots understanding at policy level, struggle of programme managers to implement these ever changing policies and sufferings of communities because of poor implementation of these programmes.

Further, the deliberations at the National Consultation on Nutrition organized by Centre for Legislative Research and Advocacy (CLRA) and CARE helped me visualize how networking with various stakeholders like local governance, activists, media, relevant line departments, political leadership and quasi judicial bodies is the key while ensuring nutrition at the grassroots. (See Annexure-6 for details of the proceedings of National Consultation)

Discussion with civil society members also helped me understand the important link between agriculture and larger food and nutrition security in our country. Over a period of time the agricultural production system in India has changed a lot especially after Green Revolution. Green Revolution focused on agricultural production and supported policies for mono-cropping and industrial agriculture, resulting in loss of food diversity. This agriculture diversity was actually the basis of food security and culinary diversity of different regions in India. Thus there is a need to promote such agricultural policies and production system that actually help preventing widespread malnutrition by supporting this agricultural diversity of different regions. This will not only ensure food and nutrition security of communities, but also help improve the income of poor and marginalized farmers groups, through conservation and sustainable use of their resources.

Finally, I understood that to improve nutrition in the communities at large there is a need to work towards "Food Sovereignty[1]," which is... the right of peoples to healthy and culturally appropriate food produced through

- Ecologically sound and sustainable methods, and
- Their right to define their own food and agriculture systems.

Food sovereignty implies new social relations free of oppression and inequality between men and women, peoples, racial groups, social classes and generations.[2]

[1] Food Sovereignty: A Right For All. Nyéléni 2007 - Forum for Food Sovereignty, 23rd - 27th February 2007, Sélingué, Mali. Can be accessed at: http://www.nyeleni.org/spip.php?article125)

Annexure-1

Field Visit during Orientation:

Jagrutha Mahila Sangh (JMS): First day we were introduced to Jagrutha Mahila Sangh (JMS) members, a collective of 42 Sanghas/Self-help groups (SHGs) across various villages. Its mission is to reach the unreached Dalit women and empower them in the process of providing voice to the voiceless women. Atrocities against Dalits make their life vulnerable by discriminating them at various places and providing less opportunities.

Strategies used by this group include folk songs, street plays, slogans, training, collecting people at one place and going house to house. Initially landlords resisted formation of these Sanghas but these women were determined. These women faced resistance within their families but they convinced their families. Now, community recognize Sangha members as volunteers to help them and giving them information on NRHM, NREGA, PDS, facilities from gram Panchayats, Pension Scheme, Annantodaya yojana (AAY) and Akshaya Card for BPL families. Sangha does savings and it has Sanchalikas, 1 working in 5 villages. They plan on Monday and then go to their respective villages and come back on Saturday. Sangha member once launched a complaint to Food Inspector at Taluk level against PDS shop owner, who was not giving ration to a Dalit. Then shop-owner had to give a written declaration that he will not discriminate in future. With their efforts now all PDS shops also have charts with details.

Once a girl was raped and the issue was discussed in 42 groups. Women decided to protest and around 500 women from various villages gathered with sickles in their hands and burnt male effigy and pledged that "women will not tolerate any more". This made women strong and confident in discussing the issue of violence. Now, there is immediate reaction to such events, where as it took around 4 weeks to come to notice earlier. In another instance, landlords gathered 1,000 men to kill Dalit youth. JMS protested against it.

Jagir Pannur: We found that many Dalit families got converted to Christian religion to get education and health facilities provided by the missionaries. It has a government school till 5th class and Christian priest takes all school going children to residential school after 5th class to attend classes till 10th standard. **Health:** They have to go to Pothnal PHC or Manvi govt. hospital (CHC). One visiting private practitioner is also there, who charges Rs 15/- per injection and Rs 50/- for 2 injections. They also take medicines from chemist on their own. **PDS:** PDS shop is in another village (Chikliparve) and it supply ration to BPL families 3 days a month. Kerosene: 3 litre (Rs 11/- per liter); Rice: 15 Kg (Rs 3.50 /- per kg) and Wheat: 3 Kg (Rs 10/- for 3 kg) is available. They shared that for getting BPL card sometimes they have to give bribe (Rs 100/- per card). PDS shop owner write 20 kg on their cards but give only 15 kg of rice and also to get extra ration, they have to pay double the price. **AWC:** We got to know that AWC hadn't opened for 1 week. AWW is from another village, who comes around 10:00am and goes around 11:00am. She doesn't supply IFA or ORS and says there is no stock. Helper prepares cooked meal thrice a week and gives food to child from Dalit communities in their hand not in utensils. Here AWW has support from upper caste. Whoever asks for services the AWW gives her extra and ask her to keep quite. **ASHA:** With her own initiative a women from Dalit community has been appointed as ASHA, two months ago. She got 21 days training in Raichur but hasn't been provided the drug kit. She has cleared 10th and had negotiated with Panchayat and ANM to get this job. She has taken 2 pregnant women for institutional delivery and got Rs 200/- for each delivery. She also referred TB patients to PHC. She said that she works with ANM but there is no coordination with AWW. In coordination with JMS two groups are present in this village: Preeti Mahila Sangh (4 years, 15 members) and Navjeevan Mahila Sangh (8 years, 16 members). They do savings for loan and advocate for NREGA, NRHM and PDS. They

have also supported JMS campaigns and protested against the discriminations done at various levels.

Chikokotnakal: We went to Gram Panchayat office. The Panchayat includes 7 villages. Only the peon was there, who hadn't got his salary for 1 year. There was information on panchayat members, Panchayat president year-wise, NREGA programme and work done under it and also on Indira Awas Yojana (IAY). He also informed that Panchayat meeting happens once in 2-3 months.
Kotnakal: We went to another Gram Panchayat, which covers 2 villages and has 20 panchayat members. The typist was there and he gave us information that Manvi taluk has 36 Gram Panchayats and every Panchayat has computer and typist appointed under NREGA. They handle all applications, provide job cards, prepare labour list and activities taken under this scheme.
Amritsweri Camp: We met the mahila sangh, "Saubhagya Mahila Sangha", working there for 9 years. It has 20 members, some of them are involved in Terracota work. They have resolved small fights for water within Dalit community. 1-2 members also work as Arogya Karyakarta and support NRHM work. In this village with the help of Nav Nirman Trust one cotton project is going on. Four agencies i.e. DFID, AGROCEL, SEWA and Nav Nirman Trust are supporting this, where DFID and AGROCEL mainly provide fund and SEWA looks after production of cotton and Nav Nirman Trust facilitate Vermi-compost. The market rate for cotton is Rs 300/- per quintile. **PDS:** Here also 10 kg. of Rice is given at the rate of Rs 3.50/-per kg, Wheat 3kg @ Rs 3.50/kg and Kerosene 3 litres @ of Rs. 11 per litre. Sangha member said whoever asks from the shop owner why he is writing 20 kg on BPL card and giving 10, he gives her the allotted amount. **Health:** The people here go to Pothnal or Kotnakal for treatment. There is a clinic of a private doctor, who takes Rs 15 for consultation and one injection. Also they take herbal medicine from Arogya Karyakarta and go to the Thursday clinic at Pothnal. **AWC:** Here also the AWW lives in another village and comes for 1 hour (12:00pm- 1:00pm). She takes weight of children once a year and distribute ready to eat food every day. Only sometimes she cooks meal. IFA and ORS are available with her but she doesn't give it to any body. In this village the AWC was closed as AWWs got 10 days summer holidays.

Chillipilli School: Chillipilli means the sound of the birds, it's a school for child labourers. The idea behind it is that child should also grow freely like birds, so this facilitates child labourers to get back to mainstream education. It started in 2000 in Markamdinni village enrolling 50 children. Then on, it got shifted to Torandinni, Tadkal, Begwat, Bagalwara and Pothnal. Uptil now it was a Day school running in community centre of each village. In Pothnal now it is functioning as residential school. It first assesses capacity of children and then teaches them by Activity based learning (ABL) approach. Every child get a stipend of Rs. 100/- per month and this sum is used for their clothes, books and education material. The school has a staff of 3 teachers, 1 cook and 1 person looking after accounts. JMS supports the salaries of these staff. The school provides education till 8th standard. After 2-3 years of training and according to individual capacity the child is helped integrate into mainstream education. It is a government recognized school for child labourer. Thirty five children have been mainstreamed to formal education till this date.

Livelihood Initiatives in JMS

1. **Herbal Medicine:** Sixteen Health workers have been trained in traditional herbal medicine. Every Thursday they set-up a Clinic at JMS. Mainly they are known for remedies for fever, diarrhea, vomiting, skin problems, gynaecologic problems, kidney stones, paralysis. They take case history of patient and accordingly give medicine. If illness can't be managed by them they assist patient in getting referral treatment.

2. **Terracota Work:** Eight years ago, the women had started this work after getting training for 1 year. Presently 15 artists are doing this, earlier they were working as agricultural labourers. They buy mud from Bangalore for this work, each time they buy a whole lorry of mud, which last for 2-3 years. They have started from few motives but now they express their own creativity in making different items like wall hangings, anklets, bracelets etc. Now, they get order for organizing exhibition of their work three times a year. They find this work satisfying and less labour intensive than working in fields especially in the summer. They are also happy that their work is appreciated outside. We especially found that the colour combinations chosen by these women were really very attractive.

3. **Neem Project:** The women involved in this work call their sangha as Jhansi Rani Mahila Sangh. There are 14-15 members in this Sangha and it's running for last 8 years. They had started this sangha for savings and were taking loans for their children's education. They were working as daily wagers and both men and women used to get skin problems because of pesticides and fertilizers. However, they were not aware of how to make manure from Neem. They had seen few Dalit women, who used to collect neem seeds from nearby villages and selling them. The women then thought of developing manure themselves. They have taken Rs 50,000/- loan from JMS. From last 4-5 years they are doing this Neem project. Three months in a year they work on this project of collecting neem seeds and preparing manure from it. They sell it at the rate of Rs 12/Kg (1200 Rs/Quintle). The group had received the Citigroup award of micro-entrepreneurship for small scale industries in 2005.

Visit to Tadkal Village where Dalit Communities are facing Social Boycott

This village is 6 km from Pothnal. During the discussion with the community members we came to know that initially the construction of the sub-centre was planned in a piece of land in the Janta Colony. The Landlord who had taken the contract for construction decided to build it in common place used by the Dalits for collecting their cow-dung and manure. One night his people emptied the place and started to build sub-centre at that place. The Dalit community complained to the Police but the landlord organized all other communities against the Dalits. Presently this community is not given work by anyone, not allowed to use tempo for transport and also their grains are not processed in flour mills. The landlords also formed a committee, which fined anyone trying to provide work to this community. Earlier they were also not allowed at hotels but now they can go there.

They also shared that JMS women complained to District collector, who has asked tehsildar to look into the matter but nothing has happened. On 8th March one woman from Dalit community but in good terms with landlords complained about a boy of her community, it seems that the landlord community was just looking for a reason. The same night, they collected people and attacked the Dalit community. They injured everyone coming in their way. Women stood out of their homes to save their husbands but they were first dragged and kicked and then men from their homes were beaten up. One old lady and one pregnant woman were injured, who were later admitted to hospital. These people even threw stones on their cattle and goats. Few people, who were hiding in a room were locked from outside and stones were thrown.

This incidence made me realize the atrocities still happening with Dalit communities and how upper caste communities use their socio-economic power for their advantage and violate the basic human rights of survival and dignity.

ROOVARI, Raichur

In the afternoon we went to an NGO, Roovari (Meaning, instrumental in leading). It has been associated with CHC in Community Monitoring Project of the NRHM. Initially the organization started working on Sanitation, as their main focus was on Health and Sanitation. They had got

few projects on building toilets in the villages. They also worked on education issues to reduce drop outs in urban areas. ROOVARI provided vocational training for livelihood options with government schemes providing 50% subsidies to start a vocation and 50% loan. Presently they want to focus more on health issues. They have done a survey of 3 gram panchayats and found 35 severely malnourished children.

They told us the stepwise process of execution of the pilot project on "Community Monitoring in NRHM". After 5 days training at state level they selected 3 Taluks in Raichur district. In 1 taluk they selected 3 PHC and 15 villages, so 5 villages under each PHC. Thus, in total they selected 9 (3x3) PHCs and 45 (15x3) villages in 3 taluks. After state level training, they organized district level orientation including DHO, CDPO, MO, AWW, Taluk Health Officer and NGOs. Then they organized Taluk level workshop with health and PRI members including VHSC, AWW, supervisor, MO, ANM, CDPO, taluk health officer.
Finally they stayed 3 days in each village. First day, they found that there is no VHSC formed as reported and then approached the appropriate persons to form it. On second day, they gathered information on resources, health status, households through Resource Mapping and Ven diagram. Third day, they built the action plan according to the second day's findings. The priorities were given to mother and children related issues and also to water and sanitation. Then they were asked what they want to use untied fund in terms of the priorities found out by the group.

They have also done a transect walk in the village to know the actual situation before resource mapping. For identification of issues the questions were asked from SC/ST and general caste both separately on Village Report card and then the color rating (<50=Red, 50-75=Yellow and >75=Green) was done with calculating average of these 2 responses on Equity Index. Questions were asked on following issues: Prevention of diseases, untied fund, children health, Accredited Social Health Activist's (ASHA) work, Communities opinion on ASHA, Health Services to mother, Side effects after services, Janani Suraksha Yojana (JSY), Disease surveillance, Quality of services.

In the first Public hearing at PHC level there was quarrel on various issues like JSY and Madilu scheme. But in the second hearing 50-60% of issues were discussed and resolved .
Few actions taken after this:

- Untied Fund, concerned officials were not aware about it however fund was available for 1 year. Now, they have started taking actions and using it.
- Earlier, number of eligible beneficiaries were not defined for JSY. Now it has been done. Also with people's pressure JSY incentive amounts has been distributed.
- Madilu kit: Earlier only 30 kits come for each PHC not for sub-center now they have demanded for these as well.
- Prasuti Rik: For maternal nutrition care in this scheme there is a provision of Rs 500/- before and 1000/- after delivery. Now people know and ask for these.
- Now community know the activities of ASHA worker and ASHA worker also feel encouraged to perform her duties
- There is an increase in institutional deliveries
- Now 24x7 services are provided by appointing required personnel with use of available resources.

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Annexure-2

Tools used to observe various nutrition related programmes in M.P.

Interview Guides for Supervisor & AWWs:

- **Does AWC has an Independent building** and **its** distance from disadvantaged group dominated habitation
- **Minimum infrastructure and** facilities (weighing scales, storage arrangements, drinking water, cooking utensils, medicine kits, child-friendly toilets, a kitchen shed, toys, etc.)
- **Roles and responsibilities (administrative and managerial)**
- **Challenges and problems** in implementing services:
  1. **Supplementary Nutrition**:
     a) **Availability and proper supply** of SNP (quantity, quality, how many days in a week/month/year);
     b) **Beneficiaries** (no. of children, pregnant and lactating women, adolescent girls), SC/ST coverage and any special effort for involving these groups
  2. **Growth Monitoring:**
     a) Proper availability of equipments and materials required,
     b) GM linked with **nutrition health education and extra SNP and**
     c) Referral of severely malnourished children (if **yes, no. of SAM children and referred** children in their area) (Eg./Case study)
  3. **Nutrition health education** (on Immunization, Antenatal Care, Breastfeeding and Complementary feeding) if **yes, frequency**
  4. Child Care (Crèche) and pre-school education
- **Functional liaison** with panchayats, voluntary organizations, mahila mandals, youth clubs and primary schools in the area and **Community participation** in terms of food supplies, building materials, voluntary services
- **Interaction with ANM and ASHA**: joint training, joint participation in monthly "health and nutrition day", and joint home visits.
- Involvement of PRIs and VHSC in monthly "health and nutrition day"
- **How to improve nutrition at community level**

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Interview Guides for ASHA:

- **What are their job responsibilities?**
- **Nutrition related activities/services**
- **Challenges and opportunities** in providing these nutrition related services:
  - Assist in beginning breastfeeding within one hour, and establishing exclusive breastfeeding as an accepted community norm,
  - Positively influencing complementary feeding practices of families and at the community level,
  - Encouraging adoption of hygienic practices regarding water and sanitation,
  - Early detection and management of childhood illness especially management of diarrhoea.
  - Counselling and follow up of families with severely undernourished children and referral of sick children. **any e.g./ case study**

- Working with women, families and the community to ensure adequate weight gain through appropriate nutrition, reduction in workload, rest and accessing timely health services especially supporting clean and institutional delivery

- **Interaction with AWW**: joint participation in monthly "health and nutrition day", and joint home visits.
- **Her experience with other programmes**: VitA, IFA, IDD, MDM, PDS, NREGA
- Perception about community participation and involvement of PRIs for better implementation of these programmes
- **How to improve nutrition at community level**

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Interview Guides for ANM:

- **What are their job and responsibilities?**
- **Nutrition related activities/services:** VitA, IFA, IDD
- **Challenges and opportunities** in providing services:
  - Assists in beginning breastfeeding within an hour (if she is conducting delivery)
  - Management of severely undernourished children and providing timely curative and referral services.
  - What are the facilities available for children suffering from Grade 3 or 4 malnutrition and their mothers at Nutrition Rehabilitation Centres- PHC level, **(An interview with beneficiary if possible)**
  - How they are ensuring care for other SAM children not coming to NRC **any e.g./ case study**
  - Introduction of ready to use therapeutic foods (RUTF)
  - Nutrition as an integral part of a treatment package provided to people living with HIV/AIDS and TB
- **Interaction with AWW**: joint participation in monthly "health and nutrition day"
- **Her experience with other programmes**: MDM, PDS, NREGA
- Perception about community participation and involvement of PRIs for better implementation of these programmes
- **How to improve nutrition at community level**

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Focus Group Discussion Topics:

Mothers groups (SC/ST women)

1. What are the problems participants perceive in nutrition and health of children, adolescents and pregnant and lactating women in their area
2. Attitude of the participants towards AWWs and ICDS
   - Nutritional quality, quantity and regularity of Supplementary food
   - Regularity of Growth Monitoring, is it link with nutrition education and their perception about that
   - Nutrition health education provided on "infant and young child feeding", nutrition counselling, immunization, antenatal care
   - Crèche facility and pre-school education
3. Experience with other schemes like Vitamin A, IFA, IDD Programs, MDM, PDS, Antodaya scheme, NREGA etc.
4. Reach of these programmes to disadvantaged and excluded groups

5. How to improve nutrition at community level: their views on Community Participation and Monitoring; and role of PRIs and VHSC in these programmes

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Adolescents:

1. How are their daily lives and work load, their source of information
2. What are the problems participants perceive in terms of their nutrition and health and also with other vulnerable groups i.e. children and pregnant and lactating women in their area
3. Attitude of the participants towards AWWs and ICDS
   - Nutritional quality, quantity and regularity of Supplementary food
   - Any experience of observing Growth Monitoring session at AWC, was it link with nutrition education, how was that
   - Experience with Nutrition health education provided on "infant and young child feeding", nutrition counselling, immunization, antenatal care
   - Crèche facility and pre-school education
4. Experience with other schemes like Vitamin A, IFA, IDD Program, MDM, PDS, Antodaya scheme, NREGA, etc.
5. Reach of these programmes to disadvantaged and excluded groups
6. How to improve nutrition at community level: their views on Community Participation and Monitoring; and role of PRIs and VHSC in these programmes

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Elderly Women:

1. What are the changes in food practices, food availability and nutrition situation over the years in your area (agriculture practices, production of crops, attitudes, knowledge)
2. What are the problems participants perceive in terms of nutrition and health of vulnerable groups i.e. children, adolescents, pregnant and lactating women in their area
3. Attitude of the participants towards AWWs and ICDS and any experience of observing various activities at AWC:
   - How was the nutritional quality, quantity and regularity of Supplementary food
   - Growth Monitoring, it's regularity at AWC and whether it was linked with nutrition education
   - Is nutrition health education provided at AWC on issues like "infant and young child feeding", nutrition counselling, immunization, antenatal care
   - Crèche and pre-school education facilities present at AWC and the quality of that
4. Experience with other schemes like MDM, PDS, Antodaya scheme, NREGA, Vitamin A IFA, IDD Program etc.
5. Reach of these programmes to disadvantaged and excluded groups
6. How to improve nutrition at community level: their views on Community Participation and Monitoring; and role of PRIs and VHSC in these programmes

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PRI members:

1. What are the changes in food practices, food availability and nutrition situation over the years (agriculture practices, attitude, knowledge)
2. What are the problems participants perceive in terms of nutrition and health of vulnerable groups i.e. children, adolescents, pregnant and lactating women in their area

3. Attitude of the participants towards AWWs and ICDS and any experience of observing various activities at AWC:
   - How was the nutritional quality, quantity and regularity of Supplementary food
   - Growth Monitoring, it's regularity at AWC and whether it was linked with nutrition education
   - Is nutrition health education provided at AWC on issues like "infant and young child feeding", nutrition counselling, immunization, antenatal care
   - Do Crèche and pre-school education facilities are present at AWC and the quality of that
4. Experience with other schemes like MDM, PDS, Antodaya scheme, NREGA, Vitamin A Supplementation Program etc.
5. Reach of these programmes to disadvantaged and excluded groups
6. How to improve nutrition at community level: their views on Community Participation and Monitoring; and role of PRIs and VHSC in these programmes

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Interview Guides for Civil Society Organizations:

1. What are issues they are working on?
2. What is the status of implementation of various Direct & Indirect Nutrition Interventions by Government?
3. What is the status of MP State Nutrition Policy
4. Some successful examples of NGOs working for ensuring nutrition?
5. How to improve nutrition at community level?

Annexure-3

Observations during field visits to various nutrition related programmes in M.P.

ICDS

The Aanganwadi centre (AWC), I visited was located adjacent to sub-centre and very near to the main road. When I entered, I found few children sitting at floor in a dark room where AWW was not happy with the sudden, flying visit of her supervisor, just before some minister was supposed to come there. I came to know that this village has 2 AWCs; one in SC and one in ST area. The AWC, I visited was in SC area and the AWW was from upper caste. I observed that there was a "chullha" but cooking was going on at AWW's home and utensils and SNP materials were also at her home. There was an adult Indian toilet but that was not functional. As per AWW some rodents have damaged the toilet and the floor of AWC. She also told that there was a hand pump in front of AWC but PHE department has taken it away by saying "that it is of no use here". She was aware of all health messages need to be conveyed to the mothers and adolescent girls. However, when I asked to make children sing some rhyme taught by her, she said that these children are new and older children got admission in school in this academic session. She complained about the 20 registers she need to maintain (though she found it difficult to remember even the names of these) and showed me dust filled registers. I observed that they need to maintain 4-5 registers for SNP and often have to fill same figures at various places in different registers; sometimes these figures also get changed in the process of reporting at so many places. Recently AWWs received training on IMNCI and got 2 more registers to maintain. She also felt that nobody listen to their concerns in the system, she hasn't received salary for 4 months and gets low salary because of her education, however she said that other AWWs also do the same work but get more salary.

During my FGD with mothers, I came to know that AWC has provided only immunization and polio drops, and they were not aware about other services ICDS is supposed to provide; namely Nutrition and Health Education (NHED), Health check-up and referral, Immunization, Pre-school Education (PSE) and Supplementary Nutrition (SNP). One woman shared that if AWW doesn't give good response to one woman it discourages many. She added that like for PDS they don't have any card for ICDS to demand for services. FGD with adolescent girls revealed that often mother-in-laws think that it's disgraceful for their families that their daughter-in-laws go to AWCs for such a small amount of SNP (the necessity of SNP to supplement the daily diets of pregnant and lactating women has not gone well in the communities). They also shared that AWCs timing till 2pm doesn't help care-giver and they prefer to take child with them to the field or keep them at home with elderly women for the whole day. While discussing with PRI members, they raised their concern that if in front of the AWC water was stagnant and mosquitoes are breeding in it, nobody would like to send his/her child to the centre.

In my discussions with various programme implementers at district and block level, they shared the practical day to day problems they face in implementation of ICDS. First of all they were very discouraged with linking malnutrition directly to the failure of ICDS. One CDPO shared that ICDS is often made responsible for malnutrition like a lady is responsible for everything happening at home, irrespective of so many factors playing in the backdrop like inadequate health care, poor sanitation and open defecation practices. They felt that there is duplicity in work of different departments in M.P. "Bal Sanjivini Abhiyan" (biannual, month long, campaign for weight measurement, health check-up, immunization and Vit-A supplementation) was conducted till 2008 and now (from 2009 onwards) health department has started "Bal Poshan Mah" with similar objectives. It was also revealed that, "Bal Sanjivini Abhiyan" is discontinued because of discrepancies with NFHS data on malnutrition figures. It was showing a decline in malnutrition situation over a period of time but NFHS-III has shown that underweight (60%) and wasting (33%) in under-5 population, increased from NFHS-II (54% and 20% respectively). However, one CDPO all of a sudden came to know (on 10th July) that she has to conduct "Bal

Sanjivini Abhiyan" from 15th-21st July, how she would have managed to do that is another question?

Thus the CDPO and supervisor felt that under ICDS, the message on why SNP or IFA tablets are provided is not clear, as people can meet their requirements with local foods available at home. It just a supplement given for pregnant and lactating women to fulfill their extra needs during early hours of the day, when they are busy. SNP is also not according to local dietary habits and food availability. The CDPO complained about new schemes introduced too often (like "Sanjha Chulha," where common meals will be cooked at one place for MDM and ICDS), till the system accustomed to one type of working, something new get introduced. Earlier, only Dalia was provided in SNP. Presently, a different menu is cooked on all the days: Monday- Poha; Tuesday- Kheer Puri; Wednesday- Upma, Thursday-halwa, Friday-Daliya, Saturday- Poha; for 3-6yr old. The take home ration is *"Panjiri" for* pregnant, lactating women and 6 months to 3 yr old children. She felt that as in the procurement of these items SHGs are involved, this has made the system more cumbersome without any quality check on these SHGs. In urban block, one SHG is actually providing the cooked meals to all 100 AWCs in the urban area.

IFA, Vitamin A and deworming tablets supply is not regular by health department, as BMO supplies these to ANM at every sub-centre but whether ANM is giving it to the AWW is not followed-up. Supervisor felt that for regular health check-up monthly camp need to be organized at each section of the Block, but for that there is no child health care fund available at Block level. If made available they can organize these camps as now Health and ICDS have same sectors. Immunization is good in this area as the previous collector has devoted 3,000 Rs for Action Plan on Immunization. First 7 days of every month were focused on immunization first 5 days to conduct in villages and then 6th -7th day on outreach to uncovered area.

The Supervisor said that as there is no syllabus for pre-school education and not many AWWs provide pre-school education and also say that it is difficult to make child stay in AWC. However, the supervisor felt that monitoring is weak in ICDS but with formation of Mother Support Group it would improve.

I also interacted with a group of 6 supervisors and all of them said that AWCs are often run in very small, dark rooms without any electricity facilities. They felt difficult to sit at AWCs during their visits, and told that it is a challenge for AWWs who are managing it daily. These are not child friendly so community also doesn't realize the importance of the services. They shared that there is a provision in policy where community has to provide a place for ICDS centre but community thinks that it's a govt. programme, so govt. will arrange the place also. They shared that caste system is still very much prevalent and children from upper caste don't eat if AWW or helper, who cooks food, is from lower caste. This devoids children from other services provided at AWC. They opined that when SC/ST has priority in selection then may be dry food as SNP can be given which is accepted by people without this kind of discrimination.

All of these implementers felt that AWWs are overburdened and often not trained enough to coordinate effectively. During interaction with the Deputy Director ICDS, she shared that there is a circular sent to other departments that if they are using AWWs services they have to pay them 100Rs/day honorarium. However, she felt that there is no provision for recognition and reward to AWWs, who are demotivated. She said that Nutrition and Health education (NHED) is weak and monthly weight monitoring is not coordinated with NHED, small messages like "No Bottle feeding, Exclusive BF for 6 months, Complementary feeding with local family foods" need to be conveyed. For this the reason cited is lack of supportive supervision to AWWs, if supervisors are doing flying visit, qualitative appreciation can't be done.

Health

I visited the village and found that sub-centre was closed. We found the Multi purpose worker (MPW) and one Auxiliary Nurse Midwife (ANM) from another village. On enquiring I found out that this sub-centre has 2 ANMs. One of the ANM has come under RCH budget and started coming from district, the other ANM staying in the village also started living in district. Thus, no ANM was present at the sub centre. They often visit once a week or four times a month on Tuesdays, the immunization days. MPW said that political connections and administrative pressure work in the system and the new ANM says that "Chief Minister is my relative," so nobody asks her about her absence. In general, people fear that if they will raise their voice it will threaten even whatever is available now. At the time of ANC registration, health check-up, information on immunization, institutional delivery and feeding is given, however women usually come alone. MPW and ANM complained that in tribal areas they have to walk long distances with all equipments and medicines, as people don't collect at one place and expect service providers to deliver services at their door step, even in difficult areas. Often parents don't give importance to immunization and don't care for the children till he/she falls ill. Sometime public is also responsible for corruption, as they use political pressure or give money to get their work done, as a result, the individual benefits but the system fails. They felt that only functionaries can't ensure services, community participation in monitoring and quality regulation is needed. Community also needs to realize their accountability towards their children.

In this village ASHA is from upper caste and is not supported by AWW/ANM, and is so not performing her duties.

During my FGDs with the mothers' group, I found that only three women (out of 12) has taken IFA given to them and they also took only 1 packet. Most women got 2 Tetanus Toxoid (TT) injections, some got one. These women were not aware about how many injections a child needs to get to be fully immunized.

Block Medical Officer (BMO) at Ichhawar Block CHC told us that there are 30 sub-centres under that CHC and in only 9 villages ANMs were from same villages. In these villages primary treatment and health services are good. During selection of ASHA, poor/widow/ SC/ST women are preferred for better outreach and services. Out of 70 ASHA in the block 10 are from higher caste as the Gram Panchayat during selection thought that they may be useful to them in future in some way. He also shared that as in first trimester woman experience nausea and vomiting, so IFA tablets are given after first 3 months. Earlier IFA tablets and also deworming tablets were distributed by teachers to all children for 100 days in every academic session, under the School Health Programme, which was a good initiative.

The Chief Medical Officer (CMO) at the District level said that Counselling is required for better feeding and care of children and consumption of IFA tablet by pregnant women. As infrastructure is very poor and hospitals are overcrowded, doctors are not able to give sufficient time to each patient to advise them on feeding and caring of sick children.

While interacting with District Programme Manager, NRHM, I came to know that health department organizes small camps 2-3 times per year to identify Grade III and IV children and admit them to 2 NRCs in the district. Dist. collector also makes sure that every AWC identifies, admits and facilitates treatment of malnourished children at NRC. UNICEF has provided technical support to these NRC, almost 3,375/- Rs package for treatment, management of each malnourished child. However, follow-up at NRC is weak, here motivation is a factor at various levels. Sometime AWW doesn't get incentive on time for referring children to NRC and gets demotivated. Health Dept. from 2009 has started "Bal Poshan Mah" (every 6 month) and provide vitamin A dose with immunization. Last year with the interest Collector shown in reduction of malnourishment VHSC and sub-centre provided 250ml. milk and 1 egg to every malnourished child at their home as outreach is not possible sometime and it is difficult to take children to NRC and make them stay there for 14 days. However, it was not implemented in full district and not carried out on regular basis. She felt that sometimes a program gets started and

after 1-2 year end abruptly without any follow-up or withdrawal strategy. Earlier health volunteers were named as "Jan Swasthya Rakshak" and now ASHA. However Dais are important at community level, as they can manage delivery and handle complication. The need is how to strengthen them rather than building another pillar. There is no state and district level follow-up strategy or target. May be this is the reason for high malnutrition status. Often Health and WCD department blame each other for not functioning well and the beneficiary is finally in loss. Also as soon as change in government or administration happens, programme focus also changes. District level officers have their limitations and face pressure to do certain things.

Mid-Day Meals (MDM)

I visited the school at lunch time and find children eating MDM, only *dal* was given with *Rotis.* However, children have finished the amount given and there was no wastage. They also said food is good.

During my interaction with teachers, I came to know that earlier PTA was managing MDM but now SHG constituted by Gram Panchayat are managing this. However, teachers felt that they were managing better. In MDM 6 days menu is decided: Mon/Wed/Thu- GLVs, *Dal and Roti;* Tues/Fri- *Rajma, Moong, Tuar dal;* Saturday-*Kheer, Puri, Aloo Tamatar.* SHG buys vegetables daily and other things weekly. However, they said that MDM has no impact on enrollment and earlier provision of 2kg wheat per child was good as 2-3 children from a family were going to school, family was getting 5-7 kg. Wheat. They complained that cooked meal sometimes is not eaten by the child and also disturbs teachers work.

While conducting FGDs, women shared that sometime MDM is good like on Saturdays then more children eat MDM. They also felt that SHGs are managing MDM quite efficiently. FGD with adolescent boys revealed that only *dal* and *roti* were often provided, vegetables were missing from the menu but still as tribal mostly eat maize, their children get extra meal in this form. Only 2 days (26 Jan and 15 Aug) they get good food. They believe that initiative is good and improved attendance as now more children from poor families come and get books and food at school. Earlier older children used to take care of younger ones but now they come to school. These boys also shared that SHG members are fighting with each other for money and think to save as much as possible from allotted amount. Still they feel that SHG are better than PTA as nobody had the guts to say anything against teachers but now PTA is acting as watchdogs and pinpointing if SHGs are not working properly. PRI members also felt that cooked meal in MDM is a good scheme.

The District Programme Manager (MDM) said that earlier MDM was for only primary schools now it is extended to middle schools and in drought affected areas it is even given 7 days a week during summer holidays. Often planning is done taking average 80% attendance as norm. In primary schools 100 gm wheat and 2.08 Rs/- (0.50 state and rest center) and in middle schools 150 gm wheat and 2.60Rs/- (0.50 state and rest center) per child/day is given. In 2004-05 cooked meal has been started as earlier parents used to sell the ration for children given at school/PDA shop. Attendance has increased after MDM as earlier children used to go home for lunch and often not return back. Enrolment has increased from interior and tribal areas, even siblings of the enrolled child come along sometime. MDM cell at the district level has 1 programme manager, 1 task manager and 2 quality monitor. In Sehore district, 1460 primary and 599 middle govt. or govt. aided schools provide MDM with the help of 2,000 SHGs and 50-60 PTAs. However, SHG have a mandate to save 500 Rs per month and meet twice per month to discuss various matters and save money. The collector at district level, and the SDM at block level are the

assigned authorities to monitor and evaluate the functioning of these. Earlier children were not eating food cooked by SC members. But CEO and DPM went to the school, ate the food and ensured with the teachers that children eat food otherwise some legal action can be taken against teachers. He shared that PTAs were managing better, as teachers were more accountable to the system and maintained quality and menu. However, SHG works with political pressure, but with time and proper monitoring SHGs will also work well.

During discussion he mentioned that money given in this scheme is not enough to ensure everyday quality food for children, besides this Saturdays and national holidays (15 August and 26 January) are suggested to be feast days but there is no extra allotment given for these. Also with the allotted money, MDM is assumed to promote savings and provide employment to SHGs. PDS shop owner often takes a cut of 10-50% from the ration allotted for MDM. He shared that in villages main problem is that often higher caste or influential people get these opportunities and they don't feel themselves accountable to serve poor and low caste people, this weakens the outreach. Finally, the aim to provide employment to lower caste poor people is defeated as in upper caste family both husband and wife get job and in lower caste both of them have to struggle. Leadership influences the implementation. Sometimes influential people create problems and for handing this, transparency is necessary.

Public Distribution System (PDS)

On my first visit to the village I came to know that fair price shop opens only twice (Wednesday, Thursday) a week, so I planned my next visit to the village on Wednesday. I found that shop keeper was sitting outside the shop and doing entries in the card. The board with information on rations was placed in a corner of the shop. Only wheat and kerosene oil was available. However, I found more people carrying wheat and not oil.

During my FGDs with the community I came to know that they get 20 kg wheat @ 3 Rs/kg and 5 litre kerosene @ 10 Rs/kg. Antyodaya Ann Yojana (Yellow card holder) gets wheat @ 2Rs/kg and also get 2 kg Rice @ 3 Rs/kg and 3kg Sugar @ 14 Rs/kg. Shop opens every Wednesday and Thursday but distributes ration only for 2 days in a month. If missed once shop keeper doesn't give extra next month. They said some poor families don't have ration cards. They said 20 kg they get from PDS but it last 8-9 days and again they have to buy these from market, so 20 kg. is not sufficient. Youth shared that often people, who come under BPL criteria don't possess BPL cards. Sometime wheat and oil supply are not proper and if for some reason one missed to take his ration one month shopkeeper doesn't give that month's supply next month. 3 litres oil lasts more than one month and often people don't take it every month so shop keeper is selling it in the black market. The shop keeper also has to give food inspector 1000/- Rs per month. Some BPL card holders actually don't belong to BPL category and they don't take ration so shop keeper also get benefit on these cards. One person shared an experience of buying 3 quintiles of wheat at the rate of 7 Rs/kg while giving 100 Rs extra to shop keeper.

DPM, Public Distribution System: BPL card holders are entitled to 20 kg Wheat per month at 3 Rs/kg and under Antyodaya Ann Yojana 33kg Wheat at 2 /- Rs per kg and 2 kg Rice at 3 /-Rs per Kg is available at Fair Price shop. They can get 15 kg more at the rate of 7/-Rs per kg. Total BPL card issued under this scheme is 96767 (79861-Rural and 16908-Urban). Under Antyodaya Yojana 20785 cards has been issued (17141-Rural and 3643-Urban). In total 315 fair price shops are functional in the district i.e. 42 in urban area and 273 in rural area. Data on SC/ST population is not available. According to the act within 3 km radius one PDS shop should be available. These shops are run by local cooperative societies. Now these shops are mandated to open for 8hrs per day for 6 days a week in rural areas (10am -6pm) in urban areas (8-12pm and

2-6 pm). However from Aug-Sept it will be opened 30 days a month and for this every shop will be manned by 1 person.

Challenges: In communities, who is eligible under BPL criteria don't have BPL card and who is not eligible is actually holding these cards because of corruption in the system. Systems are also built in a modules/part like MDM is under the Panchayat, ICDS under WCD, and if in one department decentralization is so difficult, one can imagine how difficult intersectoral coordination would be. Public mentality is also a problem, if a BPL card holder sells his ration at higher price in the market and buys liquor, who is responsible for their poor nutritional status. Lack of awareness and knowledge is also a problem there is always a difference between literate and educated. If not educated, expected results can't be met. Public awareness in remote areas is must that can be given physically, or through electronic and print media. Constant regular process is needed rather than acting for 1 year and forgetting it for next 5 yrs. If it's a regular process it will appeal somewhere. Some people opine that giving subsidies can create problem as people are becoming dependent on the system. They felt that BPL card and other facilities provided under SC/ST categories are actually harassing peoples' self-image permanently. They suggested there is a need to empower people rather giving subsidies. Here it is worth noticing that corporate also get huge subsidies to set-up industries and they gain profits which is not shared with people or govt. without effecting their self-image.

Annexure-4

Meetings with Civil Society members in M.P.

Dr. Arti Pandey, Journalist, Bhopal

13th July 2009

She has written 12-13 articles on SNP analysis, Right to food, MP Nutrition Policy Analysis etc. She explained that Malnutrition has various aspects and several issues like weight measurement, IFA tablet and Vit A spoon supply.

ICDS: There is no proper training of AWWs, before managing AWCs they are trained in batches of 90 for 3 months. Here these women have to stay away from their family and can't concentrate on the training. Without infrastructure and proper supply of requirements aim of ICDS can't be met. Till UNICEF supplied material AWCs were having medicine kits and other things but now supply is irregular or in some places there is no supply at all.

There is no provision of calculating nutrient availability in SNP. Mostly protein is deficient in these items. Quality is also not good and satisfactory. Infact SNP is increasing malnutrition, as often most items are cereal based. Now if AWC will open from 8 am -2 pm, children will lose 2 meals at their home. For malnourished children double SNP need to be given but the money allotted is not double, this is due to lack of field understanding. SNP is mostly providing empty calories like flaked rice but not something nutritious like chick pea, peanuts etc.

MDM: Nutritional requirement is not met. Ration from PDS is often of poor quality and the items prepared don't have good taste in absence of proper ingredients.

Parents also become dependent on these programmes and don't provide enough at home so children are actually loosing from both sides. Here vit A and protein need to be focused to reduce malnutrition. If in these programmes budget is increased and how it is getting spent (like provision of butter milk, peanuts, chickpea, gur) can be devised, then it is possible to fulfil all nutritional requirements.

NREGA: Corruption is also rampant in rural areas. Poverty is also one reason. In India NREGA is number one in MP on papers, however PRIs are facing problem in its implementation. PRI members if SC/ST or women they face problem in bringing projects in their areas, as they don't have capacity to plan proposal. They get less projects and have more labourers and therefore when work is evaluated it cost much less. Why wages are dependent on pre-determined work, which is based on capacity of a healthy person, if NREGA is to provide employment and source of earning to poor people the criteria should also be determined keeping their capacity in mind. Elderly women can be employed in "Jhulla ghar" (play area for children)

PDS: Central govt. is providing 35kg while MP state govt is giving 20 Kg. Farther people get 17-18 Kg. only. If one person's daily requirement is 3,000-3,600 Calories, the amount given for a family is not sufficient to meet the requirements of even one individual.

Actually the food consumption has decreased over a period of time.

NRC: In NRCs women are taught how to prepare however they don't have food so how they can cook. Unemployment is the reason of poverty and poverty is the reason behind malnutrition.

Earlier UNICEF used to supply CSB powder rich in protein and Soyabean oil that was good but now SNP is in hands of SHGs and quality wise not good. At AWCs there is no facility for storage and thus often SNP get infested.

Suggestion:

Make beneficiaries as stakeholders in MDM and ICDS. In Maharashtra, local committees having parents of these children as members are made responsible to manage, cook and serve and things have improved. As parents will give good food. In rural areas ignorance and lack of time also contribute to malnutrition. In AWC there is no proper storage space and AWWs are pressurized to distribute SNP even if it is not good. Corruption is so rampant in the system AWWs/SHGs have to give commission to supervisors, this is the reason behind why beneficiaries are actually not getting benefits. Monthly progress report of all field functionaries (CDPO, Supervisors, AWWs, ANMs, LHVs) include home visit but there is no awareness in the community. The aim of

providing food through SHGs is actually to provide employment at local level but political interference actually disrupts the implementation. During discussion it was discussed that Supervisors often don't want AWWs to be part of "AWW Sangthan" and there is political and other vested interest in the system which often influences the working of ICDS.
NREGA provides guarantee for 100 days why not for all 365 days in a year. The aim of reducing migration has not fulfilled and it has increased. Every geographic location is different and one policy can't suit everywhere
Malnutrition is not a health issue alone, to tackle this creating demand for food with proper employment is needed.

Mr. Narendra, ActionAid, Bhopal

13th July 2009

In MP hunger deaths are due to lack of purchasing capacity. In MP there is diversity and tribal especially primitive tribes i.e. Sahariyas, are mostly affected as of now. Nearly 94% of children are malnourished in some pockets. Action Aid and other organizations have concentrated the efforts in these villages. Another point is now another tribal groups, who doesn't come under primitive tribes like Korku and Bhil/Bhilala are in vulnerable situation, in last 1 yr more than 100 deaths have occurred among these groups and covered by media at national level. In MP govt has identified 50 Blocks as hot spots for malnutrition, while Action Aid has found that severe malnutrition is prevalent in 250 tribal blocks.

Reasons: Contract farming, privatization and industrialization and export of grains are the main reason behind food insecurity. Policies like globalization/SEZ, infrastructure adjustment, all benefit companies and it comes with some package to address the problem at grassroots. These policies are not made with grassroots people in mind.
State-wide reason is SNP supply is not smooth at grassroots level, often there is imbalance in supply and demand, like which hamlet need to be chosen. Often most marginalized groups don't get justice in planning and delivery of these services.
In MP double the AWCs are needed and the allocation per child for SNP is also increased now. So in the past, children were actually not getting what they needed. Not only in terms of SNP, other factors like child friendly, enabling environment and safe drinking water is missing while planning the infrastructure of these AWCs. AWWs are not trained in pre-school education. They often give bribe to supervisors to continue their job, even for transportation of SNP they need money that is not provided so often it leads to black marketing of stock.
AWWs sometimes comes from another village and often don't belong to tribal community while AWC is in tribal area, this leads to poor services. Often most marginalized communities don't take benefit from AWCs.
At AWC level often there is lack of timely supply of SNP, proper identification of beneficiaries, and quality and quantity provided.
In identification process grassroots politics is involved and issue of social dominance and feudal system is obvious.
NREGA: This is a strategic programme and has its own politics.
PDS: Considering family as unit doesn't ensure food security for individual member as either it causes scarcity (if more members) or surplus (if less members). Cooperative societies are managing it but actually the leaders and political influence is working in the system wherever communities/beneficiaries are involved in distribution and decision making system is working better.
Suggestion:
Alternate strategy has to be found ICDS has 6 components and include caring, education and preparedness by providing healthy and enabling environment. CARE-Integrated Nutrition and Health project (INHP) guidelines focus on reducing purchasing power of the families. UNICEF in its under-6 programme focuses more on 0-3 yr old children through NRC and extra support

through Ready-to-use Therapeutic Food (RUTF). These RUTF are not local and there are issues of sustainability, access and availability. Often this dry RUTF powder chocks the throat of the children and cause vomiting in them. Tribal food was nutritious but because of displacement they don't have access to it now.

There is no system available from which we can find out the deaths among marginalized communities. They don't have livelihood options. If we trace malnutrition deaths it's among tribal and marginalized sections of the society. Children are malnourished because their mothers are malnourished, intra-household food distribution is another reason. In NRC children are the focus but what about their malnourished mothers and other children at homes. Birth Spacing is another problem where mother doesn't have the power to decide.

Unless food security and health issues are not people centred and communities are involved, implementation structure will have its loopholes in terms of identification of beneficiaries, distribution system and policy review. For better implementation of any programme local governance with people is needed. For fulfilment of basic survival needs there is a need to find out the governance and person providing agenda and community involvement in supporting and monitoring of related activities. Mostly marginalization is because of planned discriminatory practices by govt. and people, where one can rule and another has to follow. In Governance accountability is required everywhere. In system SC has made collector accountable for hunger deaths. He mentioned District Poverty Initiative Project (DPIP) a good example of forming common interest group (CIG) and providing space for individuals to intervene and contribute.

Dr. S.K. Trivedi, IIDM, Bhopal

13th July 2009

Since 1997 this development organization is involved in research, consultancy and training. Mainly the area of focus is health, women and children and uptil now completed 75 projects in Kearla, Gujarat, Delhi, Orissa and Assam. The specialization is in Training on BCC/Intra communication, conduct research mainly evaluation studies (NRHM, ICDS, UDISHA, AWTCs/MLTCs) and facilitate local agencies in monitoring and evaluation. Also involved in operational interventions to reduce MMR and NMR. Now trying health insurance for rural areas in association with Apollo and ICMR and another proposal in pipeline is with Hindustan Lever "Swasth Bharat Abhiyan" first pilot phase in Chattisgarh and MP.

Reasons: He opined that ICDS is for supplementary nutrition not for providing basic food security and blaming ICDS for malnutrition deaths is actually demoralizing functionaries/AWWs in ICDS

Suggestion: He suggested that community behaviour need to be changed to improve nutrition level and it's a process where creating awareness and knowledge is not enough to change attitude as there is some value attached with any belief and the strength of this value actually determine how strong is the attitude. Beliefs can't be changed but the value attached to it can, if given with scientific exploration or some fact against the value attached, attitude can be changed. In BCC

Investment is proportional to Attachment
Attachment is proportional to Ownership
Ownership is proportional to Commitment
Commitment is proportional to Implementation
Implementation is proportional to Investment

With OD methods of BCC people realize why this is needed and then invest their time. He also explained in the process consultation actually PAK is the concept where practices and then attitude and then knowledge get changed. He felt that there is a need for developing skills in Development communication.

Finally he suggested that community need to realize the value of nutrition but how to do it is a challenge. Unless community people realize malnutrition as a problem, nutrition level can't be improved.

Ms. Sudeepa, Women Movement, Bhopal

14th July 2009

There is gender budgeting under 2 grades: grade I -100% and grade II- 30-100% allotted for women. She shared often women share that their mother-in-law's say that for that small SNP the daughter-in-law's will not go to AWCs. PDS is for all basic needs why only grains and even sugar is for AAY only. Under MDM SHGs don't have autonomy for decision making and Sarpanch in involved, often there are issues of quality, mechanism and regularity. Health department has its own issues like irregular supply, community pressure where coverage area is too much and staff has to attend too many meetings and even struggle to get travel allowance from superiors. These non-health issues/ social determinants also need to be addressed. Service providers are often not trained enough and have too much work load. She said looking at nutrition issues from gender lens and analyzing gender budgeting and other issues will be useful.

Mr. Anurag, Micronutrient Initiative, Bhopal

14th July 2009

For last 4 years, MI is looking after Vit A supplementation program in coordination with 2 departments: Health and WCD. Initial 2 yrs CINI was implementation partner but for last 2 yrs MI India Trust is looking after MP and Bihar. In MP MI has 6 divisional consultants: Indore, Ujjain, Gwalior, Jabalpur, Sagar and Rewa. MI supplements govt. supply by funding UNICEF. With Vit A supplementation however consultant also monitor immunization but not responsible for reporting officially. Vitamin A first dose is given during routine immunization and 2nd-9th dose are covered under biannual rounds (every 6 months). Earlier Bal Sanjivini Abhiyan (Nodal Dept. WCD) and now Bal Poshan Mah (Nodal Dept. Health) provides deworming, immunization, Vit A and IFA supplementation. MI builds capacity and provides technical inputs to AWW/ANM/MPWs and in last 1 year there is increased awareness about Vit A among stakeholders.

He felt that in MP problem is with the system, state level experts are needed. However, health dept. has improved but WCD still needs strengthening. Supervisor level staff in both health and WCD department is the weakest link and need technical knowledge and skill to execute their duties. If ICDS is expanding it needs to do that with quality by building capacity of technical support training team. At state level these training teams also need refresher training programs. In ICDS IV UNICEF and MI has provided technical support to state government.

Suggestion:

1. To improve nutrition in MP low cost, region specific recipes and practical tips to manage good nutrition status need to be focused upon. (CARE has compiled 17 recipes). Often in any intervention management agenda get fulfilled and community needs remain unaddressed. Often Malnutrition is seen as food insecurity and Infant and Young Child Feeding (IYCF) issues don't get addressed. For this committed training teams are needed to provide IPC with SNP. Often even counsellor employed under health programmes are not trained in Inter-personal Communication (IPC). MP needs experts in nutrition like UNICEF is providing technical support for NRC. But after discharge from NRC what these children are going to eat, follow-up is weak. CINI and CHETNA have good community level model, where communities are involved in addressing malnutrition.
2. He felt that funding is not a problem but **field level innovations** are needed. In one example milk and honey was given to malnourished children in the community. In ICDS some 5-6 years back there was one scheme on "Akshar Vatika," where in every sector 1 AWC having enough space and water showcase kitchen garden, but it hasn't lasted for more than a year.
3. There is a need of working dist and block level model, CARE has worked in Harda district in MP. He cited the example of Chattisgarh govt, where field level staff is working well, as there is enough motivation for Mitanin to become ASHA and ASHAs are becoming ANMs.

In MP, however there is lack of motivation among AWWs as they remain AWWs and not promoted to supervisor level.

4. Under Shaktiman programme in ICDS 3 meals were given to tribal children but often AWWs were busy in cooking and other components/services get neglected. Under Shaktiman project FGDs were done in 3 districts and it was revealed that Annaprashan is normally done with Biscuits. The advertisement of these products (often involving SHGs and panchayat members) is better than IEC of nutrition programmes.
5. He shared one innovative programme in Sheopur under MPRLP for community level management of malnutrition. Here 30-40 select villages were selected and 3 days training was given to field level staff on 5-7 crucial points to address Nutrition and Sanitation at community level. Evaluation of this is still in process.
6. Chief Minister has asked WCD, Health, tribal, food and civil supply and rural development department to bring a coordinated programme, which is a positive idea.
7. Finally he suggested that to improve nutrition counselling need to be strengthened. Staff vacancies need to be advertised and filled. State core group on nutrition and working groups are needed. If there is some budget available at district level this can be used for local innovations. However, malnutrition is an issue in MP but still organization working on this issue need to further strengthen the networking among them.

Ms. Shibani, The Hunger Project (THP-India), Bhopal

14th July 2009

THP has 6 state level offices and 7 states are directly supervised by national office at New Delhi. THP has 3 components/strategies: strengthening women leadership/elected representatives; influencing public opinion; and building alliances. Women elected representatives get leadership modules in 1st year, get need based training in 2nd year, 3rd year form collectives as Federations, which have constitutional power. By 4th year if process is good these block, district and state level federations address larger policy issues in a process called SWEEP (Strengthening Women Empowerment in Electoral Processes). THP influences public opinion by working with media (print, electronic) in doing need based research studies, and bridging the gap between partner NGOs and journalists/stringers. THP also builds issue based alliances with Right groups, civil society and media.

In MP malnutrition is prevalent as gendered construction of resources/food/supplement n families also first to males and then to female if at all.

Traditional dietary habits/medicine/herbs were sustainable now these systems are breaking down and govt. is introducing unsustainable food items. Kitchen garden in every household is a sustainable system but govt is facilitating short-term approaches. Migration also cause pressure on families, nuclear families have greater work load then nutrition, child education these issues get subsided.

Schemes implementation is often not proper, often quality is not good and these benefit MNCs and in terms are inadequate and inappropriate for body system and requirements and further are not at all sustainable.

Broader issues like globalization and how it has increased marginalization and food insecurity is a case to study in India and then in MP of course.

MDM has its functional lacunae in terms of human resources and devolution. Some issues while selection of beneficiaries: participation, need assessment, how well evaluated and checks are brought.

Suggestions:

Involvement of community in assessment of need/nutritional needs and considering how they were meeting their nutritional requirements earlier. This can provide alternate model that is also locale specific rather than making them dependent on the system.

Schemes never considers community's point of view thus have gaps in working out effective plans to meet nutritional needs. Schemes need to leave space for locale specific modifications.

Community if involved in monitoring it will have joint ownership for the programme as well.
Earlier communities used to have Feast together, which was a good place to share and learn about healthy balanced diet. Some like this can be tried out under ICDS programme.
There is so much corruption in the system as govt. is sub-contracting all its responsibilities.
At policy level for proper community involvement, ample representation of women is necessary to bring in gender perspectives
Devolution of authority, responsibility is necessary.

State IEC Consultant, IEC Bureau, Bhopal
15th July 2009

He said that IEC fund pool is a problem so every consultant is looking at IEC from their section and sits at respective offices.
He shared decentralize plan making approach used by him, where first Community Need Assessment was done. However it requires skilled man force for 313 blocks, which was a big HR issue and challenge. As a short cut adopted, certain pamphlets using certain indicators (like IMR, MMR, FP, ARSH) were developed and used in last 1 year to identify high alert blocks/villages. Now he has district IEC plans (using print, electronic, traditional and IPC) but it will take another 2 yrs in implementation. NRHM has State IEC Consultant, District IEC Consultant, Block Extension Educator (BEE), ANM/LHV/ASHA. At district level District IEC consultant, BEE and District Media Officer are the incharge for the planning of district level plans. He shared the concern that now no new appointment is done for BEE post so it's a dying cadre and MPW is becoming the in-charge without any proper training and qualification on IEC.
He shared that now they have planned training for BEE on proper training. District Media Officer also needs training on articulation to make them able for planning, implementation and reporting of IEC activities.
He shared a successful example of using VHSC for conducting "Swasthya Chaupal" in 10 villages of 2 districts. He opined that opinion leaders/gate keepers need to be involved and supported for success of any IEC campaign.
Reasons: Poverty, population and discrimination against girl child are the main reason of malnutrition. In NRC more boy child is coming especially from rural areas. When both parents are working as labour there is no one to care for children. On one hand there is lack of awareness and proper knowledge on low cost foods and on the other dealing with myths and misconception is a challenge. Schemes have corruption, even fool proof plan have problems in implementation and there is wastage of time and manpower in leakage.
Suggestion: IEC need strengthening. People need to know what malnutrition is and what are its effects? Clear cut message in local vocabulary on how to maintain good nutritional status with low cost foods and also what are the provisions available by govt. under different schemes and how to access them. He said that on DD-I a programme "Qunki Jeena Isi Ka Naam Hai" explains provisions under different govt. schemes/programmes.
He suggested conducting a people forum with involvement of opinion leaders to make community aware about the need of various services and provision under different programmes. Under NRC follow-up need to be focused more so that proper locally available food items can be ensured to children after discharge.

Mr. Prashant, Mr. Sachin Jain, Ms. Rolly Shivhare, Vikas Samvad, Bhopal
15th July 2009

Vikas Samvad is involved in training of stringers and other grass root NGO workers on issues related to health, nutrition, PDS and human resource. It also train/orient these in discussing and writing skills. However, this lead to many discussions but there was no regular follow-up and NGOs also has shown less interest. From 2004-05, Media Fellowship got started for mainstream journalist to bring policy changes. Vikas Samvad work as a resource center for

journalist. Media Forum also got organized in 12 districts to discuss, share and exchange views and perspective on such development issues. Media also get exposure and grassroots and middle level NGOs get training on Right to Food, RTI and NREGA provisions under these and SC orders, so that these NGOs can be part of the process and support in advocacy. Vikas Samavad has done some studies on NREGA and ICDS and shared with state govt.

Reasons:

1. **ICDS:**

- Here they have found out that treatment of SAM need some community based approach and Coordination is a problem.
- Policies need to come from the bottom as solution vary district wise. In 4 yrs SNP policy got changed 16 times.
- Besides this, no Nutritionist is appointed to calculate nutritional requirement and SNP nutritional value.

2. NREGA also has problems like delayed payment, no wage guidelines of state govt. and 40-60% fake entries. People are not empowered enough to handle their bank accounts. NREGA task are according to physical and mentally healthy person. It is debatable as to how tasks under NREGA are defined for providing employment to food insecure population. Actually this is systematic exclusion of this population. Further it's too early to see NREGA effect on food security.
3. There are broader issues related with malnutrition like how society perceives development, and the right of 1-18yrs old. First we need to provide them protection and optimal development opportunities, then we can expect them to contribute. In govt. system or even in society children don't share rightful relation, earlier socially these rights were ensured but now these are missing. Now development is seen as economic growth based priorities. This has created a special class conflict with children/older people according to age/life cycle. Where there is conflict on resources and livelihoods and control over water and food children get malnourished. This is not mere coincidence that malnutrition is most prevalent among tribals.
4. Services either don't reach at community level or not with dignity. Service providers expect people to come themselves to get services when there is stigma and exclusionary practices against SC/ST. For tribal community their own health system has collapsed and they are left with no alternate as don't have faith in public health system.
5. How important is nutritional status of children (under 6), 16% of the population can be seen from these figures: they get 1% of the budget, don't have any legal accountability from the system or comprehensive child Right Act, no accountability to ensure their entitlements.
6. In system WCD blame health and Health blame WCD otherwise these two department come together and blame community.
7. There is segmented approach for treatment of diarrhea, Vit A deficiency, Iron deficiency Anemia and malnutrition.
8. No convergence in action or joint ownership under different schemes as there is no conceptual framework or one approach to deal with this issue. Everytime look for readymade solution may be only nutrition programmes is not the solution for this problem. SNP looks at calorie deficiency it should be in perspective to protein deficiency as well. According to govt. circular there is a gap of 550 calories however MDM try to provide 300 calories, thus schemes are not fulfilling the nutritional needs.
9. Demolition of natural food economy raises two issues of larger food security and food security for children.
10. PDS: After 90s govt. has done a reduction in subsidies, first in 1992 there was a rise in PDS commodities and then in 1997 it became targeted PDS for BPL families, 36% of the population so 64% systematically excluded for policy support. In MP further to this according to central govt estimate of 37% BPL families PDS ration comes for 41.25 lakh however state has 67 lakh BPL cardholders, thus state distribute 20 kg ration to these

families rather than 35 kg distributed elsewhere in the country. Further corruption in implementation not allows this to reach to the beneficiary level.

11. With recurrent droughts livelihood system reduced.

Suggestion:

There is a social perspective of govt. policies, conditional cash transfer is not the answer as it is actually lack of faith/belief in govt. machinery. No system of accountability if there is no system/social protection net. As ours is welfare state, it has the duty to ensure human development and take every measure to facilitate fulfilment of related human rights. Sustainable livelihood may be the solution rather than 100 days labour under NREGA.

1. All schemes ICDS, MDM, PDS are cereal grain based however according to NIN cereal constitute only 40% of the balanced diet thus these should ensure other 60% of the nutritional requirements by including pulses, edible oil, milk, vegetables, egg under it. MDM gives 2.0 Rs per child for pulse and vegetable purchase???
2. Larger livestock and agriculture policies also contribute to undernutrition as they also ignore vitamin and mineral requirements in human diet. Pulse production has reduced to only 25% of the 1960s production. These are especially important as schemes only can't ensure household food security.
3. Community based mechanism to deal with malnutrition need to be in place. NRC deal with severe malnutrition but mild and moderate still need attention. These mild and moderate malnourished children and even severe malnourished children without complication can be treated at community level with natural household food (SAM-high calorie diet), regular health check-up and immunization, growth monitoring, deworming, systematic SNP (local, hot cooked meal) and household support in terms of food security.
4. Calorie dense food RUTF further can be debated for its non commercialization, as it should address the need to the community where it is required. Non involvement of MNCs, decentralize approach and involving cooperative sector is sustainable.
5. NRC needs to be strengthened further, as only 145 are fully operational to treat 10 lakh critically malnourished children. Quality of F75 and F100, state level monitoring as packaged food is not the solution, more community based and decentralized approach is needed.
6. Further exclusive breastfeeding, timely and adequate complementary feeding and safe drinking water are also important.
7. Actual interest and intentions get changed at various levels like earlier policy intention for ICDS was for SC/ST and universalization was not envisaged. Therefore out of 10 million children only 5 million are enrolled and budget allocation, accountability, monitoring and evaluation all are weak, accordingly.
8. Many a times political interest work in the system, who will be the AWW/ANM is decided by them and education criteria and other things systematically exclude few groups. At various levels non-politicalization of child right issues is needed.
9. According to NSSO- monthly per capita expenditure (2008), MP has lowest grain consumption, average monthly consumption is 9.72 Kg/person however 14 kg/person is recommended to meet nutritional requirements.
10. Larger issues need to be addressed with a holistic approach. ICDS and MDM are for a particular segment and can't solve malnutrition problem alone. However, mode of access to the services/ provisions under these schemes and addressing exclusion issues are major challenges.

Annexure-5

Meetings with Civil Society members in Bangalore

Meeting with Dr. Vanaja Ramprasad, GREEN Foundation
11th June; BTM layout, Bangalore

Dr Vanaja explained how Health and environment are interrelated with Agricultural system. She further explained how Green revolution and focus on mono-cropping are responsible for loss of food diversity. She said that first Convention on Biodiversity (CBD) talked about how agricultural diversity is the only answer of food diversity ultimately leading to food security. She explained how political decisions on agriculture in last 2-3 decades have actually caused more pollution, loss of diversity and soil salinity.
She suggested while doing Micro-study in M.P. it will be a good idea to look at the agricultural practices changed overtime especially the variety of crop produce. This discussion helped me understand the link between changing agricultural practices with the changing food patterns of the communities and increasing malnutrition.

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Meeting with Dr. Anil, SVYM
Dollars colony, Bangalore

Dr Anil explained the SVYM initiative on Vit-A funded by Micronutrient Initiative (MI), where they focus on inter-sectoral coordination (AWW, ANM); community participation and monitoring with stakeholders (civil society) role influencing govt. policies and programs. Vit A supplementation is actually implemented through govt. centres (Health (provides service) & ICDS (for community mobilization). He shared that VitA supplementation is done in 2 rounds (Jan & July) and the coverage is 90% in state. However, coverage is 50% and >90% in urban and rural areas, respectively. This discussion helped me understand the systemic structure of Health and WCD departments as SVYM is working in collaboration with them.

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Meeting with Ms. Kathyayni Chamraj, CIVIC
19th September; Santhinagar, Bangalore

She talked about her papers in InfoChange and Deccan Herald on Food Security. She has shared that in a study it came to notice that living in a slum requires around Rs 5,100/- and minimum wages are insufficient to get that so children are also into work. Even after child labour family is able to get around Rs 4,000/-. This is according to the food they are taking now, not the balanced diet which they should take.
To improve nutrition she suggested working towards ensuring optimal Infant and Young Child Feeding (IYCF) practices, Crèche facilities and appropriate Information, Education and Communication (IEC). On all government run programmes delivery centres "Citizen Charter" should be placed.

She also opined that NGOs must work towards ensuring development in the changing scenario rather than protesting against without looking at the ground realities and working towards ensuring the basic rights. For e.g. Water privatization and child labour. NGOs are protesting against charging for water and installation of water meters but they are not looking at how much time and energy these women are loosing in queues to collect water daily. She said that civil

society has a role to suggest constructive and practical alternatives, what changes are needed and how.

Finally, to ensure food security in today's context, we need to work towards:

1. Ensuring food affordability
2. Providing nutrition education
3. Day long Crèches
4. Safe Drinking water (Piped Supply)
5. Sanitation

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Meeting with Asha Kilaru, Belaku Trust
12th October; JP Nagar, Bangalore

Belaku Trust's current focus is on income generation, however they have worked with ICDS. To ensure community participation and ownership they have facilitated a process of building village level committees in 6 villages. One volunteer from these committees is paid by the organization to support Anganwadi worker (AWW) in her work. With time communities has taken more ownership and now they want to support this volunteer themselves.

Uptil now CDPOs were supportive in this initiative but paying this volunteer by communities make them uncomfortable as this will mean that community is paying to implement government programme.

She also shared the nutrition education intervention done in 11 villages. She has given 2 papers published out of this study where the effect of interventions was analysed against infant growth.

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Meeting with Mr. C. Murali, ILID
26th October; Dollars Colony, Bangalore

Discussing the cause of malnutrition he said that lack of general awareness and economic factors are the key challenges. He said that Nutrition related programs can be supplement but not substitute and working for self-sufficiency at village level is the only answer. Through multitude of programs locally available nutritious food items and optimal infant feeding need to be encouraged. Building awareness or improving perceived value for nutrition can be done through education. SHGs, school/colleges and co-operative societies should be made part of this awareness campaign. If awareness is improved the disposable surplus created through cash cropping will be used appropriately.

Habit is formed through constant reinforcement and as awareness created among children in school and colleges will actually change the life long practices. Many a time's children question their parents and prove change agents for the communities. Also village centres can be used for disseminating information. However, govt. alone can't solve this huge challenge and UPA govt. new initiative Aam Adami Ka Sipahi (AAKS) is a good initiative to create awareness among communities on government programmes and schemes. It can bring long term benefit.

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Meeting with Ms. Aditi Iyer, IIM Bangalore
28th October; IIM, Banerghatta Road, Bangalore

I briefed her about my micro-study on Nutrition related programmes in M.P. She suggested that as the sample size is very small, while presenting the findings "who said what" and then analyzing the reason behind it will be good idea. She suggested that positionality of the persons actually determine what they say in terms of issues with access, quality and operations. While

finding out the Barriers to Access for the nutrition related programmes, we found that on the supply side there are: systemic, logistic/infrastructural issues and incentive based service provisions, while on the demand side there are knowledge/awareness related issues which were also related to broader social issues like caste, class, gender. The interface between the supply and demand sides need to be strengthened with awareness building.

She said that often admitting problem or failure is an issue, as people are not supposed or encouraged to come out with problems and they have to project as they are doing good job. There is also a huge human resource issue: supervision and that too supportive supervision. After analyzing all the barriers it will be good to look at: What, Why and what is the potential of changing, what it takes to come out with a set of actions according to priority. Also actions need to be based on who is going to use them, for NGOs to do similar study, some methodology: protocols/questions, tools, check-list can be developed. Some policy briefs can also be developed by learning from organizations working on health/nutrition in other countries.

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Annexure-6

National Consultation on Nutrition

Organized by CLRA and CARE; 23rd September; India International Centre IIC, New Delhi

Mukesh Kumar, Senior Program Director, CARE presented the Jharkhand model "Prioritizing Nutrition: Learning from the field." He shared how the myths of poverty, food insecurity the reason behind malnutrition got busted during the interaction with women and mothers at the grass roots level. He then shared that networking with all stakeholders like local governance, activists, media, relevant line departments, political leadership and quasi judicial bodies is the key while ensuring nutrition at the grassroots.

Then Viplove Thakur , MP Rajya Sabha talked about the "Role Of Political Leaders In Preventing Malnutrition," she suggested that awareness about nutrition, balanced diet, why child need micronutrients and others like malnutrition and its consequences is needed especially in rural areas. Political leaders also need awareness about this grave problem and involving MPs is the key. She further suggested that food habits and behaviours are very much locale specific and any strategy should be according to state.

Gerard la Forgia, Led Health Specialist, The World Bank shared "Political Leadership to improve Nutrition: experiences from other countries." He said that to achieve significant benefits we need to do "Business unusual," as nutrition is nobody's responsibility but business of institutional and political interest. In Latin America the prime minister and president led the nutrition mission and in Mexico also high level commission financed nutrition activities with making ministries accountable for results. Division of responsibilities and financing for inter-sectoral coordination should be clearly defined like who is accountable, for whom and for what. Accountability for results should be for at both levels community and at top. Thailand has experience of reducing malnutrition from 50% to 8% with institutional arrangements for 1 program in coordination with 4 ministries; it is overlooked by deputy Pm reporting to PM. Technical and political support is also needed from CBOs. Learning from experience suggests that regular monitoring, with appropriate monitoring indicators and community mobilization are crucial to attain nutrition security.

In the key note address, Krishna Tirath, minister W&C development said that 90% of ministry's fund is for children. Ministry is taking various measures like setting up Appex Body, tracker system and control rooms, so that rigorous monitoring and implementation of programmes can be done with the help of CBOs, teachers and housewives.

Shreeranjan, Secretary W&C, said that in ICDS IV World Bank has supported the system improvement and it will tackle malnutrition from intergenerational cycle point of view. There is a need to propagate information on how nutrition is interlinked with health, PDS, education.

Mr. Divakar from JNU presented a study on "Undernutrition in India: A Resource Gap Analysis," where NSSO survey household intake. BMI in women, ICDS coverage, access index for nutrition Schemes and SNP index and Health Index. Findings showed a clear gap in resource actual allocation and intentions.

In a group session on "Nutrition Security and Role of Different Stakeholders" 2 MPs from West Bengal i.e. Dr Kakoli Ghosh and Dr Saha, Ashi Kathuria, World bank, Anand Madhav, Jagaran Pehel and Nayana Sir Dorabji Tata Trust presented their views. Dr. Kakoli Ghosh said that article 39 A of constitution talks about right to food and article 47 makes state accountable. She said that nutrition is an intersectoral issue. She also said that PDS only looks at energy (25 kg cereal at 3Rs/kg.) other requirements like protein, minerals, vitamins should also be looked into. Recent trends like increasing number of agriculture labourers and reducing calorie consumption in India should be looked while planning policies, as right now government system is not reaching last people. For better implementation appropriate women representation in an interdisciplinary high power committee with proper budget allocation is required. That can take

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up issues like water, transport, supportive prices to farmers, proper store house and procurement mechanism. There is also need to create awareness on what kind of food should be taken by mother for herself and for her child (BF and CF).

Dr Saha, another MP, suggested that proper implementation and utilization of fund with appropriate surveillance of implementation of policies is necessary. Social behaviour to women, sanitation, and drinking water are other issues. However, food availability is not a problem but its wrong distribution is.

Anand Madhav said that media's role is more in behaviour change, but as media has also become a commodity, it's difficult to cover social issues and sometimes it's more challenging to deal with too many expectations. He suggested that awareness is needed on what all is required and media partnership should be from beginning as continuous effort. Finally, the points came include:

- It's critical to create awareness,
- Mapping malnutrition by involving PRIs and multiple stakeholders,
- Rewarding ICDS/SHGs who are able to bring 0-6 malnutrition down,
- Bringing together right to food and right to nutrition,
- promoting community action (involving men)
- Convergence
- Scaling up good practices
- Monitor the quality and feasibility of local food models
- Proper modification in policy
- Evidence based advocacy

Victor, UNICEF said that ultimate solution is working at window of opportunity (pregnancy to 2yrs old) by focusing on home/household based care through providers and not providing all solutions at AWCs. Focusing on health visitors (AWWs) home visits for under twos and exclusive breastfeeding intervention is crucial.

Ashi Kathuria, World Bank also said that focus should be on window of opportunity (pregnant, nursing women and 0-2 yr old children; 10 essential intervention areas and behaviour change at household level. Here media can provide simple messages, MPs can ensure women participation and CBOs can do community mobilization by bringing together all stakeholders.

Mira Shiva, talked about that nobody has a clue on existing national plan of action on Nutrition, health has only IFA, Vit A and IDD; Food productivity and equitable distribution issues are also there and women has to bear the triple burden because of Fuel and water policy.

In the end, CARE Jharkhand Model on prioritizing nutrition highlighted the decentralization of nutrition program and food model, to ensure nutrition security. Through prioritizing home visits it ensures:

- Self reliant community based nutrition programs
- Community participation

Devolution of responsibility and participation is the key.

II. Concept Plan- Campaign activities

1. Monitoring government policies and programs by launching:
    - Food supplement watch
    - Food subsidy monitoring
2. Campaigning against the food dumping by the powerful nations like United States.
3. Campaigning against the use of chemical manure in farming and Promoting organic farming.
4. Campaigning against the genetically modified foods.
5. Boycotting the multinational companies promoting unhealthy food like soft drinks, canned foods and MSG (Monosodium glutamate) containing food products.

III. Concept Plan-Action

Some of the immediate actions are as follows:

1. Networking and developing this concept plan with IPHU alumni and others involved in PHM
2. Carry out pilot studies
3. Review and extend
4. Fund raising
5. Evaluation

To ensure food security in the society the PHM initiative would understand issues at local level and take up strategies at regional, national and global level.

Let's come together, to work towards "FOOD SECURITY" to achieve **"Health for All, NOW"**

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