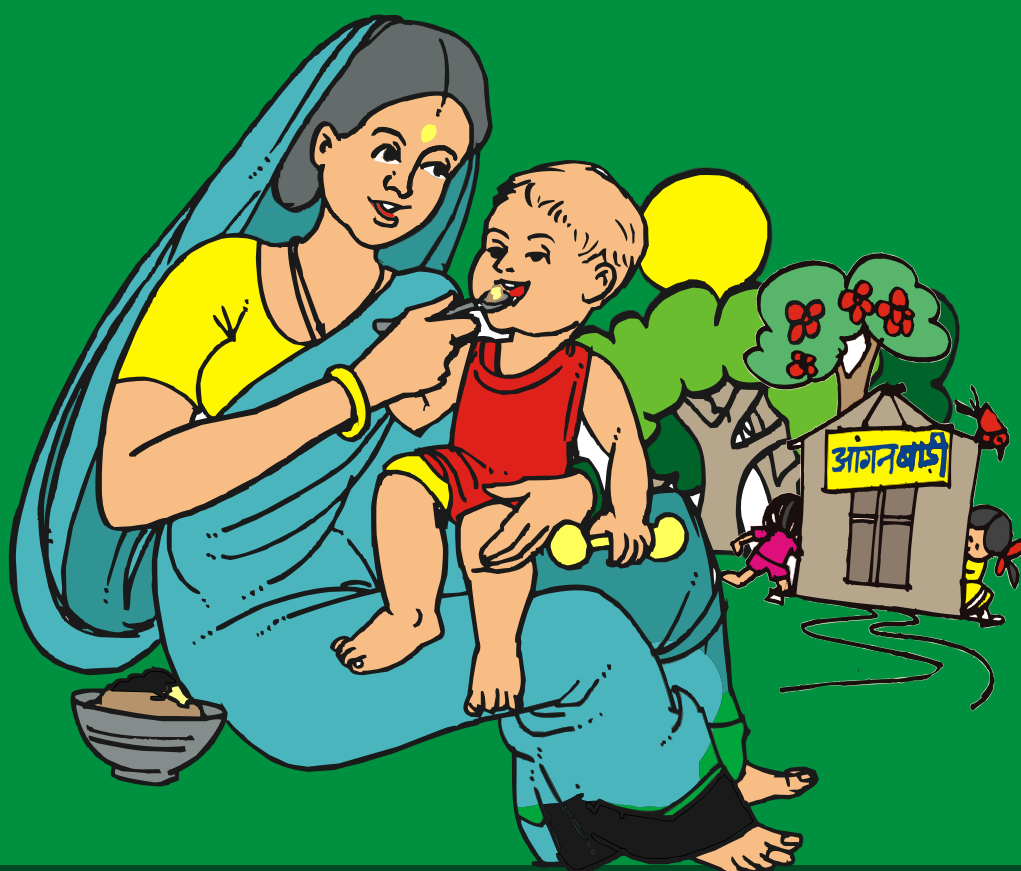


Right to Food and Nutrition of Mother and Children in India



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Where we are?

Note on state of malnutrition in India

The National Family Health Survey (NFHS 3 - 2005-06) findings are:

Children

- 38.4% of children under the age of three are stunted, that is too short for their age and 46% are underweight that is too thin for their age. Both indicators have slightly improved from 1998-99.
- Wasting, defined as an abnormally low weight for the child's height affects 19% of children under the age of three with a slight deterioration from 1998-99.
- Overall girls and boys are about likely to be undernourished. Under-nutrition is higher in rural areas and is strongly correlated with the level of maternal education showing a two-fold difference between non-educated mothers and 10-year and above educated mothers. This may be linked to a stark difference in access to a nutritious diet and complementary feeding at 6-9 months.
- Most children under age three are anemic (79.2%). The prevalence is slightly higher in rural areas and among non-educated mothers. High prevalence of anaemia may be linked to poor variety of diet, poor hygienic conditions and limited access to iron supplementation.

Women

- More than a third (36%) of women have BMI below 18.5 indicating a high prevalence of nutritional deficiency.
- Malnutrition levels are higher amongst girls. Almost half the girls 15-19 are undernourished.
- Prevalence of undernutrition is nearly two times higher amongst women with no education than amongst those with 12 years or more of schooling {More than half the women in the highest income quintile are underweight}.
- Undernutrition is more prevalent in rural areas.
- The anemia situation has worsened over time for women.
- The prevalence of anemia is marginally higher in rural areas than in urban areas. More than 50 % of the women in urban areas are anemic with almost third of them with moderate to severe anemia.

The dismal state of affairs could be summarized:

(see www.motherchildnutrition.org)

- For every ten children aged three or less, born to illiterate mothers, 5 children are stunted - too short for their age. This is a sign of chronic malnutrition. (Compared with: 2 children born to well-educated mothers).
- For every ten children aged three or less, born to illiterate mothers, 5 are underweight - too thin for their age. This is a sign of acute and chronic

- malnutrition. (Compared with: 3 children born to well-educated mothers).
- For every ten children aged three or less, born to illiterate mothers, 2 are wasted - too thin for his/her height. This is a sign of acute malnutrition and the child is at risk of dying from malnutrition or from any common child disease like diarrhoea or respiratory infections. (Compared with: 1 child born to well-educated mothers).
- For every ten children aged 6-9 months, born to illiterate mothers, 5 children receive solid or semi-solid foods in addition to breast milk as recommended. (Compared with: 7 children born to well-educated mothers)
- For every ten children aged one to three years, born to illiterate mothers, less than 2 children received Vitamin A supplement in the last six months prior the survey. (Compared with: 3 children born to well-educated mothers)
- For every ten illiterate women aged 15-49 years, 4 have a Body Mass Index (BMI) below normal - too thin. (Compared with: 2 well-educated women). The prevalence of women with a lower BMI is two-fold higher in rural areas than in urban areas.
- For every ten pregnant illiterate women, 6 women are anaemic but less than one takes Iron and Folic Acid (IFA) supplementation for 90 days as recommended. (Compared with: 5 well-educated pregnant women with an equal number accessing IFA supplementation as recommended)
- In India, for every ten women, 4 women are illiterate and 6 are educated. 8 out of 10 illiterate women belong to the lowest wealth quintile. Among the educated women, 2 are well-educated (10 years complete and above), less than 2 have 8-9 years complete and 2 have less than 8 years complete.

Even sub-Saharan Africa has a better record of child malnourishment at 30 per cent while China records eight per cent and Pakistan 37 per cent. A massive 440 million people languish at the bottom of the economic pyramid in India and about 500,000 children are born deformed each year due to vitamin/mineral deficiencies. India's child sex ratio is still a nettlesome 927 girls for every 1,000 boys while even some of the poor African countries (Nigeria at 965 and Ghana at 964) fare better - as does neighbouring Pakistan with 958.

National Institute of Nutrition carried out studies on diet and nutritional status of the special age groups such as adolescents and elderly people. The results revealed that both the groups were subsisting on inadequate diets and their diets were deficient of almost all the nutrients. About half of the elderly were suffering from CED and the prevalence of under nutrition was about 53% and 40% in adolescent boys and girls respectively

While the focus is on women and children, little has been done to study and remedy the problem of those who do manual work. They are essentially calorie machines. Most often these men consume themselves since the calorie output is more than the input.

ICDS and Child Rights :

Child Rights and Integrated Child Development Services:

Children are in the process of growth and development and thus have particular needs, vulnerabilities and strengths that are the basis for their having special rights. The most crucial period in a child's growth is the first six years of life, when around 40% of his or her physical and 80% mental growth are believed to take place. It has been established that poorly nourished children grow less rapidly than well-nourished children, both physically and mentally. Malnutrition during the growing periods of infancy and childhood leaves some physical and psychological damage in later years of life. Children under the age of five are most vulnerable to malnutrition. The World Health Organization (WHO) links malnutrition to at least half of the approximately ten million child deaths that occur every year. Younger children are more vulnerable to disease resulting from malnutrition and they also experience irreversible physical and mental damage that affects them throughout their lifetimes

India faces a severe challenge in the area of children and nutrition. Presently:

- Every third malnourished child in the world lives in India
- 47% of Indian children under the age of six years are malnourished
- Every second child in India is underweight
- One third of Indian children are stunted
- Three out of four children in India are anemic
- 79% of children aged between six and 35 months are anemic which increased at a 4% rate in 2006
- The decline in male-female ratio is maximum in 0-6 years 927 females per thousand males
- Birth registration is just 62% (RGI-2004)

Major factors relating to child malnutrition are children's poor diets, mothers' health during pregnancy, and mothers' diets during pregnancy. Malnutrition tends to occur during the first thirty-three months of a child's life: from conception until the child's second birthday. Thus, this is, nutritionally speaking, the most critical period of a child's life. After a child's second birthday, it becomes much more difficult to reverse the effects of malnutrition particularly in terms of brain development.

Children may be born already malnourished if their mothers have poor diets and poor health during pregnancy. Thus, ensuring that both pregnant women and who may become pregnant are healthy and eat balanced, nutritious diets, will be enormously effective in combating malnourishment in children.

Constitutional and Legislative Framework :

The Constitution of India sets forth certain safeguards regarding children and food access:

- Article 39-f of the Constitution provides: Children shall be given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity and that childhood and youth shall be protected against moral and material abandonment;
- Article 39-e provides: The State shall direct its policy towards securing that the health and strength of workers, men and women and the tender age of children are not abused and that they are not forced by economic necessity to enter vocations unsuited to their age and strength;
- Article 47 provides: the “state shall endeavor to raise the level of nutrition and standard of living and improve public health.”
- Article 243-g, read with Schedule 11, provides for institutionalization of child care, by seeking to entrust programmes of Women and Child Development to Panchayats (see: Item 25 of Schedule 11), aside from education, family welfare, health and sanitation, and other items bearing on the welfare of children.

Judicial Opinions:

The Supreme Court of India has held, “[the] right to life guaranteed in any civilised society implies the right to food, water, decent environment, education, medical care and shelter” and the right to life protected by Article 21 includes the right to water and “the right to live with human dignity and all that goes along with it, namely, the bare necessities of life such as adequate nutrition, clothing and shelter over the head. . . .” The People's Union of Civil Liberty filed a writ petition with the Supreme Court in April 2001, seeking, among other things, clarification of the “right to life” under Article 21 of the Constitution. The basic argument of the petition is that, since food is essential for survival, the right to food emanates from the fundamental “right to life” enshrined in Article 21 of the Indian Constitution. Although the Court has not yet handed down a decision, it has passed significant interim orders. The interim orders are effective while the case is pending, and may be reiterated in a final judgment if and when the case is decided. The first major interim order was issued on 28 November, 2001, and focused on eight food-related schemes. Certain of these schemes are pertinent to the issue of children and nutrition, such as:

- Mid Day Meal Scheme (MDMS) “We direct the State Governments/Union Territories to implement the Mid-Day Meal Scheme by providing every child in every Government and Government assisted Primary Schools with a prepared mid day meal with a minimum content of 300 calories and 8-12 grams of protein each day of school for a minimum of 200 days. Those Governments providing dry rations instead of cooked meals must within three months start providing cooked meals in all Govt. and Govt. aided

Primary Schools in all half the Districts of the State (in order of poverty) and must within a further period of three months extend the provision of cooked meals to the remaining parts of the State”.

- Integrated Child Development Scheme (ICDS) “We direct the State Govts./Union Territories to implement the Integrated Child Development Scheme (ICDS) in full and to ensure that every ICDS disbursing centre in the country shall provide as under: Each child up to 6 years of age to get 300 calories and 8-10 grams of protein; Each adolescent girl to get 500 calories and 20-25 grams of protein; Each pregnant woman and each nursing mother to get 500 calories & 20-25 grams of protein; Each malnourished child to get 600 calories and 16-20 grams of protein; Have a disbursement centre in every settlement”. These figures were later updated so that children are now to receive 500 calories and 12-15 grams of protein, severely malnourished children are to receive 800 calories and 20-25 grams of protein, and women are to receive 600 calories and 18-20 grams of protein.
- National Maternity Benefit Scheme (NMBS) “We direct the State Govts./Union Territories to implement the National Maternity Benefit Scheme (NMBS) by paying all BPL pregnant women INR 500/- through the Sarpanch 8-12 weeks prior to delivery for each of the first two births”.

International Commitments:

India has ratified all international treaties relevant for protecting the right to food as well as children's rights, including the International Covenant on Economic, Social and Cultural Rights, the main international instrument protecting the right to food, the International Covenant on Civil and Political Rights (art. 6), the Convention on the Rights of the Child (arts. 24 and 27) and the Convention on the Elimination of All Forms of Discrimination against Women (arts. 12 and 14). This means that, under its international commitments, the Government of India is obliged to ensure the right to food of all Indians.

Two of the 10 MDGs set by the 191 member states of the United Nations in 2000 to reduce child mortality rates by two-thirds and maternal mortality rate by three-fourths by 2015 are also relevant with regard to child development and care.

Millennium Development Goals (MDG)-1, 4 and 5

- MDG 1: Eradicate extreme poverty and hunger
- Targets: Reduce by half the proportion of people who suffer from hunger
- Prevalence of underweight children under-five years of age
- Proportion of population below minimum dietary energy consumption
- India is far from achieving MDG 1:
- MDG-4: Reduce Child Mortality
- MDG-5: Improve Maternal Health

The United Nations Convention on the Rights of the Child (1989):

Article 24 addresses the need for adequate food, and directly calls for the

inclusion of clean drinking water in consideration of the health and nutritional well-being of the child. This treaty was drafted to identify and protect the best interests of the child.

This article further recognizes "the right of the child to the highest attainable standard of health" is immensely important. State parties commit to taking steps toward ending child and infant mortality, and eliminate the circumstances that lead to child death including illness and malnutrition. Governments must provide children with food and water security.

This treaty ties the rights of the mother to the well being of the child. Article 24 acknowledges the mother's right to appropriate pre and post-natal health care, as well as access to information and education regarding child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation.

The Integrated Child Development Service (ICDS) Scheme:

Prior to the Fifth Five-Year Plan, the government's focus was on child welfare through the promotion of basic minimum services for children, which culminated in the adoption of the National Policy for Children in 1974. The Fifth Five-Year Plan (1974-79) saw a shift of focus from welfare to development and the integration and co-ordination of services after the Integrated Child Development Services (ICDS) 1975. The ICDS is the only Government program in the country that addresses the needs of children under the age of six. As this programme is an outcome of national policy for children adopted by the Gov't in 1974, acknowledging that majority of Indian children live in impoverished economic, social and environmental conditions, which impede their physical and mental development. It seeks to provide young children with an integrated package of services such as supplementary nutrition, health care and preschool education. Since health and nutrition needs can not be addressed in isolation from those of his/her mother, programme extends to adolescent girls, pregnant women and nursing mothers. This programme began on small scale, in selected blocks (generally of the most vulnerable groups of the Indian population), with policy commitment to universalize child development.

ICDS Objectives:

- 1) To improve the nutritional and health status of children below the age of six.
- 2) To reduce the incidence of mortality, morbidity, malnutrition etc.
- 3) To achieve effective coordination of policy and implementation among various departments to promote child development.
- 4) To enhance the capability of the mother to look after the normal health, nutritional and developmental need of the child through proper community education.

ICDS services are provided under the responsibility of the Department of Women and Child development, through a vast network of ICDS centers, best known as anganwadi centers (AWC). These centers are operated by modestly paid anganwadi workers (AWW), assisted by anganwadi helpers or shayika. Each anganwadi is supposed to cover a population of about 1000 persons (200 families).

The basic services provided by ICDS fall under three broad headings: Nutrition, Health and Pre-education.

A. Nutrition

- 1) Supplementary Nutrition (SNP): The nutrition component varies from state to state, but usually consists of a hot meal cooked at the anganwadi, based on a mix of pulses, cereals, oil, vegetables, sugar, iodized salt, etc. Take home rations (THR) are provided for children under the age of three years.
- 2) Growth Monitoring and Promotion: Children under three are weighed once a month, to keep a check on their health and nutrition status. Elder children are weighed once a quarter. Growth charts are kept to detect when a child's growth is faltering.
- 3) Nutrition and Health Education (NHE): The aim of NHE is to help women aged 15-45 years to look after their own health and nutrition needs, as well as those of their children and families. NHE is imparted through counseling sessions, home visits and demonstrations. It covers issues such as infant feeding, family planning, utilization of health services etc.

B. Health

- 1) Immunization: children under the age of six are immunized against DPT (Diphtheria, Pertussis, Tetanus), measles and tuberculosis, while pregnant women are immunized against tetanus. Immunization is a joint responsibility of ICDS and the Health Department. The main role of the AWW is to assist health staff to maintain records, motivate the parents, and organize immunization sessions.
- 2) Health Services: A range of health services are supposed to be provided through the AWC, including health checkups of children under six, ante-natal care of expectant mothers, post natal-care of nursing mothers, recording of weight, management of under nutrition and treatment of minor ailments.
- 3) Referral Services: This service is intended to link sick or undernourished children, those with disabilities, and other children requiring medical attention with the public health care system Primary Health Centers (PHC).

C. Pre-School Education (PSE)

The aim of PSE is to provide a learning environment to children aged 3-6 years

and early care. PSE is imparted through the medium of “play” to promote the social, emotional, cognitive, physical and aesthetic development of child as well as to prepare him/her for primary schooling.

Government programs are only meant to provide supplemental food and nutrition. Each child up to six years of age is officially provided 300 calories and 810 grams of protein, each adolescent girl 500 calories and 2025 grams of protein and each malnourished child 600 calories and 1620 grams of protein. This may be enough for one meal.

Universal coverage of beneficiaries:

The Supreme Court has sought to categorically ensure coverage to all children below the age of six, pregnant and lactating mothers, and adolescent girls, who live in rural habitations or urban slums. This coverage should include all nutritional and health services of the ICDS. The Court has issued instructions accordingly. The order of the Court dated 28th November, 2001 stated, “We direct the State Governments/Union Territories to implement the Integrated Child Development Scheme (ICDS) in full and to ensure that every ICDS disbursing centre in the Country shall provide as under:

- (a) Each child up to six years of age to get 300 calories and 8-10 grams of protein [updated figures: 500 calories and 12-15 grams of protein];
- (b) Each adolescent girl to get 500 calories and 2025 grams of protein;
- (c) Each pregnant woman and each nursing mother to get 500 calories & 2025 grams of protein [updated figures: 600 calories and 18-20 grams of protein];
- (d) Each malnourished child to get 600 calories and 12-15 grams of protein [updated figures: 800 calories and 20-25 grams of protein];
- (e) Have a disbursement centre in every settlement”

Further, the order dated 13th December, 2006 states that “The universalisation of the ICDS involves extending all ICDS services (Supplementary nutrition, growth monitoring, nutrition and health education, immunization, referral and pre-school education) to every child under the age of six, all pregnant women and lactating mothers and all adolescent girls.”

Although the coverage of children under six under the Supplementary Nutrition Programme of the ICDS increased from 5.8 crore in the previous year to 6.8 crore in 2007-08, this is still less than 60% of the under-six population as identified by the anganwadis in the country. The NFHS-3 data showed that 81% of children under six years of age were living in an area served by an AWC. About 20% of children have not even been covered by the anganwadi survey and can be assumed to be left out of any of the anganwadis' benefits. Therefore, if we calculate for the entire population of children under six, then only about 46% of the children are covered by the SNP services of the ICDS.

The number of pregnant and lactating mothers covered under the SNP of ICDS was 1.4 crore in 2007-08, an increase from 1.2 crore the previous year. This increase is even less than the kind of increase seen in the coverage of children under six. Furthermore, as estimated by the Seventh Report of the Commissioners, there are about 4 crore pregnant and lactating mothers in the country. Thus, only about 35% of pregnant and lactating mothers are presently covered.

Universal coverage of habitations:

The Supreme Court in various orders directed the Government of India and the State/UT governments to ensure not only that every child, adolescent girl and woman of required eligibility be covered, it also requires the scheme to be geographically universalised, or in other words that there must be an anganwadi centre near every habitation in the nation.

Accepting the submissions to the Supreme Court by the Commissioners would indicate that at least 14 lakh anganwadi centres are required nationwide. In the judgment of 13th December 2006 it was stated that "Government of India shall sanction and operationalised a minimum of 14 lakh AWCs in a phased and even manner starting forthwith and ending December 2008. In doing so, the Central Government shall identify SC and ST hamlets/habitations for AWCs on a priority basis." Although the government has not been able to meet the deadline set by the Supreme Court, there has been a lot of progress made since the passing of this order. As of March 2008 10.1 lakh anganwadis were operationalised of the 10.5 sanctioned anganwadis. Further in the end of 2008 the Government of India has sanctioned another 2.1 lakh anganwadis taking the total number of anganwadis to 14 lakh. The state governments and Government of India have to make serious efforts to ensure that these centres are operationalised at the earliest.

According to an estimation made in the Sixth Report of the Commissioners, the procedures adopted for the Recruitment of personnel, finalization of locations of anganwadi centers and training of staff alone are anticipated to take over a year to complete. It was hence recommended that to the extent possible, administrative Procedures be taken up simultaneously rather than sequentially to prevent delays in the expansion of the ICDS.

National Infant and Young Child Feeding/ Breastfeeding Policy:

The Scheme:

The National Infant and Young Child Feeding Policy have been officially adopted by the government. It promotes exclusive breastfeeding for the first six months, complementary feeding to be started after six months and continued breastfeeding up to two years and beyond. A National Plan of Action has been developed with the policy which is adequately funded. The established National Breastfeeding (Infant and Young Child Feeding) Committee is linked with all other sectors like health, nutrition, information etc. effectively.

Adolescent Girls schemes:

In the case of adolescent girls the coverage is incomparably poor. Adolescent girls are not part of the main Supplementary Nutrition Program. The ICDS reaches out to adolescent girls mainly through two programs, the Kishori Shakti Yojana, KSY, and the Nutrition Program for Adolescent Girls, NPAG. There are no data available on the number of beneficiaries under this scheme, but looking at the financial allocations made for its implementation, one can estimate how many girls can be covered: the budget allocated is sufficient to cover 19.4 lakh girls. In comparison, as per the census of 2001, the total female population in the 1118 year age group stands at approximately 844 lakhs. It is therefore estimated that only 2.3% of the adolescent girls are being covered under this scheme, even if there are no leakages.

Adolescent girls continue to be an ignored section under the ICDS scheme.

The Government of India has announced that a new scheme called Rajiv Gandhi Scheme for Empowerment of Adolescent Girls will be introduced soon, which will universalise coverage. However the details of this scheme are not yet available and until the year 2009-10, no budget allocations have been made for such a scheme.

ICDS Finances

ICDS is a Centrally-sponsored Scheme implemented through the State Governments/UT Administrations with 100% financial assistance for inputs other than supplementary nutrition which the States were to provide out of their own resources. From 2005-2006, it has been decided to extend support to States up to 50% of the financial norms or 50% of expenditure incurred by them on supplementary nutrition, whichever is less. This Central assistance has been proposed to ensure that supplementary nutrition is provided to the beneficiaries for 300 days in a year as per nutritional norms laid down under the Scheme.

The cost of supplementary nutrition varies depending upon recipes and prevailing prices. However, the Central Government issues guidelines regarding cost norms from time to time. The Government of India has in November 2008 issued new guidelines that are to be effective from 2009-10.

New Financial Norms:**Existing Rates (per beneficiary per day)/Revised (per beneficiary per day)**

- (i) Children
(6 months to 72 months)
Rs. 2.00 Rs. 4.00
- (ii) Severely malnourished Children
(6 months to 72 months)

Rs. 2.70 Rs. 6.00

(iii) Pregnant women and Nursing mothers Rs. 2.30 Rs. 5.00

The cost sharing ratio between Centre and States to be effective from 2009-10 (for these new cost norms) are as under:

- (i) 90:10 for all components including SNP for North East
- (ii) 50:50 for SNP and 90:10 for all other components for all States other than North East

**Expenditure for SNP under ICDS: in relation to present beneficiaries:
The Supreme Court in its order dated 13th December 2006 states that:**

All the State Governments and Union Territories shall fully implement the ICDS scheme by, inter alia,

- (i) allocating and spending at least Rs. 2/- per child per day for supplementary nutrition out of which the Central Government shall contribute Rs. 1/- per child per day.
- (ii) allocating and spending at least Rs. 2.70 for every severely malnourished child per day for supplementary nutrition out of which the Central Government shall contribute Rs. 1.35 per child per day.
- (iii) allocating and spending at least Rs. 2.30 for every pregnant women, nursing mother/adolescent girl per day for supplementary nutrition out of which the Central Government shall contribute Rs. 1.15.”

Since the central government releases funds to the states for SNP based on the expenditure of states for this Purpose. The actual amount that was spent on SNP in the year 2007-08, Per beneficiary per day expenditure is calculated as (total expenditure on SNP/no. of beneficiaries)/300 since SNP is to be provided for 300 days in a year. (The beneficiaries included are children in the age group of 6 months to 6 years and pregnant and lactating mothers. Adolescent girls have not been included because the nutrition for this age group is given out of a separate budget.) Based on this calculation we find that at an All India level Rs. 1.78 was spent on each beneficiary per day in 2007-08 (beneficiaries include both pregnant and lactating mothers and children under six). The states that spent less than Rs. 2 per beneficiary per day are Assam, Orissa, Jammu and Kashmir, Delhi, West Bengal, Gujarat, Uttar Pradesh, Rajasthan, Maharashtra and Chhattisgarh. State spending less Re.1 per beneficiary per day: Assam 13 States spending less Rs. 1.50 per beneficiary per day: Gujarat, West Bengal, Delhi, Jammu and Kashmir, Orissa and Assam.

Case Studies:

The following case studies highlight some of the challenges faced by the anganwadi centres and workers.

Background information on Firozabad:

The first two case studies focus in villages in Firozabad District in Uttar Pradesh. Some background information on Firozabad and the state of migrant workers there may prove useful for understanding the need for and challenges faced by the anganwadi centres.

Beautiful bangles are a very big part of Indian culture as it signifies a happy life, one of married women and most recently that of fashion. In the production of these bangles comes the plight and strife of the children who make these bangles. Firozabad is famous all around India for the glass bangle industry in which child labour and their exploitation is rampant (there are approximately 50,000 child labourers). Many of the families living in this district are migrant workers (approximately 200,000 workers) as they have come from various parts of India in search of employment opportunities. As migrants these people are not entitled to any state schemes or programs. Most families in Firozabad district are large and consist of seven to eight people or live in joint families of fourteen members and the reason behind such large families is that each hand that is there is used for income and survival, even a child. In Firozabad, children as young as four years old can be found helping their parents in the production of bangles. They typically help with bangle straightening, joining or decorating.

Originally, the glass bangle industry operated in the glass factories. However, with the intervention of many NGO's, this practice has been stopped and many children have been rescued out of child labour. Regardless of this achievement, contractors have now outsourced the production of bangles to homes in the Firozabad district. Consequently, child labour still remains widespread in this district. Those children who are in school begin work at 5 am, attend school, then immediately after school begin work again and continue until they sleep, without any time for homework or play.

All members of a family have to work because they earn on a piece basis and not a wage basis as contractors pay for the bangles per bundle (a bundle usually consists of 312 bangles). For each bundle, a family receives Rs. 2 and in a day a family can usually produce 10-20 bundles, resulting in an average income of Rs. 20-40 per day per family. The earnings of an entire family are significantly below the minimum wage of one person and it is for this reason all members of a family are required to work for around 15 hours per day. Additionally, because these families do not earn a minimum wage, they are unable to purchase adequate food. Due to the fact that most of these workers are migrants, they are unable to get the "below poverty line" status which would provide them with food rations (food at subsidized cost). Without government protection or possibility of advancement in their employment, these workers are systematically being denied their fundamental right to food.

The conditions in this industry are extremely hazardous as many workers involved in this industry suffer from health problems which include excessive coughing, high rates of tuberculosis, back problems, severe rashes and peeling of skin and loss of eye sight. Due to the minimal income the family earns from bangle work, many children are malnourished. Also, because many hands are needed for work, it is difficult for children to attend school. Most children remain illiterate and school drop out rates are very high in this area compared to other areas.

Case Study - 1

Raipura, Firozabad, UP

There have been three ICDC centers in operation in this region for the past 6 years. However, all three still run in the open air as the centres do not yet have their own buildings. They are run within the open grounds of the primary school, though the school building is scarcely large enough for running its regular primary classes.

Under the Scheme, beneficiary children are divided into two groups: seven months to three years and three years to six years. Third group of beneficiaries is pregnant and lactate mothers. Pregnant mothers become beneficiaries after the fourth month of conception and lactate mothers from immediately after delivery until the child is six months old. A woman also gets Rs. 1400 at the time of delivery.

Nine hundred grams of mixed various food grains and cooked flour (this mixture is called panziri) is given to pregnant and lactate mothers on a weekly basis. And children get the same kind of food everyday for the last six years (weekly 480 grams) as a supplementary food. A centre receives Rs. 1300 each 15 days for providing supplementary food to 60 children. In reality, only 15-20 children attend the classes as children don't like the food and sometimes vomit as soon as they eat. Mothers have also complained that children have gotten worms due to this food. In the three centers, 180 children are enrolled but only 55-60 children come to attend the school and none of them like to eat the food. When asked why they do not eat panziri, the children replied that instead of panziri, they should be given peanuts, black gram, or fruits. No cooked food is given to the children.

Centre has to be closed down during rainfall or if it is severely cold or hot, as all these centers have been in open spaces for the last six years. The centres have only a few charts for educational materials, and for games only five small balls are provided for 120 children. The centres have thin flooring (daries) for children to sit on and one chair for the person in charge. The helper has to stand from 8 am to 1 pm and after that they are suppose to visit the houses of beneficiary mothers.

There is no drinking water, so the facility helper has to go and fetch water from outside. There are also no toilets for children or even for teachers. No physical monitoring of growth of children or mothers can be taken at the centres as the

equipment has not been maintained. Weighing machines were deposited five years ago when they went out of order and the authorities promised to return repaired machines after the next budget. To measure children's height, inch tape was also given but it broke long ago and has not been replaced to date. No medical facility is available. If children fall sick they are sent home, as there is no doctor or medical equipment available.

The AWW and helper receive Rs.1563 and 800 respectively per month for working six hours everyday, but they are not paid on a regular basis. Furthermore, they must cover fuel and transportation expenses themselves, as such expenses are not refundable.

Case Study - 2

Milik, Firozabad, UP

ICDS centre runs along with the primary school of this village and has one small room within the primary school building. There are 60 children enrolled but the room can accommodate only 25 children at one time. Typically, only about 15 children attend classes. Till 23rd December, 2009, children were getting panziri as supplementary food, but from 24th Dec children are now getting khichri mixed with rice and lentils and dalia cooked in water as the amount paid to the centre is Rs. 1300 for 15 days per 60 children. Fuel and transportation expenses are borne by the AWW and helper. The AWW and helper have, at times, had their salaries withheld for up to six months without cause. Health records are not maintained in this centre as they have not been provided a weighing machine or inch tape.

The centre is kept neat and clean. However, no education material or games for the children are available at the centre.

Case Study - 3

Deveri Akhanv, Post-Piska Nagri, Thana- Nagri, Ranchi, ICDS: Sahiyka-Sukro Topo

Village Deveri is in the outskirts of Ranchi under Piska Nagri Block. This village is tribal and 80 families have lived there for generations. Most of the male members of the families go out to the large cities to work as labourers and some of them have also migrated to work in Brickiln. This region of Jharkhand is facing drought for several years. Since their male counterparts are away, women here manage family affairs by working here and there for their livelihood. ICDS programme was introduced in 1990, but it has never run smoothly on regular basis. Most of the people are unaware of the entitlement schemes. Presently there are 83 children enrolled (but attendance if beneficiaries is very low) between the ages of six months to six years, and a small number of pregnant or lactate mothers and adolescent girls enrolled. However, this centre has received direction from the local government to limit the number of beneficiaries, so some potential

beneficiaries are currently being excluded from the centre's programs.

The community was informed that the ICDS centre is closed most of the time and only opens for two or three days in a week and only for a few hours each day. Children are provided with khichri most of the time and food grains are given to pregnant and lactate mothers once per month with 1 kilogram of rice and half kg of lentil. A few adolescent girls are also enrolled and given the same food once per month. Though there are more girls of that age who needs this nutrition, they are denied as per the government order that only five girls can be covered by this centre. Registers show 100% presence of every child every day, but in reality there are approximately 10-15 children that come when the centre opens for a few hours. Only food is distributed; no education or any other activities are carried out at the centre.

There is no regular health or growth monitoring and no records are available. When the nurse from PCM visits to immunize the children, she occasionally takes growth measurements. One woman named Birsi had five-month-old baby and reported that after the birth of her child his weight and other measurements were taken only once. The AWW has reported that at times it has become difficult even to provide a meal for beneficiaries on a daily basis, as the centre is poorly funded. The AWW and helper receive reimbursement from their department after producing bills, but on a very irregular basis. Their monthly salaries of Rs. 1200 are rarely paid on time. Since salaries are paid at uneven intervals of three to six months, management of the centre is challenging. The AWW has been forced to accept part-time employment elsewhere in order to meet her personal expenses.

Case Study - 4

Kalwaria, Post-Kardhana, Sewapuri, Varansi

This anganwadi centre of Kalwaria village has been in operation since 2001. This village is primarily a Muslim weaver community. Before opening the centre, a survey was conducted by the sevika. In the center there are 80 children enrolled between the ages of three to six years though the survey found 123 children of that age group. Similarly, 90 children between the ages of seven months to three years were located in the survey, but only 84 are enrolled and out of 50 adolescent girls only three are enrolled as per the order from the authorities and criteria for selecting the girls which state that to be eligible, girls must be both poor and out of school. All the pregnant and lactate mothers who were identified during the survey are enrolled in the centre. All these mothers and girls get supplementary food in the form of mixed panjiri once per week.

There is no health monitoring at the centre because there are no weighing machines or measuring tape. Additionally, the centre does not have any educational materials or games for the children. Children sit on torn daries in a

small room of the Panchayat Ghar of the village; the centre has no other space or equipment. There is construction of a health centre going on near to the Panchayat, so all the construction materials are stored in the same room where the ICDS centre runs. According to Sevika Manjul Singh, since this is a Govt. building they cannot lock the room, so all articles including teaching materials, games, and even weighing machines were stolen. The AWW removes the registers every day and brings the food in the morning. Rs. 2700 was given as a budget to be spent for 80 children per 25 days.

No health records are maintained, but an ANM/Asha worker visits once per month for immunization. The health centre is in another Block, seven to eight km away from the village. The AWW also complains of irregular salary payment, though the salary has been increased from Rs. 1200 to Rs. 1700 per month.

Case Study - 5

Kardhana Bodhapur, Post-Kardhana, Thana-Mirzamurad, Block Sewapuri, Varansi, Uttar Pradesh

Kardhana village has population of 1079 families and is mainly a Muslim weavers' community. The village is also home to a substantial population of OBCs and Schedule Castes. Male members of that village have also migrated in search of livelihood. Before opening the centre a survey was conducted and out of 125 children between the age of 0 months to 3 months found only 18 are enrolled. Of the children aged seven months to three years, there are 80 children enrolled, and between the ages of three to six years 75 children are enrolled as per the record. There are also 12 pregnant mothers, 18 lactate mothers and only 3 adolescent girls(out of 60 surveyed) enrolled in the centre. Centre is opened from 9 am to 1 pm. Children are mostly given Panjiri and some time children are also served with cooked meal of Khichri, Dalia cooked in water. Primary health centre is away for 7-8 km and it is difficult for people to visit. Now a sub primary centre is under construction and it will make easy access to health services to the people as informed by one villager. ANM visits the centre once in a week and do the immunization. No health monitoring or growth monitoring records were found as informed it is not being maintained.

Case Study - 6

Saimuddinpur, Post-Gazipur, Lucknow, Uttar Pradesh

Saimuddinpur village is a semi-urban village and habitants living there are mostly daily wage earners. An ICDS programme has been in operation in this village since 1983. The anganwadi worker has been there since its beginning along with helper. Forty Children enrolled in this centre are between the ages of three to six years and they are given 50 grams of panjiri six days in a week. Sixty-four children between seven months and three years of age are enrolled and are given 125

grams of panjiri to take home for six days. Sixty-five adolescent girls were identified by survey, but supplementary food is provided to only three girls as per the instructions from higher authorities. So every day three girls come and collect their ration but the girls are rotated so that different girls collect the rations each day. Keeping records becomes extremely difficult and frequently only the girls' names are recorded. There are also thirteen pregnant mothers and eight lactate mothers who are provided with supplementary food. These mothers don't visit the centre only comes once in a week and collect the ration. The centre also provides cooked meals with a different menu for each days: Monday -- moong dal khichri, Tuesday -- sweet dalia, Wednesday -- arhar dal khichri, Thursday -- sweet dalia, Friday -- moon dal, and Saturday -- poha.

Though this menu and food provision sounds very good but in reality children and women were making complain of food of bad quality. Especially panjiri which has come from one company named Lalji from Noida based, people complained of having diarrhea after eating this and if Angwari worker try to complain to higher authorities she is being asked to leave the job or manage with this. She does not have any option except to bear with the situation. She is there since 1983 and drawing her honorarium of RS 175 and presently getting 1700 pm but on irregular basis and helper who also started since beginning at RS50 and now getting Rs 800 pm but that too on irregular basis. Some time there salaries are stopped if they fail to brig the cases for family planning. At centre they work between 9-1pm and after that one hour for field visit. Earlier there was provision for rent to run the centre and now it is being withdrawn so the anganwadi worker had to arrange for the place to run the centre free of cost. Currently, she is running this centre in her house. There were 12-15 children present when the centre was visited. The centre once had a weighing machine, but it broke and was never repaired. The centre has some educational charts that are used with the children. Every Saturday an ANM and a nurse visit the centre to immunize the children. All the children enrolled there are immunized.

Though all the money is transferred through the bank, for every transaction, a Centre worker has to pay back the amount of Rs. 1200 per month for approving the bills of food and fuel.

Effects of ICDS and Other Schemes:

The nutritional status of children has gone up marginally, but in some states like Gujarat and Madhya Pradesh, it has actually worsened. NFH-II shows that though the nutritional status of children has improved marginally, the improvement has not been as high as expected, given the amount of money spent on nutritional supplementation schemes both by the centre and states. "The government has implemented existing programmes half-heartedly and any improvement over the past five years has been due to pressure from the Supreme Court.

At an all India level only about half the children (56.6%) identified by the Anganwadi survey are beneficiaries of the Supplementary Nutrition Provision (SNP). The coverage of children under six is even poorer (see National Census 2001). While there are about 16 crore children in the 06 years age group, the number of SNP beneficiaries is only 5.8 crores , thus only 35.5% children under six years of age are receiving SNP under the ICDS, leaving out about 10 crore children (66%). Further, in the states of Assam, Bihar, Kerala and Rajasthan the percent of children getting the benefit of supplementary nutrition is less than even 40% of the eligible children.

The coverage is even worse among pregnant and lactating mothers. The number of pregnant women and nursing mothers is estimated to be 4% of the total population at any point in time as per ICDS Scheme guidelines. According to the 2001 Census, there are about 4.1 crore pregnant women and nursing mothers in the country. According to an Anganwadi survey, only 2.1 crore pregnant women have been identified and of these only about 1.2 crore women are beneficiaries of the SNP. Hence, currently only about 25% of the eligible pregnant women and nursing mothers are being reached out to under the SNP of the ICDS.

In the case of adolescent girls the coverage is incomparably poor.

The National Advisory Council (NAC; is the political advisory wing of the government) were “appalled by the lack of improvement in nutrition level of children, they claimed that one of the reasons for this was due to leakages within the food scheme system. For example in 2004-05 grain leakage from Orissa's Ganjam and Kalanhandi districts was 68% and 37%. The NAC also made mention that the ICDS centers open erratically, function for only a couple of hours and attract very less number of children.” Thereby, these facts provide an indication that this program is not working as many children are not being served under this scheme and even those that maybe served are still suffering from malnutrition and anemia. In order to address this issue the Supreme Court of India has given an order to government to open more ICDS centers (anganwadi centers) from the current 6.73 lakh centers to 14 lakh centers and the NAC has sought a constitutional amendment to make the ICDS accountable to the public.

Conclusions

The ICDS -as shown above- has been weak in addressing the needs of children specially below the age of three years. If ICDS is to have serious impact on child malnutrition, it needs to focus on management of severe malnutrition in the 0-3years age group. Supplementary nutrition for this age group should be not just food grain, as is the case in many parts of the country, but specially prepared weaning foods made from nutritious locally grown food and appropriate for this age-group. The latest National Nutrition Monitoring Bureau (NNMB) data (20062007) show that there is a deficit of over 500 calories in the intakes of one to three year olds and about 700 calories among the three to six year olds. Lakhs of

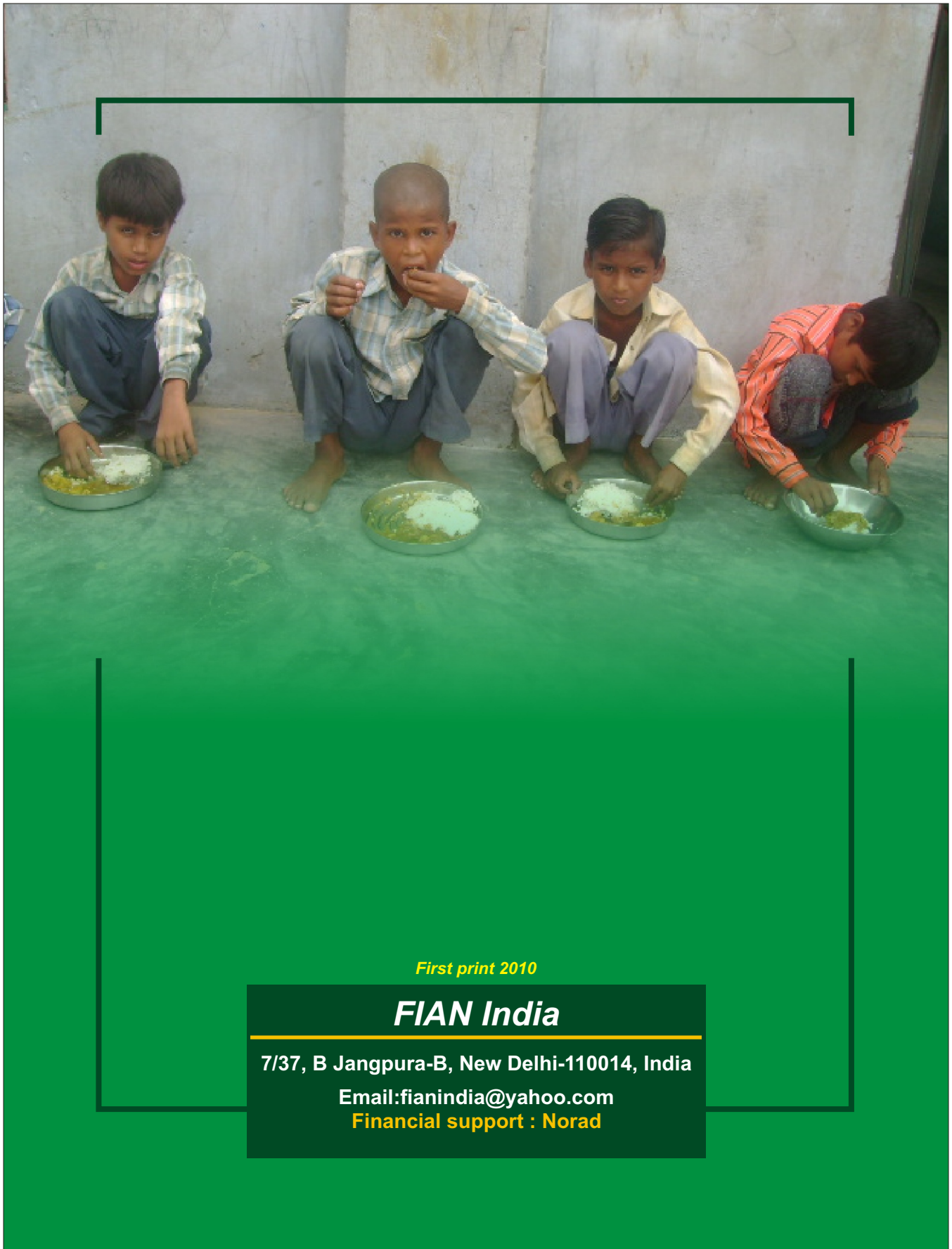
lives could be saved by clear ensuring proper nutrition both in quality and quantity as stated by the World Breast Feeding Trends Initiative 2008. There is a lack of effective coordination mechanisms though structures do exist, a lack of policy status for the National Guidelines on Infant and Young Child Feeding and the existing guidelines do not have a clear plan with objectives and allocated budget

Recommendations:

1. Universal Coverage: All children in the age group of 0-6 years should be entitled to basic nutrition, health and pre-school education services under the integrated child development services (ICDS).
2. Government of India must operationalise all the sanctioned anganwadis at the earliest.
3. Children in the 36 year age group should be provided a hot cooked meal at the anganwadi centre everyday. The SNP so provided should be age-appropriate, culturally appropriate, nutritious and locally procured.
4. Tiny or scattered habitations: In habitation of less than 300 persons, ICDS services should be provided through extension services or mini-Anganwadis, linked with the nearest Anganwadi.
5. Anganwadi on demand: Rural communities and slum dwellers should be entitled to an “Anganwadi on demand” – A simple procedure for setting up an “anganwadi on demand” must be put in place so that an AWC is Sanctioned and operationalised within three months of such a demand being made, in accordance with the order of the Supreme Court dated 13th December.
6. The right to food of children in the age group of 0-6 month's must be ensured through services to the mother, including support at birth' skilled counseling especially to promote breast feeding; maternity entitlements; and crèche facilities at the work place.
7. Maternity benefits: Maternity benefits of at least Rs. 1,000 per month (at 2009-10 prices) for six months, from the 7th month of pregnancy, should be extended to all pregnant women for care during pregnancy. No conditionality's should be attached to maternity benefits. In particular, the benefits should apply irrespective of the place of birth, age of mother or number of children.
8. Special provisions should be made for the inclusion of marginalized children in ICDS, including disabled children, street children, and children of migrant families.
9. Make adequate budget allocations for the ICDS programme so as to be able to provide SNP to every child under six, every pregnant and lactating mother and every adolescent girl.

10. The Government of India must make provisions for supplementary nutrition for all adolescent girls at the same norms as has been set for SNP for pregnant and lactating mothers.
11. The states appoint Grievance Redressal Officers at the block and district level to entertain all grievances made with respect to the non implementation of the provisions.
12. Strict action must be taken at all levels against the false reporting of data that shows inflated figures of enrolment and deflated figures of malnutrition. To check on this practice of false reporting a system of independent monitoring must be put in place, such that a sample of the households are routinely checked and the data verified by that reported by the ICDS.
13. Upholding and implementing International Protocols and consensuses like ICESCR, CRC and MDGs.
14. Associating civil society organizations in policy formulation and monitoring.

Without a major shake-up in policy and an improvement in the effectiveness of its implementation, the attainment of the MDGs in this regard by India looks extremely unlikely



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