

REPORT

ASIAN REGIONAL SEMINAR ON MILLENIUM DEVELOPMENT GOALS

MDG 4 - Child Mortality & MDG 5 - Maternal Health

FIAN INTERNATIONAL

New Delhi

4th and 5th of July 2009

The Asian Regional Seminar on Millennium Development Goals (MDGs) 4 and 5 reducing child mortality and improving maternal health, was organized by FIAN International on July 4th and 5th 2009 in New Delhi.

Following specific objectives were articulated to be achieved through this Seminar.

- A. To make an assessment of the implementation of MDG 4 and 5 in the Asian Region
- B. To exchange ideas and strategies, using the right to food framework/ using a rights based approach, to combat child mortality and improve maternal health
- C. To elaborate a joint action plan on making joint efforts to contribute to reducing child mortality and improve maternal health through increased access to nutritious food.

Participants from different Asian Countries were invited for the Seminar to discuss the progress made by individual countries and the region as a whole in the achievement of MDG¹. Following is the brief report of the event.

Welcome and Introduction

Dr. Neetu Sharma, FIAN, India extended a warm welcome to all the participants and expressed her gratitude for accepting the invitation and coming for the Seminar. After a brief round of self introductions, Mr. Sanjay Rai, National Coordinator, FIAN India took the participants through the objectives of the Seminar. Highlighting the challenges confronting the achievements of the MDGs, he said that the prospective beneficiaries do not get their dues and are systemically deprived of their entitlements.

Further, he said that there is a need to ensure synergy and coordination among various government departments when it comes to the implementation of the policies and programmes and in this scenario civil society must take on the role of motivating the people and the concerned officials. He said that all the government departments have good programmes and schemes for the welfare of the poor and vulnerable, however, striking a balance and ensuring coordination among these initiatives is a challenge. Considering that the organisations like ours cannot work as a parallel government to implement the schemes and programmes, Mr. Rai said that we must organize campaigns and sensitisation programmes all over the country. As potential strategies

¹ List of the participants along with their contact details is attached as annexure.

he suggested translating and disseminating the relevant documents into regional languages, advocacy with the parliamentarians and follow up on the Supreme Court case on Right to food.

Session I: Millennium Declaration and Millennium Development Goals: What have we achieved?

Mr. Biraj Patnaik - Principal advisor to the Supreme Court Commissioner on the Right to Food Case

Mr. Patnaik said that the Millennium Development Goals (MDGs) were extracted from the eight chapters of the Millennium Declaration and were adopted in the year 2000. The targets set by these MDGs are to be achieved within a given timeframe by all the countries who have endorsed them. He emphasized that the rights based approach that was articulated in the Declaration was diluted when the 8 goals and the targets thereof were adopted.

While referring to the MDG 1 (poverty elimination) that sets the target of ‘reducing the number of people surviving at the per capita income of \$ 1 per day to half’ and ‘halving the number of malnourished people and children by 2020, Mr. Biraj said that the comparative analysis of the data from Asian countries indicates that countries like Afghanistan, Bangladesh and Srilanka are doing better than India towards achievements of these targets. Despite being the second fastest growing economy of the world, there are more than 360 million poor people in India. He said that according to the well known socio-economist Mr. Arjun Sengupta about 77% of India’s population survives on a consumption expenditure of Rs. 20 per day.

According to the Global Hunger analysis done by the International Food Production Research Institute (IFPRI) 46% of Indian children are malnourished, 70% women are anaemic and maternal mortality rate is above 300. India ranks 112 in the WHO ranking of the world hunger and all this is despite that fact that the Government has excess buffer stocks. Recalling an instance of the sheer apathy on the part of the government, Mr Patnaik said that at the time of severe drought and acute starvation in many areas the government encouraged export of food grains.

Talking about the schemes identified in the right to food case by the Supreme Court of India, Mr. Biraj said that, that access to food is a legal entitlement, but we do not have legal redressal mechanism in case of violations. In this situation the Apex Court had envisioned the Commissioners as a monitoring tool for the implementation of the court decisions and expected them to take up individual case grievance redressal. However, given the wide scope of this work it was humanly impossible to ensure the implementation of these orders across the length and breadth of the country. In the absence of legislative framework, it is very difficult to make the Right to Food justiciable in the court of law.

Mr. Biraj said that India has the largest food security programme in the world but ironically about 50% of the deserving poor are unable to enjoy these benefits. With the adoption of the Targeted Public Distribution System (TPDS) the bottom 30% of the impoverished people have been hit hardest. He said that the problem is that except Mid Day Meals Scheme, Integrated Child Development Services (ICDS) and national

rural employment Guarantee Scheme (NREGS) all the food security schemes are targeted schemes, however, the fact of the matter is that 50% of the poor are not recognised as while implementation of these schemes, rather 42% of the rich people have managed to get identification cards of Below Poverty Line (BPL). Ambiguity in the definition of poverty is also a factor behind such a dichotomy in the administration of food schemes. He also referred to a draft report, on identification of BPL people submitted by an expert group headed by Mr. N.C. Saxena. He said that the report suggests a completely different way of defining poverty using simple, measurable and verifiable indicators, including socio- economic vulnerabilities. Using these criteria for defining poor people would see the number of recognised poor going up dramatically and the food subsidies will have to be increased by 20 billion dollars. However, the government sees this as a conspiracy to increase food subsidy.

In addition to the ‘fulfillment obligation’ of the government, Mr. Patnaik also expressed his concern over government’s shortfall in respecting and protecting the right to food that have manifested in land grabbing, livelihood destructions and subsequent displacements. Talking about the proposed Food Security Act, he said that the Act has enormous potential to ensure justiciability and recourse mechanisms against violations.

Discussing the importance of the importance of food sovereignty, Mr. Patnaik said that biggest threat to the right to food is the changing pattern of land usage where fertile agricultural land is being converted and used for commercial purposes. He added that the proposed Food Security Act to be effective must take note of this aspect, in order to ensure right to food, rather than mere freedom from hunger.

Assessment of Millenium Development Goals in Asia

Dr. Arun Gupta - IBFAN Asia

Dr. Gupta was of the view that adopting the targets under the MDGs has brought into forefront the most serious issues affecting the poor population in the world. In the case of MDGs 4 and 5, according to World Health Organisation (WHO) report the coverage of the vaccinations is improving and there is very little progress on the front of improving maternal health and reducing child mortality. However, enough advancement is not being made in encouraging the preventive measures such as breastfeeding because of misjudged priorities. He said that with regard to exclusive breastfeed some of the countries have witnessed progress, however in some countries it has been negative. There is not enough emphasis on initiating breastfeeding within the first hour of the delivery and this despite the scientifically established fact that 22% of the neonatal mortality can be cut with this simple preventive measure. He said that 75% of the deaths occurring in the first year of life are preventable and access to clean water Exclusive Breastfeeding are the keys to reduce infant mortality substantially.

Dr. Gupta expressed his concern over the fact that no satisfactory progress has been made in containing child mortality rates on MDG 4 in the country. Discussing the progress made on MDG 5, he stated that in Afghanistan maternal mortality rate is 800, in India 300, and in Nepal it is 830. Most of the countries are actually half way, in

relation to programmes and policies in place to promote Exclusive Breast Feeding, very few countries have national policies in place and implementation of the code is better in few countries than the rest of the different countries. Dr. Gupta emphasised that Food security of the baby depends largely on maternity protection, however, enough progress hasn't been made in this regard. In case of India the number of institutional births has not improved.

There has been good high or increasing coverage in the administration of Vaccinations, providing Vitamin A and insecticide treated bed nets. However, there are gaps or low coverage when it comes to reaching to the mothers and children especially in the first few weeks when both are at highest risk, provision of skilled birth attendance, nutritional indicators initiation, exclusive breastfeeding and complementary feeding. Another matter of concern is the little or no progress in combating under nutrition which is an underlying cause for 1/3rd of child deaths and 20% of maternal deaths at delivery.

While reflecting upon the challenges and problems in accelerating the pace towards the attainment of MDGs 4 and 5, he said corporate interests and the market driven interventions lead to the selection of wrong priority areas. He said that instead of curative measure like GAIN (2002), GAVIN (immunization, vaccines) and the RUTF - ready to use therapeutic food, it is required to focus and strengthen the preventive measures such as exclusive breastfeeding, primary health care and proper sanitation

He upheld the importance of improving and supporting family health system by reaching out to the mother and the child in the first week of delivery, developing good public health infrastructure, rather than using curative measures like Vaccines only which should only complement basic measures such as clean water and Breastfeeding. Conversely, there is no dedicated budget line for breastfeeding or for making provisions for clean and safe drinking water. At the macro level structural adjustment has taken the toll of the public water systems.

Integrating the work done by various government ministries and departments and ensuring adequate coordinated policies and programmes, are also equally important for improving child and maternal health. Dr. Gupta also emphasized the importance of information dissemination and sensitization of community as well as the medical practitioners to encourage breastfeeding. In addition, it is equally important to support breastfeeding mothers by providing conducive environment and financial support. He also pointed out that approximately 5\$ per an year are require to support one lactating mother. It is equally important to discourage the use of baby foods like formula milk and others.

Given that the 40% of all child deaths occur in first month and 2/3rd within one year, and having also seen that in south Asia progress is minimal in this regard, with only Nepal and Bangladesh being on track, it is important for the South Asian region to focus on newborn /infant, including clean delivery and postnatal care with quality. He specifically recommended the following:

- Maternity benefits to all women including cash benefits to poor

- Work site crèches
- Home visiting with skilled counselling
- Infant and Young Child Feeding /Breastfeeding Counselling centers in health facilities
- Bring the Promotion of All Baby foods to an end and implementation of the International Code of Marketing of Breast- milk Substitutes universally
- Achieving WHO Growth standards as a indicator to realise child rights
- Policy and strategy for each country
- Budget line
- An action plan on Infant and Young Child Feeding /breastfeeding within child health /nutrition

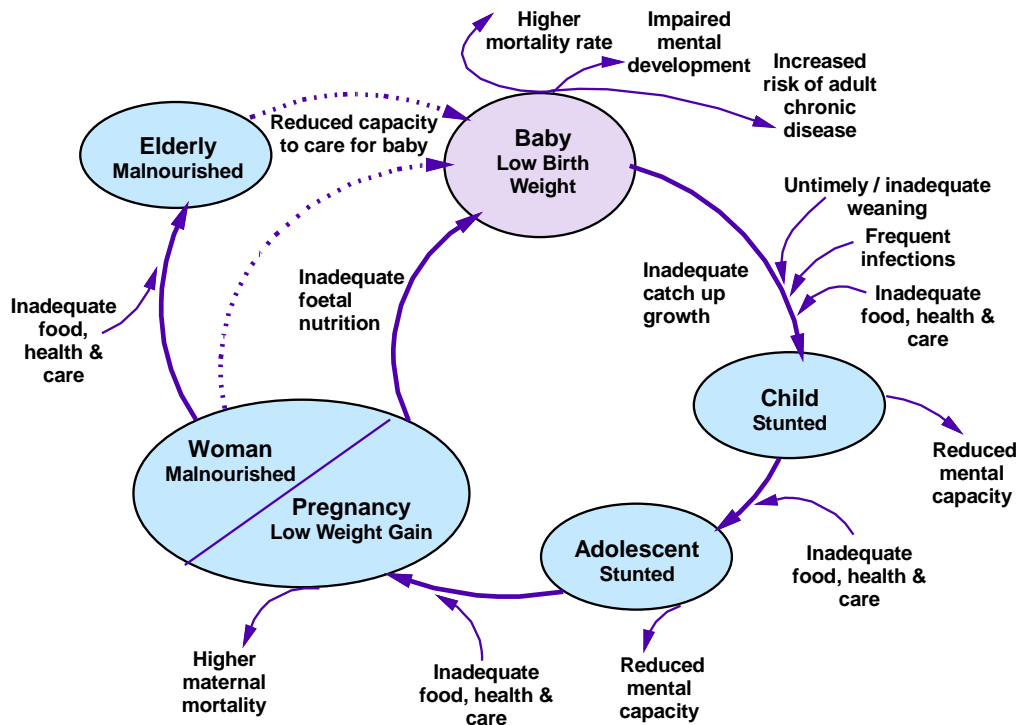
Dr. Gupta during the discussion said that resource allocation to improve and encourage breastfeeding is equally important and as active representatives of civil society we must advocate the rights of the women be with the infants to enable breastfeeding. He added that the perception that breastfeeding does not require allocation because breast milk is not purchased, is one of the biggest barriers in get in on policy makers on board and convince them that it requires ample support from the state machinery.

In addition to this, access to clean and safe drinking water and training of the health care provider is also fundamental to the health of the child and realization of the right of the infant to be breastfed. Participant from Egypt also stressed on the importance of resource allocation for breastfeeding and shared the experience from her country where strict code is being developed for early initiation of breastfeeding

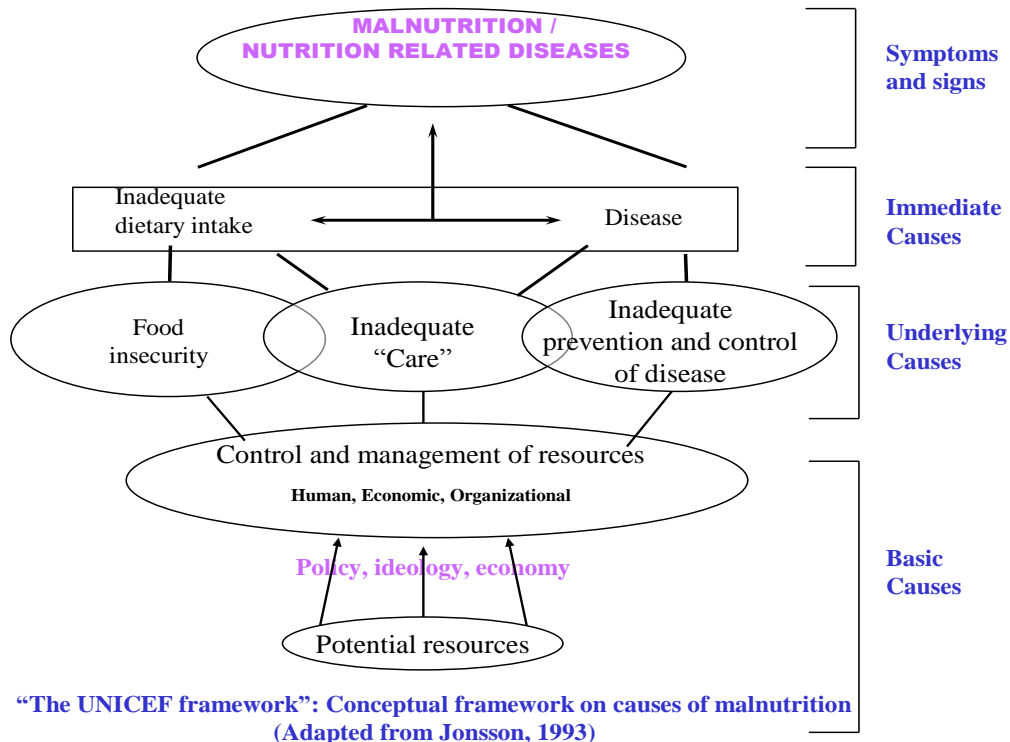
Right to Food for Children and Infants

Ms. Siri Damman - FIAN Norway

At the onset Ms. Damman quoted that human rights are the standards that one continuously strives to achieve and in case of the right to food for children and infants this commitment of the international community has manifested through the MDG 4 and the prevalence of underweight children under the age of 5 years. She explained that low birth weight in babies continues to thwart their growth and nutritional level in adolescence and adulthood also which in terms results in high maternal mortality and undernourishment among women and again low birth weights. She explained this phenomenon with the help of the following diagram.



With the help of the following picture Ms. Damman explained the systemic causes responsible for the prevalence of malnourishment among children. She said that the policy, normative beliefs and economic factors play important roles in the control and management of the resources required to curb food insecurity, provide adequate care and prevent diseases among the infants and children. She also said that inability of the mother to feed the infants at the time of birth and after that leads to malnourishment among the children and this cycle can be broken by providing adequate maternity support and ensuring maternal nutrition.



Referring to the United Nations Declaration on Human Rights (UDHR) and the International Covenant on Economic Social and Cultural Rights (ICESCR), Ms. Damman emphasized the need and the relevance of the human rights approach and the states’ obligations to respect, protect and fulfill the right to food for individuals and the groups. She also reiterated the inherent indivisibility of the human rights and the need to focus on the right to food for all, irrespective of their caste, ethnic and religious identity. She also said that vulnerable groups must be at the focus while making any policies and programems for ensuring nutrition, as it has been established that the nutritional levels have been below the national averages among these communities that have been traditionally discriminated against.

STATE OBLIGATIONS AS REGARDS FOOD SECURITY					
FOOD SECURITY STATE OBLIGATIONS	ADEQUACY OF THE DIET			STABLE SUPPLY AND ACCESS TO FOOD	
	Nutritionally adequate food	Safe food	Culturally acceptable food	Environmental sustainability	Economical and social sustainability
Respect (do no harm)	Policies do not undermine healthy diets				State respect land rights, livelihoods
Protect (allow no harm)		Food safety laws and law enforcement			Protection of livelihoods law/police
Fulfill (facilitate & provide good contitions)	Facilitation of breastfeeding Food aid in crisis				Minimum salaries

Alliance Building for Right to food for Children

Ms. Suman, FIAN UP

Starting with the appalling state of children in India where a huge number of infants are born with dangerously low birth weights, 40% children die either because of chronic hunger or malnourishment, 70% of the total child population is anemic, Ms. Suman held the a situation responsible for this where the Child has never been on the priority. Despite the fact that a child is a vulnerable, yet independent entity, and needs special care and attentions, she is never considered even at par with adults when it comes to the drafting of national economic policies. Pointing towards the plight of the older children, she said that the definition of child in India is quite confusing that results in exclusion of the children from the age of 14 to 18 years from the schemes and programmes meant for children.

Ms. Suman maintained that India has been unable to convert its international obligations related to child rights into reality in the national scenario and this is a direct result of the fact that the rights of the child has never been on the agenda of the policy makers, they are assumed only as part of the family, not recognized in their individual self. Even in existing legal and administrative framework has failed in catering to the needs of the children owing to the problems such as lack of coordination among various state departments, absolute absence of the monitoring mechanisms and rampant corruption. Even when the government implements the schemes and programmes it is done as a charity to the children, not with a rights based approach that regards children as well as bearers of human rights. Non accountability, bureaucracy and redtapism further add to the agonies of the children

who have either migrated from one place to another or have been displaced from their original habitat.

Such a situation can only be tackled with a concerted effort by the civil society and initiating a movement for the children's rights to food. Recollecting her experience in the movement against bonded labour, she said that only with such unified and collective efforts can the right to food for children be made one of the national priorities for the governments. While doing so it is important to sensitise the masses, generate awareness among key stakeholders and thereby creation of pressure groups to exerting the demands on the government to formulate and execute child friendly programmes. She added that only by way of alliance building one can with the likeminded individuals and organizations that we can hold the government as well as the key functionaries accountable. Use of the Right to Information Act also comes in handy to build pressure on the government machinery.

Right to food for children is an all encompassing issue on which achievement of all the development goals relies. Such a nature of this issue not only demands but also facilitates bringing together of the groups and networks working on the issue. Alliances build in such a way has great potential in mainstreaming the issue of the right to food for children in the political agenda, influencing the policies and getting them implement as well.

Discussion and Summary of the Session I

Responding to an issue raised by Dr. Pramila Kumari, FIAN Andhra Pradesh, about the responsibility in case of the high mortality rates, Dr. Valente said that State must be hold responsible for such a situation as it is the State that commits itself to respect, protect and fulfill rights and this commitment is also reflect in the national laws and policies adopted by the state. There are various ways through which one can hold the government responsible, for example using the Right to Information Act and building networks and alliances with the like minded individuals and organizations, academia, media and politicians, etc. Nevertheless, legal action and taking the issue to the judiciary could also be one of the options that can be used in conjunction with other measures.

The first session was summarized by Dr. Valente. He said that it is a known fact that in the achievement of the MDGs we have not made enough progress and its is even more horrific to see regional and sectoral variations that indicate towards the absolute lack of the human rights approach that demands equity as well. If the development goals are not met for every body then such an achievement is definitely hollow. We must have human rights approach included even when it comes to our efforts made towards the achievement of MDGs. It is also important to look at the larger picture and not get illusioned by only the MDGs that are restricted and fragmented that entails that not only these goals but also the means of achieving these goals are important. Instead of the curative approach we must adhere to the preventive approaches and find local solutions to the problems as far as possible. This would also curb the menace of exploitation of natural resources unnecessarily and would thereby save the livelihoods

Discussing more about the rights based approach, Dr. Valente said that the advantage of this approach is that the most affected or vulnerable are in focus and their dignity is maintained. Recalling the presentations made by various speakers, he said that all the problems and challenges pointed out are intrinsically connected and demand holistic approach where duty bearers as well as the rights holder are made part of the loop and participants to decision making process. He said that coordinated efforts by an organized civil society are equally important especially in a situation when at times resource allocation is not done adequately and implementation is a perennial problem.

Session II: Campaigning for Breastfeeding

Dr. J P.Dadhich - BPNI

Dr. Dadhich started his presentation with the statement that infants are the most vulnerable groups when it comes to the realization of right to food that can be made possible only through successful breastfeeding. He maintained that breastfeeding is fundamental to a child's survival, development, nutrition and health, even when s/he is growing up, or is in adolescence and adulthood. Not only this, breastfeeding is also good for mother's health, environment and is even economical.

Recognizing that breastmilk is the only food available for the infants to survive, Dr Dadhich defined breastfeeding with four major characteristics - it must begin within an hour of the birth of the child, it must be exclusive for 6 months, i.e., no supplementary food should be given to the infants until they complete 6 months, complementary foods must be given only after completion of six months and breastfeeding must be continued for 2 years.

He shared a multidimensional approach for the breastfeeding to be successful. Firstly, a robust national policy that promotes and encourages breastfeeding must be in place; secondly, lactating mother should be provided with adequate support in terms of maternity benefits like maternity leave, health care and correct information; and thirdly, enhanced and organized efforts by the civil society in the direction of generating awareness and ensuring action on the part of the government.

While sharing about WABA's efforts in this field, he said that the organization has adopted a three pronged strategy to encourage and promote breastfeeding that is based on the three principles of availability, accessibility and safety. He said that to promote breastfeeding WABA organizes various campaigns. Of these most important are:

- World Breastfeeding Week (WBW) is being organized for the last 18 years is now adhered by over 150 countries and various promotional activities like sensitization programmes, talks, discussion are organized from August 1st to 7th every year. Organizing WBW every year has resulted in strengthened networking and enhanced participation from the community over the issue.

- Maternity Protection Campaign (MPC) is another such initiative that seeks to get the MPC 183 ratified and six months of paid leave to be given by the employer to the lactating mothers.
- World Breastfeeding Trend Initiative (WBT) *for child survival* seeks to identify the trends on the basis of indicators related to breastfeeding across the world that subsequently helps in identifying the problems and suggesting feasible and pragmatic solutions to these problems. Such a process of constant monitoring and assessment that involves various partners from different sectors - government, United Nations, civil society provides ample opportunities to build partnerships at national as well international level.
- One Million Campaign - is another such campaign which is going on now that seeks to get one million people sign a petition for prohibiting the advertising of baby foods. Dr Dadhich said that more than 58, 000 people from 166 countries had already signed the petition which was drafted in seven languages. He said that another such campaign is being planned on the prohibition of the marketing of the substitute of the breast milk
- Gender programme - Through this programme WABA sensitizes males to provide requisite support to females to enable them to breastfeed

Coming to the end of presentation, Dr. Dadhich said that all such campaigns have been extremely successful in mobilizing the community as well as advocating at the policy level to provide environment conducive to breastfeeding. He maintained that in order to promote breastfeeding it is important to bring it in the rights framework where breastfeeding is considered as right of the women and also an essential component of the women's reproductive health.

Session III : Status of Maternal Health in India and the Challenges Confronting

Dr Rajib Dasgupta - *Centre for Social Medicine and Community Health, JNU*

MDG 5 aims at improving maternal health and reducing maternal mortality rates have come to the focus in such context. Lack of access to adequate health services is the most important cause of maternal mortality and consequently most of women at the time of delivery die because of the medical problems like *hemorrhage* (38%) and *Sepsis* (11). According to the National Family Health Survey III conducted by the Government of India is lagging behind and is unlikely to achieve this goal by 2015.

In India average MMR is 301, however it varies from state to state with; MP at 379, Orissa at 358, Rajasthan at 445 and UP at as high as 517. However, in southern states the average is 117. There is also huge gap between MMR among ST/SC population and others which is the result of the inaccessibility to the adequate health services. Apart from mortality rates, instances of anaemia and malnutrition are also very high especially among scheduled tribe women. Such regional, sectoral and sectional variations are very common particularly in the case of developing countries

According to the Sample Registration Survey conducted by the Government of India, causes of maternal maternity do not change in variations, and the trend shows that

the inequities are going to be even sharper. The Survey also indicates achieving MDG 5 is a distant possibility and the shortfall could be as high as 70 to 80%.

Discussing the findings of the Second Common Review Mission (Nov - Dec 2008), Dr. Dasgupta said that in general there is an increase in the utilization of the public health services and sharp increase in the institutional deliveries and ancillary services even in rural areas, however, such increased utilization is not uniform across the regions and states. There is a clear shortage at the local level of basic facilities like specialized personnel, approaching roads, ambulances, hygienic conditions, and even delivery rooms. The quality of ante natal services has also not increased.

Session IV: Assessment and experiences from the countries

Violation of Right to Food for Children in Uttar Pradesh

Ms. Vartika Singh, FIAN UP

The right to food for children is being constantly violated in Jalalpur village, Lakhimpur district, and in Raj and Puja Brick Kilns at Deva Road, Barabanki district.

Some facts about children in India*

- 19% of the world's children are living in India.
- Every second Indian child is underweight.
- 3 of 4 children in India are anemic.
- 46% children are born with low birth weight.
- Every second new born has reduced learning capacity due to iodine deficiency.
- The Maternal Mortality Rate in India is 540 maternal deaths per 100,000 births (rising to 619 in rural areas).

*Source: www.unicef.org

Health Status in Uttar Pradesh*

- The population of Uttar Pradesh is 166 million (16.6 Crore).
- Infant Mortality Rate is 69 (Urban) and 86 (Rural). (deaths per 1000 live births)
- Maternal Mortality Rate is 517(deaths per 100,000 births).
- Only 22.9 % of children (every 3rd child) between 12 to 23 months get fully immunized.
- Only 7.3 % of children between 12 to 35 months received Vitamin A dose in last 6 month.
- 85.1 % of children between 6 to 35 months are anemic (in 1998-99 only 73.8%).
- 47.3% of children under 3 years are underweight (49.4 % in rural areas)

*Source: (SRS 2007, Sample Registration Service)

Integrated Child Development Services (ICDS) were started in India in d in 1975 Implemented in 1975, India with an objective to address the health and nutrition needs of children under the age of six. These services are provided through a vast network of ICDS centers called "Anganwadis" (AWCs) where children are provided (supplementary nutrition, health care and pre-school education). According to the

interim order of the Supreme Court of 13 December 2006, it is mandatory for State Government to provide an ICDS to every settlement with 40 children.

Nutritional guidelines under the ICDS

Beneficiaries	old (since 1975 till 2008)	New (since 2008)
Children from 6 month -3 years	300 calories	500 calories
	8-10 g proteins	12-15 g proteins
Children from 3-6 years	300 calories	500 calories
	8-10 g proteins	12-15 g proteins
Severely malnourished children	600 calories	800 calories
	16-20 g proteins	20-25 g protein
pregnant and lactating women and adolescent girls	500 calories	600 calories
	20-25 g proteins	18-20 g proteins

There are about 300 families about 100 children in Jalalpur village in Lakhimpur district of Uttar Pradesh. These children do not receive any benefits ICDS or school feeding programme (Mid day Meal Scheme). There is another case from the raj and Puja Brick Kilns in Barabanki district of Uttar Pradesh where there are about 70 families and about 50 children. Most of these families have been migrated from different places and children have no access to ICDS

FIAN UP is demanding to universalize the Integrated Child Services and make the benefits of this scheme available to the children of their families. In addition to organizing regular visits to these areas FIAN UP has organized Public meetings with the participation from community and other stakeholders. Attempts are also being made to lobby and advocate for availability of ICDS to these children and regular meetings are being organised with the concerned authorities and government department. A range of information, education and communication material has also been made and distributed among the community as well as the concerned officials in order to generate awareness.

Right to Food for Children in the Justice System

Dr. Neetu Sharma- FIAN Bangalore Group

Right to food for children has been a contentious issue in Indian context and has received much needed attention even by the Apex Court in India. Mid Day Meal Scheme (MDMS) and the Integrated Child Development Services (ICDS) are two schemes

that cater to the nutritional needs of the school going children and the children in the age group of 0 to 6 years, respectively. However, there the right to food and the nutritional requirements of the children in the justice system that housed in various government run and NGO run institutions.

The Juvenile Justice (Care and Protection) Amendment Act, 2006 that deals with the children in conflict with law and the children in need of care and protection, has provision of quasi judicial bodies, child welfare committees (CWCs) and Juvenile Justice Boards (JJBs) to take decisions with regard to the children coming in direct contact with law. There are provision for various types of residential institutions under the Act such as Children's Home meant for the children in need of care and protection, Observation Homes for children in conflict with law, Special Homes for reception and rehabilitation of children in conflict with law and the Fit Institutions that run by NGOs and have accreditation from the government departments.

Juvenile Homes in Karnataka	
- Observation Homes	8
- Children Homes	45
- Fit Institutions	16

There is no precise data available with regard to the number of children housed in various juvenile homes in Karnataka, partly because of high turn rates and partly because of the reluctance on the part of authorities to share such data. These children ideally should reap the benefits of the Mid Meal Scheme and Integrated Child Development Services and get the optimum level of nutrition. However, gross violations have been witnessed with regard to the availability and access to food and hence the right to food for the children in these homes is being constantly violated.

Although the JJ Act is silent about the standards of nutrition and availability of food, the Juvenile Justice (Care and Protection of Children) Rules of 2007 prescribe few guidelines in this regard. According to (Rule 44) following nutrition and diet scale shall be followed by the institutions

- a. The children shall be provided four meals a day
- b. Menu shall be prepared with the help of a nutritional expert or a doctor to ensure balanced diet and variety in taste as per the minimum nutritional standards and diet scale
- c. Every institution should adhere to the minimum nutritional standard
- d. Juvenile or the child should be provided with a special meal on holidays or festival
- e. Infant or the sick children shall be provided with special diet

Despite these norms being in place, the study conducted by the Bangalore Group and Center for Child and the Law (CCL) at national law school of India University has revealed that these standards are not met in many of such homes. Instead of the four meals including breakfast children are given only two meals a day and there is severe scarcity of clean and safe drinking water. Although there are children of various age groups (between 0 to 18 years), there different needs are not taken into account before allocating food. Similarly there is no special arrangement for the teenaged girls

to be provided with additional iron supplements. The Rules clearly say that ill children must be provided with special diet with milk and fruits, not surprisingly, this is also not followed.

The study revealed that the menu remains the same for years together and there is no initiative for changing or making it interesting. This is partly because of the reason that the staff of these homes is not provided with any training and there is no provision to organize any capacity building programmes by the state as well.

In addition to this, there apparently infrastructural as well as administrative problems as well in making the adequate food available to these children. In many of the homes there is no availability of proper kitchen, cooking utensils and/or other staples required for cooking. And even if it is available, are not kept in a hygienic manner.

Lack of Coordination within different State departments and agencies that are involve in the supply chain - Department of Women and Child Development (DWCD), Department of Public Instructions (DPI), Prison Ministry, Food Corporation of India (FCI) and of course Child Welfare Committee (CWC) and Juvenile Justice Boards (JJB). Such a situation more often than not results in irregular supplies of food grains, vegetables and other staples. Such a situation has led to malnourishment among almost all the children. There were severe deficiencies of Vitamin A, C and iron, were found in most of the children. Almost 90% of the children were underweight and water bourn diseases and skin allergies were rampant.

FIAN Bangalore Group along with the Centre for Child and the Law (CCL) at National Law School of India University in Bangalore has adopted a comprehensive approach and in addition to building the capacities of the staff, concerned authorities and NGOs and sensitizing them on the issue of human right to food, attempts are also being made to conduct social audits for various juvenile homes in partnership with the state departments, staff at the homes as well as legal services authorities at the state level. As curative measures, regular health checkups and review of the menus are being organized and the group is also advocating taking full time nutritionist on board to prescribe nutritional guidelines for these children. The centre is also on the monitoring and evaluation committee (M&EC) for one of such homes in Karnataka and has been trying to influence the authorities and the staff and these homes to provide the adequate food and follow the nutritional standards as per the Rules 2007.

Right to Food of Women and Children in Philippines

Rafael Rey Leon Hipolito - FIAN Philippines

In its latest report "*Philippine Midterm Progress Reports on the Millennium Development Goals 2007*" that came out in 2007, the government Philippines has assessed the progress on MDGs as 'on track'. The Asian Development Bank, on the other hand, commented in its 2006 report that Philippines is one of the countries with greatest concern that are falling behind in the achievement of MDGs. Actually the MDGs progress over the past 7 years still shows continuing evidence of inequity and disparities even in periods of economic growth and the benefits of growth are not yet sufficiently been shared across sectors, regions and communities

Goal 4 - Child mortality: Under goal 4, the Philippine government targeted to reduce the Under 5 Mortality Rate (U5MR) from 80 deaths per 1000 live births to 26.7 by 2015. The government claims that this is attainable because in 2006 the U5MR was down to 32 deaths per 1000 live births. However, the World Health Organization (WHO) data revealed that there are higher child deaths among the poor, the least educated and rural families as the table shows:

Under 5 Child Mortality Rate among different levels

Under 5 Mortality Rate/1000 live births Highest Educational Level of Mother	28.5/1000 live births
Under 5 Mortality Rate/1000 live births Highest Wealth Quintile	21/1000 live births
Under 5 Mortality Rate/1000 live births Lowest Educational Level of Mother	104.7/1000 live births
Under 5 Mortality Rate/1000 live births Lowest Wealth Quintile	66/1000 live births
Under 5 Mortality Rate/1000 live births Rural Area	52.2/1000 live births
Under 5 Mortality Rate/1000 live births Urban Area	30.4/1000 live births

(WHO, “Philippines Country Context”, www.wpro.who.int/counties/2008/phl)

According to the data collected in 2006, the IMR in Philippines is 34. While the national target seems within reach, there are geographic regions whose IMR is much higher than the national average. These are Bicol, MIMAROPA, Cordillera Administrative Region, Eastern Visayas, Zamboanga Peninsula, CARAGA, Autonomous Region of Muslim Mindanao and Davao Peninsula. These regions are also in the list of areas where there are high incidences of poverty. While compared to other countries in the Southeast Asia, the Philippines is not doing as good as the others. The under 5 mortality rate of Malaysia is 12; Vietnam, 23; Thailand, 21; and 38 in Indonesia.

The World Health Organization advised the Philippine government to deal decisively with infant deaths within the first 28 days of the neonatal period. 40% of under 5 deaths occur during the neonatal period. WHO also noted that child malnutrition remains a big problem in the Philippines. The report of WHO said that “In 2005, the prevalence of underweight pre-school children (0-5 years) was 24.6%, 26.3% were stunted, 4.8% were wasted and 2.0% were overweight.”

MDG 5- Maternal Mortality Rate: In its 2007 report, the Philippine Government admitted that the goal to reduce the Maternal Mortality Rate or MMR will most likely not be achieved. The report stated that “In view of the fact that the decline has slowed down considerably and appears to have stalled, this goal has been identified as the least likely to be achieved for the Philippines.” (NEDA, “Philippine Midterm Progress Reports on the Millennium Development Goals”, 2007) This was seconded by the UNICEF Representative, Ms. Vanessa Tobin who said “The MMR in the Philippines is listed as the MDG least likely to be achieved by 2015”. (IRIN, Phil. MMR not making sufficient progress, March 24, 2009)



In 1993, the MMR of the country was 209 deaths/100,000 live births. This went down to 106 deaths in 2006. The Philippines is one of the 68 countries which contribute to 97% of the MMR in the world. 11 Philippine mothers die everyday while giving birth or 4,500 per year. (UNICEF Philippines, “DOH launches strategy to reduce maternal and newborn deaths”, May 11, 2009) The most common causes of maternal death are severe hemorrhage, hypertensive disorders, sepsis, obstructed labour and abortion.

There are three major reasons responsible for the country’s high MMR. One is the inadequate reproductive health services. Second, very few mothers are attended by skilled birth attendants before, during and after giving birth. Only 60% of births are attended by skilled birth attendants and thirdly, lack of access to Emergency Obstetric Care Services. Inadequate budget allocation for health services is one of the reasons why the Philippines lack skilled birth attendants. The expenditure on health of the government is only 6.4% out of the total government expenditures. Midwives number only more than 136,000 or 1.65 per 1000 population. Compared to other ASEAN countries, the percentage of births attended by skilled birth attendants in the Philippines is the smallest at 59.8%; Indonesia is at 71.5%; Malaysia, 97.4%; Thailand, 99.3% and Vietnam, 85%. (ADB, UNDP, UNESCAP, “MGDs: Progress in Asia and the Pacific”, 2006)

Right to food for HIV positive Women and Children in Nepal
Mr. Satya Twayna, FIAN Nepal

As per the indicators like Infant Mortality Rate, Under-five mortality rate and the proportion of 1 year-old children immunized against measles, Nepal has seen a remarkable progress in achieving the MDGs Remarkable reduction has been seen in child mortality rate in Nepal over the decades. From a staggering 200 per 1000 live births some 30 yrs ago, the IMR today is 61 per 1000 live births.

Indicators	1990	1995	2000	2005	2015
IMR	108	79	64	61	34
UFMR	162	118	91	82	54
Proportion of one-year olds immunized against measles	42	57	71	85	90

The under 5 mortality rate (U5MR) was found to be 91 per 1000 live births in the 2000 survey which was decreased to 82 in 2005. The most prominent causes of the decline in IMR are improvements in the management of diarrhoea, improved immunisation, Vitamin A supplementation and the management of acute respiratory infections especially pneumonia. Going by the official data, it seems likely that Nepal will achieve this target for 2015.

However, it must be emphasized that the country’s Child Mortality rate is the 5th Highest among the East Asian Region. And the issues of paramount concern are: the

proportion of neonatal deaths has increased from 40% of infants' deaths in 1887 to 60% in 2001, in Nepal newborn mortality is the third highest in the world and of every 1000 newborns, 39 die within the first month of life. And the most important causes for this are infection, birth asphyxia/ trauma, prematurity and hypothermia

The progress in reducing child mortality is mainly a result of increased awareness and accessibility to various programmes that prevent child deaths for example:

- a. Community based Integrated Management of Childhood Illness package, etc.
- b. Control acute Respiratory Infection program
- c. Vitamin A programme Nationwide measles Campaign
- d. The essential Health Care Package
- e. National Neonatal Strategy Developed the Profile of Newborn Care
- f. Expansion of health program by Government agencies

Role of civil society and media role is very important in contributing to the progress in these Goals especially in relation to family education, health education, education about tobacco and indoor pollution, breast feeding and so forth. In addition to this employing qualified medical and nursing personnel in remote areas is also required.

Right to Food for Women living with HIV: Women comprise more than half of Nepal's population. Nepal Living Standard Survey of 2004 indicates that 31% of Nepalese fall below the poverty line. Although more than 60% of women are involved in agriculture and related activities, only about 11% have ownership of land.

Mr. Satya discussed the case of single women affected with HIV, a case that FIAN Nepal section is following. Village Kausati Kot is located in the Achham district of Nepal and this is one of the most vulnerable districts of Nepal in terms of HIV AIDS infection. During the last couple of years there have been 331 deaths due to HIV AIDS infection, out of which 30 were women and rest were the men. 230 women are widowed because of death of their husbands from HIV AIDS.

There is a large section of male population who seasonally migrate to India for employment to earn livelihoods which is not secured in their hometowns. These men get the HIV infection because of unsafe sex and carry the infection with them and on their return transmit the virus to their wives. Husbands abandon their wives and these women are left with responsibility of their families with no support system in place. These women neither have land or properties, nor do they have support from husbands, and children are too small to support her

Right to food of these women and their children is challenged, especially after the death of their husbands. They are landless at present because whatsoever land was with them was either sold or mortgaged for treatment of their husbands and themselves. Most of them illiterate and do not have any employment opportunities. Physical illness (constant fever, headaches) also do not allow them to go to other places for work. Food is so inaccessible that at times mothers somehow manage to feed their kids but have no food for themselves for many days. Treatment never becomes a priority in the situation when they have nothing eat to eat properly. These

women are also not able to send their kids to school. Quality or nutritious food is far from reach from them, where quantity itself is questionable.

Summing up

Dr. Flavio Valente

Based on the aforementioned discussion, Dr. Valente raised some key issues. Firstly, working on cases has enormous importance from human rights based perspective. It is important to document and highlight various cases of human rights violation irrespective of the numbers of the people whose rights are being violated. The cases of violation must be documented and fought for even if the number of people involved is not large.

Secondly, in terms of achievements, it is important to maintain equity in the realization of MDGs. It is not enough to achieve the goals only statistically. We must also take due cognizance of the systemic discrimination women and few communities are subjected to. In addition to this, we must also not forget that the right to food also encompasses the realisation of right in dignity not as a welfare measure towards an individual or a group. Dr. Valente also admired the case work presented by the groups in India, Nepal and Philippines.

It is important to brainstorm on certain contentious issues such as – how to hold the government accountable while looking at the implementation of MDGs, especially in a situation where even the minimum standards are not being met. We must also endeavour to strengthen our case work in order to denounce wide regional and gender imbalances, and disparities and fight the injustice being done to people, for instance in children in conflict with law who just land up in prison for no fault of their own,

Similarly, one must also explore the possibility about national and regional campaigns aimed at involving, informing and supporting communities and making them a part of the entire struggle for human rights.

Group Work on Identifying Areas for Future Collaborations

In the back drop of the proceedings of the previous day, three issues were identified and groups were formed to discuss and make presentations:

A. How to hold government accountable in achieving the MDGs with equity?

Presentation of Group A

A number of strategies were suggested by this Group in order to hold the government accountable in achieving the MDGs. First and foremost is the articulation of the international obligations of the state and review of the extent to which these obligations have actually got translated into the relevant policies, schemes, programmes and indicators at national level. It was also suggested to look at the budget specified for such schemes, concrete entitlements as well as the monitoring mechanisms.

It is also important to have a look at the available data, segregate it for various sections of the society and in a gender specified manner, analyse it from a human rights perspective and then use it for further lobbying and advocacy. It was also suggested by the group to disseminate the available relevant reports by the government, non government and international agencies such as FAO, UNICEF and UNESCO, to be translated in vernacular languages in disseminated at local levels. On the basis of such information national and regional level campaigns can be organized to hold the government accountable on certain specific issues. Right to Information Act can also be widely used to get the information wherever it is not readily available. This information may range from statistical data with regard to certain vulnerable groups to the qualitative information such as the measures taken by the government to achieve these MDGs with equity. Such information/data can be triangulated with the alternative data collected by the civil society.

Ultimately, establishing the justiciability of the rights through a law having legal recourse mechanism built into it, can certainly provide impetus to the endeavours in the direction of holding the government accountable.

B. What kind of case work can be done on MDGs 4 and 5 from the point of view of the mandate of FIAN?

Presentation by Group B

While exploring the potential for case work three major areas were suggested. First, who are we looking at - identifying the most vulnerable groups; themes for intervention; and strategies of intervention.

The focus of the case work could be the most vulnerable groups such as: children, women, older people, people living with diseases like HIV and tuberculosis, etc., differently abled, people living below the poverty line, children in justice system, mineworkers and the internally and externally displaced population.

The themes on which interventions can be made include health as a stand alone issue, access and coverage under the government sponsored vaccination systems, nutrition especially for pregnant and lactating women, right to water in terms of access and quality. Some cases can also be documented with regard to the rights of farmers being violated because of the lack of knowledge and technical expertise.

In terms of the strategies community based education and capacity building may help in realization of the rights at the local level. Well documented cases can be taken to the government and to the international agencies with demand for immediate action and restoration of rights. At the regional level such case work must include documentation of cases with similar violation, such case work must be published and advocacy must be done at the international around them.

C. Role of civil society for lobbying and possible campaigns

Presentation by Group C

Civil society must take on the role of generating awareness among the community by networking with media, professional associations like doctors, lawyers associations, other progressive groups with similar objectives, NGOs, trade Unions and youth associations etc. Workshops, Meetings and Seminars at local, state, national and regional levels can be organized and Online Forums can be used to disseminate information.

The content of these workshops meetings etc. must include description about MDGs, their progress analysis and the available government schemes related to these MDGs. There should also be special emphasis on how to cover discriminated groups. It is also important to identify the difficulties in accessing the programmes / schemes related to MDGs and the possible redress mechanisms including legal recourse. Most effective monitoring mechanism should also be discussed in such fora.

The Group was of the view that civil society must also organize, facilitate, lead and encourage campaigns on various issues having bearing for the Right to food to food and MDGs 4 and 5. These campaigns can be organized around the availability and accessibility of health programmes, school feeding programmes, employment guarantee act, other social security schemes, right to information, housing and right to access to other productive resources without any discrimination

It was also suggested to document cases as well as mobilize resources to conduct activities at international and regional level where similar issues from various countries could be addressed.

Responses and Discussion

Mr. Sanjay Rai emphasized the importance of regional approach in addressing the common issues of concern. Dr. Valente appreciated the presentations by the groups and said that the issues raised in these presentations provide fertile soil for future interventions. He said that we must focus on most pragmatic interventions that can be done in an organized and consulted way and thus it implies that these workplans should be operational, realistic and time bound. He further said that the human right to adequate food is the mandate of FIAN and we must make concerted efforts towards the realization of it, particularly for the vulnerable groups. He cautioned against the food assistance programmes being treated as the rights in themselves, we must not lose sight of the dignity, which is an intrinsic part of the human rights based approach.

He reiterated that using the human rights approach is our strength and our strength to use the human rights that helps us analyse the human rights violations and holding the duty bearers accountable when the breach happens at the national level. Further, we must involve the communities whose rights are being violated while making any strategy for interventions.

Ms. Siri Damman informed that October 1st 2009 is the deadline for submitting any proposal to be submitted to Norwegian Development Agency (NORAD) and research on the cases from various countries of Asia and the interventions therein could make a proposal of interest to NORAD. It was also suggested that the issues can even be raise

in various regional platforms such as SAARC and commonwealth. Mr. Gurusamy highlighted the importance of adequate documentation of cases with sound facts and quality data, the absence of which the case work would go in vain.

Recommendations

The presentations from the groups based on the brainstorming provided interesting starting point. The task ahead is to focus and define a manageable work plan for the region, and for each country, in relation to how to work with the MDGs 1, 4 and 5, from the Human Right to Adequate Food perspective. The possible dimensions to take into account would be:

- a. Stay with the focus on the RTF even when working with related rights.
- b. Identify a broad spectrum of themes and affected populations as discussed in Group 2.
- c. Use the human rights based analysis.
- d. Document violations of the Human Right to adequate using the existing international covenants and conventions, and related national legislation, identifying:
 - i. Specific Right holders
 - ii. Duty bearers.
- e. Elaborate strategies together with the affected communities
- f. Then establish specific activities to overcome the violations
- g. Share cases and eventually have a joint publication and campaign at regional level

Dr. Valente proposed that a smaller group should narrow down the discussion and propose a realistic work plan, with goals, timeline and responsibilities. One representative from each country should start the process prepare a workplan that could later be shared with everybody. This could eventually lead to a project application to NORAD or other agency. NORAD is interested in receiving a project until October 1st 2009. He also emphasized the need for proper documentation of cases and the importance of training and capacity building.

Vote and thanks and concluding: The seminar was ended with a vote of thanks by Dr. Neetu Sharma. She extended her heartfelt gratitude to all the participants for sharing their insights and value adding to the discussions.

Annexure

List of participants

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