

Rethinking ICDS: A Rights Based Perspective

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# Rethinking ICDS: A Rights Based Perspective

*The ICDS programme is one of the most important public programmes in India, reaching out to the most neglected sections of the population. However, its coverage needs to be expanded to include every child, pregnant and nursing mothers, and adolescent girls. Its functions need to be separated, with a specialised person to provide pre-school education and another worker to take charge of health and nutrition aspects. Coordination between the health and education departments is required for maximum efficiency. Also, it is important to set clear goals, so that achievements can be assessed and work given direction.*

DIPA SINHA

Little Savithri of Chittempally Tanda in Ranga Reddy district was 18 months old, but looked like she was three months old and weighed only 5.5 kilos. She could not even turn over when she was lying down, there were no expressions on her face, and she had extremely thin hands and legs and looked terminally ill. Her family (consisting of her parents, grandparents, uncles and aunts) had given up on her, as they could not afford to buy expensive tonics.

Her mother, Jaya, already had Savithri's brother, a three year old, to take care of. She was now seven months pregnant. She was 14 years old when she got married, and now, at the age of 19, she is expecting her third child. She had to do all the household chores and also work on the family land. The only person who had time to take care of Savithri was 14-year old Sukhi, her father's younger sister. Sukhi had dropped out from school, as she was to be married in a month's time.

This family is not an exception in rural Andhra Pradesh. There are thousands of children who are malnourished, with no special care, and large numbers of mothers who are too young to have healthy children but have had repeated pregnancies. Many of these young mothers are overburdened with work, undernourished, and in urgent need of healthcare. A large proportion of adolescent girls are out of school, and face the prospect of early marriage or sexual harassment, with little hope of freedom.

According to the second National Family Health Survey (NFHS-2), conducted in 1998-99, the infant mortality rate in Andhra Pradesh is 66 per 1,000 live births. About 38 per cent of children under three years of age are underweight, over 50 per cent of deliveries take place at home, and only about 60 per cent of children in the age group of 12-23 months are fully vaccinated. About 54 per cent of girls in the 11-14 age group, and 20 per cent of girls in the 15-17 age group, are in school. The median age at marriage for women aged 20-49 in rural areas is 14.9 years. Further, there has been little change in the condition of women and children (especially girl children) with respect to health in the last decade. In spite of the hype about Andhra Pradesh being a "hi-tech" state, leading the IT industry in the country, there has been a slowdown in reduction of infant and maternal mortality in the last two decades.

The situation at the all-India level is similar, if not worse. According to NFHS-2, only 65 per cent of women access antenatal care, and less than half of all deliveries take place with skilled attendance. The maternal mortality ratio is as high as 540. About 50 per cent of women are anaemic, and the median age at marriage is 16.7 years, in spite of a law against child marriages. The infant mortality rate is 67.6 per 1,000 live births, and 45.5 per cent of children under the age of five are chronically undernourished. The rate of decline in infant mortality has slowed down from the 1990s onwards in India, even when compared to countries like Bangladesh and Nepal. The recent

World Health Report also puts India among slow progressing nations in child and maternal care.

## ICDS and Its Impact

This paper discusses the reasons for dilution of the Integrated Child Development Services (ICDS) programme. It argues that for ICDS to be effective in reducing infant mortality, combating malnutrition and improving child health there must be: (a) a firm conviction that every mother and child has a right to health and well-being and that this is non-negotiable; (b) an assertion of the state's obligation to ensure that all mothers and children have access to basic healthcare and nutrition; (c) a change in the existing social norms that allow the violation of the rights of mothers and children; and (d) uncompromising public action on the rights of mothers, adolescent girls and children.

The only institution at the village level that is responsible for the health and well-being of mothers, children and adolescent girls is the anganwadi centre. The anganwadi centres were created under the ICDS programme, which started in 1975 with the following objectives:<sup>1</sup> to improve the nutritional and health status of children in the age group 0-6 years; to lay the foundation for proper psychological, physical and social development of the child; to reduce the incidence of mortality, morbidity, malnutrition and school drop-out; to achieve effective co-ordinated policy and its implementation amongst the various departments to promote child development; to enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education.

ICDS was initiated in 33 blocks in 1975, and expanded to cover almost 6,500 blocks in 2004. The programme recognises that in order to reduce infant mortality and malnourishment, it is extremely important to also cater to the health and well-being of the mother. Initially, the focus was on the period from the time she got pregnant until she delivered. Later, it was realised that the mother needed nurturing from much earlier, and therefore the programme for adolescent girls, the Kishori Shakti Yojana (KSY), was started in the year 2000-01.<sup>2</sup>

To some extent, ICDS has been a successful programme. Infant mortality

declined from 94 per 1,000 live births in 1981 to 73 in 1994. Severe malnourishment has decreased from 15.3 per cent during 1976-78 to 8.7 per cent during 1988-90 [Chandrasekhar and Ghosh 2005]. However, the dismal status of child health in India shows that there is a lot more to be done.

Field surveys such as that recently conducted by the Centre for Equity Studies in association with the commissioners of the Supreme Court (N C Saxena and S R Sankaran) show that the overall conditions of ICDS in the country is far from satisfactory, though there are considerable differences in the performance of the scheme between different states [Drèze and Sen 2004]. The experience of many working in rural India also shows that there is a huge gap between what is planned under ICDS and what is actually happening on the ground.

Further, the reach of the ICDS programme is very limited. There are only six lakh anganwadis in the country, compared with an estimated 17 lakh required for universal coverage based on existing norms. Supplementary nutrition is currently provided to 3.4 crore children, as opposed to 16 crore children (half of whom are undernourished) in the age group of 0-6 years [Drèze and Sen 2004].

### Beginnings of a Public Debate

The poor condition of mother and child health in India is not a matter of wide concern and public debate. Governments are seldom pulled up for not succeeding in providing better access to health and nutrition to the most vulnerable. Improving ICDS or primary health services is not on the election agenda of any of the political parties, and receives only cursory mention in the manifestos. The state of child health or the functioning of the ICDS centres rarely make headlines in the newspapers. It is therefore not very surprising that the anganwadi centres or the primary health centres (PHCs) do not function effectively, since for any public institution to function, it is necessary to ensure accountability through public action. "What the government ends up doing can be deeply influenced by pressures that are put on the government by the public. But much depends on what issues are politicised and which deprivations become widely discussed and electorally momentous" [Drèze and Sen 1995:87]. The task of protecting the rights of infants

and young children and their mothers is yet to become a social issue that concerns everybody.

There have been some positive developments in the last few years that are a ray of hope for the women and children of our country, and need to be worked upon. Firstly, in response to the writ petition filed by People's Union for Civil Liberties (PUCL) in April 2001, the Supreme Court issued an order in November 2001 directing the government to ensure that ICDS is immediately expanded to cover every hamlet in the country. This order also states that ICDS should reach every child below six years of age, every pregnant and lactating mother and every adolescent girl. Further, all SC/ST hamlets in the country should be covered as a matter of priority. The impact of a similar order on mid-day meals, issued by the Supreme Court on the same day, provides some important lessons as to what legal action can achieve when it is combined with public action.<sup>3</sup>

Secondly, the present UPA government in its common minimum programme has committed itself to universalising the ICDS scheme to "provide a functional anganwadi in every settlement and ensure full coverage for all children" (national common minimum programme of the government of India, 2004:6).<sup>4</sup> Being a coalition government, its stability depends on its performance with respect to the objectives of the common minimum programme. This can be used by other parties, and by the public, to exert pressure. As the performance of the government will be appraised based on what it has done on each of the pledges made in the common minimum programme, the coverage and quality of ICDS is likely to come under close scrutiny.

Thirdly, the National Advisory Council (NAC) has shown keen interest in ICDS, and made detailed recommendations to improve the coverage and quality of the programme. These include a sixfold increase in financial allocations for ICDS over a period of two to three years. This would provide for the expansion of ICDS to all the habitations in the country, and for doubling per-child expenditure as a first step towards facilitating quality improvements (NAC's recommendations on ICDS, August 2004).<sup>5</sup>

Although there is now an emphasis on universal coverage of ICDS, the anganwadi centre is still not explicitly acknowledged as an institution created

to fulfil the state's obligation towards the protection of the rights of the mothers and children. This issue requires further mobilisation.

### Absence of Social Norms

The issues that are to be addressed by ICDS, such as maternal/child health or nutrition or adolescent health, are as much about social norms as they are about poverty, access to resources, etc. For instance, gender discrimination deeply influences the status of women and children in the community. Likewise, attitudes towards women, pregnancy, nutrition, and early childcare have a great impact on the status of maternal and child health.

Especially in rural areas and among the poor, pregnancy and childbirth are extremely private issues, rarely addressed beyond the circle of concerned women. For instance, if a woman goes to the hospital and there is no doctor, and she delivers under a tree, this does not become an issue of protest in the community. Should an infant die as soon as it is born, or a mother die due to excessive bleeding after delivery, there is no expression of shock or outrage. Similarly, if the child is severely undernourished, it is seen as an act of god, resulting from some kind of 'karma'. Anxious parents who consult doctors spend lots of money and are seldom given proper advice on feeding the child differently. When girls are married at 13 or 14 years of age, there is no debate; this is seen as an accepted norm.

Women and children, the beneficiaries of the ICDS programme, are not given any importance in the community and therefore the anganwadi centre is also not given any respect. Absence of a social environment conducive to giving support to the most vulnerable sections of society, dilutes the services of the anganwadi worker as well as the healthcare system. For example, the messages that women must eat green leafy vegetables, eggs, milk, fruits and so on when they are pregnant are so unrelated to the predicament of women that they fall on deaf ears. The fact that women are not even eating leafy vegetables (let alone eggs or fruits), despite being advised to do so for 30 years, is seldom examined. It is assumed that it is enough just to tell women that they should take care of themselves and eat a good diet. It does not matter that social norms to encourage such practices

and support structures to make them possible, do not exist.

### Creating a New Social Environment

Any programme that aims at improving the health of women and children must begin by addressing the lack of norms. In the absence of a supportive environment, even the best of services (such as ante-natal care or supplementary nutrition or micronutrient supplementation) do not reach the target group. This acts as a significant barrier against women's access to what is due to them. It is the responsibility of the government, through the anganwadi centres, to work towards creating new norms that support mothers' and children's rights. To change norms, the entire community has to be mobilised to protect the rights of women and children. Everyone in the community, men and women, old and young have to be involved in a process of debate and discussion on what is best for the health of the mother and the child. The gram panchayat and local bodies must review the functioning of the anganwadi centres and also the status of mother and child health in the village regularly.

An environment should be created where the village appreciates a man who brings water, fetches firewood or helps his wife with cooking, bathing and feeding the child. Such assistance often invites derision, as the man is seen to be womanly. If a girl is married off very young, then the community must react and get together to stop the marriage. A malnourished child or an infant death must become the concern of the entire village. It is only when this happens that there will be some meaning to the food given in the anganwadi centre and the colourful posters telling the woman what she should eat. If it is accepted that the woman has a right to a safe delivery, and that it is the government's duty to protect her right, then the ICDS programme needs to address the social norms that undermine women's rights.

### Strengthening ICDS

Given that women and children have a right to health and nutrition, it becomes the responsibility of the government to create, through ICDS, a norm where these rights are not violated. For ICDS to play such a role, the following are some issues that need to be considered.

*Community involvement in ICDS:* To ensure the involvement of the community,

every anganwadi centre should have a mothers' committee that meets regularly to review and monitor the functioning of the centre. In Andhra Pradesh, this committee consists of two pregnant women, two lactating mothers, two mothers of children in the age-group of 0-6 years, and two mothers of adolescent girls. It is usually women who are in the neighbourhood of the anganwadi centre who are chosen to be members of this committee. The meetings are rarely held. These women have not been trained, and do not know what their role is supposed to be as members of the mothers' committee. The anganwadi worker (AWW) too is not clear about the role of such a committee. As there is little respect for this committee in the village, it often remains on paper, and makes little difference on the ground. There are names listed only because the AWW has to report every month to her supervisors. Since there is no public debate and discussion in the community on the anganwadi centre, its function and purpose, mothers' committees become substitutes for a meaningful community involvement.

The ICDS programme reaches out to only a small section of the village population, giving the impression that it is a "project" and not a universal entitlement. The number of beneficiaries gets fixed on an arbitrary basis and there is no flexibility to change it. For instance, supplementary nutrition in Ranga Reddy district is to be provided to six pregnant women, six nursing mothers, 16 children in the age group of 6 months to 35 months, and 30 children in the age group of 3-6 years. As the programme excludes a majority of women and children, the active involvement of the community is difficult to achieve. The ICDS programme is seen not as a rights-based institution, but a 'podi' (powder) centre where, once in a while, some white powder is distributed on the basis of the AWW's likes and dislikes.

This lack of public ownership of the programme also opens the door to large scale and blatant corruption. It is no secret that in many places the supplementary nutrition powder is sold by the AWW to farmers as feed for buffaloes. In other instances, the powder is strained to extract the sugar. So much so that during 'Ugadi' in Andhra Pradesh, people ask for the anganwadi 'jaggery' to make the festival sweets because it is of good quality! There is more public discussion of how good the jaggery is, and how one should try and get it for the Ugadi celebration, than there is

on why so many children are malnourished, why there has been an infant death in the village, or why a woman has not been able to go to the hospital for delivery.

Involving the community in ICDS is important so that the village feels a sense of ownership of the centre. It would also render the AWW more accountable and acceptable to the community.

*Responsibilities of AWWs:* The AWW, in many instances, is the only available government servant in the village and is responsible for the most vulnerable groups in the community. Yet she does not get the recognition she deserves. At the village level, the AWW is not involved in any of the village meetings concerning discussions on children, adolescent girls and women, even those where say, the school-teachers are involved. She is not consulted on any agenda. At the mandal<sup>6</sup> level too, it is seen that although those in the revenue, social welfare, education and health departments sometimes coordinate with each other, the members of the ICDS project such as the community development programme officers (CDPOs) are not participants. Even at public functions, for instance, the CDPO never gets invited in the way that a mandal revenue officer (MRO) or a mandal development officer (MDO) are. Right from the beginning, the design of the ICDS programme has been such that it works in isolation from other departments, and is also poorly integrated with the community. This has resulted in the entire programme receiving little importance.

In the village, the AWW is viewed as just a "social worker" paid by the government and not as a functionary of the government. She gets paid only Rs 1,000 a month (less than the minimum wage), and even this amount is not paid regularly. On the other hand, the number of tasks that the AWW is expected to perform is impossible for most workers to complete.

The AWW, as mentioned earlier, is supposed to cater to the needs of pregnant and nursing mothers, adolescent girls and children below six years of age. She also has other responsibilities in the context of other programmes such as family planning, DOTs follow-up for tuberculosis, and girl child protection schemes. Each of these is a major task in itself, requiring a lot of effort. Although the needs of the three target groups under ICDS (children under six, adolescent girls, and pregnant and nursing mothers) are linked to each other, each group's well-being raises

independent issues. While it is true that in the long-term today's children are the adolescents of tomorrow and the parents of the day after, right now they are three different groups with specific needs, calling for immediate attention. Each of these is a specialised task requiring professional skills.

To begin with therefore, as many have suggested, there has to be a separation of the 0-3 year old, adolescent girls and women's programme from the pre-school education programme for 3-6 year old children [Ramachandran 2005]. The pre-school education programme for the 3-6 year olds could be linked to the primary school, with the mid-day meal as supplementary nutrition. In some villages of Andhra Pradesh where the centres are linked to the primary school, it is seen that the attendance at the anganwadi centre is greater because the younger children come to the centre along with their siblings who are in school. Further, the AWW feels part of the larger institution and is therefore motivated to work. The children also like having a proper meal along with the older children in the afternoon. A kindergarten section in the school, open to all children in the age-group of 3-6 years, can be visualised, with the number of teachers being decided according to the number of students.

There is a need for a separate full time trained professional worker to carry out the other tasks of providing nutrition for the under-3s, ante- and post-natal care, immunisation and adolescent health. This person could also be responsible for conducting meetings in the village with the different groups such as women, youth, gram panchayat and so on, working towards creating a norm in favour of children and their rights. This person will have to work closely with the auxiliary nurse midwife (ANM) and the health department. *Comprehensive planning and decentralisation:* Many of the functions of the ICDS programme depend on the health department for their success. For instance immunisation, ante-natal care, family planning and referral services are all provided by the health department. The role of the AWW is to act as a motivator and a link person between the community and these services. At present there is no institutionalised mechanism for this coordination beyond the village level. At the village level the ANM liaises with the AWW as a contact person in the village and gets data from her on who is pregnant

and whether any deliveries or deaths have taken place. Some times, basic first-aid material is also left with the AWW, e.g. oral rehydration solution (ORS) packets and paracetamol tablets.

This kind of coordination is not the result of a careful plan of action worked out by the concerned departments at the higher level. Since all the activities are linked, there is a need to understand the significance of this kind of convergence. Two small examples, drawn from the MV Foundation's experience (see next section), may help to illustrate the point. In the first case, a meeting was held with all the AWWs in one mandal in Ranga Reddy district and their help was sought in motivating women for institutional delivery. The AWWs said that they had given up doing that because when they did take women along to the PHC, there was nobody there to provide the service, and if they dared to ask, they were shouted at by the ANMs. The ANMs, for their part, do not see why the AWWs should have anything to say about the PHC. Coordination at a higher level, along with informing the ANMs that this is part of the role of the AWW, would have been helpful.

Another instance was a meeting in one mandal, held at the PHC, with the ANMs and the medical officer and all the AWWs. The PHC had been given orders that the entire population should be immunised for filaria within two days. The dates had already been fixed for the entire state. The medical officer therefore called the AWWs for a meeting to instruct them to carry out this job under the supervision of the ANMs. It would be impossible for the ANMs to do it alone, as each of them was looking after 5-6 villages. The AWWs however refused to cooperate, saying that it was the last week of the month and that they had to finish all their records in time for their monthly meeting, failing which they would be pulled up by their superiors. There was a long fight between the AWWs and the PHC staff. Ultimately, some of the AWWs agreed to cooperate, while others said they would have nothing to do with the programme. In this case too it was felt that it would have been better for the medical officer to have a meeting with the CDPO and for the two of them, to plan the entire programme together. Smooth coordination between different departments is extremely important for effective implementation of such programmes.

Closely related to lack of coordination is the problem of haphazard and top-down

planning. Most programmes are ad hoc, suddenly launched without any preparation or follow up, highly centralised and without involvement of the community. There is, out of the blue, a rally with school children on institutional delivery, a meeting with adolescent girls on HIV/AIDS, or a week to celebrate breastfeeding with no information to the community. Usually it happens this way because it is planned at the state or central level and suddenly passed down to the AWWs as a task to be completed. This makes it very difficult for the AWW, who is the frontline worker facing the community, to implement the programme in a meaningful manner.

There is no clarity on the roles of the supervisor and the CDPO. Since all planning, to the last detail, comes from above, at the level of the project office, there is no space for any creative thinking. The supervision is reduced to monitoring the different registers that are to be maintained by the AWW. This top-down approach to planning must be replaced by a more decentralised system where the AWWs are given space to review their experiences and share what they think must be done to achieve the goals of ICDS. There should be clarity on what must be planned at the level of the central and state governments and what must be left for the anganwadi centres, the local community and the local bodies to decide for themselves.

### **MV Foundation Experience<sup>7</sup>**

The above recommendations on ICDS are based on the experience of the MV Foundation in mobilising the community for protection of child health in eight mandals of Ranga Reddy district, Andhra Pradesh. The MV Foundation, drawing on its experience with children's right to education, recently began working on the issue of children's health. Initially, data were collected on every birth that took place in the village each month and the prevalent practices of delivery and child care. It was found that almost 50 per cent of the women delivered at home, and that infant mortality was very high. When these figures were compared with PHC statistics, it emerged that the government did not report most deaths.

More disturbing was the fact that even when eight to nine children died in a month in a mandal, there was total indifference. It did not become a matter of

concern for anyone in the village – the gram panchayat, the anganwadi centre and the community evaded the issue. At best, people sympathised with the family. Invariably, it was seen as a personal issue, not something that required any social action.

Rallies and marches were organised in the village on the issue of children's right to health. Meetings were held at the village and mandal level, where this information was shared with the entire community to discuss how each of these deaths could have been prevented. This entire exercise was also to help create an environment where the community felt responsible for the well-being of the children born in the village. It was then decided that the gram panchayat should review the condition of all children in the village every month along with all the concerned government functionaries such as the AWW, the ANM and the school headmaster.

Members of youth groups and mothers' committees, among others, also attended these meetings in the village. Consequently, in about 50 villages, each month the ANM and AWW, along with the sarpanch and the ward members, now review the number of children who have been immunised; whether supplementary food was reaching the children; details on whether any children died during the month, and so on. They even discuss cases where families did not cooperate or refused to get children immunised, or were unwilling to take the supplementary nutrition provided at the anganwadi centre. The gram panchayat, along with others, then visits these families and motivates them to access the services.

Some changes have already taken place through this process. The gram panchayat in many villages now feels responsible for the children in the village. The ANM and AWW discuss with the gram panchayat the obstacles in delivering services. For instance, in Sheriguda, the ANM explained that she was not doing ante-natal check-ups because there was not enough space with privacy in the village. In response the gram panchayat decided to convert a godown into a centre for the ANM and the material stored in the godown was shifted to the gram panchayat office.

In some villages the AWW was caught red-handed while she was trying to sell the supplementary food, and action was taken against her. At the same time, should the AWW require any support from the village, it is provided. In many villages, there

were complaints that the ANM was not available. She, in turn, claimed to be making the requisite number of visits. To resolve this problem, a public announcement (with drum beats – 'dappu') is now made the previous evening, informing everyone about the ANM's visit and asking parents to send their children for immunisation and health check-ups. Such issues are now being tackled at the village level, with government departments and the community coming together.

More importantly, as a result of this process of public mobilisation on child health, what was so far seen as a private issue confined to the family (and even within the family, primarily the mother's concern) has now become an issue for the entire village. In village after village, ceremonies are held where the sarpanch gives out birth certificates to all children below the age of two. Once the backlog is covered in an institutionalised manner, all children in the village are given birth certificates as soon as they are named. For the sake of the certificate, families are naming their children within the first month itself. Through this exercise of giving birth certificates, the panchayat and the community now celebrate the birth of every child – a significant shift from the earlier position where the death of a child was considered as the mother's fate.

It is in such an environment that the specific issues of each child are taken up. The families are informed and motivated to avail the services available to them from the ICDS and health departments. At the same time, there is also a discussion on giving children time, and sharing of responsibilities within the family. Through regular review meetings, the community exercises pressure to ensure that the ANM comes regularly and that the anganwadi centre functions.

The community is thus being sensitised to the well-being of pregnant women, mothers and children. With increasing community interest in the anganwadi centre, the AWW is empowered and ICDS is beginning to have a presence in the village. Issues that cannot be resolved at the village level are being taken up by the gram panchayat to higher authorities. For instance, a number of petitions have been submitted to the CDPO asking for better buildings for the anganwadi centres, sanction of additional centres, and steps to activate non-functional centres. The rights of mothers and children are becoming a public concern, with the community

demanding from the state what is due to mothers and children.

## Conclusion


ICDS is one of the most important public programmes in India, reaching out to the most neglected sections of the population. It can go a long way towards protecting the rights of mothers and children. India cannot dream of progressing with high rates of maternal and child mortality and extremely high levels of malnutrition.

However, a lot needs to be done to enable ICDS to reach its objectives. The coverage of ICDS has to be expanded to reach out to every child, pregnant or nursing mother, and adolescent girl. It is important to demand universal coverage of mothers, children and adolescent girls, dealing with the issue from a rights-based perspective. This involves a clear commitment to the protection of children's rights on the part of the state, and public mobilisation to ensure that rhetoric translates into action.

Secondly, the functions of ICDS have to be separated, with a specialised person to provide pre-school education and another trained worker to take charge of the health and nutrition aspects of the programme. Active steps should be taken to implement widely-supported recommendations such as keeping anganwadi centres open for the whole day, setting up crèches for younger children, providing take-home rations for those under three years of age, etc. Further, there must be coordination between the health and education departments to provide these services efficiently. Also, the National Rural Health Mission's plan to post community health workers in each village should be integrated with the ICDS programme, to avoid creating a parallel system and to ensure better coordination between ICDS and the health system.

Thirdly, it must be recognised that the anganwadi centre is expected to perform multiple functions, each of which is equally important and needs to be carefully thought out. There is a need to first have a vision of what is best for the protection of the rights of mothers, children and adolescents, and of the state's responsibilities in this regard. Based on such a vision one could then estimate the required resources, how these resources can be mobilised and how they should be spent. It is important to set clear goals, so that achievements can be assessed and work given direction. As things stand, the process works the other way round. There is first an

estimate of the resources available, and then "realistic" demands and plans are made, contingent on these pre-specified resource commitments.

The health and well-being of mothers and children must be recognised as an overwhelming priority, and all efforts made to realise this goal. Children are the future of the country and cannot wait any longer. There has to be a serious debate on this issue, involving all sections of society, leading to a vision of what we aspire to be. Backed by a clear vision as well as political commitment to the rights of mothers and children, the ICDS programme and the AWW could play a key role towards the development of the country. 

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## Notes

[This paper is based on the MV Foundation's experience of working on children's right to health in eight mandals of Ranga Reddy district. The author is Health and Population Innovation Fellow of the Population Council and is associated with the MV Foundation.]

- 1 See <http://wcd.nic.in/udisha/htm/objectives.htm> (Department of Women and Child Development, government of India).
- 2 See <http://wcd.nic.in> (Department of Women and Child Development, government of India).
- 3 For further details of these orders, and of the campaign that has built around them, see [www.righttofoodindia.org](http://www.righttofoodindia.org).
- 4 See <http://pmindia.nic.in/cmp.pdf>.
- 5 For further details, see [www.nac.nic.in](http://www.nac.nic.in).
- 6 A mandal in Andhra Pradesh, is an administrative unit consisting of about 30-40 villages and an average population of around 50,000. The administrative structure in Andhra Pradesh comprises the district, mandal and gram panchayat.
- 7 The MV Foundation is a voluntary organisation working on issues of child labour and children's right to education. It is currently active in 6,000 villages of Andhra Pradesh.

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## CHHATTISGARH

# Grassroot Mobilisation for Children's Nutrition Rights

*As a part of the right to food campaign initiated in Chhattisgarh to improve children's access to nutrition especially in the tribal dominated areas, this article analyses the exemplary work of the Mitani programme, a statewide community health volunteer programme in Koriya district.*

SAMIR GARG

Semi-starvation and chronic hunger are widespread in Chhattisgarh, especially amongst the tribal communities. Huge proportions of tribal children and women face constant malnutrition. According to the second National Family Health Survey (NFHS) (1998-99), 55 per cent of all tribal women in Chhattisgarh are undernourished (Body Mass Index – BMI – below 18.5). The same survey found that 61 per cent of all children (66 per cent of girls, 69 per cent for STs) are underweight, based on standard weight-for-age criteria. Protein-energy malnutrition is the most widespread form of malnutrition, especially amongst children below the age of three years. The child undernutrition levels are particularly high in tribal regions.

In addition to protein-energy malnutrition, iron deficiency anaemia is also very common in Chhattisgarh. The NFHS data show that the prevalence of anaemia among children in the age group of six to 35 months is 88 per cent. It leads to increased risk of mortality as well as poor cognition and motor development. Iodine deficiency is another important form of malnutrition, with 40 per cent of households in the state still not having access to iodised salt. This affects all stages of child development and is the single most significant cause of preventable mental retardation and brain damage. Vitamin A deficiency, which increases the risk of blindness, is also widespread. These deficiencies, combined with protein-energy malnutrition, also increase the morbidity rates amongst children. A very high proportion of children are born with low birth weight. This form of malnutrition is very high in the tribal areas and urban slums,

which have poor access to public healthcare. Poor maternal healthcare, maternal malnutrition, anaemia, heavy work during pregnancy and low age at marriage contribute to the high prevalence of low birth weight. In tribal regions, most of the deliveries take place at home, in remote hamlets. The government even finds it difficult to identify most of the low birth weight babies. This situation is starkly reflected in a recent study of child malnutrition in the tribal-dominated Manendragarh block (tribal population proportion 70 per cent) of Koriya district. Select findings of this study are reported in Table 1.

Similar patterns were found in other tribal-dominated areas of Chhattisgarh. Such severe rates of malnutrition result in extremely high child morbidity and mortality. Severe malnutrition causes high susceptibility to diarrhoea, malaria, TB and related diseases. Chhattisgarh's infant mortality rate of 81 and child mortality rate of 123 are much higher than the all-India average (68 and 85 respectively), and malnutrition is largely responsible for this situation.

## State Nutrition Policy

The government of Chhattisgarh does have a state nutrition policy ('Suposhan Neeti'). This policy is founded on the goals of the National Nutrition Policy and the 10th Plan. The major goals set to be achieved by 2010 are: (1) Bringing down the infant mortality rate from 81 to 35 per thousand live births; (2) Reducing the prevalence of chronic undernutrition amongst children by 50 per cent, i.e., from the present 26 per cent to 13 per cent; (3) Reducing the prevalence of anaemia amongst children by 25 per cent, i.e., from 88 per cent to 66 per cent; (4) Raising immediate breast-feeding of new-born