

Tackling Malnutrition

# Right to Food and Nutrition

## The Basics

Manasi Chandavarkar

Advocacy Primer I



## About the series

India has made significant progress in improving food and nutrition security over the last decade and a half. However, absolute levels of stunted and wasted children remain high. Achieving nutrition security for all, and especially for the underprivileged is still a challenge for the nation. Elimination of hunger, security of food and nutrition is a priority in the list of Sustainable Development Goals.

Building awareness about issues related to nutrition, ranging from basic understanding of nutrition to a complex myriad of public policies is an important ingredient of advocacy for nutrition security. Building awareness acquires more significance in the present times when basic premises of nutrition measurements are being questioned by none other than economists of international repute and leaders responsible for implementation of the SDGs in the country.

This series of Advocacy Primers is our effort for building awareness and basic understanding on issues concerning nutrition security. We hope that this series will help activists and all interested in their work.

Do write to us with your suggestions and feedback.





**Right to Food and Nutrition: The Basics**  
Tackling Malnutrition : Advocacy Primer I

Author: Manasi Chandavarkar  
Author is a consultant with National Centre for Advocacy Studies

**Design:** Ashok Sulochana Ganpat

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[blogs.wsj.com](http://blogs.wsj.com)  
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**Published by**  
**National Centre for Advocacy Studies**  
Serenity Complex, Ramnagar Colony, Pashan, Pune 411021  
Maharashtra, India  
Tel/Fax: + 91 20 22952003/22952004  
Email: [ncas@ncasindia.org](mailto:ncas@ncasindia.org)  
Website: [www.ncasindia.org](http://www.ncasindia.org)

**July 2017**

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**A**s a first in a series of notes that discusses the Right to Nutrition, this note attempts to explain the concept of nutrition vis-a-vis the interlinking of food security, nutrition security and public health; outline the history of nutrition as a human right mentioning important Indian policies, schemes and relevant statistics; discuss the complex nature of malnutrition, measurement practices and the causes of malnutrition using the UNICEF framework; detail important nutrients and micronutrient deficiencies; and suggest what it means to operationalize this right at a micro-level. This note is not an exhaustive introduction to nutrition as a concept or as a human right, but a mere peek into its history and myriad complex aspects that we need to understand and question further, in order to implement this right better.

### **What is Nutrition, nutrition security and food security?**

Nutrition plays a fundamental role in people-centered development. Nutritional well-being is recognized both as a primary objective of development and an essential input into the sustainable development process. The World Health Organisation (WHO) defines nutrition as ‘a process by which living organisms utilize food for maintenance of life, growth and normal function of organs and tissues, and the production of energy.’ Nutrition Security is achieved when secure access to an appropriately nutritious diet is coupled with a sanitary environment, adequate health services and care, to ensure a healthy and active life for all household members. On the other hand, Food Security exists when all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food which meets their dietary needs and food preferences for an active and healthy life. (World Summit on Food Security, Rome, November 2009 cited in FAO Report 2011)

Reflecting an increasing understanding of its multidimensional character, the definition of food security has undergone many changes over the years, moving from a food production-focused definition to one that largely embraces nutrition. The original definition arose in 1974 at the World Food Conference to focus on the “availability at all times of adequate world food supplies of basic foodstuffs to sustain a steady expansion of food consumption and to offset fluctuations in production and prices” (FAO 2013 cited in Ayala and Meier 2017). Expanded over the following years to focus on public health, the 1996 World Food Summit focused on the need for nutrition as a basis of health: “when all people, at all times, have physical and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life” (FAO 2003 cited in Ayala and Meier 2017). Today, the FAO conceptualizes food security as having four dimensions that should be fulfilled simultaneously: the physical availability



of food, the economic and physical access to food, the body's utilization of the nutrients found in food, and the stability of the previous three dimensions over time (FAO 1996 cited in Ayala and Meier 2017). In summary, thus, food security and nutrition security are interlinked and must be dealt with simultaneously to deal with associated public health challenges. It would be appropriate to say Food, Nutrition and Public Health are three corners of a triangle.

### **History of Nutrition as a Human Right** *(Source: Fish 2005)*

The right to food, to maintain a standard of living adequate for health and well-being, which is at the core of nutrition, was included in the first few universal/international declarations post World War II, as follows

- The Constitution of the World Health Organization (1946), commits the organization to the “promote... the improvement of nutrition” (Art. 2) as a means of achieving its fundamental objective: “the attainment by all peoples of the highest possible level of health” (Art. 1);
- The Universal Declaration of Human Rights (1948) claims “everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food ...” (Art. 25(1));
- The International Covenant on Economic, Social and Cultural Rights (1966) declares that “The States Parties to the present covenant recognize the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing, and housing...” (Art. 11);

Gradually, various international declarations started focusing on nutrition requirements of vulnerable target groups, concentrating on health and hunger eradication. For example,

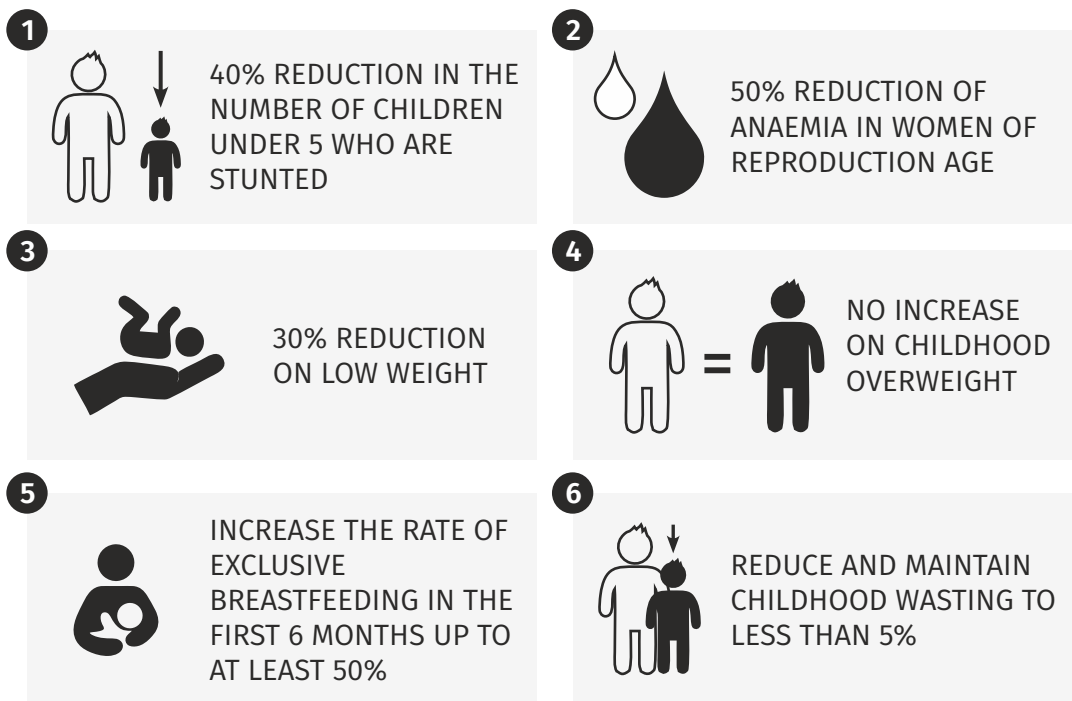
- The 1979 Convention on the Elimination of All Forms of Discrimination Against Women recognizes a woman's right to health to include “adequate nutrition during pregnancy and lactation;”
- The International Code of Marketing of Breast Milk Substitutes (1981) recognizes “the right of every child and every pregnant and lactating woman to be adequately nourished as a means of attaining and maintaining health” (Preamble, para. 1) and emphasizes the provision of “safe and adequate nutrition for infants” (Art. 1);
- The Convention of the Rights of the Child (1989), states that “States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health ...” and shall take appropriate measures “to combat disease and malnutrition” through the provision of adequate nutritious foods, clean drinking-water, and health care; Furthermore, Article 27 (3) of the Convention says that States Parties “shall in case of need provide material

assistance and support programmes, particularly with regard to nutrition, clothing, and housing”.

- The World Declaration on Nutrition (1992) addresses nutrition largely through the lens of hunger eradication, concerning itself with the people who lack access to the foods necessary to meet basic daily nutritional requirements (para. 1) and specifically refers to “access nutritionally adequate safe food” as a “right of each individual.”
- The Rome Declaration on World Food Security (1996) reaffirms “the right of everyone to have access to safe and nutritious food, consistent with the right to adequate food and the fundamental right of everyone to be free from hunger”.

Then, in 2000, it was acknowledged that attaining several of the Millenium Development Goals (MDGs) will be impossible without ensuring nutritional rights and vice-versa. Over the past decade, momentum around nutrition has been steadily building: In 2012 the World Health Assembly adopted the 2025 Global Targets for Maternal, Infant and Young Child Nutrition.

### World Health Assembly Global Nutrition Targets



Source: WHO (2017) <http://www.who.int/nutrition/global-target-2025/en/>

The next year, at the first Nutrition for Growth Summit, donors committed US\$23 billion to improve nutrition. With 2016–2025 being considered as the United Nations Decade of Action on Nutrition, people have increasingly begun to recognize the importance of addressing malnutrition in all its forms. In 2015, the UN Sustainable Development Goals enshrined the objective of “ending all forms of malnutrition,” challenging the world to think and act differently on malnutrition-to focus on all its faces and work to end it, for all people, by 2030 (IFPRI 2016).

India has ratified, been signatory to, and thus adopted all the above declarations, conventions and goals. Translating them to national level action has led to the following important policies/ schemes/ programs/ Acts dealing with food and nutrition security

- Public Distribution System (June 1947)
- Integrated Child Development Scheme (2nd October 1975)
- National Nutrition Policy (1993) and National Plan of Action on Nutrition (1995)
- Mid – day meal scheme (15th August 1995)
- National Rural Health Mission (12th April 2005)
- National Food Security Act (12th September 2013)

However, health and nutrition indicators of vulnerable groups in India tell a very different story. The table below compares data from the National Family Health Survey (NFHS) 3 and 4 with reference to the global nutrition targets.

<i>Indicator</i>	<i>NFHS 4 2015-16 (Rural)</i>	<i>Global Nutrition Target</i>	<i>India's targets with reference to GNT</i>
<i>Children under 5 who are stunted</i>	41.2%	40% reduction	16.48%
<i>Anemia in women of reproductive age</i>	54.2%	50% reduction	27.1%
<i>Low Birth weight</i>	30%*^	30% reduction	9%
<i>Exclusive breastfeeding in the first 6 months</i>	56%	Increase to at least 50%	
<i>Childhood wasting</i>	21.5%	Reduce to less than 5%	4.9%

\*source: As per DHS 1999 <http://apps.who.int/iris/bitstream/10665/43184/1/9280638327.pdf>

^71% children are not weighed at birth

## **What is Malnutrition?**

### **What are the causes of malnutrition?**

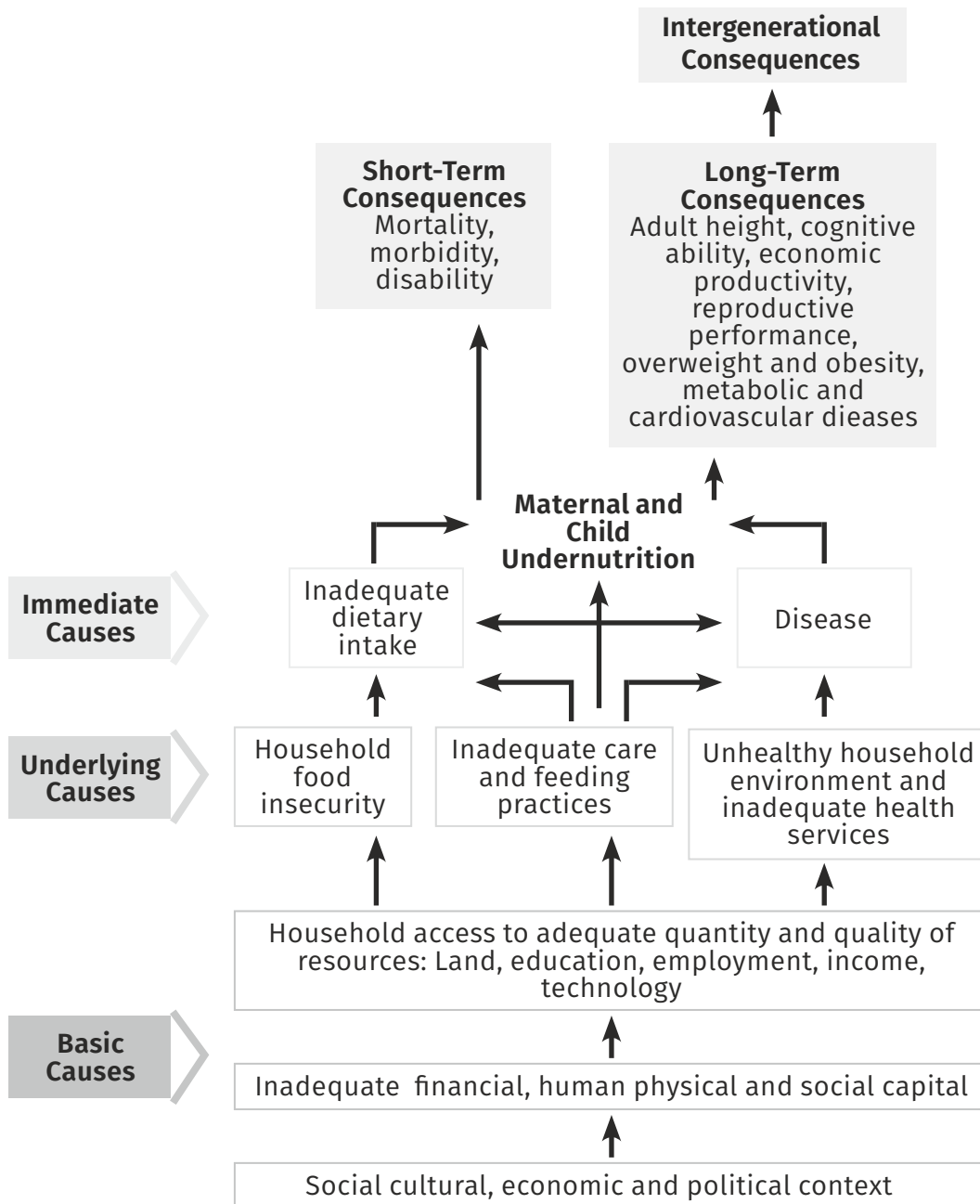
To understand these statistics better, we need to first know what the indicators mean. Malnutrition refers to an abnormal physiological condition caused by inadequate, excessive or imbalanced intake in macronutrients - carbohydrates, protein, fats, and micronutrients – vitamins and minerals. The condition includes all deviations from adequate nutrition including under-nutrition (a deficiency of proteins, carbohydrates and fats and/or vitamins and minerals), over-nutrition (an excess of certain food components such as saturated fats and added sugars in combination with low physical activity), and specific deficiencies (or excesses) of essential nutrients such as vitamins and minerals (FAO 2013). In several developing countries under-nutrition and over-nutrition are occurring simultaneously among different population groups, a phenomenon referred to as the “double burden” of malnutrition. However, this note concerns itself with the problem of under-nutrition since that is at the core of the human rights concern.

Undernutrition is the outcome of insufficient food intake and repeated infections (UNSCN, 2010 cited in FAO 2013). The causes of under-nutrition are multisectoral, embracing food, health and caring practices. A conceptual framework on the causes of malnutrition was developed in 1990 as part of the Unicef nutrition strategy. Therein causes are classified as immediate, underlying, and basic, whereby factors at one level influence other levels.





Figure 1: The UNICEF conceptual framework of undernutrition



Source: UNICEF. *Improving Child Nutrition: The achievable imperative for global progress*. United Nations Children's Fund; 2013. p. 4.

The basic causes are systemic-level challenges to do with the structural and political processes in each society, which includes social, economic, environmental, and political issues that lead to the lack of or unequal distribution of capital. Capital includes financial, human, physical, social, and natural resources. The underlying causes include household food security, adequate care and feeding practices, access to health services, and residing in a healthy environment. The immediate causes are the impact of the basic and underlying causes at the individual level through inadequate food intake and disease. The framework, thus, provides an interface between these broader systemic-level issues and the community, household, and individual levels (UNICEF 1998).

**Which are the important types of under-nutrition?  
How are they measured? What are their clinical symptoms?**

Undernutrition is the outcome of insufficient food intake and repeated infections (UNSCN, 2010 cited in FAO 2013). Protein Energy Malnutrition (PEM), micronutrient deficiencies such as vitamin A deficiency (VAD), Iron Deficiency Anemia (IDA), Iodine Deficiency Disorders (IDD) and vitamin B-complex deficiencies are the nutrition problems frequently encountered, particularly among the rural poor communities (NIN 2011). Undernutrition can affect any segment of the population but the most vulnerable segments are infants, children and adolescents, pregnant and lactating women and the elderly.

Recent evidences indicate that in utero undernutrition may set the pace for diet-related chronic diseases in later life. Undernutrition therefore starts as early as conception. Because of extensive maternal undernutrition (underweight, poor weight gain during pregnancy, nutritional anaemia and vitamin deficiencies), infants are born with low birth-weight (<2500 g). Undernutrition is widely prevalent even during early childhood and adolescence (NIN 2011). Undernutrition is measured using three techniques, for children – underweight, stunting and wasting.

Underweight is measured by comparing the weight-for-age of a child with a reference population of well-nourished and healthy children (FAO 2011). Studies have shown that there is a steep increase in the prevalence of underweight with increase of age, from 6 months to 24 months. In addition to inaccessibility of safe and nutritious food, this is attributable to faulty infant and young child feeding practices prevailing in the community. (NIN 2011)

Stunting reflects shortness-for-age; an indicator of chronic malnutrition and calculated by comparing the height-for-age of a child with a reference population of well-nourished and healthy children. Stunting is caused by long-term inadequate dietary intake and continuing bouts of infection and disease, often beginning with maternal malnutrition, which leads to poor foetal growth, low birth weight and poor growth. Stunting causes permanent impairment to cognitive and physical development that can lower educational attainment and reduce adult income (FAO 2011).

Wasting reflects a recent and severe process that has led to substantial weight loss, usually associated with starvation and/or disease. Wasting is calculated by comparing weight-for height of a child with a reference population of well-nourished and healthy children. (FAO 2011)

As per The Mother and Child Health and Education Trust (2017), Acute malnutrition is a result of recent (short-term) deficiency of protein, energy together with minerals and vitamins leading to loss of body fats and muscle tissues. Acute malnutrition presents with wasting (low weight-for-height) and presence of pitting oedema of both feet. Screening for acute malnutrition includes,

1. Severe wasting i.e. weight for height score is less than -3SD (WHO/ UNICEF 2009)
2. Use and interpretation of Mid-Upper Arm Circumference (MUAC): MUAC is a quick and simple way to determine whether or not a child is malnourished using a simple colored plastic strip. MUAC is suitable to use on children from the age of 12 months up to the age of 59 months. However, it can also be used for children over six months with length above 65 cm. It involves measuring the circumference of the child's left mid-upper arm. If it is found to be less than 115 mm, the child is in high risk of death (WHO/ UNICEF 2009)
3. Checking for nutritional oedema: Oedema is the retention of water in the tissues of the body. Bilateral oedema is a sign of kwashiorkor, a form of severe acute malnutrition.

To diagnose oedema, normal thumb pressure is applied to the tops of the feet for about three seconds. If there is oedema, an impression remains for some time (at least a few seconds) where the oedema fluid has been pressed out of the tissue. These children are at high risk of mortality and need to be treated in a therapeutic feeding program urgently.

Persistent undernutrition throughout the growing phase of childhood leads to short stature in adults. Undernutrition in adults is measured by the body mass index (BMI) which is a value derived from the mass (weight) and height of an individual. The BMI is defined as the body mass divided by the square of the body height. Individuals with a BMI of 18.5 or less are considered to be underweight indicating Chronic Energy Deficiency (CED). (NIN 2011)

To help understand under-nutrition, particularly nutritional deficiencies, mentioned below are the various types of nutrients, their sources, functions and clinical signs of deficiencies.

### **What are the various types of nutrients? What are their sources and functions? What are the clinical signs of micronutrient deficiencies?**

According to the dietary guidelines of NIN (2011), nutrients can be classified into two main types – macronutrients i.e. Carbohydrates, fats and proteins, which are needed in large amounts and micronutrients i.e. Vitamins and minerals which are required in small amounts. On the other hand, there are four basic food groups – cereals, millets and pulses; vegetables and fruits; oils, fats and nuts; milk and animal foods. Technically, a balanced diet should include proportionate foods from all four groups such that carbohydrates provide around 50-60% of total calories, preferably complex carbohydrates, about 10-15% of the total calories are obtained from proteins and 20-30% from both visible and invisible fat. In addition, it should provide other non-nutrients such as dietary fibre, antioxidants and phytochemicals.

Carbohydrates are either simple or complex, and are major sources of energy in all human diets. They provide energy of 4 Kcal/g. The simple carbohydrates, glucose and fructose, are found in fruits, vegetables and honey, sucrose in sugar and lactose in milk, while the complex carbohydrates are starches in cereals, millets, pulses and root vegetables and glycogen in animal foods. The other complex carbohydrates which are resistant to digestion in the human digestive tract are cellulose in vegetables and whole grains, and gums and pectins in vegetables, fruits and cereals, which constitute the dietary fibre component. In India, 70-80% of total dietary calories are derived from carbohydrates present in plant foods such as cereals, millets and pulses. (NIN 2011)

Proteins are basic structural and functional components of every living cell. Almost fifty percent of the protein in our body is in the form of muscle and the rest is in bone, cartilage and skin. Proteins perform a wide range of functions and also provide energy (4 Kcal/g). Protein requirements vary with age, physiological status

and stress. More proteins are required by growing infants and children, pregnant women and individuals during infections and illness or stress. Animal foods like milk, meat, fish and eggs and plant foods such as pulses and legumes are rich sources of proteins. (NIN 2011)

Fats are a concentrated source of energy providing 9 Kcal/g, and are made up of fatty acids in different proportions. Dietary fats are derived from two sources viz. the invisible fat present in plant and animal foods; and the visible or added fats and oils (cooking oil, butter, ghee). Fats serve as a vehicle for fat-soluble vitamins like vitamins A, D, E and K and carotenes and promote their absorption. They are also sources of essential polyunsaturated fatty acids. Diets should include adequate amounts of fat particularly in the case of infants and children, to provide concentrated energy since their energy needs per kg body weight are nearly twice those of adults. (NIN 2011)

Vitamins are chemical compounds required by the body in small amounts. They must be included in the diet as they cannot be synthesized in the body. Vitamins are essential for several body processes and for maintenance of the structure of skin, bone, nerves, eye, brain, blood and mucous membrane. They are either water-soluble or fat-soluble. Vitamins A, D, E and K are fat-soluble, while vitamin C, and the B-complex vitamins such as thiamin, riboflavin, niacin, pyridoxine, folic acid and cyanocobalamin are water-soluble. Fat-soluble vitamins can be stored in the body while water-soluble vitamins are not and get easily excreted in urine (NIN 2011) and therefore need to be consumed accordingly.

Minerals are inorganic elements found in body fluids and tissues. Important minerals such as sodium, potassium, calcium, phosphorus, magnesium and sulphur, zinc, copper, selenium, molybdenum, fluorine, cobalt, chromium and iodine are required for maintenance and integrity of skin, hair, nails, blood and soft tissues. They also govern nerve cell transmission, acid/base and fluid balance, enzyme and hormone activity as well as the blood-clotting processes. (NIN 2011) Iodine deficiency could lead to goiter or cretinism.

Iron is an essential element necessary for the formation of haemoglobin, the red pigment present in red blood cells. Haemoglobin plays an important role in the transport of oxygen to the tissues. Reduction of haemoglobin in blood leads to anaemia, a condition characterised by paleness and easy fatigue and increased susceptibility to infections. Iron is available in plenty in green leafy vegetables. But the absorption of iron is limited. Vitamin C rich foods must be consumed daily to improve iron absorption (NIN 2011). Clinical symptoms of Iron deficiency anemia include pale conjunctivae (inner eyelid), nailbeds, gums, tongue, lips and



skin, tiredness, headaches, breathlessness (The Mother and Child Health and Education Trust 2017).

Vitamin A is necessary for clear vision in dim light, and for maintaining the integrity of epithelial tissues. Vitamin A also has a role in maintaining resistance of the body to common infections. Sources include fruits and vegetables that are green or deep yellow/orange in colour, such as green leafy vegetables, carrots, tomatoes, sweet potatoes, papaya, mango etc. (NIN 2011). The Mother and Child Health and Education Trust (2017) lists the clinical symptoms of Vitamin A deficiency as follows: night blindness; eye dryness accompanied by foamy accumulations on the conjunctiva (inner eyelids), that often appear near the outer edge of the iris (Bitot's spots); eye dryness, dullness or clouding (milky appearance) of the cornea (corneal xerosis); eye softening and ulceration of the cornea (keratomalacia). This is sometimes followed by perforation of the cornea, which leads to the loss of eye contents and permanent blindness.

Vitamin C is an essential nutrient required for bone and teeth health. It also promotes iron absorption. Vitamin C deficiency is characterised by weakness, bleeding gums and defective bone growth. Vitamin C is abundantly available in fresh amla, citrus fruits, guava, banana and certain vegetables such as tomatoes. (NIN 2011)

Folic acid is a vitamin essential for multiplication and maturation of red cells in our body. Folic acid intake during pregnancy protects the foetus from developing certain congenital defects. It also promotes the birth weight of infants. Folic acid deficiency increases homocysteine levels in blood, thereby increasing the risk for heart disease. Green leafy vegetables, legumes, nuts and liver are good sources of folates. (NIN 2011)

Since the entire population requires a balanced diet, and the quantities and kinds of foods needed to meet the nutrient requirements vary with age, gender, physiological status and physical activity, nutrition education and awareness needs to play a substantial role in efforts focused on reducing under-nutrition by empowering the community.

## Conclusion

### What does it mean to operationalize the right to Nutrition?

As seen earlier, tackling under-nutrition and associated health concerns has always been and remains at the core of ensuring human rights. Given the technicality of the concept of under-nutrition and the complexity of factors affecting it, operationalizing the right to nutrition at a micro-level is a challenging task that requires persistent multi-sectoral and multipronged efforts. On the ground, ensuring nutrition security as a right, would translate not only into ensuring appropriate planning and implementation of food security and nutrition related food provisions, but also sustained implementation of nutrition and health education, gender equality, child rights and health care services. Using a human rights approach to build community capacity to advocate for themselves, is an empowering and sustainable method to do so. To begin with, it would require appropriate problem definition along with the community and defining indicators of change (process and outcome) in order to design an appropriate action plan.



## References

- Ayala, A., & Meier, B. M. (2017). A human rights approach to the health implications of food and nutrition insecurity. *Public Health Reviews*, 38(1), 10. Available: <https://publichealthreviews.biomedcentral.com/articles/10.1186/s40985-017-0056-5> [Accessed: 17 July 2017]
- DWCD Government of India (1993) National Nutrition Policy. Available: [http://wcd.nic.in/sites/default/files/nnp\\_0.pdf](http://wcd.nic.in/sites/default/files/nnp_0.pdf) [Accessed: 26 July 2017]
- DWCD Government of India (1995) National Plan of Action on Nutrition. Available: <http://wcd.nic.in/fnb/fnb/Publications/FNB%20Booklets/national%20Plan%20of%20Action.pdf> [Accessed: 26 July 2017]
- FAO. The State of Food and Agriculture 2013. Available: <http://www.fao.org/docrep/018/i3300e/i3300e02.pdf> [Accessed: 21 July 2017]
- FAO Report. EVALUATION OF FAO'S ROLE AND WORK IN NUTRITION. Rome, 2011. Available: <http://www.fao.org/3/a-bd644e.pdf> [Accessed: 21 July 2017]
- Fish, M. (2005). Nutrition, health and human rights. *Review Digest: Human Rights & Health*, 105-111. Available: <http://www.du.edu/korbel/hrhw/researchdigest/health/nutrition.pdf> [Accessed: 18 July 2017]
- International Food Policy Research Institute (2016) Global Nutrition Report 2016: From Promise to Impact: Ending Malnutrition by 2030. Washington, DC. Available: <https://data.unicef.org/wp-content/uploads/2016/06/130565-1.pdf> [Accessed: 21 July 2017]
- International Institute of Population Sciences (2016). National Family Health Survey (NFHS) – 4, 2015 – 16. Available: <http://rchiips.org/nfhs/pdf/NFHS4/India.pdf> [Accessed: 25 July 2017]
- Kent, G. (2000). The human rights approach to reducing malnutrition. Available: <http://www.eolss.net/sample-chapters/c11/E1-13-05-05.pdf> [Accessed: 18 July 2017]
- National Institute of Nutrition (2011) Dietary guidelines for Indians - A Manual (Second edition). Hyderabad, India. Available: <http://ninindia.org/dietaryguidelinesforinwebsite.pdf> [Accessed: 28 July 2017]
- The Mother and Child Health and Education Trust (2017) Available: <http://motherchildnutrition.org/malnutrition/index.html> [Accessed: 27 July 2017]
- UNICEF. The State of the World's Children, 1998. Available: <https://www.unicef.org/sowc98/fig5.htm> [Accessed: 21 July 2017]
- UNICEF (2010). Nutrition in emergencies, Section 2: Basic concepts in nutrition in emergencies, Lesson 2.5 Causes and most vulnerable to undernutrition. Available: <https://www.unicef.org/nutrition/training/2.5/1.html> [Accessed: 19 July 2017]
- WHO (2017). Global Targets 2025 - To improve maternal, infant and young child nutrition. Available: <http://www.who.int/nutrition/global-target-2025/en/> [Accessed: 24 July 2017]
- WHO/UNICEF Joint statement. WHO child growth standards and the identification of severe acute malnutrition in infants and children. Geneva, New York, 2009. Available: [http://apps.who.int/iris/bitstream/10665/44129/1/9789241598163\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/44129/1/9789241598163_eng.pdf?ua=1) [Accessed: 27 July 2017]



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## **NATIONAL CENTRE FOR ADVOCACY STUDIES**

Serenity Complex, Ramnagar Colony, Pashan, Pune - 411 021, INDIA.

Tel/Fax: +91 20 22952003 / 22952004

e-mail: [ncas@ncasindia.org](mailto:ncas@ncasindia.org)

web: [www.ncasindia.org](http://www.ncasindia.org)