In the light of the fact that elimination of hunger, security of food and nutrition is a priority in the Sustainable Development Goals, on 5th September 2017 the NITI Aayog called for a renewed focus on Nutrition as it launched the National Nutrition Strategy. Time and again, India has articulated and attempted to act upon its concern about tackling nutrition insecurity, yet, the pace of decline of overall levels of undernutrition in both women and children (as seen in NFHS-4) is far below what several countries with comparable growth trajectories to India have achieved. Absolute levels of stunted and wasted children in India remains high, especially among disadvantaged populations.

Nutrition insecurity is as much a household challenge as it is, a community, local, regional and national challenge. It is not the only failure in ensuring the right to food but also the failure to ensure access to health services, clean and safe drinking water, sanitation, income & livelihoods, gender equality and child rights. Since nutrition is hinged on multi-sectoral and multi-level variables, and given that ensuring nutrition security is a complex, often technical endeavour, achieving nutrition security for all, and especially for the underprivileged is indeed a challenge for the nation. However, we can never ever resign to accept that food and nutrition security is defined circumstantially. Addressing concerns of nutrition is a collective responsibility, in fact, currently, more a responsibility of those in privilege, with voice.

The nature of nutrition insecurity calls for cooperative efforts that are multi-sectoral and multi-level. The importance of the convergence of services provided by various departments and ministries has always been iterated in policies and strategy papers, yet again in the NITI Aayog National Nutrition Strategy. Nonetheless, it can never be overstated. This understanding seems to largely reflect in intervention design but not as much in implementation.

Building awareness about issues related to nutrition, ranging from understanding nutrients to public policies and interventions to ensure nutrition security, is an important ingredient of advocacy for nutrition security. Building awareness acquires more significance in the present times when i) the National Nutrition Strategy (2017) has given prominence to demand and community mobilisation as a determining factor to address India's nutrition concerns; ii) 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 advocacy primer is our effort to demystify nutrition security and build awareness about it. It has three chapters – the first details the basics of nutrition security vis-a-vis the interlinking of food security, nutrition security and public health; the history of nutrition as a human right mentioning important Indian policies, schemes and relevant statistics; the complex nature of malnutrition, measurement practices and the UNICEF framework of causes of malnutrition; important nutrients and micronutrient deficiencies. The second chapter introduces important direct and nutrition-sensitive interventions being implemented in India; and the third chapter discusses three very diverse effective interventions implemented in India to ensure the right to food and nutrition, such that one can learn from project design and implementation features.

We hope that this primer will help activists, community-based organisations and all direct and indirect advocates of nutrition security.

Do write to us with your suggestions and feedback.
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Right to Food and Nutrition
Tackling Malnutrition : Advocacy Primer

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THE BASICS
This section of the Advocacy Primer that discusses the Right to Food and Nutrition attempts to explain, 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 security 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 enquire further, in order to implement this right better.

What is nutrition, nutrition security and food security?

Nutrition plays a fundamental role in people-centred 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 “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 on 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.

<table>
<thead>
<tr>
<th>World Health Assembly Global Nutrition Targets</th>
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<tr>
<td><strong>1</strong></td>
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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 a 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 Services Scheme (2nd October 1975)
- Midday meal scheme (15th August 1995)
- National Rural Health Mission (12th April 2005)
- Indira Gandhi Matritva Sahyog Yojana (2010)
- Rajiv Gandhi Scheme for Empowerment of Adolescent Girls - SABLA (2011)
- 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) 4 with reference to the global nutrition targets.
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.

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

*source: As per DHS 1999 http://apps.who.int/iris/bitstream/10665/43184/1/9280638327.pdf
^71% children are not weighed at birth
Figure 1: The UNICEF conceptual framework of undernutrition

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?**

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.

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 an 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 a recent (short-term) deficiency of protein, energy together with minerals and vitamins leading to loss of body fat 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 coloured 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 at high risk of death (WHO/ UNICEF 2009)
3. Checking for nutritional oedema: Oedema is the retention of water in the tissues of the body. 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 with 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 goitre 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 the 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 anaemia 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 the 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. All the more reason for us to persistently attempt 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


INTERVENTIONS IN INDIA

Tackling Malnutrition
Right to Food and Nutrition
Advocacy Primer
To address under-nutrition in India, nutrition-specific or direct nutrition interventions are delivered through Centrally Sponsored Schemes (CSS) of the Ministries of Health and Family Welfare i.e. the National Health Mission (NHM), and Women and Child Development (MWCD) i.e. Integrated Child Development Services (ICDS) Scheme, SABLA (Rajiv Gandhi Scheme for Empowerment of Adolescent Girls) and Indira Gandhi Matritva Sahyog Yojana (IGMSY). On the other hand, nutrition-sensitive interventions are delivered through various schemes (18 CSS) via nine Ministries/Departments. (List in Annexure) (Srivastava et al, 2017)

Given this context, this primer introduces some of the important direct and nutrition-sensitive interventions created to ensure the rights to food and nutrition. A clear understanding of these is warranted to be able to plan and implement a rights-based approach to tackling malnutrition at a micro-level. This primer attempts to introduce the objectives, provisions, institutional structures, monitoring and grievance redressal mechanisms of these interventions to be able to envisage micro-level features to garner community action. Some of these features vary across States (including the names of certain schemes/ provisions) since State governments play a substantial role financially, own the implementation process and some States additionally implement State-funded schemes. This primer details the design of the interventions as introduced centrally, with special reference to the State of Maharashtra at times. It is crucial to bear in mind that this primer discusses ‘what should be, as per the mandate’ not ‘what is’. Further, considering that the information herein is only an introduction, links have been provided in the document and in the end to the schemes/ acts and/or relevant detailed information, where possible.

National Food Security Act, 2013 (NFSA)

The Government of India notified the National Food Security Act, 2013 on 10th September 2013 with the objective to provide for food and nutritional security in human life cycle approach, by ensuring access to adequate quantity of quality food at affordable prices to people to live a life with dignity (DFPD, 2016). This marked a shift from a welfare approach to rights based approach to address the problem of food and nutrition security. The NFSA converts existing food security programmes of the Government of India into legal entitlements. It includes the Midday Meal Scheme, Services in the ICDS scheme and the Public Distribution System as well as maternity entitlements under the IGMSY (DFPD, 2015). The Midday Meal Scheme, ICDS, IGMSY are universal in nature whereas the PDS is targeted. Each of these has been clarified in the following sections. Chapter 5 of the Act states that for the purpose of monitoring and review of the
implementation of the Act every State Government shall, by notification, establish a grievance redressal mechanism. In Maharashtra District, Grievance Redressal Officers have been appointed in every district and the State Food Commission has also been set up (FCSCPD, 2017) Details are available on...

Public Distribution System (PDS)

Evolution of public distribution of grains in India had its origin in the ‘rationing’ system introduced by the British during the World War II. Later, after Independence, PDS was continued as a deliberate social policy of the government with the objectives of:

i) Providing food grains and other essential items to vulnerable sections of the society at reasonable (subsidised) prices;

ii) to have a moderating influence on the open market prices of cereals, the distribution of which constitutes a fairly big share of the total marketable surplus; and

iii) to attempt socialisation in the matter of distribution of essential commodities. (Nawani, 1994)

As per DFPD (2017), in June 1997, the PDS changed from a universal scheme to a targeted one that concentrated on the poor. Under the Targeted PDS (TPDS), States were required to formulate and implement foolproof arrangements for the identification of population Below Poverty Line (BPL) for delivery of food grains and for its distribution in a transparent and accountable manner at the Fair Price Shop (FPS) level. State Governments were advised to identify BPL families by involving Gram Panchayats, Gram Sabhas and Nagar Palikas. While doing so the thrust was to include the really poor and vulnerable sections of the society. Thereafter the Antyodaya Anna Yojana (AAY) launched in December 2000 was a step in the direction of making TPDS aim at reducing hunger among the poorest segments of the BPL population, by providing food grains at a highly subsidized rate of Rs.2/- per kg. wheat and Rs.3/- per kg rice. The AAY Scheme has since expanded to cover 2.50 crore households as follows:

a) Landless agriculture labourers, marginal farmers, rural artisans /craftsmen, such as potters, tanners, weavers, blacksmiths, carpenters, slum dwellers and persons earning their livelihood on daily basis in the informal sector like porters, coolies, rickshaw pullers, handcart pullers, fruit and flower sellers, snake charmers, rag pickers, cobblers, destitute and other similar categories in both rural and urban areas.
b) Households headed by widows or terminally ill persons/disabled persons/ persons aged 60 years or more with no assured means of subsistence or societal support.
c) Widows or terminally ill persons or disabled persons or persons aged 60 years or more or single women or single men with no family or societal support or assured means of subsistence.
d) All primitive tribal households.

Under the NFSA priority, households are entitled to receive food grains @ 5 kg per person per month at the issue prices of Rs. 3.00, Rs.2.00 and Rs. 1.00 kg for rice, wheat and coarse grains respectively. The AAY households are to receive 35 kg of foodgrains per household per month at the same subsidized price (DFPD, 2017).

PDS is operated under the joint responsibility of the Central and the State Governments. The Central Government, through Food Corporation of India (FCI), assumes the responsibility for procurement, storage, transportation and bulk allocation of food grains to the State Governments. The operational responsibility including allocation within State, identification of eligible families, issue of Ration Cards and supervision of the functioning of FPSs etc., rest with the State Governments (DFPD, 2017). The PDS operates through FPSs at the village level.

The Maharashtra State Government with an aim to monitor the distribution of the essential commodities through the PDS and thereby to ensure the participation of the Public in the monitoring of PDS, has constituted vigilance committees at various levels viz. village, taluka, municipal council, municipal corporation and district level. The State level Advisory Committee has also been constituted under the chairmanship of Minister for Food, Civil Supplies and Consumer Protection.

• The Sarpanch of the village is the President of the Village Level Vigilance Committee which consists of total 13 members including official and non-official members.
• The Member of the Legislative Assembly representing the maximum area of the Taluka is the President of the Taluka Level Vigilance Committee. It consists of 17 members including official and non-official members.
• The Member of the Legislative Assembly representing the maximum wards of the Municipal Council area is the President of the Municipal Council Level Vigilance Committee which consists of 15 members including the official and non-official members.
• The Guardian Minister of the district is the President of the District Level Vigilance Committee. It consists of 21 members including official and non-official members.
• The Member of the Legislative Assembly representing the Rationing Area of the Municipal Corporation is the President of the Municipal Corporation Level Vigilance Committee which consists of 21 members including official and non-official members.

• Out of the total non-official members in each of the above-mentioned Vigilance Committees, 50% are to be women.

• The concerned District Collector needs to initiate disciplinary action under Maharashtra Civil Services (Conduct) Rules, 1979 against those Secretaries of the Vigilance Committees who fail to conduct regular meetings of the Committees. The concerned Additional Collector and Controller of Rationing, Mumbai need to personally monitor that the meetings of the Vigilance Committees are conducted regularly and they need to ensure that the report regarding this is submitted to the Secretary of the Department by the 15th day of every month.

• Meetings of the Taluka and District level vigilance committees need to be held on every Lokshahi Din and wide publicity needs to be given to these meetings. Complaints received from the public regarding supply department are to be discussed and resolved in these meetings. (FCSCPD, 2017)
Integrated Child Development Services Scheme

The ICDS scheme was launched in India on 2nd October 1975 in pursuance of the National Policy for Children. It is a multi-sectoral program and involves the convergence of several government departments. The primary responsibility for the implementation of the program lies with the DWCD at the Centre and nodal department at the states, which may be Social Welfare, Rural Development, Tribal Welfare or Health Department or an independent Department. The program provides an integrated approach for converging all the basic services for improved childcare, early stimulation and learning, health and nutrition, water and environmental sanitation aimed at the young children, expectant and lactating mothers, other women in the 15-44 age group and adolescent girls in a community. (Kapil, 2002)

The ICDS team comprises an Anganwadi Workers (AWW) and Anganwadi Helpers (AWH) at each Anganwadi Centre (AWC), Supervisors, Child Development Project Officers (CDPOs) at each Block and District Programme Officers (DPOs) in each district who report to the State Directorate. Besides, Medical Officers (MO), Auxiliary Nurse Midwife (ANM) and Accredited Social Health Activist (ASHA) who are a part of the NHM form a team with the ICDS functionaries to achieve convergence of different services. (MWCD, 2009)

The objectives of ICDS are

• 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 dropout;
• to achieve effective coordination of policy and implementation amongst the various departments to promote child development; and
• 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 (MWCD, 2009)

To help achieve these objective ICDS offers six services, viz.

1) Supplementary Nutrition
Provision of supplementary nutrition under the ICDS Scheme is to bridge the gap between the Recommended Dietary Allowance (RDA) and the Average Daily Intake
(ADI) of children and pregnant and lactating women. This service is an entitlement under the NFSA. Snacks and hot cooked supplementary food are provided to 3-6-year-old children in the Anganwadi 25 days a month. Take Home Rations (THR) with prescribed nutritional norms are provided to pregnant women, lactating mothers, and 6-36-month-old children. For severely underweight children a food supplement of 800 calories of energy and 20-25 gms of Protein per child per day in the form of Micronutrient fortified and/or energy dense food as THR is to be provided (MWCD, 2009).

In Maharashtra, the Governor amended NFSA in November 2016 in its application to the Scheduled Areas of the state. In a notification issued by the Governor, the word ‘Take Home Ration’ used in the National Food Security Act (Schedule II) has been replaced by the words ‘Hot Cooked Meal’. The notification adds a provision that eggs shall be provided to children aged above 7 months and up to 6 years, as an additional item in Anganwadis in the Scheduled Areas of Maharashtra, at least four times a week. It further mandates that suitable alternatives may be provided to children who may not prefer eggs (Anonymous, 2016). The government had accordingly initiated the APJ Abdul Kalam Amrut Ahar Yojana.

2) Pre-school non-formal education (PSE)

PSE, as envisaged in the ICDS, focuses on holistic development of children up to six years to ensure a significant input towards a sound foundation for cumulative lifelong learning. For around three and half hours in the morning, six days a week, the Anganwadi is to provide a learning environment for the promotion of social, emotional, cognitive, motor, physical and aesthetic development of the child. It is to also contribute to the universalization of primary education, by providing the child necessary preparation for schooling and offering substitute care to younger siblings, thus, freeing the older ones—especially girls to attend school. (MWCD, 2009)

3) Nutrition & health education

This includes growth monitoring and promotion of young children’s (0-6 years) health and development using WHO growth charts and family retained mother & child protection card; Identification of growth faltering and appropriate counselling of caregivers especially on optimal Infant and Young Child Feeding (IYCF) and health care; lactation support for new mothers; Maternal care counselling for household members of pregnant and lactating women; parent and community education on integrated child development, health and nutrition services. Village Health and Nutrition Days and SNEHA SHIVIRS are to be an important platform for nutrition, health and hygiene education. Hands-on training on caring practices are to be given at Sneha Shivirs to mothers and
Caregivers of underweight children at AWCs for 12 days, followed by 18 days of home practice. This is to help the child to gain weight and within 6-8 sessions, the child should be on the path of rehabilitation. Those severe underweight children requiring medical attention are to be referred to NRCs in consultation with ANM and/or MO. Close monitoring and follow-up of these children after discharge is to be facilitated by AWWs. Also, monthly sessions, small group meetings of mothers/Mahila Mandal, community and home visits, village contact drives, local festivals, a celebration of special events and days like Nutrition Week, ICDS day, Breastfeeding week etc. are to be organized to sensitize the community. (MWCD, 2009)

4) Immunization
Immunization of pregnant women with tetanus and infants against six vaccine-preventable diseases poliomyelitis, diphtheria, pertussis, tetanus, tuberculosis and measles is facilitated by functionaries of ICDS scheme (U Kapil, 2002). Primary Health Centres (PHCs) or Sub-Health Centres (SHCs) are responsible for carrying out immunization as per the national immunization schedule. Children are also to be given Vitamin A and booster doses. The AWW and ASHA assist the health functionaries incomplete coverage of the target population for immunization as well as in organizing the fixed day immunization sessions- popularly known as “Village Health Nutrition Days (VHND)” at the AWC. (MWCD, 2009)

5) Health check-up
This includes health care of children under six years of age, antenatal care for pregnant mothers and postnatal care for lactating mothers. The various health services provided for children by ANM and PHC staff (MO) include regular health check-ups, recording of weight, immunization, support to community-based management of malnutrition, treatment of diarrhoea, deworming and distribution of iron and folic acid and medicines for minor illnesses. A medicine kit is to be provided at every AWC every year containing basic medicines for controlling common ailments like fever, cold, cough, worm infestation, etc. including medicines and basic equipment for first aid. NHM is to provide doctors for health check-up at AWC level preferably on monthly basis but at least once in a quarter. (MWCD, 2009)

6) Referral services
During health check-ups and growth monitoring sessions, sick and malnourished children as well as pregnant and lactating mothers in need of prompt medical attention would be referred to health facilities. The AWW would facilitate the referrals and also detect disabilities in young children and refer to health facilities. ANM and/or MO would be primarily responsible for referrals. (MWCD, 2009)
The last three services are related to health and are provided by Ministry /Department of Health and Family Welfare through NHM & Health System. For better governance in the delivery of the Scheme, convergence is one of the key features. This convergence is inbuilt in the Scheme in the form of AWCs which provides a platform for providing all services under the Scheme. (MWCD, 2009)

MWCD has the overall responsibility of monitoring the ICDS Scheme. At the village level, the Village Health, Sanitation and Nutrition Committee (VHSNC); at the block level, the Panchayat Samiti / Standing Committee; at the district level, the Zila Parishad lead by the CEO / District Magistrate / Collector (decided by States); at the State level, the concerned Executive Committee under the State Nutrition Council and at the National level the Empowered Committee headed by the Secretary, MWCD is responsible for the registration and redressal of all complaints/grievances concerning ICDS. (MWCD, 2009)

**Indira Gandhi Matritva Sahyog Yojana** *(Source: NITI Aayog, 2017)*

This conditional cash transfer maternity benefit scheme is aimed at improving the health and nutrition status of Pregnant and Lactating women and their young infants by:

i. Promoting appropriate practices, care and service utilization during pregnancy, safe delivery and lactation.

ii. Encouraging women to follow (optimal) IYCF practices including early and exclusive breastfeeding for the first six months.

iii. Contributing to better enabling environment by providing cash incentives for improved health and nutrition to pregnant and lactating women.

This scheme which is an undertaking of the MWCD and managed through the ICDS mechanism aims to provide partial compensation (Rs.6000) for wage loss so that the woman is not under compulsion to work till the last stage of pregnancy and can take adequate rest before and after delivery. This compensation is to be provided in 2 instalments (Rs. 3000 each) to the pregnant and lactating woman upon fulfilment of certain conditions.

i. Pregnant women above the age of 19 years are eligible for benefits under IGMSY for the first two live births.

ii. All organized sector employees are excluded from the scheme as they are entitled to paid maternity leave.

iii. The first transfer (at the end of second birth/pregnancy trimester) of Rs. 3,000 requires the mother to:
a. Register her pregnancy at the AWC within four months of conception;
b. Attend at least one prenatal care session, and take iron-folic acid tablets and
tetanus toxoid injection, and
c. Attend at least one counselling session at AWC or health care centre.

iv. The second transfer (three months after delivery) of Rs.3,000 requires the
mother to:
a. Register the birth;
b. Immunize the child with oral polio vaccine (OPV) and Bacillus Calmette–
Guérin (BCG) vaccine at birth, at six weeks, and at 10 weeks of age; and
c. Attend at least two growth monitoring sessions within three months of
delivery.

v. Additionally, the scheme requires the mother to:
a. Exclusively breastfeed for six months and thereafter introduce
complementary feeding;
b. Immunize the child with OPV and diphtheria, pertussis, and tetanus (DPT)
vaccine; and
c. Attend at least two counselling sessions on growth monitoring and infant
and child nutrition and feeding between the third and the sixth month after
delivery.

Each instalment is to be transferred through bank accounts in the name of the
beneficiary. Mother and child protection card certified by AWW serves as the
means of verification.
SABLA (Source: MWCD, 2010)

This scheme is to be implemented using the platform of ICDS Scheme through Anganwadi Centres. The Scheme covers adolescent girls in the age group of 11-18 years under all ICDS projects in selected 200 districts in all the States/UTs in the country. In order to give appropriate attention, the target group is subdivided into two categories, viz. 11-15 & 15-18 years and interventions planned accordingly.

The objectives of the Scheme are to

i. Enable the Adolescent Girls (AGs) for self-development and empowerment
ii. Improve their nutrition and health status.
iii. Promote awareness about health, hygiene, nutrition, Adolescent Reproductive and Sexual Health (ARSH) and family and child care.
iv. Upgrade their home-based skills, life skills and tie up with National Skill Development Program (NSDP) for vocational skills
v. Mainstream out of school AGs into formal/non-formal education
vi. Provide information/guidance about existing public services such as PHC, CHC, Post Office, Bank, Police Station, etc.

An integrated package of services is to be provided to AGs that would be as follows
i. Nutrition provision
ii. Iron and Folic Acid (IFA) supplementation
iii. Health check-up and Referral services
iv. Nutrition & Health Education (NHE)
v. Counseling/Guidance on family welfare, ARSH, child care practices and home management
vi. Life Skill Education and accessing public services
vii. Vocational training for girls aged 16 and above under National Skill Development Program (NSDP)

Details about each service are available at http://wcd.nic.in/sites/default/files/1-SABLAscheme_0.pdf

Emphasis is on the convergence of services under various schemes/programmes of Health, Education, Youth Affairs & Sports, Labour, PRI etc. so as to achieve the desired impact. Coordination of efforts of different line Ministries/Departments at all levels is an essential component for the success of the Scheme. In particular, IFA supplementation, including the supply of IFA tablets; Health check-up and referral services; Nutrition & Health Education; Family welfare, ARSH will be provided by establishing convergence with Ministry of Health and Family Welfare.
and Department of National Aids Control Organisation. For entry/re-entry into formal schools and motivation to do the same, coordination with Department of School Education and Literacy under the Right to Free and Compulsory Education Act and Saaksharta Abhiyan is to be established. Life skill education and other interventions require convergence with National Programme for Youth & Adolescent Development, existing youth clubs of Ministry of Youth Affairs & Sports. Ministry of Labour provides Vocational Training under NSDP for which an optimum convergence may be established. PRI is to be involved in community monitoring and Information, Education and Communication activities.

The monitoring and supervision mechanism set up under the ICDS Scheme at the National level, the State level and the Community level are to be used for this Scheme as well. (MWCD, 2010)

**Mid-day meal scheme**

As per MHRD, with a view to enhancing enrollment, retention and attendance and simultaneously improving nutritional levels among children, the National Programme of Nutritional Support to Primary Education (NP-NSPE) was launched as a Centrally Sponsored Scheme on 15th August 1995, initially in 2408 blocks in the country. By the year 1997-98, the NP-NSPE was introduced in all blocks of the country. It was further extended in 2002 to cover not only children in classes I to V of government, government aided and local body schools, but also children studying in Education Guarantee Scheme (EGS) and Alternative Innovative Education (AIE) centres. In September 2004 the scheme was revised to provide cooked mid-day meal with 300 calories and 8-12 grams of protein to all children studying in classes I to V in Government and aided schools and EGS/ AIE centres. In October 2007, the scheme was further revised to cover children in upper primary (classes VI to VIII) initially in 3479 Educationally Backwards Blocks (EBBs). The programme was extended to all areas across the country from 2008-09.

The objectives of the mid-day meal (MDM) scheme are:

i) Improving the nutritional status of children in classes I – VIII in Government, Local Body and Government aided schools, and EGS and AIE centres.

ii) Encouraging poor children, belonging to disadvantaged sections, to attend school more regularly and help them concentrate on classroom activities.

iii) Providing nutritional support to children of primary stage in drought-affected areas during summer vacation. (MHRD, 2011)
<table>
<thead>
<tr>
<th>Components</th>
<th>Primary</th>
<th>Upper Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calories</td>
<td>450</td>
<td>700</td>
</tr>
<tr>
<td>Protein</td>
<td>12 gms</td>
<td>20 gms</td>
</tr>
<tr>
<td>Micronutrients</td>
<td>Adequate quantities of micro-nutrients like Iron, Folic Acid and Vitamin-A.</td>
<td></td>
</tr>
</tbody>
</table>

Source: MHRD, 2011

The Department of School Education and Literacy has prescribed a mechanism for monitoring and supervision of the Mid-Day Meal Scheme which includes arrangements for local level monitoring. Representatives of Gram Panchayats/Gram Sabhas, members of Village Education Committees, Parent Teacher Associations, School Development and Monitoring Committees as well as Mothers’ Committees are required to monitor the following on a daily basis:

i. regularity and wholesomeness of the mid-day meal served to children,
ii. cleanliness in cooking and serving of the mid-day meal,
iii. timeliness in procurement of good quality ingredients, fuel, etc,
iv. implementation of varied menu,
v. social and gender equity.

In order to ensure that there is transparency and accountability, all schools and centres where the programme is being implemented are required to display information on:

i. Quantity of food grains received, date of receipt.
ii. Quantity of food grains utilized
iii. Other ingredients purchased, utilized
iv. Number of children given mid-day meal.
v. Daily Menu
vi. Roster of Community Members involved in the programme (MHRD, 2011)

Information about the grievance redressal mechanism set up in Maharashtra is available at www.mhrd.gov.in/sites/upload_files/mhrd/files/upload_document/Maharashtra-GRM.pdf
National Rural Health Mission (NRHM)

NRHM (2005-12) was launched in April 2005 by GOI to provide accessible, affordable and quality health care to the rural population, especially the vulnerable groups (NHM, 2016). The goals of the NRHM include: (i) reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR); (ii) universal access to integrated comprehensive public health services; (iii) child health, water, sanitation and hygiene; (iv) prevention and control of communicable and non-communicable diseases, including locally endemic diseases; (v) population stabilization, gender and demographic balance; (vi) revitalize local health traditions and main-stream AYUSH; and (vii) promotion of healthy lifestyles. (MFHW, 2005)

The mission linked villagers and health centres through “Accredited Social Health Activists” (ASHA). One ASHA was raised from every village or cluster of villages. The ASHA is trained to advise village populations about sanitation, hygiene, contraception, and immunization; to provide primary medical care for diarrhea, minor injuries, and fevers; and to escort patients to medical centres. They are also expected to deliver direct observed short course therapy for tuberculosis and oral rehydration; to give folic acid tablets and chloroquine to patients; and to alert authorities to unusual outbreaks. (Kapil, 2005)

Additionally, as mentioned in NHM, 2017, one of the key elements of the National Rural Health Mission is the Village Health, Sanitation and Nutrition committee (VHSNC) which is formed to take collective actions on issues related to health and its social determinants at the village level. They are envisaged as being central to ‘local level community action’ under NRHM, which would develop to support the process of Decentralised Health Planning. Thus the committee is envisioned to take leadership in providing a platform for improving health awareness and access of community for health services, address specific local needs and serve as a mechanism for community based planning and monitoring.

The committee is formed at the village level and should act as a sub-committee of the Gram Panchayat. It should have a minimum of 15 members comprising elected members of the Panchayat who shall lead the committee, all those working for health and health related services, community members/beneficiaries and representation from all community sub-groups especially the vulnerable sections and hamlets/ habitation. ASHA residing in the village shall be the member secretary and convener of the committee.
Roles and Responsibilities

- Create awareness about nutritional issues and significance of nutrition as an important determinant of health.
- Carry out survey on nutritional status and nutritional deficiencies in the village especially among women and children.
- Identify locally available food stuffs of high nutrient value as well as disseminate and promote best practices (traditional wisdom) congruent with local culture, capabilities and physical environment through a process of community consultation.
- Inclusion of Nutritional needs in the Village Health Plan – The committee will do an in-depth analysis of causes of malnutrition at the community and household levels, by involving the ANM, AWW, ASHA and ICDS Supervisors.
- Monitoring and Supervision of Village Health and Nutrition Day (more information: http://nhm.gov.in/communitisation/village-health-nutrition-day.html) to ensure that it is organized every month in the village with the active participation of the whole village.
- Facilitate early detection of malnourished children in the community; tie up referral to the nearest Nutritional Rehabilitation Centre (NRC) as well as follow up for sustained outcome.
- Supervise the functioning of AWC in the village and facilitate its working in improving nutritional status of women and children.
- Act as a grievances redressal forum on health and nutrition issues. (NHM, 2017)
Conclusion

As stated in the beginning, this note discusses ‘what should be, as per the mandate’ not ‘what is’. Its limitation is that it does not discuss challenges in the implementation of the above interventions. To be able to formulate key aspects in community action initiatives, one needs to understand not only aggregated challenges in each of these schemes as discussed in relevant documentation, but also actual challenges in the geographical/ focus areas one is working. Prioritising and sequencing challenges to be addressed is a crucial step before one begins to design action plans on garnering community action. It is hoped that this note provides enough information and impetus to inquire further, seek and address those challenges.

Furthermore, as highlighted in the UNICEF framework of causes of under-nutrition (Ref. Note 1), the causes of under-nutrition are multi-sectoral (including food security, health, household behaviour, the roles and status of women) and the need for action is therefore at all levels from national through community and household (Pelletier et. al 2013). As advocates of an equitable society, using a rights-based approach, evaluating the design and provisions of the schemes/ policies/ acts critically, and not just in terms of challenges faced in implementation, is also essential. As a next step, in advocating nutrition security, it is crucial to think through and consolidate all such concerns about the design and provisions. Only then will it be possible to strategically design advocacy initiatives to motivate a wide range of policy-makers and civil society organisations at many levels.
References


PROMISING INITIATIVES

Tackling Malnutrition
Right to Food and Nutrition
Advocacy Primer
The National Family Health Survey (NFHS 4) nutritional indicators demonstrate some improvement but leave much to still achieve. However, in pockets in India, there have been a few rewarding interventions to ensure that the community secures its rights to food and nutrition. There are considerable lessons to be learnt from them. This note, third in the series of advocacy primers focusing on the Rights to food and nutrition, presents three such prolific cases. The interventions are in diverse areas affecting food and nutrition security i.e. a public food distribution system, a direct nutrition intervention and a communication strategy (an entertainment-education program on Television). The main aim of this note is not to argue whether these interventions were successes or not, and to what extent; there is already literature doing so. It attempts to discuss crucial facets to help brainstorm and outline key learning from the following interventions

1. The Public Distribution System (PDS) in Chhattisgarh,
2. The Tamil Nadu Integrated Nutrition Project and

The note hopes that this discussion provides vital food for thought in designing and advocating appropriate changes in programs that tackle undernutrition.

The PDS in Chhattisgarh

Several of the reforms introduced as part of the National Food Security Act (NFSA) are based on the reforms of the PDS implemented in Chhattisgarh. These reforms are widely believed to be the reason behind the successful distribution of food grains through PDS in the State. A study conducted by Prasad et. al (2013) confirms Chhattisgarh’s PDS success. Moreover, they found that not only did people in the State eat more PDS rice, they also improved the quality of their diet by eating more pulses, produce, and animal meat products, compared to people in the districts of States bordering Chhattisgarh. This increased the amount of proteins and nutrients such as minerals and iron in their diet.

As compared to most of its neighbouring States, Chhattisgarh is a fairly young State carved out of Madhya Pradesh in November 2000. At the State’s inception around 55% of its population was below the poverty line whereas only about 10% of households were consuming PDS rice from the shops run by the State Cooperatives Network. This number increased to over 33% by 2010. (Prasad et. al, 2013) This change was a cumulative effect of PDS reforms starting in the year 2001.
First, in 2001 the government allowed private dealers to apply for licenses to run Fair Price Shops (FPSs). Privatisation almost doubled the number of FPSs in the state. This jump in the number of FPSs is crucial because PDS access in Chhattisgarh was especially poor. Compared to its neighbouring states, Chhattisgarh started off with less than half the number of FPSs per 1,000 persons. The reform significantly narrowed this gap. (Prasad et al, 2013)

Second, the government increased the amount of PDS rice that it procured directly from farmers within the state. Starting in 2002, Chhattisgarh began to participate in the decentralised procurement scheme in which state governments procure rice and wheat directly from local farmers. As a result, between 2002 and 2004, PDS rice procurement increased from just under one million metric tons to just under two million metric tons - an increase of approximately 100%. (Prasad et al, 2013)

Third, in 2004, the ration shops were again de-privatised. As per Dreze & Khera (2010), while the privatization in 2001 allowed the network of ration shops to widen, it also created a new nexus of corrupt players whereby dealers paid politicians to get licences as well as protection when they indulged in corrupt practices. In 2004, the government, despite severe opposition from dealers, put Gram Panchayats, Self-Help Groups, Van Suraksha Samitis and other community institutions in charge of the ration shops. In addition to bringing ration shops closer to people’s homes, this helped to introduce accountability in the PDS.

“When people run their own ration shop, there is little incentive to cheat, since that would be like cheating themselves. Community institutions such as Gram Panchayats are not necessarily “people’s institutions” but, nevertheless, they are easier for people to influence than corrupt middlemen or the government’s bureaucratic juggernaut.” (Dreze & Khera, 2010)

The fourth was to ensure “doorstep delivery” of PDS grains. Grains are delivered by state agencies to the ration shop each month, instead of dealers having to lift their quotas from the nearest godown. This helps because corrupt dealers who diverted grains to the black market (open market) before they could even reach the village and sold reduced quantities to the consumers saying there was a shortfall at the godown are not able to do so. Once the grains are delivered to the ration shop in the village, it is much harder for dealers to divert it without opposition. In addition, truck movements from the godowns to the ration shops are carefully monitored and, if a transporter cheats, the dealers have an incentive to mobilise local support to complain against him. (Dreze & Khera, 2010)
Fifth, electronic weighing machines were introduced in the ration shops.

Sixth, rigorous monitoring often involving creative use of technology and improved grievance redressal was also put in place. For e.g. a system of ‘SMS alerts’ was launched to inform interested citizens of grain movements, and all records pertaining to supplies, sales, timelines etc. were computerized. Grievance redressal based on helplines which are often used by cardholders stood a good chance of timely response. The action was not limited to enquiries; in many cases, FIRs were lodged and some corrupt middlemen have also landed in jail. (Dreze & Khera, 2010)

Seven, increased transparency measures were introduced to eliminate bogus ration cards e.g. in several areas houses have a large round sign, painted next to the door, displaying the type of ration card held by that household and the corresponding price and quantity entitlements. This serves two purposes i) generating awareness about entitlements and ii) ‘naming and shaming’ those who possess a ration card for which they are not eligible.

Eight, and possibly a major step in the PDS revamp was a significant expansion in the coverage of PDS. Close to 80 percent of the rural population, including all SC/ST households, is entitled to PDS grains at either one or two rupees per kilo. Since most rural households have a strong stake in the PDS, the otherwise poor and disempowered rural cardholders have found an enhanced voice to generate immense pressure on the system. (Dreze & Khera, 2010)

Last but not the least, this has all been possible due to political will. Whether that will was generated and fueled by the larger interest of the community and especially the marginalized is a debatable question. However, in the process, it showed striking results.

**Tamil Nadu Integrated Nutrition Project (TINP)**

In the 1980s Tamil Nadu had a total of twenty-five different intervention programs, including the Integrated Child Development Services Scheme and the Chief Minister’s Noon Meal Program. Governmental commitment to the population's health and nutrition was obvious but the need for a more practical and streamlined approach to health care was apparent. (Shekhar, 1991)

To reduce malnutrition and consequent high mortality in children under-three, and to improve their health and nutritional status, and that of pregnant and lactating women, the Government of Tamil Nadu/Department of Social Welfare
and TINP Project Coordinator's Office through the Directorate of Social Welfare and the Directorate of Public Health and Preventive Medicine implemented the TINP from October 1980 to March 1989. The project was supported by the World Bank. (UNSCN, 1991)

TINP operated with the following objectives:

- Nutrition surveillance through regular growth monitoring of all children in the age group 6−36 months.
- Help rehabilitate the malnourished and head off proximate malnourishment through short term food supplementation.
- Reduce the mortality and morbidity due to protein−energy malnutrition and specific nutrient deficiencies.
- Improve the nutritional status of pregnant and nursing women.
- Strengthen health services to provide adequate back−up support to the nutrition effort.
- Improve home child care and feeding practices through education.
- Improve the efficiency and the impact of the above through sustained performance monitoring and evaluation.

As per UNSCN (1991), to help achieve these, the project had three major components: nutrition, health, and communications. Project implementation was to be monitored by the monitoring wing continuously and evaluated by an outside agency periodically.

Nutrition services delivery formed the core of TINP. A Community Nutrition Centre was established in each village (population 1500) and run by a Community Nutrition Worker (CNW). The CNW surveyed all households in the area (survey updated every quarter) and registered target children in the age group 6−36 months. These children were weighed each month and their weights plotted on growth charts to determine their nutritional status on a weight−for−age basis and to monitor their growth. Children determined to be at risk (i.e. with Grade III/IV severe malnutrition, or showing signs of growth faltering − losing weight, failing to gain weight or showing inadequate weight gain between successive weighings) were admitted to a short term supplementary feeding program. Pregnant women were also selectively fed. The supplement consisted of a cereal−pulse mix which was roasted, ground and sweetened with jaggery. The CNW administered Vitamin A prophylaxis (a 200,000 IU mega−dose every six months) to all children, along with deworming treatment (piperazine citrate, three times a year). Iron and folic acid were distributed to pregnant/lactating women. Monthly weighing sessions also provided workers with the opportunity to check on the children's health needs (e.g. immunisation, management of diarrhoeal episodes) and to educate mothers. (UNSCN, 1991)
It was decided to simultaneously upgrade the infrastructure, supply position, and worker skills in the existing health system, in order to improve the delivery of mother & child health services. The project helped to deploy and train one female multi-purpose health worker (MPHW) in a health sub-centre for a population of 5000 (4–5 villages), and in the absence of a village based health care worker, sought to establish a functional linkage between the nutrition and health care systems through the CNW. Specifically, those children who failed to respond to supplementation were to be referred to the health worker by the CNW for diagnosis, treatment and referral upward if necessary. The MPHW was also expected to deliver her package of MCH services through the Community Nutrition Centre, with the help of records and contacts made by the CNW. They were to make joint house visits for the purposes of nutrition and health education. (UNSCN, 1991)

Both the health and nutrition components were to be reinforced by a Communications Component which was designed to:

i) make mothers more fully aware of the nutritional needs of children;
ii) bring about better intra-family food distribution; and
iii) Enable the community to better handle its health and nutritional needs.

The strategy used was to encourage families to adopt a limited number of specific practices to improve the nutrition and health status of children. These included the importance of colostrum and breast feeding, timely introduction of solid foods to supplement breast milk, home management of diarrhoea, immunization, and improved environmental hygiene. (UNSCN, 1991)

As per Shekhar (1991), specific features in project design that seem to contribute to the success of the project include the following:

• Targeting - precisely defined area targeting coupled with beneficiary targeting allows project inputs to be honed to the neediest groups;
• CNW workloads - realistic worker-to-client ratios and well-defined and limited work routines ensure a manageable workload for CNWs;
• Recruitment and training of workers - recruitment of fresh cadres of workers with an aptitude for the work required and appropriate training followed by regular in-service training creates strong worker commitment and competence;
• Adequate supervisory support - prudently designated worker to supervisor (CNW: CNS) ratios allow for adequate time and energy for supervisory support to grass-roots level workers;
• Community participation - project design lays heavy emphasis on eliciting community participation, which has been envisaged as both a means and an objective.
• Information generation, management, and use - a well-organized system for the generation, management, flow, and utilization of project information is crucial to the success of the program.

Attention to the very minutest of details in planning the project is so intense that its contribution to the successful implementation of TINP cannot be overestimated. However, what is indeed remarkable is the fact that this kind of detailed planning has not detracted from the built-in flexibility in program implementation. For example, while the CNWs work routine is charted out fairly precisely, it does not prevent her from varying the time of feeding to suit local needs. (Shekhar, 1991)

On the other hand, specific features in project implementation that seem to contribute to the success of the project include the following:

• Worker-supervisor interaction ensures regular two-way communication;
• Recruitment of local CNWs facilitates implementation;
• Recruitment of married, poor women with healthy children as CNUs enhances worker credibility;
• Community cooperation contributes much toward successful implementation. Special mention is required here of Women’s Working Groups and Community Working Groups;
• Use of a snack-food supplement reduces chances of substitution (however, the lack of variety in food still needs attention);
• Growth charts serve as a tool for nutrition education;
• Involvement of a foreign donor agency increases answerability and hence increases pressure to perform. At the same time, worker morale has been adversely affected during periods of uncertainty about project extension. (Shekhar, 1991)

In 1975, only 4.5 percent of all children between 1 and 5 years of age in Tamil Nadu were "normal" based on the National Center for Health Statistics (NCHS) standards. The percentage increased to 7.1 in 1989 while the percentage of severe malnutrition declined from 13.7 in 1975 to 5.3 in 1989. While the success of TINP is evident, there were some constraints that were recognized too. These include inadequate attention to the location of community nutrition centres (CNC) and consequently less utilization of services by the neediest, some lost opportunities for mid-project design modifications, and limited emphasis on community participation (different from community co-operation). (Shekhar, 1991)
In conclusion, effective direct intervention, community-based nutrition project design depends on (a) detailed knowledge and understanding of the health and nutritional problems of the target population; (b) an understanding of viable measures to combat the problems identified; and (c) adequate flexibility to allow for design modifications based on feedback from the field (Shekhar, 1991). Success lies in meeting stated outcome and process objectives with a focus on sustainability. The ability to do so is governed by sociopolitical factors like political will, administrative support and community participation; technical factors like infrastructure and personnel capacity; and financial factors (Sanders, 1999). Ultimately, all these factors need to (be made to) function like wheels in gears, synergistically.

**An entertainment-education television program – Kyunki Jeena Issi Ka Naam Hai**

The Ministry of Health and Family Welfare, UNICEF and Prasar Bharti, the public service broadcaster, joined hands to reach out with essential information about child health, nutrition and development through the television program - Kyunki Jeena Issi Ka Naam Hai. This entertainment-education program weaving together elements of drama and education to communicate with women, families and communities about key social issues, was launched on 7 April 2008. A total of 501 episodes were aired between 2008 and 2011, making it the longest-running entertainment-education-program and most watched soap opera in India. (UNICEF, 2013)

As per UNICEF (2013), 100 million Indian households own a television set – by far the most popular medium for communication and entertainment. 45 percent of rural households have access to television programs. Recognising the need for educating public opinion about maternal and child nutrition and related entitlements, and the massive reach of the television, an entertainment-education television soap opera – a popular entertainment format with Indian audiences, was used as a means of communication. The program was aired from 8.30 pm to 9.00 pm three times a week to entertain while sharing information and influencing the knowledge, attitudes and practices of individuals, families and communities to foster positive individual and social change.

The serial utilizes engaging stories and drama to provide information on critical health, education, equality, and protection issues, messages which also aid community workers in their interpersonal and group communication mandates. Rigorously pretested and supported by continuous research, the serial promoted prosocial change and encouraged self-efficacy through persuasive modelling. The program drew its educational content from the “Facts for Life global
communication initiative” created by a number of United Nations agencies. The Facts for Life Communication Initiative acts on the connection between two strategic principles: 1) behaviour change outcomes are best assured through an efficient and synergistic mix of mass media, small group, and interpersonal communication interventions; and 2) given the range of behavioural outcomes associated with the MDGs, communication needs to be convergent, holistic, and systematic to be effective. (UNICEF, 2011)

UNICEF (2013) states that the serial was watched by over 145 million people, 61 percent of whom were women between the ages of 15 and 35 years, indicating that it achieved a balance between social messaging and prime-time entertainment.

Specific features in project design and implementation that seem to contribute to the success of the project include the following:

- Broadcast on the national television network, Doordarshan, a choice because of its large penetration even in the most remote corners of rural India.
- The convergence and collaboration of a variety of agencies and institutions to develop the content, identify the right messages, connect information and entertainment, and ensure that the messages delivered were clear, factual, visually correct, actionable and appealing.
- The program was backed by a robust monitoring and evaluation plan, which included concurrent monitoring, rapid assessments, and baseline and endline assessments for direct audience feedback.
- Concurrent monitoring and evaluation were used to generate real-time feedback from the viewers and help track reach, coverage and impact, helping scriptwriters, producers and message developers design more impactful future episodes. (UNICEF, 2013)

The first rapid audience assessment was conducted among randomly selected women aged 15–34 in 4 of 6 targeted states (Rapid Audience Survey I, Centre for Media Studies cited in UNICEF, 2011). Key findings included:

- 95 percent of total respondents liked the show.
- 92 percent of them could identify their lives with the serial more than any other serial on television
- 48 percent of respondents discussed the storyline and characters with their family or friends.
- In Madhya Pradesh, 75 percent of respondents expressed their intention to take action after watching the serial
• After viewing the show, Anganwadi workers in Rajasthan and Uttar Pradesh reported that they had been motivated to conduct surveys of children, enrol them in the Anganwadi and promote a nutritious diet.
• Auxiliary nurse midwives (ANMs) from Jharkhand and Madhya Pradesh were inspired by the serial’s nurse to perform their duties with renewed dedication.
• Accredited social health activists (ASHAs) in Jharkhand felt that the serial had reinforced their existing knowledge on antenatal check-ups and taught them more about social work and working with under-served populations (in-depth interviews, Centre for Media Studies).

Other evaluation findings, mentioned by UNICEF (2013) indicated that

• 95 percent of the viewers exposed to the program recalled messages on breastfeeding;
• 87 percent recalled messages related to early initiation of breastfeeding and colostrum feeding;
• 85 percent recalled messages on exclusive breastfeeding for six months and
• 67 percent recalled messages about the introduction of complementary foods after the first six months.

Since the average cost of reaching a viewer was less than INR0.70, UNICEF (2013) established that entertainment-education is an ideal medium to engage and maintain audience attention, impart vital information on infant feeding, nutrition and care, and encourage dialogue between families and communities. UNICEF is collaborating with satellite and regional broadcasting networks to re-broadcast the show. A radio adaptation of the serial and its use for the development of short video clips for inter-personal communication and dialogue are also planned.

In conclusion, entertainment-education develops and disseminates critical messages that are educational in substance, entertaining in structure, and popular in style. The entertainment-education strategy works at the nexus of culture and development to achieve behavioural results and supplement program interventions. Through this strategy, it allows communicators to tackle and talk about underlying and basic causes of problems that are often sensitive or socio-culturally entrenched. (UNICEF, 2011)
Conclusion

While the three interventions discussed above are diverse, they have all helped improve food and/or nutrition security in various ways, thereby directly or indirectly helping to tackle undernutrition. It will be a worthwhile exercise to examine these programs using the UNICEF causes of undernutrition framework, to analyse which of the causes they address/ do not address, why and how. Such analysis helps with understanding trade-offs in the project and implementation design, a fundamental factor in any design process. Further discussion to fuel actionable changes in the areas (geographically and sectorally) we work in, to ensure the rights to food and nutrition, is urged.

Literature reviews during the course of writing this note have indicated that there are success stories in tackling malnutrition across the world – Thailand, Indonesia (UPGK), Tanzania (Iringa project), Zimbabwe (CSFP/SFPP) are a few examples. We really need to introspect and critically examine why, in spite of such proven cases, in India and elsewhere, we still struggle to ensure everybody’s right to food and nutrition. The urgency in doing so can never be overstated.
References


Annexure I: Useful Links

- Mid-day Meal Scheme Website - http://mdm.nic.in/
- About MDMS (archived) - http://pib.nic.in/archive/flagship/bkg_mdm1.pdf
- Mid-day meal scheme (Maharashtra annual work plan and budget 2017-18) http://mdm.nic.in/Files/PAB/PAB-2017-18/Maha/1_MAHARASHTRA%20State%20WRITE%20UP.pdf
- About ASHA http://nhm.gov.in/communitisation/asha/about-asha.html
- About NFSA - http://dfpd.nic.in/nfsa-act.htm
- SABLA - http://wcd.nic.in/sites/default/files/1-SABLAscheme_0.pdf
## Annexure 2: Ministries/Departments and programmes/schemes delivering NSIs, Union Government
(Source: Srivastava et. al, 2017)

<table>
<thead>
<tr>
<th>Ministry and Department/s</th>
<th>Programme/ Scheme</th>
<th>Purpose</th>
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<tbody>
<tr>
<td></td>
<td>National Mission on Oilseeds and Oil Palm (NMOOP)</td>
<td>Enhance production of traditional oilseeds and tree-borne oilseeds.</td>
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<tr>
<td></td>
<td>National Mission for Sustainable Agriculture (NMSA)</td>
<td>Improve ‘water use efficiency’, ‘nutrient management’ and ‘livelihood diversification’ through adoption of sustainable development pathway. Special focus on dryland agriculture and managing climatic shocks.</td>
</tr>
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<td></td>
<td>National Horticulture Mission</td>
<td>Enhance horticulture production; augment farmers’ income through promoting value addition and small scale agri-industries. Also, strengthen nutritional security.</td>
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<td></td>
<td>Rashtriya Krishi Vikas Yojana (RKVY)</td>
<td>Integrated development of agriculture sector through interventions on food security, sustainable agriculture, production of oil seeds, oil palm and agriculture extension.</td>
</tr>
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<td></td>
<td>Blue Revolution-Integrated Development and Management of Fisheries</td>
<td>Contribute to food and nutrition security through sustainable development of fisheries and utilizing full potential of water resources. Achieve economic prosperity for fishermen and the country.</td>
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### Annexure 2: (Continued)

<table>
<thead>
<tr>
<th>Ministry and Department/s</th>
<th>Programme/Scheme</th>
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<tbody>
<tr>
<td><strong>Sector: Education</strong></td>
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<tr>
<td>Ministry of Human Resource Development (Department of School Education and Literacy)</td>
<td>Mid-Day Meal (MDM)</td>
<td>Enhancing school enrollment, attendance and retention; improve nutritional status of children (6-14 years), in government and government-aided schools.</td>
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<td></td>
<td>Rashtriya Madhyamik Shiksha Abhiyaan (RMSA)</td>
<td>Promote secondary education, especially among girls</td>
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<tr>
<td><strong>Sector: WASH</strong></td>
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<tr>
<td>Ministry of Drinking Water and Sanitation</td>
<td>National Rural Drinking Water Programme (NRDWP)</td>
<td>Accelerate achievement of universal access to safe and clean drinking water</td>
</tr>
<tr>
<td>Ministry of Urban Development (Department of Urban Development)</td>
<td>Swachh Bharat Abhiyan (SBA) / Swachh Bharat Mission (SBM) / Nirmal Bharat Abhiyaan (NBA)</td>
<td>Accelerate achievement of universal access to safe and clean drinking water and improved sanitation facilities</td>
</tr>
<tr>
<td><strong>Sector: Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ministry of Health and Family Welfare (Department of Health and Family Welfare)</td>
<td>National Health Mission (NHM)</td>
<td>Improve access to equitable, affordable and quality health care services.</td>
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<tr>
<td>Ministry of ANaturopathy, Unani, Siddha and Homoeopathy (AYUSH)</td>
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<tr>
<th>Ministry and Department/s</th>
<th>Programme/Scheme</th>
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<tr>
<td>Ministry of Rural Development (Department of Rural Development)</td>
<td>Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS)</td>
<td>Livelihood security through legal right for at least 100 days of unskilled wage employment to willing adult members of a household- initially in 200 most backward districts and now at-scale.</td>
</tr>
<tr>
<td>Ministry of Urban Development (Department of Urban Development)</td>
<td>National Rural Livelihood Mission (NRLM) / Ajeevika</td>
<td>These programmes aim at creating efficient and effective institutional platforms of the rural and urban poor, enabling them to increase household income through sustainable livelihood and improved access to financial services.</td>
</tr>
<tr>
<td>Ministry of Rural Development (Department of Rural Development)</td>
<td>National Urban Livelihood Mission (NULM)</td>
<td></td>
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<tr>
<td>Ministry of Consumer Affairs, Food and Public Distribution (Department of Food and Public Distribution)</td>
<td>Public Distribution System / National Food Security Scheme</td>
<td>Ensure to 2/3rd of country's population has access to affordable food grains through subsidies.</td>
</tr>
<tr>
<td>Ministry of Rural Development (Department of Rural Development)</td>
<td>National Social Assistance Programme (NSAP)</td>
<td>Ensuring minimum national standard for social assistance complementing benefits that states are currently providing or might provide in future. Includes various pension benefit schemes.</td>
</tr>
<tr>
<td>Ministry of Women and Child Development</td>
<td>Indira Gandhi Matritava Sahyog Yojana (IGMSY)</td>
<td>Providing cash assistance (conditional) to pregnant and lactating women from the end of 2nd trimester of pregnancy up to 6 months after delivery. INR 6000 are provided to the pregnant and lactating women to address short term income support objectives with long term objective of behaviour and attitudinal change. The scheme is being implemented in 53 districts across the country on a pilot basis. The scheme attempts to partly compensate for wage loss to pregnant and lactating women both prior to and after delivery of the child.</td>
</tr>
</tbody>
</table>
National Centre for Advocacy Studies (NCAS) is a social change resource centre that aims to strengthen rights based and people centred advocacy. NCAS endeavours to create enabling conditions for people’s empowerment at the grassroots level as well as to facilitate efforts for human rights, social justice and transparent and accountable governance.