

**Towards Integrated Management of
Malnutrition:
NCPCR Interventions Aug 2012-Oct 2013**



**NATIONAL COMMISSION FOR PROTECTION OF
CHILD RIGHTS**

Contents

I. Introduction	1
II. Recent Programmatic Reforms in ICDS with Potential Impact on Malnutrition	1
III. Current Programme for Children with Malnutrition	2
• <i>At the AWC</i>	2
• <i>AT the NRC</i>	3
IV. Gaps in the current system for managing malnutrition and extent to which the policy provisions above will fulfill these gaps.	5
i. <i>Prevention</i>	5
ii. <i>SNP</i>	6
iii. <i>Sneha Shivirs</i>	6
iv. <i>Extra Worker for Under Threes / Link Workers</i>	6
v. <i>Falling between two stools; inconsistencies between referral criteria of ICDS and admission criteria of NRCs</i>	6
vi. <i>Limitations of the NRC Programme</i>	7
vii. <i>The Lack of Interministerial Convergence</i>	11
V. The vision; A comprehensive programme for management of malnutrition	12
VI. State-Wise Interventions and Recommendations	14
A. Deliberations with States	15

B. State Recommendations and Action taken	16
1. Madhya Pradesh	16
2. Maharashtra	22
3. Odisha	30
4. Jharkhand	32
5. Andhra Pradesh	35
6. Puducherry	38
7. Rajasthan	39
8. Haryana	41
9. Bihar	45
10. Gujarat	46

C. Number of Individual Complaints from Four States	49
--	----

VII. Consolidated Policy Recommendations for Seamless Transitions and Continuum of Care in the Context of Malnutrition	50
---	----

Annexures

References

Abbreviations

AWC	Anganwadi Centre
AWH	Anganwadi Helper
AWW	Anganwadi Worker
BCC	Behaviour Change Communication
CTC	Child Treatment Centre
ICDS	Integrated Child Development Services
IEC	Information Education Communication
IFA	Iron and Folic Acid
IMM	Integrated Management of Malnutrition
IYCF	Infant and Young Child Feeding
MAM	Moderate Acute Malnutrition
MTC	Malnutrition Treatment Centre
MUAC	Mid-Upper Arm Circumference
MUW	Moderately Underweight
MOHFW	Ministry of Health & Family Welfare
MoWCD	Ministry of Women & Child Development
NRC	Nutrition Rehabilitation Centre
NRHM	National Rural Health Mission
SAM	Severe Acute Malnutrition
SNP	Supplementary Nutrition Programme
SUW	Severely Underweight
VCDC	Village Child Development Centre

**Towards Integrated Management of
Malnutrition: NCPCR Interventions**

Aug 2012-Oct 2013

Towards Integrated Management of Malnutrition: NCPCR Interventions Aug 2012-Oct 2013

I. Introduction

There has been a long drawn process of research and policy advocacy by various bodies; governmental, advisory and civil society, with respect to the grave situation of malnutrition amongst young children (particularly under three years) along with specific recommendations towards strategies for better impact¹²³. It is noteworthy that many of these recommendations have been taken into account by the recently declared strengthening and restructuring of the ICDS (Government of India,2013).

This report is based upon the work of the Commission on these issues (2012-2013), which has entailed detailed field observations, case-by-case investigations of deaths due to malnutrition, programmatic analysis, and policy and legal analysis. These processes have resulted in specific recommendations to Centre, States and Districts with a view to monitoring and improving services for children with malnutrition.

II. Recent Programmatic Reforms in ICDS with Potential Impact on Malnutrition

The programmatic reforms offered to the States (for 200 Districts in Phase I) by the Ministry of Women and Child Development as part of ICDS restructuring are extremely timely and important. These include infrastructural improvements of the Anganwadi centres, enhanced financial allocations for SNP, enhanced HR for nutrition counseling of the families of under-three children, crèches in upto 5% of the AWCs, essential convergence between the ICDS and the NRHM as well as camps (SNEHA SHIVIRS) for community based management of moderate and severe malnutrition. These are all welcome and significant measures. To quote the strategies / activities specifically aimed at reducing malnutrition:

¹ NAC,2011

² WGPU6,2007

³ Sinha, D (2006)

With a view to address the menace of malnutrition in those districts where it is prevalent most, Nutrition Counselor cum Additional Worker (per AWC) would be provided in 200 high burden districts.

Further, for other districts, a provision has been kept for a link worker, as specified in the Broad Framework of Implementation. The incentives proposed for link workers including ASHA workers under NRHM would be linked to outcomes.

Further, management of moderately and severely undernourished children (Sneha Shivirs, IEC/ Advocacy, promoting IYCF practices, strengthening monitoring and evaluation and MIS & ICT, grading and accreditation of AWCs and reward scheme would also be undertaken as per the Broad Framework for Implementation.

Though the provision of crèches has not been seen as a specific strategy for malnutrition, it is the experience of many experts that crèches are likely to have a major impact upon the nutritional status of attending children since a comprehensive system of care is being provided which allows for close monitoring and frequent feeding of the attending children. The provision of crèches is as follows:

The provision of day care crèches is essential for care and development of children in the 6-72 months of age, whose mothers go for work. As a new initiative on experimental basis 5% of the existing AWCs would be converted into AWC-cum-Creche. States/UTs will have the flexibility in choosing such AWCS.

III. Current Programme for Children with Malnutrition

At the AWC

While the AWW is expected to provide general care including monitoring of infant and young child feeding, growth monitoring and health status, specific programmes for malnutrition are limited and not defined for children in the mild and moderate categories of malnutrition.

Current norms for children with severe malnutrition in the ICDS is to start them on double rations and refer them to NRCs for a 15 day package of intensive health and nutrition management after which they are released back to the community and the ICDS.

The ICDS recommends that children with severe malnutrition according to measurements of weight- for- age are referred to the NRC. These are then evaluated by the NRC by the criteria of

severe acute malnutrition (SAM) which is not diagnosed by weight- for- age but by the criteria as described below.⁴

At the NRC⁵

The admission criteria for the NRC are as follows:

i. Children 6-59 months

Any of the following:

- MUAC <115mm with or without any grade of oedema
- WFH < -3 SD with or without any grade of oedema
- Bilateral pitting oedema +/++ (children with oedema +++ always need inpatient care)

WITH

Any of the following complications:

1. Anorexia (Loss of appetite)
2. Fever (39 degree C) or Hypothermia (<35 C)
3. Persistent vomiting
4. Severe dehydration based on history and clinical examination
5. Not alert, very weak, apathetic, unconscious, convulsions
6. Hypoglycemia
7. Severe Anemia (severe palmar pallor)
8. Severe pneumonia
9. Extensive superficial infection requiring IM medications
10. Any other general sign that a clinician thinks requires admission for further assessment or care

In addition to above criteria if the caregiver is unable to take care of the child at home, the child should be admitted.

⁴ GOI, 2011

⁵ ibid

ii. Infants < 6 months

Infant is too *weak or feeble* to suckle effectively (independently of his/her weight-for-length).

or

WfL (weight-for-length) < -3SD (in infants >45 cm)

or

Visible severe wasting in infants <45 cm

or

Presence of oedema both feet

Other reasons for inpatient enrolment:

Readmission: Child previously discharged from in-patient care but meets admission criteria again.

Return after default: Child who returns after default (away from in-patient care for 2 consecutive days) and meets the admission criteria.

Once admitted, the child is managed in three phases, namely: **Stabilization Phase, Transition Phase and Rehabilitative Phase.**

Three Phases of Management of Children with SAM

Stabilization Phase: Children with SAM without an adequate appetite and /or a major medical complication are stabilized in an in-patient facility. This phase usually lasts for 1-2 days. The feeding formula used during this phase is Starter diet. All children must be carefully monitored in this phase.

Transition Phase: This phase is the subsequent part of the stabilization phase and usually lasts for 2-3 days. The transition phase is intended to ensure that the child is clinically stable and can tolerate an increased energy and protein intake. The child moves to the Transition Phase from Stabilisation Phase when there is:

- * At least the beginning of the loss of odema
- AND
- *Return of appetite
- AND
- *No nasogastric tube, infusions, no severe medical problems
- AND
- *Is alert and active

The **ONLY** difference in management of the child in transition phase is the change in type of diet from Starter diet to Catch up diet.

Rehabilitative Phase: Once children with SAM have recovered their appetite and received treatment for medical complications they enter Rehabilitative Phase. The aim is to promote rapid weight gain, stimulate emotional and physical development and prepare the child for normal feeding at home. The child progresses from Transition Phase to Rehabilitative Phase when:

- *S/he has reasonable appetite; finishes >90% of the feed that is given, without a significant Pause
- *Major reduction or loss of oedema
- *No other medical problem

Source: *Operational Guidelines on Facility Based Management of Children with Severe Acute Malnutrition, GOI 2011*

Discharge criteria have been created keeping in mind whether a programme for community based management of malnutrition (CMM) exists or not. However, since in most cases there is no current programme for CMM, generally the discharge criteria relate to achievement of 15% weight gain and recovery of health and appetite, and most children are discharged after 14 days. The protocol lists various preparatory measures with the family as well as the AWW, ANM and ASHA. It recommends follow up till the child is in the normal category. However, while it defines non-responders, it provides no guidelines for action to be taken if children fail to respond except for 'repeat home visits'.

IV. Gaps in the current system for managing malnutrition and extent to which the policy provisions above will fulfill these gaps.

i. Prevention

Impact on malnutrition necessitates strategies for both prevention and management of existing children with malnutrition. Prevention requires high quality services for the health and nutrition of pregnant and lactating women and adolescents and action to prevent early marriages and pregnancies. Prevention also requires high baseline services to fulfill children's right to good quality diverse food as well as healthcare, water and sanitation. In terms of preventative action, the proposed ICDS restructuring has the scope to improve the quality of services to all beneficiaries in a general sense.

ii.SNP

The improved allocations for SNP are unlikely to fulfill the current protein-gap that exists in children since protein rich foods are expensive and food prices are rising sharply. However, if necessarily combined with the procurement of cereals from FCI at subsidy, and the use of locally available cereals, the investment in SNP is likely to produce richer dividends.

iii. Sneha Shivirs

The main thrust on achieving impact on malnutrition seems to be through the strategy of behavior change communication. The link-worker / nutrition counselor is employed for this purpose. Further the Sneha Shivirs are also largely to promote IYCF practices. This hardly takes into account the current gap; the near-complete absence of any specific programme for community based management of severe malnutrition. It is submitted that a camp approach for children with severe and moderate malnutrition will merely incur similar programmatic limitations as the NRC though the geographical limitations will be better managed, and a tenure- based programme rather than an outcome-based programme is not the best way to deal with children with severe / moderate malnutrition. However, the potential for developing such an outcome-based programme exists thanks to the provision of crèches and extra HR. It would only require some additional inputs to convert this piece-meal approach to a comprehensive package of care to prevent and manage malnutrition.

iv. Extra Worker for Under Threes / Link Workers

Children are known to suffer from growth faltering which may or may not result in severe malnutrition. **Previously, no specific programmatic protocols came into play for action on any child whose growth was faltering but had not currently reached the situation of 'severe' malnutrition.** Extra interventions for malnutrition are basically employed only once the child has hit the serious situation of 'severe malnutrition', which has been an illogical practice. It is hoped that the extra HR being made available through the proposed restructuring will be able to tackle growth faltering by IYCF, home visits and management of childhood infections. It is also hoped that clear protocols will be developed to refer children if these simple steps do not suffice to stem the downward trend of the child's nutritional status.

v. Falling between two stools; inconsistencies between referral criteria of ICDS and admission criteria of NRCs⁶

As mentioned above, the ICDS recommends that children with severe malnutrition according to measurements of weight- for- age are referred to the NRC with a conveyor-belt approach.

⁶Prasad, V et al. (2012)

These are then evaluated by the NRC by the criteria of severe acute malnutrition (SAM) which is not diagnosed by weight- for- age but the criteria mentioned above (Pg 5).

Since there is no neat correlation between severe weight- for- age and weight- for- height, many referred children do not qualify for admission and are sent back leading to a waste of effort by the AWC and the family. Equally, there would be some children in the community with SAM that do not get included by screening with weight- for- age. To avoid this, AWWs use the only common criterion between the ICDS and the NRC that can be done at the level of the AWC; the MUAC, leading to a further narrowing of the numbers of children referred and thereby admitted. This also leads to neglect of growth monitoring by the AWW and loss of skills for the same⁷.

vi. Limitations of the NRC Programme

NRCs provide for a small number of beds for inpatient management of severe acute malnutrition (SAM) which is, in most states, less than 0.1% of estimated children with SAM. In any case, experts deem that not more than 20% of children with SAM need to be admitted and the rest should be catered to through community based programmes for malnutrition. Experience shows that families find it extremely hard to accept fifteen days of admission to a distant NRC since it affects their livelihood and the care of other children, fields and animals despite the wage-loss compensations in the programme. Anecdotal data collection shows that while the stay in NRCs does make some small impact in terms of perhaps reducing mortality, treating infections, initiation of weight-gain and training of parents in how to manage the malnutrition of their children at home, the impact on nutritional status per se is miniscule⁸⁹. The discharge criterion of NRCs is a mechanical 15% of current weight or 15 days of inpatient care. In many cases, specially in tribal pockets of states such as Madhya Pradesh, Jharkhand and Maharashtra, this does not translate into a change of nutritional status for the child as highlighted by Case studies 1 and 2. **As it happens, a child admitted to an NRC who has received intense management to the cost of about 50 Rs per child per day for consumables (food and medicine) goes back to a programme that has no specific follow up and no additional resources, in the same severe grade of malnutrition.** Follow-up has been found to be deficient and many children relapse (Case Study 3). This fact is not denied by policy makers and implementers. Thus, while NRCs play a vital and important role in the management of SAM, they do not offer any comprehensive system for 'cure' or even continuity of care.

⁷ NCPCR,2013a

⁸ NCPCR 2013b

⁹ Madhya Pradesh ATR

Illustrative Cases

	<u>Case 1</u> Lakshmi	<u>Case 2</u> Rinku
Name of the child:	Lakshmi	Rinku
Age:	13 months	15 months
Sex	Female	Male
Father:	Pintu	Ganesh
Mother:	Remrati	Sunita
Caste:	Scheduled Tribe	Scheduled Tribe
Address:	Veerpur Sahrana, Vijaypur Block, Sheopur District	Bankuri, Karhal Block, Sheopur District
Date of admission:	September 13, 2012	September 16, 2012
Weight at admission:	3.184 kg	4.500 kg
Length:	59 cm	66 cm
W/H Z score:	< -3 (SAM)	< -3 (SAM)
Target weight:	3.661 kg	5.175 kg
	If discharged at this target weight, W/H Z score will remain: < -3 (SAM)	If discharged at this target weight, W/H Z score will remain: < -3 (SAM)

Case 3

Name of the child: Muskaan

Age: 7 months

Sex: Female

Father: Prakash

Mother: Aarti

Caste: Scheduled Tribe

Address: Tilangpura Village, Vijaypur Block, Sheopur District

Date of admission: June 20th, 2012

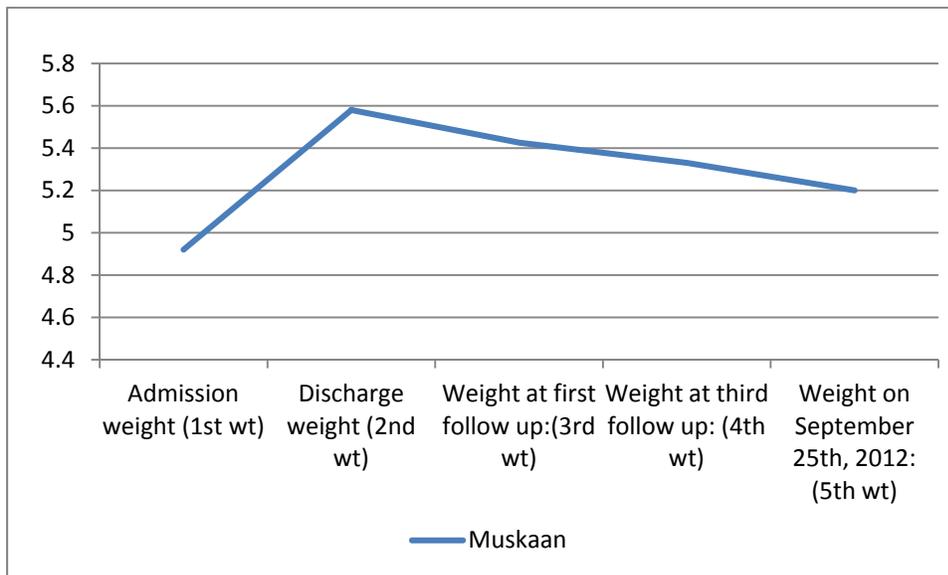
Admission weight: 4.920 kg

Discharge weight: 5.580 kg

Weight at first follow up: 5.426 kg

Weight at third follow up: 5.339 kg

Weight on September 25th, 2012: 5.200 kg (continuous decline)



Case 4

Name of Child: Abhay Bajju Jamunkar

Age: 3 years & 3 months (DOB 9/06/2011)

Sex: Male

Fathers name: Bajju Punya Jamunkar

Mothers name: Pinaki Jamunkar

Address: Malur Forest, Taluka Dharni, Dist Amravati.

Month	Weight	Grade	Month	Weight	Grade
June 11	2.7	MUW	Aug 12	5.6	SUW
July 11	3.2	MUW	Sept 12	5.6	SUW
Aug 11	3.7	MUW	Oct 12	6.0	SUW
Sept 11	4.5	MUW	Nov 12	6.0	SUW
Oct 11	5.0	MUW	Dec 12	Absent	
Nov 11	5.4	MUW	Jan 13	Absent	
SDec 11	5.5	MUW	Feb 13	Absent	
Jan 12	6.0	MUW	Mar 13	6.6	
Feb 12	Absent		Apr 13	6.3	SUW
Mar 12	Absent		May 13	6.1	SUW
Apr 12	Absent		June 13	6.1	SUW
May 12	5.6	SUW	July 13	6.4	SUW
June 12	5.4	SUW	Aug 13	7.0	SUW
July 12	5.5	SUW	Sept 13	7.1	SUW

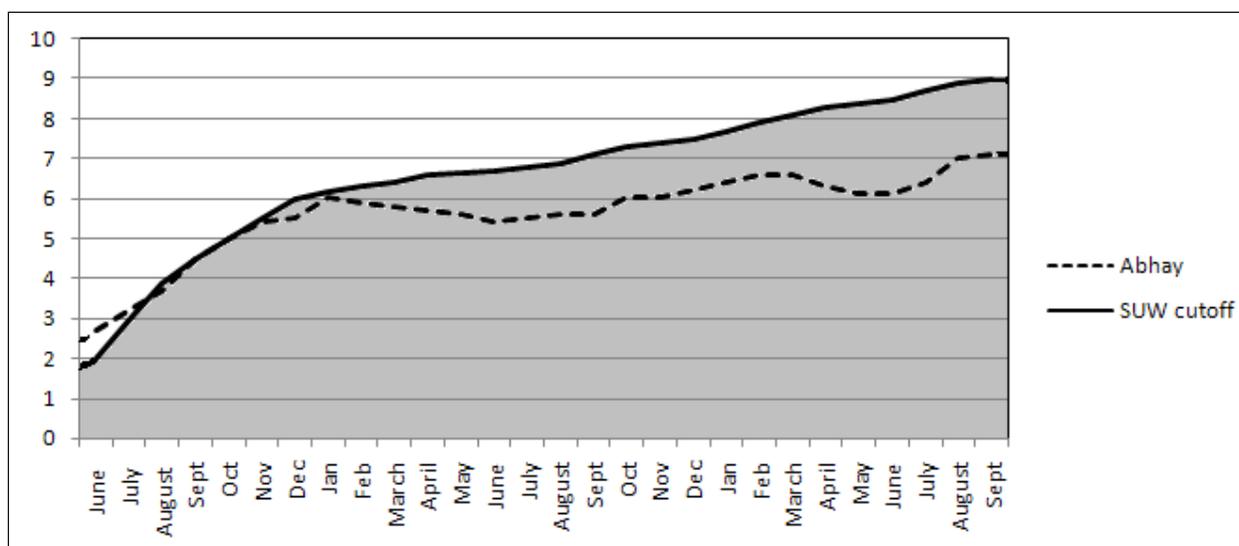
Admission in VCDC

VCDC conducted from 17/07/2012 to 19/08/2012 at Malur forest. Abhay was selected for admission but he was not admitted. The mother goes to Kohana taluka, Chikaldhara with her child.

Abhay admitted in VCDC from 14/08/2013 to 17/09/2013. At the time of admission the weight of child is 6.80 kg (SAM) and at time of discharge 7.00kg (SAM)

Referral Services to NRC

- Referred to NRC, Dharni on 6/09/2013 and child was admitted from 6/09/2012 to 19/09/2012. At time of admission the weight of child was 5.70kg (SAM) and at time of discharge 6.00 (SAM).
- Referred to NRC, Dharni on 11/10/2012 but child was admitted one day only, and child went home against medical advice. At the time of admission, the weight of child was 6.00 kg (SAM)
- Referred to NRC, Dahrni at 19/07/2013 and the child admitted from 19/07/13 to 02/08/2013. At the time of admission, the weight of child was 6.20kg (SAM) and at the time of discharge 6.82kg (SAM)



The optimal management of severe undernutrition thus, requires a combination of facility and community based approaches such that a child discharged from the NRC is handed over into a community-based programme that also systematically tracks the progress of the child and provides direct feeding. Well defined procedures need to be laid out for the children who are found to be 'non responders'. Such an approach would also imply the need to track severely undernourished children across the health and ICDS programmes.

vii. The Lack of Interministerial Convergence

It is evident that if we are to move towards a seamless integrated programme for malnutrition that allows for continuity of care and is cost effective and rational, common protocols and close coordination are required between the main ministries involved, namely Min WCD and Min H&FW. Unfortunately, opportunities continue to be missed in arriving at common protocols that have been created and disseminated jointly to present a consensus programme, such as the opportunity provided by the protocols on Infant and Young Child Feeding that have been recently been brought out by the MoHFW. The manual on integrated management of malnutrition also has been held up due to lack of consensus between key players. In fact, the Commission had to intervene in one version of the draft by the Health Ministry that would have created parallel systems to the ICDS for community based management of malnutrition¹⁰ which then had to be recalled. The matter has not progressed substantially despite the Commission's intervention to call common meetings between the two ministries and promote a joint consensus programme for community based management of malnutrition where, again, both agencies would have to play a critical role; Health to deal specifically with referrals of children with persistent growth faltering, sick malnourished children and micronutrient

¹⁰ NCPCR, 2013c

supplementation, and WCD to primarily be in charge of the child and deal with overall care, IYCF counseling, supplementary nutrition (including THR), growth monitoring and liaison with health. However, recently, joint guidelines have been put forward by the concerned ministries on community based management of malnutrition “ Community Based Management of Children with Severe Acute Malnutrition- Operational and technical Guidelines (MOHFW, June 2013)” which have certainly made headway in achieving both consensus and rational management (NCPCR,2013c) between the ICDS and the NRCs. These guidelines have not yet been shared with State governments or put in the public domain.

Some overlaps do exist between the roles of the ASHA and AWW, but these are not insurmountable barriers to effective action, provided an environment of collaboration and partnership in the best interests of the child is fostered by the leadership.

It is likely that the facilitation of a supraministerial agency like the PMO, the Planning Commission or NCPCR may be required to create convergence at the highest policy level for integrated management of malnutrition to become a reality in policy and implementation.

V. The vision : A comprehensive programme for management of malnutrition

The only way to maximize current investments, approach severe malnutrition and use the NRCs in a rational and logical way is to house the NRC inputs in an overall comprehensive programme which provides for continuity of care, referral to NRC if required and follow up after discharge from NRC till the child achieves normalcy or atleast has improved from severe to moderate malnutrition.

This entails a programme of close growth monitoring with a focus on growth faltering, health surveillance as well as additional calorie-dense, protein rich food supplements which can be easily prepared locally using local products. There are many models that demonstrate such programmes¹¹¹²¹³¹⁴ including initiatives by the State governments or districts themselves. Extra food costs for these programmes is estimated to be about 20 Rs / per child per day for a period of about three months to ensure significant impact on the child’s nutritional status. However many of the interventions such as the programme being run in Melghat through the Rajmata Jijau Mother-Child Health & Nutrition Mission (RJM) suffer from being time-bound rather than outcome-bound, i.e; the interventions lapse after a fixed time period rather than after a desired outcome, leaving many children still in dire circumstances.

¹¹ Public Health Resource Network (2012)

¹² <http://www.validinternational.org>

¹³ Govt of Maharashtra (2005)

¹⁴ Govt. Of Madhya Pradesh (2012)

The current programme thus does not make any arrangements for a well defined programme for community based management of severe malnutrition with additional resources for food supplementation, health care and growth monitoring. It is re-emphasized that any camp approach for children with severe and moderate malnutrition will merely incur similar programmatic limitations as the NRC, though the geographical limitations will be better managed, and a tenure- based programme rather than an outcome-based programme is not the best way to deal with children with severe / moderate malnutrition. However, the potential for developing an outcome-based programme exists thanks to the provision of crèches and extra HR. It would only require some additional inputs to convert this piece-meal approach to a comprehensive package of care to prevent and manage malnutrition. This idea is now being reflected in the recently brought-out “*Community Based Management of Children with Severe Acute Malnutrition- Operational & Technical Guidelines, MOHFW 2013*”.

In a nutshell, a comprehensive package for preventing and managing childhood malnutrition (after birth) requires:

1. Good quality baseline care, health and nutritional services (as creches, adequate and good quality food through AWCs, convergence with NRHM)
2. A protocol for growth faltering as the trigger for first response, regardless of existing nutritional status
3. A programme for CBM of malnutrition
4. A protocol for referral to the NRC from the above
5. A referral back to the CBM programme from the NRC
6. Discharge from the CBM only after the child has achieved full ‘cure’ from severe malnutrition.

The proposed ICDS restructuring and strengthening should be able to take better care of point number 1. Points 2, 3, 4, 5, 6 do not currently exist specifically though some elements of each of the points above have been provided through the current programmes. Thus the potential exists to convert the current piecemeal programme to a more comprehensive programme for care of children with malnutrition through additional programming and resource allocation. The main concern is that the current additional allocations may not result in desired benefits because of critical programmatic and resource gaps that do not allow these valuable investments to have optimal impact. It is suggested that the first phase of the restructured ICDS can be used as a pilot and the time period of phase I be used as an opportunity to further the required programmatic changes in subsequent phases. Concurrent state-level interventions for CBM can also be acknowledged and accommodated in subsequent phases with support from the Centre.

VI. State-Wise Interventions and Recommendations¹⁵¹⁶¹⁷¹⁸¹⁹²⁰²¹²²²³²⁴

The response of various State Governments to the challenge of IIM has been variable. While most states were quick to assess the merits of issues being raised and took some action, depending upon practical limitations, a few were recalcitrant and slow to respond. The Commission found Madhya Pradesh to be actively involved in programmatic reforms to tackle malnutrition at State level and it incorporated many of the recommendations of the Commission after due and serious consideration. In contrast, the States of Jharkhand and Maharashtra received summons due to persistent non-responsiveness to requests for enquiries pertaining to IMM. As the details below indicate, however, many of the issues being raised in the section above were seriously examined by the State Governments. **Of note are the State level notifications issued by Madhya Pradesh pertaining to management of referrals and NRC programme protocols, that have preceded and expanded the central government notifications in the true spirit of providing maximum inputs to families while their children are admitted in the NRC (see Section B, 1 Madhya Pradesh)**

On the whole, it was perceived that the Health Department of NRHM was able to respond much more easily for issues relating to NRCs than the WCD department relating to ICDS functioning. The NRCs also, were perceived to be functioning broadly better than the ICDS with respect to IMM. This may improve as a result of the new ICDS Mission that will allow greater decentralization and flexibility in ICDS functioning, similar to that in the NRHM.

¹⁵ NCPCR 2012a (Madhya Pradesh recommendations)

¹⁶ NCPCR 2012b (Maharashtra recommendations)

¹⁷ NCPCR 2013f (Odisha recommendations)

¹⁸ NCPCR 2012c (Jharkhand recommendations)

¹⁹ NCPCR 2012d (Andhra Pradesh recommendations)

²⁰ NCPCR 2013e (Puducherry recommendations)

²¹ NCPCR 2013d (Rajasthan recommendations)

²² NCPCR 2013g (Bihar recommendations)

²³ NCPCR 2013h (Gujarat recommendations)

²⁴ NCPCR 2013m (Haryana recommendations)

A. Deliberations with States made by the Commission (Aug 2012- Aug2013)

Sr. No.	States	Dates
1.	Madhya Pradesh Visit to Sheopur and Satna Districts Visit to Rewa District Meetings with State Officials	24 th -27 th Sept, 2012 28 th -30 th Jan, 2013
2.	Maharashtra Visit to Mumbai Visit to Melghat region, Amravati District and Meeting with State Officials Visit to Mumbai Summons Hearing held in New Delhi	21 st Aug, 2012 9 th -11 th Oct, 2012 11 th -13 th July, 2013 3 rd Oct, 2013
3.	Odisha Meeting with State officials	26 th March 2013
4.	Jharkhand Visit to West Singbhum District Meeting with State Officials Summons Hearing held in New Delhi	19 th - 21 st Sept, 2012 19 th July, 2012
5.	Andhra Pradesh Meeting with State officials	5 th Dec, 2012
6.	Puducherry	14 th March, 2013
7.	Tamil Nadu Public Hearing on Governance Issues and ICDS Scheme in Tamil Nadu (report available in file)	15 th March 2013
8.	Rajasthan Visit to Bhilwara Meeting with State Officials at Jaipur	8 th -10 th Jan, 2013
9.	Haryana Meeting with State Officials in New Delhi Visit to Sikandarpur, Manesar and Gurgaon	23 rd Nov, 2012 12 th March, 2013
10.	Bihar Visit to Gaya and Patna districts Meeting with State officials at Patna	9 th -11 th May, 2013
11.	Gujarat Visit to Rajkot and Kutch Districts Meeting with State Officials at Gandhinagar	23 rd -26 th July 21013
12.	Delhi Public Hearing on ICDS Nutrition Expert Committee for Review of MDM	21 st Feb 2013 and 26 th Feb, 2013 6 th , 8 th , 14 th and 16 th Aug, 2013

B. State Recommendations and Action Taken²⁵

1. Madhya Pradesh

Dr. Vandana Prasad, Member, National Commission for the Protection of Child Rights (NCPCR) visited hamlets and blocks of Sheopur and Satna Districts, Madhya Pradesh from September 24-27, 2012 to review the situation of child health and nutrition in these areas.

A second visit to the state was undertaken from 28th to 30th January, 2013 with a tour of Jawa Block, Rewa District, Madhya Pradesh followed by a State level meeting on 31st January, 2013 to discuss issues arising out of the Rewa Tour as well as other significant issues pending with the Commission relating to the State of Madhya Pradesh. A detailed meeting with DM and senior officers was also held in Rewa.

i. Recommendations following visit to Sheopur and Satna Districts (24th-27th Sept., 2012)

Sr.No.	Recommendations (vide F.No.35/8/2012-NCPCR(PD)/25793-99 dated 12th Oct, 2012)	Action Taken
I.	Nutrition Rehabilitation Centres	
1	Accompanying family members (mother and other siblings) of the admitted child should be provided necessary nutrition and health services based on evaluation of nutritional status and Hb.	Directives issued for health checkups for mothers and siblings and provision of necessary nutrition and health services.
2	Either the cheque system of compensation for wage loss is to be abandoned or banking services to open accounts must be provided while the child is admitted at the NRC.	Cheque system of payment of wage loss compensation and transportation charges to mothers during follow-ups has been relaxed. Hence, cash payments are made to mothers and compensation are being paid for all 4 follow-ups.

²⁵ District level recommendations and ATRs have not been included here for shortage of space. District level letters are available in respective State files.

3	The immunisation status of the admitted and accompanying child should be checked and immunisation ensured.	Immunisation status of the admitted child and accompanying siblings are checked and immunization is ensured.
4	In the absence of community based management of malnutrition, a child should be discharged only if there is shift in her nutritional status from < -3 SD to < -2 SD on indicators of underweight and wasting.	* Plans for Community based management of malnutrition in convergence with DoWCD have been incorporated in PIP 2013-14. *Health checkups of all severe underweight, moderate underweight children with growth faltering and SAM children discharged from NRCs will be ensured to diagnose common infections and prevention of further slipping grades. *Directives have also been issued for need based extension of stay period of SAM children at NRCs
5	A discharged child should be provided with IFA tablets and multivitamin tonic as well as the THR due to her from the AWC for the period that she was in the NRC.	Prevention of childhood anaemia programme is an ongoing programme under which all children between 6m-60m are provided IFA syrup (100 ml) for prophylactic iron supplementation. At discharge symptomatic and supportive treatment is provided to the SAM children.
6	A complete health check up should be conducted of children who do not respond to nutritional rehabilitation.	Strict directives have been issued for detailed medical examination of non- responder children especially to rule out underlying medical conditions and chronic diseases like TB, HIV etc.
7	Every NRC should benefit from the advice of a Paediatrician, especially those serving vulnerable tribal areas. Special efforts should be made to ensure that NRCs in such areas are visited by a Paediatrician on at least a fortnightly basis.	It has been directed to ensure visit by a pediatrician or a medical train on NRC protocols at NRC. In places where pediatricians available in the district is to be arranged.
8	Transportation costs should be provided for all 4 follow up visits of a discharged child.	A total amount of Rs. 400/- to be provided towards transportation costs of 4 follow up visits of children discharged from NRCs as per directions issued by NRHM MP vide letter 2441 dated 15/10/2012
9	Children should be admitted whenever they arrive based on bed availability and the fixed day approach should be abandoned.	Strict abandonment of fixed day admission process being observed in some of the NRCs.
10	The NRC should be considered as a resource base for leadership & capacity building for growth monitoring at the block level.	Pending

11	All available development and welfare services should be provided to families of children admitted to NRC on a priority basis to ensure that the living conditions of the undernourished child improve.	Pending
I	The highest priority should be accorded to vulnerable tribal pockets to ensure the provision of all development services and the socio-economic development of communities. This should include: i. Mapping & microplanning for additional AWCs for tribal hamlets ii. Mapping & microplanning for supportive supervision for AWCs in tribal hamlets	Proposal for new/additional AWCs based on district population according to census 2011 has been submitted to GOI vide letter no.ICDS-1099/12-13 dated 19.03.2013.
II	Human resource policies at the state level should be reformed to ensure: a. Clear TORs for every post that specify accountability b. Transparent transfer & placement policy for difficult areas c. Incentives for difficult area postings d. Appropriate disciplinary action for supervisory lapses e. Detailing of a comprehensive integrated plan for community based management of severe undernutrition that includes clarity on role of NRC, admission and discharge criteria of NRC and provision of additional nutrition for severely undernourished children at the community level.	a. TORS have been specified earlier. They are revised periodically. b. Transfers are carried out as needed. Postings of officials is under process. Currently due to demand from Sheopur collector, c. Currently, there is no such provision according to guidelines laid down by GOI or State Govt. Officials posted in tribal areas are given incentives according to rules of State Government. d. The Collector has the power to direct disciplinary action/ enquiry against erring officials (upto grade 3). At district level, monitoring and supervision is done monthly. e. Atal Bal Arogya Poshan Mission is ongoing to tackle malnutrition and for community based management of malnutrition. Day care centres are being provided at Sheopur and Shivpuri.
III	Particularly Vulnerable Tribal Group status to be accorded to Mawasi, Khairwar, Kol and Korku tribes	Special district specific plans to be made keeping in mind prevention of malnutrition in tribes like Mawasi, Kol and Korku.

ii. Recommendations following visit to Rewa Dist. (28th-31st Jan, 2013)

Sr.No.	Recommendations (vide D.O.No.35/8/2012-NCPCR (PD)/27034 dated 14th Feb,2013)	Action Taken
1	Priority be given to tribal applicants for all fresh appointments to ASHA, AWW, AWW Helper and ANM categories.	There is no provision for reservations in these posts. Merit list is prepared according to rules of recruitment. Priority for candidates of Scheduled tribes exists.
2	Rationalization of the implementation of the Ladli Lakshmi Scheme to relieve / decrease the burden on the CDPOs.	Ladli scheme is run by the Women Development Commissionerate. Under this, appointment of women development project officers in 313 community development blocks is under process. Following the appointment of such officials, CDPOS shall be relieved off the burden of Ladli scheme.
3	Reconsideration of MUAC as being the sole referral criterion for NRCs and correction of the resultant lack of focus on growth monitoring at AWC level.	As per state policy referrals of children with MUAC<11.5 cm to NRCs are majorly done by AWWs through MUAC screen as MUAC is a cost effective and simple to use tool. Training of AWWs on use of MUAC has been done by the ICDS department under the ABM. The recommendation of reconsidering of MUAC as being the sole referral criterion for NRCs had been well taken and contemplated by the State. However, the State is of the opinion that provisioning of stadiometers/length boards and training the frontline workers on the use of the same is not feasible in terms of limited technical competence of the frontline workers as well as the expenditures involved for the procurement of the height measuring tool.

4	<p>Clear orders to be sent out that all patients who are serious enough to be referred to a higher facility must be first registered as in-patients and must be provided with such immediate care as is available at the facility to which they present. It must be made very clear that simply referring as an out-patient is not an acceptable course of action for a patient who cannot be taken care of at the facility to which he/she presents.</p>	<p>Directives have been issued to comply with directives issued vide letter no./ /13/487 dated 08/05/2013 regarding referral of patients. It is required that all patients are to be first registered and provided immediate care and be referred only if required specialized treatment is not available at the facility. Referral slip must carry the signatures of the physician. Contact should be made with the higher facility where patient is to be referred.</p>
5		<p>Moreover, the State has long felt the void of not having a robust community based management plan and hence is in the process of developing comprehensive integrated plan for community based management of severe acute malnutrition in convergence with ICDS. In coordination with ICDS, medical checkups along with provision of nutritious food for all children with severe underweight, moderate underweight having static weight/growth faltering and those discharged from NRCs at sub centre level C-NRCs (Community Nutrition Rehabilitation Clinics) have been planned under PIP2013-14. With this strategy in place, the State envisages to cater to the needs of those children who do not fall into the MUAC <11.5cm category, yet requiring attention to avoid mortality risks.</p>

6	<p>It appears that the guidelines that have already been issued in response to our previous recommendations that non-responders at the NRC must be referred for a pediatric opinion are not being respected. These need to be reinforced.</p>	<p>Directives have been issued to the districts regarding need-based extension of NRC stay of SAM children upon medical advice of in-charge Mos vide letter no. CH-N/RCH/2013/4226 dated 18.01.2013. The criteria for discharge from NRC include return of appetite, absence of odema and no medical complications. 15% weight gain over admission weight is set as discharge criteria for discharge from programme. These children fulfilling the discharge criteria and when out of mortality risk will be followed up at the C-NRCs.</p>
7		<p>The State sought approval for revision of norms for treatment cost per SAM child; which has been revised to Rs.3090/- from Rs.2500/- upon approval from GOI for the provision of transportation cost for all 4 follow-ups of the children discharged from NRCs. Directives regarding the same have been issued to districts vide letter no.CH-N/RCH/2012/2441 dated 15.10.2012 (attached with letter).</p>

2. Maharashtra

The Commission visited the Melghat region of Amravati District, Maharashtra during 9th-11th Oct,2012 to assess the situation of health and nutritional services for children in the region.

Sr. No	Recommendations (vide D.O.No. Member (VP)/NCPCR/26038 dated 7th Nov, 2012)	Action Taken	Remarks
1.	<p>Interventions within nutritional programmes</p> <p>i.) As parallel programmes for nutrition are running, clarity amongst functionaries regarding these (VCDC, CDC and NRC) programmes needs to be ensured. Additionally, nutritional status of child should be the criteria for discharge, instead of time duration ie 14 days currently used. Since the VCDC is the only point for special care for children with SAM in the community, it is recommended that the VCDC programme be made permanent at every anganwadi that has SAM children registered, and that the programme be offered till the child exits the SAM criteria.</p>	<ul style="list-style-type: none"> The VCDC started at Anganwadi level even if one child registered in SAM category. As per the instruction of Rajmata Jijau Mission, SAM & MAM child once admitted in VCDC cannot be admitted second time within the period of 6 month. Also the child can be admitted in VCDC two times only & if not proper improvement in VCDC, the child should be referred to CTC/NRC. The detailed circular of Rajmata Jijau Mission is attached as annexure –A. 	<p>No clear directives issued. They have also attached some issues addressed by way of ‘frequently asked questions’ from Rajmata Jijua Mission. But they do not appear to be very clear directives ffrom the Mission.</p>
	<p>ii.) Tracking component within all nutritional programmes needs to be strengthened. Careful tracking of children with SAM from AWC / VCDC to CTC to NRC and back is required to tackle the issue of non-</p>	<ul style="list-style-type: none"> Health & ICDS machineries are conducting regular meetings with peripheral health & ICDS workers regarding careful tracking (Home → VCDC → CTC→NRC likewise → SOS Higher Center). Initially there was poor response for follow-up but now it is improved and we are doing our best to make it 100% 	

	<p>responders. A software needs to be urgently developed to assist the district to be able to achieve this.</p>	<ul style="list-style-type: none"> The development of software for tracking of SAM & MAM children is under process by Rajmata Jijau Mother - Child Health & Nutrition Mission Mumbai. 	
2.	<p>NRC i.) Gaps in human resources need to be filled. Human resource needs of the NRC need to be addressed with immediate effect. At the time of our visit, we found that there was no dietician appointed at the NRC Dharni. This alongwith the fact that the Staff Nurse had only recently joined and hadn't yet received training made it difficult for the task at NRC to be carried out effectively.</p>	<ul style="list-style-type: none"> Taking into consideration the need of Dietitian in Melghat, the official process to post one Dietitian at SDH Dharni is in final stage. One dietitian will be made available very soon. 	
	<p>ii.) Training of staff on specific nutritional requirements of SAM/MAM children must be ensured, so as to enable them to counsel mothers appropriately on matters regarding cooking of food, use of oil, frequency of meals etc for such children. The staff nurse appointed recently at NRC, Dharni was found lacking in NRC specific training, and thus unable to counsel mothers on these points.</p>	<ul style="list-style-type: none"> The training of Breast feeding to all Health & ICDS machinery was conducted with the help of BPNI, and also by Rajmata Jijau Mission. The training program for Staff nurse appointed at NRC will be organized with the help of Rajmata Jijau Mission regarding cooking of food, Use of oil, frequency of meals etc. 	
	<p>iii). Investigate why children were not gaining weight during the period of admission in the NRC. The Commission is concerned that most children didn't show weight gain during their stay at the NRC. It directs the authorities to investigate and submit a report within 30 days, on the manner in which therapeutic food is prepared, frequency of meals, cooking</p>	<ul style="list-style-type: none"> It is noted & investigation report will be submitted soon. 	

	<p>demonstrations etc are undertaken at the NRC.</p>																														
	<p>iv.) Non Responders: Currently no action is being taken for non responders even though most children at NRC were found to have gained little or no weight at discharge. It is recommended that non responders be defined for the programme after it has been rationalized as above, and each child who qualifies as a non responder be medically assessed (investigated) for underlying medical conditions.</p>	<p style="text-align: center;">Information of NRC</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th colspan="7" style="text-align: center;">Monthly Output JAN - 13</th> </tr> <tr> <th></th> <th>Discharge from NRC</th> <th>Defaulter</th> <th>Non Responders</th> <th>Deaths</th> <th>Children due for follow-up (in the month)</th> <th>Children followed-up in the month</th> </tr> </thead> <tbody> <tr> <td>During Month</td> <td style="text-align: center;">4</td> <td style="text-align: center;">0</td> <td style="text-align: center;">1</td> <td style="text-align: center;">0</td> <td style="text-align: center;">21</td> <td style="text-align: center;">20</td> </tr> <tr> <td>Progressive</td> <td style="text-align: center;">87</td> <td style="text-align: center;">23</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">148</td> <td style="text-align: center;">54</td> </tr> </tbody> </table> <ul style="list-style-type: none"> • There is one child not responding to treatment as per current definition of non responders. A child is referred to Amravati Government Hospital for expert care. 	Monthly Output JAN - 13								Discharge from NRC	Defaulter	Non Responders	Deaths	Children due for follow-up (in the month)	Children followed-up in the month	During Month	4	0	1	0	21	20	Progressive	87	23	1	2	148	54	
Monthly Output JAN - 13																															
	Discharge from NRC	Defaulter	Non Responders	Deaths	Children due for follow-up (in the month)	Children followed-up in the month																									
During Month	4	0	1	0	21	20																									
Progressive	87	23	1	2	148	54																									
	<p>v.) Tracking: While a good referral system seemed to be in place, tracking of children after their stay at the NRC was found to be lacking. The Commission, has asked the concerned</p>	<ul style="list-style-type: none"> • Health & ICDS machineries are conducting regular meetings with peripheral health & ICDS workers regarding careful tracking (Home → VCDC → CTC → NRC likewise → SOS Higher Center). Initially there was poor response for follow-up but 																													

	<p>authorities to urgently develop a system of tracking children after their stay at the NRC. Specifically, the Commission has asked for a report to be submitted on the nutritional status of the following children within 30 days:</p> <ol style="list-style-type: none"> 1. Abhay Jamunkar age 18 months old, Malur Forest 2. Dipali Motarbhedha 3. Vaishnavi Ganesh, Mandur 4. Abhay Mangal, Tembli 	<p>now it is improved and we are doing our best to make it 100%</p> <ul style="list-style-type: none"> • The development of software for tracking of SAM & MAM children is under process by Rajmata Jijau Mother - Child Health & Nutrition Mission Mumbai. • The monthly nutritional status of respected four children is as follows 	<p style="text-align: center;">Nutritional status of children not submitted.</p>
<p>3.</p>	<p>AWCs</p> <p>i.) Action to be taken against AWW for not opening anganwadi regularly. Two remote anganwadis one at village Bhiroja and the other at Keli village were found to be opening very irregularly or not at all, even though there was a high percentage of SAM + SUW (10%) and tribal population norms were not being followed even though over 150 children were registered. Disciplinary action needs to be taken against non attending AWWs and their supervisors. Where irregular opening of AWCs is attributed to non-local AWW been appointed (villages Bhiroja and Keli), the Commission recommends adherence to norms of selecting AWW workers from same village specially in remote areas. The District administration is required to survey remote hamlets within 30 days and inform the Commission about how</p>	<ul style="list-style-type: none"> • Dharni & Chikhaldara are two talukas in Melghat area. ICDS project Dharni was started in 1975 & Chikhaldara in 1982. At that time mostly tribes were illiterate & candidates who fulfilled the basic qualification for AWW were not found in many villages. Hence non local candidate posted as AWW (37 AWW in Dharni project & 103 AWW in Chikhaldara project). Most of them stay at headquarter with their families & works satisfactory. New posts of AWW & vacant posts by retirement are being strictly filled up by selecting the local candidate. • 5 AWW from Dharni project & 4 AWW from Chikhaldara project were not working properly. The notices to take disciplinary action were issued to all these AWW. After that out of 9 AWW 8 are working properly & 1 AWW from AWC Lawada is not working properly, hence last chance is given to her to do proper work. She does not improve the performance, she will be dismissed. 	

	many are found to have non-local AWWs and are not opening daily.		
	ii.) General development of infrastructure at AWCs. Most were founding facing severe space crunch and lacking in infrastructure including electricity, water and toilet facilities. The allocation for building new anganwadis is currently 4.5 lakhs which falls short by about 1 lakh due to higher cartage in difficult areas. The Commission would encourage investigation into construction of low-cost anganwadis with better design using local materials and involving gaon panchayats for their design and construction rather than contractors. Local NGOs have committed their support for facilitating such a process.	This is noted and process is being started for construction of low – cost Anganwadi with better design using local materials and involving gram panchayats for their design and construction rather than contractors. Local NGOs have committed their support to facilitate the process.	
5.	Much more monitoring and supervision needed. It is recommended that a dedicated desk be created for monitoring malnutrition in Melghat. The ADHO office may be given this charge and provided with an issue expert for nutrition.	<ul style="list-style-type: none"> • Dr.Kishor Bobade, Senior Medical Officer in the Amravati district is deputed as Add. District Health Officer Melghat, Taluka Health Officer also appointed at Dharni & Chikhaldara for monitoring & supervision. The Medical Officer at 11 PHCs in Melghat area are supported for monitoring & supervision. 	
6.	Supervisory cadres for the ICDS need to be enhanced in terms of numbers, roles and capacities. The Commission would like a report on status of staffing gaps in AWW supervisors in Melghat and action being proposed/ taken to fill these gaps.	<ul style="list-style-type: none"> • There were 18 posts of Anganwadi Supervisors sanctioned in Melghat area. One post is increased in Chikhaldara project, hence there are 19 posts of ICDS supervisors. All these 19 posts are filled. 	

<p>7.</p>	<p>Expediate the process of building <i>palnaghars</i>. The Commission was gravely concerned that in the absence of crèche facilities and with both parents going out for work, a child Priti Bhurelal Mawaskar of village Kusumkot (Bada) previously admitted to NRC, was under the care of her 7-8 yr old sibling. The Commission was informed that 100 <i>palnaghars</i>/crèches have been sanctioned, but haven't taken off yet. The Commission recommends this to be expediated.</p>	<p>There are 100 palanaghar sanction & established in Melghat area. One Palanaghar established at village Kusumkot (Bada).</p> <p>Priti Bhurelal Mawaskar is kept in Palanaghar. Her nutritional status is improved as follows,,</p> <table border="1" data-bbox="892 479 1621 609"> <thead> <tr> <th>Month</th> <th>Weight</th> <th>Nutritional status</th> </tr> </thead> <tbody> <tr> <td>Oct.12</td> <td>6.00 Kg</td> <td>SUW</td> </tr> <tr> <td>April 13</td> <td>8.500 Kg</td> <td>Normal</td> </tr> </tbody> </table>	Month	Weight	Nutritional status	Oct.12	6.00 Kg	SUW	April 13	8.500 Kg	Normal	<p>Palnaghar established at village Kusumkot visited by NCPCR team.</p> <p>Nutritional Status of Priti , has been reported and shows improvement.</p>
Month	Weight	Nutritional status										
Oct.12	6.00 Kg	SUW										
April 13	8.500 Kg	Normal										
<p>8.</p>	<p>The Commission has also asked for an investigation by CEO, Dharni block regarding submission of bogus bills in the supply of Eggs-Banana by a local contractor</p>	<p>The enquiry conducted by Chief Executive Officer, Zilla Parishad Amravati through Child Development Project Officer Anjangaon Surji & Morshi. In this enquiry it is found that, there was no bogus bill submitted in the supply of Eggs-Banana in Dharni & also in Chikhaldara project.</p>										
<p>9.</p>	<p>It is recommended that a joint survey be undertaken with local NGOs in Melghat within a period of 60 days for an accurate situational analysis regarding malnutrition in the region so as to reconcile gaps between official data and NGO surveyed and put fears of under-reporting to rest.</p>	<ul style="list-style-type: none"> The data show in this para is of Amravati district including Tribal & Rural area. The State of Maharashtra is the first state to start the Anti Malnutrition campaign as Rajmata Jijau Kuposhan Mukta Gram Abhiyan from 14th of November 2011 to 6th April 2012 and Rajmata Jiju Arogya & Poshan Abhiyan from 14th of November 2012 to 6th April 2013. During the said campaign children were weighted openly in presence of Guardian, NGOs & villagers and plotted the Malnutrition chart. Due to various measures under this campaign malnutrition decreases in rural area. But there is not a substantial decrease in Tribal area. Total number of children in Tribal area (Melghat) in September 2012 is as follows, 										

A) As per child's weight with respective age

Category Grade	No.of Children	Percentage
Normal	20005	59.44
MUW	10585	31.45
SUW	3065	9.11
Total	33655	--

B) As per child's weight with respective length/height

Category Grade	No.of Children	Percentage
Normal	31755	94.35
MAM	1630	4.84
SAM	2270	0.80
Total	33655	--

- NGOs are collecting the data of child's weight with respective age i.e. MUW & SUW. The above figure shows that, there was 9.11 % SUW & 31.45 % MUW in Melghat as per Government data. This data is nearly correlated with NGOs data.

Summons: The Maharashtra Govt. was summoned for failure to respond to the Commission's enquiry pertaining to issues of child health and nutrition observed during the Commission's visit to the Melghat region in October 2012. Despite numerous reminders and even after almost a year of the visit, the Commission has not received suitable and adequate Action Taken Report (ATR) from the CEO, Amravati Zilla Parishad with regards to detailed nutritional status reports of children found to be severely malnourished. The Commission had also sought an enquiry into the death of one of these children which has not been forthcoming. The Commission had noted that the Nutrition Rehabilitation Centre (NRC) at Melghat was failing to show significant impact and had sought for an enquiry followed by corrective action. This too, received no response despite personal intervention and official reminders, indicating a high level of apathy (Summons Notice attached, Annexure).

The Summons hearing revealed that the concerned children had been severely underweight for many months (17 in one case and 26 in another) right upto the present moment and the interventions of ICDS, VCDC, CTC and NRC had failed critically at various levels, even to conform to stated guidelines. This has been taken very seriously by the commission. The NRC continues to function sub-optimally though it shows some signs of improvement in recent months as per the testimonies of senior officials who presented at the Summons. However, state efforts to provide support in terms of human resource and oversight need to be improved. The Commission noted that campaigns for BCC need to be launched with civil society organisations working in the area to interact more intensely with the tribal communities.

3. Odisha

Odisha was visited on the 26th March 2013, to review issues of child rights. A meeting was held with State Government officials wherein issues pertaining to health, nutrition, protection and education were discussed through a presentation made by the State Government. While the Commission noted that the ICDS programme was running fairly well from the data, accounts of civil society participants, visit to centres and the presentation by the State Government, the certain issues pertaining to ICDS, were brought up for discussion.

Dr. Vandana Prasad, Member, NCPCR had also been invited by the Dept. of W&CD, Govt. of Odisha to address the Technical Session on Working Towards Addressing Under-nutrition in the State of Odisha, organised by the State Government on the 9th Oct., 2013 at Bhubaneshwar (Programme attached, Annexure).

Sr. No.	Recommendations (Vide DO letter No. Member (VP)/NCPCR/Odisha/2013/27855 dated 22.04.2013)	Action Taken (vide Letter No. 852/SWCD dated 17 th August, 2013)
1.	There are high numbers of severely malnourished children in the State. Some headway has been made with additional programmes in 15 high burden districts; such as for better supervision, infrastructure, distribution of hygiene kits, BCC and mobilization of women’s groups etc. Additionally, the Pushtikar Diwas attempts an Integrated Management of Malnutrition (IMM) that details the components of Community Based Management of Malnutrition in addition to Facility Based Care. The Commission also notes the CMAM pilot in Kandhamal (4 blocks) and looks forward to the reports that emerge. It was suggested that some immediate actions in this regards could be to create a greater focus on growth faltering specially of the under-threes, with advisories to feed THR with increased	An instruction has already been issued to the field functionaries to this effect. This was also been incorporated in the revised guidelines for the Hot Cooked Meal and Take Home Ration under Supplementary Nutrition Programme issued by the Department vide letter No. 590 S/WCD dated 28.06.2013 read with 768/SWCD dated 27.07.2013 which have been webhosted in the website of W&CD Department. Besides, IEC on growth faltering along with use of community growth charts is being taken up.

	<p>frequency and with addition of tolerable amounts of oil. Meanwhile, a state policy for IMM needs to be developed that includes the provision of extra calorie-rich high protein food for children with severe forms of malnutrition within the protocols.</p>	
2.	<p>There are many financial problems being faced by the State in its attempt to provide good quality meals to children since the costs of transportation, fuel etc have not been separated from the food costs nor linked to inflation. This needs to be taken up at a policy level by NCPCR. Once millets are included in the PDS, they should also be available at subsidy to the programme for use in THR / HCMs.</p>	<p>This is a laudable decision taken by the Commission for taking up the issue at the policy level. However, it is brought to the kind notice of the Commission that while Government of India has allowed revision of ration cost under SNP in 15 districts in the state of Odisha in a phased manner, the State Government has started implementing the revised ration cost in all the 30 districts with effect from 1.07.2013. With this three eggs per week have been introduced in the hot cooked meal component and two eggs each per week for each category of THR beneficiaries has been introduced along with the wheat based chhatua already provided to them with the instruction for consumption of the boiled eggs at the AWCs by the THR beneficiaries. Similarly, for SAM children one packet of rassi ladoo of 100 gms weight is being provided over and above the provisions made in the hot cooked meal as well as THR component under the revised ration cost of SNP.</p>
3.	<p>Anganwadi centres are not using appropriate storage bins for storing food grains; this has been reported by NGOs and was also observed by the Member at the AWCs visited.</p>	<p>Comprehensive guidelines for food safety in Anganwadi Centrew have been issued by the Department where suitable instructions have been issued for storage of food items, similarly THR protocol has already been issued. Anganwadi workers have been given flexi funds for procurement and storage bins.</p>

4. Jharkhand

The Commission visited West Singhbhum District from 19th- 21st Sept,2012, in response to a complaint received regarding the death of six (6) children from Chaibasa, West Singhbhum District of Jharkhand, and to review the status of health and nutrition services in the area.

Sr.No.	Recommendations (vide F.No.35/7/2012-NCPCR (PD)/25755-59 dated 5th Oct,2012)	Action Taken
1.	A notification / reminder to be sent to all MTCs for nutritional assessment of the accompanying siblings and mother (including BMI and Hb) of all children admitted in the MTCs so that opportunities are not missed.	Notification issued (letter vide 9/RCH-607/2012-1464 dated 6/11/12) and reminder sent on 8/1/13 Nutritional assessment of accompanying siblings (WHO criteria and MUAC tape). Maintain separate register for such children and if found malnourished, then should be immediately admitted to MTC.
2.	A notification / reminder to be sent to all MTCs to ensure that MTC in charges are aware of protocols for babies under 6 months with SAM so that no such babies are refused admission.	Notification issued (letter vide 9/RCH-607/2012-1464 dated 6/11/12) and reminder sent on 8/1/13 0-6 months babies found malnourished to be treated at MTC according to Operational guidelines on Facility based Management of Children with SAM under 6 months of age.
3.	Instructions to be given to MTCs for all children to receive a total of 100 days of iron and folic acid at discharge.	Notification issued (letter vide 9/RCH-607/2012-1464 dated 6/11/12) and reminder sent on 8/1/13 Iron Folic Acid Syrup to be given for 100 days to all children at discharge from MTC.
4.	Pediatric oversight to be ensured at each MTC, which can be organized by periodic visits by pediatricians allocated to the District Hospital even if no pediatricians are available at the CHC.	Notification issued (letter vide 9/RCH-607/2012-1464 dated 6/11/12) and reminder sent on 8/1/13 A pediatrician to be made available at MTC. If no pediatrician is available at CHC, then visits by pediatrician from Dist. Hospital are to be made. If none at Dist level, then MTC be in charge of F-IMNCI trained personnel.
5.	Data on current infrastructural status of anganwadis	Current data on the infrastructural status of AWs in the state being

	in the State to be shared with the Commission along with plans for improvement with time lines.	<p>Collected through Real Time Monitoring cell at the state level was shared with the Commission vide ATR (Letter No.211/SW/2013 dated 22nd June,2013).</p> <p>Along with this, under the 13th Finance Commission, funds received by the state have been duly distributed to the district for construction of 1746 AWs in 15 different districts, with all physical infrastructures, through the State Govt.'s letter no-133/2013-30. So, this number of AWs will be an add on, the data available on the infrastructure this year. With the further release of funds in coming one to two years nearly double of this number anganwadi centres will be developed (vide ATR (Letter No.211/SW/2013 dated 22nd June,2013, Annexure 1,2).</p>
6.	Immediate action to be taken to provide rents for anganwadis running in private premises as an interim measure, with arrears.	<p>Through the Union Government letter vide no.14-11/2005 where rent prescribed for AWCs have been stated. However, an changes to the same has been looked into by the concerned officials at Secretariat (vide ATR (Letter No.211/SW/2013 dated 22nd June,2013, Annexure 3).</p> <p>This does not address the issue that is recommended.</p>
7.	Immediate action to be taken with respect to supply of pediatric iron and folic acid at angawadi level as well as the same (weekly dose) for adolescents at AW level.	<p>The supply of the pediatric iron and folic acid at AW level is taking place with the convergence of Health Department.</p> <p>IFA and Folic Acid supplements Pediatric, Maternal and for adolescents are to be procured by the Health Dept., all over the state; allocation of 120,368.81 & 935.85 lakhs was approved under the PIP 2012-13 respectively for all three areas. The procurement process for one quarter is already done and the simultaneous process is continued for rest quarters. Due to delay in procurement, the availability was affected in the AWCs but now the accessibility is ensured at AWC level in most districts.</p>

8.	Data to be made available to the commission on staffing gaps currently existing in the supervisory and CDPO cadre and plans to fill these gaps as well as build capacities at these levels	JPSC has been requested to conduct the examination.
9.	Instructions to be given for a special annual Gram Sabha to be held on Nutrition on, PDS, MDM and functioning of AWC.	<p>Jharkhand as a state, Gram sabhas are held where the Scheduled caste is a major part of the populations and not held in areas where there are no scheduled caste population. Due to non-availability of the Gram asbha and presence of Panchayati Raj institutions in each and every area, the dept has made efforts to substantially strengthen the Panchyati Raj institutions for monitoring and evaluation of the functioning of AWC and other related issues of the department. The letter no.2080/s.w , dated 11-12-2012, by the Director, Social Welfare has been issued as an initiative which clearly reflects that rights given to PRIs and further approach to pursue the close collaboration for greater integration between the Dept and PRIs (vide ATR (Letter No.211/SW/2013 dated 22nd June,2013, Annexure 4)</p> <p>Does not respond to recommendation.</p>
10.	AAY cards to distributed to all families of SAM children.	Pending
11.	Since many left out children who were even more likely to require nutritional services were noted in hamlets surrounding anganwadis, the Commission recommends a state-wide survey of hamlets to identify such left out children. As a beginning, the survey may be conducted in the Khuntpani Block of Chaibasa District and results reported to the Commission.	<p>The state owns the 'Jeeva ASha' Programme, which is an integrated program to address SAM and MAM.Under the auspices of the programme, a baseline state wide nutritional survey by a Natioanl level recognised survey agency is being proposed and awaiting the final decision.</p> <p>Does not fulfill the recommendation.</p>

5. Andhra Pradesh

Dr. Vandana Prasad, Member, NCPCR visited Hyderabad during 5th-6th Dec, 2012 and held meetings with state officials of concerned departments to review issues pertaining to child rights in the State.

Sr.No.	Recommendations (vide D.O No. Member(VP)NCPCR/AP/2012/26510 dated 13th Dec, 2012)	Action Taken
1	There is a serious staffing gap at supervisory levels in the ICDS. This needs to be resolved at the earliest along with regularization of contractual staff.	<ul style="list-style-type: none"> • There are 40% of vacancies in the cadre of Supervisors in the cadre of supervisors in the state for the last 3 to 4 years/ This is effecting proper monitoring of AWCs. Due to vacancies of AWWs &AWHs, the service delivery is badly affected. • Efforts are being made to fill up the vacancies of AWWs AWHs & Supervisors at the earliest. 302 Grade – I Supervisors are recruited through the Service Commission in the month of March 2012. Further the Govt. has also given permission to appoint 850 Grade-II Supervisors from the cadre of AWWs. During 2012-13, 1032 &442 posts were filled.
2	The feeding of full meals to pregnant and lactating mothers in 102 projects may be accompanied by full hot cooked meals (HCM) to the attending children as well, in the spirit of the SC orders (IN THE CASE: PUCL v. UOI & Ors. WRIT PETITION (Civil) No. 196 of 2001) related to HCMs for children aged 3-6 yrs who attend anganwadis.	<ul style="list-style-type: none"> • Hot Cooked Meal for 3-6 years children in AWCs of 102 IAH ICDS Projects is being implemented w.e.f March 2013.
3	The Commission has been recommending Community Based Programmes for Management of Malnutrition in children under three years in addition to the strategy of NRCs since NRCs cannot be the solution to lakhs of	<ul style="list-style-type: none"> • Instructions were issued to the field officers to send the list of malnourished children to Medical Officer, PHC for health check – ups and to identify children who need to be referred to NRCs and who require Community Based Management. AWWs are being

	<p>children suffering from severe forms of malnutrition not all of whom need admission in NRCs. Many models and experiences exist which could inform State initiatives in this regards and NCPCR would be pleased to facilitate the exchange of information on the same. If any initiatives have been taken by the State Government, we would like to receive the details.</p>	<p>given training on management of severely malnourished children & counselling to be given to parents.</p>
	<p>There seems to be a data gap between the data being generated by the ICDS and the data available from other surveys and estimates being made by the Health Department and NRHM on the quantum of severe forms of malnutrition in AP. These need to be resolved through joint surveys / analysis of existing data</p>	<ul style="list-style-type: none"> • The data is being shared between Health & Family Welfare Dept and WD&CW Dept., and integrated MIS is being developed to resolve discrepancies in data.
<p>4</p>	<p>The LFM needs to be studied in comparison with the RTE model from the point of view of community participation, acceptability, improvements in livelihoods of mothers, improvements in dietary diversity and impact on child health and nutrition.</p>	<ul style="list-style-type: none"> • A state level SNP Committee was constituted under the Chairmanship of MD, A.P Foods with representatives from NIN, UNICEF, NGOs, Home Science College & Joint Director, ICDS & SNP, WD&CD, Nutrition experts etc., to study the Food models in the state as well as other states. The members of the Committee visited Karnataka, Orissa and few districts in the state in the month of Feb & March 2013. Further, a meeting was also held on 21st March 2013 with the RJDs, PDs, CDPOS, Supervisors and AWWs from each of eth six regions to discuss on the present food models and to seek their views for revision of food models. • The SNP Committee, RJDs,PDs,CDPOs etc., have suggested to revise the present food models as detailed for implementation in all projects. • To develop 2-3 types of food (MTF) for 7m-3 yrs children instead of one type of food as children in this category cannot consume the entire quantity in one sitting. • Hot Cooked Meal with rice, dal, vegetables everyday & 2 Eggs per

		<p>week for 3-6 yrs children in the AWCs to improve acceptability & improve pre-school attendance.</p> <ul style="list-style-type: none"> • Take Home Ration of rice, dal, & oil for pregnant, lactating and adolescent girls.
5	Millets can be considered for use in the LFM since they are high in micronutrients and proteins.	<ul style="list-style-type: none"> • A millet based SNP to 3-6 yrs Pre-school children in 02 ICDS projects ie Seethampeta and S.M Puram of Srikakulam district is being piloted from January with the support of WASSAN (an NGO). • Mothers Committee groups are providing Jowar based SNP to the beneficiaries of 02 ICDS Projects i.e Siricilla and Vemulawada of Karimnagar district. • Efforts are being made to introduce Millets in MTF supplied by AP Foods.
6	Delays in fund flows of the IGMSY are affecting the impact of the scheme and these need to be taken up with the Central Government. NCPCR will meet with the concerned officers to request some streamlining of the fund-flow process.	PENDING
7	It was noted that pediatric formulations of iron supplements in syrup form are not being made available for children under 6 yrs. This needs to be rectified since childhood anemia is widespread and contributes significantly to the situation of malnutrition.	PENDING

6. Puddcherry

Sr.No.	Recommendations	Action Taken PENDING
1.	A rapid survey be undertaken to assess the situation of under threes in the State and whether they are attending AWCs or preschool facilities. This should include (i) number of 3 -6 years enrolled in ICDS; and (ii) budgetary expenditures on HCM in the last 6 months.	
2.	Convergent activities be planned with Department of Education to ensure that HCMs, growth monitoring and health services are available to under threes whatever be their physical location.	
3	Hot cooked meals to be made available to all children attending the AWC regardless of their age since a biscuit is not sufficient to cover a four hour period in the centre.	
4	The ICDS should be put to greater focus on under threes and AW-cum-Creches should be Considered	
5	The ICDS should be able to achieve a greater focus on children of migrants, homeless children and children with disability considering that it does not seem to have onerous responsibilities of handling malnutrition or preschool activities for children 3-6 yrs.	

7. Rajasthan

A visit to the brick kilns of Bhilwara was undertaken on the 8th Jan, 2013 to assess the situation of services relating to nutrition, health, and education being provided for children at the brick kilns.

Sr. No.	Recommendations (D.O.No.Member (VP)/NCPCR/2013/26775-26782 dated 18th Jan 2013)	Action Taken
1.	Registration of all workers; male and female on brick kilns and lists of children to be organized by the labour department	Dpty Lab Commr has noted that there are no provisions for registration and issue of identity cards to brick kiln workers according to any law. However, directions have been issued to all brick kiln owners to issue identity cards to workers working on their brick kilns, from their side.
2.	Additional AWCs to be placed in each brick kiln with more than 40 children under six and mini AWCs to be placed for smaller brick kilns with fewer children.	Directives have been issued by the Dpty Dir, ICDS, Bhilwara to all CDPOs to conduct survey of 0-6 yrs children and to submit proposals for setting up new AWCs.
3.	Schools (with MDMs) to cover all children in brick kilns for ages 6-14yrs either through schools on-site or by providing transport to nearby schools.	Directives issued to carry out survey of children on brick kilns, and to make arrangements for education of all 6-14s. Directives issued for setting up of hostels for migrant children.
4.	Employers to provide space and woman worker for running of crèches which could be supplemented by the ICDS programme to provide the full complement of services to children under 6 yrs.	
5.	ASHAs to be deployed for the population living in brick kilns as per the population norm of 1 per 1000.	
6.	Mobile units to provide primary health care services including curative	Proposals to set up mobile medical units at

	care, immunization , ANC and other RCH services	brick kilns has been submitted to Central Govt. Such services shall commence, subject to approval received. Arrangements have been made to provide teams for health check ups every week to brick kiln areas on a rotational basis. Immunisation of children is being undertaken (Bhilwara district).
7.	Involved districts to carry a specific section on status of children on brick kilns within their District PIPs.	Directives issued by Directorate of Health services, Rajasthan for a specific section on status of children on brick kilns for inclusion in State PIP for monitoring as well as budgetary allocations .(dated 30/1/13)
8.	The State PIP should also have a specific section on status of children on brick kilns within the State PIP to enable planning and monitoring as well as specific budgetary allocations.	
		Directives by Directorate of Health Services- i.) Estimation of pregnant women and children ii.)Estimation of malnourished children and severely malnourished children. iii.)Ensure visit of ANM to all brick kilns for immunization, health checkups, ANC and RCH services made available iv.) Ensure monthly visit of doctor/health officials from PHC to brick kilns.

8. Harayana

The Commission had undertaken a visit to crèches being run by the Construction Workers' Welfare Board in Gurgaon, Haryana on 12.03.13.

Sr. No.	Recommendations (F. No.14/03/2012 NCPCR-(PD)/27009 dated 11 th Feb, 2013 and D.O.No.14/03/2012NCPCR-(PD)/27757 dated 9th April 2013)	Action Taken Vide letter No.HBOCWWB/2013/98 dated 5 th March 2013 and
1.	Sanctioning of crèches through the Board.	The Board in its meeting held on 11.6.2008 had decided to provide crèche facilities for construction workers by establishing removable crèches which would be under the charge of female trained in the care of children and infants. These facilities are presently available in four Worker Facilitation Centres running one each at IMT Manesar, Village Sikandarpur and two in Faridabad.
2.	Setting up of Coordination Cell involving Factory Inspectors and WCD Dept.	The nomenclature of Factory Inspectors has been changed to Assistant Director, Industrial Safety & Health in the State. Creches facility specially for children/kids of female construction workers are required to be set up by an employer at construction sites as per section 35 of BOC Act, 1996. Regular inspections are carried out by the departmental officers of the Labour Det., to ensure their safety and protection, besides the local officers of Dept consult WCD Dept for guidance as and when required for crèche purposes.
3.	A phased manner of universal registration of all construction workers.	Though the field machinery of the Dept is taking all necessary steps to ensure registration of construction workers found working at the construction sites. However, 1.70 lacs (approx) construction workers have been registered so far. Registration of construction workers is a regular and continuous process.
4.	Coordination and collaboration with WCD Dept. for planned and phased setting up of crèches on construction sites.	WCD Dept was consulted at initial stage for setting up of movable crèches for accommodating 30-35 children/kids for giving them food items, cradles, etc in the crèches

		and the Dept. is following guidelines issued by the WCD Dept.
5.	Planning and coordination for training of caregivers etc to be done by WCD Dept.	The filed machinery of the WCD Dept., for imparting training to the female employees deployed in Worker Facilitation Centres being run by the Board has been consulted from time to time for setting up crèches. Four such centres are functioning under the supervision of Dy. Dir, Industrial Safety & Health and the Dy. Dir, Industrial Health –cum-Certifying Surgeon of the area as per guidelines of WCD Dept.
6.	Coordination with WCD Dept for oversight and outreach services including supervision and monitoring , capacity building , health check up, growth monitoring, immunization and referrals.	(Vide Memo No. /SPSU/ICPS/2013 dated nil) Directives issued BY Director General, WCD Dept, Haryana to Dist. Child Protection Officers (ICPS)/Prog.Officers (ICDS), to ensure coordination with Labour Dept for providing capacity building, health check up, growth monitoring, immunization and supervision and monitoring on creches services that they are providing and to also inform then about ICDS services and draft a workable action plan in areas where crèches are. Copy also sent to Director, Education & Labour, Govt. Of Haryana for information and necessary action.
7.	Coordination with SSA/Education Dept to facilitate the admission of older/eligible children in schools.	<p>Letter received (No. HBOCWBB/2013/4215 dated 19th Sept, 2013) from Jt. Dr, HBOCWBB, containing:</p> <p>1.) Proceedings of coordination meeting between Edn. , WCD and Lab Dept. held on 25.04.2013 for provision of crèches for children of construction workers in Haryana-</p> <p>a.)It was decided that a district level coordination cum monitoring committee shall be set up at district Gurgaon and Faridabad. Dist prog officers from WCD</p>
8.	Procedures for opening of crèches /day care centres to be run at the sites identified above be initiated.	
9.	Record keeping related to budgets and food to be maintained for each crèche.	

		<p>Dept, Dist Coordination Officer from SSA and DEEO from Edn Depty, Asst. Dir, IS&H-I &III, Asst. Dir, IH , Secretary District Child Welfare Society shall be members of the Committee.</p> <p>b.) The committee shall be responsible for the requisite co-ordination between all the stake holders, proper supervision and monitoring of all crèches and shall ensure smooth functioning for better services at all the crèches in the dist run by the B&CWFB for the development of children of construction workers.</p> <p>c.) It shall draw up preliminary guidelines and regularly monitor:</p> <ul style="list-style-type: none">• For organising training for all crèche workers• Preparing nutritional food menu as per requirements of eh children• Organising regular health check-up and growt monitoring of crèche children• To ensure older children be sent to schools• To ensure availability of educational material, play toys at all crèches• Maintence of records related to budget & food• To ensure comfortable living atmosphere, cleanliness and good sanitary conditions at all crèches <p>d.) It shall meet at least once in two months and shall submit ATR to Lab. Commissioner, Haryana.</p> <p>e.) It shall also identify the cluster of construction sites and check feasibility for opening more day care centres (crèches) for the children of construction workers and make recommendation to the Welfare Board</p>
--	--	--

		<p>accordingly.</p> <p>2.) Proceedings of meeting held on 16th July, 2013</p> <p>i.) Medical Check up of Children-: A schedule for medical check up of all children in all crèches running on construction sites would be prepared by Asst. Dir, (IH) with the help of ESI Dept and Health Dept.</p> <p>ii.) Nutrition Diets: It was decided that Dist. Child Welfare Officer and Dist Prog Officer, WCD would visit all construction sites for monitoring/coordination and improvement of child development. Asst. Dir (IH) and Dpty. Dir (IS&H) would monitor creches for improvement in providing hygienic conditions of crèches.</p> <p>iii.) A list of construction sites where creches have been provided by employers was submitted.</p> <p>iv.) DEEO, Edn noted that education to children over 4 yrs would be provided free of cost in nearby schools. It was also decided that concerned Asst. Dir will coordinate with DEEO, Edn & SSA Edn frequently. SSA Dept. would provide list of crèches being run by NGOs.</p>
--	--	--

9.Bihar

A visit was undertaken to Patna and Gaya districts (Mohanpur and Barachatti blocks, Gaya) from 9th -11th May 2013 to assess and review programmes of child health and nutrition, education and child protection.

Sr. No.	Recommendations	Action Taken No ATRs received till date
1.	Growth Monitoring: State to provide a report on the current status of functional status of weighing machines in the State and plans to ensure each AWW has a functional weighing machine.	
2.	Materials at the AWCs: there seems to be a general paucity of materials for cooking, serving food, preschool activities at the Anganwadis. The Commission desires a status report on the same.	
3.	Capacity Building of AWWs: The Commission requires to know the current status of training of AWWs	
4.	Since there seems to be an absence of any reliable growth monitoring, the Commission requires to know on what grounds NRCs are receiving children to the NRC.	
5.	A notification must be sent out to all NRCs for ensuring that children are not being discharged while still in a critical state even if they have been admitted for the customary 21 days.	
6.	AWWs to be informed about children being discharged from the NRC through the ICDS system.	
7.	The Commission would like information on any programmes being designed for Community Based Management of Malnutrition in Bihar	

10. Gujarat

The Commission visited Maliya block of Rajkot district and Khavda region of Bhuj, Kutch district (23rd-25th July, 2013) to assess health and educational services for children and in response to specific complaints received.

Sr. No.	Recommendations (Vide Letter D.O. No. Member(VP)/NCPCR/Gujarat/2013/3099-30406)	Action Taken ATRs awaited.
1.	<p>ICDS and Educational Services for children in ‘left-out’ pockets: while Gujarat has achieved a good track record for improving the services for children in general, there are specific geographical areas and communities where large numbers of children are getting marginalized. These include children in urban low-income areas (e.g Bombay hotel, Vatva, Dani Limbda, Narol, Gomtipur), children of migrant workers (e.g salt pan workers, prawn industry workers of Maliya) and geographically distant (Kajarda Block, and Khavda region, Kutch). Since basic services do not exist with a full complement of workers, no data (including nutritional data) is collected for these areas, making them entirely invisible. Thus, a mapping of actual service provision rather than geographical location of infrastructure is critically required, leading to specific action plans that may require specific programming for such pockets. This needs to be facilitated at State level since it may require the State to create area-specific flexible programmes to supplement the national programmes like the ICDS. In particular,</p> <ol style="list-style-type: none"> a. The data of functional anganwadis should be disaggregated to highlight anganwadis without workers. For example, 55 anganwadis exist without workers in Rajkot District. These do not qualify as functional anganwadis since many functions such as preschool education and growth monitoring cannot happen adequately in the absence of a regular AWW. b. It appears that a flexible approach would be required to appoint HR such as anganwadi workers for interim relief to children where regular appointments have been known to be difficult as per current norms and will continue to be difficult for some years to come. A 3- 5 year relaxation 	

	<p>of norms may be required to fill posts in these areas.</p> <p>c. In addition, the Commission recommends a focus on daycare as a strategy to provide an overall umbrella for health, nutrition and early childhood education services in areas with migrant workers. Since this is provided for in the restructured ICDS, a priority may be accorded to these areas. We note that some plans have already been made in this direction (mobile anganwadis etc).</p> <p>d. As a starting point, we request a plan for strengthening ICDS services in Maliya Block of Rajkot District, which could become a pilot for state level action in other such marginalized areas.</p>	
2.	<p>Nutricandy: The Commission noted the daily distribution of Nutricandy in the ICDS programme for children aged 3-6 yrs with concern and recommends a reevaluation of this strategy. The issues are as follows:</p> <p>a. Sugar candy is not a desirable carrier for micronutrients since it promotes a daily State-sponsored usage of an edible with high sugar content which is related to, among other problems, dental caries and a general acculturation towards sweets and junk food.</p> <p>b. There are National Programmes run by the Health Department for Iron and Vitamin A. The Commission is concerned with ensuring that they function optimally and has been working with the Central Ministry to ensure oversight of this issue. In particular, National Programmes are currently offering High Dose Vitamin A to all children aged 9 months to 5 years and we should be delivering Iron through biweekly syrups also (see notice of health ministry attached). In this case, expenditure of approx 23 paise per child per day through a nutritionally dubious route for additional Vitamin A and Iron is an unnecessary overlap. If the Department of WCD is concerned to supplement micronutrients through its own resources as well, it is best placed to do so through adding components of animal-based proteins, fruits and vegetables, as any nutritionist would support,</p>	

	rather than candy.	
3	<p>Take-Home-Ration: We note the State's intention to decentralize the production of THR for the ICDS through SHGs over time, as conveyed by Secretary WCD, though current practice is to source it from private manufacturers. The Commission is concerned that already the funds allocated to THR and SNP are too low to allow for good nutrition for children and that a further extraction of profits by statedly profit-making agencies is not in the best interests of children. Decentralised production has further advantages of improving the economic status of village communities, demonstrating good nutrition to affected communities and potentially stimulating local agricultural production. Of course considerations of quality and safety must be met to a reasonable standard and this can be achieved through building local capacities as some State models have demonstrated. We would like to see a road map towards the ultimate vision of removing profit-making agencies from THR and SNP.</p>	

C. Number of Individual Complaints on Malnutrition from Four States received by the Commission (from 2007 till Date)

S. No.	States	No. of total Cases	Closed Cases	No. of cases (ongoing)
1.	Madhya Pradesh	72	27	45
2.	Maharashtra	4	3	1
3.	Odisha	4	4	0
4.	Jharkhand	1	0	1

Consolidated Policy Recommendations for Seamless Transitions and Continuum of Care in the Context of Malnutrition

I. Health/NRHM

All children presenting with a health problem requiring transfer / referral to another facility must be registered and admitted at the presenting facility, given documented primary medical care, provided with referral slips, and free transport organized before sending out from the premises.

A. NUTRITION REHABILITATION CENTRES (NRCs)

ADMISSION

1. Children should be admitted whenever they arrive based on bed availability and the fixed day approach should be abandoned.
2. The immunisation status of the admitted and accompanying child should be checked and immunisation ensured.
3. A notification / reminder to be sent to all MTCs to ensure that MTC in charges are aware of protocols for babies under 6 months with SAM so that no such babies are refused admission.

FAMILY

1. Accompanying family members (mother and other siblings) of the admitted child should be provided necessary nutrition and health services based on evaluation of nutritional status, including BMI and Hb.
2. Either the cheque system of compensation for daily wage loss is to be abandoned or banking services to open accounts must be provided while the child is admitted at the NRC.
3. All available development and welfare services should be provided to families of children admitted to NRC on a priority basis to ensure that the living conditions of the undernourished child improve.

DISCHARGE

1. In the absence of community based management of malnutrition, a child should be discharged only if there is shift in her nutritional status from < -3 SD to < -2 SD on indicators of underweight and wasting.
2. A discharged child should be provided with 100 days of iron and folic acid tablets and multivitamin tonic as well as the THR due to her from the AWC for the period that she was in the NRC.
3. Transportation costs should be provided for all 4 follow up visits of a discharged child.

NON RESPONDERS

1. Investigate why children were not gaining weight during the period of admission in the NRC.
2. Non-responders at the NRC must be referred for a pediatric opinion and a complete health check up should be conducted of children who do not respond to nutritional rehabilitation.
3. In particular, TB, malaria, HIV and Non Communicable Diseases need to be considered and ruled out for persistent non responders.

STAFF at NRC

1. Human resource needs of the NRC need to be addressed with immediate effect. Every NRC should benefit from the advice of a Paediatrician, especially those serving vulnerable tribal areas. Special efforts should be made to ensure that NRCs in such areas are visited by a Paediatrician on at least a fortnightly basis.
2. Training of staff on specific nutritional requirements of SAM/MAM children must be ensured, so as to enable them to counsel mothers appropriately on matters regarding cooking of food, use of oil, frequency of meals etc for such children.
3. The NRC should be considered as a resource base for leadership & capacity building at the block level for growth monitoring.

B. GENERAL HEALTH SERVICES

1. Clear orders to be sent out that all patients who are serious enough to be referred to a higher facility **must be first registered as in-patients and must be provided with such immediate care as is available at the facility** to which they present. It must be made very clear that simply verbally referring as an out-patient is not an acceptable course of action for a patient who cannot be taken care of at the facility to which he/she presents.
2. It was noted that pediatric formulations of iron supplements in syrup form are not being made available for children under 6 yrs. This needs to be rectified since childhood anemia is widespread and contributes significantly to the situation of malnutrition.
3. Delays in fund flows of the IGMSY are affecting the impact of the scheme and these need to be taken up with the Central Government. NCPCR will meet with the concerned officers to request some streamlining of the fund-flow process.
4. Mobile units to provide primary health care services including curative care, immunization, ANC and other RCH services where it is difficult to set up such services.
5. ASHAs to be deployed as per the population norm of 1 per 1000 even for construction workers and migrant populations, especially where clusters of populations; like those living in brick kilns, can be found.

C. COMMUNITY BASED PROGRAMMES FOR MANAGEMENT OF MALNUTRITION

1. The Commission has been recommending Community Based Programmes for Management of Malnutrition in children under three years in addition to the strategy of NRCs since NRCs cannot be the solution to lakhs of children suffering from severe forms of malnutrition not all of whom need admission in NRCs. Many models and experiences exist which could inform State initiatives in this regards and NCPCR would be pleased to facilitate the exchange of information on the same.
2. **Some immediate actions in this regards could be to create a greater focus amongst ASHA and AWW on growth faltering specially of the under-threes, with advisories to feed THR with increased frequency and with addition of tolerable amounts of oil.** Meanwhile, a state policy for IMM needs to be developed that includes the provision of extra calorie-rich high protein food for children with severe forms of malnutrition within the protocols.
3. **The programmes for Community Based Management of Malnutrition to be offered till the child exits the severe categories of malnutrition.**

II. ICDS

A. INTERVENTIONS WITHIN NUTRITIONAL PROGRAMMES

1. Reconsideration of MUAC as being the sole referral criterion for NRCs and correction of the resultant lack of focus on growth monitoring at AWC level.
2. Hot cooked meals to be made available to all children attending the AWC regardless of their age.
3. Once millets are included in the PDS, they should also be available at subsidy to the programme for use in THR / HCMs since they are high in micronutrients and proteins.
4. Nutricandy: The Commission noted the daily distribution of Nutricandy in the ICDS programme of Gujarat for children aged 3-6 yrs with concern and recommends a re-evaluation of this strategy (see pg 40-41 for rationale).
5. The Commission notes that the current practice in some States is to source THR from private manufacturers. The Commission is concerned that already the funds allocated to THR and SNP are too low to allow for good nutrition for children and that a further extraction of profits by statedly profit-making agencies is not in the best interests of children. We would like to see a road map towards the ultimate vision of removing contractors and profit-making agencies from THR and SNP, in favour of decentralized production by SHGs, or centre-based production.

6. Immediate action to be taken with respect to supply of pediatric iron and folic acid at anganwadi level as well as the same (weekly dose) for adolescents at AW level.

B. PLANNING AND MONITORING

1. Since many left out children who were even more likely to require nutritional services were noted in hamlets surrounding anganwadis, the Commission recommends a state-wide survey of hamlets to identify such left out children.

2. Much more monitoring and supervision needed. Supervisory cadres for the ICDS need to be enhanced in terms of numbers, roles and capacities. **A dedicated desk with an issue expert for nutrition is recommended in districts with high burden of malnutrition for monitoring malnutrition.**

3. The highest priority should be accorded to vulnerable tribal pockets to ensure the provision of all development services and the socio-economic development of communities. This should include:

- a. Mapping & microplanning for additional AWCs for tribal hamlets
- b. Mapping & microplanning for supportive supervision for AWCs in tribal hamlets

4. Expediate the process of building/setting up crèche facilities /*palnaghars*.

a. Urgent establishment of ICDS cum Creche under the ICDS restructuring with special reference to habitations with high numbers of women working in the informal sector, such as brick kilns, construction sites etc.

b. In addition, the Commission recommends a focus on daycare as a strategy to provide an overall umbrella for health, nutrition and early childhood education services in areas with migrant workers. Since this is provided for in the restructured ICDS, a priority may be accorded to these areas. We note that some plans have already been made in this direction (mobile anganwadis etc).

5. A joint survey with local NGOs is recommended for an accurate situational analysis regarding malnutrition in regions with high malnutrition so as to reconcile gaps between official data and NGO surveyed and put fears of under-reporting to rest.

The data of functional anganwadis should be disaggregated to highlight anganwadis without workers. These do not qualify as functional anganwadis since many functions such as preschool education and growth monitoring cannot happen adequately in the absence of a regular AWW.

5. Joint monitoring systems between ICDS and NRHM.

C. HUMAN RESOURCES/ RECRUITMENT OF PERSONNEL

1. Human resource policies at the state level should be reformed to ensure:

- a. Clear TORs for every post that specify accountability
- b. Transparent transfer & placement policy for difficult areas
- c. Incentives for difficult area postings
- d. Appropriate disciplinary action for supervisory lapses

e. Disciplinary action needs to be taken against non attending AWWs and their supervisors. The Commission recommends adherence to norms of selecting AWW workers from same village specially in remote areas.

f. Priority be given to tribal applicants for all fresh appointments to ASHA, AWW, AWW Helper and ANM categories.

g. It appears that a flexible approach would be required to appoint HR such as anganwadi workers for interim relief to children where regular appointments have been known to be difficult as per current norms and will continue to be difficult for some years to come. A 3- 5 year relaxation of norms may be required to fill posts in these areas.

D. INFRASTRUCTURE

1. General development of infrastructure at AWCs. Most were found facing severe space crunch and lacking in infrastructure including electricity, water and toilet facilities. **The Commission would encourage investigation into construction of low-cost anganwadis with better design using local materials and involving gaon panchayats for their design and construction rather than contractors.**

2. Anganwadi centres are not using appropriate storage bins for storing food grains resulting in episodes of food poisoning.

3. There are many financial problems being faced by the State in its attempt to provide good quality meals to children since the costs of transportation, fuel etc have not been separated from the food costs nor linked to inflation. This needs to be taken up at a policy level.

4. Immediate action to be taken to provide rents for anganwadis running in private premises as an interim measure, with arrears.

E. CONVERGENCE BETWEEN ICDS AND NRHM, EDUCATION, LABOUR, TRIBAL WELFARE ETC

1. Joint surveys / analysis of existing data and monitoring by the ICDS and the Health Department and NRHM.
- 2. Joint Tracking component within all nutritional programmes needs to be strengthened. Careful tracking of children with SAM from AWC / VCDC to CTC to NRC and back is required to tackle the issue of non-responders. A software needs to be urgently developed to assist the district to be able to achieve this.**
3. Joint guidelines and trainings for all associated functionaries that deal with children with malnutrition.
4. Convergent activities be planned with Department of Education to ensure that HCMs, growth monitoring and health services are available to 3-6s whatever be their physical location; preschool or anganwadi.
5. Formation of a Convergence Committee/ Coordination Cell with Collector, concerned officials of Education, WCD, Health, Social Justice, Labour Departments, CWC and members of Civil Society.

III.LABOUR

1. Registration of all workers; male and female on brick kilns, construction sites etc and lists of children to be organized by the labour department.
2. Employers to provide space and woman worker for running of crèches under labour laws, which could be monitored and supplemented by the ICDS programme to provide the full complement of services to children under 6 yrs.

IV. PUBLIC DISTRIBUTION SYSTEM

1. Ration cards to distributed to all families of children with severe forms of malnutrition under priority.

V. PANCHAYATI RAJ INSTITUTIONS

1. Instructions to be given for a special annual Gram Sabha to be held on Nutrition on, PDS, MDM and functioning of AWC.

In conclusion, the Commission is pleased to note that some shifts are happening in policy in favour of creating rational programmes that have the potential to offer a seamless continuum of care for children with malnutrition. However, there is a long way to go in terms of realising these on the ground. NCPCR is committed to persevere in its efforts to monitor both policy and programme to this end.

References

1. Dipa Sinha **“Rethinking ICDS: A Rights Based Perspective”**, EPW, Vol. XLI No.34, August 26, 2006.”
2. Government of India (2013), **‘Re-structuring and Strengthening of the ICDS’**
3. GOI (2013a) **“Community Based Management of Children with Severe Acute Malnutrition”**
4. GOI (2011), **“Operational Guidelines on Facility Based Management of Children with Severe Acute Malnutrition”**
5. Government of Maharashtra, Department of Women & Child Development (2005), Rajmata Jijau Mother-Child Health & Nutrition Mission, <http://www.nutritionmissionmah.gov.in>
6. Government of Madhya Pradesh (2012), Presentation on Atal Bal Yojana
7. National Advisory Council (2011) **“Recommendations for a Reformed and Strengthened ICDS”**
8. Prasad, V et al (2012), **“Falling Between Two Stools: Operational Inconsistencies between ICDS and NRHM”**, Indian Pediatrics, Vol 49,181-185
9. Public Health Resource Network (2012), **‘Action Against Malnutrition (AAM)’**, <http://www.phrnindia.org>
10. Working Group on Children Under Six (WGPU6) (2007), **‘Strategies for Children under Six’**, *Economic & Political Weekly*, Vol 42, No.52,87-101
11. <http://www.validinternational.org>

Letters by the Commission:

1. NCPCR (2013a) : **Letter to Secretary, MoWCD, GOI** (Letter D.O.No. Member (VP)/NCPCR/2013/27030 dated 24th Jan, 2013)
2. NCPCR(2013c): **Letter to Secretary, MOHFW, GOI** (Letter D.O.No. Member (VP)/NCPCR//IMM/2013/30893 dated 16thSept, 2013)

3. NCPCR(2013): **Letter to Secretary, MOHFW, GOI** (Letter D.O.No. Member (VP)/NCPCR/26826 dated 18th Jan, 2013)
4. NCPCR (2012a) :**Madhya Pradesh recommendations** (Letter no. F.No,35/8/2012-NCPCR (PD)25793-99 dated 12th Oct, 2012 and D.O No.35/8/2012-NCPCR (PD)/27034 dated 14th Feb,2013)
5. NCPCR (2012b): **Maharashtra recommendations**, (Letter D.O. No. Member (VP)/NCPCR/26038 dated 7th Nov,2012) .
6. NCPCR (2012c): **Jharkhand recommendations**, (Letter F.No. 35/7/2012-NCPCR (PD)/25755-59 dated 5th Oct, 2012)
7. NCPCR (2012d) : **Andhra Pradesh recommendations**, (Letter D.O. No. Member(VP)NCPCR/AP/2012/26510 dated 13th Dec, 2012)
8. NCPCR (2013d): **Rajasthan recommendations** (D.O.No.Member (VP)/NCPCR/2013/26775-26782 dated 18th Jan 2013)
9. NCPCR (2013e): **Puducherry recommendations**, (D.O.No.Member (VP)/NCPCR/Puducherry/2013/27611 dated 18th Jan 2013)
10. NCPCR (2013f) : **Odisha recommendations**, (DO letter No. Member (VP)/NCPCR/Odisha/2013/27855 dated 25th, March, 2013)
11. NCPCR (2013g): **Bihar recommendations**, (D.O.No.Member (VP)/NCPCR/Bihar/2013/29052 dated 1st June 2013)
12. NCPCR (2013h): **Gujarat Recommendations**, (Letter D.O. No. Member(VP)/NCPCR/Gujarat/2013/3099-30406)
- 13.NCPCR (2013i): **Letter to Jt. Secretary, MoWCD** (Letter D.O. No. Member (VP)/NCPCR/2012/27124-27126)
14. NCPCR (2013j): **Letter to Secretary MOHFW**(Letter No. D.O. No. Member (VP)/NCPCR/27096 dated 26th Feb, 2013)
15. NCPCR (2013k) : **Letter to Jt. Secretary, MoWCD, MOHFW** (Letter D.O. No. Member (VP)/NCPCR/27605-07 dated 25th Mar, 2013)

16. NCPCR (2013l) : **Letter to Secretary MOHFW, MoWCD; Jt. Secretary MOHFW, MoWCD**
(Letter No: Member (VP)/NCPCR/IMM/2013 dated 29th April, 2013)

17. NCPCR (2013m): **Haryana Recommendations**, (F. No.14/03/2012NCPCR- (PD)/27009 dated 11th Feb,2013 and F. No.14/03/2012NCPCR- (PD)/27757-59 dated 9th April, 2013)

Annexures

Annexure 1: Letters of the Commission on Integrated Management of Malnutrition

1. NCPCR (2013a) : **Letter to Secretary, MoWCD, GOI** (Letter D.O.No. Member (VP)/NCPCR/2013/27030 dated 24th Jan, 2013)
2. NCPCR(2013c): **Letter to Secretary, MOHFW, GOI** (Letter D.O.No. Member (VP)/NCPCR//IMM/2013/30893 dated 16thSept, 2013)
3. NCPCR (2013i): **Letter to Jt. Secretary, MoWCD** (Letter D.O. No. Member (VP)/NCPCR/2012/27124-27126)
4. NCPCR (2013j): **Letter to Secretary MOHFW**(Letter No. D.O. No. Member (VP)/NCPCR/27096 dated 26th Feb, 2013)
5. NCPCR (2013k) : **Letter to Jt. Secretary, MoWCD, MOHFW** (Letter D.O. No. Member (VP)/NCPCR/27605-07 dated 25th Mar, 2013)
6. NCPCR (2013l) : **Letter to Secretary MOHFW, MoWCD; Jt. Secretary MOHFW, MoWCD** (Letter No: Member (VP)/NCPCR/IMM/2013 dated 29th April, 2013)
7. NCPCR(2013): **Letter to Secretary, MOHFW, GOI** (Letter D.O.No. Member (VP)/NCPCR/26826 dated 18th Jan, 2013)

Annexure 2: State Recommendations

1. NCPCR (2012a) :**Madhya Pradesh recommendations** (Letter no. F.No,35/8/2012-NCPCR (PD)25793-99 dated 12th Oct, 2012 and D.O No.35/8/2012-NCPCR (PD)/27034 dated 14th Feb,2013)
2. NCPCR (2012b): **Maharashtra recommendations**, (Letter D.O. No. Member (VP)/NCPCR/26038 dated 7th Nov,2012).

3. NCPCR (2012c): **Jharkhand recommendations**, (Letter F.No. 35/7/2012-NCPCR (PD)/25755-59 dated 5th Oct, 2012)
4. NCPCR (2012d): **Andhra Pradesh recommendations**, (Letter D.O. No. Member(VP)NCPCR/AP/2012/26510 dated 13th Dec, 2012)
5. NCPCR (2013d): **Rajasthan recommendations** (D.O.No.Member (VP)/NCPCR/2013/26775-26782 dated 18th Jan 2013)
6. NCPCR (2013e): **Puducherry recommendations**, (D.O.No.Member (VP)/NCPCR/Puducherry/2013/27611 dated 18th Jan 2013)
7. NCPCR (2013f): **Odisha recommendations**, (DO letter No. Member (VP)/NCPCR/Odisha/2013/27855 dated 22nd April, 2013)
8. NCPCR (2013g): **Bihar recommendations**, (D.O.No.Member (VP)/NCPCR/Bihar/2013/29052 dated 1st June 2013)
9. NCPCR (2013h): **Gujarat Recommendations**, (Letter D.O. No. Member(VP)/NCPCR/Gujarat/2013/3099-30406)
10. NCPCR (2013m): **Haryana Recommendations**, (F. No.14/03/2012NCPCR- (PD)/27009 dated 11th Feb,2013 and F. No.14/03/2012NCPCR- (PD)/27757-59 dated 9th April, 2013)

Annexure 3: Programme Technical Session on Working Towards Addressing Under-nutrition in the State of Odisha, organised by the State Government on the 9th Oct., 2013 at Bhubaneshwar

Annexure 4: Summons Notice issued to Officials of Govt. of Maharashtra