UNIT 10 NUTRITION POLICY AND PROGRAMMES

Structure

10.1 INTRODUCTION

In Units 7 and 8, we learnt about the various methods of assessment of nutritional status. Unit 9 focused on the concept of monitoring and surveillance of nutritional status. In this unit, we are going to study about the intervention programmes and the policy of the Government of India (GOI), which is designed to ensure good nutritional status of the population.

Widespread poverty resulting in chronic and persistent hunger is the single biggest affliction of the developing world today. In India about 50 percent of the people live below the poverty line and even after spending 80 percent of their income on food, they cannot have a balanced diet. The physical expression of this continuously re-enacted tragedy is the condition of under nutrition. In the face of continuing poverty and malnutrition, a strategy of development, comprising a frontal attack on poverty, unemployment and malnutrition, became a national priority. Various intervention programmes have been launched by the government, to improve the provision of basic services to the poor and to device a security system, through which the most vulnerable section, viz. women and children, could be protected. These programmes are discussed in this unit.

In 1993, the GOI adopted the National Nutrition Policy (NNP), in recognition of the magnitude of under nutrition in the country. The salient feature of the NNP is the other major focus in this unit.

Objectives

After studying this unit you will be able to:

- describe the national nutrition policy;
- enlist the various nutrition intervention programmes launched by the Government; and
- discuss the major features of the nutrition intervention programmes.

10.2 NATIONAL NUTRITION POLICY

The National Nutrition Policy, formulated by the Department of Women and Child Development, Government of India (GOI) was approved by the Cabinet in April 1993 and tabled in both houses of the parliament in August 1993. The policy advocates a *"comprehensive, integrated and inter-sectoral strategy for alleviating the multifaceted problem of malnutrition and achieving the optimal state of nutrition for the people"*. The National Plan of Action on Nutrition (NPAN) was released in 1995 to implement the National Nutrition Policy, which included strategies specifically to address the prevention and control of micronutrient deficiencies.

Let us now review the important aspects of the NNP. These include: a) Aims of NNP, b) Nutrition Policy Instruments and c) Policy implementation. We shall begin with the aims of NNP.

10.2.1 Aims of the National Nutrition Policy

The NNP is based on the conviction that reduction in malnutrition and improvement in nutritional status of the people will contribute significantly to development of human resources and the overall economic and social goals of the country.

The main aims of the NNP are:

- To draw attention to the urgent need to reduce malnutrition in the country

To highlight the need for inter-sectoral coordination to achieve nutritional goals

To orient relevant sectors to perceive nutrition as an outcome of their sectoral activities, and

To identify short term, intermediate and long-term strategies for achieving nutritional goals either through direct policy changes or indirect institutional or structural changes.

Next, let us get to know what nutrition policy instruments have been advocated for achieving these above listed aims.

10.2.2 Nutrition Policy Instruments

Realizing the fact that nutrition is a multi-sectoral issue and needs to be tackled at various levels, the nutrition policy instruments focused on tackling the problem of nutrition both through nutrition interventions, for especially vulnerable groups, as well as, through various development policy instruments that will create conditions for improved nutrition. A direct intervention (short term strategy) and an indirect policy instrument through long term institutional and structural changes were advocated.

Let us then look at the nutrition policy instruments highlighting short and long- term measures.

A. ***Direct Short Term Intervention***

The short-term measures focus on the following strategies:

1. Nutrition intervention for specially vulnerable groups by a) expanding the nutrition intervention net through Integrated Child Development Services (ICDS) so as to cover all vulnerable children in the age group 0-6 years; b) Improving growth monitoring between the age group 0-3 years in particular, with closer involvement of the mothers, in a key intervention; c) Reaching the adolescent girls through the ICDS so that they are made ready for a safe motherhood, their nutritional status is improved and they are given some skill up-gradation training in home-based skills and covered by non-formal education, particularly nutrition and health education; d) Ensuring better coverage of expectant mothers, such coverage to include supplementary nutrition starting from first trimester of pregnancy to the first year after pregnancy.
2. Fortification of essential foods, for example, salt with iodine and/or iron.
3. Production and popularization of low cost nutritious foods from indigenous and locally available raw material, by involving women in this activity
4. Control of micronutrient deficiencies among vulnerable groups - deficiencies of vitamin A, iron, folic acid and iodine among children, pregnant women and nursing mothers.

Next, let us look at the indirect policy instruments.

B. ***Indirect Policy Instruments***

Long Term Institutional and Structural Changes

The long term strategies for achieving the national goals through indirect institutional or structural changes includes:

i) Ensuring food security, a per capita availability of 215kg/person/year of food grains.

ii) Improvement in the dietary patterns by promoting the production and increasing the per capita availability of nutritionally rich foods.

iii) Policies for effective income transfers so as to improve the entitlement package of the rural and urban poor by re-orienting and restructuring the poverty alleviation programmes (like Integrated Rural Development Programme) and employment generation schemes (like Jawahar Rozgar Yojna etc.) to make a forceful dent on the purchasing power of the lowest economic segments of the population and by ensuring an equitable food distribution, through the expansion of the public distribution system (PDS).

iv) Implementing land reforms.

v) Health and Family Welfare.

vi) Basic Nutrition and Health Knowledge, with special focus on wholesome infant feeding practices.

vii) Prevention of food adulteration, by strengthening/gearing up the enforcement machinery.

viii) Nutrition surveillance.

ix) Monitoring of nutrition programmes.

x) Communication through established media for effective implementation of the nutrition policy.

xi) Ensuring an effective, minimum wage administration.

xii) Community participation, by involving the community through their panchayats /beneficiary committees or through actual participation, particularly of women, by promoting schemes relating to kitchen gardens, food preservation etc. and generation of effective demand at the level of the community for all services relating to nutrition.

xiii) Education and literacy, and

xiv) Improvement of the status of women.

The policy states that the measures enumerated above are to be administered through inter-sectoral coordination and activities. Next, we will look at how the National Nutrition Policy is being implemented.

10.2.3 National Policy Implementation

The nodal responsibility at the central level for policy implementation rests with the Ministry of Human Resource Development under the chairmanship of Secretary, Department of Women and Child Development. SectoralMinisteries/Departments concerned like Agriculture, Food, Civil Supplies, Health and Family Welfare, Rural Development, Education and Environment, whose role is crucial for sustainable improvement in nutritional status of the population, are represented on the *Inter-Ministerial Coordination Committee. A National Nutrition Council* is constituted in the Planning Commission with the Prime Minister as its President and concerned Union Ministers, a few State Ministers by rotation, and experts, representatives of non-governmental organizations and grass root leaders (especially women) as its members. Further, the effective implementation of the NNP is dependent to a large extent on the State Governments/Union Territory Administrations and the constitution of State Nutrition Councils.

From the above discussion it must be evident that we have a very comprehensive national nutrition policy in place, which addresses malnutrition through multi sectoral approach. In the next section, we will discuss the nutrition intervention programmes

designed and implemented by government of India. But first let us recapitulate what we have learned so far.

Check Your Progress Exercise 1

1. List the main aims of National Nutrition Policy.

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2. List any two direct short term interventions and two indirect policy instruments of National Nutrition Policy.

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3. NNP is implemented through a multisectoral approach. Elaborate.

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Now that we are aware about the Nutrition Policy, let us get to know about the nutrition programmes being run by the government to combat malnutrition.

10.3 NUTRITION PROGRAMMES: AN OVERVIEW

The National Nutrition Policy, about which we have studied above, was formulated only in 1993. However, prior to that, since the last four decades, Government has launched a variety of nutrition intervention programmes to combat malnutrition. One of the first nutrition programmes launched by the government was the Applied Nutrition Programme (ANP), way back in 1963. Thereafter, numerous programmes have been launched. Some of these programmes are in operation and some are not. Some new programmes focusing on ensuring food security for all and employment-based programmes have also been initiated by the government. We will now study about all these programmes, under the following sections:

— National Nutrition Mission (POSHAN ABHIYAAN)

— Integrated Child Development Services (ICDS) Programme, which remains one of the world's most unique community based, outreach programme for early childhood care and development.

— Food Supplementation Programmes (Mid day Meal Programme and Pradhan Mantri Gramodaya Yojana).

— National Health Mission (NHM)

— Nutrient Deficiency Control Programmes, namely National Prophylaxis Programme for Prevention of Blindness due to Vitamin A deficiency, National Nutritional Anaemia Control Programme, National Iodine Deficiency Disorder (IDD) Control Programme.

— Infant and Young Child Nutrition Programme (IYCN) and Mothers Absolute Affection (MAA).

— Food Security Programmes, namely Public Distribution System (PDS), Antodaya Anna Yojana, Annapurna Scheme, National Food for Work Programme, and

— Self Employment and Wage Employment Schemes, namely Sampoorna Gramin. Rojgar Yojana, Swarnajayanti Gram Swarajgar Yojana and National Rural Employment Guarantee Act 2005 (NREGA)

We shall begin our exhaustive study of these programmes with a discussion on Poshan Abhiyaan.

10.4 NATIONAL NUTRITION MISSION (POSHAN ABHIYAAN)

To deal with the problem of malnutrition on a war footing, Government of India approved setting-up of the National Nutrition Mission (NNM) on November 30th, 2017, which was then renamed as POSHAN Abhiyaan on May 25th, 2018. Poshan Abhiyaan is a flagship programme of the Ministry of Women and Child Development (MWCD) Government of India.

The POSHAN Abhiyaan aims to achieve the following objectives:

- To improve the nutritional status of children (0-6 years), adolescent girls, pregnant women and lactating mothers in a time bound manner over a period of three years beginning 2017-18.
- To reduce the prevalence of anaemia among the young children (6-59 months), women and adolescent girls (15-49 years).
- To reduce the low birth weight during the next three years beginning with 2017-2018.

Major impact:

The programme targets to reduce stunting, undernutrition, anaemia (among young children, women and adolescent girls) and reduce low birth weight by 2%, 2%, 3% and 2% per annum, respectively. Mission would strive to achieve reduction in Stunting from 38.4% (NFHS-4) to 25% by 2022 *(Mission 25 by 2022)*.

Benefits & Coverage:

More than 10 crore people will be benefitted by this programme. All the States and districts are covered in a phased manner i.e. 315 districts in 2017-18, 235 districts in 2018-19 and remaining districts will be covered in 2019-20.

Implementation strategy

The implementation strategy is based on intense monitoring and convergence action plan right upto the grass root level. NNM-POSHAN Abhiyaan is rolled out in three phases from 2017-18 to 2019-20.

10.5 INTEGRATED CHILD DEVELOPMENT SERVICES (ICDS) PROGRAMME

The Integrated Child Development Services is the world's most unique welfare programme, which holistically addresses health, nutrition and development needs of young children, adolescent girls and pregnant/nursing mothers across the life cycle. Launched by the Government of India in 1975-76, in 33 blocks, today, it has expanded to 5652 community development blocks. Currently 7072 projects and 13.46 lakh anganwadi centres (AWC's) are operational.

ICDS contributes not only to the achievement of women and child goals related to health, nutrition and early child development – but also to other primary health care goals and the goals of universal elementary education, as enunciated in the National Plan of Action for Children 1992. Integration of services and consideration of the mother and child as one 'biological unit' are the unique features of this programme. We will look at the 1) objectives, 2) target groups, 3) programme components and, 4)implementation of ICDS. Let us begin with the objectives.

A. Objectives of the ICDS

The ICDS scheme aims at the holistic development of children in the age group of 0-6 years, nursing and pregnant mothers belonging to the most deprived sections of the society. The specific objectives of the ICDS are to:

improve the nutritional and health status of children in the age group of 0–6 years and adolescents,

lay the foundation for proper psychological, physical and social development of the child,

reduce the incidence of mortality, morbidity, malnutrition and school drop-out,

achieve effective coordination of policy and implementation amongst the various departments to promote child development, and

enhance the capability of the mother to look after the health and nutritional needs of the child through proper nutrition and health education.

Let us next learn about the beneficiaries who receives the benefits of the programme. i.e. the target groups.

B. Target Groups

The main beneficiaries of the ICDS programme are:

Children less then 3 years of age

Children between 3-6 years of age

Pregnant and Lactating women

Adolescent Girls (11-18 years) and

All women, 15-45 years of age.

We will now review the services and the components of the ICDS programme.

C. Programme Components and Interventions

ICDS programmes is a package of four major components: Early Childhood Care Education & Development, Care and Nutrition Counsellling, Health Services and Community Mobilisation, Awareness, Advocacy & IEC, as highlighted in the Figure 10.1.

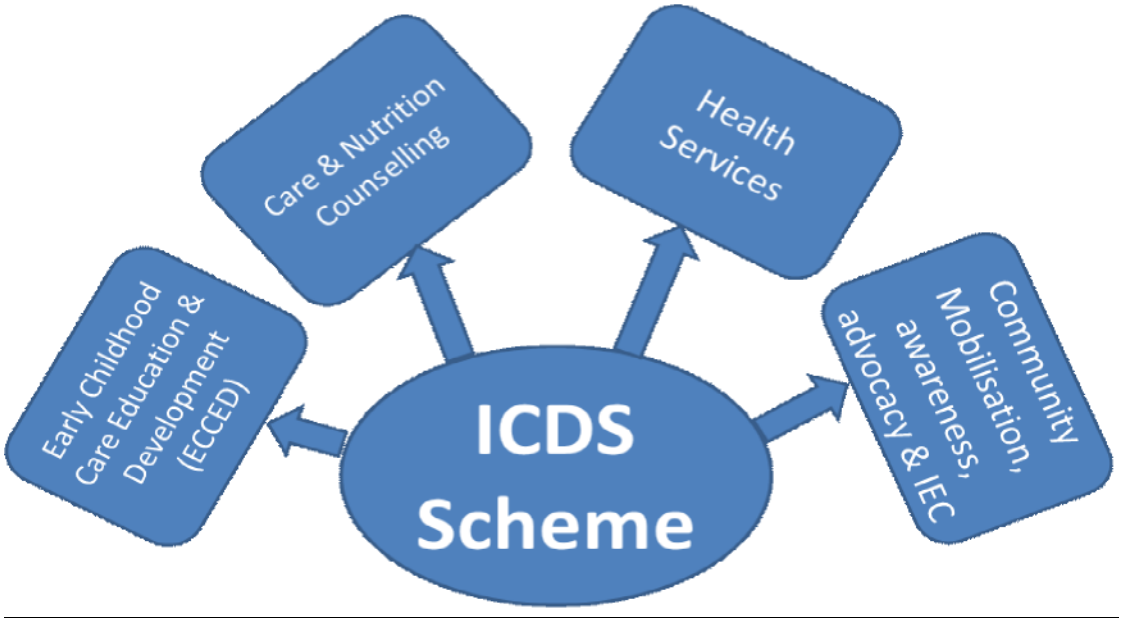

Figure 10.1: ICDS Components

Under each component various services are provided for the target beneficiaries as given in Table 10.1.

Table 10.1: Interventions/Activities of four major components of ICDS

Component 1 - Early Childhood Care Education & Development (ECCED)

Services	Intervention/ Activities
Providing early childhood care and education/Preschool non-formal education	- Provide non-formal preschool education activity based on semi structured play and learning method to channelize child's energy. - Make children school ready with holistic development activities. - Engage with Parents group / Mothers group to enable them train their children through play mode. - Conduct ECCE day–involve NGOs and School teachers in ECCE Days.
Supplementary Nutrition (Bridge between RDA and the Average Daily Intake (ADI) of beneficiaries)	- Provide morning snack, hot cooked meal and Take Home Ratio (THR) as per the following norms: for children aged 6 months - 6 years (supplementary nutrition providing 500 calories and 12-15 g of proteins). - Supplementary nutrition to be ensured for a minimum of 300 days in a year.

Component 2 - Care and Nutrition Counseling

Services	Intervention/ Activities
Infant & Young Child feeding (IYCF) Promotion & Counseling	- Advice on IYCF practices including breastfeeding for first six months of life and appropriate complementary feeding. - One to one counseling through home visits.

	- Advice women on Food intake. - Regular growth monitoring to examine optimal breastfeeding practices.
Maternal Care & Counselling	- Supplementary nutrition to pregnant and lactating mothers to meet calorie/protein gap, providing 600 Kcal and 18-20 g proteins. - Early registration of pregnancy, monitoring weight gain and examination for pallor and oedema and any danger signs. - Lactation support for initiation of breastfeeding through skilled counselors - Counselling and Behaviour Change Communication (BCC) to women regarding: ● Basic Health Care, Nutrition, Maternal Care and healthy food habits ● Appropriate diet, rest and IFA compliance during home visits ● Home based nutrition counselling to women (15 – 45 years), essentials for newborn care and counselling on spacing ● Utilization of health services, family planning and environmental sanitation
Care, Nutrition, Health & Hygiene Education	- Monthly health and nutrition education sessions - Education on improved caring practices – feeding, health and hygiene and psychosocial - Knowledge sharing for care during pregnancy, lactation and adolescence - Promotion of local foods, appropriate food demonstration and family feeding - Celebration of Nutrition week, Breastfeeding week, ICDS day etc. - Weighing of children 0-3 years on monthly basis and 0-6 years children on quarterly basis and maintain growth charts (as per WHO Child Growth Standards) for all children (0-6 years) - Identifying growth faltering and appropriate counselling of care givers on optimal infant and young child feeding and health - Providing joint Mother and Child Protection card to each mother to track the nutritional status, immunization schedule and developmental milestones for both child and pregnant and lactating mothers
Community based care and management of Underweight Children	- 100% Weighing of all eligible children and identification of underweight children - Referral to NRCs/MTCs for children requiring medical attention - 12 day nutritional counseling and care sessions for required children (Sneha Shivirs) &18 day home care and follow up during home visit. - Supplementary nutrition to the Severely Malnourished Children (SAM) (6 months - 72 months) providing 800 Kcal and 20-25 g protein.

Component 3 - Health Services

Services	Intervention/ Activities
Immunization and Micronutrient Supplementation	- Ensure immunization of pregnant women (TT) and infants. - Children (9 months-5 years) to given Vitamin A and Booster Doses as per the national immunization schedule - IFA supplementation (infants after 6 months of age) - Deworming as per guidelines & Counselling - Organizing and conducting fixed day immunization sessions, known as "Village Health Nutrition Days (VHND)" at the AWC
Health Check-up	- Antenatal Care (ANC)/ Post Natal Care (PNC)/Janani Suraksha Yojna (JSY) - Support for Integrated Management of Neonatal & Childhood Illness (IMNCI)/ Janani Shishu Suraksha Karyakram (JSSK) - Identification of severely underweight children requiring medical attention & support - Carry out regular health check-ups, recording weight, immunization, support to community based management of malnutrition, treatment of diarrhoea, deworming and distribution of iron and folic acid and medicines for minor illness. - AWC to control common ailments like fever, cold, cough, worm infestation etc. including medicines and basic equipment for first aid.
Referral Services	- During health check-ups and growth monitoring sessions refer sick and malnourished children as well as pregnant lactating mothers in need of prompt medical attention, to the Health facilities.

Component 4- Community Mobilisation, Awareness, Advocacy & IEC

Services	Intervention/ Activities
IEC, Campaignsand Drives etc.	- Information dissemination & awareness generation on entitlements, behaviours & practices - Sharing of nutritional status of children at Gram Sabhas meetings - Linkage with Village Health Sanitation & Nutrition Committee (VHSNC), Action Groups, Community - Sensitization and engagement of PRIs/SHGs/Mothers. - Social mobilisation campaign in partnership with Song and Drama Division in tribal areas, rural areas. - Use of mainstream media channels like TV, radio, print media, newsletter etc. for propagating good practices of child & women health. - Interpersonal Communication through home visits, the mothers-in-law, mother and other care givers are also sensitised to ensure appropriate care and feeding practices at home.

Having gone through Table 10.1, you would be aware that the main services provided under ICDS are early childhood care, supplementary nutrition, immunization, health check-ups, referral services, growth monitoring etc. Along with all these components ICDS also have provisions for adolescent's girls as summarized in Figure 10.2.

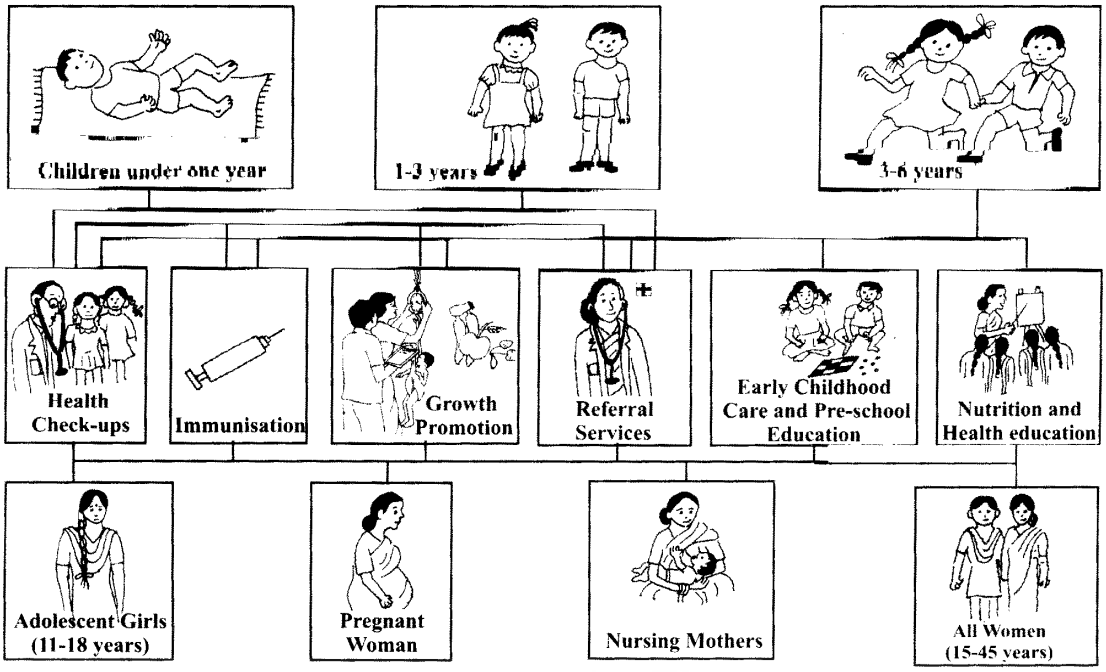

Fig. 10.2: ICDS target groups and components

A brief review about the Adolescents Girls Schemes under the ICDS infrastructure is provided next.

Adolescent Girls Scheme:

The Adolescent Girls (AG) Scheme under ICDS primarily aims at breaking the inter-generational life cycle of nutritional and gender disadvantage and providing a supportive environment for self-development.

The AG Scheme has been revised and renamed as Kishori Shakti Yojna (KSY) and put into operation from November, 1991. The programmes covers all unmarried adolescent girls (11-18 years) whose family's income is below Rs. 6400 per annum as the beneficiaries of the program. Services provided are educational activities through nonformal and functioned literacy pattern, immunization, and general health checkup every 6 months, treatment for minor ailments, deworming, prophylaxis measures against anaemia, goitre, vitamin deficiencies, etc., referral to Public Health Centres (PHC)/district hospital in the case of acute need, and convergence with Reproductive Child Health Scheme.

Another scheme for adolescents has been implemented using the platform of ICDS through anganwadi centres is Rajiv Gandhi Scheme for Empowerment of Adolescent Girls, 'SABLA'.

Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG) or SABLA

SABLA was implemented in the year 2011. It focuses on all out-of-school adolescent girls. The objectives are to enable the adolescent's girls for self development and empowerment, to improve their nutrition and health status, promote awareness about health, hygiene, nutrition, reproductive/sexual health, life skills and tie up with National Skill Development program (NSDP) for vocational skills, mainstreaming out-of-school adolescent girls into formal/nonformal education and to provide information about existing public services (PHC/community health centres/Post office/Bank/Police station).

Services provided are nutrition provision of 600 calories, 18-20 g of protein and micronutrients per day for 300 days in a year, iron and folic acid supplementation, health checkup and referral services: Kishori Diwas, Nutrition and Health Education (NHE), counselling/guidance on family welfare, ARSH, child care practices and home management, life skill education and accessing public services and vocational training for girls aged 16 and above under NSDP.

Besides the adolescent girl, scheme under the ICDS, since 2017, a maternity benefit programme has been implemented in all districts of the country in accordance with the provision of the National Food Security Act, 2013. The programme is named as 'Pradhan Mantri Matru Vandana Yojana (PMMVY), which has been envisaged to be implemented using the platform of Anganwadi service schemes under ICDS. A brief review on PMMVY follows:

Pradhan Mantri Matru Vandana Yojana (PMMVY)

PMMVY is a centrally sponsored scheme, which provides grant-in-aid directly in accounts of pregnant women and lactating mothers (PW/LM) who are the beneficiaries of this programme.

The objectives of PMMVY include:

Providing partial compensation for the wage loss in terms of cash incentives so that the woman can take adequate rest before and after delivery of the first living child.

The cash incentive provided would lead to improved health seeking behaviour amongst the Pregnant Women and Lactating Mothers (PW&LM).

The benefits under PMMVY include:

PW & LM shall receive a cash incentive of Rs 5000-/ in three installments at the different stages as specified in Table 10.2.

Table 10.2: Conditions and Installments for PW/LM enrolled under PMMVY

Conditionalities and installments		
Installments	**Condition**	**Amount (in Rupees)**
First installment	Early registration of pregnancy	1000-/
Second installment	Received at least one ANC (can be claimed after 6 months of pregnancy)	2000-/
Third installment	i. Child Birth is registered ii. Child has received first cycle of BCG, OPV, DPT and Hepatitis-B or its equivalent/substitute	2000-/-

The eligible beneficiaries would receive the remaining cash incentives as per approved norms towards maternity benefit under Janani Suraksha Yojana (JSY) after institutional delivery so that on an average, a woman will get Rs. 6000/- .

D. Programme implementation

The ICDS programme is implemented, at the central level, by the Department of Women and Child Development, Ministry of Human Resource Development in coordination with the Ministry of Health. At the State level, implementation is the responsibility of either the Department of Social Welfare/Women and Child Development/Health or a separate Directorate of ICDS. The programme infrastructure along with the designation of the programme functionaries at the

Block to Village/Community levels is presented in Figure 10.3. The Anganwadi center (AWC) – a courtyard play center – is the symbol of Government systems and services, closest to disadvantaged communities, at village/hamlet level. It is the focal point for converging various government programmes for young children, girls and women from disadvantaged communities. The Anganwadi Worker assumes a pivotal role in the ICDS structure due to her close and continuous contact with the community. As the crucial link between the community and the government administration, she becomes a central figure in asserting and meeting the needs of the community she lives in.

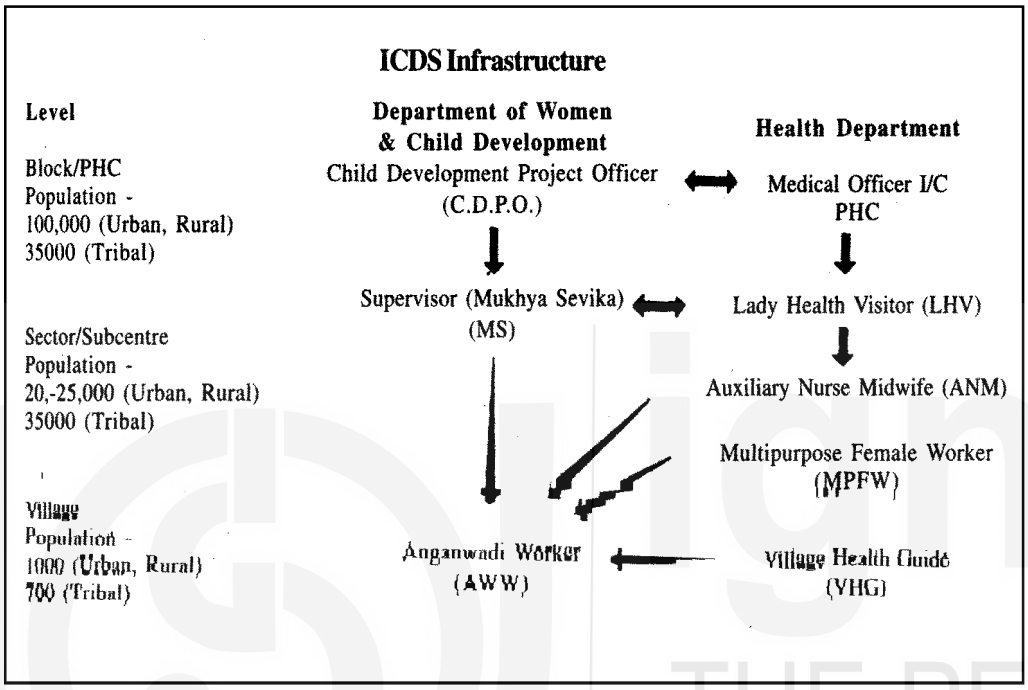

Figure 10.3: ICDS infrastrucure

From our study so far you would have realised that ICDS is a unique and largest programme in the world providing integrated services which holistically address the health, nutrition and development needs of young children, adolescent girls and pregnant/nursing mothers. In the next section, we would discuss the supplementary feeding programmes of the government of India. But first let us answer the questions given in check your progress exercise 2 to assess our learning of this section.

Check Your Progress Exercise 2

1. List the various nutrition programmes launched by our government to combat malnutrition.

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2. Enumerate the goals/objectives of ICDS .

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3. Write the programme components of the ICDS.

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4. What are the objectives of PMMVY?

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10.6 SUPPLEMENTARY FEEDING PROGRAMMES

Food supplementation programmes have a very important role to play combating malnutrition. The aim of these supplementary feeding programmes is to improve the nutritional status of vulnerable groups through distribution of food supplements.

Different types of supplementary feeding programmes have evolved over the years as short-term measures to combat malnutrition. Some of these are on going and some are no longer in operation now. We will study about the following supplementary feeding programmes in this section:

1. National Programme of Nutritional Support to Primary Education (Mid-Day Meal Programme).
2. Pradhan Mantri's Gramodaya Yojana (PMGY)

Let us get to know about these programmes then.

10.6.1 National Programme of Nutritional Support to Primary Education (Mid-Day Meal Programme)

The National Programme of Nutritional Support to Primary Education commonly known as Mid-Day Meal (MDM) programme was launched in August, 1995 consequent to the favourable impact of the scheme on children in some States, as well as, the comfortable food stock position in the country, and to relate primary education with nutrition, health and ICDS.

The mid day meal programme is one of the most important ongoing feeding programmes organized by the Department of School Education and Literacy not only to improve nutritional status of school children but also to attract poor children to school. Further, school age children are in a phase of rapid growth and development. Their nutritional needs are considerable. However, children, particularly from poor families, do not get enough food to eat. Their home diets are often inadequate. Many, especially in rural areas, come to school partly hungry

and some even on empty stomach, trekking long distances. Under such circumstances, they are unable to concentrate on the studies and benefit from the education. Hence, providing a supplement in school would complement the home diet and sustain the interest of children in learning so that drop out rates are lowered and school attendance improves. We would study about the objectives, target group, programme component and strategy of MDM programme. Let us look at the objectives first.

Objectives

The programme is intended to give a boost to universalisation of primary education by increasing enrolment, retention and attendance and simultaneously impacting upon nutritional status of students in primary classes.

Target Group

All students of primary classes (I-V) in the Government, Local Body and Government aided schools in the country are covered in all States/UTs (except Lakshadweep). From October 2002, the programme has been extended to children studying in Education Guarantee Scheme and Alternative and Innovative Education (EGS&AIE) Centres. Private Un-aided schools are not covered under the programme. The main beneficiaries of the programme are therefore school children between 6-11 years of age attending elementary/primary schools. In 2007, GOI extended the mid-day meal scheme to cover children in upper primary class in 3479 Educationally Backward Blocks (EBBS), which was than further revised in 2009-10 to cover the children studying in National Child Labour Project (NCLP) Schools also.

Let us now review the programme component and strategy.

Programme Component

To achieve the above objectives a cooked mid day meal with nutritional content as shown in Table 10.3 is provided to all children studying in classes I – VIII.

Table 10.3: Recommended food amount and nutrient content of MDM/day/ child

Class of the Children	Amount of Food Grain	Calorie Content (Kcal)	Protein Content (g)	Amount of Pulses (g)	Amount of Vegetable (g)	Oil & Fat (g)
I-V (Primary)	100	450	12	20	50	5
VI-VIII (Upper Primary)	150	700	20	30	75	7.5

The food supplements provided through the programme vary from ready-to-eat food like fruit bread etc. to cooked food like 'upma' or 'khichri' or others, which are convenient to eat. In Tamil Nadu, traditional '*rice-sambar*' preparation is used in the programme. In Rajasthan *ghugri* (porridge) is being provided. Whereas, in the State and Delhi a six day cycle menu of cooked foods is being used for MDMP. The raw materials supplied by the international agencies include corn soya meal (CSM), wheat soya blend, soya fortified bulgar (SFB) and salad oil. The programme was conceived for inculcating the qualities of discipline, comradeship, good food and healthy habits and knowledge about nutrition through the provision of nutritious meal daily.

Programme Implementation

The programme is operated by the Department of Education and is being implemented through Panchayats and Nagarpalikas. The feeding is usually carried out within the school premises. The school teacher is responsible for the distribution of food and maintenance of records such as food stock register, health cards and attendance register relevant to the programme. Cook cum helper are responsible for cooking the meals for schools, two cooks-cum-helper for schools with 26 to 100 students and one additional cook-cum-helper for every additional of upto 100 students is provides. The revised guidelines have a provision of financial support upto a maximum of Rs. 60,000/- per shed, for the construction of Kitchen sheds. A one time grant of Rs 5,000/- per school towards assistance for cooking/kitchen devices such as gas stoves with connection, stainless steel water storage tank, cooking and serving utensile, etc. are given. Also, subsidy for transportation of food grains is provided to 11 special category states at PDS rates and up to a maximum of Rs.75.00 per quintal for other than special categories States/UTs.

We will now go over to the next supplementary feeding programme. i.e Pradhan Mantri's Gramodaya Yojana (PMGY).

10.6.2 Pradhan Mantri's Gramodaya Yojana (PMGY)

In order to achieve the objective of sustainable human development at the village level, a new initiative in the form of Pradhan Mantri's GramodayaYojana (PMGY) has been introduced in the Annual Plan 2000-01. This focuses on the creation of social and economic infrastructure in five critical areas with the objective of improving the quality of life of our people specially in rural areas. Schemes related to health, nutrition, education, drinking water, housing and rural roads are undertaken within this programme. The PMGY has two components: Programmes for rural connectivity with 50 percent allocation, and other programmes of primary health, primary education, rural shelter, rural drinking water and nutrition with the remaining 50 percent allocation.

The PMGY envisages allocations for Additional Central Assistance (ACA) for selected basic minimum services in order to focus on certain priority areas including nutrition. The allocation under nutrition component of PMGY, which is essentially meant as an additionality for providing the complete nutritional requirements to all below poverty line (BPL) children in the age group of 6 months to 3 years only, is to be made under the Supplementary Nutrition Programme component of ICDS. The minimum allocation for Nutrition Component is 15% of the Additional Central Assistance for PMGY.

Let us now do an exercise to recapitulate our knowledge.

Check Your Progress Exercise 3

1. Read the following carefully and mention whether true or false and correct the false statement.
   a. Mid day meal programme was launched not only to improve nutritional status of children but also to attract poor children to school.
   b. The department of women and child development operates the mid day meal programme.
   c. The nutrition component of PMGY is to be made under the supplementary nutrition programme component of the ICDS.
2. Enumerate the Programme Component of MDM programme.

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10.7 NUTRIENT DEFICIENCY CONTROL PROGRAMMES

The Government of India has implemented various prophylaxis (preventive) programmes to combat malnutrition. Under these schemes, commercially prepared vitamins and minerals are supplied to vulnerable sections of the population through organized programmes. These programmes are known as Nutrient Deficiency Control Programmes.

The three important ongoing nutrient deficiency control programmes are:

1) National Prophylaxis Programme for Prevention of Blindness due to Vitamin A deficiency

2) National Nutritional Anaemia Control Programme, and

3) National Iodine Deficiency Disorder Control Programme (NIDDCP).

We will now discuss the important aspects of these programmes such as objectives, target group, programme strategy and implementation. Let us begin with the National Prophylaxis Programme for Prevention of Blindness due to Vitamin A deficiency

10.7.1 National Prophylaxis Programme for Prevention of Blindness due to Vitamin A Deficiency

You have read in Unit 3 that Vitamin A deficiency has been recognized to be a major controllable public health nutritional problem. In India, milder forms of vitamin A deficiency affecting conjunctiva, like bitot spots are observed in about 1–5% preschool children. According to WHO, >0.5% prevalence of bitot spot in preschool children is indicative of public health significance. Longitudinal community studies reveal that in some parts of the country, the incidence of corneal xerophthalmia is about 0.5 to 1 per 1000 preschool children. It is estimated that about 30-40,000 children in the country are at risk of developing nutritional blindness every year. In recent years, however, there appears to be a significant change in the profile of vitamin A deficiency. The repeat survey of the National Nutrition Monitoring Bureau (NNMB) carried out in 2011-12 indicated a decline of bitol spot from about 2% in 1975-79 to about 0.2% amongst preschool children. It is, however, important to understand that even mild vitamin A deficiency probably increases morbidity and mortality in children, emphasizing the public health importance of this disorder. Hence, there is a need for the National Prophylaxis Programme for the prevention of Nutritional Blindness due to vitamin A deficiency. Let us look at the objective of the programme.

Objective

The National Prophylaxis Programme for the Prevention of Nutritional Blindness due to vitamin A deficiency aims at protecting children 9 months to 5 years at risk from vitamin A deficiency. Let us look at the target group of the programme.

Target Group

All children, of 9 months to 5 years, particularly those living in rural, tribal and urban slum areas, are beneficiaries of the programme. Next, let us review the programme strategy.

Programme Strategy

The programme focuses on two strategies a) prevention of Vitamin A deficiency and b) treatment of Vitamin A deficiency. Let us study each strategy in detail.

a) *Prevention of Vitamin A Deficiency*

The prevention strategy within the programme comprises a long-term and a short-term intervention. While the short-term intervention focuses on administration of mega dose of vitamin A on periodic basis, dietary improvement is the long-term ultimate solution to the problem of vitamin A deficiency. We will study the long-term intervention first i.e promotion of consumption of Vitamin A rich foods.

i) *Long term intervention-Promoting consumption of vitamin A rich foods*: Actionpoints under this intervention include that:

- Regular dietary intake of vitamin A rich foods by pregnant and lactating mothers and by children under 5 years of age must be promoted,
- The mothers attending antenatal clinics and immunization sessions, as well as, mothers and children enrolled in the ICDS Programme must be made aware of the importance of preventing vitamin A deficiency,
- Breastfeeding including feeding of colostrums must be encouraged,
- Feeding of locally available β-carotene (precursor of vitamin A) rich food such as green leafy vegetables and yellow and orange vegetables and fruits like pumpkin, carrots, papaya, mango, oranges etc. along with cereals and pulses to a weaning child must be promoted widely. In addition, whenever, economically feasible, consumption of milk, cheese, paneer, yoghurt, ghee, eggs, liver etc. must be promoted.

For increasing availability of vitamin A rich food, growing of vitamin A rich foods in home gardens and consumption of these must be promoted.

We will now study the short term intervention i.e. administration of massive dose of vitamin A.

ii) *Short term intervention-administering massive dose of vitamin A :* Administration of massive dose of vitamin A to preschool children at periodic intervals is a simple, effective and most direct intervention strategy. This is a short-term strategy. Unlike most other micronutrients, vitamin A is stored in the body for prolonged periods and hence periodic administration of massive dose ensures adequate vitamin A nutrition.

- Under the massive dose programme, every infant 6-11 months and children 1-6 years is to be administered vitamin A every 6 months. Priority is to be given for coverage of children 9 months to 3 years since the highest prevalence of clinical signs of vitamin A deficiency is reported in this age group. The recommended schedule is as follows:

  9 months — one dose of 100000 IU with measles immunization

  16-18 months — 200000 IU wih DPT booster

  Every 6 months upto 5 years of age - 200000 IU

  Thus, a total of 9 mega doses are to be given from 9 months of age upto 5 years.

  The contact with an infant during administration of measles vaccine at the age of 9 months is considered a practical time for administering the vitamin A supplement

- A camp approach may be used for administering vitamin A to children 1-3 years and 3 - 5 years. However, the DPT/OPV booster in mid-second year to a child is a suitable time for the second dose of

vitamin A (200000 IU). The 9th and 10th plan recommends the administration of Vitamin A drops to children 9 months-36 months of age through RSSK/ICDS system.

We will now study the second strategy i.e. treatment of vitamin A deficiency.

b) *Treatment of Vitamin A deficiency*

All children with clinical signs of vitamin A deficiency must be treated as early as possible. Treatment schedule includes:

— Single oral dose of 200 000 IU of vitamin A immediately at diagnosis

— Follow up dose of 200 000 IU 1-4 weeks later.

Infants and young children suffering from diarrhoea, measles or acute respiratory infections must be monitored closely and encouraged to consume vitamin A rich food. In case, early signs of vitamin A deficiency are observed, the above treatment schedule must be followed. We will now study the implementation strategy of the vitamin A programme.

Implementation Strategy

The National Prophylaxis Programme for the prevention of Nutritional Blindness due to vitamin A deficiency is implemented through the Primary Health Centers and sub-centers. The multi-purpose worker (F) and other paramedicals working in the Primary Health Centers are responsible for administrating vitamin A concentrates to children under 5 years and for imparting nutrition education. The services of ICDS, under the Department of Women and Child Development, Ministry of Welfare, is utilized for the distribution of vitamin A to children in the ICDS Blocks and for the education of mothers on prevention of vitamin A deficiency.

The Mother-Infant Immunization Card/Mother – Child Protection Card is used to record and monitor the administration of vitamin A dose to children under two years. The Growth Monitoring Card/Register used for monitoring the growth of children under the ICDS programme, is used for recording and monitoring administration of vitamin A solution till the age of five years. We will now study the second nutrient deficiency control programme. i.e National Nutritional Anaemia Control Programme.

10.7.2 National Nutritional Anaemia Control Programme/National Iron Plus Initiative (NIPI)

You have read in Unit 3 in nutritional problems that nutritional anaemia is a serious public health problem. Although, anaemia is widespread in the country, it especially affects women in the reproductive age group and young children. It is estimated that over 50 percent of pregnant women are anaemic. Nutritional anaemia, due to iron and folic acid deficiency, is directly or indirectly responsible for about 20 percent of maternal deaths. Recently the NFHS-4 (2015-16) data revealed that 59% of children (6-59 months) had heamoglobin levels below 11 μg/dl, 28% mild, 29% moderate and 2% had sever anaemia. Anaemia is a major contributory cause of high incidence of premature births, low birth weight and perinatal mortality. To reduce the prevalence of anaemia in pregnancy the National Nutritional Anaemia prophylaxis programme of iron and folic acid distribution to pregnant mothers was initiated by Government of India in 1972.

More recently a comprehensive set of actions have been identified in national guidelines for control of iron deficiency aneamia in the form of *National Iron + Initiative (NIPI)*. The NIPI is an attempt to look at iron deficiency comprehending across all life stages including adolescents and women in reproductive age groups.

Let us look at the objectives of the programme.

Objectives

The National Nutritional Anaemia Control Programme aimed at significantly decreasing the prevalence and incidence of anaemia in women in reproductive age group, especially pregnant and lactating women, and preschool children. Let us look at the target group of the programme.

Target Group

The beneficiaries of the programmeincluded :

- Women in the reproductive age group, particularly pregnant and lactating mothers
- Children 1-5 years of age
- Adolescent Girls
- Family planning acceptors (women who accept family planning measures like intrauterine devices (IUD) and tubectomy)

We will now look at the programme strategies.

Programme Strategy

The programme focuses on primarily three strategies: a) Promotion of regular consumption of foods rich in iron b) Promotion of consumption of iron and folic acid supplements to the 'high risk' groups and c) Identification and treatment of severely anaemic cases. We will study each strategy briefly now. Let us start with the first strategy i.e. Promotion of regular consumption of foods rich in iron.

a) *Promotion of regular consumption of foods rich in iron. Various action points under this strategy include:*

- Regular dietary intake of iron and folic acid rich foods by pregnant and lactating women, adolescent girls and children under 5 years of age must be promoted.
- Regular consumption of iron rich foods such as green leafy vegetables (such as mustard leaves(sarsoks sag), amaranth (chaulai sag), colocasia (arbi) leaves, knoll khol greens (Ganth Gobi ka sag), bengal gram greens (chana sag), turnip greens (shalgam ka sag), cereals (such as wheat, ragi, jowar, bajra), pulses, especially sprouted pulses and jaggery (gur) must be promoted widely. In addition, wherever culturally and economically feasible, consumption of animal foods such as meat, liver, poultry etc. must be encouraged.
- Ensure incorporation of iron rich foods such as green leafy vegetables in the weaning foods of infants.
- Vitamin C (ascorbic acid) promotes absorption of iron. Regular consumption of vitamin C rich foods such as lemon, orange, guava, amla, green mango along with iron rich foods must be promoted.
- For increasing availability of iron rich foods, growing of iron rich foods in home gardens and consumption of these must be promoted.
- Tea inhibits absorption of iron. Advice a reduce consumption of tea, specially during pregnancy, for improving the absorption of iron and prevention of anaemia. Let us discuss the second strategy now.

b) *Promoting consumption of iron and folic acid supplements to the 'high risk' groups.*

As a priority, all pregnant women, irrespective of haemoglobin levels, must be provided with the recommended dose of iron and folic acid (folifer) supplements. Preschool children, especially those in tribal areas and ICDS blocks, should be given on priority the recommended dosage of iron and folic acid supplements. The National Iron Plus Initiative (NIPI) aims to reach the following age groups:

1. Bi-weekly iron supplementation for children in the age group of 6–60 months
2. Bi-weekly iron supplementation for preschool children 6 months to 5 years
3. Weekly supplementation for children from 1st to 5th grade in Govt. & Govt. aided schools
4. Weekly supplementation for out of school children (5–10 years) at Anganwadi Centres
5. Weekly supplementation for adolescents (10–19 years)
6. Daily supplementation for pregnant and lactating women
7. Weekly supplementation for women in reproductive age

The recommended doses of folic acid and iron supplements are given in Table 10.4.

Table 10.4: Recommended doses of iron and folic acid supplement

Age Group	Intervention /Dose	Regime	Service Delivery
6–60 months	1ml of IFA syrup containing 20 mg of elemental iron and 100 mcg of folic acid	Biweekly throughout the period 6–60 months of age and de-worming for children 12 months and above.	Through ASHA Inclusion in MCP card
5–10 years	Tablets of 45 mg elemental iron and 400 mcg of folic acid	Weekly throughout the period 6–10 years of age and biannual de-worming	In school through teachers and for out-of school children through Anganwadi centre (AWC) Mobilization by ASHA
10–19 years	100 mg elemental iron and 500 mcg of folic acid	Weekly throughout the period 10–19 years of age and biannual de-worming	In school through teachers and for those out-of-school through AWC Mobilization by ASHA
Pregnant and lactating card women	100 mg elemental iron and 500 mcg of folic acid	1 tablet daily for 100 days, starting after the first trimester, at 14–16 weeks of gestation. To be repeated for 100 days post-partum.	ANC/ ANM /ASHA Inclusion in MCP
Women in reproductive age (WRA)	100 mg elemental iron and 500 mcg of folic acid	Weekly throughout the reproductive period	Through ASHA during house visit for contraceptive distribution

Source: Guidelines for control of Iron Deficiency Anaemia, NRHM, 2013

Let us go over to the third strategy.

c) *Identification and treatment of severely anaemic cases*

Women with haemoglobin levels below 7g/dl are considered to be severely anaemic. Testing of blood for haemoglobin concentration at field level is neither considered safe or practical. Therefore, as far as possible, severely anaemic cases should be identified on the basis of clinical signs. All health workers should be trained to identify such anaemic cases. Further, cases of severe anaemia should be referred to the PHC medical officer for diagnosis of the causative factors and treatment. Recommended therapeutic dose for women in the reproductive age group is three adult tablet per day for a minimum of 100 days. Also albendozole (400 mg) tablet for biannual de-warming for helminthic control is recommended. We will now study how the programme is implemented in the field.

Programme Implementation

The programme is implemented through the Primary Health Centres and its sub-centres under the National Health Mission (about which you will learn in sub-section 10.9). The Multipurpoe Worker (F) and other paramedicals working in the Primary Health Centres are responsible for the distribution of iron tablets (adult and paediatric doses) to the beneficiaries. The functionaries of ICDS programme - such, as anganwadi worker (AWWs) assist in the distribution of iron tablets and for imparting education to mothers on prevention of nutritional anaemia. Department of Food (Ministry of Food and Civil Supplies) is responsible for promoting consumption of iron rich foods. In addition, services of other community level workers and involvement of formal and non-formal education, media, Horticulture Departments and voluntary organizations is utilized for the effective implementation of the programme. In addition, records of under fives and antenatal care maintained under the material and child health services and ICDS programme, is used for identifying beneficiaries as well as for recording and monitoring the distribution of iron and folic acid supplements.

Under NIPI, all children aged 6 to 60 months, receive IFA supplements under the direct supervision of ASHA worker on fixed days on a biweekly basis. ASHA workers are also responsible for the doorstep distribution of IFA supplements to the pregnant women and women in reproductive age group (WRA) on weekly house basis.

We will now study the third nutrient deficiency programme i.e. National Iodine Deficiency Disorders Control Programme (NIDDCP).

10.7.3 National Iodine Deficiency Disorders Control Programme (NIDDCP)

You have read in Unit 3 that Iodine Deficiency Disorders (IDD) form a spectrum of abnormalities which include goitre, mental retardation, deaf mutism, squint, difficulties in standing or walking normally and stunting of the limbs. Iodine deficient women frequently suffer abortions and still births. Their children may be born deformed, mentally deficient or even cretins. All these problems are caused by simple lack of iodine, and goitre is the least tragic of them. No State in India is free from IDD. In India, out of the 239 districts surveyed (in 29 states and union territories), 197 districts have goitre prevalence rates ranging from 10% to 65%. Women in child-bearing age and children under the age of 15 years are most susceptible to IDD. With every passing hour, 10 children are being born in India who will not attain their optimum physical and mental potential due to iodine deficiency. In 1962, the Government of India launched the National Goitre Control Programme (NGCP), which aimed at controlling goitre by supplying and ensuring consumption of iodized salt to the population living in the endemic region. The

Government re-structured the NGCP in 1986, and aimed at achieving the goal for universal iodization of salt to control IDD in India by 1992. The National Goitre Control Programme, referred to as the National Iodine Deficiency Disorders Control Programme (NIDDCP) has now being revised in 2006. The revised NIDDCP aims at universalizing iodisation of all edible salt. Let us now look at the objectives of the NIDDCP.

Objectives

The objectives of the NIDDCP include:

1. Surveys to assess the magnitude of the Iodine Deficiency Disorder.
2. Supply of iodated salt in place of common salt.
3. Resurvey after every 5 years to assess the extent of iodine Deficiency Disorders and the Impact of Iodated salt.
4. Laboratory monitoring of Iodated salt and urinary iodine excretion.
5. Health education and publicity.

The NFHS-4 (2015-16) surveyed the households for the presence of Iodine in their salts. Among the households in which salt was tested, 93 percent had iodized salt, much higher as reported in NFHS-3 where only 76 percent were using iodized salt. Among the states, the use of iodized salt is lowest in Andhra Pradesh (82%), Tamil Nadu (83%), and Dadra & Nagar Haveli (71%). Overall, the private sector handles 94% of salt iodisation with the public sector handling a miniscule 6%. The level of iodization has been fixed at 30ppm of iodine in salt at the manufacturing level and 15ppm at the household level by the Goverment. To ensure exclusive use of iodized salt in endemic areas, the sale of non iodized salt is being discouraged nationally. Let us look at the target population for NIDDCP.

Target Group

Entire population, particularly women in child bearing age and young children.

Now, let us look at the implementation strategy.

Implementation strategy

The NIDDCP is executed by a multiplicity of agencies comprising the health, Industry and Railway Ministeries of the Central Government. The Ministry of Health and Family Welfare and Directorate General of Health Services (DGHS) is responsible for the national implementation of the programme. The Salt Department, under the Ministry of Industry, is the nodal agency for production, distribution, monitoring and quality control of iodised salt. The Salt Commissioner, in consultation with the Ministry of Railways, arranges for the movement of iodized salt from the production center to the States. The State Government is responsible for the distribution of the iodized salt within the state either through the Public Distribution System or through the open market. For effective implementation of the NIDDCP, a central IDD Cell is established at the DGHS level and is responsible for coordinating surveys, training, monitoring and management of the IDD programme. All the states/UTs have been advised to set up IDD Control Cell.

Thus, you saw that government has very well conceptualized and formulated programmes to combat micronutrient deficiency in our country.

Now, let us check our learning by answering the questions included in the check your progress exercise 4 given next.

Check Your Progress Exercise 4

1. List the various nutrient deficiency control programmes? Enumerate the objectives of any one of the programmes.

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2. Explain the dietary actions you would take to promote foods rich in Vitamin A.

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3. Mention the dosage of iron and folate, supplement for pregnant and preschool children and dosage of vitamin A for infants and pre-schoolers.

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10.8 INFANT AND YOUNG CHILD NUTRITION PROGRAMME (IYCN)

Since long, efforts have been carried out to implement optimal breastfeeding and complementary feeding practices to achieve a healthy nutritional status among infants and young children in our country. In this section we will learn two initiatives specific to IYCN.

10.8.1 Infant and Young Child Feeding (IYCF) Guidlines

Recent times, after the adoption of the Global Strategy on Infant and Young Child Feeding by the 55th World Health Assembly in May 2002, and adoption of the Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Amendment Act, 2003 by the Parliament in June 2003, National Guidelines on Infant and Young Child Feeding were formulated by the Department of Women and Child Development. These guidelines are aimed at creation of a movement among State Governments, district authorities, national institutions and social organizations for achieving optimal infant and young child feeding practices in the country. Let us look at the objectives of National Guidelines on Infant and Young Child Feeding (IYCF).

The objectives of the National Guidelines on IYCF are:

- to advocate the cause of infant and young child nutrition and its improvement through optimal feeding practices nationwide
- to disseminate widely the correct norms of breastfeeding and complementary feeding from policy making level to the public at large in different parts of the country in regional languages

- to help plan efforts for raising awareness and increasing commitment of the concerned sectors of the Government, national organizations and professional groups for achieving optimal feeding practices for infants and young children
- to achieve the national goals for Infant and Young Child Feeding practices so as to achieve reduction in malnutrition levels in children

A summary of the norms defined under the IYCF guidelines are presented in the Box 1.

Box 1	**Norms for Infant and Young Child Feeding**
➢	Initiation of breastfeeding immediately after birth, preferably within one hour.
➢	Exclusive breastfeeding for the first six months i.e., the infants receives only breast milk and nothing else, no other milk, food, drink or water.
➢	Mother should communicate, look into the eyes, touch and cares the baby while feeding.
➢	Appropriate and adequate complementary feeding from six months of age while continuing breastfeeding.
➢	Continued breastfeeding up to the age of two years or beyond.
➢	WHO growth charts recommended for monitoring growth.

Some of the important strategies of appropriate infant and young child feeding practices are highlighted herewith:

a) **Breastfeeding:**

- Breastfeeding (BF) should be promoted as the gold standard feeding options.

b) **Complementary nutrition:**

- Appropriately thick homogenous complementary foods home-made from locally available foods should be introduced at six completed months while continuing breastfeeding.
- Each meal must be made energy dense by adding sugar / jaggery and ghee/butter/oil.
- Adequate total energy intake should be ensured by addition of one to two nutritious snacks between the three main meals.
- Consistency of foods should be appropriate to the developmental readiness of the child in munching, chewing and swallowing.
- Easily available, cost-effective seasonal uncooked fruits, green and other dark colored vegetables, milk and milk products, pulses/ legumes, animal foods, oil/ butter, sugar/ jaggery may be added in the staples gradually.
- Foods can be enriched by making a fermented porridge, use of germinated or sprouted flour and toasting of grains before grinding. The details of food including; texture, frequency and average amount are summarized in Table 10. 5.
- Hygienic practices are essential for food safety during all the involved steps viz. preparation, storage and feeding.

Table 10.5: Amounts of foods to offer to an infant and young child

Age	Texture	Frequency	Average Amount Each Meal
6-8 months	Start with thick porridge, well mashed foods	2-3 meals per day plus frequent BF	Start with 2-3 tablespoon full
9-11 months	Finely chopped or mashed foods, and food stuff that baby can pick up	3-4 meals plus BF. Depending on appetite offer 1-2 snacks	½ of a 250 ml cup/bowl
12-23 months	Family foods, chopped or mashed if necessary	3-4 meals plus BF. Depending on appetite offer 1-2 snacks	¾ to one 250 ml cup/bowl

Some of the key recommendations related to infant and young child feeding are summarized in Box 2.

Box 2	Key Messages Related to Infant and Young Child nutrition

- Initiation of breastfeeding as early as possible after birth, preferably within one hour
- Exclusive breastfeeding in the first six months of life and no other foods or fluids.
- Appropriate and adequate complementary feeding after completion of six months. Complementary foods should not be confused with supplementary foods.
- Hand washing with soap and water at critical times– including before eating or preparing food and after using the toilet.
- Avoid junk food. Home food should be preferred over artificial, commercial, tinned or packaged food.
- Promote and establish Human Milk Banks.
- Full immunization and Vitamin-A supplementation with deworming.
- Effective home based care and treatment of children suffering from severe acute malnutrition.
- Adequate nutrition and anaemia control for adolescent girls, pregnant and lactating mothers.
- Effective implementation and monitoring of IMS Act and other laws related to child nutrition.

10.8.2 Maternal Absolute Affection (MAA)

A nationwide programme named MAA was launched on 5th August, 2016, in an attempt to bring undiluted focus on promotion of breastfeeding, in addition to the ongoing efforts through the health system. The goal of the MAA programme is to revitalize efforts towards promotion, protection and support of breastfeeding practices through health systems to achieve higher breastfeeding rates. Let us look at the objectives of the MAA programme.

The following are the objectives of the programme in order to achieve the above mentioned goals:

1. Build an enabling environment for breastfeeding through awareness generation activities, targeting pregnant and lactating mothers, family members and society in order to promote optimal breastfeeding practices. Breastfeeding, to be positioned as a important intervention for child survival and development.
2. Reinforce lactation support services at public health facilities through trained healthcare providers and through skilled community health workers.
3. To incentivize and recognize those health facilities that show high rates of breastfeeding along with processes in place for lactation management.

Components of MAA programme include:

- *Awareness generation* – Building and enabling environment and demand generation through mass media, mid media and community.
- *Community level activities* – Capacity building of community health workers-ASHAs, AWWs , ANM's on breastfeeding and community dialogue through mothers' meeting conducted by ASHA. Trained ANMs at sub-centres for providing skilled care in the communities.
- *Health facility strengthening* – Capacity building of ANMs/nurses/doctors – at all delivery points. Role re-enforcement regarding lactation support services.
- *Monitoring* – Recognition for best performing baby friendly facilities.

Check Your Progress Exercise 5

1. Enumerate the Norms for Infant and Young Child Feeding.

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10.9 NATIONAL HEALTH MISSION (NHM)

The National Health Mission (NHM) was launched in 2013 subsuming the National Urban Health Mission to provide quality health services. The Mission adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, education, society and gender equality, sanitation, hygiene and safe drinking water. NHM is proposed to cover the entire country with special focus on 18 States including 8 Empowered Action Group (EAG) (Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttaranchal and Uttar Pradesh), identified to have weak public health indicators and /or weak health infrastructure.

The major goals of NHM can be enlisted as:

- To reduce MMR to 1/1000 live births
- To reduce IMR to 25/1000 live births
- To reduce TFR to 2.1
- Prevention and reduction of anaemia in women aged 15–49 years,
- Prevent and reduce mortality & morbidity from communicable, non-communicable; injuries and emerging diseases,

- Reduce household out-of-pocket expenditure on total health care expenditure
- Reduce annual incidence and mortality from Tuberculosis by half 8
- Reduce prevalence of Leprosy toreduce prevalence of Leprosy to <1/ 10000 population and incidence to zero in all districts
- Annual Malaria Incidence to be <1/1000
- Less than 1 per cent microfilaria prevalence in all districts
- Kala-azar Elimination by <1 case per 10000 population in all blocks

Some of the major initiatives under National Health Mission (NHM) are as follows:

Accredited Social Health Activists

Community Health volunteers called Accredited Social Health Activists (ASHAs) have been engaged under the mission for establishing a link between the community and the health system. ASHA is the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services in rural areas. ASHA Programme has increased the utilization of outpatient services, diagnostic facilities, institutional deliveries and inpatient care.

Untied Grants to Sub-Centres

Untied Grants to Sub-Centers have been used to fund grass-root improvements in health care. Some examples include:

- Improved efficacy of Auxiliary Nurse Midwives (ANMs) in the field that can now undertake better antenatal care and other health care services.
- Village Health Sanitation and Nutrition Committees (VHSNC) have used untied grants to increase their involvement in their local communities to address the needs of poor households and children.

National Iron + Initiative (NIPI)

The National Iron + Initiative is an attempt to look at Iron Deficiency Anaemia in which beneficiaries receive iron and folic acid supplementation irrespective of their Iron/Hb status. This initiative work with existing programmes (IFA supplementation for: pregnant and lactating women, and; children in the age group of 6–60 months) and introduced new age groups as given in Table 10.3 under section 10.7.2.

Various programmes related to women and children health have also been included under the NHM. These programmes are briefly discussed here:

10.9.1 Reproductive, Maternal, New-born, Child and Adolescent Health Programme (RMNCH+A)

This is a comprehensive programme for improving the maternal and child health under National Health Mission (NHM). Earlier programme naming Reproductive and Child Health (RCH 1) launched in 1997-98, targeted only two components i.e. women and children. Later, it was realized that reproductive, maternal and child health cannot be addressed in isolation as these are closely linked to the health status of the population in various stages of life cycle importantly adolescents. Therefore, a new programme called Reproductive, Maternal, New-born, Child and Adolescent Health (RMNCH+A) was formulated in 2013, which includes integrated service delivery in various life stages i.e. adolescence, pre-pregnancy, childbirth and postnatal period, childhood and through reproductive age. Some of the major goals and components established during initiation of the programmes are listed below:

Goals established in the 12th Five Year Plan

- Reduction of Infant Mortality Rate (IMR) to 25 per 1,000 live births by 2017
- Reduction in Maternal Mortality Ratio (MMR) to 100 per 100,000 live births by 2017
- Reduction in Total Fertility Rate (TFR) to 2.1 by 2017

Components of health care under RMNCH+A includes:

For Adolescents and women in reproductive age health care

- Adolescent nutrition, iron and folic acid supplementation
- Facility-based adolescent reproductive and sexual health services (Adolescent health clinics)
- Information and counsellling on adolescent sexual reproductive health and other health issues
- Menstrual hygiene and preventive health checkups.
- Prevention and management of sexually transmitted and reproductive infections (STI/RTI)
- Comprehensive abortion care (includes MTP Act)
- Community-based promotion and delivery of contraceptives

For maternal and child health care

- Immediate essential newborn care and resuscitation
- Delivery of antenatal care package and tracking of high-risk pregnancies
- Postpartum care for mother and newborn
- Home-based newborn care and prompt referral
- Facility-based care of the sick newborn
- Integrated management of common childhood illnesses (diarrhoea, pneumonia and malaria)
- Child nutrition and essential micronutrients supplementation (IFA, Vitamin A)
- Immunizations
- Early detection and management of defects at birth, deficiencies, diseases and disability in children (0–18 years)

Let us move on to the next pogramme which is initiated for the adolescents i.e. Rashtriya Kishor Swasthya Karyakram.

10.9.2 Rashtriya Kishor Swasthya Karyakram (RKSK)

In order to ensure holistic development of adolescent population, the Ministry of Health and Family Welfare launched Rashtriya Kishor Swasthya Karyakram (RKSK) on 7th January 2014, to reach out to 253 million adolescents - male and female, rural and urban, married and unmarried, in and out-of-school adolescents with special focus on marginalized and undeserved groups. The programme expands the scope of adolescent health programming in India - from being limited to sexual and reproductive health to ambit nutrition, injuries and violence (including gender based violence), non-communicable diseases, mental health and substance misuse. The strength of the program is its health promotion approach. It is a paradigm shift from the existing clinic-based services to promotion and prevention and reaching adolescents in their own environment, such as in schools, families and communities.

As a part of the scheme, promotion of menstrual hygiene among adolescent girls in the age group of 10-19 years primarily in rural areas has also been initiated. Under the scheme, knowledge about menstrual hygiene, access and use of good quality sanitary napkins and safe disposal of sanitary napkins, are being provided. Also, there is a provision for providing sanitary napkins packs at subsidized rate (Rs 1/napkin, Rs 6 for a pack of 6 napkins) to the rural adolescent girls by the ASHA workers on monthly basis.

Additionally, weekly Iron-Folic acid Supplementation (WIFS) programme for school going adolescent is being scaled up in the entire country. WIFS programme offers an opportunity for imparting education on self and family care to adolescent girls. The iron supplementation (100 mg elemental iron and 500 mcg folic acid using a fixed day approach) is to be administered to adolescent of 6th to 12th class (boys and girls aged 10 to 19 years) through school health programme. Biannual deworming (Albendozole 400 mg) is also provided for control of helminthic infestation.

10.9.3 Janani Suraksha Yojna (JSY)

JananiSurakshaYojna was proposed under NRHM by modifying the existing National Maternity Benefit Scheme (NMBS). Earlier the scheme provide cash assistance to pregnant women from Below Poverty Line (BPL) families for better diet. While under JSY cash assistance is linked to antental care during pregnancy, institutional care during delivery and immediate post-partum period in a health centre. This is coordinated by a village level health worker. JSY is a 100% centrally sponsored scheme.

- To reduce maternal mortality ratio and infant mortality rate.
- To increase institutional deliveries among BPL families.

10.9.4 Janani Shishu Suraksha Karyakram (JSSK)

It was launched on 1st June 2011 to assure free service to all pregnant women and sick neonate accessing public health institution. The scheme envisage free and cashless servces to pregnant women including normal deliveries and caesarean operations and also tratment of sick newborn (up to 30 days after birth) in all government health institutions across all State/UTs. Entitlements would include free drugs and consumables, free diagnostics, free blood whereever required, and free diet for the duration of a women's stay in the facility, expected to be three days in case of normal delivery and seven in case of a caesarean section. Similar entitlements have been put in place for all sick newborns. They would also be entitled to free treatment besides free transport, both ways and between facilities in case of a referral.

With this we end our study about NHM. Now, let us check your learning by answering the quesions given in the check your progress excercise 6.

Check Your Progress Exercise 6

1. Enumerate the goals/objective of NHM.

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2. What are the components of child health care under RMNCH+A

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3. What are the main goals of Janani Suraksha Yojna (JSY).

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10.10 FOOD SECURITY PROGRAMMES

Food security as you may recall studying in Unit 2 refers to access by all people at all times to enough food for an active and healthy life. It is now well recognised that the availability of food grains is not a sufficient condition to ensure food security to the poor. It is also necessary that the poor have sufficient means to purchase food. The capacity of the poor to purchase food can be ensured in two ways – by raising the incomes or supplying food grains at subsidized prices. While employment generation programmes attempt the first solution, the public distribution system (PDS) is the mechanism for the second option. Our government has made consistent efforts to improve availability of food for poor. Besides the PDS, other programmes such as, the Antyodaya Anna Yojna (AAY), the Annapurna Scheme, National Food for Work Programme (NFFW) has also been launched. Let us learn about these programmes, here in this section. We shall begin with the PDS and TPDS.

10.10.1 Public Distribution System (PDS) and the Targeted Public Distribution System (TPDS)

A well targeted and properly functioning Public Distribution System (PDS) is an important constituent of the strategy for poverty alleviation. PDS continues to be a major instrument of Government's economic policy for ensuring food security to the poor. With a network of more than 4.62 lakh fair price shops (FPS) distributing commodities worth more than Rs 30,000 crore annually to about 160 million families, the PDS in India is perhaps the largest distribution network of its kind in the world. For effective functioning of PDS, the Central Government bears the responsibility for procurement and supply of foodgrains namely, wheat and rice, besides sugar, imported edible oils and kerosene to the State governments and the Union Territories for distribution. Some States /UTs distribute additional items of mass consumption also through the PDS outlets.

The PDS as it was being implemented earlier, had been widely criticized for its failure to serve the population *Below the Poverty Line* (BPL), its urban bias, limited coverage in the States with high concentration of the rural poor and lack of transparent and accountable arrangements for delivery. Therefore, in June 1997, the Government of India launched the *Targeted Public Distribution System* (TPDS) with aim to provide subsidized food and fuel to the poor through a network of ration shops. On December, 2012, National Food Security Act, 2013 was launched. The Act provided statutory backing for improving TPDS.

Under the new system a *two tier subsidized* pricing system has been introduced to benefit the poor. The essential features of TPDS are: Government of India is committed to provide available foodgrains to the States to meet the requirement of foodgrains at the scale of 10 Kg per month per family at specially subsidized prices to population falling below the officially estimated poverty line (BPL families). The states would also receive the quantity needed for transitory allocation to Above Poverty Line (APL) population. The state governments to streamlined the PDS by issuing special cards to BPL families and selling essential articles under TPDS at specially subsidized prices, with better monitoring of the delivery system.

The BPL households were determined on the basis of population projections of the Registrar General of India for 1995 and the State wise poverty estimates (1993-94) of the Planning Commission for 1993-94. In 2013, 4.09 crore BPL families and 11.52 crore APL families were entitled for the subsidized food grains such as wheat and rice. Also states have the discretion to provide other commodities like sugar, kerosine and fortified atta under TPDS.

Keeping in view, the consensus on increasing the allocation of foodgrains to BPL families, and to better target the food subsidy, Government of India increased the allocation to BPL families from 10 Kg to 35 Kg of foodgrains per family per month. The allocation of APL families has also been revised and increased from 15 to 35 kg of food grain per family.

The end retail price is fixed by the States/UTs after taking into account margins for wholesalers/retailers, transportations charges, levies, local taxes etc. Under the TPDS the States are requested to issue food grains at a difference of not more than 50 paise per Kg over and above the Central Issue Price (CIP) for BPL families. Flexibility to States/UTs. has been given in the matter of fixing the retail issue prices by removing the restriction of 50 paise per Kg over and above the CIP for distribution of foodgrains under TPDS except with respect to Antyodaya Anna Yojana (AAY) where the end retail price is to be retained at Rs. 2/- Kg. for wheat and Rs. 3/- Kg. for rice. We shall learn about the AAY scheme in a little while from now.

For identification of BPL families under TPDS, Gram Panchayats and Nagar Palikas are involved. While doing so the thrust is to include the really poor and vulnerable sections of the society such as landless agricultural labourers, marginal farmers, rural artisans/craftsmen such as potters, tapers, weavers, black-smith, carpenters etc. in the rural areas and slum dwellers and persons earning their livelihood on daily basis in the informal sector like potters, rickshaw-pullers, cart-pullers, fruit and flower sellers on the pavement etc. in urban areas.

Scale and Issue Price

The scale of issue under *APL, BPL* and *AAY* has been revised to 35Kg per family per month with effect from 1.4.2002 with a view to enhancing the food security at the household level

10.10.2 Antyodaya Anna Yojana (AAY)

Antyodaya Anna yojana has been launched by the Hon'ble Prime Minister of India on the 25th December, 2000. This scheme reflects the commitment of the Government of India to ensure food security for all and create a hunger free India in the next five years and to reform and improve the Public Distribution System so as to serve the poorest of the poor in rural and urban areas. It is for the poorest of poor that the Antyodya AnnaYojana has been conserved. It is estimated that 5% of population are unable to get two square meals a day on a sustained basis through out the year. Their purchasing power is so low that they are not in a position to buy food grains round the year even at BPL rates. It is this 5% of out population (5 crores of people or 1 crore families) which constitutes the target group of Antyodaya Anna Yojana.

Scale and Issue Price

Antyodaya Anna Yojana contemplates identification of one crore families out of the BPL families who would be provided food grains at the rate of 35 Kg per family per month. The food grains are issued by the Government of India @ Rs.2/- per Kg for wheat and Rs. 3/- per Kg for rice. The Government of India suggests that in view of abject poverty of this group of beneficiaries, the State Government may ensure that the end retail price is retained at Rs.2/-per Kg for wheat and Rs.3/-

per Kg for rice and Rs. 1 for course grain. AAY families can also buy 1 kg of sugar at a rate of 18.50 / kg via ration shops.

Identification of Beneficiaries

The most crucial element for ensuring the success of AAY is the correct identification of Antyodaya families. It is estimated that there are 4.09 crore families below poverty line in the country as on year 2013. These families are being provided food grains under the TPDS at highly subsidised rates. One croreAntyodaya families would constitute about 15.33% of the BPL families in the country. The identification of these families are carried out by the State Government / UT administrations, from amongst the number of BPL families within the state.

Issue of Ration Cards

After the identification of Antyodaya families, distinctive ration cards to be known a "Antyodaya Ration Card" are issued to the Antyodaya families by the designated authority. The ration card have the necessary details about the Antyodaya family, scale of ration etc.

In the Union Budget 2005-06, the AAY has been expanded to cover 50 lakh BPL households. As on 30.04.2009, 242.75 lakh AAY families have been covered by the States/UTs.

Finally, let us get to know about the Annapurna Scheme.

10.10.3 Annapurna Scheme

The Annapurna scheme aims at providing food security to meet the requirement of those Senior Citizens who though eligible have remained uncovered under the National Old Age Pension Scheme (NOAPS). Under the Annapurna Scheme, *10 Kg of food grains per month are to be provided 'free of cost' to the beneficiary*. The number of persons to be benefited from the Scheme will, in the first instance, be 20% of the persons eligible to receive pension under NOAPS in States/Union Territories. The National Old Age Pension Scheme (NOAPS), launched in 1995, seeks to provide pension from Rs. 250 to 1500 depending on the different states. As per the data of 2014-15 the number of beneficies under this scheme are 928333.

Who are eligible for this scheme and how are they identified? Let's find out next.

Eligibility Criteria

Central assistance under Annapurna Scheme is provided to the beneficiaries fulfilling the following criteria:

a. The age of the beneficiary (male or Female) should be 65 years or above.

b. The benificiary must be "destitute" in the sense of having little or no regularmeansof subsistence from his/her own source of income or through financial support from family members or other sources. In order to determine destitution, the criteria (if any) currently in force in the State/UTs could also be followed.

c. The beneficiary should not be in recipient of pension under the NOAPS or State Pension Scheme.

d. The beneficiery should not be AAY/BPL category ration card holder.

Identification of Beneficiaries

a. The Gram Panchayat is required to identify, prepare and display list of persons eligible to receive benefits under the annapurna Scheme, after giving wide

publicity to the Scheme. The Panchayat is also responsible for the distribution of the *Entitlement Card* to beneficiaries, the dissemination of information about theScheme and the procedure for securing benefits under the same. The Municipality is responsible for the above activities in the implementation of the scheme in their respective areas. The State Government communicates the targets for "Annapurna" to the Panchayat and municipalities for identification of the beneficiaries.

Next, who is responsible for implementation of this scheme? The following paragraph highlights this aspect.

Implementing Authorities

a. The Department of Public Distribution, Union Ministry of Consumer Affairs and Public Distribution ensures the supply of required quantities of prescribed quality food grains from the godowns of the Food Corporation of India (FCI) to the agency designated by the State Government.

b. At the State level, the State Department of Public Distribution (Departments of Food, Civil Supplies and Consumer Affairs) and at the District level, the Collector/District Magistrate/Chief Executive Officer, Zila Panchayat is squarely responsible for the implementation of the scheme. The state Food, Civil Supplies and Consumer Affairs Department will purchase the food grains from the Food Corporation of India on payment of economic cost and will ensure that the FCI supplies the food grains to the district as per district-wise allocation decided by the state within the overall allocation of the State concerned. The Collector/CEO, through the District Officers of the State Food, Civil Supplies and Consumer Affairs Department is responsible for ensuring the availability of food grains atthe District level and for distributing the same through the Network of Fair Price Shops under the Targeted Public Distribution System (TPDS). The Collector/CEO makes arrangement for the distribution of food grains and issue the Entitlement Cards through the Panchayat/Municipalities and ensurethatthe beneficiaries covered under Annapurna are not receiving any old age pensions.

10.10.4 National Food for Work Programme (NFFWP)

The National Food for Work Programme has been conceived with the objective to provide additional resources apart from the resources available under the Sampoorna Grameen Rozgar Yojana (SGRY) (about which we shall study in the next section) to 150 most backward districts of the country so that generation of supplementary wage employment and providing of food-security through creation of need based economic, social and community assets in these districts is further intensified. The NFFWP is open to all rural poor who are in need of wage employment and desire to do manual and unskilled work. The programme is self-targeting in nature.

Distribution of foodgrains as part of wages under the NFFWP is the focus of the programme and based on the principle of protecting the real wages of the workers besides improving the nutritional standards of the families of the rural poor. Under the scheme, foodgrains are given as part of wages to the rural poor at the rate of 5 Kg per man per day. More than 5 kg foodgrains can be given to the labourers under this programme in exceptional cases subject to a minimum of 25% of wages to be paid in cash. The State Governments will take into account the cost of foodgrains paid as part of wages, at a uniform BPL rate. The workers will be paid the balance of wages in cash, such that they are assured of the notified Minimum Wages.

The programme initially covered 150 most backward districts of the country and provided additional supplementary wage employment through creation of need-based economic, social and community assets. Works relating to water conservation, drought proofing and land improvement, flood control and rural connectivity of all-weather roads are taken up to create wage employment. The Centre provides food grains and cash component to the states to generate additional wage employment. Distribution of foodgrains to the workers under the programme is either through PDS or by the Village Panchayat or implementing agency or any other Agency appointed by the State Government. Distribution of foodgrains is made to the workers, most preferably, at the work site. Now, the programme has been subsumed with the NREGA, about which you will learn under the section 10.11.

With this we end our study about the programmes being run by the government to ensure adequate availability of foodstuffs for the poor. In addition to the programmes discussed above there are a few employment schemes linked with food security. We will review a few of these next.

10.11 SELF EMPLOYMENT AND WAGE EMPLOYMENT SCHEMES

Poverty alleviation and employment generation programmes have been in operation for several years. The specifically designed anti-poverty programmes for generation of self employment and wage employment in rural areas have been redesigned and restructured to improve their efficacy/impact on the poor and ensuring food security. Some of these programmes are discussed in this section.

10.11.1 Sampoorna Gramin Rojgar Yojana (SGRY)

The Sampoorna Gramin Rojgar Yojana (SGRY) was launched by the Government of India on 1st September, 2001 to attain the objective of providing gainful employment for the rural poor. The Yojana was started merging the provisions of Employment Assurance Scheme (EAS) and Jawahar Gram Samridhi Yojana (JGSY). The scheme has provision for women, scheduled castes, scheduled tribes and parents of children from hazardous occupations, while preference is given to the families under BPL. The scheme is self targeting in nature. Under the scheme the food grains are distributed to the labourers as a part of wages at the BPL rate.

The *main objective* of the scheme is to give the security to the rural poor and create a water conservation/watersheds, roads and small infrastructures by generating the employment for poverty alliviation through the employment and foodgrains. Generation of supplementary employment for the unemployment poor in the rural area is the focus of the scheme.

The SGRY is available for all the rural poor (BPL and APL), who are in need of wage employment and are willing to take up manual on unskilled works in an around his/her village and habitation. The programme is implemented as a Centrally Sponsored Scheme on cost sharing basis between the Central and State in the ratio of 75:25.

Next, we move on to the Swarna jayanti Gram SwarozgarYojna.

10.11.2 Swarnajayanthi Gram Swarozgar Yojana (SGSY)

The initial Scheme Swarnajayanti Swarozgar Yojana (SGSY) was launched in 1999, which was renamed as National Rural Livelihood Mission (NRLM) in 2011, and then finally merged by Deen Dayal Antyodya Yojana (NRLM-DAY) in November, 2015.

The yojana aims at reducing urban poverty by improving livelihood opportunities through skill training and skill upgradation for self-employment, subsidized bank

loans for setting up micro-enterprises, organising urban poor into self-help groups, among others.

The objective of DAY is skill development of both urban and rural India as per requisite international standards. Since the inception (2014 to 2018) skills has been imparted to 4.54 lakh urban poor, giving employment to one lakh (22%) such people.

DAY-NRLM integrates various agencies - District Rural Development Agencies, banks, line departments, Panchayati Raj Institutions, Non-Governmental Organizations (NGOs) and other semi-government organizations.

10.11.3 National Rural Employment Guarantee Act 2005 (NREGA)

NREGA was started in 2006, renamed as the "Mahatma Gandhi National Rural Employment Guarantee Act" (or, MGNREGA), is an Indian labour law and social security measure that aims to guarantee the 'right to work'. It aims to enhance livelihood security in rural areas by providing at least 100 days of wage employment in a financial year to every household whose adult members volunteer to do unskilled manual work. NREGA was started in 2006, renamed as the Mahatma Gandhi National Rural Employment Guarantee Act (or, MGNREGA), is an Indian labour law and social security measure that aims to guarantee the 'right to work'. It aims to enhance livelihood security in rural areas by providing at least 100 days of wage employment in a financial year to every household whose adult members volunteer to do unskilled manual work.

It is "the largest and most ambitious social security and public works programme in the world". The main objective of MGNREGA is to "enhancing livelihood security in rural areas by providing at least 100 days of guaranteed wage employment in a financial year, to every household whose adult members volunteer to do unskilled manual work" and to create durable assets (such as roads, canals, ponds, wells).

With this we end our study of the food security and the wage employments schemes. Do answer the check your progress exercise given herewith. This will help you recapitulate what you have learnt so far.

Check Your Progress Exercise 7

1. Fill in the blanks:
   a. ……. is the main food subsidy programmes implemented by the government to provide food security to poor people in India.
   b. ……. and …… are the local bodies involved in the identification of BPL families.
   c. …. Yojana launched on 25the December, 2000 serves the poorest of the poor in rural and urban area.
   d. Distribution of food grains is done as a part of wages under the programme ……..
   e. The implementing authority of Annapurna Scheme at the state level is …… of public distribution.
2. Why were the Food Security Programme sinitiated. List the various Food Security programmes initiated in our country?

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3. Enumerate the working of the PDS. Also mention the highlights of TPDS.

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4. Who are the beneficiaries of Annapurna Scheme? Discuss the criteria for being eligible for this scheme.

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5. List the salient features of National Food for Work Programme.

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10.12 LET US SUM UP

In this unit we studied that the Government of India has undertaken several measures in alleviating the problems of malnutrition in the country. Some of these include formulation and implementation of National Nutrition Policy and various nutrition intervention programmes like Integrated Child Development Services Scheme, nutrient deficiency control programmes and supplementary feeding programmes. The National Nutrition Policy advocates a "comprehensive, integrated and inter-sectoral strategy for alleviating the multifaceted problem of malnutrition and achieving the optimal state of nutrition for the people". The Integrated Child Development Services is the world's most unique welfare programme, which holistically addresses health, nutrition and development needs of young children, adolescent girls and pregnant/nursing mothers across the life cycle. The three important ongoing Nutrient deficiency control programmes are: 1) National Prophylaxis Programme for Prevention of Blindness due to Vitamin A deficiency 2) National Nutritional Anaemia Control Programme, and 3) National Iodine Deficiency Disorder (IDD) Control Programme. These programmes aim towards reduction/elimination of vitamin A deficiency, iron deficiency anemia and iodine deficiency disorders respectively. Mid Day Meal Programme is one of the most important ongoing supplementary feeding programmes organized by the Department of Education. It is aimed at not only to improve the nutritional status of school children but also to attract poor children to school. In addition to these progtrammes the programmes linked to food security and wage employment such as PDS, food for work programme, SGRY and DAY were alco described.

10.13 GLOSSARY

Intrauterine device : A birth control device, such as a plastic or metallic loop, ring, or spiral, that is inserted into the uterus to prevent implantation.

Mahilamandal : Women's group formed to carry out specific activities

10.14 ANSWERS TO CHECK YOUR PROGRESS EXCERCISES

Check Your Progress Exercise 1

1. The main aims of the NNP are:

   - The draw attention to the urgent need to reduce malnutrition in the country.
   - To highlight the need for inter-sectoral coordination to achieve nutritional goals.
   - To orient relevant sectors to perceive nutrition as an outcome of their sectoral activities, and
   - To identify short term, intermediate and long-term strategies for achieving nutritional goals either through direct policy changes or indirect institutional or structural changes.

2. The two direct short-term interventions of Nutrition Policy Instruments are.

   a. Fortification of essential foods, for example salt with iodine and / or iron.

   b. Production and popularization of low cost nutritions foods from indigenous and locally available raw material, by involving women in this activity.

   The two indirect policy instruments of Nutrition policy are:

   i. Ensuring food security, a per capita availability of 215Kg/ person/ year of food grains

   ii. Improvement in the dietary patterns by promoting the production and increasing the per capita availability of nutritionally rich foods.

3. The nodal responsibility at the central level for policy implementation rests with the Ministry of Human Resource Development under the chairmanship of Secretary, Department of Women and Child Development. Sectoral Ministries/ Departments concerned like Agriculture, Food, Civil Supplies, Health and Family Welfare, Rural Development, Education and Environment, who role is crucial for sustainable improvement in nutritional status of the population, are represented on the Inter-Ministerial Coordination Committee. A National Nutrition Council is constituted in the Planning Commission with the Prime Minister as is President and concerned Union Ministers, a few State Ministers by rotation, and experts, representatives of non-governmental organizations and grass root leaders especially women) as its members. Further, the effective implementation of the NNP is dependent to a large extent on the State Governments/ Union Territory Administration and the constitution of State Nutrition Councils.

Check Your Progress Exercise 2

1. The various nutrition programmes include: Integrated Child Development Services Programme (ICDS), Nutrient Deficiency Control Programmes namely National Prophylaxis Programme for Prevention of Blindness due to Vitamin A deficiency, National Nutritional Anaemia Control Programme, National Iodine Deficiency Disorder (IDD) Control Programme, Food Supplementation Programmes like the Special Nutrition Programme (SNP), Balwadi Feeding Programme, Composite Nutrition Programme and Applied Nutrition Programmes. Food Security Programmes, namely Public Distribution System (PDS), Antodaya Anna Yojna, Annapurna Scheme, National Food for Work programme and the Self Employment Programmes, linked to Food security namely Swaranjayanti Gram Swarozgar Yogana, Sampoorna Gramin Rojgar Yogana.

2. The major objectives of ICDS are:

   - To improve the nutritional and health status of children in the age group 0-6 years and adolescents.
   - Lay the foundation for proper psychological physical and social development of the child.
   - Reduce the incidence of mortality, morbidity, malnutrition and school drop-out.
   - Achieve effective coordination of policy and implementation amongst the various departments to promote child development.
   - Enhance the capability of the mother to look after the health and nutritional needs of the child through proper nutrition and health education.

3. Programme components of ICDS's scheme are supplement Nutrition, immunization,periodic health and check-ups, treatment of minor ailments and referral services, growth monitoring, non-formal pre-school education, health andnutrition education, adolescent girls scheme, safe drinking water.

4. Objectives of PMMVY

   To improve the health and nutrition status of Pregnant and Lactating (P & L) women and their young infants by:

   - Promoting appropriate practices, care and service utilization during pregnancy, safe delivery and lactation.
   - Encouraging women to follow (optimal) Infant and Young Child Feeding (IYCF) practices including early and exclusive breastfeeding for the first six months.
   - Contributing to better enabling environment by providing cash incentives for improved health and nutrition to pregnant and lactating women.

Check Your Progress Exercise 3

1. a) True

   b) False. The MDM programme is operated by department of education

   c) True

2. The major components of the MDM programme in food supplementation, this consists of:

   — 100/150 g of food grains (wheat or rice) per child per school day where cooked meals are served; 3/4.5 kgs food grains per student per month where food grains are distributed.

   — Transport subsidy up to maximum Rs.75 per quintal for movement of food grains from the nearest FCI depot to schools.

   — Food grains (wheat/rice) is supplied through FCI the cost of which is reimbursed at BPL.

Check Your Progress Exercise 4

1. The various nutrient deficiency control programmes are:

   a. National Prophylaxis Programme for Prevention of Blindness due to vitamin A deficiency.

   b. National Nutritional Anaemia Control Programme.

   c. National Iodine deficiency Disorders Control Programme (NIDDCP).

The objectives of NIDDCP are:

The objectives of the NIDDCP include:

- Surveys to assess the magnitude of the Iodine Deficiency Disorder.
- Supply of iodated salt in place of common salt.
- Resurvey after every 5 years to assess the extent of iodine Deficiency Disorders and the Impact of Iodated salt.
- Laboratory monitoring of Iodated salt and urinary iodine excretion.
- Health education and publicity.

2. Various dietary actions one would take to promote foods rich in iron include:

   - Regular dietary intake of vitamin A rich foods by pregnant and lactating mothers and by children under 5 years of age must be promoted
   - The mothers attending antenatal clinics and immunization sessions, as well as mothers and children enrolled in the ICDS Programme must be made aware of the importance of preventing vitamin A deficiency
   - Breastfeeding including feeding of colostrums must be encouraged
   - Feeding of locally available B-carotene (precursor of vitamin A) rich food such as green leafy vegetables and yellow and orange vegetables and fruits like pumpkin, carrots, papaya, mango, oranges etc. along with cereals and pulses to a weaning child must be promoted widely. In addition, whenever, economically feasible, consumption of milk, cheese, paneer, yoghurt, ghee, eggs, liver etc. must be promoted.

3. Dosage recommended for pregnant and preschool children for iron are as follows:

   a. Pregnant Women: One big (adult) tablet per day for 100 days (each tablet containing 60 mg/100 mg of elemental iron of 500 mcg folate, in the first trimester of pregnancy.

   b. Preschool Children (1-5 years): One paediatric (small) tablet containing 20mg iron and 100 mcg folic acid daily for 100 days every year.

The recommended dosage of vitamin A for the pregnant and pre-school childrenis:

a. Infants (6-11 months): one dose of 100000IU every 6 months

b. Preschool children: a dose of 200000IU every 6 months

Check Your Progress Exercise 5

Norms for Infant and Young Child Feeding:

- Initiation of breastfeeding immediately after birth, preferably within one hour.
- Exclusive breastfeeding for the first six months i.e., the infants receives only breast milk and nothing else, no other milk, food, drink or water.
- Mother should communicate, look into the eyes, touch and cares the baby while feeding.
- Appropriate and adequate complementary feeding from six months of age while continuing breastfeeding.
- Continued breastfeeding up to the age of two years or beyond.
- WHO growth charts recommended for monitoring growth.

Check Your Progress Exercise 6

1. The main goals of NHM are:
   - To reduce MMR to 1/1000 live births
   - To reduce IMR to 25/1000 live births
   - To reduce TFR to 2.1
   - Prevention and reduction of anaemia in women aged 15–49 years
   - Prevent and reduce mortality & morbidity from communicable, non-communicable; injuries and emerging diseases
   - Reduce household out-of-pocket expenditure on total health care expenditure
   - Reduce annual incidence and mortality from Tuberculosis by half 8
   - Reduce prevalence of Leprosy toreduce prevalence of Leprosy to <1/10000 population and incidence to zero in all districts
   - Annual Malaria Incidence to be <1/1000
   - Less than 1 per cent microfilaria prevalence in all districts
   - Kala-azar Elimination by <1 case per 10000 population in all blocks
2. Components of child health care under RMNCH+A include:

   For Adolescents and women in reproductive age health care

   - Adolescent nutrition, iron and folic acid supplementation
   - Facility-based adolescent reproductive and sexual health services (Adolescent health clinics)
   - Information and counsellling on adolescent sexual reproductive health and other health issues

- Menstrual hygiene and preventive health checkups.
- Prevention and management of sexually transmitted and reproductive infections (STI/RTI)
- Comprehensive abortion care (includes MTP Act)
- Community-based promotion and delivery of contraceptives

For maternal and child health care

- Immediate essential newborn care and resuscitation
- Delivery of antenatal care package and tracking of high-risk pregnancies
- Postpartum care for mother and newborn
- Home-based newborn care and prompt referral
- Facility-based care of the sick newborn
- Integrated management of common childhood illnesses (diarrhoea, pneumonia and malaria)
- Child nutrition and essential micronutrients supplementation (IFA, Vitamin A)
- Immunisations
- Early detection and management of defects at birth, deficiencies, diseases and disability in children (0–18 years)

3. The goals of Janani Suraksha Yojna (JSY) are:
   - To reduce maternal mortality ratio and infant mortality rate.
   - To increase institutional deliveries among BPL families.

Check Your Progress Exercise 7

1. a. PDS/TPDS
   b. Gram Panchayat, Nagar Palikas
   c. Antyodaya Anna
   d. National Food for Work
   e. State Department

2. The Food Security programmes were initiated in order to give access to all people enough food for an active and healthy life. It aimed at the concept of food security, that is to remove the imbalance between demand and supply.

   The various food security programmes are:

   i) Antyodaya Anna Yojana (AAY)

   ii) Annapurna Scheme

   iii) National Food for Work Programme

3. The PDS is an essential part of the GOI to alleviate poverty in our country, and in turn ensure food security. The backbone of the PDS is the extensive network of 4.62 lakh Fair Price Shops (FPS) that distributes essential commodities such as, whaet, rice, sugar, imported edible oil and kerosene worth more than 30,000 crore annually to160 million families.

The main highlights of the TPDS are as follows:

a. The commitment of the GOI to meet the requirement of food grains at the scale 10 kg per month at specially subsidized rates for BPL families.

b. The provision to states, a transitory allocation to Above Poverty Line (APL) population.

c. The issuing of special cards to BPL families and selling essential articles under TPDS at subsidized rates, thus streamlining the PDS.

4. The beneficiaries of Annapurna Scheme are the senior citizens who have remained uncovered under the new Age Pension Scheme (NOAPS). The eligibility criteria for this scheme is –

   a. the age of beneficiary should be 65 years or above,

   b. the beneficiaries must be a destitute.

   c. The beneficiary should not be in receipient of pension under the NOAPS or State Pension Scheme.

5. The salient features of National Food for Work programmes are:

   — to provide additional resources apart from the resource available under Sampoorna Grammen Rozgar Yojana (SGRY) to 150 most backward districts.

   — Distribution of food grains as part of wages under the WFFWP is also one of the focus of this programe.