Govandi Nagar North East and Malad West visit Report, Mumbai
Maharashtra
11th March, 2011

National Commission for Protection of Child Rights

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Introduction

Place visited : Mumbai, Maharashtra

Dates of Visit : 11th March 2011

Purpose:

1. NCPCR while taking a *suomotu* cognizance on the news item which appeared in the New Delhi Edition of the Hindustan Times on the subject cited 16 children under six died of Malnutrition and related diseases in Mumbai in one slum dated 13/12/2010. The other complaint pertaining to the AWCs that appeared in Mumbai edition of Navbharat Times pertaining to Children under threat of poisonous food dated 10/02/2011. The Maharashtra Government was advised repeatedly to inform regarding the status of children in these AWCs. However, considering the gravity of the situation, Commission decided to physically visit the place and enquire into the facts.

Number of places visited on :

1. AWCs
   - No. 50, 84 and 95
   - AWC Gate No. 7 at Malwadi Complex, Malad West

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India today is one of the most malnourished countries of the world as reported by NFHS 3. As the world approaches the 2015 deadline for achieving the MDGs – which include a goal of reducing the proportion of hungry people by half – the 2010. GHI offers a useful and multidimensional overview of global hunger. The 2010 GHI shows some improvement over the 1990 GHI, falling by almost one-quarter. Nonetheless, the index for hunger in the world remains at a level characterized as "serious." The result is unsurprising given that the overall number of hungry people surpassed 1 billion in 2009, even though it is decreased to 925 million in 2010, according to the FAO of the United Nations[1].

However, eradicating hunger remains a key challenge. Malnourishment is also an indicator of food insecurity. In 1990 when the MDGs were formulated 53.5% of all Indian children were malnourished. Since then, progress has been slow. In India the proportion of underweight children below three years has declined to 46% in 2005-06 while the MDGs has set up the target of half of 53.5%.[2]

Among children under three years in the State of Maharashtra, the prevalence of underweight is 39.7%, stunting is 37.9% and wasting is 14.6%[3]. Overall the child nutritional status is slightly better than the national average; however the wasting indicator alone is over 10% which is the WHO threshold for recommended management of moderate and severe acute malnutrition through supplementary and therapeutic feeding programs[4].

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[1]International Food Policy Research Institute, 2010 Global Hunger Index, The challenge of hunger: Focus on the crisis of child undernutrition, http://www.ifpri.org/publication/2010-global-hunger-index

[2] United Nations Development Programme, http://www.undp.org.in/mdgs/eradicate_extreme_poverty_and_hunger

[3] NFHS 3, 2005-06

[4] Mother, Infant and Young Child Nutrition and Malnutrition, Nutrition Component of the Child Development Centre (CDC) Programme in Maharashtra, India, http://motherchildnutrition.org/india/pdf/mcn-child-development-centre-maharashtra.pdf

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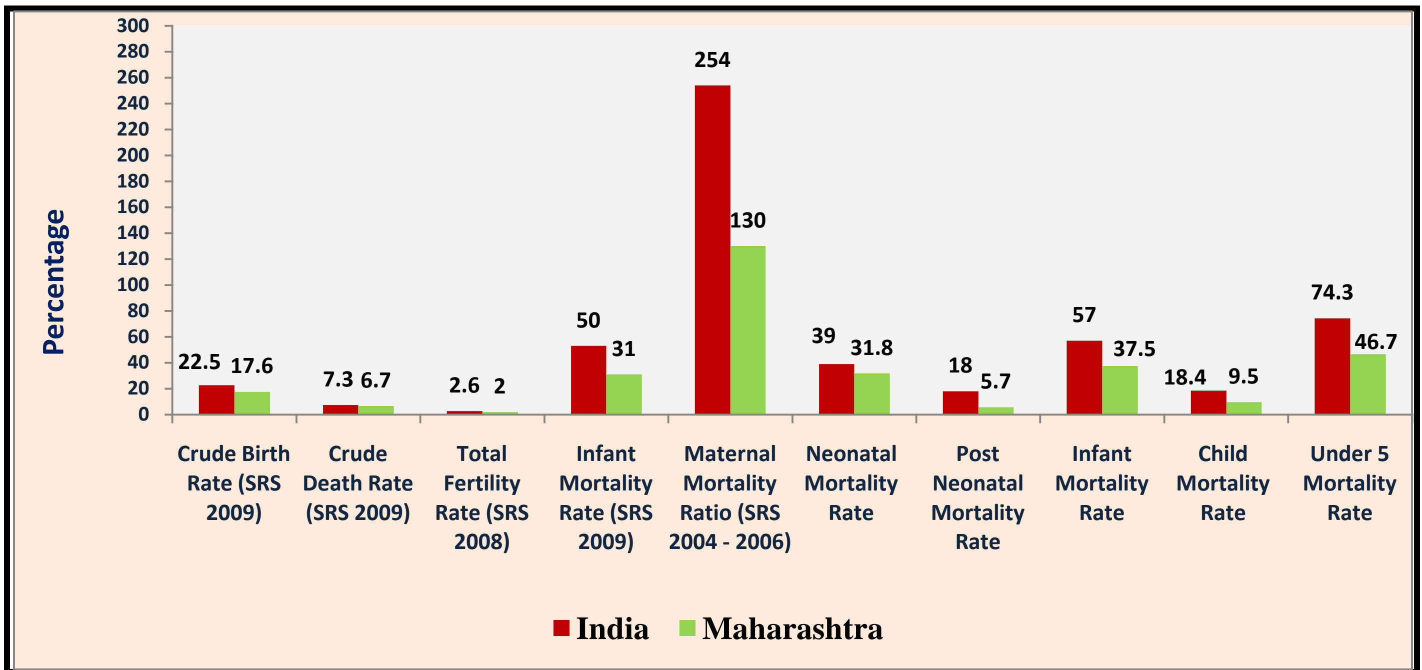
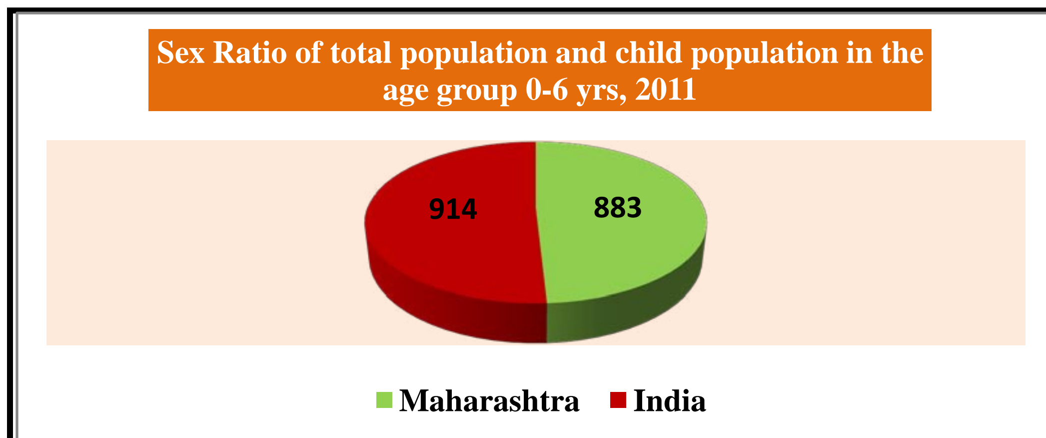
Key Health Indicators of Maharashtra vis a vis National Figures



** Source for Neonatal Mortality Rate, Post Neonatal Rate, IMR, CMR, U5MR: NFHS 3, 2005-06*



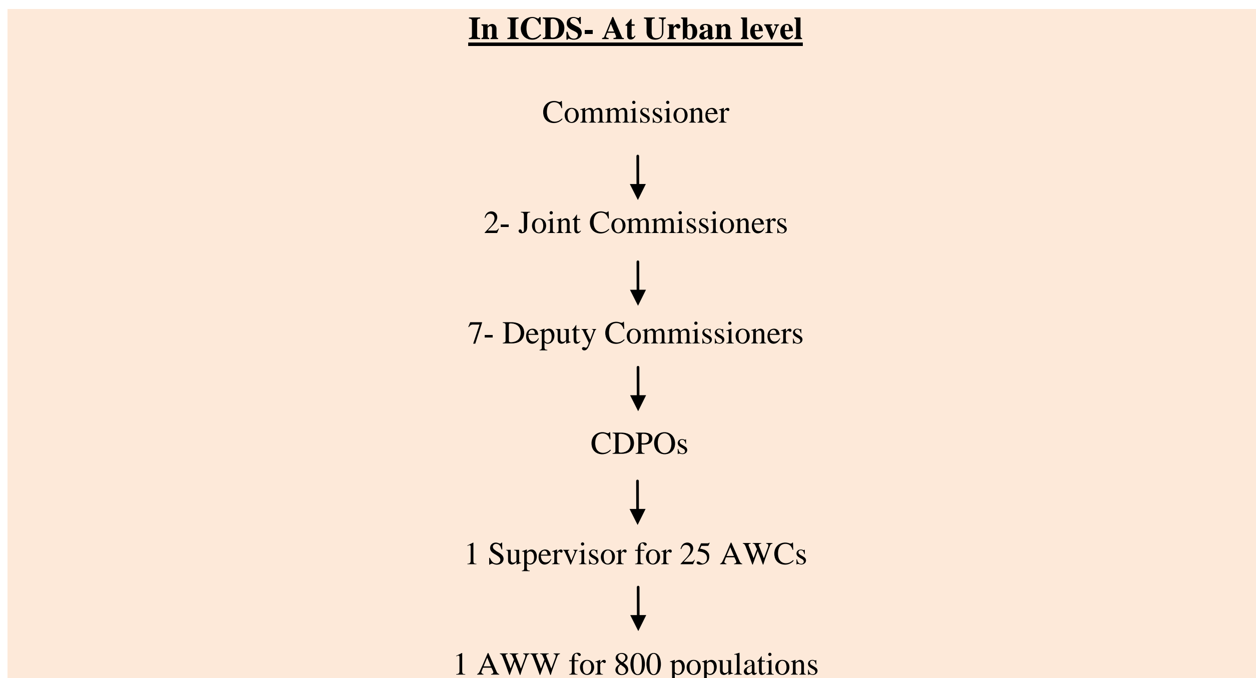
** Source: Census, 2011*

ICDS in Mumbai:

Total No. of projects	33
Total no. of AWC	5,136
Total no. of beneficiaries	4,78,071 (6mths- 6yrs, 3 AGs per AWC, PW and LM)
Total no. of children (6 mths- 3 yrs)	4,916
Total no. of children 3- 5 yrs	3,958
Total no. of children (6 mths- 5yrs)	8,874
Total no. of Pregnant women and Lactating mothers	40,643
Total no. of Adolescent Girls	11,472 (eligible for nutrition)
Total no. of MAM kids	81,482
Total no. of SAM kids	9,748

Source: Women and Child Department, Mumbai.

ICDS Infrastructure Organizational Chart at Urban level:



**Source: Women and Child Department, Mumbai.*

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Profile of AWCs visited:

Sl No.		AWC 50	AWC 95	AWC 84	AWC at Malad West, Malwani Complex
1.	Total Population under cover AWC	853	923	1026	1234
2.	Total no. of Beneficiaries 6 mths-3 yrs	50	58	72	N.A.
	Boys	24	25	39	N.A.
	Girls	26	33	33	N.A.
3.	Total no. of Beneficiaries 3 yrs - 6yrs	45	51	58	N.A.
	Boys	24	24	29	N.A.
	Girls	21	27	29	N.A.
4.	Total no. of enrolled children 6 mths – 3 yrs	50	58	84	N.A.
	Boys	24	25	43	N.A.
	Girls	26	33	41	N.A.
5.	Total no. of enrolled children 3-6 yrs	100	65	87	50
	Boys	48	33	50	27
	Girls	52	32	37	23
6.	Total no. of PW	7	6	3	7
7.	Total no. LW	11	23	10	4
8.	Total no. of AGs	89	84	68	N.A.
9.	Total SAM patient detected 6 mths – 3 yrs (Jan. 2011)	3	6	15	N.A.
	Boys	0	5	8	N.A.
	Girls	3	1	7	N.A.
10.	Total SAM patient detected 3 yrs- 6 yrs (Jan. 2011)	3	6	8	N.A.
	Boys	2	4	4	N.A.
	Girls	1	2	4	N.A.
11.	Total no. of SAM kids 0-6 yrs referred to hospital, March, 2011- Boys	12	8	5	N.A.
12.	Total no. of SAM kids 0-6 yrs referred to hospital, March, 2011- Girls	18	4	5	N.A.
13.	Total no. of deaths	8	10	0	N.A.
	Male	3	2	0	N.A.
	Female	3	2	0	N.A.
	Still Births	2	6	0	N.A.
14.	Education level of AWW	12	12	BA	N.A.

N.A: Not Applicable (Data not provided by the State government)

Comparative study of the AWCs and facilities provided:

1.	Infrastructure	▲	▲	▲	●
2.	Approachability to AWC	▲	▲	▲	●
3.	Accessibility of AWC to the Community	●	●	●	●
4.	Behavior and General appearance of AWW	■	■	■	●
5.	Appearance of AWH	▲	▲	▲	●
6.	Appearance of children	▲	▲	▲	Not interacted
7.	Regularity of AWW	■	■	■	■
8.	Pre School education for the children	▲	▲	▲	▲
9.	Size of AWCs	▲	▲	▲	▲
10.	Space for outdoor activities	▲	▲	▲	▲
11.	General Hygiene of the Anganwadi premises	▲	▲	▲	●
12.	Type of toilet facilities	▲	▲	▲	▲
13.	Health Services	▲	▲	▲	▲
14.	Referral systems	▲	▲	▲	▲
15.	Fresh water Supply	▲	▲	▲	■
16.	Knowledge of plotting of graphs	■	■	■	■
17.	Malnutrition indices duly filled	■	■	▲	■
18.	Follow up of the referred kids	▲	▲	▲	▲
19.	Children's satisfaction with the quality of food	●	●	●	●
20.	Refresher training attended	▲	▲	▲	▲

▲ Poor, Not approachable, Not accessible, Inadequate, Insufficient, Not available

■ Fair

● Good, Approachable, Accessible, Adequate, Sufficient, Available

Findings:

1. **Infrastructure:** All the AWCs visited are plagued with infrastructural problems of rented premises, inadequate space, leaking roofs, make shift space for AWW, unavailability of potable water, lack of toilets, unhygienic surroundings *etc.* The possible explanation stated was that the nearby land being a dumping ground and the majority of inhabitants being rag pickers, it is difficult to maintain hygienic standards. Moreover, the amount fixed for renting the premises of AWC by the government is too meager to get a reasonable space. The unhygienic surroundings, non-availability of space for children to play, overcrowding of kids in a small unventilated room coupled up with lack of potable water was the norm.

2. **Food:** As per the version of the local residents, the food served in AWCs is reasonable and supply is consistent. The food is being served through the local SHGs (Maha Laxmi Mahila Mandal) of the area. However, the team could not visit the kitchen which was located quite far off. But the khichri when tasted was satisfactory. In Mumbai, kids are given one breakfast and one meal. Two meals are provided to the children one in the morning at around 10.30-11.00 comprising of Murmura ladoo and Murmura chivada and one hot cooked meal in the afternoon consisting of Channa, Wheat lapsi, Rice based khichri at the rate of Rs. 8/-/child/day. However, considering the escalation in the cost of raw material and cooking and transportation, it was not turning out to be feasible for the SHGs. On conditions of anonymity one officer informed that the SHGs are running only because of over enrolled children at the AWC or absentees. It is not feasible for the Mahila Mandals to provide 2 meals at this cost.

   THR is provided by the AWCs. A month's ration of THR is distributed on a single day. Thus, loosing the opportunity of interacting with the kids and their parents repeatedly and hence missing out the possibility of early detection of abnormalities, diseases and imparting health care and education.

   Secondly, the safe storage of THR packets for one month in unhygienic and improper surroundings of their homes becomes doubtful. Moreover, their end-use and end-user can never be assured.

3. **AWWs/ AWH:** The AWW we met during the visit were dedicated and hard working. They knew their jobs well, but were working under immense pressure both from the officials and concerned NGOs/ Social Welfare Groups. The onus of poor services is always put on them. However, their concern, their hardships, their support system has always been neglected. The concept of Pre- School education and its importance needs to be reinforced. AWHs are also working diligently as per their scheduled tasks.

4. **Supervisory staff:** Including Supervisors and CDPO's are over worked, we were told that there is acute shortage of CDPOs. Each officer has to look after 300-400 AWCs which is hindering the smooth functioning of the system. Secondly, at the urban level, CDPO's are directly reporting to the Commissioner. Thus, the action on their reports is often delayed.

5. **On alleged Malnutrition deaths:** Again, this is not possible on verbal autopsies, retrospective inspection of the records and with communicating with the parents to say that malnutrition was the sole cause of death. However, wide prevalence of malnutrition in these areas cannot be denied especially in girl child.

6. **On Rice Weevils:** On communicating with the AWW and other officials we were informed that the month supply of THR was getting unloaded on that particular day (Day of Report) and torn out packets were kept aside not to be distributed. As there is no provision of storing the THR at AWC, no question of the presence of Rice Weevils in the food arises.

7. **Post SAM Detection:** Despite of all the limitations the AWCs are still able to identify MAM and SAM in time but in absence of the clear-cut guidelines to the AWWs even after detection they feel helpless. Non- cooperation from the parents worsens the problem. There is no established referral axis for the SAM children. Children are referred to the main health system/government hospitals/PHC. Where he/she is treated at par with the other children without recognizing that his/her needs are different. There is no system of nutritional rehabilitation and no designated beds/OPD in government hospitals for the children who have been referred from the AWC. This eventually abates all the positive actions done at the AWCs. There is no point in early identification of MAM/SAM, if a well oiled machinery to manage them successfully is lacking.

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Recommendations:

1. The location and infrastructural facilities at AWC needs a lot of improvement. The overcrowding, shabby tinned roof hutments, *kuchha - pucca* rooms increases the chances of children falling prey to infectious and communicable diseases more so at the time of epidemics. Though it may be difficult in the space crunched Mumbai, alternative arrangements with the school managements (afternoon shift), community halls, spaces from hospitals/PHC/Police stations, BMC public spaces can be considered to run the AWCs which runs only for few hours in a day.

2. THR should be on weekly distribution so as to facilitate more interaction of the beneficiaries with the AWWs. It will also increase the chances of early detection of major illnesses/ deformities and malnutrition.

3. SHGs or Mahila Mandals are to be trained for monitoring of quality of food on day to day basis. Their concern regarding the financial non-viability of project also needs to be addressed. There has also to be a system of getting feed back from the beneficiaries and the nominated reputed members of the local society.

4. Support and supervisory visits through the CDPO to the AWW should be enhanced, Though announcement of increased salary has been a boost for them, but still they deserve better working environment. The CDPO should be made responsible for not more than 100-125 per AWCs and their one visit in a month to each AWC should be must.

5. A specified time has to be given for pre-school education in each and every AWCs and AWWs should be sensitized on the issue of pre-school education.

6. The basic purpose of AWC and AWW besides providing nutrition and pre- school education is repeated contact with the children and though children with their families just so that AWW becomes a sort of health mentor not only for the child but for the family. NGO's and social organizations working in these areas should cooperate with the AWW to bridge this gap between parents and AWWs.

7. There is an urgent need for creating a dedicated referral system for SAM kids. It is necessary to establish Nutritional Rehabilitation Units area wise, so that SAM children and their families do not face the hassles of community. The AWW who has first identified SAM or MAM leading to SAM should have clear guidelines on where to refer the child, who will be looking after the child and in case of hospitalization, where will the child go. She should be made a part of the Nutrition Care Unit and have clear protocol on management of a SAM child post management. There has to be a referral axis from AWCs → Nutritional Care Units → Referral hospitals and back to AWC.

8. Besides this the total improvement in the living standards, of the residents of these areas through active involvement of all the governmental agencies is the need of the hour.

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Abbreviations Used

NCPCR	National Commission for Protection of Child Rights
ICDS	Integrated Child Development Scheme
CDPO	Child Development Project Officer
NGO	Non- Government Organization
BMC	Bombay Municipal Corporation
HR	Human Resource
NFHS	National Family Health Survey
THR	Take Home Ration
AWC	Anganwadi Centres
AWW	Anganwadi Worker
AWH	Anganwadi Helper
PW	Pregnant Women
LW	Lactating Women
AG	Adolescent Girls
MAM	Moderately Acute Malnutrition
SAM	Severely Acute Malnutrition
PHC	Primary Health Centres
SHG	Self Help Group
MDG	Millennium Development Goals
GHI	Global Hunger Index
FAO	Food and Agriculture organization
WHO	World Health Organization
IFPRI	International Food Policy Research Institute
UNDP	United Nations Development Programme
CDC	Child Development Centre
SRS	Sample Registration System
OPD	Out Patient Department
IMR	Infant Mortality Rate
CMR	Child Mortality Rate
U5MR	Under 5 Mortality Rate

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