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Research Paper

Community Participation through empowerment in India's Supplementary Nutrition Programme

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ABSTRACT:- *Started with an objective of providing nutrition to children below six years, pregnant and lactating mothers India's Integrated Child Development Services (ICDS) scheme is the world's largest Supplementary feeding programme. However, various evaluations and studies have highlighted that the approach of increasing coverage through food distribution rather than changing family based feeding and caring behavior has resulted in lower impacts on the nutritional statistics of beneficiary population. The present paper explores role of community participation through empowerment and how it can help asocial sector scheme achieve its objective of breaking vicious cycle of under nutrition thereby improving child health status. "Jahangirpuri model" representative of a non-government organization's partnership in a self-help group exemplifies as how women who are beneficiaries at one end can also be service providers. This model helps community gain quality services; improved feeding behaviours; practices and better health status. Under the model, kitchensfor serving hot cooked meal (supplementary nutrition) for distribution through Anganwadis were set up in the urban slum clusters. The 25 sq. yard kitchens managed by women of community depicted change in attitudes, better understanding of nutrition withenhanced awareness regarding requirements and entitlements, the prerequisites for an effective programmed livery.*

Keywords:- *Supplementary feeding programme, Integrated Child Development Services (ICDS), Community participation, Jahangirpuri model, Empowerment, Non- Government Organization, Self Help Group.*

I. INTRODUCTION

India is a signatory to the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights and the Convention on the Rights of the Child. Article 39 (a) of the Constitution of India obliges the State to direct its policy towards ensuring that the citizens, men and women, equally, have the right to an adequate means of livelihood. Whereas, article 47 of the Constitution of India makes it one of the primary duties of the State to raise the standard of nutrition and the standard of living of its people and to improve public health.

Urban poor is a rapidly increasing segment of India's population. With more than 90 million people living in urban poor settlements, the rate of urban poverty in India is staggering. An analysis of population growth trends between 1991 and 2001, depicted that while India grew at an average annual growth rate of 2%, urban India grew at 3%, mega cities at 4% and slum populations rose by 5 to 6%. These numbers are expected to rise and if the predictions are correct, then in the next 25 years the number of urban poor could end up in excess of 200 million. Childhood malnutrition among urban poor is similar to or higher than rural poor. Prevalence ofmalnutrition among the urban poor is a cause of major concern. According to National Family Health Survey-3(NFHS-3) data Delhi is having 33.1 percent of children under three who are underweight. Poor living environment, inadequate hygiene and sanitation conditions further add to health challenges of these colonies [1].Even with the existence of world's largest feeding programmes –Integrated Child Development Services (ICDS) for supplementary feeding and Mid Day meal scheme (MDMS) covering children up to 14 years age group the nutritional statistics (NFHS-3)indicate alarmingstatistics [2].

- Around 43% of children 0-5 years are underweight; 48% stunted and 20% wasted
- Twenty two percent babies are born with low birth weight, 50 out of 1000 live births did not complete their first year of life.

- 36% of women are below the BMI cut off point of 18.5 while 34% of men are in this category.
- Anaemia levels are much higher for women with 55% of women being anaemic as against 24% of men.

Studies reported association of improved nutritional status and immunization status of children less than 3years age, with ICDS services [3,4] whereas others reported no such association [5,6]. According to National Family Health Survey(NFHS-3), though 81.1% children under age six years were covered by AWCs,but those who received any service from AWC were only 28.4% [7].

According to national data Anganwadiscenters (the centers of service delivery for ICDS) are available only to one- third of the children for the supplementary food scheme and reaching to only about 26% of children.Many urban poor remain left out from nutrition and health benefits of ICDS [8]. The BPL lists and slum lists used to identify beneficiaries may exclude the 'hidden' construction site workers, pavement dwellers and migrants. Such exclusion or partial inclusion may leave these vulnerable sections out of the ambit of many schemes without any health or nutritional benefits. ICDS in these areas even if having an existence, would require a strong awareness campaigns to have more effective community outreach. Thus, for more effective programme absorption it is required that the community is also sensitized and made aware of their requirements and entitlements.

To tackle the intergenerational problem of malnutrition it is important that a life cycle approach is adopted with an active participation of the community. Community studies have indicated that apart from understanding requirements social entitlements also require due consideration.As a rule, women even during pregnancy or breast feeding enjoy the lowest level of entitlements in the family. In the land of diverse cultures and religious customs sometimesthe breast feeding by a womanmay not pertain to the hunger of a child but is dependent upon astrological positioning of stars to start the feed. Unless these social customs are tackled through community education and social reforms the intergenerational problem cannot be resolved. It is necessary to bring in innovation through experimentation.

The key to success is community involvement in social sector schemes. This paper focuses on community participation in the delivery of hot cooked food through ICDS that focuses on women and children.

II. ICDS: THE INTENT

Presently, ICDS is having around 9croresupplementary nutrition beneficiaries served by around 12 lakh functional anganwadis (WCD,2010). Simple arithmetic would show that, based on entitlement, if the entire delivery were hot cooked food, the amount of food being cooked/ processed every day, under the scheme, would be around 25-30 thousand tonnes requiring huge work force. The Hon'ble Supreme Court emphasized on community participation in execution of the world's largest public Nutrition Programmes -Supplementary Nutriton Programme (SNP) under ICDS and Nutritional Support to Primary Education(NPNSPE) commonly known as Mid- Day meal scheme through various orders[9]. From the delivery point of view the most important orders are:Supreme Court order dated 7th October 2004 [CWP no. 176/2001 - point 3]

"The contractors shall not be used for the supply of nutrition in Anganwadis and preferably ICDS funds shall be spent by making use of village communities, self –help groups and MahilaMandals for buying grains and preparation of meals."

Through the orders the policy directives have shifted to involve the community in a big way and move away from treating malnutrition either as an administrative or a commercial proposition. However, there is a need for administrative mechanisms, organizational structures based on responsiveness; capability and governance to be created in a mannerso that the disadvantaged sections of the population gain maximally from the scheme [10]. Appropriate strategies/training programmesare required to tap the huge potential that could be created for women from low income families.

III. INVOLVING WOMEN

Under nutrition is a multi-dimensional problem. A critical remedial method is hot cooked food. Cooked food should imply that which is culturally accepted and when consumed gives a sense of satisfaction. Also the process of cooking should be an instrument for community participation. The involvement of local women in community feeding programmes would not only result in employment but also better understanding of both nutrition and hygiene.

Providing equal work opportunity to women where she is also a beneficiary may not be so easy but definitely a step towards ensuring better social and nutritional health. It must be understood that the women need to be supported for their early morning working hours; physically stressful work; daily routine of timely deliveries; limited holidays; feeble health status with no respite from household work and thus required a more gender sensitive approach.

For women participation and ownership certain minimum conditions that need to be met are:

- Preliminary and continuous on job training for providing and improving the skills.
- Proper laid out procedures and processes in local language with pictorial representations for easy understanding and absorption
- Handholding with supervisory control for at least one year with sharing of accountabilities and responsibilities as initial confidence level is low.
- Ensuring proper wages with benefits as health check- ups, meals during service hours, uniforms and safe environment for work.

IV. JAHANGIRPURI MODEL: A CASE STUDY

The Swami Sivananda Memorial Institute (SSMI) has addressed the questions of women's empowerment and decentralization through Jahangirpuri Model.The model adopted an approach of livelihood Creation through participation (LCTP) which led to the formation of cohesive groups or Self Help Groups (Fig. 1). The project in Jahangirpuri under ICDS,was started in June 2006 with the requirement of feeding 5,000 children.First stage involved identification of women in community who would want to get involved as a food server for preparing food under ICDS. Through various interactions for about two weeks helped women to understand the project and also how they can support by being the key partners. The impact of discussions and understanding was such that against need of 8 women 150 got enrolled. On- job training for the selected group involved handling of the bulk preparations. The women were trained for recipe formulations, understanding process requirements for bulk preparation, pre-preparations, measurements, cooking in large vessels, hygiene and safety aspects. They were trained for a period of six days to handle different recipes in a large scale. During this training they learned to handle bulk preparations in a hygienic manner, time management for production and safe delivery of the hot cooked meal. However, the raw material sourcing was done by the supervisors of the institute.During the second week of training women were motivated to handle preparations independent of trainers. They were continuously monitored and corrected by the supervisors. When the women were trained enough to handle preparations, the concept of raw material sourcing, quality checks and its storage was explained. By end of one month the women knew about daily report filling, raw material sourcing, bulk preparations, uniform and quality product delivery. So was the efficiency and commitment portrayed that within a period of two months the operations increased from 5000 to 14000 meals per day. The employment of women increased from 8 to 23.The women who joined in later were trained by the supervisors and women who were already involved in the preparations. The earlier operations having started in one kitchen gradually increased to 8 kitchens in a time span of 27 months with infrastructural and other facilities provided by the organization.

Continuous training and monitoring has been key mechanisms to achieve effective programme delivery in the target area (Fig.1). Presently, the model has spread to other areas of slum clusters with fifteen independent Self Help Groups (SHGs) formed under the project. Fourteen SHGs are working amidst the community in a decentralized manner with one SHG in a separate facility preparing weaning food (take home ration for children below 2 yrs) which requires more of quality control and can't be handled in a decentralized manner.

SSMI intervention in the programme was women employment through Livelihood Creation through participation (LCTP) approach which was also an instrument for community involvement in the programme.
The LCTP model had the various endogenous factors as strengths accounting for the success of the model whereas the NGOs partnering in this model as an opportunity for sustenanceand meeting the objectives of provision of safe and wholesome meal under the program (Figure 2).

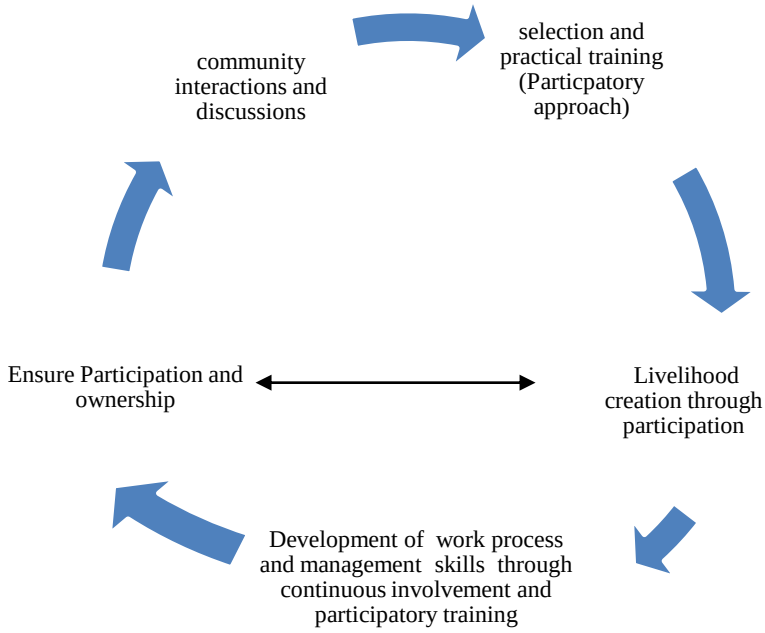

Figure 1: The Jahangirpuri Project-Empowering women for child welfare programmes developing encouraging Women participation in the programme resulted in increased awareness of requirements and entitlements. This also resulted in change of the subordinate status of women in society with limited access to and control over assets and resources.

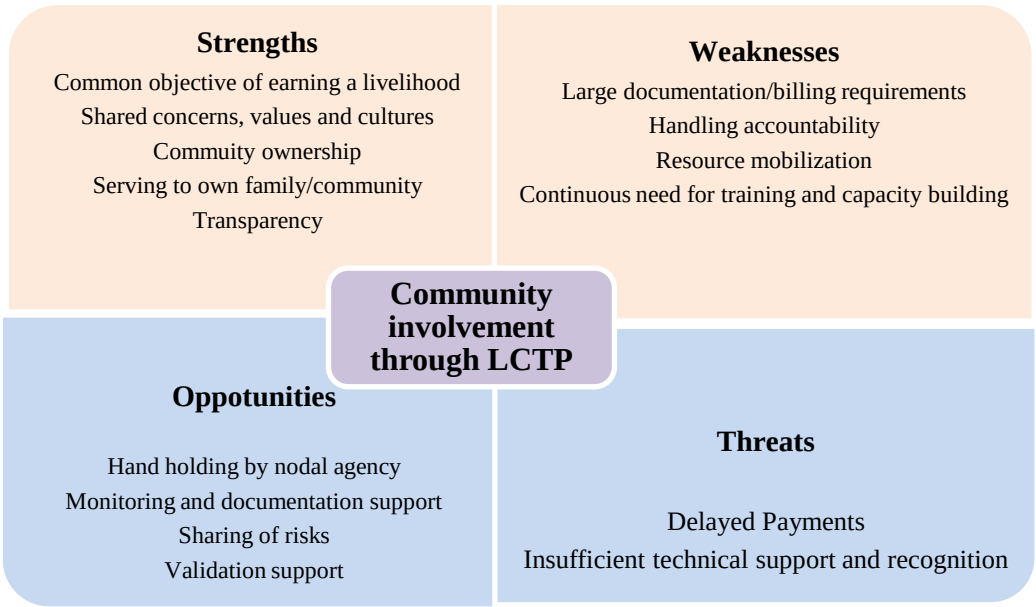

Figure 2: SWOT analysis of LCTP model

V. ISSUES OF FOOD SAFETY

In any feeding programme food safety is a serious and legal obligation. It is about enforcing the Food Safety and Standards Act, 2006. Food safety concerns should stretch from processing of raw material to cooked food, transportation and distribution and right up to the lack of water for children to wash their hands before eating the food. The effectiveness of safe food production and consumption is judged by occurrence, extent and frequency of food borne diseases. Lack of control of diseases like diarrhoea defeat the purpose of providing nutrition. Unlike any restaurant or a food serving unit where the safety concerns majorly revolve around hygienic preparation and handling of food, the large scale feeding programme as ICDS requires more critical control over the time gap between production and consumption owing to handling of food under unsafe

temperatures after preparation. Another cause of concern is lack of hygiene in distribution, particularly lack of facilities for washing hands.

However, decentralized community based kitchens lowers risks as time for which the food travels before consumption is controlledbecause of location thus, the hot hygienically preparedfood has minimal chances for spoilage and is safe for consumption.It is important that the kitchens though located in slum communities follow all standards of good manufacturing practices with proper infrastructure laid out for hygienic preparation; segregation of areas for storage, cleaning, cooking and distribution. Jahangirpuri model has controlled processes and uniform production across all kitchens as standard operating procedures for each recipe has been designed and communicated. Daily checks and better capacities of women to deal with deviations has definitely helped the programme achieve its objectives of providing safe and wholesome supplementary nutrition.

VI. DECENTRALIZED KITCHENS WITHIN COMMUNITIES: PRINCIPLES AND ACHIEVEMENTS

A kitchen working in the neighbourhood can lead to increased transparency as well as awareness regarding the food being prepared in the kitchen. Constant community interactions and training was adopted as key tools for empowerment, which enabled sensitization, enhanced knowledge and skills along with capacity building that led to a sense of ownership and accountability. Participatory training process was used which encouraged lot of experience sharing, questioning regarding process and opened up space for more innovation required in the programme.

This model was adopted as step process to achieve empowerment in decentralized kitchens of ICDS. The principles governing the Jahangirpuri model are:

- **Transparency:** The kitchen is in the midst of the beneficiary community to involve the community.
- **Employment:** Technologies and work flow that generate maximum women's employment and employ from amongst the beneficiary community have been adopted.
- **Appropriate industrial practices:** Good manufacturing practices, management principles form the base of the programme.
- **Safe food production:** Personnel and work place hygiene practices followed with annual health check-ups of all persons involved.
- **Well cooked hot food** Minimum time gap between production and delivery ensures distribution of hot food
- **Awareness:** Increasing community awareness regarding the requirement and entitlement.
- **Sustainable:** Continuous training is the part of the model thereby building capacities for more sustainability.

The success of Jahangirpuri model as a decentralized community kitchen model run by empowered women for large scale feeding under ICDS can be measured as the same model has been replicated in other areas as Nawada, Madipur and even for cooked Mid Day Meal programme in Chandigarh. Presently, the model is supporting livelihood for around 70 women and around 21 men (rickshawalas) in the community under ICDS. The model alsohelped community women attain positive self- image and confidence; better understanding of the ICDS as a nutrition support programme and child welfare scheme;increased family incomes; changes in personal and social relationships; increased access to resources; awareness regarding requirements and entitlement; capacities to question and participate in process improvement. The model provided stage for positive interactions, developed a sense of belongingness, helped women to explore potentials and became a platform for overall development and learning through picnics, festive celebrations, team work and annual events.

Non-Government Organization (NGO) supportedempowerment and facilitated strategies for improvements in processes required for delivery of well cooked, wholesome hot meal and helped develop many community linkages. Community participation through network of linkages developed as both women and men (rikshawalas) became members of Self Help Groups committed to achieve targets as food servers and distributors laid the foundation of delivery of a successful decentralized model.A centralized kitchen model which is more capital intensive oriented towards capturing larger number of beneficiaries lacks community participation (Table 1)

Table 1 Shows comparison between Centralised and Decentralised kitchen models.

Centralized Kitchens	Jahangirpuri Model (Decentralized)
Capital Intensive	Within reach of SHG funding
Minimizes Human Intervention	Maximizes women's employment
Isolated and out of bounds for the beneficiaries	Maximizes transparency as located amidst beneficiaries
Food travels long distances in tropical climate to cover large areas	Food travel distance and time minimized
Food safety a major concern outside unit as food travel involved for longer time after preparation	Food remains hot and safe as minimum travel after preparation

VII. CONCLUSION

It is important that public nutrition is moved from being just a government sponsored and bureaucratically controlled scheme to a community participation scheme. However, public participation and ownership is possible only when the public nutrition schemes are completely decentralized and linkages are built while involving women and other members of the community. Continuous training and capacity building are key tools for empowerment.

The model with the LCTP approach treats each person as co-producer, with authority and control over decisions and resources devolved to the lowest appropriate level. Their participation with a sense of ownership is critical to ensure commitment to change. However, to sustain inclusion certain efforts are required from the nodal agency as to identify strengths of the target community, ability to identify opportunities that would create sustainable enterprises, ability to train and motivate the target communities, and the ability to manage culture change with laying down standard processes, quality until the beneficiaries develop a sense of ownership.

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