When People Act Together For Nutrition

Community Based Monitoring And Action For Child Nutrition In Maharashtra

We will destroy the world if even a single person doesn't have food.
- Subramanya Bharthi

A. Why community based monitoring of nutrition services?

Widespread and continuing undernutrition in the state of Maharashtra alongside high economic growth is a glaring and persistent paradox. Almost half of the children in Maharashtra are stunted, one fifth are severely stunted, and over one-third (36.2%) of women are undernourished. These figures demonstrate how a high per capita state like Maharashtra is failing its most vulnerable populations - particularly women and children.

Given this background, from 2012 onwards SATHI and other like-minded organizations involved in health and nutrition related issues in various parts of Maharashtra felt the need to develop and execute a project aimed at strengthening Integrated Child Development Services (ICDS), while making these services accountable. This common concern regarding poor nutrition related services, and recognition of need for civil society action, was instrumental in forming the Nutrition Rights Coalition (NRC), with support from the Narotam Sekhsaria Foundation.

SATHI's ongoing experience of coordinating community based monitoring and planning (CBMP) of health services in Maharashtra since 2007 underlined the importance of creating an autonomous channel of information about the actual functioning of the health services as perceived by the community. Key insights drawn

from CBMP-Health process formed the basis for community based monitoring of nutritional services in Maharashtra. The objective of this initiative was to improve ICDS functioning, enable vulnerable populations to reclaim ICDS services as their right, and ensure regular dialogue between providers and people. In many ways, this was a unique social experiment to improve nutritional services by direct involvement of people, in an otherwise centralized and inflexible program like ICDS.

This document provides a summary account of this integrated multicentric approach to challenge accountability deficits in nutritional services, through implementation of community based monitoring and action processes concerning nutrition related programmes, in selected areas in the state of Maharashtra especially during 2013 to 2017.

Geographic scope, implementing organizations and number of Anganwadis

Sr. No	District	Block/ Project	Name of Organization	Number of Anganwadis
1.	Gadchiroli	Kurkheda	Aamhi Aamchya Arogyasathi	15
2.	Amravati	Dharni and Chikhaldara	Khoj	30
3.	Nandurbar	Dhadgaon	Janarth Aadivasi Vikas Sanstha	15
4.	Pune	Velhe	Rachana Society for Social Reconstruction	15
5.	Nagpur	Reshimbag and Hanuman nagar Projects	Aamhi Aamchya Arogyasathi	22
6.	Mumbai	Shivajinagar Projects	Lok Seva Sangam	17
Expansion in June 2015 onwards				
7.	Thane	Murbad and Shahapur	Van Niketan	30
8.	Palghar	Jawhar and Mokhada	Kashtakari Sanghatana	30
9.	Raigad	Karjat	Disha Kendra	15
			Total number of Anganwadis	**189**

B. Objectives and scope of Community based monitoring and action (CBMA) for ICDS

The main objectives of CBMA for ICDS have been as follows-

1. **To** raise awareness among community members about their rights and entitlements from ICDS, and to facilitate greater community engagement in the delivery of ICDS services.
2. **To** demonstrate a model of Community based monitoring of ICDS services and develop structures for dialogue between the officials and the community at the village, block, district and state levels.
3. **To** promote positive action at household and community level for improving nutrition of children and women.

The process of **Community based monitoring and action (CBMA) to improve child nutrition** was initiated

by Nutrition rights coalition with official mandate from Women and Child Development (WCD) Department through issuing government resolution on June 2013. Initially, this process was spread over 114 Anganwadis, in 75 villages from 5 blocks and 39 urban clusters were selected for intensive CBMA activities from June 2013[1] onwards. Based on positive experiences, this process has been subsequently renewed through GR for another three years until June 2017, additional 75 Anganwadis were included after issuance of a second GR in June 2015.

In total 114 Anganwadis, spread over 75 villages from 5 blocks and 39 urban clusters were selected for intensive CBMA activities. Additional 75 Anganwadis were included after issuance of a new GR[2] in 2015.

Geographic scope, implementing organizations and number of Anganwadis

C. Structure and processes for CBMA-ICDS: Multilevel activities linking grassroots mobilization with systemic action

Key stages involved in the CBMA-ICDS process:

a. Developing the organizational framework for CBMA-ICDS -

Prior to implementation, a range of preparatory processes have been conducted at different levels including a state level workshop for conceptualization and finalization of operational framework; capacity building of CSOs who were involved in facilitation of the CBMA process; and detailed understanding of the overall status of people's utilization and experience of Anganwadis through situational analysis. Block / Project level workshops have been organized in the intervention areas involving diverse stakeholders including ICDS officials, PRI members / municipal corporators, and CSO representatives, to ensure shared vision and understanding regarding the emerging CBMA process.

b. Strengthening community awareness and capacity building of various stakeholders-

Various innovative processes have been promoted for community awareness on nutrition issues such as informative cultural programmes, demonstration through pictorial stories, and community meetings. Training and capacity building workshops were organized in all the intervention areas for different stakeholders such as community members, members of VHNSC committees, Mother's committee, Anganwadi workers to enhance capacities of various official and non-official stakeholders in this process.

c. Developing Anganwadi tool, data collection and preparation of Report cards-

To understand the present status of ICDS/Anganwadi services, a detailed tool was designed and pretested, which includes infrastructural issues, quality of food, challenges faced by Anganwadi workers and issues related to utilization of Anganwadi services. Successive rounds of data collection have been completed through various methods such as group discussion, interviews of beneficiaries, interview of Anganwadi Workers and direct observation. This tool has fed into the poster-style public report card, which has formed a community rating instrument enabling participatory assessment of the Anganwadi.

d. Facilitating multi stakeholder dialogue-

Issues which were identified through data collection such as, poor quality of cooked food, irregularities in distribution of cooked food as well as Take Home Ration (THR), irregularities in the functioning of Anganwadi, have been periodically presented and discussed in various multi-stakeholder committees as well as block level Jan Samvad / Jan Sunwais (see below).

Hence the CBMA process includes activities at these levels –

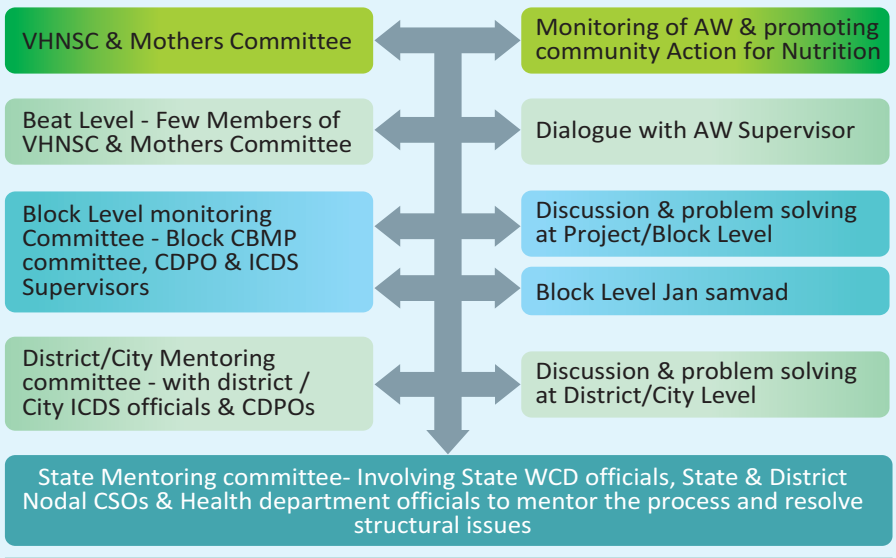
- **At Village level**

Conducting Community based monitoring of ICDS services and awareness building regarding nutrition rights and services at village level through Village Health Nutrition, Water Supply and Sanitation Committee (VHNSC) & mother's committee formed under ICDS.

- **At Beat / Supervisor level**

Conducting dialogue related to anganwadi services with the presence

Broad Organisational Framework of CBMA for ICDS



1 : Women and Child Development department, Maharashtra Govt. Resolution No.ICDS-2013/Case No.-52/Ka-5/dated 13th June 2013
2 : Women and Child Development department, Maharashtra Govt. Resolution No.ICDS-2013/Case No.-52/Ka-5/dated 29th June 2015

of few members of VHNSC & mother's committee at Beat level with Anganwadi Supervisor.

• At Block level

Resolving issues emerged at block level dialogue with Block monitoring and planning committee in presence of CDPO and ICDS supervisors. Organised mass public dialogue (Jan Samvad) at block level once in a year.

• At District level

Mentoring CBMA process and resolving district level issues dialogue with District mentoring committee (formed under NRP project) with District ICDS officials and CDPOs .

• At State level

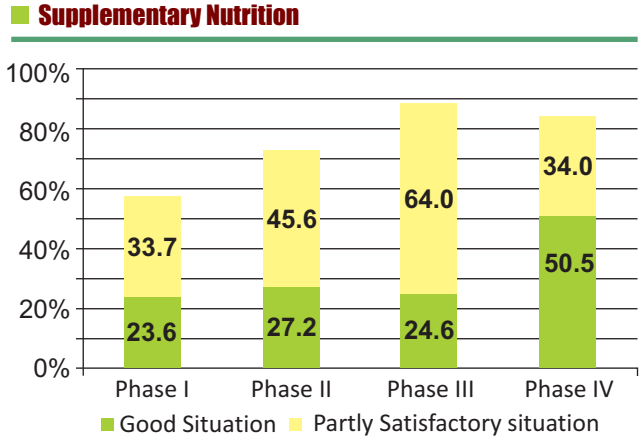
Mentoring CBMA process and to resolve state level process related issues including systemic issues dialogue at state level with State mentoring committee in presence of State WCD officials, state and district nodal NGOs representatives and Health department officials.

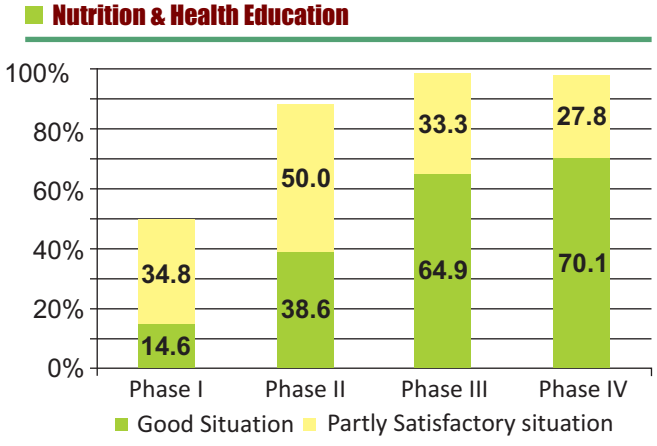
D. Evidence of positive impact of Community based monitoring

a Analysis of data from report cards: Phase I to Phase IV

The first round of community-based data collection using a standardized tool and report card was conducted in all areas during Aug. to Nov. 2013, and this process was repeated after every six months. The report cards were shared with Anganwadi workers and ICDS officials at various levels, and was also presented in Jan Samvads with mass participation. Over a period, these accountability processes have led to a range of improvements in the functioning of Anganwadis in project areas. Rating of the key services as 'good' and 'partly satisfactory' (as opposed to 'bad') has gone up during this period of intervention over four rounds of data collection, as illustrated in following diagrams.

We see that despite some fluctuations, there is overall consistent improvement in nutrition and health education, with the CBMA process leading to much more frequent and systematic nutrition demonstrations being conducted. Moderate improvement is also seen in the provision of supplementary nutrition, as well as related to immunization, health checkups & availability of medicines from the Anganwadi, due to continuous community monitoring and visits by mothers groups to the Anganwadi.

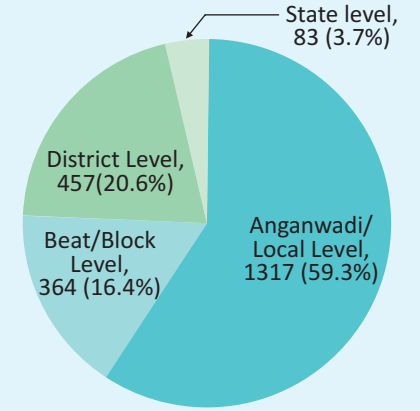




b Analysis of issues raised and resolved through community based monitoring

An analysis was carried out for the period April to September 2014, where 2221 issues were raised through the community monitoring process at different levels. The data was analyzed to understand the proportion of problems which were resolved at various levels, as well as nature of unresolved issues. The maximum number of issues 59% (1317) concerned the local level (village and Anganwadi), out of which nearly half of the issues, i.e., 45% of the issues (593) were found to be resolved. However many problems concerning higher levels of the ICDS system remained unresolved; many of these might not have been amenable to local solutions as they mostly pertained to Anganwadi infrastructure, functioning of Nutrition Rehabilitation Centres, conduction of Village Child Development Centres (VCDCs), and availability of instruments for growth monitoring.

Out of 2221 issues raised, nearly half (44%) of local level issues resolved through community monitoring



Issues at Anganwadi level which were resolved in more than half of the instances (April to September 2014)

Issues resolved at Anganwadi level	Frequency of issues raised	Percentage of issues resolved through CBMA process
Cleanliness of anganwadi premises	5	80
Availability of supplementary food	154	66
Attention to malnourished children through monitoring, additional food and guidance	167	59
Growth monitoring in anganwadi	50	58
Regular maintenance of reports and records	98	57
Guidance and referral for health care	69	54
Management of anganwadi	101	54
Educational material in anganwadi	100	52

Issues at Anganwadi level which were resolved in more than half of the instances (April to September 2014)

Hence significant proportion of issues concerning the Anganwadi could be resolved through community accountability and dialogue. However it was also observed that upstream governance issues like vacant posts are difficult to resolve at the local level. Further, several of the so-called 'local' problems are related to state policy, and cannot be tackled locally. For example, the supply and quality of THR cannot be improved by local solutions.

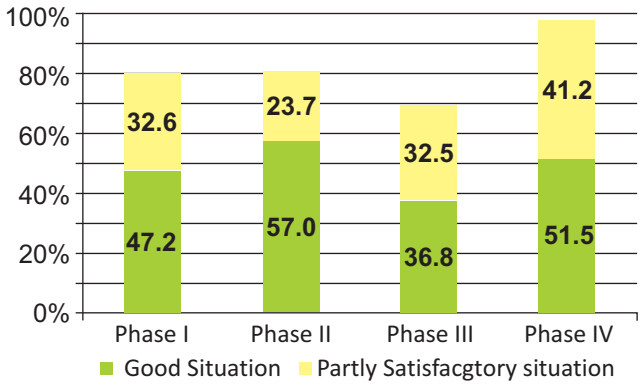
Hence a layered picture emerges, where certain type of issues which are amenable to local pressure and dialogue get resolved through the community based monitoring mechanism, while other more systemic and policy related issues remain 'resistant' to community accountability processes.

E. Illustrative stories of change due to Community monitoring and action

1 Gandhigiri for improving the Anganwadi

In Bainganwadi area of Govandi (West), Mumbai, people from this largely slum area never really concentrated on the functioning of the

Immunisation, Health Checkup & Medicines



Anganwadis, due to preoccupation with their daily struggle for survival. During one of the community meetings linked with CBMA, it came to light that people were not even aware about the timings of the Anganwadi; as per their understanding the timing started whenever the AWW chose to come and open the Anganwadi often just for an hour or so! When the monitoring committee members were informed by the nodal organization Lok Seva Sangam that the Anganwadi should be functioning for at least four hours daily, they were shocked.

The manner in which monitoring committee members tackled this problem was unique they decided to adopt a peaceful 'Gandhigiri' approach. All they did was that one of them was present everyday when the Anganwadi opened, equipped with a register to note the timing of opening the Anganwadi and the reason for the delay. Initially the AWW came up with several reasons for delay, but soon she started running out of explanations. To see the children gathered around the Anganwadi before her arrival was also embarrassing and finally the strategy worked, and the AWW has started coming to the Anganwadi punctually, running the facility for the required time daily.

2 Resolving issues through community action

Chikhaldara is a remote tribal block in Amaravati district, and is part of 'Melghat' region which is known for high levels of malnutrition. One of the villages in this block - Mansudhavadi, populated mostly with Korku adivasis, had two Anganwadis. One was sanctioned, had posts of AWW and helper, but no building ...while the other had a building, but no Anganwadi helper or cooking utensils! The AWWs, in spirit of 'adjusting' with the situation, found a solution by combining the children from both the Anganwadis, using the building of one, while utilizing the utensils of the other Anganwadi. However, this led to double strain on the helper, and the children were also cramped up in limited space. Unfortunately, none of the staff had any forum to complain or resolve this issue.

Here the Community monitoring process stepped in. Local monitoring committee members began following up for sanctioning a building for the second Anganwadi. The local ICDS officer and the Anganwadi supervisor were invited to the village. The Gram panchayat provided land and also made funds available from the Zilla Parishad. But once the construction was complete, the contractor refused to hand it over due to nonpayment of his last installment. Monitoring committee members and activists from the nodal organisation 'Khoj' followed up and ensured the final payment. The building was cleaned collectively by the villagers, and as promised during the local Jan samvad, a set of required utensils were gifted by the monitoring committee to the Anganwadi.

F. Promoting Community action for nutrition (CAN) for improved nutrition practices

After two years of implementing the process of Community based monitoring and action to improve ICDS, in mid-2015 Nutrition Rights Coalition (NRC) decided to take another step forward. It is well known that for improving the nutritional status of children, along with ensuring accountability of services through community monitoring, promoting household-based improved practices for nutrition is important. The child coming to the Anganwadi, remains there for only around four hours while remaining feeding takes place at home. Considerable evidence from initiatives in various states of India shows that based on local resources, communities and families can mobilise for improved feeding practices, thus substantially improving child nutrition and health. Such expectations were repeatedly expressed by the community members as well, in project areas. Hence in response to this, promotion of

- *for 53% of SUW children and 47% MUW children in Nagpur, their nutritional status improved after the CAN intervention.*
- *Subsequent follow up with several children in early 2017 has shown that their improved nutritional status has been well sustained even after one year.*

community and household based actions for improved nutrition practices was introduced as a small pilot intervention in mid-2015 in seven project areas (Rural – Amaravati, Gadchiroli, Nandurbar, Pune, and Urban – Nagpur and Mumbai) where Community monitoring of ICDS was already being implemented. For this small pilot, three habitations (villages / urban communities) were covered in each project area.

This intervention included two focused activities-

a. Individualized counseling of mothers and caretakers of malnourished children, for im-proving household child nutrition practices, along with follow up related to each of these children.

b. Building general community awareness about key nutrition issues using various innovative methods, and promoting collective community actions especially involving mothers of young children. This included promoting desirable feeding practices and avoiding junk foods for children.

The strategy was based on organizing regular awareness events in each village, involving groups of women, members of mother's committees, etc.

Field facilitators from CSOs were provided training through a series of capacity building workshops regarding healthy nutrition practices, based on which field facilitators from involved CSOs shouldered the responsibility of implementation of this newly introduced process. A couple of examples of innovations which emerged in the Community Action for Nutrition process are briefly outlined here, illustrating how bottom-up initiatives emerge in such situations.

Bal Hakka Gat

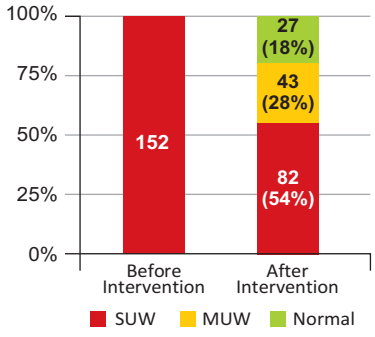
Apart from the women's committees in existence at all NRP sites, an innovative strategy which emerged particularly in Pune and Nagpur is the 'Bal Hakka Gat' or Child Rights Group. As part of this initiative, adolescent boys and girls are inducted into engaging with and strengthening their Anganwadis. Women from the community as well as young Bal Hakka Gat members have raised issues to improve their Anganwadis, sometimes succeeding and sometimes not. These represent a genuine struggle at village level to shift entrenched power relations, where ordinary village women and school going children have often taken on the might of contractors, BDOs and Panchayat officials, as well as errant Anganwadi workers or SHGs providing poor quality food. Others demonstrate voluntary contributions of materials and labour to improve the condition of the Anganwadi.

Bal Kopara (Child Corner) in every house -

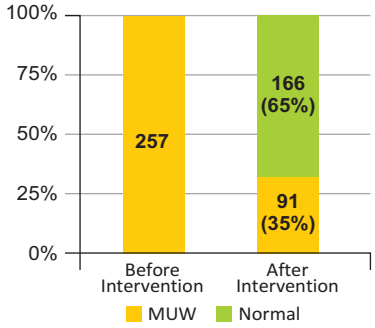
Local innovations can significantly improve the effectiveness of existing government programs. 'Bal Kopara' (Child Corner) is an innovation which emerged in Velhe Block of Pune District. Through participatory mobilisation processes, community members were

Improvement in grade of nutrition after CAN intervention - seven areas combined

1: Grade of nutrition of 46% SUW children improved after intervention across 7 areas

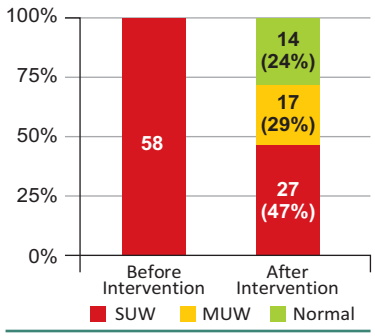


2: Grade of nutrition of 65% MUW children improved after intervention across 7 areas

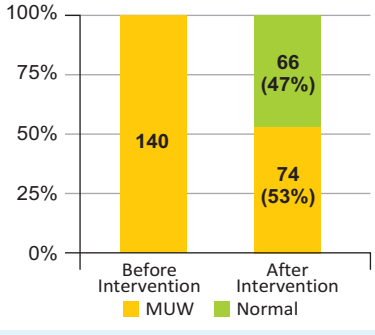


Improvement in grade of nutrition after CAN intervention in Nagpur

3: Grade of nutrition of 53% SUW children improved after intervention - Nagpur



4: Grade of nutrition of 47% MUW children improved after intervention- Nagpur



convinced that children need easy access to nutritious foods, so that they can avoid eating low nutritive processed food like biscuits and fried snacks. In consultation with activists of the nodal organization Rachana Trust and with support from CDPO, several communities modified the official scheme of "Bal kopara" - wherein nutritious food was kept in one corner of the Anganwadi, and implemented this in each household. This has ensured that children have access to nutritious food throughout the day, beyond the limited Anganwadi working hours. This innovation was recognised and endorsed by various block level officials.

Some impacts of the CAN process

The processes of promoting healthy nutrition practices at community level and counselling, follow up related to malnourished children were expected to yield some positive impacts. To track these changes, at the inception of the pilot in September 2015, the list of children who were severely underweight (SUW) and moderately underweight (MUW) were taken from the Anganwadi register in each intervention habitation. Referring to this list, a total of 409 malnourished children were covered by this intervention during September 2015 to March 2016.

Preliminary analysis of nutritional data within a span of just seven months of the intervention (September 2015 to March 2016), show significant improvement in the grade of nutrition of children in intervention areas. Of total 409 malnourished (SUW / MUW) children across seven blocks / urban areas, the grade of nutrition improved among 58% (236 children) in this span of seven months (see graphs 1&2). Out of these, 193 children (47%) improved completely to normal status, while 43 children (10.5%) improved from severe underweight to medium underweight category, taking them out of the risk zone.

On disaggregating data to the district level, Nagpur urban area has shown maximum improvement. In Nagpur, out of 58 SUW children, 17 improved to normal category and 14 improved to MUW category. Thus regarding 53% of SUW children and 47% MUW children in Nagpur, their nutritional status improved after the CAN intervention (see graphs 3&4).

Subsequent follow up with several children in early 2017 has shown that their improved nutritional status has been well sustained even after one year.

Hence there seems to be significant

reduction in levels of malnutrition linked with the Community action for nutrition processes, even though the experience is on a small scale and of preliminary nature. To complement these figures, the story of change mentioned below describes the qualitative processes that may have enabled such improvement in nutrition of scores of involved young children.

How Aditri started going to the Anganwadi, and moved out of malnutrition

Aditri, born on 25th November, 2013 was a Low Birth Weight (LBW) baby. She was never sent to the Anganwadi (AW) by her parents, since they considered themselves to be a well to do family. In 2016, when she was about 3 years old, she was severely underweight (SUW), linked to frequent illnesses. Aditri's mother was under pressure from her family members to not send the child the child to the Anganwadi, since they considered themselves prosperous, and it was below their dignity to take food for their child from outside. As part of the community action for nutrition activity, field facilitators from the nodal CSO 'Khoj' visited Aditri's house. They noticed the status of malnourished Aditri and met her mother as well as other family members.

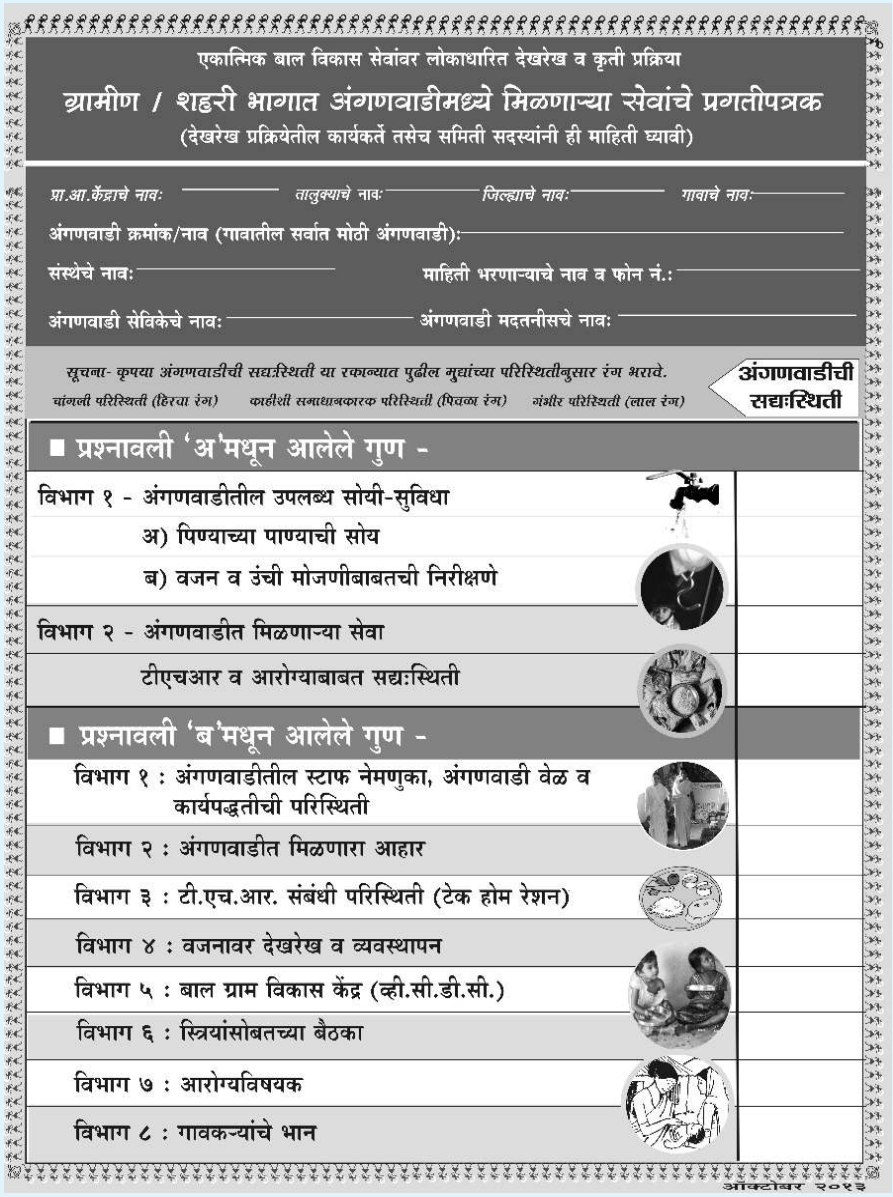
Family members were initially reluctant to take any advice from the facilitators. However and Khoj activists carried out individualized counselling through their frequent visits to Aditri's house and guided her parents regarding consequences of malnutrition, improving household nutrition practices, relevance of Anganwadi etc. Facilitators gave information about key nutrition messages and conducted demonstrations of preparing nutritious food for Aditri. As a result of these efforts, since Aditri's mother was keen on saving her daughter, she accordingly started cooking and serving nutritious food for Aditri. Also gradually her mother realised the importance of nutrition services of Anganwadi including health services, and started sending her daughter to the Anganwadi. After positive response from Aditri's mother, the Anganwadi worker also took initiative and started providing extra food for her from time to time at her house. As a result of combined efforts of frontline facilitators, family members especially her mother and the Anganwadi worker, Aditri's nutrition status gradually improved, and she moved from being severely underweight (SUW) to having normal grade of nutrition.

G. Challenges, lessons and way forward

Challenges encountered in the CBMA process

The CBMA experience in Maharashtra shows that some aspects of Anganwadi functioning have significantly improved in implementation areas, within a short period. Notably, the process has led to enhanced community participation and ownership of local AW services, raised staff attendance, and improved responsiveness of providers towards recipients of services. However, there are deeply entrenched governance challenges in the ICDS system which require vertical integration of civil society action, deploying strategies for multilevel monitoring. This is likely to be a longterm process, which can evolve only with sustained community engagement, preferably combined with some degree of institutional support from proreform voices within the government. Certain key challenges which need to be specifically addressed for further development of this process are described here.

Need for strong official support and institutionalised mandate for



एकात्मिक बाल विकास सेवांवर लोकाधारित देखरेख व कृती प्रक्रिया

ग्रामीण / शहरी भागात अंगणवाडीमध्ये मिळणाऱ्या सेवांचे प्रगतीपत्रक

(देखरेख प्रक्रियेतील कार्यकर्ते तसेच समिती सदस्यांनी ही माहिती घ्यावी)

प्रा.आ.केंद्राचे नाव: _____ तालुक्याचे नाव: _____ जिल्ह्याचे नाव: _____ गावाचे नाव: _____

अंगणवाडी क्रमांक/नाव (गावातील सर्वात मोठी अंगणवाडी): _____

संस्थेचे नाव: _____ माहिती भरणाऱ्याचे नाव व फोन नं.: _____

अंगणवाडी सेविकेचे नाव: _____ अंगणवाडी मदतनीसचे नाव: _____

सूचना- कृपया अंगणवाडीची सद्यःस्थिती या रकान्यात पुढील मुद्यांच्या परिस्थितीनुसार रंग भरावे.

चांगली परिस्थिती (हिरवा रंग) काहीशी समाधानकारक परिस्थिती (पिवळा रंग) गंभीर परिस्थिती (लाल रंग)

अंगणवाडीची सद्यःस्थिती

■ प्रश्नावली 'अ'मधून आलेले गुण -

विभाग १ - अंगणवाडीतील उपलब्ध सोयी-सुविधा

अ) पिण्याच्या पाण्याची सोय

ब) वजन व उंची मोजणीबाबतची निरीक्षणे

विभाग २ - अंगणवाडीत मिळणाऱ्या सेवा

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■ प्रश्नावली 'ब'मधून आलेले गुण -

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विभाग २ : अंगणवाडीत मिळणारा आहार

विभाग ३ : टी.एच.आर. संबंधी परिस्थिती (टेक होम रेशन)

विभाग ४ : वजनावर देखरेख व व्यवस्थापन

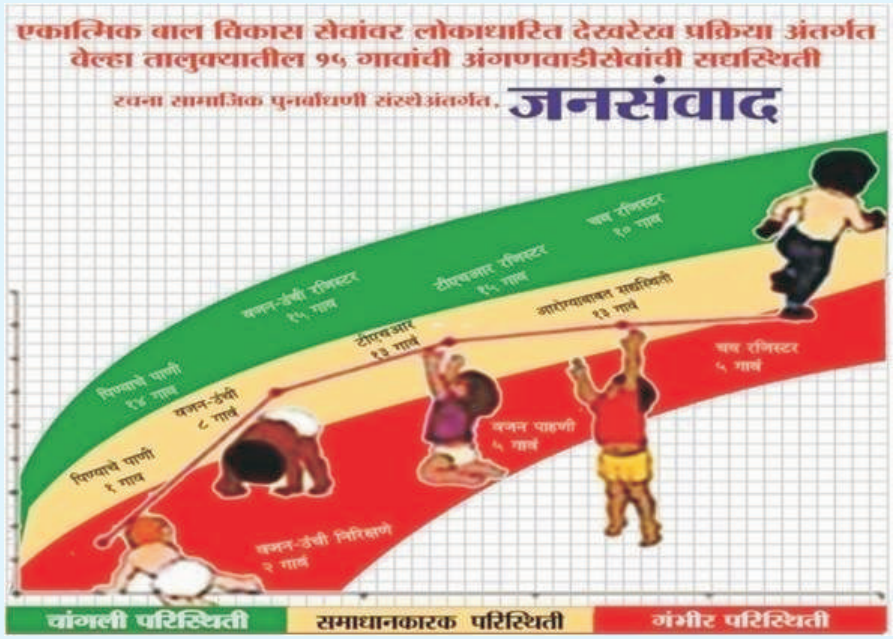
विभाग ५ : बाल ग्राम विकास केंद्र (व्ही.सी.डी.सी.)

विभाग ६ : स्त्रियांसोबतच्या बैठका

विभाग ७ : आरोग्यविषयक

विभाग ८ : गावकऱ्यांचे भान

ऑक्टोबर २०१३



I continuation and ex-pansion of the CBMA process -

The CBMA process has shown its potential for ensuring the delivery of ICDS services in a community oriented and sensitive manner. Future sustainability and geographic expansion of CBMA would be linked with multilevel support by public sys-tems, especially the WCD department, which needs to issue relevant updated Government Resolutions (GRs) and orders at the state level, to ensure cooperation of official functionaries at all levels. Experience of the pilot phase suggests that clear government sanction not only legitimizes community mobilization, but often helps in ensuring participation of public officials in the process, while promoting a culture of accountability within its ranks. Recognizing the need and impact of the CBMA process, this strategy should be logically be included as a core component in the framework of ICDS at the national level.

It is also notable that after certain initial official support to the CBMA process, Government support to these accountability processes has been waning progressively in Maharashtra. This also points to need for developing sustainable memory regarding scalable social initiatives within the government decision making apparatus.

II Addressing systemic, structural and policy issues-

The CBMA process has been conceptualized as a mechanism for making ICDS services responsive to the communities which they serve. However, this demandside process can effectively function only in tandem with supply-side changes such as improvements in infrastructural facilities, human resources, and delivery systems. For example, vacancies of supervisory staff such as CDPOs, and the lack of basic amenities such as weighing scales in Anganwadis, are issues which cannot be solved at the local level. In the slum areas of Mumbai, most of the Anganwadis do

not have adequate space for carrying out their activities, which are instead held in cramped individual houses. In such cases there is no point in questioning the Anganwadi worker for not maintaining basic infrastructural facilities in the Anganwadi. All such issues are crucial, and directly affect the delivery of ICDS services. Hence the entire range of systemic and structural issues emerging from the CBMA process need to be addressed at the state level on a priority basis.

Equally importantly, certain critical policy decisions such as supply of packaged Take Home Ration (THR) for under-3 children which is eminently ineffective and wasteful, need to be re-viewed and replaced by provision of locally produced, freshly cooked food which is appropriate for under-3 children. The need to restart regular VCDCs (Village Child Development Centres), and expand services for under-3 children through provision of crèche-like facilities and more effective home visits, are similar policy decisions which need to be taken at state level, to provide a conducive environment for improving child nutrition across the state.

III Convergence of public systems, especially coordination between WCD and Health departments

Certain services related to child nutrition are provided by the Public Health Department, such as managing Severe Acute Malnourished (SAM) children in Public Health Institutions. However, since these two departments come under separate ministries as well as being separate functional bureaucracies, it is observed that there are significant issues related to coordination between the two; even the methodology for classifying nutritional grade of children in practice is presently different for the two departments, leading to denial of essential care to malnourished children. Further as mentioned above, analysis of issues raised and resolved through CBMA has shown that none of the issues related to VCDCs and NRCs

were resolved. Hence steps must be taken to ensure effective coordination between both of the departments at all levels, linked with their answerability to participatory bodies such as multi-stakeholder monitoring committees, which can demand effective delivery of ICDS as well as health services to the community. There is clear need to strengthen platforms for accountability and regular dialogue such as multistakeholder committees and Jan samvads initiated by the CBMA process, involving officials of both departments as well as PRI members, civil society organizations and active community members, where pressure for 'convergence from below' can lead to improved coordination from village to state level.

Lessons emerging from community based monitoring and action

Some of the key lessons emerging from the experience of implementing CBMA-ICDS in Maharashtra over the period 2013 to 2017 include the following:

a Key role of nodal CSOs with a Rights based approach, and participatory spaces created by CBMP of health services-

As mentioned earlier, the process of CBMA has been led in Maharashtra by the Nutrition Rights Coalition (NRC) a network of seven CSOs working with a rights-based approach on health and nutrition services and social issues. Most of these CSOs had been involved in the implementation of CBMP of health services since past several years, hence this rich experience as well as the spaces created by CBMP considerably facilitated the implementation of CBMA at various levels. This social capacity was also found helpful in ensuring the participation of ICDS officials in public dialogues and monitoring committee meetings, and overall in ensuring responses by public systems to the issues raised through CBMA from local to district and state levels.

b Need for social supervision and participatory action, rather than targeting the frontline Anganwadi worker -

While implementing CBMA - ICDS, it has been widely recognized that the Anganwadi worker is a very vulnerable actor, and she is in a very different situation compared to Medical Officers in Health services. Therefore, exclusive targeting or holding her primarily responsible for failures of the larger system is not an appropriate strategy for resolving issues. Hence the CBMA

process aims to address gaps in the delivery of services with community participation, rather than blaming frontline providers. When services are provided at community level through a person who belongs to the same community, then ensuring responsiveness of the delivery system cannot be achieved merely through confrontation with such frontline workers, but rather through an approach of 'social supervision' and dialogue, which values her work and takes cognizance of her problems, while ensuring that she fulfils her responsibilities to the maximum extent possible within the given constraints.

c Sensitization of ICDS functionaries regarding CBMA, ensuring positive responses from the system

As a part of the CBMA process, when community members give critical feedback to the system or hold concerned staff or officials accountable, the system should not respond mechanically by either denying the problem or taking blanket disciplinary action against frontline staff. Resistance or reactive responses by ICDS officials at any level would be counter-productive. Hence the state needs to ensure that ICDS officials and staff at various levels are provided proper orientation and sensitization regarding the CBMA process, with active involvement of concerned nodal CSOs.

d Integration of rights based community monitoring with community action for nutrition

While the CBMA process started as an 'outward looking' activity for the community, scrutinizing the functioning of the Anganwadi, it paved the way for subsequent more 'inward looking' collective and household actions to improve nutritional practices, termed Community Action for Nutrition. In fact these two arms of action have been complementary and mutually reinforcing, and organically evolved based on the realities and demands emerging from the grassroots. While rights based action was a priority to ensure that public delivery systems like the Anganwadi function optimally, it was frontline activists who pointed out the need to ensure some concrete improvements in nutritional status of malnourished children in the immediate sense, through promotion of improved practices. The need to implement these two forms of activity in an integrated manner emerged as a key learning in this process.

Charting the way forward

The process of community based monitoring and action to improve child nutrition in selected areas of Maharashtra has been an exciting and challenging journey over the last few years. While the implementation of this process has clearly demonstrated the positive impacts that can be generated through rights based community action, in terms of improving the functioning and responsiveness of Anganwadis, the resistance and challenges faced from various levels of the system have also been formidable. Overall it is evident that without strong endorsement of such accountability processes by public systems, it would be impossible to sustain and generalise these as collaborative mechanisms having official mandate. Hence constantly regenerating such public systems ownership of community monitoring, not only by ICDS and Health systems, but also by departments concerned directly with malnutrition like Tribal development departments, is one key frontier of further work.

At the same time, even if official buyin of accountability frameworks remains suboptimal, this does not mean that efforts to promote such processes should remain stalled. Rather the tools, methodologies and capacities developed in the CBMA-ICDS process can be used by rights oriented civil society organisations, as well as people's organisations and movements on a wide scale, as part of their range of activities to ensure accountability and effectiveness of public programmes which impact on nutrition.

We can consider that this first, pilot phase of community monitoring and action to improve child nutrition has been a fruitful initial step, which can open up many further opportunities for partnership based action in the coming period. Preferably with official endorsement, but if need be without such sanction, the movement for nutrition rights must continue to march forward. We cannot postpone such action to an indefinite future, since we can see the continuing nutritional injustice in our country in the face of every malnourished child who is being denied its right to a healthy future. In the words of the poet Gabriela Mistral, to these millions of children we cannot answer 'Tomorrow'; their name is 'Today'.

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