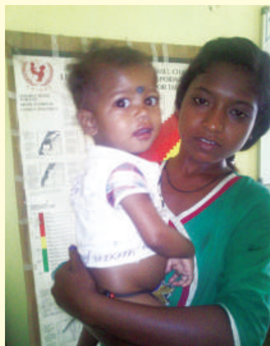
the MTCs did not have an access to clean and safe drinking water. Out of eight MTCs visited, three did not have access to purified drinking water .

6. Most of the MTCs did not have a pediatric doctor and/or a pediatric ward.
7. Follow-up: The turnout for follow-up was poor, increasing dropout rates were observed with each successive follow-up.
8. An important area of debate is the amount of reimbursement paid to the mothers during their stay at the centers to compensate their wage loss. The present amount of Rs. 100 per day is much less as compared to the minimum daily wages presently paid through the labour schemes of Government of India.
9. It was observed that the number of girl children receiving in-patient treatment in MTCs was more than the number of boys, drawing attention the trend that girls are at disadvantage since an early age. Hence, requiring an early intervention to break away from the intergenerational cycle of malnutrition
10. Children who are denied admission to NRCs because they are in I or II grade of malnutrition do not have access to any services that would prevent them from faltering further.
11. Programme implementation is not well coordinated among different actors involved (MoHFW and Ministry of Women and Child Development) – this is evident in the institutional differences in screening, referral, and follow-up. (Please find a detailed analysis of the same in the full report)



A 11 month old child in MTC Gola (Ramgarh) was being taken care by his cousin during daytime (herself a child of 13 years) as the the mother had to go for work.

The dysfunctional water purifier in MTC Gola (Ramgarh)

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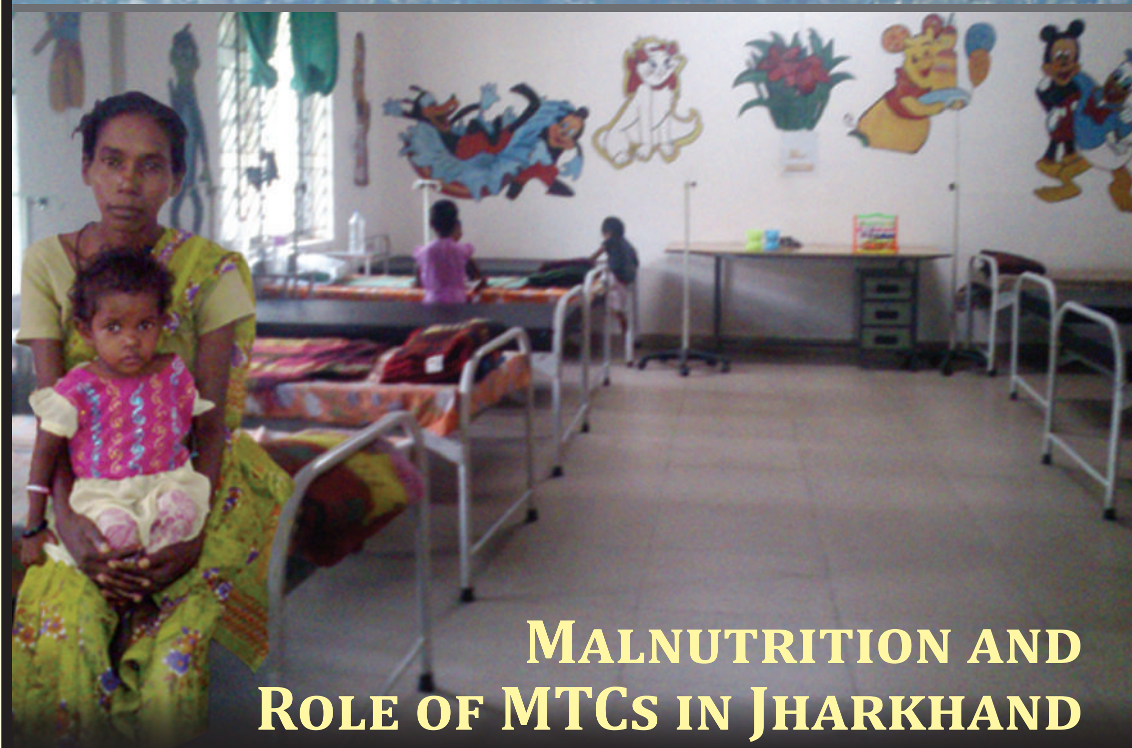
PAIRVI means advocacy. It is used commonly in India as a legal term for advocating on behalf of persons seeking justice, as well as raising voice of the people. PAIRVI (Public Advocacy Initiatives for Rights and Values in India) works for enhancement of advocacy competence of grassroots organizations working in Central and North India.
PAIRVI is committed to work for food security and malnutrition in India. We hope to undertake similar exercises in high burden states of North India-Rajasthan, Jharkhand, Bihar, Madhya Pradesh, and Chhattisgarh to get policy inputs from local organizations and experts working on the field.



Malnutrition and Role of MTCs in Jharkhand

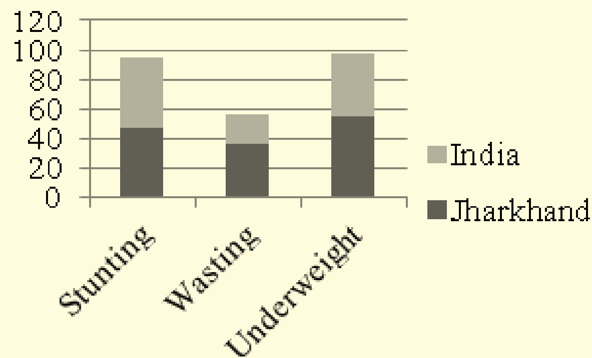
State Consultation | 31st October, 2013 | Vikas Bharti, Ranchi

Objectives

- To discuss the role of MTCs in addressing Malnutrition in Jharkhand
- To share the findings of the snap assessment of MTCs with different stakeholders.
- To get policy inputs from state civil society organizations and experts working in the field.

Background: Child Malnutrition in India

India is home to 40 percent of the world's malnourished children and 35 percent of the developing world's low-birth-weight infants ; every year 2.5 million children die in India, accounting for one in five deaths in the world . Prime Minister Dr. Manmohan Singh, in 2011 termed the high incidence of malnutrition among children a matter of national shame.



Graph 1: Showing the percentage of undernutrition among children below 3 years in Jharkhand vs. the national average (Source: NFHS 3)

Jharkhand: A high burden state

Jharkhand with unacceptable levels of undernutrition, higher the national average, is one of the most vulnerable and high burden states in India. Out of 24 districts in Jharkhand, 6 districts figure among '200 worst Child Nutritional Districts' (World Bank 2007). As per the India State Hunger Index (ISHI 2008) Jharkhand stands the 16th rank in the state hunger index ranking (second last in the studied 17 states). The proportion of underweight among children <5 years in Jharkhand is 57.1% which is alarmingly high. The severity of hunger index for the state is 28.67 which come under alarming category. The HUNGaMA report 2011 has surveyed 13,310 children in 14 districts of the state to understand the level of malnutrition in the state. The report highlights the high level of malnutrition in the state. The districts Chatra, Deoghar, Dumka, Garhwa, Giridih, Godda, Gumla, Kodarma, Lohardaga, Pakaur, Palamu, Paschimi Singhbhum, and Sahibganj covered under the HUNGaMA study showed high levels of undernutrition. In many of these districts, the level of acute malnutrition exceeds globally accepted WHO emergency threshold of 15%. In a survey conducted by World Vision India in 2012 in eight urban slums in Ranchi, out of 32213 children surveyed 26.3% children were identified as SAM, 22.3% as MAM and 26.4% were mildly malnourished.

As per the NFHS 2005-06, nearly 35 percent of total children in the state –roughly 45,000 -were malnourished. Among them 55 percent were identified as SAM. To combat malnutrition NRHM (National Rural Health Mission) Jharkhand had a vision for Management of Severe malnourished Children in state which was envisaged in 2008 using WHO standards, based on Hospital/Facility Based Management. Services provided in MTCs include: medical care, feeding therapeutic diet, micronutrient supplementation, counselling on infant and young child nutrition. In addition to the initiation and expansion of MTCs, the Government of India and Government of Jharkhand has introduced a number of schemes in an effort to reduce the incidence of malnutrition and fulfill India's commitment of reducing malnutrition.

Snap Assessment

PAIRVI conducted a snap assessment of eight 8 MTCs in five districts of Jharkhand. The process also involved discussions and interviews with people from civil society organizations working in the field of nutrition and food security. Following are some of the key observations on the basis of the visit – interaction with MTC staff, mothers of children receiving treatment in the MTCs and community health workers. The conclusion and recommendations are based on the views expressed during our interactions with various stakeholders supported by existing literature review.

Key observations and findings

1. The MCP card of children receiving treatment at the MTC did not have any record of their growth monitoring. The mothers are often not informed of their child's weight or its implication. The mothers stated that since the distribution of THR, immunization and growth monitoring happens on the same day, AWW and ASHA workers do not have time for individual attention or counseling.
2. The MTCs were attached to a CHC (block level) or DH (District headquarters), with each MTC covering 2-3 surrounding blocks. The MTC staff shared that lack of transportation and poor connectivity makes the MTCs less accessible.

MCP card of a child in MTC Gumla (Sadar). The card had no growth monitoring record, a story shared by many.

3. In the absence of specialized human resources , the mothers attending the centers had limited knowledge regarding the basic concepts of nutrition, the Government Health Programmes on nutrition and the composition and preparation of therapeutic feeds at the centers.
4. In many of the MTCs, children below two years who are required to be breast feed at regular intervals were accompanied by their grandmothers or an elder sibling/ cousin during the day as the mother either had to look after other children at home or they had to go for work and could not afford to lose their wages.
5. At a time when children are more susceptible to infections and diseases, many of