CENTRE FOR INNOVATIONS IN PUBLIC SYSTEMS (CIPS)

College Park Campus of ASCI, Banjara Hills, Hyderabad - 500 034, India

Fulwari Scheme in Chattisgarh

A Case Study with Details for Replication

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Acronyms

AAM	-	Action Against Malnutrition
AWC	-	Anganwadi Center
AWW	-	Anganwadi Worker
BC	-	Block Coordinator
CCT	-	Conditional Cash Transfer
CEO	-	Chief Executive Officer
DC	-	District Coordinator
ECCE	-	Early Child Care and Education
GOI	-	Government of India
ICDS	-	Integrated Child Development Service
IMR	-	Infant Mortality Rate
JSS	-	Jana SwasthyaSahayog
MDM	-	Mid-Day-Meal
MPCE	-	Monthly Per Capita Consumption Expenditure
MT	-	Mitanin Trainee
NHFS	-	National Health and Family Survey
NRC	-	Nutritional Rehabilitation Center
NRHM	-	National Rural Health Mission
NSS	-	Nutrition Surveillance System
NSSO	-	National Sample Survey Organization
PDS	-	Public Distribution System
PRI	-	Panchayat Raj Institutions
PSE	-	Pre-School Education
RTE	-	Ready To Eat
SAM	-	Severely and Acutely Malnourished
SDTT	-	Sir Dorabji Tata Trust
SNP	-	Supplementary Nutrition Program
SHRC	-	State Health Resource Center
TPDS	-	Targeted Public Distribution System

TSC - Total Sanitation Campaign
THR - Take Home Ration
UNICEF - United Nations Children Emergency Fund
VHND - Village Health and Nutrition Day
VHSC - Village Health and Sanitation Committee
WHO - World Health Organization
WSHG - Women Self Help Group

Map, Tables and Figures

Executive Summary

The young children are considered as the future of the nation. They are regarded as indispensable assets, hence losing their lives is a great loss to the country. The young children, mostly suffer from lack of nutrition which results in high rates of infant & child mortality. The nutrition related problems are more complex, involving inter-generational development and may not get resolved with simple measures. When malnutrition occurs in early childhood, it also leads to poor physical and intellectual development which have an impact throughout one's life. It is considered that the early years of life are the building blocks of the life to follow and hence, targeting the growth and development of children less than three years of age would to some extent make the future of adolescent population relatively healthier. Hence, it is the felt need of India to plan, intervene and execute strategies to combat malnutrition among the young children.

India as a signatory to the Millennium Development Goals (MDG) has the obligation of accomplishing objectives of eradicating poverty, hunger along with reducing child and maternal mortality and striving to improve their health. Further, if India has to launch itself into a sustainable post-reform, development trajectory, it is quintessential that the current development policy lay foundations to develop a healthy and productive labor force for the future. In this backdrop, the obligation of having a strategic policy intervention targeting the eradication of malnutrition amongst children needs to be appreciated. It is even more pertinent to have such interventions in the backward regions that lie in distress and poverty.

Despite substantial improvement in health and well-being of the population, undernutrition remains alarming in India, where almost half of the children under the age of three are underweight, 30% of newborn are with low birth weight, and 52% of women and 74% of children are anemic. It is the underlying cause of about 50% of the 2.1 million under five deaths in India (NHFS-3: 2005-06). The prevalence of undernutrition is the highest in Madhya Pradesh (55%), Bihar (54%), Odisha (54%), and Uttar Pradesh (52%), while Kerala (37%), and Tamil Nadu (27%) have the lowest rate.

The State Chhattisgarh has been facing a number of challenges of child survival, early child care and child development that are possibly the most critical issue for attention. The government intervention is necessitated due to the high rate of prevalence (47%) of malnutrition, 48% of children are underweight, 38% women are underweight (< 18.5 BMI) and anemic (NHFS-3: 2005-06).Nearly 50% of deaths of children reported in Chhattisgarh, are due to malnutrition.

Government of India has accorded the highest priority to combat malnutrition as it remains persistently and stubbornly high in spite of several programs and multitude of efforts to eradicate

malnutrition. The key issue is to prevent and reduce maternal and child undernourishment as early as possible, across the life cycles. The State embarked on a comprehensive health policy to institutionalize rural health sector. It had initiated different strategies to combat malnutrition, but constraints remained in the implementation process. Various national level programs that contribute to improve nutritional outcomes include Integrated Child Development Service (ICDS), Mid-Day-Meal (MDM) Scheme, Targeted Public Distribution System (TPDS), and National Food Security Mission (NFSM) among others had limited or negligible impact on the children aged between 6 months to 3 years.

The children need nutritional supplements after 6 months along with breast-feeding. Children, particularly those under 3 years of age are prone to malnutrition as there is usually no one to feed them on a regular basis as they cannot feed themselves. Undernourished children grow into undernourished adults, have weak immunity and are also prone to frequent illnesses that leads to poor working capacities thereby affecting their earning capabilities in the future. Undernourished girls grow into weak mothers and give birth to underweight babies, thus maintaining the vicious cycle of illness and poverty.

The Fulwari scheme is a nutrition program, introduced in 2006 by the Jana SwasthyaSahayog (JSS), an NGO working in Bilaspur District of Chhattisgarh. The JSS is sensitive to the needs of young children and started a child care center or Rural Crèche for the children aged between 6 months to 3 years. The main objective of this program is to provide child care with supplementary nutrition for poor children along with pre-school stimulation activities.

The success of the JSS initiative inspired the Government of Chhattisgarh (implemented through Panchayati Raj Institution, PRI) to part-replicate the strategy on a pilot basis in Surguja district in 2012. The initiative of both (JSS and PRI) primarily focuses on the prevention of child malnutrition. This initiative supports the rural working mothers to go to work by leaving their young children at the Fulwari centers. The scheme is funded by the Government of Chhattisgarh through Panchayati Raj Institutions (PRIs) and managed by the mothers of the children on a voluntary rotation basis with technical supports from the State Health Resource Centre (SHRC). The children are provided with one hot cooked meal and two high protein snacks every day, which takes care of 70% of their daily nutrition requirements. The spot feeding practice through Fulwari scheme enhances the weight gain of the children and it imbues health messages (hand wash practice) and stimulates pre-school learning activities. The incidence of undernourishment has come down considerably where the Fulwari centers are functioning.

With this initiative, the Zilla Panchayat of Surguja District started a multi-pronged program called "Surguja Suposhan Abhiyan" at 300 habitations in 2012 to combat malnutrition prevalent amongst the children aged between 6 months to 3 years belonging to the tribal community and also to low socioeconomic classes. The scheme got extended to 2850 habitations in 85 identified blocks by the year 2014. The program is a community managed intervention to reduce malnutrition. It was designed to envisage supports from Mitanin (ASHA) volunteers. The Mitanin facilitates early diagnosis of illnesses (endemic and communicable) in young children and helps in promoting nutrition awareness campaign.

This best practice indicates encouraging outcomes with evidences of weight gains among the children. Community participation in this process created health awareness in the community. State and Civil Society complements each other to revamp and institutionalize rural health to the devoid of rural quacks and superstition that is the most obvious positives in the process. The survival of young children and institutionalization of health is interrelated in this practice. The convergence of health with other sectors, departments and partners enhanced this innovative practice in the right direction to address the malady of malnutrition

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1. Background

More than half of the world's population is adversely affected by malnutrition according to Food and Agricultural Organization (FAO). Worldwide, 200 million children suffer from under-nutrition while two billion women and children suffer from anemia and other types of nutrition deficiencies. India is one among the many countries where child malnutrition is severe, about 40% of children under three years of age are underweight (weight for age), 23% wasted (weight for height) and 45% stunted (height for age). In India, almost half of children under age five years (48%) are chronically malnourished. In addition to these, the country has severe and moderate rate of anemia respectively 4% and 49% among the children between 6-35 months. The nutritional status of pregnant women is also alarming, 58% of the pregnant women are anemic and 33% are having >18.5 Body Mass Index (BMI) in the country.[1] These are some of the major underlying causes of child and maternal mortality in India. Apart from the severity of child and maternal nutrition status at the national level, some of the States have also alarming rate of malnutrition and anemia among both the mother and child that contribute tothe large volume of maternal and child deaths in different States in the country.

Chhattisgarh is carved out of Madhya Pradesh on 1stNovember 2000. The State has a population of 2.55 Crore with a high percentage (33%) of the Schedule Tribes (STs) and 11% of Schedule Castes (SCs), accounting for 44% of the total population. Thus, almost half of the State population comprises of socially and economically disadvantaged groups and those who are far from the mainstream of the society. The magnitude of the problem is high in rural areas with disguised unemployment (40%), poverty (44.6%)[2] with poor health and education infrastructure. According to the NSSO (2004-05), 55% of villagers are below Monthly Per Capita Expenditure (MPCE) of Rs. 365 or Rs. 12 per day and 25% are below MPCE of Rs. 270 or Rs. 9 per day. The purchasing capacity is very low and added to that are the vestiges of extreme poverty conditions that have relatively put the young population at the high risk of undernourishment and starvation.

The process of ensuring that every child is taken care as a matter of right involves societal pressure through public action and democratization of all public institutions. Achieving a rapid reduction in child undernourishment, however, will require scaling up delivery of evidence based nutrition and

1 *National Family Health Survey (NFHS-modified) 3: 2005-06, Nutrition in India, Ministry of Health and Family Welfare, Govt. of India, August, 2009.*

2 *Report of The Expert Group to Review The Methodology for Measurement of Poverty, Number and Percentage of Population Below Poverty Line By States: 2011-12 (Tendulkar Methodology),Government of India, Planning Commission, June, 2014.*

health intervention to all women of reproductive age and young children below three years of age. India is among the many countries where child malnutrition is severe and is the cause for child mortality. The problem has caught the attention of policy makers and researchers for several decades. Various studies and surveys have been conducted to find out the root cause of child malnutrition. All these studies, including the National Family Health Surveys (NFHS: 1, 2 & 3) reveal that malnutrition is not the result of a single cause; the problem is multifaceted, the causes acting singly or in combination with other complex factors like poverty, purchasing power, health care, ignorance of nutrition and health education, female illiteracy, and social convention etc.

1.1 Profile of Chhattisgarh: Geographic, Demographic and Administrative

Geographically, Chhattisgarh is located in the central part of India and it is the 10th largest States in the country. It shares its border with six States; Uttar Pradesh in the North, Jharkhand to the North-East, Odisha to the East, Madhya Pradesh to the West and North-West, Maharashtra in the South West and Telangana to the South-East. The geographical area of the state covers 135,194 square kilometers. In Chhattisgarh, almost three-quarters (76.75%) of the population live in the rural areas and most parts don't have an all-weather road connection. A large section of the States rural population is still isolated from the mainstream, thus depriving them of the benefits of the nation's economic growth. Improper road connectivity is one of the main reasons hindering growth in the rural areas.

Chhattisgarh has a population of 2.55 Crore including 0.59 Crore urban and 1.96 Crore (76.75%) rural in 27 Districts. The local government is organized into three tiers Panchayati Raj System with 27 Zilla Panchayats, 146 Jan Pad Panchayats and 9193 Gram Panchayats including 2,0126 villages. The State has a high density of impoverished tribes dwelling in 85 blocks out of a total of 146 blocks with indigent existence in inhospitable terrains and inaccessible areas. The State has the highest (33%) of Scheduled Tribes (STs) and 11% of Scheduled Castes (SCs) population, amounting to 44% (almost half of the total) population of the State. The results of socioeconomic survey as well as reported data on social indicators of the SC & ST population bear out the high degree of vulnerability of the State's population. International Institute of Population Science in its study of district vulnerability has identified that 12 out of the 27 districts as socially and demographically backward with a composite index of less than 50. The UNDP Human Development study of 2005 places the predominantly tribal districts at the bottom of the development pile. Seven of the 27 districts and 86 of the 146 health blocks have a tribal concentration of more than 50 percent.

Map-1: Chhattisgarh District Map

Table-1: Demographic, Administrative and Health Profile of Chhattisgarh

Demographic (Census - 2011)	Chhattisgarh	Administrative (Census - 2011)	Chhattisgarh
Population (Persons)	25,545,198	Area	1,35,194Sq.Km
Male	12,832,895	Number of Districts	27
Female	12,712,303	Number of Tehsil/Taluka	97
Sex Ratio (Persons)	991	Number of Zilla Panchayats	27
Rural Population (Persons)	19,607,961	Number of Jan Pad	146
Urban Population (Persons)	5,937,237	Number of Gram Panchayat	9193
Child Population (0-6 years)	3,661,689	Number of Villages	20126
Rural Child (0-6 Years)	2,924,941	Health Indicators (SRS-2012)	Chhattisgarh
Urban Child (0-6 Years)	736,748	Crude Death Rate (CDR)	7.9
Child Sex Ratio (Persons)	969	Infant Mortality Rate (IMR)	47
Density of Population	189	Neonatal Mortality Rate	31
Literacy Rate% (Persons)	70.3	Post Neonatal Mortality Rate	15
Literacy Rural (Persons)	66%	Under 5 Mortality Rate	55
Literacy Rural Male%	77	MMR (SRS-2010-12)	230
Literacy Rural Female%	55.1	% of Under Weight (NFHS-3)	40
ST Population	33%	% of Wasted (NFHS-3)	23
SC Population	11%	% of Stunted (NFHS-3)	45

1.2 Health Profile of Chhattisgarh

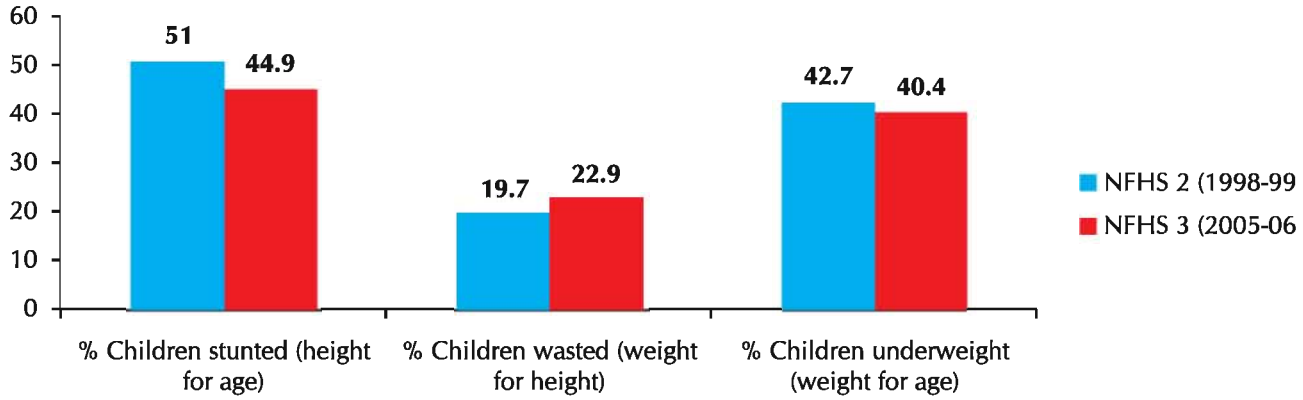
Table-1 shows that the Infant Mortality Rate (IMR) in Chhattisgarh is currently estimated at 47 as against the national average of 42 per 1,000 live births (SRS-2012).The IMR is higher in the rural areas 48than the urban areas 39 per 1,000 live births. Similarly, the Crude Death Rate (CDR) is also high 7.9 per 1,000 live births followed by the Maternal Mortality Ratio (MMR)230 per 1,00,000 live births, whereas at the national level CDR stands 7.0 per 1,000 live births and MMR 178 per 1,00,000 live births. According to India State Hunger Index-2009, Chhattisgarh is ranked 14 (more prevalent) among the 17 States surveyed for prevalence of hunger (undernourished and underweight etc.) in the year 2009. It has 12.19 million people living below subsistence level and 47.6% children are underweight (children < 5 years) and 23.3% of children undernourishment.

1.3 Nutritional Status of the Children and Mothers

The study conducted by the Government of India through the National Family Health Survey (NFHS) indicates that during the period between NFHS-2 (1998-99) and NFHS-3 (2005-06), decline has been observed (Figure-1) for stunting and underweight among children under three years of age, whereas the percentage of children wasted has increased. It is a well-known fact that, the nutritional status of pregnant and lactating mothers has a very significant bearing on the nutritional status of children. The NFHS-3 results support this as malnutrition among children is highest for underweight mothers.

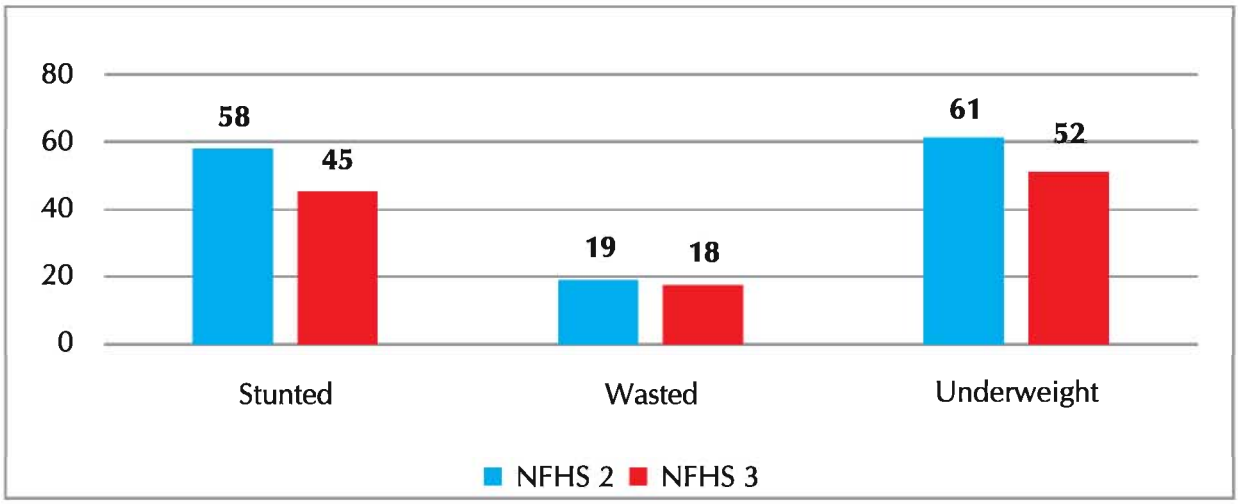
Figure - 2 shows that almost half of children (45%) in Chhattisgarh under age three are stunted, a reflection of chronic under-nutrition; one-fifth of children (18%) are wasted, indicating acute under-nutrition; and 52% are underweight, which takes into account both chronic and acute under-nutrition in the State.Figure-3 shows that the nutritional status of children is strongly related to the nutritional status of their mothers. Children whose mothers are underweight (with a body mass index less than 18.5 kg/m2) are much more likely than other children to be stunted, wasted and underweight. On the other side, children whose mothers are overweight are least likely to be undernourished.

Figure-1: Nutritional status of children in India under 3 Years of Age



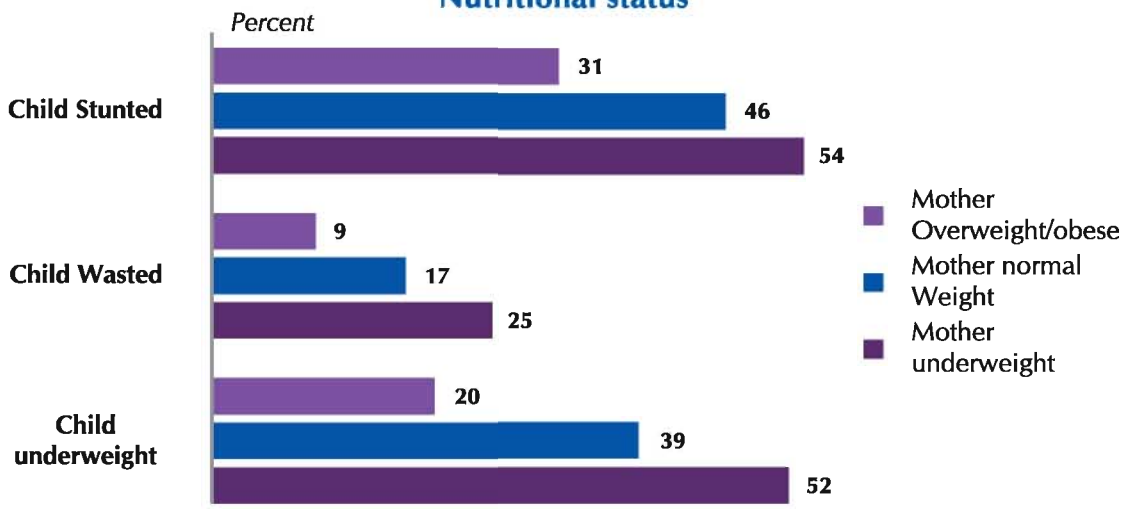
Source: NFHS-2 (1998-99) &NFHS-3 (2005-06), Nutrition in India, MoH&FW, Govt. of India

Figure-2: Nutritional status of children under 3 Years of Age in Chhattisgarh



Source: NFHS-2 (1998-99) & NFHS-3 (2005-06), Nutrition in India, MoH&FW, Govt. of India

Figure-3: Stunting, Wasting and Underweight among children under 5 years of Mother's Nutritional status



Source: NFHS-2 (1998-99) & 3 (2005-06), Nutrition in India, MoH&FW, Govt. of India

1.4 Constitutional Provisions and National Policies on Health for Children in India

India as a welfare State provides some basic Rights to the citizens. The provision of health care is the basic human Rights of the people and it is the duty of the State to fulfil it as health comes under the State list of the Constitution. The following are some of the basic Rights on health envisaged under the Constitution of India.

- Article 45 of the Constitution specifies that the State shall endeavor to provide early childhood care and education for all children until they complete the age of 6 years.
- Article 47 states that the State has a primary duty to raise the level of nutrition and the standard of living, as well as to improve public health and monitor the development and well-being of children in the country.
- The 73rd and 74thConstitutional Amendment has empowered the local self-government specifically to the Gram Panchayat with devolution of power and responsibilities in the rural health, education and sanitation.

The State embarked on a comprehensive health policy to institutionalize rural health sector.The National Nutrition Policy-1993was introduced to combat the problem of undernutrition. It aims to address this problem by utilizing direct (short term) and indirect (long term) interventions in the area of food production, public distribution, health, family welfare, education, rural and urban development, woman and child development etc.

The National Population Policy-2000 aims at improvement in the status of Indian children. It emphasized free and compulsory school education up to age 14, universal immunization of children against all vaccine preventable diseases, 100% registration of birth, death, marriage and pregnancy, substantial reduction in the infant mortality rate and maternal mortality ratio etc.National Health Policy-2002 emphasizes on how to achieve an acceptable standard of good health amongst the general population in India. The approach is to increase access to the decentralized public health system by establishing new infrastructure in deficient areas, and by upgrading the infrastructure in the existing institutions. Overriding importance is given to ensuring a more equitable access to health services across the social and geographical expanse of the country. The following are some important schemes implemented for the improvement of nutritional status of Children in the country:

1. Integrated Child Development Service
2. Integrated Child Protection Scheme
3. Balika Samriddhi Yojana.
4. Nutrition Programme for Adolescent Girls

5. Welfare of Working Children in Need of Care and Protection
6. Rajiv Gandhi National Creche Scheme for children of working mothers.
7. National Rural Health Mission
8. Rajiv Gandhi Scheme for Empowerment of Adolescent Girls – SABLA

The prevalence of malnutrition among children under 3 years of age is still alarming in the country in spite of various schemes, strategies, plans and policies implemented by the Union Government as well as by different State Governments. Special efforts are the felt need to address the various issues on malnutrition that would focus on the most vulnerable children with particular emphasis on age (under 3 years), economic and gender equality (poor families need more support) and on socially excluded groups (based on social identity or gender discrimination). The gender inequality is also wide in various States in India, calling for special attention on girl child.

2. Innovation Context

The Census 2011 estimates that, in India there are 158. 8 million children below 6 years of age. Nearly 40% of these children are undernourished that means more than 63 million children are suffering from malnutrition as the nutritional problems are substantial in every State in the country. The proportion of children under age 5 years who are underweight was lowest in Sikkim (19.7%) followed by Mizoram (19.9%). The States with more than 50% of children under 5 years of age, underweight are Madhya Pradesh (60%), Jharkhand (56.5%) and Bihar (55.9%). Other States where more than 40% and up to 50% of children are underweight are Meghalaya, Chhattisgarh, Gujarat, Uttar Pradesh, and Odisha. Although the prevalence of underweight is relatively low in Mizoram, Sikkim, and Manipur, even in those States more than one-third of children are stunted. Stunting was more prevalent in Uttar Pradesh (56.8%) followed by Bihar (55.6%) and Meghalaya (55.1%). Wasting is most common in Madhya Pradesh (35%), Jharkhand (32%), and Meghalaya (31%). These results reveal that, the severity of child malnutrition varies across States in India.

Despite substantial improvement in health and well-being, undernutrition remains a silent emergency in India since independence. Almost half of all children under the age of three are underweight, 30% of newborn with low birth weight, and 52% of women and 74% of children are anemic. It is the underlying cause of about 50% of the 2.1 million under 5 deaths in India (NHFS3-2005-06). The prevalence of undernutrition is highest in Madhya Pradesh (55%), Bihar (54%), Odisha (54%), and Uttar Pradesh (52%), while Kerala (37%) and Tamil Nadu (27%) have lower rates.

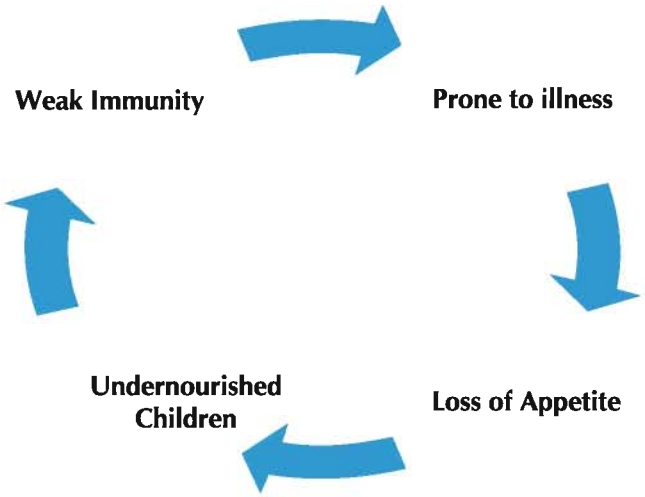
The basic determinants of undernutrition include poverty, lack of agriculture, improper public distribution systems, lack of education and communication, water and environmental sanitation,

control and use of resources (human, economic and natural) shaped by the macro-socio-economic and political environment. Undernutrition is an outcome of insufficient dietary intake, absorption and inadequate prevention and management of disease/infections. Malnutrition occurs mainly because of irregular food habits, types of food intake, livelihood, nutritional security, income inequality, and lack of attention on the health needs of adolescent girls. The most obvious reasons behind malnourishment among children under 3 years of age are: unavailability of food, long working hours of mothers and no adult to look after or feed them during the day, inadequate knowledge on nutritional need of children after six months of age. Other underlying causes also include lack of access to health, child care services, hygienic environments, and lack of access to household food security, livelihoods, inadequate caring and feeding practices for children.

The golden interval for intervention is believed to be from pregnancy to 2 years of age, after which under nutrition may cause irreversible damage for future development. Poor fetal growth or stunting in the first two years of life leads to irreversible damage. Inadequate cognitive or social stimulation in the first two to three years has a lifelong negative impact on educational performance and psycho-social functioning. The key lies in feeding nutritious diet, even when the child is not well. In spite of several focused initiatives addressing the various needs of children in India, it is very evident, a lots need to be done to improve their condition in all realms of child survival, child development and child protection.

The Breast-feeding is sufficient for a child under 6 months of age. Thereafter, the child needs other nutritional supplements along with breast-feeding. Children under 3 years of age are especially prone to malnutrition since there is usually no one to regularly feed them if parents g for work and they cannot feed themselves. Undernourished children grow into undernourished adults who have weak immunity to illness and poor work capacities that affects their earning capabilities. Undernourished girls grow into weak mothers, give birth to under-weight babies, thus maintaining the vicious circle of illness and poverty.

Figure - 4: Vicious Circle of Illness



The Government of India and State Governments have taken different strategies to combat malnutrition and safeguard childcare, but constraints remained in the implementation process. Various National level program that contribute to improved nutrition outcomes include: ICDS, NRHM (Janani Suraksha Yojana), TSC, National Rural Drinking Water Program, Mid-Day-Meal Scheme, Targeted Public Distribution System, MGNREGA, National Food Security Mission and National Rural Livelihood Mission among others.

The MNREGA also envisaged opening up of crèches at the work site and wages for the care taker for its smooth functioning. However, owing to several reasons a large proportion of workers choose to get employed outside the realm of MNREGA. And for such workers who get employed as wage laborers locally, alternative facilities for childcare were required.

Community based-work, public education and behavior change communication at family level have been chosen as key strategy for change in public behavior and nutritional status. It requires coordination and support among government, civil society, non-government organization, community and people at all levels of governance.

The surveillance made by the NGO organizations such as Jana Swasthya Sahayog (JSS), UNICEF brought to light the incidence of high rates of malnutrition among the children, especially in the age group of 6 months to three years. It is known and proven universal fact that to reduce infant mortality the control on malnutrition is the best way for developing countries.

As per NFHS-3 (2005-06), 48% of children under age 5 years are stunted (too short for their age) which indicates that, half of the country's children are chronically malnourished. Acute malnutrition, as evidenced by wasting, results in a child being too thin for his or her height. 19.8% of children less than five years in the country are wasted which indicates that, one out of every five children in India is wasted. 43% of children under age five years are underweight for their age.

The Sample Registration System of Govt. of India, in 2010, estimated that, out of the total deaths reported, 14. 5% are infant deaths (< 1 years), 3.9% are the deaths of 1-4 years children, 18.4% are deaths of children of 0-4 years and 2.7% deaths pertained to children of 5-14 years. The percentage of infant deaths to total deaths varies substantially across the States. From a moderate level of 2.8% in Kerala, 5.0% in Tamil Nadu to as high as 21.8% in Rajasthan, 21.2% in Uttar Pradesh, 20.4% in Madhya Pradesh with other States figuring in between these States. At the national level, the percentage share of infant deaths to total deaths in rural areas is 15.8%, whereas in urban areas, the same is 9.7%.

In 2010, IMR is reported to be 47 at the national level, and varies from 51 in rural areas to 31 in urban areas. Infant mortality has declined for males from 78 in 1990 to 46 in 2010 and for females the decline was from 81 to 49 during this period. Though the urban and rural gap in infant mortality has declined over the years, still it is very significant. The IMR has declined in urban areas from 50 in 1990 to 31 in 2010, whereas in rural areas IMR has declined from 86 to 51 during the same period. Nearly 50% of child deaths reported are due to malnutrition. The State intervention is necessitated due to the alarming rate of prevalence of malnutrition in Chhattisgarh- 47% percent children born are underweight (< 2.5 Kg), 38% women are underweight (< 18.5 BMI) and anemic (NFHS-3/2005-06).

2.1 Gaps in Intervention

There is no strategy which is universal? Strategies require an in-depth understanding of local problems, customs and tradition. Only when community invests its time in evolving a strategy for a programme from its inception to planning and execution, the undernourishment can be addressed effectively.

There are different strategies followed globally. Brazil has a Conditional Cash Transfer (CCT), where all the family members are mandated to visit hospital for checkup in every month and secondly the school age elder siblings have to compulsorily attend school. Bangladesh has a 1,000 day critical window which encapsulates care right from conception to two years of child age. India has the distinction of floating a comprehensive child care service (ICDS) as early as in 1975. The ICDS caters primarily to the children in the age group of three years to six years. The younger child in the age group of six months to three years is given take home ration of ready to eat supplements, which in most cases is diluted at the family level. The backyard poultry, kitchen gardens are encouraged for self-sufficiency in food security which did not yield the desired results. Various national level program discussed in earlier contribute to improved nutrition and early child care, but has little impact of improvement of nutritional status of children. UNICEF is supporting State Government with its Total Sanitation Campaign to promote hygiene and safe drinking water, and to eradicate open defecation that have a high impact on children's health.

The program and policy initiatives lacked rigor in addressing problems unique to the young child under 3 years and undernourished women in the child life cycle process. The concerns of under 3 year old children are different because of their young age. The cognitive development of the child is at its best in the first 2 years of their growth. The young child needs protective care and frequent feeding as they cannot feed for themselves. Strategies apart, the key lies in effective implementation process with

tangible outcomes. Any strategy is optimal only if it can be assimilated into the existing structures of governance. A radical paradigm shift is no solution for the rural health sector. It needs an evolving environment to safeguard community interests, child care and introduce moderate changes to institutionalize the resultant processes. The focus is on the implementation strategy within the existing structures and making the institutions more sensitive to the needs of young children and vulnerable women.

2.2 New Approach to Address - Issues on Malnutrition

Malnutrition, a serious problem in Chhattisgarh, afflicts 65% of children under five, and causes over 50% of all deaths in this age-group. Undernutrition creeps in very early, by age one, when solid foods start to play a significant role. The initiative to prevent malnourishment in young children is a challenge addressed through innovation of best innovative practices aimed at preventing malnutrition and improving rural health and sanitation.

The New innovation aimed to focus on women and children with greater direct and visible impact on nutritional status and adopting a life cycle approach to child nutrition involving multiple stakeholders, strengthening community convergence, universalizing health practices. The innovation not only controls and prevents malnutrition, but also stimulates capacity building in children. The new approach aims to reduce the numbers of malnourished children and reduce the infant and child mortality rate caused due to malnutrition. Good exposure to family and community of undernourished children, to learn community based management practice (CBMP) for checking malnutrition, to which now they can use in a lifetime. Capacity building of field functionaries' viz. Anganwadi Worker (AWWs)/Mitaninon community based management of malnourished children and instituting practices/system of referral to the Nutritional Rehabilitation Center (NRCs).

2.3 Initiatives of State Health Resource Centre

State Health Resource Centre (SHRC), Chhattisgarh is an autonomous institution formed in the year 2004, under the aegis of the Department of Health and Family Welfare, Government of Chhattisgarh to provide the technical support the government for improving the access, quality and equity in the public health system. It also comprehends rural health concerns, conceptualize alternative solutions, design a workable framework, train human resources required and monitor the process implementation. Prevention of the high incidence of malnutrition among the young children, which was adversely affecting the child's life cycle process is one of the main concerns of the SHRC. As

the Government sponsored program and interventions failed to deliver desired results in addressing child malnutrition, an urgent need was felt to improvise and innovate new schemes within the existing framework, for tangible outcome based results. The SHRC persuaded the district collector of Surguja to introduce rural Crèche for young rural children aged less than three years from the funds available at his discretion. On a pilot basis, Surguja District collector released an amount of Rs. 25,000/- to start the initiative through the Panchayati Raj Institutions.

The Zilla Panchayat Surguja District initiated a multi-pronged program to combat malnutrition called "Surguja Suposhan Abhiyan" in August 2012. The objective of the program was to provide hot cooked meals of spot feeding to the children aged 6 months to 3 years at a rural Crèche and also provide child care in a safe and protective environment for the children in the day time when mothers go to work. The scheme was a part- replication of a similar scheme launched by JSS an NGO which was sensitive to the needs of the young children from a poor socio economic background in rural areas. The JSS was in the community medicine and rural health care since 2000. Thereafter the scheme was extended to 300 selected habitations in Surguja district.

Fulwari is a community managed intervention initiated and started by the SHRC, Chhattisgarh. It is an outcome of community capital with the technical support from the SHRC to improve the nutritional status among the rural children in the State. It is the vision of SHRC and JSS to ensure children aged under 3 years get fed frequently and enough food goes directly into their stomach. The innovative strategy of spot feeding to the young child directly at the Crèche had positive and encouraging results. With sustained emphasis on the early childhood care and education, the Fulwari in a large extent transformed the nutritional status of the rural children.

2.4 Objectives of the Fulwari Scheme

1. To give child care and supplemental nutrition food to poor children, along with pre-school stimulation activities.
2. To provide spot feeding to the rural, tribal children to enhance their nutrition status.
3. To improve the household food security level through the promotion of kitchen gardens, horticulture, backyard poultry, systemic root intensification etc.
4. To imbue health messages and pre-school learning activities among the children along with the feeding practices through the Fulwari centers.
5. To converge Department of Health with Department of Education, Panchayati Raj Institutions, Water and Sanitation, and the Department of Rural Development.

Methodology

The present study uses both qualitative (interview with the key officials and focus group discussion Fulwari workers, Mothers and Mitanin) and a limited amount of quantitative data collected from field visits and also provided by the JSS and the SHRC. Indepth interviews were administered to the key persons associated with the Fulwari scheme both at the JSS and SHRC. Observation methods also applied during visits to Fulwari centers and different habitations and meeting various stakeholders. The following key officials were interviewed during the field survey.

- Dr. Prabir Chatterjee, Director, SHRC, Govt. of Chhattisgarh
- Samir Garg, Program Coordinator, SHRC, Govt. of Chhattisgarh
- Dr Yogesh Jain, JSS, Ganiyari, Bilaspur
- Dr. Ravindra, Program Coordinator, JSS, Bilaspur

A sample survey was conducted to understand the process of working of Fulwaris and its' practices in Gariyabund, Kenker, Rajnandgaon and Bilaspur districts in Chhattisgarh. The weight of children measured and compared with the data recorded in the registers of the previous months. An effort was made to understand the impact of the scheme on rural families especially on working women. The study also utilized the data from various secondary sources of government gazette notifications and other relevant documents.

3. Implementation Process of the Fulwari Scheme

The Zilla Panchayat is the nodal agency to initiate the process, execute and monitor the progress of the Fulwari along with the Gram Panchayat based on the support structure of the Mitanin program at the habitation level. Fulwaris are primarily community managed interventions. In the habitation level meetings, the Mitanin Trainee will share details and the necessity of starting a Fulwari. The community after due consultation process has to raise a demand note expressing willingness to start Fulwari in their habitation by coming forward to provide safe, voluntary space and with the list of volunteers willing to work at the Fulwari center.

3.1 Selection Process

Owing to limited resources, only 30 Fulwaris will be started per Jan Pad concentrating primarily on the poorest of the habitations identified by the Mitanin Trainee (ASHA) in their field surveys. Mitanin Trainee will have two to three consultative meetings with the habitation members and with the parents of the children in the age group of 6 months to 3 years. The written demand to start a Fulwari requires to be seconded by the Gram Sarpanch (Village Head) or Ward Panch. Fulwari can be started with at least

five children. If the number of children ismore than twenty then it is divided into two different Fulwaris. If there is more than one application to start the Fulwari at the same habitation, the decision of the Jan Pad is final.On concurrence with the objectives of Fulwarischeme, the habitation is accorded permission to start the Fulwari by the Gram Sabha.The Gram Sabha is bestowed with the power to scrutinize the records, supervise the operations, adviceand monitor the regular functions of the Fulwari scheme.

3.2 Requirements to Set-up a Fulwari Center

The following requirements are essential to set-up a Fulwari centers in the villages.

a) **Rural Creche:** It is called Fulwari center, a place which is safe for children and provided by the Gram Panchayat. It will have a separate kitchen and walled court yard for the safety of the children

b) **Facilities:** Plates, glass and spoons depending on the number of children, ultra violet drum (Water disinfectant), mosquito nets, utensils to cook food, soft toys, pre-school material, plastic mats or reeds, swings for the children to sleep-in, first-aid kits etc.

c) **Working hours:** It will have at least eight hours with flexible opening hours according to the season.

d) **Fulwari worker:** Either a paid worker or mother, volunteer to take care of the children with at least one per ten children.

e) **Health worker:** Health monitoring and services are managed by Mitanin (ASHA) or village health worker.

f) **Coordinator:** At least one coordinator per block or cluster to supervise

g) **Monitoring:** It is monitored by the community through monthly meetings

h) **Growth monitoring:** Nutritional supplements, according to the age of the children. Each child's weight and height were measure at the time of entry to the Fulwari, along with the date of birth followed by monthly weight measurement and half yearly height measurements to be recorded clearly.

i) **Family Involvement:** Child care and nutrition education for parents.

3.3 Check List

As the children need a safe and protected environment, so it is imperative to prepare a check list before starting a Fulwari center anywhere in the villages.

- To ensure consultative meeting has taken place before starting
- To check the availability of the duty chart
- To check for safe environment
- To check for menu chart
- To confirm serving of egg thrice in a week is incorporated in the menu chart
- To check the availability of mats
- To ensure availability of sufficient utensils to cook food & feed.
- To ensure mosquito net
- To check the existence of the Mothers Committee with Mitanin as a member
- To ensure the purchasing committee gets the first installment of the funds
- To ensure purchases are made locally
- To ensure availability of fire wood, vegetables and eggs on day to day basis
- To check whether the Sarpanch is aware of the starting of Fulwari
- To check whether the Women Panch (Head) is aware of the Scheme
- When is the date fixed for establishing the Fulwari
- How many children in the age group of 6 months to 3 years are there?
- How many pregnant and lactating women are there?

3.4 Provision of Nutritional Supplements

The following provisions of nutritional supplements are given to the young children in each and every Fulwari centers on the regular and rotation basis.

a. **Sattu or RTE (Ready to eat supplements):** 60 gram/day, once daily, providing 305 Kcaland 6 gram of protein.

b. **Khichdi or Dal-Chawal (mixture of rice and dal):** Twice in a day with a teaspoon of oil

c. **Boiled Eggs:** Twice in a week.

d. **Iron supplement (Vitcofol):** 3mg / Kg twice in a week

e. **Sattu:** Sattu is prepared by women's groups in the villages, which is purchased by the JSS for distribution to the Fulwaris. It is a mixture of Wheat (50%), Barley (25%), and Bengal gram

(25%), which are cleaned, roasted and powdered. 200 gram of this dry mixture and 100 gram of sugar are packed together for delivery to the Fulwari. The Fulwariworkers cook each packet of Sattu in water and serve it to 5 children. The children are fed Sattu each morning, soon after they arrive at Fulwari.

f. **Khichdi:** 100 gram of rice and 20 gram of pulses per child are mixed and boiled with turmeric and salt, and given with a teaspoon (5 ml) of oil to the children twice during their day at the Fulwari. If not Khichdi, the child can also be fed hot cooked rice and pulses or rice and green vegetable curry. The menu described gives about a total of 780 Kcal and 19 gram of protein per day (about 70% of daily calorie requirement) to each child. The parents are expected to feed the children twice at home (the remaining 30% of the daily calorie requirement) and also to add oil in their food.

3.5 Regular Practices at the Fulwari Centers

The Fulwari concentrates on child-centric diet, maintaining cleanliness at the center, imparting hygiene practices to the child. The State is collaborating with Center for Learning Resources (CLR), Pune for cognitive faculty improvements in children, which is in its formative stage of development. The Fulwari is mandated to prominently display the Timings Chart, Menu and Duty Chart of Volunteers. It is the responsibility of the caretaker to register the weight and date of birth of the child at the time of joining the Creche. Subsequently, the weight and height of the child is measured once in a month and once in six months respectively. The center also imparts health messages through charts and posters of locally available fruits, vegetables and flowers. The child is made to practice on reflexes and on Eye-Hand coordination through soft toys and stimulates learning abilities. The time table is practiced every day for the child to understand the importance of hand washing practice before and after eating food. The parents are also encouraged to practice it at home. The child continues to follow the practice at home before eating food.

Table-2: Time Table Followed at the Fulwari Centers

Time	Child Activities
9:00 to 9:15	Entry of Children to the Fulwari
9:15 to 9:30	Hand wash of children
9:30 to 10:00	Breakfast
10:00 to 12:00	Play time, storytelling and other activities
12:00 to 12:15	Hand wash of children before lunch
12:15 to 13:00	Lunch
13:00 to 14:00	Sleeping
14:00to 15:00	Play time
15:00to 15:15	Hand wash of children
15:15 to 16:00	Lunch 2
16:00 to 17:00	Child leave the Fulwari

The duty chart is prepared well in advance with the consultation held at the community level meetings. The duty chart envisages 1:10 ratio of caretaker and children. In case of more than ten children, two mother volunteers have to be present. If a mother (volunteer) is absent on the day of the duty it is her responsibility to make alternate arrangements.

Table-3: Duty Chart of Caretaker

Day	Name of the Mother Volunteer
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

Table-4: Menu Chart

Day	Breakfast	Lunch 1	Lunch 2
Monday	Ready to Eat	Rice-Dal and Egg	Rice and green Vegetable
Tuesday	RTE	Rice- Green Vegetable	Rice- Dal
Wednesday	RTE	Rice-Dal and Egg	Rice green Vegetable
Thursday	RTE	Khichdi	Rice Dal/Green Vegetable
Friday	RTE	Rice-Dal and Egg	Rice and Green Vegetable
Saturday	RTE	Khichdi	Rice-Dal*/Green Vegetable
Sunday	RTE	Rice-Dal and Egg	Rice and Green Vegetable

4. The Panchayati Raj Institution (PRI) Model and the Jana Swasthya Sahayog (JSS) Model of Fulwari Scheme

This section discusses on the Panchayati Raj Institution (PRI) model as well as the Jana Swasthya Sahayog (JSS) of the Fulwari scheme. It also describes the salient features and various activities of the PRI model and JSS model.

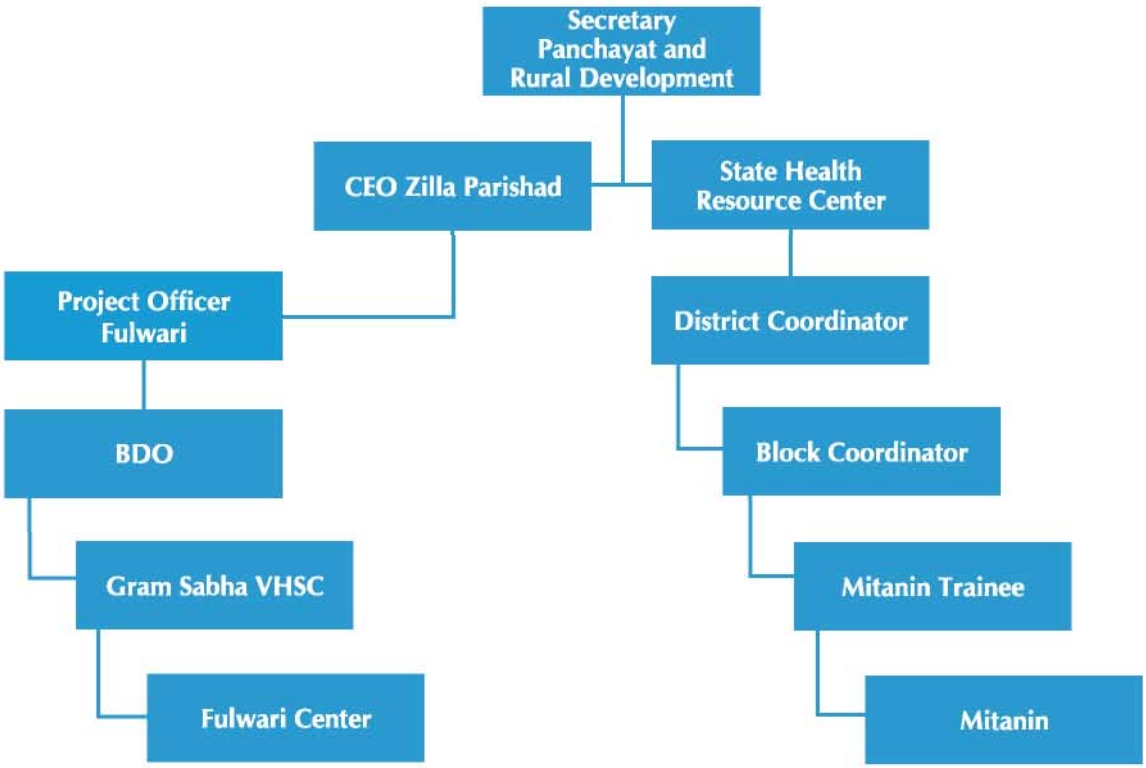
4.1. Organizational Structure of the PRI Model

The PRI has two parallel structures coordinating both at vertical and lateral levels in the Fulwaris.

A) Administrative and Financial Structure: The Secretary of Panchayat and Rural Development is at the top of the hierarchy in the organizational structure of the Fulwari center. Chief Executive Officer of the Zilla Parishad is the Project Officer (Fulwari) followed by the Block Development Officer, Sarpanch and member of the VHSC.

B) Facilitative Structure: The Director of SHRC is at the topof the ladder with a defined role to design, train, monitor, and evaluate the implementation process of the Fulwari scheme followed by the State Program Coordinator, Zonal Coordinator, District, Block Coordinator, Mitanin Trainee and Mitanin.

Figure-5: Organizational Structure of PRI Model



4.2 The Salient Features of the PRI Model

- To care and adopt best feeding practices for children in the age group of 6 months to 3 years
- To protect the child from endemic and communicable diseases and provide the safe protective environment.
- To feed at least once in a day hot cooked nutritious diet to pregnant and lactating mothers to improve weight gain
- To encourage kitchen garden, backyard poultry in community households
- To integrate and consolidate PRI in health and nutrition with active Gram Sabha participation.

The PRI model follows the details of the role and key responsibilities of various organizations in its three-tier structure.

4.3 Various Activities of the PRI Model

A) Gram Sabha

- To have a constructive role in rural health, education, social welfare of the people
- To monitor the performance of Fulwari
- To release funds to VHSC or Women Self-Help Groups to make funds available to the Fulwari Mothers Committee and subsequently prepare a detailed utilization certificate of the funds and sent reports to Block Panchayat or Jan Pad.
- To cooperate and interact with the Mothers Committee constituted to run the Fulwari.

B) Jan Pad Panchayat

- To cooperate and maintain consultation process with the members of Gram Panchayat or Secretary, Gram Panchayat
- To help in the opening of bank account for the purpose of starting a Fulwari
- To advance funds to the Gram Panchayat on time
- To scrutiny the funds utilization certificate of Gram Panchayat and forward to Zilla Panchayat
- To monitor the activities of the Secretary, Gram Panchayat

C) CEO Zilla Parishad

- To have a comprehensive monitoring of the Fulwari schemes in the district
- To advance funds to Block Panchayat on time
- To monitor the activities of Block Panchayat

D) Mitanin

- To inform the habitation about the need and utility of the Fulwari
- To monitor the health of illness prone children and women and advice appropriate remedy.
- If a child is absent for three days at Fulwari, the Mitanin has to visit the household to find the reason and suggest appropriate remedy.

E) Village Health and Sanitation Committee (VHND)

- To facilitate the release of funds to procure the basic materials required to start a Fulwari and advance funds from time to time for the successful working of Fulwari.
- To Submit funds utilization certificate of Fulwaris to the Gram Panchayat

F) Mitanin Trainee (MT)

- To have meeting with habitation and inform necessary precautions from time to time.
- Helps to form the Mothers Committee to operate Fulwari in rotation every week and submit the list of volunteers with assigned days of duty to the Gram Panchayat
- To inform the Mothers Committee on the guidelines to be followed in the working of a Fulwari.
- To help Purchase Committee constituted from among the Mothers Committee with Mitanin as a member, prepare the funds utilization certificate to be submitted to Village Health and Sanitation Committee
- Maintains necessary communication with Gram Panchayat
- In case of any emergency the issue to be brought to the notice of Block Coordinator (Mitanin Program) for further action.
- Ill health children and Women get free advice on remedial measures by the Mitanin
- Mitanin monitors the health and nutrition status of Children and Women
- The weight of the children and Women are measured and recorded every month with the support of AWW
- Counsel to the family on child upbringing and nutritional value of severely malnourished children.
- The communities are encouraged to cultivate kitchen gardens for green vegetables, backyard poultry for eggs etc.
- Mitanin program immensely improved community participation in Fulwari Yojana, and made the program durable and sustainable. They receive training from SHRC.
- To ensure at least two meetings of the mothers per month at Fulwari
- MT in one of the meetings takes the measurement of the weight of the children
- The Mothers are also trained to record the measurements

- ☛ MT enlightens the mothers on the nutritional status and health issues.
- ☛ The recorded weight is compared with the data of the past two months to see the progress
- ☛ If there is no weight gain from the past two months the child is given special care
- ☛ Severely and Acutely Malnourished children are referred to the Nutritional Rehabilitation Center situated at the Head Quarter.
- ☛ All children in the Fulwari are given 1 ml of Iron Supplements twice in a week on Fridays and Saturdays.

G) Block Coordinator (Mitanin Program)

- ☛ To monitor the activities of Mitanin Trainees
- ☛ To coordinate with Block Panchayat
- ☛ To inform field related problems to Block Panchayat and also to the District Coordinator (Mitanin Program).

H) District Coordinator (Mitanin Program)

- ☛ To monitor the activities of Mitanin Trainees and Block Coordinators
- ☛ To coordinate necessary communication between Block Panchayat and Zilla Panchayat

I) State Health Resource Center

- ☛ To impart training and make available training materials
- ☛ To monitor the activities of District Coordinator
- ☛ To monitor the process and inform field related problems with solutions to Panchayat and Rural Development Department.
- ☛ To open regional training centers and train field coordinators.

The Mitanin (Village Health Activist-ASHA) is the backbone of the innovation. The Mitanin is the change agent in this innovative practice. The State has appointed 60,000 Mitanins serving to the needs of every habitation. The Mitanin monitors the physical well-being of the child and periodically help with immunization program and in the surveillance of endemic or communicable diseases. Whereever necessary the Mitanin helps in referring to the child to the Nutritional Rehabilitation Center located at the district level for further rehabilitation.

J) Other Practices at the Fulwari Centers

- ☛ The Mothers Committee prepares a menu chart

- Where the child does not eat eggs, alternately milk or fruits to be fed
- The Mothers Committee would constitute a purchasing committee with at least three women members.
- It is the responsibility of the purchase committee to procure funds from VHSC and make appropriate arrangements to provide balanced diet to the young children and mothers.
- It is suggested to make purchases locally.
- The expenses met are recorded in a register along with receipts.
- It is Mitanin Trainee's responsibility to get the expenses approved.
- To take care of the young children and women a duty chart of volunteers is prepared well in advance.
- The volunteer can have one meal at the Fulwari on the day of her duty.
- Children are provided medicine at the Fulwari. Depending upon necessity iron supplements are fed to children in the form of tablets.

4.4 Nutritional Rehabilitation Center

The Nutritional Rehabilitation Center (NRC)is located in every district in the State. The severely and acutely malnourished are referred to these centers. Moderately undernourished are usually not referred. A model menu is prepared for moderately undernourished. They are kept under observation and if the condition doesn't improve over a period of two months the child is referred to the NRC. When a child is admitted at the NRC, it takes about 20 days for the child to rehabilitate. The parents find it difficult to stay for 20 days without going to work and earn for their own sustenance, hence, they ignore. There are 20 NRCs in Chhattisgarh. The NRC takes care of severely malnourished children of the age 1 to 5 years. The Centre not only provides regular health checkups, medicine and required nutritious food for the children, but also counsels the parents regarding proper dietary feeding habits.

The following services are rendered at the Nutritional Rehabilitation Centre (NRC)

(i) 24 hour care and monitoring of the child
(ii) Treatment of medical complications
(iii) Therapeutic feeding
(iv) Providing sensory stimulation and emotional care
(v) Assessment of family to identify and addressing contributory factors
(vi) Counseling on appropriate feeding, care and hygiene
(vii) Follow up of children discharged from the facility

4.5 Initiatives of the Jana Swasthya Sahayog (JSS)

The organizational structure of the JSS is both vertical and lateral that addresses the multi tasks functioning in the rural and community health sectors. Instead of a rigid hierarchical structure they follow a flexible pattern with individual assigned and trained in a multi-tasking environment.

Children are given iron supplements in the form of syrup every day. Fulwari center provides high calorie food, child centric diet and monitors the periodic growth of the child. The child is made to practice of hand wash at the hand wash stations placed at the center before and after eating food. The weight of the child is measured and recorded in every month and the height is measured and recorded once in six months. The emphasis is on early child care and education in a safe and protective environment. The menu chart is prominently displayed. Health messages are taught to children. The emphasis is on nutrition status of the children, child survival and the holistic growth and development of the children.

Table-5: Menu Chart of the JSS

Day	Breakfast	Lunch 1	Lunch 2
Monday	Ready to Eat (RTE)	Khichdi with Boiled Egg	Khichdi
Tuesday	RTE	Khichdi	Khichdi
Wednesday	RTE	Khichdi with Boiled Egg	Khichdi
Thursday	RTE	Khichdi	Khichdi
Friday	RTE	Khichdi with Boiled Egg	Khichdi
Saturday	RTE	Khichdi	Khichdi

Figure-6: Organizational Structure of the JSS

Table-6: Cost Analysis of the JSS to Runa FulwariCentre

Items	10 Children Per Month	10 Children per Year
Sattu	1000	12000
Oil 10 Ml /Day/Child	250	3000
Eggs Twice weekly	300	3600
Rice and Dal for Khichdi	625	7500
Transportation of Food	80	960
Wages for Village Health Worker	2000	24000
Medicines/Others	80	960
Soap, Cloth etc	40	480
Rent for Fulwari	125	1500
Supervision Cost	60	720
Additional Nutritional Supplement	500	6000
Misc.	250	3000
Total	5310	63720
Other Annual One Time Costs		
Pre-School Learning Material	0	500
Mats, Buckets, Plates etc.	0	700
Cooking Utensils	0	400
UV DRUM	0	1800
Insecticide treated Mosquito Net	0	300
Total	0	3700
Total Recurring + Annual	5310	67420
Total Cost of a Child	4570	

Source: Fulwari – Summary of proposal for the year - 2011

4.6 Comparison of the JSS and Panchayati Raj Institutions

It is important to understand and explore the comparative analysis of both the PRI and JSS model.

Table-7 shows the comparative picture of both the models

Jana Swasthya Sahayog Model	Panchayati Raj Institutions Model
Empowerment and community health	Decentralization and community health
Wages: Care taker is paid Rs 2,600/- per month and trained by JSS. It is open for 6 days in a week.	Wages: No Wages. Voluntary work. Work on rotation. Open 7 days in a week
Target Group:Children in the age group of 6 months to 3 years	Target Group: Children in the age group of 6 months to 3 years and pregnant and lactating mothers.
Funding: Committed aid from individuals and friends and private aid	Funding: The State provide funds Rs. 20 Crore has been allocated for the financial year 2014-15
Cost per Fulwari: Rs 65,000/- per annum for a crèche with ten children and a caretaker. (Rs. 23/- per child per day)	Cost Per Fulwari: Rs. 50,000/- per annum for a crèche with ten children and food for caretaker,pregnant women and lactating mothers(Rs.6/- per child per day and Rs.15/- per women per day)
Status: Active	Status: Active
Period of Implementation: JSS-2006 onwards	Period of Implementation: PRI- August 2012 onwards

4.7 Process Analysis of the Fulwari Scheme under the PRI Model

The Mitanin programs and Gram Sabha are central to the success of the initiative of Fulwari scheme. Mitanin is a change agent, Gram Panchayat is the facilitator and the community as the participator. Though the PRI model is evolving, but the results are very encouraging. There is a recorded weight gain among the pregnant women and the children those who attended the Fulwari scheme. The PRI model envisaged two way process analyses with sustained stress on bottom-up approach. The JSS incorporated top-down approach with particular emphasis on quality of delivery. The decision making process is centralized and the impact is evaluated from time to time. The program coordinator is instrumental in bringing perceptible inputs if required, to make the initiative a success. The feedback mechanism helps in sustaining the program and suitable changes are incorporated at the field level. Nevertheless the JSS has limited presence as far as area of operations is concerned and Panchayat model has a more constructive role to play with increasing presence and wider population covered under the scheme.

The coordinators at the Jan Pad and District level are directly engaged in monitoring the health and physical growth of children in the implementation process. It is the responsibility of the Jan Pad coordinator to visit each of the 30 habitations in his area of operation and collect feedback from the mothers, Mitanin and Gram Sabha. Gram Panchayat is the monitoring agency of Fulwari at the habitation level. The short comings or problems in the implementation process are recorded and a detailed report is sent to the SHRC for further action and necessary arrangements are made to redress the concerns. Each of the Fulwari center has a weighing scale to measure and record the growth of weight and height of children once in a month and once in six months respectively. The District Coordinator prepares a monthly report on the functioning of Fulwari in his area of operation. The SHRC prepares a report on the activities of Fulwari and submits to Panchayat Department as well as Department of Health and Family Welfare, Government of Chhattisgarh.

4.8 Process Mechanism of the Fulwari Scheme under the JSS Model and the PRI Model

The JSS has a controlled distribution mechanism to distribute food raw materials to the Fulwari centers. It has evolved an empowerment model where the Crèche worker is paid and given a weekly off. The JSS village health worker visits the center once in a week to monitor the health of the children. The Crèche supervisors visit once in a week to arrange supplies and redress problems. The Program Coordinator monitors the activities of the Crèche from time to time. The center only caters to children aged 6 months to 3 years. The Crèches are evolved to impart quality health consciousness among the

children and families. The feedback mechanism is crucial to the success or failure of any strategic innovation as adopted by the JSS.

The PRI model has decentralized structure in place where members of the community participate both in program formulation to implementation. The service is completely voluntary under the PRI model and there is no worker appointed to run the Fulwari center. The Mothers/Purchasing Committee procures the raw materials locally. Along with children pregnant and lactating women are also fed at the center. Mothers have the freedom to cook vegetables of their choice, however the quality of the food is not compromised. The Menu Chart, Duty Chart, Time Table are need for prominently displayed for public view. The Mitanin visits Fulwari centre every day. The Mitanin Trainee conducts two meetings with the mothers of the children in a month. Block and District Coordinators visit the centers once in a month and once in three months respectively. The District Coordinator sends a report on the working of the Center to the SHRC. The innovation is possible at the field level. The field level issues or problems if properly communicated up the ladder, the policy makers can make suitable changes to make the process more effective and community friendly.

4.9 Inter-Sector Convergence for the Program Implementation

The Fulwari scheme is converged with various Departments of Government of Chhattisgarh. The programalso demands proper coordination and convergence with Health, Education, Public Health Engineering, Panchayati Raj Institutions, and Department of Rural Development etc. The integration of various Departments enhances the public delivery system under the Fulwari scheme.

The Fulwari begins with community initiative and at every stage the community manages the local concerns. It reflects the community participation in the program. Mitanin again played a crucial role in organizing Gram Sabha and making door to door campaign on the utilities of Fulwari Scheme and eradicating the threat of malnutrition.

The Village Health and Nutrition Day (VHND) is celebrated every week at the habitation levels. The Bal Bhoj, Goud Bharai, Annprashan are some of the activities that facilitate community participation and changes behavior of the family. For the cross learning and knowledge management a Monthly/Quarterly/Bi-Annually/annual magazine Angana Ke Gonthhas been started for all AWWs. Nawa Jatan Program has been initiated for community based management of malnourished children.

4.10 Financial Model

Initially, the Fulwari scheme was launched with the funds from the discretionary quota available to the District collector with an allocation of Rupees 25,000 per Fulwari center covering 300 centers in Surguja district. Subsequently, the Govt. of Chhattisgarh has made a budgetary allocation of Rs. 10 Crore in the year 2013-14 through the Panchayati Raj Institutions to start Fulwaris in 2,850 habitations covering the most remote and backward of 85 blocks to meet the nutrition needs of the socially disadvantaged rural habitations. Subsequently, the Government of Chhattisgarh has increased the allocation to Rs. 20 Crore for the current financial year to extend the support to at least 5,700 habitations covering the remaining blocks in the State. Funds are allocated to the Gram Panchayat and Gram Panchayat gives grants to the Village Health and Sanitation Committee (VHSC). The VHSC in turn releases the funds in installments to the Purchasing Committee/ Mothers Committee of the Fulwari. The Gram Panchayat has the overall responsibility over the functioning of the Fulwaris.

A) Flow of Funds

- The Zilla Panchayat allocates Rs. 10 lakh to the identified (Jan Pad) Block Panchayat.
- The Block Panchayat on the recommendation of the Mitanin Trainee release Rs. 30,000/- to each Gram Panchayat, where the community has come forward to start the Fulwari.
- The Gram Panchayat in turn will release funds to VHSC an installment of Rs. 10,000/- to open a Fulwari.
- The VHSC based on the requirements and recommendations of the Purchase Committee constituted Mothers Committee within the habitation to release funds as and when required.
- The Purchase Committee is empowered to buy basic utensils, plates, spoons, toiletries, mosquito net, registers to record, and soft toysnot exceeding an initial amount of Rs. 4,000/-.
- The Fulwari spends Rs. 6/- per day per child and Rs. 15/- per day per women for feeding hot cooked food.
- On the utilization of funds a certificate to be prepared with the help of Mitanin Trainee and submitted to the VHSC for further release of funds.
- The VHSC will submit the funds utilization certificate to the Gram Panchayat and Gram Panchayat to (Jan Pad) Block Panchayat within the financial year for further allocation in the subsequent years.

5. Impact of the Fulwari Scheme

The impact lies in garnering community support to the initiative. It is inclusive to the community interests and program to sustain through community management. The major success of the implementation is generating community awareness towards health hazards and in particular of malnutrition and its impact on the growth potential of children and expectant mothers. Combating of malnutrition is a time bound process, and requires a multi-faceted approach. The severe malnutrition among the children is detected in very early that gives better result to the very young children and one cannot ignore the golden interval for intervention of children aged under 2 years.

The UNICEF-CLR evaluation report of March 2014, documented that after children have spent one year at Fulwari, child malnutrition rate (under-weight) overall came down from 45% to 34%, that means a reduction of 24% over one year. Severe malnutrition amongst 0-3 year aged children declined by 38%. Birth weight of children born to pregnant women fed in Fulwari is better in preliminary assessment. Impact on child mortality rates is under research. Initial data on first year of Surguja district suggests only 12 deaths among the children aged between 6 months to 3 years as opposed to 45 deaths elsewhere in the State in similar populations without access to Fulwari. The report also indicates that 82% of Gram Panchayats helped for smooth functioning and fund flow for Fulwari. The Gram Panchayat also started learning about child nutrition and maternal health through various meetings.

The JNM Hospital evaluation report confirms weight gain among children at the Fulwari center. Even the pregnant and lactating women have gained moderate weight. The JNM Hospital independent assessment found that there is improvement in wasting and weight gain but not in stunting. The JSS model has almost eight years of presence in the domain, but it has a very limited reach in terms of geographical area. It is mostly confined to two blocks of Bilaspur District. The results at the habitation level are very positive and encouraging where the JSS Fulwaris have a presence. The nutrition related problems are most likely more complex, involving inter-generational development, and may not get resolved with simple measures.

Table-8: JSS Comparative Study in Bilaspur District

Indicators	Before implementation (2009) in Percentage (%)	After implementation (2011) in Percentage
Wasted	26	10
Stunted	60	59
Underweight	56	44

The study conducted by the JSS in Bilaspur district of Chhattisgarh shows (Table- 8) that there is declining of underweight from 56% in 2009 to 44% in 2011 but not in height for age (stunting). There is also a reduction of wasted (low weight for height) from 26% in 2009 to 10% in 2011. The weight is measured once in a month and recorded in the register. The height is measured once in six months. There is a visible weight gain in children at the center. But the data are awaited to confirm stunted growth. Even the JSS independent evaluation has results confirming weight gain, but not proportional height gain.

Table-9: Field Visit Report

Age group of Children in Months	Age Weight in Kg.	Previous Avg. Weight in Kg.	Weight Gain in Kg.
0-11	7.400	7.211	0.189
12-23	8.861	8.299	0.562
23-36	9.898	9.312	0.576

The field study conducted by the researcher in four districts (Gariyabund, Kenker, Rajnandgaon and Bilaspur) in Chhattisgarh shows (Table-9) the positive results in weight gain among the children. There is a more weight gain (0.576 grams) among the children aged between 23 to 36 months.

The rapid sample survey does confirm weight gain among children at the Fulwari. Weight gain is one of the aspects in combating malnutrition and it is a positive indicator in the implementation process. Frequent feeding and rich diversity of diet resulted in the weight gain. Though the sample size is very small to generalize, but various studies highlighted the positive result of weight gains.

Child survival and their development is the focus of the Fulwari scheme. The major success of the innovation is the institutionalization of the rural health protection of the children and pregnant women. It restored nutritional status among the undernourished children in the habitations. The scheme also provides pre-school training to the children aged under 3 years that helps to develop their cognitive capacity building. The Fulwari with the help of Mitanin support structure, immensely got benefitted and provides services to the needy undernourished children in the rural tribal habitations. Community managed intervention is the most suited innovation in Indian scenario.

(I) Access to Food Security

Young children get three times high nutritious diets in every day. It is necessary to cultivate kitchen gardens and backyard poultries in the rural areas to provide food security and also to supplement their family incomes. The young children are fed 70% of his/her daily nutritional requirements at the Crèche. The soft toys and flex banners/charts, locally available fruits, flowers, and vegetables stimulate the cognitive abilities of the young minds. It improves the physical reflexes and helps in improving eye-hand coordination. The child is provided a secure environment and comfort in the absence of their

mothers. Pre-school education promotes social cohesion among children and prepares them for formal schooling in their later life. The visible benefit is weight gain as recorded in various evaluation reports.

(ii) Increasing Community Interest in the Fulwari Scheme

Since the Fulwari is a community managed intervention, the families at the habitations found it necessary and willingly extended support and cooperation to the initiative. The rural mothers could go to work without worrying about their children. The lactating and pregnant women are fed one hot cooked meal in every day to improve their nutritional status. The elder siblings could attend school. The health awareness program encourages the pregnant women for the institutional delivery. The JSS with its presence in rural and community health since 2000 has institutionalized rural delivery system. The promotion of health awareness, improvement of nutritional status of the children, lactating and pregnant mothers are the significant achievements of the Fulwari scheme. Children have practiced to wash their hands before and after meals even at homes. The activity based program and safe environment at the Fulwari center has encouraged communities to send their children.

(iii) Transparency in Community Managed Intervention

The active involvement of mothers, Mitanin and village Sarpanch in the intervention ascertained there is no corruption in the implementation process. Quality of service is not compromised as the mothers themselves being the caretakers. The necessity to make local purchases and the intervention of Purchase Committee and Gram Sabha has weeded out any possibility for corrupt practices.

(iv) Creating Awareness about Malnutrition

Nutritional awareness is created among the members through meetings conducted at the Gram Sabha, different types of health awareness program and health messages etc. Village nutrition day is celebrated on every Tuesday and Friday when Take Home Ration is distributed. The UNICEF with the collaboration of Government of Chhattisgarh established Nutrition Surveillance System (NSS) in the year 2009 to monitor the health status of the children. The convergence and active involvement of Gram Sabha, Women Self Help Groups, Mothers Committee, Sarpanch, and Mitanin focus on the child survival and development.

5.1 Challenges in Implementation

Inspite of the recent progress in the health sector, as exhibited by the statistical indicators, the situation is not adequate to ensure a bright future for the children of India. This is a multifaceted problem which is directly linked to a large extent to mother's health conditions, place of delivery, the socio-economic status of the family, and largely along with the country's health care system. Over the

time, the nation has implemented a number of child centric program, much remains to be done to guarantee better health conditions for the children.

The major challenge to malnutrition is mobilizing the community support in the decision making process. Most of the decisions are taken at the district or State level and the community is expected to implement the program. But if the community is involved as a stakeholder in the decision making process, then overcoming the challenges will be easy.

The nutrition related problems are most likely more complex, involving inter-generational development, and may not get resolved with simple measures. It is difficult to accurately monitor child survival indicators such as the percentage of malnourished children. About two thirds of adolescent girls suffer from anemia, an iron deficiency that makes them prone to serious illness.

A State level nutrition communication policy needs to be formulated. During the implementation process, the local culture and folk based activities (Kala Jattha, Nukkad drama, Puppet show, Pandwani, Karm and other folk dance/songs) are needed to be included to make the program more people centric and popular. The radio, TV, slogan writing, exhibition, film show, poster, chart, etc. mediums also need to be used to reach out the large number of population.

(I) Low Resource Mobilization - Human and Financial

A) The intervention is not only needs financial assistance but, also voluntary services. It is difficult to generate potential employment in rural areas as most of them are dependent on agriculture, and work as the daily wage earners the below par earnings - make it difficult to survive.

B) Education status is also a concern, as there is low enrolment and school completion of children from disadvantaged groups. About 1,78,000 children in the age group between 6 years to14 years are out-of-school, with half of these children coming from the five districts of the Bastar region. The program and policy initiatives like Sarva Shikha Abhiyan (SSA) and Right to Education (RTE) have contributed to a new vibrancy, meaning and urgency in the country's efforts to universalize elementary education, and are expected to infuse new life in the schooling system in the years to come. However, the issue of drop outs continues as a major issue in all levels of education. Also the net enrolment ratio in upper primary level is far from satisfactory. Urgent and more focused measures are required to address and tackle these enduring problems in education that has a high impact on health of both mothers and children.

(ii) Lack of clarity in understanding the viciousness of the problem:

Malnutrition is not the result of a single cause; the problem is multifaceted, the causes acting singly or in combination with other complex factors like poverty, purchasing power, health care, ignorance on nutrition and health education, female Illiteracy, and social convention etc. will have high impact on the issue.

5.2 Sustainability and Potential for Replication

There is ample scope for process re-engineering. The PRI model is decentralized and this atmosphere encourages honest feedback to be incorporated at a later stage. There is no compromise on quality of service delivery as the mothers are in charge of running the Fulwari center. The UNICEF has launched software in 2009 to track malnourished children that will help the State Government to implement the program in a needy place/region. The JSS follows a controlled mechanism and there is little scope for process re-engineering, whereas the PRI model has high a opportunity to reach out the targeted population. They focus on quality of service and its delivery is the vital part of the success of the program.

The Fulwari scheme is currently funded by the Government of Chhattisgarh but program needs to be community managed in terms of program planning and execution. Kitchen gardens, backyard poultry, and horticulture practices are encouraged to improve food security at the family as well as at the village level and also as an alternate source of income for the families in habitation.

States across the country with a high incidence of severe malnutrition can learn from the experience of Chhattisgarh initiative. The community managed intervention with persistent leadership from the Gram Panchayat enables significant advances in combating child undernourishment. Malnutrition can be prevented in very early stage of a child with persistent intervention by the local community at the micro level and the State as the macro level.

The golden interval for intervention is believed to be from pregnancy to 2 years age of the child, after which undernutrition may cause irreversible damage for future development of the child. A cycle of illness and malnutrition can be deadly for vulnerable children, particularly those are under 2 years age. Appropriate feeding both during and after illness is critical not only for recovery from a current illness, but also to prevent a child from succumbing to this vicious cycle of illness over a period of time. Approximately half of all children who die from common illnesses would survive if they were properly nourished in right time.

The precious young lives can be saved with the innovative practices adopted for child survival and development. The distinctive idea of a dedicated and committed rural Crèche is in consonance with the idea of inclusive growth with reference to the empowerment and decentralization of the rural health sector. The success of Chhattisgarh initiative is a source of inspiration to worst performing States on nutritional index in India.

6. Lesson Learnt and Key Takeaways

The following are some of the lessons and key takeaways of the study.

(i) To start a programme like Fulwari, you need not to focus more on the development of infrastructure built on proper community based monitoring of regular feeding practice and care within a safe and protected environment suitable for the children.

(ii) Awareness campaign can create a revolution for the success of any program and it should begin within the community.

(iii) We need to move from the contemplative mode of intervention to the active mode of intervention to achieve the desired results of the program.

(iv) The basic practice of Hand Wash will ensure the diseases stay away from the children.

(v) Local Gram Panchayat can provide leadership to convergent various welfare schemes that will bring together elements of health, nutrition, education and horticulture for the development of the rural population

(vi) Local community active engagement in the Fulwari scheme brings smiles to the children.

(vii) Community control and judicious management of funds show transparency in the program that leads to achieve expected outcomes.

(viii) Involvement of the community health workers (Mitanin - ASHA) and facilitating structures like SHRC are critical to the success of the scheme.

(ix) The helping hand of the civil society organization in any program with the State Government may produce desired results.

(x) A strategic policy intervention targeting malnutrition amongst children needs to be appreciated. It is even more pertinent to have such interventions in backward regions in the country.

(xi) Malnutrition can only be addressed "in the context of vibrant and flourishing local food systems that are deeply ecologically rooted, environmentally sound and culturally and socially appropriate.

(xii) Food sovereignty is a fundamental precondition to ensure food security and guarantee the human right to adequate food and nutrition.

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Annexures

Annexure - 1 (A)

छत्तीसगढ़ शासन
पंचायत एवं ग्रामीण विकास विभाग,
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कमांक / पंचा. / पंग्राविवि / 2013 / 135 रायपुर, दिनांक 29-05-2013

प्रति,

1. समस्त कलेक्टर,
(रायपुर, बलौदाबाजार–भाटापारा, महासमुंद, दुर्ग, बेमेतरा, कबीरधाम, मुंगेली, जांजगीर–चांपा को छोड़कर)
छत्तीसगढ़

2. समस्त मुख्य कार्यपालन अधिकारी,
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छत्तीसगढ़

विषय :– फुलवारी योजना का कियान्यन।

—00—

एकीकृत बाल विकास परियोजना की वर्तमान व्यवस्था में 06 माह से 03 वर्ष तक आयु के बच्चों को गर्म पका हुआ भोजन देने का प्रावधान नही है। इस कमी को पूरा करने के लिये प्रदेश के ग्रामीण अंचलों में फुलवारी योजना प्रारंभ किया जा रहा है। प्रारंभिक तौर पर यह योजना अनुसूचित क्षेत्र के समस्त 85 विकासखण्डों में प्रायोगिक तौर पर प्रारंभ किया जाय।

2– फुलवारी योजना में 06 माह से 03 वर्ष उम्र तक के बच्चों, गर्भवती एवं शिशुवती महिलाएं लाभान्वित होंगी। योजना का संचालन ग्रामीण महिलाओं की सहभागिता तथा पंचायतों की देख–रेख में की जायेगी। पंचायतों को पोषण व स्वास्थ्य के महत्वपूर्ण क्षेत्रों में अपनी भूमिका को और सुदृढ़ करने का अवसर मिलेगा।

3– इस पत्र के साथ योजना के उद्देश्य, विभिन्न स्तर पर अधिकारियों एवं पदाधिकारियों की भूमिकाएं, कार्य योजना, कियान्वयन प्रकिया, मॉनिटरिंग एवं राशि की उपयोगिता आदि के संबंध में दिशा–निर्देश संलग्न है। योजना से संबंधित बजट आबंटन आपको पृथक से उपलब्ध कराया जा रहा है। यह ध्यान रखा जाय की योजना के तहत् प्रदाय की गई राशि का शासन द्वारा समय–समय पर जारी आदेशों एवं निर्देशों के तहत् अंकेक्षण कार्य भी संपन्न कराया जाना सुनिश्चित करें।

कृपया योजना के प्रभावकारी कियान्वयन हेतु संलग्न दिशा निर्देश के अनुरूप समुचित कार्यवाही किया जाकर इस विभाग को तत्काल अवगत कराया जाय।

संलग्न :— उपरोक्तानुसार।

(विवेक ढाँड)
अपर मुख्य सचिव
छत्तीसगढ़ शासन,
पंचायत एवं ग्रामीण विकास विभाग

पृ.क./पंचा./पंग्राविवि/2013/136 रायपुर, दिनांक 29-05-2013

प्रतिलिपि :—

1. प्रमुख सचिव, माननीय मुख्यमंत्री, छत्तीसगढ़ शासन, महानदी भवन, मंत्रालय, नया रायपुर की ओर सूचनार्थ।
2. विशेष सहायक मान. मंत्री जी, पंचायत एवं ग्रामीण विकास विभाग, मंत्रालय नया रायपुर की ओर सूचनार्थ।
3. मुख्य सचिव के अवर सचिव, छत्तीसगढ़ शासन, मंत्रालय, नया रायपुर की ओर सूचनार्थ।
4. अपर मुख्य सचिव, वित्त विभाग, मंत्रालय, नया रायपुर की ओर सूचनार्थ।
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8. परियोजना निदेशक, जिला ग्रामीण विकास अभिकरण बलौदाबाजार भाटापारा/गरियाबंद/बालोद/बेमेतरा/मुंगेली/सूरजपुर/बलरामपुर/सुकमा/कोण्डागांव छत्तीसगढ़ की ओर सूचनार्थ।
9. कार्यकारी संचालक, राज्य स्वास्थ्य संसाधन केन्द्र, रायपुर छत्तीसगढ़ की ओर सूचनार्थ एवं आवश्यक कार्यवाही हेतु।
10. समस्त जिला अंकेक्षक, जिला ..... छत्तीसगढ़ की ओर सूचनार्थ।
11. सर्व संबंधित मुख्य कार्यपालन अधिकारी, जनपद पंचायत ..... (रायपुर, बलौदाबाजार–भाटापारा, महासमुंद, दुर्ग, बेमेतरा, कबीरधाम, मुंगेली, जांजगीर–चांपा को छोड़कर) छत्तीसगढ़ की ओर सूचनार्थ।

अपर मुख्य सचिव
छत्तीसगढ़ शासन,
पंचायत एवं ग्रामीण विकास विभाग

अध्याय – 1
प्रस्तावना

तीन साल से छोटे बच्चों, गर्भवती महिलाओं एवं शिशुवती माताओं के लिए फुलवारी केन्द्र की आवश्यकता :–

पोषण विद्यों अनुसार बाल कुपोषण का मुकाबला करने के लिए 6 माह से 3 वर्ष के बीच की आयु सबसे अधिक महत्वपूर्ण है। 6 माह की आयु के बाद बच्चों के कुपोषण में वृद्धि बहुत तेजी से होती है। इसे ठीक करने का सबसे अच्छा अवसर भी 6 माह से 3 वर्ष के बीच ही रहता है। इसलिए इस उम्र के बच्चों की देखभाल और खान–पान पर पर्याप्त समय और विशेष देखभाल की जरूरत होती है। किन्तु अधिकांश गरीब महिलाओं को घर के काम व आजीविका अर्जन हेतु बाहर अधिक समय देना पड़ता है। साथ ही गरीबी के कारण बहुत से परिवार गुणवत्ता पूर्ण भोजन पदार्थ जैसे कि अण्डा, दूध, सब्जी, फल, दाले आदि पर्याप्त रूप से बच्चों को नहीं खिला पाते हैं।

आंगनवाड़ी कार्यक्रम का वर्तमान ढ़ांचा 3 से 6 वर्ष के बच्चों पर केन्द्रित है। 3 से 6 वर्ष के बच्चे रोज आंगनवाड़ी आते है। आंगनवाड़ी के मुख्य संसाधन अर्थात भवन, आंगनवाड़ी कार्यकर्ता, सहायिका 3 से 6 वर्ष तक के बच्चों को भोजन व शाला पूर्व शिक्षा पर केन्द्रित हैं। 3 साल से छोटे बच्चों के लिए आंगनवाड़ी से मुख्यतः साप्ताहिक रेडी–टू–ईट आहार ले जाने की सुविधा है।

गर्भवती महिलाओं को भी समुचित आहार नहीं मिल पाने के कारण गर्भावस्था में उनके वजन में पर्याप्त वृद्धि नहीं होती है। इसका कुप्रभाव नवजात बच्चे का वजन जन्म से ही कम होने के रूप में दिखाई देता है। शिशुवती महिलाएं (0 से 6 माह के बच्चों की माताएं) भी आहार की कमी से कमजोर हो जाती है, जिससे उनके द्वारा भविष्य में कुपोषित बच्चे को जन्म देने की संभावना बढ़ जाती है। परिवार स्तर पर पौष्टिक आहार जैसे कि सब्जी, फल, अण्डा आदि की उपलब्धता भी कम है। उनके लिए भी आंगनवाड़ी से मुख्यतः साप्ताहिक रेडी–टू–ईट आहार का ही प्रावधान है।

अतः आंगनवाड़ी से चल रहे कार्यक्रम के साथ–साथ छोटे बच्चों को दिनभर देखने व खाना खिलाने के लिए फुलवारी आरंभ किये जाने की योजना छत्तीसगढ़ शासन द्वारा प्रावधानित की गई है। जिला पंचायत सरगुजा द्वारा अगस्त 2012 से जिले में फुलवारी का प्रयोग आरंभ किया गया था, जिसमें ग्राम पंचायतों के माध्यम से 300 फुलवारी संचालित हैं। कार्यक्रम का संचालन ग्राम पंचायतों व मितानिन कार्यक्रम के बीच Convergence के माध्यम से किया जा रहा है। सरगुजा जिले के सफल प्रयोग को देखते हुए फुलवारी योजना हेतु दिशानिर्देश तैयार किये गये हैं।

अध्याय – 2
फुलवारी योजना के उद्देश्य

योजना का मुख्य लक्ष्य 3 वर्ष से छोटे बच्चों की कुपोषण दर में कमी लाना है। इस लक्ष्य को प्राप्त करने के लिए योजना के निम्नलिखित उद्देश्य हैं :–

1. 6 माह से 3 वर्ष के बच्चों को देखभाल व संतुलित गर्म पका आहार उपलब्ध कराना।
2. 6 माह से 3 वर्ष के बच्चों की संक्रामक बीमारियों से रक्षा करना।
3. गर्भवती व शिशुवती महिलाओं को संतुलित गर्म पका आहार उपलब्ध कराना।
4. 3 साल से छोटे बच्चे अथवा गर्भवती वाले परिवारों में सब्जी, फल आदि पौष्टिक आहारों का उत्पादन बढ़ाना।
5. पोषण एवं स्वास्थ्य के क्षेत्र में पंचायती राज संस्थाओं की भूमिका को सशक्त बनाना।

अध्याय – 3
मुख्य भूमिकाएं

ग्राम पंचायत :–

- फुलवारी का क्रियान्वयन शिक्षा स्वास्थ्य तथा समाज कल्याण स्थायी समिति द्वारा किया जायेगा।
- फुलवारी के क्रियान्वयन की निगरानी करना।
- ग्राम स्वास्थ्य स्वच्छता एवं पोषण समिति या महिला स्व–सहायता समूह को समय पर अग्रिम राशि जारी करना, उनसे उपयोगिता प्रमाण पत्र लेना व जनपद पंचायत को निर्धारित उपयोगिता प्रमाण पत्र प्रस्तुत करना।
- फुलवारी के क्रियान्वयन में पालकों की समिति को आवश्यक सहयोग प्रदान करना।

मुख्य कार्यपालन अधिकारी जनपद पंचायत :–

- ग्राम पंचायत प्रतिनिधियों एवं सचिवों के उन्मुखिकरण हेतु सहयोग सुनिश्चित करना।
- फुलवारी योजना हेतु ग्राम पंचायतों के नये बैंक खाते खुलवाने की निगरानी करना।
- ग्राम पंचायतों को अग्रिम राशि समय पर जारी करना।
- ग्राम पंचायतों द्वारा तैयार उपयोगिता प्रमाण पत्रों को संकलित कर जिला पंचायत को प्रेषित करना।
- पंचायत सचिवों के कार्य की निगरानी करना।

मुख्य कार्यपालन अधिकारी जिला पंचायत :–

- जिले में फुलवारी योजना की समुचित निगरानी करना।
- जनपद पंचायतों को अग्रिम राशि समय पर जारी करना।
- जनपद पंचायत की उपरोक्त भूमिका की निगरानी करना।

मितानिन :–

- फुलवारी गठन व इसके सफल संचालन हेतु समुदाय को प्रेरित करना।
- हितग्राही बच्चों व महिलाओं के स्वास्थ्य की निगरानी करना एवं आवश्यकता अनुसार सलाह देना।

ग्राम स्वास्थ्य स्वच्छता एवं पोषण समिति :–

- पालकों की समिति द्वारा तय क्रय समिति को आवश्यक सामग्री क्रय हेतु राशि उपलब्ध कराना।
- समय पर उपयोगिता प्रमाण पत्र ग्राम पंचायत को प्रेषित करना।

मितानिन प्रशिक्षक :–

- पारा चयन हेतु आवश्यक जानकारी एकत्रित करना एवं समुदाय के साथ बैठक आयोजित करना।
- चयनित पारे में पालकों की समिति का गठन कर इसकी जानकारी निर्धारित प्रपत्र में ग्राम पंचायत को देना।
- पालकों की समिति को फुलवारी की सभी गतिविधियों पर आवश्यक मार्गदर्शन प्रदान करना।
- पालकों की क्रय समिति व ग्राम स्वास्थ्य स्वच्छता समिति को अभिलेख रखने, उपयोगिता प्रमाण पत्र बनाने आदि में सहयोग देना।
- ग्राम पंचायत से आवश्यक समन्वय करना।
- यदि कोई समस्या हो तो ब्लॉक समन्वयक (मितानिन कार्यक्रम) को सूचित करना।

ब्लॉक समन्वयक (मितानिन कार्यक्रम) :–

- मितानिन प्रशिक्षक की भूमिका की निगरानी करना।
- जनपद पंचायत के साथ समन्वय करना।
- क्षेत्र में यदि कोई समस्याएं आ रही हो तो इसकी जानकारी जिला समन्वयक (मितानिन कार्यक्रम) एवं जनपद पंचायत को देना।

जिला समन्वयक (मितानिन कार्यक्रम) :–

- मितानिन प्रशिक्षकों एवं ब्लॉक समन्वयकों के कार्य की निगरानी करना।
- जनपद पंचायत व जिला पंचायत से आवश्यक समन्वय करना।

राज्य स्वास्थ्य संसाधन केन्द्र :–

- प्रशिक्षण हेतु आवश्यक सामग्री तैयार करना।
- प्रत्येक स्तर पर प्रशिक्षण हेतु स्त्रोत व्यक्ति की उपलब्धता सुनिश्चित करना।
- जिला समन्वयक की उपरोक्त भूमिका की निगरानी करना।
- प्रक्रिया की निगरानी करना एवं क्षेत्र में आ रही समस्याओं के लिए संभव समाधान पंचायत एवं ग्रामीण विकास विभाग को प्रस्तुत करना।

अध्याय – 4

फुलवारी योजना की कार्ययोजना एवं क्रियान्वयन प्रक्रिया

(क) कार्य योजना :–

वर्ष 2013–14 में फुलवारी योजना के तहत अनुसूचित विकासखण्डों में कुल 2850 फुलवारी केन्द्र स्थापित किये जाने हैं। सरगुजा जिले में गत वर्ष से संचालित 300 फुलवारी केन्द्रों का इस योजना में समावेश किया जावेगा। इससे इस वर्ष 2550 और फुलवारी केन्द्र आरंभ करने की आवश्यकता होगी जिन्हें 85 अनुसूचित विकासखण्डों में 30 फुलवारी केन्द्र प्रति विकासखण्ड आरंभ किया जावेगा (विकासखण्डवार सूची परिशिष्ट–1)।

(ख) क्रियान्वयन प्रक्रिया :–

योजना का क्रियान्वयन जिला पंचायतों द्वारा किया जावेगा। इस हेतु जिला पंचायतों द्वारा ग्राम पंचायतों के माध्यम से व मितानिन कार्यक्रम से समन्वय कर समुदाय स्तर पर फुलवारी गठित एवं संचालित किये जावेंगे। यह क्रियान्वयन निम्नलिखित प्रक्रिया अनुसार किया जाना है–

1. <u>वित्तीय प्रावधान व प्रक्रिया</u> :–

जिला पंचायतों को प्रति अनुसूचित विकासखण्ड 10 लाख रू. की दर से राशि जारी की जावेगी। जिला पंचायत द्वारा इसी दर से राशि संबंधित जनपद पंचायतों को जारी की जावेगी। जनपद पंचायत द्वारा मितानिन कार्यक्रम के सहयोग से फुलवारी खोलने हेतु पारा का चयन पूर्ण किया जावेगा एवं चयनित पारा की संख्या के आधार पर 30,000 रू. अग्रिम राशि प्रति फुलवारी की दर से संबंधित ग्राम पंचायतों को जारी की जावेगी।

ग्राम पंचायत द्वारा प्रत्येक चयनित पारा से संबंधित ग्राम स्वास्थ्य पोषण एवं स्वच्छता समिति या महिला स्व–सहायता समूह को 10,000 रू. की किश्तों में अग्रिम राशि जारी की जावेगी। ग्राम स्वास्थ्य पोषण एवं स्वच्छता समिति या महिला स्व–सहायता समूह संबंधित बसाहट की माताओं की क्रय समिति को आवश्यकता अनुसार राशि जारी कर फुलवारी में भोजन की व्यवस्था सुनिश्चित करेगी। उपरोक्त राशि में से बर्तन, चटाई, मच्छरदानी, खिलौने आदि पर प्रति फुलवारी अधिकतम 4000 रू. व्यय क्रय समिति द्वारा किया जा सकता है। भोजन के लिए आवश्यक सामग्री हेतु प्रति बच्चा 6 रू. प्रति दिन एवं प्रति गर्भवती/शिशुवती महिला/सहयोगी 15 रू. प्रतिदिन का प्रावधान है। प्राप्त किश्त का 60 प्रतिशत अथवा अधिक उपयोगिता करने पर ग्राम स्वास्थ्य पोषण एवं स्वच्छता समिति या महिला स्व–सहायता समूह ग्राम पंचायत में उपयोगिता प्रमाण पत्र जमा करेगी एवं अगली किश्त प्राप्त कर सकेगी। ग्राम पंचायत फुलवारी हेतु प्राप्त 50,000 रू. में से 60 प्रतिशत अथवा अधिक उपयोगिता कर लेने अथवा 2013–14 वर्ष पूर्ण होने

पर इसका उपयोगिता प्रमाण पत्र जनपद पंचायत में जमा करेगी। इस आधार पर ग्राम पंचायतों को आगामी वर्ष हेतु राशि जारी की जावेगी। प्रत्येक स्तर से जारी किये जाने वाले उपयोगिता प्रमाण पत्र का प्रारूप संलग्न है।

2. फुलवारी केन्द्रों हेतु बसाहटों का चयन :–

फुलवारी उन्हीं स्थानों पर आरंभ किये जा सकते हैं, जहां स्थानीय समुदाय व पंचायत स्वयंसेवी रूप से फुलवारी चलाने के लिए तैयार हों। बसाहटों का चयन जनपद पंचायत द्वारा मितानिन कार्यक्रम के सहयोग से किया जावेगा। इस हेतु सर्वप्रथम प्रत्येक मितानिन प्रशिक्षक के क्षेत्र से अधिक पिछड़े, निर्धन व कुपोषण ग्रस्त 2 से 3 पारों को चिन्हांकित किया जावेगा। उपरोक्त पारों में मितानिन प्रशिक्षक द्वारा 2 से 3 बैठक प्रति पारा किये जावेंगे। पारा में 3 साल से छोटे बच्चों की संख्या 5 से लेकर 20 तक होनी चाहिए। यदि किसी पारा में 20 से अधिक बच्चे हों तो उसे दो भागों में बांटकर 2 फुलवारी हेतु बैठक की जावेगी। इन बैठकों में मितानिन प्रशिक्षक द्वारा फुलवारी की आवश्यकता एवं इसके स्वरूप पर समुदाय को जानकारी दी जावेगी। यदि समुदाय एवं माताएं फुलवारी के लिए स्वैच्छिक रूप से आवश्यक समय व स्थान देकर चलाने के लिए तैयार हों तो इसकी पुष्टि कम से कम 2 बैठकों में होने पर इसका लिखित प्रस्ताव तैयार कर मांग पत्र (प्रारूप संलग्न) प्रस्तुत किया जावेगा। इसमें ग्राम पंचायत के संबंधित पंच व सरपंच द्वारा फुलवारी का समर्थन किया जाना अनिवार्य होगा। यदि कार्ययोजना से अधिक संख्या में पारा फुलवारी हेतु मांग पत्र प्रेषित करते हैं तो इनमें से अंतिम चयन जनपद पंचायत द्वारा किया जावेगा।

3. फुलवारी में भोजन प्रदाय करने की व्यवस्था –

6 माह से 3 वर्ष के बच्चों, गर्भवती महिलाओं व शिशुवती (0 से 6 माह के बच्चों की माताएं) को देखभाल व संतुलित गर्म पका आहार उपलब्ध कराया जावेगा। इस हेतु मितानिनों के सहयोग से पालकों की समिति गठित की जावेगी।

पालकों की समिति द्वारा साप्ताहिक मेन्यू तैयार किया जावेगा। मेन्यू में प्रतिदिन सब्जी, दाल व तेल होना अनिवार्य होगा। सप्ताह में 4 बार आधा–आधा अण्डा दिया जाना होगा। जहां अण्डा खाने के लिए पालक सहमत न हो तो इसके स्थान पर फल अथवा दूध दिया जाना होगा।

पालको की समिति द्वारा 3 महिला सदस्यों की क्रय समिति चयनित की जावेगी। क्रय समिति ग्राम स्वास्थ्य स्वच्छता एवं पोषण समिति या महिला स्व–सहायता समूह से राशि प्राप्त कर आवश्यक भोजन एवं अन्य सामग्री उपलब्ध करायेगी। यथा संभव स्थानीय अनाज, दलहन, सब्जियाँ आदि खरीदने का प्रयास किया जावेगा। क्रय समिति द्वारा खर्च की जानकारी को पंजी में संधारित किया जावेगा। इसको सुनिश्चित कराने की जिम्मेदारी मितानिन प्रशिक्षक की होगी।

Annexure - 1 (B)

Government of Chhattisgarh

Panchayat and Rural Development

Mahanadi Bhavan, Mantralaya, Naya Raipur

Sl. No/Panchayat/PGVB/2013/135 Raipur, Date: 29-05-2013

To,

1. All the Collectors, Chhattisgarh
   (Excluding - Raipur, Balodabazar – Bhatapara, Mahasamund, Durg, Betetara, Kabirdham, Mungeli, Janjgir-Champa) Chhatisgarh
2. All Chief Executive Officers,Zilla Panchayat, Chhattisgarh
   (Excluding – Mahasamund, Kabirdham, Janjgir-Champa) Chhattisgarh

Sub: Implementation of Fulwari Scheme

***

1. The Integrated Child Development Scheme (ICDS) has no provision to feed the children aged between 6months to 3 years. To fill this gap, the Fulwari Scheme will be started in the rural areas of the State. As a starting initiative, it will be experimented in 85 identified tribal development blocks.

2. Under the Fulwari Yojana, the children aged between 6 months to 3 years, pregnant women and lactating mothering will be benefited. The Scheme will be operated by the rural mothers under the guidance of the Panchayat. The Panchayat will have the opportunity to play a significant role in rural nutrition and health.

3. Along with the letter, the guidelines and objectives of the Scheme, roles and responsibilities of different executive officers and sub-ordinates, plan of the work, process of implementation, meetings and utilization of funds etc. are enclosed. The distribution funds related to the Scheme will be provided separately. It is informed that, the funds allocated under the Scheme will be monitored and audited from time to time according to the guidelines issued by the administration.

4. It is requested to the concerned Officers to start theScheme as per the given guidelines and immediately inform to this Department.

(Vivek Dand)
Additional Chief Secretary
Government of Chhattisgarh
Department of Panchayat and Rural Development
Raipur, Date: 29-05-2013

Annexure - 2 (A)

फुलवारी आरंभ करने हेतु पारा का मांग पत्र

दिनांक .....

प्रति,

मुख्य कार्यपालन अधिकारी,
जनपद पंचायत.....
जिला.....छ.ग.

ग्राम पंचायत ..... ग्राम .....के पारा ..... में समुदाय फुलवारी केन्द्र आरंभ किये जाने के लिए इच्छुक है। समुदाय के परिवार फुलवारी में खाना बनाने व बच्चों की देखभाल के लिए दैनिक 7 घंटे का स्वैच्छिक समय और स्थान देने के लिए तैयार हैं। ग्राम पंचायत समुदाय के इस संकल्प हेतु आवश्यक सहयोग देने के लिए सहमत है। कृपया उपरोक्त पारा में फुलवारी केन्द्र आरंभ करने हेतु अनुमति प्रदान करें।

संलग्न :– पारा द्वारा बैठक कर सर्वसम्मति से पारित प्रस्ताव की प्रति।

सरपंच
ग्राम पंचायत

ग्राम पंचायत सचिव

मितानिन प्रशिक्षक

Annexure - 2 (B)

Requisition to Start Fulwari

Dt. _____

To,

Chief Executive Officer

Jan Pad Panchayat _____

Dist. _____, CG.

Village Panchayat _____ Village _____ and Habitation _____

Is willing to start community voluntarily. The family members of the habitation are willing to voluntarily work for seven hours in a day and also to provide free Space to run Fulwari. We are willing to extend cooperation to this Gram Panchayat Yojana. Hence, Request to grant permission to start Fulwari at thus habitation. Minutes of the meeting of the habitation attached.

Sarpanch Panchayat Secretary Panchayat Mitanin Trainee

Annexure - 3 (A)

ग्राम स्वास्थ्य स्वच्छता एवं पोषण समिति
फुलवारी का उपयोगिता प्रमाण पत्र

पारा .....ग्राम.....पंचायत.....विकासखण्ड.....

अवधि – दिनांक ..... से .....तक

1. अवधि की पहली तारीख को फुलवारी हेतु शेष राशि :– .....
2. अवधि में फुलवारी हेतु प्राप्त राशि :– .....
3. अवधि में फुलवारी हेतु कुल उपलब्ध राशि :– .....
4. अवधि में फुलवारी पर खर्च राशि : – .....
5. अवधि की आखिरी तारीख को शेष राशि :–.....
6. अवधि में बच्चों की कुल उपस्थिति :–.....
7. अवधि में गर्भवती महिलाओं की कुल उपस्थिति :–.....
8. अवधि में शिशुवती माताओं की कुल उपस्थिति :–.....
9. अवधि में सहयोगी माता/व्यक्तियों की कुल उपस्थिति :–.....
10. संयोजक मितानिन के हस्ताक्षर :– .....
11. अध्यक्ष पंच के हस्ताक्षर :– .....
12. पारा की मितानिन के हस्ताक्षर :– .....
13. पारा के 2 माताओं के हस्ताक्षर :–

    1. .....
    2. .....

Annexure - 3 (B)

Village Health and Sanitation Committee

Fulwari Utilization Certificate

Habitation_____ Village _____ Panchayat _____Block _____

Period- Date _____to _____

1. Available balance of funds on 1 st of the Month : _____
2. Funds released in installment _____
3. Funds allocated to Fulwari _____
4. Expenses incurred in the month _____
5. Available balance on the last day of the Month _____
6. Total Number of Children at Fulwari _____
7. Total Number of Pregnant Women _____
8. Total Number of Lactating Women at Fulwari _____
9. Number of Mother Volunteers at Fulwari _____
10. Signature of Mitanin Trainee _____
11. Signature of Sarpanch _____
12. Signature of Habitation Mitanin _____
13. Signature of two Mothers

    1. _____

    2. _____

Annexure - 4 (A)

जनपद पंचायत
फुलवारी का उपयोगिता प्रमाण पत्र

जनपद पंचायत..... जिला .....

अवधि – दिनांक ..... से .....तक

1. अवधि की पहली तारीख को फुलवारी हेतु शेष राशि :– .....
2. अवधि में फुलवारी हेतु प्राप्त राशि :– .....
3. अवधि में फुलवारी हेतु कुल उपलब्ध राशि :– .....
4. अवधि में फुलवारी पर खर्च राशि : – .....
5. अवधि की आखिरी तारीख को शेष राशि :–.....
6. विकासखण्ड में संचालित फुलवारी की संख्या :– .....

हस्ताक्षर

मुख्य कार्यपालन अधिकारी,
जनपद पंचायत .....
जिला .....
छत्तीसगढ़

Annexure - 4 (B)

Janpad Panchayat

Fulwari Utilization Certificate

Jan Pad Panchayat _____ Dist. _____

Period – Date _____ to _____

1. Available balance with Fulwari on the beginning of the Month _____
2. Funds received at Fulwari during the Month _____
3. Total Available funds at Fulwari _____
4. Total Expenses incurred during the month _____
5. Available balance at the end of the month _____
6. Total number of Fulwari's in the Block _____

Signature
Block Development Officer
Jan pad Panchayat _____
Dist. _____
Chhattisgarh

Annexure - 5 (A)

ग्राम पंचायत
फुलवारी का उपयोगिता प्रमाण पत्र

ग्राम पंचायत..... विकासखण्ड .....

अवधि – दिनांक ..... से .....तक

1. अवधि की पहली तारीख को फुलवारी हेतु शेष राशि :– .....
2. अवधि में फुलवारी हेतु प्राप्त राशि :– .....
3. अवधि में फुलवारी हेतु कुल उपलब्ध राशि :– .....
4. अवधि में फुलवारीवार खर्च राशि : –

फुलवारी का नाम	अवधि में खर्च राशि
कुल	

5. अवधि की आखिरी तारीख को शेष राशि :–.....
6. पंचायत सचिव के हस्ताक्षर :– .....
7. सरपंच के हस्ताक्षर :–.....

Annexure - 5 (B)

Gram Panchayat

Fulwari Utilization Certificate

Gram Panchayat _____ Block _____

Period – Date _____ to _____

1. Available funds on 1st day of the month at Fulwari _____

2. Funds received during the month to Fulwari _____

3. Total available funds at Fulwari _____

4. Total expenses incurred in the month _____

Name of the Fulwari	Expenses for the Month
Total	

5. Available funds at the end of the month _____

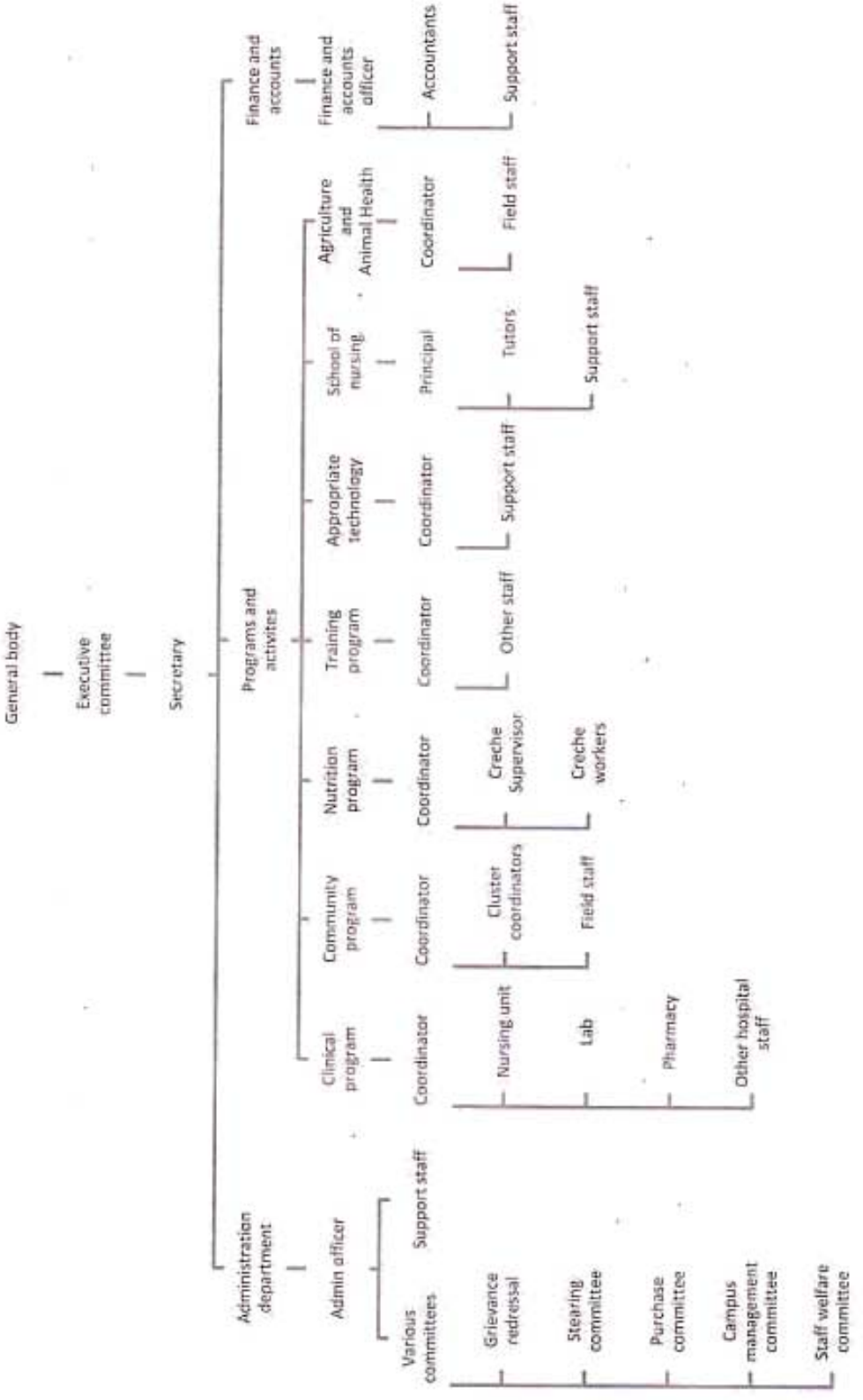
6. Signature of Secretary Panchayat _____

7. Signature of the Sarpanch _____

Annexure - 6

फुलवारी योजना के क्रियान्वयन की संरचना

Annexure - 7


General body
Executive committee
Secretary
Administration department
Admin officer
Support staff
Various committees
Grievance redressal
Steering committee
Purchase committee
Campus management committee
Staff welfare committee
Programs and activites
Clinical program
Coordinator
Nursing unit
Lab
Pharmacy
Other hospital staff
Community program
Coordinator
Cluster coordinators
Field staff
Nutrition program
Coordinator
Creche Supervisor
Creche workers
Training program
Coordinator
Other staff
Appropriate technology
Coordinator
Support staff
School of nursing
Principal
Tutors
Support staff
Agriculture and Animal Health
Coordinator
Field staff
Finance and accounts
Finance and accounts officer
Accountants
Support staff

परिशिष्ट–1

अनुसूचित विकासखण्डों में फुलवाड़ी की लक्षित संख्या एवं आवंटित राशि (2013–14)

क्र.	जिला	क्र.	विकासखण्ड	पूर्व से संचालित फुलवाड़ी की संख्या	वर्ष 2013–14 में नई फुलवाड़ी की संख्या	वर्ष 2013–14 हेतु कुल फुलवाड़ी संख्या	वर्ष 2013–14 में फुलवाड़ी हेतु आवंटित राशि
1	बालोद (7/7)	1	बालोद	0	30	30	10 लाख रु.
		2	नरहरपुर	0	30	30	10 लाख रु.
		3	चारामा	0	30	30	10 लाख रु.
		4	भानुप्रतापपुर	0	30	30	10 लाख रु.
		5	दुर्गकोन्दल	0	30	30	10 लाख रु.
		6	अंतागढ़	0	30	30	10 लाख रु.
		7	कोयलीबेड़ा	0	30	30	10 लाख रु.
2	कोण्डागांव (5/5)	8	कोण्डागांव	0	30	30	10 लाख रु.
		9	फरसगांव	0	30	30	10 लाख रु.
		10	माकड़ी	0	30	30	10 लाख रु.
		11	केशकाल	0	30	30	10 लाख रु.
		12	मड़ैराजपुर	0	30	30	10 लाख रु.
3	बस्तर (7/7)	13	जगदलपुर (नानगुर)	0	30	30	10 लाख रु.
		14	बस्तर	0	30	30	10 लाख रु.
		15	बकावण्ड	0	30	30	10 लाख रु.
		16	बास्तानार	0	30	30	10 लाख रु.
		17	दरभा	0	30	30	10 लाख रु.
		18	तोकापाल	0	30	30	10 लाख रु.
		19	लोहण्डीगुड़ा	0	30	30	10 लाख रु.
4	सुकमा (3/3)	20	सुकमा	0	30	30	10 लाख रु.
		21	कोन्टा	0	30	30	10 लाख रु.
		22	छिंदगढ़	0	30	30	10 लाख रु.
5	दंतेवाड़ा (4/4)	23	दंतेवाड़ा	0	30	30	10 लाख रु.
		24	गीदम	0	30	30	10 लाख रु.
		25	कुआकोण्डा	0	30	30	10 लाख रु.
		26	कटेकल्याण	0	30	30	10 लाख रु.
6	नारायणपुर (2/2)	27	नारायणपुर	0	30	30	10 लाख रु.
		28	ओरछा	0	30	30	10 लाख रु.
7	कोरबा (5/5)	29	कोरबा	0	30	30	10 लाख रु.
		30	करतला	0	30	30	10 लाख रु.
		31	कटघोरा	0	30	30	10 लाख रु.
		32	पाली	0	30	30	10 लाख रु.
		33	पोड़ीउपरोड़ा	0	30	30	10 लाख रु.

क्र.	जिला	क्र.	विकासखण्ड	पूर्व से संचालित फुलवाड़ी की संख्या	वर्ष 2013–14 में नई फुलवाड़ी की संख्या	वर्ष 2013–14 हेतु कुल फुलवाड़ी संख्या	वर्ष 2013–14 में फुलवाड़ी हेतु आवंटित राशि
8	कोरिया (5/5)	34	बैकुण्ठपुर	0	30	30	10 लाख रु.
		35	मनेन्द्रगढ़	0	30	30	10 लाख रु.
		36	सोनहत	0	30	30	10 लाख रु.
		37	खड़गवां	0	30	30	10 लाख रु.
		38	भरतपुर	0	30	30	10 लाख रु.
9	गरियाबंद (3/4)	39	गरियाबंद	0	30	30	10 लाख रु.
		40	छुरा	0	30	30	10 लाख रु.
		41	मैनपुर	0	30	30	10 लाख रु.
10	जशपुर (8/8)	42	जशपुर (लोदाम)	0	30	30	10 लाख रु.
		43	मनोरा	0	30	30	10 लाख रु.
		44	बगीचा	0	30	30	10 लाख रु.
		45	कांसाबेल	0	30	30	10 लाख रु.
		46	दुलदुला	0	30	30	10 लाख रु.
		47	फूलवुरी	0	30	30	10 लाख रु
		48	फरसाबहार	0	30	30	10 लाख रु.
		49	पत्थलगांव	0	30	30	10 लाख रु.
11	धमतरी (1/4)	50	नगरी	0	30	30	10 लाख रु.
12	बालोद (1/5)	51	डोण्डी	0	30	30	10 लाख रु.
13	बिलासपुर (3/7)	52	मरवाही	0	30	30	10 लाख रु.
		53	गौरेला	0	30	30	10 लाख रु.
		54	पेण्ड्रा	0	30	30	10 लाख रु.
14	बीजापुर (4/4)	55	बीजापुर	0	30	30	10 लाख रु.
		56	भैरमगढ़	0	30	30	10 लाख रु.
		57	उसूर	0	30	30	10 लाख रु.
		58	भोपालपट्टनम	0	30	30	10 लाख रु.
15	राजनांदगांव (3/9)	59	अ. चौकी	0	30	30	10 लाख रु.
		60	मोहला	0	30	30	10 लाख रु.
		61	मानपुर	0	30	30	10 लाख रु.
16	रायगढ़ (6/9)	62	खरसिया	0	30	30	10 लाख रु.
		63	घरघोड़ा	0	30	30	10 लाख रु.
		64	तमनार	0	30	30	10 लाख रु.
		65	लैलूंगा	0	30	30	10 लाख रु.
		66	धरमजयगढ़	0	30	30	10 लाख रु.

क्र.	जिला	क्र.	विकासखण्ड	पूर्व से संचालित पुलवाड़ी की संख्या	वर्ष 2013–14 में नई पुलवाड़ी की संख्या	वर्ष 2013–14 हेतु कुल पुलवाड़ी संख्या	वर्ष 2013–14 में पुलवाड़ी हेतु आवंटित राशि
17	सरगुजा (7/7)	67	अम्बिकापुर	29	30	59	24 लाख रु.
		68	लखनपुर	49	30	79	34.5 लाख रु.
		69	सीतापुर	44	30	74	32 लाख रु.
		70	प्रतापपुर	33	30	63	26.5 लाख रु.
		71	उदयपुर	63	30	93	41.5 लाख रु.
		72	लुण्ड्रा	49	30	79	34.5 लाख रु.
		73	मैनपाट	34	30	64	27 लाख रु.
18	सूरजपुर (6/6)	74	सूरजपुर	0	30	30	10 लाख रु.
		75	भैयाथान	0	30	30	10 लाख रु.
		76	रामानुजनगर	0	30	30	10 लाख रु.
		77	प्रेमनगर	0	30	30	10 लाख रु.
		78	ओडगी	0	30	30	10 लाख रु.
		79	प्रतापपुर	0	30	30	10 लाख रु.
19	बलरामपुर (6/6)	80	राजपुर	0	30	30	10 लाख रु.
		81	वाड्रफनगर	0	30	30	10 लाख रु.
		82	शंकरगढ़	0	30	30	10 लाख रु.
		83	रामानुजगंज	0	30	30	10 लाख रु.
		84	बलरामपुर	0	30	30	10 लाख रु.
		85	वाड्रफनगर	0	30	30	10 लाख रु.
कुल				300	2550	2850	1000 लाख रु.

Annexure - 8

Young children taking rest under the mosquitonet at a Fulwari Centre

Annexure - 9

Detailed list of Identified Blocks with Budget Allocation to Start Fulwari (2013-14)

S No	District	No.	Block	No. Existing Fulwari's	New Fulwari's in 2013-14	Total Fulwari's 2013-14	Funds allocation 2013-14
1	Kankera (7/7)	1	Kankera	0	30	30	10 Lakhs
		2	Naraharpura	0	30	30	10 Lakhs
		3	Charama	0	30	30	10 Lakhs
		4	Bhanuprathapur	0	30	30	10 Lakhs
		5	Durgukondal	0	30	30	10 Lakhs
		6	Anthagad	0	30	30	10 Lakhs
		7	Koyilibeda	0	30	30	10 Lakhs
2	Kondagaon(5/5)	8	Kondagaon	0	30	30	10 Lakhs
		9	Farsagaon	0	30	30	10 Lakhs
		10	Makdi	0	30	30	10 Lakhs
		11	Keshkaala	0	30	30	10 Lakhs
		12	Baderajpura	0	30	30	10 Lakhs
3	Basthar (7/7)	13	Jagdalpura	0	30	30	10 Lakhs
		14	Basthar	0	30	30	10 Lakhs
		15	Bakavandu	0	30	30	10 Lakhs
		16	Basthanar	0	30	30	10 Lakhs
		17	Darbha	0	30	30	10 Lakhs
		18	Thokapal	0	30	30	10 Lakhs
		19	Lohandiguda	0	30	30	10 Lakhs
4	Sukma (3/3)	20	Sukma	0	30	30	10 Lakhs
		21	Konta	0	30	30	10 Lakhs
		22	Chindagarh	0	30	30	10 Lakhs
5	Danthewada(4/4)	23	Danthewada	0	30	30	10 Lakhs
		24	Geedham	0	30	30	10 Lakhs
		25	Kuwakonda	0	30	30	10 Lakhs
		26	Katekalyan	0	30	30	10 Lakhs
6	Narayanpura (2/2)	27	Narayanpura	0	30	30	10 Lakhs
		28	Orcha	0	30	30	10 Lakhs
7	Korbha(5/5)	29	Korbha	0	30	30	10 Lakhs
		30	Karthala	0	30	30	10 Lakhs
		31	Katdhora	0	30	30	10 Lakhs
		32	Paali	0	30	30	10 Lakhs
		33	Podivuparoda	0	30	30	10 Lakhs
8	Koriya (5/5)	34	Baikuntapura	0	30	30	10 Lakhs
		35	Manendragarh	0	30	30	10 Lakhs
		36	Sonahath	0	30	30	10 Lakhs
		37	Khadgambha	0	30	30	10 Lakhs
		38	Masthpura	0	30	30	10 Lakhs

9	Gariyabund(3/4)	39	Gariyabund	0	30	30	10 Lakhs
		40	Chrha	0	30	30	10 Lakhs
		41	Mainpura	0	30	30	10 Lakhs
10	Jashpura (8/8)	42	Jashpura	0	30	30	10 Lakhs
		43	Manaura	0	30	30	10 Lakhs
		44	Baghicha	0	30	30	10 Lakhs
		45	Kansabela	0	30	30	10 Lakhs
		46	Dhuldhula	0	30	30	10 Lakhs
		47	Kunkuri	0	30	30	10 Lakhs
		48	Farsabahar	0	30	30	10 Lakhs
		49	Pathyalgaon	0	30	30	10 Lakhs
11	Dhamthari(1/4)	50	Nagari	0	30	30	10 Lakhs
12	Balodha(1/5)	51	Dhondi	0	30	30	10 Lakhs
13	Bilaspura (3/7)	52	Marwahi	0	30	30	10 Lakhs
		53	Gaurela	0	30	30	10 Lakhs
		54	Phonda	0	30	30	10 Lakhs
14	Bijapur(4/4)	55	Bijapura	0	30	30	10 Lakhs
		56	Bhairamgarh	0	30	30	10 Lakhs
		57	Usoor	0	30	30	10 Lakhs
		58	Bhoopalpatnam	0	30	30	10 Lakhs
15	Rajnandgaon(3/9)	59	A. Chowki	0	30	30	10 Lakhs
		60	Mohala	0	30	30	10 Lakhs
		61	Monpura	0	30	30	10 Lakhs
16	Raigarh(5/9)	62	Kharsiya	0	30	30	10 Lakhs
		63	Gharghoda	0	30	30	10 Lakhs
		64	Thamnara	0	30	30	10 Lakhs
		65	Lailunga	0	30	30	10 Lakhs
		66	Dharmajaygarh	0	30	30	10 Lakhs
17	Surguja (7/7)	67	Ambhikapur	28	30	58	24 Lakhs
		68	Lakhanpur	49	30	79	34.5 Lakhs
		69	Seethapura	44	30	74	32 Lakhs
		70	Bathouli	33	30	63	26.5 Lakhs
		71	Udayapura	63	30	93	41.5 Lakhs
		72	Lundra	49	30	79	34.5 Lakhs
		73	Mainmaat	34	30	64	27 Lakhs
18	Surjhapur(6/6)	74	Surjhapur	0	30	30	10 Lakhs
		75	Bayathan	0	30	30	10 Lakhs
		76	Ramanujanagar	0	30	30	10 Lakhs
		77	Premnagar	0	30	30	10 Lakhs
		78	Odagi	0	30	30	10 Lakhs
		79	Prathappura	0	30	30	10 Lakhs
19	Bathrampura(6/6)	80	Rajpura	0	30	30	10 Lakhs
		81	Kushmi	0	30	30	10 Lakhs
		82	Shankergarh	0	30	30	10 Lakhs
		83	Ramanujagunj	0	30	30	10 Lakhs
		84	Balrampura	0	30	30	10 Lakhs
		85	Wardfanagar	0	30	30	10 Lakhs
	Total			**300**	**2550**	**2850**	**10000 Lakhs**

Glossary

Hunger: The body's way of signaling that it is running short of food and needs to eat something. Hunger can lead to malnutrition.

Malnutrition: It is defined as a state in which the physical function of an individual is impaired to the point where he or she can no longer maintain natural bodily capacities such as growth, pregnancy, lactation, learning abilities, physical work and resisting and recovering from disease. The term covers a range of problems from being dangerously thin (see -Underweight) or too short (see - Stunting) for one's age to being deficient in vitamins and minerals.

Undernourishment: It describes the status of people whose food intake does not include enough calories (energy) to meet minimum physiological needs. The term is a measure of a country's ability to gain access to food and is normally derived from Food Balance Sheets prepared by the UN Food and Agriculture Organization (FAO).

Underweight: It is measured by comparing the weight-for-age of a child with a reference population of well-nourished and healthy children.

Protein Energy Malnutrition: It is a form of malnutrition measured not by how much food is eaten but by physical measurements of the body - weight or height - and age (see - Stunting, Wasting, Underweight).

Stunting: It reflects shortness (low height)-for-age, and calculated by comparing the height-for-age of a child with a reference population of well-nourished and healthy children. Stunting is caused by long-term insufficient nutrient intake and frequent infections. Stunting generally occurs before age two, and effects are largely irreversible. These include delayed motor development, impaired cognitive function and poor school performance. Nearly one third of children under five in the developing world are stunted.

Wasting: It is considered as low weight for height and reflects a recent and severe process that has led to substantial weight loss, usually associated with starvation and/or disease. Wasting is calculated by comparing weight-for-height of a child with a reference population of well-nourished and healthy children. Wasting is a strong predictor of mortality among children under five. It is usually the result of acute significant food shortage and/or disease.

Live Birth: A live birth is the complete expulsion or extraction from its mother of a product of

conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life - such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles—whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered a live birth.

Infant Mortality Rate: Probability of dying between birth and exactly one year of age expressed per 1,000 live births.

Child Mortality Rate: Probability of dying between birth and under the age of five years expressed per 1,000 live births.

Under-Five Mortality Rate: Probability of dying between birth and exactly five years of age expressed per 1,000 live births.

Maternal Death: It is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. To facilitate the identification of maternal deaths in circumstances in which cause of death attribution is inadequate, a new category has been introduced: pregnancy-related death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the cause of death.

Maternal Mortality Ratio (MMR): The MMR is the ratio of the number of maternal deaths during a given time period per 100,000 live births during the same time-period. The maternal mortality ratio can be calculated by dividing recorded (or estimated) number of maternal deaths by total recorded (or estimated) number of live births in the same period and multiplying by 100,000.Measurement requires information on pregnancy status, timing of death (during pregnancy, childbirth, or within 42 days of termination of pregnancy), and cause of death.

Sources:
UNICEF: http://www.unicef.org/progressforchildren/2007n6/index_41505.htm
World Health Organization: http://www.who.int/healthinfo/statistics/indmaternalmortality/en/
World Food Program: http://www.wfp.org/hunger/glossary
Millennium Development Goals Indicators:
http://mdgs.un.org/unsd/mdg/Metadata.aspx?IndicatorId=0&SeriesId=561

Questionnaire

Name of the Respondent: _____, Age: _____

Designation: _____, Department: _____

Village: _____, Tehsil: _____, District: _____, State: _____

1. How did you identify the undernutrition?
2. What are the measures adopted to address the problem?
3. What is the context for the intervention?
4. What are the objectives of the intervention?
5. How did the intervention evolve and change the existing system?
6. What are the intervention practices?
7. Who are the stakeholders involved in the Fulwari scheme?
8. What are the phases in the intervention process?
9. What is the organization structure?
10. Who is the nodal agency engaged for implementation of the program?
11. What is the funding source for the intervention?
12. What is the role of ASHA (Mitanin)?
13. What are the initiative taken in the community levels?
14. What are the steps/initiatives taken for implementation of the Scheme?
15. What are the reasons for replication?

Issues/problems for Discussion:

(i) Budgetary allocation
(ii) Flow process in implementation
(iii) Reporting system of the scheme
(iv) Target Assessment
(v) Process evaluation
(vi) Involvement of the human resources
(vii) Compliance and Regulatory Requirement
(viii) Issues on convergence of various Departments
(ix) Role of ASHA (Mitanin)
(x) Recognition/Awards
(xi) Impact Evaluation
(xii) Initiative to increase the Community
(xiii) Process re-engineering, Service Deliver and role of Information Technology?
(xiv) Review of the Challenges in implementation/adopting within the existing system?
(xv) Awareness campaign
(xvi) Suggestions for improvement of the scheme