These chapter narrates the major findings from the quantitative data analysis and qualitative method used in the study and explained the findings with corresponding objectives. Attempt has been also made to compare the results with other similar kind of studies carries out in the country. To build the argument a comparison has been made with the national level study conducted by the Govt or other ministry and autonomous institutions.

In the present study, researcher has made attempt to understand the socio-economic and cultural background of the families having malnourished children enrolled in the 20 ICDS centres of Ghansyampur and Kiratpur block of Darbhanga district, explored the various causal factors influencing the malnutrition, examine the accessibility and effectiveness of the Govt services meant to address the malnutrition and moreover exploring the perception of the mothers on cause and effect of malnutrition in the lives of the children.

Indepth information pertaining to age, sex, birth order, religion, caste, economy of the family, occupation of the parents, reasons for indebtedness, type of family, family size, birth order, education of parents, maternal health care practices like antenatal check up, postnatal care, immunization of the children, places of child birth, colostrums feeding practices, breast feeding practices, time of providing supplementary feeding, mother age at marriage, mothers age at first child birth, vulnerability of children to common diseases, health seeking behaviour, accessibility to major programs like ICDS and PDS etc have been taken into consideration in this study. Mother’s perception on cause and impact of malnutrition was also explored and narrated with findings.

Quantitative analysis was corroborated with the findings from focus group discussion and observation outcome of the case studies. The study was conducted with 200 mothers who have malnourished children in 6 months to 36 months age group and are enrolled in the ICDS centers in Kiratpur and Ghansyampur block of Darbhanga district of Bihar.
The major findings of data analysis have been presented in this chapter and attempt has been made to correlate the findings with other studies conducted in same theme in the country.

5.1 Major findings

5.1.1 Socio-economic and cultural profile of the parents

In the present study, it has been found that out of 200 underweight children identified for the study, 53% children are female and 47% children are male in the age group of 6 months to 36 months enrolled in the ICDS as beneficiaries.

5.1.1.2 Caste, Gender and religion wise distribution

Block wise distribution shows that Kiratpur has representation of 53% boys and 47% girl children in age group of 6 months to 36 months as severe underweight. In Ghansyampur block, 41% male boys and 59% girl children are severely underweight based on the 200 sample children obtained from the ICDS. It was also observed that, 94% respondents are from Hindu and 6% are from Muslim community.

Sampling selection criteria was based on the indicator of higher number of Scheduled caste population covered by the ICDS centers. However, sample population mainly constituted of Scheduled caste, other backward classes and extreme backward classes. It was found that, 84.5% of children belong to Scheduled caste community and 9.5% belong to other backward classes mainly the Yadav community. The rest 6% comes from the extreme backward classes mainly.

5.1.1.3 Family type and size of the Family

In the present study, children are mainly distributed in Joint and Nuclear type of families. It has come out that 75.5% of families respondent are nuclear type family and only 24.5% of families are joint family. Here it may be considered that, in rural area nuclear family is emerging up rather than joint family. This data is also supported by the findings of research work outcome on epidemiology of PEM of children between 6 months to 5 years in slums of Guwahati by Das. Krishna (2013). This cited
research also produced that nuclear families have more malnourished children than joint families.

Data also explored the fact that, in joint family percentage of girl children who are malnourished is higher than boy child. The joint family has prevalence of underweight children in tune of 40.8% among boys and 59.2% are girl children. Thus, we may infer that in joint family girl children are more vulnerable than male child. In Nuclear family, the gender share is mostly same.

Family size is also an important determinant in food distribution and availability matrix. This study reveals the fact that, 44% of families having malnourished children have 3-5 family members and 41.5% families have 6-8 members. It was also found that 14.5% families have more than 8 family members.

5.1.1.4 Education of Parents:

Exposure to information and educational background of parents is very important determinant. Thus, this aspect was thoroughly examined during the data collection process. Educational background has been analysed in this study and observed that 75.5% respondent mothers are illiterate. Census data 2011 of Darbhanga district reports that, 84% of women are illiterate. In this study, we have also found that 9% women can write and read their names and 12.5% of mothers from the sample population are educated till elementary level (Class I to Class VIII). Therefore, we can conclude that, educational level amongst mothers seems not very encouraging after six decades of Independence in the country. Study of Sengupta Paramita, Nina Philip and A.I Benjamin (2010) in Urban slums of Ludhiana also claimed that prevalence of underweight children were found majorly amongst illiterate mothers.

In case of father’s education level, research data shows little brighter picture in comparison to mothers education level. Father’s literacy level is higher than mother’s counterpart in the area and peaks to 22.5% of sample population. Data also observed that 43.5% of father of the malnourished children are illiterate and 21.5% fathers received education upto class eight standard. The data also records that, 10% of fathers received their education upto class ten. Only, 2.5% fathers received education upto graduation level. The census data of 2011 gives a district picture where we get
that, 33% of population are illiterate. But this study reports higher than the census report of 2011.

5.1.1.5 Occupational Status of Parents

It is observed in the present study that, primarily male population (90%) of Kiratpur and Ghansyampur villages work as unskilled daily wage labourer either in the villages or outside the state. Very insignificant sample population (1% and 0.5%) is engaged with the share cropping and marginal farming in the area. The data also observed that, 7% father of the malnourished children are engaged in multiple seasonal occupations and 1.5% male are being engaged in the private jobs outside the state. In this study, most of the mothers 64% were found to be unemployed, followed by 35% daily wage seasonal labour engaged mostly in agricultural field in cropping time.

5.1.1.6 Economic profile of the Family

This research work reveals the fact that 83% of families of underweight children have monthly income below Rs. 5000 per month. It has found that 43% are in category of Rs. 2000 to Rs. 3500 and 40% are in category of Rs. 3500 to Rs. 5000. Thus, we may conclude that 83% of families live below Rs. 5000 per month.

The families have monthly income in the range of more than Rs. 5000 to Rs. 6500 are only 11.5% and 5.5% are above Rs. 6500. The Socio-economic and caste census 2011 data of Darbhanga district is also very closer to this research finding. The SECC 2011 data reveals that 75% of families have monthly income less than Rs. 5000.

5.1.1.7 Migration of head of the families

During the time of data collection and interaction with the community it was learnt that, there is rampant migration of the male members to other states. Lack of employment opportunity, recurrent flood compelled the male folk to migrate to different parts of the country and even outside the country. The research finding reports that, 83% of families’ head of the household migrate to other states for their livelihood. Only 17% male folk of the family work locally and don’t migrate. The tenure of migration generally spans stretch of 8-9 months in a year. Study of Ministry of Minority Affairs, GOI and ICSSR (2008) revealed that 66% of households in this
Darbhanga district have migration. This research has revealed a higher percentage than that study.

5.1.1.8 Destination of Migration

The data found that, most popular destination place is Punjab in this country. Analysis leads to conclude that, 39% of people’s destination is Punjab followed by Delhi and Mumbai (13%). Labourer in insignificant number also travel to Bangalore(4%), Rajasthan(1%), Kolkata(2%), Gujrat (8%), Chennai (1%), Bhadoi-UP (2%), Hyderabad (2%), Pune (1%). It was found to be interested to note that 2% of respondents also work in Nepal. So, it was almost 100% migration outside the district and state. Study of Ministry of Minority Affairs, GOI and ICSSR (2008) revealed that 93% of households in this Darbhanga district migrate outside the district and state. This research has revealed a slight higher percentage than the referred study.

5.1.1.9 Sending Money while in Migration

In the present study, it was revealed that majority of migrated male person 94.6% send money to their families and only 5.4% of families didn’t receive money from their migrated male counterpart. The data also found that only 36.3% send money regularly (monthly-bi monthly) but 63.7% migrated labours send money irregularly as it depends upon the availability of unskilled daily jobs in the destination cities.

5.1.1.10 Medium of Money transfer

In the present study, medium of money transfer has come up with a diverse picture. But majority of (58.6%) migrated labour prefers to send through fathers/wife/own bank account. It was interestingly found that, 35% of migrant labour also sends money through other villages account and for that they had to pay usages charges in the villages. It was also found that 2.5% does cash transaction through others hand and 3.8% brings by self.

5.1.1.11 Amount of Money transfer

During the interview process, amount of money sent by their male members was also probed. The data found that, 21% labourer sent money upto Rs. 2500 on average.
Next category of 32.5% labour sends money in range of Rs. 2501 to Rs. 4000. It was also found that, 38% labour send in tune of Rs. 4001 to Rs. 5500 and only 7.6% sends money more than Rs. 5500. This was done based on the average computation and based on the reporting of women respondents.

5.1.1. 12 Indebtedness, Quantum and Reasons

The study has found high burden of indebtedness amongst the respondent’s families. It was found to be 88.5% of families are indebted and only 11.5% of families were not indebted during the data collection. The range of borrowed amount varies according to the research. It was found that, 42.37% of families have outstanding amount upto Rs. 20,000 followed by 42.37% in range of Rs. 20001 to Rs. 50000. Present research revealed that, 15% of respondents have outstanding in range of Rs. 50,001.

5.1.1.13 Source of borrowing

There is high prevalence of non-institutional credit. The proportion of families borrow money from non-institutional sources is almost 100%. The study report of Ministry of Minority Affairs and ICSSR (2008) reported that almost 94% of families borrow money from non-institutional credit sources.

5.1.1.14 Rate of Interest

Present research also explored the rate of interest prevalent in the locale of the study. Large number of respondents (82%) in sample population borrowed loan in tune 5% rate of interest per month. And 12% respondents are reported to have loan in tune of 5% to 7% per month. Only, 6% respondents have loan in the rate of more than 7% per month.

Rate of interest is determined by the caste status of the borrower and period of loan. It was also learnt that, there is practice of 25% rate of interest based on exigency of borrower.
5.1.1.15 Purpose of Indebtedness

The study report, explores various reasons for borrowing loan. It was found to be health and food cost as highest magnitude of borrowing loan. It was surfaced up that, 64.41% population are indebted to meet the health and food cost for their families. The report also reveals that 19.21% of respondents borrowed money exclusively for health purposes. Next proportion is due to marriage which compels 8.47% of people borrowing money and 3.39% of respondents exclusively for addressing the cost of food in the household level. There are also insignificant numbers who borrowed loan for the purpose of education (0.56%), addressing other rites & rituals (1.13%) and 2.82% for the agricultural and house building purposes.

5.1.1.16 Crisis of food grains (purchasing capacity)

Present study has also attempted to highlight the food crisis in household level. Data was found to be very interesting. Among the sample population, 1.5% population found to be struggling for food across the year. It exhibits that, 25.5% families do face food crisis recurrently in a year and 35% population faces food crisis sometimes in a year. It signifies that, 60% of population do face food crisis in a year and while 38% found to be food secured throughout the year.

5.1.1.17 Housing Pattern, room’s availability

In this research, majority of the houses were found to be kuchha. Study reports that, 75% of houses are made kuchha and jhopri type and 18% houses are semi pucca and only 7% houses were pucca. This data is also supported by the findings of research work outcome on epidemiology of PEM of children between 6 months to 5 years in slums of Guwahati by Das. Krishna (2013).

The study outcome also narrates the number of living room. It was found that, 65.5% population have only one room and 32% population have 2 rooms. Only 2.5% population reported of having three rooms or more.

Present study has also taken into consideration other infrastructural aspects of the household. The data produced that, only 95% of household doesn’t have separate kitchen shed and only 5% has their separate kitchen shed.
5.1.1.18 Drinking water and sanitation facility

Handpump or tube well is the only source of drinking water in the study area. The present data outcome shows that 47.5% of population possesses their own hand pumps and 45.5% of respondents collect drinking water from Govt installed community well. It has also produced that, 7% of respondents avail drinking water from neighbours. This research data is almost corroborative in nature with the outcome of study conducted by Ministry of Minority affair, GOI and ICSSR (2008) which reports that 43% of population in avail from their private handpumps and 46% collect from Govt installed hand pumps.

Present study exposes very deplorable condition of sanitation facility. Significant population in tune of 98.5% population does not have access to sanitation facility. This data is very close to the finding of study conducted by Ministry of Minority affair, GOI and ICSSR (2008). According to their study, 94% of household doesn’t have own sanitation facility. But the outcome data of present study is in contrast with NFHS-IV data (2015-16) which reports that 25% of rural household has sanitation facility.

5.1.1.19 Household and basic amenities

The present study also shows that 96% household does not possess any radio and 97% of population does not have any TV set in the family. Hence, we may conclude that interface with mass communication is very less. People majorly don’t (64.5%) have any cycle. Only 35.5% population family possesses cycle and only 9 families have motorbike. But data found to be higher in regards to accessibility of mobile phones. Its found to be 95.5% families do have mobile phones. Only, 5(2.5%) families reported of having refrigerator in comparison to 2.06% as reported in SECC 2011 data. It has been also found that 24 families (12%) have their own LPG connection. The exposure of male members in the urban cities has been a causal factor behind the insignificant presence of LPG and refrigerator in the households.

The Socio-economic and caste census 2011 data reports that 75% households in the district, has mobile phone which is less than the outcome of this present study.

5.1.1.20 Availability of Agricultural land and Homestead land
In the present study, it seems that majority of households surveyed in the research work don’t possess agricultural land. The study exposes that 80% sample population is landless and 20% has very small and insignificant landholding in regards to agriculture purposes. This is very similar to SECC data 2011 which records that 74% of HH doesn’t have any land.

In the research, researcher has also explored the availability of homestead land. It had been observed that, 80% of sample population have their homestead land and 20% of population lives in Govt or others land.

5.2 Various factors and correlates of maternal and child health

Present study also factored in the various influencing aspects pertaining to maternal and child health like aspects pertaining to health care, food intakes, health and hygienic conditions, age of marriage, age at first child birth, practice of breast feeding and practice of supplementary feeding, place and type of child birth, types of assistance during the home delivery and most importantly birth weight of the child.

5.2.1 Place of Child birth

While analyzing the data pertaining to place of child birth, it was found that half of the child birth is taking place as non-institutional in the study area. Institutional or facility based child birth was found to be 50.5% among the sample population. This finding is in similar with recent data published in NFHS-IV which reports that 47% of child birth is institutional in Darbhanga district.

5.2.2 Place of Child birth block wise distribution

This study also analyses the block level data of child birth. Data reveals the fact that Ghansyampur block has 58% institutional (facility based) child birth and 42% are home based. In contrast, the Kiratpur block has 57% home delivery and 43% are facility based. Recurrent flood and water logging, difficult geographical location makes the difference.
5.2.3 Assistance in child birth in non-institutional case

In the present study prevalence of assistance during non-facility based child birth found to be very alarming. Data exposes that almost 99% of non-institutional child birth is assisted by untrained traditional birth attendant. This data is in contrast with the NFHS-IV report (2015-16) which records that 13.7% of home delivery conducted by skilled personnel.

5.2.4 Type of delivery in facility based child birth

Present study also reveals the prevalence of c-section techniques in the facility based child birth. It came out with the findings that, 5% of facility based child birth takes place through c-section and 95% through normal procedure. This is very much in sync with the NFHS-IV data (2015-16). NFHS-IV data shows Darbhanga has 4.9% C-section cases in public health facility.

5.2.5 Term of Delivery

Term of delivery was also studied in this present study. Data presents that 98% are full term babies (40 weeks of gestation period) and only 2% birth takes place before 37 weeks.

5.2.6 Availability of Birth weight

Collection of birth weight information was difficult in study population because all mothers were not having birth record or birth weight was not mentioned in the card. While analysing the birth weight, it was found that 55.5% cases child birth weight was not available and only 44.5% cases reported the birth weight.

5.2.7 Birth weight distribution

The present study also has taken the birth weight as important factor while understanding the underweight of the child. The 48% children were born with the birth weight between the 2.5 Kg to 3.0 Kg range and 37% children were born with higher than 3 kg birth weight. The mean birth weight comes around 2.73 Kg which is just higher than 2.5 kg of normal birth weight. Further analysis shows that, 13 children out of 89 children were born with less than 2.5 Kg which comes 15%. The
study report of Bharati P, Pal M et al (2011) using the NFHS-III data revealed that India has 20% low birth weight babies.

5.2.8 Gender wise distribution of Birth weight

Present study also leads to build understanding on gender based birth weight pattern. It has been found that, 16.67% boys and 13% girls are born as LBW babies. Data analysis also established the fact that 47.62% boys and 49% girls are born in weight category of 2.5 kg to 2.99 Kg. In category of 3 Kg and above girls represent with higher value and record that around 38% girls are in this category in comparison to 35.71% male children.

5.2.9 Age wise distribution of malnourished children

Present study also examines the prevalence of underweight children in different age group. From the data, it was very evident that maximum children 45.5% belong to 1 year to 2 years and 35% malnourished children are from 2 years to 3 years age group. The study findings of Narkhede V, Likhar S, Pitale S, Durge P. on Nutritional status and dietary pattern of under five children in urban slum area Nagpur (2011) has also similar findings. They have found maximum malnourished children in this 13-24 months age group. The data also reveals that, in all age categories the girl children are more vulnerable as underweight children.

5.2.10 Practice of Colostrum feeding

In the present study, it was found that 89% mothers reported to have started their colostrums feeding to their children within one hour of child birth. About 11% mothers did not apply their colostrums feeding. This finding is in contrast to NFHS-IV data. The NFHS-IV data of Darbhanga district shows that only 23% of children under 3 years breastfed with in one hour and in Bihar collated data shows around 42%.

5.2.11 Immunization status of the Children

Present study also explores the status of immunization in study area. This report describes that, amongst the 200 sample malnourished children 94.5% children have received their age appropriate dosages. The table reveals that, only 5.5% children missed age appropriated dosages and thus their status in incomplete. Data findings is
in corresponding value with the data of Block Health action plan under NRHM 2011-2012. Kiratpur Block Health action plan (2011-12) shows that immunization coverage is almost 99% where as Ghansyampur Block health action plan shows 85% immunization achieved in 2011-2012.

5.2.12 Status of birth registration of the Children

Birth registration data is very depressing. Data found only 35.5% children possess their birth registration certificate and 64.5% children don’t have their birth certificate.

5.2.13 Distribution of malnourished children with their birth order grade

Analysis of child birth order observed evidently that, third order and more birth order is most vulnerable in terms of prevalence of malnutrition. It has been found that, 22.5% children from first order child birth are malnourished and respectively 23% children of second order birth order are malnourished. The large sample population i.e 54.5% children belong to third or greater than third order of their birth. This similar finding was also noted in the work of Shibulal A (Study on the prevalence of under nutrition and its determinants in Anganwadi children of Mallapuram district of Kerala; 2013).

5.2.14 Status of Ante-natal check up of mothers and IFA tablet intake

This study reveals that, 96.5% mothers have been covered under ante-natal care services limited to administering the TT dosages and IFA tablet only. An insignificant number (3.5%) was not put under these services. The NFHS-IV data of district, which doesn’t match with these findings, shows that 84% of women’s last child is protected on TT.

The study reveals the fact that, 81.5% mothers had intake of IFA tablets supplied from the Anganwadi for 100 days and 18.5% women did not consume the same. This data doesn’t match with NFHS-IV findings.

5.2.15 Status of Post -natal check up of mothers

The research data exposes significant gaps in PNC. Data shows that 98.5% mothers didn’t have their post natal care by the health care provider. Only 1.5% women
reported to have postnatal care by the private provider. This data is very contrasting with NFHS-IV (2015-16) data.

5.2.16 Food intake of mothers during pregnancy and cultural taboos

Present research data exhibits the distribution that, 72.5% mothers reported to have adequate food and 27.5% did not have their adequate food. The food diversity pattern was explored through focused group discussion and revealed that no such food diversity and special food has been provided to the pregnant women during their pregnancy.

During the study, emphasis was also made to understand the prevalence of cultural taboos pertaining to food intake. The data found that 33.5% of women faced different type of food taboos and 66.5% women reported not to be victims of food taboos. During the FGD, this issue was dealt in depth and revealed that, in laws and neighbours are establishing this taboo. Mostly full meal, sour fruits, heavy protein item is prohibited during the pregnancy.

Study findings on Food taboos during antenatal and postpartum period among the women of rural and urban areas of Tamilnadu by K. Kouser Banu, A.Prathipa et all (2016) also reported presence of food taboos among 63% of respondent women in their study. Narasimha BC, Ravish KS and Ranganath TS (2016) in their study found that 75% of pregnant women from urban slum of Bengaluru has some form of food taboos.

5.2.17 Vitamin Supplements intake after child birth and food intake status of mothers

This study also reveals the fact that only 20.5% mothers had consumed Vitamin supplements in form of syrups after child birth through open market. Large portion of respondent’s i.e 79.5% of mothers didn’t consume the additional vitamin supplements in form of syrup.

From the research finding, we may argue that 69% women sample population have 3 times food intake in a day where as 31% of women reported to have food intake twice a day.
5.2.18 History of Miscarriage and child death

The research found that, significant number of 13.5% women has cases of miscarriage and 86.5% women respondent had no experience of miscarriage. In the present study, it is observed that prevalence of child death (live birth babies) experienced by 12.5% mothers.

5.2.19 Medical Complication Post child birth

In this research work, medical complication Post child birth of mothers reported to be found among 25% of respondent’s mothers. High percentage of women i.e 75% of respondent reported that they didn’t face any complications after child birth.

5.2.20 Age of marriage of parents

The present study depicts an alarming picture in regards to age of marriage of mothers. It was found that 84% of marriage takes place before 17 years of age. Data observed that 36% of respondent women were married in the age group of 11 to 14 years. The highest percentage of marriage i.e 48.5% takes place in the range of 14 years to 17 years. Only 15.5% of women got married after 17 years.

Father’s marital age was also considered in the present study. The data observed that 48.5% male got married in between 17 years to 21 years and only 14.5% male members got married after 21 years which is legal age of marriage in India.

5.2.21 Mothers age at first Child Birth

Mother’s age at first child birth is considered very crucial. From the research finding we may say that 52.5% of women age at first child birth is in the category of 14-17 years. Only 35% of women give their first child birth in between 17 years to 20 years age group and 8.5% of women’s age at first child birth is higher than 20 years.

5.2.22 Supplementary feeding of children

The study finds an alarming fact that 58.6% of children received their supplementary feeding after 12 months. And, it was also very critical to note that, 10% children started their supplementary feeding even after 18 months. Only 28% of children were
provided supplementary feeding after six months which is sync with NFHS –IV data of 2015-16.

5.2.23 Practice of hot cooked meal

This study also examines the culture of serving hot cooked meal. The data found that only 19% mothers provide hot cooked meal to the children and 81% mother accepted that they also provided leftover food to their children.

5.2.24 Usage of Iodised Salt in the family

From the data analysis, it was found that, 100% families do use the iodised salt while cooking. Different brands were available like Goayal, Tata Salt, Patanjali Salt etc in the family. These all brands were locally available. The NFHS-IV data reveals the fact that 92% of households use Iodised salt in the district.

5.2.25 Drinking water management

The data analysis found that, 21% of household don’t store the drinking water rather they directly use from the water sources and most importantly 79% store in the pot for the drinking and cooking purposes. The present research also shows that amongst 70% of population keep water as open in the pot and only 30% keep in covered pot.

5.2.26 Hand washes practice of Mothers

This present study also observed that 82% of mothers wash their hands with water before and after feeding their children and 18% only use soap while feeding their children. Interestingly, after defecation 37.5% of mothers wash their hands with soap and large number i.e 62.5% of mothers use water and soil for hand washing.

5.2.27 Consumptions of tobacco and alcohol among parents

Present study also shows the consumptions prevalence of tobacco and alcohol among the fathers. It was found that 42.5% father has habit of smoking Bidi & Cigarette and 57.5% do not smoke. On the other hand large number of father i.e 75% are addicted to tobacco chewing (khaini) and 34% of male partners do consume alcohol and 66%
don’t consume. The recent published NFHS-IV data also reports that 52% of rural population of Bihar use any kind of tobacco and 30% of male consume alcohol.

Mother’s addiction to tobacco and alcohol was also studied. It was found that only 1.5% of mothers do smoke and 3.5% mothers do have habits of tobacco chewing in the sample household. It is very much similar with NFHS-IV data of Bihar which claims that 3% of rural women use any kind of tobacco.

5.2.28 Health seeking Behaviour and source of services

The findings of present study reveal that, 55% of malnourished children reported to have common cold and fever as causal factor for seeking medical attention. Interestingly, 4.5% of children also reported to be victim of Pneumonia, The 36% of children did have complains of cold, fever and water borne disease for treatment and only 1.5% children reported to have gastro related issues.

The present study also exposes a low trust on public health care systems. It was found that, only 9.5% mothers do avail public facility i.e Primary Health center situated in Kiratpur and Ghansyampur but 75.5% mothers reach to local quacks for treatment. There is also a significant 15% parents who compelled to avail high cost private facility after travelling miles for addressing the child health issues.

5.2.29 Child Care Support System

The study also observed that 30% of families get support from their in-laws and 19.5% mothers accepted that their elder children also provide support. Amongst the respondents, it was also come out that 47% of women do care their children by themselves.

5.2.30 Decision making pattern in the family

This present study also analyses the decision making pattern in the family. While analyzing the data it was found that 59% male influence the decisions of type of food procurement while 41% women take the decision. But 87.5% of women decide the menu in the family to be cooked. Male partner i.e 65% take the ultimate decision pertaining to the financial issues and only 35% of women have say in that process.
Thus, we may conclude that women do have less control over the finance in domestic level.

5.3 Access to Govt Services meant to address the malnutrition and food

The present study has also explored the accessibility and effectiveness of the service systems mainly designed to address the malnutrition issue amongst the children. In this regard, ICDS, MNREGS and PDS issue was closely observed, analysed based on the obtained data. The critical findings are as follows,

5.3.1 MNREGS card holding status:-

Present study findings depict a very dismal situation of MNREGS implementation. It was reported that, only 29% of respondent families have their MNREGS card and 71% even do not have their MNREGS card. Those who got jobs in this area worked from 10 days to 30 days in 2016. During the data collection it was felt that, poor wage package does not attract the local labours to work in the MNREGS programme and there is no such employment opportunity created by the government to stop the migration. Finding of study conducted by Ministry of Minority affair, GOI and ICSSR (2008) revealed that the awareness of people on MNREGS is very medium. Therefore, people don’t have access to this employment generation program.

5.3.2 PDS card holding status

The present study found that, 72% of PDS beneficiaries receive their food grains in irregular time period and only 17% got their PDS food grains regularly. It was also found that, 11% respondents even don’t have their own PDS card.

5.3.3 Availing PDS services last month

Information’s pertaining to availing the PDS services, it was found that 60% of respondent families availed last month PDS (Sept, Oct 2016). Further, in the present study it was observed that 40% respondents didn’t receive their last month PDS given food grains.
5.3.4 BPL card holding status

Present research shows that, 77.5% respondents have their own BPL card and 22.5% respondents reported not to have their card.

5.3.5 Access to Take Home ration during pregnancy

The study findings observed that, 80% women were provided take home ration irregularly during their pregnancy and 20% of mothers reported that they didn’t get the THR while they were pregnant.

5.3.6 Sharing of Growth monitoring outcome with mothers

In this present study, it was also found that 14% of mothers were informed on the outcome of GMC of her child enrolled in the ICDS and 86% of mothers didn’t receive any information’s pertaining to her child’s growth.

5.3.7 Providing Take Home ration to the children enrolled in the ICDS

Sample mothers under the study were asked whether their child received THR from the ICDS centers where he/she is enrolled. It was observed that, 100% of mothers reported negatively. It was found that 44% of mothers do receive THR irregularly for her malnourished child and 56% were not provided THR since last six months preceding the research work.

5.3.8 Participation of Women in ICDS interface

The present study brought out a dark picture as far as the qualitative interface between the ICDS workers and mothers is concerned. It was found that, only 22.5% of mothers attended any kind of interface meeting in ICDS centres and 77.5% mothers even didn’t attend any interface with the ICDS.
5.4 Parents perceptions on causality and implications of malnutrition in the lives of the children

Understanding mothers perspectives on cause and impact of malnutrition among the lives of the children was an integral qualitative part of this present research work. Keeping in mind the challenges of deploying the different scales close ended questions and opinions were placed to the mothers. The major findings are as follows,

5.4.1 Exposure of particular word “Malnutrition”

In this study, mothers from sample population were asked whether they heard, come across the word Malnutrition ( KUPOSHAN) in their lives. It was found that, 85% mothers even did not come across or heard this particular word and do not have exposure on particular word malnutrition. It was reported that only 15% mothers heard the word malnutrition.

5.4.2 Understanding on particular term “nutrition”

Present study revealed that majority of the mothers (67%) are not conversed with the term and meaning of nutrition. Only 9.5% respondents reported to have some understanding and 23.5% were struggling to describe nutrition.

5.4.3 Understanding of nutrition- its different notion

The present study further went on to probe the understanding of 66 mothers (33%) who attempted to describe the concept of nutrition. Further probing explored that, majority of mothers (30.3%) understand breastfeeding as nutrition and followed by 15% who perceives nutrition as adequate food. Data also observed that, 33.3% of mothers perceive nutrition as the combination of many aspects. It was also surfaced up that, 6% of mothers recognize nutrition is a concept of balanced diet.

5.4.4 Poverty as causal factor behind Malnutrition

The study further went on to explore other socio-economic and cultural as structural drivers of malnutrition. In this regard, present study revealed that 66% of mothers whose child is identified as underweight perceive the poverty as important causal
factor for malnutrition. In contrast, 31.5% of mothers were undecided on this proposition.

5.4.5 Recurrent Pregnancy as significant causality

Pertaining to health aspects as causal factor, the recurrent pregnancy aspect was placed as question to the mothers. It was observed that majority of the mothers accepted recurrent pregnancy as cause of poor nutritional status of their children. Only 15.5% women were undecided on this statement.

5.4.6 More Children as causal factor

Health aspects were probed further. The mothers were asked to seek information’s pertaining to impact of more children in the family as determinant for poor nutritional status. Widely held perspectives were that women consider it as important and only 2% of women were disagreed and 4% of women were undecided.

5.4.7 Early marriage impacts the child health

The present study also sought to understand the women’s experiences on early marriage as key to poor child health status. Early marriage issue was largely accepted by the women (83%) as significant reason for poor child health. Only 16.5% of women were undecided on this proposition.

5.4.8 Health and Hygiene practice as determinant of nutrition

The present study also attempted to understand the importance of health and hygiene practices from the mothers point of view. Data observed that, 44.5% of mothers perceive the hygienic practices as important and 54.5% of women were undecided. From this status we may infer that hygienic practices is still a de-prioritized area.

5.4.9 Malnourished children don’t progress in education

Study also examined their understanding on implications of malnutrition in the lives of the children. It evidently came out that, 73.5% of mothers acknowledged that malnourished children don’t progress and face lot of challenges in later part of the life. Only 25% women were undecided in this matter.
5.4.10 malnourished children are more prone to diseases

In sync with previous trigger, it is also placed that 82% of mothers accepted that malnourished children are susceptible to many diseases but in contrast 17% of mothers were undecided on this case.

5.4.11 Nutrition is key factor for all round development of the child

Present study found that, majority of mother’s accept that nutrition is most significant requirement for the all round child development in the family and 22% of women were undecided in this question.

5.4.12 EBF as significant preventing factor

The mainstream idea on exclusive breast feeding was also reported in the study. It was observed that 94.5% of mothers believe that exclusive breast feeding is a preventive factor. Only, 5.5% of mothers were undecided in this question.

5.4.13 Rural women work load impacts the child care

In regards to the nature of work load among the rural women folk, it was found that 78.5% of women recognize it as a challenge for proper child care. The data also found that, 16% of women couldn’t opine on this case and 5.5% of women were in disagreement.

5.4.14 Time poverty as causal factor

Along with the work load, time poverty issue was also explored in the present study. It was a mainstream notion as 80% women opined in favour of this opinion. Only 14.5% were in undecided mood.

5.4.15 Discrimination during breastfeeding

The present study further dipped to understand the practices of mothers while breastfeeding to their children according to the gender. It was observed that, 85.5% women rejected while 11.5% of mothers accepted the discriminatory practices of
breast feeding based on the gender. Very insignificant numbers of women were undecided in this opinion.

5.4.16 Disparity in Food according to Gender

Present study also explored the discriminatory practices of providing food in the household based on the gender orientation. Data observed that, 88% of women were in agreement and only 4.5% were in disagreement mood.

5.4.17 Education and awareness closely linked with nutrition

In the present study mothers were probed to understand their opinion on importance of education and awareness as linking bridge with malnutrition. Data observed that, 57.5% of mothers were agreed that education, exposure to mass communication, information’s are very much linked with the nutrition. It was also observed that 42.5% of women couldn’t take a position on this case.

5.4.18 Govt Programs effectiveness addressing the malnutrition in household

Finally, it was attempted to understand women’s locus standi on the issue of effectiveness of Govt programs combating the malnutrition issue. It was found that, majority of mothers (63.5%) were in refusal mood and only 6.5% of women expressed their happiness on Govt programs. Data also observed that, 30% of women were undecided in this ground.

Major qualitative findings based on observation, Focus Group discussion and in-depth case study:

Researcher also conducted focused group discussion with semi-structured trigger in diverse setting in the locale of the study to strengthen the argument and discussion. The subjective outcome and oral presentation of the participants were consolidated and triangulated with the quantitative analysis.

From, the focused group discussion, we may conclude that household level poverty has critical impact in the domestic food intake process and overall health care of the children. Lack of local level employment opportunity, landlessness and impact of
flood influenced the agricultural activities in the operational area and thus works as push factor for male migration.

Abject poverty has direct relationship with the indebtedness. Families borrowed loans from non-institutional sources in high interest rate and therefore they repay the loan from their daily wages earned from destination places. The rate of interest also varies across the caste line and tenure of the loan. People accepted this indebtedness as integral part of the life and consider it as inevitable for their survival. While building argument on domestic level food crisis, it may be concluded that poor vulnerable families face 3-4 months in a year as most tough time to ensure two square meals for the family members.

Agricultural productions impacted due to recurrent flood and moreover landlessness caused the low agricultural productions specially the green vegetables. The non-veg communities depend on crabs, snails in their food basket. Food diversity was identified as another significant causality for underweight status of the children. People basically depend on Potato based vegetables in their meals and eat different green leafy vegetables (in summer Ghera, Shaku, Patu and winter Bathua and Botu). Left over Rotis are generally provided as breakfast to the children.

Women have come out from their age old practices and now administering the colostrums with in one hour of child birth. But, the concept of exclusive breast feeding was defeated in the field. Women due to lack of uniform understanding about the importance of EBF, they start administering alternative milk, water, honey before the children attend six months. Delayed initiation of supplementary feeding has been also understood as causal factors. Therefore, we may conclude that, poor feeding practice, absence of diversified food, poor hygienic practices during feeding caused the malnutrition among children.

From the health care perspectives, we may conclude that people principally depend on the local quacks and private institutions. Trust on Govt health care institutions was not found at all. Non-institutional child birth is highly prevalent in the area and assisted by the unskilled birth attendant. High burden on health is major factor for their indebtedness. Geographical location is also a crucial determinant. Ante Natal check is ensured but mostly covered by the TT and post natal check up is completely absent.
Structural drivers of malnutrition also hint a poor status of women in terms of care, food intake during and post pregnancy. Rampant child marriage and early motherhood has come out as another crucial factor. High burden dowry as causal factor of child marriage is important to note and it has been a cultural practice.

Women hitherto are impacted due to existence of food taboos during the pregnancy and lactation. Many food items and protein rich food are prohibited as it is perceived as factor for extra foetus growth which will lead to costly c-section of mothers. Hence, women take less food during the pregnancy. Cold and fever, diarrhea and Pneumonia were reported as most critical health hazards for the children. The high cost and dreadful disease was Pneumonia in the field.

Functioning and effectiveness of two major Govt programmes had been criticised by the women in the field. Besides the success of mission mode immunization mothers rejected the effectiveness of ICDS in the field. Irregularity of THR for the pregnant and lactating mothers, 6 months to 3 years children, and non-implementation of nutrition health education programs under the umbrella of ICDS was major grievances. Ineffective implementation of MNREGS was critical push factor for large scale migration.

Causality, its symptoms and impact of malnutrition is little understood in the community. Malnutrition has been perceived by the women as weak, skinny children and prone to diseases. Malnutrition mostly perceived as DUDHKATUWA children characterised with early weaning. Though women are illiterate but through their life experiences perceive early marriage and early motherhood as significant factor of poor nutritional status of child and mother.

Information, knowledge and practices on birth spacing were absolutely missing and gender patriarchy caused havoc. Son preferences across the caste line were very much prominent. Though there was no gender based discrimination on breastfeeding but there is difference in providing food according to gender. Lack of education, awareness and exposure also influences the health care and nutritional status of the child.

From the amassed case studies, we may draw a comprehensive conclusion about diverse determinant of malnourishment status of their children. Families with high
indebtedness are just struggling to ensure food availability for the children across the months in a year. Health cost and food costs have been identified as significant contributor for indebtedness.

The lack of information and practice among the mother on EBF, weaning, initiation of supplementary feeding had been also crucial causal factor for the poor child health and nutritional status. Women compelled to work for hours keeping the children unattended. Mothers were denied from adequate and balanced food during the pregnancy and moreover proper ANC packages. The zero PNC outreach by the health workers makes the situation worst.

There are practices of non-institutional child birth which compounded by no post natal care. Trust deficit on the Govt health care pushed the families to seek high cost private care. Local quacks and private practitioner provides the treatment in higher cost. Door step treatment and credit based treatment; availability of 24X7 makes them popular in the field. Food diversity in the family comes up as critical factor. Poor health and hygienic situation, cleanliness in the house, unhealthy practices as observed are crucial factor of recurrent illness of the child.

Families even didn’t adopt preventive and rehabilitative measures. Extra feeding, medical care, reaching out to tertiary care, reaching out to health care providers for discussion was not also mooted by the parents. Lack of awareness and understanding on the implication could have been described as causal factor.

In regards to the Govt services, it may be concluded that services appeared to be failed to address the health and nutritional requirement of the child and mother. PDS systems were functioning with utter irregularity and beneficiaries were not provided with the food grains as it is provisioned. ICDS found to be and ineffective institution in the field. These severely malnourished children are not attended by the ICDS nor referred to the Nutritional rehabilitation center.

Community level screening process, health and nutrition education, developing community based malnutrition management, empowering the women towards taking up measures for proper feeding practice are not taken up. The important outcome of GMC process is also not communicated to the mothers for encouraging them to take
preventive and rehabilitative measures. Hence, it may be concluded that child nutritional health is not prioritized agenda.

**Conclusion:-**

The present research work successfully described the socio-economic and cultural context of the families having malnourished children and explored significant factors pertaining to maternal and health care practices, food intake, food diversity, supplementary feeding, health seeking behaviour, sources of health services, age of marriage, age at first child birth etc. It also throws light on the access and effectiveness of major social programs responsible to combat malnutrition. Finally, the present study investigates the perception of mothers on cause, effect and best practices around the nutrition theme.

In this study, role of different factors influencing malnutrition has been examined. Household level economy has played a major role in terms of providing qualitative food to children and their mothers. Income and trap of indebtedness is directly impacting the qualitative food intake at household level. It evidently came out that, repayment of their loan actually takes lion share of their monthly income.

Landlessness, no opportunity of employment in the locality and most importantly non-implementation of MGNREGS in the area, are compelling factors for migration of male members to other states. Migration of male members is an important factor for poor women and child health care.

Accessibility to health facility significantly influences the overall health care of the families. In Kiratpur block, due to poor transportation facility and difficult geographical location people largely depend on local quacks who treat at exorbitant rate. In Ghansyampur block, though the PHC is situated at block headquarter but people do not have trust on the quality of services of the PHC.

Gender aspect has also been examined in this study with utter emphasis. It was found that, prevalence of girl children in joint family is high. Lack of care for girl children in the joint family has been a major factor. Though, there was no reported discrimination during breastfeeding practices but discrimination in food distribution has been
identified as a critical factor. Women accepted that, son gets more preference while serving good qualitative food.

Pregnant women and their health care status have also been critically examined in this study. Lack of adequate care and supplementary food during pregnancy leads to birth of low birth weight babies. In the realm of ANC package, women are mostly given TT dosages. Pregnant women were not provided other services in the realm of ANC. Experience of miscarriage and death of new born babies came up as a significant issue from respondents. But positive picture was reported in immunization of the children and initiation of colostrums feeding. Delayed initiation of supplementary feeding emerged as a critical contributor.

After quantitative and qualitative observation it can be concluded that there is still prevalence of non-institutional child birth practice in the villages and are mostly conducted by the untrained local traditional birth attendant. Responding to health issues and ensuring food availability at household level came out as critical components for their indebtedness. Dependency on local quacks and chemist at high rate pushes the families into debt trap. Common cold and fever was reported as common reasons for their visit to doctors. Pneumonia was identified as most critical disease among the families. Provision of safe drinking water, sanitation facility, type of household is indirectly determining the living standard of the families as the families live in kuchha jhopri in damp condition.

Educational status, exposure to information and knowledge of the parents are also crucial factors. It impacts the overall care of children. Birth order of children variable is significant and it was found that three and more birth order children are more vulnerable as underweight children.

The food diversity picture was not encouraging. Mostly, people depend on locally available vegetables and leafy vegetables. As this locality is flood prone and characterised with water logging, therefore people depend on outside supply. Existence of food taboos during pregnancy and post pregnancy in the community is a critical correlate.

Absence of financial institutional arrangements and access also increases the dependence on local money lender. Exorbitant monthly rate of interest by the local
money lender multiplies the magnitude of debt trap. Migrated labour sends money to their families by using account of other villagers. In discussion and field work, researcher collected information that migrated labour also pays money to the account holder for using their account.

Landlessness was also reported in higher degree among the respondents. Thus agricultural production has no role in their daily food intake. Food crisis was found as an important factor. Poor functioning of PDS systems and household level economy plays an important role. Power structure in the villages also influences the PDS functioning, as reported during interaction with the communities.

Effectiveness of Government services mainly PDS and ICDS was not found satisfactory. All of the beneficiaries agreed that, ICDS is largely ineffective as it is not regular in terms of THR distribution, organizing health, nutrition education programme and most importantly sharing the outcome of the growth monitoring of the children. MGNREGS implementation has also been found as most ineffective scheme.

Early marriage and early motherhood is directly impacting overall health situation of mothers and children. From the analysis we can argue that, early marriage and motherhood is a significant determinant.

The study also concluded that, male members are key economic decision maker. Though they do not influence decisions related to food but they do have a greater say in important economic decisions. Thus, we may conclude that women do have less control over finance at domestic level.

This study also examined the perception of mothers on causes and implications of malnutrition in the lives of the children. Though women were not educated but could identify some critical influencing factors like early marriage, recurrent pregnancy, large number of children, poverty, workload, lack of time. These factors have been considered as significant for their child nutritional status. They also accepted the fact that, food discrimination practice based on gender is present in the community. Exclusive breast feeding is considered unanimously as preventive factor for malnutrition.
Women also acknowledged that malnourished children don not progress and face lot of challenges in later part of their life. They have also experienced over the years that malnourished children are susceptible to many diseases.

Lack of education, lack of exposure to mass communication, insufficient information related to food and health care, do contribute to poor nutritional status of their children. Finally, majority of mothers accepted that Government programs are inadequate to combat the issue of food crisis and primarily malnutrition.

Thus, we may conclude that malnutrition is no longer merely a subject of food availability or food intake rather it is a holistic and comprehensive concept. It now encompasses large spectrum of health, care, knowledge related issues and more over includes accessibility of government services.

But domestic income has played a major role in this study. The structural drivers of malnutrition is closely linked to economy of the household, food diversity, breast feeding, administering supplementary nutrition, marital age of mothers, age at first child birth and so on. The structural aspects also build understanding on gender based discrimination at household level, access to health care and overall care received by women during pregnancy and post pregnancy. Though education has a greater role at the household level but women from their life experiences perceive the implications and causes of malnutrition in the community.

The systemic driver talks about the access of the poor vulnerable community towards the major government programs which seem to be largely ineffective in nature and calls for comprehensive actions at ground zero.
Recommendations:

We must consider the fact that health and nutrition are human rights. Therefore State has its own accountability to ensure the services to all people irrespective of their caste, gender and religion.

At this critical juncture malnutrition calls for a comprehensive action to match the scale of Sustainable Development agenda. Keeping in mind its complexity and multi-dimensional nature, nutrition sensitive intervention demands a unified rejuvenated effort from across the lines. In this research, it has been lucidly placed that the systemic drivers and structural drivers impact the status of malnutrition among the children. Therefore, the recommendation has been placed keeping in mind those drivers. After long fieldwork and amassing practical nuances, the researcher recommended the following actions,

- Improvements in healthy living environment with proper housing and sanitation facility can lead to dramatic improvement in nutritional and health status of children and mothers.
- There is urgent need to escalate the economy of the families. Being geographically flood prone, alternative economic generation activities need to be implemented. Hence, land distribution program for the landless and integrated agricultural approach, cash transfers, and wage employment like MGNREGS can be geared up towards income generation in the families. Creation of common property resources through implementation of MGNREGS may be placed. But ensuring economic growth in the families merely may not be enough to combat malnutrition. Hence, multi-sectoral interventions need to be taken up.
- The most critical factor that need immediate attention is action towards eradicating gender based biasness in the villages. Gender based discrimination needs to be factored in while designing the program. Women’s access to economic decision impacting the lives of their children needs to be promoted.
- Large scale awareness campaign is required to eradicate the biasness and prejudices, age old practices that impact the food practices and child care practices in the area. Here, local language based IEC materials and locally
nuanced cultural tool can be deployed towards overall awareness building on malnutrition and its correlates in the community.

- Most importantly, there is need for a comprehensive program design towards increasing the level of awareness amongst the community to build malnutrition as critical health agenda.
- Access to government financial institutions need to be in place. To reduce dependency on non-institutional source of loan, there should be some kind of alternative institutional arrangements regulated by the Government to bring out the families from debt trap
- Overall, education campaign by using locally nuanced cultural tools need to be deployed to build understanding, knowledge and change in the practice amongst the community
- ICDS as a major institution to address the issue needs to be augmented. Infrastructural improvement, accountability building of the workers and most importantly transparent functioning needs to be ensured. In this process, empowered community groups can play the monitoring role.
- Reaching to the unreached children by the ICDS also need to be institutionalized. Though the State Government has initiated to increase the reach out through the expansion of ICDS services but all children in 0-5 years need to be brought under the services of ICDS.
- Community based screening of malnourished children and referral of severely malnourished children as per the operational protocol of treatment of severely acute malnourished children needs to be integrated. The linkages between ICDS and district level NRC need to be organically placed. The prevention mechanism in the community and community based rehabilitation mechanism can be pioneered, based on the locally available food and resources. Hence, the platform of VHSND in the ICDS can be well explored and instrumental.
- It is also important to record that, NRC is situated at the district headquarter and therefore linkages are not established. Moreover due to distance and difficult geography parents do not want to access the services. Therefore, keeping in mind its easy access, NRC decentralization and establishment at the block level adjoining the PHC is another important contextualised recommendation.
• There is large need for reviving the public health facility in the field with skilled workers, infrastructures and more over transportation facilities to enhance the number of institutional child birth and management of new born babies. Low birth weight management is also an area that needs to be incorporated mandatorily for the outreach worker. Mandatory recording of the birth weight in JACHHA BACHHA CARD (mother and child health record card issued by ANM) needs to be ensured for all institutional and non institutional child birth. Nutrition issue should not be treated in isolation rather should be taken up comprehensively with other health related determinants.

• Integrated actions are required to enhance the practice of exclusive breast feeding, colostrums feeding, safe institutional delivery, timely initiation of complementary feeding, achieving the agenda of full immunization and Vitamin A supplementation.

• It has been accepted that, malnutrition travels through generation. Thus, continuum approach of intervention under the guidance of health workers needs to be ensured. Efforts are also essential to ensure Iron folic supplementation for the mothers and adolescent girls.

• ASHA, ICDS workers must be monitored while providing ANC and PNC care and family planning choices. There is need for massive health nutrition intervention drive to be facilitated by ICDS. Therefore, ASHA and ICDS workers can play an instrumental role to link the beneficiaries with the public facility to improve the health and nutrition outcome indices.

• There is immediate need for overall revival of ICDS, MGNREGS and PDS schemes implementation in the field. The macro level issues in terms of funding and approval of financial resources on time needs to be ensured. Moreover at ground level activation of the ICDS, building accountability and skills of ICDS workers need to be plugged in.
Along with these operational recommendations, researcher would also like to place some macro level recommendations for consideration during the policy formulation, large scale public opinion building and making it a political agenda.

The recommendations are,

- In India, locally elected governance units are not so much accountable to ensure quality health and education services. Though in recent past, the elected representatives have been included in various monitoring bodies across the layers but primarily they are focused on the development work. Hence, to utilise their full potential, reforms should be undertaken to make them accountable monitoring mechanism in the area.

- There is an urgent call to make it a political choice across the political spectrum in the country. Political will can only end malnutrition in all forms. Emphasis on political debate on malnutrition can lead to positive direction towards action by the bureaucrats. Informed political leadership should take the driver’s role in this transformation process.

- ICDS and PDS are the two important pillars in India’s welfare systems. Therefore, administrative and technical bureaucrats at apex level and Anganwadi workers at the grass root level have the responsibility to implement the policies and placing the institutional arrangements. Thus, a concentrated, focused intervention is required instead of just achieving the data centric target work. An attitudinal change is required among the care givers and policy makers. Ideologically access to ICDS and health care is a right of the children.

- In India, if we look at the nutrition specific resource allocation then we can see an insignificant increase in the backdrop of magnitude of malnutrition in the country. Hence, there is urgent need for adequate resource allocation to augment nutrition intervention especially through ICDS, PDS, MDM and other health entitlements under NHM. Along with resource enhancement, allocation also need to be planned accordingly and based on the local need. Increase in per child investment, probably will give a window to escalate the intervention process. The political discourse must recognize the investment on
nutrition specific programs as tool to ensure economic growth for future and achieve the global target.

- Along with the Government’s deployment of resources the non-state actors need to join hand and combat the agenda. Hence, investment from Government can be scaled up with additional financial and technical support from donor organizations, international grant making organizations and most importantly the corporate houses as their mandate of social responsibility. The investments must be in holistic sector rather than schematic. Therefore, investment is required in the field of strengthening the health systems, sanitation, hygiene and water facility, agriculture, education and other social aspects.

- Finally, in India the systems of generating data towards developing plan is periodical. Generally, nationwide health survey takes place after long gaps. Therefore, it becomes difficult to design the actual program. Hence, periodical data generation needs to be in place. In this process, different academic institutions, research organization can be roped in. We can argue for a more focused research and evidence for formulating the policies and identifying the priorities.