DISCUSSION DRAFT

Towards a Food Rights Code:

The State, Food Denials and Food Rights

This volume will argue for and outline a proposed Food Rights Code, that lays down statutory duties for public authorities to secure the right to food of all people at all times, normal and emergent. It will begin with a discussion of the only food related official Codes that currently exist, a range of Famine, Drought and Scarcity Codes. It will trace briefly the historical context of these Codes, and argue that they need to be completely rewritten for the contemporary context of a democratic polity. In the light of this review of Famine Codes, past and present, this volume tries to suggest an alternative Food Rights Code, which delineates duties of public authorities to a) ensure the right to food of all people in normal times; b) acknowledge, verify and address individual and mass starvation; c) identify people and groups which live with chronic hunger even in normal times and take special measures to protect them from starvation and secure their rights to food; and d) address emergent situations of food scarcity arising from extraordinary natural, human made and economic situations.

Centre for Equity Studies, for Dan Church India
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Preface

This volume will try to argue for and outline a proposed Food Rights Code, that lays down statutory duties for public authorities to secure the right of all people to food at all times, normal and emergent.

It will begin with a discussion of the only food related official Codes that currently exist - a range of Famine, Drought and Scarcity Codes. It will briefly trace the historical context of these Codes, and argue that they need to be completely rewritten for the contemporary context of a democratic polity. These Codes, and even their successor Scarcity and Drought Codes of independent India, come into force only after people in a region are ravaged by major natural disasters - mainly failures of rainfall and consequent disruption in agricultural production. They have rarely dealt with starvation and the duties of the State to prevent and mitigate it, and also do not aim to help realise people's right to food in normal times, and the duties of public authorities towards people who live with prolonged denials of adequate food.

In light of this initial review of Famine Codes, past and present, this volume tries to suggest an alternative Food Rights Code, which delineates duties of public authorities to a) ensure the right to food of all people in normal times; b) acknowledge, verify and address individual and mass starvation; c) identify people and groups which live with chronic hunger even in normal times and take special measures to protect them from starvation and secure their rights to food; and d) address emergent situations of food scarcity arising from extraordinary natural, human made and economic situations.

The volume compiles, draws on, and includes contributions from many sources. The segment on food rights in normal times is based on 'Supreme Court Orders on the Right to Food: A Tool for Legal Action' originally written by Yamini Jaishankar and Jean Dreze for the Right to Food Campaign Secretariat in 2005. It has been subsequently revised by Biraj Patnaik and Spurthi Reddy in September 2007. The segment on starvation and the detailed annexures on verbal autopsies and other methods to verify starvation, are drawn entirely from an excellent document, 'Guidelines for Investigating Suspected Starvation Deaths', prepared by the Jan Swasthya Abhiyan's Hunger Watch Group, based on a consultation organized in Mumbai in 2003[1]. In writing the segments reviewing famine and scarcity codes,

[1] This conference was attended by Veena Shatrughna (Deputy Director, National Institute of Nutrition, Hyderabad), Vandana Prasad (Paediatrician), Narendra Gupta (Prayas), Sunita Abraham (Christian Medical Association of India), Sarojini (SAMA and Convenor of MFC), C. S. Kapse (Professor, Department of Forensic Medicine, D. Y. Patil Medical College), Neeraj Hatekar (Professor, Department of Economics, University of Mumbai), Sanjay Rode

past and present, I have received valuable research support from M. Kumaran and learnt much from the painstaking reviews undertaken of some of these Codes by Sana Das[2]. The research in preparing this volume is supported by a research grant from Dan Church India.

This is only a preliminary discussion document, and will no doubt be refined and greatly improved by extensive consultations.

Harsh Mander
Centre for Equity Studies
December, 2007

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[2] Sana Das undertook these reviews for Action Aid India in 2001

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Chapter 1

Famine Codes, Past and Present: A Review

In contemporary India, there remain large gaps in the statutory codification of the claims and entitlements of people from the State for realising their right to food, in normal times, but also in periods of both acute food distress and in situations of chronic food deprivation (acute denials being the result of natural and human disasters, and chronic deprivations the more routine denial of sufficient food for a healthy and active life, even in normal times).

During episodes of food scarcity caused by drought and failures of the rains, district authorities in many regions of the country are still substantially guided in crafting their responses by locally updated, adapted and amended versions of the Famine Codes that were initially developed by colonial administrators. These Codes detail the duties of governments in such times of great human distress, and the operational strategies that should be adopted by them when confronted with these challenges. These remarkable, almost legendary documents were compiled by colonial rulers to regulate the declaration of food scarcity and famines based mainly on sample field crop assessments, and to inform the range of subsequent administrative measures required to be taken by local administrations to address the impacts of food scarcities as and when they occurred.

However, an enormous amount of water has flowed through the Ganga in over a century since many of these Codes were written. Among the epochal changes that have occurred in the context of these Codes, one of the most significant is that India has since become an independent democratic socialistic republic. The nature of food scarcities has transformed dramatically - from cataclysmic events leading to the loss of enormous numbers of life due to starvation, to periodic local scarcities precipitated a range of factors such as failures or fluctuations of monsoon, of forest produce and agricultural prices, with very little loss of life but otherwise considerable human tribulation; and the persistence even in normal times of endemic hunger and widespread malnutrition, especially among children (particularly those in very difficult circumstances), disabled and infirm people, and old people without care-givers, single women in particular and women in general, and socially vulnerable groups such as SCs (or dalits), STs (or adivasis), minorities, urban slum dwellers and homeless people. The Indian Constitution recognises the right to life as a fundamental right, and many regard this as including the right to food and work with dignity. A conditional statutory guarantee to the right to work has been created by the National Employment Guarantee Act, 2005. India is also a signatory to a number of international covenants, including those of economic, social and cultural rights and those related to gender justice and child rights. The realisation of these rights is closely monitored by activist people's organisations, often in alliance with an activist

judiciary. The State is committed to affirmative action for most vulnerable groups, such as SCs, STs and women; to decentralisation of governance to local bodies; and transparency and accountability through powerful Right to Information legislation. The Indian government runs some of the largest food assistance programmes in the world, including direct food and income transfers; procurement of foodgrains at support price, storage of buffer stocks to prevent shortages and shocks, and sale of subsidised grain in a nation-wide network of shops; and wage employment through public works, which as observed was recently converted into a qualified legal guarantee.

This paper will try to briefly summarise some of the major policy debates relevant to this vastly altered context of Famine and Scarcity Codes, and track both the continuities and departures in these discussions and practices from colonial to present times. It will argue in favour of the careful and comprehensive codification of statutory and judiciable duties of public authorities to secure the right to food of all citizens at all times. These should apply firstly to spells of acute food crises caused by periodic local scarcities (spurred by monsoon failures or natural and human made disasters), but also others caused by other adversities for farmers such as large unfavourable fluctuations in agricultural prices, or failures of forest produce which could be critical for tribal and other forest dwelling communities. However, it will contain measures to address endemic hunger and starvation, unlike both colonial and contemporary Codes (also called manuals or handbooks), all of which exclude responding to everyday hunger endemic to the lives of many dispossessed communities, social categories, households and individuals. It will propose some principles that it suggests should inform the codification of State duties, practices and procedures for assessing and dealing with food scarcity and endemic hunger, in conformity with democratic values, a rights based approach, gender, social and class justice, and accountability and right to information.

Famine Codes: Continuities and Changes from Colonial Times

During the eighteenth and nineteenth centuries, the people of India were ravaged by a series of cataclysmic famines, precipitated less by failures of nature and more by colonial policies - such as rack-renting (both legal and illegal), neglect of agriculture, 'free-trade' policies and additional levies for wars. There are terrifying contemporary accounts of these famines, such as of rivers 'studded with dead bodies'[3], of whole settlements being wiped out by hunger and epidemics that followed in their wake, of desperate loot and plunder, and of the cumulative tragic loss of a numbing 15 million women, men and children[4]. Initially the colonial government had no cohesive policy to deal with these emergencies except to prevent hoarding and crime, which was followed by ad hoc relief measures such as stray food kitchens,

[3] Alamgir, Mohiuddin. (1980). *Famine in South Asia: Political Economy of Mass Starvation*. Cambridge, Massachusetts: Oelgeschlager, Gunn & Hain. p. 48, 64.

[4] GoI. *The Drought of 1987. Response and Management, Volume 1, National Efforts* Ed. D.C. Mishra. Dept. of Agriculture and Co-operation, GoI, New Delhi.

poorhouses and public works[5]. It was the appointment of the Famine Commission in 1878 that resulted in the first Famine Code (based substantially on one which had been written by Elliot in 1883 for Mysore) being adopted as a national model[6], and being suitably adapted in different regions of British rule. These Codes evolved under the influence of two subsequent Famine Commissions in 1898 and 1901, to provide comprehensive institutionalised guidelines to colonial administrators. These included instructions to anticipate famines, and to save lives but explicitly at the lowest possible cost to the exchequer - by providing employment at subsistence wage, and 'gratuitous' relief to the 'unemployable'.

In independent India, state governments variously adapted and amended these Famine Codes. In states carved out of the former Bombay and Central provinces – Maharashtra, Gujarat, Madhya Pradesh and Chhattisgarh – these were renamed Scarcity Relief Manuals, scarcity being defined as a marked deterioration of the agricultural season dues to failure of rains or floods, or damage to crops due to insects resulting in severe unemployment and consequent distress among agricultural labour and small cultivators[7]. Orissa wrote and adopted its Relief Code in 1971, updating the Orissa Famine Code of 1930, and further updated it in 1996. The Madras Famine Code has remarkably not been amended since 1901. In many states, these codes or manuals exist in the form of administrative circulars and government directives, which have tinkered with the Codes but not substantially rewritten these to reflect the imperatives of a democratic polity. The Andhra Pradesh government used the colonial Madras Code to guide its district officers until 1981, when it drew up its own Handbook on Drought[8], which builds substantially on the Madras Code. The Andhra Pradesh Handbook was further updated in 1995.

In their objectives, many of these Codes, manuals or handbooks make significant advances on their colonial predecessors. The Orissa Code expands its mandate to go beyond mere relief in crises to the 'maintenance of a certain standard of economic health of the people', whereas the Madhya Pradesh Code aims to prevent physical deterioration and loss of morale of its people because of unemployment, to enable them to restore their ordinary pursuits when better times return[9]. However, as we shall observe, most Codes do not live up to such aspirations, let alone to the duties of a democratic State to its vulnerable citizens as pledged in its Constitution - and are severely handicapped also because they are not backed by consistent and sufficient fiscal and administrative arrangements. I believe that the shadow of

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[5] Alamgir, Mohiuddin, (1980). *Famine in South Asia: Political Economy of Mass Starvation*. Cambridge, Massachusetts: Oelgeschlager, Gunn & Hain. p. 63-65.

[6] Ibid, p. 73.

[7] GoI. *The Drought of 1987. Response and Management, Volume 1, National Efforts* Ed. D.C. Mishra. Dept. of Agriculture and Co-operation, GoI, New Delhi.

[8] Ibid.

[9] Das, Sana. (2001). *A Critique of Famine Codes in India: A study of the Orissa Relief Code & Vulnerable People's Entitlements*. New Delhi: Action Aid. p. 22.

the values of colonial administration continues to fall long on the culture and practices of the bureaucracy, even 60 years after freedom. In this section, it is these many paradoxical and unacceptable continuities in public policy and practice related to drought and scarcity relief from colonial times that I will try to trace, while acknowledging also the many ways in which we have traversed in more progressive directions in the journey towards protecting our people from want.

(i) **Codes are non-enforceable:** All famine, drought and scarcity Codes, both colonial and contemporary, cannot be enforced in any court of law. They lay down duties of various public authorities, but contain no provisions that enable citizens (or subjects) to take these authorities to court, or to penalise them if they fail in performing these duties, even if this leads to the preventable death and suffering of people. In other words, the Codes are not rights based, in that they do not create legal entitlements and still depend in the last resort on the will of the State to act in specific ways. In colonial times, the timing, nature and extent of State support of people affected by drought and famine, depended on the 'benevolence' of the State, which was guided by considerations of doing the least that was necessary for containing unrest and crime born out of the desperation of mass hunger. It may be argued with merit that democratic polities hold State authorities accountable through the electoral process, and this binds them to their duties. But it is also true that the permanent bureaucracy that continues to be charged with most responsibilities under these Codes never faces elections, and that the people who are most in need of State assistance are often also most powerless and often practically disenfranchised, and therefore cannot influence electoral outcomes in any substantial way.

In recent times, some related rights have been turned into legal entitlements, most importantly by the National Rural Employment Guarantee Act, 2005 (NREGA) which provides a statutory guarantee to every rural family that demands 100 days of wage employment at statutory minimum wages a year. The State cannot plead fiscal or administrative constraints in providing such employment, and there is even a token fine on the public exchequer for failures to provide work in the legally prescribed time. The Supreme Court has also converted government schemes for school meals and supplementary nutrition for infants, small children and nursing and expectant mothers into legal entitlements in the writ petition 196 of 2001, PUCL vs. the Union of India and others. However, the entire Code should be legally enforceable to create legally binding duties of State authorities towards people who are living with threats to their lives because of denials of food and livelihoods, including clear accountability lines and penalties for failures.

(ii) **Minimising Relief Expenditures:** British Codes were explicit in casting a duty on public officials to spend the *minimum* that was necessary – to only prevent the loss of lives, and nothing beyond that. The 1941 Bengal Famine Code, for instance, puts this starkly: 'Government is obliged to limit its assistance to what is absolutely necessary for the preservation of life. When life is secured, the responsibility to the afflicted ceases and the responsibility to the tax paying public begins'[10]. Administrators were warned not to undertake relief works on such a lavish scale as to impair thrift and self-reliance among the people and the structure of society[11].

This minimising of relief was accomplished, in part, through a series of stern 'tests' of the desperation and urgency of want, to discourage all but those unfortunate persons who were most in most drastic need to report for work: the first of these was of distance, that the work should be far away from one's home so as to make it unattractive; the next was the 'residence' test, under which they were required to live at the work site for the duration of their employment away from their families; along with the 'labour' test, by which the work was required to be monotonous, arduous and compensated at very low wages, carefully calibrated to ensure that it enables nothing more than the purchase of bare essential food[12]. Men engaged in hard labour were paid enough to buy 1.5 pounds of food grains a day (and little else), which amounts to 2500 calories, women 'a little less', and working children from 7 to 12 years half the male rate. Despite the fact that children laboured even at such a young age in famine works, British commentators like Blair describe the multitude of children 'the bugbear of famine relief-works'[13], even though most children above 7 years were also required to work. One result of this minimalist approach to levels of relief meant that households could not save anything from their wages, and therefore suffered 2 or 3 months of negligible access to food between the closure of relief works and the next harvest. All efforts to expand the wages for and duration of work, and improve and humanise its conditions, were rejected peremptorily as wasteful.

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[10] Govt of Bengal. (1941). "*Famine Manual",* Revenue Dept, Govt of Bengal. p. 3.
[11] Das, Sana. (2001). *A Critique of Famine Codes in India: A Study of the Andhra Pradesh Handbook on Drought Management and Vulnerable People's Entitlements.* New Delhi: Action Aid. p 21.
[12] Singh, K.S. (1993). "Famine and Society" in *Famine and Society* Ed. Jean Floud and Amrita Rangasami, Water Project Series, New Delhi: The Indian Law Institute.
Dubhashi, P.R. (1992). "Drought and Development" *Economic and Political Weekly* 27 (13).
[13] Blair, Charles. (1986). *Indian Famines: Their Historical, Financial & Other Aspects* New Delhi: Agricole Reprints Corporation. p. 170.

At one level, much has improved since Independence. There is a positive continuity with the past in the reliance on public works for ensuring adequate food to households in such trying times. Enduring small public works closer to the homes of people affected by scarcity are now recommended (Most Codes require the works to be located at less than 5 kilometres from the place of residence), and there is legislation to ensure equal wages for men and women and for banning child labour (although some field studies report that children continue to be observed in some relief works, helping their parents[14]. Test works to verify need were discontinued in states like Andhra Pradesh and Orissa, although the colonial practice persists in Rajasthan.

However, wages are still fixed at bare subsistence levels, just sufficient for survival of the person and dependents. Scarcity and Drought Codes of most state governments today still contain no provision for raising wage rates in times of great distress. Instead they actually reduce them, on the specious grounds of reaching larger numbers[15]. The Rajasthan Code (paragraph 83) explicitly states that the principle of the famine wage scale is to pay the lowest amount that is sufficient to maintain a healthy person in health. The Orissa government is an exception, and it has authorised Collectors to enhance wages up to 20 per cent in times of dire need.

Workers in practice (in relief and even NREGA works in most locations in the country) are paid on not just the basis of daily attendance, but on the amount of work done[16], an illegal and exploitative 'double whammy'. The worker cannot leave if the work required is completed early, and is not paid more if more work is done; in effect, the minimum wage is also the maximum wage[17]. In practice, it is found that workers are paid less than minimum wages in public relief works. This has been challenged in a series of public interest petitions in the higher courts. A landmark case was Sanjit Roy vs. the State of Rajasthan (1983), in which the Court held that payment of wages that were lower that statutory minimum wages to people in famine relief works violated the Constitutional right to equality, and the state government should not take advantage of the helplessness of people living in conditions of drought and

[14] Das, Sana. (2001). *A Critique of Famine Codes in India: A Study of the Andhra Pradesh Handbook on Drought Management and Vulnerable People's Entitlements.* New Delhi: Action Aid. p. 70.
[15] Ibid p. 46
[16] Singh, K.S. (1993). "Famine and Society" in *Water Project Series* Ed. Jean Floud and Amrita Rangasami, New Delhi: The Indian Law Institute.
[17] Das, Sana. (2001). *A Critique of Famine Codes in India: A Study of the Andhra Pradesh Handbook on Drought Management and Vulnerable People's Entitlements.* New Delhi: Action Aid. p 158.

scarcity. It deemed such work at wages lower than minimum wages to be forced labour, punishable under law.

Standards such as shades and crèches for children and clean drinking water at work sites continue to be mostly neglected, although the Rajasthan Code lists a number of required on-site facilities and workers benefits. These include the right to a healthy and sanitary environment, shelter if the site is distant from the village, clean water, and even three weeks of maternity allowance.

In no Code is work guaranteed to all who seek it; and in fact it the Rajasthan Famine Code actually applies ceilings. NREGA is a great step forward, but it is still conditional and not an open-ended guarantee, which applies to one person in each rural family, with an upper limit of 100 days. Public works continue to be closed before the onset of the rains rather than with the reaping of the harvest, as in colonial times, and these can be times of the most severe food deprivation. This timing is specifically laid down in many Codes, such as the Andhra Pradesh Handbook. Indeed, it has been observed that even NREGA works are closed when rains start (and many state governments have issued written orders to this effect, even though these contravene the law, which requires works to be run whenever there is a demand by workers for them). It can be speculated that this is done in order to keep agricultural wages depressed during the agricultural season, to benefit larger farmers. Agricultural wages are typically well below the statutory minimum wage, and if workers have options to higher wage employment in public works, it would force farmers to offer higher wages.

In some of the major scarcities and droughts from the 1960s to late 1980s, there was relatively greater fiscal freedom for local officials to respond to actual demand for work; but from early 1990s onwards, relief works are seriously constrained by resources, and only minimalist interventions are permitted. The NREGA rectifies this with its significant scale and recent expansion to all districts of the country, but it still is not an open ended guarantee, ensuring not more than 100 days of work for one person in each rural family a year, regardless of the specific exigencies of emergency situations.

(iii) **Culture of Denial:** In colonial times, there was a culture of official denial - of 'masking famines' and indeed of often blaming the victim. I would suggest, maybe provocatively, that such a culture survives in milder and disguised forms even in contemporary India. A drought or failure of monsoon may trigger famine, but it is not in itself the cause of the famine. Students of famine suggest that bureaucracies tend to 'mask' famines first as separate episodes of mass deaths rather than ongoing processes of pauperisation, denial and inequality;

and second see these as the unfortunate outcome of rainfall shortfalls, floods or other production failures, as acts of nature for which there is little human responsibility. These create the normative framework of minimalist interventions, mainly in the short-term character of crisis management[18].

Droughts may not result in serious food scarcity situations and famines if people have enough food reserves and opportunities for employment at fair wages[19]. Von Braun, in a major study of food scarcity in sub-Saharan Africa concludes that 'production failures caused by drought, even those lasting several years, do not translate into famines unless other socio-economic conditions are prevalent' that are usually the direct result of failures of public policy. These include policies on agricultural technology, the scarcity of non-farm technologies, lack of savings, poor public health facilities and lack of infrastructure[20]. It is therefore appropriate to describe the Codes not as drought manuals (as is done, for instance in Andhra Pradesh), but as scarcity manuals (which is the name in Maharashtra and Madhya Pradesh) because this at least tacitly admits to scarcity that occurs due to factors that may extend beyond natural failures like drought and floods. New forms of agrarian distress have also surfaced in the form of farmers' suicides, which have spread like an epidemic through many parts of rural India, resulting from exploitative private credit, cost intensive agricultural technologies and forced unprotected integration into global markets. Codes provide for remission of loans from the formal banking sector, but leave untouched usury by the private moneylender.

Blaming the victim was explicit, even racist, in many colonial records. I can do no better than quote Charles Blair, an Executive Engineer of the Indian Public Works Department who writes in 1874 of the 'bigotry, fatalistic attitudes, apathy, or any of the other subtle influences that prevail in the East (which) was the cause of the sufferers concealing their necessities, or of refusing proffered work, wages, or food…'[21]. He quotes a journalist of the Daily News covering the great Orissa famine of 1866, who wrote, '*Kismet!* It is their fate: it has been the fate of their forefathers, of their caste, from times immemorial, to toil when toil and wage are offered; to hunger and to starve when wage and food failed them[22].' He even suggests

[18] Floud, Jean and Amrita Rangasami (1993) "The Masking of Famine: The Role of the Bureaucracy" in *Famine and Society* Ed. Jean Floud and Amrita Rangasami, Water Project Series, New Delhi: The Indian Law Institute.
[19] Das, Sana (2001) *A Critique of Famine Codes in India: A Study of the Andhra Pradesh Handbook on Drought Management and Vulnerable People's Entitlements.* New Delhi: Action Aid, p. 16.
[20] Von, Braun. (1991). *A Policy Agenda for Famine Prevention in Africa.* Washington D.C: IFPRI.
[21] Blair, Charles (1986) *Indian Famines: Their Historical, Financial & Other Aspects* New Delhi: Agricole Reprints Corporation. p. 85.
[22] Ibid, p.107.

duplicity, 'Able-bodied men who were offered work would refuse it, and would sit under a tree till they got thin enough to get gratuitous relief'[23].

Denials of starvation by public officials today are not often so openly racist, but they still routinely blame the alleged wanton neglect of their health due to superstition and ignorance, of especially tribal folk, as the cause of many deaths which activists and journalists claim are starvation deaths - and claim an indolent preference for relief rather than self-reliant and self-respecting honest toil. The Bombay Sanitary Commissioner of 1880 attributed mass deaths to cholera, measles, small pox, malaria, and diarrhoea; but tellingly left out starvation. The same happens today when starvation deaths occur. Census data also is never allowed to reflect deaths due to starvation, or migration due to intense food scarcity[24]. There is also a neglect of psycho-social care, as well as rehabilitative measures for survivors in Codes, past and present, suggesting an indifference to the enormity of human suffering associated with mass and individual hunger.

(iv) **Weak Early Detection Systems:** The persisting view of scarcity as the outcome mainly of natural failures, especially of rainfall, is that Codes today, as in the colonial past, continue to depend on diagnosing 'scarcity' principally on the basis of sharp shortfalls in total rainfall, and in agricultural production. The latter is measured by processes prescribed in the Codes, and is described as *annawari* or *paisawari.* Crop-cutting data, or sample checks of production compared with the average production, is required in Rajasthan, Andhra Pradesh and Orissa, for instance. In Orissa, drought is declared when there is 50 to 75 per cent damage loss in paddy, *ragi* and maize crops, which are the basic cereal crops of the area. Unlike Andhra Pradesh, the Orissa Code does not recognise irregular spacing of rain as contributory to drought.

The complicated and long drawn out administrative procedures (sometimes called 'crop-cutting experiments') seek to assess whether crop production in particular regions of specific mainly food crops are alarmingly below the average for that region and crop. These tests are possible only at the time when crops are ready for harvest. One outcome of this is that drought is declared well after the neediest people have migrated and pulled back on their food intake, usually only late in December of the year in which rains have failed, or even later. The

[23] Ibid, p.106.
[24] Rangasami, Amrita. (1993) "The Masking of Famine: The Role of the Bureaucracy", in *Famine and Society* Ed. Jean Floud and Amrita Rangasami, Water Project Series, New Delhi: The Indian Law Institute.

Orissa Code contains a very progressive provision, that allows government to start labour intensive works even before drought is formally declared, but this is rarely acted upon.

Up to the late 1980s, when large-scale scarcity relief works (employing sometimes more than one lakh persons daily in a district) were still the norm in many regions like Chhattisgarh and Rajasthan, the declaration of scarcity used to be an intensely politically fraught process, and District Collectors were frequently placed under great informal pressure even to fudge these statistics, in order to entitle the district to large funds for relief works. I have observed first hand that such political pressure frequently arose from lobbies of contractors, bureaucrats and politicians, rather than from impoverished people.

There are many problems with these outmoded methods of early diagnosis of impending food scarcity. Not only do they lend themselves to manipulation, but they establish scarcity only when it is well on the way; and therefore is less preventive and more enabling of fire fighting, after much avoidable suffering is already underway. They neglect many early signals of distress and decline into destitution, such as changes and reduction in food intake, distress migration and sale of assets, distress wages and so on. They overemphasise rainfall failures, and neglect rainfall variations which may be more damaging to crop production - but also price fluctuations that can be devastating for farmers producing for an increasingly globalised market, damage to forest produce such as *mahua* or *tendu* leaf, on which local populations may be more dependent, or the flowering of bamboo, or fall in water table and consequent drying up of sources of drinking water[25].

The Andhra Pradesh Handbook includes not only unusual migration of people and herds but also many offbeat and socially insightful early signs of scarcity, such as decline in rail travel and festival participation, increase in crime, and consumption of liquor. However, in practice, relief works are still linked only to rainfall failures or aberrations[26]. A three-year average is taken as the baseline; but this is misleading in chronically drought prone districts, where the baseline is itself too low to secure rural well-being. The Handbook does not recognise failure of non-timber forest produce as a source of drought, which discriminates against the food survival needs of the poorest forest dependent communities.

(v) **Neglect of non-farm rural poor, nomadic and migrant workers:** The Famine Codes of the past recognised that non-farm rural poor persons, like artisans and weavers, may be very hard

[25] GoI, *The Drought of 1987. Response and Management, Volume 1, National Efforts* Ed. D.C. Mishra. Dept. of Agriculture and Co-operation, Govt of India, New Delhi.

[26] Das, Sana (2001) *A Critique of Famine Codes in India: A Study of the Andhra Pradesh Handbook on Drought Management and Vulnerable People's Entitlements.* New Delhi: Action Aid, p 68.

hit by famine, but did little to address their food needs, even while recognising that they were not equipped physically and culturally to participate in the kind of manual labour that is required in public relief works. This required the design of public works that catered to their specific skills. This was never done, except for casual references in some public documents of those times to the effect that the distribution of cloth as part of gratuitous relief would hopefully create some opportunities for work for weavers. Although weavers and other artisans continue to suffer enormous setbacks today - even more so because of their highly unequal integration with global markets - and reports pour in of both starvation and suicides by weavers, they are neglected in even in contemporary Codes. The Andhra Pradesh Handbook, for instance, contains just one section that requires the listing of village artisans affected by drought, but follows this with no specific relief. The Rajasthan Code provides for loans against collateral for *ambar charkhas* (or modified spinning wheels) for weavers, with no provision for marketing or to ensure them a daily living wage during the period of scarcity.

In many regions like Rajasthan, nomadic pastoral communities migrate to survive scarcity. British administrators were averse to what they saw as 'aimless wandering' and found it potentially socially disruptive, and therefore discouraged it. These attitudes persist, and efforts are constantly made to 'settle' these communities[27]. The shrinking of commons and curbing of forest rights and access have led to reduced pastures and fodder availability to pastoral communities dependent on livestock. This has led to still greater dependence of these communities on State support for their fodder needs, and various Codes include provisions for cattle camps and *gaushalas* for starving cattle in times of acute scarcity[28], but the scale remains small, and the needs of these communities remains substantially unaddressed both in situations of crisis. The Andhra Pradesh Handbook, for instance, provides for cattle camps where starving cattle are fed at government expense, and fodder banks which supply farmers cattle feed at half cost, but there is no special focus in any of this for the specific protection of the small pastoralist and farmer. Besides, there is no assurance that these camps will actually be started, and if so when, therefore affected people do not know whether or not they should migrate[29].

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[27] Kavoori, Purnendu. (1998) *The Social Distribution of Land and the Variable Significance of Migratory Pastoralism in the Ecological context of Drought: Interpreting Some Evidence from Western Rajasthan,* Jaipur: IDS.
[28] Singh, K.S. (1993) "Famine and Society" in *Famine and Society* Ed. Jean Floud and Amrita Rangasami, Water Project Series, New Delhi: The Indian Law Institute.
[29] Chattopadhaya, Boudhan. (1991) " Food Security and the Social Environment: Food Systems and the Human Environment. Vol 1. Calcutta: Cressida Research Team, K.P Bagchi Co.

Distress migrants to cities, both in normal times of want and in extraordinary emergent situations of food scarcity, are again neglected both in Codes and contemporary food schemes. Because they are not of local residence in places where they migrate, they are routinely deprived of ration cards; they have to buy food from private shops in an unfamiliar market and have been found to buy broken rice fit only to be fed to cattle; their children are debarred entry into ICDS feeding centres, and from schools both to access education and mid-day meals; women are denied maternity benefits as well as the services of ICDS, and aged and disabled people their pensions. These problems are aggravated in instances of migration between states, where the host state refuses to expend its resources for migrants who have come to it in search of work, often in semi-bonded conditions. The Andhra Pradesh Handbook, as well as the Rajasthan Code, is silent about the food needs of migrants from other states. At the same time, their rights and those of their dependents need to be protected at the places of their origin as well. The Andhra Pradesh Handbook assures entitlement to women, children and the aged who are left behind when able-bodied members migrate, to gratuitous relief and supplementary nutrition.

(vi) **Gratuitous Relief and Social Security:** Gratuitous relief is the provisioning of food, cash or other life needs like clothes without requiring labour or collateral from the people who receive this form of relief. British relief policy haltingly incorporated programmes of gratuitous relief for persons who were physically incapable of working on relief sites (or were culturally barred because of *purdah* and 'high' caste). There was provision in the Bengal Relief Code[30] for instance, to 'distribute such gratuitous relief, in the forms of money or food, as may be necessary' and to 'open and maintain such temporary hospitals, poor houses, orphanages, and places for the gratuitous distribution of food as may be necessary'. The quantum of assistance and numbers thus served, however, were severely restricted.

In independent India, during some major scarcities, large community kitchens were set up and dry rations distributed, but by and large these have been found inessential in context of the changed nature of mass food scarcity. The Andhra Pradesh Handbook contains provisions for gruel kitchens and relief camps, but the quantum of assistance is not specified, and these are rarely set up. The rules themselves exclude those who benefit from pensions and other schemes, neglecting their enhanced needs in such times, and there is no special targeting of single women and children. An excellent feature is to feed dependents such as children and old people of those who migrate. This is sorely needed but not found in Codes like Orissa, but

[30] Govt of Bengal. (1941). "*Famine Manual",* Revenue Dept, Govt of Bengal. p. 4.

there are no operational details and much of this remains on paper[31]. The Orissa Code also specifically includes out of school children for feeding, and people who may have migrated from other district or place. The Rajasthan and Orissa Codes continues to use outdated and politically incorrect derogatory terms like idiots, the insane, the crippled and women of 'respectable birth' (as though those born into disadvantaged castes are not respectably born!) to list those entitled to gratuitous relief, but more gravely they leave large gaps in coverage of people in need, and frequently do not in practice provide such assistance at all[32].

It may be argued that 'gratuitous' relief as a form of State charity has given way gradually to social security as rights, the public distribution system (PDS), entitlement feeding programmes like the ICDS, mid-day school meals and pensions for aged and disabled people and widows. However, these are rarely adapted to the special needs created by situations of food scarcity, except for stray instances such as recent orders to distribute meals to school going children at schools even during vacations, in districts reeling under drought. But even this was not by executive order, but by intervention by the Supreme Court in the writ petition 196 of 2001, PUCL vs. the Union of India and others. A large emergency feeding programme was introduced in the 'KBK' districts of Orissa infamous for endemic hunger, again at the intervention of the statutory National Human Rights Commission. The Andhra Pradesh Handbook directs that care should be taken to ensure adequate stocking and functioning of PDS shops in drought areas, and doubles the allocations for drought-affected populations. However PDS targeting introduced from 1996 excludes many needy persons, and even the double allocation is less than the minimum prescribed by the Supreme Court even for normal times, namely 35 kilograms per family per month. It ranges instead between 10 and 16 kilograms. It does not place a discretionary stock of 2 quintals of grain with the Sarpanch for immediate intervention to prevent starvation, as is provided for in both Orissa and Rajasthan (one quintal). But even in these states, this amount is token, barely sufficient to meet the scale of need.

The Andhra Pradesh Handbook describes drought as a 'creeping disaster', leading to invariable food shortage, and especially high infant mortality[33]. It provides for supplementary feeding to children below 15 years, pregnant and lactating mothers, and old people. The Orissa Code excludes the last. The Rajasthan Code mentions only 'famine orphans' for special feeding. With the universalisation of ICDS and mid-day meals, there is need now for

[31] Das, Sana (2001) *A Critique of Famine Codes in India: A Study of the Andhra Pradesh Handbook on Drought Management and Vulnerable People's Entitlements.* New Delhi: Action Aid. p 76.
[32] Ibid, p. 16.
[33] Ibid, p. 68.

greater convergence with food schemes of normal times, and for augmenting these with higher allocations per head in times of scarcity, and inclusion of left out groups like out of school children for mid-day meals. The Andhra Pradesh Handbook also is sensitive to the exclusion and higher food vulnerability of SC ST populations, and therefore directs that these are located in SC ST villages, as well as slums. The Orissa Relief Code provides for 3 kinds of gratuitous relief: emergent (in natural disasters like cyclones but not droughts), ad-hoc (food and clothes for a maximum of 15 days), and 'on cards' (where crop loss is more than 50 per cent). The last is a more enduring entitlement, enabling them to access cooked food from on-going feeding programmes, but studies have shown that in practice large numbers are excluded from these schemes like emergency feeding[34]. The Rajasthan Code does not provide for emergent relief, but gratuitous relief can be given to those unable to work who are not getting pensions. But like in other states, this is rarely operated. This was a spur for the PUCL to file a petition on the right to food in the Supreme Court in 2001, to which reference has already been made (196 of 2001, PUCL vs. the Union of India and others).

The State also mostly persists in the characterisation of vulnerable people with special needs as, in effect, unemployable. It overlooks the fact that most disabilities are social rather than biological constructions, and schemes can be sensitively designed for the dignified employment of disabled people, single women and aged people, but these have to break out of the overarching model of conventional public works. The Rajasthan Code specifically debars disabled people from employment in relief works, and at the same time (in violation of the law) permits children to labour in relief works[35].

There is also the continuous preoccupation in separating out the 'deserving' from the 'undeserving' poor. This findings echoes even in the mandate of free India's Constitution (Article 41), which enjoins the State to secure the right to work, to education, and to public assistance in cases of unemployment, old age, sickness, disablement, and in other cases of 'undeserved want'. The notion that some bring penury and destitution upon themselves or that they somehow deserve it is, however, questionable, because of the complex ways in which social inequities come to bear on individual actions.

(vii) **Neglect of Starvation, Malnutrition and Chronic Hunger:** British famine policy limited itself to preventing mass starvation deaths, but ignored the consequences of malnutrition from

[34] Centre for Development Research and Training. *The Murky Twilight: An Unending Quest for Survival, Bolagir Drought-2001*. Orissa, Western Orissa Resource Centre, Xavier Institute of Management.

[35] Das, Sana (2001) *A Critique of Famine Codes in India: A Study of the Andhra Pradesh Handbook on Drought Management and Vulnerable People's Entitlements.* New Delhi: Action Aid. p. 9.

prolonged food denials, such as succumbing to eminently curable ailments. Today bureaucracies again deny starvation deaths, and do not hold themselves accountable for the deleterious effects of prolonged food denials. Indeed, it is again reiterated that with the end of large scale famines, the most important manifestation of hunger is not in the acute denial of food, associated with famines and scarcities, but with endemic chronic denials as a way of life even in ordinary times, but even more threatened in times of personal, local or larger emergencies. These are people who may not always die of starvation, but live with it, as an element of daily living. Codes, past and present, do nothing to address these. In fact, in the past, Codes have strictly warned against the 'misuse' of relief by people who live even in normal times with denial.

Many contemporary Codes, such as that of Rajasthan, do not even admit to the possibility of deaths by starvation. Even other Codes like Orissa's recognise only mass deaths as an indication of famine, and individual starvation is so difficult to prove[36] that in effect it has been banned simply by official decree! The Andhra Pradesh Handbook requires that the Collector gives weekly reports of starvation deaths, but it is completely silent about how such deaths are defined and verified, and the responsibilities to the victim family, psychosocial counselling and rehabilitation of survivors, and the accountability of public officials. The Orissa Code is even more stringent, requiring Collectors to submit a report within 48 hours of a starvation death, but there are no penalties for their failures to do so (despite the fact that such lapses remain the rule rather than the exception). In a landmark judgement in the Kishan Patnaik vs. the State of Orissa case in 1989, the Supreme Court confirmed the veracity of complaints of starvation deaths, but held that it had no reason to disbelieve that the state government was doing all it could to deal with the unfortunate situation.

Government programmes are woefully inadequate to prevent starvation and address destitution. Our evidence demonstrates that apart from major leakages and corruption, the coverage of these schemes is so meagre that they leave gaping holes in the social security net, through which large numbers of most destitute women and men, girls and boys slip. It is stressed that this is a duty not to the dead, but to the precariously living. It requires public vigilance about individuals, communities and several categories living with starvation and absolute hunger.

[36] Das, Sana (2001) *A Critique of Famine Codes in India: A Study of the Andhra Pradesh Handbook on Drought Management and Vulnerable People's Entitlements.* New Delhi: Action Aid. p. 38-39.

Central and state governments do run some of the largest entitlement feeding programmes, distribute subsidised foodgrains through a massive network of fair-price shops, and support vulnerable groups like old people, widows and disabled people, with pensions, and mothers with maternity benefits. Famines in British India were seen as famines of 'work' rather than of 'food', assuming that there was enough food and this could easily be transported to places with scarcity through the network of railways. However, the enormous devastation of the Bengal Famine of 1943 exploded this myth, and this contributed in India to the creation of an impressive Public Distribution System, although government has limited it coverage through targeting since 1996. It required the mediation of the Supreme Court in the writ petition in the writ petition 196 of 2001, PUCL vs. the Union of India and others, to convert some of these measures into universal entitlements, such as noon day school meals and supplementary feeding of infant, small children and expectant mothers. 60 years after Independence, a modest pension has been converted into an entitlement of all aged people who are designated poor.

These schemes still fall short of addressing hidden hunger in 3 main ways: a), gender, caste and other social barriers, as well as governance failures such as of corruption and leakages, exclude large numbers of the most needy from accessing these schemes; b) even in times of declared food scarcity, there is no augmenting of these food schemes and entitlements; and c) in the background of denial of a situation of large numbers of people living with starvation even in normal times, they do not recognise the need for special intensive interventions for households that live in conditions of chronic hunger, and of fully excluded groups. An example of the former is that a child from a home with absolute shortfalls of food will still receive supplementary nutrition from ICDS centres, when she actually lacks even primary nutrition. It is only when she slips into third or fourth grade malnutrition will she be entitled to additional food, but by then her body and brain has already been irreparably damaged. And of the latter, an example is of working, street and disabled children, and children of migrant working families, who are out of school, and therefore denied access to mid-day school meals.

(viii) **Governance Failures:** It is remarkable that contemporary scarcity manuals and codes continue to rely principally on the permanent bureaucracy at village, block, district and state government levels, to manage situations of food scarcity – much like colonial times. It is not surprising that many state governments therefore face little difficulty in applying Famine Code procedures developed by colonial administrators to a democratic polity. This

bureaucracy is not directly accountable to the people democratically; therefore matters literally of life and death, and the onerous responsibilities for preventing enormous human suffering and loss of life, cannot be left alone to the non-elected executive. Panchayats today at best have some role in implementing local relief (as in Madhya Pradesh, Gujarat, Rajasthan and Orissa) but decision-making remains in the hands of the bureaucracy. Panchayats and other local bodies need to be drawn into the leadership of all aspects of the management of scarcity; from its early detection, to its withdrawal and further prevention. This is not to deny the powerlessness and frequent disenfranchisement of most people who are condemned to live with hunger. But the creation of legal justiciable rights, and organised civic action around these, have been found to slowly build democratic sinews of even the weak in securing their rights, especially to life with dignity.

The procedures and rules under the Codes also remain completely opaque, another continuity with the past. The Codes need to be rewritten in ways that inform and engage with affected people at every stage - from the early detection of food scarcity, its diagnosis, mitigation and relief strategies including relief works, emergency feeding and other food and survival support to the vulnerable, fodder camps, arrangements for drinking water, and the ending of relief and preventive strategies. All of these should be transacted in participatory ways, such that people have the required information and the spaces to be consulted at every turn, to be informed of their rights such as to wages and how they are to be calculated, and to socially audit not just expenditures but also the adequacy of the actions of elected and permanent public officials to deal with the enormous challenges posed by the conditions of food scarcity and denial.

Chapter 2

A Scarcity Code for Contemporary Times: Suggested Features

The persisting culture of vigorous official denial that surrounds living and dying from hunger and destitution requires a decisively new Scarcity Code that breaks away decisively from the colonial legacy of Famine Codes, which still influence State response to food scarcity in a range of ways described in the first chapter of this volume. The objectives of such a Code would need to need to surge much beyond the minimalist agenda of the Codes of the past, aiming just to prevent the outbreak of mass deaths due to starvation in famines at minimum cost to the State exchequer. It would need to contain cast-iron provisions to protect all men, women and children from short and long term food denials, hunger, malnutrition and starvation, both in times of unusual emergency and in more normal times, to enable each of them to secure with dignity their right to assured and adequate food required to lead a healthy and active life.

We have observed that Codes in the past came into force only after major natural disasters, mainly failures of rainfall and consequent disruption of agricultural production. They rarely dealt with starvation and duties of the State to prevent and mitigate it, and also did not deal with right to food in normal times, and the duties to people who live with prolonged denials of adequate food. The relief and protections they afforded to the unfortunate people who lived with acute food denials depended on the will and benevolence of the State, and was severely constrained by budgetary limits, and a limited agenda to prevent mass starvation.

In the light of this discussion, this volume tries to suggest an alternative Food Rights Code, which delineates duties of public authorities to a) ensure the right to food of all people in normal times; b) acknowledge, verify and address individual and mass starvation; c) identify people and groups which live with chronic hunger even in normal times and take special measures to protect them from starvation and secure their rights to food; and d) address emergent situations of food scarcity arising from extraordinary natural, human made and economic situations.

Legal Binding:

The first feature of this Code is that its provisions should be binding on the State: on all governments, central, state and local. It should carry the force of law. This may be achieved through two paths, either by acts of Parliament and state legislatures, or by direction of the Supreme Court of India. It should create not just legal but also moral rights for all people. It must contain measures of enforceability, such as the right to information, grievance redressal mechanisms, participatory monitoring mechanisms such as social

audits, and clear lines of accountability of public officials at various levels, including of penalty for failures. It would be appropriate, therefore, to describe these not as Famine, Drought or even Scarcity Codes but as Food Rights Codes.

Objectives:

The proposed objectives of the Food Rights Code are as under:

1. To ensure that all people at all times have assured have physical, economic and social access to sufficient, safe and nutritious food to meet with dignity their dietary needs and food preferences for an active and healthy life.

2. To establish processes of investigating starvation that are transparent, reliable and respectful of the dignity of the survivors; and mandatory protocols for intervention for relief, prevention and accountability.

3. To identify individuals, dispossessed communities, classes and social categories of people who live with prolonged hunger, malnutrition and starvation, and to intervene with short, medium and long term measures to mitigate, prevent and sustainably reverse this situation of chronic hunger.

4. To ensure that emergent situations that threaten mass access to food, such as natural and human made disasters are anticipated, mitigated and addressed with equity and speed, without consequences of mass food scarcities.

In subsequent chapters, each of these objectives will be clarified, including the duties and rights that they create, and the ways in which they can be realised.

Chapter 3

Securing the Right to Food of All People at All Times[37]

Objective 1 of the Food Rights Code:

To ensure that all people at all times have assured have physical, economic and social access to sufficient, safe and nutritious food to meet with dignity their dietary needs and food preferences for an active and healthy life.

The Code must first lay down the duty of government at all levels to ensure that all people are able to realise at all times their right to food. The right to food is a human right, inherent in all people, to have regular, permanent and unrestricted physical, economic and social access with dignity, either directly or by means of financial purchases, to quantitatively and qualitatively adequate, assured and sufficient, safe and nutritious food corresponding to the cultural traditions of people to which the consumer belongs, for an active and healthy life[38].

The legal basis of the right to food has been helpfully spelt by the National Human Rights Commission (NHRC) in the proceedings of a hearing held on 17 January 2003:

> "Article 21 of the Constitution of India guarantees a fundamental right to life and personal liberty. The expression 'Life' in this Article has been judicially interpreted to mean a life with human dignity and not mere survival or animal existence. In the light of this, the State is obliged to provide for all those minimum requirements which must be satisfied in order to enable a person to live with human dignity, such as education, health care, just and humane conditions of work, protection against exploitation, etc. In the view of the Commission, the Right to Food is inherent to a life with dignity, and Article 21 should be read with Articles 39 (a) and 47 to understand the nature of the obligation of the State in order to ensure the effective realization of this right. Article 39 (a) of the Constitution enunciated as one of the Directive Principles, fundamental in the governance of the country, requires the State to direct its policy towards securing that the citizens, men and women equally, have the right to an adequate means of livelihood. Article 47 spells out the duty of the State to raise the level of nutrition and the standard of living of its people as a primary responsibility. The citizen's right to be

[37] This booklet has been adapted from "Supreme Court Orders on the Right to Food: A tool for Legal Action" originally written by Yamini Jaishankar and Jean Dreze for the Right to Food Campaign Secretariat in 2005. It has subsequently been revised by Biraj Patnaik and Spurthi Reddy in September 2007.

[38] This definition of the right to food derives from and build upon a definition suggested by the UN Special Rapporteur on the Right to Food, 2002.

free from hunger enshrined in Article 21 is to be ensured by the fulfilment of the obligation of the State set out in Articles 39(a) and 47. The reading of Article 21 together with Articles 39(a) and 47 places the issue of food security in the correct perspective, thus making the Right to Food a guaranteed Fundamental Right which is enforceable by virtue of the constitutional remedy provided under Article 32 of the Constitution."

The relevant Articles of the Constitution are as follows[39]:

Article 21: "No person shall be deprived of his life or personal liberty except according to procedure established by law."
Article 39 (a): "The State shall… direct its policy towards securing that the citizen, men and women equally, have the right to an adequate means of livelihood…"
Article 47: "The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties…"
Article 32 (1): "The right to move the Supreme Court by appropriate proceedings for the enforcement of the rights conferred by this Part is guaranteed."

Ensuring Specific Rights to Food in Normal Times

The Supreme Court of India has elaborated many specific on-going rights to food of specified segments of people in the Civil Writ Petition, PUCL vs. Union of India and Others (No. 196/ 2001).

The schemes that have been covered as food entitlements under this case can broadly be divided into the following categories:

- **Entitlement Feeding Programmes**

  - **Integrated Child Development Services (ICDS)**: Covers all Children under the age of six, pregnant and lactating mothers and adolescent girls. Six essential services are provided as part of the ICDS. These are:

[39] Article 32 (1) applies to the rights conferred in Part III of the Constitution, known as "fundamental rights". Article 21 appears in Part III, but not Articles 39(a) and 47. These appear in Part IV, under "Directive Principles of State Policy".

- **Mid Day Meal Scheme (MDMS)**: Covers all primary school children

- **Food Subsidy Programmes**

  - **Targeted Public Distribution System (TPDS)**: Provides 35 kgs / month of subsidised food grains at half the cost of the economic price to all families identified as living below the poverty line (BPL families)

  - **Antodaya Anna Yojana (AAY)**: Provides 35 kgs of rice / month @ Rs. 3 per kilo or 35 kgs of wheat / month @ Rs. 2 per kilo. This is to around 40 per cent of the poorest of poor families.

- **Employment Programmes**

  - **National Rural Employment Guarantee Scheme** (100 days of employment at minimum wages)
  - **Sampoorna Gramin Rojgar Yojana** (Food for work programme that is being phased out and replaced by the NREGS)

- **Social Assistance Programmes**

  - **National Old Age Pension Scheme** (Monthly pension to all BPL adults above the age of 65)
  - **National Family Benefit Scheme** (Compensation of Rs. 10,000 in case of death of bread winner of BPL families)
  - **Annapurna Yojana** (Provides 10 kgs of free food grain for destitute poor who are not covered under the National Old Age Pension Scheme NOAPS)

THE PUBLIC DISTRIBUTION SYSTEM

Background

The Public Distribution System (PDS) is a means of distributing foodgrain and other basic commodities at subsidised prices through "fair price shops". Every family is supposed to have a ration card. In 1997,

the PDS became "targeted": wherein different ration cards were issued to households "Below the Poverty Line" (BPL) and those "Above the Poverty Line" (APL), and each category has different entitlements. Today, both BPL and APL households are entitled to 35 kgs of grain per month, but the issue price is higher for APL households. In fact, it is so high that most APL households do not buy grain from the PDS. Thus, in practice the PDS is restricted to BPL households. Even in years when the APL prices correspond very closely with the market prices, the offtake of APL has remained very low since State Governments are not lifting their APL quotas. The Government of India has now reduced the APL quotas for all States and restricted it to the average of the last three years of APL offtake for that particular State.

In 2001 Antyodaya cards were introduced as a sub-category of BPL cards. However, the Supreme Court later stated that the Antyodaya programme should not be restricted to those with a BPL card (see Section 2.3). Thus, Antyodaya cards have become a separate card, distinct from either BPL or APL. Some households also have other cards, such as Annapurna cards (see Section 2.9).

The PDS, like many other large-scale food and employment schemes is also confronted with many governance-related issues, including widespread leakages and corruption at all levels of operation. The Supreme Court has taken notice of this and formed a Central Vigilance Committee on the Public Distribution System in its order dated 12 July 2006. The CVC (PDS) is chaired by Justice (Retd.) DP Wadhwa with the Commissioner of the Supreme Court, Dr. NC Saxena as the Member-Convenor. The Committee is presently looking into the maladies that are affecting the proper functioning of the Public Distribution System and suggesting remedial measures. The CVC has since submitted its report (August 2007), which will be taken up by the Supreme Court shortly.

Supreme Court Orders

1. **Identification of BPL families**: On 28th November 2001, the Court directed the State Governments "to complete the identification of BPL families, issuing of cards and commencement of distribution of 25 kgs. grain per family per month latest by 1st January, 2002". Note that the entitlements of BPL families were subsequently raised from 25 kgs of grain per month to 35 kgs.

The Planning Commission announced (in 2004), the BPL percentage population to be at 26 per cent, which would have meant a drastic reduction in grain allocation by the Central Government. However the order of 14th February 2006, directed the central government to allocate food grain on the basis of

Planning Commission estimates of 1993-94 poverty rations, which is at 36 per cent. On the BPL list, see also para 6 below.

2. **Accessibility of ration shops and regular supply of grain**: On several occasions, the Supreme Court directed the government to ensure that all ration shops open regularly. For instance, one of the very first interim orders (dated 23 July 2001), states: "We direct the States to see that all the PDS shops, if closed, are re-opened and start functioning within one week from today and regular supplies made." Similarly, an interim order dated 8 May 2002 states: **"**The respondents shall ensure that the ration shops remain open throughout the month, during fixed hours, the details of which will be displayed on the notice board."

3. **Accountability of PDS dealers**: The licenses of PDS dealers and shop-keepers should be cancelled if they: "(a) do not keep their shops open throughout the month during the stipulated period; (b) fail to provide grain to BPL families strictly at BPL rates and no higher; (c) keep the cards of BPL households with them; (d) make false entries in the BPL cards; (e) engage in black-marketing or siphoning away of grains to the open market and hand over such ration shops to such other person/organizations". Further, "the concerned authorities/functionaries would not show any laxity on the subject".[40]

4. **Monitoring of the PDS[41]:** A Central Vigilance Committee has been constituted to investigate the maladies affecting the proper functioning of the public distribution system, and suggest remedial measures. "For this purpose, the Committee shall, amongst other things, focus on: - a) The mode of appointment of the dealers; b) the ideal commission or the rates payable to the dealer and; c) modalities as to how the Committees already in place, can function better. d) Modes as to how there can be transparency in allotment of the food stock to be sold at the shops." Apart from this the Committee shall also suggest a transparent mode of appointing PDS dealers; and ways to make the existing vigilance committees more effective.

5. **Permission to buy in instalments:** Arrangements must be made to "permit the BPL household to buy the ration in instalments".[42]

[40] Supreme Court Order dated 2nd May, 2003.
[41] Supreme Court Order dated 12th July 2006
[42] Supreme Court Order dated 2nd May, 2003.

6. **Awareness generation**: **"**Wide publicity shall be given so as to make BPL families aware of their entitlement."[43]

7. **BPL list**: Orders relating to the "BPL list" are also relevant to the Public Distribution System, since the BPL list is the basis on which BPL and APL ration cards are distributed. Note in particular that (1) the Central and State Governments have been directed to "frame clear guidelines for proper identification of BPL families"[44] in consultation with the Supreme Court Commissioners[45] and; (2) no-one is supposed to be removed from the BPL list until such time as the Court deliberates this matter.[46]

Comments

1. The Supreme Court orders on the PDS should be read together with the Central Government's "PDS (Control) Order" of August 2001. This Order contains sweeping directions for holding FPS managers and others accountable, and should be read in conjunction with the Essential Commodities Act. Taken together, these three sets of orders (Supreme Court orders, PDS Control Order and Essential Commodities Act) can be used quite effectively to ensure that people get their due.

2. BPL targeting has attracted widespread criticism. There is much evidence that the "BPL list" is highly unreliable: well-off households often have a BPL card while poor households have an APL card, if they have a card at all. This is partly because the "BPL survey" used for identifying families below the poverty line is fundamentally flawed. This issue has been taken up in Supreme Court hearings from time to time – see Section 2.12 for further discussion.

3. Orders relating to Antyodaya Anna Yojana and Annapurna (see below) are also relevant to the Public Distribution System, since these schemes are implemented through the PDS.

ANTYODAYA ANNA YOJANA

Background

The aim of this scheme, launched in 2000, is to provide special food-based assistance to destitute households. These households are given a special ration card (an "Antyodaya card"), and are entitled to

[43] Supreme Court Order dated 2nd May, 2003.
[44] Supreme Court Order dated 8th May, 2002.
[45] Supreme Court Order dated 14th February, 2006.
[46] Supreme Court Order dated 5th May, 2003.

special grain quotas at highly subsidised prices. Today, Antyodaya cardholders are entitled to 35 kg of grain per month, at Rs. 2/kg for wheat and Rs. 3/kg for rice. Initially, the Antyodaya scheme covered 1 crore families, but this was later expanded to 1.5 crore families and then 2 crore families. Currently, around 40 per cent all BPL families are included in the Antyodaya category.

Supreme Court Orders

1. Orders related to the Public Distribution System also apply to Antyodaya Anna Yojana (AAY), since AAY is a component of the PDS. For instance, the order of 23rd July 2001, directing State Governments to ensure regular supply of grain to the ration shops applies to AAY also.

2. The State Governments were requested to consider providing grain free of cost to those who are so poor that they are unable to lift their quota, even at the highly subsidised AAY prices.[47]

3. The Central Government "shall formulate the scheme to extend the benefits of the Antyodaya Anna Yojana to the destitute section of the population".[48]

4. On 2nd May 2003, the Supreme Court declared that all households belonging to six "priority groups" would be entitled to Antyodaya cards. More precisely, the Government of India was directed "to place on AAY category the following groups of persons:

(1) Aged, infirm, disabled, destitute men and women, pregnant and lactating women, destitute women;

(2) widows and other single women with no regular support;

(3) old persons (aged 60 or above) with no regular support and no assured means of subsistence;

(4) households with a disabled adult and assured means of subsistence;

(5) households where due to old age, lack of physical or mental fitness, social customs, need to care for a disabled, or other reasons, no adult member is available to engage in gainful employment outside the house;

(6) primitive tribes."

[47] Supreme Court order dated 28th November 2001.
[48] Supreme Court order dated 29th October 2002.

5. Possession of a BPL card is not necessary for inclusions in the AAY category. The Central Government was directed to issue guidelines to this effect. [49]

6. In April 2004, the Court asked the Central Government to direct the State Governments to "accelerate the issue of Antyodaya cards especially to primitive tribes". Further, "the guidelines issued to State Governments shall be implemented in letter and spirit".[50]

7. In the order dated 17th October 2004, the State Governments were directed to complete the identification of AAY families and the distribution of AAY cards "by the end of the year", and to begin the distribution of grain to AAY cardholders "immediately". Further, the AAY cardholders "should not be made to pay, directly or indirectly, any amount other then what they are liable to pay for the supply taken".

Comments

The most important order here is the order of 2nd May 2003, whereby six "priority groups" are entitled to Antyodaya cards as a matter of right. However, the government is yet to devise (and implement) an effective procedure to ensure that all households in these priority groups are identified and covered under AAY. In the case of (so-called) "primitive tribes", the task is relatively easy, and in some states at least Antyodaya cards have been distributed to most families in this group. The other groups, however, by and large do not have universal access to the AAY scheme.

MID-DAY MEAL SCHEME[51]

Background

As mentioned earlier, the Supreme Court order of 28th November 2001 directs State Governments to start providing cooked mid-day meals in primary schools. Every child who attends a government or government-assisted primary school is now entitled to a cooked, nutritious mid-day meal every day.

The provision of cooked mid-day meals in primary schools is an important step towards the right to food. Indeed, mid-day meals help to protect children from hunger (including "classroom hunger", a mortal

[49] Supreme Court Order dated 20th April, 2004.
[50] Supreme Court Order dated 20th April, 2004.
[51] For a more detailed discussion of mid-day meals, see *Mid-Day Meals: A Primer*, available from the secretariat of the Right to Food Campaign as well as from the office of the Commissioners of the Supreme Court.

enemy of school education), and if the meals are nutritious, they can facilitate the healthy growth of children. Mid-day meals also serve many other useful purposes. For instance, they are quite effective in promoting regular school attendance, and in that respect mid-day meals contribute not only to the right to food but also to the right to education. Mid-day meals also help to undermine caste prejudices, by teaching children to sit together and share a common meal. They reduce the gender gap in school participation, provide an important source of employment for women, and liberate working women from the task of having to feed children at home during the day. Aside from this, mid-day meals can be seen as a source of economic support for the poorer sections of society, and also as an opportunity to impart nutrition education to children. For all these reasons, the Supreme Court order on mid-day meals has been widely welcome, especially among disadvantaged sections of society.

Supreme Court Orders

So far, there have been two crucial Supreme Court orders on mid-day meals: on 28th November 2001 and 20th April 2004, respectively. Further orders have been issued from time to time as well. The landmark order of 28th November 2001 clearly directed all State Governments to introduce cooked mid-day meals in primary schools:

> "The State Governments/Union Territories to implement the Mid Day Meal Scheme by providing every child in every Government and Government assisted Primary Schools with a prepared mid-day meal with a minimum content of 300 calories and 8-12 grams of protein each day of school for a minimum of 200 days."

This was supposed to be done within six months. But most State Governments took much longer, prompting the Supreme Court to issue stern reminders to them from time to time (e.g. on 2nd May 2003). A series of important follow-up orders were issued on 20th April 2004, to speed up the implementation of earlier orders, improve the quality of mid-day meals, and address various concerns raised in the Commissioners' reports. These orders include the following:

1. **Timely compliance:** "All such States and Union Territories who have not fully complied with the order dated 28th November, 2001 shall comply with the said directions fully in respect of the entire State/Union Territory… not later than 1st September, 2004."

2**. No charge:** The meal is to be provided free of cost. Money for the meal is not to be collected from parents or children under any circumstances.

3. **Priority to SC/ST cooks and helpers:** "In appointment of cooks and helpers, preference shall be given to Dalits, Scheduled Castes and Scheduled Tribes."

4. **Extension to summer vacations in drought-affected areas**: "In drought-affected areas, mid-day meal shall be supplied even during summer vacations."

5. **Kitchen sheds:** The Central Government was directed to "make provisions for construction of kitchen sheds" and also to contribute to the cooking costs.

6. **Quality improvements:** "Attempts shall be made for better infrastructure, improved facilities (safe drinking water etc.), closer monitoring (regular inspection) and other quality safeguards as also the improvement of the contents of the meal so as to provide nutritious meal to the children of the primary schools."

7. **Fair quality of grain**: In the order dated 28th November 2001, the Supreme Court directed the Food Corporation of India (FCI) to "ensure provision of fair average quality grain" for mid-day meals. Joint inspections of the grain are to be conducted by the FCI and State Governments. "If the food grain is found, on joint inspection, not to be of fair average quality, it will be replaced by the FCI prior to lifting."

8. **Extension to Class 10:** On 20th April 2004, the Government of India was directed to file an affidavit within three months, "stating as to when it is possible to extend the scheme up to 10th Standard in compliance with the announcement made by the Prime Minister." In response to this, an affidavit was filed by the Department of Elementary Education (Ministry of Human Resources Development) in 2004, but the Court is yet to examine it.

In October 2004, the Court noted that some progress had been made with the implementation of earlier orders on mid-day meals. However the feedback received from the States made it clear that implementation was being held up by a lack of funds in many cases. The Court then directed the Central Government to provide financial assistance of "one rupee per child per school day" to meet cooking costs. The Court also clarified that the responsibility to monitor the implementation of the mid-day meal scheme

"essentially lies with the Central Government".[52] Again, the Court stressed the urgency of the situation and directed that "every child eligible for a cooked meal under the Mid-Day Scheme in all States and Union Territories shall be provided with the said meal immediately".

Comments

Although the MDMS is now one of the relatively better performing schemes as compared to other schemes, the implementation of these orders has been a long and arduous process, but over time, most State Governments have fallen in line. Today, about 12 crore[53] children are getting a cooked mid-day meal at school every day. However, the quality of mid-day meals remains quite poor in many states: the content of the meal is inadequate, health safeguards are lacking and social discrimination is common. Also, nothing has been done to extend mid-day meals beyond the primary stage. Further action is required to consolidate the gains that have been made and to ensure that mid-day meals live up to their promise.

INTEGRATED CHILD DEVELOPMENT SERVICES

Background

ICDS is the only major national programme that addresses the needs of children under the age of six years. It seeks to provide young children with an integrated package of services such as supplementary nutrition, health care and pre-school education. Because the health and nutrition needs of a child cannot be addressed in isolation from those of his or her mother, the programme also extends to adolescent girls, pregnant women and lactating mothers.

These services are provided through ICDS centres, also known as "anganwadis". Today there are 8.44 lakh anganwadis in the country, covering 5.8 crore children in the age group 6 months to 6 years.[54] This is less than half of all children in the 0-6 age group[55]. The coverage of ICDS is therefore far from universal. Further, the quality of ICDS services is very low in most states. The Supreme Court orders on ICDS are essentially aimed at achieving "universalisation with quality" within a reasonable time frame.

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[52] Supreme Court Order dated 17th October 2004.
[53] Official figures available on the website of the Ministry of Human Resource Development www.education.nic. for the year 2005-06.
[54] Seventh Report (March 2007) of the Commissioner appointed by the Supreme Court in the 'Right to Food' case. To read the full report, please visit www.righttofoodindia.org.
[55] It is estimated that population of children in the 0-6 years age group is about 14 crores. (Government of India 2007, "Sarva Baal Vikas Abhiyan" [draft] Ministry of Women and Child Development, p. 1; based on 2006 Population Projections from Census data).

Supreme Court Orders

Here again the crucial order goes back to 28th November 2001, when the Supreme Court directed the government to "universalize" ICDS:

> "(i) We direct the State Govts./Union Territories to implement the Integrated Child Development Scheme (ICDS) in full and to ensure that every ICDS disbursing centre in the country shall provide as under:
> (a) Each child up to 6 years of age to get 300 calories and 8-10 gms of protein;
> (b) Each adolescent girl to get 500 calories and 20-25 grams of protein;
> (c) Each pregnant woman and each nursing mother to get 500 calories & 20-25 grams of protein;
> (d) Each malnourished child to get 600 calories and 16-20 grams of protein;
> (e) Have a disbursement centre in every settlement."

This order, however, received very little attention for several years. Virtually nothing was done to implement it. In April 2004, several marathon hearings on ICDS were held in the Supreme Court and detailed orders were issued, followed by further orders on 7 October 2004. This was followed by a landmark judgement regarding the ICDS scheme on 13 December 2006. However before, detailing the 13 December orders, we shall look at a few key directions of the 7 October 2004 order. The key orders in this series are as follows:

1. The Supreme Court directed the Government of India to increase the number of anganwadis from 6 lakh to 14 lakh habitations, and to "file within three months an affidavit stating the period within which it proposes to increase the number of anganwadi centers (AWCS) so as to cover the 14 lakh habitations."

2. "All the State Governments/UTs shall allocate funds for the ICDS on the basis of one rupee per child per day, 100 beneficiaries per AWCS and 300 days feeding in a year, i.e. on the same basis on which the centre makes the allocation."[56]

[56] This order effectively raises the budget norm for supplementary nutrition under ICDS to "two rupees per child per day". On 7th October 2004, when the above order was issued, the Supreme Court also stated that "the aspect of sanctioning 14 lakhs AWCS and increase of norm of rupee one to rupees 2 per child per day would be considered by this Court after two weeks". However, this follow-up discussion is yet to take place.

4. All SC/ST habitations should have an anganwadis "as early as possible". Until the SC/ST population is fully covered, all new anganwadis should be located in habitations with high SC/ST populations.

5. "All State/UTs shall make earnest effort to cover the slums under the ICDS."

6. ICDS services should never be restricted to BPL families ("BPL shall not be used as an eligibility criteria for ICDS").

7. "Contractors shall not be used for supply of nutrition in Anganwadis and preferably ICDS funds shall be spent by making use of village communities, self-help groups and Mahila Mandals for buying of grains and preparation of meals."

8. ICDS funds provided by the Central Government under the Pradhan Mantri Gramodaya Yojana (PMGY) should be fully utilised by the State Governments. Further these funds supplement, and not substitute for, ICDS funds provided by the State Governments. *However the PMGY has been discontinued since 2005/06 and the programme has been closed.*

9. "The Central Government and States/UTs shall ensure that all amounts allocated are sanctioned in time so that there is no disruption whatsoever in the feeding of children."

10. "All State Governments/UTs shall put on their websites full data for the ICDS schemes, including where AWCS are operational, the number of beneficiaries category-wise, the funds allocated and used and other related matters."

11.The entitlements of children under six have been further strengthened in the Supreme Court judgement of 13 December 2006. This can be considered a landmark judgement because in general, the judiciary refrains from imposing a financial responsibility on the state. The directions contained in this order are seminal and are presented below.

> "(1) Government of India shall sanction and operationalize a minimum of 14 lakh AWCs in a phased and even manner starting forthwith and ending December 2008. In doing so, the Central Government shall identify SC and ST hamlets/habitations for AWCs on a priority basis.

(2) Government of India shall ensure that population norms for opening of AWCs must not be revised upward under any circumstances. While maintaining the upper limit of one AWC per 1000 population, the minimum limit for opening of a new AWC is a population of 300 may be kept in view.

Further, rural communities and slum dwellers should be entitled to an 'Anganwadi on demand' (not later than three months) from the date of demand in cases where a settlement has at least 40 children under six but no Anganwadi.

(3) The universalisation of the ICDS involves extending all ICDS services (supplementary nutrition, growth monitoring, nutrition and health education, immunization, referral and pre-school education) to every child under the age of 6, all pregnant women and lactating mothers and all adolescent girls.

(4) The order also specifies the monetary allocation to be made per beneficiary under the ICDS scheme. The court instructs all State Governments and Union Territories to fully implement the ICDS scheme by, interalia,

> (i) allocating and spending at least Rs.2 per child per day for supplementary nutrition out of which the Central Government shall contribute Rs.1 per child per day.
>
> (ii) allocating and spending at least Rs.2.70 for every severely malnourished child per day for supplementary nutrition out of which the Central Government shall contribute Rs.1.35 per child per day.
>
> (iii) allocating and spending at least Rs.2.30 for every pregnant women, nursing mother/adolescent girl per day for supplementary nutrition out of which the Central Government shall contribute Rs.1.15.

(6) Chief Secretaries of all State Governments/UTs are directed to submit affidavits with details of all habitations with a majority of SC/ST households, the availability of AWCs in these habitations, and the plan of action for ensuring that all these habitations have functioning AWCs within two years.

(7) Chief Secretaries of all State Governments/UTs are directed to submit affidavits giving details of the steps that have been taken with regard to the order of this Court of October 7th, 2004 directing that 'contractors shall not be used for supply of nutrition in Anganwadis and preferably

ICDS funds shall be spent by making use of village communities, self-help groups and Mahila Mandals for buying of grains and preparation of meals'. Chief Secretaries of all State Governments/UTs must indicate a time-frame within which the decentralisation of the supply of SNP through local community shall be done."

Comments

The Supreme Court orders of April and October 2004 gave a useful wake-up call to the government, as far as the universalization of ICDS is concerned. The universalization of ICDS was included in the National Common Minimum Programme of the UPA Government in May 2004.The judiciary's continued focus on ICDS starting with the December 2006 judgement promises to keep the issue alive until universalisation of ICDS is effected. The National Advisory Council submitted detailed recommendations for achieving "universalization with quality" in October 2004, and some "follow-up recommendations" in February 2005[57]. The expenditure of the Central Government on ICDS was roughly doubled (from Rs 1,500 crores to Rs 3,000 crores) in the Union Budget 2005-6.

However, according to conservative estimates, the recent judgement (13 December 2006) necessitates a budgetary allowance of Rs 9000 crore per annum. In this light the 2007-08 Union Budget allocation of Rs 4,761 crores is minimalistic. This allocation has barely increased in real terms, and remains virtually unchanged as a proportion of GDP.

As far as the situation on the ground is concerned, the issue of entitlements of children under six, as embodied by ICDS, has attracted the attention of civil society organisations. A Children's Right to Food Convention, held in April 2006, helped build consensus on the issue of universalization with quality. Since the convention many activities have been held across the country to highlight the social importance of *anganwadis*; and the issue has also broken into the public consciousness.

NATIONAL OLD AGE PENSION SCHEME

Background

This scheme was launched in 1995 to provide "old age pensions" to senior citizens (aged 65 years or more). It is part of the National Social Assistance Programme, which also includes two other schemes: the National Family Benefit Scheme (NFBS) and Annapurna.[58]

[57] see www.nac.nic.in

[58] The National Social Assistance Programme also included the National Maternity Benefit Scheme (NMBS) till it was transferred to the Ministry of Health and Family Welfare in 2001-02.

The National Old Age Pension Scheme (NOAPS) is primarily addressed to old men and women with no assured means of subsistence, but the eligibility conditions vary from state to state, as does the coverage of the scheme. The pensions are given in cash, with the Central Government contributing Rs. 75 per month, often supplemented with a contribution from the State Government (e.g. in Rajasthan the old age pension is Rs. 200 per month). The Central Government enhanced its contribution to Rs. 200 per month, in March 2006. One of the main problems with this scheme is its small coverage: there are plenty of applications, but funds are limited to 50 per cent of the BPL individuals above the age of 60. Even within this, the conditionality imposed by the scheme of the individual not being "supported" by other family members further restricts the outreach of the programme.

In 2002-3, NOAPS was "transferred" to the State Governments (along with other National Social Assistance Programme schemes): from a "Centrally Sponsored Scheme", it became part of the State Plans. This was meant to be a relatively minor administrative reform, whereby the Central Government gives a cash grant to the State Government (under "Additional Central Assistance") and lets it run the scheme, instead of co-implementing the scheme with the State Government. In practice, however, this "transfer" tends to have an adverse impact in several ways. First, the cash grants disbursed by the Central Government are often "diverted" by State Governments for other purposes, or released after long delays. Second, after a scheme is transferred to the State Plans, the Central Government stops monitoring it. Third, the transfer has also terminated the payment of administrative charges by the Central Government, and State Governments often fail to make up for this. Aside from NOAPS, other schemes under the National Social Assistance Programme (i.e. Annapurna and the National Family Benefit Scheme) have also been transferred to the State Plans.

Supreme Court Orders

1. State governments have been directed to complete the identification of persons entitled to pensions under NOAPS, and to ensure that the pensions are paid regularly.[59]

2. Payment of pensions is to be made by the seventh day of each month.[60]

3. The scheme must not be discontinued or restricted without the permission of the Supreme Court.[61] This actually applies to all the schemes covered by the interim order of 28th November 2001. However it

[59] Supreme Court Order dated 28th November, 2001.
[60] Supreme Court Order dated 28th November, 2001.
[61] Supreme Court Order dated 27th April 2004.

is particularly relevant to schemes such as NOAPS, because these schemes are quite "fragile": there are no strong lobbies to defend them, and they often come under the financial axe when State Governments face a financial crisis.

4. The NOAPS grants paid by the Central Government to the State Governments under "Additional Central Assistance" should not be diverted for any other purposes.[62]

Comments

Even though the enhancement of the contribution of the Central Government for the pension amount was announced in the budget speech of the Finance Minister in March, 2006, the funds reached the state only by September. Many states therefore did not enhance the pensions for the financial year 2006-07. A recent announcement by the Prime Minister has enhanced the entitlement under this scheme to Rs. 400 per beneficiary per month. More significantly, the cap on 50 per cent of BPL has been removed and BPL persons who are 65 and above have been brought within the ambit of this scheme. It is hoped that this will go a long way in ensuring more secure entitlements to one of the most neglected and marginalized section within out society.

There are many implementation issues with this programme in the States. For instance, in many states, old people are forced to walk long distances to collect their pensions from the Block headquarters and often do not get it on time – with the pensions reaching once in six months rather than monthly. There is a possibility of streamlining distribution of pensions through bank accounts, money orders or transfer through panchayats.

Even with all its flaws, this is the only programme which provides a chance for a dignified living to old people living below the poverty.

NATIONAL FAMILY BENEFIT SCHEME

Background

This scheme, like NOAPS, is part of the National Social Assistance Programme. It provides for lump-sum cash assistance of Rs. 10,000 to BPL families on the death of a primary breadwinner, if he or she is aged between 18 and 65 years. A "primary breadwinner" is a household member whose earnings contribute substantially to household income. The amount of assistance is Rs. 10,000 for accidental deaths and Rs.

[62] Supreme Court Order dated 18th November 2004.

5,000 in the case of death due to natural causes. The payment is to be made to the "surviving head" of the household, after a local enquiry.

Supreme Court Orders

1. As with other food-related schemes, the Supreme Court order of 28th November 2001 calls for prompt implementation of the National Family Benefit Scheme. BPL families are to be paid Rs. 10,000 within four weeks through the local Sarpanch when the breadwinner dies.[63]

2. As with NOAPS, this scheme is not to be discontinued or restricted in any way without the permission of the Supreme Court.[64]

4. None of the benefits should be withdrawn from this scheme as a result of this order till further orders, by any of the State Governments or Union Territories.[65]

Comments

So far, the National Family Benefit Scheme has not received much attention in the Supreme Court hearings, interim orders. While information available from the field as well as the analysis of the macro-data on the utilization in this scheme brought out by the Commissioners Office point out to glaring gaps in the way the scheme is functioning, the scheme has not received the attention it deserves from the Campaign groups.

ANNAPURNA

Background

The Annapurna Scheme was launched on 1st April 2000. The target group consists of "senior citizens" who are eligible for an old age pension under the National Old Age Pension Scheme (NOAPS), but are not actually receiving a pension. The beneficiaries, to be identified by the Gram Panchayat after giving wide publicity to the scheme, are entitled to 10 kgs of grain per month free of cost through the Public Distribution System (special ration cards are issued to them for this purpose). The intention appears to be to provide some sort of emergency food security to elderly persons who are waiting for a pension to be

[63] Supreme Court Order dated 28th November, 2001.
[64] Supreme Court Order dated 27th April 2004.
[65] Supreme Court Order dated 18th November 2004.

sanctioned to them under NOAPS. However, the coverage of Annapurna itself is very limited. In 2002-3 this scheme was "transferred" to the State Plans, like NOAPS.

Supreme Court Orders

1. As with other food-related schemes, the Supreme Court order of 28th November 2001 calls for prompt implementation of Annapurna ("the States/Union Territories are directed to identify the beneficiaries and distribute the grain latest by 1st January, 2002").[66]

2. As with NOAPS and NFBS, this scheme is not to be discontinued or restricted in any way without the permission of the Supreme Court.[67]

Comments

The status of Annapurna is not very clear. Field reports suggest that the coverage is very limited. Also, there are occasional reports of the scheme being discontinued in particular states, in violation of Supreme Court orders. Ideally, those who are eligible for Annapurna should be promptly covered by the National Old Age Pension Scheme. As mentioned earlier, with the upward revision of the central assistance for the NAOPS, there is an urgent need to upwardly revise the entitlements under the Annapurna scheme as well.

NATIONAL MATERNITY BENEFIT SCHEME

Background

This scheme is a timid attempt to introduce "maternity benefits" in India's social security system. It was introduced in 1995 as part of the National Social Assistance Programme, and later transferred to the Health Ministry. Under NMBS, pregnant women from BPL families are entitled to lump-sum cash assistance of Rs. 500, up to two live births. The payment is to be made 8-12 weeks before delivery, but in practice there are long delays, partly due to the complex application procedures. Women are often paid months, if not years after delivery, and this defeats the purpose of the scheme. Further, the coverage of this scheme is very low: according to official figures, the number of women who actually received cash payments under NMBS in 2003-4 was as low as 4.3 lakhs - less than 2 per cent of the total number of births in that year.

[66] Supreme Court Order dated 28th November 2001.
[67] Supreme Court Order dated 27th April 2004.

Supreme Court Orders

1. As with other food-related schemes, the Supreme Court order of 28th November 2001 calls for prompt implementation of the National Maternity Benefit Scheme.

2. As with NOAPS, this scheme is not to be discontinued or restricted in any way without the permission of the Supreme Court.[68]

3. On 9th May 2005, the Supreme Court refused to allow the Government of India to phase out NMBS and provide maternity benefits under a new scheme, Janani Suraksha Yojana (JSY). The reason for this refusal is that it is not clear whether the new scheme preserves all the benefits available under NMBS, as the government claims. The Court requested the government to submit further information on JSY, and asked the Commissioners to "examine the matter in depth and file a report". "Meanwhile, the existing National Maternity Benefit Scheme will continue."[69]

Comments

This scheme is in very bad shape. The procedures are complicated, the quantum of benefits is small, payments are often delayed for months if not years, and the coverage is very limited. The government has merged this with the JSY, but JSY itself has many flaws. In fact, the main focus of JSY is not maternity entitlements but the promotion of institutional deliveries and safe motherhood. Also, it is not clear whether this new scheme preserves the earlier NMBS entitlements, in particular maternity benefits in cases of a delivery at home. Despite unambiguous instructions that Rs. 500 needs to be paid, even in the case of home deliveries, this message does not seem to have been communicated adequately to the State Governments and there are multiple field reports from across the country about the non-implementation of this scheme.

[68] Supreme Court Order dated 27th April 2004.
[69] Supreme Court Order dated 9th May, 2005.

SAMPOORNA GRAMEEN ROZGAR YOJANA

Background

The initial PUCL petition, submitted in April 2001, argued that assured employment at a living wage is the best protection against hunger. In this and other ways, the right to food is closely connected to the right to work. Employment issues have figured in the Supreme Court hearings from time to time.

Sampoorna Grameen Rozgar Yojana (SGRY) is a centrally-sponsored employment scheme. It was initiated in August 2001, and officially aimed at generating 100 crore person-days of employment each year. According to the official guidelines: "The SGRY is open to all rural poor who are in need of wage employment and desire to do manual and unskilled work in and around his/her village/habitat. The primary objective of the scheme is to provide additional wage employment in rural areas, thereby provide food security and nutritional levels. The secondary objective is the creation of durable community, social, economic assets and infrastructural development in rural areas. While providing employment preference shall be given to agricultural wage earners, non agricultural unskilled wage earners, marginal farmers, women, members of the Scheduled Castes/ Scheduled Tribes and parents of child labour withdrawn from hazardous occupations, parents of handicapped children or adult children of handicapped parents who want to work for wage employment."[70]

This scheme however is being gradually replaced by the NREGA. Unlike the SGRY, the NREGA provides for a right to a hundred days of employment, and has in addition a compensatory mechanism in case employment is not provided. It is therefore a far more robust means of ensuring entitlement than the SGRY.

Supreme Court Orders

Important orders pertaining to SGRY were issued by the Supreme Court on 28th November 2001, 8th May 2002, 2nd May 2003, and 20th April 2004. These include:

1. **Speedy implementation**: Several directions were issued (notably on 8th May 2002, 20th April 2004 and 17th October 2004) to the effect that SGRY should be implemented "expeditiously" by the Central

[70] GoI (2002), *Guidelines for Sampoorna Grameen Rozgar Yojana*. New Delhi: Ministry of Rural Development p. 1.

Government and State Governments. In particular funds should be released on time and fully utilised, and SGRY funds should not be "diverted" for other purposes.[71]

2. **Priority groups**: "The respondents shall focus the SGRY programme towards agricultural wage earners, non agricultural unskilled wage earners, marginal farmers and, in particular, SC and ST persons whose wage income constitutes a reasonable proportion of their household income and to give priority to them in employment, and within this sector shall give priority to women."[72]

3. **Doubling of SGRY**: On 2nd May 2003, the Court directed the government to "double" the scale of SGRY, in view of drought conditions prevailing in large parts of the country: "The present SGRY system should be expanded, at least doubled, both in terms of allocation of food-grain and cash for the months of May, June, and July". On 20th April 2004, this direction was extended: "The directions for doubling the food grains as also cash in terms of the order dated 2nd May, 2003 shall be applicable this year also."

4. **Timely wage payments**: Wage payments under SGRY are to be made on a weekly basis.[73]

5. **Ban on contractors**: The use of contractors is "prohibited".[74]

6. **Minimum wages**: "The State Governments/UTs are directed to pay minimum wages to the workers under the Scheme."[75]

7. **Ban on labour-displacing machines**: The State Governments were also directed to "stop use of labour displacement machines" under SGRY.[76]

8. **Role of Gram Panchayats**: Gram Panchayats are entitled to "frame employment generation proposals in accordance with the SGRY guidelines for creation of useful community assets that have the potential for generating sustained and gainful employment". Further, "these proposals shall be approved and sanctioned by the Gram Panchayats and the work started expeditiously".[77]

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[71] Supreme Court Order dated 8th May, 2002.
[72] Supreme Court Order dated 8th May 2002.
[73] Supreme Court Order dated 8th May 2002.
[74] Supreme Court Order dated 8th May 2002.
[75] Supreme Court Order dated 20th April 2004.
[76] Supreme Court Order dated 20th April 2004.
[77] Supreme Court Order dated 8th May 2002.

9. **Social audits**: Gram Sabhas are entitled to conduct social audits of SGRY (and indeed of all food-related schemes). On receipt of any complaint of misuse of funds from the Gram Sabhas, the implementing authorities shall "investigate and take appropriate action in accordance with the law".[78]

10. **Transparency**: "Access to all public documents including all muster rolls shall be allowed to such persons who seek such access and the cost of supplying documents shall not be more than the cost of providing copies of the documents."[79]

Comments

Field reports suggest that most of the above orders are routinely violated in most states. Some specific instances, such as the violation of Court orders on SGRY in Badwani District (Madhya Pradesh), have been taken up by the Commissioners or even referred to the Supreme Court through Interim Applications. However even there, attempts to seek redressal have been partially successful at best.

The National Rural Employment Guarantee Scheme is set to replace the SGRY in all districts of the country.

THE NATIONAL RURAL EMPLOYMENT GUARANTEE SCHEME

The National Rural Employment Guarantee Act 2005 (NREGA) was unanimously passed by the Indian Parliament in August 2005. So far, the implementation of this Act has not come under the scrutiny of the Supreme Court, since the Act is yet to come into force. In particular, the Employment Guarantee Act is not mentioned in any of the Interim Orders. However, public works programmes are often mentioned, and the directions relating to these programmes (e.g. regarding prompt payment of wages) can be regarded as applicable to the NREGA also. Further, it is very likely that the implementation of the Employment Guarantee Act will figure quite soon in the Supreme Court hearings. Thus, employment guarantee is an integral part of the agenda of "legal action for the right to food".

[78] Supreme Court Order dated 8th May 2002.
[79] Supreme Court Order dated 20th April 2004.

Chapter 4

Starvation: Definition, Verification and Response

Objective 2 of the Food Rights Code:

To establish processes of investigating starvation that are transparent, reliable and respectful of the dignity of the survivors; and mandatory protocols for intervention for relief, prevention and accountability.

Definition of Starvation

It is remarkable that Famine Codes of the past, as well as contemporary Codes, do not contain an agreed definition of starvation. The Code must define starvation carefully and rigorously, and yet in ways that are accessible to the lay public.

Hunger may be understood as the denial of adequate food to ensure active and healthy life. If hunger is prolonged to an extent that it threatens survival, or renders the person amenable to succumb because of prolonged food denials to curable ailments, then the person is living with starvation. If these conditions actually lead to death, then this is a starvation death, even though the proximate cause in every case would be a medical failure. However the cause of death is not the medical failure, but the prolonged denial of nutrition that led to a person succumbing to medical conditions that a well-fed healthy person would easily be able to combat and survive.

This definitions of starvation and modes of verification in this chapter and its annexures, are derived very substantially from an excellent document, 'Guidelines for Investigating Suspected Starvation Deaths', prepared by the Jan Swasthya Abhiyan Hunger Watch Group, based on a consultation organized in Mumbai in 2003[80].

The document points out firstly that 'starvation is ultimately not primarily a technical issue, but is rather related to deep-rooted socio-economic inequities, which require radical and systemic solutions'. It adds that 'while approaching the issue of hunger related deaths, we should start with the basic fact that

[80] This conference was attended by and attended by Veena Shatrughna (Deputy Director, National Institute of Nutrition, Hyderabad), Vandana Prasad (Paediatrician), Narendra Gupta (Prayas), Sunita Abraham (Christian Medical Association of India), Sarojini (SAMA and Convenor of MFC), C. S. Kapse (Professor, Department of Forensic Medicine, D. Y. Patil Medical College), Neeraj Hatekar (Professor, Department of Economics, University of Mumbai), Sanjay Rode (Ph. D. student, Department of Economics, University of Mumbai), Abhay Shukla (Co-ordinator, SATHI Cell, CEHAT), Neelangi Nanal, Amita Pitre and Qudsiya (all researchers at CEHAT).

starvation and malnutrition related deaths are *public health problems requiring community diagnosis*. In this sense they differ from classical "disease related mortality". The diagnosis of a death due to tuberculosis may be approached as an individual diagnosis. But *the diagnosis of a "malnutrition death" cannot be just an individual diagnosis;* we have to document the circumstances prevailing in the family and community along with the individual to reach such a conclusion'.

It adds that the dilemma is deepened because 'generally prevalent "baseline" malnutrition, gradually worsening severe malnutrition and definite starvation merge with each other along a seamless continuum. In a community which is used to barely subsistence intake, three years of drought reduces this further and then some families start eating once a day, a few poorest families eat on alternate days … where exactly is the dividing line between malnutrition and starvation? When exactly does the situation change from "a chronic problem" to "an alarming situation"?'

Public officials, the lay public, and sometimes even professionals, believe that starvation requires no intake of food. This underlies some of the denials when post mortems of the corpses of the deceased show some grains of food, or investigators are able to find some foodgrains in the homes of the person who recently died, and the cause of whose death is being contested. The Hunger Watch group defines starvation as levels of food intake that are unsustainable for the continuance of life itself. In assessing this, one challenge, as already observed, is that 'malnutrition, starvation and starvation deaths seem to lie along a continuum. How is it possible to demarcate one from the other?'

An adult who eats 850 kilocalories of food daily or less may be presumes to be starving. This cut-off is based on research that shows that a person who weighs 50 kilograms, if she or he engage in no physical activity altogether, they require at least 850 kilocalories merely to stay alive, even though they perform no work at all. Thus if it is established that the adult had access to less that 850 kilocalories, then this is not compatible with life itself, and the person is undoubtedly starving[81].

Another reliable physiological indication of starvation is a BMI (Body Mass Index) of 16 and less. Body Mass Index or the BMI is the ratio of the weight of the adult in kilograms to the square of their height in metres. This is a very good indicator of adult nutritional status, as it is age independent. Values of BMI that fall between 20 and 25 are deemed to be normal. On the other hand, significant research finding is that in adults, if BMI is below 19, mortality rates start rising. Mortality rates among adults with BMI below 16 are nearly triple compared to rates for normal adults[82]. Thus in adults a BMI of 16 and less should be used as a cut-off point to demarcate starvation from under-nutrition.

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[81] In the word of the Hunger Watch Group (mimeo, 2003) 'Based on a requirement of 0.7 Kcal / kg / hour, a 50 Kg person needs about 850 Kcal per day to maintain oneself at Basal Metabolic Rate, without any physical activity. Thus any food intake that is sustainedly lower than 850 Kcal per day would be incompatible with life in due course and is an indication of starvation'.

[82] 'Jan Swasthya Abhiyan Hunger Watch Group (2003). *Guidelines for Investigating Suspected Starvation Deaths* (mimeo).

The nutritional status of children is easy to derive from the child's weight and age, and most ICS workers are trained in assessing this. NCHS standards for ideal body weights for children, both male and female are available. Classification systems based on these standards enable us to decide from the age of the child and its weight if the child has a normal nutritional status, or is either undernourished or overweight. The weight of the child should be compared to the ideal weight for that age mentioned in the NCHS standards. A percentage of up to 80 per cent is deemed normal, 60 to 80 per cent is deemed mild to moderately malnourished, and below 60 per cent the situation is severe, below 50 per cent alarming.

Verifying Starvation

The duty to investigate and verify complaints of starvation must be shared by public officials, elected representatives, affected people and local communities, and professionals. Each must have clear and well-defined roles.

In practice, if large numbers of people die of starvation, it occasionally captures media attention, and there is transient public outrage. Government officials in every part of the country hotly deny allegations of starvation deaths. Most claim that the deaths result from illness, some even quibble that people were just chronically malnourished, but not starving. Issues of food security and hunger surface briefly in public consciousness, whenever there are media reports on starvation deaths. The brief public outrage that follows such reports lead almost invariably to unseemly wrangles about whether this was indeed a starvation death, with angry denials by officials, post mortems and other evidence being mustered to establish that there was indeed some grain in he stomach of the diseased or available to the family and therefore this does not constitute a starvation death.

Apart from this, even the media and political establishment tend to react only when reports emerge of actual starvation deaths surface; reports of destitution that led to this final collapse fail to stir interest or action. There is in this sense, in both State and non-State circles a certain 'normalisation' of destitution, of conditions in which people are forced to live with starvation. They can expect the State to act or public opinion to be outraged only when people begin to die.

Few people die directly and exclusively of starvation. They live with severe food deficits for long periods, and tend to succumb to diseases that they would have survived if they were well nourished. Official agencies do not recognize these as conditions of starvation, and instead maintain that the deaths were caused by the proximate precipitating factor of infection. We have also seen that starvation does not require absolutely zero food intake, but rather prolonged periods of such low food intake as to be incompatible with survival.

In the aftermath of media complaints of starvation deaths, while analysing deaths due to starvation, the official investigator usually conducts a conventional enquiry in which he or she fires a series of

humiliating questions soon after the death has taken place to the victim's. This would only leave scars on the family of the deceased. The usual line of questioning is about whether the individual or family had access to any food at all in the period immediately preceding the death, or whether the death was due to illness or natural causes. There are sometimes post mortems to show even a few grains or wild leaves and tubers on the stomach, to demonstrate spuriously that the death was not due to starvation.

Investigating the Living by Public Officials

The National Human Right Commission in its investigation into alleged starvation deaths in Orissa[83] established some important principals. The first of these is that death is not necessary as evidence of starvation. In the words of Mr. Chaman Lal, former Special Rapporteur of The National Human Rights Commission (NHRC)[84], 'A person does not have to die to prove that he is starving. This insistence on death as a proof of starvation should be given up. Continuance of a distress situation is enough proof that a person is starving'. We agree that medical post mortem inquiries do not serve much in the process of preventing starvation deaths and in assuring the right to food. Indeed, it hurts and humiliates those families and communities who have lost people painfully to starvation. Citizens, especially the ones who are starving, have a right to dignity. Starvation is also rarely an isolated instance, but reflects instead prolonged denials of adequate nutrition to households, communities, or social categories. Such people are usually very impoverished and dispossessed or destitute.

The discourse around starvation, especially among public officials and the media, should shift in such times from not just those who died, but those who survived but are deeply threatened. They need to recognise starvation to be a condition not just of the dead but also of the living. It is crucial to understand and accept that death or mortality is not a pre-condition for proving the condition of starvation. Long-term unaddressed malnutrition and endemic prolonged phases of hunger must be recognised as situations of starvation, and the duty of the state to prevent deaths of persons who are living with starvation.

There are many ways that allegations, complaints and fears of starvation arise. In any such situation, the focus of the investigations by public officials must focus not on the dead, but on the living survivors, and people of the family, class or community who may be similarly threatened. This would ensure that the survivors of the deceased are not traumatised further, and measures for relief and prevention are put in place without delay.

However, it is important also to establish the veracity of complaints of starvation deaths. This should be done by processes of community investigations and verbal autopsies by public health officials in collaboration with local people.

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[83] 'Feedback from Dr. Amrita Rangaswamy on starvation deaths', Tanushree Sood, CES, Mimeo, 2005.
[84] Personal communication

In the event of complaints, through application or verbal, made in the media, by affected people or activists or any other source, local panchayat representatives and revenue official must inform the District Panchayat head and the District Collector immediately, who in turn will inform each other, the local officials, and panchayat functionaries at various levels. They would be debarred from issuing denials, in the absence of investigation by public health functionaries, and instead the effort should be to identify the sources of distress, and respond to mitigating and ending these.

It would be the duty of the District Panchayat head, with the District Collector, the Chief Medical Officer, heads of departments of civil supplies, women and child welfare, social welfare and forests, to personally visit the location expeditiously, and in nay case not later than 48 hours after receiving the complaint or information is received. They should investigate the overall field situation in the family and community: not whether there was a starvation death, but whether the specific family, as well as in that location the local community (such as Musahars) and the social (such as single women) and class (such as landless workers) categories to which she or he belongs, subsist in conditions of prolonged deprivation of adequate food with dignity, or in continuous uncertainty about the availability of food, or dependence on charity or debt bondage for food. On receiving reports of people living or dying of starvation, these may be analysed, by a process described sometimes as verbal autopsy. They should meet the family of the victim, and learn from them about their general food and livelihood situation, and with the neighbourhood, and the local community, tribe, caste, class, gender or age group to which the affected people belong, and the village (or urban settlement) at large.

This public investigation should be conducted in consultation with and seeking the support of the affected people. It may occur in two phases. In phase one, discussions are held with the family of the victim and some neighbourhood families. During these discussions, the victims' families may be asked questions about the food and livelihood conditions and deprivations of the individual and the household, access to food and work, periods of hunger, and so on. The idea is not only to probe death and its causes, but to understand the poverty and destitution faced by the families and by similarly affected people. Attempts should also be made to understand the root cause of poverty such as livelihood crisis, heavy debt, crop failures etc.

In the second phase of investigation, discussions should be carried forward with the other members of the tribe, caste, class, gender or age group to which the affected people belong. During these discussions, questions may be posed about the food and livelihood conditions and deprivations of the class and communities of deprived people, their access to food and work, and periods of hunger. Broader questions regarding functioning of the food and livelihood schemes may be asked, such as (i) is there an operational anganwadi centre running in the village, (ii) is the nearby government school providing mid-day meals to the children, (iii) does the ration shop provide foodgrains in the right quantity, price and on time, (iv) how

many elderly persons in the village obtain social security benefits or pensions from the state; and so on. At the same time, the people should be provided enough space to reveal situations on their own. They should not be crowded out by questions from the investigator. It may also be worth asking if any change has occurred in their way of living over the years. In other words, have the government policies brought about a change in the way of living of the people? There is a need to document the circumstances prevailing in the family and community at large special focus needs to be laid on tribal and backward rural areas. Also there may be cases of starvation of individuals who for one reason or another are without families, or abandoned by their families and excluded from their communities. The investigations should be sensitive to these as well.

These findings should be recorded by the District Panchayat head and District Collector in writing, and their report shared and explained in the local language to affected people and communities, local elected leaders and local officials. The report should contain a clear time-bound action plan for intervention.

Investigating the Causes of Death to Verify Starvation

Even as measures to mitigate and address the deprivation and prevent further deprivation, destitution, under-nutrition and starvation are undertaken (and these will be outlined in the next section), it is important that the examination of whether the deaths were of starvation also proceeds side by side. The Hunger Watch Group of the Jan Swasthya Abhiyan[85] suggests four parts to this investigation. These are as follows:

1. Assessing whether there is an abnormally high death rate in the villages: A cluster of such villages, from where there have been reports of suspected starvation deaths, may be taken up for investigation. All the deaths that have taken place in these villages during the period of serious food deficit (say a period of at least three months, may be six months or one year) would need to be documented. Details would be collected by visiting families of the deceased, the mortality records maintained by the ANM, and other local enquiries. In parallel, the exact population of all the villages and hamlets in the cluster would be ascertained from census and voter lists and local enquiries. We need to ascertain whether the number of deaths in this particular area is significantly higher or not. This is done by comparison (bearing in mind seasonal variations); to see whether the number of deaths in the area we are investigating is significantly higher than the previous year in the same area; or than that of deaths in nearby villages in the same year; or in the same area in the same period in the previous year; or the

[85] Jan Swasthya Abhiyan Hunger Watch Group (2003). *Guidelines for Investigating Suspected Starvation Deaths* (mimeo).

average deaths for the district in that period[86].

2. Anthropometry to assess nutritional status of the community: The second method is to use physiological measures of height and weight to assess the nutritional status of the community. One needs to take a representative sample of hamlets, villages, and within then of various age, gender, occupational and identity groups, and measure the BMI of adults, and the nutrition levels of children. The detailed methodology for this is provided in Annexure 2.

3. Assessing malnutrition deaths among children: For children, the following criteria may be used to establish malnutrition deaths:[87]
   - Increased death rates among under-five children compared to state under-five mortality rate (U5MR). An exercise must be done to calculate age specific death rates, and compare this with the state averages to define increased death rates.
   - Siblings of children who have died of suspected malnutrition can be assessed. Their anthropometry may show very poor nutritional status and this would be supportive evidence.
   - Access ICDS records and records from other sources for weight of the deceased child shortly before death if possible.
   - High mortality from minor infections (e.g. diarrhea, measles) is itself an indicator that the underlying cause of death is malnutrition. We need to compare mortality rates due to the infection in the sample community with 'standard' mortality rates for that illness. If say the case fatality rate for measles in a community is 20 per cent compared to the known case fatality rate of 2 per cent then the 'measles deaths' in the community are actually malnutrition deaths in which the terminal event is measles.

4. Verbal Autopsies: Verbal autopsies are individual investigations to reveal whether at least a few deaths in which starvation is suspected to be an underlying cause of death (irrespective of the immediate cause, which may often be infections etc.). Verbal autopsies should be used only in conjunction with the other methods outlined above, to document specific starvation deaths. It is reiterated that 'individual starvation deaths are only extreme examples of the severe nutritional deprivation being suffered by the entire community, and should always be presented in the larger

[86] Detailed methodology is provided in Annexure 1.
[87] Jan Swasthya Abhiyan Hunger Watch Group (2003). *Guidelines for Investigating Suspected Starvation Deaths* (mimeo).

context of community starvation'.

Verbal Autopsy is a scientific method of proven validity used for establishing the cause of death of individuals in a community, where forensic autopsies have not been or cannot be conducted for any reason. These also less distress caused for the bereaved family by verbal autopsies than forensic autopsies. This method has been successfully employed in India, Bangladesh, Kenya, Nigeria, Philippines, Indonesia, Egypt, and several other countries to determine the cause of death of individuals in various circumstances, especially to identify causes of maternal and infant mortality. It should look into a sample of 'suspected starvation deaths', or any death where family members report that the deceased had significantly reduced food intake due to non-availability of food, during the month prior to death. The questionnaire to conduct a verbal autopsy is somewhat medicalised in nature, hence a person with some experience of health work may find it useful, but for transparency local field workers can and should be given appropriate training to administer it. It begins with the caregiver or family member (or any one lese most familiar) explaining what happened in their own words, details of food security, subsequent illnesses, and responses to treatment received till the death of the deceased. The statement is recorded verbatim, supplemented by questions in the attached questionnaire (Annexure 4). A special section is devoted to collecting information concerning family food security. Another section elicits the dietary history relating to the deceased, during the week and during the month prior to death. The filled questionnaire is then sent to a panel of three independent physicians along with available medical records of the deceased, who do not communicate with each other.

State Interventions in Situations of Suspected Starvation

Even without awaiting the outcomes of the community investigations and verbal autopsies to establish starvation deaths, public authorities of the Panchayat and district administration must implement a range immediate measures as soon as they are convinced that conditions of grave and threatened food and scarcity prevail in a local area of community, which results in people being forced to live in conditions of prolonged under-nutrition and even starvation.

Once it is established that there exist conditions of people of a dispossessed community, class or social category who live with starvation or grave threats to their food and livelihoods security, it is the duty of the State (jointly of the District Panchayat and district administration led by the District Collector) first to provide relief in case of conditions of starvation or long term unaddressed under-nutrition and failure of food schemes to prevent or remedy this. In its current form, 'gratuitous relief' is in the nature of charity. Such an ideology cannot bring about long term and permanent change in the condition of people who are

vulnerable to starvation or the system of administration. Thus, such ideology needs to be converted into a system of entitlements. In other words, relief needs to be in the form of entitlements and not charity.

If a certain region has been diagnosed as suffering from intense hunger, the state should be alerted immediately, and be asked to place systems of relief, immediate, short term and the long term.

1. Relief for Family of Deceased: The first immediate relief must be for the affected family itself that has suffered the loss of persons for reasons associated with prolonged deprivation of adequate and assured food with dignity. Some of the measures that may be relevant include:

a) ensuring immediate food availability to the family, free of cost, for at least for a period of six months and then continuously on a more permanent basis at highly subsidised rates. This would be by the distribution to them of special AAY cards with the specific provision that they would get their food entitlement without any cost for the initial six months;

b) ensuring early sanction and release of insurance under NFBS, and release of an ad hoc amount of the same amount for all dead as compensation regardless of whether or not they were adult bread earners;

c) identifying in consultation with the survivors in the family, the reasons for livelihoods denial, collapse or insecurities and assisting them to build a secure livelihood through measures like land allotment and restoration in case of alienation;

d) ensuring their coverage of all food and livelihood schemes for which they are eligible such as ICDS, MDMS, NREGA and old age, widows and disability pensions;

e) for children, ensuring their admission to SC ST hostels if they choose, so that their education, food and protection is secured;

e) organising psycho-social support through professional and trained lay counsellors to the survivors of the deceased;

and (f) for infants, small children, expectant and nursing mothers, doubling their quota of food entitlements, hospitalisation where necessary, arrangements for nutrition rehabilitation, and health-care including immunization.

2. Relief for others identified to be similarly threatened: The next stage of intervention would be for the community, class or social category to which the family of the affected person belongs. This must begin with publicising and opening NREGA works for all those who seek it, within a week of the receipt of the information. The ceiling on 100 days for one member of each family must be relaxed for the affected people for a period of 2 years from the time a situation of starvation is identified. Simultaneously the mid-day meal in the school will be extended to all days in the year, and open to all children, even if out of school, and old and disabled people and single women who seek it. The ICDS centre will also provide children of 3 to 6 years hot cooked meals twice a day instead of once, and this will be open also to pregnant and lactating mothers, and single women.

This must be followed with a careful official as well as well-publicised affected people's social audit of why they could not access their food rights from the food and livelihood schemes relevant for them. For instance, were their small children enrolled and regularly availing of the services of ICDS, and was their decline of nutritional status identified and addressed on time; if not, why not? Were the older children in school, and did they access regular and nutritious mid-day meals? Did they have ration cards, AAY or at least BPL, and did they regular receive the prescribed quota of 35 kilograms of subsidised food grains from the ration shop; if no, again why not? Did all old people receive pensions, and were these distributed at their doorstep on time every month? The same questions would apply to widows and disabled people in states with schemes for pensions for these groups. Did they seek job cards and work, and was this given to them in accordance with their legal entitlements under the NREGA?

From such an enquiry, the reasons for failures of food and livelihood schemes, and the exclusion of these most food vulnerable people from their reach, should be clearly diagnosed. The District Panchayat and Collector should clearly fix responsibility at all levels, punish those found guilty, remedy gaps of funds, resources and personnel, and address issues of discrimination and social exclusion. There should then be a time-bound coverage of all affected and threatened people by AAY ration cards, job cards under NREGA, old age, widow and disability pensions, and ICDS services, including nutritional rehabilitation and hospitalisation where found necessary, within a period of one month from the date of initial information. Failures to do so, if they result in further loss of life or deterioration in people's nutritional condition, will be the personal responsibility of the district leaders of the Panchayat and administration.

In the long run, local structural sources of pauperisation will be identified and local solutions developed in consultation with the gram sabha and village panchayat. These may include failures to implement land reforms, tribal land alienation, caste discrimination, micro minor irrigation and watershed development, availability of formal credit for agriculture and artisans, access to forests and choices of agricultural technology and cropping patterns.

Chapter 5
Addressing Chronic Hunger

Objective 3 of Food Rights Code:
To identify individuals, dispossessed communities, classes and social categories of people who live with prolonged hunger, malnutrition and starvation, and to intervene with short, medium and long term measures to mitigate, prevent and sustainably reverse this situation of chronic hunger.

Once again, Codes in the past did not address and often did not even admit to certain segments of the population who live with critical hunger and chronic food denials even in normal times. This is closely linked to the neglected phenomena of destitution. What usually goes unrecognised is that death by starvation is only the outcome of the much more chronic, invisible, malaise of destitution. There are large numbers of forgotten people who live at the edge of the survival. Each day comes afresh with the danger of one push that will hurtle them down the precipice. This may come from an external emergency, like a natural disaster, epidemic or riot, but even from local crises: a sickness in the family, a sudden untimely death of a bread earner, or a brush with the law. The problem of starvation and hunger can be overcome only when people who live on a regular basis in constant peril of slipping into starvation, or at least chronic, long term, unaddressed hunger - people who may be described as destitute - are protected from destitution.

Government programmes are woefully inadequate to address destitution. Our evidence shows that apart from major leakages and corruption, the coverage of these schemes is so meagre that they leave gaping holes in the social security net, through which large numbers of most destitute women and men, girls and boys slip; through measures to prevent and reverse starvations, or the persistence absolute hunger. It is stressed that this is a duty of the State not to the dead, but to the precariously living. It requires public vigilance about individuals, communities and several categories living with starvation and absolute hunger. It requires the State to act, not after there is an emergency like a drought or flood, not even *after* people die of starvation, but pro-actively before people slip into destitution, and fail to access in an assured and reliable manner, with dignity, the nutritious and culturally appropriate food they require to lead healthy lives.

In a sense, this set of duties are pro-active measures by the State to prevent hunger and starvation and to promote well-being and the right to food of all people: to anticipate and forestall starvation, by recognising and arresting destitution well in time, before it pushes hapless people into starvation. The previous chapter on starvation was reactive, whereas this is actively protective and deterrent. The extent

to which public authorities are able to implement the measures in this chapter, to that extent the interventions listed in the past chapter will become infructuous, and an enormous amount of human suffering avoided.

This requires local authorities, mainly panchayats and local bodies, to identify those classes, social categories and local communities, who are destitute in normal times, who lack the resources, financial and material, the employment, assets, access to credit, and social and family support and networks, to secure sufficient and assured food for themselves and in many cases for their dependents. These are people who are frequently powerless and disenfranchised, socially isolated and devalued, sometimes stigmatised and even illegalised, and often with special needs born out of disability, illness, social standing and age.

Even in the more intimate context of a village, many of these socially excluded groups are invisible, barely known and acknowledged, and the panchayats will therefore have to take special steps to identify them. In diverse cultural and socio-economic contexts, these may vary widely - such as certain denotified and nomadic tribes in one place, some specially disadvantaged dalit groups like Musahars or Madigas in another; weavers, artisans and particularly disadvantaged minority groups in yet another - all designated 'primitive tribal groups'; and so on. In addition, studies have established that in all cultural contexts, the following rural social categories consistently tend to be very dispossessed and vulnerable in their access to food: disabled people, both as bread winners and dependents; single women and the households that they head; aged people especially those who are left behind when their families migrate or who are not cared for by their grown children; people with stigmatised and debilitating ailments such as TB, HIV AIDS and leprosy; working and out of school children; and bonded workers.

In the bridge between the rural and urban destitute are distress migrants - at the bottom of the heap both where they move for work, and from where they come. In the urban contexts are street children, with or without responsible adult caregivers, urban homeless people, slum dwellers and a wide range of unorganised workers, both seasonal migrants and settlers, such as rickshaw pullers, porters, loaders, construction workers and small vendors, and people dependent on begging.

It is impossible for a Code like this to list all the measures that need to be taken for each of these groups - these would have to be locally evolved. However the extent to which these are instituted and implemented, and the extent to which destitution is effectively combated, hunger and starvation would be prevented. This Code will list a few illustrations:

a. The Panchayat may consult with special assemblies of single women, disabled people, bonded workers, stigmatised communities and distress migrants, and identify all families among them with children that live with chronic hunger. It would ensure that all these children are enrolled in the

nearest ICDS centre; and even before they slip into advanced stages of malnutrition, are given as a preventive measure higher levels of nutrition which would have been given to them if they were identified to be in fourth grade malnutrition.

b. The same assembly would also include old people, and they would be organised to demand work under NREGA. Special plantation works that require less hard labour would be opened specially for these groups, and care would be taken to include all adults from these categories in these works, and also people from such occupations as weavers and artisans who cannot cope with conventional manual works.

c. All households would be covered by AAY cards, and all persons who are of the required age or social category such as widows and disabled people would be covered by pensions. The Panchayat would ensure systems of doorstep delivery of pensions in the first week of every month.

d. All children who are out of school would be identified, and a residential bridge course organised in order to secure their bridge education as well as adequate nutrition. If parents such as single mothers and disabled people are unable to feed these children, and this is what pushes them into work, then the Collector would ensure their admission in the nearest government hostel.

e. All seasonal distress migrants would be organised to demand work under NREGA, especially if it enables them to stay back from migration. But even if they still choose to migrate, The Collector should establish camps, and vigilantly ensure that all are registered to get the protection offered by the Inter State Migrant Workers Act.

f. All children and women would be eligible for all services in the ICDS, regardless of whether or not they are residents of that village. This would enable children and mothers of migrant families to access supplementary nutrition and immunisation.

g. Old people should be permitted to eat at the school mid-day meals, with no questions asked. This would act as the last defence against starvation for the destitute aged people of the village, at no additional cost except the cost of additional food.

h. For children of migrant families and aged people left behind when they migrate, the local school should be coveted into a community-based hostel. The aged people would be the caretakers of the children, and both the aged people and the children would be entitled to all 3 meals. This would ensure dignified survival of old people, even while it enables children of the poorest distress migrant workers to continue their education, while also securing their nutrition.

An illustrative list of measure for urban areas is:

a. For children on the street, both without parental support and those with parents who are also homeless, a series of community-based residential schools should be created in existing government schools, in the nature of an additional shift after regular school hours. This is the only way that tens of thousands of such children in most cities can be assured nutritious food, as well as protection and their right to education, at very little additional cost. The children can be bridged to eventually get admission in the same school.

b. All homeless people should get AAY cards, and slum dwellers BPL cards. One reason why these are denied to them in many cities is that ration cards are also treated as de facto identity cards. But this will not act a barrier to these most vulnerable urban residents from getting their right to food.

c. People who live by begging should be carefully surveyed, but from a rehabilitative perspective. There are many among them who are aged, disabled with leprosy or polio, or single women. They should be given pensions that would enable them to give up begging.

d. Areas of the city that are widely populated by migrant workers, particularly single men who migrate without their families, should be mapped. In these places, wholesome, hygienically prepared food should be distributed with the help of trade unions and other organisations who work with unorganised workers, with some subsidy from the government. Religious and secular charitable organisations may be drawn in to contribute both with financial and management resources, and volunteers.

Chapter 6

Addressing Emergencies with Equity

Objective 4 of Food Rights Code:
To ensure that emergent situations that threaten mass access to food, such as natural and human made disasters are anticipated, mitigated and addressed with equity and speed, without consequences of mass food scarcities.

We come finally to the more conventional and familiar content of the Food Code, and this deals with emergencies. The problems as well as recommendations flow out of the first chapter, which reviews past and existing Famine, Drought and Scarcity Codes. What is more, if the other objectives of the Code already recounted securing right to food in normal times, addressing, mitigating and preventing starvation, and special support for destitute groups who live with chronic hunger even in normal times is executed - then many of the needs and crises of emergencies are already addressed. We will therefore only briefly recapitulate what should be the major principles and measures to deal with emergencies.

1. Declaration of Scarcity: The declaration of food scarcity must break away from the cumbersome, bureaucratic, opaque and long-drawn out provisions that still can be found in most Codes even today, which result in such delays that the suffering, hunger, distress migration, distress sale of cattle and other assets, and indebtedness have long set in before the State takes any ameliorative measures. It needs also to recognise emergencies that may not be linked to less rainfall.

   The District Panchayat and District Collector should be authorised to identify a range of emergent situations that may result in mass food scarcity. This could include low or ill-timed rainfall for crops and farmers who are dependent on rainfall and workers whom they may employ; sharp slump in prices of agricultural produce; worrying fall in the water table; failures in such non-timber forest produce on which local communities depend substantially for food or livelihoods; flowering of bamboo; war, riots and ethnic clashes; the sudden closure of a major industry that employs a large number of workers; and floods, cyclones and earthquakes. They should send their report with reasons to the state government. It should be examined by a small inter-ministerial group, which also includes also the leader of the opposition, and this group should be required to give their decision within two weeks of receipt. They should give reasons for their decision, and in

case there are disagreements, there should be provision for an appeal to the State Human Rights Commission, whose decision would be final.

2. Public works: After the commencement of NREGA, public works need to be converged with NREGA, rather than creating a separate machinery and set of rules for relief works. However, after the declaration of scarcity in an area, the District Panchayat should be authorised to raise wages by up to 20 per cent of the minimum wage. Likewise, the limit of 100 days and employment of only one adult per family should be fully waived for the period of the scarcity. There should be a certain proportions of works selected which require less demanding manual labour, and this should be available to old, disabled and infirm people, as well artisans and weavers. However, there should be a strictly enforced ban on children working in any of the sites.

3. Gratuitous Relief: Likewise, provisions for gratuitous relief should also be converged as far as possible with existing schemes. The Panchayats at all levels will take special care to ensure that all eligible aged and disabled people, as well as members of specially vulnerable communities like the designated 'Primitive Tribal Groups' are fully covered by AAY cards, and those who are eligible for pensions also receive this. The administration of ration shops and pension distribution should also be streamlined. The entitlement under each of these (subsidised rations and pensions) should also be raised by 50 per cent during the period of scarcity.

   Likewise emergency feeding should be converged with the ICDS and mid-day meals. ICDS food entitlements should be doubled during the period of the scarcity, and hot meals for children in the age group 3 to 6 years provided twice a day instead of once. The timings of the hot meals should be adjusted in ways that expectant and nursing mothers are able to eat at least one of the hot meals, of not both. Old and disabled people, and out of school children, should be encouraged to join the mid-day meals, which should continue during the vacations.

Annexure 1

***Assessment of Death Rates*[88]**

An important component of investigating suspected starvation deaths is the calculation of death rates, in a specific area and pertaining to a specified period during which suspected starvation deaths have been reported.

Identifying the area for investigation - Anecdotal reports may be received about unusually high number of deaths from certain villages. A cluster of such villages, from where there have been reports of suspected starvation deaths, may be taken up for investigation. All the deaths that have taken place in these villages during the period of serious food deficit (say a period of at least three months, may be six months or one year) would need to be documented.

Once the villages and the period have been finalised, all the deaths during the period should be recorded by means of small group enquiries throughout the area (covering all hamlets and house clusters)/ house to house survey in that area to document deaths in that particular period of time. The families of all the deceased would need to be visited, the date / month of death should be verified for all deaths being investigated. Deaths whose timing falls outside the study period should be excluded from the calculation.

To confirm the timing of all deaths, and in order not to miss any deaths, an attempt should be made to compare this data with the mortality records maintained by the ANM for the area. Our experience is that the ANM may be better at recording neonatal and infant deaths, since she does antenatal registration, but she may not record certain deaths esp. of adults in remote hamlets, which she visits infrequently.

Local calendars, local festivals, phases of the moon and local market days may be used to ascertain the date of death in case of all deaths in the specified period. The exact number of deaths in this period should be used for the calculation of death rates. The shorter the recall period, greater will be the accuracy in assessing the date of deaths.

A parallel important exercise is to assess the exact population of all the villages / hamlets in the cluster, which would form the denominator. The Gram Panchayat would usually have figures and voter lists, yet this may be cross-checked against the actual estimation of number of households based on information from local people.

How can we check whether the number of deaths in this particular area is significantly higher?

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[88] Jan Swasthya Abhiyan Hunger Watch Group (2003). *Guidelines for Investigating Suspected Starvation Deaths* (mimeo).

There are two major issues involved if we calculate the death rates for a comparatively shorter period (e.g. three months) and in a small sample, and then extrapolate it to the whole year and compare it with the state figures. Firstly, there is seasonal variation in deaths. For e.g. there may be more deaths in the rainy season due to water-borne diseases like diarrhoea. If the death rate we have calculated in our study coincides with a period in which there are seasonally higher deaths in that region, and then we extrapolate this to the whole year, the death rate that we have calculated will certainly be an overestimate compared to the annual death rate. Thus it is essential to consider the seasonal variation in deaths while calculating death rates for a shorter period. One way of doing this is to compare death rate in a specific season *this year* with the death rate during *the same season last year.* A higher rate this year indicates a definite and significant increase.

A second important issue related to calculating death rates in this manner is that if the sample population we have covered is too small in size, and it is then compared with the rates of the state, it may give an inaccurate estimate of death rates for that sample population being higher than the total state. For this, we need to take certain minimum population while calculating death rates (*to be estimated*), and perform a statistical *comparison of proportions*, which will take into account the difference in sample size.

To see whether the number of deaths in the area we are investigating is significantly higher than the previous year in the same area or than that of the nearby villages in the same year, we will have to follow certain steps:

- Document all the deaths in the area we are investigating in the specified period of time in which we are suspecting that the starvation deaths have occurred.
- Find out the number of deaths in the same area in the same period in the previous year through Gram Panchayat data.
- The data for deaths in that District in the same period can be collected from the NSS records.
- Find out the number of deaths for the district in that period.

To overcome the problem of seasonal variation in deaths, here we are comparing the deaths in the same period during last year in the same population. To calculate whether the deaths in the area we are investigating are significantly higher, we can apply the comparison of proportions test or chi-square test. For comparison, age specific deaths should be compared.

For example, the total number of deaths in the age group of 0 to 5 years in the village we are investigating are 17 in the year of investigation, and the total number of children in this age group is 138. In the previous year in the same village the total number of children in the same age group was 154 and the total deaths that took place were 13. Then to find out whether the number of deaths is significantly higher or not, we apply the proportion test.

Annexure 2

Anthropometry to assess nutritional status of the community[89]

An effective nutritional survey involves an assessment of the nutritional status of children and adults in the area based on anthropometric measurements, assessment of specific deficiencies, socio-economic status, along with current sources of income, availability of food and social security measures such as a fair price shop, ration shop and Anganwadis. The following strategies could help in an accurate estimation of nutritional status based on anthropometric measurements. The other parameters could be tackled with the help of a short questionnaire answered by people in a village meeting.

At the outset explain what you are going to do to the activists who are helping you. Repeat this when you go to the actual villages. Explain the procedure patiently to each person involved in the study. Take their oral consent after informing them about the nature of the study, what is the objective behind it and where will the results be used. Assure them that the names of all participants will be strictly confidential in case they are alarmed about this. Lastly tell them that they can withdraw from the study at any stage.

Sampling- It is the method of choosing a part of the study population, rather than the entire population, for participation in the study. It should be representative of all the strata in the population. Sampling makes the study easier, economical and enables us to study a larger area.

Various methods can be employed for this according to our needs. In case of the present study we can study two or three hamlets in the area, which will give us a good idea of the nutritional status in the whole area.

In order to take a representation from all the groups in the population we can select hamlets such that:

♦ Hamlets close to the road and away from road are covered.

♦ Hamlets of different tribes, and or backward castes/ classes/ areas we are interested in working with are covered

♦ Hamlets with and without an Anganwadi facility are covered.

We can choose 2-3 hamlets, which cover these aspects. This would be a representative sample of the people we would like to work with. Within the hamlet we need not choose a further sub-sample if the hamlet is as small as of 30-40 households. In case it is as large as that of 100-200 households, we can take a 50 per cent sample, i.e. we can choose every alternate house. This will give us a good representation of that hamlet. We can study the children in the age group of 1-5 yrs and adults above the age of 18 years in

[89] Jan Swasthya Abhiyan Hunger Watch Group (2003). *Guidelines for Investigating Suspected Starvation Deaths* (mimeo).

the chosen households. This sampling scheme will be repeated in each area we want to study.

Nutritional survey of children- The weight of a child is a sensitive indicator of its nutritional status. NCHS standards for ideal body weights for children, both male and female are available to us (see Annexure 6). Classification systems based on these standards enable us to decide from the age of the child and its weight if the child has a normal nutritional status or is either undernourished or overweight. The IAP standards (Indian Academy of Paediatrics) are most commonly used, as they are also the standards used by the ICDS (Integrated Child Development Scheme). In order to use this classification the weight of the child in Kilograms (Kg) and the age of the child in months should be available. It is also desirable to measure the height of the child to know the Height for age and whether there is 'stunting' which shows chronic/ long term undernutrition.

Tools required-

1 Weighing scale
2 Height measuring tape
3 Indian / local Calendar to ascertain the exact date of birth.

Weighing children above the age of 2 years is not a problem as they can stand on the weighing scale. To weigh children between the ages of 12 months to 24 months, ask any responsible adult to hold the child in her arms. Weigh them both together. Then weigh the adult alone and calculate the difference between the two weights.

Precautions to be taken while measuring weight:

(a) The zero error of the weighing scale should be checked before taking the weight and corrected as and when required.
(b) The individual should wear minimum clothing, and be without shoes.
(c) The individual should not lean against or hold anything , while the weight is recorded.

For accurate measurement of height, ask the person to stand against a straight wall. The position should be as such that both the feet are together, heels to wall and chin parallel to ground looking straight ahead. As record of vital statistics is very poor in rural India, many times there is no reliable record of the child's age. Hence make sure that you are acquainted with the local festivals or landmark events, and take an Indian Calendar while recording the date of birth of the child. Make as accurate an estimation in months of the child's age. This is important for the following calculation.

The weight of the child should be compared to the ideal weight for that age mentioned in the NCHS standards. Calculate what percentage of the NCHS standard is the child's weight, using the formula-

Percentage of the NCHS standards = Weight of the child x 100 Expected weight for that age (NCHS std)

IAP classification of Nutritional Status

Grade of Nutrition	**Weight as Percentage of NCHS weight standards**
Normal	> 80%
Mild to moderate undernutrition I II	71-80% 61-71%
Severe undernutrition III IV	51-60% 50% <

Tabulate the number of children falling in each category of nutrition status.

Nutritional Status of Adults- This is assessed based on the Body Mass Index or the BMI. BMI is the ratio of the weight of the adult in Kgs to the square of her/his height in meters.

BMI = Weight in Kgs /Height in meters^2

This is a very good indicator of adult nutritional status, as it is age independent. It measures the person's weight for her height. Values of BMI between 20 to 25 are normal. Undernutrition is measured using the following parameters.

Nutritional Status using BMI

BMI analysis	**Grade of undernutrition**
1. BMI <16	III degree CED*
2. BMI 16-17	II degree CED
3. BMI 17-18.5	I degree CED
4. BMI 18.5 to 20	Low normal
5. BMI 20 to 25	Normal
6. BMI >25	Overweight

*CED - Chronic Energy Deficiency

Criteria to define starvation in Adults – An important issue is that malnutrition, starvation and starvation deaths seem to lie along a continuum. How is it possible to demarcate one from the other? A significant research finding is that in adults, below a BMI of 19, mortality rates start rising. ***Mortality rates among adults with BMI below 16 are nearly triple compared to rates for normal adults.***

Thus in adults a B.M.I of 16 and less should be used as a cut off point to demarcate starvation from undernutrition. Based on a requirement of 0.7 Kcal / kg / hour, a 50 Kg person needs about 850 Kcal per day to maintain oneself at Basal Metabolic Rate, without any physical activity. Thus ***any food intake that is sustainedly lower than 850 Kcal per day would be incompatible with life in due course and is an indication of starvation***.

Annexure 3

Verbal Autopsy Procedure[90]

Verbal Autopsy is a scientific method of proven validity used for establishing the cause of death of individuals in a community, where forensic autopsies have not been or cannot be conducted for any reason. This is particularly useful in situations where the proportion of deaths occurring under medical care are low, and where no autopsies are routinely carried out. This method has been successfully employed in India, Bangladesh, Kenya, Nigeria, Philippines, Indonesia, Egypt, and several other countries to determine the cause of death of individuals in various circumstances, especially to identify causes of maternal and infant mortality. At the Bhopal Peoples' Health and Documentation Clinic run by the Sambhavna Trust, Verbal Autopsy (VA) was used as a method for monitoring mortality related to the December 1984 Union Carbide disaster in Bhopal.

Sampling- Ideally, all the recent deaths in the area should be considered for VA, so there is no sampling involved. All deaths during a specified period (from one to three months) should be taken. Recall of details becomes poorer with respect to deaths prior to 3 months before the time of VA, and should be avoided.

A less demanding method is to conduct VA only on *suspected starvation deaths* during a specified recent period. However, here a working definition of 'suspected starvation deaths' needs to be used, for example 'any death where family members report that the deceased had significantly reduced food intake due to non-availability of food, during the month prior to death'. This option would thus involve a two-stage survey process, first identification of suspected starvation deaths and then VA on the selected suspected starvation deaths.

Technique of Verbal Autopsy- This method is based on the assumption that most causes of death have distinct symptom complexes and these features can be recognized, remembered, and reported by lay people. It involves trained workers administering a questionnaire to the carer / close family member of the deceased. Information thus collected on the symptoms suffered and signs observed is given individually and independently to a panel of experts for ascertaining the probable cause of death.

Steps for carrying out the Verbal Autopsy

[90] Jan Swasthya Abhiyan Hunger Watch Group (2003). *Guidelines for Investigating Suspected Starvation Deaths* (mimeo).

- **Training-** The questionnaire to conduct a VA is somewhat medicalised in nature and hence we recommend that a person with some experience of health work be given appropriate training in administering it. Familiarity with the local language would be necessary. However given the circumstances in which it has been successfully used earlier, a well-trained fieldworker with good knowledge of the local language can also be suited for the job. The section wise details of the questionnaire will be provided later. All fieldworkers have to be given the background for conducting this VA, and be trained in interviewing skills, administration of the questionnaire and signs and symptoms of diseases.
- **Identification of households-** The fieldworkers would conduct a survey to identify and list households where deaths have taken place during the specified time period. Then for the VA, they would question the carer of the deceased on the medical history and clinical symptoms suffered. It is best to identify a single carer who has been with the deceased and nursed her/him through the illness, and get all the information through this person. In case of children, the mother is the best person, though this would depend entirely on the circumstances. Using culturally appropriate language, the fieldworkers, should apply stringent criteria in the collection and recording of information. Information would be recorded on a questionnaire designed to elicit details of the last illness, bodily appearance at the time of death, details of food availability in the house, medical examinations and their results, treatment including duration etc.

  The VA questionnaire- At the outset, the interviewer must explain to the carer the purpose of conducting the VA, and take informed consent to proceed. This may be written or oral in case of non-literate carer, but this should be explicitly recorded. The verbal autopsy questionnaire (VAQ) begins with general, introductory questions to determine the lifecycle of the deceased. Field workers use an instruction sheet as a guideline for administration of the questionnaire. The instruction sheet should be translated into the local language where it is to be administered. The health workers would also confirm which medical records of the deceased are in the possession of the carer. General questioning familiarizes the carer with the type of information to be collected and enables the interviewer to create favorable conditions for the carer to speak openly, regarding personal and often traumatic details concerning the deceased. The health worker then begins an open section in which the interviewee is invited to explain what happened in their own words, details of food security, subsequent illness/es, and responses to treatment received till the death of the deceased. The statement is recorded verbatim. With the use of filter questions, specific recordings of the symptoms related to different body systems are then made. While the interviewer should be cautioned against asking leading questions, the questionnaire consists of all important symptoms and signs relating to the major body systems, which should not be left out in

case their importance is not realized by the carer. Thus the health worker identifies a body system, e.g. the respiratory system and encourages the carer to provide voluntary information on any particular symptoms, e.g. breathlessness, cough, expectoration tightness in chest etc. Care is taken to ensure that the interviewer does not provide any direct or indirect suggestions during questioning. Information on medical treatment received and documents related are also gathered. A special section is devoted to collecting information concerning family food security. Another section elicits the dietary history relating to the deceased, during the week and during the month prior to death.

- **Assessment of Completed Verbal Autopsy Questionnaires-** The filled VAQ is then sent to a panel of three independent physicians along with available medical records of the deceased. The physicians in the verbal autopsy assessment panel (who do not communicate with each other about their opinions) fill in a VA analysis table for their convenience, and then write their opinions on the probable immediate, underlying and contributory causes of death of the individual. The final opinion is arrived at on the basis of the level of agreement among the three independent medical opinions. In case all the three doctors in the assessment panel opine that the underlying cause of death has been ‘starvation’, then the final opinion states that the 'most probable' cause of death is attributable to ‘starvation’. The final opinion states 'probable' in case two of the three doctors agree on the nexus between starvation and subsequent death and 'possible' if only one of the doctors in the panel mentions starvation as a probable cause of death. In case all three doctors opine that the disease or condition of death is not related to ‘starvation’, the final opinion states that the cause of death is unrelated to ‘starvation’.

Validity of the method of Verbal Autopsy in ascertaining cause of death- Through numerous studies carried out in different parts of the world, the method of Verbal Autopsy has been found to have a positive predictive value in the range of 70 per cent to 80 per cent depending on the cause of death and age of the deceased. This range of validity has been confirmed through comparison of opinions on cause of death as ascertained through usual autopsies (post-mortem examinations) and that through Verbal Autopsy.

Appropriateness of Verbal Autopsy in ascertaining starvation as a cause of death- The areas where Verbal Autopsy is going to be used to assess starvation as a cause of death are also the areas where availability of medical care is poor. This includes reasons related to extreme poverty and physical lack of access to any government or private medical facility. Also, an overwhelming majority of these deaths occur in people's homes, as a result of which autopsies are rarely conducted, and there is often no

competent doctor to certify the cause of death. Although some care may have been available, medical records of the deceased prior to death are often unavailable or where available, these are often incomplete. Given such a situation, VA appears to be the most appropriate method to assess the cause of death.

The VA has to be supplemented in these circumstances by a thorough recording of the conditions of 'Food Security' prevailing in the community in general, including natural disasters of drought, famines, rain and crop failure or conditions of gross/sudden unemployment, indebtedness etc, similar conditions in the individual household, any signs of desperation to find food such as borrowing, begging, stealing, consumption of unusual foods and incidents of suicide etc. Also an analysis of the 'Calorific value' of whatever food is available and eaten should be undertaken, to see whether the deceased was getting enough calories through food. To further strengthen the findings anthropometric measurements of the living siblings in case of children and the Body Mass Index of the living adults in the same household should be obtained.

Dietary Survey and Calorific Value of Locally Eaten Foods

Dietary survey is an essential part of the verbal autopsy process, which gives idea about whether starvation/insufficient food intake is a cause of death or not.

Whenever a dietary survey is carried out in any community to investigate starvation deaths, we first identify major local staple foods (basically cereals) eaten in that community. Then we give a fixed amount (say 1 kg.) of flour or grains of that cereal in any two houses of that community. We ask them to prepare their usual preparations out of the raw material given. We then calculate the amount of flour used to make one roti or amount of pulse used to prepare one Katori of dal. Then prepare a master chart indicating nutritive value of locally available foods. For example, In Badwani district of Madhya Pradesh where verbal autopsies were conducted, one kilogram of maize flour was given to two families each and they were asked to prepare roti. Out of one kg. flour, six roties were made which means each roti contains approximately 170 gms. of flour. Since 100 gms of maize gives 342 calories, it was concluded that one roti in this area gives 580 Kcal approximately.

In case of calculating calorie intake of the deceased, information should be elicited regarding the food eaten by the deceased one week and one month prior to death. Note the number of meals eaten by him/her in a day. List the food items and their ingredients in details. In case of children, note the history of food intake up to three months prior to death. With the help of the master chart of calorific value of locally available foods, then calculate the total calorie intake of the deceased per day prior to death.

Based on a requirement of 0.7 Kcal/kg/hour, a 50 Kg person needs about 850 Kcal per day to maintain oneself at Basal Metabolic Rate, without any physical activity. ***Thus any food intake that is sustainedly***

lower than 850 Kcal per day would be incompatible with life in due course and is an indication of starvation.

It may be noted here that the intake during the week prior to death may be reduced due to the illness itself, and is less significant to identify starvation compared to the intake one month prior to death. The data on intake has to be combined with data on food availability for the family to come to a conclusion *about lack of food intake due to non-availability of food, in other words, starvation.*

History of consumption of unusual or 'famine' foods like toxic roots, leaves, tubers etc. or consumption of substances eaten to suppress hunger should also be noted. It indicates the non-availability of other edible food items like pulses, grains etc.

Confirming the Date of Death

To determine the exact date of death, local events calendar should be used. A local events calendar shows all the dates on which important events took place during a past one year period. It shows the different seasons, months, phases of moon, local festivals and events in the agricultural cycle.

It is important to accurately determine the date of each death also in the context of calculation of death rates (section III).

Mode and Causes of Death

Even medical professionals are often not very clear about the difference between mode of death and cause of death, and types of causes of death; hence the need for us to be clear about these terms when we talk of starvation as a cause of death.

The Death Certificate issued by a doctor should contain the following-

Cause of death: A disease or injury that results in the death of the individual. If there is a time delay between the onset of the disease or injury and the time of death, then the cause can be divided into the following categories:

(a) **Immediate cause of death**: This is the disease or injury that developed just before the death and resulted in the death. E.g. Pneumonia, Diarrhoea, Ischaemic Heart Disease, Burns, Accident.

(b) **Underlying cause of death:** When there is a delay between the onset of the disease or injury and the ultimate death, this is the process that started the chain of events that eventually resulted in the death. For example, measles could be the underlying cause of pneumonia which resulted in death of the individual; atheromatous or narrowed blood vessels could be the underlying cause of ischaemic heart disease. In the same way, severe malnutrition or starvation could be the underlying cause of death in a case where the immediate cause is diarrhea.

(c) Contributory cause of death is inherently one not related to the principal cause, but it must be shown that it contributed substantially or materially; that it aided or lent assistance to the production of death. It must be shown that there was a causal connection. For example, Undernutrition in death due to Pneumonia, High blood pressure in Ischaemic Heart Disease.

To illustrate the difference, take the case of a woman who is severely anemic during pregnancy. Her severe anemia remains untreated, and immediately after delivery she has moderate amount of bleeding and dies. (A healthy, non-anemic woman with similar amount of bleeding may have survived.) In this case, immediate cause of death is post-delivery bleeding, while underlying cause is severe anemia.

Mode of death: A pathophysiologic derangement that is incompatible with life. It is a common final pathway to death for a number of disease processes. Modes of dying include organ failure (e.g. 'heart failure', 'renal failure', multi-organ failure'), cardiac or respiratory arrest, coma, cachexia, debility, uraemia and shock.

Therefore it is important to recognize that 'Cardio-respiratory arrest', which is often erroneously mentioned as the immediate cause of death *is in fact the mode of death in a person.* To state 'cardio-respiratory arrest' as a *cause* of death is not only factually erroneous, it may also be a deliberate subterfuge by a medical official, to avoid commenting on the actual cause of death, such as starvation.

As a general rule, a number of pathways can be responsible for a mechanism or mode of death, but causes of death are specific. For example, shock has a number of causes and therefore is a mode of death. However the post-partum sepsis that resulted in shock is the cause of death.

Another way of looking at it is, if all dead people have the entity that you would like to list as a cause of death, then it is likely to be a mode of death. All dead people suffer from low blood pressure (shock), cardiac arrest and pulmonary arrest.

Starvation and Undernutrition as a cause of death- It is obvious that Starvation and Undernutrition would generally occur as the underlying or contributory cause of death in an individual. The final clinical event before death may be a minor infection such as diarrhea or measles, which may become the immediate cause of death. As we are going to deal with actual human beings in real life situations, the individuals would suffer from gradual reduction in the calorie intake while having to keep up desperate efforts to find work and food for the family. The children would have to cope with demands for their growth. Rather than an absolute deprivation of food leading directly to death, we would have a chain of events where starvation (<850 Kcal daily intake) is the underlying cause, and an infection becomes the immediate cause of death.

Ethical issues related to conducting VA

There are certain serious ethical issues, which come up during the process of conducting a verbal autopsy in such a social situation. Some of the issues encountered and how they may be addressed are outlined below-

(a) Distress to relatives caused by the verbal autopsy procedure: The verbal autopsy process involves a detailed questioning of the relatives about the illness, food intake, treatment and various other aspects of the deceased prior to death. This is a process, which is liable to cause distress among the relatives of the deceased when they are questioned. To deal with this issue, an attempt should be made to carefully explain the purpose of the study to the relatives of the deceased. Also, the option of not participating in the study should be kept open for the respondents. In some situations, where the respondents are not in a mental frame to answer the questions, a second visit may be made to conduct the questioning at a later stage, or the asking of information may be spread over two visits. Of course, the interviewer must properly introduce himself/herself, state the purpose of his/her visit, and thank the respondents for their co-operation etc.

(b) Possible raising of false expectations among respondents: Measuring of nutritional status of children and adults and detailed questioning of relatives of the deceased might lead to generation of expectation of some immediate benefit to be given by the interviewers to the respondents. This is especially likely if the interviewer is a person from outside the area, of apparently better socio-economic background etc.

This problem may be partly avoided if the basis of contact is by means of a local organisation or person who is already known to the people. If possible, the verbal autopsy should be conducted by a person who is known to the community, or is linked to a local organisation. People may be already aware of the method of working of the local organisation and would not expect any personal preferential 'dole' from a person who is linked to the organisation. Rather it should be made clear that the findings of the survey would be used to generate pressure for better implementation of relief measures in the area, which would benefit everyone, provided that such an attempt is planned.

(c) Need to share the results of the study with the people in their language: Such a study should preferably be conducted on the demand of a local organisation, and should help to strengthen their demand for relief facilities. In the same spirit, the results of the survey should be communicated to the people in their own language, in village meetings and also by means of a simply written note in the local language.

Method of preparing the final report and drawing the 'Hunger Pyramid'

The methodology of investigation as described in previous chapters has been devised to ensure a thorough, factual and relatively objective investigation of a death as well as its context. However, the report is not a mere collation of the facts thus collected. The report is a statement of our opinion on the basis of the facts collected along with corroborative arguments and evidence. It is, therefore, an analytical document carefully arguing a case once our investigation is complete and has led us to an opinion.

If the investigation convinces us that the death concerned is not a starvation death we must make our report accordingly if asked to do so by any agency. However, henceforth, this chapter assumes that we are making the report of what we consider to be starvation death(s), either of children or adults, in the setting of a starving community.

The objectives of the report are twofold:

1. To verify and certify **starvation death**(s)
2. To clearly detail the prevailing **community conditions** of malnutrition and starvation leading to morbidity (sickness) and further mortality (death) if action is not immediately taken.

Such a report can be used for demanding immediate action such as compensation and appropriate state action to ensure food security for the entire community, as well as build evidence and pressure for long term policy changes.

The report should have the following sections, at least –

1) Introduction
2) Under five mortality rates of the given community and comparison with state under-five mortality rates
3) Death rates within the community and comparison with state crude death rates
4) Estimation of malnourished children based on weight for age
5) Estimation of severely malnourished adults based on BMI
6) Details of starvation / malnutrition deaths among children
7) Details of starvation deaths among adults
8) Community situation of food security
9) Hunger pyramid for the community and overall assessment
10) Recommendations

1. Introduction

This section should outline the initial information (press reports, personal communication), which

originally led the team to investigate starvation deaths in this particular community. It should also contain some information about the area (district, taluka, villages), organisations and individuals involved in the investigation, and overall setting of food insecurity in the state / region (drought, failure of food security schemes etc.)

2. Under five mortality rates of the given community and comparison with state under-five mortality rates

3. Death rates within the community and comparison with state crude death rates

These death rates should be calculated and compared with the relevant state mortality rates. Then the number of excess deaths (actual deaths minus deaths expected according to state mortality rates) can be calculated. *All excess deaths taking place in a situation of serious food insecurity may be regarded as malnutrition deaths unless proved otherwise*. Here the absence of any major disasters or accidents may be quoted to rule out other causes of excess deaths.

4. Estimation of malnourished children based on weight for age

All children with weight for height less than –3SD should be enumerated and listed individually also. The number should be expressed as a percentage of all children and compared with the state/block average as per ICDS records / NFHS II records, whichever available. ICDS records are preferable. Increase should be shown as percentage increase and it has to be argued that **according to the WHO any child with -3SD or less weight for age is considered in need of emergency treatment**.

It has been documented that **mortality rates among children increase several fold and drastically when the weight for age is below 60 per cent of the expected weight.** Hence these children are at very high risk of mortality. Any increase in numbers of such children indicates that the entire community of children is at risk. Therefore, emergency measures must apply to all children in that particular community.

According to the WHO criteria, if more than 30 per cent of children in a community have low weight-for-age, it is a very high prevalence level. Although practically all poor rural communities in India have higher than this level of malnutrition, this too may be cited as evidence of very high level of malnutrition.

Prevalence group	**% of children with low weight-for-age (below –2 SD scores)**
Low	<10
Medium	10-19
High	20-29
Very High	≥30

(Criteria laid down in the WHO expert committee report on Anthropometry - WHO TRS 854, 1995)

For effective advocacy, the weights of the children in the affected area should be compared with those of middle class children in the same age group. This would bring out the differences more sharply than do figures of percentages in the various categories of undernutrition.

5. Estimation of severely malnourished adults based on BMI

The number and percentage of adults with BMI less than 18.5 and BMI less than 16 should be computed and presented. Adults with BMI less than 16 are at high risk of mortality from starvation. If over 40 per cent of adults in the community have a BMI of < 18.5, the community may be termed at 'critical risk for mortality from starvation' or a starving community.

Low prevalence	5-9% population with BMI< 18.5
Medium prevalence	10-19% population with BMI< 18.5
High prevalence (serious situation)	20-39% population with BMI< 18.5
Very high prevalence (critical situation)	>= 40% population with BMI< 18.5

(Criteria laid down in the WHO expert committee report on Anthropometry - WHO TRS 854, 1995)

6. Details of starvation / malnutrition deaths among children

This part of the report is based upon

1. Verbal autopsy
2. Anthropometry of siblings and family members
3. Community Situation of Food Security
4. Community Child Death Rates

These are used to argue the following points -

1. Evidence that the dead child was already malnourished (description of physical appearance, hair, skin, nails, previous anthropometric /medical records, siblings and other family members being malnourished – by anthropometry)
2. Evidence that there was acute shortage of food to the individual. This is done by relating dietary history for the last few days to caloric intake. Since this is relatively difficult for a child, specially a breast feeding child, this part of the report should be commented upon by the technical support team (nutritionist / pediatrician)
3. Evidence that there was an acute shortage of food in the household (dietary history of other household members, examination of household food supplies, loan taken recently, recent migration of able bodied family members, eating of unusual food, recent beggary / crime for food, failure to receive food from PDS, ICDS or any other schemes due to non availability, illness or debility)

4. Evidence that there is an abnormally raised child death rate in the community (section 2 of the report). Even if the terminal event in most of the deaths are infections (diarrhea, pneumonia, measles) if the death rate is significantly higher than the under five death rate for rural areas in the state, this is evidence of hunger related deaths provided there is a community setting of food insecurity.

Infection as the terminal event

When the terminal event is an infectious disease, which is the commonest scenario, such as pneumonia or diarrhoea, the 'diagnosis' of starvation death need not change. This logical progression to disease, which forms the terminal event, is well documented in cases of starvation. The last two points suffice to call a death a starvation death.If there has been an outbreak of a disease (e.g. measles) and all the deaths have been attributed to the outbreak, the logical argument in the context of starvation would be that normally speaking the mortality of a disease does not exceed x per cent of cases. The fact that mortality has been so much higher proves that death was due to starvation, not disease.

7. Details of starvation deaths among adults

This part of the report depends upon -

1 Verbal autopsy and dietary history

2 Anthropometry of family members

Verbal autopsy

This is to establish that death did not take place due to accident or other physical trauma, and to document the clinical events preceding death, as also dietary history and body appearance.

The dietary history component should be analysed in terms of caloric value by referring to the charts of caloric values of local food for assistance or taking the assistance of the technical support group. Caloric intake of less than 850kcal per day for an adult establishes the diagnosis of starvation.

Food security of the family – substantiating findings of food stores within the family, recent loans, migration of able-bodied members, eating of unusual foods, beggary should be documented.

Anthropometry of surviving family members

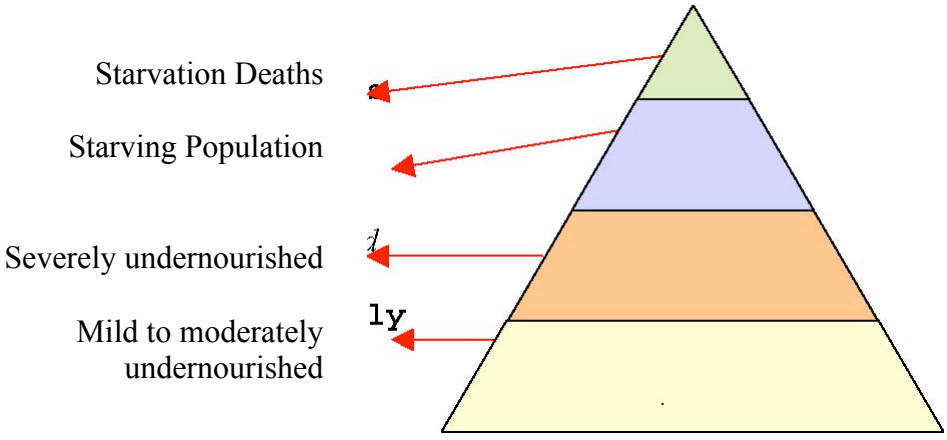
BMI of less than 18.5 amongst adults of the family, and weight for age less than 3SD in the children is supportive evidence that the whole family is in a situation of starvation.

8. Community situation of food security

The provision of supplies, access and uptake from PDS, Food for Work Programmes if any, ICDS, MDMS, maternity benefit and other schemes should be described.

9. Hunger pyramid for the community

The above mentioned two objectives are fulfilled by drawing the entire 'hunger pyramid' that prevails within a community, of which the starvation death/s are only the tip.



Appropriate figures or percentages should be given for each of these categories, to give a complete idea of the situation, e.g. in a particular village –

Starvation deaths – 6 persons (4 adults, 2 children)
Starving population – 7 per cent families
Severely undernourished – 15 per cent adults, 18 per cent children
Mild to Moderately undernourished – 43 per cent adults, 62 per cent children

Starvation deaths are those deaths which have been identified as being due to starvation / malnutrition on the basis of the Verbal autopsy process.

Starving population is the proportion of families where adults have a daily caloric intake of less than 850 Kcal.

Severely undernourished population is the proportion of adults with BMI < 16 and in case of children, those with weight for age less than 60 per cent of expected. (deduct the proportion of starving population from this to avoid overlap)

Mild to moderately undernourished population is proportion of adults with BMI < 18.5, proportion of children with weight for age less than 80 per cent of expected (deduct the previous two proportions from this to avoid overlap)

The investigating team along with the Hunger Watch group should express an overall opinion. This should categorically express an opinion regarding the deaths that have taken place – starvation

deaths or not starvation deaths. It should also make a community diagnosis – community at risk for further starvation deaths (starving community) or not.

10. Recommendations

Finally, the report should make recommendations for immediate action at the local level. Recommendations should include compensation for the deceased, measures to feed and supply food, hospitalization where necessary, arrangements for nutrition rehabilitation, healthcare including immunization, long term food security measures.

Annexure 4

Verbal Autopsy Questionnaire - Adults
(Above 15 years of age)

Preliminary Information

Name of the deceased:

Date of interview:

Age in years at time of death:

Sex: Male/Female

d. If Female: Pregnant / Lactating/ Neither

Age of eldest living child:

Marital status:

* Married * Unmarried *Divorced * Widowed *Others

Address:

Name of the informant(s) -
Informant's relation to the deceased -
Who, among the informants, was present at the time of the fatal illness?
Occupation (give details of type of work)–

i) Working person, active till death

ii) Working person, stopped working for some period before death (specify period)

iii) Not working person

Family structure -Nuclear / Joint

Total No. of Members

Male adults

Female adults

Children

Income and food supply: (Relates to the family)

Agriculture:

Total Land owned _____

Irrigated land owned_____

Crop from last harvest was sufficient to adequately feed the family till which month -

Wages: (In the last six months)

Work as agricultural labour –

No. of days in last 6 months _____ Daily

Wage-

Work on Govt. relief works –

No. of days in last 6 months _____Daily

Wage-

Work outside the village (State the type of work)

No. of days in last 6 months _____ Daily

Wage-

Any other source of income: _____

Has the total income during last six months been sufficient

to adequately feed all family members?

Yes No

If not then what was the approximate proportionate decrease (proportion of usual)? -

Which items in the diet specifically were decreased -

Foodgrains (Maize, Wheat, Jowar, Rice etc.)

Pulses

Vegetables

Oil, milk etc.

In the last six months relating to the deceased and family -

Were any unusual or 'famine' foods being eaten (roots, tubers, leaves etc.)?

Were other members of the family eating such unusual things ?

Any substances being eaten to suppress hunger?

Was the family purchasing PDS rations?

Did the family avail of drought relief?
Yes / No
If so in what form?

Deaths of cattle or other animals

Distress sale of cattle, vessels, implements and other belongings to obtain food

Borrowing or begging food from neighbours, relatives or others

Personal habits

i. Smoking Yes No
If yes
Duration
Bidi / cigarette per day

ii. Alcohol Yes No
If yes
Duration
Quantity per day

Date of death

Day Month Year

Weather at the time of Death:
Extreme cold / Extreme heat / Neither

Place of Death

i. Home
Staying alone / With family

b. Families in immediate neighborhood:Yes / No Health centre / Hospital

iii On the way to Health Centre/Hospital

iv. Any other

Whether Death Certificate Available

Yes/No

If not why?

_____

If yes:

Mention Cause of Death as certified

2. Medical history related to death

2.1 Was the deceased seeing a health care provider before death: 1.yes 2.no

2.2 If yes, specify (name, profession, address.):

2.3 For how long:

_____ years

2.4 For what complaint (specify):

2.5 Was the deceased taking any medication:

1.yes 2.no

2.6 If yes, specify (ask for remaining containers / unused medicines):

2.7 Was the deceased hospitalized before death: 1.yes 2.no

2.8 If yes, specify where (name, address):

2.9 For how long: _____ days

2.10 Did the deceased leave hospital (before death): 1.yes 2.no

If yes, how many days before death?

_____ days

2.11 Did the deceased undergo any surgical operation during this hospitalization: 1.yes 2.no

2.12 If yes, when (before death):

_____ days

2.13 Do you know what was the operation: 1.yes 2.no

2.14 If yes, specify:

2.15 Was the deceased or any member of the family ever told the nature (the diagnosis) of the illness:
1.yes 2.no

2.16 If yes, what was it (specify as clearly as possible):

Was there any accident / poisoning / bite / burn or other unnatural event shortly before death-

1. yes 2. no

2.17.1 If yes, what was the accident:

2.17.2 If yes, specify hours / days before death:

2.18 Where did the accident occur:

1. at work:
2. road (vehicular accident):
3. at home:
4. other (specify):

2.19 Organs/part of body injured during accident_____

2.20 Other unnatural events-

Drowning

Poisoning

Hanging

Bite by snake or other venomous animal

Burns

Violence

Any other (specify):

How long before the death did this event take place?

(Hours /days)_____

Details of the event (in case of poisoning, what agent was used; in case of violence, what type of violence etc.)

3. Specific disease related information

3.0 Open ended question about the illness –

According to what you know what did the deceased die of and how? Please narrate.

(All questions in the sections below pertain to the illness immediately preceding death unless specified otherwise)

3.1 Cardiovascular system

Did the deceased ever complain of unusual breathlessness? :

1.yes 2.no

If yes, was it on:

Exertion: 1.yes 2.no

If yes, how much exertion:

1 Walking on level surface

2 Walking up an incline

3 Climbing stairs

Breathlessness while lying down flat:
1.yes 2.no

At night, relieved by sitting up in bed:

1.yes 2.no

3.1.2 Did the deceased ever complain of chest pain:
1.yes 2.no

If yes:

3.1.2.1 Was it persistent for several hours:
1.yes 2.no

Was it accompanied by excessive sweating:
1. Yes 2. No

3.1.2.2 Was it relieved by rest:
1.yes 2. no

3.1.2.3. Did the deceased ever complain of cyanosis on the lips, fingers or nails:

1.yes 2.no

3.1.2.4 Did the deceased ever complain of swelling on the body (the lower limbs, foot and leg, eyelids, abdomen, back):
especially if lying down:
1.yes 2.no

3.1.2.5 Did the deceased ever complain of an episode of palpitations (sudden rapid heart beats for one hour or more):
1.yes 2.no

3.1.2.6 Did the deceased ever complain of recurrent sore throat, joint pain and inflammation (migrating, fleeting and affecting several joints):

1.yes 2.no

Respiratory system

3.2.1 Did the deceased have cough:
1.yes 2.no

3.2.2 Dry cough / Productive cough
If productive, was the sputum:

3.2.2.1 Clear and sticky:
1.yes 2.no

3.2.2.2 Yellowish or greenish:

1.yes 2.no

3.2.2.3 Stained with blood:

1.yes 2.no

3.2.2.4 Whether large quantity of sputum and offensive smell: 1.yes 2.no

Duration of the cough _____

Was the cough related to season ? If so, in which season was it worse?

_____

3.2.5 Chest pain: 1.yes 2.no

If yes

3.2.5.1 Was it increased with cough and / or deep breath :

1.yes 2.no

3.2.5.2 Was it localized and tender:

1.yes 2.no

3.2.6 Wheezing:

1.yes 2.no

Digestive system

Did the deceased ever complain of:

3.3.1 Abdominal pain 1.yes

2.no

If yes, since when?

Was the pain

3.3.1.1 Persistent:
1.yes 2.no

3.3.1.2 Localized over one area:
1.yes 2.no
If yes:
3.3.1.2.1 Central abdomen:
1.yes 2.no

3.3.1.2.2 Left upper abdomen
1.yes 2.no

3.3.1.2.3.Right upper abdomen
1.yes 2.no

3.3.1.2.4 Lower abdomen

1.yes 2.no

If yes then –

left side
right side
entire lower abdomen

3.3.1.2.5 Loin radiating to the groin (inguinal region)
1.yes 2.no

3.3.1.2.6 Relieved by meals (food):
1.yes 2.no

3.3.1.2.7 Aggravated by meals (food):

1.yes 2.no

3.3.2 Persistent heartburn:
1.yes 2.no

3.3.2.1 Was it sometimes accompanied by water brash
(belching of sour fluid in the mouth :

1.yes 2.no

3.3.3 Diarrhoea:
1.yes 2.no
If yes, was it:

3.3.3.1 Acute (less than 15 days)

3.3.3.2 Chronic (more than 15 days)

3.3.3.3 Accompanied by blood

1.yes 2.no
Alternating with constipation:
1.yes 2.no

3.3.4 Vomiting blood: 1.yes 2.no
If yes:

3.3.4.1 Was the blood:
1.bright red 2.dark brown

3.3.4.2 Did this vomiting of blood last until death:

1.yes 2.no

3.3.4.3 For how long before death:

_____ month(s)

3.3.4.4 Was the deceased or any member of the family informed of the nature or the cause of this vomiting blood:

1.yes 2.no

If yes:

3.3.4.5 What was it

3.3.5 Normal stools with blood in the stools:

1.yes 2.no

If yes:

3.3.5.1 Was the blood:

1.red 2.dark brown

3.3.5.2 Did the symptoms last until death:

1.yes 2.no

If yes:

3.3.5.2.1 For how long before death:

months

3.3.5.3 Was the deceased or any member of the family informed of the nature or cause:

1.yes 2.no

If yes:

3.3.5.3.1 What was it:

3.3.6 Jaundice:

1.yes 2.no

If yes:

3.3.6.1 For how long before death:

_____ days

3.3.6.2 Did jaundice last until death:

1.yes 2.no

3.3.6.3 Was the deceased or any member of the family told of its nature or cause:

1.yes 2.no

If yes:

3.3.6.3.1 What was it:

3.3.7 Persistent vomiting:

1.yes 2.no

If yes:

3.3.7.1 Did it last until death:

1.yes 2.no

_____ days

3.3.7.1.1 What was the duration: (before death):

_____ days

Urinary system

3.4.1 Did the deceased ever complain of one of the following symptoms:

3.4.2 Blood in urine:

1.yes 2.no

If yes:

3.4.2.1 Did blood in urine last until death:

1.yes 2.no

If yes:

3.4.2.1.1 For how long (before death):

_____month(s)

3.4.2.1.2 Was Blood in urine ever associated with pain:

1.yes 2.no

3.4.2.2 Was blood in urine:

1. persistent

2.intermittent

3.4.3 Problems in urination:

1.yes 2.no

If yes:

3.4.3.1 Decreased volume of urine: 1.yes

2.no

3.4.3.2 Complete retention of urine lasting for more than a

few hours:

1.yes 2.no

If yes:

3.4.3.2.1 Was this retention:

1.recurrent 2.transient

3.4.3.2.2 Did this retention last until death:

1. yes 2. no

3.5 Infectious diseases

3.5.1 Did the deceased ever complain of fever in the month prior to death:

1. continuous 2. intermittent 3. never complained

If continuous or intermittent:

3.5.1.1 Did fever last until death: 1. yes 2. no

If yes:

Was the fever on alternate days or every day at a fixed time?

_____

Were there chills / rigors accompanying the fever?

Was there continuous fever for more than one week?

3.5.1.2 Was the deceased or any member of the family ever informed of the nature of the diagnosis of this fever:

1.yes 2.no

If yes:

3.5.1.2.1 What was it:

Reproductive mortality

If the deceased is a female aged 12-50 years:

3.6.1 If married and living with her husband OR separated, divorced, or widowed for less than 3 months, did she complain before she died of:

3.6.2.1 Continuous fever: 1. yes

2. no

3.6.2.2 Vaginal bleeding:
1. yes 2. no

3.6.2.3 Abortion (up to 42 days (6 weeks) before death):

1. yes 2. no

3.6.3 Was she pregnant and delivered before her death (up to 6 weeks before death) regardless of gestation age:

1. yes 2. no
If yes:

3.6.3.1 Where did the delivery take place: 1. hospital 2. home 3. other

(specify)

Any significant symptoms or events related to the pregnancy or delivery

Unusually large amount of vaginal bleeding before / during / after delivery

Inability to deliver within 24 hours of onset of labour

Severe continuous pain in the abdomen during labour

Pain in lower abdomen with fever / foul discharge after
delivery

Malignancies

Did the deceased ever complain of:

3.7.1 The presence of any mass or tumour in any part of the body:
1.yes 2.no
If yes:

3.7.1.1 Where: (specify, if a woman emphasize mass in
breast)

3.7.1.2 Did this tumour persist until death:
1.yes 2.no

3.7.2 Continuous loss of weight with no apparent reason
1.yes 2.no

3.7.3 Abnormal vaginal bleeding aside from the menstrual
cycle especially after menopause

3.7.4 Lump in the cheek / tongue

3.7.5 Was the deceased or any member of the family ever informed of the possible existence of a malignant tumour or growth:

1.yes 2.no
If yes:

3.7.4.1 Where in the body (specify as clearly as possible):

3.7.4.2 What was the outlook for the patient:

1.not mentioned

2.good

3.reserved

4.bad (fatal)

Did the person have obvious loss of weight in the three months prior to death?

3.8 Other

Did the person have paralysis / extreme weakness on one side or a particular part of the body?

Did s/he have severe continuous unremitting headache?

If yes, was there accompanying fever and inability to bend the head forwards?

Did s/he have convulsions? If yes, did these last until death?

Was the body stiff/ arched back for some hours or days before death?

Was the person unconscious before death? if so, for what duration?

Specific information related to malnutrition / starvation:
Food intake (semi-quantitative) – here the interviewer has to estimate the caloric intake if possible based on detailed dietary history.

Daily intake during the week prior to death:
How many meals did the deceased have in a day ?
Morning
Noon
Afternoon / evening
Night
Other meals / snacks
(Quantify exact amounts of roti, rice, ghat / rabdi
(porridge), dal etc. as far as possible)
Was this food enough to satisfy his hunger?
Daily intake during the month prior to death
How many meals did the deceased have in a day?
Morning
Noon
Afternoon / evening
Night
Other meals / snacks
Was this food enough to satisfy his hunger?

4.2 a. Water intake – Normal / reduced / increased / do not know

b. Source of Water -

Did s/he complain of

Constant complaint of hunger

Loss of feeling of Hunger

Dizziness on standing up

Extreme weakness and inability to walk

Inability to see at night

What were the observations of the family members regarding the deceased person:

Eyes: Sunken/ Normal/ Do not know

Skin: Creases, wrinkles over forehead and face as usual

Increased

Do not know

Normal / Scaling or peeling / Do not know

Hair: Normal / Dry or discoloured / Do not know

Cheeks : As usual/ very sunken /Do not know

Ribs: As usual / very prominent/ Do not know

Limb bones: As usual / prominent/ Do not know

Abdomen: As usual/ very sunken /Do not know

Hipbones: As usual/ prominent and projecting /Do not know

Tongue: Dry / coated or fissured / Do not know Normal pink colour / very pale or whitish / Do not know

Lips: Normal / Dry or cracked / Do not know

Gums : normal / loose teeth, bleeding / do not know

Swelling over Ankle : Y/N

If yes -unilateral / bilateral

Face: Y/N Upper limbs: Y/N

Palms and nails: Normal pink colour / very pale or whitish / do not know

Body temp: Normal / Cold / Do not know

Bed sores: None

If yes, site: Shoulder blade/ Lower back / Hip/Calf /Other part

Behavioral changes: None /Muttering or irrelevant talk / Unconscious

5. Presumed cause of death

5.1 From death certificate if available:

5.2 From verbal autopsy form:

5.21 Immediate cause of death:

5.22 Underlying cause(s) of death

5.23 Contributory cause(s) of death:

Questionnaire modified from - Mortality and causes of death in Jordan 1995-96:assessment by verbal autopsy, S.A. Khoury, D. Massad, T. Fardous, Bulletin of the World Health Organization, 1999, 77 (8)

Annexure 5

Verbal Autopsy Questionnaire for Children

Instructions to interviewer: Introduce yourself and explain the purpose of your visit. Ask to speak to the mother or to another adult carer who was present during the illness that lead to death. If this is not possible, arrange a time to revisit the household when the mother or carer will be home.

Section 1: Background information on child and household

(*To be filled in before interview*)

1.1 Address of household

1.2 Name of child

1.3 Sex of child: 1. Male 2. Female

Section 2: Background information about the interview

2.1 Language of interview _____

day/month/year

Date of first interview attempt_____

Date of second interview attempt_____

Date of third interview attempt_____

Date of interview_____

Section 3: Information about carer/respondent

3.1 What is the name of the main respondent?

3.2 What is the relationship of main respondent to deceased child? (*tick relevant box*)

Mother

Maternal Grandmother

Paternal Grandmother

Maternal Grandfather

Paternal Grandfather

Paternal Uncle

Maternal Uncle

Maternal Aunt's Husband

Paternal Aunt's Husband

Maternal Aunt

Paternal Aunt

Paternal Uncle's wife

Maternal Uncle's wife

Elder brother

Elder sister

1. Other male (specify) _____

17.Other female (specify)_____

3.3 What is the age of main respondent (in years) ___ ___

3.4 How many years of school did the main respondent complete? ___ ___

3.5 Were other people present at the interview?

1. Yes 2. No (*If "No",go to question 3.5.3*)

3.5.1 Of those present at the interview, which were present at the illness that led to death/hospitalization?

3.5.2 Total number giving information at interview __ __

3.5.3 If mother is not present at the interview, is the mother still alive? Yes No

Section 4: Information about the child

4.1 Date of birth of child: ___/___/___ (dd mm yy)

4.2 What was the date of death? ___/___/___ (dd mm yy)

4.3 Where did the child die? (*tick relevant box*)

1 Hospital

2 Other health facility

3 On route to hospital or health facility

4 Home

5 Other (specify _____)

4.3.3 For deaths at hospital or health facility, record facility name and address:

Section 5: Open history question

5.1 Could you tell me about the child's illness that led to death?
Prompt: Was there anything else?

Instructions to interviewer - Allow the respondent to tell you about the illness in his or her own words. Do not prompt except for asking whether there was anything else after the respondent finishes. Keep prompting until the respondent says there was nothing else. While recording, underline any unfamiliar terms.
Take a moment to tick all items mentioned spontaneously in the open history questionnaire.

5.3 Was care sought outside the home while he/she had this illness?

1. Yes 2. No 3. Don't know (*If "No" or "Don't know", go to section 6*)
5.3.1 (*If yes ask:*) Where or from whom did you seek care? *(Record all responses)*

1. Traditional healer . . . . . .
2. Governmental health centre or clinic . . . . . .
3. Government hospital . . . . . .
4. Community-based practitioner associated with health system including trained birth attendants..
5. Private physician . . . . . .
6. Pharmacy, drug seller, store, market . . . . . .
7. Other provider . . . . . .

6 Relative, friend (outside household) . . . . . .

After respondent finishes prompt: Did you seek care anywhere else? Keep using this prompt until respondent replies that they did not seek care from anyone else.

Note: Above categories should be country-specific.

Section 6: Accident

6.1 Did the child die from an accident, injury, poisoning, bite, burn or drowning?

1. Yes 2. No. 3. Don't know (*If "No" or "Don't know", go to section 7)*

6.1.1 *(If yes ask):* What kind of injury or accident?
Allow respondent to answer spontaneously. If respondent has difficulty identifying the injury or accident, read the list slowly.

1. Motor vehicle accident
2. Fall
3. Drowning
4. Poisoning
5. Bite or sting by venomous animals
6. Burn
7. Other injury (specify) _____

6.1.2 How long did the child survive after the injury, poisoning, bite, burn or drowning?

1. Died within 24 hours

2. Died 1 day later or more

Section 7: Age determination and reconfirmation

7.1 *Record the child' s date of birth from question 4* _ /__ _/___ dd mm yy
Record child' s date of death from question 4.2 __ _/__ _/___ dd mm yy

7.2 *Take a moment and calculate the age of the child at the time of death. Read out:*

I have calculated that the child was __ ____ __ days (or months or years old as appropriate) at the time of death. Is this correct?

If the respondent indicates this is not correct, reconcile the inconsistency by re-checkin the child' s date of birth and date of death. Make the necessary corrections here and in section 4.

If child died within 24 hours from injury or accident, go to section 10 – treatment and records. If child was less than 28 days old do not record any details as that is beyond the purview of this study. If child was 28 days old or more at the time of death, go to section 8 – post-neonatal deaths.

Section 8: Post-neonatal deaths

8.1 During the illness that led to death, did he/she have a fever?

1. Yes 2. No 3. Don't know (*If "No" or "Don' t know", go to question 8.2)*

8.1.1 *(If fever ask):* How many days did the fever last? . . . . . .__ __ days

8.2 During the illness that led to death, did _____ have frequent loose or liquid stools?

1. Yes 2. No 3. Don't know

8.2 During the illness that led to death, did he/she have (local terms for diarrhoea)?

Note: When preparing the country-specific questionnaire, include local terms for diarrhoea.

1. Yes 2. No 3. Don't know

(*If "No" or "Don' t know", for both questions 8.2 and 8.3, go to question 8.4*)

8.3.1 (*If frequent or loose stools or local terms for diarrhoea ask*):

For how many days did he/she have loose or liquid stools?

. . . . __ __ days

8.3.2 Was there visible blood in the loose or liquid stools?

1. Yes 2. No 3. Don't know

8.3.3 During the time with the loose or liquid stools, did the child drink 'Rabdi' or 'Salt and Sugar solution' or ORS?

1. Yes 2. No 3. Don't know

8.3.4 During the illness that led to death, did the child have a cough?

1.Yes 2. No 3. Don't know

(*If "No" or "Don' t know", go to question 8.5*)

8.5 During the illness that led to death, did the child have difficult breathing?

1.Yes 2. No 3. Don't know (*If "No" or Don' t know", go to question 8.6*)

8.6 During the illness that led to death, did the child have fast breathing?

1.Yes 2. No 3. Don't know (*If "No" or Don' t know", go to question 8.7)*

(*If yes ask*): For how many days did the difficult breathing last? __ __ days

8.6.1 *(If yes ask):* For how many days did the fast breathing last? . . . . __ __ days

8.7 During the illness that led to death, did he/she have indrawing of the chest?
1. Yes 2. No 3. Don't know

8.8 During the illness that led to death, did he/she have noisy breathing? (*Demonstrate each sound*)

8.8.1 Stridor . . . . . 1. Yes

2. No 3. Don't know

8.8.2 Grunting . . . . 1. Yes

2. No 3. Don't know

8.8.3 Wheezing . . . . 1. Yes

2. No 3. Don't know

8.9 During the illness that led to death, did his/her nostrils flare with breathing?

1. Yes 2. No 3. Don't know

8.10 During the illness that led to death, did the child have pneumonia?

1. Yes 2. No 3. Don't know

Note: When preparing country-specific questionnaires include local terms for pneumonia here.

8.11Did the child experience any generalized convulsions/fits during the illness that led to death?

8.121. Yes 2. No 3. Don't know

8.13Was the child unconscious during the illness that led to death?

1. Yes 2. No 3. Don't know

8.14 At any time during the illness that led to death, did the child stop being able to grasp?

1. Yes 2. No 3. Don't know

(*If "No" or Don't know", go to question 8.14)*

8.15 At any time during the illness that led to death, did the child stop being able to respond to a voice?

1. Yes 2. No 3. Don't know

(*If "No" or Don't know", go to question 8.15)*

8.16At any time during the illness that led to death, did the child stop being able to follow movements with their eyes?

1. Yes 2. No 3. Don't know

(If "No" or Don't know", go to question 8.16)

8.15.1 *(If yes, ask):* How long before he/she died did the child stop being able to follow movements with their eyes?

1 Less than 12 hours

2 12 hours or more

8.17 Did the child have a stiff neck during the illness that led to death? (*Demonstrate*)

1. Yes 2. No 3. Don't know

8.18 Did the child have a bulging fontanelle during the illness that led to death?

1. Yes 2. No 3. Don't know

8.19 During the month before he/she died, did the child have a skin rash?

1. Yes 2. No 3. Don't know

(If "No" or Don' t know", go to question 8.18)

8.18.1 (*If yes, ask*) Was the rash all over the child's body?

1. Yes 2. No 3. Don't know

8.18.2 Was the rash also on the child's face?

1. Yes 2. No 3. Don't know

8.18.3 How many days did the rash last? . . . __ __. __ __ days

8.18.4 Did the rash have blisters containing clear fluid?

1. Yes 2. No 3. Don't know

8.18.5 Did the skin crack/split or peel after the rash started?

1. Yes 2. No 3. Don't know

8.18.6 Was this illness "measles"?

1. Yes know 2. No 3. Don't

Note: When preparing country-specific questionnaire include local term for measles.

8.18 During the illness that led to death, did the child become very thin?

1. Yes 2. No 3. Don't know

8.20 During the illness that led to death, did the child have swollen legs or feet?

8.21 1. Yes 2. No 3. Don't know

(If "No" or Don' t know", go to question 8.21)

8.20.1 *(If yes, ask):* How long did the swelling last? Number of weeks __ __

8.22 During the illness that led to death, did the child's skin flake off in patches?

1. Yes 2. No 3. Don't know

8.23Did the child's hair change in colour to a reddish (or yellowish) colour?

1. Yes 2. No 3. Don't know

Note: When preparing country-specific questionnaire, terms for colour to be locally adapted.

Did the child have "marasmus" during the month before he/she died?

1. Yes 2. No

3. Don't know

Note: When preparing country-specific questionnaire, local terms for marasmus should be included.

8.24 During the illness that led to death, did the child suffer from "lack of blood" or "pallor"?

1. Yes 2. No 3. Don't know

Note: When preparing country-specific questionnaire, local terms for "lack of blood" or "pallor" should be included.

8.25 During the illness that led to death, did the child have pale palms?

1. Yes 2. No 3. Don't know

Note: When preparing country-specific questionnaire, local terms for "pale palms" should be included.

8.2.7 During the illness that led to death, did the child have white nails? (*Show photo if possible*)

1. Yes 2. No 3. Don't know

Note: When preparing country-specific questionnaire local terms for "white nails" should be included here.

8.26 During the illness that led to death, did the child have swellings in the armpits?

1. Yes 2. No 3. Don't know

8.27 During the illness that led to death, did the child have swellings in the groin?

1. Yes 2. No 3. Don't know

8.28 During the illness that led to death, did the child have a whitish rash inside the mouth or on the tongue?

1. Yes 2. No 3. Don't know

9. Information about the Nutritional status of the child

9.1 What and how much was the child eating about one week before death?

9.1.1 How many meals did the child have in a day?

9.1.2 Approximately what and how much was the child eating in the

Morning

Afternoon

Evening

Night

Other

(Try to quantify approximately how much each of Roti, Ghat, Raabdi. Etc)

9.1.3 Was this food enough to satisfy the child's hunger?

9.2 What and how much was the child eating about one month before death?

9.2.1 How many meals did the child have in a day?

9.2 2.Approximately what and how much was the child eating in the

Morning

Afternoon

Evening

Night

Other

(Try to quantify approximately how much each of Roti, Ghat, Raabdi. Etc)

9.2.3 Was this food enough to satisfy the child's hunger?

9.3 What and how much was the child eating about three months before death?

9.3.1 How many meals did the child have in a day?

9.3.2 Approximately what and how much was the child eating in the

Morning

Afternoon

Evening

Night

Other

(Try to quantify approximately how much each of Roti, Ghat, Raabdi. Etc)

9.3.3 Was this food enough to satisfy the child's hunger?

9.4 Was the child being given any unusual foods apart from what is usually given? (e.g. leaves, roots, tubers)

Were others in the family also eating such unusual foods?

Were any foods being eaten to suppress hunger?

9.5 Information about the Income and Food security of the family.

9.5.1 Agriculture

Total land owned-

Total irrigated land owned

Harvest of the previous year was sufficient to feed the family for how many months?

9.5.2 Labour

Work in the form of agricultural labourer- No. of days in the last six months

Work as daily labourer-

• Work obtained in the relief work started by the Government-How many days in the last six months-

Daily wages-_____

• Work obtained outside the village-How many days in the last six months-

Daily wages-_____

9.5.6 Was the income in the last six months enough to adequately feed the family?

9.5.7 If not then how much was the decrease?

(Approximately estimate what proportionate paise of a rupee)

The decrease was seen in which eatables

1 Main food (Maize, Jowar, Rice, Wheat)

2 Pulses

3 Vegetables

4 Oil. Milk etc

5 Meat, Fish, Eggs etc

9.6 How much water was the child drinking in the week before death?

1 Usual quantity

2 Less than usual

3 More than usual

4 Do not know

9.7 Did the child suffer from 'Night Blindness'?

1. Yes 2. No 3. Do not know

9.8 Were the corners of the child's mouth cracked, or did he/she have ulcers in the mouth/ tongue?

1. Yes 2. No 3. Do not know

9.9 Did the child have problems such as bleeding gums or loose teeth?

1. Yes 2. No 3. Do not know

9.10 Did the child have 'bow legs' ?

1. Yes 2. No 3. Do not know

Section 10: Treatment and records

I would now like to ask a few questions about any drugs the child may have received during the illness that led to death.

10.2 Do you have any prescriptions, case papers or other health records that belonged to the child?

1. Yes 2. No 3. Don't know

(If "No" or Don' t know",go to question 10.5)

10.2.1 (*If yes ask*): Can I see the health records?
1. Yes 2. No 3. Don't know

(If "No" or Don' t know ",go to question 10.5)

If respondent allows you to see the health records, transcribe all the entries within the 12 months before the child died.

10.3 Weights (most recent two)

10.3.1 Record the dates of the most recent weight, two weights

1 __ /__ /__ (dd/mm/yy)

2 __ /__ /__ (dd/mm/yy)

10.3.2 Record the most recent two weights.

1 _____

2_____

10.4 Medical notes

10.4.1 Record the date of the last note. . . _ _/_ _/__ (dd/mm/yy)
10.4.2 Transcribe the note

10.5 Was a death certificate issued?

1. Yes 2. No 3. Don't know

(If "No" or Don' t know", go to question 10.7)

INSTRUCTIONS TO INTERVIEWER - Ask to see the death certificate and record whether you have been able to see it.

10.5.1 Able to see death certificate?

1. Yes 2. No (*If "No",go to question 10.7*)

10.6 Record the immediate cause of death from the certificate _____

Record the first underlying cause of death from the certificate_____

Record the contributing cause(s) of death from the certificate _____
Now I would like to ask a few questions about the child's mother.

10.7 Has the child's mother ever been tested for "HIV"?

1. Yes 2. No 3. Don't know

(If "No" or Don' t know", go to question 10.8)

10.7.1 (*If yes ask*)*:* Was the "HIV" test ever positive?

1. Yes 2. No 3. Don't know

10.8 Has the child's (biological) mother ever been told she had "AIDS" by a health worker?

1. Yes 2. No 3. Don't know

11. From verbal autopsy form: _____

11.1 Immediate cause of death:_____

11.2 Underlying cause(s) of death:_____

11.3 Contributory cause(s) of death:_____

END OF INTERVIEW

THANK RESPONDENT(S) FOR THEIR COOPERATION

(Modified from - WHO/CDS/CSR/ISR/99.4; A STANDARD VERBAL AUTOPSY METHOD FOR INVESTIGATING CAUSES OF DEATH IN INFANTS AND CHILDREN)

Annexure 6

Expected Weight for Age (NCHS Standard)

	Weights in Kg.	
Age in months	**Male**	**Female**
12	10.2	9.5
15	10.8	10.1
18	11.5	10.8
21	12.5	11.3
24	12.6	11.9
27	13.1	12.4
30	13.7	12.9
33	14.2	13.4
36	14.7	13.9
39	15.2	14.5
42	15.7	15.1
45	16.2	15.5
48	16.7	16
51	17.2	16.4
54	17.7	16.8
57	18.2	17.2
60	18.7	17.7
63	19.2	18.1
66	19.7	18.6
69	20.2	19.5
72	20.7	19.5
75	21.2	20

***Reference**-Weight in Kg are 50th percentiles of Boys and Girls;* NCHS growth curves for children, Birth-18 yrs. National Centre for Health Statistics, Publ No. DHS 878-1650, 1977. Hyattsville MD, USA

Annexure 7

IAP classification for weight for age

Weight for Age				
Years	**Age**	**Boys**		**G irls**
1	1 2	1 0.2		9 .5
1.3 m	1 5	1 0.8		1 0.1
1 1/2	1 8	1 1.5		1 0.8
1.9 m	2 1	1 2.5		1 1.3
2	2 4	1 2.6		1 1.9
2.3 m	2 7	1 3.1		1 2.4
2 1/2	3 0	1 3.7		1 2.9
2.9 m	3 3	1 4.2		1 3.4
3	3 6	1 4.7		1 3.9
3.3 m	3 9	1 5.2		1 4.5
3 1/2	4 2	1 5.7		1 5.1
3.9 m	4 5	1 6.2		1 5.5
4	4 8	1 6.7		1 6
4.3 m	5 1	1 7.2		1 6.4
4 1/2	5 4	1 7.7		1 6.8
4.9 m	5 7	1 8.2		1 7.2
5	6 0	1 8.7		1 7.7
5.3 m	6 3	1 9.2		1 8.1
5 1/2	6 6	1 9.7		1 8.6
5.9 m	6 9	2 0.2		1 9.5
6	7 2	2 0.7		1 9.5
6.3 m	7 5	2 1.2		2 0