Policy Watch

No. 8

Fixing Child Malnutrition in India: Views from a Public Policy Practitioner

Venkatesan Ramani

THE HINDU CENTRE
for
Politics and Public Policy

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Cover Photo: A 2016 photo of a woman in Tala Nagada village feeding her child with Energy Dense Nutrient Rich Food distributed by the government health department to the villagers of Nagada hills in Jajpur district, Odisha.
Photo: Biswaranjan Rout – The Hindu

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ABSTRACT

India is home to the one of the world's largest flagship programmes for under-6 children, the Integrated Child Development Services (ICDS), which was introduced more than four decades ago on October 2, 1975. Tragically, India continues to languish way down in international rankings on child nutrition indices. Nonetheless, there has been a progressive evolution in policies, advanced at times by judicial interventions. Significant financial resources have also been expended on the ICDS and related programmes. Yet, substantial improvements are yet to be seen, especially in the laggard heartland States of northern and eastern India.

In this Policy Watch, **Venkatesan Ramani**, a retired Indian Administrative Service (IAS) officer of the Maharashtra cadre and the first Director-General of the Rajmata Jijau Mother-Child Health and Nutrition Mission, the first such mission to be set up in the country in 2005, analyses why both planning and implementation of programmes impacting child nutrition have been deficient. Data gaps have impeded the framing of sound policy measures, leading to one-off actions to solve the problem rather than a concerted effort to address underlying economic and social causes, especially in pockets of high incidence of child malnutrition in the country.

Drawing on his experience in Maharashtra, Ramani suggests measures to help reduce child malnutrition in the coming years. Political will and administrative skills, he writes, are key to such changes and need to be accompanied by adequate funding and activating what, in many States, is a rather moribund ICDS machinery.

I. INTRODUCTION

Almost half a century after the inception in 1975 of the world's largest programme focused on children under six, the Integrated Child Development Services (ICDS), the fact that we are still talking about the problem of under-5 child malnutrition in India is a matter of deep concern. South Asian nations, with the exception of Sri Lanka, occupy the last 30 places in the list of nations in the prevalence of under-5 child stunting, along with Sub-Saharan Africa and the poorer parts of South-East Asia.

India, ranked 114 out of 132 countries[1], is behind Bangladesh, Nepal and Bhutan and just ahead of Afghanistan and Pakistan. This has grave implications for public health; indeed, it is a matter of life and death, given that malnutrition accounts for 45 per cent of mortality in children under five years of age.

Anthropometric measurements, biochemical indicators, and clinical signs are the three tests recommended by the World Health Organisation (WHO) to establish the existence of malnutrition. Apart from its ease of large-scale use, anthropometric measurements allow for a quick assessment of the nutrition status of the individual. While Body Mass Index (BMI) is used to assess the existence of malnutrition in adults, the WHO Growth Standards (2006) for children under-5 rely on three measures of nutrition: weight for age, height for age, and weight for height.

Growth charts derived from children optimally breastfed in healthy environments in a representative sample of countries are used as a benchmark. Then, the measures mentioned above highlight those children who are moderately to severely underweight or are suffering from moderate to severe stunting and wasting, based on the standard deviations of their anthropomorphic indicators below the numbers for the standard population.

Malnutrition has necessarily to be approached from a life cycle perspective. An underweight, anaemic pregnant teen mother has to contend with early pregnancy, inadequate spacing

[1] **International Food Policy Research Institute. *2016*. "*Global Nutrition Report 2016: From Promise to Impact: Ending Malnutrition By 2030*".** *[http://www.ifpri.org/publication/global-nutrition-report-2016-promise-impact-ending-malnutrition-2030].*

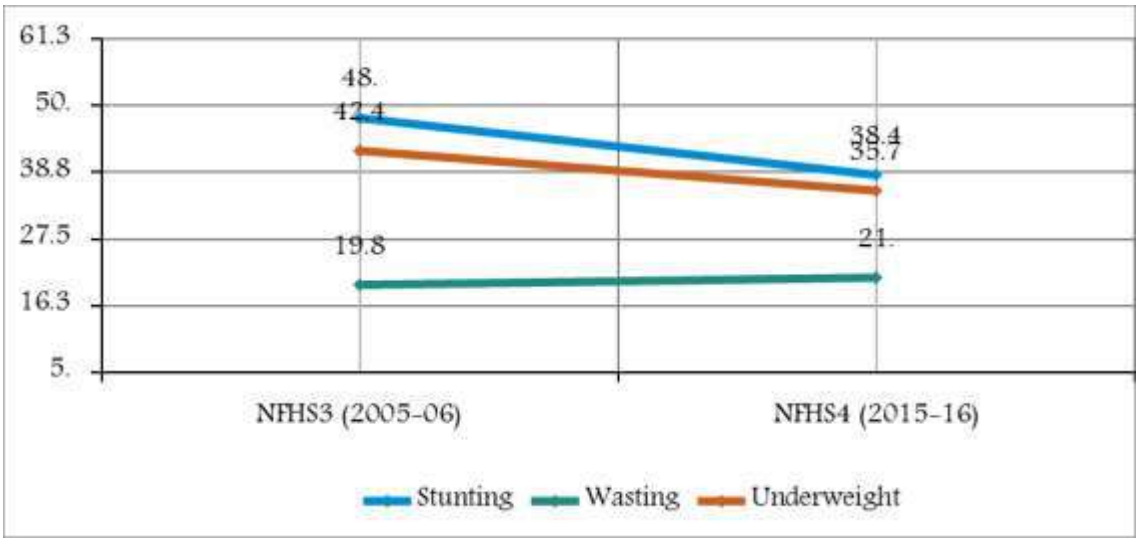
between successive births and poor prenatal nutrition and healthcare. The resulting low birth weight baby faces poor healthcare, hygiene and nutrition practices and develops into a stunted and underweight adolescent. This pattern is replicated over subsequent generations of mothers.

If a child's dietary intake of protein, carbohydrates, fat and micronutrients is inadequate, she could suffer from malnutrition, adversely affecting her health and increasing her susceptibility to disease. Equally critical are the underlying determinants that operate at the household level — food security, nurture-care for the mother and child and a healthy environment, including safe drinking water, hygiene and sanitation, shelter and accessible healthcare. Ultimately, whether these basic rights are available or not to individuals and households depends on the social and economic arrangements that determine access to resources and the ability to effectively use these resources.

II. THE TALES TOLD BY THE NUMBERS

Unfortunately, child malnutrition figures for India and its different States have been published only at intervals of eight to 10 years, with the National Family Health Survey-4 (NFHS-4) Report being the latest to be published in December 2017. It is heartening to note from the NFHS-4 data that stunting rates have come down by 20 per cent over a decade (2006-2016) and underweight rates in the same period by 16 per cent (Chart 1). Wasting rates have, however, gone up by six per cent from under 20 per cent to 21 per cent. This indicates that height gains in the child population under five years of age over the decade in question have not been matched by weight gains.

Chart 1: Child Nutrition Indices over a Decade



Source: NFHS-4

The persistent high stunting rates, especially in the heartland States of India – Uttar Pradesh, Bihar, Jharkhand, Madhya Pradesh and Rajasthan – that push India towards the bottom of the world's stunting rate table is worrying. Even worse, as many as 50 districts in the country, several of them larger than many countries in Asia, Africa and Latin America, figure at the very bottom of the table in international comparisons of stunting percentages of children under five years of age.

Table 1: Stunting Rates in States of India (NFHS-4 2015-16)

CATEGORY A		CATEGORY B		CATEGORY C	
STATE	NFHS-4 STUNTING %	STATE	NFHS-4 STUNTING %	STATE	NFHS-4 STUNTING %
Bihar	48.3	Chhattisgarh	37.6	Sikkim	29.6
Uttar Pradesh	46.3	Assam	36.4	Arunachal Pradesh	29.4
Jharkhand	45.3	Karnataka	36.2	Manipur	28.9
Meghalaya	43.8	Maharashtra	34.4	Telangana	28.9
Madhya Pradesh	42.0	Odisha	34.1	Nagaland	28.6
Rajasthan	39.1	Haryana	34.0	Mizoram	28.0
Gujarat	38.5	Uttarakhand	33.5	Jammu & Kashmir	27.4
		West Bengal	32.5	Tamil Nadu	27.1
		Delhi NCR	32.3	Himachal Pradesh	26.3
		Andhra Pradesh	31.5	Punjab	25.7
				Tripura	24.3
				Puducherry	21.1
				Goa	20.1
				Kerala	19.7
Stunting > 38.4%		Stunting = 30% - 38.4%		Stunting < 30%	

To understand the magnitude of the malnutrition problem, it might be appropriate to classify States by their relative levels of child malnutrition. A classification of States into three categories, based on the stunting percentages shown in NFHS-4 is given at Table 1. The surprise States which have stunting rates above the all-India average are Gujarat and Meghalaya. It is heartening to see that, apart from most of the smaller States, some with populations above 25 million – Kerala, Punjab, Tamil Nadu and Telangana – have stunting rates below 30 per cent.

A combination of social, economic, and geographic-climatic factors has contributed to the current state of affairs. Indian society is characterised by certain regressive features, not least of which are the pervasive role of caste inequality (and the attendant complexes that go with it) and gender inequality, which permeate most social transactions. In a recent article[2], Dianne Coffey and Dean Spears stressed that open defecation reduction has been slow, given the "continuing importance of untouchability and caste-related norms of ritual purity and pollution". This has adversely affected a reduction in stunting, which is positively correlated with the prevalence of open defecation.

They also identified poor maternal nutrition as a crucial factor that affects the proper growth and nurture of the next generation. Annexure-I (at the end of this paper) has compared the child nutrition status in 12 districts in four States of India – five each from Uttar Pradesh (UP)

[2] **Coffey, D and Spears, D. 2019**. "Child height in India: New data, familiar challenges", *Ideas for India,* February 11. [https://www.ideasforindia.in/topics/human-development/child-height-in-india-new-data-familiar-challenges.html].

and Tamil Nadu (TN) and one each from Karnataka (KN) and Maharashtra (MH). The UP districts are among those with the highest rates of stunting in India while the TN districts are at the lower end of the stunting scale. In terms of climate, there is little difference in the annual rainfall figures for the districts in the two States. But the relatively higher rate of use of improved sanitation facilities in the TN districts compared with abysmal levels in the UP districts, impacts the levels of stunting.

Even more noteworthy are the significantly higher rates of female literacy in TN and the higher percentage of women who have completed at least 10 years of schooling. Though anaemia levels among women in the 15-49 age group in the districts under study in UP and TN are broadly similar, the mothers in TN have far greater access to ANC (Ante Natal Care) than their sisters in UP. This contributes to much better delivery outcomes, higher baby weights at birth and reduced cases of stunting and being underweight among children under five years of age. The lower percentage of agricultural labour in the TN districts probably reflects a more equitable pattern of land holdings as also opportunities for non-farm employment, missing to a large extent in the UP districts bordering Nepal.

There are no great variations in the percentages of Scheduled Caste and Scheduled Tribe populations in the UP and TN districts either. In contrast, Maharashtra's Nandurbar district has a tribal population of nearly 70 per cent, in line with a number of districts in Madhya Pradesh, Chhattisgarh, Odisha, and Jharkhand, most of which have high levels of child malnutrition. The high stunting, underweight, and wasting rates in the districts of Koppal and Nandurbar reflect both geography (in the case of the latter) and inadequate attention to development processes (in both districts) on the part of the state.

The NFHS-4 Report highlights the continued differentials in the relative status of men and women. The literacy differential percentages have come down over the last 10 years from 23 per cent to 17 per cent, but only 31 per cent of currently married women are employed as compared with 98 per cent for men. Just about 63 per cent of women participate in household decision-making. What is particularly intriguing is that more women, especially as they age, justify wife-beating and there has been little change in this percentage over the past decade. Conservative, regressive social attitudes have been internalised to a significant extent among women and this has major implications for their nurture and care during pregnancy as well as in the post-partum period.

The structure of society and the economy influence the pattern of distribution of physical and financial resources between communities, families and individuals; agro-climatic and geographical factors place certain groups at a disadvantage in partaking of the fruits of development. Nevertheless, the state has a crucial role to play in creating an enabling environment for the healthy development of children, backed by the advances in knowledge and technology over the past few decades. Reducing child malnutrition and bringing down child mortality sharply are important components of the Sustainable Development Goals that the nations of the world have committed to; it is now imperative that these pious declarations are translated into practice.

This paper does not intend to pursue the well-beaten path of recommending only increased budget allocations for the ICDS as a panacea for tackling malnutrition. While more funds are definitely welcome, several pragmatic policy actions are required to move forward.

III. THE WAY FORWARD

What gives one hope about the capacity of Indian public systems to tackle the problem of child malnutrition is the substantial thought and effort that has gone into mapping the incidence of undernutrition in children under-5 and the various policy measures initiated over the past forty years by the Union and State governments. The framework for implementation already exists, strengthened by executive and judicial interventions over the years. Not many countries can boast of a public service system for children under-5 that covers every village and city/town in the country. The quality of child nutrition data has steadily improved over the years and information on the nutrition status of every child under-5 is available at the anganwadi level. Independent, third-party surveys like the NFHS have, over the past thirty years, yielded a rich body of temporal and cross-sectional data on various facets of maternal and child health and nutrition. What is now the need of the hour is to put all this wealth of data to productive use and to devise strategies and action plans that reach every mother and child. This section highlights what needs to be done to use data more meaningfully, where policy interventions will yield the greatest dividends and how to motivate and incentivise the government machineries at the State and local levels to deliver the expected outcomes.

A. Using data effectively for implementation and as a policy tool

The fundamental problem lies in the non-availability of ongoing real-time data on the nutrition status of individual children pertaining to stunting, wasting and being underweight. Effective action under the ICDS to tackle child malnutrition requires reaching out to every child, monitoring her/his growth pattern systematically on a monthly basis from birth to the age of five, and ensuring attention from both the ICDS and the public health machinery at the sub-district level and below to their nutrition and health needs.

The NFHS-4 exercise has broken new ground by publishing, for the first time, district level data on a whole host of health and nutrition processes and outcomes. But to tackle the issue squarely, the heights and weights of children under five years of age in every anganwadi in the country must be recorded. This growth monitoring exercise must specially ensure that children from underprivileged communities and from far-flung hamlets are not excluded, in line with

the Supreme Court directives on universalisation of the ICDS. Based on these monthly recordings of children's heights and weights, the focal points of child malnutrition in specific anganwadis serving villages, hamlets and urban slums can be identified for initiating remedial action on the health and nutrition fronts. This approach, named "the Marathwada Initiative", was taken in Maharashtra's Aurangabad Division from 2002 onwards. Thereafter, it was extended from 2005 on a mission basis throughout the State of Maharashtra as the Rajmata Jijau Mission[3].

Government systems are generally laggard in using data to inform policy directions, particularly if it is not flattering to the government of the day. The ICDS Monthly Progress Reports (MPRs), collated in every State from every anganwadi, giving data on the weight status of children under five in anganwadis, have to be sent electronically every month to the Ministry of Women and Child Development, Government of India. In practice, this data is often sent late and probably, in some States, not even sent on a regular basis. Although Section 4(1) of the Right To Information Act, 2005 has mandated the computerisation of and easy access to all records that are not specifically exempted from disclosure under the exemptions provided in Section 8 of the Act, ICDS MPRs are not available, except in Maharashtra, on the internet at any of the websites of the Union or State governments. The lack of availability of this data in the public domain has a number of implications for the successful implementation of policy. For one, it encourages either sloppy or no reporting of child nutrition status data by a number of States, since there is no penalty for inaction and no accountability for not sending data regularly. Secondly, given that surveys like the NFHS are conducted only periodically, there is no real-time data available in the intervening period as a guide to administrative policy and praxis. Finally, the absence of public accountability that such non-sharing of data implies means that civil society, including nutrition and health experts/researchers, communities, non-governmental organisations (NGOs) and community-based organisations (CBOs) are not able to access such data and enforce actionable responses from the public service delivery systems. My personal experience, as a former Director General of Maharashtra's Nutrition Mission, is that the ICDS machinery (not just in Maharashtra, but probably in all States) tends to under-report underweight numbers, because of lack of emphasis on accurate growth monitoring, as also to avoid criticism. The fairly widespread prevalence of under-reporting of malnutrition rates in ICDS MPRs is confirmed by a comparison of the figures for the same period of

[3] **Ramani, V. nd**. *The Maharashtra State Nutrition Mission: Learning By Doing – An Analysis of the Experience of the Rajmata Jijau Mother-Child Health and Nutrition Mission, Aurangabad (2005-2010).*

percentages of underweight children drawn from the NFHS-4 data and from the Maharashtra ICDS MPR (Table 2).

Table 2: Maharashtra – State and District Variations in Underweight Percentages

District	NFHS-4 Moderately and severely underweight Under-5 children (%)	ICDS MPR June 2015 Moderately and severely underweight Under-5 children (%)	Variation between NFHS-4 and ICDS MPR (%)
Buldhana	41.30	9.16	32.14
Chandrapur	40.30	15.12	25.18
Dhule	47.50	11.47	36.03
Gadchiroli	42.10	20.18	21.92
Gondia	40.10	7.49	32.61
Jalna	43.60	7.41	36.19
Nandurbar	55.40	31.30	24.10
Nashik	42.90	10.25	32.65
Osmanabad	44.50	8.54	35.96
Parbhani	42.30	6.94	35.36
Washim	42.90	6.28	36.62
Yavatmal	49.10	9.09	40.01

Sources: NFHS-4 (2015-16) and Maharashtra ICDS MPR (June 2015)

Since the NFHS-4 survey was carried out in mid-2015, a comparison of district-wise under-5 children underweight percentages as shown in the June 2015 ICDS MPR was made with the district-wise figures of the NFHS-4 data. The analysis revealed that as many as 20 districts showed ICDS MPR underweight percentages that were more than 25 per cent below the corresponding NFHS-4 figures. If we consider the districts with over 40 per cent underweight children, we find percentage variations ranging from 22 per cent to 40 per cent. Unless one wishes to contest the accuracy of the results of the NFHS-4 sample survey, the only conclusion that can be drawn is that the ICDS MPR figures are understated.

This is not surprising as no mechanisms have been put in place in any State in India to check blatant underreporting. The ICDS-CAS (Integrated Child Development Services - Common

Application Software) developed for use in the ICDS by the National Nutrition Mission (NNM) is based on data entry by Anganwadi Workers (AWWs) using smartphones. This envisages replacing paper registers with electronic registers; but entries still have to be made by the AWWs.

It is unfair to expect the AWWs to key in all the required data on a daily basis, given their educational levels, lack of familiarity with the software and paucity of time as they would have to work longer hours to complete this task in addition to their regular duties. Besides, there is the issue of verification of the data filled in by them. Glowing reports about the work being done in the Aspirational Districts[4] may indeed be true, but the fact remains that there is no independent mechanism to ascertain the accuracy of the data entered, especially that relating to the distribution of supplementary nutrition and growth monitoring. The ICDS-CAS literature indicates an overwhelming emphasis on monitoring at higher levels and not enough details on how exactly the AWW will be assisted in her important tasks by technology.

As of date, there are still no assessments of how the ICDS-CAS system has worked in practice and whether it has enabled those at the field and supervisory levels to get a firm grip on the actual malnutrition situation at the anganwadi level, enabling early remedial action. Informal discussions with ICDS functionaries and their superiors in different States indicate that the level of comfort with the ICDS-CAS is still not satisfactory. In the absence of independent third-party evaluations, such information will have to, for the time being, be taken with a pinch of salt. But unless accurate monthly data is available to field workers and policy planners, implementation will suffer and unpleasant shocks experienced when the next round of NFHS data is released.

B. Operating at the sub-district level

It needs to be recognised clearly for policy purposes that child malnutrition exists in larger numbers in specific pockets at the district and sub-district levels. Identification of these

[4] The "Aspirational Districts" programme, launched in January 2018, aims at transforming 115 districts from 28 states of India to ensure equitable development across the country. The focus is on 49 key development indicators, covering the sectors of health, nutrition, education, agriculture, water resources, financial inclusion, skill development and basic infrastructure. Monthly monitoring of these indicators and annual ranking of performance of districts would assist in monitoring progress, introduce a measure of competition among districts and help fine-tune implementation of government programmes. Implementation of these measures is some of the most backward districts of India is intended to improve the country's Human Development ranking index, raise the living standards of its citizens and ensure inclusive growth for all.

pockets, going down to the anganwadi level, is the key to solving the malnutrition conundrum. An example from just two districts of Maharashtra would throw light on this issue (Table 3).

Table 3: Comparative Underweight Rates in Under-5 Children in Different ICDS Projects in the Same District (Monthly Progress Report (MPR), November 2018)

District	ICDS project	Moderately and severely underweight children (%)
Amravati	Daryapur (Rural)	9.75
Amravati	Morsi (Rural)	8.30
Amravati	Dharni (Tribal)	34.28
Amravati	Chikhaldara (Tribal)	32.56
Nashik	Niphad (Rural)	8.91
Nashik	Sinnar (Rural)	6.79
Nashik	Harsul (Tribal)	33.05
Nashik	Tryambakeshwar (Tribal)	23.07

Source: Maharashtra ICDS MPR, November 2018

These figures show clearly that the children in the ICDS projects in tribal areas are more underweight than those in rural areas in these two districts — this is also borne out by the author's personal experience in Maharashtra. Tribal projects have a malnutrition (underweight) rate of three to four times that of non-tribal rural projects. The intra-district picture given in Table 2 above would be even more starkly clear if we had the child nutrition figures for individual ICDS projects in the highest-incidence districts in UP, Bihar and MP: the intra-district variations would stand out. The figures would look even more skewed were we to examine the underweight rates in different anganwadis in a specific ICDS project (though that data is not available for examination here).

A recent article [5] talks of making parliamentary constituencies (PCs) and assembly constituencies (ACs) the focus for policy changes in reducing child malnutrition. The authors argue that this would increase accountability for Members of Parliament (MPs) as well as Members of Legislative Assemblies (MLAs). They also feel that this would facilitate the targeting of specific PCs and ACs in the POSHAN (Partnerships and Opportunities to Strengthen and Harmonize Actions for Nutrition in India) Abhiyaan undertaken in the

[5] **Swaminathan, A, et al. 2019**. "Burden of Child Malnutrition in India – A View from Parliamentary Constituencies", *Economic & Political Weekly*, January 12, Vol. 54, No. 2.

country since early 2018. But would elected representatives really involve themselves with issues related to maternal and child health and nutrition, given their preoccupation with many other matters? There is also the question of what utility there would be in just making data on child nutrition available at the PC and AC level. Such data still cannot serve as a guide to action, which has to take place in villages, hamlets and urban slums – the epicentres of the malnutrition problem. Moreover, just accessing data through sources like the NFHS at a particular point of time will serve little purpose: unless there is ongoing engagement with nutrition and health data at the sub-district level accompanied by prompt remedial action, valuable time will be lost in addressing the problem of child malnutrition as and when it occurs in individual children. The experience of the author during his stint in this sector in Maharashtra clearly affirms the critical need to zero in on each and every child in every anganwadi. The Maharashtra Mission referred to each child as a "live voucher" who could never be lost sight of. With modern software available that highlights online the nutrition status (weight for age, height for age and weight for height) of every child, regular monitoring and follow up by field-level functionaries and supervisory staff can ensure that no child is denied prompt nutrition and health treatment.

C. Designing policy interventions

i) **Effective use of SNP**: The SNP has been bedevilled by employment of private contractors for supply of ready to eat food in a number of States, in contravention of the Supreme Court directives of 2004. States like Tamil Nadu, Karnataka and Telangana have provided hot cooked meals to children in the 3-6 age group. States like Chhattisgarh have shown encouraging results by entrusting the production of take home rations (THR) to women self-help groups. However, in States where private contractors have been hired, the THR has often been fed to cattle or sold in the market. Given that the annual THR budget for an average State could amount to anywhere between ₹600 crores to ₹800 crores, this represents an enormous waste of public funds, necessitating the breaking up of the contractor-politician-bureaucrat nexus. A move in all States to management of the THR supply (for children in the under-3 age group) and hot cooked meals (for pregnant women and breastfeeding mothers and 3-6 age group children) by women from local self-help groups, supervised by local government functionaries, would check leakages to a large extent.

Maternal nutrition programmes are even more crucial to the nutrition status of the child, given that nearly 23 per cent of women have a sub-normal BMI and over 50 per cent of women are anaemic. Tamil Nadu has a forty year history of nutritious meals for pregnant women and breastfeeding mothers and it is heartening that States like Karnataka and Telangana have followed suit. The Karnataka Mathrupoorna programme for 12 lakh mothers is expected to annually cost the exchequer about ₹700 crores, a worthy investment for ensuring the health of future generations.

ii) **Food security:** The National Food Security Act, 2013 has guaranteed the supply of food grains to poorer households at vastly subsidised rates. However, it is crucial to the success of this legislation that the public distribution system (PDS) is streamlined to ensure that households receive their assured supplies in a timely manner. States like Chhattisgarh have significantly improved the access of households to the PDS through using local bodies and community-based organisations, decentralising procurement systems and enhancing transparency through community monitoring. The linking of Aadhaar cards to ration cards, while intended to check leakages, has created problems in States like Jharkhand, where failures in Aadhaar linkages have deprived many families of their rations. Alternative processes like carrying out Aadhaar authentication only once a year and providing barcoded coupons which can be encashed at fair price shops (both tried but unfortunately aborted in Madhya Pradesh) could check exclusion errors and overcome the limitations of technology.

iii) **Focusing on the thousand-day window of opportunity and promoting health-ICDS synergy:** Research has established the critical importance of the first thousand days in the life of the child for her physical, mental and cognitive development. Ensuring a healthy child requires timely registration of pregnancy, full ANC, safe delivery and post-partum care of the mother and infant. While the southern States, especially Tamil Nadu and Kerala, provide fairly comprehensive ANC services, post-partum home based neonatal care is still not adequately provided in most States. Kerala has now sought to address this deficiency by screening all children from birth onwards and providing them with appropriate healthcare. Of critical importance, as my experience and that of many other practitioners at the field level testifies, is the need for convergence in the activities of the health department and the ICDS right from the registration of pregnancy onwards, moving through childbirth and infancy till the child reaches the age of five. This would

include measures to address issues relating to the health and nutrition status of the pregnant mother, ensuring she receives good nutrition, managing a safe delivery and attending to the child, especially during her/his infancy.

The welcome move of the Government of India to pay attention to both height and weight figures in monitoring the nutrition status of the child will enable focus on tackling both stunting and wasting issues simultaneously, recent research having established that both contribute to increased mortality in under-5 children. What is needed is a systematic recording of weights and heights in the districts with high stunting, underweight and wasting rates, and initiating health and nutrition measures to tackle these in the pockets of highest incidence.

iv) **Getting local governments to take the initiative**: A lot of the inefficiency (and corruption) in the ICDS programme arises from the centralisation of powers in the ICDS Commissionerate/Directorate in the different States and the State departments. Not only does this delay the flow of funds to the implementing levels, it also destroys local initiative in tackling a problem that ultimately involves dealing with communities, families and caregivers. My personal experience, borne out in discussions with many local-level elected officials, is that local bodies can play a very constructive role both in mobilising funds from different sources and in getting communities activated to tackle the issue. This is of equal relevance in both rural and urban areas; in fact, the neglect of child malnutrition in urban areas, especially in the slums that have come up over the last three to four decades, has led to levels of child malnutrition in urban ICDS projects that match those in rural/tribal ICDS projects.

v) **Adequate budgetary support**: It is extremely difficult to quantify the exact amount of funds which get spent on programmes related to maternal and child nutrition, since a number of programmes in different sectors have a direct or indirect impact on nutrition outcomes. With the share of untied funds to States being enhanced from 32 per cent to 42 percent, as per the recommendations of the Fourteenth Finance Commission and the rationalisation of centrally sponsored schemes, tracking the actual outlays and expenditure in different States becomes even more challenging. A study by the Centre for Budget and

Governance Accountability and UNICEF[6] for financial year (FY) 2015-16 reveals that budget resource gaps for the supplementary nutrition programme (SNP) for 6 month to 6 year children and pregnant women/breastfeeding mothers were as much as 50 per cent for Odisha, 32 per cent for UP and 22 per cent for Bihar. Only Chhattisgarh (in the four States surveyed) more or less met its required SNP budget.

The budget provision at the central level for the Core ICDS/Anganwadi services has increased to ₹23,234 crores for FY 2019-20 from the revised estimate of ₹20,951 crores for FY 2018-19. Doing back of the envelope calculations for about 13.50 lakh anganwadi staff and SNP for about 170 million children between 6 months – 6 years, it could be said that the budget provision by the central government is adequate as per existing funding norms and sharing patterns between the Union and State governments, keeping in mind the fact that not all ICDS staff positions are filled and that a certain proportion of the children will not be availing of the SNP. Even so, the major lacunae in the implementation of the SNP in States like UP, as brought out in a recent study[7], give cause for concern that budget allocations can be frittered away through corruption. Also, while States in the southern and western parts of India are likely to make adequate budgetary provision for ICDS, fiscally strapped States in other parts of India are likely to provide inadequate funds, especially with the current trend of going in for populist freebies and farm loan waivers.

vi) Cash transfers: There has been considerable debate on the issue of cash transfers versus public service provision. Of course, the two need not be mutually exclusive and cash transfers could well help the poor access public services like healthcare and the PDS more effectively. There is also the issue of whether the cash transfers should be conditional or unconditional. The results of a Self Employed Women's Association (SEWA) – UNICEF pilot project in Madhya Pradesh in 2013 indicates that an unconditional cash transfer scheme has worked well. Basic income transfers to individuals in all the households in a village have contributed to enhanced economic status and to improvements in food sufficiency and to seeking healthcare. Improvements in the nutritional status of children,

[6] **Centre for Budget and Governance Accountability (CBGA) and UNICEF India. 2017**. "Budget Outlays for Nutrition-Specific Interventions: Insights from Bihar, Chhattisgarh, Odisha and Uttar Pradesh, Working Paper 1".

[7] ***Leveraging Agriculture for Nutrition in South Asia (LANSA),* 2017**. "Implementation of the ICDS in Chhattisgarh and Uttar Pradesh (India): a systemic study", *Research Brief,* June, Issue 06. [https://opendocs.ids.ac.uk/opendocs/bitstream/handle/123456789/13418/Implementation_of_the_ICDS_in_Chhattisgar_and_Uttar_Pradesh.pdf?sequence=1&isAllowed=y].

especially girls, positive impact on school enrolment and empowerment of women, in terms of access to finance and decision-making roles in spending the basic income, are some other spin offs of the project.

With the renewed interest in universal basic income (UBI) and the emphasis of the Government of India on financial inclusion through the opening of bank accounts under the Jan Dhan Yojana, it would be worthwhile to consider UBI implementation on a pilot basis in certain areas as a measure of social protection. Widening financial inclusion would require an emphasis on doorstep banking given the limited reach of the banking system. An innovative approach might be to use the services of AWWs and Accredited Social Health Activists (ASHAs) as banking correspondents, given their close access to families and communities. This would also incentivise them to earn additional income through bringing individuals into the formal financial network.

Since the supply of THR in many States is ridden with controversy and since provision of hot, cooked meals to 3-6 year children in some areas may not be feasible given the lack of women SHGs, the possibility of moving to cash transfers for SNP (both for mothers and children) could be seriously considered. For a start, pilot projects could be started in tribal ICDS projects with a high incidence of child malnutrition, with subsequent extension, based on successful pilot implementation, to the rest of the State.

D. Augmenting public service delivery capabilities

Public service delivery competencies are affected straightaway when posts are not filled in. Many States have significant vacancies in the ICDS, both at supervisory levels (Child Development Project Officers (CDPOs) and Supervisors) and at the field worker level (AWWs and Anganwadi Helpers (AWHs)). The same holds true for health personnel, particularly in tribal areas. Filling these in on priority basis obviously has to be a primary task of State governments.

Enhancing knowledge and skills of AWWs and supervisory capabilities of CDPOs and Supervisors is another area where State governments have to focus. With the introduction of stunting as a measure of undernutrition, AWWs will have to be trained in taking the heights and lengths of under-5 children. They will also have to be acquainted with the use of online

technology for monitoring the nutrition status of children and with the latest knowledge on measures for tackling stunting and wasting.

Motivating AWWs and other ICDS staff is another long-neglected area. It is my personal experience, right from my days in the field in Aurangabad Division in the early 2000s, that child nutrition outcomes ride on the back of the efforts of AWWs and Supervisors. Many of them have played a stellar role in reducing child malnutrition in their respective areas, displaying enthusiasm and initiative in developing innovations and dedicating themselves to the women and children in their care. Appreciating their efforts and, more importantly, delegating powers to them to spend money on day to day activities would go a long way in motivating them.

What needs to be given very serious thought is raising the honorarium paid to AWWs/AWHs and a policy to gradually convert their status to that of regular government employees. The recent decision of the Government of India to raise the honorarium of AWWs to ₹4,500 is grossly inadequate. AWWs, in my view and the views of many of my colleagues who work in this field, contribute as much, if not far more, to society than many other equivalent levels of government employees. Since the ICDS is a scheme that is here to stay, regularising the services of field workers is a step that is long overdue.

For a State like Karnataka, with about 65,000 AWWs/AWHs, providing a monthly honorarium/salary of ₹12,000 to AWWs and of ₹8,000 to AWHs would imply an annual outlay of about ₹1,560 crores. If this amount is shared equally between the State and Union governments, the State's share would amount to about ₹780 crores annually. Karnataka State today gives AWWs ₹8,500 per month and AWHs ₹4,250 per month. The State has to pay ₹5,800 as its 40 per cent share monthly per AWW and ₹2,900 per AWH, after the recent revision of AWW/AWH honorarium. The State government will spend about ₹670 crores in FY 2019-20 on honoraria for AWWs/AWHs in about 65,000 anganwadis.

The financial burden on a State like Karnataka would not increase greatly if monthly honoraria/salaries are hiked as mentioned above to ₹12,000 and ₹8,000, though the burden on states which pay less to AWWs/AWHs would increase considerably. Of course, the financial burden on the Government of India under a 50:50 sharing formula at the higher rates of honoraria/salary would go up from about ₹6,500 crores at present to ₹16,200 crores.

Whether this provision of additional financial resources is a small price to pay for the health and productivity of future generations is a question the mandarins in Delhi have to answer.

A 4-D approach has to form the policy basis for tackling child malnutrition. Real-time **Data** availability has to be the lynchpin of efforts, with such data being available at the level of each and every child in each and every anganwadi in the country. Using this data, action has to be undertaken at a **Disaggregated** level, starting from the sub-district level and drilling down to every village, hamlet and urban settlement. Policy **Design** has to focus on the primary factors that influence favourable outcomes for mother and child health and nutrition, ranging from food availability to proper healthcare, sanitation and shelter. These are all areas where the state has to play a major role and skilful budgeting targeted at high-burden areas can give the best results. Finally, public service **Delivery** mechanisms, not just in the ICDS but in all the sectors that play a part in improving health and nutrition outcomes, need to be made responsive and accountable.

IV. PARTING THOUGHTS

Having engaged closely with the political leadership and the bureaucracy in a large State like Maharashtra during my five years as head of the State Nutrition Mission, I feel there are some thoughts I must share on what, at the government level, would make for a successful effort to tackle the vexed problem of child malnutrition:

A. Championing the cause

The political and administrative leadership needs to have a clear vision on what it will take to significantly reduce child malnutrition. The scepticism expressed in an earlier section about focusing on parliamentary and assembly constituencies is no reflection on the commitment and dedication of many elected representatives. However, meaningful action requires a clear approach to the problem and a determination to achieve certain goals. Champions need to emerge at all levels – from the village and urban ward to the sub-district, district, State and national levels. In particular, champions are needed at the State level, among the political and administrative class, who will inspire and motivate field-level formations to give of their best. Unless there is sustained interest from the very top of government in the programme, accompanied by regular reviews and an insistence on bureaucratic accountability, encouraging results will not be forthcoming.

A word of caution is needed here on the temptation to entrust the task to a Nutrition Mission. Such efforts have been made in various States and now at the national level. But such missions tend to degenerate into mere administrative formations, with no real powers to bring convergence between departments, no direct approach to the highest policy-making levels and no ability to influence funding decisions. So, the Mission leader, whether drawn from the public or the private sector, should be appointed full-time for a tenure of, ideally, five years with the mandate to bring about change in the existing situation. The Mission should have a small, dedicated team of domain experts, as well as those experienced in dealing with government systems. Their primary role should be to build capacities and provide knowledge and skills rather than micromanage processes of departments.

B. A clear development focus

Though inexcusable, there may be easy excuses to trot out for child malnutrition in tribal areas – connectivity, poverty, illiteracy, inadequate employment opportunities. But there is no reason why districts and sub-districts located in areas with flowing rivers and fertile soil in the Gangetic plains of India's largest States should lead not just the country, but even the world, in the incidence of under-5 child stunting and underweight rates. The lack of a sound development policy, coupled with poor public service delivery mechanisms, are major contributory factors. Concentration on a few key development areas like education, especially for the girl child, healthcare and food security would go a long way in improving the status of women and children. The earlier point about champions applies here too: unless politicians and civil servants take up the implementation of development programmes sincerely, with sufficient funding, these areas of the country will remain mired in a development deficit.

C. Outcomes, not just inputs/outputs

A welcome step in the Government of India's POSHAN Abhiyaan campaign is the specific mention of outcomes. Care should be taken to see that this departure from "business as usual" practices does not degenerate over time into a concentration on inputs and outputs, a natural tendency of bureaucracies everywhere. One has to point here to the work done over the past four years under the Swachh Bharat Mission. Although there can be no doubt that toilet construction has greatly increased (output), there is still no reliable evidence to show whether this has led to a reduction in open defecation (outcome). The ICDS-CAS still has too many entries relating to process, which takes away the focus from nutrition outcomes. Nor is one very enthused by the publicity given to Aspirational Districts which are apparently doing great work. As a grizzled veteran of many government campaigns, my fear is that competition for achieving targets leads to sloppy planning and programme implementation and to misreporting of outcomes. While the NFHS-5 exercise is under process, a separate third-party assessment of outcomes in districts showing good results during 2019 would reassure data sceptics that good work is being done.

D. Reposing faith in the field-level machinery

Instead of indulging in the usual blame game where the lower level government machinery is concerned, the upper echelons of government should introspect on whether they have created the appropriate environment for a creative, proactive response to the problem of child malnutrition. This includes provision of skill and knowledge opportunities to field-level staff, encouraging local initiatives by them and appreciating good work, if possible, by incentivising innovation and performance. The author can vouch for the fact that such an approach works wonders even when monetary incentives are not offered.

E. Giving time for results

The need for patience in tackling a phenomenon like child malnutrition, which results from a variety of economic and social factors, requires to be underscored. Time frames for achieving objectives have to take into account gradual changes in behavioural patterns and evolution of responsive public service delivery systems. Failures have to be accepted and learnt from by making course corrections.

ANNEXURE-I
Some Key Factors and their Relation to Child Malnutrition

State	District	Stunting (%)*	Under-weight (%)*	Wasting (%)*	At least 4 ANCs (%)*	Women >10 years schooling (%)*	Female literacy rate (%)*	House-holds using improved sanitation facility (%)*	15-49 years women anaemia (%)*	ST (%)**	SC (%)**	Agricultural labour (%)**	Annual rainfall (mm)#
UP	Bahraich	65.1	44	13.7	4.3	16.2	33.8	12.9	52.7	0.3	14.6	41.9	1176
UP	Balrampur	62.8	43.5	10.3	10.8	12.9	36.8	13.8	55.8	1.2	12.9	43.2	903
UP	Gonda	56.9	38.6	9.8	13.5	20.6	46.1	11.1	54.4	0	15.5	36.9	921
UP	Shrawasti	63.5	39.2	10.1	8.3	9.3	32.7	10.4	48.7	0.5	16.9	40.9	1032
UP	Siddharth Nagar	57.9	43.5	13.7	14.8	18.3	47.1	14.9	56.6	0.5	16	45.1	928
TN	Kanniyakumari	17.2	12.8	9	81.5	73.9	95.4	85.6	44.6	0.4	4	10.7	1329
TN	Madurai	21.2	19.5	12.7	69.5	48.9	81.2	54.4	52.5	0.4	13.5	27.5	969
TN	Ramanathapuram	22.5	22.6	17	65.9	43.2	77.4	45.4	50.3	0.1	18.4	25.5	1077
TN	Sivaganga	20.9	22.7	18.8	86	50.2	82.3	47.6	54	0.1	17	32.2	1068
TN	Thoothukudi	21.2	17.6	12.4	64.8	46.8	79.9	50.4	59	0.3	19.9	26.8	799
KN	Koppal	55.8	49.9	26.4	60.5	28.1	56.2	48.9	45.6	11.8	18.6	41.7	677
MH	Nandurbar	47.6	55.4	39.8	52.5	24.8	46.1	23.6	60.2	69.3	2.9	55.3	1085

Sources: * - NFHS-4; ** - Census of India 2011; # - Indian Meteorological Department (2004-2010)

UP: Uttar Pradesh; TN: Tamil Nadu; KN: Karnataka; MH: Maharashtra

About the Author

Venkatesan Ramani, who topped his civil services batch in 1980, is a retired IAS officer of the Maharashtra cadre, with degrees in Economics and Law. He has served in various capacities in the Governments of India and Maharashtra between 1980 and 2010. He was the Director General of the Maharashtra State Nutrition Mission, which he helped set up in 2005. The Mission's work in child malnutrition reduction saw significant improvements in the nutrition status of under-2 children.

Post-retirement, he continues to work in this area with governments, international organisations, corporates and non-profits. He was selected as one of the 10 "Transform Nutrition Champions" worldwide for 2015 by Transform Nutrition, a transnational consortium of research organisations and nonprofits working in the areas of health and nutrition. His blogsite, The Gadfly Column (www.vramani.com) analyses current happenings in India and elsewhere.

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