Policy Brief

Ashoka University | ICPP Isaac Centre For Public Policy

By AMARJEET SINHA

20 May 2024

Kuposhan Mukta Bharat - Devolution, Human Capital, Incomes, Food Diversity Matters

India's performance with regard to stunting and under-weight children has been unsatisfactory. It has moved from a little above 50 percent to a little above thirty percent, between the first and the fifth National Family Health Survey (NFHS 1998-99 and 2019-2021). The national figures conceal an even higher incidence of undernutrition in a large number of resource-and-income-poor regions and districts of India. S.V. Subramaniam's analysis using NFHS-5 confirms a higher incidence of stunting and underweight among lower quintiles.

This is also confirmed by Niti Aayog's multi-dimensional poverty, and wealth indices – prepared based on NFHS-5 – which indicate a higher incidence of undernutrition in income poor regions/districts. The Monthly Consumption Expenditure data for 2022-23 also reflects higher challenges in States that are at the bottom of the table. While states like Odisha improved their performance in nutrition by ensuring the decentralized management of the Integrated Child Development Services (ICDS), their nutrition performance has slowed down in recent years. This may well be due to consumption expenditure not rising fast enough. Odisha also conceals huge inter-district variation in the incidence of undernutrition and female literacy, despite the strong presence of women's collectives under Mission Shakti and the social capital generated by them.

India's unsatisfactory performance at a time when free, assured food grains are being made available to eight hundred million persons has made a few commentators to question the nutrition standards determined by the World Health Organization (WHO). Food grain security alone is not equal to nutritional security as many nutrients, proteins, minerals, and vitamins are equally important. The

standards are aspirational, having been set after the 1997-2003 study, observing the growth standards of infants born in a few well-endowed households of South Delhi that suffered from no deficits! However, being aspirational does not make them unachievable. There are no genetic pool issues either, considering some other South Asian countries report better performance. Indian kids brought up without deficits also report outstanding nutritional standards.

The small, hilly state of Sikkim has reduced stunting by eight points between NFHS-4 (2015-16) and NFHS-5 (2019-2021). This affirms the fact that there is nothing wrong with the standards. Besides strengthening the ICDS system and developing locally-produced protein-rich food, Sikkim used the Mahatma Gandhi National Rural Employment Scheme (MGNREGS) to clean spring sheds, deliver piped clean water to every household, and promote the use of bio-fertilizers and bio-pesticides from the dairy sheds of farmers. Sikkim observed an increase in income due to cardamom plantations, convergent community-led action for a functional ICDS, Health Sub Centre and School, and the coming together of women's collectives and Gram Panchayats to enable decentralized community action for nutritional transformation. Sikkim reinforces the confidence that change is possible.

Bihar and Uttar Pradesh have also recorded a 5-point and 6.6-point decline in stunting between NFHS-4 and NFHS-5, respectively. The Jeevika movement in Bihar promoted dietary diversity across communities. Efforts were also made to align ICDS with Jeevika for a Kuposhan Mukt Bihar during this period. Independent evaluation confirms improvement in dietary diversity. Uttar Pradesh started by recognizing the challenge and incentivizing Anganwadi workers to report the true size of the nutrition problem. Thereafter, persistent efforts by women's collectives, universal availability of high-protein local food, convergence with Accredited Social Health Activists (ASHA) and Auxiliary Nurse Midwife (ANM) workers and the health system, governance improvements, and assured financial support, have led to the significant decline. This highlights the important role of women's collectives and decentralized, convergent community action in enabling nutritional transformation.

An analysis of the ICDS since its inception in 1975 brings out its 'project focus'. It was expected that 100 centre projects with Anganwadi workers, women supervisors, and child development project officers would co-ordinate and converge all nutrition initiatives. However, as the 2006 FOCUS study highlighted, this was not the case. Besides Tamil Nadu, which had near universal ICDS buildings with food and medicines even at that time, the performance of most other States has remained unsatisfactory. The thrust has remained on the food for children of ages 3-6 and some rudimentary pre-school education. The 0-3 age group, which faces the real challenge in nutrition, has not received the attention it deserves.

The FOCUS study also pointed out the importance of basic medicines in the village itself, considering that over fifty percent of the children surveyed had some minor ailments – fever, skin rashes, eye infection, diarrhoea/ dysentery – that needed neither a hospital nor a doctor. Such ailments simply required the availability of basic drugs with the Anganwadi/ ANM workers. This is important as unattended minor ailments lead to repeated bouts of illnesses, making the child wasted and eventually stunted.

Science tells us the importance of early and exclusive breastfeeding. While sincere efforts for this have been made in maternal and child

health, the non-adoption of the right technique for breastfeeding often leads to the infant not receiving the right quantum of milk and forces the mother to give it water instead. This defeats the purpose. Further, our inability to look after the nutritional needs of 10-12-year-old adolescent girls at the time of their maximum growth spurt also leads to the persistence of a very high percentage of underweight babies being born.

The life cycle approach needs flexible financing to set up day-care centres for infants, adolescent girls and pregnant and lactating women. The undivided Andhra Pradesh set up 4200 such community-managed Nutrition-Cum-Day-care Centres (NDCC) between 2007 and 2011. It was observed that the infant mortality rate of over 13,300 births by women who attended NDCCs in 2007-11 was 10 per 1000 live births compared to 49 for Andhra Pradesh as a whole. Further, maternal mortality was 0.34 per 100,000 births compared to 134 for the state. The NDCC villages reported higher performance in complete ante-natal check-ups, institutional deliveries, and a reduction in new born weighing less than 2.5 kg at birth. Complete immunization levels also reported improvement. The cost of NDCC was far more than what ICDS provided and had to be abandoned as the National Rural Health Mission only supported a pilot. Where incomes are low, day-care centres are a necessity.

The Southern Indian states display better indicators on nutrition, highlighting the role of women's collectives, adolescent girls' education, and the functional health care system. Other factors include better governance of ICDS, higher disposable incomes within households, and social opportunities to develop one's fullest human capital. Wages of dignity are important for nutrition as no amount of State-led welfare is a substitute for higher incomes and choice at the family/household level.

The National Rural Health Mission pushed the community activity of Village Health, Sanitation, Nutrition, and Health Days (VHSND). This thrust translated into an improvement in nutrition indicators. Community interface and oversight of nutrition initiatives are imperative as they do not follow departmental boundaries. If we want to make a difference, many sectors, especially health, have to be fully engaged simultaneously. Decentralization through Panchayats and Urban Local Bodies with funds, functions, and functionaries becomes imperative to make need-based choices and meet resource needs.

Everyone wants to use the word 'janbhagidari' without understanding the nuances of a community-led action. Every process has to be well defined and every performance measure has to be quantified and institutionally followed up for 'janbhagidari' to be effective. Otherwise, what passes as community action is often only a one-time gathering of people. Communities need attractive and periodic activities with a role in the monitoring of their children's progress. If more people in a village, including Panchayat leaders, women self-help groups (SHGs), and cooperative institution representatives can weigh and measure infants, timely interventions to tackle undernutrition are possible. Timely availability of basic medicines often reduces the incidence of wasting caused by seasonal illnesses drastically. It is time every infant and pregnant mother is monitored by a frontline worker or a community volunteer, and local governments have the responsibility and resources to seek redress for past deficits.

There is a very strong case for wider determinants of health priority, considering the impact of clean water on water-borne

diseases, sanitation on vector-borne diseases, improved housing, and safe cooking on the physical and environmental health of poor households. With a thrust on these sectors as part of the pro-poor public welfare and improving ease of living, it is a good time to make quantum gains in nutrition. These wider determinants have the potential to improve the ability of poor households to fight undernutrition. Much more work is needed on 'Waste to Wealth' initiatives and behavioural changes for hygiene and cleanliness.

While food grains contribute to food security, this does not alone address the challenge of chronic hunger and undernutrition. Infants in their growing age and pregnant women need a range of vitamins, minerals, and proteins that are not there in food grains alone. They need a balanced and diverse meal where fruits and green vegetables, milk, eggs, pulses, oil, and paneer, are all integral parts of the food. Diversity of food in adequate quantity and of appropriate quality is the way forward.

If we want to improve our position on the Global Hunger Index, we will have to address undernutrition as a societal mission where the women SHGs, the Panchayat leaders, the frontline workers, and the households, all have well-defined responsibilities. Every process needs to be measured and monitored with sufficient flexibility in the system for need-based interventions. Flexibility and mid-course changes at the cutting edge to respond to felt needs are a must in any system of public management. Same-size-fits-all is a recipe for disaster and flexibility calls for enormous public accountability. We need far more trained caregivers to manage nutrition centres and creches to enable mothers to work and develop their human capital.

We need to develop institutions of accountability through community monitoring and action, social audits, community-led planning, and implementation. The Gram Panchayat development planning process has to give primacy to nutrition as most of the 29 transferred sectors with Panchayats have a direct role in improving nutrition. Alongside community organizations like the Livelihood Mission, SHGs, and strong primary agricultural cooperative societies, Panchayats can play a pivotal role in transforming the nutrition of infants. Some very poor villages or hamlets may also need day-care centres and other support, and the programme has to be flexible enough to provide for need-based interventions at the local level.

Measurement holds the key as it will facilitate a focus on those who need immediate attention. There may even be a need for care and support at a facility if infants have already fallen into severe undernutrition. One has to be careful about the most optimal supplementary support, and there are very few (if any) substitutes for natural food diversity. It is for this reason that the efforts at local nutrition kitchen gardens, and fruits and vegetables being grown on school premises and other public lands, will create a societal impact on undernutrition. Food diversity and in appropriate quantities is critical for child survival. The Gadhchiroli experiment bears this out.

Undernutrition also leads us to appreciate the need for mature age of marriage and delivery, as underage mothers give birth to a larger number of under-weight infants. While the age of marriage has been increasing over the years, we still need to give the issue further importance. Social movements for women's rights and care during adolescence and pregnancy need a strong thrust. Gender relations also influence the state of nutrition – with more women in Panchayats and a large presence of women SHGs under the Livelihood Mission in rural areas, there is an opportunity to make a difference.

Flexible and well-funded interventions have to be tailored to the evidence available. Efforts to make use of monitoring data at the local level for immediate rectification ought to be the focus. Data in the Poshan tracker must be fed after community validation by Panchayats and women's collectives, to ensure social accountability. The support for immunization and health services and periodic health assessments by trained local community frontline workers is helpful. Guidance to parents is needed on a regular basis and the greater the interaction of the frontline worker with households, the greater the likelihood of timely interventions. Let us address the curse of undernutrition with the complete involvement of state, and local governments, civil society, community organizations, and all of society.

***Amarjeet Sinha is a retired civil servant. The views are personal.**

© 2023. All Rights Reserved.