Lifting the Curse: Overcoming Persistent Undernutrition in India

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Abstract With rapid economic growth and little progress in banishing undernutrition, India is an economic powerhouse and a nutritional weakling. This article surveys the others in this collection and concludes that such a situation represents a failure of governance at many levels. The article suggests a number of ways in which the state and civil society in India can strengthen the governance of nutrition in terms of capability, responsiveness and accountability. It also calls for more frequent data collection on nutrition service delivery and nutrition outcomes so that the state and civil society can sustain pressure on the need to improve nutrition. Finally, the outlines of a new research focus are described.

1 Introduction

India is home to one-third of the world's undernourished children. That is an alarming statistic for any country, especially for a G20 member, but it is the persistence of undernutrition in the face of India's economic growth that is truly extraordinary. In 1992–3, 52 per cent of infants under three years of age were underweight. In 2005–06, the corresponding figure was 46 per cent.[1] At that rate of decline, the MDG1 target will be attained in 2043 rather than 2015. Can India afford to wait the extra generation for nutrition status to improve?[2] Not if it wants the next generation to maximise survival, minimise brain damage, perform well in school and sustain India's rapid economic growth.

Growth has been very impressive in economic terms. The past 25 years have seen one of the greatest spurts of GDP *per capita* in modern history, one that has the admiration of the world. From 1980 to 2005 Indian real GDP per head grew at 3.95 per cent per year. In other words, in 1950 real *per capita* income in India was two-thirds of Kenya's, while today it stands at two and a half times the Kenyan level (Deaton and Drèze 2009). But the contradiction between economic growth and nutrition stagnation is striking. It is no wonder that in his August 2008 Independence Day speech, Prime Minister Manmohan Singh called undernutrition 'a curse that we must remove'.

'Economic powerhouse and nutritional weakling' – how does India move away from this Dr Jekyll and Mr Hyde existence? This is the focus of the authors in this *IDS Bulletin*, nearly all of whom are Indian or India-based. The Bulletin first reviews child nutrition in India: what is going up and what is going down, and for whom and where? As we will see while the direction of change is far from clear, movement is sluggish. We then ask why economic growth is not doing more to reduce undernutrition. We know that income and nutrition are not always tightly wedded, but are at least related. In India, they seem to be ships passing in the night. Why is this? The articles conclude that it is a rather toxic mix of incentives that prioritise the delivery of social inputs over outputs and practices that exclude large groups of individuals, including women and girls, from access to quality services. The delivery of nutritional services, involving behaviour change and coordination across sectors, suffers more than most from this misalignment of incentives, resulting in a mismatch of services and needs. On discrimination, the enduring legacy of the incidental and active exclusion of historically less favoured castes keeps the stock of undernutrition high. In other words, the governance of nutrition resources in India is highly problematic.

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Table 1 **The state of infant nutrition in India, 1992–2006**

Percentage of infants	National Family Health Survey Data (NCHS standards) Children under 3 years of age			National Nutrition Monitoring Bureau Data (NCHS standards) Children aged 1–5 years of age			
	1992–3	1998–9	2005–06	1988–90	1996–7	2000–01	2004–05
Underweight (weight for age below 2 standard deviation cut-off)	52	47	46	69	62	60	55
Stunting (height for age below 2 standard deviation cut-off)	n/a	46	38	65	58	49	52
Wasting (weight for height below 2 standard deviation cut-off)	n/a	16	19	20	19	23	15

Source Adapted from Deaton and Drèze (2009).

Next, we turn to existing interventions, focusing largely on the Integrated Child Development Scheme (ICDS), and review how they could be fundamentally changed to accelerate undernutrition reduction. These articles give some cause for optimism. Despite much evidence that ICDS is deeply flawed (see Gragnolati *et al.* 2006 for a good summary of its strengths and weaknesses), the articles cite examples of success within ICDS that have clear implications for the next-generation programme. Most of these examples and innovations revolve around: (1) focusing strongly on the infant 0–24 month age group; (2) matching services to needs (e.g. not being so exclusively food-focused); (3) moving away from centralised tracking of inputs to lower levels of accountability, including community monitoring; (4) improving outreach to traditionally excluded groups, and (5) investing in the quality of services as well as their coverage, with a special emphasis on the number, skills and incentives of ICDS workers. These articles also clearly highlight the constraints to making progress in reducing undernutrition. These include weak ability of civil society to demand improved services, weak incentives for ICDS to improve nutrition outcomes, few consequences of poor ICDS performance, and a weak ability to link ICDS services to improved outcomes due to the weak state of M&E, flawed impact evaluations and very patchy nutrition data.

Does the co-existence of these two personas – Jekyll and Hyde – reflect a failure of governance? The articles that follow would argue strongly that this is the case. A poor capacity to deliver the right services at the right time to the right populations, an inability to respond to citizens' needs and weak accountability at the local level are all features of weak nutrition governance. The articles also highlight many ways in which the governance of nutrition can be strengthened to rapidly make undernutrition history. Throughout the articles there is an additional cross-cutting message – the need for a new research emphasis on the politics and governance of nutrition.

2 Nutrition status at the all-India level

The data confirm that the very impressive wave of economic growth has crashed against the rock of undernutrition. International evidence shows that for every 3–4 per cent increase in *per capita* income, undernutrition rates as measured by low underweight rates should decline by 1 per cent (Haddad *et al.* 2003). For India, this relationship does not seem to hold. Income increases do not seem to move nutrition status significantly, even though they seem to translate through to declining poverty rates.

Table 1 indicates stasis, albeit wrapped in confusion. The National Family Health Survey data show that underweight rates (low weight for age) are stationary, stunting rates (low height for age) are declining quite fast, but with wasting rates (low weight for height) increasing. The National Nutrition Monitoring Bureau data indicate that underweight is declining slowly, stunting increasing and wasting decreasing. We cannot therefore say if undernutrition in India is

increasing or declining. What one can say is that the movements – in either direction – are not rapid. Given the rapid price increases of 2008 and the current global financial crisis, the nutrition situation is only likely to get worse. Addressing undernutrition now is the best way of denying the current global crisis an intergenerational legacy.

The Government of India (GoI) has committed to tackle this national 'curse'. There are plans to expand resources for the main platform for nutrition interventions, the ICDS. The political will is there at the most senior levels. We know which interventions are most cost-effective and we know the age windows in which it is most important to act. Is this cause for optimism? Resources do need to be increased – for example we know that one worker per ICDS centre is insufficient. Political interest at the top is needed to keep the issue near the top of a very crowded agenda. But does the allocation of more resources channelled through existing institutions and structures under existing incentives and governance models represent a case of throwing good money after bad? Many of the articles argue yes. Their case is bolstered by the rather weak inter-state correlations between ICDS coverage, ICDS expenditures and underweight rates (see Gragnolati *et al.* 2006), although while not conclusive, they do not suggest strong ICDS impacts on undernutrition.

The articles in this collection argue that additional resources must be accompanied by a complementary effort to strengthen governance, at all levels, to improve: (a) the capability to deliver services, (b) the responsiveness of the state to the needs of all its citizens and (c) accountability to those the interventions are intended to benefit. The articles identify a number of institutional and incentive roadblocks in the efforts to improve infant nutrition and make recommendations on how those blockages can be dissolved, sidestepped or overcome.

3 Why isn't economic growth doing more?

How credible is the assertion that governance matters for nutrition? What is the *prima facie* evidence that incentives and institutions for spending existing and additional resources matter if they are to actually have an impact on infant nutrition? One has to look no further than the inter-state variation in infant nutrition rates and spending on infant nutrition (Gillespie and Haddad 2003). Some states spend more per undernourished child and some achieve more in terms of reduction per unit of resource. In other words, there are choices to be made about resource levels and their deployment. These are both mediated by the governance of nutrition resources.

We know that different states have very different performances in terms of undernutrition reduction and this begs the question why? Harriss and Kohli's article in this collection sets the stage by presenting suggestive but inconclusive correlations at the state level between more rapid declines in undernutrition and (a) higher elasticity of growth for poverty reduction (capability), (b) better state service delivery (responsiveness) and (c) electoral balance of power (accountability). Econometric analysis of these kinds of variables is not possible due to data limitations. The Menon *et al.* article vividly indicates the different choices states make in terms of which nutrition gaps they tackle. From their data, it is difficult to see how the nature of the problem guides resource allocation at the state level, bolstering the 'good money after bad' argument. One also needs to look within states. Several articles document increasing welfare disparities within states, often along caste lines which, it is argued, exacerbate India's sclerotic nutrition performance (see Thorat and Sadana; Himaz, and de Haan *et al.*, this *IDS Bulletin*).

Walton, in this issue, argues that much of this sclerosis is due to the clash of two fundamental drivers: the nature of the social contract between the state and agents of social service delivery and the complex and demanding nature of nutrition-related public goods. He argues that there are two social contracts which result in political stability and wealth creation in India – between the state and business and between the state and social groups. Both of these contracts are underpinned by rent creation and capture by relatively small groups, to the detriment of broader social welfare. In the past ten years, the contract between the state and business has been reformed and has reduced the rent-based nature of it, generating substantial growth, especially at the upper reaches of the income distribution. But the contract between state and social groups – state patronage in return for political loyalty – has remained static; there have been laudable

shifts in spending and policy, but within the existing system. This results in effort levels within the state that focus more on rent preservation rather than on service delivery. Much public action on social issues is therefore poorly aligned with these political and administrative incentives. Nutrition action is especially poorly served because it involves a complex mix of public goods (a mix of behaviour change and more vertical health delivery); and fragile cross-departmental alliances between health, agriculture and women's ministries. While fully acknowledging the different circumstances, Walton describes examples of public policy reform from Mexico (on the conditional cash transfer issue) that could usefully influence the debates in India.

De Haan *et al.* in this *IDS Bulletin* tell us a tale of two states, Orissa and West Bengal, both poor, but each with different experiences. On the one hand, there is Orissa, seemingly impervious to external initiatives, with rapidly growing inequality which, as the authors imply, is going to be the main driver of change. On the other hand, West Bengal's leadership has embraced the idea of meaningful decentralisation of resources, responsibility and authority and initial impact assessment results from these suggest that things are improving in terms of nutrition outputs and outcomes.

A counter view of Orissa follows and is provided by Saxena and Srivastava. Using NFHS data, they point out that Orissa's average underweight rates have improved the most in terms of reductions in percentage points between NFHS-2 (1998–9) and NFHS-3 (2005–06). Has this improvement in the average state of nutrition been at the expense of marginalised groups? We need more disaggregated nutrition data to answer that question. We know from Sharma *et al.* that low castes – Scheduled Tribes (ST) and Scheduled Castes (CT) – in Orissa have higher stunting and wasting than the state average, but we do not know if these rates have declined as much as for all Orissa. As Sharma *et al.* note in this issue, Orissa is culturally diverse with 93 castes, 62 tribes and 3–4 main religious groups. It is too much to expect ICDS alone to converge nutrition status across these divides – other more fundamental political determinants of undernutrition also need to address these differences.

Thorat and Sadana's article confirms the negative correlations of low caste and nutrition and health: child mortality, morbidity and nutrition are all worse for these groups by 50–100 per cent compared with the more favoured castes. Differences are maintained even when controlling for education and welfare levels. Access to general health services is also worse. Conversely, the use of ICDS centres (*Anganwadi* Centres or AWCs) is higher and this may simply represent an exclusion from better quality services. Thorat and Sadana call for ICDS to undertake a number of measures to reach out to the lower caste children, including locating more AWCs where these children live, giving greater control to these castes in the running of community health schemes, and generating greater incentives for all to serve the lower caste groups. However, as with Sharma *et al.*, Thorat and Sadana also note that the perceptions and beliefs that fuel inequalities run deep in culture and will require more than a child development programme – no matter how big – to address them.

Himaz's preliminary econometric results from longitudinal data in Andhra Pradesh confirm the negative associations of caste and nutrition. She demonstrates the persistence of nutrition by tracking children from birth to school age. Her results on the caste variables in her equations suggest that the hurtful power of exclusion is not easily shaken as childhood progresses. Being from a scheduled caste or a backward tribe substantially increases the probability of a child being stunted – and persistently so. The only other variables to have this effect were lack of mother's education and height both reflecting discrimination from a generation past.

4 How to strengthen existing interventions?

The articles in this *IDS Bulletin*, by Ved and by Saxena and Srivastava focus on the design of ICDS. They show that India-wide, only 33 per cent of children under six living in an area served by an AWC utilise a centre; only 20 per cent of eligible children have received even one immunisation and only 12 per cent of mothers received a healthcare check up during pregnancy.

The design flaws they identify include: (1) an insufficient focus on children under two – the critical window to address because development losses here are irreversible; (2) an overemphasis

on food as a determinant of nutrition status to the exclusion of care behaviours, sanitation and health; (3) the complexity of the ICDS leading to heavy coordination and management demands and services often simplified by convenience – not by need and impact; (4) location of AWCs in ways that exclude the most marginal and vulnerable with little outreach capacity to compensate; (5) the need to improve AWC staffing up to two workers per site; (6) the need to improve the support to AWCs in terms of training, ICT, and mentoring of AWC workers (Menon *et al.*); (7) the need to improve the capacity of the Ministry of Women and Child Development to monitor non-ICDS inputs needed to combat undernutrition and; crucially (8) a need to move to nutrition outcome reporting, building in more credible impact designs as part of doing business, including community feedback for a complete service, learning and accountability package.

There is consensus on these issues from the articles that assess ICDS in this *IDS Bulletin*. Some of these improvements are planned for the next phase of ICDS (e.g. the two *Anganwadi* worker norm, a greater focus on the youngest infants, and greater access for marginalised groups). But these plans for 'universalisation with quality' cannot rely on mere multiplication. Using a scaling-up management model, Ved emphasises that the skills needed to develop an effective pilot are not the same as the skills for effective scale-up. Past and current scaling-up of ICDS (at present there are approximately 940,000 AWCs with a target of 1.4 million) have faltered because of (a) the demanding nature of delivering the intervention (high behaviour change content, many interventions and age groups, need to adapt to very different economic and cultural settings) and (b) the failure to involve and think through the role of the institutions intended to deliver effective pilots at scale (e.g. an inability of ICDS to converge with health departments – there is no cadre of staff assigned to this, unlike in the successful pilots). To sum up, Ved notes, 'It appears that in scaling-up the interventions, in principle fidelity to the model was considered more important than the capacity of the implementing organisations to deliver outcomes'.

Many of the articles argue that this weak average performance of ICDS to date reflects the supply-side incentives that Walton describes, but also the weak demand-side accountability of service delivery to those they are intended to benefit. Menon *et al.* describe some of the above supply and demand incentives for Bihar and Karnataka, giving us some insight as to how coverage of ten major inputs to overcome child undernutrition can fall so far short of the goal of universalisation.

Ved and Saxena and Srivastava describe how the supply side can be strengthened. This requires data to make the choices about how to allocate scarce resources that have alternative uses. Adhikari and Bredenkamp later describe some of the data and analyses needed to improve the supply side of ICDS in real time and to assess its impacts. They note that significant amounts of data are already collected on ICDS functioning, but they often focus on inputs, not outcomes such as appropriate infant care and feeding behaviours (nutrition status data are useful, but attribution is difficult and hence should be collected judiciously). When data are collected they are not fed back to field workers and administrators at the sub-State Block and District levels. Moreover, data are often processed by those with limited technical capability, monitoring needs to converge across sectors (the Ministry of Women and Community Development cannot monitor all nutrition relevant data), and we need to be careful about collecting too much data (a temptation when ICDS has six interventions and four age groups).

Sharma *et al.* attribute much of the decline in undernutrition in Orissa to innovations in ICDS service delivery. ICDS functioning may well have improved with these innovations, but it is impossible to say how much this contributed to undernutrition reduction without constructing some counterfactual scenario (i.e. what would have happened without improved ICDS functioning). Many of the innovations they cite are ICDS-specific (capacity building of AWWs, AWW reward systems, community-based nutrition analyses, and citizen charters to help close the gap between ICDS policies and implementation) at the project level. But the authors also cite the importance of institutional innovations that promote intersectoral convergence with the Department of Health on immunisations, treatment of diarrhoea, deworming and referrals.

Kumar *et al.* describe a USAID funded programme, IHNP-II operating on an ICDS platform, operationalised by CARE. Using an 'innovate-demonstrate-advocate-replicate' approach they aimed to tackle exclusion, including caste-based, through enhanced outreach methods such as tracking those left out of ICDS, prioritising home visits, and selecting volunteer change agents in each hamlet to promote system responsiveness and convergence across different delivery agents. The authors suggest these innovations worked, although again, in the absence of a control group it is impossible to be conclusive. If effective, the authors are optimistic that the innovations are scalable because what works for the excluded should work for all. But as Ved notes, the level of complexity and whether or not the innovations can be embedded in existing institutional capacities and incentives are key determinants of scalability.

On the demand side, Swain and Sen describe recent efforts to generate feedback loops from citizens to local government through social audits in Andhra Pradesh (AP) and Orissa. Social audits are processes whereby the state and civil society work together to monitor and evaluate the planning and implementation of a programme. They require a partnership between the two. In Orissa, the social audit was led by a CSO without the cooperation of local government. Many ICDS deficiencies were identified, but it is not clear whether any improvements were made. In AP, local government was involved and service uptake and community participation in ICDS have improved, although no effort to estimate the impact on nutrition has yet been made. The authors speculate on whether another state, Madhya Pradesh, is ready for social audits and conclude that not enough of the preconditions are in place: a readiness for a shift in the balance of power, a culture of social audit in government programmes, strong civil society capacity, the culture of public debate and commitments to long term grassroots capacity building. As with so many issues analysed in this *IDS Bulletin*, the main innovations are absent in the areas that can least afford them to be.

5 Addressing the governance gap

It is perhaps no coincidence that India, the country with 34 per cent of the world's undernourished infants (*Lancet* 2008) has produced some of the world leaders in thinking about undernutrition. MS Swaminathan, is one of those. The article outlines a domestic leadership agenda for action on undernutrition. The article notes the leadership demonstrated by India in so many areas and urges new leadership to 'make child undernutrition history'. The ten interventions and ten priority approaches outlined are indeed urgently needed. Despite being developed in a consultative participatory process, will they influence the central and state politicians? Will they be implemented as conceived by health workers? The articles here would argue only if the governance gap is recognised and tackled head on.

Biswas and Verma go on to deliver a compelling agenda for action on governance. Using a conventional but useful governance model, the capability-responsiveness-accountability model also used by Harriss and Kohli, they outline changes needed to strengthen governance in addressing undernutrition. On capacity, they urge the GoI to continue to spend political capital on the issue and find ways to work across Departments with the National Council on India's Nutrition Challenges as a potential coordinating mechanism that needs to be replicated at several levels. On responsiveness, continue responding to the Comptroller and Auditor General reports on ICDS as standard. On accountability, stronger systems from below need to be built for demanding rights and holding *panchayats*, self-help groups (SHGs) and *anganwadis* accountable, recognising that capacity development is also needed for those duty bearers so they can better deliver on their obligations.

Many of these critiques and suggestions also apply to external partners. Improved nutrition is in everyone's interest but few international agencies have taken responsibility up to now. There are signs that this may be changing. DFID, for example has recently increased their commitment to nutrition. Their renewed focus reflects many factors – the food price crisis, a critical report from a UK government oversight committee, and several pieces of analysis that were critical of their previous efforts. As Amery and Philpott note, DFID have responded to these critiques with new energy and a new nutrition strategy. Their co-funding of this collection of articles is one sign of renewed interest. DFID's comparative advantage is not in funding more direct interventions (those

directly aiming to improve nutrition) but in making indirect interventions in the areas of agriculture, social protection and health more nutrition-friendly – and that requires a nutrition strategy. DFID is also a leader on governance, and this as we have seen is a core gap for nutrition – both at the national and international levels. Finally, drawing on historical experiences from the UK and contemporary experience from the HIV/AIDS field, the Amery and Philpott article points out that international advocacy for undernutrition will only grow if elites in rich and poor countries alike can connect with the issue, much in the same way they connected with HIV/AIDS. One precondition for this is a coming together of the international community to agree on vision, messages, and roles, including fundraising. DFID is vastly experienced in facilitating the development of such coalitions and I hope this is a role they would see themselves playing in the future.

6 Conclusion and key messages from this *IDS Bulletin*

So, what are the key messages coming out of this *IDS Bulletin*?

First, India is the world's Jekyll and Hyde: an economic powerhouse and a nutritional weakling. At current rates of progress, the MDG1 target for nutrition will only be reached in 2043. This will have severe consequences for human wellbeing and economic growth.

Second, more resources and leadership from the top will help, but the missing link is improved governance of nutrition at the community, local, state, national and international levels. Indeed the weak link between growth and nutrition is the very definition of weak nutrition governance.

Third, a number of recommendations emerge on where and how to strengthen governance. In general terms, these would be, to:

- open up space for public debate on social policy alternatives to ICDS (e.g. conditional cash transfers)
- improve cross-Departmental working at state and national levels to coordinate multiple nutrition inputs and outcome monitoring
- allow the Comptroller and Auditor General Reports to set operational standards and audit performance in nutrition
- strengthen efforts to promote the status of women through improved education and greater representation in local government – their ability to make decisions about fertility, healthcare and their own time allocation is vital to their own health and to the health of the 0–24-month-old group
- generate and make available more data on nutrition status – this is the lifeblood of change agents in the media, civil society and government. We do not need more mega surveys like the NFHS, but more frequent and slimmer surveys. Annually streamlined comparable data will support debate on policy formation and performance and sustain pressure on the need to improve performance.

Regarding ICDS:

- make community monitoring of ICDS – in partnership with local government – the norm
- support civil society to find ways to claim spaces to ensure previously excluded groups are involved in nutrition budgeting, ICDS operation and evaluation
- focus on tracking ICDS outputs and outcomes, not only inputs – this is especially important for the under twos and the interventions most vital to them
- ICDS should engage women from excluded SC/ST communities in actively participating in the running and using of ICDS services
- plan for and resource the scale-up of an ICDS that can adapt to different governance realities
- use a more transparent rationale for the distribution of new health and ICDS centres to serve communities where they are most needed and where nutrition indicators are worst
- ICDS desperately needs decent impact evaluations in nutrition. Before and after surveys without control groups will not do. We are groping in the dark without them.

These are not technical suggestions, but are recommendations on the operational processes and institutions that should form the basis of future resource allocation in nutrition.

Finally, we need a new type of research programme around nutrition governance. It would use disciplines that are sensitive to power, voice and accountability with quantitative and

qualitative methods to identify and learn whether innovations in institutional and governance arrangements can improve the capacity, responsiveness and accountability of the state and civil society to generate improved nutrition outcomes.

The existence of so many stunted and wasted children amid a sea of rapid economic growth defies casual observation and must seem like a curse. But as this collection of articles has shown, there is no shortage of ideas from within India about what to do to lift that curse – many of them relate to strengthening governance. In building on some of these ideas and by lifting the curse, the Indian government will raise the stature of its children. It will also raise its own standing in the world.

Notes

* I would like to thank Sushila Zeitlyn for helpful comments on an earlier version of this article. All errors in this current version are mine.

1 National Family Health Survey Data (see Table 1 in this article).

2 See Figure 1 in Swaminathan in this *IDS Bulletin* for a graphic representation of how undernutrition happens early in life In India.

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