



Policies Without Politics: Analysing Nutrition Governance in India

Analysing Nutrition Governance: India Country Report

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Abbreviations

AHS	Annual Health Survey
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BPL	Below Poverty Line
FPS	Fair Price Shop
ICDS	Integrated Child Development Scheme
IGMSY	Indira Gandhi Matritva Sahyog Yojana
JSY	Janani Suraksha Yojna
NAC	National Advisory Council
NNP	National Nutrition Policy
NPAN	National Plan of Action on Nutrition
NREGA	Mahatma Gandhi National Rural Employment Guarantee Act
NRHM	National Rural Health Mission
PDS	Public Distribution System
PRI	<i>Panchayati Raj</i> Institutions
PUCL	People's Union for Civil Liberties
SC	Supreme Court
TPDS	Targeted Public Distribution System
VHND	Village Health Nutrition Day
VHSC	Village Health and Sanitation Committee

I. Introduction

The paradox of growth in India stems from the fact that while ‘India is prospering, Indians are not’ (Aiyar 2010a). India’s growth miracle has not yet translated into social development. Despite a high GDP growth rate of over 9 per cent annually,² India has one of the highest incidences of child malnutrition in the world. 45 per cent of its children under the age of 3 are stunted, 23 per cent are wasted and 40 per cent are underweight (IIPS 2007a).³ The proportion of underweight and stunted children rises to almost half (43 per cent and 48 per cent respectively)⁴ if those under the age of 5 are considered (UNICEF 2009a). This puts India at the very top of a country-wise ranking of stunting rates, and makes it home to 31 per cent of the world’s children under-5 that have stunting (about 61 million children in all)⁵ and 37 per cent of the world’s total underweight children (UNICEF 2009a & 2011).

Over the 7-year period between 1998-99 and 2005-06 India reduced its stunting rates in the population of children under 3 years of age by 6.1 per cent. The reduction in underweight figures was less impressive, at only 2.3 per cent, while the rate of wasting actually increased by 3.2 per cent (see Table 1) (IIPS 2007a). Though it has had some success in reducing stunting rates, it is obvious that India has a long way to go in terms of its fight against child malnutrition. Its 6.1 per cent decrease in stunting rates of children under 3 years of age over seven years amounts to a less than 1 per cent decrease per year. At this rate India will need another half century to ensure that none of its children are malnourished. In fact, even to meet its Millennium Development Goal 1 target of reducing the proportion of underweight children under the age of 5 to 27 per cent by 2015, India needs to double its annual rate of reduction from the current 0.87 percentage points to at least 1.6 per cent.

Malnutrition in India is a complex issue. The country grows sufficient food, has a functional democratic system with effective feedback mechanisms, the world’s largest public distribution system in place for food delivery and an extensive network of state mechanisms to reach every citizen in the country. Enough policy attention has also been paid to health and nutrition issues in recent years for it to have been classified as having ‘strong’ Nutrition Governance (with the maximum score of 11) by the WHO’s Landscape Analysis study (WHO 2009). Yet, its malnutrition rates remain high.

This report seeks to understand this puzzle — why despite many of the right ingredients has India not had greater success with reducing the malnutrition of its children? It does so by analysing India’s recent policy experience with reducing rates of child malnutrition. It uses a series of interviews conducted in New Delhi in August 2011 to identify the main factors credited with the improvement in nutrition levels, and to understand the challenges

² World Development Indicators, World Bank.

³ National Family Health Survey 2005-06 (NFHS-3) data.

⁴ WHO Child Growth Standards

⁵ The extent of this stunting burden can be judged from the fact that the country that ranks second, China, has only 6.1 per cent of the world’s children under 5 with stunting (12.5 million).

that remain.⁶ In order to nuance the country study and to capture part of India's complexity, a short case study of Orissa — based on additional interviews conducted in the state capital Bhubaneswar — is included to understand the state's remarkable 10 point decrease in underweight figures between 1998-99 and 2005-06.

The study takes a political economy approach to unravelling the identified puzzle. It seeks to take forward a governance-focused discussion of malnutrition in India initiated in an issue of the IDS Bulletin, titled *Lifting the Curse: Overcoming Persistent Undernutrition in India* (2009, Vol 40.4), that considered in particular the role of state capability, responsiveness and accountability in improving nutrition outcomes. In this study we expand this discussion through a particular focus on actors and institutions, and analyse in particular the impact of specified governance factors on improved nutrition outcomes, which include: well-designed, multidimensional social policies that are well aligned with the incentives of political actors, and strategies that are supported by multiple stakeholders both within and outside the government, and that are coordinated in the implementation of malnutrition policies and programmes. The report looks at three main dimensions of nutrition governance: inter-sectoral coordination on the part of government, donors and other non-state actors; vertical coordination within the country's nutrition policy and implementation systems; and the modes of funding that are available for the implementation of nutrition policy and programmes. It also looks at how monitoring and data systems may support or undermine these forms of coordination and organisation.

In doing so this study moves beyond sociological explanations of malnutrition, such as caste and gender, and a discussion of more health specific interventions and recommendations. It does so both because these are well-documented elsewhere (Gragnotati *et al.* 2005, Narayan 2006, Biswas & Verma 2009, Ved 2009, Paul *et al.* 2011, amongst others), and because it seeks to focus on governance-related explanations and interventions that focus on the role that policy, actors and institutions can play despite the continuing presence of caste and gender-based discrimination.⁷ This approach leads the study to conclude that child malnutrition in India remains high because of a lack of cross-sectoral collaboration between the different institutions that deal with this issue, a lack a strong national agenda against malnutrition that emanates from within the highest executive offices of the state, and a lack of consistent monitoring of the situation based on reliable data. Instead, India has dealt with the issue through a bureaucratic approach with few incentives for state officials to go beyond their prescribed functions. State action has expanded in recent years as a response to judicial and civil society activism, but malnutrition has not yet become a political or electoral issue, the legislature's involvement is missing, and it has only very recently garnered executive interest from the office of the Prime Minister.

This country report proceeds as follows: Section 2 considers issues of data and monitoring, Section 3 identifies the main factors that have contributed to India's recent success with reducing malnutrition rates. Sections 4, 5 and 6 analyse why nutrition rates have not come down further or faster, and divide the explanations between; (a) a lack of horizontal

⁶ The analysis presented in this study relies heavily on perspectives and material collected through the primary fieldwork conducted in India in Aug 2011 in the form of interviews with multiple stakeholders across various sectors (see Annex 4 for a list of interviews). It does not attempt a literature review of existing material but adds value to these through a synthesis of current perspectives on the political economy of nutrition governance in India.

⁷ A discussion of these is, however, briefly included in the last section on policy interventions.

coordination, (b) siloed, bureaucratic vertical articulation, and (c) inadequate financial outlays. Section 7 presents a case study of Orissa, a state that has demonstrated important improvements to reduce the incidence of malnutrition. Section 8 considers the challenges that remain and identifies key entry points for policy interventions.

II. State of Malnutrition in India: Rates and Data

a) Malnutrition according to the National Family Health Survey

There are two main sources of data for nutrition figures in India. The first, widely used and considered credible, is the data from the National Family Health Survey that is collected periodically by the International Institute for Population Sciences (IIPS), designated for the purpose by the Ministry of Health and Family Welfare. This is a large-scale, household level sample survey conducted all over India that provides information on the main outcome indicators of malnutrition — underweight, stunting and wasting, along with a host of other health indicators. Three rounds of data have been collected so far — NFHS-1 in 1992-93, NFHS-2 in 1998-99 and NFHS-3 in 2005-06. The figures used in this report for the current state of malnutrition in India, and changes in these, are based on this data (Table 1). NFHS has been influential in garnering attention for malnutrition from policy-makers but according to recent reports it may be discontinued and replaced with the Annual Health Survey (AHS), a more regular but limited data collection effort that is, at present, implemented in only a few states. More importantly, as of yet, it lacks indicators on malnutrition.

Table 1: Reduction in malnutrition rates for children <3 in India

	NFHS-1	NFHS-2	NFHS-3
	1992-93	1998-99	2005-06
Stunted %	na	51	44.9
Wasted %	na	19.7	22.9
Underweight %	51.7	42.7	40.4

Source: NFHS-3 (IIPS 2007a)

The extent of malnutrition varies greatly across India's 28 states and 7 union territories. For example, stunting rates vary from 26.5 per cent in Kerala to twice that much in Chattisgarh, at 52.6 per cent. There is less variation in wasting rates while underweight figures also vary greatly from 21.2 per cent in Kerala to 57.9 per cent in Madhya Pradesh (IIPS 2007b).

Similarly, the performance of the states in reducing rates of malnutrition has also been variable. While stunting has gone down by only 1.5 per cent between NFHS-2 and NFHS-3 in Kerala, it has reduced by an impressive 10.5 per cent in Punjab, and 8.2 and 8.6 per cent in Chhattisgarh and Madhya Pradesh respectively (IIPS 2007b). The average figures for India, therefore, conceal a lot of regional variation, and while some states have managed to do very little in terms of reducing malnutrition, others have contributed majorly to reducing the overall figures for the country (see Figure 1 in Annex 2).

b) Malnutrition according to ICDS data

The second, used only by some state departments and considered unreliable by many respondents, is collected through India's flagship programme for dealing with child malnutrition — the Integrated Child Development Services (ICDS) scheme of the Ministry of Women and Child Development.⁸ This collects data mostly on state inputs into the ICDS scheme and its functions, one of which is the regular monitoring of the weight of children under the age of 6. It, therefore, provides underweight figures only, categorised by grades of malnourishment as moderate (Grade I and II) and severe (Grade III and IV).

A number of respondents pointed out that ICDS data under-reports the proportion of children in India that are severely malnourished. This is borne out by a comparison between comparable figures provided by ICDS and UNICEF in 2009 (Table 2).⁹ While ICDS data provides a significantly higher figure for moderately malnourished children (45 per cent, of which 32 per cent are classified as only mildly malnourished), it classifies only 0.40 per cent of all children under 6 as severely malnourished (MoWCD 2009).¹⁰ UNICEF (2009a), on the other hand, puts 16 per cent of children under 5 in this category.

Table 2: Proportion of underweight children¹¹ reported by UNICEF and ICDS in 2009

	UNICEF*	ICDS
Moderate malnutrition	27%	45.47%
Severe malnutrition	16%	0.40%
Total	43%	45.87%

Source: UNICEF 2009a & MoWCD 2009.

*WHO Child Growth Standards

Though ICDS data is little used, respondents pointed out that it has affected political debate, as well as the perspectives of some politicians and state governments who use it to insist that India no longer has a serious issue of malnutrition. This was also pointed out to me by a politician who refused to be interviewed on an issue that he did not believe exists. A key respondent connected to the Planning Commission of India asked, 'how can you make policy to deal with something you don't recognise?'

There are a number of reasons for the lack of credible data collected by the ICDS scheme. Foremost amongst these is the fact that reliable data collection is not incentivised in any way — it earns an over-worked ICDS worker, called an Anganwadi worker (AWW), little extra by way of funds for reporting higher rates of malnourishment in her village. Instead, there seems to be some pressure to maintain 'correct data' that reflects a steady decrease in malnutrition rates. A respondent that monitors the situation pointed out that even in a centre that has no working scale for weighing children, records of weight and progress are

⁸ See Annex 1 for details.

⁹ NFHS data does not disaggregate underweight figures by similar categories of severity, and so is harder to compare.

¹⁰ See Table 1 in Annex 2 for state-wise variation in rates of malnutrition according to ICDS data.

¹¹ Under 5 years of age for UNICEF (2009) and under 6 years of age for ICDS (MoWCD 2009).

still maintained for bureaucratic purposes and diligently passed upwards within the ministry. Furthermore, '...few AWWs are aware of the purpose and utility of data collection and, instead, view their data collection tasks as routine, boring and burdensome' (Gragnolati *et al.* 2005). Reporting the real incidence of malnutrition is, in fact, referred to as a 'high risk, low reward' activity.¹²

III. Factors Leading to Reduction in Malnutrition Rates

The government of India has paid policy attention to the issue of malnutrition over the last two decades. Nevertheless, the main contributors to India's limited success in reducing malnutrition are the state response to judicial and civil society activism, combined with electoral dynamics and the indirect impact of related government policies on corruption and economic growth.

a) Government policy

Policy, Plan and Mission

Nutrition came to the policy forefront in India in the mid 1990s, with the 1993 National Nutrition Policy (NNP) and the 1995 National Plan of Action on Nutrition (NPAN). However, according to most respondents, these interventions had minimal impact in terms of reducing India's rates of malnutrition. In September 2003 the Prime Minister set up the National Nutrition Mission aimed specifically at increasing effective coordination between the various nutrition related interventions of different ministries. The Mission created national-level leadership for the issue and included the Chief Ministers of states (by rotation), federal ministers, along with academics, NGOs and technical experts. The Mission launched a pilot project in 51 'nutritionally deficient districts' to distribute food grains¹³ free of charge through the Targeted Public Distribution System (TPDS) to adolescent girls and pregnant/lactating women in the Below Poverty Line (BPL) category. In 2008 the Prime Minister's National Council on India's Nutrition Challenges was constituted, but this met only recently in November 2010, when it focused on reforming the ICDS, and recommended strong institutional and programmatic convergence at the state, district, block and village level for dealing with 200 'high burden malnutrition districts' (NAC 2011).

National Advisory Council

In 2004 the National Advisory Council (NAC) was created within the Prime Minister's office to provide an interface with civil society. Though not a nutrition specific body, it has a general mandate of working on social policy and the rights of poorer, disadvantaged groups, and provides policy and legislative inputs to the government. After a period of inactivity it was re-instituted in March 2010, and now has special working groups on Food Security and ICDS reforms.

¹² Interview with a member of the National Advisory Council.

¹³ Mainly wheat and rice.

b) Judicial and civil society activism

Judicial Activism and the expansion of the ICDS scheme

In 2001 a Public Interest Litigation was lodged with the Supreme Court by a civil society group called the People's Union for Civil Liberties (PUCL). The verdict of the case¹⁴ is still awaited but in the interim the Supreme Court passed a number of orders that contributed directly to improvements in rates of malnutrition. The leading amongst these came in 2001 when the SC ordered the universalisation of the ICDS. The order called for 1.4 million Anganwadi centres¹⁵ (AWC) to be established in all, each covering about 1,000 people. There were about 600,000 Anganwadi centres in India in 2004 when the implementation of the order started in earnest. By 2010 there were over 1.2 million AWCs, with another 125,000 sanctioned. It is estimated that 81 per cent of under-6 children are now covered by a centre.¹⁶ The order provided legal entitlements to government interventions on malnutrition. For example, a December 2006 court order states that 'Rural communities and slum dwellers should be entitled to an 'Anganwadi on demand' not later than three months from the date of demand in cases where a settlement has at least 40 children under six but no Anganwadi'.¹⁷

Another interim order set up the Commissioners of the Supreme Court in 2002. These Commissioners were mandated to investigate violations of the interim orders, to monitor and report on their implementation status within each state, and to respond to hunger-related emergencies. Their constant vigilance and their role in raising issues before the courts for action got one respondent from a civil society organisation to remark, 'the Supreme Court has been in a running battle with state governments. If it weren't for the Supreme Court, nothing would be happening here on malnutrition'.

Civil Society Activism and the Right to Food Campaign

The Right to Food Campaign grew out of the PUCL case, and has been instrumental in putting malnutrition on the policy agenda and highlighting it regularly through the media. The Campaign is a network of various non-state organisations that functions as an advocacy lobby on issues of child malnutrition, and is focused in particular on calling for the expansion and universalisation of the Targeted Public Distribution System (TPDS).¹⁸ It works closely with the National Advisory Council and the Commissioners of the Supreme Court. A parallel group, the *Jan Swasthya Abhiyan* — the Indian chapter of the worldwide People's Health Movement and a coalition of over 100 health-related networks and organisations — has worked with the state since 1999 and was instrumental in affecting a

¹⁴ PUCL vs. Union of India and Others, Writ Petition (Civil) 196 of 2001.

¹⁵ Community centres that are the main vehicle of the ICDS.

¹⁶ Kandpal (2011) establishes a positive impact of having access to an ICDS centre on reduction of malnutrition, providing a connection between this expansion and the reduction in stunting and underweight rates captured by the NFHS-3 data.

¹⁷ Right to Food website.

¹⁸ The PDS operated as a universalized programme until 1992 and was available to everyone. This was replaced first by the Revamped PDS (RPDS) in 1992 in 1775 blocks – that were drought prone, tribal, hilly or remote – and then by the Targeted PDS (TPDS) in 1997 that is currently operational and specifically targets the BPL population all over the country (Saxena 2008).

change in state discourse on health and malnutrition. In fact, it was closely involved in the design phase of the National Rural Health Mission¹⁹ (NRHM) and now monitors its work. These active coalitions of civil society organisations meant, in the words of a senior member, that ‘when the state was finally listening [after the UPA victory in 2004],²⁰ we were ready with a tangible plan and proposals’ and were thus able to affect change.

The combination of judicial activism, the Commissioners, the Campaign and media attention has proved to be particularly potent in some cases. For example, when the media reported the deaths of 13 children from hunger in a village in Madhya Pradesh, the Campaign referred the issue to the Commissioners of the Supreme Court, who led an enquiry that established negligence by the state government and a lack of provision through the ICDS scheme. An interim application was also submitted by the Campaign to the Supreme Court. Soon after, an AWC was set up, an Auxiliary Nurse Midwife²¹ (ANM) appointed and TPDS food supplies initiated (CIRCUS 2006). Together, media and civil society have also ensured that politicians, including the Chief Ministers of many states, now champion the cause. Madhya Pradesh's poor rating on IFPRI's Hunger Index (Menon *et al.* 2009) was highlighted by activists through the media to the extent that it became a political embarrassment for the state government. The Chief Minister has since personally taken an active interest in increasing nutrition-related interventions. Furthermore, the Citizen Alliance against Malnutrition, which includes young parliamentarians, journalists, movie actors and directors, musicians, and activists, and is closely linked with UNICEF, has publicised the issue with an aim to increase both awareness and pressure for more effective state interventions, and has received media attention due to the involvement of politicians and celebrities. It recently commissioned and released the highly-publicised HUNGaMA (Hunger and Malnutrition) report that was formally launched in January 2012 by the Prime Minister himself, and helped land the issue centre-stage.

c) Impact of related government policy

Electoral dynamics

In the May 2004 general election the Bharatiya Janata Party (BJP) was ousted from power after running with an ‘India Shining’ manifesto aimed at the middle class that focused on the government’s liberalisation reforms and an increasing economic growth rate. According to some respondents, the fact that the vast majority of India's electorate had been left unimpressed with these reforms signalled to the victorious Indian National Congress (INC) Party that it had to bring the focus back to social reforms and a greater concentration on the poor. This was further emphasised through its partnering with the parties of the Left Front in the United Progressive Alliance (UPA) coalition. Soon after the election the UPA government instituted a number of progressive reforms — the universalisation of the ICDS (2004), the Mahatma Gandhi National Rural Employment Guarantee Act (2005), the Right to Education Bill (2005), and the Right to Information Act (2005) to increase the transparency

¹⁹ See Annex 1 for details

²⁰ See below

²¹ See Annex 1 for details

of development schemes. With the exit of the Left Front from the coalition after the 2009 election many feared that the state's focus would once again move away from the poor, but by most accounts the UPA government appears to have maintained a concentration on social development through a social democratic platform articulated by the ruling party. In fact, the reforms have become institutionalised to an extent where they are now considered safe from the threat of reversals under future opposition governments.

Control of corruption and the TPDS

The Targeted Public Distribution System (TPDS), the Indian government's largest food-related scheme, targets the country's poorest groups through the subsidised provision of food grains through about 500,000 Fair Price Shops (FPS) all over the country (Srinivasan & Narayanan 2007). Improvements in the TPDS — especially in terms of controlling corruption, leakages and pilferage, and better monitoring mechanisms — were credited by some respondents for having contributed to the reduction of malnutrition through greater food security by ensuring that FPS are operational in more areas.²² For example, in Tamil Nadu and Chattisgarh GPS systems were installed to monitor trucks transporting PDS supplies from producers and warehouses to FPS to ensure that the cargo was not diverted enroute to the market. In fact, respondents pointed out that most southern states have had success in making the PDS more effective by tracking the movement of food from supply to delivery.

The TPDS has, however, become the subject of an active current debate. The National Food Security Bill — drafted by the NAC, forwarded as a Bill of the Department of Food and Public Distribution,²³ passed by the 'Empowered Group of Ministers' and the Cabinet — proposes the replacement of the TPDS with a cash transfers programme. The Right to Food Campaign has rejected the current Bill as a fairly 'diluted' version of the original that was drafted by the NAC. The main contentions are based on the fact that while the original NAC version called for a more universal PDS, with about 90 per cent coverage of the rural population, the current Bill has reduced it to 75 per cent. Also, while the NAC version wanted access to be based on a universal criteria, the current Bill uses the poverty line as a demarcator of access, which is itself at the centre of a raging debate on the extremely low level at which it has been set.²⁴ The Campaign alleges that the government's current stance is based on an unwillingness to commit itself to universal coverage at a time when it expects that the country's phenomenal economic growth will eventually trickle down to lift people above the poverty line and thereby limit the government's outlays on food provision.²⁵

Economic growth

Many respondents believed that the 9 per cent economic growth rate of the country had managed to contribute to some extent to reducing overall rates of malnutrition. This impact has largely affected urban areas more than the country's rural areas, but increased

²² This view is also supported by Ramachandran 2004, Drèze & Khera 2011 and RTF 2011.

²³ In the Ministry of Consumer Affairs, Food and Public Distribution.

²⁴ ₹25 (33p) per person per day in rural areas, and ₹32 (42p) per person per day in urban areas.

²⁵ This raging debate may explain why many respondents stressed the role that the TPDS plays in the lives of the poorest citizens (also supported by Nag 2011 and other recent media reports). A survey conducted by the RTF Campaign in 2005 reported that about 82 per cent of rural respondents used the TPDS and that there was a great dependence on TPDS rations among the poor (RTF 2005).

remittances from urban migrant workers to their rural families is expected to have raised family incomes and allowed better access to food and health services.

India's puzzle is, as always, unique — why, despite its current economic growth rate of 9 per cent, institutionalised nutrition policy and high levels of judicial and civil society activism, have malnutrition rates not come down faster or further? This is analysed in the next three sections.

IV. Horizontal Coordination

a) Lack of horizontal coordination at the national level

The framework of this study defines horizontal coordination as the efforts made by the central government to discuss, adopt and implement nutrition policies across different government sectors, and with the support of non-government agencies. In India cooperation between state and non-state organisations on malnutrition has been limited. The cooperation between the judiciary, the NAC, the media, civil society groups, and the UNICEF-led initiative has already been discussed. Beyond this, however, there is little evidence of planned inter-sectoral coordination between state and non-state actors, and interventions to deal with nutrition are largely state-led through the work of different ministries. Within government too there is little visible horizontal coordination across ministries, despite the fact that both the NNP (1993) and NPAN (1995) called for greater multi-sectoral coordination across a list of government departments²⁶ to deal with malnutrition. Each ministry has a separate operational and regulatory structure. For example, nutrition may be the joint responsibility of the ICDS and the NRHM and they may work together in village-level AWCs, but they function as two completely separate systems in terms of authority and accountability.

State agencies do, however, understand the lack of horizontal coordination to be a problem. The ministries of Women and Child Development (WCD) and Health and Family Welfare (HFW) have recently renewed their efforts at coordination with not just one another but also with other ministries, largely to ease up their own burden of sole responsibility for dealing with India's malnutrition rates. In a 2010 joint strategy paper produced by the two ministries after consultations with parliamentarians, citizens' alliances, civil society organisations, and development partners, the need for greater horizontal coordination was clearly discussed. In particular, the joint strategy paper identified the need for greater convergence between the ICDS scheme and two other flagship programmes of the government — the NRHM and the Total Sanitation Campaign at the district and village-levels — and called for making nutrition a focus in the programmes of the ministries of agriculture, and food and public distribution as well. These are, however, recent proposals and so far there are no coordinating bodies, integrated work plans or joint budget lines to deal with malnutrition.

²⁶ Agriculture, civil supplies, education, environment and forest, family welfare, food, food processing industries, health, information and broadcasting, labour, rural development, urban development, welfare, and women and child development.

A recent change from the separated and siloed manner in which ministries have worked to date has come through the various state-level Nutrition Missions set up to monitor delivery and to increase monitoring and accountability. Maharashtra's Nutrition Mission is a very successful example and is already in its second phase. Karnataka and Madhya Pradesh also have functioning Missions, while Gujarat and a number of other states are in the process of forming one. Missions not only have a more outcome-oriented approach (based on their 'mission' to lower malnutrition rates) but also have the potential to leverage budgets from related departments to develop more integrated nutrition-related work plans.

Many respondents pointed to a lack of horizontal coordination as a major reason for why more had not been done on the nutrition front. A respondent associated with a research institution pointed out an interesting example of the impact of a lack of coordination. To reduce the risk of infections the government's flagship Total Sanitation Campaign subsidises the building of toilets to reduce the incidence of open defecation in Indian villages. The subsidy has resulted in almost 62 per cent rural households having built a toilet over a short period. However, an investigation into their usage revealed that the new toilets were being used as grain stores or chicken coops, and that people were still defecating in the fields. The respondent pointed out that changing traditional practices requires changing mindsets, which can be attempted through the ICDS Anganwadi centres (AWC), but because of a lack of coordination between the two programmes and their respective ministries, this has not happened.

b) Village-level convergence

The most substantive horizontal coordination in dealing with malnutrition occurs within the village-level AWC, between the AWWs of the Ministry of Women and Child Development, and the ASHAs and ANMs of the Ministry of Health and Family Welfare.²⁷ The workers of the AWC maintain a 'Mother and Child Protection Card' for each mother and child that is registered at the centre. The card has been jointly produced by the ICDS and the NRHM, and is used by both ministries for record keeping and monitoring. Furthermore, the two ministries also jointly convene a monthly Village Health Nutrition Day (VHND) within the AWCs, where the ANM provides antenatal and postpartum services and immunisation, and the ASHA mobilises mothers and children to ensure that they attend. Besides this, Village Health and Sanitation Committees (VHSC) (renamed in August 2011 as the 'Village Health, Sanitation and Malnutrition Committee') was set up under the NRHM to integrate various village-level actors. The VHSC includes the head of the *gram panchayats* (village councils), the ASHA, AWW and ANM, and other village citizens, and is expected to develop village health plans based on the specific needs of the community, and serve as a mechanism to promote better health practices within the community. However, the VHSC are relatively new and are functional in only a few states so far (NRHM 2007, NHSRC 2011).

However, despite these defined mechanisms for convergence, the responsibility of each worker is separately defined by the respective ministry, to whom s/he is also separately accountable through vertical reporting processes. The responsibility for non-

²⁷ See Annex 1 for details.

implementation, therefore, is easily passed around between the various village-level workers. More importantly, so far there has been little coordination of the AWC's workers with the *gram panchayats*, which coordinate actively with other state programmes, such as NREGA and the mid-day meal in schools scheme. This, according to many respondents, is a tremendous missed opportunity for convergence, coordination and accountability at minimal extra cost.²⁸ As the ex-minister for Panchayati Raj put it,

...the National Rural Health Mission [relies] on its own ASHA-based structures, and not democratically elected and democratically responsible *panchayats* and *gram sabhas*, to deliver basic health and reductions in infant and maternal mortality; the Integrated Child Development Scheme [relies] on Government-appointed 'volunteers', not elected community-based institutions to deliver child and maternal nutrition (Aiyar 2010b).

V. Vertical Articulation

The Indian government's mode of delivery and implementation is classically centralised and bureaucratic. Policy is set at the centre, programmes and interventions are similarly devised in New Delhi, aims and objectives are set, and these are then passed down to the states as Centrally Sponsored Schemes (CSS) and from there to districts and so on for implementation. More than one state official in Bhubaneswar explained that their concern was not with policy, programme design or objectives and outcomes. Their job was to ensure that programmes devised at the centre were properly implemented and monitored, financial outlays were sufficient, records were maintained and information was passed back upwards as required. As one state official explained, 'The centre provides policy design and funds, and the state provides human resources and implementation'. This was not entirely an accurate depiction of the process. States do often undertake independent schemes and put their own stamp on programmes (see Section 7). Nevertheless, it remains generally true that most interventions that are being implemented at present were devised and defined by the centre.

Implementation of such schemes remains highly siloed, and has often been critiqued for being single-mindedly concerned with providing inputs and monitoring outputs (number of centres established, number of staff trained, amount of money spent, number of village nutrition days organised), rather than being focused on outcomes and objectives. The outcome-focused 'mission approach' recently introduced through the NRHM is considered a step in the right direction towards more outcome-oriented implementation. However, much remains to be done in other areas — a fact that is demonstrated well by the way the ICDS scheme is implemented.

Despite its impressive expansion over the last seven years to cover almost 81 per cent of India's children, many respondents believe that the ICDS scheme could have done much more than it has in the fight against child malnutrition. Three studies found that having an AWC in the village makes no significant difference in the nutrition status of children (World Bank 2004, Bredenkamp and Akin 2004, Das Gupta *et al.* 2005). Insufficient success has been explained by a number of reasons:

²⁸ Also discussed in Paul *et al.* 2011.

1. It has concentrated far more on universalisation and the spread of AWCs, than on actually improving the quality of services these centres offer.
2. It has come to concentrate almost entirely on one of its seven stipulated functions — supplementary feeding — and its over-worked staff spends little time on raising awareness or advocating better health practices and behavioural changes.²⁹
3. The AWCs focus on children between the ages of 3 and 6, by which time malnutrition has already set in, rather than on children under 3, when its onset might be best controlled. It has been argued that the ICDS's centre-based approach may be unsuited to concentrating on children under-3 years of age, for whom home visit-based outreach programmes may be more suitable (Saxena 2010).
4. A World Bank study found that the ICDS has not managed to adequately target marginalised groups. Poorer households, girls and lower caste groups are regularly being left out of the centres' operations and focus. The poorest states and those with the highest malnutrition rates still have the lowest coverage and least programme funding (Gragnotati et al. 2005).

However, a more recent study used the later NFHS-3 data to carry out a rigorous analysis, based on matching children in terms of characteristics³⁰ in ICDS and non-ICDS villages, to find that access to an ICDS centre has a positive and significant impact on the reduction of child stunting. This impact is, however, stronger for moderate stunting and boys, than it is for severe stunting and girls, and it is still less focused on children under 2 years of age (Kandpal 2011).

Greater effectiveness of the ICDS scheme is also limited by human resource problems. There is one AWW per 800 population, compared to one per 100 in Thailand. They are chosen from within the community, receive little training and have inadequate skills. Nevertheless, they are over-burdened and have a multitude of stipulated tasks — the Ministry of Women and Child Development's web site lists 21 tasks for the single AWW that exists at each centre.³¹ Despite this, the AWW is called an 'honorary worker' who receives an 'honorarium' that is set at less than the minimum wage, and there are few performance-related incentives.³² Some states, such as Tamil Nadu, have attempted to deal with part of the problem by introducing the 'two-worker model' in which each AWC is run by two AWWs and a helper. This not only means that the work burden is shared but also that while one AWW runs the centre with the helper, the other is able to visit homes to carry out community outreach, awareness raising, and concentrate on children under 3 years of age.³³ Many of these issues are under review in recent national-level discussions on the

²⁹ Paul *et al.* found that AWWs spend "spent 40 per cent of their time on education of this age group [3-6 year olds], 36 per cent on provision of supplementary nutrition, 16 per cent on record keeping, and 9 per cent on the rest of their activities. Little time was left to work with infants or for activities such as home visits, growth promotion, health and nutrition education, and community mobilisation" (2011: 341).

³⁰ Age, birth order and sex of the child, the mother's age, education, caste, and religion, household wealth, village population and other community-level development indicators.

³¹ In which they are supported by an Anganwadi helper.

³² Though there are discussions around incentivising some of their work under the IGMSY (see Section 7).

³³ Interestingly, AWWs in Tamil Nadu also conduct food counselling as a regular part of their job, which involves helping poor families decide how to prioritise spending limited incomes to target malnutrition.

restructuring of the ICDS, which is expected to be included in the 12th Five Year Plan due in 2012.

VI. Funding Nutrition Initiatives

The story of funding for interventions on malnutrition in India is fairly straightforward. The government has increased its social sector outlays in recent years — the 2011 budget saw a 17 per cent increase (Mukherjee 2011). The budget allocation for ICDS has in particular been increased by the Planning Commission from about ₹100 billion (\$2 billion) in the 10th Five Year Plan (2002-2006) to ₹424 billion (\$8.6 billion) in the 11th Five Year Plan (2007-2011), mostly to finance the universalisation of the ICDS ordered by the SC's interim orders (Mehrotra 2010). The budget for its supplementary nutrition component also increased manifold. While there was no separate budget for this earlier, ₹80 billion (\$1.6 billion) was allocated in the financial year 2009-10. This may explain why over the years the focus of the ICDS scheme has shifted almost exclusively to supplementary feeding. Despite these increases, given India's population and the size of the ICDS and NRHM networks, the money is far from sufficient in terms of targeting malnutrition itself.

To highlight the insufficiency of the current allocation, respondents connected with the Right to Food Campaign pointed out that while the 11th Five Year Plan made ₹424 billion (\$8.6 billion) available over five years to deal with malnutrition, in order to effectively reach India's 160 million children under the age of 6 through the ICDS the minimum requirement is ₹500 billion (\$10.5 billion) each year³⁴. Despite the enormity of the sum, they pointed out that it is only one-tenth of the ₹5000 billion (\$104.6 billion) that the state offers the private sector each year as tax subsidies. In fact, the 2011 budget listed \$112 billion as the state's foregone revenue through exemptions for the corporate sector.

There are early indications that the budgetary allocation for ICDS may see a manifold increase in the 12th Five Year Plan due in April 2012, which may approximate the demand put forth by the Right to Food Campaign. However, other respondents pointed out that the funding shortfall is also the result of corruption. The issue made front-page news this year when the murders of three Chief Medical Officers in Lucknow, the capital of Uttar Pradesh, were found to be linked to corruption that grew from the sudden influx of money from the central state after the launch of the NRHM in 2005. The central government handed over \$2 billion to the state, well known for its high levels of corruption, without oversight or monitoring mechanisms. The little monitoring that does exist is based on checking forged official records and tampered registers (Khetan 2011, Polgreen 2011). Respondents maintained that, in general, the lack of credible record-keeping and lax monitoring and accountability mechanisms ensure that allocated funds are unable to effectively target malnutrition (also highlighted in Saxena 2010).

³⁴ This amount would increase dramatically if it is price-indexed, and if expenditure required for other determinants of malnutrition (access to potable drinking water, sanitation and universal primary health care) is included.

VII. Orissa — A Case of Horizontal Convergence and Vertical Articulation

According to NFHS-3 data, Orissa is a high-performing state that has had relatively greater success in reducing its rates of malnutrition. Table 3 below shows that between NFHS-1 and NFHS-2 there was barely any change in the indicators of malnutrition in Orissa. In fact, until the late 1990s Orissa was one of India's worst performing states in nutrition. In 1998-99 its stunting rates were below the India average (at 49.1 per cent compared to 51 per cent for India), but the figures for wasting were exactly 10 percentage points above the Indian average (29.7 per cent as compared to 19.7 per cent for India), and those for underweight were almost 8 percentage points higher (50.3 per cent compared to 42.7 per cent). However, from 1998-99 to 2005-06 its performance on all indicators improved dramatically, with underweight figures coming down by almost 11 per cent and those for stunting by 5 per cent. This improvement has brought most of Orissa's rates down to the Indian averages. For example, while wasting rates increased for India as a whole between 1998-99 and 2005-06 by 3.2 percentage points, Orissa reduced them by 6 per cent to 23.7 per cent to bring them closer to the Indian average of 22.9 per cent (Tables 3 and 4).

Table 3: Reduction in malnutrition rates for children <3 in Orissa

	NFHS-1 1992-93	NFHS-2 1998-99	NFHS-3 2005-06
Stunted %	50.8	49.1	43.9
Wasted %	28.2	29.7	23.7
Underweight %	50.0	50.3	39.5

Source: NFHS-3 (IIPS 2007a)

Table 4: Comparison of change between India averages and Orissa

	India	Orissa
Stunted %	-6.1	-5.2
Wasted %	+3.2	-6.0
Underweight %	-2.3	-10.8

Source: NFHS-3 (IIPS 2007a)

The period of improvement coincides with Chief Minister Patnaik's term in office, who came to power in 2000 and has ruled consistently since then. Respondents within ministries in Bhubaneswar mentioned the length of his term in office as a factor that had led to consistent and stable policy over the last decade. Of greater importance though is the attention that nutrition has received during his term in office. This has been manifested in both, greater horizontal coordination across ministries and non-state agencies, and better vertical articulation within ministries.

As far as horizontal coordination is concerned, there has been greater emphasis on inter-sectoral coordination between the various departments over the past decade. The work of the ministries of Women and Child Development and Health and Family Welfare were in particular coordinated through committees at the district, block and sector levels (see Annex 3). In 2010 the Chief Minister's Nutrition Council was set up to help further improve policy convergence across ministries. The state government has also been particularly open to working with non-state development partners. The DFID-funded Technical and Management Support Team (TMST) brought together development organisations, like CARE and Options, to work with the ministries of Women and Child Development, Health and Family Welfare and other key departments to plan, monitor, and implement the state's health sector plans.³⁵ Interestingly, state officials mentioned that regular inter-departmental coordination meetings were a requirement under the assistance agreements of the nutrition action plan that was jointly developed by these state and non-state actors.³⁶

In terms of vertical articulation there has been a greater emphasis on improving the capacity of each ministry. First, state officials with an academic or practical background in nutrition were given key positions within the ministries.³⁷ Second, the ICDS programme was reoriented under these officials to concentrate on children under the age of 3. Third, there is an increased emphasis on regular monitoring across the various tiers of government within each ministry (see Annex 3). Fourth, there has been a greater focus on training and motivating frontline workers, and especially on empowering and training AWWs in proper growth monitoring and enabling them to link growth charts with improved nutrition outcomes.³⁸ AWC staff was trained in the 'Positive Deviance' (PD) approach of motivating the community through the positive examples of mothers from within the same community that have well nourished children. This was implemented under the '*ame bhi paribu*' or 'I too can' approach that motivated both AWWs and parents alike to reduce rates of malnutrition within the village. The programme, however, has limited outreach and was implemented in only 6200 AWCs out of a total of almost 70,000.

The state has also taken initiatives to expand centrally designed and funded schemes. Orissa's latest 'Mamata' programme provides an interesting example of this. Since 2005 India has had the Janani Suraksha Yojana (JSY) scheme that provides a one-time conditional cash transfer to a woman above the age of 19, whose family income is below the poverty line, for institutionalised deliveries of her first two live births. In November 2010 the central government announced the Indira Gandhi Matritva Sahyog Yojana (IGMSY), which integrated the JSY scheme into a larger conditional cash transfer programme implemented through the ICDS. The new scheme adds three other transfers³⁹ worth ₹4000 to the existing JSY, which provided ₹1400 at birth only. The scheme identified 52 high priority districts where it would initially be implemented, of which only two were in Orissa — Bargarh and Sundargarh. However, the Orissa government transformed the IGMSY into the state-sponsored 'Mamata' scheme, under which the scheme was launched in October 2011 in all

³⁵ Similar teams were also set up in Bihar, West Bengal, Madhya Pradesh, and Andhra Pradesh.

³⁶ Apparently this was not actually a condition of support but was reflected as such by respondents.

³⁷ Paul *et al.* (2011) point out that a lack of this at the national level and in other states (together with a lack of stable state policy) is a key reason for weak governance in the area of nutrition.

³⁸ Also documented in Sharma *et al.* (2009), and outlined in detail in an interview with the author of this case study.

³⁹ At the registration of the pregnancy at a AWC, at 3 months after birth with the first set of vaccinations, and at 6 months after birth with the last set of vaccinations and the confirmation of exclusive breast-feeding.

30 districts of the state. Orissa thus adopted a centrally defined and designed scheme and extended it through its own funds to cover the entire state. A number of other state-level initiatives led by both the government and non-state actors are documented in Sharma *et al.* (2009).

In summary, Orissa's comparatively better performance is explained by a combination of factors, including strong political commitment and leadership, and a coordinated state-level nutrition agenda, support for which emanates from the highest executive office. The fact that the agenda is set at this level and malnutrition is monitored by the Chief Minister impacts political and bureaucratic commitment to the issue at different levels of the state apparatus.

VIII. Preliminary Findings and Continuing Challenges

a) Summary and preliminary findings

Through key interventions over the last decade India has managed to reduce the stunting rates of its children under three years of age by 6 per cent between 1998-99 and 2005-06. Respondents indicated that they expected the rates to show a further decrease in NFHS-4, based on greater policy attention and the formulation of national-level bodies like the NAC.⁴⁰ Much of this success, however, is attributed to judicial and civil society activism that has sought to universalise state interventions aimed at hunger reduction and food provision, and to political imperatives that have resulted in a greater ownership by the ruling coalition of the issue of malnutrition. More media attention, a phenomenal economic growth rate, and policies aimed at controlling corruption within government schemes are also factors that have contributed to the recent reduction of the incidence of malnutrition in India. State-level evidence from Orissa also indicates that greater horizontal coordination between state agencies, and between these and non-state actors, coupled with better vertical articulation within ministries can result in above average performance in the struggle against malnutrition.

However, despite this success, India's rates of malnutrition are still much higher than those of its poorer neighbours (Dreze & Sen 2011). Many respondents agreed that the Indian state's limited success in dealing with malnutrition is based on a number of governance factors, including; a lack of political will and commitment within higher political offices; an uncoordinated, dis-incentivised, bureaucratic approach to the fight against it; and an inability to comprehend it as a holistic issue affected by the state and quality of interventions across a number of sectors, including water and sanitation, control of infectious diseases, education, agriculture, and others. Instead, it still views it primarily as a problem of hunger and food distribution, and continues to deal with it through supplementary feeding and subsidised distribution systems. This limited vision is

⁴⁰ At the time of interviews in August 2011 the NFHS surveys had not yet been discontinued.

compounded by a lack of holistic planning and budgeting aimed specifically at malnutrition, and ineffective and infrequent monitoring and accountability within ministries, coupled with inadequate funding.

b) Continuing challenges and entry points for policy interventions

The analysis of the three dimensions of nutrition governance in the preceding sections highlights a number of key entry points for state intervention.

Improvements in horizontal coordination:

1. Integrated, issue-based planning and budgeting:

The case of Orissa, as well as the comments of a number of respondents, highlighted the central importance of greater horizontal coordination and convergence in reducing rates of malnutrition. In particular, many suggested that ministries should develop joint work plans and budget lines for interventions that target nutrition through the work of various ministries. The new Nutrition Missions are a good platform for these and the ICDS could perhaps be integrated more closely within this initiative.

2. Decentralised decision-making:

A key component of greater effectiveness, according to many respondents, would be the integration of NRHM and ICDS staff not just with one another but also with the local Panchayati Raj Institutions. Besides enabling greater coordination at the village level between various institutions and programmes, this will also pave the way for more decentralized decision-making, funding and responsiveness (especially to emergencies) on malnutrition issues through these locally elected bodies that are located within village communities.

Improvements in vertical articulation:

3. Data collection, monitoring and accountability:

There is a great need to improve the processes through which the central government and the states monitor the AWCs, and through which data and reports move up the system to inform the next phase of work and funding. The fact that many government officials referred to awaiting the results of NFHS-4 in order to evaluate the state's recent performance on malnutrition has severely affected its ability to regulate its work in the interim, or modify it according to the needs of the target population. Through the improvement of ICDS data collection the government would have more regular access to reliable data that could inform improvements in the services that the scheme offers and in its design.⁴¹ This is all the more important if the NFHS surveys are to be discontinued, or at least until malnutrition indicators are added to the AHS.

4. Incentivised service delivery:

⁴¹ A detailed discussion of what this entails is provided by Adhikari & Bredenkamp (2009).

Improved vertical articulation also requires that state interventions get incentives right and motivate frontline workers to deliver effective, high-quality services. Maharashtra's relatively greater success in reducing child malnutrition is based on the fact that the state government reversed incentives to make reporting real figures by AWWs a 'low risk, high reward' activity that would lead to greater funding and inputs. Orissa's success is also attributed to the outcome-based motivation of frontline workers (Sharma *et al.* 2009).

Improved funding initiatives:

5. Increased, issue-based funding and reduced leakages:

A more effective struggle against malnutrition will also require increased funding. A greater portion of the budget needs to target malnutrition in specific (as opposed to food provision or infrastructure development). Furthermore, there is also a need to make state interventions more transparent so that corruption and the leakage of funds can be controlled. This will both increase delivery and make it more effective in terms of targeting poorer groups.

6. Targeting beneficiaries:

In order to better target those that are malnourished or are at risk, and most require the services offered by state interventions, there is also a need to improve the definition of the poverty line, or otherwise make interventions universal so that the poor are sure to be adequately covered by state interventions. This is at present a raging debate in India. The Planning Commission has proposed the replacement of the TPDS and ICDS's supplementary nutrition programme with conditional cash transfers. It argues that not only will they be more cost-effective than provision in kind, but will provide social safety nets and affect social change faster than has been possible to date in India. However, cash transfers target households below the poverty line (BPL), a group defined by an extremely contentious poverty line that by most accounts has been set too low and will, therefore, end up excluding many households who need access to state schemes in order to avoid malnutrition. Opponents of the case transfers proposal, mostly within research institutions and civil society, thus argue for the universalisation of state services.

Related interventions:

7. Reduced gender and caste-based discrimination:

Compared to most other countries, India has enormous social and gender barriers based on complex hierarchies that have led to the low status of women and caste-based discrimination. Both have a negative impact on the reduction of malnutrition. A respondent that works with rural communities on health issues pointed out that gender inequality in rural society limits women's access to both food and state services, so that the food intake of women in rural India is still lower than that of men. Narayan (2006) points out that in India a girl child has a 50 per cent higher likelihood of not reaching the age of 5 than a boy in the same family, while Paul *et al.* refer to a 'care-seeking bias against girls' (2011: 337). Caste discrimination also limits access to state services. For example, if the AWW in a village is from a higher caste, she will often be unwilling to visit lower caste homes, assist lower caste mothers or help with their children. On the other hand, if the AWW is of a lower caste,

higher caste groups will not use the AWC or allow the AWW to take care of their children or come to their homes. Either way, a significant part of the village ends up without access to state services. Caste-based social barriers are a major reasons for why even though 81% of India's children are now covered by an AWC, only about one-third of all children use any of its services, only 18 per cent have their growth monitored and only 26.5 per cent benefit from its supplementary feeding programme (Saxena 2010). Therefore, culture and mindsets have to be directly targeted through state and non-state interventions to reduce both gender and caste discrimination to make the fight against malnutrition more effective.

Final remark

India and its relatively recent concern with malnutrition are both in transition. The ICDS and the PDS are under reform, the NRHM has evolved in the right direction but its impact so far has been limited (NHSRC 2011, Paul *et al.* 2011), multi-sectoral cooperation is being stressed, nutrition missions are being established, the Food Security Bill is under review, the Right to Food Campaign is actively pressing for change, and malnutrition has been receiving greater attention from political actors, including the Prime Minister. There are high expectations that many of the required reforms, especially in terms of improved coordination, monitoring and funding, will be included in the 12th Five Year Plan, expected in April 2012, and that future surveys will provide evidence of a stronger performance in reducing malnutrition indicators. Given all of this, there is an air of expectancy. In fact, regardless of where anyone stood on particular issues and debates, everyone that was interviewed — from state officials to activists within the Right to Food Campaign — agreed that despite the problems and limitations India was heading in the right direction in its fight against malnutrition, and had evolved the right mix of interventions to deal with the attendant challenges.

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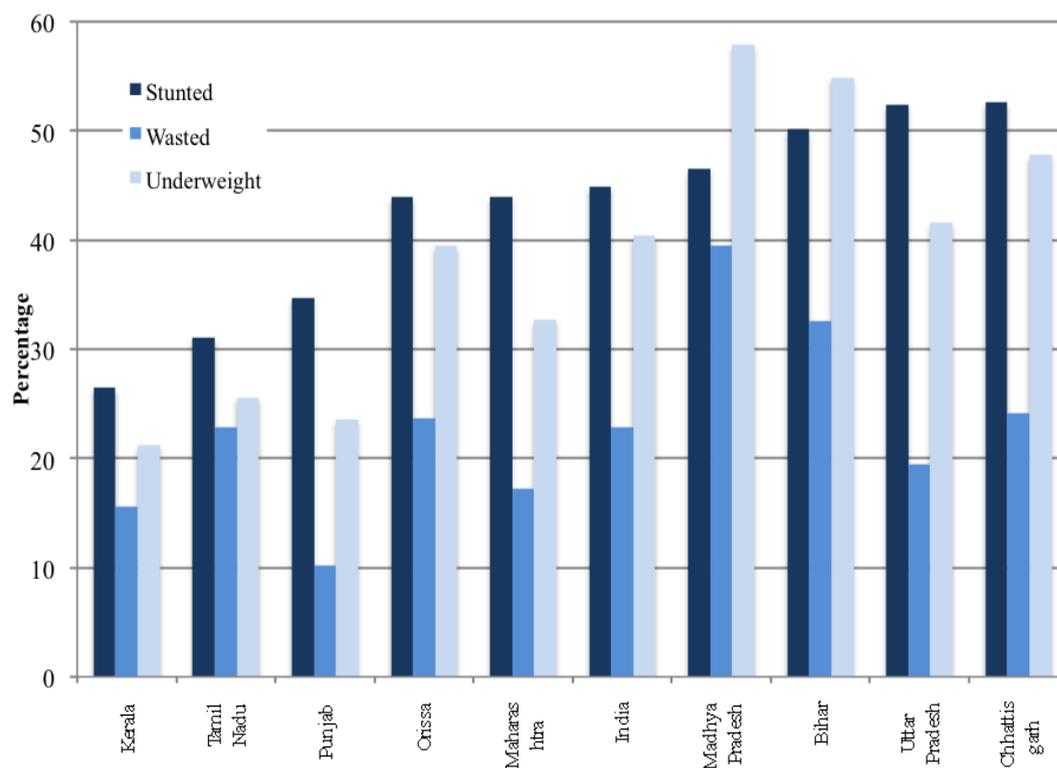
Annex 1: Main government interventions on malnutrition

	Name of intervention	Host Ministry	Year of initiation	Specific mandate	Implemented through	Target population
1	Integrated Child Development Scheme	Ministry of Women and Child Development	1975 2001 (Universalisation)	<u>Nutrition:</u> 1. Supplementary Nutrition 2. Growth Monitoring and Promotion 3. Nutrition & Health Education <u>Health:</u> 4. Immunisation 5. Health check-up 6. Referral services <u>Education</u> 7. Pre-school non-formal education	Anganwadi centres (AWC) that are run by one Anganwadi worker (AWW) and an Anganwadi helper.	- Children under 6 - Pregnant and lactating women
2	National Rural Health Mission	Ministry of Health and Family Welfare	2005	1. Community-based health care 2. Immunisation 3. Institutionalised deliveries (JSY) 4. Nutrition 5. Sanitation 6. Hygiene 7. Safe drinking water	Accredited Social Health Activist (ASHA) Auxiliary Nurse Midwife (ANM)	- Poorer groups - Rural populations - Pregnant women below the poverty line (JSY)
3	Targeted Public Distribution System	Ministry of Consumer Affairs, Food and Public Distribution	1997	1. Subsidised food provision 2. Food purchases from producers	Rations cards issued by the state that are used in Fair Price Shops	- Population below the poverty line (BPL)
4	Mahatma Gandhi National Rural Employment Guarantee Act	Ministry of Rural Development	2005	1. Provision of employment	<i>Panchayati Raj</i> Institutions and village-level social audits	- 'Work on demand' provision to poor groups
5	Commissioners of the Supreme Court	Supreme Court	2002	1. Monitor implementation by states of hunger and malnutrition-related policies	Commissioners in New Delhi have an Assistant, a Nodal Officer and an	- Population affected by or at risk from hunger and malnutrition

				2. Report on implementation status 3. Investigate violations of orders 4. Respond to hunger-related emergencies	Advisor in each state	
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Annex 2: Comparison of malnutrition between selected States in India

Figure 1: State-wise comparison of key indicators



Source: NFHS-3 (IIPS 2007a)

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Table 1: State-wise variation in malnutrition – ICDS data (December 2009)

	Classification of Nutritional Status			
	Normal	Grade I - Mild	Grade II - Moderate	Grade III & IV - Severe
Kerala	62.82	29.89	7.24	0.06
Tamil Nadu	63.53	34.82	1.63	0.02
Punjab	65.15	31.87	2.88	0.10
Orissa	47.33	37.17	14.69	0.82
Maharashtra	62.11	31.73	6.03	0.13
India	54.16	32.40	13.07	0.40
Madhya Pradesh	56.14	29.93	13.53	0.41
Bihar	na	na	na	na
Uttar Pradesh	47.34	32.04	20.18	0.45
Chhattisgarh	46.97	33.82	18.48	0.74

Source: MoWCD (2009)

Annex 3: Convergence between the Ministries of Women and Child Development and Health and Family Welfare at various levels in Orissa

Ministry of Women and Child Development <u>State-level Convergence</u> Secretary of the Ministry and the Directors of the Departments The Secretary and Directors of the two Ministries meet regularly under the Chief Minister's Nutrition Council ?	Ministry of Health and Family Welfare Secretary of the Ministry and the Directors of the Departments CDMO, MO of blocks MO, health supervisors Health supervisors, ANMs
<u>District-level Convergence</u> DSWO, CDPO of blocks The District Collector presides over the District level coordination committee (DLCC) that deals with various development schemes, and for nutrition brings together the Chief District Medical Officer (CDMO) and block-level Medical Officers (MO) of the health ministry, with the District Social Welfare Official (DSWO) and block CDPOs of the ICDS. ?	CDMO, MO of blocks MO, health supervisors
<u>Block-level Convergence</u> CDPO, sector supervisors A Block level coordination committee (BLCC) brings together MOs and sector-level health supervisors, with the Child Development Project Officer (CDPO) and the sector supervisors of the ICDS. PRI representatives also participate in some areas ?	MO, health supervisors Health supervisors, ANMs
<u>Sector-level Convergence</u> Sector supervisor, AWWs Each ICDS sector has 15 to 20 villages. The 15 to 20 AWWs meet on a particular date each month and a sector supervisor reviews work and records. MOs, all ANMs, and the sector-level health supervisors are also present. ?	Health supervisors, ANMs
<u>Village-level Convergence</u> AWW AWW, ANM, ASHA work together through the AWC	ANM, ASHA

Annex 4: List of Interviews

New Delhi

S.No	Designation/Organisation
Government	
1.	Joint Secretary, Ministry of Woman and Child Development
2.	Assistant Commissioner, Ministry of Health and Family Welfare
3.	Joint Secretary, Ministry of Finance, Govt. of India (previously Joint Secretary, Food and Public Distribution Dept.)
4.	Director, Institute of Applied Manpower Research, Planning Commission
5.	Member of the National Advisory Council (previously Secretary, Planning Commission)
6.	Union Cabinet Minister for Law and Justice; and Minority Affairs
Government-Civil Society Interface	
7.	Member of the National Advisory Council; Executive Director, Centre for Equity Studies
8.	Office of the Commissioners of the Supreme court of India
9.	Office of the Commissioners of the Supreme court of India
10.	Executive Director, National Health System Resource Centre, National Institute of Health & Family Welfare
Media	
11.	Investigative reporter, OUTLOOK Magazine
Non-Governmental Organizations	
12.	Chief, Nutrition, UNICEF India
13.	Research Fellow, Poverty, Health and Nutrition Division, International Food Policy Research Institute (IFPRI)
14.	Secretary and National Convenor, Public Health Resource Network (PHRN)
15.	Director, Nutrition Foundation of India
16.	Senior Advisor for MNCHN (Maternal, Newborn, Child Health and Nutrition), Save the Children India
17.	Director, Public Health Nutrition and Development Centre
18.	Programme Coordinator, Oxfam India
19.	Independent Consultant on nutrition-related issues

Bhubaneswar

S.No	Designation/Organisation
Government	
20.	Secretary, Ministry of Cooperation (previously, Secretary, Department of Women and Child Development)
21.	Mission Director, National Rural Health Mission
22.	Commissioner-cum-Secretary, Department of Women and Child Development
23.	Director – Social Welfare, Department of Women and Child Development
24.	Assistant Technical Advisor, Food and Nutrition Board – Department of Women and Child Development
25.	Chief Medical Officer – Public Health, Department of Health and Family Welfare
Government-Civil Society Interface	
26.	State Advisor to the Commissioners of the Supreme Court
Non-Governmental Organizations	
27.	Maternal & Child Health Specialist, Care India

28.	Head of Nutrition and Child Development, UNICEF
29.	Director, Regional Medical Research Centre