Child malnutrition in India:
Why does it persist?

Report by Sam Mendelson
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cini
help the mother
help the child...

An estimated forty per cent of the world's severely malnourished children under five live in India.

This is a shameful stain on a country that, with China, will be one of the great economic power-houses of the coming century.

India has made huge strides in the past decades in warding off the spectre of famine. The Green Revolution should have gone a long way to tack-ling child malnutrition, Norman Borlaug's creation of dwarf spring wheat strains in the 1960s meant that India could feed itself at last. Better farming techniques and food security policies have made mass starvation a thing of the past.

Yet the problem of child malnutrition remains critical, and the reasons it deserves concerted attention are many. Besides the obvious moral obligation to protect the weakest in society, the economic cost to India is – and will be – staggering, and the global food crisis this year can only be significantly worsening the problem[1][2]. Moreover, statistics from as recently as 2006 may well underestimate the problem, as rampant food price inflation takes its toll on many millions of Indian families.

So why are levels of child malnutrition so shame-fully high in India? What are the contributing factors? What possible solutions exist?

FACTS – AND MYTHS

A few facts – and myths - to begin:

FACTS:

- 47 percent of India's children below the age of three years are malnourished (underweight).[3] The World Bank puts the number – probably conservatively – at 60 million.[4] This is out of a global estimated total of 146 million.
- 47 percent of Indian children under five are categorised as moderately or severely malnourished.[5]
- South Asia has the highest rates – and by far the largest number – of malnourished children in the world.
- The UN ranks India in the bottom quartile of countries by under-1 infant mortality (the 53rd highest), and under-5 child mortality (78 deaths per 1000 live births).[6] According to the 2008 CIA fact book, 32 babies out of every 1,000 born alive die before their first birthday.[7]
- At least half of Indian infant deaths are related to malnutrition, often associated with infectious diseases.
- Malnutrition impedes motor, sensory, cognitive and social development [8], so malnourished children will be less likely to benefit from schooling, and will consequently have lower income as adults.
- The most damaging effects of under-nutrition occur during pregnancy and the first two years of a child's life.
- These damages are irreversible, making dealing with malnutrition in the first two year crucially important.[9]
- A close reading of available statistics shows the problem to be far from uniform.[10]

[1] http://mobile.latimes.com/detail.jsp?key=177180&rc=world&full=1
[2] The World Bank says micronutrient deficiencies could be costing India US$2.5bn per year. http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/SOUTHASIAEXT/0,,contentMDK:20916955~pagePK:146736~piPK:146830~theSitePK:223547,00.html
[3] According to A.K.Shiva Kumar, a development economist and consultant for UNICEF (http://www.littlemag.com/hunger/shiv2.html)
[4] http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/SOUTHASIAEXT/0,,contentMDK:20916955~pagePK:146736~piPK:146830~theSitePK:223547,00.html
[5] UNICEF statistics, found at www.unicefi.org/infobycountry.index.html
[6] http://www.un.org/esa/population/publications/wpp2006/WPP2006_Highlights_rev.pdf
[7] https://www.cia.gov/library/publications/the-world-factbook/rankorder/2091rank.html
[8] Health Education to Villages, Programmes for Mother and Child Nutrition at www.hetv.org/programmes/nutrition.htm
[9] Malnutrition causes heavy economic losses, contributes to half of all child deaths, but can be prevented – new World Bank report, March 2nd 2006, at http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:20839585~pagePK:64257043~piPK:437376~theSitePK:4607,00.html
[10] From the executive summary of the 2005 World Bank report: *"Disaggregation of underweight statistics by socioeconomic and demographic characteristics reveals which groups are most at risk of malnutrition. Underweight prevalence is higher in rural areas (50 percent) than in urban areas (38 percent); higher among girls (48.9 percent) than among boys (45.5 percent); higher among scheduled castes (53.2 percent) and scheduled tribes (56.2 percent) than among other castes (44.1 percent); and, although under-weight is pervasive throughout the wealth distribution, the prevalence of underweight reaches as high as 60 percent in the lowest wealth quintile. Moreover, during the 1990s, urban-rural, inter-caste, male-female and inter-quintile inequalities in nutritional status widened.*

There is also large inter-state variation in the patterns and trends in underweight. In six states, at least one in two children are underweight, namely Maharashtra, Orissa, Bihar, Madhya Pradesh, Uttar Pradesh, and Rajasthan. The four latter states account for more than 43 percent of all underweight children in India. Moreover, the prevalence in underweight is falling more slowly in the high prevalence states. Finally, the demographic and socioeconomic patterns at the state level do not necessarily mirror those at the national level (e.g. in some states, inequalities in underweight are narrowing and not widening, and in some states boys are more likely to be underweight than girls) and nutrition policy should take cognizance of these variations".

The Life Cycle Approach

CINI has adopted the "Life Cycle Approach" – targeting resources in all its current programmes i.e. towards the critical nutritional periods of the human life cycle which includes the following: vulnerable women during pregnancy, the first two years of life of the child and during adolescence.

Latest UNICEF statistics on nutrition in India (Nov – 08)

Nutrition	to the top
% of infants with low birthweight, 1998-2005*	30
% of children (1996-2005*) who are: exclusively breastfed (<6 months)	37
% of children (1996-2005*) who are: breastfed with complementary food (6-9 months)	44
% of children (1996-2005*) who are: still breastfeeding (20-23 months)	66
% of under-fives (1996-2005*) suffering from: underweight, moderate & severe	47
% of under-fives (1996-2005*) suffering from: underweight, severe	18
% of under-fives (1996-2005*) suffering from: wasting, moderate & severe	16
% of under-fives (1996-2005*) suffering from: stunting, moderate & severe	46
Vitamin A supplementation coverage rate (6-59 months), 2004	51
% of households consuming iodized salt, 1998-2005*	57

MYTHS

1 MYTH: Indian children are better nourished than most African children.

In fact, the average rate of malnourishment for under-3s in Sub-Saharan Africa is 30 percent. India's corresponding rate is 37 percent. 30 out of 37 countries in Sub-Saharan Africa report lower levels of child malnutrition than India. And Bihar (54 per cent), Orissa (54 per cent) and Madhya Pradesh (55 per cent) report child malnutrition rates higher than the maximum reported in Sub-Saharan Africa by Angola (51 per cent).[11]

2 Myth: India's low per-capita income is the major underlying cause.

In fact, the correlation between per-capita income and child nutrition is a tenuous one: 28 out of 37 Sub-Saharan African countries have lower per-capita income than India, and – as said above – most have lower levels of child malnutrition.[12] Other countries too have both lower per-head wealth and lower child malnutrition, Mongolia, Vietnam and Haiti being just three. And within India itself, there is no discernible correlation. Manipur reported a per capita income of Rs 8114 in 1998 and a malnutrition rate of 28 per cent.[13] Gujurat, on the other hand, reported a per capita income of Rs 16,251 and a rate of 45 per cent, according to the *Women's Feature Service*.[14] The percentage of underweight children in Gujarat (one of India's richest states) increased from 45 per cent at the start of the decade to 47 per cent in 2006.[15]

Therefore, despite reporting and measurement differences and political factors inherent in reporting levels, one thing is clear: malnutrition is not predominantly caused by low income.

[11] http://www.littlemag.com/hunger/shiv2.html
[12] http://www.alertnet.org/db/an_art/52132/2008/07/7-105403-1.htm
[13] Manipur's low malnutrition levels may be attributable to a high status of women compared to other states – a subject considered below. In Manipur, a significant number of people observe the matriarchal system.
[14] http://www.littlemag.com/hunger/shiv2.html
[15] http://www.indiatogether.org/2007/apr/chi-nutrition.htm. Gujarat, by contrast with Manipur, tends towards a low general status of women and has a significant tribal population who are illiterate and marginalised.

Simple solutions that save lives

CINI works with locally trained women who go from house to house, advising mothers how to add supplementary foods available at home such as rice/chapatti and dal with mashed, locally-grown green leafy vegetables to a child's diet from six months onwards, while maintaining breastfeeding as long as possible. The best way of conveying this simple message is by saying that all one needs is a "fistful of food every day" to meet the calorie and protein gap of a child under three.

Indian mothers tend to breastfeed until about two years and do not add semi-solid supplementary foods to children's diets, perpetuating the calorie and protein gap. Under-nutrition, diarrhoea and respiratory infections act together as a vicious cycle to lead to further malnutrition, higher morbidity and mortality in this age group. CINI breaks this cycle by training and motivating mothers to access health care at the first sign of illness from nearby health centre and give more food to their child at regular intervals during the day to improve the immune response. A trained health worker has about 100 to 150 such children and families under her direct supervision and she monitors their growth.

3 Myth: Poverty is the cause of malnutrition.

In fact, there is no obvious linkage between levels of child malnutrition and income poverty. 26 per cent of India's population lives below the poverty line, yet 46 percent of children under three are malnourished. Most Sub-Saharan countries report higher levels of income poverty than India even though levels of child malnutrition in India are consistently higher. And within India itself, in 1993-4 in Haryana, 35 per cent of children were reportedly malnourished with 25 per cent of the population under the poverty line.[16] In Assam, 36 per cent of children were malnourished, yet a full 41 per cent lived in poverty. In other words, although the destitute poor have higher rates of malnutrition than the rich, poverty itself is not a sole cause. And the quantity of food required to adequately feed an infant is affordable for practically all families – half a chapatti or half a banana or a boiled potato or a bowl of dal.[17]

4 Myth: International growth standards to assess malnutrition skew the results.

Some have argued that Indian children do not grow as fast or as large as in other places, so global standards of malnutrition ought not to apply. However, global standards of height and weight have in fact been applied to Indian children too, as repeatedly established by the Nutrition Foundation of India.

Growth monitoring

CINI health workers maintain each child's growth record on growth cards retained by the parents, and explain to mothers the relationship of improved growth to adequate feeding and care.

5 Myth: It's about not having enough food.

Between 6-18 months, food availability within the household is usually not the critical factor causing malnutrition. It is more often inadequate knowledge about feeding practices that are in the

[16] Again, Haryana is one of the states with a poor general status of women. There is an adverse sex ratio in Haryana and female literacy is also particularly low.
[17] http://www.hindu.com/2007/06/22/stories/2007062250151000.htm

best interests of the child. As A.K Shiva Kumar writes, "The denial of as little as 200-300 calories in a young child's daily diet is what makes the difference between the normal growth and the faltering that starts the descent towards illness and death." [18]

Working with mothers-in-law

The lack of appropriate feeding knowledge with locally available nutritious foods are dealt with by CINI-trained health workers. A worker visits the homes regularly to advise mothers on feeding, prevention of diseases by adopting hygienic practices, and the use of safe drinking water. Young brides move into the homes of their mothers-in-law on marriage in most parts of India. Unfortunately mothers-in-law often force their daughters-in-law to work too hard during pregnancy, leading to a negative calorie balance and low birth weight infants. CINI health workers talk to mothers-in-law and husbands about the importance of pregnant women getting adequate food and rest in order to avoid damage not only to the mothers' health, but also that of their unborn children.

Child malnutrition in India

India in 2008: A Snapshot

A walk through the gleaming, towering central business district of Mumbai tells a tall tale about prosperity in this country of 1.1 billion people. In many ways, India's future is bright.[19] It's democratic, English-speaking, has had sustained economic growth and a swelling urban middle-class, the work ethic and educational level of which is noticeably draining skilled jobs from the West.

The journalist Tom Friedman, a well-known author and writer for the *New York Times*, describes, in his 2005 bestseller *The World is Flat*, arriving at the offices of Infosys Technologies Limited in Bangalore:

"You are in a different world. A massive resort-size swimming pool nestles amid manicured lawns. There are multiple restaurants and a fabulous health club. Glass-and-steel buildings seem to sprout up like weeds each week. In some building, employees are writing specific software programs for American companies; in others, they are running the back rooms of major American and European-based multinationals. The playing field…is being levelled".

It may well be that the forces of globalisation are outsourcing IT and knowledge-based jobs to India, and in doing so, building a significant and affluent middle-class. But it is far from the whole story. Mumbai, India's commercial capital and with Kolkata its largest city, is in many ways a microcosm of the country. Next to the breath-taking opulence of the down town area and the booming financial services industry, lies Asia's largest slum, the bustling Dharavi, home to two

[18] http://www.littlemag.com/hunger/shiv2.html

[19] The 2005 UN Human Development Report states: India has been widely heralded as a success story for globalization.
Over the past two decades the country has moved into the premier league of world economic growth; high-technology exports are booming and India's emerging middle-class consumers have become a magnet for foreign investors. As the Indian Prime Minister has candidly acknowledged, the record on human development has been less impressive than the record on global integration. The incidence of income poverty has fallen from about 36% in the early 1990s to somewhere between 25% and 30% today. Precise figures are widely disputed because of problems with survey data. But overall the evidence suggests that the pick-up in growth has not translated into a commensurate decline in poverty. More worrying, improvements in child and infant mortality are slowing— and India is now off track for these Millennium Development Goal targets. Some of India's southern cities may be in the midst of a technology boom, but 1 in every 11 Indian children dies in the first five years of life for lack of low-technology, low-cost interventions. Malnutrition, which has barely improved over the past decade, affects half the country's children.

million people – many of whom lack clean drinking water and basic sanitation. And statistics aside, it's clear to any visitor that so many Indian children are malnourished, so many Indians are living beneath the World Bank's poverty level of US$1.25 per day, that India faces a stark reality. Without a comprehensive effort to address child malnutrition, the country's considerable aspirations of becoming a world power in the coming century will not be realised.

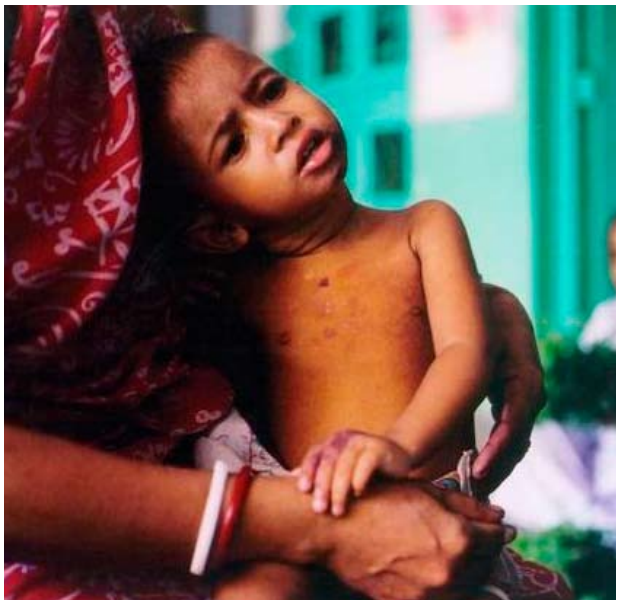
But India is by no means the poorest country on earth, it doesn't have the lowest life expectancy or literacy, or the highest rate HIV/AIDS. India isn't at war, there is considerable foreign direct investment, and there is a large buffer stock of food grains.

So why is the problem so severe in India?

Why are malnutrition levels in India so high?

According to the National Family Health Survey (NFHS-3) carried out in 2005-06, child malnutrition rates in India are disproportionately high. The NFHS-3 is the third pan-India survey conducted since 1992 (covering 200,000 people from 15-54 years, and the definitive guide to Indian health statistics).

The results are sobering: 46 per cent of children under three are underweight, compared with 28 per cent in Sub-Saharan Africa and 8 per cent in China – another country with an enormous rural poor population. In addition to the 46 per cent who are underweight, 39 per cent are stunted, 20 per cent severely malnourished and 80 per cent anaemic. More than 6,000 Indian children below the age of five die every day due to malnourishment or lack of basic micronutrients such as vitamin A, iron, iodine, zinc or folic acid.



So important is the provision of micronutrients to children in the developing world, that the Copenhagen Consensus 2008 has listed it as the top development priority of this year.[20]

Crucially, it's necessary to look beyond income levels, economic expansion, conventional poverty levels and food availability, none of which explains in itself the causes of the problem in India.

Is *funding* the problem? Well, even though children form a substantive third of India's billion-plus population, their share in the Union budget is a mere 4.86 per cent, according to the *Women's Feature Service*, and out of which, 70 per cent is allocated for education, and only 11 per cent for health. There's no doubt a shortfall in funding for child health is a problem.

Micronutrient work

CINI collaborates with Micronutrient Initiative Foundation in India to help improve the distribution and consumption of Vitamin A and Iron-folate supplements for women and children in some of the poor states in India such as Jharkhand, Chattisgarh and Madhur Pradesh.

[20] The Copenhagen Consensus is a theoretical exercise first carried out in 2004 when a group of the world's top economists got together to prioritise issues and solutions affecting 10 global challenges. If a sum of money ($50bn at the time) were available to address needy issues, what would be the most effective way of using it? The panel of eight economists included five Nobel Laureates. Thirty proposals were considered. The result was a ranked list of 10 solutions. These were considered the most cost effective ways of achieving results. The first list had as its top four priorities the control of HIV/AIDS, the provision of micronutrients to address malnutrition (iron deficiency anaemia), trade liberalisation, and the control of malaria (using chemically treated bednets).
The aim is to repeat the Copenhagen Consensus exercise every four years. The new list for 2008 comes up with 30 ranked solutions that would be addressed if $75bn were available. The top four solutions are, as mentioned, micronutrient supplements for children vitamin A and zinc), followed by the Doha development agenda on trade, micro-nutrient fortification (iron and salt iodisation), and expanded immunisation coverage for children. (Taken from www.developmentratings.com, a charities rating agency which provides an excellent guide to charities which are doing a great deal with too few funds, and which advises on efficient philanthropy)

Need for medical professionals in India to learn about malnutrition

The National Rural Health Mission launched recently has allocated resources to correct the deficiencies in health care delivery and access in all parts of the country. Unfortunately, little emphasis has been given to malnutrition in this programme. The teaching of malnutrition is grossly inadequate in medical and nursing schools. This leads to doctors and nurses in the health care system relegating nutrition care to dieticians and nutritionists.

Is the problem specific to India? **No:** In fact, it's part of a wider regional anomaly. Fifty per cent of children across South Asia suffer from malnutrition. So is it therefore cultural in origin? In 1996, India's pre-eminent physician-nutritionist, Professor Ramalingaswami, along with Drs. Jonsson and Rohde, wrote an article entitled "The Asian Enigma". At the time, there was insufficient prior research, and no clear consensus on the underlying causes of malnutrition. After considering various theories – including high rates of vegetarianism in South Asia – the researchers placed the blame predominantly on the extremely low social status of women relative to men in South Asia (compared, say, to Sub-Saharan Africa).[21]

The status of women is readily linked to child nutrition. A malnourished mother will give birth to a baby of low birth weight – the single most important predictor of child survival.[22] Common practices such as allowing all the males of the household to eat first goes some way to explaining the 83 per cent rate of iron deficiency anaemia among Indian women (compared to 40 per cent in Sub-Saharan Africa).This problem is compounded by the need for pregnant women to be cared for, by ensuring proper nutritional diet and reducing the burden of work during gestation. Child rearing is usually the predominant responsibility of mothers. In other words, a pregnant mother who has children already suffers an even greater risk of a malnourished child after birth. And according to the International Food Policy Research Institute, a woman's control over resources within the household also affects her children. Numerous studies have shown that income or assets controlled by women are more likely to be spent on items that benefit children and themselves, such as food, clothing and health care, than assets controlled by men.[24] Very revealing is the statistic provided by the NFHS-3 that malnutrition among Indian children below the age of three born to illiterate mothers (55 per cent) is more than twice the level (26 per cent) reported among mothers who have completed more than ten years of schooling. As a mother's education *per se* cannot conceivably affect the health of a child, this number speaks a great deal: both child malnutrition and education are strongly correlated with women's social status.

Most infants, as stated earlier, get malnourished between six and 18 months of age. A.K. Shiva Kumar puts it succinctly: *"This raises three important issues relating to the care of the child… six-month-old babies cannot eat by themselves; they need to be fed small amounts of food frequently. Feeding a[n]…infant…is time-consuming. Many rural women simply do not have the luxury of time to feed infants. The task is often entrusted to an older sibling who understandably may not have the required patience to feed an infant".* [23]

Early marriage and underweight births

Early marriage in adolescent girls, who are malnourished themselves and have not yet attained physical and mental maturity, leads to early pregnancy and birth of undernourished children. CINI tries to help break this cycle by working with young people and their parents to delay marriage and delay first pregnancy.

[21] www.ifpri.org/pubs/abstract/131/rr131ch07.pdf
[22] www.ifpri.org/media/BeijingPlus10/briefIndia.pdf
[23] http://www.hindu.com/2007/06/22/stories/2007062250151000.htm
[24] www.ifpri.org/media/BeijingPlus10/briefIndia.pdf

CINI's holistic approach

CINI started in 1974 as a nutrition and health-focused organisation. For the last ten years, education has been included in its mission and, along with protection is being integrated into all its activities. Very few health-focused organisations take up the challenge of education as it involves a massive effort to re-educate existing health workers to the mportance of education.

The link between women's status and child malnutrition took a long time to be empirically established. The IFPRI has been running one of the most significant modern studies on effective strategies to reduce malnutrition. The IFPRI – along with the Department of International Health at Emory University – sought to address the shortfall in empirical research with a 2003 study.[25] The study brought together data from 36 developing countries, spanning over 100,000 children under the age of three, and a similar number of mothers.

The study identified three factors contributing to the nutritional gap between Sub-Saharan Africa and India. The most important was women's status, followed by sanitation and urbanisation.[26] No effective solution will be complete without a real effort to address women's low social status in – particularly rural – India. This issue – so often framed in 'rights' discourse, is integral for health promotion, and human rights and health advocacy groups would do well to recognise their overlapping objectives and to work together.

Another clue lies in low birthweights. Birthweights below 2,500 grams have been found to be very closely associated with poor growth – not only during infancy but throughout childhood. Estimates for India reveal that 20 to 30 per cent of babies fall into this category. The underlying health and nutritional status of the mother – also closely tied to social status – is the main cause of low birthweight. According to NFHS-3, close to a third of Indian women suffer from Chronic Energy Deficiency, and have a Body Mass Index[27] of less than 18.5.

Tackling health, nutrition, education and protection issues

Giving a practical shape to the "rights based approach", CINI has started setting up "Woman and Child Friendly Communities" (WCFC) in population groups of roughly 10,000. CINI works closely with the local government, elected representatives (i.e., via the Panchayat political system in rural areas and via urban and local body members in cities) who are trained by CINI to access services related to health, nutrition, education and protection from the existing government sources. The communities ensure that no child is left out of school; that they are in a protected environment and not being used as child labourers or being trafficked; and that all women and children have access to preventive and curative health and nutrition care services.

[25] "The importance of women's status for child nutrition in developing countries"; Research Report 131. Washington, D.C. International Food Policy Research Institute (IFPRI)
[26] The difference in women's status between India and Sub-Saharan African was not found to be that large. Instead, results showed that the negative impact of women's low status in South Asia on child nutrition was much more severe. That is, it is the nature of women's low status in India which affects their ability to nurture their children.
[27] The BMI is the ratio of weight in kilograms to the square of the height in metres.

The Nutrition Foundation of India undertook a significant study on this issue.[28] Several factors have been associated with intrauterine growth retardation (IUGR) and consequent low birth weight (LBW), including maternal anaemia and under-nutrition, low age at marriage, short inter-pregnancy interval and infections. Multiple micronutrient deficiencies may co-exist in the pregnant woman and interact, with effects on various pregnancy outcomes.

The findings? The percentage of new-borns with birth weights below 2.5 kg were 36.3, 18.2 and 6.1 respectively in three groups: "control", "experimental group with iron folate", and "iron folate with green leafy vegetable (GLV) supplement". The study showed a positive and significant impact of iron folate supplementation on the birth weight of the babies. The study showed that an important part of the nutritional management of pregnant women will consist in ensuring that their dietary intake of GLV is adequate.

So again, any sustained effort at reducing child malnutrition must begin with a reduction in women's malnutrition and improvement in women's health generally.

The public health service – or its shortfall, especially in poorer, rural areas – is a major factor too. In 2005-06, according to the NFHS-3, only 44 per cent of children aged 12-23 months were fully immunised; only 26 per cent of children with diarrhoea were given oral rehydration salts. Less than two thirds (64 per cent) of children suffering from acute respiratory infection or fever were taken to a health facility. And antenatal care is severely lacking. The NFHS-3 demonstrates a worrying shortfall: barely half (51 per cent) of pregnant women receive at least three antenatal visits, and – perhaps even more shockingly – only 48 per cent of births during 2005-06 were attended to by a trained birth attendant.[29]

After birth as well as during pregnancy, the NFHS-3 reveals causes. Breast milk is vital to a child in the early years of life, but it is insufficient. After 4-6 months, it must be supplemented by solid foods. Despite this, only 23 per cent of sampled children under the age of three were breastfed within an hour of birth and less than half the babies (46 per cent) up to five months old were exclusively breastfed. Only 56 per cent of children aged between six and nine months received the necessary combination of breast milk and solid or semi-solid food. With this adverse start in life, undoing the damage is difficult. Education in the importance of breastfeeding and the provision of solid or semi-solid foods will be crucial to bring India's levels of child malnutrition anywhere close to acceptable global standards.

Adolescent girls help others while getting support to stay in education

In Kolkata slums, CINI works with young Muslim girls who are provided stipends to access high school and university education. In exchange, they are expected to go on home visits in their neighbourhood to motivate mothers to breastfeed, add supplements to the children's diets, and accompany them to seek health care from public facilities. They teach parents to provide stimulation to their children through simple teaching aids, songs and dances. These teenage girls are widely respected in their communities and have gained confidence that will serve them well in the future.

[28] http://nutritionfoundationofindia.res.in/research8.asp
[29] A doctor, nurse, woman health worker, auxiliary nurse midwife or other health personnel.

What's been tried?

In 1975, the Integrated Child Development Services (ICDS) was first implemented. It is a major programme to tackle malnutrition and the ill health of mothers and children which followed the adoption of a National Policy for Children. This programme is now the single largest programme for the country's children. Yet more than thirty years later, its performance remains unsatisfactory. Examining its failings is the best approach to finding new strategies for dealing with the problem.

In August 2005, at about the same time that the NFHS-3 was being compiled, the World Bank produced a weighty report on the subject of India's child malnutrition.[30] It examined India's successes and failings through the prism of the Millennium Development Goals (MDGs) – halving the prevalence of underweight children by 2015 as a key indicator of eradicating extreme poverty and hunger. The World Bank reviewed the ICDS, finding that although it had been successful in many ways, it was yet to make a significant dent in child malnutrition. It advocated the development of the skills of grass-roots workers an efficient management system, and recommended public investment in ICDS be directed towards the younger children (0-3) and the most vulnerable populations in states with the highest malnutrition.

The Word Bank's findings include:

- The focus on food supplementation has been to the detriment of other important tasks such as improving child-care behaviour and education on family food budgeting;
- Insufficient focus has been given to the youngest children (0-3) who could benefit the most;
- Children from wealthier households have participated much more than poorer ones;
- The ICDS has only partially succeeded in preferentially targeting girls and lower castes (who are at higher risk of under-nutrition);
- Although program growth was greater in under-served than well-served areas during the 1990s, the poorest states and those with the highest levels of malnutrition still have the lowest levels of program funding and coverage.

The report observes, too, that more attention has been given in the ICDS to increasing coverage than to improving the quality of service delivery, and to delivering food rather than changing family-based feeding and caring behaviour. To quote the report: "This has resulted in limited impact".

There is, crucially, a mismatch between the intentions of the program, and its actual implementation.

Yet not everyone agrees on the effectiveness of ICDS. The Nutrition Foundation of India is more equivocal – and even positive:

> *"The ICDS programme aimed at providing food supplementation for vulnerable groups such as pre-school children, pregnant and lactating women, covers nearly all blocks in the country. The Midday-meal programme aimed at improving the dietary intake of primary school children and reduction in the school dropout rates has been operationalised throughout the country. Over decades, health infrastructure and manpower has been built up and there is universal access to essential primary health care. National programmes for tackling anaemia, iodine deficiency disorders and Vitamin-A deficiency are being implemented.*

[30] India's Undernourished Children: A Call For Reform And Action, August 2005.

> *"As a result of all these interventions, there has been a substantial reduction in severe grades of* ***under-nutrition*** *in children and some improvement in the nutritional status of all the segments of population. Kwashiorkor, marasmus, pellagra, beriberi and blindness due to severe vitamin-A deficiency have become rare. However there are still many problems to be tackled and there is a need to accelerate the pace of improvement in nutrition and health status of the population".*[31]

But it has its own recommendation:

> *"Dietary diversification, better coverage under the national anaemia control programme, massive dose vitamin. A administration, universal access to iodised and later iron and iodine fortified salt are some of the interventions that could help the country to achieve rapid reduction in micronutrient deficiencies."* [32]

Despite what incremental improvements may have taken place – and taking into account the difficulty of acquiring reliable statistics in an enormous country of limited literacy and considerable bureaucracy – there can be no doubt: A concerted, cooperative, more thoughtful and more efficiently targeted effort is required to pull India once and for all out of poverty, and to give hundreds of millions of current and future Indian children a real shot at sharing the wealth of the new and miraculous Indian economy.

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[31] http://nutritionfoundationofindia.res.in/fao%202007/FAO2007/11%20Summary%20and%20Conclusion/11%20Conclusion%20.pdf
[32] http://nutritionfoundationofindia.res.in/fao%202007/FAO2007/11%20Summary%20and%20Conclusion/11%20Conclusion%20.pdf