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The Reluctant State: Lacunae in Current Child Health and Nutrition Policies and Programmes in India

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Child health and nutrition remains a matter of grave concern in India despite significant gains in terms of economic development in the recent past, and some would argue, even as a 'result' of the developmental paradigm that has resulted in a highly skewed economic growth benefiting mostly a particular, tiny section of the population.

India has experienced consistently high economic growth in the last three decades. In the last decade it has been the second fastest growing economy, after China. However, this growth has been accompanied with increasing inequality and poor human development improvements (Ghosh and Chandrashekhar 2007, Himanshu 2007, Bonnerjee and Koehler 2010, Patnaik 2011, Chandrashekhar and Ghosh 2011). The average annual reduction in Under Five Mortality Rates (U5MRs) and Infant Mortality Rates (IMRs) for India are 3.4 per cent (from 123 to 74 children per 1000 live births) and 2.2 per cent (from 84 to 56 infants per 1000 live births) respectively, during 1990–2005, putting India among countries with the lowest rates of decline during this period (Gupta and Trivedi 2008). IMR in India is high even compared to a much poorer country such as Bangladesh. IMR in India for the year 2011 was 47 per 1000 live births, in Bangladesh it was 37 per 1000 live births while the per capita income of India is twice as much as in Bangladesh. India ranks the highest amongst the world's 16 poorest countries (outside of sub-Saharan Africa) in terms of per capita income (2011) but its rank in terms of IMR and U5MR is 10. The coverage of children with the measles vaccine in India is lower than 10 other countries in this list (Drèze and Sen 2013).

It is in this context that this paper seeks to assess some of the main policies and programmes related to child health and nutrition by looking at the contestations between 'desirable' public health tenets and their translations to policy. Further, the dichotomy between stated objectives in policy documents and firm translations into programme design, human resources (HR) policies, budget allocations, implementation mechanisms, decision-making structures, etc is also analysed. It must be understood that the Integrated Child Development Services (ICDS) programme serves as a comprehensive umbrella service housing interventions of pre-school education, health, nutrition, and care for children in the critical age group of birth to six. The main child health interventions are positioned through the National Rural Health Mission (NRHM), with the Accredited Social Health Activist (ASHA) playing a significant role at community level as a link to the public health system. Thus, analysis of policies and implementation related to the ICDS and child health in the NRHM forms the main thrust of this paper.

The government's policy framework on child health to an extent can be derived from the National Policy for Children (NPC) of 2013 and the National Early Childhood Care and Education Policy (NECCEP), 2013. Although there is a National Health Policy (GoI 2002) and National Nutrition Policy (GoI 1993), these are both quite outdated. The National Food Security Act of 2013 also addresses the issues of child nutrition. Programme documents such as the ICDS restructuring framework document and the chapter on health in the Twelfth Five Year Plan are also relevant.

While these different statements of intent mostly have laudable objectives, on a close reading, the compromises and accommodations that are made to cater to an overall hegemonic policy framework are revealed. Notably, there is a tension between comprehensive, universal, non-discriminatory, state-led, and rights-based approaches on the one side and approaches that are minimalistic, targeted, and promoting privatization and commercial interests on the other. Some sort of compromise between the two is arrived at with statements of intent being in favour of the former and concessions being made in law, policy, and implementation in such a manner that rights and equity considerations are often conceded. These compromises also affect the pace of public health advances since critical lacunae are left in programmes which then fall short of the requirement for impact, making investments infructuous and inefficient.

As a quintessential example, one of the most deplorable shortcomings of child rights efforts in India has been its ineffective impact on malnutrition. While sound public health approaches would suggest a comprehensive and wide approach to such a high prevalence of malnutrition (Rose 1992), the country continues to focus most narrowly on the management of severe acute malnutrition in the near-absence of preventative and community-based strategies. This, despite almost a decade of 'technical' inputs by a wide variety of experts (Dasgupta et al. 2014, Prasad 2013a, Dasgupta, Sinha, Jain et al. 2013, Dalwai et al. 2013, Working Group for Children under Six (WGCU6) 2007, WGCU6 2012).

Laudable Statements of Intent—And Shortfalls

National Policy for Children

The most recent policy articulation in favour of child health is the NPC 2013, which should ideally be considered as overarching for all sectoral policies relating to children. As a policy, the NPC offers a broad vision that speaks of universal and comprehensive approaches. For instance, with respect to child health and nutrition, at the very outset, it declares (GOI 2013a):

> The right to life, survival, health and nutrition is an inalienable right of every child and will receive the highest priority.
>
> The State stands committed to ensure equitable access to comprehensive, and essential, preventive, promotive, curative and rehabilitative health care, of the highest standard, for all children before, during and after birth, and throughout the period of their growth and development.
>
> Every child has a right to adequate nutrition and to be safeguarded against hunger, deprivation and malnutrition. The State commits to securing this right for all children through access, provision and promotion of required services and supports for holistic nurturing, wellbeing with nutritive attainment of all children, keeping in view their individual needs at different stages of life in a life cycle approach.

In terms of strategies, the policy mentions interventions based on continuum of care, with emphasis on nutrition, safe drinking water, sanitation, and health education. It speaks of focused behaviour change communication efforts to improve new born and childcare practices at the household and community level; provision of universal and affordable access to services for prevention, treatment, care, and management of neo-natal and childhood illnesses and protection of children from all water borne, vector borne, blood borne, communicable, and other childhood diseases; and availability of essential services, supports, and provisions for nutritive attainment in a life cycle approach.

However, the NPC shies clear of making any context-specific binding declarations by which it could be held accountable—either with respect to financial allocations, or time-lines. It also fails to either spell out or protect the approaches to be used to achieve its goals, such as decentralization, community ownership, and prohibition of commercial enterprise. This is to be left to the action plan, which, typically, can be circumscribed on grounds of lack of funds or 'phased' targeted approaches in the name of prioritization.

In comparison, if one were to examine the draft NPC put up by the National Commission for Protection of Child Rights (NCPCR) in consultation with civil society groups, the recommended changes that have not been accommodated by the final policy are telling. The NCPCR recommendations suggested for example, that 'the State shall ensure and be responsible for the welfare and development of all children and will continue to be ultimately responsible even if non-State (private or non-governmental) actors are involved in some way'.[1] However this is replaced by: 'The State is committed to take pro-active measures for inclusion of all children in accessing their rights' (GoI 2013a). Recommendations pertaining to direct provisions such as ensuring 'the availability of funds, infrastructure, skilled health personnel and drugs' have also not been accepted. Thus, taking responsibility for services, is replaced by facilitating inclusion in *access*; a subtle but significant departure. Specific policy recommendations for programmes for malnutrition such

as universal maternity entitlements and universal access to crèche facilities were also not included.[2]

In addition, the NPC even as it stands, does not find coherence with other significant overarching statements of policy such as the Twelfth Plan as discussed below.

NATIONAL EARLY CHILDHOOD CARE AND EDUCATION POLICY

The NECCEP was brought out after consultation with and inputs from civil society organizations and experts to 'achieve holistic development and active learning capacity of all children below six years of age by promoting free, universal, inclusive, equitable, joyful and contextualized opportunities for laying foundation and attaining full potential'. The policy further goes on to mention in its objectives, the provision of universal and comprehensive care, adequate infrastructure, trained HR, and quality standards. Further, it states that to ensure these objectives the government will primarily work through the ICDS platform where the Anganwadi Centre (AWC) becomes a 'vibrant child friendly ECD centre' with 'adequate infrastructure, financial and human resources'. The policy states that universal access to integrated child development remains the primary responsibility of the government through the ICDS (GoI 2013c).

This policy also mentions the need to review all the existing policies which have a bearing on ECCE such as the National Heath Policy, National Nutrition Policy, and National Policy on Education so that they are realigned and oriented with the current policy.

The NECCEP does not, however, set outcome indicators or a roadmap for 'how' it proposes to achieve its goals. While the policy states that the main platform through which it is to be implemented is the ICDS, there is no analysis of the gaps in the ICDS, such as serious problems of lack of space, budgets for rent, lack of toilets and safe drinking water, capacity gaps of the child care workers, and, resultantly, what specifically the new norms will be in terms of infrastructure or HR.

NATIONAL FOOD SECURITY ACT

The National Food Security Act states that it is an Act to 'provide for food and nutritional security in human life cycle approach, by ensuring access to adequate quantity of quality food at affordable prices to people to live a life with dignity and for matters connected therewith or incidental thereto'. Therefore, by talking about a life cycle approach and mentioning quantity and quality of food, the National Food Security Act also begins with a promise of a comprehensive approach to food security for all, including children. Significantly, it acknowledges the role of universal maternity entitlements in enabling breast feeding, albeit with some limitations. The National Food Security Act also provides one age-appropriate free meal for children in the age group of six months to six years through the local anganwadi and a mid-day meal for school children. It mentions promotion of exclusive breastfeeding for children under six months of age (Section 5 (a)).

While it is positive that these entitlements have been included in the Act, there are many demands by civil society that have been left out (Prasad 2013b, WGCU6 2009). For instance, there is no mention of universalization of the ICDS and all its services, as guaranteed by the well-known Right to Food case in the Supreme Court.[3] Further, there are no minimum norms or standards specified for the AWCs in terms of infrastructure, HR, or funds. Other important entitlements related to management of severe malnutrition, nutritional counselling, and other programmatic issues requiring legal guarantees have also been wholly omitted. What has been retained is just lip service to some cursory and ill-defined entitlements to additional food.

Entitlements for adolescent girls (which are included in Supreme Court orders) have not been made part of this Act nor have the rights of children to child care services through crèches/day-care centres. The acknowledgement of maternity entitlements in the Act as a fundamental support to breast feeding is welcome. However, as wage compensation, they ought to have been linked to minimum wages. The entitlement is also ambiguously worded to say that it shall be 'subject to such schemes as may be framed by the Central Government'. This raises an alarm regarding intent for true universalization since the current maternity benefit scheme of the government, the Indira Gandhi Mathru Shishu Yojana (IGMSY), is riddled with many unacceptable conditionalities such as excluding women under 19 years of age and women with more than two children, which only serve to exclude the poorest and most deserving (Lingam and Yelamanchili 2011).

The Act provides only for cereals for about two-thirds of the country's population in contrast with the National Nutrition Policy of 1993 which states that, 'the Public distribution system shall ensure availability of essential food articles such as coarse grains, pulses and Jaggery, besides rice, wheat, sugar and oil; conveniently and at reasonable prices to the public particularly to those living below the poverty line' (GoI 1993). Thus, nutritional security is compromised.

Policy Interpretation by Plans And Programmes

twelfth five year plan

At the very outset, the Twelfth Plan starts with a limited vision:

> The Twelfth Plan seeks to strengthen initiatives taken in the Eleventh Plan to expand the reach of health care and work towards the long term objective of establishing a system of Universal Health Coverage (UHC) in the country. This means that each individual would have assured access to a defined essential range of medicines and treatment at an affordable price, which should be entirely free for a large percentage of the population. Inevitably, the list of assured services will have to be limited by budgetary constraints. But the objective should be to expand coverage steadily over time (GoI 2013d)

Thus, the vision of universality is compromised immediately. However, it does promise 'the universal provision of high impact, preventive and public health interventions …the Government would universally provide within the Twelfth Five Year Plan' (GoI 2013d).

Where specifics on child health are concerned, the list of preventive and public health interventions to be funded and provided by the government are quite comprehensive including full immunization; ante-natal, natal, and post-natal care; iron and vitamin A supplementation; iodine and iron fortified salt; health education; nutrition and health counselling; diagnostic and treatment services for malaria, tuberculosis, and HIV; community-based and referral care for diarrhoea and other childhood illnesses; emergency transportation; and so on.

Although the health chapter of the Twelfth Five Year Plan sufficiently identifies the overall major problems as being availability, quality, affordability, and low public expenditure on healthcare, the status analysis itself shies clear of determining 'why' systems have failed and, thus, 'how' remedial action may be taken. Similarly, while acknowledging that 'the challenging state of nutrition in India, highlighted by high rates of child malnutrition has been a matter of grave concern and a legitimate focus of criticism' (GoI 2013d), the child health and nutrition sections do not have any specific directives towards tackling malnutrition.

The shortcomings of the analysis are revelatory and shocking when we look at how National Nutrition Monitoring Bureau (NNMB) data related to nutritional intakes is used. Based on data which shows that there has not been any substantial improvement in the dietary intake of children over the last *two decades*, it concludes that what is needed is a strengthening of infant and young child caring and feeding practices (by the family) instead of acknowledging that children are living in dangerous and shameful situations of food insecurity.

restructured integrated child development services

Clearly, the ICDS is the main vehicle for housing comprehensive health and nutrition care for children under six. The framework of implementation for the ICDS restructuring is a fairly detailed document that lays out clearly the gaps in the current ICDS, the need for restructuring, and the proposed changes and mechanisms for their implementation. This is supposed to be implemented in 'mission mode' in phases starting with 200 districts in the first phase. It offers programmatic reforms including infrastructural improvements of the AWCs, enhanced financial allocations for the Supplementary Nutrition Programme (SNP), enhanced HR for nutrition counselling of the families of under-three children (additional Anganwadi Worker (AWW) in 200 high burden districts), crèches in up to 5 per cent of the AWCs, essential convergence between the ICDS and the NRHM, as well as camps (Sneha Shivirs) for community-based management of moderate and severe malnutrition (GoI 2013b). These are all welcome and significant measures.

The main thrust on achieving impact on malnutrition seems to be through the strategy of behaviour change communication through the additional worker. The Sneha Shivirs (12-day nutritional counselling and care sessions for moderately and severely underweight children) are also largely to promote infant and young child feeding (IYCF) practices.

This camp approach to deliver a 'visit-based' service for a fixed period of time at a centralized point away from the village has limitations and cannot be considered a comprehensive community-based programme for severe malnutrition. A tenure-based programme rather than an outcome-based programme is not the best way to deal with children with severe/moderate malnutrition (Prasad et al. 2012). However, the potential for developing an outcome-based, community programme exists thanks to the provision of crèches and extra HR. It would only require some additional inputs to convert this piecemeal approach to a comprehensive package of care to prevent and manage malnutrition (Prasad 2013a).

It is important to have a continuum of care so that prevention is also ensured. Therefore, protocols need to be put in place to identify children at risk through regular

growth monitoring which would be more meaningful if it identified children whose growth is faltering, rather than only those who have already reached the dire circumstances of severe malnutrition. This continuum of care approach, acknowledged in the NPC is lacking in the Restructured ICDS.

NATIONAL RURAL HEALTH MISSION

The only institutional care available for severe malnutrition is available in the form of Nutrition Rehabilitation Centres (NRC)/malnutrition treatment centres set up by the Health Ministry. These too are beset by staffing gaps, lack of capacity, and failures of back-up investigation and referral services (Prasad 2013a) and their impact itself is questionable because of the lack of community-based services for malnutrition as referred to in the sections above (Dasgupta et al. 2014).

Some state governments have started creating models and pilots for community-based management of malnutrition, such as the Village Child Development Centre (VCDC) programme in Melghat, Maharashtra (GoM undated), Atal Bal Mission in Madhya Pradesh (GoMP 2012), Bihar Malnutrition Project (MSF undated), and protocols for addressing 'growth faltering' through the ICDS in Odisha (GoO 2013). However these remain limited in the absence of support from central schemes and finances.

In fact the various piecemeal programmes on malnutrition merely fulfil some kind of schematic requirement, with no accountability for the final impact upon the child. Not only is this a critical violation of child rights, it is also irrational and cost-ineffective with high investments within NRCs being wasted due to lack of follow-up (Prasad 2013a, Prasad et al. 2012, Dasgupta et al. 2014).

Where healthcare services are concerned, the NRHM has hitherto offered general services to children but has recently embarked upon a highly ambitious programme; the Rashtriya Bal Swasthya Karyakram (RBSK) aimed at screening over 270 million children from 0–18 years for 4 Ds—Defects at birth, Diseases, Deficiencies, and Development Delays including Disabilities. Children diagnosed with illnesses are to receive follow-up, including surgeries at tertiary level, free of cost under the NRHM. The programme is yet to roll out but since it relies heavily on HR that are already suffering from critical gaps as analysed below, there are valid concerns about its implementation. The budgetary allocations are also to be derived from the already circumscribed budget as described in the section on budgets below.

The Subtext of Public Private Partnerships, Privatization, and Promotion of Commercialization in Nutrition and Health Policy

While one finds slow improvements in the quality and coverage of programmes for child health and nutrition, simultaneously what is being witnessed is systematic attempts to divert all the benefits of the expanded resources and coverage of these schemes to commercial interests. Notably, it is on the issue of privatization and entry of commercial interests that the policies remain silent or ambivalent thus permitting this trend.

For example, one of the recommendations of the NCPCR for the NPC, 2013 that were not adopted pertains to regulation of the private sector. Similarly, an area where the National Food Security Act makes a compromise is with relation to the supply of the food under the ICDS. The Act remains silent on the involvement of commercial interests in the supply for the meals. Based on a demand by the Right to Food campaign, the National Advisory Council (NAC) draft for instance, included the following clause, which was deleted in the final Act: 'No private contractors shall be used for the production and processing of take-home rations or freshly cooked meals under any maternal and child feeding programme' (NAC 2011).

Strangely, while many of its sections suffer from a lack of specificity and detail, the Twelfth Plan is quite specific regarding strategies related to the use of products like double-fortified salt and food fortification which have been the subjects of current academic debate in India (GoI 2013d, Expert Group 2003). Divided opinions exist on the evidence-base for their effectiveness in comparison to the use of diversity of diets and conventional supplementation programmes. When read alongside the other gaps such as the absence of decentralization and community ownership as overarching non-negotiables, and the absence of pronunciations to curtail profit-making through public programmes, these strategies seem designed to promote commercialization.

This contest between centralized, private-sector-led strategies versus decentralized delivery mechanisms with greater community control has been most pronounced in the arena of public programmes for nutrition. The ICDS programme has long been a site of contestation for the role of profit-making commercial interests in the supply of food in public programmes. In October 2004, the Supreme Court passed an order banning private contractors in the supply and distribution of the SNP

in ICDS and directed that local village bodies, Self Help Groups (SHGs), and panchayats must be given priority for this. Until then, in virtually every state in the country the SNP of the ICDS was being provided by contractors.

Besides compromising on quality and nutritive value, the contractor system proved disadvantageous in other ways as well. This system did not allow for monitoring to be decentralized, or for the community or panchayats to exercise any control whatsoever on the nature and quality of food given at the anganwadis, if it reached them at all (Patnaik 2006). The battle to dislodge contractors from the ICDS system, however, is far from over. Only about 6–7 states in the country can be said to be truly rid of the contractor system.

While many states are blatantly violating the Supreme Court orders, for instance Uttar Pradesh, where a major part of the contract is given to one company (Real Value Foods, which was owned by Ponty Chaddha, a well-known liquor baron who was known to be close to politicians from the main political parties in the state); other states have used innovative methods allowing backdoor entry of contractors. Therefore, it was seen that in Maharashtra eligible mahila mandals were defined in a way that the Take Home Rations (THRs) in the entire state were supplied by three mahila mandals which were front organizations for private companies (Patnaik 2012a) while on the other hand Gujarat argued that 'original manufacturers' are different from private contractors and, therefore, can be allowed. In other states such as Madhya Pradesh and Andhra Pradesh while the supply is supposed to be done by state-owned food corporations, in practice they actually sub-contract out to private companies. Jharkhand has recently put out a tender inviting SHGs and private manufacturers for supply of THRs where the odds are heavily loaded in favour of private manufacturers since the turnover expected from the SHG is that of Rs 10 million annually—something no genuine SHG would be able to demonstrate (WGCU6 2014).

The pressure for the entry of commercial products in public programmes was noted even earlier when the biscuit industry actively lobbied with the Government of India for the introduction of biscuits in school mid-day meals in place of provision of cooked food (Khera 2013, Baru et al. 2008, Sethi and Mukul 2008a and 2008b). Another arena where there is constant pressure for including commercial, product-based solutions is with community-based treatment for severe acute malnutrition (SAM) in children. Although India refused to import 'Plumpy Nut', a patented product for the treatment of SAM, product-driven strategies recommending commercial products continue to be actively pushed for by many development agencies, while campaigns have been arguing for community-based alternatives (Prasad et al. 2009). It is the lack of a clear policy at national level that allows these repeated attempts at bringing in such products.

The silver lining comes from states like Kerala, Odisha, and Chhattisgarh, who have put in place alternative mechanisms with well-defined processes that successfully facilitate such decentralized production of nutritional products for public programmes. These state-wide models provide evidence that decentralized production should and can be made a reality even while keeping safety and quality issues in mind (WGCU6 2014, Patnaik 2012b). This commitment to decentralization and community participation in some states such as Odisha and Chhatisgarh is also visible in terms of impact on infrastructure and pre-school education as noted by the recent Public Evaluation of Entitlement Programmes (PEEP) survey report (Drèze and Khera 2014).

Similarly, as a response to the poor status of public health services in terms of quantity and quality,[4] one of the main strategies being pushed by the government to offer 'universal access to heath care' (Baru 2012, Rao 2012) is that of Public Private Partnerships (PPPs) (Sundararaman and Prasad 2009). In terms of implementation, it is clear that the government has failed to monitor PPPs to allow even for the immediate gains to the public, thus allowing private partners to get away with profits without delivering their end of the bargain (Dasgupta, Nandi, Kanungo et al. 2013, Acharya and McNamee 2009, Mohanan et al. 2014). This is also well exemplified by the poor utilization of 'free beds' given to private hospitals in exchange for massive subsidies for land in New Delhi, by paediatric patients (Prasad 2013c).

Public Investment in Child Health and Nutrition

The most indisputable and obvious gap in policy-translation to services is that the investments that have been made in child health and nutrition, have been far from sufficient. This underlines the fact that the government is not willing to 'put its money where its mouth is' where children are concerned.

According to an analysis by the HAQ Centre for Child Rights, the overall percentage share of budget for children in the Union Budget is down from 4.76 per cent in 2012–13, to 4.64 per cent in 2013–14; a reduction for over 30 per cent of the population of this country that is also the most vulnerable (HAQ 2013).

Since the inception of the programme, the ICDS has always suffered from low budgets and very poor infrastructure even though there have been absolute increases in allocation. The budgetary allocation for the ICDS programme was Rs 103.917 billion during the Tenth Five Year Plan and was enhanced to Rs 444 billion in the Eleventh Plan period and Rs 1230 billion over the Twelfth Plan period (GoI 2013d). While there has been an impressive increase in the scale and coverage of the ICDS in the last 10 years, it remains insufficient to meet the requirements of an ICDS which is to be universalized with quality. For the roll out of the Restructured ICDS, beginning with 200 districts in the first year, the Ministry estimated a requirement of Rs 1830 billion for the entire scheme in the Twelfth Plan (Planning Commission 2011) as against the approved amount of Rs 1230 billion. Further, the actual budget allocation in 2012–13 was Rs 177 billion, even short of the annual Rs 246 billion budget which should have been provided on the basis of the Twelfth Plan allocation (GoI 2012). In the face of such a major budgetary cut, the fate of the ICDS Mission and the overall restructuring and strengthening of the ICDS once again teeters in the balance.

The unit cost for food under the ICDS is so low that there is no way in which a 'quality' meal can be provided with that amount. While the allocation for supplementary nutrition has gone up almost four times in the last 10 years—from 0.95 p per child per day in 2004 to Rs 4 per child per day currently (and Rs 6 per child per day in the 200 high burden districts)—this is not sufficient to provide good quality nutritious food and is in fact barely sufficient to meet the inflation effect. At the same time the required nutritional content of the SNP to be given has been increased from 300 calories a day to 500 calories a day. Therefore, in principle while it is being shown that children are being given more food under the SNP, the allocations have not been increased commensurately to make this change in quantity and quality possible.

Even in the case of budgets related to health, while there has been an overall increase in the budget in the last decade, it remains grossly insufficient to meet requirements. While the government has proclaimed in various policy documents that the goal is to spend about 2.5 to 3 per cent of GDP on health, the current public expenditure on health remains close to 1 per cent of GDP. Further, in the year 2013–14 the budget for health was only increased by a mere 8.2 per cent. Moreover, the increase in NRHM allocation was only 2 per cent which does not even compensate for inflation resulting in decline in allocation in real terms. Further, revised estimates are almost always less than budget allocations. For the National Health Mission, for example, while the budget estimate for 2012–13 provided over Rs 185 billion, the revised estimate was Rs 170 billion even though the department was well within what is the accepted rate of expenditure (PHRN 2013).

However, even relatively impoverished state governments are stepping into the gap to some extent, perhaps as a response to public pressure. For instance, Odisha and Madhya Pradesh have decided to increase the allocations to SNP for all their districts from state funds over and above the ICDS restructuring in limited districts. Madhya Pradesh has allocated Rs 5 billion to the Atal Bal Mission which provides for food security for malnourished children at village level (GoI 2010).

Impacts on Implementation

We now focus on outreach, and HR as a proxy factor for effectiveness and quality of implementation upon child health and nutrition. Broadly speaking, as is also clear from the analysis of policy and plans, the ICDS suffers from a failure to institutionalize through law and policy, resulting in problems with both outreach and quality. The health services, on the other hand are beset with similar problems despite decades of institutionalization, partially as a result of the lack of investment and planning reflected above. Not only is the outreach of services to children poor, there is an enormous crisis of quality of healthcare services for children from primary services to even in the best case scenarios of dedicated tertiary care centres which relate to low priority and poor implementation of existing policies (Paul et al. 2011, Bansal 2013, Prasad 2013d).

The lack of quality in the ICDS programme is well accepted by the government as well as civil society (Barooah et al. 2014, GoI 2013b, CAG 2013, Diwakar 2010, Dhuru 2009, Neenv 2007, CIRCUS 2006). Nonetheless, quality standards for the ICDS have not been set down in policy except for the ECCE policy which has not yet seen implementation.

OUTREACH

Many improvements in outreach have been made to the ICDS programme in the last few years. Following Supreme Court orders, there has been a significant increase in the number of AWCs, from 33 blocks in 1978 to almost every village across the country now being covered with an AWC. While there were about 540,000 AWCs in 2002, we now have 1.34 million operational

anganwadis. Similarly the coverage of children under the ICDS has also increased manifold. The number of children covered under the SNP has gone up from less than 30 million to 85 million children in the age group of six months to six years. In spite of these increases, the coverage under ICDS is nowhere close to universal.

One estimate suggests that 1.7 million AWCs are required to achieve universal coverage (NAC 2004). Further, in comparison with the number of children under six years of age according to Census 2011, the current coverage under the ICDS SNP programme is about 65 per cent of children under six years of age.[5] Moreover, it is well known that the official statistics tend to overestimate coverage. Therefore, the actual coverage of children under the ICDS can be expected to be even less. If this is the level of coverage, on an average each AWC serves 70 children and 16 mothers as beneficiaries (MWCD 2013), clearly a number too large for one AWW to manage with the help of one helper considering all the tasks that she is supposed to do.

In terms of other child health services as well it is found that the coverage is still poor. The repeat Annual Health Survey conducted in 2011–12 shows some improvement in most indicators compared to 2010–11. However, the change is slow, especially in some states. Among the nine states covered under the Annual Health Survey, with regard to immunization the state with the highest coverage is Uttarakhand with 78 per cent of children being fully immunized, and the least is Uttar Pradesh where only 48 per cent of children aged 12–23 months were fully immunized. While the coverage of Vitamin A supplementation ranges from 39 per cent in Uttar Pradesh to 73 per cent in Odisha, in all the states included in the survey the coverage of children in the age group of 6 to 35 months under the iron supplementation programme was less than 40 per cent with Rajasthan, Uttar Pradesh, Uttarakhand, and Jharkhand having a coverage of even less than 20 per cent (per cent of children receiving any Iron Folic Acid (IFA) syrup/tablet in the last three months).

HUMAN RESOURCES ISSUES

The Twelfth Plan as well as the Restructured ICDS documents bemoan the massive HR gaps that beset the public health system and the ICDS. The Twelfth Plan states that the 'gap between staff in position and staff required at the end of the Plan was 52 per cent for ANM and nurses, 76 per cent for doctors, 88 per cent for specialists and 58 per cent for pharmacists' (GoI 2013d). These shortages are attributed to delays in recruitment and to postings not being based on work-load or sanctions. Within this overall scenario, there are certain specific challenges that affect children more directly.

Approximately 800,000 ASHAs have been appointed as per the NRHM and one of their main tasks is to support families for child health and nutrition. However, a clever manipulation of the contradiction of being an 'accredited health *activist*' has lead to a situation whereby she is to report to the health system, take orders from it, and also depend upon it for payment of incentives for various tasks decided by the health department, but not be paid as a regular health worker. One of the outcomes of this is that the ASHA tends to focus more on incentivized activities such as promotion of institutional deliveries rather than on other functions such as nutrition counselling or activating the Village Health, Nutrition, and Sanitation committees. The capacities of the ASHA as well as her support structures have also suffered from poor implementation and governance (NHSRC 2013).

Though ASHAs are trained to recognize illness and refer children for health interventions, they are scarcely able to leverage the same in a situation where hardly any referral back-up is available. For example, 18 per cent of Primary Health Centres (PHCs) are without a doctor, about 38 per cent are without a laboratory technician, and the staffing gap for paediatricians lies at about 47 per cent (Rao et al. 2011). Meanwhile, one of the weakest areas of the ASHA programme remains the availability and use of the drug kit for immediate medical care.

As with the ASHA, AWWs, on whose shoulders delivery of most of the basic nutrition services rest, are paid very poorly. The AWW is supposed to work for six hours a day and is paid Rs 3000 a month, enhanced from Rs 1500 a month in 2011. However, this is not even as much as minimum wages for unskilled workers. Further, the AWW's wages are not inflation-indexed and, therefore, in real terms her wages are decreasing with each passing year.

In the case of the ICDS too, there is a severe shortage in supervisory staff. According to the latest available data, 35 per cent of sanctioned supervisor posts and 33.6 per cent of sanctioned Child Development Project Officer (CDPO) posts are still vacant (MWCD 2013). Such high vacancies obviously affect the management, monitoring, and supervision of the programme. Clearly, these lacunae hinder quality and outreach of services by design.

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Our analysis and experience of public policy, programmes, and the lives of children through the decades reveals a

systemic situation in India that would be interesting in its paradox had it not been also so disappointing, given that we have had almost seven decades to be able to deliver on promises of equal rights, opportunities, and welfare of all children.

The policy environment is forced to respond to a contested arena of pulls between people's aspirations and the pushes of the classes benefiting from privatization and institutionalized exploitation. The state's response is either to shy clear of a policy statement at all, or to create laws and policies exemplified in some ways by the National Food Security Act which take no clear positions and make articulations that attempt to simply place side-by-side, even those recommendations that may be contradictory to each other. All possible strategies, thus may find a way to go forth within the spaces currently allowed within policy depending upon political will. Thus, for instance, it is left to implementers to choose to centralize health and nutrition programmes, target them narrowly, and distribute them to private agencies as they more often prefer, or decentralize them to allow greater community control and a focus on more sustainable mid-term to long-term strategies. Since the decision-making is in the grips of a dominant paradigm of liberalization and privatization, the public is often left with a Hobson's choice—take what is being offered or nothing at all. The silver lining in the cloud, nonetheless, is the fact that while national efforts limp towards the actualization of child rights, many lagging states are starting to take independent action and invest in child nutrition. In the unforgivable absence of recent data on nutrition, the impact, however, remains to be seen.

In this contestation, it has been the role of civil society, organized (for instance, the Right to Food Campaign, People's Health Movement-India), or sporadic, to keep up a constant struggle to tip the balance in favour of more comprehensive, sustainable, community-owned, rational, cost effective, and child-centric processes. These, necessarily, are not amenable to profiteering or showing superficial immediate results often attributed to more 'technical' fixes (results which also, significantly, do not pass the test of rigorous evaluation!). Historically, though the disciplines exist, 'preventive', 'social', or 'community' medicine have not been given primacy in developing, managing, or monitoring public health programmes. It is perhaps for this reason that there has been such poor focus on the preventative and inter-sectoral aspects of issues like nutrition. A public health approach has the potential to create common understanding and common cause between the clinical and social sciences. It is hoped that the emergence of this domain, though recent and tenuous, will allow for more comprehensive and convergent action.

Meanwhile, the lack of political will and insufficient investments ensure that children continue to suffer needlessly in the absence of the very basics of nutrition and health care. The situation is further compounded by gross failures of implementation, such as the complete lack of iron syrups in the field for years on end (a strategy which would be contested by no one at all), delayed payments to SHGs for months, and so on, as our antediluvian and notorious bureaucratic systems (Satish 2004) fail the public again and again with impunity and successfully resist accountability.

The imperatives for action, thus are truly monumental—from the creation of favourable policy to strategizing programmes, to forcing the implementation of basic actions related to education, livelihoods, water, sanitation, healthcare services, and food security; and the only answer to why this has not happened hitherto, is housed not in technical debates, but entirely, as Virchow reminds us, in politics.

Notes

1. From the personal records of author Dr Vandana Prasad who was a member of NCPCR at the time and party to the framing of recommendations made to the Ministry.

2. Personal communication from Vandana Prasad, Member NCPCR, New Delhi during the period August 2012 to November 2013.

3. The ongoing Public Interest Litigation (PIL) in the Supreme Court, PUCL v. Union of India & Ors (CWP 196/2001) is commonly known as the 'Right to Food' case. The petition focuses on the general need to uphold the right to food, which follows from the fundamental 'right to life' enshrined in Article 21 of the Indian Constitution. In this case the Supreme Court has passed more than 50 interim orders and judgments some of which are significant in their scope and content. Some of the orders include provision of cooked meals in all government schools, provision of anganwadi services in all habitations, timely payment of old age pensions, following of transparency norms by PDS shops, distribution of excess stocks of food grains in government godowns, opening of shelters for the homeless in urban centres, and so on. *See*, http://www.righttofoodindia.org/case/case.html (accessed on 23 March 2015) for details on the case and corresponding orders of the Supreme Court.

4. For instance, *see*, the articles published in the special issue of *The Lancet* on India: Towards Universal Health Coverage, 11 January 2011.

5. It can be estimated that there are about 129 million children in the age group of six months to six years according

to Census 2011. The coverage of children in this age group under the ICDS SNP programme is 85 million.

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