I dream

India: Free from Hunger

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In the last decade and a half that India has successfully embraced economic reforms, a curious problem has haunted the country and vexed its policy makers: India's excellent growth has had little impact on food security and nutrition levels of its population. Per capita availability as well as consumption of foodgrains has decreased; unemployment among agricultural labour households has sharply increased from 9.5 per cent in 1993-94 to 15.3 per cent in 2004-05; the percentage of underweight children has remained stagnant between 1998 and 2006; and more than half of India's women and three-quarters of children are anaemic with no decline in the last eight years.

A recent UNDP survey of 16 districts in the seven poorest states of India showed that for 7.5 per cent of respondents access to food is highly inadequate, and for another 29 per cent of the households it is somewhat inadequate. A West Bengal government survey too reported that 15 per cent families were facing difficulties in arranging two square meals a day year round. The NSSO's calorie data shows that at any given point in time the calorie intake of the poorest quartile continues to be 30 to 50 percent less than the calorie intake of the top quartile of the population, despite the poor needing more calories because of harder manual work. Second, daily calorie consumption of the bottom 25 per cent of the population has decreased from 1,683 kcalories in 1987-88 to 1,624 kcalories in 2004-05. These figures should be judged against a national norm of 2,400 and 2,100 kcalories/day for rural and urban areas fixed by GOI in 1979. Similar downward trend is observed for cereal consumption too. As the relative price of food items has remained stable over the past twenty years, declining consumption can be attributed to the lack of purchasing power and contraction of effective demand by the poor, who are forced to spend a greater part of their limited incomes on non-food items like transport, fuel and light, health, and education, which have become as essential as food.

In short, all indicators point to the hard fact that endemic hunger continues to afflict a large proportion of Indian population. Internationally, India is shown to be suffering from alarming hunger, ranking 66 out of the 88 developing countries studied by IFPRI in 2008. India as part of the world community has pledged to halve hunger by 2015, as stated in the Millennium Development Goal 1, but the present trends show that this target is unlikely to be met.

According to the National Family Health Survey, the proportion of underweight children remained virtually unchanged between 1998-99 and 2005-06 (from 47 to 46 percent for the age group of 0-3 years). These are appalling figures, which place India among the most "undernourished" countries in the world. Higher child malnutrition rate in India (for that matter in the entire South Asia) is caused by many factors. First, Indian women's nutrition, feeding and caring practices for young children are inadequate. This is related to their status in society, early marriage, low weight at pregnancy and their lower level of education. The proportion of infants with a low birth weight in 2006 was as high as 30 per cent. Underweight women produce low birth-weight babies which become further

vulnerable to malnutrition because of low dietary intake, lack of appropriate care, poor hygiene, poor access to medical facilities, and inequitable distribution of food within the household.

Second, many unscientific traditional practices still continue, such as delaying breast feeding after birth, no exclusive breastfeeding for the first five months, irregular and insufficient complementary feeding after between 6 months to two years of age, and lack of disposal of child's excreta because of the practice of open defecation in or close to the house itself. Clearly government's communication efforts in changing the age old practices are not working well.

And lastly, poor supply of government services, such as immunisation, access to medical care, and lack of priority to assigned primary health care in government programmes also contributes to morbidity. These factors combined with poor food availability in the family, unsafe drinking water and lack of sanitation lead to high child under-nutrition and mortality. About 2.1 million deaths occur annually in under-5 year-old children in India. Seven out of every 10 of these are due to diarrhoea, pneumonia, measles, or malnutrition and often a combination of these conditions.

Policy recommendations

Hunger is caused by a large number of factors and hence solutions too have to be multi-sectoral in nature. First, revamp small holder agriculture. Because of stagnating growth in agriculture after the mid-1990s there has been employment decline, income decline and hence a fall in aggregate demand by the rural poor. The most important intervention that is needed is greater investment in irrigation, power, and roads in poorer regions. It is essential to realize the potential for production surpluses in Central and Eastern India, where the concentration of poverty is increasing.

Second, launch watershed development programmes in uplands, where most tribes live. In a successful watershed programme the poor benefit in three ways. First, as the net sown area and crop intensity increases more opportunities for wage employment are created, which may also increase the wage rate besides the number of days of employment. Second, increased water availability and reduced soil erosion increases production on small and marginal farmers' lands. And last, the higher productivity of Common Property Resources (CPRs) improves access of the poor to more fodder, fuelwood, water and NTFPs.

Third, start a drive to plant fruit trees on degraded forests and homestead lands that belong to or have been allotted to the poor. This will not only make the poor people's diet more nutritious, but will also diversify their livelihoods and reduce seasonal vulnerability.

Fourth, create more job opportunities by undertaking massive public works in districts with low agricultural productivity. The legal guarantee of 100 days wages available under the National Rural Employment Guarantee Act (NREGA), according to the Comptroller and Auditor General of India (CAG), has been fulfilled in only 3 per cent of the cases. In addition to increased outlays, the scheme should have a food component, now that GOI has a comfortable stock of foodgrains. Monitor the inclusion of old people especially

widows among the wage workers, who are often turned away illegally from the worksite. Their work guarantees should be extended to 150 days through an amendment in the Act.

Fifth, provide separate ration cards as well as NREGA job cards to all 'single' women, regardless of whether they live alone, with dependents, or in their natal or husband's home. Likewise for aged, infirm and disabled people who may or may not live with 'able-bodied' caregivers.

Sixth, improve the skills of the poor for market oriented jobs, so that they are absorbed in the sunrise industries such as hospitality, security, health, and construction.

Seventh, improve the distribution of subsidized foodgrains to the poor through the Public Distribution System (PDS). This would require a correct listing of BPL families, as errors mean many BPL families are excluded and above poverty line (APL) families are included. Launch a drive in collaboration with civil society to cover the poorest, as a large number of homeless and poor living in unauthorised colonies in urban areas have been denied ration cards, and are thus not able to avail of PDS, on the ground that they do not have an address!

Eighth, restructure ICDS (Integrated Child Development Services). Despite a three-fold increase in its budget by the GOI in the last five years and the contention of the Ministry of Women and Child Development that there are 1.5 early child-care centres (ICDS Centres) per village now, ICDS is reaching only 12.5 per cent children in the age group 6 months to 6 years. As the Centre is likely to be located in the richer part of the village, it may not reach the vulnerable children of poorer households and lower castes and those living in remote areas. The programme targets children mostly after the age of three when malnutrition has already set in. It does not focus on the critical age group of children under three years, the age window during which health and nutrition interventions can have the most effect.

The focus of ICDS should be health and nutrition education, encouraging women to breastfeed exclusively for six months and after that add semi-solid family food four to six times a day in appropriate quantities for the infant, which alone can improve the infant's nutrition levels. For nutrition to improve, we have to strengthen proper breastfeeding and complementary feeding, together with complete immunisation and prompt management of any illness.

Ninth, cover all adolescent girls under ICDS or Mid-day meals programme. They need to be graded according to age, such as 10-15 group, 16-19 group and pregnant girls. Then they should be weighed regularly, and given appropriate nutritious food containing all the desired micro-nutrients and iron. Similar initiative is needed for all women.

Tenth, establish ICDS centres on priority within one year in all primitive tribal group (PTG) settlements and the most discriminated Scheduled caste settlements, without any ceiling of minimum children; and all other hamlets with more than 50 per cent SC, ST, or minority populations within two years. In all these centres, ICDS staff should be locals from the discriminated communities, and two hot meals should be served instead of one to children aged 3 to 6 years; and weaning foods be given at least twice daily to children below 3 years.

Eleventh, prepare a comprehensive list every two years of all destitutes needing free or subsidized cooked food. Open up mid-day meals kitchen to these old, destitutes and hungry in the village. This is already being done in Tamil Nadu, and its replication in other states should be funded by the GOI. Establish community kitchens across cities and urban settlements to provide inexpensive, subsidised nutritious cooked meals near urban homeless and migrant labour settlements.

Last, India requires a significant increase of targeted investments in nutrition programs, clinics, disease control, irrigation, rural electrification, rural roads, and other basic investments, especially in rural India, where the current budgetary allocations are inadequate. Higher public investments in these areas need to be accompanied by systemic reforms that will overhaul the present system of service delivery, including issues of control and oversight. Outlays should not be considered as an end in itself. Delivery of food based schemes requires increasing financial resources, but more importantly the quality of public expenditures in these areas. This in turn requires improving the governance, productivity and accountability of government machinery, as discussed below briefly.

Improve accountability

The Indian state implements massive food, livelihood and social security programmes – some of the largest in the world – which theoretically support vulnerable people from even before their birth to their survivors after death. On paper, expectant mothers are fed in ICDS centres, along with infants, children up to the age of six, and adolescent girls. Children in school get school meals. As adults, women receive maternity support, bread earners are guaranteed 100 days of wage employment in public works; and if identified as poor, they can buy subsidised cereals from a massive network of half a million ration shops. The aged – and in many states widows and disabled people – are given pensions. And if an earning adult dies prematurely, the survivor is entitled to insurance.

This looks good on paper but the ground reality is different. These programmes are plagued by corruption, leakages, errors in selection, delays, poor allocations and little accountability. They also tend to discriminate against and exclude those who most need them, by social barriers of gender, age, caste, ethnicity, faith and disability; and State hostility to urban poor migrants, street and slum residents, and unorganised workers. Therefore, not only do we need to identify the destitutes and run special programmes for them, but improve monitoring and accountability for all programmes that impinge on hunger.

In the ultimate analysis, the constraints to reduction in hunger are rooted in bad policies, faulty design, lack of appropriate monitoring and evaluation, poor governance and lack of political will. Action is needed on all the fronts. Economic growth alone is insufficient to bring about significant reductions in the prevalence of malnourishment among children, or increase in food intake of the poor. Without a major shake up in policy and an improvement in the effectiveness of its implementation, the attainment of the MDGs by India in this regard looks extremely unlikely.