Overview of Take-Home Rations

This is an abridged article based on the Pharos Global Health Advisors’ policy brief for Tata Trusts - The India Nutrition Initiative. Reproduced with permission.

Key messages

- India’s Supplementary Nutrition Programme receives INR 15,000 crore in funding from the central government, making it one of the largest such initiatives in the world, reaching 8.5 crore children under six & 2 crore pregnant and lactating women. It has three components: hot cooked meals and a morning snack in the Anganwadi Centers and Take-Home Rations for home use.

- In 2000, the Government of India restarted its Integrated Child Development Services programme to all states, and in 2006, the Supreme Court ruled for universal access. Universalization, coupled with financial expansion in 2009, has resulted in improved coverage across states as well as increased reach for a wide range of marginalized groups.

- To fill the nutrient gap, the Supplementary Nutrition Programme mandated the provision of fortified blended supplementary food products called Take-Home Rations for home use for children under three years, pregnant and lactating women and, in some states, adolescent girls.

- The Take-Home Ration program has made great strides over the last 20 years, but enduring challenges must be tackled in order to meet nutrition goals and ensure that all children and pregnant and lactating women are given adequate supplementary foods for healthy development.

The Architecture of the Integrated Child Development Services

India is home to one-third of the world’s stunted children (4.7 crore) and half of the world’s wasted children (2.6 crore), while nearly 41% of Indian children less than five years old are anemic. To combat malnutrition, the Government of India (GoI) launched the Integrated Child Development Services (ICDS) in 1975, which offers a variety of nutrition and health services in order to impact the first 1,000 days of life. This timeframe is imperative for preventing long-term consequences associated with malnutrition, particularly during pregnancy, and later as infants transition out of breastfeeding. Housed within ICDS is the Supplementary Nutrition Programme (SNP) that aims to fill the gap in nutrition amongst children under six as well as pregnant and lactating women (PLW). The SNP is supposed to provide hot cooked meals and micronutrient-fortified and energy-dense food called Take-Home Ration (THR) across the country. Specifically, the program stipulates that THR should meet 50% of the daily Recommended Dietary Allowance (RDA) per beneficiary. Today, the GoI allocates over $2 billion annually to the SNP, making it one of the largest supplementary feeding programs in the world. In total, ICDS serves ~8.5 crore children under six and ~2 crore PLW. Namely, the THR program has three categories of beneficiaries: children 6 to 36 months old, children 6 to 72 months with severe acute malnutrition (SAM) and PLW. India’s ICDS program is directed and executed by the Ministry of Women and Child Development (MWCD). The central government stipulates guidelines, RDA standards and cost norms, based on criteria outlined by the Indian Council of Medical Research (ICMR). Through MWCD, these guidelines are distributed to the country’s 29 States and 7 Union Territories. Each state has the liberty to generate distinct THR products and ingredients, using the central government’s standards and guidelines as a reference. However, this devolution of responsibilities creates large variations in THR products and delivery models between states. Under the 2017 Supplementary Nutrition Rules, Monitoring and Review Committees at the national, state, district, block and Anganwadi Centre (AWC) levels are responsible for monitoring and reviewing proper sanitation, supply, and functioning of THR distribution within AWCs. Meanwhile, it is the responsibility of District Project Officers (DPOs) and Child Development Project Officers (CDPOs) to ensure the quality of the supplementary nutrition with reference to food safety norms.
and food composition.\(^7\)

Originally, states were responsible for funding their own SNPs. Due to limited funding coverage by states, it was decided in the year 2005-06 that the GoI would pay for 50% of the expenditures incurred. However, in the year 2009-10 the GoI modified payment proportions to reflect actual funding requirements by different states (Table 1). So, some states continue to pay in 50:50 ratio, while for others, the central government bears all or 90 per cent of the supplementary nutrition costs.\(^8\)

### Scaling Up and Universalization

In 2013, reviews of effective nutrition interventions estimated that scaling up a set of proven nutrition-specific interventions could reduce stunting globally by 20% and reduce child mortality by 15%.

ICDS was expanded to all states in the year 2000, and soon after in the year 2006, the Supreme Court of India ruled for universal access to ICDS services. The goal of universalization was to reach the most marginalized and malnourished children and PLW through the establishment of 14 lakh ICDS centers across India.\(^9\)

Then in 2009, financial expansion was implemented as well as the rights-based framework for supplementary food. Finally, in 2012, the Supreme Court ordered that THR should be manufactured through processes that safeguard infection through any form of contamination, preferably through an automated facility.\(^9\)

![TABLE 1: Current Central-to-State Payment Ratios, with information from MWCD, n.d.](image)

Not only has universalization allowed for improved coverage across all states, but also enhanced reach for a wide range of marginalized groups. The reach of supplementary food across India is illustrated in figure 1 below. Nevertheless, research conducted by Chakrabarti et al. also demonstrates that while service-use has increased significantly, the expansion of services has failed to reach the poorest quintiles, particularly in the poorer states and states with high burden of undernutrition.\(^9\) These shortfalls indicate that performance of THR production and distribution in high-poverty states could lead to continued exclusions if facilities are not strengthened. Further, inadequate reach of beneficiaries amongst the poorest quintiles is compounded by the challenge of reaching remote rural areas.

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### The National Nutrition Mission

Given these persistent challenges and gaps, in 2018 the GoI launched the National Nutrition Mission (NNM) which aims to strengthen the ICDS framework, systems and functions as well as converge nutrition activities...
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At all the levels of the government (central, state, and local). Within the NNM, State Program Management Units oversee nutrition agendas and activities, Convergent Action Plans are developed to execute nutritional strategy and coordination across stakeholders, and district and state-level officers regularly review data and targets. Nutrition targets in India are based on a wide range of frameworks and organizational strategies. For instance, the United Nations’ Sustainable Development Goals (SDGs) significantly influence ICDS targets given that at least twelve of the seventeen SDGs contain indicators related to nutrition. Within the NNM framework, the GoI aims to reduce all forms of undernutrition by 2030. Specifically, three indicators were conceptualized by the GoI with targets for 2022. First, reduction of underweight children below five (35.7% to 20.7%). Second, reduction in prevalence of anemia in children below five (58.4% to 19.5%). Lastly, reduction in prevalence of anemia in PLW 15 to 49 years old (53.1% to 17.7%). The GoI has made tremendous investments in scaling-up the SNP program and universalizing THR access. As such, SNP coverage has increased from 26.3% in 2006 to 48.1% in 2016. Further, between 2005-06 and 2016-18, prevalence of stunting declined from 48% to 34.7%, underweight from 42.5% to 33.4% and wasting from 19.8% to 17%. This data indicates that the THR program has made great strides over the last two decades, but enduring challenges must be tackled in order to meet nutrition goals and ensure that all children and PLW are given adequate supplementary foods to support their healthy development.

Key milestones

The milestones of THR program under ICDS programme is illustrated in table 2.

Looking Forward

FIGURE 1: Proportion of women with children under five years of age who received foods supplements during pregnancy throughout India

Top 10 districts (%)
- Subarnapur (OR) 96.9
- Nuapada (OR) 96.6
- Baudh (OR) 96.5
- Kandhamal (OR) 95.7
- Balangir (OR) 95.6
- Belgaum (KA) 95.5
- Bargari (OR) 95.4
- Nabarangapur (OR) 95.2
- Dhamtari (CT) 95.1
- Khandwa (MP) 94.7

Bottom 10 districts (%)
- Mon (NL) 3.0
- East (DL) 3.3
- West Siang (AR) 3.4
- Dibang Valley (AR) 3.8
- North (DL) 4.4
- West Kameng (AR) 4.8
- Mewat (HR) 4.8
- Dimapur (NL) 5.1
- Palwal (HR) 5.2
- Longleng (NL) 5.2

Source: NPHS-4 (2015-16)
TABLE 2: Key milestones of the SNP programme

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<tr>
<th>Year</th>
<th>Milestones</th>
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<td>1975</td>
<td>ICDS launched in 33 blocks with 4891 AWCs; SNP was an integral part of it.</td>
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<td>1978</td>
<td>ICDS Scheme discontinued.</td>
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<td>2000</td>
<td>ICDS scheme restarted in all states catering to 6 lakh AWCs.</td>
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<td>2004</td>
<td>Commercial contractors excluded from THR production ruled by the Supreme Court of India.</td>
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<td>2005</td>
<td>Up to 50% of the expenditures borne by by States/UTs are supported by Central Govt.</td>
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<td>2006</td>
<td>Universal access to ICDS services ruled by the Supreme Court of India. Minimum nutrition provision to be guaranteed by ICDS and decentralisation of THR production involving local SHGs and mahila mandals mandated.</td>
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<td>2009</td>
<td>Financial expansion and revised nutrition and feeding norms implemented. Cost-sharing pattern between Central and North-Eastern states changed from 50:50 to 90:10 ratios.</td>
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<td>2012</td>
<td>Supreme Court emphasized on quality and safety standards during THR production and role of automated machines in it. Further, it underscored the importance of micronutrient fortification and certification of SNP under ICDS scheme in various states. They ruled that THR should only be produced by competent groups who comply with the Revised Norms, regardless of whether they are SHGs, Mahila Mandals, Village Community or a manufacturer.</td>
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<td>2016</td>
<td>The difference in odds of reaching beneficiaries amongst scheduled castes and tribes and general castes declined from 2 times to 1.45 times.</td>
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<td>2018</td>
<td>GoI launched the National Nutrition Mission (NNM) with THR program as the centrepiece of ICDS strengthening</td>
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References