

Structural Failures and Surveillance: India's Health System and the Persistence of Anaemia

A Case Study of Damoh District, Madhya Pradesh

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Abstract

Background: India's public health system has been characterised by chronic underfunding, unequal access, and a progressive shift towards privatisation. Despite numerous national programmes, anaemia remains a major public health crisis, affecting the majority of women, children, and working-class populations across the country.

Objectives: This article examines the structural determinants of anaemia prevalence in India, with particular focus on Damoh district in Madhya Pradesh. It critically analyses the gap between India's stated health policy objectives and the lived realities of marginalised populations, drawing on Foucault's concept of the surveillance state to interrogate the role of data-driven governance in public health.

Methods: A mixed-methods approach was employed, combining secondary data analysis of NFHS-4 (2015–16), NFHS-5 (2019–21), and WHO World Health Statistics 2021 with primary qualitative research conducted in Damoh and Tendukheda blocks, Damoh district (2021–22). Qualitative data were gathered through Focus Group Discussions (FGDs) and In-Depth Interviews (IDIs) at both provider and community levels.

Results: Anaemia rates among all key demographic groups have worsened between 2015–16 and 2019–21, despite existing interventions. India lags significantly behind comparable economies in healthcare infrastructure, health expenditure (3.1% of GDP), and physician density (9.3 per 100,000 population). Field evidence from Damoh reveals that poverty, seasonal unemployment, lack of nutritional awareness, and eroded public trust in healthcare institutions are the primary drivers of persistent anaemia at the community level.

Conclusion: Anaemia in India is fundamentally a political and socio-economic problem. Curative and data-surveillance approaches alone are insufficient. Sustained improvement requires increased public health expenditure, universal preventive healthcare, poverty alleviation, and community-level education and awareness programmes.

Keywords: *Anaemia, Health Policy, Surveillance State, Public Health, NFHS, Madhya Pradesh, Health Equity, Social Determinants of Health, India*

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I. Introduction

Social change is an ongoing process in which advances in knowledge, scientific innovation, and healthcare are central to improving human life. Modern states have established elaborate institutional frameworks to ensure that these advances are universally accessible. However, in practice, access to quality healthcare is frequently determined not by need but by economic privilege, geographic location, and social class. India represents a compelling and troubling case study in this regard.

India's health system occupies a precarious position: poised between an aspirational welfare mandate and the realities of chronic underfunding, bureaucratic inefficiency, and rapid privatisation. While private healthcare has expanded exponentially, it remains financially inaccessible to the majority of the population — those who work in informal sectors, agriculture, and construction, often in hazardous conditions without social security. The public health system, which is meant to serve this majority, is paralysed by insufficient infrastructure, staff shortages, and a lack of accountability.

This paper argues that India's health policy has operated, to a significant degree, as what Michel Foucault would call a 'surveillance mechanism' — a system preoccupied with generating population-level data and monitoring demographic indicators, while failing to translate this information into meaningful improvements in health outcomes (Foucault, 1975; Gandy, 1993; Zuboff, 2019). The creation of national health surveys, disease registries, and digital databases does not, in itself, constitute healthcare delivery. It constitutes the management of populations as objects of knowledge rather than subjects of welfare.

To ground this critique empirically, this article focuses on the specific public health crisis of anaemia — a condition that affects more than half of Indian women and over two-thirds of children under five — and situates it within the structural failures of India's healthcare system. The analysis draws on both national survey data (NFHS-4 and NFHS-5) and primary qualitative research conducted in Damoh district, Madhya Pradesh, to illuminate the gap between policy intent and lived experience.

II. Theoretical Framework

This study employs Foucauldian critical theory as its principal analytical lens, specifically the concept of 'biopower' and the disciplinary surveillance of populations (Foucault, 1975). Foucault argues that the modern state governs not merely through laws and force, but through the production of knowledge about populations — their births, deaths, diseases, and behaviours. Public health systems, from this perspective, are simultaneously mechanisms of care and instruments of control.

In the Indian context, this theoretical lens draws attention to a paradox: the state's investment in health data infrastructure — national family health surveys, the Aadhaar-linked health database, the Ayushman Bharat digital health mission — is extensive and sophisticated, yet the material conditions that produce ill-health (poverty, malnutrition, polluted working environments, inadequate nutrition) remain largely unaddressed. The state becomes, in Foucauldian terms, an expert in describing illness rather than eliminating its structural causes.

This framework is complemented by Oscar H. Gandy Jr.'s concept of the 'panoptic sort' (1993), which describes how data systems classify populations in ways that tend to reinforce existing inequalities, and by Shoshana Zuboff's (2019) analysis of surveillance capitalism, which highlights how data collection can serve accumulation rather than welfare. Together, these perspectives support the paper's central argument: that India's health surveillance apparatus has outpaced its health delivery capacity, and that this inversion must be corrected if anaemia and related conditions are to be meaningfully reduced.

III. Historical Development of Healthcare Policy in India

India's engagement with systematic healthcare dates to antiquity. The Indus Valley civilisation developed environmental sanitation programmes, including drainage systems and public bathing facilities, as early as 3000 B.C. (Deodhar, 1982). Ayurvedic traditions provided community-based medical care for centuries, and while these practices were not clinical in the modern sense, they offered a framework of community health embedded in social life.

The arrival of British colonial administration in the nineteenth century marked the beginning of a modern, institutionalised health system, though one that was limited in scope and skewed in its beneficiaries. The first significant public health document in British India was the 1863 Report of the Royal Commission on the Sanitary State of the British Army in India (Harrison, 1994). Motivated primarily by the health of colonial troops following the Rebellion of 1857, this report initiated a wide-ranging inquiry into conditions across the subcontinent. Colonial health policy was therefore designed principally to protect the colonial apparatus rather than to serve the Indian population (Amrith, 2009).

Following independence, India undertook ambitious efforts to build a modern, inclusive health system. The Bhore Committee Report (Government of India, 1946) — produced by the Health Survey and Development Committee under Sir Joseph Bhore — was the foundational document of post-colonial Indian health policy. It recommended a comprehensive, integrated health service emphasising both curative and preventive care, improved nutrition, and expanded medical research. It advocated for a ratio of one primary health unit per 10,000 rural inhabitants.

In practice, implementation fell far short of this vision. The Murlidhar Committee (1959) evaluated the limited progress made during the first two Five-Year Plans, finding that health infrastructure remained grossly inadequate. By the end of the Second Plan, there was one Primary Health Unit per 140,000 rural inhabitants — fourteen times fewer than the Bhore Committee had recommended (Government of India, 1980). The first formal National Health Policy was not adopted until 1983, nearly four decades after independence.

From the 1980s onwards, economic liberalisation accelerated the growth of the private health sector. While this expanded the quality and variety of services available to wealthier urban populations, it simultaneously marginalised the public system, which suffered from declining relative investment, deteriorating

infrastructure, and a crisis of accountability. Today, India's public health system is unable to meet the demands of the world's most populous nation, and a large proportion of health expenditure is borne out-of-pocket by patients — a situation that pushes millions into poverty each year.

IV. Methodology

This study adopts a mixed-methods research design, integrating secondary quantitative data analysis with primary qualitative fieldwork. This approach enables both a macro-level understanding of anaemia trends and a micro-level appreciation of the social and structural factors that shape health outcomes in a specific locality.

4.1 Secondary Data Analysis

National-level and state-level data were drawn from the National Family Health Survey, Rounds 4 and 5 (NFHS-4: 2015–16; NFHS-5: 2019–21), published by the Ministry of Health and Family Welfare, Government of India. Global comparative data were sourced from the World Health Statistics 2021, published by the World Health Organization. Indicators analysed include prevalence of anaemia by age, gender, and rural/urban residence; maternal mortality ratio; under-five and neonatal mortality rates; health workforce density; and national health expenditure as a proportion of GDP.

4.2 Primary Qualitative Research

Fieldwork was conducted over two phases between 2021 and 2022 in Damoh and Tendukheda blocks of Damoh district, Madhya Pradesh. Damoh was selected as a purposive case study site because it is a predominantly rural district with significant scheduled caste and tribal populations, high rates of poverty and agricultural employment, and below-average health outcomes — making it representative of the conditions faced by marginalised communities across central India.

Two complementary qualitative methods were employed:

- **Focus Group Discussions (FGDs):** A total of six FGDs were conducted — four at the community level and two with frontline health workers (ASHA and ANM workers). Community-level FGDs included women of reproductive age, mothers of young children, and male household heads. Discussions explored community perceptions of health, anaemia awareness, access to public and private healthcare facilities, and experiences with government health schemes.
- **In-Depth Interviews (IDIs):** Fourteen in-depth interviews were conducted with purposively selected informants, including community members, healthcare workers, and local health administrators. Interviews explored individual experiences of anaemia, barriers to treatment, and perceptions of the effectiveness of government programmes such as Anaemia Mukh Bharat.

All FGDs and interviews were conducted in Hindi, audio-recorded with participants' consent, and subsequently transcribed and translated. Thematic analysis was employed to identify recurring patterns, drawing on an inductive coding approach. Ethical clearance was obtained from the institutional ethics committee, and all participants were assured of anonymity and the right to withdraw.

4.3 Reflexivity

The researcher acknowledges that, as an insider to the academic discourse on Indian health policy, their prior commitments may shape the interpretive process. An effort has been made to ensure that analytical claims are grounded in empirical evidence and that field participants' voices are represented faithfully and contextually.

V. Anaemia as a Public Health Crisis

5.1 Clinical and Epidemiological Profile

Anaemia is a haematological condition in which the haemoglobin concentration in the blood falls below normal thresholds, reducing the blood's capacity to carry oxygen to body tissues. The condition arises most commonly from inadequate dietary iron intake, malabsorption, blood loss, or increased physiological demand (as in pregnancy and lactation). It affects individuals of all ages but is particularly severe among children under five, adolescent girls, and women of reproductive age, for whom it carries heightened risks of cognitive impairment, complications in pregnancy, and increased susceptibility to infection (Kulkarni, Durge, and Kasturwar, 2012).

The World Health Organization classifies a public health problem as severe when anaemia prevalence among children exceeds 40%, or among women of reproductive age exceeds 40%. By these criteria, India faces a severe anaemia crisis across virtually all demographic groups.

5.2 Trends in Anaemia Prevalence: NFHS-4 to NFHS-5

Table 1 presents the percentage of anaemic individuals across key demographic groups in India and Madhya Pradesh for the NFHS-4 (2015–16) and NFHS-5 (2019–21) survey rounds. The data reveal a deeply concerning pattern: anaemia prevalence has increased rather than decreased across most categories over the five-year

period, despite the existence of national programmes including the National Iron Plus Initiative and Anaemia Mukh Bharat.

Table 1: Percentage Prevalence of Anaemia by Age Group — India and Madhya Pradesh, NFHS-4 and NFHS-5

Age Group	NFHS-4 (2015–16) India %	NFHS-4 (2015–16) MP %	NFHS-5 (2019–21) India %	NFHS-5 (2019–21) MP %
Children (6–59 months)	58.0	68.9	67.1	72.7
Adolescent Girls (15–19 yrs)	54.0	53.2	59.1	64.5
Adolescent Boys (15–19 yrs)	29.0	36.5	31.1	22.5
Women of Reproductive Age (15–49 yrs)	53.0	52.5	57.0	54.7
Pregnant Women (15–49 yrs)	50.0	54.6	52.2	52.9
Lactating Women	58.0	58.4	66.3	57.0

Source: National Family Health Survey, Rounds 4 (2015–16) and 5 (2019–21), Ministry of Health and Family Welfare, Government of India.

The data demonstrate several important patterns. First, anaemia among children aged 6–59 months increased from 58.0% to 67.1% at the national level and from 68.9% to 72.7% in Madhya Pradesh — indicating that more than two-thirds of young children in the state are anaemic. Second, anaemia among women of reproductive age rose from 53.0% to 57.0% nationally. Third, lactating women experienced the sharpest national increase, from 58.0% to 66.3%. Only adolescent boys in Madhya Pradesh showed a declining trend (from 36.5% to 22.5%), which may reflect increased male participation in formal employment and associated improvements in nutrition. These trends establish that existing curative interventions — primarily iron and folic acid supplementation — are not sufficient to reverse anaemia at the population level. The data point instead to the need for structural interventions that address the underlying socio-economic determinants of nutritional deficiency.

6. India in Global Comparative Perspective

Situating India within a global comparative framework reveals the depth of its health deficit. Table 2 compares India with selected developed countries and WHO regional groupings across five key health indicators for 2017–2020.

Table 2: Comparative Global Health Indicators — Selected Countries and WHO Regions

Country / Region	Anaemia in Women 15–49 (%) 2019	Maternal Mortality per 100k 2017	Under-5 Mortality per 100 births 2019	Neonatal Mortality per 1000 births 2019	Child Stunting <5 yrs (%) 2020
USA	11.8	19	6	4	3.2
United Kingdom	11.1	7	4	3	—
China	15.5	36	8	4	4.7
India	53.0	145	34	22	30.9
African Region	40.0	525	74	27	31.7
Americas Region	15.4	57	13	7	8.9
South-East Asia Region	46.6	152	32	20	30.1
European Region	18.8	13	8	4	5.7
Eastern Mediterranean	34.9	164	46	25	26.2
Western Pacific	16.4	41	11	6	9.3
Global	29.9	211	38	17	22.0

Source: World Health Statistics 2021, World Health Organization.

India's anaemia prevalence among women of reproductive age (53.0%) is nearly five times that of the United States (11.8%) and the United Kingdom (11.1%), and more than three times that of China (15.5%). India's maternal mortality ratio of 145 per 100,000 live births is more than seven times the United Kingdom's figure of

7, and its under-five mortality rate of 34 per 100 live births compares unfavourably with the USA (6), the UK (4), and China (8).

Importantly, these disparities broadly correlate with differences in public health expenditure and healthcare infrastructure. Countries with lower anaemia and mortality rates devote substantially larger shares of their GDP to health. In 2019, the United States spent 16.2% of GDP on health, the United Kingdom 10.2%, and China 5.4%. India spent 3.1% — and this share has declined over time, from 4.2% of GDP in 2004–05 to 3.1% by 2016–17, even as the population's healthcare needs have grown.

Within India, significant interstate variation mirrors these global disparities. Kerala, a state with historically high social development indicators, recorded an anaemia prevalence of 36.5% among women aged 15–49 — compared with 54.7% in Madhya Pradesh. This intra-national variation confirms that anaemia is not merely a consequence of national poverty, but of differential investment in education, public health infrastructure, and social welfare.

7. Healthcare Infrastructure and the Structural Deficit

The quantitative evidence on India's healthcare workforce and infrastructure further contextualises the persistence of anaemia and poor health outcomes. Table 3 presents data on anaemia by urban/rural residence and gender for 2019–21, confirming that rural populations bear a disproportionate burden.

Table 3: Anaemia Prevalence by Population Group, Residence, and Gender — India, NFHS-5 (2019–21)

Population Group	Urban (%)	Rural (%)	Total (%)
All Women (15–49 years)	53.8	58.5	57.0
Adolescent Women (15–19 years)	56.5	60.2	59.1
Non-Pregnant Women (15–49 years)	54.1	58.7	57.2
Pregnant Women (15–49 years)	45.7	54.3	52.2
All Men (15–49 years)	20.4	27.4	25.0
Adolescent Men (15–19 years)	25.0	33.9	29.2
Children (6–59 months)	64.2	68.3	67.1

Source: National Family Health Survey, Round 5 (2019–21), Ministry of Health and Family Welfare, Government of India.

In every category, rural anaemia prevalence exceeds urban prevalence by a significant margin. Pregnant women in rural areas, for example, show an anaemia rate of 54.3%, compared with 45.7% in urban areas. For adolescent men, the rural rate (33.9%) is more than a third higher than the urban rate (25.0%). This urban-rural divide reflects the geographic concentration of healthcare facilities, nutritional food markets, and educational resources in urban centres, leaving rural populations — who constitute the majority of India's poorest — systematically underserved.

Table 4: Density of Medical Doctors and Nursing Personnel — Selected Countries and WHO Regions

Country / Region	Medical Doctors per 100,000 pop. (countries: 2011–2019; WHO regions: 2018)	Nursing & Midwifery per 10,000 pop. (countries: 2011–2019; WHO regions: 2018)
USA	26.0	156.9
United Kingdom	58.2	102.9
China	51.8	133.2
India	9.3	23.9
African Region	2.8	0.3
Americas Region	28.4	82.7
South-East Asia Region	8.7	24.5
European Region	43.2	77.8
Eastern Mediterranean	10.9	16.4
Western Pacific Region	18.9	36.9
Global	17.5	39.0

Source: World Health Statistics 2021, World Health Organization.

Table 4 confirms India's severe health workforce deficit. With only 9.3 medical doctors per 100,000 population, India has approximately one-third the global average (17.5) and less than a sixth of the United Kingdom's density (58.2). The nursing and midwifery workforce is similarly sparse: 23.9 per 10,000 population, compared with 156.9 in the United States and 133.2 in China. These workforce deficits directly limit the capacity of the public health system to provide maternal health services, nutritional counselling, and preventive care — all of which are essential to reducing anaemia.

According to the World Health Statistics 2021, the total number of doctors in Primary Health Centres (PHCs) as of 31 March 2019 was 29,799 in rural areas and 4,457 in urban areas. Given that India's rural population is approximately 900 million, this translates to roughly one PHC doctor per 30,000 rural inhabitants — far below any internationally recognised standard of adequate coverage.

8. Field Findings: Damoh District, Madhya Pradesh

The qualitative fieldwork conducted in Damoh and Tendukheda blocks of Damoh district provides granular evidence of the structural conditions underlying anaemia prevalence. The findings corroborate and enrich the picture presented by national survey data, revealing the lived dimensions of health inequality.

8.1 Poverty, Seasonal Employment, and Nutritional Deficiency

Across all FGDs and interviews, poverty emerged as the foundational determinant of poor health. Participants described livelihoods that were predominantly dependent on seasonal agricultural work, with significant periods of unemployment. During lean agricultural seasons, household income dropped sharply, and expenditure on food — particularly protein and micronutrient-rich foods — was curtailed.

One elderly male participant in Tendukheda block described the situation succinctly: 'We know we should eat better food, but when there is no work and no money, we eat what we have. Sometimes just roti and salt.' This observation reflects a structural reality: the nutritional knowledge to prevent anaemia may exist at the community level, but the economic capacity to act on it does not. This finding challenges the predominant policy assumption that nutritional education alone is sufficient to address anaemia — an assumption that appears to underestimate the primacy of poverty as a barrier.

For older women and for households without a male earner, the situation was described as particularly dire. Women in such households were constrained from migrating for work and were entirely dependent on erratic local income. Several participants reported that health concerns, including persistent fatigue and breathlessness (common symptoms of anaemia), were routinely ignored because the cost of losing a day's work outweighed the perceived benefit of seeking medical care.

8.2 Erosion of Trust in Public Healthcare

A recurrent theme across both FGDs and IDIs was a profound erosion of trust in the public health system. Participants consistently reported preferring private facilities, despite their higher costs, citing poor infrastructure, absenteeism of healthcare staff, and a perceived lack of dignity and accountability in public facilities.

One female FGD participant in Damoh block stated: 'In the government hospital, the doctor is sometimes not there. Sometimes the medicines are not there. If you go to private, at least someone will see you.' This sentiment was echoed by multiple participants and aligns with broader evidence from India on the declining utilisation of public health facilities among even low-income populations (Sengupta and Nundy, 2005).

This erosion of trust has direct implications for anaemia prevention and treatment. Antenatal care visits — critical for anaemia screening, iron supplementation, and nutritional counselling — were reported as irregular, particularly after the first visit. National data confirm this: NFHS-5 records that while 70.0% of mothers attended at least one antenatal check-up, only 58.1% completed the recommended four or more visits. The gap is wider in rural areas: 67.9% versus 54.2%, respectively. Participants attributed this drop-off not only to logistical barriers (distance, transportation) but also to discouraging experiences during initial visits — long waiting times, dismissive treatment, and unavailability of medicines.

8.3 Awareness, Education, and Superstition

Levels of health literacy were found to be low, particularly among older women and in more remote villages. Superstitious beliefs and traditional remedies were commonly cited as alternatives to formal medical care. Several participants reported that anaemia was not recognised as a medical condition but attributed to spiritual causes or interpreted as a normal aspect of womanhood.

However, fieldwork also revealed that younger, educated women — particularly those who had completed secondary education — were significantly more likely to be aware of anaemia, to have attended antenatal care, and to be taking iron supplements. This observation is consistent with the NFHS-5 data: the national female literacy rate is 71.5% overall, with a pronounced rural deficit (65.9% in rural areas versus 83.0% in urban areas). The data suggest that investments in girls' education have compounding returns for public health — a finding that supports a preventive, multi-sectoral approach to anaemia reduction.

A frontline health worker (ASHA) interviewed in Damoh block described the challenge of community outreach: 'We go to the houses, we give the tablets, we explain. But people forget, or they think the tablets make them feel sick. Some women do not take them regularly. Without better education and support, it is very difficult.'

9. Discussion

The convergence of national statistical evidence and field-level qualitative data produces a coherent and sobering diagnosis. Anaemia in India is not a clinical anomaly to be addressed through pharmaceutical supplementation alone; it is a social disease — a condition produced and reproduced by structural inequality, inadequate public investment, and a health system that has increasingly prioritised private provision over universal welfare.

Returning to the Foucauldian framework, it is notable that India's health surveillance apparatus has become highly sophisticated. The NFHS is one of the world's most comprehensive demographic and health survey programmes. The Ayushman Bharat digital health mission aims to create a universal health ID for every Indian citizen. Yet the data generated by these systems consistently reveal worsening health outcomes among the most vulnerable populations. The question that must be asked is: for whom are these data being collected, and to what end are they being used?

If surveillance data were being translated into targeted, adequately resourced interventions — if the government's knowledge of anaemia's prevalence were matched by commensurate investment in nutrition, income support, healthcare staffing, and rural infrastructure — one would expect to see improvements. The trend data show the opposite. This suggests that the data function primarily as instruments of governance and accountability performance, rather than as drivers of genuine health improvement. The state can point to the existence of programmes; the data can report their nominal reach. But the programmes are underfunded, the frontline workers are overstretched, and the structural causes — poverty, agricultural precarity, gender inequality — remain unaddressed.

This is not to dismiss the value of health data or surveillance. Rather, it is to insist that surveillance without welfare is not health policy. It is administration. Genuine health policy requires the state to act upon what its data reveal — to invest, to redistribute, and to prioritise the health of its most vulnerable citizens.

10. Policy Recommendations

Based on the findings of this study, the following policy recommendations are advanced:

- **Increase Public Health Expenditure:** India must progressively increase health expenditure to at least 5% of GDP — consistent with WHO recommendations — with a focus on primary and preventive care in rural areas. The chronic underfunding of public health infrastructure is the single most consequential structural failure documented in this study.
- **Strengthen Primary Healthcare Infrastructure:** The density of doctors, nurses, and allied health workers must be substantially increased, particularly in rural and tribal areas. Incentive structures for healthcare professionals to serve in underserved districts — including Damoh and similar areas in central India — must be developed and implemented.
- **Address Socio-Economic Determinants:** Anaemia cannot be resolved through health interventions alone. Poverty alleviation programmes, guaranteed rural employment, food security schemes, and nutritional supplementation must be expanded and effectively implemented. The Anaemia Mukh Bharat initiative requires increased resourcing and integration with social protection mechanisms.
- **Invest in Girls' and Women's Education:** Field evidence confirms that women's literacy is a powerful predictor of health awareness and healthcare utilisation. Universal secondary education for girls, with particular attention to rural and economically marginalised communities, is a necessary long-term investment in public health.
- **Rebuild Trust in Public Healthcare:** Restoring community confidence in the public health system requires measurable improvements in service quality, accountability of healthcare providers, and reliable availability of medicines and diagnostics. Community health workers (ASHAs) must be better trained, better supported, and better remunerated for their critical frontline role.
- **Reorient Health Surveillance Toward Action:** The government's considerable investment in health data systems should be matched by institutional mechanisms that translate data into targeted, resourced action — particularly for populations and regions identified as high-burden. The gap between data generation and policy response must be urgently narrowed.

11. Conclusion

This paper has examined the structural dimensions of India's anaemia crisis through a combination of national survey data and qualitative fieldwork in Damoh district, Madhya Pradesh. The evidence is unambiguous: anaemia prevalence is rising, the public health system is chronically underfunded and under-

staffed, and the communities most affected — poor, rural, and informal-sector workers — are systematically excluded from both private healthcare and effective public provision.

Applying a Foucauldian analytical lens, this study has argued that India's health governance has come to privilege the production of health data over the delivery of health outcomes. This inversion — surveillance in place of welfare — is not merely an administrative failure; it is a structural injustice that reproduces inequality across generations. Children born anaemic into anaemic households, in districts without adequate healthcare infrastructure, to parents unable to afford either nutritious food or private medicine, face a systemic disadvantage that no amount of survey data, without corresponding material investment, can resolve.

Good health is both a fundamental human right and an economic necessity. A healthy population is a productive population; a society that fails its most vulnerable members pays a compounding cost in human suffering, lost productivity, and diminished development potential. India possesses the knowledge, the institutional capacity, and — given its growth trajectory — the financial resources to significantly reduce anaemia and improve public health. What is required is the political will to reorient policy from surveillance to substantive welfare.

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