HUNGER AND MALNUTRITION

10.8 An attempt to assess the food security status and the relative position of states can often be misleading in the absence of a clear understanding of the relationship between the notion of hunger, poverty and malnutrition. Incidence of hunger, estimated from NSS data for 2004-05 in terms of households having inadequate food, is seen to be only affecting a small percentage of households at all-India level at 1.9 per cent (Table 10.4). It also is concentrated in states like West Bengal, Orissa and Assam though again in small dimension. Inadequacy of food is being addressed through the public distribution system (PDS). PDS is a major state intervention to ensure food security to people especially the poor. The Eleventh Five Year Plan has observed that PDS seems to have failed in making foodgrain available to the poor as is evident from falling levels of cereal consumption over the last two decades. PDS was redesigned as Targeted PDS (TPDS) where higher rates of subsidies were given to the poor and the poorest among poor. However, some major deficiencies were also identified in TPDS. These included high exclusion and inclusion errors, non-viability of fair price shops, leakages and failure in price stabilization. In this situation, it may be useful to introduce food stamps/coupons which may be valid outside the PDS outlets once the markets get better integrated. Food coupons will allow the consumers a wider choice. However, their value needs to be indexed to the food inflation. Multi-application smart cards will also enhance the efficiency of administering various schemes. In PDS system, the smart card will reduce the incidence of bogus ration cards or diversion of foodgrains. Leakages can also be restricted by redirecting subsidies currently under PDS to better funding of other schemes like Mid-Day Meal scheme or the ICDS.

10.9 While poverty rates have declined significantly, malnutrition has remained stubbornly high. Malnutrition, as measured by underweight children below 3 years, constituting 45.9 per cent in children under 3 years of age as per the National Family Health Survey 2005-06 (NFHS 3) has still remained much higher. It has also not significantly declined from its level of 47 per cent in 1998-99 (NFHS 2). Malnutrition reflects an imbalance of both macro and

micro-nutrients that may be due to inappropriate intake and/or inefficient biological utilization due to the internal/external environment. Poor feeding practices in infancy and early childhood, resulting in malnutrition contribute to impaired cognitive and social development, poor school performance, and reduced productivity in later life. Malnutrition therefore is a major threat to social and economic development as it is among the most serious obstacles to attaining and maintaining health of this important age group. It is evident that existing policies and programmes are not making a significant dent on malnutrition and need to be modified. While per capita consumption of cereals has declined, the share of non-cereals in food consumption has not grown to compensate for the decline in cereal availability.

10.10 It may be observed that malnutrition cannot entirely be explained by poverty though it is an important determinant (Table 10.4). Even Punjab with poverty ratio of only 8.4 per cent has 27 per cent children below 3 years as underweight. Andhra Pradesh, Assam, Gujarat and Haryana are some other examples of high malnutrition among children with lower levels of poverty. Hence, there is need to focus on the malnutrition issue in our policies and programmes. While the ability to access such food items depends on household income and is addressed through programmes like NREGS, there are other factors which are equally important but are ignored. Household/family knowledge and information about the locally available food is useful from the nutrition perspective. This knowledge is based on traditional knowledge, ability to read coupled with availability of appropriate reading material on nutrition, access to media such as newspapers, radio and TV, along with propagation of such information on the radio and special programmes that directly educate mothers about child rearing and nutrition such as ICDS. The ICDS programme seems to have helped in providing public health education to mothers and thus contributed to the outcome in states like Tamil Nadu and Himachal Pradesh. However, in order to have larger impact beyond nutrition to other health outcomes, a comprehensive programme for improving civic amenities of a public health nature to a defined standard is necessary to remove visible symbols of divide between rich and

Table 10.4 : Incidence of hunger, poverty, malnutrition and availability of public health facilities in major States

States	Inadequate food (%) 2004-05	Poverty % of population (URP) 2004-05	Malnutrition under 3 yrs. underweight children (%) 2005-06	Public health % of households drinking water facilities (2001)*	Public health % of households access to toilet facility 2005-06
A.P.	0.5	15.8	36.5	80.1(67.8)	42.4
Assam	5.0	19.7	40.4	58.8(11.6)	76.4
Bihar	2.7	41.4	58.4	86.6(4.2)	25.2
Gujarat	0.2	16.8	47.4	84.1(72.7)	54.6
Haryana	0.1	14.0	41.9	86.1(61.1)	52.3
H.P.	0.0	10.0	36.2	88.6(65.1)	45.6
Karnataka	0.2	25.0	41.1	84.6(57.4)	46.5
Kerala	2.3	15.0	28.8	23.4(24.6)	96.0
M.P.	1.6	38.3	60.3	68.4(25.0)	27.0
Maharashtra	0.8	30.7	39.7	79.8(78.6)	53.0
Orissa	5.3	46.4	44.0	64.2(10.2)	19.3
Punjab	0.7	8.4	27.0	97.6(54.6)	70.8
Rajasthan	0.0	22.1	44.0	68.2(45.4)	30.8
T.N.	0.3	22.5	33.2	85.6(84.2)	42.9
U.P.	1.5	32.8	47.3	87.8(10.3)	33.1
W.Bengal	9.0	24.7	43.5	88.5(27.9)	59.5
Chhattisgarh	2.2	40.9	52.1	70.5(16.8)	18.7
Jharkhand	0.6	40.3	59.2	42.6(11.3)	22.6
All-India	1.9	27.5	45.9	77.9(42.0)	44.5

Source : NFHS 3, NSSO, Planning Commission, O/O RGI.

*** Figures in parentheses give corresponding position regarding households using piped drinking water as per NFHS 3 (2005-06).**

poor, that slums and other neighbourhoods with poor drainage and sewerage create.

10.11 Improvement of public health education and public health facilities also have an important and positive link with nutrition outcomes. Social welfare, while giving additional weight to the income/ consumption of the poor, must also give importance to the access of the poor to public goods. This is due to the fact that individual welfare depends not only on the private consumption but also on public goods and services supplied by the state. Public health and literacy are interlinked, higher literacy levels lead to quality public health. Longevity and mortality reduction are more related to public health than to treatment of individual diseases. Public health includes better drainage and sewerage system (sewage treatment plants) that provides solid waste disposal management and drinking water system that delivers disease-free water. The current position is illustrated by the low proportion of the population with access to improved sanitation facilities across many states especially Bihar, M.P., Orissa, Rajasthan, Uttar Pradesh, Chhattisgarh and Jharkhand (Table 10.4). Public health also includes public education about nutrition, hygiene and disease to reduce the problem of asymmetric information. Literacy and primary education aids in this process and contributes to the general well-being. Together these can contribute immensely to the quality of life of all citizens, particularly the poor. Hence, quasi-public goods are of critical importance to the poor. The Government must ensure that every citizen has access to education and also making it more relevant by providing information on matters that will improve their lives (health, hygiene, nutrition). Public health initiatives such as clean drinking water, sanitation, sewerage, control of communicable and epidemic diseases and public health education play an important role in reducing mortality rates at every age and across the gender. These should be the focus of the Government as part of its strategy to promote inclusive growth.