The consequences of child under-nutrition are enormous, as it has significant impact on mortality, morbidity and productivity, which reduces potential economic growth. There is a growing volume of research indicating South Asia has become the global hub of the malnutrition problem. This article has tried to examine available literature on this subject, identify underlying causes for severe child malnutrition, examine some of the interesting interventions launched in the country to tackle this issue and has tried to propose a policy framework for tackling this problem in a time-bound and outcome oriented manner. The period between pregnancy and the first two years of life is the major “window of opportunity” in which to address under-nutrition. Malnutrition is a multidimensional phenomenon. Protein energy malnutrition manifests itself through poor gains in height, weight, and circumferences of head and mid-upper arm. Symptoms such as skin peeling, abdominal distension, liver enlargement and sparse hair and as behavioural characteristics such as anxiety, irritation, and attention deficit may also accompany protein deficiency. Micronutrient deficiency results from inadequate levels of iron, folate, iodine, and various vitamins, including A, B6, D and E. These deficiencies lead to anaemia, goitre, bone deformities and night blindness.

2. Convention on Rights of Child (1989) provides for appropriate prenatal and postnatal health care for mothers and recognises that every child has right to a standard of living adequate for the child’s physical, mental and social development. Second MDG target is to halve between 1990 and 2015, the prevalence of underweight children under five years of age and the proportion of population below a minimum level of dietary energy consumption.

Review of the Existing Literature on malnutrition, its extent and forms

3. Child undernourishment is multi-causal problem where socio-economic factors are highly relevant. Earlier literature identified maternal features, personal illness and prenatal care as mechanisms that induce stunting during pregnancy. Mosley and Chen (1984) have identified five determinants which directly affect morbidity and mortality and these are – (i) maternal factors; (ii) environmental contamination; (iii) nutrient deficiency; (iv) injury, either accidental or intentional, and (v) personal illness control.

4. Studies by Anand and Ravallion (1993) have tried to explore the link between health, per capita national income, poverty and outreach of social services and have shown that poor have lower life expectancy and spent more on public health. In a typical poor country, doubling the female education will result in reduced infant mortality rate by 27 points in next

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1 By Charu Mishra and Anand Mohan Tiwari (2019). This Status Paper was updated as part of lecture to M.S.A. students of Central University of Gujarat. Copyright rests with authors.
decade (Subarao and Raney, 1995). Wagstaff and Watanabe (1999) finds very strong correlation between poor children and high prevalence of stunting. Other studies have also shown that chronic malnutrition is associated with weak socioeconomic position. Maternal education, socio-economic position of the household, source of drinking water, breast feeding, mother’s height, wealth and age have a positive association with child’s health. Coming from a poor family or having low-educated parents, living in rural areas, or belonging to indigenous groups are facts directly and significantly correlated with child malnutrition. Safe drinking water access rate beyond 40% has only a marginal impact on child malnutrition.

5. In a study of Latin American countries of Bolivia, Colombia and Peru, it was observed that antenatal care seems to matter only marginally. Children born in wealthier families or from more educated or taller women tend to be healthier. In that sense, over-coming chronic malnutrition among children becomes a more difficult task as variables that could be controlled by policy makers such as antenatal care programs seem to be less directly associated with child health than factors like low household income which are more difficult to tackle (Ramirez, 2010).

6. Improving the medical services or doubling of national income per capita would have much more impact on infant mortality and country’s income may itself be affected by health of its citizens. Conversely, education and increase in the income have a potential to raise health status (Pritchett and Summers, 1996). There is a positive relation between GDP per capita growth and improvement in the weight of children where every one point increase in growth rate leads to 0.24% decrease in underweight prevalence every year. Child malnutrition rate falls below 25% when the annual per capita GDP is over US$ 3000, whereas below per capita GDP of US$ 2000, there can be up to 71% child malnutrition in South Asia and Sub-Saharan Africa. A one-point increase in GDP growth rate can lead to 0.24% decrease in underweight prevalence.

7. South Asian malnutrition rate is much higher than the Sub-Saharan Africa despite equal or favourable poverty rates, higher food availability and better levels of health and sanitation services (Osmani 1997). It is conclusively shown that low birth weight and low status of women in South Asia are an important cause of child stunting and the four key variables which influence child malnutrition are per capita national income, level of women’s education, effectiveness of national health services and per capita availability of food.

8. Between the years 1975 and 1995, improvement in women’s education has contributed the most (43%) of the total reduction, national food availability has contributed 26%, health environment contributed 19%, whereas women’s status within the family contributed 12% only. Per capita income, which has contributed to 7.4% reduction, is another important variable. A study by Smith and Haddad (2000) projects various scenarios for child malnutrition and points out that South Asia will have the highest prevalence of malnourished children till 2020. Although a decline of 23% will be experienced, 30% or 167 million
9. Food availability, which is presently very low at 2300 kcal, is a strong determinant of malnutrition but does not help in reducing child malnutrition beyond 3120 kcal. Efforts to promote food security must focus on promoting access to food at the household level as well (Smith and Haddad, 2000). They classify the developing countries into three food availability groups, a high impact group with per capita daily energy availability up to 2300 kcal, medium impact group between 2300 and 3120 and a low impact group with per capita daily energy supply about 3120 kcal. Most of the countries in South Asia fall into the high impact group. Food availability emerges as a factor that needs to change the least to bring about a 1% drop in child malnutrition rate. As such, it is the most important factor in reducing child malnutrition in South Asia. Surprisingly, health environment improvement appeared to be a relatively weak force for reducing child malnutrition.

10. An increase in developing country per capita GDP of $ 202 is needed to reduce the child malnutrition by 1%, however this factor loses its force over $ 4750. In case, South Asian per capita GDP is brought to that level, child malnutrition will fall by 18.5%. In China, the prevalence of child underweight fell at an annual rate of more than 8%, backed by a 12% annual growth rate. As far as the relation between access to safe drinking water and female secondary education is concerned, 13.1% increase in safe drinking water will cause same impact as a 4.6% increase in female secondary education (Smith and Haddad, ibid).

11. Iron deficiency anaemia affects about 2 billion people in developing countries and results into increase risk of low birth weight, premature delivery, fatigue and a quarter of maternal deaths. Treatment of Iron deficiency can raise national productivity levels by 20%. The most vulnerable, the poorest and the least educated are disproportionately affected by iron deficiency. The comprehensive intervention package features (i) iron supplements, iron-rich diets, increasing iron absorption and fortification, (ii) control of hookworm infections, malaria and schistosomiasis, and (iii) control of major nutrient deficiencies.

12. Iodine deficiency during pregnancy is associated with low birth weight, cretinism and mental impairment. It impairs physical growth, causes goiter, preventable mental retardation and brain damage. Globally, 2.2 billion people live in regions where iodine deficiency is endemic. Iodine-deficient children have been shown to have IQs that are, on average, 13.5 points lower.

13. Vitamin A deficiency (VAD) is a public health problem in 118 countries, especially the Africa and South-East Asia, hitting hardest young children and pregnant women in low-income countries. For children, lack of vitamin A causes severe visual impairment and blindness, and significantly increases the risk of severe illness, and even death, from such common childhood infections as diarrhoeal disease and measles. For pregnant women, deficiency occurs especially during the last trimester when demand by both the unborn child
and the mother is highest. Breast milk is a natural source of vitamin A. Periodic supply of high-dose Vitamin A in swift, simple, low-cost, interventions is being increasingly used to control VAD. Food fortification of sugar in Guatemala maintains vitamin A status for high-risk groups.

14. Malnutrition also causes reduced capacity to learn and fewer total years of schooling. Children with higher nutritional status during the preschool years start primary school earlier, repeat fewer grades and have higher high school completion rates. Physical impairment associated with malnutrition is estimated to cost more than 2-3% of GDP per annum. Iron deficiency decreases productivity by 5-17%. Iodine deficiency causes productivity losses totalling approximately 10% of GSP. Micronutrient deficiencies alone may cost India US$ 2.5 billion annually.

15. Over-crowding, congestion, shortage of clean water and inadequate facilities for the disposal of human excreta contribute to the development of gastrointestinal infections, such as diarrhea. Good water and sanitation at the neighbourhood level has a positive effect on the height of children.

**Physiology of malnutrition**

16. Mechanism that brings stunting among children starts by intrauterine growth restriction. Malnutrition, maternal underweight, smoking and alcohol use may increase the risk of growth restriction. Similarly, hypertensive disease, insufficient weight gain and obstetric complication increase the risk of lower birth rate. Growth failure is the main sign of undernourishment and problems like vitamin-A deficiency and anaemia may emerge during in utero stage (Ramirez, 2010).

17. Malnutrition and micronutrient imbalances weaken immune defence, cause decreased resistance of infection, low T-cell production, abnormal function of monocytes and macrophages, abnormal function of neutrophils and leukocytes, impairment of thymus-mediated immunity, poor or depressed response to new antigens and deterioration of lymphoid tissues. Malnutrition induced failing immunity is the leading cause of death of children. Many of the infectious diseases can be prevented and controlled by simple and affordable measures like nutrient supplementation (Niedzwiecki, A. and Rath, M.).

18. Protein-energy malnutrition and micronutrient deficiencies retard physical and cognitive growth and increase susceptibility to infection. Child malnutrition is responsible for 22 percent of India’s burden of disease and undermines educational attainment and productivity. Most growth retardation occurs by the age of two and is largely irreversible.

19. Protein-energy malnutrition weakens immune response and aggravates the effects of infection, causes severe diarrheal episodes and higher risk of pneumonia. Women are at more risk of obstetric complications and low birth weight deliveries result is an intergenerational cycle of malnutrition, coronary heart disease, diabetes, high blood pressure and poor cognitive and motor development.
20. Iodine Deficiency is the world’s most prevalent cause of brain damage. Serious iodine deficiency during pregnancy may result in stillbirth, abortions and congenital abnormalities such as cretinism, a grave, irreversible form of mental retardation that affects people living in iodine-deficient areas of Africa and Asia. Sub-clinical Vitamin A deficiency is a well-known cause of xerophthalmia and keratomalacia which lead to blindness, limit growth, weaken the immune system, exacerbate infection respiratory and gastrointestinal infections. Occurring concurrently among children with PEM, is estimated to be responsible for about 1 million child deaths annually.

21. Sudden food deprivation due to natural or manmade emergencies produces a condition known as kwashiorkor. Apathy, swelling (oedema) of the extremities, torso and face, cracked, peeling, infection-prone skin and unnaturally blond, sparse hair are its visible characteristics. Marasmus causes depletion of fat and muscle tissues and the skin hangs in loose folds with the bones.

22. After inclusion of child malnutrition as one of the MDG goals, the pressure to come up with estimates of the proportion of children suffering from malnutrition grew. As a result, height and weight, which are easy to measure quickly became the focus of attention. Under-nutrition is measured as the prevalence of underweight, stunting or wasting. World Health Organization (WHO) has identified weight-for-height, height-for-age and weight-for-age as some of the key anthropometrics indicators of child growth.

**Food prices**

23. In addition to their economic, social and political impacts, food prices spikes worsen the problem of hunger by increasing poverty. They can lead to long-term, irreversible nutritional damage among children. Poorer households with consumption levels that were already below the calorie adequacy threshold are the worst affected as their calorie intake is further reduced.

24. The problem of global hunger will progressively aggravate due to demands of bio-fuels and issues like climate change and localised production of key staple commodities. Global reserves for maize and wheat are at historically low levels which may increase food prices and lead to deterioration of diets and erode households purchasing power. Increasing food prices in Bangladesh and Pakistan left 80% of the households worse off between 2006-2008. Among the worse off, the poorest households experienced the greatest losses in spending. Poverty rose by 5% in Bangladesh during that period resulting into further decline in the calorie intake of those houses and large reduction in calorie consumption were found in households with children younger than two years of age. During period of inflation, it is often food intake that suffers because food consumption is more flexible expenditure than rent, school fees and transport (IFPRI, *Ibid*).

**The Indian Situation**

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25. Bihar, Madhya Pradesh, Uttar Pradesh, and Rajasthan account for more than 43 percent of all underweight children and the prevalence in underweight is falling more slowly in the high prevalence states. Interestingly, under-nutrition is concentrated in a mere 10 percent of villages and districts which account for 27-28 percent of all underweight children. More than 75 percent of preschool children suffer from iron deficiency anaemia (IDA) and 57 percent of preschool children have sub-clinical Vitamin A deficiency (VAD). Iodine deficiency is endemic in 85 percent of districts. 46% of children were stunted and 16% could be classified as wasted. Even mild malnutrition is linked to a two-fold increase in mortality and these levels of undernutrition significantly compromise health and productivity (Gragnolati, M. ibid). 52% of all ever-married women aged 15 to 49 years have some degree of anaemia. Prevalence of anaemia (up to 87%) and iodine deficiency in pregnant women are estimated to have so far caused the congenital mental impairment of about 6.6 million children.

26. Malnutrition plays a role in about half of all child deaths and more than half of child deaths from major diseases such as malaria (57%), diarrhea (61%) and pneumonia (52%). Paediatric malnutrition is a risk factor for 22.4% of India’s burden of disease. When food intake is low, the intake of many other nutrients is usually also inadequate. Children who are underweight or stunted are at greater risk for childhood morbidity and mortality, poor physical and mental development, inferior school performance and reduced adult size and capacity for work.

27. Underweight prevalence is so pervasive throughout the wealth distribution that even in the wealthiest fifth of the population 33% of children are underweight and 8.5% are severely underweight. Thus, most at risk for underweight are girls whose families are poor, belong to schedule tribes or caste, and live in rural areas. The chance that a girl with all these characteristics is underweight is as high as 0.92.

28. The percentage reduction in severe underweight prevalence from 1992/93 to 1998/99 was dramatically higher in urban areas (26%) than in rural areas (16%) and greatest percentage reduction in prevalence of underweight and especially severe underweight, accrued to children in the wealthiest quintiles. Decline in male underweight prevalence fell by 14.3% compared to the 6% decline in female underweight prevalence during this period. Percentage decline, however, was smaller for scheduled caste and tribes.

29. Interstate disparities are quite significant. Rajasthan and Orissa even registered a sharp increase in total underweight prevalence. Gujarat (50%) has a rural underweight prevalence. Tripura’s urban underweight prevalence of 52% is not only higher than the national urban average of 38%, but also exceeds the rural underweight prevalence. In Delhi and Orissa, the percentage of underweight boys is higher than the percentage of underweight girls. Even the wealthiest quintile has a prevalence of malnutrition (33%) that far exceeded the MDG goal. Economic growth alone is unlikely to be sufficient to lower the prevalence of malnutrition.

South Asian Enigma

Mishra, C. and Tiwari, A. M. (2019) | Approach to tackle malnutrition in India
30. In South Asia, 50% of children under age 5 are malnourished compared to 31% in Sub-Saharan Africa. This huge difference has been called an “enigma” because South Asia is doing much better than Sub-Saharan Africa for most of the determinants of child malnutrition. It has 31% better access to safe water, 17% better female secondary education, 220 kilo calories of higher dietary energy supply and per capita national income of $1136 in PPP terms compared to 778 of Sub-Saharan Africa.

31. Six countries worsened their hunger situation after 1990 and all of them except North Korea were from Sub-Saharan Africa. The hunger level for India in the year 2011 was 23.7% and it was very close to highly poor countries like Mozambique (22.7%) and Angola (24.2%). Interestingly, India was able to improve its hunger level by 6.7% in two decades compared to 13% improvement achieved by Mozambique and 18.8% by Angola. Countries like Rwanda, Pakistan, Nepal, Kenya, Uganda, Myanmar, Republic of Congo, etc. fared much better than India. The hunger score for China was 5.5% in the year 2011 (IFPRI, 2011).

32. The prevalence of underweight among children in India is amongst the highest in the world, and nearly doubles that of Sub-Saharan Africa. In the year 1999, 47% of children under-3 were underweight or severely underweight while another 26% were mildly underweight. Although the prevalence of underweight among children under-3 fell by 11% during the first seven years of the economic reforms, this achievement was much lower than what was achieved by countries with similar economic growth rates. Underweight prevalence is higher in rural areas (50 percent) than in urban areas (38 percent), higher among girls (48.9 percent), higher among scheduled castes (53.2 percent) and scheduled tribes (56.2 percent) and prevalence of underweight reaches as high as 60 percent in the lowest wealth quintile (Gragnolati, et. Al., 2005).

33. Under-nutrition rates in South Asia are presently double those in Sub-Saharan Africa. The “South Asian Enigma” can be explained by three key differences between South Asia and Sub-Saharan Africa. Low birth weight is the single largest predictor of under-nutrition and over 30% Indian babies are born with low birth weights, compared to approximately 16% in Sub-Saharan Africa, women have lower status and hygiene and sanitation standards in South Asias are well below those in Africa.

34. The debate on “South Asian Enigma” has recently got further complicated by Panagariya (2013), who questions that African children are healthier than Indian children. Chad has just 48 years of life expectancy against India’s 65 years, an infant mortality rate (IMR) of 124 against India’s 50, an under-five mortality rate of 209 relative to India’s 66 and a maternal mortality ratio (MR) of 1,200 compared to India’s 230. Similarly, Senegal has 4.25 times the infant mortality rate of Kerala, almost six times Kerala’s under-five mortality and 4.3 times Kerala’s maternal mortality ratio. However, rates of stunting and underweight children are lower than India in both these countries (Panagariya, 2013). A higher incidence of child
malnutrition in Kerala is even more puzzling given its significantly higher female literacy rate than Senegal’s 29%.

35. Panagariya (ibid) is of the view that the height of an individual can vary for both genetic and nutritional reasons and one cannot conclude whether the reason was malnourishment or genetic factors unless detailed medical examination is carried out. He also questions the WHO norms which are premised on the assumption that all differences in height between populations of children of a given age and sex occur due to difference in nutrition. Although Japanese adults have grown much taller over the generations but have remained 12 to 13 centimetres shorter than their Dutch counterparts.

36. “Gradual catch-up” hypothesis takes several generations of balanced diet for a population of children to achieve its full potential height and weight and “Catch-up” deficit takes several generations to eliminate. The findings of Tarozzi (2008) that approximately one-third remain stunted and one-quarter underweight even among high wealth category largely support the Gradual catch up premise.

37. Deaton (2007) finds high stature of Africans the hardest to explain. Variables such as per capita income in childhood, incidence of infant and child mortality rates, per capita calorie availability and mother’s education which are conventionally considered to correlate with height all fail to explain the exceptionally tall stature of African men and women. A sustained balanced diet does not eliminate low height in the case of either adult or child populations. Moroccan children born in the Netherlands begin to fall behind their Dutch counterparts in height as early as 2 years of age but exhibit high BMI.

Some of the best practices

38. Iodine fortification of salt is a popular means of controlling iodine deficiency. Salt was chosen because it is widely available and consumed in regular amounts throughout the year, and the costs of iodizing it are extremely low. Where salt iodization has been in place for over five years, improvement in iodine status has been overwhelming. Over the last decade, the number of countries with salt iodization programmes doubled, rising from 46 to 93. As a result, 68% of the 5 billion people living in countries with IDD have access to iodize salt and global rates of goitre, mental retardation and cretinism are falling fast. In Kenya, a cash transfer pilot programme was able to significantly improve their food security and dietary diversity and reduce negative coping strategies. The average number of meals per day increased from 1.6 at the beginning of the program to 2.5 at the endline. The practice of trading sex for money or food declined from 21.9 to 9 percent, and engagement in child labour dropped from 38.8 to 12.2 percent (IFPRI, Ibid).

39. In the two decades after 1990, 15 countries were able to reduce their hunger level. The Sub-Saharan country of Ghana achieved it by increasing its investments in child immunisation, mid-day meals programme for school children, agriculture, rural development, education and health.
40. Integrated Child Development Services (ICDS) programme in India is designed to address the major cause of child under-nutrition in India. Unfortunately, over last two decades more attention was given to increasing coverage than to improving quality of service delivery. Its actual implementation suffers from very high focus on food supplementation and very high focus on coverage of older children and children from wealthier households. It fails to preferentially target girls, lower caste or poorest villages.

Some other relevant studies

41. At a rough estimate, Government spends up to one percent of GDP providing subsidised cereals to the poor. However, there are studies showing that such welfare measures distort market signals, promote black marketing and diversion, and encourage elite capture. This practice also creates large wealth effect, which results into substitution of food with lower nutritional factors.

42. Staple food like rice, wheat and maize are basic goods, which can also be called "poor goods" or inferior goods which offer high calories at low cost. In contrast to this, "fancy goods" or wealth goods like meat and eggs are liked due to their better taste but they do not provide as much calories per unit of money and therefore, they are costlier sources of calorie. When staple food are heavily subsidised by Government, funds of poor are released for spending in other ways and induce wealth effect.

43. Jensen and Miller (2011) have described an interesting study carried out in China to estimate the effect of reduction of expenditure on inferior goods on nutritional intake of the family. Approximately 3660 extremely poor families were given free cash vouchers of three different denominations to subsidise the cost of rice in Hunan, and wheat flour in Gansu provinces. The main purpose of this study was to test the existence of Giffen behaviour and extent of increase in nutritional intake.

44. Their study observed that the poor in Hunan actually reduced their intake of calories after such food subsidy and the intake did not increase in Gansu. The subsidy on rice resulted into reduced consumption of rice, vegetables, pulses and fats, whereas consumption of expensive sea food increased, which resulted into net decline of calorie intake. The study suggested that policies aimed at poor should be evaluated on terms of their net welfare impact. In this case, food coupons increased household's net real wealth and staple food was substituted by those food which is less nutritious but consumed by richer households.

45. In view of this finding, there is a need to study the result of (a) impact of other cash transfer programmes in India like public distribution system, ICDS, MGNREGS, pensions for

2 Poor goods are not consumed by poor only. They are called so due to their affordable prices.

3 Giffen behaviour is named after Scottish economist who reported this paradox in purchasing habits of Victorian era poor. It suggests that poor consume more of Giffen goods as price of the good rises contrary to the basic law of demand and supply.
the poor or health insurance scheme, (b) what impact can be obtained by subsidising "wealth goods" for the extremely poor, and (c) how can the wealth goods for the extremely poor be defined?

46. A related and unpublished study carried out through a 3 years' long action research by GNFC as part of their CSR tried to observe the impact of wealth goods on the nutritional status of the expecting mothers. This study focussed on observing weight of the new born child and impact of wealth goods on the incremental gain in its weight. The study observed that there was slight increase in the average weight of the child at birth, the acceptability of wealth package was the highest and drop out was least in this category. The level of absenteeism was the highest in normal packaged meal.

47. Another useful study carried out by Mohan, P. (2016) suggests that extent of resource limitation and extent of denial of their entitlement under various social safety network schemes are directly correlated with level of malnutrition. In a study of Scheduled Tribes dominated districts of Gujarat, they observed that about 25% families did not possess ration card, only 56% families received wheat from Public Distribution System, MGNREGA coverage was 3.6% among women and they got employment of 15 days only under the scheme, 44% children had not eaten anganwadi food and a large number of family were not consuming pulses regularly. As a result of these disadvantages, the level of stunting, wasting and underweight children was 10-20% higher in this area. This study raises an interesting question that will better access of the rural families to various social safety net schemes significantly improve the nutritional level of the family?

Conclusion and Issues for policy makers

48. Another interesting fact about malnutrition in India is the fact that it is concentrated within 10% districts and certain groups. The Scheduled Tribe women and Central India tribal belt covering parts of Gujarat and Rajasthan, MP, Chhattisgarh, Jharkhand, Orissa and parts of Andhra Pradesh are likely to have very high incidence of this problem and well targeted interventions specially aimed at this group have a high chance at cracking this problem.

49. The two flagship programmes, namely ICDS and Mid-day Meals schemes presently do not encourage any state specific initiatives. There is an urgent need to recast these programmes in the malnutrition prone areas to have complete flexibility so that area specific interventions can be designed by local administration to address this problem in a time bound manner.

50. A comprehensive nutrition plan must cover following strategic action areas (i) malnutrition control must be mainstreamed with the national level goals, (ii) household level food security must be improved, (iii) infectious diseases must be controlled, (iv) an effective sub-strategy must be developed for the nutritionally vulnerable, (v) specific micronutrient deficiencies must be controlled, and (vi) massive awareness generation must be taken up to promote nutritious diets and healthy life-styles.
51. Household-level food security is not necessarily assured by macro-level food security. Household level consumption is determined by local prices, income, effective transport infrastructure and relative bargaining power of household members. Food is neither produced nor distributed equitably. Hunger is a question of mal-distribution and inequity – not a lack of food. This calls for critical assessment of programmes like Antyodaya Food Grain Scheme in order to make it compatible with the needs of the poorest and most vulnerable.

52. Malnutrition among children and women is an age old issue as far as India is concerned. There is no country in the world which has devoted such a large amount of time, resources and funds to address this issue through various Government agencies. However, either due to faulty programme design, weak implementation in the field, resistance of line departments to converge their schemes and resources to effectively handle this issue or wrong approach, we are yet to find a way out. In the meanwhile, a large number of country's young population is being wasted. As big problems require bold solutions, there is a need to develop few out of the box solutions to address this problem.

ASSIGNMENTS

53. You are expected to go through this case study, carry out further study on various articles on this theme before the lecture. Some of the students will be asked specific questions on issues and suggestions discussed here. You are also expected to develop a small study covering at least 50 families in 3 villages of your choice on an issue or idea identified by you.

Some of the likely areas of study can be-

a. The three questions raised in para 45 of this case study;

b. The question raised in para 47 of the case study;

c. Study Department-wise social safety schemes of Government of Gujarat and study the extent of their coverage and quantitative impact in the villages, and their likely role in reduction of malnutrition; and

d. Study issues related to convergence and develop a plan for converging 7-8 social safety net related schemes of at least 4 departments.

References


