The Nutrition Gap: How Public Policy and Social Development Shape Child Health in India

Recently, a child under the age of two reportedly died in Keralam due to severe anaemia and malnutrition. This cannot be considered an isolated issue. The issue is not limited to some specific areas but happens across India.

Malnutrition refers to deficiencies, imbalances and excesses in a person's intake of food. Malnutrition is affecting millions of children and adults hindering their growth, learning capacity, productivity and sustainability. Malnutrition, in all its forms, includes undernutrition, micronutrient related malnutrition or overweight, obesity and diet related Non-Communicable Diseases (NCDs). Beyond all the visible forms of malnutrition lies a big challenge of hidden hunger.

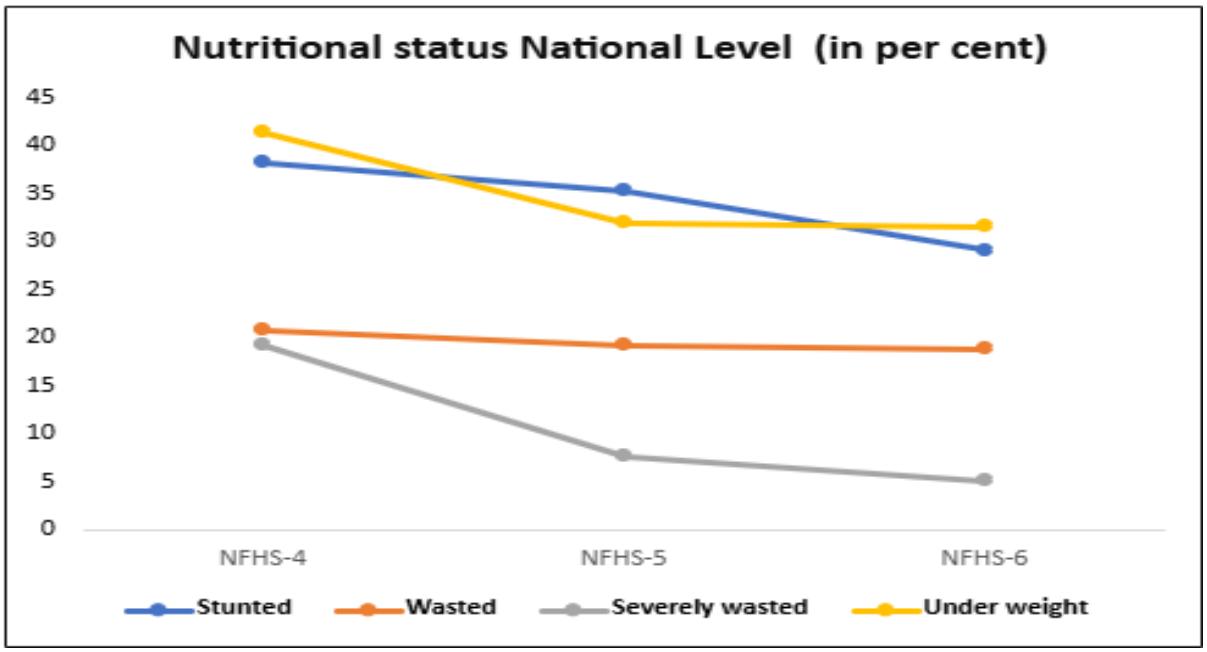
According to the Global Hunger Index India is ranked 100th out of 122 countries in 2026, placing itself in the serious category. Recent National survey finding NFHS-6 also reported a slight reduction in national child stunting to 29.3 per cent from 35.5 per cent in NFHS 5. Even though wasting remained within 19 percent, the prominence of underweight remained the same with little marginal difference to 31.8 per cent from 32.1 per cent. This indicates that the programmes in reducing undernutrition have not brought much progress.

Different schemes were initiated all over India, but the coverage, implementation and structural gap pose a question. Hence the central dilemma is whether the states in India are able to achieve their nutritional outcomes despite its increased financial health and policy initiatives. In this article we are considering the performances of three states viz. Keralam, Tamil Nadu and Uttar Pradesh for the analysis.

Malnourishment through the eyes of NFHS 4 and NFHS 5 (and NFHS 6 at National Level)

Malnourishment assessed mainly through some indicators for children under the age of 5, namely stunting (low height for age), wasting (low weight for height) severely wasted (most life-threatening form of malnutrition) and underweight (low weight for age). The indicators showcase different dimensions of malnutrition and should not be used interchangeably. On national level improvements in stunting have more prominence than wasting and underweight. Stunting reported 29.3 percent in NFHS 6 down from 35.5 percent in NFHS 5. Wasting shows a marginal decrease from 19.3 percent in NFHS 5 to 19.0 per cent in NFHS 6. Severely wasted in NFHS 6 is 5.2 percent compared to 7.7 in NFHS 5. Underweight also decreased only 0.3 percent resulting 31.8 percent in NFHS 6. This necessarily showcases the next phase of polices should address the diet quality, infection reduction, high nutritional adequacy to vulnerable children.

Diagram 1: Nutritional Status at the National Level



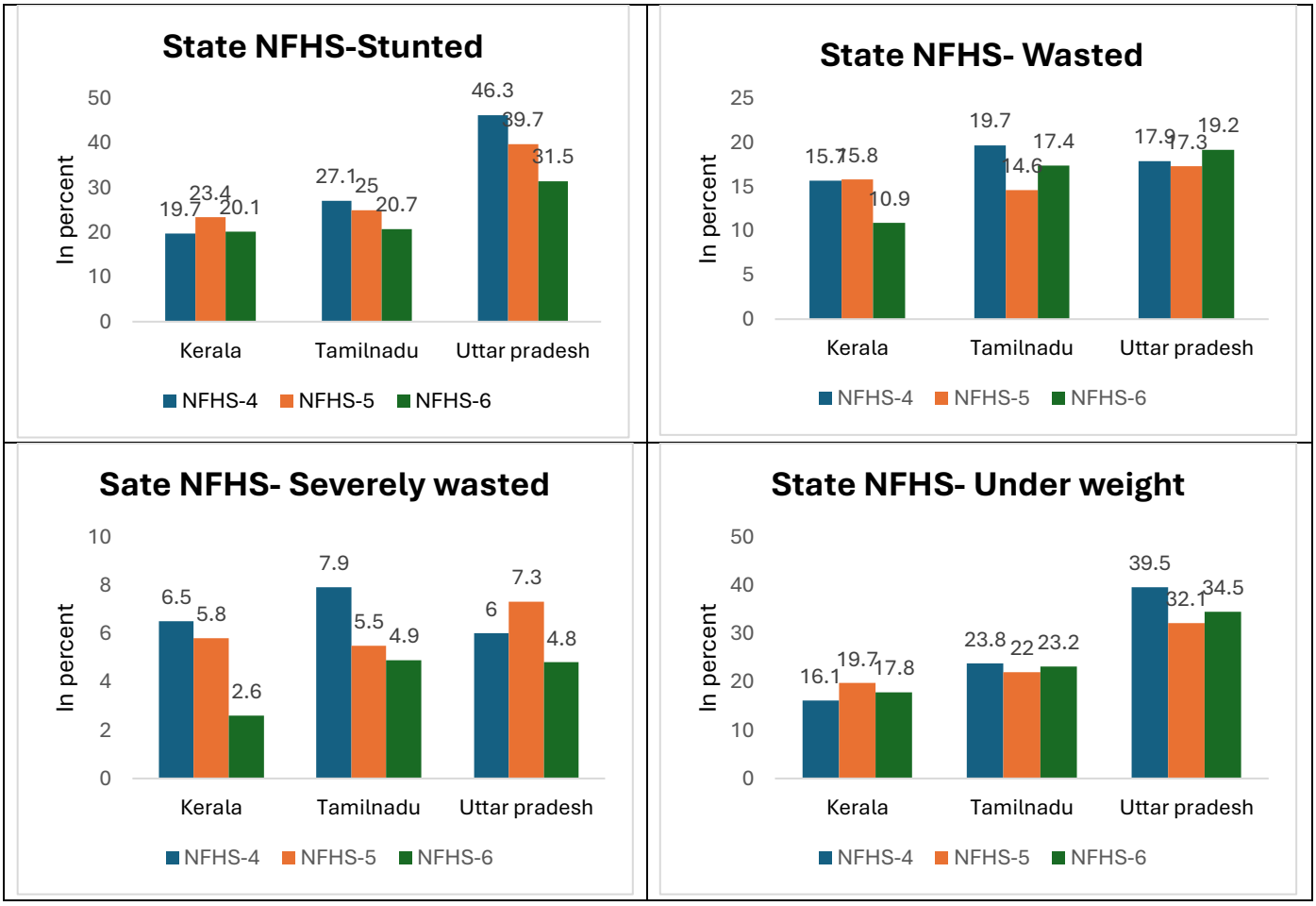
Source: NFHS Portal

In the state level, Keralam's usual favourable position did not guarantee continuous improvement. From NFHS 4 and NFHS 5 it is seen that stunting rose from 19.7 per cent to 23.4 per cent while underweight prevalence increased from 16.1 to 19.7. The severe malnutrition showed a decrease of 0.7 percent from 6.7 per cent. Underweight has shown an increase of nearly 3.6 per cent which is drastically high. This indicates that the higher literacy, better healthcare facilities and stronger social development indices cannot in itself guarantee better fight against malnutrition.

Uttar Pradesh, however has shown substantial progress comparatively, but still faces chronic undernutrition. Based on the survey, stunting declined by 6.6 per cent and underweight by 7.4 per cent. The scale of state's population presents that even a moderate percentage represents a very large affected population.

Compared with the two states Tamil Nadu has recorded improvements in all the three indicators. Stunting declined by 2.1 per cent, wasting by 5.1 per cent and underweight prevalence by 1.8 per cent. This accurately shows a reduction in nutritional deficits although inequalities and burden between districts raises concern.

Diagram 2: Nutritional status of States according to NFHS 4 and NFHS 5



Source: NFHS Portal

Government Nutritional Programmes: Coverage, Effectiveness and Limitations

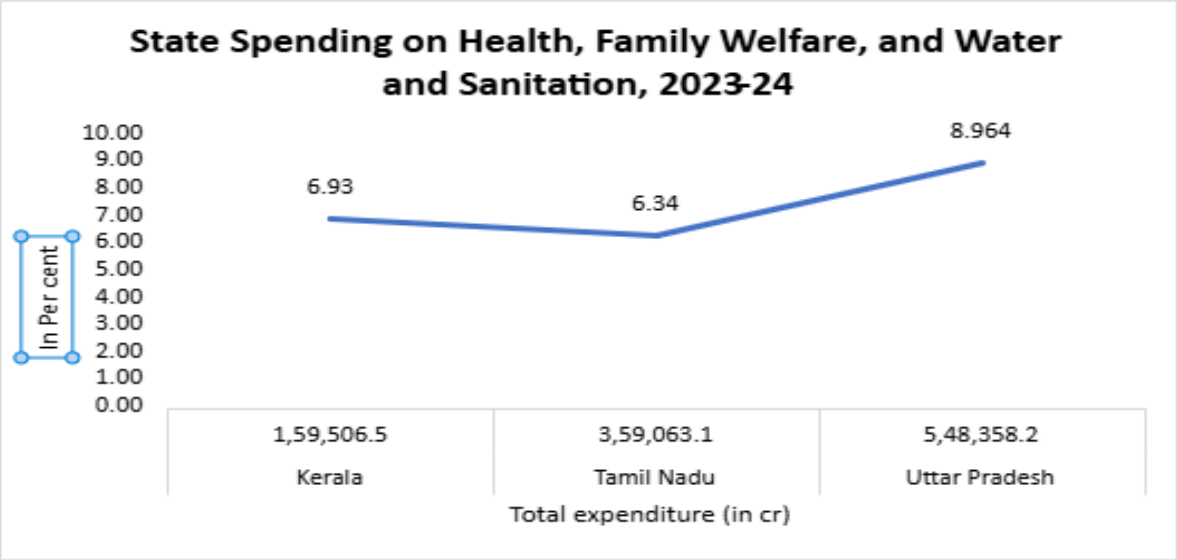
Based on the existing limitations in the nutritional standards different schemes were initiated. Integrated Child Development Scheme (ICDS), the Anganwadi system, POSHAN Abhiyan and Mission Saksham Anganwadi and POSHAN 2.0, POSHAN Tracker, PM Poshan Shakti Nirman scheme, PM Matru Vandana Yojana all focussed in nurturing the younger generation. ICDS and Anganwadi system is particularly important in addressing services including supplementary education, pre-school education, nutrition and immunisation of mothers and infants. POSHAN Abhiyan promotes coordination among departments, behavioural changes and technology-based monitoring for efficient delivery of nutritional services at community level. Hunger reduction among children is aimed through PM POSHAN Midday meal scheme. It also enhances the dietary intake. Maternal health and support during pregnancy and child birth is taken care through PM Matru Vandana Yojana.

In addition to the above, states under analysis have implemented fully state funded schemes also to ensure the nutrition of the citizens especially the children. In Tamil Nadu, the Chief Minister's Breakfast Scheme, which serves children in Classes 1-5, is funded entirely by the state. It received Rs 500 crore in the 2023-24 budget and was extended to 29,463 more schools in August 2023.In Uttar Pradesh, the Mukhyamantri Sakhsham Suposhan Yojana targets child malnutrition

and was allocated ₹100 crore in 2023-24, unchanged from the year before. In Keralam, the best-known scheme is Amrutham Nutri mix, a fortified supplement for children aged 6 months to 3 years. It is a Social Welfare Department project through Kudumbashree since 2006. Kudumbashree units produce and distribute Amrutham Nutri mix through Anganwadi.

As per RBI's data, in the year 2023-24, Uttar Pradesh spent almost 8.96 per cent of their state expenditure on Medical Health, family welfare, Water supply and sanitation, followed by Keralam with 6.93 per cent and finally Tamil Nadu with 6.34 per cent. Since the Uttar Pradesh has the largest population out of these 3 states, the amount per person is much lower than the totals suggests.

Diagram 3: State spending on Health, Family Welfare Water and Sanitation



Source: RBI, Handbook of Statistics

According to census of India 2011, the population density of Keralam is 860 per square km and that of UP is 828, while in Tamil Nadu it is only 555 per square km. The states UP and Keralam has nearly same population density despite different levels of urbanisation, human development and public service access. Even though, highly dense areas can create opportunities for delivering services to large number of people in a relatedly small area, it can also create pressure on urban health, housing, sanitation and public services. On the other hand, areas of lower density can also increase travel distance, cost of delivering services in remote communities. Hence, state like Uttar Pradesh due to its extensive population necessitates the requirement of Anganwadi as relatively small service delivery gaps can affect large number of children. Priority should be given to ensure eligible women in poorer and underserved communities to register and receive benefits without barriers. Tamil Nadu though shows more proficiency in the scheme delivery; it is essential to check whether the supplementary nutrition and preschool linked services consistently reach children from low-income households and whether the growth is monitored. Keralam with its high social development indices still should focus on vulnerable households and on the prevention of deterioration among children. Both states Tamil Nadu and Keralam should insist on timely payments, beneficiary awareness and integration with antenatal care. Apart from that the effectiveness of ICDS, it cannot solely depend on the number of centres. Irregular staffs, limited nutritional counselling and lack of sufficient infrastructure etc. needs to be addressed. Underutilization of allotted funds is another serous issue. For example, in the Pradhan Mantri

Mathru Vandana Yojana in 2023-24, Keralam used only 20.33 crores of its allotted CSS share of 61.06 crores. Tamil Nadu and Uttar Pradesh haven't received any central share, as they have unused balance from preceding years.

Children identified as undernourished by Anganwadi workers need to be linked to health facilities, supplementary nutrition, household counselling and appropriate treatment and its monitoring should be done digitally. School meals should be identified as a component of nutritional cycle and should complement with Anganwadi services and maternal and child health care. Apart from expenditure perspective, progress should be evaluated based on maternal dietary diversity, antenatal care, infant feeding and birth outcomes.

According to PLFS 2025, Keralam recorded Female literacy rate at 95.6 per cent while Tamil Nadu and Uttar Pradesh showed 82 per cent and 70 per cent respectively. Female literacy rate needs to be enhanced in Tamil Nadu and UP as they can influence nutritional outcomes through access to health information, infant feeding, maternal care. Educated women can make better decisions on household spending in healthcare and child diets.

India ranks 108th out of 193 countries with a score of 0.437 on the Gender Inequality Index according to the United Nations Development Programme (UNDP) Human Development Report. It clearly indicates the persistence of inequality especially indicated through the metrics. Gender inequality in household facing food shortages can increase nutritional risks which can be identified through the reproductive health metric. Hence, it necessitates reduction of inequality to improve nutritional health. According to NFHS 5, maternal anaemia has recorded at 52.2 per cent of which severe anaemia condition is at 1.4 percent at national level. States should focus on reducing maternal anaemia, undernutrition and unequal care responsibilities. States should ensure women have resources, information and right to protect their health and that of their children.

NFHS-5 reported that only 5.9 per cent of children aged 6–23 months in Uttar Pradesh received an adequate diet. In Keralam, the corresponding number is 23.5 per cent. Poverty, lack of food security and lack of proper sanitation are other underlying causes. Unsafe drinking water, inadequate sanitation and poor hygiene can increase exposure to diarrhoeal disease and other infections. The state of UP should ensure that sanitation infrastructure is functional, drinking water is safe and hygiene practices are real. The state of Keralam should focus on the tribal areas like Attapady and the outskirts of Malappuram and other vulnerable community areas to address sanitation and nutritional gaps.

The most useful lesson is that the governments should compare them with other state mechanisms, institutions and interventions to produce better results. Uttar Pradesh can focus on service delivery and welfare systems of Keralam and Tamil Nadu. On the other hand, Keralam and Tamil Nadu can learn the importance of targeted interventions and requirement of intensive follow up in vulnerable communities and region. Overall, reducing malnutrition requires a shift from a programme-centred approach to an outcome-centred strategy. Governments must ensure that every eligible mother and child receives the right support at the right time, that resources reach the communities most in need and that improvements are verified through reliable evidence. The experience of these three states can then inform a more equitable and effective national nutrition policy.

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