International Journal of Recent Advances in Multidisciplinary Research
Vol. 02, Issue 08, pp.0588-0593, August, 2015

Review Article

THE STATE OF NUTRITION OF THE MARGINALIZED COMMUNITY IN INDIA

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ARTICLE INFO

Article History:
Received 08th May 2015
Received in revised form
21h June, 2015
Accepted 28th July, 2015
Published online 31st August, 2015

Keywords:
Nutrition,
Dalits,
Marginalized,
Social exclusion

ABSTRACT

This paper analyses the level of malnutrition among women and children from disadvantaged groups in India. In India, economic productivity has increased and impressive efforts have been made in nutrition interventions, but significant improvement in nutritional status has not accompanied these advances. While aggregate levels of undernutrition are shockingly high, the picture is further exacerbated by the significant inequalities across states and socioeconomic groups – girls, rural areas, the poorest and scheduled tribes and castes are the worst affected –and these inequalities appear to be increasing. Often it is found and reported that people belonging to schedule caste, schedule tribes or other backward classes fall prey to "social exclusion" which prevents them to gain access to government services and programmes. This further worsens their health and nutritional status. The paper thus, analyses the magnitude of problem and highlights policy recommendations to address the discrimination and promote "social inclusion" in nutrition programmes.

INTRODUCTION

India has recorded strong economic growth in recent years but has shown little progress in tackling malnutrition. It is evident that economic growth alone will not solve the malnutrition problem and sustaining growth will require human capital development (Lives, 2012). According to UNDP (2013), India ranks 136 on the Human Development Index (HDI) worldwide out of 187 countries, which is based on factors such as life expectancy, adult literacy rate and per capita income. It is a standard means of measuring well-being, especially child welfare. However, the index differs widely for the numerous states that constitute India ranging from 0.790 in Kerala to 0.358 in Chhattisgarh state (UNDP, 2013). India's population, which was 439 million in 1961 has crossed 1210 million in 2011. India has more than two thousand ethnic groups, and every major religion is represented. Of the total population of India in 2001, 80.5 per cent were Hindus while Muslims accounted for 13.4 percent and Christians 2.3 percent respectively of the total population. Sikhs accounted for 1.9 per cent of the total population. The proportion of Buddhists, Jains and other religions was 0.8 per cent, 0.4 per cent and 0.6 per cent respectively. Further, 16.2 per cent of the population comprised of scheduled castes (SC's) and 8.2 per cent of scheduled tribes (ST's) (Census, 2011).

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According to National Family Health Survey-3 (2005-2006) (NFHS), the population comprised of 19 per cent SC's, 8 per cent ST's and 41 per cent other backward classes (OBC's) (NFHS 3, 2006). According to 2010 data from the United Nations Development Programme, an estimated 37.2 per cent of Indians live below the country's national poverty line. A 2010 report by the Oxford Poverty and Human Development Initiative (OPHI) states that 8 Indian states have more poor than 26 poorest African nations combined which totals to more than 410 million poor in the poorest African countries (Times of India, 2010; BBC News, 2010). According to a new poverty Development Goals Report, as many as 320 million people in India and China are expected to come out of extreme poverty in the next four years. The report also indicates that in Southern Asia, however, only India, where the poverty rate is projected to fall from 51 per cent in 1990 to about 22 per cent in 2015, is on track to cut poverty in half by the 2015 target date (Times of India, 2011).

Nutrition is increasingly being recognized as an important indicator of development at national and international levels. Nutritional well being of the population is considered as an economic asset and a pre-requisite for national development. Investing in nutrition has both economic and social benefits. Improved nutritional status has an enhancing effect on investments in other sectors such as health, education and agriculture. Moreover, the enormous social and financial costs of malnutrition are averted when nutritional status is improved.

It is often reported that the nutritional, economic and social status of those belonging to SC and ST group is compromised as compared to other social groups. Also, the coverage, delivery, acceptability and usage of the schemes, services and programmes meant for these groups have numerous loopholes. Thus, the present paper addresses the nutritional status of SC's and ST's and the level of exclusion experienced by these groups from different services.

It especially focusses on women and children, because it is through women and their off-spring that the pernicious effects of malnutrition are propagated to future generations. A malnourished mother is likely to give birth to a low birth-weight (LBW) baby susceptible to disease and premature death, which only further undermines the economic development of the family and society, and continues the cycle of poverty and malnutrition.

Malnutrition among Women

Women's nutrition assumes additional importance due to its critical but complex association with their well-being and the implication it has for human development. Malnutrition in women perpetuates an intergenerational cycle of malnutrition. There are huge socio-economic disparities in women's malnutrition in India. A major gap is seen between social groups; nearly 47 and 68 per cent of women (15-49 years) from the ST suffer from Chronic Energy Deficiency (CED) and anaemia, respectively. In fact, more than one-third of them suffer from the double burden of CED and anaemia together. The incidence of malnutrition declines with the so-called rise in social status. By extension, such decline also means huge disparities between social groups: more than 15 percentage points difference is found between women from ST and others. Thus, the proportion of women suffering from CED and anaemia together among ST comes closer to double the proportion of the same among advantaged social groups (Jose and Navaneetham, 2008).

Comparing NFHS-2 and NFHS 3 data, the incidence of CED has declined in both rural and urban areas and among women from all social groups. The extent of decline is rather large among the advantaged social groups (4 to 5 percentage points) and quite marginal among the ST women. By contrast, overweight or obesity has increased in both the regions leading to an overall increase in the all-India proportion as well (Jose and Navaneetham, 2008).

Contrarily, women from all social groups seemed to have experienced an increase as far as incidence of anaemia is concerned. The increase, around 4 percentage points, is evident in both rural and urban areas. Also, there is a marginal increase in the incidence of moderate and severe anaemia in the country, though it has declined in urban India (Jose and Navaneetham, 2008). In both CED and anaemia, there has been an increase in the incidence among tribal women as against a decline, though negligible, among women from other social groups, especially the SC and OBC. Thus, the levels of malnutrition, which were already higher, have increased further among tribal women in India. In fact, the disparity between social groups, especially between ST and others has increased over time in CED as well as CED and anaemia together (Jose and Navaneetham, 2008).

Malnutrition among Children

According to the NFHS-3, 25 million Indian children under five years old were wasted (acutely malnourished) and 61 million were stunted (chronically malnourished). Importantly, with 43 per cent of children underweight (with a weight deficit for their age) rates of child underweight in India are twice higher than the average figure in sub-Saharan Africa (22 per cent). However, the more recent HUNGaMA Survey (2011) covering 100 rural districts in 6 states of India reported that 11.4 per cent of children under five were wasted, 42.3 per cent were underweight and 58.8 per cent were stunted.

Of the children suffering from stunting, about half are severely stunted (Hungama Survey Report, 2011). Underweight prevalence is higher in rural areas (50 per cent) than in urban areas (38 per cent); higher among girls (48.9 per cent) than among boys (45.5 per cent); higher among scheduled castes (53.2 per cent) and scheduled tribes (56.2 per cent) than among other castes (44.1 per cent); and, although underweight is pervasive throughout the wealth distribution, the prevalence of underweight reaches as high as 60 per cent in the lowest wealth quintile (NFHS 3, 2006).

Nutrition data from NFHS 3 (2005-06) shows that malnutrition is particularly prevalent among the STs, SCs, OBCs and Muslims. Children from households belonging to a Scheduled Caste or Scheduled Tribe generally have worse nutrition, but the specific effects vary considerably by state. Children from households identified as Muslim did have significantly worse nutrition except in Himachal Pradesh (NFHS 3, 2006). The determinants of nutritional levels of children have been analysed by several scholars (Sabharwal, 2011; Baru et al. 2010; Baraik and Kulkarni, 2006 and Roy et al. 2004).

The incidence of malnutrition is significantly higher among poor households, mothers of children without any education and those belonging to SC and ST social groups. The likelihood of SC children being malnourished is 1.4 times that of children belonging to other social groups even after controlling for education and health (Sabharwal, 2011). One econometric study using longitudinal data from Himachal Pradesh finds being from a scheduled caste or a backward tribe substantially increases the probability of a child being stunted and persistently so. The only other variables to have this effect were lack of mother's education and height, both reflecting discrimination from a generation past (Himaz, 2009).

Such inequalities are also reflected in the nutritional status of under five children, with SC and ST children showing underweight prevalence that is about 14 and 20 per cent higher than that among children from the general category (Table 1). Child mortality rates are similarly over 15 per cent higher for SC/ST children than for general category children. OBCs are worse off in comparison to general category but better off than the SC/ST (Sabharwal, 2011 and Thorat and Sabharwal, 2011). The incidence of malnutrition was found to be higher among STs (56.1 per cent) and SCs (50.6 per cent) and "others" (36.3 per cent) (Thorat and Sabharwal, 2011). The results of caste disadvantage in nutritional levels, controlling for socio economic determinants, strongly suggest discriminatory access of SC households to health and nutrition programmes both in terms of quantity and quality (Mamgain and Diwakar, 2012).

Policies and Programmes to tackle malnutrition

There are number of government programmes and schemes operating in the country to tackle and eliminate the problem of malnutrition in the country. The Ministry of Health and Family Welfare, Ministry of Women and Child Development along with other line ministries like Ministry of Agriculture, Ministry of Human Resource and others work in convergence to address this issue in a holistic way. Table 2 provides the list of various programmes and initiatives implemented by the Government of India.

Contrarily, a report have documented discrimination based on social class in MDM. According to their paper, based on a study conducted in about 550 villages in five states, SC, ST children are discriminated against when it comes to the midday meal scheme. These children are often denied the meals, are told to sit separately, are the last to be served, are punished if they ask to be served first, are not served sufficient quantities of food and are served from a distance (Thorat and Sabharwal, 2011). A recent news report further reinforces caste and gender bias in the implementation of the MDM programme (Times of India, 2011).

Table 1. Malnutrition among women and children across social and religious groups in rural India

Social roups	Women BMI<18.5kg/m2	Children Wt/age<Med- 2SD	Children (proportion of underweight <Med-2SD)				
			Hindu	Muslim	Christian	Sikh	Others
SC	44.7	50.6	51.3	57.6	30.6	33.5	43.4
ST	48.4	56.1	56.9	36.5	44.1	NA	NA
OBC	39.7	45.7	45.6	46.7	27.3	19.6	NA
General	35.8	36.3	33.7	43.5	27.7	18.8	NA

Adapted from Thorat and Sabharwal (2011); based on NFHS 3 (2005-06)

Table 2. Existing Nutrition and Welfare Interventions of the Government of India

Target Group	Schemes	Expansion
Pregnant and Lactating Mothers	Integrated Child Development Scheme (ICDS), Reproductive & Child Health-II (RCH-II), National Rural Health Mission (NRHM), Janani Suraksha Yojna (JSY), Indira Gandhi MatritvaSahyogYojna (IGMSY) – The CMB Scheme	NRHM (2005-06) JSY (2006-07) ICDS (2008-09)
Children 0 – 3 years	ICDS, RCH-II, NRHM, Integrated Child Protection Scheme (ICPS), Rajiv Gandhi National Creche Scheme (RGNCS)	RGNCS (2005-06) ICDS (2008-09)
Children 3 - 6 years	ICDS, RCH-II, NRHM, ICPS, RGNCS, Total Sanitation Campaign (TSC), National Rural Drinking Water Programme (NRDWP)	TSC (2008-09)
School Going Children, 6 – 14 years	Mid Day Meal (MDM), SarvaShikshaAbhiyan (SSA), ICPS, Weekly Iron and Folic Supplementation (WIFS)	SSA (2002/2005-06) MDM (2008-09)
Adolescent Girls, 11 – 18 years	Rajiv Gandhi Scheme for the Empowerment of Adolescent Girls (RGSEAG), Kishori Shakti Yojna, TSC, ICPS, National Rural Drinking Water Programme (NRDWP), WIFS	NRDWP (2010) RGSEAG (2010-11)
Adults	Mahatma Gandhi National Rural Employment Gaurantee Act (MGNREGA), NRLM, Skill Development Mission, Women Welfare and Support Programme, Adult Literacy Programme, Targeted Public Distribution System (TPDS), AAY, Old and Infirm Persons Annapurna, RashtriyaKrishiVikasYojna, Food Security Mission, Safe Drinking Water and Sanitation Programme, National Horticulture Mission (NHM), National Iodine Deficiency Disorder Control Programme (NIDDCP), Nutrition Education and Extension, Bharat Nirman, RashtriyaSwasthyaBimaYojna	NHM (2005-06) MGNREGA (2005-06) NRLM (2010-11) NIDDCP (1992) RSBY (2007) Bharat Nirman (2005)

(Source: Ministry of Women and Child Development)

Exclusion from the Government Programmes

There are number of reports that show that the socio-economic status of Dalit/tribal people and their access to government services is worse than that of dominant caste group (Acharya, 2010; Mander and Kumaran, 2010; Sachar Committee, 2006; Gragnolati et al. 2005; Sinha, 2005; Thorat and Lee, 2005; MHFW, 2002). This paper examines two major flagship programmes by the Government of India which aim to improve the nutritional status of children and women – Integrated Child Development Scheme (ICDS) and Mid Day Meal Programme (MDM).

MDM has been successful in significantly increasing school enrolment, improving attendence and keeping students in school. It has been especially beneficial to girl students who were earlier discriminated into leaving school prematurely. Preference for Dalit cooks and construction of cooking sheds have helped to further increase employment and income among the specially targeted socially weaker castes and gender (Kapur, 2011).

It states “The flagship midday meal scheme in Rajasthan, Odisha, Karnataka and Madhya Pradesh is afflicted with large-scale caste and gender-based discrimination. While the discrimination was gender-based in Karnataka’s Chamarajanagar, Haveri and Uttara Kannada; it was both gender and caste-based in Orissa’s Kandhamal and Boudh. The maximum discrimination has been reported from Rajasthan where the HRD ministry’s monitoring agency found that upper caste children were not sharing midday meals with lower caste children in Karauli.

In Dausa, scheduled caste children were made to sit separately and eat midday meals. In Sirohi too, children were segregated on caste lines. The situation was worse in Dungarpur. The monitoring agency, Institute of Development Studies, said 85 per cent school children were found sitting in caste groups. A similar story of caste segregation was found in Jaisalmer. Additionally, in urban areas of Jaisalmer, upper caste children refused to eat food with dalit children. In Pali, 57.5 per cent school children were sitting in caste-based groups and it was also found that in 10 per cent schools, only upper caste

children were served the mid-day meal. Gender discrimination could be seen in 12.5 per cent schools as girls were made to serve the food. In MP's Narsinghpur, the monitoring agency found that in 17.5 per cent schools, upper caste children did not eat mid-day meal as cooks were of lower castes. The monitoring agency MP Institute of Social Science Research, Ujjain, reported the practice of untouchability on the premises of schools in Betul, Satna, Chhindwara, Burhanpur, Balaghat, Shivpuri, Narshingpur and Hoshangabad. In Satna, upper caste, SC and OBC children sat separately. In Panna, dalit children were served food from a distance. In some places, children of one social group for fear of their plates being touched by the lower caste got their own plates from home. In Hoshangabad, girls of higher castes sat separately from lower caste girls."

In another paper, based on the findings of a survey conducted in 531 villages of five states have exposed patterns of caste-based exclusion and discrimination that afflict, if not overwhelm, the Midday Meal Scheme and Public Distribution System. While 63 per cent respondents reported that caste discrimination did not afflict the MDM in their villages, and, reporting extremely wide variation from state to state, the national averages of respondents who report discrimination in quantity and price in the PDS, as well as caste favoritism and "untouchability" practices by the PDS dealer, are each less than 50 per cent. In many places, then, these government food-related programs are living up to their legal and constitutional obligations (Thorat and Lee, 2005).

The problem, however, of dominant castes sabotaging the progressive potential of the MDM and PDS through practices discriminatory and exclusory toward Dalits, remains massive. In terms of scale, caste discrimination afflicts more than one out of three PDS shops and more than one out of three government schools serving midday meals. In terms of geographical spread, it is unquestionably a nationwide problem - from 24 per cent in Andhra Pradesh to 52 per cent in Rajasthan, to the vast majority in Uttar Pradesh and Bihar; respondent villages from every state reported problems of caste discrimination and exclusion in the MDM or its dry grain equivalent. Likewise with the PDS, no state is free of patterns of discrimination from 17 per cent in Andhra Pradesh to 86 per cent in Bihar. For instance, every state reports a substantial percentage of dominant caste PDS dealers practicing caste-based discrimination in the distribution of PDS goods.

While the problem is nationwide, its degree varies considerably from state to state, and this variation, considered in light of a parallel variation in other indicators, points to possible solutions. Where higher percentages of MDM cooks and organizers are Dalit, and where a higher percentage of midday meals are held in Dalit colonies, lower incidences of caste discrimination in the MDM are reported. In Andhra Pradesh, where indicators of Dalit participatory empowerment and access are relatively high (49% of respondent villages have Dalit cooks, 45% have Dalit organizers, and 46% are held in Dalit localities), reported caste discrimination in the MMS stands at 24 per cent. In Tamil Nadu, where the same empowerment and access indicators are lower (31%, 27%, and 19%, respectively), reported discrimination stands at 36 per cent; and Rajasthan, where indicators are alarmingly low (8% Dalit cooks, 0% Dalit organizers, 12% held in Dalit colonies), reported discrimination stands extremely high at 52 per cent. Simply put, it appears that increased Dalit access (in terms of village caste geography) and participatory empowerment (in terms of employment and decision-making power in the government program) correspond with decreased incidence of exclusion and caste discrimination. A similar pattern emerges in the PDS data, where higher proportions of Dalit PDS dealers and PDS shops held in Dalit colonies correspond with lower proportions of reported discrimination and "untouchability" practices. While the Andhra Pradesh government still has a formidable problem of caste discrimination to confront, its relative success in attaining higher access and participatory empowerment/ ownership indicators and lower discrimination levels appears to lie in its engagement with local women's groups in the practical implementation of the government programs.

Implementation of the MDM through DWACRA groups, as opposed to the usual government machinery, for instance, increases the scope for Dalit women to make empowered, effective and participatory interventions to ensure their children's equal access to the Right to Food and the Right to Education, as well as their own Right to Employment (as MDM cooks, organizers, or teachers). Swain and Kumaran (2012) reports that in case of ICDS, the most affected and excluded include the Dalits, tribals and minority population who mainly reside on the fringes of the villages (Swain and Kumaran, 2012).

The Way Forward

Nutrition should be clearly stated as an important input and output parameter for judging development and should not be treated as trickle down beneficiary of economic and industrial development. It should not get subsumed under curative or preventive health care in general, where emphasis tends to be on chronic diseases and immunization–important as they are.

Leadership and efficient governance are required at all levels to ensure synergy through convergence between Programmes/Missions/Acts which impact nutrition directly or indirectly (income, sanitation, drinking water, feeding programmes etc.) run by different departments/ ministries like health, women and child development, agriculture, civil supplies, and others. Planning and execution should be done with community participation and involvement of trained nutrition leaders from the community. There should be greater scientific dialogue and interaction between nutrition scientists and scientists belonging to agriculture, food technology, medicine, public health, and basic sciences as well as social scientists. The buzz word should be Nutrition Security for all.

The Marginalized groups should be identified and focussed. Ending gender based inequities, discrimination and violence faced by girls and women must be accorded the highest priority. The Jan Sahas Social Development Society's Report on "Exclusion and Inclusion of Dalit Community in Education and Health: A Study" (2009) has made several recommendations to ensure inclusion of Dalit groups in development programmes of the Government. Some of the salient ones are (Jan Sahas Social Development Society, 2009):

Actions to Address Exclusion of Dalits at Policy Level

- Make changes at policy level in government operated developmental schemes and public services to ensure the participation of Dalit community.
- Create an environment for the Dalit community to join public services in villages and to eliminate the reasons for their social exclusion.
- Give due emphasis to overcome social inclusion of Dalit and deprived communities in ICDS and health services, run under government machinery.
- Form rules to have the participation of Dalit women in mothers committee constituted for monitoring and functioning of Anganwadi centers, as mandatory.

Actions to Address Exclusion of Dalits At Community Level

- Create a Social Inclusion Coordinator post at district and block level to prepare, plan and implement Anganwadi, education and health services for social inclusion. This will help in proper implementation of social inclusion in public services.
- Make the participation of Dalit community members mandatory in local committees.
- For villages, where Anganwadi building is not available, the Anganwadi is to be conducted either at public building or a rented building which is not a home of any family, to avoid caste based discriimination.
- Sensitize and build capacity of government officials to link public services with Dalit communities. Voluntary organization and social organization could undertake this activity.
- As civil society organizations are related to grassroots and they know ground realities, involve them in this program to make it more effective, useful and practical.
- Include members of the Dalit community in public services at village level. Activities related to training and monitoring as well as activities related to various communication medium for disseminating the provisions of various schemes can be included. The message in the society would then be that the Dalit community has every right to use public service and depriving them with this is violation of basic rights.

Actions to Address Gender Discrimination at Policy Level

- Promote enrolment of girls at the primary level and provide life skills education to adolescent girls.
- Link school attendance tohigher education opportunities and subsequent linkages to skill development.
- Design and implement suitable interventions for reducing under-nutrition and anaemia among these groups.

Actions to Address Gender Discrimination at Community Level

- Provide sanitation facilities, including construction of toilets with water facility in schools to facilitate the attendance of girls in schools.
- Devise imaginative programs to draw men into taking part in the health seeking behaviour and practices of their wives.
- Engage PRIs and SHGs to address women's participation in food and nutrition, and promote nutrition awareness, transparency and community accountability.

Being well nourished is the one of the rights of every child and the State has an obligation to ensure proper nutrition to all children irrespective of gender and ethnicity. To meet national development targets, and achieve the MDGs, a more strategic, life-cycle approach that emphasises the importance of adequate nutrition in the early years is needed. India's public investment in nutrition is far below the required level and three key issues require immediate action: the scale, design and implementation of government programmes (Young, 2012). These three key issues hold more importance for the upliftment of the marginalized communities in India.

Author Disclosures

Authors declare no conflict of interest.

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