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Review Article

An Overview of Initiative Policies and Programmes on Malnutrition in India

Kandasamy Karthikeyan[1], Rajendran Geetha[2]

[1]Assistant Professor and Research Supervisor, [2]PhD Research Scholar, Department of food Science and nutrition, Periyar University, Salem, Tamil Nadu, India

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I N F O

Corresponding Author:
Kandasamy Karthikeyan, Department of food Science and nutrition, Periyar University, Salem, Tamil Nadu, India
E-mail Id:
profkarthi@periyaruniversity.ac.in
Orcid Id:
https://orcid.org/0009-0002-4795-5835

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A B S T R A C T

Introduction: Malnutrition among children under five years remains a significant public health challenge in India, encompassing both undernutrition and the emerging issue of overnutrition. It is influenced by multiple socio-economic and environmental determinants, including poverty, inadequate sanitation, and low maternal education. Despite several national nutrition programmes, the burden of malnutrition continues to persist across regions.

Methodology: This study adopts a narrative review approach to analyse malnutrition and related policy interventions in India. Relevant literature published between 2015 and 2023 was included, focusing on children under five years, maternal nutrition, and national nutrition programmes. Data were obtained from sources such as PubMed, National Family Health Survey (NFHS-3, 4, and 5), the World Health Organization, and NITI Aayog. Keywords including "malnutrition in India," "child undernutrition," "stunting and wasting," and "nutrition programmes India" were used with Boolean operators. Data were categorised and synthesised narratively.

Results: Findings indicate that undernutrition remains highly prevalent among children under five in India. According to NFHS-5, 35.5% of children are stunted, 19.3% are wasted, and 32.1% are underweight. Additionally, 3.4% of children are overweight, highlighting the growing dual burden of malnutrition. Government initiatives such as the Integrated Child Development Services (ICDS), Mid-Day Meal Scheme (PM POSHAN), and National Health Mission have contributed to improvements; however, gaps in implementation, monitoring, and service delivery remain evident.

Conclusion: The study underscores the need for strengthened, multi-sectoral strategies to address malnutrition in India. Improving community awareness, enhancing access to existing nutrition programmes, and addressing key determinants such as poverty, sanitation, and maternal education are essential. Furthermore, context-specific, local-level interventions are necessary to reduce regional disparities and improve child nutritional outcomes.

Keywords: Malnutrition, Undernutrition, Stunting, Wasting, Underweight, Integrated Child Development Services, Public Health

Introduction

Malnutrition in India exhibits significant regional disparities, reflecting underlying socioeconomic and infrastructural inequalities. According to the National Family Health Survey-5 (2019–21), the prevalence of stunting, wasting, and underweight varies considerably across states.[2] States such as Bihar, Jharkhand, and Uttar Pradesh report some of the highest levels of undernutrition. For instance, Bihar records stunting levels exceeding 40%, while Jharkhand and Uttar Pradesh also show consistently high rates of child undernutrition. These states are characterised by higher poverty levels, lower maternal education, inadequate healthcare access, and poor sanitation conditions, all of which contribute to adverse nutritional outcomes. In contrast, states such as Kerala and Tamil Nadu demonstrate relatively lower prevalence rates. Kerala, in particular, has achieved significant improvements due to higher literacy rates, better maternal health indicators, effective public health systems, and improved access to sanitation and healthcare services. Tamil Nadu's strong implementation of nutrition programmes, including the Mid-Day Meal Scheme and ICDS, has also contributed to better child nutrition outcomes.[11,6]

Regional differences are further influenced by variations in dietary practices, cultural factors, urbanisation, and the effectiveness of programme implementation. Additionally, tribal and rural populations often experience higher levels of malnutrition compared to urban populations due to limited access to healthcare and nutrition services.[12] These disparities highlight the need for context-specific, regionally targeted interventions rather than a uniform national approach. Strengthening local governance, improving maternal education, enhancing sanitation infrastructure, and ensuring efficient implementation of nutrition programmes are critical to reducing these regional inequalities.

Aim of the Study

To provide a comprehensive overview of the major initiatives, policies, and programmes implemented in India to address malnutrition, with a focus on their scope, effectiveness, and role in improving nutritional outcomes among vulnerable populations.

Objectives of the Study

- To examine key national nutrition policies and programmes aimed at reducing malnutrition in India.
- To analyse the impact of these initiatives on maternal and child health.
- To identify gaps and challenges in the implementation of nutrition-related interventions.
- To suggest measures for strengthening existing strategies to combat malnutrition effectively.

Government initiatives and programme evaluation

Government nutrition programmes in India have contributed to measurable improvements in child health and nutrition; however, their overall effectiveness remains constrained by persistent implementation challenges.

The Integrated Child Development Services (ICDS) has significantly expanded access to supplementary nutrition, immunisation, and early childhood care through Anganwadi centre.[11] Evidence from national surveys indicates that ICDS has improved service coverage and contributed to reductions in undernutrition over time. However, its impact varies across states due to uneven infrastructure, irregular supply of supplementary nutrition, inadequate training of Anganwadi workers, and limited community engagement.

The PM POSHAN (formerly Mid-Day Meal Scheme) has demonstrated strong positive effects on school attendance, retention, and calorie intake among children.[6] Studies show that the programme has helped improve dietary diversity and reduced short-term hunger among school-going children. Despite these achievements, concerns remain regarding food quality, hygiene, supply chain disruptions, and variations in implementation across regions.

The National Health Mission (NHM) has strengthened maternal and child healthcare services, including antenatal care, immunisation, and institutional deliveries.[7] This has indirectly contributed to better nutritional outcomes by addressing health-related determinants of malnutrition. Nevertheless, disparities in healthcare access persist, particularly in rural and tribal areas, where shortages of trained personnel and infrastructure limit the programme's effectiveness.

The National Food Security Act (NFSA) has improved household food security by providing subsidised food grains to a large proportion of the population.[8] While this has enhanced caloric intake, its impact on nutritional outcomes is limited, as the scheme primarily focuses on staple cereals rather than dietary diversity. Additionally, issues such as targeting errors, leakages in the Public Distribution System, and exclusion of eligible beneficiaries reduce its efficiency.

Similarly, the POSHAN Abhiyaan (National Nutrition Mission) has introduced a convergent, technology-driven approach to improve nutrition indicators.[4] Early evidence suggests improvements in monitoring, data-driven decision-making, and inter-ministerial coordination. However, challenges such as digital infrastructure gaps, data quality issues, and

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limited last-mile connectivity continue to hinder optimal implementation.

Across programmes, several common barriers persist:

- Administrative inefficiencies and weak monitoring systems
- Inadequate infrastructure at Anganwadi centres and health facilities
- Human resource constraints, including overburdened frontline workers
- Socio-cultural factors, such as poor infant feeding practices and gender disparities
- Low awareness and utilisation of available services among beneficiaries.[11,6,7]

These findings indicate that while India's nutrition programmes have achieved notable progress in improving access and service delivery, their impact on reducing malnutrition remains uneven. Strengthening implementation through improved governance, better resource allocation, capacity building of frontline workers, and enhanced community participation is essential to maximise programme effectiveness.

Understanding Malnutrition: Forms, Causes, and the Dual Burden in Children

The World Health Organization defines malnutrition as a condition resulting from excessive or inadequate intake of nutrients, an imbalance of essential vitamins and minerals, or the body's inability to effectively utilise these nutrients.[9] Malnutrition presents a dual burden, encompassing both undernutrition and overnutrition, including overweight, obesity, and diet-related non-communicable diseases. Undernutrition manifests in four forms: underweight, stunting, wasting, and micronutrient deficiencies.[9]

Wasting is defined as low weight for height, reflecting acute undernutrition. It usually results from recent and severe weight loss due to insufficient food intake or illness. If not treated promptly, wasting significantly increases the risk of mortality among children. Stunting, defined as low height for age, is caused by chronic or recurrent undernutrition and is often associated with poverty, poor maternal health and nutrition, frequent infections, and suboptimal feeding and caregiving practices.[9] Children who are stunted are unable to reach their full physical and cognitive potential. Underweight is defined as low weight for age and may reflect a combination of both stunting and wasting.[9]

The United Nations General Assembly proclaimed the Decade of Action on Nutrition (2016–2025) to accelerate global efforts to address all forms of malnutrition. The initiative aims to eliminate malnutrition by promoting access to safe, nutritious, and sustainable diets for all.[1]

Malnutrition is particularly prevalent during pregnancy and lactation, affecting both mothers and young children who have increased nutritional requirements. Children are especially vulnerable, as malnutrition weakens the immune system, increases susceptibility to infections, and delays recovery. Severely underweight children face a significantly higher risk of mortality compared to healthy-weight children. Undernutrition contributes substantially to child mortality, including deaths associated with infectious diseases such as pneumonia and malaria.[10]

Recent national data further emphasise the scale of the problem. According to the National Family Health Survey-5, 35.5% of children under five years in India are stunted, indicating persistent chronic undernutrition. At the same time, 3.4% of children are overweight, reflecting an emerging dual burden of malnutrition, where undernutrition coexists with rising levels of overnutrition.[2]

As shown in Figure 1, approximately 144 million children less than five years old suffer from stunted growth globally, 47 million suffer from wasting, including 14.3 million who are seriously wasted, and 38.3 million are overweight.

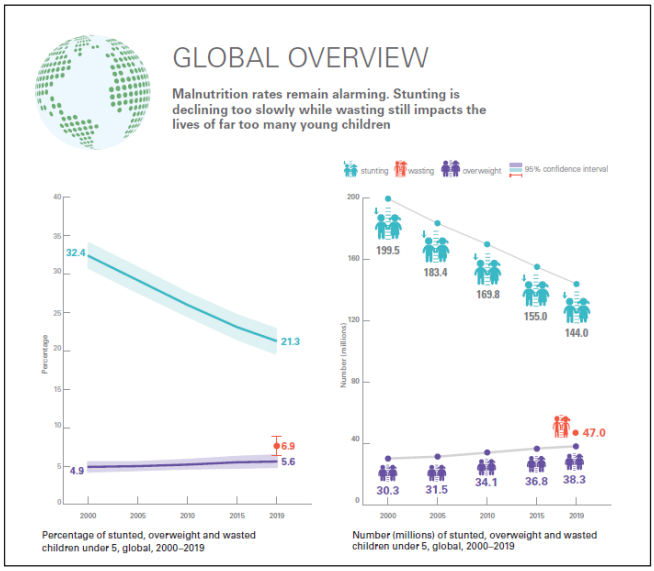

Figure 1.Percentage of stunted, overweight and wasted children under 5, global, 2000–2019
Number (millions) of stunted, overweight and wasted children under 5, global, 2000–2019

Childhood malnutrition remains a significant public health issue in many developing nations. Apart from causing serious physical and cognitive harm to individuals, it also restricts the broader developmental prospects of these countries. This is largely because malnourished children tend to perform poorly in school, have reduced physical capacity, and often require increased parental support as they grow. Moreover, malnutrition represents a violation of children's human rights.[9,12] The causes of child malnutrition

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and the policy measures implemented by governments in emerging economies like India can provide valuable insights for other developing countries aiming to strengthen public interventions and reduce childhood malnutrition.[9]

Despite India's remarkable progress in economic growth, educational attainment, and technological innovation, the country, along with its neighbouring South Asian nations, continues to bear a disproportionate burden of global child malnutrition, accounting for a significant share of the world's malnourished children.[1,2]

India ranked 100th out of 119 countries in the Global Hunger Index 2017.[1] A substantial proportion of children in the country suffer from malnutrition, posing a serious challenge to child survival, economic development, and national productivity. Estimates suggest that a large percentage of children experience nutritional deficiencies, and neonatal mortality remains a concern. Furthermore, earlier reports indicated that a high proportion of children under five were affected by stunting and underweight conditions.[2,3]

According to the NITI Aayog National Nutrition Strategy, an analysis of data from the National Family Health Survey (NFHS-3 and NFHS-4) indicates that although progress has been made in reducing child undernutrition in India, considerable challenges persist.[4] The proportion of underweight children under five has declined across most states and Union Territories. However, due to population growth, the absolute number of undernourished children has not decreased significantly.[3,4] For example, NFHS-4 reported that 35.7% of children under five were underweight, compared to 42.5% in NFHS-3.[3] Similarly, stunting declined from 48% to 38.4%, reflecting gradual improvement.[3] In contrast, wasting increased slightly from 19.8% to 21%, indicating that acute malnutrition remains a serious concern.[3] According to NFHS-5, 35.5% of children under five years are stunted, demonstrating that undernutrition continues to be a major public health issue requiring sustained and targeted interventions.[2] Figure 2, comparative bar chart showing the trends in child malnutrition indicators underweight, stunting, and wasting based on NFHS-3, 4 and 5 data.

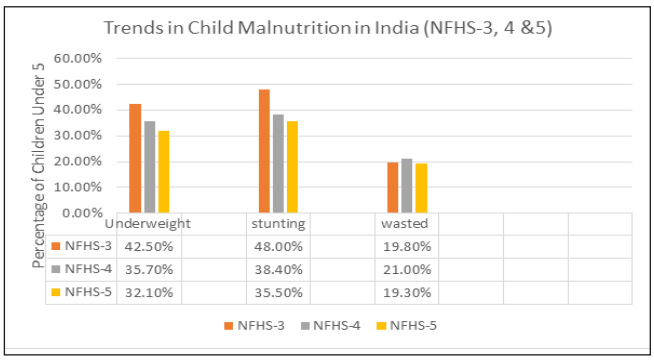

Figure 2.Trends in Child Malnutrition in India (NFHS-3, 4 &5)

The strategy highlights that malnutrition is an intergenerational issue, directly linking a mother's health and education to her child's nutritional outcomes.[4] It emphasises the importance of addressing the root causes of malnutrition, such as food insecurity, poor sanitation, limited access to healthcare, and low levels of women's education, rather than viewing malnutrition solely as a medical problem. The strategy also calls for coordinated action across multiple ministries to effectively tackle these interconnected challenges.[4]

Furthermore, previous estimates suggest that a substantial number of women and children in India die each year from malnutrition-related causes, underscoring the severe health consequences of this condition. Malnutrition remains a major contributor to the global burden of disease among children under five years, particularly through its association with pneumonia, diarrhoeal diseases, and neonatal conditions.[9,12]

Proper nutrition is essential not only for a child's physical and cognitive development but also for overall socioeconomic well-being. It serves as a cornerstone of lifelong health. Malnutrition poses a serious threat to long-term human development by reducing adult productivity, impairing cognitive abilities, and limiting the capacity of low-income families to achieve economic stability. Consequently, poor nutritional status significantly affects a nation's socioeconomic progress, particularly among its most disadvantaged populations.[9]

Integrated Child Development Services (ICDS)

The Integrated Child Development Services (ICDS) programme, launched in 1975 by the Ministry of Women and Child Development in collaboration with the Government of India and UNICEF, is one of the largest initiatives globally aimed at improving child development and maternal health.[11] The programme was designed to provide essential healthcare and nutrition services to children under six years of age and to their mothers. To achieve this, Anganwadi centres were established across the country, particularly in rural and underserved areas, in line with the National Policy on Children.11

These centres provide services such as health check-ups, immunisation, supplementary nutrition, and early childhood education. A key component of ICDS is supplementary nutrition, which aims to bridge the gap between actual dietary intake and the Recommended Dietary Allowance (RDA). The programme targets vulnerable groups, including pregnant women, lactating mothers, and children aged 6 months to 6 years.[11]

Following the identification of implementation gaps, the Pradhan Mantri Matru Vandana Yojana (PMMVY) was

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introduced (initially launched as the Indira Gandhi Matritva Sahyog Yojana) to provide conditional cash transfers to pregnant and lactating women. The scheme aims to compensate for wage loss and promote better maternal and child health outcomes. However, despite provisions under the National Food Security Act, many eligible women remain excluded due to stringent eligibility criteria and administrative barriers.[5,8]

PM POSHAN (Mid-Day Meal Scheme)

One of the most prominent school-based nutrition interventions in India is the Mid-Day Meal Scheme, now known as PM POSHAN, introduced in 1995 to address classroom hunger and improve school enrolment, attendance, and retention.[6] The scheme provides free cooked meals to children in government and government-aided schools, including those attending special training centres.

According to nutritional guidelines, primary school children are provided with meals containing at least 450 kilocalories and 12 grams of protein, while upper primary students receive meals with a minimum of 700 kilocalories and 20 grams of protein. These meals typically include cereals, pulses, vegetables, and occasionally milk or eggs, depending on regional practices.[12]

In 2021, the scheme was restructured as PM POSHAN, with an expanded focus on nutrition gardens, fortified foods, and improved monitoring through social audits and digital systems. Despite its wide reach and positive impact on school participation and dietary intake, challenges such as food quality, hygiene, infrastructure gaps, and inter-state variations in implementation persist.[6]

National Health Mission (NHM)

The National Health Mission (NHM), launched in 2013, aims to strengthen healthcare delivery systems across rural and urban areas, particularly for vulnerable populations.[7] It integrates the National Rural Health Mission (NRHM) and the National Urban Health Mission (NUHM) to provide accessible, affordable, and quality healthcare services.

NHM focuses on maternal and child health, immunisation, family planning, and disease prevention, thereby addressing key determinants of malnutrition. Community health workers, particularly Accredited Social Health Activists (ASHAs), play a crucial role in connecting communities with healthcare services. However, disparities in infrastructure, workforce availability, and service delivery continue to limit the programme's effectiveness in certain regions.[7]

National Food Security Act (NFSA)

The National Food Security Act (NFSA), enacted in 2013, aims to ensure food security by providing subsidised food grains to approximately two-thirds of India's population.[8] Under the Targeted Public Distribution System (TPDS), eligible individuals receive 5 kilograms of food grains per person per month at subsidised rates.

The Act also incorporates the Antyodaya Anna Yojana (AAY), which provides 35 kilograms of food grains per month to the poorest households. While NFSA has significantly improved access to food and enhanced caloric intake, its impact on nutritional outcomes remains limited due to its primary focus on staple cereals rather than dietary diversity. Additionally, challenges such as leakages, targeting errors, and administrative inefficiencies reduce its overall effectiveness.[8]

Table 1.below indicates the Comparison of Major Food and Nutrition Schemes in India

Comparison of Major Food and Nutrition Schemes in India				
Scheme	**Launch Year**	**Target Group**	**Key Benefits**	**Implementing Agency**
ICDS (Integrated Child Development Services)	1975	Children (0–6 years), pregnant & lactating mothers	Supplemental nutrition, immunisation, health screenings, and preschool education	Child Development and Women's Ministry
PMMVY (Pradhan Mantri Matru Vandana Yojana)	2010 (as IGMSY); renamed in 2017	Pregnant & lactating women (19+ years, first live birth)	₹5,000 financial assistance to compensate for wage loss and encourage institutional delivery	Child Development and Women's Ministry
MDM (Mid-Day Meal Scheme)	1995	School children (Class I–VIII in government/ aided schools)	Free cooked lunch to improve nutritional levels and school attendance	Education Ministry (Department of School Education)
NFSA (National Food Security Act)	2013	~67% of the population	5 kg/month of cereals per person at subsidized rates; AAY households receive 35 kg/month	Ministry overseeing Consumer Affairs and Food Distribution in India

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AAY (Antyodaya Anna Yojana)	2000	Poorest of the poor households	35kilogram of eating grains every month at significantly discounted prices	Ministry overseeing Consumer Affairs and Food Distribution in India
NHM (National Health Mission)	2013 (revised from NRHM)	Entire population, with focus on rural areas, women, and children	Strengthening health systems, RMNCH+A services, nutrition interventions	Health and Family Welfare Ministry

Village Health, Sanitation, and Nutrition Committee (VHSNC)

The Village Health, Sanitation and Nutrition Committee (VHSNC), established in April 2005 under the National Rural Health Mission, is a key initiative aimed at decentralising health governance and empowering local communities to improve sanitation and nutritional outcomes.[7] The VHSNC enables local self-government institutions, such as panchayats, to supervise and manage essential public health services. It also oversees the activities of frontline health workers, including Accredited Social Health Activists (ASHAs) and Anganwadi Workers (AWWs), as well as personnel from departments such as rural development, water supply, and sanitation.[7]

Members of the VHSNC are expected to be well informed about their roles and responsibilities and are trained in participatory planning, budgeting, and basic health management skills. The committee receives regular updates from ASHAs and Auxiliary Nurse Midwives (ANMs) regarding the nutritional status of children under five years of age.[7]

In addition, the VHSNC functions as a crucial link between the community and healthcare services, ensuring that children under three years of age and pregnant and lactating women receive take-home rations. It also monitors the provision of supplementary nutrition for children aged three to six years through Anganwadi Centres (AWCs). The committee is responsible for verifying that AWCs provide hot cooked meals in accordance with prescribed guidelines. However, gaps remain in monitoring mechanisms, particularly due to the lack of standardised procedures for food quality inspection and reporting.[7,12]

Village Health and Nutrition Day (VHND)

Village Health and Nutrition Day (VHND) is a community-based platform through which ASHAs, ANMs, and AWWs mobilise villagers—especially women and children—to attend services at Anganwadi Centres on a fixed day each month.[7] During VHND sessions, healthcare professionals provide information on nutrition, maternal and child health, family planning, sanitation, and the prevention of infectious diseases.

These sessions are also used to deliver essential health services, including immunisation (particularly for children who have missed routine vaccinations), growth monitoring, and the distribution of essential medicines. VHND further facilitates awareness regarding postpartum care, access to safe drinking water, and improved sanitation practices. Strengthening community participation, particularly through Panchayati raj institutions, can further enhance the effectiveness and outreach of VHND services.[7,11]

POSHAN Abhiyaan (National Nutrition Mission)

The National Nutrition Mission (NNM), also known as POSHAN Abhiyaan, was launched with a budget of approximately USD 1.3 billion for the period 2017–2020 to address malnutrition in a comprehensive and convergent manner.[4] The mission aims to coordinate nutrition-related interventions across multiple ministries and sectors to address key challenges such as stunting, undernutrition, anaemia, and low birth weight.[4]

The programme was implemented in a phased manner, covering 315 districts in 2017–2018, 235 districts in 2018–2019, and all remaining districts by 2019–2020 [4]. It targets improvements in nutritional outcomes among children, pregnant women, lactating mothers, and adolescent girls.

The key objectives of POSHAN Abhiyaan include:

- Reducing stunting by 2% annually
- Reducing undernutrition by 2% annually
- Reducing anaemia by 3% annually in children and 2% in women and adolescent girls
- Reducing low birth weight by 2% annually

The mission also aims to reduce the prevalence of stunting from 38.4% (NFHS-4) to 25%, highlighting its focus on measurable and time-bound outcomes.[3,4]

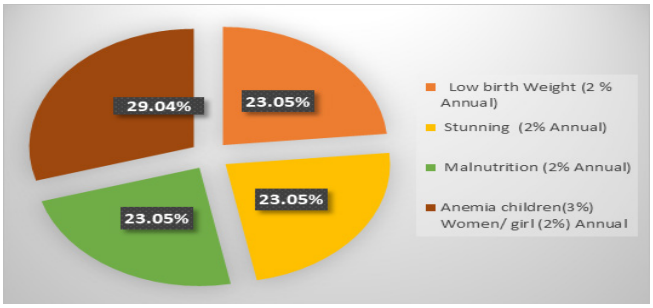

Figure 3.Target Annual Reduction Focus Area Under National Nutrition Mission

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Implementation Strategy

- **Convergence Action Plan:** Emphasis is placed on co-ordinating and integrating services offered during gestation and early childhood, particularly crucial interventions during the baby's first thousand days of life.[4]
- **Effective Local-Level Monitoring:** Strengthening monitoring systems ensures proper programme implementation and improves service delivery in antenatal and postnatal care, immunisation, and regular home visits facilitated by ASHA and AWW personnel.[7,9]
- **Ministries Involved:** Multiple ministries and departments are engaged, including those responsible for health, child development, and nutrition services.[4]

By fostering collaboration across sectors and encouraging active participation from states and Union Territories, the National Nutrition Mission (NNM) aims to effectively reduce malnutrition and its associated risks in vulnerable populations across India.[4]

Objectives of the ICDS Programme

- Improve Nutritional Status and Health: Enhancing dietary intake and overall health of children aged 0–6 years during the critical growth period.[7]
- Promote Healthy Development: Supporting physical, social, and cognitive development of children.[7]
- Reduce Mortality, Morbidity, and Malnutrition: Addressing child mortality, illness, and school dropouts.[7]
- Coordination Across Departments: Ensuring intersectoral coordination for effective programme implementation.[7]
- Empower Mothers: Promoting maternal awareness and capacity to meet children's nutritional and health needs.[7]

Key Components of Nutrition and Services

- **Supplementary Nutrition:** Addresses nutritional deficiencies, including micronutrient deficiencies and anaemia.[7]
- **Growth Monitoring:** Regular assessment of children's growth through weight tracking and health records.[7]
- **Community Surveys:** Identification of eligible beneficiaries for targeted interventions.[7]
- **Feeding Assistance:** Provision of supplementary nutrition for approximately 300 days per year.[7]
- **Addressing Nutritional Gaps:** Bridging the gap between actual intake and recommended dietary requirements.[7]

The ICDS programme remains a cornerstone of India's child development strategy, significantly contributing to maternal and child health outcomes, particularly among disadvantaged populations.[7]

Health Check-ups

The programme provides healthcare services to children under six years, pregnant women, and lactating mothers. Services include immunisation, growth monitoring, treatment of common illnesses, and provision of basic medicines through Anganwadi workers and Primary Health Centre (PHC) staff.[9,12]

Pre-school Education Services under ICDS

Early childhood education is provided to children aged 3–6 years through Anganwadi Centres (AWCs) under the Pre-school Education (PSE) component. It includes play-based learning, storytelling, and group activities to promote cognitive, social, and emotional development, preparing children for formal schooling and integrating nutrition and health services.[9,13]

Types of Nutritional Supplement

- **Children under six months:** Exclusive breastfeeding initiated within one hour of birth.[12]
- **Children aged 6 months to 3 years:** Provision of Take-Home Rations (THR), though utilisation may be limited due to intra-household sharing.[7,12]
- **Children aged 3–6 years:** Provision of hot cooked meals at AWCs. Meals may be distributed across multiple servings to meet caloric requirements, along with supplementary items such as milk or fruits.[7–9]

Results and Discussion

Malnutrition in India remains a significant public health challenge despite gradual improvements. According to NFHS-5 (2019–21), 35.5% of children under five are stunted, 19.3% are wasted, and 32.1% are underweight, reflecting a persistently high burden of undernutrition. At the same time, 3.4% of children are overweight, highlighting the emerging dual burden of malnutrition.[2]

Maternal health is crucial in determining child nutritional outcomes. High maternal anaemia, inadequate dietary intake during pregnancy, and poor access to antenatal care contribute significantly to low birth weight and subsequent undernutrition, reinforcing the intergenerational nature of malnutrition.[6,7]

Socioeconomic inequalities and regional disparities further exacerbate the problem. States such as Bihar, Jharkhand, and Uttar Pradesh report higher levels of undernutrition, whereas Kerala and Tamil Nadu demonstrate better outcomes due to improved healthcare systems and effective programme implementation.[11,18]

Government initiatives such as ICDS, PM POSHAN, NHM, and NFSA have improved access to nutrition and

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healthcare services. However, their effectiveness remains uneven due to implementation gaps, including inadequate infrastructure, supply chain inefficiencies, shortages of trained personnel, and weak monitoring systems.[7,9,20,22]

Additionally, poor sanitation, unsafe drinking water, and suboptimal infant feeding practices continue to hinder progress. The coexistence of undernutrition and overnutrition further complicates the nutritional landscape, requiring integrated and multi-sectoral policy responses.[7,10,12]

Conclusion

Malnutrition in India continues to pose a major public health and developmental challenge, particularly among children under five years. Despite the implementation of multiple large-scale government programmes, undernutrition prevalence remains high, and the emerging burden of overnutrition adds further complexity.

Malnutrition is driven by interconnected factors, including poverty, maternal health, inadequate sanitation, and limited access to healthcare and nutrition services. While initiatives such as ICDS, PM POSHAN, NHM, and NFSA have improved service delivery, their impact is constrained by persistent implementation gaps and regional disparities.

Addressing malnutrition requires a comprehensive, multi-sectoral approach extending beyond food provision to include maternal education, healthcare strengthening, water and sanitation improvements, and behavioural change communication. Strengthening monitoring systems, enhancing community participation, and improving last-mile service delivery are essential for maximising programme effectiveness.

Future strategies should prioritise context-specific interventions, particularly during the first 1,000 days of life, which are critical for child development. Sustained political commitment, increased investment, and coordinated action across sectors are essential to achieve long-term improvements in nutritional outcomes.

References

1. Food and Agriculture Organization of the United Nations (FAO). The State of Food Insecurity in the World 2015: Meeting the 2015 International Hunger Targets—Taking Stock of Uneven Progress. Rome: FAO; 2015.
2. Ministry of Health and Family Welfare, Government of India. National Family Health Survey (NFHS-5), 2019–21: India Report. Mumbai: International Institute for Population Sciences; 2021. Available from: https://dhsprogram.com/pubs/pdf/FR375/FR375.pdf
3. Ministry of Health and Family Welfare, Government of India. National Family Health Survey (NFHS-4), 2015–16: India Report. Mumbai: IIPS; 2017. Available from: https://dhsprogram.com/pubs/pdf/FR339/FR339.pdf
4. NITI Aayog. National Nutrition Strategy: A Precursor to the National Nutrition Mission. New Delhi: Government of India; 2017.
5. Ministry of Women and Child Development, Government of India. Pradhan Mantri Matru Vandana Yojana (PMMVY) Guidelines. New Delhi: Government of India; 2017.
6. Ministry of Education, Government of India. PM POSHAN (Mid-Day Meal Scheme): Guidelines and Objectives. New Delhi: Government of India; 2021.
7. Ministry of Health and Family Welfare, Government of India. National Health Mission (NHM): Framework for Implementation. New Delhi: Government of India; 2012.
8. Ministry of Consumer Affairs, Food and Public Distribution, Government of India. National Food Security Act (NFSA): Guidelines. New Delhi: Government of India; 2013.
9. World Health Organization. Child Growth Standards and Malnutrition Database. Geneva: WHO. Available from: https://www.who.int/tools/child-growth-standards
10. World Health Organization. Children: Reducing Mortality. Geneva: WHO. Available from: https://www.who.int/news-room/fact-sheets/detail/children-reducing-mortality
11. Government of Tamil Nadu. ICDS Policy Note 2021–2022. Available from: https://www.icds.tn.gov.in/icdstn/pdf/Policy_Note_2021.pdf
12. National Institute of Nutrition. Dietary Guidelines for Indians. Hyderabad: NIN; 2011.

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DOI: https://doi.org/10.24321/2278.2044.202606