

# Chapter 18

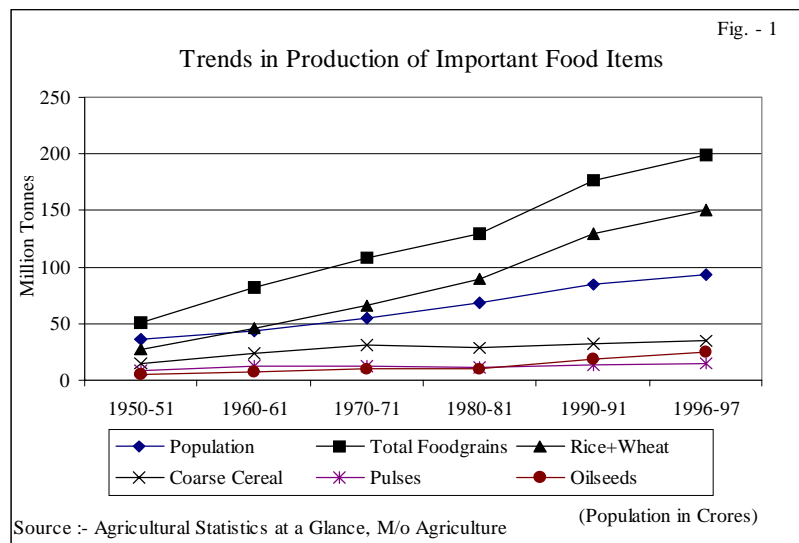
## Nutrition

Currently the major nutrition-related public health problems are:

- a) Chronic energy deficiency and under-nutrition
- b) Micro-nutrient deficiencies
  - anaemia due to iron and folic acid deficiency
  - Vitamin A deficiency
  - Iodine Deficiency Disorders
- c) Chronic energy excess and obesity

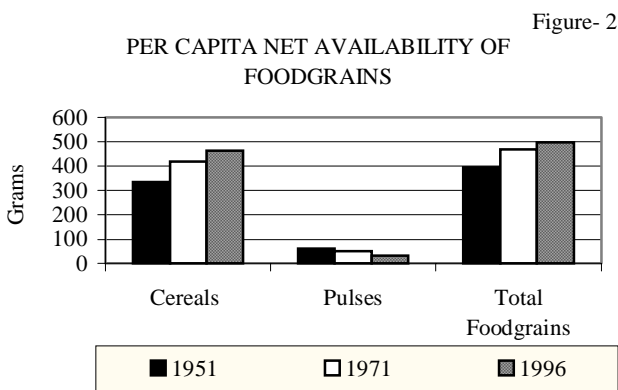
### Nutritional Implications of Changing Food Production Patterns

2. One of the major achievements in the last fifty years has been the green revolution and self-sufficiency in production. Food grain has increased from million tons in 1950-51 million tons in 1998-99 a matter of concern the cereal production growing steadily at a than the population rates, the coarse grain production has not similar increase Consequently there reduction in the per availability of pulses grams in 1951 to 34 grams per day in 1996 (Fig 2).



food production 50.82 to 200.88 (Prov.). It is that while has been rate higher growth and pulse shown a (Fig.1). has been a capita from 60.7

3. During the last few years the country has imported pulses to meet the gap in pulse requirement. There has been a sharp and sustained increase in cost of pulses, so there is substantial decline in per capita pulses consumption among poorer segment of population. This in turn could have an adverse impact on the protein intake. However there is some beneficial effect also. With the reduction in consumption of kesari dal there has been considerable reduction in the incidence of neurolethyrism in Madhya Pradesh. The pulse component of the "Pulses and Oil Seeds Mission" needs to receive a major thrust in



terms of R&D (Research & Development) and other inputs, so that essential pulse requirement of growing population is fully met.

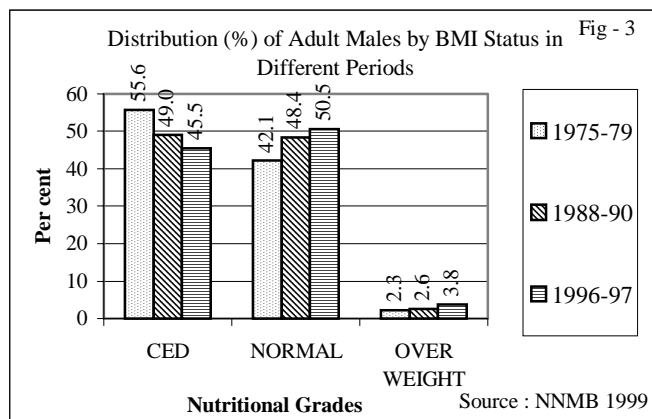
4. Over years the coarse grain production has remained stagnant and per capita availability of coarse grain has undergone substantial reduction. There has been a shift away from coarse grains to rice and wheat consumption even among poorer segment of population. Coarse grains are less expensive than rice and wheat; they can thus provide higher calories for the same cost as compared to rice and wheat; they are richer in minerals, some micronutrients and fibre. Coarse grains which are locally produced and procured could be made available through TPDS (Targeted Public Distribution System) at subsidised rate; this may not only substantially bring down the subsidy cost without any reduction in calories provided but also improve "targeting" as only the most needy people are likely to access these coarse grains.

## Horticultural Production

5. India ranks first & second in production of vegetables and fruits in the world. However, per capita consumption of these is very low. In addition to vital micronutrients, vegetables provide phytochemical and fibre; and consumption of adequate quantities of vegetables is essential for health. At present there is lack of sufficient focus and thrust in horticulture especially cultivation and marketing of the low cost locally acceptable green leafy vegetables and yellow vegetables and fruits; because of this, availability of vegetables especially green leafy vegetables and yellow/red vegetables throughout the year at affordable cost has remained an unfulfilled dream both in urban and rural areas. Health and nutrition education emphasizing the importance of consuming these inexpensive rich sources of micronutrients will not result in any change in food habits unless there is harnessing and effective management of horticultural resources in the country to meet the growing needs of the people at affordable cost. States like Tamil Nadu and Himachal Pradesh have initiated some efforts in increasing vegetable production and improving marketing; similar efforts need to be taken up in other States also. Processing of fruits and vegetables at or near the areas where they are grown would minimize the inevitable losses during transport and reduce transport costs. Processing units in rural areas would also provide employment opportunities and economic benefits due to value addition.

## Changes in Dietary Intake and Nutritional Status

6. Over the last three decades there have been substantial changes in status as well as life style of the population. The data from NNMB surveys indicate that there has been an increase in energy intake in adults - both men and women - over the last three decades. The National Nutritional Bureau (NNMB) data also has been some decline in energy deficiency) over years and increase in obesity (Fig-3).



decades there has been a socio-economic population. The data indicate that there has been an increase in energy intake in over the last three decades. Monitoring indicates that there has been a decline in CED(chronic energy deficiency) simultaneously an

## Adolescent Nutrition

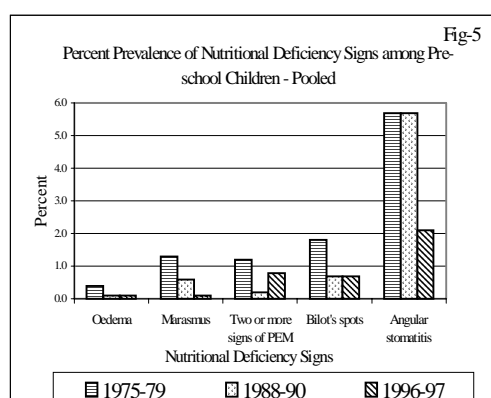
7. Adolescents who are undergoing rapid growth and development are one of the nutritionally vulnerable groups who have not received the attention they deserve. In under-nourished children rapid growth during adolescence may increase the severity of under-nutrition. Early marriage and pregnancy will perpetuate both maternal and child under-nutrition. At the other end of spectrum among the affluent segment of population, adolescent obesity is increasingly becoming a problem. Available data from NNMB on nutritional status of adolescents indicate that under-nutrition continues to be a major problem in adolescents. In addition, over years there has been some increase in obesity. In view of these problems, nutrition education, health education and appropriate nutritional interventions for adolescent are being taken up under ICDS (Integrated Child Development Scheme) and RCH (Reproductive & Child Health) Programmes. In order to reduce anaemia, supplementation of iron and folic acid to adolescent is also being taken up on a pilot basis under both these programme. Department of Women and Child Development has launched an adolescent girls scheme to take care of specific needs of adolescent girls in 507 blocks. The Department proposes to cover 1493 additional blocks during remaining period of the Ninth Plan.

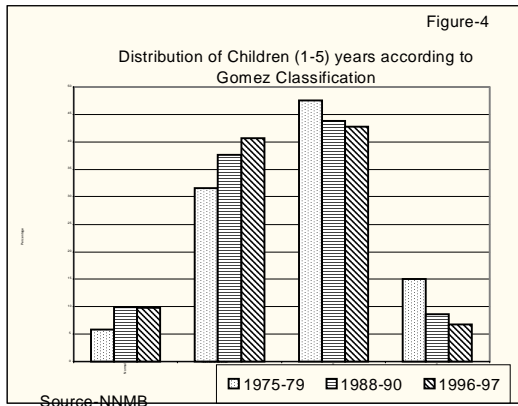
## Prevention & Management Of Chronic Energy Deficiency

8. It is a matter of concern that prevalence of low birth weight and under-nutrition in pregnant women and children between 6 and 24 months has not declined. Though there has been a 50% reduction in severe under-nutrition in under five children, the decline in moderate and mild under-nutrition is marginal. While mortality has come down by 50% and fertility by 40%, reduction in under-nutrition is only 20%. India with less than 20% global children accounts for over 40% under-nourished children. Pregnant and lactating women have been an identified priority group for receiving food supplement through ICDS. However, experience over the years indicate that very few needy, at-risk pregnant women regularly access and benefit from ICDS food supplements. Effective antenatal care is also not readily available. Awareness generation programmes have been undertaken to sensitize the community, the health care and ICDS systems to recognise the 'at risk' cases and respond by appropriate remedial measures.

## CED in Pre-school children

9. Pre-school children constitute the most nutritionally vulnerable segment of the population and their nutritional status is considered to be a sensitive indicator of community health and nutrition. Over the last two decades there has been some improvement in energy intake and substantial reduction in moderate and severe under-nutrition in pre-school children (Fig. 4).



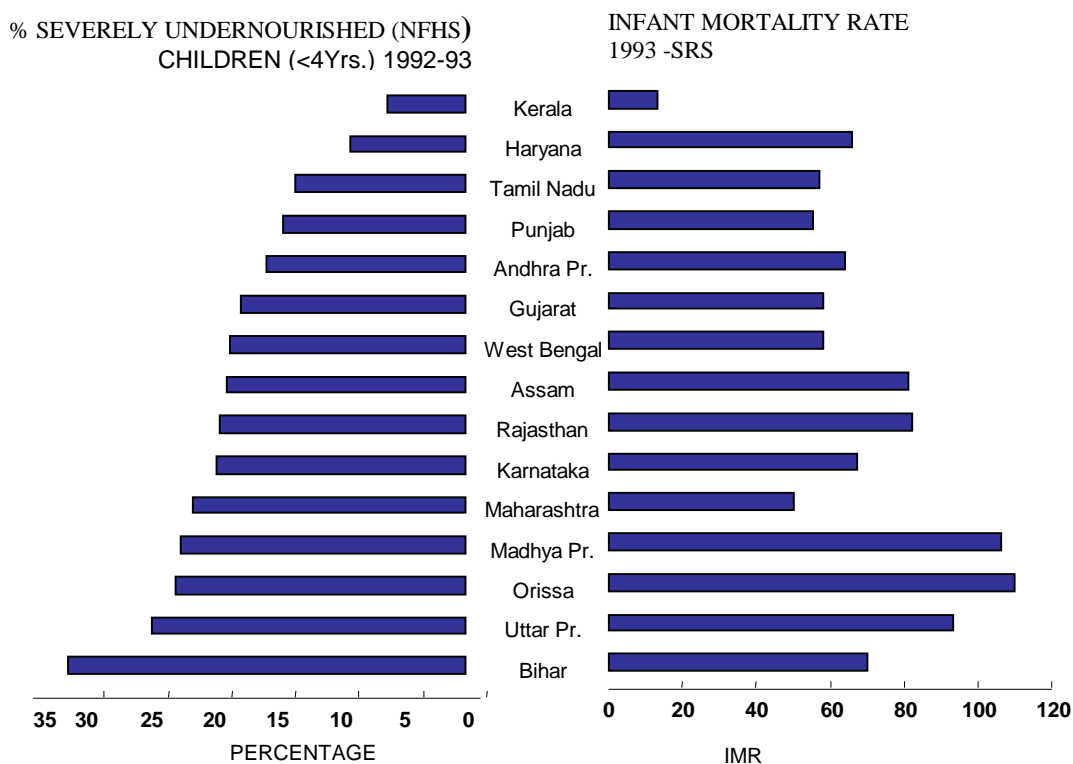


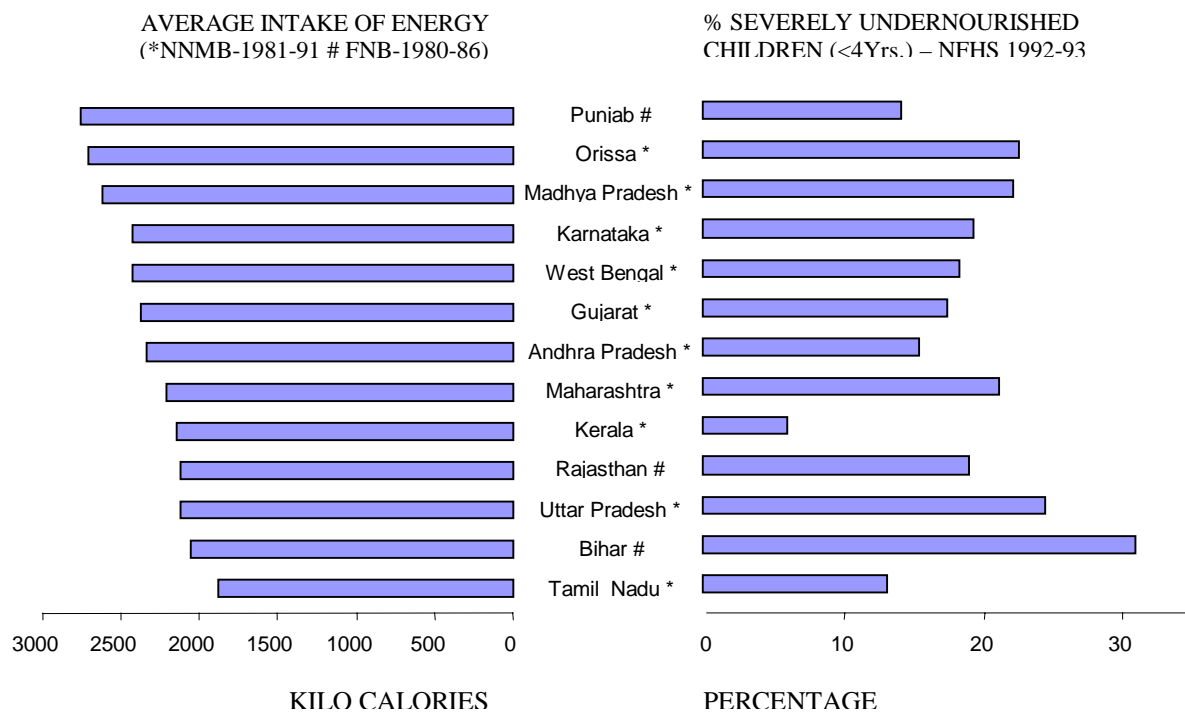
10. Though there has not been any change in the intake of green leafy vegetables and other vegetables, there has been substantial decline in prevalence of nutritional deficiency signs (Fig 5).

### Inter-State Differences in Dietary Intake, Undernutrition & Under-five Mortality

11. State-wise data on energy intake, prevalence of severe CED and infant mortality are given in Figures 6 & 7.

Figure-6 & 7





12. Low dietary intake is the most important cause of under-nutrition. Other major factors responsible for under-nutrition in children are low birth weight, poor infant feeding practices, infections due to poor sanitation, lack of safe drinking water and poor access to health care. In spite of low dietary intake prevalence of severe under-nutrition is lower in Kerala because of more equitable distribution of food between income groups and within families and better access to and utilization of health care. In spite of higher average dietary intake, under-nutrition rates are higher in UP, MP and Orissa because of lack of equitable distribution of food and access to health care. Identification and appropriate nutrition and health intervention among 'at risk' groups and in under-nourished children are essential for optimal results. This is currently being attempted in ICDS programme in Orissa.

13. Under-nutrition increases susceptibility to infections. Infection aggravates under-nutrition. If uninterrupted this vicious circle could result in death. In most of the states with high under-nutrition the infant mortality is high. In Kerala both severe under-nutrition and IMR (infant mortality rate) are low. In spite of high per capita income, dietary intake and access to health care, both under-nutrition and IMR are relatively high in Punjab. It is therefore imperative that health and nutrition programmes are co-ordinated to achieve optimal synergy between the two interventions so that there is improvement in nutritional and health status.

14. Another factor responsible for under-nutrition in childhood is poor intra-familial distribution of food. Studies by NNMB show that in over 20% of the families where adults get sufficient food the pre-school children do not get enough food; this problem is inversely related to the maternal education level. Nutrition education by Angan Wadi Worker (AWW) has a key role in improving intra-familial distribution of food and ensuring that the preschool child gets its share.

### **Nutritional Component of the Integrated Child Development Scheme (ICDS)**

15. ICDS, perhaps the largest of all the food supplementation programmes in the world, was initiated in 1975 with the following objectives:-

- i) To improve the health and nutrition status of children 0-6 years by providing supplementary food and by coordinating with state health departments to ensure delivery of required health inputs;
- ii) To provide conditions necessary for psychological and social development of pre-school children through early stimulation and education;
- iii) To provide pregnant and lactating women with food supplements;
- iv) To enhance the mother's ability to provide proper child care through health and nutrition education;
- v) To achieve effective coordination of policy and implementation among the various departments to promote child development.

16. The initial geographic focus was on Scheduled Tribe, drought-prone areas and blocks with a significant proportion of Scheduled Caste population. In 1975 there were 33 ICDS blocks. As of 1996, the number increased to 4,200 ICDS blocks with 5,92,571 anganwadis in the country; the beneficiaries increased from 5.7 million children and 1.2 million mothers in 1985 to 18.5 million children and 3.7 million mothers in 1996.

### **Evaluation of Nutrition Component of ICDS :**

17. During the Ninth Plan ICDS programme in Orissa and Andhra Pradesh were evaluated by the National Institute of Nutrition. There was a major review of the nutrition sector and ICDS programme by the World Bank (WB) and Government of India in 1997. The findings were:

- ICDS services were much in demand but there are problems in delivery, quality and coordination. The programme might perhaps be improving food security at household level, but failed to effectively address the issue of prevention, detection and management of undernourished child/mother.
- Children in 6-24 months age group and pregnant and lactating women did not come to the Anganwadi nor did they get food supplements.
- Available food was shared between mostly 3-5 year old children irrespective of their nutritional status.
- There was no focussed attention on management of severely undernourished children
- No attempt was made to provide ready mixes that could be given to 6-24 month child 3-4 times a day; nor was nutrition education focussed on meeting these childrens' need from

the family pot.

- Childcare education of the mother was poor or non-existent.
- There were gaps in workers training, supervision, and community support.
- Inte-sectoral coordination was poor.

18. Efforts are under way to rectify some of these problems. Closer collaboration between the ICDS and the Health functionaries at all levels is being attempted. The Department of Women and Child Development proposes to operationalise 318 new projects under ICDS-III in the states of Uttar Pradesh, Maharashtra, Kerala and Rajasthan and 143 projects under ICDS-APER (Andhra Pradesh Economic Rehabilitation) in Andhra Pradesh.

## Funding of ICDS programme

TABLE - I						
Nutrition Spending in Selected States, 1992-95						
State	Population Below Poverty line (%)	Severe and Moderately Mal-nourished Children (%)	Net Annual State Domestic Product Per Capita (Rs.)	Nutrition Spending As a % of State Domestic Product		
	93-94	92-93	94-95	92-93	93-94	94-95
Andhra Pr.	0.23	0.49	57.18	0.11	0.10	0.10
Assam	0.41	0.50	49.73	0.11	0.12	0.17
Gujarat	0.24	0.50	81.64	0.31	0.31	0.29
Haryana	0.25	0.38	90.37	0.17	0.17	0.16
Karnataka	0.33	0.54	63.15	0.08	0.08	0.10
Kerala	0.25	0.29	57.68	0.10	0.09	0.12
Madhya Pr.	0.43	0.57	45.44	0.20	0.16	0.18
Maharashtra	0.37	0.54	98.06	0.08	0.08	0.08
Orissa	0.49	0.53	41.14	0.32	0.33	0.36
Rajasthan	0.27	0.42	52.57	0.09	0.12	0.13
Tamil Nadu	0.35	0.48	66.70	0.62	0.53	0.58
West Bengal	0.36	0.57	55.41	0.07	0.08	0.08

Note : Nutrition spending figures include GOI and state government expenditures on ICDS, NMMP and other nutrition programs  
Source : World Bank - India Wasting Away

19. Table-I sets out findings of a Government of India(GOI) –World Bank (WB) review of funding of nutrition programmes by the State Governments, including the nutrition component of ICDS programme and other supplementary feeding programme eg. Tamil Nadu - Mid day Meal Programme. It is obvious that expenditure on food supplementation does not have any correlation with level of under-nutrition or State Domestic Product. States which have higher prevalence of under-nutrition are not investing higher amounts in food supplementation programme. Expenditure on supplementary nutrition is not the only critical determinant of under-nutrition level. Kerala spends very little on nutrition programmes, yet it has the lowest under-nutrition rates, perhaps due to more equitable distribution of food and effective health care.

20. Outlays and expenditure for food supplementation through ICDS during the Ninth Plan are given in Annexure – I. Planning Commission reviewed the State Government funding of nutrition component of ongoing ICDS programme in 1999. The current norms envisage that funds for feeding 72 beneficiaries are to be provided to every anganwadi (against the average of about 200 eligible children and women in the community). The programme guidelines are uniform for all blocks. At the national level only 30 million out of the country's 162 million children are covered. The children so covered may not belong to the most needy group. There are no guidelines for targeting the available food to the most needy.

21. Planning Commission computed the state-wise requirement of funds as per the existing ICDS guidelines and supplements being limited to women and (0-4) children from BPL (below poverty line) families taking into account state-specific birth rates (1997) and BPL rates (1994). The gap in funding under these two scenarios were calculated and the data are presented in Annexure- II. It is obvious that under both these scenarios there are huge gaps between required funds and amount actually provided. The State Governments have been asked to initiate steps to fill this critical gap to the extent possible. In addition to funds under BMS (Basic Minimum Services) in the State Plans, the funds under PMGY (Pradhan Mantri's Gramodaya Yojana) may have to be effectively utilized to reduce the gaps.

### **Addressing Needs of Very Young Children**

22. Under the Pradhan Mantri's Gramodaya Yojana, an Additional Central Assistance of Rs 375 crore has been provided to States for funding take-home food supplements based on locally acceptable cereal, pulse and oilseed mix for the nutritionally most vulnerable under three year children. The States have been requested to contribute as much as possible for nutrition sector from PMGY funds so that the large gaps in availability of food supplements under the ICDS programme can be bridged.

### **Monitoring of ICDS:**

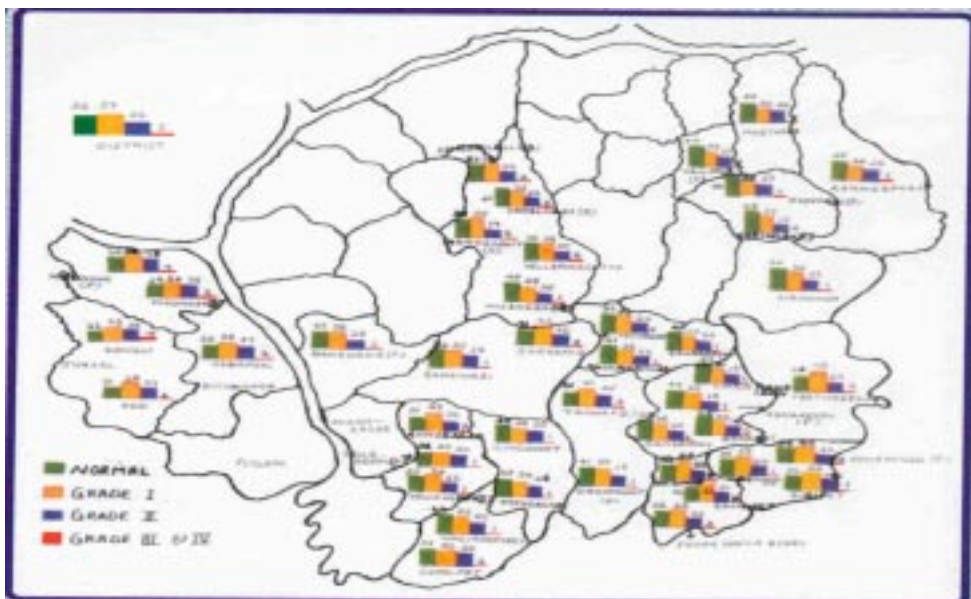
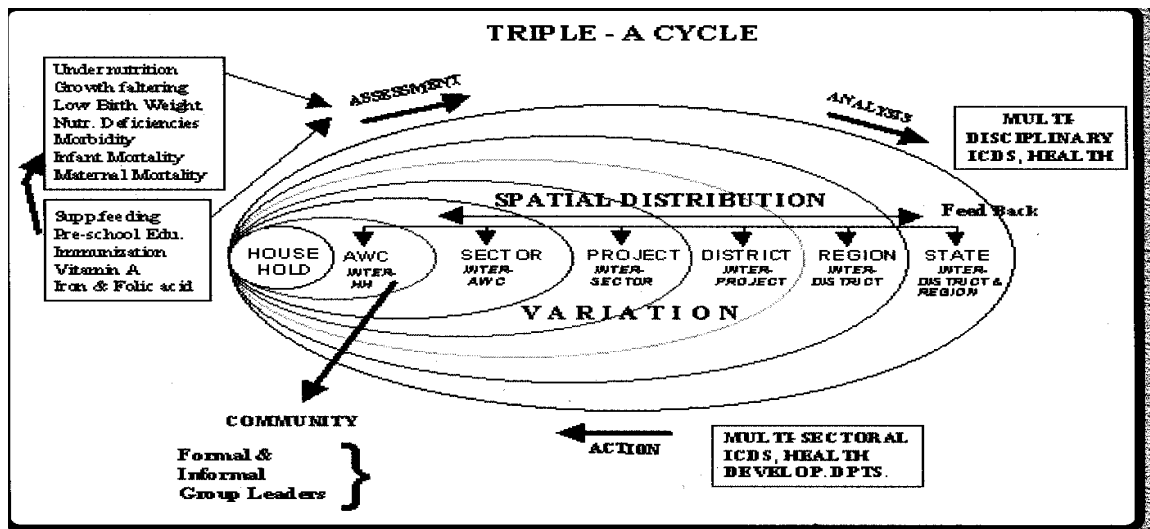
23. The ICDS-monitoring format currently being utilised by the Department of Women and Child Development (DWCD) contains mainly process indicators. Information on nutritional status though collected at Anganwadi and reported to Child Development Project Officer (CDPO) is not being compiled, analysed and sent to DWCD. As a part of the PMGY initiative, Planning Commission has designed a simple format for compiling and reporting district-wise disaggregated data on nutritional status of under- three and under -five children. Collection, compilation and use of this data may improve monitoring the impact of ongoing programmes in prevention and management of under-nutrition and enable district-specific intervention.

24. In Orissa, attempts were made to improve the monitoring, coverage and quality of services such as identification of the 'at risk' children, ensuring that they do take supplements, assessing the response to food supplements and, if there are non- responders, referring them to the PHC (primary health centers) for examination and management. It has been reported from data on three monthly moving average of children with severe under-nutrition in those blocks during the last two years that there was a decline in the severe



grades and reduction in the seasonal variation in prevalence of severe grades of under-nutrition. These efforts should be sustained in the state.

25. National Institute of Nutrition has carried out a study in Andhra Pradesh for improving the monitoring of nutritional component of ICDS programme at district level. ICDS functionaries were trained and oriented to improve the quality and timeliness of the reporting. Analysis of the data and discussions on the implications of the reports with the functionaries facilitated the implementation of midcourse corrections ( shown in the



diagrams above ) and led to improvement in performance.

26. Nutritional status based on weight for age is documented and reported in ICDS project. The data are seldom analysed and used because of fear that they may not be robust enough. However data from the AP study (shown in the GIS mapping of data above)

indicates that the data generated by AWW is useful for monitoring of the block and district situation and could over time be useful for building up data base for nutritional surveillance. Based on the data, appropriately targeted interventions could be initiated. An increasing use of the data would encourage workers correctly to file their monthly reports. Under the Reproductive and Child Health initiatives the Auxiliary Nurse Midwife (ANMs) are to identify and refer 'at risk' undernourished women and children. Collaboration between ANM and AWW at the village level would improve implementation and monitoring of both health and nutrition programmes.

## **Micronutrient deficiencies**

### **Anaemia**

27. Anaemia is the most wide spread yet most neglected micronutrient deficiency/ disorder in India. Poor dietary intake of iron and folic acid are the major factors responsible for anaemia. Pregnant women and pre-school children are the worst affected. Prevalence of anaemia among pregnant women ranges between 50% - 90%. Training programmes to improve screening of pregnant women for anaemia and initiating appropriate therapy have been initiated as a part of RCH programme. However, the programme is yet to be operationalised. In the past serious shortage and poor quality of iron and folic acid tablets had crippled the programme. The RCH programme aims at eliminating these.

### **Iodine Deficiency Disorders**

28. Iodine deficiency disorders (IDD) have been recognised as a public health problem in India since mid-twenties. The National Iodine Deficiency Disorders Control Programme has concentrated largely on ensuring the iodisation of salt and is one of the successful micronutrient programmes. However, production of iodised salt has been short of requirements, quality control is inadequate and transportation bottlenecks remain. Although most States have banned the sale of non-iodised salt, such salt is still available widely, even in goiter-endemic areas. The poor probably benefit least from IDD programme as they are more likely to consume uniodised salt which is cheaper.

29. As a part of its drive to prevent IDD among the general public, the Central Government issued a notification making it mandatory (w.e.f. May 1998) for all manufacturers of edible salt to iodise their product. There was a debate, however, on whether as a public health measure iodisation should be enforced through such statutory provision. In view of this, the Central Government has issued a preliminary notification in May 2000 proposing a future withdrawal of the compulsory statutory iodisation of edible salt. The issue is now open for public debate.

### **National Prophylaxis Programme against Nutritional Blindness:**

30. There has been low coverage under the programme for massive dose of Vitamin A due to problems in accessing the children and shortage of Vit A. There has not been any improvement in consumption of foods stuffs rich in Vit A. However, there has been reduction in prevalence of blindness due to Vitamin A deficiency (from 0.3% in 1971-74 to 0.04% in 1986-89) and Bitot's spots (from 1.8% in 1975-79 to 0.4% in 1996-97).

31. Linking administration of first dose of massive dose Vit. A with measles immunisation had resulted in substantial improvement in coverage of first dose of Vit. A. In an attempt to improve coverage for second and subsequent doses of Vit A, Orissa had linked administration of Vit. A with pulse polio immunization (PPI) campaign. It is reported that the State took precautions to prevent overdosing by stopping Vit A administration in preceding six months. The State reported improved coverage. Problems with this strategy include:

- Special efforts are needed to ensure that only children between 1-3 years received Vit.A and 0-5 yrs. old children receive polio. This may not be easy as PPI is a massive campaign covering over 12 crore children and the booths are manned by persons who are not health professionals.
- Second dose of Vit. A for the year has to be administered through alternative strategy  
In view of this it might be preferable to use a sustainable strategy for improving Vit.A status of children such as:
  - Administration of massive dose of Vit.A through AWW twice a year say April and October .
  - Nutrition education by AWW to improve intake of green/yellow vegetable

### **National Nutrition Policy**

32. The National Nutrition Policy adopted in 1993 advocates a comprehensive inter-sectoral strategy for alleviating the multi-faceted problem of malnutrition and achieving an optimal state of nutrition for all sections of the society. Several of the concerned sectors have since reviewed the progress achieved and have revised their targets for the Ninth Plan/2010 AD. For instance the Family Welfare programme has undergone a paradigm shift and under the RCH programme Family Welfare targets have been revised. The goals set in National Plan of Action for Nutrition may have to be revised accordingly .

## Annexure-I

**OUTLAY FOR NUTRITION IN THE STATES & UNION TERRITORIES**

(Rs. In lakh)

STATES	9th Plan OUTLAY NUTRITION	1997-98		1998-99		1999-2000
		OUTLAY NUTRITION	Act. Exp. NUTRITION	OUTLAY NUTRITION	RE NUTRITION	OUTLAY NUTRITION
1	2	3	4	5	6	7
1 ANDHRA PRADESH	29985.00	4000.00	2515.00	7500.00	7500.00	4500.00
2 ARUNACHAL PRADESH	1940.00	331.00	281.00	241.00	224.00	228.00
3 ASSAM	8000.00	845.00	768.00	913.00	855.00	920.00
4 BIHAR	19500.00	2530.00	1098.00	3500.00	0.00	1400.00
5 GOA	400.00	70.00	47.00	45.00	45.00	50.00
6 GUJARAT #	82500.00	12550.00	11433.00	14000.00	12400.00	14000.00
7 HARYANA	2508.00	500.00	495.00	693.00	525.00	525.00
8 HIMACHAL PRADESH	4220.00	600.00	600.00	800.00	800.00	940.00
9 J & K	NA	835.00	738.00	825.00	825.00	825.00
10 KARNATAKA	16000.00	3738.00	3741.00	3884.00	3560.00	3850.00
11 KERALA	510.00	75.00	65.00	75.00	75.00	45.00
12 MADHYA PRADESH	12617.00	4139.00	3738.00	4700.00	4700.00	4960.00
13 MAHARASHTRA	17892.00	4339.00	3671.00	7538.00	7538.00	7458.00
14 MANIPUR	1630.00	200.00	188.00	230.00	230.00	230.00
15 MEGHALAYA	1400.00	200.00	179.00	250.00	244.00	260.00
16 MIZORAM	866.00	185.00	185.00	200.00	200.00	250.00
17 NAGALAND	1800.00	183.00	183.00	183.00	183.00	183.00
18 ORISSA #	47199.93	8200.00	5780.00	7329.00	7329.00	6474.00
19 PUNJAB	3458.00	300.00	294.00	300.00	225.00	500.00
20 RAJASTHAN	10225.00	1810.00	1007.00	1810.00	1262.00	1135.00
21 SIKKIM	1000.00	226.00	195.00	195.00	195.00	195.00
22 TAMILNADU #	50000.00	9086.00	10579.00	10220.00	13230.00	12417.00
23 TRIPURA	4773.00	695.00	682.00	578.00	578.00	658.00
24 UTTAR PRADESH	23200.00	3558.00	536.00	4500.00	1956.00	4500.00
25 WEST BENGAL	7291.32	2622.00	1262.00	2614.00	2613.00	4100.00
<b>TOTAL STATES</b>	<b>348915.25</b>	<b>61817.00</b>	<b>50260.00</b>	<b>73123.00</b>	<b>67292.00</b>	<b>70603.00</b>
U T s						
1 A & N ISLANDS	400.00	55.00	45.43	61.00	61.00	50.00
2 CHANDIGARH	25.00	5.00	5.07	5.00	5.00	5.00
3 D & N HAVELI	237.25	47.25	47.25	47.25	47.25	47.00
4 DAMAN & DIU	177.00	34.00	27.00	30.00	30.00	28.00
5 DELHI	15000.00	2075.00	2025.21	2920.00	2000.00	3210.00
6 LAKSHADWEEP	87.14	18.80	16.78	19.00	19.00	30.00
7 PONDICHERRY	2100.00	310.00	405.62	518.00	518.00	623.00
<b>TOTAL UTs</b>	<b>18026.39</b>	<b>2545.05</b>	<b>2572.36</b>	<b>3600.25</b>	<b>2680.25</b>	<b>3993.00</b>
<b>GRAND TOTAL (STATES &amp; UTs)</b>	<b>366941.64</b>	<b>64362.05</b>	<b>52832.36</b>	<b>76723.25</b>	<b>69972.25</b>	<b>74596.00</b>

# Includes funds for food supplement to groups other than ICDS beneficiaries.

Source : 1) STATE PLAN DIVISION, PLANNING COMMISSION  
2) ANNUAL PLAN DOCUMENT, STATE GOVERNMENT

## Annexure - II

## Annual financial Requirement for supplementary nutrition of Pregnant Women and Children

State	Planning Commission's Computation of Annual Requirement of funds (Rs. Crores) for supplementary nutrition (&)			No. of target beneficiaries estimated by Deptt. of WCD (Lakh) 1999-2000	Funds to be required by Deptt. of WCD (crores) 1999- 2000	Funds allocated by the state Govt. 1997-98 (Rs. Crore)	Gap/(Surplus) (Rs.Crore)	
	Pregnant women	Children (0- 4) years	Total				Plg. Comm.	Deptt. Of WCD
Andhra Pr.	24.59	55.63	<b>80.22</b>	34.1	102.3	<b>40.00</b>	<b>40.22</b>	<b>62.30</b>
Assam	19.68	45.36	<b>65.04</b>	2.84	8.52	<b>7.86</b>	<b>57.18</b>	<b>0.66</b>
Bihar	112.83	233.29	<b>346.12</b>	17.85	53.55	<b>19.13</b>	<b>326.99</b>	<b>34.42</b>
Gujarat	19.45	40.86	<b>60.31</b>	50.81	152.43	<b>125.50</b>	<b>(65.19)</b>	<b>26.93</b>
Haryana	9.15	20.71	<b>29.86</b>	0.96	2.88	<b>5.00</b>	<b>24.86</b>	<b>(2.12)</b>
Karnataka	25.55	60.02	<b>85.57</b>	28.01	84.03	<b>37.79</b>	<b>47.78</b>	<b>46.24</b>
Kerala	9.61	23.13	<b>32.74</b>	10.06	30.18	<b>0.75</b>	<b>31.99</b>	<b>29.43</b>
Madhya Pr.	70.14	141.11	<b>211.25</b>	6.43	19.29	<b>41.54</b>	<b>169.71</b>	<b>(22.25)</b>
Maharashtra	50.65	123.77	<b>174.42</b>	9.8	29.4	<b>43.39</b>	<b>131.03</b>	<b>(13.99)</b>
Orissa	30.18	63.47	<b>93.65</b>	28.15	84.45	<b>62.38</b>	<b>31.27</b>	<b>22.07</b>
Punjab	4.23	10.13	<b>14.36</b>	17.51	52.53	<b>3.00</b>	<b>11.36</b>	<b>49.53</b>
Rajasthan	30.57	62.89	<b>93.46</b>	43.76	131.28	<b>10.10</b>	<b>83.36</b>	<b>121.18</b>
Tamil Nadu	26.91	62.18	<b>89.09</b>	39.15	117.45	<b>104.00</b>	<b>(14.91)</b>	<b>13.45</b>
Uttar Pr.	150.26	288.90	<b>439.16</b>	2.89	8.67	<b>5.00</b>	<b>434.16</b>	<b>3.67</b>
West Bengal	41.11	102.43	<b>143.54</b>	1.76	5.28	<b>21.60</b>	<b>121.94</b>	<b>(16.32)</b>
Arunachal Pr.	0.64	1.73	<b>2.37</b>	1.07	3.21	<b>2.81</b>	<b>(0.44)</b>	<b>0.40</b>
Delhi	2.74	7.50	<b>10.24</b>	3.5	10.5	<b>20.75</b>	<b>(10.51)</b>	<b>(10.25)</b>
Goa	0.22	0.88	<b>1.09</b>	25.82	77.46	<b>0.50</b>	<b>0.59</b>	<b>76.96</b>

Himachal Pr.	2.78	7.08	<b>9.86</b>	10.78	32.34	<b>6.64</b>	<b>3.22</b>	<b>25.70</b>
J&K	5.06	9.30	<b>14.36</b>	25.85	77.55	<b>7.33</b>	<b>7.03</b>	<b>70.22</b>
Manipur	1.07	3.14	<b>4.21</b>	0.45	1.35	<b>1.87</b>	<b>2.34</b>	<b>(0.52)</b>
Meghalaya	1.78	3.40	<b>5.19</b>	40.01	120.03	<b>2.00</b>	<b>3.19</b>	<b>118.03</b>
Mizoram	0.23	0.90	<b>1.13</b>	2.47	7.41	<b>1.85</b>	<b>(0.72)</b>	<b>5.56</b>
Nagaland	0.82	2.35	<b>3.17</b>	80.38	241.14	<b>1.83</b>	<b>1.34</b>	<b>239.31</b>
Sikkim	0.29	0.85	<b>1.15</b>	39.64	118.92	<b>1.95</b>	<b>(0.80)</b>	<b>116.97</b>
Tripura	1.73	5.44	<b>7.17</b>	0.31	0.93	<b>6.95</b>	<b>0.22</b>	<b>(6.02)</b>
A&N Islands	0.16	0.49	<b>0.65</b>	0.25	0.75	<b>0.55</b>	<b>0.10</b>	<b>0.20</b>
Chandigarh	0.12	0.37	<b>0.49</b>	2.95	8.85	<b>0.05</b>	<b>0.44</b>	<b>8.80</b>
D&N Haveli	0.17	0.36	<b>0.53</b>	0.11	0.33	<b>0.47</b>	<b>0.06</b>	<b>(0.14)</b>
Daman & Diu	0.04	0.08	<b>0.12</b>	0.07	0.21	<b>0.34</b>	<b>(0.22)</b>	<b>(0.13)</b>
Lakshadweep	0.03	0.07	<b>0.09</b>	0.05	0.15	<b>0.19</b>	<b>(0.10)</b>	<b>(0.04)</b>
Pondicherry	0.49	1.53	<b>2.02</b>	0.59	1.77	<b>4.16</b>	<b>(2.14)</b>	<b>(2.39)</b>
<b>Total</b>	<b>643.26</b>	<b>1379.36</b>	<b>2022.62</b>	<b>528.38</b>	<b>1585.14</b>	<b>587.28</b>	<b>1435.34</b>	<b>997.86</b>

# Requirement was computed taking into account the population projections and % of BPL families; number in in the age group 0-4 years for each of the state/UT other than 15 major states, the average of the states/UTs has been used

& Annual financial requirements based on average cost of Rs.1.00 per Child and Rs.2.00 per woman per day for 300 days in a year