



Speaker Summary Note

Session: Social Inclusion in Agriculture, Nutrition, and Health

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Title: Social Exclusion, Agriculture, and Nutrition Linkages:
Consideration for inclusive policy

Group inequalities in Malnutrition

Group inequalities in malnutrition is a feature which is often seen in many countries. At given (average) level of malnutrition, the magnitude is particularly high among certain social groups. In several countries malnutrition level is persistently high among the persons belonging to the groups distinguished by race, colour, social origin (like caste), ethnic and indigenous background, religion, gender and territorial location (Ellen Van and others 2008, Carlos Larrea and Wilma Freire 2002, Thorat and Nidhi Sadana 2009, Nidhi Sadana 2010, Kulkarni 2010).

Selective evidence also indicate that, while malnutrition is closely associated with the economic location of the poor, within the broad category of undernourished poor, the high degree of malnutrition is also caused by the social location (or social belonging) of the poor (Table 1) (Thorat 2009). Studies indicate that limited access to income earning assets (agricultural land and nonfarm business), regular employment, lack of access to education and public health services causes high level of under nutrition. While malnutrition level tend to be low among the poor persons yet “within,” the “economic category of the poor,” the poor belonging to certain social and minority groups suffered from much higher level of poverty and malnutrition as compared to their counterpart from “rest of the poor.” This indicates that beside economic factors, the constraints associated with social/cultural/religious and other markers of group identity of poor belonging to these social grouping also matters. Factors that causes poverty are similar both for poor belonging to certain social groups and rest of the poor, but the “channels of causation” which aggravate high degree of malnutrition for the poor from “social groups,” in some respect is different. It is now recognised that malnourished poor from certain social/cultural groups suffered from social exclusion—the processes through which they are excluded from having “equal” accesses to sources of income, employment, education and public health services. People who are excluded are not just like the “rest of the poor.” They are also disadvantaged by who they are or where they live and as a result are locked out of the benefits of development. Social exclusion deprives people of choices and opportunities to escape from poverty and malnutrition (DFID 2005). “Nutrition outcomes are greatly affected by social norms, values and customary practices that, within the family, the community, or the market, lead to exclusion of women, ethnic, religious, indigenous and racial groups or the socially disadvantaged.” It is this **unfair exclusion** from access to opportunities through markets and non-markets transaction and **unfair inclusion,**”

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(access with discriminatory terms and conditions) which cause high malnutrition among the socially excluded groups and communities.

How Does Social Exclusion Induce Poverty and Malnutrition?

Broadly speaking social exclusion is defined in the literature as “the process through which individuals or groups are wholly or partially excluded from full participation in the society within which they live. The exclusion could also manifest itself in diverse ways in terms of “causes and outcomes.” Sen, therefore, refers to various meanings and manifestations of social exclusion, particularly, with respect to the causes of discrimination in a given society. Exclusion could occur through direct exclusion, violating fair norms of exclusion (that is unfavourable exclusion), or through inclusion, but under unfavourable conditions, again violating fair norms of inclusion (that is unfavourable inclusion), or through deliberate government policies (that is active exclusion), and through unintended attempts and circumstances (passive exclusion), which caused exclusion. The mainstream economic literature throws more light on discrimination that works through markets and developed the concept of market discrimination with some analytical clarity. In the market discrimination framework, exclusion may operate through restrictions on the entry in market, and/or through “selective inclusion,” but with an unequal treatment in market and non-market transactions (this is close to the Sen’s concept of unfavourable inclusion).

For the purpose of conceptual clarity it is necessary to recognise the group characteristic of exclusions. It is necessary to recognise, that economic exclusion or discrimination is independent of income, productivity or merit of individuals in a group. Often people do get excluded from access to markets due to lack of income or in employment due to low productivity/skill or in admission due to low merit. In these cases low income, productivity and merit is direct cause of exclusion. In the case of group based exclusion on the other hand, the basic of exclusion is group identity and not the economic characteristics of a group. The centre of exclusion is social group and not individual.

Consequences of Social Exclusion on Malnutrition and Poverty

The social exclusion aggravates poverty directly by denying the fair access to opportunities channelized through markets and non market transactions and indirectly by adversely affecting economic growth. The insight from theoretical literature indicates that markets discrimination does hampered economic growth, and bring unequal income distribution outcome. Insights from theory imply that the since employment discrimination involve hiring of labour based on ascribe characteristic and less on efficiency, it lead to inefficient allocation of labour. The market discrimination in other markets also brings imperfections in resource allocation. The less than optimal allocation and use of resources lead to less than optimum outcome.

In case of consequence on poverty and malnutrition, it is quite clear that in so far as exclusion and involve the denial of access to resources, employment, education and common facilities that other have, it can certainly impoverishes the lives that individual from excluded groups can enjoy. Thus, economic discrimination has potential to aggravate poverty indirectly by slowing down the economic growth and directly by reducing the access to various markets resulting lack of access to income earning assets, jobs, education.

India—A Case Study

In this background, we discuss the Indian experience with a purpose, first, to provide evidence of high malnutrition level among the social/ethnic/religious groups; second, to provide explanation for high level of malnutrition; and, thirdly, to indicate the inclusive policy, with experience from India. We first present the inter-social group inequalities in malnutrition level for children, women and men through relevant indicators in rural area of India using the National Family Planning Health Survey data (NFHS) for the recent year 2005/06 and then explain inter-social groups disparities in term of variations in income, education, access to public health services, and the social belonging of the individuals.

For the inter-group analysis, the paper takes the groups by their wealth status (proxy for income), caste, ethnic, and religious belonging. For the caste groups, the NFHS provides data for schedule caste, other

backward caste and higher caste and the schedule tribe and religious groups. Within the religious groups, it gives data by their caste and ethnic origin. Thus, the NFHS capture the inter-social group inequalities with respect to their wealth status, caste, ethnic and religious-back group and beside general factors (such as wealth status, education, access to health services, etc.), also enable us to estimate the impact of social belonging (in term of social exclusion from the access to opportunities) on the health our comes of various groups.

The indicators which capture the malnutrition include underweight children (weight for age) and body mass index (BMI) for women and men. The height and weight measurements in NFHS-3 are used to calculate the BMI. The BMI is defined as weight in kilograms divided by height in meters squared. BMI less than 18.5 is used to define thinness or acute under-nutrition.

Inter-Group Inequalities in Nutritional Status in Rural India

As expected in 2005, the degree of malnutrition measured in term of underweight children, anaemia, and infant mortality is high for schedule caste, schedule tribe, and other backward caste compared to “others.” In 2005, 56% of ST and 51% of SC children less than 5 years of age suffered from malnutrition (based on weight for age) followed by 45% of OBC children as compared to 36% for others. The incidence of anemie among the ST and SC children was also quite high, as nearly 78% of ST children and 74% of children from SC social group suffer from anaemia followed OBC (72%) and the other children (67%).

Analysing the level of malnutrition amongst women through BMI of less than 18.5 kg/m² which indicate chronic energy deficiency we find (a) gender differentials and (b) social group differentials for both women and men. A social group pattern similar to children is also observed for women and men, indicating higher malnutrition among the ST and SC followed by OBC and the lowest for others.

As regard religious groups the situation of children from Hindu religious group followed by Muslim is the worst compared to religious groups of Christian, Sikh and others. Within the Hindu religious groups, the situation of children from Hindu ST is the worst (57%) followed by Hindu SCs and SC Muslim. In fact, the situation of children from Muslim SC social group is the worst amongst all socio-religious groups.

The pattern of the level of nutritional status for women and men across religious and socio-religious groups is similar to children’s status. Women and men belonging to Hindu and Muslim religious groups had lower nutritional level as compared to other religions in 2004-05. With respect to men, we find that Hindu men (38.7%) and Muslim men (38%) had a lower nutritional status as compared to men from Christian, Sikh and other religion. Among the socio-religious groups, it is the ST Hindu men (45.2%) who had the worst nutritional levels followed by SC Hindus and non-SC/ST/OBC Muslims.

Factors Associated with High Malnutrition—General and Group Specific

We find that the nutritional problem is particularly serious for children, women, and men from the excluded groups of scheduled tribes, scheduled caste and other backward classes. Both, general factors and the group specific factors seem to cause high malnutrition among these social groups.

General factors. In the general factors, we take income (consumption expenditure as proxy variables) poverty and wealth index (with five levels), education and access to health services. The factors associated with social belonging are capture by using the logistic regression.

The **data for 2005** shows a direct link between the per capita expenditure and nutritional levels as the groups which have a lower expenditure also have lower nutritional levels. Same is true for households dependent on farm income. Similarly, wealth index also reveals a close connection between nutritional status and standard of living. As expected, children from wealthier households are not as malnourished as those from the poor households. The gap between the poorest and the richest quintile is very wide, over 30 percentage points. The gap in nutritional status between the poorest and the richest quintiles is very wide for men and women as well and across social groups. The results show that even after controlling for the other factors, differentials by wealth index are large. As one moves along the wealth index ladder from the poorest to the richest, the proportion of under-nutrition children reduces indicating the wealth effect.

The 2005/06 NFHS data also revealed close inter-relation between level of education and malnourishment—the percentage of children who are underweight is higher for women with no literacy as compared to women who are literate and who have high level of literacy

The SC and ST mothers and their children also suffer from relatively poor use of public health services. As result the health services help only in limited way to overcome the constraints imposed by the poverty and low education level. The OBC mother's access is better-off than the SC and ST while it is lower as compared to non-SC/ST/OBC mothers.

To confirm the validity of the descriptive statistics observed in this paper, we conducted a logit analysis and the results support the relationship of poverty levels and education with the level of malnutrition among children. Ethnicity, wealth of household, mother's education, and body mass index of the mother are the significant (at 1% level) factors affecting differentials in child under-weight.

Importantly, the results of the exercise indicate that children who have better access to health services such as vaccination and ante natal care are the significant (at 1% level) factors affecting differentials in child under-weight. Similarly, ethnicity, religion, wealth of household, education and occupation of women are significant determinants for differentials in women and men BMI.

For women and men as well, wealth of the household and education are significant determinants for differentials in women and men BMI. Thus, wealth, educational level, access to health services and social belongings are important determinants impacting nutritional levels of children, women and men.

Thus, the analysis indicates that poor health status of all social groups is closely linked with poverty and education level. The per consumption capita expenditure (as proxy for income) and nutritional levels are also closely interlinked. The results show that even after controlling for the other factors, differentials by wealth index are large. As one moves along the wealth index ladder from the poorest to the richest, the proportion of under-nutrition children, women and men reduces indicating the wealth effect. The net effect of income within a similar category varies for children, men and women with children benefitting the least. The 2005/06 NFHS data also revealed close inter-relation between level of education and malnourishment. Percentage of children who are underweight is higher for women with no literacy as compared to women who are literate and who have high level of literacy. Among the significant determinants of nutritional levels of children, women and men, ethnicity, religion, wealth of household, education and occupation of women are significant.

The results also showed that, even for individuals with similar standards of living and levels of education, the health status of the SC and ST is lower than that for their counterparts from the 'other' castes. The SC and ST mothers and children lag the other social groups in terms of access to various public health services. This indicates that, in addition to their poverty and education levels, SC and ST suffer from unequal access to public services. Although there are limited studies on this theme, some studies do provide evidence in this direction, highlighting unequal access by these groups to public health services as well as to schemes that guarantee food security to children in schools.

Group Specific Factors. The preceding analysis brings out two important features of health status and malnourishment of the social groups. It shows that, the malnutrition level of caste and ethnic group of SC and ST is higher compared to OBC and 'other' groups. The OBC groups lagged behind the "others" but are better than the SC and ST. Importantly, the results of the logistic exercise indicate that SC and ST children, women and men are more likely to be under-nourished compared to children, women and men from the "non-SC/ST" and OBC category.

Once controlled for other factors, there are differentials in nutritional levels by social groups as well for children, women and men as the results. The net effect of the social belonging on nutritional level is greater for children as compared to women and men. The difference between the SC and Other children is 7.4% points while the difference for SC adults is only 3% points. Additionally we also find that, within the SC, ST, OBC social groups, the risk faced by children seemed to be higher than the women and men in that group.

Among the socio-religious group, the probability of the risk being under-nourished for Hindu and Muslim children is relatively low and insignificant but for men and women the risk is greater and significant.

Between men and women, it appears that after controlling for the other factors, differentials in the nutritional levels is wider between Hindu and Muslim women and men from same religious background.

Thus, we find that social belonging matters to greater degree for children as compared to women and men from the SC and ST social groups as there are wide differentials in the nutritional levels after controlling the effects of factors of wealth index, education of mother, father's occupation, religion, sex of child, antenatal care, BMI of mother, child receive vaccination and supplementary nutrition. While between men and women, it appears that after controlling for the other factors, differentials in the nutritional levels is wider between Hindu and Muslim women and men from same religious background.

Socially Inclusive Policies

This result have specific policy implications for the countries in which certain groups suffered from high malnutrition level both due to general factors and group specific factors. It demands that general health polices be accompanied with group-specific measures to address the specific problems arising out of social exclusion. The general polices include increased access of poor to income through assets and earning so that individual's capabilities to access food and related needs are ensured. Similarly there is need to improve the education level and the access to the public health services.

In the case social groups who face discrimination in accessing the sources of income ,education and public health service, beside these general measures they would also require additional policy measures to overcome the constrains imposed by processes of social exclusion in accessing sources of income ,education and public health services. This will require measures to provide safeguards against discrimination and measures to promote equal and non-discriminatory access to assets and employment, to education and to health care services to mothers and children from socially excluded groups and religious minorities.

Large number of countries in the world have recognised the excluded groups and developed special policies. Several countries in the world have one or more minority groups within their national territories; groups distinguished by their own ethnic, linguistic, or religious identity that differs from that of the majority population and suffered from some degree of social exclusion resulting in to denial of equal opportunities. The problems of minorities are different from country to country but suffer from social exclusion in various manners, resulting in lack of access to income earning assets, employment, education, and health services.

In Asia, minorities are identified mainly based on caste, ethnicity, indigenous origin and religion and these include India, Japan, Nepal, China, Malaysia, Sri Lanka, Pakistan, and Philippines. In Latin American and African countries, minorities are identified in the line of race, colour, ethnicity, gender and disabilities. In the United States, it is based on race, gender, and disability; and in Canada, it is based on ethnic minority. In Europe, the application of affirmative action in Northern Ireland is based on religion. But in United Kingdom, it is in the line of race and ethnicity. In France, affirmative action is based on territorial location. And, in general, various governments have anti-discrimination policy for disabilities and women. In Germany, the discriminated groups are the minorities (gypsies) and women. In New Zealand, the discriminated groups are identified based on ethnicity.

Indian Government Policy

Indian government has used both general policy and group specific policy. As regard health and nutrition the Indian government has developed program for children and women. Integrated Child Development Services (ICDS) is the major national programme that addresses the health and nutrition needs of children under the age of six. ICDS provides young children with an integrated package of services, including supplementary nutrition, health care and pre-school education. The programme also extends to adolescent girls, pregnant women and nursing mothers as it is recognized in the programme that the needs of a young child cannot be addressed in isolation from those of his or her mother. ICDS services are provided through a vast network of ICDS centers known as "Anganwadis."

Mid-day meal is the other important program. India's mid-day meal programme is the largest nutrition programme in India and is implemented through provision of free meals in government schools and the anganwadi centers.

The other important health programmes implemented by the government to improve nutritional status of newborns and infants are:

- (a) Initiation of breastfeeding massages immediately after childbirth, preferably within one hour (Ministry of Women and Child Development, 2006). This message forms an important component of the National Rural Health Mission.
- (b) Use of vitamin A supplements every six months until children reach three years of age, starting at age 9 months. This service is provided through Anganwadi centers.
- (c) As Iodine is an important micronutrient, in 1983–84, the Government of India adopted a policy to achieve universal iodization of edible salt by 1992. All states and union territories were advised to issue notifications banning the sale of edible salt that is not iodized.

To improve the availability of and access to quality health care, especially for those residing in rural areas, the poor, women, and children, the government recently launched the National Rural Health Mission for the 2005–2012 periods. The provision of iron and folic acid (IFA) tablets to pregnant women to prevent nutritional anemia forms an integral part of the safe motherhood services offered as part of the Reproductive and Child Health Programme in India.

The other general schemes include employment guarantee schemes and the Public Distribution System (PDS) which plays an important role in ensuring minimum income and the provision of food security. Beside there are number of schemes in the form of affirmative action for SC, ST and OBC and Muslim ensuring access to income earning assets and business, employment, education, housing and other.

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Table 1—Social groups identified as most deprived: Selective example across the countries

Continent	Country	Social/Cultural/Religious Groups	Social Identifier
Asia	India	Low caste and tribal minorities Religious minorities: Muslim	Caste, Ethnicity, Religion
	Japan	Burakumin Okinawans, Ainu Japanese-born Koreans	Caste-based group; Indigenous groups; Minorities
	China	56 minorities	Ethnic Minorities
	Malaysia	Bumiputras	Ethnic Majorities
	Pakistan	Baluch, Pakhtun, Tribal	Regional Backwardness Ethnicity
	Sri Lanka	Sinhalese	Ethnic Majorities
	Nepal	Dalits Indigenous Groups	Caste, Ethnicity
Latin America	Brazil	Afro-Brazilian Handicap, Women	Race Disability, Gender
	Bolivia	Quechua, Aymara, Afro-Bolivian, Handicap, Women	Ethnicity Race Disability, Gender
	Peru	Quechua, Aymara Handicap, Women	Ethnicity Disability, Gender
	Mexico	80% of the indigenous women	Ethnicity gender
Africa	Nigeria	Ethnic Groups Women	Regional representation Gender
	South Africa	Blacks (African, Indians, colored), Women	Race Gender
	Namibia	Black Women	Race Gender
America	USA	Black American, Hispanics, Asian Women, handicap	Race Gender, disability
	Canada	Aborigine (American Indians, Metis, Inuit) Visible Minorities (Blacks, Muslims, Jewish, South Asians, Chinese, Canadians)	Ethnicity Minority
Europe	Northern Ireland	Catholics	Religion
	U.K.	Black (Caribbean), Ethnic minorities, Roma, gypsy, traveler	Race, ethnicity, minority
	France	Economically Backward Territory. Women. Handicap	Gender Disability
	Germany	Danish, Sorbs, Friesians, Sinti and Roma. (Immigrant) Women	Minorities Gender
NEW ZEALAND	New Zealand	Maori Tribe	Ethnicity

Note: List does not necessarily cover all the countries in the world. This is particularly the case with respect to Latin America and Africa.

Source: International Experience of Affirmative Action Policies, Indian Institute of Dalit Studies, 2005, Delhi, India.

Table 2—Nutritional status of children (0–5 yrs), women (15–49 years) and men (15–54 years) in rural area by social group

Social Group	Children (Weight for age) <Med -2SD (Under-weight)	Women BMI <18.5 kg/m2(Thin)	Men BMI <18.5 kg/m2 (Thin)
SC	50.6	44.7	42.3
ST	56.1	48.4	43.3
OBC	45.7	39.7	37.7
Others(Non SC/ST/OBC)	36.3	35.8	33.0
All	45.6	40.5	38.0

Source: National Family Health Survey-3 (2005–06).

Table 3—Health Status Indicator for children in India(2004–05)

Health Status Indicators	SC	ST	OBC	Others	All
Anaemia	74.0	77.9	71.7	66.9	71.6
Infant Mortality Rate (IMR)	66.4	62.1	56.6	48.9	57.0
Neo-Natal Mortality	46.3	39.9	38.3	34.5	39.0
Post Neonatal Mortality Rates	20.1	22.3	18.3	14.5	18.0
Child Mortality Rate	23.2	35.8	17.3	10.8	18.4
Under Five Mortality Rate	88.1	95.7	72.8	59.2	74.3

Source: NFHS-3, 2005–06.

Table 4—Nutritional status of children in different social group by religion

Social groups	Religion				
	Hindu	Muslim	Christian	Sikh	Others
SC	51.3	57.6	30.6	33.5	43.4
ST	56.9	36.5	44.1	NA	NA
OBC	45.6	46.7	27.3	19.6	NA
Others	33.7	43.5	27.7	18.8	NA
All	46.3	44.0	37.0	24.6	44.5

Source: National Family Health Survey-3 (2005–06)

NA- indicates frequency less than 50

Table 5—Nutritional status of women in different social group by religion

Social groups	Religion				
	Hindu	Muslim	Christian	Sikh	Others
SC	45.3	45.2	36.1	27.7	48.1
ST	51.1	31.0	24.5	NA	38.5
OBC	39.9	39.3	25.0	21.9	NA
Others	35.3	42.9	26.6	15.1	NA
All	41.3	40.6	27.4	19.4	44.2

Source: National Family Health Survey-3 (2005–06)

NA- indicates frequency less than 50

Table 6—Nutritional status of men in different social group by religion

Social groups	Religion				
	Hindu	Muslim	Christian	Sikh	Others
SC	42.9	33.0	24.6	23.4	49.1
ST	45.2	38.9	18.8	NA	41.6
OBC	37.9	36.6	26.9	33.7	NA
Others	32.6	40.2	31.8	14.7	NA
All	38.7	38.0	24.1	18.8	46.6

Source: National Family Health Survey-3 (2005–06)

NA- indicates frequency less than 50

Table 7—MPCE by Household Type and Social Groups in Rural Sector, 2004–05 (at 1999–2000 prices)

SRG	Business	Farm Wage Labour	Other Labour	Farmers	OTHER	Total	2004 NL			
							PR	C	W	M
2004-05										
ST	462.7	331.7	373.6	414.6	611.6	396.2	47.64	56.1	48.4	43.3
SC	456.7	372.3	442.2	466.7	639.8	434.5	36.8	50.6	44.7	42.3
OTHERS	582.1	398.8	507.1	564.0	779.1	552.5	22.7	36.3	35.8	33.3
Total	552.4	380.0	471.5	536.1	744.5	511.3	28.29	45.6	40.5	38.0

Source: Calculated by the authors using NSSO CES unit record for relevant rounds

PR=Poverty Rate, NL=Nutritional level, C=Child, W=Women, M=Men

Table 8—Nutritional status of children in different social group by wealth index

Social groups	Wealth Index				
	Poorest	Poorer	Middle	Richer	Richest
SC	57.4	51.5	45.0	36.2	22.7
ST	61.0	54.2	48.0	33.1	24.5
OBC	56.6	48.7	42.3	34.9	19.3
Others	48.7	46.2	34.0	29.6	17.2
All	56.3	49.2	40.8	32.9	18.6

Source: National Family Health Survey-3 (2005–06)

Table 9—Nutritional status of women in different social group by wealth index

Social groups	Wealth Index				
	Poorest	Poorer	Middle	Richer	Richest
SC	54.4	47.6	39.8	29.4	19.4
ST	53.4	49.1	42.7	27.5	27.1
OBC	47.8	45.5	39.1	30.3	19.9
Others	52.1	46.7	36.9	29.5	19.7
All	51.5	46.6	38.8	29.5	19.8

Source: National Family Health Survey-3 (2005–06)

Table 10—Nutritional status of men in different social group by wealth index

Social groups	Wealth Index				
	Poorest	Poorer	Middle	Richer	Richest
SC	50.2	44.1	37.2	33.4	22.6
ST	48.9	39.3	38.0	34.2	14.9
OBC	47.6	42.7	37.6	27.6	20.3
Others	48.7	41.1	35.3	28.0	18.3
All	48.8	42.5	37.1	28.4	19.0

Source: National Family Health Survey-3 (2005–06)

Table-12—Nutritional status of Children, women and men by social groups
(Children under 5 years, Women from 15 to 49 and Men from 15 to 54 of age, NFHS-3)

Social Group	Under-weight Children <Med -2 SD	Women BMI<18.5 (Thin)	Men BMI<18.5 (Thin)
All	45.6	40.5	38.0
SC	50.6	44.7	42.3
ST	56.1	48.4	43.3
OBC	45.7	39.7	37.7
Others	36.3	35.8	33.0
	Odds ratios@	Odds ratios*	Odds ratios*
SC	1.350	1.126	1.134
ST	1.418	1.169	1.084
OBC	1.218	0.977	1.032
Others	1.000	1.000	1.000
	Adjusted percent@	Adjusted percent*	Adjusted percent*
SC	47.9	42.4	39.8
ST	49.1	43.3	38.7
OBC	45.4	38.9	37.6
Others	40.5	39.5	36.8

Source: Computed from NFHS-3 individual data file.

Table 13—Nutritional status of Children, women and men by religious groups
(Children under 5 years, Women from 15 to 49 and Men from 15 to 54 of age, NFHS-3)

Religious group	Under-weight Children <Med -2 SD	Women BMI<18.5 (Thin)	Men BMI<18.5 (Thin)
All	45.6	40.5	38.0
Hindu	46.3	41.3	38.7
Muslim	44.0	40.6	38.0
Others	37.5	28.1	27.2
	Odds ratios@	Odds ratios*	Odds ratios*
Hindu	1.092	1.574	1.466
Muslim	1.065	1.704	1.481
Others	1.000	1.000	1.000
	Adjusted percent@	Adjusted percent*	Adjusted percent*
Hindu	46.0	42.0	39.3
Muslim	45.4	43.9	39.6
Others	43.8	31.5	30.7

Source: Computed from NFHS-3 individual data files.

Odds ratios shown in bold letters indicate significant difference (at the 1 % level) from the reference category 'Others'.