

CLUES TO THE PUZZLE OF CHILD MALNUTRITION IN INDIA

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Why are levels of child malnutrition high?

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Reducing child malnutrition requires enhancing women's freedoms and promoting gender equality.

Levels of child malnutrition in India are exceptionally high. According to the recently released National Family Health Survey, NFHS-3, carried out in 2005-06, 46 per cent of India's children under the age of three are underweight. The corresponding levels of child malnutrition are much lower in most other countries — 28 per cent in Sub-Saharan Africa and eight per cent in China. Scientific evidence suggests that compared with the risks a well-nourished child faces, the risk of death from common childhood diseases is doubled for a mildly malnourished child, tripled for a moderately malnourished child, and may be even as high as eight times for a severely malnourished child.

Three commonly used measures — stunting (height-for-age), wasting (height-for-age), and the proportion of those underweight (weight-for-age) — provide somewhat different information about the nutritional status of children. Stunting captures chronic under-nutrition as it reflects a failure to receive adequate nutrition over a long period of time or chronic or recurrent diarrhoea. Wasting captures the thinness of children and indicates the prevalence of acute malnutrition. The third indicator, weight-for-age (underweight), captures elements of both stunting and wasting. The proportion of underweight children is used most widely as a comprehensive measure of malnutrition as it captures elements of both stunting and wasting.

Why are levels of child malnutrition so high in India? Several misconceptions cloud public opinion. Many believe, for instance, that India's low per capita income is the major underlying cause. This is not entirely true. A majority of the countries in Sub-Saharan Africa report lower levels of per capita income than India — and most of them report lower rates of child malnutrition as well. Again, within India, we find that Gujarat and Uttar Pradesh report the same proportion — 47 per cent — of underweight children even though the per capita income in Gujarat is several times higher than in Uttar Pradesh.

Others argue that income poverty is a major underlying cause of child malnutrition. Here too, we find no obvious linkage between levels of child malnutrition and income poverty. For example, 26 per cent of India's population lives below the poverty line and yet 46 per cent of children under the age of three

are malnourished. Again, it was believed that use of international growth standards to assess malnutrition is not right. However, extensive studies by the Nutrition Foundation of India have established that the growth patterns of Indian children who are well-fed and well-looked-after are similar to those of adequately nourished children in other parts of the world, no matter where they are born — in New Delhi, New York or New Zealand. Yet others believe that Indian children are malnourished because families are too poor to feed their children. This again is not true as even the poorest of families can get the quantity of food needed to feed an infant — half a chapatti or half a banana or a boiled potato or a bowl of dal.

What then explains the high levels of child malnutrition in India? Answers lie in looking beyond income levels, economic expansion, conventional poverty, and food availability. The first clue is found in the proportion of low birthweight babies. Estimates for India reveal that 20 to 30 per cent of babies weigh less than 2,500 grams at birth. This suggests the onset of malnutrition in the womb itself and reflects an inter-generational transfer of malnutrition from the mother to the child. Adversely affecting the birth of well-nourished babies is also the poor health and nutritional status of women. According to NFHS-3, close to one-third of Indian women suffer from Chronic Energy Deficiency and have a Body Mass Index (BMI) of less than 18.5 kg/m².

The second factor has to do with the limited reach of public health services and messages. In 2005-06, for instance, only 44 per cent of children aged 12 to 23 months were fully immunised. And only 26 per cent of children with diarrhoea were given oral rehydration salts. Barely two-thirds (64 per cent) of children suffering from acute respiratory infection or fever were taken to a health facility. Also affecting the health and nutritional well-being of children is the limited reach of, and access to, maternal care services. Here again, NFHS-3 reveals some glaring shortfalls. In 2005-06, barely half (51 per cent) of mothers across the country received at least three antenatal care visits during pregnancy; and less than half (48 per cent) of births are attended to by a trained birth attendant, which includes a doctor, nurse, woman health worker, auxiliary nurse midwife, and other health personnel.

The third clue lies in the care of the child. Breast milk provides vital nutrients throughout the first year of life; but it alone is not sufficient. Beyond four to six months, infants must be given solid foods to supplement breast milk. Despite the importance of breastfeeding and appropriate feeding for preventing malnutrition, only 23 per cent of children under the age of three were breastfed within one hour of birth and less than half the babies (46 per cent) up to five months old were exclusively breastfed. And only 56 per cent of children aged six to nine months received solid or semi-solid food and breast milk. It is, therefore, not surprising that a child typically becomes malnourished between six and 18 months of age, and remains so thereafter. In most cases, nutritional rehabilitation is difficult.

And the fourth clue is found in the limited opportunities available to women. Access to education, for instance, makes a big difference. According to NFHS-3, malnutrition among Indian children below the age of three born to illiterate mothers (55 per cent) is more than twice the levels (26 per cent) reported among mothers who have completed more than 10 years of schooling.

It is also well known that most infants get malnourished between six and 18 months of age. This raises three important issues relating to care of the child. First, six-month-old babies cannot eat by themselves; they need to be fed small amounts of food frequently. Feeding a six-month-old infant, however, is time-consuming. Many rural women simply do not have the luxury of time to feed infants. The task is often entrusted to an older sibling who understandably may not have the required patience to feed an infant. Related to this is the need to care for pregnant women by ensuring proper nutritional diet and by reducing the burden of work on mothers. Child rearing in most families is made the primary responsibility of mothers. It is important for fathers too to recognise their role in child care and share the burden with mothers. And third, it is important for state interventions to focus on care of newborns and those under the age of three.

States' records vary

Levels of undernourishment vary widely across Indian States. Punjab, Kerala, Jammu and Kashmir, and Tamil Nadu report the lowest proportions of underweight children (27 to 33 per cent); whereas Chhattisgarh, Bihar, Jharkhand, and Madhya Pradesh report the highest levels of underweight children (52 to 60 per cent). What explains the better nutritional levels among children in the first set of States? It is not surprising that, by and large, in the four States with the lowest proportion of underweight children, provisioning of health services, care of children especially of newborns, and the nutritional status of women are better than in the four high malnutrition States. For instance, 60 to 81 per cent of children aged six to 35 months were fully immunised in the low malnutrition States, whereas the proportion is much lower — 33 to 49 per cent — in the high malnutrition States. Reach of maternal care services is also poorer in the high malnutrition States. In the low malnutrition States, 63 to 97 per cent of mothers receive at least three antenatal care visits; this proportion varies between 17 and 55 per cent in the high malnutrition States. Again, 53 to 100 per cent of births were assisted by a trained birth attendant in the low malnutrition States whereas in the high malnutrition States the proportion varied between 17 and 55 per cent. And finally, the nutritional status of women is better in States where children had lower levels of malnutrition. For instance, whereas 14 to 24 per cent of women in the low malnutrition States have a BMI below normal, the proportion varies from 40 to 43 per cent in the high malnutrition States.

To conclude, the linkages of child malnutrition with women's health and well-being are strong. Reducing child malnutrition requires enhancing women's freedoms and promoting gender equality. At the same time, the focus has also to

shift from enhancing incomes and food availability to understanding how members of a household establish command over food, health, and care. It is important to understand how family members acquire and apply knowledge on child caring and rearing practices, allocate time to look after children, and protect the cleanliness of the environment. But, above all, India's high levels of child malnutrition reflect the continuing neglect of health, the inadequate reach and efficacy of health and child care services, and the failure of strategies to reach newborn children and those under the age of three. These deficiencies need to be addressed immediately.

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