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Nutritional Status in Maharashtra

An Interview with Manisha Karne

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Dr Manisha Karne is Professor of Development Economics at University of Mumbai (MU). Her areas of interest are women issues, health and environment. Currently she is working on identifying constraints and gaps in constraints human development indicators at a disaggregate level in India. Her ongoing research are studying the Educational Inequalities in Maharashtra; Reviving the role of state in health: A potential reality; Health inequity – evidences from India.

Malnutrition is widely recognized as a major public health problem in India. In this interview, Dr Karne addresses the nutritional status in Maharashtra and the factors affecting. Malnutrition has an irreversible effect on health and human development and thus the interview talks about the link between the high rate of child malnutrition and the poor sanitation and assessing the nutritional status among women and children in Maharashtra.

The health of Indian women is intrinsically linked to their status in a society where disparities in socio-economic status and education level exist. Can you throw some light on the nutrition status of women and children in Maharashtra?

My observation is wherever the female literacy rate is low and the gender gap in literacy is high, the percent of women with anemia (with HB level of less than 7) is also high. Literacy rate and infant mortality rate are inversely related indicating a direct link between the education level of women and child health status.

Secondly, if we see the list of most backwards Talukas in Maharashtra, ranked on the basis of the Development Indices (Kelkar Committee Report 2012), all the fifteen talukas are tribal. This clearly indicates the intrinsic link between Social status, educational level, poor nutritional status and economic backwardness.

As far as children in the age group of 0-6 are concerned, nutritional status is worst among STs in Maharashtra. The maximum percentage of children in MUW+SUW category for tribal blocks is 55.47 in Jawhar 2 in whereas for non-tribal rural blocks the maximum is 21.56 per cent (Vasai block) in Maharashtra.(MPR, ICDS, 2014-15).Thus, one can see in both the categories, the worst performing blocks are from Palghar District. This is enough to highlight the enormity of the problem in Palghar district.

The inter-district analysis indicates this percentage of children with normal birth weight is only 45 to 55 percent in some blocks of Palghar and Nandurbar (which is ranked as the most backward district of Maharashtra) whereas in the economically advanced districts this percentage of children with normal birth weight is well above 90 percent.

What nutrition-sensitive interventions need to be implemented by the government of Maharashtra in order to tackle undernutrition status in children? How far do you think access to PDS has made an impact on food insecurity status in Maharashtra?

The primary survey of the study undertaken to examine the nutritional status of children in the tribal parts of Thane indicated that PDS is important for tribal mainly due to large-scale income poverty among tribal. There is the absence of sustainable livelihood options, adequate employment opportunities in NREGA and lack of alternative employment opportunities in the tribal regions owing to interior geographical locations. There is a lack of educational capabilities which further constraints their employability.

Under PDS in tribal regions, there is an initiative to supply the essentials at the doorstep of the tribal in the Tribal habitats in the most interior parts. However, many times, there is a delay in supply of grains which adversely affects the wellbeing of the absolutely poor as they are totally dependent on PDS. Secondly, though getting ration is important, not everyone possesses a ration card and sometimes loans are taken against ration card, hence ration is denied due to its use as collateral for taking loans. These are some of the peculiarities observed in the tribal blocks. Hence, PDS has addressed the problem of food insecurity in tribal regions only partially.

According to Comprehensive Nutrition Survey in Maharashtra, there is a high prevalence of food insecurity in rural areas as compared to urban areas. What corrective measures do you suggest to address this problem?

Removing income poverty, better livelihood options and redistribution of land and better inputs for agriculture are some of the long term options and are part of the broader policy framework. But, in the short run, improving the availability of ration, smoothening the procedures for getting BPL cards and ration cards, timely supply of grains and improving the road connectivity in the rural and tribal areas should be emphasised.

What have you identified to be the main nutritional challenges during the making of DHDR report in Maharashtra?

As the official approval from the government is awaited, I cannot quote anything from the report. But I am sharing some of the insights from my observations about this problem in the last few years. There is a problem of malnourishment among tribal people in Thane district; however, the extent of it is much lesser than that of Palghar. Murbad, Shahapur, Bhiwandi and urban slums in Thane need more attention and these should be kept at the center of any policy perspective on malnourishment for the district. Also, wherever there was external intervention or monitoring by NGO, the intervention of Supplementary program seemed to function more efficiently. So there has to be pressure from below and regular monitoring by external agencies of these schemes.

Recently there were 600 child malnourished deaths due to starvation this year in Palghar district in Maharashtra. How far do you think are government actions and various nutrition schemes converged to improve the overall health and nutrition in children?

Recent starvation deaths in Palghar are a sad state of affairs. There is an absolute lack of apathy in handling the known problem in the district. Post-bifurcation, there is a clear evidence pointing to the worst nutritional scenario in Palghar as compared to Thane. The percentage of children in MUW and SUW category in Thane (New) is around 18 percent. However, for the tribal blocks of Palghar, it is quite high. For instance, the tribal blocks of the newly formed Palghar district such as Jawhar 2 (55.47 %) and Jawhar (55.42 %), Mokhada (42.69 %) and Vikramgad (38.17) are worst affected in % children with MUW and SUW (MPR 2014-15, ICDS).

It is the biggest challenge as it may cause mortality due to starvation or it may have adverse implications on child immunity or the physical and mental growth of such children, further affecting their capabilities in the later stages of their lives in the long term.

As a response to the second part, there were several child development centers (CDC) aiming at such convergence, however, the funds have been cut majorly for ICDS, hence CDC must be difficult to manage.

Do you think the introduction of Take Home Ration (THR) program have resulted in the exclusion of children under three years from the supplementary food given through the ICDS in Maharashtra?

Take Home Ration has been criticised on several grounds. Apart from problems in overall availability and shortages, lack of taste and substandard quality was observed. The observation from the field revealed except Shira other packets were disliked and sometimes were used for feeding the animals. It was also found by the evaluation studies that the calorie and protein content of these packets was lower than the cooked food. For tribal, if the food is not culturally appropriate, the program is unlikely to succeed. Due to all these problems children in the age group of 1-3 years among tribal have been mostly excluded from receiving the supplementary nutrition in a concrete way.

Off late this scheme has been replaced by Dr. APJ Abdul Kamal Amrut Ahaar Yojana in Maharashtra especially for pregnant women in tribal areas. Under which, there will be a direct transfer of funds for procuring grains, fruits etc. at the lowest level viz. village committee consisting of a women panchayat samitee member and also the pregnant women can be part of the committee. I feel the scheme is yet to take off in the rural Maharashtra.

So my overall impression about health and nutrition programs is that there is a lot to be achieved yet. Apart from the specific schemes like ICDS, CDC etc, the tribal community needs to be educated about environmental sanitation and personal hygienic practices, and also proper child rearing, breast-feeding and weaning practices. The lack of education, ignorance, and superstitions among tribal should be tackled to address the problem of malnourishment and morbidity among tribal children at the earliest.

Malnourishment is not only a health problem but is also concerned with social, economic and cultural affairs. Do you think the combined effects of inadequate sanitation, unsafe water supply, and poor personal hygiene lead to malnutrition in children?

Absolutely, and it is more so for tribal as they are different culturally. There are several barriers

in convincing them about nutrition, health and hygiene issues. But it is not an impossible task. Secondly, the community participation in making appropriate changes in dietary habits, child rearing practices, sanitation and treating water can go a long way in improving the health status of tribal.

We need an appropriate nutritional program designed for pregnant women and lactating mothers and children in the age group 1-6 and it should be customised for tribal people. Also, community participation is essential for a comprehensive child survival program with supplementary feeding, growth, and development monitoring and early, prompt treatment during morbidity. Concurrently such programs will have to be devised and implemented ensuring community participation. In addition to this, a well-equipped mobile unit for catering the health and nutritional needs of tribal in the interior areas and monitoring the nutritional status of children on regular basis could be very helpful.

Making the PHC as the center point for health care as well as malnourishment problem in the rural areas, strengthening the ASHA and AWWs by incentivizing them with better and regular remunerations, special training to administrative staff handling health and nutritional problems in the tribal areas to improve their understanding and enhance their capacities are some additional recommendations which I would make for long-term improvement in tribal welfare. Incentivizing the human resources in health care services is also a very big challenge. Lastly, it is observed that the major part of the TSP remains unspent pointing to poor governance and failure in implementation which needs to improve and the administration needs to introspect on their efficiency and administrative capabilities urgently.

How did you become interested in the field of health and nutrition? What are your ongoing studies in Maharashtra? How did your career path lead you to where you are now?

Teaching development economics and economics of health gave me exposure to analytical and empirical studies in the area of growth, inequalities, and poverty and health-poverty trap. I was involved in two studies funded by the planning commission to evaluate Maharashtra's economy and the progress of flagship programs in Maharashtra which further enhanced my understanding of these issues for the state. Thereafter, inter-district analysis of socioeconomic disparities in Maharashtra has become my prime area of interest.