

Inequity and Health Is Malnutrition really caused by Poor Nutrition?

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Abstract

Objective: To look at inequities leading to malnutrition and from the wider picture to find root causes and deal with them in order to alleviate malnutrition.

Method: Literature review.

Results: The health of the population is adversely affected by the inequities in the country. Women and children being most vulnerable are worst affected. The prevalence of Protein Energy Malnutrition (f.E.M.) in children under five years of age is 51 percent. Such a magnitude of malnutrition in a country, where availability of food per capita is more than adequate, points towards the fact that the inequities within the country are at the root of the problem. Poor income is not the only predictor of malnutrition, gender, urban-rural differences in access, utilization and quality of health care also influence health. In addition, there are some underlying factors such as illiteracy, unawareness of the mother about healthy behaviors, lack of decision-making power of women, along with deep-rooted cultural values of a patriarchal system.

Conclusion: Malnutrition is caused by a multitude of factors, some of which are biological, others are environmental, cultural or social. Education of the invisible half of the population, who actually look after the children and the family, is an important strategy to alleviate this problem (JPMA 50:273, 2000).

Is malnutrition really caused by poor nutrition?

All human beings by right should have access to effective health services, to maintain good health. It is not just in the Third World countries like Pakistan, that inequity in health and health care exists, but they also plague the developed world perhaps in more subtle ways. Whitehead defines health inequities as health differences which are not only unnecessary and avoidable, but in addition, are considered unfair and unjust¹. Inequity is entrenched in our traditional and cultural value system. Its roots are present in the political, economic and social systems of the country. Health of the people being a by-product of these systems is greatly affected by these injustices. The country needs to deal with the inequities of the system, because they burden the country with an ailing population, which is unproductive. In addition, ethically and morally a country is obligated to treat its sick and provide them with appropriate and adequate health care. Pakistan comprises of 0.6 percent of the world's area and 2.2 percent of the world's population. Its total population of 130 million makes it the seventh most populous country. Approximately 70 percent of the people live in rural and 30 percent in urban areas². The overall health statistics of Pakistan provide a dismal picture. The infant mortality rate is 95 per thousand live births and the under five child mortality rate is 136. The prevalence of Protein Energy Malnutrition (underweight) is 51 percent in children under five years of age³. It is not just the children who suffer poor health; women in Pakistan are also in a deprived state, suffering from multiple nutritional deficiencies. The gender development index of Pakistan is 0.31-0.40, while the average of 133 countries is 0.6. This means that women suffer the double deprivation of gender

disparity and low achievement⁴.

Pakistan is mainly an agricultural country, where production of food is ample, yet it has such a great magnitude of malnutrition. The poor are more malnourished, but it is not because of the lack of availability of food, except perhaps in some pockets, like the Thar Desert. Therefore, lack of income alone cannot justify such large numbers of malnourished children. The causes run deeper. Malnutrition can be attributed to inequities in the social, political and economic conditions of the country.

On the surface the causes of malnutrition of infants and children include poor breast-feeding practices, inadequate knowledge of appropriate weaning, recurrent infection such as diarrhea, respiratory tract infections and measles. In women of child-bearing age, low nutritional status may result due to chronic childhood under-nutrition, insufficient dietary intake to meet the demands of closely-spaced pregnancies and lactation and a lack of awareness of the daily dietary requirements. These factors, along with illiteracy and poverty, are inter-linked to each other.

Malnutrition is a vicious cycle. A malnourished child becomes a malnourished adolescent and ultimately a malnourished mother. Teenage pregnancies complicate the situation further. The cycle repeats itself when a malnourished woman delivers a low birth weight (LBW) baby. Most LBW babies are avoidable. About 25-34 percent of babies are LBW babies in Pakistan⁴. Even if adequate food is available to the poor, cultural practices lead to discrimination. The mother eats last and the least, leading to poor weight gain during pregnancy. Women do not have the power to decide about spacing of their pregnancies. They are the invisible half of our patriarchal system. This is not surprising, because men are considered strong and powerful if they have control over the female members of their family. This argument has been strongly supported by Zaidi (1996). He says, 'in societies dominated by men, women usually are identified as 'belonging to' their husbands/fathers/sons, ---- they are not independent entities^{4,5}.

Poverty may restrict the variety of food. Although a cereal and vegetable-based diet may provide complete protein, if supplemented with small amounts of animal or alternate protein, it is bulky and provides fewer calories per unit. Therefore P.E.M. in Pakistan is more a problem of energy deficiency because of low-energy diets. Hakeem (1997) reports that the average caloric intake of adult females of the low-income families was 1481 calories/day and that of the middle and high income families was 1753 and 1649, respectively. Such a difference is due to discrepancies in the income level and has a close correlation to infant mortality, life expectancy, height and morbidity⁶.

In addition to dietary imbalance, differences in the income level lead to exposure to unhealthy living conditions such as over crowding, lack of basic waste disposal system, limited access to safe drinking water and so on. The poor environmental conditions increase the risk of infectious diseases thus resulting in a vicious cycle of infections and malnutrition. People of low-income strata are forced to live in such filthy conditions and consequently the prevalence of malnutrition is higher. The ratio of underweight children in low, middle and high income category was found to be 41, 34 and 18 percent respectively⁸. Health differences due to unhealthy living conditions are far greater than those called for because of income variations.

Inequity also exists in urban versus rural populations. While 82 percent people had access to safe water and 77 percent to adequate sanitation in urban areas, only 69 and 22 percent of the rural population had similar access³.

Prevalence of stunting* in urban areas of Pakistan is 32.5 percent and 38.5 percent in rural areas. Wasting# was lower with a prevalence of 13.5 and 16.5 percent in urban and rural areas, respectively⁷. These differences may be attributed to limited access and utilization of health

services. Thirty-five percent of rural areas have access to health facilities, whereas ninety-nine percent of urban areas have access⁴. In addition women are not allowed to go out alone. But, perhaps if the literacy level were better, mothers would be aware of health promoting and disease preventing ways and would be able to manage the child adequately until he/she reaches a health facility.

* **Stunting**; below minus two standard deviations from median height-for-age of reference population.

Wasting: below minus two standard deviations from median weight-for-age of reference population.

Although Pakistan is a patriarchal society, there is conflicting evidence with regard to gender bias in child nutrition. Previous studies show a marked favor towards male children⁸, but more recently the trend seems to be changing. In the province of Sindh the Nutrition Support Programme (1997) found 42.2 and 48.9 percent males and females to be malnourished, which is only a small difference⁹. Zaidi (1996) argues that it is not the patriarchal system nor gender that is to blame, but it is the structure of the health care system that leads to poor access to health resources and consequently poor health. Illiteracy, unhygienic sanitary conditions, unsafe water, lack of preventive and curative health facilities, all of which combine together to lead to the poor health status of females in our society⁵.

There is no doubt that health and utilization of health care facilities is greatly influenced by the social and economic conditions of a family. There is a strong correlation between income level and literacy, which in turn is a strong predictor of malnutrition. In 43 percent families where the mother was not educated, the child was underweight, as compared to the 21 percent underweight children of mothers who had completed secondary level education⁷. Usually women from illiterate households are not allowed to go out alone, neither can they make decisions about the use of household income and nor what health services to avail. As a consequence both they and their children suffer. Education and ability to pay are directly associated with utilization of services. One may have the means to pay, but without adequate information may end up being treated by a quack. With a literacy rate of 24 and 50 percent for females and males respectively, more females rely on treatment provided by dispensers, paramedics, hakims and pirs, than men³. About 37 percent females and 22.7 percent males go to such facilities for treatment. This difference is even more pronounced in rural areas where literacy rates are even lower, 41.7 percent female avail such facilities as compared to 27.7 percent rural males. Therefore quality of health care available for females is restricted⁷.

Apart from being inadequate, the quality of care in the public hospitals is quite poor. On the other hand the private practitioner may or may not provide better service. The economic status clearly defines, who avails what services. A malnourished child with multiple infections may die, waiting for treatment in the emergency room of a government hospital; or he/she may not be able to afford the drugs required for treatment. Such scenes are not rare, yet commitment to deal with inequity based on income is weak. Thus in view of the above, it is apparent that the ultimate prevention of malnutrition has to come from the wider socio-political picture and not just medical sources.

What to begin with?

The principles and strategies of action must deal with the root causes of malnutrition and not only the superficial causes. They must take into account the effect of, not only improving the nutritional status of children and women, but also the social status. Although a lot needs to be done, if I were to make a health policy, within given resources, I would focus on improving the

awareness and literacy level of women. An excellent example of the benefits of female education can be seen in Sri Lanka.

An increase in females literacy would mean; greater decision making power about reproduction; greater decision making power about allocation of household resources; utilization of health services effectively; better nutritional status of the mother and the child; awareness about disease prevention and improvement of living conditions which are in the control of the mother, like clean house and boiled water.

In addition there are a number of ways in which the government can improve the malnutrition situation by improving the overall situation. These include providing opportunity for the poor to increase income and improve stressful conditions at work; better health infrastructure; legislation to contain escalation health costs; wiser spending cost effectively. High tech and specialized equipment uses up chunks of the government resources and leaves a lesser proportion for the requirements of the poorer majority, who cannot afford the use of such expensive equipment; decentralized decision making, involving the people and making them responsible for solving their problems with the governments help; more sensitive donor agencies that deal with the needs of the community, rather than dictating their own. objectives and improve record keeping, monitoring, analyses and evaluation of the data at health facilities as well as have a central collection unit for analyzing data. This information should be used to target area specific problems. Keeping in mind that whenever such programs are planned the local people should be made a part of the decision making process.

Conclusion

So, is malnutrition really caused by poor nutrition? At the forefront; yes it is.

It is not a lack of food, but a mal-distribution, along with poor quality of food available to the child and the mother. But this is not all. Denying freedom to the women, no education and no means of achieving it, coupled with limited access and utilization of health services are the basic causes of malnutrition. The quality of available services is also poor, especially for the low-income strata of the population.

The inequities in health and health care systems are therefore due to a variety of causes. Some are biological in origin and cannot be done away with. Others which are either due to environmental or lifestyle factors or have their origin in social and economic injustices, need to be tackled head-on.

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