The Malnutrition Market
Let Them Eat Paste

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Health activists have critiqued the Maharashtra government's proposal to provide a ready-to-use therapeutic paste to malnourished children across the state, despite strong evidence of the benefits of cheaper, more appropriate and locally produced foods. The move is one more example of how malnutrition, a condition that results from the widespread deprivation and inequities exacerbated by a market-driven economic system, is being converted into an opportunity to expand markets and make profits.

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According to the classic anecdote from late 18th century France, on hearing of the demand for bread by the poor of Paris, Queen Marie-Antoinette retorted, "Let them eat cake!" In Maharashtra today, we have a situation where, setting aside cheaper, more appropriate and locally produced foods, a state department seems set to impose an expensive form of packaged nutrition on the children of the poor, defying logic. A deeper analysis reveals the possible dynamics behind this move.

Maharashtra's women and child development (WCD) department is currently proposing a policy for the introduction of a packaged nutrient paste, known as ready-to-use therapeutic food (RUTF), for malnourished children across the state (Mahamulkari 2017a). This is a controversial decision, questioned from many quarters, including ministers and officials from other concerned departments.

This proposal exemplifies how a common condition (malnutrition), which is actually the result of widespread deprivation and inequities exacerbated by a market-driven economic system, is paradoxically being converted into an opportunity to expand markets and push profits. In this policy regime, public health evidence, developmental considerations, and social preferences all become secondary to a narrowly technical approach to a complex social problem, which conveniently opens the way for the promotion of commercial products. Children's bodies end up being used to expand the space for capital accumulation, and certain sections of the state are actively colluding in this process.

Starving Public Systems

Maharashtra is a paradoxical state, with one of the highest per capita incomes among major Indian states, as well as high levels of malnutrition (Sardeshpande et al 2009). Even more seriously, during a decade of "economic growth" from 2005–06 to 2015–16, a comparison of data from the National Family Health Survey-3 (NFHS-3) and National Family Health Survey-4 (NFHS-4) shows that severe wasting among children in Maharashtra has nearly doubled (IIPS 2015–16). In September 2016, the National Human Rights Commission issued a notice to the Maharashtra government over reports of 600 children dying in Palghar district, many of these deaths reportedly linked with malnutrition.

Such serious levels of malnutrition are linked with a deepening agrarian crisis that constrains the purchasing power of rural and tribal populations. A weakening of public nutrition and health-related services compounds the problem. For instance, the current state government has imposed savage budgetary cuts on the Integrated Child Development Services (ICDS) scheme in the last few years. The budget for the concerned WCD department in 2016–17 was slashed by a whopping 62% compared to the previous year (2015–16). Following protests organised by the social sector platform Jagnyachya Hakkache Andolan (Movement for Right to Live) (Rawal 2017) and *anganwadi* worker unions, this cut was partly reversed through increases in the supplementary budget for 2016–17. However, the WCD budget for 2017–18 again saw a cut of 22% compared to revised estimates for 2016–17. Parallel to this, the programme for village child development centres (VCDCs) providing special nutrition and care to malnourished children since 2010, was shut down across the state in 2014–15, the rationale being lack of required funds, pegged at roughly ₹17 crore annually. The VCDC programme had shown promising results in treating malnourished children with locally produced foods, but it is now severely curtailed.

In contrast, large-scale finances have been made available for certain market-friendly "solutions," such as "take home ration" (THR) packets. In Maharashtra, while children in the three to six years age group are provided cooked food in anganwadis, families of children under three are provided packets of THR powder, to be mixed with warm water or milk

and fed to the child. Although technically supposed to be nutritious, there is widespread experience that children under three find THR unpalatable, making it ineffective. Two rounds of study by the Nutrition Rights Coalition in four districts of Maharashtra in August 2013 and October 2014 showed that 88% and 95% respectively of children under three years of age were not consuming THR regularly (Marathe et al 2015). Of those families that were not feeding this powder to their children due to lack of acceptability, 78% opted to feed it to cattle and other domestic animals! Following civil society activism and orders from the Bombay High Court, in the Melghat area of Amravati district, THR was officially replaced by hot cooked meals for children under three years. The study by the Nutrition Rights Coalition (mentioned above) showed that the level of severe malnutrition among children under three years in villages in Amravati where cooked meals are given was 2.8%. This is half of the average level of 5.7% in other districts where THR packets are being provided, strengthening the evidence in favour of hot cooked meals compared to THR.

However, despite Supreme Court orders prohibiting the involvement of contractors in the supply of food for children in anganwadis, THR packets continue to be manufactured and distributed across Maharashtra by selected companies operating under the guise of "women's organisations." A few resourceful, mutually connected businessmen reportedly run these organisations. The total budget planned for purchase of THR in Maharashtra over seven years is estimated at around ₹5,300 crore, indicating the lucrative nature of the "malnutrition market." THR has continued despite protests by civil society organisations, representations in the Supreme Court, and resistance from many anganwadi workers who are compelled to impose THR packets on reluctant "beneficiaries." While the intended beneficiaries—children in poor families—have hardly benefited from THR, the two main gainers from this political decision seem to be the disguised companies that manufacture the THR and the cows that are fed the powder—a sign of our times!

Medicalising Malnutrition

Given the abysmal failure of THR as commercial packaged food, what evidence from the Indian context justifies the introduction of another packaged product in the form of the centrally produced RUTF for treating malnutrition? Studies from India show that there is hardly any added value in centrally produced RUTF compared to locally prepared foods, and any higher impacts on increasing the weight of children are at best transient.

The findings of one of the larger and more recent trials on RUTF in India (Bhandari et al 2016) show that compared to centrally produced RUTF, locally prepared RUTF emerges as slightly better, while home-prepared foods with the addition of nutrients show comparable results. Rates of recovery from malnutrition among groups receiving locally prepared RUTF were 56.9%, 47.5% for those receiving centrally produced RUTF, and 42.8% for augmented home-prepared foods. Importantly, 16 weeks after the intervention, overall improvement declined to just 15%, and much of the improvement could be attributed to extra support for feeding by local peer supporters, who enhanced the engagement and skills of the mother in child feeding (Bhandari et al 2016).

The only published trial on RUTF in Maharashtra is hospital-based rather than community-based, dealing with a more controlled and supervised environment. This study shows that after eight weeks, 82.8% of children on medical nutrition therapy (MNT, similar to RUTF) moved out of severe acute malnutrition (SAM) status, compared to 64.4% of children on standard nutrition therapy (based on nutritious local food ingredients). However, the difference between the two groups concerning rate of weight gain was statistically insignificant after four weeks. At the end of six months, there was no statistical difference in nutritional status of both groups, showing that RUTF had only a minor and temporary advantage over locally produced food in improving the nutrition of malnourished children, even in a closely supervised hospital setting (Jadhav et al 2016).

Studies in other countries (Tadesse et al 2015) have documented many concerns and adverse impacts related to the adoption of RUTF, which include shaping young children's preferences towards the sweet taste, developing a resistance to healthy foods, and even the possibility of permanent alteration of metabolic functions. A series of case studies on 14 children who had experienced a trial of RUTF in Nandurbar district, recently carried out by Jan Arogya Abhiyan, Maharashtra, revealed disturbing findings after the conclusion of the trial. One of the parents stated that the "anganwadi worker had strictly told us not to offer any food to the child other than paste, unless all the required paste packets were consumed by the child. The child has now become addicted to the sweet paste and after its discontinuation continuously cries for paste, and refuses to eat home-cooked food" (Jan Arogya Abhiyan 2017).

Even UNICEF has expressed caution on RUTF, especially its potential for commercial exploitation and risk of undermining existing good practices for child feeding (UNICEF 2013). Studies have noted that RUTF-based "standalone" programmes usually have very weak links with existing food security and nutrition programmes, compromising their sustainability (Greiner 2014). Overall, RUTF is embedded in a problematic paradigm that views malnutrition as a "disease" that must be treated with nutrients as "medicines" with extremely demanding specifications, which can only be produced by technically sophisticated corporations.

Poor System, Costly Product

According to available information, the current proposal for RUTF is linked with restarting VCDCs across Maharashtra. The latter would be a welcome and long overdue step, and can definitely improve care of malnourished children across the state. However, the economics of the proposal seem to be weighted towards providing substantial resources for purchase of the commercial paste, while the ICDS system delivering the product remains under-resourced. If ready-to-use foods are provided to both severely

and moderately malnourished children across the state, the budget would be in the range of ₹100 crore per year. Here we would focus on severe acute malnourished children, who officially number around 83,000 in Maharashtra (Ministry of Women and Child Development 2017) (a grossly under-reported figure compared to more reliable NFHS-4 data). Each SAM child would be provided three packets of paste every day, for a period of 72 days. Each packet provides 500 calories, so three packets would provide 1,500 calories, while the daily energy requirement of a child in the age range of 1–6 years is 900–1,400 calories. This implies that if the protocol were followed, *each child would be expected to eat only RUTF paste from morning to night, with practically no consumption of normal food, continuously for over two months!* The advisability and feasibility of such an artificial form of dietary intake, especially in community conditions where the child would be weakly supported in case of adverse effects, is seriously questionable.

Since each RUTF packet costs ₹25, with three packets provided daily, the cost per child per day would come to ₹75. Given such significant amounts, imagine the alternative nutritious foods that could be locally provided, socially rooted and culturally appropriate, encouraging the local economy and helping to reshape household dietary practices in a sustainable manner. We outline an example of such locally provided food from Maharashtra in the next section. The proposed RUTF provision can also be compared to the current amount allocated for regular meals in the anganwadi, which is barely ₹6 per child per day. Clearly, priorities are skewed, with scarce resources being made available to prevent malnutrition among all children, but lavish resources provided to purchase commercial products for treating malnutrition.

Further, the company that may supply RUTF packets on a large scale in Maharashtra (since it has provided the eeZeePaste NUT packets used in the recent RUTF pilot in Nandurbar) is the Norwegian G C Rieber Compact, which has a subsidiary in India with a manufacturing plant in Gurgaon, Haryana. The website of this company carries the following enigmatic statement:

> India as production site is strategically important as it is the world's largest democracy and has a population which counts for 1/6th of the world population. The population growth creates challenges regarding distribution of wealth and services. Adequate and correct nutrition supplies are in high demand, and therefore India is an important place to be present as the challenges develop further. (G C Reiber Compact 2017)

Apparently, India's population growth (not its socio-economic system) is responsible for its "challenges regarding distribution of wealth" (that is, major inequities and poverty). More importantly for G C Reiber Compact as a multinational company, as these "challenges develop further" there is high demand for "correct nutrition supplies" (that is, packaged nutrients). In short, growing poverty is good for business, since presumably we have no choice but to depend on a multinational corporation to feed our malnourished kids "correctly." (Did anyone mention "Make in India"?)

Ignoring Alternatives

Nutrient paste is obviously not the only solution available to treat malnourished children. There is ample scientific evidence on the effectiveness of approaches based on locally produced, culturally acceptable nutritious foods, which are far more appropriate than centrally manufactured RUTF. These approaches need priority, instead of the large-scale promotion of commercial packaged foods. Significant initiatives have been introduced in India which have reduced malnutrition based on promotion of improved household feeding practices, individualised counselling of caretakers of children, and better support to children under three through crèches and similar measures. A multi-strategy intervention termed Action Against Malnutrition (AAM) (Prasad and Sinha 2015) has been adopted in a nested manner, with the running of crèches, mobilisation of the community through structured participatory learning and action meetings, and systems-strengthening to improve health services and ICDS. This approach demonstrated a very significant reduction in severe acute malnutrition from 8% to 4%, while normalcy was fairly well maintained. Another trial of local therapeutic food, accompanied by community-based interventions by MAHAN Trust in Maharashtra, showed significant reductions in the prevalence of SAM and severe underweight children at the end of the study, demonstrating the efficacy of locally produced foods, and the effectiveness of community-based models to tackle acute and chronic malnutrition (Dani et al 2016).

More Profitable Than Prevention

Malnutrition is an "embodiment" of poverty and deprivation, linked with deepening agrarian distress, limited household incomes, and large-scale seasonal migration, especially in tribal areas of Maharashtra. However, going by ongoing policies for the agricultural sector, as well as recent state budgets for key areas like ICDS and food security, the state is weakening its emphasis on prevention of malnutrition through wider socio-economic measures and programmes. Even focusing on the short-term need to tackle existing malnutrition, locally anchored and empowering options such as promotion of improved nutrition practices with women's groups, individualised counselling of caretakers of malnourished children for dietary improvements, and organisation of publicly supported crèches, are being ignored. However, once certain children inevitably fall into severe malnutrition—one extreme of the wide spectrum of ongoing deprivation—the state seems eager to "rescue" them, perhaps for a few months, through provision of commercially manufactured paste. This seems to be exceptionally myopic, since the improvements may only last for a short time, after which such children may fall into the next round of malnutrition, given that the underlying causes have remained unaddressed.

Critical Voices

Although powerful global bodies are endorsing RUTF, alternative voices are now arguing with evidence that locally produced and socially rooted solutions for malnutrition are equally effective and much more sustainable. Recently, a group of 16 senior nutrition and health experts from across India have written a letter to the

union health minister,[1] cautioning against the introduction of products like RUTF:

> We, the undersigned, make a fervent appeal for framing local evidence based policy that seeks to reduce burden of severe wasting in a sustainable manner, instead of focusing upon distractive and uncertain "quick fixes" … Prudent, cost-effective and sustainable strategies to address SAM (severe acute malnutrition) should follow the holistic preventive route, instead of diverting funds towards distributing nutrient-products with evanescent benefits for the mere tip of the iceberg …
>
> We are concerned that in spite of this evidence from India, some states are in the process of scaling up "ready to use therapeutic foods" (RUTF) and energy dense food (EDF) for treating SAM children in partnership with agencies. This defies evidence-based programming, and could be resulting from the absence of a clear national policy to guide such interventions.

Recently, the civil society networks Jan Arogya Abhiyan (People's Health Movement, Maharashtra) and Anna Adhikar Abhiyan (Right to Food campaign, Maharashtra) released statements to the media, sharply critiquing the proposal by the WCD department to introduce RUTF on a large scale in Maharashtra, which led to significant coverage of the issue (*Asian Age* 2017). It is notable that even Maharashtra's minister for tribal development has publicly expressed reservations regarding this proposal, while the state health ministry has also not supported it (Mahamulkari 2017b).

To conclude, we feel that there is a need for large-scale social mobilisation to resist the weakening of public service systems, and to counter tendencies to move from a "welfare state" to a "warfare state." Linked with this is the need to critique the growing commercialisation of welfare, which is emerging as a new area of state-assisted accumulation. Seemingly arbitrary decisions that promote vested interests while ignoring healthier and much more socially sustainable options are unacceptable in an age that demands evidence-based policy and democratic decision-making. Just as war is too important to be left to generals, nutrition is too important to be left to nutrition experts and nutrient manufacturing companies. Undue promotion of commercial interests in the guise of welfare must be exposed, alternative healthier options must be prioritised, and public good must prevail.

NOTE

1 Letter by 16 nutrition and public health experts to the health minister on "Policy for Child Undernutrition: An Emerging Need to Reduce Severely Wasted Children Than Just Treat Them with RUTF," unpublished communication, 19 April 2017.

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