Caste, Religion and Malnutrition Linkages

NIDHI SADANA SABHARWAL

The poor are not uniformly disadvantaged. Across most health indicators, the situation of the scheduled castes, scheduled tribes and Muslims is significantly worse than that of others. While nutritional status is closely linked with levels of income, education and public health services, the social belonging of persons also acts as an additional aggravating factor for nutritional inequity.

The problem of malnutrition has of late received a great deal of attention at the policy level. The persistence of a high degree of malnutrition among the poor, particularly among certain social groups has led to a renewed concern at the governmental level. Increasingly, it is being recognised that although the malnutrition level is relatively high at the overall level, among the malnourished, some groups suffer more from malnourishment than the others. There are significant inter-group disparities in the nutritional levels between poor and non-poor, between caste, ethnic and religious groups. Earlier studies shed some light on the factors which result in high malnutrition and point towards low income, high illiteracy and poor access to health services as key determinants of malnutrition. However, these studies show limited insight into the causes of a relatively high level of malnutrition for caste, ethnic and religious groups such as the scheduled castes (SCs), scheduled tribes (STs) and Muslims. In this context, we develop an understanding of the possible reasons for a relatively high malnutrition level in general and among the SCs, STs and Muslims in particular. We first present the inter-group disparities in malnutrition and then provide reasons for the particularly high malnutrition among certain social and religious groups.

Inter-group Disparities

The inter-group disparities in the nutritional level in rural areas are examined using the National Family Health Survey (NFHS) for 2005-06. Indicators of malnutrition include percentage of the underweight children, a body mass index (BMI) below 18.5 kg/m² and anaemia.

The percentage of underweight children at the aggregate level was about 45.6. However, the nutritional problem is particularly serious for children, women and men belonging to the SCs, STs, and OBCs. Table 1 (p 17) shows that underweight rates are approximately 50% and anaemia 10-20% higher in the SC/ST children compared with the rest. A BMI of less than 18.5 kg/m² which indicates chronic energy deficiency is particularly serious for the SC/ST and

The author would like to thank Sukhadeo Thorat for comments on this article.

Nidhi Sadana Sabharwal (nidhi@dalitstudies.org.in) is with the Indian Institute of Dalit Studies, New Delhi.
table 1: malnutrition among children across social and religious groups in rural india

<table>
<thead>
<tr>
<th>social groups</th>
<th>cmr (weight for age)</th>
<th>bmi &lt;18.5</th>
<th>hindu</th>
<th>muslim</th>
<th>christian</th>
<th>sikhs</th>
<th>others</th>
</tr>
</thead>
<tbody>
<tr>
<td>sc</td>
<td>25.6</td>
<td>50.6</td>
<td>44.7</td>
<td>51.3</td>
<td>57.6</td>
<td>30.6</td>
<td>33.5</td>
</tr>
<tr>
<td>st</td>
<td>38.3</td>
<td>56.1</td>
<td>48.4</td>
<td>56.9</td>
<td>36.5</td>
<td>44.1</td>
<td>na</td>
</tr>
<tr>
<td>obc</td>
<td>18.7</td>
<td>45.7</td>
<td>39.7</td>
<td>45.6</td>
<td>46.7</td>
<td>27.3</td>
<td>19.6</td>
</tr>
<tr>
<td>others</td>
<td>13.3</td>
<td>36.3</td>
<td>35.8</td>
<td>33.7</td>
<td>43.5</td>
<td>27.7</td>
<td>18.8</td>
</tr>
<tr>
<td>average</td>
<td>21.0</td>
<td>45.6</td>
<td>40.5</td>
<td>46.3</td>
<td>44.0</td>
<td>37.0</td>
<td>24.6</td>
</tr>
</tbody>
</table>

source: computed from national family health survey-3 (2005-06) data file, na- indicates sample size less than 50 so not considered. cmr: child mortality rate.

the social and religious belonging.

compared with the other women. this

women, these women too suffer from low

off than their male counterparts. like all

women from these social groups are worse-

compared to the average in those groups).

similarly, women from the sc/st children

than for the “other” children. the obcs are

worse off in comparison to the “others”,

though better off than the sc/st.

similar differences are observed for

social groups by their religious background

(table 1). children from the christian and

sikhs have relatively better nutritional

status than those from hindu and muslim

groups. among social groups, the sc

muslims have the highest proportion of

underweight children followed by st and

sc hindus. in fact, the situation of children

from the sc muslims is the worst amongst

close to 58% of the sc muslim children were malnourished as

compared to the average for that group.

similarly, women from the st hindus and

sc muslims have the highest incidence of

malnutrition (51% and 45% respectively, as

compared to the average in those groups).

women from these social groups are worse-

off than their male counterparts. like all

women, these women too suffer from low

nutritional levels as compared to men but

the sc, st and muslim women suffered most

compared with the other women. this

heightened deprivation can be attributed to

the social and religious belonging.

factors common to all

using logistic regression analysis for rural

areas in 2005-06 we try to capture the key

factors affecting child malnutrition in rural

areas. we have taken the proportion of

underweight children as a measure of

malnutrition, and income (wealth index – proxy

for income), education of the mother, access

to antenatal care (indicator for access to

health services), social and religious belong-

ning, occupation of the father, gender, place

of residence, and supplementary nutrition

as determinants of child nutrition (table 2).


taking each of these factors separately it

emerged from the logistic regression

analysis that children from wealthier

households have a lower incidence of mal-

nutrition than the others. when all other

factors, including the social group, are held

constant, the likelihood of the poorest

children being malnourished is about three

times that of children from the highest

wealth quintile (odds ratio of children from

poorest households to those from the

richest = 1/0.342 = 2.9). the gap in nutritional

status between the poorest and the

richest quintiles is very wide for men as well

as women. as one moves along the wealth

index ladder from the poorest to the richest,

the proportion of under-nutrition women

and men reduces indicating that income
does matter for a better nutrition level.

the education level of mothers also

affects the nutritional status of children. the

likelihood of children of illiterate mothers being malnourished is twice that

of children of mothers with secondary or higher education (odds ratio of illiterate

mothers to those having higher education = 1/0.463 = 2.16).

access to health services is the third

crucial factor affecting nutrition. the im-

pact of a poor standard of living and edu-

cation level could be overcome to a great

extent, particularly by the poor individu-

als through better access to affordable

public health services. data indicates that

mothers who have better access to health

services, such as antenatal care, have lower

odds of having malnourished children,

and the likelihood that they will have mal-

nourished children is 0.67 times that of

mothers who do not receive such services.

caste and religion

certain social, ethnic and religious groups

are disproportionately affected by child

malnutrition. the logistic regression indi-

rectly captured the influence of caste,

ethnic and religious background on the

incidence of malnutrition. it estimated the

likelihood of children from these groups

being malnourished as compared to the

rest, when the wealth index, education,

access to health services and other factors

are held constant. in other words, it cap-

tures the malnutrition level for identical

persons in terms of their wealth, education,

access to health services and other factors.

the logistic regression exercise indicates

that the likelihood of sc and st children

being malnourished is about 1.4 times that

of children from the “other” category. the

same results for muslim children indicate

that although their nutrition levels are lower

than other religious groups, the difference

is not statistically significant. for women

and men, we ran a logistic regression

controlling for limited variables, namely,

educational level, wealth and occupation.

for sc women, the likelihood of being

malnourished is 1.1 times that of “other”

women after controlling for wealth, occu-
pation and level of education. for the st

women, the likelihood of being malnour-
ished is 1.2 times that of women from the

“other” category. the logistic regression

further indicates that the likelihood of the


Muslim women’s group being malnourished is 1.7 times and that of Hindu women is 1.5 times that of the rest of the religious categories. The likelihood of SC and ST men being malnourished is 1.1 times and that of Muslim men is 1.5 times that of the others after controlling for wealth, occupation and level of education. It is clear that Muslim women seem to have a higher likelihood of being malnourished, followed by the women from the STs and SCs, in that order.

Thus in the case of the SCs, STs and Muslims even after controlling for factors such as income, educational level, access to health services, etc, the malnutrition rates turn out to be high indicating that there are constraints that are associated with their social and religious belongings. Because of lack of data we could not include such constraints in the regression equation. However, some field-based studies indicate group-specific factors for high malnutrition levels. These group-specific factors generally relate to the discrimination that these communities face in accessing income earning assets, education and government schemes providing services like food and health. There is some evidence for the SC. The SC faced discrimination in accessing food from the public distribution system (PDSs). The SC children also faced discrimination in accessing food (mid-day meal) in schools and anganwadi centres, which adversely affects their food intake and thereby their nutritional levels (Thorat and Lee 2010; Jan Sahas 2009). Sangamitra’s study (2010) provides evidence of the discriminatory access of SC women and children to primary health services leading to lower utilisation of the health services. Indeed, the NFHS data for 2005-06 reveals that SC mothers and children have relatively poorer access to public health services than others. For example, the immunisation rates for SC children are about 20% lower than the others (Table 3). Access to health services at the time of delivery is also lower for the SC mothers compared to the others. Thus, discrimination resulting in limited access appears to be an additional pervasive factor contributing to the higher rates of malnutrition among the SC compared with others.

The issue of discrimination-induced malnutrition has been neglected in the literature which in fact needs more research.

**In sum, malnutrition is a direct outcome of not only income levels, education and public health services, but also the indirect one of the discriminatory access to income opportunities, health and food security-related services from mid-day meal, the Integrated Child Development Scheme (ICDS), the PDS and others. This indicates that the income level, education and access to health services are important factors to reduce malnutrition for all, including the SCs, STs and Muslims. But in the case of the SCs, STs and Muslims additionally, safeguards against discriminatory access to education, health services, food security schemes and livelihood opportunities are necessary.**

**Policy Implications**

These results have policy implications which are dual in nature. They call for measures common to all poor (including poor from the social and religious groups), and supplementary measures for the SC, ST and the Muslims to provide safeguards against discrimination. Among measures which are common to all (including the social and religious groups) are increasing incomes of the poor through improved access to assets and earnings which is essential for better diet and access to healthcare. Similarly, there is a need to improve the education level and access to the public health services and food security. Increasing the enrolment levels of girls and retaining them in school is critical at least until the secondary education stage. Expanding the functional health services to the rural and poorly served urban areas is necessary for improving access of the poor to health. At the same time, programmes to create awareness of nutrition, and healthcare are necessary to inform critical feeding and caring behaviours at the family level and to promote use of health services.

In the case of the SC and ST who face discrimination in accessing the sources of income, education and public health service, besides these common measures, they would also require supplementary policy measures to overcome the constraints imposed by processes of social exclusion and discrimination in accessing earning, education, public health services and food security. This will require measures to provide safeguards against discrimination and measures to promote equal and non-discriminatory access. These measures may include: establishing ICDS – anganwadi centres, health facilities and “fair-price food shops” in underserved SC, ST and Muslim habitations, monitoring and using data disaggregated by social group at all levels to identify underserved communities/groups. Recruitment of ICDS anganwadi workers (AWW) and auxiliary nurse midwives (ANM) from the SC, ST and Muslim communities is equally necessary to improve the coverage of these groups. Thus, increasing their education levels will be an important measure. The AWW and ANM training courses must emphasise the adverse effects of caste, ethnic and religious discrimination on access to public health and food security schemes. Conducting national public awareness campaigns against discriminatory practices and ensuring that organisations delivering public/social services do undertake such campaigns should constitute a part of these measures.

**REFERENCES**


<table>
<thead>
<tr>
<th>Table 3: Access to Health Services in Rural India (2005-06)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Essential Health Services</td>
</tr>
<tr>
<td>SC</td>
</tr>
<tr>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Percentage of children vaccinated</td>
</tr>
<tr>
<td>% distribution of children 0-59 months covered by AWC by frequency of weighing</td>
</tr>
<tr>
<td>Place of delivery at home (in %)</td>
</tr>
<tr>
<td>Assistance during delivery (in %)</td>
</tr>
<tr>
<td>(a) From Dai (TBA)</td>
</tr>
<tr>
<td>(b) By friends/relative</td>
</tr>
<tr>
<td>(c) By skilled provider</td>
</tr>
<tr>
<td>Postnatal check-up: less than four hrs (in %)</td>
</tr>
</tbody>
</table>

Source: Computed from National Family Health Survey-3 (2005-06) data file.