Kathmandu University Medical Journal (2005) Vol. 3, No. 1, Issue 9, 2-3

Editorial

Child nutrition in Nepal

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Nutrition is a multidisciplinary subject with community as its practice area. It is a focal point for health and well-being. It has special significance in countries with disadvantages in socioeconomic and hygienic standards. The problems of poverty, safe drinking water, environmental hygiene and poor literacy contribute to the problems of nutrition and public health. Protein Energy Malnutrition (PEM) particularly stunting, has severe functional consequences, including increased vulnerability to disease and increased risk of mortality, lethargy with reduced capability to benefit from stimulation and reduced learning capacity.

Nutrition is an important determinant of immunological status; and under nutrition can impair immuno competence and increase susceptibility and vulnerability to infections. The immediate cause of over half of South Asia's under five mortality is the synergistic effect of inadequate dietary intake and frequent episodes of diseases. Not only severe malnutrition, but also even mild to moderate malnutrition, increases the risk of a child dying due to common infections by over 50 %. Nearly 40% of the under five mortality results from the episodes of diarrhoea or acute respiratory infection; which are curable in first stages with simple home remedies when nutritional status is good[1]. Fifty percent of child deaths in developing countries are related to malnutrition's potentiated effects and 83% of these deaths are attributable to mild to moderate malnutrition[2].

The WHO global database on protein energy malnutrition (PEM) and child growth shows that the prevalence of PEM in children under five years in developing countries worldwide has progressively fallen from 42.6% in 1975 to 34.6% in 1995. However, in South East Asia region the fall in prevalence has not been as rapid as the growth in population. Currently, over three fourth (79%) of the world's malnourished children live in this region. South Asian countries carry the worst burden of malnutrition in the world[5], so that for the improvement in the nutritional status of the children worldwide, the burden in South Asia has to be reduced first. Despite sustained increase in the per capita dietary energy supply in the entire south East Asian countries, the position regarding under nutrition (which is less than – 2S. D. NCHS (U.S. National Centre for Health Statistics) median weight for age and height for age in children below five years) is far from satisfactory[2].

An estimated 99000 children in Nepal die every year before they reach their first birthday. Although there have been dramatic improvements over the last twenty years, under five mortality still exceeds ten percent; and ten girls die for every seven boys[3]. About 29% of children are low weight at birth and nearly two thirds of them under three are severely or moderately malnourished[4]. Nepalese children show evidences of under nutrition as indicated by their stunting, wasting or wasting and stunting combined along with the features of various micronutrient deficiency disorders.

According to Nepal Demographic and Health Survey, 2001, the percent prevalence for underweight and wasted children of under five years of age are 48.3 and 10 percent. Around 50% percent of the under five children are stunted. Children in rural areas are more likely to be stunted (52%) than in urban area (37%)[10] Nepal Micronutrient Status Survey, 1998(6 – 59 months) indicate that 54.1 % were stunted, 6.7% showed wasting and 47.1% were underweight. National Family Health Survey (NFHS, 1996) in a nationally representative sample of children (6 – 36 months) showed that overall, 54.8% were stunted, 12.7% showed wasting and 54.2% were underweight. The first national nutritional survey in 1975 also showed similar findings of 48.1% stunted, 2.8% wasted and 50% underweight. The data suggest that there is no improvement in the nutritional status in the country, although per capita energy consumption showed an upward trend of 2270 kcal per day[2].

Studies have showed that breast-feeding has positive effects on the nutritional status. Early initiation of breastfeeding is vital because the first breast milk contains colostrum full of nutrition and antibodies that protect the newborn from the infections. Around 31% of the children in Nepal are breastfed within one hour and 64.9% of them receive it within one day of birth. More urban children are breastfed within one hour (34.2%) and within one day (72.3%) as compared to rural children with 30.9% and 64.4%

respectively. Around 69% of the children are fed with the first breast milk[5].

Many people in Nepal do not have access to Vitamin A rich food. The denied access is revealed through Nepal Demographic and Health Survey 2001 data which shows that only 28% of the children under three years of age consumed the fruits and vegetables rich in vitamin A at least once in the seven days prior to survey. Thirty seven percent of urban children as compared to 28% of rural children consumed fruits and vegetables rich in Vitamin A. However, the proportion (four out of five) of rural children who received the direct vitamin A supplementation exceeds the proportion (three out of four) of children in urban area.

Good nutrition is a fundamental right. Nepal with its ratification in 1990 of the 'Convention on the Rights of Child, by UN General Assembly in 1989', committed itself to recognising and implementing a wide range of civil and political rights for Nepalese children. The convention recognizes children's right to survival and to the highest attainable standard of health (Articles 6, 24), implies a healthy environment, nourishing food, quality health services and parental awareness[6]. In order to improve the nutritional status of the children in Nepal, the national nutrition programme has set out certain goals. One of the main strategies is to promote, facilitate and utilize community participation and involvement for all nutrition activities. Few more strategies are to ensure the coordination among other agencies involved in nutritional activities, decentralization of authority from the very beginning of needs assessment through planning, implementation and monitoring; and to conduct the national and social advocacy campaigns[7]. A vital strategy of distribution of vitamin A capsules has been adopted to overcome the vitamin A deficiency through the Nepal National Vitamin A Programme since 1993. The programme covers nearly all the districts [5].

Studies show that the causes of malnutrition in Nepalese children can be tackled. There are lack of knowledge related to health and nutrition and economic constraints. The preventive and curative approach to the health of the children in Nepal is essential to overcome many of the obstacles. Social and cultural factors need to be addressed properly before developing and implementing any nutrition programme in Nepal.

References

1. UNICEF. Atlas of South Asian Children and Women. 1996. UNICEF, ROSA. Nepal.
2. WHO. Nutrition in South East Asia. 2000. WHO Regional Office for South East Asia. New Delhi.
3. UNICEF Nepal and NPC. Children and Women in Nepal: A Situation Analysis. 1996. UNICEF Nepal
4. CBS 1995 cited in Action Aid Nepal. Gender Strategy. 1999. Action Aid. Kathmandu.
5. Ministry of Health, New Era, ORC Macro. Nepal Demographic and Health Survey 2001.2002.
6. Save the Children, UNICEF, Seto Gurans national Child Development. Bringing Up Children in a Changing World – Who's right? Whose Rights? 2000. Wordscape, Kathmandu.
7. Ministry of Health, Department of Health Services. Annual Report. 2002/2003.