

FACTS *against* MYTHS

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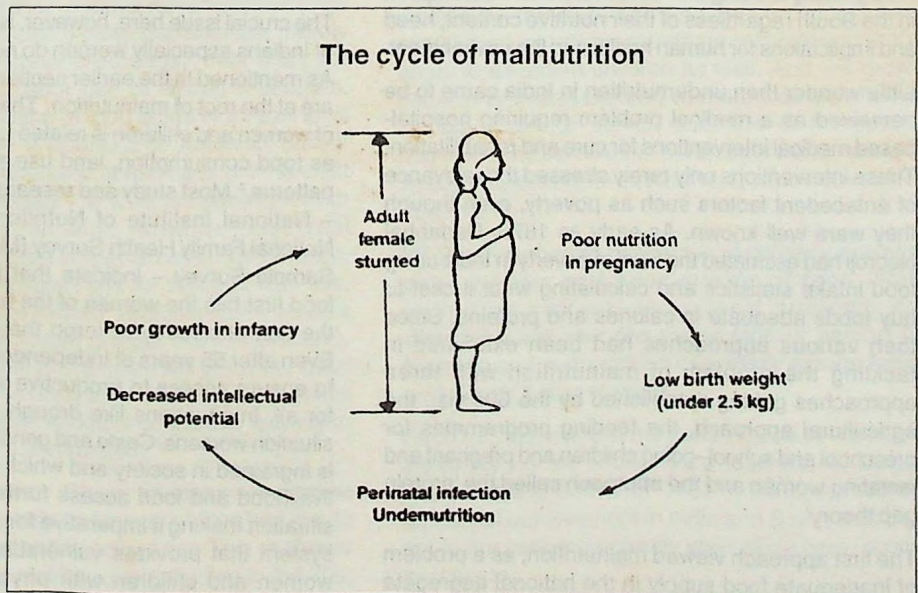
INFORMATION BULLETIN

Paradox of Hunger & Overeating: The Myths behind the Nutrition-Malnutrition Complex - Part II

COMMENT

Historically, the incidence of nutritional disorders was negligible as long as people were able to eat well. Nutritional disorders emerged as public health issues as soon as human relations of production changed with the emergence of unequal terms of global trade, etc. These exploitative relations led to the collapse of the age-old livelihood support systems and the disruption of the ecological balance compelling people to live in the most degrading environment. Later, the cross-fertilization of the disciplines of chemistry, biochemistry, physiology and clinical medical science gave rise to nutrition science and subsequently triggered off a series of scientific breakthroughs: nutritional elements were identified, balanced diets established, the complex pathways in the metabolism of proteins worked out, and various forms of primary nutritional disorders identified as outcomes of specific deficiencies.

The cycle of malnutrition



In time, nutrition education, food processing and animal nutrition became additional complements of the sciences of nutrition. Undoubtedly, this advancement made a major contribution to the body of knowledge. However, with the increasing scientific content in this body of knowledge, the focus of studies moved further away from the problems of humans in their ecological settings. In the process traditional knowledge systems of both mainstream society and cosmological worldviews of the Adivasis were neglected or considered "unscientific", and steadily displaced by modern medical systems and structures. The age-old customs, practices and habits on nutrition and nutritious diet began to likewise diminish in relevance. Instead, biochemical laboratories and animal houses became the venues for the study of human nutritional. This shift in emphasis was not unintentional. Market interests promoted such research because nutrition became fertile ground for the rapid promotion of the food and drug industries. The symptoms were emphasized while the root cause was obscured. Nutrition education too was dislodged from its ecological and socio-cultural moorings and concentrated instead on 'selling' nutritional disorders, prescriptions and their cures⁷ Nutrition scientists now talked of the high incidence of protein deficiency among people and advocated the use of animal protein, thus creating a market for the protein food industry. The same was true for baby food peddled by food MNCs like Nestle and other food chains. The preoccupation of these institutions with research has divorced them from the ecological, sociological, socio-economic and other factors that impinge upon the nutritional status of a people. The situation today is no different on its basic premises except that under the WTO regime industrial agriculture and the production and trade in food globally is being fine-tuned for mass consumption in the South regardless of their nutritive content, need and implications for human health and the environment.

Little wonder then undernutrition in India came to be perceived as a medical problem requiring hospital-based medical interventions for cure and rehabilitation. These interventions only rarely stressed the relevance of antecedent factors such as poverty, even though they were well known. As early as 1876, Dadabhai Naoroji had estimated the level of poverty in India using food intake statistics and calculating what it cost to buy foods adequate in calories and proteins. Since then various approaches had been examined in tackling the problem of malnutrition with three approaches getting established by the 60s viz., the agricultural approach, the feeding programmes for preschool and school-going children and pregnant and lactating women and the approach called the 'protein gap theory'.

The first approach viewed malnutrition, as a problem of inadequate food supply in the national aggregate and thus the advocacy to increase food production

became a major priority. It coincided, not accidentally, with the launching of the so-called Green Revolution to boost food production to (supposedly) eradicate mass hunger once and for all. The second approach was in recognizing the problem of maldistribution of food among the population, the implementation of large-scale feeding programmes would take care of the residual problem in a short space of time. The third approach involved in focusing in developing better protein quality in farm crops, and protein-based supplements. These three broad approaches formed the core of later integrated efforts that began to evolve through accumulated knowledge about the multiple cause of malnutrition and got mirrored in the country's 5-Year Plans.

Since then, long debates over whether it is calorie or protein insufficiency that is the root cause of malnutrition have taken place. Attention was initially focussed on protein deficiency alone. Estimates of the extent of malnutrition revolved around a mechanistic view of measurement in terms of protein/calorie consumption and relating this to the allowance recommended by various national and global agencies like the FAO, World Bank, among others, that is highly questionable and Eurocentric. Nutrition scientists being particularly vulnerable to manipulation by these market forces are in turn hand in glove with political forces. For instance, this diagnosis of malnutrition had resulted in a huge market for so-called tonics and other spurious supplements. Similarly with coconut oil that had been replaced by powerful industries promoting refined edible oil. Or, the case of common salt that is being displaced by the so-called refined or free-flow iodized table salt unnecessary for urban consumers but an essential need in iodine-deficient regions but where the poor lack purchasing power.

The crucial issue here, however, is that a large majority of Indians especially women do not get enough to eat. As mentioned in the earlier section multifarious factors are at the root of malnutrition. The deteriorating health of women and children is related to such crucial factors as food consumption, land use and food production patterns.⁴ Most study and research reports on women – National Institute of Nutrition (Hyderabad), the National Family Health Survey (Mumbai), the National Sample Survey – indicate that poverty and lack of food first hits the women of the household. They are the first one ready to forgo their share in the food. Even after 55 years of Independence, India has failed to ensure access to productive livelihoods and food for all. In situations like drought and epidemics the situation worsens. Caste and gender discrimination that is ingrained in society and which has a bearing upon livelihood and food access further exacerbates this situation making it imperative for a nutritional security system that provides vulnerable groups especially women and children with physical and economic access to a balanced diet, safe drinking water and

proper sanitary facilities and arrangements. It is essential therefore to demystify the whole issue of nutrition and unravel some of the claims as it applies particularly to gender and realities in the South.

MYTH: *Undernutrition is one of the major causes of underdevelopment in the South.*

FACT: Undernutrition is a symptom rather than the cause of underdevelopment! The genesis of this myth goes back to the 70s characterized by the nutritionists who suggested that low food energy was the cause of low work output and tardy economic development. That is, there was a severe lack of the essential proteins in the diet. This paradigm was subsequently adopted by the then Indian government² who maintained that "unless immediate steps are taken to supplement food intakes...backed by massive food aid and family planning, the economic and social development of the people is likely to be completely arrested". This has led, eventually, to massive supplementary school feeding programmes which, however, failed to demonstrate any significant impact. It was an over-simplified solution to a complex problem. When available data was examined, no clear evidence was found to support the thesis that diet consumed lacked the minimal quantities of protein. Instead it was noted that the "... dietary problem is more often due to inadequate energy which causes the body to catabolise the protein eaten or due to additional stress from a communicable disease insult which causes the body to catabolise up to twice its normal protein need".² Furthermore, there is no correlation between the quantitative level of food intake and productive work output. In fact, the poor often work much harder than the rich!

Thus, the approach of food supplementation programs is the answer to neither underdevelopment nor even malnutrition. It is at best a palliative. Besides, merely dumping food at school children is, 'inter alia', not enough but also a poor use of limited resources. Moreover, the provision of food at the individual level would be effective if anorexia is resolved first, if recuperation from illness is achieved and if the child is removed or protected – at least temporarily – from his degraded environment. However, nutritional recuperation is required in special cases, for instance, for malnourished children and for those at high risk, that is, when they are wasted" (wasting is defined as a deficit of weight for height greater than 20 percent). Thus, energy-protein malnutrition will persist or even recur with greater severity after dumping food unless the basal social and biological conditions leading to growth retardation are corrected..."²

A related myth viz., those children who were hospitalized during infancy for malnutrition had low IQ scores when they reached school age. This myth was however exploded in subsequent studies in the 70s, which showed that while undernutrition in early life

could directly retard brain growth and alter brain structure, this did not in itself affect mental development. These studies also indicated that it was only when undernourished children were also deprived of love and understanding, security and creative pursuits, they showed symptoms of abnormal behavior. Moreover, as experiences of community workers working with street children show, children despite growing up in a hostile environment of poverty, misery and cultural deprivation tended to develop normally and scored well in the so-called IQ tests when exposed to congenial living and working conditions.

Whilst such studies convincingly disprove the myth that under-nutrition leads to mental retardation they also at the same time made use of to show that children from poor classes are abnormal. This is because it is believed that such children lack access to a rich and stimulating environment. However, expressions like 'IQ', ('juvenile delinquency' and the like) mirror the socio-cultural prejudices and bias of western society. Social researchers who hail from cultural and western-oriented backgrounds are at diapodes to those from the South. Such studies naturally judge and measure the poor from their own criteria and yardsticks. This explains the warped perceptions on health of the poor in the South.

MYTH: *The application of the international growth standards to assess malnutrition is the explanation behind India's high levels of child malnutrition.*

FACT: As the above makes it very clear this claim is baseless!

This claim is related to another fallacious point that because of their biological and genetic makeup Indian children do not normally grow as fast or as large as children in other countries do. However, extensive studies by the Nutrition Foundation of India have established that global standards of height and weight apply to all Indian children as well. And the growth patterns of Indian children who are well fed and well looked after are similar to those of adequately nourished children in other parts of the world, no matter where they are born – in New York, New Delhi or New Zealand.

MYTH: *Poor health policies and delivery systems, poor income and poor quality of food intake including cultural-behavioral customs and dynamics are also the major factors behind the high rates of malnutrition especially among Indian and South Asian women.*

FACT: To corroborate the points made in Part I, this claim as far as India is concerned, is largely inapplicable and invalid! That is, the poor record of nutritional achievement in India and South Asia does not fit the pattern generally valid elsewhere, outside the country.

Recent studies indicate that the missing variable that impacts child nutrition in India is the incidence of low birth weight babies i.e., babies born at full term with a body weight of less than 2.5 kg. South Asians fare particularly badly with regard to this variable. 1 in 3 newborns of this region is low birth weight baby, as against the average of 1 in 5 in other countries of the South. Africa has a lower incidence of low birth weight babies – 1 in 6, which is just about half of the incidence in South Asia.

The genesis of low birth weight can be explained by examining the link between low birth weight with the nutritional level of the child and adult population. That is, the occurrence of low birth weight is mainly a mirror of poor maternal nutrition i.e. women who experience greater nutritional stress during pregnancy tend to bear more low birth weight babies. These babies are born with an initial handicap, having been deprived of adequate nutrition in the foetal stage. The consequence of this handicap can persist for a long time. Inadequate foetal nutrition hampers the development of their immunological competence, which is why neo-natal death is far more common among these babies than normal babies. Those who survive with a defective immune system fall prey to frequent infections in their early childhood and get trapped in the vicious cycle of the nutrition-infection nexus. The deprivation of energy and other nutrients that follows from this cycle retards their physical and mental growth. Thus, a society with a greater prevalence of low birth babies is likely to be one that suffers from a greater degree of child — and eventually adult — malnutrition, other things being the same.¹ But this begs the question as to what is the explanation in the very high level of malnutrition in South Asia?

As mentioned above, low birth weight is essentially a manifestation among women of reproductive age is likely to cause low birth weight as well. This brings us back to all the variables imbedded in this claim, under question, which indeed can have adverse impact on maternal nutrition. An additional factor is that female age at first marriage, because it is well known that very young mothers tend to produce more low birth weight babies. But these factors fail to explain why the incidence of low birth weight is so high in South relative to the rest of the world. The explanation behind this dilemma is that there are some aspects of maternal nutrition in South Asia responsible for the exceptionally high incidence of low birth weight in South Asia, which in turn is responsible for the very high level of malnutrition in this region, namely, that their mothers happen to suffer from a peculiar disadvantage not experienced elsewhere. South Asian women generally get a raw deal in the allocation of food and healthcare facilities within the family household. (Cf. also pg 5) The result of such discrimination is manifested in higher morbidity, and eventually higher mortality, of women relative to men. This is what accounts for what

Prof. Amartya Sen called 'missing women' (Sen 1990) — the fact that there are far fewer women per hundred men in this region than in any other region of the world.

Age-specific comparisons of male-female mortality shows that the disadvantage suffered by South Asian women is not a simple biological phenomenon that begins at birth. Neonatal mortality, i.e., mortality within the first week of life, is in fact smaller for females even in South Asia. The disadvantage actually begins to emerge later; by the time the child becomes one year old, the mortality pattern begins to get reversed. This is the time when external food and healthcare become much more important than mother's milk for the nutritional well being of a child.

Insofar as the treatment of girls is indicative of the treatment of women in general, this is clear evidence of discrimination suffered by Indian and other South Asian women. But a more direct evidence of the predicament of adult women is the high incidence of anemia among pregnant South Asian women. Further, there is also the evidence provided by the number of effective life-years lost due to illness-related disability. For women of reproductive age, this loss is generally higher than for men of the same age group because of the stress women inevitably suffer during pregnancy and lactation, but in South Asia the gap appears is unusually large. For instance whereas in the South as a whole females of reproductive age tend to lose effective life-years 30 per cent more than men, in India they tend to lose 60 per cent more.¹

However, it must be noted that the etiology is much more complex. The etiology and correction of some intrauterine growth retardation still puzzles physicians the world over. For instance, the weight gain of a child is adequate during exclusive breastfeeding, despite his low birth weight. With the commencement of weaning — process extending for 1 to 3 years in villages — the child underwent progressive malnutrition resulting primarily from recurrent infections. Most employees in hospitals and health centres or conducting nutrition surveys would classify such a child as malnourished if seen at any point after weaning began². Little or nothing would be known about his past, even if the mother is interviewed, as language and other cultural barriers will frustrate interpretation. The cause of the child's malnutrition will probably be accepted as "lack of food".

In the meanwhile new findings continue to emerge making the situation more complex. For instance, a John Hopkins study of nearly 22,000 infants born over a 11-year period, found that only 1 in 12 babies born with seizures met the American College of Obstetrics and Gynaecology's criteria for neurological diseases linked to the birthing process, a low Apgar score (a measure that identifies those in resuscitation) 5 minutes after birth, and a high level of acid in the umbilical cord — a measure of oxygen deficiency. It

revealed that neurological problems in these infants are not always related to the delivery process but could be due to many other factors like the mother's medical history!

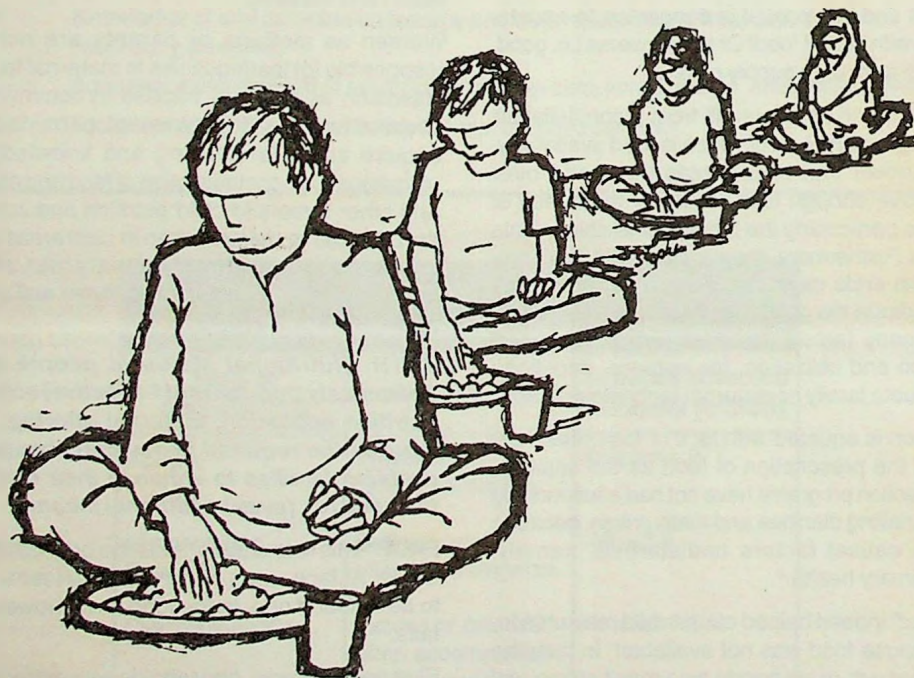
MYTH: *The high status women and children enjoy in Indian culture and civilisation rules out any assumption of differences in the nutritional status between women and children.*

FACT: Micro level studies⁸ however shows that the contrary is the case. That is, the diets of female children and women in India are inadequate as a result of discrimination in intra-household food allocation. Discrimination against females begins during infancy. Starting with breast-feeding, infant girls receive less milk, less frequently and for shorter duration than boys. Where there is already one surviving child, the girl child has a greater mortality risk. Weaned earlier, they do not get the required quantity of food, predisposing them to malnutrition. These studies (again) have shown this problem to continue through childhood and adolescence. In times of food scarcity, women's access to food is further circumscribed. These studies (illustrated above as well), of the nutritional status on

adults of different socio-economic backgrounds also reveal significant male/female differences with poor women being the most deprived. Females are also discriminated against in terms of quality of food available to them. Another study (Dasgupta, 1987) found that fewer than 4 males in Punjab receive larger quantities of cereals, fats, milk and total calories than females. A major consequence of such discrimination is that girls fail to achieve full growth potential. Other data has since shown that between 12 and 33 per cent of women in the 20 to 24 age groups have heights less than 145 cm and between 15 and 29 per cent have weight below 38 kg. Below this level women are at risk from obstetric complication and tend to produce low birth weight babies, thus furthering the vicious cycle. One study showed that 35.5 per cent incidence of low birth weight babies among poor short women, while a 24 per cent incidence was found among poor women over 145 cm in height.

In 1996, in a paper, "The Asian Enigma"⁹ the late Prof. V. Ramalingaswami, physician and nutritionist, and his colleagues had concluded that the single most important factor behind the persistence in child malnutrition in India and South Asia is the subordinate

Women and Nutrition



Who Eats First?

status of women in these regions; a factor responsible in hamstringing their ability to nurture their children. It is also the factor explaining the prevailing disparity in children's nutrition between Indians and Africans.

MYTH: *Motherhood being the most crucial period in a child's health, the focus on expectant and nursing mothers ensures the health of the child in any Maternal and Child Health Programme.*

FACT: While it is true that the child's health is dependent upon its mother this claim is no justification for concentrating on a woman's health only during motherhood. For, such a view appears to be insensitive with what happens to the woman before, between or after her pregnancies. For instance, as shown above, the incidence of iron deficiency anemia is high among Indian women generally. Yet, anemia assumes an importance in maternal services only because of its relationship to still-birth and deaths during pregnancy.¹⁰ Such a myopic view of the health problem of women mirrors the mindset of especially "mainstream" society that includes the medical sciences and disciplines whose focus is only the woman's reproductive function and not the other equally crucial aspects of her life. In recent years there has been an added insult (to injury) with the growing practice of "amniocentesis", a modern form of female infanticide. (Cf. FAM #3, 1995)

MYTH: *Lack of food is the cause of child malnutrition in India.*

FACT: First and foremost, it is dangerous to equate malnutrition with lack of food! Or the converse i.e. good nutrition with adequate supply of food.

Good nutrition and health result from a constellation of interacting factors, one of which is food availability. It is well known that households the world over generally have enough food to satisfy the needs of most people particularly the highly vulnerable infants and toddlers. Furthermore, many mothers not only know how to make ends meet but more importantly they know to maximize the good use of available resources. However, many factors interfere with proper food consumption and utilization, for instance, infections and inadequate family or maternal technology.

If malnutrition is equated with lack of food, the likely outcome is the prescription of food as the solution. Food intervention programs have not had a resounding effect on curtailing diarrhea and malnutrition, because they leave causal factors undisturbed, namely, deficient primary health.⁸

"Lack of food" indeed helped cause child malnutrition, but not because food was not available! In fact, the child does not eat, or ate poorly, as a result of frequent and recurrent infectious diseases often accompanied by anorexia. Actually, the longitudinal study showed that most children experience chronic recurrent diarrhea and other illness during one-third or more of their first 3 years of life.⁸

The effect of diarrhea and other infectious diseases is multiple: anorexia, vomiting, impaired digestion, impaired absorption, metabolic alterations and increased nutrient needs and wastage (See pg. 3) To illustrate one aspect of the impact of infection on the nutritional state, is what is referred to as the negative effect of two hormonal substances⁹ – *Interleukin 1* and *cachetin* (tumor necrosis factor) – both released by body monocytes under the stimulus of infectious or other stressful factors. These hormones account for formidable actions: in the brain, the beginning of fever and anorexia; in muscle, the breakdown of proteins and loss of tissue mass; in liver, the synthesis of abnormal macroglobulin; among others. These phenomena represent a host defense against infection – at a high nutritional cost. Even with mild infections, the body loses cells, plasma, electrolytes, amino acids and vitamins. Infected children may not accept food, even of the best quality. The paradox of "hungry children who cannot eat" actually exists. Lack of appetite in children is a common complaint of mothers worldwide.

Finally, nutritional deprivation also frequently relates to deficient "maternal technology" (i.e. family technology, See Box on pg.7) That is, cultural and technological endowment, and the application of knowledge skills on prevention and control (development of sanitary infrastructure and medical services) are also equally relevant as socio-economic factors in explaining the dramatic improvement in health and survival.

Women as mothers or parents are not entirely responsible for inadequacies in maternal technology, inasmuch as they are trapped in communities and social structures that have not permitted them to acquire an understanding and knowledge of the ubiquitous fecal contamination of food and environment and other threats to child nutrition and survival. On the other hand, many women in rural areas and urban slums possess effective maternal skills and technologies, and their children thrive well despite the odds and hardships.

MYTH: *Nutritional status of people improves enormously through (cost-effective) schemes like nutrition education, maternal tutoring, etc., that induces the required behavioral change thereby enabling families to enhance their diets without the need for (even) additional income.*

FACT: This formulation¹⁰ was the brainchild the World Bank! At face value and in the short term it appears to be a sound one. In the long term, however, it often fails.

First and foremost, households with extreme cases of malnourished members especially children are frequently deprived of other essential needs let alone family members having the purchasing power. Reports from time to time show that a nutrition education was effective only in those households that also received

a good subsidy. Apart from the other illustrations elsewhere in this issue, deaths of Adivasi children in the Amravati district of Maharashtra due to malnutrition had been reported during July-August 1993. However, the then Government of Maharashtra had stopped the supply of nutritious 'sukhdi' (a mixture of wheat flour and jaggery) given as supplementary diet to school-going children. Further, the Adivasis had also been deprived of their traditional livelihood because of severe restrictions of their entry in their traditional forest habitats to collect forest products. Deaths of Adivasi children between July to September further increased in the monsoon season because the water was polluted.

Several Adivasis starved, as they could not get any work. Discontinuing food subsidies to these and other vulnerable groups becomes a matter of life and death. In such a situation, "nutrition education" and "maternal tutoring" evidently becoming meaningless exercises. Thus, while SAP imposed programs by the World Bank and other global institutions result in more severe impoverishment and lack of essentials especially food, efforts continue to be made by these very agencies to cloud the issue, claiming that education or management principles and skills will uplift — via the trickle down theory — the health status of the rest of society.

Good Maternal (Family) Technology⁸

- ✧ Adequate technique to store and handle water for drinking and cooking;
- ✧ Correct handling and disposal of human and animal feces;
- ✧ Hand-washing and use of soap or ashes before handling children and preparing food; sufficient hand-washing after using the toilet;
- ✧ Successful breastfeeding and adequate food supplementation during weaning, and during illness and convalescence; knowledge about adequate mixing of traditional foods and child-feeding technique;
- ✧ Capacity to recognise dangerous signs and symptoms of disease, and seek prompt treatment;
- ✧ Knowledge of oral dehydration therapy and other resources to treat diarrheal and respiratory diseases;
- ✧ Acceptance and demand of health care; prenatal care, immunisation, antibiotic treatment;
- ✧ Acceptance of safe sex and adequate reproductive behavior.

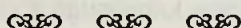
**Types and Effects of Malnutrition,
and Number Affected Globally, 2000**

Type of Malnutrition	Nutritional Effect	Number Affected Globally (billion)
Hunger	Deficiency of calories & protein	At least 1.2
Micronutrient Deficiency	Deficiency of vitamins & minerals	2.0 – 3.5
Overconsumption	Excess of calories often accompanied by deficiency of vitamins & minerals	At least 1.2

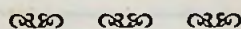
Note: Hunger and overconsumption correspond to underweight or overweight populations. There is considerable overlap between micronutrient deficiency and other forms of malnutrition.

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Note: The Previous issue of FAM was inadvertently misnumbered.
It should be read as **No. 10-2001** and not **No. 10-2002**.



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