Essential Interventions for Reducing Malnutrition in Infants and Young Children in India: A Leadership Agenda for Action

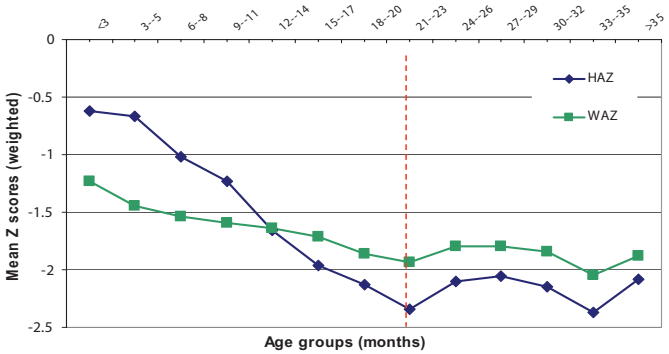
Summary

This is a summary of a document prepared and released by the Coalition for Sustainable Nutrition Security in India.

Malnutrition remains a major threat to the survival, growth and development of Indian children[1]. The latest National Family Health Survey (NFHS-3, 2005-06) shows that 25 million Indian children – 20 per cent of children under five years old - are wasted (acutely malnourished) and 61 million children – 48 per cent of children under five years old - are stunted (chronically malnourished).

Rates of child malnutrition in India are among the highest in the world. The prevalence of child wasting in India (20 per cent) is twice as high as the average prevalence of child wasting in sub-Saharan Africa (9 per cent) and ten times higher than that in Latin America (2 per cent). The prevalence of child stunting in India (48 per cent) is more than four times higher than the prevalence of child stunting in China (11 per cent). More worrisome, the nutrition situation of Indian children has not improved significantly over the last decade. For example, according to NFHS-3, there has only been a very slight 0.5 per cent annual decrease in the prevalence of underweight children over the past six years.

Figure 1: India, child weight-for-age (WAZ) and height-for-age (HAZ), by age



Source, NFHS-III 2005-06

Child malnutrition in India happens very early in life. NFHS-3 shows that 56 per cent of severe wasting happens before the age of two. Their nutritional status deteriorates rapidly over the first two years of life (Figure 1), and once this damage is done, catch up and recovery are almost impossible.

Therefore, improving the quality of foods, feeding practices, and the nutrition situation of children in the first two years of life, represent a critical window of opportunity to break the inter-generational cycle of malnutrition. If this critical opportunity is missed, child malnutrition will continue to self-perpetuate: malnourished girls will become malnourished women, who give birth to low birth weight infants, who suffer from poor nutrition in the first two years of life. The best opportunity to break this vicious inter-generational cycle is to concentrate efforts on improving the nutrition of infants and young children from conception through the first two years of life.

The Coalition for Sustainable Nutrition Security in India, chaired by Professor M. S. Swaminathan, is a group of public and private sector leaders who have united in an effort to improve nutrition security, ensuring that every Indian citizen has access to a balanced diet, safe drinking water, environmental hygiene, sanitation and primary health care. The Coalition has reviewed, endorsed and released this Leadership Agenda for Action to promote policy, programme and budgetary focus on the most essential interventions needed to reduce malnutrition in this most critical group: infants and young children (see text box "Developing the List of Essential Interventions").

[1] For the purpose of this paper, the word 'malnutrition' refers to nutritional deficiencies in children as measured by wasting, stunting, underweight, micronutrient deficiencies and/or anaemia.

The Coalition calls for an increased policy, programme, and budgetary focus on ten proven interventions that can dramatically reduce malnutrition in infants and young children, as follow:

1. **Timely initiation of breastfeeding within one hour of birth:** Every newborn starts breastfeeding within one hour of birth to take advantage of the newborn's intense suckling reflex and alert state and to stimulate breast milk production. Good breastfeeding skills - including proper positioning and attachment - are established to increase the newborn's suckling efficiency, mother's breast milk production, and infant's breast milk intake.
2. **Exclusive breastfeeding during the first six months of life:** Every infant is exclusively breastfed in the first six months of life. The infant is fed only breast milk and is not given any fluids, milk, or foods, not even water. Exclusive breastfeeding, with frequent, on-demand feedings ensures maximum protection against malnutrition, disease, and death, while contributing to child spacing and lower fertility rates.
3. **Timely introduction of complementary foods at six months:** Every infant starts receiving complementary foods by the beginning of the seventh month of life, while breastfeeding continues until 24 months and beyond. By the beginning of the seventh month of life, breast milk alone cannot meet an infant's energy and nutrient requirements. At this time complementary feeding should begin. Introducing complementary foods before is both unnecessary and dangerous.
4. **Age-appropriate complementary feeding, adequate in terms of quality, quantity and frequency for children 6-24 months:** Every child 6-24 months old is fed age-appropriate, energy and nutrient-dense, diverse complementary foods with increased quantities, nutrient density, and frequency as the child increases in age. Child feeding is responsive and active. Children are given prophylactic iron and folic acid supplements to prevent anaemia. Hygienic practices are followed when feeding children.
5. **Safe handling of complementary foods and hygienic complementary feeding practices:** Every child 6-24 months old is fed using safe handling (preparation and storage) and hygienic feeding practices of complementary foods by – among others - washing caregivers' and children's hands before food preparation and eating, serving foods immediately after preparation, using clean utensils, and avoiding feeding bottles.
6. **Full immunisation and bi-annual vitamin A supplementation with deworming:** Every child is protected from vaccine preventable diseases through a full course of immunisation delivered through the routine immunisation system at set times in the child's first year of life. In addition, all children 6-59 months old are further protected from mortality, morbidity, and malnutrition with preventive vitamin A supplementation and deworming twice yearly.
7. **Frequent, appropriate, and active feeding for children during and after illness, including oral rehydration with zinc supplementation during diarrhoea:** Every child is fed, actively and frequently, with age-appropriate and nutrient dense foods, during and after illness, while frequent, on-demand breastfeeding continues to increase fluid and nutrient intake. Children with diarrhoea also receive appropriate rehydration therapy including a full course of zinc supplements as per national guidelines for the treatment of diarrhoea.
8. **Timely and quality therapeutic feeding and care for all children with severe acute malnutrition:** Every child with severe acute malnutrition is provided with therapeutic foods and care in a timely manner, for life-saving rapid weight gain and recovery. Care for children with severe acute malnutrition requires early case detection (before the development of medical complications), optimal therapeutic feeding and care protocols, and access to therapeutic foods, including ready-to-use therapeutic foods.
9. **Improved food and nutrient intake for adolescent girls particularly to prevent anaemia:** Every adolescent girl is protected against nutritional deficiencies and anaemia through dietary counselling, weekly iron and folic acid supplementation, twice yearly (six months apart) deworming prophylaxis, and life-skills development to avoid early marriage and early pregnancy.
10. **Improved food and nutrient intake for adult women, including during pregnancy and lactation:** Every woman has access to sufficient quality and quantity of food, including during pregnancy and lactation. Every pregnant woman and lactating mother takes iron and folic acid supplements daily to reduce maternal anaemia and improve pregnancy and lactation outcomes. Universal regular consumption of salt with adequate levels of iodine (> 15 ppm) is required, especially for pregnant women, in order to prevent foetal brain damage associated with iodine deficiency.

This paper also identifies specific opportunities for taking these ten essential interventions to national scale so as to reach every child, everywhere in India, to achieve an unprecedented impact on reducing child malnutrition and its associated poor health, growth, development and waste of human capital. This will also have the impact of reducing poverty and improving economic growth. The most important opportunities identified are listed below:

- Promote an evidence-based approach to the design and revision of key nutrition programmes, considering replication of proven interventions and programmes from within and outside of India.
- Focus on evidence-based, low-cost, high-impact interventions and deliver them at state-level for maximum impact in reducing the burden of malnutrition.
- Develop and expand the national policy framework to include 1) deworming for children 1-5 years of age, and provision of immunisation and vitamin A supplementation, 2) provision of weekly iron and folic acid supplementation, twice yearly deworming prophylaxis and nutrition and life-skills counselling for adolescent girls, and 3) standard, state-of-the art feeding and care for children with severe acute malnutrition, including the indigenous production and provision of ready to use therapeutic foods.
- Improve the performance of primary level providers and counsellors through improved results-focused training, communications materials, job aids, motivation, and supportive supervision.
- Harmonise nutrition communication guidelines and core messages across ministries and programmes.
- Initiate denominator-based planning and monitoring to expand coverage, starting with community-based micro-plans, anchored in good mapping of pregnant mothers and children 0-23 months old in the community.
- Promote monthly coordination and convergence meetings between Ministry of Health and Family Welfare (MHFW), Ministry of Women and Child Development (MWCD), development partners, and other non-governmental organisations (NGOs) as appropriate, especially at district and block level.
- Support and expand Village Health and Nutrition Days to deliver these essential nutrition interventions.

India's leadership in many fields is recognised globally. The questions now are - Can India show its strength and leadership in improving the nutrition and well being of its children? Can India ensure that its economic successes are shared more equitably so that none of its children suffer from malnutrition? Can India uphold the national and international commitments it has made to the basic rights of children to nutrition and life?

The evidence and expert opinion indicate that implementing these ten Essential Interventions could halve the rates of child malnutrition in India over the next five years. Now is the time to combine the existing technical knowledge and political will to make history for children in India.

Developing the List of Essential Interventions

In February 2008, the Coalition for Sustainable Nutrition Security in India requested an Expert Task Force to identify the most important evidence-based, cost-effective interventions to reduce malnutrition in infants and young children (0-24 months old) in India. The Expert Task Force, chaired by UNICEF, adopted the following process:

- Inviting a wide range of national and international experts and stakeholders, representing different perspectives, to contribute as Expert Task Force members and/or reviewers;
- Agreeing on the goal, objectives, methodology, and expected results of the Expert Task Force deliberations and work;
- Reviewing existing global and national epidemiological and programmatic evidence;
- Building consensus on the most important evidence-based, high-impact, cost-effective interventions with the greatest potential to make a major contribution to the reduction of malnutrition in infants and young children in India; and
- Identifying the intervention (referred to as the "what?"), the rationale (the "why?"), and the existing opportunities for scaling up (the "how?") for these essential interventions.

The Coalition requested USAID to support a Secretariat, which provided administrative and logistical support to the Expert Task Force. All the members of the Expert Task Force declare that the best interests of Indian children has been the one and only guiding principle in their contribution to this Leadership Agenda (see Attachment 1 for names and affiliations of the members of the Expert Task Force).

Following this careful and participatory process, the Expert Task Force submitted its recommended Leadership Agenda for Action to reduce malnutrition in infants and young children in India to the Coalition. The Coalition reviewed and endorsed this Leadership Agenda in September 2008.

List of Expert Task Force Members

S. No.	Name and Organisation
Chair	
1.	**Victor M. Aguayo (Dr)** UNICEF
Members	
2.	**A.K. Gopal (Dr)** National Institute of Public Co-operation and Child Development
3.	**Anne Philpott (Ms)** DFID India
4.	**Ashi Kathuria (Ms)** The World Bank
5.	**Deoki Nandan (Dr)** National Institute of Health and Family Welfare
6.	**Dora Warren (Ms)** CARE India
7.	**G.N.V. Brahmam (Dr)** National Institute of Nutrition
8.	**Luc Laviolette (Mr)** Micronutrient Initiative
9.	**Minnie Mathew (Dr)** World Food Programme

S. No.	Name and Organisation
10.	**Nita Bhandari (Dr)** Society for Applied Studies & Action Society for Essential Health and Training
11.	**Panna Choudhury (Dr)** Maulana Azad Medical College
12.	**Purnima Menon (Dr)** International Food Policy Research Institute
13.	**Rajan Sankar (Dr)** Global Alliance for Improved Nutrition
14.	**Rajesh Mehta (Dr)** World Health Organisation
15.	**Rajiv Tandon (Dr)** Office of Population, Health & Nutrition USAID, India
16.	**Sanjay Zodpey (Dr)** Public Health Foundation of India
17.	**Shashi Prabha Gupta (Dr)** Consultant (ex- Ministry of Women and Child Development)
18.	**Usha Kiran (Ms)** Bill and Melinda Gates Foundation

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For the full report or further information, contact :
Secretariat
Coalition for Sustainable Nutrition Security in India
A 2/35, Safdarjung Enclave, New Delhi - 110029
Phone : 011-46019999, Fax : 011-46019950, Email: csnsi@intrahealth.org