The Slippery Slope of Child Feeding Practices in India

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National Family Health Survey 4 (NFHS-4) data shows a ten percentage point decline in timely complementary feeding rates in the backdrop of increases in breastfeeding indicators. There is large-scale decline in this indicator across all regions and states. An understanding of social determinants is critical for generating transformative ideas to address these challenges.

Keywords: *Complementary feeding, Decline, National health surveys, Social determinants.*

The recently released National Family Health Survey 4 (NFHS-4) data brings our focus on the decline in timely complementary feeding rates, from 52.6% (2005-06) to 42.7% (2015-16), in the backdrop of increase in exclusive breastfeeding (46.4% (NFHS-3) to 54.9% (NFHS-4)), and decrease in underweight and stunting levels [1]. We unpack some of the nuances of data related to Infant and Young Child Feeding (IYCF) and highlight key social determinants of the problem. This assumes relevance in the context of the significance of 'critical window of opportunity' for prevention of growth faltering and improving nutritional status of under-five children.

KEY IYCF INDICATORS FROM NFHS-4

The NFHS-4 reported that merely 9.6% children aged 6-23 months receive an adequate diet; this includes 14.3% of non-breastfeeding children and 8.7% of breastfeeding children; urban indicators are better in most cases by a few percentage points. There is no comparable data for these indicators in the previous round. Comparison is possible for another indicator: children (6-8 months) receiving solid or semi-solid food and breast milk (***Table* I**).

There is large scale decline in this indicator across all regions and states, barring a few exceptions (Manipur, Nagaland, Chhattisgarh and West Bengal). In 12 states (Haryana, Sikkim, Meghalaya, Assam, Mizoram, Arunachal Pradesh, Bihar, Jharkhand, Odisha, Karnataka, Tamil Nadu and Kerala), the decline is below the national average. Among the Empowered Action Group (EAG) or high focus states, Bihar (23.8%), Jharkhand (13%), Odisha (10.5%) and Assam (10.2%) reported the maximum declines. Notably, the largest declines were reported from the Southern states (ranging from 13% to 30% in Karnataka, Tamil Nadu and Kerala).

TABLE I CHANGES IN IYCF INDICATORS FROM NFHS-3 TO NFHS-4 (SELECTED STATES)

States		*Children receiving solid or semi-solid food and breast milk (%)*		*Trend (%)*
		NFHS-3 (2005-2006)	*NFHS-4 (2015-2016)*	
India		52.6	42.7	-9.9
North	Rajasthan	38.7	30.1	-8.6
	Punjab	50.9	41.1	-9.8
	Uttar Pradesh	41.2	32.6	-8.6
North-East	Sikkim	85.4	61.8	-23.6
	Manipur	77.4	78.38	1.4
	Arunachal Pradesh	80.2	53.6	-26.6
West	Gujarat	54.1	49.4	-4.7
	Maharashtra	45.5	43.3	-2.2
Central	Madhya Pradesh	46	38.1	-7.9
	Chhattisgarh	49	53.8	4.8
East	Bihar	54.5	30.7	-23.8
	Jharkhand	60.2	47.2	-13
	West Bengal	47.1	52	4.9
	Odisha	65.4	54.9	-10.5
South	Karnataka	69.7	46	-23.7
	Tamil Nadu	81.2	67.5	-13.7
	Kerala	93.9	63.1	-30.8

Source: International Institute of Population Sciences (IIPS). National Family Health Survey, India: Key Findings from NFHS-4 (2015-16); IYCF: Infant and young child feeding; NFHS: National family health survey.

State level indicators in the current round point towards low rates of optimal child feeding practices, both in states that have witnessed some of the largest declines

as well as some of those with improvements, with the exception of Tamil Nadu and Kerala that have higher rates despite an overall decline (***Table* II**).

UNRAVELING THE SOCIAL DETERMINANTS

IYCF is influenced by multiple factors: early initiation, delay or inadequacy (consistency, number of feeds and quantity), practice of the popular notion of 'feeding on demand', autonomy of decision-making, poor control over time spent on care and feeding, knowledge gap of mother/caregiver on complementary feeding, and the need to resume work by mother. Mothers' engagement in household chores, livelihood and responsibility of children leave them with little time and choice to cook and prepare age-appropriate complementary foods [2]. Mothers engaged in income generation face greater difficulty in infant and young child feeding while caregivers (siblings, elders or neighbors) are unable to serve as an adequate alternative for care. In absence of support for child care at workplace or an alternative for child care, mothers find it difficult to practice exclusive breastfeeding or timely complementary feeding [2]. Early initiation of complementary feeding is reported among low birthweight and preterm infants [3]. Children are thus often initiated complementary feeding before 6 months of age, and with food that is low in nutrition and diversity but high in calories (packaged/convenience foods). Children are primarily looked after by the caregivers who feed children 'whenever the child is hungry' or 'whenever the child asks for food' [3].

It is amply evident from ***Table* II** that states with high levels of chronic poverty and repeated cycles of male migration have poor IYCF indicators. In households with multiple migration cycles, left-behind (a new and unique vulnerability that is gaining recognition) children face the consequences of early initiation – inadequacy as well as low quality of complementary feeding [4]. The growing number of male migrants and episodes/cycle of migration has led to feminization of agriculture and waged labor, with consequent challenges for childcare and feeding (worse in households where children are left in the care of elder siblings). Over-burdened women get little time for food-gathering (green vegetables, fruits or tubers from commons) or cooking food separately for children, who end up eating diets meant for adults (with little diversity) [5,6].

NO MAGIC BULLETS

Anganwadi Workers (AWWs) and Accredited Social Health Activists (ASHAs) are the frontline workers trained to promote IYCF and counsel caregivers of children. The emphasis during training and the knowledge and focus of the workers is disproportionately on breastfeeding than age-appropriate complementary feeding [7]. This imbalance is partly the product of the promotion of

TABLE II CHILD FEEDING PRACTICES IN KEY STATES (NFHS-4)

	Total children age 6-23 mo receiving an adequate diet (%)	*Children age 6-8 mo receiving solid or semi-solid food and breast milk (%)*	*Breastfeeding children age 6-23 mo receiving an adequate diet (%)*	*Non-breastfeeding children age 6-23 mo receiving an adequate diet (%)*
India	9.6	42.7	8.7	14.3
Bihar	7.5	30.7	7.3	9.2
Jharkhand	7.2	47.2	7.2	7.1
Madhya Pradesh	6.6	38.1	6.9	4.8
Chhattisgarh	10.9	53.8	11.1	8.4
Odisha	8.5	54.9	8.9	5.0
Rajasthan	3.4	30.1	3.4	3.7
Assam	8.9	49.9	8.7	10.8
Uttar Pradesh	5.3	32.6	5.3	5.3
Karnataka	8.2	46.0	5.8	14.4
Kerala	21.4	63.1	21.3	22.3
Tamil Nadu	30.7	67.5	21.4	47.1
Maharashtra	6.5	43.3	5.3	12.2
Gujarat	5.2	49.4	5.8	2.8

Source: International Institute of Population Sciences (IIPS). National Family Health Survey, India: Key Findings from NFHS-4 (2015-16).

breastfeeding that has its roots in the Child Survival and Development Revolution (CSDR) since 1982, followed by later initiatives including the Baby Friendly Hospital Initiative by the WHO and UNICEF –that to a significant extent was shaped by HIV/AIDS concerns. But it also goes deeper than that. Nutrition counseling provided by ASHAs was also reported to be low in some of the key states and their knowledge on complementary feeding was poor [8]. While the ASHA is incentivized for home visits during which she has to counsel and promote complementary feeding, there are no robust monitoring mechanisms or supportive supervision.

Issues of child feeding and its bearing on nutrition may contribute to our understanding on the rising epidemic of 'metabisity' in a life-course perspective. Recent analyses suggest that roles of government, technical agencies, funders, civil society, media and the industry range from being supportive to the issue of IYCF (at best), and unsupportive, or even antagonistic and confrontational (at worst) [9]. On the other hand, there is scant policy attention to inequalities that women face as producers, consumers, and home food managers [10]. Healthworker-based interventions and advocacy for behavioral change, including through the Integrated Child Development Services (ICDS), have made limited impact in rapidly transitioning societies (where men and women make profound adjustments to preferences, ideas and beliefs with consequences for health). The lack of maternity protection and support mandates are nested within larger food insecure environments (chronic, transitory or cycles) that need to be recognized as entitlement failures and addressed urgently in a social justice framework. Transformative ideas are needed that must entail posing critical questions, interpretation and expository writing as well as skill development to enable translating slogans to skills.

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