राष्ट्रीय स्वास्थ्य मिशन

सत्यमेव जयते

Ministry of Health and Family Welfare
Government of India

POSHAN Abhiyaan
PM's Overarching Scheme for Holistic Nourishment
सही पोषण - देश रोशन

Comprehensive National Nutrition Survey

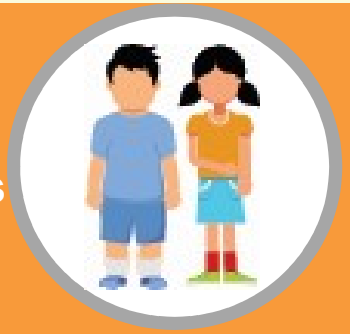
2016 - 2018

Delhi
State Presentation

CNNS
Birth to Adolescence

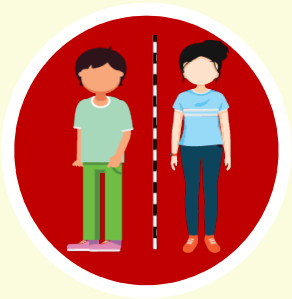
Largest Micronutrient Survey ever conducted: CNNS 2016-18

112,316
Children and adolescents interviewed



51,029
Blood, stool and urine samples collected

2500
Survey personnel in 30 states



360
Anthropometric measurers

30
Microscopists

100
Data Quality assurance monitors

200
Trainers and coordinators

200
Lab technicians

900
Interviewers

360
Phlebotomists

Justification and Objectives

- To assess the prevalence of malnutrition in both children and adolescents with special focus on assessment of micronutrient deficiencies through biochemical measures.
- To identify determinants and associations of various risk factors for anaemia in both children and adolescents.
- To assess biomarkers for hypertension, diabetes, cholesterol and kidney function and their associations with various risk factors for Non-Communicable Diseases (NCDs).

Malnutrition is responsible for 68% of total under five mortality in India*

CINNS Birth to Adolescence

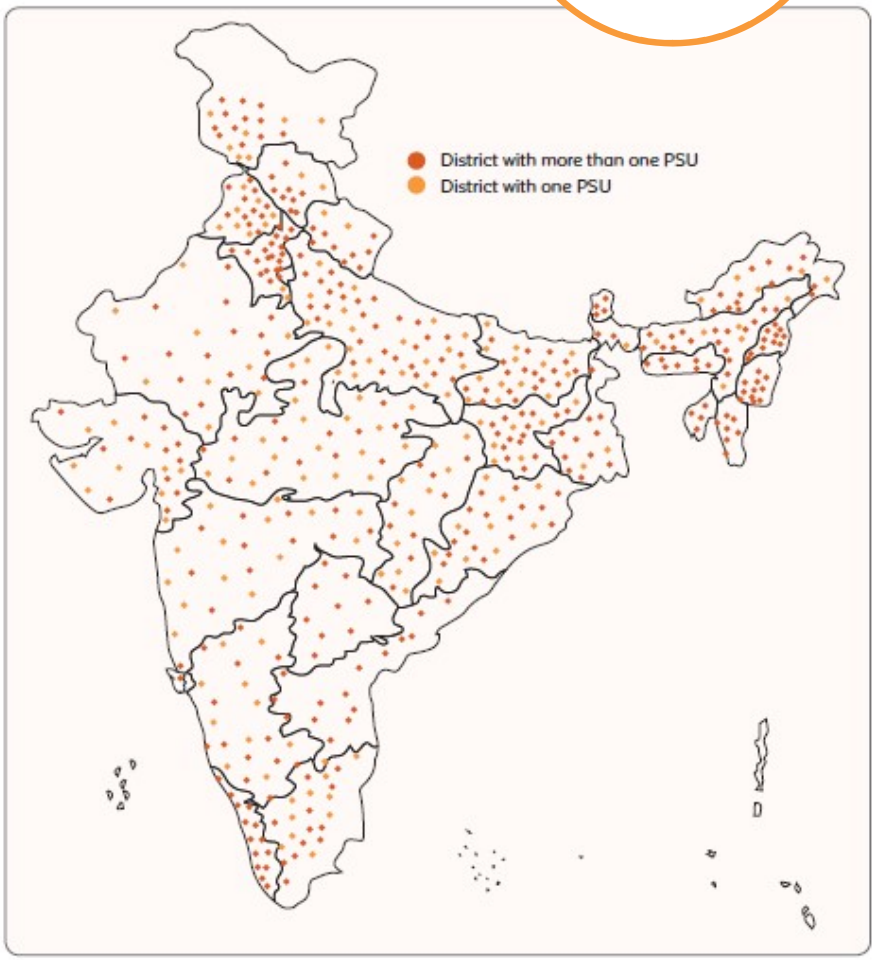
*Soumya Swaminathan, et al. (2019), The burden of child and maternal malnutrition and trends in its indicators in the states of India: the Global Burden of Disease Study 1990–2017. https://doi.org/10.1016/S2352-4642(19)30273-1

Survey Design

CNNS is a cross-sectional, household survey using a multi-stage sampling design.

CNNS covered **2035 Primary Sampling Units (PSUs)** from more than **82%** of all districts from the Census 2011 (516 out of 628 districts) across 30 states:

- 160 Districts- one PSU
- 356 Districts- two or more PSUs



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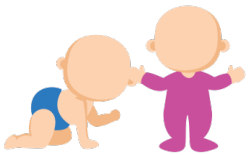
Anthropometry data

	Pre-school children (0-4 years)	School-age children (5-9 years)	Adolescents (10-19 years)
			
Anthropometric measurements	• Height • Weight • Mid-upper arm circumference (MUAC) • Triceps skinfold • Subscapular skinfold (1-4 years)		
		• Waist circumference	

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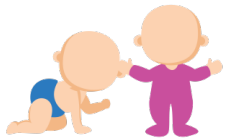
Biochemical indicators - micronutrient deficiencies and NCDs

Indicator Group			
Anaemia and haemoglobinopathies	• Haemoglobin • Variant haemoglobins		
Inflammatory biomarkers	• C-reactive protein		
Protein	• Serum protein and albumin		
Micronutrients	• Iron: Serum ferritin, serum transferrin receptor • Vitamin A: Serum retinol • Zinc: Serum zinc • B-vitamins: Erythrocyte folate, serum B12 • Vitamin D: Serum 25 (OH) D • Urinary Iodine		
Non-communicable diseases		• Blood Pressure • Blood glucose, HbA1c • Lipid profile: Serum cholesterol, LDL, HDL, and triglycerides • Renal function: Serum creatinine, urinary protein creatinine ratio	

Monitoring and Supervision

Three-tiers of Data Quality Assurance

Third Level

- Field work/protocol/training monitoring: by quality control team
- Biological sample quality control : by AIIMS, NIN and US CDC

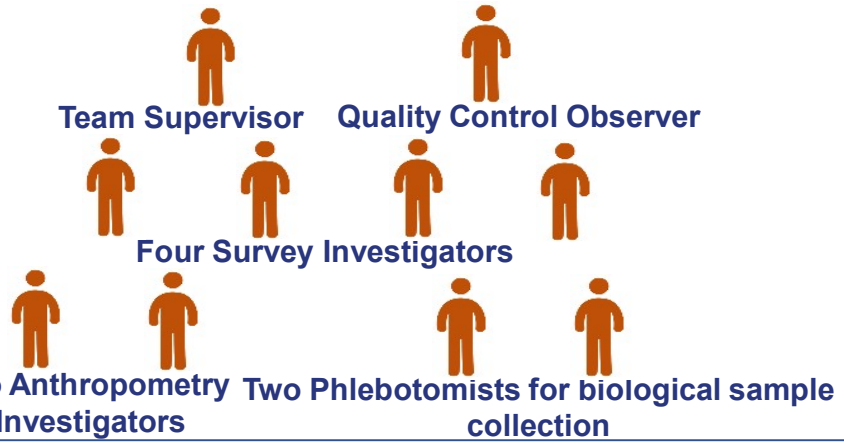
Second Level

- 3-member Data Quality Assurance (DQA) team for re-interviews & observations
- Concurrent monitoring of biological sample collection, storage and transportation by CDSA

First Level

- Internal monitoring by the Quality Control Observer
- Daily supervision of the field work by Team Supervisor

Team Composition for data collection



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Quality Assurance Measures for Data Quality

Evaluation of Interviewers
prior to employment

Survey team
- Written and oral test
- Mock interview
- Ethics test

Anthropometry team
- Standardisation
- Selection based of demonstrated capacity measured by technical error of measurements (TEM)

Quality Assurance Measures

	DQA team conducted consistency checks, and provided feedback on real time basis
	No more than 4 interviews allowed in a day by an interviewer
	Daily SMS based monitoring/ alerts system for biological sample (from PSUs, collection points and reference labs).
	Sample transportation in thermal insulation bags maintaining temperature at 2-8° Celsius for up to 16 hours
	Time and temperature monitoring of samples by digital data loggers

CINS
Birth to Adolescence

Agencies engaged in the implementation of CNNS

Survey Implementation by MoHFW, Government of India and supported by UNICEF

Technical support: US Centre for Disease Control and UNICEF	Regular review and technical guidance: Technical advisory group constituted by MoHFW
Quality assurance and external monitoring: AIIMS, PGIMER, NIN, KSCH and CDSA	Overall field coordination, training, quality monitoring, data management and analysis: Population Council
Biological sample collection, transportation & analysis: SRL Limited	Survey and anthropometric data collection: IIHMR, Kantar Public, Gfk Mode and Sigma Consulting

Sample size in Delhi

CNNS covered 100 PSUs for data collection in Delhi

Achieved following sample size by age groups:

	0-4 years	5-9 years	10-19 years	Total
Household and anthropometry data	1,735	1,745	1,572	**5,052**
Biological sample	602	729	670	**2,001**

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Period of data collection in Delhi

CNNS data collection period: March 25, 2016 to September 27, 2016

- CNNS collected data during the spring season through monsoon season of 2016
- NFHS also collected data during the spring season through monsoon season of 2016

Survey	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
CNNS 2016			March to September, 2016									
NFHS 4 2016		February to September, 2016										

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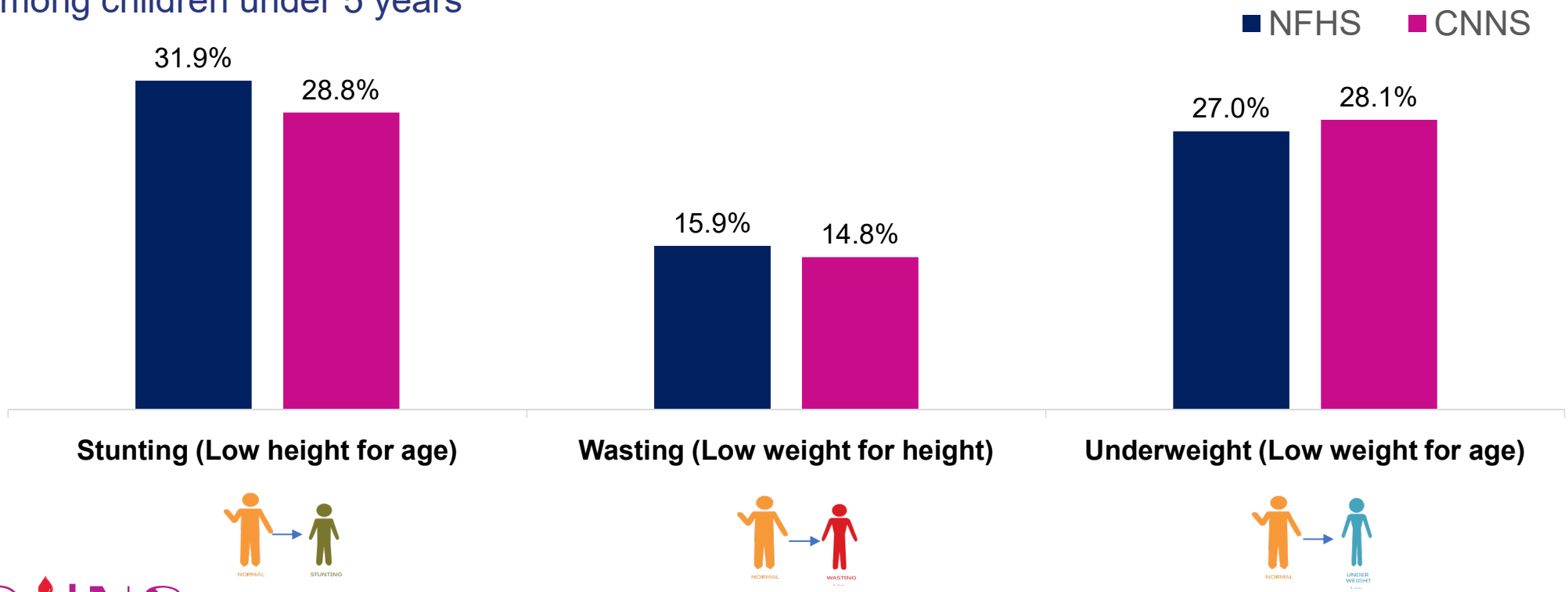
Delhi key findings: Anthropometry (1/2)

There was no significant change in prevalence of stunting, wasting and underweight in Delhi among children under 5 years



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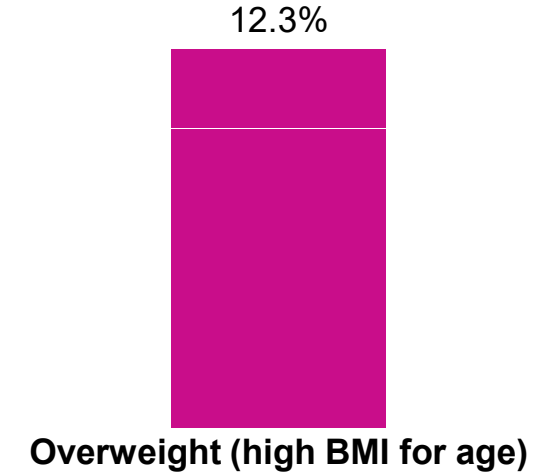
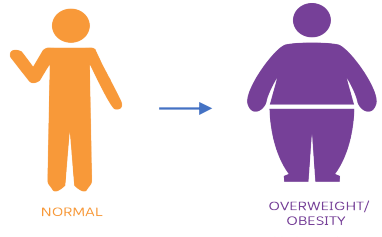
Delhi key findings: Anthropometry (2/2)

1/5 adolescents aged 10-19 years was thin for their age (BMI-Age <-2SD)

1/5 children aged 5-9 years was stunted. The school age period does not provide an opportunity for catch up growth in height.

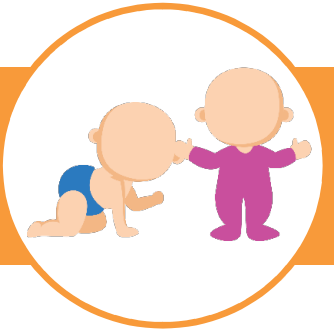
12% of adolescents aged 10-19 years were overweight or obese.





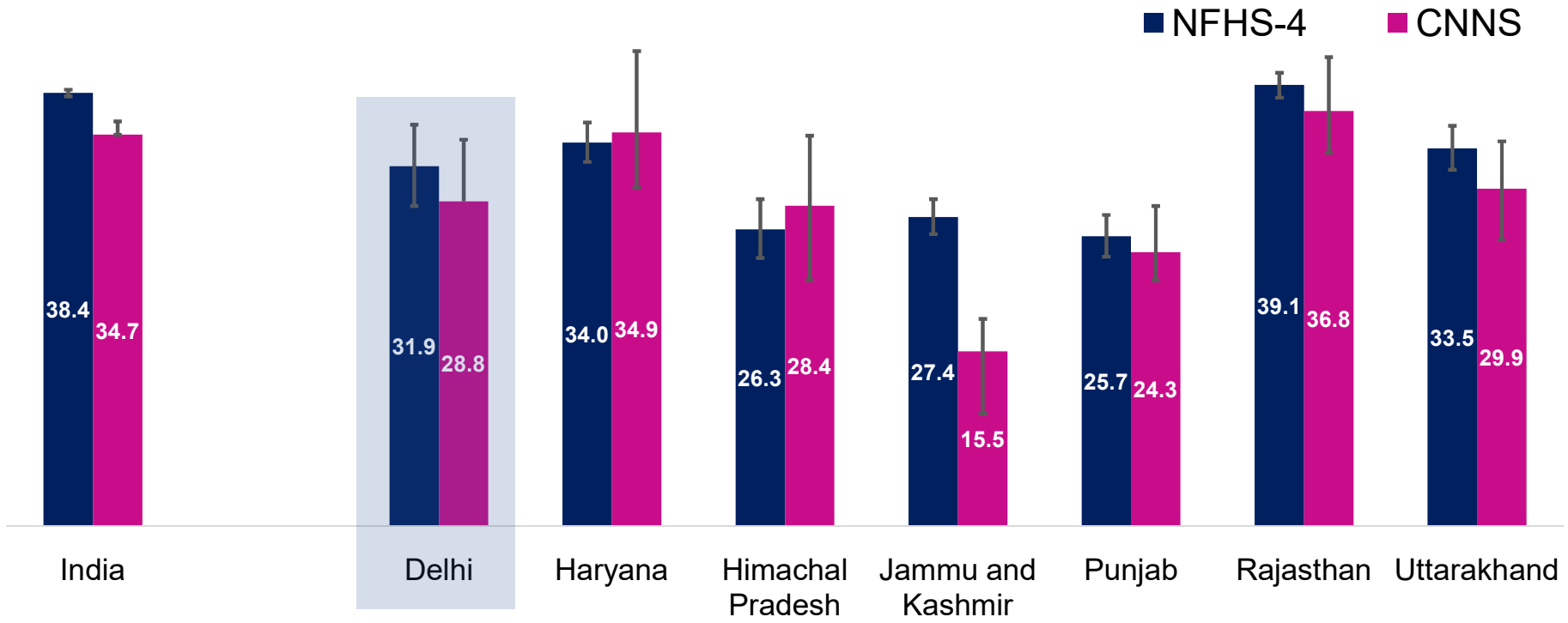
Birth to Adolescence

Stunting among children under five unchanged



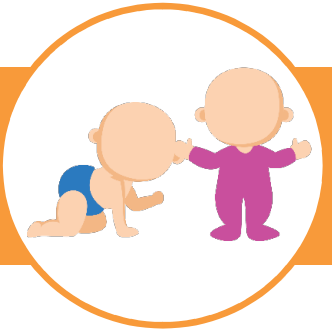
No change in prevalence of stunting was observed in Delhi between CNNS and NFHS-4 – **29%** vs **32%**

Among the northern states, stunting declined significantly only in Jammu and Kashmir – **27%** vs **16%**



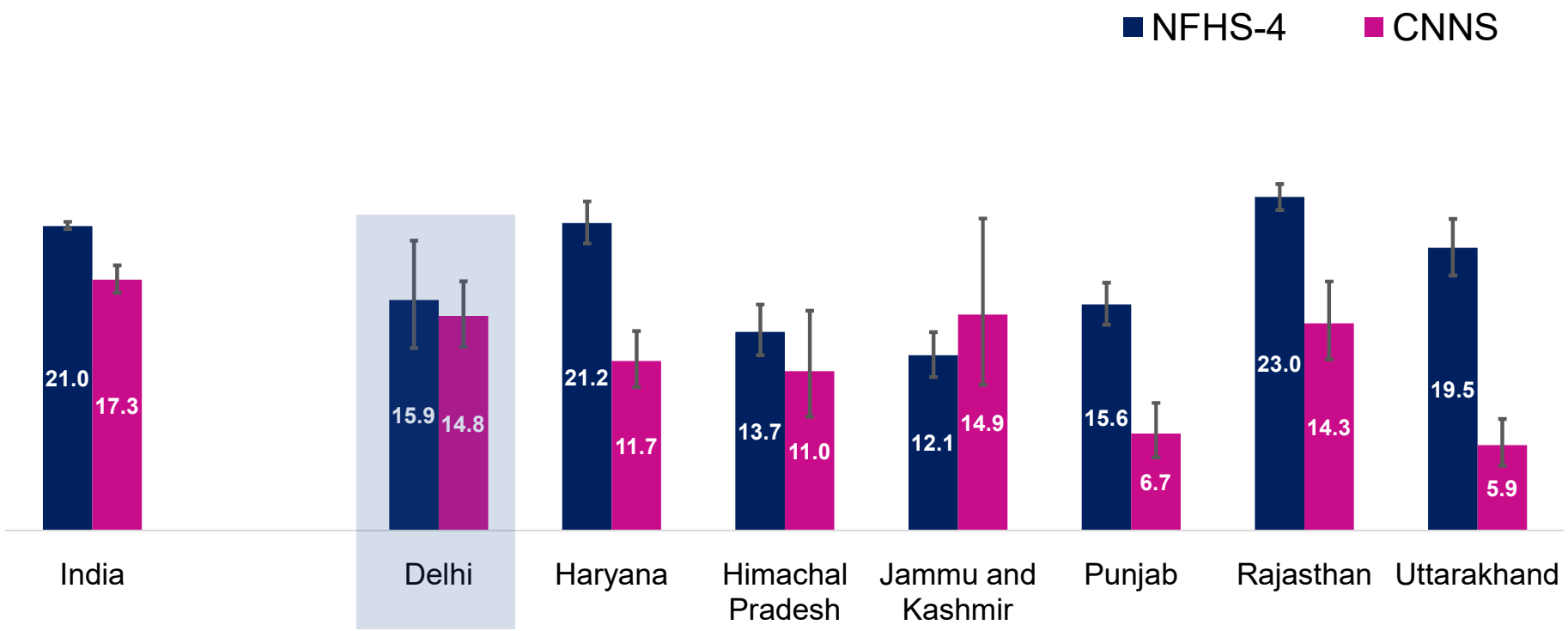
CNNS
Birth to Adolescence

Wasting among children under five unchanged



Prevalence of wasting unchanged in Delhi between NFHS-4 and CNNS – **16%** vs **15%**

In 4/7 northern states, wasting declined; except in Jammu and Kashmir, Himachal Pradesh and Delhi



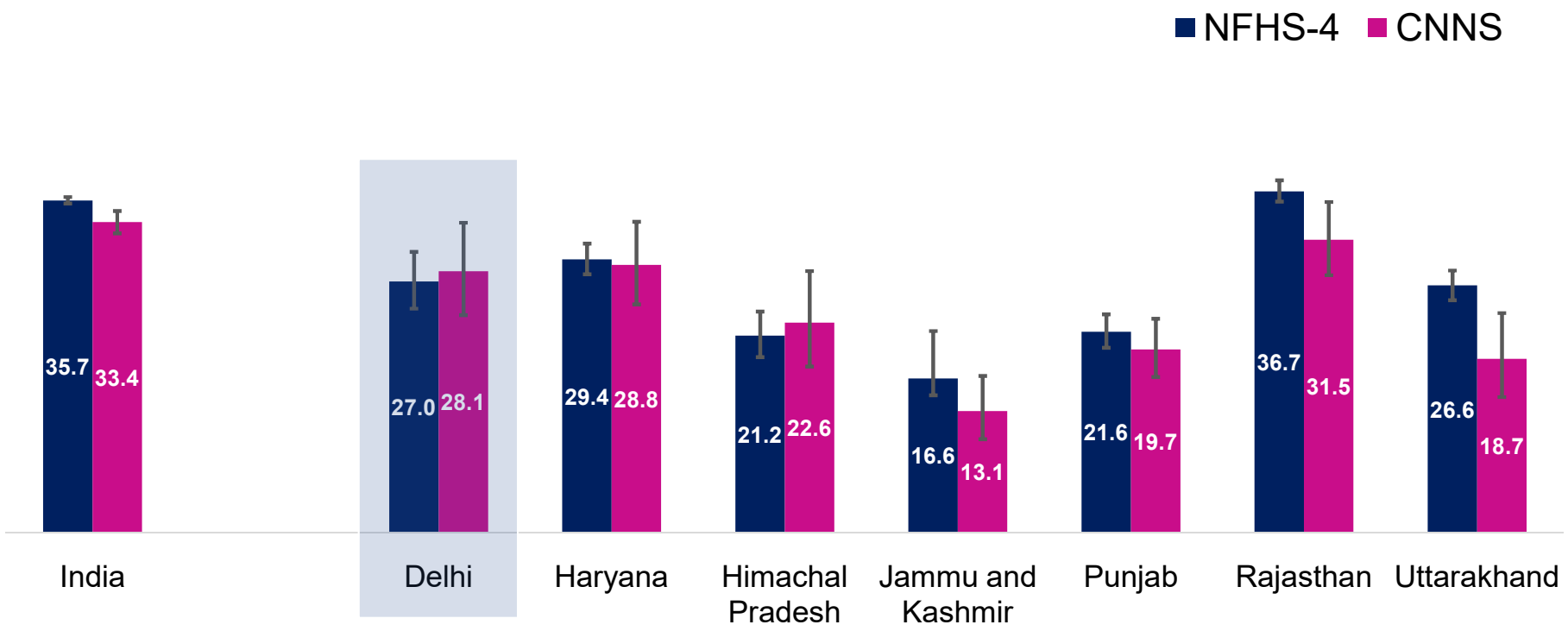
CNNS
Birth to Adolescence

Prevalence of underweight among children under five unchanged

Underweight is a composite measure of chronic and acute malnutrition

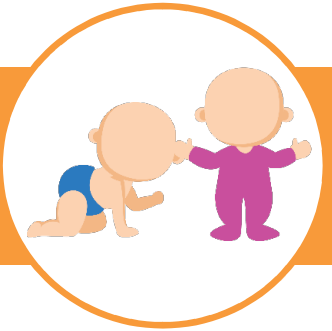
The prevalence of underweight did not change between NFHS-4 and CNNS – **27** Vs **28%**

Prevalence remained unchanged in all northern states; except in Uttarakhand

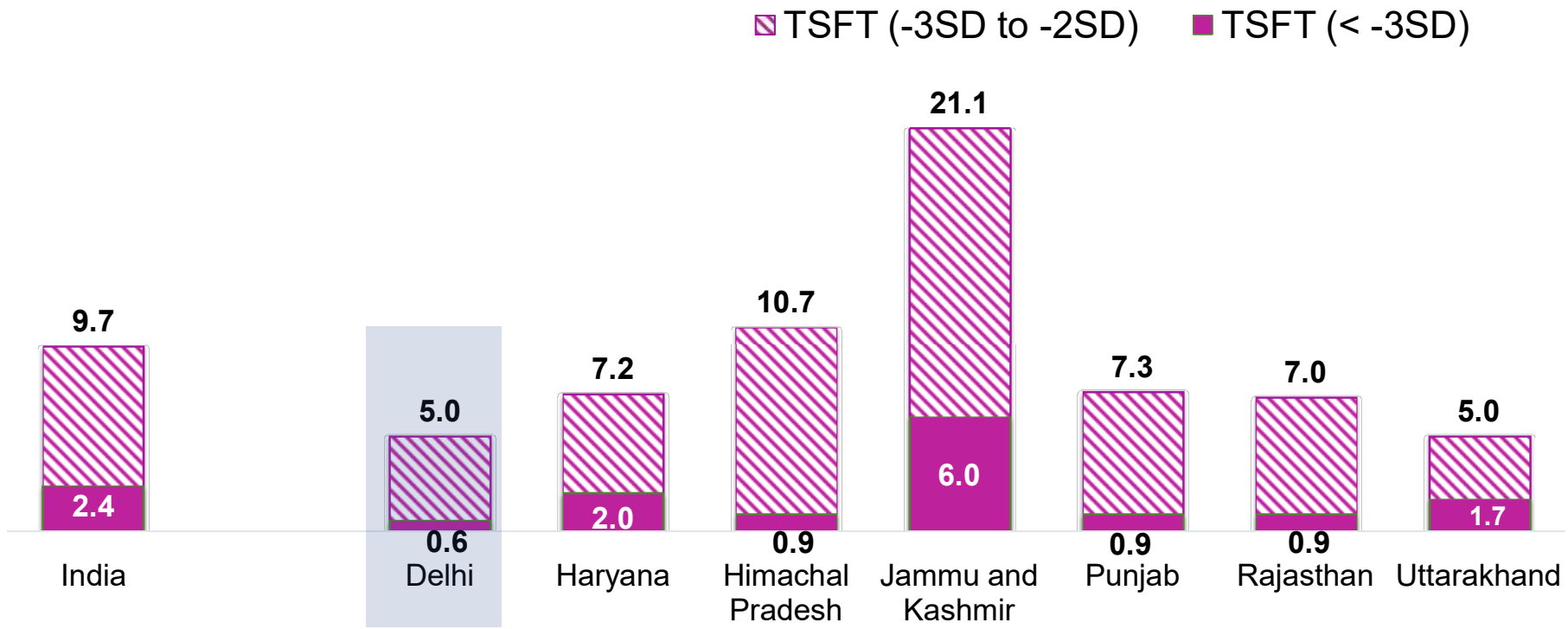


CNNS
Birth to Adolescence

Triceps Skinfold Thickness (TSFT) for children under five

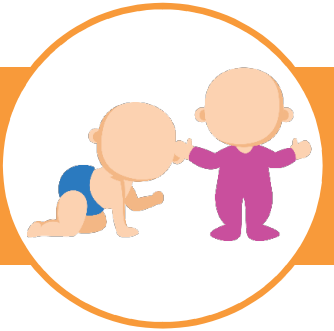


Low fat mass as reported by TSFT in Delhi (5%) was the lowest among the northern states and half the national average (10%); very high in Jammu and Kashmir (21%)

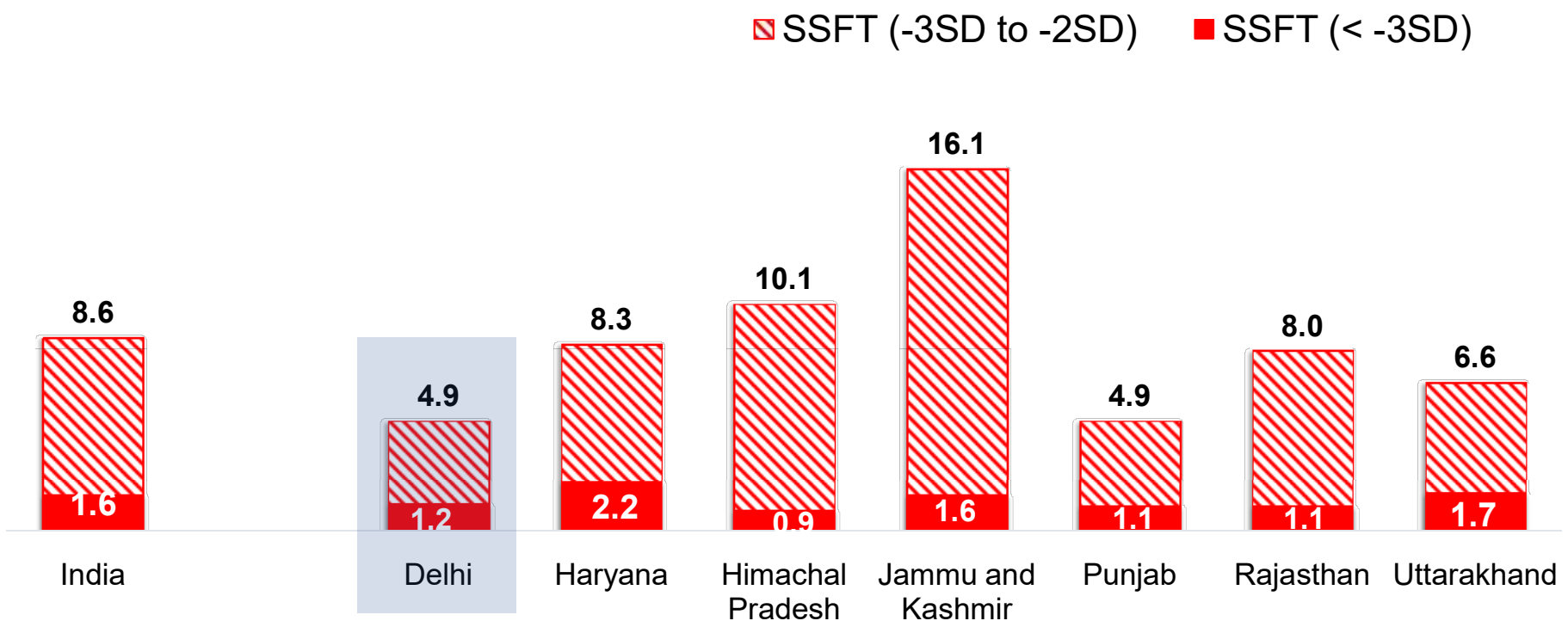


CINS Birth to Adolescence

Subscapular Skinfold Thickness (SSFT) for children aged 1-4 years



Thinness as reported by SSFT in Delhi (5%) was significantly lower than the other northern states and the national level (9%)



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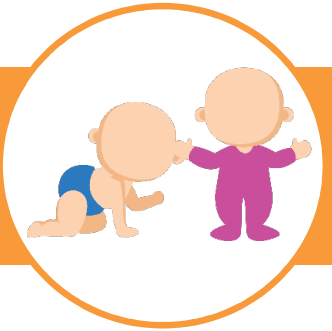
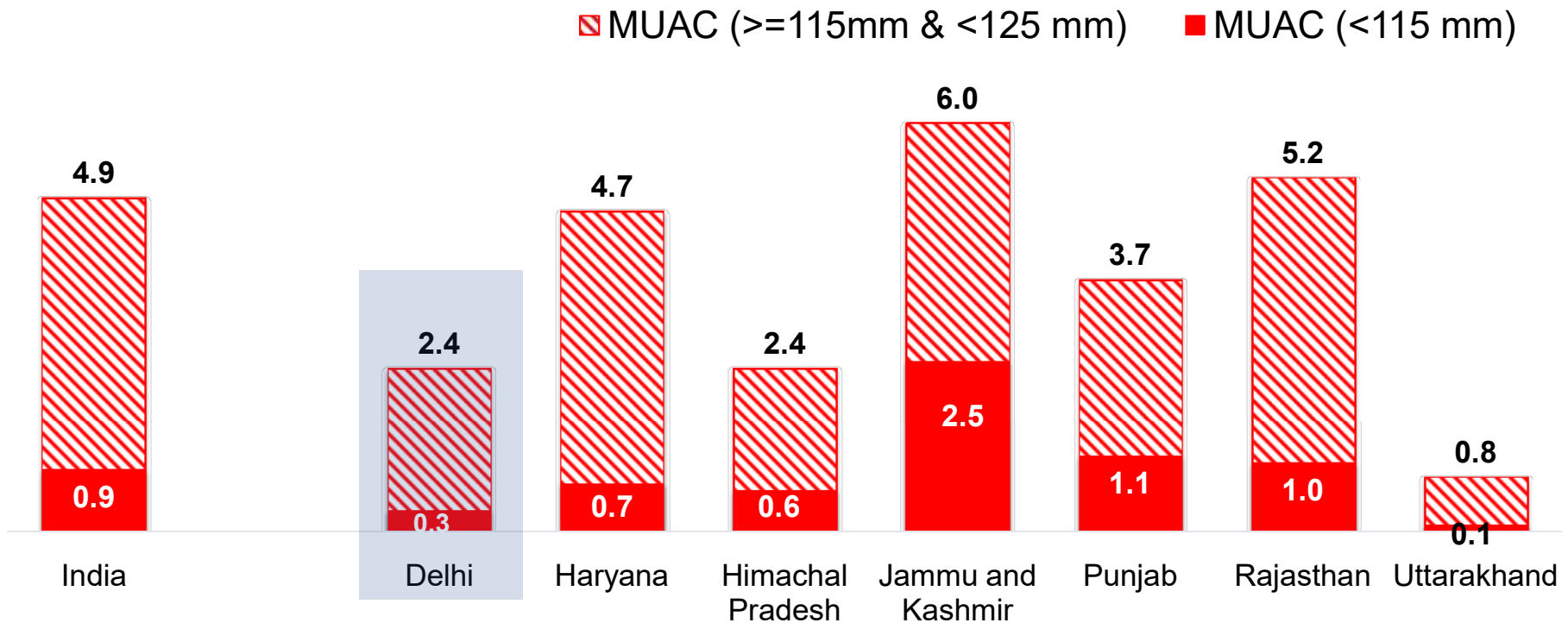
Mid Upper Arm Circumference (MUAC) for children aged 6-59 months



About **2%** children in Delhi had low MUAC

Prevalence of low MUAC ranged between **1%** and **6%** across the northern states

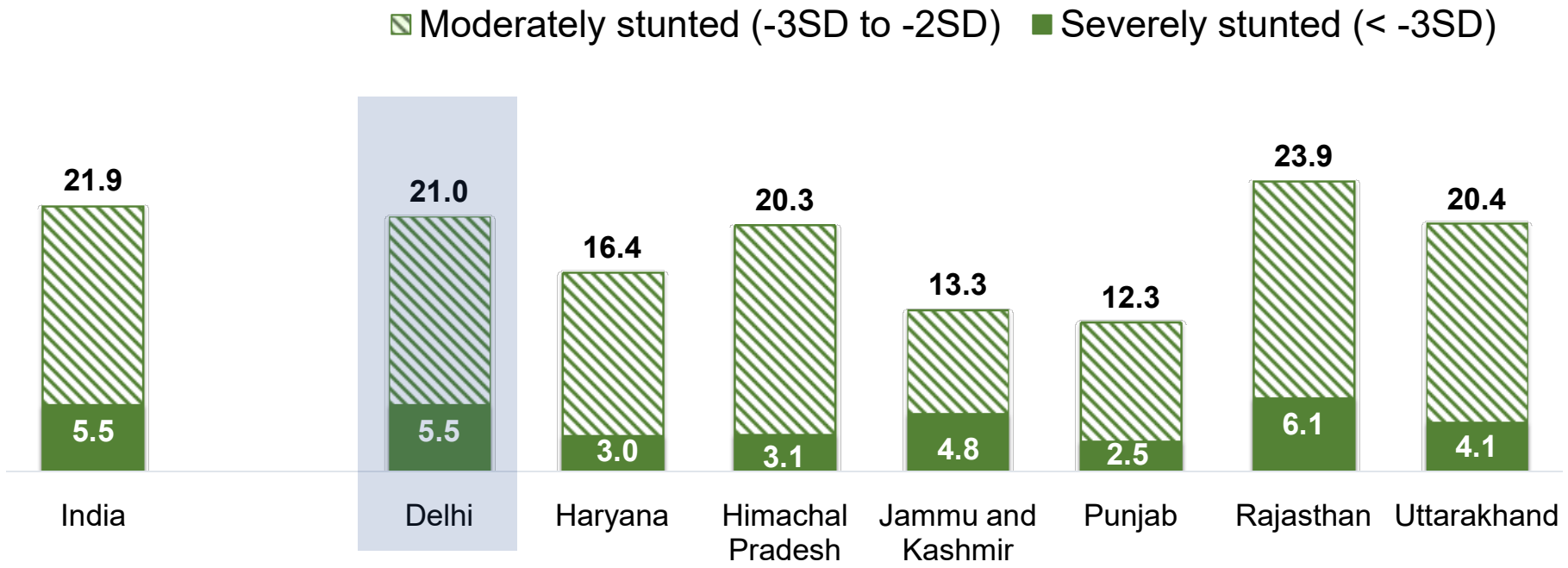


CINS Birth to Adolescence

Stunting among school-age children (5-9 years)

1/5 children aged 5-9 years was stunted; significant proportion of children who were stunted in childhood remained stunted into their schooling age reducing their potential capacity for education

Rajasthan (24%) had the highest prevalence of stunting among the northern states

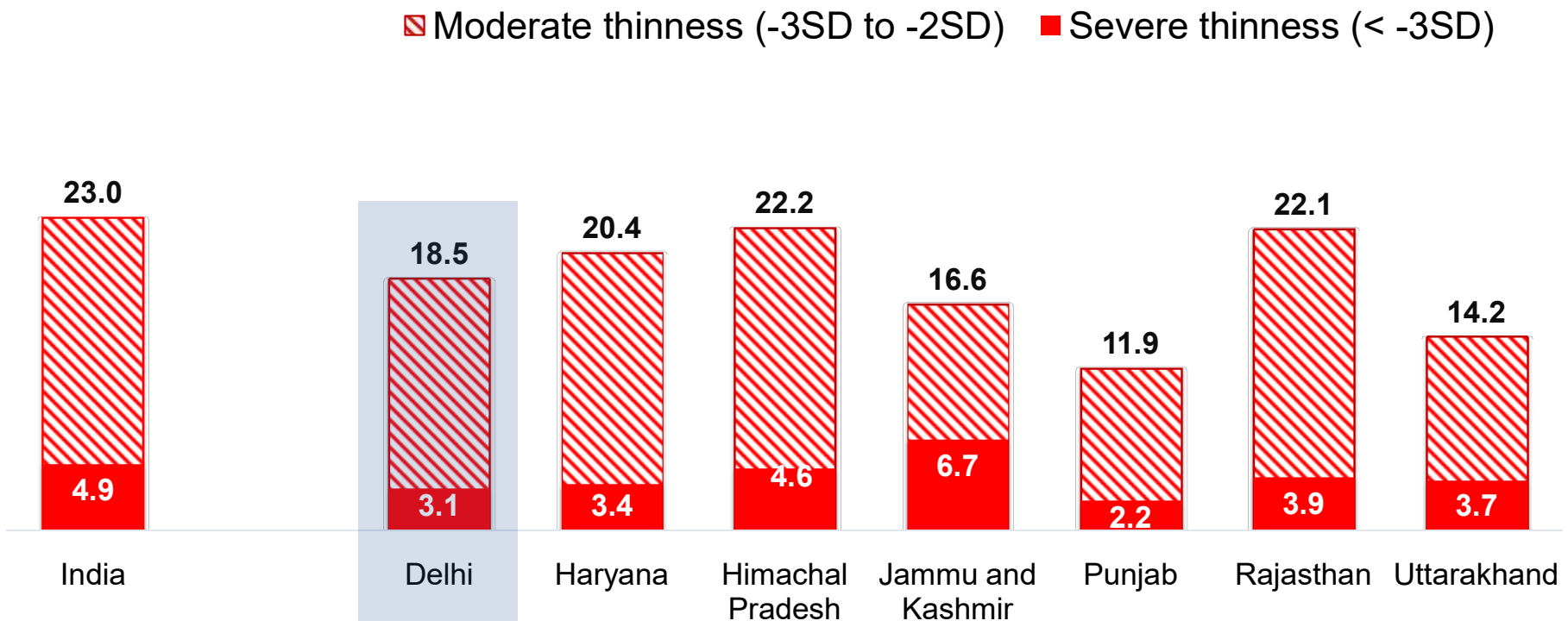


CINS Birth to Adolescence

Thinness among school-age children (5-9 years)

1/5 children aged 5-9 years was thin

Prevalence of thinness in Delhi was less than national average but higher than three northern states in the region (J&K, Punjab and Uttarakhand)



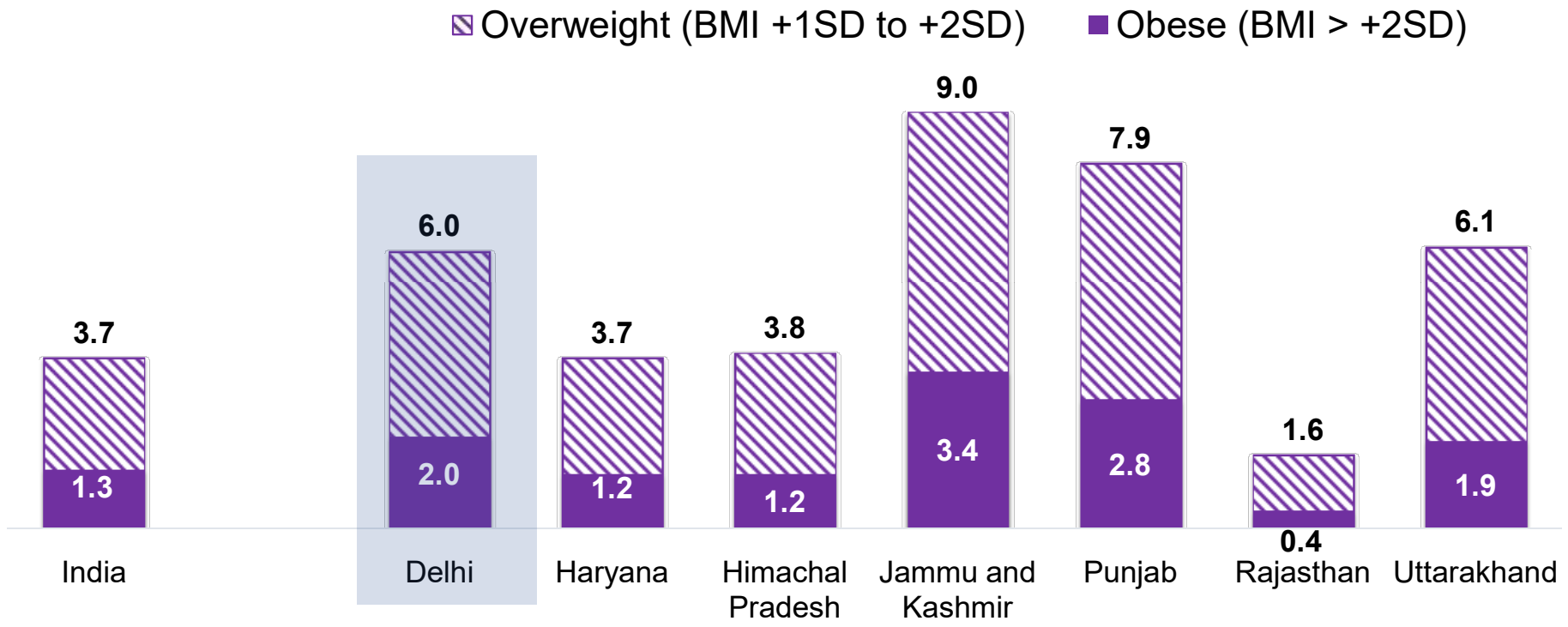
CINS Birth to Adolescence

Overweight and obesity among school-age children (5-9 years) increasing

Overweight and obesity are on rise even among children aged 5-9 years

Prevalence of overweight in Delhi (**6%**) was higher than the national average (**4%**)

Among northern states, Delhi had high prevalence of overweight in this age group

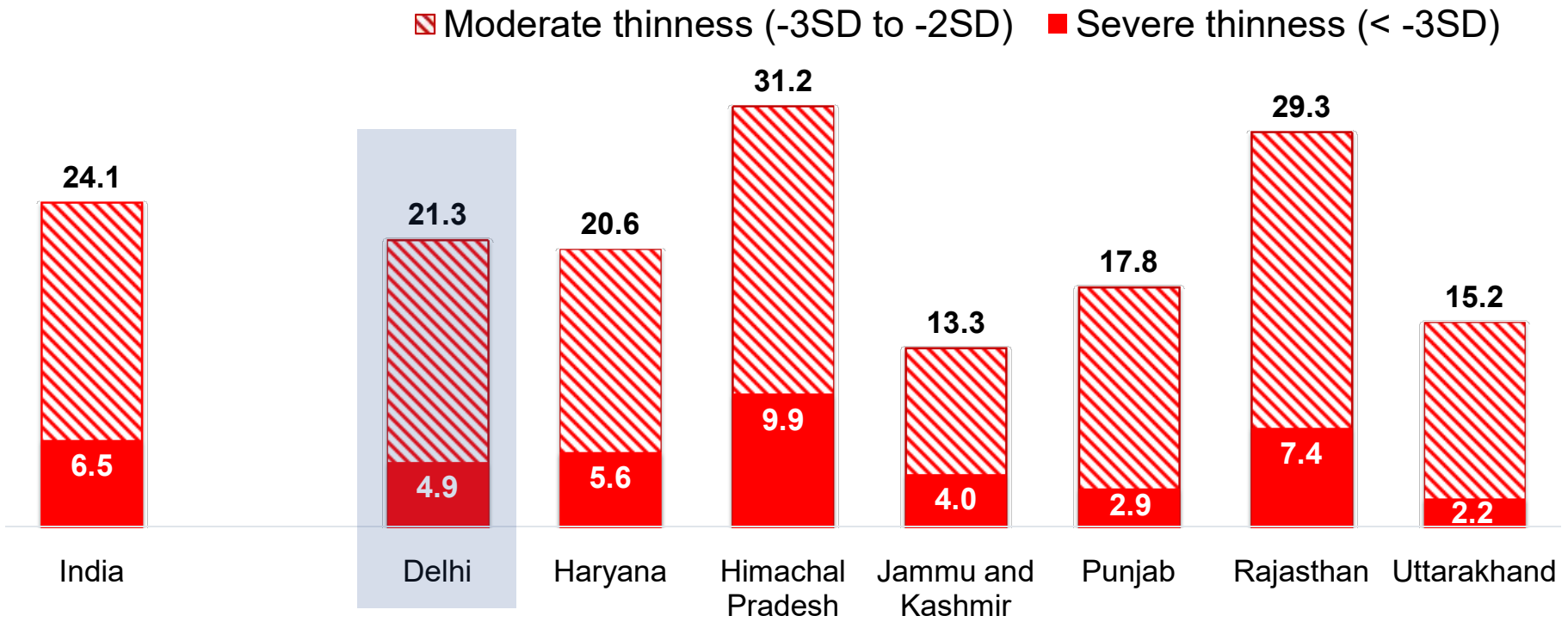


CINS Birth to Adolescence

Thinness among adolescents aged 10-19 years substantia high

1/5 adolescents aged 10-19 years was thin in Delhi (**21%**), less than national average (**24%**)

Among the northern states, Himachal Pradesh (**31%**) and Rajasthan (**29%**) had very high prevalence of thinness

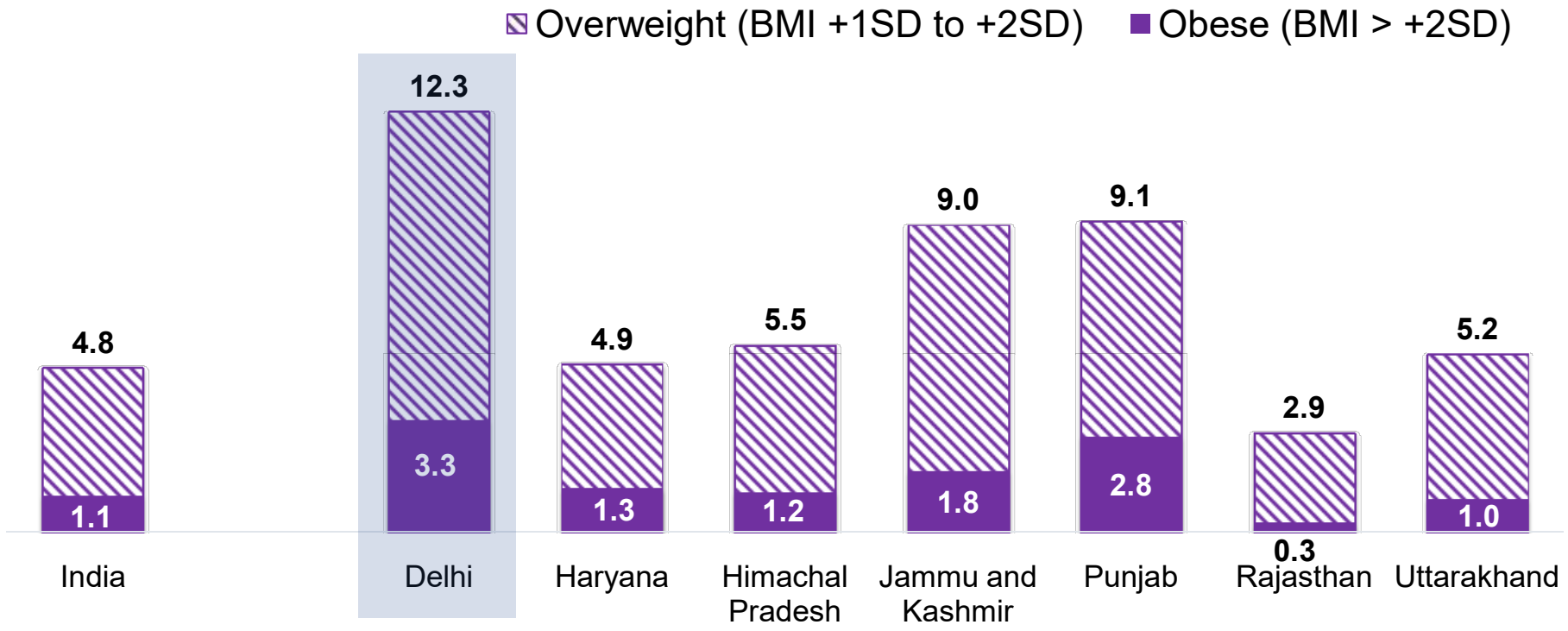


CINS Birth to Adolescence

Prevalence of overweight among adolescents aged 10-19 years high

1/8 adolescents was overweight in Delhi (**12%**), more than double the national average (**5%**)

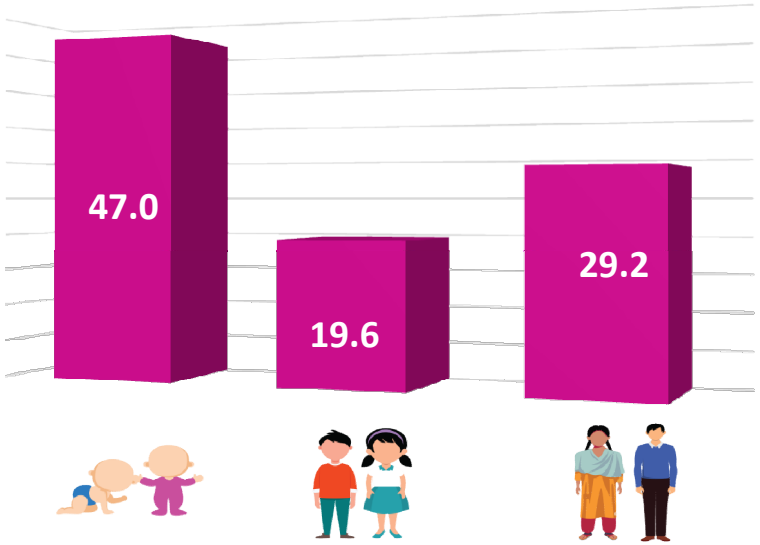
Among the northern states, Delhi had highest prevalence, also high in Jammu and Kashmir (**9%**) and Punjab (**9%**)



Birth to Adolescence

Delhi key findings: Anaemia and iron deficiency

Anaemia



In Delhi, like in most states, anaemia was significantly higher among children aged 1-4 years compared to children aged 5-9 years and adolescents aged 10-19 years

Iron deficiency

Findings indicate that children aged 1-4 years had higher iron deficiency (measured by serum ferritin) than other children or adolescents

CNNS Birth to Adolescence

Prevalence of Anaemia among children and adolescents

Nearly **1/2** children aged 1-4 years was anaemic in Delhi (**47%**), higher than national average (**41%**)

Prevalence of anaemia was highest among children aged 1-4 years, increased again in adolescence

Anaemia Cut Offs (WHO)

1-4 years: Hb<11.0 g/dl

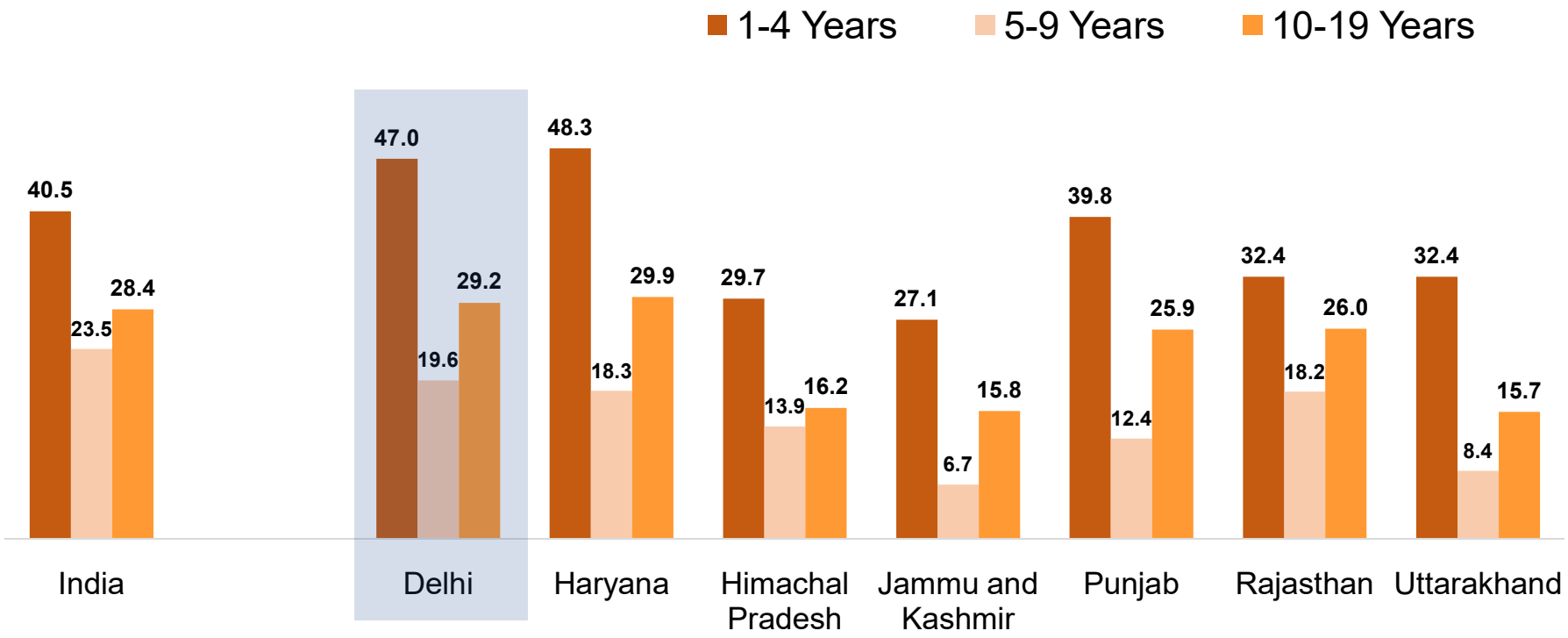
5-11 years: Hb<11.5 g/dl

12-14 years: Hb< 12 g/dl

Girls ≥15years: Hb< 12g/dl

Boys ≥15 years: Hb< 13 g/dl

(Adjusted for altitude)

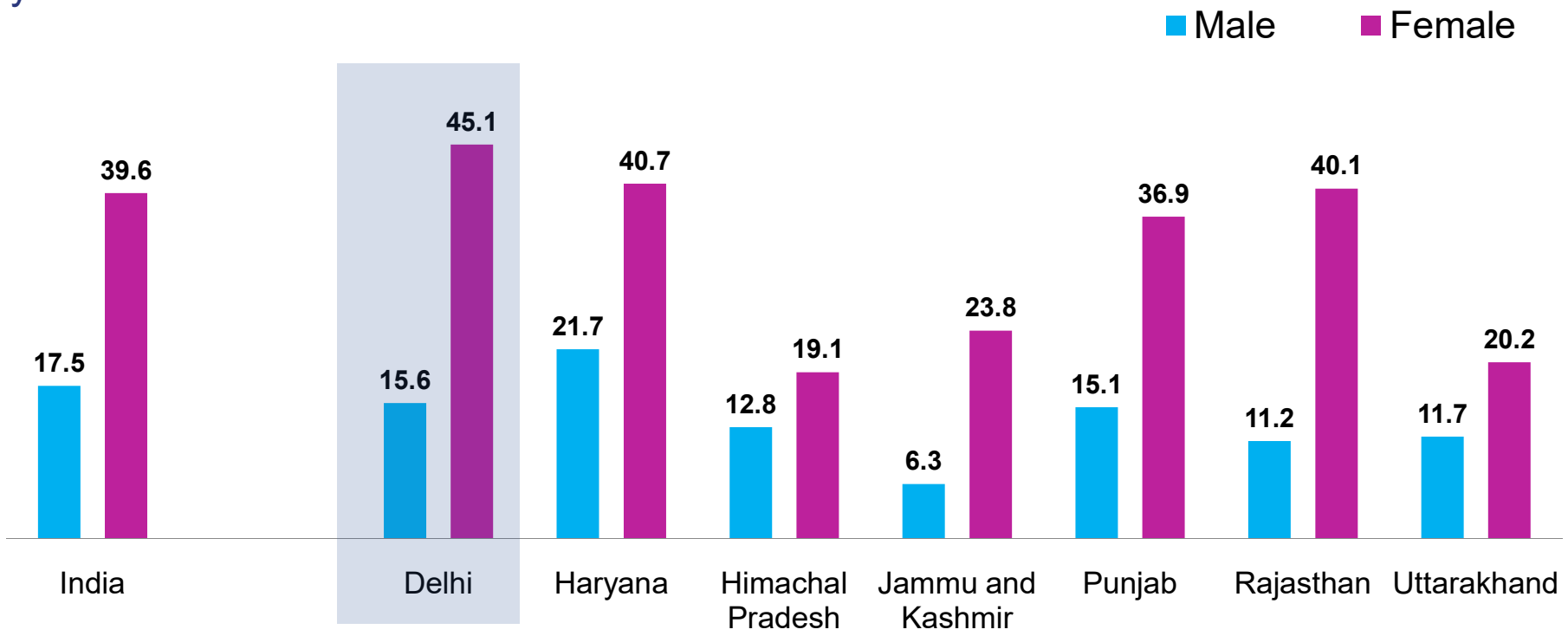


CINS Birth to Adolescence

Prevalence of Anaemia among adolescents (10-19 years)

Overall, in the country, anaemia prevalence among adolescent girls (10-19 years) was twice that of adolescent boys

In Delhi, as in many other northern states, adolescent girls were three times more likely than adolescent boys to be anaemic

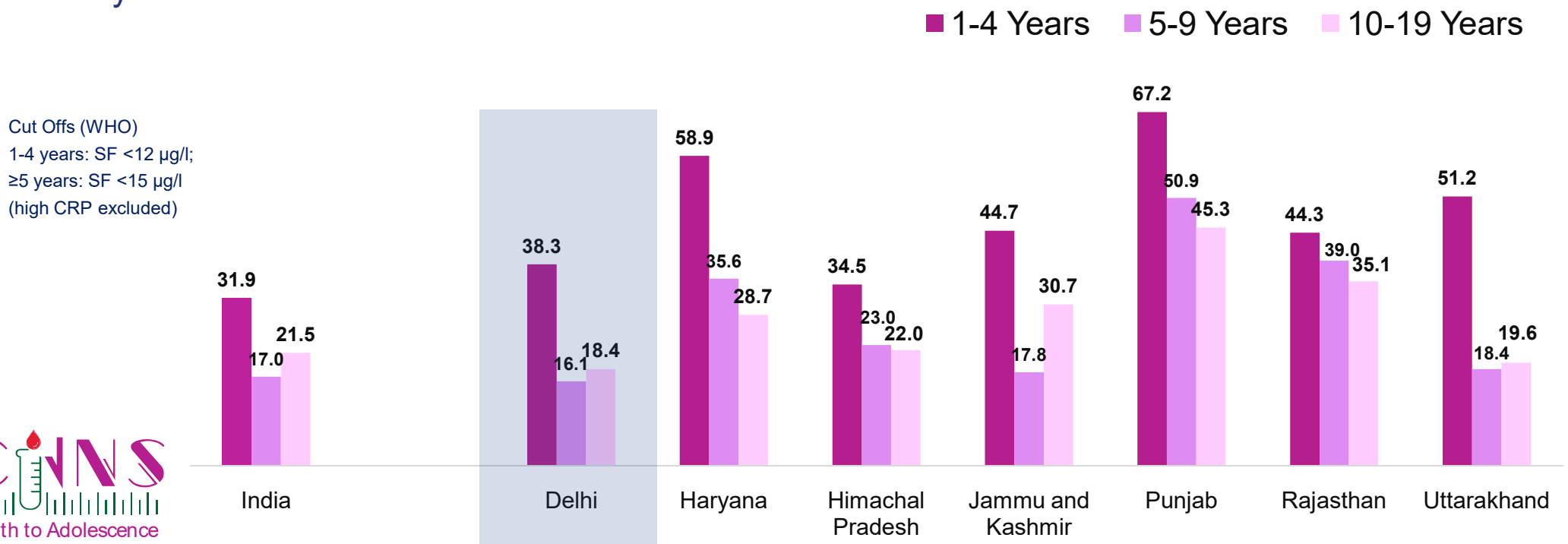


CINS Birth to Adolescence

Iron deficiency measured by serum ferritin among children and adolescents

38% of children aged 1-4 years had iron deficiency in Delhi, higher than the national average (**32%**); prevalence was highest among children aged 1-4 years

Among northern states, children from Punjab (**67%**) and Haryana (**59%**)had high prevalence of iron deficiency



CINS Birth to Adolescence

Delhi key findings: Vitamin A and Vitamin D deficiency

A

Vitamin A deficiency was high (22%) in school-age children 5-9 years

Children aged 1-4 years (18%) and adolescents (13%) were found to have lower levels of Vitamin A deficiency than children aged 5-9 years

D

Vitamin D deficiency ranged from 33% to 47% in 1-19 years age group as per cut off by expert panel of IOM.

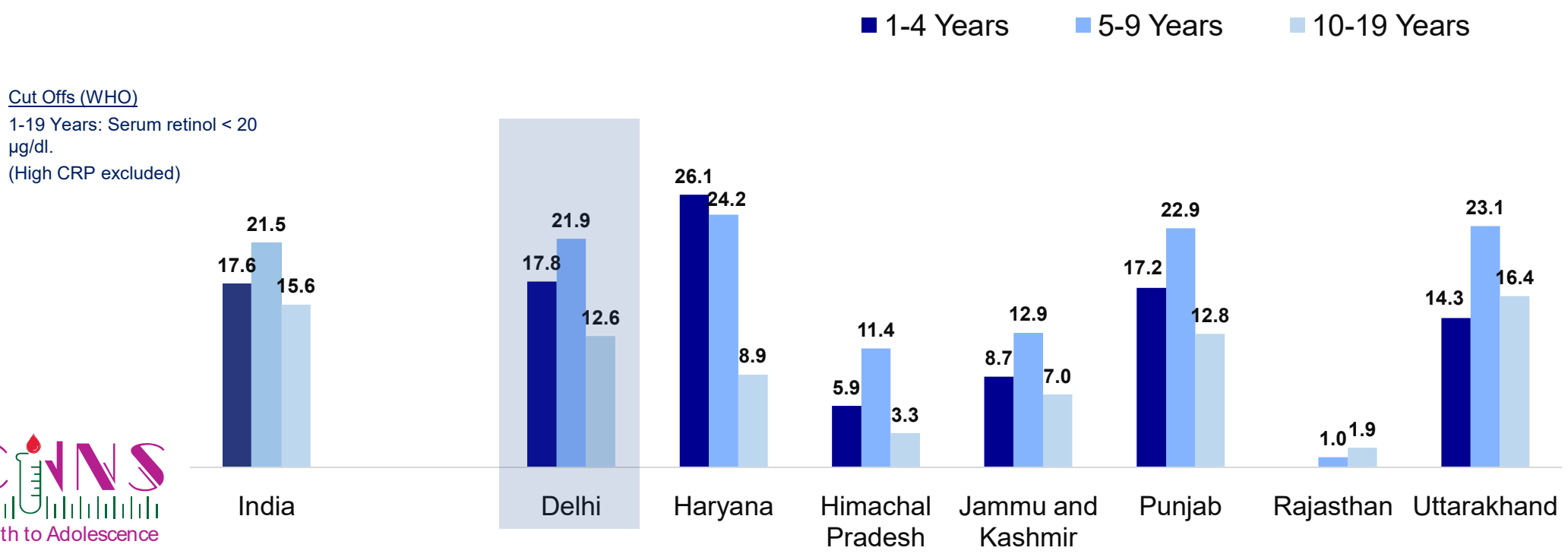
Adolescents aged 10-19 years were found to have higher level of Vitamin D deficiency than children aged 1-9 years

CINS
Birth to Adolescence

Vitamin A deficiency among children and adolescents

13-22% children and adolescents had Vitamin A deficiency in Delhi, at similar level as the national average (**16-22%**)

Prevalence of Vitamin A deficiency in all age group did not show any particular pattern among northern states

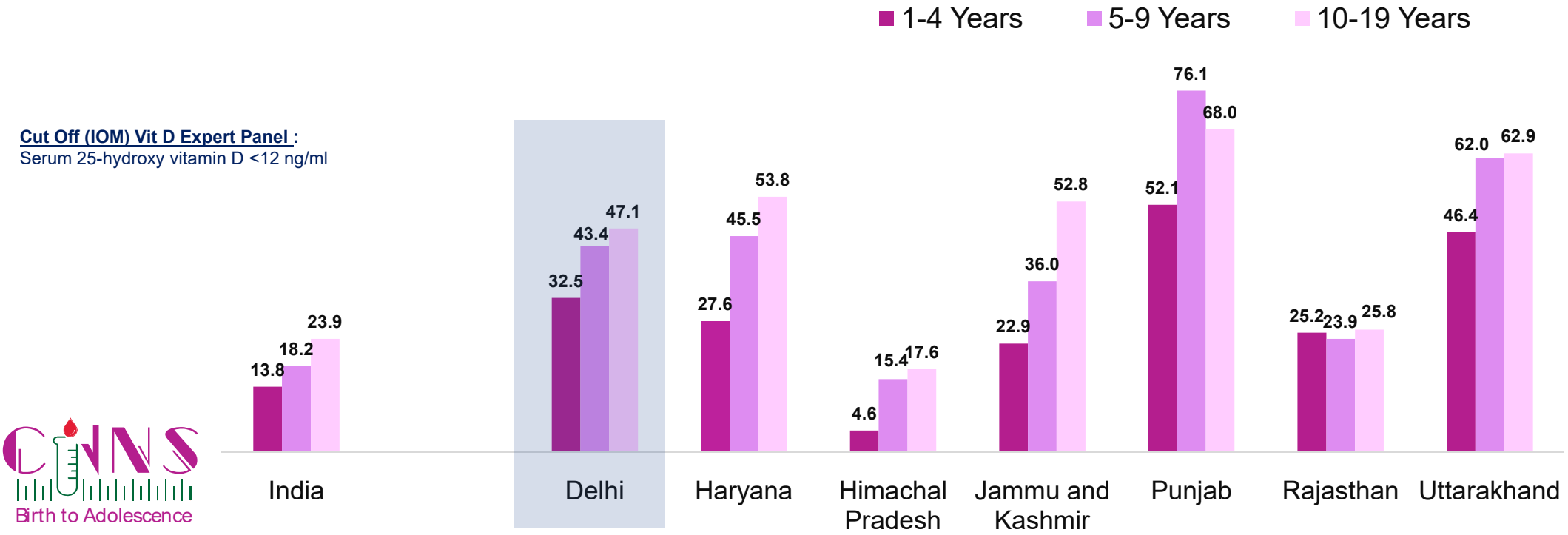


CINS Birth to Adolescence

Vitamin D deficiency increases with age

33-47% children and adolescents had Vitamin D deficiency in Delhi, much higher than the national average (**14-24%**); Vitamin D deficiency increased sharply with age.

In most northern states, except Himachal Pradesh, Vitamin D deficiency among children and adolescents was higher than national average; very high in Punjab (52-76%)



CINNS Birth to Adolescence

Delhi key findings: Non-communicable diseases

More than 5% school-age children and adolescents were found with high level of glycosylated haemoglobin (HbA1c).

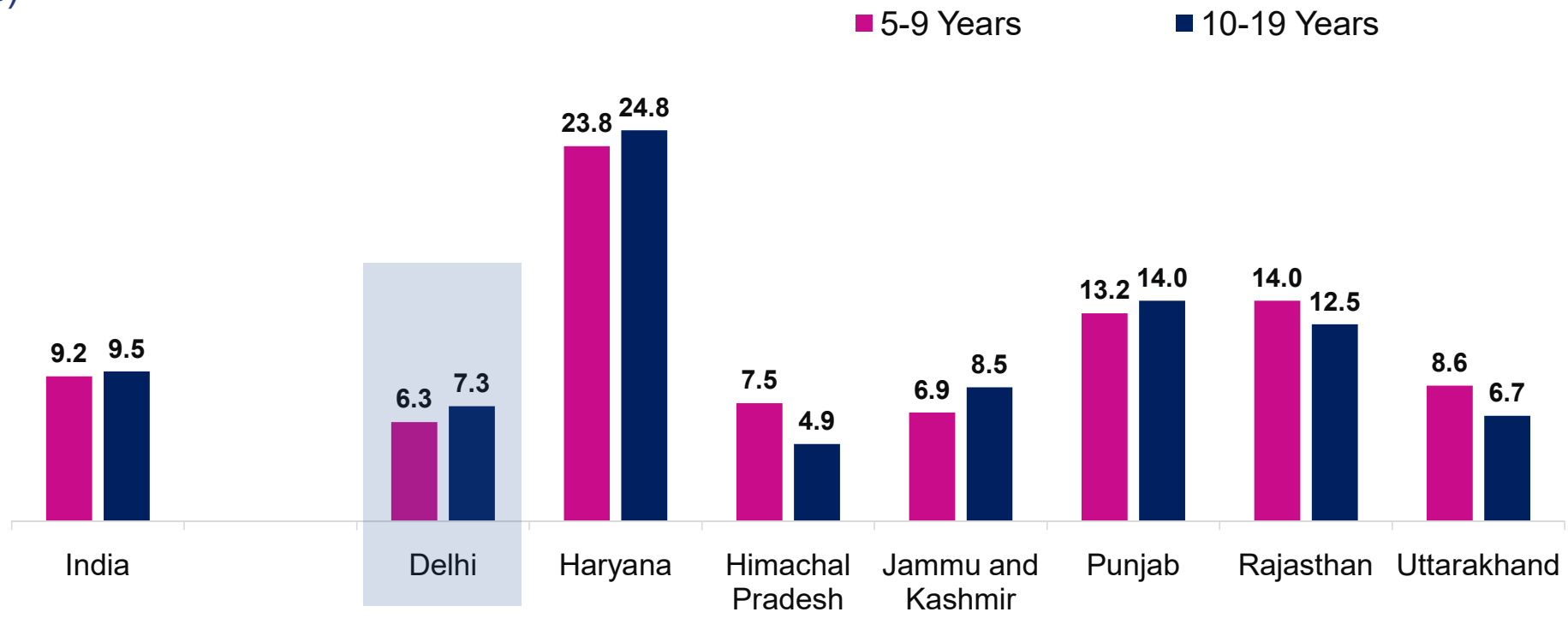
Other indicators of risks of NCDs, such as level of cholesterol, triglycerides, LDL and HDL point to increased risks of NCDs among adolescents.

CINNS Birth to Adolescence

Risk of diabetes among school-age children and adolescents

Based on Glycosylated hemoglobin (HbA1c), more than **5%** children and adolescents had increased risk of diabetes in Delhi, but lower than national average (**9-10%**)

Among all northern states, risk of diabetes among children and adolescents of Haryana was very high (**24-25%**)

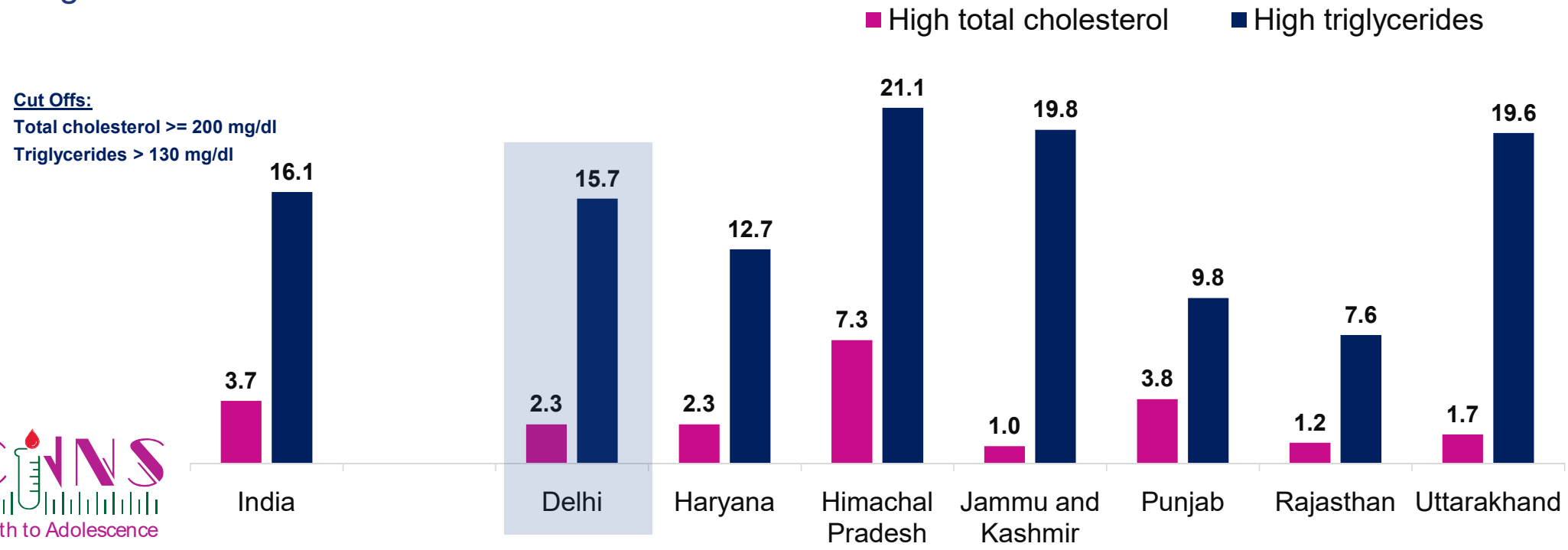


Birth to Adolescence

High total cholesterol and high triglyceride among adolescents

Elevated risk of NCDs in Delhi among adolescents – **2%** had high level of total cholesterol and **16%** with high level of triglycerides

Prevalence of high total cholesterol and high triglycerides were highest in Himachal Pradesh among northern states

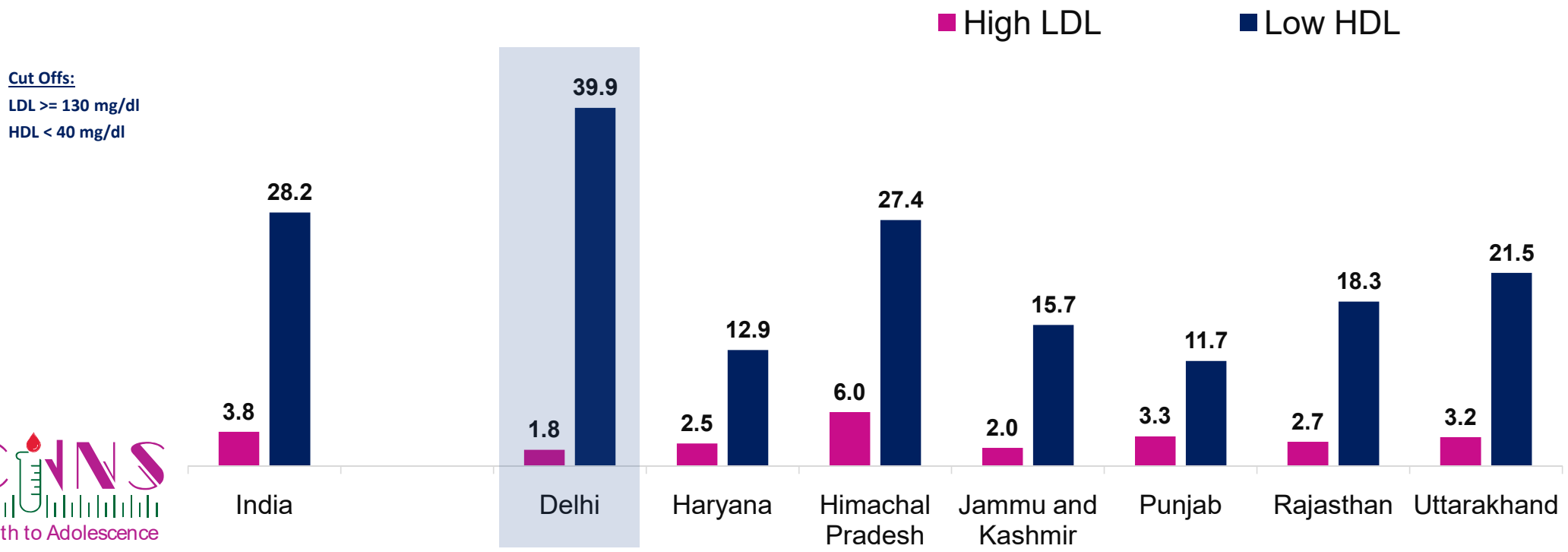


Birth to Adolescence

High LDL and low HDL among adolescents

Risk of NCDs among adolescents in Delhi was high – **2%** had high level of LDL and **40%** had low level of HDL

Among northern states, prevalence of low HDL was highest in Delhi



CINS Birth to Adolescence

Preliminary Policy Discussions from CNNS

- Only about half of anaemia is caused by iron deficiency. Programmes must address all causes of anaemia but continue to address iron deficiency in children under five and adolescent girls (population with largest burden).
- Vitamin A deficiency is still high. Along with Vitamin A supplementation, interventions such as dietary diversification and fortification can be taken to scale to address the burden.
- Vitamin D deficiency is an emerging public health issue among urban children and adolescents. Scaling up of fortification efforts can be considered. Further research is required to uncover the effects of pollution and other factors to design better programmes.
- Urinary Iodine data need to be examined in conjunction with salt consumption data for the population and level of iodine in salt at the household level.
- Control of NCDs such as diabetes and cardiovascular disease must start in the early ages to instil lifelong healthy habits as adult diseases start in childhood.

CNNS Birth to Adolescence

The survey was conducted with generous financial support from

Aditya and Megha Mittal

and technical support from

unicef | for every child

POPULATION COUNCIL
Ideas. Evidence. Impact.

AIIMS New Delhi

CDSA

CDC Centers for Disease Control and Prevention
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