



**SOUTH ASIA REGIONAL  
ACTION FRAMEWORK FOR**

**nutrition**



**SOUTH ASIAN ASSOCIATION FOR  
REGIONAL COOPERATION (SAARC)**



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SOUTH ASIAN ASSOCIATION  
FOR REGIONAL COOPERATION  
SECRETARIAT

SAARC

SECRETARY GENERAL



## FOREWORD

South Asia has the world's largest population with more than a quarter of the world's children living in this region. It also houses the highest number of undernourished children. We know that undernutrition in children has detrimental consequences not only on child survival, growth and development, but also impacts on their brain development, academic achievements and reduces overall adult productivity; thus impeding social and economic development. Undernutrition in children in the form of stunting and severe acute malnutrition epitomize social inequities and are considered as a marker for poverty and underdevelopment. In fact stunting, which results due to persistent nutritional deprivations cannot be cured – it can only be prevented. Once a child is stunted he/she is stunted forever. Stunting is a violation of children's rights and is also a huge burden for nations, whose future citizens will be neither as healthy nor as productive as they could have been.

Accelerating progress towards the reduction of undernutrition, more specifically stunting is central to development of this region. Presently, there is a lot of global momentum around stunting. With initiatives like Scaling Up Nutrition (SUN) and World Health Assembly's global target of reducing the number of

stunted under-fives by 40 percent by 2025, it is essential that countries in South Asia address this issue and enhance their efforts to meet this goal.

South Asian Association of Regional Cooperation (SAARC) recognizes under-nutrition as a problem in South Asia and is committed to its reduction. SAARC envisions that all children in the region are healthy, grow and develop to their full potential, and in their adulthood contribute to the development of the region. During the second and third meeting of the SAARC Health Ministers, the member countries urged the Technical Committee on Health and Population Activities (TCHPA) to prepare guidelines for basic healthcare services, nutrition, safe drinking water, sanitation and hygiene. We are thankful to UNICEF Regional Office for South Asia (ROSA) for providing technical support to the SAARC Secretariat to prepare these guidelines.

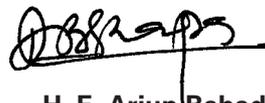
The Regional Action Framework for Nutrition has been developed at a time when investing in nutrition is recognized as an international development priority. The Framework encourages the eight member countries to prioritize the reduction in child undernutrition and provides guidance on coherent approaches

that can be applied across the region to address undernutrition, focusing on the most vulnerable (i.e. children and women). Within the Framework, a set of principles have been outlined which each country can adapt and apply in order to develop policies and programmes that address undernutrition. The Framework highlights that these processes require political commitment, robust planning, dedicated budgets, improved capacities, effective implementation and monitoring of nutrition goals and outcomes.

The Framework also reiterates that in order to address stunting, nutrition interventions can impact the direct causes of undernutrition. Underlying factors like poverty, migration, urbanization, socio-cultural factors, disasters, and climate change etc., can be addressed through nutrition-sensitive interventions. In order to address these underlying factors, it is essential that different sectors that work on issues related to agriculture, women's empowerment, hygiene and sanitation and

water quality and social protection need to collaborate and act in a convergent manner.

SAARC will continue to play a supporting role to the countries in their efforts towards improving the nutrition situation within the South Asia region. SAARC provides a platform for its Member States to work collaboratively, address certain common issues that transcend the political/geographical borders, share experiences and learn from one another. I sincerely hope that this Framework will assist the countries in the South Asian region in their efforts to overcome the challenge of child undernutrition and ensure that all children in the region are healthy and grow and develop to their full potential.



**H. E. Arjun Bahadur Thapa**  
Secretary General of SAARC

# INTRODUCTION

**T**he **Regional Action Framework on Nutrition** provides guidance to the eight member countries of South Asian Association of Regional Cooperation (SAARC) on a coherent approach to address common nutrition issues across the region with a special focus on improving nutrition among children, as this is the most vulnerable group that need attention.

From a life-cycle perspective, the most crucial time to meet a child's nutritional requirements is the 1,000-day period that spans from conception to age two. During this time, the child has increased nutritional needs to support rapid growth and development, is more susceptible to infections, and is totally dependent on others for nutrition, care and social interactions.

In tackling the issue of child undernutrition, stunting, which denotes long-term nutrition deprivation, has gained importance as there is a better understanding of the importance of the 1,000 days comprising pregnancy and the first two years of the child's life and better knowledge on how by focusing on stunting, undernutrition can be addressed in the present generation and prevented in future generations.

Globally, one in four children (25 percent in 2013) are stunted. In absolute numbers this translates to approximately 165 million children with stunted growth; these children are chronically undernourished due to long term nutrition deprivation<sup>1</sup>. South Asia has a stunting rate of 38 percent, comparable to sub-Saharan Africa (38 percent), and over three times higher than East Asia and the Pacific (12 percent) or Latin America (11 percent).

Child under nutrition is caused not just by the lack of adequate food, but also by frequent illness, poor care practices and poor access to health and other social services. Stunting and other forms of undernutrition reduce a child's chance of survival, while also hindering optimal health and growth. Stunting is associated with suboptimal brain development, which is likely to have long-lasting harmful consequences for cognitive ability, school performance and future earnings. This in turn affects the development potential of nations.

Because of the well documented, irreversible and detrimental consequences of stunting on the human capital and economic development of a country, stunting has become a major focus of the work of Public Health Nutrition

<sup>1</sup> United Nations Children's Fund (UNICEF). Improving Child Nutrition: the Achievable Imperative for Global Progress. 2013.

specialists, policy makers and economists. Additionally, stunting is being considered to replace underweight as the post 2015 nutrition indicator. This shift is reflected in the emphasis by the World Health Assembly, which has set the goal of achieving a 40 percent reduction in the number of stunted children under five by 2025 (i.e. approximately 70 million children saved from stunting). It has also set the goal of reducing child wasting to less than 5 percent. Most of the burden stunting and wasting, lies in the South Asia region. Therefore the global goals cannot be achieved unless efforts are made to accelerate progress in South Asia.

The present Framework has been developed at a time when attention for nutrition is increasing dramatically and investing in nutrition is recognized as an international development priority. A package of evidence based and cost-effective nutrition interventions to reduce undernutrition have been characterized and outlined in the 2013 Lancet Nutrition Series. There is also comprehensive evidence on the need to promote optimal growth during this critical period in order to avoid an elevated risk for non-communicable diseases, such as obesity and diabetes in adulthood.

The Scaling Up Nutrition (SUN) movement is contributing to this momentum by supporting

countries to build national commitment to accelerate progress towards reducing undernutrition. Efforts to scale up nutrition programmes nationally are giving encouraging results within countries in this region. Many countries have been able to reduce undernutrition by reaching mothers and children through a focus on the critical period from conception to the age of two years (the critical 1,000 days). What these countries have in common is a coherent set of elements such as political commitment at the highest level, national policies and programmes based on sound situation analysis, addressing undernutrition through a multi-sectoral approach, adequate capacity at national and sub-national level, community involvement and participation sustained by effective communication and advocacy, and a strong monitoring and accountability system.

This Framework has been developed following the recommendations of the Third Meeting of the SAARC Health Ministers (2006). It is based on the nutrition situation of the region, takes into account recent developments in public health nutrition, and promotes the adoption of proven strategies to improve nutrition outcomes, with special focus on addressing undernutrition. It also proposes for discussion key areas of engagement of the SAARC Secretariat for improving nutrition outcomes in the region.

## REGIONAL NUTRITION SITUATION

In South Asia, 38 percent of children under five are stunted due to persistent nutrition deprivation, 32 percent are underweight and 16 percent are wasted<sup>2</sup>. According to the MDG Report 2012, the proportion of children under five who are underweight in South Asia declined from 51 percent in 1990 to 33 percent in 2010. When disaggregated by wealth quintile, the prevalence of underweight children in the poorest quintile of households is much higher than that of children from the richest quintile, highlighting disparities in South Asia, which are greater than in other regions<sup>3</sup>.

Wasting in South Asia (16 percent) is the highest compared to other regions and is twice the world average (8 percent). Wasting represents an acute form of undernutrition and wasted children are at a markedly increased risk of death.

Stunting is a condition which often goes unrecognized in the developing world. Stunting, more accurately than underweight, reflects the long-term nutritional deficiencies and recurring illnesses that occur during early life, which hamper optimal growth and development. Despite the decline in stunting prevalence from

62 percent to 39 percent in the period 1990 to 2010, the absolute numbers of stunted children are still frightening. The high prevalence of stunting combined with the region's large population explain why the number of stunted children in South Asia is so high. The proportion of stunted children in the poorest households is higher than in the richest households. Likewise, rural children under five are more likely to be stunted than urban children.

Stunting is associated with an increased risk of mortality from infections in childhood and an increased risk of non-communicable diseases in adult life. Women who were stunted in early childhood are more likely to give birth to underweight children, perpetuating the intergenerational cycle of undernutrition. Evidence shows that stunted children enroll later in school, have higher drop-out rates, and perform poorly in school. This leads to reduced earning capacity in adult life (average 22 percent reduction in earning rates but upto 45 percent has been reported) and perpetuates the intergenerational cycle of poverty and deprivation in families, communities and society. With over 37 million children born every year in South Asia and stunting affecting over one third of them, there is evidence that

<sup>2</sup> For the definition of undernutrition, its measurements and implications refer to annexure 1.

<sup>3</sup> State of World Children, UNICEF, 2014.

the return on investments currently being made in elementary education could be lost because of childhood stunting. Therefore, stunting is not only a problem affecting the survival of children but is a development challenge for the region. Moreover, a stunted child enters adulthood with a greater propensity for developing obesity and chronic diseases. With increasing urbanization and the changes in diet and lifestyle in South Asia, many countries could face the challenge of the double burden of stunting and overweight/obesity with new economic and social consequences.

By far, South Asia has the greatest regional incidence of low birth-weight, with one in four children born weighing less than 2500 grams. Low birth-weight children are at a higher risk of death and of not developing to their full potential. The data on birth-weight are likely to be underestimating the true magnitude of the problem due to the low percentage of women who deliver assisted by qualified health personnel. Low birth-weight is associated with maternal undernutrition and anemia. Even if there are no recent data on the prevalence of anemia in pregnant women in South Asia as a whole, the public health problem linked to anemia in pregnancy in the region has been classified by WHO as "severe".

According to World Bank<sup>4</sup> the loss of GNP per year due to undernutrition is as high as 2-3 percent, which translates in millions of USD per year. South Asia has a growing economy, however economic growth is not enough for fighting undernutrition. There is evidence that differences in average height across developing countries are not well explained by differences in wealth. There are other factors that need to be taken into consideration. As highlighted by a recent document published by World Bank

(February, 2013) the prevalence of child stunting in some South Asian Countries is higher than in many poorer sub-Saharan African countries; this paradox, referred to as "the Asian enigma" has received attention from economists and nutrition specialists. Some explain that a large fraction of the international difference in child height could be explained by the linkages between child stunting and poor sanitation. Open defecation, which is exceptionally widespread in South Asia, could account to a large extent for the high rates of stunting in the region. Even if much needs to be done for explaining the Asian enigma, recent publications confirm the need for multi-sectoral approaches to address undernutrition. The inter-linkages between Nutrition and Sanitation have been recognized by SAARC who has taken the initiative to develop coherent Nutrition and Sanitation Action Frameworks for South Asia.

In the international arena, countries with emerging economies such as Brazil, China, and Thailand have demonstrated that child undernutrition can be drastically reduced. In South Asia we have the example of Maharashtra, in India, which had an unprecedented 16 percentage-point decline in the prevalence of stunting among children under the age of two over a six-year period (2006-2012). In Nepal, the prevalence of stunting in children under-five dropped from 57 percent in 2001 to 41 percent in 2011, showing that even in difficult conditions, impressive gains can be made. These examples indicate that the reduction of child stunting in South Asia is feasible within a short period of time. It requires effective policy, programme and budgetary actions that tackle the main determinants of undernutrition particularly for the most vulnerable: the youngest, the poorest and the most excluded children and women.

<sup>4</sup> Scaling up Nutrition; How much would it cost? World Bank Report 2009

## INTERNATIONAL COMMITMENTS

During the first International Conference on Nutrition (Rome, 1992) a World Declaration and Plan of Action was adopted which underlined the need to eliminate chronic hunger and undernutrition, including micronutrient deficiencies, especially among the vulnerable sections of society.

The Paris Declaration (2005) and the Accra Agenda for Action (2008) focused on ownership, alignment of donor funding with country strategies and systems, harmonization of external assistance, reduction in fragmentation, management for results, and mutual accountability for improved nutrition outcomes. These principles are integral parts of achieving sustainable improvements in nutrition. In May 2012, the World Health Assembly agreed on a new target of reducing the number of stunted children by 40 percent by 2025. The Group of 8 (G-8) of the world's

wealthiest countries has put nutrition high on its development agenda, and the United Nations Secretary-General's Zero Hunger Challenge includes the elimination of stunting as a goal.

Recently at the global level, renewed impetus to act on nutrition is gathering momentum through the Scaling Up Nutrition (SUN) movement, endorsed by over 100 international development institutions. SUN strongly advocates for the adoption of a multi-sectoral approach which includes a combination of nutrition-specific and nutrition-sensitive interventions. The nutrition-specific interventions largely focus on issues that have a direct bearing on undernutrition while the nutrition-sensitive interventions address its underlying or root causes. In the SAARC region, Bangladesh, Nepal, Pakistan and Sri Lanka governments have joined the SUN movement.

## REGIONAL COMMITMENTS

SAARC member states have jointly committed to the reduction of maternal and child undernutrition in the region. Article VII of the SAARC Social Charter indicates that State parties agree to extend all possible support to reduce low birth weight, undernutrition, anemia, morbidity and mortality in children and women through the inter-generational life cycle approach, increased education, literacy, and skill development amongst adolescents and youth, especially girls, and the elimination of child/early marriage. These commitments are also reflected in the SAARC Development Goals (Annexure 2).

In August 1996, at the Inter-Ministerial Conference in Rawalpindi resolved to halve undernutrition rates between 1990 and 2000 and to then further halve them again by 2010. A need for strong advocacy was invoked which led to the SAARC undertaking the following responsibilities:

- Monitor the nutrition situation and ensure sustained implementation of policies to reduce undernutrition (including micronutrient deficiencies) and household food insecurity;
- Initiate age-specific programmes for the reduction of undernutrition;
- Ensure institutional support for such programmes; and
- Encourage mass awareness about undernutrition and its consequences through electronic and other mass media.

At the ninth SAARC Summit in 1997, SAARC leaders agreed to launch an initiative on nutrition through the Malé declaration. Furthermore, the third meeting of the SAARC Health Ministers (Dhaka, 25-26 April 2006), recommended that guidelines for a regional initiative on basic healthcare services, nutrition, safe water and sanitation be developed.

# SAARC REGIONAL ACTION FRAMEWORK FOR NUTRITION

## Key principles

The Universal Declaration of Human Rights (United Nations General Assembly, 1948) declares freedom from hunger and undernutrition as a basic human right. The convention asserts that “everyone has the right to a standard of living adequate for the health and well-being of himself and his family” (Article 25).

The Convention on the Rights of the Child (United Nations General Assembly, 1989) states that children are the most vulnerable to undernutrition and very likely to suffer its consequences over the long term. Article 24 of the Convention states that “States parties recognize the right of the child to enjoyment of the highest attainable standard of health, and shall act appropriately to combat disease and undernutrition through the provision of adequate nutritious foods, clean drinking water, and healthcare.”

In the World Declaration on Nutrition, adopted at the Joint FAO/WHO International Conference on Nutrition (Rome, 1992) the international community affirmed that “access to nutritionally adequate and safe food is a right of each individual”. In the Rome Declaration on World Food Security (World

Food Summit, 1996) heads of state and government reaffirmed “the right of everyone to have access to safe and nutritious food, consistent with the right to adequate food and the fundamental right of everyone to be free from hunger”.

Responsibilities for the fulfillment of the right to nutrition lie with governments, service providers, communities, households, caregivers and individuals. The primary role of government is to establish a policy environment conducive to the attainment of the “right to nutrition” in an equitable manner and promulgate appropriate laws, enforce and regulate these laws, monitor nutrition services and promote optimal nutrition practices. To facilitate this process, communities need to be active actors and participate in this changing process. Only then will the change be sustainable.

The basic right to adequate food and nutrition applies in any emergency response and is reflected in the Humanitarian Law the context of emergencies, critical aspects of nutritional well-being needs to be addressed among the affected populations. Poor decisions without any long term visions can have a negative impact.

### Goal and strategic pillars

To ascertain that children in South Asia grow and become healthy and productive adults who contribute to the development of their countries, the Regional Action Framework addresses the issue of undernutrition and provides a response that is achievable and sustainable. The Framework highlights that optimal nutritional outcomes in children can be achieved by building an enabling environment and supporting the scale-up of sustainable nutrition actions that will lead to reduction in undernutrition. In order to achieve this goal, the following overarching approaches – termed as strategic pillars are proposed to the SAARC countries. These can be implemented in partnership with different stakeholders, like governments, civil societies, academic institutions, professional bodies, etc.

**PILLAR 1:** Solicit high level political commitment to improve nutrition governance, strengthen programme planning, and implement multi-sectoral policies and plans addressing all determinants of undernutrition.

**PILLAR 2:** Scale up cost-effective evidence based, sustainable nutrition-specific and nutrition-sensitive interventions for all, with focus on women and children.

**PILLAR 3:** Increase human and institutional capacity to manage nutrition programs at national and sub-national level.

**PILLAR 4:** Increase effectiveness and accountability of stakeholder's implementing nutrition interventions through a coherent monitoring framework, reporting and knowledge management system.

# KEY POLICY AND PROGRAMMATIC AREAS OF WORK

The essential drivers for improving nutrition outcomes for women and children in South Asia that governments and their partners are encouraged to take into consideration are hereby detailed below:

**PILLAR 1: Solicit high level political commitment to improve nutrition governance, strengthen programme planning, and implement multi-sectoral policies and plans addressing all determinants of undernutrition.**

- Leadership for nutrition has to be placed at the highest political level to ensure that nutrition gets positioned in the development agenda and is prioritized across multiple sectors and ministries such as Agriculture and Food Security, Water Hygiene and Sanitation, Education, Finance, Social Protection and other relevant ministries. In addition, multisectoral planning for nutrition and oversight of the plan needs to be carried out at the highest level and not be housed within one ministry.
- Sound situation analysis that identifies the groups more vulnerable to undernutrition and the basic and underlying causes of

their vulnerability needs to be conducted and updated periodically. This will help governments to design evidence-based multi-sectoral policies and programs that addresses both direct and indirect determinants of undernutrition. The situation analysis will help to identify the reasons for the increase of noncommunicable diseases and help countries ensure timely actions and avoid the double burden of malnutrition.

- At the planning stage, adequate and predictable allocation of budgets at the country level and effective mobilization of funds from various sources (ministries and development partners) is essential in order to make fruitful investments in programming for improved nutrition.

**PILLAR 2: Scale up cost-effective evidence-based, sustainable nutrition-specific and nutrition-sensitive interventions for all, with focus on women and children.**

- Country-driven scaling up of nutrition interventions should be tailored to meet local needs and address all vulnerable populations keeping in mind equity

principles. This should also include actions targeting the prevention of overweight for those countries in the region who are at risk of facing the double burden of malnutrition.

- A package of proven nutrition-specific interventions that effectively prevent and treat undernutrition during the 1,000 day window of opportunity from pregnancy to age 2 years needs to be implemented. Interventions which directly address undernutrition, include: 1) promotion of optimal nutrition practices - maternal nutrition, exclusive breastfeeding, appropriate complementary feeding; 2) meeting micronutrient requirements through staple food fortification, supplementation, home fortification and dietary diversity; 3) prevention and treatment of severe acute malnutrition and moderate acute malnutrition; and 4) adequate water sanitation and hygiene (WASH) interventions such as hand-washing with soap and hygiene, provision of potable drinking water, latrines and waste disposal.
- To address the intergenerational cycle of undernutrition and avoid undernourished mothers to deliver low birth weight children, a package of interventions for improving adolescent nutrition needs to be put in place before adolescent girls enter motherhood.
- Nutrition-sensitive interventions that draw upon complementary sectors such as Agriculture, Social Protection, Education, and Gender Empowerment need to be implemented in addition to nutrition-specific ones. These affect the underlying and basic determinants of undernutrition and child development which include poverty, food insecurity, and lack of access to adequate care (for additional details refer to annexure 3).

**PILLAR 3: Increase human and institutional capacity to manage nutrition programs at national and sub-national level.**

- Conduct periodically a capacity needs assessment to inform the development of nutrition capacity strengthening plans for government and other stakeholders in the area of public health nutrition.
- Develop the capacity of decision-makers and service delivery personnel at all levels to design policies and programs that have a multi-sectoral approach in order to address undernutrition; and implement these programmes in an effective and sustainable manner.
- Support institutions in carrying out operational research on multi-sectoral approaches to improve nutrition (e.g., research in double burden of malnutrition, social transfers and nutrition, women's health before pregnancy, urban agriculture, etc.)
- Develop capacities of communities, community-based organizations, and civil society groups to analyze and address undernutrition within their communities through decentralized planning and finding innovative local solutions.

**PILLAR 4: Increase effectiveness and accountability of stakeholder's implementing nutrition interventions through a coherent monitoring framework, reporting and knowledge management system.**

- Strengthen and/or establish results-based management systems and strong monitoring, evaluation and knowledge management framework(s) for tracking progress against a set of pre-defined indicators.
- Nutrition information systems need to be established/strengthened to provide disaggregated data by gender, rural/urban habitat, and socio-economic groups in order to monitor progress in the most disadvantaged segments of the population and ensure an equitable approach in improving nutrition outcomes.
- As part of the nutrition-sensitive interventions, data on social, political, economic determinants as well as on consequences of different hazards, including climate change etc. should be collected and made available for analysis.
- The nutrition information system will inform policy and programming efforts to make necessary adjustments reflecting environmental changes (social, political, economic, climate, etc.)

## KEY ACTIONS BY SAARC SECRETARIAT FOR STRENGTHENING NUTRITION OUTCOMES IN THE REGION

SAARC has a major role to play in supporting countries to improve their nutrition situation. SAARC can provide a platform for countries to work collaboratively, advocate, and work in partnership to address common issues (like adolescent girls' nutrition) that transcend political/geographical borders, share experiences and learn from each other. SAARC also provides an opportunity to reinforce the concept that nutrition has a multisectoral domain and undernutrition needs to be addressed at the country level.

SAARC as a body can be instrumental in joint advocacy so that countries prioritize and reposition nutrition as a central issue within their development agenda. This would entail advocating with different ministries within governments such as Nutrition, Health, WASH, Agriculture, and Education and ensure that they prioritize investments in nutrition. In order to do this, SAARC is working/can consider working towards the following:

- Nutrition framework for the region. The Regional Action Framework has been jointly developed and agreed upon by the member states. With the formal endorsement of the present Framework, SAARC can consider developing a regional nutrition strategy or plan of action to inform country led action plans.
- Nutrition be included as a subject of decision and action in the agenda of the Technical Committee of Health and Population meetings and can be expanded into all the other Technical Committees meetings. At a further stage and in line with its multisectoral dimension, nutrition can be placed higher under the SAARC Standing Committee comprising of Foreign Secretaries from the member countries.
- SAARC can serve as a platform to discuss certain cross border issues pertaining to nutrition. Some examples of cross border issues that can be discussed during SAARC meetings include
  - Harmonization of food standards and quality control of foods (e.g. food fortification with micronutrients, iodized salt, regulating complementary foods under the Code of Marketing of Breastmilk Substitutes). This issue can be included in the agenda of the SAARC Regional Standards Organization (SARSO).
  - Since South Asia is prone to frequent emergency situations like floods, droughts and civil unrest, nutrition-related issues can be included within the Standard Operating Procedures (SOP's) of the SAARC Disaster Management centre.

For e.g. issues concerning the code of conduct for donation and distribution of various food commodities and its compliance with the Code of Marketing of Breastmilk Substitutes during emergency situations can be addressed.

- SAARC can support the member countries in strengthening their human and institutional capacity by offering courses in Public Health Nutrition which will empower the countries to develop policies and programmes and implement them effectively. Expertise on Public Health Nutrition can be drawn from each member country to jointly develop courses which can be offered through the University Grants Commission or the Regional South Asian University (Delhi, India) through either online or regular classes.
- SAARC can also serve as a knowledge management platform to share experiences, better practices, and lessons learnt. It can also be a forum for regional consultations between member states. For the nutrition related information to be readily available to the member states, SAARC Documentation Centre and SAARC Information Centre can be utilised as the repository. These centres can also be used to collate and analyse nutrition related information for the region.
- SAARC development funds could provide grants for operational and formative research on nutrition related issues such as experience in multi-sectoral nutrition programming.

# ANNEXURE 1

## Common terminology

### What is Malnutrition?

Malnutrition is a general term. Often used interchangeably with **undernutrition**, it is a phenomenon resulting from inadequate consumption of food, poor absorption or excessive loss of nutrients. The term malnutrition also encompasses **overnutrition**, resulting from excessive intake of specific nutrients.

An individual will be undernourished if inappropriate amounts of, or quality of nutrients essential for healthy growth and development are not consumed for an extended period of time.

Undernutrition encompasses stunting (chronic undernutrition), wasting (acute undernutrition) and deficiencies of micronutrients (essential vitamins and minerals).

### How can undernutrition be measured?

In children, undernutrition is synonymous with growth failure. Undernourished children are shorter and lighter than they should be for their age/height. To get a measure of undernutrition in a population, young children are weighed and/or their height is measured and the results compared to those of a reference population (known to have grown well).

Measuring weight and height is the most common way of assessing undernutrition

in a given population. Such use of measurements of dimensions of the human body is known as anthropometry. Anthropometry is a widely used, inexpensive and non-invasive measure of the general nutritional status of an individual or a population group. The three commonly used anthropometric indices are:

- Weight-for-Age (WFA).
- Length-for-Age or Height-for-Age (HFA).
- Weight-for-Length or Weight-for-Height (WFH).

### What are the types of undernutrition?

The three indices - weight-for-age, height/length-for-age, weight-for-height/length are used to identify three nutrition conditions: underweight, stunting and wasting, respectively. Each of the three nutrition indicators is expressed in standard deviation units (z-scores) from the median of the reference population based on which undernutrition may be further classified as moderate or severe.

**Underweight:** Underweight, based on weight-for-age, is a composite measure of stunting and wasting. This condition can result from either chronic or acute undernutrition, or both. Underweight is often used as a basic indicator of the status of a population's nutrition as weight is easy to measure.

Evidence has shown that the mortality risk of children who are even mildly underweight is increased, and severely underweight children are at even greater risk of death. An underweight child has a weight-for-age z-score that is at least two standard deviations (-2 SD) below the median in the World Health Organization (WHO) child growth standards.

**Stunting:** Failure to achieve expected height/ length as compared to healthy, well-nourished children of the same age is a sign of stunting. Stunting is an indicator of linear growth retardation that results from failure to receive adequate nutrition over a longer period and/or recurrent infections. It may be exacerbated by recurrent and chronic illness. It is associated with a number of long-term factors including chronic insufficient nutrient intake, frequent infection, sustained inappropriate feeding practices and poverty. Stunting often results in delayed psycho-social and cognitive development and poor school

performance. This in turn affects economic productivity at national level. A stunted child has a height-for-age z-score that is at least two standard deviations (-2SD) below the median for the WHO child growth standards.

**Wasting:** Wasting represents a recent failure to receive adequate nutrition and may be affected by recent episodes of diarrhea or other acute illnesses. Wasting indicates current or acute undernutrition resulting from failure to gain weight or actual weight loss. Causes include inadequate food intake, incorrect feeding practices, disease, infection or, more frequently, a combination of these factors. Wasting in individual children and population groups can change rapidly and shows marked seasonal patterns associated with changes in food availability or disease prevalence to which it is very sensitive. A wasted child has a weight-for-height z-score that is at least two standard deviations (-2SD) below the median for the WHO child growth standards.

# ANNEXURE 2

## **SAARC Development Goals (SDGs): An Engagement with Hope**

### **Livelihood SDGs**

- Goal 1: Eradication of Hunger Poverty
- Goal 2: Halve the proportion of people in poverty by 2010
- Goal 3: Ensure adequate nutrition and dietary improvement for the poor
- Goal 4: Ensure a robust pro-poor growth process
- Goal 5: Strengthen connectivity of poorer regions and of poor as social groups
- Goal 6: Reduce social and institutional vulnerabilities of the poor, women, and children
- Goal 7: Ensure access to affordable justice
- Goal 8: Ensure effective participation of poor and of women in anti-poverty policies and programmes

### **Health SDGs**

- Goal 9: Maternal health
- Goal 10: Child health
- Goal 11: Affordable health-care
- Goal 12: Improved hygiene and public health

### **Education SDGs**

- Goal 13: Access to primary/communal school for all children, boys and girls
- Goal 14: Completion of primary education cycle
- Goal 15: Universal functional literacy
- Goal 16: Quality education at primary, secondary and vocational levels

### **Environment SDGs**

- Goal 17: Acceptable level of forest cover
- Goal 18: Acceptable level of water and soil quality
- Goal 19: Acceptable level of air quality
- Goal 20: Conservation of bio-diversity
- Goal 21: Wetland conservation
- Goal 22: Ban on dumping of hazardous waste, including radio-active waste

## ANNEXURE 3

### Nutrition-specific and Nutrition-sensitive Interventions

#### Nutrition-specific Interventions:

- Support for exclusive breastfeeding up to 6 months of age and continued breastfeeding, together with appropriate and nutritious food, up to 2 years of age;
- Fortification of foods;
- Micronutrient supplementation; and
- Treatment of severe acute malnutrition.

#### Nutrition-sensitive Interventions:

- **Agriculture:** Making nutritious food more accessible to everyone, and supporting small farms as a source of income for women and families;
- **Clean Water and Sanitation:** Improving access to clean water and optimal sanitation to reduce infections and diseases;
- **Education and Employment:** Making sure children have the energy that they need to learn and earn sufficient income as adults;
- **Health Care:** Improving access to services to ensure that women and children stay healthy;
- **Support for Resilience:** Establishing a stronger, healthier population and sustained prosperity to better endure emergencies and conflicts; and
- **Women's Empowerment:** At the core of all efforts, women need to be empowered to become leaders in their families and communities, leading the way to a healthier and stronger world.

## ANNEXURE 4

Proposed indicators: For monitoring nutrition situation of children in South Asia

<b>Impact</b> (adapted from WHA, 2012)	<ol style="list-style-type: none"> <li>1. Percentage of stunting among children under 5 years of age</li> <li>2. Percentage of wasting among children under 5 years of age</li> <li>3. Percentage of women aged 15-49 with anemia</li> <li>4. Incidence of low birth weight</li> <li>5. Exclusive breastfeeding rates</li> </ol>
<b>Equity</b>	1. Gap in the impact indicators by wealth quintile and population groups and gender
<b>Governance and management</b>	1. Number of countries in the region with strong nutrition governance (using the nutrition governance score developed by WHO)



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