सत्यमेव जयते

Ministry of Health and Family Welfare
Government of India

Comprehensive National Nutrition Survey

2016 – 2018

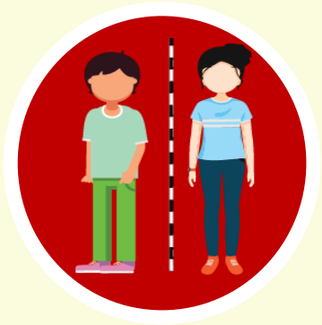
Kerala
State Presentation

Birth to Adolescence

Largest Micronutrient Survey ever conducted: CNNS 2016-

112,316
Children and adolescents interviewed

51,029
Blood, stool and urine samples collected



360
Anthropometric measurers

2500
Survey personnel in 30 states

30
Microscopists

100
Data Quality assurance monitors

200
Trainers and coordinators

200
Lab technicians

900
Interviewers

360
Phlebotomists

Justification and

- 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*

CINS
Birth to Adolescence

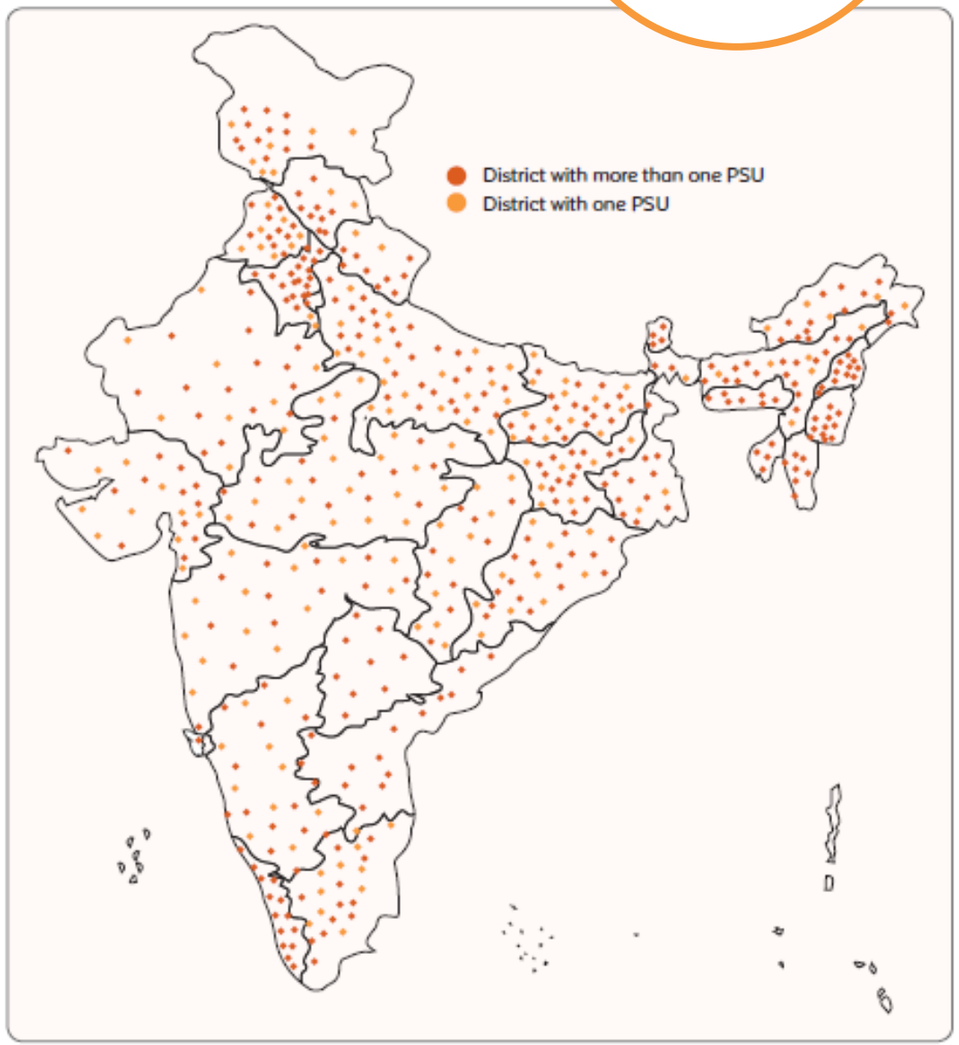
*Soumya Swaminathan, et al. (2019), The burden of child and maternal malnutrition and trends in its indicators in the states of India: the Global Burden of Disease Study 1990–2017. https://doi.org/10.1016/S2352-4642(19)30273-1

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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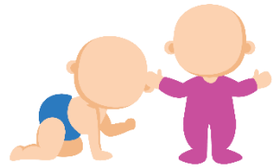
Anthropometry data

	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 (1-19 years)		
		• Waist circumference	

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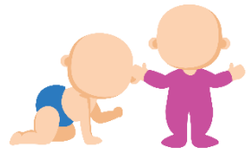
Biochemical indicators - micronutrient deficiencies and NCDs

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

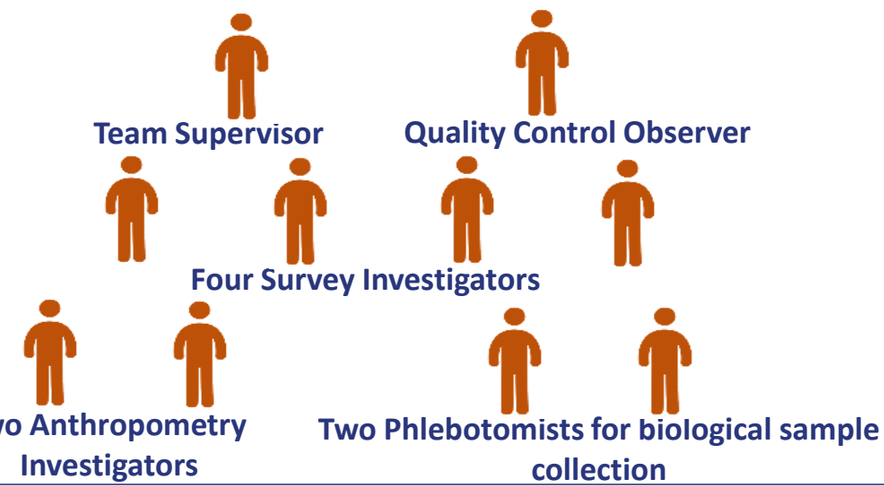
Second Level

- 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 Kerala

CNNS covered 50 PSUs for data collection in Kerala

Achieved following sample size by age groups:

	0-4 years	5-9 years	10-19 years	Total
Household and anthropometry data	898	907	842	**2,647**
Biological sample	523	431	381	**1,335**

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Birth to Adolescence

Period of data collection in Kerala

CNNS data collection period: October 8, 2017 to April 10, 2018

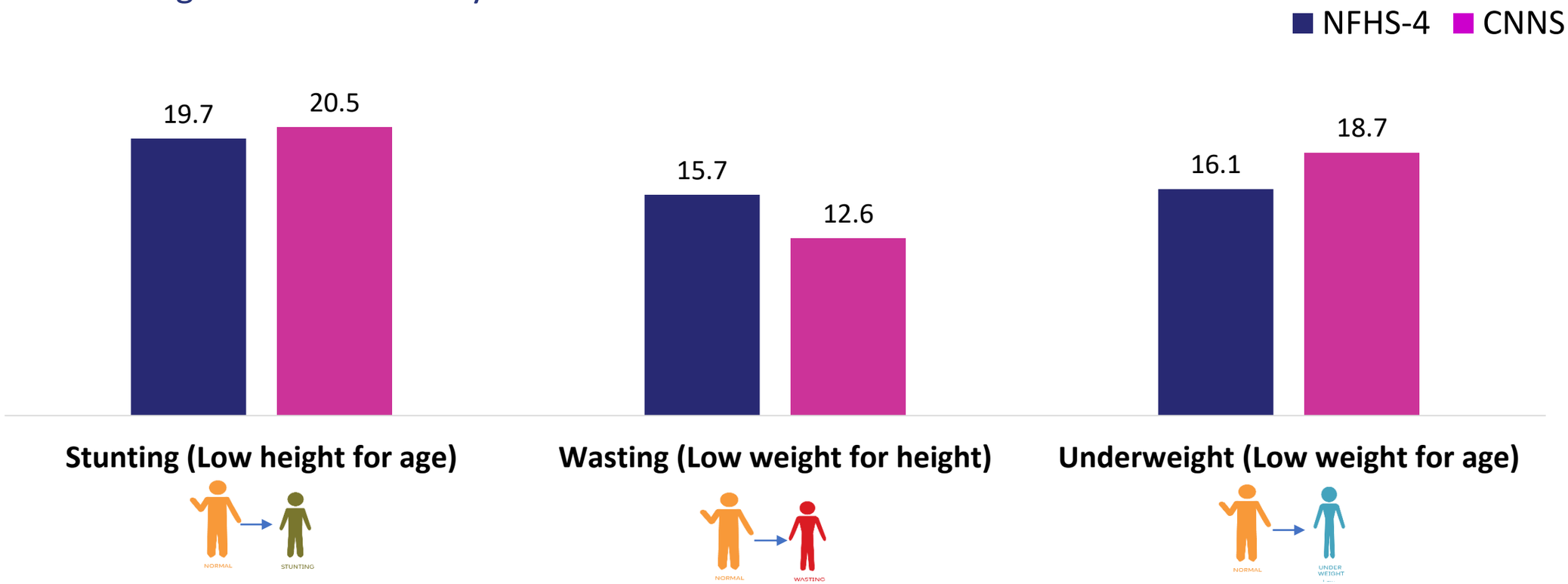
- CNNS collected data during the autumn season of 2017 through spring season of 2018
- NFHS collected data during the spring season through early autumn season of 2016

Survey	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
CNNS 2017-18	April, 2018									October, 2017 to		
NFHS 4 2016			March to October, 2016									

CNNS
Birth to Adolescence

Kerala key findings: Anthropometry (1/2)

Stunting, wasting and underweight prevalence remained nearly at same level in comparison with NFHS-4 among children under 5 years



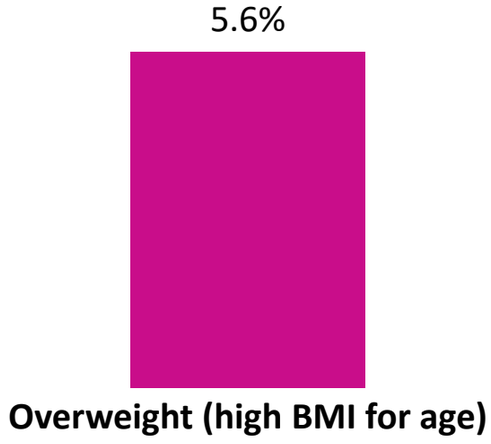
Birth to Adolescence

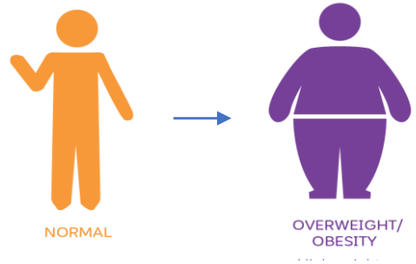
Kerala key findings: Anthropometry (2/2)

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

1/10 children aged 5-9 years was stunted. The school age period does not provide an opportunity for catch up growth in height.

6% of adolescents aged 10-19 years were overweight or obese.





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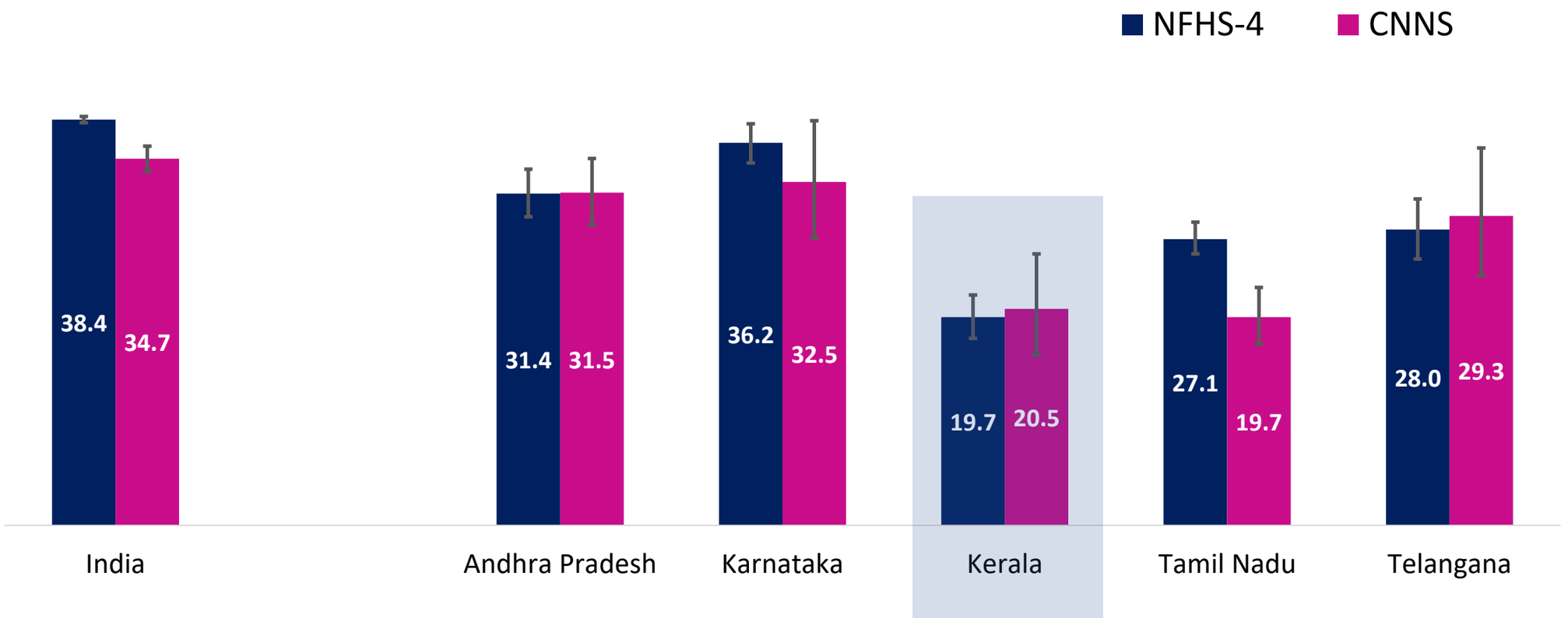
Stunting among children under five unchanged

Stunting remained at the same level between CNNS and NFHS-4 – **(20%- 21%)** in Kerala

Among all southern states significant decline in stunting was observed only in Tamil Nadu



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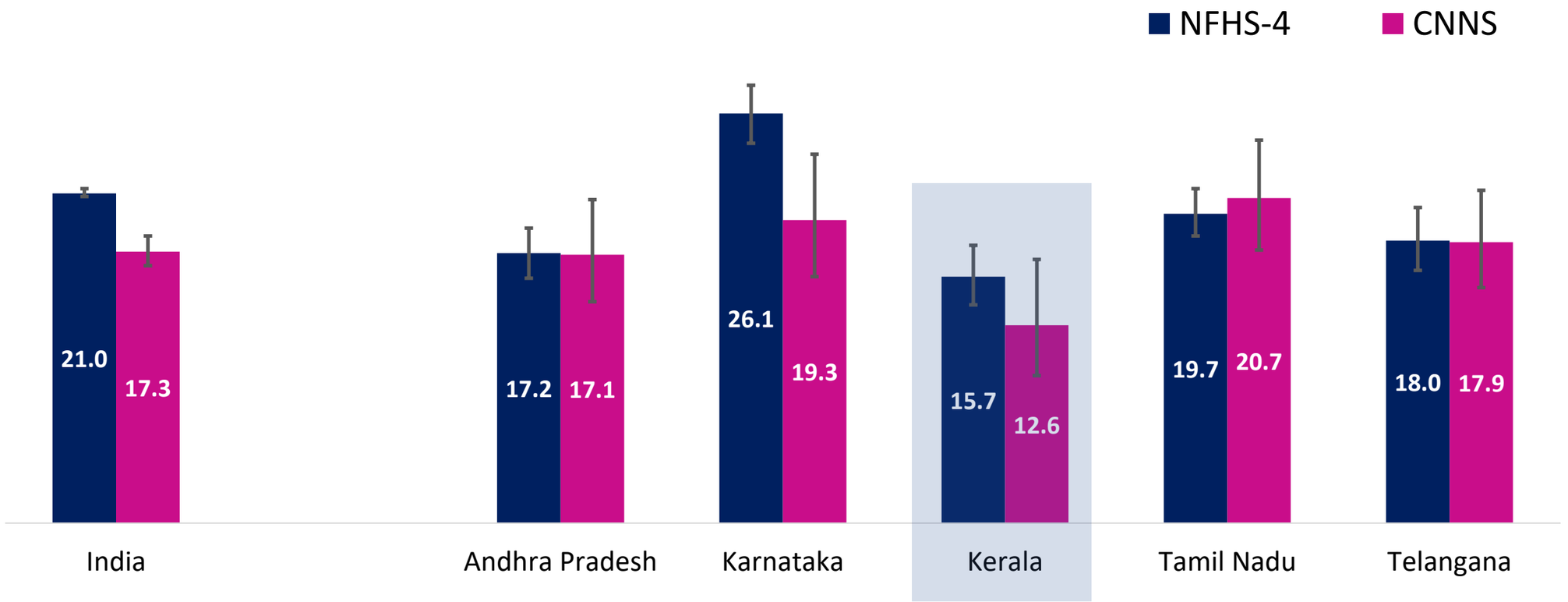
Wasting unchanged among children under five

Prevalence of wasting did not decline significantly in Kerala between NFHS-4 and CNNS – **16%** vs **13%**

Among all southern states wasting did not decline significantly in any state except Karnataka



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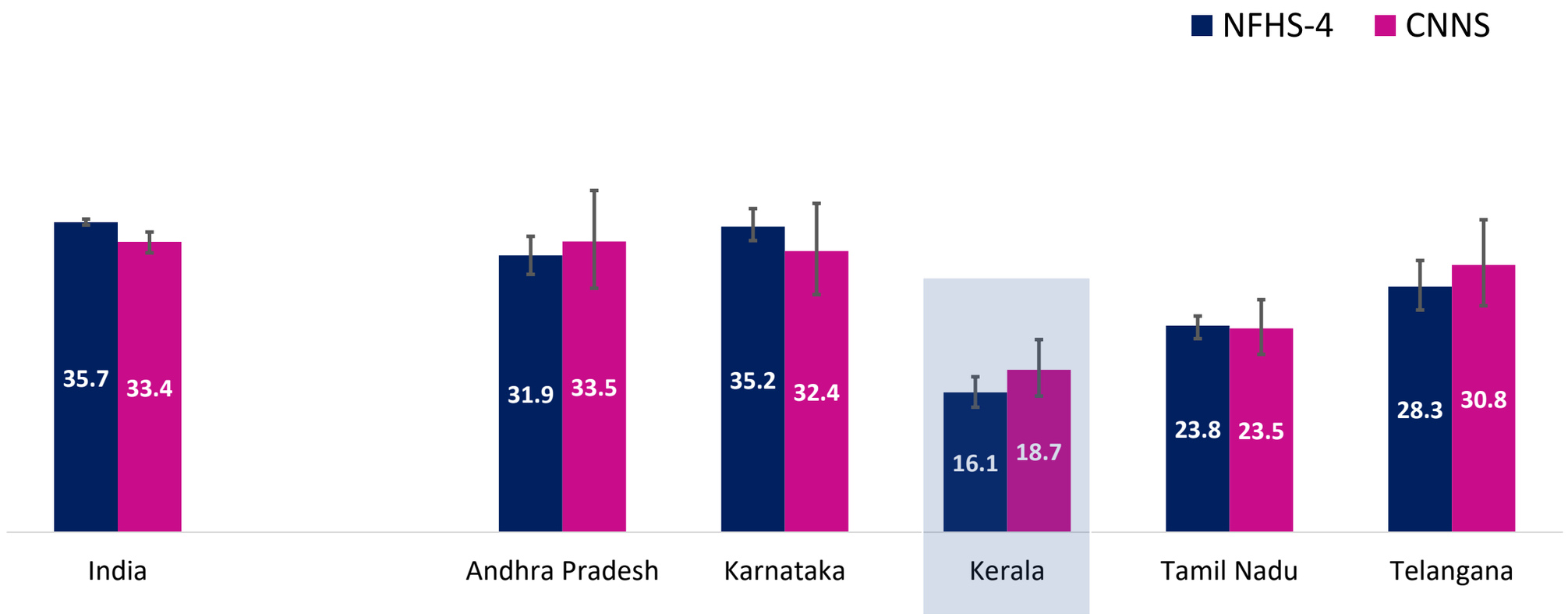
Prevalence of underweight among children under five unchanged

Underweight is a composite measure of chronic and acute malnutrition

Prevalence of underweight remained unchanged between NFHS-4 and CNNS

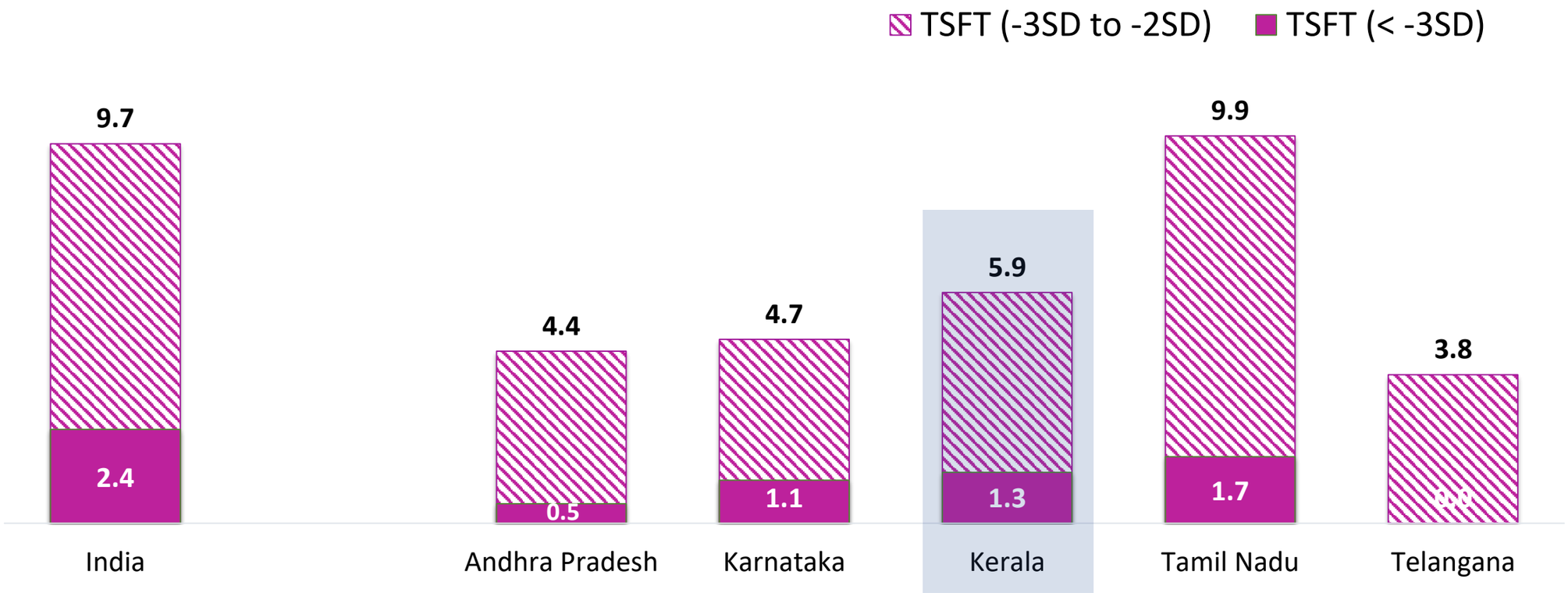
Prevalence remained nearly unchanged in all southern states



Birth to Adolescence

Triceps Skinfold Thickness (TSFT) for children under five

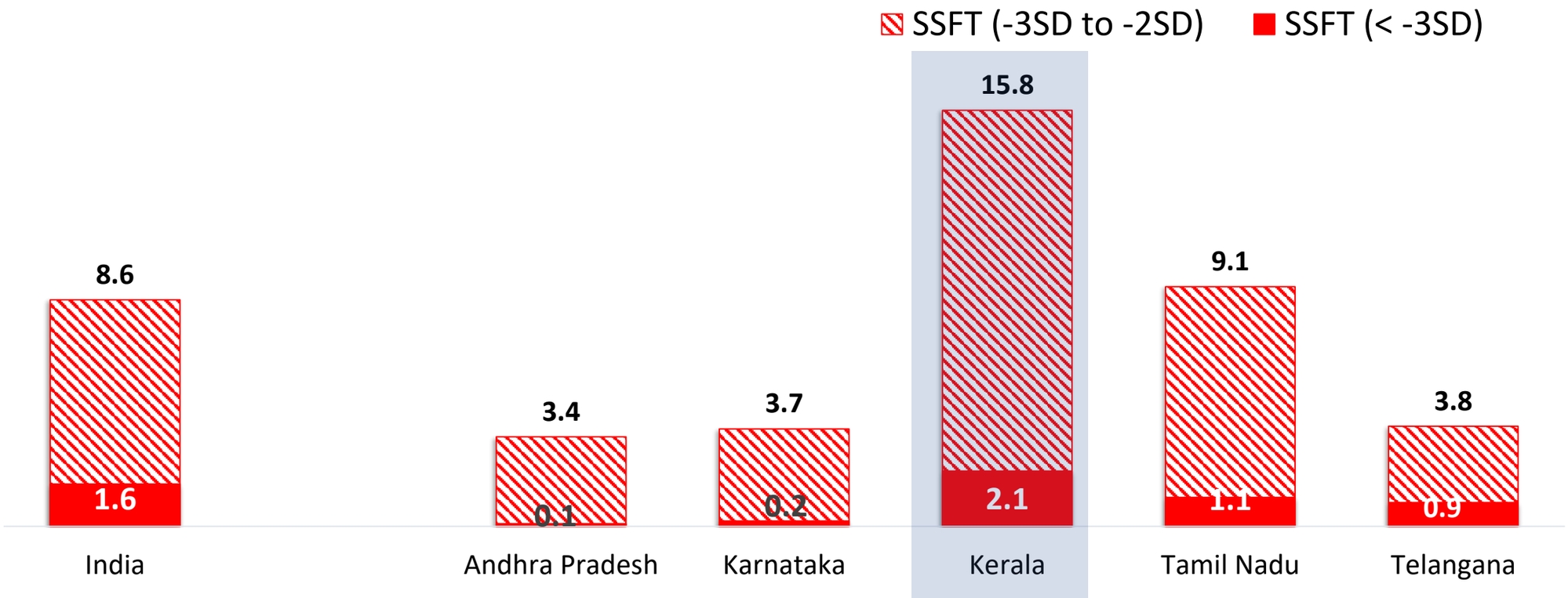
Low fat mass as reported by TSFT in Kerala (6%) much lower than national average (10%)



Birth to Adolescence

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

Thinness as reported by SSFT in Kerala (16%) was the highest among all southern states and also higher than the national average (9%)

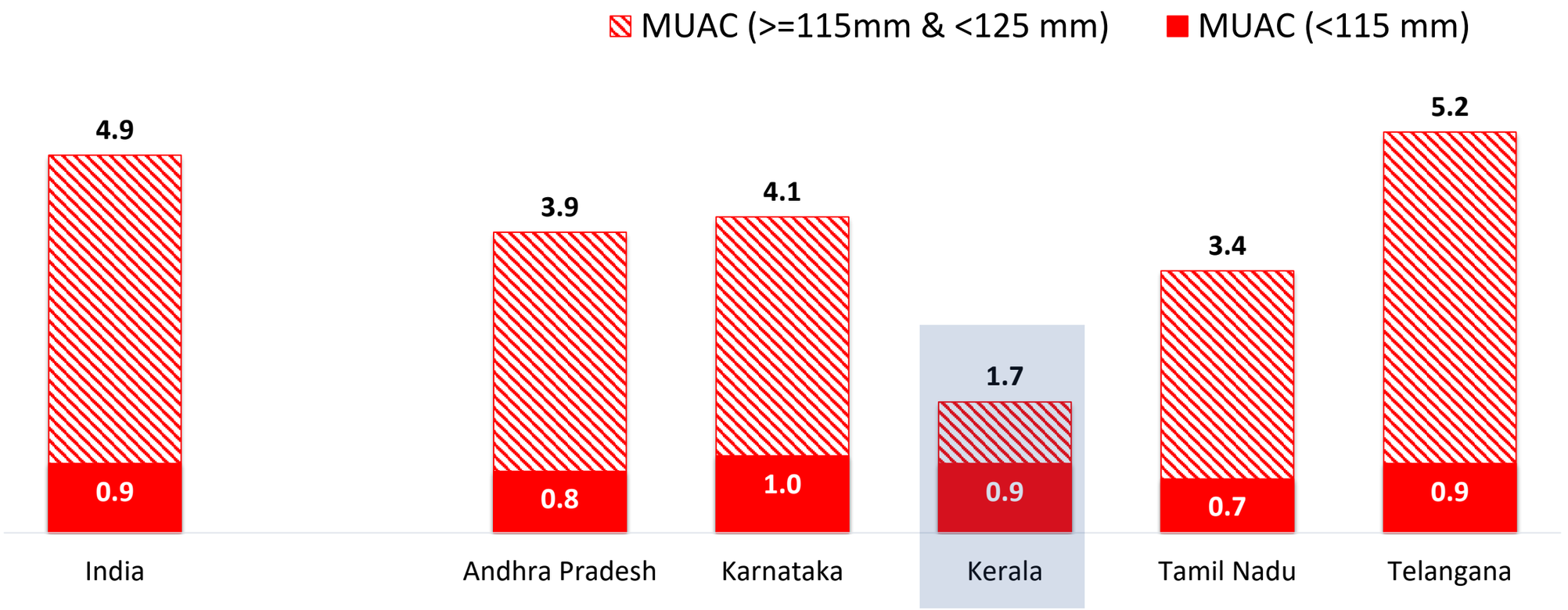


Birth to Adolescence

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

2% children in Kerala had low MUAC

Prevalence of low MUAC ranged between **2%** and **5%** across the southern states

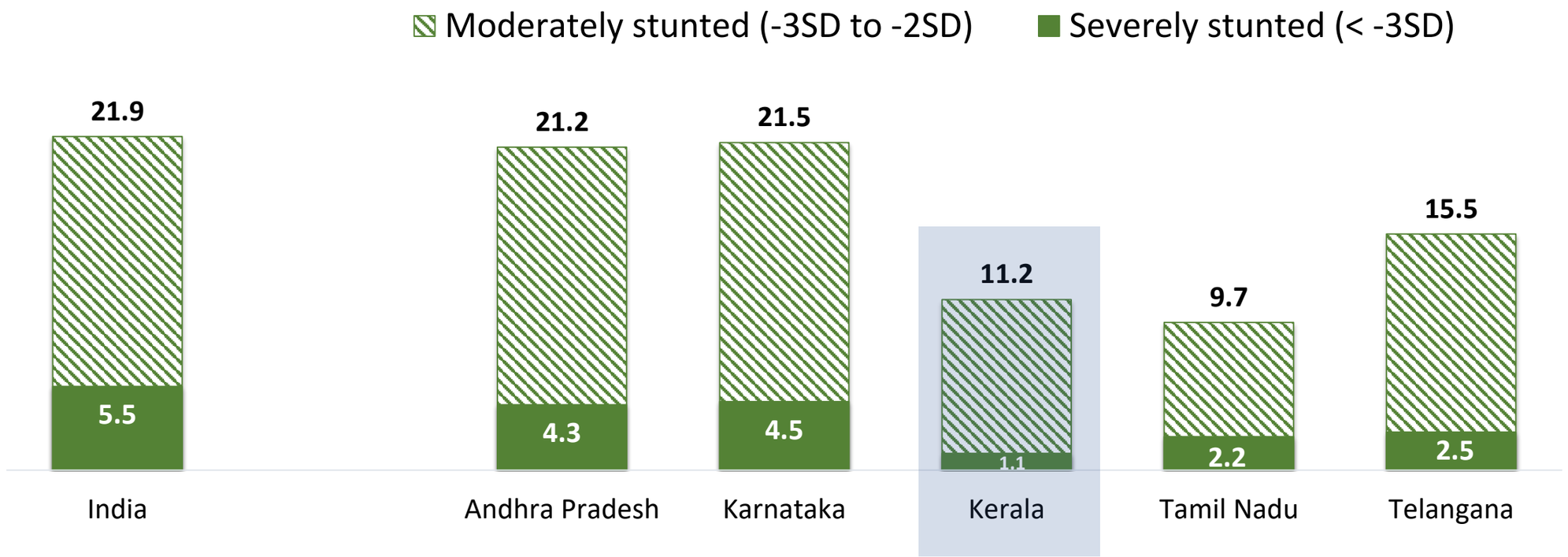


Birth to Adolescence

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

Over **1/10** 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

Karnataka and Andhra Pradesh had the highest prevalence of stunting among the southern states

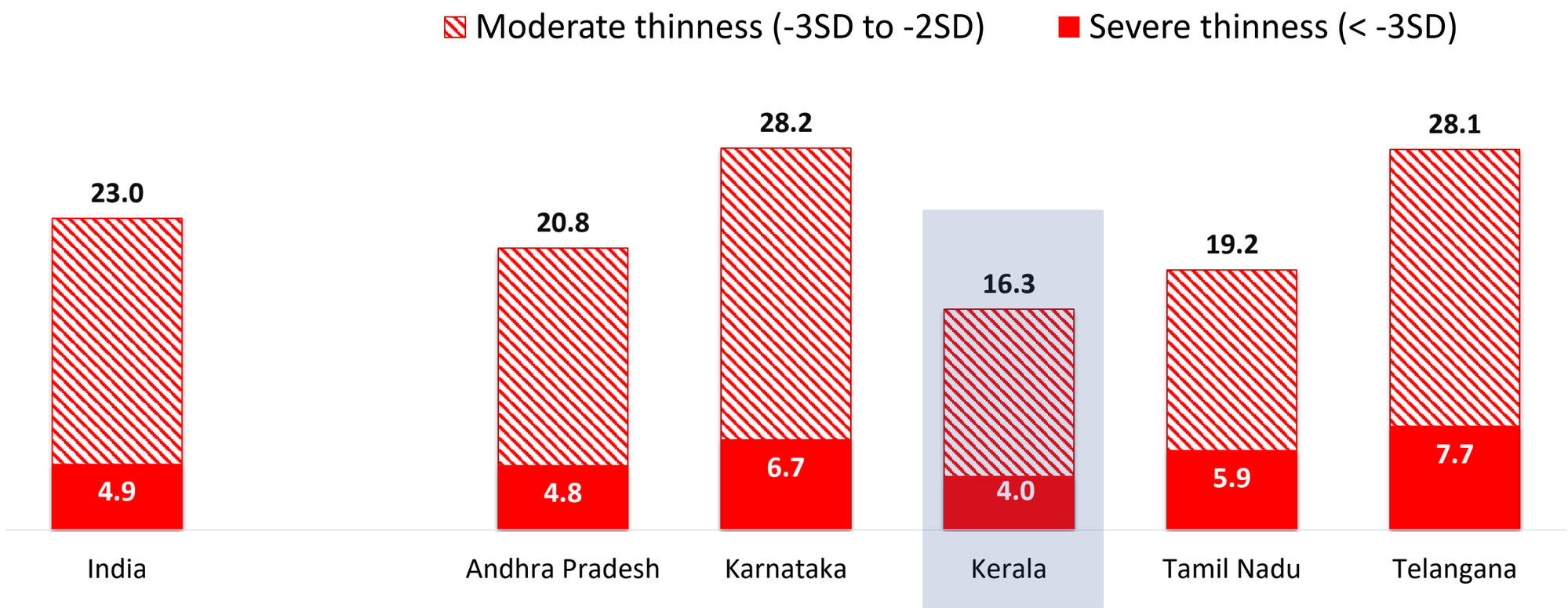


Birth to Adolescence

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

Over **1/7** of children aged 5-9 years was thin

Prevalence of thinness in Kerala was the lowest among southern states and also lower than the national average



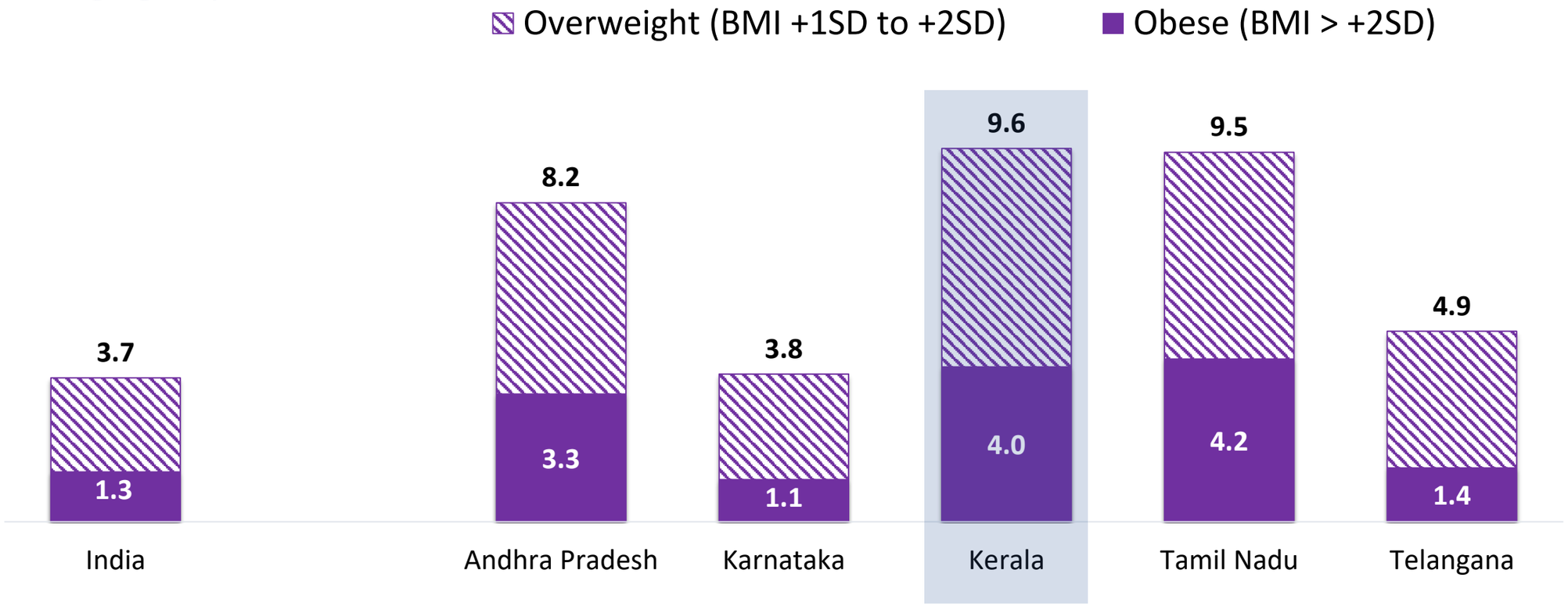
Birth to Adolescence

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 Kerala (**10%**) was more than double the national average (**4%**)

Among southern states, Kerala, Tamil Nadu and Andhra Pradesh were ones with high prevalence of overweight in this age group

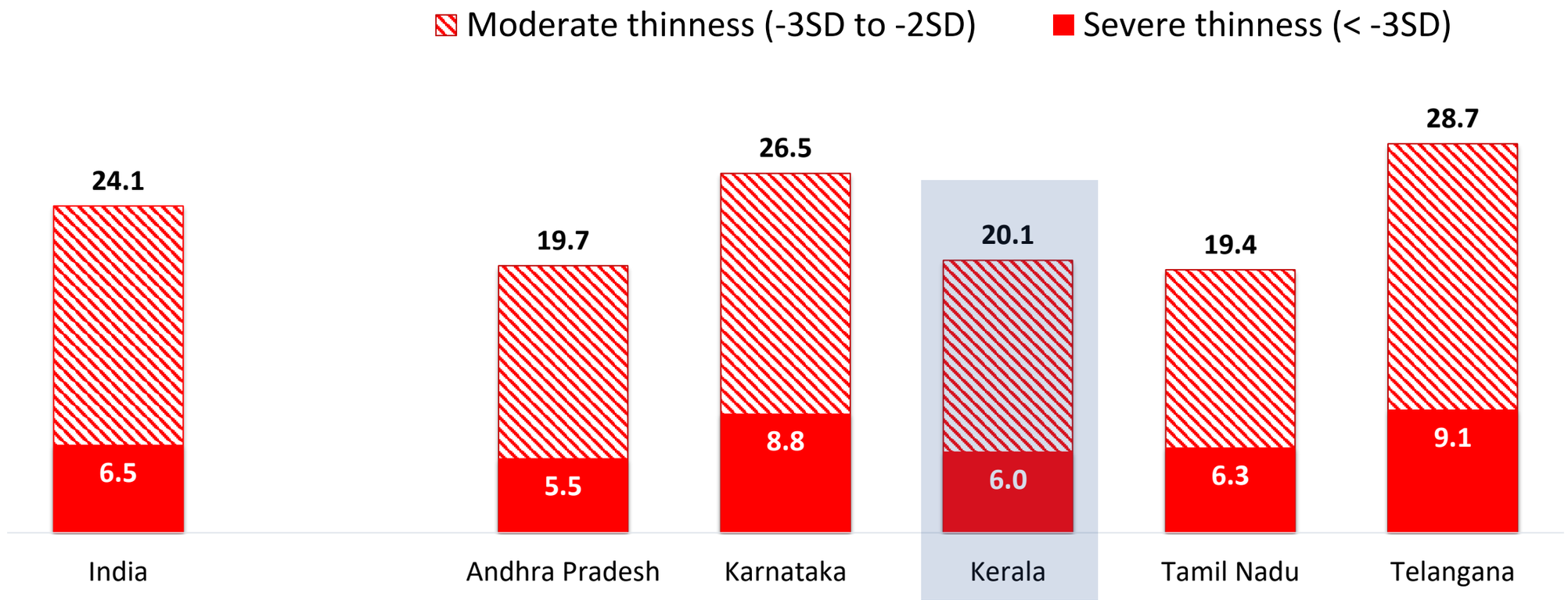


Birth to Adolescence

Thinness among adolescents aged 10-19 years substantially high

1/5 adolescents aged 10-19 years was thin in Kerala (**20**%), lower than national average (**24%**)

Among the southern states, Telangana (**29%**) had the highest prevalence of thinness

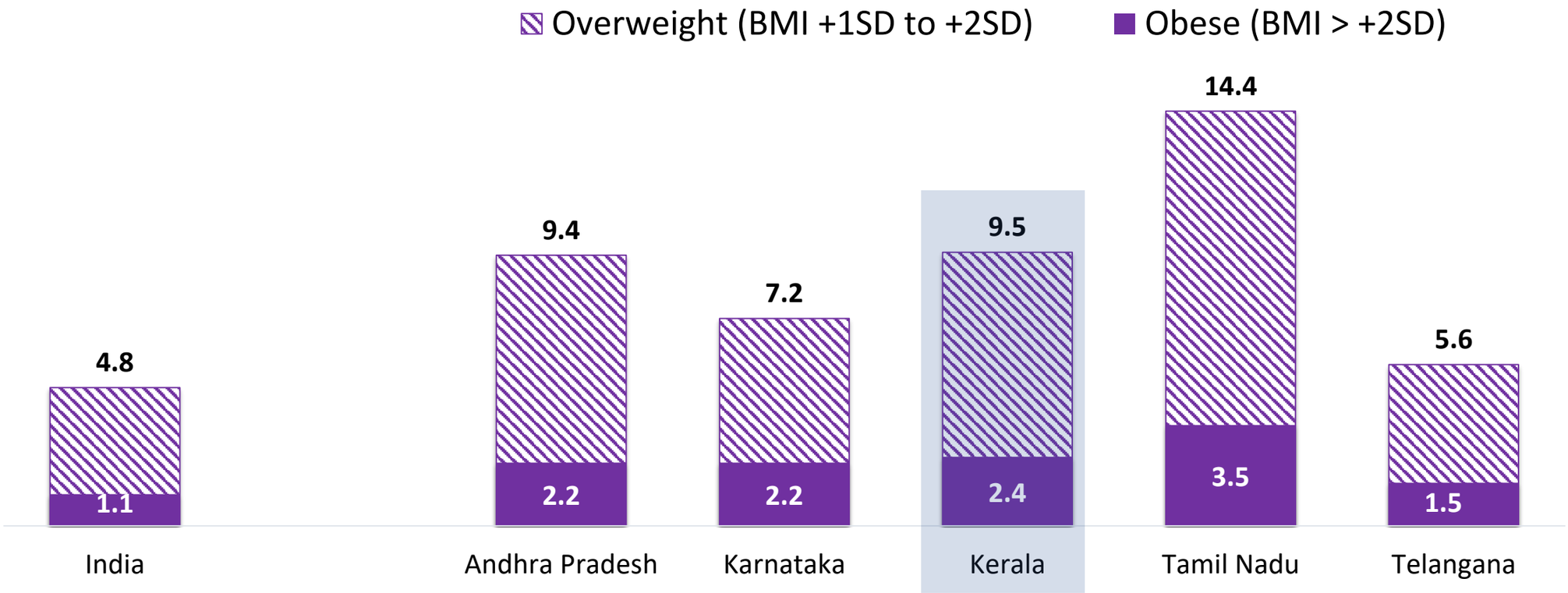


Birth to Adolescence

Prevalence of overweight among adolescents aged 10-19 years high

1/10 adolescent was overweight in Kerala (**10**%), double the national average (**5%**)

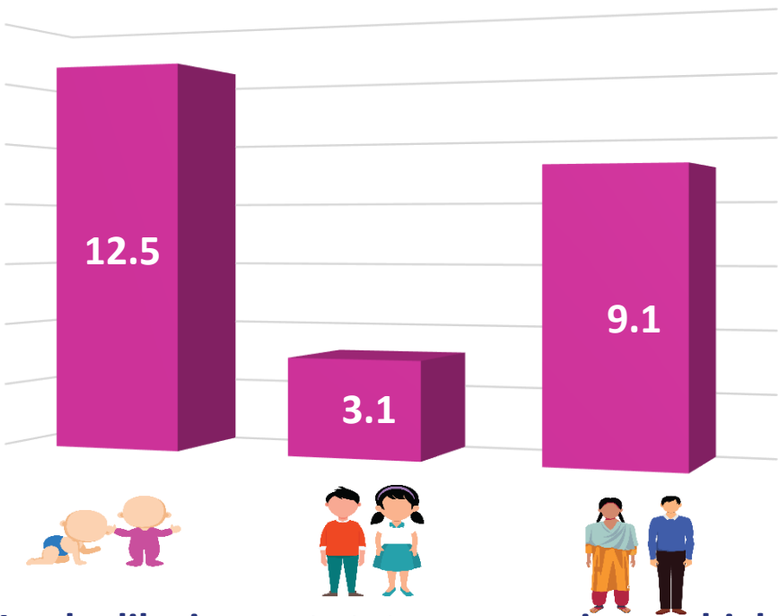
Among the southern states, Tamil Nadu (**14%**) had the highest prevalence of overweight



Birth to Adolescence

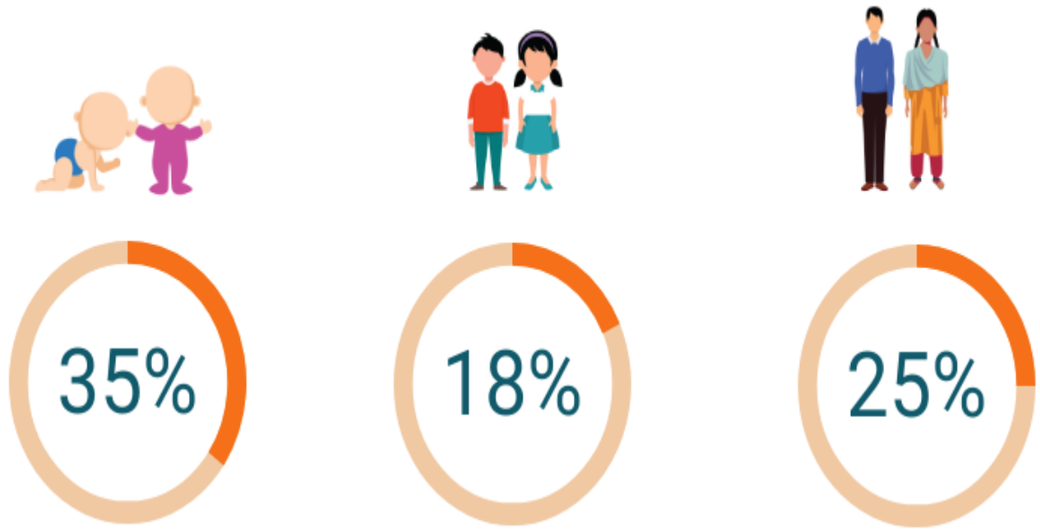
Kerala key findings: Anaemia and iron deficiency

Anaemia



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

Iron deficiency



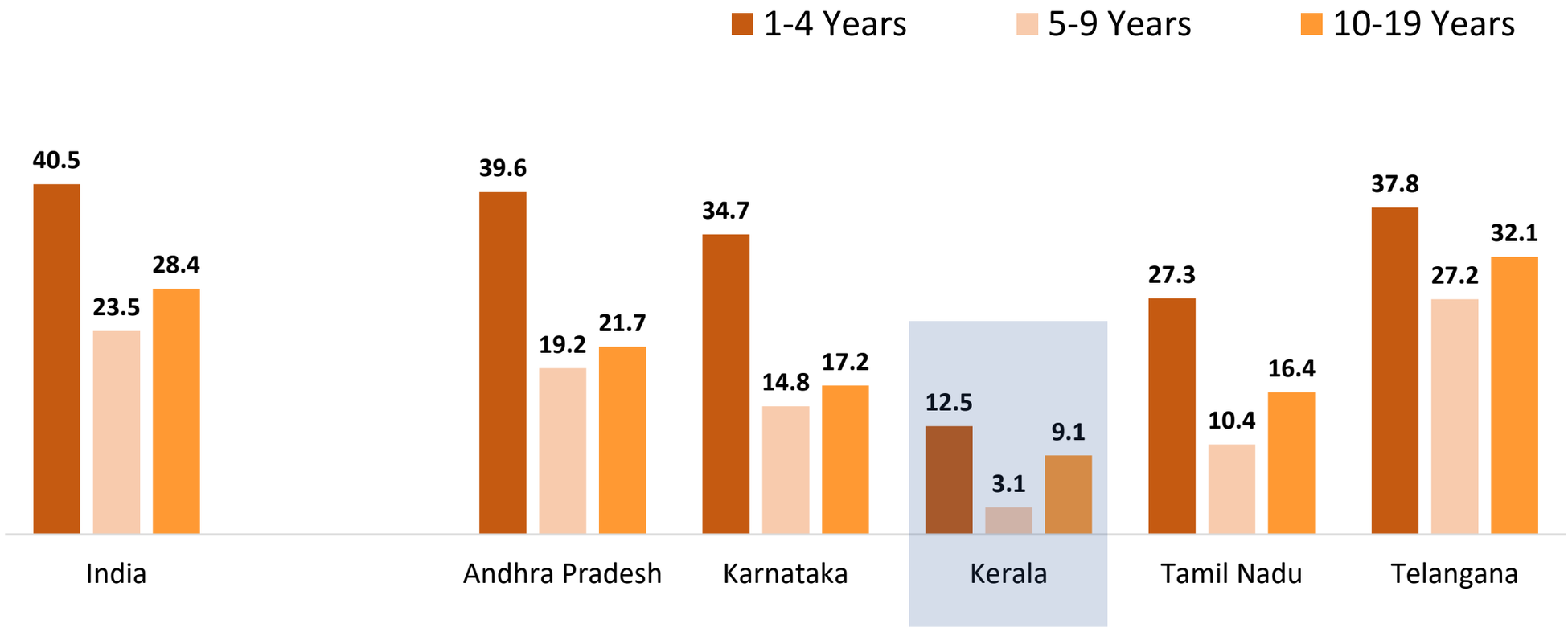
Findings indicate that children aged 1-4 years had higher iron deficiency (measured by serum ferritin) than other children or adolescents

CNNS Birth to Adolescence

Prevalence of Anaemia among children and adolescents

1/8 children aged 1-4 years was anaemic in Kerala (**13**%), significantly lower 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)

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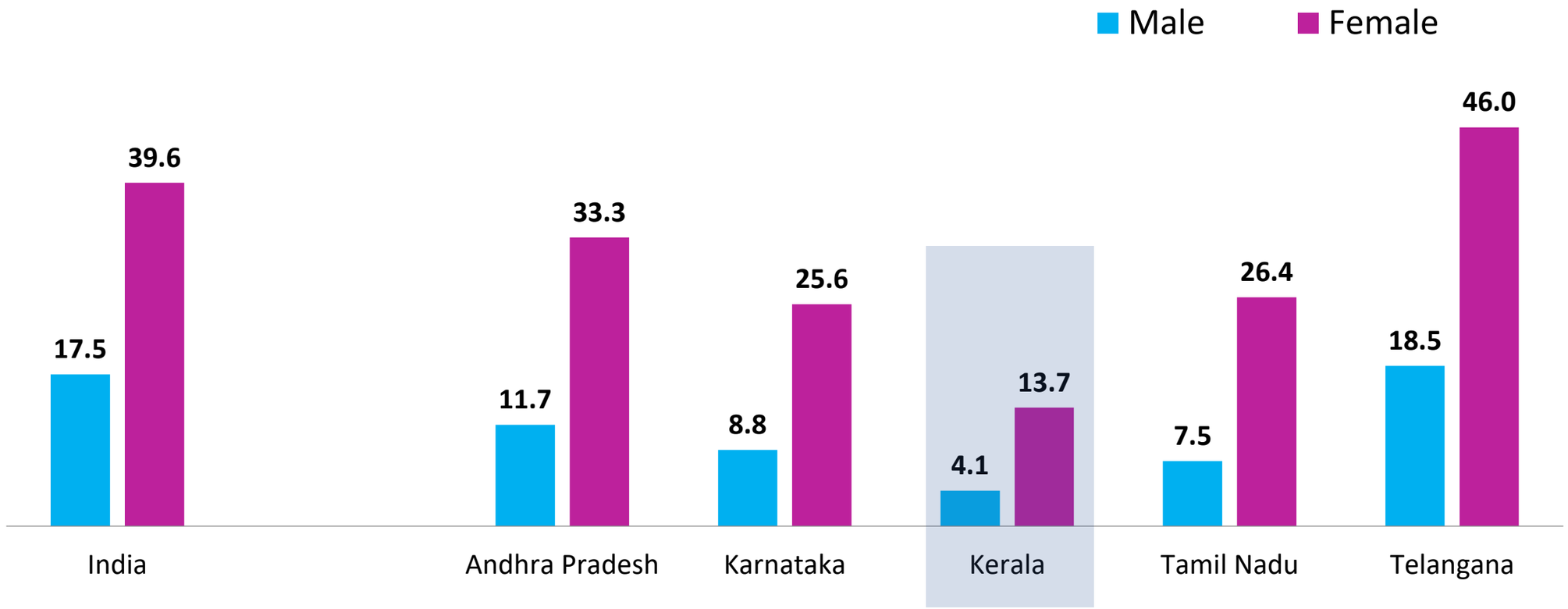
Prevalence of Anaemia among adolescents (10-19 years)

Overall, in the country, anaemia prevalence among adolescent girls was twice than adolescent boys

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

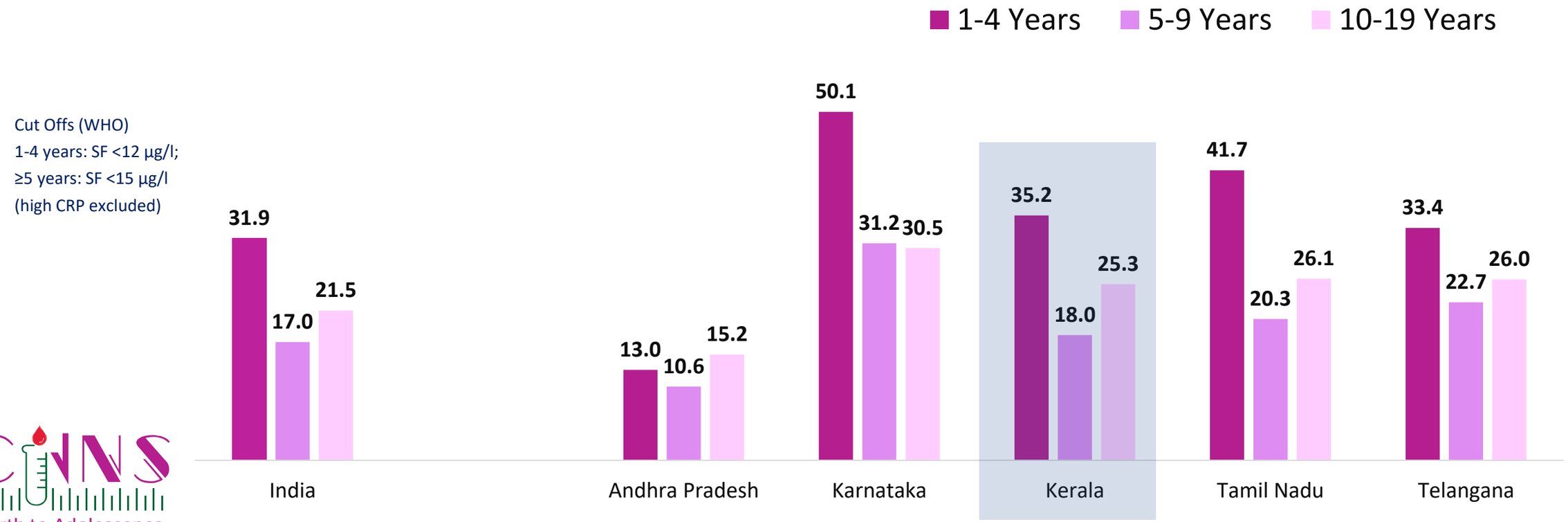


Birth to Adolescence

Iron deficiency measured by serum ferritin among children and adolescents

1/3 children aged 1-4 years had iron deficiency in Kerala (**35%**), slightly higher than the national average (**32%**);

Among southern states, children from Karnataka had highest prevalence of iron deficiency



Birth to Adolescence

Kerala key findings: Vitamin A and Vitamin D deficiency

Vitamin A deficiency was high (27%) in school-aged children 5-9 years indicating the need for policy review.

Children under five and adolescents had significantly lower prevalence (17% and 13%) compared to school-aged children.

Vitamin D deficiency ranged from 12% to 32% in 1-19 years age group as per cut off by expert panel of IOM.

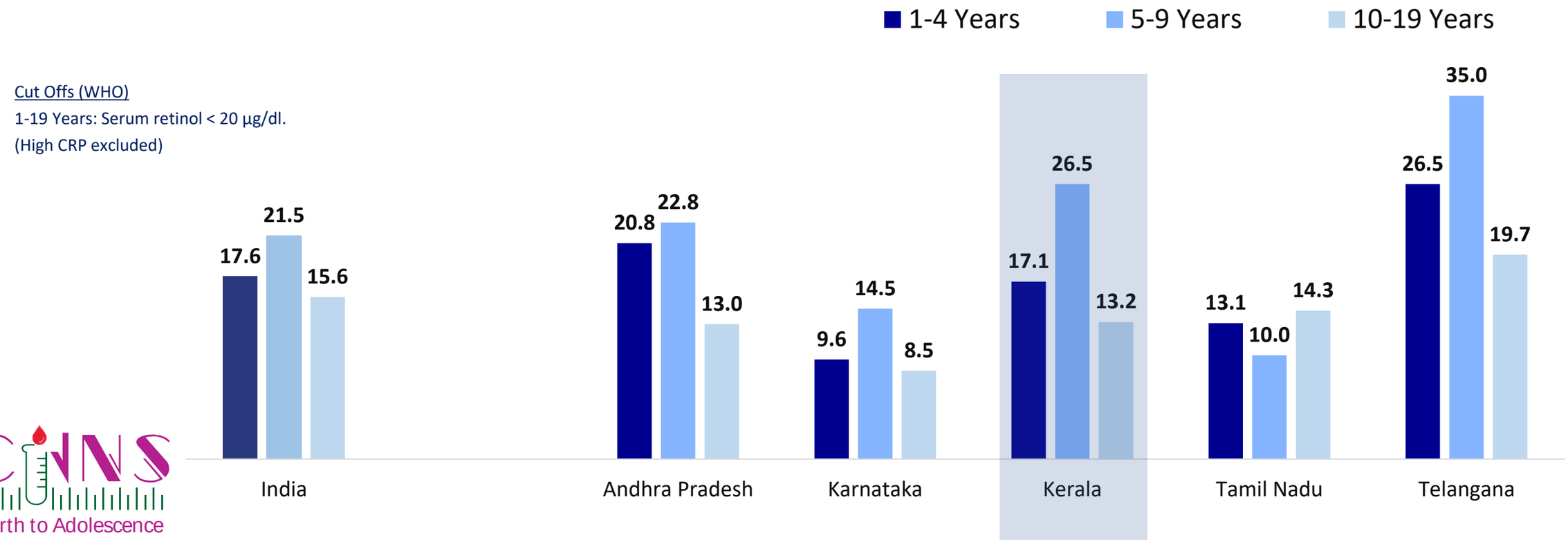
Vitamin D deficiency was found in increasing order from preschoolers to adolescents – 12% in children 1-4 years, 23% in children 5-9 years and 32% in adolescents.

CINS
Birth to Adolescence

Vitamin A deficiency among children and adolescents

Vitamin A deficiency varies from 13% to 27% in children and adolescents in Kerala, similar to the national average (**16-22%**)

Among southern states, Karnataka and Tamil Nadu had lower prevalence of Vitamin A deficiency than other three states

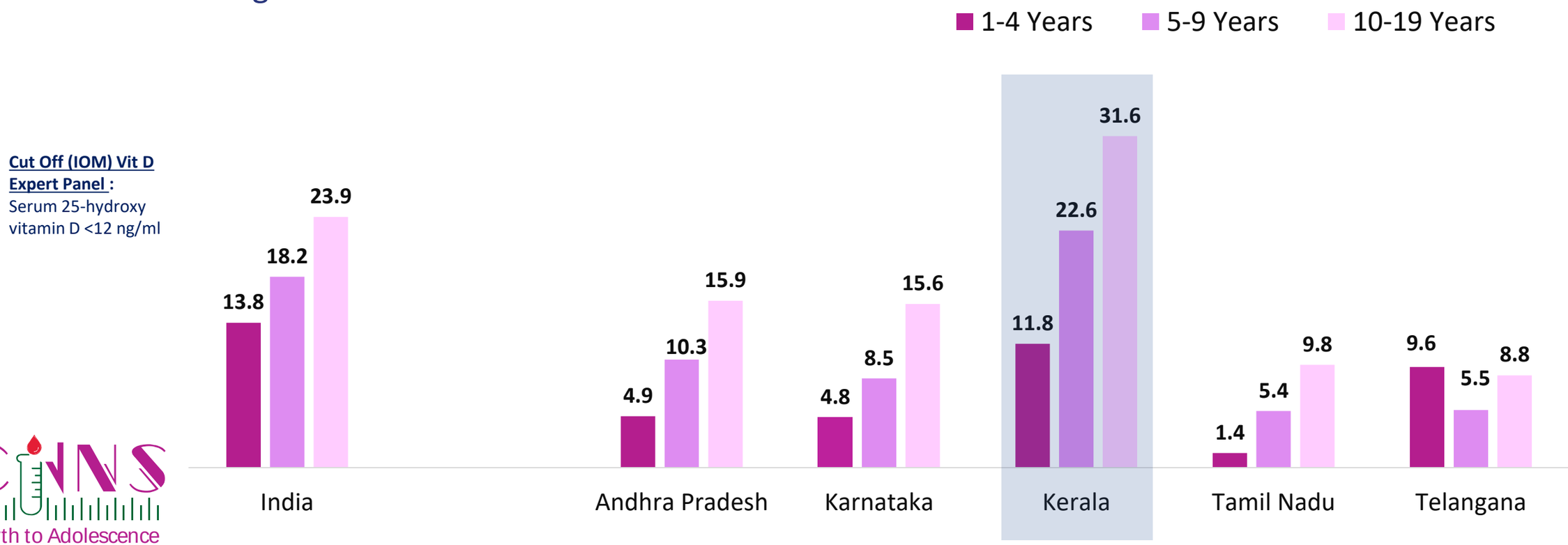


Birth to Adolescence

Vitamin D deficiency increases with age

12-32% children and adolescents had Vitamin D deficiency in Kerala, slightly higher than the national average (**14-24%**); Vitamin D deficiency increased sharply with age.

In most southern states, except Kerala, Vitamin D deficiency among children and adolescents was lower than national average.



Birth to Adolescence

Kerala key findings: Non-communicable diseases

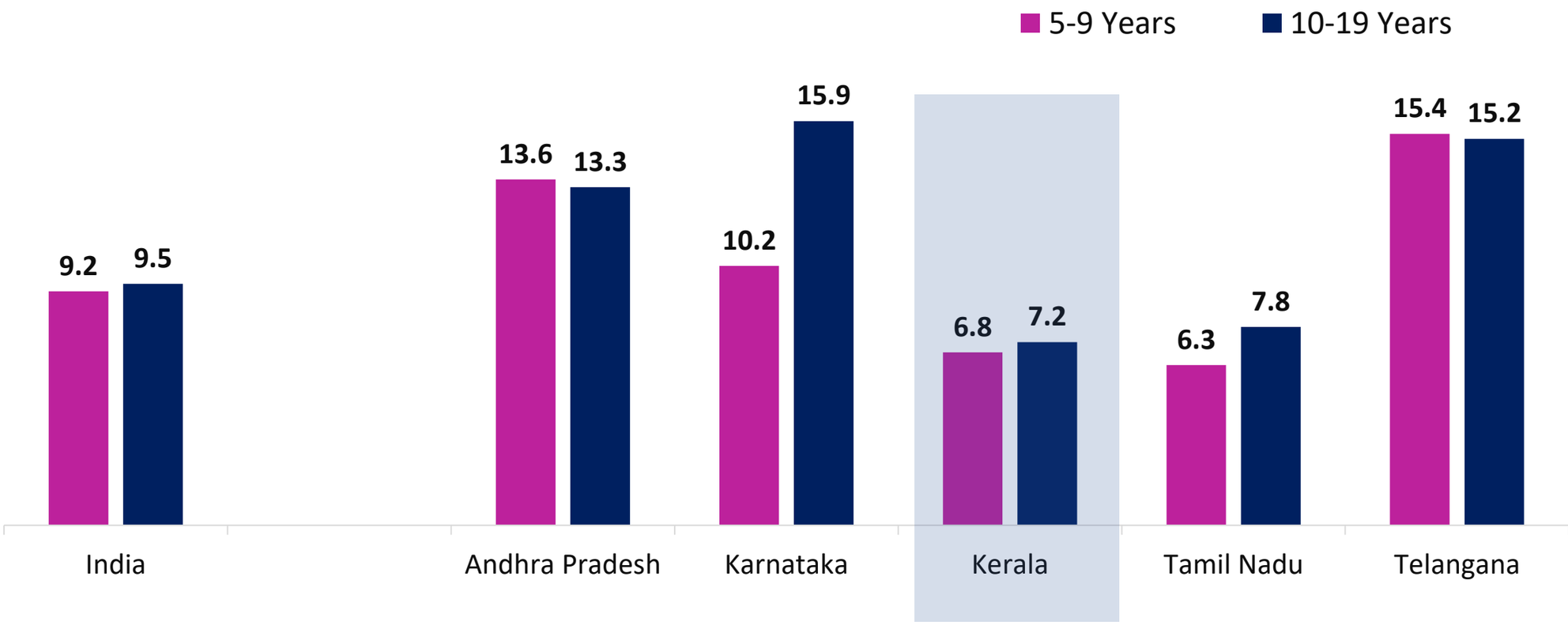
Around 7% of school-aged children and adolescents were found with high level of glycosylated haemoglobin (HbA1c).

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

Risk of diabetes among school-age children and adolescents

Based on Glycosylated hemoglobin (HbA1c), **7%** children and adolescents had increased risk of diabetes in Kerala, which was slightly lower than the country as a whole (**9-10%**)

Among all southern states, risk of diabetes was the lowest in Tamil Nadu and Kerala

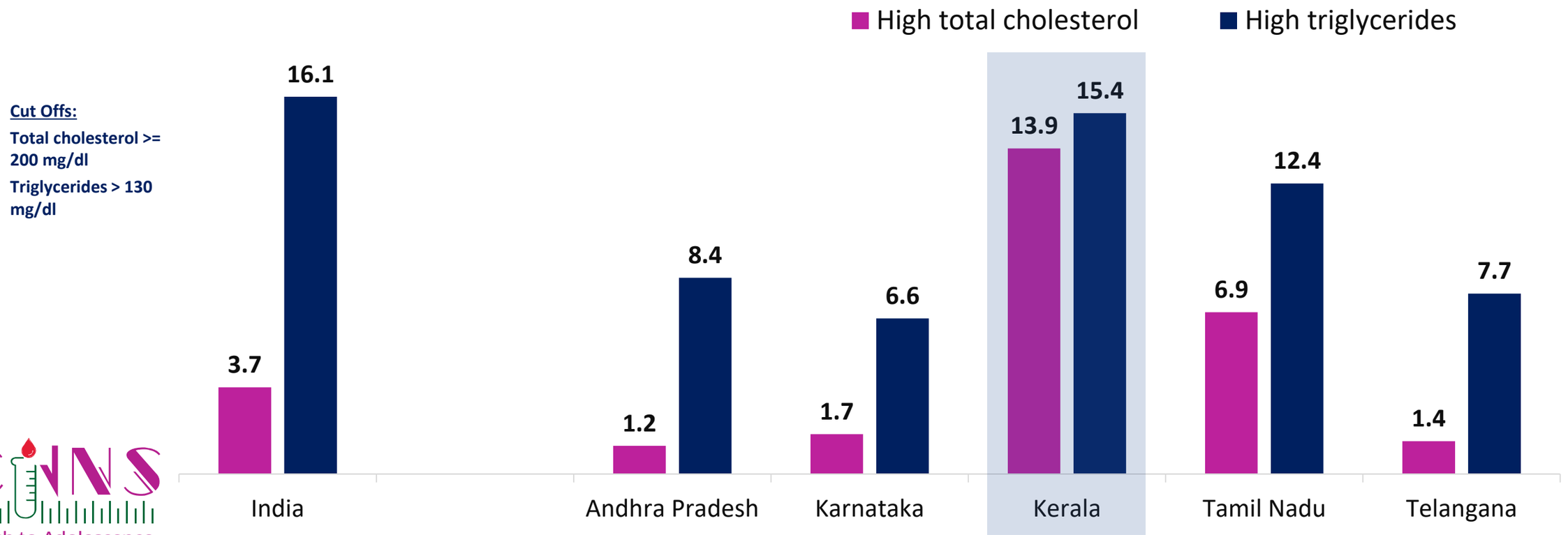


Birth to Adolescence

High total cholesterol and high triglycerides among adolescents

Elevated risk of NCDs in Kerala among adolescents – **14%** had high level of total cholesterol and **15%** with high level of triglycerides

Among southern states, Kerala had the highest prevalence of high total cholesterol and triglycerides

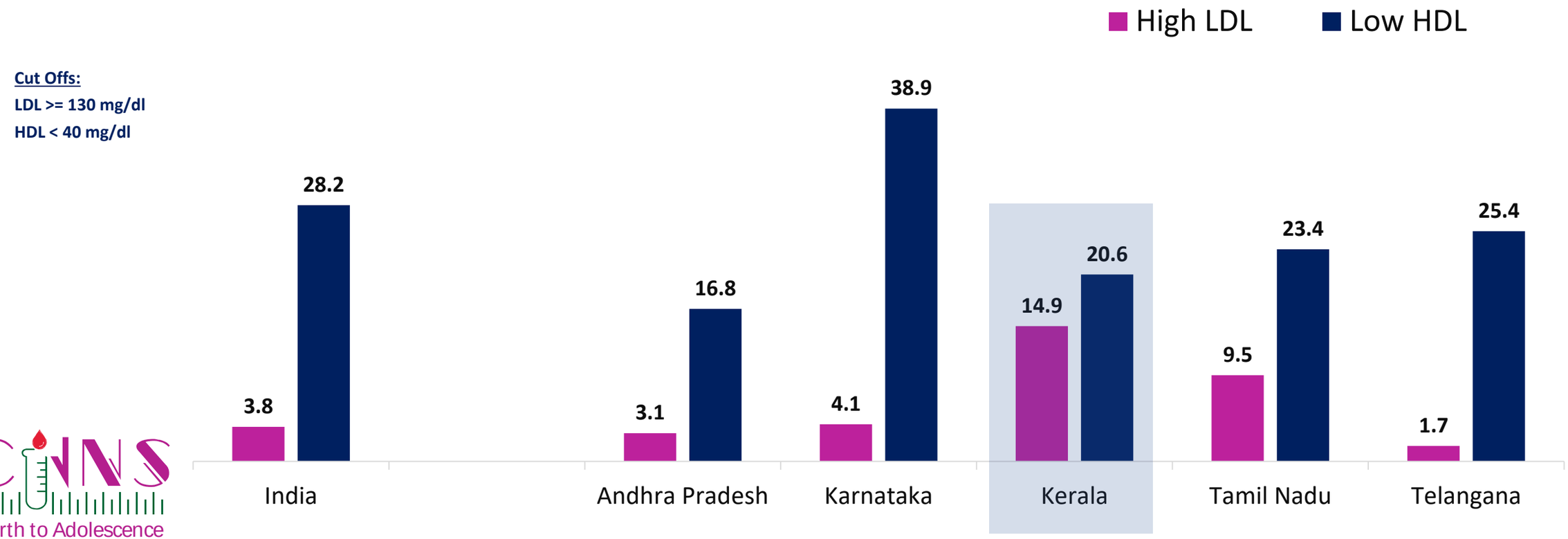


Birth to Adolescence

High LDL and low HDL among adolescents

Risk of NCDs among adolescents in Kerala was high – **15%** had high level of LDL and **21%** had low level of HDL

Among the southern states, in Kerala and Tamil Nadu, prevalence of both high LDL and low HDL was high



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 less prevalent than expected. Policy review is warranted. Interventions such as dietary diversification and fortification can be taken to scale to address the remaining 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