

Why Invest in Nutrition?

- Of the 165 million children under 5 years of age who are stunted in the world, more than one-third of them (57.9 million) live in India, and of the 120 million children under 5 in India, approximately 48% are stunted. These undernourished children have an increased risk of mortality, illness and infections, delayed development, cognitive deficits, poorer school performance, and fewer years in school.
- The mortality rate for children under 5 in India is 74 per 1,000 live births—nearly 45% of these child deaths are attributable to various forms of undernutrition.
- Malnutrition undermines human capital and economic productivity and can limit progress in achieving at least 6 of the 8 Millennium Development Goals and the World Health Assembly targets. Given its significant population, making progress on reducing stunting in India is necessary to achieve global targets to reduce malnutrition worldwide.
- Investing in nutrition in India can significantly reduce the global prevalence of stunting among children under 5, and within India, can reduce child mortality, improve children's school performance, and result in greater economic productivity for the nation.

Summary of Nutritional Status and Priorities

Close to half of adolescent women in India (over a third of whom will begin childbearing by 19 years of age) are chronically malnourished, and more than a quarter of births are low birth weight. Twenty percent of children are stunted and 30% are wasted before 6 months of age, and 82% of children are anemic by 2 years of age. This is a result of poor prenatal nutrition compounded by poor infant and young child feeding practices and high rates of disease. Addressing malnutrition in India requires a life cycle approach that focuses on adolescent nutrition, delaying the age of first marriage and pregnancy, maternal nutrition and nutrition during pregnancy to reduce low birth weight (including micronutrient supplementation), essential newborn care, appropriate infant and young child feeding practices (including, early and exclusive breastfeeding), and community management of acute malnutrition.

Adolescent nutrition. Adolescent girls are the most malnourished (48%) among women of childbearing age, and over time this has remained unchanged. Childbearing begins by the age of 19 for more than a third of women, contributing to poor maternal nutritional status and birth outcomes, including low birth weight. The prevalence of adolescent pregnancy is declining, but is still a major contributor to malnutrition in young children.

Maternal nutrition and low birth weight. Women of reproductive age suffer concerning rates of malnutrition and anemia. Prevalence of underweight and short stature have declined slightly between 1999 and 2006, while prevalence of anemia among women has increased. These prenatal factors are a significant contributor to childhood rates of stunting and wasting in India.

Stunting. Although stunting has been slowly declining since 1999 (at roughly 0.6 percentage points per year), close to 48% of children under 5 remain stunted. Stunting affects 60% of children under 5 in the lowest wealth quintile compared to 25% in the highest (United Nations); poverty affects 22% of the population and remains an important driver of malnutrition in India. The greatest increases in stunting prevalence occur between approximately 6 and 18 months of age and between 20 and 30% of children are already stunted and/or underweight during the first 6 months of life due to the high rate of intrauterine growth restriction and low birth weight, as well as suboptimal breastfeeding practices (including significantly delayed initiation and a short duration of exclusive breastfeeding).

Wasting. Since 1999, the prevalence of wasting has largely stayed the same, affecting 1 in 5 children under

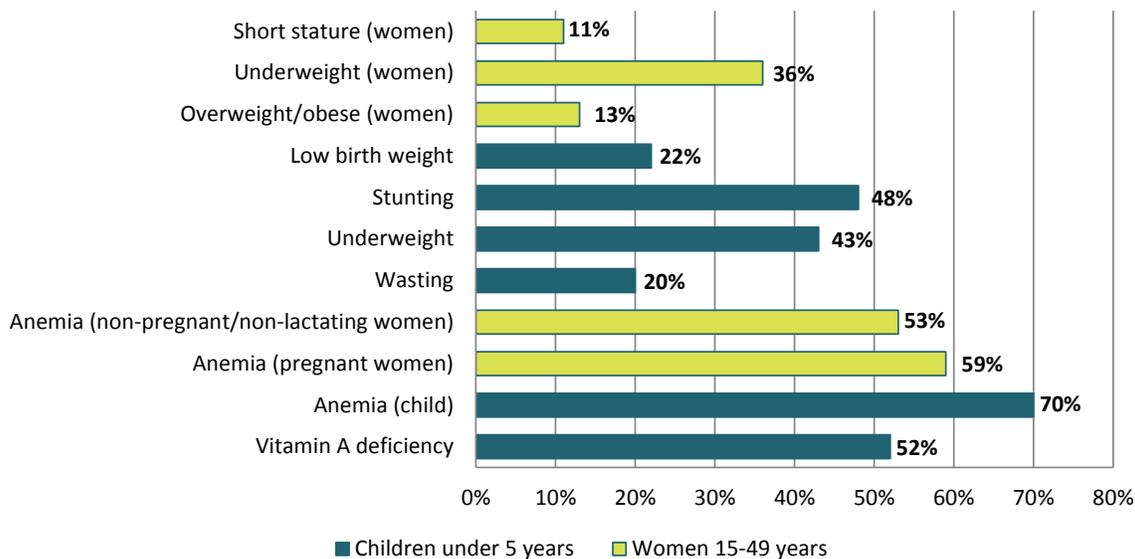
5. Wasting is highest among children under 1 year, particularly among children under 6 months among whom 30% are wasted, and 13% severely wasted. Wasting prevalence gradually decreases with age after the first year of life.

Child anemia. In addition to high rates of maternal anemia, 70% of children under 5 are anemic and an alarming proportion (82%) of children under 2 years of age are anemic, at least partially reflecting the low intake of iron-rich food in this age group (as well as low dietary diversity of complementary food in general), the absence of regular iron supplementation, and minimal deworming medication use, as well as high rates of low birth weight and maternal anemia which compromise iron endowment at birth. Other nutritional and non-nutritional causes of anemia (such as lack of vitamin A, malaria, and infection) likely play a role in India.

Micronutrient deficiencies. Vitamin A deficiency is at concerning levels among women and children in India at least partially due to low coverage of vitamin A supplementation and low dietary diversity. Iodine status at the national level is deemed in the adequate range, however, there is uneven coverage of households with iodized salt (reaching roughly half of households nationally, ranging from 31 to 94% coverage by states).

Overweight and obesity. Overweight and obesity affect approximately 13% of women of reproductive age (15–49 years) but close to twice that number (24%) of women 45–49 years of age. The prevalence of overweight and obesity among “ever married” women has increased by 4 percentage points between 1999 and 2006.

Malnutrition Indicators Among Children and Women in India



Sources: India DHS 2005–2006; UNSCN 2010 (for vitamin A deficiency)

Notes: Overweight/obese and underweight indicators exclude pregnant women and women with a birth in the previous 2 months. The median urinary iodine concentration (UIC) for school-age children is 133 ug/L; the proportion of school-age children with low UIC (< 100 ug/L) is 31% (WHO 2007).

Key Drivers of Maternal and Child Malnutrition in India

Immediate and Underlying

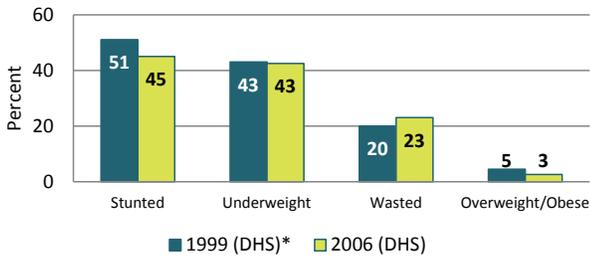
- Maternal malnutrition and low birth weight
- Suboptimal infant feeding practices including significantly delayed initiation of breastfeeding, short period of exclusive breastfeeding, and delayed introduction of complementary foods
- Low dietary diversity and dietary quality due to:
 - Low intake of micronutrient-rich foods among women and children under 2
 - Low coverage and utilization of micronutrient supplementation, particularly iron and vitamin A for children and iron for pregnant women
 - Inadequate and uneven levels of iodized salt availability and consumption
- Inadequate sanitation and hygiene practices (including access to hygienic toilets/latrines)
- Infectious disease burden, particularly gastrointestinal infections and intestinal parasites, as well as acute respiratory infections and malaria
- Insufficient access to/utilization of preventative and curative health and nutrition services including services for common childhood illnesses and pregnancy/delivery care
- Inadequate nutrition service provision due to inappropriate targeting, lack of training and skills, and lack of evidence-based interventions being implemented
- Low vaccination coverage
- Food insecurity, particularly due to insufficient food access caused by high levels of poverty, as well as food price volatility and limited land for cultivation

Basic

- Low social status of women (and girls), which restricts access to health services and control of income
- High levels of poverty and income disparity
- Marriage and childbearing during adolescence, leading to poor birth outcomes (e.g., low birth weight) as well as worsened nutritional status among adolescent mothers
- Bias/discrimination toward scheduled tribes/castes
- Weaknesses in nutrition governance, particularly:
 - Vertical implementation of the main program providing nutrition services without coordination with other sectors
 - Absence of a shared national- and state-level vision of malnutrition—what it means and what is needed to combat it
 - Reliance on unreliable data that minimizes the magnitude of the malnutrition problem
 - Lack of strong political leadership to coordinate and lead action in reducing malnutrition

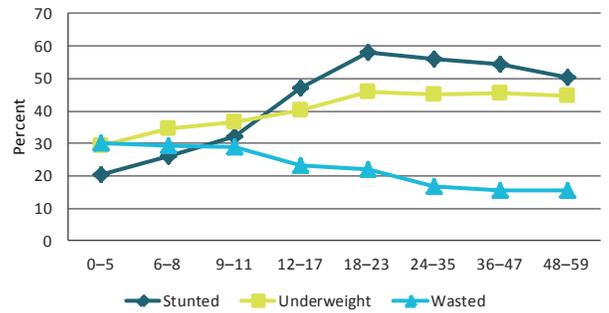
Child Nutrition

Trends in Nutritional Status of Children Under 3 Years, 1999–2006*

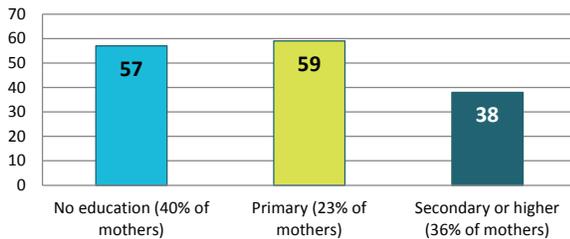


* The 1998–1999 DHS only included children under 3 years of age, thus for trend analysis, the 2005–2006 DHS data were restricted to children under 3.

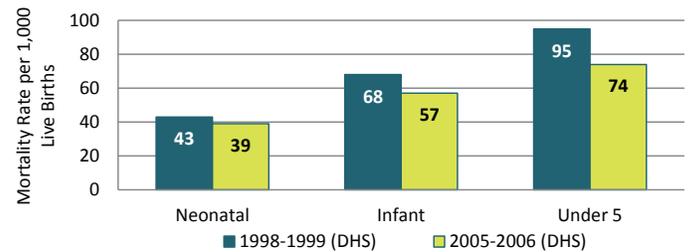
Nutritional Status of Children by Age (2005–06 DHS)



Stunting Prevalence in Children Under 5 by Maternal Education Levels (2005–06 DHS)

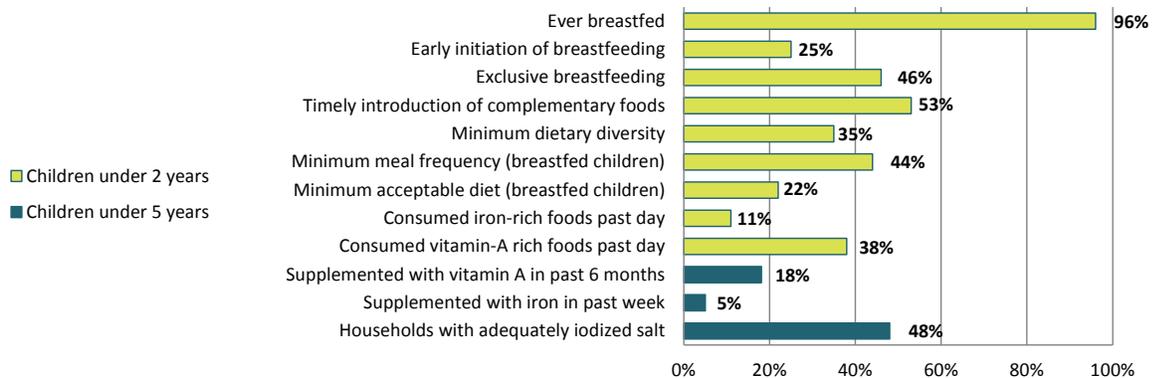


Child Mortality, 1998–2006

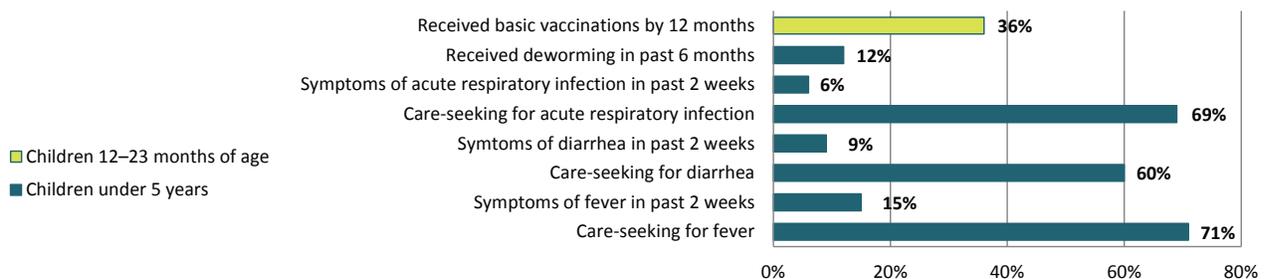


Note: Data are for the time period within the previous 5 years of the survey.

Dietary Practices of Children (2005–2006 DHS)



Child Health Indicators (2005–2006 DHS)

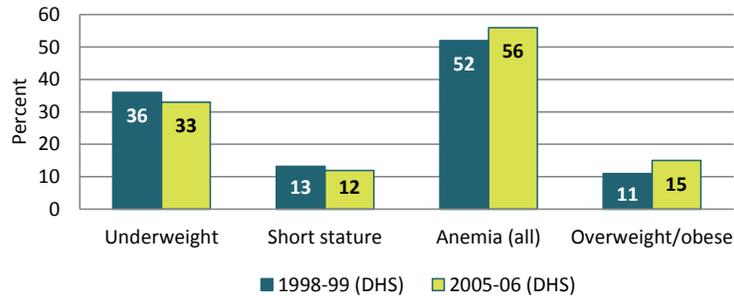


Note: Basic vaccinations include BCG, measles, and three doses each of DPT and polio vaccine.

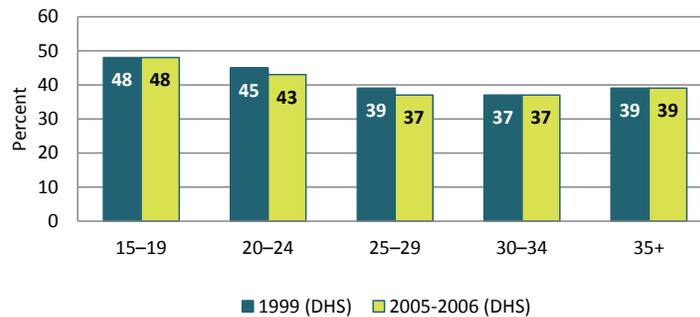
Regional Undernutrition Prevalence of Children Under 5 (2005–2006 DHS)			
State	Stunting (%)	Wasting (%)	Underweight (%)
Kerala	24.5	15.9	22.9
Goa	25.6	14.1	25.0
Tamil Nadu	30.9	22.2	29.8
Jammu and Kashmir	35.0	14.8	25.6
Manipur	35.6	9.0	22.1
Tripura	35.7	24.6	39.6
Punjab	36.7	9.2	24.9
Sikkim	38.3	9.7	19.7
Himachal Pradesh	38.6	19.3	36.5
Nagaland	38.8	13.3	25.2
Mizoram	39.8	9.0	19.9
New Delhi	42.2	15.4	26.1
Andhra Pradesh	42.7	12.2	32.5
Arunachal Pradesh	43.3	15.3	32.5
Rajasthan	43.7	20.4	39.9
Karnataka	43.7	17.6	37.6
Uttaranchal	44.4	18.8	38.0
West Bengal	44.6	16.9	38.7
Orissa	45.0	19.5	40.7
Haryana	45.7	19.1	39.6
Maharashtra	46.3	16.5	37.0
Assam	46.5	13.7	36.4
Jharkhand	49.8	32.3	56.5
Madhya Pradesh	50.0	35.0	60.0
Madhya Pradesh, including Chhattisgarh	50.7	31.2	56.9
Gujarat	51.7	18.7	44.6
Chhattisgarh	52.9	19.5	47.1
Bihar, including Jharkhand	54.4	28.2	56.1
Meghalaya	55.1	30.7	48.8
Bihar	55.6	27.1	55.9
Uttar Pradesh, including Uttaranchal	56.4	15.0	42.2
Uttar Pradesh	56.8	14.8	42.4

Maternal Nutrition

Trends in Nutritional Status of “Ever-Married” Women (15–49 years), 1998–2006

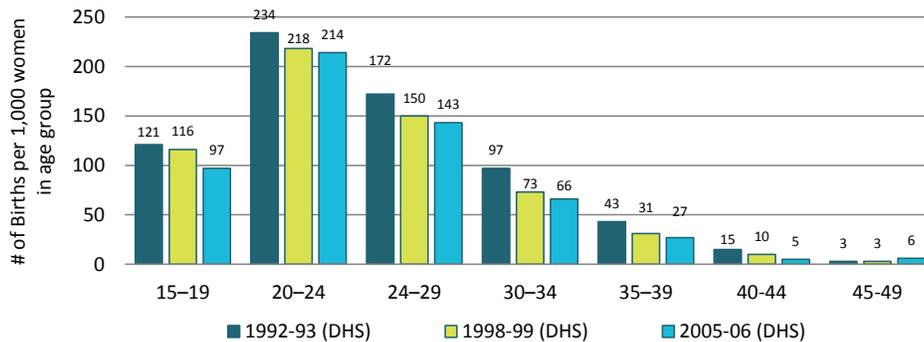


Trends in Underweight by Age Among “Ever-Married” Women (15–49 years), 1998–2006

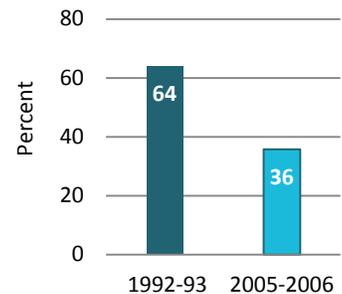


Note: Data refer to “ever-married” women with birth in the past 3 years and may differ from elsewhere in the report where data on all women 15–49 are used.

Fertility Rate by Age Among Women (15–49 Years)



Women 15–19 Years Who Have Begun Childbearing by 19*



* Data from 1992-93 refer to only women 17-19 years.

Maternal Health Indicators		
Maternal mortality ratio (per 100,000 live births)	200	
Total fertility rate (children per women)	2.7	
Median age at first marriage (of women 20–49 years)	17.2	
Median age at first birth (of women 20–49 years)	20.0	
% of women 15–19 years who have begun childbearing by age 19	35.7	
Median number of months since preceding birth (15–49 years)	No data	
% of married women currently using any method of family planning	56.3	
% of married women with an unmet need for family planning	13.9	
% of women 15–49 years with a live birth in the past 5 years receiving antenatal care from a “medically-trained” or “skilled” provider*	74.2	
% of women 15–49 years with a birth in the past 5 years who delivered in a health facility	38.7	
% of women 15–49 years with a birth in the past 5 years who delivered with a medically-trained or skilled provider*	46.6	
	(overall)	55.3
% anemic (pregnant: Hb < 11 g/dL; non-pregnant: Hb < 12 g/dL)	(pregnant)	58.7
	(non-pregnant/non-lactating)	53.2
% of women with a birth in the last 5 years given vitamin A supplementation after birth of last child	No data	
% of women with a birth in the last 5 years given any iron supplementation during last pregnancy	65.1	
% of women with a birth in the last 5 years who took at least 90 days of iron supplementation during pregnancy of last child	23.1	
% of women with a birth in the last 5 years who took deworming medication in last pregnancy	3.8	
% of women 15–49 years of age living in households with iodized salt	No data	

Sources: DHS 2005–06; UNICEF 2012

* “Skilled” provider (as defined in the DHS 2005–2006) included doctor, nurse, auxiliary nurse midwife, midwife, lady health visitor, and “other health personnel.”

Food Security; Diet Diversity; and Water, Sanitation, and Hygiene

Food Security Indicators	
Global Hunger Index (2013)	21.3 (alarming level of hunger)
% of households with poor or limited food consumption (food insecure)	No data
Proportion undernourished in total population (%) (2012)	18
Food supply (kcal/capita/day) (2009)	2,321
Depth of food deficit (kcal/capita/day) (2011–2013)	135
Diet Diversity Indicators	
% of dietary energy supply from cereals, roots, and tubers (2009–2010)	62
Average supply of protein from an animal source (grams/capita/day) (2008–2010)	11
Water, Sanitation, and Hygiene Indicators	
% of population with access to improved drinking water sources	88
% of population with access to sanitation facilities	29
% of households using appropriate treatment method for drinking water	No data

Sources: FAO 2013; von Grebmer et al. 2013 (for Global Hunger Index); FAO et al. 2012 (for undernourished); FAOSTAT (<http://faostat3.fao.org/faostat-gateway/go/to/browse/FB/FB/E>) (for food supply); 2005–2006 DHS (for water, sanitation, and hygiene indicators)

Gender

Gender inequality is pervasive in India and is a significant underlying factor that exacerbates food insecurity and malnutrition. The clearest manifestation of this relationship is the high prevalence of early marriage and adolescent pregnancy, which reflect prevailing gender norms that discriminate against women and girls and contributes significantly to the high prevalence of low birth weight and chronic malnutrition in their children. More than a third of adolescent girls have given birth to a child by 19 years of age, which is a lower percent compared to data from previous DHS surveys. In India, marriage occurs early for women relative to men. Nearly 58% of women 20–49 years of age are married by the age of 18, in contrast only 16% of men 20–49 years are married by the age of 18.

Gender inequality is also reflected in several other key indicators. For example, 43% and 99% of women and men 15–49 years reported being employed respectively; however 24% of women reported not being paid for their work compared to only 5% of men. Of those women who are paid, only 24% reported being able to decide on their own how to use their income and 74% reported being paid less than their husbands. Domestic violence is also widely prevalent and 40% of women of childbearing age reported ever having experienced various forms of domestic violence in their lifetime. The 2005–2006 DHS also reported that 37% of women of childbearing age 15–49 years reported participating in decisions about their own health, major household decisions, their children's health and visiting relatives, but among adolescent girls 15–19 years, only 15% reported participating in these same decisions. With childbearing beginning early, young women with children under the age of 2 have the least decision-making power and the least access to resources when their children have the greatest nutritional needs. The decision of when and whom to marry is made by family members, and subsequently the decision of when and at what age to begin childbearing is also made by family members. In this context promoting shared responsibility for the nutritional status of women and children among husbands and parents-in-law in addition to working with young mothers is essential. But delaying marriage and first pregnancy will also go a long way toward reducing the overall prevalence of malnutrition in India.

Government Policies and Program Environment: Needs and Challenges

Policies. Currently, India does not have an active national nutrition policy/strategy; in 1993 the National Nutrition Policy was implemented (through 2000) followed by the National Nutrition Plan of Action in 1995 (through 2000). The 12th Five Year Plan of the Planning Commission of the Government of India lays out the country's nutrition plans and targets. Malnutrition has gained media and political attention through civil society groups such as the Right to Food Campaign and the Citizen Alliance against Malnutrition who advocate for greater attention to malnutrition issues (Mohmand 2012; Saxena and Srivastava 2009).

Nutrition-Specific Policies

Guidelines for Enhancing Optimal Infant and Young Child Feeding Practices (2013)

Food Security Bill (2013)

National Rural Health Mission (2008–2012)

Infant and Young Child Feeding Guidelines (2010, revised from 2004)

National Plan of Action on Nutrition (1995–2000)

Infant Milk Substitutes, Feeding Bottles and Infant Foods Act (1992, amended in 2003; regulation of production, supply, and distribution)

Programs. Government nutrition services are provided to young children and pregnant/lactating women through the Integrated Child Development Services (ICDS), which provides a package of six basic services including preschool education, supplementary nutrition (for children under 6 and pregnant and lactating women), immunization, health check-ups, referral services, and nutrition and health education through village-based centers (*anganwadis*) staffed by village volunteers (Saxena and Srivastava 2009). At the national level, although coverage is high (81% of children under 6 are estimated to be

covered by an ICDS center), utilization of ICDS services are low (potentially due to long distances to service centers), including utilization of nutrition services, with supplementary nutrition occasionally reaching roughly a quarter of children under 6 and 16–20% of pregnant and lactating women (ibid). However, in areas where the ICDS has been most effective (for example, where the outreach of the program has been extended into communities through additional volunteers, improved targeting of children, and improved training of volunteers), progress on malnutrition has been better, indicating that there is room for improvement (Biswas and Singh Verma 2009; Menon et al. 2009; Mohmand 2012; Saxena and Srivastava 2009). India is currently restructuring ICDS in an effort to improve maternal and child nutrition outcomes. Under the first phase of ICDS restructuring, the focus will be on 200 high burden districts. These districts would be provided with an additional *anganwadi* worker who would focus on home visits of children under 3 years and counsel caregivers/mothers to promote child care and appropriate feeding. An additional 200 districts will be added in the second phase.

Needs and challenges. Policy analyses to identify reasons for the persistent problem of malnutrition in India have cited a “lack of cross-sectoral collaboration between the different institutions that deal with undernutrition, a lack [of] a strong national agenda against malnutrition that emanates from within the highest executive offices of the state, and a lack of consistent monitoring of the situation based on reliable data” (Mohmand 2012). There is little horizontal collaboration within the government between sectors, and implementation is highly centralized. There appears to be greater coordination at the village level, but strong political leadership from within the government to address nutrition has been identified as lacking by several analyses (Mohmand 2012; Biswas and Singh Verma 2009). A cohesive view and understanding of malnutrition at the national level and its causes is also impeded by reliance by some policymakers on unreliable malnutrition data (collected by ICDS) indicating that malnutrition is no longer a problem, as well as a pervasive view by many that malnutrition is a problem solely due to food security and can be solved through food distribution and supplementation (ibid).

Development Partner Support

The Government of India receives loans from the World Bank for nutrition-related activities, technical assistance to strengthen the nutrition policy framework and health system, and capacity strengthening to improve nutrition. This includes support for: setting up the National Rural Health Mission, which will set up a network of nutrition centers that cater to pregnant women and children up to 5 years of age; ensuring that households have access to food; improving the child nutrition delivery system; creating infant and young child feeding guidelines and tools; and reforming and strengthening the national ICDS program. In addition, India also receives funding from the Bill and Melinda Gates Foundation, which will implement a program through a partnership with the Government of Bihar to improve key health, nutrition, and sanitation indicators in the state. Several U.N. agencies including UNICEF, WFP, and FAO also provide nutrition-related funding. UNICEF provides support at the central and state level for strategic planning and implementation of activities to contribute to reduction of the stunting rate and an improved infant and young child nutrition situation. UNICEF’s primary support is for promotion of appropriate child feeding practices, management of severe acute malnutrition, and prevention of vitamin A, iodine, and iron deficiencies. Both WFP and FAO provide funding for food security activities.

Recommended Nutrition Priorities

Key nutrition priorities for India require a life cycle approach and include focusing on adolescent nutrition, maternal malnutrition and low birth weight, stunting, wasting, anemia and micronutrient deficiencies, and essential newborn care. Programs and activities should be focused on women and children in the lowest wealth quintile, who are disproportionately affected. In order to achieve gains in reducing undernutrition, there is a need for governance in nutrition at the national and state levels and an updated and expanded policy framework for nutrition that would guide efforts across the country. USAID is funding health programming in India, however virtually no funds are earmarked for nutrition specifically. Given the scale of undernutrition in India and the fact that India alone could hold the world back from achieving global targets and commitments for undernutrition, there is a need for strategic and direct investment in nutrition. Given the nature of USAID's relationship with the Government of India, a few focused high-level activities could have a significant impact on improving accountability for and governance of nutrition, at a minimum. Among existing USAID-funded activities and programs this includes continuing to expand and support the integration of evidence-based nutrition-specific interventions and actions, and capacity-strengthening. Additional opportunities include:

- Supporting nutrition advocacy at the national and state levels in partnership with local civil society partners (such as the Right to Food Movement and Citizen Alliance against Malnutrition) to strengthen national and state level multisectoral coordination and nutrition service delivery, and augment accountability and governance for nutrition
- Continued support for quality and regular national data collection (e.g., National Family Health Surveys/ DHS) that includes globally-recommended nutrition indicators
- Investing in community-level nutrition service delivery and strengthening community health worker skills in nutrition (particularly of the ICDS)
- Investing in quality improvement of nutrition service delivery
- Investing in nutrition using a life cycle approach focused on adolescent nutrition and delaying marriage and pregnancy, improving maternal nutrition during pregnancy and postpartum, and strengthening essential newborn care and infant and young child feeding practices

- Investing in tackling acute malnutrition through policy, advocacy, and system and capacity strengthening
- Providing support to integrate nutrition into infectious disease efforts, for example, supporting efforts to expand immunization coverage, expand deworming among children and pregnant women, expand malaria prevention and treatment among pregnant women and young children for anemia reduction, expand coverage of vitamin A capsule distribution, and expand micronutrient supplementation
- Expanding technical assistance and support to improve water and sanitation
- Supporting and expanding access to micronutrient supplements and fortified foods

Opportunities to support the Government of India include:

- Engaging strategically with the Government of India to update and expand the nutrition policy framework at the national and state levels
- Assisting to strengthen nutrition governance by supporting greater intersectoral coordination of nutrition activities within the government; supporting greater and more visible political commitment to malnutrition; and supporting creation of a unified vision of malnutrition and its causes in India
- Supporting improved nutrition service delivery within the ICDS including implementation of evidence-based interventions with an aim to strengthen quality of nutrition service delivery and capacity strengthening and a focus on nutrition-specific interventions focused on adolescent nutrition; delaying marriage and first pregnancy; maternal nutrition; essential newborn care; expanding immunization and micronutrient supplementation coverage; prevention, management and treatment of acute malnutrition; and prevention of malnutrition in children under 2.
- Investing to strengthen community-level nutrition service delivery and the capacity of community service providers, family welfare assistants, and health assistants to provide quality nutrition services

USAID can work in close coordination with other donors to:

- Strategically coordinate approaches to strengthen nutrition governance and accountability for nutrition at both the national and state levels
- Align and strategically invest resources (and leverage the resources of other donors) for greater coordinated impact on reducing malnutrition, focusing on areas that need added resources such as the management of acute malnutrition, adolescent nutrition, and quality nutrition service delivery

Recommended Indicators to Monitor Nutritional Impact

USAID should consider incorporating the following key nutrition indicators into the programs and projects it funds in order to specifically monitor the impact of USAID programs on maternal and child nutrition status:

1. Prevalence of underweight children under 5 years of age (< -2 SD)
2. Prevalence of stunted children under 5 years of age (< -2 SD)
3. Prevalence of stunted children under 2 years of age (< -2 SD)
4. Prevalence of wasted children under 5 years of age (< -2 SD)
5. Prevalence of underweight women (BMI < 18.5)
6. Women's dietary diversity: mean number of food groups consumed by women of reproductive age
7. Prevalence of exclusive breastfeeding of children under 6 months of age
8. Prevalence of children 6–23 months receiving a minimum acceptable diet

While nutrition-sensitive interventions can have an impact on these indicators, it is critical to implement nutrition-specific activities that address the direct causes of malnutrition in order to see reductions in these key indicators.

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Recommended Citation:

Chaparro, C.; Oot, L.; and Sethuraman, K. 2014. *India Nutrition Profile*. Washington, DC: FHI 360/FANTA.

This nutrition profile is made possible by the generous support of the American people through the support of the Office of Health, Infectious Diseases, and Nutrition, Bureau for Global Health, U.S. Agency for International Development (USAID) and USAID Bureau for Asia under terms of Cooperative Agreement No. AID-OAA-A-12-00005, through the Food and Nutrition Technical Assistance III Project (FANTA), managed by FHI 360.

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