

Chronological Summary of Nepal's Efforts in Nutrition

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Introduction

Child mortality rate in Nepal has seen a significant decline in the past fifteen years and is expected to achieve 'Millennium Development Goal (MDG) four' before the stipulated time.¹ A substantial improvement has been seen in controlling micro-nutrient deficiencies and childhood illnesses in the country, yet Protein Energy Malnutrition (PEM) among under five year children remains a stagnant problem posing a threat to child growth and development and a challenge to sustainability to what has been achieved in saving child lives. Statistics from Nepal Demographic and Health Survey (NDHS) 2006, NDHS 2001, Nepal Family Health Survey (NFHS) 1996 and first national nutrition survey in 1975 showed PEM unabated in last 35 years.²⁻⁵ During the period, various strategies, programs and policies have been developed and implemented in Nepal to improve nutritional status of the people. This article attempts to identify such efforts and explore the strengths and gaps remained within them.

Efforts on nutrition in Nepal

Nepal's effort to address nutritional problems can be broadly categorized into two broad headings - A) Studies and research efforts and B) Policy, strategies and Programmatic efforts.

Studies and research efforts

A number of study/research efforts have been made in Nepal at different times to find out nutrition and related burden. Some of such efforts are as follows.

1. Nepal Health Survey 1966
2. National Nutrition Survey 1975
3. Review of different sample studies between 1975-90
4. Other small scale studies on Low Birth Weight (LBW), Iodine Deficiency Disorders (IDD) and Iron Deficiency Anemia (IDA) at different times
5. National Multiple Indicator Surveillance (NMIS) 1995-96
6. Nepal Family Health Survey (NFHS) 1996
7. National Micronutrient Status Survey (NMSS) 1998
8. Nepal Demographic and Health Survey (NDHS) 2001
9. Nepal Demographic and Health Survey (NDHS) 2006
10. Nepal Nutrition Assessment and Gap Analysis 2010

The first health survey 1966 was conducted by University of Hawaii. It provided information on diet and nutritional status of Nepalese people. It showed that the diet as a whole was lacking in protein, calcium, vitamin A, riboflavin and ascorbic acid.⁵ Thereafter, Nepal nutrition status survey conducted by government of Nepal with support of Center for Disease Control (CDC) Atlanta and USAID in 1975 showed very high rate of prevalence of undernutrition, stunting and wasting among children (50% underweight, 48.1% stunted and 2.8% wasted). It also showed nutritional anemia as an important nutritional problem in Nepal.⁶

No population based studies on nutrition were conducted since 1975 to 1990. Dr Ramesh Kanta Adhikari made an effort to review various smaller studies done in the period with an objective to give a composite picture of state of nutrition in Nepal. The findings of review were nutritional status of children showed a worsening trend; Vitamin A Deficiency (VAD) and Iodine Deficiency Disorders (IDD) were major public health problems; IDD showed a decreasing trend because of salt iodization and iodized oil; and anemia was very common among women in reproductive age.⁷

Nepal multiple indicator surveillance in 1995 showed only half of the shops (51%) sold salt with less than 30 PPM of iodine; 53% of children aged 6-36 months have chronic malnutrition (stunting); 16% of children aged 6-36 months have acute malnutrition (wasting). It also explored the factors affecting malnutrition-mother's food security; breast feeding practices, type of foods given to young children and feeding frequency.⁸

Nepal family health survey 1996 showed that 48% of children under age 3 were stunted, 11% percent were wasted, and 47 % were underweight. Children living in the Mountains and

in the Far-western regions of Nepal were more likely to be malnourished than other children. More than one of four women fell below the cutoff of 18.5 for body mass index (BMI).⁴

Nepal Micronutrient Status Survey (NMSS) showed that the prevalence rate of low serum retinol levels (<0.70 micromol/l) among preschool children (32.3%) indicate a chronic inadequacy of vitamin A intake and possibly a high burden of infectious morbidity. Prevalence rates of 4.7% and 6% of night blindness among non-pregnant and pregnant women indicating VAD still a public health problem of significant importance. There has been significant progress towards the control of IDD in Nepal as household iodized salt coverage increased to 63%. It showed iron deficiency anemia as a severe public health problem in Nepal. Children aged 6-23 months had the highest prevalence of anemia.⁹

Nepal demographic and health survey 2001 showed that 51% of children under age five were stunted and 21 % were severely stunted. Children in rural areas were more likely to be stunted (52%) than children in urban areas (37%). 10% of children were wasted and 1 % were severely wasted and 48% of Nepalese children were underweight and 13 % were severely underweight.³

Nepal demographic and health survey 2006 showed that exclusive breastfeeding was relatively short, with a median duration of 2.5 months. At 6-9 months, only three in four children were receiving complementary foods. Nearly one in two Nepalese children age 6-59 months were classified as anemic. PEM was significant with 49% under five years children stunted, 39% underweight and 13 % wasted. Similarly, 24% of Nepalese women were malnourished-below the cutoff of 18.5 (BMI) and 36% of women age 15-49 were anemic.²

Nepal Nutrition Assessment and Gap Analysis (NAGA) was undertaken in 2010 and report published to provide information to develop a detailed multi-sectoral nutritional action plan for next 5 years. It was build upon Nutrition Action Plan 2007 and made feasible and evidence based recommendations for health, agriculture, education, and welfare sectors. It also recognized community based nutrition approach for the improvement of food and care related behavior, agricultural interventions to ensure food availability, access and affordability and strengthening nutritional information system.¹⁰

Policies, strategies and programmatic efforts

There are a number of policy/strategy documents and programs developed at different times and implemented in Nepal to improve nutritional status. Some important among them are

1. National Nutrition Strategy 1978
2. National Nutrition Strategy for Nepal 1986

3. Nepal National Plan of Action for Nutrition 1998
4. Nepal Health Sector Programme- Implementation Plan 2004-2009
5. National Nutrition Policy and Strategy 2004
6. National Plan for Action on Nutrition (NPAN) 2007
7. National Nutrition Policy and Strategy 2008
8. Current national Nutrition Program

The poor nutritional status of children and women has been considered a serious problem since many years in Nepal. Initiatives focusing on nutrition have been taken for more than 3 decades. Specific to nutrition, National Nutrition Policy Coordination Committee (NNPCC) was established in 1976. National planning commission was a member and Ministry of Health was the chair of the committee.⁷

National nutrition strategy workshop 1978 was organized by NNPCC in Pokhara with collaboration of WHO and UNICEF. The output of the event was Pokhara Declaration I. The declaration identified prevailing state of malnutrition and strategies and measures to address them. It drew up a multi-sectoral strategy for improving nutrition. As a result of Pokhara Declaration, a number of initiatives were followed. These were formation of nutrition focal points in 4 ministries viz. Health, Agriculture, Education and Panchayat and establishment of nutrition section under DoHS in MoH. The Joint Nutrition Support Program (JNSP) to implement the major activities of the four ministries was also started. JNSP was later dismantled as a result of donor dissatisfaction.¹¹

A workshop to formulate national nutrition strategy for Nepal was organized in 1986. It reaffirms the multisectoral strategy of Pokhara declaration I i.e. four major sectors – health, agriculture, education and panchayat, and local development. It also identified gaps and weaknesses to reduce IDD. It focused on controlling micronutrient deficiencies – Xerophthalmia and nutritional anemia. This indicated the urgent need to control malnutrition to achieve health for all by the year 2000. It recommended for the integration of vertical government health programs; emphasis to increase purchasing power of weaker section; nationwide nutrition awareness programs; nutritional implication of agriculture and food policy; and formation of technical coordination committee under NNPCC.¹²

National Seminar on Nutrition was organized in 1991 identified that proper treatment of childhood diseases, overall child care and child feeding practices will bring about major reduction of malnutrition in our part of the world.⁷ Similarly, National Health Policy 1991 also recognized it and identified promotion of breast feeding, growth monitoring, prevention of IDD, iron and vitamin A deficiency and health education to enable mothers to meet the daily requirements of children through locally available resources as priority programs of the government.¹³

Thereafter, in 1998 – national nutrition plan of action was

developed as Nepal's response to world declaration on nutrition in 1992. Main themes of the document were household food security, food safety and quality control, infection, malnutrition and micronutrient deficiency status; and nutrition education and training.¹⁴

In 2000, Nepal became signatory to millennium declaration and made commitment to achieve MDGs. Improved nutrition was a direct output of goal one and related to goal two, four, five and six. Nepal Health Sector Programme Implementation Plan (NHSP-IP) 2004-2009 also aimed to reduce under-5 mortality and nutritional deficiencies in children and adults through strengthening vitamin A supplementation, eliminating iodine deficiency disorders, reduced rates of nutritional anemia and protein energy malnutrition. It also aimed at piloting some alternative models for prevention of childhood malnutrition.¹⁵

Thereafter, national nutrition policy and strategy came after a series of discussions and exercises in 2004. The document identified six bases, nine guiding principles and 13 monitoring, short term and long term strategic approaches to improve nutritional status. The Six Bases were Human Right, Pre-condition of development, healthy life, Universal primary education, Prioritized group, people's participation and Gender. The nine guiding principles were Community Participation, Co-ordination among inter and intra sectors, Decentralization, Advocacy and communication, Integration, Monitoring and evaluation, Research, Capacity building. The short term strategies were PEM, IDA, IDD, VAD, Intestinal worm infestation, LBW, Infectious diseases and nutrition in exceptionally difficult circumstances while long term strategies were household food security, dietary habit, lifestyle related disease and school health and nutrition. The national nutrition policy and strategy was revised in 2008. It included the data of NDHS 2006.¹⁶

National plan of action on nutrition 2007 aims to improve the nutrition status of children under 5 years and women of reproductive age. The strategies were to improve child care practices; improve care of pregnant women and lactating mothers – adequate food, rest, birth preparedness and timely identification of danger signs and treatment; scale up and strengthen responsive health services; food supplementation for vulnerable groups; reduce household work burden for children; improve women's status through girl education; and food security in food insecure areas and groups.¹⁷

The NHSP IP II draft is currently under preparation which has aim to improve the health and nutritional status of the Nepali population, especially for the poor and excluded. Further reductions in under-five and infant mortality will be accomplished by scaling up community-based newborn care and by implementing a more comprehensive nutrition programme which is a major focus of NHSP-2.¹⁸

Current national nutrition program includes - growth monitoring for screening and prevention of PEM; control

of IDD; control of vitamin A deficiency disorder; control of iron deficiency (IDA); de-worming; intensification of Maternal and Neonatal Micronutrient Program (IMNMP); and protection and promotion of Infant and Young Child Feeding (IYCF) Counseling. Other partners' programs includes wheat flour fortification program; social marketing of low cost fortified blended complementary food - 'Champion'; nutrimix distribution-Mother and Child Health Care (MCHC) program; school health and nutrition program-Syangja and Sindhupalchowk; piloting new born vitamin 'A' dosing in 4 districts (Nawalparasi, Tanahu, Banke, and Sindhuli); piloting micronutrient sprinkles (Syangja, Tanahu, Banke, Surkhet, Makwanpur and Dhading); and piloting community based management of acute malnutrition in 3 districts (Bardiya, Achham, and Mugu).¹⁹

Conclusion

Nepal attempted various efforts at different times to combat nutritional problems in the country. Though good nutrition is fundamental human right enshrined in the 'Convention on the Rights of the Child (CRC) 1989', data suggest there is no improvement in the protein energy undernutrition status in the country in last 35 years. Most of the policy documents and strategies in Nepal seemed to be advocated for multi-sectoral and comprehensive approach to nutrition while implementation status of the policies and strategies are not found in line with them. Even an exemplary multi-sectoral program was started in Nepal in seventies could and was not made sustained. Now at this point of time, donor community and civil society are coming with lot of enthusiasm and resources to act on nutrition and recent NAGA report also recognized nutrition as not only health but also a comprehensive development agenda. So this is a high time to identify, pilot, develop and scale up community based inter-sectoral comprehensive nutrition models which realizes the people's participation and use of local resources to solve the nutritional problems in the community.

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