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Commentary

Preventing growth faltering in India: a policy perspective for strengthening prevention within POSHAN 2.0 and CMAM

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ABSTRACT

Growth faltering during early childhood remains a major public health challenge in India despite substantial reductions in stunting over the past two decades. Persistent levels of wasting indicate important gaps in early-life nutrition, growth monitoring, and preventive interventions. This perspective examines the current policy landscape and proposes strategies to strengthen prevention within existing national nutrition programmes. This is a policy perspective synthesized evidences from national survey data, government policy documents, programme evaluations, and published literature on child undernutrition and growth faltering in India, used to identify gaps and propose strategies for strengthening prevention within POSHAN 2.0 and Community-Based Management of Acute Malnutrition (CMAM). Existing national nutrition programmes provide platforms for identification and management of malnutrition. Preventive nutrition services could be strengthened through earlier detection of growth faltering, particularly among infants younger than six months, alongside consistent growth monitoring, enhanced frontline worker capacity, stronger convergence across health and nutrition programmes, and improved use of routine surveillance data. Integrating trajectory-based growth monitoring and preventive counselling within community-based platforms offers an opportunity to support earlier identification and timely intervention while strengthening programme delivery systems. Integrating growth faltering as a preventive trigger within POSHAN 2.0 and CMAM can shift India's response to malnutrition from reactive management to proactive prevention. Strengthening programme convergence, frontline capacity, community engagement, and growth surveillance can improve child nutrition outcomes and long-term human capital development.

Keywords: Growth faltering, CMAM, Malnutrition, Dietary diversity, Niti Aayog

EXECUTIVE SUMMARY

Growth faltering is one of the most significant factors leading to childhood undernutrition. Growth faltering causes both physical disability and cognitive development disorders.[1] National trends indicate that while stunting has declined substantially across successive NFHS rounds, wasting has remained largely stagnant at around 19 to 21%, including approximately 19% in NFHS-6, highlighting persistent challenges in preventing acute undernutrition despite ongoing nutrition programmes.[2]

According to NFHS-5 report, there are 27% infants aged below six months that are wasted, among which 13% suffer from severe wasting, while 28.5% are underweight3. Also 18% infants suffer from low birth weight at birth.[3] Undernutrition costs Indian economy an estimated 4% of GDP annually.[4]

This perspective analyses the issue of growth faltering and the current policy strategies in India. The document finds that current interventions largely focus on curative approaches rather than preventive in addressing such a health problem. Further, the perspective recommends:

integration of nutritional programmes for effectiveness and reaching last mile beneficiaries, and importance of convergence between MWCD and MoHFW for early-life nutrition surveillance.

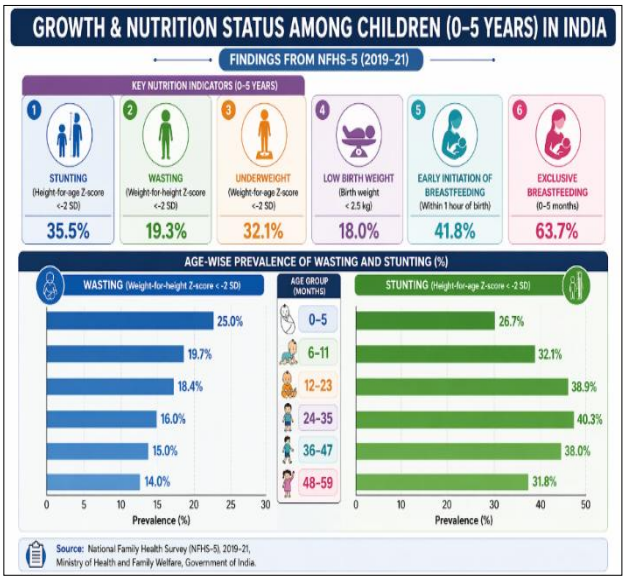

Figure 1: Growth and nutrition status among children (0-5 years) in India.

PREVALENCE OF MALNUTRITION IN INDIA

Undernutrition is one of the key challenges that affects children between 0 to 5 years of age, and is associated with cognitive impairment, impaired growth, and increased infections and morbidity. According to NFHS-5 (2019-21) in India, 35.5% of children were stunted, 19.3% were wasted, and 32.1% were underweight among children aged below 59 months.[3] Only 41.8% of children are breastfed within one hour of birth and, only 63.7% of infants under the age of six months are exclusively breastfed.[3]

The immediate consequences of malnutrition during formative years (6 months to 23 months), as well as in utero and the first 6 months of life include impaired growth, significant morbidity and mortality, and delayed motor, cognitive, and socio-emotional development. In the long term, undernutrition in early childhood leads to reduced work capacity and earnings and, among girls, reduced reproductive capacity.[1] Diet quality and diet diversity remain insufficient. In India, current data underscores this critical gap: only 11.1% of breastfeeding children aged 6-23 months receive an adequate diet, while it is 12.7% among non-breastfeeding children in the same age group.[3]

Growth faltering takes place when the growth rate of the child falls short of the normal standards for the child's age and gender. It includes both below normal weight and length/height. Early identification of growth faltering presents an essential intervention point for prevention of long-term impairment in early childhood, especially within the first 1,000 days of life. NFHS-5 statistics suggest that about 27% of babies younger than six months suffer from wasting, where 13% are extremely wasted. Further, around 28.5% are underweight while 18% of the newborns suffer from low birth weight.[3] The above data clearly indicates that poor nutrition starts early in life. Nonetheless, this problem persists indicating that the existing nutritional programs are inadequate to solve early life nutrition problems.

Growth faltering may be identified through inadequate weight gain over time, downward crossing of growth centiles, or reduced growth velocity relative to WHO Child Growth Standards, often preceding the onset of clinically detectable wasting or underweight.

PROGRESS OF CHILD NUTRITION OUTCOMES

Observing the national trends over the past two decades through a longitudinal lens demonstrates a complex trend regarding children's nutritional status. Based on the successive surveys conducted by the National Family Health Survey, the rate of stunting fell from 48.0% in NFHS-3 (2005-06) to 38.4% in NFHS-4 (2015-16) to further 35.5% in NFHS-5 (2019-21).[3,5,6] Likewise, the rates of underweight have been reduced from 42.5% to 35.8% and to 32.1%. However, the improvement in rates of wasting has not been much effective. Levels have stagnated over time, remaining around 19% to 21% per round of surveying conducted.[3,5,6] NFHS-6 indicates substantial progress in reducing stunting from 35.5% to 29.3% while wasting has remained largely unchanged from 19.3% to 19%, highlighting the need for greater focus on early-life nutrition and growth monitoring.[2]

Such trends suggest that although chronic undernutrition has gradually improved, acute and early-life nutritional problems linked with growth faltering have remained persistent. The phenomenon of growth faltering and malnutrition comes with significant economic impacts apart from health outcomes.

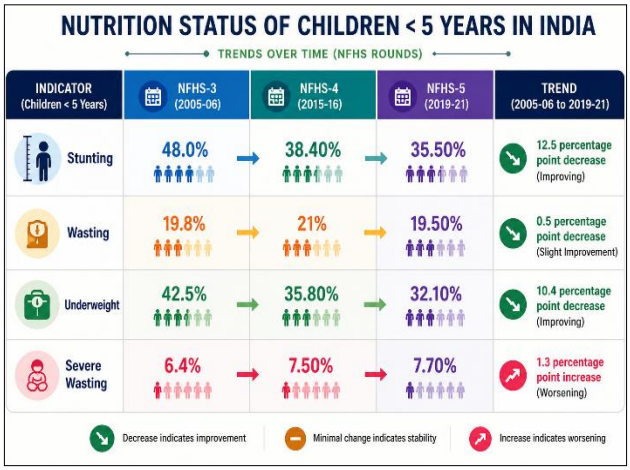

Figure 2: Nutrition status of children <5 years in India

DETERMINANTS OF GROWTH FALTERING

Growth faltering is the result of interactions between biologic, social, environmental and economic factors. Data from India indicates that certain factors play significant roles especially within the first two years of the child's development. Factors that influence growth of a child in early life include those involving the mother and the fetus. Malnutrition and anaemia in mothers, lack of prenatal care and low birth weight predispose children to malnutrition during infancy. Children born with low birth weight suffer continuous malnutrition due to intrauterine and postnatal causes. The intergenerational impacts of maternal undernutrition and anaemia are evident in India due to the high prevalence rates.[3]

Other determinants of growth faltering during infancy involve post-natal factors. Feeding problems are evidenced by the delayed start of breast feeding, low rates of exclusive breast feeding and inadequate food intake during complementary feeding. Minimum acceptable diet for infants aged 6-23 months is consumed by less than half of all children indicating poor feeding diversity and adequacy.[3]

Empirical studies have shown that inappropriate feeding practices are closely associated with an increased risk of growth faltering, particularly in the first year of life when nutritional requirements are highest.[7] These results emphasize the important influence of caretaker actions and knowledge on the nutritional outcomes for children.

Another critical area of concern that contributes to growth faltering in India is anaemia. According to NFHS-5, about 67% of the children between ages 6 to 59 months are anaemic as a result of iron deficiency and poor micronutrient composition.[3] Anaemia not only hinders growth but also adversely affects brain development and immune function. With such high prevalence of anaemia along with dietary insufficiency of nutrients, growth faltering and the progression are significantly accelerated.

The socio-economic factors play a role in some of the underlying reasons mentioned above. Persistent poverty creates a poverty-nutrition trap. For households that experience persistent poverty, food intake and consumption are inadequate, and their access to proper health services and sanitation facilities is low. This translates into poor nutritional statuses, which result in low physical and cognitive ability, as well as economic productivity, leading to deprivation cycles across generations.[8]

Gender-related inequities influence childhood nutrition primarily through intergenerational pathways. Poor maternal nutrition, unequal access to healthcare, and sociocultural norms affecting caregiving practices may increase the risk of growth faltering among infants and young children. Strengthening maternal nutrition and ensuring equitable access to health and nutrition services should therefore remain an integral component of preventive strategies against childhood malnutrition.

POLICY CONTEXT AND GAPS

Nutrition interventions in India include the large scale POSHAN Abhiyaan, ICDS, and NHM programs to tackle malnutrition. As of October 2023, CMAM has been introduced to ensure better diagnosis and treatment of malnutrition in children aged 0 to 5 years through MWCD and MoHFW.9 While the protocol includes provisions for infants below six months who exhibit visible signs of wasting, bilateral pitting oedema, or severe weakness that interferes with breastfeeding, the overall approach remains largely focused on the identification and treatment of established malnutrition. There is comparatively limited emphasis on routine growth monitoring and early detection of growth faltering among infants before severe manifestations emerge.

NITI Aayog Evaluation (2022-23) of POSHAN Abhiyaan reveals that there have been improvements in convergence, awareness raising, and digitalization efforts, but there are challenges in last mile delivery, real-time data usage, and behavioural change.[10] According to CAG audit (2017) of ICDS, there have been weaknesses in infrastructure provision, growth monitoring practices, training of front-line workers, and service delivery.[11] The major weakness in these interventions includes treatment-oriented approach rather than preventive approach. Interventions focus more on management of SAM and MAM cases only after the deficiency has set in. The Poshan Tracker enables real time monitoring but faces issues of data quality, technological barriers, and frontline worker compliance.

There is insufficient focus on infants below six months old despite the evidence of high prevalence of wasting and underweight among them, inconsistent growth monitoring practices, and limited knowledge among frontline workers including Anganwadi workers on protocols, tools, and techniques involved. Disintegration between ICDS and NHM makes the initiative less effective due to the lack of coordination between them. CMAM is inconsistent in being incorporated in routine interventions, making the strategy less sustainable and increasing the likelihood of relapse.

The above mentioned gaps show the disconnect between the goals and practice of addressing childhood malnutrition, especially at early stages. In order to ensure a successful and effective initiative, improvements in growth monitoring, data usage, targeting of vulnerable age groups, and program convergence should be implemented.

While existing programmes emphasize identification and management of established malnutrition, there remains limited institutional focus on detecting deviations in growth trajectories before wasting or severe acute malnutrition develops. This perspective therefore proposes integrating growth faltering as an upstream preventive

trigger within existing community nutrition platforms, thereby complementing rather than replacing current CMAM and POSHAN 2.0 strategies.

INTEGRATING GROWTH FALTERING INTO COMMUNITY-BASED PLATFORMS

There is need for incorporation of the concept of growth faltering within the community-based frameworks. There are mechanisms for screening, follow-up and referrals provided in the framework of the community-based management of acute malnutrition (CMAM) and hence, it can provide the basis for this integration. The CMAM needs to be transformed from a treatment model into an integrated care continuum including growth faltering detection and preventive measures. The proposed framework does not establish a parallel programme but strengthens existing frontline delivery platforms under POSHAN 2.0 and CMAM. Growth faltering assessment can be integrated into routine village health sanitation and nutrition days (VHSNDs), Anganwadi growth monitoring sessions, and ASHA home visits using existing anthropometric tools and the Poshan Tracker reporting system.

The innovation lies not in creating additional infrastructure, but in shifting from periodic measurement to trajectory-based growth monitoring and early counselling before progression to wasting or severe acute malnutrition. By leveraging existing frontline systems, the framework minimizes additional financial and human resource requirements while enhancing preventive effectiveness. Such an approach will focus on home visits, Anganwadi centre-based activities, village health and nutrition days. It is in contrast to the conventional approach where measurements of anthropometric assessment are made periodically. Here, the emphasis is placed on the patterns of growth, enabling earlier identification of growth faltering.

The model will have three main components, which will interact with each other. In the first component, systematic and consistent screening at the community level will be implemented, including infants under the age of six months, to identify their growth patterns. The second component refers to structured follow-ups, through home and community-based activities to keep track of the condition of children at risk. The third component entails strengthening the referral process between community platforms and healthcare institutions to address complicated cases and maintain continuity of care.

There is ample evidence regarding the feasibility of such an approach. For example, in Rajasthan, CMAM proved effective in providing high coverage and recovery rates while also having robust follow-up mechanisms in place.[12] The independent assessment of the intervention carried out and confirmed that structured community engagement was very beneficial in addressing the problem of SAM in children.[12]

Importantly, the model also highlighted the potential for leveraging repeated community-level contacts to strengthen caregiver practices and reduce relapse, thereby creating an entry point for integrating preventive components such as growth faltering identification.

Figure 3: Integrated community-based framework for preventing growth faltering.

The proposed framework introduces a preventive layer that complements existing systems by identifying growth faltering before progression to wasting and acute malnutrition.

POLICY RECOMMENDATIONS:

Addressing growth faltering in India requires an integrated policy response that prioritizes early identification and sustained community engagement. The given recommendations are categorized in different sections like immediate priority, intermediate priority and long-term priority.

SHORT TERM PRIORITY: (TIMELINE: WITHIN A YEAR)

Focus on early life interventions (0–6 months)

It is necessary to strengthen early life interventions which include breastfeeding and early growth monitoring. The

joint implementation of these activities needs to be led by the Ministries of Women and Child Development as well as Health and Family Welfare using ASHAs and Anganwadi workers.

Early detection and surveillance systems

It is important to build on continuous growth monitoring so that prevention replaces treatment. Making the most of digital tools such as the Poshan tracker can help with greater responsiveness, subject to improvement in data quality and workforce readiness.

Integration of prevention into community-based management

Building on existing CMAM to cover early detection and prevention of malnutrition would lead to more effectiveness. Adding in the early screening of growth faltering under CMAM will ensure intervention before escalation to acute forms.

Enhancing frontline capability and community engagement

Frontline staff are important actors in nutrition-related processes and their capability needs to be strengthened so that they can provide precise assessment of growth status of children and effective counselling. Importance of self-help group and peer-based initiatives, and community leaders in raising demand for nutrition services. It is imperative that Panchayat Raj Institutions and community organizations are engaged so that there is greater sense of local ownership and accountability.

MID-TERM PRIORITY: (TIME LINE: WITHIN 3 YEARS)

Convergence

The multiple causes of growth faltering imply a need to ensure convergence among sectors of nutrition, health and WASH. Coordination between schemes such as ICDS, NHM and WASH will help ensure better service provision. There is evidence to show that this leads to greater efficiency.

Implementation strategies should also be tailored to state-specific burden and health system capacity rather than adopting a uniform national approach. High-burden states such as Bihar, Madhya Pradesh, Rajasthan, and Uttar Pradesh may require intensified growth monitoring, seasonal nutrition interventions, and strengthened community outreach, whereas states with better nutrition indicators may prioritize quality improvement and sustained surveillance.[13]

Such differentiated implementation would improve efficiency while reducing regional disparities.

Funding and accountability processes

Interventions related to nutrition are usually part of various other interventions but lack special allocations. Funding should be institutionalized in POSHAN Abhiyaan and ICDS in order to maximize their effectiveness. Considering that undernutrition is estimated to cost India approximately 4% of its GDP annually, investments in preventive growth monitoring and early intervention should be viewed as investments in human capital rather than programme expenditure alone. Such investments are likely to generate substantial long-term returns through reduced healthcare costs and improved productivity. There is enough evidence from research to show that there is substantial return on investments made in early-life nutrition.[4]

LONG-TERM PRIORITY: (TIME LINE 3 TO 5 YEARS)

Structural determinants and social protection approach

Overcoming the problem of growth faltering requires taking care of socio-economic vulnerabilities such as food insecurity and poverty. Strengthening linkages between nutrition programs and various social protection initiatives such as food distribution, livelihood initiatives and cash transfers will help to overcome problems of access to nutrition as well as financial barriers.

Integrating growth faltering into POSHAN 2.0 and CMAM can help India shift from reactive management of malnutrition to proactive prevention to reduce wasting and severe malnutrition and from long-term development losses.

CONCLUSION

The topic of growth faltering needs to be discussed as one of the crucial aspects of preventing malnutrition among children in India since it is relevant at the time when intervention is most beneficial. Strengthening the systems of detecting malnutrition issues, ensuring improved nutrition among pregnant women and infants, and relying on community-based initiatives could be the right solution. A combined preventive and curative treatment strategy would be helpful for minimizing the negative consequences of malnutrition problems and providing better health results. The implementation of POSHAN 2.0 in India creates opportunities for addressing the problem of growth faltering and integrating prevention initiatives within existing programs. Beyond improving child survival and development, such investments represent an economically sound strategy for reducing long-term productivity losses and strengthening India's human capital, given the substantial economic burden associated with undernutrition. There will be numerous ways to achieve better monitoring of this process by creating appropriate data collection and analysis systems. The recent NFHS-6 provides an important baseline for

monitoring future progress. Integrating growth faltering into existing community platforms offers India an opportunity to shift from reactive treatment to proactive prevention, thereby strengthening child health and long-term human capital development.

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