Improving Children’s Diet: Approach and Progress

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Worldwide, fewer than one-third of children aged 6–24 months receive adequate dietary diversity and only about half receive a sufficient number of meals each day. Such suboptimal complementary feeding practices put millions of infants at risk for stunting and developmental delays. Food insecurity and/or limited access to high-quality foods continue during the preschool age years with implications for poor development and increased risk of facing the dual or even triple burden of malnutrition associated with protein-energy malnutrition, micronutrient deficiencies, as well as overweight or obesity.

Strategies to improve the adequacy of dietary intakes in young children have focused on improving both dietary quality and quantity of food consumed. While access to quality food that will meet the nutrient needs of young children remains a problem in many resource-poor settings, the importance of initiation and maintenance of sustained behavior change has been recognized as foundational to improving child feeding practices especially during the first 2 years of life. A wide range of interventions that aim to improve dietary intakes of young children have been evaluated in large-scale effectiveness trials with varying success and challenges. This presentation highlights key findings from these various studies with a focus on the ones conducted in Sub-Saharan Africa and South and South-East Asia. The interventions include one or more of the following: (a) provision of targeted food-based supplements, (b) food-aid packages, (c) counseling and behavior change interventions, (d) conditional cash transfers, (e) nutrition-sensitive intervention such as home gardening and promotion of orange flesh sweet potato, and (f) micronutrient supplements and fortification (staple foods and point of use). Among the 64 interventions that used behavior change techniques (BCTs), interpersonal communication (IPC), either individually or in groups, was the most commonly used platform. The number of techniques used by any one intervention also ranged from 2 to 13, with a median of 6. All interventions provided instruction on how to perform the behavior, and
other commonly applied BCTs included use of a credible source \( (n = 46) \); demonstration of the behavior \( (n = 35) \); and information about health consequences \( (n = 30) \). Forty-three interventions also reported strategies to shift the physical or social environment. We identified five large multi-country studies that included Alive & Thrive (Bangladesh, Ethiopia, India, Vietnam); Windows of Opportunity (CARE, multi-country); Nutrition at the Center (CARE, multi-country); Enhanced Homestead Food Production (Helen Keller International- HKI, multi-country); Shourado II (CARE, Bangladesh); ENGINE (Save the Children, Ethiopia); MICAH (World Vision, multi-country); and RAIN (Concern Worldwide, Zambia). Detailed reports of country-specific activities were found only for Alive & Thrive (A&T) and a limited number of HKI's HFP programs that focused on young children. Of note, the A&T Project in Bangladesh combined intensified IPC with mass media and community mobilization and reported significant improvements in a variety of child diet indicators including proportion of young children (6–24 months) consuming a minimally adequate diet and minimum diet diversity. This at-scale project reached over 8 million mothers and was implemented by a strong community-based nongovernmental organization. Some key factors that contributed to the success of this program included the formation of alliances with key stakeholders, availability of funds and technical support from multiple donors, well-defined interventions and indicators, and streamlined processes and tools to aid implementation. A key finding of this systematic review is the lack of detail related to intervention design and implementation including cost and feasibility, all of which have important implications for the adoption, replication, and scale up of effective strategies. Another concern is the limited data on strategies targeted toward improving the diet of preschool age children (3–5 years).