

India: Reducing undernutrition through community partnerships

Challenge

Despite vast improvements in the country's economy, undernutrition continues to be a problem in India. In 1999, the National Family Health Survey found that 47 per cent of all children under age three were underweight – a higher average prevalence than in sub-Saharan Africa. Data from the most recent round of the survey, completed in 2006, show only a very small decline, with undernutrition levels remaining around 45 per cent for children under three; in several states, such as Madhya Pradesh and Bihar, undernutrition levels have increased since the previous survey. Reasons for this high prevalence include the inadequate knowledge of caregivers concerning correct infant and young child feeding, frequent infections worsened by bad hygiene, high population pressure, the low status of women and girls, and suboptimal delivery of social services.

To combat undernutrition in young children, the Government of India relies largely on the Integrated Child Development Scheme (ICDS). Begun in 1975, the scheme provides health and nutrition education for mothers of infants and young children, along with other services, such as supplementary nutrition, basic health and antenatal care, growth monitoring and promotion, preschool non-formal education, micronutrient supplementation and immunization. These services are delivered through a network of some 700,000 community *anganwadi* workers. The effectiveness of ICDS has been limited, however, by a variety of factors, ranging from the

limited skill and knowledge of *anganwadi* workers to a lack of supervision, vacancies and flaws in programme policy, such as inadequate focus on very young children.

Strategy and approach

UNICEF is collaborating with the Government of India to increase the effectiveness of ICDS. The specific interventions supported include: strengthening the management and supervision system; improving the knowledge and skills of *anganwadi* workers and increasing the time and attention they give to infants; improving community involvement through joint village situation analysis, identifying village volunteers and providing them with basic training in infant care; and increasing the number of home visits made by *anganwadi* workers and volunteers in order to increase the caring behaviour of parents and improve the outreach of health services.

Results

The strategy described above was carried out in six states, in each of which at least 1,000 villages were covered, affecting more than a million people per state. After the interventions had been operational for about three years, impact assessments were conducted in several of the states, using representative household-based surveys to compare intervention villages with socially, economically and geographically similar control villages. In Rajasthan, for instance, it was found that early initiation of breastfeeding was higher and the prevalence of stunting significantly lower in intervention

villages than in control villages (see Figure 3.1). In West Bengal, early initiation of breastfeeding (76 per cent in intervention villages versus 44 per cent in control villages), vitamin A supplementation (50 per cent versus 33 per cent) and immunization rates (89 per cent versus 71 per cent for measles) were higher in intervention villages than in control villages, and undernutrition rates were lower (27 per cent stunting versus 32 per cent). The cost of these 'add-on' interventions is modest: US\$150–\$200 per village per year,

representing 9–10 per cent of the government's ongoing ICDS costs per village per year.

Lessons learned

Considering the continued high level of childhood undernutrition in India, it is important to demonstrate that low-cost changes can be made to the existing ICDS to significantly improve health care for infants and young children and that these changes can lead to nutritional improvements in a limited period of time. India has approximately 43 per cent underweight children under age five, so the success of low-cost solutions to undernutrition in the high-priority states of this country will have a global impact.

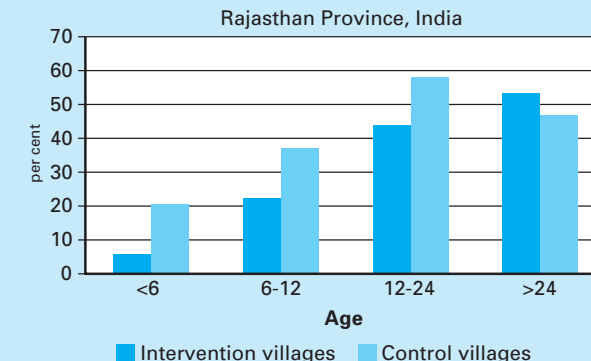
Remaining challenges

The governments of the states where these interventions are being implemented have decided to take them to larger scale using their own resources. UNICEF will continue to collaborate in order to assure that the quality of implementation remains adequate, as well as to address some behaviours that have been more difficult to change, such as the tendency of caregivers to delay the start of complementary feeding (much later than six months of age). Although the nutritional status of infants and children in the states involved has improved, it is clear there remains ample room for further improvement in the future.

See References, page 107.

Figure 3.1

Prevalence of stunting by age (months)



Source: UNICEF India, *Annual Report 2006*, p. 47.