addresses in greater depth in Chapter 4, can face obstacles and bottlenecks. In fact, just being able to maintain adequate participant number and structure is one of the greatest challenges. Existing programmes, regardless of their scale, grapple with poor training, inadequate supervision, lack of supplies and poor relationships with the communities they intend to serve. Attrition rates in community health worker programmes are often high. One review, for example, found attrition rates of 30 per cent over nine months in Senegal and 50 per cent over two years in Nigeria. Similar challenges have been identified in India, Sri Lanka and the United Republic of Tanzania.

Attrition is related to multiple factors. Fulfilling the responsibilities of a community health worker takes time and financial resources, and may involve significant opportunity costs. Community health workers, particularly those who are volunteers or paid in kind or part, may have obligations to meet and require income to support their families. If the demands on their time and resources prove overwhelming, there is a risk they will not function effectively as health workers or will drop out of community partnerships.

The sustainability of community health worker programmes depends on creating a package of incentives that is sufficiently attractive to prevent attrition. These packages will vary among settings, reflecting the different functions community health workers undertake in different communities. But all need to focus on priorities that include compensating community health workers for lost economic opportunities; providing adequate supervision and peer support; offering personal growth and development opportunities; and creating a strong support system within the community.

The incentives required to retain and motivate community health workers are not necessarily monetary. The disappointing results of evaluations of poor Alma-Ata large-scale training and deployment of community health workers underscore the fact that sound programme management and refresher training are more efficacious at sustaining workers’ effectiveness than initial training. Active community participation and support is a vital element of successful and sustainable community health worker programmes throughout the world. In the Philippines, for example, health workers at the barangay level, the smallest political unit in the country, have become a significant driving force behind improved child survival. This success has been encouraged by the Barangay Health Workers’ Benefits and Incentives Act of 1995, which includes such provisions as subsistence allowances, career enrichment and special training programmes, and preferential access to loans. Similarly, in Ceará, Brazil, a programme using a decentralized approach that allows community health workers to earn a substantial monthly income (twice the local average) has led to dramatic improvements in child health, including a 32 per cent reduction in child mortality.

Adequate programme supervision and support

Supervision and support systems for community partnerships in primary health care can diminish the community health workers’ sense of isolation and help sustain interest and motivation, reducing the risk of attrition. Skilled health workers based in, or closely linked to, health facilities generally undertake the supervisory function, which can add to their already heavy workloads. Supervisors themselves require training to acquire the appropriate skills for oversight of community-based programmes. Resource constraints—human, financial or organizational—can limit the breadth and depth of supervision and support systems.

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 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 infants and young children. 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 61 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 versus 32 per cent). The cost of these ‘add-on’ interventions is modest: US$10–$200 per village per year, representing 8–10 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.

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 services to more than a million 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...