

Research Article

Children's Right to Nutrition: Improvement through Community-Based Supervision in Aligarh

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ABSTRACT

Children are deprived of adequate nutrition, which adversely affects their health and survival. Severe acute malnutrition (SAM) among children enhances mortality risk and stunting. National Family Health Survey (NFHS-3) data show that about 8 million children under 5 years of age are SAM victims. This study, based on Strengthening Comprehensive Child Survival Programme Through Supportive Supervision (S-CCSP-SS) in Aligarh district, reveals that feeding practices for children have been substantially changed by community-level workers, especially Accredited Social Health Activists (ASHAs). Data suggest that initiation of breastfeeding within 1 h, 24 h and >24 h has changed from 40 to 80, 13 to 15 and 47 to 5 per cent, respectively (during 1st and 2nd surveys), due to community-level intervention. Furthermore, exclusive breastfeeding has also improved from 30 to 71 per cent with ASHAs' intervention. It is further buttressed by the fact that among the three exclusive breastfeeding advisors, namely doctors/auxiliary nurse midwives (ANMs), ASHAs and family members, breastfeeding has changed from 11.5 to 4, 58 to 91.6 and 30.5 to 4.4 per cent, respectively. It clearly shows the crucial role played by ASHAs. The findings from the present study suggest the significant role played by the community workers in ensuring and enhancing nutrition to neonates.

Keywords: Nutrition, Severe Acute Malnutrition, Community-Based Supervision, Exclusive Breastfeeding, Pre-lacteal

INTRODUCTION

Nutritional Rehabilitation Centres (NRCs) under National Rural Health Mission (NRHM) for treating SAM cases have quite a few limitations. Therefore, an alternative to NRCs has been advocated (Prasad 2012: 181–185). The present study is an attempt to fill the gap by examining the successful experience based on community supervision by ASHAs, ANMs and local-level participants in twelve blocks of Aligarh district and exploring community-based alternative to NRCs working under NRHM. Harmful traditional practices have been examined, which perpetuate malnutrition in general and

SAM in particular. Successful stories from the Aligarh Model have been highlighted towards behaviour modification by interpersonal communication and counselling through 'behaviour change communication' skills of ASHAs. The proposed alternative will not only reduce SAM but also substantially reduce the cost of running the programmes in pursuit of children's health improvement. The improved skills through regular handholding and supervision of frontline health functionaries, i.e. ASHAs, will surely strengthen the community-based alternative for ensuring children's right to nutrition.

Malnutrition is responsible, directly or indirectly, for about one-third of deaths among children under 5 years. Well above two-thirds of these deaths, often associated with inappropriate feeding practices, occur during the first year of life. Every year nearly 40 per cent of all under-five child deaths are among newborn infants, babies in their first 28 days of life or in the neonatal period. Newborn, or neonatal, deaths account for 40 per cent of all deaths among children under 5 years. Seventy-five per cent of all neonatal deaths occur during the first week of life. A total of 25–45 per cent neonatal deaths occur within the first 24 h. The main causes of newborn deaths are prematurity, low birthweight and various infections. India is home to the highest number of malnourished children in the world. What is puzzling is that despite the recent spurt in the economic growth rate, the decline in malnutrition has been unimpressive. Despite sustained growth in the national and per capita incomes over the last two decades, it is seen that there is a minimal decline in the rate of malnutrition among children. International evidence shows that, in average using cross-country analysis, for every 3–4 per cent increase in per capita income, under-nutrition rates as measured by low underweight rates decline by around 1 per cent. Rates of malnutrition in India, and also in other South Asian countries, are higher than those of many poorer countries including those in Sub-Saharan Africa; this phenomenon has been called the ‘Asian Enigma’. One of the main factors to which this is attributed is the poor status of women. Studies have also considered economic factors, child care practices, health-seeking behaviour, and so forth for explaining malnutrition. According to the 2005–2006 National Family Health Survey (NFHS-3), 40.4 per cent children under 3 years of age in the country are underweight. This is a fall of only 2 per cent in the 7 years since the previous survey was conducted. In 1998–1999, by the same measure, 42.7 per cent children were found to be underweight (NFHS-2). Other indicators of malnutrition from these surveys are also quite poor. About 45 per cent of children under 3 years are stunted, and almost 70 per cent children under 5 years of age are anaemic. Even among adults, about one-third of all men and women have a low body mass index (BMI, less than 18.5). Malnutrition rates in rural

India are high and the situation in Uttar Pradesh is, in general, worse than for the country as a whole. Therefore, although 50.7 per cent of all rural children in India are stunted, in rural Uttar Pradesh, 58.4 per cent children are stunted (WHO 2012; <http://www.who.int/mediacentre/factsheets/fs333/en/index.html>; <http://www.who.int/nutrition/topics/infantfeeding/en/index.html>; <http://www.themedguru.com/20101014/newsfeature/india-home-highest-number-malnourished-children-86140958.html>; MHFW 2007).

BACKGROUND

Uttar Pradesh in general and Aligarh district in particular have high infant mortality rate (IMR). IMR of UP is above the national average and very high compared with some states, namely Kerala. The IMR of Aligarh is dismal at 67, which calls for intensive efforts for its reduction. One of the crucial reasons for this problem is high mortality rate of the child. It has been rightly pointed out that the gap in government’s child survival initiatives is the lack of an in-built mechanism of follow-up and supportive supervision. The Multi-Country Evaluation of IMCI Effectiveness has rightly pointed out in this connection that either inadequate or weak supervision in most countries has resulted in addressing the issue of ineffective child survival programmes. In 2009, the IMR of Aligarh at 73 was alarming. To address this challenge, in 2009, a project on Supportive Supervision of CCSP was taken up in six blocks of Aligarh district, by the Department of Sociology and Social Work (Aligarh Muslim University, Aligarh, UP) with support from UNICEF. It was implemented in close coordination with the District Administration of Aligarh. Phase I (July 2009 to June 2010), Phase IIa (July 2010 to March 2011) and Phase IIb (April 2011 to September 2011) produced encouraging results in terms of ASHAs’ assessment skills and eventually saving the lives of children.

The current project, entitled Strengthening of Comprehensive Child Survival Programme Through Supportive Supervision (S-CCSP-SS) in Aligarh district (October 2011–December 2012), themes around strengthening the CCSP programme and sustainability for scalability. Major components have been phased out

following the guidelines by Dr. Henri van den Hombergh, Chief, Health Section, UNICEF-Country Office, India. S-CCSP-SS focuses on the reduction of IMR and feasibility of replication of AMU, the Aligarh Model, by governmental agencies in India and abroad in general and Uttar Pradesh in particular.

BREASTFEEDING AS RIGHT TO NUTRITION

The World Health Organization (WHO) recommends that infants start breastfeeding within 1 h of life are exclusively breastfed for 6 months, with timely introduction of adequate, safe and properly fed complementary foods while continuing breastfeeding for up to 2 years of age. Breast milk provides the ideal exclusive source of nutrition for babies up to the age of 6 months, offering health-protective effects that cannot be matched by any other food source. Exclusive breastfeeding during the first 6 months is the best way to strengthen infants' immunity, reduce exposure to infectious agents, reduce the risk of obesity and other factors related to heart disease, help overcome low birth weight and reduce stunting. Breastfeeding remains a critically important source of nutrition and health up to the age of 2 years, along with appropriate complementary foods. There is also an important link between breastfeeding and vitamin A. Babies who are not breastfed cannot maintain optimal vitamin A status for more than a few weeks. Benefits of breastfeeding extend to the mother as well, including bonding between mother and child, improved postpartum recovery, reduced iron loss, reduced risk of breast and ovarian cancers and increased child spacing. Exclusive breastfeeding is the leading preventive child survival intervention. Nearly 2 million lives could be saved each year through 6 months of exclusive breastfeeding and continued breastfeeding with appropriate complementary feeding for up to 2 years or longer. This could be significant for realising children's right to adequate nutrition.

RESEARCH DESIGN AND DATA

Two surveys: baseline and end line were carried out during July–August 2009 and November–December 2011 respectively. The sections that follow is based on these two surveys. Both the surveys were an integral part

of the S-CCSP-SS in Aligarh district. Data were collected using 25 variables in the baseline survey and 30 variables in the end line survey. Data and tables in this section are based on these two surveys. The trends focused in the study are initiation of breastfeeding with colostrum, exclusive breastfeeding, exclusive breastfeeding advisor, pre-lacteal feed and types of pre-lacteal feed with breastfeeding. The data have been collected using schedule from households having mother and her child less than 1 year of age. The sample has been taken in July–August 2009 from 6 blocks of Aligarh (namely Atrauli, Dhanipur, Gangiri, Jawan, Khair and Lodha), with a sample size of 200. In December 2011, the data was collected again, now from the 12 blocks of Aligarh district, with a sample size of 600. Two households were selected from each village, one most near and the other distant from the house of ASHA from randomly selected subcentres. Names of the blocks are Akrabad, Atrauli, Bijoli, Chandaus, Dhanipur, Gangiri, Gonda, Iglas, Jawan, Khair, Lodha and Tappal. The findings are listed below in Table 1.

Initiation of breastfeeding: According to the guidelines of IMNCI/CCSP, breastfeeding should start within 1 h of delivery. Figure 1 shows that during the final survey (November–December 2011), in 80 per cent cases, breastfeeding was initiated in less than 1 h after delivery; in 15 per cent cases, it was within 1–24 h; and in 5 per cent cases after 24 h, compared with the first survey (July–August 2009) where it was 40 per cent in the case of initiation in less than 1 h after delivery, 13 per cent within 1–24 h and 47 per cent after 24 h. This shows significant improvement in the breastfeeding trend among the community.

Exclusive breastfeeding: International guidelines recommend exclusive breastfeeding for the first 6 months based on scientific evidence of the benefits for infant's nutrition, survival, growth and development. Breast milk provides all the energy and nutrients that an infant needs during the first 6 months. Exclusive breastfeeding reduces infant deaths caused by common childhood illnesses such as diarrhoea and pneumonia, hastens recovery during illness and helps increased child spacing. Figure 2 depicts that during the final survey (November–

Table 1

Sl. No.	Indicator		1 st Survey (July–August 2009) (%)	2 nd Survey (November–December 2011) (%)
1.	Initiation of Breastfeeding	<1 h	40	80
		1–24 h	24	15
		>24 h	36	5
2.	Exclusive breastfeeding		30	71
3.	Exclusive breastfeeding on whose advice	ASHAs	58	91.6
		Doctors/ANMs	11.5	4
		Family members and others	30.5	4.4
4.	No. of babies given pre-lacteal		47	16.3
5.	Types of pre-lacteal along with breastfeeding	Janam Ghutti		
		Cow milk		
		Buffalo milk		
		Pehuan		

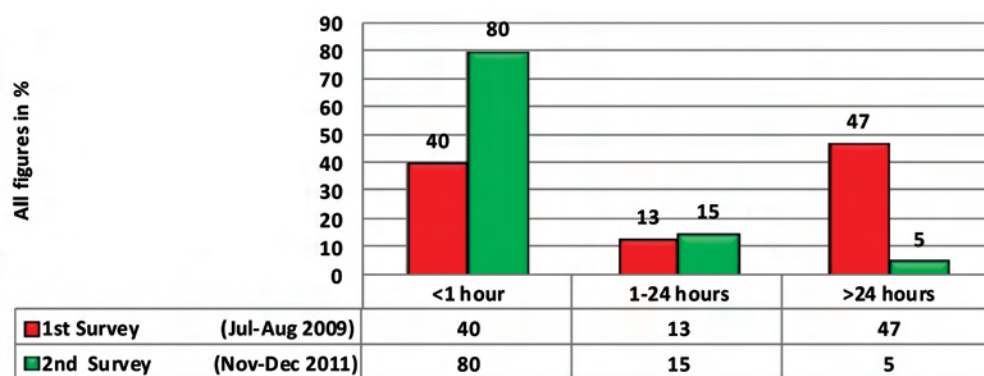


Figure 1: Initiation of Breast Feeding

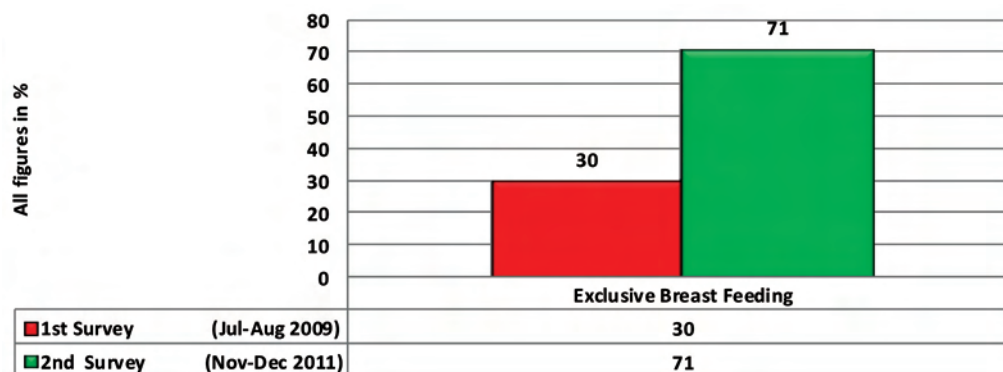


Figure 2: Exclusive Breast Feeding

December 2011), it was found that 71 per cent babies were exclusively breastfed compared with the first survey (July–August 2009) wherein only 30 per cent cases exclusive breastfeeding practice was observed.

Exclusive breastfeeding advisor: Figure 3 indicates that during the first survey (July–August 2009), exclusive breastfeeding was adopted in 58 per cent cases on ASHAs' advice, in 11.5 per cent on doctors'/ANMs' advice and in the remaining 30.5 per cent cases on advice of the family members and others. However, during the final survey (November–December 2011), it was remarkably encouraging to observe that in 91.6 per cent cases exclusive breastfeeding was done on ASHAs' advice, in 4 per cent on doctors'/ANMs' advice and in the rest 4.4 per cent cases by advice of the family members and others. This shows the acceptability and improvement in ASHAs counselling skills in view of regular support from the S-CCSP-SS project.

Pre-lacteal feed: Any fluid other than breast milk given for the first time to a newborn is defined as pre-lacteal feeding. Pre-lacteals are harmful to a newborn mainly due to two reasons. First, pre-lacteals being of poor quality increase the risk of early infections to a newborn, and second, as a simple consequence, it reduces the practice of exclusive breastfeeding. Many mothers, with the belief that colostrum is harmful to the child, start breastfeeding after 1–2 days of birth. By that time, colostrum is no longer available. Instead, they continue to give water sweetened with honey or crystalline sugar (*misry*), *pehua* or plain water to the newborn, which are of poor quality and do not contain the required nutrients. Pre-lacteals often result in gastrointestinal infections such as diarrhoea. Furthermore, the pre-lacteal liquid is given with a finger or a spoon often while the child is asleep or crying, which increases the danger of aspirating the fluid into the air passages and lungs. Thus, this feeding process

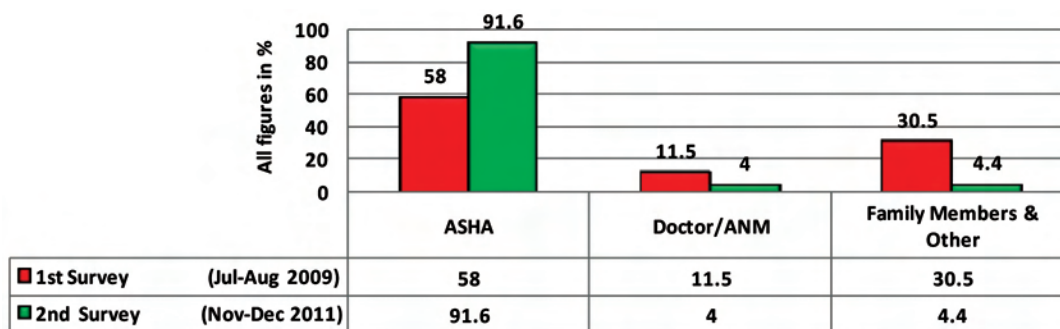


Figure 3: Exclusive Breast Feeding on Whose Advice

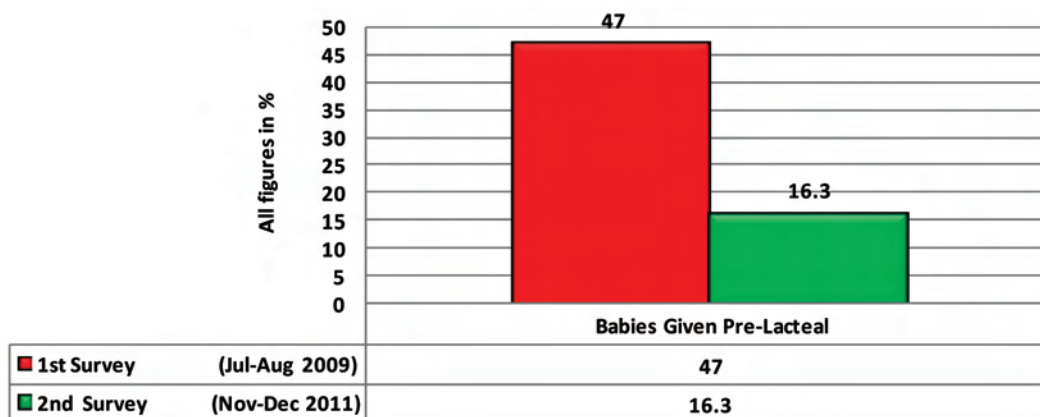


Figure 4: Babies Given Pre-Lacteal

Table 2: Improvement in ASHAs' Skills

S. No.	Assessment Skills	Phase I (July–September 2009), N=905	Phase I (May–June 2010), N=850	Phase II (July–September 2011), N=1624	Ongoing Phase (July–September 2012), N=1608
1.	Assessing breastfeeding (attachment and suckling) (%)	40	80	83	84
2.	Using chart booklet for classification (%)	8	70	71	78
3.	Giving treatment according to classification (%)	10	71	76	76
4.	Giving advice on breastfeeding (%)	23	80	84	86
5.	Counselling for homecare (%)	12	80	82	83
6.	Performing home visit (%)	13	80	86	88

can be dangerous to the child and may even prove fatal. Figure 4 reflects that during the first survey (July–August 2009), the practice of giving pre-lacteal was observed in 47 per cent cases, which reduced to only 16.3 per cent cases as found during the final survey (November–December 2011). The support given to the ASHAs by facilitation of village health awareness meetings and in assessment of newborns during home visits by the S-CCSP-SS project resulted in the promotion of healthy feeding practices in the community.

COMMUNITY-BASED SUPERVISION THROUGH ASHAs: SELECTED INDICATORS

Areas of newborn, child health and nutrition were focused in an array of skills of ASHAs to be strengthened through supportive supervision. In addition, use of behaviour change communication strategies through facilitation of ASHAs' village health awareness meetings was maximised, besides strengthening interpersonal communication during home visits. It is evident from Table 2 that the project provided strength and gained sustainability of results as the performance of ASHAs related to crucial indicators either remained stable or increased over a period of time. During the first round of Phase I (July–September 2009), 40 per cent ASHAs were able to 'Assess Breastfeeding (Attachment and Suckling)' properly. The effort has been made to encourage and promote the breastfeeding pattern by S-CCSP-SS and the output is shown in the above-mentioned table. The assessment of breastfeeding increased from 40 per cent to 80 per cent in Phase I (May–June 2010), which further increased from 83 per cent to

84 per cent in Phase II (July–September 2011) to the ongoing phase (July–September 2012).

The S-CCSP-SS project intensely and rigorously worked on the facilitation and augmentation of the skills of ASHAs. Table 2 depicts the skills of ASHAs in 'using the chart booklet for classification' to classify infants according to their health status. During the first round of Phase I (July–September 2009), only 8 per cent ASHAs were using the chart booklet for classification. This increased to 70 per cent in Phase I (May–June 2010), which further increased from 71 per cent to 78 per cent in Phase II (July–September 2011) to the ongoing phase (July–September 2012).

The same trend was used to obtain the desired result in treatment according to classification. The Table 2 Table 2 shows the growth from 10 per cent in Phase I (July–September 2009) to 76 per cent in the Ongoing Phase (July–September 2012), with the difference of 66 per cent. If ASHAs found improper breastfeeding, difficulty in breastfeeding or difficulty in suckling, they would advise the mother about the proper way of breastfeeding. S-CCSP-SS's intervention in the 'Advice on breastfeeding' has resulted in a 63 per cent increase in the improvement of the proper way of breastfeeding from Phase I (July–September 2009) to Ongoing Phase (July–September 2012).

It is an old saying that prevention is the best remedy. This is followed by ASHAs through counselling the mother of the infant and other members of the family about the hygienic and scientific way of caring for an infant. Effective counselling can only be possible in a

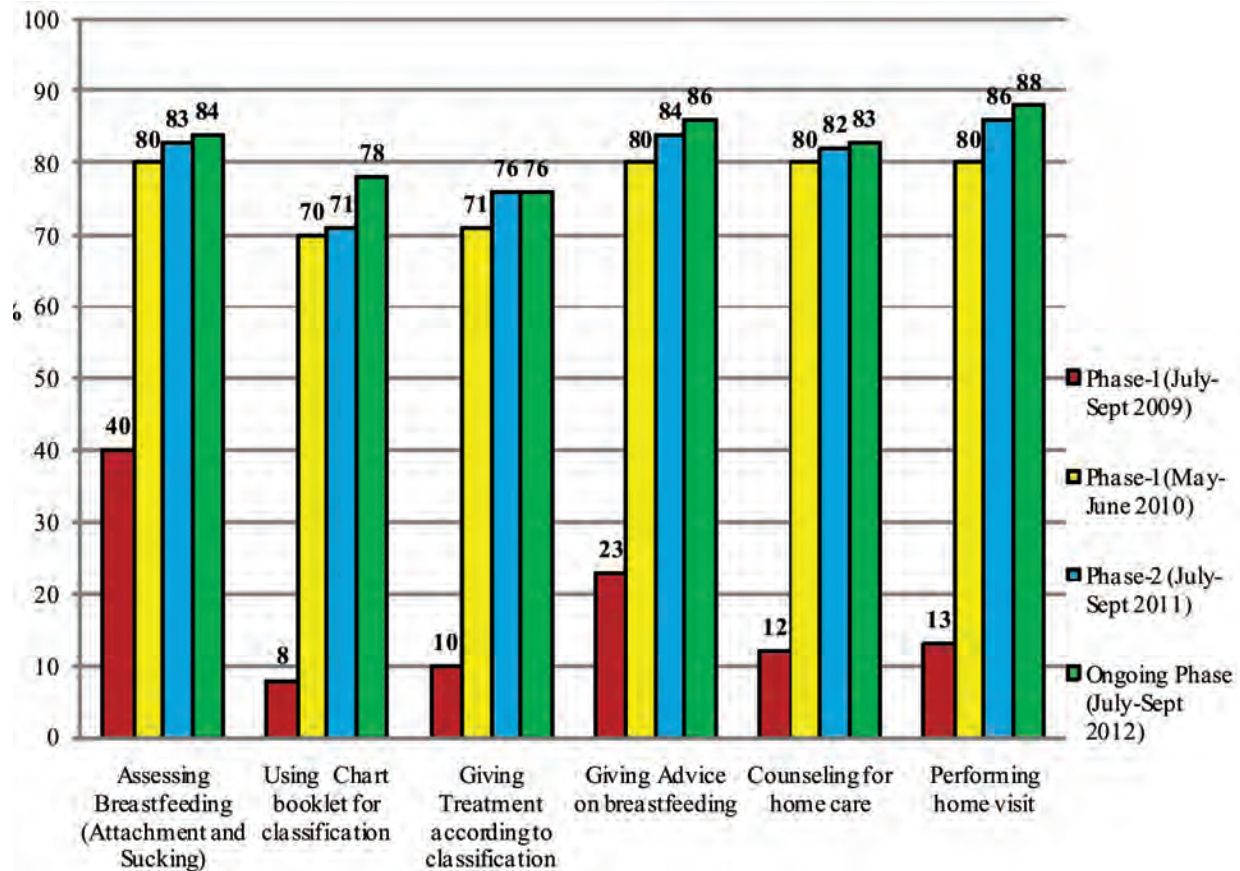


Figure 5: Improvement in ASHAs' Skills

situation when ASHAs develop friendly and close relationships with the family of an infant. Therefore, ASHAs are advised to win over the confidence of an infant's family and advised on scientific ways in caring of an infant as well as preventing the family from resorting to unhygienic customary practices. After the project involvement, the communication skills of ASHAs increased. Currently, ASHAs can counsel the family about proper care of infants. We have achieved a growth difference of 71 per cent in "counselling for homecare", as seen in Phase I (July–September 2009) to the ongoing phase (July–September 2012). Visiting the home of newborn babies by ASHA is an integral aspect of the CCSP. It is prescribed that an ASHA should visit three times (i.e., on the 1st, 3rd and the 7th day after birth), if the weight of the baby is 2.5 kg. On the contrary, if the

weight is less than 2.5 kg, she should visit six times (i.e., 1st, 3rd, 7th, 14th, 21st and the 28th day after birth). It is the core attempt of the project to promote the "home visit" by ASHAs. The result-oriented endeavour by the project has improved the difference of 75 per cent from Phase I (July–September 2009) to ongoing phase (July–September 2012). The outcomes have also been illustrated in Figure 5.

CONCLUSION

This study reveals the importance of community supervision at the grass-roots level. The performance of frontline functionaries (namely ASHAs, ANMs and AWWs) directly influence child health. It is evident that ASHAs' support has resulted in encouraging outcome with regard to improved nutritional pattern in the

community. It is high time that Anganwadi or Integrated Child Development Services (ICDS) functionaries coordinate with ASHAs and ANMs to further enhance the prospects of ensuring children's right to nutrition and improvement in their health. Stakeholders working for child rights and health may unite to address the problem of nutrition in the country and advocating for community's participation in delivering the goods. It may be noted here that community-based initiatives as proposed could do miracle with little resources in ensuring children's right to nutrition in pursuit of their survival and overcoming SAM in a country of scarce resources.

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