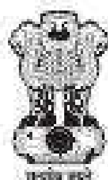

Government of West Bengal

HEALTH SYSTEMS DEVELOPMENT INITIATIVE

THE WEST BENGAL STATE NUTRITION STRATEGY 2008-2017

HIGHLIGHTS AND IMMEDIATE PRIORITIES

Department of Women & Child Development and Social Welfare
Government of West Bengal

List of abbreviations

ANM	Auxiliary Nurse-cum-Midwife
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BCC	Behaviour Change Communication
BMI	Body Mass Index
CBO	Community-based Organisation
DFID	Department for International Development
DWCD	Department for Women & Child Development and Social Welfare
GP	Gram Panchayat
HSDI	Health System Development Initiative
ICDS	Integrated Child Development Services
IFA	Iron and Folic Acid
IYCF	Infant and Young Child Feeding
MIS	Management Information System
NFHS	National Family Health Survey
NGO	Non-Government Organisation
O&M	Operation and Maintenance
ORS	Oral Rehydration Salt
PRDD	Panchayat and Rural Development Department
PRI	Panchayati Raj Institution
SD	Standard Deviation
SHG	Self-help Group

THE WEST BENGAL STATE NUTRITION STRATEGY 2008-2017

Goal

The state shall strive to achieve optimal nutritional health for all people, especially the poorest and those in greatest need, through intersectoral collaboration.

Objectives

1. Reduce under-nutrition including micronutrient deficiencies particularly in women and young children as a prerequisite for good health
2. Ensure uninterrupted delivery of quality nutrition services through the Integrated Child Development Services (ICDS) Scheme in collaboration with primary health care services and Panchayati Raj Institutions (PRI) particularly to the nutritionally vulnerable, poor and excluded groups.
3. Improve inter-departmental convergence to address the various factors that contribute to mal-nutrition, including food security and safety, access to health care, water safety, sanitation, empowerment of women, education etc.

The Current Nutrition Situation in West Bengal

West Bengal is the most densely populated state of India. Nearly half the state's population comprises the contextually backward groups, the scheduled castes, scheduled tribes and minority religious groups. This unique ethno-cultural environment has shaped traditional practices and attitudes in the caring and feeding of children, women and the girl child.

Among the states of India West Bengal has maintained a middle position in economic growth in the country. The improvement in health has been more impressive and the mortality rates have almost halved over the last two decades. But, prosperity and improved survival have not resulted in improved nutrition outcomes.

Key Nutrition trends and Indicators West Bengal (source Fact sheets NFHS 3 2005-06)

Indicator	Trends West Bengal NFHS 2 to 3	West Bengal NFHS 3	All India Average NFHS 3
Children		%	%
Underweight weight for age 0-35m	Improved 5.2%	43.5	45.9
Stunting height for age 0-35m	Improved 8.5%	33	38.4
Wasting weight for height 0-35m	Worsened 5.4%	19	19.1
Breast fed within 1 hour of birth (0-3y)	Worsened 1.3%	23.7	23.4
Exclusively breast fed 0-5m	NA	58.6	46.3
Fed semi-solid/ solid food & breast milk 6-9m	Improved 9%	55.9	55.8
Anaemia in children 0-35m	Improved 9%	69.4	79.2
Children 12-35 months received one dose of Vitamin A in the last six months	Improved 25%**	48.1*	21.0
Households using adequately iodised salt	Improved 7.4%	69.1	51.1
Women			
Anaemia in married women 15-49y	Worsened 1.1%	63.8	56.2
Anaemia in pregnant women	Worsened 6.3%	62.6	57.9
Pregnant women consumed 90+IFA in last pregnancy	NA	24.3	22.3
Maternal under-nutrition 15-49y (BMI <18.5)	Improved 6%	37.7	33

* Data source NFHS 3 India report , ** Data for comparison NFHS 2 West Bengal State report

It is apparent from the trends that several nutrition indicators have shown gradual improvement. However, the increasing trend in anaemia in women and wasting in children is a grim reminder that the nutritional situation is still grave and affects a large number of women (64% anaemic) and children (69% anaemic).

However, it is possible to reduce malnutrition prevalence at accelerated rates through well planned and focused interventions as demonstrated in India and other countries[1].

Taking into account the nutrition goals of the Eleventh Five year plan of the Government of India and the commitment to "Universalise ICDS with quality" the state has set itself ambitious targets for nutrition outcomes over the next ten years.

The state recognises the dynamic context of the issues and any strategy to address them would need to be flexible and adaptive.

Medium- and long-term Nutrition Outcome Targets

Though the state has set medium (2010) and long-term (2016) targets, it is the Nutrition outcomes that will be a measure of the success of the strategy.

Medium- and long-term Nutrition Outcome Targets

Indicator	Current Status (source NFHS 3)	West Bengal 2010	West Bengal 2016
	%	%	%
Underweight children 0-35 m	43.5	35	22
Anaemia in pregnant women	62.6	55	35
Anaemia in children 0-35 m	69.4	60	45
Vitamin A supplementation	41.2	55 (9m-5y)	80
Use of adequate Iodised salt in households	69.1	80	90
Infants breastfed within one hour of birth	23.7	28.7	40
Exclusive breast feeding	58.6	80	90
Complementary feeding	55.9	80	90

For the medium term – 2008-2010 – the state has focused on some key elements in the West Bengal State Nutrition Strategy. It will target the most critical issues particularly those that have long-term, inter-generational implications. The thrust of the strategy will be on preventing and treating early malnutrition.

[1] Lancet series on Maternal and Child Nutrition, www.lancet.org
World Bank 2006 *Repositioning Nutrition as Central to Development: A Strategy for Large-Scale Action*
Gragnolati M, Shekhar M, Gupta M D, Bredenkamp C and Lee Y K (2005), *India's Undernourished Children: A Call for Reform and Action*

The Goal

The Government of West Bengal shall strive to achieve optimal nutritional health for all people especially the poorest and those in greatest need through intersectoral collaboration

Improving the quality of ICDS

- Strengthening supervision – introduce coordinators at GP level selected from AWWs pool, one per 10 - 12 AWCs
- Improving management at state and district levels
- Enhancing capacity of human resource
- Development of Infrastructure to improve access to marginalised and poor groups

Targeting the most vulnerable

- Preventive Interventions focused on children 0 - 3 years, pregnant and lactating women
- A community based rehabilitation plan for malnourished children
- Improved access for marginalised and poorer groups

Strengthening, Monitoring and Evaluation

- Developing monitoring indicators
- Strengthening monitoring and supervision processes
- Strengthening state MIS to facilitate evidence based reforms / policy
- Conducting studies and appraisals periodically

Empowering the community

- Linking home-based approach with centre based service delivery
- Developing area specific interventions based on lessons learned from successful pilots
- Developing local capacity (SHG, CBO) for nutrition actions

Promoting Convergence with health

- Ensuring essential nutrition care to women and children through planned activities – fixed Health and Nutrition days and biannual nutrition weeks.
- Activating State, district and block level existing monitoring and coordination committees to monitor nutrition actions

Strategic Priorities

The strategic priorities are:

I. **Target the most vulnerable** groups of the population

II. **Improve the quality of ICDS Services** to achieve Universalisation with quality.

III. **Promote convergence** to ensure availability of services, inter-departmental collaboration and community participation

IV. **Empower communities** and families to adopt sound nutrition practices particularly for the most vulnerable.

V. **Strengthen Monitoring and Evaluation** to ensure the programme remains on track.

I. Target the most vulnerable

Certain groups in the population are more susceptible to the ill-effects of nutritional deprivation and are therefore considered nutritionally vulnerable. Young children (0-2 years) carry the damage inflicted by early malnutrition all their lives. Chronically undernourished, anaemic women pass on their nutrition deficits to children thus making nutrition an intergenerational phenomenon. The risk of disease and mortality is increased several times among children who are malnourished[2]. NFHS surveys have shown that the incidence of malnutrition is higher among economically and socially backward groups.

The strategy will target these groups with appropriate interventions and nutrition actions, which will include

- Preventive interventions for children under 3, pregnant, and lactating women
- Community-based rehabilitation plans for malnourished children
- Improved access (to nutrition services) for marginalised and poorer groups

Nutrition actions[3]

- Early and exclusive breastfeeding for six months
- Adequate complementary feeding starting at 6 months with continued breastfeeding, including nutritional care of sick and severely malnourished children
- Adequate Vitamin A intake by women (diet) and children, Vitamin A supplementation of children 9-59 m
- Adequate intake of iron for women and children, IFA supplementation and encouraging compliance
- Extra diet and rest during pregnancy
- Adequate intake of iodine by all members of the household

II. Improve the quality of ICDS services

The Integrated Child Development Services (ICDS), which has a network of community level Anganwadi Centres (AWCs) across the whole state, is the largest direct nutrition programme for women and children. The strategy aims to increase the effectiveness of ICDS to combat malnutrition by focusing on strengthening systems. The key areas are:

- **Management**: A State Nutrition Strategy Management Unit will be formed under the Department of Women and Child Development and Social Welfare (referred to as DWCD) to improve programme management and implement the strategy. Management at district and block levels will also be strengthened.
- **Supervision**: Anganwadi coordinators will be appointed at the Gram Panchayat (GP) level to improve supervision. Each GP will have two coordinators and each co-ordinator will oversee a cluster of 12-15 Anganwadi Centres.
- **Human resource**: A capacity building and sensitisation process will be initiated and institutionalised to train people at all levels – from the committees that will guide the implementation of the strategy, to the staff on the ground (AWWs, PRIs, NGO workers, health staff, school teachers, village health and sanitation committees). A training plan will address key capacity building issues, like institutional and decentralised training, knowledge and skills for nutrition interventions and on-job supervision and guidance.
- **Physical Infrastructure**: The gaps in infrastructure will be filled by building Anganwadi Centres with basic sanitation facilities so that poor and marginalised groups have access to these facilities. The state plans to construct one Anganwadi centre in every GP area annually, over the next three years.

III. Promote convergence

Convergence encourages the participation of different departments, sectors and programmes in the delivery of nutrition interventions. To promote convergence, the state will:

- Ensure essential nutrition care to women and children through targeted and planned interventions.

  a) Conduct Nutrition and Health Days: A monthly activity to be organised by the "Gram Unnayan Samiti" in its role of the village health, water and sanitation committee of the "Gram Sansad ". AWW, ANM and ASHA (where available) will participate.

b) Organise biannual Nutrition and Health Weeks: Some nutrition actions such as Vitamin A supplementation to children and deworming are six-monthly interventions. These will be provided biannually (during May and November) and will include intensive nutrition awareness generation activities.

- Activate existing monitoring and coordination committees: The National Rural Health Mission will oversee the strategy at the state level, and existing committees of the PRDD will be sensitised to monitor nutrition issues and actions at the district and block levels.

a) Strengthen monthly meetings of ANM and AWW: Encourage meaningful interaction between ANMs and AWWs during their monthly meetings. This should promote convergence in planning, delivery of services, reporting and monitoring.

IV. Empower the community

Families and communities will be empowered through nutrition awareness campaigns. This will promote behaviour change towards improved care practices for women and children and enable families to initiate nutrition actions at their levels. It also aims to increase awareness of and demand for nutrition services. The key approaches will include:

- Linking a home-based approach with centre-based service delivery
- Developing area specific interventions based on lessons learned from successful pilots
- Developing local capacity (SHG, CBO) for nutrition actions
- Introducing community-based interventions for rehabilitation of malnourished children.

V. Strengthen monitoring and evaluation

A detailed monitoring and evaluation plan will be developed. This will involve people at all levels of the system including the community. The key considerations for monitoring include:

- Developing a set of common nutrition monitoring indicators that can be used across all sectors.
- Strengthening monitoring and supervision processes
- Strengthening state MIS to facilitate evidence based reforms/ policy
- Conducting studies and appraisals periodically.

Operationalising the State Nutrition Strategy

The State has already undertaken a Health Systems Development Initiative (HSDI), which is a programme for reform and investment in the Health and Nutrition Sector. The HSDI is supported by the United Kingdom Department of International Development (DFID). DWCD will be the nodal department for implementing the Nutrition component of HSDI. The HSDI Nutrition programme outputs and milestones for the first year are as under.

Programme Outputs in June 2010	Milestones for the first year 2008
1. Improved ICDS service Delivery, especially in the six poorest districts	1.1 State training plan developed for enhanced training and supervision capacity to ensure focus on IYCF and micronutrients supplementation among children under 3. Implementation of training plan initiated 1.2 Infrastructure of AWC strengthened in six poorest districts, esp in remote tribal blocks, according to agreed poverty criteria and O&M norms. 1.3 Selection and training of cluster coordinators (cadre of supervisors) in at least half the districts of the state, including 6 poorest districts 1.4 Nutrition related activities incorporated in the agenda of health supervisors. 1.5 In 6 poorest districts, increase in the coverage of 25+ feeding days at AWCs
2. Strengthened convergence	2.1 Existing state, and district and block level coordination committees for health (NRHM) sensitised and oriented to monitor implementation of the Nutrition strategy. 2.3 AWCs established as depot holders for IFA, ORS and contraceptives.
3. Community actions for improved child feeding practices	3.1 Existing communication strategies in the state reviewed and a comprehensive BCC plan developed 3.2 CBOs/ SHGs to support BCC interventions oriented on their roles in selected districts and blocks
4. Strengthened institutional and financial management for responsive, accountable and inclusive service delivery	4.1 State Nutrition strategy and monitoring unit established with agreed staffing pattern, and functional 4.2 Monitoring plan developed and introduced to ICDS, Health and PRDD 4.3 State & district Nutrition MIS cell strengthened to improve data quality and analysis 4.4 Baseline study of nutritional status and practices in six priority districts. 4.5 Fiduciary risk mitigation action plan implemented (First year actions)

Indicators used to assess nutritional status

Undernutrition: A composite indicator of chronic and acute malnutrition indicated by low weight for age (<-2SD of median of reference population).

Stunting: A chronic restriction of vertical growth indicated by low height for age (<-2SD of median of reference population).

Wasting: Acute weight loss indicated by low weight for height (<-2SD of median of reference population).

Stunting, wasting and under-nutrition are usually caused by diets that lack sufficient nutrients and a high rate of infectious diseases.

Maternal under-nutrition: Low body mass index (<18.5) indicates underweight for height and is a measure of thinness and chronic under-nutrition in adults. BMI is expressed as weight in kilograms divided by height in metre squared (kg/m2).

Anaemia: Characterised by low haemoglobin levels in the blood. Haemoglobin values of <11.0 gram per decilitre of blood in the case of children and pregnant women and <12.0 gram per decilitre of blood for non-pregnant women indicate anaemia.

Other indicators pertain to breast feeding, complementary feeding and consumption of micronutrients.

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