India has 20% of the world's children, unfortunately, 46% children under three years of age are underweight and 38% are stunted. In state of Gujarat, the prevalence of underweight (47%) and stunting (42%) among children under 3 years is as high as per the national average (NFHS-3, 2005-2006). Faulty Infant and Young Child Feeding (IYCF) practices, especially inappropriate breastfeeding and complementary feeding are a major cause of under-2 malnutrition. Government policies, programme guidelines and resources have primarily given more attention to the rural poor with rather less attention to the urban poor. Attention is required as much in the urban areas as in the rural areas. The Ministry of Women and Child Development (Food and Nutrition Board), Government of India has brought out a revised second edition of National Guidelines on Infant and Young Child Feeding in 2006, which include specific guidelines and recommendations for optimal BF and CF practices.

**The Home Visit Strategy as a means for improving IYCF**

The home visit strategy, has tremendous potential for empowering families of vulnerable under 3 year olds to improve home level IYCF practices; because it offers an opportunity for one-to-one communication or interpersonal communication (IPC) so important to bring about behavior change.
In the national ICDS program, nutrition-education-communication and home visits are among the several important services that are expected to empower families to improve home level practices for women and child nutrition. Home visits also need to be backed up by community based IEC/BCC activities to help get social sanction for the desirable IYCF Practices and to provide the much needed community and neighborhood support to child caregivers to improve home level practices.

As a part of the action group (http://www.solutionexchange-un.net.in/food/res30040801.doc), a study is planned as a capacity building intervention which will aim to strengthen the home visit strategy (supported by community BCC events), in rural and urban ICDS blocks in order to improve the calorie, micronutrient content and safety of complementary foods at home level as per the National IYCF Guidelines. The primary aim of the intervention study is to document best practices and lessons learnt for enabling effective behavior change to improve IYCF through existing programs; with behavior change being targeted in both program functionaries as well as the community. These lessons/practices could subsequently be applied in other settings and for other nutrition-health ‘problem behaviors’.

The study will comprise three phases:
1. Prior to initiating the intervention, a Best Practices Review paper will be prepared consisting of a comprehensive review of available program evaluations/operations research focusing on implementation and impact of the Home Visit strategy and community/neighborhood BCC activities for improving IYCF.

The Intervention Phase will comprise of Extensive Phase and the Intensive Phase.
2. Extensive Phase: This will be a capacity-building phase, which will primarily be in the form of interactive training workshops for Anganwadi workers (AWWs) and their supervisors.
3. Intensive Phase: Among the AWCs in the extensive phase, 10% will be randomly selected for intensive follow up, documentation and process-impact evaluation, which will include both the functionary and beneficiary perspective – the study group.

Based on the discussion outcomes from the 2nd Annual Forum at Hyderabad, I would like to first document the best practices and lessons learnt for improving CF (and related BF) practices in ongoing programs and with existing institutions. In this context, I would request members to share:
- Experiences/reports as regards the home visit function and community IEC activities in ICDS especially in area of child feeding and nutrition
- What could be some specific steps to follow to enable BCC strategies to get internalized in the ICDS system given the current workload/diversified activities carried out by its functionaries
- Success stories documenting behavior change in IYCF; especially complementary feeding
- Information on other IEC strategies that have helped in bringing about behavior changes in the areas of child feeding and nutrition

The discussion outcomes would help in developing the best practice review paper and implementation of extensive phase of the Action Group intervention.

Responses were received, with thanks, from
1. Ragini Pasricha, Population Services International, New Delhi
2. Shubhada Kanani, The M S University of Baroda, Vadodara (Response 1; Response 2; Response 3; Response 4)
3. Harish Kumar, United Nations Children’s Fund (UNICEF), New Delhi
Face-to-Face or one-to-one interactions tend to be the most successful way of bringing about behavioral changes under Information Education Communication (IEC) initiatives. Exploring the effectiveness of using ‘home visits’ as an IEC strategy for improving the health and nutrition status of children (6-24 months), members discussed the idea of home visits, listed constraints related to implementation, looked at ways to internalize Behavior Change Communication (BCC) strategies, listed suggestions for effectively implementing home visits, and shared relevant experiences.
Respondents **applauded the idea using home visits** as part of an IEC strategy to improve the nutritional status and health of children. They pointed out how home visits provide individual support to mothers and are considered the best intervention for increasing breast-feeding rates. According to an operations research study, conducted by the Indian Institute of Health Management Research, women identified one-to-one communication and the home visits as the factors enabling them to understand and comprehend “why they should follow certain practices”. Discussants also cited the results of the **Integrated Management of Neonatal and Childhood Illnesses** intervention that involved Anganwadi workers (AWW) in conducting home visits to provide newborn care and promote breast-feeding.

Members stressed the critical nature of visiting families in their ‘homes’ to ensure both the child and the mother are receiving good nutrition during all stages. They also emphasized need for the person conducting the visit to have the right attitude and appropriate emotional intelligence (i.e. self-awareness, self-regulation and management, self-motivation, social awareness and skills).

Respondents agreed having service providers, such as Auxiliary Nurse Midwives (ANM), AWWs, Accredited Social Health Activists (ASHAs), adolescent girls or members of women self-help groups (SHGs) conduct home visits has tremendous potential to induce behavioral change and reduce child malnutrition and mortality. Further, they felt it is important to involve and educate community-based organizations in mainstreaming breastfeeding into the government health and nutrition programmes.

Discussants also underlined the need for appropriate communication strategies. The strategy must include the right mix of different communication channels and techniques, proper segmentation of target populations, clear goal and objectives, unambiguous messaging, and differentiated approaches for advocacy, services and addressing social barriers. Involving communities in identifying communication needs, developing BCC strategies, evolving IEC materials and analyzing impact, will go a long way in conceiving and implementing the strategy, members felt.

Outlining **constraints to effective implementation of home visits**, respondents argued there is inadequate knowledge and skills at the community level (urban and rural) among service providers (doctors, nurses and frontline healthcare workers). This results in field level workers using different standards, as compared to researchers, to identify malnutrition. They also noted AWWs overburdened with various tasks, which affects the quality of home visit interactions. Moreover, the extensive reporting AWWs and ANMs are required to do, demand a high level of motivation and facilitation, which is generally lacking. These concerns raise the question of credibility of the health care workers.

Another challenge mentioned is the lack of attention to convergence and coordination between various government programmes and voluntary action/NGO-led programmes increases the workload of extension personnel and other service providers and creates unnecessary confusion. Moreover, local governance institutions tend to be neglected because parallel village level committees are often created.

Respondents also explained that the conception of BCC strategies under government programmes are at state or central level, and thus tend to not be specific enough to effectively address local issues. BCC strategies need to be suited to local requirements and conditions.

Exploring ways to **internalise BCC strategies** related to children’s health and nutrition into the ICDS system, members identified the development of an enabling environment and creation of a suitable communication approach as the important steps. Another critical input mentioned was
training AWWs, ANMs, and other field staff to help families prepare to care for both the mother and child. Members specifically noted the Infant and Young Child Feeding (IYCF) courses conducted by the Breastfeeding Promotion Network of India (BPNI) as an example of how families, if given adequate training can adopt supportive practices towards breastfeeding and complementary feeding and help others adopt the same.

Respondents also pointed out NGOs as part of IEC activities educate pregnant mothers on nutrition, but noted this approach is resource intensive. Thus they recommended involving local community members in following up on home visits. They also suggested introducing the subject “human nutrition” in school and advocated establishment of Nutrition Rehabilitation Centres (NRC) attached with health centres as in Lalitpur district of Uttar Pradesh, which can serve as demonstration-cum-BCC skill learning centres. Members stressed that an effective BCC strategy has the potential to usher in changes to a community’s perceptions regarding breastfeeding and nutrition for infants.

Recognizing the value of communicating nutrition and health messages to vulnerable households through home visits, discussants brought up points to consider during implementation. Supervisors need to have thorough understanding of the issues involved with home visits and have the management skills necessary. For example, the Gorakhpur Medical College in Uttar Pradesh successfully mainstreamed optimal breastfeeding into their health and nutrition system by facilitating dissemination of the appropriate information at the right time through skilled counselors. Respondents felt that by slightly modifying the home visit register format to include aspects like time spent, messages imparted, response of the household member, and a follow up note monitoring and supervision system could be strengthened.

Members also felt programmes need to take advantage of the various opportunities available for interpersonal communication, including village level meetings, Take Home Ration Days, Nutrition Health Weekly Days, meetings of Matra Samitis (Mother’s Committees), Mahila Samakhya (networks), SHGs, and village melas (fairs), to advocate the best feeding practices.

Additionally, discussants noted that careful identification of the determinants of inappropriate breastfeeding and complementary feeding are necessary. Once there is an understanding of why certain practices are done, appropriate messages can be devised, including the compilation of a list of frequently asked questions (i.e. ‘what is exclusive breastfeeding?’, ‘what is the appropriate age for complementary feeding?’ and ‘what are appropriate complementary feeding foods?’).

Along with the above, members also recommended considering the following when planning and implementing home visits:

- Clearly defining the roles and responsibilities of various stakeholders
- Ensuring good training to enhance ‘skills’ based on scientifically accepted protocols and guidelines
- Providing ongoing supportive supervision which involved local governance institutions, mothers’ groups and socio-religious groups, private practitioners and para-medical workers
- Integration of aspects related to hygiene and sanitation in various communication strategies for child feeding and nutrition
- On a long-term basis appropriate change in the curriculum of MBBS, Nursing and Nutrition and NIPCCD courses that empathizes on practical training considering the ground reality and skill development.

In addition, discussants shared successful communication strategies from programmes across the country, which helped bring about behavioral changes in the areas of child feeding and nutrition. The Integrated Nutrition and Health Project (INHP) demonstrated significant improvements in terms of behavior by strengthening the coverage of clients to participate for
availing the services through home visits. Cluster randomized trial in Haryana demonstrated improved breast-feeding practices, when an IMNCI training tool was adapted to provide workers better communication skills. Additionally, in Rajasthan, home visits formed the core strategy under a programme where Sahayoginis carry out the BCC activities. In Afghanistan and Zambia formative research on the TIPs (Trials for Improved Practices) methodology showed that involving community field staff and nutrition promoters in the initial assessment as well as face-to-face counseling of mothers and families are necessary for a successful intervention.

Along with experiences with communication strategies, members also listed experiences where complementary feeding practices improved. In Jharkhand local NGOs and CBOs in partnership with CARE oriented families to develop nutritious food products from locally available grains and pulses. In the tribal belt of Maharashtra, an initiative taught families to prepare nutritious food from fresh indigenous grains and pulses, resulting in a reduction in malnutrition-linked child mortality.

In addition, an ICDS intervention in two villages in Uttar Pradesh showed that home visit counseling and village level BCC activities led to tremendous improvements in the complementary feeding practices of infants aged 6-12 months. Another campaign in Uttar Pradesh involved medical colleges in building up a dedicated band of Bal Parivar Mitra (Community Health-Nutrition-Sanitation Mobilisers) trained in interpersonal communication by the Community based Maternal and Child Health Nutrition programme. This helped reduce severe malnutrition among infants in the villages. Finally, members shared a study on the nutrition education programme in Delhi, which documented behavioral changes in IYCF, especially related to complementary feeding practices and the iron status of infants.

Finally, members referred to the nutrition education material developed jointly by the Food and Agriculture Organization of the United Nations (FAO) and the Ministries of Agriculture and Health in Afghanistan, which promoted the use of local foods for complementary feeding.

Overall members supported the proposal to carry out home visits as an effective tool for bringing in required behavioral change provided the personnel carrying out home visits appropriately trained and motivated to carry out these functions.

Comparative Experiences

Madhya Pradesh

Auxiliary Nurse and Midwives (ANMs) Trained on Home Based Care, Dhar District (from Harish Kumar and Gaurav Arya, UNICEF, New Delhi)
Most deliveries were occurring at home, due to long distances between health centers and a shortage of trained nurses, equipment and supplies. To address this, UNICEF helped raise awareness and concern among families about having a trained attendant present during delivery. So far, more than 90 ANMs were trained in standard midwifery practices and given equipment for standard deliveries. As a result there has been considerable improvement in managing deliveries and newborn at home. Read more

Jharkhand

Community Based Nutrition Approach, Gumla District (from Prasant Saboth, Abhilasha Trust, Bhubaneswar)
CARE India trained NGOs and CBOs (women's groups) on how to develop nutritious food products from locally available grains and pulses to feed their children. The training was given to
parents at no cost. The AWWs were also involved in the follow-up and training of illiterate tribal mothers. Along with the training, the community developed a self-monitoring system for tracking the weight of all the children every month and regularity of extra food intake. The results have thus far been promising.

Maharastra

**Home Visits Help Reducing Malnutrition** *(from Nagesh Tekala, Navdrushti, Mumbai)*
A programme working on child malnutrition in tribal areas, introduced the concept of nutritious, freshly cooked breakfast, made of indigenously available grains & pulses. Children not attending the programme were traced to their homes, & found to be at a Grade IV stage of malnutrition. To help them, programme staff regularly took them to where the breakfast was served. After six months malnutrition was gone. The home visit strategy proved to have tremendous potential for addressing malnutrition in children under two.

Uttar Pradesh

**Food Preparation Demos during Home Visits, Ghaziabad District** *(from Aashima Garg, Lady Irwin College, New Delhi)*
An intervention worked to improve complementary feeding practices of infants (6-12 months) through home visits. Trained village level community counselors, ASHA workers, and AWWs conduct the visits. This counseling showed tremendous improvement in feeding and has also enhanced the quality and quantity of complementary foods fed to infants, and this was attributed to the "food demonstration at household level" carried out during the home visits.

Community Based Health and Nutrition Interventions, Agra, Allahabad, Jhansi, and Varanasi *(from Ashok Singh, Vistaar, Lucknow and Sheila Vir, UNICEF, New Delhi)*
UNICEF and various government agencies implemented a community-based maternal and child health nutrition project. A Bal Parivar Mitra was appointed for reaching and establishing regular contact with selected ‘at risk’ families for undernutrition. The project also established an effective monitoring system. These efforts resulted in considerable improvements in community behaviour towards nutrition and health, the project’s success was largely attributed to its systematic and well planned activities. Read more

Nutrition Rehabilitation Centres Prove Effective in Providing Home Based Care, Lalitpur *(from N C De, CINI, Kolkata)*
The Nutrition Rehabilitation Centre, housed within Lalitpur’s Community Health Centre has opened with the hope of providing healthcare and nutrition services to expecting mothers and undernourished children. Within 3 months of establishment, it was offering free residential and institutional care. The AWWs manage minor problems at home through counselling, dispensing basic drugs and referring critical cases (severe undernutrition) to the nearest health centre. Read more

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**Related Resources**

**Recommended Documentation**

**Integrated Management of Neonatal and Childhood Illnesses (IMNCI)** *(from Harish Kumar and Gaurav Arya, UNICEF, New Delhi)*
Article; UNICEF
Available at [http://www.unicef.org/india/health_369.htm](http://www.unicef.org/india/health_369.htm)
Discusses how to strengthen home-based care and health workers during home visits and also train mothers on newborn care, how to recognize diseases and when to seek medical help

From Harish Kumar, UNICEF, New Delhi

Effect of Community-Based Promotion of Exclusive Breastfeeding on Diarrhoeal Illness and Growth: A Cluster Randomised Controlled Trial
Article; by Nita Bhandari, Rajiv Bahl, Sarmila Mazumdar, et al; The Lancet; 26 April 2003; Permission Required: Yes, for personal use, only reproduce with permission from The Lancet Publishing Group
Available at [http://www.solutionexchange-un.net.in/food/cr/res12050801.pdf](http://www.solutionexchange-un.net.in/food/cr/res12050801.pdf) (PDF Size: 88 KB)

| Argues that promoting exclusive breastfeeding until 6 months through existing primary health-care services is feasible, especially through home visits

An Educational Intervention to Promote Appropriate Complementary Feeding Practices and Physical Growth in Infants and Young Children in Rural Haryana, India
Report; by Nita Bhandari, Sarmila Mazumder, Rajiv Bahl, et al; American Society for Nutritional Sciences; 11 June 2004
Available at [http://www.solutionexchange-un.net.in/food/cr/res12050802.pdf](http://www.solutionexchange-un.net.in/food/cr/res12050802.pdf) (PDF Size: 104 KB)

| Assesses the effectiveness of educational intervention like home visits to promote adequate complementary feeding practices

Healthy Food, Happy Baby, Lively Family (from Ellen Muehlhoff, FAO, Rome, Italy)
Book; by Charity Djiririmwe; Food and Agriculture Organization of the United Nations (FAO); Afghanistan; 2008
Available at [http://www.solutionexchange-un.net.in/food/cr/res12050803.pdf](http://www.solutionexchange-un.net.in/food/cr/res12050803.pdf) (PDF Size: 2 MB)

| Provides practical skills on how to prepare improved recipes for children and family as IEC material to improve the nutritional status of children

Final Evaluation of Project on Baby Friendly Health Initiative (from Arun Gupta, Breastfeeding Promotion Network of India, New Delhi)
Report; B. R. D. College, Gorakhpur; Y.G. Consultants and Services (P) Ltd; Lalitpur District, Uttar Pradesh; March - April 2008
Available at [http://www.solutionexchange-un.net.in/food/cr/res12050804.doc](http://www.solutionexchange-un.net.in/food/cr/res12050804.doc) (Document Size 1 MB)

| Shows significant success of project where district/block level counselors and frontline workers were trained on infant and young child feeding practices through home visits.

Effectiveness of Nutrition Education, Iron Supplementation or Both on Iron Status in Children (from Deeksha Kapur, IGNOU, New Delhi)
Study Report; by D. Kapur, S. Sharma and K. N. Agarwal; Indian Pediatrics ; 12 September 2003
Available at [http://www.indianpediatrics.net/dec2003/dec-1131-1144.htm](http://www.indianpediatrics.net/dec2003/dec-1131-1144.htm)

| Suggest nutrition education and IEC interventions showed a positive affect on the iron status of children in urban slums of Delhi

Community Based Maternal and Child Health Nutrition (MCHN) Project (from Ashok Singh, Vistaar, Lucknow and Sheila Vir, UNICEF, New Delhi)
Evaluation Report; GoUP (Directorate of Family Welfare and Directorate of ICDS) and UNICEF, Lucknow; ORG Centre for Social Research; September 2006
Available at [http://www.solutionexchange-un.net.in/food/cr/res12050804.pdf](http://www.solutionexchange-un.net.in/food/cr/res12050804.pdf) (PDF Size: 4.6 MB)

| Evaluation report of MCHN that aims to establish a community based system for improving maternal and child health and nutrition primarily through home visits

From Avanish Kumar, Insight Research Network, New Delhi
Overview and Executive Summary of Taru Project – Quantitative Report
Reports; by Arvind Singhal, Kim Witte, Nithya Muthuswamy, and Desiree Duff; Population Communications International; December 2003
Available at http://www.population.org/multimedia/Taru-Quantitative-reports-exec-summary2.pdf (PDF Size: 40 KB)

Presents quantitative and qualitative evaluation results of entertainment education radio soap opera, Taru, in Bihar, effectively used as an IPC tool under IEC strategies for BCC

Overview and Executive Summary of Taru Project – Qualitative Report
Reports; by Arvind Singhal, Kim Witte, Nithya Muthuswamy, and Desiree Duff; Population Communications International; December 2003
Available at http://www.population.org/multimedia/Taru-Qual-reports-exec-summary1.pdf (PDF Size: 70 KB)

Presents quantitative and qualitative evaluation results of entertainment education radio soap opera, Taru, in Bihar, effectively used as an IPC tool under IEC strategies for BCC

Nutrition Rehabilitation Centre Brings Hope for Newborn Health in India (from N C De, CINI, Kolkata)
Article; UNICEF
Available at http://www.unicef.org/infobycountry/india_42885.html

Mentions that nutritional supplements and daily follow-up home visits by a pediatrician and nutritionist at a nutritional rehabilitation centre have shown promising signs health improvements

Recommended Organizations and Programmes

Breastfeeding Promotion Network of India (BPNI), New Delhi (from Nirmala Selvam, Independent Consultant, Chennai)
BP-33, Pitampura, Delhi 110088; Tel: 91-11-27343608; Fax: 91-11-27343606 bpni@bpni.org; http://www.bpni.org/bpni.html

Works through advocacy and IEC interventions to protect, promote and support breastfeeding and how to provide appropriate complementary feeding of infants and young children

Institute of Health Management Pachod (IHMP), Pachod (from Wadgave H. V., HALO Medical Foundation, Solapur)
Ashish Gram Rachna Trust, Pachod, Dist. Aurangabad 431121 Maharashtra; Tel: 91-2431-221382; Fax: 91-2431-221331; ihmp@vsnl.com; http://www.ihmp.org/programmes_and_activities_pachod.html

Implements various IEC intervention programmes in rural areas and urban slums to improve IYCF along with home visits as a major IEC strategy

Recommended Portals and Information Bases

Training Material for Integrated Management of Neonatal and Childhood Illnesses (IMNCI), Ministry of Health and Family Welfare (from Harish Kumar, UNICEF, New Delhi)
http://mohfw.nic.in/dofw%20website/training_material_for_imnci.htm

Provides training modules for physicians and health workers to recognize illnesses early and seek timely care for mothers and newborns during home visits under IMNCI

Related Consolidated Replies

Available at http://www.solutionexchange-un.net.in/food/e-discuss/ediscuss01-05120601-public.pdf (PDF, Size: 216 KB)
Explores reasons behind neglect of NHEC, lessons learned, members’ experiences and suggestions to improve NHEC programmes for improved nutritional status

Responses in Full

Ragini Pasricha, Population Services International, New Delhi

When you say that inappropriate breastfeeding and complementary feeding are a major cause of under-2 nutrition, consider the determinants of this behavior. If you think that this is due to social norms relating to infant feeding practices, consider whether IPC by Anganwadis will be effective in impacting the targeted behavior.

Home visits mean you expect an individual to change behavior. But if everyone in my family or village does something in a particular way and does not see that as a problem, would an individual change simply because someone - an AWW - came and asked them to do something differently. Is the AWW a sufficiently credible source of information. Are you looking at it purely as a knowledge issue - people do not know what is right and therefore, they aren't feeding their children correctly? And telling them what is correct will automatically lead to that change. Even if lack of knowledge is the issue, are AWWs a credible source or should you possibly be looking at mass media support via TV/radio with a nutritionist backing the AWWs message.

My suggestion would be to look at the key determinants of the behavior, see which have the greatest logistics odds ratio in terms of the behavior, then consider which are the most possible to change - some determinants may be too complex to address in a short time span or some may not have as much scope to change. Once you decide a determinant to address, then see which communication format will be most effective.

Although this may involve taking a couple of steps back to look at the problem again, I urge you to consider doing so in order to address the most significant determinant with a focused message delivered using appropriate media.

Shubhada Kanani, The M S University of Baroda, Vaddodara (response 1)

I thank Ragini for her inputs. I agree that determinants of behaviour need to be elucidated for focusing the message and that family and community support is also needed for behaviour change.

In this regard, in the proposed action group (http://www.solutionexchange-un.net.in/food/cr/res30040801.doc), we have planned for a ‘Rapid Qualitative Appraisal’ at baseline which will include the component of ‘behaviour analysis’ and subsequent identification of ‘problem behaviours’. The media and communication strategy will be based on this appraisal; the “best practices review paper” which will be compiled will be based on the ICDS workers’ own experience. This will help in focused messages to be given. Secondly, as the proposal says, the strategy will be family centered and not individual centered - and will include community based events - as time and again it is seen that without family and community support, behaviours do not change easily.

Finally, yes, credibility of AWWs is an issue that needs to be considered; I believe its also her competence/communication skills which limit or enhance the effectiveness of the AWW as change agents; and importantly, the time she gives to this task of family contacts and home visits. Region specific solutions will need to be considered for these and other issues.

If you have documents or reports of success stories or interventions in this area, which could help in the review, paper preparation; it will be helpful. All reports/papers used in the review will be acknowledged.
**Harish Kumar, United Nations Children's Fund (UNICEF), New Delhi**

Shubhada has initiated an interesting issue of home visitation as a mean for improving IYCF. In fact, why AWW was involved in Integrated Management of Neonatal and Childhood Illnesses (IMNCI) ([http://www.unicef.org/india/health_369.htm](http://www.unicef.org/india/health_369.htm)) by the adaptation group was to have home visit concept of newborn care with breast-feeding promotion as one of the component. Home visitation with individual support to mothers has been shown to be the single best intervention for improving breast-feeding rates and there are many reports available from Global and Indian experience.

In India, this has been tested in Cluster randomized trial from Haryana, Faridabad by Neeta Bhandari and others published in Lancet 2003, 361, 1418-1423 ([http://www.solutionexchange-un.net.in/food/cr/res12050801.pdf](http://www.solutionexchange-un.net.in/food/cr/res12050801.pdf)) and showed improved breast-feeding behaviors. The workers were trained by an adapted IMNCI training tool ([http://mohfw.nic.in/dofw%20website/training_material_for_imnci.htm](http://mohfw.nic.in/dofw%20website/training_material_for_imnci.htm)) where communication skill building is an important component.

In another article published by the same group complementary feeding also improved. Although this was not reflected in significant changes in anthropometric parameters. IMNCI with its strong nutrition component including home visitation for newborn care can be the tool as shown by Haryana trials to improve IYCF behaviors.

The reports of Haryana Trial are available at this link ([http://www.solutionexchange-un.net.in/food/cr/res12050802.pdf](http://www.solutionexchange-un.net.in/food/cr/res12050802.pdf) (PDF, Size: 104 KB)

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**Nirmala Selvam, Independent Consultant, Chennai**

If the AWW is well trained on IYCF counseling and support skills home visits will go a long way in helping families change behaviour and adopt optimal infant and young child feeding practices.

Inappropriate breastfeeding and complementary feeding are a major cause of under 2 malnutrition. There is both a lack of knowledge and skills involved both at the community level (urban and rural) and at the service provider level (all categories - doctors, nurses and health care providers).

Let us look at the knowledge first.

What is exclusive breastfeeding? This is in itself is not clearly understood by the majority. It literally means nothing other than breast milk is fed to the baby - no water, no prelacteal feeds such as sugar water etc. An infant should be on exclusive breastfeeding for the first six months of life. From the 7th month, the infant should continue breastfeeding in addition to being fed age appropriate complementary foods.

Complementary feeding appropriate for the age of the infant is a grey area for the vast majority - the knowledge should cover what family foods can be introduced in what manner - frequency consistency and combinations from the 7th month onwards gradually till the infant graduates to eating what the family eats regularly. Most are unaware of what to give the infant and often we find people starting an infant on dal -paani or very thin gruel or go for the expensive commercial infant foods thinking that feeding the infant this readymade mix is all that baby needs.

Now let us take the situations for initiating and maintaining breastfeeding successfully. Attaching the baby at the breast correctly for ease in breastfeeding is very important but unfortunately, for a lot of young mothers this does not happen correct automatically. We find many holding the breast around the nipple between their thumb and forefinger and thrusting it into baby's mouth. This will not help the mother and infant succeed in breastfeeding. We also find quite a few mothers who feel they have no milk because they are unaware that the watery. Sometimes clear, sometimes yellowish fluid that comes in
drops is breast milk (colostrum) then there are cases where the baby is premature and is separated from the mother. The mother needs to be taught how to express breast milk without causing pain and injury to the breast.

During our training programs we have helped our participants (doctors/nurses/nutritionists) learn how to counsel and help women to succeed at breastfeeding. They in turn are able to help the families who come to them for help. The IYCF training courses conducted by BPNI include clinical practice sessions everyday.

Most people are unaware that expressed breast milk can be stored at room temperature in a cool dry place in a clean covered stainless steel katori for up to 8 hours. Most people are not aware and have not had opportunity to feed a premature new born or sick baby (too weak to suckle) with a cup. Once they learn the technique it is not difficult. Most people have never had the opportunity to help a mother and a baby with a physical difficulty succeed at breastfeeding. Correct position (how baby is held), correct attachment (how baby is latched onto the breast) and self-confidence help a woman to succeed with lactation.

Health service providers, family members and the community at large play an important role in helping or hampering breastfeeding. Unfortunately in many cases exclusive breastfeeding is hampered by health service providers and the family/community that is conditioned by myths and the infant food marketers.

Let us take the situations for introducing and progressing with complementary feeding for the under twos. Most families do not have the right knowledge about what local foods can be cooked and fed to the infant in what consistency. Infants need to be introduced natural foods according to their capacity to digest and assimilate the food. They need to be introduced to varying textures and tastes gradually. Most importantly, families need to know what foods need to be combined or given at what frequency and in what consistency. In the urban households, a large majority still opt to feed the commercially processed infant foods as they are not aware of how to prepare the infant's food from natural sources and also have the misguided notion that the commercially marketed infant foods are the best for their baby.

So training the AWW is important and will go a long way in helping families prepare when the woman is pregnant to create an enabling environment when the baby comes for successful breastfeeding. When families learn and understand IYCF practices they will adopt it, promote and support exclusive breastfeeding and select locally available foods for complementary feeding to meet the nutrition requirements of the infants. They will also understand and support the needs of the lactating woman.

It will be good if our education system introduces lessons on human nutrition. It can be graded according to the students age and written in a language that they can easily understand. One is never too young to learn and when they learn about mammals and their young ones we need to include human beings too. Please visit [www.bpni.org](http://www.bpni.org) for information on breastfeeding and complementary feeding.

**Wadgave H.V., HALO Medical Foundation, Solapur**

IEC through home visits will be the vital step to improve the nutritional status of the children of 6-24 months age. This practice of nutritional education is already in practice by NGOs like HALO Medical Foundation, Andur and IHMP, Pachod where the tool is used for IEC activities among the Pregnant Mothers but not yet in case of the child. Even though it is an effective tool it requires lot of resources, e.g. Manpower. Only relying on Anganwadi workers, ANMs will not be sufficient for home visits if we take the present workload of AWW & ANMs.
It will be a great opportunity to involve and educate the community based CBOs like Self Help Groups, which are now in the dynamic process of Social work and development. I am in favour of involving the CBOs because:

- The present workload of AWWs and ANMs is much more so it will not possible to them to give sufficient time for IEC at home level
- Repeated visits for IEC and follow up will not be possible for them due to time constraints.
- Even though we involve them it will not solve the problem at all, as it requires the community involvement e.g. CBOs, Community leaders for the sustainable development/improvement.

So while planning, the role of CBOs should also be taken into consideration.

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**Radha Holla**, Breastfeeding Promotion Network of India (BPNI), Noida

As rightly point out by Ragini, it is determinants of behaviour that need to be addressed to make any significant change in breastfeeding practices. At BPNI, our experience is that this requires action on three fronts: first, and most important in a way, is the mainstreaming of optimal breastfeeding in health and nutrition system of the country, second - correct information with frontline workers such as ASHA, AWW, TBA, etc. and third - access to a skilled counsellor. The first requires that all health institutions stress on the need for optimal breastfeeding practices from the first contact with the pregnant woman and her family; that the health system has a worker in place to support women who deliver to initiate breastfeeding within one hour; that all training of PRIs, SHGs, etc. have breastfeeding mainstreamed in them; and vitally, that there is a earmarked budget for improving breastfeeding practices.

The second requires that the current modules regarding breastfeeding in the training of frontline workers be enhanced to cover not just the benefits of breastfeeding, but also identification of problems, their amelioration, including when to refer, and with special stress on the perception of not enough milk.

The third requires that that a skilled breastfeeding and IYCF counsellor, with special counselling skills be in place for every 5000 population to assist the mother with emotional and physical problems. This is especially important as so much of the success of breastfeeding depends upon the oxytocin reflex, which in turn is dependent upon the confidence of the mother in her ability to feed her infant. This in fact, is the key to success in our experience.

In fact, even the recently released Lancet series on Maternal and Child Malnutrition stresses on the need for one-to-one counselling as evidence points out that this is far more effective than the current style of IEC.

The Gorakhpur Medical College has actually put these three factors in place to create a district level model at Lalitpur in UP, where merely within a year, breastfeeding rates have risen significantly.

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**Nutan Jain**, Indian Institute of Health Management Research (IIHMR), Jaipur

According to one of the operations research study (conducted by IIHMR, Jaipur and supported by DWCD, GoR/World Bank) findings, the women suggested that they need one-to-one communication. In meetings, they were not able to understand complete message. Another important feature was that they were not told, “WHY they should do this” and if they were told they were not able to understand/comprehend.

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**Prakash Nayak**, Tata-Dhan Academy, Madurai
I sincerely thank Ms Shubhada for initiating such an interesting discussion on Infant and Young Child Feeding (IYCF) and Home Visits by Anganwadi Workers. There is an urgent need to study the trend of IYCF in different context.

We, the programme managers and strategists, are all divided on our opinions on Home Visits as an IEC Strategy for Nutrition Improvement of Children 6-24 Months. While some people are against the idea of putting more pressure on AWWs and ANMs, some are hopeful of initiating positive behaviors among mothers and children. Mostly AWWs and ANMs are providing services and products on service delivery mode. There are no harm adding soft skills in counseling and interpersonal communication. These skills are not "add on" but very much integral part of their work. There is no clear cut boundary where service ends and communication starts.

There are best success stories in different pockets of the country on communication strategies that have helped in bringing about behavior changes in the areas of child feeding and nutrition. This is high time we should document those best practices and replicate in other areas.

**Dharmesh Lal**, National Institute of Health and Family Welfare, New Delhi

It is great idea to have home-based IEC, but I would like to begin at Panchayat level first and then trickle down to household level leading to capacity building of panchayat, a vital component for helping in formulation of village health action plan and later on in monitoring activities. IMNCI also has some component of household IEC activities; but I think to begin with it should be above that level. Otherwise to start with household level is huge gigantic task having great potential to falter.

**Ellen Muehlhoff**, Nutrition and Consumer Protection Division, Food and Agriculture Organization of the United Nations (FAO), Rome, Italy

I would like to draw your attention to a nutrition education material ([http://www.solutionexchange-un.net.in/food/cr/res12050803.pdf](http://www.solutionexchange-un.net.in/food/cr/res12050803.pdf)) (Size: 2 MB) that we developed in Afghanistan jointly with the Ministries of Agriculture and Health, focusing on the promotion of local foods for complementary feeding. The recipes were developed and tested jointly with mothers based on local dietary patterns and focus on the use of foods that are available at different times of the year, affordable and culturally acceptable, including indigenous foods.

I would be pleased to share with you the methodology used for developing the material. We have used and adapted the Trials for Improved Practices (TIPs) formative research methodology both in Afghanistan and in Zambia in southern Africa, where we assisted the MOH and local nutrition institutions in developing a similar material. Community field staff and nutrition promoters (with no formal training) were engaged in the initial assessment as well as face-to-face counselling with mothers and families. I would be pleased to share more information with you. Please don't hesitate to contact me.

**Aditi Aikat**, Department of Health and Family Welfare, Government of West Bengal, Kolkata

In this regard, I would like to share with you all, a simple tool that I had devised to locate mothers of 9-24 month old children in need of urgent BCC intervention. It remains a fact that those mothers who are in need of focal attention are often not those who demand and actually use the health care needed. But in face of expensive health care, prioritization, such that resources could be optimized, with maximal overlapping of need, demand and use. This quantified approach of scoring of mother's child care skill by the health workers, on their house visits could go a long way in concentrating specially on at-risk mothers of child having malnutrition, regarding health education and active intervention if need be so.
Professed correlates regarding childcare skill were tried out through pilot study and statistically significant ones were finally chosen for devising a simple scoring chart to be used by health workers on house visit. It yielded results with quite high specificity when applied on a larger scale. With limited workforce in hand, focused attention works very well instead of generalised approach.

**Arun Gupta**, Breastfeeding Promotion Network of India (BFPNI), New Delhi

The Lalitpur final draft report is available at [http://www.solutionexchange-un.net.in/food/cr/res12050804.doc](http://www.solutionexchange-un.net.in/food/cr/res12050804.doc) (Size: 1 MB) attached for your information and for you to comment. What I would like to suggest that discussion could be below 24 months or 0-24 months to give the full perspective to Infant and Young Child Feeding. The report of a project implemented at the size of a district will certainly be useful for any efforts in this direction.

**Prasant Saboth**, Abhilasha Trust, Bhubaneswar

CARE has done extensive work on reducing malnutrition in preschool children in its focus area by adopting practical strategies. In Gumla district of Jharkhand, they had partnership with local NGOs and CBOs (women group) in the villages and oriented them to develop nutritious food product from locally available grains and pulses. The proportion of protein was high in the powder. It was prepared by the village women and was given to the parents of all children at no profit no loss cost. The AWWs were also involved for follow up and training the illiterate tribal mothers. The community with little guidance also developed a self-monitoring system of making drawings on their walls for tracking the weight of the child every month and the regularity of extra food intake.

So I will suggest two things - one is promotion and encouraging locally available, affordable and acceptable (to the children) recipe, second is monitoring system by the community.

The mothers, grand mothers, temple priests, schoolteachers and PRI members should also be given the responsibility of monitoring capacity building and training for upgrading the nutrition requirement of the children in their community.

In addition, Iron supplementation and regular treatment of Hookworm/other worm infestation should be also considered.

All the above ideas and products should be made available at some cost and not free to the community (Social Marketing).

**Nagesh Tekale**, Navdrushti, Mumbai

Since last decade, I am working on child malnutrition in tribal belt of Maharashtra. The major focus is 6-24 month age group in which mortality is very high. To reduce the malnutrition linked child mortality we have first time introduced concept of nutritious breakfast concept freshly made from indigenously available grains and pulses. The experiment was a grand success. We also first time used the voucher system for collecting the breakfast.

This NGO run project was linked with ICDS. Kids who were not attending the programme were traced at home and found to be in grade IV malnutrition. The treatment was given and later on taken in to community where breakfast was served. At the end of six months project the malnutrition was totally eradicated. The entire project was made sustainable through local self-help group. I fully agree that home visit strategy has tremendous potential for empowering families of vulnerable under 24 month old to improve child malnutrition and reduce mortality.
Home visits by service providers specially Anganwadi Workers and ANM along with volunteers (Change agents) adolescents’ girls, members of women self-help groups to counseling for desired behaviors change of clients (earlier called beneficiaries).

Home visits are very excellent tool for BCC and strategy to reduce malnutrition and significant change in IMR/MMR. Prioritising the ‘Home’ to visits is very critical to choose by visitor like:

- Last trimester
- First day of delivery
- First week of delivery
- 28 days from birth of child
- 4 to 6 month of child
- 9 to 11 month of child
- 15 to 24 month of child

Visitors are expected to adhere these critical life cycles to assure good nutrition of child as nourishing mothers.

We have experienced good result in last 10 years of Integrated Nutrition and Health Project (INHP). External evaluations result findings as well as NFHS-II and NFHS-III results shows that significant improvement are shown in indicators of behaviors as its outcome. But improvement are slow as per input so to speed up the same we have only one strategy that presently needs improvement is to strengthen the 100 percent of coverage by strengthening clients to participate for availing the services and this can be assure only through Home visits.

Home visits are performing perfectly by knowledge attitude and practice (KAP) and KAP need Emotional Intelligence (E.I.), which has five dimensions:

1. **Self-Awareness**
   a. Emotional self-awareness
   b. Accurate self-assessment and knowing one's strength and limits
   c. Self-confidence

2. **Self-Regulation/Management**
   a. Self control
   b. Trust worthiness
   c. Conscientiousness
   d. Innovation
   e. Adaptability

3. **Self-Motivation**
   a. Achievement drive
   b. Initiative
   c. Optimism

4. **Social awareness (Empathy)**
   a. Understanding of others
   b. Developing others
   c. Service orientation
   d. Empathy
   e. Organization awareness

5. **Social skills**
   a. Communication
   b. Conflict management
   c. Building bond
   d. Collaboration and cooperation
e. Team capacities

I would like to say those home visits are excellent strategy in communication for desired behaviour change. Congratulations to Shubhada for inclusion of such a nice subject, which certainly address the exclusion, and thanks to SE for including the same for discussion.

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**Ravishwar Sinha, Independent Consultant, New Delhi**

Thank you for bringing up this very important issue that has been engaging the attention of people working in this sector.

While fully agreeing with the views expressed by members, Home visits and optimum utilization of the contact with the community for spreading the messages and services are the need.

Some focus should also be placed on the actual implementers also; I would like to bring to the attention the AWW, ASHA and the Helper who are to deliver the services. We all know and recognise that these vital workers shoulder the implementation of all programs in the development sector.

Essentially, they are contractual part time workers drawn from generally from the weaker sections of society. They are compensated for about four hours of their time daily, working from very resource challenged circumstances generally. The duties demanded are more than full time. Over time a little + a little have been added to the duty lists. There is a very old adage that says 'the best way to make anything dysfunctional is to overload it'.

Involvement of the PRIs and the mother groups and different socio/religious groups should also receive attention in their development planning of the programs.

At the community level, they are the important stakeholders and active development activity sharing at all stages should be inbuilt more strongly. It is very encouraging that public private partnerships are being talked about and also implemented.

Home visits by the field staff, be they AWW or ASHA or ANMs should be synchronised. One of the major reasons is the verticality of the program management at the implementation levels. It is interesting to note from the records maintained by them that they go to different people in the same locality for the same range of services.

This should mean that in total there are more recipients than actually reported in the different programs. This should also reflect in the different independent surveys conducted. This not the case. This does throw up questions and concerns and beg for solutions.

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**Neeti Goswami, Lady Hardinge Medical College, New Delhi**

Home visits must be compounded with involvement of local private practitioners in the area and more specifically the para-medical workers involved in providing services at these places.

Experiences gained in promotion of breast-feeding in one of resettlement colonies of East Delhi highlighted the miniscule role private clinics play in encouraging early and exclusive breastfeeding.

Once mother delivers, a healthy baby marks the end of their role and duo are left with relatives to carry out the rest according to their socio cultural practices. This is more prevalent especially in urban slums and resettlement colonies because of majority of migrant population.
**Shubhada Kanani, The M S University of Baroda, Vaddodara** (response 2)

I have read with interest the responses and am very encouraged to note that there is an overall agreement from members regarding the fact that face-to-face communication, which is facilitated through home visits, is the key to real behaviour change; though of course community level BCC events and community support is also required for social sanction for desirable IYCF practices. Some field experiences as given by CARE and others give good insights on what has worked. I agree with Ellen from FAO that the TIPS method is useful for BCC interventions as I have been a trainer for TIPS in the AED-LINKAGES project in India and later in M.S. University and have found it very useful to improve counseling skills.

Some members have raised the issue of AWWs and ANMs being too busy to do home visits effectively. These and many other managerial issues are indeed there in government systems but ways have to be found to overcome them; especially if home visits are expected from these workers. Hence, I request for experiences, which highlight how these challenges have been met; or what can be done regarding time and other support needed by these workers.

Also if I can get more website links/soft copies of reports documenting projects or experiences for my review paper, it will be useful.

**Aashima Garg, Lady Irwin College, New Delhi**

I have been implementing an intervention to improve the complementary feeding practices of infants by strengthening the ICDS service delivery in 2 villages of District Ghaziabad, Uttar Pradesh.

In our intervention, home visits counseling along with village level BCC activities have shown a tremendous improvement in the complementary feeding practices of infants aged 6-12 months. The home visits and IPC is being done by the trained village level community counselors, ASHA workers and AWWs.

The major strength of our home visit counseling, which has shown major improvement in the quality and quantity of complementary foods fed to the infants is "food demonstration at household level" using locally available foods at the time of home visit. This strategy has proved to be a real success in our area and helps in building the confidence in the mothers to feed their infant.

**Gaurav Arya, United Nations Children Fund (UNCEF), New Delhi**

It has been really heartening to read all your observations on home visits. There does not seem to be any doubt that home visits are an excellent "opportunity" towards bringing about the desired behavior changes.

Our experience of working on IMNCI - a key infant and child survival strategy informs us that "Home visits" by trained health and ICDS workers have a significant impact on neonatal and infant health. ANMs, AWWs and ASHAs who are effectively trained and supervised on the IMNCI skills have a visible impact on improving the rate, early initiation and the technique (positioning, frequency, effective suckling etc.) of breast feeding. They have demonstrated a notable impact on early recognition and appropriate referral of neonates and infants suffering from common illnesses like acute respiratory infections, diarrhea etc.

The important consideration here is to clearly determine the roles and responsibilities of various stakeholders in the field; ensure good training on scientifically accepted protocols and guidelines and provide ongoing supportive supervision to the field functionaries. Both the health and ICDS systems are
extensive enough to reach most of the eligible infants and their mothers - the challenge is to channelize their potential maximally.

**Ragini Sahay, United Nations Volunteers (UNV), New Delhi**

I had been reading various responses on the Home Visit (HV) strategy and come to the same conclusion as you draw. I have certain observations in general which may not be directly answering your questions.

Though HV is an effective way of conveying communication, I do not think so that people in rural setting need to know the importance of breast feeding practices. They are well aware of these things however the issue comes on prioritizing these practices. Despite knowing the utility of breast feeding and other nutritional/health practices for infants, women are unable to implement as other domestic chores become relevant in day-to-day life.

In one of the villages where I stayed for two months in Delhi for my research course, observed the lives of Meo women closely, I found that women were completely burdened in running the household economy of the house due to which she had to stay away from infants for long hours. In her absence the infants were sometimes not fed for hours. On returning back in the evening the group of women together sat, relaxed and then breastfed their babies. So the awareness for breast feeding was there in their minds however due to other domestic chores the infants were just neglected. The whole issues is interlinked: the HH economy, role of women, number of children, cooperation from family members, socio-cultural practices etc. One of the points you discussed was that to communicate to all family members, which is very valid. In some rural settings, I have learnt that lactating mothers sometimes interchange or even fed the babies of their kith & kin, which shows that women have enough knowledge as far as matters of breast-feeding, is concerned.

Other important point is that various responses which we read had shown that implementation of HV was successful in various programmes/areas. It is positive, I agree but what when these interventions are not taking place? How long the women sustain all these things in the absence of AWW/ANM/ASHA /or any other. In one of my study on reproductive health in urban slums, it was found that despite providing services at doorsteps to women the facilities were not utilized viz iron tablets were taken by pregnant women by ANM but not consumed. The beliefs for not taking were plenty and rational from their point of view. The success programmes, which I read, are for short duration only.

The BCC as you are suggesting may bring the change in perception of community regarding the breast-feeding but again where does this come in the priority of family. Since feeding of infants will be a solely women's work and require frequent sittings also, women managing the economy of the houses are somehow unable to give that much of time for this job. In this connection, I would also like to add that a large number of educated urban women being well aware of the breast-feeding practices are not practicing it due to their pre occupation with jobs or some other reasons too.

While taking up your study for understanding the determinants of behaviour in "breast feeding practices" I would suggest you to also take the views of health workers on perception of women in BF rather than only from women. I hypothesize from my own experience that ANM/AWW are not only overburdened but are also saturated on conveying such messages to women and family. By including the views of Health Worker you can understand the causes as well strategizing as per the perception of community.

**Vikas Dagur, Urban Health Resource Centre (UHRC), New Delhi**

It's really wonderful to be a part of this discussion. I would like to provide inputs from field experiences of Rajasthan. Home visits are one of the most effective methods of IEC, BCC activities. IMNCI experience of Rajasthan is one of the experiences where Sahayoginis of ICDS department are supposed to do the task.
Local mobilizer from the same community having access to all families, women and children can better understand the rural dynamics, subsequently implement, and disseminate the information on health and nutrition. I would like to mention that here challenge lies in dedication of the workers at the fields level, their understanding of the issue, management of the program and seriousness of supervisors. In the absence of mentioned features, any home visit based program is not achieved properly and unequal achievements are reflected at the end of the day. Lot of other factors pushed by society also resides in this such as role of local leaders/power players and traditional restrictions to accept few innovations related to breast feeding etc.

It is essential to draw strong mechanism so to avoid dropout cases in the field implementation. Involvement of local organizations in the government programs should also be promoted so to gain maximum benefit of the program. On a rough basis, I can say from my own experiences that around 40-45% of the mobilizers are working effectively and conducting home visits and thus providing excellent results whereas as per norms a huge investment is being done on 100% trainings of the worker. Monitoring mechanism needs to be strengthened so that out of 100% trained, at least 80% should give output.

Deeksha Kapur, Indira Gandhi National Open University (IGNOU), New Delhi

We had undertaken a study to review the maternal knowledge and understand the attitudes and determinants of behaviour in “infant and child feeding practices”. Based on the findings developed a nutrition education programme and documented behavior change in IYCF; especially complementary feeding and its impact on iron status. This data is documented in our study published earlier:


A detailed paper on Nutrition knowledge, attitudes and practices of Mothers towards child nutrition is being finalized, which I shall be happy to share with you.

Shubhada Kanani, The M S University of Baroda, Vaddodara (response 3)

Many insights have been obtained from the discussion so far. Reverting to two of my original queries for which I have requested for responses from members, it will be helpful to know your views/experiences/research evidence relating to:

1. Internalizing and 'making routine' the home visit function in ICDS which serves its true purpose of educating and communicating nutrition-health care messages/practices to vulnerable households - especially the monitoring and supervision systems. For example, in a research, we did recently in urban ICDS on home visits; with mutual consultations with ICDS, the home visit register was modified to reflect the time spent in each household; the message imparted, response of the household member and note on follow up required. Short entries were expected- this helped them to get sensitized and also helped the supervision.

However, it is more common to face resistance from government if any change in recording system is suggested or attempted; which is partly justified. However, while recording procedures have to be minimal, they have to be meaningful and useful. How does one work on this challenge, which is true for any service.

2. Second is the issue of time and workload; I liked what Ravishar Sinha has said that 'the best way to make anything dysfunctional is to overload it'. He also talks of verticality of implementation rather than integration at field level, which is an example of poor coordination and time-activity planning.
How does one do effective advocacy for rationalizing the workload of the AWW and bring about more integration of various parallel programs?

**Ashok Singh, Vistaar, Lucknow**

There is no doubt about importance and success of home visits to influence IYCF practices. Few years back in Uttar Pradesh similar efforts were made with the support of UNICEF and four medical colleges, through community based Maternal and Child Health Nutrition project. (Report of the project available at http://www.solutionexchange-un.net.in/food/cr/res12050804.pdf (PDF, Size: 4.6 MB)

The districts were Jhansi, Allahabad, Varanasi and Agra. A total population of 1,331,549 of 907 villages of eight development blocks of these 4 district were covered. The main strategies of the project were convergence among ICDS (AWW) Health (ANM) and PRIs with the help of local volunteers BPMS (Bal Privar Mitras). The baseline and end line compression results shows that BPMS emerged as biggest source of information and knowledge level of the community increased by more than 50% points about IYCF, but when developing strategies for at scale programming that demands intensive human resource for capacity building. There are few following important concerns about it.

- Building such interventions as part of regular programing like ICDS/NRHM
- Non-availability of technical agencies to built capacities of AWWs/ASHAs and ANMs to enhance their counseling skills with quality
- Monitoring and supervision of related issues and poor commitment among service providers (regular and constant home visits by frontline service provider )
- Onsite counseling training to volunteers and front line workers

**Biplab Nandi, Food and Agriculture Organization of the United Nations (FAO), Bangkok, Thailand**

I was following the discussions with great interest. Having worked in India and associated with ICDS some years back my experience suggests that overall activity is entirely dependent on the implementer. If the implementer's intention is good and she/he is convinced of the positive outcomes, there is no need to be worried about the established procedure so long it is in public interest. The supervisor needs to be taken into confidence and the beneficiaries should recognize that there is a potential benefit of doing such an exercise. In any case this will be seen as an experimental episode. I am sure Shubhada Kanani will be successful in this initiative.

**Avanish Kumar, Insight Research Network, New Delhi**

I would like to thank Shubhada Kanani for initiating such an important discussion. I have been associated with various health and HIV communication projects as well as with grassroots issues like Decentralization and Panchayati Raj for many years. I would like bring member’s attention on following issues:

- Most of the government’s projects/program (like ICDS, RCH, TIs of SACS) try to develop BCC strategy for entire state (and some time these strategies are developed at central level) which can not be effective enough to address local issues and cultural aspects. BCC strategy and IEC materials /strategy must be developed locally for effective intervention. Community must be involved in the process of developing a communication strategy. IEC materials must be developed, pre-tested and corrected with appropriate involvement of community.
- Interpersonal communication/ home visits are one of the most effective medium of social/health related communication. Many researches and experiences in India have already proved this fact. However, interpersonal communication can be only a channel among various channel of communication under any BCC. Important component for effective BCC may include; creating enabling environment, communication for addressing social barriers, communication for services,
communication for advocacy. We can learn from successful health communication project, other than ICDS, in this regard. Any health/social communication of BCC must have following component for effective intervention;

- Clarity in the goal and objectives of communication-clear messaging (BBCWST’s EE project) ([http://www.bbc.co.uk/worldservice/trust/mediacoverage/story/2004/04/040426_wstindiadecanherald.shtml](http://www.bbc.co.uk/worldservice/trust/mediacoverage/story/2004/04/040426_wstindiadecanherald.shtml))
- Separate communication strategies for, advocacy, services, and addressing social barriers-communication for social change (for creating enabling environment for change)
- Involvement of community in the process of identifying communication needs, developing BCC, IEC materials and analyzing the impact of communication. (Everything should be in a participatory environment for developing ownership about the ICDS activities, among community members)

- There is a lack of convergence and coordination between various government programs and between government programs and voluntary actions/NGO led programs. An effective advocacy campaign is required for addressing the issue of lack of convergence and parallel programming. Issue of 'workload' is one of the important aspects in this regard. Most of the extension personnel and even schoolteachers get worried and confused due to increasing workload under various parallel programs. Panchayats are also being neglected due to parallel village level education and health community or other committees created under various projects.
- ICDS and other related activities are delegated to local Panchayati Raj Bodies in most of the states. Therefore, Monitoring and supervision of the ICDS system is a prior responsibility of Local Panchayats. One may argue that most of the Panchayati Raj Institutions are not functioning well, according to their assumed responsibility. However, it would not be a correct approach to sideline Panchayats only for this reason. Panchayati Raj bodies are getting maturity with time, however, slowly. Process of developing effective monitoring and supervision system would empower Panchayati Raj system, as well.
- A community based monitoring and supervision system would be effective in this regard. This would be a challenging task requiring people (catalyst) with different mindset (with participatory paradigm) rather than people nurtured in top-down environment.

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**N C De, Child In Need Institute, Kolkata**

I must thank Shubhada Kanani, ‘Solution Exchange’ and all the community members for very relevant and serious discussion on the subject of home visits/effective BCC activities by ICDS /other field level workers in improving IYCF and nutrition.

Over years, our knowledge has increased; but the tragedy is that, the knowledge is not applied/implemented and even if implemented, it has not been sustained. The result is clearly shown in NFHS-3, even 60 years after independence.

I fully agree with the findings, suggestions and the steps to be taken in this regard as brought out in the background paper of this discussion. However, the following are my comments and suggestions to further focus our attention on some critical related issues.

- Regarding home visits and community IEC activities in ICDS in the area of child feeding and nutrition, one most important missing factor is the ‘Skill’.
- The skill can only be acquired/learnt by practice/training. This is possible in a Nutrition Rehabilitation Centre (NRC), which is functional. (Attached to preferably a district hospital). All the trainers (supervisors/CDPOs) must internalize the essence of IYCF, the techniques of BCC and mobilizing
support (participation, accountability and sharing responsibility) of the community (Panchayat) for the desired change.

- NRC is a 'live laboratory'; a demonstration centre for feeding and caring practices, where BCC skill can be taught/learnt. Success stories at NRC can be documented with pictures, 'before' and 'after' intervention. Management of lactation failure should be the integral part of NRC.
- Other important strategies that should be integrated in child feeding and nutrition are hygiene (personal & environmental), sanitation and an all out offensive against any form of 'superstitions'.
- The other long-term but essential strategy should be appropriate change in the curriculum of MBBS, Nursing and Nutrition and NIPCCD courses, stressing on practical training considering the ground reality and skill development.
- Lastly, I have a personal observation on the term ‘Best practices’. Let us call it ‘Rational/Scientific practices’, because there could be a practice better than the best.

Sheila Vir, Public Health Nutrition and Development Centre, New Delhi

With interest, I have followed up the exchange of thoughts and experiences. In this context, a few details on experiences of UP programme are presented.

Community based Maternal and Child Health Nutrition (MCHN) programme was implemented in Uttar Pradesh state by four medical colleges in collaboration with Government of Uttar Pradesh (GoUP), Directorate of FW and Directorate of ICDS and UNICEF. A total of 907 villages of 8 blocks of 4 districts (Agra, Allahabad, Jhansi and Varanasi) with a total population of 1.3 million were covered. The primary focus was on influencing maternal and child health, hygiene, feeding and sanitation practices for reduction of undernutrition. Community Health-Nutrition-Sanitation Mobilisers (referred as Bal Parivar Mitra or BPMs), volunteers were selected and trained specifically for interpersonal communication (IPC) to influence practices at family level along with ICDS and health frontline workers. Regarding IPC, following principles were followed and proved very effective - right advice at right time to the right family. (Sahi Samay Per Sahi Salah).

Towards operationalisation of this principle, the first critical decision was defining the families at the highest risk of undernutrition so that maximum difference can be made by timely advice. Taking into consideration the month wise analysis of undernutrition in UP, it was evident that incidence of malnutrition is highest between 8-11 months and about 30% infants start life with LBW. The families “at highest risk of undernutrition” were defined as those families with a child below 2 years, a child with clinical signs of severe malnutrition, pregnant mothers, lactating mothers or a newly wed women (married for less than two years and not pregnant). In a population of 1000, at one time there were on an average 50-60 such families and counseling these families by 2-3 volunteers and AWW was found to be feasible. It was aimed to reach a family at least twice a month unless required for any specific reasons such as severe malnutrition, illness etc.

Secondly, the messages for IPC were standardised for a specific stage of pregnancy and for a specific age of young child. All persons whether Health, ICDS or BPMs followed the same standardised messages.

A very simple pictorial monitoring card for each family was used for recording number of contacts for counseling and for recording practices observed to be followed. The same pictorial card was used for counseling during IPC sessions (details of pictorial card with other details on MCHN document is posted by Ashok Singh on 28th May [http://www.solutionexchange-un.net.in/food/cr/res/res1205084.pdf]. In fact the monitoring cum counseling card was central to the MCHN programme. It may be noted that the same pictorial format was used for training and was presented in the training manuals, training display or wall charts. The usage of standardised pictorial format helped to reinforce the messages.
The IPC activity was supported by monthly joint meeting of ICDS, health, volunteers and community members every three months to review the progress and check counseling cum monitoring cards. Volunteers were paid fees against the submission of monitoring reports/cards. To ensure community support, month-wise themes were standardised and village level activities such as group discussion with women, wall paintings etc was conducted. It may be noted that no additional printed IEC materials were developed nor the concept of growth monitoring promotion was used. The cost of project per beneficiary was estimated to be about Rs 16 per beneficiary.

Following 4 years of implementation, severe malnutrition was reduced significantly by 43%. The increase in percentage of children in the normal grade was only 12%. Impact on some practices such as initiation of breastfeeding within an hour, colostrum feeding, introduction of complementary feeding at right time, using the appropriate source of water, practice of washing hands after defecation, rest during pregnancy was statistically significant as compared to baseline. While very little impact was observed on influencing prelacteal feed or exclusive breastfeeding, increase in total food intake during pregnancy. It was noted that practices, which are primarily in the control of mothers, were easily influenced as compared to others where proposed practices are closely linked with traditional myths and misconceptions. The latter possibly indicates a need to influence the entire community through other communication methods.

Based on the lessons learnt from the MCHN experience, ICDS programme in UP developed “Home Visit Guidelines” for ICDS workers and evolved a “Mission Poshan” strategy in 2006 which was incorporated in the 11th Five Year plan of GoUP (see www.icdsup.org for details). The following major modifications have been introduced --- "families at highest risk" to include families with infants including newborns and not extended to children under two years. Remaining criteria of selection of risk families not changed. This specific change was considered important since most health and nutrition behavioural practices as well as public health services must reach on priority basis to those families with under ones (including pregnant and lactating mothers) for addressing intergeneration cycle of growth failure as well as for breaking the infection-nutrition cycle. Moreover by including only under one families for home visits, the number of "at risk" families will be reduced to a very small "doable" manageable task of regularly making home visits to 30-35 families twice a month in a ICDS project area with about 1000 population. Daily workload will not be significantly changed for making routine home visits by an ICDS worker with the Support of BPMs or ASHAs.

In addition to daily home visits, Mission Poshan strategy emphasises the Weekly Nutrition and Health Days (WNHDs) using a “fixed day “approach (Weekly Child Nutrition Health Days). Every Saturday of the week is fixed for IEC activities with a specific group i.e. first Saturday for weighing of under threes and discussing with caregivers, second Saturday for meeting with only pregnant mothers, third Saturday for meeting with women groups and fourth Saturday for health and nutrition education of adolescent girls including newly weds. This is in addition to the MCHN days of NRHM, which is organised on RI day and where immunisation contacts are proposed to be used for promotion of IYCF. In Mission Poshan, daily and weekly activities are further supported by Biannual Child Health and Nutrition Months (Bal Swasthya Poshan Mah) which focuses on a number of interventions including block level meeting of ICDS functionaries to develop skills in IYCF counseling including feeding demonstrations. Accordingly, role of supervisors has been modified.

I would like to add that in our efforts to promote IYCF through BCC, let us also address issues of maternal nutrition and health services. For addressing behavioural practices, we must actively involve both ICDS and Health sectors. For increased community involvement and acceptance of proposed behaviour, it is important to bring public health nutrition issues up front---changing the name of “Village Health and Sanitation Committee” to “Village Health, Nutrition, Sanitation Committee” would be a right step for creating the appropriate supportive environment.
Abhishek Mendiratta, Independent Consultant, New Delhi
The State Plan of Action of Nutrition (SPAN) 2002-2010, highlights the role of Departments of Child Development and Health & Family Welfare for reducing undernutrition by addressing immediate causes of undernutrition i.e. child and maternal care and feeding, as well as prevention and treatment of illness in women and children etc.

Lot of opportunity for interpersonal communication during sector and village level meetings like Take Home Ration (THR) Days, (now being referred as Nutrition Health Weekly day) mothers meeting, network of Mahila Samakhya, Self Help Groups etc. Focus group discussions with these groups, especially on Maternal and Child Health issue including routine immunization (RI) is undertaken. These group
members are promoted as "community catalysts" for strengthening the community's ownership for improved health of women and children. Pictorial counselling cards and monthly theme calendars are developed for usage of ANM and AWW. In addition, video films and spots are developed for usage by mobile publicity teams and mass media. The mobile teams of field publicity division is helping in social mobilization of difficult to reach areas, Channels of IEC Bureau of Family Welfare is utilized for promoting awareness by linking with the routine activities.

Ashok K. Singh, Vistaar Project. Lucknow
I agree with Sheila Vir as she has suggested to involve Village Health and nutrition committee to create conducive environment to promote household level counseling. In this context I would like to add that after the Mission Poshan Government of Uttar Pradesh has taken a decision to form MATRA SAMITI "Mother's committee" in each village and these committees has provided with bank account and they are purchasing commodities from local market where hot cooked food scheme is being implemented.

The major responsibilities of these committees to ensure regularity, quality and provide community support to AWC. They can also play a major role in house hold level counselling and support to AWW.

Shubhada Kanani, The M S University of Baroda, Vadodara
The response by Sheila Vir giving the experiences of the UP MCHN Project using the IPC approach and targeting high risk families for regular contacts; as well as impact evaluation data - have given very useful insights into what is possible within ICDS and Health Systems. Especially encouraging was the feasibility (manageable no. of families to be reached) and the low cost, since a frequent criticism against IEC/BCC by program implementers is that IEC is cost and time intensive and not feasible in "real situations".

What is needed to make it work in real situations; just as we are making even relatively more complex interventions work like immunization, HIV/AIDS control - which entail considerable cost, logistics and time. So its really a matter of whether we want to consider IEC important enough to give it the serious attention it deserves

Prakash Kotecha, Academy for Education Development, USAID Micronutrient Project, New Delhi
Child malnutrition is unacceptably high and though acknowledged well by researchers, largely programmers and health care planners and providers have neglected it or are indifferent with a resigned attitude towards taking any action.

At the identification stage, AWW are using Very Different measures to identify malnutrition as compared to researchers; as a result, AWW measuring 5% malnutrition in her registered children when examined by NFHS standards indicate 50% malnutrition. How can we blame her then?

We are overburdening AWW and she has not only been doing her assigned jobs but any thing and everything that calls for a person who has some approach and understanding for health and are available in a village.

She has tremendous potential for home visits and if motivated, encouraged and adequately compensated, she can show results beyond doubts. For this to realistically happen, however she will have to be free from all other jobs in which she has been dragged by anyone and everyone. In other words her potential are under utilized.
Two major obstacles are: One her knowledge in line with her own conviction; many things that she has been advising is not really with her own conviction and therefore the commitment and motivation is missing; the second is her own standing in the society in the area of feeding. She has been accepted to some extent for health care but food and feeding is largely not part of health care for rural community families. So AWW is not motivating families with conviction and commitment and whatever efforts are being done, largely society with its own cultural environment is not easily ready to change.

Home visits by AWW have a reporting format, which if we look at, will convince us that expecting IYCF counseling to the level of malnutrition reduction at universal level across country is a high hope. If supported with motivation and facilitation; however we can hope to see some bright results.

Challenges are high. Path is difficult. But if successful, results are worth any and all efforts.

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*Kshama Metre*, Chinmaya Organization for Rural Development, Dharamshala

Read the practical macro-approach by Dr. Sheila Vir dated 31 May 2008 to combat infant malnutrition. A number of points highlighted by her could be easily adopted to focus our attention on those at highest risk. Being a paediatrician working at the grass-roots level, I find “doing” a demonstration of weaning is an important component in introducing weaning food at the right time for the community to adopt and assimilate the practice. For instance, we held once month demonstration of home made food for infants, in camps for a series of months (3 usually) in front of mothers and other women of the area. This intervention changed patterns of food intake by the infants to healthy quantity, quality and frequency in this short period in a new area.

Mind you, it did not cost much as the material in small quantities came from home of the community. The total quantity was small and easily shared once a month for 10-20 infants under 2 year.

Twenty-three years of such practices in villages of India (600 villages) has shown good results for our work and thought I would share it with you all.

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*Many thanks to all who contributed to this discussion!*

If you have further information to share on this topic, please send it to Solution Exchange for the Food and Nutrition Security Community in India at se-food@solutionexchange-un.net.in or Solution Exchange for the Maternal and Child Health Community in India se-mch@solutionexchange-un.net.in with the subject heading “Re: [se-food][se-mch] DISCUSSION: Home Visits as an IEC Strategy for Nutrition Improvement of Children 6-24 Months. Additional Reply.”

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