



INTERNATIONAL JOURNAL OF RESEARCH IN COMMERCE, IT AND MANAGEMENT

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MALNUTRITION AMONG INFANTS: KEY TRENDS AND STATUS

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ABSTRACT

The health status of infants is the powerful indicator of a nation's health, for; they are the precious human resource of tomorrow. Early childhood constitutes the most crucial period in life when the foundations are laid for the physical and sensual development. India has the largest child population with 157.8 million below the age of six years (2001 census), but is performing very poorly by most indices of child well-being worse than even sub-Saharan African countries. Forty six per cent of our children are nutritionally deprived. The central purpose of this paper is to examine and report on the trends and status of malnutrition in India. An attempt is made to identify and discuss malnutrition and child feeding practices, malnutrition and infant mortality, mother's health and malnutrition, reasons for the dismal performance of the programmes based on secondary data and information and to focus on the target specific programmes to combat the situation.

KEYWORDS

Malnutrition, Infant, Integrated Child Development Service, Health

INTRODUCTION

The health status of infants in any country is the reflection of the socio-economic development of that country. It is determined by various factors such as the level of income, standard of living, housing, sanitation, education, health consciousness, personal hygiene, availability, accessibility and use of public health distribution. The poor health status is the product of inadequate nutrition during the early period of a child's growth. A child during the earliest period of its life is referred as infant in the Oxford Dictionary. From the time of delivery to 3 years of age is infant stage. During this stage the child begins to walk, talk and becomes able to consume solid food. Physical and sensual development begins (Muthuswamy, 2000). Proper nutrition care and development during this period will lead to a healthy and productive life. Therefore, growth monitoring, health check up, identification of risk cases, treatment of minor diseases, deworming, prophylactic measures and referral of serious cases etc., should become the major concern of everybody. Deaths in infancy are indicative of a poor state of maternal and child health services (Bose, 2006).

However, child malnutrition is the central health problem in India and the largest human development gap that the nation faces (Shivakumar, 2006). India is performing poorly by most indices of well-being of children. The results of the recent National Health Family Survey (NFHS), show that not only is the nutrition and health status of children in the country poor, but also they are showing very slow signs of improvement. For instance, 46 percent of children under three are under weight which is an improvement of only one per cent age point compared to National Family Health Survey 2 which was carried out 8 years back. The corresponding level of child malnutrition is much lower in most other countries- 28 per cent in Sub Sahara Africa, and 8 per cent in China (Shivakumar, 2006). Ranked on an index that adjusts child malnutrition level to GDP, India had the second highest level of malnutrition - worse than all of Africa, second only to Bangladesh, and closely followed by Nepal and Pakistan. A high proportion of children are nutritionally challenged even prior to birth, with as many as 25 per cent of all babies born with low birth weight. This high proportion of under nourished children cannot be a matter of pride in a food-surplus economy, where government is regularly mooted public health programmes to combat the situation. Despite, its vibrant programmes like Integrated Child Development Services (ICDS), Reproductive Child Health (RCH), National Rural Health Mission (NRHM) the malnutrition among infants continues unabated.

A peep into the trends and status of malnutrition as reported in the National Family Health Surveys (NFHS) will give an insight into the graveness of the problem. In this paper an attempt is made to analyse the reasons for the dismal performance of these programmes and to focus on the target specific programmes for infants hailing from different socio-economic backgrounds in the country. We find that there is obvious imbalance between the targets set and goal achieved. The article is set out as follows. Section II reviews the relevant literature and section III discusses the trends and status of infant health in the country. Section IV deals with the government sponsored health programmes, while section V attempts to highlight the deficiencies of these public health programmes. The final section summarises study.

REVIEW OF LITERATURE

Studies show that malnourished children are at greater risk of dying than healthy children. Malnutrition has been identified as the biggest single contributor to child mortality in developing countries. A new analytical framework for the study of determinants of child survival in developing countries is proposed by Mosley, Chen (1984). The approach incorporates both social and biological variables and integrates research methods employed by social and medical scientists. The framework is based on the premise that all social and economic determinants of child mortality necessarily operate through a common set of biological mechanisms, or proximate determinants, to exert an impact on mortality.

The Cebu Study Team (1992) estimated child health production functions for diarrhea and febrile respiratory infection, and weight with data from Cebu in Philippines for children up to 2 years old and examined the infants with exclusive breast feeding, breast feeding supplemented with nonnutritive liquids, and breast feeding with nutritive supplements and found that children in any of the breast-fed categories weighed more than those not breast-fed. The results of the study from the National Health and Nutrition Survey (1989) conducted in Brazil strengthen the compelling case for breastfeeding by documenting its significant beneficial effects on reducing illness and improving growth among infants and young children. The clear benefits of breast feeding beyond a child's first six months are perhaps the most important finding of this study (Senaur et al.2000).

Infants born at low birth weight conventionally defined as a birth weight less than 2500 grams experience severe health and developmental difficulties that can impose substantial health costs on society (Almond, 2005). The onset of the malnutrition is usually between the child's six month and second birthday. In India the high prevalence of low birth weight (almost a third of the babies born in India weigh less than 2.5 kg at birth) is due to the young age, poor nutrition of the mother, which is compounded by the stress of repeated pregnancies. Mortality among these low birth weight babies is higher than in normal weight babies. The

main reasons are lack of awareness of the young child's food requirements, poor living conditions, unsafe water, and poor sanitation, resulting in repeated infections (Ghosh, 2006).

Studies from different parts of the country have reported a widespread prevalence of protein calorie malnutrition caused by inadequate food intake and deficiencies in the consumption of micro nutrients, vitamins and minerals. Child malnutrition is intimately related to inappropriate infant and young child feeding practices, and its beginnings set in during the first two years of an infant's life. As more than 90 per cent of the brain actually develops during the first two years of an infant's life, it is at this age the nutritional status of Indian children deteriorates in an irreversible way. If we are serious about malnutrition we have to focus on this age group says Shanti Ghosh (2006). This requires interventions such as home visits and nutritional counseling. The Tenth Five Year Plan (GOI 2002:337) document quoting NFHS-2 notes "As a result of these faulty infant feeding habits, there is steep increase in the prevalence of under nutrition from 16 per cent at less than six months, to 63 per cent in the 12-23 month's age". And this per cent age does not change much after two years. The Infant and Young Child Feeding programme (IYCF) is in need of an immediate reappraisal. To ensure the IYCF's optimal efficacy, it needs to be integrated into health, welfare and outreach programmes presently underway in urban as well as in remote and far-flung remote areas. Arun Gupta (2006) presents specific prescription on IYCF, "exclusive breastfeeding for the first six months (starting within one hour of birth) and continued breast feeding for two years or beyond, along with adequate and appropriate complementary feeding after six months" and calls it "Optimal IYCF", reflects a unique global consensus on issues related to IYCF. According to Jeane Dreze (2006), India has some of the worst indicators of child well-being. About half of all Indian children are undernourished more than half suffer from anemia, and a similar proportion escape full immunization. There is therefore, an urgent need to re-examine what India is doing for the survival, well-being and rights of children under the age of six years.

Ashokan (2006), in his study deal with issues related to health care system and its utilization specifically focusing on the implications for maternal and child health in rural areas. He points out to the wide gaps and inefficiency in health care services in rural areas and suggests for inter-sectoral co-ordination within the rural health network by integrating activities and the primary health centres, non-government organizations and the integrated child development services to meet the health needs of women and children.

Shivakumar (2007), that the onset of malnutrition in the womb itself and reflects an inter-generational transfer of malnutrition from the mother to the child, and he further says one of the reasons for the same is the 'limited reach of public health services and messages'. The cycle of malnutrition begins with undernourished mothers giving birth to low-weight infants. These infants grow into stunted and under weight children. With their physical and mental potential unachievable they tend to reach adulthood as men and women with poor physique and little prowess, either in the mental or physical sphere, doomed to earn a pittance, live a life of deprivation and give birth to yet another under nourished generation. While both men and women go through the life cycle together, it is only the women who the capacity to affect changes at every stage. Not only through her reproductive role, but equally so, through her caring function, does a women affect the nutritional status of her family. As such, policies to effect nutritional improvements must focus on women (Ramachandran Nira, 2005). A similar study conducted by Gangadharan (2006), found that children in the low socio-economic profiles both in urban and slum avoided certain dose of immunization. The problem of underweight children is acute in slum where 33.3 per cent are underweight. The problem of underweight is mainly the result of low calorie intake of the mothers during pregnancy period and low intake of food due to poverty resulting from low per capita income of the family. The malnourished mother gives birth to a low weight baby. Malnourishment after birth lowers the child's resistance to disease. A malnourished child may suffer mental impairment and thus, benefit less from any education that is provided for (Rout, 2007)

Mere reduction in Infant Mortality Rate (IMR) does not necessarily imply an improvement in the health of children who survive. It reflects only survival status of the child in the first year of life. Kerala has low IMR of 13 per 1000 for both rural and urban. The morbidity problem among the children in Kerala is high compared to other Indian states (Registrar General 1998). Though Kerala is considered with the advanced countries of the world in respect of several socio-economic indicators, the health status of mother and children are poor due to inadequate utilization of antenatal and postnatal health services, inadequate services provided by the Government. Health Centres and due to the condition of these hospitals (Gangadharan, 2006).

India is the home of the largest child population in the world. "The development of children is the first priority on the country's development agenda, not because they are the most vulnerable, but because they are our supreme assets and also the future human resources of the country". In these words the Tenth Five Year Plan underlines the fact that the future of India lies in the future of Indian children-across income groups, geographical locations, gender and communities. However, only about one per cent of the total union budget is spent on children under 6 years of age. In a democracy, every child must be regarded as indispensable and the government must be accountable for the deaths of children and mothers. Unfortunately, the issue of children's health seldom finds space in contemporary political discourse in India (Sinha, 2006). There is, therefore, an urgent need to prioritize policies towards children

Henry Mosley and Lincoln Chen in the Bulletin of the World Health Organisation 2003, presents an analytical framework for the study of child survival in developing countries. The purpose of an analytical framework in the study of child survival is to clarify our understanding of the many factors involved in the family's production of healthy children in order to provide a foundation for formulating health policies and strategies. There are numerous situations in which a multi-disciplinary approach to the study of child survival could provide guidance for health policymakers in the developing world. For example, in many developing countries, large differences in infant and child mortality have been observed between various regions, or between mothers with different educational or social characteristics within a given area. In-depth investigation to connect these ecological or socio-economic factors to specific proximate determinants can give policymakers insight into health-related development strategies that could reduce these differentials.

MALNUTRITION: KEY TRENDS AND STATUS

The National Family Health Surveys conducted during 1996-97, 1998-99 and 2005-06 are extremely useful indicators of infant health in the country. The results of these surveys give important insights into the health and nutrition conditions of the 29 states. The National Family Health Surveys have emerged as an important source of reliable information on demographic, health and nutrition for India.

The NFHS3 present data on three commonly used measures of child malnutrition among children under three years of age:

- (1) **Stunting (deficit in height for age):** It is a measure of linear growth retardation. It reflects a failure to receive adequate nutrition over a long period of time or from chronic or recurrent diarrhoea
- (2) **Wasting (deficit in weight for height):** It captures the thinness of children and indicates the prevalence of acute malnutrition. Wasting is typically the result of failure to receive adequate nutrition in the period immediately preceding the survey.
- (3) **Under weight (deficit in weight for age):** weight for age captures elements of both stunting and wasting that is chronic as well as acute under nutrition.

TABLE 1: NUTRITIONAL STATUS (PER CENT)

Particulars	NFHS1(1991-92)	NFHS2(1998-99)	NFHS3(2005-06)
Per cent age of underweight children below 3 years of age	51.5	47	45.9
Children 6-35 months incidence of anaemia	NA	74.2	79.2

Source: NFHS Fact sheet.

In NFHS3, the proportion of underweight children below 3 years of age is 46 per cent which is 1 per cent lower than 47 per cent in NFHS2. The proportion of underweight children in rural areas is significantly higher at 49 per cent compared to 36 percent in urban counter parts. In NFHS3, all the children with haemoglobin level below 11 g/dl are classified as anaemic. Nearly four fifth of the children aged 6- 35 months had some degree of anaemic. The per cent of children under 3 who are anaemic has actually increased from 74.2 per cent to 79.2 per cent which is 5 per cent age points higher compared to NFHS2. The prevalence of anaemia is higher in rural (81 per cent) compared to urban areas (73 per cent). The prevalence of anaemia among children in eight states- Chattisgarh, Madhya Pradesh, Gujarath, Karnataka, Haryana, Punjab, Uttar Pradesh and Bihar were found to be high. There is deterioration of nutritional status of infants during the survey period. Anaemia in India is primarily linked to poor nutrition.

TABLE 2: NUTRITIONAL STATUS OF INDIAN CHILDREN RESIDENCE WISE–NFHS3 (2005-06)

Children under 3 years who are	Urban (%)	Rural (%)	All India (%)
Stunted	31	41	38
Wasted	17	20	19
Underweight	36	49	46

Source: NFHS3 Fact Sheet

According to NFHS2 47 per cent of Indian children under the age of 3 are under weight. In other words, of the estimated 75 million survivors below the age of 3, about 36 million are under weight. This has profound negative consequences on the physical and mental health and development of children, and thus on the Indian society (Gupta, 2006).

TABLE3: NUTRIENT INTAKES OF CHILDREN UNDER SIX

Age(years)	Intake(calorie)	RDA(calories)
1-3	791	1240
3-6	1020	1690

RDA-Recommended Daily Allowance.

Source: National Nutrition Bureau, 2006

Looking at the results of a recent survey by the National Nutrition Monitoring Bureau it is seen that today there is a deficit of over 500 calories in the intake of children 1-3 years and 700 calorie among those 3-6 years old. Therefore, there is clearly gap in access to food (quality and quantity)and health services for children(Dipa Sinha) There are bound to be additional multiple vitamin deficiencies when there is a forty per cent deficit in calories.

The latest UNDP Human Development Report 2005, states India has the highest proportion of under-nourished children in the world, along with Bangladesh, Ethiopia and Nepal.

STATE OF IMMUNISATION

Childhood is an important stage where the child is prone to certain illness and faces a group of communicable diseases like polio, diphtheria whooping cough etc. proper immunization can prevent these among children.

TABLE 4: VACCINATION COVERAGE OF CHILDREN 12-23 MONTHS -2005-06

Vaccine	Urban	Rural	Total
BCG	87	75	78
3 Doses of Polio	83	77	78
3 DPT Injections	69	50	55
Measles	72	54	59
BCG+3polio+3 DPT+ Measles	58	39	44
Received vitamin A dosage in last 6 months	23	20	21

Source: NFHS3 Fact Sheet

MALNUTRITION AND CHILD FEEDING PRACTICES

The link between malnutrition and infant feeding has been well established (Chowdhry, 2006). Recent scientific evidence reveals that malnutrition directly or indirectly contributes to about 50 per cent to 55 per cent of all deaths among children under 5 years annually, and two-third of these deaths are often associated with inappropriate feeding practices occurring during first year of life. Mother's milk is the perfectly balanced food for the infants. It is nature's way of ensuring a sound, healthy start to life and it meets all the nutritional needs of the child safely and adequately. A longer duration of breast feeding is practiced in rural areas than in urban areas.

TABLE 5: MALNUTRITION AND CHILD FEEDING PRACTICE (PER CENT AGE) - 2005-06.

Particulars	Urban (%)	Rural (%)	Total(%)
Children under 3 years of age Breast fed within 1 hour of birth	29	22	23
Children aged 0-5months exclusively breast fed	40	48	46
Children aged 6-9 months received solid, semi solid food and breast milk	62	54	56

Source: NFHS3 Fact Sheet

It is observed that only 23 per cent of children under three years of age were breast-fed within one hour of birth and about 46 per cent were exclusively breast-fed of 0-5 months. 56 per cent of children aged 6-9 months who received solid, semi solid and breast milk. Inadequate complementary feeding, late introduction of complementary food, inadequate frequency quality (including micronutrient content) energy density and quantity-also contribute to young child malnutrition. Under nutrition increases nearly five folds between 0-6 months and 12-23 months of age mainly because of poor Infant and Young Child Feeding practices.

TABLE 6: TREATMENT OF CHILDREN DISEASES UNDER THREE YEARS OF AGE-NFHS3

	Urban (%)	Rural (%)	Total (%)
Children with diarrhoea in the last two weeks who received ORS	33	24	2
Children with diarrhoea in the last weeks taken to a health centre	55	56	58
Children with acute respiratory infection or fever in the last two weeks taken to health centre	72	90	64

Source:NFHS3

MALNUTRITION AND INFANT MORTALITY

Another indicator of health status among infants is the Infant Mortality Rate, which gives the number of deaths of children of age less than one year per one thousand live births in a year. The IMR is widely used as a measure of the health situation of the nation as a whole, and is included among the basic indicators of the state of development of a country. Globally, whopping 10.9 million children under the age of 5 die annually. Four million of them in the first month and 2.42 million (roughly one quarter) of these deaths are in India alone. Worse yet, the survivors are not able to develop to their full potential.The IMR has declined from 129 in 1970 to 114 in 1980, 80 in 1990, 68 in 2000 and 58 in 2004. Though there is decline in IMR over the period of time the IMR among rural children is much higher compared to urban counterparts. According to NFHS the incidence of IMR is found to fall with a rise in the level of education of the mother and with a rise in the standard of living index.The IMR was found to increase when the birth interval is less than 24 months. Children born to younger mothers of age less than 20 years and older mothers aged 40- 49 were found to have a higher IMR than mothers in middle age groups. The IMR was also found to rise when the birth order was more than six. Absence of medical care also led to a higher rate of IMR (Bose, 2006)

TABLE 7: MALNUTRITION AND INFANT MORTALITY

Infant Mortality Rate (per '000 live births)	1980	1990	2000	2001	2002	2003	2004
Rural	124	86	74	72	69	66	64
Urban	65	50	44	42	40	38	40
Combined	114	80	68	66	64	60	58

Source: Office of the Registrar General of India

CHILD MALNUTRITION AND MOTHER'S HEALTH

The linkages of child malnutrition with women's health and well being are very strong. The dietary inadequacy during pregnancy coupled with malnutrition, poor environment, sanitation and inadequate medical service make the child more vulnerable to fall into the vicious cycle of poverty-malnutrition-disease- poverty-ill health (Gupta et al.1998). According to NFHS3 ,close to one third of Indian women suffer from chronic energy deficiency and have a Body Mass Index of less than 18.5 kg/m² (Shivakumar, 2006) It is widely argued that the economic condition is the most important criterion of the nutritional status. The poor health and nutrition status of mothers is reflected in the large incidence of low birth weight babies. Many women remain in ill health and are ill-fed, they are prone give birth to low weight babies and tend not to be aware of how best to feed them (Somini, 2009).

LOW BIRTH WEIGHT (LBW)

Infants born at LBW conventionally defined as a birth weight less than 2500 grams-experience severe health and developmental difficulties that can impose substantial costs on society (Almond, 2005) Studies have also established correlation between LBW and high blood pressure, cerebral palsy, deafness, blindness, asthma and lung diseases, among children as well as with IQ, test scores, behavioral problems, cognitive development. Birth weight is the primary measure of a baby's health and welfare in economic research. Estimates for India reveal that 20-30 per cent babies weigh less than 2500 grams at birth. This suggests that the onset of malnutrition in the womb itself and reflects an intergenerational transfer of malnutrition from the mother to the child. In the United States , reducing the incidence of LBW has been a stated agenda of several social programmes targeting infant health, including Medicaid, and publicly funded nutrition programmes such as the Women, Infant and Children (WIC) programme. The causes of malnutrition are micro-nutrient deficiency, iodine deficiency, zinc deficiency, vitamin A deficiency.

PUBLIC HEALTH PROGRAMMES AND MALNUTRITION**INTEGRATED CHILD DEVELOPMENT SERVICES (ICDS) IN COMBATING MALNUTRITION**

The ICDS refers to a visionary system, providing interventions in nutrition, health and education concerned with the holistic development of the child. Launched on second October 1975, on an experimental basis in 33 blocks over the country, it is now a comprehensive programme and aims to integrate all related Government departments providing the necessary supportive services. Today, it is operational in almost every block, and the country has more than seven lakh Anganwadis. It is regarded as world's largest community based child development programme. The ICDS is aimed at the most vulnerable sections of the population and at disadvantaged areas such as backward rural areas, tribal tracts, and urban slums. Anganwadi centres are the focal points in the delivery of services. Provision of nutrition supplement to tackle nutritional deficiencies in women and children is one of the important components of the programme. This supplement is being served at the AWC's -300 calories + 10-12 grams of protein for children up to 6 years, 500 calories and 20-25 grams of protein to pregnant women, nursing mothers, and adolescent girls through ready to eat , or in the form of cooked hot meal. In addition intervention is provided for micro nutrient deficiencies through Vitamin A and Iron and folic Acid supplements. The growth monitoring and promotion component of the programme is aimed at early identification of malnutrition and its removal. Children below three years are weighed once a month and children between 3-6 years on a quarterly basis. Weight for age cards are maintained for all children, and special care is supposed to be taken for malnourished and at risk cases.

REPRODUCTIVE AND CHILD HEALTH PROGRAMME (RCH)

The RCH programmes that are being implemented by the GOI are expected to provide quality health services. There has been a positive paradigm shift from the method mix target-based activity to client-centred and demand-driven quality services in India. An attempt has been made by the government not only to reorient the programme and change the attitude of service providers at the grass root level, but also strengthen the services at outreach level. The new approach requires decentralization of planning, monitoring and evaluation of services. Under such objectives, district being the basic nucleus of administration, it is necessary to generate district level data on the utilization of the services provided by the government health facilities, other than service statistics (Sekher, 2006)

The Universal Immunisation Programme, Maternal and Child health programmes of eighties integrated under the Child Survival and safe Motherhood Programme of nineties and all these were integrated into RCH programme in the late nineties. The programme envisages up gradation of the level of facilities for providing various interventions and quality of care. The First Referral Units being set up at sub-district level will provide comprehensive emergency obstetric and new born care. Similarly, the RCH related facilities in Primary Health Centers will be substantially upgraded. The responsibility of making the programme a success lies in the hands of health managers, health workers, and the people alike (Srinivasan, Durgaprasad, 2000).

NATIONAL RURAL HEALTH MISSION (NRHM)

The launch of NRHM from 1st April, 2005, has provided the central and state government with a unique opportunity for carrying out necessary reforms in the health sector and to achieve the goals of the National Health Policy and National Population Policy. Government has set up an Anganwadis for every 1000 population in rural India, where one government worker provides immunization health education, growth monitoring and referral services for children and pregnant women to improve the health status of the rural population especially women and children. (Kumar, Sandhyavani, 2008)

The Accredited Social Health Activities (ASHA) under the NRHM is responsible for the promotion of an early initiation of breast feeding within one hour of birth, colostrums feeding and followup support for the first two weeks. She would also be responsible for home-based neonatal care by making home visits during the first month after birth. These activities of ASHA must be incentivised. ASHA has the additional responsibility of mobilizing the community towards local health planning, help in developing village health plan, escort women and children requiring medical treatment provide primary medical care, promote construction of toilets and so on.

REASONS FOR THE FAILURE OF PUBLIC HEALTH PROGRAMMES

The high proportion of malnutrition cannot be a matter of pride in a food-surplus economy. A number of commentators have argued that limited progress has been made by the several schemes implemented to address malnutrition in India and that a wide disparity exists in nutritional status between rural and urban areas. Moreover, there is gender discrimination in the same households as far as malnutrition is concerned. Commenting on the performance of ICDS, the Comptroller and Auditor General of India concluded in its report in 2000 that "it was a poorly integrated body of efforts falling apart. Twenty five years of operation of the scheme has done little in improving the health status of children, nor has it made any appreciable dent in prevailing conditions of child development, child health and maternal care. It is not possible to provide health by building hospitals and expertise of doctors. Our healthcare is in crisis, and is collapsing due to lack of proper planning and prioritization (Sasidharan, 2008). The effective reach of ICDS remains quite limited; there are only six lakh Anganwadis in the country as compared with an estimated 17 lakh required for universal coverage based on existing norms. Supplementary nutrition is currently provided to 3.4 crore children, as opposed to 16 crore children (half of whom are under nourished, in the age group of 0-6 years). The infrastructure base of the AWC's revealed a grim picture in most of the states. The lack of public ownership of the programme also opens the doors to large scale and blatant corruption. The ICDS suffers from high levels of corruption and mismanagement (Working group on children under six, 2006) The linkage between the Ministry of Health and the Family Welfare or the National Institute of Health and family Welfare at the apex and the Primary Health Centres at the village level is weak either due to the

inefficient functioning of the health delivery system or due to the ignorance, illiteracy and poverty of the people or both. Lack of coordination between ANM's and AWW's and ASHA in the implementation of the programme has resulted in poor performance.

Supplementary Nutrition Programme of ICDS does not reach Children under three adequately. The SNP consists of poor, cereal based items that have little nutritional value..

The Primary health care network in most areas is in a sad state. There are big shortages in funds, manpower, equipment, medicines, and in training (Bose,2006). The states have done little to reform the system. The poor suffer the most as they have to go to private practitioners, often quacks, or suffer from untreated ailments.

In the pilot study undertaken on ICDS Devendra Gupta (1998) observes the need for upgradation of physical infrastructural facilities and also focuses on the region specific programmes. The failure of the public health programmes is not only a result of poor implementation, corruption, and low motivation of health workers, but also systematic issues of low budgets, design flaws, low priority and poor focus, inadequate reach, lack of coordination. The key reasons for the dismal state are political, administrative and managerial. But there are a few examples where the initiatives taken up by the Government and NGO's at the regional level have given fruits in the achievement of targets which are listed below:

Mitannin- the health activists mobilized by Adivasi Adhikar Samiti to improve child malnutrition among tribals in Chattisgarh; **MV Foundation of Andhrpradesh** in mobilizing public on child health issue; **Bal Sanjivini Abhiyan launched** in Madhyapradesh to address IMR and malnutrition; **Kano Parbo Na (why can't we do it?)** the positive deviance approach in early childhood care in selected districts of West Bengal; **Aame be Paribo(we can also do it)** an innovative regional specific programme to tackle malnutrition for tribal children in two districts of Orissa; enlightened women in **Tamilnadu**; **Malnutrtion Mission in Maharastra** through community participation to address malnutrition among infants have evoked good response.

CONCLUSION

Malnutrition continues to be a big challenge for India. It is a problem wider than poverty and it should be remembered that malnutrition is not the result of single cause but of multi-faceted problems acting singly or in combination with other complex factors like poverty, purchasing power, health care, ignorance on health education and nutrition. There has been constant effort on the part of the government, to curb malnutrition, through public health programmes. In spite of having health facility practically in every village, programmes have not been marketed successfully. There is an obvious imbalance between the targets set and the goal achieved. Enough research has not taken place to throw light on the existing gap. Our study emphasizes the need for a more detailed investigation into the gap through the successful implementation of social marketing policies and practices. A suitable social marketing approach can bring about significant change in the behaviour of the service users and can bring about significant improvements in the effectiveness and efficiency of the programmes. To improve the prevailing situation, the problem of infant health is to be addressed both at macro level (national and state) and micro (district and village) levels. A paradigm shift in the approach from 'health for people' to 'health by people' has to be adopted for the effective implementation of the various programmes taken up by the government.

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