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BEST PRACTICES IN THE INTEGRATED CHILD DEVELOPMENT SERVICES: *SOME LESSONS FOR ITS RESTRUCTURING AND STRENGTHENING*

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Some innovations within the Integrated Child Development Services (ICDS) have demonstrated significant improvements in the nutritional status of children. This note discusses four such innovations, assessed as 'best practices' by a World Bank study, and the critical components and factors that possibly led to their success in improving nutrition. Each of these innovations had focused on the critical 'window of opportunity'–pregnant, nursing mothers and children under three–to improve nutrition, and ensured improved quality and coverage of key nutrition services, importantly household counseling for behavior change. Since the best practices were implemented through the existing system and functionaries, albeit with additional support, they establish an important fact–if well supported, it is possible for the ICDS to have an impact on nutrition

The ICDS, India's primary response to address malnutrition, is one of the world's largest outreach child development programs. Within the ICDS a large number of innovations, of varying nature and scale, have been piloted. There is wide variation in how the impact of these innovations was assessed, both in terms of the outcomes measured and the evaluation methods used. This note focuses on innovations of integrated intervention packages[i], identified as 'best practices' by a study commissioned by the World Bank in 2007[ii]. Considering that these best practices have demonstrated nutritional impact within the ICDS context, they offer valuable lessons for the national ICDS program to more effectively reduce child malnutrition, especially in the context of its planned restructuring and strengthening.

How were the best practices selected?

This note discusses four innovations that used an integrated package of direct nutrition interventions. The World Bank study, through a literature review (including internet review) identified innovations in design, management, and implementation of the ICDS from across states and settings (urban/rural/tribal, private/NGO/public etc.) and used two criteria to assess best practices: effectiveness as determined by its impact on nutritional status as compared to a counterfactual, and the potential for replication as determined by the scale of implementation or demonstrated expansion, in either case covering a population of at least one million.

The best practices: what did they do differently and what was their impact?

The four best practices identified by the study, *Anchal Se Angan Tak* (ASAT), *Dular*, Positive Deviance (PD) and the Reproductive and Child Health Nutrition program (RACHNA) are discussed here.

Aanchal Se Aangan Tak (ASAT), implemented in Rajasthan by the Department of Women and Child Development with assistance from UNICEF, reached an estimated population of 6.6 million. ASAT focused on children under three years of age, adolescent girls, and pregnant and lactating women. It emphasized household counseling, and strengthened monthly, fixed day-fixed site events to improve immunization, vitamin A and IFA supplementation per protocols, and weighing of pregnant women and children. To do so, ASAT provided additional support to the ICDS in several ways. At the village level, an additional worker besides the Anganwadi worker (AWW), the Sahyogini, was recruited and a cadre of local volunteers, namely the Gram Sampark Samooh (GSS) was developed. All workers and volunteers were trained and provided tools. Over time, ASAT developed supportive structures at various levels, such as a Block Support team in some blocks, District Mobile Monitoring Training teams, and District Support teams.

Dular, implemented in Bihar and Jharkhand by the Department of Women and Child Development with assistance from UNICEF, reached about eight million people from across six districts of Bihar and four from Jharkhand. The *Dular* strategy focused on children under three years of age, adolescent girls, and pregnant and lactating women. At the village level, *Dular* introduced a new cadre of volunteers, the Local Resource Persons (LRPs) to assist the AWW, and built capacities of all functionaries and LRPs, enhanced household counseling,

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regular weighing of children, and promoted community engagement in the program. It established support structures such as District Mobile Monitoring Training Teams, District Support Teams to provide supportive supervision, improve coordination between sectors, and support implementation and review; and at the State level, established a task force to support communication and training.

Positive Deviance (PD) is a model that has been tried in several states and by several agencies. The identified best practice in the study was implemented in West Bengal by the Department of Women and Child Development with assistance from UNICEF and covered a population of about 2.4 million. The innovation targeted children under three and their mothers. All steps necessary for implementing the PD model, such as preparatory planning, training, sensitization and community mobilization were undertaken, and special tools for growth monitoring, community mapping and such were developed. Special nutrition counseling and child care sessions for households with malnourished children were introduced and a Management Information System specific to the PD model was set up.

RACHNA, implemented in 78 districts across nine states[iii] by the respective departments of Women and Child Development with assistance from CARE, covered a population of over 102 million. RACHNA focused efforts on pregnant and lactating women and children under three. It developed a cadre of community volunteers at the village level, the Change Agents to focus on 20-25 households and involved *Panchayat* and NGO representatives in the program. It built capacity of functionaries, volunteers, NGOs and *Panchayat* representatives, introduced the monthly Nutrition and Health days (NHDs) for converging ICDS and Health services, and facilitated geographical convergence between the two sectors. RACHNA emphasized and provided tools for household counselling, supportive supervision, and community-based monitoring. Further, it introduced periodic rapid household surveys in selected districts to track critical care and feeding behaviours. It established block and district level teams comprising ICDS, Health, NGOs and Panachayat representatives to provide ongoing implementation support.

Impact on nutritional status: Each of these best practices demonstrated a significant impact on nutritional status of children when compared to a control. Box 1 shows the specific impact of each best practice.

Outcomes achieved: The innovations also demonstrated a statistically significant improvement in key outcomes associated with nutrition. For example, behaviours such as Infant and Young Child Feeding (IYCF) practices improved significantly when compared to control areas. However, despite the significant improvement in most areas, IYCF rates were still low. ASAT and *Dular* significantly improved outcomes, such as colostrum feeding (and reduced pre-lacteal feeds), IFA coverage, hand washing with soap and reduced diarrhoea episodes. PD achieved significantly higher rates of early initiation of breastfeeding, exclusive breastfeeding at 4-5 months, introduction of complementary foods at 6 months of age, complete immunization and vitamin A supplementation as compared to non-PD areas. RACHNA achieved higher rates of antenatal service utilization, supplementary food receipt by pregnant and post partum women, early initiation of breastfeeding (and reduced rates of pre-lacteal feeds), introduction of complementary foods at 6-8 months, as well as vitamin A and IFA supplementation in comparison to the control.

Box 1: Impact of the best practices on nutritional status of children

Anchal Se Angan Tak (ASAT)

Significantly reduced stunting (stunting prevalence of 35 percent in ASAT groups vs. 45 percent stunting in non ASAT group).

Dular

Significantly reduced underweight and stunting (56 percent underweight and 62 percent stunting in *Dular* areas vs. 65 percent underweight and 72 percent stunting in non-*Dular* areas).

Positive Deviance

- Significantly reduced stunting in under threes (26.5 percent stunting amongst under threes in PD areas vs. 32 percent in control areas);
- Significantly reduced underweight and stunting among children 12 17 months old (underweight: 46 percent in PD areas vs. 63 percent in control region; stunting: 25 percent in PD vs. 37 percent in control regions).

RACHNA

- Significant protective effect on wasting in Operations Research conducted in UP (wasting increased from 5 percent to 9 percent in intervention area vs. from 7 percent to 14 percent in control area);
- Significant reduction in anemia (decreased from 89 percent to 87 percent in intervention areas vs. increase from 83 percent to 87 percent in control areas);
- Program wide 8 percentage point reduction in underweight (61 percent to 53 percent reported in pre-post without control evaluation).

What were the critical components that possibly led to success?

Since all best practices were implemented and evaluated as a package of interventions that enhanced several aspects of the ICDS, it is not possible to assess the individual components that led to impact. However, there are several components common to the four best practices that are highlighted as contributors to success.

Focus on the 'window of opportunity': Each of the best practices, while operating within the ICDS and working through its systems, prioritized pregnant and nursing mothers, and children under the age of three. They achieved a higher coverage for these groups which is confirmed by the improved rates for utilization of nutrition-related services.

Household counseling: Continuous and in-depth counseling of mothers during pregnancy and through the first two years of the child's life by trained volunteers and the AWW and/or ANM was found critical to changing behaviors. ASAT used the Sahyogini, while *Dular* used LRPs to visit household for counseling. The PD model had intensive counseling sessions with mothers, and RACHNA used the trained change agents and focused on training AWWs. In each case tools and aids were provided to workers/volunteers for counseling.

Capacity building of functionaries and supportive supervision: The best practices invested in building capacity of workers and volunteers to enhance their skills and competencies. While different approaches or mix of approaches to build capacity were followed, such as systematic training sessions, joint health and ICDS training, use of mobile training teams–each of the programs ensured on-going support for skills development and supportive supervision to supplement the usual ICDS training.

Improved monitoring systems and tools: Enhanced systems to monitor process and progress were developed and implemented in all the cases. For example, RACHNA introduced annual household level rapid assessments (RAPs) and mini-RAPs to track key processes and outcomes, *Dular* developed a monitoring system and a *Dular* cell at the state level, while PD had a specially designed monitoring system for its model. Development of community-based monitoring tools, such as community growth charts, several pictorial tools and cards for mothers to monitor their own behaviors, was done in each case. These enhanced systems and capacities for monitoring critical processes and outcomes, served to strengthen ICDS appreciably.

Enhanced planning at all levels: Systematic planning at all levels was a feature of all best practices. Appropriate tools to facilitate planning, especially micro-plans to help field functionaries prioritize key actions were developed. Joint planning or plans that brought about systematic convergence with other allied departments, particularly health, was another critical feature of these best practices.

Enhanced community participation: Mobilization and involvement of women's groups, local volunteers as change agents, PRI members and such, strengthened community participation in ICDS. Community participation is an essential, though generally weak, link of the ICDS program. As mentioned earlier, community volunteers were an integral part of the four best practices.

Supportive structures at all levels–state, district, block, sector and village: Each of the innovations established additional supportive structures at all levels (state, district and below) to enhance effectiveness and efficiency, support implementation, monitor progress and build capacity. These included, for example, task force at the state level, district teams, block support teams, state project management units and such. Besides the village level support structures noted earlier (see household counseling above), block and district level structures to foster convergence, support and monitor implementation, and solve problems were critical. For example, *Dular* established district and block levels teams to support and monitor implementation; RACHNA placed a district team of four officials to support and guide NGOs and ICDS/RCH staff on technical and operational aspects. The state level task force/advisory body set up in several cases, were crucial to build commitment, facilitate coordination and convergence, and support expansion of the model. In each case, technical support from the state and national level CARE and UNICEF teams was also available.

Convergence with health–joint planning, training and use of fixed day strategy: Convergence with health was achieved through joint planning, training, use of tools and consistent messaging. These synergies were crucial in effective delivery of services such as immunization, vitamin A supplementation, and referrals. Two approaches that have particularly proven effective in this regard and have effectively improved service delivery and coverage rates for specific health and nutrition activities are:

- Regular monthly fixed day-fixed site health and nutrition days where health and nutrition services are delivered with the engagement of communities;
- Twice yearly events to proactively deliver services such as vitamin A supplementation, catch-up for immunization and weighing of children.

Both these strategies have since been expanded considerably, and are now being implemented by the ICDS and the National Rural Health Mission (NRHM) across almost all states. There is, however, a huge variability in the quality of their implementation at scale.

What key learnings are relevant for ICDS restructuring and strengthening?

As each of these best practices was implemented within the ICDS and through the existing system and functionaries, albeit with additional support, they establish an important fact–if well supported, it is possible for the system to have an impact on nutrition. With the ongoing efforts to restructure and strengthen the ICDS, the experiences from the best practices are highly relevant. Some of the key lessons are:

1. Adequate support structures and mechanisms for

enhanced service delivery at all levels of the ICDS need to be established. At the village level, well-trained additional workers including volunteers to support the AWW and the Helper are key. At the block, district and state levels, supportive structures to guide, support, supervise and monitor implementation are critical. These support structures call for both technical and management leadership and capacity for effective functioning.

2. Systems for planning, training, supervision, monitoring and overall management require reform and strengthening. Systems should focus on and measure 'outcomes', promote flexibility and be responsive to local needs. In addition, operational means of 'convergence' with other departments, especially health, need to be institutionalized at all levels. Systems strengthening to ensure quality in service delivery and active engagement of communities in the program is also key to enhancing the effectiveness of the ICDS.

3. Focus on pregnant, nursing women and children under three years of age is essential for nutritional impact. ICDS must make this paradigm shift and its systems must facilitate reaching every household in this critical 'window of opportunity' with a package of essential nutrition interventions. Achieving sufficient scale and high coverage rates for these priority groups is critical for impact.

4. The package of key direct interventions includes behaviour change communication for recommended IYCF practices, (early initiation and exclusive breastfeeding for six months, timely and age-appropriate complementary feeding with continued breastfeeding for two years or beyond, appropriate feeding during illness); improved feeding and care during pregnancy and lactation, hygienic practices; micronutrient supplementation (twice annual vitamin A for children, IFA for pregnant/nursing mothers and children, and zinc during and after diarrhea); management of infections, including immunizations; and therapeutic feeding and care of children with severe acute malnutrition. Critical to behavior change is household counseling and support of trained and skilled personnel.

5. Of the 135 innovations within the ICDS, the World Bank study found only a few had been evaluated rigorously, i.e., against a counterfactual. A culture of innovations and rigorous evaluation must be built into the restructured ICDS to continually test new approaches, evaluate their impact and assimilate learnings to strengthen the program.

In conclusion, improvements in nutrition, while modest, were possible through a supported and strengthened system. Most of the critical change in the functioning of the system was catalyzed at the local levels (district and below), and within the existing framework of institutional organization, incentive structures, motivation levels and governance. It is, therefore, not inconceivable to expect a larger impact if the entire system, right from the central to the village level is strengthened and well-supported, and some of the levers critical to improved organization, resources–both human and financial, capacity, incentives, governance and leadership are better aligned to achievement of results.

[i]The innovations reviewed in the study fell in to two broad categories: i) those that were delivered as an integrated package of interventions to improve immunization, health check-ups, referral services, growth monitoring and nutrition and health education; and ii) those that aimed to improve the impact of the Supplemental Feeding in the ICDS.

[ii]Review of 'Best Practices' in ICDS, May 2007. The study was conducted for the World Bank by the Micronutrient Initiative.

[iii]The nine states were Andhra Pradesh, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh and West Bengal.

REFERENCES:

[1] Micronutrient Initiative. Review of 'best practices' in ICDS: a study conducted for the World Bank. The World Bank; 2007 May

For further information on '**Best practices in the integrated child development services: *some lessons for its restructuring and strengthening***' contact Ashi Kohli Kathuria at akathuria1@worldbank.org

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