सत्यमेव जयते

नई दिशा की ओर
Towards a new dawn

Potential Good Practices

The ICDS Experience

Government of India
MINISTRY OF WOMEN AND CHILD DEVELOPMENT
Child Development Bureau
And
NATIONAL INSTITUTE OF PUBLIC COOPERATION
AND CHILD DEVELOPMENT

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This document is an endeavour of the Ministry of Women and Child Development, Government of India to highlight the effective initiatives taken by the states and union territories for implementation of ICDS

This document is a compilation of information gathered both from secondary sources and those shared by States and Union Territories

कृष्णा तीरथ
Krishna Tirath

नए समाज की ओर
Towards a new dawn

सत्यमेव जयते

राज्य मंत्री (स्वतंत्र प्रभार)
महिला एवं बाल विकास मंत्रालय
भारत सरकार
नई दिल्ली–110001

MINISTER OF STATE (INDEPENDENT CHARGE)
MINISTRY OF WOMEN & CHILD DEVELOPMENT
GOVERNMENT OF INDIA
NEW DELHI-110001

MESSAGE

I am pleased to share the document on "***Potential Good Practices – the ICDS Experience***", a compilation of successful pilots, integrates projects which have been pioneered through ICDS showcasing practices that played a significant role in improving delivery of services under ICDS which currently operates through more than 13.18 lakh Anganwadi centres, each manned by an anganwadi worker who provides an integrated package of health, nutrition and early childhood education services targeted to children aged below six years; pregnant and nursing mothers; and adolescents girls.

It is widely recognised that ICDS is a well designed programme having a wide outreach, bottlenecks in service delivery hamper harnessing full potential of the programme. Considering the fact that better service delivery is a pre-requisite for inclusive growth, variations in implementation of specific components of ICDS, as a response to local needs, are being adopted in States and some of the initiatives have been found to be more effective than the prescribed guidelines.

The document Potential Good Practises clearly demonstrates the fact that participants of people and community ownership of the programme is essential for success of any programme. Also an important point which stems out is that best practices in this document are not only from states that fare well on development indicators but also from states that are lagging behind highlighting the fact that all states irrespective of their positions vis-a-vis human development indices, are striving to implement programmes innovatively in order to make a dent on improving maternal and child health and nutrition.

The Ministry of Women and Child Development, Government of India has also reviewed the practices articulated by the States and agencies during different interactive sessions with a

purpose to look at best context-specific options for up scaling and replication in other States, where conditions are appropriate. In this direction, an attempt has been made through this document, to identify and illustratively describe activity-linked processes in some of the potentially good practices and processes.

I appreciate the efforts put in by officials of MWCD and NIPCCD in bringing out the document and hope that this document by the Ministry of Women and Child Development will be a useful resource for administrators, programme manages, implementers, ICDS officials and policy makers in providing direction for innovations that impact the well-being of our children and women.

(Krishna Tirath)

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GOVERNMENT OF INDIA
MINISTRY OF WOMEN & CHILD DEVELOPMENT
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Website : http://www.wcd.nic.in

FOREWORD

ICDS programme over the years has been explored for innovations, pilots and various models. Most of these initiatives are unique in nature and have helped ICDS achieve its objectives of holistic development of the child and contribute significantly to reduction in mortality, morbidity and malnutrition. The integrated but flexible nature of the programme coupled with inherent convergence with health and other sectors make it a suitable platform of convergence and the first outpost for human developments efforts at the habitation level.

I appreciate the efforts of the States Union Territories and Development Partners who have recognised the importance of the ICDS programme and are continuously striving to improve its management, delivery mechanisms to address gaps in its implementation. These numerous endeavours have not been documented and disseminated sufficiently.

This document on "**Potential Good Practices – The ICDS Experience**" has been assimilated with the goal of documenting some of the good practices, analyzing them in detail and providing motivation for replication. It tries to capture a range of pilots and interventions all of which may not be existent today, but have generated ample lessons, demonstrated potential or achieved verifiable results.

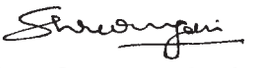
I understand while each practice is unique and combinations of it can be applied in child development programmes, there is no single or combined best ways to improve programme approach in a country with large diversity. Each region needs to define and implement the most appropriate strategy based on specific needs of community.

Documentation, more so of processes and good practices needs to be internalized and made systemic in ICDS, this handbook is one such step and I hope many more would come.

I would request States and Union Territories to take initiative and create repositories of good practices, upload on website and use them for cross learning within and with larger community of child development.

Several persons have provided technical support in reviewing, selection and documentation of different good practices. I extend my earnest thanks to all those who gave contributed in making this publication a reality.

I sincerely hope that this document would serve as an info-pack and compendium of potential good practices and will benefit programme managers, implementers, ICDS officials and policy makers in providing direction for scaling up good practices and innovate further.



(Dr. Shreeranjan)

ACKNOWLEDGEMENTS

Dr. Dinesh Paul
MBBS, MD, MNAMS
Director, NIPCCD

The Report, *Potential Good Practices - the ICDS Experience* is a compilation of best practices, successful pilot projects and integrated projects on child care and growth & development in different states across India being pioneered under Integrated Child Development Services (ICDS) scheme. The document is a joint effort of the Ministry of Women and Child Development and the National Institute of Public Cooperation and Child Development (NIPCCD). It is believed that the successes achieved in different regions shall be quite valuable for others to be considered for replication in their settings.

I extend my gratitude and sincere thanks to the members of the Committee constituted by Ministry of Women and Child Development (MWCD), under the Chairmanship of Director NIPCCD along with Dr. Arun Gupta of Breastfeeding Promotion Network of India (BPNI) and Ms.Deepika Srivastava in Planning Commission fortheir inputs and valuable suggestions to improvise the report .

I extend my gratitude to Women and Child Development Departments of all the State Governments for providing valuable information on innovative practices being experimented in their respective states.

I appreciate the efforts put in by Ms Farheen Khurshid, Consultant (MWCD) and Dr. Neelam Bhatia, Dr.D.D.Pandey & Dr. Rita Patnaik from NIPCCD who have put immense efforts in bringing out the document.

Dinesh Paul

(Dinesh Paul)

Contents

List of Abbreviations

Addl. CMO	Additional Chief Medical Officer
AIR	All India Radio
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Tract Infection
ASAT	Anchal Se AnganTak
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWH	Anganwadi Helper
AWW	Anganwadi Worker
BCC	Behaviour Change Communication
BLRM	Block Level Resource Mapping
BRT	Block Resource Team
BPL	Below Poverty Line
BSPM	Bal Swasthya Poshan Mah
BSPKs	Bal Shikshan Prasar Karyakartas
CB	Capacity Building
CBMS	Community-Based Monitoring System
CBO	Community-Based Organisation
CDPO	Child Development Project Officer
CHC	Community Health Centre
CHW	Community Health Worker
CIG	Common Interest Group
CNC	Community Nutrition Centre
CNS	Community Nutrition Supervisor

CNW	Community Nutrition Worker
CPCRI	Central Plantation Crops Research Institute (CPCRI)
CLR	Centre for Learning Resource
CSB	Corn Soya Blend
DIET	District Institute of Education and Training
DMMTT	District Mobile Monitoring Training Team
DPMU	District Programme Management Unit
DST	District Support Team
DWCD	Department of Women and Child Development
ECD	Early Childhood Centre
ECE	Early Childhood Education
EGS	Employment Guarantee Scheme
FGD	Focus Group Discussion
FNHD	Fixed Nutrition and Health Days
GIS	Geographic Information Systems
GMP	Growth Monitoring and Promotion
GMIS	Geographical Management Information System
GSS	Gram Sampark Samooh
HMIS	Health Management Information System
HMRI	Health Management and Research Institute
IAY	Indira Awaas Yojana
ICDS	Integrated Child Development Services Scheme
ICMR	Indian Council of Medical Research
IEC	Information Education Communication
IECD	Integrated Early Child Development
IFA	Iron-Folic Acid

INHP	Integrated Nutrition and Health Project
IPC	Interpersonal Communication
LHV	Lady Health Visitor
LRG	Local Resource Group
LRP	Local Resource Person
MCH	Mother and Child Health
MCPC	Mother and Child Protection Card
MCHN	Mother and Child Health and Nutrition
MDM	Mid-Day Meal
MGNREGA	The Mahatma Gandhi National Rural Employment Guarantee Act
MHU	Mobile Health Units
MIS	Management Information System
MO	Medical Officer
MOHFW	Ministry of Health and Family Welfare
MPR	Monthly Progress Report
MSG	Mothers Support Group
NCCS	Nutrition Counselling and Care Session
NCERT	National Council of Educational Research and Training
NCHS	National Centre for Health Statistics
NDCC	Nutrition-cum-Day Care Centre
NGO	Non-Governmental Organisation
NHD	Nutrition and Health Day
NHE	Nutrition and Health Education
NIPCCD	National Institute of Public Cooperation and Child Development
NHED	Nutrition and Health Education Day
NMP	Noon Meal Programme

NRC	Nutrition Rehabilitation Centre
NRHM	National Rural Health Mission
NRHS	National Rural Health System
NSS	Nutrition Surveillance System
NTT	Nursery Teachers Training
ORS	Oral Rehydration Solution
P&L	Pregnant & Lactating
PD	Positive Deviance
PDI	Positive Deviant Inquiry
PDS	Public Distribution System
PHC	Primary Health Centre
PNC	Post Natal Care
PPP	Public Private Partnership
PRI	Panchayati Raj Institution
RCH	Reproductive and Child Health
RVO	Refined Vegetable Oil
SIERT	State Institute of Educational Research and Training
SHG	Self-Help Group
SOE	Statement of Expenditure
SNP	Supplementary Nutrition Programme
SPMU	State Programme Management Unit
SSA	Sarva Shiksha Abhiyan
TB	Tuberculosis
THR	Take Home Ration
TINP	Tamil Nadu Integrated Nutrition Project
UNICEF	United Nations International Children's Emergency Fund

UT	Union Territory
VCD	Village Contact Drive
V-CDC	Village Community Development Centre
VHND	Village Health and Nutrition Day
VHSNC	Village Health Sanitation and Nutrition Committee
VO	Village Organisation
WAZ	Weight for Age Z –Score
WHO	World Health Organisation
WHZ	Weight for Height Z –Score
WWG	Women Working Groups

List of Tables

Introduction

Introduction

The Integrated Child Development Services (ICDS) provides an integrated approach for converging six basic services for improved childcare, early stimulation and learning, health and nutrition, education, primarily targeting young children (0-6 years), expectant and nursing mothers.

The Anganwadi Centre is the operational unit of ICDS at habitation level which is also used for other related schemes like SABLA, IGMSY and RCH which benefit pregnant women, children and adolescent girls. ICDS has been the seat of several good practices over the past two decades and the States and Union Territories continue to add newer endeavours each year.

The Ministry of Women and Child Development acknowledges the efforts of the States, Union Territories and the collaborative effort of Development Partners in this connection. The Ministry has put together a compilation of successful pilot projects, integrated projects which have been pioneered through ICDS. A desk review of website publications, evaluation reports, process documentation, briefing papers, Annual Programme Implementation Plans (APIP) and evidence reviews have helped to shortlist a set of good practices in ICDS. The Ministry has also considered the practices articulated by the States during different interactive sessions.

The selection of these practices was based on certain criteria a) effective service delivery b) successful bridging of systemic gaps and quality improvement c) community participation and mobilisation d) convergence e) sustainability and scalability f) impact etc.

The document has been organised in five distinct sections.

System Quality Improvement, which specifically mentions the endeavours which have brought about a major 'shift' in ICDS**,** and has led to systemic improvement and implementation with quality.

Strengthening Delivery of the Services under ICDS: Emphasises on State-specific mechanisms of service delivery which have been implemented for some time and are found to be effective. It also reflects on the importance of ICDS in delivery of health services like immunisation, micronutrient supplementation health check-up referral, and management of undernourished children and captures several convergent models including innovations in village health and nutrition days.

Programme Management focuses on practices for bridging pertinent systemic gaps and issues of ICDS such as lack of community engagement and mobilisation, weak monitoring systems, low capacity etc. Some key areas discussed in the section include involvement of

SHGs, mothers' committee in provisioning of supplementary nutrition, monitoring of Anganwadi centre, use of monitoring tools, tracking of malnourished children and mobilisation for improved utilisation of services. It also covers important components like Management Information System (MIS), web-enabled systems, GIS mapping and name-based tracking of malnourished children, social audits and efforts for improving financial management in ICDS.

Snap Shot lists some outstanding innovations and good practices by States, which serves as learning for others.

Assisted Integrated Approaches: This section acknowledges the support and technical assistance of Development Partners like UNICEF, CARE, World Bank in piloting innovative community-based approaches through ICDS. Most of these approaches were piloted during the year 2000-08. These may not be existent today but they have provided ICDS with improved outcomes in child development, malnutrition reduction, and decrease in morbidity. All these integrated projects are supported by evidence reviews and evaluations. The compilation tends to do a comparative study of both the processes and impact of these packages.

Documentation of several good practices and innovations are confined to the state of origin and are often not available for wider learning.

This compilation is a humble attempt of the Ministry to identify and illustratively describe activity-linked processes in some of the potential good practices in ICDS. It aims to facilitate cross learning and exchange of ideas and views for better understanding and replication of these practices.

SECTION - A

Systems Quality Improvement

1 Systems Quality Improvement

The commitments for ICDS in the Eleventh Five-Year Plan emphasised on systems quality improvement, system strengthening, greater convergence with NRHM and universalisation with quality.

The Ministry of Women and Child Development took forward the Plan commitments and several initiatives were taken up to bring about systemic improvement and convergence with other sectors specially NRHM.

In this connection two noteworthy examples can be cited namely the adoption of New WHO Child Growth Standards and subsequent introduction of the joint Mother and Child Protection Card.

Another initiative of the Ministry in this direction is to improve the ICDS reporting mechanism. The Management Information System (MIS) for ICDS has also been revised for better assessment, analysis and planning.

These initiatives of the Ministry bring out the clear intent on child-centric approach which takes into consideration the health, nutrition, cognitive, emotional and social needs of the child.

It is envisaged that these efforts of systems quality improvement will help to focus on every child and strengthen linkages with Health in order to achieve the objective of reducing mortality, morbidity and malnutrition in women and children.

The section elaborates on these major “shifts” in ICDS, for systems quality improvement which was initiated in the Eleventh plan period and the results will be visible during the Twelfth plan period.

1.1 Adoption of New WHO Child Growth Standards

In ICDS growth monitoring is an important activity and earlier Harvard Standards were used specifying Normal, Grade I/II/ III and IV (Mild, moderate, severe and very severe underweight). These standards were based on growth patterns of formula-fed children. It was felt that a standard which recognises the breastfed infant as the normative model would be the preferred choice in India.

The New WHO Child Growth Standards were adopted in India by Ministry of Women and Child Development and Ministry of Health & Family Welfare. The new standards are based

on growth patterns of healthy breastfed children and provide different and new classifications with options for analysing, updating and harmonising the use of child growth standards. It demonstrates that children born in different regions of the world, when given an optimum start in life, have the potential to grow and develop within the same range of height and weight for age.

A joint policy directive was issued on 6 August 2008, for use of the standards across the country for monitoring and promotion of young child growth and development within the Integrated Child Development Services and National Rural Health Mission.

As per the new directive in all Anganwadi centres, nutritional status of the child is being assessed against Weight- for -Age using individual growth charts separate for girls and boys. The new growth standards will enable parents, communities and child care providers can assess early faltering of growth and take timely corrective actions.

As many as 6,666 projects and 12,71,889 AWCs are implementing the new WHO standards across the country. Intensive training and orientation on the New WHO Child Growth Standards is continually being imparted through NIPCCD to functionaries of ICDS. A manual of the New WHO Child Growth Standards has also been developed by NIPCCD.

New growth standards in use at ANC

1.2 Adoption of Joint Mother and Child Protection Card

Subsequent to the introduction of the New WHO Child Growth Standards, Mother and Child Protection Card was introduced jointly by Ministry of Women and Child Development and Ministry of Health & Family Welfare in March 2010 to be used nationwide in both ICDS and NRHM.

The Mother and Child Protection Card (MCPC) provides information on comprehensive package of services addressing the needs of pregnant women and children up to 3 years of age. It is a simple tool to track maternal and child health and ensuring optimal delivery of services to both.

The card integrates health, nutrition and development along a life cycle continuum, pictorial representations, support easy understanding of positive care practices and developmental milestones. Sections on antenatal and postnatal care capture critical maternal health parameters. According to the New WHO Child Growth Standards separate individual growth charts for boys and girls have been incorporated in the card for assessing the nutritional status of children.

The card has the potential to empower families and communities, encourage demand of services by raising awareness on child care practices and monitor the individual status of maternal, child health, growth and development. It is perceived as best practice and means of functional convergence between ICDS and NRHM.

The card helps ANMs, AWWs and ASHAs for tracking of each child right from conception till age three; it is also used as an entitlement card for several schemes such as Indira Gandhi Matritva Sahyog Yojana, Home-based new-born care and Janani Suraksha Yojana.

The card also portrays the utilisation of services from ICDS and NHRM and its use is linked to critical contact points such as VHND, home visit, post-partum new born care and birth registration. It also serves as a tool for detecting developmental delays and provides care for development. A strong means of verification, the card is well aligned to the revised ICDS MIS.

The card is currently being rolled out in the States/ UTs and training of frontline workers in its use is in progress. A comprehensive guidebook has also been developed by NIPCCD which serves as an invaluable training manual for using the card, as well as a ready reckoner for filling the information on health and nutrition indicators by Anganwadi workers, ANMs, ASHAs and other programme implementers.

As many as under 6,621 projects ,10,12,153 AWCs are making use of the card.

Mother and Child Protection Card

Integrated Child Development Services
National Rural Health Mission

Mother and Child Protection Card

Photograph of Mother & Child

Family Iden ification

Mother's Name _____ Age

Father's Name _____

Address _____

Mother's Education: illiterate/primary/middle/high school/graduate

Pregnancy Record

Mother's ID No. _____

Date of the last menstrual period / /

Expected date of delivery / /

No. of pregnancies/ previous live births /

Last delivery conducted at: Institution Home

Current delivery: Institution Home

JSY Registration No. _____

JSY payment Amount Date / /

Birth Record

Child's Name

Date of Birth / / Birth Weight kgs gms

Girl Boy Birth Registration No:

Institutional Identification

AWW _____ AWC/Block _____

ASHA _____ ANM _____

SHC / Clinic _____

PHC / Town _____ Hospital / FRU _____

Contact Nos. ANM _____ Hospital _____

Transport Arrangement _____

AWC Reg. No Date Sub-centre Reg. No Date

Referral

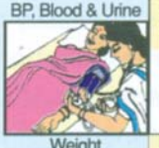
Ministry of Women & Child Development, Government of India
Ministry of Health and Family Welfare, Government of India

Regular checkup is essential during pregnancy

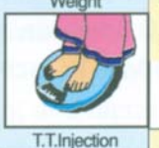
Months: 1st 2nd 3rd 4th 5th 6th 7th 8th 9th

Registration — Register with the health centre in the first trimester.

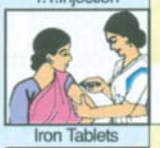
ANC — Have at least 3 antenatal checkups, afterregistration



BP, Blood & Urine — Have blood pressure (BP) checked and blood and urine examined at each visit.



Weight — Have weight checkup at each visit. Gain at least 10-12 kg. during pregnancy. Gain at least 1kg every mth. during the last 6 mths. of pregnancy.



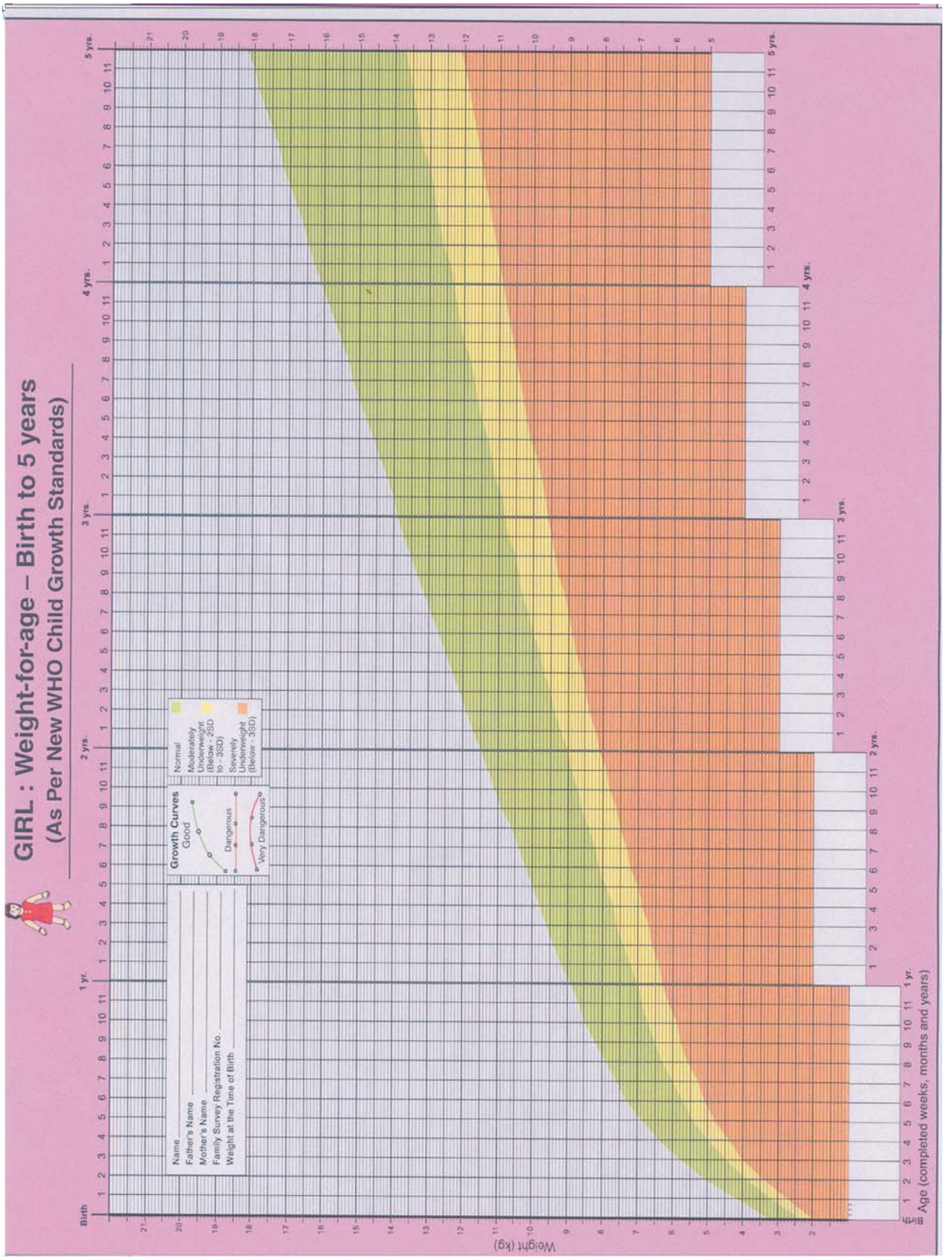
T.T.Injection — Take two T.T. injections. T.T.1 when pregnancy is confirmed and T.T.2 after 1 month. (Fill in the date)

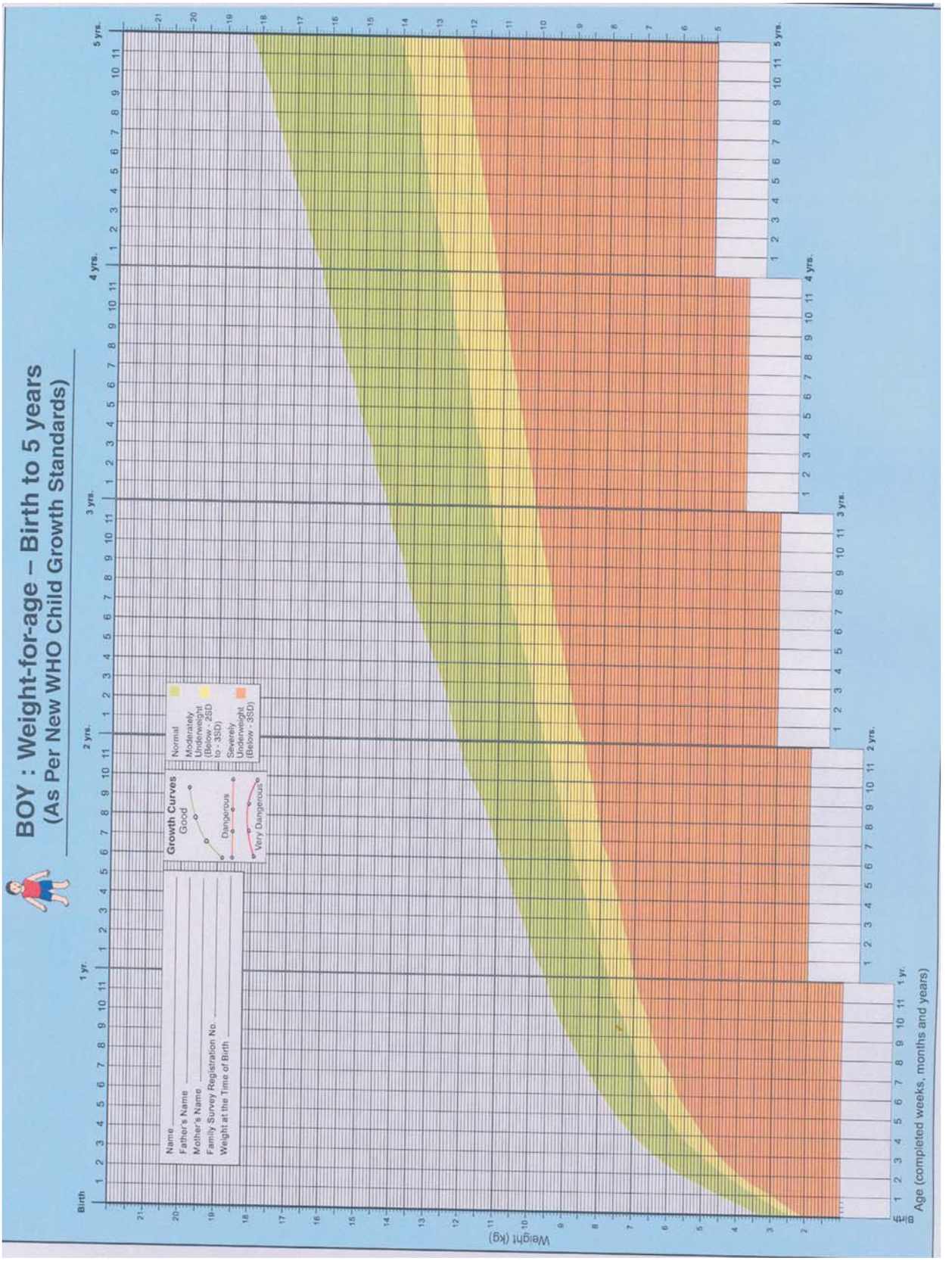
Iron Tablets — Take one tablet of iron and folic acid a day for at least 3 months. Take at least 100 tablets. (Fill in quantity and date issued)

Care During Pregnancy

- Consume a variety of foods
- Consume more food – around ¼th times extra than the normal diet
- Consume SNP from the AWC regularly
- Take at least two hours of rest during the day. In addition to 8 hours of rest at night.
- Use only adequately iodised salt

Ensure nutrition counselling at every ANC


GIRL : Weight-for-age – Birth to 5 years
(As Per New WHO Child Growth Standards)
Name
Father's Name
Mother's Name
Family Survey Registration No.
Weight at the Time of Birth
Growth Curves
Good
Dangerous
Very Dangerous
Normal
Moderately Underweight (Below - 2SD to - 3SD)
Severely Underweight (Below - 3SD)
Weight (kg)
Birth
1 yr.
2 yrs.
3 yrs.
4 yrs.
5 yrs.
Age (completed weeks, months and years)


BOY : Weight-for-age – Birth to 5 years
(As Per New WHO Child Growth Standards)
Name
Father's Name
Mother's Name
Family Survey Registration No.
Weight at the Time of Birth
Growth Curves
Good
Dangerous
Very Dangerous
Normal
Moderately Underweight (Below - 2SD to - 3SD)
Severely Underweight (Below - 3SD)
Weight (kg)
Birth
1 yr.
2 yrs.
3 yrs.
4 yrs.
5 yrs.
Age (completed weeks, months and years)

1.3 Revised Management Information System (MIS) in ICDS

The Management Information System in ICDS has been a standardised data collection procedure implemented uniformly across all States/UTs. The process relies on manual entries and compilations. All primary data relating to service delivery are recorded by the AWWs in prescribed registers. Every month, AWWs compile this information and collate it into a standardised Monthly Progress Report (MPR) that contains a number of input, process and impact indicators. These MPRs are then sent to the Supervisors (each of whom supervises about 25-30 AWCs) who consolidate the reports and forward these to the Child Development Project Officers (CDPOs), who in turn assemble the reports by project/block and remit them to the State HQs. At the central level, some of the key indicators are analysed and Quarterly Progress Reports (QPRs) are prepared and detailed feedbacks are sent to State government. These key indicators include information on ICDS personnel, operationalisation of projects and AWCs, beneficiaries of supplemental nutrition and pre-school education, number of births and deaths, nutritional status etc.

At the State level, programme monitoring data captured through AWC MPRs/Half-yearly Progress Reports (HPR) are compiled for all the operational projects using the CDPOs' Monthly Progress Reports (MPRs). Additionally, the State Reports include information on field visits to AWCs by ICDS functionaries, VHNDs, health-check-ups, immunisation, home visits by AWWs, etc.

As part of strengthening and systems quality improvement, the Ministry had initiated revamping of the MIS with an aim to ensure consistent and accurate recording and reporting of the critical programme data. This was also done to minimise drudgery and reduce time spent by functionaries in data compilation and allow more time for programme activities like home visits and counselling of mothers.

Through a long consultative process with the States and other stakeholders, and after pilot testing in six States, all primary records and registers that are maintained at the AWCs have been revised / rationalised. On 28 March 2012, the Ministry introduced the revised MIS and issued detailed guidelines for roll-out of the 11 newly designed colour-coded registers along with Report formats viz., monthly progress reports (MPRs) and annual status reports (ASRs).

Glimpses of some of the sample registers produced by MWCD

To ensure uniformity and standardisation in design across the States, the Ministry, for the first time, undertook centralised designing of these basic MIS formats in all major languages and produced *print-ready* versions for release to the States for printing. Print-ready formats in local languages have been released to all 35 States/UTs. The Ministry has also prepared detailed roll-out plan including (i) guidelines for induction training on revised MIS for the ICDS functionaries, (ii) User's Manual for use by the AWWs and their Supervisors, and (iii) Training Facilitator's Manual to be used for imparting induction training of ICDS functionaries at different levels, particularly for the training of AWWs at the sector level. These manuals are currently being translated in local languages by the respective States.

Concurrently, the Ministry is also working with the National Informatics Centre (NIC) for developing a web-enabled MIS which will help capturing basic programme monitoring data entry from the Anganwadi/project level as well as help compilation and generation of progress reports at different levels. This will help in collecting and providing data on a real time basis to support timely programmatic actions and interventions. A new web-portal (www.wcd.nic.in/icds) has been created for enabling the MIS data entry by the States/UTs.

SECTION - B

PRACTICES FOR STRENGTHENING SERVICE DELIVERY

2 Improving Service Delivery in ICDS

The ICDS programme is a major flagship programme of Government of India which reaches out to all habitations in the country. It currently operates through more than 13, 00,000 Anganwadi Centres, each manned by an Anganwadi Worker and an anganwadi helper. It provides an integrated package of health, nutrition and early childhood education services targeted at children aged below six years; pregnant and nursing mothers; and adolescent girls. Nutritional and health education services are also provided, in general, for all women in the age group 15 to 45 years. The programme is universal, and reaches out to women and children with low socio-economic status as primary beneficiaries. Specific services provided through the programme include:

– Immunisation

– Health Check-up

– Referral Services

– Nutrition and Health Education

– Supplementary Nutrition

– Early Childhood Care and Pre-school Education

Some services are provided directly by ICDS programme while services like immunisation, health check-up and referral services are provided in convergence with the Health and Family Welfare Department. The convergent functions being utilisation of Anganwadi centres (AWCs) as a common platform for service delivery and coordinated planning and organising of service delivery by Anganwadi worker (AWW) and Health functionary (ANM/ LHV/ Mitanin/ Sahyogini/ ASHA workers) at village level.

In the implementation of ICDS, different States /UTs have adopted innovative approaches to enhance the effectiveness of their efforts which is being dealt in this section.

The purpose of this section is to learn from the 'good practices in ICDS' and look at best context-specific options for up scaling and replication in other States, where conditions are appropriate. Besides the above, the use of the section is to capture how effective the interventions are and identify indicators of change. Best Practices for each of the services of ICDS were identified through literature review of the ICDS programme implemented within the States/UTs in India.

2.1. Good Practices in Early Childhood Education

The early learning component of the ICDS is a significant input for providing a sound foundation for cumulative lifelong learning and development. Preschool education (PSE), as envisaged in ICDS, focuses on holistic development of the child, aged up to six years. The programme for the 3-6 years old children in the anganwadi is directed towards providing and ensuring a natural, joyful and stimulating environment, with emphasis on necessary inputs for optimal growth and development. For the vast majority of disadvantaged children in India, ICDS is the only avenue so far for providing preschool education. But there is overwhelming evidence that the preschool education component of the ICDS scheme is particularly deficient in quality, and almost non-existent in anganwadis, in some parts of the country. Nevertheless, some States have taken initiatives towards improving the quality of preschool education. These are illustrated below.

Pictorial books

Instruction Material

2.1.1 Initiatives in Early Childhood Care Education (ECCE) in Rajasthan

The State has established a State level Coordination Committee having linkages with SIERT, NCERT, UNICEF and some reputed NGOs. The committee initiated following innovative measures for strengthening the PSE component.

- Establishment of a Child Media/Resource Laboratory for material development, operational research, advocacy etc.
- Appointment of NTT trained in 500 tribal Anganwadi Centres in ICDS under Tribal Sub plan.
- Strengthening of ECCE at grass root level through community ownership in 9 districts and functioning of District level Coordination committees through DIETs. Community-based monitoring system through network of PRIs, youth, old people is put in place.

Community Sessions

- With the help of DIETs, an ECE experimental pilot project is also being implemented in nine districts of the State. Each DIET of the state has also adopted 25 AWCs to develop them as Child-Friendly Centres (CFCs). Audio CD of ECE songs, rhymes, riddles and an animation film to advocate the concept of ECCE have also been developed in the state with the financial support from the UNICEF. Other innovation, which the state of Rajasthan is trying out, includes joint training of AWWs with Primary School teachers, evolving community-based monitoring system to strengthen ECE in CFCs and creation of ECE resource faculty and resource centre in all DIETs of the State.

2.1.2 Early Childhood Education in Tamil Nadu

Tamil Nadu has been one of the first States to have given importance to ECE and high level advisory committee has been constituted so that quality education is delivered through ICDS. Some of the initiatives undertaken by the State are:

- **Development of ECCE Curriculum:** Working Committee was formed to develop a curriculum for ECCE called Odi Vilayadu Paapa, through a consultative process involving ICDS cadres; subject experts and Block Resource Trainers and primary school teachers of SSA. The curriculum is intrinsically linked with Activity-Based Learning (ABL), the pedagogy currently practiced in primary classes in Tamil Nadu. Monthly framework and weekly and daily activity plans have been prepared for the transaction of the curriculum. The framework comprises of Seidhu Arivom (Individual Choice Time), Pesi Padi Magizhvom (Circle Time), Vilayadi Karpom (Structured Play), Arindhu Magizhvom (Concept Time) and the daily activities are conducted according to the monthly and weekly framework. The domains addressed in the bilingual curriculum include (a) sensorial alertness (b) physical growth needs (gross and fine motor development, coordination, balance) (c) self-care life skills education (food, toilet, cleanliness, participation in daily life) (d) communication (listening, responding, speaking, conversation), (e) social-emotional development (moral, social) (f) cognitive development (concept formation, discrimination, pre-reading, pre-writing, pre-math, imagination).

- **Development of PSE Kit:** This has been done in convergence with Sarva Shiksha Abhiyan (SSA) in Tamil Nadu. Each AWC gets two types of kit materials in alternative years (Kit A & Kit B). It comprises of material for individual choice, activities consisting of wooden and plastic blocks; jigsaw puzzles; balls; stacking cups; coloured beads; geometric pin board; lacing boards; shape and colour sorter; wooden numbers; English

and Tamil alphabet inlets; shape, size and colour of game; sorting and sequencing frame and mazes.

2.1.3. Initiatives taken by Gujarat in Early Childhood Care Education

At least four out of five 3-4 year old children in Gujarat attend Balwadis or Anganwadis; by age 5, an estimated 3 out of 4 children have moved into primary school, but they are too young and not developmentally ready, affecting their ability to learn and stay in school. In 2009, with assistance from UNICEF, the Government of Gujarat, tried to improve ECE through a pilot initiative in two districts and took the following measures.

- ***Development of Standards and Indicators****:* Standards and indicators to assess children between the ages of 3 to 6 years were developed. A total of 23 indicators were selected across all domains of development namely physical, social, emotional, cognitive, linguistic, approaches to learning, creative arts and values.

- ***Toy Bank Initiative:*** With the extensive support from community, community-based organisations, NGOs and the officials of DWCD, the Government of Gujarat have explored the idea of setting up a Toy Bank to provide deprived children the opportunity to play with toys and experience play way learning. Through this initiative, the joyful learning opportunities are being provided for better cognitive, social, emotional and physical development. There are about 17 lakh children covered by around 25,000 AWCs in the state.

- ***AWCs School Enrollment Drive –*** Shala Praveshhot in Gujarat: In order to boost on Education for All and bring down the drop-out rate at school, every year in June, a massive drive is being conducted in the State of Gujarat wherein all the eligible children are enrolled in their respective AWCs and eligible children of AWCs get enrolled to primary Schools. This drive has the patronage of Hon'ble Chief Minister, State Ministers, officials of State Government and other dignitaries.

2.1.4 Initiatives in Early Childhood Care Education in Andhra Pradesh

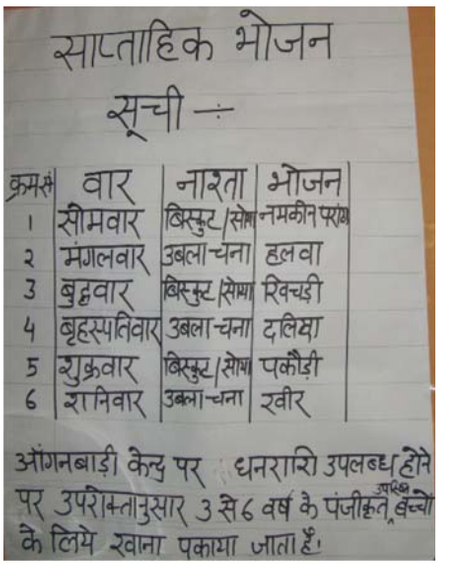
The State has developed Preschool kit for each AWC by engaging Andhra Mahila Sabha. The kit consists of child-friendly and developmentally appropriate play and learning material, story cards, flash cards, puppets etc. A Pre-School syllabus for 10 months and Activity book (Aduthu Padhuthu Module), story cards (Chitti Patti Kathalu) have been prepared as teaching mater. The state has also introduced a system of issuing Pre-School Certificate for 5+ children who leave AWC to join Class I.

Table 1: Initiatives to Strengthen Preschool Education in Some Other States	
State ECCE Policy	*Chhattisgarh*
Curriculum/ Activity Books	Thematic Curriculum (*Andhra Pradesh, Assam, Chhattisgarh, Karnataka, Madhya Pradesh, Punjab, Tripura*), Calendar of Activities (*Bihar*), Activity Books (*Orissa, Punjab, Bihar, Chhattisgarh, Karnataka*), rhyme and song books (*Assam, Tripura*)
Celebration of ECCE Day	Bachpan Divas (*Bihar*), ECCE Day (*Karnataka)*, Bal Sabha (*Madhya Pradesh*), *Kanya Kelavani (Gujarat)*
Child-Friendly Anganwadis	AWCs based on BaLA (Building as Learning Aid) concept (*Madhya Pradesh, Karnataka*)
Awarding of Preschool Certificates	Andhra Pradesh
Uniform for Children	Sikkim and many other States

2.2. Initiatives for Improving Management of Supplementary Nutrition

Supplementary nutrition is an essential service of ICDS. It provisions for dry ration for children between 6 months - 3 years and pregnant and lactating mothers, thereby ensuring availability of food at the critical period of an individual life cycle. Morning snacks and hot cooked meals are provided to children (3-6 years) who attend the Anganwadi centre daily for preschool education. The States are delivering this service through several innovative ways especially for procurement and supply chain management.

There are about 10 initiatives in this domain in 10 states - Gujarat, Kerala, Tamil Nadu, Madhya Pradesh, Andhra Pradesh, Chhattisgarh, West Bengal, Orissa, Uttarakhand and Rajasthan. Eight initiatives depict varied institutions through which the SNP is supplied. The initiatives are cited in following table.


साप्ताहिक भोजन सूची :-

क्रमसं	वार	नाश्ता	भोजन
1	सोमवार	बिस्कुट/सोया	नमकीन पराठा
2	मंगलवार	उबला-चना	हलवा
3	बुद्धवार	बिस्कुट/सोया	खिचड़ी
4	बृहस्पतिवार	उबला-चना	दलिया
5	शुक्रवार	बिस्कुट/सोया	पकौड़ी
6	शनिवार	उबला-चना	खीर

आंगनबाड़ी केन्द्र पर धनराशि उपलब्ध होने पर उपरोक्तानुसार 3 से 6 वर्ष के पंजीकृत बच्चो के लिये खाना पकाया जाता है।

Menu for Supplementary Nutrition

Table 2: Supplementary Nutrition — Supply and Procurement	
Initiative	**Brief Description**
Gujarat's model *(Gujarat)*	– Weekly recipes for the AWC charted out and followed – Fortified THR: Four premixes (Bal Bhog, sukhadi, upma, sheera) for preparing around 77 recipes – Rasoi shows are organised for orientation on benefit and preparation of premixes – Community contribution and participation on special days
Kerala's enterprise groups *(Kerala*)	– THR is being provided through 396 enterprise groups (CPCRI). Three gram panchayats are being covered by 1 enterprise group. This is monitored centrally. – Within Kudumbashree Mission of Ministry of Panchayati Raj and Rural Development, crisis management fund has been created which was utilised for SNP purchase.
Weaning food by women's cooperative (*Tamil Nadu*)	– 25 women cooperatives involved in preparation of weaning food. – Recipe chart for the week is drawn and followed. – Diverse recipe with 3 eggs / banana given every week.
Sanjha Chulha (*Madhya Pradesh)*	– Common chulha/ cooking arrangement are maintained in convergence with MDM to cook food. – Morning snacks and lunch cooked by SHGs is supplied to AWCs.
AP food Model *(Andhra Pradesh*)	– The state of Andhra Pradesh provides semi-processed foods like the suji/ semolina, upma, halwa which are pre-mixed with either salt or sugar and need simple cooking procedures at household level (for THR) or at AWC (for spot feeding).

Initiative	Brief Description
Commodity supplies managed by women Self-help Groups (*Chhattisgarh* and *several other states*)	– Women groups in the community are allocated AWCs for which they are required to purchase pulses, soya, condiments, oil etc. and provide them to the AWW on a daily basis for spot-feeding and for THR distribution on a weekly/ fortnightly basis. – The AWWs and the SHG members together manage the THR distribution. – ICDS pays the SHG for these supplies on a periodic basis. The rice for the feeding programme of ICDS is routed through the fair price shops of PDS.
Decentralisation of procurement and supply to districts and blocks(*West Bengal* and *Uttarakhand*)	– West Bengal have delegated the procurement-related decision making to the district level for some of the commodities like pulses, and to the block level for other minor commodities while rice is supplied through PDS/ civil supplies corporation. – In Uttarakhand, the hot cooked meal is provided by mother's committee and fund is directly transferred to their bank account.
Decentralisation of procurement and management of commodities to AWC level (*Orissa)*	– Fixed weekly schedule for morning snacks and hot cooked meal – Rice supplied through FCI, for remaining ingredients procurement decentralised to village level – AWW and select mothers as members to manage the local purchase of food commodities; joint accounts held; e- transfer done by 7th of every month – Jaanch Committee formed at the village level (comprising of retired government officials, SHG presidents, members of mothers committee etc.) – Monthly monitoring at GP level – Greater involvement of PRI & community

Initiative	Brief Description
Engaging SHGs to supply processed food to AWCs (*Orissa* and *Rajasthan)*	– Women members of SHGs/ SHG federation are offered contracts by ICDS to supply processed foods (THR) – Standardised packaging of THR with details of date of manufacture, ingredients, method of use etc.
Daily distribution of hot-cooked meals by private sector involvement (*Delhi, Rajasthan, AP, Gujarat)*	– In case of select cities and sub-urban areas in several States/UTs, ICDS has involved non-governmental agencies like *Akshya-patra* Foundation and *Naandi foundation, Non- Profit Organisations (NPOs)* etc. to provide hot cooked food to feeding centres on a daily basis.

2.3. Nutrition, Health Education and Counselling

It is a major component in ICDS programme to ensure that mothers/ parents / community receive health and nutrition education. The AWWs are primarily responsible for making home visits for educating parents and families of children below three years who are not attending the AWCs so that the mother/ family of the child is enabled to play an effective role in child's growth and development. Specific practices related to Nutrition and Health Education (NHED) seen in different States are cited here.

Counselling during Home Visit

2.3.1 Nutrition Counselling and Child Care Sessions in Positive Deviance, West Bengal

Intense nutrition counselling and child care sessions were implemented in the positive deviance project, where care givers of moderate and severe undernourished children are provided intensive counselling sessions (for 12 consecutive days) by AWWs and the supervisors. Along with supervised feeding for the undernourished children, thematic demonstrations and counselling sessions are conducted on all 12 days to caregivers.

2.3.2 Nutrition Education in Tamil Nadu Integrated Nutrition Programme (TINP)

Nutrition education was provided to all mothers who maintain contact with the centre. Monthly education and demonstration sessions were held either at the Child Nutrition Centre or at the home of one of the mothers. One innovation of the TINP in this context is the women's working groups (WWG). Mothers got together to form small groups, one mother assuming the role of the leader and the Child Nutrition Worker, acting as a group facilitator. These group meetings were the focal points for nutrition education and in some areas, for income-generating activities. In some centres, the leader of the women's group was encouraged to assume charge of 10 other women in the locale, whose continued participation is ensured by the leader. Children's working groups were also initiated in some of the project areas wherein member children educate other children and adults about simple nutrition/health-related messages through songs and jingles. The communications component of the programme focused on organisation of special campaigns and drives on topics of common interest.

2.3.3 Use of Media for Health Education

Health Education on 52 thematic areas related to adolescent reproductive sexual health, maternal health, child health and family planning is aired on Doordarshan. The service providers (ASHA) will be sensitised and provided with health bulletin (Booklet on health messages on 52 themes) to help facilitate group discussion in Gram Kalyan Samitis on monthly thematic areas.

2.3.4 *Sas Bahu* Sammelan

In Uttar Pradesh, joint meetings of daughters-in-law, mothers-in-law, elderly ladies of the family, female PRI members, ICDS functionaries, NGOs and women's groups were organised. These meetings provided the stakeholders a common learning platform. The meetings were held once every year at the district and block levels. At the district level, the Addl. CMO (RCH or Maternal Health) and at the block level the MO was responsible for organising such meetings in coordination with ICDS staff. An agenda for the same was prepared well in advance. During these meetings, women's health issues, role of various family members, harmful social practices & beliefs, significance of nutrition, information of various programmes and schemes, role of other stakeholders in improving health practices in the community were addressed. The meetings were also videographed and useful feedbacks documented thereby helping in refining communication strategies, development of communication material and interventions.

Annaprasan

2.3.5 Mangal Diwas, Madhya Pradesh

In Madhya Pradesh Mangal Divas is observed in ICDS. Every Tuesday events like Janamdin, Ann Prasan, Godbharai and Kishori Divas are organised with small celebrations signifying complete immunisation, introduction of complementary feeding after six months of age, early registration of pregnancy and importance of adolescent period respectively. Both Health and ICDS functionaries jointly conduct Mangal Divas. Similar practice is also observed in Uttar Pradesh.

Godbharai

2.4. Convergent Models for Improving Health Services through ICDS

Village Health & Nutrition Day

A single concept of **Village Health and Nutrition Day (VHNDs)** mandated under NRHM, is in practice in all the states. A fixed day and site approach with joint planning of ICDS, Health and PRIs encourages community involvement and mobilisation and appropriate logistics management for a basket of services to be delivered. These include Immunisation, micronutrient supplementation, health check-up, ANC, PNC, counselling and referral. The approach has shown rapid increase in access of health and nutrition services to remote and unreached locations. Provision of THR for pregnant and lactating mothers adds as an incentive to attract pregnant and lactating women and children below 3 years to the AWC. The approach also enables common monitoring and reminder to the drop outs. In conducting these VHNDs, effective community and PRI support has been forthcoming in most States.

2.4.1 Variations in Village Health Nutrition Day

- **HMRI / 104 initiative :** The monthly fixed-day fixed-site health service provision through mobile team being implemented in states like AP, Gujarat and Uttarakhand is example of further adaptation of the HMRI or 104 initiative concept of VHND to suit to the local needs and resources. In AP, 104 initiative deploys mobile health units (MHUs) to render

4 hours service once a month in each habitation with a population of 1,500. Each mobile health unit covers two habitations in a day and 56 villages a month.

- **Fixed Nutrition and Health Days under INHP (FNHD):** It combines the principles of fixed day, fixed-site provision of outreach services such as immunisation, antenatal care, and food supplement distribution, health and nutrition education with the principles of convergence of services and community participation and monitoring. Processes involved include preparation of roaster by PHC of every habitation with specific dates on immunisation. VHND in some States is so planned that it coincides with the dates of THR distribution. Prior to FNHD, ANM and AWW list children and pregnant and lactating women due for vaccine and antenatal check- up and invite them in advance. This list is reviewed at the end of the day and reminders are sent to families. During the FNHDs line department functionaries and community leaders are involved to ensure check and balance. The AWW, AW helper, ASHA and ANM together with local volunteers organise the FNHDs such that waiting time is minimised for the mothers and caretakers who bring children.

- **Mamta Diwas:** Village Health and Nutrition Day (VHND), Mamata Diwas, a concept for interdepartmental convergence having desirable health outcomes of children below five years, is being introduced in the State of Orissa by the Department of Health & Family Welfare. The programme is organised once a month in every Anganwadi Centre on a fixed day basis (either Tuesday or Friday) with joint efforts of ANM, AWW and ASHA. On an average, there are six to eight AWCs under the operational jurisdiction of one Sub Centre and thus there would be about eight fixed days in a month per Sub Centre. Advance Such days should be fixed beforehand in consultation with all AWCs for the entire month, so that the service providers and the community are aware of it much in advance.

2.4.2 Referral Services in ICDS

During health check-ups and growth monitoring sessions, sick or undernourished children, in need of prompt medical attention, are referred to the Primary Health Centre or Sub-Health Centres. The anganwadi worker has also been oriented to detect disabilities in young children. She enlists all such cases in a special register and refers them to the medical officer of the Primary Health Centre/ Sub-centre. States like Madhya Pradesh, Maharashtra, Rajasthan and few other States under NRHM have established Nutrition Rehabilitation Centres (NRCs) at the district hospitals and CHCs. ICDS extends support in referring children with medical complication to these centres.

These referral services are essential in meeting urgent needs of the sick and undernourished children. The referral mechanisms in different States /UTs are cited below:

- **Pustikar Diwas in Orissa:** Health and Family Welfare Government of Orissa in collaboration with Women and Child Development Department observes "Pustikar Diwas" on the 15th day of every month at the Block PHC/CHC level for effective management, treatment and referral of undernourished and sick children under five years of age. ICDS functionaries from each of the Anganwadi centre prepare a list of beneficiaries for referral.

- **Referral Mechanism of Undernourished Children in Madhya Pradesh:** An incentive of Rs. 100 is paid to AWW for identification of severely undernourished children with medical complication and accompanying child and caregivers to Nutrition Rehabilitation Centres (NRCs) at the district or block level.

- **Referral from Village Child Development Centres (VCDC) in Maharashtra:** The AWW conducts feeding sessions for 30 days providing three additional meals apart from the routine SNP. Antibiotics and micronutrients are given under supervision of the health department. The VCDC opens for 4 hours in the morning and 2 hours in the evening which is supervised by MO and ICDS Supervisor. Children gain weight within 30 days. From these centres the AWW identifies undernourished children with medical complication based on weight for age, while height measurements and wasting criteria are certified by health officer before referral to health facility.

- **Referral of Undernourished Children in Karnataka:** Severely underweight children are provided food and medicine @ Rs. 750 per child. Neonatal and severe undernourished children are referred to 6 identified hospitals.

- **Indira Bal Swathya Yojna in Haryana:** The scheme provides for health check-up, health cards and medicine for undernourished children of BPL families. Linkages of ICDS for referral with Medical institutes - PGI Chandigarh, Rohtak Medical College and AIIMS, Delhi have been created for providing free check-up to these children.

2.4.3 Event-based Initiatives and Campaign-based Activities

Several health-related services like immunisation, Vitamin A supplementation are effectively delivered at the village level in a campaign mode or observed as an event.

A list of such activities is cited below in Tables 3 and 4.

Table 3: Event-based Initiatives

Innovation	State	Brief Description
Jacha Bacha Swasthya Divas	Uttarakhand	– A camp approach; fixed day visit schedule for providing ANC and child health services in all villages located in a sub-centre area on a rotational basis. – ANMs provided Rs. 50 per camp for assisting in handling equipment and supplies.
Mamta Abhiyan	Gujarat	– It comprises of four components- Mamta Divas, Mamta Mulakat, Mamta Sandarbh and Mamta Nondh – Mamta divas is a fixed Day when Health and nutrition services, immunisation, ANC, distribution of Supplementary Nutrition, Growth monitoring and counselling and critical services are delivered. – Mamta Mulakat is post natal visit by AWW, ANM during first week and first month of life. – Mamta Sandharbh is provision of referral by AWWs. – Mamta Nodh Service AWWs and ANMs fill the Mamta Card carried by pregnant and lactating women.
Haat Clinics in Tribal areas	Gujarat	– A temporary camp is held in the markets where doctors and other staff are deputed on a rotation basis. – The camps provide services on minor ailments and vaccination. – Awareness generating activities are also undertaken during these camps.

Innovation	State	Brief Description
Annual Deworming	Andhra Pradesh	– A campaign in all Gram Panchayats for anaemia control in children (3-12 years) based on clinical symptoms. – Children are administered IFA and deworming tablets. – Sensitisation workshops are conducted in each habitation with the target groups to obtain the support and participation of all families in the campaign.
Bal Swasthya Poshan Mah (BSPM)/ Bal aposhan Mah for Micronutrient Malnutrition	Uttar Pradesh, Madhya Pradesh, Other states	– Biannual Vitamin A supplementation along with intensive promotion of exclusive breastfeeding, complementary feeding, iodised salt consumption and referral of severely undernourished children are organised in the fixed months twice a year.

Table 4: Campaign Mode Initiatives

Innovation	State	Brief Description
Well Baby campaigns	Andhra Pradesh	– Well Baby shows organised in all the Gram Panchayats where children below one year are assessed on the basis of their immunisation status, nutritional status and milestones for growth and development.
Vaccine Delivery through Mobile vans	Bihar	– Maximising the coverage of immunisation and Vitamin 'A' supplementation through the strategy of mobile van approach to cover inaccessible areas.
Panchamrit Campaign	Rajasthan	– A week-long intervention programme for Mother and child Health and nutrition Camps are held during the first three months of the year.
Annual immunisation census	Andhra Pradesh	– One week per year is dedicated for tracking of all mothers and children based on their immunisation status. – The women health volunteers, AWWs and ANMs form teams and conduct the surveys, simultaneously giving mop-up immunisation for non-immunised children.
Young infant health assurance scheme	Andhra Pradesh	– A voucher scheme, enabling infants of rural BPL families to access the services of the private sector hospitals, paediatricians and general medical practitioners in small towns and large Panchayats for health care services.
Muskaan	Bihar	– Identification of all beneficiaries (pregnant women and children under two years of age) and tracking to ensure complete immunisation coverage. – Increasing the number of sessions so that immunisation services are provided in all health

Innovation	State	Brief Description
		sub-centres on Wednesdays and in two to three anganwadi centres on Fridays. – Introduction of performance-based incentives and penalties to community mobilisers as well as to providers at all levels of the service system. – Village-level mahila mandals served to sensitise mothers to the benefits of immunisation.
Catch-up Rounds for Immunisation and Zero Diarrhoea Programme	Jharkhand	– A package of services - vaccines, IFA, deworming, Vitamin A and surveillance for malaria and TB in the catch-up round are being provided on a biannual basis to "the last person in the last household to the last village".
Mother and ChildHealth Month	Assam	– During the MCH month, the emphasis is on the provision of the services to be provided at the sub-centres, anganwadi centres (AWCs), during Village Health and Nutrition Days (VHNDs) and out-patient departments of all health institutions; these service include Vitamin A prophylaxis up to children of three years, deworming of children between one to five years, treatment of anaemia in children between one to five years (IFA small tablets), treatment of ARI cases and cases of dehydration with ORS and zinc tablets.
Hirkani Kaksha	Maharashtra	– A scheme for promotion of exclusive breastfeeding of infants which provides the facility of a special room/kaksha where working women can breastfeed her child in privacy. There are facilities also for storing the breast milk of working women who are into exclusive breastfeeding to be used later.
Immunisation Drive	Kerala	– A campaign to strengthen immunisation coverage in the State through intensive IEC/BCC campaigns and inter-sectoral convergence of the ICDS, Education and Health departments.

SECTION - C

PRACTICES FOR IMPROVED PROGRAMME MANAGEMENT

3 Improving Programme Management in ICDS

ICDS is a well-designed programme but faces the challenge of good implementation. This is primarily due to issues related with programme management. States/ UTs realise the importance of the programme and have tried to bridge several of these gaps. Integrated approaches have introduced several management components into ICDS which have provided systemic strength.

Good management on the ground and effective use of information along with community participation has brought success to several community-based programmes, like ICDS.

Important managerial reforms in ICDS could focus on community processes like community mobilisation, community engagement and participation, human resource development, behaviour change communication, convergence etc.

ICDS programmes has no clear cut directions in community processes, it depends on individual workers and their proactive approach in engaging community. Integrated pilots have explored the effects of community processes to realise important objectives, especially those pertaining to change in care behaviours and reduction in under-nutrition.

The other set of managerial reforms would include quality data collection, analysis for differential planning and supervision for improved action at community level. ICDS today generates a large quantum of data, which is left unused and the quality has often been questionable. The large number of registers, the flow of data and rigorous procedures make the process tedious especially for the Anganwadi worker. Some states have realised the importance of quality data and have simplified the reporting pattern, brought in the use of web-enabled MIS and GMIS for surveillance, monitoring through ICT. These are quite a few examples in ICDS.

This section intends to collate some of these experiences and study the feasibility of scaling up these practices and processes.

3.1 Community Mobilisation

In several state ICDS programme and development agencies have used innovative approaches to adapt prevailing cultural practices/ customs/ ceremonial occasions to promote specific set of behaviours and to enhance community participation in ICDS. In projects like Dular, ASAT and INHP, it was done by a band of local women called local resource persons

(LRPs), Gram Sampark Samooh (GSS) or Change Agents respectively. These women were often assigned households in their neighbourhood to support the target families for behaviour change. They were provided two or three rounds of training on critical maternal and child health and nutrition issues and were often equipped with some basic communication aids for talking to mothers.

Community Mobilisation

3.2 Use of Monitoring Tools

Use of monitoring tools

It is a necessity in contemporary scenario to support planning of services, tracking of undernourished children and utilisation of ICDS services and monitoring of AWCs.

In ICDS monitoring tools like community growth chart, mother & child protection card have been in use since long. Integrated projects implemented through the ICDS channel have used these tools widely and these are found to evoke excellent community response. In addition social mapping, colour coding of tools in ASAT, INHP and PD have been an effective exercise generating extensive community participation in monitoring of health and ICDS services. Mapping and colour coding proved to be powerful communication and monitoring tools in Positive Deviance Approach. In INHP, use of innovative pictorial tools for families to track service utilisation and behaviour change from pregnancy till the child is two years old were useful for families to remember services and behaviour. Currently colour coded Mother and Child Protection Card (MCPC) is used in ICDS both as an IPC tool, and a self-monitoring tool. The use of community growth charts is found only in very few states and should be revived.

3.3 Community Participation and Monitoring

Several states have taken special efforts to involve community groups like SHGs, mothers groups, PRIs etc. in participating and monitoring of day to day functioning of AWCs. In Gujarat formation of matru community (mothers groups) provides support on Tithi Bhojan days by

contributing vegetables. In the state, community participation is enhanced through rasoi shows and competitions. In Kerala Village level monitoring of AWC is done by ward members and panchayat level health education committee. Two AWCs are assigned per member / committee in Tamil Nadu, for bringing children to the centre. They contribute to providing play materials, construction of infrastructure and maintenance of kitchen garden. Madhya Pradesh has identified high burden districts and blocks in these areas: one person from the community is identified to monitor 15 households and ensure service uptake from health and ICDS infrastructure. Odisha has set up monitoring committee (Janch Committee) for monitoring SNP, photo display of these members are available at AWC. Monthly monitoring of AWCs is also done at the GP level.

3.4 Incremental Learning and Supervision

Interpersonal Counselling

Supervision has itself been a challenge in programme management. ICDS supervisors were appointed for supervision and support to the AWW. The number of centres devolved per supervisor is high to provide substantial supervision. Programmes of UNICEF, CARE and World Bank that supported ICDS implementation have focused on improving the supervision system and to strengthen mechanisms for on-going capacity building of workers through different mechanisms. In INHP supervisory checklists were designed in a participatory manner focusing on critical behaviours and services. Based on trends denoted from checklist and interaction with AWWs, the supervisors were helped to develop and conduct capacity building (CB) sessions for AWWs during the monthly review meetings at sector level. Additional block level nutrition instructress within TINP, ASAT, Dular and INHP utilised external resource persons; including local NGO staff, master trainers etc. to help the ICDS staff to conduct supportive supervision and to provide on the job capacity building inputs. In Jharkhand, selected AWWs were designated as cluster coordinators and were assigned additional responsibility to support about 10 to 12 AWWs around their village.

3.5 Behavioural Change Communication

It is one of the strategies to sustain positive behaviours practices within the community. Community listens, speaks, learns, understands and analyses their behaviours vis-a-vis the positive ones and adopts, depending on support. MCHN and Dular conducted interpersonal counselling for Behavioural Change Communication. Dular strategy used flash cards for Interpersonal counselling by AWW during home visits. IPC involves social interaction creating awareness, building knowledge and emphasising on its practice. This BCC can be sustained by reemphasising the messages through continuous interactions during home visits, group counselling, community meetings etc.

3.6 Convergence

Programme Convergence essentially tried to bring together ICDS and health functionaries to jointly identify issues and plan appropriate actions in setting the agenda, facilitating quality discussions, and reviewing data from district and block, monthly progress reports and field visit observations. It also helped to overcome deficits by leveraging both physical and intellectual resources. Most of the integrated projects have tested different models for convergence between ICDS and health functionaries at sector, block and district levels for joint planning, review and solving operational problems. While most of these efforts were focused around ensuring joint monthly or quarterly meetings of multiple stakeholders at block and district level, some efforts were made to bring together all ANMs, ASHAs and AWWs together at sector level on a monthly basis. Block and district level convergence forums reviewed the programme implementation and provided guidance to solve any operational problems. Convergence in itself is a challenge as working it out needs a clear agenda and mechanisms in place for flow of information.

3.7 Programme Monitoring and Management Information System

States have tried to improve their monitoring mechanisms and have taken several steps related to it, which include simplification of reporting formats, web enabling of MIS, introduction of GIS for the purpose of surveillance and financial monitoring. Some of these initiatives for improved and timely reporting have been undertaken with the support of Development Partners and other technical agencies. Civil societies and NGOs have added a new dimension to programme monitoring in ICDS by the introduction of public participation in conducting social audits and opening up channels of dialogue with providers and receivers, through public hearing.

Some of the innovations are enlisted below.

- ***Nutrition Surveillance System (NSS):*** Pioneered by States of Chhattisgarh and Maharashtra, Nutrition Surveillance System locates and tracks every month all severely malnourished children by name and by location, and captures ICDS data from all Anganwadi centre of the State. It brings out meaningful information through analysis and reports to higher levels of appropriate authority by collating the data as per requirement at each level. Introduction of NSS made valuable data useable at different levels by ensuring easy analysis and feedback to improve performance. The analysis through NSS was done in the following ways: Area wise analysis (project wise, sector wise and anganwadi centre wise); Indicator wise analysis (nutrition indicators as total under-nutrition disaggregated by age and health indicators as Maternal and Child Deaths); Time wise analysis through graphs generated at all levels (AWC, Sector, Project, District and State levels); and dual maps generated through GIS which give the time series analysis. Data analysed through the geographic information systems (GIS) embedded in the software is a potential tool for sensitising functionaries on various performance indicators of ICDS as well as prepare action plans for improving low performing indicators or areas. Analysis shows that over a period of time, the reporting system of ICDS has shown improvement both in terms of quantity and quality.

- ***GMIS in Andhra Pradesh:*** The system has been piloted in 3 districts of the state. The AWW is trained to enter beneficiary wise data on laptop installed with software. At the sector level, the reports are generated on information such as drop outs on immunisation, growth monitoring etc. At the sector level data is uploaded to central server, where reports and data are used by CDPOs and supervisors for planning and monitoring. Gaps and issues are displayed as geographical representation to identify clusters/sectors which require more attention and focussed interventions.

- ***Web-Enabled MIS:*** Madhya Pradesh and several other States have established web-enabled MIS. Monthly Progress reports are being received at the State Directorates online. The existing monthly reporting format was revised to capture relevant and appropriate information aiming to enhance personnel efficiency, more effective use of data and sustainability for actions. It reduces the drudgery of manual data transfer and generating several copies of the same.

The new streamlined monthly progress report saved significant amounts of staff time (AWWs said they previously spent 2 to 3 days completing the report, which now takes less than an hour), leaving more time for service provision; they also found it simpler to complete and therefore made fewer mistakes and provided more accurate data, thus the form supported improved service planning and delivery. The web-enabled MIS provided up to date information,

saved staff time (supervisors, statistical officers, Child Development Project Officers); improved supervision and coordination between AWWs, supervisors, CDPOs; and increased access to and use of information at all levels.

3.8 Transparency and Accountability in ICDS

In recent years, several States have taken keen interest in critically looking at the implementation of ICDS and streamlining this flagship programme. NGOs and civil societies, have conducted social audits with the support of district administration.

Social audit in Progress

The drought-prone Anantapur district of Andhra Pradesh was the first in the country for public evaluation and social auditing of the ICDS. The audit of the ICDS programme was conducted on 24-25 September 2008. Thereafter similar social audits of the ICDS programme have also been held in various places of Odisha namely Mirdhapali Gram Panchayat of Bolangir district, Ratakhandi Gram Panchayat of Loisingha block of Bolangir and in 14 Gram Panchayats of Koraput district.

Organisations like Care India and FORCES in coordination with the authorities have also been conducting social audits in different states of India like Uttar Pradesh, Bihar, Rajasthan, Jharkhand and Delhi. The social audits have not only increased transparency in ICDS, but also provided critical inputs for strengthening service delivery and taking important decisions related to functioning of the AWCs.Public hearings have also been held in ICDS, in Allahabad slum; public hearing was held to identify public grievances and find solution.

3.9 Initiatives in Financial Management

Financial Management is a vital component for effective implementation of ICDS. Few states have already initiated streamlining data management by incorporating effective data mining and data warehousing techniques along with the timely reporting of financial details in the form of Statement of Expenditure (SoE). Unlike initial years of ICDS, it is now possible to calculate the financial status of States pertaining to various components constituting ICDS (G). Besides, different modules for real time data monitoring are in pilot stage to be rolled out

in near future. Examples of few States like MP, Chhattisgarh, Maharashtra, and AP can be considered as benchmarks for imbibing technology into ICDS for better control of funds in order to optimise the expenditure within the prescribed budgetary constraints. AP has pioneered Geographical Information System (GIS) technology for mapping AWCs thereby enabling a linkage of operational and financial MIS. Maharashtra has separate module for FMIS. Likewise, MP is planning and controlling funds with the help of in-house developed software like Mudra and Mudra Prahari as well as real time financial data is reflected through its treasury website (online financial system).

Despite the lacunae like lack of human resource, hold of funds by State finances, less flexibility and decentralised planning, efficiency of fund utilisation has shown some improvement but a still a long way to go in order to achieve noticeable impact. With this motive, process for developing a web-enabled online financial monitoring system at National level is already in place, and expected to serve as a key step for streamlining the financial system of ICDS.

SECTION - D

SNAPSHOT OF SOME OUTSTANDING PRACTICES

4 Snapshot of Selected Good Practices

A 'practice' is generally defined as a 'way of doing things in a usual or expected manner'. Different definitions of 'Good Practice' imply a practice with various special characteristics such as innovativeness, ability to lead to an actual change, having an impact on policy environment, replicability and sustainability. A best practice could also be distinguished by its contribution to increase the efficiency of the initiative (that is, optimum use of resources to enhance outputs and outcomes) or its effectiveness (that is, its contribution to the achievement of the set objectives of the scheme in which the practice occurs). In its implementation, several States/ UTs have adopted unique approaches to enhance the effectiveness of ICDS. The section gives a snapshot of such initiatives.

4.1 Construction of Anganwadi Centre, PPP Model, Tamil Nadu and Gujarat

Anganwadi Centre—PPP Model

Lack of well-designed centre with all amenities to provide a joyful learning environment is one of the major constraints of ICDS. States like Tamil Nadu and Gujarat have overcome this through Public Private Partnerships (PPP). In Tamil Nadu, Lufthansa Airways came up with a proposal. Similar Initiative has been taken up in Gujarat where 47 percent of AWCs are constructed through public private partnerships.

4.2 Strengthening AWC Monitoring, Karnataka

An intensive monitoring activity of AWCs is being undertaken by Department of Women and Child Development, Government of Karnataka. Detailed monitoring checklist has been prepared for validation at each AWC. Team of officials observes merits and demerits of ICDS service delivery and infrastructure along with assessment of other programmes of the department. The report has been submitted to Deputy Director in the State, who as a follow-up action addresses the identified problems in coordination meetings with the line departments.

4.3 Increasing Reach and Coverage in Gujarat and Haryana

Mobile Anganwadi Centre

To address the needs of socially and geographically excluded population mostly in the remote interior areas, Government of Gujarat has started Mobile Anganwadi Vans to provide services to the beneficiaries in these areas using the State's Budget. In Haryana 'Bhatta Patshala' mobile AWCs are operational with the help of NGOs for providing preschool education to children of migrant labourers.

4.4 Anganwadi entry festival / Campaign in Kerala and Gujarat

In Kerala, May 31 has been declared as Anganwadi admission date. It is observed in all anganwadis with celebrations. School bags, tiffin box, umbrella, uniform etc. are collected from the community and given to the newly admitted children.

In Gujarat, with thrust on Education for all and lessen dropout rates from school, every year in June, a massive drive is conducted wherein all the eligible children are enrolled in their respective AWCs.

4.5 Kuposhan Mukti Abhiyan, Chhattisgarh

Mashall Rally organised for mass awareness

A special campaign to eradicate under-nutrition is initiated by state government since 2009 using its State budget. The campaign emphasises to create awareness amongst community and family members on under-nutrition among children. The severely undernourished children are identified and referred to the health system. A unique feature of the campaign is that the community adopts severely undernourished children. For treatment of severely undernourished, Rs. 800/- per beneficiary is earmarked for medical checkup and medicines and Rs. 1500/- as consultation fees of private paediatrician.

4.6 Joint Cooking Arrangement "Sanjha Chulha", Madhya Pradesh

Sanjha Chulha

ICDS in convergence with Mid-Day Meal Scheme implements joint supplementary feeding programme "Sanjha Chulha" for AWC children. In the programme, two hot cooked meals i.e. morning snacks and lunch are prepared with the help of local SHGs and served at the AWCs.

This allows AWW and AWH to spend more time with for preschool education activities as well as for home visits and counselling for under threes.

4.7 Geographical Monitoring and Information System (GMIS), Andhra Pradesh

Anganwadi Workers using Laptops

To improve the accountability and programme effectiveness in ICDS with support of technology, Andhra Pradesh has initiated GMIS. This is a unique pilot project where technology is used up to the Anganwadi level to track the beneficiary. It is being implemented with support of CARE in three districts viz. Hyderabad, Vizianagaram and Kurnool covering 200 ICDS projects. The Anganwadi worker enters the beneficiary wise data in a laptop at sector level using a customised software, which generates reports for the AWWs such as due list for immunisation, home visit list to vulnerable and at risk families and any other consolidations that the AWWs requires. The sector level data is uploaded to the central server where Supervisor and CDPO use the information for tracking the progress and developing action plans.

4.8 Use of ICT for Daily Monitoring of Supplementary Nutrition, Madhya Pradesh

In one district Shajapur of Madhya Pradesh, the mobile technology has been piloted to provide real time data from the Anganwadi centre. Toll free numbers are provided to report the AWC status for the day. After food distribution each AWW sends a report through SMS to respective supervisor; Supervisors in turn provide the information to CDPO and through the DPO the

report is received by the District Collector and the ICDS Director in the State. Details of daily food distribution are received from all 52 sectors in the district; replication of this model is underway.

4.9 The Rajmata Jijau Mother-Child Health & Nutrition Mission, Maharashtra

The Mission was constituted by the Department of Women & Child Development, Government of Maharashtra in 2005 with the primary objective of reducing under-nutrition amongst children in 0-6 age group. Initially the Mission was launched to combat under-nutrition in 5 districts of Gadchiroli, Amravati, Nasik, Thane and Nandurbar. Later, with effect from 1 April 2006, 10 more districts viz. Gondia, Nagpur, Chandrapur, Yeotmal, Dhule, Jalgaon, Ahmed Nagar, Pune, Nanded and Raigad were included in the scope of the Mission activities.

Focus on growth Monitoring

The first phase was completed in 2010 and the period of Mission was extended for another five years. The Mission steering Committee is headed by the Chief Minister and the Mission Implementation & Monitoring Committee works under the Chairmanship of the Minister for Women & Child Development. Mission Advisory Committee works under the Chairmanship of the Chief Secretary.

Special focus was given to (a) complete survey and enrollment of all eligible children 0-6 years (b) weighment of all eligible children (0-6 years) i.e. ensuring a weighing efficiency of 100 percent (c) identification of underweight children and provision for treatment and care of these children (d) Special attention to children below 3 years, (e) emphasis on appropriate feeding practices of pregnant women and children (f) care of pregnant and lactating women (g) care of adolescent girls (h) convergence (i) capacity building and (j) monitoring and assessment.

The Mission ensures provision of facility-based care from Child Development Centres (CDC) (set up at the PHCs and other health facilities) and community-based approaches established at Anganwadi Centres (Village Child Development Centres, VCDC).

VCDC functions with support from health and ICDS functionaries, after assessment of the child. Children who are admitted in VCDC attend sessions for 30 days. During these 30 days

three especially designed extra meals are provided to children from the AWCs in the morning and evening, micronutrient supplementation and antibiotics are also administered under the supervision of medical officers.

The Mission has now been extended beyond Mother and child care centres for prevention of under-nutrition in P & L mothers with emphasis on (a) IYCF, (b) proper feeding practices (c) diarrhoea and deworming (d) Iron and Zinc deficiency.

4.10 The Success Story of Lalitpur, Uttar Pradesh

BRD Medical College, Gorakhpur, UP conceptualised and implemented the Baby-Friendly Community Health Initiative' (BFCHI) project in Lalitpur district. The project started in November 2006 and continued up to December 2012 covering all 6 blocks i.e. Birdha, Jakhaura, Talbehat, Madawara, Mehrauni and Baar in a phased manner benefitting 951 ICDS villages.

Complementary Feeding

The overall objective of the project was to test a district-based model for promoting optimal infant and young child feeding with the view of its scaling up through the ICDS and NRHM programme. The project contributed in improving the nutritional status of children 0-2 years through optimal Infant Feeding (IYCF), immunisation of children and improved growth monitoring and promotion.

Counselling by MSG

The project adopted both centre-based and community-based strategy. At the cutting edge is a skilled Mother Support Group (MSG) comprising of AWW, ASHA, and traditional birth attendant/an active mother from the village. The mother support group together with the existing community groups worked to promote optimal breastfeeding and complementary feeding at the household-level. The trainers at the block level serve as mentors and guide for the AWW and well as to mother support group.

The MSG members were trained by middle level trainers, especially to inform and counsel mothers and provide hands-on support for early breastfeeding, correct positioning and attachment, lactational problems etc.

A total of 951 MSGs in 951 ICDS villages were formed. Each MSG consisted of 3 members; as a result total 2,853 trained MSG members were available in the whole of Lalitpur.

With the 'village level counsellors' having been close to mothers, Lalitpur has shown tremendous increase in breastfeeding rates. The percentage increase in initiation of breastfeeding within one hour of birth has gone up from 10.6 per cent (2006) to 62 per cent (2011).

Counselling by MSG

Exclusive breastfeeding for the first six months has gone up from 6.6 per cent (2006) to 60 per cent (2011). Timely and appropriate complementary feeding during 6-8 months has gone up from 53.8 per cent (2006) to 95 per cent (2011). These are much above the average of Uttar Pradesh State. This project has demonstrated convergence at village level and a heightened motivation of trainers and village level counsellors to prevent malnutrition and morbidity associated with faulty infant and young child feeding practices through skilled peer counselling.

4.11 Multisectoral approach in VHND, Tripura

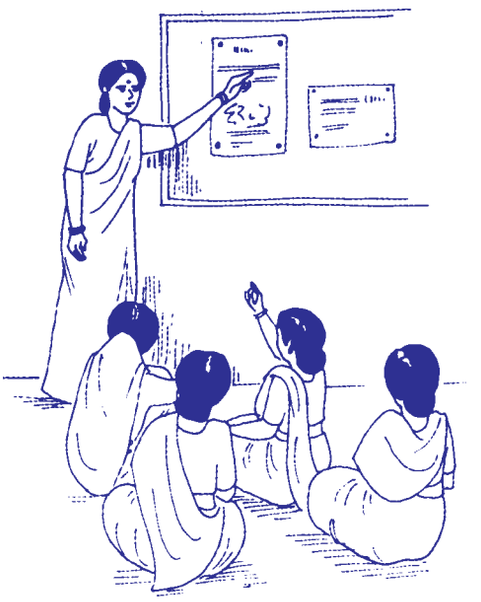
Absence of data, incidences of child deaths and difficult to reach area prompted the district administration to adopt a multisectoral approach in delivering health and nutrition services to the remote tribal village of Unakoti. Coordination was established with departments of health, ICDS, social welfare, drinking water and sanitation, rural development, panchayat and school education.

The activities are village-based and 3-4 habitations (AWCs) come together for delivering services on this day.

The funds available with various developmental schemes including ICDS, NRHM IEC and funds of other schemes are pooled together to organise VHND. The CDPO, MO, Deputy Inspector of Schools and sub divisional officers meet quarterly and decide the draft schedule

of the VHND which is approved by block level PRI body, Panchayat Samiti. VHND is organised by involving frontline workers of different sectors - AWW, ICDS Supervisor, MPW, ASHA, pump operator of drinking water department, gram pradhan, field facilitator, livelihood facilitator, youth volunteers, school head master, teacher of mid-day meal, mid-day meal cook, staff of disaster management body, district disability rehabilitation centre, awareness volunteers of district administration etc. Detailed role and responsibilities of these functionaries has been developed for ensuring proper coordination. Specific modules have been developed to train functionaries of line departments for organising various activities.

Activities organised on this day include awareness generation on 14 major illnesses, weighing of children, health check-up and small quiz for mothers and children on primary health issues and immunisation. All women, children and adolescent girls and the headmaster along with students up to class 10 attend the VHND. Programmes like blindness control, malaria eradication, tuberculosis control, AIDS prevention, disability rehabilitation, first aid during disasters are also delivered. The school health programme has also been merged with VHND and the head master has been trained to generate awareness on health issues amongst children. In order to seek larger participation of the community, cultural activities like folk dance, group songs, baby shows, sports and street drama are organised. IEC material in local language has been developed for information dissemination in the villages. Youth teams comprising boys and girls of 18 to 22 years have been trained to mobilise community. Overall monitoring is done by village panchayat. Reporting registers with duplicate perforated sheets have been supplied for data collection and for entering the same on the state web portal. The register is countersigned by gram pradhan and representatives of various other departments. Validation of the data is done by health department. The data is being put on public portal for larger dissemination. Since 2010, almost 2140 VHNDs have been organised in the district of Unakoti with the participation from 3,28,947 adults and 1,34,700 children. A total of 30,685 children have been immunised and 61,619 children weighed; also, 1,293 under-weight children have been identified and 7,019 infants administered Vitamin-A supplementation and 671 ANCs have been conducted.



4.12 Nutrition-cum-Day Care Centres (NDCC), Andhra Pradesh

Community-assisted and supervised feeding centres called NDCCs are operated in Andhra Pradesh. These centres are managed by Village organisations (VOs) who are provided one time grant of Rs 2,50,000 under Indira Kranti Patham Initiatives towards providing balanced diet (3 meals per day) to the pregnant women

and children under two belonging to beneficiary families (those enrolled as SHG members). The NDCC is managed by a team comprising of one health activist, two health sub committees members and one cook. NHED sessions are held for pregnant lactating women and children below 2 years. The cook is an SHG member and the meals are supplied by SHGs at Rs 30 per day per person.

Each VO leases 2-3 acres of land for vegetable gardening and revenue generated is used for running NDCCs. These centres help in promotion of use of green leafy vegetables and millets. Each VO and NDCC is responsible for Shram Shakti Sanghas (P&L women and women with under 2 children) at NDCCs to get 100 days of work under EGS category. The programme envisages establishing convergence with ICDS, Health and PRI Departments.

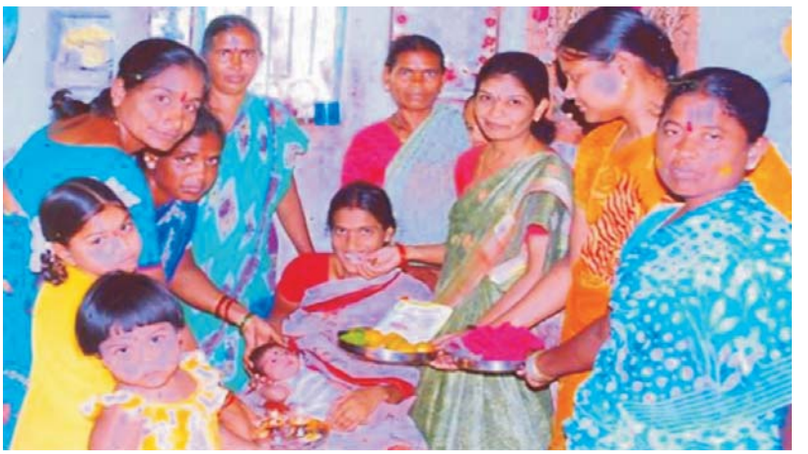
Convergence with ICDS is attained by

- Supply of ration to VOs from AWCs for beneficiaries enrolled in NDCC
- Support from AWWs for NHED sessions
- AWH may provide support as cook

Health and nutrition intervention with emphasis on Community Resource Persons, screening camps, NDCCs and MCH education sessions in NDCCs has been useful in reducing under-nutrition and improving low birth weight.

4.13 Balintadarshanam, Andhra Pradesh

In the State of Andhra Pradesh, AWW mobilises the ANM, ASHA and female PRI members to visit the households of lactating mothers so as to explain them about neonatal care, post-natal care and nutrition within 7 days of delivery. Further in order to ensure colostrum feeding within one hour of birth and to ensure exclusive breast feeding for six months and introduction of complementary feeding immediately after completion of 6th month, Cradle Ceremony and Annaprasana events are also being organised.



NHED Sessions at VHND

4.14 Gas Chullah Connections, Gujarat

Use of LPG at AWC.

In order to provide freshly prepared supplementary nutrition every day at the AWC and in order to save the AWW and AWH from harmful exposure of the smoke from 'Chulha', the States of Andhra Pradesh, Gujarat and Haryana are providing Gas Connection from the flexi funds. In the state of Gujarat, Stove and an 'Idli' cooker have also been provided at each AWC.

SECTION - E

INTEGRATED APPROACHES IN EARLY CHILDHOOD CARE

PROCESSES AND LESSONS LEARNT

5 Integrated Approaches Assisted by Development Partners

The persistent high levels of under-nutrition amongst children and women in India led to the thought that food alone cannot resolve the problem; a constellation of services and methods need to be put in place which would involve the community, policy makers and implementers and empower those at the family and grass root level.

By mid-2000 there was increased attention on Early Childhood Care for survival growth and development of children. This was a turning point and Development Partners like World Bank, Care and UNICEF were prompted to pilot some of best integrated approaches for reduction in under-nutrition through ICDS. Comprehensive strategies were designed in partnership with State Governments.

All these programmes had similar aims, that is, reduction in under-nutrition rates and contributing to decreased mortality and morbidity in children, objectives very similar to that of ICDS. Each of these programmes brought in a set of basic services, and additional interventions which included mass mobilisation, empowerment through capacity building, micro level planning, behavioural change, use of monitoring tools and action at the community level. ICDS was a ready to use platform for these pilots. Further each of these programmes was guided by a set of monitorable indicators specific to the need of the community.

These programmes have been evaluated, several lessons have emerged and the impact has been well studied, however the details of scaling up of these programmes have not been worked out.

The purpose of including this section on comparative analysis of the Community-based approaches is to evoke a response towards possible scale up of most effective components of these models through ICDS.

5.1 The Innovative Approaches

The innovative approaches enlisted are Dular strategy, Positive Deviance (PD), Anchal Se Aangan Tak (ASAT), Integrated Nutrition and Health Programme (INHP) and Tamil Nadu Integrated Nutrition Programme (TINP). Efforts are made to provide process followed against each activity within the approach. The note reviews the key activities, process and the impact of these approaches.

5.1.1 The Dular Strategy

The Dular strategy is a nutrition initiative initiated by UNICEF India in collaboration with the States of Bihar and Jharkhand. Designed to complement the government's Integrated Child

Development Services (ICDS) and build upon its infrastructure, one of the major goals of the Dular programme is to capitalise and develop community resources at the grassroots level. The emphasis of the Dular programme is on establishing a community-based tracking system of the health status of women and of children 0 to 36 months of age by neighbourhood-based local resource persons (LRPs). The main objectives of the Dular programme include increased prenatal attendance, improvement in breastfeeding and colostrum, safe delivery, improved nutritional practices and decreased under-nutrition. The strategy promotes simple low or even no-cost home-based interventions and focuses on enhancing the capacity of caregivers to nurture a person from birth through early childhood and adolescence to adulthood. Since January 2007, 'Dular' strategy has become a part of the Bihar Government's ICDS programme when it was expanded from four pilot districts to all 38 districts state-wide.

Table 5: Key programme Inputs - The Dular Strategy

Key Activities	Process
Village contact drive (VCD)	– This event consists of 2 days of training and advocacy during which the objectives of the strategy are discussed with community and information is gathered regarding local beliefs and practices related to women. This information is used to plan project activities appropriate to local conditions that are maintained over a consistent period. – The VCD uses participatory methods and demonstrations to enhance awareness and participation of the community.
Local Resource Persons (LRPs) to assist the AWW at the village level	– LRPs identified during the village contact drive collectively form a local resource group (LRGs), which meets weekly with the AWW to review progress. – Criteria for LRP selection are that she should be a resident of village, vocal, educated if possible and active. – LRGs assist AWW with distribution of THR, identification and enrolment of beneficiaries and creating awareness within the community through counselling and household visits and prove instrumental in identifying households with pregnant and lactating women. – Training of LRPs and functionaries is held at Block level using specific training tools and modules. – The LRPs participate in the "Mahila Mandal" meeting.

Key Activities	Process
Household counselling on various issues related to health and nutrition	– LRPs provide counselling to allotted households on Dular indicators- Breastfeeding (colostrum feeding within 1 hour of birth, initiation of breastfeeding, exclusive breastfeeding for six months, complementary feeding from 7th month onwards along with continued breastfeeding till child reaches 2; institutional delivery; IFA consumption; consumption of iodised salt; motivate the families for weighing and immunisation. – Dular kit consisting of 10 flash cards is used by LRPs and AWW to counsel households and for training purposes. – Dular folder depicting positive behaviours is used in counselling. – LRGs spend considerable time talking to women in an effort to educate them on new practices. – An adolescent card is provided to the adolescent girls who tracks compliance of IFA tablet and provides information on key health nutrition and hygiene issues.
Regular weighing of children and its monitoring	– Regular weighing of children is done in AWC by AWW with support of LRGs, who identify and mobilise caregivers for weighment of their children. – At household level a dular card is provided to the caregivers to monitor progress of their children.
Assessment of capacity and communication needs within the community	– A Task Force at the state level assesses and develops communication and training needs based on block and district review and report from field.
District Mobile Monitoring Training Team (DMMTT) to monitor progress and provide on the job guidance to village teams	– The members of DMMTT are CDPOs and Supervisors. – Orientation of Mobile Monitoring Training Team (DMMTT) in batches by the District Dular Team. – Monthly monitoring of centres conducted by each DMMTT member using MPR formats.

Key Activities	Process
District Support Team (DST) to improve coordination between sectors, review overall progress, and ensure effective implementation across the district	– Issues arising from the Block Coordination committee taken up in monthly review meeting of the District Support Team and block level officials under the chairmanship of District Collector convened by District Programme Officer.
Dular Cell to monitor progress of Dular and link it to overall quality improvement of ICDS	– Dular MIS is integrated in the ICDS MIS.– MIS data utilised to monitor the quality improvement of ICDS.

5.1.2. Positive Deviance Approach

The Positive Deviance Approach is based on the notion that even in poorest communities there are children with better nutritional status. These children are referred to as Positive Deviants (PD). The approach involves referring to Positive Deviants, in counselling parents of undernourished children for promoting positive behaviour amongst the families of under nourished children. The approach was pioneered for reduction of under-nutrition through ICDS in West Bengal the programme, and given a local name Kano Parbo Na (We Can Do It). Positive outcomes from pilot districts in West Bengal led to upscaling in West Bengal and its replication in Orissa. The state of Orissa adopted Positive Deviance Approach as Ami Bhi Paribhu (I Can Also Do It). Both the states have been able to reduce under-nutrition substantially and promote sustainable care practices at the family level. It enabled families to break the dependence on supplementary nutrition programme by identifying cheap, locally available nutritious food which only some families (PD) used. Under this initiative, behavioural change is emphasised through participatory learning and hands-on training of caregivers on how to prepare and feed high protein and energy meals to their children. It is characterised by 12-day regime followed by an 18-day home practice. A gain of 200-400 gm is envisaged in 12 days. Further, community mobilisation, an in-built component of the programme, has resulted in overwhelming positive response from communities in organising and participating in various

collective and creative activities at village level and emergence of motivators and champions at the grassroots level. It has also significantly strengthening linkages between key stakeholders (the community, ICDS, the Panchayat and MOH ICDS).

Table 6: Key Programme Inputs- Positive Deviance Approach

Key Activities	Process
Preparatory activities and planning	– A survey of the children in the age of group of 0 to 3 years is carried out in the village. The community members along with the AWW and supervisor participate in the survey. – During the survey, all children are weighed to identify healthy (positively deviant) and undernourished children. The survey forms the basis for selection of the village / area for the project. – A Village Social Map is prepared indicating the homes of positively deviant and malnourished children in the village. – The Community Growth Chart is maintained depicting the nutritional status of children.
Orientation of Opinion Leaders	– The opinion leaders are oriented on the nutritional status of children in their village, based on the Survey results. – A village committee is formed to oversee the programme implementation
Capacity Building	– Joint training on Positive Deviance Approach to Service Providers (CDPOs, LHVs, Supervisors, AWW, ANM, ASHA) and PRIs.
Community orientation and sensitisation	– The gravity/scale of the problem is advocated in the community. – This process is done using social map and community

Key Activities	Process
	growth chart. – This advocacy leads to community decisions to tackle the problem.
Discovering Positive deviant behaviour	– The uncommon successful practices of the positive deviant families is discovered through positive deviant inquiry (PDI) tool (a simple questionnaire). – Focus group discussion (FGD) is conducted to identify current common practices in the village.
Analysis of PDI and FGD with Community	– The AWWs and supervisors invite the community to discover the desired practices that contribute to the better growth and development of the child, decisions to conduct Nutrition Counselling and Care Sessions (NCCS) are taken herein.
Special interventions for severe and moderate Underweight children	– The Nutrition Counselling and Childcare Sessions conducted for 12 days of each month mostly at the Anganwadi centre or any other place in the village as per caregivers' convenience. – The child is weighed on the first day and again on 12th day. – Mothers/ caregivers learn care practice (feeding, hygiene, health and psychosocial practices) through learning by doing technique facilitated by AWWs and Positive deviant mothers. – Care givers learn to cook nutritious meal for the child. – The foods given are from SNP, green leafy and yellow vegetables, egg, peanuts, soyabeans etc. are contributed by caregivers and community. – Care givers feed the child on spot. – NHEDs are held emphasising about good feeding practices, health, hygiene and psycho-social care of the children. – On the 12th day the child is weighed again, the child gains 200-400 gm in these 12 days. Children failing to gain weight are referred.
Monitoring and follow-up	– Mothers/ family use Mother Child Protection Card to monitor the growth of the child. – After 12 days NCCS, mothers and caregivers follow the cooking methods and feeding, health, hygiene and psychosocial practices for the remaining 18 days of the month at their home.

Key Activities	Process
	– The AWWs and supervisors monitor the follow-up of NCCS through home visits and provide interpersonal counselling. – Children come back for a new cycle of Nutrition and Childcare Session the following month. Children continue till they graduate to Normal.

5.1.3 Anchal Se Angan Tak (ASAT)

Rajasthan State Plan of action guided by 'first call for children' has been prepared to give thrust and impart sense of emergency in enhancing status of the girl child so that there is discernible reversal in the deteriorating sex ratio, increase in age of marriage and better opportunities for her education and development. In keeping with requirement ASAT was conceptualised.

ASAT was an integrated early child development (IECD) programme, supported by UNICEF and Implemented in seven districts of Rajasthan. It aimed at improving child survival, growth and development. The rationale was to improve the nutritional and health status of children below 3 years, pregnant and nursing women, and adolescent girls through behavioural change in care practices at the family and community level. The life cycle approach was adopted to improve the health, nutrition and psychosocial status of children with special focus on children under 3 years of age, pregnant and nursing mothers, and adolescent girls. The strategies included advocacy, community mobilisation and participation, capacity building of functionaries, caregivers and community members. Joint training programmes were conducted for all the anganwadi workers (AWWs) and auxiliary nurse-midwives (ANMs) of the seven districts. Gram Sampark Samoohs (GSSs), each comprising 18-25 members had been organised in the villages and urban slums. The GSS was a link between the community and the AWW and provided assistance to the AWW in conducting the activities of ICDS programme. Kishori Balika Mandals and Self-Help Groups have been organised to impart such skills to women and girls that can later be utilised for income generating activities. Family-retained 'Mamta card' was used for tracking health and nutrition status of the children and pregnant mothers; it was also used for educating the mothers and family on child development and age appropriate feeding.

Table 7: Key Programme Inputs- Anchal Se Angan Tak (ASAT)

Key Activities	Process
Community mobilisation and participation	– Formation of Gram Sampark Samoohs (GSS) per AWC. – AGSS comprised of 18-25 members. Each GSS member was responsible for 15-20 households at village level. They reviewed the progress of activities and prepared plan of activities for next month with the anganwadi worker (AWW), the anganwadi helper (AWH), the local teacher and the representatives of PRI in the village. – GSS coordinated the activities, which included registration of children and pregnant women, mapping of the area/village to identify and focus on households with malnourished/sick children, demonstrations for preparing complementary food for young children, preparation of ORS solution, weighing children below 2 years of age, growth promotion and use of media/puppet shows to impart knowledge on IECD. – The GSS provides information about on going and forthcoming events. – Competitions such as mehndi, acting and poems were conducted to stimulate cohort learning and participation. – Self-learning process introduced through community-based organisation as mahila mandals and Kishori balika mandals in their respective meetings.
Household counselling on various issues related to health and nutrition	– The home visits and home-based counselling of women and families was conducted by AWW, AWH and GSS with use of IEC.
Mother and Child Health and Nutrition Day (MCHN)	– Held at the AWC and facilitated by the ANM and AWW with assistance from the Sahyogini.
Fixed weighing and counselling day	– Day was fixed one week prior to the MCHN day. – Held at the AWC and facilitated by the ANM and AWW with assistance from the Sahyogini.

Key Activities	Process
Advocacy	– Use of folk media to communicate mother and child care. – Mass media such as All India Radio (AIR) and Doordarshan were used to communicate messages on health and nutrition issues. – Use of local dialect.
Training and Capacity Building	– District and Block Level functionaries capacitated on importance and modalities of implementing IFA supplementation, safe delivery and self-hygiene. – PRIs and SHGs trained on health nutrition psychosocial issues and monitoring indicators of child development. – Primary School teachers trained on importance and methods of providing IFA supplementation to school going adolescent girls. – GSS conducted capacity building of the target families and communicating the nutrition and health messages of the Mamta cards.
Empowerment of women and adolescent girls	– IEC material had been developed and animators, AWWs and anganwadi helpers were trained to use this material for counselling women and care givers. – Adolescent girls were also trained.

5.1.4 Integrated Nutrition and Health Programme (INHP)

The initiative focussed on what mothers can do to safeguard their families' health, such as practicing good hygiene and nutrition. The programme augmented support to ICDS and RCH programmes with additional interventions to support improvements in maternal and child health and nutrition services, behaviours and outcomes, such as promotion of antenatal care and neonatal care, breastfeeding, complementary feeding and child nutrition, family planning, nutrition and health education. INHP-II was built upon a three-decades-long relationship between CARE-India and the ICDS programme, and was designed to address child health and nutrition at scale, with the objectives of helping reduce malnutrition and mortality in children. It adopted a two-track approach – supporting service providers to improve the quality and coverage of MCHN services and systems and engaging communities to support better infant feeding and caring practices and sustain activities for improved maternal and child health and survival.

The organisational structure of INHP-II was designed to provide opportunities for engaging the ICDS and RCH programme at sub-district, district, state and national levels. Beginning with a set of best practices from INHP-I, the project used a demonstration-replication approach. This involved local partnerships with NGOs for demonstrating the implementation of these best practices, which were then taken up by ICDS and RCH programme functionaries for similar implementation in the rest of the project area.

The implementation was facilitated by small programme teams of CARE, located at the district, state and national levels, and working closely with the functionaries of the ICDS programme and the programme of the MoHFW, and with a range of partners, including local NGOs and Community-Based Organisations (CBOs). The project worked through 7,700 anganwadi centres in eight states: West Bengal, Orissa, Bihar, Uttar Pradesh, Rajasthan, Andhra Pradesh, Chhattisgarh and Madhya Pradesh.

Table 8: Key Programme Inputs- Integrated Nutrition and Health Programme

Key Activities	Process
Antenatal Care	– Focus on improving birth outcomes through existing interventions like immunisation, IFA supplementation, monitoring of weight gain and abdominal check-up
Nutrition Essentials	– Package of critical nutrition interventions like Health and nutrition education, IPC, growth monitoring, promotion of infant and young child feeding – Education
Immunisation	– Fixed Day NHED was initiated to strengthen immunisation and tracking mechanism
Food supplements	– Providing the in-kind commodity i.e., corn-soya blend (CSB) and refined vegetable oil (RVO)
Involvement of Change Agents / Reproductive health Change agents	– Change agents selected from the community were responsible for monitoring and mobilising 15 – 25 households with the support of AWW

Key Activities	Process
Community-Based Monitoring System (CBMS)	– Locally designed individual self-monitoring tools and use of social mapping to track caring practices and service utilisation
Block level resource mapping (BLRM)	– A process of programme review and action by functionaries at block level using the social map
Nutrition and Health Day (NHD)	– Every month fixed day where take home rations are distributed and ANM visited the AWC to offer health services
Demonstration sites	– In partnership with local NGOs, model sites called demonstration sites in 10% AWCs were created where programme implementation could be demonstrated and then replicated in other sites
Strengthening Supply Chain Management	– Streamlining supplies/distribution of Supplementary nutrition
Community outreach and mobilisation	– Efforts at involving communities including change agents/ CBOs/ PRIs in monitoring and supporting behaviour change activities
Capacity Building	– Capacity building had three components – technical content, process skills and motivation. Besides formal training, it included non-training inputs such as cross-visits, joint programme reviews, supportive supervision and on-going capacity building through review meetings. – All INHP staff, system functionaries, NGO functionaries including government staff participated in structured training programmes. – On-going learning mechanism was followed and informal training was imparted at sector meetings.
Behavioural Change Communication	– Formative research conducted in the initial across states, helped identify barriers in different socio-cultural contexts, this was useful in the development of culturally appropriate communication for different contexts. – Efforts were made to work with other stakeholders to get consensus on the key messages and avoid any duplication.

Key Activities	Process
	– Use of multiple channels of communication, including mainly, interpersonal communication.
Programme monitoring	– A brief set of indicators was reported monthly from every AWC. – Rapid assessments conducted in panel of districts. – HMIS collated at central level.
Addressing gender and social inequities	– Disaggregated data analysis. – Improved inclusion and tracking systems. – At the community level, the programme also integrated gender and equity dimensions into capacity building, BCC activities and the best practices.
Focussed Supervision and Home Visits on Critical Life Cycle Interventions	– Simple tools and checklists were drawn up for supervisors, again using early versions already in use elsewhere in the programme. – Home visits diary maintained by AWW.
Synergising Efforts at the Sector Level	– The NGO staff supported the sector supervisor as well as the CDPO and coordinated with district team in conducting effective sector meetings and field visits until they learnt to do it on their own.

5.1.5. Tamil Nadu Integrated Nutrition Programme (TINP)

The programme was implemented in Tamil Nadu in two phases.

Phase I

The overall goal of the project was to improve the nutritional and health status of preschool children, primarily those 6-36 months old and pregnant and nursing women. For this purpose, a package of services was provided: nutrition education, primary health care, supplementary on-site feeding of children who were severely undernourished or whose growth was found to be faltering, education for diarrhoea management, administration of vitamin A, periodic deworming and supplementary feeding of a limited number of women. A principal characteristic of this project was the use of growth monitoring through monthly weighing of all children 6-36 months old to target delivery of these nutrition and health services to needy children and to

serve as an educational device for mothers. Indeed, this project was the first large-scale use of growth monitoring for this purpose. Project funds were utilised, among other things, to establish, equip and operate some 9,000 Community Nutrition Centres (CNCs) and 2,000 new health sub centres in 173 of Tamil Nadu's 373 rural blocks (an administrative unit covering a population of about 100,000).

Phase-II

Phase-II was designed to cover, in a phased manner, 316 of the total 385 rural blocks in Tamil Nadu, with an estimated total population of 32.8 million. The target group had been extended to encompass young children from birth until six years of age (as against 6-36 month old children in Phase-I). Further, in recognition of the duplication (geographic and age-group) of the services of Phase-I and the Noon-Meal Programme (NMP), Phase-II merged Phase and NMP centres, to promote complementarity. Phase-II centres were opened in select non-Phase-I areas, while existing Phase-I centres were simultaneously converted to Phase-II centres. TINP blocks were converted to ICDS depending on governmental allocations for ICDS. A total of 9194 Community Nutrition Centres functioned under Phase-II, covering 98 new blocks, over and above the 177 Phase-I blocks. An additional 5257 centres were opened in the new phases. An IDA loan of US $ 95.8 million spread over an eight-year project implementation period (1991-98) was approved for the second Tamil Nadu Nutrition Project. The specific objectives of Phase-II include:

- Reduction of severe malnutrition among 0-36 month old children by 50% in new project areas, and 25% in Phase-I areas;
- Increasing the proportion of children classified as 'normal' by 50% in new and 35% in Phase-I areas;
- Contribute to a reduction in infant mortality to 55 per thousand live births;
- Contribute to a 50% reduction in incidence of low birth weights.

The new Phase-II design included preschool education, and was less selective in identifying beneficiaries for supplementary feeding. Both features bring the TINP design closer to that of the ICDS. Further, the field-worker: supervisor ratio has also been reduced (from 10:1 in Phase-I to 15:1 in Phase-II) making it akin to the 25:1 ratio followed in the ICDS. There are some indications that much of the uniqueness of TINP design is being lost in this apparent shift towards the ICDS.

Worker training seemed to be lagging behind TINP-II phasing-in, so that in many of the newer project areas, the essence of TINP-I is missing. Without the planned training, there were several anomalies relating to the duties of the NMP worker and the TINP worker who have simply been instructed to function from the centre. The two workers were not clear about the demarcation of duties, and/or the changes in the objectives or design of the TINP.

Table 9: Key Programme Inputs- Phase I & Phase II

Key Activities	Process
TINP I	
Supplementary nutrition	– Supplementary nutrition was provided to grade 3 and 4 and those children faltering for 3 consecutive months. – All children in grade 3 and 4 fed double ration *(Selective targeting).*
Nutrition education	– For 10 Community Nutrition Worker (CNW) there was 1 Community Nutrition Supervisor (CNS) and for 4-7 CNS there was 1 Block community nutrition Instructor. – CNS and CNW had two months pre-service training.
Growth Monitoring	– Mother linked child health card used record child health status. – Each month, CNWs generated a set of management information which was publicly displayed for their own and the community's use on a blackboard on the outside wall of the CNC. – Community growth charts also displayed on the CNC wall.
TINP II	
Programme design	– Emphasis on service delivery, fixed day service. – Emphasis on coordination between health and nutrition sectors. – Training plan modified.
Target Group	– 0-60 months, increased outreach and coverage.
Amalgamation of TINP programme with the State's Noon Meal Programme	– Combining TINP and NMC where both existed. – Addition of a Community nutrition worker in NMP centres (two-worker model).
Expansion of Community nutrition centre network	– Physical investment, developing new centres in un-served areas.
Communication strategy	– Emphasis on the communications component, with special attention to developing and operationalising a specific communications strategy.

5.2. Lessons Learnt from integrated packages

The processes followed in each initiative suggest certain common factors elemental in success of the programme. The factors distilled from the note relate to mostly programme specific factors. These factors had been inbuilt in programme design, content and its management in differential ways in each of the integrated initiatives. Obviously not every factor is required for a programme or project to work but those below serve as a useful checklist of desired characteristics for a community-based initiative. An exhaustive list of factor wise processes is provided in Annex A.

5.2.1. Process leading to Programme Development

- Conducive policy environment - Each of the initiatives was supported by the ICDS mechanisms in village, block, district and state level.

- Assessing and analysing nutrition situation - Most of the initiatives conducted social mapping to assess and analyse child and mother health situation in the intervention areas. Besides this Positive Deviance conducted survey of all the children and ASAT followed triple A process of assessment, analysis and action.

- Selection of an entry point – Most of the initiatives are addressing priority problems such as strengthening ICDS delivery and providing education on care of mother and child health.

5.2.2. Programme Design and Content

- Growth monitoring and promotion - It had been one of the key component of all the initiatives. Dular, ASAT, INHP, and TINP promoted facility-based growth monitoring and promotion in VHNDs whereas Positive Deviance facilitated community-based growth monitoring and promotion in NCCS. The GMP was linked with adequate counselling and feedback to the caregivers and actions. In PD a community-based feeding is conducted in response to information collected whereas in other initiatives-facility based action is upheld.

- Nutrition Education – Nutrition education is provided in all the initiatives by field level functionaries mostly through household counselling sessions and also during NCCS in Positive Deviance.

- Adopting Inter-sectoral approach – In all the initiatives health-related interventions such as immunisation, promotion of institutional delivery, IFA supplementation was quite apparent.

- Advocacy – In all the initiatives local groups/change agents/ community nutrition worker in TINP were responsible for advocating the programme strategies related to health and nutrition within the community.
- Improving care of women and children – More emphasis was given on care of children. Care of mothers was limited to facility-based ANC and PNC at AWC or health centres.
- Capacity Development and Training – In all the initiatives training was one of the key components. Training was conducted for all stakeholders at all levels using participatory methodologies. In INHP (later phases) training was done in an informal environment as Sector level meetings.

5.2.3 Programme Management and Implementation

- Community involvement – Community involvement was sought in problem identification, planning and implementation in all the initiatives through tools such as social mapping, resource mapping, survey, and community growth charts etc.
- Social Cohesion – Community-based groups suchas LRGs/ Gram sampark samuhs/ were formed for the initiatives in the intervention areas.
- Collaboration – These initiatives were run in collaboration with the ICDS delivery systems.
- Staffing and their remuneration – At village level except for the AWW and CNW all other persons involved were unpaid volunteers who were remunerated for travel out of the village for programme purposes. These personnel were provided trainings to function at the community level.
- Information sharing – This was facilitated vertically through group meetings and horizontally through passing out of information in prescribed templates as well as sector level meetings.

5.2.4. Sustainability

Positive Deviance demonstrated strong sustainable mechanisms involving community and SHGs respectively in identifying, analysing, and devising plan of action at the local level.

5.2.5. Scaling Up

Positive deviance is one amongst all the initiatives that can be scaled up in short time span as minimal risks adhering to it.

5.2.6. Impact on under-nutrition

As cited in Annex B, except in INHP, the initiatives reported statistically significant decline in weight for age, height for age and weight for height.

Comparison of Common Features and Characteristics of Integrated Approaches

Characteristics	Dular	Positive Deviance	ASAT	INHP	TINP
1. Contextual Factors					
Policy environment	Universalised ICDS scheme for all children under 6 and P& L mothers				
Assessment and Analysing nutrition situation	Training and advocacy during Village Contact Drives	Village survey and Weighment of all children, Analysis of nutritional Status of children through Triple A approach Analysis of positive deviant behaviours and common practices	'Triple A' process followed by Gram Sampark Samuh	Community-based monitoring systems, Block level resource mapping	Mother-linked child health cards
Selection of an Entry point	Feeding behaviours, deliveries, consumption of IFA and Iodised salt, weighing and Immunisation	Feeding practices, emphasis on health hygiene and psychosocial care of children	IFA supplemen-tation, safe delivery, personal hygiene, health, nutrition and psychosocial care	Immunisation, food supplements	Supplementary nutrition to target children, nutrition education, growth monitoring

Characteristics	Dular	Positive Deviance	ASAT	INHP	TINP
2. Programmatic Factors					
Growth monitoring and promotion	Regular weighing of children done in AWC by AWW with support of LRGs, who identify and mobilise caregivers for weighment of their children. At household level a dular card is provided to the caregivers to monitor progress of their children.	Growth Monitoring is the basis of the approach. Weight gain is monitored in every session. Mother Child Protection Card used Community Growth Charts used to display nutritional status of children.	On MCHN day children are weighed. It is held at the AWC and facilitated by the ANM and AWW with assistance from the Sahyogini.	During Fixed NHDs	Done at NHDs Mother-linked child health card used record child health status Each month, CNWs generated a set of management information which was publicly displayed for their own and the community's use on a blackboard on the outside wall of the CNC Community growth charts also displayed on the CNC wall
Nutrition education	LRPs provide counselling to allotted HHs on dular indicators. Dular kit consisting of 10	The Nutrition Counselling and Childcare Sessions conducted for 12 days Learning by doing technique is	Home visits and home-based counselling of women and families conducted by AWW, AWH and	Nutrition Education given on FNHD. AWW and change agents responsible for it	At the centre level the Community nutrition training sessions at the centre or SHG level with the support of volunteers from

Characteristics	Dular	Positive Deviance	ASAT	INHP	TINP
	flash cards was used by LRPs and AWW to counsel households Dular folder depicting positive behaviours was used in counselling.	used. Discussions are held about good feeding practices, emphasis also given on health, hygiene and psycho-social care of the children.	LRGs with use of IEC.		among the SHGs and CNWs.
Advocacy	In Village Contact Drives	The opinion leaders oriented on nutritional status of children in their village based on complete weighment. The scale of the problem is advocated in the community using social map and community growth chart.	Use of folk media and local dialect to communicate mother and child care. Mass media such as All India Radio (AIR) and Doordarshan was used to communicate messages on health and nutrition issues.	In partnership with local NGOs developed demonstration sites in 10% AWCs where programme implementation could be demonstrated and then replicated in other sites. First few months in a handful of sites to give	None

Characteristics	Dular	Positive Deviance	ASAT	INHP	TINP
				field teams hands on learning opportunities.	
Improving care for women and children	Emphasis on breastfeeding, institutional delivery, consumption of IFA and iodised salt, weighment and immunisation	Care of under nourished children through counselling on improved care practices- feeding health, hygiene and psychosocial.	Care of children through weighing, demonstration of complementary feeding and counselling Care of women through counselling and training of adolescent girls.	Counselling by AWW and care of women and Change agents.	Care of selective children by providing double ration. Care of all children through growth monitoring and Promotion.
Capacity development	Systematic training sessions with specific training tools and modules used to train all functionaries and LRPs at Block level	Joint training to Service Providers (CDPOs, LHVs, Supervisors, AWW ANM, ASHA) and PRIs Training of local groups and committees	District and Block Level functionaries capacitated on importance and modalities of IFA supplementation, safe delivery and self-hygiene. PRIs and SHGs trained on health, nutrition, psychosocial	Capacity building had three components – technical content, process skills and motivation. Besides formal training, it included non-training inputs such as cross-visits, joint programme	Institutional training of village workers and job training by Community Nutrition Instructor

Characteristics	Dular	Positive Deviance	ASAT	INHP	TINP
			issues and monitoring indicators of Child development. Primary School teachers trained on importance and methods of providing IFA supplementation to school going adolescent girls. GSS conducted capacity building of the target families and communicating the nutrition & health messages of the Mamta cards	reviews, supportive supervision and on-going capacity building through review/sector meetings All INHP staff, system functionaries, NGO functionaries including government staff participated in structured training programmes	
Convergence and Intersectoral approach	With Health	With Health and PRIs	With Health	With Health	With Health

Characteristics	Dular	Positive Deviance	ASAT	INHP	TINP
3. Programme Manage					
Community involvement and mobilisation Community Monitoring tools	LRPs should be residents of village, vocal, educated and active. Collectively they form a local resource group, LRGs which meets weekly with the AWW to review progress LRGs assist AWW in distribution of THR, identification and enrolment of beneficiaries and creating awareness within the community through counselling and household visits.	Opinion leaders are oriented on the approach; Village health committee is formed from the local residents of the village. This committee assists the AWW and oversees the entire programme. The committee helps to prepare village maps indicating the houses of the positively deviant and malnourished children in the village and tracking of children for immunisation, growth monitoring follow-up of	Gram Sampark Samooh (GSS) per AWC comprised of 18-25 members. Each GSS member was responsible for 15-20 households at village level. GSS coordinated the activities, including registration of children and pregnant women, mapping of the area/village to identify with malnourished/ sick children, demonstrations for preparing complementary food, preparation	Change agents (CA) that focus on 15–25 households working with the support of AWW. They were selected by community members.Use of social map to ensure representation of CA from all pockets of village. Efforts at involving communities including change agents / CBOs / PRIs in monitoring and supporting behaviour change activities. Social Maps, Wall Paintings,	None Mother-linked Child Health Card

Characteristics	Dular	Positive Deviance	ASAT	INHP	TINP
	They are instrumental in identifying households with pregnant and lactating women. Dular Card, adolescent Cards	undernourished etc. Positive deviant mothers act as local resource persons at the 12 day counselling session. Community Orientations are held to create awareness on under-nutrition. Community growth Chart, Village maps, PD Mascot, MCPC	of ORS, weighing children below 2 years of age and use of media/ puppet shows to impart IECD. Competitions such as on mehndi, acting and poems were conducted to stimulate cohort learning. Self-learning process introduced at meetings of mahila mandals and Kishori balika mandals; Mamta Card	Individual tracking mechanisms	
Social cohesion	Local Resource Groups	Village Health Committee	Gram Sampark Samuh	Change Agents	None
Collaboration with other programme	ICDS and Health	ICDS, Health and PRI	ICDS and Health Education	ICDS, Health and PRIs	ICDS and State Noon meal Programme

Characteristics	Dular	Positive Deviance	ASAT	INHP	TINP
Staffing	Block coordinators District support team (DST) Dular Cell at state level	Utilised the ICDS and health personnel at various levels Block and District coordinators in some Districts.	Utilised the ICDS and health personnel at various levels.	Support staff (technical and programme) at district state and national levels	Additional Community nutrition worker ateach centre, Community nutrition supervisor for 10 CHW and Block level community nutrition lady instructors
Information sharing at all levels	District Monitoring Team monitors the progress of the centres using MPR formats and provides guidance to village teams. Block coordinator visit centres and collects monthly MIS and shares it with District team.	Dular Cell Block level coordination committee shares information in District level review meeting.	NCCS results displayed at each AWC and shared with community MPR of NCCS provided to CDPOs and DPOs Data analysed at District level	None	A brief set of indicators was reported monthly from every AWC. Rapid assessments conducted in select panel of districts. HMIS collated at central level. Mother-linked Child Health Card at Centre level Village MIS displayed by CNW on CNC blackboard Community growth chart displayed on CNC wall

Characteristics	Dular	Positive Deviance	ASAT	INHP	TINP
Sustainability	The approach is sustainable as capacity of local resource persons are built	The approach tries to find solution from within the community hence it is practically sustainable	Depends on Convergence mechanisms between Health Department, NGOs and ICDS. The Gram Sampark Samooh needs to be organised and consolidated for effective functioning.	As community ownership was not sought within the programme sustenance after NGO withdrawal led to collapse of the mechanisms.	The approach is selective targeting with less emphasis on community ownership.
Scale up	Dular is a low cost replicable strategy, which emphasises systematic involvement of the family and community and channelises their effort and resources towards proper	Replication is possible as recurring costs are low; Up scaling can be done in short duration	Replication of capacity building inputs for the Gram Sampark Samoohs, PRIs, SHGs and district and state level functionaries involves recurring costs	Capacity building plans provide a fairly robust mechanism of scaling up. In Demonstration sites, the NGO staff tended to marginalise the role of workers of ICDS and RCH.	The approach was gradually translated into ICDS.

Characteristics	Dular	Positive Deviance	ASAT	INHP	TINP
	development of the child			The self-monitoring tools were scarcely used as it was process intensive. Low scope of mid-course correction changes	

Annex B

Comparative Analysis of Impact on Malnutrition

Dular	Positive Deviance	ASAT	INHP	TINP
Malnutrition rates (underweight) reported between the Dular and non-Dular villages as 55.5% vs. 65.4%	Overall prevalence of stunting was significantly lower (p<0.01) in PD area (26.5%) compared to control area (32%). Prevalence of underweight (45.6%) and stunting and (25.2%) was significantly lower (p<0.01) in the PD area compared to control area (63.2% and 37.4% respectively) in children aged 12-17 months. ***Weight for Age*** In general, the proportion of children with underweight (weight for age < Median-2SD) was about 43% in PD areas and 45% in control area, while that of severe underweight (weight for age <Median –3SD) was about 11% and 12% respectively.	Frequencies of WHO WHZ scores by district Z score WHZ>-0.99 35.6% ASAT and non-ASAT 38.5% -2.99 <- WHZ<-2.00 ASAT 21% and non-ASAT 20.2% WHZ<-3.00 ASAT 6.7% Non ASAT 4.6% (p=0.314) Frequency of WHO HAZ scores by district WHZ>-0.99 ASAT 31.8% and non-ASAT 26.1% and -2.99<-WHZ<-2.00 ASAT 20% non-ASAT 26.3% (p value 0.002 level of significance) Frequencies of WHO WAZ score by district WHZ>-0.99 ASAT 22.1% non-ASAT 19.7% -2.99<-WHZ<- ASAT 26.% non-ASAT 28.1% (p value 0.636) Frequencies of NCHS WHZ scores by district Z score	**Child malnutrition did not decrease** In AP, incidence of underweight increased from 25.7% to 29.2% in the intervention area and from 28.5 to 30% in control. In UP, incidence of underweight increased from 36% to 41% in the intervention area and from 36% to 38% in control However a pre-post evaluation across 8 states saw an 8 percentage point decrease in underweight among young children over 5 years. Decrease from	The mean weight of 6 months old in 1990 are 360 g heavier than in 1982 (6.5% gain in weight). At 36 months age the weight difference from 1982 to 1990 was 650 g (6.2% gain in weight). These differences were statistically significant in all monthly ages between 6 and 36 months. Percentage of children below -2SD of NCHS decreased by 10.12 percentage points between 1982 and 1990.

Dular	Positive Deviance	ASAT	INHP	TINP
	The prevalence of underweight in the age group of 12-17 months in PD area was significantly low (p<0.01), compared to control areas ***Height for Age*** The extent of overall stunting (Height for age<Median-2 SD) children was significantly lower (p<0.01) in PD area (26.5%) as compared to control area (32%). The prevalence of severe stunting (height for age <median–3SD) was about 7% and 10% in PD and control areas respectively. ***Weight for Height*** About 14% of the children in PD and 12% in control area were wasted (for height <Median-2SD).	WHZ>-0.99 ASAT 31.9% and non-ASAT 36.0%, -2.99 <- WHZ<-2.00 ASAT 21.3% and non-ASAT 20.1%, WHZ<-3.00 ASAT 6.7% non-ASAT 4.6% (p value 0.276) Frequency of NCHS HAZ scores by district WHZ>-0.99 ASAT 35.4% and non ASAT 28.2% and -2.99<-WHZ<-2.00 ASAT19% non-ASAT 28.7% (p value of 0.001 level of significance) Frequencies of NCHS WAZ score by district WHZ>-0.99 ASAT 20.5% non-ASAT 17% -2.99<-WHZ<- ASAT 30.8% non-ASAT 36% (p value 0.124) Weight for height Z score means WHO WHZ ASAT -1.42 SE 0.039 non-ASAT -1.31 SE 0.038 (p value 0.044); NCHS WHZ ASAT -1.37 SE 0.033 non-ASAT -	61% to 53% (> -2 Z scores) Mean weight for age Z score (WAZ) among children 12-17 months (UP: baseline -2.00 and end line -2.20, AP: baseline -1.66 and end line -1.84) in intervention and in control (UP: baseline -2.09 and end line -2.10, AP: baseline -1.88 end line-1.88 and difference of -0.19 in UP and - 0.18 in AP)	Nutritional Status: Severe Malnutrition - declined by a third and a half among children 6-24 months and by about half among 6-60 months. Moderate malnutrition decreased by 14% in the 1st project area and increased in the area in 2nd and 3rd phases. Independent survey-severe malnutrition declined by 44% over 5-year period. Moderate malnutrition in new areas (where TINP1 was not being implemented) saw a 23% reduction.

Dular	Positive Deviance	ASAT	INHP	TINP
		1.27 SE 0.032 (p value 0.036) Height for age Z score means WHO HAZ ASAT -1.63 SE 0.071 non-ASAT -1.92 SE 0.059 (p value 0.002); NCHS HAZ ASAT -1.48 SE 0.063 non-ASAT -1.73 SE 0.054 (p value 0.003) Weight for age Z score means WHO WAZ ASAT -1.91 SE 0.049 non-ASAT -2.02 SE 0.045 (p value 0.117); NCHS WAZ ASAT -1.98 SE 0.046 non-ASAT -2.08 SE 0.041 (p value 0.104)		

Source: Evidence Review Growth Monitoring and Complementary Feeding July 2007

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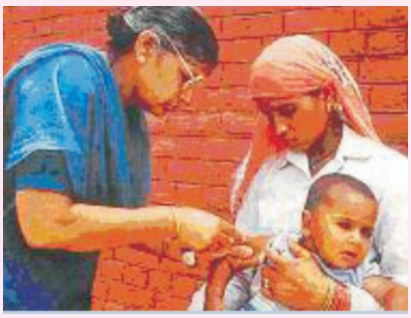
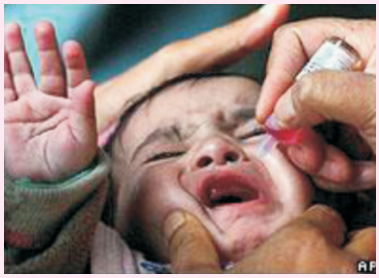
SERVICES OFFERED

HEALTH CHECK-UP



REFERRAL SERVICES

IMMUNIZATION



SUPPLEMENTARY NUTRITION

NON FORMAL PRE-SCHOOL EDUCATION

NUTRITION AND HEALTH EDUCATION