POSHAN
Led by IFPRI
Partnerships and Opportunities to Strengthen and Harmonize Actions for Nurition in India
Implementation Note
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The Health Subcenter as an Effective Platform for Coordinated Capacity Building and Supportive Supervision of Frontline Workers

BACKGROUND

In India, the Department of Social Welfare, Ministry of Women & Child Development oversees programs for the holistic development of women and children. Among these programs is the Integrated Child Development Services (ICDS) program, which provides informal preschool education and supplementary nutrition for pregnant and lactating mothers and children under 6 years old. Other elements of ICDS include health and nutrition education for mothers and children, support for immunization, referrals for illnesses, and growth monitoring of children. At the village level, ICDS is represented by the *anganwadi* worker (AWW) and her assistant, an *anganwadi* helper. Ministry norms stipulate one *anganwadi* centre (AWC) for a population of 1,000 in most places, or 700 in tribal areas.

The goal of the Department of Health, Ministry of Health and Family Welfare is to ensure universal access to quality health care. The unit of the ministry closest to the community is the subcenter, which is staffed by an auxiliary nurse midwife (ANM) and covers an average population of 5,000 (about three to five villages). The subcenter offers a mix of center-based and field outreach services, particularly primary health care interventions focused on maternal and child health.

Under the Department of Health is the National Rural Health Mission (NRHM), which was established to strengthen the health care delivery system with a focus on the needs of the poor and vulnerable sections among the rural population. One of the main tenets of the mission is to identify one accredited social health activist (ASHA) per 1,000 people in the rural areas, with the purpose of supporting the community to access public health services. The ASHA is expected to create awareness of maternal and child health and nutrition, mobilize the community toward local health planning, and increase utilization of the existing health services.

Given the range of frontline staff in ICDS and NRHM, and their complementary aims, the health subcenter represents an optimal geographical and demographic unit for health and nutrition programs to target specific outcomes through nutrition-specific interventions. It is a natural platform for convergence among staff of both the Department of Health and the Department of Social Welfare.

Since 2011, CARE India, through its Integrated Family Health Initiative (IFHI), has been facilitating such convergence in Bihar. IFHI is a 5-year initiative (2011–2015) that was launched in all 137 blocks of eight districts within Bihar, and supports the government in scaling up activities to the remaining 30 districts of Bihar in 2013. IFHI supports the improvement of outreach and facility-based services through maximizing collaboration between the Department of Health and Department of Social Welfare, and promotes evidence-based interventions to enhance health and nutrition outcomes.

One of the goals of IFHI is to maximize both the effectiveness of frontline workers in promoting specific health and nutrition practices, and the coverage of essential preventive services at the family level. In support of this effort, the initiative began instituting monthly meetings among frontline workers at subcenters in Bihar. Each subcenter caters to approximately 10,000 to 12,000 people.

APPROACHES AND METHODS FOR COLLABORATION

CARE learned from its previous experience in the Integrated Nutrition and Health Project (1996–2010) that the crucial lever for covering essential preventive services at the family level was name-based tracking and AWW home visits to families with mothers and children during the "window of opportunity" (i.e., between pregnancy and the first 2 years of the child's life). They also learned that the AWW needed supportive supervision to achieve this.

At the outset of IFHI, most of the positions of supervisors in ICDS were vacant, and the only regular link to ASHAs and AWWs were the ANMs, who visited each AWC once a month for the routine immunization day. Thus, it was decided to use the ANM to provide much-needed supportive supervision of the ASHA and AWW. It was felt that by encouraging the two frontline workers to work in tandem under a common supervisor, there would be high potential for achieving better outcomes in maternal and child health and nutrition.

The only existing opportunity for supervisory interactions between the ANM and the ASHA/AWW was the immunization day or the village health, sanitation, and nutrition day each month. An additional opportunity was created at the subcenter, where the ASHA and AWW would come together under the technical supervision of the ANM during scheduled monthly meetings. IFHI staff obtained departmental approvals for using this platform across the eight project districts and is now using this as a primary mode of engaging frontline workers on a regular basis for program planning and review and capacity building. IFHI staff provides home visit planners to the ASHAs and AWWs to track all targeted women and children. ICDS began recruiting lady supervisors (LSs) in 2010, who now join the ANMs as joint facilitators of the monthly subcenter meetings.

The time required to cover all basic health and nutrition topics is about 18 monthly meetings, which could take about 2 years to complete in practice, due to predictable interruptions. The sequencing of topics is entirely a matter of what the department considers a priority.

The agenda for each monthly 2–3-hour meeting is designed to allow for incremental learning and consists of three sequential parts: program implementation review, facilitated discussion of a new topic, and a negotiated action plan. The objective is to structure the "how" of the full range of tasks expected of the AWW/ASHA into a series of 45-minute "packets," each being small enough to easily understand and execute. Each packet in the monthly meeting consists of a facilitated discussion about the current status of a particular health or nutrition behavior or service in the community, challenges, and options for improvement. Typically, each monthly meeting covers two such packets. Where appropriate, role playing or practical demonstrations are included to illustrate how to bring about change. There is a demonstration of how to use the home visit planner to identify the mothers and children in the target age group, how to use the appropriate interpersonal communication tool to enhance effectiveness of the conversation aimed at behavior change, and how to correctly use the data tool (various service registers) to improve service coverage. Each meeting ends with a simple set of agreed-upon actions that the frontline workers are expected to start implementing after the meeting. At the beginning of the subsequent monthly meeting, the previous actions are reviewed before introducing new content for that month.

The ANM and LS facilitators are expected to review the implementation of negotiated actions by the frontline workers during their routine field visits over the subsequent month, and to bring their field observations to inform the implementation review at the next month's meeting. IFHI paid for an external co-facilitator in the eight districts to build the facilitation skills of the ANM and the LS to guide this work. The ANM and LS are separately engaged at least once a month at the block level for more than 3 hours in a meeting designed to review the previous month's implementation and prepare the next month's agenda. These meetings are currently facilitated by CARE's block-level project staff, with a built-in process of handing over facilitation to program leaders of the respective departments over time.

In Bihar, the topics covered in this manner in the first 15–18 months of implementation, starting May 2012 in eight districts (about 2,300 subcenters), included infant and young child feeding, maternal care, newborn care, family planning, and immunization. Joint communications issued by the Department of Health and the Department of Social Welfare formalized the initiative and are, in effect, instructions to all districts to jointly conduct subcenter meetings and monitor both the process and the outcomes. CARE continues to support the design of sessions and the related materials and tools.

KEY FINDINGS

The subcenter model of collaborative action between the two departments has achieved high levels of participation by functionaries of both departments in the monthly subcenter meetings. The meetings have been conducted consistently, and planned content has been delivered for 9–10 months a year, with frontline worker attendance averaging about 70 percent. The use of the home visit planners and counseling tools has become universal among the frontline workers, and program monitoring data, particularly periodic random sample lot quality assurance survey (LQAS) data, showed consistent improvements over time in service coverage and almost all maternal and child health practices, including child-feeding practices. Analysis of the LQAS data revealed associations between frontline worker efforts and improved practices. The data also indicate that both ASHA and AWW efforts are contributing to the improvements.

Recognizing the value of this platform, the Government of Bihar requested support from NHRM to cover incidental expenses for conducting monthly subcenter meetings across the state under a separate budgetary code for supportive supervision. The intervention is now being refined and scaled up across the 30 remaining districts with much less external catalytic support from CARE than in the original eight districts.

Using lessons from the Bihar experience, a similar model of incremental learning at the health subcenter is also being implemented in seven other states under the ICDS System Strengthening and Nutrition Improvement Project, supported by the World Bank.

Photo courtesy of CARE

Implementers have reportedly appreciated the value of this approach, and have proposed integration of more content areas into the platform. However, there is still limited appreciation of the ability of frontline workers to achieve "soft" outcomes, such as behavior change in health and nutrition practices among families, through systematic approaches, such as carefully timed home visits and simple counseling. Within government programs, intensive, short campaign approaches are generally considered more feasible to implement and are likely to be more effective than a systemic, sustained, long-term effort.

The process of convergence between the two departments was relatively smooth in Bihar for a number of reasons. Enlightened leadership at the state level in both departments and the position of a senior bureaucrat as the Development Commissioner overseeing coordination between several departments were instrumental in forging agreements. The explicitly stated agenda of the project in helping both departments find operational solutions to maximize results helped as well. The initiation of the project with a clear memorandum of cooperation between the Bill & Melinda Gates Foundation and the state government also helped to legitimize the effort. In the case of subcenter meetings, demonstrating the feasibility of the model in a few blocks led to block- and district-level leaders of the two departments to champion the approach.

However, challenges remain in implementation. The subcenter meeting model is a mechanism that attempts systematic and incremental improvements of system performance, but it depends explicitly on the ability of supervisory cadres to take on leadership roles in driving changes in outcomes, including soft outcomes, such as behavior change. However, higher leadership in the health system has a tendency to understand and appreciate vertically driven short campaigns, rather than soft interventions, such as those intended to engender behavior change. This can create some challenges. Although ensuring regular implementation of the meetings and participation by all has been relatively easy, support from program leadership to encourage supervisors to focus on soft outcomes is limited. This in turn can hamper the efforts of frontline workers. Thus, unless behavioral outcomes are valued and measured, this will remain a challenge.

SIGNIFICANCE AND APPLICATION

The success of the subcenter model demonstrates the importance of building one element of systematic reform into program operations. The approach integrates the full range of reproductive, maternal, newborn, and child health activities and leaves room for integrating more, while simultaneously easing and supporting the convergent actions of two departmental programs. It also integrates systems of supportive supervision, refresher training, and data use that conventional programs lack. Looking ahead, the roles of the various actors, the processes, and the tools can be tweaked to integrate more ambitious multisectoral implementation plans involving other government programs and schemes. Building this structure around the now established concept of identifying and tracking families could help to converge interventions, such as sanitation or food security, on the same households and thus support behavior change for nutrition.

NOTES

1. IFHI partners include CARE India (lead), Janani (family planning), Abt Associates (public-private partnership), Columbia University – Averting Maternal Death and Disability/AMDD (maternal health), Emory University (nutrition), and Save the Children/Saving Newborn Lives/SNL (newborn health).

2. Program monitoring data, IFHI, CARE-India, Bihar. Analyzed data available on request.

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Partnership members:

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Public Health Foundation of India (PHFI)

One World South Asia

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Save the Children, India

Public Health Resource Network (PHRN)

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Together for Nutrition 2014
Working Across Sectors to Improve Nutrition in India

transform nutrition

This Implementation Note was prepared for the *Together for Nutrition 2014: Working Across Sectors to Improve Nutrition in India* conference, held October 29–30, 2014, in New Delhi. This conference was co-hosted by POSHAN and Transform Nutrition and served as an important platform for learning and facilitating discussion around the challenging task of bringing diverse sectors together to improve maternal and child nutrition in India. For more about the conference and other papers on the topic of multisectoral convergence, please visit *http://poshan.ifpri.info/*.

About Transform Nutrition

Transform Nutrition is a consortium of five international research and development partners funded by the UK government. Over 5 years, from 2012-2017, Transform Nutrition aims to transform thinking and action on nutrition and strengthen nutrition-relevant evidence in order to accelerate undernutrition reduction in South Asia and sub-Saharan Africa. For more information, please visit *www.transformnutrition.org*.

ABOUT POSHAN

Partnerships and Opportunities to Strengthen and Harmonize Actions for Nutrition in India (POSHAN) is a 4-year initiative that aims to build evidence on effective actions for nutrition and support the use of evidence in decisionmaking. It is supported by the Bill & Melinda Gates Foundation and led by IFPRI in India.

ABOUT IMPLEMENTATION NOTES

Implementation Notes summarize experiences related to how specific interventions or programs are delivered. They are intended to share information on innovations in delivery and are not research products.

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