KNOWLEDGE COMMUNITY
ON CHILDREN IN INDIA

KCCI / 2010 – 09

Documentation of Positive Deviance Programme in Orissa

Esha Gupta
Jocelyn Williams
Vardhna Puri

In collaboration with
KIIT School of Management, KIIT University
Bhubaneswar

Disclaimer

The views expressed in this case study are those of the authors alone and do not necessarily reflect the policies or the views of UNICEF and/or the School of Management, KIIT University, Bhubaneswar.

Contents

List of Tables and Figures

Acknowledgments

We take this opportunity to thank state office of UNICEF Orissa, UNICEF India and the Knowledge Community on Children in India (KCCI) programme for allowing us to be a part of their team.

We also thank our host institution School of Management, KIIT University, Bhubaneswar, and our supervisor, Professor Amiya Kumar Sahu, for their support and guidance during the internship.

Further, we would like to acknowledge the Positive Deviance (PD) Cell Consultants Ms. Neena Sharma and Mrs. Mridula Pandey for their assistance in procuring data and for helping us during our fieldwork.

Sincere thanks to all the concerned ICDS staff at various levels, viz, the ICDS Director, the PD Cell members, the District Social Work Officer, the Programme Officers, the Child Development Programme Officers, the Sector Supervisors, the Anganwadi Workers and the Caregivers in Mayurbhanj and Koraput districts for their active participation and involvement in the interviews which made the fieldwork a valuable learning experience.

Finally, special thanks to our co-supervisor Mr. Kumar Premchand who helped us at every stage from beginning till the end. We extend our gratitude for his unrelenting support, inspirational guidance, light-hearted humour and his concern for humanity. More than just a supervisor, he has been a mentor and guide to all of us during the entire study period.

Acronyms and Definitions

AWC	Anganwadi Centre
AWW	Anganwadi Worker
CDPO	Child Development Programme Officer
CG	Caregiver
DSWO	District Social Welfare Officer
ICDS	Integrated Child Development Scheme
NCCS	Nutrition Counselling and Childcare Session
PD	Positive Deviance
PM	Programme Manager
PO	Project Officer
SS	Sector Supervisor
WHO	World Health Organization

Definitions

Caregiver is a person who looks after the child for a majority of the time or person who attends the Nutrition Counselling and Children Session.

Under-nutrition is defined as the outcome of “insufficient food intake and repeated infectious diseases” (UNICEF, 2006).

Foreword

The Knowledge Community on Children (KCCI) in India is a partnership between the Government of India and UNICEF which aims to fill knowledge gaps and promote information-sharing on policies and programmes related to children in India. In 2010, under the aegis of this initiative, 44 graduate students from India and across the world visited and documented initiatives focused on child rights and development. Their vibrant perspectives, commitment, and hard work is reflected in this series of case studies, which are published by UNICEF.

These 2010 case studies identified interventions working at different levels – institutional mechanism to safeguard rights of children at state and national level, implementation of a flagship programme at a district level, and within community such as tribal tea community in Assam. More importantly, these case studies document the challenges and potentials of cutting edge models that invest resources, human and financial, in supporting individuals and their communities forge the long hard path towards greater empowerment and entitlement to public resources.

UNICEF recognises the potential and power of young people as drivers of change and future leadership across the globe. As such, the KCCI Summer Internship Programme also aims to develop a cadre of young research and development professionals with an interest, commitment and skills relating to the promotion and protection of child rights. UNICEF will continue this collaboration with young researchers, the Government of India and academia, so as to bring fresh perspectives and energy to development research and our ongoing efforts towards the fulfillment of the rights of children and women in India.

Karin Hulshof
Representative
UNICEF India

Executive Summary

This study to document the Positive Deviance (PD) programme in Orissa is not intended to be an evaluation of the programme. This study will provide qualitative insights into the PD programme to complement current studies related to quantitative analysis of the programme in Orissa. It aims to contribute to learning by documenting various stakeholders' perceptions regarding the process and initial performance of the programme, constraints and recommendations for the programme, issues related to scaling up the programme, and the perceived value added by the programme to the Integrated Child Development Scheme (ICDS). The study is exploratory in nature. A mix of random and purposive sampling along with structured and semi-structured interviews have been used to collect data from stakeholders at all levels spread across 12 sectors in six blocks in Koraput and Mayurbhanj districts.

Aims and outcomes of the PD programme are perceived differently by different stakeholders. The aims and outcomes of the programme focus on teaching ICDS approved practices rather than replicating local best practices or psycho-social care. The PD programme adds value to the ICDS. The constraints at the implementation stage, however, restrict the value additions. The number of Anganwadi centres (AWC) implementing the programme have been increased yet the quality expected is not visible on the ground. The process, content and methodology of PD training differ between trainers. As a result concepts become distorted. There is a need for refresher training and participatory training methods at all levels. There is a lack of differential planning, particularly for tribal communities, and counseling sessions do not address social issues. A specialised focus on children with disabilities and a greater focus on interdepartmental coordination are required.

The extent of community participation varies across locations. Due to limited involvement of the community in the initial stages of the programme and their socio-economic conditions, the capacity building and participatory involvement of the community is limited. There is no defined benchmark to measure or monitor the extent of community participation. Relationship between the ICDS staff and communities is not always positive, indicated by negative language used by the ICDS staff to describe communities, Anganwadi workers (AWW) pressurising Caregivers (CG) to participate, and incidence of community inequalities during counselling sessions.

Provision and maintenance of infrastructure and supplies are irregular. There is confusion regarding definition and identification of best local practices in communities. All CGs do not regularly attend counselling sessions, and the health of children is often linked primarily or

exclusively to food. Many CGs do not receive support from their families to attend counselling sessions or implement PD practices at home. Limited quality counselling and home visits impact CGs' understanding of childcare practices and sometimes counselling is equated with teaching rather than using participatory approach. The concept of graduation is not understood by AWWs and CGs, and long term behaviour change is absent in some cases. Since no specific roles are assigned to men in the PD implementation process, male participation is minimal.

The PD programme has various reporting mechanisms to collect monitoring data but monitoring mechanism itself is limited and so is the mechanism to collect qualitative data. Irregularity on the part of the ICDS staff visiting the AWCs impacts quality data collection. Feedback is limited and generally restricted to only certain levels at the ICDS. Criteria of data collection are not universal and there is an absence of a benchmark for community participation. Regularity, quality and relevance of monitoring meetings vary, and there is no data to indicate the sustainability and long term effects of the programme.

Therefore, the PD programme does add value to the ICDS and contributes to achieve the aims and objective of the ICDS. However, constraints in the implementation process limit the value of the PD programme and impact the programme in its initial performance. The final section of this study offers recommendations for ways forward for the programme within the themes of planning, implementation, community participation and monitoring.

Introduction

This research is not an evaluation of the Positive Deviance (PD) programme in Orissa. Rather, it will contribute to scholarship by documenting the initial performance, perceived value, gaps and constraints as perceived by various stakeholders. It will also provide a qualitative insight into the programme to complement current studies documenting quantitative data analysis of the programme in Orissa. However, not enough qualitative data has been collected to analyse the effectiveness and sustainability of the PD programme or to analyse whether the programme can achieve its aims of community empowerment and self reliance, or to explain why PD programmes have varying levels of success in different locations. The study records perceptions of various stakeholders regarding the effectiveness of PD programme to address undernutrition in Orissa. The focus is on effectiveness of planning, implementation and monitoring of PD programme, the extent to which the PD programme achieves its aims of sustainability, community self reliance and empowerment and highlight possible knowledge gaps between different stakeholders. The study provides qualitative data to contextualise current quantitative data with indicators related to quality.

Background

Importance of Nutrition

Undernutrition "imposes a staggering cost worldwide, both in human and economic terms" (Horton, 2010) as it is "responsible for more than one-third of all deaths among children under five worldwide [3.5 million]... and the loss of billions of dollars in forgone productivity and avoidable health care spending" (Horton, 2010). Individuals "lose more than 10 per cent of lifetime earnings, and many countries lose at least 2–3 per cent of their gross domestic product to under nutrition" (Horton, 2010). Under-nutrition among children severely impacts the morbidity and mortality rates.

Importance of Child Nutrition

The effects of undernutrition are most damaging during pregnancy and early childhood as feeding practices impacts child survival (WHO, 2008). The research on brain development has highlighted the importance of "critical period" and "window of opportunity" for learning. The "poorer cognitive development… [and] behavioural problems" emerge as a result of poor nutrient intake (Martorell et al, 2009; Sigman, Neuman, Jansen & Bwibo, 1989). This impacts the educational outcomes which lead to "reduced productivity in adulthood" and "diminished quality of life" (Monteiro et al, 2009; Dreze, 2004). Therefore, "child growth patterns are … strong predictors of future human capital and social progress and of the health of future generations" (Monteiro et al, 2009). Hence, nutrition programmes are most effective when aimed at pregnant and lactating mothers and children below two years of age (Martorell et al, 2009).

Importance of India

The inclusion of India in child development programmes is important because India is "home to one-fifth of the world's children" (UNICEF, 2009) and has the largest child population (0-4 years) in the world (World Population Prospects, 2008). Even by 2026, the child population (0-18 years) in India is predicted to be almost 400 million and the annual number of births in India will remain above 20 million (Office of the RGI, 2000). The Government of India has ratified the United Nations Convention on the Rights of the Child which argued for right to survival and development for children. Also, the worldwide Millennium Development Goals (MDGs) such as reducing child mortality and eradicating extreme hunger cannot be achieved without India as higher numbers of undernourished (wasted and stunted) children reside in India. The global community has designated halving the prevalence of underweight children by 2015 as a key indicator of progress towards the MDGs.

Importance of Orissa

Within India, the implementation of child nutrition and development programmes is particularly important in Orissa. Although the Infant Mortality Rate? (IMR) of Orissa has declined significantly from 112 in NFHS(1992-93)-1 to 65 in NFHS(2005-06)-3, but still it is one of the eight states that are responsible for 70 per cent of deaths of children under the age of five per year. The PD programme has been initiated in Orissa to address undernutrition.

Table 1: Situation in India

DLHS(?)-3	India	Orissa	Mayurbhanj	Koraput
Population(in millions) [Census 2001]	1027	36.707	2.223	1.181
SC/ST Population (%)	22.9	23.7	64.3	62.6
Literacy rate (of age group 7 and above) (%)	72.2	69.2	64.9	41.8
Children under 3 years breastfed within one hour of birth (%)	40.5	63.7	77.4	66.2
Children in the 6-9 months age group receiving solid or semi-solid food and breast milk (%)	57.1	59.8	98.2	94.3

Literature Review

In India, child undernutrition has been the focus of various programmes and policy considerations. The focus on right of children to receive appropriate nutrition has resulted in formulation of various policy documents to reduce undernutrition. The ICDS is a major programme in India which focuses on children below six years of age. In states, the Department of Women and Child Development has been entrusted with the responsibility of implementing this scheme along with other components (Rao, 2007). The ICDS has been addressing issues of undernutrition but various evaluations have highlighted unevenness in the implementation to address various issues. (Grangnolati, Bredenkamp, Gupta, Lee and Shekar, 2006; Sinha 2006). The number of severely malnourished children has been addressed to a certain extent though wider concern relating to child health remain dismal (Ghosh and Chandrashekhar, 2005). The need to emphasise children below three years of age through ICDS programme has gained momentum. (Ghosh, 2006). A World Bank evaluation has highlighted various gaps in the ICDS programmes which need to be addressed in order to enhance its impact. The issues highlighted relate to focus on children under three, increasing community participation and decentralisation, addressing AWW training, and greater collaboration with health programmes (Grangnolati et.al, 2006). Thus, PD programme aims to fill the gaps highlighted in the ICDS programmes.

The approach describes children belonging to “poor families” who have a better nutrition status than their counterparts in “high risk environments” (Sternin, Sternin & Marsh, 1998; Bergrren & Wray, 2002). It has been widely studied that behaviours of caregivers affect child nutrition, for instance, decision making, willingness to “seek advice during illness” and other quality childcare practices which culminate into optimum development of a child (Antwiwaa Nti & Lartey, 2008; Bégin, Frongillo, & Delisle, 1999; Englea, Bentleya & Pelto, 2000). It has been highlighted that counselling at six months of age has outcome for quality child care practices through initiation of complementary feeding (Ramji, 2009). The child development context and relevance of psycho social aspects of families has also been considered important to improve nutrition outcomes for children (Zeitlin, Ghassemi & Mansour, 1990). The PD approach focuses on the premise that solutions exist within a community. (Sternin, et.al, 1998). The positive deviant behaviour is seen as “uncommon practices” which confer particular “advantage” to people following these behaviours (Marsh, Schroeder, Dearden, Sternin, & Sternin, 2004). These activities are “affordable, acceptable and sustainable” and are not in conflict with the cultural practices. (Marsh et.al, 2004). The PD programme integrates certain basic components such as PD Inquiry, nutritional sessions, growth monitoring, which are manifested differently in different situations (CORE, 2005; Sternin et.al, 1998).

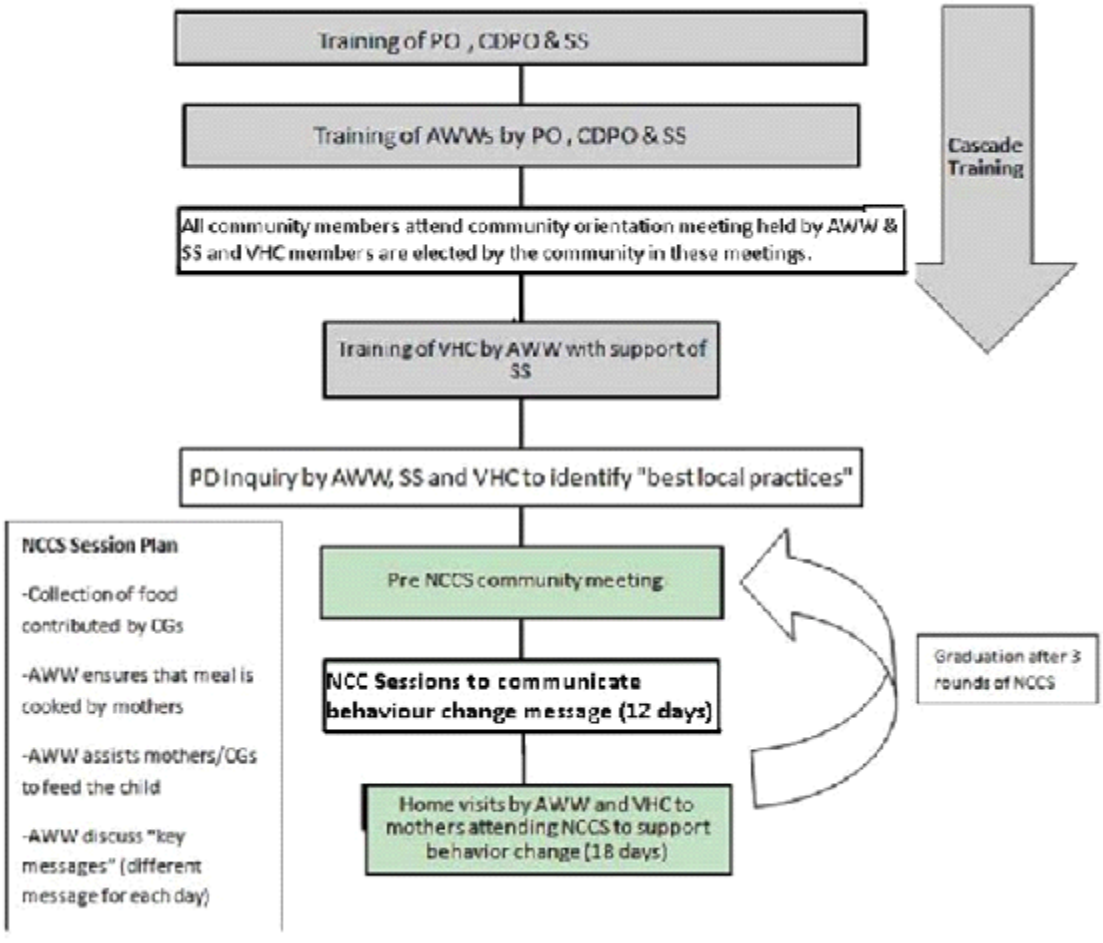
The PD approach has wide scope of implementation demonstrated by its uptake in various communities. PD Inquiry was found to be an effective method of identifying the best practices in a community, additionally sustained child care practices benefited younger siblings (Mackintosh, Marsh & Schroeder). Similar positive effects for siblings were highlighted in a study done in Pakistan (Lapping, Mackintosh, Marsh, Albalak & Jabarkhil, 2004). A study highlighted that discontinuation of PD practices was attributed to economic issues and reducing attendance requirement of the session by the mothers (Bolles, Speraw, Berggren & Lafontant, 2002). One of the studies in rural Vietnam highlighted modifications required in the strategy when adapted from urban areas as focus need to change from severe to moderate malnutrition (Marsh, Pachón, Schroeder, Thu Ha, Dearden, Lang, Hien, Tuan, Thach & Claussenius, 2004). The empowerment outcomes were also highlighted in the study as, researchers postulated, change in confidence among women at an individual level through knowledge.

The PD approach has been taken up in Bihar, Rajasthan, Uttar Pradesh and West Bengal with the support of state governments through the mechanisms established by the ICDS programme. The effectiveness of approach has been documented through research. The studies highlight factors affecting implementation and the constraints impacting the change in nutritional status of children. Dular programme in Bihar has documented effect of counselling through local resource groups which influence the nutrition level of children. The crucial finding was the effect of mother's education and literacy level on nutrition on the "immediate factors of malnutrition" and improved child care practices (Levinson, Barney, Bassett, & Schultink, 2007). In West Bengal the positive impact of community participation has been most poignant as mothers were found to be mobilised due to motivation of AWWs/NGOs. The cumulative effects of good nutrition were reflected in the lower under weight and stunting levels of children 12 months to 17 months of age. A small scale study with mothers of infants in slums of Delhi highlighted various psychosocial factors influencing the adoption of practices through counselling by positively deviant mothers (Sethi, Kashyap, Seth & Agarwal, 2003). The PD programme in Uttar Pradesh highlighted the role of grandmothers as facilitators of positive practices and also as health volunteers. (Sethi, Kashyap, Seth, Agarwal,Pandey & Kondal, 2007).

In Orissa, most of the literature regarding undernutrition has focused on quantitative indicators which may exclude issues at the community level. A research study indicated that 70 per cent children between six months and 12 months of age in Orissa accessed the ICDS services. The highest uptake of services was in tribal community though rate of undernutrition continued to be high. The need for social security measures, behaviour change, mobilisation and capacity building of communities and AWWs was emphasised (Sharma, Sarangi, Kanungo, Sahoo, Tripathy, Patnaik, Tewari & Rath, 2009). These issues set a backdrop for implementation of PD programme, "Ame bi Paribu" (We too can) which is a flagship programme of Government of Orissa, supported by UNICEF. The PD programme was initiated in 2004 in three blocks of

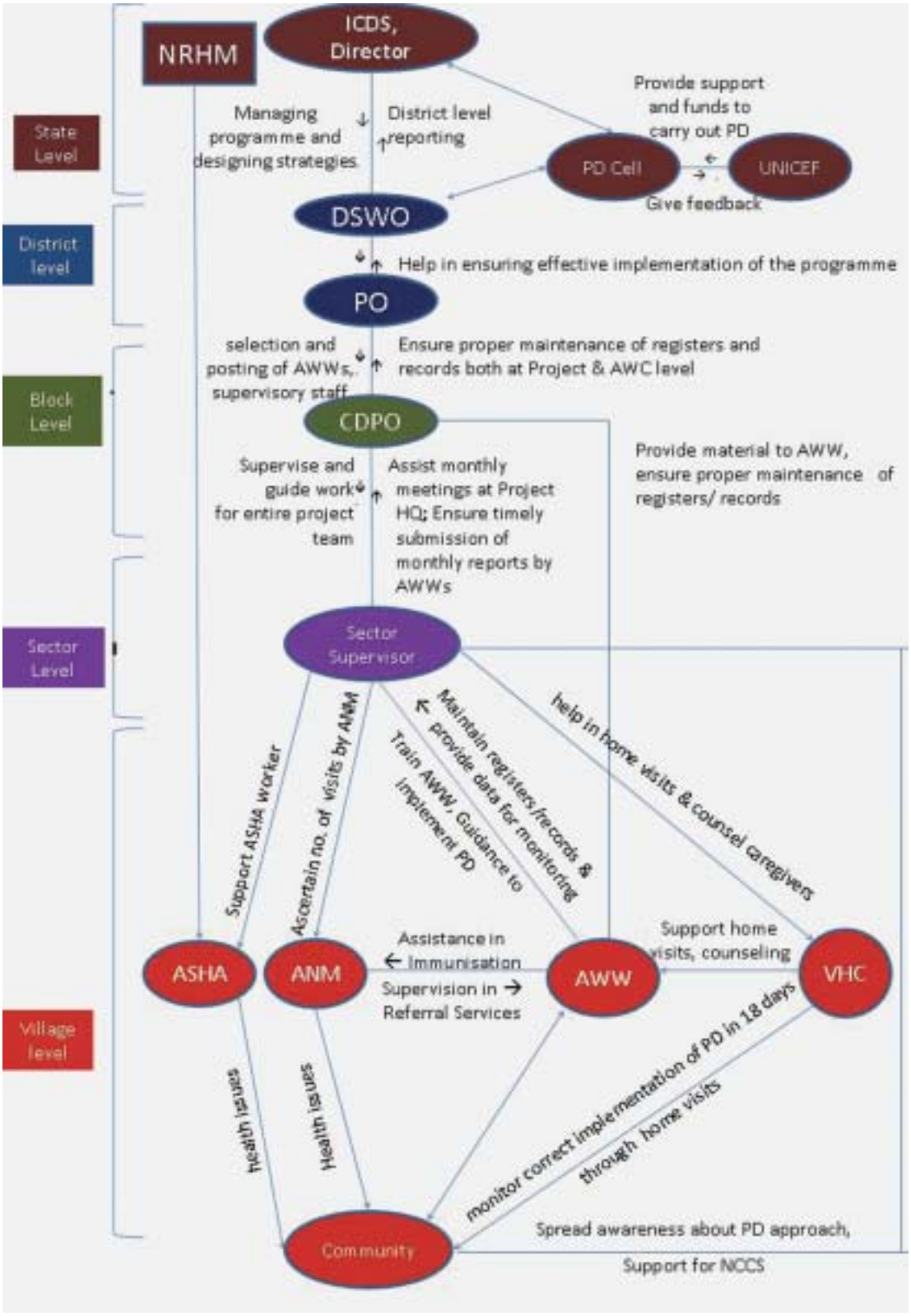
Mayurbhanj district which is currently being up scaled. The aim of the PD programme is to enhance community ownership of nutrition programmes and encourage the use of local, sustainable, community lead practices to improve nutritional status of children and encourage communities to be self reliant .The PD programme implementation is elucidated in Figure 1 which is formulated from the process document present in the form of a manual for training AWWs.

Figure 1: Process of the PD Programme



The implementation of the PD programme is essentially carried out by functionaries in the ICDS hierarchy with coordination from Accredited Social Health Activist (ASHA) workers. Different roles and responsibilities of entities under the paradigm of the ICDS have been highlighted in a diagrammatic form through analysis of secondary data. (Figure 2)

Figure 2: Hierarchy of roles and responsibilities of PD programme



Research Methodology

This study is qualitative and exploratory analysis of the perceptions of various stakeholders regarding the PD programme. The qualitative nature of the study fills the gap in current literature on PD programmes in Orissa which mainly relies on quantitative analysis of PD programmes. Qualitative data will be used to contextualise and increase understanding of current quantitative data and highlight issue which are not reflected in current analysis. The study was exploratory in order to record data without a preconceived hypothesis so that analysis and findings accurately and fully reflect the perceptions of participants. The study has recorded and analysed the perceptions of stakeholders because the PD programme aims to be a community lead, owned and orientated programme. Therefore, the perceptions of the community regarding the effectiveness of the PD programme are important. Analysis of the perceptions of different stakeholders will differ from each other which may indicate knowledge gaps or issues with the programme. The proposed study is not meant for an evaluation of the PD programme in Orissa. However, some of the questions / issues to be addressed are:

1. To study the perceptions of various stakeholders regarding the process and initial performance of the PD programme:
   - Planning
   - Implementation
   - Monitoring at different levels
   - Degree of ownership and participation of community in the PD programme
2. To document the perceived value added by the PD programme to aims and objectives of the ICDS:
3. To explore stakeholders' perceptions regarding gaps/constraints in the PD programme and their suggestions to improve the programme
4. To understand the issues related to scaling up the PD programme as perceived by various stakeholders.

Data Collection Procedures

The study has gathered qualitative data to record and analyse the perceptions of different stakeholders regarding the initial performance of the PD programme to address undernutrition in Orissa. Research surveys were semi-structured and used open ended questions to maximise the ability of researchers to accurately reflect the perceptions of various stakeholders. Since, the study was exploratory researchers had the freedom to adapt surveys and questions according to findings during field the research. Prior to commencing field research an Institutional Review Board was constituted to analyse and raise issues regarding the methodology of the study. The

first day of field research was dedicated to conducting a pilot study of the research tools and editing the research tools wherever necessary. Field research had to be completed in June as the Nutrition Counselling and Childcare Session (NCCS) only occurs at certain times of the month but in some of the villages the NCCS was over due to non-uniformity of days of the NCCS. July was kept for the researchers to do the tabulation, analysis and data writing.

The study made use of a mix of random and purposive sampling for selection of districts, blocks, sectors, AWCs, AWWs and CGs. Two districts were chosen by UNICEF staff in Orissa for data collection. Mayurbhanj was chosen since it was the first district where the PD programme was implemented. So the district was expected to highlight the long term effects of the PD programme. Koraput was chosen because the PD programme was up scaled in 2009 to incorporate the district. So Koraput was expected to highlight issues related to upscaling the PD programme. In total, Koraput consists of 14 blocks and Mayurbhanj consists of 26 blocks. From this lot, three blocks from each district were selected by the researchers for analysis on the basis of the Scheduled Caste(SC)/Scheduled Tribe(ST) population, distance from the district headquaters, percentage of undernourished children in Class II, III and IV, and percentage of adult literacy. In each block two sectors were chosen by the researchers and within which one AWC was selected. Although blocks visited were quite far from district headquaters, the villages visited were not far from sector HQ The proximity of these AWCs to the Sector headquaters was important because further the AWCs from the sector headquarters more pronounced would have been the issues due to lack of accessibility to the sector supervisor and the ICDS staff. AWCs and AWWs were chosen by sector supervisors at a random basis. CGs were selected for interview if they had children currently or recently attended the NCCS. Given below was the sample plan on the basis of which the survey was carried out:

Figure 3: Sample Plan

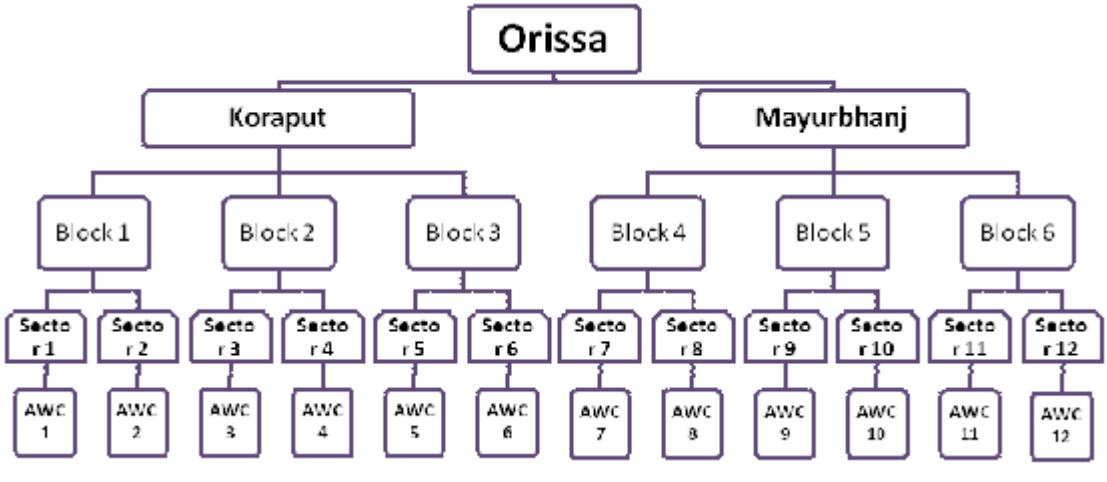


Table 2: Specification of study design

11Key Questions	Respondent	Method of Data	Expected
1 Planning process and issues	ICDS Director(1) UNICEF PM,PO(2) PD Cell (3) DSWO (1) CDPO (1) SS (3 groups) AWW (12)	Collection Semi-structured Interviews Naturalistic observations FGD	**Outcomes** Process, roles, responsibilities and feedback mechanisms of ICDS staff/ part-time volunteers
2 Training process and issues	ICDS Director(1) UNICEF PM,PO(2) PD Cell (3) DSWO (1) CDPO (1) ICDS PO (2) SS (3 groups) AWW (12)	Semi-structured interviews Naturalistic observations FGD	Training mechanisms; effectiveness of training; possible loopholes in the training
3 Implementation process and issues	ICDS Director(1) UNICEF PM,PO(2) PD Cell (3) DSWO (1) CDPO (1) ICDS PO (2) SS (3 groups) AWW (12) Caregivers (50) VHC (2 groups)	Semi-structured interviews Naturalistic observations FGD	Field experience of AWWs; possible loopholes in the implementation; value of PD programme to ICDS
4 Monitoring process	ICDS Director(1) UNICEF PM,PO(2) PD Cell (3) DSWO (1) CDPO (1) ICDS PO (2) SS (3 groups) AWW (12)Caregivers (50)VHC (2 groups)	Semi-structured interviews Naturalistic observations FGD	Effectiveness of PD programme; monitoring issues at different levels
5 Community participation	AWW (12)Caregivers (50)VHC (2 groups)	Semi-structured interviews Naturalistic observations FGD	Involvement of community; sustainability; ownership

At the district, block and sector level various personnel related to PD programme were interviewed. In each AWC, the AWW and approximately four CGs were approached for interview. The specification of study design showed the topics covered under the research and to whom were those topics addressed.

Village Health Committe (VHC) groups were yet to be formed in the villages of Koraput district where interviews were conducted. Some of the CGs left the interview incomplete due to time constraint. Table 3 shows the statistics related to how many people at each level were planned to interview and how many were actually interviewed.

Table 3: The Number of Respondents Planned to be Interview and the Respondents actually Interviewed.

Respondents	No of respondents planned to be interviewed	No of Respondents interviewed	% Covered
Senior Officials	10	8	80%
Block Officials	4	1	25%
Sector Officials	4 groups	4 groups	100%
AWWs	12	12	100%
Caregivers	60	51	85%
VHC	4	2	50%

Ethical Consideration

Confidentiality and Voluntary participation: Participation of respondents in the survey was voluntary. The consent of participants was sought and confidentiality of participants' information was ensured. Names of villages, AWCs, AWWs and CGs were kept confidential to encourage participants to air their opinions freely. Any analysis and subsequent reports and manuscripts did not mention the names of participants. An informed consent form was read to participants in their language of preference prior to commencing the interview (Appendix 1). If the participant agreed to be interviewed, it was conducted only after the interviewer signed the consent form.

Privacy of interview setting: Every effort was made to ensure privacy during interviews. For instance, participants from the community were interviewed away from the AWWs and interviews of CGs were mostly at homes. Similarly, whenever it was possible AWWs were interviewed in private, away from CGs and ICDS personnel.

Translation to local language: The questionnaire in English was provided to translators prior to the interview to facilitate their understanding. Each question was translated according to the participants' language of preference.

Data Analysis

Analysis of qualitative data was done through contrast themes and perceptions of various stakeholders regarding the PD programme. However, analysis has not been used to generalise the progress of PD programmes since stakeholders' perceptions were highly subjective. Data analysis consisted of thematic analysis, data tabulation and graphic representation of data from AWW and primary CGs. Excel Sheet had been used to facilitate correlation, analysis and drawing inferences from the data. Primary data from field research was also corroborated with secondary data to analyse the effectiveness of PD programmes.

Study Limitations

- Issues related to language barriers such as translating concepts from English to Hindi and Oriya for surveys.
- Power relationships/inequalities between participants and researchers, within participant groups and between government workers and communities.
- Misinterpretations during observations by researchers as they had limited knowledge of local traditions, culture and customs.
- The study was insufficient to provide a multilevel analysis of PD.
- Time limitations since the NCCS happen at certain times of the month.

Major Findings

Planning

Aims and Outcomes

The PD programme was initiated in Mayurbhanj district in 2004 and the programme was upscaled in 2009 in Koraput district. The focus of the programme has been on rehabilitation of the undernutrition, sustenance of the rehabilitation and prevention of new cases of undernutrition. The aims were perceived differently at the district, block, sector and AWC level with main focus on the reduction of undernutrition. Aims related to sustainability and prevention of undernutrition were emphasised by some stakeholders at district and sector level. For instance, "stay[ing] normal" and "stopping children entering Class II, III, IV" were seen as critical views. At the AWC level one of the 12 AWWs highlighted prevention and two AWWs highlighted the sustainability of rehabilitation as aims of the PD programme. Additionally one AWW was unaware about aims of the PD programme. At the AWC, two AWWs perceived implementing "good practices" as aims of the programme as opposed to the outcome implying confusion between the two.. Ensuring health of the child was also seen as an aim by four AWWs. The outcomes of the programme highlighted by the district, block and sector level ICDS staff were implementation of good "habits" and "practices" as opposed to best local practices. Increased interaction with communities was perceived as an outcome by stakeholders. There was confusion regarding outcomes as district level staff mentioned activities not related to the PD programme such as counselling of pregnant and lactating mothers as outcome. Additionally hospital delivery was seen as an outcome by one of the AWWs.

There was focus on implementing good practices that impacted nutritional status of children. Issues such as psycho social care of children, empowerment and capacity building of women, however, did not receive adequate importance. Conflicting views regarding empowerment were reflected by various stakeholders. For instance, on the one hand a block level official highlighted confidence among mothers, on the other hand sector level officials felt "women [are] not empowered, [they] do what the AWW tells them to do". A higher emphasis on the capacity building of women could impact on long term changes among communities.

Value added to ICDS

The PD programme is planned to add value to the ICDS programme, according to the ICDS staff at various levels. Sector and state level staff highlighted the value added by the PD programme to various components of the ICDS. A district level staff however said, "The ICDS aims are separate from the PD aims" and differed in target groups and funding plans. According to a block level official the PD programme added value by "increase(ing) community awareness

and interaction" and that "ICDS main goal was participation by the community and grass roots". A PD cell member and UNICEF staff highlighted an essential value added by the PD programme was the focus on children from 0-3 years as it was missing in the ICDS programme. Contrasting ideas regarding community participation were reflected as a district level official felt the PD programme "is their [the community's] programme, it is their duty to tackle malnutrition" whereas a member of the PD cell felt that "PD improves community participation so that the community can work with and give feedback to AWWs". The PD programme was designed to add value to the ICDS programme by addressing issues affecting nutritional status of children. Gaps in the ICDS system, however, affected implementation of the PD programme reducing the overall impact.

Upscaling

The PD programme has been taken up by the Government of Orissa on a large scale with the programme implemented in three blocks and upscaled to 12,740 AWCs. According to stakeholders at the district level, official planning was done at the district level by a PD monitoring committee comprising District Social Welfare Officer(DSWO), Chief District Medical Officer (CDMO) and sector supervisors. Some UNICEF and district level stakeholders reported that the AWCs were taken under the purview of the PD programme on the basis of the level of undernutrition. A PD cell member, however, felt it was not always the case. The member pointed out that sometimes indicators from various AWCs happened to be overlooked before deciding to upscale the programme. For instance in an AWC visited, the PD programme was being implemented with three mothers rather than following guidelines which state presence of at least 7 mothers to conduct PD programme. Thus it may impact the reach of PD programmes to the centres requiring focused attention. A stakeholder suggested that key indicators should be the basis of formulating district scale up plan.

The upscaling of PD programme is concomitant with the training process. There is a difference of opinion regarding the effectiveness of AWW training in the light of upscaling. While a district level official said there are no issues with scale-up training of AWWs, the sector level ICDS, PD Cell and UNICEF staff reported issues with the quality and provision of AWW training. For instance, if the PD programme in AWCs was started without prior training it might undermine the importance of the training procedure. The sector level officials highlighted that large number of AWCs were being upscaled with higher focus on quantity than quality. Preference for gradual upscaling emerged during group discussions with sector level officials. As a sector level official suggested implementation of the programme at four centers at a time to focus on the quality issue.

Training

The design of the PD training ensured an efficient transfer of information of childcare practices through ICDS hierarchy to CGs But training was of uneven quality, and use of cascade method

as knowledge was transferred quality of training decreased and concepts got distorted. The ICDS staff at block, sector and AWC level was trained, though a district level official reported not having received any training. The training followed a specific module. But, a PD cell member pointed that trainings did not follow operational plan regarding "ten steps" of the PD programme. This was corroborated with the fact that one AWW was aware of these steps in training. An AWW highlighted that training by sector supervisor and CDPO was not effective as they lacked training skills. She emphasised the requirement of external facilitators for training.

The components of training were perceived differently at various levels. UNICEF staff and sector level officials described components regarding PD tools, training community members, Focus Froup Discussion (FGD) with fathers, PD Inquiry, collating data, plan NCCS and inform community about malnutrition and impact of health and economy. Majority of AWWs had received training related to nutrition education which was essential to bring about change in nutritional status of children. However three AWWs reported being trained to conduct community meetings and one of the AWW reported learning about conducting the NCCS. The process of PD Inquiry was not highlighted by the AWWs, which was corroborated by ineffective understanding of the AWWs about the "best local practices". The discussion on psycho-social aspect of child development was not given emphasis as two AWWs reported inclusion of this issue in their training.

The PD training was designed to equip AWWs to enable mothers follow sustainable best practices. However, participatory approach was not evident at any level within the ICDS or communities, making it a top down approach rather than emanating from the field experiences. In a training session observed by the researchers, a dialogical approach was observed rather than participatory method. Similarly a majority of the AWWs were taught to conduct the NCCS by "teaching" child care practices. While some district and sector level officials highlighted the field visits conducted as part of the PD training, a few noted absence of field exposure. AWWs suggested several modifications in the training process such as use of "brainstorming" and other methods to facilitate better understanding of the PD process. The need for refresher trainings for different level of the ICDS staff was highlighted by all the stakeholders. Also, the training process did not take into the account limited educational experience of the AWWs. Effective training was essential for smooth transaction of concepts from one level to another.

Issues in Planning

The PD programme is planned to cover children between six months and three years of age although some stakeholders mentioned a change in planning to include pregnant and lactating women who were the target group of the ICDS programme. The PD programme planning took into account various issues such as community ownership and sustainable long term change through capacity building of CGs, etc. The programme focused on the "local best practices". Few stakeholders, however, pointed lacunae in planning such as lack of differential planning

for tribal communities. For instance, in tribal communities issues such as alcoholism, which affect child care, were not under the purview of the programme and counselling did not address social issues arising in a community. (PD was implemented as a uniform strategy and was not locally adapted.)

The planning process did not consider children with disability as a separate group though disability heightened nutritional issues. Stakeholders at district and block levels emphasised the need for "special attention" to children with disabilities. Currently disabled children received assistance through other Government programmes such as health camps. But often treatment of disabled children has relied on the efforts of an individual AWW, according to a district level official. The need for greater interdepartmental coordination such as communication between state/district nutrition cell with PD cell was also an issue.

Community Participation

The PD programme was a community based programme. Therefore participation of the community was required for the programme to be effective, according to UNICEF staff and district level ICDS staff. While in some locations community participation in the PD programme was strong, in other areas it continued to remain an issue, according to ICDS staff. The extent of community participation in the PD programme varied depending on environmental factors, socio-economic issues and efficiency of the ICDS staff. At the district, block and sector level, the ICDS staff raised the issue of inaccessible locations, particularly forested or hilly areas.

At times the socio-economic factors restricted the capacity and motivation of community members to participate in the PD programme. It came to light that alcohol abuse was a major social issue, particularly in tribal areas, that affected economic and childcare activities, and limited ability of community members to participate in the programme. Alcohol abuse resulted in the reduced capacity of parents to take care of their children leading to limited care of children, according to a PD cell member and district level official. Social issues such as alcohol abuse were not discussed during the NCCS. Issues like domestic violence, consumption of alcohol by mothers during pregnancy and economic issues affecting community members and children, were highlighted by a few AWWs.

Economic issues, resulting in the need for women to work, was highlighted by district and sector level ICDS staff and AWWs as an issue effecting mother's capacity to participate in the PD programme. AWWs pointed that economic problems limited capacity of the CGs to implement PD practices as one AWW said, "*chawal kharidne ko bhi paisa nahi hai, kapde kahan se kharidenge? Yahan zadatar log garib hain jinke paas apni zameen nahi hai.*" (When they do not even have enough money to buy rice, how can they buy clothes? Most of these people are poor who do not own land). Five CGs said that time constraints affect their capacity

to attend the AWC. Sector level officials reported that men's support to women attending NCCS decreased over time and Sector Supervisor (SS) have to discover ways to "keep caregivers interest alive" to attend the NCCS. However, one sector level official argued that community ownership of the programme was limited because "adequate reasonability was not given to them" and the community has become "bored with the programme".

A determining factor of the level of community participation in the PD programme was involving the community in the initial phase of implementation as this raised the community's feelings of ownership, according to the ICDS, UNICEF and PD cell staff. These stakeholders highlighted that often initial community meetings were not implemented effectively and the community was not properly involved in identifying local best practices which lead to limited community ownership. The concept of 'community participation' was not defined in the PD training manual which led to difference of opinion on the issue among the ICDS staff, and some staff saw community participation as only the shifting of "reasonability" for the programme to the community. Lack of a definition also meant it was not possible for supervisors to create benchmarks to measure the extent of community participation within the programme.

Community meetings were an important tool to increase community understanding of and participation in the PD programme and to identify local PD families. However, the quality and regularity of community meetings varied between different AWCs. A member of the PD cell emphasised the importance of community meetings prior to implementing the PD programme and prior to each NCCS every month. He cited the PD programme in West Bengal where effective community meetings increased community ownership of and participation in the programme. Five out of 12 AWWs conducted one community meeting prior to initiating the PD programme and two AWWs not only conducted meetings before initiating the programme but after the programme also. SS highlighted language barriers between themselves and/or AWW with communities. The PD cell reported that limited orientation of community member during PD programme meetings meant communities' lack of understanding and confidence about the programme and hence, they did not have the capacity to question, evaluate or support the programme.

The PD cell emphasised the need forinvolving men in community meetings on the PD programme.It was brought to the notice that the PD manual provided limited definition on the role of men in the PD programme and the meetings were mostly focused on VHC members, none of whom were men.

Involvement of PD mothers in the programme was essential to translate local good practices to non PD mothers. Majority of the AWWs reported help from PD mothers. There were also instances in which some mothers did not support the PD programme but attended the NCCS to understand the child care process.

The concept of positive deviant families was not clear to many of the AWWs as some of them believed economically rich mothers meant PD mothers because their children were healthy.

Community groups, such as VHC and Self-Help Groups (SHG), were vital to support AWWs when implementing the PD programme. However, many AWWs reported that involvement of the community groupswas minimal in the PD programme implementation process. Few AWWs reported that either the VHC was not present in their villages or they did not assist with the PD programme. Majority of the AWWs explained that although VHCs assisted with the PD programme, absence of uniform roles and responsibilities for VHC members lead to confusion in the implementation process. Although some AWWs reported VHC members advocating benefits of the PD programme or motivating the community to attend NCCS, few mentioned about VHC members visiting homes of those families implementing PD practices. VHC meetings were also held at different times and at different intervals. About 65 per cent of the CGs did not even know how often VHC meetings were held. While some CGs mentioned about their families having interacted with VHC members, few pointed out that VHC meetings were held only when the SS visited the AWC.

Case Study: SHG

In a village in Mayurbhanj district PD programme has been going on for past two years. According to the SHG members six children in the village, who were not gaining weight, were attending the PD programme. There has been an improvement in their height since the time they started attending the programme. The SHG advocated parents about hygiene related practices such as washing hands with soap and utensils with hot water. SHG members meet at least two-three times in a month to discuss various issues and they are confident that good health would have cognitive development of their children and they would study well from pre-school to high school.

Since the PD programme relied on community participation a positive relationship between ICDS staff and community members was vital to ensure the success of the programme. Perceptions of majority of the stakeholders suggested that relationship between the ICDS staff and communities was mostly not positive.

The ICDS and district level staff of government and AWWs described community members as “not very civilised or intelligent”. Even if their children were malnourished, they would have another child next year, it was pointed out. . This was despite the fact that 71 per cent of the CGs said they encouraged other women to attend the NCCS to learn about child health care practices.

Instances of coercion were also mentioned by some of the CGs to attend the NCCS. Sometimes mothers were told to cook during the NCCS lest some inspection took place. At times mothers reacted negatively when asked to attend the NCCS by stating that while the AWWs get salary they do not, according to a few AWWs..

The CGs feared that instances of community inequalities during the NCCS could lead to low motivational level of the community to participate in the PD programme. Caste discrimination was a problem at the AWC. It was pointed out that in some AWCs CGs who belonged to the ST category were made to bring plates to feed their children during the NCCS whereas general category CGs were provided with plates from the AWC. CGs who faced such discrimination reported that the ST CGs did not accept food at the AWC if cooked by the Scheduled Castes (SC). Instances of such caste discrimination were corroborated by some of the general category CGs who reported that they too did not accept food at the AWC if cooked by ST or SC CGs. The Sector level staff highlighted nutrition differences between community groups, emphasising that the malnutritioned children were greater among the SC population.

The CGs showed limited awareness of activities carried out in the AWC, indicating not enough communication between the AWWs and community. While 14 CGs were aware of immunisation programmes carried out at the AWC, only eight knew about pre-school teaching, six each had knowledge about referral services and, counselling and care sessions for mothers and young women, and two CGs referred to AWC as a 'place to play'.

The ICDS staff focused on provision of incentives, primarily financial or food provision, to substitute income lost by CGs when they attend the NCCS. This was to increase community participation in the PD programme. The ICDS focus on incentives showed that they recognised the socio-economic influences as a deterrant for the community members from participating in the programme. However, the impact of inequalities during the NCCS, ineffective implementation of methods aimed at increasing participation and negative interaction between ICDS staff and the community on the capacity and motivation of community members to participate in the PD programme was often not understood properly.

Implementation of the PD Programme

Infrastructure

A sound infrastructure background was essential for implementation of the PD programme. Although various resources were provided at AWC level, there was uneven supply and maintenance of these resources. While some district and sector level officials said most of the AWCs had their own building, other sector level staff and PD cell members reported otherwise. Block and sector level officials said all AWCs were equipped with the weighing scales. According to the ICDS staff at all levels issues such as lack of toilet facilities and drinking water facilities;

damaged buildings, etc were pertinent, which was highlighted by three of the 12 AWWs at AWC level as they talked about lack of infrastructure.

The PD programme required presence of basic resources for effective implementation. These requirements were fulfilled by the ICDS programme in various AWCs. However lack of resources at the AWC level was reported by most of the AWWs, for instance utensils, fuel for cooking, vegetables, soap, etc. District and sector level officials pointed the need for a contingency plan to support AWWs for the PD programme. Some of the sector level officials also mentioned about no separate supplies for the PD programme to the AWWs, for instance, there were no soaps and towels to support hand washing during the NCCS sessions. Sector level officials suggested use of 'facilities survey' to fulfil gaps in the infrastructure.

The Information Education Communication (IEC) material required for conducting the PD programme was not available in all the centers. An AWW highlighted that she had not received MCHN kit. Five of the 12 AWWs highlighted the need for IEC materials such as posters and charts to conduct the NCCS sessions. Sector and block level officials also highlighted the "asymmetry in presence of charts and posters". A PD cell member highlighted that IEC material was distributed at the district level but to the AWWs.

PD Inquiry

The PD Inquiry is a vital tool for the AWWs to discover and replicate local best practices, according to a PD cell member, UNICEF and district level officials. District and sector level officials emphasised on the importance of local practices as they felt that solution to the cause existed in villages. The PD Inquiry was conducted by visiting the homes of PD children and interacting with the families regarding the child care practices (Appendix 1, Module 7 of Training Manual). In some situations the process was carried out inefficiently. Only one out of the 12 AWWs conducted PD Inquiry through observing and interacting with PD families, however, seven AWWs were unable to recall the process of a PD Inquiry and two AWWs conducted their PD Inquiry through group discussions with mothers and adolescent girls where they discussed either attending the NCCS or the weight of children. A PD cell member reported that the VHC did not support the AWW for the PD Inquiry as they were not trained due to lack of interaction with SS.

The best local practices forms a foundation for implementation of the PD programme though not aptly highlighted by AWWs. Some of the AWWs highlighted the practices such as six months exclusive breastfeeding, supplementary nutrition, taking care of frequency of food, hand washing, cutting nails, mashing the vegetables, etc. However, differentiation between the existing local practices and the post PD programme practices were not made. The comprehension of best local practices varied as few AWWs said there were no such practices while others reported the process of identifying children for the NCCS as the best local practice. The low

awareness of PDI was corroborated with the fact that none of the AWWs reported learning about PD Inquiry during the training.

NCCS

- **Knowledge about the PD programme**

The knowledge about the PD programme and practices reflected effectiveness of concepts passed on to the CGs Major theme reflected was food or feeding as mentioned by most of the CGs.. A PD cell member highlighted manifestation of the programme as a "feeding" programme. Additionally health of the child was mentioned by some of the CGs. Other themes that emerged were tools of the PD programme, hygiene, weight, food and weight. However, one of the CGs mentioned playing with the child as a part of the programme and another Caregiver mentioned the role of ANM and ASHA workers in training them for the PD programme. The AWW trains CGs regarding various child care practices. While most of the CGs mentioned one or more PD practices, some CGs reported practices unrelated to the PD programme. For instance, 10 of the 37 CGs mentioned NCCS as a PD practice indicating issues with terminology. However, focus on following locally available practices was mentioned by one of the CGs.

- **Activities at NCCS**

The NCCS was a 12-day session involving CGsto understand local best practices related to childcare. Identification of target group was a prerequisite for NCCS session. The three steps in identifying children i.e. weighing the child, plotting the weight of the child and including all children from the age of six months to one year, were highlighted by some of the AWWs. Additionally, others AWWs used weighing, grading process and/or age. However a very few AWWs mentioned that they focus on women in villages who lead a good life but did not maintain cleanliness.

The reasons to attend the NCCS varied among the CGs. Health was the main reason for 39 per cent of the CGs for attending the NCCS regularly, 30 per cent joined since their children would get food and 17 per cent for the weight and health of their children. Among other reasons cited were coercion and verbal abuse if they did not attend the NCCS.It was apparent that positive behaviour change was the main focus of the NCCS that attracted the CGs to willingly attend the sessions on a regular basis.

The perception of activities as a part of the PD programme varied among CGs. Of the 43 CGs, 41 per cent mentioned counselling as a part of the PD programme 28 per cent thought meetings for discussing health and feeding practices, and 20 per cent highlighted the home visit aspect. A few felt that "conducting NCCS" was part of the PD programme. As a part of the programme, some of the CGs thought AWWs ensured hygiene and health care for children, cooking food and weighing the children. Different activities were reported on the last NCCS attended by the CGs. Of the 43 CGs, 27 per cent reported that food was cooked for the children. Additionally

many CGs reported, "AWW gave food" or they "did not stay for long, returned after getting food" or "AWW cooked *khichdi* (rice and pulse mixed dish) that day as researchers were visiting" or some even said that they left the child at the NCCS to go to work. Thus, mothers' involvement was sometimes limited to bringing the child to the AWC rather than equipping them with capacity to prepare nutritious food.

The duration of the NCCS posed issues as CGs failed to turn up, according to UNICEF staff and a PD cell member. While some officials at district level highlighted the need to increase the number of days, a UNICEF staff suggested reducing the number of days to six.

- **Counselling**

Counselling is an essential part of the NCCS which focuses on 12 key messages prepared by the AWWs for the benefit of the community. Discussions and use of Information Education Communication (IEC) material was highlighted. The discussions during counselling varied in different AWCs. While issues most often discussed was sanitation and hygiene (handwashing with soap, nail cutting, washing utensils, use of mosquito nets, washing clothes of the child, and keep the child clean), other isssues included feeding practices and nutrition.

Counselling was mentioned by 32 per cent of the 43 CGs as an activity in the last NCCS that they attended. Some of the CGs highlighted the "teaching" aspect of the NCCS.. Majority of the CGs reported discussions on health practices followed by hygiene and feeding practices, and issues related to pregnancy and lactation. A few CGs stressed on the need to **"**weigh the child so that the child's health improved"**.** This gave a glimpse of significant emphasis placed on weight as an indicator of health by the AWWs which was communicated to the CGs.. Another CGs felt "attending NCCS would improve health of the child" which indicated a communication gap regarding implications of the NCCS. One of the CGs focussed on "playing with the child and spending time with the child" which indicated focus on cognitive development and socio-emotional development through 'stimulation'.

The ICDS staff at various levels highlighted the importance of counselling to bring about changes in the behaviour although a uniform conceptualisation of counselling was missing. A UNICEF staff highlighted that counselling skills of the AWWs were not appropriate as they did not focus on individual assessment of each child. A PD cell member and a UNICEF staff mentioned that counselling did not occur for all the 12 days. Since the quality of counselling has a bearing on the understanding of childcare practices adopted by the CGs, inefficient counselling process could impact the PD programme. A UNICEF staff suggested use of intensive module on counselling prepared by the WHO. The improved counselling skills could have huge impact on the way the AWWs communicate with the individual members of the community for better understanding of health and nutritional aspects.

- **Evaluation of NCCS by stakeholders**

The physical changes in a child was seen as the most crucial impact of the NCCS though limited attention was given to cognitive and socio-emotional development. Majority of the CGs said that they kept a track on the physical changes in their child; 29 CGs mentioned about their children gaining weight. The improvement in health of the child was mentioned by 11 CGs. Notwithstanding the fact that gaining weight was not the only criteria to assess a child's health, some CGs perceived that their children were healthy if they gained weight. . Activity level of the child was seen as an indicator of change by some CGs Playfulness and responsiveness were seen as an indicator of health as one of the CGs mentioned that her child was playing more than earlier and another CG explained that her child had gained weight but was not so playful. This indicated limited reference to cognitive and socio-emotional development.

Data on Positive Deviance Approach from the ICDS headquaters, Kapatipada, Mayurbhanj suggested that children undernourished before PDA(Positive Deviance Approach) was 27.6 per cent which now stood at 19.3 per cent. However, deeper analysis was required to understand the change in grades of undernutrition, particularly keeping in mind that new grades had evolved from the WHO standards. Since Koraput district had recently undergone upgradation, data to understand the effectiveness of PDA was not available.

A PD cell member pointed out that low weight gain after NCCS, implied ineffectiveness of the 12-day implementation programme of the scheme. Issues such as overburden with ICDS and non ICDS related activities was brought to light by some of the AWWs leading to difficulty in conducting the NCCS and the PD programme. One of these AWWs mentioned that duties related to other government schemes affected her ability to carry out the programme.

The concept of graduation was not understood by the AWWs and CGs as highlighted by a UNICEF staff and a PD cell member. This was corroborated by the fact that a few AWWs were not able to explain the concept of graduation. According to a few AWWs, some mothers did not continue the PD practice after graduation. One of the AWWs said that after the child gained weight mothers discontinued the PD practice, implying that long term behaviour change may not happen. Sector level officials also highlighted the issue of overburden though a PD cell member pointed out ineffective implementation as the reason for overburden. Thus, a cause and effect cycle was established.

- **Role of family in helping Caregivers to access NCCS**

About 43 per cent of the CGs said they did not receive any help from their family. Almost half of the 57 per cent CGs who received help did not reply who helped them or in what way they were helped. Most of the CGs were helped either by their husbands or mothers-in-law, except in a few cases in which their mothers came forward to help. Lot of CGs said that people took children to the AWCs although their focus was not on attending the NCCS. A few of the CGs

mentioned about their husbands attending the NCCS while some others said that their mothers-in-law supported and motivated them to attend the NCCS for the sake of the child's health improvement.

Home visits

The home visits are conducted for 18 days after the NCCS to support mothers and also reinforce practices learnt during the NCCS. Although AWWs conducted home visits, there was no designated time or planning to conduct the visits as frequency of visits ranged from every day to once a month. Higher numbers of visits were reported where AWWs lived close to the CGs indicating discrepancies in number of visits.

AWWs are key implementers for PD programme. As highlighted by a sector level official "jahan AWW active hai wahan community active hai" (where AWW is active, community is active).

The home visits by the AWWs entailed observation of the PD practices, however, only a few AWWs reported conducting observations. Majority of the issues discussed by most of the AWWs related to feeding, hygiene and sanitation practices. Of the 31 CGs, 61 per cent reported that the AWW discussed issues with them and 39 per cent reported AWWs discussed with them and their families. Some CGs reported that they discussed about the child's health with their families. A CGs mentioned that health of a child was discussed mostly with the mother as other family members used to be mostly at work. While some CGs reported that AWWs discussed family problems, social and financial issues, others felt that AWWs visit to their homes were only to chit chat and had little to do with pursuing the PD practices. According to some CGs a few of the AWWs visited them only when a child was sick, or during the home visits the AWWs asked them not to have more than two-three children. In other words, home visits were not focussed on proper implementation of the PD practices. An important aspect of the home visits was to involve the family during discussions. However, in most cases the AWWS seemed to have overlooked this aspect.

- **Effectiveness of PD practices followed at home**

The effective implementation of the PD practices by CGs is an essential outcome of NCCS. Out of the 38 CGs, while 76 per cent reported no problems in the implementation process, many AWWs believed that there was an ineffective implementation of the practice by the CGs at home. For instance, an AWW mentioned that sometimes mothers even after cooking the food leave it behind without feeding the child. The PD practices consist of a wide spectrum of activities. While 90 per cent of the times feeding and cooking were reported as compared to 51 per cent times for hygiene and sanitation practices. There were some misconceptions regarding the PD practices as some of the CGs said they "feed the child with food given by the AWWs", they "cook according to the wish of the child" or "cooking PD recipes (rice, gram, but no

vegetables)". A few of the CGs said they followed the PD practices by "washing hands during the day and not at night". This kind of understanding undermines the importance of effective implementation of the practice. Few CGs mentioned prioritizing 'time' for the child before leaving for work, or playing with the child. Therefore, while many CGs felt they were implementing the PD practice effectively, the AWWs pointed towards ineffective implementation of the practice. Since there was a misconception about the PD practice, it was clear that the CGs had not been explained about the PD practice at home level properly.

Case study:

Geeta (name changed), mother of a one-year-old child has been attending the PD programme since the child was one month old. She attended 12 days of the NCCS and the first day of the mothers' meeting. Her child has gained weight and is healthy now. She is aware of several PD practices such as cooking food separately, feeding the child, taking care of child, giving medicines to the child when ill, hand-washing and giving time to the child. Different dishes were prepared on all 12 days of the NCCS. She is aware of the immunisation programme at the centre. According to her, even if the AWW doesn't call, mothers go to the centre and plan cooking schedule. Her family supports her by pursuing the PD practices themselves.

Some of the CGs reported difficulty in conducting the PD practice on account of difficulty in cooking separately, unavailability of vegetables, going out to work, time constraints and need to provide separate food not seen as "child gets separate food in AWC". A PD cell member highlighted that mothers do not consider food prepared in the NCCS as an additional meal. A CG mentioned that in case it was difficult for everyone in the family to implement a practice, the family did not follow it. Similar issues affecting implementation were echoed by the AWWs. Few AWWs highlighted that lack of awareness about child care by mothers-in-law affected the implementation plan. The AWWs also raised issues such as lack of "right attitude" and financial constraints to buy soap; child care by sibling; low motivational level and other economic factors affecting implementation.

- **Role of secondary care givers in implementation of PD at home**

The role of families is crucial for the implementation of the PD practices though involvement does not happen as anticipated. Contrasting views were put forth by the AWWs and CGs as five out of 12 AWWs highlighted that men did not support women in the PD programme. However, the help from men was reported by 78 per cent of the 23 CGs. Men took up role such as purchasing vegetables from market and helping the CGs in bathing the child, taking care of the child's health and so on. Support in cooking the food and feeding the child was reported by five CGs though only two of the CGs reported that their husbands cooked food according to the PD practices. This reflected the importance of men in the implementation process although no specific roles have been assigned to them in the PD programme. Some of the AWWs also

highlighted that men asked women to “listen” to the AWWs. The patriarchal norms can be construed as in many instances men have the decision making power regarding issues impacting child care.

Monitoring

Reporting mechanisms exist, and are utilised by the ICDS staff, in the PD programme to collect quantitative data regarding the progress of the programme. Although ICDS has implemented reporting mechanisms, they have had limited success implementing monitoring mechanisms and collecting qualitative data about the PD programme.

The quality of monitoring of the PD programme is affected by low regularity of visits by the ICDS staff to the AWCs. A member of district level staff reported that the CDPO tries to visit the AWC at least once a month and the AWC which are far away, the CDPO tries visiting those once in every three months. While one of the AWWs reported that the CDPO conducted home visits, another reported that the CDPO counsels mothers. Yet a few AWWs reported that SS visited them during the NCCS. However, an AWW reported that the CDPO comes once or twice in a year, takes a cursory glance, lectures and goes away and another AWW reported that her CDPO comes only once in every two or three months. Sector level staff reported that they try to visit the AWC at least once per month where they watch the NCCS and help the AWWs use the PD tools.

Sector and AWC staff highlighted that they are overburdened which limits their capacity to effectively monitor the PD programme. Sector level staff reported that they work 12 hours a day because of less manpower and generally one SS has to monitor 30 to 40 AWCs when ideally they should monitor 15 to 20 centres. The SS emphasised that they “have to do more office work than field work” and as a result “supervision is not up to the mark”. Sector level staff reported that AWWs have to maintain more than 20 registers at a time and five AWW reported that they feel overburdened. The SS felt the number of registers maintained by the AWWs should be reduced to “four to five”.

A member of the PD cell reported that community involvement in the PD programme is the hardest task to monitor. Four AWW reported that the SS motivate the mothers to attend the PD programme through home visits and counselling. Block level staff reported that SS attended community meetings to solve the problem and improve communication between the AWWs and communities. Five AWWs also reported participation of SS in meetings with the community. All 12 AWW reported that they were often supervised/ monitored by the SS and seven of them said they were sometimes supervised/ monitored by the CDPO.

Feedback regarding the implementation of the PD programme is limited, according to majority of the stakeholders. Block level staff reported that the SS ask the AWWs for suggestions on

improving the PD programme. District level staff reported that AWWs tell the SS about village problems and that the SS report these problems during meetings. Some of the SS reported that feedback is collected regarding the nutrition grade of children, community contributions, questions the mothers if the children were not brought for weighing. However, other SS emphasised that feedback was not very detailed, the steps for feedback were "tedious" and feedback was "not fulfilled timely". One AWW reported that she provided feedback to the CDPO during visits. An AWW reported that she does not discuss issues with her SS rather if mothers do not contribute to the Akhya Patra (food basket) she substitutes it with other food available from ICDS. Another AWW reported that "if they [SS and CDPO] get to know that some visitors are coming they visit a day before and tell me what has to be done".

Case Study: Anganwadi worker

Sarita (name changed) has conducted NCCS ever since she received training from her supervisors. She conducted PD Inquiry by observing how people fed their children during the home visits. She conducted counselling with the help of pictures received from the ICDS. During the home visits she explained about quantity of food, cleanliness of the child and also, continual feeding of the child when she fell sick. Whenever she was overburdened, VHC helped her with the home visits. Support from the supervisors helped her during the PD programme. The supervisors attending the NCCS visited the homes and explained issues which Sarita cannot. Both CDPO and Supervisor keep a track on whether the women were being involved or not.

Although all stakeholders discussed feedback provided by the AWWs to SS, however, only two ICDS staff (at the district and sector level) referred to feedback taken by AWWs from CGs. Few CGs reported about the AWW taking feedback from them regarding the PD programme. About 15 CGs out of 49 reported their AWW taking feedback regarding different issues. However, many of these issues should be classified as counselling as they discussed matters regarding contributions for food prepared during the NCCS and child healthcare, sanitation and feeding practices. A few CGs specified that the AWW took feedback at mothers meetings at the AWC every month. The PD cell mentioned that the PD cell consultants conduct field visits and give feedback to district and block level staff. A PD cell member reported that monitoring and feedback was getting stronger since the creation of the PD cell.

The ICDS utilise mechanisms to collect quantitative data. Although mechanisms for qualitative data have been put in place, they are less effectively implemented. District level ICDS staff reported that the AWW training and PD programme data was collected during review meetings at the district level. Block level staff reported that the community level data, including growth charts, were collected by the AWWs. According to the sector level staff the AWW data was provided in "total format" rather than for individual children. Block level staff highlighted that

a SS collect data regarding implementation of the PD programme and submit it during sector level meetings at the block level office. The long compilation process for data collected showed the ICDS staff often skipping analysis and data collection. A member of district level staff reported that senior officials interest in the PD programme had diminished since the programme first started due to work pressure and difficulties faced with monitoring and supervision.

Data collected by the ICDS staff regarding the PD programme was not universalised which led to difficulties with analysis of the effectiveness of the PD programme. A PD cell member highlighted that data collected in 2005 was no longer available since the format for data collection had been revised multiple times and in the process lost the data, impacting the ability of the Government to analyse the long term effect of the programme. The PD cell members also reported that the state level analysis and reports were not shared with other levels of the ICDS. Therefore district, block and sector level staff were not able to monitor and evaluate the progress made in the programme. Block level staff reported that SS review PD activities every month in all AWCs, discuss all issues, review enrolment and nutritional status of children and assist the AWWs with community interaction. However, only one AWW reported improvement in nutrition grades. The weight of children attending NCCS is being monitored. The ICDS staff at sector, block and district level use different methods and data (NCCS data, skills of AWW, past and present data) to rate the efficiency of the AWC implementing the PD programme, and then they forward this data to the district level for compilation.

The ICDS staff held meetings to monitor the implementation of the PD programme widely used by ICDS staff but success of such meetings varied. An AWW reported that a meeting was arranged in the AWC with SHGs and Gram Kalyan Smatis (GKS) and SS. But the meeting ended with general discussions. The ICDS staff provided different reports regarding monitoring meetings for the PD programme. Different ICDS staff described different meetings, including district, block, sector level meetings and pre-NCCS mothers' meeting. But none of them provided an overview of the PD monitoring meetings. The ICDS staff also used different terminology to describe the PD monitoring meetings such as project meetings, PD specific meeting, PD review meeting. The ICDS staff reported during the meetings that the staff reviewed the programme, collected data, resolved implementation issues and shared good work from AWCs to motivate well performing AWWs. Another district level official highlighted that district level PD monitoring committee was planning to visit two AWCs per month but it was yet to happen.While seven AWWs reported going to specific PD programme meetings, five AWWs reported no specific meeting and only one AWW reported holding two programme meetings relating to PD since PD programme started.

A gap in monitoring mechanisms lacked data, indicating long term effects on the PD programme. Few AWWs reported that the PD practices were being followed after a child graduated from the NCCS and monitoring was done during the home visits. While some did not even understand

the concept of graduation, a few others spoke about mothers not continuing PD practices. One AWW highlighted that mothers stop pursuing with the PD practices once their child gained weight. This lead to no monitoring of long term behaviour change. Two AWWs reported mothers did not follow PD practices due to economic issues or difficulty accessing nutritious food or time constrains. A member of the PD cell reported that the PD programme data format did not collect the number of children attending the last trimesters nor did it provide monthly analysis of children's attendance. Therefore, estimates of graduation data from the NCCS rely on the AWW perception. Another PD cell member agreed that the length of each child's attendance at the NCCS was not monitored. In her opinion children often graduated after five-six months but there was "no data to support this". Therefore, it was not known whether the PD practices were being continued after the monitoring period.

Conclusion

The research work is an exploratory study to understand perception of various stakeholders involved in the PD programme. The nature of the study is not evaluative and hence, it is difficult to make assumptions about the effectiveness of the PD programme on a large scale. Behaviour change is observed over a period of time and is one of the most important outcomes of the PD approach which was difficult to capture in the study.

- The planning of the PD ensures that, in theory, the programme is an effective method to impact undernutrition. However, systemic issues within the ICDS affect the quality of implementation of the PD programme.

- Senior officials are not provided with quality training regarding the PD programme which in turn affects the quality of training provided to the AWWs and Caregivers since training is implemented through a cascade system. Ineffective initial training and the cascade system create a knowledge gap as information is diluted during the process of transmission. Many stakeholders attributed the effectiveness of the PD programme primarily to the actions of the AWWs, however, other stakeholders highlighted that since the AWW are not provided with quality training this limits their capacity to implement the PD programme effectively.

- Ensuring ownership of the PD programme by women in a society influenced by patriarchal norm is problematic without addressing issue of gender empowerment. The PD programme contributes to the ICDS aim build the capacity of women to implement effective child care and nutrition related practices. Active involvement of women, as seen in some of the villages, can heighten efficacy of the whole programme.

- The mechanisms for monitoring the PD programme are present although the utilisation of these mechanisms is limited. Data collected for the ICDS and the PD programme is largely quantitative and nuances regarding the effectiveness of the programme, which could determine the long term behaviour changes in a particular community, are not recorded.

- The solutions perceived by various stakeholders focus on strengthening the monitoring and supervision of the PD programme. Focus on supportive supervision is required especially in the context of the PD Inquiry, counselling and home visits because some of the AWWs lack skills in these areas which limits the effective implementation of the PD programme.

Way Forward

Planning

- A member of the PD cell emphasised that the PD programme should not be implemented as a uniform strategy but should be adapted to local requirements since across Orissa 30 per cent of the population belong to tribal groups which have specific issues and contexts and even individual communities are not homogenous groups, rather they are collections of distinct and sometimes competing stakeholders which can impact the effectiveness of the PD programme.

- In order to achieve differential planning for local communities either the AWW training should focus on methods to adapt the PD planning according to local requirements or locally adaptable plans should be formulated at the state level which can be replicated by the AWWs.

- UNICEF staff recommended that alongside improving the PD programme the ICDS should aim to improve the systemic issues within the system such as overburden on anganwadi worker and sector supervisors, lack of supportive supervision among others which limit the effective implementation of the PD programme and other ICDS programmes.

Collaboration

- Members of district level and UNICEF staff recommended that staff involved in the PD programme should increase coordination with other government departments and non-government organisations that can support the PD programme of the ICDS. District level ICES staff emphasised the need for collaboration with health staff who are involved only in programme training. A PD cell member emphasised the need for collaboration between the state and district nutrient cells with the PD cell.

- A member of the PD cell recommended that the ICDS staff coordinate and collaborate with the Department for International Development, better known as DFID, funded experts (in nutrition, behaviour change communication, training and monitoring and evaluation) who are implementing the new Nutrition Operation plan for Orissa.

- A PD cell member recommended that scale-up of the PD programme should be near to the AWCs where PD has been running successfully that can support scale-up.

Human Resources

- District level staff recommended that the number of the ICDS staff at all levels be increased to fill empty posts, particularly at the field level, to cope up with the PD programme scale up, and to fill the positions which have been created through court order need to rapidly implement the court order. Increased number of field level staff is required to build the capacity of sector level staff to frequently and regularly monitor AWCs, conduct meetings regarding PD and positively interact with communities.

- Support staff should be hired at the block, district and state level to reduce overburdening of current staff and to carry out data collection, analysis and report creation to increase capacity of DSWO, CDPO and PO to efficiently manage and monitor the PD programme.

- The monitoring and data collection process at all levels should be computerised to increase ease of data analysis, use and dissemination and reduce time spent by ICES staff compiling data at the district and state levels and thus, reduce the overall time constraint upon the staff.

- Roles and responsibilities of the ICDS staff in the PD planning should be defined and a summary of these should be provided to every level of staff in the PD programme to facilitate coordination and collaboration.

Training

- Sector level staff recommended that the quality of AWW training should be improved; trainers should always provide AWWs with an exposure visit to AWCs, and AWWs should receive refresher training.

- One AWW recommended that the PD training should be provided through demonstrations rather than through lectures. Several AWWs recommended that AWW training for the programme be made longer to facilitate an in-depth learning.

Implementation

- Sector level staff recommended that the AWC infrastructure should be improved to enable the AWW to effectively carry out the PD programme activities. District and sector level staff recommended that sufficient facilities, particularly transport, should be provided for SS to enable them to efficiently supervise and monitor the PD programme.

- AWW and SS should emphasise the importance of socio-emotional development of children attending the NCCS and the use of multiple indicators, such as responsiveness, to assess the child's health. Currently, increasing weight is often assumed to mean the child's nutrition

and health has improved although weight alone cannot indicate the health of a child. Emphasis of the NCCS on weight as the primary indicator of health may produce long term negative effects if mothers replicate weight orientated childcare behaviours throughout the child's life.

- District and sector level staff recommended that financial incentives should be provided to the AWWs to motivate them and a contingency fund should be provided to the AWWs for daily expenses incurred in the PD programme implementation.

- UNICEF staff recommended lesser number of NCCS days to enable the CGs to attend all sessions without resulting in severe income loss. UNICEF feels this will encourage the CGs to attend all sessions and not a few as currently being followed.

Community Participation

- One group of SS recommended that mothers attending the NCCS also be taught economic activities, receive financial incentives and be involved in the SHGs. Provision of training would motivate mothers to attend the NCCS, encourage their husbands to support them in attending the sessions and eventually help in increasing their family's economic security and financial capacity by implementing the PD practices at home.

- PD training for the ICDS staff and the AWWs should focus on positive, participatory interaction between the ICDS staff and community members, and build up the capacity of the ICDS staff to ensure an active, meaningful role of the community and groups in planning and implementing the PD programme, in encouraging community participation and reducing burden on the AWWs and SS.

- A member of UNICEF recommended that adolescent groups be involved in assisting the AWWs to implement the PD programme because they are an active group and their involvement in the programme would sensitise them to issues within the programme before they become mothers.

- One AWW recommended greater communication between block level ICDS staff and community members to encourage community understanding of and support for the PD programme and AWWs work. Block level member of the ICDS staff recommended increased involvement of the SHGs, panchyat, teachers and community members in community meetings to encourage community participation. One of the UNICEF staff recommended that the NCCS timings and other PD activaties should be organised according to the needs of the mothers to ensure their participation.

Monitoring

Planning

- A PD cell member recommended that the coordination and organisation of monitoring should be improved by designating a specific day for data collection and conducting the NCCS to make it easier for the SS as well as other levels of the ICDS. The PD cell member also recommended that monitoring should be planned by and coordinated between the state and district level and the CDPOs, rather than by the SS.

Data

- Monitoring data should provide socio-emotional development data of every child in the NCCS. Currently this data is not collected. Therefore, there is no mechanism to assess whether the psycho-social aspects of the PD programme are being implemented effectively or not.

- SS recommended that the 20-odd monitoring registers maintained by the AWWs should be reduced to only four or five. This will reduce burden on the AWWs.

- A PD cell member recommended greater emphasis by the ICDS on the collection of qualitative data. Although mechanisms are in place to record qualitative data, collection of data is limited.

Data Collection

- Community members (NCCS CGs, community groups and other community members) should have a specific and emphasised role in monitoring and evaluation of the PD programme. Community feedback will provide important data regarding the quality of implementation of the programme and increase the community's sense of ownership over the programme.

- CDPO, DSWO and PO should focus primarily on management of the PD and other ICDS programmes and facilitate the monitoring process rather than participate in data collation or training of the ICDS staff. Limiting responsibilities of the district and block staff would increase their capacity to manage and coordinate the PD programme, provide increased support to the field level staff to interact with communities.

- A member of UNICEF recommended that the ICDS should involve external monitors in qualitative data collection and analysis for the PD programme. A cost effective method would be to hire four people (from NGOs or local communities) for one month to visit 40 villages and collect qualitative data through community focus group discussions and at the end of it produce a data report for the district level ICDS staff to supplement ICDS's quantitative data record.

Supervision

- A member of the PD cell recommended a district level PD cell for monitoring and supervision of the PD programme.
- The sector level staff recommended a separate supervisor, may be from the community itself, be designated to supervise the quality of the PD programme.
- A member of UNICEF recommended that methods of supportive supervision be highlighted during training of the ICDS staff and AWWs to encourage coordination at various levels of the ICDS.

Meetings

- Block, district and sector level staff recommended improving the quality, frequency and regularity of supervision of the PD programme, particularly through regular reviews of the PD programme and meetings with communities and improving the quality and regularity of home visits.

References

Agnes, U., Mackintosh, T., Marsh, D. & Schroeder, D. (2002) – "*Sustained positive deviant child care practices and their effects on child growth in Viet Nam*", Food and Nutrition Bulletin, Vol. 23, No. 4 (Supplement), The United Nations University

Antwiwaa Nti, C. & Lartey, A. (2008) – "*Influence of care practices on nutritional status of Ghanaian children"*, Nutrition Research and Practice, Vol. 2, No. 2, pp. 93-99

Bégin, F., Edward, A., Frongillo, Jr. & Delisle, H. (1999) – "*Caregiver Behaviors and Resources Influence Child Height-for-Age in Rural Chad*", Journal of Nutrition, Vol. 129, pp. 680-686

Berggren, W. & Wray, J. (2002) – "*Positive deviant behavior and nutrition education*", Food and Nutrition Bulletin, Vol. 23, No. 4 (Supplement), The United Nations University

Bolles, K., Speraw, C., Gerggren, G., & Lafontant, J. (2002) – "*Ti Foyer (hearth) community-based nutrition activities informed by the positive deviance approach in Leogane, Haiti: A programmatic description*", Food and Nutrition Bulletin, Vol. 23, No. 4 (Supplement), The United Nations University

Engle, P., Bentley, M. & Pelto, G. (2000) – "The role of care in nutrition programmes: current research and a research agenda", Proceedings of the Nutrition Society, Cambridge University Press, Vol. 59, pp. 25-35

Ghosh, Shanthi (2004): "*Food Dole on Health, Nutrition and Development Programme*", *Economic and Political Weekly*, vol.41, no.34, August 26, pp 3664 – 3666.

Gragnolati, M. et al. (2006) – "*ICDS and Persistent Undernutrition – Strategies to Enhance the Impact*", Economic and Political Weekly, March 25 (Special Articles), pp. 1193-1201

Hendrickson, J. et al. (2002) – "*Empowerment in Rural Viet Nam: Exploring changes in mothers and health volunteers in the context of an integrated nutrition project*", Food and Nutrition Bulletin, Vol. 23, No. 4 (Supplement), The United Nations University

Horton, S. et al. (2010) – "*Scaling up nutrition: What will it cost?"*, The World Bank.

Lapping, K. et al. (2002) – "*Comparison of a positive deviant inquiry with a case-control study to identify factors associated with nutritional status among Afghan refugee children in Pakistan*", *Food and Nutrition Bulletin, V*ol. 23, No. 4 (Supplement), The United Nations University

Levinson, F., Barney, J., Bassett, L. & Schiltink, W. (2007) – "*Utilization of positive deviance analysis in evaluating community-based nutrition programs: An application to the Dular program in Bihar, India*". Food and Nutrition, Vol. 28, No. 3, The United Nations University

Marsh, D. et al. (2002) – "*Design of a prospective, randomized evaluation of an integrated nutrition program in rural Viet Nam*", *Food and Nutrition Bulletin, V*ol. 23, No. 4 (Supplement), The United Nations University

Marsh, D. et al. (2004) – "*The power of positive deviance*", BMJ, Vol. 329, pp. 1177-1179

Martorell, R. et al. (2009) – "*Weight Gain in the First Two Years of Life Is an Important Predictor of Schooling Outcomes in Pooled Analyses from Five Birth Cohorts from Low- and Middle-Income Countries.",* The Journal of Nutrition.

Monteiro, C. et al. (2010) – "*Narrowing socioeconomic inequality in child stunting: the Brazilian experience.",* Bull World Health Organization.

Office of Registrar General, India (2000) – "*Population projections 2001-2026"*

Ramji, S. (2009) – "*Impact of infant & young child feeding & caring practices on nutritional status & health"*, The Indian Journal of Medical Research, Vol. 130, November, pp. 624-626

Sethi, V., Sushma, K., Veenu, S. & Siddharth, A. (2003) – "*Encouraging appropriate infant feeding practices in slums: A positive deviance approach*", Pakistan Journal of Nutrition, Vol. 2, Issue. 3, pp. 164-166

Sharma, M. et al. (2009) – "*Accelerating Malnutrition Reduction in Orissa*", IDS Bulletin, Vol. 40, No. 4, 4 July 2009

Sternin, M., Sternin, J. & Marsh, D. (1998) – "*Designing a Community-Based Nutrition Program Using the Hearth Model and the Positive Deviance Approach - A Field Guide*", Save the Children, USA

UNICEF (2009) – "*The State of the World's Children – Celebrating 20 Years of the Convention on the Rights of the Child*", United Nations Children's Fund, New York, November (Special Edition), pp. 33

WHO (2008) – "*Indicators for assessing infant and young child feeding practices"*, Conclusions of a consensus meeting held 6–8 November 2007 in Washington, DC, USA

Zeitlin, M., Ghassemi, H. & Mansour, M. (1990) – "*Positive Deviance in Child Nutrition - with emphasis on Psychosocial and Behavioural Aspects and Implications for Development"*, The United Nations University

Websites:

Chandrasekhar, C. & Ghosh, J. (2005) – "*The Unfulfilled Potential of the ICDS*", Macroscan, http://www.macroscan.org/fet/mar05/fet210305ICDS.htm, [Date Last Accessed 29/07/2010]

Jena, M. (2008) – "'*Ame Bi Paribu': Positively Deviant*", Nutrition, India, UNICEF, http://www.unicef.org/india/nutrition_4622.htm, [Date Last Accessed 29/07/2010]

Rao, J. (2008) – "*The History of Child Rights in India*", The Children, India, UNICEF, http://www.unicef.org/india/children_3220.htm, [Date Last Accessed 29/07/2010]

UNICEF (2006) – "*Undernutrition*", Progress For Children, http://www.unicef.org/progressforchildren/2006n4/undernutritiondefinition.html, [Date Last Accessed 29/07/2009]

Annexure

Informed Consent Form

Title of study: Documentation of Positive Deviance Programme in Orissa to address under-nutrition among infant & young children**.**

Introduction: Namaste, We are___ and we are conducting a study on PD, as a part of our internship programme with UNICEF and KIIT University. We are conducting data collection to understand the PD Process in Orissa. We would very much appreciate if you participate in this survey.

Reasons for selection of caregiver:

We have chosen to speak to you because you have a child below three years of age who is attending 'AWC feeding programme'. We are interested in learning about this programme.

Procedures: We would be asking you about your knowledge, perceptions and experience about the PD programme in your area. If you agree to take part, we will ask you for information about your knowledge and perception and related issues to this programme. We will also ask for information about your age, education and work experience. The amount of time needed will be about half-an-hour. If you allow we would like to take some photographs.

Benefits: It will help us to document the PD process and thus help the government as well as other agencies to understand the programme better and further strengthen the programme. By taking part in the questionnaire you will help increase our understanding of PD, and Children's health issues and needs.

Confidentiality: Whatever information you provide will be kept strictly confidential and will not be shown to any other person or organisation.

Voluntary participation: Participation in this survey is purely voluntary. After starting answering of questions, if you decide not to participate, at any point of time you may stop answering questions.

Permission: I hope that you will participate in this survey since your views are very important to us. Please feel free and give me the answers of the questions I am going to ask you.

Further Information: If you have any question , please ask do so and I shall be happy to answer you.

Are you willing to participate in this study?

Consent YES / NO (Please circle)

Signature of Interviewer: _____ ***Date:*** _____

RESPONDENT AGREES FOR INTERVIEW.....Continue

RESPONDENT DOES NOT AGREE FOR INTERVIEW.....----------> END

Background Note on Internship Programme

Knowledge Community on Children in India (KCCI) initiative aims to enhance knowledge management and sharing of policies and programmes related to children in India. Conceived as part of KCCI, the objectives of the 2010 Summer Internship Programme were to give young graduate students from across the world an opportunity to gain field-level experience of and exposure to the challenges and issues facing development work in India today.

UNICEF India hosted 44 interns from Australia, Canada, Nigeria, Poland, Russia, United Kingdom, and United States of America to participate in the 2010 Summer Internship Programme. Interns were grouped into teams of four or five and placed in sixteen different research institutions across 9 states (Andhra Pradesh, Assam, Bihar, Delhi, Madhya Pradesh, Maharashtra, Orissa, Rajasthan and West Bengal), studying field-level interventions for children from 31 May to 3 August 2010.

Under the supervision of partner research institutions, the interns conducted a combination of desk research and fieldwork, the end result of which were 12 case studies of interventions aimed at promoting the rights of children and their development. The case studies cover key sectors linked to children and development in India, and address important policy issues for children in the country. These include child health, nutrition, water and sanitation, education, child rights, and polio eradication.

Another unique feature of this programme was the composition of research teams comprising interns with multidisciplinary academic training and multicultural backgrounds. Teams were encouraged to pool their skills and knowledge prior to the fieldwork and devise a work-plan that allowed each team member an equal role in developing the case study. Group work and cooperation were key elements in the production of outputs, and all of this is evident in the interesting and multifaceted narratives presented by these case studies on development in India.

The 2010 KCCI Summer Internship Programme culminated in a final workshop, at which all teams of interns presented their case studies for a discussion on broader issues relating to improvements in service delivery for every child in the country. This series of case studies aims to disseminate this research to a wider audience and to provide valuable contributions to KCCI’s overall knowledge base.