Accredited social and health advisors (ASHAs) use counselling cards on a home visit to a 14-month-old malnourished child, in Bihar

Translating the Home-Based Care for the Young Child initiative into action for young child feeding in Bihar state, India

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Introduction

The Indian state of Bihar has the highest percentage of stunted children under the age of five among all states, at approximately 48% – almost 10% higher than the national average of 38%2. Moreover, wasting prevalence in children under five years old is a staggering 21%, second only to the neighbouring state, Jharkhand[2]. In addition, underlying care and feeding practices continue to be sub-optimal in Bihar, with an estimated 53% of children aged 6-23 months being exclusively breastfed for the first six months of life, and alarmingly only 7% receiving a minimally adequate diet[3].

Urgent action is needed to improve the care and feeding practices of infants and young children in India in order to achieve the targets of POSHAN Abhiyaan, India's national nutrition mission. Efforts to strengthen the implementation of national-level policies are focusing on approaches to improve the coverage, continuity, intensity and quality of essential nutrition services. Due to its high burden of malnutrition, Bihar was chosen one of the states to roll out a new initiative, Home-Based Care for the Young Child (HBYC), a joint initiative of the Ministry of Health and Family Welfare (MoHFW) and Ministry of Women and Child Development (MWCD) that seeks to improve the health, nutrition and development of young children through home visits by community-based frontline workers. An example of translating national policy into action on the ground, HBYC is being implemented in a phased manner across the country, starting with a focus on 117 aspirational districts in various states, including

[1] The Alive & Thrive initiative, managed by FHI 360, is funded by the Bill & Melinda Gates Foundation, Irish Aid, the Tanoto Foundation and UNICEF.
[2] https://globalnutritionreport.org/resources/nutrition-profiles/asia/southern-asia/india/#profile National Family Health Survey (NFHS)-4 (2015-16).
[3] Percentage of children 6-23 months who received foods from four or more food groups from seven food groups (grains/tubers/roots, legumes/nuts, flesh foods, dairy products, eggs, vitamin A-rich fruits/vegetables and other vegetables/fruits).

districts in Bihar[4]. The HBYC initiative is intended to intensify efforts to counsel caregivers on infant and young child feeding (IYCF) practices in India.

Overview of India's IYCF programme

At the national level, IYCF services are delivered through two large-scale platforms: the Integrated Child Development Services (ICDS) programme under the MWCD, with nearly two million frontline workers (Anganwadi workers); and the National Health Mission under the MoHFW, with nearly one million frontline workers (Accredited social and health activists (ASHAs). The latter cadre of incentivised frontline workers provide services, including caregiver counselling, through home visits and community outreach programmes.

Experiences from the MoHFW-led Home-Based Newborn Care (HBNC) programme demonstrate that home visits in the first month of life by ASHAs can support mothers and caregivers to provide optimal health and nutrition care for newborns. Currently, ASHAs primarily focus on essential newborn care, including breastfeeding support, through scheduled visits during the first month of life, spread across days 3, 7, 14, 21, 28 and 42 in cases of institutional deliveries, and on days 1, 3, 7, 14, 21, 28 and 42 in home deliveries. Thereafter, ASHAs conduct follow-up visits only for the mobilisation of age-appropriate vaccinations up to 12 months of age. Contact with mothers and caregivers of children aged 6-23 months are at present limited and do not focus on providing information and support on complementary feeding.

Home-based care for the young child

As part of efforts to strengthen the Government of India's IYCF programme, Alive & Thrive (A&T) led a national consultation with the Government and development partners. A&T shared evidence from its experience in Bangladesh. IYCF interventions were successfully scaled up and achieved significant increases in dietary diversity, meal frequency and consumption of iron-rich foods by introducing between five and seven quality contacts between frontline workers and mothers, from conception to second birthday[5]. This evidence, together with learning from the HBNC programme, informed the revision of India's IYCF guidelines, which paved the way for the development of the HBYC programme.

The initiative is intended to place families at the centre of nurturing care for young children during the first two years of life. It aims to fill the gap in contacts with mothers and caregivers by expanding the schedule of home visits by ASHAs during the crucial 3-15-month period to complement existing home visits and outreach services through Anganwadi workers. Home visits under the HBYC initiative are designed to ensure specific support and counselling to caregivers of children for exclusive breastfeeding, complementary feeding, growth monitoring, vaccination, iron-folic acid (IFA) and vitamin A supplementation, age-appropriate play and stimulation, water, sanitation and hygiene (WASH) practices, and prevention and management of common childhood illnesses, such as diarrhoea. It is envisaged that, under the HBYC, ASHAs and Anganwadi workers will work collaboratively under the supportive leadership of auxiliary nurse midwives, who are based at village-level health centres.

Generating evidence to inform HBYC programme design

In Bihar, HBYC is being piloted in 13 aspirational districts through government systems and with support from development partners including A&T, the United Nations Children's Fund (UNICEF) and the Piramal Foundation. In 2018, a baseline study was conducted in two pilot districts, Gaya and Sitamarhi, to understand the current levels of IYCF knowledge and practice among caregivers of children under two years of age; the knowledge and skills of frontline workers; and system preparedness to implement HBYC as designed[6]. Findings from the study showed that, while knowledge of breastfeeding practices was high among mothers (~80%), only 50% initiated breastfeeding within one hour and only 36% breastfed exclusively[6]. Exclusive breastfeeding declined from 47% at three months to only 21% at five months[6]. Furthermore, less than one in five children aged 6-23 months were consuming a minimum diverse diet6. Consumption of eggs and flesh foods (14% and 15%, respectively) was low, as was consumption of vitamin A-rich fruits and vegetables (22%); and one quarter of children consumed commercially processed snacks. Less than 10% of children aged 6-23 months received IFA syrup[6].

Low diet diversity was primarily found to be due to a lack of awareness, and existing feeding and food-related norms and beliefs regarding what types and quantity of food a young child can eat or digest. For example, animal-source foods were avoided, watery foods such as light lentil soup were considered easily digestible and children were not fed from a separate bowl, making it difficult for caregivers to gauge a child's food consumption.

The baseline study also examined caregiver's access to IYCF counselling. Around 80% of mothers reported being contacted at home by Anganwadi workers and ASHAs. While two out of three mothers with infants under six months of age received breastfeeding counselling, only two in five received guidance on the introduction of CF and around half of mothers with children aged 6-23 months reported receiving only general CF information. In-depth counselling by frontline workers was missing; for example, only 11% of mothers received counselling on feeding diverse nutritious foods.

Strategies and actions to optimise HBYC delivery

The baseline findings indicated the need to optimise the use of existing home visits by frontline workers while focusing on new visits under HBYC. The programme has focused on improving the content and quality of IYCF counselling, with a special focus on increasing the knowledge and skills of mothers for adoption of age-appropriate complementary feeding practices. This, in turn, has required strengthening of frontline worker knowledge and counselling skills to deliver focused messages; for example, suggesting adding eggs (where acceptable) and vitamin-A rich fruits and vegetables to enhance diet diversity in complementary feeding.

As part of capacity building, frontline worker performance has been supported by regular mentoring and review to improve programme delivery. The Government is being supported by development partners through coordinated and harmonised actions for quality implementation of HBYC. Regular updates are also being provided to NITI Aayog, India's national think tank entrusted with the task of monitoring POSHAN Abhiyaan and undertaking periodic evaluations. Recognising that there are socioeconomic barriers to uptake of counselling messages, the population of Bihar is being supported through other programmes to help it overcome barriers to affordability of diverse high-quality foods.

[4] NITI Aayog has identified 117 districts across India as aspirational districts, based on composite indicators from health and nutrition, education, agriculture and water resources, financial inclusion, skills development and basic infrastructure, and that have an impact on the Human Development Index. https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=967&lid=587

[5] www.aliveandthrive.org/wp-content/uploads/2018/07/Alive-Thrive-Bangladesh-complementary-feeding-results.pdf

[6] Baseline Study report for implementation of the HBYC initiative in two districts of Gaya and Sitamarhi in Bihar, India 2019; A&T (unpublished).

Programme ownership and roll-out

A high level of ownership of HBYC exists at the state and district level in Bihar. Progress on HBYC is tracked during the monthly review meetings held under the chairmanship of the Executive Director of the State Health Society in Bihar (SHSB) and under the district magistrate in the pilot districts.

A core implementation support group comprised of government and development partners has been constituted under the leadership of the Executive Director of SHSB to facilitate quality roll-out of the programme. Development partners have been allocated specific districts to provide technical assistance support, which includes operational planning and quality assurance of ASHA training in the districts, regular quality monitoring using a common monitoring checklist, and mentoring support to ASHAs during the home visits. The development partners are also expected to facilitate regular review meetings of the ASHAs at district and state level and drive actions based on feedback.

Supporting frontline workers

A cascade training model has been adopted, with 100 district-level trainers being trained by state-level trainers to roll out training of ASHAs on HBYC. As of February 2020, 600 batches of trainings have been conducted in the 13 districts and 4,279 out of 14,725 ASHAs; 329 out of 1,451 ASHA facilitators; and 703 out of 3,279 auxiliary nurse midwives have been trained. (No training took place between March–June due to COVID-19). Training coverage has been delayed as ASHAs are required to complete prior training modules under HBNC as a prerequisite for HBYC training. Supporting tools and materials such as job aids and mother and child protection cards are available to all districts, with support from development partners.

The SHSB in Bihar aims to strengthen and regularise the 'triple A' meetings (between ASHAs, Anganwadi workers and auxiliary nurse midwives) at sub-block level to increase coordinated actions between the three groups and improve coordination between health and ICDS functionaries. Baseline findings also highlighted lack of adequate supervision and support to ASHAs during home visits. To address this gap, SHSB has directed the ASHA facilitators to prioritise joint home visits with ASHAs to provide supportive supervision. Block supervisors have been advised to organise refresher training sessions for ASHAs during the monthly review meetings on topics that emerge as gaps during the monitoring visits.

Challenges and next steps

Programmatically, there are challenges in forging the desired collaboration between the ASHAs and Anganwadi workers as envisaged under the HBYC programme. This is a result of coordination challenges as MWCD is still building on its ownership of the programme. Targeted advocacy is needed with the ICDS platform to encourage the active involvement of the Anganwadi workers to complement the role of ASHAs, and for engaging ICDS leadership to improve coordinated and harmonised delivery of IYCF services; especially counselling to families with children under two years old.

Key priorities for the HBYC programme include: effective acceleration of HBYC training of ASHAs; provision of supportive supervision and mentoring support to ASHAs for home visits, as per HBYC schedule; and establishing an institutional mechanism for regular review and monitoring for programme improvements. Coordinated efforts by the core group of development partners will continue to be critical for ensuring quality and driving improvements in programme performance through regular concurrent monitoring and targeted advocacy with the ICDS platform for active involvement of the Anganwadi workers.

Mothers and other caregivers need to be increasingly empowered to practice optimal IYCF behaviours. This HBYC initiative provides focused counselling support (with the capacity building of frontline workers) to build their knowledge, skills and confidence on complementary feeding, facilitating increased access to timely nutrition, health and WASH services, and creates an enabling environment promoting positive social norms on food and feeding for children.

Auxiliary nurse midwife, ASHA and ASHA facilitators during HBYC training in Muzaffarpur district, Bihar