

Form2: Evidence Review for Growth Promotion and Complementary Feeding

Name of Intervention: Anchal Se Angan Tak (ASAT) - An Early Childhood Care for Survival Growth and Development

Date of Review: July 2007

1. Location and Scale				
Number of villages by block, district and state names	Population covered	Comments	Time Period	
In seven districts , 61 blocks, 7610 AWCs Seven districts of Rajasthan: Alwar, Tonk, Rajsamand, Baran, Jhalawar, Dholpur and Jodhpur	Estimated population of 6.6 million		Project period: 2001-2006	

2. Agencies				
Lead agency(ies)	Other Key Agencies (Partners)	Implementing agencies	Sponsor/Donor	Comments
		List	Category of agency	
ICDS, Rajasthan and UNICEF		ICDS, Rajasthan	Government	UNICEF

3. Intervention Description				
Goal /Objectives	Key Strategies (5-10)	Key Components (3-5)	Primary target group	Secondary target group
The goal of the ASAT strategy is to strengthen the ICDS program so as to achieve its goal of improving child survival, growth and development	<ul style="list-style-type: none"> ▪ Life cycle approach is the cornerstone of the program strategy ▪ Counselling on health and nutrition at the household level; ▪ Communication interventions: Advocacy for awareness generation in the community, mass media, counselling, folk media, ▪ Training and capacity building ▪ Community mobilization and participation: <i>Gram Sampark Samooh (GSS)</i>-Community based action, group of 18-25 members in each group. Each household is responsible for 15-20 households. ▪ Partnership and convergence ▪ Maternal and Child Health and Nutrition (MCHN) Day - held at the AWC and facilitated by the ANM and AWW with assistance from the Sahyogini and the AWC 	<ul style="list-style-type: none"> ▪ The Mamta Card is used to monitor progress of children ▪ ASAT introduced a new cadre of local volunteers at the village level named Gram Sampark Samooh (GSS) ▪ At the Block level ASAT has just initiated (start 2006) a Block Support Team (BST) in a few blocks. Their role is to assist the staff at the block and village level to implement the program ▪ At the district level, ASAT has added a District Mobile Monitoring Training Team (DMMTT) to monitor progress and provide on the job guidance to village teams. This has just been initiated in a few districts ▪ A District Support Team (DST) has also been constituted to improve coordination between sectors, review overall progress, and ensure effective implementation across the district ▪ A State Level Training and Monitoring Unit has been formed. This is 4 member team headed by the ASAT Nodal Officer in Charge, Training and Monitoring. Three officers work under the supervisor focusing at the field level ▪ Fixed Weighing and Counselling Day - This state-wide initiative started recently (February 2006) and occurs on a fixed day one week prior to the MCHN Day. All children in the village less than six years of age are weighed. The AWW and Sahyogini facilitate the process ▪ Special Plan of Action was initiated in 2005 in 14 blocks. The goal of SPOA is to manage child malnutrition through support of ICDS by training ICDS functionaries, adopting WHO standard protocols, strengthening referral services and counselling families. The strategy focuses efforts on interventions and capacity building at the three levels: community - AWCs; family based interventions; and, district hospitals 	Pregnant women Nursing women Children between zero to six years Adolescent girls	ICDS workers Gram Sampark Samooh (GSS) members Family members

4. Information Sources			
Publication Name	Website's)/on-line	Unpublished project documents	Comments
Best practices in community-based early childcare models-DWCD-Rajasthan		World Bank India's Review of Best Practices2007 draft report	
Draft ASAT strategy evaluation report- Christine McDonald, Laura Rowe & Sarah Sadison Friedman School of Nutrition Science & policy-Tufts University			

5. Results and Data			
Methodology		Key measures/variables	Key lessons learnt (share challenges or negative results, if possible)
Designed	Implemented		Overall ASAT was well designed intervention, in spite of persistent and wider spread shortcomings of ICDS, ASAT has been fairly successful in improving certain child care and feeding practices
Cross sectional study with control .ASAT and non ASAT area by using anthropometric measurements. Note: No Baseline comparison in ASAT and non ASAT area.	As designed Final evaluation done by Tufts University, Boston	To evaluate the timeliness of introduction of appropriate complementary food To determine the extent to which BF practices are correct To evaluate immunization status To assess the appropriateness of diarrhea management To assess the appropriateness of caregivers' hygiene practices To assess the child nutritional status- growth To evaluate the effectiveness of ICDS service To evaluate ICDS management, training, and structure under ASAT strategy	<p>Strengths: ASAT strategy was well planned and comprehensive in scope, training for ICDS staff were well designed, stocks at AWCs increased</p> <p>Weaknesses: No full ownership by ICDS, trainings are poorly attended, heterogeneous group training,, lack of motivation of workers at all levels, persistent lack of monitoring & supervision of AWWs Lady Supervisors, there is indiscriminate and insufficient allocation of supplementary food, no proper distribution of supplies, political motivations are the underlying cause of much poor performance, insufficient guidance and support to community level staff, a serious lack of proactive decision making exists at all levels, lack of transportation for supervisors</p> <p>Sustained focus on under threes result in positive outcomes. Convergence and joint sessions of capacity building efforts lead to joint action in the field</p> <p>The involvement of PRIs and communities is essential for creating demand and utilization of services</p> <p>Effective government and NGO partnerships results in improved service delivery</p> <p>Gram Sampark Samooh (GSS) is quite innovative as it facilitates community participation and ownership of sustainable development of the children through better utilization of ICDS services</p> <p>Overall ASAT was well designed intervention, in spite of persistent and wider spread shortcomings of ICDS, ASAT has been fairly successful in improving certain child care and feeding practices</p> <p>Recommendations for change suggested by evaluators:</p> <ul style="list-style-type: none"> ▪ Improve training quality ▪ Establish an effective and timely monitoring system ▪ More collaboration for implementing the program
6. Program Cost			
Total per year	Estimated cost per component	Estimated cost per beneficiary/unit	Comments
NO COST DATA AVAILABLE			<p>Cost estimate: Source: WB Review of "Best Practices" in ICDS, May 2007 draft report</p> <p>For each AWC, cost of initiating and operating ASAT for one year is estimated to be INR 12,971 or US\$ 295. Of that US\$ 295, US \$240 (or about 81%) is estimated to be annually recurring costs, assuming that training will take place at all levels at least once a year. Considering only the recurring costs, the additional cost of implementing ASAT is estimated to be 11 per cent more than the regular ICDS program. The additional cost of ASAT activities (capital and recurring costs) is estimated to be 13 per cent more than the total costs of running an AWC</p>

FORM 3a - Data sheet for Effectiveness - Growth Promotion and Complementary Feeding

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List of "impact" indicators with achievements(1)	List of "outcome" indicators with achievements(1)	List of "output" indicators with achievements(1)	List sources of impact, outcome & output data	Quality of data(2)	Specify if the intervention targeted and reached women and/or vulnerable(3)
<p>Frequencies of WHO WHZ scores by district Z score WHZ>-0.99 35.6% ASAT and non ASAT 38.5% -2.99 <- WHZ<-2.00 ASAT 21% and NON ASAT 20.2% WHZ<-3.00 ASAT 6.7% Non ASAT 4.6% (P value .314)</p> <p>Frequency of WHO HAZ scores by district WHZ>-0.99 ASAT 31.8% and non ASAT 26.1% and -2.99<-WHZ<-2.00 ASAT 20% Non ASAT 26.3% (P value .002 level of significance).</p> <p>Frequencies of WHO WAZ score by district WHZ>-0.99 ASAT 22.1% non ASAT 19.7% -2.99<-WHZ<- ASAT 26.% non ASAT 28.1% (P value 0.636)</p> <p>Frequencies of NCHS WHZ scores by district Z score WHZ>-0.99 ASAT 31.9% and non ASAT 36.0%, -2.99 <- WHZ<-2.00 ASAT 21.3% and NON ASAT 20.1%, WHZ<-3.00 ASAT 6.7% Non ASAT 4.6% (P value 0.276)</p> <p>Frequency of NCHS HAZ scores by district WHZ>-0.99 ASAT 35.4% and non ASAT 28.2% and -2.99<-WHZ<-2.00 ASAT 19% Non ASAT 28.7% (P value of 0.001 level of significance).</p> <p>Frequencies of NCHS WAZ score by district WHZ>-0.99 ASAT 20.5% non ASAT 17% -2.99<-WHZ<- ASAT 30.8% non ASAT 36% (P value 0.124).</p> <p>Weight for height Z score MEANS WHO WHZ ASAT -1.42 SE 0.039 non ASAT -1.31 SE 0.038 (P value 0.044); NCHS WHZ ASAT -1.37 SE 0.033 non ASAT -1.27 SE 0.032 (P value 0.036)</p> <p>Height for age Z score MEANS WHO HAZ ASAT -1.63 SE 0.071 non ASAT -1.92 SE 0.059 (P value 0.002); NCHS HAZ ASAT -1.48 SE 0.063 non ASAT -1.73 SE 0.054 (P value 0.003)</p> <p>Weight for age Z score MEANS WHO WAZ ASAT -1.91 SE 0.049 non ASAT -2.02 SE 0.045 (P value 0.117); NCHS WAZ ASAT -1.98 SE 0.046 non ASAT -2.08 SE 0.041 (P value 0.104)</p>	<p>Significant difference in the per cent of women who feed the newborn colostrums (18% versus 47%).</p> <p>Significant difference in substance given to child before initiating breastfeeding - 39.6 per cent of ASAT mothers gave sugar water compared to 51.3 per cent of non-ASAT mothers</p> <p>Mean age of introduction of complementary foods 9.39 in ASAT and 9.92 in Non-ASAT</p>	<p>Seven District level monitoring committees were formed which comprises 10 members in each committee.</p> <p>Capacity building was done at various level including PRIs but data not available in the report.</p> <p>Child ever received supplementary food from AWC: has received 63.1 per cent in ASAT and 56.4 per cent in non-ASAT</p> <p>Regular growth monitoring by AWW: yes 59.7 per cent in ASAT and yes 42.3 per cent in Non-ASAT</p> <p>Direct contact by child or mother with AWW in ASAT 53.7 per cent non ASAT 46.8 per cent (P value 0.001 of significance)</p> <p>Direct contact by child or mother with Sahyogni in ASAT 49.7 per cent non ASAT 42.2 per cent (P value 0.005 of significance)</p>	<p>Final evaluation done by Tufts University, Boston</p>	<p>Qualitative data collected but not available, Final evaluation done by Tufts University, Boston both project and control site data and compression available No comparison with any baseline data</p>	

(1) Achievements as compared to baseline and/or control group

(2) Comments should include factors such as rigor of evaluation design, independence and multiple sources

(3) Comment as whether the intervention reached and/or had impact, outcome and output results on women and/or vulnerable. List the results