Nurturing Care Interventions for Realizing the Development Potential of Every Child: From Pilot to Scale Up in Maharashtra

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The WHO-UNICEF nurturing care framework (NCF) for early childhood development provides a roadmap for action, focusing on pregnancy and the first three years of life. It emphasizes the need to invest in capacity building and empowerment of service providers, families and communities to create a conducive environment that promotes child development. We describe our experience of implementing nurturing care interventions, beginning with a pilot project in Maharashtra covering a population of 10000 to and scaling it up to a model called *Aarambh* (the beginning), catering to a population of 1,500,000. Opportunities available within the existing services across multiple sectors were used; Integrated Child Development Services (ICDS) scheme, the health sector, and others. It utilized multiple approaches for promoting NCF within families; home visits by frontline workers (FLWs), mothers' meetings, growth monitoring and promotion sessions, and community-based events as key opportunities. Joint training for FLWs, establishing supervisors of FLWs as their trainers, and an interactive training curriculum were critical elements identified for the success of the model. An environment of appreciation for the FLWs and their supervisors helped build their confidence and helped them own the interventions.

Keywords: *Capacity building, Early childhood development, Nurturing care.*

Chronic malnutrition along with other risk factors like poverty puts children at risk of suboptimal development. India faces a very high burden of chronic child malnutrition, with 38% of children below five years reported as stunted [1]. The risk of poor development gets further augmented if a stunted child does not receive adequate responsive care [2]. With economic development and progressive improvement in child survival, it is time for India to increase the investments in nurturing care for early childhood development (NC for ECD) that helps children reach their full potential in cognitive, physical, and social-emotional development.

Pregnancy and the first three years of life is a period in which brain growth is observed to be faster than at any other time in life, and synapse formation is influenced by the experiences to which a child is exposed. Thus, the 'within family' environmental attributes influence the domains of early childhood development (ECD). Interventions focusing on development of young children build long term human capital by improving their developmental trajectory. This translates into better scholastic performance and acquisition of skills in school, and increased adult productivity. The global nurturing care framework (NCF) provides a roadmap for action for helping children to survive and thrive to maximize human potential, at the level of the individual, community, and nation [2]. Scientific evidence indicates that the provision of responsive care and early stimulation to stunted children helps them to catch up in growth to the level of their non-stunted peers [3,4]. Babies born in underprivileged families who receive all the components of nurturing care (good health, adequate nutrition, safety and security, responsive parenting and opportunities for early learning) exhibit an increase in their developmental potential. For a nation, investing in ECD is a cost-effective way to promote inclusive economic growth, end extreme poverty and break intergenerational cycles of inequity [5].

Our institution has been involved in the development, piloting and scale-up activities for nurturing care in Wardha district of Maharashtra state in India since 2010 (**Fig. 1**). This has been in partnership with frontline workers from the Integrated Child Development Services (ICDS), village level health workers i.e., accredited social health activists (ASHAs) and auxiliary nurse midwife (ANMs), and community groups. The lessons learnt from the pilot project were utilized to subsequently initiate 'Aarambh' ('The beginning'), a scale-up project that was implemented in ten ICDS projects in two districts of Maharashtra in 2018. Involvement of the local government agencies from the ministries of Woman and Child Development (ICDS) and Health and Family Welfare (ASHA and ANM) and community groups continued in this phase. Based on the cumulative positive experience of implementing these

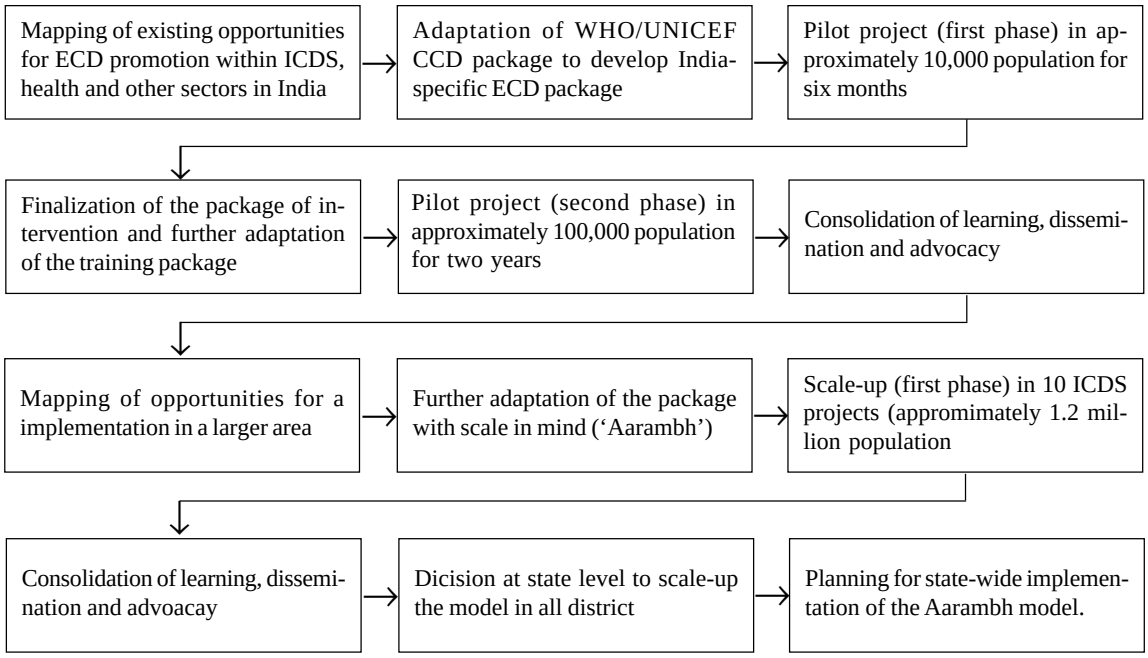

Fig.1 The journey leading from pilot to the *Aarambh* model (A model of nurturing care interventions for early childhood development).

interventions for ECD in the community, and the observed benefits in the growth and development of the included children, the Department of Woman and Child Development (WCD), Government of Maharashtra state decided to implement the 'Aarambh' model across all the districts of the state with government resources in 2021. The aim of this article is to sequentially share our experiences and lessons learnt during the entire implementation process (from pilot to block-level scale-up phase).

PILOT PHASE

The goal of the WHO/Intervida collaborative project (2010-14) was to test the feasibility and effectiveness of the WHO-UNICEF 'Care for Child Development' (CCD) package, that has been used successfully in many low- and middle-income countries (LMICs), after being adapted to our country's cultural context and community needs. The population that was covered by these interventions included a rural population of 10,000 in Wardha in the initial six months, and subsequently a population of 100,000 in the remaining duration of two years. The primary objective was to deliver a set of interventions for nurturing care using this adapted package to children aged 0-3 years, using the existing services of ICDS, the health sector, and various local community channels.

The adapted India-specific WHO-UNICEF CCD package for promotion of NC for ECD comprised of a participant's manual, facilitator's guide, counselling cards, flip charts for health education, and video films for advocacy and training. The training curriculum included an initial 3-days training of village workers i.e., anganwadi workers (AWWs) and ASHAs, followed by 1-day refresher sessions conducted every 6 months. In addition, monthly meetings of health workers at the primary health centres (PHC) were utilized for continued capacity building of the frontline workers (FLWs). An educational guide was also prepared for parents of the 0-3-year-old children in the local language. The intervention package was delivered during the monthly home visits by ASHAs and AWWs, weekly meeting of mothers of different age-group children, growth monitoring and promotion sessions annual parents' workshops, and community-based organizations like women's self-help groups and adolescent girls' groups.

The evaluation of the intervention package was undertaken by a lot quality assurance sampling (LQAS) survey that was conducted at the onset and subsequently at 6-monthly intervals. Fourteen prioritized childcare practices for nurturing care were included in these surveys during the pilot phase (**WebTable I**). Four hundred children (100 children in each age-group: 0-5, 6-11, 12-23 and 24-35 months) and their primary caregivers were covered in each round [6]. The survey also included administration of the WHO Self-Reported Questionnaire (SRQ) for identification of maternal depression. The salient observations that were seen over two years included: improvement in the coverage and quality of CCD interventions, better child-caregiver

interactions as reported by parents, increase in the proportion of mothers regularly attending mothers' group meetings (from 47% to 86%), and decline in the proportion of primary caregivers identified with maternal depression by SRQ (from 24-19%) [7].

A sub-study was planned within the pilot project to understand the nutritional outcomes (as per standard definitions) among the children under five years of age following the CCD interventions for nurturing care in the project area over a period of one year. Children with wasting were enrolled to observe the effect on their weight gain. The rate of weight gain [(mean SD)] per month was significantly more among the enrolled children in the intervention area [(161(75) vs 119 (57)g] compared to the control area. The decline in the proportion of children with severe wasting, stunting and underweight was more significant in the intervention area compared to the control area. A significantly larger proportion of children moved from the wasted to normal categories in the intervention area compared to the control area. The proportion of children with severe wasting declined from 23.0% to 2.7% in the project area, compared with the decline observed from 19.6% to 10.9% in the comparison area [8]. All these observations signify the positive effect of nurturing care provided by the caregivers who had been supported by the trained frontline workers using the intervention package. The key lessons that emerged from the pilot project are as follows:

- Parents and additional caregivers in the family are receptive to gaining information and skills related to enhancing ECD and highly value it, irrespective of the socio-economic status.
- FLWs demonstrated an interest to learn nurturing care.
- FLW developed the capacity to provide age-appropriate information and skills to parents and families; however, there is a strong felt need for continuous capacity building, beyond the initial training.
- The father and other family members need to be involved besides the mother to bring about the desired change in household childcare practices.
- Meetings of groups of mothers of children of a specific age-band was more effective in bringing about behavior change compared to mothers of a mix age-group.
- Community-level activities like parenting workshops and celebration of a dedicated 'Child development day' provide effective opportunities to reach mothers, fathers and family members.

SCALE-UP PHASE

The implementation of the Aarambh project was started by our institution with support from the state UNICEF office in 10 blocks of two districts in Maharashtra (Aurangabad and Yavatmal) in the last quarter of 2018. The aim was to develop a scalable model similar to the initial phase, except the beneficiaries would be parents and caregivers of children aged 0-6 years.

The Aarambh model adopted the principles of appreciative inquiry (AI) approach that includes participatory and consultative process of engaging the relevant stakeholders. This ensures that they jointly own the project and work together to achieve a shared vision of helping every child to achieve her/his maximum development potential. As in the initial phase, the Aarambh model used the already existing human resources and opportunities within the ICDS and health department, and their routine contact points with parents and other caregivers to deliver the NC interventions during their ongoing service delivery activities.

The intervention package was developed around the Mother and Child Protection (MCP) card implemented jointly by the MoHFW and WCD. The MCP card served both as a tool for counselling caregivers and tracking service provision [9]. **Table I** summarizes the opportunities to make existing services more nurturing and ensure enabling environment for child development at the family and community level.

Box I enlists components of the package under the Aarambh model for nurturing care interventions. Community engagement activities included home visits, mothers' meetings, monthly early childhood care and education (ECCE) days, village health and nutrition days (VHNDs), parents' meetings ('*Palak Melawa'* that was a village level platform for building community norms conducive to ECD), and other community group meetings. A cascade model of training was adopted for FLWs and their supervisors. ICDS supervisors and ASHA facilitators were trained in 5-cycles of 5-days each. They in turn provided training to AWWs and ASHAs through an initial 3-days CCD training followed by 12 sessions of 'once-a-month' refresher training. Demonstration of the approaches for community engagement and changing social norms were included in the training at all levels in the cascade. The field training was financed by the district administration to ensure sustenance.

We witnessed improvement in the nutritional and developmental outcomes of the beneficiaries. The proportion of children with underweight, stunting and wasting declined from 39.1%, 42.8% and 17.4%, respectively (November-December 2018), to 32.5%, 41.0% and 12.4%, respectively in the corresponding period in 2019 [10]. During the same period, there was a significant improvement in the mean development quotient measured by Development Screening test [11] from 107 (36) to 137 (26); and mean social quotient using the Vineland Social Maturity Scale [12] from 152 (47) to 162 (54) [13].

Table I Existing Opportunities Mapped Under Aarambh Project for Delivering Nurturing Care Interventions

Communication approaches	*Opportunities for behavior change*	*Target audience*
Customized messaging	Home visits by AWWs & ASHAs Growth monitoring and promotion	Families with pregnant women or with a child in 0-6 y age-group
Peer learning	Mothers' meetings/Parents' meetings	Caregivers (pregnant women, and those with children in 0-6 y age-group)
Community norm building	*Palak Melawa* (Parents' meeting) CBEs under *Poshan Abhiyan* *Panchayati Raj* institutions and self-help groups of women	All stakeholders at the community level (families with pregnant women or with a child in 0-6 y age-group, adolescent girls and boys, members of *Panchayati Raj* institutions and other community-based organizations, religious leaders, other influential members at community level
Opportunities at outreach and health facility	Village health and nutrition days; Healthy and sick child visits at health facilities	Caregivers (families with pregnant women or with a child in 0-6 y age-group)

Box I Key Strengths and Challenges During Implementation of the Aarambh Model

Key strengths

Training approaches

- Establishing supervisors as trainers using incremental learning approach (ILA)
- Experiential learning
- Demonstrations
- Learning by doing
- Innovative

Field implementation

- Use of Mother and Child Protection card
- Use of multiple approaches (home visits, group meetings, social norm building) for behaviour change
- Supportive supervision

Insystem

- Use of 'appreciative inquiry' as the core approach
- Participatory approach
- Coordination between ICDS and Health sector
- Involvement of other sectors; Panchayati Raj institutions, self-help groups (such as MSRLM)

Challenges

- Vacant positions of supervisors and mid-level managers
- Periodic campaigns; e.g. Pulse Polio interrupt schedules
- No provision for travelling allowance for ASHAs if an additional day of training is required
- Centralised MIS with no flexibility for adding indicators for an innovative program
- Multiple training programs being rolled over together
- Challenges of supportive supervision

MSRLM: Maharashtra State Rural Livelihood Mission; ICDS: Integrated Child Development Services Scheme; ASHA: Accredited Social Health Activist; MIS: Manage-ment Information System

As a result of this participatory and inclusive approach, the community members, families, FLWs, the mid-level ICDS and health sector managers and the line supervisors collectively understood the value the promotion of responsive caregiving. They also realized that they could play a role as agents of change and promoting inter-sectoral coordination. Use of this appreciative approach helped build the confidence of both FLWs and their supervisors. It resulted in the development of a supportive environment for delivering nurturing care in addition to their routine work of providing services related to health and nutrition. Interactions with FLWs revealed that they felt motivated to deliver the NC interventions. These encouraging experiences led to a decision being taken by the district administration in 2020 to scale-up the model across all the administrative blocks of both the districts.

DISCUSSION

The theory of change for implementing nurturing care interventions is grounded in Bronfenbrenner's social ecological model (SEM) that highlights the multi-pronged approach for empowering caregivers to create a conducive environment for nurturing children to help them realize their developmental potential [13]. The theory explains how child development is influenced by the interconnected structures within an individual child's environment. There are five nested and interrelated levels; individual, interpersonal, community, organizational and an enabling policy environment. For the success of reaching optimal developmental potential, one needs to ensure cohesive actions across all five levels in the child's environment. This strengthens the protective factors (the five components of NCF) and mitigates common risk factors (toxic stress, adverse childhood experiences) that could derail the development trajectory of children. When system level changes create an enabling environment to facilitate development of every child, it not only creates approaches to facilitate development of normal children, but also enables care of children with special needs.

The Aarambh model (**Fig. 2**) attempted to establish approaches at different levels, namely by empowering

Table II Components of the Package for Nurturing Care Interventions Under the Aarambh Model

Stakeholder	*Components of package*
Supervisors of frontline workers	A manual for facilitators (separate for each cycle of training) A book of energizers (containing participatory games, team building activities) A book of action songs
Anganwadi workers/ ASHAs	Job aid Manual for play and communication (activity banks) Nutrition card (containing messages on responsive feeding, food diversity, food frequency)
Caregivers	Parenting guide for nurturing care Messages on early learning activities, nutrition & health Posters for public places and health facilities Slogans for wall writings

individuals, facilitating peer networks and collaborative learning, creating a social norm at the community level (through community events), and by making organizational support available at the village (e.g., VHSND sessions) and health facility levels. A mapping of the opportunities for empowering parents to promote NC in the family and community settings was undertaken within the ICDS and health sector. This was used to prepare a contextual and scalable model for implementation through the public programs. Establishment of multiple approaches contributed to the success of the at-scale implementation. This was achieved by enabling the FLWs through imparting the evidence-based knowledge and skill building to deliver the NC interventions through their existing routine service delivery activities. In addition, they received supportive supervision by line-supervisors who were also trained in CCD. Supplemental approaches were also used like the engagement of representatives from local government agencies like panchayats, self-help community groups, and religious leaders.

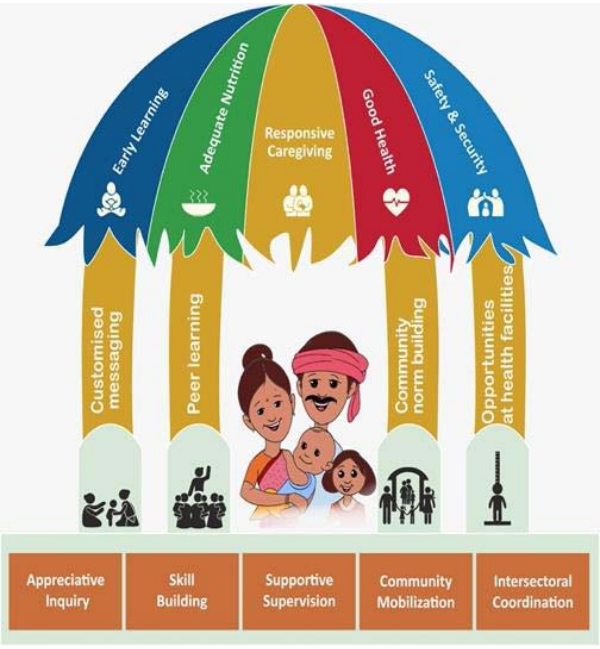

Fig. 2 The Aarambh model integrating the social ecological model and the nurturing care framework.

Aarambh builds its approaches based upon pre-existing opportunities within various sectors. The model offers joint ownership for promotion of nurturing care to ICDS and health sector and promotes a close collaboration between the two sectoral programs at field level. At the same time, it also tries to build a 'whole of society' approach for making the change happen. Our experience confirms that there are significant entry points within the existing services in various sectors for implementing interventions for NC and empowering families and communities. The need is to assess these opportunities carefully, make minor or substantial adjustments or restructure (as required) to effectively harness these. It requires investment in building capacity of the FLWs that includes a supportive structure and enabling environment. Establishing supervisors as trainers using an incremental learning approach (ILA) in the form of initial training followed by refresher training sessions helped to improve the supportive supervision of the trained FLWs [14]. The training of trainers for the line-supervisors of AWW and ASHA and FLWs themselves included demonstrations of the approaches to engage with families and communities (e.g., home visits, mothers' meetings and parents' meetings). The supervisors clearly expressed that such demonstrations of community processes must continue.

Continued engagement of the family and community is essential to ensure good quality childcare. Parents' aspirations for improving their children's development makes it easier for them to accept the concept easily and ensure adoption of ECD-directed interventions in their routine childcare activities. The concept of play and communication (responsive caregiving and opportunities for early learning) was easily understood by all stakeholders. The added bonus that caregivers find these activities

enjoyable makes them good entry points for behavior change. **Box II** includes qualitative expression of voices from the field that conveys feelings regarding the NC interventions that were used. In addition to strong evidence on efficacy of the interventions, the local experience of implementation and its results is also important to ensure buy-in from the policy makers and program managers [2]. For instance, the successful experience during the pilot phase was instrumental in convincing concerned people at all levels; FLWs, supervisors, local community, policy makers and representatives of local government.

The pilot and subsequent Aarambh initiative was implemented within the existing systems amidst operational realities and resource constraints that are common to the public sector across India. A few challenges were noticed during scale-up. These included the establishment of an ongoing intersectoral coordination mechanism at district, divisional and state levels. Also, existing monitoring systems at all levels are weak and there is a need to include appropriate performance indicators within the existing management information system. Minimum standards of services should be in place and a quality assurance mechanism prepared for the training as well as for the services at household and community level. However, the success of this endeavor due to the participatory processes, continued capacity building, and an appreciative and enabling environment demonstrates the potential of scalability at the state and even country level.

The lessons learnt from Aarambh project are listed in **Box III**. Adoption and scaling up in other settings needs attention of both the researchers and the administrators.

Acknowledgements: The India-specific ECD Package implemented during the pilot phase was developed by SWACH, Haryana in partnership with WHO and INTERVIDA, which was later implemented by two organizations - SWACH, Haryana and the Mahatma Gandhi Institute of Medical Sciences (MGIMS), Sewagram. The scale-up phase (2017-2021) was implemented by two teams; MGIMS, Sewagram in Aurangabad and Yavatmal districts, Maharashtra and SAVE THE CHILDREN and Gram Mangal in Pune and Palghar, Maharashtra. The current paper describes the experiences of the team atMGIMS, Sewagram.

Note: The author is a staff member of the World Health Organization. The author alone is responsible for the views expressed in this paper and they do not necessarily represent the decisions, policy or views of the World Health Organization.

Box II Voices From the Field

Regarding training of trainers

"*We did not feel that we were being trained. Our experience was valued and we were consulted."* - Anganwadi supervisor, Aurangabad (after participating in the first cycle of training of trainers)"

We have never attended such an interactive and lively training like this one." – ASHA facilitators, Aurangabad (after participating in the first cycle of training of trainers)

Regarding brain wiring game

"*My husband is an alcoholic. Life isn't easy for me, and I feel dejected with the environment at home. The easiest way for me to vent my frustration is to yell and snap at my baby. I have even hit him at times. I thought the kid would not understand this and would cry himself to sleep. How was I to know that my actions were affecting him for life? How can I forgive myself for this? I swear I will never beat my child or yell at him. I hope God forgives me for this. What have I been doing?"- Mother of a child 18 months old, Yavatmal (after participating in the brain wiring game during a mothers' meeting)*

Regarding home visits

"*You don't necessarily need lots of money to help a child grow and develop better. You need to spend time and generate curiosity within the child. We have learnt so much from the demonstrations by ASHAs during home visits."* - Father of a young child, Yavatmal

Regarding Palak Melawa (Parents' fair)

"*Through the Palak Melawa, the whole 'child care for development' has become a community agenda."* - Deputy CEO, ICDS, Aurangabad"*Palak Melawa serves as a great platform for the community to understand the importance of early childhood development"* – Sarpanch of a village in Aurangabad

Regarding training and joint ownership of the program by ICDS and health workers

"*We got the right direction because of ECD training, learned the importance of customized messages, and the participation of family members or fathers …. and most importantly, we ensured the best possible coordination between ICDS and Health department."* – Anganwadi supervisor, Yavatmal

The overall program

''The satisfaction of seeing visible change is immense, we have managed to create curiosity and excitement in the mothers about how they bring up their children. You can see them engaging with their children differently. - AWW, Yavatmal"

Anganwadi Tai told us how to provide a loving environment to my little daughter, how to play with her, and talk to her. These joyous moments will make her smarter. Now, I talk to her in a gentle and encouraging manner"- A mother from, Yavatmal.

Box III Lessons Learnt From Aarambh

1. Families and communities easily understand the value of nurturing care for ECD due to the aspirations they have for enhancing their children's development.
2. Local experience for effective delivery of nurturing care interventions and documentation of positive impact helps in buy-in from the program managers and policy makers.
3. Enhancing competencies of all FLWs (including demonstration of community engagement), proper supervision, continued training, and an enabling environment are crucial for the success of scaling up of NC interventions.

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Annexure

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Critical inputs during the pilot project (2011-14)

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Critical inputs during the scale-up project (2017-20)

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Web Table I Childcare Practices Included in the 6-Monthly Surveys

Items related to 'expressing love and affection'
Kissed, stroked, hugged the child
Looked directly in the child's eyes
Said kind words to the child
Smiled at the child
Items related to 'promoting child learning through play'
Encouraged the child by copying or mimicking the child
Given some toys to play
Played with the child
Gone outside home together
Spent time naming, counting or drawing with the child
Helped the child to learn something new
Items related to 'promoting child learning through communication'
Talked directly to the child
Talked with the child while doing household chores
Sung a song to the child
Spent time with the child telling a story together