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Replication of Integrated Nutrition and Health Project Approaches in Non-CARE Assisted ICDS Areas: Operational Guidelines

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TABLE OF CONTENTS

ACRONYMS	i
EXECUTIVE SUMMARY	iii
1. BACKGROUND	1
2. REPLICATION OF PROVEN GOOD PRACTICES OF INHP IN NON-CARE ICDS	2
3. INHP APPROACHES	3
3.1. Replication Package	3
3.2. Capacity Building.....	5
4. FORGING PARTNERSHIPS.....	8
5. STRENGTHENING SYSTEMS	10
5.1. Strengthening Systems: Processes at different levels.....	11
6. INTEGRATING REPLICATION PROCESS IN THE ANNUAL PLANS.....	13
7. SUPPLY CHAIN MANAGEMENT	14
8. HOW TO REPLACE INTENSIVE RESOURCE INPUTS OF CARE IN REPLICATION AREAS ..	15
8.1. Extent of Support from CARE Available for Replication.....	15
8.2. Setting up Coordination/Advisory Committee	16
9. OPERATIONAL STEPS: IMPLEMENTATION PLAN.....	20
9.1. National Level: Operationalization	21
9.2. State Level: Operationalization	24
9.3. District Level: Operationalization	28
10. COMMUNITY LEVEL INVOLVEMENT AND PARTICIPATION	33
11. ROLE OF CARE	33
ANNEX 1. LETTER OF APPROVAL FOR INTEGRATED NUTRITION AND HEALTH PROJECT (INHP III).....	35
ANNEX 2. SETTING UP OF A NATIONAL ADVISORY PANEL OF INHP REPLICATION IN NON- CARE ICDS AREAS.....	36
ANNEX 3. SETTING UP OF THE STATE WORKING GROUP ON INHP REPLICATION IN ANDHRA PRADESH AND CHHATTISGARH, TERMS OF REFERENCE	41
ANNEX 4. NOTICE FOR THE FIRST MEETING OF THE NATIONAL ADVISORY PANEL FOR INHP REPLICATION, MARCH 22, 2007	46

ANNEX 5. MINUTES OF THE FIRST MEETING OF THENATIONAL ADVISORY PANEL FOR INHP REPLICATION	47
ANNEX 6. OPERATIONAL SCALE OF REPLICATION OF INHP IN NON-CARE—ICDS AREAS	57
ANNEX 7. ILLUSTRATIVE GUIDELINES FOR ORGANIZATION OF . NUTRITION AND HEALTH DAY (NHD).....	58
ANNEX 8. ILLUSTRATIVE STATE OPERATIONAL PLAN FOR INHP REPLICATION	66
ANNEX 9. ILLUSTRATIVE TOOLS FOR INHP REPLICATION	67
ANNEX 10. MINUTES OF THE MEETING OF THE SWG OF ANDHRA PRADESH HELD ON JUNE 15, 2007.....	68

LIST OF FIGURES

1. Strengthening Sector Level Systems.....	13
2. Existing Structure: Proposed Operational Structure	19
3. Key Milestones of INHP Replications: A Road Map	20

LIST OF MAPS

1. District Map of Chattisgarh	31
2. Districts of Andhra Pradesh	32

LIST OF ANNEXES

1. Letter of approval for Integrated Nutrition and Health Project (INHP III).....	35
2. Setting Up of a National Advisory Panel of INHP Replication in non CARE – ICDS Areas.....	36
3. Setting Up of the State Working Group on INHP Replication in Andhra Pradesh and Chhattisgarh, Terms of Reference.....	41
4. Notice for the First Meeting of National Advisory Panel for INHP Replication, dated March 22, 2007	46
5. Minutes of the First Meeting of the National Advisory Panel for INHP Replication.....	47
6. Operational Scale of Replication of INHP in non-CARE – ICDS Areas	57
7. Illustrative Guidelines for Organization of Nutrition and Health Day (NHD)	58
8. Illustrative State Operational Plan for INHP Replication	66
9. Illustrative Tools for INHP Replication.....	67
10. Minutes of the Meeting of the SWG of Andhra Pradesh held on June 15, 2007	68

ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
AP	Andhra Pradesh
ASHA	Accredited Social Health Activist
AWC	Anganwadi Center
AWW	Anganwadi Worker
BCC	Behavior Change Communication
B-E	Baseline vs. End line Surveys
BLAC	Block Level Advisory Committee
BLRM	Block Level Resource Mapping
BTT	Block Training Team
CA	Change Agent
CBMS	Community-based monitoring system
CBO	Community-based Organization
CDPO	Child Development Project Officer
CG	Chhattisgarh
CHC	Community Health Center
CSB	Corn Soy Blend
DAP	Development Assistance Proposal
DLAC	District Level Advisory Committee
DPT	Diphtheria, Pertussis, Tetanus vaccine
DTT	District Training Team
ER	Evaluation Research
FANTA	Food and Nutrition Technical Assistance Project
FP	Family Planning
FY	U. S. Fiscal Year (October-September)
GEAC	Genetic Engineering Approval Committee
GOI	Government of India
HFW	Health and Family Welfare
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRBG	High-risk Behavior Group
ICDS	Integrated Child Development Services
IEC	Information, Education, Communication
IFA	Iron and Folic Acid
IFPRI	International Food Policy Research Institute
IMR	Infant Mortality Rate
INHP	Integrated Nutrition and Health Project
IYCF	Infant and Young Child Feeding
LHV	Lady Health Visitor
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation

MIS	Management Information System
MOHFW	Ministry of Health and Family Welfare
MOST	Micronutrient Operations Strategy and Technology Project
MOWCD	Ministry of Women and Child Development
MPW	Male Multi-Purpose Health Worker
MTR	Mid-term Review
NFHS	National Family Health Survey
NGO	Non-governmental Organization
NHD	Nutrition and Health Day
NIPCCD	National Institute of Public Cooperation and Child
NRHM	National Rural Health Mission
PE	Peer Educator
PHC	Primary Health Center
PRI	Panchayati Raj Institution
RACHNA	Reproductive and Child Health, Nutrition and HIV/AIDS
RAPS	Rapid Appraisal Survey
RCH	Reproductive and Child Health Program
RH	Reproductive Health
SHG	Self-help Group
SM	Social Marketing
SNP	Supplementary Nutrition Program
TA	Technical Assistance
THR	Take-home Ration
TOT	Training of Trainers
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WCD	Women and Child Development
WHO	World Health Organization

EXECUTIVE SUMMARY

In 1996, CARE and USAID initiated the **Integrated Nutrition and Health Project (INHP)**, which transformed the Title-II program support to ICDS from primarily a provider of supplementary food into a maternal health and child survival initiative. The project aims at providing basic food, child health and nutrition information services. The INHP was conceived as a ten-year initiative having two phases, each of five years – (1996-2001 and 2002-2006). CARE India at the end of the two phases has proposed a three-year phase-out program to consolidate lessons over the past few decades and support Government systems to replicate these approaches in other areas. INHP is presently underway in 75 districts of eight states (Andhra Pradesh, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh, and West Bengal). The project covers over 100,000 Anganwadi Centres (AWCs) and is implemented in partnership with the Ministry of Women and Child Development (MoWCD) and Ministry of Health and Family Welfare (MoHFW) of the Government of India and their departments in the states.

Since its initiation, INHP has developed several successful approaches and practices and has attempted to get these incorporated within ICDS system through capacity building and support provided to government partners within the CARE assisted areas. Some of these approaches include: *facilitating convergence of ICDS and Health departments, and strengthening commodity management and monitoring systems to be more responsive to context-specific needs and problems*. There is a large body of evidence that indicates that INHP has contributed significantly in making ICDS and RCH achieve improved health and nutrition outcomes in its program sites.

In view of the above replication of the proven INHP practices beyond CARE assisted ICDS is a strategic priority during the phase-out period (2007-2009)

The MoWCD has agreed to undertake the initiative of replicating a package of selected proven practices in the states of AP and Chhattisgarh, involving state departments with technical inputs of CARE in the twenty-one districts currently not covered by INHP. In order to develop the strategy and operational processes for replication, USAID and CARE have solicited technical inputs from the **Food and Nutrition Technical Assistance (FANTA) Project** of the Academy for Educational Development (AED). Through a consultative process, a strategy has been decided upon for replication of the selected proven practices/ approaches of INHP into ICDS areas not currently covered by CARE assistance in the two aforementioned states.

The strategy proposes a package of approaches worthy of replication, mechanisms and processes, tools and instruments to be used, and management of human and financial resources for taking INHP Practices beyond CARE assisted ICDS areas. In order to streamline the process of participation of key partners in replication, two formal fora—namely, **National Advisory Panel** and a **State Working Group** in the two states have been constituted by MoWCD. These fora will provide technical inputs, undertake periodic review of progress, add state specific inputs, facilitate coordination, and solicit support of the administration in the two concerned states.

The respective state governments and state offices of CARE would will the replication process as the key players. In each district, besides the cadres of the government systems, partnership with other stakeholders will be solicited to implement replication.

The replication of INHP approaches in non-CARE areas of ICDS in the two identified states has found a place in the INHP-III Phase out Plan (2007-2009) of CARE, and has been approved by USAID for financial support for technical and other support envisaged for the activity. The MoWCD has also agreed to mobilize its resources for implementation and to leverage funds available within the government for complementing interventions included in the replication package. **Evidence based documentation** will be carried out for the process of replication, to facilitate going to scale and further expansion.

The present document of **Operational Guidelines** has been prepared for the use of all partners to have a common understanding of the replication process. It is intended to facilitate smooth implementation and ensure uniformity and quality in the way in which the process is adopted in various settings.

The document describes the background and rationale for replication of the proven INHP practices beyond CARE assisted ICDS areas. It has attempted to draw the road map by indicating the major landmarks. It has detailed the sequence of activities to be undertaken at national, state, district and block/village levels, to implement the replication process.

The guidelines have proposed a consultative process amongst partners to arrive at consensus on issues of replication. It spells out various operational details of the replication, comprising:

1. Content and processes of the replication.
2. Approaches and strategies to embed the elements of the package in the existing structures/systems of ICDS.
3. Capacity building and training methodologies to upgrade skills and capacities of service providers (ICDS/ Health).
4. Soliciting participation of the stakeholders and community members.
5. An attempt has also been made to delineate the roles and responsibilities of the partners.
6. Strategies and ways of pooling and mobilizing human and financial resources have also been suggested.
7. The proactive advisory role to be played by NAP and SWGs has been considered vital for smooth implementation of the replication.
8. Tools and techniques to facilitate the process have been suggested and their contextualization emphasized.

9. Broad guidelines have been provided for monitoring and evaluation of the process.
10. It has been recommended that the process documentation be carried out to facilitate scaling up in other states.

In conclusion, this document highlights the major features of the replication process. It is described as a dynamic process and not a mere replication of the selected practices. It points out that building capacities and skills of service providers is crucial for the replication. The activity cannot be a stand-alone or adjunct to ICDS; rather, it needs to be integrated into existing ICDS systems and processes.

1. BACKGROUND

Since 1984, CARE has been a close ally and partner of the Ministry of Women and Child Development (MoWCD) in supporting the *Integrated Child Development Services (ICDS)* scheme through the provision of food for supplementation and technical support for improving program practices. For achieving the health and nutrition objectives, CARE also collaborated with the Ministry of Health and Family Welfare (MoHFW), both at national and state levels. ***Integrated Nutrition and Health Project (INHP)*** is the flagship health sector project of CARE that has been in operation since 1996, with financial and technical support from United States Agency for International Development (USAID). It has been supporting the implementation of ICDS covering 750 blocks of 78 districts in nine states (*Andhra Pradesh, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh, and West Bengal*), during Phase II of the program that ended in September 2006. The interventions of INHP address child malnutrition and infant mortality and are aligned with the objectives of national programs such as, *Integrated Child Development Services (ICDS)*, *National Rural Health Mission (NRHM)*, and *Reproductive Child Health (RCH)*, covering the poor and marginalized communities in particular.

The program has completed its first two phases (1996-2006) and has now entered the final phase from 2007-2009 with due approval of MoWCD (Annex I). There is a large body of evidence conferring the contributions of INHP in helping ICDS and RCH achieve improved health and nutrition outcomes in the areas of its operation. While working with the national programs, CARE seems to have also gained considerable insights related to implementation of these programs. It is strategically poised to offer lessons on how a large-scale public health and nutrition program can be rendered more effective to deliver results. The evidence provides information on approaches that work in different contexts, as well as and what it takes to make these more effective through the use of existing financial and human resources. It is important to note that this has been made possible without much additional cost, as reported in the recently completed study of INHP costing (Fiedler, J, 2006).¹

In the context of the current policy and programming environment, the experiences of CARE hold considerable promise and significance to inform the redesigning of national programs. It is an opportune moment as the implementation strategies for ICDS, RCH and NRHM are undergoing finalization for the 11th Five Year Plan. The final phase out program of INHP III (2006-2009) proposes to consolidate gains made in the last decade of its operation, and has indicated its intentions of leaving behind a legacy of capable government systems. It has envisaged that the major national programs mentioned above be strengthened enough at the state, district and block levels to reach the most vulnerable women and children with critical interventions to address infant mortality and child malnutrition.

During the last 2-3 years, CARE/USAID, through a consultative process with MoWCD, has agreed to integrate proven practices of INHP in non-CARE ICDS areas. Accordingly, replication of good practices in blocks, districts and states beyond CARE assisted ICDS is a strategic priority of INHP III. The efforts of replication will have varied approaches:

¹ A Cost Analysis of CARE India's Reproductive and Child Health and Nutrition and HIV/Aids Program" document of USAID and CARE.

1. Replication of good practices in 269 new blocks, in addition to 711 blocks in 75 districts of current program that CARE supports in 8 states (AP, Chhattisgarh, Jharkhand, MP, Orissa, Rajasthan, UP, and West Bengal).
2. Replication of good practices to be implemented by the State Government and CARE jointly in 21 districts of AP (15) and Chhattisgarh (6,) covering 300 blocks where CARE currently is not operating.
3. Providing responsive technical and operational assistance to scale up proven practices within ICDS and RCH/ NRHM at the national level across all states.

2. REPLICATION OF PROVEN GOOD PRACTICES OF INHP IN NON-CARE ICDS

The present document of the operational guidelines relates to the second approach of replication of good practices in the states of AP and CG in 21 districts not currently covered by CARE (Annex-6). The MOWCD has agreed to undertake the initiative of replicating mutually agreed upon proven good practice packages from INHP in the larger ICDS program, involving state departments of WCD and Health with CARE/USAID as the key partner. The envisaged program support from CARE is the technical expertise/assistance required for planning, implementing, and monitoring the replication process. The INHP III Proposal spells out the inputs to be made by CARE for replication in areas beyond its operation “*provide methodology, tool kits and capacity building support at state and district levels to plan and implement.*”²

In turn, CARE/USAID have solicited technical inputs from the *Food and Nutrition Technical Assistance (FANTA) Project* at the *Academy for Educational Development (AED)* to develop plans and strategy for replication. The ***Ministry of Women and Child Development*** has set up two structures to facilitate the replication process and interaction among key partners:

1. ***National Advisory Panel*** at the central level in Delhi. The panel provides technical inputs, undertakes periodic reviews of the progress and facilitates coordination with the administration in the two concerned states (AP&CG).
2. ***State Working Group*** in each of the states of AP and Chhattisgarh, to have a state specific perspective for ensuring smooth implementation of the replication process.

The composition and Terms of Reference of these structures are in Annex 2-3.

² CARE (2006), INHP-III, Integrated Nutrition and Health Project Proposal for Phase-out of Title II Program(October 2006-September2009) p20.

3. INHP APPROACHES

3.1. Replication Package

Since its inception, INHP has been developing several innovative approaches and practices that have helped in achieving health and nutrition objectives of ICDS and RCH in the CARE assisted project sites. These practices have also undergone considerable refinement and sharpening over the years and have been implemented in multiple contexts. Technical interventions of INHP comprise *essential nutrition action, community-based newborn care and antenatal care, and primary immunization*. These are supported by strategies of *prioritization; focus on most critical interventions and universal coverage engaging ICDS and RCH systems, supplemented by behavioral changes at household levels through multi-channeled communication*. CARE has also added sophistication to *specific activities and tools* to improve the existing ICDS/RCH processes related to *home visits, supportive supervision, and sector level review of service delivery*. *Involvement of NGOs* to provide support and act as a catalyst for implementation of interventions and *training* of concerned health and ICDS personnel for capacity and skill building has been an integral component of INHP.

Based on the experience of graduation plan of INHP, the aim/objective of the replication process may be operationally defined as sustainable and independent in its functioning of health and nutrition activities without CARE's intervention. Where inputs and resources can be managed, the quality and timelines of activities can be maintained—and the desired outcomes and objectives are thus met by the existing ICDS system/structure. The phase out approach in INHP III proposes to **strengthen systems, empower communities** and **build capacities** of functionaries and service providers to ensure sustainability.

3.1.1. Evidence Based Proven Practices of INHP

Through a series of discussions and consultations held among partners (CARE, FANTA, USAID and WCD) giving credence to multiple factors involved in replication, a consensus emerged, that, following proven practices of INHP are worthy of inclusion in the replication package.

1. **Inclusion and Tracking** of all eligible/entitled beneficiaries using tools like social maps, mother and child card, etc.
2. **Nutrition and Health Days (NHD) and Take Home Ration (THR)** to be organized periodically and effectively to ensure changes in nutritional, feeding, health and caring practices of families and communities towards children below two years.
3. **Streamlining supplementary nutrition supply chain.**
4. **Prioritized home visits** during the critical periods of life cycle (late pregnancy, first day, first week, first month, 1-5 months, 6-8 months, 9-11 months using AWW home visit planner).

5. Focused supervision/monitoring of all critical interventions by block and district leadership.

3.1.2. How to select a Manageable Replication Package

The above list has been drawn from the evidence-based feedback related to proven approaches/practices of INHP, which have resulted in the desired health and nutrition outcomes. It may be too ambitious at this stage to include all elements of the package suggested in the context of replication to be undertaken in the non-CARE assisted ICDS for AP and CG. Instead, it may be worthwhile to select only a few practices to begin with, out of the suggested list. The factors such as *extent of commitment/willingness of the state departments (ICDS & Health) to undertake replication, status of convergence between allied/concerned departments, effectiveness of administrative and supervisory mechanisms, community participation, availability of facilitating structures (SHGs/PRI/CBOs, technical institutions), and above all, the status of women and children and political commitments towards their development*, are all crucial considerations before the intervention package for replication is finalized. The other two important aspects that may impose further constraints are limited human and financial resources.

Given the above backdrop, the process of compiling the core elements of the replication package involves critical decision-making. It has to be taken judiciously, particularly when the state does not have extensive human and financial resources available for INHP implementation in CARE assisted ICDS. It is suggested that through a consultative process partners may take the decision as to which practices will be replicated. However, it is advisable to select only a few of these practices, which can be rapidly adopted, are easily manageable, and can produce quick results. It is pertinent here to mention three of the good approaches and practices that have been validated in multiple contexts and have a standardized content to a great extent. These practices/processes are also an integral part of ICDS and RCH systems but are not effectively implemented or regularized. It may be a good idea for the states to initiate replication with these approaches:

1. Nutrition and Health Day (NHD)
2. Take Home Ration (THR)
3. Supply Chain Management (SCM)

Through a rolling model, additional and complex approaches/practices may be integrated in a phased manner over time. The elements of the replication package contents may not be uniform and similar across the state. Within the selected core components identified, flexibility need to be provided for making variations in the package to cater to the state and community specific needs.

3.1.3. Supporting Processes and Approaches for Replication

It must be underscored that replication is not a mechanical integration of the identified proven/good practices to ICDS. In fact, it needs to have an enabling environment with conditions that are conducive for implementation of the package. While finalizing the core elements of the replication package, it is important to be informed about the strategic approach of INHP implementation and the lessons learnt about what really worked. Empirical evidence has

indicated that interventions—when embedded in the mandatory and routine activities of ICDS/RCH systems—were adopted and accepted readily. Through capacity building and the use of simple tools and techniques, INHP interventions attempted to streamline and strengthen the processes existing within ICDS/RCH systems. Based on the rapid surveys and informal feedback, CARE identified a few **processes that resulted in positive outcomes**. These are enumerated below as per the level of operation and illustrate the point that INHP regularized the existing processes of ICDS/RCH.

3.1.4. Supporting Process and Systems

Village Level	<ul style="list-style-type: none"> ▪ Mechanisms to minimize exclusion ▪ Timely home visits using simple planner ▪ Strengthening fixed day /fixed site services- Nutrition and Health Day(NHD)
ICDS Sector Level	<ul style="list-style-type: none"> ▪ Sector meeting attendance by health staff (ANM/LHV/MO) ▪ Strengthening field visits of supervisors using supervisory tools ▪ Facilitation of meetings at various levels assisted by NGOs
Block and District Level	<ul style="list-style-type: none"> ▪ Periodic joint reviews with participation of ICDS, health and PRI ▪ Use of evidence for action plan development

The real challenge for the replication endeavor is to ensure that elements of the package are integrated in the operational system of ICDS and result in effective delivery of services for better outcomes.

Based on the INHP experience, three critical approaches—capacity building, networking and partnership, and strengthening systems—have been considered essential for the replication activity. These are likely to facilitate smooth implementation and add quality and effectiveness to the operational process.

3.2. Capacity Building

The capacity building comprises the organization of a series of training and orientation workshops and other programs to build skills and competence required for replication. It mainly needs to be targeted at the service providers and stakeholders of ICDS and RCH/NRHM at various levels of the programs. There are at least four categories of people that need to be trained:

1. **Planners, policy makers, administrators and finance managers**
(National/state/district/block administrator and officials of ICDS and Health)
2. **Service providers- directly delivering services (functionaries)**
(AWW, Supervisor, CDPO, ANM, ASHA, TBA, LHV and MO)
3. **Trainers who impart training at various levels**
(Master trainers, Instructors of AWTC/MLTC)
4. **Others who support programs and services**
(NGOs/PRI, SHG, Private health care providers)

The capacity building needs for these categories will vary depending on the expected role and responsibilities assigned to them in the context of replication. Accordingly, different training modules will be required.

Training Need Assessment (TNA) may be undertaken to plan capacity building of individuals/functionaries/personnel concerned with the replication process at various levels. In-depth experience of CARE in capacity building of various target groups, and knowledge about the existing gaps in skills and competence of the personnel in the context of INHP implementation is a great advantage. It is likely to facilitate planning and execution of the training activities of replication in an effective manner. Accordingly, CARE as a partner has agreed to support the state government in planning the training calendar, and developing prototype training modules and materials needed for capacity building in the states of AP and Chhattisgarh.

It will also financially support two rounds of training of health and ICDS personnel up to the sector level of 21 districts (AP-15, CG-6) in two states.

3.2.1. Capacity Building Methodologies

The training efforts of CB are aimed at achieving effective implementation of replication through enhancing knowledge, skills and competence of all concerned with the process at different levels. Informed by INHP experience, three components—technical content, process skills, and motivation—will comprise the training curriculum. The vast experience of CARE within INHP in organizing such diverse trainings will prove useful by furnishing appropriate training content and modules for the replication sites. The existing CB material of INHP will have to be adapted and modified as per the elements of the package. An illustrative list of few core elements relevant for enhancing competence/skills needed for implementation of the replication package are listed below. The training content for each of these elements will vary for different categories of trainees. It will focus on the specific role expected of them for the intervention proposed in the package.

1. Achieving convergence at sector level
2. Having supportive and structured supervision at all levels
3. Making effective home contacts at critical stages
4. Using data to plan and deliver and monitor services
5. Ensuring behavioral changes at household level

To illustrate, *Achieving convergence at sector level* as an element of training for **state level policy makers/administrators** will focus on the need to take pro-policy decisions, and executions of the orders; whereas **DPOs, CDPOs, and MOs at district level** need to learn how to implement orders effectively and monitor compliance. **Supervisory level personnel**, for their part, need to be imparted with skills to plan as well as implement events and activities related to convergence (NHD /THR, etc.). And the frontline workers must learn to optimize/mobilize resources and establish linkages to promote convergence at their respective AWCs. **Trainers**

and master trainers will be informed about the content details and methodology to be used for covering the topic. The **Service supporters'** group will be provided a different perspective and orientation to the concept during training.

A multi-pronged approach is required at this stage to meet CB needs related to replication, and a combination of several training methodologies needs to be tried in innovative ways, depending upon the target group/audience and the objective of the CB activity. Listing of some of these methods is given below, which may be useful while planning for CB at the state level.

1. Integrating elements of replication in Job and Refresher trainings curricula of the concerned cadres of ICDS/RCH
2. Thematic training at various levels to meet immediate CB needs
3. Cross Site visits (Across INHP and replication districts/states)
4. Hand holding and Supervision, field visits by trainers/instructors and adoption by technical/academic institutions
5. Field visit observation and exposure visits
6. Orientation and Sector Meetings

3.2.2. Management Issues and Guiding Principles

Technical support will be made available by CARE to the WCD departments in the respective states to plan training and CB activities. In order to cover large numbers that require CB in a short span, it is essential that *CB Implementation Plan* is prepared with complete details of technical aspects, calendar of activities, logistics, and resource requirements. The State Working Group may want to set up a CB Task Force comprising inter-institutional/agencies and experts/professionals as a group to facilitate details. The TOR may be worked out with clear roles/responsibilities and time frame. There is a well-established system of training within ICDS and Health that uses a network of institutions and structures (AWTC, MLTC, state/district health training institutes). It is advisable to make optimal use of these for various CB activities.

Cascade model of training is likely to be both a cost-effective and efficient way to cover large numbers. A cadre of **master trainers of replication** may be created at the state level, numbering 20-30. This resource group can be used in multiple training situations and events related to replication. It is understood that ICDS already has District Training Teams that are used for continuing education and thematic workshops for on-the-job skills. CARE has also proposed to set up **state and district level resource groups** from within the system (ICDS, RCH, CARE, technical institutions), with operational experience of engagement in the current phase of INHP. These may be tapped for technical support and materials required for CB activities. Involvement of NGOs in following up and endorsing good practices has proved to be an effective strategy for sustainability of upgraded knowledge/skills and behavioral change at grassroots.

Departments of WCD and Health at the state level may be required to pool and mobilize available resources to meet training requirements. The tapping and leveraging of funds of ICDS training with GOI may also be explored (see Annex-5, Minutes of NAP).

There are a few **guiding principles** of training and CB which are non-negotiable. It is relevant to recapitulate these here while we are strategizing training and CB for replication. There is a need for consensus on concepts, processes, and definitions related to replication. All concerned need to arrive at a common understanding about these across all levels. Instead of reinventing training strategies and materials afresh, it is advisable to adapt and use existing materials and tools to ensure uniformity/consistency. Simple low cost documents/tools may be disseminated to one and all, and are likely to serve a better purpose than overly sophisticated/technical cost intensive items provided to a few. Training pedagogy must be made skill-oriented and less didactic for all types of CB programs. Joint training with vertical and horizontal participation of different cadres needs to be encouraged. For example, health and ICDS personnel should be trained together and vertical integration of personnel at various levels within same department (CDPO, Supervisor, and AWWs) should be promoted to ensure better understanding and coordination across levels. Continuing education while on the job through follow-up visits of instructors, supportive supervision, and mentoring by peers is a proven, effective strategy and needs to be integrated in CB methods. In order to ensure uniformity and quality in the replication process, a well spelled-out **manual /guidebook / handbook** on replication needs to be prepared and provided as a reference document during the initial orientation/training of the main actors. It is understood that CARE, with technical support of FANTA is to undertake these two activities.

4. FORGING PARTNERSHIPS

The implementation process conceived for Integrated Nutrition and Health Project (INHP) from its inception has promoted the concept of partnership with various stakeholders—MoHFW, MoWCD, NGOs/CBOs, and other institutions and structured groups at grassroots. Particularly for grass roots interventions, support and participation of community members have been solicited for INHP interventions. Lately with devolution of power to PRIs as a result of an amendment in the Constitution (Article 73 & 74), their role has gained considerable importance. The women empowerment movement also has opened several new vistas for women to participate in their development. The emergence of SHGs—village-level communities headed by elected women members and Panchayats—have changed the political/social arena at the field level. CARE has very strategically used these opportunities and expanded partnership and involvement of stakeholders in INHP to enable communities to address their nutrition and health problems.

Against this backdrop, the intention of INHP-III to focus on consolidation of lessons/experience of a decade in CARE districts, and **replicating selected interventions** beyond areas covered by it in partnership with stakeholders, has been a strategic move. The objective is to ensure institutionalization of processes and a smooth transition of program inputs and resources to the community and government to ensure sustainability. For achieving this objective, an organized effort may have to be planned to actively involve stakeholders at all levels and network them with existing structures/groups working in the field of health and nutrition. Replication sites may be used as an opportunity to begin the process and pilot the proposed strategy.

CARE will have a considerably reduced intensity of its involvement in replication process as compared to INHP due to limited financial and human resources. It is therefore imperative, to

strengthen relationships among the key partners and stakeholders, so that dependence on CARE is replaced and eventually phased out. There is also a need to identify new partners and seek their support in various activities and processes of replication.

Interestingly the replication endeavor has been a participatory process from its inception stage. The replication strategy has a built-in provision of involving concerned partners and stakeholders at all stages of its implementation. The major players—GOI/State Government, USAID/CARE, NGOs and professional experts—have conceptualized the process jointly. The terms of reference of the two structures, NAPs and SWGs, set up to facilitate replication, recommend forging partnership for implementation, capacity building, mobilization of human and financial resources and for monitoring interventions and raising accountability of service providers. With the increasing trend of corporate interest in social issues, if approached and involved, such overtures may result in several benefits for replication activity, such as, supporting research, manpower, commodities, technical support, etc.

We are aware that the convergence and coordination amongst allied government departments is always subscribed and recommended for improved impact of interventions. But we also know how difficult and hard it is to achieve this end in practice. Replication activity during its implementation must explore and try out innovative ways and processes of enhancing convergence for different elements of replication. It is also felt that linkage and partnership needs to be further expanded to other departments besides health and ICDS, such as *information and broadcasting, rural development, Panchytraj, water and sanitation, and education, etc.* These measures surely will take us towards our objective of wider outreach and sustainability.

Involvement of the community and its participation in social/health intervention has received considerable attention in recent years. For ensuring sustainability, it has been rated as the top priority. **Community members** need to be made aware of their importance for interventions, their entitlements to access services, the need for their participation, and right to demand quality services. Without generating this kind of awareness, hardly any headway can be made in bringing improvements in the services. Using *advocacy tools, social mapping, and participatory planning*, community members may be sensitized about critical issues related to health and nutrition services.

Nutrition and Health Day (NHD) has found an effective platform in INHP for imparting technical content related to health and nutrition of children (Annex 7). As mentioned earlier, NGOs can undertake this role effectively. With the provision of ASHA in NRHM and adolescent girls of Kishori Shakti Yojna in ICDS, there is a possibility of having a band of volunteers that may provide additional support in the replication endeavor and serve as change agents. Tools, techniques, and procedures available with CARE may be reviewed, modified, and adapted for replication areas.

The issues/decisions related to the extent of involvement of stakeholders, and forging and expanding partnerships may be taken at the state level by the SWG through a consultative process with partners. All the same, the ability and readiness of the stakeholders to undertake the roles assigned, and time, cost, and resources available for orientation are other considerations that have to be kept in mind.

5. STRENGTHENING SYSTEMS

Final evaluation of INHP clearly demonstrated that large-scale programs like ICDS and RCH could be improved with focused managerial and technical interventions of CARE. The approach of INHP-III, therefore, focuses on institutionalization of critical processes and systems during the final phase in primary program areas. It also proposes to provide technical and operational assistance for strengthening systems in replication sites (21 non-CARE assisted districts in AP and CG). The extent of CARE's involvement and strategies to be used are going to be different. In these districts, CARE will not be directly implementing interventions related to strengthening systems, but will assist district/block level leaders of ICDS/Health to absorb the "science of the art" through technical assistance and sharing of relevant tools. In fact, it provides an opportunity to test out and establish relevant mechanisms of cross-learning across districts. It will form an important experience for scaling and extending practices to be used for strengthening of systems beyond INHP states.

Strengthening of systems is one of the important supporting processes for unrolling the replication package and to achieve desired outcomes. Sustenance of the practices initiated during replication also requires effective administrative structure and units for continued support. Unless the systems within ICDS and RCH are regulated and reformed, the service delivery is not likely to improve. It seems that the role and responsibilities assigned to various service providers do not have the desired focus. Spelling out details and unpacking tasks assigned to them may help in reorienting their functioning and result in better performance.

Interestingly, INHP practices have evolved in such a way that they are targeted at improved performance and in bringing behavioral reforms in the functioning style of personnel at various levels. It does not entail any additional role or responsibility. Through *capacity building*, and the use of simple *procedures/tools*, *functionaries* are enabled to *prioritize actions/activities*, give sharpened *focus* to interventions, undertake *self-appraisal*, and have *improved performance* over a period of time.

The approach/strategy is relevant for replication as well. However, the intensive capacity building, handholding and follow-up supports available in INHP will not be there in case of replication. As mentioned in the section on CB, some type of media will have to be identified for providing continued support after initial orientation/inputs are given—to improve crucial processes for strengthening systems.

The section below describes some of the processes that are required to be streamlined in the context of the replication endeavor. It enumerates the extent of change required in the process, and the mechanisms/tools that are likely to facilitate achieving the desired results. It is only an illustrative example and may not be taken as a prescriptive list. It may also be noted that the term *level* here refers to ICDS implementation structure. Thus, the process that needs to be improved at a particular level is likely to generate a series of actions cutting across all levels of administrative structures in ICDS (State, District, Block, Sector, and AWC). The personnel at each level are expected to contribute their part towards the change proposed, as per their prescribed job responsibilities.

5.1. Strengthening Systems: Processes at different levels

AWC

1. Registration and coverage of all beneficiaries using appropriate tools, social map and C.A. records
2. Regular Periodicity for NHD in coordination with ANMS
3. Critical interventions made available at critical stages to vulnerable groups through home visits (ANM/AWW)
4. Ensure supply of THR & check dilution of rations
5. Collection, analysis and recording of relevant information/data
6. Encouraging participation of women's groups in AWCs activities & monitoring

Sector

1. Availability of supportive supervisors regularized visits (once per month compulsory)
2. Monitor progress and outcomes, using a checklist
3. Joint sector reviews with health every month
4. Continuing education through technical inputs and tools
5. Institute incentive and recognition system (i.e., criteria for AWCs to be ranked as good performers with a flag)

Block

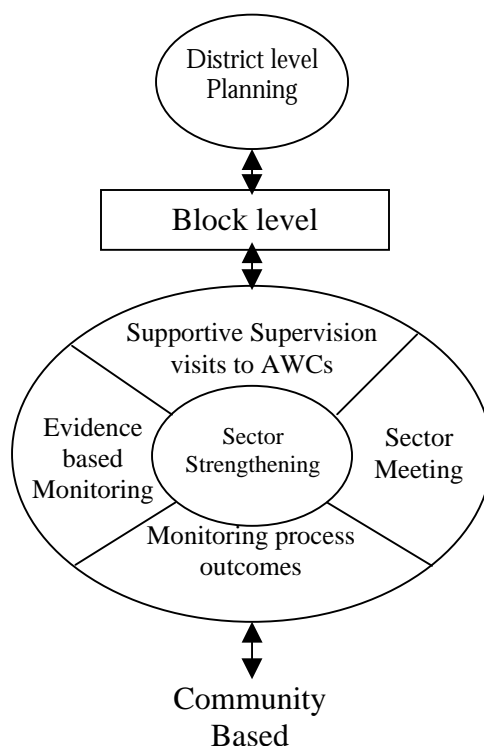
1. Regular visits—at least 3-5 in a month to AWC
2. Review of each sector's performance
3. Strengthening Supply Chain Management
4. Ensuring convergence & coordination at block level
5. Promoting community's participation in VLAC/BLAL
6. Documentation of processes

The personnel/functionaries will be oriented and briefed about the mechanisms /processes of strengthening systems in CB activities using varied methods. The themes to be covered will depend on the elements included in the replication package and the time frame available for capacity building. The staff dedicated to replication at state offices of CARE will work closely with ICDS/RCH departments to select viable processes that need to be improved. FANTA has assured support for developing a series of manuals/guide books to facilitate common understanding of the processes and mechanisms identified to streamline actions and activities for replication. All these endeavors are aimed at strengthening the existing systems of ICDS/RCH.

An effective/efficient implementation system in any set up must be backed by **supportive supervision** and better **monitoring processes**. Several mechanisms are normally integrated and created in the system to ensure optimal utilization of human and other resources of the program. In the context of ICDS—due to its multi-sectoral program—there are several functionaries from various allied departments who are responsible for providing specific services to the target beneficiaries at the grassroots. The state department of WCD as the nodal department for ICDS coordinates the interaction amongst departments of health, education, water and sanitation, rural development and Panchayati Raj etc. It will shoulder the responsibility of establishing linkages and soliciting support needed for replication from other departments and government structures at the state level.

A well-designed review and monitoring system must also be set up to ensure effective implementation of replication plan. The figure below provides a pathway to strengthen the existing ICDS system by proposing *district as the planning unit, block, and sector for taking periodic reviews, and community level for monitoring action through participation of the community*. This bottom-up participatory system of planning, review, and monitoring has been tried out in INHP, and showed positive results. It is worthy of consideration and the possibility of using it needs to be explored due to several of its merits. For initiating such an innovative planning and review system, specific actions and steps are required. In the present context, interventions are geared to meet health and nutrition needs of women and children. The perceived needs of the community have to be assessed through a participatory process using tools and techniques of social/resource mapping. The health and nutrition status needs to be ascertained, priorities identified, and gaps in interventions, resources, and processes assessed. Using principles of micro-planning to meet the diverse needs of the communities, action plans are to be made at the district level—the smallest administrative unit of the government. Implementation strategies need to be worked out at the block level, and backed up with review at the sector level. Interventions will be provided at the community level in the case of ICDS at AWC.

District level planning is likely to help in meeting the diverse need-based requirements of the communities. At the block level, appropriate action and periodic review are likely to ensure effective delivery of services as planned jointly by the CDPO and MO. Notwithstanding, the best result may be achieved by strengthening the sector level systems. Namely, a supervisor has within her purview a manageable number of AWCs (15-20) and is expected to confer with each AWC under her jurisdiction at least once a month. Regularity of these visits using planner/checklist to give needed inputs/support to the worker will go a long way in improving service delivery. Improving competence of the supervisor to be able to provide continued support to the front line worker AWW is one of the priority inputs in replication. The capacity building inputs at the block and district level are aimed at ensuring that CDPOS and DPOS monitor this role of the supervisor during monthly review. Further in the existing sector review meeting, analysis of MPR data—if done along with LHV and ANMs—will not only improve convergence of health and ICDS services but will facilitate the uptake of timely corrective actions as well.

Figure 1. Strengthening Sector level Systems

6. INTEGRATING REPLICATION PROCESS IN THE ANNUAL PLANS

As suggested in the section on forging partnership, there is a need to involve various government departments. It will facilitate pooling and mobilize resources (human and financial) needed for replication. The SWG has a provision of inducting representatives from government and voluntary sectors in group/thematic sub-committees to facilitate tapping of the resources from all possible quarters. State WCD department accordingly will be responsible for taking the initiative of approaching the departments and other structures for the needed support.

Each state department prepares a Program Implementation Plan (PIP) annually at the state level. It reflects all activities/projects/schemes, the state department proposes to undertake during the year, as well as the convergence and coordination it intends to have with other departments. As agreed by GOI, state ICDS and Health departments are the main implementers of the **Replication of INHP Approaches in non-CARE assisted ICDS** areas. This activity accordingly must find a place in the PIPs of the concerned departments. Such a move will give legitimate status to the replication activity within the state government's set up and also facilitate allocation and mobilization of resources (financial/human) needed for implementation.

The replication package may be contextualized according to the area specific needs of the communities in the districts to be covered. All activities and processes to be undertaken during the year such as: *capacity building, material development, strengthening of systems including*

supply chain management, monitoring and evaluation and documentation must be reflected as stipulated in the PIP, and given the budget line.

7. SUPPLY CHAIN MANAGEMENT

Besides propagating innovative programmatic interventions, CARE has developed technical expertise in *supply chain management* while implementing INHP. There is empirical evidence to indicate that the tools and procedures adopted for monitoring the supply chain resulted in improved management of resources/commodities, increased beneficiary coverage, and mitigated losses at block and AWCs. Effective need-based allocation of Supplementary Nutrition (SN) food and reduced feeding interruptions due to effective inventory management has also been achieved.

Within the ICDS program, (SN) is the most crucial intervention. It has earned ICDS the status of the country's major *food safety net* program that caters to the nutritional needs of the poor children and women. Lately, an interim order has been issued by the Supreme Court of India in response to the petition filed by *People's Union for Civil Liberties (PUCL)*. The honorable court has directed GOI and state governments for effective implementation of food safety net programs. This development directly brings *Supplementary Nutrition* component of ICDS under scrutiny and vigil. It is vital that SN food items are delivered effectively to the target beneficiaries for compliance.

The current supply chain management of ICDS is far from being satisfactory. In most cases, it is characterized by delays in fund release, untimely procurement of food items and improper inventory management. All these factors resulted in feeding interruptions, wrong targeting, and low coverage of beneficiaries.

In view of the above within the replication endeavor, it has been proposed to provide technical assistance to improve the *supply chain management*. The technical assistance for supply chain management comprises several key steps: *planning, budgeting and procurement, allocation/utilization of funds, warehousing/transportation, supply and distribution, and loss tracking mechanisms*. The TA must also address issues that need to be covered under technical assistance with specific strategies to avoid mismatch of commodities, low deliveries, and less utilization of funds. The formats and reporting procedures developed by CARE are amenable to integration with ICDS systems. Commodity Managers of State Offices and CARE have adequate skills to orient respective government functionaries on critical aspects related to supply chain management.

CARE has both the credibility and experience in this regard, and can act as a technical resource in supply chain management. It has also piloted in the states of AP & MP for the element of decentralization with the different procurement *food models*. Lately, GOI has been considering that *procurement, processing and distribution* of SN of ICDS be decentralized across states involving *SHG/women* at the community level. INHP experience indicated that such a local model enhanced timely delivery, reduced inventory and transportation costs, and empowered women by generating cash income—along with having control over food supply chain. In some cases, women/groups got involved in monitoring regularity and quality of the feeding at the

AWC. These are some of the options available for the state to consider in choosing elements of the supply chain it intends to implement in the replication sites. Depending on the response of the state government, an attempt may also be made to advocate for the adoption of tools and procedures of the supply chain management at the state level, rather than solely for replication districts.

8. HOW TO REPLACE INTENSIVE RESOURCE INPUTS OF CARE IN REPLICATION AREAS

8.1. Extent of Support from CARE Available for Replication

Replication in non-CARE assisted ICDS areas is an integrated program activity within INHP-III. A broad strategy for the extent of support CARE proposes to give for replication has been enumerated in the INHP III document. It is based on the long association of CARE in implementing INHP and working with the government system. It is pertinent now to review the details of the inputs committed by CARE, and to propose a realistic/viable approach for the state WCD departments to gear up to fill the gaps in the resources and systems required to undertake replication.

The CARE team, dedicated at the state/district levels is responsible for providing technical and operational assistance to replication efforts. In order to coordinate the replication activity and liaise with the partners, a position of Replication Manager has been created at the respective CARE state office—who is assisted by a team of Replication Support officers (RSO) (AP-6, CG-3). Each RSO has been assigned 2-3 districts, for providing technical assistance and support to ICDS/RCH departments in implementing the replication package with the resources (human/financial) available in the system. In addition, FANTA has provided the services of a Consultant to support the state office of CARE with guidance in planning, implementing, capacity building, and documentation related to the process. The Consultant is also expected to network with partners, make field visits, and facilitate the roll out of the different aspects of replication process. The endeavor is guided, overseen, and advised by the NAP, SWG, and CARE India office in Delhi.

In the context of Replication of INHP Approaches in non-CARE assisted ICDS, the INHP-III has outlined the strategy for supporting replication. It is based on the assumption that replication will be implemented mainly by district/block staff of ICDS & Health. The real emphasis will be on strengthening the capacity of the ICDS system in replication areas to go through the process, rather than trying to replicate specific identified practices. Accordingly, the highlights of the support to be provided by CARE will focus on:

1. Build district level *resource pool* to assist in replication
2. Upgrade capacities of Block level staff to be able to *focus on critical interventions* package
3. Facilitate the creation of *block level resource groups*, form the ranks of the motivated staff of ICDS/Health, Local experts and other key influential leaders for continued *sector level support*
4. Support the *streamlining of supply chain management* at district and block levels

5. Help to prepare *micro- level block level plans* for implementation and monitoring of NHD/THR and other relevant interventions
6. Provide relevant *tools and processes* for inputs related to home visits, supervisory field visits, and convergence forums
7. Provide *feedback for block and district reviews* based on *monitoring data and field visits of AWs* to households
8. Support ICDS/RCH with sharpening mechanisms of MPR/other formats, so as to capture progress in priority interventions at household, village, and sector levels.

It is clear from the description above that only CARE is going to perform a supporting and facilitating role. The real task of implementing the replication is to be carried out by WCD through its system—soliciting participation of other partners (Allied State Departments, NGOs, PRIs, community leaders, and local experts). The emergent replication strategy has attempted accordingly to embed various approaches and processes in the existing government systems of ICDS/RCH. The structure and set-up of ICDS are well conceived and have functionaries positioned from village to state levels to ensure delivery of services. Their roles and responsibilities are well defined and if the mandated functions are executed effectively, the objectives of ICDS are likely to be achieved successfully by meeting the varied needs of the target groups. Unfortunately, this is not the case at present; the functionaries, due to several reasons, are not able to perform their roles in a satisfactory manner. As a result, the quality of services of ICDS is far below the desired level. It is felt that if the state WCD succeeds in integrating the approaches and processes of replication in implementation of ICDS, the quality of services and outcomes will improve significantly—first in selected districts and then scale across the state with equal effort.

8.2. Setting up Coordination/Advisory Committee

It is both envisaged and hoped that the personnel of ICDS/RCH will be able to implement the replication package with the technical support of CARE. Upgraded competence/skills of personnel, sharpened focus of interventions, improved monitoring and review mechanisms, and thorough use of tools and techniques are the expected outcomes from the inputs made during replication. The remaining challenge is to plan how the catalytic role of follow-up, handholding, and continuous motivating of functionaries habitually performed by CARE will be substituted for.

ICDS, being multi-sectoral in nature, is expected to utilize all existing resources and services available at the state, district, block, and community levels of various departments of the government. Optimal utilization of the resources of other departments for effective delivery of ICDS package requires adequate coordination and convergence across the concerned departments. For achieving this end, ICDS scheme made a provision of setting up **Coordination Committees** at different levels: *state, district, block, and village/community from the time of its inception*. The guidelines for composition of the respective committees, frequency of holding meetings, and terms of reference and roles expected, were issued as an office order as early as the year 1975 by GOI (letter no6-11/75-CD dated 1st August, 1975). The formal and informal feedback related to the functioning of these present some interesting facts; in a majority

of states, the committees were set up and do exist on paper—but in most cases, these are dysfunctional in terms of promoting or achieving the desired convergence across departments.

The terms of reference of these committees promote the joint decision-making related to implementation and convergence of services of the varied departments at the AWC or for its beneficiaries. The ICDS network is used as an entry point for a range of services, covering: RCH, immunization, family welfare, sanitation, gender equality, AIDS control, etc. It not only facilitates outreach but also makes access and utilization of services easy. The classic example is the role played by ICDS cadres (AWW, supervisors, CDPOs) in contributing to the success of the pulse-polio campaign aimed at eradication of polio in India. The frequency and regularity of these meetings are well defined and provide an effective forum to deal with issues and problems of common interest together in an attempt to solve them as a team. The face-to-face interaction promotes better interaction and the tendency of blaming and passing the buck is likely to get reduced. Instead, all actions are owned by all concerned. Furthermore, the recorded decisions in the minutes get official sanctity and greater likelihood of compliance. INHP experience has also endorsed the usefulness of having such a set-up at various levels. These were referred to as advisory committees in INHP.

The issue in the context of replication is how to make these committees get revitalized and active. The idea of resource groups given in the earlier part of the document can facilitate the setting up and revitalizing of these committees. The positive and facilitating role played by NGOs in making these advisory committees functional and effective, particularly at the levels of district, block and village/community, has also been reported in a recently completed national level evaluation of ICDS.³ Given the fact that convergence of services is vital for replication, it will be essential to constitute or revive **co-ordination committees** in the *identified districts*. These may substitute for the DLAC, BLAC, and VLAC of INHP and perform functions related to coordination and convergence of services and mobilization of the community to keep everyone enthused about doing things together and well. Hopefully, the availability of such a provision within ICDS scheme will make it easier to set up committees at different levels—and states may want to consider involving the local level, CBOs/NGOs—to ensure their effective functioning.⁴

Another approach relevant for replication and worthy of consideration is the involvement of members of the SHGs wherever in existence. It provides a promising platform where women get together at least once a month for microcredit/saving activities. Most of them are likely to be eligible ICDS beneficiaries, but may not be availing services. AWWs and Supervisors under the guidance of CARE Staff (replication) may intervene in making these groups vibrant for supporting ICDS activities in general, and components of replication in particular. In several places, if the Chairperson of Panchayat/Village Committees happens to be a woman, her involvement in AWC's activities can make a significant difference in improving coverage, minimizing exclusion, and enhancing community's involvement. CARE's experiences achieving functional convergence between ICDS and RCH, and engaging PRIs at the community level, carry some critical lessons and offer operational nuances that are worthy for replication.

³ (NIPCCD 2006, Three Decades of ICDS: A National Level Appraisal)

⁴ The MoWCD in the working group report for the 11th Five years Plan has proposed several strategies to improve convergence and coordination between departments to improve ICDS services which are worthy of consideration as well.

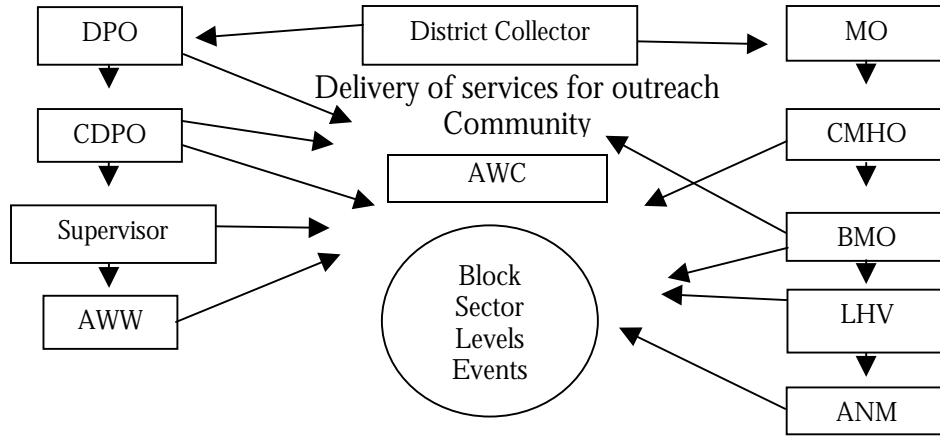
Another idea that the government is actively considering is utilizing ASHA in NRHM and *Kishori Balika* (Adolescent Girl) in ICDS at the community level as social immobilizers/change agents. If these two volunteers exist in replication sites, the possibility of their involvement may be explored. The extent of their involvement should be decided in the context of the community and the practice being replicated.

Against the above backdrop, figure-2 attempts to illustrate that the existing personnel of health and ICDS and other structures, if mobilized optimally, have the potential to replace the role played by CARE. The simple mechanism of strengthening inter-linkages between existing structures is likely to improve convergence between health and ICDS. The provision of coordination committees from village to district levels, if made functional, is likely to undertake periodic review of program implementation and make functionaries accountable—all of which can result in improved service delivery. The review also provides an opportunity to recognize and praise good work and serves as an incentive for others to follow suit. The committees at the block level, for example, can plan a calendar of NHD to streamline immunization and antenatal checkups. If a review system is put in place, referencing the calendar could denote how many of these sessions were held, and if not, why those in question were not. The problems and constraints faced as a result of the review in the meeting could be resolved on the spot.

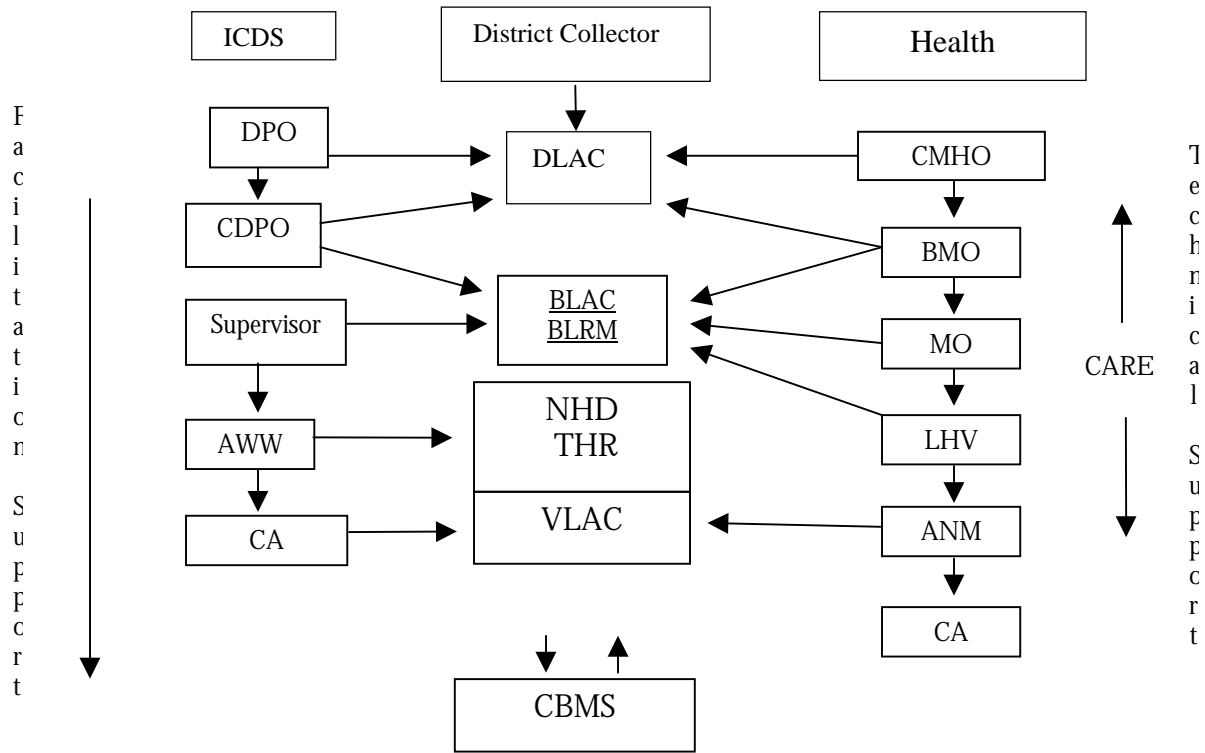
The other illustration is the role that can be played by the village level coordination committee. The committee has local leaders and PRI representatives on board as well. Using simple tools such as, village *level social map*, along with mechanisms of tracking outreach to monitor dropouts of registered target group beneficiaries can result in improved access and outreach of services. These processes and many others, when combined, may become key elements of **Community Based Monitoring System (CBMS)**. What will be selected for CBMS will depend on the capacities and readiness of the communities and the replication partners. Nonetheless, the main point is that the advisory/coordination committees can serve several purposes and add the important dimension of involving stakeholders, thereby ensuring interface and linkages amongst all—as attempted in the proposed structure.

Figure 2. Existing Structure: Proposed Operational Structure

Existing Structure –



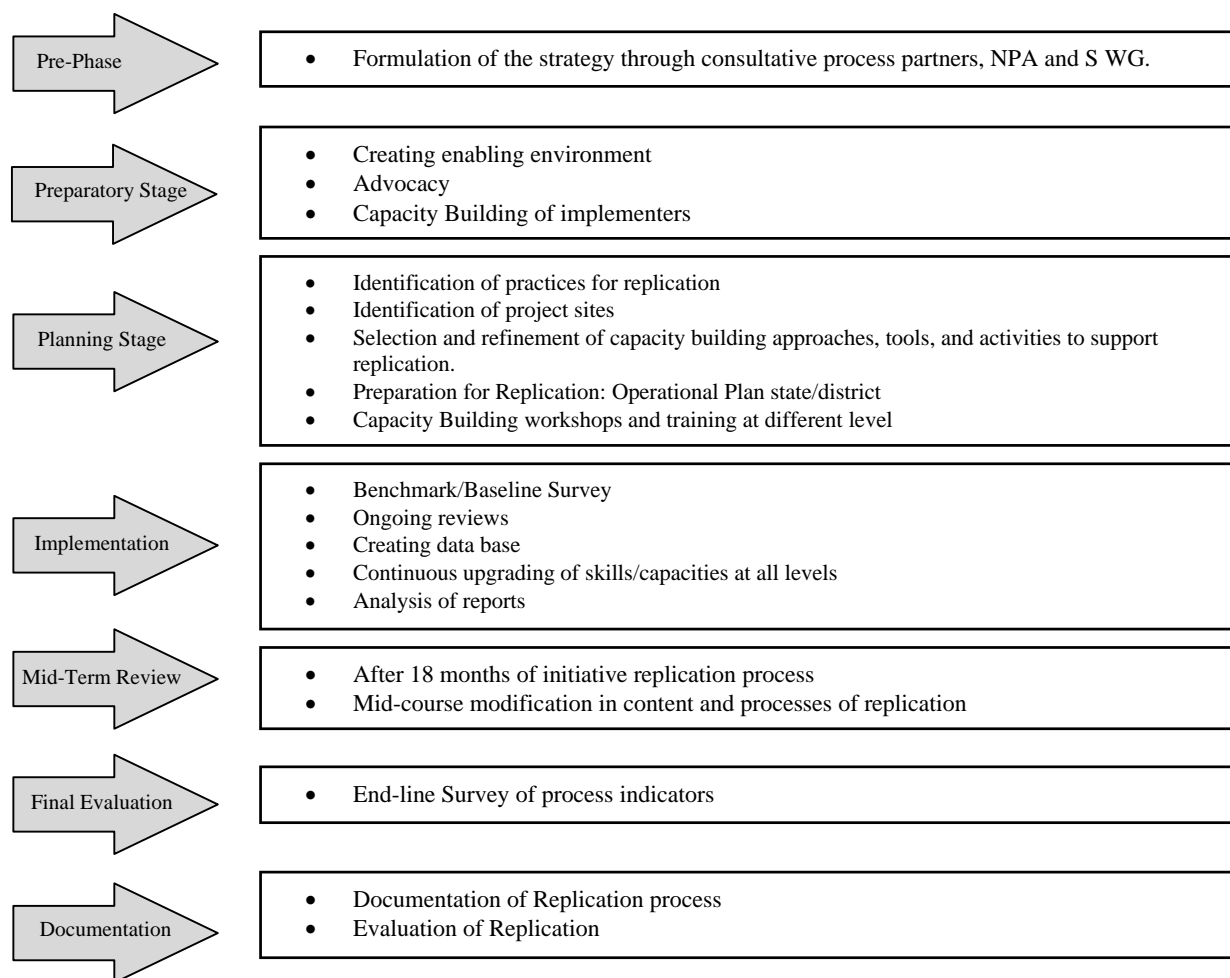
Proposed Structure –



9. OPERATIONAL STEPS: IMPLEMENTATION PLAN

Conceptualization of the endeavor of replication for INHP approaches was initiated as early as 2005. Recognizing that the INHP experience presents an opportunity to strengthen ICDS and RCH programs, GOI, USAID, and CARE agreed to strategize replication through a consultative process. It was felt that an intentional scheme of replication may be attempted, giving due regard to the dynamic institutional structures and systems of ICDS, covering manageable geographical areas beyond CARE assisted ICDS. Concerted efforts of the partners resulted in the evolution of the strategy for replication of proven approaches to be initiated in two states – AP and Chhattisgarh. The activity found a place within the INHP-III Proposal of CARE (October 2006-September 2009). The proposal has been given due approval/concurrence for funding by USAID and implementation by MoWCD. The major milestones envisaged are presented: in the *Road Map* at Figure 3.

Figure 3. Key Milestones of INHP Replications: A Road Map



These indicate steps for initiating the series of activities—and some of these are of a continuing nature, likely to be in operation concurrently.

This section spells out steps to be taken at national, state, district, block, and village levels to initiate the replication process. It enumerates the sequence of actions, enlisting activities to be undertaken by partners and stakeholders. An attempt has been made to specify expected roles of all concerned during the preparatory and, operational/implementation phases. These have been spelled out to facilitate smooth launching of the INHP replication package in non-CARE assisted districts of AP and Chhattisgarh. The suggested guidelines are advisory in nature, and may be modified, if required as per circumstances. While the steps have been listed in a sequence, some activities may have to be carried out simultaneously/concurrently. In any event, a consultative process may be followed involving partners (CARE, state WCD& Health departments, and SWG) through all stages/phases of replication. It is recommended that a *state-level Implementation Plan* is prepared; composed of: *geographical coverage*, description of the *elements of the package*, *rolling out plan/strategy*, description of *supporting processes*, *capacity building strategy* and calendar, *tools and material* to be used, *management of human/financial resources*, and *time schedule*, as well as any other pertinent details.

9.1. National Level: Operationalization

The government and its institutions are the key replicators of the identified package of proven practices of INHP. The commitment has to come from the nodal Ministries of Women and Child Development and Health and Family Welfare. The support requires zeal and responsiveness from the top, which must percolate down to the level of the project—for which a concerted preparation has to be done by CARE through documentation and advocacy, as planned during the Phase out Plan of INHP-III. The program has to be marketed and sold well as a proven program for reducing mortality, morbidity, and malnutrition in children. Necessary advocacy has to be undertaken for policy changes and directives that facilitate adoption of the proven practices proposed for replication. Documentation and dissemination of advocacy material is a prerequisite for enhancing responsiveness. The National Advisory Panel (NAP) constituted for INHP replication has an important role to play. Since it has been institutionalized as a legitimate body, its main function is to facilitate replication through administrative support to the two state governments involved (A.P. and Chhattisgarh). The Ministry of Women and Child Development must ensure that motivation in and interest of state replication is sustained by systematic follow up. It is both imperative and essential that key players of the replication (GOI, USAID/ CARE) are involved in decisions related to the replication process at all stages. Sharing of progress reports, decisions taken, problems faced—and solicitation of their solutions have to be taken through a consultative process.

9.1.1. Preparatory phase

The coordination and liaison with state partners and government machinery for replication can best be achieved through intervention of GOI, when initiated at the level of NAP. A few important steps to initiate replication process have already been taken at the national level:

1. As mentioned earlier, the MoWCD has constituted NAP and SWG to facilitate the process of replication of INHP (vide No. 24-6/2005-CD1/CDIII dated January 18, 2007) (see Annex 2-3)

2. The MoWCD, MoHFW and State Departments of ICDS and Health from AP and Chhattisgarh have nominated representatives for NAP and State Working Groups as per the composition proposed.
3. The first meeting of NAP was convened on March 22, 2007 with Joint Secretary MoWCD in chair (Annex-4). It should be ensured that NAP meetings are held regularly to guide and advise the states for their effective implementation of replication. Several important decisions were taken in the first meeting, having policy implications for the states to use to propel the process of replication of INHP practices in non-CARE assisted ICDS (Minutes in Annex 5).
4. Replication of INHP practices beyond CARE is an integral part of INHP-III. The MoWCD has approved INHP-III vide letter no. F.N013-8/2006-CDII/CDIII dated 28th October 2006. As such, there is concurrence, and MoWCD is already available for initiating replication process and its implementation in the states of AP and CG in non-CARE assisted ICDS areas (Annex 1).
5. Furthermore, the MoWCD and MoHFW may be approached by CARE to issue office orders/memorandums to their respective departments in the states dealing with ICDS and Health with a request to provide administrative support and cooperation in implementing the replication of INHP practices.

The Director of ICDS in MoWCD and Assistant Commissioner of Health in MOHFW have been designated as nodal officers for facilitation of routine follow up and processing of matters related to replication. The officers will also coordinate with USAID/CARE/FANTA and serve as a link between GOI and the states. The aim is to ensure smooth implementation of the process and timely resolution of bottlenecks and problems.

9.1.2. Policy Related Actions

Several specific recommendations have emerged from the Final Evaluation of INHP that have direct bearing on bringing quality improvements in the content and processes of RCH and ICDS. The empirical evidence has been shared with the nodal ministries for their consideration in making policy decisions to exact necessary changes. Some of the salient aspects that need to be pursued at this stage are:

1. To make NHD and THR as mandatory modes of SNP distribution for pregnant and lactating women and children for 6-36 months. (Annex 7)
2. Greater nutrition focus on children under 2 years old within ICDS, and change in approach from growth monitoring to prevention by controlling “growth faltering”, rather than by treatment of grades 3-4.
3. Making Joint visits of ANM and AWW a mandatory requirement during antenatal period, and in particular, the postnatal period.
4. Strengthening of the existing MIS system within ICDS and Health is required to improve accountability and assessment outcomes. It is an area in which CARE has developed expertise in the last 10 years, working with INHP. CARE has the expertise to give technical inputs for this activity, both at the national and state levels. The respective ministries are required to be made responsive to accept the idea of incorporating major

elements related to process monitoring, and indicators related to impact, in their existing systems.

5. The supply chain management is another aspect that has a bearing on SNP distribution. There is empirical evidence to indicate that tools and procedures of supply chain management in INHP resulted in increased beneficiaries coverage, mitigated losses at the levels of block & AWC, assured need based allocation, and reduced feeding interruptions. The SNP inventory management of SNP needs to be improved with the technical inputs of CARE.

9.1.3. Role of Partners

The proposed solutions have positive policy implications and enough scope to bring the desired changes in ICDS and RCH programs. If accepted by the government, they are likely to not only facilitate the present process of replication, but also, the nationwide scaling of INHP practices within ICDS at a later stage. The USAID and CARE India are required to make concerted efforts to follow-up the above actions—and through a consultative process, get these recommendations endorsed for policy change in NAP. These are in line with the ultimate objective of strengthening the Governmental system. The following are several suggestions to take the process forward:

1. National level consultations/seminars may be organized from time to time with an objective to disseminate information related to innovative efforts for implementing ICDS. Such collegial sessions, when shared with a wide audience comprising planners, administrators, policy-makers, practitioners and professionals in the field of health and nutrition, are likely to improve the designing of interventions and their implementation.
2. A national level meeting, *Confluence*, was organized by CARE on 11th January 2007, at Delhi, to disseminate findings and emerging lessons from INHP for stakeholders. The aim and objective of the event was to share evidence of improved health and nutrition outcomes achieved by ICDS in INHP areas, with an analytic eye towards what contributed to those results. The other objective was to identify and recommend the significance of these lessons for the improvement of national programs, especially ICDS and NRHM. The event was a great success and was attended by a wide range of stakeholders, including national and state level officials from MoWCD and MoHFW, NGOs, Development partners, as well as academic research and technical agencies. Field functionaries from ICDS and Health shared their experiences and served as resource persons. Such events may be organized from time to time to share experiences of field level innovations within ICDS by MoWCD/donors and other NGOs. These efforts provide visibility and recognition to micro level efforts and help in bringing about quality improvements in the approaches and practices of the existing national level health and nutrition programs.
3. The USAID and CARE need to take a proactive role in having a dialogue with MoWCD to influence restructuring of ICDS during the 11th Five Year Plan period for promoting health and nutrition status of women and children, based on INHP lessons and experiences. Some efforts have been made, but it needs to be followed up during the plan period. While giving approval for INHP-III, MoWCD has a special interest in the setting up of a web-based portal by CARE to serve as a national resource centre. It proposes

making available a description of successful practices, tools, and ‘how to’ guidelines to various stakeholders—and especially for replication. The information will be updated on an ongoing basis and is likely to be interactive. It will be developed using the expertise of an IT technology partner. Once ready, after discussion with GOI and other needed negotiations, it will be handed over to an appropriate body/institute to carry forward the process to future interventions.

4. As a part of replication process, USAID and CARE are also proposing to standardize the processes involved in replicating the varied elements of the package. Such standardization is aimed at ensuring both uniformity and quality. The activity is at a very exploratory stage, and FANTA has agreed to provide technical inputs.
5. The possibility of organizing a *capacity building* and orientation program for senior administrators and bureaucrats on using data for planning nutrition and health interventions, along with the procedures/process to be used for implementation, may be explored. It would be a concrete contribution and a step towards enhancing planning skills needed for program designing as well as the strategies for implementation. Facilitating the integration of INHP best practices into the larger government system would constitute another positive development.
6. The MoWCD/MoHFW and their state departments need to consider the suggestions and organize capacity building accordingly. CARE in INHP-III is already committed to give technical inputs for such trainings.

9.2. State Level: Operationalization

9.2.1. Preparatory Phase

The replication is proposed to be implemented by state offices of CARE in **Andhra Pradesh** and **Chhattisgarh** in partnership with state departments of ICDS and Health, facilitated by NGOs/CBOS/Technical Institutions at the district level. The State Working Groups set up for the respective states have a crucial role to play in terms of finalizing several aspects related to the implementation of the replication process (Refer TOR of SWG at Annex 3). It is imperative that the **State Working Groups** constituted by GOI and set up at the state level in AP and Chhattisgarh become dynamic and vibrant structures. The credibility CARE has acquired over a decade from its association with state governments forms a comfortable base from which to extend elements of INHP into non-CARE assisted ICDS areas in these two states. The familiarity of the state officials and functionaries from ICDS and RCH with INHP in these states is likely to serve as an advantage in taking this process forward. The states of AP and CG have eight/ten districts with INHP already in operation across 70/96 ICDS projects, respectively. As per the graduation and phase out plan proposed, INHP is likely to be scaled up in the remaining uncovered projects of the CARE assisted districts. Nonetheless, some ground work is required for launching replication, CARE state office, being the main technical implementers, will have to take the lead role in initiating the following actions at the state level, in partnership with the ICDS and health departments.

1. *Working Group may be made functional* by holding meetings regularly and periodically. Besides sharing the concept of the replication process, it needs to be used as an opportunity for *policy advocacy* and *dissemination* of the findings of the INHP Final

Evaluation and phase out plan as proposed in INHP-III. The replication process needs to be made more participatory and state specific. The state working group may be expanded as suggested in NAP to have the benefit of a wider representation of experts and NGOs within the state. (Minutes of first meeting on 22.03.07)

2. The consultative process at the state level is likely to provide state specific elements related to the processes and content of the strategy. The Plan of Action for replication may be worked out by the state to highlight, in particular, the selection/identification of replication sites, the training calendar, time frame, mobilization of human and financial resources, and other possible contributions the state chooses to incorporate. The section on supporting processes has enumerated the guidelines for capacity building, strengthening systems, and forging partnership in detail. If followed, these are likely to facilitate the planning process. SWG of AP has proposed to set up a core committee of replication, having representation of key partners to draft the state level plan (Annex10). CG may likely to follow it.
3. At the state level, the major administrative responsibility for coordination of the replication activities will rest with Department of WCD, who has a team of officers, comprising—Director ICDS, Deputy Directors and Program Officers/District Officers—who can be assigned roles to assist replication. A senior level officer of WCD may be designated as the nodal officer for INHP replication. He/she is expected to facilitate the organization of the State Working Group Meeting in consultation with State departments at intervals suggested in TOR and/or whenever the need arises.
4. Similarly, a nodal officer will be identified in the health department to facilitate convergence of ICDS and health activities included under replication. Both these officers will be counterparts to each other for Operationalization of INHP components relevant to their respective departments, as per the scheme/design of replication.

Once the SWG finalizes the implementation plan, a two-day *orientation workshop* may be organized jointly by CARE and WCD at the state level to familiarize the concerned state level officers about the contents of the replication and its associated procedures. The District Program Officers (DPO) and Medical Officers (MO) from the districts identified for replication sites need to attend the workshop, along with state level officers. The main objective of this workshop will be to prepare the **Implementation Plan** of replication for the state through a participatory mode. It will include all operational details required, as mentioned in the section above. CARE will provide support to WCD for planning the program design of the workshop and other details. The salient aspects to be covered during the workshop agenda/program are:

- a) Arriving at a consensus about the content and processes of operations of the replication package (as suggested in the previous section). State specific variations need to be given due consideration.
- b) Identification of districts and *project sites* for replication has already been firmed up. All non-CARE assisted districts in AP and CG will be the replication sites. However,

- rolling out decisions may be taken by choosing one of the following options: a) Instead of launching the strategy in all districts at once, selection of districts can be done in a phased manner. b) Within a district, selection of blocks/projects may be done all at once, or in a phased manner. c) Districts are selected on the basis of nutrition and health scenario status as per the survey. All the same, as outlined in the strategy plan, a district is considered as a unit of replication. Therefore, all projects of the selected districts will be covered.
- c) The involvement of *NGOs/CBOs/technical institutions* has been found to facilitate the initial process of handholding and coordination of training and the review of services at the grassroots. The matter has been deliberated both in the NAP, as well as also in the SWG meetings. It is felt that it may be worthwhile to involve them at initial stages of replication. Envisaging the facilitation role these organizations are expected to perform, CARE-state office as well as state government jointly may engage an NGO with a proven track record and experience of working with ICDS. The workshop may also deliberate on *criteria of selection* and recommend a list of potential NGOs that can be considered by the state, depending upon available resources and the decision of the SWG to engage NGOs.
 - d) Reviving or constituting state/district/block/project coordination/advisory committees and spelling out the roles these will play in the replication process. The existing pattern be shared and if needed modified.
 - e) The strategy has identified three approaches: *capacity building, community empowerment* and *strengthening systems*. A decision has to be taken with respect to which sub-aspects within these three approaches, the state is ready to incorporate or adopt. Through a consultative process, decisions need to be taken on these issues as these will have a bearing on the operational plan to be proposed, particularly with respect to the time frame and the costs involved.
 - f) CARE proposes to set up *resource groups* in the districts identified and undertake capacity building for scaling up within the districts. How such groups are best accessed needs to be worked out.
 - g) State and district level Technical assistance/support to ICDS and RCH *for replication* will be provided to CARE by FANTA on mutually agreed components, such as tools, training manuals, and monitoring procedures.
 - h) (viii) INHP-III proposes and plans to reach the district block and sector level staff with tools and methodologies through structured training and cross visits.

9.2.2. INHP Replication: Other Actions

1. It is suggested that the state may benefit from identifying a *Core Group* to work on the *preparation of an Operational Action Plan for replication*. It will contain a detailed listing of activities, selection of sites, capacity-building trainings/workshops, strengthening of systems, tools to be used, setting up of coordination committees, time

frame, and roles and responsibilities. An illustrative state Implementation plan is included in Annex 8.

2. Based on INHP implementation, certain aspects have been identified to facilitate the removal of bottlenecks and impediments that are likely to be encountered while carrying out the replication of INHP. The state may have to take important administrative actions or policy decisions to facilitate smooth implementation of the process. For example:
 - a) In selected project sites, all sanctioned posts must be filled and functionaries need to be in position.
 - b) Regular supply of SNP & other essential commodities must be ensured.
 - c) Directives need to be issued regarding the roles and responsibilities assigned to functionaries related to INHP. If any reward or incentive system has to be introduced it must be taken up with the state government.
3. Integrate the components of INHP at state/ district/block levels in the Program Implementation Plan (PIP) prepared annually by the departments of ICDS and health. The mobilization of financial resources for capacity building related to INHP needs to be reflected in the PIP of the respective departments.
4. INHP has crafted some **effective tools** that need to be reviewed at the state level to consider using in the existing monitoring system. Some of these are: AWWs home visit planner, supervisors check list and sector meetings guidelines (Annex 9). Necessary modifications may be required in the MIS, both for ICDS and health, to monitor the progress and get feedback on the INHP replication process. These, and other identified aspects, must become an integral part of the existing ICDS/health systems that are likely to get sharpened and regulated with improved efficacy and efficiency of ICDS.
5. Once the **State Level Implementation Plan** and operational action plans are formulated, these need to gain concurrence from the State Working Group.
6. States may wish to begin with the INHP replication process with a base line survey in the project sites. The details of the survey may be developed jointly by CARE and DWCD, based on the survey techniques/tools used in INHP-III, with minor modifications.
7. The ICDS program has provisions of convergence with health, education, water, sanitation and other wide-ranging government sectors/schemes at the state level. These are rarely followed, however. At the state level, DWCD may take a proactive role and act as a catalyst to facilitate convergence—which is an already mandated provision. A plan to promote this aspect needs to be worked out at the level of the state, and necessary orders and memorandum for compliance may be issued.
8. The nodal officer may be given the responsibility to coordinate collection of data for review of replication process as per the format as it stands. The data analysis may be disaggregated at the district level, and findings must be discussed in the monthly State

Level Coordination Committee every month. The reports may be forwarded to the chairperson of the State Working Group for information and so highlights of the findings can be shared in the SWG meeting.

9. Based on the review, follow-up action reports should be generated. Field visits may be undertaken for issuing instructions, directives and recommendations for resolving problematic areas may be shared in the meeting.
10. Documentation of the replication process will go a long way in transferring these learnings for wider adoption. CARE, with FANTA's inputs, is likely to undertake process documentation of replication activity. However, the state WCD department may want to document progress of replication in its Annual Report. The CARE state office and concerned NGO can facilitate this activity and its formatting.
11. The possibility of mobilizing state budget resources for providing training and giving incentives in recognition of good work by functionaries needs to be explored and incorporated in the budgetary allocations. The matter was deliberated in great detail in the first meeting of NAP and may be taken up in SWG/State ICDS Department for consideration as a policy decision. (Refer to minutes, Annex 5).

9.3. District Level: Operationalization

As mentioned in the design, a district would be designated as the unit of replication. Accordingly, the State Governments (AP & CG)—through a consultative process—may identify districts beyond CARE assisted areas to implement the INHP replication. It would be desirable to select geographically contiguous districts for easy implementation and for sharing human and other resources while planning the implementation plan. Proximity to CARE assisted districts may be another consideration for easy transference of knowledge and information through exposure visits, etc. Furthermore, with universal coverage of blocks in these districts, impact and learning will take place at a meaningful scale, due to multiple districts in a cluster. However, the final decision related to the approach and strategy of coverage has to be taken by partners jointly and concurred by the SWG. The envisaged scale of replication is 21 districts (AP-15, CG-6) covering around 300 blocks (Annex 6).

1. After finalization of the plan of covering districts selected, the next step would be to set up/revive District Level Coordination/Advisory Committees (DLCC/DLAC). The District Program Officers, NGOs from the selected districts, and CARE are likely to play a proactive role in the constitution of the committees and make these functional after orienting and building the capacity of its members.
2. The planning at the district level has to have a strong focus on *seeking and solving local problems*. The support of technical and operational inputs would be required to enable functionaries to have a results-oriented, evidence based approach to prioritizing actions for the quality implementation of the package to be undertaken. The community based planning, using tools like resource mapping, strengthening sector level review and other

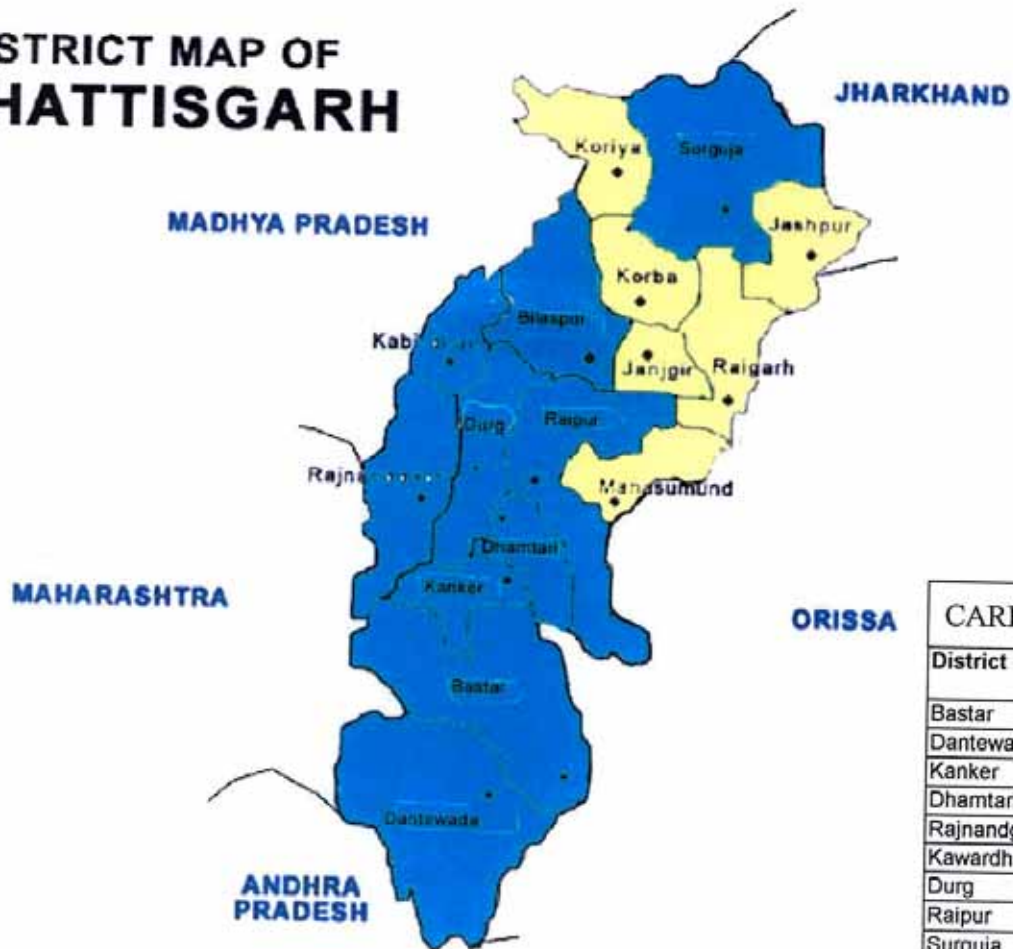
processes, are prerequisites to ensure need based planning—and for taking corrective actions.

3. Concerned officer of CARE at the district level and identified NGO/District Program Officer of WCD have a joint responsibility to drive progress of the replication process/procedure. The design and process of INHP-II has provided specific strategies to take interventions to scale. Informed by past experiences, the cogent set of practices identified as a package needs to be implemented jointly by partners with clear cut roles assigned. There are already existed sites with well-established proven practices of INHP in other districts of the states at various stages of operation, and these are likely to serve as examples and models for adoption.
4. District/block level functionaries of the ICDS and health from the replication area may be taken for exposure visits to CARE assisted INHP. It will be useful if this is done prior to the planning of the district level operational plan. *Mentors* and *role models* may be identified to provide motivation and incentive to the counterparts of non- CARE replication sites for emulating the good work done by others within the system. The whole experience is likely to build confidence and conviction that it is *do-able* as a process.
5. Through a consultative process with district officials of ICDS, RCH, PRI, and the technical support provided by CARE/NGO, the district plans are to be developed. Implementation of these rests on assigning mandatory roles and responsibilities through official channels. *Sector Level Operations* in the scheme of replication process are of crucial importance for review and monitoring. The convergence of health and ICDS services, the accountability of service providers, and the tracking of supplies are best achieved at sector level due to its manageable size. *Supervisors and Lady Health Visitors* are identified as key functionaries and main players to implement the operational plan across the jurisdiction of their sectors, covering the entire district.
6. The capacity building activities must focus on developing monitoring and supervisory skills of all concerned. The middle level functionaries could be utilized as trainers to train frontline workers; equipping them with communication and training technology skills is imperative to prepare them as effective trainers. The final modules of capacity building must focus on technical aspects, managerial skills and other aspects related to replication. The manual/guidelines/tools used in INHP have a wealth of information. These can be reviewed and contextualized for use.
7. If CDPOs take a positive approach and take the initiative to be proactive, monthly meetings of Block/Sector reviews have a scope to be used for providing continuing education and upgrading technical knowledge of AWWs.
8. Forging linkages and support of PRIs, community members, and beneficiaries is an integral domain of action. Community empowerment is a central tenet—comprised of several elements, such as awareness building, augmenting participation and their involvement in planning, and implementing and monitoring. A subsequent section

elaborates some of these approaches and strategies. The program officer must encourage CDPOs to plan a calendar of workshops.

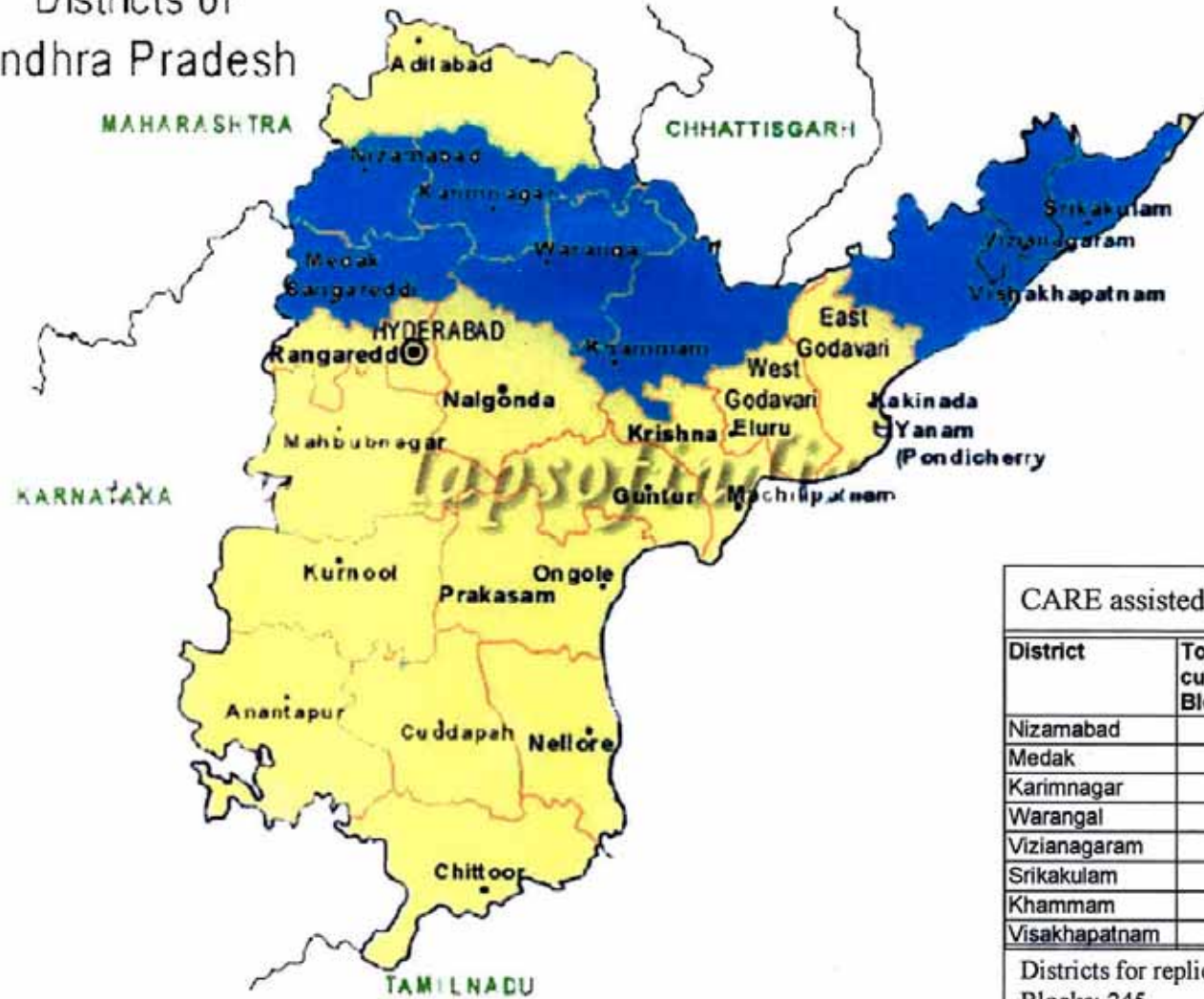
9. *Resource Mapping* is the key tool for participatory planning. It facilitates in identifying critical issues at district/block/village level requiring urgent action. Using strategic indicators that make planning more focused by involving people in meeting their felt needs, and suggesting action components of Replication Package may be made as an important aspect of the people's agenda. The actions carried out at the block level must focus and sharpen interventions, and make service providers more accountable.
10. The linkages and interconnection among different levels of the organizational structures play a vital role and synergizes the actions. It is visualized that the NGO/CBO to be engaged will play the facilitation role to initially link and connect these structures, and sustain and strengthen them in a way that these are institutionalized in the system. As the District is the reporting unit, it needs to have the software and hardware required for recording, storing, collating, and analyzing data related to replication process. The purpose is to have evidence based on monitoring and review of progress. The existing MIS of ICDS and health may be used with modifications/additions/adaptations to indicate effectiveness and efficiency of the replication process. With technical inputs, these indicators are to be ultimately finalized at the state level.

DISTRICT MAP OF CHHATTISGARH



CARE assisted District		
District	Total Current Blocks	New Blocks
Bastar	14	0
Dantewada	11	0
Kanker	7	0
Dhamtari	4	1
Rajnandgaon	3	7
Kawardha	4	0
Durg	7	6
Raipur	16	2
Surguja	19	1
Bilaspur	11	0
Districts for replication : 6		
Blocks: 55		

Districts of Andhra Pradesh



CARE assisted Districts		
District	Total current Blocks	New Blocks
Nizamabad	7	3
Medak	5	6
Karimnagar	9	6
Warangal	10	6
Vizianagaram	8	7
Srikakulam	8	9
Khammam	11	4
Visakhapatnam	12	10
Districts for replication : 15		
Blocks: 245		

10. COMMUNITY LEVEL INVOLVEMENT AND PARTICIPATION

Based on INHP, it is felt that NHD is the focal point and an entry point for reaching the target women beneficiaries, local women's groups, and panchayat bodies. Focus group discussions and many participatory tools available must be used to undertake advocacy related to health and nutrition issues at the community level when NHD is conducted. The details related to the conduction of NHD, worked out by CARE MP are placed at Annex 7 as an illustration. It is essential to heighten their responsiveness and awareness about INHP as an intervention. Use of folk media, street plays, puppets and other communication techniques/channels having appeal for communities need to be tried out at initial stages of project implementation to establish rapport. This can be a good beginning to initiate the idea of setting up village level advisory/coordination committees.

NGOs and CARE are expected to help supervisor and AWW to undertake these actions to facilitate replication. These are resource intensive measures and require both planning and time. Information and Broadcasting Department of the government is expected to assist and support the government schemes; the concerned offices at the district/state level may be contacted for organizing the required activities. However, technical soundness of the content and consistency in messages has to be overseen by CARE/NGO. There have been positive experience and learning within INHP which may inform decisions related to this aspect. Change Agents and women leaders may be involved to attract a larger number of beneficiaries to attend these meetings. Resource mapping can also be used at some appropriate stage to see if services are used by all concerned.

11. ROLE OF CARE

INHP replication beyond CARE assisted ICDS areas is being executed by state WCD/health departments. CARE has to perform multiple roles as a technical partner in the endeavor to ensure success. In the previous section, the extent of technical support available from CARE has been described in great detail. An attempt here is made to once again recapitulate the responsive technical and operational assistance of CARE during initial stages of replication.

1. Transferring capacities for evidence based participatory planning and implementation of critical child health and nutrition interventions to key ICDS staff.
2. Strengthening sector as a unit for supervision and on-going capacity building by validating the sector level managerial tools and processes and adapting these to local contexts.
3. Capacity building at district and sub-district level for sustained focus on critical interventions including enhanced service coverage and behavior change.
4. Technical and operational assistance to improve commodity supply chain management at district and sub-district levels.
5. Facilitating convergence between ICDS and RCH at all levels.

CARE in INHP-III proposal, has indicated that there will be a pool of technical staff at the state level to provide above inputs. It is also setting up resource groups at national and state/district levels to provide information and technical inputs. The composition of the dedicated team for

replication work to be available in each State office with specific roles has already been described in the document. Leadership and oversight will be available from SPR and FANTA Consultant.

ANNEX 1. LETTER OF APPROVAL FOR INTEGRATED NUTRITION AND HEALTH PROJECT (INHP III)

F.N013-8/2006-CD II/ CD III
Government of India
Ministry of Women & Child Development

Shastri Bhavan,
New Delhi, 28th October 2006,

To

Mr. Steve Hollingsworth,
Country Director,
CARE India,
27, Hauz Khas Village,
New Delhi -11 0 016.

Subject: Integrated Nutrition and Health Project (INHP III) _proposal.


Sir,

I am directed to refer to your letter No. Nil dated 08.11.2006 on the subject mentioned above and to convey the approval of this Ministry to the **Integrated Nutrition and Health Project (INHP III)** for a period of three years with effect from January 2007, subject to the following conditions:

- i. Best practices of INHP II should be continued for INHP III
- ii. Plan of action for establishment and functioning of National Resource Agency should be submitted to this Ministry for approval in due course of time
- iii. Periodic Quarterly Progress Report (QPR) on activities undertaken under INHP III may be submitted to the Ministry by 15th of the following month of the quarter for which report is prepared
- iv. The approval of the donor may be intimated to this Ministry at the earliest

Yours faithfully,


(Dr. Meenakshi Jolly)
Under Secretary to the Govt. of India.

Request through P.O. No. 4/2006


ANNEX 2. SETTING UP OF A NATIONAL ADVISORY PANEL OF INHP REPLICATION IN NON-CARE ICDS AREAS



D.O.No.24-6/2005-CD/ICD :

शरद कौमर
Joint Secretary

Fax No. : 23381495
Fax No. : 23381800
Fax No. : 23381654
Telegrams : WOMEN CHILD

भारत सरकार
महिला एवं बाल विकास मंत्रालय
GOVERNMENT OF INDIA
MINISTRY OF WOMEN & CHILD DEVELOPMENT

शास्त्री भवन, नई दिल्ली-110 001, दिनांक
Shastry Bhawan, New Delhi-110 001, Dated

18th January 2007.

Dear Dr. Adarsh,

As you are aware, CARE has been implementing the USAID-supported Integrated Nutrition and Health Project (INHP) in 78 districts in the States of Andhra Pradesh, Bihar, Chattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh and West Bengal. The project covered around 1,00,000 Anganwadi Centres and is implemented in partnership with the M/o WCD and M/o H & FW. Second phase of the Project viz. INHP II has ended on 31.12.2006 and the next phase i.e. INHP III has been launched on 01.01.2007.

2. Over the period of time CARE, through the INHP, has developed several successful practices, approaches and has attempted to incorporate these within the ICDS system through capacity building of functionaries, technical and managerial support to improve the service delivery system etc. Based on the learning of many years of partnership with ICDS, CARE, during the next three years of the final phase of INHP, would focus on extending technical assistance by integrating proven practices to non-CARE assisted ICDS areas. Replication of the good practices would be initiated in the States of Andhra Pradesh and Chattisgarh.

3. In order to facilitate the process of replication beyond the current programme areas and ensure interaction/liaison amongst key partners, it is proposed to set up a National Advisory Panel. The panel will undertake periodic reviews of the progress, facilitate co-ordination and solicit support of the administration in the two States. State Working Groups would also be set up in the two States to give state specific perspective and to ensure smooth implementation of the replication process.

4. I am pleased to invite you to serve as a member of the National Advisory Panel.

5. A detailed background note on the replication of INHP, composition and terms of reference of the National Advisory Panel is enclosed.

6. Kindly confirm your acceptance to serve on the National Advisory Panel.

With regards,

Yours sincerely,


(Charan Kumar)

Dr. Adarsh Sharma,
Consultant INHP- Replication,
FANTA,
T-27/3, DLF Phase III,
Gurgaon,
Haryana-122 002.

Advisory Panel and Working Group for Replication of INHP Good Practices by CARE India

Background

CARE implements the USAID-supported **Integrated Nutrition and Health Project (INHP)** in 78 districts in nine states (Andhra Pradesh, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh, and West Bengal). The project covers around 100,000 Anganwadi Centers (AWCs) and is implemented in partnership with the Ministries of Women and Child Development (MoWCD) and Health and Family Welfare (MoHFW).

Since the initiation of the INHP, the project has developed several successful approaches and practices and has attempted to get these incorporated with-in the ICDS system by capacity building and support provided to government partners in the CARE assisted areas. Some of these approaches include *facilitating convergence of ICDS and Health departments, strengthening commodity management and monitoring systems to be more responsive to context-specific needs and problems*. The monitoring and evaluation system of CARE and the formal evaluations carried out at various stages of INHP have provided evidence about the impact of the INHP approaches on the target groups and has demonstrated quality improvements in the service delivery and behavior change components of ICDS and Reproductive and Child Health (RCH) programs with-in the INHP operation areas.

Using the learning from many years of partnership with the ICDS and RCH programs, during the next three years, the final phase of the INHP (INHP-III), CARE through USAID support will consolidate the gains made over a decade period. It intends to leave behind capacity in these national programs at state, district and sub-district levels to target and reach the most vulnerable women and children with the most critical interventions. During this period, CARE will continue to be actively engaged in policy discussions at the national and state levels to advocate for and support integration of proven practices in Government of India (GoI) programs that provide health and nutrition services to the rural poor. Program inputs through INHP III will largely focus on extending technical assistance to the ICDS program for operationally integrating the proven practices to non-INHP blocks.

The successful experiences of the last ten years of CARE with the INHP merit serious attention and consideration to replicate these processes in projects/blocks of ICDS not covered by CARE. It has been agreed by CARE and USAID to solicit technical inputs under the Food and Nutrition Technical Assistance (FANTA) project, to support replication of key INHP approaches in non-CARE assisted ICDS areas. It is envisaged that the stakeholders and partners i.e. USAID, CARE, GoI and the state governments would work together to conceptualize the replication process. Based on our discussions with the MoWCD, state governments' interest, CARE state program capacities, and discussions, the replication is to be under taken to begin within two states, Andhra Pradesh and Chhattisgarh. In this regard, USAID, CARE, and FANTA have had earlier discussions with the MoWCD at the national and state level in AP and Chhattisgarh. CARE also plans to support such replication in all the non CARE-supported ICDS blocks in the districts where it works. Additionally, some components could have national approach, such as documentation and sharing lessons learnt to inform the national program efforts in terms of

training and program management and monitoring, or possibly establishing a national resource center under NIPCCD to strengthen the ICDS training component.

In order to facilitate the process of replication beyond the current program areas and ensure interaction and liaison between key partners and stakeholders it is proposed to set up an **Advisory Panel** at the Delhi level. The panel would provide technical inputs, undertake periodic review of progress, and facilitate coordination and solicit support of the administration in the two concerned states.

A State **Working Group** would be set up in each of the two states to provide state specific perspective and ensure smooth implementation of the replication process. The working groups' inputs would be fed to the advisory panel for information and action if any.

Names and addresses of the members of the Advisory Panel at NATIONAL level

1. Mr. Chaman Kumar
Special Advisor
Department of Women
& Child Development
Govt. of India
Gate No.3, Room No.615
Wing A, Shastri Bhawan
New Delhi- 110001
Ph: 23386227
Joint Secretary
2. Mr.B L Agrawal-IAS
Secretary, Health & Family Welfare
Government of Chhattisgarh
Department of Health & Family Welfare,
DKS Bhavan, Mantralaya,
Raipur – 492 001.
Member
3. Mr. Jawahar Srivastava-IAS
Secretary, Women & Child Development
Government of Chhattisgarh
Department of Women & Child Development
DKS Bhavan, Mantralaya,
Raipur – 492 001.
Member
4. Smt. Vasudha Mishra, IAS
Principal Secretary,
Secretary to Govt. of AP,
Women Development, Child Welfare & Disabled Welfare Department
L. Block, Room No. 201, AP Secretariat
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040-23456852 Fax 040 23450008
Vasudhamishra@yahoo.com
Member

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| 5. | <p>Shri C.B.S. Venkatramana, IAS
 Commissioner, Health & Family Welfare
 Department of Medical, Health and Family Welfare,
 DMHS Campus, Sultan Bazar
 Koti, Hyderabad - 500 095
 040 24650365 Fax 040 24652267
 cfwhyd@ap.gov.in</p> | Member |
| 6. | <p>Dr. Narika Namshum
 Deputy Commissioner, Child Health,
 Ministry of Health and Family Welfare
 Nirman Bhavan, Maulana Azad Road,
 Government of India,
 Room No. 211, D Wing, New Delhi – 110 011
 Ph. 23062791</p> | Member |
| 7 | <p>Mr. Mahesh Arora
 Deputy Secretary, ICDS
 Ministry of Women & Child Development
 Govt. of India
 Room No 638, Shastri Bhawan
 New Delhi-110001
 Ph: 23389434</p> | Member |
| 8. | <p>Ms. Ashi Kathuria
 Deputy Office Director
 Office of Social Development
 USAID/India, US Embassy
 Chanakyapuri, Shantipath
 New Delhi - 110021
 Mob: 9811083350</p> | Member |
| 9. | <p>Mr. V. Ramesh Babu
 Program Management Specialist
 Office of Social Development
 USAID/India US Embassy
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 Mob: 9873004702</p> | Member |
| 10. | <p>Ms. T. Usha Kiran
 Senior Program Director
 CARE/India
 27 Hauz Khas Village
 New Delhi -110016
 Ph: 26566060 Ext 505</p> | Member |
| 11 | <p>Mr. Mukesh Kumar
 Regional Program Director
 CARE/India
 27 Hauz Khas Village</p> | Member |

- New Delhi -110016
Ph: 26566060 Ext 580
12. Ms. Deepika Sharma Member
Director, Food Resource Mgmt & Govt Liaison
CARE/India
27 Hauz Khas Village
New Delhi -110016
Ph: 26566060 Ext 680
- 13 Ms. NVN Nalini Member
State Program Representative,
CARE/Andhra Pradesh
6-3-608/1 Khairatabad, Anand Nagar Colony
Hyderabad - 500 004
Ph: 040 – 23313998
14. Mr. Basanta Kar Member
State Program Representative
CARE/Chhattisgarh
C-52, Shailendra Nagar
Raipur - 429 001
Ph: 0771 – 4053070 / 71
15. Dr. Adarsh Sharma Convener
Consultant INHP-Replication
FANTA
T-27/3
DLF Phase III
Gurgaon
Haryana - 122002
Mob: 9810206006

ANNEX 3. SETTING UP OF THE STATE WORKING GROUP ON INHP REPLICATION IN ANDHRA PRADESH AND CHHATTISGARH, TERMS OF REFERENCE

Terms of reference for the state working group:

The state specific working group will service as an operational group to plan and manage the process of replication in the states of Andhra Pradesh and Chhattisgarh. Like the advisory panel, the working group is represented by the stakeholders from MoWCD, MoHFW, CARE, and FANTA to periodically meet to plan and execute the replication processes.

1. Roles and Responsibilities:

- (i) The group will develop the state specific INHP replication plans specifically with respect to the following points:
 - Development of content, process, and timelines for replication in each state including the content, process and timelines, selection of geographical areas for the replication activities.
 - Development of tools and methodologies for replication.
 - Development and implementation of capacity building plan.
 - Identification of roles and responsibilities at state, district and sub-district levels for different stakeholders
 - Development and implementation of monitoring and evaluation mechanisms
- (ii) Mobilizing resources and commitment at state and district levels to implement the replication plans.
- (iii) Create an enabling environment for implementation of replication process, e.g. by advocating key stake holders across levels (state/district/ block/village) or using any other appropriate methods
- (iv) Review the implementation progress periodically, may be on a monthly basis in the early period followed by quarterly reviews. The reviews will be done through field visits, review of reports and meetings.
- (v) Support to resolve problems and impediments in the replication process. Nodal persons may be designated for taking follow up actions in ICDS and Health departments.

The Convener will convene the Working Group meetings. The Group may induct and specially invite any other person/s considered suitable for giving inputs in its meetings with concurrence of the Chairperson. The Convener will convene the Working Group meetings. The concerned office of CARE will make logistic arrangements for holding meetings of the Working Group.

Members of State working group (Chhattisgarh)

- | | | |
|----|--|-------------|
| 1. | <p>Mr. Jawahar Srivastava-IAS
 Secretary, Women & Child Development
 Government of Chhattisgarh
 Department of Women & Child Development
 DKS Bhavan, Mantralaya,
 Raipur – 492 001.</p> | Chairperson |
| 2. | <p>Mr.B L Agrawal-IAS
 Secretary, Health & Family Welfare
 Department of Health & Family Welfare,
 Government of Chhattisgarh
 DKS Bhavan, Mantralaya,
 Raipur – 492 001.</p> | Member |
| 3 | <p>Mr.Dinesh Shrivastava-IAS
 Commissioner,
 Department of Women & Child Development
 Government of Chhattisgarh
 DKS Bhavan, Mantralaya,
 Raipur – 492 001.</p> | Member |
| 4. | <p>Representative of MoWCD, GoI
 (Director ICDS/Nominee)</p> | Member |
| 5. | <p>Dr Pramod Singh
 Director, Health & Family Welfare
 Directorate of Health & Family Welfare,
 Old Nurses Hostel, Raipur – 492 001.</p> | Member |
| 6. | <p>Dr B S Sarva
 Joint Director
 Directorate of Health & Family Welfare,
 Old Nurses Hostel,
 Raipur – 492 001.</p> | Member |
| 7. | <p>Mr.Prateek Khare
 Joint Director
 Directorate of Women & Child Development
 Old Nurses Hostel,
 Raipur -492001</p> | Member |
| 8. | <p>Ms.Christeena Lal
 Joint Director
 State Training Resource Center
 Department of Women & Child Development,
 Anand Nagar,
 Raipur – 492 001.</p> | Member |

- | | | |
|-----|---|----------|
| 9. | Ms.Archana Rana
Joint Director
Directorate of Women & Child Development
Old Nurses Hostel,
Raipur – 492 001. | Member |
| 10. | Dr. Adarsh Sharma
Consultant INHP-Replication
FANTA
T-27/3
DLF Phase III
Gurgaon
Haryana - 122002
Mob: 9810206006 | Member |
| 11. | Mr. Mukesh Kumar
Regional Program Director
CARE/India
27 Hauz Khas Village
New Delhi -110016
Ph: 26566060 Ext 580 | Member |
| 12. | Mr. Basanta Kar
State Program Representative
CARE/Chhattisgarh
C-52, Shailendra Nagar
Raipur - 429 001
Ph: 0771 – 4053070 / 71 | Convener |

State Working Group (Andhra Pradesh)

- | | | |
|----|--|-------------|
| 1. | Smt. Vasudha Mishra, IAS
Principal Secretary,
Secretary to Govt. of AP, Women Development,
Child Welfare & Disabled Welfare Department
L. Block, Room No. 201, AP Secretariat
Hyderabad - 500 022
040-23456852 Fax 040 23450008
Vasudhamishra@yahoo.com | Chairperson |
| 2. | Shri C.B.S. Venkatramana, IAS
Commissioner & Principal Secretary (Ex-officio),
Health & Family Welfare
Department of Medical, Health and Family Welfare,
DMHS Campus, Sultan Bazar
Koti, Hyderabad - 500 095
040 24650365 Fax 040 24652267
cfwhyd@ap.gov.in | Member |

- | | | |
|----|--|----------|
| 3. | <p>Ms. Y.V. Anuradha, IAS
 Director, DWCW
 Department of Women & Child Welfare,
 Behind Sarathi Studios, Vengalraonagar,
 Ameerpet, Hyderabad
 Tel. 040 – 23733848 Fax 040-23733665</p> | Member |
| 4. | <p>Representative of MoWCD, GoI
 (Director ICDS/Nominee)</p> | Member |
| 5. | <p>Ms. Abdi Chandrika
 Deputy Director (Nutrition), DWCW
 Department of Women & Child Welfare,
 Behind Sarathi Studios, Vengalraonagar,
 Ameerpet, Hyderabad
 Tel. 040 – 23733848 Fax 040-23733665</p> | Member |
| 6. | <p>Dr. Hymawathi Joint Director,
 Health & Family Welfare
 Department of Medical, Health and Family Welfare,
 DMHS Campus, Sultan Bazar
 Koti, Hyderabad - 500 095</p> | Member |
| 7. | <p>Dr. Adarsh Sharma
 Consultant INHP-Replication
 FANTA
 T-27/3, DLF Phase III, Gurgaon
 Haryana - 122002
 Mob: 9810206006</p> | Member |
| 8. | <p>Mr. Mukesh Kumar
 Regional Program Director
 CARE/India
 27 Hauz Khas Village
 New Delhi -110016
 Ph: 26566060 Ext 580</p> | Member |
| 9. | <p>Ms. NVN Nalini
 State Program Representative,
 CARE/Andhra Pradesh
 6-3-608/1 Khairatabad, Anand Nagar Colony
 Hyderabad - 500 004
 Ph: 040 – 23313998</p> | Convener |



Chaman Kumar
Joint Secretary

D.O.No.24-6/2005-CD/ICD III

Fax No. : 23381495

Fax No. : 23381800

Fax No. : 23381654

Telegrams : WOMEN CHILD

भारत सरकार
महिला एवं बाल विकास मंत्रालय

GOVERNMENT OF INDIA
MINISTRY OF WOMEN & CHILD DEVELOPMENT

शास्त्री भवन, नई दिल्ली-110 001, दिनांक

Shastri Bhawan, New Delhi-110 001, Dated

16th January 2007.

Dear Dr. Sharma,

1. As you are aware, CARE has been implementing the USAID-supported Integrated Nutrition and Health Project (INHP) in 78 districts in the States of Andhra Pradesh, Bihar, Chattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh and West Bengal. The project covered around 1,00,000 Anganwadi Centres and is implemented in partnership with the M/o WCD and M/o H & FW. Second phase of the Project viz. INHP II has ended on 31.12.2006 and the next phase i.e. INHP III has been launched on 01.01.2007.
2. Over the period of time CARE, through the INHP, has developed several successful practices, approaches and has attempted to incorporate these within the ICDS system through capacity building of functionaries technical and managerial support to improve the service delivery system etc. Based on the learning of many years of partnership with ICOS, CARE, during the next three years of the final phase of INHP, would focus on extending technical assistance by integrating proven practices to non-CARE assisted ICOS areas. Replication of the good practices would be initiated in the States of Andhra Pradesh and Chattisgarh.
3. In order to facilitate the process of replication beyond the current programme areas and ensure interactionnaision amongst key partners, it is proposed to set up a National Advisory Panel. The panel will undertake periodic reviews of the progress facilitate co-ordination and solicit support of the administration in the two States. State Working Groups would also be set up in the two States to give state specific perspective and to ensure smooth implementation of the replication process.
4. I am pleased to invite you to serve as a member of the State Working Group.
5. A detailed background note on the replication of INHP, composition and terms of reference of the State Working Group is enclosed.
6. Kindly confirm your acceptance to serve on the State Working Group.

With regards,

Yours sincerely,

(Chaman Kumar)

Dr. Adarsh Sharma,
Consultant INHP- Replication,
FANTA,
T-27/3, DLF Phase III,
Gurgaon,
Haryana-122 002.

ANNEX 4. NOTICE FOR THE FIRST MEETING OF THE NATIONAL ADVISORY PANEL FOR INHP REPLICATION, MARCH 22, 2007



Mahesh Arora
Deputy Secretary
Tel No.23388434

D.O.No.24-8/2005-CD ICD III

Fax No. : 23381495
Fax No. : 23381800
Fax No. : 23381654
Telegrams : WOMEN CHILD

भारत सरकार
महिला एवं बाल विकास मंत्रालय
GOVERNMENT OF INDIA
MINISTRY OF WOMEN & CHILD DEVELOPMENT

शास्त्री भवन, नई दिल्ली-110 001. दिनांक
Shastri Bhawan, New Delhi-110 001, Dated

18th March 2007.

Dear *Dr. Adarsh Sharma*,

Kindly refer to this Ministry's D.O letter No.24-8/2005-CD ICD III dated 18th January 2007 regarding setting up of a National Advisory Panel (NAP) to facilitate replication of the good practices of Integrated Nutrition & Health Project (INHP) of CARE India in non-CARE assisted ICDS areas in the States of Andhra Pradesh and Chattisgarh. Since the project is to be launched in the coming financial year, it is proposed to hold the first meeting of NAP at Delhi with Shri Chaman Kumar, Joint Secretary, Ministry of Women & Child Development in chair. The objective of the meeting is to discuss the strategy and process of replication of good practices and to ensure smooth implementation of the activity.

2. The first meeting of National Advisory Panel has been scheduled at Delhi as per the following details:

Date: 22.03.2007

Time: 11.30 AM – 04.30 PM

Venue: Mahogany Committee Room, India Habitat Centre, Auditorium Block, Lodhi Estate, New Delhi (Entry from Gate No.3)

3. Kindly make it convenient to attend the meeting and confirm your participation at the earliest to this Ministry and also to Dr.Adarsh Sharma, Consultant, INHP Replication at:
Mobile number 9810206006 or
Email: sharma_adarsh@hotmail.com

4. Agenda of the meeting is enclosed.

With regards,

Yours sincerely,

(Mahesh Arora)

Dr Adarsh Sharma,
Consultant INHP- Replication,
FANTA,
T-27/3, DLF Phase III,
Gurgaon,
Haryana-122 002.

ANNEX 5. MINUTES OF THE FIRST MEETING OF THE NATIONAL ADVISORY PANEL FOR INHP REPLICATION

F.No.24-6/2005-CD I/CD III
Government of India
Ministry of Women & Child Development

Shastri Bhavan,
New Delhi, 07th May 2007.

To

Dr. (Smt) Adarsh Sharma,
Consultant,
INHP-Replication, FANTA Project,
CARE India,
27, Hauz Khas Village,
New Delhi-110 016.

Subject: Minutes of the National Advisory Panel Meeting held on 22.03.2007

Madam,

I am directed to refer to your letter No. Nil dated 10.04.2007 on the subject mentioned above.

2. Please find enclosed herewith a corrected copy of the minutes of the first meeting of the National Advisory Panel on Replication held on 22.03.2007 at New Delhi, for sharing with the other members of the Panel.
3. It is requested that a corrected copy of the minutes of the meeting may also be forwarded to this Ministry for information.

Yours faithfully,


(Dr. Meenakshi Jolly)

Under Secretary to the Govt. of India.

**First Meeting of the National Advisory Panel (NAP):
Replication of INHP Good Practices in non-CARE Assisted ICDS Areas
Thursday, March, 22, 2007**

1. Minutes and Summary of the Decisions for Action

The first meeting of the National Advisory Panel was held on March 22, 2007 at 11.30 AM in Mahogany Committee Room of the India Habitat Center in Delhi. The list of members present for the meeting is at **Annex-I**. *Mr. B.L. Aggarwal*, Secretary, Health and Family Welfare and *Mr. Jawahar Srivastva*, Secretary, Women and Child Development from the Government of Chhattisgarh regretted their inability to attend the meeting due to their preoccupation with budget session in the state. The agenda of the meeting is placed at **Annex-II**.

2. Welcome and Introduction

The meeting was chaired by *Mr. Chaman Kumar*, Joint Secretary, Ministry of Women and Child Development (MoWCD). The chairperson welcomed the members; highlights of his address are given below:

- a) Mr. Kumar commended the long association and partnerships of the Government with USAID/CARE for support in the forms of food and technical/ programmatic inputs to ICDS. He expressed appreciation of the innovatively planned phase out strategies of CARE within INHP III. He mentioned that the MoWCD had concurred with the INHP III, and endorsed the idea of integrating some of the proven practices of INHP during the next three years in to non- CARE assisted ICDS areas in the states of Andhra Pradesh (AP) and Chhattisgarh (CG). The replication of the identified good practices could be implemented in partnership with CARE by the state governments.
- b) Mr. Kumar described in detail the present replication activity and clarified and that the replication strategy could be implemented by the governments in two states with technical and other managerial inputs from CARE. MoWCD has set up two structures under its wings- **NAP** at the national level and State Working Group (SWG) at the state level to facilitate smooth implementation of the replication strategy. He elaborated the critical role and responsibility entrusted to the states to take the process forward, optimally utilize the available resources within the state. The **Terms of Reference (ToR)** clearly spell out what is expected from the states.
- c) He advised the two states and CARE to make the replication contextual and specific to the situations in the respective states. He urged that, through a consultative process, implementation mechanisms of the replication be worked out to the threadbare details at the state level. This should form the agenda for the first meeting and that the preparatory discussions needed to be held urgently. Considering that INHP III is likely to roll out in June 2007, the SWG meetings may be held in AP and CG as early as possible.

- d) **Identifying viable models of public- private partnership** - He informed that there was readiness amongst business houses and corporate sector to provide resources under the corporate social responsibilities commitment and the GOI was open to the idea of encouraging such an input in its national programs. The Chairperson suggested that CARE-USAID could perhaps work out a few models, identify thrust areas of such partnership, and share the information with the ministry. Ms. Ashi Kathuria said that USAID was committed to fully exploring the potential for public-private partnerships with respect to the replication process.
- e) Several illustrations were given by Mr. Kumar as to how the government resources could be mobilized, tapped and leveraged to achieve ends common to the two Ministries/Departments viz DWCD and H&FW. The two Secretaries/Commissioners of ICDS and Health present from AP were requested to explore such a pooling of resources for replication activity in their states. He also assured full support of the GOI in giving concurrence to specific/ deserving proposals forwarded by states to utilize funds available in the ICDS for capacity building/training related to replication.
- f) Chairperson suggested that we may consider making the SWG composition more broad based by inducting academicians, experts and other grassroots level leaders. The inputs and expertise of these members were likely to add value to the process of replication.
3. **Two presentations were made to cover the agenda items I and II of the meeting. Copies of the slides of the presentations are placed at Annex – III.**

Agenda Item 1: *Background and Introduction to INHP*

First presentation entitled *Replication of Evidence Based Practices to Reduce Child Malnutrition and Infant Mortality* was made by Ms T. Usha Kiran, Senior Program Director, CARE/India. It highlighted the current problem of malnutrition and infant mortality and attempted to relate the factors that contribute to the problem. Evidence based activities that helped in achieving the objectives such as: community based new born care; infant and young child feeding, micronutrient, supplementary feeding and immunization were delineated. The presentation lucidly described the specific actions taken as well as the approaches that were used at various levels (village, sector, block and district) to achieve alignment in the systems within ICDS and Health to deliver services effectively. A few of these, which appeared to have worked, using specific practices and tools, were:

- **Inclusion and tracking** of beneficiaries through social maps, mother and child registers, Nutrition and Health Days and regulating and streamlining of nutrition supply chain.
- **Prioritized home visits** during the critical periods of lifecycle- AWW to use home visit planner
- **Supportive supervision** at sector level-supervisory checklists, sector meeting guidelines
- **Focused supervision** and monitoring and enhanced accountability by block and district level leadership

4. It was also highlighted that the costing study done by an independent consultant had concluded that INHP was found to be highly cost effective and a good value for money. Further, CARE would be happy to continue to work with GOI as a partner in its endeavor of reducing Infant Mortality and Child Malnutrition in the country.

Agenda Item 2: Concept of Replication Strategy

5. The concept of replication strategy and the evolution of the process were presented by Dr. Adarsh Sharma, Consultant, Food and Nutrition Technical Assistance (FANTA) project of the Academy for Educational Development. She informed that the proposed replication strategy was a result of a consultative process involving main players and partners-MoWCD, MOHFW, State Departments of ICDS /Health, USAID, FANTA, and CARE. The key elements of the proposed replication process comprising geographic spread, preparatory activities, description of roles and responsibilities, resource requirements/ mobilization, techniques of monitoring /evaluation and process documentation plan were also shared with the members. Not letting replication to be a mechanical process, flexibility, contextual relevance of the content, embedding it in the system and presence of leaders/ champions/mentors to energize the system were delineated as the non-negotiable guiding principles of the replication process. The presentation ended with listing up of further actions and steps to be taken.
6. Following the presentations, the members deliberated on several issues related to replication in particular and ICDS in general. At the instance of chairperson, both Secretaries/Commissioners of Health and ICSD from AP openly interacted with each other to find out ways and means of pooling of resources for strengthening/organizing activities related to replication and for improved quality of services in the respective departments. Highlights of the suggestions and proposals were:
 - i. Mr. Venkataramana, Commissioner FW, and Director NRHM of AP suggested that any viable proposal mutually agreed by the concerned departments for sharing of resources needed to be reflected /included in the annual Proposed Implementation Plan (PIP) of the department/s, which are presently under preparation. Ms Vasudha Mishra was requested to arrange for a meeting between Health and ICDS departments at the state level to take the matter forward. **(Action: ICDS & Health Departments of AP)**
 - ii. In order to strengthen critical areas of concern related to health and nutrition, it was proposed that themes may be identified i.e. infant young child feeding practices, sanitation, clean potable water, home based newborn care etc. and promoted through campaign mode. The possibility of using IEC funds available at the state level may also be explored. **(Action: State Health and ICDS Departments)**
 - iii. Recognizing that the neonatal mortality contributes to the bulk of infant deaths in the first year, both health and ICDS departments need to make plans jointly to optimally use AWW, ANM and ASHA as significant human resource to deal with the problems of infant/child mortality and malnutrition at the state level.
 - iv. Mr. Venkataramana informed that there was a provision of about 5% of allocation within NRHM for promoting synergy across departments, the possibility of tapping this could also be explored. **(Action: State level department/s)**

- v. The committee members dwelt upon the merits and modalities of joint training of Health and ICDS functionaries to promote convergence and quality of services. Dr. Narika Namshum and Dr. Sangeeta Saxena from MoHFW informed of the policy of the ministry to support such trainings through cascade approach by training a team of master trainers and taking specific messages up to the grassroots/ frontline workers. It was suggested that CARE could provide technical support and content for such training and work out modules and manuals in the context of replication components such as home visits, newborn care, nutrition faltering , IMNCI etc. Reference was also made to the provision of funds under other trainings within ICDS that could be used for capacity building at various levels. **(Action: CARE, & State Departments)**
 - vi. The need to sustain momentum and motivation of all concerned in replication and in improving services received a lot of concern and led to a prolonged discussion about ways and means to achieve this end. Several options were given; participation and involvement of PRIs; NGOs/CBOs, identifications of champions/ leaders capable of giving support and advocacy at various levels were considered. Ms. Mishra, Secretary ICDS suggested that within social audit provision, conducting child nutrition audit should be possible and solicited CARE’s expertise, and help in planning it for AP.
 - vii. At this juncture, the experience of CARE in involving NGOs for INHP was reviewed and it was felt that presence of NGOs was vital to facilitate the replication process. The extent of their role perhaps needs to be redefined in the context of replication for hand holding, networking, coordination with stake holders and monitoring. These aspects may be resolved in the meetings of the SWG. Chairperson offered that states may approach the MoWCD for funds if needed by submitting a proposal for involvement of NGOs in replication **(Action: MoWCD, ICDS Department–AP&CG and CARE for facilitation)**
7. Before breaking for lunch, Mr. Chaman Kumar, Joint Secretary thanked everyone for their active participation in the deliberations of the meeting. He once again reiterated that ministry would provide all support to the endeavor of replication. He opined that states being the main player needed to carry the process forward. State Working Group has been set up to play a crucial and vital role. It has to be ensured that it is a vibrant and dynamic structure that contributes towards effective implementation of the replication process. Referring to TOR of the SWG, he remarked that it provided an outline and a framework that could be refined and modified to meet state specific needs. It was desired that SWG meetings be held as early as possible to ensure rolling out of replication activity as scheduled by June, 2007. He regretted his inability to stay for the post lunch session due to important work in the ministry. Mr. Mahesh Arora, Deputy Secretary was requested to carry on with the remaining agenda.
8. **Agenda Item 3: Role of NAP and SWGs and Agenda Item 4: TOR of State Working Group**
 Given that key aspects of these agenda points were discussed as part of Mr. Chaman Kumar’s opening remarks and in the other preceding agenda items, the members felt that further discussion on these points was not required. It was summed up that the NAP was an advisory and facilitating body. The State Working Groups had a crucial role to play and based on broad guidelines their role could be further detailed, along with a review of the TOR in the respective SWG meetings in AP and Chhatisgarh.

9. **Agenda Item 4: Any Other Matter** Mr. Mahesh Arora invited the two Senior Officials (ICDS & Health) from AP to raise any point related to the process of replication. Availing the opportunity, both the senior officers discussed several issues relevant to AP.
- i. It was opined by Ms. Mishra that for effective delivery of services it was important to have streamlined *Commodity Supply Chain Management* in place both in the replication sites as also across the state. She informed that AP had already solicited CARE inputs to regulate, review and monitor procurement, allocation and distribution of SN. The technical inputs ranged from capacity building to providing of formats and forms and techniques of analysis and follow up action.
 - ii. In order to improve convergence between Health and ICDS, Mr. Venkataramana suggested that both departments should have a joint discussion and identify aspects/mechanisms that needed to be implemented. It was proposed that necessary guidelines and instructions could be issued by both the departments jointly for institutionalization of the processes such as joint home visits, referral of cases and institutional deliveries.
 - iii. Another possibility suggested was to use provisions available within NRHM for orientation of ASHA workers state wide covering 10 villages as a cluster. Technically sound module covering critical areas of concerns could be developed with assistance of CARE and frontline workers of both departments—AWW & ANM along with ASHA who could also be given training to promote similar messages in the community (**Action: Department of ICDS and FW of AP**).
 - iv. It was stated that due to its vast field experience and strong technical knowhow CARE could take up the role of a State Level Nodal Agency in AP to provide continuing education, act as a clearing house—a forum of information/experience sharing and documentation etc. for NRHM. Mr. Venkataramana was of the view that CARE could pursue the matter at the state level systematically. NRHM had allocations available for setting up such a structure. It would go a long way in improving services and enhancing capacities and skills of concerned functionaries of ICDS and Health and PRIs. (**Action: CARE, AP-Dept. FW**).
 - v. One of the strategies suggested was to take up actions and good practices one by one and move to the next in a phased manner once it was firmly institutionalized in the system. Such an approach was likely to ensure both success and sustainability. Keep the arrow light to hit the target forcefully, remarked AP Commissioner of FW.
 - vi. It emerged from the discussion that distribution of SN alone was not the solution to the problem of malnutrition. Several linked action are required, taking actions mechanically may not lead to the desired goals. The critical issues of creating leadership, enhancing commitment and motivation, changing mindsets are difficult endeavors but if pursued sincerely can bring results in human resource development.
 - vii. The other concern that received attention in the discussion was setting up of the coordination groups at state, district, block, sector and village levels. CARE shared its experiences but cautioned that it was a difficult task to keep these functional and making their perform supportive role. The involvement of District Collector and district level administration has lot of benefits but it involves a lot of preparatory work to enhance commitment and understanding through advocacy. State offices of CARE and NGOs can facilitate this due to their long experience with INHP.

10. Mr. Arora suggested a few activities that needed to be taken up by AP and CG in consultation with CARE for initiating replication. These were:
- i. In house consultation within departments of ICDS and FW/Health to plan preparatory activities
 - ii. Identification of committed/motivated champions inside and outside the system who could play important role.
 - iii. Assessing and ascertaining resource requirements and finding ways to mobilize resources for meeting the shortfall.
 - iv. Representatives of CARE state offices from AP & CH in their capacity as conveners were requested to do the ground and preparatory work to organize the meeting of SWG in their respective states latest by last week of May 2007. The concerned SWG members may accordingly be briefed and chairpersons may be requested to facilitate organization of SWGs at the earliest.
 - v. The objective of the meeting is to decide content and implementation plan for replication using consultative process for decisions by involving Departments of ICDS and Health/FW. It will be desirable to solicit technical inputs and support of CARE for the replication endeavor at all stages
 - vi. The MoWCD may be kept informed; clarification/administrative support may be sought, if required.

Concluding the discussions' Mr. Arora thanked all members for attending the meeting and making valuable contribution to the discussions.

The first meeting of the National Advisory Panel (NAP) of INHP replication in non-CARE assisted areas, March 22, 2007

List of the members of the National Advisory Panel Members present:

- | | | |
|-----|--|-----------------|
| 1. | Mr. Chaman Kumar
Joint Secretary, GOI | Special Advisor |
| 2. | Smt. Vasudha Mishra, IAS
Principal Secretary, GOAP | Member |
| 3. | Shri C.B.S. Venkatramana, IAS
Commissioner, Health & Family Welfare, GOAP | Member |
| 4. | Dr. Narika Namshum
Deputy Commissioner, Child Health, GOI | Member |
| 5. | Mr. Mahesh Arora, MoWCD, GOI
Deputy Secretary, ICDS | Member |
| 6. | Ms. Ashi Kathuria
Deputy Office Director, USAID | Member |
| 7. | Mr. V. Ramesh Babu
Senior Program Manager, USAID | Member |
| 8. | Ms. T. Usha Kiran
Senior Program Director, CARE | Member |
| 9. | Mr. Mukesh Kumar
Regional Program Director, CARE | Member |
| 10. | Ms. Deepika Sharma
Director, Food Resource Mgmt & Govt. Liaison | Member |
| 11. | Ms. NVN Nalini
State Program Representative, CARE/AP | Member |
| 12. | K.P. Sunil Babu
State Program Representative, CARE/CG | Special Invitee |
| 13. | Dr. Adarsh Sharma
Consultant INHP-Replication | Convener |
| 14. | Dr. Sangeeta Gopal Saxena
Asst. Commission (CH), MHFW, GOI | Special Invitee |

Regrets

- | | | |
|----|---------------------|--------|
| 1. | Mr. B L Agrawal-IAS | Member |
|----|---------------------|--------|

Secretary, Health & Family Welfare, GOCG

2. Mr. Jawahar Srivastava-IAS
Secretary, Women & Child Development, GOCG Member
3. Basanta Kar
Operational Director, CARE/CG Member

First Meeting of National Advisory Panel on Replication of Good Practices of Integrated Nutrition and Health Project (INHP) in non-CARE assisted ICDS Areas on 22nd March, 2007 at 11:30 AM at New Delhi.

AGENDA

Welcome and remarks of Chairperson

1. Background & Introduction to INHP
2. Concept of Replication and Strategy
3. Role of National Advisory Panel & State Working Groups in Andhra Pradesh and Chhattisgarh
4. Review of Terms of Reference (TOR) for National Advisory Panel and State Working Group
5. Any other matter with the permission of the chair.

ANNEX 6. OPERATIONAL SCALE OF REPLICATION OF INHP IN NON-CARE—ICDS AREAS

List of districts without INHP along with number of blocks

Andhra Pradesh

Sl.No	Name of the Districts	No. of Blocks
1	East Godavri	24
2	West Godavri	18
3	Krishna	21
4	Guntur	23
5	Ongole	20
6	Nellore	17
7	Adilabad	14
8	Hyderabad	5
9	Rangareddy	11
10	Nalgonda	18
11	Mahaboobnagar	16
12	Chittoor	21
13	Ananthapur	17
14	Cuddapah	14
15	Kurnool	16
	Total	255

Chhattisgarh

Sl.No	Name of the Districts	No. of Blocks
1	Korea	5
2	Korba	5
3	Janjgir	9
4	Mahasamund	5
5	Rajgarh	10
6	Jashpur	8
	Total	42

ANNEX 7. ILLUSTRATIVE GUIDELINES FOR ORGANIZATION OF NUTRITION AND HEALTH DAY (NHD)

Source: CARE, Madhya Pradesh

NUTRITION AND HEALTH DAY: A Nutrition & Health Day (NHD) is defined as a set day, when take-home rations are distributed and an Auxiliary Nurse Midwife (ANM) visits the *Anganwadi* center (AWC) and offers immunization and/or antenatal care services. This day occurs at least once a month.

Objective of NHD as a Best Practice in INHP:

1. Convergence of ICDS & Health services at various levels, with a focus on coordinated service delivery at the community level.
2. All the eligible children below three years, pregnant women and lactating women fully utilize the services provided at the AWC at a convenient timing, on a fixed day, at a fixed site.
3. Involve men groups, couples in the NHD.

Place: usually held at the *anganwadi* Center or an alternate place convenient to and selected by the community

Frequency: monthly

THE PROCESS

Step I: Preparatory Phase

1. Conduct three to four community meetings at AWC level to:
 - a) Discuss the reasons for under utilization of the services by pregnant, lactating women and children under 3 years children
 - b) Organize a social mapping exercise in the village to map out the beneficiaries for all the AWC & Health services.
 - c) Identify AWCs with Mens' groups & discuss how men can be involved,
 - d) Discuss the gender differentials, inequalities, and vulnerability. Discuss also the reasons for differentiation.
 - e) Socialize the NHD concept -- to provide all the services at a time, place and venue convenient to the beneficiaries
 - f) Clarify the eligibility criteria for different services including take-home ration
 - g) Develop roles and responsibilities of ANM, AWW and community members, including women's or men's groups, in implementation

- h) Identify community members who would support to conduct the NHD
 - i) Prepare the beneficiary list for all services (food & non – food beneficiaries) i.e. immunization, health services etc.
 - j) Update existing survey and ensure that all eligible are enrolled for different services
 - k) Identify a suitable place & convenient day for the NHD, taking into consideration the ANM's schedule for immunization
2. Enroll eligible pregnant and lactating women and children only 6-36 months (for THR).
 3. Orient the ANM, AWW, identified community members on their roles on Nutrition and Health Day.
 4. Divide the area into zones to provide services on different days if the population of the AW is more than 1000 or the AW area is too scattered with hamlets.
 5. Ensure that CSB and RVO are available at the AWC for at least next month.
 6. Ensure that the AWW have complete understanding of ration size for different categories of beneficiaries.
 7. Calibrate the ration measures for single and double rations for the decided frequency (fortnight, or month).
 9. Weighing scale always need to be in working condition.
 10. Make sure that accessories like rope, registers, ration cards and training materials to educate mothers, fathers and parents are available.
 11. Ensure availability of IFA tablets, & other essential drugs at the PHC, Block, and SHC & AWC levels.
 12. Inform the beneficiaries about the date, time, and venue of the first Nutrition and Health Day, through various mechanisms.

Step II: Organizing Nutrition and Health Day

1. ANM and AWW to reach the AW at least an hour before the actual agreed upon time for NHD.
2. Conduct NHED session on the topic decided earlier based on the needs. Incorporate the perspective of gender differentials, why & implications.
3. Sequence all the services provision with the help of community representatives and beneficiaries- The services should be organized systematically.

4. ANM conduct the health checkups for all pregnant women and children who need a checkup & Immunize all the eligible children and pregnant women.
5. AWW weighs, and plot the weights of children up to age of 36 months and counsel mothers accordingly. Observe for gender differentials, understand why & counsel accordingly.
6. Identify children with infections like diarrhea or pneumonia.
7. Give Vitamin A, ORS, cotrimoxazole, contraceptives, mebendazole, IFA and other medicines to all the eligible and who need them and enter the information in the register.
8. AWW with the help of community representatives distribute the take-home ration for eligible pregnant women, lactating women and children under threes.
9. The ANM & AWW update the respective records and list the beneficiaries who missed the NHD.
10. Community members and change agents follow-up with the beneficiaries who missed the NHD, including those who are not eligible for THR but are eligible for all the other health services.
11. Adequate arrangements are made for sterilizing needles/ syringes for immunization.

****Except for THR, everyone is eligible for all services**

A nutrition and health day can be successful only when:

1. The entire community knows the date, time and venue for the Nutrition and Health Day and shows up for it!
2. Nutrition and Health Day is seen as the day to focus on children under three and pregnant and lactating women.
3. Community representatives including men understand the need and actively participate in the management of Nutrition and Health Day.
4. Gender differentials are addressed during NHED, individual counseling for parents on growth promotion etc.

Essentials of ration distribution:

1. Ration should be given for a minimum of 22 days in month.
2. Pregnant women, lactating women and malnourished children (III and IV grade) get double ration (i.e. 130 gm of CSB and 16 gm of RVO per day); other children get single ration (i.e. 65 gm of CSB and 8 gm of RVO per day).

3. Issue of ration should be recorded in the feeding attendance register and ration card.
4. Children who complete three years should be deleted from take-home ration register and enrolled in pre-school category. Observe for & address gender differentials in enrollment.
5. Community should be informed about the next NHD date.

Step III: Monitoring NHDs

1. The replication of NHDs is reviewed at the District level & Block level review meetings, against the action plan.
2. The quality & quantity of supplies (*e.g.* vaccines & related equipment, food commodity, medicines etc.) need to be reviewed during the DLAC and BLAC.
3. Enact a series of random visits to villages on the NHD by District Teams and Supervisors to monitor quality of NHDs.

ILLUSTRATIVE OPERATIONAL PLAN FOR REPLICATION

S.N.	ACTIVITY The SWG may constitute sub-committee to work on the plan	TIMELINE -----MONTHS-----												RESPONSIBLE PERSON	SUPPORT		
		1	2	3	4	5	6	7	8	9	10	11	12				
A	SELECTION OF PACKAGE & DISTRICTS																
A.1	Selection of the elements to be replicated and districts to be covered ¹	*														Director ICDS	CARE
A.2	Selection of blocks in selected districts in consultation with district administration and stakeholders. Identify partners and processes required for replication	*	*													Collector	Director ICDS DMO/ DPO CARE
B	CAPACITY BUILDING																
B.1	Orientation of key implementers at district (CMHO+Media Officer+DPO+DTO+APO+DWCD+3CDPOs+3MOs= approximately 10 Participants per batch per Dist) For 3 districts 30 participants (1 batch) for 2 days.	*	*													Director ICDS Replication Manager CARE	CARE Technical Resource Team
B.2	Block level Training (3 selected blocks in the first phase) Trainers: CDPOs/Mos support from District level Participants: Sector Supervisors & LHVs For 3 blocks of one district: one batch of 25-30 participants for 2 days – one batch (Active AWWs/ANMs can also be involved)		*	*												CDPO and BMO CARE	Director ICDS and Collector
B.3	Sector Level Training (AWWs and ANMs for each sector) Trainers : Supervisors support from CDPOs/ Mos Participants : AWWs and ANMs, A batch of 30 participants for 2 days, (Approx 4-5 batches)		*	*													
B.4	Members PRIs/Community/ SHG/ members and ASHA Training (3-4 per AWC) Trainers : Supervisors / AWW and ANMs A batch of 40 participants at sector level for one day (*	*	*				*	*	*					

	10 batches approx)																	
B.5	Sector meetings for actual implementation (Each supervisor / LHV to train AWW and ANM of her area in monthly meeting2)		*														ICDS Supervisor / LHV	CDPO and MO
B.4	Regular follow ups and supportive supervision	*	*	*	*	*	*	*	*	*	*	*	*	*			ICDS Supervisor / LHV	CDPO and MO
C	CONVERGENCE																	
C.1	State level co-ordination meeting	*							*								Commissioner Health & ICDS	CARE
C.2	District Level Advisory Committee-Constitution 3	*															DPO	Collector
C.3	Action planning for implementation and first meeting	*															DPO	Collector
C.4	Follow up and problem solving			*			*			*				*			DPO	Collector
C.5	Block Level Advisory Committee-Constitution 3		*														CDPO and BMO	Collector
C.6	Action planning for implementation and first meeting		*														CDPO and BMO	Collector
C.7	Follow up and problem solving			*	*	*	*	*	*	*	*	*	*	*			CDPO and BMO	Collector
C.8	Block Level Resource Mapping4 – orientation / cross visit		*														DPO	CARE
C.9	Updating the map with area specific action plan in BLAC		*			*			*				*				CDPO and BMO	DPO
D	NUTRITION & HEALTH DAY																	
D.1	Directives from Health & ICDS		*														DPO and CMHO	Collector
D.2	Prepare Roster for ANM		*														BMO and CDPO	CMHO and DPO
D.3	Ensure that THR is available and distributed			*	*	*	*	*	*	*	*	*	*	*			AWW	CDPO
D.4	Ensure Immunization and ANC			*	*	*	*	*	*	*	*	*	*	*			ANM	MO
D.5	Organize Nutrition & Health Education			*	*	*	*	*	*	*	*	*	*	*			ANM and AWW	Supervisor
D.6	Involvement of PRI, CBOs			*	*	*	*	*	*	*	*	*	*	*			AWW	Supervisor

E	LOCAL SUPPORT GROUP																	
E.1	Selection of local support group through village meetings				*												AWW	Supervisor
E.2	Capacity Building of Support group members				*	*	*	*	*	*	*	*	*				AWW and ANM	Supervisor
E.3	Home visits by LSG					*	*	*	*	*	*	*	*				CA	AWW
E.4	Monthly village Meeting – mahila mandal meetings					*	*	*	*	*	*	*	*				AWW	Supervisor
F	COMMUNITY BASED MONITORING SYSTEM																	
F.1	Drawing the social map in each AWC with mapping of critical indicators					*	*	*	*	*	*	*	*				AWW	Supervisor
F.2	Tracking service utilization in each monthly meeting using social map						*	*	*	*	*	*	*				AWW and CBO/CA	Supervisor
F.3	Joint Planning with CBO/LSG for promotion of service utility ⁵						*	*	*	*	*	*	*				AWW and CBO/CA	Supervisor
F.4	Tracking use of self monitoring tool, if any						*	*	*	*	*	*	*				AWW and CBO/CA	Supervisor

(Source: based on the Project proposal for Replication of INHP best practices submitted to Govt. of Madhya Pradesh by CARE office at Bhopal)

Some guidelines are provided below to make operational plans:

1. Adjoining districts could be selected keeping the cost involved in mind. Responsiveness of community and availability of human resources could be another consideration
2. Supervisor would first do the orientation of AWW and ANMs on the replication elements and would build their capacities for implementation of the package using tools and processes in a phased manner during monthly meetings and other techniques/ cross visits/ field visits etc
3. DLAC – District Collector to chair, members must be DPO/DWCDO, CMHO, DIO, DTO, CEO Panchayat, members from other depts. Like education and members from other significant organizations form DLAC. A similar body is formed at block level (BLAC). At regular meetings, they review the progress and plan future steps after essential problem solving through co-ordination.
4. Block level & village level coordination/ advisory committees be set and revived involving local leaders and NGOS–
5. In monthly meeting with CBOs and local group on the basis of service utility and indicators mapped, which house to select for home visits, who would visit, issues to be taken up at Gram Sabha etc, may be decided.
6. Training Need Assessment (TNA) to be undertaken to plan logistics and time frame for CB
7. Identification of trainers and their training be undertaken
8. Documentation of events be done
9. Role responsibilities be designated
10. Support and expertise of CARE and other technical experts be mobilized and used

ANNEX 8. ILLUSTRATIVE STATE OPERATIONAL PLAN FOR INHP REPLICATION

Operationalization

Strategies for Operationalization could be developed by taking into account the existing and available Institutional Framework. In the same context the following points could be noted.

1. Rather than including all the districts at one go, selection of the districts could be done in a phased manner (The detail operational plan suggests selection of three adjoining districts initially and within each selected district, three blocks to be selected in first phase, which gradually can be increased.)
2. A single district could be the unit of replication and within district blocks can be selected in phased manner.
3. Inter agency coordination meeting/ advisory committee meetings could be called for, at regular intervals as specified in operational plan.
4. CB sessions need to be undertaken for incorporation of the new components in the project ensuring that CB has qualitative assessment as an in built component.
5. MIS needs slight modification for monitoring the progress regarding the new inputs in the project.
6. Establishment of additional forum at District / Block / Community level in the form of District and Block level Advisory Committee (DLAC, BLAC), with the help of available resources, will build the bridges at respective levels and improve the convergence right up to the grass root level.
7. Rewards and recognition could be incorporated as incentive for improved performance at various levels, as per the availability of the budget. Detail parameters for assessing the performances can be worked out at forums like BLACs.

ANNEX 9. ILLUSTRATIVE TOOLS FOR INHP REPLICATION

Illustrative Tools of INHP

(Relevant in the context of replication)

1. Social maps – village /block/district, tracking tools
2. Structured Supervision formats
3. Self Monitoring Tools- adapted as per cultural context
4. Home Visit Guide (AWW & ANM)
5. Nutrition Advocacy Material- relevant to the message to be communicated
6. Supply Chain Management formats, Inventory & record sheets
7. Commodity Supply Management –Practices
8. Food Procurement Models including CBLFM
9. Monitoring Evaluation Mechanisms- bench mark, ongoing monitoring, end line and replication progress review
10. Joint Sector Reviews.

These tools are meant for various specific processes such as training, supervision, planning, monitoring, and strengthening of systems.

Suggestive List of Material for Replication

FANTA will be providing support to develop material for Capacity Building. Based on some exploratory work of Dr. Karabi Acharya, the following list is proposed for different category of trainees.

1. Policy makers/ Administrators- Advocacy tool information sheet containing actions needed.
2. Trainers-Information related replication Package with pedagogical instructions- different levels of trainers.
3. Implementers- Modify CARE material suitably for thematic training for different elements of replication, guidelines for cross visits/sector meetings, supportive supervision and handholding tips.
4. Other trainings- how to hold community meeting, advocacy material for nutrition and child care- essential nutrition booklet etc.

ANNEX 10. MINUTES OF THE MEETING OF THE SWG OF ANDHRA PRADESH HELD ON JUNE 15, 2007

First Meeting of the State Working Group

Replication of the INHP Good Practices in non CARE-assisted ICDS Areas in Andhra Pradesh, 15th June 2007

Minutes and Summary of the Decisions for Action

The first meeting of the State Working Group (SWG) was held at the Senate Hall in Hotel Green Park, Hyderabad. The list of members present for the meeting is given as Annex – I. The agenda of the meeting is given as Annex –II.

Agenda 1 - Welcome and introductory remarks by Chairperson

The meeting was presided by Ms. Vasuda Misra, Secretary, Department of Women Welfare Child Development and Disabled Welfare. In her introductory remarks, she welcomed the members and the Special invitees for the meeting. Following are the highlights of her remarks:

1. The State Advisors to the Supreme Court Commissioners on Right-to-Food Campaign would be co-opted as members of the State Working Group. **(Action : State Advisors to send letters of confirmation to the chairperson to be forwarded to the Chairperson of the National Advisory Panel (NAP)**
2. She advised that replication should take an analytical perspective and not be mechanistic in approach. The good practices for reduction in malnutrition and infant mortality have been demonstrated in the CARE-supported ICDS areas, across eight districts. The efforts and resources in these eight districts could have been intensive, yet the SWG should be selective in choosing a few good practices for up scaling to the remaining 15 districts.
3. She outlined the scope of the SWG meeting and stated that discussions should provide a skeletal district framework, which could be fine-tuned later at the district level.
4. The Chairperson emphasized that replication is a Government priority and CARE would serve as resource organization.
5. The Secretary requested CARE for more details of the Integrated Nutrition and Health Project (INHP) implementation costs in the CARE-supported districts. While the evaluations show that the INHP II interventions are a cost-effective and ‘good buy’ yet the absence of specific details inhibits the Government to estimate the nature/unit costs required for replication. This is critical for Government to plan for the resources. Although CARE/AP shared the RACHNA costing study, the Secretary wanted to know the capacity building costs per block/district from experience.
(Action – CARE to share the INHP capacity building costs with the GoAP)

6. Since the replication is embedded in the implementation of ICDS, most costs could be met from the current budget provisions, within the ICDS norms. Reiterating the decision of the NAP on the sharing of costs between the GoAP and the GoI, the Chairperson stated that, in case of additional resource requirement the State would approach the Government of India (GoI) to top up with resources especially for those proposals which are innovative.

Mr. Rajeswar Rao, Director ICDS (World Bank), GoI in his remarks stated that before he left for the meeting he had a discussion with the Joint Secretary (JS), Mr. Chaman Kumar to understand his perspective on the replication activities. Mr. Rao mentioned that the JS is very keenly monitoring the progress and wanted to preside over the next NAP to discuss the state operational issues. Mr. Rao further mentioned the following:

1. He reiterated the GoI's keenness on moving forward with the replication activities.
2. ICDS, as per its design is well conceptualized. He emphasized that the GoI's expectation from replication in AP and Chhattisgarh is to learn on how ICDS can be implemented differently to achieve results.
3. Significant improvements have to be made in filling the knowledge gaps of Anganwadi Workers (AWW) and Supervisors. Assuming that 30% of the AWWs are non-performers, the program should aim to bring the low performers too to a minimum standard of performance. There is a need to establish mechanisms for the accountability. Information, education and communication (IEC) and capacity building need more emphasis.
4. Supervisors and CDPOs need to develop critical skills for data analysis vise-a-visa malnutrition reduction. Presently, the senior ICDS staff at the district level are unable to review the program, as they are ignorant of the links between various inputs and processes in malnutrition reduction.
5. It was suggested that the ICDS training institutions need to be made more vibrant, and linked to the direct implementation of ICDS in the particular state. Innovative ideas like MLTCs have provisions for internet facilities, which will enable them to access updated information.
6. Involvement of the members of the State Legislature/political bodies may bring quality and accountability into the program. This aspect was discussed as having advantages, as well as disadvantages, yet the idea merits serious consideration.
7. Mr. Rao recommended that the Orissa model, which was successful in tracking the women and children, is worth exploration. Mr. Rao proposed that the lessons from the Orissa model could be replicated as a practice to track excluded populations. **(Action: GoI to share the Orissa model, as well as the compilations of studies and Government Orders on ICDS)**

8. Mr. Rao suggested that funds could be mobilized for innovative ideas to bring quality to the ICDS program funds could be mobilized. He strongly felt the need to bring visibility to the ICDS program at the community level.

Agenda 2 - Presentation on Replication by CARE

Ms. N.V.N. Nalini, State Program Representative CARE/Andhra Pradesh made a presentation on 'Replication of evidence based practices to reduce Child Malnutrition and Mortality'.

The presentation (placed as Annex-III) captured the experiences and results from CARE's INHP. Some of the highlights of the presentation and discussions are as follows –

1. The emphasis on infant feeding practices is required in ICDS to bring down malnutrition and mortality. The technical package being proposed for replication is backed by global research, as evidenced from the recent Lancet series on child survival.
2. Discussions also focused on the role of food insecurity on the feeding practices. It was recognized that there are more families with malnourished children than the poor households. The concerns are also that cereals and pulses alone do not improve nutrition status. Therefore, there is a need to work on the concern around the quality and variety of food options. There are several variations within districts too regarding the availability of variety of foods.
3. Comparison of results between Kalahandi and Khammam: The discussion on the achievement of better results in Kalahandi than in Khammam indicated that the nutrition and newborn care agenda was universal agenda with the community based groups, service providers, and other stakeholders. The SWG members requested CARE to provide more detailed information to understand the factors which contributed to better results in Kalahandi. (**Action: CARE/AP to share a note to the working group members**)
4. Availability of the ICDS services to pregnant women who come to the maternal homes for delivery was discussed in detail. It was suggested that the services should be provided to all the women and children and need to identify mechanisms for continuity of the services for the mother and child, after they return to their native homes after childbirth.
5. It was clarified to the SWG members that the good practices, which were presented as the *suggested content and the processes*, has specifically defined components, which have produced the intended results. It was emphasized that tools, formats, and guidelines would be ineffective in themselves to yield the results, therefore maintaining the rigor in the processes is important.
6. The role of NGOs in the INHP was discussed in great detail. The Chairperson commented that the NGOs should not duplicate the work of the ICDS functionaries, which could lead to dependency on the NGOs. The NGOs were instrumental in

providing the handholding/on-the-job support, which was critical in making the ICDS functionaries at the village Sector and Project levels more effective. The INHP experiences indicate that the effectiveness of the functionaries was significantly improved due to the on the job support received from NGOs. Districts that did not have NGO support took longer to become effective.

7. INHP experiences also showed that initially all functionaries would need similar inputs, and over a period of time need – based support was prioritized by the NGOs. Such prioritization of the functionaries for support helped to maintain the facilitative role rather than create duplication or dependency. Strategically, CARE also increased the ratio of the NGO staff to the geographic area coverage by the NGO. There were two NGO staff per block during the initial stages which was reduced to one staff/block. It was discussed that in the context of Replication it is important to identify organizations/institutions like the ICDS/RCH training institutions, which could provide on-the-job handholding support.
8. The involvement of the training institutions was suggested and discussed with two purposes: availability of the resource persons from MLTCs and AWTCs for the handholding support to ICDS projects, and secondly replication as an opportunity for updating the training institutions. The Chairperson mentioned that she will be able to depute some of the strong Supervisors to take-up the training role in the institutions and withdraw the trainers for training the AWWs on the replication activities.

Agenda 3 - Consensus on Good Practices

1. It was agreed by the group that the following content and processes would be key components of the package for replication :
 - Inclusion and tracking mechanisms
 - Prioritized home visits
 - Supportive supervision
 - Focused supervision and monitoring by block and district leadership.
 - Good practices in food commodity supply chain management.
2. The involvement of the village *panchayats* in the Nutrition and Health Day (NHD) was discussed. The differences in the quality of the NHDs being organized in the CARE supported districts and other districts, was discussed, in terms of regularity and coverage for services. It was felt that the preparation of ‘duelists’ of clients for various services, and ensuring the regularity of ANM presence on THR/NHD was critical to the success. The examples of West Bengal where ICDS and Health Department programs are reviewed by the PRIs on a fixed-day were discussed. Experiences showed that regularity and accountability of service providers had increased.
3. The need to develop an agenda on nutrition and health for discussion and review at the Mandal level was discussed. **(Action: State core group)**

4. Convergence between the AWW, ANM, and Women Health Volunteer (WHV) has to be clarified. It was suggested that replication effort could aim at bringing role clarity and complementarities in service delivery. The possibility of geographic divisions within the functionaries could be explored. **(Action: State core group , District resource group)**
5. As was also discussed in the National Advisory Panel, an orientation to the ASHAs (WHVs in AP) would be needed. As a point of convergence between Health and Family Welfare and Women and Child Development Departments, it was felt that the ANM visits to the homes of newborn, and nutrition advises by the WHVs and ANM are important. It would help reinforce the messages by the AWW, as she also reinforces messages on maternal, newborn care, and childhood immunization. The Joint Director, Family Welfare (FW) Department, Dr. Hymavathi suggested that the funds under the State Population Policy , and the NRHM are available for any IEC activities, or trainings which can be tapped. **(Action: Director WCD, Commissioner Family Welfare and CARE)**
6. It was suggested that the untied funds under the Village Health and Sanitation Committee (VHSC) could be used for local support for nutrition and health activities. **(Action : Block resource groups)**
7. In response to a query by Prof. Kodandaram regarding the types of commodities used for the SNP in ICDS, it was clarified that the ready-to-eat (RTE) food, and the rice - dal and RTE food under the community managed supplementary nutrition program (CMSNP) are in implementation.
8. The discussion focused on the Supreme Court's mandate to remove the contractors in the ICDS – SNP and hand over the management of SNP to community based organizations. The Chairperson clarified that, in AP, decentralized SNP models managed by the Mother's Committees exists. She also informed that through the Chief Secretary's affidavit, the GoAP has committed to pilot the provision of hot –cooked meal for children between 2-6 years, through various community based groups- Mother's Committees, Swayamsiddha, Samakhyas, Self-Help Groups managed by the local NGOs across 45 mandals in eight districts, with support from CARE and it's partner NGOs. The GoAP has already initiated activities in the direction.
9. The discussion also focused on the lack of readiness and the limited capacities of the community groups to manage the commodity supply chain in a viable manner, as against the commercial contractors. She explained that the community groups also expect some remuneration for the time and effort, either as service charges, or incomes/profits. She reiterated the GoAP's commitment to gradually phase-out the contractor system.
10. The commodity supply chain management good practices in the ICDS involves a specific set of interventions aimed at ensuring optimal and timely availability of food commodities at the AWCs for universal coverage. While the interventions have limited effectiveness for streamlining the supply chain at the district and above levels, it helps in ensuring that the commodities available at the Block levels are planned, distributed and optimally managed to last longer to absorb the vagaries in the supply chain. The Director, WCD shared the

Bheemli ICDS project experience, where the block was not affected by the non-availability of dal, while the rest of the projects in the Vizag district faced shortages of dal supply. The Secretary requested for more information on the beneficiary coverage and feeding days from CARE-supported and other blocks to assess the effectiveness of the CARE's good commodity management practices and technical support. **(Action: CARE/AP to provide the data on the effectiveness of the supply chain management practices).**

11. Three different types of commodities existed in the 15 replication districts, and initial assessment showed that the appropriate systems for monitoring and reporting especially for the RTE food were lacking in the projects. Therefore, it was suggested that software can be developed for effective management of the food supply chain. CARE has the experience of handling such software and replication of such a software can be explored. **(Action: CARE/India and FANTA consultant to explore the possibilities)**
12. The possibility of reorganizing the ICDS and ANM sub-health center catchment area as co-terminus was discussed. The Joint Director, FW mentioned that the GoAP is recruiting new ANMs and the plan is to have one ANM for every two villages. She felt that once this is done up, there should not be any coordination problems.

Agenda 4 & 5 - Approaches, Mechanisms, and Rollout plan

1. It was agreed that the involvement of the PRIs would be important in the replication effort. **(Action : State core group, Project Directors- ICDS)**
2. The VHSCs constituted under the NRHM was discussed as an important forum for reviewing the ICDS and Health Department activities at the village level. The need to explore their role and engagement in improving nutritional outcomes was discussed as an important part in replication. The need for orientation to the VHSC members was discussed. It is a reiteration of the discussions in the NAP. **(Action: Commissioner Family Welfare and Director WCD)**
3. It was decided that the replication activities could start in all districts simultaneously, although it was recognized that the districts and blocks would be at varying levels of readiness. Thus a differential approach needs to be adopted for each of the districts depending on the malnutrition status and infant mortality rates of the district. **(Action: SWG , PD- ICDS)**
4. It was discussed that the District RCH Societies under the NRHM could be expanded to include the child nutrition agenda. The Chairperson agreed to this suggestion and accepted to write a letter to all the District Collectors advising them to induct the District Project Directors, CARE staff and other nutrition experts of the district into the RCH Societies. Echoing to this suggestion, Dr. Hymavathi said that the district and sub-district level committees could be good forums for undertaking the replication activities. She indicated that funds (Rs.500,000 for PHCs and Rs.100,000) could be mobilized for the nutrition and health activities, as the nutrition component is part of the NRHM. **(Action: Commissioner Family Welfare and Secretary- WCD)**

5. The possibility of utilizing funds under the NRHM and State Population Policy for procurement and distribution of IFA tablets, provision of social maps to all AWCs, provision of additional food to the ICDS was discussed. **(Action: Director- WCD, Commissioner Family Welfare)**
6. Since it was recognized that the NGOs have a significant role in facilitation of hand- holding, on-the-job support, it was discussed that grooming new NGOs for this job in the replication districts will be a time consuming process. Therefore, it was agreed that the CARE's current partner NGOs could act as resource persons to help development of district and block operational/implementation plans.
7. It was informed by CARE that the cost implications for such NGO support have to be worked out. Chairperson felt that the NGO related activities should be quantified, and costs should be estimated for developing proposals for obtaining funding support from the GoI, GoAP or any other donors. **(Action: CARE to submit a note on estimated costs for engaging the NGOs)**
8. It was suggested that the RCH mother NGOs could be included as partners in the respective districts, since they would have certain level of orientation to the maternal and child health issues. **(Action: PD-ICDS, DMHOs and District Resource groups)**
9. It was proposed that a communication, jointly signed by the Secretary WCD , and Commissioner Family Welfare could be sent out to all the District Collectors in the 23 Districts informing them on the replication activities and seeking their close involvement in its effective operationalization. **(Action–Secretary WCD , Commissioner FW)**
10. A State Core Group would be constituted by the Chairperson to work out a generic implementation plan for the replication, timelines, responsibilities, recommendations for the district level consultations, membership of the district resource groups, and the rollout plan for the replication. The core group will be headed by the Director – WCD with members from WCD, Family Welfare Commissionerate, NGOs and CARE Suggestions were made to include the DD- ICDS, JD - RCH, JD-Child Health, as part of the group. It will be helpful to include JD Nutrition in the group. **(Action: Chairperson SWG to constitute the core group)**
11. A district level resource group headed by the Project Director, WCD would be constituted by the Secretary WCD, to facilitate the planning process in the districts. **(Action: Secretary WCD)**
12. The district resource group will include all members who would express willingness to participate in the effort to reduce malnutrition and Infant mortality in the particular district. The District Resource group would also have the responsibility to monitor the progress and report to the District Collector for the necessary support. **(Action: PD– ICDS and CARE to identify potential members for district resource groups, through a consultation process).**

13. It was decided that the resource group could include media persons, civil society groups, corporate sector stakeholders, and NGOs. It was informed to the group by Professor Kodandaram that apart from CARE, M.V. Foundation and SADHANA are the two NGOs who have been associated with the Supreme Court Commissioners on enforcement of the interim orders, in AP.
14. It was mentioned by the WCD Director that all the blocks in the eight CARE- supported districts are not on the same levels of progress. She indicated a need to consolidate in the primary program areas too. CARE has responded that the staff and NGOs in the primary program districts have detailed plans for the consolidation especially focusing on the program leadership development at the CDPO and PD levels.
15. CARE informed that the phase-out program plans to cover all the blocks in the current eight districts. It may be noted that the CARE support in each of the districts was limited to some blocks only. In this regard a suggestion was made to constitute a core group of resource persons to replicate the practices in the non-CARE blocks too. **(Action: INHP Regional Managers, and PD – ICDS in the 8 districts)**
16. CARE also informed the group that six Replication Officers and one Replication Manager would be exclusively supporting the replication activities in the new 15 districts. The ratio is 2-3 districts per one officer. The Secretary –WCD mentioned that she had already communicated to the 15 new districts on the replication activities and placement of CARE officers in the districts. She had advised the PDs and RDDs to provide the necessary co-ordination support.
17. The chairperson suggested that appropriate indicators should be developed to review the progress and gauge performance. In this context, the need for standardization of the processes in ICDS was felt. FANTA and USAID had offered to explore such opportunities to facilitate the process in AP. It was discussed that accreditation needs to be done in a non-threatening manner, and to serve as a motivation too. **(Action: State core group to develop common set of indicators. FANTA/USAID to organize a brief presentation to WCD officials on the standardization process).**
18. With regard to the monitoring mechanisms, a need to generate independent data was recognized. In this context the usefulness and feasibility of conducting quick mini-rapid assessments for validation of the internal monitoring data was discussed. CARE's vast experience with using mini – assessments for internal monitoring purposes was shared. CARE had not planned for the resources for monitoring. **(Action: CARE/India, FANTA and USAID to finalize monitoring indicators for replication activities; GoAP, FANTA / USAID to explore the resources).**
19. There is a lot of expectation in the global public health community, and specifically the GoI to learn from the replication process. The progress is being watched keenly and with interest to offer lessons to other Indian States and countries across the world on the large scale replication. In this context the need for a strong documentation support from FANTA/USAID was felt. **(Action: FANTA consultant).**

List of Participants for the State Working Group (Andhra Pradesh) Meeting on 15th June, 2007.

Sl.No.	Name & address of the member	Holding
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10.	Mr. Rajeswara Rao, IAS Director, ICDS Ministry of Women & Child Development Govt. of India, Room.No. 638, Shastry Bhawan New Delhi-110 001.	Special Invitee
11.	Dr. M. Kodandaram State Advisor, Supreme Court Commissioner on RTF Department of Political-Science Osmania University, 12-13-578, Nagarjunanagar, Tarnaka Secunderabad 500 017 Tel: 040-27175353 ®	Special Invitee
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