

## Annual Results Report

### A. Introduction

Launched in 2007, as a three year phase-out project (POP) INHP III, was designed to consolidate lessons from INHP I and II and leave behind a legacy of good practices for sustained improvement of maternal child health and nutrition outcomes by strengthening the government systems. It is being implemented in partnership with the Government of India's (GoI) Ministry of Women and Child Development (MoWCD), Ministry of Health and Family Welfare (MoHFW) and local Non-Government Organizations (NGOs). The project covers 1297 blocks of 96 districts<sup>1</sup> of eight states namely Andhra Pradesh (AP), Chhattisgarh (CG), Jharkhand (JH), Madhya Pradesh (MP), Orissa (OR), Rajasthan (RJ), Uttar Pradesh (UP) and West Bengal (WB). The project has over 230 million population base with a direct reach to around 16 million pregnant women, lactating mothers and children under two years age. During the POP period, direct support in Primary Program Areas (PPA) of INHP III was phased out in an accelerated manner and replication of best practices through government programs<sup>2</sup> was undertaken in new blocks within Primary Program Area. By September 2009, INHP III has been able to phase out the direct support from all blocks of primary program area<sup>3</sup> (which included 711 blocks of 75 districts across eight states<sup>4</sup>). While the block level support has been phased out completely<sup>5</sup>, INHP III continues to provide technical assistance to Integrated Child Development Services (ICDS) and Reproductive and Child Health (RCH) programs at the district and state levels<sup>6</sup>, which is scheduled to continue till December 2009.

This annual results report is for the period October 2008 through September 2009. While the program is scheduled to end in December 2009, CARE India has proposed for no cost extension of INHP III till September 2010.

#### Highlights

- Program has been able to phase out direct support at block level from all 711 blocks of primary program area. The NGO's direct facilitation support has been withdrawn completely and there is no direct training or BCC support to the blocks and AWCs in PPA. However, it continues to provide district level support for engaging CBOs and PRIs for making system and program accountable.
- Program Leadership Development (PLD) trainings for District and Block level managers of ICDS and RCH in PPA have been rolled out in all



<sup>1</sup> The total operation area consists of Primary Program Area (PPA) for INHP III means 711 blocks of 75 districts in seven states, 283 replication blocks in the PPA and 303 blocks in 21 non INHP districts of CG and AP

<sup>2</sup> Integrated Child Development Services (ICDS) of MoWCD and Reproductive and Child Health (RCH) program of MoHFW are the main national health programs to which INHP provides technical and operational support.

<sup>3</sup> Primary Program Area (PPA) refers to the blocks where INHP was being implemented at the end of the second phase, i.e. September 2006

<sup>4</sup> The Eight states where INHP III is implemented include, Andhra Pradesh (AP), Chhattisgarh (CG), Jharkhand (JH), Madhya Pradesh (MP), Orissa (OR), Rajasthan (RA), Uttar Pradesh (UP) and West Bengal (WB).

<sup>5</sup> A detailed note on phase out process and current status of blocks phased out during previous three-years is provided in Appendix H.9

<sup>6</sup> In all except Madhya Pradesh, which was phased out in the year in September 2008

states. The PLD module has been customized by the respective state governments. These initiatives strengthened the leadership abilities of district and block level managers for better program convergence, supportive supervision, data analyses for decision-making and human resource management.

- INHP final evaluation survey has been undertaken and data analysis of the quantitative and qualitative surveys is underway with the guidance of Technical Advisory Group members and final evaluation team members. The representatives of Government of India and state governments have been involved in the process of final evaluation of INHP III.
- Project Management indicators show sustaining and stabilization of critical processes at community level in phase-out blocks. The nutrition and health days and participation of CBOs and PRIs in the NHDs achieved the project target excluding WB. In Orissa and Jharkhand THR has been resumed with result of successful advocacy.
- Through a systematic and structured advocacy, convergence of service delivery has been successfully scaled up in NRHM through Village Health and Nutrition Days (VHND, which is the adapted version of NHD) and Block and District level forums. All the states are now focusing on organizing and monitoring fixed-day, fixed-site sessions for health services in coordination with ICDS.
- Lessons learned from INHP was disseminated through National level dissemination workshop with support of USAID. Representatives from a large number of government departments, bilateral and multilateral agencies, national and international development agencies participated. A series of technical papers were released for use by public health programs in the country.
- MWCD, NIPCCD and CARE with support of USAID reviewed the existing ICDS training system in the country through consultative process and contributed to incorporate best practices in its design with INHP experiences. This work is half way through and would require at least six more months to complete.

INHP in close coordination with USAID and MWCD official worked at national level to revise 30 years old MIS in ICDS across the country to incorporate learning from INHP monitoring system. As a part of the first phase of the MIS revision, the records and registers have been modified and approved by GOI. The second part is the revision of the reporting formats, which have been field tested. Based on the field test results, these formats will be finalized and Government has sought support from CARE and USAID for its roll out across the country.

- In the replication districts of AP and CG, after pilot testing of standardized good practices, the state governments adopted them for scale up to all the replication districts. Production and distribution of implementation guidelines up to the AWW level was accomplished along with the capacity building of district, block and sector level staff of ICDS and RCH in all the replication districts. Through trained members of district resource groups and ICDS supervisors the tools and guidelines for replication were oriented to AWWs through sector meetings.
- Commodity technical assistance was provided to ICDS for improving need based allocation through data analysis and its management in all the states during the reporting period. To

- NGO partners and other civil society organizations were engaged on building community capacities in monitoring health service delivery. Thematic partnership was introduced in select states engaging PRI and CBOs to sustain the community level process and promote transparency and public accountability.
- INHP has been able to highlight critical program delivery issues in ICDS by engaging the commissioners and advisors of the Supreme Court and representatives of Right-to-Food Campaign in the states. There has been a sustained advocacy with SC Food advisors to influence the state governments on implementation of THR across the project area. The engagement with Right to Food Groups enabled INHP contributing to upcoming country legislation on Food Rights Act.

To enable BCC trigger at grass-root level, culture and language specific BCC interventions were carried out through community media, folk media and mass media. The partnership with media brought out wider dissemination of INHP good practices and service and supply issues.

### Challenges

- Continued increase of AWCs under the Supreme Court mandate of universalization in ICDS in the states without adequate supervisory and managerial staff put in place, constrained the program to ensure quality delivery of services as the existing supervisors were overloaded with their current job assignments. This affected quality supervision and home contact at critical period.
- Due to elections to state assemblies in some of the states and the federal parliament there were frequent changes in the state and district level bureaucratic leadership. Stoppage of program activities before 45 days of elections and at least a month after government formation is due to enforcement of model code of conduct during election period has severely affected the field implementation in many states and centre level. Frequent changes of the bureaucrats in ICDS, Health and PRI department after the elections affected pace and quality of replication processes also.
- With change in policy of UP government on supporting and working-with the external technical assistance agencies in the state ICDS and RCH programs affected pace for engaging with the department in the state.
- Sustaining staff morale and motivation through out the phase-out project period has been a challenge. To some extent, the staff turnover and attrition inhibited the project to achieve the desired pace of implementation.



Drought in a number of INHP districts in RJ, WB, OR, JH and UP during the reporting period affected sustained uptake of program services delivery. Similarly, the high incidence of LWE (Left Wing Extremis) in the states like Jharkhand, Orissa and Chhattisgarh was a great challenge to ensure access and availability of essential services and supplies to the remote areas.

## B. Annual Food Aid Program Results

### 1.1 Progress against plan during FY '09 - Achievement of management indicators

During the financial year 2009, (FY 09), INHP has been able to sustain and stabilize all the critical program management indicators at the targeted levels. Despite variations among states, the project has been able to meet performance targets set for the period. More detailed discussion of state – wise accomplishments and challenges are presented in the state updates provided in **Appendix A**.

#### 1.1.1 Capacity building

*Indicator: Number of people given training in maternal health and new born care topics using USAID resources*

During FY 2009, a total of 121,141 people at system and community level were trained using USG resources exceeding the plan to train 83,169 people. Of these 85 percent were women. The table presented below, provides category wise achievements, which is inclusive of both Primary Program Areas and Replication Districts in AP and CG.

**Table 1: Capacity Building achievement against target during FY 2009**

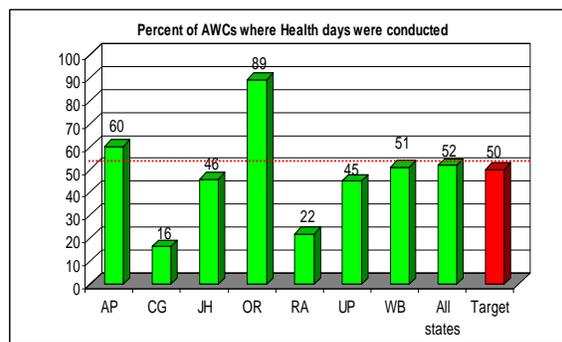
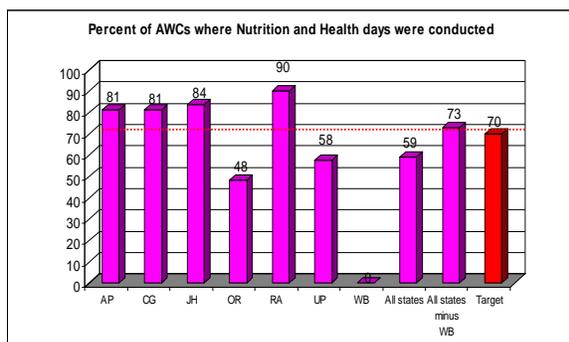
Participants	Plan for the year			Total achievement		
	M	F	Total	M	F	Total
Communities (includes community members, Panchayat Members, Members of CBOs and Change Agents, ASHA/Sahyogini, Mitanin)	12,069	21,152	33,221	10,396	44,540	54,936
Village and sector level functionaries (includes AWW, ANMs and Supervisors)	787	26,535	27,322	1,315	40,743	42,058
Block level Functionaries (includes medical officers, Child Development Project officers)	2,883	1,683	4,566	703	1,011	1,714
Non Government organizations (NGOs)	2,471	840	3,311	2,310	890	3,200
District and state level officials (includes Health and ICDS officials)	857	458	1,315	345	225	570
Others	1,567	11,867	13,434	3,113	15,550	18,663
<b>Total</b>	<b>20,635</b>	<b>62,534</b>	<b>83,169</b>	<b>18,182</b>	<b>102,959</b>	<b>121,141</b>

The achievement is more than the plan in all categories due to extension of program leadership development trainings that reached up to sector level in some of the states in the PPA. The number of community members and village level functionaries increased above the planned levels due to conducting trainings for PRI members and selected village level functionaries to enhance sustainability of community initiatives beyond phase out. The project achieved more than the targets with result of the project team's planning within the available resources by leveraging partial cost-share arrangements with other government programs and NGOs.

### 1.1.2 Nutrition and Health days (NHDs) and Provision of Health Services in the absence of THR at AWC (Health Days)

*Indicator 1: Percentage of AWCs conducting at least one NHD in the last month with take – home ration and immunization or antenatal check ups*

*Indicator 2: Percentage of AWCs Where Immunization and/or Antenatal check up were provided on a Scheduled NHD, in the absence of THR last month (Health Day)*



In all the states except West Bengal, NHDs are being continued. While the state of Rajasthan has reached near universal level of NHD. The states of AP, CG and JH report nearly 80 percent of AWCs of PPAs (including the new AWCs). The percentage of NHD including West Bengal stands at 59 percent.

NHD trend and pattern during the period, demonstrates continued convergence in delivery of health and nutrition services following fixed day- fixed site approach, reaching the targeted level of 50 percent for the year. While this indicator is used to analyze the reasons for absence of convergence in service delivery in other areas, higher level of sustaining of fixed health day at AWC is being observed especially in the states with low NHDs. The states like Orissa and Jharkhand have also demonstrated resumption of THR in many areas.

#### Highlights

- In Orissa, there is progress in reverting back to convergent delivery of both health and nutrition services on the same day. Similarly in AP, UP and WB the observation of health days in the absence of THR is high and meets the intended target levels.
- The program staff have been able to ensure re-initiation of NHD in several districts by advocating inclusion of THR and supporting rolling out of Village Health and Nutrition Days (VHNDs) being mandated through NRHM in UP, JH, OR and WB.
- With continued emphasis of NRHM on VHNDs and with the development partners' emphasise on regular session monitoring and prioritization of convergence between ICDS and RCH in most of the states, the NHD observation gained importance.
- Through the leadership development trainings, convergence between ICDS and RCH was emphasized and the ICDS and RCH officers in the state focused on quality elements of NHD/VHND.

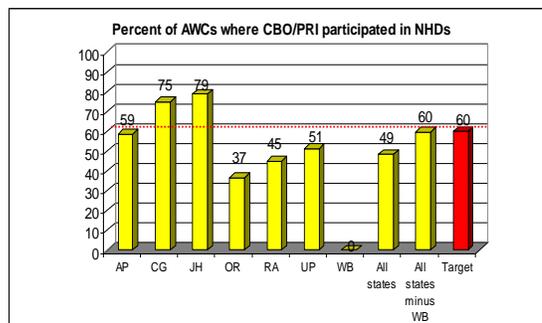
## Challenges

- The systematic advocacy efforts at West Bengal on re-introduction of NHD is yet to yield any result. ANMs continue to conduct most of the immunization sessions at the health sub-centers and not at the AWCs.
- In UP, due to frequent rounds of polio and Japanese Encephalitis vaccination, the routine immunization session schedules continue to get disrupted. Though the health functionaries often undertake sessions on non-scheduled days or club sessions together in some months, the convergence of service provision often gets missed out.

### 1.1.3 Involvement of Community based organizations (CBO)/Panchayat Raj institutions (PRI) Members

*Indicator: percent of nutrition and Health days where CBO and/or PRI members participated last month*

At the national level, INHP has sustained the CBO/PRI participation in NHD at the targeted level of 60 percent. As West Bengal continues to have no NHDs the CBO/PRI participation in other program interventions is not captured in this figure.



## Highlights

- In Jharkhand, there is an increase on participation of CBOs in the absence of elected PRIs in NHDS. In CG, there has been a significant improvement in participation of women groups in management of commodities for SNP in AWC and continued association of PRIs for NHD monitoring, which is indicative of sustaining of this process.
- In states like Orissa, Uttar Pradesh and West Bengal INHP III successfully converged with NRHM on mainstreaming the nutrition discussion in key NRHM forums like VHSC (Village Health Sanitation Committee). and Gram *Unnyan Samiti* in WB.
- In states of UP, RA, WB and CG thematic partnerships and workshops on community engagement strategies with NGO partners and program staff, have contributed to sustained focus on CBO/PRI participation both in NHD and HD.
- Program staff and NGO partners focused on participation in block level PRI forums, especially in new blocks and blocks to be phased out in September 09 and they attempted to institutionalize active role of PRIs in health of the community.

## Challenges

- NRHM's priority to functionalize Village Health and Sanitation Committees (VHSCs) is yet to progress in a substantial way. While INHP has experiences on involving PRIs and CBOs in ICDS and RCH programs at the community level, it continues to be a challenge to institutionalize and mainstream in the VHSCs at a scale in spite of its successful engagement in few districts/states.
- Techno-managerial skill development of the PRI leaders requires long-term support and consistent efforts.
- Enhancing leadership qualities of block and district level elected PRI leaders remain a challenge. These leaders assume critical importance due to their legitimate positions in key decision making areas like resource leverage, monitoring and realization of local governance mandate.

## **1.2 Project Implementation activities**

While the management indicators discussed above, are community level processes and are based on reporting from each of the AWC, the program also monitors processes at the sector, block and district levels. Based on the reports received on sectors and blocks from ICDS staff, and districts level processes reported by INHP program officers, the following additional indicators are discussed.

### **1.2.1 Sector<sup>7</sup> strengthening**

Building on the lessons, INHP III strengthened approaches on use of tools for improving AWW home visits, better supervision and in-service training during sector meeting. The tools such as a) AWW home visit planner b) guidelines for facilitating sector meetings c) tools for conducting sector meetings and d) ICDS supervisors centre visit tool focused on improving specific service delivery and program review components.

Across states, there has been continued emphasis on strengthening ICDS sector functioning. Structured sector meetings, supervisors' AWC visits and use of sector meetings for data review and ongoing CB continued in all blocks including the ones already phased out of block level support. In new blocks that were phased out in September 09; the program staff and NGO partners made frequent field visits to support sector level processes.

The MIS data reveals that the use of tools by sector supervisors has sustained over time (38 percent in FY 08 to 39 percent in FY 09) and on going CB has increased from 76 per cent to 82 percent. Further, the MIS data shows that in the blocks phased out during 2007 and 2008, the analysis of sector supervisor's tools and on-the-job training have sustained. The issues discussed at the sector meetings were documented and unresolved issues were carried to block or district level convergence forums for appropriate actions, which indicate sustenance of key process.

### **1.2.2 Leadership Development**

The Program Leadership Development (PLD) during FY09 got strengthened with roll out of three day training module developed by INHP with support from Indian Institute of Management, Calcutta and Bankura Medical College. Between May and September 2009, PLD training was conducted in all the states reaching to all the district and block officers. Refresher training was also conducted for the CDPOs of three districts in WB to understand the impact of PLD processes on improving the service coverage and behaviors change. The ICDS officials who were trained on managerial, technical, and operational aspects were provided handholding support through out the implementation processes. On request of the government of UP, the leadership trainings were organized for ICDS sector supervisors as well. The District Program Officers and CDPOs in AP, WB, UP, and CG took the special interest in setting the agenda, facilitating quality discussions, reviewing data from district and block MPRs and field visit observations.

After the PLD trainings and handholding process, ICDS officers adopted the following processes in their program management in different states: a) identification of program gaps during their joint field visits; b) supporting AWWs to minimize the gaps; c) using sector forums to develop differential plan of action especially in OR, AP, WB, CG, and JH; d) CDPOs preparing their tour plans as per the grading indicators of AWCs in OR, RA, JH, AP and UP and e) developing performance indicators for rewarding AWWs in AP, CG, and WB.

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<sup>7</sup> A sector consists of 15 to 20 Anganwadi Centres, which is supervised by a ICDS supervisor.

### **1.2.3 Commodity Technical assistance**

During the reporting period, INHP supported ICDS to improve food supply chain management to ensure uninterrupted food stocks to the feeding centers. Capacity building helped enhancing skills of ICDS staff to improve inventory management, address transportation bottlenecks, need based allocation of stocks, data review analysis and strengthened the monitoring and review mechanisms. Recognizing the technical expertise of INHP, the state governments of AP, RA, OR have sought support to strengthen the decentralized food models in their states. Besides, the program advocated for regular food supplies, fund flow management wherever feeding interruptions were noted. For example, In UP, INHP's advocacy with Supreme Court Food Commissioner and SC Food Advisors led to issuance of directives for implementation of new financial norm.

INHP developed and rolled out a software to help ICDS in enhancing timeliness of supplies and easy review of critical indicators. Currently this package is being used in the states of AP, OR, RA and WB. Further details of commodity technical assistance are provided in Appendix B.

### **1.2.4 Community participation and Empowerment to hold systems accountable**

Continuing with the key-strategy 2, INHP engaged at the community level with CBOs, PRIs and key structures of PRI like Gramsbahas, VHSC and elected PRI members for ensuring transparency and public accountability. Working with Accredited Social Health Activist (ASHAs), community volunteers and different types of people's networks at state, district and sub-district levels contributed to bring out service and supply gaps and dissemination of good practices for a scale up. In order to enhance the sustainability of INHP's processes, there were ongoing advocacy to mainstream INHP good practices in NRHM mandated forums like VHND, VHSC at village level and Rogi Kalyan Samitis<sup>8</sup> at Block/district levels. At the state level the partnership with SC Food Commissioners/Advisors, media and various civil society networks focused issues of entitlements, deprivation, exclusion and policy gaps. The thematic partnership with the NGOs facilitated addressing context specific issues and mobilized the community members specifically women to raise issues of local relevance. NGO partners also supported various social sanction activities through campaigns, and mass mobilization activities that facilitated addressing underlying issues of myths and misconceptions. In many of the states communication materials targeted at PRI members were produced and disseminated widely to PRIs.

### **1.2.5 Replication in Andhra Pradesh and Chhattisgarh**

During FY 09, replication in AP and CG rolled out the protocols of standardized good practices on the ground. This roll-out process was staggered due to elections to the state assembly in both the states. The standard protocols developed with the support of FANTA have been approved by both the state governments, subsequently the protocols, related tools and formats were printed and sent to all the districts for distribution. Now all the CDPOs, supervisors and AWW are using the revised tools and formats and respective state governments have issued orders to use INHP good practices. The district and divisional resource teams have been constituted and trained on INHP good practices in both the states.

In AP, the district trainings have been completed and the divisional level trainings are currently progressing. AP is following a cascading approach for training CDPOs and supervisors,

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<sup>8</sup> Rogi Kalyan Samitis are the registered societies constituted in the hospitals as innovative mechanism to involve the peoples representatives in the management of the hospital with a view to improve its functioning through levying user charges.

considering the number of functionaries to be trained. In CG all the CDPO, Supervisors and trainers of AWTCs have been trained on INHP good practices and in some districts the refresher trainings are also initiated. The state governments in both states have agreed to reach to AWWs for two days to train them on NHD and Home contacts.

In both the states, job aids for home contacts are available with all the AWWs, supervisors and CDPO. The functionaries were trained on their use during regular monthly meetings and class room trainings. In AP, the program leadership trainings for district and block officers of 12 out of the 15 districts were completed. As part of replication of INHP good practices, both the state government have issued a number of directives and issued letters to their functionaries and to other departments for planning and executing replication activities. In both the states, the departments have demonstrated ownership and accountability in scaling up INHP good practices.

The stage is now set for replication of these best practices in both the states. The nature of INHP support in the proposed no cost extension phase will focus on completion and consolidation of implementation process and development of communication/dissemination products for large advocacy.

### **1.2.6 Behavior Change Communication**

BCC activities conducted during FY-09 based on culture, languages and tradition of states and accordingly state-level strategies were formulated and followed in individual state. Besides strengthening IPC to promote BCC at AWC and community levels, community and mass media were utilized by INHP in all the states. Through use of mass media, during the reporting period, CARE engaged with radio and newspapers to create awareness and promote health and nutrition seeking behaviors at community at large. Language and culture specific folk media were used extensively to reinforce IPC on critical issues like NBC, IYCF and RI. The achievement in this regard include: a) radio magazine on health and nutrition issues in Orissa and Chhattisgarh. In West Bengal, Chhattisgarh and Orissa language specific radio jingles and spots were produced and aired on NBC, IYCF and Routine immunization; b) folk teams to sensitize on health and nutrition issues in West Bengal, Uttar Pradesh, and Andhra Pradesh. Similarly puppetry was used in Rajasthan; c) social mobilization, *Mela*, exhibition and observation of international or national theme based days; d) mass media, particularly vernacular newspapers for greater coverage of nutrition and health day. In Rajasthan media fellows were deployed to raise the issues and best practices; and e) interpersonal tools in the form of flip charts, stickers, ready reckoner and charts for reinforcement of key behaviors.

### **1.2.7 Advocacy**

In FY 09 the program was able to participate and influence many policy level changes at national and state levels. With the support of World Bank, INHP embarked on a political advocacy campaign for prioritizing nutrition which helped to highlight the issue of malnutrition to a range of stakeholders. It started with community level traditional *Panchayat* leaders of JH and went up to the level of the Union Ministers for Women and Child Development as well as Food-Processing, several members of parliament and health advisors in planning commission, media officials, academia and rights groups like right to food campaign.

INHP in close coordination with USAID and MWCD officials worked at the national level to revise MIS in ICDS across the country. The program worked closely with National Institute for Public Cooperation and Child Development (NIPCCD) and training division of MWCD, GOI to organize three regional level workshops to identify the areas for improvement within training

system of ICDS, to contribute to its design based on INHP experiences. The learnings from these regional workshops will form a set of recommendations for MWCD to revise its training curriculum and method of delivery across the country, later this year. Besides with support from USAID and WCD, the national MIS of ICDS is being field tested and revised with inputs of CARE.

In health sector, CARE worked as member in the core group on immunization to introduce new vaccines like HiB and Rota virus, which will be used for the first time in public health programs in India. CARE is also part of core group on introduction of 'home based new born care' within public health system. After persistent efforts of last three years, the curriculum for home based new born care has been finalized now.

In Orissa, INHP in collaboration with DFID's Orissa Health Sector Reform project is supporting the state government on drafting State Plan of Action on Nutrition. In UP, AP, Jharkhand and Orissa, engagement with SC Food Commissioner/Advisors and Right to Food Group opened up INHP's strategic alliance for legislative advocacy.

### **1.2.8 Synergy with other projects**

In UP, JH, CG, Orissa and West Bengal, synergy was established among various CARE projects like Sure Start, ISOFI, ESD, Social Audit of maternal and infant deaths, *Dakhsta*, and micro planning in Panchayats on health issues. These efforts helped INHP to deepen accountability, mainstream gender and strengthened technical strategies related to neo natal, childhood illnesses and maternal health. This also supported demonstrable engagement with healthy system and mainstreaming good practices in NRHM. The INHP state teams participated in joint planning, micro level convergence and joint field review to bring synergy of program efforts on the ground and optimize and leverage resources. Besides, support from FANTA II project for replication was also very helpful in rolling out standardization process in replication areas of AP and CG.

### **1.2.9 Monitoring and Evaluation**

During the reporting period, final evaluation of the program was planned and carried out. A Technical Advisory Committee was constituted to advise evaluation design, methodology and data analysis. The final evaluation was carried out with quantitative and qualitative assessment followed by a review of the results by a panel of technical experts. For the first time, INHP evaluation design followed quasi-experimental design for comparison in four states. The analyses of the results and report are still awaited. A brief summary of preliminary results against the PTT indicators is attached in the annex.

## **2. Success Stories**

### ***Grass-root Democracy getting stronger-Andhra Pradesh***

During the year 2004-05 Raja Ram was elected as PRI president of J.D. Petta Gram Panchayat. After becoming the President of the Panchayat, he decided that he would participate in all the training programs on health and nutrition, safe delivery practices and community mobilization process jointly organized by CARE and ICDS. The exposure sensitised him for he started to look the situation differently. With his new learning, he started mobilising and monitoring the ICDS program in his village. He ensured 100 percent immunization to all the children of the age group of 0-2yrs, all pregnant and lactating mothers. He organized health meetings with the mother's committee members. For common diseases he ensured availability of medicines at Panchayat level especially for diseases like malaria, diarrhea, cough and cold.

He expressed with emotion that training inputs of CARE helped him to improve services for the betterment of the people. He proclaimed that, to some extent the beliefs and superstitious practices in the community reduced. He felt very much happy to attend the NHDs, sector meetings and convergence meetings within or the outside of the village. He said that, this positive thought process happened in his life because of his involvement in NHDs and other committee meetings. He also felt that through NHDs, he was able to learn many things including the courage to volunteer and lead the community to fight for their rights and privileges. He motivated everyone to think about the future generation and strengthen cultural heritage. *“Keeping aside the cultural and social values and norms the real social development couldn’t be possible”*. Raja Ram proudly said – *“CARE personnel’s showed the path to identify his strengths and inner talent to empower him”*.

### ***Program Leadership led to improve child nutrition in West Bengal***

A quick review of ICDS MPRs before August 2008 indicated that weighing efficiency of children less than three years had been in the range of 60-70 percent in Purulia district of WB. During the Program Leadership Development (PLD) workshop for CDPOs held in August 2008, this issue came to light in a group work on the data analysis and management session. This in itself was a revelation to the counterparts, as the weighing efficiency was not expected to be so low. A deeper analysis of the situation revealed that after universalization of ICDS (during 2007-08) the situation had worsened. It was during this period, the weighing efficiency dropped by 9 percentage points when the district registered a 57 percent increase in the number of AWCs. This drop was due to new AWWs not trained in growth monitoring, less availability of weighing scale particularly in new AWCs, and only 60 percent supervisors in place which had an effect of proper monitoring.

During PLD workshop, action plan was made to improve weighing efficiency of children less than three years and to provide counseling at the door step. Program Officers focused more on this issue with the CDPOs through regular follow up at block and district level. The NGOs were trained on data analysis to carry out a similar activity with the supervisors. Regular data analysis and review of weighing data were done across the district. Additionally, strategies were adopted to capacitate the new AWWs through ongoing capacity building during sector meetings. Sharing of weighing scales from nearby AWCs was also discussed. And this trickled down to the AWCs and within months, there was upward trend in weighing efficiency and critical home contacts. The overall district figure shows a positive trend in improving weighing efficiency of children less than three years. Therefore, improvement in managerial skill at the block and district level, analyzing data periodically helped in ensuring early growth promotion leading to better child health.

### **3. Lessons learnt**

1. Replication of good practices requires systematic and structured pilot and scale up of practices having proper protocol, standardization and documentation. The policy, resource commitment and executive mandate by both national and state governments are contributing factors for high success.
2. Content delivered through program leadership trainings like the data management, human resources management, logical frame-work approach to programming etc are very effective for middle level managers of government programs. Beyond the technical and operational components, it is also important to build leadership among critical staff of national programs.

3. With minimal facilitation from the district level, critical processes at AWC and sector level could be sustained, with use of monitoring data in critical review forums.
4. Engagement with NGO partners and properly selected other civil society groups can be beneficial to enhance the sustainability of community mobilization and empowerment processes initiated under INHP. The enhancement of capacities of elected PRI members at block and district level on quality leadership is necessary to strengthen accountability and larger ownership.
5. Issue focused association with Supreme Court advisors and quasi-judicial bodies can be an effective approach to make state governments move on critical issues.
6. Training system within ICDS can be improved further and despite its wide variability and scale. There is immediate need and enough scope for introducing ongoing capacity development modules at the sector level. This will bring much needed effort towards continuing education within ICDS system.
7. Establishing meaningful dialogue with political leadership and quasi-judicial bodies helps in bringing the often forgotten issue of 'nutrition' to the forefront.
8. MHFW is now open to discussing introduction of 'home based newborn care' along with IMNCI and JSY program based on experiences of INHP and SEARCH project in Ghadchiroli.
9. Government is now open to introduction of new vaccines in public health system and is open to civil society participation in the issues like micro-planning and supportive supervision. These issues are taken care in NRHM.
10. A number of lessons in INHP specific to replication process can be useful for informing other flag-ship national programs beyond health and nutrition programs.
11. There is a need to document impact of universalization and rapid expansion of ICDS services on the quality of implementation. The ongoing documentation of KM (knowledge management) products are necessary for evidence based advocacy.
12. The project has to clearly articulate the role evolution and devolution of key stakeholders like government, implementing agency, partner NGOs, PRI, NGO and community members at different phases of project life cycle. This would facilitate the sustainability.
13. The structured and systematic advocacy at policy, people and legislative level with a focus on exclusion are necessary to address issues of poor governance and better access and control over services by the marginalized. The political commitment can bolster the advocacy initiatives for better result.
14. The behavior change interventions are needed to integrate elements that can address underlying issues of myths and misconceptions, cultural factors and inter-intra-household disparities. Home contact alone would not be a sufficient intervention for this as the issue is more structural and underlying.