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TECHNICAL
ASSISTANCE



Assessment of CARE India's Integrated Nutrition and Health Project Tools and Change Agents

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ABBREVIATIONS AND ACRONYMS

AED	Academy for Educational Development
ANC	Antenatal care
ANM	Auxiliary Nurse Midwife
AP	Andhra Pradesh
ASHA	Accredited Social Health Activist
AWC	Anganwadi Center
AWW	Anganwadi Worker
CA	Change Agent
CARE	Cooperative for Assistance and Relief Everywhere
CDPO	Child Development Project Officer
DPT	Diphtheria, Pertussis, Tetanus vaccine
DS	Demonstration site
DT	District Team (CARE)
EBF	Exclusive breastfeeding
FANTA	Food and Nutrition Technical Assistance
GOI	Government of India
GPO	Government Partnership Officer
HFW	Health and Family Welfare
HV	Home Visit
ICDS	Integrated Child Development Services
IEC	Information, education, communication
INHP	Integrated Nutrition and Health Project
LODO	Left-Out and Drop-Out
MO	Medical Officer
MHFW	Ministry of Health and Family Welfare
MTR	Mid-term review
MWCD	Ministry of Women and Child Development
NRHM	National Rural Health Mission
NGO	Non-governmental organization
NHD	Nutrition and Health Day
OR	Orissa
PHC	Primary Health Center
PRI	Panchayat Raj Institution
RAP	Rapid appraisal
THR	Take-home ration
TT	Tetanus Toxoid
UP	Uttar Pradesh
US	United States
USAID	United States Agency for International Development
3Rs	Right message at the Right time to the Right person

Executive Summary

Purpose of the Assessment

CARE/India's Integrated Nutrition and Health Project II (INHP), funded by the United States Agency for International Development (USAID), concluded in 2006. USAID/New Delhi and its partners have developed a three-year phase-out plan to transfer responsibility for key program activities to communities and the Government of India (GOI). The GOI is keen to apply the INHP lessons and products to the broader Integrated Child Development Services (ICDS) program, and sought input from the INHP implementation experiences for the 11th GOI Five-Year Plan, which will commence in April 2008. The INHP Final Evaluation report in 2006 recommended assessing the effectiveness of some of the program's tools and approaches before advocating for replication in the wider ICDS program.

This assessment focused on three programmatic approaches that CARE has implemented in recent years: 1) **Inclusion and tracking** of services to ensure equitable coverage (especially for hard-to-reach families), and to sustain healthy behavior change; 2) **Strengthened supervision of Anganwadi Workers (AWW)** by their supervisor, with an emphasis on home visits. Supervisors are expected to conduct home visits as part of their routine monitoring visits to Anganwadi Centers (AWC). They are advised to visit homes of women who are not following practices recommended by the AWW. 3) **Home Visits** to deliver the Right message to the Right person at the Right time (3Rs). At critical time periods of their lifecycle, mothers would receive the key health and nutrition messages.

In particular, the effectiveness of specific tools and community volunteers to support these approaches was assessed. By evaluating the effectiveness of the tools and identifying the associated processes surrounding their application, this assessment aims to determine whether these tools may be considered or offered for wider replication in the ICDS program. The findings identify ways to improve the tools and their use as reflected by perceptions of the end-users.

Research Questions

The objective of this study is to assess the effectiveness of tools and the community volunteers known as Change Agents applied in CARE/India's INHP in supporting the three programmatic approaches. The tools include a Home Visit Diary (HV Diary), Supervisor's Checklist, and guidelines on facilitating and preparing agendas for sector level meetings. This assessment addressed specific questions, such as whether the tools and Change Agents significantly contributed to key approaches the program aimed to achieve; the processes associated with the application of these tools and Change Agents; and conditions that support or detract from the use and effectiveness of these approaches. Following are the three principal study questions:

1. What are stakeholders' perceptions¹ of the contribution the tools and Change Agents have had on the achievement of program approaches (inclusion and tracking, supervision, home visits)?

¹ For research question 1, the analysis examined perceptions according to the type of stakeholder, e.g., AWW, supervisor, CDPO, etc.

2. What conditions and factors support or detract from the *use* of the tools?
3. What conditions and factors support or detract from the tools' and Change Agents' *effectiveness*?

Methodology

This was a qualitative study that used a purposive sampling approach in an attempt to capture the diversity of experiences in implementing the identified tools and the Change Agent strategy. There was an explicit bias to sample stronger, high performing districts where the tools and Change Agent strategy were fully implemented, so that the research team could observe the use and adaptations of the tools. A total of eight blocks in four districts in four states (Uttar Pradesh, Andhra Pradesh, Rajasthan, and Orissa) were selected. Within each block, one AWC was selected. In each site, semi-structured interviews were conducted with the CARE district team, the Child Development Project Officer (CDPO), NGO staff, AWW, sector supervisor, Change Agents and the Auxiliary Nurse Midwife (ANM). Focus group discussions were conducted with other sector supervisors and beneficiaries. All interviews were conducted in the local language, translated in the field, and entered into MS Word. The data were then coded using the qualitative data analysis software, QSR Nudist, using codes based on the research questions. Variables were created to capture the intent of each of the sub-questions. During analysis, new variables were created that covered recurring themes in the analysis that were not anticipated. Also during analysis, some variables were combined because they encapsulated similar information.

Limitations of the Study

The assessment was intended to provide programmatic recommendations for future use, adaptation, and replication of the tools and approaches. This assessment was not intended to document impact or outcomes attributable to specific program tools or the Change Agent strategy. With these data, one cannot make generalizations about the whole INHP area but rather highlight common themes, challenges and innovations that have implications for future use of the tools, as well as implications for the National Rural Health Mission (NRHM) Accredited Social Health Activist (ASHA) workers based on the Change Agent experience.

Because strong suits were purposively selected, results do not indicate which tools can be used effectively within weaker systems or those without strong CARE interventions.

Findings

Research Question #1—Contribution the tools and Change Agents have had on the achievement of program approaches (inclusion and tracking, supervision, and home visits):

Concerning **tracking and inclusion**, the HV Diary was not used for this purpose, nor was it intended to be. Similarly, the Supervisor's Checklist was not used—and nor was it intended to be—to ensure inclusion of all families in services. Every year, the AWW conducts a household survey to identify eligible households. In general, most ICDS respondents felt that no one was left out of the annual survey done by the AWW. This survey (with updates every three to six months) serves as the denominator for coverage rates and is intended to capture every household in the catchment area. Based on information from this survey, both the AWW and supervisor use other registers to identify people for services. Sector meetings sometimes touch on the issues of tracking and inclusion, though this does not seem to be a priority issue for most participants. One

of the premises of the Change Agent strategy is that Change Agents would come from all sections of the community and hence facilitate the tracking and inclusion of pregnant women and young children for services. Change Agents were sometimes described as the “eyes and ears” of the AWW throughout the community. However, Change Agents do not maintain or review any sort of records or registers, and would have no knowledge if a particular household was left out. In Uttar Pradesh (UP), respondents acknowledged that it was often difficult to recruit Change Agents from the Scheduled Caste (SC) community “*because they have no time*”. In other words, since members of SCs are often the poorest families and work as day laborers, they do not have time to do any volunteer work. In all the areas visited, respondents reported that Change Agents made an important contribution by facilitating the early registration of pregnant women. Another one of Change Agents’ major contributions was to visit the homes of drop-outs and those due to be immunized around the time of the Nutrition and Health Day (NHD) and motivate them to come to the AWC. In many settings, the Change Agents would remind women a few days prior to the NHD to return for vaccination.

The HV Diary was not intended to be used for **strengthening supervision**, though many supervisors take advantage of information contained within this Diary and re-visit homes to assess the content and quality of the AWW’s home visits. The Supervisor’s Checklist is designed expressly to guide the interaction between the supervisor and the AWW during a site visit and by structuring this interaction the Checklist strengthens supervision. In some sites, Supervisor’s Checklists are reviewed by the CDPOs, contributing to that level of supervision. The relationship between the AWW and her supervisor has been bolstered by the invigorated sector meetings. Through the sector meetings, the supervisor has an opportunity to be seen as someone who can facilitate peer learning and actively help to solve problems. During these meetings, the supervisors interact with AWWs as a group and often individually. Combined with the Supervisor’s Checklist, the sector meeting has strengthened the connections supervisors have with AWWs. Some CDPOs attend the sector meetings and find it a useful way to learn what is happening in the different sectors. As volunteers, the Change Agents were not within the supervisory system.

The entire focus of the HV Diary is to orient the AWW to critical time periods, and the Ready Reckoner defines what messages to give at each of those time periods during **home visits**. Both AWW and supervisors prioritize their home visits for the following categories: pregnant women near their due date, recent newborns (within 1-2 days of birth), homes of six-month-old children to give advice on complementary feeding, severely malnourished children, and drop-outs from immunization. The Supervisor’s Checklist draws attention to the 3Rs, similar to the HV Diary. The Checklist is a reference to revolve supervisory visits around the messages needed for particular sub-groups of beneficiaries. But neither of these tools ensures the home visits are actually occurring. There was some evidence supporting occurrence of AWWs’ home visits; however, there was not much verification that the supervisors are making many home visits. In all areas visited, respondents reported that sector meetings now focus much more on health and nutrition issues. During the discussion time, most of the topics are related to communication around the three Rs, with attention to specific behaviors and “convincing people” to use services. Some supervisors (often with the NGOs) establish a theme for each month so that over the course of a few months, key topics are covered. Other supervisors review the problems that came up the month before and build an agenda around those issues. One of the

main objectives of the Change Agent strategy was to counsel mothers and family members on specific behaviors. Most Change Agents talked about *ad hoc* conversations that occurred when collecting water or when they saw the women in the neighborhood. Some Change Agents felt their role was not only to talk to the specific mother, but also her elders who may have more decision-making authority.

Research Question #2—Conditions and factors that support or detract from the use of the tools: The **HV Diary** had mixed reviews on the ease of use. When asked directly, most respondents claimed the tool was user-friendly; however, throughout the interviews, there would be references to AWWs who needed to learn how to use the tool—and once they did—they used it correctly. The HV Diary requires literacy. Currently, AWWs are expected to have completed 8 years of formal education; nevertheless, some of the existing AWWs are illiterate. For those AWWs, the expectation is to pay someone else to complete the tool for you. The best use of the Diary for some is as a reference material before embarking on home visits, irrespective of its use as a log to record visits. The HV Diary is most consistently applied in the original CARE/India version without any modification.

The most common constraint to increased use of the **Supervisor's Checklist** is time. In general, the Checklist is only being used on some of the AWC visits each month. The Checklist pushes the supervisor to spend a few hours at a site, which is not always possible given her workload. In addition, the original format does not capture all the needed inputs during a site visit. The Checklist has been adapted in several places. One revision has a decision-tree format that guides the supervisor step-by-step to focus on the essentials. In another district, the supervisors modified the tool to encompass more than just home visits, and converted the Checklist into a reporting mechanism.

There is wide agreement that the content and quality of **sector meetings** have improved since the Mid-term review (MTR). Even though respondents rarely referred to any particular “Sector Meeting Guidelines” *per se*, the objectives behind the guidelines are being met. Respondents did not talk about the tool, but rather dwelled on the process of what happens at sector meetings.

Research Question #3—Conditions and factors that support or detract from the tools' and Change Agents' effectiveness:

By design, the study team observed the implementation of the tools and Change Agent strategy in optimal circumstances. Many pre-existing conditions were in place and functioning well, thereby providing fertile ground for any tool or strategy. The biggest source of support for tool implementation is derived from the NGO representatives. In addition to providing direct technical assistance to the supervisors, the NGOs also have played a very large role in strengthening the sector meetings. There are external obstacles that affect even the best settings. Several external government agencies routinely tap into ICDS human resources to implement their vertical programs and drives such as Pulse Polio and others. Based on very rough estimates, ICDS functionaries are routinely spending about one-quarter of their time on these external government objectives.

As the emphasis from CARE/India headquarters waned for the Change Agent approach, correspondingly attention at the local level was minimized. Some Change Agents took the

decreased interest on the part of the AWW as a signal that their role was no longer needed. The NGO staff had been one of the primary contacts for the training and recruitment of many of the Change Agents and once this strategy was “de-emphasized”, NGO staff reported feeling that they needed to avoid the Change Agents since they had “*nothing to offer them*”. The simple lack of attention to the Change Agents was very demoralizing for many of them.

There is much evidence that the HV Diary and Supervisor’s Checklist positively influenced the way the AWWs and supervisors do business. Supervisors have recounted distinct changes since the Supervisor’s Checklist has been in use. During one FGD with supervisors, they recalled that earlier they were not able to prioritize which home to visit during their AWC visits. They were not conversant in the life cycle or how to prepare a woman for the next time period in the cycle. They feel the Checklist helps them to plan their visits better.

There is good consensus that the content and quality of sector meetings have improved since the introduction of the Sector Meeting Guidelines. After the initial changes in the focus and structure of sector meetings were established—often with and through the support of the NGOs—the supervisors were able to maintain this new method of conducting sector meetings. Sector meetings have changed from simply a time to submit reports to a time for capacity building, *or as one respondent remarked, “...completely shifted from reports collection to MCH services”*. Another distinct change in work behavior since the MTR is greater coordination with the MHFW. ANM attendance at sector meetings varies from place to place but has improved in many areas. ANMs are consistently conducting NHDs in close collaboration with the AWWs. At a handful of centers visited, ANMs spend time comparing and updating their registers with the AWWs.

Recommendations

General

- **Consider the pivotal role the NGOs have had in transforming supervisors’ behaviors.** The supervisors have especially benefited from having NGOs assist them and demonstrate their roles and responsibilities. Ideally, contracting a combination of CARE staff and NGOs experienced with the CARE approaches would be an effective option for the GOI to hasten its learning curve and build upon lessons learned from other sites. But replicating the intense one-on-one support NGO representatives gave to the supervisors is most likely not a sustainable plan for the MWCD to implement and manage.
- **Develop a CDPO tool that aggregates the information from the revised Supervisor’s Checklist.** The existing tools are geared for supervisors and AWWs, but there are no comparable tools targeted for CDPOs that allow them to aggregate relevant inputs needed for block-wide decision making.
- **Distinguish between job aids and reports.** A job aid should be emphasized as a reference source rather than as another report or register. Records that are “reported-up” to superiors are given higher priority by functionaries; and at times they are susceptible to erroneous completion because functionaries are obliged to report something to their supervisor.

Supervisors

- **Broaden the scope of the Supervisor’s Checklist** to encompass much more than just home visits and action plans based on those visits. The content of this Checklist should be based on the overall perspective of the ICDS program priorities. Action plans should be the main outcome of this Checklist. The Pali Rajasthan version of the Supervisor’s Checklist is the most comprehensive and functional of those reviewed and should form the starting point for a revision.
- **Involve end-users in the development and field testing of revised tools.** No matter what revisions are going to be made to the Supervisor’s Checklist, supervisors should be involved in the design and field testing of the adapted Checklist before finalization, as was done in Pali, Rajasthan.
- **Tracking of Supervisor’s Checklists.** Among the set of tools under review, the field adaptations of the Supervisor’s Checklist are most significant. The utilization of this Checklist could be optimized if each AWC site report were organized into a folder or binder that has been designated for each AWC.
- **Reconcile the Supervisor’s Checklist within the ICDS reporting system.** Beyond the basic organization of the Checklists into the designated folder per AWC, the Supervisor’s Checklist needs to be reconciled with the information reported in the Monthly Progress Report to assure there is no duplication in efforts.
- **The Supervisor’s Checklist should be modified to include a careful review of the accuracy of the household survey register and the immunization register.** Currently there is no check on the accuracy of the household survey. There may be far-off hamlets or sub-populations that have failed to be enumerated.
- **Develop a systematic tracking and reporting method to account for daughters-in-law who leave villages during the most critical time periods in the life cycle** (i.e., around seven months pregnant, returning approximately six weeks postpartum). Immunization cards might be one alternative, but a backup reporting system is needed for women who lose or do not carry their cards.
- **Systematize guidance on care for pregnant women who deliver in their parents’ villages.** Sector meetings should raise the topic of reaching women and newborns during the most critical of all time periods—birth and the first weeks of life—to transmit clear guidance on how to identify and provide services for these beneficiaries while they are away from home.

Anganwadi Workers

- **Guidance on improving interpersonal communication (IPC) skills of AWWs.** The HV Diary does a superb job detailing the content of the key messages included, when to give it,

and to whom. However, there is no guidance in this tool on how to communicate these messages. Communication skills appear to be covered in some of the sector meetings through a positive deviance approach, but it would be helpful to reinforce IPC skill-building by including such guidance in the Ready Reckoner and continuing to raise this as an interactive agenda topic for sector meetings.

- **The HV Diary instructions need to be revisited** so AWWs are clear about whom to enter into the register and when. The instructions should take into account potential lapses of time when the Diary is not being updated.
- **Consider adding another critical time period for the first week of life.** It would be useful to break down the critical time period for 0-30 days into two columns: 0-7 days and 8-30 days. This might increase the chance that the AWWs visit newborns during the most crucial weeks in the first month of life.
- **The HV Diary should not be adapted to serve the function of Tracking and Inclusion.** Since functionaries are already referring to the immunization register, modifying the HV Diary to include this information would not only be duplicative reporting, it would also introduce the chance of error each time figures are transferred from the immunization register to the Diary.
- **Formalize the opportunities for supervision to occur during sector meetings.** Supervision need not be limited to the AWW. When and where possible, the CDPOs can use sector meetings to supplement their supervision of supervisor performance.
- **Supervisors should use home visits to assess AWW performance.** Supervisors should continue to confirm the AWWs' ability to deliver the 3Rs by visiting homes recently visited by the AWWs. Back in the AWC, positive, constructive feedback should be given to the AWW, as some supervisors are already doing.

I. Rationale and Purpose of the Study

a. CARE Phase-out Plan

CARE/India's Integrated Nutrition and Health Project II (INHP II), funded by the United States Agency for International Development (USAID), concluded in 2006. USAID/New Delhi and its partners have developed a three-year phase-out plan to transfer responsibility for key program activities to communities and the Government of India (GOI). It is envisioned that by December 2009: a) government social safety net programs will effectively meet the food security, health and nutrition needs of a significant portion of the most vulnerable women and children in marginalized communities of INHP areas; b) these marginalized communities will be empowered enough to exercise their right to access government safety nets; and c) effective INHP practices will positively influence implementation of the GOI's two flagship programs, i.e., the Integrated Child Development Services (ICDS) scheme and the National Rural Health Mission (NRHM).

To uphold these goals, USAID is supporting replication of some of the INHP approaches and practices in non-CARE-supported ICDS districts in Andhra Pradesh and Chhattisgarh, and in the non-CARE-supported blocks in the current 75 CARE-supported ICDS districts. The GOI is keen to apply the INHP lessons and products to the broader ICDS program, and sought input from the INHP implementation experiences for the 11th GOI Five-Year Plan, which will commence in April 2008.

The primary approaches targeted for replication (e.g., improved commodity management practices and Health-ICDS convergence through Nutrition and Health Days (NHD)) have been shown to lead to improved outcomes. There are also a set of tools that appear promising, but require an in-depth review in order to determine whether they merit wider replication. The INHP Final Evaluation report recommended assessing the effectiveness of these tools before advocating for replication in the wider ICDS program.

Some of these tools were developed and field-tested following the 2004 INHP Mid-Term Review (MTR). (A few tools had been developed before the MTR by CARE field staff.) They were developed to 1) support Anganwadi Workers' (AWW) visits to the homes of pregnant women and their children under 18 months of age, 2) sharpen the focus of supervisor field visits, and 3) support sector level meetings to enhance the effectiveness of the ICDS sector meetings facilitated by supervisors, and to encourage participation of counterparts from the Ministry of Health and Family Welfare (MHFW) at these meetings. The tools were developed in close consultation with counterparts from ICDS and MHFW and have been modified and adapted to local contexts and languages. These tools have been used by AWWs, ICDS supervisors, and CARE's partner NGOs in most of the INHP states and districts.

Also of interest is to glean lessons learned from CARE/India's Change Agent strategy. Change Agents are mostly young, female volunteers selected from the community, and were engaged to supplement the ICDS program areas supported by INHP. Lessons from this experience can help inform both the larger ICDS program and the ASHA component of the GOI's NRHM.

The objective of this study is to assess the effectiveness of tools and the community volunteers known as Change Agents applied in CARE/India's INHP. The tools include a Home Visit Diary (HV Diary), Supervisor's Checklist, and guidance on facilitating and preparing agendas for sector level meetings. This assessment will address specific questions such as whether the tools and Change Agents significantly contributed to key approaches the program aims to achieve; the processes associated with the application of these tools and Change Agents, as well as conditions that support or detract from the use and effectiveness of these approaches.

By evaluating the effectiveness of these tools and identifying the associated processes surrounding their application, this assessment aims to determine whether these tools may be considered or offered for wider replication in the ICDS program. The findings will identify ways to improve the tools and their use as reflected by perceptions of the end-users. With regard to the involvement of Change Agents, the assessment will examine to what extent the Change Agent strategy was implemented as originally envisaged, how the strategy contributed to achievement of project objectives, and the emerging lessons for similar initiatives in other large-scale programs.

b. Research Questions

The five questions below (1-5) are the overarching research questions. Under each question, several sub-questions were used to design the data collection instruments and guide the data collection process and analysis of results. For a complete listing of all the sub-questions, refer to Appendix 1.

1. *What are stakeholders' perceptions² of the contribution the tools have had on the achievement of program approaches?*
2. *What conditions and factors support or detract from the use of the tools?*
3. *What conditions and factors support or detract from the tools' effectiveness?*
4. *What are stakeholders' perceptions of the Change Agents' contribution toward the achievement of program objectives/or approaches?*
5. *What conditions and factors support or detract from Change Agents' ability/capacity to fulfill their roles?*

² For research questions 1 and 4, the analysis examined perceptions according to the type of stakeholder, e.g., AWW, supervisor, CDPO, etc.

II. Brief Overview of INHP II Approaches³

CARE has taken a serious learning approach to its program strategies by continually reviewing empirical data and modifying program approaches accordingly. Assessments of early implementation sites in mid-2003 had highlighted the need for: 1) increased and better quality contacts by service providers, as this was found to correlate best with improved health behaviors and service coverage, and 2) active inclusion of system functionaries in the change management process. Annual Rapid Assessment Surveys (RAPs) (from one panel district in each state starting in late 2003), showed low levels of many indicators, including service coverage, key behaviors and contacts, and home visits by service providers.

By the end of 2004, results from the second round of RAPs were available and showed variable, albeit small, changes in behavior and service related indicators in most of the districts. These data confirmed the findings of the MTR: improvements were apparent, but they were clearly insufficient to bring about the impact anticipated.

Given the resource requirements for this vast program, there was also the need to “de-emphasize” strategies that were not yielding short term results (i.e. Change Agent). While Change Agents were able to mobilize communities—linking beneficiaries to the Anganwadi Centers (AWCs)—they were not reaching a large proportion of households through home visits as had been hoped.

a. CARE’s Post-Mid-Term Review Strategy

Following the MTR, a revised strategy was put into place. The ICDS supervisors were identified as the lynchpins of this strategy. The supervisor and the AWW needed simple tools to help them correctly focus on interventions and approaches that were most likely to be effective. Some of the tools were piloted by various states. In most of the states, the CARE District Teams (DT) introduced some formats based on the need. These experiences were consolidated and CARE/India rolled out the tools for local adaptation and implementation in 2005.

Simple tools and Checklists were developed for supervisors and AWWs. Most of the capacity building of AWWs at this point would now happen on an ongoing basis during sector meetings, where operational issues were raised and learning opportunities provided. CARE’s partner NGOs were requested to assign one staff member per block who could support the supervisor at the sector meetings as well as make joint visits with her to the AWCs. These NGO staff supported the supervisor as well as the Child Development Project Officer (CDPO), and coordinated with the CARE District Teams to ensure the integrity of the program’s technical content and processes. To enable CARE DTs to concentrate on these areas, new recruitment of Change Agents was not emphasized and trainings for the existing agents were discontinued; although they did continue to receive some support from ICDS staff, primarily AWWs and their supervisors. This strategy was established on the ground in most districts over the first six to nine months of 2005, with the active cooperation of the CARE DT. Available evidence was offered to key district and block leaders to persuade them of the need to enhance the convergence

³ Source: *Summary of Approaches and Results*, CARE/India, January 2007

between the ICDS and MHFW programs. The idea was to sharply hone in on a few critical interventions at critical time periods in the life cycle in order to make measurable impact on health and nutrition indicators. The selected post-MTR approaches are:

1. Inclusion and Tracking of services to ensure equitable coverage, especially for the hard-to-reach families and to sustain healthy behavior change.
2. Home Visits to deliver the Right message to the Right person at the Right time (3Rs). At critical time periods of their lifecycle, mothers would receive the right messages at the right time. Prioritized Home visits targeting pregnant women and their children less than 18 months old was the mechanism selected to promote improved interpersonal communication (IPC) directly with beneficiaries and their families.
3. Strengthened Supervision of AWWs by their supervisors with an emphasis on home visits as noted above. Supervisors are expected to conduct home visits as part of their routine monitoring visits to AWCs. They are advised to visit homes of women who are refusing to follow practices advised by the AWW.

Apart from the three listed approaches above, a cross-cutting approach was to reach scale through sector strengthening. CARE targeted all AWWs in the INHP program area on an on-going basis (approximately 95,000 AWWs) with these approaches.

III. Description of Tools and Change Agents

To facilitate implementation of these approaches, CARE/India developed four generic tools to be used as prototypes for field adaptations. (The original CARE/India versions of the tools are found in Appendix 2; refer to Tools 1-4.) These tools were intended to be job aids and not meant to be included in the reporting system for monitoring purposes. By design, each of these tools reinforces each of the three approaches. One of the main objectives of this assessment is to confirm this stated intent of supporting the approaches with field-based data from selected sites. See Table 1 below for a list of the tools under review, as well as their intended purposes and a brief description.

Table 1: CARE Post-MTR Tools Reviewed in the Assessment

TOOL	Purpose and Description of the Tool
Home Visit Diary (HV Diary)	The Diary is a job aid for the AWW to increase the likelihood she will make home visits at the critical time periods for pregnant woman and children less than 18 months of age. The accompanying “Ready Reckoner” provides focused key messages relevant to critical time periods. The Diary is a simple matrix that breaks down the critical time periods between pregnancy and the first 18 months of childhood. There are eight columns indicating the time periods when home visits are recommended. The horizontal axis is where the AWW writes the names of the beneficiaries. She is expected to, at a minimum, write the date of her visits in the corresponding boxes.
Supervisor’s Checklist	This is a job aid specific for a sector supervisor’s visit-interaction with an AWW at the AWC to review all her registers including the HV Diary above. Based on this review, the sector supervisor visits selected homes. This tool outlines questions to ask the mothers during the same critical time periods as listed in the HV Diary so as to confirm and learn first hand about community behaviors and practices. The tool helps the supervisor to understand the behavioral changes that are taking place at the community level, understand the difficulties of the AWWs’ translation of key messages, and to draw an action plan to overcome the identified problems. Input from supervisor home visits can be used to inform capacity building of AWWs at sector level meetings.
Sector Meeting Guidelines	Tool for Conducting Sector Meetings This tool provides step-by-step content and respective questions to be covered during a sector meeting for the plenary session. It also gives detailed guidelines for facilitating the group work.
	Guidelines for Facilitating Sector Meetings These guidelines define the purpose of the sector meetings, and delineate how to prepare to facilitate the meetings and the proposed structure for the meetings, dividing them into the plenary sessions and group work.

a. Home Visit Diary

The AWWs’ Home Visit Planning Register is known as the Home Visit Diary. The objective of having a home visit register (HV Diary) is to enable the AWW to prioritize and plan her home visits so she will reach beneficiaries at the right time. The accompanying “Ready Reckoner” is meant to help her understand the priority behaviors for particular life cycle time periods. The Reckoner is organized to provide the messages pertinent to each time period in the life cycle.

This HV Diary provides at-a-glance information about home visits conducted or to be conducted during critical times from early pregnancy until the child is 18 months old. It is structured as follows:

- i. Rows for information about individual women (mothers). Each row has empty boxes to allow for recording of all relevant information.
- ii. The first column is for recording the names of pregnant women/children below 18 months in the village and other relevant information, such as Expected Date of Delivery (EDD), date of birth (in case of children), and whether the woman is a daughter or a daughter-in-law of the village.
- iii. Each subsequent column is designated to a critical period during which a home visit must be conducted.
- iv. The names are listed with the oldest pregnancy at the top and the most recent pregnancy at the end of the list, so that new pregnancies can be added to the bottom when identified.
- v. It is expected that the AWW will record, in the appropriate column, the date of the visit and any relevant information about problems identified. The AWW need not write down what she advised the mother. What the AWW will do during these visits becomes self explanatory, and the AWWs are encouraged to counsel using an “Ask-Assess-Advise” protocol.

The use of the HV Diary incorporates much flexibility in the sense that it is not intended to be used as a mechanism for upward accountability but rather as a job aid. The purpose is to help the AWW to understand the critical time periods and expected behaviors during those periods – she and her supervisor then can determine which beneficiary requires visits, at what frequency, what messages to focus on, etc.

b. Supervisor’s Checklist

The Supervisor’s Checklist is intended to help structure the conversation between the AWW and her supervisor during supervisory visits. The tool is also intended to help the supervisor prioritize the home visits she will make. The first section provides a format for the supervisor to review key behaviors among pregnant women (during the third trimester) and infants (between birth and 15 months), representing five of the eight life cycles delineated in the HV Diary. Based on information from field interviews with AWWs, supervisors are expected to select a minimum of three homes to visit where mothers/families are either refusing to follow advised practices or have dropped out from vaccination. Priority is given to pregnant women in their last trimester and newborns less than one month old. If there are no such high risk households, the supervisor selects at least 1-2 other homes to visit so she can understand household level behaviors and provide any additional support that might be needed. The tool gives prompts in the form of questions for the mother to guide the supervisor through the home visits. The gathered information is consolidated at the end of each month and used to prepare the sector meeting agenda for discussion with the AWWs and/or to identify a need-based topic for ongoing capacity building.

c. Tool for Conducting Sector Meetings

Previously, sector meetings facilitated by ICDS supervisors were primarily intended to collect monthly progress reports from AWWs. Usually these meetings were unstructured. CARE found this to be one of the opportunities to interact with all the AWW at one place and decided to structure these meetings to encourage information sharing and ongoing capacity building.

The Tool for Conducting Sector Meetings emphasizes the need for supervisors to be well prepared to facilitate sector meetings. This guide provides a Checklist to encourage review of the following:

- i. a few selected indicators based on the consolidated data obtained through use of the Supervisors Tool (see Section “b” above for a description of the Supervisor’s Checklist),
- ii. the health information system including supplies and NHD-related data⁴,
- iii. progress on expected actions from block and district levels as discussed in previous sector meetings,
- iv. action plans from previous sector meetings,
- v. observations from field visits in the past month, by thematic area, and
- vi. any prioritized activities of the Ministry of Women and Child Development (DWCD) or its District Administration.

Preferably, these preparations should involve supervisors, Auxiliary Nurse Midwives (ANMs), Lady Health Visitors (who supervise ANMs), and the CDPO. If feasible, there should be involvement by the NGO/Block Resource Team (BRT) members, and CARE DT members. A comprehensive pre-sector meeting should be convened a few days before the scheduled sector meeting each month. A smaller meeting with the CDPO immediately following sector meetings could be useful to review findings from the sector meetings every month, and identify issues to resolve at block/district levels.

d. Guidelines for Facilitating Sector Meetings

The purpose of sector meetings as described in the toolkit is to reach scale with effective content through AWWs with support from their supervisors, and backed by predictable services from ANMs. CARE saw the potential for sector meetings to become a powerful forum for communicating with AWWs and for coordination with the health department, primarily with the ANMs. These meetings also provide a ready forum for other agencies offering capacity building activities. The guidelines suggest a structure for the effective use of sector meetings, as follows:

- i. assess the current status in a given sector in order to determine priorities (e.g., to introduce concepts such as critical home visits where they are not occurring),
- ii. encourage the presence of ANMs to reinforce key behaviors,
- iii. divide the sector meeting into two sessions: a plenary discussion that will include any formal capacity building, and group-work that discusses operational details and relevant action plans.

This guideline suggests a set of questions to facilitate the two meeting sessions. The facilitator can be either a supervisor or a NGO functionary. It should be an interactive session, led by

⁴ The data review is not meant for presentation in the sector meeting, but to understand gaps and identify issues for discussion in sector meetings.

facilitator's questions. While this can be a typical pattern for subsequent meetings, the first one or two meetings will probably need to be more focused on selecting the interventions to hone in on, and to reach an agreement on immediate operational steps for the AWW and ANM (such as focused home visits). The tool aims to stimulate thematic discussions and encourage listing action points that emerge.

e. Change Agents⁵

Within INHP, a community volunteer is known as a Change Agent and is defined as “an active, interested member from the community who acts as a promoter and monitor of health and nutrition practices in the neighborhood (15-20 families).” Use of Change Agents began well before the MTR. These volunteers were supposed to be chosen from different socio-economic hamlets within villages so that members of the diverse social structure of the village could be reached by a person who belongs to their community. Maintaining approximately five to six Change Agents in a village would form a reasonable resource base to mobilize the community and facilitate service provision. Change Agents were intended to facilitate inclusion of all households for services and “serve as a link between service providers and the community.” The primary objective of the Change Agent, however, was to promote and sustain behavior change among the households she was assigned. Change Agents were to be selected by the community using village social maps to ensure that all households are covered. The specific selection criteria intended were:

- accepted by the community
- active and interested in ICDS services
- belong to the same village/hamlet
- sensitive to vulnerabilities faced by community members
- concern for the well-being of her neighborhood
- able to devote time to volunteer activities

As unpaid volunteers, Change Agents were not expected to work more than a few hours per day. The Change Agents were to attend 2-3 short trainings on INHP interventions and expected to have frequent interactions with the AWWs. (Travel allowance and tea were usually provided at the trainings.) Ten activities were suggested for the Change Agents to implement:

- Stay in touch with households that have pregnant and lactating mothers, children under two, and eligible couples.
- Identify program participants as early as possible and motivate them to enrol at the AWC (with special attention to pregnant women).
- Facilitate birth planning and counsel women on care during pregnancy.
- Visit every new child born, along with the Traditional Birth Attendant (TBA). Make daily visits for the first week to households with a newborn.
- Identify barriers to exclusive breastfeeding and complementary feeding and assist family members to overcome them.
- Under the direction of the AWW, follow and counsel households with children under 2 for immunization, growth promotion, and birth spacing.
- Participate in NHD activities to support the AWW and ANM in delivery of services
- Counsel families on importance of birth spacing and provide basic information on

⁵ Based on information from Annex 6.2 in RACHNA BP 2, CARE, December 2003.

contraception.

- Act as depot holders for iron and folic acid, oral re-hydration salts, and contraceptives.
- Identify all the un-reached and drop-outs (using social maps) in their catchment area and bring to service providers' attention so as to enhance coverage.

While the Change Agents were expected to work closely with the AWW, she was not to be “supervised” by the AWW.

IV. Methodology

a. Sampling Approach

CARE management is decentralized to the district level where each district has a four-person district team. The ultimate objective of the sampling approach was to visit high performing districts where the tools and Change Agent strategy were fully implemented. Districts with strong CARE management were purposively selected based on the assumption that better performing districts and functionaries would be more likely to have used the tools effectively, to understand each tool's intended purpose, and to have explored beyond the original tool, making modifications to optimize the full potential of the tool. Stronger districts are more likely to have adjusted the tools to the needs of the end-users. It was important to conduct interviews with functionaries where the tools and Change Agents worked well so as to optimize the brief time available for data collection. Ideally, it would have enriched the study to also solicit input on why the tools or Change Agents were not implemented, and the challenges faced in those settings. However, the team deliberately sought the positive examples rather than split an already limited sample between strong and weak sites. Weak sites also carried the risk that functionaries might not have ever seen or used the tools to be able to form an opinion on them.

To examine a simulation of “real-life” scenarios surrounding the districts, the sample selection was mixed in terms of the support the district teams received from their state level regional management and the degree to which they influenced the blocks under their jurisdiction. Thus, in order to mix-up the possible scenarios within which a strong district would be functioning, the sample included both states that provide the CARE DT relatively more support and those that provide relatively less support. Similarly, one block under the district team's purview was selected that was strong and one that was average. The rationale for not selecting the weakest performing blocks was to avoid defeating the purpose of visiting a strong district in the first place.

The assessment team selected four states, one district within each state, two blocks within each district, and one AWC within each block. The selection at each level was done purposively with the exception of the AWC. AWCs that met specified selection criteria were listed and then one AWC was randomly selected.

The specific steps for site selection are described below:

- i. **Four states** were selected such that two selected states had higher performing CARE program management, and two selected states had less than optimal CARE program management. The performance of these states generally reflected the level of ICDS program implementation (relative to other CARE INHP states), in terms of their systems support and implementation of approaches in their respective states. The other criterion for state inclusion was for program implementation to be at sufficient scale that there would likely be an opportunity to locate a strong district. This criterion mainly applied to the selection of less than optimal performing states. Based on that criterion, two states, Bihar and Madhya Pradesh, were eliminated from the universe of eligible states because their program areas are very small relative to the other states. Bihar was included in

INHP II later than the other eight states and has had inconsistent implementation. Madhya Pradesh is implementing the program in only three districts. Jharkhand was also eliminated because there are only a nominal number of supervisors, thereby compromising the depth of implementation. Among the six eligible states, four states were selected according to the above criteria.

To guide the selection of the states, a matrix was completed by the CARE/India and BASICS team that ranked each state's performance in terms of acceptance and implementation of the INHP II approaches and Change Agents (See Table 2 below). Based on these inputs, Andhra Pradesh (AP) and Orissa were selected to represent the stronger states and Uttar Pradesh (UP) and Rajasthan were chosen to represent the less than optimal states vis-à-vis CARE program management.

Table 2: Performance Ranking of INHP II Approaches and Change Agents at the State Level

<i>State</i>	Tracking	Home Visits	Supervision	Change Agents	Total
<i>Andhra Pradesh</i>	+++	+++	++	+	9+
<i>Bihar</i>	-	-	-	None	0
<i>Chhattisgarh</i>	+	++	+	++	6+
<i>Jharkhand</i>	++	+	-	+	4+
<i>Madhya Pradesh</i>	+	+	+	+	4+
<i>Orissa</i>	++	+++	++	++	9+
<i>Rajasthan</i>	+	+	++	+	5+
<i>Uttar Pradesh</i>	++	+ / +++	+ / +++	+	5-7+
<i>West Bengal</i>	+++++	++	-	+	7+

Source: BASICS and CARE/India INHP Team Perceptions

- ii. **One district within each state** was selected that was strong for that state in terms of INHP management. Given that the district is the smallest unit of CARE program management, strong districts were where the study team was likely to encounter local adaptations of the tool used in full force over a period of time. One district in each of the four states was selected by the working group (CARE/India, BASICS, and AED Assessment team) in consultation with the CARE DTs.
- iii. In consultation with the CARE DTs in each state, **two blocks within each district** were selected upon arrival at each district. One block was among the strongest blocks relative to the district and the other block was average for that district. The strong block was for the most part, where the tools, approaches and Change Agents are working well. The average block was to have typical results for the district vis-à-vis their use of the tools, program approaches and Change Agent experience. Selection of blocks with weak program implementation was avoided based on the assumption that not much information could be gleaned in settings where the INHP approaches are not applied to an appreciable level. The purpose of sampling one strong and one average block in each district was to

observe a range of experiences within a district—from innovative approaches and tool adaptations to more typical implementation within a particular district.

- iv. **One AWC within each block** was randomly selected among a list of all the AWCs that met three conditions: 1) Change Agents are known to be in the village (whether or not they are active), 2) there have been changes in health and nutrition practices at the village level, and 3) the AWW is thought to be using the CARE version of the HV Diary. The rationale for imposing these AWC selection criteria was to avoid any biases that might be exerted by CARE or ICDS functionaries that would detract from the intent of the sampling objective.⁶ Because there was anecdotal input that behavior change had occurred at the village level, these sites were deliberately visited with an eye for any influence the Change Agents, and to a lesser extent the tools, may have exerted.

Table 3 below summarizes the selection criteria and gives the location of the data collection sites.

⁶ Consideration was also given to capture the diversity of contexts in which the tools/approaches and Change Agents are implemented. In addition, AWCs were selected to ensure that the final sample includes sites with variation in the degree of economic and social homogeneity within the AWC catchment area (religion, caste/ethnicity, education, economic status). The role the tools and Change Agents play and the ways they are implemented may differ in less homogenous contexts from the roles and implementation in more homogenous areas. Consideration was also given in regard to physical access to the ANM and health facilities (distance, roads, transport, etc.). Application and usefulness of the tools and approaches might vary depending on access to health services, especially since some of the tools and approaches focus on increasing such access.

Table 3: Criteria for Site Selection

<u>STATE</u> Selection Criteria: 1. CARE program management and performance 2. Consistent level of program implementation during INHP II (2 high performing states, 2 less than optimal performing states)	<u>DISTRICT</u> Selection Criteria: 1. CARE program implementation 2. Use of Tools/ Change Agents (A district strong for the state. NB: Once this criterion was met, districts were selected based on feasibility of access within the given time period for data collection.)	<u>BLOCK</u> Selection Criteria: Program Implementation and Use of Tools/ Change Agents (Select two blocks—one that is strong and one that is average for the district)	<u>AWC</u> Selection Criteria: 1. Change Agents are known to be in the village (whether or not they are active) 2. Changes in health and nutrition practices at the village level, and 3. AWW is using the CARE HV Diary
State 1: Andhra Pradesh (high)	District 1: Khammam	Block 1 Madhira (strong)	AWC 1 Rayapatnam
		Block 2 Kothagudem (average)	AWC 2 Annadaivam
State 2: Orissa (high)	District 2 Khandamal (Phulbani)	Block 3 Phirangia (strong)	AWC 3 Gerupada
		Block 4 Tikabali (average)	AWC 4 Gohana
State 3: Uttar Pradesh (less than optimal)	District 3 Rae Bareli	Block 5 Maharajgunj (strong)	AWC 5 Hardoi
		Block 6 Jagatpur (average)	AWC 6 Poorav Gaon 1
State 4: Rajasthan (less than optimal)	District 4 Pali	Block 7 Bali (strong)	AWC 7 Chimunpura
		Block 8 Sojat (average)	AWC 8 Karmawas I

b. Data Collection: Semi-structured Interviews and Focus Group Discussions

Semi-structured interviews were conducted with a wide range of respondents. The respondents included the key stakeholders within the ICDS system at the block, sector, and community levels. ANMs were also interviewed. Focus group discussions (FGDs) were conducted separately with supervisors and mothers. In the FGDs with mothers, some of the participants’ children were ICDS beneficiaries at present, and some were previously. The team attempted to select beneficiaries who were currently pregnant or had a younger child (less than 18 months),

and who also had another older child (3-5 years), so they could discuss ICDS services across time. Each respondent was administered informed consent translated into their local language (See Appendix 3). Verbal informed consent was obtained from illiterate respondents. The interviews and FGDs began by asking about the strategies each respondent uses to ensure inclusion, appropriate supervision, and specific behavior change. If the relevant tool was not mentioned, probing questions were asked to ascertain their understanding and use of the tool. There was a fair amount of overlap in the questions asked to each of the different respondents in order to understand their perspective on both the approaches and specific tools. This integrated approach to understanding each tool and approach from multiple perspectives provides a rich foundation for describing the ways in which the tools support the program approaches. The interview and FGD guides are included in the Appendices 4-13.

Before data collection, some of the more critical instruments were pilot tested in a CARE-supported ICDS block in the Ghaziabad district of UP. The home visit interview guides and FGD guide for beneficiaries were not pilot-tested due to time constraints and availability of respondents. Nominal changes were made to the structure and order of the questions in the interview guides based on the results; no substantive technical content revisions were needed. Table 4 summarizes the number of people interviewed in each site according to the respondent category.

Table 4: Summary of Total Persons Interviewed according to Respondent Category										
	CARE DT	CDPO	NGO	AWW	Supervisor Individual	Supervisor FGD	Home Visits	Change Agents	Beneficiary FGD	ANM
Block 1 Madhira Andhra Pradesh	1	1	1	1	1	1	3	4	1	1
Block 2 Kothagudem Andhra Pradesh		1	2	1	1	1	3	2	1	Holiday
Block 3 Phiringia, Orissa	1	1	3	1	1	1	3	4	1	Not available (na) ⁷
Block 4 Tikabali, Orissa		1	2	1	1	1	3	4	1	1
Block 5 Maharajgunj Uttar Pradesh	1	1	1	1	1	1	2	2	1	1
Block 6 Jagatpur Uttar Pradesh		1	1	1	1	1	1	3	1	1
Block 7 Bali, Rajasthan	1	1 ⁸	3	1	No time	1	2	na	1	No time
Block 8 Sojat, Rajasthan		1	1	2	1	No time	1	3	1	1
Total Respondents	4	8	15	8	6	8	20	20	8	5

⁷ ANM post vacant and male worker was on leave

⁸ CDPO was unable to complete the entire interview due to unanticipated, pressing commitments.

c. Coding and Analysis

The content of the interviews was translated into English and transcribed into MS Word documents. In turn, these Word documents were imported into a qualitative software program (QSR Nudist ®) for coding purposes. The study team devised a coding structure based on the sub-questions related to each research question. For the most part a variable was assigned for each sub-question, and after coding commenced some additional variables were created.

One study team member was responsible for coding all the transcriptions and organized them into four data sets: HV Diary, Supervisor's Checklist, Sector Meetings and Change Agents. Each data set was comprised of numerous files—a file was a specific variable. Study team members then analyzed the data sets and their respective variables, identifying recurring themes and trends. Each transcription quote or passage was identified according to the individual respondent so the reviewer knew exactly who made each statement. To protect the confidentiality of the respondents, this report will not identify the sources of data presented. In addition, notations were made for variables that were over or under-represented by a district. Follow-up discussions ensued with the respective team members who visited these sites to confirm the recorded text. When necessary, the raw data were used as a reference when questions arose from the coded data files.

V. Limitations of the Assessment

It is important to recognize the limitations of this assessment. The assessment was intended to provide some programmatic recommendations for future use, adaptations, and replication of the tools and approaches. The assessment was not intended to document impact or outcomes attributable to specific program tools or the Change Agent strategy. This assessment is a qualitative study that describes the context of the program implementation in an attempt to highlight critical issues. As described in the methodology, a purposive sampling approach was used in an attempt to capture the diversity of experiences in implementing the identified tools and the Change Agent strategy. Within the sampling approach, there was an explicit bias to sample stronger districts so that the research team could observe the use and adaptations of the tools. With these data, one cannot make generalizations about the whole INHP area but rather can highlight common themes, challenges, and innovations that have implications for future use of the tools, as well as implications for the ASHA workers based on the Change Agent experience.

Another limitation related to purposively selecting strong sites is that the study results cannot inform about which tools could be used effectively within weaker systems, or those without strong CARE interventions. There may be cases where the tools and Change Agent strategy are being effectively implemented despite all odds (e.g., under poor district management), but this study design does not allow for review of those situations.

This study does not assess the broader program approaches themselves but only the *contribution these specific tools and Change Agents have had on the three INHP program approaches*. The reader should curb the propensity to further extrapolate the interpretation of the findings beyond this study objective.

Attributions and associations between variables cannot be directly made. The findings should help to inform programming but should not be interpreted as a prescription for implementation.

VI. Findings

As noted in the Methodology Section of this report, the study design attempted to encapsulate variation in management support from the state level, hence the selection of higher and less than optimal CARE management states. At the same time, it was important to examine strong districts where there was a good chance of talking to stakeholders who have carefully reviewed and perhaps modified the tools, as well as have implemented the Change Agent strategy. The team selected “strong” and “average” blocks in each district. Again, the strong blocks were selected to determine how well the tools and Change Agents work in the best of conditions. These blocks were juxtaposed with “average” blocks to assess more typical situations under the best of CARE’s district management.

Once in the field, the lines differentiating types of states and blocks selected were blurred. In a couple districts, the “average” blocks were stronger than the “strong” blocks. Suffice it to say that with the exception of one block in UP, all other blocks studied were fairly strong. Thus, with the exception of this one block, the majority of the findings are representative of the best scenarios where conditions are optimal to effectively implement the tools and Change Agent strategy.

During the data analysis process, there was a natural flow to consolidate the five research questions into three main questions. Research question 4 is a reiteration of research question 1, only from the Change Agent perspective. Similarly, research question 5 directly pertains to question 3, again through the lens of Change Agents. The newly revised question 3 is explicitly about the conditions and factors that support or detract from the “effectiveness” of the tools and Change Agents. Originally, question 5 was specifically in reference to the Change Agents “ability or capacity to fulfill their roles,” which is basically a proxy for conditions that influence the Change Agents’ effectiveness. Granted, a Change Agent could be capable of fulfilling her role but still not be effective (e.g., the limitations of a Change Agent’s influence faced with intractable cultural beliefs within a family). However, there is just as much evidence collected on the conditions supporting and detracting from the Change Agent’s effectiveness, as there is to assess the conditions influencing the tools’ effectiveness. Given that backdrop, the data are presented together for the original questions 3 and 5, thus raising the level of the respective Change Agent question to be at par with the tools question.

Hence, in an effort to streamline the interpretation of the findings, the verbiage of questions 4 & 5 have been melded into the newly revised questions 1 and 3, respectively, and now are:

- 1. What are stakeholders’ perceptions of the contribution the tools and Change Agents have had on the achievement of program approaches (inclusion and tracking, supervision, and home visits)?*
- 2. What conditions and factors support or detract from the use of the tools?*
- 3. What conditions and factors support or detract from the tools’ and Change Agents’ effectiveness?*

Research question 1 relates directly to the contribution the tools and Change Agents have had on the program approaches. Therefore, the findings will be presented according to each of the three CARE INHP approaches: Tracking and Inclusion, Supervision, and Home Visits to Communicate the 3-Rs. For each of these approaches, a general description and main highlights will be summarized first. These general descriptions lend an understanding of the roles the tools play in the broader programmatic context. Following this general discussion, more specific information will be presented for each tool and Change Agents.

The focus of the discussions with the respondents naturally revolved around the ICDS program and its approaches, rather than specific tools. While it is not within the scope of this assessment to study the program approaches, respondents were not diverted from these discussions. On the contrary, the interview guide was purposely structured to open the discussion on these program approaches to see what responses emerged naturally, and if indeed, any of the tools or Change Agents were mentioned unprompted.

Because research question 2 does not relate to the Change Agent strategy, the findings for this question will be organized by tools only. The relevant variables studied include: 1) Ease of Use of the Tool which includes information on the technical capacity to use the tools, any references to training on the use of the tools, and challenges to using the tool, if mentioned, 2) Implementation of the Tools which looks at how the tools are used in the field, and 3) Adaptation of the Tools which describes local modifications.

Lastly, the findings for research question 3 are structured according to some of the cross-cutting themes studied, without disaggregating by tool or Change Agent strategy. These variables include the 1) Context or existing conditions including a discussion on external obstacles, 2) the context specific to Change Agents only, 3) Changes in Work Behaviors before and after the introduction of the tools, and 4) Limitations of the tools and Change Agent strategy. The rationale for this arrangement is that the conditions that support or detract from effectiveness are not particular to any tool. Externalities outside the control of the ICDS functionaries relate equally to all tools, and often Change Agents. Much of the discussion on changes in work behaviors were not related specifically to a particular tool, but rather to differentiate between before and after the MTR. Post MTR, the three program approaches were emphasized and the tools were rolled out as a package. The respondents did not disentangle the tools from the approaches in the way the study team did. Conversely, the discussion of limitations does lend itself to distinct discussions for each tool and the Change Agents.

a. Research Question 1: What are stakeholders' perceptions of the contribution the tools and Change Agents have had on the achievement of program approaches?

i. Tracking and Inclusion of Services

Tracking and inclusion of services was a topic that respondents spoke about at length. Clearly, CARE's message has been sent to the ICDS functionaries to target the hard-to-reach, and follow up with the beneficiaries already registered. Tracking is interpreted by CARE staff and ICDS functionaries to mean following beneficiaries to be sure that they take advantage of the ICDS services, primarily the THR and the immunizations on NHD. Inclusion is a term loosely used to

assure that every family in a village is listed in the survey register—to allow the AWW a ready reference of all the beneficiaries under her purview. It was not within the scope of this study to assess the degree to which tracking and inclusion is actually occurring, but rather to analyze how the tools and Change Agents improved tracking and inclusion, if at all.

With the exception of one block in UP, there were consistent responses from ICDS functionaries, CARE DTs, and NGOs that exclusion is less of a problem than it had been in the past. The respondents spoke of an array of measures to assess and improve coverage levels. Briefly, the survey register and the immunization register are the tools cited as the means for implementing this program approach. The four tools under review in this assessment were not spontaneously mentioned during these discussions, and when prompted by the interviewers, the respondents had little to say other than to refer back to the survey and immunization registers. Tracking and inclusion is an important agenda item during sector meetings, although respondents did not elaborate much on this point except in the instances where health department staff, namely ANMs, join the meetings. Many respondents (AWWs, ANMs, and supervisors) spoke of AWWs comparing their immunization denominators with the ANM's denominators. Both parties are sharing information on new births and pregnant women, and updating their registers accordingly.

An important function of the Change Agent was to “fetch and carry” people from home to the AWC on NHDs. Change Agents increased their emphasis on the follow-up of immunization drop-outs. In addition, they encouraged, and often succeeded at, early registration of pregnant women. As one Change Agent said, *“We are still finding out about pregnant women. Whenever we go to work, we ask. We are friends with everyone.”*

Home Visit Diary—Irrespective of the degree of inclusion and tracking occurring, the HV Diary is not mentioned when respondents relayed the various mechanisms used to track drop-outs and include left-outs. The initial inputs for the HV Diary originate from the household survey register and new names are added as children are born and new pregnant women present themselves (except for daughters who are temporarily in the village to give birth at their mothers' homes). Even the most updated HV Diary would not be the main reference to assure that inclusion and tracking are happening—this occurs through other registers as mentioned above. Yet, this is not how the tool was intended to work nor has it evolved in the field to serve this purpose. The HV Diary is a job aid and therefore does not function as a complete registry.

It is important to distinguish the HV Diary from the actual act of conducting a home visit. AWWs learn about new people in the village while conducting home visits but the HV Diary alone has no influence on whether people receive ICDS outreach services.

Supervisor's Checklist—The Supervisor's Checklist is squarely focused on home visits, mirroring the key messages to be given during the critical time periods as found in the HV Diary. This tool provides no specific guidance on how to track or include beneficiaries. Nevertheless, supervisors who do conduct home visits might learn through the community about people the AWW has not yet reached. This is the main external resource and cross-check a supervisor has to understand issues beyond the AWC walls. Otherwise, the supervisors are dependent upon the AWW and her registers. As reported by a few AWWs and supervisors independently, some

supervisors will do rough calculations of the number of births and pregnancies they would expect in a village of a certain population size. They will question the AWWs when they see numbers falling below those estimates. Any efforts to monitor tracking and inclusion on the part of the supervisor are done on her own accord; neither the original version of the Checklist nor any of its adaptations provides input on this program approach.

Sector Meetings—Sector meetings sometimes touch on the issues of tracking and inclusion, though this does not seem to be a priority issue for most people. In general, most ICDS respondents felt that no one was left out of the annual survey done by the AWW. This survey (with updates every three to six months) serves as the denominator for coverage rates and is intended to capture every household in the catchment area. As mentioned earlier, sometimes this area coincides with the ANM catchment area but this is the exception rather than the rule. With the exception of several respondents in UP, there was no acknowledgement that some households or individuals might be left out of the annual survey. As a result, tracking and inclusion were not reported to be a big problem by most ICDS respondents and therefore not a high priority sector meeting agenda item.

Change Agents— One of the premises of the Change Agent strategy is that Change Agents would come from all sections of the community and hence facilitate the tracking and inclusion of pregnant women and young children for services. Change Agents were sometimes described as the “eyes and ears” of the AWW throughout the community. In some areas, the social maps were used to select Change Agents from each section of the community and ensure that everyone was covered. In UP, respondents acknowledged that it was often difficult to recruit Change Agents from the Scheduled Caste (SC) community “*because they have no time*”. That is, because members of SC are often the poorest families and work as day laborers, they do not have time to do volunteer work.

In all the areas visited, respondents reported that Change Agents made an important contribution by facilitating the early registration of pregnant women. One AWW told the team that women in her village will not disclose their pregnancies before 5 months and they do not come to the center to inform her. In this community, the Change Agent has been a good resource to capture newly pregnant women: “*Another source is the Change Agent; they meet the women at a variety of locales, such as while fetching water. She will go to the family and start probing about any new news in the family or any happiness. She will ask women about their last menstrual period as well.*”

Change Agents do not maintain or review any sort of records or registers, and would have no knowledge if a particular household was left out. Yet one AWW recounted a “tagging exercise” that helps link the habitations located on the outskirts of a village to the AWC to ensure inclusion.

Another one of Change Agents’ major contributions was to visit the homes of drop-outs and those due to be immunized around the time of the NHD and motivate them to come to the AWC. In many settings, the Change Agents would remind women a few days prior to the NHD to return for vaccination. The Change Agents were often vocal and articulate women who used all means to bring people to be immunized. As one Change Agent described:

“No one gets left out. Sometimes people refuse to take polio and we try to convince them. But there is no problem for the other immunizations, where would they go?”
[Implying the Change Agents would track them down wherever they are.]

To recap, ICDS functionaries, CARE DTs and NGOs overwhelmingly do not view exclusion as much of a problem anymore. The survey register and immunization register are the tools cited as the means for implementing this program approach.

ii. Strengthening Supervision

In regard to supervision, the ICDS program has the distinct advantage of having a cadre of professionals devoted to this objective. The primary function of the supervisors is to conduct site visits to AWCs under their purview to assure smooth implementation of the ICDS program. CARE/India identified the supervisors as being central to the success of their program objectives, and accordingly placed a good deal of emphasis on this post-MTR approach. Local NGOs were contracted to support supervisors, working hand-in-hand and walking them through processes and interventions. At times, NGO representatives were functioning in place of supervisors. As a complement to this intense technical assistance effort, all of the tools studied have the potential to contribute to strengthening supervision of AWCs, some more explicitly than others. As for the Change Agents’ contributions, it is not within their purview to facilitate supervision.

Home Visit Diary—The HV Diary was designed to be a job aid for the AWW to enhance her capacity to deliver the appropriate messages to beneficiaries. Many supervisors take advantage of information contained within this Diary and re-visit homes to assess the content and quality of the AWW’s home visits. Before this Diary was developed, the supervisors relied directly on inputs from within the walls of the AWCs to monitor AWW performance. Now some supervisors are optimizing the content found in the HV Diary to give them a way to objectively confirm the AWW’s ability to implement the 3Rs.

Supervisor’s Checklist—The Supervisor’s Checklist is designed expressly to guide the interaction between the supervisor and the AWW during a site visit. The original version of this tool was presented in the form of a job aid and was narrowly focused on the content of home visits. In many ways, it is the mirror image of the HV Diary allowing the supervisor to extract into her Checklist the names of beneficiaries who are not following the advised practices. Yet the Checklist could have direct significance for monitoring AWC performance beyond AWW home visits. Not surprisingly, one of the adaptations of this Checklist (Pali, Rajasthan’s modified Supervisor’s Checklist) evolved into a more comprehensive reporting mechanism that covers much more than just home visits.

In two districts, Pali and Khamman, these Supervisor’s Checklists are reviewed by the CDPOs and perform a dual supervisory function. In Pali, the Checklists are required reporting and in Khamman, it is not required to report but the CDPOs are reviewing them *ad hoc*. At the very least, the modified Checklists give the CDPOs information on how well supervisors are canvassing their respective sectors, and it informs them which AWCs received a visit in the past month. At best, the Pali Checklist has been revised to encompass immunization coverage, malnutrition status, hygiene and sanitation, pre-school enrolment and attendance, supplies, status

of the information systems (reports and records) and an action plan, all in addition to the HV Diary observations. The original is handed over to the CDPO and the supervisor retains two carbon copies for herself and the AWW. All visits are recorded in chronological order in a notepad.

More generally speaking, however, the contributions the Supervisor's Checklist has had on strengthening supervision of the AWW is primarily by acting as a catalyst for more quality time for the supervisor to interact with the AWW. The process of going through each of the technical points delineated in the Checklist reveals the depth to which the AWW understands the 3Rs. This focused time discussing technical points one by one is appreciated by both the AWWs and the supervisors—this is when performance is assessed, constructive feedback is provided, and rapport is built.

Sector Meeting Guidelines⁹--The purpose of the sector meetings is to communicate program content to the AWWs at scale. While the proposed Sector Meeting Guidelines do not overtly refer to opportunities for supervision, there clearly are implications for supervision of AWWs in this group setting. One of the two sector meeting sessions is devoted to record review of all the registers completed by the AWW. During this session, the supervisor corrects errors in reporting and counsels accordingly. In an informal, unstructured way, supervisors are taking advantage of the sector meeting forum to monitor AWW performance. Nevertheless, the Sector Meeting Guidelines do not directly address this opportunity for strengthening supervision.

The relationship between the AWW and her supervisor has been strengthened by the invigorated sector meetings. Through the sector meetings, the supervisor has an opportunity to be seen not only as someone who reviews registers, but as someone who can facilitate peer learning and actively help to solve problems. During the sector meetings, the supervisors interact with AWWs as a group and often meet with them individually as well. Combined with the Supervisor's Checklist, the sector meeting has strengthened the connections supervisors have with AWWs and local communities. According to one CDPO:

“The new approach [...] gives them immediate satisfaction because now they are more involved with the field activities because they can see the changes first hand at the village level. Now they are helping the AWWs get their work done; even they have developed rapport with the community—before they weren't in touch with the communities.”

In some areas, the sector meetings provide a focus for communication between the CDPO and the supervisors. Some CDPOs attend the sector meetings and find it a useful way to learn what is happening in the different sectors. In some blocks, the supervisors meet with the CDPO the day before the sector meeting to plan the agenda together.

The Change Agents were not expected to have an influence on strengthening supervision of the ICDS program. This is consistent with the data gleaned from the field visits in this study. The Change Agents themselves were not expected to be supervised because they are unpaid

⁹ From this point forward, the two tools related to sector meetings—“Tool for Conducting Sector Meetings” and “Tool for Facilitating Sector Meetings” will be collectively referred to as “Sector Meeting Guidelines”.

volunteers who blended their contributions into their daily lives and work. But they were to receive support from the AWWs as AWWs were their main link within the ICDS system. As the emphasis from CARE/India headquarters waned for the Change Agent strategy, correspondingly attention at the village level declined as well. Some Change Agents took the decreased involvement/interest of the AWW in their contributions as a signal that their role was no longer needed. The absence of a systematic communication channel between the AWW and Change Agent impaired the flow of feedback and joint planning and may be part of why the Change Agent strategy did not show sustained impact over time.

iii. Home Visits to Communicate the 3-R's: Right message to the Right person at the Right time

The thrust of the HV Diary and the Supervisor's Checklist is to improve communication of the right message at the right time to the right person. Home visits are the preferred communication mechanism for the 3Rs. These two tools do contribute to this program approach. Change Agents support this program approach also, by mobilizing beneficiaries with a special emphasis on tracking drop-outs.

Over and over again in the transcripts, the ICDS functionalities talk about the 3Rs. A quote such as the following from an AWW reverberated across all sites: *“Earlier I used to say everything at once [to a woman]. Now I think about who needs what advice at what time. I know which homes to visit... [the HV Diary] helps me know where I need to go and where I have already visited... Earlier we didn't know what to say to mothers. Now we know.”*

In a beneficiary FGD at the same site quoted above, an interesting discussion ensued when the group was asked what they learned from the AWW during home visits. One woman said that women learned to give their newborns colostrum now. An older woman in the FGD rebutted that that was the wrong thing to do. At that point, 4-5 of the women teased the older woman and said *“What age are you living in? It's been a long time since you had a baby!”* A similar discussion followed in reference to delayed bathing of newborns. These women said that they hear the same messages from the AWW, the ANM, and on television. Their AWW also attends Mahila Mandal meetings where these messages were discussed. These women confirmed that the Change Agents further reinforce the same messages. By using a multi-pronged communication strategy, CARE/India and ICDS have accomplished their 3R objective.

Identifying the right message for the right woman at the right time is probably the most significant impression CARE's post-MTR efforts have made on the ICDS program. Beneficiaries with older and younger children were able to note differences in the way they cared for their children based on consistent messages coming from multiple sources.

HV Diary— The perception of the HV Diary relayed by the majority of CARE and ICDS functionalities alike is that it is used to plan whom to visit and to prioritize interventions to children less than 2 years of age. The entire focus of the HV Diary is to orient the AWW to critical time periods, and the Ready Reckoner defines what messages to give at each of those time periods. Less clearly delineated in the Diary is among all the HVs that fall within the different time periods, which ones should the AWW prioritize first. For example, should the AWW go first to a pregnant woman in her ninth month before she visits the home of a newborn

child? Respondents were probed in-depth about how they prioritize their home visits. The top responses were usually pregnant women near their due date, a recent newborn (within 1-2 days of birth), homes of six month old children to advise on complementary feeding, severely malnourished children, and drop-outs from immunization. These sub-populations are mentioned more or less in order of the priority placed by the AWWs and supervisors. In terms of the highest priority groups, there was about equal attention given to pregnant women near their EDD and recent newborns.

The HV Diary is very helpful in orienting the AWWs toward the critical time periods. It serves best as a reminder of which women need a visit. A couple AWWs said they “know” who needed to be visited because there are only a handful of beneficiaries in the priority critical time period. Just the same, the HV Diary helps all AWWs to “jog their memory.”

Following is the perspective of one CDPO: *“The tools have increased the relationship between the program participants and the functionaries—two way communication and building rapport. Revisions are not needed at this stage.”*

This quote from an AWW succinctly summarizes the main contribution of the HV Diary: *“...Helps me to know where I need to go, [who] I have already visited....Earlier we didn’t know what to say to mothers. Now we know.”*

The findings from the beneficiaries and during many of the team’s home visits corroborate the above statements. The HV Diary is an important job aid that is helpful to many, but not needed by all. It orients the AWWs to the 3Rs and serves as a mechanism for prioritizing and planning home visits.

Supervisor’s Checklist— The Supervisor’s Checklist clearly delineates the 3Rs. The AP version of the Checklist does a nice job of walking the supervisor through a decision tree to tailor the precise message needed for a particular woman. The tool provides the necessary inputs to achieve this objective. Nevertheless, the interviews raised some doubt as to whether supervisors are indeed conducting site visits (in some sites, it appeared that they were recording visits never made) and among the visits made, it was uncertain if the supervisors themselves were taking the time to use the HV Diary to prioritize the homes she should visit. These doubts were raised through the triangulation of data collected from the supervisors, the AWWs and the beneficiary FGDs. In one site, the beneficiaries in the FGD were certain they had never met the supervisor before even though she had claimed to have made recent home visits in their small village. In another site, the beneficiaries consistently recollected the supervisor had only visited once three months ago, despite the supervisor’s contrary statements. After much probing of the AWW and supervisor in one site, the interviewers determined that the same women were receiving home visits—the ones who live on the path between the AWC and the bus.

Like the HV Diary, the Checklist also provides a focal point for drawing attention to the 3Rs. Also similar to the Diary, the Checklist is a reference to revolve the supervisory visit around the content of the messages needed for particular sub-groups of beneficiaries. But neither of these tools assures the home visits are actually occurring. Unlike the evidence supporting the AWWs’ home visits, there was not much verification that the supervisors are making as many routine

home visits as anticipated. Nevertheless, both of the above tools are important adjuncts to convey the importance of the 3Rs.

Sector Meeting Guidelines—In all areas visited, respondents reported that sector meetings now focus much more on health and nutrition issues. Most AWWs come with their registers completed (a change from before) which allows more time to discuss issues they are facing. During the discussion time, most of the topics are related to communication around the three Rs with attention to specific behaviors and “convincing people” to use services.

Some supervisors (often with the NGOs) establish a theme for each month so that over the course of a few months, key topics related to the three R’s are covered. Other supervisors review the problems that came up the month before and build an agenda around those issues. The conduct of the meetings varies from place to place and by the supervisor’s own facilitation skills. Some meetings include a more didactic session on specific topics. In one state, for example, low birth weight babies were identified as a big problem based on the data from the Supervisor’s Checklists, and supervisors are promoting the identification of “weak pregnant women”. The supervisors used information, education, and communication (IEC) materials to teach the AWWs about this issue. Other meetings promote a peer learning approach where AWWs share how they have solved problems that other AWWs are facing. Some areas have made extensive use of role plays for practicing how to communicate with mothers about various issues. In the district where sectors are aligned, the Medical Officers (MOs) take the lead on capacity building.

Throughout all the reports of sector meetings relayed to the study team, the 3Rs is a given—it is the foundation from which the discussions are launched. The team found much less evidence that the Sector Meeting Guidelines *per se* explicitly contribute to the 3R approach.

Change Agents—In addition to tracking and inclusion, one of the main objectives of the Change Agent strategy was to counsel mothers and family members on specific behaviors. However, some Change Agents reported that their main responsibility was to call people for immunizations, especially during NHDs, and they did not in fact make home visits or counsel women on specific behaviors.

Many Change Agents reported their main responsibility was to “convince people” of important messages. Change Agents in a couple sites reported using the HV Diary to help them remember the key advice. Many, perhaps most, of the messages given by Change Agents related to motivating people to use a service. This included tetanus toxoid, children’s immunizations, iron tablets, or vitamin A. In many areas, Change Agents had a very active role in the polio eradication work.

Some Change Agents talked about visiting women in their homes for the specific purpose of giving advice; however most Change Agents talked about more *ad hoc* conversations when collecting water or when they saw the women in the neighborhood. Some Change Agents felt their role was not only to talk to the specific mother, but also her elders who may have more decision-making authority. *“Sometimes the daughter-in-law understood but we had to convince the mother-in-law. They listen to us because we have been trained and we meet outsiders.”*

Change Agents reported that many of the messages they gave to women were supported by messages the women received from the AWW, the hospital and other sources. One Change Agent gave the example of breastfeeding and how the hospital has been promoting exclusive breastfeeding. When this Change Agent went to talk with a mother about breastfeeding, the mother said she had heard all about it from the hospital. It is clear that the Change Agents serve as a way to reinforce messages from other channels. At the same time, the credibility and status of the Change Agent are enhanced when her messages are supported by medical staff.

In sum for Research Question 1, key points regarding contributions the tools and Change Agents have had on the achievement of each of the three program approaches are as follows:

Tracking and Inclusion of Services:

- According to most ICDS functionaries interviewed, exclusion is less of a problem than it was in the past, and the relevant tools cited for implementing this approach were overwhelmingly the survey and immunization registers, not the tools under review here.
- Change Agents do not have records or registers, but they do make critical contributions in facilitating early registration of pregnant women, as well as in visiting homes to encourage those needing vaccinations to get them done.

Strengthening Supervision:

- HV Diaries help supervisors assess AWWs' ability to implement the 3Rs.
- In the instances in which the Supervisor's Checklists were modified by sites, benefits were generated not only due to the more comprehensive nature of the Checklists, but also by improving monitoring of supervisors because CDPOs see which AWCs the supervisors visited during the past month.
- While the Sector Meeting Guidelines do not directly address supervision, the sector meetings allow supervisors to better gauge AWW performance.

Home Visits to Communicate the 3-R's

- The HV Diary is a helpful tool to ensure greater adherence to the 3Rs. It is less helpful in prioritizing visits among women at different stages of the life cycle.
- In a similar fashion, the Supervisor Checklist provides the right inputs to tailor the most appropriate messages, but does not ensure that supervisors make home visits, and considerable feedback indicated that Supervisors often did not make the visits (let alone visiting the optimal person based on the guidance of the HV Diary).

b. Research Question 2: What conditions and factors support or detract from the use of the tools?

i. Home Visit Diary

Ease of Use of the HV Diary—The HV Diary had mixed reviews on the ease of use. When asked directly, most respondents claimed the tool was user-friendly; yet throughout the interviews there were references to AWWs who needed to learn how to use the tool, and once they did, they used it correctly. Training on the use of the tool was primarily at the sector meeting venue and through reinforcement by the supervisors during their center visits. According to one NGO, about 50% of the AWWs can use the Diary effectively. Some AWWs view this Diary as an additional work burden.

The biggest barrier to the user friendliness of the HV Diary is literacy. Currently, AWWs are expected to have completed 8 years of formal education. Some of the existing AWWs are illiterate. These AWWs may pay someone else to complete the tool for them. In one site, the team saw a pictorial version of the HV Diary but there was not much information on its use. From the perspective of one CDPO, *“The diaries are easy to complete without a problem. Sixty to seventy percent [of AWWs] are using them effectively and some are making mistakes filling out the forms... [it may be] the person filling out the forms for her didn’t make the home visits and that is why there are inaccuracies. There are some people who are lazy, others understand but don’t comprehend.”*

Implementation of the HV Diary—For literate AWWs, implementation of the HV Diary is a matter of personal inclination. Because it is a job aid, there is no expectation that it be used *per se*. Simply having the HV Diary available, echoing messages from supervisors and CDPOs, seems to be sufficient to serve the purpose of a job aid. The best use of the Diary for some is as a reference material before embarking on home visits, irrespective of its use as a log to record visits.

Some AWWs are only listing dates of home visits without having actually made the visits. The interviewers looked at the HV Diary for names recorded in the two- to four-week period prior to the study team’s arrival. In two sites, the family members said the AWW had not visited them as she had recorded. In one of those sites, one of the three women interviewed by the team said that the AWW had talked to her while she passed her in the street in front of her house, but did not purposely come to her home for a visit. In five sites, there were consistent responses between the home visits recorded by the AWW and the recall of the women the team visited. Interestingly, one of the highest performing AWWs interviewed conducts home visits diligently applying the 3Rs without using the HV Diary. She was able to easily recall off the top of her head whom she visited and when, which was corroborated by the team’s home visit interviews. This AWW assimilated the 3Rs through capacity building exercises and uses her existing immunization register and an ICDS tracking bag with completed immunization card duplicates to know which visits to prioritize.

Adaptations of the HV Diary—Among the three tools, the HV Diary is most consistently applied in the original CARE version without any modification, though there is one notable variation. One block experienced a shortage of printed Diaries so the AWWs were only able to use the original version for about three months. Afterward, the AWW and the ASHA developed two registers to replace the HV Diary. One book is for pregnant women and the other is for children. There is a little overlap in the recordkeeping between the books to allow for cross-referencing a mother and her child. Immunization status has been added as a column in both books. The most important change is their decision to add a column for home visits of children during the first week of life. The AWW and ASHA divided the critical time period for the first month of life into two time periods—0-7 days and 8-30 days—to remind them to make a visit during the early neonatal period. This is quite important since the majority of neonatal deaths occur in the first week of life. In the original version, there is less emphasis placed on the first week of life. The other revisions in this adaptation did not embellish the original HV Diary but rather created duplication of effort since by repeating information recorded in the immunization diary.

ii. Supervisor's Checklist

Ease of Use of the Supervisor's Checklist—There were no complaints in reference to the Checklist's ease of use. Again, the Checklist was in concert with an overall program approach that filtered to all supervisors through CARE-contracted NGO representatives.

From the interviews, it was difficult to discern if there were specific trainings on any of the tools including the Supervisor's Checklist. Perhaps it was part of broader training agendas. However, despite direct questioning on training on the use of this tool and the HV Diary there were not consistent responses. Given the intense support of the NGO representatives, supervisors might have learned about the tool through on-going interactions and therefore they could not tease out exactly when and where they were trained on the use of the tool. In addition, the study team was not provided any instructions or guidance on how to use the Supervisor's Checklist.¹⁰ The fact that there are instructions helps explain why there was not much said regarding the Checklist's ease of use.

Implementation of the Supervisor's Checklist—By far, the most common constraint to increased use of the Supervisor's Checklist is time. In general, the Checklist is only being used on some of the AWC visits each month. The Checklist pushes the supervisor to spend a few hours at a site. When a supervisor only has time for a "flying visit", she does not have sufficient time to go through the Checklist and to make home visits. Most supervisors, NGOs, and CDPOs report that supervisors can visit 15-20 AWCs per month barring being called upon to perform external duties for other agencies. In AP, supervisors are only expected to complete the Checklist in 5-7 of the weaker sites; the remaining site visits are 'flying visits'. In other sites, it takes a supervisor between two to five months before completing all her site visits. Factoring in the array of responsibilities outside of site supervision, supervisors probably have roughly 9-12 working days to make these visits.¹¹

According to one CARE DT, *"Despite all efforts, only about 50-60% of the supervisors are using the tool qualitatively. Although at the beginning it was decided that each supervisor would make around 2-5 AWC visits, depending upon the geography, most of them are filling only one for the month and in a few cases, they complete two per month."*

CDPOs also take part in the implementation of the Supervisor's Checklist. Sporadically from site to site, CDPOs review the Supervisor's Checklists. Much of the information contained in the Checklist is more detail than a CDPO needs. But more importantly, her review generates vital discussions with supervisors. One CDPO says she uses the Checklist to monitor the performance of supervisors. She visits homes where the supervisors have already visited to ensure the correct messages were given. This is in contrast to another site where CDPO positions are vacant in 3 of the 12 blocks. This has ramifications for effective implementation of the Checklist and supervision more broadly.

¹⁰ After this report was drafted, the study team learned that there are indeed guidelines for completing the Supervisor's Checklist. They were inadvertently excluded from the CARE Toolkit. Based on the assumption there were no guidelines, the interviewers did not probe the respondents on this topic.

¹¹ This rough calculation is based on a 19 day work month. Block level meetings account for anywhere from 2-5 days and about 5 days are spent on other government drives and activities.

Another CDPO working in a block where the supervisors are using the original version of the Checklist commented: “...it is a department requirement and takes considerable amount of supervisor’s time for preparing. There is much more information that is not in the Checklist that should be covered for all the AWCs that are visited each month.”

Thus, the two central issues surrounding the use of the Supervisor’s Checklist are that it is time consuming, and that in its original format it does not capture all the needed inputs during a site visit.

Adaptations of the Supervisor’s Checklist—The AP Adaptation of the Checklist is an oversized, large fold-out that contains all the original content of the Checklist with a few additional columns. The best feature of this revision is the decision-tree format that guides the supervisor step-by-step to focus on the essentials. The AP format has space to accommodate 7 AWC visits. Supervisors prioritize which AWCs they will be visiting in the following month based on the needs identified during the sector meetings. As a result, they tend to focus in on the weakest 5-7 AWCs (they do not necessarily track the same AWCs from one month to the next). The Checklist includes some information that feeds into the sector meetings, mainly derived from the action plans. The back of the revised AP Checklist contains detailed action plans that, if used, could prove to be quite useful; however, they cannot be readily monitored over time.

As noted previously, in Pali District, Rajasthan, the supervisors modified the tool to encompass more than just home visits. This district elected to convert the Checklist into a reporting mechanism. Supervisors provide a copy to the AWW at the end of their visit so they can refer to their agreed upon action plans, among other points. The one downside of this version is the Checklists are presented chronologically in a notebook; as such, all AWCs are listed according to the date of the visit, making it very difficult to track progress over time. Nevertheless, this can be easily remedied.

Embellishing the Supervisor’s Checklist to encompass other site visit priorities for supervisors, a CDPO from another state explained:

“To avoid duplication of work and reduce the burden of preparing many time consuming reports by the supervisor, she agreed that the Checklist can include more indicators (such as pre-school education, self-help groups, milestones in pre-school education, etc.) to meet their ICDS reporting requirements. Hopefully this should save the supervisor’s time and invest the savings in using the Checklist.”

Also in Pali District, the supervisors have an additional register called the LODO Register (Left-Outs and Drop-Outs). This information is a compilation of all the household survey registers among all the AWCs a supervisor covers. While this is a distinct register unrelated to the Supervisor’s Checklist, it deserves to be highlighted here as a local tool developed for supervisors.

The supervisors feel the LODO is a useful tool to provide a back-up mechanism for tracking and including beneficiaries. Before a local CARE DT introduced this tool in August 2006, there was

no mechanism in place for supervisors to directly monitor the tracking and inclusion of beneficiaries. One of the NGO representatives commented: *“The HV Diary is being used for counselling purposes but the “LODO” register is making a difference and improving the problem of left-outs and drop-outs—this information comes forth during sector meetings. The LODO tool is effective, but there is inconsistent use by the supervisors; on average, supervisors are using this tool. If used, the tool is effective at resolving problems with tracking and inclusion.”* However, the LODO is only as good as the AWW’s household survey. If routine updates are not added by the AWW and subsequently recorded in the LODO Register, the supervisor might not be aware of the households that were never enumerated.

iii. Sector Meeting Guidelines

Ease of Use: Sector Meeting Guidelines— There is wide agreement that the content and quality of sector meetings have improved since the MTR. Interestingly, rarely did respondents refer to any particular “Sector Meeting Guidelines” *per se*, yet the objectives behind the guidelines are being met. A few supervisors, CDPOs and NGOs referred to sector meeting agendas themselves, but not the guidelines on how to prepare the agendas. This begs the question: Who used these guidelines and when? Given that NGO and BRT representatives work hand-in-hand with supervisors, it seems probable that the supervisors learned about revamping sector meeting agendas through this intense interface rather than through the guidelines since no one seemed to recollect when or where they saw the guidelines, if at all.

Implementation of the Sector Meeting Guidelines— In two districts, the completion of the agenda (an iteration of minutes) was used as a way to report on progress to the CDPO, and not as a way to prepare for the sector meeting. In another state, supervisors initially saw the tools as *“...additional work load because it forced them to go to the field, then analyze, and follow-up.”*

Little more can be said on the ease of use and implementation of these Guidelines since respondents did not recall anything more than the agendas themselves. They did not talk about the tool but more about the process of what happens at sector meetings.

Adaptations and Variations of the Sector Meeting Guidelines—No modifications or variations from the original sector meeting guidelines were observed. These guidelines were originally developed in one of the districts visited and those NGOs and supervisors seem to use them in their original format, though as a reporting mechanism to the CARE DT and CDPO, respectively; they do not use them as guidelines *per se*.

In sum for Research Question 2, key points pertaining to conditions and factors that support or detract from the use of the three tools are as follows:

Home Visit Diary:

- Poor AWW literacy is the main impediment to using (and implementing) the HV Diary, but even when literacy is not an issue, some AWWs do not use this tool effectively.
- In terms of adaptations, the original HV Diary was only diverged from in one of the blocks visited, where it was replaced with one registry for pregnant women and one for children. The most helpful adaptation was the addition of a column for home visits of children during the first week of life.

Supervisor's Checklists:

- In general, supervisors do not utilize the Checklist to its full potential primarily because of time constraints, which lead to many 'flying visits' and few supervisor home visits.
- Various adaptations of the Checklist have been made, including a decision-tree format, adding content beyond home visits, and using it as a reporting mechanism.

Sector Meeting Guidelines:

- While there is general consensus that the content and quality of sector meetings have improved since the MTR in ways suggested by CARE guidance, respondents provided little information about how they used the Sector Meeting Guidelines.

c. *Research Question 3: What conditions and factors support or detract from the tools' and Change Agents' effectiveness?*

i. Context

By design, the study team observed the implementation of the tools and Change Agent strategy in optimal circumstances. Many pre-existing conditions were in place and functioning well, thereby providing fertile ground for any tool or strategy. To generalize, most sites visited had the following supporting features:

- Regular NHDs conducted on fixed days of the month with consistent ANM attendance
- Active support from an NGO/BRT working one-on-one with supervisors
- Change Agent support, albeit nominal, though some were no longer existent
- AWW living in the same village as the AWC¹²
- ANM collaborating with AWWs to normalize registers and work with the same denominators
- Active involvement of the supervisor (who is using Checklist and visiting AWC at least every other month)
- Active incentive paid volunteer (ASHAs, Sahyogini, community health workers, etc.)
- Sector meeting agendas focused on problem identification and solutions and relevant capacity-building

All of the above factors being relatively equal, the biggest source of support for tool implementation is derived from the NGO representatives. In addition to providing direct technical assistance to the supervisors, the NGOs also have played a very large role in strengthening the sector meetings. In some areas, the NGO staff still develops the agendas for the meetings and often facilitates the meetings. In most other areas, supervisors have taken over this responsibility.

“Initially, the preparation of the sector agenda was completely an NGO role because the supervisors were in the back seat. Then the tools came out and the supervisors took the lead and the NGOs took a support role.”

While the above delineates a highly supportive environment for the ICDS functionaries interviewed in this study, there are external obstacles that affect even the best of settings. Several

¹² One AWW lived in the same village for 8 years before moving to another village 2 years ago.

external government agencies routinely tap into ICDS human resources to implement their vertical programs and external drives such as Pulse Polio and Vitamin A, among others. (There actually are roughly estimated to consume 25% of functionaries' time.) This was a very common complaint brought out in most interviews. Further exacerbating this issue, some supervisors expressed frustration that their time was not used effectively when assisting with external programs:

“Whenever we go to the drive, they force us to sit the whole day. Even though they have one hour of work for us, we cannot leave. We are not free to do our regular work because we are waiting for this one hour of instruction from higher officials. About 15 departments will sit together while we wait for our turn.”

One site did emphasize other constraints in addition to the external government programs. In that site, many of the respondents mentioned ICDS vacancies as well as geographic access as barriers to reaching all their AWCs more than bimonthly, or even once a quarter for some supervisors.

Indeed, overall there is an enabling environment for the tools to be more widely implemented, and to greater effect; nonetheless, real barriers exist as well, primarily fairly significant external governmental demands on the functionaries' time.

ii. Context Specific to Change Agents

Change Agents were introduced in the spirit of a long tradition of community health volunteers with the hope and objective of engaging communities more broadly in achieving their own health goals. The draft *Working Paper on Engaging Communities and Community Volunteers*¹³ puts the Change Agents within this historical context and lays out the broader goal of the Change Agents under INHP.

“The objective of establishing Change Agents, [under INHP] was thus to have a cadre of nutrition and health resource people at the community level, who would potentially contribute to achievement of community level behavior change outcomes of [INHP] and facilitate the community monitoring of the health and nutrition programs.”

As the emphasis from CARE/India headquarters waned for the Change Agent approach, correspondingly, attention at the local level was minimized. Some Change Agents took the decreased interest on the part of the AWW as a signal that their role was no longer needed.

The NGO staff had been one of the primary contacts for the training and recruitment of many of the Change Agents. Once this strategy was “de-emphasized”, NGO staff reported feeling that they needed to avoid the Change Agents since they had “*nothing to offer them.*” The simple lack of attention to the Change Agents was very demoralizing for many of them.

¹³ Draft working paper #S2: “Engaging Communities and Community Volunteers for Improved Health and Nutrition Outcomes”, CARE, February 2, 2007.

As the ASHA workers were being recruited, many of the Change Agents were selected. In fact, one of the motivations for becoming a Change Agent was in anticipation of improving their social status and to position themselves for professional growth. One of the CARE DTs convinced district officials about the Change Agents' contributions, which led to their recognition and support through various non-financial incentives like rewards to selected Change Agents during public functions. In another site, a Change Agent glowed with pride as she recounted her opportunity to share her contributions at a large community forum.

There was little consistency from site to site on the selection process and criteria for becoming a Change Agent. The Change Agents were selected in different ways in different areas. Even within the same site, the process and criteria were often described differently depending upon the respondent. This topic of discussion, in fact, had the least amount of triangulation among respondents within a site. In almost all settings, Change Agents were nominated first by others, and then they were approached to determine their interest—women did not step forward on their own accord to volunteer. In some areas, the Change Agents were selected by the AWW, often in consultation with the NGO staff. The usual criteria for selection included that they should live in the specific neighborhood they were covering, be able to go out of their homes and be articulate or outspoken. Other Change Agents were selected through a process of confirmation during community or Mahila Mandal meetings. Some communities used the social maps to ensure that everyone was covered by a Change Agent. In Rajasthan, the Change Agents strategy did not seem to have been fully launched because a similar statewide program of Sahyogini workers was already operating, and these workers received monetary incentives from the MHFW. Change Agents, however, were not given any monetary compensation.

The Change Agents were trained two to three times over a nine month time period (each training lasted three days). They were given a travel allowance and tea. When asked why they were motivated to do this work, most of the Change Agents talked about the joy of learning something new, and most responded that they wanted to contribute to the well-being of their community. Many of the Change Agents were active in other areas of community life, including women's groups and Panchayati Raj. A few Change Agents mentioned that they liked having outsiders visit them because it increased their status in the community.

iii. Changes in Work Behaviors

During the interviews, ICDS respondents were directly asked to compare work patterns, styles, and habits before and after the tools were introduced. The time period of mid-2005 was used, since this was when the tools were being rolled out in most states. Another way for the study team to assess changes before and after the tools were introduced was to select beneficiaries for the FGD and home visits who had at least two children—one less than 18 months and one between 3-5 years. (Pregnant women replace women without a younger child.) The interviewers asked mothers to compare the advice the AWWs gave them with their older children and with their younger child. This methodology worked well to triangulate the distinct differences pre- and post MTR noted by most stakeholders. The findings that follow on changes in work behaviors are presented according to the level of change: AWWs, supervisors, and sector meetings.

There is much support that the HV Diary and Supervisor's Checklist positively influenced the

way the AWW and supervisors do business. The triangulation of data from a variety of respondents within each site substantiated this finding. During a home visit interview, one woman recounted the differences in how the AWW's messages influenced changes in her practices between her older child and younger infant:

"... [the AWW] talked about many good things, like immunization, exclusive breastfeeding, and colostrum. With my older child I gave 'gutti' [pre-lacteal feed] and I did not get her all her immunizations. But this time, I have carefully followed all that she said to me. I have not given anything to my baby other than my milk for the first 6 months and I have taken her for all her immunizations."

Following is an excerpt from an NGO representative:

"Now they [AWWs] are giving the messages based on the need of the beneficiary, and because of this tool, the number of home visits has gone up, the beneficiaries are getting the correct messages, and the AWW checks that the practices are changing from one visit to the next. Before this register [HV Diary], the AWW would give messages on child immunizations to pregnant women. Now the quality [of the home visits] has improved and people are getting the correct messages at the correct time. Earlier she used the immunization register to make the home visits. Now they understand the need to prioritize pregnant women in their 9th month, newborns, immunization drop-outs, and the introduction of complementary feeding at six months."

Supervisors have also described distinct changes since the Supervisor's Checklist has been in use. During one FGD with supervisors, they recalled that earlier they were not able to prioritize which home to visit during their AWC visits. They were not conversant in the life cycle or how to prepare a woman for the next time period in the cycle. They feel the Checklist helps them to plan their visits better. Before, they were making home visits but were not prioritizing. The Checklist is also helpful to them to record issues that will be addressed in sector meetings.

Many of the supervisors, AWWs and some CDPOs concurred that previously the main focus of a supervisor's visit to an AWC was to check the food stocks and review the pre-school enrolment and attendance. On some occasions she might have reviewed other registers, before signing the AWC visitor book and leaving. Most of this was accomplished in between 5-30 minutes. These 'flying visits' still occur, but they are designated as such by the supervisors themselves, with the intent of having a follow-up visit when they will complete the Supervisor's Checklist and conduct home visits. These home visits take a few hours to complete and include follow-up with the AWW afterwards to provide constructive feedback.

An enthusiastic group of supervisors at one site attributed many behavior change practices at the community level to the use of the Checklist: *"Now the community is aware of the [NHD] services on a particular day....there are less pre-lacteal feeds, women are giving colostrum to their babies, they are delaying the first bath, there is improved initiation of complementary feeding after six months of exclusive breastfeeding...These are all the changes attributed to the implementation of the [modified] Supervisor's Checklist."*

There is good consensus that the content and quality of sector meetings have improved since the introduction of the Sector Meeting Guidelines, though as mentioned earlier respondents did not generally discuss use of the Guidelines themselves. After the initial changes in the focus and structure of sector meetings were established—often with and through the support of the NGOs—the supervisors were able to maintain this new method of conducting sector meetings.

Sector meetings have changed from simply a time to submit reports, to a time for capacity building; “...completely shifted from reports collection to MCH services.” Sector meetings now occur on fixed days of the month and usually run from about 10:00-11:00AM until 4:00-5:00PM. In some blocks, all the sector meetings occur on the same day, and in others, they occur across three days. Previously, late arrivals and absences were not unusual. Now they are the exception. Before, AWWs used the entire sector meeting to complete records, submitting them at the end of the meeting. Post MTR, AWWs are expected to arrive with their records already completed, and they use only half of the sector meeting time for review and corrections with the supervisors.

Some respondents felt that the sector meetings were helping a great deal with replication: “Earlier the emphasis was on the demonstration and replication sites. Now all the AWW are getting the same emphasis and focus. The sector meetings are helping to speed up replication.”

Another distinct change in work behavior since the MTR is greater coordination with the MHFW. While ANM attendance varies from place to place, it has improved in many areas. “The AWWs and ANMs are able to tally their immunization records at this meeting and discuss why some [beneficiaries] are still left out and plan ways to reach out. Since these are jointly planned, there is less chance of getting the immunization schedule cancelled.”

iv. **Limitations**

HV Diary—There are no overarching limitations to the HV Diary as a job aid. It is focused on a specific approach and the emphasis is mostly on providing guidance rather than reporting events. The main limitation is that it is most useful to literate AWWs, although illiterate AWWs can also take advantage of its input through support from others who complete the required documentation for them.

Furthermore, the Diary’s instructions seem to imply that the AWW picks a point in time when she begins to use the tool. At that juncture, she enters all the names of the currently pregnant women and then adds names as other women become pregnant. Similarly, the children are added as they are born (AWWs inferred this, but it was not explicitly written in the instructions as such). While not discussed during the interviews, this rolling registry might not work well if there are long periods of time when the Diary has not been used. During periods of decreased diligence to update the Diary, women will continue to become pregnant and babies will be born but they might not be entered into the Diary. The instructions do not anticipate and plan for inconsistent use.

Supervisor’s Checklist—The Supervisor’s Checklist attends to action planning in a superficial manner. The necessary content is contained therein, but there are loose expectations for completion. Furthermore, end-users (i.e., AWWs, supervisors, and CDPOs) under-emphasize completing it as well. Optimal use of the action plans or any other information from the

Checklist is compromised because the completed reports are not organized by AWC. In other words, if asked to see all the Checklists in the last year for a particular AWC, Pali District supervisors would have to sort through and identify that AWC among all the other centers visited. Khammam District supervisors have individual sheets that contain at most seven AWCs for a given month. And those seven AWCs are continually changing, so there is no easy way to track one center over a period of time. Also, the AP AWWs have no copies of the action plans, so they must rely on memory or their personal journals to respond accordingly. Follow-up of action plans is crucial to their utility. The current versions of the Supervisor's Checklist do not lend themselves for tracking progress over time. At best, they present monthly snapshots of the individual AWCs without any compilation of sector-wide data for effective monitoring of the tools' outputs over time.

Sector Meeting Guidelines—The following bullets list some of the limitations of the Sector Meeting Guidelines, and the sector meetings in general.

- Completing all the information in the tool takes quite a bit of the supervisor's time.
- Direct implementation of the guidelines is not necessary to induce changes in sector meeting agendas.
- The value of the sector meetings depends greatly on the facilitation skills of the supervisors.
- NGOs have been playing a very strong role in the sector meetings, which has implications for replication in non-CARE areas.
- It is important to be realistic about what written guidelines can accomplish. It is difficult for any kind of guidelines to strengthen the ability of supervisors to identify the main issues faced by the AWW they supervise and then create a space for joint problem-solving. This kind of approach is new to many supervisors and must be practiced.

Change Agents—Change Agents have the potential to encourage changes in social norms and provide critical support to the AWWs. The concept of volunteer health workers is compelling for many reasons, which is why large-scale health programs keep returning to the concept and trying to understand how it can be effective and sustainable. There is a long and challenging historical record of such efforts, to which the CARE experience has added some insights—alas, no magic bullets. Some of the limitations of the Change Agents include:

- By serving as a “link” between the community and service providers, the Change Agent was neither part of the system nor a true community representative.
- Expectations of what Change Agents can do must be in line with the fact that she is a voluntary worker with at most 1-2 hours per day.
- The effectiveness of Change Agents may be limited in very poor or marginalized areas because women from those communities rarely have time to volunteer for community work.
- Even with minimal support (2-3 short trainings), it is very difficult and expensive to implement a Change Agent strategy due to the huge numbers of people involved when the program is at scale.
- It is difficult to identify the minimum set of non-monetary incentives that would motivate and support Change Agents.
- After some time in their volunteer role, many Change Agents expected to move into a paying position (and some have become ASHAs).

- The quality of the Change Agent work and their effectiveness depend greatly on the individual women selected.

In sum for Research Question 3, key points regarding conditions and factors that support or detract from the tools' and Change Agents' effectiveness are as follows:

Context:

- There were several favorable pre-conditions in place at the observed sites, and the NGOs/BRTs have been the most critical conduit for assuring effectiveness of the tools. Their technical assistance has built up the capacity of supervisors, added rigor to the sector meetings, and ushered in the transfer of leadership to supervisors.
- The primary factor impeding effectiveness of the tools is the large amount of ICDS functionaries' time (estimated at 25% of total time) taken by non-ICDS government agencies and their various drives. Respondents at one site also pointed to ICDS vacancies and geographically remote locales as additional obstacles.

Context Specific to Change Agents:

- Waning emphasis on Change Agents in the national INHP program led to declining interest at the NGP and community level as well, and a sense among Change Agents that their contributions were not valued.
- The selection process of Change Agents varied considerably across sites.

Changes in Work Behaviors:

- There is evidence that the HV Diary contributed to more effective home visits and communication of more timely messages.
- Supervisors reported that the Supervisor's Checklist has helped them to plan AWC visits, prioritize home visits, and record issues for later discussion at sector meetings.
- The Supervisor's Checklist has also helped distinguish between more superficial "flying visits" and more comprehensive AWC visits and has helped highlight the need for the latter type of visit.
- The content and quality of sector meetings have improved significantly, with emphasis on review of records and capacity building – an important improvement over earlier meetings which were often used by AWWs to complete their records.

Limitations:

- The primary limitations of the HV Diary are the challenges illiterate AWWs face in using it, and that it is not designed to easily adjust for gaps in registering pregnant women.
- A limitation of the Supervisor's Checklist is that completed reports are not organized by AWC and thus are not conducive to tracking progress.
- The Sector Meeting Guidelines are only as effective as the extent to which the meeting implementer is a skilled facilitator. NGO/BRT representatives have played a pivotal role in transforming sector meetings to their current status, which may have implications for replication.

- Change Agents' volunteer status, positioned between the community and service providers, can be a precarious position from which to launch a far-reaching and sustainable campaign for change.

VII. Implications for ICDS Program

CARE has used a multi-pronged strategy to grapple with some of the most difficult approaches to successful implementation - tracking and inclusion, supervision, and home visits. The literature is riddled with studies of the importance of these three approaches for affecting behavior change at the village level. Changing social norms is not an easy business. However, CARE has astutely focused on approaches that, when implemented, will help improve health practices. In many of the sites, it was apparent there were community-wide behavior changes, indeed this was deliberately screened for when selecting AWCs for this assessment. While a qualitative study cannot intimate cause and effect, the extensive triangulation used in this study unveiled many recurring themes among the respondents.

In regard to implications for universal replication of these tools, the following should be taken into consideration:

- A government circular to delineate a detailed roll-out plan.
- A core group (about 10-15 members) comprised of ICDS and MHFW functionaries to support skill-building.
- Emphasis on on-going capacity building with field exposure to high performing ICDS sites.
- The role of CARE and its partner NGOs as master trainers.
- Involvement of PRIs for grassroots level supervision, especially of ASHAs.
- On-going documentation of the replication process from the onset.

a. Short-term Implications for INHP III Tools

Each of the tools has different implications for CARE's three program approaches. The main implications are presented below, organized by the three approaches.

i. Tracking and Inclusion

The HV Diary is not particularly helpful for tracking and inclusion nor should it be revised to try to accommodate this approach. Neither is the Supervisor's Checklist targeted at improving tracking and inclusion. However, the LODO register developed in Pali District is explicitly developed for this purpose and should be further scrutinized to determine its relevance for replication.

Of the three tools, the Sector Meeting Guidelines has the most potential for addressing tracking and inclusion head-on. One clear way this can be accomplished is through convergence when ICDS and MHFW functionaries meet to compare and jointly identify left-outs and drop-outs. Cross-fertilization between the two GOI departments is more likely to succeed if the invitees (e.g. ANMs and MOs) see the space for creative engagement at sector meetings. The revamped sector meeting agendas reduce time wasters, thereby freeing up quality time for capacity building and information sharing. In essence, the revised sector meeting agendas serve as a precondition to set the stage for convergence; otherwise, the MHFW would have little interest attending ICDS meetings that follow the old agendas. But the central issue surrounding these Guidelines is their ability to be used by the field as a guide rather than as a template for agendas.

ii. Strengthening Supervision

While not an explicit purpose of the HV Diary, this tool can contribute to strengthening supervision. For AWWs who use the Diary to record the dates of their visits, their supervisors can see if home visits are being prioritized according to the critical time periods. In addition, supervisors can re-visit the homes recorded to cross-check the ability of the AWW to communicate her messages to mothers. While it is important for the supervisor to make home visits to beneficiaries who are dropping out, she can also take advantage of the tool to periodically confirm that the AWW is making successful home visits.

The Supervisor's Checklist could be improved to also become a tool for CDPOs to check on the quality of supervision visits. At a minimum, the Checklist indicates where the supervisors are likely to have made more thorough visits, as opposed to a "flying visits". Currently, the CDPOs are using the Checklists informally to gauge supervisor's performance. The Pali District example in Rajasthan deliberately formalized this process and is a good model to work from.

Given that respondents did not reference the Sector Meeting Guidelines during the interviews, it is unlikely that they were imperative to strengthening supervision. Nonetheless, individual and group supervision is continuing to happen during sector meetings. More attention could be given on "how" to supervise (i.e., providing positive feedback, constructive and confidential criticism, etc.) and how to optimize the sector meeting as a forum for supervision.

iii. Home Visits to Deliver the 3Rs

The HV Diary and the Supervisor's Checklist are precisely focused on the 3R approach and have served this purpose well. The next step is to strengthen IPC skills as requested by some AWWs and supervisors. Currently, the AWWs confidently grasp the content of the concrete messages they are supposed to deliver. They need to better develop the ability to tailor *how* messages are communicated in an array of scenarios and vary the means by which they communicate the messages. For example, AWWs want to learn to better judge the optimum time to intervene; how to build rapport and trust; how to know when to curtail a visit; how to cast the same messages in a variety of ways, etc.

To a lesser extent, the Sector Meeting Guidelines have contributed to home visits. Agendas do entail case studies and peer-to-peer training, at which times experiences from home visits are shared. Thus, if and when used, the Guidelines lay the groundwork for supervisors and AWWs to build upon the input gleaned from home visits.

b. Lessons from Change Agents for ASHAs

The National Rural Health Mission has begun to recruit and train ASHA workers at the community level. There are many lessons to be learned from the experience with Change Agents that are relevant to ASHA workers.

Contributions of Change Agents:

Many Change Agents are making important contributions to the INHP program, despite the "de-emphasis". ASHA workers have the potential to make similar contributions. The contributions and benefits identified by this assessment include:

- Change Agents often focus their messages and attention on “secondary target audiences”, such as mothers-in-law and elders.
- Change Agents facilitate the flow of information among community members, and to and from the AWW.
- Change Agents serve as an additional communication channel that reinforces other channels. This reinforcement also furthers the credibility of the Change Agent when they agree with or can explain information coming from a highly credible source, such as a physician or a radio show.
- There is some evidence that, by having several Change Agents, the AWWs, and the ANMs, all giving consistent messages in the same community, social norms are beginning to change.
- Change Agents were highly motivated by low-cost inputs such as a couple three-day trainings, and visits and recognition by “outsiders” such as the ICDS supervisor.
- Change Agents were often not very highly educated but many were some of the most active women in the community, with strong connections throughout the community and excellent verbal communication skills.
- Despite the decline in support and attention, many Change Agents report that they continue to do the same work both in linking people to services and in promoting specific behaviors.

Issues to consider for the ASHA program:

Note that many of the implications for ASHA workers have been written up very well in the “*Working Paper on Engaging Communities and Community Volunteers for Improved Health and Nutrition Outcomes*”. Some issues that were highlighted by the results of this assessment include:

- It will be important to promote a “team approach” with the AWW and any other community volunteers. It would be very detrimental to everyone if the incentives were structured in such a way that these two people competed against each other.
- With the educational requirements, it is unlikely that many ASHA workers will come from marginalized groups, hence special efforts must be made to meet their needs.
- Social recognition is a strong motivator for volunteers. Attention should be placed on non-financial incentives, such as achievement rewards, public speaking opportunities, and the like.
- Nevertheless, financial incentive is the fulcrum that directs the attention of volunteers. Activities that yield higher pay-offs may be prioritized.

VIII. Recommendations

a. General Recommendations

i. Consider the pivotal role the NGOs have had in transforming supervisors' behaviors. The supervisors have especially benefited from having NGOs assist and define new roles and responsibilities. The GOI will need to test ways for enhancing the quality of AWC site visits (i.e., through the use of newly modified Supervisor's Checklists) and the sector meeting agendas. CARE could test these approaches out now during the phase-out period. This might be accomplished through an increased focus on the CDPO, although she will not likely have the luxury to focus on the supervisors to the extent a contracted NGO has been able to. It might mean a more diluted form of individualized support for supervisors. Any new iteration of how to use external technical assistance should be tested out in the coming years before a national roll-out.

Ideally, contracting a combination of CARE staff and NGOs experienced with the CARE approaches would be an effective option for the GOI to hasten its learning curve and build upon lessons learned from other sites. But replicating the intense one-on-one support NGO representatives gave to the supervisors is most likely not a sustainable plan for the MWCD to implement and manage. Assuming funding such technical assistance is not a constraint, there also would need to be a system in place to manage this external support. The CDPO is already strapped with an array of responsibilities, and some CDPOs need management support themselves. Hence, some CDPOs might not be in a position to manage external human resources who would assist supervisors in the way the CARE NGOs have been supporting them. Given this backdrop, adjustments as to how to best use the support of the NGOs and CARE needs to be well thought-out and planned. As a start, a technical advisory board should include representation from these experienced CARE players.

ii. Develop a CDPO tool that aggregates the information from the revised Supervisor's Checklist. The existing tools are geared for supervisors and AWWs, but there are no comparable tools targeted for CDPOs that allow them to aggregate relevant inputs needed for block-wide decision making. It seems reasonable to develop a CDPO tool that extrapolates data from the Supervisor's Checklist and presents trends across all the AWCs in a block. Rather than have all the information from a revised Supervisor's Checklist reported up to the district level (which would not likely be used beyond the CDPO) there should be a streamlined system for consolidating the most important problems and plans needed at the block level. The CDPO in turn, would report-up only information that requires decision-making at the district level. Again, this information should be in consideration of the data reported up through other registers and reports (i.e., from the Monthly Progress Reports).

iii. Distinguish between job aids and reports. A job aid should be emphasized as a reference source rather than another report or register. Records that are "reported up" to superiors are given higher priority; and at times, they are susceptible to erroneous completion because functionaries are obliged to report something to their supervisor.

- The HV Diary works best as a job aid and should not be reported-up to a superior. The

Ready Reckoner should be printed within this tool and not as a separate document. The Supervisor's Checklist might include quality control checks of home visits by visiting the homes of women recently visited by the AWW and determining if the right messages were communicated effectively

- If modified to encompass ICDS priority interventions rather than just focus on home visits, the Supervisor's Checklist could be a useful reporting mechanism to guide the CDPO about a supervisor's problematic areas.
- At best, Sector Meeting Guidelines function as references. What should be reported up are unresolved issues for the CDPO to address through coordination with other agencies. In general, information that is reported up should be limited to that which needs decisions taken at the higher level.

b. Recommendations Relevant to Supervisors

i. Broaden the scope of the Supervisor's Checklist to encompass much more than just home visits and action plans based on those visits. The content of this Checklist should be based on the overall perspective of the ICDS program priorities. Action plans should be the main outcome of this Checklist but vis-à-vis a broadened scope, not just in relation to the findings from home visits. The Pali Rajasthan version of the Supervisor's Checklist is the most comprehensive and functional of all the sites visited, and should form the starting point for the new revision. This revision should be in concert with any tool developed for CDPOs.

ii. Involve end-users in the development and field testing of revised tools. No matter what revisions are going to be made to the Supervisor's Checklist, supervisors should be involved in the design and field testing of the adapted Checklist before finalization, as was done in Pali, Rajasthan.

iii. Tracking of Supervisor's Checklists. Among the set of tools under review, the field adaptations of the Supervisor's Checklist are the most significant. Utilization of this Checklist could be optimized if each AWC site report were organized into a folder or binder that has been designated for each AWC. After each site visit, the supervisor could place the completed Checklist into its respective folder. This would allow the supervisor and her CDPO to review all the site visits made to a particular AWC across time. She could have at her fingertips the action plans recorded on the previous visits to help her streamline the focus of her upcoming visit.

iv. Reconcile the Supervisor's Checklist within the ICDS reporting system. Beyond the basic organization of the Checklists into the designated folders per AWC, the Supervisor's Checklist needs to be reconciled with the information reported in the Monthly Progress Report to assure there is no duplication in efforts. Apparently, there was an extensive review of all the AWC reports conducted in Chhattisgarh in the recent past. There were roughly 18-24 records and registers reviewed with an attention to duplication of reporting. The results of that study should be reviewed in light of the findings of this assessment to assure that a revised Supervisor's Checklist corresponds with other required reports. For example, there is an ICDS report called the "Monthly Allowance Report". It appears that the content of that report could be subsumed into the Supervisor's Checklist.

v. **The Supervisor’s Checklist should be modified to include a careful review of the accuracy of the household survey register and the immunization register.** The survey register should not be taken on blind faith. While an AWW might assure you that everyone is indeed covered, there may be far off hamlets or sub-populations which have failed to be enumerated. Equally important is the diligence with which the AWW keeps these surveys updated on a quarterly basis. In addition, supervisors should assess if there are people left out or who dropped out from services and attempt to get at the root causes while conducting home visits.

vi. **Sector Meeting Guidelines should be revisited in light of decreased NGO support of supervisors.** With decreased technical assistance from the NGOs, the importance of the sector meeting guidelines might become more apparent. A useful output from the sector meetings are simplified action plans for each AWC that include problem identification, possible solutions, person responsible for follow-up, and description of resolutions. More attention to the process of developing action plans is warranted.

vii. **Develop a systematic reporting method to account for daughters-in-law who leave villages during the most critical time periods in the life cycle** (i.e., around seven months pregnant, returning approximately six weeks postpartum). Immunization cards might be one alternative, but a backup reporting system is needed for women who lose or do not carry their cards.

viii. **Systematize guidance on care for pregnant women who deliver in their parents’ villages.** Sector meetings should raise the topic of reaching women and newborns during the most critical of all time periods—birth and the first weeks of life—to transmit clear guidance on how to identify and provide services for these beneficiaries while they are away from home.

c. Recommendations Relevant to Anganwadi Workers

i. **Guidance on improving IPC skills of AWWs.** The HV Diary does a superb job detailing the content of the key messages included, when to give it, and to whom. However, there is no guidance in this tool on how to communicate these messages. Communication skills appear to be covered in some of the sector meetings through a positive deviance approach, but it would be helpful to reinforce IPC skill-building by including such guidance in the Ready Reckoner.

ii. **The HV Diary instructions need to be revisited** so AWWs are clear about whom to enter into the register and when. The instructions should take into account potential lapses of time when the Diary is not being updated. Even though it is recommended to routinely use the HV Diary without any lapses, in practice use might be inconsistent due to extenuating circumstances.

iii. **Consider adding another critical time period for the first week of life.** It would be useful to break down the critical time period for 0-30 days into two columns: 0-7

days and 8-30 days. This might increase the chance that the AWWs visit newborns during the most crucial weeks in the first month of life.

iv. **The HV Diary should not be adapted to serve the function of Tracking and Inclusion.** For the HV Diary to aid in tracking drop-outs, it would need to include information on immunization status. Yet, since functionaries are already referring to the original source—the immunization register—modifying the HV Diary to include this information would not only be duplicative reporting, it would also introduce the chance of error each time figures are transferred from the immunization register to the Diary. Thus, the HV Diary is not an appropriate mechanism for monitoring tracking and inclusion of services.

v. **Formalize the opportunities for supervision to occur during sector meetings.** Supervision need not be limited to the AWW. When and where possible, the CDPOs can use sector meetings to supplement their supervision of supervisor performance. The latter recommendation is contingent upon the ability of the CDPO to be present at each supervisor's sector meeting within a certain time frame (e.g., quarterly).

vi. **Supervisors should use home visits to assess AWW performance.** Supervisors should continue to confirm the AWWs' ability to deliver the 3Rs by visiting homes recently visited by the AWWs. Back in the AWC, positive, constructive feedback should be given to the AWW, as some supervisors are already doing. Guidance to this effect should be included in the revised Supervisor's Checklist and reinforced through sector meetings (i.e., include supervision role plays as a suggested sector meeting agenda item in the Sector Meeting Guidelines).

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APPENDIX 1: RESEARCH QUESTIONS

RESEARCH QUESTIONS TO ASSESS PROGRAM TOOLS

1. ***What are the stakeholders' perceptions¹⁴ of the contribution the tools have had on the achievement of program objectives?***
 - a. What are the stakeholders' perceptions of the purpose of each tool?
 - b. What are the stakeholders' perceptions regarding the tools' influence on the quality of provider services (esp. AWW and ANM)?
 - c. What are the stakeholders' perceptions regarding the tools' influence on the coverage of ICDS and Health services?
 - d. What are the stakeholders' perceptions regarding the tools' influence on key systems such as training, supply chain management and information management?
 - e. Do stakeholders think that the tool has significantly contributed to program improvements? How does this vary by type of stakeholder (AWW, CDPO, etc.)?

2. ***What conditions and factors support or detract from the use of the tools?***
 - a. How easy has it been for the intended users to apply the tool and associated processes?
 - b. Where and when has the tool been used more widely?
 - c. Where and when has the tool been used less widely?
 - d. Were there specific activities or inputs that led to greater use of the tool? If so, what were they?
 - e. Were there specific activities or inputs that led to greater use of the tool? If so, what were they?
 - f. What have been the challenges and obstacles to using the tool?
 - g. Do users have sufficient technical(?) capacity to use the tool?
 - h. What, if any, aspects of the tool have limited its use?
 - i. What have been the opportunity costs of using the tool?
 - j. What modifications might be needed to the tool to enable wider use?
 - k. What local modifications have been made to the tool and why?

3. ***What conditions and factors support or detract from the effectiveness of the tools?***
 - a. What changes do functionaries perceive in their work since the introduction of the tool?
 - b. Where and under what circumstances have these changes occurred?
 - c. Where and under what circumstances have the tools been used but the changes did not occur or not occur as strongly?
 - d. What, if any, activities or inputs have helped the tool to generate these changes?
 - e. What, if any, aspects of the tool have limited how well the tool has worked?
 - f. What, if any, external obstacles (i.e. not part of the tool) have limited how well

¹⁴ The analysis will examine the perceptions according to the type of stakeholder, e.g., AWW, CDPO, etc.

- the tool has worked?
- g. What modifications might be needed in the tool to make it more effective?
 - h. To what extent has the tool helped ICDS and Health functionaries to focus on the critical interventions and critical time periods? Why or why not? [Clarification: Does “critical time periods” mean periods such as the first three days of a newborn’s life, first six months of an infants life, etc.?]

RESEARCH QUESTIONS TO ASSESS CHANGE AGENTS

4. ***What are the stakeholders’ perceptions¹⁵ of the Change Agents’ contribution toward the achievement of program objectives?***
 - a. What perceived gaps or needs in the program did the Change Agents fulfill?
 - b. What are stakeholders’ perceptions of the contribution of Change Agents to improving knowledge about maternal and child health and nutrition?
 - c. What are stakeholders’ perceptions of the contribution of Change Agents to changes in child health related behaviors?
 - d. What are stakeholders’ perceptions of the contribution of Change Agents to minimizing exclusion from services such as provision of food assistance, immunization, antenatal care, micronutrient supplements, etc.?
 - e. To what extent do stakeholders perceive Change Agents have contributed to reaching more families with information?
 - f. To what extent do stakeholders perceive Change Agents have contributed to reaching more families with services?
 - g. To what extent do stakeholders perceive Change Agents have contributed to improving the equity of service provision?

5. ***What conditions and factors support or detract from Change Agents’ ability/capacity to fulfill their roles?***
 - a. What was the role of Change Agents as perceived by the functionaries of the ICDS and Health programs?
 - b. What changes do stakeholders perceive in their own and others’ work since the introduction of Change Agents?
 - c. How did the role of change agents integrate with the functions of AWWs and ANMs?
 - d. What process was used to identify, train, and “roll out” Change Agents?
 - e. What were the mechanisms and types of ongoing support to change agents – by ICDS, the community, CARE, other NGOs?
 - f. Were the type and intensity of support provided for Change Agents appropriate? If not, what improvements could have been made?
 - g. What constraints limited the extent of support provided?

¹⁵ The analysis will examine the perceptions according to the type of stakeholder, e.g., AWW, CDPO, etc.

- h. How did the absence of financial incentives influence the performance of change agents?
- i. Where and under what circumstances did Change Agents contribute significantly to program performance and outcomes?
- j. Which outcomes?
- k. To what extent was this because of the Change Agent herself? What about the Change Agent?
- l. To what extent was this because of community support and characteristics of the community? Which characteristics?
- m. To what extent was this because of external activities and inputs? Which activities?
- n. To what extent was this because of other factors? What were they?
- o. Where and under what circumstances did Change Agents NOT contribute significantly to program performance and outcomes?
- p. To what extent was this because of the Change Agent herself? What about the Change Agent?
- q. To what extent was this because of community support and characteristics of the community? Which characteristics?
- r. To what extent was this because of external activities and inputs? Which activities?
- s. To what extent was this because of other factors? What were they?

APPENDIX 3: Informed Consent

I am part of a team that is studying how to build capacities for better health and nutrition of mothers and children. We are here to learn about the strategies and approaches used in your setting.

Please note that this is not an assessment or evaluation of your work but an exercise for developing an understanding and appreciation of your efforts.

Your name will be kept confidential among our study team members and not shared outside the team. The interview will take about one hour and your participation is completely voluntary. You are not required to participate in this interview, however, we hope you will so we can learn from your experiences. If you decide to participate and change your mind, you may stop answering questions at any time if you are not comfortable. You may also decide not to answer a particular question.

Do you want to ask me anything about this interview at this time?

By signing this form, you are agreeing that you are giving your permission to be interviewed.

Name:

Title:

District:

Block:

AWC:

Signature:

Date:

APPENDIX 4: Anganwadi Worker Interview Guide

Main Objective of the Interview: To understand her perception of the effectiveness of the HV tool to improve MCH BC, in terms of identifying women, knowing the critical time periods, and giving the right message. Also to understand her comfort level and ease of use with the tool.

Date:

Time Start:

Time Finish:

Interviewer:

Respondent Profile

Name:

Block:

AWC:

Educational qualification:

Background Information

1. How long have you been working as an AWW? How long have you been working at this AWC?
2. Do you live in the same village or operate from another village?
3. Tell me a little bit about your village. (e.g. SC, OBC, etc.)
4. According to your survey, what is the approximate population you cover? About how many pregnant women and children under 3 years are in your area according to the last survey?

Pregnant women:

Children <3:

5. Did you complete a social map of your area? Can you show it to me? [Take a picture of it.]

Tracking and Inclusion for Service Delivery

6. How do you come to know about a pregnant woman? [Use social map to probe to explore the degree of actively identifying women, rather than waiting to hear about it. Probe on women coming from other villages.]
7. How do you come to know about a newborn baby? [Use social map to probe to explore the degree of actively identifying babies, rather than waiting to hear about it. Probe on babies coming from other villages.]
8. Once you have identified a new baby or a pregnant woman, can you explain to me the whole process of what you do?
9. How do you remember who is due for a specific immunizations, or antenatal check-up?
10. What are some of the things you do to ensure that all families receive services?
11. Has the way that you try to include all families changed over the past few years? Can you describe how it has changed?
12. Are there any families in your survey area who do not come or are left out of services? How do you know that they are left out? Why do you think this is so? What do you think could be done to improve the situation?
13. Do you ever meet with the ANM? When/How often?
14. Is a NHD day is planned in your area? When? How many times has it happened in last 3 months?
15. What do you discuss when you see the ANM?

Change Agents

16. Do you have change agents in your village? If yes, how many?
17. How were they selected? [Probe who did the selection and what the criteria were.]
18. Did the Change Agents receive any training? If so, explain [Probe: Who conducted the training, for how long, was it sufficient for them to adequately perform their function?]
19. How do you see the purpose and role of the Change Agent?

20. What is the connection between your work and that of the Change Agents? Has your work changed with the addition of Change Agents? If yes, explain. What happened before the Change Agents were in this village?
21. Do you think they should be performing other roles? If yes, explain.
 - a. Are certain roles *inappropriate* for Change Agents to be performing? If yes, explain which roles and their rationale for this response.
22. What benefits do you see in having Change Agents? [Probe the following:]
 - a. Improving knowledge about maternal and child health and nutrition
 - b. Changes in child health related behaviors
 - c. Minimizing exclusion from services such as food assistance, immunization, antenatal care, IFA or vitamin A supplementation
 - d. Improving the equity of service provision
23. Who supports the Change Agents? What do you think motivates them to be active and engaged with the ICDS program?

Interpersonal Contacts for Behavior Change

24. As you have told me, a part of your duties is visiting women in their homes. Can you explain this process to me? [Walk through the process step by step]
 - a. How often and when do you usually conduct home visits?
 - b. How do you decide who you will visit each day? [Probe for specific criteria and to understand how they prioritize their visits. Which time period receives the highest priority? If she brings out the diary, skip to that part of the interview.]
 - c. Once you have decided who to visit, what do you do once you arrive? [Probe to understand how they determine what is to be discussed with a particular woman.]
 - d. Once you have decided what topics need to be covered, how do you begin the discussion? [Probe for use of the *Ask, Assess, Advise* approach rather than one-way message giving.]
 - e. How do you remember which advice to give to which women? [e.g. any tools or job aides]

Note to Interviewer: After the AWW answers this question, ask her to show you a copy of the tool she is referring to.

25. Can you describe a few recent home visits to me? (Probes: Why did you decide to visit that home? What did you discuss with the woman?)
26. Has the way that you conduct home visits changed over the past few years? Please describe.

Strengthening Supervision

27. How often does your supervisor come to visit your centre?
28. Can you describe the last time your supervisor came to visit you? [Probe the following]
- How much time spent with you at this center?
 - What did she discuss with you? [Probe to see if the supervisor asked about any difficult cases or other issues facing the AWW, what advice was given by the supervisor?]
 - Did she make a home visit together with you? Did she visit women on her own? How did you and she decide which women to visit?
 - Did she help you to solve any difficult cases or resolve any problems? Give 1-2 examples.
29. In general, what are the topics that she discusses most with you? What does she seem most interested in?
30. In the time she has been your supervisor, have you noticed any changes in her approach?

Now let's turn our attention to sector meetings. Are you familiar with sector meetings?

31. What are the purposes of the sector meetings?
32. Did you attend the last sector meeting? Can you describe everything that happened at that meeting – or the most recent one that you attended? [Probe the following]
- Who attended the sector meeting?
 - What activities were discussed?
 - Did the last sector meeting you attend help you to resolve any specific problems? Describe.
33. Have you noticed any changes in the sector meetings over the past couple years? If so, please explain. [probe the following]
- What are the benefits of these changes?

- b. Have you learned about new interventions or different ways to perform your duties?
- c. Have you developed new skills through your participation at these sector meetings?

34. If you could do anything, how would you change the way sector meetings are conducted?

Additional Questions on Specific Tools if not already Discussed

35. Are you familiar with the **home visit register**? Do you have a home visit register you can show me? [Probe the following]
- a. What is the purpose of the register?
 - b. When did you start this register?
 - c. Before this how were you recording this same information?
 - d. How did you decide on home visits before you had the register?
 - e. Can you explain to me how you use it? [Have her walk through a page on the register. Ask who will she visit today? Why that particular woman? Who will she see tomorrow? Try to assess how she is deciding on the home visits.]
 - f. Other than you, who else sees the information you enter into this register?
 - g. How does this person(s) use the information in the register; Did your supervisor or CDPO ever review this register?

36. What kind of training did you receive in the use of the home visit register?

Probe: Was this training adequate? Was anything missing? Please explain.

37. What other kinds of training have you received?

38. Have you noticed any changes in the way you do your work as a result of the register?

39. If you could change it in any way you wanted, what changes would you make in the register? Why?

Note to Interviewer: Once the AWW mentions a particular tool during the interview (i.e. the home register, the supervisor's tool, sector meeting agendas), ask the AWW to describe any significant changes due to the introduction and use of the tool. Probe them to describe the differences in their work and noticeable outcomes among their beneficiaries before and after the tool were used.

4. What are you most interested in finding out when you visit an AWC?
5. Do you usually make home visits when you visit an AWC? How do you decide which homes to visit? Give some examples.
6. *If not mentioned above, ask:* Do you use any tools or job aides when you supervise the AWW? Could we take a look at this tool and will you explain how you use it?

Probes:

- a. What is the purpose of this tool?

Note to the Interviewer: We want to determine if the Supervisor views this tool as a job aid or a registry for reporting up to her superiors.

- b. To what extent have these tools helped you to focus on the critical interventions and critical time periods? Why or why not?

Now let's turn our attention to sector meetings. We would like to learn about what happens at these meetings.

7. How do you prepare for the sector meetings and decide what issues should be covered? [Give examples from the last few sector meetings.]
8. In the past couple years, have you noticed any changes in the way sector meetings are conducted? Please explain.
9. Do you think these changes led to an increase in outreach? Are more families receiving services?
10. If you could do anything, how would you change the way sector meetings are conducted?
11. Are you familiar with this tool? [Show sector meeting tools] Do you ever use them? Can you explain to me how you use them?

Tracking and Inclusion for Service Delivery

12. Now let's talk about families who are not receiving the services they need. What are the main reasons families in your community do not come or are left out of services? What do you think could be done to improve this situation?

13. We understand the AWWs in your area using a Home Visit Diary. What is your understanding of the purpose of this diary? [Show Diary]

- a. To what extent has the tool helped the AWW to focus on the critical interventions and critical time periods? Why or why not?

14. Since the time the diary was introduced, what changes have you seen?

15. If you could change it in any way you wanted, what changes would you make in the diary? Why?

Change Agents

16. Let's switch our focus to the Change Agents. Are there or were there any Change Agents in your villages? What role do/did they serve in the community?

Probe: How do/did the Change Agents help the AWWs?

17. How did you motivate the Change Agents to create awareness in your communities?

APPENDIX 6: Sector Supervisor Interview Guide

Main Objectives of this Instrument:

- To examine the factors that contribute to the variation among AWW performance in relation to two of the program approaches—inclusion and tracking and inclusion for service delivery and home visits—from the Supervisors’ perspectives.
- Usefulness of NGOs in operationalizing the approaches (indirectly assessed through the responses; this is not directly addressed)

Date:

Time Start:

Time Finish:

Interviewer:

Respondent Profile

Name:

District:

Block:

Sectors:

AWCs:

Background Information

1. Could you tell me about your work as an ICDS supervisor? How long have you been working in a CARE-assisted area?
2. Let’s talk about any trainings you received that helped you better perform your job in the field and in the sector meetings. Did you ever get an orientation to the ICDS program?

Note to Interviewer: We are trying to ascertain if the Supervisor learned about the three program approaches and/or if she was trained on the use of the Supervisor’s tool.

Probes:

- Were there any other trainings or on-going capacity building?
- *Probe if she mentions the Supervisor’s Tool:* Was there any follow-up to this training? Please explain.

Strengthening Supervision

3. We would like to learn about your role in the ICDS program. Do you mind telling us some details about your specific responsibilities?

4. How many AWWs do you supervise?

5. How many AWCs are you able to visit each month? With so many centers to choose from, how do you choose which Centers to visit in a month?

Note to Interviewer: If she mentions “weak” Centers, ask how she determines whether a Center is weak.

6. Have you always had the same approach to supervision or have you changed over the years?

Probe: When and why did you make these changes?

7. We would like to have an idea of what happens when you visit a Center. What is the first thing you do you usually do when you arrive at Center...what else do you do?

8. What did you discuss with the AWW the last time you visited a Center?

Probes:

- What registers or other records did you look at?
- Were there any difficult cases or other issues facing the AWW? If so, what advice was given by the supervisor?

9. *If not mentioned above, ask:* Do you use any tools or job aides when you supervise the AWW? Could we take a look at this tool and will you describe it to me?

Probes: What is the purpose of this tool?

Note to the Interviewer: We want to determine if the Supervisor views this tool as a job aid or a registry for reporting up to her superiors.

10. **Now let's turn our attention to sector meetings.** We would like to learn about what happens at these meetings. Can you describe the structure and process of sector meetings, for example, how often are they conducted, how long do they last, who frequently attends, how are the agendas set, etc.

Probe: How do you prepare for the sector meetings and decide what issues should be covered?

11. To help us better picture what happens at a sector meeting, can you describe what issues were raised and how were they addressed? Also give us an idea roughly how many AWW/ANMs attended, was anyone else there; what topics were discussed, how much time was devoted for reporting and how much for discussions with the AWW, and so on.

Probe: Can you give me an example of a problem or issue was raised that couldn't be resolved at the meeting?

Note to Interviewer: Probe to see if there are any connections or linkages to the CDPO without being explicit.

12. In the past couple years, have you noticed any changes in the way sector meetings are conducted? Please explain.

Probe: Have these changes led to an increase in outreach? Are more families receiving services?

13. If you could do anything, how would you change the way sector meetings are conducted?

Tracking and Inclusion for Service Delivery

14. Now let's talk about families who are not receiving the services they need. What are the main reasons families in your community do not come or are left out of services?

Probe: What do you think could be done to improve this situation?

15. How do you know who needs and how many beneficiaries are there each for specific services such as immunizations, vitamin A, antenatal check-ups?

16. We understand the AWWs in your area using a Home Visit Diary. What is your understanding of the purpose of this diary?

Probe: To what extent has the tool helped the AWW to focus on the critical interventions and critical time periods? Why or why not?

17. You have the advantage of learning from a wide range of AWC experiences. Tell us something about the AWWs who use the Home Visit Diary effectively and those who do not use it very effectively. What factors or conditions contribute to use of this Diary? In other words, why are some AWW able to use the Diary well for tracking and inclusion purposes and other AWWs do not use the Diary as effectively?

Probe: What kind of capacity building you conducted for AWW for use of the register and how do you follow it up?

18. Since the time the diary was introduced, what changes have you seen?

19. If you could change it in any way you wanted, what changes would you make in the diary? Why?

Change Agents

20. Let's switch our focus to the Change Agents. Are there or were there any Change Agents in your villages? How were these Change Agents selected?

21. What role do/did they serve in the community?

Probe: How do/did the Change Agents help the AWWs?

22. Has your work changed as a result of these Change Agents?

23. What kind of training, if any, did these Change Agents receive?

24. How did you motivate the Change Agents to create awareness in your communities?

Interpersonal Contacts for Behavior Change

25. Do you ever need to make home visits or is that only the AWWs responsibility? Can you describe the last home visit you made, for example, why did you decide to visit that particular familiar and what did you discuss with the family?

Probes:

- How do you remember important advice and when to give it to the family?
- What category of beneficiary was this family

Additional Questions on Specific Tools if not already Discussed

26. Are you familiar with the **Supervisor's Tool** first developed by CARE? Do you have one that you can show me and explain to me how you use it? What is the purpose of the tool?

Probe: Other than you, who else sees the information you enter into this register and how do they use it?

27. Before you used this tool, how were you recording this same information and did that other method help you prioritize your work?

28. To what extent has the tool helped you to focus on the critical interventions and critical time periods? Why or why not?

29. If you could change it in any way you wanted, what changes would you make in this Supervisor's Tool and why?

30. Are you familiar with two tools that help you develop the agenda for Sector Meetings? Do you have any of these that we could look at together and discuss? First, what is the purpose of the tool?

Probe: Other than you, who else sees the information you enter into this register and how do they use it?

31. Before you used these tools, how did you prepare the agendas for Sector Meetings?

32. To what extent have these tools helped you to focus on the critical interventions and critical time periods? Why or why not?

33. If you could change it in any way you wanted, what changes would you make in the register? Why?

APPENDIX 7: Change Agent Interview Guide

Main Objective of the Change Agent Interview: To understand the selection, criteria, training, motivation, retention, support/supervision to sustain the interest in the right interventions/activities, including reasons for not conducting home visits.

Date:

Time Start:

Time Finish:

Interviewer:

Respondent Profile

Name:

Block:

AWC:

Background Information

1. Could you tell me about your work as a change agent? How long have you been working as a change agent?
2. How were you selected to become a Change Agent?
3. Why did you decide to become a Change Agent?
4. How do you see your role as a change agent?
Probe: Should you have more or less responsibilities? Explain
5. How much time do you spend each month on your Change Agent activities?
6. What is the approximate population you cover? About how many pregnant women and children under 3 are in your area?
7. Do you ever meet with the AWW? If so, when? What do you discuss when you see her?

Tracking and Inclusion for Service Delivery

8. How do you find out about a pregnant woman or a new baby? [Probe to explore the degree of actively identifying people, rather than waiting to hear about it.]
9. Once you have identified a new baby or a pregnant woman, can you explain to me the whole process of what you do?
10. How do you remember who is due for an immunizations, or antenatal check-ups?
11. Are there any people in your community who do not come or are left out of services? Why do you think this is so? What do you think could be done to improve the situation?
12. What are some of the things you do to ensure that everyone in your area/neighborhood comes for services?
13. What do you think has been the contribution made by change agents in this community?

Interpersonal Contacts for Behavior Change

14. As you have told me, sometimes you visit women in their homes. Can you explain this process to me? [Walk through the process step by step]
 - b. How often and when do you usually conduct home visits? How many have you conducted in the past month?
 - c. How do you decide who you will visit each day? [Probe for specific criteria and to understand how they prioritize their visits. Do you give a higher priority to newborns?]
 - d. Once you have decided who to visit, what do you do once you arrive? [Probe to understand how they determine what is to be discussed with a particular woman.]
 - e. Once you have decided what topics need to be covered, how do you begin the discussion? [Probe for use of the Ask, Assess, Advise approach rather than one-way message giving.]
 - f. How do you remember the important advice? [e.g. any job aides]
15. Can you describe a few recent home visits to me?
16. What are some of the things that make it difficult to conduct home visits?

APPENDIX 8: Beneficiary Focus Group Discussion Guide

Main Objective of the Focus Group: To understand the community perspective on the Change Agents and the benefits. To understand the community perspective on inclusion.

[The focus group should be conducted with a group of 6-8 women. Preferably select women who are either pregnant or have a child less than 18 months old and who have an older child as well between 3-5 years of age.]

Date:

Time Start:

Time Finish:

Facilitator:

Block:

AWC:

Number of participants:

Background Information

1. Ask each person about the number of children and/or month of pregnancy.

Name	# Children <3	Month of pregnancy

Interpersonal Contacts for Behavior Change

2. How does the AWW find out about a pregnant woman or a new baby? [Probe to explore the degree of actively identifying people, rather than waiting to hear about it.]

3. Has the AWW visited each of you? Can you explain to me the whole process of what you discussed with her? [Probe the following]
 - g. How often does the AWW come?
 - h. What does the AWW do when she comes?
 - i. How do you find out when specific services will be provided?
4. The AWW talks to you about lots of different things, some may be difficult for you to do and some things might be easy for you to do. Can you describe something that was hard for you to do? What happened?

Tracking and Inclusion for Service Delivery

5. How does the AWW know who needs specific services such as immunizations, vitamin A, iron folate, antenatal check-ups?
6. Are there any people in your community who do not come or are left out of services? Why do you think this is so? What do you think could be done to improve the situation?
7. What are some of the things that can be done to ensure that no one in your community is left out from the services?
8. What would make it easier to ensure no one is left out?

Change Agents

9. Are there any change agents in your community?
10. What benefits do you see in having Change Agents? [Probe the following.]
 - j. Improving knowledge about maternal and child health and nutrition
 - k. Changes in child health related behaviors
 - l. Minimizing exclusion from services such as food assistance, immunization, antenatal care, IFA or vitamin A supplementation
 - m. Improving the equity of service provision
11. What do you think has been the contribution made by change agents in this community?

Strengthening Supervision

12. Has the Supervisor ever visited you in your home?
 - n. What was the purpose of her visit/
 - o. What questions did she ask you?
 - p. What did she discuss with you?

6. We are interested in learning more about the identification and tracking of pregnant women and newborns. Thinking back in the last three month, how do you know that you are capturing all pregnant woman early enough in their pregnancies?
7. Similarly, how know that every time a child is born, he will be entered into the child register?

Note to the Interviewer: If you find good practices, probe:

Since when have you had these good practices? What do you attribute any changes from poor to good practices?

8. When is your next NHD? Who are the children that are due for immunization on that day?
9. How do these children's families know that they should come to the NHD?
10. What is the name of the AWW here in_____ (name of village)?

11. Do you ever visit her AWC? How often you usually visit the Center?
If yes: What do you do when you visit an AWC?

Probes:

- Do you or the AWW ever use social maps to identify families?
- Does the AWW ever tell you about a pregnant woman or newborn baby who was not already in your registry? If yes, how does the AWW find out about these families?

12. *Note to the Interviewer: If not already answered ask:* Does the AWW ever make home visits? Please describe what she does during these visits.

13. Does the AWW support your efforts to provide maternal and child health services such as antenatal care, immunization and vitamin A, to the families who need them? Please explain.

Probe: In what way do the AWWs help you during National Health Days?

14. How about the Change Agents? Do/did any of the Change Agents support your efforts to provide maternal and child health services to the families who need them? Please explain.

Probe: In what way do the AWWs help you during National Health Days?

15. Now let's turn our attention to **sector meetings**. Are you familiar with sector meetings?
What are the purposes of the sector meetings?

16. Did you attend the last sector meeting? Can you describe everything that happened at that meeting – or the most recent one that you attended?

Probes:

- Who attended the sector meeting?
- What activities were discussed?
- Did the last sector meeting you attend help you to resolve any specific problems? Describe.

17. Have you noticed any changes in the sector meetings over the past couple years?
If so, please explain.

Probes:

- What are the benefits of these changes?
- Have you learned about new interventions or different ways to perform your duties?
- Have you developed new skills through your participation at these sector meetings?

18. If you could do anything, how would you change the way sector meetings are conducted?

19. Have you ever been trained INHP program by CARE? Please describe.

APPENDIX 11: CDPO Interview Guide

Main Objective of this Instrument:

To determine the CDPO’s level of awareness of these tools/approaches in their block. Are they perceiving changes in sector meeting agendas? What are the key changes that have happened

Date:

Time Start:

Time Finish:

Interviewer:

Background Information

1. How long have you been working as a CDPO in this block?
2. How many Anganwadi workers and supervisors come under your supervision?
.....
3. Can you share about the relative strengths and weakness of different sector supervisors? What approaches the” good ones” are following?
4. Can you share about the approaches that have been introduced to improve the ICDS services?

Tracking and Inclusion for Service Delivery

5. How do you ensure that inclusion (explain) is happening in your areas of operation?
6. How are “left out families are actively included to receive the intended services? What are some of the approaches that you think is assisting (coming handy) your supervisors and AWWs to ensure that no one in their communities is left out from the services? Can you explain how? What used to happen in the past (before the tools were implemented)?

Interpersonal Contacts for Behavior Change

7. What do you think is the frequency of home visits by the AWWs?

How do they prioritise these visits? How do they decide what message to be communicated?
[Probe for use of the Ask, Assess, Advise approach rather than one-way message giving by the AWWs in their respective villages. How do the AWWs remember the important advice?
[e.g. any job aides]

Strengthening Supervision

8. How often do you meet your supervisors and your AWWs?

9. How often do your supervisors visit the AWWs?

10. When was the last time you met your supervisors? Can you describe what happened during that meeting?

- a. What questions did you ask from them?
- b. What registers did you look at?
- c. What did you discuss with them? [Probe to see if the CDPO is aware if supervisors asked about any difficult cases or other issues facing the AWW, what advice was given by the supervisor?]
- d. Do you know if the AWWs and Supervisors made a home visit together? Did the supervisors made any home visits on her own? How did the AWWs and Supervisors decide which women to visit?

11. When did you attend the last sector meeting? Can you describe everything that happened at that meeting?

- a. Who facilitated the meeting?
- b. Who attended the sector meeting?
- c. What are the purposes of the sector meetings?
- d. What issues came up in the last meeting? What problems were identified? How were they addressed?
- e. How do the sector meetings help you do your work?
- f. How have sector meetings changed since July 2005?
- g. What are the benefits of these changes?
- h. If you could do anything, how would you change the way sector meetings are conducted?

Additional Questions on Specific Tools if not already discussed

(note for interviewer-proceed with the questions regarding specific tools only if there is awareness/familiarity regarding the tools)

12. Are you familiar with the **home visit register** (show local version of this)?

Do you think if this tool is contributing to improved performance?

- a. Purpose of the register
- b. How does it help the AWW do her work?
- c. What makes it difficult to use the register?
- d. What makes it easier to use the register?
- e. To what extent has the tool helped the AWWs to focus on the critical interventions and critical time periods? Why or why not?
- f. How did they decide on home visits before you had the register?
- g. If you could change it in any way you wanted, what changes would you make in the register? Why?

13. Are you familiar with the **ICDS Supervisor Field Visit** tool? What do you think about this tool?

- a. Purpose of the tool
- b. How does it help the supervisors do their work?
- c. What makes it difficult to use the tools?
- d. What makes it easier to use the tools?
- e. What changes have you seen in Supervisor's field visits since the introduction of the tools?
- f. If you could change it in any way you wanted, what changes would you make in sector meetings? Why?

14. Are you familiar with the **tools for planning and holding a sector meeting**? What do you think about the tool?

- a. Purpose of the tool
- b. How does it help your team do their work?
- c. What makes it difficult to use the tools?
- d. What makes it easier to use the tools?
- e. What changes have you seen in sector meetings since the introduction of the tools?
- f. If you could change it in any way you wanted, what changes would you make in sector meetings? Why?

15. Has your team worked with any Change Agents in their communities?

How do you see their role? Their responsibilities?? Their contribution???

16. How will you ensure that some of the approaches that are being followed in your block are sustained even after you have been transferred to another location?

APPENDIX 12: NGO Interview Guide

Main Objective:

What was the NGO role in the roll out of these approaches. Operationalization of the tools and approaches?

- For the purpose of triangulation.

Date:

Time Start:

Time Finish:

Interviewer:

NGO Profile-

Name of the Organisation

Person/s interviewed-

Block covered-

Background Information

1. Could you tell me about your work related to ICDS? How long have you been performing this role?

2. Can you tell me about your impression regarding relatively good performing vs not so good sectors that fall under your area of operation?
What way some of them are better than others? (ask this to find out if inclusion, interpersonal communication etc are happening better and what is aiding this ?
Also find out if this is a recent development?)

Tracking and Inclusion for Service Delivery

3. How do you know that
 - i. all pregnant women and new babies are being identified by the AWWs proactively? (Probe to find out if this is being actively done rather than the AWWs responding to only those who turn up at the centres) and
 - ii. AWWs know who needs specific services ?(What are some of the approaches that you think is assisting (coming handy) your supervisors and AWWs to ensure that no one in their communities is left out from the services? Can you explain how? What used to happen in the past (before the tools were implemented)?

Interpersonal Contacts for Behavior Change

4. As you have told me, a part of your role is ensuring that the all ‘eligible’ women in their homes are visited by the AWWs and the AWWs are supported by the Supervisors... Can you explain this process to me? [Walk through the process step by step]
 - a. How often and when do the AWWs usually conduct home visits?
 - b. How do they decide who they will visit each day? [Probe for specific criteria and to understand how the AWWs prioritize their visits.. Do the AWWs and Supervisors give a higher priority to newborns?]
 - c. Once the AWWs have decided who to visit, what do they do once they arrive? [Probe to understand how the AWWs determine what is to be discussed with a particular woman.]
 - d. Once the AWWs have decided what topics need to be covered, how do they begin the discussion? [Probe for use of the Ask, Assess, Advise approach rather than one-way message giving by the AWWs in their respective villages. Do they too visit some homes?]
 - e. How do the AWWs remember the important advice? [e.g. any job aides]

Strengthening Supervision

5. How often do the supervisors meet the AWWs?
6. How often do the supervisors visit the AWWs?
7. How many AWCs did you (NGO) visit during the last one month?
8. How many AWCs were visited by the CDPO/ACDPO during last month?

9. Which are the AWCs that were not visited by ICDS Supervisors during the last two months? Or even by the NGOs during the same period?
10. When was the last time you met the supervisors? Can you describe what happened during that meeting?
11. Did you attend the last sector meeting? Can you describe everything that happened at that meeting?
 - a. Who facilitated the meeting?
 - b. Who attended the sector meeting?
 - c. What are the purposes of the sector meetings?
 - d. What issues came up in the last meeting? What problems were identified? How were they addressed?
 - e. How do the sector meetings help the different stakeholders do their work?
 - f. How have sector meetings changed since say, last year and a half?
 - g. What are the benefits of these changes?
 - h. If you could do anything, how would you change the way sector meetings are conducted?

Additional Questions on Specific Tools if not already Discussed

12. Are you familiar with the **home visit register** (show local version of this)? Can you explain to me how this is contributing to improved performance?
 - a. Purpose of the register
 - b. How does it help the AWW do her work?
 - c. What makes it difficult to use the register?
 - d. What makes it easier to use the register?
 - e. To what extent has the tool helped you to focus on the critical interventions and critical time periods? Why or why not?
 - f. How did the AWWs decide on home visits before you had the register?
13. Are you familiar with the **ICDS Supervisor Field Visit** tool?
 - a. Purpose of the tool
 - b. How does it help the supervisors do your work?
 - c. What makes it difficult to use the tools?
 - d. What makes it easier to use the tools?
 - e. What changes have you seen in Supervisor's field visits since the introduction of the tools?

14. Are you familiar with the **tools for planning and holding a sector meeting**?

- a. Purpose of the tool
- b. How does it help the participants do their work?
- c. What makes it difficult to use the tools?
- d. What makes it easier to use the tools?

(Before you finish the above section on individual tools explore the role of NGO in the role of tools and processes)

15. What changes have you seen in sector meetings since the introduction of the tools?

16. Has your team worked with any Change Agents in their communities?

Can you describe their selection criteria? And the process of selection? How were they trained?

What roles they played? What did they do? and what was their contribution?

How were they supported?

17. Okay, what if you ICDS has to do it in blocks where there are no NGOs. If ICDS has to do this, can you suggest better ways to change behaviors (EPI, ANC). Through the use of these tools/approaches.

Probe: How do you facilitate these meetings?

Probe: What types of inputs do you receive from the NGOs/BRTs? What do you learn from this information?

5. Are there ever joint meetings between the ICDS district and the health system staff at the district level? Describe who is at these meeting, what is discussed, how you facilitate these meetings.

[Show the tool/give them the printed one.]

Tools

CARE has developed many IEC materials, job aides and tools over the years. Let's start with the **Home Visit Register**.

6. What are your perspectives on the use and effectiveness of this Home Visit Register?

Probe: Before the AWWs used this tool, how did they prioritize their work?

Probe: Did home visits increase among the AWWs who use this tool?

7. To what extent has the tool helped the AWWs focus on the critical interventions and critical time periods?
8. Describe any changes needed in the Home Visit Register in order to help them prioritize their work so the right people get the right message at the right time?
9. Now let's turn our attention to the **Supervisor's Tool**. What are your perspectives on the use and effectiveness of these tools?

Probe: Before the supervisors used this tool, how did they prioritize their work?

10. To what extent has the tool helped the supervisors focus on the critical interventions and critical time periods?
11. Describe any changes needed in the Supervisor's Tool in order to help them prioritize their work so the right people get the right message at the right time?

12. Turn your attention now to another tool. Are you familiar with two tools that help you develop the agenda for **Sector Meetings**? What are your perspectives on the use and effectiveness of these tools?

Probes: What is the purpose of the tool?

13. How has the conduct of the sector meetings changed since the introduction of the tools? How does this vary within the district? Can you explain these variations? Why were some areas weaker and others stronger?
14. Describe any changes needed in these tools in order to keep the focus of the sector meetings on the critical interventions and critical time period.
15. The last tool we wish to discuss is the **NGO Tool for Sector Level Analysis and Planning**. What are your perspectives on the use and effectiveness of these tools?

Probes: What is the purpose of the tool?

16. Before the NGOs had this tool, how did they document and share sector-wise progress in the block to the CARE district team?
17. Describe any changes needed in this tool in order to facilitate prioritization and planning with the sector supervisors?

Change Agents

18. Let's switch our focus to the Change Agents. Are there or were there any Change Agents in your villages? How were these Change Agents selected and what criteria were used?
19. What role do/did they serve in the community?

Probe: How do/did the Change Agents help the AWWs?

20. What motivated Change Agents to do their work?

Probe: Do ICDS supervisors/AWW encourage/motivate Change Agents?

21. What kind of training, if any, did these Change Agents receive?

22. Can you talk about the amount of effort to establish and sustain these Change Agents?

Probe: How many, how well spread out, how did you manage to do such a big effort?

23. What changes are needed in the change agent strategy in order to facilitate inclusion of everyone for services?

Program Implementation

24. Now let's discuss all of these tools and Change Agents collectively for the remainder of our time together. What is your opinion regarding the use of these tools and the Change Agents to sustain INHP II approaches, namely:

- a. Strengthening Supervision
- b. Tracking and Inclusion for Service Delivery
- c. Interpersonal Contacts for Behavior Change

25. Finally, we're interested in learning the implications for universal replication of these tools and the Change Agents based on your experience. Please describe the implementation of these tools in terms of the pace and scale of the roll-out process. Feel free to use specific examples as you wish.

Probe: What might the alternatives to using a local NGO to support a national scale-up?

26. If two children, did she talk to you about each child? What did she say? Did she visit on the day of the birth for either child?

27. Did she ask you what difficulties you might have in following her advice?

28. What did you think about what she said? Do you think you would be able to follow her advice? Why or why not?

29. Did she talk to anyone else in your family about these issues? Describe.

Change Agents

30. Are there any change agents in your neighborhood? [If none, skip the rest of the questions.]
31. What is the main role of the change agents?
32. Did you have any interaction with her? If yes, describe.
33. What benefits have you seen to having change agents in your neighborhood?
34. What do you think motivates women to volunteer as change agents?