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Name of document	**Integrated Nutrition and Health Project (INHP III) Final Evaluation Report**
Full title	**Integrated Nutrition and Health Project (INHP III) Final Evaluation Report**
Acronym/PN	IND 109 – INHP
Country	India
Date of report	June 2006
Dates of project	01-01-2007 to 31-12-2010
Evaluator(s)	Judian MacNulty, Team Leader Heather Goldman Ron Waldman Rajesh Kumar Sanjay Zodpey Purnima Menon
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Scope	*Project*
Type of report	*final evaluation*
Sector(s)	Child Health and Nutrition
Brief abstract (description of project)	INHP III focused on mainstreaming and sustaining key elements of INHP I and II by the central government of India (GOI) and the governments of eight states. With a total budget of USD 41 million, and reaching approximately 15.54 million women and children in 96 districts, the scale of INHP is massive when compared to programs funded by USAID Food for Peace in other countries. INHP III has worked directly with the government at all levels from local to national to enhance their capacity to deliver services and community outreach, but did not intervene directly at the community level during this phase.
Comment	

Integrated Nutrition and Health Project (INHP III)

Title II India/CARE India Multi-Year Assistance Programs
Cooperative Agreement # FFP-A-00-07-00024-00

Final Evaluation Report

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Prepared for USAID/CARE India
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List of Acronyms

ANM	Auxiliary Nurse Midwife	MOHFW	Ministry of Health and Family Welfare
AP	Andhra Pradesh	MP	Madhya Pradesh
AWC	Anganwadi Center	NFHS	National Family Health Survey
ASHA	Accredited Social Health Activists	NGO	Non-Governmental Organization
AWW	Anganwadi Worker	NHD	Nutrition and Health Day
CA	Change Agents	NRHM	National Rural Health Mission
CDPO	Child Development Project Officer	NIPCCD	National Institute of Public Co-operation and Child Development
CG	Chhattisgarh	OR	Orissa
CSB	Corn Soya Blend	PIP	Project Implementation Plan
CIHQ	CARE India Head Quarters	PPA	Primary Program Area
DPO	District Program Officer	PRI	Panchayati Raj Institution
DFID	Department for International Development	RACHNA	Reproductive and Child Health, Nutrition and HIV/AIDS
FANTA	Food and Nutrition Technical Assistance	RA	Rajasthan
FE	Final Evaluation	RCH	Reproductive and Child Health (Program)
FFP	Food for Peace	TAG	Technical Advisory Group
GMP	Good Manufacturing Practices	UP	Uttar Pradesh
GoI	Government of India	UNICEF	United Nation Children's Education Fund
ICDS	Integrated Child Development Services Scheme	USAID	United Sates Agency for International Development
IFPRI	International Food Policy Research Institute	WB	West Bengal
IPTT	Indicators for Performance Tracking Table	WHO	World Health Organization
INHP	Integrated Nutrition and Health Project		
JH	Jharkhand		
MOHRD	Ministry of Human Resource Development		
MOWCD	Ministry of Women and Child Development		

ACKNOWLEDGMENTS

The evaluation team thanks USAID and CARE for selecting six team members with the requisite experience to undertake an evaluation of this complex and large program in three weeks. The team also particularly appreciated the input from the GOI-appointed counterparts who accompanied team members to the states. The team would especially like to acknowledge the dedication and commitment of CARE India's staff in New Delhi and in the state offices. The administrative support for the evaluation team was outstanding in every way, including the support provided to the counterparts designated by the GOI who joined the field visits. The CARE briefings were very helpful and the evaluation could not have been completed without the CARE Director and staff's unflagging energy and availability to answer questions. The team also acknowledges the efforts that ICDS staff made to meet and inform the team and to accompany team members to the far-flung areas. Finally, we acknowledge the enthusiasm of the frontline workers and local leaders, and admire their efforts to improve the lives of women and children in their communities.

"This document is made possible by the generous support of the American people through the United States Agency for International Development (USAID) and the CARE. The contents are the responsibility of the authors and do not necessarily reflect the views of USAID or the United States Government and/or CARE".

EXECUTIVE SUMMARY

In October, 2006, CARE India began a three-year phase-out after ten years of Title II funding for the Integrated Nutrition and Health Project (INHP). This final phase, called INHP III, focused on mainstreaming and sustaining key elements of INHP I and II by the central government of India (GOI) and the governments of eight states: Andhra Pradesh (AP), Orissa (OR), West Bengal (WB), Chhattisgarh (CG), Madhya Pradesh (MP), Jharkhand (JH), Uttar Pradesh (UP), and Rajasthan (RA). With a total budget of USD 41 million, and reaching approximately 15.54 million women and children in 96 districts, the scale of INHP is massive when compared to programs funded by USAID Food for Peace in other countries. Because of the sheer scale and the emphasis on sustainability, INHP III has operated very differently than many other Title II-funded programs. INHP III has worked directly with the government at all levels from local to national to enhance their capacity to deliver services and community outreach, but did not intervene directly at the community level during this phase.

Through its long-standing partnership with the Integrated Child Development Services (ICDS) of the Ministry of Women and Child Development (MoWCD), CARE strengthened operations and service delivery in village-level Anganwadi centers (AWCs) throughout a target area. ICDS greatly expanded its reach during the life of INHP III under a mandate known as universalization. When the INHP III proposal was written, CARE India anticipated impacting 94,592 AWCs in the Primary Project Areas (PPAs). Because of expansion under universalization, that number increased to 126,418 by September, 2009, in addition to those added under the replication strategy bringing the total of AWCs affected by INHP III to 234,891.

Another partner in INHP III is the Ministry of Health and Family Welfare (MoHFW), Department of Reproductive and Child Health (RCH), specifically, their National Rural Health Mission (NRHM) program which was launched in 2006. This program is responsible for maternal and child health services at the community level, and the design incorporates key elements from INHP I and II, including convergence of services with ICDS during community Nutrition and Health Days (NHDs), creation of a cadre of volunteer change agents now called Accredited Social Health Activists (ASHA), and mobilization of local NGOs and local governing bodies (Panchayat Raj Institutions or PRIs) to promote services and monitor service delivery.

During INHP III, CARE India implemented four key strategies towards achieving sustainability:

For Consolidation and Phase out from Primary Program Areas
Key strategy 1: Technical, managerial and operational support to ICDS at district and sub-district
levels in current districts
Key strategy 2: Support to strengthen mechanisms to enhance capacities and opportunities for

community leaders and organizations to hold service providers and programs accountable

For Influencing ICDS and RCH beyond Primary Program Areas
Key strategy 3: Responsive technical and operational assistance to selected states to replicate INHP approaches outside of the primary program areas
Key strategy 4: Advocacy and Sector-wide support to influence policies and larger ICDS and RCH Programs

As INHP III draws to a close, CARE commissioned an external final evaluation team (see Annex 1) to review results of large quantitative surveys and qualitative data collected as part of the final evaluation process, and to interview government staff and stakeholders in all the states. The purpose of the evaluation was to assess progress and strategies towards achieving sustainability, document lessons learned, and make recommendations on scaling-up and sustaining large and complex rural health programs. GOI officially designated counterparts to participate in the field trips (Annex 7). This report covers the evaluation findings during October and November, 2009.

Sustainability
By September 2009, INHP III phased-out support from all blocks of the Primary Program Area[1] . Half of this was accomplished in 2007, with others phased out on schedule during 2008 and 2009. CARE involved local NGOs in monitoring and in mobilizing local leaders and organizations to take on responsibility for community health actions and accountability in service delivery. CARE provided technical support to the state governments of AP and CG, in replicating proven practices from INHP I and II in all districts in which CARE had not previously been working, thus assuring complete coverage in each of these two large states. This process continues, dependent on the pace of the governments, but uptake is very positive. Additionally, CARE assisted replication of INHP practices in blocks not previously supported in districts where INHP was operational. In this way, the INHP model has been mainstreamed into an additional 303 blocks of 21 districts in AP and CG and 283 blocks (sub-districts) of 72 districts in PPAs in other states (Table 1 in report on page 16).

At the national level, key components of INHP have been mainstreamed into national programs such as the MoHFW's National Rural Health Mission, mentioned earlier. The management information system and training curricula are also being adopted at the national level. At the state level, ICDS has adopted tools, systems, planning methods, management information systems and training curricula from INHP, mandating their use in all districts. ICDS's adoption of CARE's commodity management system has enabled them to continue food distribution with minimal interruptions.

[1] Primary Program Area (PPA) refers to the blocks where INHP was being implemented at the end of the second phase, in December 2006

As in the past when CARE and USAID provided program experience for the government's Eleventh Five Year Development Plan and the new World-Bank supported phase of ICDS, CARE continues to serve on working groups and contribute to the integration of successful ICDS approaches into national policies. CARE is also a member of the National Nutrition Council which aims to coordinate and implement effective nutrition policies. One example of CARE's contributions is the evolution in ICDS service delivery policies. Now, children under two years of age and their mothers are not making daily journeys to AWCs but are receiving more attention, especially through home visits. Newborn care is provided in the home and children under two years come with their mothers on specific days to receive food and preventive health services from trained providers. CARE's involvement in revising the national training program for AWWs is assuring that INHP practices and methods are being mainstreamed into all future ICDS service delivery.

Findings and Conclusions

The evaluation team found that the intensive systems-strengthening effort during INHP III has resulted in sustainable delivery of supplemental food rations and essential health services through community-based anganwadi centers. Management and delivery of these health and nutrition interventions did converge at community and sector levels, positioning government outreach programs to tackle more complex issues in the future, such as the persistent high rates of malnutrition, in a coordinated manner. The involvement of community leaders in mobilizing at-risk populations and monitoring service delivery was increased, with elected leaders meeting regularly with frontline workers.

According to project indicators, state governments have been able to maintain or increase delivery of key services after CARE's phase-out. The fact that ten out of the seventeen service and household practice indicators show no statistically significant decline and that one indicator improved significantly, indicates that the government systems have been able to maintain many of the positive practices achieved under INHP II. In five out of the seven states surveyed, nutritional status has not significantly deteriorated in spite of adverse conditions such as drought-affected harvests, rising food prices and pockets of civil unrest. So while it is not possible for the team to definitively say which factors are responsible for one-half of children under two years of age being underweight in the summer of 2009, it is a fact that all the major surveys over the last two decades in India are indicating similar rates of child malnutrition and these rates are unacceptably high. The evaluation team unanimously concludes, therefore, that ICDS's current approach to reducing malnutrition, largely through food distribution, is not having the desired outcome, and more work is needed to find the set of cost-effective interventions needed to improve weight gain in young children. Quantitative findings and more detailed conclusions start on page 32 of the evaluation.

Recommendations

The success in converging two sectors to deliver services to target populations should be explored in other sectors that impact health and nutrition, such as rural development, water and sanitation and agriculture. Similarly, lessons from INHP's operational coordination with governments at all levels from the center to state, district, and peripheral levels, are useful in informing strategies and plans for new or reformed programs. The ICDS program, as it is now structured, has important potential to be included as a partner when USAID explores new initiatives to address hunger, health, and food security. The team believes that one way forward is to build on the partnership. The MoWCD has years of experience in developing women's participation and leadership in improving lives in their communities. The yield on any additional investment would be considerable.

The Indian government and its donor and NGO partners would benefit from adapting and expanding both successful systems and alliances developed during the INHP program, particularly at the community level. ICDS would benefit from expanding successful INHP partnerships to increase community engagement and local governance. Efforts to maintain committed central and state leadership have proven to be essential in scaling-up successful approaches from target states.

As the project winds up, existing data and resources should be used during a no-cost extension to test and understand aspects of sustainability, an issue of global importance. The replication process should be completed and lessons applied to its expansion by ICDS. Project data sets can be used to increase the quality of home visit interactions, a key component of behavior change. In addition, putting in place a small-scale effort within ICDS to better understand barriers to proper maternal and child feeding and care, dietary diversity, and improved hygiene at the household level is a high priority. This pilot effort could inform future behavior change strategies to more effectively improve nutrition on a larger scale.

INTRODUCTION AND CONTEXT OF THE FINAL EVALUATION

An external evaluation team examined the final three years of CARE's Integrated Nutrition and Health Project (INHP), designed to phase out assistance and leave sustainable systems and best practices for successfully implementing large, complex programs. CARE's thirteen year program operated as an intrinsic part of the Government of India's massive Integrated Child Development Services Scheme (ICDS). The phase-out project was originally approved for USD 37 million including food commodities and 202e funding; the latter completely covering FY 2008 and FY2009. Due to additional yield of about $2 million from monetization in 2007 and cost share from CARE of nearly half a million dollars, the total budget was USD 41.3 million. INHP III has ambitious objectives to institute sustainable improvements in government delivery of basic health and nutrition services in villages of seven states, thereby eventually improving selected health and nutrition indicators for 15.54 million pregnant women, lactating mothers and children under two years of age, including those in the replication areas.

The objectives are ambitious because of the complexity of reaching millions in diverse communities and because of the magnitude and scale of India's nutrition problem. According to the USAID-supported 2006 National Family and Health Survey (NFHS), almost one-half of India's young children are underweight for their age, affecting their health, survival and ability to learn and be productive.

Under the Ministry of Women and Child Development (MoWCD), the Indian government's flagship program to provide nutrition services for preschool children is the Integrated Child Development Services (ICDS) established in 1975. This innovative child development program is implemented by over a million community workers through a network of grassroots "anganwadi" (courtyard) centers. Supplementary feeding, vitamin A and iron/folate supplementation, nutrition counseling on maternal and child feeding practices, and growth monitoring are components along with early childhood development. Over the last 13 years, CARE has assisted ICDS in improving the delivery of supplementary food, either cooked and served at the center daily, or given in the form of take home rations. CARE has also played a central role in helping the government improve supervision and coordination between frontline health workers (ANM) and anganwadi workers (AWW) in delivering basic nutrition and health services. Recently, government attention has focused on expanding program coverage nationally. Food distribution has been a central component, often referred to by GOI and state governments as the nutrition intervention, with less effort given to changing family-based feeding and caring behaviors. Under the Eleventh Five Year Development Plan (2007-2012), GOI is planning to scale up key interventions and improve their effectiveness, budgeting over $US 1.5 billion annually for this massive outreach scheme. The ICDS budget for food in the PPAs where CARE has been working includes approximately US$ 207 million plus a state contribution, bringing the total to about US$ 3 million annually.

Purpose of Final Evaluation

Since this project caps over 57 years of USAID food assistance to India, USAID/India has asked the final evaluation team to take a longer-term perspective; but, documenting CARE's entire history in India is beyond the scope of this evaluation. USAID asked the evaluation team to focus on the sustainable impact after 13 years of CARE's INHP support and assess application for future nutrition and food security programs. USAID/India was also specifically interested in use of the large knowledge and data banks that CARE has created with USAID contributions. CARE is interested in the team's assessment of whether the processes it has developed are going in the right direction and in how to replicate and mainstream the tools, methodologies, training curricula, and community mobilization approaches that they have developed. Specifically, the team was asked to:

1. Assess INHP achievements, outcomes, and processes
2. Examine INHP strategy and efforts to sustain improvements in ICDS implementation
3. Document lessons learned
4. Make recommendations on scaling up and sustaining large and complex rural health programs

History of CARE's Food and Health Assistance in India

A brief sketch of the longstanding partnership between the Indian government, CARE and USAID follows. It is included as background to CARE's catalytic technical and operational role in assisting the evolution of a more effective and responsive national child development scheme for India's vulnerable populations. Reform and decentralization of the national scheme is constantly underway.

CARE's long-standing partnership with the Government of India

CARE and India have had a bilateral partnership since 1950 and CARE began distributing Public Law 480 Title II food commodities in 1955. Through a strong network of trained resource personnel and well-equipped state and district offices, CARE has consistently managed food assistance and grant funds for India's vulnerable populations. The assistance levels have decreased in annual values from peaks of US$1.5 billion in 1960 to $100 million in 1994 to less than $12 million annually in 2009. CARE has been a key partner in distributing food and other commodities for famine and disaster relief, as well as in school feeding through many decades. The staff generated a wealth of experience in helping the government make nineteenth century management systems more modern. In over fifty years of shipping and accounting for food commodities from America's heartland to India's ports, onto railways, and into huge warehouses and block-level "go-downs" for onward transport to some of India's most remote villages and schools, CARE's humanitarian programs have evolved.

In 1984, CARE's partnership with ICDS started with the delivery and monitoring of USAID PL480 Title II food commodities to village-based anganwadi centers. During the 1990s, USAID required results-oriented assistance. CARE phased out support to ICDS in

all of the remaining southern states in which it was still operational so that USAID resources could be concentrated in the northern states with the highest mortality rates and poorest health and nutritional status. During the last 13 years, the emphasis of Title II food assistance was also shifted from food supplementation as the primary nutrition intervention to integrating food supplementation with more targeted services likely to improve birth weights and nutrition in children under two years of age. To improve the impact of US Farm Bill assistance through ICDS, CARE initiated a ten year effort to integrate health and nutrition programming with food assistance. In 2002, with USAID India funding, CARE broadened its technical assistance role in supporting ICDS through the implementation of a USD 26 million add-on five-year reproductive, child health, and HIV/AIDs program.

In 2003, the distribution of US fortified corn-soy blend came to an end after the Indian Genetic Engineering Approval Committee disallowed its importation. This decision coincided with a decision by the Food for Peace Office (FFP) in AID to reduce its budgets significantly for India due to the competing global emergency demands for the Title II food commodities. The import of Title II edible oil ended in 2007. Title II refined soybean oil and pulses, both commodities which can be imported under open general license in India, were monetized for the last time in 2007 and the sales proceeds are helping fund INHP III.

Given CARE's competency in managing food delivery systems, State Governments requested their assistance in handling the shift to state government procurement and delivery of Indian food commodities. Over the last five years, CARE and the governments drew up new agreements within six months, with transfer of CARE's commodity management systems allowing for a successful transition to sustained delivery of supplementary food rations.

CARE's unique opportunity for long-term health assistance

The progression of three INHPs has provided both assistance to ICDS in delivering its services, and a unique opportunity for USAID and GOI to test service delivery approaches and analyze the most effective and sustainable nutrition and health interventions. The three projects have reached around 266 million women and children since 1995.

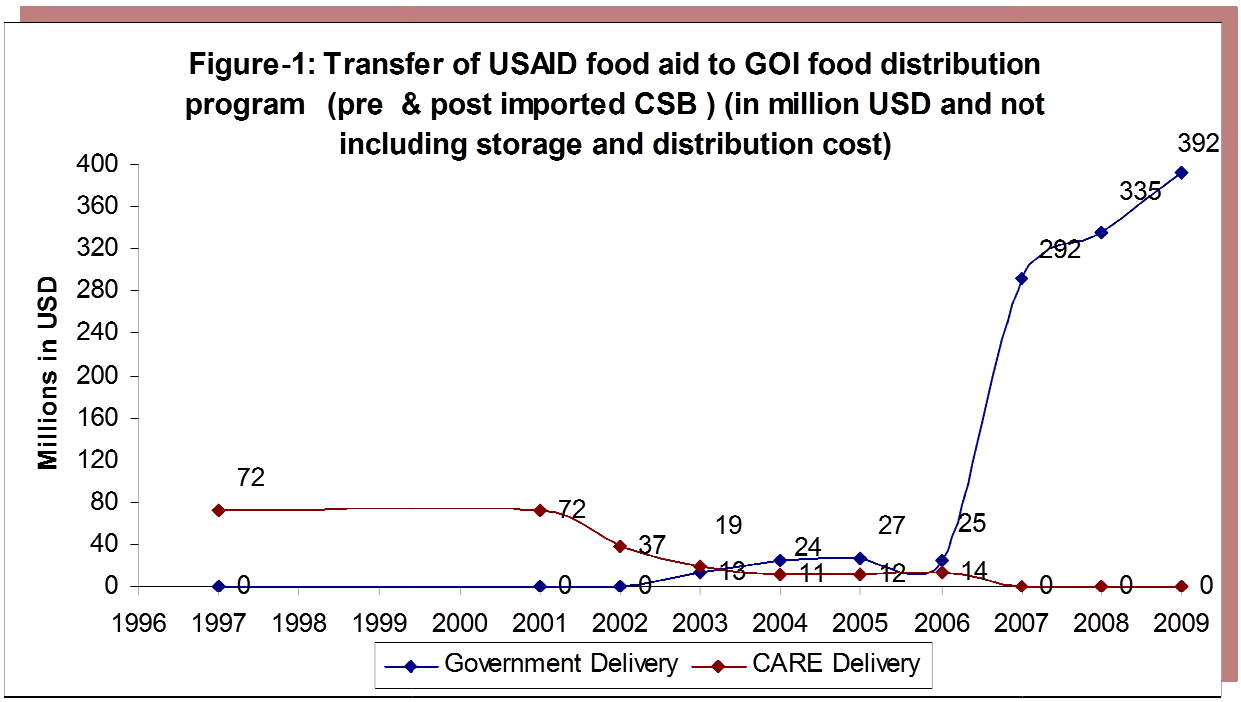
The first INHP, implemented from 1996 to 2001, demonstrated models of improving child health and nutrition through selected ICDS sites and initiated replication of successful approaches to delivering a basic package of services in districts. It was implemented in seven states and provided supplementary food rations for 6.63 million mothers and children. The strategy to work through local NGO partners introduced a way to increase delivery of key services and target coverage of at-risk mothers and children. The concept of take-home rations was introduced to increase outreach to pregnant and lactating women and children under two years old who were not coming to the anganwadi centers. The concept of convergence with maternal and child health

departments through jointly-managed Nutrition and Health Days (NHD) was introduced to improve delivery of auxiliary nurse-midwife (ANM) services critical for better pregnancy outcomes and child growth. To implement these concepts, training packages, monitoring and evaluation systems, and approaches to engage communities were developed. The final evaluation of this first stage found that best practices in demonstration villages did not diffuse across block barriers and that the follow-on project should replicate practices within the government system.

The second INHP, implemented from October 1, 2002 through September 30, 2006, focused on a few technical interventions known to have impact on nutritional status. These interventions were funded by a combination of monetization, 202e grant funds, and additional child survival funding from USAID India. The interventions were antenatal care, newborn care, child immunization, micronutrient supplementation, food supplementation, and infant and child feeding behaviors. Through additional USAID funding, reproductive health services were added to the basket of health services delivered on nutrition and health days. The intensive approach produced increasing coverage of key services. Over one hundred long-term partnerships with local NGOs successfully contributed to helping monitor ICDS systems and mobilize the communities for scaling up coverage of key interventions. INHP introduced the concept of change agents which contributed to a GOI decision to create a cadre called ASHA under the GOI's National Rural Health Mission. Under CARE's program, each agent was to contact and mobilize 25 to 30 households to access services and to track behavior change in households. Program implementation worked, including mechanisms to minimize social exclusion, such as timely home visits, modified registers, and social mapping.

In 2003, when the Indian government discontinued the import of Title II Corn Soy Blend for the food supplementation program of ICDS, state governments quickly replaced CSB with a level of centralized procurement of commodities in some cases, and in others, a decentralized[2] approach for locally-procured food grains (Figure 1). State governments turned to CARE to help them institute efficient, transparent food commodity delivery systems. Decentralized food models were also tested.

[2] Centralized procurement refers to all food procurement done by state or district. Procurement at the AWC or through community based organizations such as self-help groups is called decentralized.



To enhance delivery of health and nutrition services, the concepts of supportive supervision and convergence were strengthened at sub-district levels through improved supervisory training, record-keeping, automated management systems and joint meetings of health and ICDS staff. Officers were trained in using checklists and data for supportive supervision of the 20 to 25 anganwadi workers in their sector. Tools, such as home visit planners, were introduced to assist AWWs in prioritizing home visits and providing critical messages during those contacts.

The third INHP, implemented from FY2007-2009 was designed to phase out Title II assistance to India by consolidating the lessons learned over the past decade, sustaining proven practices in 711 blocks and mainstreaming them into ICDS for sustainability, as well as, applying them to geographic areas within the target states which did not previously receive USAID and CARE's food and technical assistance. Since this is the project that the evaluation team is specifically evaluating, it is summarized in more detail after the next section.

Current Environment in India Impacting Health and Nutrition

Investment in nutrition is known to enhance efforts in other sectors, especially health, education, agriculture, and economic production. India adopted a National Nutritional Policy in 1993 under the aegis of the Department of Women and Child Development. It is a comprehensive, intersectoral policy that stresses the need to incorporate nutrition goals into the overall development strategy. A number of initiatives have been undertaken by the Food and Nutrition Board, Women and Child Development (both when it was a Department and after when it became a Ministry), on policy instruments including nutrition advocacy, efforts to combat micronutrient malnutrition, district

nutrition profiles, and the like. For readers not familiar with India, Annex 5, entitled Nutrition Environment in India, gives a description of the Indian government's efforts to date to promote nutrition of its citizens through an intersectoral approach. Recently a coalition of entities who are involved in combating malnutrition in India has been formed under the leadership of the USAID VISTAAR Project (IntraHealth). The Coalition for Sustainable Nutrition Security in India has been instrumental in building consensus among international agency staff and academics on priority interventions for nutrition. CARE and INHP experiences have fed into these processes successfully, and these experiences are reflected in the recommendations of the Expert Task Force on programs for Children-Under-Two.

The National Common Minimum Program mandates health as a major thrust over the next five years, but planned expenditures, specific to nutritional interventions, are not available. Rather, resources to improve nutrition are invested in various direct and indirect mechanisms through a wide range of policy measures and financial pathways. The Indian government is a signatory to various international declarations, such as the Millennium Developmental Goals. The National Rural Health Mission was launched to carry out necessary architectural correction in the basic health care delivery system and to encourage a synergistic approach to interventions through an intersectoral district health plan, including interventions to improve access to water, sanitation, nutrition, and public health.

The "right to food" movement is gaining momentum in India. The Supreme Court of India issued interim orders to the national and state governments on the implementation of food safety net programs and appointed two Food Commissioners to monitor compliance with its directives in response to a petition filed in the highest court. States have also instituted monitors or advisors to the Supreme Courts on "right to food" issues.

Similarly, there is heightened attention to improving the quality of child development services, minimizing exclusion of marginalized populations, and enhancing public accountability mechanisms. Coupled with these efforts is the new legal environment provided by the "Right to Information" Act. All of this is creating a positive environment for renewed interest in combating malnutrition.

Description of Integrated Nutrition and Health Program III

Purpose

The third phase of CARE's Integrated Nutrition and Health Project was designed to consolidate lessons from the previous decade and support government systems in mainstreaming sustainable methods, tools, and systems. The project is consistent with FFP's strategy to target the most vulnerable and food insecure groups, namely pregnant and lactating women and children under two years of age, and especially those who are geographically and socially excluded groups. The efforts were focused in two areas: 1) engaging systems and community representatives in selected interventions to enhance sustainable outcomes in operational CARE districts in eight states supported by INHP;

and, 2) replicating successful practices that strengthen the capacity of ICDS systems and staff and their accountability for improving nutritional status of rural mothers and children. Since the Indian government is committed to sustaining supplementary food distribution through the ICDS and has adequate funding to do so, this third phase devoted US Farm Bill inputs and 202e funds to assure that previous investments would be maximized through supporting ICDS to institutionalize and scale up the successful interventions of INHP I and II.

Approaches to achieving program objectives

The strategic approach to structuring the program included two levels of effort: consolidation and phase-out from CARE's primary program areas; and, influencing relevant government authorities to mainstream best practices in replication areas.

Maintaining momentum from INHP II, 72 districts in eight states were primary program area (PPA) of the final phase-out INHP. Districts were categorized according to the quality of their leadership and capacity in eight states as shown in the adjacent box. Category A districts were phased out within a year, then those in Category B, and by September, 2009, Category C districts had received sufficient technical support to also be phased out.

Category A **districts**: good, trained leadership to sustain implementation at the block level with CARE supporting districts; NGO partners focus on remaining quarter of blocks needing sector-level support. New blocks were seldom added.

Category B districts: average capacity at the district level; support to half the blocks where the knowledge of frontline workers is deeper, was phased out. NGO support was directed to less-developed blocks and new blocks received CARE and NGO assistance.

Category C districts: limited capacity to manage ICDS at the district and block level; assistance concentrated on developing program leadership, management systems and implementation capacity at the community level. In keeping with the FFP strategy, category C districts were also those where the most new and additional blocks were added, with the addition of thousands of untrained new workers.

The second strategy involved replicating good practices from INHP in the remaining blocks of districts where CARE worked during INHP II. This was accomplished in spite of rapid expansion of ICDS which meant strengthening systems to support thousands of new anganwadi centers. At the request of two state governments, CARE agreed to assist them in replicating selected proven practices of INHP throughout all districts. CARE formed state and national resource groups to assist with this process.

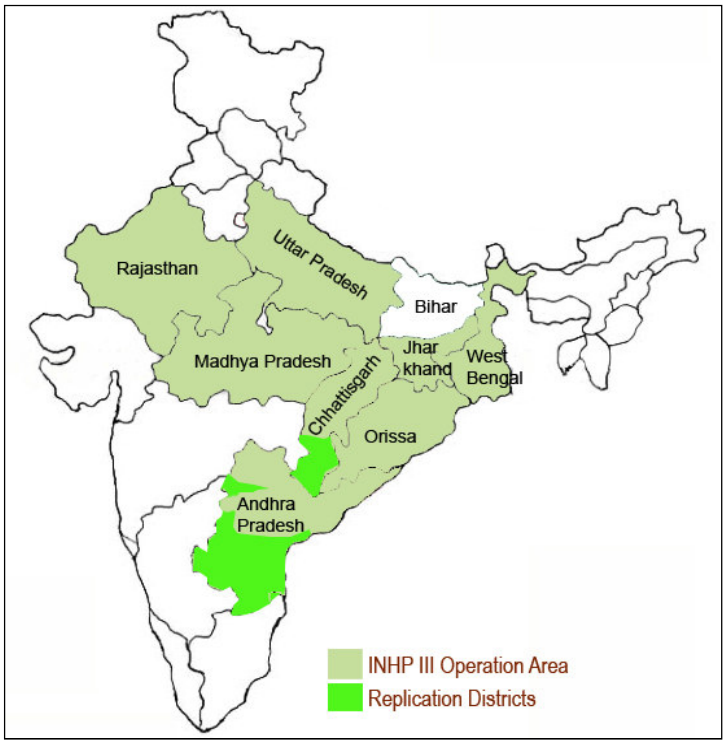
To summarize, the program had three components:

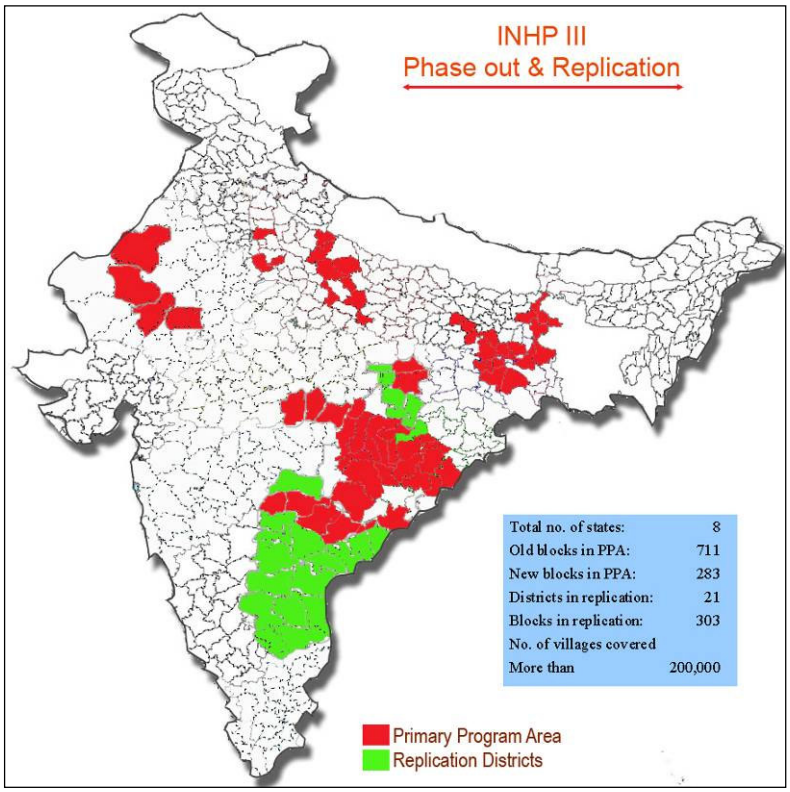
1. Accelerated phase out from 711 blocks in 72 districts in PPA where INHP was operational in previous phases.
2. Replication in 283 new blocks of the 72 districts where INHP previously worked in other blocks

3. Replication of proven practices in new areas of two states comprised of 303 blocks in 21 districts

Geographic Coverage

The maps on the following page show the geographic coverage of INHP III in the eight target states. The target districts of the PPA were selected during previous phases based on their poor health and nutrition indices. The project reached 15.5 million women and children as shown in Table 1.


Rajasthan
Uttar Pradesh
Bihar
Madhya Pradesh
Jhar khand
West Bengal
Chhattisgarh
Orissa
Andhra Pradesh
INHP III Operation Area
Replication Districts


INHP III
Phase out & Replication
Total no. of states: 8
Old blocks in PPA: 711
New blocks in PPA: 283
Districts in replication: 21
Blocks in replication: 303
No. of villages covered
More than 200,000
Primary Program Area
Replication Districts

Population Served

Table 1. Operational Area and Target Populations

INHP III Operational Area - Districts, Blocks, AWCs and Target population										
PPA districts										
State	No. of Districts	No. of Blocks			No. of AWCs			# of Pregnant and Lactating women reached	# of under 2 children reached	Total
		PPA	Replication	Total	PPA	Replication	Total			
Andhra Pradesh	8	70	54	124	13831	10568	24399	559000	737000	1297000
Chhattisgarh	10	96	19	115	18489	2837	21326	530000	676000	1206000
Jharkhand	17	125	47	172	18709	8464	27173	858000	1077000	1935000
Madhya Pradesh	3	29	0	29	6034	0	6034	174000	215000	389000
Orissa	9	104	2	106	12283	104	12387	262000	338000	600000
Rajasthan	7	64	3	67	10713	345	11058	575000	697000	1272000
Uttar Pradesh	12	132	54	186	23405	8067	31472	1488000	1777000	3265000
West Bengal	9	91	104	195	22954	21640	44594	882000	1225000	2107000
Total - PPA	75	711	283	994	126418	52025	178443	5327000	6743000	12071000
Replication districts of AP and CG										
State	No. of Districts	No. of Blocks			No. of AWCs			# of Pregnant and Lactating women reached	# of under 2 children reached	Total
		PPA	Replication	Total	PPA	Replication	Total			
Andhra Pradesh	15	0	260	260	0	48337	48337	1298000	1710000	3009000

										0
Chhattisgarh	6	0	43	43	0	8111	8111	204000	260000	464000
Total - Replication Area (RA)	21	0	303	303	0	56448	56448	1502000	1970000	3473000
Grand Total (PPA+RA)	96	711	586	1297	12641 8	108473	234891	6829000	8713000	15544000

Four Strategies to Phase-Out Effectively

The strategies for developing effective implementation in the current program areas are as follows:

For Consolidation and Phase-Out from Primary Program Areas (PPA)

Key Strategy 1: Technical, managerial and operational support to ICDS in on-going operational districts, including a) evidence-based, participatory planning; b)improvements in the quality of supervisory systems and locally adapted interventions at sub-district levels; c) building capacity to improve service delivery outreach and behavior change; d) assistance to improve commodity supply chain management; and, e) facilitating the convergence between child development and rural health schemes throughout all levels of government administration.

CDPO and AWW in Rajasthan

Key Strategy 2: Support to strengthen mechanisms that increase program capacity and accountability, including community engagement. To support the 73rd Amendment to the Indian Constitution that provides an enabling environment for citizens to hold government institutions more accountable, the program a) reinforces PRI participation at local levels; b) sustains change agents through the National Rural Health Mission's (NRHM) introduction of ASHAs to boost community mobilization and behavior change; c) provides information to Supreme Court monitors about bottlenecks across states; and, d) advocates for policy reform based on operational experience. Through NRHM, ANMs and elected representatives have access to 10,000 rupees (approximately US$250) in untied funds that can be replenished once expended on eligible items.

For Influencing ICDS and RCH beyond Primary Program Areas

Key Strategy 3: Replicate good practices outside of CARE's program areas through responsive technical and operational assistance in all blocks of the PPA districts with no CARE presence and in all non-presence districts in CG and AP. Replication was aided through creation of a national level Advisory Panel, State-level Working Groups and District Resource Groups focused on scaling-up effective activities; micro-planning for aligning child development with other sectors such as health (also applicable to education and local governance sectors); and improved program monitoring.

Key Strategy 4: Advocacy and sector-wide support to influence policies for more effective health and child development programs included: a) technical support for decentralized state plans under ICDS and for phasing out US food commodity assistance and decentralizing food distribution; b) development of public/private partnerships, including NGOs, PRI, and Supreme Courts to increase ability of communities to hold systems accountable and implement India's Right to Food law; c) widespread training of ICDS and RCH cadre with support to the National Institute of

Public Cooperation and Child Development (NIPCCD) on updated curricula; d) potential for a web-based portal for sharing guidelines and resource material; and e) contributions to improve ICDS targeting of interventions and populations. The strategy also aimed to replicate communication models aiming to change behavior, minimize social exclusion, and reduce gender differentials.

Advocacy at national and state levels is on-going. Health and ICDS geographic areas, staffing, and some monitoring systems are being aligned in states. Leadership training for key officials and large- scale capacity building for members of local government bodies and community-based organizations is nearing completion.

Mainstreaming Best Practices

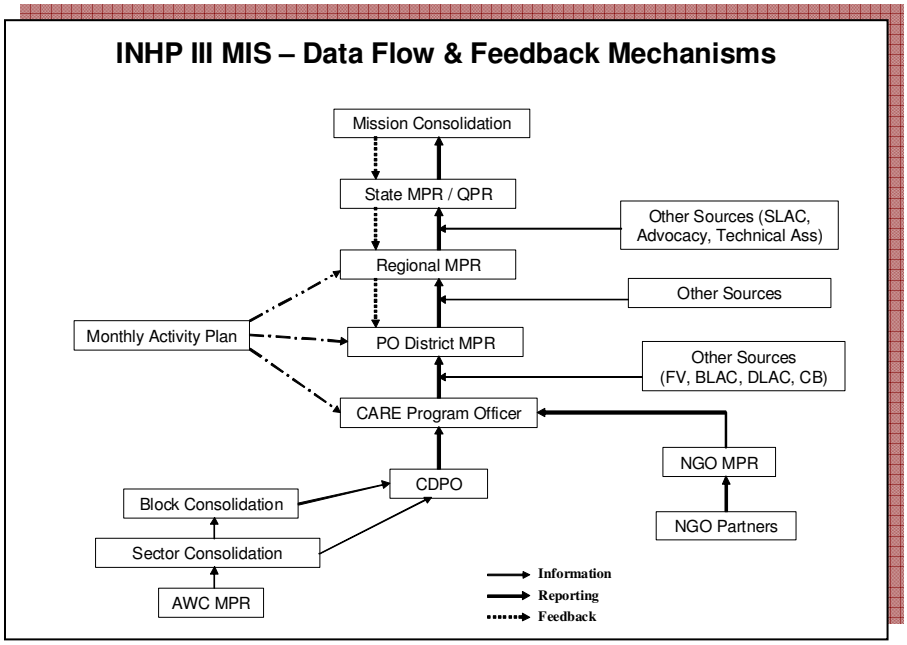
This section summarizes what the evaluation team learnt about the practices that were mainstreamed into ICDS systems and how this was done. Commodity supply and information management were two key systems. The mainstreaming was accomplished through training which is now being incorporated into the new ICDS training curricula, policy changes, and a replication process. This section ends with a discussion on GOI's interest in a National Resource Center since GOI has many partners which contribute to ICDS. The team's understanding is that GOI wants central access to all research and documents concerning ICDS to better inform them about effective approaches.

INHP Management Information System and Monitoring Plan

The program strategy to strengthen ICDS systems relies on the ongoing gathering of performance measures at each level of the system. The sources of information are from the ICDS systems, from NGO partners, from CARE overviews, capacity building reports and meetings.

The main objective of INHP monitoring is to ensure that service providers and their supervisors gather and use information about progress on critical outcomes and processes in a timely manner. CARE assisted ICDS supervisors to adopt standard checklists and reporting tools to gather information about the quality of service provision and the availability of supplies during sector-level meetings and field visits. Supervisors are assisted by NGO partners who use observation checklists and monthly reports as well as the consolidated reports of other block-level personnel.

The project continues the process of changing the emphasis from record-keeping to use of data for decision-making and feedback to field workers as shown in the following diagram.



Project resources were used to: 1) develop a monthly reporting format for anganwadi workers on key services such as Nutrition and Health Days, and PRI attendance at these events; 2) adapt a block-level format in each state, assisted by NGO partners, that reports on the number of sector-level meetings focused on program issues; and 3) minutes of block-level Advisory Committees or equivalent meetings, containing information on convergence issues. Feedback mechanisms are an inherent part of the system through quarterly reports and meetings.

In addition to internal ICDS data generation, CARE has also conducted program monitoring visits. CARE prepared biannual results reports for USAID, based upon the agreed set of outcome, process and management indicators. For the management indicators, CARE also used a three-stage validation process, verifying checklists and reports in the first stage, verifying source documents in the second stage through staff visits to centers, and reviewing CARE Program Officers' monitoring for the CARE state office quarterly progress report in the third stage. To assure quality assurance in data collection, CARE conducted an audit of source data sample for one quarter in 32 districts. The finding that workers more often underreported performance on the management indicators rather than over reporting was encouraging. Ensuing data validation processes showed that the data reported was quite accurate.

Commodity Supply Chain Management

With the switch from US monitoring of US food commodities to sole Indian government responsibility for management of food supply for the supplementary feeding component of ICDS, CARE's role shifted from direct distribution to technical assistance in commodity management. CARE helped diagnose the critical path in the food chains in order to reduce inefficiencies. CARE experts advised the state governments on how to plan so the food rations allocated at the highest levels of government reach those who need it the most.

The reduction in distribution gaps was achieved through technical transfer of automated tools for better planning of procurement and distribution as well as better targeting and monthly analysis of coverage data. CARE also conducted widespread training in planning, procurement, distribution and inventory management and introduced commodity monitoring and data management systems. It was a huge job to coordinate with the central and state governments on timely release of funds, use of proceeds from sales of empty oil containers for provision of computers, printing of reporting formats, introduction of ideal storage practices to mitigate losses, and use of regular and effective reviews on targeting of beneficiaries and end-use of the food commodities. Almost 3,000 staff needed to be trained in 2007 to help prevent feeding interruptions.


Self help group member preparing food

At the same time, the central government issued guidelines for the allocation of funds and calorie levels for the supplementary food distribution in those states encouraging decentralized food models rather than centralized state procurement of "baby mixes". In April, 2009, allocations per beneficiary were doubled. The central government and state governments now allocate a total of 4 rupees per ration of 500 calories for children 6 months to 6 years of age; 600 calories for pregnant and lactating women; and 800 calories for severely underweight children.

In states adopting decentralized food procurements, either anganwadi workers are procuring the food for their feeding activity, or women's self-help groups are being involved in processing the food for distribution. CARE has provided substantial technical support to developing these models. While a local or decentralized model contributes to the local economy and minimizes risk of corruption, a limitation is that the locally processed food cannot be fortified with micronutrients. FANTA conducted a study of the efficacy of the local food models which [3] concluded that "the decentralized food models are operationally feasible and financially viable if they are properly designed, managed and supported."

In addition, CARE introduced the concept of needs based allocation in four states to improve the use of funds and the timely replenishment of stocks at block and anganwadi centers. To do this, CARE worked with AP, Orissa, West Bengal, and Rajasthan governments on the use of needs based allocation using different formulas for vegetarian based combinations of soybean, Bengal gram or other pulses, sugar, and vegetable oil according to local availability, prices and cultural acceptability.

[3] The FANTA Project, Assessment of Decentralized Food Models in India's ICDS Program, 2007 www.fantaproject.org

Replication Strategy for Covering States of Andhra Pradesh and Chhattisgar

When INHP III was being planned, the GOI asked CARE India to assist them in scaling up the proven practices of INHP to all districts in AP and CG. There were 15 districts in AP and 6 in CG where CARE had limited previous involvement. The scale-up eventually reached 58,974 AWCs. For AP and CG, CARE chose to create a specific process for replication within ICDS which could potentially be applied in other states as well. The guiding principles of the process, which could be useful for other organizations considering scale-up through government, are found in the box at the right.

Guiding Principles of the Replication Process

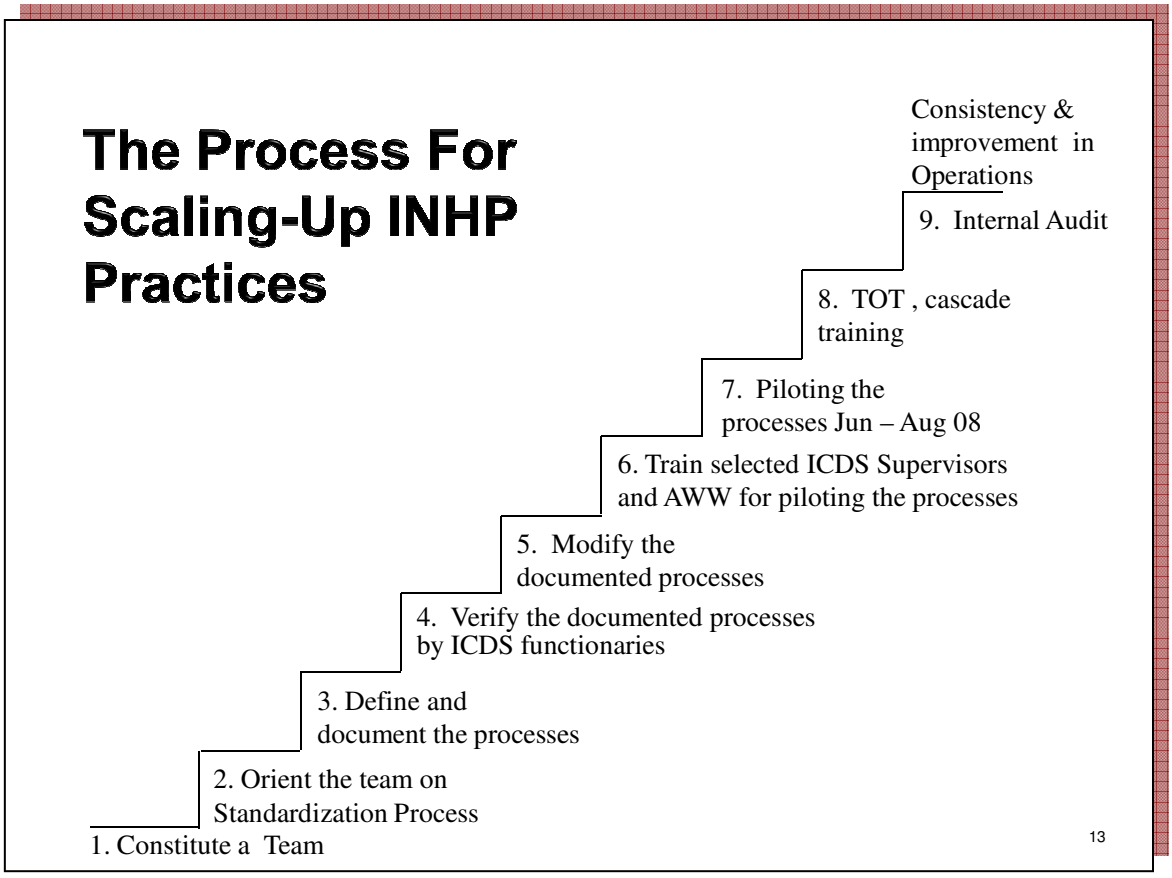
- Replication is a dynamic, learning process with shifting mindsets of functionaries across levels - not a mere reproducing of practices or approaches mechanically
- The process of replication builds capacities and adds insights about the rationale of taking actions
- Replication content has to be contextualized; it must have a built in scope of flexibility
- The process will be led by mentors and leaders within ICDS who have the ability to energize the system and act as the torch bearers
- Processes chosen for replication are not an adjunct to the existing program, they become integral to the program, evolving to meet program needs and goals
- The ultimate goal of replication is to enable ICDS to accomplish their goal of reducing child malnutrition and infant mortality

A first step was to identify the practices that could and should be replicated. For this step, CARE received technical assistance from the FANTA Project. Five practices were selected:

1. Nutrition and Health Day – convergence of services to enhance coverage and impact
2. Home Contacts – for improving nutrition and health practices in the households
3. Supervisors' Visits to the AWCs – structured supervisory visits to build capacity of AWWs
4. Sector Meeting – structured, joint ICDS/RCH meetings focusing on performance
5. Food Supply Chain Management – needs-based allocation and uninterrupted supplies

To develop the replication process, CARE created and worked with a national advisory panel and state working groups which resulted in complete ownership by the government entities. The approach involved understanding the actual operations, reviewing the chosen practices, standardizing and documenting the practices, and verifying these with ICDS officials. After piloting the standardized processes in two districts and making adjustments, CARE assisted in forming District and Block Resource Groups with responsibility for cascade training and monitoring. Besides the initial 4-day training for AWWs, there is a plan for incremental learning and support through regular sector and block meetings. CARE is now assisting with implementation of an audit process for continual monitoring improvement.

The following graphic depicts the steps in the process CARE used for going to scale, working within the government entities.



Capturing Information, Tools, and Best Practices in a National Resource Center

The idea of a creating a resource center was recommended in the final evaluation report for the RACHNA project. The evaluation team agrees that there is a need for CARE and GOI to go forward with their plans to do this. Discussions on the formation of a National Resource Center have begun with GOI and the Coalition for Sustainable Nutrition Security. A Resource Center would facilitate interagency and interdisciplinary sharing of knowledge across different levels of concern. CARE has many years of experience in health and nutrition programs with lessons on strengthening systems through technical assistance, best practices for service delivery and system management, different working models with communities and numerous assessments, strategic papers, studies, and qualitative and quantitative surveys. Other organizations also have knowledge banks and ICDS IV includes the idea of creating a central location for accessing information. A national center would house hardcopies and a web-enabled database/portal.

FINAL EVALUATION METHODOLOGY

Evaluation Team

USAID and CARE India brought together a six-person team to complete the final evaluation of the final phase of the INHP effort over three weeks. Team members included a former USAID officer, a representative of USAID Global Health Bureau, a representative from IFPRI, two public health experts from India, and the team leader who is experienced in Title II evaluations. Counterparts assigned by the MoWCD to participate in the evaluation (Annex 7 letter and listed in Annex 1) saw the CARE operations in each state and provided valuable insights. State-level ICDS personnel also participated in the field visits in some states. Over the three weeks, team members could contribute varying levels of effort due to competing job responsibilities. Team members reviewed project documents and presentations on specific project components. Three of the evaluation team members visited two states each, and two others each visited one state, enabling the team to cover all eight states (contacts listed in Annex 2).

The team members used semi-structured interview and observation guides in contacts with state, district and block functionaries as well as visiting communities, anganwadi centers and interviewing frontline project and NGO partner staff. The team reviewed the results of the quantitative and qualitative endline surveys, providing suggestions for further analysis to the independent agency Sambodhi, which was responsible for data collection and analysis. All team members were engaged in group processes to articulate the key findings, conclusions and recommendations. While the lead writer generated much of this report, other team members contributed specific sections.

Technical Advisory Group

At the suggestion of USAID, CARE India convened a Technical Advisory Group (TAG) to assist with planning the evaluation design, particularly the quantitative sampling. The TAG was comprised of five persons from New Delhi with expertise in statistics, epidemiology, impact assessments and public health surveys. The TAG met three times in 2009 to advise CARE staff, USAID and the external nodal agency which was entrusted to manage and conduct the survey and analysis independently. The TAG offered valuable suggestions which strengthened the survey design and validity of the survey.

Quantitative and Qualitative Data Collection

The final evaluation of INHP III was designed to assess progress on all key strategies of this phase of the project, including USAID's performance tracking indicators and the sustainability and replication goals. Quantitative and qualitative (process) assessments were done to provide data for the final review. Assessments were designed in consultation with the evaluation Technical Advisory Group (TAG). A nodal agency was appointed to manage the assessments, and the assessments were executed between August and October, 2009.

Design overview

A number of elements determined the design of assessments (further details on each of these is provided in Annex 6).

(1) The project design included the phase-out in INHP-II districts and inclusion of additional replication blocks.
(2) The effect of phase-out on sustainability was assessed by including benchmarking survey data from a set of blocks phased out in September 2007, which were also surveyed in September 2009.
(3) The need to document program processes, particularly sustainability-related processes.
(4) The need for comparison areas (strongly recommended by the TAG).
(5) Dropping Madhya Pradesh from the quantitative survey given the very low representation of the project area in MP
(6) Timing of assessments; in spite of the known effects of seasonality on anthropometry and some feeding practices, due to unavoidable circumstances, the final survey had to be conducted in the 'hunger' season.

Design and methodology

Quantitative assessments included household surveys and other structured assessments. Qualitative assessments included focus group discussions and in-depth interviews with a variety of stakeholders. All assessments were conducted by four field research agencies identified by competitive bidding by the nodal agency which managed all the assessments. Three of these agencies collected structured data from seven states, and one common agency conducted the qualitative data collection from all eight states. The field research agencies hired and trained field investigators. Anthropometric measurements were made by trained supervisors. Qualitative investigators were provided training in Delhi, followed by orientation to the program in their respective states, as well as field practice.

Customized software was created for data entry of all structured data. The agencies conducting quantitative assessments were required to submit double-entered and cleaned data to the nodal agency, which then analyzed the data. All qualitative data were audio-recorded and transcribed. Qualitative investigators were trained in thematic analysis after data collection was complete. A final qualitative assessment report was prepared by the nodal agency and is available upon request. The qualitative data was intended and used to triangulate information obtained directly by the evaluation team and the quantitative results. Therefore, the evaluation team felt it was not necessary to include the lengthy results in this report.

The data collection methods are briefly described below, with further detail in Annex 6.

Quantitative Assessments

Household Surveys: Household surveys were virtually identical in design to the 2006 surveys. They were designed to generate state-level estimates for all indicators, from

which project-level estimates would be derived. In addition, the sample for the 2009 survey was drawn to proportionately represent blocks by their phase out period. The comparison sample was drawn from 4 states (Orissa, Rajasthan, UP and West Bengal) by matching, to the extent possible, INHP-III districts with non-INHP districts. Only these 4 states had enough non-INHP III districts to generate a large enough comparison sample. Detailed data on the households was gathered to enable econometric matching techniques to be used.

The survey used a two-stage cluster design: selecting blocks at the first stage, and then AWCs within the blocks. Children at the AWC level were randomly sampled. Two samples were surveyed for different sets of outcomes: (1) Children 0-5 months old: for supplemental feeding, antenatal care, newborn care and breastfeeding indicators (N=733 per state); (2) Children 6-23 months old: for use of supplementary nutrition, complementary feeding, immunization, vitamin A supplementation, and malnutrition status indicators (N=733 per state). Details on the sampling, especially in relation to the phase-out block samples are presented in Annex 6.

Common tools were used in all areas, largely identical to the tools used in the 2006 surveys. Additional variables were included in the 2009 sample to accommodate the econometric matching analyses (propensity score matching).

Other structured assessments:

Interviews were conducted with a sample of service providers (AWW, ANM) and ICDS supervisors and CDPOs in the PPA blocks and comparison blocks in four states to assess technical competency. CDPOs and supervisors completed self-administered competency tests. These assessments were administered to all available staff in the blocks sampled for the household surveys. One of the evaluation team members devised a system for scoring the competency tests. The evaluation team feels the results of these tests will be most useful in helping ICDS revise the national training curriculum and create long-range plans for in-service training and performance-based supervision.

Qualitative Assessments:

Qualitative assessments were designed for a small sample of PPA and replication blocks, often a subset of the blocks sampled for the household surveys. In addition, qualitative assessments were attempted at district and state levels as well. In the four states where household surveys were conducted in comparison areas, a small sample of four blocks was covered by qualitative assessments. Qualitative assessments included methods such as focus group discussions and in-depth interviews. Respondents included ICDS supervisors, CDPOs, PRI members, AWWs, district level ICDS and health officials, and state level ICDS and health officials. Question guides for these assessments addressed topics including level of understanding about malnutrition, role clarity about programs, changes in roles over recent years, and sources of influence.

Completion rates for the structured assessments ranged from 55 percent in AP to 91 percent in Orissa, with completion rates being above 80 percent in most states. The qualitative teams were more successful in interviewing block and lower levels, where the completion rates were around 90 percent. The information obtained was useful to evaluation team members analyzing findings and enabled the team to focus their limited time on meeting key state officials.

Limitations of the Evaluation

The final phase of INHP was conducted during a period of global recession and escalating food prices. During the evaluation team's time in country, there was growing concern about the rise in price of cereal grains and pulses, among other staple foods for low-income families. In late October, the government confirmed that food prices have risen 13.4% in 2009. Almost one-half the districts in which CARE was operating suffered a drought during the period when the end-line survey was conducted. As discussed in the team's analysis of the quantitative findings, a poor harvest and insufficient food availability can impact a child's weight gain.

Gaps in supply of vaccines and iron/folate syrup and tablets, as well as vitamin A supplements affected the quality of services in some districts. Towards the end of 2007, the Indian government closed government companies producing these supplies that did not meet Good Manufacturing Practice (GMP) and there was a gap in supply until 2008 when a new bidding process was instituted. The state governments are still finding it difficult to procure sufficient iron/folate tablets because there is no incentive for commercial companies to produce IFA tablets. State governments have been able to maintain coverage of Vitamin A through the biannual campaigns in spite of procurement issues and immunization coverage has also been maintained.

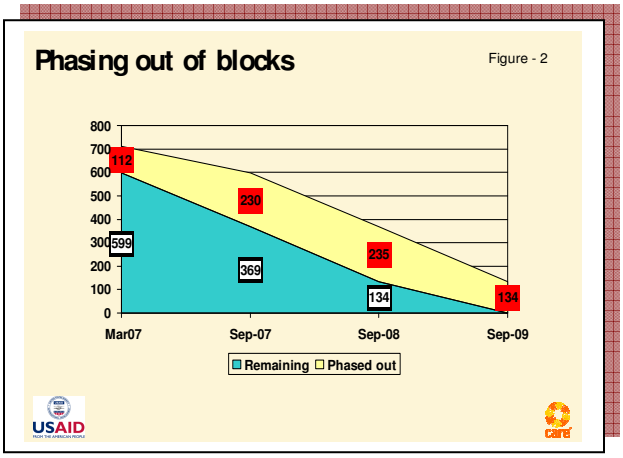
There was a large quantity of data being analyzed during the time that the team was in country. Thus, it was difficult for the research agencies to give the team a final, comprehensive briefing based on their analysis. As a result, the team was not able to include all analyses in this report. It is the team's understanding that the data are being further analyzed and will be available by contacting CARE/India.

EVALUATION TEAM FINDINGS

This section is presented in three parts. The first part discusses findings of the evaluation team related to the implementation of the four program strategies. The second part of this section lists lessons learned from state and Delhi CARE staff. The third section interprets the quantitative survey findings, especially those used for assessing the impact of USAID investments.

Consolidation and Phase-Out

The project phased-out assistance from all the states as planned (Figure 2). This timely phase-out was accomplished in spite of the complexity of working with multiple levels of government structures, the huge scale of ICDS and the diversity of the program.



The team observed that government leadership and commitment has a major effect on the program. One example of this government commitment is the successful transfer of all responsibility for the supplementary feeding program under ICDS from CARE to GOI, and the switch to Indian commodities from US food commodities. The speed and scale of the transfer is a major accomplishment given the size and the procurement and distribution challenges for GOI and state governments in sustaining supplementary feeding for over 100 million pregnant and lactating women and children regularly throughout their total program. CARE played a continuing role in advising state governments so that food distribution could be sustained. They provided advice on funding based on calculations of need, on best practices for procuring commodity mixes, transferring and automating supply management systems, and advising on guidelines for decentralizing feeding programs. Another example was the consistency in explaining ICDS goals from senior to junior levels of government in several states.

The team also agrees that, as consistently cited by authorities at multiple levels in the states, three other components of CARE's assistance are critical and are being integrated by states to help ICDS achieve its objectives: 1) Contributions to ICDS Program Planning; 2) Independent Monitoring; and 3) Capacity Building and training materials.

Strengthening Systems

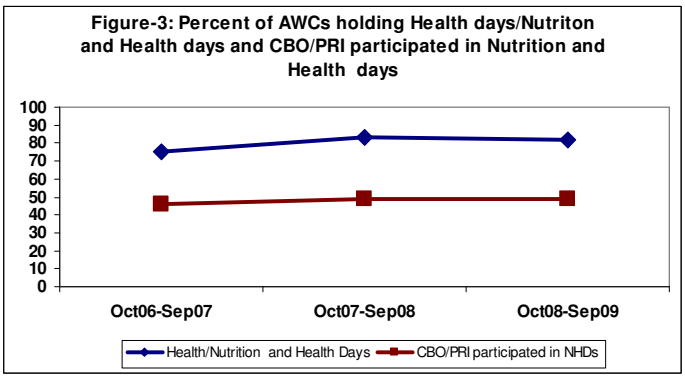
During the field visits, the evaluation team examined how systems and policy mechanisms were executed at multiple levels of ICDS and learned which elements were appreciated and being sustained by state government authorities. The team returned from the field impressed with the overall enthusiasm and commitment of CARE staff and government authorities. The team's synthesis on use of key activities was compiled after their meetings and field visits in the states (Table 2). These impressions are verified by the extensive qualitative interviews and observations conducted earlier by the independent research group

Table 2: Team Observations from Visits to States
+ (observed) +/- (observed sporadically) – (not observed)

	AP	CG	WB	JH	UP	RA	OR	MP
Regular converged health days at	+	+	+	+	+	+	+	+

AWCs								
Inter dept. coordination/sector meetings	+	+	+	+	+	+	+	+/-
AWW – ASHA coordination	+	+	+/-	+	+	+	+	+
Local leader participation	+	+	+	+	+	+	+	+
Supervision tools used	+	+	+	+	+	+	+	+
Use of data for decisions/feedback	+	+	+	+/-	-	+	+	+
Reducing exclusion	+	+	+	+	+	+/-	+	+
Value of Leadership training cited	+	+	+	+	+	+	+	+
State level implementation planning	+	+	+	+	+	+	+	-
District Resource Groups mentioned	+	+	+	+	+	+	+	+

The evaluation team confirms that the concept of a monthly day on which both basic health and some form of supplementary feeding rations are provided to the community is being sustained by the government to a considerable degree. The performance monitoring system found this to be the case more than 80 percent of the time (Figure 3). The team corroborates that elected and community leaders are involved in monitoring access and execution. The performance monitoring system found this to be the case on at least half of the service days and that this level of involvement was sustained.



Convergence of ICDS and RCH Services and Community

The team found some level of variation in approaches and intensity of efforts for joint sector decision-making and coordination of roles of frontline workers, effective use of monitoring data, and reduction in socio-cultural barriers to access and participation.

The team observed that the CARE model of posting a few staff in state and in districts, and then relying on local partnerships with non-governmental and community-based organizations is a fruitful approach to engaging communities. In cases where the NGO partners are now funded by government or other agencies, they have sustained their alliance with the program.

The team confirmed that local leaders are maintaining community involvement in ICDS (Figure-3 above). In some states, the AWWs participate regularly in the Panchayat meetings, helping to increase understanding of the needs and priority of ICDS. We were also given examples of how local leaders had supported the centers. There is more discussion about community engagement in the Lessons Learned Section of this report.

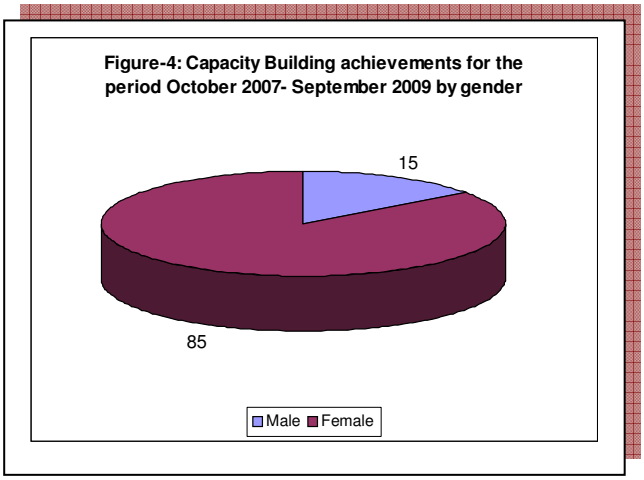
The team notes that, in support of the Indian government's drive to provide ICDS services universally, the project has facilitated training of nearly 425,000 MoHFW staff, ICDS staff, food commodity management staff, NGOs and community leaders, providing training materials and curricula for integration into government training programs (Table 3). Through training, CARE introduced tools and structures to strengthen and sustain service delivery. Several state officers mentioned the value of the leadership development training that CARE commissioned and recommended that this training should be expanded. The team was impressed with the numbers of personnel trained who have a role in the success of the ICDS and NRHM.

Table 3: **Capacity Building**

Government staff, community workers, and leaders trained

Year	M	F	Total
2007			128,140
2008	26,569	148,935	175,504
2009	18,182	102,959	121,141
Total	44,751	251,894	**424,785**

The team also finds that the high proportion of women who were trained is important for a health and nutrition program (Figure 4). One explanation for the high proportion is that the ASHAs, AWWs, their helpers, and most supervisors are women. In addition, the set-aside in PRI for women's seats ensures that there are women involved in local government.



The team heard that state governments are adapting their supplementary feeding programs according to the socio-cultural and economic context and the policy environment in which they operate. Thus, several states have modified the original distribution frequency and take-home ration approach (Annex 4). At the time of this evaluation, on average, half the blocks in AP and RA states are using needs-based allocation of resources for the supplementary feeding. Others are interested but limited by current staff vacancies. In JH and CG, the funds are allocated directly to the anganwadi workers, so the use of needs-based allocation tools is not applicable. Similarly UP is implementing mixed models for the supplementary food distribution. As will be discussed in the conclusions and recommendations, the team discussed the enigma of the persistent high rates of malnutrition in India despite its rapid economic progress. Providing food will not overcome the most significant determinants of poor nutrition in India unless ICDS adopts other, effective approaches to overcoming the most significant determinants of poor nutrition in households.

As ICDS evolves and expands, systems will be modified by states, as we saw in the case of both the food distribution and the convergence of services (Annex 4 shows the changes in approaches to nutrition and health days). There will be challenges in keeping systems fully operational. There are still huge challenges, for example, just to ensure an efficient and effective feeding program. Neither the decentralized food models nor the centralized procurement model guarantee consumption of adequate nutrient levels and both can be subject to irregular supply. While adequate government financing is not a problem, other significant issues in maintaining just this one massive and successful system are the frequent shifts in supplementary food distribution models, deployment of several different commodities, rapid expansion under universalization, decentralization of authority under the national ICDS scheme, vacant positions, inadequate skilled resources, compatibility of computer software programs, and inadequate computer hardware.

Replication for reaching scale

In spite of the type of issues listed in the last section that affect the ability to scale-up and integrate new systems, the INHP-supported program eventually reached 58,974 AWCs and 15.54 million mothers and children, including those benefiting from the replication in additional blocks and districts during INHP III. By working at multiple levels of the government system, CARE was able to achieve institutionalization of proven practices, systems, and tools in all or part of eight large states. In the six states where replication occurred, evaluation team members found a strong commitment on the part of district level staff to sustaining the new systems and practices. In the two states where replication occurred in non-INHP districts, using the formal replication process described earlier in this document, the evaluation team found the capacity of frontline workers in these new replication districts equal to those in districts which participated in earlier phases of INHP. Even in states where INHP targeted only specific districts, such as UP, the state ICDS functionaries have mandated the use of certain INHP tools or processes across the entire state. CARE will further document this during the remaining months of the project.

In the case of AP, the replication process consumed a full two years, and has yet to complete the final stages because it is fully transferred to the AP government, and is dependent on the government's pace. Although rooted in ICDS/Health systems, replication cannot be a mechanical reproduction of practices or approaches. The experience in AP proved it is a dynamic, learning process. The leadership to solve issues flowing from a rapid expansion is critical, as is shown by the AP state government's commitment to scale-up systematically.

Lessons from the initial replication in the two targeted states can be a model for adoption in other states, many of which have populations as large, or larger, than many countries. Thus the INHP replication experience may also be helpful to other countries as they strive for scaling up sustainable program improvements. While in AP and CG, much reinforcement of efforts such as accreditation, monitoring and documentation, development of communication strategies, is required to complete the process, any

replication approach ICDS may pursue in other states needs support to help the ICDS maintain quality while scaling-up.

Policy and Planning

CARE's long-term relationship with the central and state governments provides an opportunity to advocate for new policies based on scientific changes in understanding how to improve health and child development. The breadth of CARE's involvement in advocacy and government bodies is shown in Annex 3. During CARE's partnership with GOI in implementing INHP, CARE India has had important opportunities to influence national policy for ICDS. One example is the participation of CARE in providing input for the GOI's Eleventh Five-Year Development Plan, which is being implemented now. This started during INHP II, but CARE has had more systematic engagement in the follow-up during the current phase of INHP. CARE was also invited by the GOI and World Bank to participate in designing a new phase for ICDS called ICDS IV which will further serve to strengthen ICDS capacity to address malnutrition and child development.

Similarly, States have sought CARE's input in preparing their Nutrition Policy. Building on CARE's contributions to the development of a nutrition policy for Chhattisgarh during INHP II, CARE is contributing their experience in the development of State Plans of Action for Nutrition in Jharkhand, West Bengal & Chhattisgarh. CARE is a full partner with the state government of Chhattisgarh in a state-wide multi-sectoral campaign to reduce malnutrition.

At the invitation of ICDS, CARE is participating in the re-design of the national training program of ICDS workers, including AWWs. This work with the National Institute of Public Cooperation and Child Development (NIPCCD) assures that CARE-developed training curricula, methods, materials, and supervision systems are being mainstreamed into ICDS throughout the country.

The team finds that CARE's role, along with that of many others, in demonstrating the need for ICDS to target children less than two years of age is an important contribution to achieving current ICDS objectives. The team understands that CARE and others in the Coalition for Sustainable Nutrition Security will continue to advocate for well-planned interventions at an even earlier stage in the life cycle and encourages this effort. In addition, the team sees an urgent need for more attention to barriers at the household level that affect family feeding and maternal and child care.

The team learned that CARE's demonstrated success using community change agents contributed to the efforts that GOI and others have made to expand the role of change agents such as the ASHA cadre, fielded by NRHM.

Similarly, CARE and USAID demonstrated that health and nutrition services can be converged at the periphery. It is now GOI policy under NHRM to hold a joint service delivery day in the village and to manage and plan resources in a coordinated manner.

In some states, such as RA, the state government is undertaking a full sector alignment to make geographic jurisdictions and coverage harmonious.

CARE's analysis and experience with the feasibility of offering standard take-home rations has been widely examined. Implementing the ration system in conjunction with a health day assists in monitoring "right to food" legislation. Several states mentioned to team members that CARE's technical role in advising them on how to decentralize food models has been highly appreciated.

Lessons Learned

During discussions between team members and CARE India national and state-level staff, a series of lessons learned was recorded. The team also included lessons mentioned by government authorities, and community members that were interviewed in the field. The lessons learned are arranged according to the four operational strategies included in the INHP for program implementation. The first group, Program Leadership and technical and managerial support, includes lessons from both consolidation, phase-out and the system strengthening strategies of INHP III.

1. Program Leadership and technical and managerial support

- Leadership is important for program impact. CARE's field presence brings up relevant issues in a timely manner and helps ICDS and health departments find appropriate solutions to different operational problems.
- Working within government systems is much more effective in building ownership than trying to give the government models to implement later.
- Although development tools and methods can be fast-tracked, well-demonstrated program implementation takes about five to seven years to roll-out and be adopted.
- USAID and CARE's approach to results-based programming is appreciated by the government and other donor agencies. AWWs and their supervisors now use data for program management. The new community mobilizers, ASHAs, are not as familiar with this concept and could benefit from better links with other providers integrated into program management systems. Their roles at the community level also need more clarification.
- The home visits by AWW and ANMs and ASHAs are a useful tool but they need to be structured and better targeted so they give the right message, at the right time, to the right person and so that there is a concept of follow-up and support for subsequent home visits. Much data has been recorded by the AWW, who make visits to five to seven households per week, but their "diary" is not yet being regularly reviewed. District authorities also mentioned that home visits need more attention and to focus more on behavior change approaches.
- Although a government review mentioned the need for mentoring and training ASHAs on nutrition and changing behaviors at the household level, it has not yet been implemented. It appears that many frontline workers could benefit from enhancing their skills in how to deal with complicated socio-cultural barriers at the household level that impact nutrition and health.

- States who planned better for campaigns that affect health providers' time and priorities, or seasons that impact families of landless laborers, experienced less program disruption.
- Development and operationalization of a uniform software package is challenging as different states have different requirements because of different commodities.

2. Engage community leaders and increase their role in accountable social programs

- Not every state used the same partnership model to improve the quality and outreach of their programs. For example, in some states, community-based organizations have been effective, while in others the elected local bodies (PRI) are more accepted and they wanted training in health and nutrition. In a few states, the Supreme Court monitors' engagement in "right to food" issues promotes better accountability in service delivery.
- Local elected representatives can play a critical role in solving bottlenecks in funds flowing from the center to the states and down through the system. On the other hand, they also can be counterproductive if they do not have a good understanding of the government's child development program.
- Community level institutions are important in addressing cross-cutting issues such as social exclusion and gender roles. Through implementing standard monitoring systems, they also have an important role in applying them to improving health care in their communities.
- When CARE changed its approach from community mobilization to community monitoring of services, the access to information changed relationships and power structures within the community. ICDS partners were not prepared to manage the implications of empowerment and exclusion. CARE India suggests that there should be an in-depth study, with political scientists, to document how programs capitalize on the dynamic and evolving governance mechanisms in the project areas.
- CARE also learned that in UP, for example, female leaders are more interested in health issues and males leaders tend to be more interested in capital development projects such as roads, bridges, and pumps.
- Although over one hundred NGOs were trained at the block level by INHP II to monitor AWC activity, ICDS has not continued formal partnerships, affecting community monitoring and NGO confidence. A clearer discussion about transition might have helped.
- PRI can be a social change force, such as the project found with the convergence on health and nutrition services held one day per month. With one-third of seats set aside for females, the elected leaders have been very active, especially in West Bengal, and UP. The team saw examples of their positive involvement in other states.

3. Replication in New Blocks

- The state governments need evidence that practices were giving results before they could be examined and integrated into the government programs. This adoption takes time and depends on demonstrated models and credibility of the agency recommending the changes. CARE was careful to recommend only practices that were well tested. Direct input from supervisors, and the review by advisory committees facilitated the adoption of good practices.
- Standardized tools and management systems made it possible to accelerate the process of replication.
- Responsiveness to the context in which practices and systems are being replicated is critical. CARE's flexibility in assisting governments with changes in program design and policies was highly appreciated.

4. Policy Advocacy

- CARE played a critical role in tailoring training curricula to fit the practical needs of new frontline workers, so that it was less theoretical and more helpful in how to do their jobs. Placing a priority on revamping training at the time of the rapid implementation of the "universalization" policy for ICDS, was needed to help GOI train a huge backlog and start filling positions.
- When there is a good policy dialogue environment, it is important to take the opportunity to contribute to strategic planning, such as for ICDS IV.
- Clear, standard government policies are important for government and donor coordination. This is even more so when decentralization of program responsibilities occurs. On the other hand, flexible approaches allow a system to respond to diverse issues.
- Political commitment is critical for policy implementation. Where states have committed leadership, such as CG and WB, nutrition policies are higher priorities.
- Data must be summarized and well-presented for senior levels.

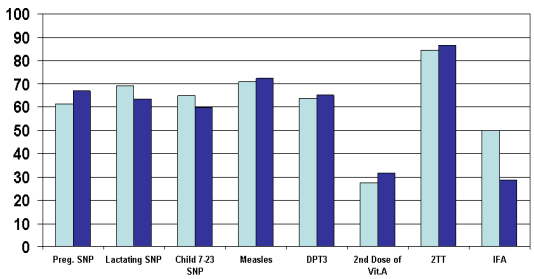
Quantitative Findings

In preparing for this final evaluation, a major effort was put into measuring changes in the performance indicators (IPTT), and other behavior changes, compared to results of the population-based sample survey that had been done in 2006. This section primarily focuses on results for comparing two data points – the results of the 2006 survey for the entire project area and those from the 2009 survey for the entire project area; and for the comparison areas in four states. Where results of the intermediary 2007 survey are pertinent, they are also presented. A more detailed report is attached in Annex 6, which shows analysis for individual states.

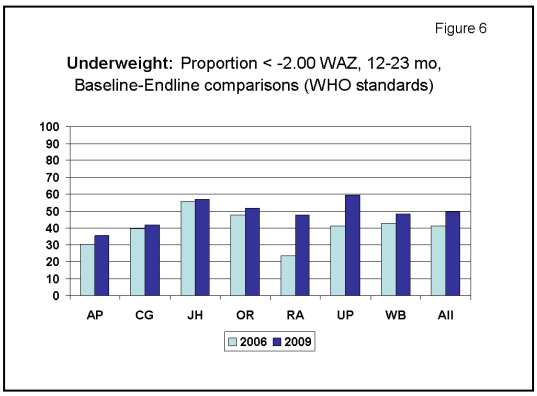
It should be emphasized that the quantitative data presented below represent, at best, a small part of the findings of this evaluation. Much of the work that CARE did during the three year phase-out period that is the subject of

Figure 5

Service delivery indicators
2006-2009



this report was directed at system-strengthening, not at the demonstration of population-level outcomes. Both literally and figuratively, the greater distance that CARE had from the points of service delivery translated into a significantly reduced opportunity to show quantitative achievements at the household level and to have measurable achievements attributed to its work. In other words, the indicators reported on here, in many ways, are not a complete reflection of CARE's work. All of the members of the evaluation team found that CARE's work to strengthen the processes through which the ICDS and NHRM function to bring about desirable results was appropriate and constructive, and that major progress on population-level outcomes will likely follow. Given the rapid schedule of withdrawal of CARE from project areas, the addition of numerous blocks and districts to their activities (replication areas) and the policy of universalization of eligibility for ICDS services, the finding that there was no statistically significant change for seven out of the eight service delivery indicators measured in the survey (which are shown in Figure 5) (exception is discussed below) could be interpreted as a sign of successful transfer of CARE's work to the GOI and state governments.



Performance Indicators

Although substantial progress had been seen during the INHP II, with a reduction of 8 percentage points in the proportion of children under-nourished, as determined by weight-for-age, further reductions were not found during the final phase of INHP III. The 2009 survey data showed no change in four of the states and indicated that malnutrition increased significantly in RA and UP. These findings highlight the complexity of interpreting determinants of change in nutritional status over time. It is clear that malnutrition rates, according to this and other parameters such as height-for-age, remain unconscionably high throughout the project states. Nevertheless, the evaluation team feels strongly that the lack of measurable progress in reducing under-nutrition, as measured by weight for age, in the project areas should not be attributed to an unsuccessful effort on the part of CARE and its partners. All of the following discussion needs to be considered in interpreting the results shown in Figure 6:

- seasonality[4]: the 2009 survey was conducted during the "hungry season", the time of year during which it is well established that malnutrition prevalence rates in India are at their highest. The 2006 survey was conducted in January-February, a quarter-year removed from the time of the final survey, a time when malnutrition prevalence rates are generally improving. Certainly not all of the differences can be attributed to this single factor, but one suspects that were a survey to be repeated during the identical months as the 2006 survey, better results might be shown. Cross tabulation of INHP data shows no relationship between underweight status and recent illness, which is sometimes also a seasonal effect, but had no apparent impact here.

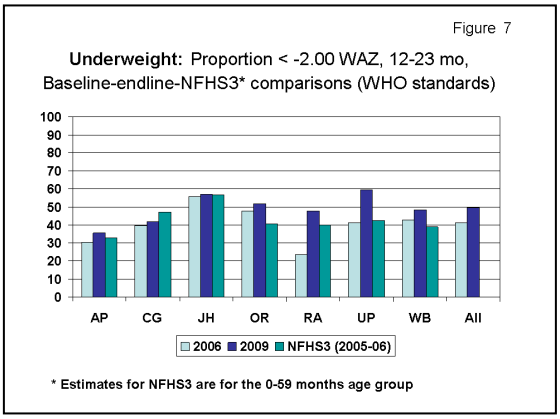
[4] Brown, K., et al. "Seasonal Changes in Nutritional Status and Prevalence of Malnutrition in a Longitudinal Study of Young Children in Rural Bangladesh", AJCN, 36, 1982, pp. 303-313.

- drought: the growing season in 2009 was seriously affected by drought and, as a result, the harvest suffered. One can surmise that families could grow less food to put on their tables, and that they had less money with which to purchase food in the market. About fifty percent of the blocks sampled for the endline survey were classified by the government as drought-affected.

- fiscal crisis: it is well known that 2009 is a year of financial crisis in most countries of the world. India, while relatively sheltered on the macro- level, was not immune at all in terms of the effect the global crisis has had on its poor.

- As a result of both drought and the fiscal crisis, food prices, including those for staples, rose drastically during the course of 2008-2009. The price of rice in some rural markets visited by the evaluation team rose by as much as one-third, and the price of dal lentils doubled. This could clearly have had an important effect on the prevalence of acute malnutrition in children and one could even argue that being able to show no statistically-significant increase in underweight prevalence in five of the seven states surveyed represents an important success of INHP III.

Figure 7



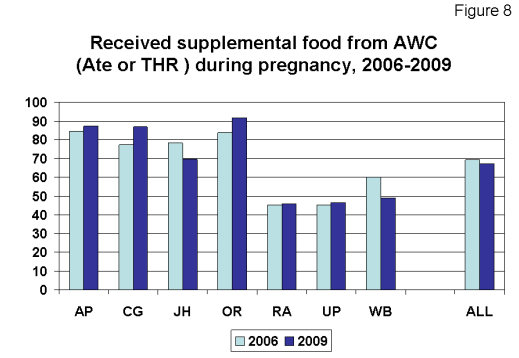
Still, based on the results shown in Figure 6, it would be hard to argue that, despite all the extraneous factors, ICDS held its own in Rajasthan and Uttar Pradesh. However, the data shown in Figure 7 make one wonder about the accuracy of the data from the 2006 survey, because the results of the CARE survey and the NFHS-III for Rajasthan are so strikingly different. While it is true that the populations reported on are considerably different (under-three year olds for the NFHS, children aged 12-23 months for the CARE survey), this difference would tend to result in higher malnutrition rates for the CARE population, the opposite of what is seen. Given the anomalous nature of these results, together with questions regarding data collection timing and the limitations of the data discussed above, the best that the evaluation team can say in regard to underweight prevalence in the project areas is that there is no sign of the remarkable reductions in malnutrition that were recorded at the end of INHP II, but that the prevalence of malnutrition seems to have remained stable during the phase-out years in four states, despite the existence of numerous factors external to the project that might have resulted in an important deterioration. Given the rapid expansion of INHP III, both geographically and in terms of target population, and its contraction in terms of hands-on interventions, the lack of significant change in most states could be interpreted in a positive light.

The evaluation team cannot end a discussion of the relationship between the project and underweight prevalence in Indian children without noting the well-known disparity between the rate of economic growth in India and the unconscionably high levels of malnutrition that remain. Clearly, something is out of kilter. Food distribution, at the level at which it has occurred in India for many years, is not having its desired effect. The evaluation team is

unanimous in its opinion that supplemental food distribution, a political right in India, and a powerful incentive that draws people into the system, including many who were previously excluded for a variety of social reasons, must be complemented by a major effort to influence and change household feeding behaviors and related community norms.

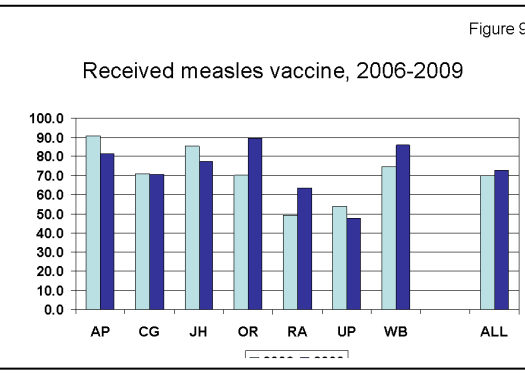
The difficulty that the team experienced in interpreting the nutrition survey findings also suggests that future efforts should select indicators that can be attributed directly to project interventions, in this case strengthening of systems. Unlike the situation in INHP II, CARE was not working in the communities and CARE's assistance to the government did not address several of the factors mentioned above that are known to have an important impact on nutritional status.

Figure 8



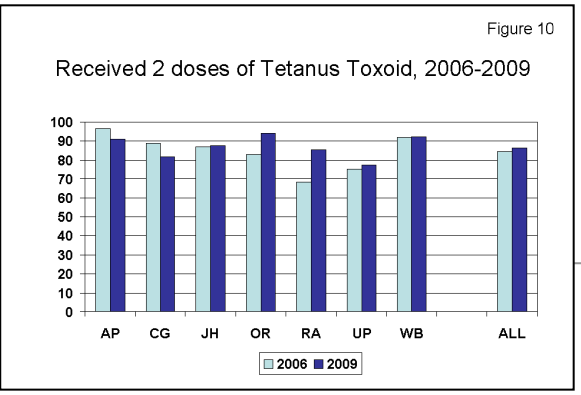
Indisputably, ICDS is functioning at a reasonable level in INHP-supported areas as Figure 8 shows that in four states upwards of 70 percent of mothers of children less than 2 years old are either receiving dry food for home consumption or bringing their children for on-site supplementary feeding. In Rajasthan, UP, and West Bengal, the numbers are substantially lower and this difference seems to persist across numerous measures of the survey. In any case, it is again heartening to see that despite the disengagement of CARE from the peripheral levels of ICDS, the numbers of vulnerable groups being served in all of the States were relatively well maintained. The evaluation team interprets this as a sign of successful transfer of INHP operations to the Government, a potentially important indicator of sustainability.

Figure 9



A clear sign of success for INHP III and of the "convergence" between ICDS and NRHM is seen in Figure 9 which documents measles vaccination coverage for children aged 12-23 months during the phase-out period. Although Rajasthan and UP continue to record lower levels than the other States, Orissa, Rajasthan and West Bengal show increases in coverage and the others are either stable or have moderate declines to still-acceptable levels. Immunization coverage levels have been generally increasing throughout India, and for the most part, there has been even higher achievement in the project areas, although the performance of UP remains considerably under par and CARE and all of its partners, especially the government, should make a special effort to raise and to sustain measles vaccination coverage levels.

Figure 10



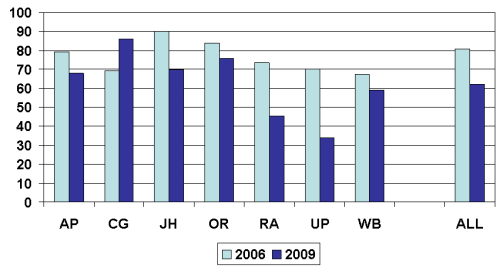
Another element of the Expanded Program on Immunization that was evaluated, tetanus toxoid vaccination of pregnant women, shown in Figure 10, says more about the effectiveness of ante-natal care programs than it does about child

health, although newborns are certainly the major direct beneficiaries of the intervention. Adequate vaccination levels have been achieved in all of the States affected by the project and in some, important increases were documented even during the phase-out period. This is indicative, again, of successful collaboration through the convergence effort between ICDS and NRHM initiated by CARE and, now, successfully embedded in Government policy and practice. Sustaining these levels of tetanus toxoid vaccination over time will result in declines in an important cause of newborn mortality.

Figure 11, though, shows that considerable effort is still required to change breast feeding behaviors. Exclusive breast feeding during the past 24 hours, shows considerable decline from 2006. For this measure, the evaluation team cannot offer a good explanation for the patterns of change, with an increase seen in Chhattisgarh and relatively important declines in this behavior documented in the other states. More analysis will be needed to understand determinants of these findings. It must be noted that the rates for 2006 reported for several of the states were much higher than those reported by the NFHS in 2006.

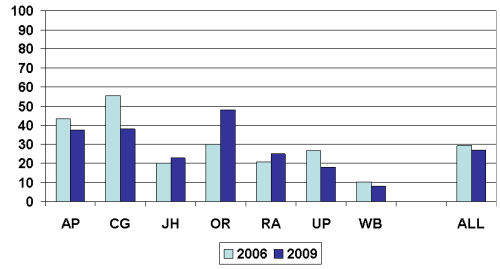
Figure

Exclusively breastfed in previous 24 hours, 2006-2009



Figure

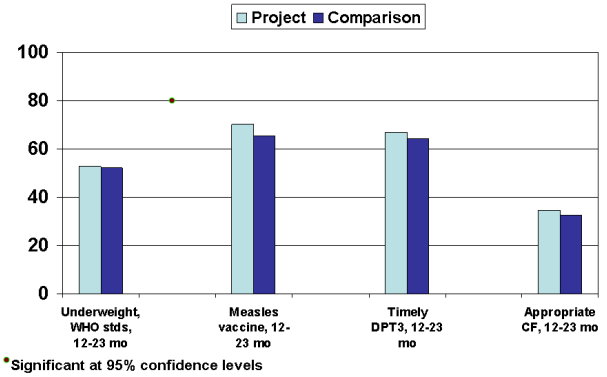
Visited by any health worker or volunteer on day of birth, 2006-2009



Other indicators of interventions aimed at improving the health of the newborn, however, have not yet been successful. Current ICDS policy is to focus on children under two and those with whom the evaluation team interacted attributed the relatively recent capacity to focus key services on under-two year olds and, increasingly, on the newborn, to CARE and its work in providing effective technical assistance in many areas of intervention. Still, the proportion of newborns visited by any health worker on the day of their birth remains fairly low. While an astounding increase in the proportion of infants delivered in health centers has been recorded over the past few years in India, the denominator for the data shown in Figure 12 is derived from at least 40% of mothers who continue to give birth in the home. "As early as possible" home visits are established good practice and a proven effective intervention for reducing maternal and newborn mortality and, in the INHP areas, as is the case undoubtedly elsewhere in India, much progress remains to be made. In fairness, however, the GOI is evolving its approach to newborn care and newborn care has not been a part of the pre-service training of AWWs.

Figure 13

Project vs Comparison areas, 4 states pooled



Comparison Data from Non-CARE Districts in Four States

As described in the methods section, the endline survey was designed to collect

quantitative data in four states which are not saturated with INHP. To further match the comparison data with the endline sample from CARE intervention areas, the independent analysis team used a statistical method known as propensity scoring which matches respondents on a variety of socio-economic variables collected in the survey.
The comparison data shows that there is no statistically significant difference between INHP areas and comparison areas in underweight. This is shown above in Figure 13. Interestingly, exclusive breastfeeding in the previous 24 hours, which appears to have declined in project areas from 2006, is still significantly better in project areas than in comparison areas, as shown in Figure 13.

Differences in service delivery in areas where CARE operated (project) and didn't operate (comparison) are shown in Figures 13 and 14. In general, coverage and behaviors were found to be better in project areas, particularly for the maternal and newborn indicators. As discussed above, a low percentage of post-partum women in project areas is receiving home visits by health workers during the first 24 hours but this occurs even less frequently in the control areas, as seen in Figure 14. It is clear from the comparison data that women and children in the project areas are having much more contact with the AWCs and AWWs than women in the comparison areas as is shown in Figure 15.

Figure 14

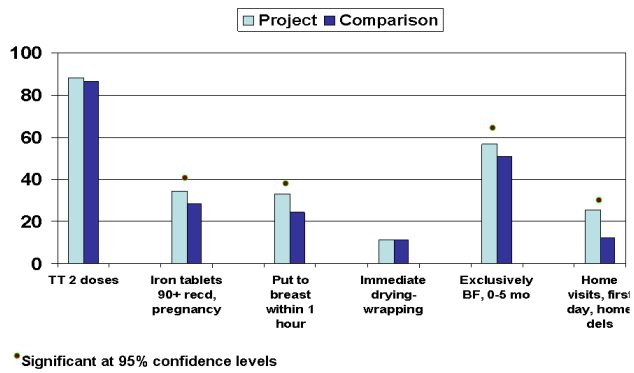
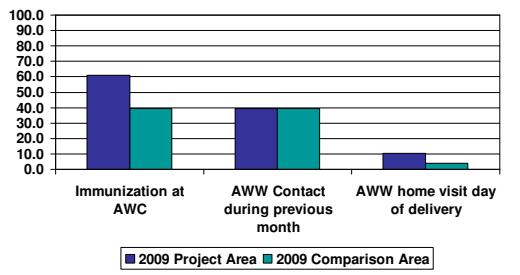


Figure 15



Due to time limitations, the evaluation team did not have the option of investigating what elements of systems strengthening of INHP might have influenced the better level of service delivery and some behavior changes in the project areas, but the results may be taken as evidence of project impact.

In summary, findings of the quantitative data regarding IPTT indicators are as follows:

- In spite of the previously mentioned limitations, the evaluation team feels that the data can be mined for considerable value. Certainly, there has been no serious deterioration in the level of the primary indicators over the last three years. The team interprets this to mean that CARE has successfully transferred key systems and capacity to GOI, through its successful support for "convergence" of the ICDS and NRHM, and has done so in a reasonably sustainable manner.

- The AWW and higher-level workers have been quite successful at raising and maintaining vaccination levels for measles in children and for tetanus toxoid in pregnant women. By extension, one could surmise that the entire vaccination program in the project areas is performing well (an impression corroborated by interviews with INHP personnel and partners, and by examination of the management and supervisory tools put into place through INHP III).

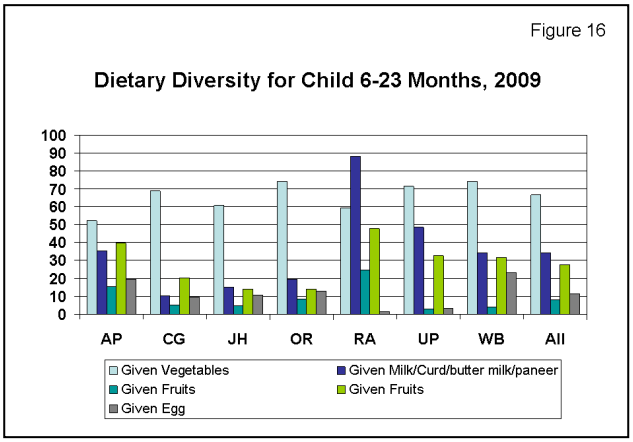
- The area which needs the most work is one of the most recent that GOI is addressing – improving newborn care. The evaluation team feels that although not much measurable progress on newborn care in INHP areas has been made to date, the systems-strengthening processes that CARE has worked on putting into place, the process of convergence and its implementation, and the health promotion work of the AWWs combined with the efforts of the relatively new cadre of ASHAs sets the stage for considerable progress in the near future.

Other Quantitative Results

The extensive survey instrument asked respondents about many health and nutrition practices besides those listed in the IPTT indicators. Those findings will be of interest to CARE, the GOI, the Coalition for Sustainable Nutrition Security and others to inform design of future maternal-child health and nutrition interventions. Data analysis continues on this wealth of information. As mentioned previously, the evaluation team recommends that future programs focus more on changing household level practices and, in line with that recommendation, the following results are of interest.

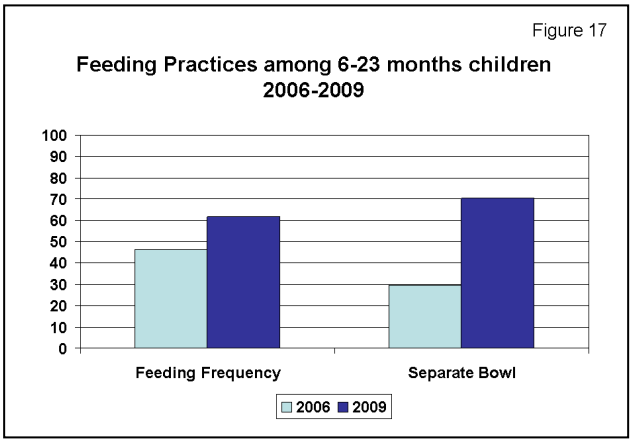
Figure 16 shows results of dietary diversity for children 6-23 months. While 100% of children were given grains, the staple of the ICDS supplemental feeding, the percentage who were given a variety other foods during the previous 24 hours was low.

Figure 16



Crosstabulation of data did not show any relationship between nutritional status and recent illness, but the crosstabulations did show a statistically significant relationship between underweight and each of the questions used to assess family food insecurity, as well as to a composite food security indicator. Crosstabulation using the composite indicator shows that 80% of households in the sample are food insecure and 76% of the underweight children (WHO standard) come from those households. This indicates a need to improve household food security sustainably beyond the current government programs. The analysis for the individual food security indicators is shown in Annex 6.

Figure 17



Although never used individually as project indicators in INHP II or INHP III, there were statistically significant improvements in two key complementary feeding indicators, which were included in the quantitative survey. The percentage of children receiving the recommended number of feedings per day in addition to breast milk for their age, increased from 46.3% at baseline in 2006 to 61.7% at endline. Similarly, children being fed out of their own bowl increased by over fifty percentage points from 29.7 to 70.4%, as shown in Figure 18. These results show that behavior change is possible in a relatively short period of time, using the approach and materials INHP instituted with the AWWs. This level of change did not occur in UP or RA, the states where the survey findings indicated that underweight prevalence increased.

Competency Tests

As a part of the final quantitative investigation, competency tests were administered to a random selection of ICDS personnel working at the community, block, and sector levels in the INHP areas of four states with the comparison areas. There was one for AWWs and another for supervisors and CDPOs. Sample sizes were too small for statistical comparison between states,

but, as shown in Figure 19, overall, ICDS staff in the project areas tended to score higher than those in the comparison areas. CARE will need to further analyze this data to determine specific subject areas which need strengthening in the NIPCCD training curriculum. This level of analysis was not required or feasible during the final evaluation.

Figure 18

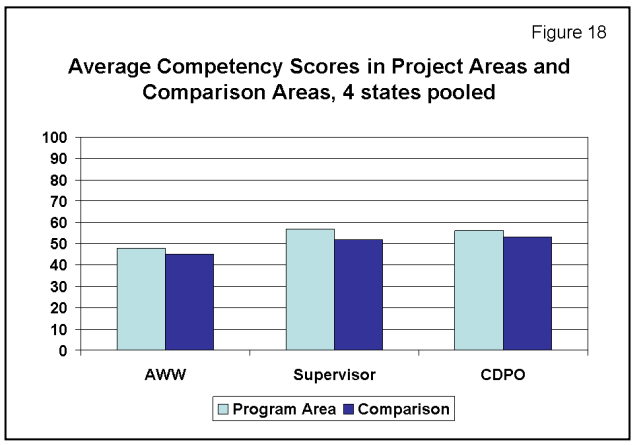


Table 4. Sample Sizes for the Competency Tests

Area	Supervisors	AWWs	CDPOs
OR Program	85	120	18
OR Comparison	60	102	15
RA Program	64	89	10
RA Comparison	46	98	12
UP Program	116	79	20
UP Comparison	80	78	22
WB Program	57	101	14
WB Comparison	66	92	11

The complete report on results of quantitative analysis done at the time of report submission is presented in Annex 6. The evaluation team recommends that CARE India, with the assistance of CARE USA, further analyze the data and share findings which will be useful to the GOI, states, and other organizations addressing food security and nutrition in India. The data base could be included in the proposed National Resource Center.

CONCLUSIONS

The evaluation team concludes that:

1. Key elements of INHP are mainstreamed into ICDS and NHRM at the central level and in all eight states. This achievement is likely to be sustained because the key processes and systems of INHP are integrated and part of the ICDS structure.

2. All four strategies of INHP were implemented as planned. CARE's assistance to the GOI and state governments in program planning, independent performance monitoring, and capacity building were needed to facilitate integration, replication, and sustainability.

3. INHP has been particularly successful in strengthening management systems and expanding coverage. Levels of service coverage were sustained, which is a very positive outcome. ICDS is better equipped to have an impact on child health and nutrition than at any prior time.

4. Government leadership has a major effect on the sustainability of systems and policy priorities. Frequent changes in leadership at multiple levels in ICDS are challenging and make it harder to improve program impact in a relatively short time.

5. INHP has furthered the involvement of local elected leaders in mobilizing communities and monitoring service delivery.

6. The multi-sectoral approach in jointly managing and delivering a few essential health services and food rations at the community level is working. Similarly, there is functional convergence with rural development objectives to engage community leaders in program accountability. This coordinated approach provides a platform for expanding convergence with other services that are critical to child health and nutrition including clean water, sanitation, and availability of diverse foods. This broader view needs to be explored in Plans of Action for Nutrition and for the next phase of ICDS.

7. The project has been especially successful in strengthening food distribution and management systems. The change in central government policy to place more emphasis on reaching children under two years of age needs to be reinforced. There are, however, major barriers to addressing India's huge nutrition challenge without more intensive behavior change approaches. The troubling prevalence of child malnutrition, indicated once again in the survey data collected during INHP III, highlights the need for greater understanding of determinants of nutritional status in India and for attention to remove barriers to adequate diets and health care at household levels. ICDS is now much better positioned to undertake behavior change and this component is a priority to bring about desirable improvements in nutrition outcomes.

8. CARE successfully developed a replication approach with two state governments and is in the process of implementing it. As of October, 2009, CARE had not quite completed the replication phase but the team found it to be on track in AP. The USAID-supported FANTA study on sustainability can further evaluate the CARE replication strategy.

9. CARE's years of involvement at the field level, through a network of staff and NGO partners, has informed their contributions to strategic planning and policy development at the national and state level. State governments value CARE's technical role and operational research for both planning and improved program implementation (Annex 3).

10. CARE has practical experience to share with the Nutrition Council, the Coalition for Sustainable Nutrition Security, and central and state governments for their ICDS planning and policy development. Coordination with other donors to ICDS such as USAID, DFID, World Bank, and UNICEF, in contributing well-researched directions at the policy level will continue to be critical in achieving an impact on nutrition.

RECOMMENDATIONS

1. Although there was an expectation that CARE's effort would end in December with this phase, their technical assistance and network of state offices is still required to consolidate the gains they have made at the procedural and structural level. More time is required to complete the replication process, capture the sustainability lessons, and contribute to strategies to improve nutrition and newborn outcomes. Leveraging USAID investments to improve nutrition in India will require sustained efforts at all levels. Thus, the evaluation team recommends a "no-cost extension" for an orderly close-out period during which project resources should focus on completing a few priorities. The time should be used to complete analysis and document the project's experience with sustainability and replication of tested interventions. INHP should also seek to contribute findings for GOI strategy development and reform of ICDS interventions (Specific technical suggestions are included in #6 below.)

2. Similarly, project research findings and key practices should be synthesized so that they could be used to inform USAID's new strategic directions. After the debriefing with the USAID Mission Director, the team recommends that USAID and GOI explore the success of INHP in linking two sectors through a few targeted interventions for possible expansion in other sectors that impact community health and nutrition.

3. In our judgment, the best way for USAID and ICDS to move forward is to continue to build on this partnership with ICDS because it provides an extensive and flexible platform for implementing critical policies and programs needed to reach vulnerable

populations, and it builds upon the current level of convergence with the Ministry of Health and Family Welfare. The yield on any additional investment would be considerable and seems to be consistent with USAID future objectives.

4. Where applicable, the GOI should scale-up successful program policies, management approaches, and systems from the target INHP states to the remaining ICDS program areas.

5. The Indian government and its partners would benefit from adapting and expanding the alliances and partnerships, particularly those CARE developed at the community level, to increase community engagement and local government accountability.

6. During the remaining time of CARE's project, CARE and USAID should consider contributing to ongoing GOI efforts to improve ICDS policies and related programs through a focus on replication, sustainability and nutrition issues:

    i. The qualitative and monitoring data sets collected during INHP III should be used to examine critical factors for sustainability. They also could be used, in conjunction with the quantitative date, to analyze causes of malnutrition in project areas. Results should be disseminated.
    ii. Since the evaluation team agreed that the prevalence of malnutrition needs to be addressed as a priority, CARE and USAID should fully implement the recommendation from the RACHNA evaluation by providing technical assistance to put in motion operations research for family feeding behaviors and behavior change approaches during home visits by AWWs and ASHAs; and, also to examine how supervision on the effectiveness of these approaches could be strengthened. Such small-scale demonstration projects are critical to support GOI policy and program development since successful models could be replicated by ICDS.
    iii. Increase accountability for major investments to reduce child malnutrition through effective measurement and reporting of nutrition status and use of such data for management and decision-making at all levels.
    iv. Transform weighing of children in ICDS into a preventive growth promotion program for under-twos, focusing more on weight gain and prevention of growth faltering and less on Nutritional Status Grades Normal through 4 and treatment of severe malnutrition.
    v. Re-orienting the priority tasks of the AWW in ICDS to focus more on growth promotion in under-twos including effective counseling, educational sessions, and home visits to improve breastfeeding and complementary feeding and hygiene practices.
    vi. To improve neonatal health, ASHAs need much more training on maternal nutrition and newborn care.
    vii. Improving the quality of early childhood development and preschool education to increase participation at the anganwadi centers.

7. CARE is well-positioned to contribute to a Resource Center for Nutrition and Health as was previously stated in the RACHNA evaluation. Additionally, CARE should seek greater involvement in the existing nutrition alliance. In cooperation with other USAID partners and the Indian government, CARE and USAID should determine where all the documentation and data created by 13 years of USAID investment can be best located and used.

8. CARE should mainstream materials into the new training curricula of NIPCCD.

ANNEX 1

Final Evaluation Team

Final Evaluation Team Members:

1. **Judiann McNulty, DrPH (Team Leader)**
2. **Heather Goldman, PhD (Lead Writer)**
3. **Dr. Rajesh Kumar**
4. **Ronald Waldman, MD, MPH**
5. **Dr. Sanjay Zodpey**

Contributions by Purnima Menon, PhD, IFPRI

Government of India Participants:

State	Dates of visit	Name of the Officer
Rajasthan	26-29 October 2009	Mrs Surendra Jain, ATA
Andhra Pradesh	26-28 October 2009	Mr Ravi Shankar, DTA, HQ
Madhya Pradesh	30-31 October 2009	Dr Saroj Adhikari, AD (Trg)
West Bengal	26-28 October 2009	Dr Sutapa Mukherjee, DTA
Orissa	29-30 October 2009	Shri Kameshwar Mishra, SO
Uttar Pradesh	26-28 October 2009	Mr Balbir Singh, SO (ND)
Chhattisgarh	29-31 October 2009	Shri A.K. Goyal, Sr. Programmer

State Level Officials accompanying Final Evaluation Team on Field Visits:

S.No.	State	Name of the officer
1	Orissa	Jyoti Kanugo, DSWO (HQ) from W&CD
2	West Bengal	Mr. P.K. Majhi, DWCD and Social Welfare Mr. P.K. Saha, DHFW
3	Andhra Pradesh	Ms. Pramodini, Regional Deputy Director, WDCW
4	Uttar Pradesh	Dr. Lily Singh, Additional Manager, ICDS
5	Rajasthan	
6	Chhattisgarh	
7	Jharkhand	Poonam Kumari, CDPO Dr. Rajmohan Xalxo, MOIC Himani Pandey, IAS, DC Mr. Lal Singh Kuril, DPO Dr. Nagendra Prasad, CS

Agencies for Data Collection

1.	Sambodhi (Nodal Agency)
2.	ORG Nelson (Data Collection Agency Quantitative)
3.	TNS Mode(Data Collection Agency Quantitative)
4.	GfK Mode(Data Collection Agency Quantitative)
5.	IMRB(Data Collection Agency Qualitative)

ANNEX 2

SCHEDULE AND PERSONS INTERVIEWED DURING STATE VISITS

Annex 2

SCHEDULE AND PERSONS INTERVIEWED DURING STATE VISITS

Andhra Pradesh:

Visiting Team:
Dr. Sanjay Zodpey, PHFI, New Delhi, Shri Ravi Shankar, Food and Nutrition Board, MWCD, New Delhi
Deputy Director, MWCW, AP Government
AP CARE Team

Dates of Field Visits: 27th and 28th October 2009 **Stakeholders: Name and designation of WDCW Official**		
1	Ms. M Chaya Ratan, IAS	Principal Secretary to Govt. Women Development, Child Welfare & Disabled Welfare, GoAP, Hyderabad
2	Ms. Y.V. Anuradha, IAS	Commissioner, Women Development and Child Welfare, GoAP
3	Ms. Pramodini Rani	Regional Dy. Director, Hyderabad Region Women Development, Child Welfare Dept.
Name and designation of CFW Official		
4	Dr. Srinivasa Rao,	Jt. Director (RCH-II)
5	Dr. Srinivas	Joint Director (Training)
6	Dr. Deva Raju	Additional Director (FW)
7	Prof. K.Kodandaram	State Advisor to the Supreme Court Commissioner on RTF
Field Visits to Nalgonda District:27th October 2009		
8	Ms. Udayalaxmi	Project Director, WD&CW Official
9	Ramannapet	Block office
10	Ms. Moti	CDPO
11	Munipampula	Sector
12	Ms. Yadamma	Supervisor
14	Ms. Anitha	
15	Ms. Anjamma	
16	MD. Gousia	
17	U. Laxmi and M. Premalatha	
Field Visits to Medak District:28th October 2009		
Gajwel		
18	Lingareddypally	
19	Viziyalakshmi	
20	Bharatmma	
21	Daultabad	
22	Aruna	
23	Kishtaiah	
24	Mr. Mahendra	
Sidddipet Block		
25	Kukunupalli	
26	Dr. Padnabu	
27	Addl. Dr. Rangareddy	
28	Mercy Grace Kumari	PD, ICDS,
29	Ramulu	Sarpanch
30	Yellaiah	CDPO
	Prof. Kondanaram	State Advisor to the Supreme Court on RTF

Madhya Pradesh:

Visiting Team:
Dr. Sanjay Zodpey, PHFI, New Delhi
Dr. Saroj Adhikari, MWCD, GOI, New Delhi
MP CARE Team

Dates of Field Visits: 30th and 31st October 2009 **Stakeholders: 30/10/2009 Seoni District**		
1	Budhani Uike	AWW, AWC Kodiyamal, Chapara Block
2	Sarla Chokse	AWW, AWC Bilacta, Chapara Block
3	Tukaram Chokse	Former Sarpanch, PRI, Bilacta, Chapara Block
4	Lilavati Pande	ICDS Supervisor, Chapara Block
5	Sati Balakram Sahoo	ICDS Supervisor, Chapara Block
6	Maya Thakur	ICDS Supervisor, Chapara Block
7	Anita Srivastava	ICDS Supervisor, Chapara Block
8	Dr. Khare	CHMO, Chapara Block
9	Mr. Kasim	District Program Manager, Chapara Block
10	Dr. Pateriya	District Program Manager, Chapara Block
11	Amin Charles	Director, Community Development Centre (CDC), Seoni (NGO)
31/10/2009: Balaghat District		
12	Dr. R.K. Pandya	In-charge DIO, Balaghat District Hospital
13	Kalpana Tiwari	District Project Officer, Balaghat
14	Smt. Manju Shukla	CDPO, Warasioni Block
15	Parvati Pancheshwar	AWW, AWC Dhanitola 1, Warasioni Block
16	Anju Baghel	Panchayat Member, Zaliwada, Warasioni Block
17	Urmila Patle	AWW, AWC 1 Zaliwada, Warasioni Block
18	Motan Chaudhari	AWW, AWC 2 Zaliwada, Warasioni Block

Rajasthan:
CARE / Rajasthan Staff

1	Vandana Mishra	State Representative
2	Arunangsu Chowdhury	Regional Manager
3	Devashish Bhattacharya	Program Support Manager
4	Praveer Goyal	Program Officer, Churu District
5	Sunita Sharma	Program Officer, Jhunjhunu District
6		
CARE/Rajasthan's NGO Partners		
7	Sudheer Bhatnagar	Secretary, Mewar Sewa Sansthan, Bhilwara
8	Manoj Agrawal	Program Manager, Ambuja Cement Foundation, Pali
9	Mrs. Shashi Tyagi	Secretary, Gramin Vikas Vigyan Samiti, Jodhpur
10	Arvind Ojha	Secretary, URMUL Rural Health Research and Development Trust
11	Rajan Chaudhry	Secretary, Shikshit Rojgar Kendra Prabandhak Samiti (SRKPS)
12	Devanand Srivastava	Project Manager, Bhoruka Charitable Trust, Churu

ICDS and RCH State Officials		
13	B. Praveen	Director, ICDS
14	JP Menon	Asst. Director, Nutrition
15	Dr. M.L. Jain	Director, RCH
Churu District		
16	O.P. Meena	Deputy Director, ICDS
17	Dr. Ajay Chowdhury	RCHO
National Rural Health Mission Representative		
18	Devindar Singh	CDPO, Rajgarh
19	Deepak Kapila	CDPO, Churu
20	AWWs Sushila	Dhadhar II
21	Parmeshwari	Ghanghu I
22	Kosala	Ghorta X
23	Suman Seni	Gram Panch, Ghorta
Jhunjhunu District		
24	B.L. Dangi	Deputy Director, ICDS and also CDP, Jhunjhunu
25	Dr. Sharma	RCH Officer
26	Vikram Singh	District Program Manager, NRHM
27	Dr. R.B. Singh	CMHO
28	Hanuman Singh	CDPO, Alsisar
29	Lali Daya	CDPO, Chirawa
30	C.P. Sharma	CDPO, Khetri
31	Mrs. Heman Chohari	CDPO, Udaipur – Wati
32	AWWs Subhita	Chimanpura, Rajghar
33	Gyani Devi	Loyal 1, Khetri
34	Prevlata	Warishupra #43
35	Anjani Devi	Panch
36	D. Jhunu	Johad Kidhan, Nawalgarh Training session involving 25 AWWs and 5 Lady Supervisors at Rajota AWC

Chhattisgarh

List of persons met by Final Evaluation Team (Dr Judiann & Mr. A. K Goel)

Place and Name	Name of the person	Designation
Date: 30st October'2009		
Block Dongargaon AWC I : Salik Zhitia	MrsRamkumari Sahu Mrs Kausalya Devi. Mrs Motin Bai Mr Nanduram Sahu	Anganwadi worker Anganwadi helper Mitanin/PRI Dy. Sarpanch
Block Dongargaon AWC II: Amlidih	MrsVimla Sonkar Mrs Sundariya MrsAnita sinha	Anganwadi worker Anganwadi helper ANM
Block: Dongargaon	Mrs.Hansu Sahu Mrs.Vimla Bhat Mrs.M. Wike	ICDS Supervisors
	Mr.Rajesh Sahu Mr.Kriparam Banjare	NGO Block Coordinator engaged in the thematic partnership(PRI engagement)
	Mrs. Kiran Sahu Mrs.Uma Devangan Mrs.Dulavi Verma	Change Agent become Panchayat Representative
District Rajnandgaon (W&CD)	Mr.Dildar S. Maravi Mr.Sumit Kedia	District Program Officer District Extender UNICEF
District Rajnandgaon (Health)	Dr. Chellani Dr. Mitlesh Chaudhary Dr. Pawan Jetani Miss. Piuli Mujumdar	District Health Officer RCH Nodal Officer District Immunization Officer District Program Manager NRHM
District Rajnandgaon(W&CD)	Mr Rajesh Choudhury	District Program Manager NRHM
State : Raipur	Mrs Archana Rana	Director State Resource Center
	Mr.Khir Sagar	Food and Nutrition Board
	Mr.Samir Garg	Supreme Court Advisor
	All staff CARE-CG	
Date: 31st October'2009 **District Mahasamund**		
District : Mahasamud	Dr.Pardal	DIO,District RCH Officer`
Block Mahasamud	Ms. Mongara Goswami	LHV
	Ms. Kameshwari Dhruv	ANM
	Ms. Y.Sheel	ANM
	Ms. Leela Sahu	AWW
	Ms. Rishi	AWW
	Ms. Anita Agrawal	DPO
	Ms. A.Tiwari	Principle AWTC
	Ms. Shweta Dave	Instructor AWTC
	Ms. Mamta Chandraker	Instructor AWTC
	Ms. A.Shrivastav	Supervisor
	Ms. Kusum Dubey	Supervisor
	Ms. Pal	Craft Instructor AWTC
District : Mahasamud	Mr. Mukherji	DPM
31st October'2009 State Level	Mrs Lata Usendi	Minister of W & CD
	Rajesh Singhi	OSD to minister W & CD

Jharkhand:

Dr. Ronald Waldman Visit to Jharkhand 29/10/09

Staff meeting at CARE Office:		
1	J.K. Kandimalla	State Program Representative
2	Anupam Srivastava	Regional Manager
3	Ravikant Upadhyay	Regional Manager
4	Dr. Anand Das	Sector Support Coordinator
5	Sanjay Patnaik	Commodity Tech Asst Officer
6	Meena Jain	M & E Officer
7	Eight CARE Program Officers	
8	Atrayee Majumdar	Admin Assistant
9	Mitu Kumari	Admin Assistant
10	Mr. Siva Purthi	CEO,ASRA (NGO)
11	Mr. Hemram	Traditional Panchayat leader
Meeting with Right to Food Representatives		
1	Prof. Ramesh Sharan	Dept of Economics, Ranchi University
2	Mr. Gurjeet Singh	RTF Activist
I	**Meeting with 'Kuru' Block Officials**	
1	Smt. Poonam	Child Development Project Officer
2	Dr. Rajmohan Xalxo	Medical Officer In Charge
3	Mr. Khurshid	NGO Representative
4	Mr. Kunti	NGO Representative
II	**Meeting at the AWC – Jamari**	
1	Ms. Kusum Devi	Anganwadi Worker
2	Ms. Leela	Lady Supervisor
3	Ms.Manikanta Verma	Lady Supervisor
4	Smt. Kaili Oraon	Helper
5	Smt. Payari Kujur	ASHA worker
6	Smt. Sangeeta Oraon	Pregnant Mother
III	**Meeting at Lohardaga District HQ**	
1	Dr. Himani Pandey, IAS	Deputy Commissioner
2	Mr. Lal Singh Kureel	Dist Program Officer
3	Dr. Nagendra Singh	District Civil Surgeon
IV	**Meeting with Secretary**	
1	Ms. Alka Tiwari, IAS	Secretary, Ministry WCD & Social Welfare, GOJ
2	Ms. Pushpa Marandi	Director, Dept. WCD & Social Welfare, GOJ
3	Mr. S.P. Verma	Assistant Director
4	Dr. Ajit Kumar	State Immunization Officer
5	Dr. Sumant Mishra	State Representative Immunization Basics
6	Dr. Dinesh Singh	State Representative JHPIEGO
7	Dr. Suranjeen Prasad	State Coordinator, CINI
8	Mr. J.K. Kandimalla	State Program Representative, CARE
9	Ms. Anupam Srivastava	Regional Manager, CARE
10	Mr. Ravikant Upadhyay	Regional Manager, CARE
11	Dr. Anand Das	Sector Support Coordinator, CARE
12	Mr. Sanjay Patnaik	Commodity Technical Assistance Officer
13	Ms. Meena Jain	Monitoring and Evaluation Officer

Orissa:

Staff meeting at CARE Office:		
1	Basant Kumar Mohanty	State Director
2	Gyan Ranjan Das	PCM
3	Jayanta Upadhyay	SPR, INHP
4	Sarbajit Pattnaik	RM, INHP
5	S.K. Indira Devi	RM, INHP
6	Ashok K. Nayak	MEO, INHP
7	Sudip Das	CTAO, INHP
8	Dr. Raghunath Behura	TSU, Team Leader
9	Biraj Laxmi Sarangi	Health Sector Reform, TMST
10	G. Laxmi	Admin. Asst.
I	**Meeting with KHUNTA Block Officials**	
1	Mr. S. Nayak	Chairman, Panchayat Samiti
2	Dr. H.K. Pati	Moile, Khunta
3	Mrs. Diptimayee Pothal	Lady Supervisor, ICDS
4	Mrs. Asima Singh	Lady Supervisor, ICDS
II	**Meeting at AWC**	
1	Mrs. Sukanti Jena	AWW, Rutei Sahi AWC
2	Mrs. Kanaklata Maiti	ANM, Rutei Sahi AWC
3	Ms. Brundavati Mahant	AWW
4	Ms. Saraswati Dei	ANM
5	Ms. Nayanmanjari Rout	AWW
6	Ms. Sarojini Jena	ANAM
III	**Meeting at MAYURBHANJ District HQ**	
1	Dr. P K Meherda, IAS	District Collector
2	Dr. K C Mohanty	CDMO
3	Mr. P K Dehuri	DSWO, ICDS
4	Mrs. Deepali Otta	DPO, ICDS
5	Mrs. Sarpati Tudu	President, Zilla Parishad
6	Mr. A Pradhan	DPM, NRHM
7	Mr. Sukanta Upadhaya	PO, INHP
8	Ms. Runa Shamim	PO, INHP
9	Mr. Jagdish Behera	NGO staff, CREFTDA
10	Mr. Chintamani	NGO staff, CREFTDA
IV	**Meeting at State Level (30.10.09)**	
1	Mrs. Sujata Kartikeyan, IAS	Director, WCD, GOO
2	Mrs. Jyoti Kanugo	DSWO (HQ)
3	Dr. Chandrabhanu Sethi	Director, Family Welfare Dept. of Health , GOO
4	Mr. Rabindra K. Mishra	Deputy Director, Demography, Dept. of Health, GOO

Uttar Pradesh:

Dr. Judiann/Mr. Balbeer Singh Govt. of India, visit to Uttar Pradesh, October -25th to 29th 2009

List of Persons with whom interacted

At State Office Lucknow dated 26/10/2009		
S.No.	**Name**	**Designation**
1	Ms. Veena Padia	State Director Care India Uttar Pradesh
2	Ms. Pratibha Sharma	State Program Representative, Care India Uttar Pradesh.
3	Ms. Shubhra Trivedi	Regional Manager , Care India Uttar Pradesh
4	Mr. Anurag Srivastava	Regional Manager , Care India Uttar Pradesh
5	Mr. Subhash Moghe	Commodity Technical Assistance Officer, Care India Uttar Pradesh
6	Ms. Meenu Bhargava	Program Officer, Agra District, Care-Uttar Pradesh
7	Mr. Anoop Murari ranjan	Monitoring & Evaluation Officer, Care Uttar Pradesh
8	Ms. Junita Nirmal	Program Officer, Ghaziabad District, Care-Uttar Pradesh
9	Mr. G. N. Yadav	Program Officer, Raebareilly District, Care-Uttar Pradesh
10	Mr. Shashi Kant Yadav	Program Officer, Kanpur District, Care-Uttar Pradesh
11	Mr. Vivek Malviya	Program Officer, Fatehpur District, Care-Uttar Pradesh
12	Mr. P.P. Srivastava	Program Officer, Barabanki District, Care-Uttar Pradesh
13	Ms. Seema Singh Koshal	Program Officer, Sitapur District, Care-Uttar Pradesh
14	Ms.Alpana mehrotra	Admin Asst.CARE UP
15	Ms.Shiji Srivastava	Admin Asst.CARE UP
16	Ms.Shyama Tiwari	Program Officer, Raebareilly District, Care-Uttar Pradesh
17	Ms. Suniti Neogi	Operation Research Officer, ISOFI, Care Uttar Pradesh
18	Mr.Prashant K.Das	Program Manager,GEP CARE UP
19	Mr.Jeet Singh	Program Support Manager CARE UP
20	Mr.Ravi Lal Das	Team Leader,Sure Start ,CARE UP
21	Mr.Pashant Gade	Program Coordinator,GEP CARE UP
22	Ms.Parul Sharma	M&DO,GEP,CARE, UP
23	Mr.Ashish Auddy	Finance Officer
24	Ms.Farid Sultana	Account,Finance Unit
25	Mr.Vivek Agrawal	Account,Finance Unit
26	Mr.Dhiraj Padamwar	Admin and Finance Officer,Sure Start CARE UP
27	Mr. Sanjay Tripathi	Monitoring & Evaluation Officer, Sure Start Project, Care Uttar Pradesh
At State Level Govt. Of Uttar Pradesh Officials dated 26/10/2009		
28	Shri Amal Kumar Verma, IAS	Principal Secretary, Department of Women and Child Development, Govt. of Uttar Pradesh, Lucknow
29	Shri Chandra Prakash, IAS	Director ICDS, Department Women and Child Development, Govt. of Uttar Pradesh, Lucknow
30	Shri Santosh Kumar	Deputy Director Systems, ICDS, Department Women and Child Development, Govt. of Uttar Pradesh, Lucknow

31	Ms. Lilly Singh	Additional Program Manager, ICDS, Department Women and Child Development, Govt. of Uttar Pradesh, Lucknow
32	Shri Hari Om Dixit	General Manger, National Rural Health Mission, Directorate of Family Welfare, Govt. Of Uttar Pradesh, Lucknow
33	Dr. Usha Gangwar	Deputy General Manager, National Rural Health Mission, Directorate of Family Welfare, Govt. Of Uttar Pradesh, Lucknow
34	Dr. A. K. Gautam	General Manger, National Rural Health Mission, Directorate of Family Welfare, Govt. Of Uttar Pradesh, Lucknow
SC Adviosr		
35	Ms. Arundhati Dhuru	Food Advisor, Supreme Court, Govt. Of Uttar Pradesh Lucknow.
At Barabanki District dated 27/10/2009		
36	Ms. Deepika Ghosh	District Program Officer , Barabanki, ICDS, Govt. of Uttar Pradesh
37	Dr. A. K. Chowdhary	Chief Medical Officer, Department of Health, Barabanki District
38	Ms. Praveena Chowdhari	District Panchayat Raj Officer, Barabanki
39	Ms. Rajshree Kashyap	Child Development Project Officer, Dewa Project, ICDS,
40	Ms. Nagma Begum	Child Development Project Officer, Banki Project, ICDS,
41	Ms. Pushpa Verma	Anganwadi Worker Khajoor Gaon center, Dewa Block, ICDS,
42	Ms. Neelam Shrivastava	Anganwadi Worker Gopal pur center, Dewa Block, ICDS,
43	Ms. Jyoti Maurya	Anganwadi Worker Ibrahim pur Kala center, Dewa Block, ICDS
44	Ms. Meena Kumari	Anganwadi Worker Khewali-1center, Dewa Block, ICDS,
45	Ms. Shanti Devi	Anganwadi Worker Khewali-2 center, Dewa Block, ICDS,
46	Ms. Rani Devi	Anganwadi Worker Khewali-3 center, Dewa Block, ICDS,
47	Ms. Zabia	Anganwadi Worker Khewali-4 center, Dewa Block, ICDS,
48	Ms. Shalza Khajoorgaan	Sector Supervisor Devmai Sector Dewa block, Barabanki
49	Ms. Neelam Khevli	Sector Supervisor Harai Sector Dewa block, Barabanki
50	Ms. Hameeda	Sector Supervisor Tidola Sector Dewa block, Barabanki
At Shahjahanpur District dated 28/10/2009		
51	Mr. Raj Mangal	Chief Development officer, District Shahjahanpur
52	Ms Vimla Bahan	Secretary, NGO Vinova Seva Ashra, Shahjahanpur
53	Mr. Avadhesh Mishra	President, NGO Gramodaya Seva Ashram, Shahjahanpur
54	Mr. Arun Singh	Project Coordinator, Gramodaya Seva Ashram, Shahjahanpur
55	Mr. Dinesh Baham	Block Coordinator, Vinoba Sewa Ashram, Shahjahanpur
56	Ms. Ankita Agnihotri	Document M&E officer, Gramodaya Sewa Ashram
57	Mr. Hari Ohm Tiwari	Assistant Project Coordinator, Gramodaya Sewa Ashram,
58	Mr. Dharmendra Singh	Block Coordinator, Gramodaya Sewa Ashram, Shahjahanpur
59	Mr. Tarun Kumar Singh	PRI coordinator, Gramodaya Sewa Ashram, Shahjahanpur
60	Mr. Sabaran Singh	Block Coordinator, Gramodaya Sewa Ashram, Shahjahanpur
61	Mr.Atul Bajpai	PRI coordinator, Gramodaya Sewa Ashram, Shahjahanpur
62	Mr. Rajendra Kumar Singh	Assistant Project Coordinator, Gramodaya Sewa Ashram,
63	Mr. Pankaj Kumar Saxena	Advocacy & Gender Coordinator, Gramodaya Sewa Ashram,
64	Mr. Ashok Singh	Assistant Project Coordinator, Vinoba Sewa Ashram,
65	Mr. Ramesh Yadav	Assistant Project Coordinator, Gramodaya Sewa Ashram,
66	Ms. Geeta Divedi	Sector Supervisor, ICDS, Block Bhawelkhera, Shahjahanpur
67	Ms. Adarsh Mishra	Sector Supervisor, ICDS, Block Bhawelkhera, Shahjahanpur
68	Ms. Shasum Saxena	Sector Supervisor, ICDS, Block Bhawelkhera, Shahjahanpur
69	Mr. Satya Praksh Shukla	BC, Gramodaya Sewa Ashram, Shahjahanpur

70	Ms. Sheela Sihn	Assistant Project Coordinator, Gramodaya Sewa Ashram,
71	Mrs.Karuna Jaiswal	District Program Officer,ICDS, Govt. of UP for Shahjanhapur
72	Dr.Ajay Verma	Program Officer,Care Shahjahanpur
73	Mr.Y.K.S.Rathore	Program Officer,Care Shahjahanpur
74	Mr.Suresh Tiwari	Project Coordinator ,Vinoba Sewa Ashram, Shahjahanpur
75	Ms.Shilpi Saxena	Anganwadi Worker Village Feelnagar,Tilhar, Shahjahanpur
76	Ms.Shahana	ANM, Feelnagar center,Tilhar, Shahjahanpur
77	Mrs.Shahida	Gram Pradhan Feelnagar Panchayat,Tilhar, Shahjahanpur
78	Mrs.Maya Rathore	Anganwadi Worker Village Sareli,Tilhar, Shahjahanpur
79	Mrs.Rekha Bhatnagar	ANM, Sareli center,Tilhar, Shahjahanpur
80	Nanhi Devi,Pradhan	Gram Pradhan Sareli Panchayat,Tilhar, Shahjahanpur
81	Anuradha Rajput	Anganwadi Worker,Ferozpur,Tilhar,Shahjanpur

West Bengal

Visit of Dr. Rajesh Kumar

AWC Level at Raina-II Name of AWC: Barajpota AWC (AWC # 5), Raina –II.
Name of the GP: Kaity Gram Panchayat, Raina-II

Sl. No.	Name	Designation
1	Sk. Sabur Ali	Sabhapati, Raina-II Panchayat Samity
2	Mr. Kailasnath Mukherjee	DPO, Dist. ICDS Cell, Burdwan
3	Mr. Nilotpal Gupta	CDPO, Raina-II ICDS Project
4	Mrs. Rasonara Mollah	Karmadhaksya, Jana Swasthya O Paribesh Sthayee Samity, Bhatar Panchayat Sammity
5	Md. Rasul Karim	Pradhan, Kaity Gram Panchayat
6	Tripti Bhattacharya	AWW, Barajpota AWC
7	Mr. Sajal Mukherjee	Health Assistant (Male)
8	Mrs. Sora Dey	Health Assistant (Female)
9	Ms. Nandita Pal Choudhury	ICDS Supervisor, Raina-II ICDS Project
10	Ms. Piyali Ghosh Banerjee	PO, CARE

Participants in Block Level Meeting at Raina –II Panchayat Samity Meeting Hall

Sl. No.	Name	Designation
1	Sk. Sabur Ali	Sabhapati, Raina-II Panchayat Samity
2	Mr. Kailasnath Mukherjee	DPO, Dist. ICDS Cell, Burdwan
3	Mr. Abhijit Ghosh	BDO, Bhatar Block
4	Mr. Nilotpal Gupta	CDPO, Raina-II ICDS Project
5	Mrs. Rasonara Mollah	Karmadhaksya, Jana Swasthya O Paribesh Sthayee Samity, Bhatar Panchayat Sammity
6	Md. Rasul Karim	Pradhan, Kaity Gram Panchayat
7	Ms. Tanushree Dhara	ICDS Supervisor, Raina-II ICDS Project
8	Ms. Nandita Pal Choudhury	ICDS Supervisor, Raina-II ICDS Project
9	Ms. Diplai Pakre	ICDS Supervisor, Raina-II ICDS Project
10	Ms. Milon Roy	ICDS Supervisor, Raina-II ICDS Project
11	Ms. Eti Adhikary	ICDS Supervisor, Raina-II ICDS Project
12	Ms. Chanchala Chatterjee	ICDS Supervisor, Raina-II ICDS Project
13	Ms. Suparna Dutta	BPHN, Bhatar
14	Ms. Putul Karpa	PHN, Bhatar
15	Ms. Rekha Mandol	Health Supervisor
16.	Ms. Piyali Ghosh Banerjee	PO, CARE
17	Mr. Rajesh Kundu	BC, PNGO – UNS, Burdwan

Block Level Meeting at Bhatar

Sl. No.	Name	Designation
1	Mr. Subrata Mallik	Jt. BDO, Bhatar Block
2	Mr. Shisti Dhar Hazra	Karmadhaksya, Jana Swasthya O Paribesh Sthayee Samity, Bhatar Panchayat Sammity
3	Mr. Bandana Roy	Karmadhaksya, Nari Sishu O Tran Sthayee Samity, Bhatar Panchayat Sammity
4	Mr. Sitanshu Bhattacharya	Karmadhaksya, Purta Sthayee Samity, Bhatar Panchayat Sammity
5	Mr. Golam Murtuza	Karmadhaksya, Sikhsha Sthayee Samity, Bhatar Panchayat Sammity
6	Dr. Haradhan Banerjee	BMOH, Bhatar
7	Ms. Purabi Chakraborty	CDPO, Bhatar ICDS Project
8	Ms. Jhuma Banerjee	ICDS Supervisors, Bhatar ICDS Project
9	Ms. Tripti Chakraborty	Do
10	Ms. Bula Roy	Do
11	Ms. Ratna Das	Do
	Ms. Malati Mishra	Do
12	Ms. Bina Barui	Do
	Ms. Dipika Orao	Do
13	Ms. Namita Mallik	PHN, Bhatar
14	Mr. Nisheet Majhi	Health Supervisor (Male), Bhatar
15.	Mr. Somen Adhikary	BC, PNGO, ADS, Burdwan
16	Mr. Chinmoy Debnath	PO, CARE

District Level Meeting at Burdwan Bhavan

Sl. No.	Name	Designation
1	Mr. Ashok Kumar Mandal	Secretary, Zilla Parishad, Burdwan
2	Mr. Kailasnath Mukherjee	DPO, Dist. ICDS Cell, Burdwan
3	Dr. Naba Kumar Sinha	Dy. CMOH-III, Burdwan
4	Md. Mustaq Ahmed,	District Project Manager, DPMU, Burdwan
5	Mr. Tapan Pal	Coordinator, District Sanitation Cell, Burdwan
6	Mr. Somen Adhikary	BC, PNGO, ADS, Burdwan
7	Mr. Rajesh Kundu	BC, PNGO – UNS, Burdwan
8	Chinmoy Debnath	PO, CARE
9	Piyali Ghosh Banerjee	PO, CARE

ANNEX 3

CARE Participation on State and National Committees

CARE MEMBERSHIP IN DIFFERENT COMMITTEES/WORKING GROUPS

AP	CG	JH	OR	RAJ	UP	WB
ASHA State Level Core Committee	State Working Group Replication	Technical Advisory Group (TAG) –maternal and Child Health	State Level Coordination Committee for implementation of ICDS	Member of State level Training Task Force, ICDS	State level Technical Resource Team (IEC/BCC) ICDS	State Nutrition Committee
State Working Group for Replication of Best Practices in AP	State core resource team ICDS IV	Governing body of Jharkhand Health society under NRHM	State level supplementary Nutrition Committee	Member of Recipe Committee	State level ASHA mentoring Core group - NRHM	Nutrition Policy Core Committee
AP State Level GO/NGO Collaboration	State Health Committee NRHM	Governing body of State AIDS Control Society	State Training Task Force of W&CD	Member of IEC Committee under NRHM	State level Core Group for Routine Immunization -NRHM	Empty Containers Procurement
State Level Monitoring for ICDS Campaign	State task force for development of BCC	Governing Body of Mid Day Meal Programme	State Routine Immunization Core committee	Member of Early Childhood Education	State level Empty Container Funds utilization	Executive Committee of State Nutrition Strategy Monitoring Committee
Geographical Management Information System (GMIS)	State level committee for life skill education	Governing Body member of Social and Reproductive Life Education of the State's Education Department	State level ASHA Mentoring Core Committee.	Member of Core group of State Project Implementation Plan (SPIP) of ICDS-IV (World Bank supported ICDS project in the fourth phase.)	State Level Committee for implementation of women policy 2006" in the state of Uttar Pradesh	Steering Committee of State Nutrition Strategy Monitoring Committee
Best AWW Selection	State level committee on supplementary nutrition program	State Level Advisory Committee (SLAC)- Health, ICDS, Rural Development	Member of Inter-Agency Group (IAG)	Member of Inter-Agency Meeting	State level Technical committee for preparation of project implementation plan for ICDS-IV in Uttar Pradesh.	Micro-Nutrient Initiative Working Group
ICDS-IV Core Committee	Member of Rastriya Mahila Kosh Governing body	Public Health Network- State level Advisory Group members	Member, Public-Private Partnership (PPP) Apex Body Committee	Member of Core group of Asha Sahyogini Diary	UP State AIDS Council under UPSACS	State Health Reform Strategy Committee

AP	CG	JH	OR	RAJ	UP	WB
Disaster Management High Level Standing Committee	Member of AWW 's Reward and Recognition finalizing committee	State Advisory Group member-ATSEC	Member, NRHM Community Monitoring Committee	Member of Consultative group of Kilkari Magazine, ICDS	Department of Women and Child Development , /ICDS, Lucknow.	State Monitoring Unit
	Member state advisory group for ICDS news letter	State RI cell	Member, IMS-92 Act, State Monitoring Committee	Member of Rajasthan Nutrition Alliance to monitor and review the Integrated Plan of Action for Food Fortification in Rajasthan		
	Member of the EC fund utilization committee	Breastfeedin g Promotion Network of India (BPNI)		Member of State level NIPI Coordination Committee		
	Member of the Weighing scale procurement committee	Alternate Food Model Development Committee		Member of Steering Committee for Routine Immunization & MCHN Day		
	Member of Technical Advisory Committee CG SACs	State level Advisory Committee to ICDS		Member of IMNCI core group		
				Member of State Level Core Group for Village Health Committee and Mentoring Group of Community Monitoring		
				Member of State Level Monitoring Committee for Strengthening ASHA Sahyogini		

Membership in GOI Working Groups/ Core Committees at National Level
o Home based newborn care – member of the national core team under the NRHM
o Member of national core group on strengthening immunization
o Core Group member to revise the ICDS functionaries training curriculum and methodology
o Member of National Advisory Panel and State working group on Replication
o Development Partners consortium that helped revise the ICDS MIS
o Member of National Nutrition council
o Member of committee to set up National Resource Centre for Nutrition
o National committee on reward and recognition of ICDS workers
o Working with NIPCCD and GOI to revamp training component of ICDS
o Development partner' of World Bank supported ICDS IV program

ANNEX 4

Adaptation of Nutrition and Health Days by States

Annex 4

Current Status of Nutrition and Health Days in States

State	Frequency of food distribution	Frequency of Nutrition and Health day / Health day
Andhra Pradesh	Once in a month - Centralized	Once in a month with food
Chhattisgarh	Once in a month - Decentralized	Once in a month with food
Jharkhand	Once in a month - Decentralized	Once in a month with food
Madhya Pradesh	Once in a month - Centralized	Once in a month with food
Orissa	Twice in a month – fixed on 1st and 15th of month - Centralized	Once in a month without food
Rajasthan	Twice in a month - Centralized	Once in a month with food
Uttar Pradesh	Once in a month - Centralized	Once in a month with food
West Bengal	Spot feeding every day -Centralized	Once in a month without food

All procurement at district or state level is considered centralized. Procurement done by the AWC or community-based organizations, including self-help groups, is called decentralized.

ANNEX 5

Nutrition Environment: GOI Approaches to Improving Nutrition

GOI Approaches to Improving Nutrition

Nutrition is a fundamental investment to health of a nation. Good nutritional status is major determinant and an input for positive health. The economic productivity and socio-economic development of a nation is dependent on healthy workforce. Nutritional status and nutritional indicators are now internationally recognized as indicators of sustainable development and social wellbeing. Good nutrition along with positive health and food security are parameters to assess nation-state commitment to its citizen's rights.

Recent decades have seen tremendous economic growth both at national and societal level; however the economic gains have not essentially being translated into socio-developmental growth. The nutritional and health status of individuals especially the underprivileged strata of society has been a major concern. It is said that the nutritional investments have positive externalities and have enhanced effect on other social sectors especially the health, education and production.

India as a nation has shown commitment for the social development by establishing the task force under planning commission to work on national nutrition policies and programmes as early as 1980's. The first National Nutritional Policy (NNP) was adopted in 1993 under the aegis of Department of Women and Child Development (DWCD), Government of India. The policy is a comprehensive document that covers various developmental sectors that have bearing on the nutrition, not only about household food security but also stresses on the need of an overall developmental strategy for the country. A number of initiatives have been undertaken by Food and Nutrition Board, DWCD on instruments of NNP like Nutrition Advocacy and Awareness Generation, Micronutrient Malnutrition Control, District Nutrition Profiles, etc.

The financial and social costs of malnutrition (both under and over nutrition) are enormous. The opportunity cost of investment in preventing the same can have huge health and social gains. Government of India, with a view to promote nutrition of its citizens through the entire developmental sector, has undertaken various direct and indirect nutrition interventions as enumerated below[3]:

Direct Interventions:
Department of Women and Child Development
Integrated Child Development Services (ICDS) Scheme
Nutritional Programme for Adolescent Girls (NPAG)
Nutritional Advocacy and Awareness Generation Programme
Ministry of Health and Family Welfare
Iron and Folic Acid supplementation programme for pregnant women
Vitamin A supplementation programme for 9-36 month age group
National Iodine Deficiency Disorder Control Programme
Department of Elementary Education and Literacy
Mid Day Meal for primary school children

Indirect Interventions:
Department of Women and Child Development
Various women and child welfare programmes
Ministry of Health and Family Welfare
National Rural Health Mission
Integrated Management of Neonatal and Childhood Illnesses
Other Public Health Measures
Department of Elementary Education and Literacy
Sarva Siksha Abhiyaan
Adult Literacy Programme
Department of Agriculture and Cooperation

Horticultural Interventions
Increased Food Production
Food and Public Distribution
Targeted Public Distribution
Annapurna Scheme
Rural and Urban Development
National Rural Employment Guarantee Scheme (NREGS)
Food for Work Programme
Poverty Alleviation Programme
Safe Drinking Water and Sanitation

Nutrition and health are increasingly being recognized as interdependent, especially after realization of the fact that health outcomes are dependant on nutritional inputs and outcomes. India has almost won the battle against nutritional deficiency syndromes such as Pellagra, Beri-Beri, Scurvy, and Kwashiorkar. Famines are rare, and adult health status has improved appreciably. However, the war against the following is still to be won;
Malnutrition especially in children and women
Micronutrient malnutrition
Emerging diet-related diseases, etc

As per the National Family Health Survey (NFHS-2), 47% of children under three years of age are underweight; 45.5% stunted; and 15.5% wasted. The prevalence of low birth weight continues to be around 30% since three decades; Chronic Energy Deficiency in adults is 39% in females and 37% in males (NNMB2002). About 68-78% of the high risk group (children under 5 years, adolescent girls, pregnant and lactating women) suffers from iron deficiency anaemia (NNMB 2002). Vitamin A deficiency continues to exist as prevalence of Bitot Spots ranged from 0.7%-1.1% during the period of 1988-2003. Iodine Deficiency Disorders are a problem in almost every state of the country. The reported total goitre rates are as high as more than 10% in 260 districts out of surveyed 321 districts. Malnourished children have a much higher risk of mortality; the majority of the deaths could have been prevented as all the interventions of prevention are available within the health system.

The National Common Minimum Programme mandates health as a major thrust area and it is proposed to enhance the expenditure in health care from 0.9% of GDP to 2-3% of GDP over the next five years. However, expenditure estimates specific to nutritional interventions are not available. Resources invested in nutritional services are through various direct and indirect institutional mechanisms, though various policy measures, and through various financial pathways. Hence their attribution to specific nutrition programs is difficult. GOI is a signatory to various international declarations such as the Millennium Developmental Goals (MDG's). Keeping in view the mandate of Millennium Development Goals and the unmet goals of previous Five Year Plans, the following National Nutrition Goals are recommended for the XI Five Year Plan to be met by 2012[3].
Reduce prevalence of underweight in children under 5 years to 20%
Eradicate the prevalence of severe under-nutrition in children under 5 years
First hour breast feeding rates to increase to 80%
Exclusive breast feeding rates to increase to 90%
Complementary feeding rates at 6 months to increase to 90%
Reduce prevalence of anaemia in high risk groups (infants, pre-school children, adolescent girls, pregnant and lactating women)
Eliminate Vitamin A deficiency in children under 5 years as a public health problem and reduce Sub-clinical deficiency of Vitamin A in children by 50%
Reduce prevalence of Iodine Deficiency Disorder to less than 5%

Government of India has set up a Working Group on Integrating Nutrition with Health which recommended the following strategies for the XI Five Year Plan[3].
Articulating malnutrition as the number one public health problem in the country
Greater emphasis on Nutrition action in the health sector at all levels
Establishing a Nutrition Information System in the country
Infant and Young Child Feeding and Nutrition Security for Survival
Creating Nutritional Awareness at all levels
Micronutrient Malnutrition Control through Intensified Programmes
Strengthening Intersectoral Coordination Mechanism
Enhancing Investment in Nutrition and Health
Building Institutional Capacity for Nutrition Action

The Government of India has launched the National Rural Health Mission to carry out the necessary architectural correction in the basic health care delivery system. It is widely stated that there is an unprecedented commitment and emphasis by the current GOI to reform health and nutrition programs and enhance the reach of programs to the poorest and most vulnerable population. The NRHM adopts a synergistic approach by relating health to determinants of good health viz. nutrition, sanitation, hygiene and safe drinking water. One of the major goals of NRHM is to universalize access to public health services such as women's health, child health, water, sanitation and hygiene, immunization, and nutrition. The core strategy identified to address universalization is preparation and implementation of an inter-sectoral District Health Plan prepared by the District Health Mission, including drinking water, sanitation and hygiene and nutrition. It is also envisaged that community participation should be the key activity to increase ownership in the community for the health programmes. Communities are encouraged to undertake a Health Day at Anganwadi centers on a fixed day/month for provision of immunization, ante/post natal checkups and services related to mother & child healthcare, including nutrition[1].

Integration of all health sector programs into NRHM, the institutional reforms to manage health sector programs and a political will to make ICDS and RCH convergence functional offer a unique situation for INHP to contribute to the national program. The "Right to Food" movement is gaining momentum in India. The Supreme Court of India, on the premise that the "right to food" flows from the right to life guaranteed in the Indian Constitution, issued Interim Orders to the national and state Governments on the implementation of food safety net programs and appointed two Food Commissioners to monitor compliance with its directives in response to a petition filed in the highest court[2].

Similarly the ICDS is being universalized and the quality of service delivery through ICDS is under serious public scrutiny. There is a heightened attention on improving the quality of service delivery, supervision and program management. While the increase in numbers of ICDS service delivery points will minimize geographic exclusion of many marginalized populations, qualitative improvements in targeting, tracking, supervision and efforts to enhance public accountability mechanisms could address some of the other forms of exclusion based on gender, class, caste and occupation. Coupled with these efforts is the new legal environment provided by *"Right to Information Act*" passed by the Parliament of India[2].

The lessons and experiences that CARE and the Government programs have gained during the INHP years are invaluable to inform the universalization of ICDS and NRHM. Experiences in targeting, tracking, interpersonal communication for behavior change, structured supervision, ongoing capacity building, functional convergence mechanisms, operationalizing public accountability mechanisms and use of data for the decision making are very critical for ICDS and RCH[2].

It is important for CARE and GOI to ensure that these good practices are institutionalized and the lessons are mainstreamed through the national programs to influence other areas as well. INHP III will leverage on the investments made by other donors in the health sector to ensure smooth transfer of responsibilities as well as serve as a platform for building contextually responsive health and nutrition programs[2].

References:

1. National Rural Health Mission (2005-2012), Mission Document
2. Integrated Nutrition and Health Project – Proposal for phase-out of Title II program (FY07–FY09)
3. Report of the Working Group on Integrating Nutrition with Health 11th Five Year Plan (2007-2012), Government of India

ANNEX 6

Complete Quantitative Survey Report (pending)

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ANNEX 7

Letter from the MoWCD Regarding Final Evaluation