CARE
Integrated Nutrition and Health Project
INHP

Final Evaluation

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ABBREVIATIONS

3 + 3	three core INHP supply-driven interventions plus 3 key messages about infant feeding
ANC	Antenatal care
ANM	Auxiliary Nurse Midwife
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BDO	Block Development Officer
BLAC	Block Level Advisory Committee
BLS	Baseline survey
BMO	Block Medical Officer
BN	Basic Nutrition
BS	Birth spacing
BVR	Block Visit Report
CB	Capacity Building
CDPO	Community Development Project Officer
CGHS	Central Government health scheme
CIHQ	CARE-India Headquarters
CMU	Commodity Management Unit
CRS	Catholic Relief Services
CSB	Corn soya blend
DAP	Development activity proposal
DIP	Detailed Implementation Plan
DLAC	District Level Advisory Committee
DPO	District Programme Officer
DS	Demonstration Sites
DVR	Daily Visit Report
DWCD	Department of Women and Child Development, of the MOHRD
FC	Field Coordinator
FCVR	Feeding Centre Visit Report
FEW	Field Extension Worker
FM	Food Monitoring
FO	Field Officer
FPAI	Family Planning Association of India
FPIA	Family Planning International Assistance
FRHS	Foundation of Research in Health Systems
GMO	genetically modified organisms
GOI	Government of India
HI	High Impact
HIB	Health Information Booth
HVQ	Home Visit Questionnaire
ICDS	Integrated Child Development Services, a programme of WCD
ICMR	Indian Council for Medical Research, under Ministry of Health and Family Welfare
IFA	Iron and folic acid
INHP	Integrated Nutrition and Health Project
IGA	Income Generating Activity
IOP	Individual Operating Partner
IRMS	Institute for Research in Medical Statistics, under ICMR
LHV	Lady Health Visitor
LI	Leveraged Impact
LOP	List of provisions
MISP	Maternal and Infant Survival Project
MO	Medical Officer
MOHFW	Ministry of Health and Family Welfare
MOHRD	Ministry of Human Resource Development
MPF	Monthly Priorities Form
MPR	Monthly progress report

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- we thank the staff of the Nutrition, Health, and Population Unit at CARE-India headquarters (CIHQ) for their good-natured and flexible response to all our many demands and their excellent organizational work in preparing for our visit
- we thank the staff in other CIHQ program and program support units for providing valuable additional information about the organizational context in which INHP operates
- we thank the members of the Technical Advisory Group and other national experts for their contributions of time and expertise during our planning and briefing week
- we thank our colleagues in the Government of India and in State government agencies, for their commitment of time and energy during our planning and our field visits; they contributed greatly to our understanding of INHP and our suggestions for the future
- we thank the INHP program counterparts at state, district, and block levels who took the time to travel with us and help us jointly explore INHP's successes and challenges
- and we extend our heartfelt thanks to the CARE field staff working in the eight states where CARE implements INHP – congratulations on both effort and results!

A NOTE TO READERS

This report is written with a main text supported by detailed technical annexes. Each technical annex was written by one member of the external evaluation team as primary author, with inputs from other team members, and each annex may be read either as a separate document or as a more detailed supplement to the main report. Because of this design, there is some deliberate but unavoidable repetition between the main text and the annexes.

ROAD MAP

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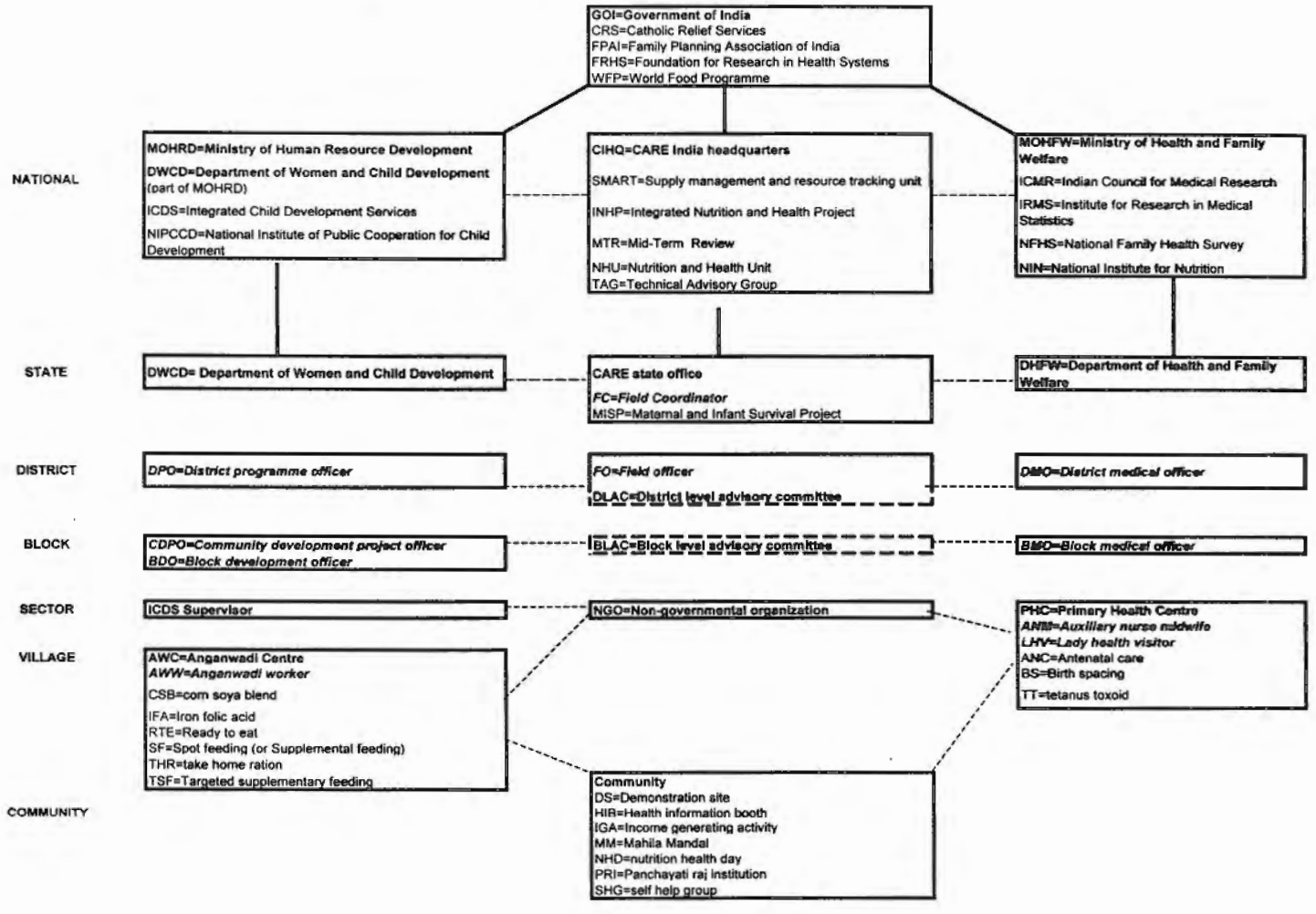
ACRONYMS, PRESENTED BY ORGANIZATIONAL LEVEL



INHP Area as of October 1996

937 blocks
114,300 AWC
6.63 million beneficiaries

EXECUTIVE SUMMARY

I. Introduction

Any assessment of development programs in India must be made within the context of India's incredible scale: India is home to 40% of the world's malnourished children; India received 16.5% of USAID's Title II non-emergency food assistance; the Government of India's contribution to CARE is the greatest made by any government in the world to an NGO working in its own country; and CARE-India's budget accounts for 20.2% of CARE-USA's total budget worldwide.

CARE developed the Integrated Nutrition and Health Project (INHP) to mobilize resources from USAID, the Government of India (GOI), non-governmental organizations (NGOs), and communities to address the enormous problem of malnutrition in vulnerable women and children. Designed in 1995-6 as CARE's first Development Activity Proposal (DAP) in India, INHP is currently working within the GOI Integrated Child Development Services (ICDS) program in eight states: Andhra Pradesh, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh, and West Bengal. To appreciate the scope of INHP, consider this comparison: INHP is operating in a geographical space as large as Indonesia, with a population 2.7 times that of Indonesia. **INHP is the largest program of its type in the world.**

II. Response to the 1999 Mid-Term Review

CARE responded enthusiastically to the suggestions of the 1999 Mid-Term Review (MTR), which called for a refinement of program implementation strategy to focus on a narrower range of interventions. Since 1999, INHP staff throughout CARE-India's organization have re-committed themselves to the strategic aspects of INHP – building capacity within communities, systems, and individuals, catalyzing convergence between the government health and ICDS departments, and empowering communities and women. INHP successfully revised the project structure in order to more effectively channel resources for maximum impact and more efficiently scale-up the program's reach. Throughout this process, the CARE field and HQ staff have fostered an environment for creativity, learning, and growth not only within their own organization but in their collaboration with government counterparts, NGOs, and community groups with whom they work.

III. Final Evaluation Methods and Processes

Consistent with the evaluation plan in the DAP, the final evaluation of INHP-I was undertaken by a multi-disciplinary team of Indian and expatriate specialists who considered a wide range of project documents and reviewed data and analytical results from three sources:

- a quantitative survey, conducted in all states where INHP works and overseen by a high-level Technical Advisory Group as recommended by the INHP Mid-Term Review;
- a qualitative survey, conducted by an external management consulting agency with key informant and focus group interviews in all INHP states;
- field visits and observations by the external evaluation team and government counterparts during visits to all INHP states.

IV. Major Findings

- The conceptualization and implementation of INHP was a programmatic and institutional revolution for CARE and for USAID food support to ICDS. CARE's expertise in health and child survival and in community capacity-building, and their expertise in nutritional interventions, is now recognized and welcome at the state, district, block, and community levels, and CARE is now viewed as a development partner.
- INHP has succeeded in bringing together ICDS and health department policies, operations and service delivery, after decades of attempts made by government and other agencies – and government departments have become more effective at reaching high coverage rates for health services as a result.

- Conviction about conceptual links between CARE's inputs and improved nutritional status is variable, and is not a driving force across the project. Food clearly does serve other roles — as an incentive for participation in services and as leverage for policy change – but the nutritional focus is important and appears to have been neglected in certain operational decisions.
- Where fully implemented, INHP is making important contributions to child survival in India through improving immunization and breastfeeding (including colostrum feeding) practices, and indirect evidence suggests that INHP is helping to reduce the under-nutrition (low weight-for-age) which increases the risk of children dying from common childhood illnesses.
- Changes to management information systems (MIS) have improved routine process monitoring and now provide useful information for field management of INHP.
- CARE has been especially impressive in systematizing, monitoring and strengthening processes and at rolling them out to scale. Their management of the commodity supply chain for the Title II food inputs is a prime example of increased institutional capacity.
- Social mapping has improved targeting of take home ration (THR) resources and thus improved targeting of program interventions to the most vulnerable – this has increased village ownership of the program activities and, in some cases, reduced social tensions over perceived distributional inequities by making the beneficiary mapping and selection process transparent and public.
- INHP's links with self-help groups, newly invigorated *mahila mandals*, village development committees, and small groups of change agents such as *dais* and adolescent girls, have empowered village women -- and those women have become effective agents for behavioral change among their peers.
- INHP's efforts to simultaneously strengthen government service delivery while building community capacity are critical for health and nutrition outcomes, sustainability, and empowerment.
- Decentralization has empowered state level staff to adapt, innovate and develop creative solutions to local problems, and has allowed Field Officers to play a key role in INHP's success.
- CARE has not yet fully defined and articulated the evolution, maturation, and completion processes and sub-strategies that will be needed to finish the work of INHP; in spite of the increasing pressure on planning for CARE's hand-over and transition, there has been only a limited planning for this transition at local, state, and national levels.

V. Major Recommendations

Reinforce INHP's nutritional focus

- Invest in building the commitment of staff, counterparts, and partners at all levels to achieve nutritional improvement through INHP.
- Review plans for INHP-II to balance and sequence nutrition and health interventions, ensuring that the nutritional focus is appropriately achieved.
- Carry out focused monitoring plus operations and evaluation research to define the extent and determinants of changes in key feeding behaviors; use the results to strengthen and promote the feeding behavior component of INHP.
- Strengthen behavior change capacity and develop a systematic approach and toolkit for dealing with behavior change; this will catalyze not only nutritional interventions but also health interventions such as IFA consumption, care-seeking and disease recognition, etc.
- Emphasize community approaches to behavioral change, not simply communication or messages directed to individuals.
- Consider the latest information about growth promotion and evaluate the possibility of undertaking a focused pilot on capacity-building for growth promotion under INHP-II.

- Discuss an explicit focus on improving quality by service providers, including *anganwadi* workers (AWWs) and auxiliary nurse midwifes (ANMs), through developing quality monitoring and improvement processes at the district and block levels in both ICDS and the Department of health and Family Welfare (HFW).

Clarify and ensure availability of technical support for key INHP Strategies

- Use participatory processes to clarify and communicate project-wide objectives and strategies for key components, including community behavioral change, capacity building, replication, and phase-out.
- Empower and facilitate state offices as they develop appropriate operational plans to achieve these objectives and strategies.
- Make more explicit distinctions between core project principles and appropriate local adaptations; identify specific INHP objectives, set standards and guidelines for state plans, and clarify division of responsibility between local and national levels.
- Increase technical support for Field Officers(FOs) and encourage peer sharing to strengthen technical capacity and improve the quality of field implementation.
- Encourage cross-learning at all levels: FOs to each other, specialists and program managers with other state personnel, and so forth.
- Commit to a focus on enhancing technical expertise throughout the states and developing mechanisms for systematically monitoring, diffusing, and replicating INHP successes.

Define INHP's end point and develop operational strategies for achieving it

- Define INHP evolution, maturation, and graduation -- what does a mature and sustainable INHP program site look like in 2006, and how do we get there?
- Review current plans to replicate demonstration sites, with a view to developing more concrete plans for diffusion and replication.
- Consolidate successful experience in role of catalyst so that even if Title II food commodities phase out or over, CARE can continue to provide assistance in the child survival and nutrition areas. **Do not** play the role of direct service provider.
- Test models for hand-over, such as the local food processing model proposed for funding partially by monetization resources, as a high priority for INHP-II to prove the financial feasibility of INHP program blocks "graduating" from Title II food and towards sustainability.
- Review and revise INHP-II implementation plans and scope to better reflect a comprehensive capacity building approach and objectives; maintaining the focus on community-level capacity building.
- Develop a plan for and conduct explicit advocacy for phasing over critical INHP functions to government, NGO and community entities – address both the why and the how.
- Carefully assess capacity building experiences (training and others). identify those successful in achieving desired outcomes; document and package those proven effective for broader use; and monitor and help adapt their use as appropriate in different situations.
- Use CARE's expertise in managing the commodity supply chain operations to assist with optimizing the delivery of other key inputs or to provide consulting expertise to government programs with supply chain problems.
- Develop milestones to measure progress in capacity building and sustainability, and provide continued support and motivation to achieve them.
- Build a joint exit strategy to gradually phase over INHP functions with key partners at all levels, and develop/use indicators to monitor outcomes of capacity building.

Develop more flexible monitoring and evaluation approaches

- Develop a more "nimble" evaluation and documentation strategy to facilitate focused evaluations, simple problem-solving studies, and perhaps prospective operations research, for key strategic issues such as community behavior change and replication/diffusion.
- Consider a strategy whereby large scale surveys would not be necessary to measure impact. This might include dropping the midterm survey for INHP-II and focusing instead on extracting data from operations research and targeted evaluations.
- Consider smaller more targeted surveys for baseline and final to cover key interventions; discuss with experts and consider whether smaller scale, targeted, evaluations can provide measures of attribution of INHP inputs to impact on nutritional status.
- Identify methods for capturing policy level changes in relation to INHP implementation and to disseminate these experiences across States in order to affect greater change.
- With data already collected, undertake a series of detailed analyses on target activities to assess changes across the INHP implementation period and to relate these changes to program inputs.
- Review coverage of individual interventions at the state and, to the extent possible, district levels; identify approaches to achieve better coverage in the context of INHP and other GOI initiatives.
- Assess the effects of INHP on overall coverage both among THR beneficiaries and beneficiaries of health services.
- Identify mothers and children not being reached with immunization and antenatal care (ANC) services and counseling; develop and evaluate approaches to reach them.
- Using an internally participative process, review the project's Health Management Information System (HMIS) to assure that information for decision-makers at all levels is available in a user-friendly fashion and consider how information is disseminated within and across the project. Involve government and NGO counterparts as appropriate.
- Encourage and support expanded community-managed monitoring as an essential step towards sustainability post-INHP.
- Continue with social mapping and updates involving the community, and increase the focus of those mapping events on reaching the marginalized and distant families in the *anganwadi* center (AWC) catchment area.

Strengthen CARE's Implementation of INHP

- Reflect on the main budget line items, especially those where costs have risen rapidly or are higher than is standard -- analyze the benefits achieved with those resources and shift resources if necessary.
- Assess AWW (and ANM) workload issues, and seek to help them carry out existing and new tasks in ways that are not disincentives for their effective participation.
- Continue the pursuit of internal gender equity, perhaps adjusting work conditions to overcome identified constraints to the employment, retention and advancement of female staff in critical field positions.
- Retain intermediate positions between FOs and the state level, but primarily for technical support; consider a possible peer support system, in which FOs within a sector team support and critique each other's work, with only occasional support from higher levels.

I. Introduction

The Integrated Nutrition and Health Project (INHP) was launched on October 1, 1996 and currently operates in more than 100,000 *anganwadi* centers (AWCs) in eight states in India: Andhra Pradesh, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh, and West Bengal. INHP seeks to reach more than 7 million women and children, primarily in rural and tribal blocks with supplementary food and with health and nutrition services. In the first phase, INHP has drawn resources from USAID (Title II food and monetization, Farmbill 202e grant monies, and container funds) and from the Government of India (GOI) for operations. In INHP-II, additional resources from USAID's child survival program are proposed for intensification of key health and nutrition interventions, building on the achievements of INHP-I.

In FY 2000, INHP managed more than 188,000 MT of Corn Soya Blend (CSB) and 25,000 MT of soybean oil, valued at $US 67 million. The annual budget of INHP, approximately $76 million (food and cash), represents 20.2% of CARE-USA's worldwide budget. Over the five-year implementation of INHP, CARE-India has managed $350 million in food resources and $30 million in cash. **INHP is the largest project of its type in the world.**

II. Methodology

INHP was conceived as a ten-year effort, and this evaluation focuses on assessing the progress and achievements of the first phase (INHP-I,1996-2001).; Based on our findings and observations , this report provides suggestions for CARE-India as it prepares to implement INHP-II. Thus, while the external evaluation team did seek to assess key aspects of INHP-I and to link those findings to recommendations on implementing INHP-II, this evaluation did **not** undertake to critique or assess the overall design for INHP-II as expressed in the new Development Activity Proposal (DAP-2).

Consistent with the DAP for INHP-I, this final evaluation was conducted by a multi-disciplinary team of Indian and expatriate specialists who considered a wide range of project documents and reviewed data and analytical results from three sources:

- a quantitative survey, conducted in all states where INHP works and overseen by a high-level Technical Advisory Group as recommended by the INHP Mid-Term Review;
- a qualitative survey, conducted by an external management consulting agency with key informant and focus group interviews in all INHP states;
- field visits and observations by the external evaluation team during visits to all INHP states.

Each technical specialist on the INHP Final Evaluation team was assigned a particular set of evaluation topics from the Terms of Reference, and field visits were guided by topic protocols designed by each specialist. The detailed synthesis of each technical topic, presented in the annexes to this report, was authored by the assigned technical specialist from the team, while the major findings and recommendations presented in the main text were discussed and agreed to by the entire team.

III. Background: Nutrition and Health in India, ICDS and INHP

The Context of ICDS and India: INHP works within the context of GOI's Integrated Child Development Services (ICDS) program, the largest program of its kind in the world, in which government health and family welfare services and donor resources are jointly leveraged to battle the persistent and troubling challenges to improving the lives of poor women and children in India. The ICDS nutrition and health interventions focus on the *anganwadi* center (AWC), a village-based entry point operated by an honorary community worker, the *anganwadi* Worker (AWW).

India is home to less than 20% of the world's children but has more than 40% of the world's malnourished children. Malnutrition varies widely across regions, states, age, gender, and social group, being worst in children under two, in women, in populous northern states, in rural areas, in tribal populations, and among scheduled castes -- and while poverty explains the high level of malnutrition in India, additional social factors concentrate the problem among women and children. The policy and resource context of INHP and ICDS includes several paradoxes:

- India is food secure at the national level but food insecure at the household level – millions of poor families lack access to adequate food and nutrition.

- India is continuing a steady move towards economic liberalization and support for market-oriented economic growth, but the current fiscal crisis affecting the central and state governments is putting increased pressure on programs serving the most vulnerable – the same poor families with whom CARE works.

The Context of CARE-India: The conceptualization and implementation of INHP was a programmatic and institutional revolution for CARE and for USAID food support to ICDS. It changed:

- how CARE operates as an institution
- how CARE staff see themselves and their program
- how CARE cooperates with and is viewed by central and state governments
- the role that CARE staff and CARE program resources play within ICDS at both the policy and operational levels

CARE's expertise in health and child survival and in community capacity-building, in addition to their expertise in nutritional interventions, is now recognized and welcome at the state, district, block, and community, and CARE is now viewed as a development partner. Their institutional transformation from a food management group to a nutrition and health development partner has been impressive, and can be best completed by reaffirming and refining the INHP program vision.

Recommendations:

- Commit to a focus on enhancing technical expertise throughout the states and developing mechanisms for systematically monitoring, diffusing, and replicating INHP successes.
- Define INHP evolution, maturation, and graduation -- what does a mature and sustainable INHP program site look like in 2006, and how do we get there?

IV. Evaluation Findings on the Developmental Hypothesis and Strategies

INHP underwent considerable strategic revisions after the 1999 Mid-Term Review, and now targets six key interventions to two major target groups, a) pregnant and nursing mothers, and b) children under two years of age. The project is currently implemented in eight states of India: Andhra Pradesh, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, West Bengal, and Uttar Pradesh, covering 7 million women and children in approximately 100,000 villages, which is about 25% of all the population covered by India's massive ICDS program. CARE staff play chiefly a facilitator role in achieving the goal of improved health and nutrition of women and children through strengthening and building the capacity of ICDS staff, NGOs and community members; and by improving the delivery of services through the government.

The available data from India and other developing countries clearly show that much of the growth retardation that occurs in early childhood (0-6 years) takes place between 6 and 24 months. Further, data on infant and under-five mortality due to various diseases also indicate a very strong synergistic relationship between malnutrition and mortality, especially in infancy -- mortality rising sharply in malnourished, and dropping equally sharply when malnutrition declines in a community. Therefore, two major hypotheses have been articulated in the INHP program.

A. **Program hypothesis on INHP inputs and key interventions**: The first hypothesis, articulated consistently in INHP program design documentation, is that nutritional improvement can occur by improving infant feeding practices (colostrum feeding, exclusive breast feeding for first 6 months and appropriate complementary feeding beginning at 6 months), and by focusing on improved delivery of food and health services to the vulnerable groups. This hypothesis is captured in the stated goal of the INHP project, "to improve the nutritional and health status of the vulnerable groups of women and children".

i. ***Role of food*** – At the individual level, the CSB and oil are targeted nutritional supplementation for vulnerable women and children. At the community level, the Title II food used in INHP acts as an incentive for community engagement with and ownership of ICDS activities, and as an entry point for INHP interventions supporting improved health and nutrition practices. At the district, state, and national level, the Title II food and CARE's technical and systems expertise are resources that figure prominently in the policy and program debates about maternal and child health and nutrition in the context of ICDS.

ii. ***Key interventions*** -- Population-based strategies replace center-based ones for supplementary food distribution, using Take Home Rations (THR) to reach the most vulnerable target groups (pregnant and lactating women, children under two). Nutrition Health Days (NHD) are organized once a month by the AWW, the

ANM, and the community as a nexus for key service delivery. Convergence of services at the village level is facilitated by promoting sustainable co-ordination between the Department of Women and Child Development and the Ministry of Health & Family Welfare, creating institutionalized mechanisms for joint planning and problem-solving and improved upward and downward communications. Innovations at different levels are pursued to enhance service utilization and behavior change. Community mobilization and empowerment are sparked through village development committees (VDC), adolescent groups, invigorated *Mahila Mandals*, and other mechanisms for creating community ownership. The capacity of individuals, community, institutions and systems to support and promote improved health and nutrition practices is built through the development of INHP-supported AWCs into Demonstration Sites (DSs) -- learning centers and examples of INHP best practices. Cross fertilization, visits to other areas, and clustering of villages around the DS are undertaken as replication strategies.

B. Program hypothesis on INHP strategies -- capacity building and sustainability: The second foundation of the INHP program posited that sustained improvements in health and nutritional status would not be possible without strengthening the capacity of communities to support women and families to practice key nutrition and health behaviors, improving the capacity of government counterparts to deliver supplementary food and health services, and building capacity of NGOs to facilitate the work of institutions in the community. Therefore, it was hypothesized that sustainable capacity building will lead to behavioral and system changes that will result in improved nutritional and health status.

C. Evidence of success: INHP is making important contributions to child survival in India, through improving immunization and breastfeeding (including colostrum feeding) practices, and reducing the under-nutrition (low weight-for-age) which synergistically increases the risk of children dying from common childhood illnesses. The basic INHP package of 3+3 is effective and has showed results; the narrowed focus after the MTR is paying off.

Small Miracles

Last year, in a village of Domakonda block in Andhra Pradesh, a one year old boy was stricken with "brain fever" – whether it was meningitis or encephalitis is now hard to tell. He survived, but when he returned to his village from the hospital, he was not only blind but could not walk or even hold his head up. Over the next several months, his parents returned with him to be examined by a number of doctors, including visiting specialists from Hyderabad. The conclusion was that the child had suffered serious and lasting neurological impairment.

Before being stricken ill, the mother had been bringing the boy to Nutrition-Health Days at the *anganwadi* center near his home, which was one of the INHP demonstration sites. When he returned home from the hospital, the *anganwadi* worker had visited. She encouraged the mother to continue participating in the Nutrition-Health Days, so that the boy could at least benefit from immunization and supplementary feeding. When the boy was brought to the center after an absence of two months, she plotted his weight and found him to have become markedly malnourished – since his illness he had declined from being well in the normal range to grade III malnutrition.

During the boy's first few months out of the hospital, the *anganwadi* worker continued to encourage the mother, but took no additional action. "I was confused," she says, "while he was seeing so many doctors." Then she decided to act. Beyond providing a double ration, she taught the mother to make a gruel that the weakened child could take in small, patient feedings. She also encouraged the mother to feed the child other nutritious foods prepared from home ingredients. Recalling that the child had not been present on the centre's last Vitamin A Day, and that vitamin A was associated with vision, she administered the child a dose of vitamin A, and a second dose six months later. She plotted and monitored his weight every month.

For the first six months, the little boy's nutritional status improved steadily, but only slowly. Then it began to improve faster. One day in the *anganwadi* centre, both the *anganwadi* worker and the mother saw the boy looking at an object "with life in his eyes." "I think he can see!" the *anganwadi* worker told the mother.

The rest of the story is short. Progressively the little boy regained strength – he began to move, to hold his head up, to talk, and finally to walk. Today, almost a year and a half later, he is a healthy three-year-old child of normal appearance, developmentally normal. He is still in the middle of the Grade I malnutrition category, but is on his way back to the normal range.

In the centre the mother sits on the floor near the *anganwadi* worker, her smiling son standing by her side. "He has been given back his life," the mother says. Looking at the *anganwadi* worker, she repeats, "**She** gave it back to him."

INHP has also succeeded in finally bringing together ICDS and health department policies, operations and service delivery, after decades of attempts made by government and other agencies – and governmental departments have become more effective at reaching higher coverage rates for health services as a result. Interestingly, although INHP has galvanized the ICDS system in clear ways with visible results, confidence among partners – government functionaries, field and program staff – about the conceptual links between INHP inputs and improved nutritional status was variable, and needs this strengthening to become a driving force across the project.

- **Recommendation**: Invest in building the commitment of staff, counterparts, and partners at all levels to achieving nutritional improvement through INHP, including a review of INHP-II to balance and sequence nutrition and health interventions.

V. Evaluation Findings on Documented Coverage, Outcomes, Impact, Attribution

CARE should be proud of their efforts and achievements in quantifying and documenting the outcomes and impact of the INHP interventions; few, if any, other projects have attempted to collect the range of information from such a large sample as in the INHP, and using such high-quality resources and technical inputs. CARE has made a tremendous effort in undertaking consistent quantitative surveys to measure program impact. However, given the rolling nature of the project, each quantitative survey has led to more questions than answers in terms of generalizability to the current operating environment when compared to the previous survey(s).

Additionally, in ways that are described more thoroughly elsewhere in this report, CARE has made significant efforts to change the way it assesses and measures "routine" activities. The approach of monitoring process, with periodic large surveys to assess outcome and impact, remains sound. However, feedback from the field suggests that at some level, outcomes should be monitored in a targeted and periodic fashion (though not on a monthly or quarterly basis as with the old Home Visit Questionnaire). This should not be seen as moving backwards, rather as further refining the systems which CARE has worked hard to set in place.

As CARE looks towards the second five years of INHP (INHP-II), it should be prepared to accept that outcomes and impact will need to be shown at a block level. Regardless of the survey mechanism chosen, comparisons should be done in such a fashion as to provide a measure of impact for the entire block. If measured through surveys, assessment of "DS areas" should be considered as secondary to the block level and should only be used to provide an inference on where the entire block can expect to be once all areas have achieved comparable implementation times (e.g. 7 years – MTR of INHP-I through end of INHP-II).

Coverage and Outcome Measures: Data from the quantitative survey can be reviewed in at least two distinct fashions - comparison to baseline and midterm surveys and comparison to the National Family Health Survey - II data (NFHS-II, conducted in 1998/99). It should be noted, though, that NFHS-II data may in fact be closer in timing to the midterm quantitative survey than to the final evaluation. Also, while INHP concentrates on backward and tribal areas, the NFHS-II sample represented the whole range of each state.

Comparison of results from survey data:
Baseline vs. Final

- Coverage rates for supplementary feeding (pregnant/lactating women and children 6-24 months) increased from baseline in 6 of 7 states (except both pregnant and lactating mothers in West Bengal).
- Coverage rates for focus interventions (ANC, iron folic acid (IFA), tetanus toxoid (TT), and childhood immunizations) increased from baseline in 5 of 7 states (except in Uttar Pradesh where IFA rates were the same or lower than baseline in DS and ALL areas).
- Coverage rates for breastfeeding and weaning practices increased from baseline in 6 of 7 states (except for exclusive breastfeeding rates in Andhra Pradesh and for complementary feeding rates in Andhra Pradesh).
- Across almost all states, indicators for "DS" had higher coverage rates than "ALL" areas (which covers both DS and non-DS). ANC, IFA, and TT coverage rates were higher in 5 of 7 states for "DS" as compared to "ALL" (except IFA in Andhra Pradesh and Uttar Pradesh), however, child immunizations, breastfeeding, and complementary feeding rates did not show the same consistent trends.

Midterm vs. Final

Comparison between midterm and final data includes the changes in approach from high impact areas (HI) to Demonstration Sites (DS) areas. Due to differences in the way the questions were asked, the comparison of midterm and final does not include questions on child supplementary feeding, and complementary feeding practices for children 6-9 months of age. Not all HI areas are DS, but it is likely that the preponderance of these sites are in common.

- Coverage rates for supplementary feeding (pregnant/lactating women) were higher in all HI blocks as compared to ALL blocks at midterm – though rates were very low in West Bengal for lactating mothers.
- Coverage rates were higher in the final survey as compared to midterm in all areas and all states except in Bihar, Madhya Pradesh, Uttar Pradesh and West Bengal. In most of these states, the supplementation rate for lactating women was more often greater than that for pregnant women in the comparison of the two time frames.
- Coverage rates for focus interventions (ANC, IFA, TT, and Immunizations) vary widely by State. In some states, the rates are virtually unchanged between midterm and final (Andhra Pradesh, Orissa, and Uttar Pradesh), while in other states, the midterm rates are higher than final (e.g. ANC and IFA in HI blocks of Bihar), while in still other states the final evaluation rates were higher than midterm (e.g. initiation of breastfeeding and exclusive breastfeeding rates in West Bengal).

Final vs. NFHS II

Comparison between final survey and NFHS II data:

- Coverage rates for focus interventions (ANC, IFA, TT, Immunizations) increased in comparison to NFHS II in 5 of 7 states for ANC (except Orissa and West Bengal)
- Coverage rates for breastfeeding and weaning practices increased in comparison to NFHS II in 3 of 7 states (except Madhya Pradesh, Orissa, Uttar Pradesh, and West Bengal - Note: initiation of breastfeeding within one hour after birth was the key indicator which was most variant from NFHS II data).

The hypothesis behind the original INHP strategy, and the subsequent unified capacity building strategy, is that the demonstration sites will show greater level of change than the non-demonstration sites. To a great extent, this can be seen in the differences between Demonstration Sites (DS) and all INHP program areas (ALL) as compared to baseline information. While there certainly are some outliers, on the whole the hypothesis seems to be born out by the data. The so-called "supply-side" interventions (targeted supplementary feeding, immunizations and antenatal care) have shown greater improvements than behavior change interventions. For example, supplementary feeding for pregnant or lactating mothers, or children 6-24 months of age, has almost universally improved across the program, and is even higher in DS as compared to ALL areas. Antenatal care has also improved across most program areas; the "dose response" is seen between DS and ALL areas, where the dose is measured in terms of INHP inputs.

INHP also conducted a panel survey in which they tracked the changes in program indicators in a specific block across the implementation period. As initially conceptualized, this block was considered "High Impact", or HI, and was a focus of intensive efforts. Only one block per state was sampled in the panel survey, so the results are generalizable only to that block. In almost every intervention area, and across all the states, the coverage rates are higher in the final evaluation as compared to the baseline survey. As most former HI blocks are likely to have a number of demonstration sites in them, this may prove to be at least a partial "picture" of where INHP can hope to be as more of the demonstration sites come on-line.

Impact Measures: INHP's goal was to improve the nutritional status of women and children. While changes in nutritional status have occurred, it is not always clear whether this is due to INHP interventions. Overall, nutritional status improved in 5 out of 7 states as compared to baseline (except Madhya Pradesh and Orissa (and the DS blocks of Bihar). Malnutrition rates in INHP areas were lower than the NFHS II data in 4 of 7 states (except Bihar, Madhya Pradesh, and Orissa). Other measures of impact exist which are not captured in a quantitative survey (e.g. leverage of State level implementation of THR, implementation of adolescent girls strategies, etc.), and are likely to be associated with INHP inputs.

Attribution: The attribution of program inputs to outcomes and impact in any project is a challenge. In a project like INHP and in a country like India, where there has been such a high degree of change in both program implementation and the operating environment of the program (floods, drought, political changes, etc.) attribution becomes an even greater challenge. This is not meant to imply that programs should not attempt to measure impact -- rather that in difficult operating environments, measuring the attribution of any program will be difficult.

Qualitative and anecdotal evidence at all levels supports the association of the changes seen since baseline to INHP inputs:

- Overall feeling that THR/NHDs helps to bring women and children to the AWC and is therefore associated with increased coverage rates of the INHP interventions
- This "pulling" of beneficiaries into the AWCs for services leads to improvements in overall health and nutritional status of both women and children.

Documenting Impact: After three surveys and perhaps as much confusion as clarity, CARE should consider whether there is really any benefit to implementing large-scale surveys. To date, the value added of these large-scale (in terms of cost, coverage, and investment of time) efforts is less than clear. As a revised strategy, CARE should consider whether smaller, more targeted evaluations would provide the level of data necessary to assess program impact without leading to further questions; given that INHP-II proposes further geographic shifts, the issue of comparability across blocks will be persistent. In INHP-II, CARE should look at the role of targeted operations research and how it can be utilized across the program to provide a gauge of program changes based on the activities being implemented. In adopting such a strategy, caution should be taken such that a re-proliferation of indicators does not occur; learn from the experiences in INHP-I, and do not repeat the mistakes!

If CARE adopts a strategy of smaller, more targeted evaluations, it should then consider, in consultation with USAID, whether a revised baseline is required. If a new baseline survey is undertaken, CARE should pay particular attention to the choice of blocks to be served (if further consolidation of the project is to occur) and the time of year when it is conducted with an eye toward the timing for any final evaluation survey and its utility in any potential further program development (i.e. timing of survey within the USAID program calendar).

Recommendations:

- CARE should consider adopting, and USAID approving, a strategy whereby large scale surveys would not be necessary to measure impact. Targeted operations research (OR), with defined evaluation criteria, could be used on a smaller scale basis to determine the degree of change associated with the intervention.
- Much smaller surveys could be done for baseline and final to cover key interventions without collecting a number of other indicators which may not be used for program implementation or as data for decision makers. Further, CARE should discuss with experts and consider whether smaller scale, targeted, evaluations can provide measures of attribution of INHP inputs to impact on nutritional status.
- CARE and USAID should consider dropping a midterm survey for INHP-II and instead focus on extracting data from operations research and targeted evaluations.
- CARE should identify methods for capturing policy level changes in relation to INHP implementation and to disseminate these experiences across states in order to affect greater change.
- To the extent practicable, CARE should consider adopting community-based strategies for monitoring INHP interventions.
- With the data already collected, CARE should consider undertaking a series of detailed analyses on target activities, to assess changes across the INHP implementation period and to relate these changes to program inputs.

VI. Evaluation Findings on CARE's Implementation of INHP

A. CARE's working relationship with all partners

CARE-India's chosen role in INHP – catalyst, facilitator, capacity-builder, technical supporter – is appropriate and has made an outstanding contribution to the convergence of health and nutrition services both in INHP and beyond to other ICDS sites.

Recommendations:

- CARE should consolidate their successful experience in these roles so that even if Title II food commodities phase out or over, CARE can continue to provide assistance in the child survival and nutrition areas.
- CARE should not play the role of direct service provider.

State government counterparts, under severe budgetary pressures due to the ongoing fiscal crisis, are resistant to discussing concrete plans for phase-out of CARE food inputs and hand-over of responsibility for further replication of the INHP model.

- **Recommendation:** Test models for hand-over, such as the local food processing model proposed for funding partially by monetization resources, as a high priority for INHP-II to prove the financial feasibility of INHP program blocks "graduating" from Title II food and towards sustainability.

B. Implementation against plan and expenditure against budget

CARE has delivered the majority of INHP project inputs on time in most states, an impressive achievement considering the external constraints such as natural disasters and changing government counterparts. In analyzing the expenditures under INHP as against the INHP budget, it is obvious that some items have risen sharply in the past two years. In addition, some budget line items, such as travel and use of outside agencies/ technical resources, appear quite high when broken down to a per-employee per-day cost and compared to standards in non-NGO sectors. We note that these increases in line items, and high levels of some of them, may be quite appropriate because of implementation of recommendations of previous evaluations and approved program revisions.

- **Recommendation:** Reflect on the main budget line items, especially those where costs have risen rapidly or are higher than is standard -- analyze the benefits achieved with those resources and shift resources if necessary. (Annex E provides an analysis of expenditures.)

Implementation of many of the recommendations contained herein will require cash resources. Although with the available data the team was not able to make a detailed judgment about the optimal current or future cash-*vs.*-food balance in INHP, it seemed clear that INHP has leveraged substantial results with the small amount of cash in the INHP-I budget. The team believes that the value-added of the cash-funded activities has been substantial, and that additional processes to implement the recommendations herein can be instituted at reasonable cost for value.

C. Technical interventions

The final evaluation team took a broad look at the basic technical interventions of the INHP program, examining the evidence that the project's inputs were likely to achieve improved coverage, behavioral change, and ultimately impact. It also included assessment of what elements might enhance achievement of such impact, in order to inform future activities under INHP-II.

i. Interventions

Coverage and utilization of the three supply-side interventions (antenatal care, immunization, and targeted supplementary feeding) appear to have substantially increased among INHP participants. There is still substantial room for further improvement, however, especially for some elements of the intervention package, since performance on some of the supply-side interventions is still relatively low (only one in two children is fully immunized by the first birthday and coverage for measles immunization is stubbornly low).

- **Recommendation**: CARE and its partners should review coverage of individual interventions at the state and, to the extent possible, district levels; identify approaches to achieve better coverage in the context of INHP and other GOI initiatives (such as maximizing the positive effect on routine immunization and vitamin A supplementation, and better using information on individual children and organization of attendance at NHDs to increase coverage beyond present levels).

CARE needs to explicitly examine the possibilities that INHP services are not adequately reaching important subsets of INHP participants (socially or geographically marginalized households), that the participant group excludes vulnerable village women and children, or that children between ages two and three are being "lost". INHP appropriately targets the poorest and most vulnerable families; however, for villages where government health services are not located, the NHD may be the sole time during a month when services including antenatal care and immunization are offered, and therefore INHP must accept responsibility for supporting broadest possible coverage for the whole population. Deferring NHD services to the sub-center level may be reinforcing the differential use of services, with the poorest and most backward possibly receiving those services less.

Recommendations:

- CARE and its partners should assess the effects of INHP on overall coverage both among THR/ICDS beneficiaries and non-beneficiaries. This might begin with field officers and supervisors reviewing ANM

and AWC records and carrying out focused interviews to identify groups that possibly are not being reached. This effort could be complemented by spot surveys.

- Mothers and children not being reached with immunization and ANC services and counselling should be identified, and approaches to reach them developed and evaluated – this should include serious consideration of re-focusing the INHP target age group to children **under three**.

INHP has made serious efforts to ensure best possible targeting of the food supplement. The "social mapping" exercise, aimed at identifying all eligible participants, has introduced greater transparency at the community level regarding eligibility and inclusion.

- **Recommendation**: The effectiveness of these targeting strategies deserves continued attention; this may be in the form of informal monitoring through interactions with village leaders such as the *panchayati raj*, community members, and front line workers.

The effect of the INHP approach on the three key infant-child feeding behaviors is less clear than on the supply-driven interventions; however, there is subjective and anecdotal evidence that in some sites important positive changes are occurring. The three child feeding behaviors promoted under INHP – with or without supplementary food – are the best hope for improving child nutrition in the poor population of India. In field visits, the team frequently found that colostrum feeding, exclusive breastfeeding, and even complementary feeding of THR are increasing in INHP sites where AWWs have learned appropriate counseling approaches and are supported by community women's participation.

Recommendations:

- CARE should carry out focused monitoring plus operations and evaluation research to define the extent and determinants of changes in key feeding behaviors.
- The results of these activities should be used to strengthen and promote the feeding behavior component of INHP.

The project does not yet have adequate or systematic approaches for behavior change, or the ability to monitor the changes in key behaviors; these will be essential to achieve maximal impact on the key feeding behaviors and child nutrition, and on other health and nutrition related behaviors. Even the approach to the identified behavioral elements of the "3+3" package are unevenly understood and implemented across the project. Without a stronger and more systematic approach, the project is almost certainly under-achieving in these and other key behavioral areas. CARE needs a better-defined behavior change approach and some key tools for use in the field.

- **Recommendation**: Strengthen the behavior change capacity and develop a systematic approach and toolkit for dealing with behavior change. Among options for this are technical support from Delhi, CARE/Atlanta, or other USAID cooperating agencies; development and application of state-specific behavior change strategies and approaches, using project wide guidelines; and use of local resources or addition of local capacity.

CARE's community engagement and empowerment activities are among the most powerful tools for behavior change. Changing behaviors through community engagement is now considered "state-of-the-art". These approaches – even though not yet maximized in INHP – are already demonstrating their potential for contributing to health and nutrition outcomes. Continued strengthening of "traditional" IEC and communication capacities aimed at individuals - such as stronger media strategies, better materials and message development, improved counselling, and other "supply side" behavior change/communication activities – is appropriate; however there needs to be more specific emphasis on, and a structured approach for, inducing and supporting behavior change through these community engagement activities ("community behavior change", or CBC).

- **Recommendation:** CARE should give greatest emphasis to building upon, strengthening, and systematizing its "community behavior change" approach with inputs from relevant experts.

Effective growth monitoring and growth promotion are central to addressing problems with child nutrition. INHP has not explicitly tackled this issue, as ICDS has been plagued system-wide by an inability to move beyond weighing and measuring towards counselling and growth promotion. There is an ongoing debate about the effectiveness of growth monitoring, within and outside India. Growth monitoring as generally practiced has not been associated with improvements in child feeding or child nutrition; analysis has shown that the key missing elements are the understanding of the information and the "action step" – the provision of effective inputs that result in positive nutritional change.

The key to transforming "weighing and plotting" into counselling and behavior change is the development of training approaches that teach recognition and understanding of growth patterns, and support for building the nutritional problem-solving skills required to counsel mothers. Because the weighing and record keeping are already being done in most sites – but done without much effect – the marginal effort for an effective approach is not great, if the skill can be engendered. One way to economize on AWW time would be to focus the growth monitoring and promotion efforts on children under two, with less frequent weighing of older pre-school children.

- **Recommendation**: With partners, CARE should consider the latest information about growth promotion and evaluate the possibility of undertaking a focused pilot on capacity-building for true growth promotion, under INHP-II – perhaps initially as an operations research activity in a limited subset of project sites where ANM and AWW success and collaboration is already proven.

CARE has done a commendable job in increasing participation levels and ensuring food availability, primarily by facilitating convergence, but effectiveness in terms of improved health and nutritional outcomes depends greatly on the quality of interactions between ANMs. AWWs, and mothers. Quality particularly affects educational efforts, including growth promotion, and any activity requiring routine household implementation. Effective quality assurance, in turn, depends heavily on appropriate quality-focused supervision within the ICDS and primary health care systems, which is currently lacking in the field implementation of INHP. Importantly, INHP does not yet have an explicit approach for building the capacity of CARE's partners to assess or improve quality.

- **Recommendation**: Discuss an explicit focus on improving quality by service providers (AWWs and ANMs) through developing quality monitoring and improvement processes at the district and block levels in both ICDS and the Department of Health & Family Welfare (HFW). The block level may be particularly important, because it is the intersection point between administration and implementation, and because in some cases technical capacity and quality at this level appeared limited.

At the service delivery level, the greatest system constraints on achieving project objectives appear to be personnel-related rather than supply-related. While shortages and stock-outs of key commodities such as IFA tablets have clearly existed in the past, at this time the team did not find these to be prevalent. On the health side, the greatest constraint seemed to be vacant ANM posts. While in theory the system has means to "cover" for a missing ANM (such as use of the male multi-purpose worker, or cross-coverage by another ANM), in practice these mechanisms are unlikely to fill the void. On the ICDS side, the greatest issue seems to be overload of the AWW; the multiple tasks of AWWs are compounded by the fact that few of them are likely to have all the capacities and skills needed for these diverse tasks. However, in field interviews AWWs in INHP areas did not complain that project activities had increased their workload. In fact, several observed that their workload had decreased (or their efficiency had improved); in part because they now have the support of women's groups who help them. AWWs also reported that the Nutrition-Health Day lets them work with the ANM efficiently in a group setting, rather than accompanying her in time-consuming house-to-house visits as was earlier customary.

- **Recommendation**: INHP initiatives should take into account AWW (and ANM) workload issues, and seek to help them carry out existing and new tasks in ways that are not disincentives for their effective participation.

Sites where the program is operating and effective in the basic "3+3" package of interventions appear capable of taking on additional interventions that could increase the nutrition and health impact of INHP. High impact child health interventions – including immunization (already in the INHP package), as well as prevention and treatment of common infections associated with infant and child illness and mortality including diarrhea, pneumonia, and malaria – contribute to both survival as well as improved nutritional status. Thus, there is a larger package of interventions that can enhance achievement of the INHP nutrition and health objectives, if it can be feasibly implemented. Where it is well established, INHP has built a system and community "platform" that can be used to sequentially introduce some of these additional high impact interventions.

The DAP-2 proposal for the second phase of INHP recognizes this potential and proposes additional health and nutrition interventions aimed at women and children. Interventions that would maximize nutrition impact include:

- **Vitamin A supplementation** (one of the most straightforward and urgent, given the malnutrition and probable high levels of vitamin A deficiency in the target population; this is already being done in some states)
- **Iron supplementation of young children** (noting the high prevalence of child anemia found in NHFS II), possibly linked to de-worming
- **Iron supplementation of adolescents**

- **Child feeding during and after illness**
- **Community-based management of severe malnutrition** (present practice is often medical referral)
- **Low birthweight reduction** (improved nutrition of adolescent girls; delayed pregnancy and increased birth spacing; increased food intake during pregnancy; intermittent presumptive treatment during pregnancy in malaria-endemic areas).

Additional interventions that are largely within the community context and that would maximize health impact include:

- **Oral rehydration therapy**, including fluids, breastfeeding, and feeding (also being done in some states)
- **Routine newborn care** (adding cord care, stimulation/resuscitation of the depressed newborn, warmth, and hygiene to maternal tetanus immunization, colostrum feeding, and exclusive breastfeeding).

Important health interventions that require additional inputs for case management – and that are therefore programmatically more complex – are:

- **Detection and treatment of acute respiratory infections, malaria, and neonatal infections** (operationally linked to detection and management of pregnancy, delivery, and post-partum complications).

ii. Implementation processes

INHP's core program elements – Nutrition-Health Days, Take-Home Rations and convergence of ANM and AWW services, supported by coordinated planning and monitoring by ICDS and HFW at the block, district and state levels and by community participation and capacity building – appear to be a recipe for success and should remain the core of INHP-II. At the same time, there should be substantial room for innovation in terms of achieving greatest effectiveness, replication, and institutionalization of the core elements, in the context of strengthened systems and empowered communities. Such innovation – and the effects of adding other technical or process elements – should be systematically evaluated in terms of value added and cost-effectiveness.

- **Recommendation:** As introduction of additional interventions is considered, it is essential that CARE and its partners consider the appropriate sequencing and timing.

It is especially important to consider the absorptive and operational capacity of the health system, the ANMs and AWWs, and the community itself; otherwise, the "platform" can be overloaded and may collapse. Given the skills and current workload of CARE staff, implementation of new technical interventions will likely require additional technical capabilities and probably staff. Such additional capabilities – along with development of relevant approaches and materials, operations research, monitoring, and diffusion – may be appropriate uses for Child Survival funds.

iii. Community-based activities

INHP's focus on involving communities and building their capacities is critical for health and nutrition outcomes, sustainability, and empowerment. Strengthened service provision by responsible government agencies will remain an important element of nutrition and health programming in India. However, INHP gives evidence that demand for and utilization of these services, as well as changes in key behaviors, provision of material resources and support, and improved health and nutrition outcomes can best result when the energy and resources of communities are engaged. The active use of community-managed health funds initiated under INHP is an indication of the success of community engagement.

Recommendations:

- This community focus should be maintained and systematically strengthened. Best practices and innovations should be identified, evaluated, and shared.
- As INHP-II evolves, the broadening and institutionalization of community involvement – such as the involvement of other community groups and of men, and the development of self-sustaining women's groups supporting woman, child, and adolescent health and nutrition – should become an increasing focus of field activity.

The "place with no worries"

Nischintpur village, Jhumpara block, Keonjahr district, Orissa: The name Nischintpur means ' place with no worries ', and this *anganwadi* center truly seemed so. Healthy kids thronged the center, and the *anganwadi* worker Sumati Mahanto and the Lady Health Visitor Nonni Bala Mahanto used a "bonny baby" competition to reward moms whose children were fully immunized and registered a consistently normal weight and growth pattern. The women's committee was quite active in counseling mothers, and they were planning to cultivate mushrooms for sale, adding to their current sales of stitched leaves used for serving food in the market.

D. Support systems

i. CARE structure, roles

A core aspect of CARE-India's institutional transformation has been decentralization. This has facilitated essential adaptation to India's complex settings, especially the existing variations in state ICDS policies, the availability of NGO partners, and the degree to which ICDS and health systems provide effective programmatic support. Where decentralization has not been so positive, however, is where it has led to diversity outside a commonly accepted conceptual framework and set of objectives. Decentralization has empowered state level staff to adapt, innovate and develop creative solutions to local problems, but it has not yet been optimized – more quality guidance and technical support is needed to develop operational approaches for nutrition improvement, community behavioral change, capacity building, and replication.

INHP has proven certain project elements and approaches, but it equally has much to learn about effective community mobilization, behavior change, replication, etc. Innovation and filling the gaps within established procedures should particularly be encouraged for these areas. Well-defined systems, as for food logistics, financial management, and certain aspects of reporting, should be standardized; but less well-developed ones, and those subject to local conditions (including targeted "nimble" evaluation) should be relatively more open. Each state must continue to participate in evolution of the national strategy, **not** deviating from agreed national principles and standards **but** reporting innovations, critiquing the national strategy, and helping the program-wide specialist to make refinements. In other words, the state program should accept a project-wide responsibility: both loyalty to mutually agreed norms **and** responsibility for contributing to evolution of the national strategy.

- **Recommendation**: INHP needs more explicit distinctions between core project principles and appropriate local adaptations. We suggest that this issue be discussed specifically with regard to the core program hypothesis – nutritional supplementation combined with health services and behavior change resulting in improved nutritional status of women and children.

The evaluation team identified four areas in which both leadership and innovation are essential: community mobilization, behavior change, capacity-building, and replication. INHP needs mutually agreed objectives and strategic frameworks, but the essential technical expertise need not reside in Delhi. The team feels strongly that these are not control issues but rather technical ones: how to get the job done efficiently and effectively. Annex I provides detailed suggestions on how this balance of technical leadership and quality control at the programmatic level and local/state innovation and learning can be approached.

- **Recommendation**: CIHQ should provide leadership in at least the four key technical areas mentioned above, but should be prepared to turn over responsibility for technical support outside Delhi (e.g., within one of the states) if someone at that level is prepared to take the lead. An internally participatory approach should be applied to identify specific INHP objectives, to set standards and guidelines for state plans, and to clarify division of responsibility between local and national levels.

The gender composition of CARE field staff is more evenly balanced in some states than in others, and efforts to improve this have had more success in certain states than in others. Certainly there are constraints to greater hiring of women in the field, especially the need for frequent local travel as well as cultural taboos. INHP remains a predominantly male organization in the field, almost certainly more so than two of three key partners: ICDS and the Department of Health and Family Welfare. CARE as an organization remains committed to equity, and appropriately so, but does not believe (nor does the team) that there is a clear gender difference in the effectiveness of male *vs.* female Field Officers and Coordinators in their primarily catalyst role vis-à-vis government and community partners.

- **Recommendation**: CARE should continue the pursuit of internal gender equity, perhaps adjusting work conditions to overcome identified constraints to the employment, retention, and advancement of female staff in critical field positions.

ii. CARE staff and technical support

Much of INHP's success rests on the facilitative skills and creativity of Field Officers. The most successful FOs have established excellent relations with district and block ICDS and health officials, and where they have worked at the community level, many have had good insight into social processes and strategies for involving communities in achieving INHP objectives. Their apparent, although variable, talent for innovation rests heavily on their solid knowledge of community life and ICDS/health processes.

In many ways, Field Officers are INHP's most valuable assets. Many Field Officers, however, are working without routine technical support or recognition for such key areas as community mobilization and behavioral change, capacity-building and replication. Some Field Officers do not currently receive adequate technical guidance and expressed interest in peer sharing: facilitating direct contact, and perhaps work sharing, between individual FOs.

Many Field Coordinators are still operating more as supervisors and data managers than as technical support personnel, problem solvers and facilitators of innovation.

Recommendations:

- INHP, especially at the state level, should seek ways to formally recognize Field Officers who are particularly effective or innovative, perhaps through an "FO of the month" award.
- INHP should not introduce technical interventions without providing continuous support for its field staff (beyond formal training), and should explicitly acknowledge that learning goes both ways. Efforts to upgrade operational planning for community mobilization, behavior change, etc., should include plans for technical support.
- INHP should retain intermediate positions between FOs and the state level, but primarily for technical support. INHP should consider a possible peer support system, in which FOs within a sector critique and support each other's work, with only occasional involvement from higher levels.

iii. Food

CARE has been especially impressive in systematizing, monitoring and strengthening processes, and at rolling them out to scale. Their management of the commodity supply chain for the Title II food inputs is a prime example of this institutional capacity: availability for the past year has been quite good, food arrives from the US in a timely manner, primary distribution from port to block is efficient and timely. Secondary distribution from blocks to AWCs, a link in the supply chain where CARE relies heavily upon government systems, is not always as good.

CARE has encouraged community involvement in supply chain improvements, such as support for the proposal that village development communities and *mahila mandals* taking up secondary distribution of food (from blocks to the AWCs). In some states, CARE has persuaded state officials to sign transport contracts in a more timely fashion and at market driven rates and to settle transport bills on time to avoid disruption in stock movement.

- **Recommendation:** Optimize CARE supply chain and use CARE's expertise in managing commodity supply chain operations to improve delivery of other key inputs or to provide consulting expertise to government programs with supply chain problems.

iv. Management decision support systems

A great deal of change in INHP's monitoring system has been made since the MTR, and the team applauds the streamlining and rationalization of routine monitoring systems. HMIS development has clearly been a participatory process, though the use of information varies across the states. Field staff's satisfaction with the new HMIS, and the degree of utilization of the information for management and action, seem to vary based on the degree of input states provided during its inception and the extent to which FCs and State INHP program managers are inclined to use it pro-actively. Some Field Coordinators say that they use HMIS actively for feedback, management, and problem solving, sharing reports with the CDPOs and discussing the observations with government counterparts to solve problems more quickly.

The focus of HMIS is, appropriately, on inputs, outputs, and processes; it does not currently capture quality, outcomes, or behavior change. The evaluation team strongly warns against re-burdening the routine HMIS with many new indicators, but suggests instead, as outlined in section V and Annex D, that

targeted operations research be used to fill perceived gaps between monitoring processes and quantitative surveys. The evaluation team commends such innovations as self- monitoring tools for mothers, social mapping for communities (updated regularly), and monthly monitoring of INHP health activities by mothers' committees (post-card campaigns to ensure ANM service delivery).

Recommendations:

- Using an internally participative process such as that used in HMIS design, review the HMIS to assure that information for decision-makers at all levels is available in a user-friendly fashion and consider how information is disseminated within and across the project. Involve government and NGO counterparts as appropriate.
- Encourage and support expanded community-managed monitoring as an essential step towards sustainability post-INHP -- spread the examples of mothers' self-monitoring tools and strategies, household monitoring of children's nutrition and health, community monitoring and pressure on government service delivery through post-card campaigns, etc.
- Continue with social mapping and updates involving the community, and increase the focus of those mapping events on reaching the marginalized and distant families in the AWC catchment area.

E. Organizational learning and diffusion

The evaluation team found numerous innovations at the state and Anganwadi level, but inadequate means for documenting them, evaluating them for quality and potential use, and sharing them systematically. Sharing of "better practices" tends to be descriptive and promotional rather than instructional (processes followed, steps taken, costs in terms of manpower and time). Transforming innovations from examples into systems is essential for effective replication either within CARE-supported areas or in government programs. There is also little or no prospective testing of potentially feasible solutions to common problems, nor operations research to test the feasibility of new interventions or strategies. Diffusion occurs easily and frequently within state offices, but sharing between states appears inadequate. CARE cannot complete its evolution from a feeding to an integrated health and nutrition organization without a much clearer learning approach to issues and innovations.

We endorse the demonstration site approach to INHP and partner learning, but note that explicit pro-active replication strategies are often inadequate.

- **Recommendation**: INHP should review its current plans to replicate demonstration sites, with a view to developing more concrete plans for diffusion and replication.

While local innovations are widespread, INHP has a limited capacity to evaluate them with any rigor or to diffuse information regarding innovative approaches.

- **Recommendation**: As described elsewhere in this report, INHP should develop a more "nimble" evaluation and documentation strategy to facilitate focused evaluations, simple problem-solving studies, and perhaps prospective operations research, for key strategic issues. These efforts should particularly focus on INHP's leading issues such as community behavior change and replication/diffusion.

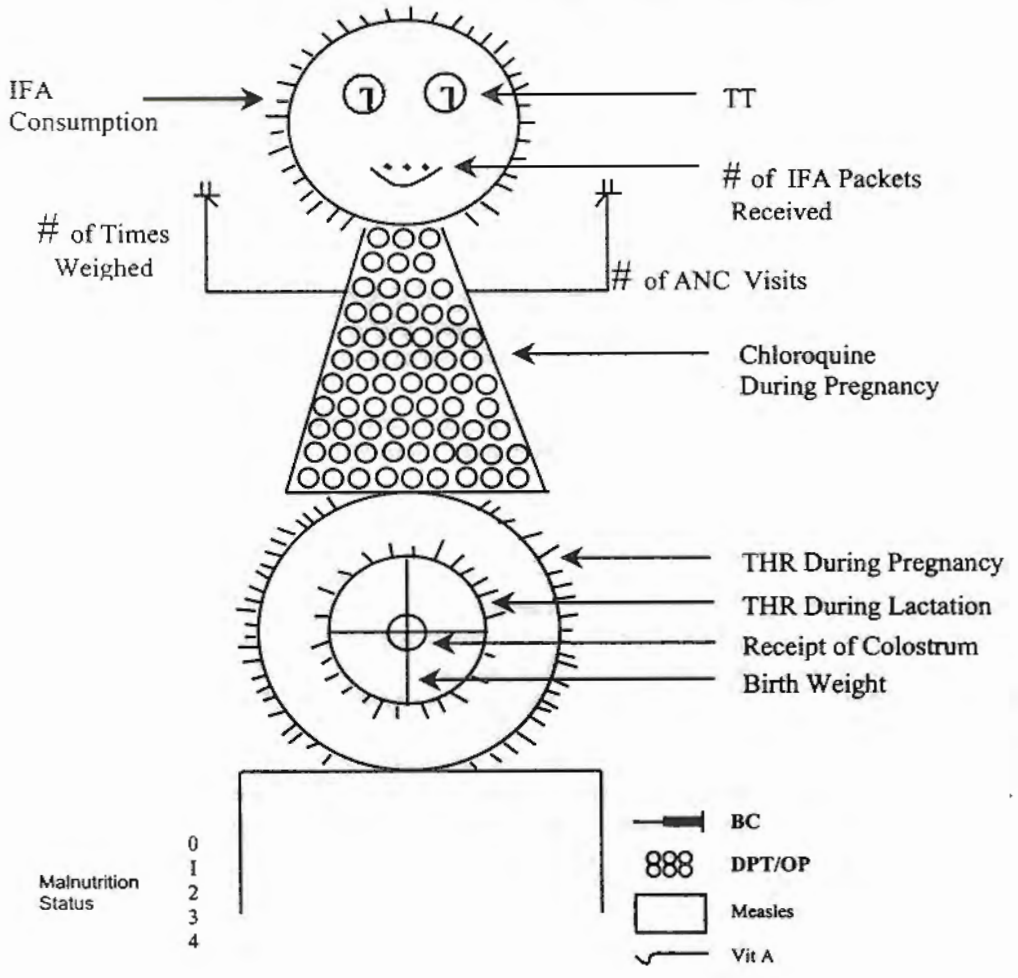
Field personnel may have more to learn from each other on certain technical and implementation issues than they do from CARE headquarters. However, routine methods for cross-learning have not been developed.

- **Recommendation**: INHP should encourage cross-learning at all levels: FOs to each other, specialists and program managers with other state personnel, and so forth.

Detailed explanations of the team's findings on institutional learning and diffusion are provided in Annex I, along with specific suggestions and recommendations.

See How Healthy I Am!

In Orissa, CARE INHP Field Officer Mr. Sandipta Bisawal developed a self-monitoring tool and the women in Jhumpura block have really taken it to heart! It is a figure to be drawn on the wall of the house by a pregnant mother to keep track of her essential health inputs -- IFA tablets, ANC visits, TT injections, all the actions and events needed for the protection of the mother and the child. If you visit the houses of pregnant women in the village, you will see them keeping a count of their interventions using a picture they themselves draw on their wall, and they will tell you -- "see how healthy I am!"



F. **Capacity building and link to sustainability, replication, and exit strategies**

The evaluation team reviewed evidence of capacity building, and looked broadly for lessons about what program components were linked to improved capacity. The objective was to identify what did or did not work, and recommendations for further improvement. The main findings are shown in bullet points with a brief discussion, and relevant recommendations follow:

- INHP-I recognized that building capacity of communities and individuals is as important as reaching short-term nutrition and health targets (e.g. DAP-I).

In the design of INHP the purpose of building capacity in communities and individuals was to assure that women and children would, a) benefit from ICDS and health services in INHP, and b) have the ability to continue to improve their nutritional and health status beyond the tenure of the INHP project.
Recommendation: The evaluation team fully endorses this hypothesis and encourages INHP-II to continue to achieve these objectives through even a more comprehensive and systematic CB strategy.

- INHP-I appropriately selected three main channels for the focus of CB efforts, community structures and change agents; government departments and institutions, and NGOs

The evaluation team endorsed the choice of institutions on which CB activities were focused. These are:

- Community based organizations and change agents (e.g. Mahila Mandals, SHGs, Village Development Committees, Panchayat leaders and their committees, adolescent girls etc)

- Government departments and institutions. Particularly after the MTR, a concentrated effort was made in the following areas, THR, NHDs and other forms of convergence, in addition to the ongoing focus of CB activities in planning, monitoring, supervision, food commodity management, nutrition and health education.
- NGOs. These were viewed initially as implementers of CARE activities, but in some states INHP found the need to build their organizational capacity and/or capacity in health and nutrition activities before they could become fully effective.

Recommendation: Based on the valuable CB experience gained in INHP-I, and a clearer appreciation of what specific skills and capacities are needed in key institutions at various operational levels, it would be valuable for INHP-II to specify milestones and indicators of capacity for critical functions in key counterparts. CB activities can then be prioritized and linked to achieving these. At this point in the development of INHP, the following questions can begin to be answered:

- What capacity is needed for key program functions?
- What does adequate capacity look like at the mid-point and end of INHP-II?
- What specific outcomes and targets should be aimed for?

- INHP succeeded in building capacity in all states to some level even though the evaluation team did not find detailed operational guidelines for linking activities to capacity outcomes. General guidance was provided by CARE/HQ, and the supportive manner in which INHP was implemented at all levels in all states clearly demonstrated a commitment to building capacity.

INHP succeeded in raising awareness at various levels within program areas, about the importance of nutrition and child survival interventions, and that ICDS can make a difference in the health and nutrition of mothers and children. The commitment to improving nutritional status and capacity to do so among partner institutions (government and NGO) needs to be further strengthened.

Examples of areas where capacity was built, included awareness of key nutrition and health behaviors at all levels (state through community/household); understanding of the importance and effective planning strategies for convergence of government ICDS and health activities at the community and block levels; and food commodity management to community level.

Gains in women's empowerment were also made. Most ICDS/health department functionaries and community members trained/provided information and skills were women, and the program therefore supported women's empowerment and advancement. In some states specific efforts were made and these appear to have succeeded in developing adolescent girls capacity, formation/strengthening of SHGs and MMs.

Areas in which the evaluation team did not find equally strong evidence of capacity being transferred/built, and which are key to sustained nutrition and health improvements include: community (and household) behavior change or CBC focused on health and nutrition behaviors, routine self-monitoring of coverage and quality, advocacy for nutritional status improvement.

Recommendations: Carefully assess capacity building experiences (training and other), identify those successful in achieving desired outcomes, document and package those proven effective for broader use. Review and revise CB approaches as the knowledge and learning base change and the program/policy environment changes.

- The intention of CARE to build capacity for long-term sustainability of key INHP components through phasing over critical components to state, district, block and community entities was not consistently and clearly understood by key stakeholders.

The feedback from state and district level partners to the evaluation team about the need for indefinite continuation of CARE in INHP, while a testimonial to the high caliber of CARE's work and the great value and esteem accorded to CARE as an institution, also raised some concern among team members about phasing over and building capacity and commitment for long-term continuation of key INHP activities that are essential for ICDS to produce health and nutrition results. This suggests that capacity building objectives (i.e. including phaseover and sustainability, in addition to achieving scale and quality) need to be jointly discussed and developed and systematically reinforced.

Recommendation: Develop a joint plan for and conduct explicit advocacy for phasing over critical INHP functions to government, NGO and community entities – address both the why and the how.

- Although early in INHP, project documents refer to a broad range of potential actions for CB, perhaps unintentionally, training appears to have become the predominant approach explicitly stated as the INHP strategy for building capacity.

The evaluation team was concerned that INHP may not progress as rapidly with phasing over key functions (including routine training functions of states for AWWs for example), if CARE/INHP became a substitute for these functions rather than a 'facilitator, coach, guide, promoter, enabler'. Focus at the community level was considered important by the evaluation team.
Recommendation: INHP should maintain its focus on capacity building at the community level (through government and NGO structures). It should not substitute for lapses in AWW training functions of the states. It can however facilitate the process through finding more effective training and supervision approaches for performance improvement, and by helping to strengthen key components e.g. testing/OR to improve CS package of interventions, routine monitoring, CBC, nutrition advocacy etc. within existing training strategies.

- Though not explicitly identified as a capacity building approach, CARE's collaborative working style that includes joint planning, frequent joint field visits, and frequent joint reviews of field monitoring information was an effective tool that led to improved capacity at all levels in certain program components. Community level capacity was also improved through NGO partnership activities. Useful experiences and tools have been developed that can be consolidated into an effective strategy for capacity building both, for the purpose of defining and operationalizing "the INHP approach" with all its vital components, and also for the purpose of achieving sustainability and successful INHP graduation.

Recommendation: Use a broader approach to capacity building than training (e.g. Appendix M in DAP-2 lists appropriate components for the training but not other CB activities). Routinely monitor indicators for training activities plus other CB activities, and even more importantly, monitor outcomes of the training/other CB activities in terms of key functions (not inputs and outputs alone).

- It is now possible to link CB activities to the main stages of INHP development (details of the model to be defined as more program learning occurs), and these stages include: identification and enhancements (e.g. adding new CS interventions) of the model, replication of the model/enhancements, phase over of critical functions.

The team was impressed with successful experiences in all states in implementing the revised strategy after MTR. There is a strong commitment to expanding lessons learned from demonstration sites more broadly and also to sustainability. Capacity building activities can now be linked to stages of INHP evolution in each state. The team was concerned that a focus on results and quality be maintained throughout this process. State INHP teams could benefit from acquiring capability in approaches such as continuous quality improvement techniques (based on principles of self-assessment and teamwork to solve problems systematically).
Recommendation: Capacity building should be more closely linked with stages of INHP development and graduation, with defined outcome indicators. These should aim to secure coverage/scale, quality and long-term sustainability of proven effective technical interventions for ICDS.

- CIHQ and INHP/states have an important role to play in building capacity at the national level in ICDS, MOHFW, and NGOs.

The team observed the interest and opportunity in national level institutions for wider application of INHP experiences beyond CARE/INHP locations. This has begun to occur spontaneously and can be systematized and further developed. Areas where transfer of skills and capacity can occur include: commodity planning and management, convergence strategies and tools, management of THRs and NHDs, and routine monitoring.
Recommendation: INHP could have a broader impact on ICDS beyond the 8 states where CARE is involved and this opportunity should be taken up through developing a portfolio of areas of excellence in INHP and a pro-active approach that includes packaging, marketing/promotion, and transfer of the experience of INHP in a strategic manner.

- Capacity building is particularly important at this stage of INHP for certain components, which include: monitoring and small studies/OR, community (and household) behavior change, and advocacy for improving nutritional status.

Designing and carrying out small, OR activities and assessments to systematically and rigorously evaluate prospective (e.g. newborn health package, delivery of 2 doses of vitamin A annually) and existing innovations (e.g. CBC +3 interventions) is important. The team felt that capacity exists in institutions at national and state levels to carry out small focused studies on the above listed topics, particularly with the guidance of CARE and its consultants. Their engagement in the INHP/ICDS program as problem-solvers and guides for decision-making could be strengthened.

For community (and household) behavior change, national and state agencies currently involved in ICDS/INHP could benefit from understanding and developing skills in an approach that includes elements such as use of formative research methods to define constraints/barriers and motivations for key behaviors; identifying options for removing constraints/barriers; defining key audiences to be reached, community-level structures/entities to be engaged, policies/program guidelines to be changed, etc.; and monitoring the implementation of program inputs, outputs, processes and outcomes.

In the area of policy/advocacy, a clear link needs to be continuously made within and outside CARE and its immediate counterparts regarding the role of nutritional improvement in reducing child mortality (e.g. Pelletier's studies, PROFILES nutrition advocacy tools), and the role of ICDS/INHP in improving nutritional status. **Recommendation:** Within the context of an overall strategy linking CB activities to stages of INHP development, and in addition to it, build capacity in selected key elements such as using small studies/OR for problem solving, community (and household) behavior change, and advocacy for nutritional status improvement.

In conclusion, as the INHP program model is finalized with its components of community mobilization, behavior change, replication, and graduation, it should become clearer as to what types and level of capacity are needed in the ICDS and health systems, in communities (particularly in women's empowerment and appropriate role of the Panchayat), in NGOs, and at policy/advocacy levels to achieve quality and impact and to assure sustainability. CB activities in INHP-II should be targeted to achieving these capabilities.

The team identified some constraints to moving ahead rapidly with capacity building for successful INHP graduation. These include:

- Need to complete the "INHP model" and its vital sub-components e.g. technical content (e.g. addition of vitamin A and newborn care), behavior change strategy, replication approach and tools.
- Lack of broad awareness and clarity among counterparts on why/how/who of phasing over of CARE/INHP inputs to community, NGO, and government functionaries.
- Need to identify suitable partners for capacity building.

In developing a comprehensive capacity building approach for INHP-II, a crucial step is participatory planning with institutions whose capacity is to be strengthened. The strategy and subsequent INHP-II documentation (e.g. monitoring tools, training plans, advocacy materials, operational plans, progress reports) should explicitly recognize that CB includes not only knowledge transfer, but empowerment, encouragement of innovation, support for problem-solving, diffusion of best practices, positive feedback, supportive supervision, and learning by doing. CARE can look within its own programs for good examples and approaches and also obtain technical assistance from projects working in other regions and countries for tools and approaches of how other programs have achieved scale with impact.

Overall, the evaluation team was greatly impressed by the dedication of INHP teams at HQ and in the states to build capacity in counterpart institutions and at community level, and the effectiveness of the participatory working style employed by CARE in implementation of the INHP program at all levels. There is a marked improvement in the capacity of ICDS institutions at various levels where CARE/INHP has worked in the past 5 years; several of these improvements can be linked to INHP activities. Some of the INHP enhancements have been taken up in non-INHP locations by state governments and at the national level, illustrating the potential for larger scale benefits resulting from INHP.

Detailed explanations of the team's findings on capacity building are provided in Annex J, along with specific suggestions and recommendations.

VII. KEY FINDINGS AND RECOMMENDATIONS

The evaluation team found evidence that INHP is making important contributions to child survival in India, through improving immunization and breastfeeding (including colostrum feeding) practices, and may be reducing the under-nutrition that exponentially increases the risk of children dying from childhood illnesses. The narrowed focus of INHP after the MTR has paid off; the basic INHP package of 3+3 is effective and has showed results.

The evaluation team also found that the respect among partners (GOI, donors, NGOs) for CARE's previously acknowledged expertise in commodity supply-chain management has broadened to include an appreciation of CARE's systems strengthening and in technical aspects of nutrition and health. CARE's role as a catalyst, a capacity-builder, a technical advisor, and a contributor to the policy discussions, is respected and welcomed. CARE's focus on capacity building and on community empowerment has been essential to the success of INHP-I to date, and increased attention to systematizing these strategies will be equally essential to fully achieving the objectives of the project in the second phase.

KEY FINDINGS	
Examples and Observations	• ***Recommendations***
The **conceptualization and implementation of INHP was a programmatic and institutional revolution** for CARE and for USAID food support to ICDS. CARE's expertise in health and child survival and in community capacity-building, in addition to their expertise in nutritional interventions, is now recognized and welcome at the state, district, block, and community, and **CARE is now viewed as a development partner**.	
CARE's **institutional transformation** from a food management organization to a nutrition and health development group has been **impressive**, and can be best completed by revisiting the INHP program vision.	• Commit to a focus on **enhancing technical expertise** in states and **developing mechanisms for systematically** monitoring, diffusing, and replicating INHP successes. • Define **INHP evolution, maturation, and graduation** -- what does a mature and sustainable INHP program site look like in 2006, and how do we get there?
CARE-India's **chosen role in INHP** – catalyst, facilitator, capacity-builder, technical supporter – is **appropriate** and has made an outstanding contribution to the convergence of health and nutrition services both in INHP and beyond to other ICDS sites.	• CARE should **not** play the role of direct service provider. • CARE should consolidate their successful experience in these roles so that even if Title II food commodities phase out or over, CARE can continue to provide assistance in the child survival and nutrition areas.
State government counterparts, under severe budgetary pressures due to the ongoing fiscal crisis, are **reluctant to discuss concrete plans for phase-out** of CARE food inputs and hand-over of responsibility for further replication of the INHP model.	• Test models for hand-over, such as the **local food processing model** proposed for funding partially by monetization resources, **as a high priority for INHP-II** to prove the financial feasibility of INHP program blocks "graduating" from Title II food and towards sustainability.
INHP has succeeded in **bringing together ICDS and health** department policies, operations and service delivery – and governmental departments have become more effective at reaching high coverage rates for health services as a result.	
Conviction among partners – government functionaries, field and program staff – **and confidence about the conceptual links** between INHP inputs and improved nutritional status were **variable**, and need strengthening to become a driving force across the project.	• Invest in **building the commitment of staff, counterparts, and partners at all levels** to achieving nutritional improvement through INHP, including a review of INHP-II to balance and sequence nutrition and health interventions.
CARE has been especially impressive in **systematizing, monitoring and strengthening processes**, and at rolling them out to scale.	• Use CARE's expertise in managing the **commodity supply chain operations** to assist with optimizing the delivery of other key inputs or to provide consulting expertise to government programs with supply chain problems.
When INHP works well, it achieves good results and makes **important contributions to child survival in India**, through improved immunization and breastfeeding (including colostrum feeding) practices. There is indirect evidence that INHP is reducing the under-nutrition (low weight-for-age) which synergistically increases the risk of children dying from common childhood illnesses. The basic INHP package of 3+3 is effective; the narrowed focus after Mid-term Review is paying off.	

KEY FINDINGS	
Examples and Observations	• ***Recommendations***
Coverage and utilization of the **three "supply side" interventions** – IFA supplementation (part of ANC), child immunization, and targeted supplementary feeding-- **have improved substantially** among INHP participants, while results from the **three key infant feeding "behavior change" interventions** are **less clear** and **need improvement.**	• Develop systematic approaches for community behavior change – not just communication of messages – in order to achieve maximum impact on the key feeding behaviors and child nutrition and health practices.
INHP establishes **a solid institutional and community "platform" for additional high impact maternal and child health and nutrition interventions**, including maximizing impact of USAID resources including both Title II food and dollars from Child Survival CSD account.	• **In a phased, carefully sequenced, manner**, add these **new interventions** – vitamin A supplementation, newborn care, intensified quality control on antenatal care, measles prevention.
Where fully and consistently implemented, INHP has demonstrated the conditions required to promote actual improvement in nutritional status; as it moves to expand its health impact in INHP-II, CARE should not lose this **opportunity to achieve & document nutrition impact.**	• Conduct a focused **evaluation of the extent and determinants of changes in key feeding behaviors** and nutritional status changes; use the results to strengthen and promote current and future feeding behavior interventions.
Demonstration sites are working both as examples of best practices and as sources of learning and program diffusion; mechanisms for systematizing the process of replication will accelerate the process of taking INHP's success to scale.	• Develop, communicate, and operationalize clear strategies and approaches for these three key INHP elements: community behavior change, capacity building, and replication/diffusion.
Changes to MIS have **improved routine process monitoring** and now provide useful information for field management.	
Although the **large-scale quantitative surveys** have been of good quality and high intellectual rigor, these mammoth efforts are not nimble or focused enough to provide rapid feedback on program interventions and innovations. While a large-scale quantitative survey is appropriate for the end of INHP-II, a similar survey at midterm would not be a cost-effective use of M&E resources.	• Restrict use of large surveys to end-of-project evaluations.
The missing element in the overall INHP is a range of **more agile operations research and targeted evaluation tools** that could validate the success of past innovations, test prospective intervention strategies, and measure results of program activities such as capacity building and behavior change.	• Develop and add **measurement mechanisms and indicators** for **behavior change, capacity building, replication and diffusion** to the overall M&E portfolio.
Social mapping has improved targeting of THR resources and thus improved targeting of program interventions to the most vulnerable – it has increased village ownership of the program activities, and in some cases reduced social tensions over perceived distributional inequities by making the beneficiary mapping and selection process transparent and public.	
THR is a vital strategy for reaching pregnant and lactating women and children under 2. However, at AWCs with catchment areas including remote hamlets, even THR has not always been able to reach those vulnerable women and children.	• Conduct a focused assessment of the issues of eligibility-enrollment-participation in selected INHP sites with remote or marginal hamlets to assess 1) coverage/ participation among target participants and 2) outreach to vulnerable women and children in outlying areas.
INHP links with self-help groups, newly invigorated *mahila mandals*, village development committees, and small groups of change agents such as *dais* and adolescent girls, have **empowered village women** – and those women have become effective agents for behavioral change among their peers.	
The emphasis within INHP in general has been on **quantity of services** – such as the delivery of adequate	• Increase the attention of both INHP staff and government/NGO counterparts to **quality of services** –

KEY FINDINGS	
Examples and Observations	• ***Recommendations***
supplies of IFA tablets to pregnant women and the communication of key messages about iron consumption.	such as extended counselling & community support that are needed to ensure consumption of 90+ IFA tablets.
Implementation of many of our recommendations will require cash resources. Although with the available data we are not able to make a detailed judgement about the optimal current or future **cash-vs-food balance** in INHP, we note that INHP has leveraged substantial results with the small amount of cash in the INHP-I budget.	
Some budget line items, such as travel and use of outside agencies/ technical resources, are very high when broken down to a per-employee per-day cost and compared to standards in non-NGO sectors. These high levels **may** be necessary due to recommendations from previous evaluations or approved program revisions.	• Reflect on the main budget line items, especially those where costs have risen rapidly or are higher than is standard -- analyze the benefits achieved with those resources and shift resources if necessary.
INHP's focus on **strengthening government service delivery systems** and on **involving communities and building their capacities** are both critical for health and nutrition outcomes, sustainability, and empowerment.	
Where **capacity building was most effective**, it was more than just training and knowledge transfer; it was **empowerment**, **hands-on skills building**, and **support for problem-solving**.	• Carefully assess capacity-building experiences, document successful efforts, and develop milestones for monitoring capacity at both community and systems levels.
Decentralization has empowered state level staff to adapt, innovate and develop creative solutions to local problems, and has allowed Field Officers to play a key role in INHP's success.	
Fully functional decentralization will require strong supportive leadership from Delhi, and **adequate accountability, monitoring, and quality assurance systems** that avoid command-and-control but flexibly deploy the needed technical and managerial resources.	• Support Field Officers – provide increased technical support through flexible resources, and encourage peer sharing to strengthen capacity and improve quality of field implementation of INHP.
While local innovations are common, INHP has limited capacity to evaluate them, to disseminate information regarding innovative approaches, or to prospectively test new approaches -- **systematic approaches to cross-learning** are needed to fully exploit field innovations.	• Develop a more systematic approach for identifying, testing, documenting, and sharing information about innovative approaches. • Develop one or more District or Block models based on INHP successes for replication across INHP and for wider replication by ICDS nationwide.

ANNEX A: METHODOLOGY

INHP was conceived as a ten-year effort, and this evaluation focuses on assessing the progress and achievements of INHP-I (1996-2001) and, based on the findings and observations of that assessment, on providing suggestions for CARE-India as it prepares to implement the second phase of the project, INHP-II. Thus, while the external evaluation team did seek to assess key aspects of INHP-I and to link those findings to recommendations on implementing INHP-II, this evaluation did not undertake to critique or assess the overall design for INHP-II as expressed in the new Development Activity Proposal (DAP-2).

Consistent with the DAP for INHP-1, this final evaluation was conducted by a multi-disciplinary team of Indian and expatriate specialists who considered a wide range of project documents and reviewed data and analytical results from three sources:

- a quantitative survey, conducted in all states where INHP works, by five independent external agencies supervised by the Institute for research in Medical Statistics under overall guidance from a high-level Technical Advisory Group as recommended by the INHP Mid-Term Review;
- a qualitative survey, conducted by an external management consulting agency with key informant and focus group interviews in all INHP states;
- field visits and observations by the external evaluation team during visits to all INHP states.

Each technical specialist on the INHP Final Evaluation team was assigned a particular set of evaluation topics from the Terms of Reference, and field visits were guided by topic protocols designed by each specialist. The detailed synthesis of each technical topic, presented in the annexes to this report, was authored by the assigned technical specialist from the team, while the major findings and recommendations presented in the main text were discussed and agreed to by the entire team.

TERMS OF REFERENCE
INHP FINAL EVALUATION

1.	Project Name	:	Integrated Nutrition and Health Program
2.	Point Person	:	Manish Subharwal, M&E Officer (HMIS), CARE India - Delhi
3.	Project Funding Cycle	:	October 1996 to September 2001
4.	Donors	:	USAID & GoI

Background of Integrated Nutrition and Health Program

CARE-India's Integrated Nutrition and Health Program is a five year initiative supported by the USAID Food for Peace Program that was launched on October 1, 1996.

Goal: "*To improve the health and nutritional status of women and children*"

The three intermediate goals of the project are:

1. Prevention and rehabilitation from Malnutrition.
2. Promotion of women's health and nutrition.
3. Management and prevention of infections and diseases.

Specifically, project activities focus on achieving sustainable improvements in "key outcome indicators of healthy behavior," which include the percentage of:

- pregnant and lactating women and children 6 to 24 months who receive and consume a supplemental meal
- children 12 to 24 months who were completely immunized by age 1
- pregnant women who receive and consume 90 or more IFA tablets before delivery
- receipt of two TT before delivery
- newborns breastfed within 6 hours of delivery
- infants exclusively fed breast milk for the first 6 months
- infants initiated on complementary foods in addition to breast milk by 6 to 10 months

Final Evaluation Objectives:

The evaluation will assess both (i) the development hypothesis and causal links between the strategies and impact and (ii) the implementation of the project.
The specific objectives are:

- To assess achievement of **outcomes/coverage rates and health impact**, since the baseline and mid-term.
- To assess achievement in enabling **sustainable institutions**, governmental and non-governmental, that can make continuous improvements in health status.
- To assess the success of key **strategies, processes, staff, structures, and systems** (including monitoring systems) of the program in achieving outcomes and sustainable impact.
- To assess as to what extent can the changes in performance indicators be attributed to the project.
- To assess implementation according to plan; and expenditure according to budget (money and food resources).
- To assess the efficiency of food management, logistics, and monitoring; and reductions in food loss.
- To summarize the project and its achievements in a stand-alone executive summary, and to make recommendations for on-going efforts, and compile a more detailed report of the assessment.

<u>The final evaluation will include three components:</u>

1. A Quantitative Survey
2. A Qualitative Assessment
3. An External Team Evaluation

1. Quantitative Survey

The quantitative survey plan primarily consists of comparisons across time but also includes some comparisons between INHP program areas and non-INHP areas using secondary data. In addition, comparisons can be made between project areas of higher and lower intensity effort. Each of these approaches have their own strengths and weaknesses. In this manner, the final evaluation is expected to document and analyze the effect size from baseline to mid-term and final evaluation and between areas of varying program effort.

Secondary data sources such as the National Family Health Survey (NFHS) and the Multi-indicator Cluster Survey results will be used as a secondary source of data, where available. Other sources of secondary data that may be used for comparison include NCAER's and other agency evaluation of ICDS.

CARE will contract with national agencies to conduct the surveys in seven states. To maintain objectivity and ensure appropriate methodology and quality control CARE will constitute a Technical Advisory Group (TAG) with representatives from CARE, USAID, FANTA and External

Experts in the field of designing population-based evaluations of large public health programs. Meetings of this group will be convened to review the survey design and to assist CARE in consolidating the results obtained from the surveys in seven states.

2. Qualitative Assessment

The focus of the Qualitative Assessment is on the interventions and strategies under the INHP Capacity Building strategy. The objective is to assess these interventions at the process and outcome levels.

The key informant model (John Paji, Mexico) would be adapted as the primary method of data collection for the qualitative assessment. This methodology involves in-depth interviews and focus group discussions with a sample of selected community members and counterparts at various levels to help the investigators to arrive at an understanding of the project strengths and weaknesses.

3. Final Evaluation Team:

CARE will contract a final evaluation team of experts in the field of health, nutrition, food security, and project management and evaluation who are external to CARE. To the extent possible, this will include representatives from the 1995 impact evaluation, and the Mid Term Evaluation team. Key stakeholders, Govt. of India and USAID representatives may also participate in the external team in a limited capacity. If possible, the Team Leader or other member(s) of the external team will be involved in reviewing the components of the evaluation (e.g., quantitative survey, qualitative assessment), prior to the external team evaluation.

Methodology / Process:

If possible, the External Team Leader will aid in the development of Terms of Reference (ToR) for each of the components of the final evaluation. CARE will also seek inputs from outside evaluation experts, USAID, GOI, CARE USA, and other key stakeholders. If possible, the Team Leader will also assist in identifying and coordinating the external evaluation team, including finalizing their terms of reference, schedules, and methodology for the external evaluation.

The purpose of the team is to bring an outside perspective and their scope of work include:

- Meet with staff from CARE, GOI and USAID to understand the project, and the key questions to be answered.
- Review project documents, (including 1995 Impact Evaluation, Annual Plans, Annual Results Reports, Monitoring Data, Baseline and Mid-term evaluations), to understand the project.
- Review and prioritize the key evaluation questions and include additional questions, which the reviewers feel are relevant to the review of the project.
- Review the quantitative survey and qualitative assessment data.
- Elaborate and agree upon a methodology and tools to collect and analyze both primary and secondary data to answer the key questions.
- Visit the states to collect primary data from participants, staff, and counterparts, as required.
- Analyze the primary and secondary data.
- Compile and summarize findings and recommendations into a report.

Sources of Data

Primary Sources of Data

This include data gathered directly by the external team through meetings with

- Project participants (mothers, fathers, pregnant women)
- Project counterparts and partners (village, block, district, state and national level)
- Project/CARE staff

- Donors

Secondary sources of information

- Project documents, generated by the project staff:
- Planning documents: Proposal, PAAs, Program Updates, implementation plans
- Progress Reports: Results Reports
- NFHS, SRS, or other surveys and studies done in India.
- Data from the MIS of Govt. of India

Reports Available to the External Team

- 1995 Impact Evaluation Report
- 1996 Baseline survey report, compiled by FRHS
- 1999 Mid-term quantitative survey report, compiled by FRHS
- 1999 Qualitative project assessments related to sustainability, partnership, convergence, etc.
- 1999 Mid-term external team's summary report.
- 1999 Report on comparability of Baseline and Mid Term Quantitative Survey by Drs. Mavalankar and Rao.
- 1999 Results Report
- 2000 PAA

Final Evaluation Time-line:

The final quantitative and qualitative assessments are expected to be completed by February 2001. The External Evaluation Team is planned to work during April 2001. The draft report of the evaluation is expected by late April 2001.

Activity	Months (2000)					Months (2001)				
	A	S	O	N	D	J	F	M	A	M
Finalize Terms of Reference for Final Evaluation										
Finalize Terms of Reference for Quantitative Survey										
Finalize Terms of Reference for Qualitative Assessment										
Finalize Scope of Work for External Team										
Identify External Team										
Finalize design of quantitative Survey										
Finalize instruments for quantitative Survey										
Identify & Finalize agencies for quantitative survey										
Identify & Finalize agencies for qualitative assessment										
Quantitative data collection										
Qualitative data collection										
Draft report of quantitative survey										
Final report of quantitative survey										
Draft report of qualitative assessment										
Draft report of quantitative assessment										
External Team Evaluation										
Final Evaluation Team Report										

ANNEX B: PROGRAM DESCRIPTION AND DEVELOPMENT HYPOTHESES

Introduction

CARE India's main focus in the INHP program is to work within the broader mandate of the Government of India's ICDS and RCH programs with the main goal of improving the nutrition and health status of the vulnerable groups of pregnant and lactating mothers and children below the age of 2 years belonging to the poorer income groups.

The INHP designed in 1996 as CARE's first Development Activity Proposal (DAP), went through major changes after the mid-term evaluation in May 1999, and currently focuses on six key interventions for the two major target groups, a) pregnant and nursing mothers, and b) children <2 years. As of now INHP is implemented in eight states of India. These are: Andhra Pradesh, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, West Bengal, and Uttar Pradesh, covering 7 million women and children in approximately 100,000 villages, which is about 25% of all the population covered by India's massive ICDS programme.

CARE staff play chiefly a facilitator role in achieving the goal of improved health and nutrition of women and children through strengthening and building the capacity of ICDS staff, NGOs and community members; and by improving the delivery of services through the government.

Developmental Hypotheses

Developmental concerns underlying the INHP are related to the links between malnutrition in children and impaired physical growth, compromised cognitive development and reduced resistance to infections which in turn can be further worsened by low birth weight if infants that is a common feature in India due to maternal malnutrition. The intergenerational cycle of malnutrition produces stunted adults with lowered work and income earning capacities, thus leading to the perpetuation of the malnutrition and poor functional performance cycle. The available data from India and other developing countries clearly show that much of the growth retardation that occurs in early childhood (0-6 years), takes place between the ages of 6m-24m. Further, early childhood mortality rate due to various diseases also indicate a very strong exponential relationship between malnutrition and mortality, mortality rising sharply in malnourished, and dropping equally sharply when malnutrition declines in a community. Thus nutritional status is an indicator of the development of the community.

The causes of malnutrition are many. Frequently they are classified into three groups, the immediate ones are low dietary intakes and inadequate access and utilization of health services. The intermediate or underlying causes are household food insecurity (it may be noted here that malnutrition in children is seen in food secure households also), lack of environmental sanitation leading to enhanced infections and inadequate care of children and women. The basic causes, however, have to do with the economic and political structure of a country with a substantial number of the people living in poverty and lacking the skills for employment and income generation.

Despite the basic causes, there is evidence to show that malnutrition can be reduced by intervening at the immediate and intermediate levels. The interventions generally found to contribute to a positive effect have included the convergence of supplementary food (to compensate for the low dietary intake) and health services, combined with improved infant feeding practices through community capacity building and empowerment.

Therefore, two major hypotheses have been articulated in the INHP program.

The first one articulated consistently in all INHP reports is that nutritional improvement can occur by focussing on improved delivery of food, and health services to the vulnerable groups and by improving infant feeding practices (colostrum feeding, exclusive breast feeding for first 6 months and appropriate complementary feeding starting from 6 months. This in fact is stated as the broad goal of the INHP project "to improve the nutritional and health status of the vulnerable groups of women and children".

The second hypothesis relating to capacity building was based on the understanding that sustained improvements in health and nutritional status will not be possible without strengthening the capacity of communities to support women and families to practice key nutrition and health behaviours, improving the capacity of government counterparts to deliver supplementary food and health services and building capacity of NGOs to facilitate the work of institutions in the community. Therefore, it was hypothesized that sustainable capacity building (CB) at the individual, household and community level on the one hand and CB at the institutional level will lead to behavioural and system changes that will result in improved nutritional status.

Several key strategies were used by the project to attain these.

Key Strategies

Population based strategies replaced center based one for food distribution. The main change with respect to food delivery was to adopt the **'Take Home Ration' (THR)** to reach the un-reached i.e. the pregnant and lactating women and children < 2y.

Nutrition Health Days (NHD) organized once a month brought together the AWW - ANM - and the community, making it possible for convergence of all services.

Convergence of Services at the village level was facilitated by promoting sustainable co-ordination between the Department of Women and Child Development's (DWCD) ICDS programme and the MoHFW's RCH programme and by facilitating the co-ordination of NGOs at the community and govt. level.

The co-ordination promoted at different levels allowed for **joint planning and problem solving** and for upward and downward communications.

Innovations at different levels were pursued to enhance service utilization and behaviour change.

Community mobilization and empowerment through village development committees (VDC) adolescent groups, and invigorated Mahila Mandals were envisaged for creating community ownership.

Building the Capacity of individuals, community, institution and systems through development of 'Demonstration Sites' and their use for diffusion of best practices was floated as one of the replication strategies. Cross fertilization, visits to other areas were other replication strategies.

For social mobilization, continuous training, monitoring and other quality improvement strategies were used.

Role of Food

Food supplement is intended to fill the gap in the dietary intake of pregnant and lactating women and children <2 years thereby expected to contribute to nutritional improvement. While coverage for supplementary food has shown a marked improvement in most INHP projects, evidence for nutritional improvement is less clear. It is apparent from the other sections that success rate of behaviour change in infant feeding practices was low and the need to pursue this component more vigorously and systematically with appropriate inputs is evident.

Food (especially THR) is also expected to act a s an incentive to get more women and children to the AWC, thereby making it possible for them to avail of the health services and the behavior change communications. There is more consistent evidence to support the role of food as an incentive in all project areas.
The value of food being considerable (around Rs. 50 crores per year $10 million in several states), it has enabled CARE to be recognized as a major resource contributor and, advocacy by CARE is likely to become more effective.

Observations from Field Visits

While the intended target groups reported consistently that they received the food supplements and other health services and this was also corroborated by observation at different levels of the systems, clarity and conviction about the link between INHP inputs and nutritional outcome was variable.

Appropriate tools for behaviour change and support for this was highly inadequate.

Quantity in relation to service delivery was emphasized but 'quality of services' needed to be strengthened, especially with reference to the behaviour change messages. It is not only important and necessary to communicate appropriate messages about infant feeding but it is also necessary to follow up mothers at the community level with counseling and support.

Nutritional status was assessed using the measurement of weight-for-age. There were other service components such as IFA the impact of which may need to be assessed using smaller community units rather than large quantitative surveys.

Recommendations

1. Invest in building conviction at all levels about the links between INHP inputs and nutritional outcome so as to make this a driving force of the project.
2. Anemia interventions for young children and focus on educational and behavioural interventions for adolescent girls can strengthen the nutritional outcome and the community capacity building and therefore may need to be considered.

ANNEX C: DOCUMENTED COVERAGE, OUTCOMES, IMPACT, & ATTRIBUTION

General

- CARE has made a tremendous effort in undertaking consistent quantitative surveys to measure program impact.
- Given the rolling nature of the project, each quantitative survey has led to more questions than answers in terms of generalizability to the current operating environment when compared to the previous survey(s).

CARE should be proud of their efforts and achievements in quantifying and documenting the outcomes and impact of the INHP interventions. Given the scale of the project, its original tiered design, its changing nature (in terms of blocks covered with interventions - e.g. 50% turn over in blocks covered in UP after 5 years), the degree to which inferences can be drawn from the survey data are limited. Even with the caveats, few, if any, other projects have attempted to collect the range of information from such a large sample as in the INHP.

It is also worth noting that CARE has produced, and provided to the team detailed State wise reports which provide table after table of data on numerous background and programmatic indicators.[1] These reports are dis-aggregated to allow comparison from the blocks in the original strategy (HI and CB), as well as providing comparisons to Demonstration Sites, and an average across "ALL" sites.

Additionally, though described more thoroughly elsewhere in this report, CARE has made significant efforts to change the way it assesses and measures "routine" activities. The hypothesis that focusing on monitoring process, with periodic large surveys to assess outcome and impact remains sound. However, feedback from the field suggests that at some level, outcomes are necessary to monitor in a targeted and periodic fashion (though not on a monthly/quarterly basis as with the old HVQ). This should not be seen as moving backwards, rather is should be seen as further refining the systems which CARE has worked hard to set in place.

As CARE looks towards the second five years of INHP (INHP II), it should be prepared to accept that outcomes and impact will need to be shown at a block level. Regardless of the survey mechanism chosen comparisons should be done in such a fashion as to provide a measure of impact for the entire block. If measured through surveys, assessment of "DS areas" should be considered as secondary to the block level and should only be used to provide an inference on where the entire block can expect to be once all areas have achieved comparable implementation times (e.g. 7 years - post mid-term of INHP I through INHP II).

Coverage and Outcome Measures:

Data from the quantitative survey can be reviewed in at least two distinct fashions - comparison to baseline and midterm[2] survey(s) and comparison to the National Family Health Survey - II (NFHS II - conducted in 1998/99) data. It should be noted that NFHS II data may in fact be closer to the midterm quantitative survey than to the final evaluation.

Comparison of baseline vs. final and midterm vs. final quantitative survey data:

Baseline vs. Final

- Coverage rates for supplementary feeding (pregnant/lactating women and children 6-24 months) increased from baseline in 6 of 7 states (except both pregnant and lactating mothers in West Bengal).
- Coverage rates for focus interventions (ANC, IFA, TT, and Immunizations) increased from baseline in 5 of 7 states (except in Uttar Pradesh where IFA rates were the same or lower than baseline in DS and ALL areas).
- Coverage rates for breastfeeding and weaning practices increased from baseline in 6 of 7 states (except for exclusive breastfeeding rates in Andhra Pradesh and for complementary feeding rates in Andhra Pradesh).

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[1] The team which undertook the midterm review strongly advised CARE to provide the final evaluation survey data at least 4 weeks prior to the team's arrival in country. However, the final evaluation team received the data for the final survey on/about the second day of their work in New Delhi, limiting their ability to integrate the details from the survey into the final report.

[2] CARE re-analyzed the midterm data applying appropriate weights in order to have this data comparable to the baseline and final evaluation surveys. This revised data was provided to the team in June 2001.

- Across almost all states, indicators for "DS" had higher coverage rates than "ALL" areas (which covers both DS and non-DS). ANC, IFA, and TT coverage rates were higher in 5 of 7 states for "DS" as compared to "ALL" (except IFA in Andhra Pradesh and Uttar Pradesh), however, child immunizations, breastfeeding, and complementary feeding rates did not show the same consistent trends.

Midterm vs. Final

Comparison between midterm and final data includes the changes in approach from high impact areas (HI) to Demonstration Sites (DS) areas. Due to differences in the way the questions were asked, the comparison of midterm and final does not include questions on child supplementary feeding, and complementary feeding practices for children 6-9 months of age. Not all HI areas are DS, but it is likely that the preponderance of these sites are in common.

- Coverage rates for supplementary feeding (pregnant/lactating women) were higher in all HI blocks compared to ALL blocks at midterm, but rates were very low in West Bengal for lactating mothers.
- Coverage rates were higher in the final survey as compared to midterm in all areas and all states except in Bihar, Madhya Pradesh, Uttar Pradesh and West Bengal. In most of these states, the supplementation rate for lactating women was more often greater than that for pregnant women in the comparison of the two time frames.
- Coverage rates for focus interventions (ANC, IFA, TT, and Immunizations) vary widely by state, in some states, the rates are virtually unchanged between midterm and final (Andhra Pradesh, Orissa, and Uttar Pradesh), while in other states, the midterm rates are higher than final (e.g. ANC and IFA in HI blocks of Bihar), while in still other states the final evaluation rates were higher than midterm (e.g. initiation of breastfeeding and exclusive breastfeeding rates in West Bengal).

Final vs. NFHS II

Comparison between final survey and NFHS II data:

- Coverage rates for focus interventions (ANC, IFA, TT, Immunizations) increased in comparison to NFHS II in 5 of 7 states for ANC (except Orissa and West Bengal)
- Coverage rates for breastfeeding and weaning practices increased in comparison to NFHS II in 3 of 7 states (except Madhya Pradesh, Orissa, Uttar Pradesh, and West Bengal - Note: initiation of breastfeeding within one hour after birth was the key indicator which was most variant from NFHS II data).

The review of the quantitative data is tempered with a number of caveats which all state level staff are quick to provide: blocks have turned over; mother's recall was used when immunization cards could not be accessed; blocks surveyed where more/less well off than in the previous surveys, etc. Additionally, there were significant concerns over the midterm evaluation data which, after further expert review, was determined to be inadequately weighted (the midterm data were re-weighted in a secondary analysis in order for the team to undertake comparisons. This data was also provided to the team in June). All of these simply serve to point out the challenges faced in collecting information on a project as large and diverse as INHP. However, it must also be pointed out that CARE held itself accountable to measure changes through such surveys.

Table I. Comparison of Coverage Rates in Baseline (BLS) and Final Evaluation (DS, ALL)
(Baseline = BLS, Demonstration Site = DS, All Sites = ALL)

	AP			BI			MP			OR			RJ			UP			WB		
Indicator	BLS	DS	ALL	BLS	DS	ALL	BLS	DS	ALL	BLS	DS	ALL	BLS	DS	ALL	BLS	DS	ALL	BLS	DS	ALL
Supplementary Feeding																					
Pregnant women	56	77	70	39	83	45	25	84	70	45	81	62	29	96	99	27	42	42	48	36	44
Lactating women	52	84	70	37	80	29	18	72	51	35	76	50	20	99	99	24	30	40	43	24	18
Children 6-24 months	57	84	65	50	70	56	24	57	59	38	65	70	37	68	64	32	40	61	43	65	58
ANC																					
3+ Check ups	89	93	88	28	58	55	29	54	37	59	82	69	31	48	37	27	27	38	62	67	58
TT	91	94	91	54	69	67	50	75	59	69	92	77	53	83	66	47	62	65	82	95	91
IFA	16	26	26	9	32	19	4	42	28	26	67	54	7	27	15	11	7	9	25	45	25
Child Survival/Nutrition																					
Full Immunizations	46	67	65	7	52	33	4	61	42	25	34	24	24	23	20	33	26	34	22	74	56
Breastfeeding w/in 8 hours	37	49	55	6	62	44	42	61	56	40	83	70	38	51	43	6	18	14	47	76	67
EBF - 4 months	54	34	40	7	26	20	36	56	61	60	75	66	5	11	12	29	46	33	32	57	27
Complementary feeding 6-9 months	60	51	42	58	82	77	46	60	55	26	57	53	40	59	57	56	52	60	70	83	67
Malnutrition																					
Normal	52	69	66	39	26	44	50	47	43	49	37	37	50	60	61	39	59	59	45	59	55
Malnourished (weight-for-age)	48	31	34	61	74	56	50	53	57	51	63	63	50	40	39	61	41	41	55	41	45

Notes:
1. Rajasthan and UP data are for HI and All blocks (not including DS).

Table I, above, further elaborates on the points mentioned, and highlights the changes since baseline as compared to final in both demonstration sites and all areas (with "All" including both demonstration and non-demonstration sites).

The hypothesis behind the original INHP strategy, and still seen with the unified capacity building strategy, is that the demonstration sites will show greater level of change than the non-demonstration sites. To a great extent, this can be seen in the differences between Demonstration Sites "DS" and All "ALL" program areas as compared to baseline information. While there certainly are some outliers, on the whole, the hypothesis seems to be born out by the data.

What has been termed, "supply side" interventions (targeted supplementary feeding, immunizations and antenatal care) have shown greater improvements than behavior change interventions. For example, supplementary feeding for pregnant or lactating mothers, or children 6-24 months of age, has almost universally improved across the program, and is even higher in "DS" as compared to "ALL" areas. Antenatal care has also improved across most program areas, with again, the "dose response" seen between "DS" and "ALL" areas, where the "dose" is measured in terms of INHP inputs.

Table II provides a comparison between the final evaluation data for the "DS" and "ALL" areas as compared to data from NFHS II. Additional columns have been added to this table to highlight the indicators where INHP interventions are higher (have theoretically improved more) as compared to the NFHS II.

Table II. Comparison of Coverage Rates in Baseline (BLS) and Final Evaluation (DS, ALL)
(National Family Health Survey - II = NFHS II, Demonstration Site = DS, All Sites = ALL)

	AP			BI			MP			OR			RJ			UP			WB				
Indicator	NFHSII	DS	ALL	NFHSII	DS	ALL	NFHSII	DS	ALL	NFHSII	DS	ALL	NFHSII	DS	ALL	NFHSII	DS	ALL	NFHSII	DS	ALL		
Supplementary Feeding																							
Pregnant women	--	77	70	--	83	45	--	84	70	--	81	62	--	96	99	--	42	42	--	36	44		
Lactating women	--	84	70	--	80	29	--	72	51	--	76	50	--	99	99	--	30	40	--	24	18		
Children 6-24 months	--	84	65	--	70	56	--	57	59	--	65	70	--	68	64	--	40	61	--	65	58		
ANC																						DS	ALL
3+ Check ups	80	93	88	18	58	55	28	54	37	47	82	69	23	48	37	15	27	38	57	67	58	7/7	6/7
TT	82	94	91	58	69	67	55	75	59	74	92	77	52	83	66	51	62	65	82	95	91	7/7	7/7
IFA	71	26	26	20	32	19	38	42	28	62	67	54	31	27	15	21	7	9	56	45	25	3/7	0/7
Child Survival/Nutrition																							
Full Immunizations	59	67	65	11	52	33	22	61	42	44	34	24	17	23	20	21	26	34	44	74	56	7/7	6/7
Breastfeeding w/in 1 hour	10	7	8	6	32	20	10	15	11	25	28	23	5	24	20	7	9	4	25	10	12	3/7	3/7
EBF - 4 months	75	34	40	55	26	20	64	56	61	58	75	66	53	11	12	57	46	33	49	57	27	2/7	1/7
Complementary feeding 6-9 months	59	51	42	15	82	77	27	60	39	30	57	53	18	59	57	17	52	60	46	83	67	6/7	6/7
No. of indicators where INHP>NFHSII		3/7	3/7		7/7	6/7		7/7	5/7		6/7	5/7		6/7	5/7		5/7	4/7		5/7	4/7		
Malnutrition																							
Normal	62	69	66	46	26	44	45	47	43	46	37	37	49	60	61	48	59	59	51	59	55		
Malnourished (weight-for-age)	38	31	34	54	74	56	55	53	57	54	63	63	51	40	39	52	41	41	49	41	45		

Notes:
1. Rajasthan and UP data are for HI and AII blocks (not including DS).
2. In comparisons between NFHS and INHP - INHP data was taken to be "better" than NFHS if it was at least 2 percentage points higher.
3. NFHS II data are for the entire State, rural data was not available, but is likely to have lower coverage rates and higher malnutrition rates.

While the National Family Health Surveys do not collect information on supplementary feeding from Anganwadi centers, they do collect information on other "supply side" interventions. For example, antenatal care (as measured through the number of check-ups that a pregnant woman receives) is higher in all "DS" and 6 of 7 (6/7) states in general. Variations still exist across states with some states having achieved higher rates than NFHS across all indicators, and some achieving higher rates on just over 50% of the targeted indicators.

Table III provides a comparison between baseline and final for what was initially an "HI" block, through a "Panel Survey."

Table III. Comparison of Coverage Rates in Baseline (BLS) and Final Evaluation (FE) for the Panel Survey (Baseline = BLS, Final = FE)

	AP		BI		MP		OR		RJ		UP		WB	
Indicator	BLS	FE	BLS	FE	BLS	FE	BLS	FE	BLS	FE	BLS	FE	BLS	FE
Supplementary Feeding														
Pregnant women	63	75	30	75	13	84	61	100	45	96	21	42	44	59
Lactating women	54	76	26	71	8	71	51	100	28	99	19	42	39	35
Children 6-24 months	57	83	55	70	11	57	55	100	56	64	22	40	37	63
ANC														
3+ Check ups	89	92	23	53	30	53	62	75	45	46	30	34	80	69
TT	94	95	58	68	60	76	79	70	71	64	36	64	92	77
IFA	18	27	14	24	7	24	32	66	15	18	16	7	37	32
Child Survival/Nutrition														
Full Immunizations	35	74	22	36	28	54	--	50	36	27	14	32	--	73
Breastfeeding w/in 8 hours	29	48	7	48	66	48	37	72	38	28	8	16	62	58
EBF - 4 months	58	40	8	66	25	66	74	69	7	10	30	54	36	45
Complementary feeding 6-9 months	--	47	--	82	--	59	--	56	--	52	--	33	--	63

Notes:

1. One block from each State which had originally been designated as "HI" was sampled at final to assess the change in that block over the course of INHP I.
2. Some States (AP, Bihar, Rajasthan) provide supplementary food for children 6-36 months of age.
3. The time period for receipt of supplementary food for children was in the last 7-10 days.

INHP conducted a panel survey whereby they tracked the changes in program indicators in a specific block across the implementation period. As initially conceptualized, this block was considered "HI" or was a focus of intensive efforts. Only one block per state was sampled in the panel survey, so the results are generalizable only to that block.

In almost every intervention area, and across all the states, the coverage rates are higher in the final evaluation as compared to the baseline survey. As most former "HI" blocks are likely to have a number of demonstration sites in them, this may prove to be at least a partial "picture" of where INHP can hope to be as more of the demonstration sites come on-line.

Impact Measures:

- Overall, nutritional status improved in 5 out of 7 states as compared to baseline (except Madhya Pradesh and Orissa (and the DS blocks of Bihar).
- Malnutrition rates in INHP areas were lower than the NFHS II data in 4 of 7 states (except Bihar, Madhya Pradesh, and Orissa).
- Other measures of "impact" exist which are not captured in a quantitative survey (e.g. state-level policies for implementation of THR, implementation of adolescent girls strategies, etc.), and are likely to be associated with INHP inputs.

INHP had as its goal to improve the nutritional status of women and children. While changes in nutritional status have occurred, it is not always clear whether this is due to INHP interventions or in spite of them. Across states, the team was provided with different explanations for the changes seen (or not seen) in coverage rates. Clearly there are a number of factors which have led to change been seen (or not seen), however as nutrition is affected by many different inputs (and insults), a "knee-jerk" response of pointing at the data is not sufficient.

Regardless of the changes seen in the malnutrition rates - whether they are better than NFHS II data, or whether there are questions in the data itself, or whether the results are just difficult to explain, the reality is that malnutrition rates remain high across all the INHP states - warranting a re-doubling and focusing of efforts on nutrition.

While tools do exist to measure policy changes and attributing them to advocacy and program demonstration, the quantitative surveys as designed for INHP have not done so. However, there are examples in the field where the INHP activities have lead to changes in policy at both state and national levels - these changes may have long term impact on maternal and child health and nutrition.

Attribution:

- INHP focus interventions appear to be associated with improvements in overall nutritional status, however, discrepancies do exist which create a challenge to explain.

The attribution of program inputs to outcomes and impact in any project is a challenge. In a project like INHP and in a country like India, where there has been such a high degree of change in both program implementation and the operating environment of the program (floods, drought, political changes, etc.) attribution becomes an even greater challenge. This is not meant to imply that though difficult to measure, programs should not attempt to, rather, that in difficult operating environments, measuring the attribution of any program will be difficult.

The team did find anecdotal evidence which would lead one to believe that INHP inputs have lead to attributable outcomes and these have been captured in the section below.

Impressions from the Field:
Qualitative and anecdotal evidence at all levels supports the association of these changes to INHP inputs.

- Overall feeling that THR/NHDs helps to bring women and children to the AWC and is therefore associated with increased coverage rates of the INHP interventions
- This "pulling" of beneficiaries into the Anganwadi centers for services, should lead to improvements in overall health and nutritional status of both women and children.

Both INHP staff and the evaluation team, believe that the "pull" of people (women and children) to the AWC through the take home rations in the NHDs, activities of the NGO partners, Mahila Mandals, the work of the change agents, etc., provides an opportunity for service provision to groups who ordinarily would not receive services. While perhaps taking longer to quantify, in line with the INHP hypothesis, this pull of beneficiaries to the center should lead, eventual, to attributable program impact.

Recommendations:
- CARE should consider adopting a strategy whereby large scale surveys would not be necessary to measure impact. Targeted operations research (OR), with defined evaluation criteria, could be used on a smaller scale basis to determine the degree of change associated with the intervention.
- Much smaller surveys could be done for baseline and final to cover key interventions without collecting a number of other indicators which may not be used for program implementation or as data for decision makers. It was originally planned to have the final survey for INHP I serve as the baseline survey for INHP II, this plan should be revisited based on any planned revisions to the coverage area of the program. If the districts and blocks covered is likely to change substantially between INHP I and INHP II, then the comment above regarding the size of the survey will become particularly important given that "new" (INHP II) coverage areas will be different than the "old" (INHP I) areas and will only feed into the past confusion over the ability to draw conclusions between survey periods.
- CARE should discuss with experts and consider whether smaller scale, targeted, evaluations can provide measures of attribution of INHP inputs to impact on nutritional status.
- CARE should consider dropping a midterm survey for INHP II and instead focus on utilizing information from ongoing operations research and targeted evaluations.
- CARE should identify methods for capturing policy level changes in relation to INHP implementation and to disseminate these experiences across States in order to affect greater change.
- To the extent practicable, CARE should consider adopting community-based strategies for monitoring INHP interventions.
- With the data already collected, CARE should consider undertaking a series of detailed analyses on target activities, to assess changes across the INHP implementation period and to relate these changes to program inputs.

After three surveys and perhaps as much confusion as clarity, CARE should consider whether there is really any benefit to implementing large-scale surveys. To date, the value added of these large-scale (in terms of cost, coverage, and investment of time), is less than clear. As a revised strategy, CARE should consider whether smaller, more targeted evaluations would provide the level of data necessary to assess program impact without leading to further questions. While no system will ever be perfect, there is clearly room for improvement, and given that INHP II proposes further geographic shifts, the issue of comparability across blocks will be persistent.

In INHP II, CARE should look at the role of targeted operations research and how it can be utilized across the program to provide a gauge of program changes based on the activities being implemented. In adopting such a strategy caution should be taken such that in the development of the operations research or other forms of targeted evaluation, a proliferation of indicators does not occur. That is, learn from the experiences in INHP I and, where possible, do not repeat them!

If CARE adopts this strategy for smaller, more targeted evaluations, it should then consider, in consultation with USAID, whether a revised baseline is required. If a new baseline survey is undertaken, CARE should pay particular attention to the time of year when it is conducted with an eye toward the timing for any final evaluation survey and its utility in any potential further program development.

Similar to the midterm in INHP I, the midterm in INHP II should assess further progress in the implementation of the unified capacity building strategy and any additional interventions that are included over the course of implementation. This review should not attempt to assess impact.

One of CARE's principal strengths is its ability to advocate at many levels: National; State; District; Block; and Community. CARE should build on this advocacy ability some measures of change which can be attributed to the program. Given the shear size of INHP and its assistance to approximately 25% of the ICDS, there is great potential to serve as an engine for change. Where these changes are brought about, particular at the State and lower levels, CARE should be sure to document and disseminate the process which lead to these changes. Replication of these advocacy efforts is likely to lead to even greater program impact.

Examples exist from previous and on-going nutrition and health programs whereby communities monitor their own progress on particular interventions. CARE should consider using some of these strategies, with modifications for India (or the individual states!), whereby communities are trained to measure this progress. Many of these tools are designed to be aggregated up to higher levels (such as block, district and state) and may serve as inputs into routine project monitoring systems as well as further empowering communities.

INHP I gathered a great deal of data. To date, it does not appear that this data has been used in any further analyses. Given the efforts noted above, which have already been put forward, CARE should consider implementing a whole host of secondary analyses. As a first step in this, CARE data managers and statisticians, should review with all levels of INHP staff the types of information and analyses which would be useful to them, and determine the feasibility of these analyses given the data available. As a second step, CARE should undertake a similar exercise with its Government of India counterparts at National and State levels (while it is unlikely that data could be disaggregated to a District or Block level, functionaries from these levels may have valuable input into the types of analyses that could be undertaken which would benefit their work). As a third step, CARE should undertake the same analysis with USAID. It is likely that while each group would be interested in the analyses conducted "for" the other groups, their particular interests would be different. The key to all of these analyses should be on providing information that can be used by program planners. Additionally, where experiences have been learned, CARE should consider the value of sharing them through various journal publications.

The further analysis may in fact, lead into the targeted operations research. For example, in virtually every state, women report decreased food intake during pregnancy. Operations research might follow from this insight and identify the barriers at the household and community level which lead to this finding. Similarly, a gender disaggregation would allow the further review of potential differential health and nutrition inputs, outcomes and impact. Thus while questions may arise when using the data from the quantitative surveys as a comparison to previous surveys, when utilized as a cross sectional survey, far fewer questions arise and detailed analysis is likely to provide a number of areas for further programmatic exploration.

ANNEX D: COMMODITY & SUPPLY CHAIN MANAGEMENT

The following comments and suggestions are based on limited field visits, interviews with CARE-India commodity staff at CHQ and the state offices and field officers. An analysis of the data on the supply chain gathered from 5 states is in Tables D-1 and D-2.

Salient points on the supply chain:

- At present the food availability is quite healthy across the supply chain. Except for major disruptions in Jharkhand for about 3 to 4 months soon after the new state was formed in Nov 2000 there have been no major stock-outs experienced for the past year.
- The supply from the ports to the district / block warehouse are more certain as there are state appointed CFAs/ transporters in operation for the primary distribution.
- It is normally the secondary distribution from the blocks to the AWCs which gets disturbed as the transport arrangements are done at the block/CDPO level. There are a large number of instances where the AWW has to collect the stocks from the blocks.
- Call forward of the stocks was being done centrally but has been transferred to the states for the last 2 qtrs. States normally get between 15 -20 shipments per year. There is usually not much variance (<5%) between the transmittal advice from the US and the actual shipment.
- The PHO certification of the food at the port takes between 2 to 15 days.
- Vizag and Kolkata ports receive a mix of barges and containers but Paradip and Jamnagar receive only barges. Container shipments are preferred as the damages are minimal.
- The dispatch advice from the port to the districts / blocks is given by the state office using a cut-off-days formula devised by CHQ which is simple and good. This attempts to balance the food allocation between the blocks.
- Not all states at the block level use the same cut-off-days formula for sending the stocks from the blocks to the AWCs. This creates imbalances in stock levels between the blocks and the AWCs also.
- Empty containers are sold at the AWC and sales value deposited in the block CDPO offices. This amount is meant for the maintenance of the godowns and the care of the food stocks.
- The entire supply chain generates a damage/shortage of around 0.3% of which two thirds is at the port. 75% of the losses are collectible. The yearly write-off is estimated at Rs 35 lakhs.
- Supply chain costs were estimated for some of the states and the details are in the tables. An extrapolation of the costs at Rs 1200 per ton means that the total amount spent per year on the total commodity movement and storage from the port to the point of consumption is Rs 1724 lakhs – which is 5.4% of the value of the commodity moved. The cost of the supply chain varies across states.
- The average lead time for the movement of the stocks from the port to the AWC is about 50 days. With a buffer of one month (25 days) in the AWC, the entire supply chain should manage with 75 days stock. For abundant caution the permitted stock level is 100 days.
- Stacking norms for the food is defined as 15 to 20 bags in height for CSB and 6 to 8 pails for RVO. In the port warehouses however these norms are not always followed.

- All the CFAs , transporters are appointed by the state govt. The warehouses are either owned or rented by the state. In all decisions on the storage and movement of CARE-India supplied food, the CARE-India officials have a say.
- Field officers in CARE-India are not normally required to spend more than 10 to 15% of their time on activities related to commodity management. In exceptional circumstances like it happened in Jharkhand they may have to spend about 25% of their time. This is also true for the point persons (FOs) appointed in some states.
- The planning process which always takes into account the inventory level before deciding the dispatch allocation ensures to a great extent that there is no excess / undelivered food in the system. The number of beneficiaries also keeps varying each month depending on the number of eligible beneficiaries actually availing the food.
- Delivery against plan and other details by state in Table D-2. The achievement levels vary between states. Obviously the states in which the state machinery is active are doing better.

Suggestions:

- Use of the state run commodity supply chain supervised by CARE-India from the port to the AWC can be used for the distribution support to health support systems, contraceptives and the public distribution system. This may help in reducing the food insecurity by moving the surplus food available in some states to the needy states.
- Some states are able to manage the supply chain at a low cost relative to the others. It is possible that all the states can attempt to manage the supply chain at 4 to 4.5% of the commodity value. This can save at the national level close to Rs 2.5 to 4 *crore* which the state can use on medicines/vaccine etc.
- By proper control it should be possible to manage the total food stock level in the supply chain at 75 days.
- Possibility of increasing the shipments through containers should be explored to reduce the damages.
- PHO certification should be possible within 7 days for all states.
- The empty container sales proceeds is estimated at Rs 170 lakhs all India even at 80% units for sale and can very effectively be used for warehouse maintenance.
- Cost / benefit analysis of the use of an intermediary district warehouse in some states to be done.
- CARE-India can persuade the block level state officials to use the cut-off-date system for deciding the dispatch plan from the blocks to the AWCs to reduce stock imbalances.
- CARE-India can encourage village communities and *mahila mandals* to take up secondary distribution of food (from blocks to the AWCs) for clusters
- CARE-India in some states is already persuading the state officials to sign transport contracts in time and at market driven rates and to settle transport bills on time to avoid disruption in stock movement.

CARE Commodity Supply Chain (data provided by state offices) **Table D-1**

Comparative parameters	Orissa	Jharkhand	Andhra Pra	W Bengal	Rajasthan
1 **Supply chain lead times (no of days):**					
Port discharge	5	3	20		
Port clearance time	3				
Transit shed		2	2		
CFA and port town warehouse		20	25		
PHO certification	2	15	3	7	
Port storage					
Port to district	20				
Port/dist to block - transit time	1	2	1		
Block storage	15	30	50		
Block to awcs - transit time	1				
AWCs storage	25	30	50		
Total No of days	**72**	**102**	**151**	**NA**	**NA**
2 **Supply chain cost per ton**	697.50	948.50	1027.50	1739.00	913.00
SC Cost %age of comm.value	3.1	4.3	4.6	7.8	4.1
3 Empty container sales- Rs lakhs per year	31.85	26.35	19.12	NA	NA
4 Shortages and damages / yr	0.3% tons	0.4% tons	0.05%	NA	NA
5 Admin costs re-imbursed / yr	Rs 140 lks	Rs 110 lks	Rs 97.41 lks	Rs 135 lks	NA
6 Total tonnage handled per yr					
CSB	28454	25399	18415	25576	12442
RBO	3502	3126	2266	3148	1531
7 No of shipments per year	15 - 20	15-20	30-40 (37)	NA	NA
8 No of beneficiaries	12,16,000	10,85,431	7,87,000	10,93,000	5,54,671
9 Avg value of commodity Rs / ton					
CSB	20.00	20.00	20.00	20.00	20.00
RBO	40.00	40.00	40.00	40.00	40.00

Commodity delivery for the year ended 30.09.2000 - Performance Table D-2

State	%age of tgt ach on beneficiaries	CSB	RVO	CSB to RVO
Standard		21 kg per ben	2.59kg	8.125
AP	101.2	22.5	2.7	8.3
Bihar	85.2	19.7	2.4	8.2
MP	91.7	17.6	1.8	4.6
Orissa	101.7	22.1	2.6	8.5
Rajasthan	91.1	18.5	2.2	8.4
UP	89.2	12.2	1.9	6.4
WB	111.3	21.1	2.5	8.4
ALL INDIA	**96.2**	**19.2**	**2.3**	**8.3**

Underlined numbers Mean **not up-to standard**
Source: Results Report FY 2000

ANNEX E: EXPENDITURE AGAINST BUDGET

While the evaluation team did not have adequate data to conduct an analysis of costs and benefits of the current food-cash balance in INHP (or of the proposed food-cash balance in DAP-2), the team **did have adequate data** to analyze the INHP current cost and budget structure in comparison with private sector standards for key line items.

Table E-1 (on the next page) presents an analysis of the most recent budget year and its line items. The calculations per employee are based on the INHP division of CARE having a total 206 staff.

NOTE: While this analysis could be altered by adding in the 50+ additional staff members who are **not** INHP program staff but who work extensively in support of INHP, the point of these calculations is to compare the INHP cost structure to relevant private sector standards, and the appropriate statistic in such a comparison is **cost per direct program employee**, not including employees who provide indirect support, however substantial.

Observations:

- The following expenses seem very high when compared with private sector standards:
  - Admin overheads of Rs 548.50 lakhs which for a 300 working day year works out to Rs 887 per employee per day.
  - Travel of Rs 328.53 lakhs which translates to Rs 530 per day per staff for 300 days.
  - Vehicle expenses are only for running and maintenance as there were no vehicles bought for the year. This works out to Rs 7200 per month for each of the 169 field staff.

- There is a very steep increase over the budget for technical assistance – Rs 103 lakhs (+89%) and monitoring and evaluation – Rs 69 lakhs (+84%)

- In addition, there is an additional Rs 203.50 lakhs (+11%) for partnerships with NGOs.

- The capacity building expenditure of Rs 281 Lakhs also includes an element of "resource persons" expenses.

- In all, CARE-India seems to have spent during the year nearly Rs 550 lakhs on outside agencies.

Suggestion:

For each of the areas of expenditure commented on above, CARE-India should do a clear cost-benefit analysis before finalising the budget for the year 2001-2002.

CARE India Expenditure - 1999-2000:

Table E-1

Item of expenditure	Budget USD-lakhs	Actuals USD - lakhs	%age incr.	Rs Lakhs (45.63)	Remarks
Salary	19.86	19.83		904.85	
Project operations	10.43	12.02	15	548.50	admin overheads
Vehicle expenses	3.36	3.19		145.55	Rs 7200 per mth for 169 field
Travel	8.46	7.20		328.53	Rs 530 per day for 206 staff
Capacity building	6.38	6.16		281.00	training, resource persons etc
Materials & Equipment	0.94	1.89	101	86.24	promotional materials for c/parts
Technical assistance	0.78	2.26	189	103.12	outside consultants
Sub-contracts	4.01	4.46	11	203.50	NGO partnerships
Monitoring / evaluation	0.82	1.51	84	68.90	Surveys by outside agencies
Exchange loss		4.05		184.80	not provided in budget
TOTAL	**55.04**	**67.29**	**22.2**	**3070.45**	
total excluding exchange loss		**63.24**	**14.8**		

Number of beneficiaries	6,670,889	
Expenditure per ben / year	Rs 46	
Average feeding days for the yr	263	
Exp per ben per feeding day	**17.50 paise**	Source : Results report FY2K

ANNEX F: TECHNICAL INTERVENTIONS

The May 1999 mid-term review undertook an in-depth technical examination of each element of the INHP program. This team believes that the majority of the specific issues raised about technical factors affecting the quality of services (such as the need to maintain vaccine diluent at cold box temperatures, and the potential negative impact of limited supplies of commodities like IFA supplements) are still relevant.

This final evaluation team took a broader look at the basic technical interventions of the INHP program. This included examining the evidence that the project's inputs were likely to achieve improved coverage, behavioral change, and ultimately impact. It also included assessment of what elements might enhance achievement of such impact, in order to inform future activities under the proposed "INHP II" Project.

From this perspective, the following are the team's findings and recommendations regarding the project's technical interventions and the programmatic approaches utilized to implement these interventions:

- ***Coverage and utilization, of the three "supply side" interventions (antenatal care, immunization, and targeted supplementary feeding) appear to have substantially increased among INHP participants.***

Across the project, the final quantitative evaluation found increased coverage of antenatal care, iron-folate supplementation, tetanus toxoid immunization of pregnant women, food supplement receipt by pregnant and lactating women and under-two children, and child immunization. Although the Demonstration Site augmented sample does not have an independent baseline and may in some cases reflect better-off communities, the consistently higher coverage and utilization of these interventions in Demonstration Sites possibly suggests a positive effect of the greater program effort in these sites.

In field visits, the team found that both utilization and community demand for these services appear to have increased. The Nutrition-Health Day approach, based on the Take-Home Ration and convergence of ANM and anganwadi services, appears to be key to this effect, and should continue as a core element of the INHP. However, data to substantiate this conclusion are still incomplete, and should be developed for both management and advocacy purposes.

- ***There is still substantial room for further improvement, especially for some elements of the intervention package.***

Within the context of this apparent improvement, overall coverage for many of the "supply side" interventions is still relatively low.

For example, only one in two children is fully immunized by their first birthday. This finding in part reflects inadequate overall coverage of the subject population. It also probably reflects lower coverage for measles, which (as noted in the mid-term evaluation) is the most important immunization in terms of preserving children's lives and nutritional status. Across state reports reviewed, there continues to be a roughly 10 to 20 percentage point lower coverage rate for measles than for other child immunizations.

Similarly, receipt of 90 or more iron-folate supplement tablets was reported by only about one in three women. Consumption appeared to be only somewhat lower than receipt. As noted in the mid-term evaluation, for this intervention interruption of supply seemed to be a major determinant of outcome.

Recommendation:

- *CARE and its partners should review coverage of individual interventions at the state and – to the extent possible – district levels. This review should inform identification of approaches to achieve better coverage in the context of INHP and other GOI initiatives (such as maximizing the positive effect on routine immunization and vitamin A supplementation of Pulse Polio activities).*

- ***The possibility that these services are not adequately reaching important subsets of INHP participants, and –equally important – of village women and under two children not participating in the anganwadi or the THR needs to be examined.***

The final "quantitative evaluation" survey methodology included women with children under two, whether or not they were INHP participants. This implies that changes in coverage and utilization found in this survey sample reflect changes beyond the direct beneficiaries of the project itself. However, the NHD strategy may be most directly benefiting mothers, infants, and young children who are going to the anganwadi center, in most cases because they are eligible for supplementary food. The possibility of such a differential effect is suggested by the observation during field visits that anganwadi and ANM records and mother's group responses suggested higher coverage among participants than that documented in the final survey, even in the augmented Demonstration Site sample. During these visits, there was also evidence that some families – whether eligible or not - may not be effectively receiving the benefit of the INHP service delivery approaches; these include families where the mother must work in the fields or in other day labor when the NHD is going on, and those living in outlying hamlets.

The fact that INHP services might be differentially benefiting the poorest and most vulnerable families is in many ways a desirable outcome, since World Bank analyses of NHFS data show that across India these families are less likely to receive the benefit of services. However, for villages where government health services are not located, the NHD may be the sole time during a month when services including antenatal care and immunization are offered, and therefore INHP must accept responsibility for assuring broadest possible coverage for the whole population.

On the other hand, in some sites where the health sub-center and ANM were located within the village, some NHD services (such as measles immunization) were actually being deferred to the sub-center. While this was not common, it might allow for differential use of services, with the poorest and most backward possibly receiving those services less (a situation well documented across India by World Bank analyses of NHFS data).

Recommendations:

- *CARE and its partners should assess the effects of INHP on overall coverage among THR and anganwadi beneficiaries and non-beneficiaries.*

[This might begin with field officers and supervisors reviewing ANM and anganwadi records and carrying out focused interviews to identify groups that possibly are not being reached. This effort could be complemented by spot surveys.]

- *Mothers and children not being reached with immunization and ANC services and counseling should be identified, and approaches to reach them developed and evaluated.*

  [Some approaches may be based on better - and better coordinated - use of information and organization at the worker and village level. For example, the mid-term evaluation suggested using register information to identify in advance children needing to be immunized, and women requiring antenatal care, at the next NHD; mobilization of village residents (such as women's groups) then serves to notify and bring in those women and children. The team saw examples of such approaches being used in selected sites, implying that they can potentially be employed more widely.]

- ***INHP has made serious efforts to ensure best possible targeting of the food supplement.***

One approach used across the project has been the "social mapping" exercise, aimed at identifying all eligible participants. This approach has also introduced greater transparency at the community level regarding eligibility and inclusion. Several – but not all - states have undertaken other approaches to improve the targeting of food rations to maximize coverage of eligible beneficiaries. The "needs-based allocation" approach to food distribution across communities in Bihar/Jharkhand, is one example.

Recommendation:

- *The effectiveness of these targeting strategies deserves continued attention; this may be in the form of informal monitoring through interactions with village leaders such as the panchayati raj, community members, and front line workers. CARE and especially their ICDS counterparts should identify approaches to evaluate and update targeting; this will be needed to ensure continued equity and transparency in the food distribution program.*

- ***The effect of the INHP approach on the three key infant-child feeding behaviors is less clear; however, there is subjective and anecdotal evidence that in some sites important positive changes are occurring.***

The three child feeding behaviors promoted under INHP – with or without supplementary food – are the best hope for improving child nutrition in the poor population of India.

For some states, these indicators appeared to increase substantially, while this was not the case for others. Some issues – including changes in indicators definition (for colostrum feeding), and the fact that the behavior change interventions aimed at these feeding behaviors were applied only in Demonstration Sites – make the interpretation of changes in relation to INHP inputs especially hard to interpret. At the same time, concerted, systematic efforts to change these behaviors are principally focused on the

Demonstration Sites, and have been applied for only a short time. This fact makes the broader survey results – including the apparent lack of difference in child nutritional status between Demonstration Sites and others – limited in their ability to indicate potential project impact on feeding behaviors and child nutrition.

In field visits, the team frequently found that in INHP sites where AWWs have learned appropriate counseling approaches and are supported by community women's participation, colostrum feeding, exclusive breastfeeding, and even complementary feeding of the THR appear to be increasing.

Recommendations:

- *CARE should carry out focused monitoring plus operations and evaluation research to define the extent and determinants of changes in key feeding behaviors.*

- *The results of these activities should be used to strengthen and promote the feeding behavior component of INHP.*

- ***The project does not yet have adequate or systematic approaches for behavior change, or the ability to monitor changes in key behaviors; these will be essential to achieve maximal impact on the key feeding behaviors and child nutrition, and on other health and nutrition related behaviors.***

CARE has appropriately recognized the central importance of behavior change to achieving INHP outcomes, and the need for increased capability in this area.

Even the approach to the identified behavioral elements of the "3+3" package are variably understood and implemented across the project. Without a stronger and more systematic approach, the project is almost certainly under-achieving in these and other key behavioral areas.

Several of the state programs visited had undertaken attempts to refine and strengthen their behavior change approaches, including adoption of approaches found in the literature like "Trials of Improved Practices" ("TIPS") and in-depth exploration of determinants and influences of key behaviors. In some cases, technical assistance had been sought and received. There was a strong felt need for increased capacity and support in this technical area. In response to earlier recommendations, CARE/New Delhi has added a full time behavior change resource person. However, there are likely to be additional requirements for technical inputs at the state and field level, which might be able to be met through use of local resources.

In any case, CARE needs a better-defined behavior change approach and some key tools for use by the project in the field.

Recommendation:

- Strengthened behavior change capacity, and a systematic approach and toolkit for dealing with behavior change, should be provided. Among options for this are technical support from Delhi, CARE/Atlanta, or other USAID cooperating agencies; development and application of state-specific behavior change strategies and

approaches, using project wide guidelines; and use of local resources or addition of local capacity.

- ***CARE's community engagement and empowerment activities are among the most powerful tools for behavior change.***

Changing behaviors through community engagement is now considered one form of the state-of-the-art. From HIV/AIDS prevention to breastfeeding promotion, "community behavior change" has been found to be powerful. Such "community behavior change" approaches include:

- the provision of information adapted to the needs and circumstances of the user through accessible community sources, and
- the modification of community norms and expectations through community engagement.

These approaches – even though not yet maximized in INHP – are already demonstrating their potential for contributing to health and nutrition outcomes.

It may be appropriate for CARE to consider strengthening "traditional" IEC and communication capacities aimed at individuals - such as stronger media strategies, better materials and message development, improved counseling, and other "supply side" behavior change/communication activities. However, CARE should give greatest emphasis to building upon, strengthening, and systematizing its "community behavior change" approach with inputs from relevant experts.

- ***Effective growth monitoring and growth promotion are central to addressing problems with child nutrition. INHP has explicitly not tackled this issue.***

There is an ongoing debate about the effectiveness of growth monitoring, within and outside India. Growth monitoring as generally practiced has not been associated with improvements in child feeding or child nutrition. Analysis has shown that the key missing elements of growth monitoring as usually practiced are the understanding of the information and the "action step" – the provision of effective inputs that result in positive nutritional change.

For this reason, the programmatic approach called "growth promotion" has come into being. Its emphasis is using information about a child's growth to drive appropriate response. This response is most effectively carried out through knowledgeable counseling and "negotiation" with the mother by a source who can help the mother analyze the problem (illness, inadequate weaning, household economic issues, etc.) and relate appropriate recommendations to her circumstances. To succeed, it also involves active follow-up and support. The INHP project approach positions it to provide these essential "growth promotion" inputs.

However, in most INHP and ICDS sites visited, we found inadequate understanding and practice of growth monitoring, resulting in failure of response to growth faltering. In sites with only ICDS inputs or with only "Capacity Building" inputs, weighing and plotting were variably practiced and not used for growth evaluation or counselling. In the better "Capacity Building" sites and in some "Demonstration Sites," weighing and plotting were being performed regularly. Even in these sites, generally neither the AWWs nor their

supervisors (nor CARE field staff in some cases) appeared to understand the use of the growth plot as a tool for identifying the nutritional progress of a child or of reacting effectively. As a result, the growth charts reviewed frequently offered evidence of growth faltering without a response by the AWW.

While modification of the growth monitoring tools is being considered, it is more likely that achieving this capacity will require greater clarity about the skills required. This would lead to development of training approaches that teach recognition and understanding of growth patterns, and the nutritional problem-solving skills required to counsel mothers. State-of-the-art international experience, and the finding of occasional AWWs having the capability to interpret growth patterns and to offer appropriate counseling in response, provide hope that this capacity can be developed. Doing so will be critical for nutrition impact.

Because the weighing and record keeping are already being done in most sites – but done without much effect – the marginal effort for an effective approach is not great, if the skill can be engendered. One way to economize on AWW time would be to focus the growth monitoring and promotion efforts on children under two, with less frequent weighing of older pre-school children. This is consistent with the decreasing frequency of pediatrician visits and associated growth monitoring that is the usual practice in developed countries.

Recommendation:

- *INHP should itself, and with its partners, consider the latest information about growth promotion and evaluate the possibility of undertaking improvement of growth monitoring under INHP 2 – perhaps initially as an operations research activity in a limited subset of project sites.*

- ***The emphasis of INHP has been on quantity of services; quality of services deserves further attention.***

Growth monitoring – though not an INHP intervention – is a good example of where "quality counts." The same principle applies to each of the INHP interventions.

Systematic information on quality was not available, and the opportunity to observe quality of services like immunization were limited. However, limited data and field visits indicate variability of quality of such services as antenatal care, IFA (considering receipt versus consumption), counseling, and record keeping.

Importantly, there is not an explicit approach for building the capacity of CARE's partners to assess or improve quality. An appropriate approach should focus on improving quality by service providers (AWWs and ANMs) through developing quality monitoring and improvement processes at the district and block levels in both ICDS and HFW. The block level may be particularly important, because it is the intersection point between administration and implementation, and because in some cases technical capacity and quality at this level appeared limited.

- ***At the service delivery level, the greatest system constraints on achieving project objectives appear to be personnel-related rather than supply-related.***

While shortages and stock-outs of key commodities such as IFA tablets have clearly existed in the past, at this time the team did not find these to be prevalent.

On the health side, the greatest constraint seemed to be vacant ANM posts. While in theory the system has means to "cover" for a missing ANM (such as use of the male multi-purpose worker, or cross-coverage by another ANM), in practice these mechanisms are unlikely to fill the void. The proportion of total ANM posts vacant varied widely by state: in A.P., the relatively small proportion of previously empty posts had recently been filled. In contrast, Jharkhand had a much greater problem with ANM posts (in one site visited, 9 of 16 ANM posts were vacant at the block level, and 39 of 97 positions were vacant across the district).

On the ICDS side, we did not find vacancies of AWW posts; here the greatest issue seems to be overload of the AWW. As one government official stated, "The AWW is the only government representative at the level of most villages; it is appropriate that she should be called on to do many things." Thus, every program from malaria to safe motherhood often turns to the AWW as a potential village-level agent. The multiple tasks of AWWs – from preschool teacher to mother counsellor to community group facilitator to food supply manager - are compounded by the fact that few of them are likely to have all the capacities and skills needed for these diverse tasks.

However, in field interviews AWWs in INHP areas did not complain that project activities had increased their workload. In fact, several observed that their workload had decreased (or their efficiency had improved). This is in part because they now have the support of women's groups who help them. It is also in part because reportedly the Nutrition-Health Day lets them work with the ANM in a group setting, rather than accompanying her in house-to-house visits as was earlier customary.

Recommendation:

- *INHP initiatives should take into account AWW (and ANM) workload issues, and seek to help them carry out existing and new tasks in ways that are not disincentives for their effective participation.*

- ***Sites where the basic program is operating and effective in the basic "3+3" package of interventions appear capable of taking on additional interventions that could increase the nutrition and health impact of INHP***

Recognizing that in India, WHO estimates that over 60 per cent of under five deaths are attributable to the underlying effects of malnutrition (including low birth weight), nutrition interventions are essential to improving child survival. Micronutrient deficiencies - especially of vitamin A and also iron – are also highly prevalent; vitamin A deficiency is itself associated with increased risk of infant, child, and possibly maternal mortality.

At the same time, high impact child health interventions – including immunization (already in the INHP package), as well as prevention and treatment of common infections associated with infant and child illness and mortality including diarrhea, pneumonia, and malaria – contribute to both survival as well as improved nutritional status.

Thus, there is a larger package of interventions that can enhance achievement of the INHP nutrition and health objectives, if it can be feasibly implemented. Where it is well established, INHP has built a system and community "platform" that can be used to sequentially introduce some of these additional high impact interventions.

The DAP-2 proposal for the second phase of INHP recognizes this potential and proposes additional health and nutrition interventions aimed at women and children. Interventions that would maximize nutrition impact include:

- **Vitamin A supplementation** (one of the most straightforward and urgent, given the malnutrition and probable high levels of vitamin A deficiency in the target population; this is already being done in some states)
- **Iron supplementation of young children** (noting the high prevalence of child anemia found in NHFS II), possibly linked to de-worming
- **Iron supplementation of adolescents**
- **Child feeding during and after illness**
- **Community-based management of severe malnutrition** (present practice is often medical referral)
- **Low birthweight reduction** (improved nutrition of adolescent girls; delayed pregnancy and increased birth spacing; increased food intake during pregnancy; intermittent presumptive treatment during pregnancy in malaria-endemic areas).

Additional interventions that are largely within the community context and that would maximize health impact include:

- **Oral rehydration therapy**, including fluids, breastfeeding, and feeding (also being done in some states)
- **Routine newborn care** (adding cord care, stimulation/resuscitation of the depressed newborn, warmth, and hygiene to maternal tetanus immunization, colostrum feeding, and exclusive breastfeeding).

Important health interventions that require additional inputs for case management – and that are therefore programmatically more complex – are:

- **Detection and treatment of acute respiratory infections, malaria, and neonatal infections** (operationally linked to detection and management of pregnancy complications).

As introduction of additional interventions is considered, it is essential that CARE and its partners consider the appropriate sequencing of this introduction. It is especially important to consider the absorptive and operational capacity of the health system, the ANMs and AWWs, and the community itself. Otherwise, the "platform" can be overloaded and may collapse.

Given the skills and current workload of CARE staff, implementation of new technical interventions will likely require additional technical capabilities and probably staff. Such additional capabilities – along with development of relevant approaches and materials, operations research, monitoring, and diffusion – may be appropriate uses for Child Survival funds.

Implementation processes

- ***The present core program elements of INHP – Nutrition-Health Days based on Take-Home Rations and convergence of ANM and AWW services, supported by coordinated planning and monitoring by ICDS and HFW at the block, district and state levels and by community participation and capacity building – appear to be a recipe for success and should be preserved.***

The INHP Project has passed through an important evolutionary process, and has made substantial investment, to achieve this apparently effective programmatic recipe. It should remain the core of INHP 2. At the same time, there should be substantial room for innovation in terms of achieving greatest effectiveness, replication, and institutionalization of the core elements, in the context of strengthened systems and empowered communities. Such innovation – and the effects of adding other technical or process elements – should be systematically evaluated in terms of value added and cost-effectiveness.

Community

- ***INHP's focus on involving communities and building their capacities is critical for health and nutrition outcomes, sustainability, and empowerment.***

Strengthened service provision by responsible government agencies will remain an important element of nutrition and health programming in India. However, INHP gives evidence that demand for and utilization of these services, as well as changes in key behaviors, provision of material resources and support, and improved health and nutrition outcomes can best result when the energy and resources of communities are engaged. This focus should be maintained and systematically strengthened. Best practices and innovations should be identified, evaluated, and shared. As INHP 2 evolves, the broadening and institutionalization of community involvement – such as the involvement of other community groups and of men, and the development of self-sustaining women's groups supporting woman, child, and adolescent health and nutrition – should become an increasing focus of field activity.

ANNEX G: SUPPORT SYSTEMS

CARE Structures and Roles

Summary: Decentralization has facilitated essential adaptation to India's complex settings, especially variations in state ICDS policies, the availability of NGO partners, and the degree to which ICDS and health systems provide effective programmatic support. CARE's decentralization parallels that of ICDS itself: certain policies are standardized and presumably practiced everywhere, but other decisions are delegated to state and perhaps lower level managers. This is appropriate. At the same time, however, CARE staff at both state and national levels express (somewhat conflicting) concerns about the balance between standardization and flexibility, and staff at all levels are looking for appropriate loci for key technical skills and programmatic learning. Decentralization, in brief, has not yet been optimized.

- **Decentralization has empowered state level staff to adapt, innovate and develop creative solutions to local problems.**

Both CARE staff and our own findings encouraged us to look specifically at issues of INHP decentralization. Field visits showed significant differences in implementation strategies, due in some cases to differing field conditions (and partner policies and preferences), but in other cases to the variable professional judgments and preferences of state-level staff. In general, the evaluation team considered decentralization positive when it encouraged appropriate innovation and adaptation; but we questioned it when it seemed to contribute more to "reinventing the wheel" or inappropriate deviation from core INHP approaches. We were pleased to find many cases in the former category and only a few in the latter.

More problematic situations arise, however, when staff disagree on the appropriateness of local variations, as well as instances in which necessary strategies had not been developed because of uncertainties about who should take the lead. The first category leads to mild friction; while the second, though relatively rare, leads to ambiguities and lack of clear direction on certain critical strategic areas. We focused our attention on possibly inappropriate deviations from core INHP approaches, as well as on strategic leadership issues for community mobilization and behavior change, capacity-building, and replication.

In general, INHP decentralization is essential to permit local adaptation and innovation, and because of staff constraints, differing state ICDS and family health and welfare policies. Community settings and NGO resources also vary greatly. Even if conditions were magically uniform, it would still make great sense to encourage local staff to try new approaches, to think on their feet instead of simply following a cook book, and to test whether even well established approaches might be improved. INHP definitely has proven approaches, but it equally definitely has much to learn about effective community mobilization, behavior change, replication, etc. Innovation and filling the gaps within established procedures should particularly be encouraged for these areas. Well-defined systems, as for food logistics, financial management, and certain aspects of reporting, should be standardized; but less well-developed ones, and ones subject to local conditions (including "nimble" evaluation) should be relatively more open. In general, INHP decentralization has been a positive development.

Recommendation: *INHP needs more explicit distinctions between core project principles and appropriate local adaptations. We suggest that this issue be explicitly discussed in relation to*

the targeted feeding/nutritional impact hypothesis and to the parameters for community mobilization.

- **INHP has not, however, provided adequate guidance and technical support to develop operational approaches for nutrition improvement, community behavioral change, capacity building, and replication.**

Where decentralization has not been so positive, however, is where it has lead to diversity outside a commonly accepted conceptual framework and set of objectives. USAID grants resources to CARE/India as a whole, not to 8 individual state projects, and it is CARE/India whom USAID holds responsible for project results. Key implementation staff should dedicate themselves to achieving the results for which USAID holds CIHQ accountable. They should also respect the project's overall lead on key implementation strategies – proven approaches, or perhaps even experimental approaches that CIHQ's agreement with USAID requires them to apply. There are, of course, other ways of doing things, some of which may actually be better than INHP's, but CIHQ's commitments and the need to consistently implement certain approaches require limits on independent decision making. Projects are designed with somewhat narrowly defined objectives, and CARE's range of activities in India allow for other purposes to be pursued through other projects.

Our concerns about decentralization focused on two general areas: (1) the widely varying degrees of commitment we found to several of INHP's basic hypothesis and strategies; and (2) lack of clear leadership and technical direction on community mobilization and behavior change, capacity-building and replication. Also emerging is a potential third area of concern: (3) the seemingly excessive centralization of evaluation and monitoring procedures, at a time when programmatic innovations have to be local. "Nimble" evaluation, as described elsewhere in this report, is a vital adjunct to innovation. Locally-based innovators need locally-based evaluation capacity to assess and document what they have done. Such local capacity should augment rather than detract from the parallel need for centrally-based evaluation.

Two areas of variable commitment stood out: (a) commitment to INHP's core nutrition approach; and (b) attitudes to community mobilization. As already reported, we found some staff committed to careful targeting of nutritional supplements and to follow through for the full achievement of intended nutritional outcomes. We found others, however, who primarily saw food as an incentive and seemed less dedicated to nutritional goals. While it is not reasonable that everyone should be equally zealous, it is reasonable for project leadership to question local variations due primarily to varying commitments to nutrition. Similarly, we found some staff approaching community mobilization with an open ended "holistic development" principle, while others concentrated on specific health management and behavioral change objectives. Once again, both views may be considered "right," in some ultimate sense, but the difference is too important to be decided solely through individual preference. CIHQ appears reluctant to enforce project-wide approaches on some of these key principles, but the evaluation team thinks they should – within a spirit of participatory decision making and mutual respect.

Decentralization also contributes to confusion about who should take the lead on certain strategies, and then how much latitude states and even individual Field Officers should be granted for implementation. This report has singled out four areas in which both leadership and innovation are essential: community mobilization, behavior change, capacity-building, and replication. (To some extent, these are NOT discrete topics.) Also required for all four is quality management: standard processes, means of monitoring and problem identification, problem solving, and continuous quality improvement. In all four areas, the team observed significant

elements of strategies in almost all state programs, but at best only vaguely comprehensive operational plans, and virtually no quality management. There seems to be confusion about who should take the lead, and where technical resources should concentrate. In general, we concluded that the project as a whole needed mutually agreed objectives and strategic frameworks, but that the best technical expertise need not reside in Delhi. Above all, these should not be seen as control issues but rather as technical ones: how to get the job done efficiently and effectively.

Using behavior change as an example (the same principles apply to all four areas), the model might look like this:

The project as a whole (CIHQ OR a consultative group of state-based specialists) should develop a common strategic framework, to include objectives and certain guiding standards. The framework might, for example, indicate: (1) that every state must have an operational plan for behavior change; and (2) that these plans must meet certain standards for both development processes and content. (In the case of behavioral change, for example, standards might require that strategies focus on community change, not just individuals; that they emphasize improved feeding practices and appropriate support for pregnant women; that they include monitoring, problem-solving, and quality management; and that certain kinds of technical support will be given Field Officers.)

CIHQ staff, or an appropriately designated specialist located elsewhere, should facilitate but not dominate development of local strategies. The states should find locally available expertise, but the project-wide specialist should ensure that the work gets done and meets national standards. If the state work isn't adequate, the national specialist should intervene until such time as the standard framework can be achieved.

Each state must continue to participate in evolution of the national strategy, NOT deviating from agreed national principles and standards BUT reporting innovations, critiquing the national strategy, and helping the program-wide specialist make refinements. In other words, the state program should accept a project-wide responsibility: both loyalty to mutually agreed norms AND responsibility for contributing to evolution of the national strategy.

The evaluation team implicitly looked for this model as we considered decentralization. In general, we found certain elements that were partially developed (especially availability of expertise), but others that hadn't been approached (agreement on objectives and strategic approaches, monitoring, quality management). We had the impression that confusion about decentralization was partly to blame: CIHQ seems reluctant to assert technical leadership, but states are reluctant or unable to obtain the necessary technical resources. Any ambiguities about this need to be resolved soon.

***Recommendation**: In the absence of a clear alternative, CIHQ should exert leadership in at least the four key technical areas mentioned above, but should be prepared to turn the project-wide responsibility over to someone outside the CIHQ office (e.g., within one of the states) if someone at that level is prepared to take the lead. An internally participatory approach should be applied to identify specific INHP objectives, to set standards and guidelines for state plans, and to clarify the division of responsibilities between local and national levels.*

- **Gender composition of CARE field staff is more evenly balanced in some states than in others; efforts to improve that balance have had more success in certain states (AP).**

The team noted that INHP remains a predominantly male organization, almost certainly more so than two of three key partners: ICDS and the Department of Health and Family Welfare. We identified constraints to greater hiring, especially the need for frequent local travel, but outside Andhra Pradesh, there were few or no Field Officers and Coordinators to interview regarding these reported constraints.

Beyond the issue of internal equity, we considered the effectiveness of men and women in their primarily catalyst role vis-à-vis government and community partners, but reached no firm conclusion regarding the urgency of achieving gender balance. CARE as an organization remains committed to equity, as that should be, but does not believe (nor does the team) that Field Officers and Coordinators can only be effective if they are female.

***Recommendation**: CARE should continue the pursuit of internal gender equity and seriously consider the respective abilities of male and female Field Officers to facilitate social and organizational change.*

Staff and technical support

- **Much of INHP's success rests on the facilitative skills and creativity of Field Officers.**

While there might have been some selection bias (state managers deciding whom to send with us), the team as a whole developed great respect for the quality and effectiveness of Field Officers. Many have established excellent relations with district and block ICDS and health officials. Where they have gone to the community level, many have had good insight into social processes and ways of organizing them for INHP objectives. Their apparent (and, of course, somewhat inconsistent) knack for innovation rests heavily on their solid knowledge of community life and ICDS/health processes. In many ways, Field Officers are INHP's most valuable assets.

As low people (mostly men) on the totem pole, however, FOs may only inconsistently receive the recognition they deserve, and may not be adequately compensated in terms of opportunities for promotion and professional growth. In some cases, this may lead to inadequate reporting of problems and innovations, in others to weak technical support. These concerns may particularly apply in situations where Officers are better grounded (and perhaps more creative) than their supervisors. (See below.)

***Recommendation**: INHP, especially at the state level, should seek ways to recognize particularly effective or innovative Field Officers, perhaps through an "FO of the month" award.*

- **Many Field Officers, though, work without routine technical support for such key areas as community mobilization and behavioral change, capacity-building and replication.**

The team noted that Field Officers are, in effect, the Anganwadi workers of the CARE staff: expected to "do it all" but with inevitably narrow personal skills and inadequate access to specialized assistance. They must build community-ICDS-health partnerships, promote community change, improve behavioral outcomes, address certain issues of intra-household gender imbalance, strengthen the sustainable capacity of partner organizations, and promote replication. They must have expertise in community organization and social change (hence the prevalence of FOs trained as social workers); health and nutrition linkages, both theoretically

(so they can motivate counterparts) and operationally (so they can overcome the practical obstacles); and must be able to train, at least to the extent of clarifying skill development requirements and judging the appropriateness of available courses. Given the weakness of currently available strategies for key processes, they must be able to either figure things out on their own or get assistance from wherever it might be available. Needless to say, they are not uniformly excellent in all of these responsibilities.

Field Officers told us that they do not currently receive adequate technical guidance from their direct supervisors, the Field Coordinators. Some expressed interest in peer sharing: facilitating direct contact, and perhaps work sharing, between individual FOs. Whatever approach is considered should recognize that learning is a two way street in this complex environment: FOs have the intense knowledge of community settings, one half of the key to innovation, but specialists know the technical issues better and are more informed of innovations elsewhere,

***Recommendation**: INHP should not introduce technical interventions without providing continuous support (i.e., not just training) for its field staff, and explicitly acknowledging that learning goes both ways. Efforts to upgrade operational planning for community mobilization, behavior change, etc., should include plans for technical support.*

- **Many Field Coordinators are still operating more as supervisors and data managers rather than as technical support personnel, problem solvers and facilitators of innovation.**

In line with a general movement from control to facilitation (particularly necessary for its transformation from food supply to development), INHP has also attempted to shift the role of Field Coordinators from traditional supervision to more appropriate facilitation, problem solving and technical support. A 1999 consultancy report highlighted the problem and suggested the solutions; these have been partly – but only partly – implemented. With varying degrees of articulation, FOs express disrespect for those who should be best placed to help them. This should indicate serious underlying problems.

Recommendation: INHP should retain intermediate positions between FOs and the state level, but primarily for technical support. INHP should consider a possible peer support system, in which FOs within a sector team support and critique each other's work, with only occasional support from higher levels.

ANNEX H: MONITORING AND INFORMATION SYSTEM in INHP

Background

The INHP, since its inception, developed a monitoring system with certain key indicators to assess outcomes with respect to performance and process indicators, to focus staff and partners on the objectives of the programme. Prior to the mid-term review in 1999, monitoring was being done using an elaborate HVQ. The data from the HVQs was transmitted to the State HQs and quarterly reports were generated. A feedback was provided to the Field Officers. The HVQ was basically to serve three purposes: counselling of mothers, monitoring of performance and measurement of outcomes.

Revised HMIS

The MTR after reviewing the HVQs, felt that there was no need to report on a large number of outcome indicators every quarter, and recommended simplifying and improving of INHP's monitoring and evaluation system. MTR also felt that the frontline workers could instead fruitfully use the time spent on collecting such large data for programmatic purpose. Consequently, a Monitoring and Evaluation Taskforce, constituted by CARE-India, after detailed deliberations, recommended the present HMIS. The revised monitoring system was implemented after pre-testing with a team of 10 FOs in UP and Rajasthan, and field testing in all the states where the INHP was in operation.

Purpose: The purpose of HMIS was to assist in regular review of data for assessment and decision-making, review of progress with the Government and regular sharing of lessons learnt with respect to the best practices.

Salient Features:

- The revised HMIS focused on monitoring of the process data and the programme.
- It included both quantitative and qualitative data to help in decision-making.
- The system used, to a large extent, data collected by the counterparts keeping in view the sustainability of the monitoring system.
- It reduced the load of data collection and provided for recording field experiences by the frontline workers. More importantly it provided for feedback at all levels.
- It also included a manual of procedures to help the workers.

Sources of Data

Every month, the FOs collected the data from different sources. It included primary data collected by them and secondary data compiled from their counterparts.

The data is collected from:

- AWC reports prepared by the AWWs,
- Observations and records of CDPOs and Supervisors,
- Training reports,
- FO's Monthly Progress Report,
- Block Visit Report,
- Anganwadi Centre Visit Report (*About 3% of the AWWs are selected randomly at the beginning of each year to prepare Anganwadi Centre Visit Report. These AWCs are spread throughout the 12-month period and the visits are made as per the plan*).

- Beneficiary Interviews (*During the AWC visit 5 beneficiaries are interviewed in each AWC area as per prescribed selection procedures.*), and
- Reports from NGOs.

Indicators:

Services	Indicator	Frequency	Source
Convergence of ICDS and Health	% AWCs conducting NHDs	Monthly	AWC Report
	% AWCs functioning as DS	Monthly	CDPOs, Supervisors, AWWs, NGOs, FO's Observations (Formal & Informal)
Targeted Feeding	%Children (6-36 mos.) enrolled for spot feeding % Children (6-36 mos.) Received THR % Children (6-36 mos.) Received spot feeding	Monthly	AWC report
	%Pregnant and nursing women enrolled for THR %Pregnant and nursing women enrolled for spot feeding %Pregnant and nursing women received THR %Pregnant and nursing women received on spot feeding	Monthly	AWC report
	%AWCs which had ≥ 22 days of feding	Monthly	AWC report
	% AWCs which had stocks for next 25 days	Monthly	AWC report
Capacity Building	% Persons actually trained	Monthly	Training Reports, Trainee Database (CARE)
	%functionaries trained in infant feeding practices	Monthly	
	% BLACs where programmatic issues wre addressed	Monthly	FO-MPR

Findings

The following are based on the observations made by the External Evaluation Team during their field visits by discussions with the Field staff and actual examination of the records.

Operational

- A great deal of change in INHP's monitoring system has been implemented since the MTR.
- HMIS development is clearly a participatory process, though the use of information varied across the States.
- On the whole, the HMIS seems to be working satisfactorily to the extent that it provides information on programme direction.
- The data flow is upwards, where it is analyzed and the results are discussed for further action.
- The Field Workers (FCs and F.Os) readily appreciate and accept the system. Some of the comments are that it is a system "by choice" and "not by force".

The F.Os believe that it helps them in monitoring the programme and provides them a feedback. Field staff's satisfaction with the new HMIS, and thus the degree of utilization of the information, may be proportional to the degree of input that they provided during its inception (that is, staff in Rajasthan and Uttar Pradesh may in fact feel a greater sense of ownership then those in other States, as they were involved not only in field-testing but in pre-testing the HMIS).

- The final evaluation team commends the monitoring innovations like self-monitoring tools by mothers, social mapping by community (updated regularly), and by monthly monitoring of the activities of INHP by mothers' committee through post- cards to increase programme effectiveness.

Data and Sources

- The emphasis of the monitoring is on supply-inputs and process-indicators.
- It is based mainly on the monthly reporting by FOs based on data collected from various sources.
- Data from ICDS's MPR - prepared by AWWs - is extensively used for information on NHDs and THRs.
- At no level, did the staff feel that they did not have adequate information.

Perceptions

- Field Coordinators say that they use HMIS actively for feedback, management, and problem solving. They say that they are able to mobilize the ICDS and health resources to solve problems more quickly rather than waiting for information from the CARE management and ICDS hierarchy.
- It is felt that after the HMIS, the whole monitoring and reporting systems with respect to food commodities is more stream-lined and rational that the Form 4 (commodity management) is actually used seriously as a planning tool for moving food.
- At higher levels in the State administration in some States it was felt that the data is not used properly. Some of the State level officials felt that community level monitoring would be more useful.
- The reports are shared with the CDPOs and the observations are discussed with the government counterparts (helps in solving the problems in joint review meetings). The CDPOs report that they regularly get these reports, which list problems and successes. The observations are discussed in the joint coordination meetings with the government counterparts. It seems to have helped in improving coordination between AWW and ANM in the organization of NHDs etc.
- There was, however, no clear demonstration of how the information was used.

Limitations

While there is no doubt that the HMIS system has been working satisfactorily, there are certain limitations in the present system, which require attention to make the system more effective to achieve the overall objectives of the programme. An attempt to make use of the data presently being generated, like growth monitoring, can improve the quality and overall effectiveness of the programme.

- The HMIS does not include information on the quality of the programme. For example, there is no evidence to suggest that the growth charts being used properly as tools for identification of undernutrition and management.

- No information is included indicating issues pertaining to management and initiating action in cases of growth faltering.
- The focus of HMIS is mostly on food commodities, food beneficiaries and NHDs held and not on community participation, behavior changes and growth faltering.
- Presently, the staff cannot monitor changes in outcomes such as feeding behaviours.
- The operational systems appear weak at block and district levels in compiling and using the substantial amount of information being generated.
- There are no clear-cut procedures of quality control or verification/validation of the data.

Recommendations:

- The HMIS should make use of information already being collected by the AWWs on growth monitoring for the purpose of assessing measures being adopted to identify and manage growth faltering so as to promote nutrition. The INHP should create technical skills among the AWWs, who ultimately would be providing the information.
- Targeted operations research could help fill perceived gaps between monitoring processes and quantitative surveys.
- Key information for decision-makers at all levels should be highlighted.
- A similar process as in the design of the HMIS should be undertaken for the use of information - that is, FOs should serve to disseminate to FOs in other States their use of HMIS outputs.
- After at least one year of implementation, review the HMIS to assure that information for decision- makers at all levels is available in a user-friendly fashion - consider how information is disseminated within and across the project.
- CARE should ensure that evaluations are concordant with strategy such that one supports the other.
- Community managed monitoring would be more sustainable and could help in successful achievement of programme objectives as far as beneficiaries are concerned. In this connection the mothers' self-monitoring tools developed in Chhattisgarh and Orissa should be considered for use elsewhere in INHP, since they help community members, apart from the programme functionaries, in identifying the outreach at the individual level. Innovative methods of monitoring by community (village level committees/mothers' committee) through monthly post-card system, which provided information to the district level administration about the programme functioning and helped in decision making, should be pursued.
- Social mapping (updated quarterly) involving the community in every AWC helps not only in capacity building of the community but also assists both the CARE and government administrators in identifying the location and the numbers of beneficiaries in each AWC area.

ANNEX I: ORGANIZATIONAL LEARNING & DIFFUSION / REPLICATION

Summary: The evaluation team found numerous innovations at the state and Anganwadi level, but documentation and evaluation of these innovations needs strengthening. Although CARE has prepared four working papers at the program level on different innovative experiences, and has documented experiences at the State level, documentation and evaluation of innovations needs to be more systematic and rigorous. Descriptions of "better practices," while increasingly available, sometimes lack clear guidance regarding processes and costs in terms of manpower and time (essential for effective replication either within CARE-supported areas or in government programs). There has also been little prospective testing of potentially feasible solutions to common problems, nor operations research to test the feasibility of new interventions or strategies. Diffusion occurs easily and frequently within state offices, but sharing between states appears inadequate. CARE cannot complete its evolution from a feeding to an integrated health and nutrition organization without a much clearer learning approach to issues and innovations.

- **We endorse the demonstration site approach to INHP and partner learning, but note that replication strategies are often inadequate.**

Following the Mid-term review, INHP moved decisively from emphasis on widely scattered "High Intensity" blocks (some of which required up to ten times normal input levels) to a new DS strategy based on an evenly dispersed 10% sample of Anganwadi centers. Because the latter were to be more common, they were to receive a lower level of inputs and to be more replicable. Persons working or residing in nearby areas could more easily visit and copy what had been done. While we heard complaints that the shift from HI to DS had been too abrupt, we generally found the new strategy appropriate and likely to be effective for its intended purposes.

To be counted as a DS, a particular Anganwadi center should have fully implemented all three components of the core INHP strategy. These are: (1) targeted supplemental feeding, through take home rations; (2) linkages to health services, through nutrition and health days; and (3) strong community participation, generally through women's groups (mahila mandal) and self-help groups (SHGs). A further consideration was that such sites should not be designated until they had been in operation for at least 6 months.

Implicit in the DS strategy was the assumption that demonstration would become learning sites, i.e., that they would model appropriate community activities so that others could see. This aspect of the demonstration, i.e., that there should be an audience and that it should take interest, was not explicitly defined nor considered as a criterion for DS designation.

The DS strategy can be assessed at several levels: (1) Is it more effective than other feasible approaches to strengthening the health and nutrition outcomes that INHP is seeking? (2) Are the resource inputs required to initiate and maintain demonstration sites ones that can be easily replicated in non-demonstration areas? And (3) are, in fact, the intended copiers taking interest in the demonstration sites and going on to copy their approaches? The evidence is clearly positive on the first criterion but mixed on the other two.

The first of these questions is addressed in the impact section above. Broadly speaking, while selection procedures and definitions for DS varied, most available data indicate that better

results were achieved in DS than in "all" sites. On the surface of it, the intuitive link between community, health and nutrition services appears powerful. Even if data were weaker, we would have little reason to doubt DS effectiveness; in fact, the tripartite links being achieved through DS lie at the heart of the INHP strategy and appear prima facie valid.

While situations obviously vary, two types of special input appear to be required for demonstration sites. One is Field Officer time. We were told in one state that FOs spend virtually all of their time on DS, while in another state we learned that FOs visit each site approximately once per month for the first six months, eventually scaling back to once per quarter. (Hopefully, the final maintenance/graduation phase will require even less time.) Presumably, FOs can shift their attention to new sites as existing ones stabilize, but this time investment is not insubstantial.

The second type of input has been focused on community mobilization, generally through an NGO. NGO characteristics and *modus operandi* varied tremendously, but the ideal situation seemed to be where an existing, possibly non-health or nutrition NGO, built on its existing activities to mobilize communities for very specific functions. Appropriate functions generally centered around community behavior change, oversight of food distribution and other Anganwadi activities, and (perhaps less immediately relevant) income generation. The first is essential, based on the team's judgment that individual behavioral change is unlikely without significant change in community norms (including on the part of the more higher status residents in the community). The latter two activities build a broader sense of community ownership, which we consider essential for sustainability. Creation of a demonstration site without an NGO partnership may be possible where the community is already involved, but the sites we visited all had such partners.

The third concern is whether the intended replicators are, in fact, taking notice and making some effort to copy. In general, we found significant instances in which state programs have, indeed, copied DS innovations, especially THR, NHDs, and a reinvigorated effort to involve community women. This was facilitated in Chhattisgarh by the fact that NGO change agents work simultaneously in demonstration and non-demonstration sites; and also by the fact that CARE works directly with 77% of the state's 152 blocks. The innovative community-based pregnancy monitoring systems that CARE developed have also been widely copied. State governments listen to CARE – give them "a place at the table" – in part because they are known innovators, but also because they form a major – often the best functioning part of the ICDS program. Thus, at the policy level, replication of DS approaches appears relatively common and easy.

The harder aspect of DS for replication may, in fact, be community mobilization, vital for impact because of the essential requirement for community level – not just individual – behavioral change. FOs certainly do not have the time, nor necessarily the skills or empathy (most FOs are men) to do this in every single participating community. NGOs are only spottily available; government programs focus on panchayati raj and only indirectly relate to health. Leaders from communities close to demonstration sites can and are coming to visit, but we question the assumption that knowledge of the model itself will generate the necessity implementation process. On the prima facie test of feasibility, we question whether the community side of the DS strategy has been adequately analyzed.

Recommendation: INHP should review its current plans to replicate demonstration sites, with a view to developing more concrete plans for diffusion and replication.

- **While local innovations are widespread, INHP has limited capacity to evaluate them with any rigor or to diffuse information regarding innovative approaches.**

INHP has come a very long way in the last 5 years, and seems to have had considerable ancillary impact on state ICDS programs as well. While there have been some big, relatively well assessed, changes, the cumulative effect of innumerable small changes has also been significant, often more in local areas where they are known than in broader state and national arenas. Some of these innovations have been described in glowing, almost promotional, terms rather than analyzed in semi-critical fashion and then rigorously evaluated. Not all innovations deserve such intensive care, but some do, and the mechanisms for initiating do not appear to be in place.

Particularly needed are "unsanitized" descriptions of the step-by-step processes by which innovations were devised, because it is usually these processes rather than the resultant innovations that should be copied. Chhattisgarh, for example, exhibits at least two different versions of a community-based monitoring tool for pregnant women, while Orissa has a third. We cannot from this distance say that the processes were identical, but clearly the products do differ. Others attempting to achieve similar results should clearly copy and adapt the process rather than the exact tool. It is likely that many similar examples exist.

Recommendation: As described elsewhere in this report, INHP should develop a more "nimble" evaluation and documentation strategy to facilitate focused evaluations, simple problem-solving studies, and perhaps prospective operations research, for key strategic issues. These efforts should particularly focus on INHP's "leading issues:" particularly community behavior change, and replication.

- **Field personnel may have more to learn from each other on certain technical areas than they do from CARE headquarters. However, routine methods for cross-learning have not been developed.**

Chhattisgarh diffuses innovations by assigning individual change agents to work simultaneously in demonstration and non-demonstration sites, Andhra Pradesh by clustering Anganwadi workers so they learn directly from each other. Seeing the benefit of this approach, state CARE officials want increased learning through direct observation of other state programs, while state government officials want CARE staff to provide direct technical assistance in non-CARE blocks. Reliance on print media and enhanced Internet connections is unlikely to be as effective as face-to-face diffusion.

As noted before, INHP staff, even within a single state, have collectively accumulated centuries of practical hands-on experience and know-how for community and systems change. It is unlikely that central staff can ever annotate or even fully understand this experience.

Recommendation: INHP should encourage cross-learning at all levels: FOs to each other, specialists and program managers with other state personnel, and so forth.

ANNEX J: CAPACITY BUILDING AND SUSTAINABILITY

This component of INHP addresses the need to strengthen capacity in counterpart institutions to enable the INHP project to achieve its objectives of improved health and nutrition on a large scale, and with assured continuity beyond CARE's involvement.

Methods of evaluating this component included documenting direct and indirect indications that capacity was built, and identifying what program components were linked to improved capacity. The team gathered this information from reports (e.g. evaluations, descriptions of various components of the program), plans (e.g. DAP-I and DAP-2), training materials, observations, interviews (CDPOs, AWWs, ANMs, CMOs, panchayat and other community leaders/members), focus groups in communities, presentations by NGOs, and discussions with partners at national, state and district levels. The evaluation team attempted to identify the specifics of 'what' and 'how' capacity building (CB) was attempted and achieved in INHP-I. The objective was to identify what did or did not work, and recommendations for further improvement. The main findings (in italics) and a brief discussion, and recommendations are given below:

- *INHP-I recognized that building capacity of communities and individuals is as important as reaching short-term nutrition and health targets (e.g. DAP-I).*

In the design of INHP, building capacity in communities and individuals was considered as important as achieving nutrition and health improvements. This was to assure that women and children would, a) benefit from ICDS and health services in INHP, and b) have the ability to continue to improve their nutritional and health status and that of their families and communities beyond the tenure of the INHP project.

Particularly important for achieving the INHP objectives, were the capacity of community structures, women's empowerment, and government systems to achieve convergence. For example, DAP-1 recognized women's empowerment as the "capacity to make choices and take actions on one's own behalf to optimize quality of life and chances of survival, with self-confidence, and from a position of economic, social, and political strength."

Recommendation: The evaluation team fully endorses this hypothesis and encourages INHP-II to continue to achieve these objectives through even a more comprehensive and systematic CB strategy.

- *INHP-I appropriately selected three main channels for the focus of CB efforts:*
  - *Community structures and change agents*
  - *Government departments and institutions*
  - *NGOs*

The evaluation team endorsed the choice of institutions on which CB activities were focused. These are:

- Community based organizations and change agents (e.g. Mahila Mandals, SHGs, Village Development Committees, Panchayat leaders and their committees, adolescent girls etc)
- Government departments and institutions. Particularly after the MTR, a concentrated effort was made in the following areas, THR, NHDs and other forms of

convergence, in addition to the ongoing focus of CB activities in planning, monitoring, supervision, food commodity management, nutrition and health education.
- NGOs. These were viewed initially as implementers of CARE activities, but in some states INHP found the need to build their organizational capacity and/or capacity in health and nutrition activities before they could become fully effective.

Although the choice of key enabling institutions was appropriate, the team did not find a clear articulation of what specific types of capacities and at what level of functioning these were needed. This could have helped focus CB efforts and track progress in achieving capacity for each type of institution involved in key program components. Such a progression can enable INHP to reach its goals of replication and sustainability more efficiently.

Recommendation: Based on the valuable CB experience gained in INHP-I, and a clearer appreciation of what specific skills and capacities are needed in key institutions at various operational levels, it would be valuable for INHP-II to specify milestones and indicators of capacity for critical functions in key counterparts. CB activities can then be prioritized and linked to achieving these. At this point in the development of INHP, the following questions can begin to be answered:

- What capacity is needed for key program functions?
- What does adequate capacity look like at the mid-point and end of INHP-II?
- What specific outcomes and targets should be aimed for?

- *INHP succeeded in building capacity in all states to some level even though the evaluation team did not find detailed operational guidelines for linking activities to capacity outcomes. General guidance was provided by CARE/HQ, and the supportive manner in which INHP was implemented at all levels in all states clearly demonstrated a commitment to building capacity.*

INHP succeeded in raising awareness at various levels within program areas, about the importance of nutrition and child survival interventions, and that ICDS can make a difference in the health and nutrition of mothers and children. The commitment to improving nutritional status and capacity to do so among partner institutions (government and NGO) needs to be further strengthened.

The most important evidence of improved capacity is that large scale improvements in selected intervention coverage levels were achieved e.g. improved immunization rates, increased ANC visits, and increased number of beneficiaries who received targeted supplementary food. This could not have been achieved with the small number of CARE staff in relation to the large numbers of program implementation units (see Table 1).

Gains in women's empowerment were also made. Most ICDS/health department functionaries and community members trained/provided information and skills were women, and the program therefore supported women's empowerment and advancement. In some states specific efforts were made and these appear to have succeeded in developing adolescent girls capacity, formation/strengthening of SHGs and MMs. More can be done in this area. The evaluation team felt that INHP would benefit from further specialized guidance on this component.

There is indirect and anecdotal evidence that other aspects of developing capacity were improved. Examples include: awareness of key nutrition and health behaviors at all

levels (state through community/household); understanding of the importance and effective planning strategies for convergence of government ICDS and health activities at the community and block levels; and food commodity management to community level. Areas in which the evaluation team did not find equally strong evidence of capacity being transferred/built, and which are key to sustained nutrition and health improvements include: community (and household) behavior change or CBC focused on health and nutrition behaviors, routine self-monitoring of coverage and quality, advocacy for nutritional status improvement.

Recommendations: Carefully assess capacity building experiences (training and other), identify those successful in achieving desired outcomes, document and package those proven effective for broader use. Review and revise CB approaches as the knowledge and learning base change and the program/policy environment changes.

- *The intention of CARE to build capacity for long-term sustainability of key INHP components through phasing over critical components to state, district, block and community entities was not consistently and clearly understood by key stakeholders.*

The feedback from state and district level partners to the evaluation team about the need for indefinite continuation of CARE in INHP, while a testimonial to the high caliber of CARE's work and the great value and esteem accorded to CARE as an institution, also raised some concern among team members about phasing over and building capacity and commitment for long-term continuation of key INHP activities that are essential for ICDS to produce health and nutrition results. This suggests that capacity building objectives (i.e. including phaseover and sustainability, in addition to achieving scale and quality) need to be jointly discussed and developed and systematically reinforced.

Recommendation: Develop a joint plan for and conduct explicit advocacy for phasing over critical INHP functions to government, NGO and community entities – address both the why and the how.

- *Although early in INHP documents refer to a broad range of potential actions for building capacity, perhaps unintentionally, training appears to have become the predominant approach explicitly stated as the INHP strategy for building capacity.*

Following the adoption of the unified strategy after the MTR, there was a spurt in training activities in 1997-1998-1999. All demonstration sites received training inputs, mostly for AWCs moving to NHDs and THR. Training was conducted for staff and supervisors in ICDS and health departments at all levels, but the main focus was on community members, groups and change agents: CBOs; AWW, ANMs, and Block level staff. Some training and workshops were held for State and District functionaries.

See Table 1 and Figure 1 for the magnitude of and trends in numbers of persons trained per year.

The evaluation team was concerned that INHP may not progress as rapidly with phasing over key functions (including routine training functions of states for AWWs for example), if CARE/INHP became a substitute for these functions rather than a 'facilitator, coach, guide, promoter, enabler'.

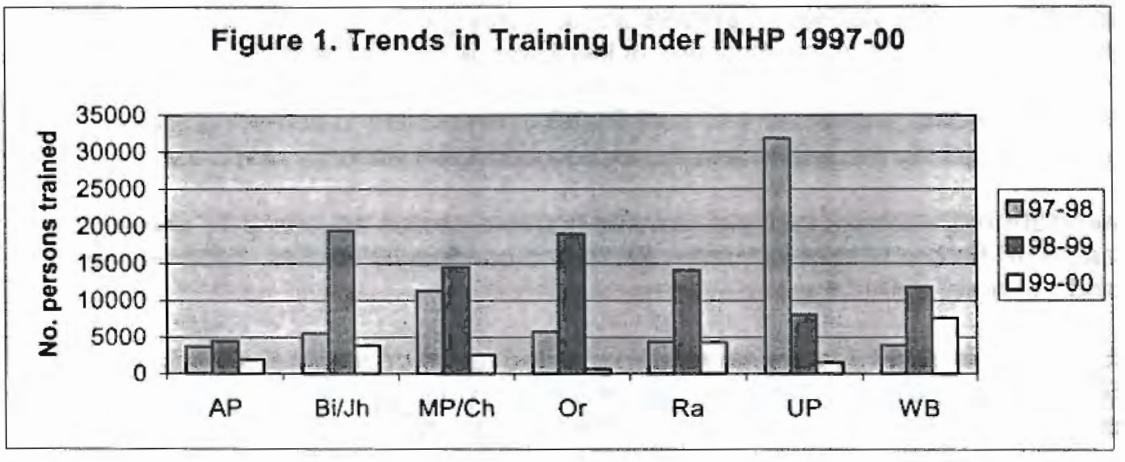
Table 1. Training Activities in Relation to Program Scale

State	No. Food recipients	AWCs	NHDs	Ave No. Trained/yr	INHP Staff	Financial Partners
Andhra Pradesh	833,000	12,205	2,954	3,392	26	11
Bihar/Jharkhand	768,000	15,324	2,640	9,620	32	13
MP/Chhattisgarh	1,107,000	18,730	3,507	9,468	34	4
Orissa	1,231,000	12,087	1,246	8,481	31	12
Rajasthan	645,000	12,257	4,033	7,614	24	10
Uttar Pradesh	931,000	12,803	3,958	13,833	25	10
West Bengal	1,142,000	15,949	960	7,801	33	24
TOTAL	6,657,000	99,355	19,298	60,209	205	84

Source: Data by provided by M.Subharwal to Evaluation Team, 5/01.

To provide an idea of the large magnitude of the training effort alone, and the emphasis placed by INHP on community level structures, in the first half of the INHP program, over 65,000 members of various partnerships received training. Of these, over 40,000 were community members and about 15,000 were village level government functionaries (Gill, 1999).

Figure 1. Trends in Training Under INHP 1997-00



Data derived from CARE-India Results Reports for 1997-2000.

Recommendation: INHP should maintain its focus on capacity building at the community level (through government and NGO structures). It should not substitute for lapses in AWW training functions of the states. It can however facilitate the process through finding more effective training and supervision approaches for performance improvement, and by helping to strengthen key components e.g. testing/OR to improve CS package of interventions, routine monitoring, CBC, nutrition advocacy etc. within existing training strategies.

- *Though not explicitly identified as a capacity building approach, CARE's collaborative working style that includes joint planning, frequent joint field visits, and frequent joint reviews of field monitoring information was an effective tool that led to improved capacity at all levels in certain program components. Community level capacity was also improved through NGO partnership activities. Useful experiences and tools*

have been developed that can be consolidated into an effective strategy for capacity building both, for the purpose of defining and operationalizing "the INHP approach" with all its vital components, and also for the purpose of achieving sustainability and successful INHP graduation.

Examples of these tools and actions that have begun to emerge (but some need to be critically evaluated and the proven effective ones codified and pro-actively expanded) include:

- Use of Demonstration Sites as learning centers for diffusion of best practices/quality standards among DSs, and in village clusters surrounding DSs
- BLAC/DLAC meetings as a venue for convergence and joint planning/problem solving/diffusion of best practices
- Continuous quality monitoring for food commodity management (e.g. audits, RSR, FO MPRs with follow-up action etc), but this technique can be applied more broadly to other vital INHP functions
- Block resource mapping (MP state) for convergence
- Village social mapping (that needs to be extended to surrounding hamlets where the most needy reside), to achieve the 'population-based approach' essential for nutritional and health impacts at the population level
- Community-based monitoring (that could include if found feasible, early detection and action on growth faltering)
- Formation and revitalization of Village Development Committees
- Mobilization of revitalized Mahila Mandals and Self-Help Groups
- Identification and training/engagement of adolescent girls
- NGO capacity building in INHP focus interventions (3+3)

Recommendation: Use a broader approach to capacity building than training (e.g. Appendix M in DAP-2 lists appropriate components for the training but not other CB activities). Routinely monitor indicators for training activities plus other CB activities, and even more importantly, monitor outcomes of the training/other CB activities in terms of key functions (not inputs and outputs alone).

- *It is now possible to link CB activities to the main stages of INHP development (details of the model to be defined as more program learning occurs), and these stages include: identification and enhancements (e.g. adding new CS interventions) of the model, replication of the model/enhancements, phase over of critical functions.*

The team was impressed with successful experiences in all states in implementing the revised strategy after MTR. There is a strong commitment to expanding lessons learned from demonstration sites more broadly and also to sustainability. Capacity building activities can now be linked to stages of INHP evolution in each state. Examples of how CB activities can be focused on INHP objectives are given below:

a) *Develop an effective district/block level program model for the state* ("evolution") e.g. in selected demonstration/learning sites document the impact on behaviors and nutritional status (using small studies and not large surveys to document impact). Example of CB indicator: State/national institutions engaged in ICDS/INHP have the capacity to design and assess the impact of technical innovations, and to use the information for making program choices.

b) *Scale up/replicate/diffuse the key elements of the proven model to achieve full coverage within and across blocks/districts* ("maturation"). Example of CB indicator: government and NGO entities in the state have the capacity to plan, implement, coordinate and routinely monitor key INHP/ICDS program elements at scale.

c) *Phase over key INHP inputs at sites within blocks/districts and from entire blocks/districts* ("graduation") to community, NGO and government institutions. Examples of CB outcome indicators:

- Block level staff are aware of community needs and constraints of AWW; know commodity management, convergence, continuous quality improvement for 3+3 interventions; have the ability to build capacity in ICDS Supervisors/AWWs/ Mahila Mandals/Panchayat members.
- NGOs are effectively advocating for and successfully obtaining non-CARE resources to continue working towards INHP objectives with improved skills.
- Community organizations (Panchayat, Mahila Mandals, Self-Help and other Groups) have taken over key elements of the projects e.g. THR distribution, tracking children's immunizations, monitoring antenatal care among pregnant women, supporting newly delivered mothers with breastfeeding; and they know the services available to them from the government, and are able to obtain them.

The team was concerned that a focus on results and quality be maintained throughout this process. State INHP teams could benefit from acquiring capability in approaches such as continuous quality improvement techniques (based on principles of self-assessment and teamwork to solve problems systematically).

Recommendation: Capacity building should be more closely linked with stages of INHP development and graduation, with defined outcome indicators. These should aim to secure coverage/scale, quality and long-term sustainability of proven effective technical interventions for ICDS.

- *INHP/HQ and INHP/states have an important role to play in building capacity at the national level in ICDS, MOHFW, and NGOs.*

The team observed the interest and opportunity in national level institutions for wider application of INHP experiences beyond CARE/INHP locations. This has begun to occur spontaneously and can be systematized and further developed. Areas where transfer of skills and capacity can occur include: commodity planning and management, convergence strategies and tools, management of THRs and NHDs, and routine monitoring.

Recommendation: INHP could have a broader impact on ICDS beyond the 8 states where CARE is involved and this opportunity should be taken up through developing a portfolio of areas of excellence in INHP and a pro-active approach that includes packaging, marketing/promotion, and transfer of the experience of INHP in a strategic manner.

- *Capacity building is particularly important at this stage of INHP for certain components, which include: monitoring and small studies/OR, community (and household) behavior change, and advocacy for improving nutritional status.*

Designing and carrying out small, OR activities and assessments to systematically and rigorously evaluate prospective (e.g. newborn health package, delivery of 2 doses of vitamin A annually) and existing innovations (e.g. CBC +3 interventions) is important. Some issues for OR identified by the evaluation team are:

- effectiveness of a streamlined and scalable essential newborn care package of interventions,
- attribution of health/nutrition impacts in selected INHP sites to program inputs,
- effective behavior change for improving complementary feeding/breastfeeding practices,
- approaches to achieve population-based results in improved infant feeding behaviors and delivery of key services (e.g. vitamin A and iron supplementation, ANC, immunization); including steps required to reach communities/families not in the officially defined AWC catchment areas (but they are in the health center catchment area),
- replication strategies centered around demonstration sites,
- role of growth monitoring and promotion to support behavior change (quality improvement techniques can be used to improve existing GMP activities)

The team felt that capacity exists in institutions at national and state levels to carry out small focused studies on the above listed topics, particularly with the guidance of CARE and its consultants. Their engagement in the INHP/ICDS program as problem-solvers and guides for decision-making could be strengthened.

For community (and household) behavior change, national and state agencies currently involved in ICDS/INHP could benefit from understanding and developing skills in an approach that includes the following types of elements:

- Use of formative research methods to define constraints/barriers and motivations for key behaviors (e.g. early, exclusive breastfeeding and use of colostrum, appropriate complementary feeding) in key population sub-groups
- Identifying options for removing constraints/barriers, and reinforcing positive motivations to support widespread adoption of the INHP desired behaviors
- Defining key audiences to be reached, community-level structures/entities to be engaged, policies/program guidelines to be changed, etc.
- Identifying how they are to be reached/changes made e.g. effective media channels, existing forums to be used for community-level actions, policy change processes and how to engage in them
- Developing messages, materials and tools
- Scheduling and developing plans for program activities such as, logistics of production and distribution of supplies, training activities etc., to achieve convergence and reinforcement at scale
- Monitoring the implementation of program inputs, outputs, processes (e.g. media, messages, training, and community meetings/joint planning/advocacy) and outcomes in terms of behavior change and at intermediate levels (e.g. recall and uptake of messages, coverage, policy/program changes, and improved skills/ownership).

In the area of policy/advocacy, a clear link needs to be continuously made within and outside CARE and its immediate counterparts regarding the role of nutritional improvement in reducing child mortality (e.g. Pelletier's studies, PROFILES nutrition advocacy tools), and the role of ICDS/INHP in improving nutritional status.

Recommendation: Within the context of an overall strategy linking CB activities to stages of INHP development, and in addition to it, build capacity in selected key elements such as using small studies/OR for problem solving, community (and household) behavior change, and advocacy for nutritional status improvement.

In conclusion, as the INHP program model is finalized with its components of community mobilization, behavior change, replication, and graduation, it should become clearer as to what types and level of capacity are needed in the ICDS and health systems, in communities (particularly in women's empowerment and appropriate role of the Panchayat), in NGOs, and at policy/advocacy levels to achieve quality and impact and to assure sustainability. CB activities in INHP-II should be targeted to achieving these capabilities.

The team identified some constraints to moving ahead rapidly with capacity building for successful INHP graduation. These include:

- Need to complete the "INHP model" and its vital sub-components e.g. technical content (e.g. addition of vitamin A and newborn care), behavior change strategy, replication approach and tools.
- Lack of broad awareness and clarity among counterparts on why/how/who of phasing over of CARE/INHP inputs to community, NGO, and government functionaries.
- Need to identify suitable partners for capacity building.

In developing a comprehensive capacity building approach for INHP-II, a crucial step is participatory planning with institutions whose capacity is to be strengthened. The strategy and subsequent INHP-II documentation (e.g. monitoring tools, training plans, advocacy materials, operational plans, progress reports) should explicitly recognize that CB includes not only knowledge transfer, but empowerment, encouragement of innovation, support for problem-solving, diffusion of best practices, positive feedback, supportive supervision, and learning by doing. CARE can look within its own programs for good examples and approaches and also obtain technical assistance from projects working in other regions and countries for tools and approaches of how other programs have achieved scale with impact.

Overall, the evaluation team was greatly impressed by the dedication of INHP teams at HQ and in the states to build capacity in counterpart institutions and at community level, and the effectiveness of the participatory working style employed by CARE in INHP implementation at all levels. There is a marked improvement in the capacity of ICDS institutions at various levels where CARE/INHP has worked in the past 5 years; several of these improvements can be linked to INHP activities. Some of the INHP enhancements have been taken up in non-INHP locations by state governments and at the national level, illustrating the potential for larger scale benefits resulting from INHP.

Main References

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4. Partnership in the Nutrition and Health Sector of CARE-India. A review of progress to date. Kirrin Gill, Jan.1999.
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5. State reports from various team members of the INHP final evaluation team.

STATE REPORT - ANDHRA PRADESH

Introduction

CARE has been operating in Andhra Pradesh (AP) since the year 1962 initially supplying food supplements for various nutrition programmes. The final goal of INHP is to improve women's capacity to attain and maintain optimal health and nutrition for themselves and their children, especially girl children. The INHP works both with government and NGOs to achieve the goal. The project strategy is to maximise the impact of ICDS supplementary food on the nutrition of children and women.

- **Target population**: Pregnant and lactating women and children under age of 2 years.
- **Interventions**: THR (targeted supplementary feeding), immunization for children by one year of age.

Nutrition and Health activities were initiated in the state during 1995-96 with capacity building in 2 districts. The programme was initiated in the state in 1996 with one HI block and 15 CB blocks in 2 districts in northern coastal Andhra Pradesh. In May 1997, it was scaled up to 7 HI blocks, while in November 1997; modified CB strategy was introduced in 25 blocks with presence in 113 blocks in 15 districts.

External Evaluation Visit

A three-member team visited the state and had discussions with the CARE-AP team, officials of Government of AP and carried out field visits. One of the members examined the aspects relating to food supply by visiting the district of Medak (Narsapur block, 4 AWCs,). Two members split into two teams to cover the district of Nizamabad (Domakonda block, 4 AWCs) in Telengana and Vizianagaram (Gantyada block, 4 AWCs) in north coastal AP. Mr.Saroj Adhikari, Assistant Director, ICDS (World Bank projects) also accompanied the evaluation team. In each district, the teams visited at least one block each and made further visits to AWCs selected at random and met AWWs, Supervisors, CDPOs, District Project Directors (PDs) of ICDS, DMHOs, MOs (PHC), members of NGOs (5 groups), change agents, community and members of mothers' committees. The teams also had discussions with the respective District Collectors. The team visiting Vizianagaram had an opportunity to observe a training program being organized for the members of mothers' committee (about 35 members) by the supervisors, AWWs and a member of Youth Development Organization (YDO), an NGO actively involved in community mobilization and education.

All the members of the team had discussions with the officials of CARE such as the State Director, INHP Manager (I/c), Field Coordinators (2), Field Officers (4 females + 1 Male), Commodity Manager and Partnership Coordinator.

Description: what were the hypothesis and key strategies?

Role of food:

Food is generally used as an incentive through NHDs (THR) to reach the unreached beneficiaries by bringing them to the AWCs to avail services like distribution of IFA, ANCs, immunization and counseling on breast-feeding practices. The CARE's allocation of food appears to be more than that prescribed by the government. A total of 18,415 MTs of CSB and 2,266 MTs of soyabean salad oil were allocated to the state. On the average, this would be adequate for about 65 beneficiaries per AWC. THR was regular. The acceptance of the food supplement was reported to be good. The Government of AP, it seems, recently reduced the number of beneficiaries per AWC to 58 from 84. There was also a concern expressed by the DWCD for sharing of THR by the beneficiaries. There is a possibility of tapering of interest in food. CARE-AP may have to document that adequate coverage is achieved with respect to services offered through NHDs.

Key Interventions:

- NHD included monthly distribution of THR, during which the ANM visited the AWC. The following activities are carried out: ANC, TT to pregnant women, distribution of IFA tablets, growth monitoring of children, immunization of all eligible children and counselling of mothers on child feeding.

- Growth monitoring is carried out monthly on all the children. While the growth charts are maintained scrupulously, prolonged growth faltering of children was observed in some AWCs. Such a trend was more obvious in the AWCs catering to the poorer segments of the population. It appeared that the functionaries were not properly equipped to handle the situation except for counselling, and required further training on this component. It also points out the need for close monitoring of the AWCs catering to the SC & ST communities where the extent of poverty and landlessness are high. Understanding growth curves is the *sine qua non* of growth promoting action. The impression is that basic ICDS training was inadequate in this regard. The INHP has fully not remedied the situation. This should be a **key area of action**.
- The Government of AP has introduced an innovation of creating a committee of mothers of the beneficiaries in each village for community mobilization, monitoring and assisting the AWW in carrying out her duties well. The members of mothers' committees are closely involved in the activities of INHP.
- The committee members send a post card, on which the activities of INHP are indicated as pictures, by scoring those that have taken place during the previous month for the purpose of monitoring the programme. These post cards are sent to the district ICDS office for information and follow-up action.
- The government both at state and district had concerns that the malnutrition levels among mothers and children were still high and felt that there was still considerable scope for improvement.
- The field staff felt that considering the field problems, there has been considerable progress with respect to organization of NHDs under INHP.
- It appeared that the common cultural beliefs of reducing intake by women during pregnancy still persisted.

Documented coverage, outcomes, impact, attribution

- At present NHDs are in operation in about 6,500 AWCs. Demonstration sites are functioning in 548 AWCs (4.4% of total AWCs) with community participation. As per the MIS for March 2001, 42% of the AWCs had NHDs during the previous month.
- The results of quantitative survey, which included 2404 index mothers from 151 AWCs, in brief were:
  - ✔ Though breast-feeding was universal, only 7% initiated breast-feeding within first hour.
  - ✔ About 36% squeezed out colostrum; half of the mothers had given some thing before the first feed.
  - ✔ EBF was reported in 40% of the children.
  - ✔ 53% of the children in the age group of 6-9 months had received semisolids.
  - ✔ Complete immunization was reported in 65% of 12-23 month old children.
  - ✔ Eighteen percent of children (12-18 mos.) had received first dose of vitamin A.
  - ✔ About 64% of the pregnant women had received IFA tablets; 26% received $\geq$ 90 tablets.
  - ✔ 61% had received THR and 16% had received on-spot feeding. Of these 89% had received for more than 3 months.
  - ✔ About 44% reported to have shared the THR. About 27.6% of the women reportedly reduced their intake during pregnancy.
  - ✔ In the case of children (6-24 mos.), 59.5% had received THR
- In the State, 11 NGOs (Vizianagaram: 5, Warangal: 3, Khammam:1, Srikakulam:1 and Vishakapatnam:1) are involved in INHP activities. At the time of survey, the team was informed that in the remaining 5 districts there are no NGOs involved in nutrition and health activities.
- Examination of records suggested high coverage under various activities of INHP like immunization, ANC, TT immunization, THR and IFA distribution.
- Food supply chain appeared to be smooth and there were no major problems. In all the AWCs visited had at least 2-month stock. In the AWCs visited, the food was stored under proper conditions.
- The extent of undernutrition reportedly has come down after the programme. As compared to non-INHP areas, the extent of undernutrition is lower in the project areas, though marginally.
- However, the achievement with respect to breast feeding practices has not been as per the targets. Inquiries with mothers and members of mothers' committees revealed that there has been considerable reduction in the practice of discarding colostrum. But, it appeared that the mothers were hesitant in adopting EBF as they felt that it would be difficult to follow the advice, particularly during summer.

Capacity building hypothesis and sustainability

- It appears that the programme has definitely contributed to improving the caliber AWWs. All the records were maintained up to date.
- The district administration felt that CARE staff contributed particularly in capacity building activities at different levels. CARE also assisted in the development of training for members of mothers' committees. Training of mothers' committee members was observed in one AWC. As per guidelines of the government 6 AWCs are included at the rate of 8 mothers per AWC. Mothers undergoing the training were quite aware of information on the components of INHP. In some instances, each batch had about 200 members making the training meaningless. CARE's intervention helped in reducing the number per batch.
- CARE has also helped in identifying and providing skills to a number of members of NGOs who in turn identified change agents and carried out their training.
- In the district of Vizianagaram, CARE officials also helped in training the students of M.SW course.
- CARE has assisted in identifying a group of capable AWWs as trainers so that they could organize training for community members from a cluster of villages.

CARE's Implementation

The Integrated Nutrition Health Programme in the state is being implemented in 10 of the 23 districts covering a total of 88 blocks (urban: 7, Rural: 55 & Tribal: 26) through 12,150 *Anganwadi Centres* (AWW) with a beneficiary population of about 7,87,700 beneficiaries. The key partners of CARE are the Government of AP (DWCD & DHFW), NGOs and the community. The Govt. of AP's establishment of mothers' committees in each village to large extent helps the organization in achieving its goals.

THR:

- In general, monthly distribution was practiced, though in some sites rations were being distributed biweekly so that two NHDs could be organized. Community reported that the distribution was regular and contributed to increase in participation of pregnant and lactating women, and under 2 children.
- The administration expressed concern about sharing of THR and thus not being a supplement. However, change agents and NGOs report that there is a gradual reduction in sharing of THR. In addition, surveys indicate that the food ration actually lasts close to the targeted time.

NHD:

- It contributed to joint working of AWW and ANM. There is recognition by the administration that this has considerably helped in increasing the access of health services provided by the ANM. However, the main concern is that the principal focus was only on NHD and the question remained as to what happened to the rest of 29 days of the month.

Coordination at different levels:

- There are regular joint review meetings at the district level under the chairmanship of the District Collector. In fact, these helped in sorting out some difficulties in coordination between MO (PHC) and CDPO at block level. One of the administrative limitations was that the geographic boundaries of PHC (*mandal*) and block were not coterminous. The Commissioner of Health and Family Welfare also highlighted this factor. There is a need for reorganizing the sectors and projects of ICDS so as to coterminous with PHC infrastructure. In addition, the health personnel were not able to participate in coordination meetings due to 'jobs of higher priority'.
- According to the NGOs, community mobilization in INHP and utilization of change agents did bring about behavioral changes leading to improvement of nutrition of vulnerable segments of population. Even, CARE staff believed that behavioral change is taking place where NGOs are working.
- Under INHP, CARE has used TIPS and recipe testing approaches in addition to developing IEC materials. Efforts were being made to educate community to consume recipes based on *ragi*; the District Collector participates in such endeavors. They are conscious of the increased behavioral change communications. There are attempts to obtain outside technical support for the purpose.

Technical interventions:

- While process variables may have achieved targets in quantitative terms, there is a need to lay emphasis on quality. For e.g., growth charts are not satisfactorily used as tools to identify growth faltering and subsequent management to reduce undernutrition in young children. The capacities of the functionaries at different levels require to be enhanced.

- Community mobilization, utilization of change agents for counseling and capacity building activities could be considered to be important components.

Community

- Involvement of community for counseling of mothers as change agents is a key component for ensuring sustainability. These change agents educate a group of women near their households. The Government of AP's initiative in creating mothers' committees is an opportunity for mobilizing community in the organization of health and nutrition programs. CARE is involved in the training of the mothers both directly and through NGOs.

Behavioral Changes

- Interviews with mothers indicate that there is a gradual decline in the habit of discarding colostrum by mothers. They are conscious of the advantages of feeding colostrum to infants. However, they are not yet convinced about EBF. There is a need to evolve suitable media strategy based on scientific communication methods.

Support systems

CARE structure, roles

- While the role of field staff and that of HQ are undoubtedly important, the present staff to AWW ratio does not really permit the field staff to be in close touch with the AWCs on a regular basis. However, the field staff should continue to play the catalytic and facilitator's role. The appointment of Partnership-Coordinator to concentrate on developing links with NGOs is an indication of the program's emphasis on community involvement.

Food

Commodity flow:

- Shipping documents received 15 to 20 days before ship arrival. Given to the state government for endorsement in favor of the state appointed CFA (Andhra Pradesh State Trading Corporation, or APSTC). A copy is sent to the Port Officer at Vishakhapatnam.
- The CFA arranges for the customs clearance etc to be completed; the surveyor (JB Boda) monitors the shipment on arrival for any shortages and damages to be claimed under marine insurance.
- If the shipment is received in barges has to be unloaded at the transit sheds; if received in containers, it is opened and given to the CFA. (A barge can carry up-to 8000 bags whereas a container carries 800 bags.)
- The sample for the PHO certificate is taken after one third of the barges are unloaded. In the case of containers the sample is sometimes even taken from the CFA trucks loaded from the container
- The CARE state office would, by then, have given the DA (dispatch advice) for the stocks to be cleared from the CFA warehouse to the blocks within 30 days in weekly desptach programs. The DA has the approval of the state government and is based on the inventory balance at the blocks and centers and a cut-off date with 3 to 4 months stock provision
- CFA is also the transporter for the port-to-block primary distribution. The secondary distribution of block to AWCs is done by a DA given by the CDPO through a locally appointed transporter (appointed by the District Collector and his committee). The permitted freight cost is 5 *paisa* per beneficiary per day.
- In AP, the INHP area has 10 districts, 88 blocks, (urban 7, rural 55 and tribal 26) covering 7.87 *lakh* beneficiaries, with commodity of CSB 18415 T and RBO 2266 T per year.

General comments:

- Assured food days are 300. Actual achieved are 280 – 285 days
- CRITICAL SUCCESS FACTORSs for commodity supply chain are: a) CFA contracts on time – the process now starts promptly in December and for a 2 year contract b) government should release funds for transport 3 months in advance – the reality is payment made 3 to 4 months after dispatch; and c) local transport rates to be in line with market – just now increased from 3p to 5p per beneficiaries.
- Carry Forwards (CF) have been decentralized to state for the past 2 quarters. For December quarter the CF would be based on March quarter stocks (this cannot be helped).
- No significant variance between budgeted and actual consumption across the supply chain

Inventory management:

- Stock norms across the supply chain are: block 2 months, AWC 2 months. Occasionally the CFA has to keep stocks at the port city also – today the port stocks are 40,085 bags.
- Equitable distribution of stocks across the blocks in ensured by working out the cut-off days of stock to be provided -- normally 100 days if stock report is received and 80 days if stock report not received.
- Quality and promptness of receipt of inventory data is almost 100 %
- The CF quantity is reflected in the TA (transmittal advice). The actual quantity dispatched is in the shipping documents – there is hardly a 5% variance between the two figures
- The number of shipments is about 30 to 40 per year – last year it was 37.

Planning process:

- LOP is the base for the entire planning of commodity. The availability in any quarter is not to exceed 25% of the LOP. CF should also not exceed monthly average requirements.
- Port to blocks DA from SMART unit at CARE state office.
- Blocks to AWCs – DA from the CDPO office.
- Frequency of feeding the blocks is monthly. Block to AWC is need-based but at least once a month.

Supply Chain lead times:

- The progress of the food from the port to the AWC is traced in terms of the number of days taken:
  - Port discharge : each barge 2 days; all 20-25 days; container 7days
  - Transit shed not more than 3 days
  - Phytosanitary certification csb 2-3 days rbo 7d
  - CFA warehouse not more than 30 days – usually 25 days (10 trucks per day)
  - Transit time to blocks: 30% of blocks can be reached in same day (in 4 districts), 40% of blocks are reached the second day, and the balance (30% of blocks) on reached on the 3rd day.
  - Storage at block warehouses (World Bank constructed) average 50 days
  - Block to AWCs – same day – ICDS staff accompany the consignment
  - AWC storage 2 months
  - TOTAL 151 days.
- CFA has never delayed truck placements at the port even in mango season.
- No demurrage charges have ever been incurred due to delayed clearance at the port.
- Service level of CFA and primary transporter measured in terms of quantity allocated per week vs. actuals, and by the DA specified time-line vs. actual movement – no variances.
- Shipments via barges average 30-40% and containers 60-70%. No shipment has both. Containers preferred as the damages are very low -- example: 2 bags out of 40,086 against 100 bags if via barge.

Supply Chain Costs:

- To track the cost incurred per ton across the supply chain for movement and storage:
  - Port cost
  - CFA cost at port town - Figures not available
  - Freight port to block – has gone up from Rs 1.29 per ton km to 1.50 per km average 350kms
  - Block to AWC freight 5 *paisa* per beneficiary per day
  - Unloading at block and AWC
  - ***The total supply chain cost for commodity for AP is: Rs 2169 per ton (about 10.8% of the food value).***
- Service levels of the movement is monitored by CARE – state government does not provide much initiative.
- From block the trucks pick up commercial loads on return – the DA is given in FTLs.
- The empty container sales proceeds with the CDPO is meant for godown maintenance etc at 75 *paisa* per bag and Rs 15 per pail.
- There is no excess loading of trucks beyond 400 bags.

- 90% of damages are collectible. Jul 2k to Apr 2001: damages were CSB 8613 kg and oil 1030 kg (including damages at the port).
- Stacking norms at the block are 15 – 16 bags high. At the port it goes from 20 to 30 even.
- At the port CFA has 2 exclusive godowns for CARE. At blocks it is exclusive to CARE.
- SCALA implemented only for financials. FOODAC package in use for commodity management.
- Port to block – each load is exclusive. For transport from block to AWC, the CDPO makes route plans, and return loads come back empty.
- GOI pays an administrative cost of around Rs. 97,41,775.

People Issues:
- Counterparts trained on commodity focus also. MIS on computers – pilot in 2 districts
- High level of awareness on importance of supply chain due to sensitization efforts – workshop for government officials, visit by port officials to a block and AWC to see the reality in the field.
- CARE district point person has special interest in commodity movement
- SMART unit has 3 people. FOs do not need to follow up much on stocks.
- Pre-monsoon extra needs are conveyed by the CDPO in advance – pro-active counterparts.
- AP State Capacity Building policy – CARE is an important contributor

Information flows:
- Excellent improvement in receipt of reports – almost 100% on time.
- No delays in ship arrivals – sometimes comes 7 to 10 days in advance.
- Already experimenting with handling IFA , PDA etc with the supply chain.

HMIS
- HMIS consisted of the prescribed survey of 3% of AWCs. The monthly report of the FOs appears to be more of an inflexible target oriented approach. On the other hand, this approach defines elements of program approach, which is apparently successful. Such an approach should not interfere with innovation. Considering INHP-II and keeping in view of the replicability, a flexible strategy will be required.

Staff and technical support
- FOs are the frontline workers of the program. They are dedicated and diligent with multifarious responsibilities and form an important pillar of INHP along with AWWs and ANMs other supporting staff. They have to be equipped with proper technical skills to transfer information on nutrition and health. They have excellent working relationship with the district administration and are identified by them as an important resource for capacity building and technical advice.

Organizational learning and diffusion
- The internal diffusion within the organization is mainly through exchange of personal experiences during the regular review meetings of Field workers. CARE also organizes workshops to discuss field strategies, experiences and plans for replication. Some of the activities like social mapping are not practiced in some of the areas visited, perhaps, due to the fact that the workers are still new to their jobs.
- External diffusion was attempted through reports. However, the district administration and the state officials should visit the INHP areas so as to appreciate the advantages of the project. This needs to be organized. It depends on the time available with the administration for the purpose. Organization of workshops closer to the areas of operation may be one of the approaches.

Capacity building and sustainability (exit strategies)

Capacity Building
- Though at the peripheral level there is good coordination, sometimes the government counterparts are not available for capacity building activities.

Community
- NGOs along with the ICDS - Supervisors and selected AWWS carry out the orientation programs for the community. Change agents strengthen these efforts by constantly counseling the mothers on different aspects of nutrition. The training of members of mothers' committees, established by the

Government of AP also contributes to building of the capacities of community. The CARE field staff also participates in these training programs.

Innovations

- For the purpose of monitoring, members of mothers' committee send a post card every month on which the events of INHP are indicated in the form of pictures. The mothers score the events that had taken place during the NHD to the district ICDS authorities for information and necessary action. This system appears to be working well in some of the areas.

Recommendations

- While the targets may have been achieved with respect to process variables, quality of services requires emphasis. An example is proper use of growth charts for nutrition promotion through identification of growth faltering. The front line workers need reorientation on this aspect.
- Feeding behaviors are difficult to change without persuasive community-based communication strategies. Focus group meetings with mothers to discuss and inform could be attempted.
- The FOs should be provided with adequate opportunities to upgrade their technical skills, particularly in the area of IEC to achieve best results with respect to feeding behavior changes.

STATE REPORT - CHHATTISGARH

Background Situation of Nutrition, Health, ICDS and INHP

Chhattisgarh state (formerly part of Madhya Pradesh, or MP) has high malnutrition and child mortality and morbidity levels. A large proportion of the population is living under drought conditions. Tribals are estimated to be about 32% of the population. Many communities though of tribal origin have adopted non-tribal life styles while retaining certain tribal beliefs. Perhaps owing partly to tribal influence, Chhattisgarh communities appear more egalitarian than elsewhere with regard to both caste and gender. They have proven to be particularly receptive to new ideas including family planning, immunizations, community monitoring of pregnancies, *bal bhojan* (community feeding of children), and other innovations.

The population density in Chhattisgarh is low making travel and follow-up cumbersome. Nevertheless, during the past few years, programs in some sectors have been able to produce results. De-centralization has been more rapid than some states such as U.P. The state of MP was recently divided (November 1, 2000) and Chhattisgarh State was formed. There is high food insecurity and some population segments have moved out of drought affected areas. In this transitional period, CARE implemented the INHP program from 1996-2001 with the aim of improving nutrition and health of women and young children in 16 districts of Chhattisgarh. While all but three of INHP's districts are in Chhattisgarh, INHP has maintained its state office in Bhopal, nearly a 1000 kilometers from Raipur (Chhattisgarh's new capital) in order to facilitate overall management of CARE/Madhya Pradesh activities as well as communication with the state government. CARE is now in the process of creating a separate state office in Raipur. Health and nutrition indicators for undivided MP are worse than India (NFHS-II), and Chhattisgarh is likely to be worse than MP.

Description: ICDS/INHP hypothesis and key strategies

The development impact objectives of the ICDS program has been adopted by MP/Chhattisgarh:

- To improve the nutritional and health status of children 0-6 years of age
- To lay the foundation for proper psychological, physical and social development of the child.
- To reduce the incidence of mortality, morbidity, malnutrition and school drop outs.

CARE's IHNP focuses on the nutrition and health impacts among pregnant and lactating women and children below three years of age, using food as an incentive to draw target groups to the AWC for health services and nutrition education. At the same level of importance, CARE emphasizes that capacity building for institutions and individuals to sustain improved behaviors is equally important.

Role of food
CARE provides about Rs. 50 *crores* worth of Title II food commodities (Corn Soy Blend and soybean oil). The food is used in two ways to support the INHP program:

- As an incentive for families to attend health services activities conducted at the Anganwadi centers, and send their preschoolers (3 to 6 years) for early childhood development activities.
- As leverage at the State and Block levels to bring about systems strengthening and adoption of effective strategies (e.g. Nutrition and Health Days, Take Home Rations, community participation).

Because of the magnitude of CARE's inputs that cover 117/152 blocks in the state, it can exercise considerable influence over the operation of the ICDS program.

Key interventions
CARE's INHP aims to achieve high coverage with the following:

- Targeted supplementary feeding
- Iron/folic acid supplements
- Immunizations (childhood and TT)
- Infant feeding practices (early initiation of breastfeeding, exclusive breastfeeding, and appropriate complementary feeding).

The program uses several approaches to operationalize these interventions at scale:

- Convergence of health and ICDS activities at the AWC one day a month
- Community awareness and advocacy for nutrition, feeding practices, and AWC activities
- Nutrition and health education through community organizations e.g. Mahila Mandals and NGOs
- Grants to NGOs to increase community participation
- Development and promotion of community-based monitoring tools
- Use of innovations at demonstration sites that function as training sites for diffusion among adjacent communities.
- Advocacy and collaboration at State, district and block levels

The capacity building hypothesis and sustainability
CARE emphasize the need for building adequate capacity among counterpart institutions and at the community level to:

- Assure continued management efficiency and health/nutrition benefits to the population beyond CARE's tenure
- Achieve ownership, mobilize community resources, and focus on community priorities
- Implement effective behavior change activities (key for achieving nutrition and health impacts)

Evaluation Methodology
Existing reports from the baseline, mid-term and recent quantitative survey reports were reviewed. Discussions were held with key informants, focus groups were conducted with CARE staff and observations/record checks were conducted in center visits.

Dr. Neelam Bhatia, of the National Institute of Public Cooperation and Child Development (NIPCCD), joined two members of the core team for the visit to Chhattisgarh. The team met with the state Director and INHP Manager (both based in Bhopal), with all three Field Coordinators, and 9 of 23 Field Officers. In addition to conducting extended focus group discussions with Field Officers and Coordinators (three separate groups in total), we also interviewed:

- The Chhattisgarh Additional Secretary for Women and Child Development and for Rural Development, and the Medical Director for Health
- One District Collector and DM
- One District Child Development Officer
- Two CDPOs
- AWW Training Center run by NYK, Rajnandgaon
- Approximately 10 AWWs

- Members of two Mahila Mandals and Self Help Groups
- 5 ANMs
- 3 NGO representatives – Sankalp, NYK (2)
- Numerous beneficiaries, primarily at Anganwadi centers

We also visited 10 Centers in 3 blocks of 2 districts, and observed 1 Nutrition and Health Day, and Mahila Jagriti Shivir.

Documented coverage, outcomes, impact, attribution

The basis for these observations on INHP impact is a combination of baseline versus final household surveys conducted in 1996 and 2001 respectively, observations of AWC and community perceptions in CARE and non-CARE AWCs, and discussions with ICDS officials on how CARE has made a difference.

Note that comparisons between "Demonstration" and "all" sites should be treated cautiously since the state quantitative assessment shows clearly that the former benefited from more educated AWWs and other favorable socio-economic factors, even before selection for demonstration.

INHP's impacts can be summarized as follows:

- ANC coverage improved from 29% in 1996 to 39% in 2000 (compared with 28% NFHS-2)
- Two TT doses increased from 50% to 59% (55% NFHS-2)
- 90 or more IFA tablets increased from 4% to 29%
- Immunization coverage increased from 4% to 42% (22% in NFHS-2)
- Infant feeding practices improved: feeding , 8 h post-partum increased from 42% to 56%; EBF for 4 months increased from 36% to 61%; % of infants 6-9 m. fed complementary foods increased.

Direct observation of CARE and non-CARE sites confirmed that CARE assistance has improved community participation and ownership, engaged community members in key behavior change activities, achieved convergence with health staff (ANMs), and begun the process of replicating innovations beyond a few demonstration sites.

External factors that helped CARE inputs translate to results include good governance, stable and active village institutions (e.g. development of Mahila Mandals over several decades through successive rural development programs). Joint meetings at state, block levels.

'Forward planning' are advocacy and partnership building guidelines developed for FOs that helped guide field implementation of these critical activities. This clearly defined the role of FOs as direct or indirect implementers, identified key stakeholders and how to approach them, suggested activities and provided guidelines on how to implement them (e.g. health and nutrition camps).

Block social and resource mapping (as compared with village level mapping) helped optimize the use of relatively few FOs in charge of a large number of centers. To build sustainability and best utilize scarce staff, CARE decided to use block level resource maps as a tool for convergence with health and ICDS, and for better planning/targeting certain geographic areas.

CARE's Implementation

Big picture, key actors, partners, evolution over 1996-2001

INHP serves 117 of Chhattisgarh's 152 blocks, a share so large that one state official asked the evaluation team to recommend that they take over the remainder as well. The state CARE office, not yet fully established, works with 4 major NGOs (Nehru Yuvak Kendra, Douglas Memorial, Sankalp, and CLEAR) as well as with three state departments (Women and Child Development, Rural Development, and Health). The Panchayati Raj System at the village level is involved in the program, and other community structures such as Self-Help Groups.

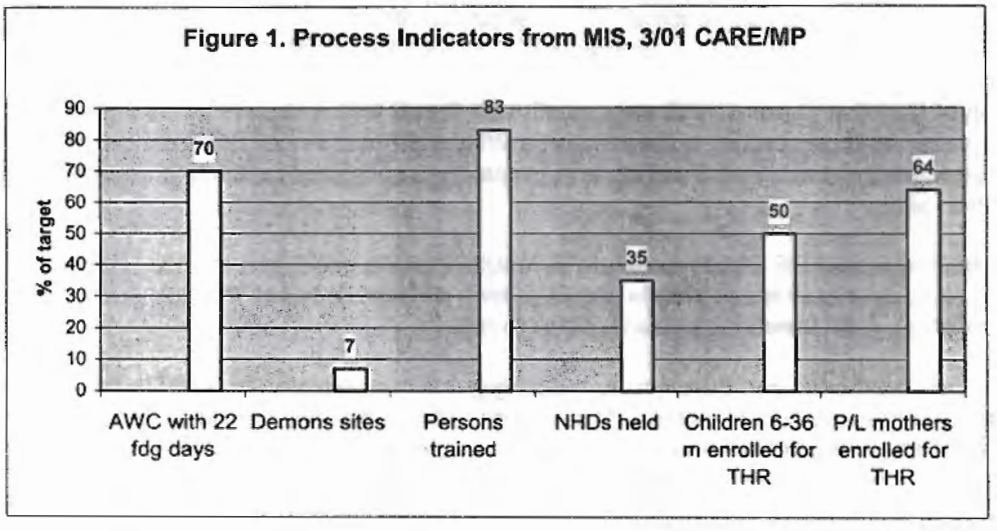
State nutrition policy has been adopted and Chhattisgarh is preparing plans for implementation of district nutrition plans. A Field Officer from CARE is a member of the committee. Other donors include: UNICEF (water and sanitation, drought assistance), WFP (food security), AUSAID (drought), DANIDA (livestock).

Other CARE projects include MISP (in old MP local food to replace imported food through local women's groups in 5 blocks, CIDA funded), POP-RH in urban slums of Jabalpur (143 slums, adolescent girls, holistic, UNFPA-funded), OK TATA (AIDS awareness, DFID and Elton John Foundation, in Raipur), Credit (women's micro-credit, in Bastar, WFP-funded). INHP covers 16 districts and 117/152 blocks. AWC =15,771; beneficiaries = 950,000; CSB MT 22463, oil MT 2765.

Role of CARE:
- Provision and monitoring of food in 75% of AWCs
- Bring about convergence in key services at community level
- Secretary. RD - Small research projects for building up a data base on priority needs and what works.
- DM/DC recommended that CARE should expand to backward areas and urban slums. CARE should help Govt. in making AWC as Shakti Kendras (centers of strength for behavior/social change). Ongoing sensitization of government to the problem of malnutrition is a role that CARE can play.

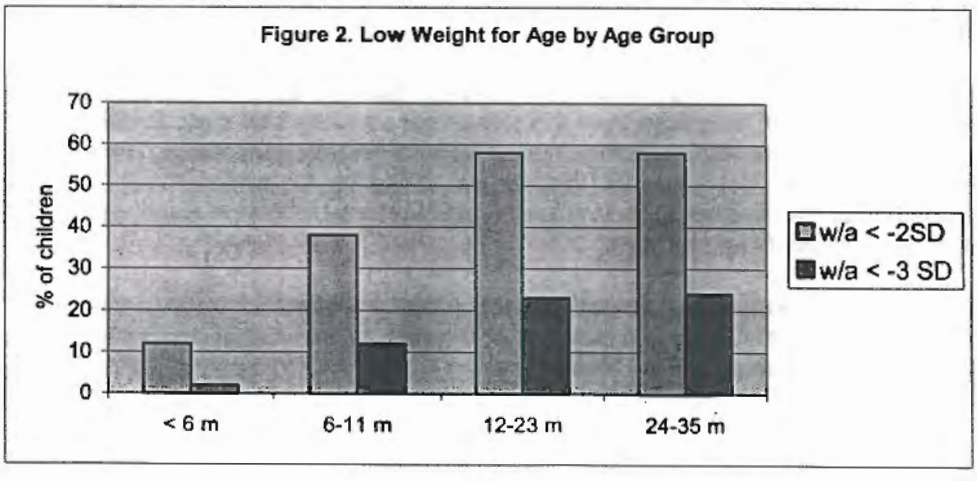
Implementation against plan and expenditure against budget
The actual beneficiaries as compared with targets is unusually low, raising questions about the intention of AWW/CDPOs to increase beneficiaries since it would take away from their food stocks. LOP commodity supplies are based on negotiations between CARE FOs and CDPOs, not on actual attendance. An example of the level of functioning versus planned targets is shown below -- some targets are being met and others are having difficulties.

Figure 1. Process Indicators from MIS, 3/01 CARE/MP



Technical interventions
The expansion of the 0-2 age group to 0-3 is appropriate given high levels of malnutrition in this age group. See Figure 2.

Figure 2. Low Weight for Age by Age Group



Interventions
In one AWC center (Paton Road-Salood), activities for every Tuesday were organized to assure the implementation of the interventions as follows:

1st Tuesday: Distribution of THR
2nd Tuesday: Meeting of Mahila Mandal
3rd Tuesday: NHD and immunizations
4th Tuesday: Nutrition and health education

This appears to be a general practice in CARE blocks. Thus INHP runs once a week and preschool education daily at AWCs.

- Targeted supplementary feeding

CARE provides food for about 75% of the ICDS centers. It has been effective in assuring commodities reach blocks and AWCs through support provided in commodity management and field monitoring. The main difference observed in CARE-assisted blocks as compared with non-CARE ICDS blocks was that wheat grain plus soy flour is provided in non-CARE sites, and the soy flour was being sieved out in both centers visited.

In the basic model being implemented, the role of the food appears to be as an incentive to draw families in to the center for health services and health/nutrition education. It also provides an important in-kind transfer for food insecure families through THR distribution. In some sites, the THR food may be shared with other family members so the direct impact on key target age groups can be limited. Where NGO and community activities were strong and emphasis had been placed on the importance of the pregnant and lactating women's diet, the team found that sharing among other family members appeared not to be a problem.

The ration sizes are: infants 6-36 months 65 g.CSB and 8 g. oil; pregnant and lactating mothers 130 g CSB and 16 g. oil; helper and AWW same as mothers; malnourished children same as mothers.

- Iron/folic acid supplements

ANMs had sufficient stocks of IFA, and the distribution and consumption was reportedly implemented according to GOI guidelines (100 mg elemental iron tablet per day for 100 days per pregnant woman). However, anemia levels are very high in M.P in young children (75%) but the focus is exclusively on anemia prevention among pregnant and lactating women. This appears to be a gap that should be addressed urgently through ICDS/health collaboration. Iron supplementation for young children combined with bi-annual de-worming (with vitamin A supplementation) is a relatively simple intervention with potential high payoffs for health and nutrition.

- Immunizations (childhood and TT)

The potential for improving immunization coverage particularly in non-demonstration sites needs to be examined. THR, NHD and convergence fostered by CARE appears to have increased immunization coverage in the enrolled beneficiaries. AWW, helpers, change agents (e.g. adolescent girls) actively promote immunizations in their enrolled groups and AWW monitor coverage of this group.

- Infant feeding practices (early initiation of breastfeeding, exclusive breastfeeding, and appropriate complementary feeding).

These components were weak and not well developed in all sites. In some demonstration sites AWWs have received communication tools and have received some orientation on the importance of these behaviors, however, the AWWs that we observed did not appear to be using these tools.

A common incorrect message being given is to feed *dal* water to infants from 6 months of age. AWWs did not know the adequate amount of foods or the principles of FADU (frequency, amount, density and utilization or hygiene) for adequate complementary feeding. Scales were not present

in many AWCs. Where scales were available, growth monitoring/promotion is not being used to support improved infant feeding practices (the common message for a case of growth faltering is to send the child to a doctor).

A major effort is needed urgently to develop a strategic approach to behavior change that reaches not only mothers but other influential members of the community, and is based on a deeper understanding of constraints and motivations for practicing desired behaviors.

Implementation processes

The main implementation processes are:

- Assuring delivery of food commodities to over 15,000 AWCs. This is done through a set of elaborate planning and monitoring mechanisms.
- Developing and replicating innovations through demonstration sites. Demo sites have Take Home Rations for pregnant and lactating women and children < 3 years. To initiate THR, training and community sensitization is conducted. CARE uses a 1-day agenda for block and community level functionaries. Adolescent girls are engaged as change agents and given 2-days training on THR, immunization and prenatal care. Bastar does not have NHDs/THR and some central Chhattisgarh blocks (non-CARE) also continue with daily supervised feeding.
- NHDs: This combines one THR distribution per month with provision of health services e.g. immunizations by the ANMs.
- Convergence: Resource mapping at the block level (village level not feasible for direct CARE involvement) by health and WCD departments – MO and CDPO. Then activities are prioritized and action plans prepared. These maps are universal in CARE blocks. The maps illustrate facilities, maternal deaths, epidemics, cut-off and low immunization status areas, etc., and effectively served as "geographic information systems without the computer" . This tool emerged from the push to convert all areas to CB with no increased staff, after the mid-term review.
- Planning and implementation of Nutrition and Health Days
- Developing and financing NGO sub-grants for community mobilization
- Information systems and monitoring
- Capacity building and training for AWW, CDPOs, ANMs.
- Evaluation and documentation

Community

- Bal Bhojan: Community food contribution and cooking for children. Traditionally occurs once a year after the harvest, but is now being promoted more frequently as a way of increasing community contributions to the INHP.
- *Anna Prashan*: Initiation ceremony made into a festival once a month by AWW and by active **Mahila Mandals** Mothers bring food and feed each other's child. Started in Rajnandgaon and now accepted throughout MP. Implemented in about 50 to100 blocks regularly, based on ICDS GO in 1997. Developed by CARE as part of High Impact strategy.
- Community based monitoring based on exterior wall drawings, started by SANKALP 'the *chand aur suraj* model' for self monitoring.

CARE does not work directly with communities but supports community mobilization through NGOs. The main NGOs are:

- Nehru Yuva Kendra has 40 blocks and uses government-subsidized workers, who want to work on nominal wages. NYK raises funds from other donors as well. Each cluster of 60 villages has one CARE funded functionary at Rs.600/month. This individual forms community groups, sets up one demonstration site per 10 villages and facilitates diffusion from the demonstration site to surrounding villages. Total CARE outlay = Rs. 20 lakhs

- Sankalp = 2 blocks Rs. 5 lakhs. This organization specializes in local theatre groups, awareness raising, and advocacy. The NGO Sankalp has trained numerous community change agents and guided them to establish and/or upgrade numerous Mahila Mandals and self-help groups. While these are both

statewide initiatives, Sankalp's facilitative support has led to rapid growth. Change agents serve 12 AWCs each, including one demonstration site and 11 replication sites; as a result, cross-fertilization and spread of new approaches has been direct and immediate.

- Douglas Memorial = 2 blocks Rs. 2 lakhs
- CLEAR = 10 blocks (mother NGO with 6 grassroots organizations) Rs.10 lakhs

This component appeared particularly strong in Rajnandgaon district. The program is attempting to engage Mahila Mandal more actively in managing INHP food distribution, which may introduce greater transparency in the AWWs handling of food stocks.

Behavior Change Strategy

The evaluation team did not find a comprehensive behavior change strategy for INHP/Chhattisgarh. The team did find a number of well developed and implemented IEC activities; however we could not assess whether these were the most effective, reached the key audiences, reached scale, or resulted in behavior change. The team recommends supporting field staff to better understand the importance of certain audiences and channels of communication, and the role of social norms/how to bring about changes at the societal level working with community influentials. As in other states, some of the appropriate activities for behavioral change are in place but the use of an analytical framework would help. This framework should be based on formative research and feedback on existing CBC activities, and should describe motivations/constraints for key behaviors, key audiences and channels, messages and materials. This is needed urgently for the +3 interventions to work.

Support systems

CARE structure, roles

As noted, CARE's Bhopal office has served Chhattisgarh until this time, though the office appears likely to be relocated within the next month. Three Field Coordinators work from district offices.

Food

State ICDS policy is to serve all eligible persons, with no requirements to be below the poverty line. The final quantitative assessment for INHP/Madhya Pradesh (largely Chhattisgarh) showed that only 59% had received food in the last month (Table 5.5.1), of whom 28% had received enough for only one to six days. Only 10.6% of children consumed AWC food for as many as 7 days; 75% of target age children reportedly did not consume any INHP food.

There are occasional food shortages due to AWCs cut off with rain flooding. Attempts are made to supply these centers with 3 month stocks. In non-CARE sites, broken wheat with soy flour is provided. But two AWCs visited sift out the soy flour due to foreign particles. There is no oil added so caloric density is lower than CARE food. AWW keep this food in their home and prepare some quantity each day for participants.

HMIS

We were unable to obtain information on use of HMIS data.

Staff and technical support

The most critical staff for INHP are the AWWs, CDPOs, ANMs and CARE field officers.
There is not a resource for technical support and oversight in critical functions. Field Officers: The roles and responsibilities need to be re-oriented to support the INHP model (see below).

Organizational learning and diffusion

INHP/Madhya Pradesh has developed a newsletter for internal (as well as presumably external) dissemination of creative new approaches. There is some evidence that this has been distributed more widely within CARE/India since community monitoring approaches developed in Chhattisgarh appear to be known elsewhere.

Internal
Diffusion of best practices within INHP is stronger than across INHP-RH and other projects. For example, the adolescent girls activities found successful in Allahabad have not yet found a place in the Chhattisgarh IHNP.

Innovations in Chhattisgarh are likely to be of value in other states. CARE/HQ staff provide the channel for communication across states. Field officers appear keen to learn from each other, going so far as to suggest that FOs pair with each other.

External
As noted, CARE dominates the ICDS scene in Chhattisgarh, supporting 75% of all ICDS blocks. Many CARE-initiated community activities (bal bhojan, chand and suraj monitoring tools, involvement of mahila mandal) are now state policy. The designation of community change agents to serve both demonstration and non-demonstration sites has also facilitated replication.

Innovations
- Block resource mapping or joint planning between ICDS and health staff, better targeting and improved convergence.
- Community groups sponsor bal bhojan (child feeding sessions with locally donated food)
- Anna Prashan (a traditional ceremony marking introduction of weaning foods). These have now been replicated widely throughout Rajnandgaon, and, per state policy, throughout Chhattisgarh.
- Folk media such as theatre groups, processions; Jan Chetna rallies for awareness generation.
- CARE-supported workers initiated and widely replicated so-called "moon and sun" and 'sakhi saheli kalash', 'suraj mukhi' tools which enable pregnant women to monitor the status of their progress toward safe delivery; these are painted on walls enabling the entire community (including ANMs and AWCs) to verify that women have obtained necessary TT shots and antenatal checkups and are taking IFA. (We asked whether someone might record actions not actually taken, and our shocked respondent said, "of course not!")

Capacity building and sustainability
ICDS and health counterpart agencies: Joint problem solving and training at all levels have been used as a means to build counterpart capacity. The block resource mapping activity has also helped transfer strategic planning and coordination skills. However, State officials did not entertain the idea of CARE phasing out completely. This is a new State with substantial organizational development still to come. CARE is highly regarded for its efficiency, independent observations and feedback from field level to key officials, and for technical capability.

AWW: Are trained on-the-job for 48 days plus 12 day's field placement. They are then sent to their projects for 4 months, and another orientation for 20 days.

CDPOs: Have 2 months on-the-job training with 15 days field placement.
Supervisors are in short supply in Chhattisgarh (their training is for 2.5 months).

The evaluation team observed gaps in technical capacity in nutrition/health and behavior change; and advocacy for nutrition to high levels in State and District offices.

Community: NGOs carry the bulk of the responsibility for engaging and supporting community leaders and groups to increase their participation and ownership of INHP activities. NYK conducted training/workshop for 18 AWWs from other demonstration sites, and trained teams of 6 key village functionaries (core groups) from 6 villages surrounding the demonstration sites to foster replication. *Mahila Mandals* have gained from workshops and 'learning by doing' in a number of AWC villages. Missing among key activities is advocacy in nutrition/health for *panchayats*.

Gender equity issues
We asked CARE's sole female Field Officer why others had not been hired and were told that jeeps were difficult to drive due to long distances and lack of power steering. Married women also found it difficult to

work away from their families. Emphasis on adolescent girls and special messages to improve the care of girl children are important aspects that were not emphasized in CARE's work as technical advisors.

Recommendations

1. Targeting
   - Review of why children < 3 years and pregnant and lactating women are not collecting their THRs. Can hamlets without an AWC be included in the NHDs of the nearest AWC?
2. The "core/minimum/basic package" of interventions.
   - Greater focus on the +3 (infant feeding) interventions.
   - Quality standards, routine self-assessment, team problem-solving.
   - Linkages with other rural development activities particularly in food security.
   - Nutrition education based on home food – not only center food; and better use of growth monitoring as a tool for behavior change.
3. Role of CARE:
   - Develop future role of FO teams as district level technical advisory and assessment unit for nutrition and health improvement for women and children; staff up accordingly to deal effectively with DM/DCPO/CMO level counterparts.
   - Technical assistance beyond CARE/food blocks e.g. State/food blocks.
   - Advocacy and data use to generate awareness at high administrative levels and general public awareness.
   - Develop priority issues topics based on real field constraints and suggest innovations for testing.
4. Field Officers/Field Coordinators roles: Examine the possibility of replacing FC positions with technical experts (e.g. nutrition/health, behavior change, OR/evaluation/documentation); more infrastructure support, especially an office at district level (the new state office is to be located in Raipur). More technical support from CARE/HQ. Teamwork among FOs in each district should be developed and supported. Current redundancies in FO/FC/PA tasks should be re-examined. Re-orientation of FOs on health/nutrition and behavior change principles, approaches and common pitfalls. Incentives and motivational activities should be conducted to support good performance and encourage innovations.
5. Balance monitoring activities to better reflect emphasis on health, community, capacity building interventions rather than predominantly food commodities. Use of feeding behaviors and growth monitoring data should be explored.
6. Develop in-house capability in nutrition/health and behavior change.
7. A systematic replication strategy for the community components needs to be developed, and consistent support provided by NGOs across all blocks. For this NGO strengthening may be needed. Some activities are already being diffused and capacity is being built. Documentation through written and video formats, and cross-site visits have been identified as promising components. Scheduling and micro-planning need to be done.
8. The behavior change experiences in Chhattisgarh need to be assessed and a comprehensive strategy built on these experiences.
9. Anemia control interventions should be extended to young children.

JHARKHAND - STATE REPORT

Acknowledgements and thanks

The CARE external evaluation team of the INHP Project – Dr. Alfred Bartlett and Dr. Subhadra Seshadri - along with GOI official Dr. Saroj Adhikari, visited nine *anganwadi* centers in four blocks in the Gumla and Lohardaga Districts of Jharkhand from May 13-16, 2001. During these visits, they were accompanied by State Government representatives from Health, District level officials from Social Welfare including District Program Officers, and CARE's field officers. The team met with numerous district-level representatives of Health and Family Welfare and ICDS including the Civil Surgeon of Gumla, the Medical Officers of ICDS Blocks, and the CDPOs and Supervisors of the ICDS program. The team also had the opportunity to

meet with civil authorities including the District Collector and District Administrative Chief in Gumla and the District Deputy Commissioner in Lohardaga.

At the State level, the team met with the Health Secretary and the Director of Social welfare. The Minister for Social Welfare was the chief guest at the debriefing session, providing the opportunity to interact with her on several issues related to INHP.

In addition, the team interviewed:

- community members participating in INHP – mothers, adolescent girls, animators, field workers, and children;
- grassroot health and ICDS workers – *anganwadi* workers, ANMs, LHVs, and Lady Supervisors;
- ICDS and Health Block officials – MOs and CDPOs;
- cooperating partners – NGO representatives and community workers.

The visit was divided into three parts. On the first day, the team met with all CARE field coordinators and field officers, and continued this meeting into a larger meeting with CARE, government, and NGO staff. During this larger meeting, the team received a briefing on INHP from the state project manager, followed by discussion. Days 2 and 3 were spent in field visits. Day 4 included final meetings with state and CARE officials, followed by debriefing.

The team was ably assisted in this complex endeavor by Mr. Mukesh Kumar, the INHP Manager, and his entire team. The CARE State Director was away, returning on May 16; before the team left, they had the opportunity to meet briefly with him.

The team's sincere thanks go to the CARE team, their government and NGO counterparts, and especially to the *anganwadi* workers, ANMs, women's groups, and residents of the villages visited, for an extremely interesting and informative visit and for the warmth and hospitality experienced.

Background Situation of Nutrition, Health, ICDS and INHP

Jharkhand, formerly a part of Bihar, became a separate state in 2001. Of the 24 districts in undivided Bihar, 17 were retained in Jharkand; these were reorganized shortly after the formation of the new state, into 22 districts. The INHP districts left in Bihar after bifurcation were dropped in April 2001 in favor of covering all 152 ICDS blocks spread through the newly constituted state of Jharkhand. CARE/Bihar shifted their headquarters from Patna in Bihar to Ranchi, the new capital of Jharkhand, and now covers 21 out of 22 districts (the left-out district has no ICDS program).

According to the 2001 census, the total population of Jharkhand was 26,909,000, spread over an area of 173,000 square kilometers. The sex ratio is 941 females to males, an upward trend from previous censuses. The literacy rate among males is 67.9 per cent, and among females 39.4 per cent; this female literacy rate is the lowest in India.

According to the 2001 NHFS II, the nutrition and health status of women and children in Jharkhand (taken as part of Bihar) is very inadequate. Among children under three years of age, 54 per cent were undernourished. Only 11 per cent of children 12-23 months were fully immunized against the six basic vaccine-preventable diseases. Only 15 per cent of children were introduced to any complementary foods by the age of 6-9 months. Prevalence of anemia among women was high (63 per cent), while receipt of iron-folic acid under the national anemia control program was reported by only 24 per cent.

The ICDS program in Jharkhand covers 21 districts, which include 152 blocks, all of which are covered by INHP as of March 2001. These blocks include a population of approximately one million.

The INHP, initiated in 1996, was in its final year of operation in May 2001 when this team made its visit to make a qualitative assessment of the process and impact of the project.

Hypothesis and key strategies

- According to the project team's own initial briefings, there are two principal strategies:
  a. Improving delivery of food and non-food inputs (supply side); and,
  b. Strengthening demand for services (demand side)

  However, on further discussion, it is clear that the second strategy goes beyond demand for services such as immunization and IFA, to include broader behavioral change, especially around the three child feeding behaviors (the "Plus 3").

- To operationalize these strategies, the project has employed the following approaches:
  a. Needs-based food allocation to improve coverage of the eligible population through a survey
  b. Take home rations [THRs] (versus site-based feeding) for pregnant and lactating women and children under age two
  c. Distribution of the THRs through Nutrition-Health Days [NHDs] providing an incentive aimed at converging ANM-delivered health services, food distribution, and *mahila mandal* activities
  d. Supporting this convergence through coordinated planning, monitoring, and problem solving at the block, district, and state levels
  e. Community level "capacity building" through identification, training, and support of "change agents," NGOs, and adolescent girl groups and through organization/strengthening of *mahila mandals*
  f. Partnerships (sub-contracts with institutional strengthening dimensions) with local NGOs, in order to carry out this community-level mobilization
  g. Development of "clusters" of 4-6 villages and formation of cluster coordination committees, to provide diffusion of experiences and mutual support among *anganwadi* workers and *mahila mandals*

- Role of food / focus on nutrition: The design and approaches actually give two major roles to the donated food component of the program:
  - Food is still seen as a nutritional supplement aimed at the ICDS target population (pregnant and lactating women and children under two in neediest families); in fact, two of the program's innovations – needs-based allocation and Take-Home Rations – are aimed at increasing the effective targeting of this food component).
  - Food is also seen as the key incentive and focus that is responsible for the success of the Nutrition-Health Days, the ANM-AWW collaboration, and increased demand for and utilization of the "supply side" services.

However, project staff express varying degrees of confidence – or lack of confidence –that the food can work to improve nutritional status of the target population, noting factors like the probable sharing of the take-home ration and the basic inadequacy of dietary intake of that population. When probed, this lack of confidence in the potential for nutritional impact goes beyond the issue of impact of the supplement. There is actually skepticism about the project's ability to realize nutritional change. While the project and staff do embrace the "3 plus 3" set of interventions, the success of "food as incentive" has to some degree overshadowed the potential for nutritional impact. Thus, there seem to be three simultaneous currents of thinking that have not been argued through to consensus:

a. Continue to emphasize "food as incentive," capitalizing on the operational success of this approach and expanding other service and community level interventions (like vitamin A, treatment of ARI and diarrhea, neonatal health, adolescent girls' activities, etc.);

b. Accept the premise that maternal and child malnutrition are "multifactoral" and that only multi-sectoral actions will make a difference (i.e., move toward broader-based integrated rural development); or,

c. Since the three child feeding behaviors in the current package – along with the supplementary food - <u>are</u> the keys to achieving near-term (post-birthweight) best possible

nutritional status of infants and young children, further emphasize the development and evaluation of project interventions to effectively induce these key behaviors.

All of these attitudes seem to co-exist within the project – and as a result, there is not a clear commitment to any one of them.

The best existing global program experiences with improving nutritional outcomes use many of the elements that INHP has put in place: community level information with group support and the development of a normative change, direct communication with mothers, use of key intermediaries (like dais). We saw community-level evidence and heard anecdotes suggesting that behavior change in the Demonstration Sites either is happening or can happen with some additional (and feasible) program inputs. However, there is not a mechanism in place to pursue this vital question in terms of whether behaviors (and ultimately nutritional status) are changing.

Documented coverage, outcomes, impact, attribution

- The Bihar (mostly Jharkhand) INHP end-of-project survey revealed coverage rates of services that substantially exceed the NHFS data for the state (for example, fully immunized child rates of 33% in project areas, versus 11% statewide from NHFS II). In addition, for some variables (such as receipt of ≥3 ANC and THR during pregnancy, receipt of IFA tablets, early initiation of breastfeeding, and full immunization) the end-of-project survey seems to indicate increasing outcome effect with increasing program effort (CB and HI sites compared with BN and FM sites). These findings suggest, but do not prove, that CARE inputs have contributed to increased coverage for some interventions – particularly the "supply side" services like ANC and immunization.

- The final evaluation report allows only comparison of the amplified sample of Demonstration Sites with "All Sites." In this comparison, the nutritional status in the Demonstration Site sample is actually lower. This may not be a meaningful comparison, since there is no baseline in the amplified DS sample; in any case, the DS approach (as opposed to HI and CB) is likely to have been operating too short a time to yet see nutritional impact, even if feeding behaviors are starting to change.

  However, this comparison does underscore the point that we do not currently have objective data to conclude that the INHP nutrition behavior change approach is working in Jharkhand... or anywhere else.

- Qualitative information from multiple sources, at all sites visited and at all levels – from state to district to block to community – are unanimous in reporting that coverage rates for these "supply side" interventions have been substantially improved. Anecdotally, health outcomes like cases of measles, frank eclampsia, and severe malnutrition coming to hospital and prevalence of anemia in women are also reported by some sources to have been reduced. This is unanimously attributed to INHP's inputs, especially the operational linkage of ICDS and HFW, the convergence of ANM and AWW around the NHD, the quality-related inputs (such as AWW training) that INHP has provided, and the community mobilization it has supported.

- "Capacity building" of the community, in the form of mobilization, organization, and technical inputs (all provided through NGO partners) are clearly a key element of the approach. CARE staff and their partners are deeply committed to this approach and believe it to be an essential element of the project's successes. Even government officials at high levels (such as the district Deputy Commissioner in Lohardaga) were now convinced that this community element was essential for health and nutrition impact among their population.

- In sites visited, the capacity building inputs had been vigorously taken up, with women's and adolescent girls' groups increasing in activities and confidence, greater linkages to services, and spontaneous formation of new women's groups.

- AWWs in CB and especially demonstration sites were clearly better able to organize their activities and counsel mothers than in non-INHP sites, and had better (but not ideal) use of growth information. While the direct effects of capacity building at the system level were not observed on the health side, both district medical officers and higher government officials stated that the technical inputs of INHP had increasede the capacity of ANMs, supervisors, and medical officers.

- CARE has taken this element a step closer to sustainability and to self-replication through the "cluster" concept, in which an average of 4-6 AWWs and villages form a cluster led by one AWW selected by the group for competence. These AWWs form support teams within their own villages, and cluster team members from all villages meet on a regular schedule (in rotating sites) to exchange experiences and provide mutual support. This approach seems to be enhancing the diffusion of technical inputs from the Demonstration Sites to other sites within the cluster, and enhancing the empowerment effect of the capacity building process.

CARE's Implementation

Big picture, key actors, partners

- The partnership among CARE, DWCD, and HFW appears to be solid, welcomed, and functioning at all levels. CARE has apparently been conscientious in directing their inputs beyond food to facilitation, catalysis, and capacity building (avoiding the temptation to provide services or commodities absent from the system. Thus, their focus has been on making the partners' systems and services work better. In turn, government partners explicitly appreciated these "software" inputs, recognizing their own responsibility to provide the "hardware."

- The partnership forged among ICDS and HFW seems to be nearly institutionalized at most levels, and there is reasonable confidence that it will be sustained. CARE expressed some concern that, without CARE facilitation, coordination mechanisms at the block level – a key level at the interface between administration and implementation – will be harder to sustain, since there is no clear convening authority at that level.

- The block level is the intersection between administration and implementation. Technical capacity actually seemed relatively weak at this level. This may be one point for quality improvement activities to focus.

- There are reportedly positive working relations and coordination between INHP and UNICEF, the World Bank, and other agencies working in related programs. However, we did not have the opportunity to meet with these partners.

Implementation against plan and expenditure against budget

- There were no grossly perceived areas where program implementation or expenditure appeared to be inadequate to maintain program activity. However, although we asked for this information, it had not been provided by the time we left.

Technical intervention:

Interventions

- As noted above, the three "supply side" interventions appear to be benefiting substantially from INHP. In addition to the evidence cited above, visits to non-INHP ICDS anganwadi centers revealed that coordination with ANMs was attempted to some degree but not facilitated, with probably lower resulting coverage.

- We were unable to systematically examine issues of quality for these services. CARE identifies this as a continuing focus that they wish to strengthen. Field visits to INHP villages did reveal apparently good record keeping by AWWs. Non-INHP centers had lower levels of participation by women and under two children; growth promotion was of noticeably lower

quality, with one non-INHP AWW reporting that she weighed children and recorded the weights, but did not complete growth charts because she had not been trained.

- The major constraint on the "supply side" interventions provided through HFW was the number of unfilled ANM posts; in one site visit, 9 of 16 ANM posts were unfilled in the block, and 39 of 97 positions were reported vacant at the district level. Shortfalls of commodities coming through the HFW system did not appear to be a critical constraint. No food outages were reported in the past (under Bihar). Presently, food shipments are being delayed by the process of negotiating new shipping contracts by the Jharkhand government; however, this process is anticipated to be resolved soon, and there is an adequate buffer supply to fill in until the anticipated resumption of shipments.

- As indicated above, there is no hard evidence to support the notion that the three feeding behaviors are being effectively changed, even in the Demonstration Sites. Therefore, it cannot be recommended that INHP-2 simply roll out the Demonstration Site model on the assumption that these feeding practices will be modified and improved infant nutrition and health will result.

There is anecdotal evidence to this effect, including: the finding of improved growth of 3-4 year olds in growth charts in one village using a local food-based complementary feeding approach; apparently improved growth (and some excellent examples of normal infants) in some villages; and clear group knowledge of breastfeeding practices and reports of woman-to-woman support, especially in the village visited where the innovative "Baby Friendly Village" approach was being piloted.

CARE/Jharkhand has experimented with more state-of-the-art behavior change approaches based on Trials of Improved Practices (TIPS), and is developing a multi-factoral behavior change model that they wish to apply. However, these models do not take full advantage of the group-based "information on demand" approach that the INHP engagement with villages permits (although it is being used to some extent in the present BCC approach).

The bottom line here is that CARE should invest effort and resources in evaluating the extent to which their different approaches are succeeding in changing these key feeding behaviors, and should seek and share approaches found effective. Technical assistance in both behavior change and operations research would probably be helpful in this evaluation. CARE/Jharkhand has actually requested a post for a BCC specialist – they should be careful in the selection of this person to make sure they get a competent and compatible resource, since BCC approaches vary widely (from media-heavy to interpersonal to community norm change oriented).

Implementation processes

a. Needs-based food allocation. We were unable to directly evaluate this approach; the project reports that it has improved food allocation, increasing the number of eligible recipients. This was the result of surveys indicating that in some cases communities that did not have adequate numbers of eligibles were receiving more rations than appropriate, allowing re-direction of these rations to needy areas.

b. Take home rations [THRs]. Reports from all levels of both ICDS and HFW, as well as village-level informants, stated that this approach has substantially increased the participation of pregnant and lactating women and children under age two. Concern about "dilution" (sharing) of the ration persists, and there is evidence of this effect in the quantitative evaluation. However, women's group members and AWWs in several (DS) communities reported that they were dealing with this issue through intensified counseling of mothers receiving THRs.

c. Nutrition-Health Days [NHDs]. These were occurring in all INHP sites (DS and non-DS), but not in ICDS non-INHP sites. Again, there was strong universal consensus that this approach has significantly increased coverage of or participation in all of the technical interventions.

ANM/AWW coordination appeared to be strong in the sites visited and by indirect report. Acting as a focal point, the NHDs also appear to be functioning to strengthen activities aimed at education and counseling of beneficiaries as well as women's group activities.

d. Coordinated planning and monitoring at the block, district, and state levels. Again, reported by non-CARE sources to be happening and to be effective.

e. Partnerships with local NGOs. CARE has a small number of fairly large local NGOs. Their identification and the building of their capacity has been a real effort by CARE. Their participation in the program has required strengthened management and technical capacity, as well as several-fold expansion of staff. However, they appear to be excellent partners, and the NGO field workers we observed had excellent relations with the communities visited and appeared to be effective "animators" and facilitators of empowering group processes. The one NGO we directly interacted with (LGSS) was very positive about the project and its working relations with CARE.

   One important issue is that CARE and others feel that the NGO work is a key element in achieving the community organization and group strengthening, especially of *mahila mandals*. However, the capacity of and number of NGO partners in Jharkhand is limited. This can be a constraining factor in expansion. The CARE staff are considering other intermediaries – including government – to carry out part of this work. Such alternatives will need to be evaluated, since it is not immediately clear that some of the groups being considered (such as ICDS supervisors) can do this work in the context of their other work and institutional demands.

f. "Clusters." This approach involves linking 4-6 AWWs from neighboring villages (with at least one DS village) into a unit. One of the most skilled AWWs is chosen as "cluster leader" and given additional training in the approach and in community organization and skills transfer. Monthly meetings of cluster AWWs are held, with the venue rotating from village to village. Cross- visits by larger groups are also organized to see practices one site is carrying out. This allows exchange of experiences. At the village level, each AWW organizes a "cluster team." The cluster leader also attends the block level monitoring committee meetings. This gives her a link to more central levels in the system, and allows her to seek solutions to problems that the cluster members have not been able to solve at their level. In itself, participation in the BLMC is an empowering process for the cluster leader and, indirectly, for the cluster.

   This model is potentially an important contribution to meeting CARE's project-wide challenge of how to provide "diffusion" of experiences and replicate the characteristics of the Demonstration Sites, without putting all the DS inputs into every village. While relatively new, it should be encouraged and carefully evaluated and documented.

Community

- Surprisingly, not just CARE staff and community members, but also ICDS, HFW, and other functionaries at various levels, including the District Deputy Commissioner, identified the community organization aspects of the INHP approach - especially the identification, training, and support of "change agents" and organization/ strengthening of *mahila mandals* – as essential to the increased service delivery and utilization being observed.

- Again, NGO inputs were seen as being essential to implementation and expansion of this approach (the Deputy Commissioner observed, "CARE and the NGOs can do this -- government cannot. This is a real value added of the project.").

- Saving schemes were part of every community women's group encountered, and the members generated ideas concerning investing the savings into income generating activities.

- In all INHP sites visited, evidence of community ownership was prominent: women's groups were helping in NHDs (food distribution, weighing children, etc.) and in a number of cases had initiated woman-to-woman outreach actions; participation in and focus of *mahila mandals* was increased; information was being absorbed, diffused, and in some cases actively sought.

Support systems

CARE structure, roles

- The addition of field officers under INHP has been a major evolution from CARE's pre-INHP structure (in which only officers at the level of field coordinators existed, operating very far from the target areas and involved mostly in input (food) monitoring). The INHP structure appears appropriate and necessary for the inputs of the INHP project. It allows CARE to provide its technical and capacity-building inputs at district and block levels, to coordinate with NGO partners, and to monitor on-the-ground progress. At the same time, it is a "programmatic" structure; with a ratio of one field officer to about 550 AWCs, it does not succumb to the temptation to work directly at community level.

- CARE has scrupulously avoided "hardware" inputs and provision of inputs that must ultimately come from ICDS, HFW, or communities themselves. Instead, we found that they concentrate on "software," innovation, and capacity building. These inputs are appropriate for CARE as facilitator and development partner, and are likely to contribute to sustainable change.

Food (Source: CARE state office and counterparts)

Commodity Flow:

- US to Calcutta port along with the stocks meant for UP and WB
- Unloaded by the port labor who are paid by the CFA (Balmer Lawrie and Co., appointed by the GOI for the 3 states)
- Container can get unloaded on the same day but barge takes 2 to 3 days. Average discharge rate is about 800 T.
- Kept in port transit shed – but has to be cleared in 72 hrs. Earlier moved to the CFA W/H by giving an Indemnity Bond to the customs on removal only after receiving the PHO certificate. Now the rule has been changed and the stocks are first moved to the customs bonded warehouse till the PHO certificate is received, and then to the CFA warehouse.
- From the CFA warehouse there is a time limit of 45 days in which to move the stocks to the blocks by the state government appointed transporter (Delhi Assam Roadways, at present).
- When the stock is about to be moved from the CFA warehouse, the CARE state office prepares the Dispatch Advice (DA) based on the previous month's closing balance of stocks. DA sent to CFA, transporter, blocks and all concerned – DA with shipment specs and quantity.
- Block to AWC dispatch plan made by the CDPO along with the FO on a need based basis by the number of beneficiaries.
- To AWC there is door delivery or the AWC picks it up from a central point or even the block. For collecting from the block they get paid but not from the central point
- Present status:
  - CFA Balmer Lawrie revised agreement for JHR made by GOI end Feb 2001 and endorsed by the state government on March 3.
  - Transport contract with Delhi Assam Railways -- the state government endorsed the earlier contract up to 31.03; presently no contract with any transporter. In the process of finalizing.

General:

- Assured food delivery 300 days. Actual between 260 to 280.
- CRITICAL SUCCESS FACTORSs for the supply chain include a) making CFA / transporter agreements in time b) choosing professional transporters for both legs.
- Call forward based on current inventory is meant for receipt 6 months later. Old inventory data + last year's performance is a basis for deciding the CF.
- At AWCs budgeted consumption is almost equal to the actuals.

Inventory control:

- Not much of gap between CF and actual receipts. Suggested stock norms : block 2 months, AWC 1 month; total 75 days.
- Ensuring equitable distribution at blocks by working out the cut-off dates for all blocks uniformly. The stock levels at blocks cannot be ensured to be at the same level as the pattern of dispatches to the AWCs is not uniform.
- Monthly inventory data from the MPRs for the month from 26th to 25th received in the first week.
- It seems that there is no difference in the quantity ordered and received from the US.
- CSB and oil can be in the same or different shipments. Receipt 15 to 20 shipments in a year. Total quantity (2001-02) 25,400 T of CSB and 3126 T of oil. All shipments almost uniform quantity.

Planning process:

- AER converted to CF by the HQ each quarter.
- Port to blocks is decided by the state office DA and the blocks to AWC by the CDPO/ FO
- All receipts are monthly

Supply Chain lead times:

- The progress of commodity in terms of the number of days taken is as follows:
  - Port discharge 2 – 3 days
  - Transit shed 2 days
  - CFA warehouse/ Customs bonded w/h 20 days
  - CFA to blocks transit 2 days
  - CFA stocking 30 days
  - Block storage 30 days
  - Phytosanitary certificate 15 days
  - TOTAL : 102 days
- Transporter does not delay truck placements at the CFA
- No demurrage is incurred in the port clearance
- Phytosanitary certificate takes an average 20 days even with CFL in Calcutta –reasons not known.
- No transhipments allowed to transporter – delays only if breakdown or accident
- Cal receives a combination of both barges and containers – proportion not known. Containers require less handling and no need for unloading in transit shed
- Avg value per kg of the food recd: CSB 18.25 Oil 40.00

Supply chain costs:

- The total supply chain cost for the food commodity for Jharkhand is estimated as Rs. 948.50 (4.5% of the food value).
- Block to AWC permitted freight : Rs. 30 for 6 to 8 bags
- CFA finalized by the GOI and state government decides the transporter based on own trucks, finance capacity and regular prompt service
- Trucks returning from blocks pick up return loads and those returning from the center go back empty. Loadability is ensured by combining loads
- Empty container sales at 25 *paisa* per bag and Rs. 18 per oil pail – collected by the CDPO
- Reported damages at about 0.4 % of value, 80% of which are collectible
- Stacking norm at the CFA or block – 20 bags height, or 8 pails high
- Space at blocks – exclusive own godowns
- SCALA implementation only financials. FoodAc package for inventory.
- Route plans left to transporter
- Admin costs paid by the GOI is based on the number of beneficiaries and is about Rs 1.1 *crores*

People Issues:

- Adequate manpower at the blocks to handle stocks – if necessary the CDPO takes charge
- Manpower committed and motivated on service levels

- Training programs on supply chain conducted by CARE to define the roles and responsibilities
- FO occasionally needs to push stocks (about 10% of his time)
- Follow-up by the Commodity Officer regularly – for example, CDPO gets a letter if block holding excess stocks

Information flow:

- From port officer – both soft and hard copies
- Block sends only hard copies – 97% of reports are prompt
- Bill of lading comes to CARE HQ 3 weeks before ship arrival – sent to Port officer under intimation to the state office
- Ship unloading can get delayed by 3 to 4 days due to draft at Calcutta port

Suggestions:

- District to choose transporter from the port to the blocks
- Blocks to contract with a transport agent for dispatch from the blocks to the centers
- Use 3P warehouses where block godowns are not owned by the state government.

HMIS

- CARE's monitoring systems focus on process indicators. Presently, there is no way - between large "quantitative evaluations" (surveys) - for project staff to monitor changes in outcomes (such as coverage of "supply side" services and change in feeding behaviors). This need is felt by some project staff, and some evaluation of outcome monitoring will be needed. However, careful thought needs to be given to this, to avoid the excessive workload and unreliability that reportedly characterized the former "household visit questionnaire" approach.

- CARE stated clearly that it does not want to create new information systems or indicators that ultimately would have to be picked up by ICDS or HFW, since such changes in these systems are unlikely to happen.

- There is information being generated at the community level by AWWs and ANMs; under the cluster mechanism, the AWW reports are being reviewed by the cluster leader. This might form the basis of a community-based monitoring approach that could also provide information to be aggregated and monitored at different levels of the system. In any case, exploration of community-based monitoring should be one aspect of the process of institutionalization of the INHP process at community level.

- Presently the most operational levels of the system (district and especially block) are weak in compiling and using the substantial amount of information they already get, and there are not clear processes for quality control or verification of this information.

Staff and technical support

- The field officer staff in Jharkhand are of high quality. Many of them have post-graduate training in highly relevant disciplines such as rural development, nutrition, and maternal/child health. Also, the majority of them are relatively senior, with substantial field and program experience (with CARE and with other organizations). This experience probably contributes to their generally excellent working and professional relationships with counterparts at the district and block levels.

- Areas where technical support are perceived by field staff themselves, and by the team, as potentially required include behavior change (especially community-based normative change), monitoring and evaluation, and operations research. Additionally, technical inputs in nutrition (growth promotion) might be useful in refining the thinking about evaluation of the feeding behavior and nutrition-related processes and outcomes of the project. If the follow-on project moves into new technical areas, such as neonatal survival and health, technical inputs should

also be sought from national or global CARE headquarters, or from relevant USAID cooperating agencies.

Organizational learning and diffusion

- There does not appear to be a systematic process for identification, evaluation, documentation, or dissemination of important experiences or major innovative approaches (such as "catch up days to increase village-level coverage of the "supply side services," or amplified approaches like "Baby Friendly Villages" to improve breastfeeding practices). This statement applies to both internal (within CARE/INHP) and external (with partners) dissemination.

- The little paragraph added to the end of the monthly DIP field report is not likely to play this function.

Capacity building and sustainability (exit strategies)

- The NHD approach is almost institutionalized, both within the system and in communities. The ICDS-HFW cooperation is also regarded favorably, and there is a fair chance it would be continued even without project inputs.

- Much of the capacity building investment by INHP seems to have had good effect. This is especially true at the community level, although presently continued inputs from the NGOs are being provided to strengthen and institutionalize the processes and technical content. Even at the system level, new skills learned by staff such as ICDS supervisors, ANMs, and AWWs are being applied and reinforced through perceived positive results. Thus, these are likely to persist.

- CARE is concerned that the collaborative planning process may be difficult to institutionalize at the block level, since there is no clear functional convening authority at that level. Technically, the block medical officer serves as medical advisor to ICDS and could play the convening role, but CARE apparently felt this was not functional in the present reality.

- Overall, the strategy for replication and diffusion (via clusters) – while it is still incompletely defined - is much better defined than the sustainability/"exit" strategy. This should be one of the major strategic issues for the start-up phase of the next project.

Gender equity issues

- Six of the (approximately 20) field officers were female
- At community level, the INHP approach clearly involves and empowers women. This is in part by giving them access to information and practices that improve their own and their children's health. It also serves as a focal point for women's organization, and reinforces existing organization such as the *mahila mandal*; this organization has the potential to expand and institutionalize itself, as seen through the strong tendency of women's groups seen to begin savings plans and consideration of income generating activities.

Key Themes

INHP strategies increase service delivery at community level
Nutrition – the need to evaluate; the need to DECIDE.
Innovation as a key to impact
- Includes a local food-based approach developed at request of Bihar

Recommendations

The majority of the evaluation's overall recommendations are relevant to the Jharkhand program In addition, the team recommends:

- that the cluster model for replication be systematically evaluated and documented; it is possibly the best structured model across INHP for making the diffusion/replication connection between Demonstration Sites and Capacity Building Sites (i.e., for scaling up from the Demonstration Sites);

- that other local innovations – such as the Baby Friendly Village approach – also be documented and evaluated in relation to their effectiveness in improving achievement of behavior change and their feasibility and potential for broader scale-up;

- that CARE begin exploring the potential of other intermediaries (government functionaries, community-based organizations, and others) to carry out the community mobilization and capacity building functions now being played in some sites by NGOs, since NGOs alone probably cannot cover the whole territory.

ORISSA STATE REPORT

Background Situation of Nutrition, Health, ICDS, and INHP

Summary information and Methodology

CARE INHP field staff in Orissa consist of 1 Project Manager, I Program Associate, 1 Partnership Officer, I intern, 4 Administrative Assistants, 3 FCs, and 24 FOs (of which 5 are women). INHP has decided to target children in the 6 month to 3 year age group for THR. The project covers 10 districts, 122 blocks (38 rural, 83 tribal and 1 urban), and 12,207 AWCs and 6381 sub-center's (a sub-center is for more remote villages where it is difficult to move commodities from the AWC out to the village and participation in the pre-school program is difficult. In these areas, commodities will be moved to the sub-center for the activities). While the ICDS notes that the target for beneficiaries should be 40% rural and 75% for tribal, the project has taken as a blanket target 65%. Estimated targets are based on taking 11% of the population for pregnant, lactating and children under 3. 8% of the population is taken for children 3-6 years. The State Director has been in place for 4 years, and the INHP Manager for 5 years.

During the fieldwork, the evaluation team, consisting of Dr. Vijayraghavan, Vasant Cavale, Rene Berger, Dr. Prabha Arora, and two representatives from state government (Ms. S. Kar, DWCD, and Dr. Niranyan Kar, DF&WF) split into two groups to cover Keonjar District approximately 250 kilometers from Bubaneshwar. One team went to the field immediately while the other remained in Bubaneshwar to meet with INHP staff and Government functionaries. Within Keonjar, the team visited 3 blocks (Ghatagaom, Jhumpura and Keonjhar Sadar), and 6 villages. At the village level, the team met with the AWW and the ANM where available, the NGO working in the area, *panchayat* members and beneficiaries. The team also met with the CDPO for Jhumpura block, and with 2 of her supervisors, as well as with the Block Medical Officer, and the District Project Officer. Within CARE, in addition to meeting with the State Director and Project Manager, the team met with 3 Field Officers and one Field Coordinator.

Description: what were the hypothesis and key strategies

Role of food

The Government of Orissa has sanctioned 9 blocks for NHDs, but also allowed for coverage of 20% of the remaining blocks (3,164 AWCs out of a total 12,207 AWCs have NHDs). As according to the ICDS guidelines, the food provided at the AWC is seen as filling a caloric gap. THR is seen as a means for bringing in pregnant and lactating mothers and children under 3 years who would perhaps not otherwise receive services from the AWC due to various constraints.

- Communities clearly appreciated the food.
- Some communities with active women's groups and/or *Panchayat* assist at the AWC including helping distribute the food.
    - One *Panchayat* member noted that women like THR as opposed to direct feeding as they only have to come to the AWC once per month. She also noted that she goes around to households to check the food levels and assured the team member that there was no sharing.
- Communities noted that it would be difficult to cope without the CARE program, particularly the food.

Key interventions
CARE staff and even the CDPO noted that the nutrition and health day included take home rations and ANC. They also noted that given the need in the communities, they held a second day per month for providing further access to immunizations for both women and children (therefore, the ANM and AWW work directly together twice per month). Growth monitoring is a consistent activity in the communities, as is social mapping to identify eligible households.

- During the NHDs communities contribute between Rs2-5 for a health fund. The fund is used for pregnant and/or lactating women and children who become sick and need to seek services from the PHC or other places. Mother's repay the fund with interest (Rs2 per month per 100 lent in one village).
- While severe malnutrition was not common, growth faltering was seen in a couple of villages particularly during the weaning period. It was clear from discussions with AWWs, ANMs and Supervisors that none of these staff are adequately prepared to provide counseling for mothers with faltering children. Monitoring of such cases is not documented in either the CARE or ICDS reports.
- Both the AWW and the Supervisor have a fund of Rs1000 for referral of children in Grade III and IV malnutrition. AWWs questioned whether this could not be expanded to children in Grade II since they did not have many children in Grade III.
- One center visited had MM groups in each corner of the room carrying out different activities from growth monitoring to immunizations (with the assistance of the ANM).
- Field Officer has designed a "self monitoring tool" also called "Jagannath" which women use when they become pregnant (see page 14 in main text). Beneficiaries were able to explain the picture and it was seen on at least one house.

The capacity building hypothesis and sustainability
In general all staff believe in their role as building capacity and for empowering women. Sustainability is discussed primarily in regard to providing support to institutions - primarily women's groups, which can sustain themselves through their empowerment.

- State Director does not believe that anything is sustainable. Require animators in place for a long time (without turn over) and then change can occur, but will need constant push/facilitation.
- Believes that for training should go with local knowledge and throw out the training guide. Role is to empower poor women - uses the action-reflection-action model and believes that groups to be trained should be homogenous as they can share experiences easier.

Documented coverage, outcomes, impact, attribution

Data from the final evaluation suggests that the coverage rates for project interventions have increased over baseline (see Table I on the next page. Ironically, the final evaluation shows higher rates of malnutrition as compared to the baseline.

- All INHP staff believed that coverage rates had indeed improved and that the malnutrition rates were not as high as the final survey suggested. They also believe that the baseline figures may have been higher than the baseline survey suggested. In general, no one was able to provide a satisfying answer as to why coverage rates had improved, but malnutrition had risen.
  - The Secretary for ICDS suggested that the team during their fieldwork should come up with an answer for this question.
  - Common nutrition related problems persist such as decreased food intake during pregnancy.
- Project staff believe that they have made significant progress in forming and empowering women's groups.
- Project staff believe that they have also made great strides in creating "convergence" between the ICDS and health.
- State Director is not very interested in quantitative data and believes that is the role of ICDS to monitor.

Table I. Coverage Rates for Targeted Interventions

Table I. Comparison of Coverage Rates in Baseline (BLS) and Final Evaluation (DS, ALL)
(Baseline = BLS, Demonstration Site = DS, All Sites = ALL)

	Orissa		
Indicator	BLS	DS	ALL
Supplementary Feeding			
Pregnant women	45	81	62
Lactating women	35	76	50
Children 6-24 months	38	65	70
ANC			
3+ Check ups	59	82	69
TT	69	92	77
IFA	26	67	54
Child Survival/Nutrition			
Full Immunizations	25	34	24
Breastfeeding w/in 8 hours	40	83	70
EBF - 4 months	60	75	66
Complementary feeding 6-9 months	26	57	53
Malnutrition			
Normal	49	37	37
Malnourished (weight-for-age)	51	63	63

CARE's Implementation

Big picture, key actors, partners

It is the clear view of the State Director - and all other staff below him flow from this vision - that their role is to build the capacity for women to demand services themselves and to be empowered to seek out solutions to their problems. His view of INHP specifically, flows from the initial focus of the ICDS when it was first developed. At the field officer level, staff believe that the project is designed to improve the health and nutrition status in line with the ICDS. They believe their main thrust is to work with government.

- State Director's view of INHP flows from larger view of ICDS - originally conceived as a community based program where AWWs served as animators
  - INHP designed to re-invigorate this process with CARE working to facilitate the animator process.
  - Issue of scale problematic - in India nothing that has been started as a pilot has gone to scale.
  - Believes the new model for INHP more realistic - did not think the old strategy would work.
  - Has a developmental framework that he believes supercedes the INHP framework.
- Field Officers noted that they play the role of catalyst - helping people to work more effectively. They noted that their work is more at the district than grassroots level.
  - Believe the revised focus makes more sense as the old HI blocks had too many interventions - 3+3 is better, and that health works on the other interventions so they are still being covered.

Implementation against plan and expenditure against budget

- State Director noted that budget process is a constraint. Instead of annual budgeting, should have quarterly - to allow for changes to be made.
  - Should have flexibility to hire more NGO/animators if this is what is required.
- Field Officer's noted no problems with budgets and noted that they develop a monthly plan then implement from there. This is one area that the new HMIS has helped them to visualize their activities.

Technical interventions

Interventions

Demonstration sites focus on the 3+3 interventions and do not seem to have difficulties structuring time to allow the ANM to attend the sessions for ANC and immunizations.

- Early feeding for males is prevalent, project is emphasizing the female side.

- Contact mothers in law and husband (*vis à vis* gender issues). Men should accompany women when they come for IFA.
- CARE field staff view their role as more to build capacity or to create an enabling environment, than to provide technical oversight on the implementation of interventions.

Implementation process
- NHDs are conducted with include the ANM providing ANC and immunizations, and the AWW undertaking growth monitoring and providing THR.
  - Availability of the different services at the AWC is appreciated by the mothers who note that THR is good as they don't have to come to the AWC as often.
  - AWW likes THR as it allows her to reach more people and frees up more of her time to do home visits and other activities.
- There was no clear sense from the FOs how the demonstration sites with NHDs would be replicated across the block and/or diffuse.
- While children are weighed on a monthly basis and this is plotted on the ICDS forms, neither the AWW, nor the ANM seem to have the requisite skills to provide counseling for children found to be growth faltering.
  - There is no way to capture growth faltering in any of the reports.

Community
- FOs and NGO work with the communities on social mapping and providing input for NHDs.
- Communities appreciate support provided by the AWC and the ability to receive services at one point. Also like THR as they don't have to come as often to the center.
  - It is not clear the extent to which the State Director's vision of the program is being implemented in terms of women's empowerment. Capacity building is taking place, women are able to draw off the health fund (based on collections), but the other dynamics within the household regarding allocations of food and other behaviors may or may not be changing.

Behavior Change
- AWWs who have been working for any length of time note that they have seen changes in the behavior of women.
  - More colostrum feeding is taking place, the duration of breastfeeding however is too short for male children and too long for female children.
- The development of the self-monitoring tool seems to facilitate behavior changes around pregnancy and lactation practices. This tool does not appear to be in use in all villages however, and may at this point be only in demonstration sites.

Support systems

CARE structure, roles, staff and technical support

Operations at the State level clearly flow from the vision of the State Director with apparently little input from CIHQ. Within the INHP staff there is a hierarchy where staff are clearly subordinate to their supervisor.
- CARE field staff are comfortable operating at the District and Block level, but it is not clear that they have all the skills beyond food monitoring to provide technical input at the AWC level.
  - Staff view their role as more in the monitoring, though "training for capacity building" was frequently mentioned (although it was not always clear "training to do what").

Food

Commodity flow:
- Receipt of the materials at Paradeep port; government clears through the designated CFA (Orissa state warehousing corporation)
- Scheduling of dispatch from the port to the 10 district warehouses done by the SMART unit (supply management and resource tracking unit) of CARE at the state office. The district warehouses are state-owned and fall under 3 zones.

- The movement from the port to the district warehouse and the blocks is done by the state appointed storage and transport agents. The District Social Welfare Officer and the CBFO – (district point person of CARE) decide the plan for the district. Stored in state owned warehouse
- District to block is also decided by the above two persons
- Block to AWCs is the responsibility of the CDPO. It is door-step delivery to the AWCs or to the nearest point. All dispatches are monthly.
- Port to district dispatches are computerized; district onwards are manual
- Orissa has 122 blocks: 1 urban, 38 rural and 83 tribal. 12.16 *lakh* beneficiaries, 18588 feeding centers of which 12207 are AWCs and 6381 sub-centers

General:

- Agreed feeding days for the year 300; days achieved last year: 280. 100% dispatches from Oct 1999 onwards
- Critical Success Factors are a) S&T agents keen to clear stocks from the port, b) regular follow-up by CARE, and c) appointing of the district point person
- In districts dropped by CARE (for example: Cuttack, Kendrapara, Jagatsinghpur, Puri) – food support was irregular, deteriorated.

Inventory management:

- Inventory levels across the supply chain are: port, nil; district, 25 days (capacity 2*25 if required); block, 25 days; AWC, 25 days; total, 75 days consumption. No godown outside the port – hence port has to be cleared of stocks.
- Call forward being handled by the state for the last two quarters based on inventory levels available.
- Blocks divided into sectors under lady supervisors who bring the inventory data from the AWCs and consolidate into monthly reports given to CARE also – mostly prompt.
- Average number of shipments 15 to 20 per year. Total for Orissa : CSB 28,454 T and oil 3502 T which is monthly 2371 T of CSB and 292 T of oil (2000T of CSB = 80,000 bags)
- Dispatches to blocks/AWCs based on stock levels in the monthly reports

Planning process:

- Dispatch advice (DA) tries to balance the cut-off date at each block or district – between inventory and the dispatch plan tries to make it around 70 days- this is to ensure equitable distribution of the food. District point person also keeps the 70 d in mind. Port to district done by state HQ and the others by CDPO / DPP.
- Project schedule of issue at monthly review meeting. Availability end of the month + requirement next month + any special needs (like pre-monsoon placement) = project consolidation of monthly forecast.
- No difference between budgeted and actual consumption except if shipments delayed.
- Ordered quantity from the US and actual receipts hardly differ by + / - 5%. The delays in shipment receipts are +/-15 days.
- All feeding at district, block and center are monthly.
- Route plans from the blocks to the AWCs are made by the CDPO.

Lead times:

- Lead times across the supply chain: port to district 23-24 days with 1-2 days in transit; district to block: same day or next day transit (FTLs); block to AWC is by LCVs or tractor trailers: same day based on route plans
- No delays in movement from the port – maximum permitted is 18 days but cleared 1 or 2 days in advance.
- Discharge rate at port depends on berth availability – about 15,000 units or 400 T per day maximum average shipment of 2000 tons should take about 5 days.
- The PHO is based at Paradip and does not take more than 2 days for the PHO certificate.
- Customs clearance takes a maximum of 2 to 3 days.
- All shipments by barges only. Container test shipment not successful as Paradip does not have facilities and SCI does not get return loads.

Supply chain costs:

- An effort has been made to estimate the costs per ton as follows:
  - Port details not available; however clearance and loading charges paid to CFA is Rs 168 per ton
  - Port to district to block by the S&T agent : first 10 kilometer is Rs 22 per ton; additional kms at Rs 1.70 per ton km
  - Block to center is 60 *paise* per quintal per km
  - Total storage Rs 45 per ton
- Shortages and damages occur around 0.3% of the total value of imports – 0.2% at port and 0.1% all other.
- GOI pays administrative charges through the state government -- Rs 1.4 *crores* per year towards monitoring and surveillance of food management. Normally the payment is made in September or October in a lumpsum for the year.
- ***Total supply chain cost budgeted is 10 paise per day per beneficiary. The actual supply chain cost per ton for last year is Rs 698.***

People Issues:

- All players are motivated and conscious of the prompt food movement – the upward community pressures ensure this.
- Major role played by the CARE people in food management – SMART unit, field staff and CBFOs.
- The state government ensures that there are no shortages / damages remaining unclaimed from the CFA or S&T agents. They are selected based on infrastructure available, past performance etc. CARE FC / DPP also participate in the selection of the S&T agents
- Return vehicles from the district or block come back empty as the last delivery point is close. Remote AWCs pick up the stocks from the block by available means (about 5% of total AWCs).
- Motivation of the counterparts on the supply chain is due to the effort of CARE; in the ICDS-only or WFP areas the contrast is evident.
- Lady Supervisors – 30 to 35 % positions vacant. AWWs also vacancies – managing with helpers. CDPO provides a regular complement but there are frequent transfers.
- No government incentive to its functionaries to make the program successful – CARE people provide the motivation.
- CARE makes efforts to train the counterparts in issues – sensitize lower rung people.
- SMART unit has 2 people. FOs are a great help in handling problems.
- Delayed freight bills of transporters – CARE persuades funds release.
- Missing AWWs are a problem area.

Information flow:

- Copy of bill of lading and all original documents at state office – 15 to 20 day before ship arrival – endorsed by the WCD dept – to CFA with dispatch advice – filed with customs – cleared to port transit shed – to S&T agents after PHO certificate.
- Continuous MIS – no changes seen or aware of.
- No new forms in the last 10 years. Nothing specific developed for this state.
- Loadability in FTLs for all legs of the dispatch – normally 10 T or 400 bags.
- Both in the district and the blocks the food is stored in exclusive godowns for CARE.
- Stacking norms for the CSB bags is 20 high and oil 5 high except if there are space constraints.
- ERP SCALA implemented for financials only.
- US approval for 3 months stocks along the pipeline.
- All villages have a PDS fair price shop for BPL families – but these are very irregular in operation.

Points made by the DSWO – Basant Kumar Raul:

- Selection of S&TA by state government will be decentralized to the district
- Transport cost permitted for the food in the state is 10 *paisa* per day per beneficiary
- Block to AWC max rate permitted is Rs. 25 per quintal
- District is only a transit point – there is no need to keep the stocks

- Paradip projects the lead time is one month + FIFO. Date of processing is mentioned on the CSB bags or oil pails.
- The PDS system – the *gram panchayat* usually runs the PDS fair price shops. Goods transported once a month.

HMIS
- Includes spot checks on 3% AWC (15 AWC) as well as data from all other AWCs. Information flows up the system, and is analyzed and discussed.
- Social mapping is also used to identify community based organizations for "animation" and change agents. To be updated quarterly.
- State Director does not believe in utility of hard copy reports. Prefers to have a verbal report out. Thinks that the social mapping at the community level serves this process. At higher levels, won't provide report unless they ask for it as he doesn't believe they will read/use it.
- In general, FOs believe the new HMIS helps them; they were able to provide input (e.g. drop some questions on commodities) and feedback during the development process. They provide their HMIS reports to the CDPO and thus provide information to the District.
- The review team saw no demonstration of how HMIS information was used, though at no level did INHP staff report that they lacked adequate information to manage and report on their activities.

Organizational learning and diffusion

Internal
- State Director has framework for development - assess staff capacity and expectations in accordance with this framework - primary role of staff is to facilitate animators at the NGO/local level.
- FOs have innovated some ideas which are known across the FOs in the immediate area - how widely known outside of this area is not clear.
- FOs note that they help support each other to undertake activities at the field level. This includes working to each others strengths (e.g. if one FO is particularly good at coordination at the District level, they may take on more of these duties, while other FOs who have better skills in other areas may focus on them).
- Zonal review meetings, quarterly review meetings, and cross visits are ways in which CARE state staff share learning and innovations from the field.

External
- CDMO have been presenting to the collectors during monthly meetings the usefulness of INHP
- Sensitization of new District Collectors is carried out through the DPP and Director, Social Welfare (DSW) would participate.

Capacity building and sustainability (exit strategies)
- CB done through training of trainers at different levels. At State level have steering committee for deciding the training curriculum. Committee made of UNICEF, DSW, Director of Health Services, Director of ICDS, INHP Manager, State Institute of Rural Development, Food and Nutrition Board Representative. Convened by Director Social Welfare. Meet quarterly. (PM)
  - Formed core team for training of district level staff.
  - Trained CDPOs, MOs, BDOs (3 day structured training program)
- District level coordinating committee reviews training and other activities under Chair of District Collector. CDMO, DSW, District Point Persons (FO and DPP=CBFO; 10 in total)). Meet monthly.
- Block level coordinating committee (meets monthly) Convened by CDPO, with MO, BDO, FO
- Village level CDPO, AWW, ANM, Self-help group member, have committee which meets monthly. -- General training about INHP activities, why/how of interventions, aspects of immunization, IEC
- State review meetings held the 10th of every month
- Exit strategies - communities can manage at the end of 5 years. If the community can contribute food for selective feeding this could be used as an exit criteria.
  - FOs believe that it will take some time before they can exit from areas and have a sustained impact. How long they note is difficult to say.

Gender Equity Issues

- Need to work on gender balance of CARE staff - difficult to hire women who know the language and who are willing to work out away from the larger cities. Once they get married, they don't stay long.
- Not clear to what degree activities meant to empower women are leading to changes in the household - had no clear examples described or seen.
    - AWW may be the one who benefits most from activities and has the greatest level of empowerment, at the same time, they are likely to be already more educated and therefore more empowered, than others.

Innovations

- Mothers' self monitoring tool (see p.14 of main text)

Recommendations

- CARE should work with State and local government functionaries to organize training for AWW, Supervisor, CDPO and ANM on the use of growth monitoring as a tool - including the need to monitor growth faltering, and appropriate messages and strategies to recuperate children found to be faltering.
- CARE should assure that the FOs participate in this training and are also facile with the activities and messages.
- CARE should identify opportunities to allow the FO to spend more time at the AWCs and less time at the Block and District levels.

RAJASTHAN STATE REPORT

Background Situation of Nutrition, Health, ICDS and INHP

Rajasthan is now the largest state in India, with widely varying geographic/topographic regions ranging from some highly productive agricultural lands to the desert on the western side, with widely scattered population. It covers a total area of 342,000 square kilometers and has a population of 56.47 million. Nutrition and health situation is poor; 50% of children below three are malnourished or undernourished, and only 17.3% of children 12-23 months old are fully immunized, and barely any of the infants are given colostrum (4.8%) (NFHS-II, 2000). The INHP was initiated in 1996 with the specific goal of improving nutritional and health status of children, pregnant, and lactating women which after the mid-term evaluation in 1999, focused on six key interventions ("3+3") in the selected blocks.

Description: what were the ICDS/INHP hypothesis and key strategies?

Role of food

Food supplement is intended to fill the gap in the dietary intake of children below 3 years and pregnant and lactating mothers, and is thereby expected to contribute to an improvement in nutritional status. Food is also expected to act as an incentive to attract women and children to the center for increased delivery of health services, thereby improving health and nutritional status. The quantitative data, as well as qualitative observations and anecdotal data from the AWC level, appears to support this hypothesis.

Key interventions

- supplementary food for pregnant and lactating women and for children under 3
- immunization of infants against 6 preventable diseases
- improved infant feeding practices (colostrum, exclusive breastfeeding, appropriate complementary foods at 6 months)
- improved maternal health practices during pregnancy, with an emphasis on IFA intake but also including antenatal check-ups and immunization against tetanus

Methodology

Mr. M.S. Negi (GOI-DWCD) and Dr. Subhadra Seshadri and Laura Bailey (CARE External Evaluation Team) visited 9 AWCs in three blocks in the Pali, Jodphur, and Barmer districts of Rajasthan from May

17-20, 2001. The team traveled with senior district officials of the ICDS and Family Welfare departments, Ms. Kamla Jawaher and Dr. Ramesh Bohra, and with Mr. H.S. Meena, Additional Director from W&CDD. We were ably assisted by the CARE-Rajasthan field staff, including INHP staff Ramesh Babu, Manish Mathur, Sanjay Sharma, Subrata Das, P.J. Trinidad, M.K. Naresh, and Bhaskar. We interviewed over 50 people, including:

- **recipients and community members:** mothers, adolescent girls, *dais*, community members, *sarpanch* representatives
- **grassroots health and ICDS workers:** AWWs, ANMs, Lady Supervisors, Lady Health Visitors
- **ICDS and Health department block officials:** Medical Officers, Child Development Project Officers
- **cooperating partners**: NGO managers, NGO grassroots workers, trainers at the independent *Anganwadi* Training Center

Documented coverage, outcomes, impact, attribution

Coverage for supplementary nutrition is high for all target groups; quantitative data (from a range of sources) and qualitative data all support this conclusion. The quantitative survey shows some improvements in nutritional status (reduced percentage of children in the 2D+3D category, and higher percentage in "normal") and NGO, Health, AWWs, and CARE field staff all report anecdotal evidence of this reduced incidence of malnutrition; evaluation team observations reinforced this -- no severely malnourished children found in villages visited, growth charts and weight data, to the extent they were available, showed upward trends. Individuals at all levels – mothers, other community members, AWWs, ANMs, block and district staff of both ICDS and Health – attributed improved nutritional status to INHP.

Quantitative survey shows coverage for complete child immunization to be stubbornly low overall, although coverage is substantially higher 68%) in the Demonstration Sites surveyed. There were no reported supply blockages or shortages of vaccines or immunization supplies during. CARE field staff and Health functionaries, down to the ANM and AWW level, feel that the data does not accurately reflect what they genuinely believe to be a small but steady improvement; they say the survey results are unrepresentative because it relied on mother to recall and name all immunizations received, which she is unlikely to be able to do. Random inspection by the evaluation team of health cards in several areas – held usually by the ANM and not by the mother – showed **much** higher immunization coverage than reported in the quantitative survey. (*See Recommendations.*) Health, ICDS, and CARE staff believe that immunization coverage may well vary substantially and be stubbornly low in areas where ANM posts are vacant or where distance and cold chain constraints make the ANM coverage of her catchment area difficult.

From team observations of the contrasts between the non-INHP non-CARE area and the various INHP areas visited – and as directly articulated by one of the ICDS supervisors! -- the differential level of coverage and impact seems to depend primarily on cooperation between ICDS-Health and on community ownership and involvement.

CARE's Implementation

Implementation against plan and expenditure against budget

Overall achievement of 93% of training activities planned to date; impressive achievement in training of change agents, AWWs, sector and block functionaries, and NGO participants (for some groups training achievements exceeded 100% of plan), but under-achievement of training of general community members such as *panchayat*, youth, farmers, and fathers. Overall expenditure against budget has been well-paced, with only capacity-building being a bit under-funded from the State staff's perspective.

Technical interventions

Interventions

There was good awareness of content and intention of 3+3 intervention packages at all levels, from district government officials all the way down to mothers and adolescent girls. Impact was much easier to see in the 3 supply-dependent interventions (food, IFA, and immunization) than in the "+3" behavioral change interventions (exclusive breastfeeding, complementary feeding, colostrum).

Implementation processes
Targeting of beneficiaries is improving through use of social mapping; villages who have been actively involved in their social mapping process have taken on the responsibility of identifying beneficiaries and no longer blame the AWW for people missed or included and tensions & suspicions about distribution of food are much less common.

THR has made it possible to reach the children under 2 and the pregnant/lactating women in larger numbers.

Coordination between the AWW-ANM with NHD serving as a catalyst for delivery of health services; routine coordination and outreach to the community to make them aware of NH Days has created the expectation of and demand for services; now villages question if the ANM doesn't arrive to immunize their children.

Linkages between key actors at different levels is happening through advisory committees at different level of government, routine joint meetings of operational staff, village development committees, etc. Mechanisms for problem-solving and sharing of innovations happens through a combination of training sessions, meetings, and oral discussions, solution implementation, and reporting back through both routine written monitoring and verbal reports.

Community involvement and participation
The social mapping process produced much higher level of community involvement and ownership, intensified by community involvement in subsequent problem-solving endeavors (moving location of AWC when the village map showed that it wasn't well-situated to serve target population, revising list of beneficiaries to better target the poorest if total resources are constrained). Where NGOs have been working in mobilizing communities through mechanisms such as recruitment and training of village health workers and formation of and support to village development committees and women's and girl's groups. Mobilization and training of change agents has energized them as individuals and helped spread messages and raise community's expectations for services. There is consensus that combination of sustained convergence of services plus community mobilization is essential for INHP to achieve full potential.

Behavior change
While community change agents and village level workers report progress in the "+3" feeding interventions, and certainly those workers themselves understand the message content, there is less evidence of widespread behavior change among mothers. CARE field staff openly recognize their need for technical support in behavior change – strategies, communication techniques, etc. – and they suggest that states like Rajasthan that are slated to be BC targets in INHP-2 should have a floating BC resource person at the state level who would spend their time in the field providing training and support in BC.

Support systems
CARE structure, roles
Repeatedly, from the District level on down to the AWW level, one of the chief benefits cited from INHP was "role clarity" – a better understanding at the district level of how Health, ICDS, and CARE divide up the tasks, a better understanding at the block and sector level of the separate and joint responsibilities of CDPOs, Supervisors, Medical Officers, and ANMs, and a better public understanding at the community level of the roles of the ANMs and the AWWs and the community's rights to demand and receive services. In fact, Rajasthan is one State where the public's right to information on government programs had been made law.

The new CARE staff structure tied to the unified CB strategy is viewed as a substantial improvement, and both field officers and coordinators feel they are more effective and closer to their program now that they are based in the field and no longer in the capital.

Some concern was expressed about the tension between being a multi-purpose field officer (jack of all trades) and also needing to be an expert in one area, usually a personal strength (master of one trade)

but overall the Rajasthan team seemed comfortable with and very aware of the cross-training and cross-support that must go one among them in order to cover all the necessary technical and operational matters

Food
THR distribution is effective in 1) delivering supplementary nutrition into the hands of the target group and 2) acting as an incentive to attract women to the AWC for services. Women, AWWs, and ICDS functionaries judge fortnightly THR at the AWC to be the best distribution strategy. Quality of the CSB and oil is perceived as high and the food (and the recipes prepared therefrom both by women at home and at the AWC for the pre-school groups) are acceptable. They have achieved a very high number of feeding days per month consistently throughout the year, even in the summer months.

The supply chain is fine: no blockages in the past year, 3+ months food in pipeline, transport problems with contractors for district-AWC transport solved with help of GOR. Their C&F agent has his own warehouse within customs area at port, so food is transferred there to await port health inspector, thus avoiding *demurrage* charges; shipments routinely receiving their certificates within 10 days or less.

HMIS
The Rajasthan field officers were quite enthusiastic about the HMIS, which tracks process and outcome indicators and elicits qualitative information as well as numbers. They see HMIS as a more efficient and useful tool than the older HVQ, which sought to track numerous impact-level indicators that FOs saw as being insensitive to change within the monthly frequency of the HVQ.

The Field Coordinators say that they use the HMIS actively for feedback, management, and problem-solving. The Commodity Officer says that with HMIS the whole monitoring and reporting systems are more streamlined and rational and that, as a result, Form 4 (commodity management) is actually used seriously as a planning tool for moving food.

The HMIS reports are shared horizontally as well as vertically -- CDPOs say that they get information on problems and successes at the same time the reports are being reviewed by the CARE FC and that they are thus able to mobilize the ICDS and Health system resources to solve problems more quickly, rather than waiting for the information to travel all the way up the CARE management ladder and then down through the ICDS hierarchy.

Staff and technical support
The ongoing vacancy of two FO posts continues to place a large burden on the FOs and the FC in that zone, but they are resigned to the fact that until they can offer a contract longer than 6-8 months (end of INHP-1) they will not be able to attract a qualified and enthusiastic candidate. Overall staffing levels are seen as adequate, but additional technical support permanently stationed in the state is required for intensified work in behavior change interventions.

Institutional Learning and Diffusion
Internal diffusion (sharing within CARE)
CARE Field Coordinators use monthly meetings as well as informal contacts to exchange information about problems and innovations within the State government. FCs and FOs report that periodic workshops and cross-visits allowing them to share with and learn from other CARE state offices are useful and should be intensified, especially in the key topics of behavior change, diffusion and replication, and partnerships.

Specific ideas (quite detailed) were suggested for regional or national workshops (to be held outside of Delhi if possible) to be undertaken on these key topics (behavior change, diffusion and replication, and partnerships) that would include selected government/NGO/community level change agents in collaborative sharing, training, and documentation efforts (*see Recommendations*).

External diffusion and replication through INHP and to non-INHP ICDS
NHDs have been enthusiastically taken up by ICDS and Health and are now systematically part of ICDS in non-INHP areas as well. This could be made more sustainable by a joint letter from GOI Health and DWCD to their State counterparts, as requested by a number of district and block officials.

CARE-Rajasthan has 8.4% of its INHP AWCs operating as full DS, and will hit their target of 10% long before September. Of the more than 1000 DSs currently operating, more than 60% are operating by ICDS rather than by CARE-funded NGOs – already a much more sustainable scenario than expected. Numerous anecdotes of Supervisors, ANMs, and CDPOs being energized by their positive experience with and the visible results of convergence and community mobilization in the Demonstration Sites and then taking the initiative to replicate best practices through training on their own without direct involvement by CARE or INHP-funded NGOs.

Structured techniques – like cross visits from AWWs in non-DS centers to those operating impressive DS – can be institutionalized through the systematic use of "clusters" like this that have been used in other states. Friendly competition" cited by two LSs, as well as informal word of mouth through community networks, has helped to spread some best practices to non-DS sites rapidly in a more organic method of diffusion. More funds for capacity-building would allow expansion of some of these diffusion and replication strategies in the first years of INHP-2.

Innovations

- Intensified block- and district-level planning and problem-solving both within CARE-Rajasthan and with ICDS+Health; beginnings of a process for bottom-up implementation planning (*see Recommendations*).
- Health department officials in one block re-aligned the sector boundaries for their ANMs to match the ICDS sectors so that they could more easily conduct joint operations with Lady Supervisors.
- An activist CDPO in one block, seeing the 50+ AWCs benefiting from NGOs support to INHP demonstration sites, worked with Supervisors and ANMs to establish 14 DSs within the remaining 50 AWCs and vows to bring of all those AWCs up to DS standards (NHDs, trained and active change agents, etc.) within the year.
- Adolescent health brigades are active in some 60-70 AWCs, consisting of 8-10 adolescent girls who work with assigned families for improved awareness of key interventions.
- Participation of *panchayati raj* members in transporting food commodity to villages is spreading in some blocks.
- Health funds managed by *mahila mandals* for emergency health costs are allowing mothers to seek assistance for sick children.
- Male groups (including adolescent boys) are being empowered to reinforce and support infant feeding and breastfeeding messages being communicated to their mothers and wives.
- A lady tailor who was a confidant of village women was trained as a change agent.
- *Dai* trained in health, nutrition, and safe delivery messages, more involved in coordinated service delivery with ANM and AWW, now finds that a greater percentage of women are choosing an institutional delivery even if they are not high risk. Although she laughs about the change -- "I'm losing business!" – she also proudly describes the changes in her own delivery methods and the decrease she perceives in low birth weight in her area – "the babies are much bigger and healthier; the last two were 3.1 and 3.3 kilos according to the Nurse".

Capacity building and sustainability (including exit strategies)
Capacity Building of NGO Partners – mixed results with NGOs in Rajasthan at the beginning of INHP's partnership activities, but they have consolidated their focus on their work with the strongest NGOs among those they work with and have worked to build the NGOs technical and implementation capacity and to facilitate a substantially improved relationship with both the Government of Rajasthan and NGOs.

Systems Strengthening and Convergence – undoubtedly the most impressive finding in the field, as true convergence is indeed happening and the changes in the activism of and cooperation between ICDS and Health is quite dramatic (compared with observations in 1999 MTR).

- At the community level -- the ANM and the AWW are working together as partners -- "we do our jobs together, and we need each other to do our job" (AWW, Bithdi village)
- At the sector and block levels -- joint planning and joint supportive supervision is being undertaken; some ANMs and Lady Supervisiors are conducting their mandatory surveys jointly, and the Medical Officer in one block even re-aligned some of its sector boundaries in order to make them congruent with the ICDS boundaries and thus allow easier cooperation and joint supervision
- At the district level – in the districts visited the District Collectors were considered active friends of the INHP program and they are used strategically by CARE to solve problems and bottlenecks that develop and to approve and enforce systematic dissemination of program innovations that need cross-department cooperation.
- At the state level there is less active convergence, as State Health officials have not received any direct mandates to encourage them to actively view ICDS as a Health program. A joint letter from the two relevant GOI Ministers sent down to the relevant state officials is, in the view of CARE and District officials, essential to promote true efficiency and convergence in service delivery. Until there is a written mandate enabling convergence, then convergence will rest at the district and block level, and every time a DC is rotated out of posting, CARE and the lower-level government functionaries will have to re-invest time in bringing that new DC around to a position of advocacy on behalf on INHP.

Documentation -- The approach to capacity building (with ICDS and Health, with NGOs, and with community change agents) and community mobilization is well-understood and articulated by all CARE field staff but could be better documented and codified so that it could be shared and taken up by ICDS, other NGOs, and thus diffused and replicated.

Recommendations

- To **reinforce the delegation of decision-making to the CARE District Team** as to which sites will be focus sites **for the INHP-II behavior change intensive focus**, allowing them to pick the sites where INHP-I has established a solid platform and where service convergence and community capacity provide the necessary foundation.

- To shed more light on the status and progress of child immunization, the CARE state staff could choose to take a random sample of sites from the list of villages covered in the quantitative survey sample and conduct a surprise **audit of ANM-held health card records** for those villages; compare the coverage rates documented by those cards to the rates shown by mother recall in the quantitative survey, and this would help validate the FOs' feeling that the survey results are biased downwards by bad recall.

- Assess the CARE-Rajasthan FCs' suggestion to **pioneer a new bottom-up implementation planning process within the State** to replace the old top-down system; district implementation plans would be developed by FOs and FCs in collaboration with district and block officials and then those would be compiled into the State Implementation Report (instead of the reverse).

- CARE-Rajasthan staff would like to participate in the **planning and hosting of a series of learning workshops** on the key INHP aspects that they believe require focused work to achieve full INHP results –
  - behavior change – **community** behavior change, beyond just **communications**
  - replication/diffusion
  - community participation and empowerment
  - measurement/monitoring of these aspects

UTTAR PRADESH STATE REPORT

Background Situation of Nutrition, Health, ICDS and INHP
Uttar Pradesh (UP) state has among the worst social development and health indicators in the country. Malnutrition prevalence, illiteracy, male to female ratio, IMR, and Under Five mortality are highest. During the past, few programs in any sector have been able to produce significant results. In this difficult situation, CARE implemented the INHP program from 1996-2001 with the aim of improving nutrition and health of women and young children in 12 districts of UP.

Description: what were the ICDS/INHP hypothesis and key strategies
UP's Integrated Child Development Scheme (ICDS) was initiated in 1975 and now covers 550 rural blocks and 21 urban slums in over 70 districts. An additional 110 blocks are being added under the World Bank's ICDS-III project.

The CARE program (INHP) currently covers 125 blocks in 12 districts. Many of these blocks are relatively new to INHP; fewer than 50% of current blocks participated in 1996. The development impact objectives of the ICDS program are stated as follows (State Plan of Action on Nutrition UP 2000):

- To improve the nutritional and health status of children 0-6 years of age
- To lay the foundation for proper psychological, physical and social development of the child.
- To reduce the incidence of mortality, morbidity, malnutrition and school drop outs.

Young children, their mothers, and pregnant and lactating women from families below the poverty line are the primary beneficiaries of the program. They are reached with a package of services (preschool education, prenatal health and nutrition, supplementary feeding of young children, immunizations, and behavior change for improved infant feeding practices) through trained community-based AWWs, helpers, supportive community structures, and women's groups. CARE's INHP program is designed to operationalize and strengthen the UP state government's ICDS model. CARE/UP states the goal of INHP as "to improve the health and nutrition status of women and children, especially girl children". CARE emphasizes that capacity building for institutions and individuals to sustain improved behaviors, are as important as achieving high coverage and rapid behavior change. The strategy is to develop innovative approaches for reaching project objectives, transfer them through 'demonstration sites' and replicate this throughout all districts.

Role of food
CARE's most visible contribution to U.P.'s ICDS program is the Title II food commodities (Corn Soy Blend and soybean oil). The food is used in three ways to support the program:

- As a nutritional supplement to fill the gap in home diets of pregnant and lactating women and of children under three.
- As an incentive for families to attend health services activities conducted at the Anganwadi centers, and to send their preschoolers (3 to 6 years) for early childhood development activities.
- As leverage at the State and Block levels to bring about systems strengthening and adoption of effective strategies (e.g. Nutrition and Health Days, Take Home Rations).

The Final Evaluation team found that the inputs and technical support provided by CARE probably contribute to improving coverage with health interventions such as immunizations, antenatal care, and iron/folic acid supplements; and also to increasing attendance for preschool education. Both these development impacts are associated with the incentive provided by the Title II food supplements that attract a high attendance of enrolled beneficiaries to the Anganwadi centers. CARE has also played an important advocacy role for improvements in the ICDS state-wide that has resulted from CARE providing substantial food inputs for the program, i.e. food as leverage. These improvements include acceptance of THR and NHDs state-wide.

Key interventions
CARE's INHP focuses on achieving high coverage with the following:

- Targeted supplementary feeding

- Iron/folic acid supplements
- Immunizations (childhood and TT)
- Infant feeding practices (early initiation of breastfeeding, exclusive breastfeeding, and appropriate complementary feeding).

The capacity building hypothesis and sustainability
CARE and GOUP emphasize the need for building adequate capacity at the community level to:

- Assure continued health and nutrition benefits to the population
- Achieve ownership, mobilize community resources, and focus on community priorities
- Implement effective behavior change activities (key for achieving nutrition and health impacts)

In addition, and more extensive than community level capacity building, INHP undertook capacity building for strengthening ICDS systems to enhance implementation of activities by DWCD and HFW departments.

Evaluation Methodology
Two members of the evaluation team spent three days in Lucknow, the state capital, and in the nearby district of Sitapur. The newly recruited Deputy Director of the UP ICDS programme, as well as the MIS director, joined us for most of the three days. In addition, one external team member traveled to Lakhimpur, a non-CARE district, for contrasting observations.

The team visited two CARE-supported Anganwadi centers selected at random, plus one in which activities were specifically scheduled for our visit. We also visited two randomly selected centers in the non-CARE district.

The team interviewed – or participated in meetings – with the following individuals at the state level:

- The Deputy Director of ICDS for Finance
- The Additional Secretary for Child Health
- The UP State Director for CARE

At the district level, CARE's Field Coordinator for Sitapur, as well as two Field Officers, accompanied us for much of our trip. We met with the District Magistrate, the Chief Development Officer, the Deputy Chief Medical Officer, and representatives of two NGOs: MSS-Seva, and the Sarvodaya Ashram. We also met with two CDPOs, two ICDS supervisors, five AWWs, 2 ANMs, at least three village leaders, and a variety of local residents and beneficiaries.

Household surveys were undertaken by an independent organization in UP. It is difficult to make definitive conclusions from the surveys due to major shifts in project sites from 1996 to 2000.

Documented coverage, outcomes, impact, attribution
Quantitative and qualitative information on the impact of CARE's INHP in 12 districts suggests the following:

- Supplementary feeding for pregnant and lactating women and young children improved considerably from baseline levels in 1996 to current levels.
- Early initiation of breastfeeding improved substantially over baseline levels.
- Immunizations did not improve over baseline but higher levels were maintained in CARE districts than all-UP rural (34% vs. 19.2%). Several campaigns were undertaken and may have disrupted routine services.
- The Final Quantitative Assessment reported that demonstration sites performed better than non-demonstration sites on the majority of indicators, even though demonstrations began only six months prior to evaluation. Demonstration sites were not randomly selected, however.
- While TT coverage appeared to improve between the baseline and the final survey, these data may be questioned because of changes in district participation; state-wide TT campaigns were also conducted during this period.
- Coverage of prenatal iron/folic acid tablets was affected by supply disruptions in the state.

- Preschool education may have benefited from CARE food commodities by increasing attendance.

Additionally, CARE's systems strengthening (e.g. food commodity management, Block Level Action Committees, joint workplans for ANMs and AWWs, monitoring and supervision) and advocacy on best practices (e.g. Nutrition and Health Days, and Take Home Rations) have been taken up state-wide and are contributing to large scale impacts. These effects cannot be quantified but are likely to be substantial.

Major constraints for achieving improved coverage and outcomes in INHP include:

- Lack of community cohesiveness, many factions, exacerbated due to recent *panchayat* elections
- Transitory government counterparts
- Changes in food commodity guidelines so that potential enrollees had to be dropped
- ANMs called away by polio and TT campaigns, new schemes such as ECCE
- Movement of blocks and centers in CARE's program so that implementation occurred for a short period of time
- Lack of health and food supplies
- High fertility rates
- Low status of girls and women

CARE's Implementation

Overall CARE implemented INHP activities efficiently and consistently with State and GOI guidelines. CARE field staff are widely recognized as effective managers and important field monitors on whom the GOUP depends for information and a substantial proportion of food commodities.

Important changes occurred in the program from a four-tiered strategy to a unified strategy with demonstration sites located in each district. Geographical consolidation further changed the location of CARE's INHP program. Less than 50% of the original blocks are now in the INHP.

Technical interventions:

Interventions

The process of identifying and reaching the 'Below Poverty Line' includes a biannual survey to identify the BPL. Food commodities are for pregnant and lactating women and 0-3 year old children in these families. However, all AWCs visited have a higher number of BPL beneficiaries than the food allotted, as shown in the example below.

Table 1. Proportion of Target Population Enrolled and Reached

Criteria	Preg	Lact	6-11 m	12-35 m	3-6 y
Age elig no.	2484	2829	4880	9206	12755
BPL no.	1831	2050	2615	4680	6715
% of age elig	74	72	54	51	53
Enrolled no.	938	1206	1695	3665	5360
% of BPL	51	59	65	78	80
Recd >15 d no.	913	1189	1583	3595	5284
% of BPL	50	58	61	77	79
% of age Eligible	37	42	32	39	41

BPL = Below Poverty Line

Source: Hargaon Block, Sitapur Dist., UP, CDPOs Monthly Report for 4/01

Most interventions should reach all age-eligible target groups e.g. breastfeeding and complementary feeding counseling, immunizations, iron/folic acid, ANC for public health impact. Only the food component is aimed at families below the poverty line. However, the 'AWC-centric' nature of the program tends to miss a large segment of the target population.

CARE's INHP focuses on achieving high coverage with the following:

- Targeted supplementary feeding

The basic model for enrolling and reaching beneficiaries needs to be re-examined. CARE has been effective in operationalizing this model as far as commodity management and field monitoring. There is a visible difference in the effectiveness and management efficiency of CARE monitored blocks as compared with non-CARE ICDS blocks.

In the basic model being implemented, the role of the food appears to be as an incentive to draw families in to the center for health services and health/nutrition education. It also provides an important in-kind transfer for food insecure families through THR distribution. THR are distributed to other family members so the direct impact on key target age groups is likely to be limited.

AWWs have selected among the BPL beneficiaries on their own initiative, leading to misunderstanding and lack of trust in the program. Because communal sentiments are widespread in UP and the recent *Panchayat* elections have heightened caste and political divisions, the AWW (who belongs to one or another of these groups) is even more distrusted.

The location of AWCs in the AWW workers home has been a problem as well, proving to be a disincentive for broad participation. Full participation is important for changing health and nutrition practices.

- Iron/folic acid supplements

This intervention appears to be implemented well according to international guidelines. However, anemia levels are very high in UP in young children and the focus appears to be exclusively on anemia prevention among pregnant and lactating women. This appears to be a gap that should be addressed urgently through ICDS/health collaboration. Iron supplementation for young children combined with bi-annual de-worming (with vitamin A supplementation) is a relatively simple intervention with potential high payoffs for health and nutrition. Adolescent girls are being given weekly iron supplements in some states and would be another anemia control intervention worth exploring in INHP-II.

- Immunizations (childhood and TT)

The potential for improving measles and TT coverage further needs to be examined. THR, NHD and convergence fostered by CARE appears to have increased immunization coverage in the enrolled beneficiaries. AWW and helpers actively promote immunizations in their enrolled groups and monitor coverage of this group. However further improvements may be possible if the center (AWC)-based focus and limitations of selecting only a small proportion of eligible women and children for the AWC program can be broadened to other members of the community and surrounding small hamlets for behavior change, community mobilization, and convergence activities.

- Infant feeding practices (early initiation of breastfeeding, exclusive breastfeeding, and appropriate complementary feeding).

These components were weak or non-existent and do not reach the majority of the target population.

In some demonstration sites AWWs have received communication tools and have received some orientation on the importance of these behaviors.

A common incorrect message observed in several places in Sitapur and Lakhimpur is to feed dal water to infants from 6 months of age. The use of diluted goats milk to newborns for the first 4-6 days and diluted buffalo milk to infants from 6 months onwards is common. Another harmful behavior in U.P. is witholding food from postpartum mothers for 4-5 days. AWW and ANMs are advising mothers to give 1 or 11/2 teaspoons of food per day from 6-9 months. Growth monitoring is not being used to support improved infant feeding practices (the common message for a case of growth faltering is to send the child to a doctor).

A major effort is needed urgently to develop a strategic approach to behavior change that reaches households beyond the few who are enrolled as AWC beneficiaries.

Private doctors and ISMPs play an important role in defining health and nutrition practices and need to be engaged in health/nutrition awareness raising.

Implementation processes
The main implementation processes are:

- Assuring delivery of food commodities to the AWC center level. An elaborate system of monitoring, random AWC visits, year end audits, godown visits, monthly monitoring of beneficiaries rosters helps keep the commodities moving to the AWC relatively on schedule.
- Planning and Implementation of Nutrition and Health Days. BLAC and DLACs are mechanisms used to plan these activities.
- Developing and financing NGO sub-grants for community mobilization. Identifying potential NGOs, helping plan their activities and providing management support are important components. Time delays from initial discussions to signing a grant can take up to 6 months.
- Information systems and monitoring. New systems are being put in to place. Meanwhile GOUP has engaged their own HMIS staff under the World Bank project and coordination will be needed between the new CARE and DWCD systems.
- Capacity building and training for AWW, CDPOs, and ANMs
- Evaluation and documentation

Community
CARE/UP supports community mobilization through a total of 11 NGOs, including Manav Sevar Santhan and Sarvodaya Ashram In Sitapur District. The latter two groups build generalized community capacity and "ownership;" they encourage health activities to flow from community initiatives but do not appear to provide specific guidance. Their efforts are seriously impeded by factional disputes attributed to recent *panchayat* elections (but almost certainly related to pre-existing divisions). AWWs are often associated with one group or another, reportedly causing members of other groups to boycott her services; to remedy this problem, the Sitapur District Magistrate has directed that AWCs be moved to public locations (*panchayat* offices, schools, etc.). This has not yet been enforced.

While any community mobilization is certain to be difficult in UP, the evaluation team questioned whether the broad, relatively undirected, approach taken in Sitapur was likely to produce tangible health benefits for even the medium term. The strategy should reflect the inevitable presence of communal tensions, addressing these constraints where feasible but working toward concrete and potentially achievable outcomes even where full community "ownership" and management are not yet possible.

Support systems:
CARE structure, roles
We were unable to meet with the state INHP Manager due to a death in his family. Field Coordinators work from a base in Lucknow, permitting frequent interchange among staff but undoubtedly weakening direct support for Field Officers or their activities. The Field Officers that we met were all male and appeared to spend the majority of their time in coordination meetings and direct support for demonstration sites.

The UP program would benefit from increased technical support and opportunities for learning in the critical areas of community capacity-development and behavior change. The current personnel structure should be examined carefully to optimize support for these emerging strategies. The great staff effort needed to build demonstration sites appears to be paying off, but does not appear replicable. Field officers are the critical factor in generating convergence, but they are spread thinly and need additional opportunities to strengthen their technical skills.

There is inadequate technical review and content in nutrition, public health, and communications.

Food
UP is the only state with ready-to-eat (RTE) commodities supplied to AWCs. A food processor collects the CSB and oil from Calcutta port godowns, processes it with the addition of sugar, finally delivering it to block level.

There have been commodity stock-outs due to a change over in the food processor/supplier (from Modern Food to Khandelwal). In the past few years food supplies were interrupted during March-April when new tenders were issued. There is a problem with moving supplies from block to AWC. AWW are paid Rs.50 per trip, but this is inadequate especially since the volume of commodities increased after THR was introduced.

In non-CARE sites the food (India Mix) is less well accepted than CARE's CSB/oil. India Mix is finely milled and contains about 100 fewer calories per 100 grams.

There appeared to be inadequate focus on how to use the CSB/oil and/or local foods for young children in the critical age group of 6-24 months.

HMIS
The state CARE office has recently hired a highly qualified demographer to develop data systems and improve managerial applications. We were unable to find anyone making effective use of the recently revised HMIS. The focus is largely on food commodities, food beneficiaries and NHDays held, and not on community participation, behavior change, or data on nutritional status from growth monitoring.

Organizational learning and diffusion
Internal
The presence of Field Coordinators within the Lucknow office certainly facilitates ongoing exchanges, and the state director confirmed that learning within UP functions well. Coordinators learn quickly of innovations and problems, as reported by other Coordinators. The State Director indicated that learning from other state programs was weak, however, leading to a suggestion of regular exchange programs between states (by counterparts as well as by CARE staff).

External
The newly hired Deputy ICDS Director for UP joined us in Sitapur and expressed great interest in learning from CARE's evolving experiences, especially for behavior change. More importantly, the Secretary for Women and Child Development requested CARE to consider the possibility of extending technical assistance from CARE to non-CARE blocks as a practical means of facilitating replication.

Capacity building and sustainability
Systems
Two main accomplishments of the CARE UP INHP are building capacity for commodities management (this has already proven useful in non-CARE sites), and facilitating convergence between DWCD and DOH. The BLACs and DLACs initiated by CARE are important for convergence and likely to remain functional even without CARE.

Though training activities are considered the main CB strategy, joint field visits and meetings focused on problem-solving are important CB mechanisms.

CARE has been less effective in strengthening technical skills in nutrition, public health, communication and behavior change. Technical modules have been developed through a partnership with an NGO on nutrition, and health. UNICEF has also developed training modules through regional resource centers in Lucknow and Agra. How effective these are and the process used is not known.

A key potential for capacity building is at the District leadership level. Ongoing advocacy and awareness raising for DM/DC, district chiefs of DWCD, Health and rural development remain to be addressed adequately by CARE. Analysis of CARE's experience, its systematic documentation, and transfer to counterparts are important activities that CARE recognizes and aims to address in the near future.

Community
In order to meet CARE targets for the designation of demonstration sites, rapid formation of community structures/groups was undertaken by NGOs supported with CARE grants in the past few months. The sustainability of these structures remains to be seen.

Within the training and CB category, the largest number of participants in training activities are community-based individuals (AWW, helpers, change agents). However the content, focus, and effectiveness of capacity building activities is not known. From presentations made to the evaluation team by NGOs and AWW skills and knowledge observed, the activities have not been effective so far. Beyond providing knowledge and skills to functionaries, the community-level capacity building needs to be expanded to include ownership and participation of community members and leaders in INHP activities. These include the newly elected Panchayat leaders and members, school teachers, priests and other key community functionaries

Gender equity issues
The gender issue for UP as well as elsewhere is less one of equity than it is of optimal effectiveness: can the program achieve its objectives without placing women in front line as well as supervisory positions? The UP program employs only male Field Coordinators, and few Field Officers are female.

The evaluation team did not observe any special activities focused on raising awareness in the communities about caring for girl children.

Recommendations

1. Targeting
   - Special study of CARE AWCs who is benefiting and who is left out? Implications for improving nutritional status?
   - Working beyond those enrolled in the food program.
2. The "core/minimum/basic package" of interventions.
   - Number and choice.
   - Phasing in and clusters of mutually reinforcing interventions that are easy to implement and with synergies in impacts.
   - Quality standards, routine self-assessment, team problem-solving
   - Linkages with UNICEF on girl child initiatives.
   - Nutrition education based on home food – not only center food.
3. Role of CARE:
   - Develop future role of FO teams as district level technical advisory and assessment unit for nutrition and health improvement for women and children; staff up accordingly to deal effectively with DM/DCPO/CMO level counterparts. Main focus on capacity building.
   - CARE is an independent monitoring entity for the government's field programs, because DWCD has too many social programs to do a thorough job.
   - Technical assistance beyond CARE/food blocks e.g. WFP and State/food blocks.
   - Advocacy and data use to generate awareness at high admin.levels and general public awareness.
   - Develop priority issues topics based on real field constraints and suggest innovations for testing.

4. Closer alliances between the State MOHFW and ICDS, because:
   - of the interactions between health and nutrition problems, interventions and outcomes
   - the need to focus both health and nutrition interventions on children under one
   - MOHFW can promote key ICDS messages in villages with less than 1000 population (which ICDS currently excludes)
5. BLACs and DLACs will be crucial channels for diffusion and replication of new ideas.
6. Consolidation still remains to be done, capacity building, advocacy/awareness, community engagement are unfinished. Some functions are already being diffused and capacity has been built (e.g. food commodity management).

WEST BENGAL STATE REPORT

Background Situation of Nutrition, Health, ICDS, and INHP

Summary information and Methodology

CARE INHP field staff in West Bengal consists of 3 FCs and 23 FOs, including 4 women. INHP targets pregnant and lactating mothers and children under 2. The project covers 13 districts, 119 blocks, and reaches 1,093,000 beneficiaries. The State Director has been in place for only 8 months but comes with many years of experience with PVOs. The INHP manager has been in place for 5 years.

During the fieldwork, Drs. Vivek Adhish and D.K. Ghorai, Mr. Kalyan Mookerjee, and Ms. Anita Boral joined the evaluation team, led by Rene Berger. The team split into two groups to cover Bankura, Burdwan, and Purulia Districts approximately 300+ kilometers from Calcutta. Prior to departure from Calcutta, the team met with the Principal Secretary DWCD, Mrs. Gupta, and the Joint Secretary Mr. Roychowdhury. The team also met with Joint Director and State Family Welfare Officer, Dr. D.K. Ghorai. Within Bankura, the team visited 4 blocks (Chhatna, Patrasayer, Saltora, and Sonamukhi. In Burdwan the team visited one block, and in Purulia, the team also visited one block. At the village level, the team met with the AWW and the ANM where available, the NGO working in the area, Panchayat members and beneficiaries. The team also met with the CDPOs, supervisors as well as Medical Officers and Public Health Nurses depending on the block. In Bankura, the team also met with the Additional DM, the CDMO, DPO, BMOs, CDPOs and others. Within CARE, in addition to meeting with the State Director and Project Manager, the team met with 2 Field Coordinators and had brief discussions with the Field Officers.

Description: what were the hypothesis and key strategies

Role of food

Food seems to be used as a nutritional supplement for women and children in the program. At the community level, there does not seem to be much of an incentive effect for food.

- Both monitoring data and AWWs reporting confirm that women attend the AWC for supplementary feeding outside of THR.

Key interventions

The Project Manager noted that a great deal of effort went into taking the INHP proposal and determining how it should be implemented. In the end, partnerships (NGOs) came through as a key intervention. Project staff also focus on the 3+3 interventions as per the UCB, but there is definitely a clear focus on building partnerships.

- Both the State Director and the Project Manager highlighted CARE's expertise in food logistics and management as a key strength that they bring to the project.

The capacity building hypothesis and sustainability

CARE West Bengal has taken the capacity building idea to heart. A great deal of their effort is focused on establishing women's groups and capacitating NGO partners. Staff clearly feel that building up these two areas will lead to sustaining activities at a local level.

- Project hopes to reach targets for NGO partners by Sept. 2001.

Documented coverage, outcomes, impact, attribution

Coverage information from the final evaluation shows improvements in most of the target indicators including a substantial decrease in malnutrition rates. Coverage data from the HMIS suggest that while many pregnant and lactating mothers and children under 2 receive supplementary feeding, attainment of NHDs is low. INHP has also formed a number of women's groups and is currently working with 29 NGO partners.

- Given that during a number of the purported NHD's reviewed, it was found that ANMs do not provide immunizations for fear that there are already too many activities going on, it is not clear how improvements in coverage of NHDs will be achieved.

CARE's Implementation

Big picture, key actors, partners

The focus of CARE WB has been to build sustainable partnerships. They noted that the *Panchayat* is very strong and feel that building up women's groups and local NGOs to take over the catalyst role is the key to improving the health and nutrition status of mothers and children in West Bengal. Also trying to integrate CASHE (micro-credit) project into the INHP areas as they believe this will further strengthen the program.

- Staff have rephrased the INHP acronym to note the key actors and partners:
  I - ICDS
  N - NGO
  H - Health
  P - *Panchayat*

Implementation against plan and expenditure against budget

The State Director noted that while the budget was sufficient, the allocation process was problematic at times. They were told at CIHQ that they would have to meet certain targets to receive their full budget request (which they did), but during the initiation of INHP they had been told that the State budget was to be reduced.

- Project reduced the number of blocks covered at two different times, from 200 blocks to 177, then to 119. Now plan to reduce to 100 blocks as they have found it difficult to implement activities in Darjeeling District and therefore plan to phase out from the District.

Technical intervention:

Interventions

WB is implementing THR as a means to further coordination and to provide better access by women to the program.

- NHD rates are low across the State. AWWs note that they find the NHDs too hectic to have an ANM also providing immunizations.
- Not clear now the State will achieve their goal of 50% NHD as ANMs are not providing this service at NHDs (which by definition requires immunizations (and ANC) to be provided).
- Growth monitoring is not being carried out systematically across the project areas. In Bankura, none of the sites visited were consistently taking and recording weights and neither Supervisors nor ANMs seemed to be in a position to correct the problem (Note: Mr. Mookerjee notes that there has been a shortage of scales in the State and that they have worked with UNICEF to obtain more - these are expected in the State by July. Still, many AWWs have a "bathroom" style scale at the AWC which, while not as accurate as a Salter type scale, would be sufficient to obtain information for recording trends on the cards. In two sites visited the AWW noted or was observed to write the weights that she did take on a sheet of paper and not the growth monitoring form.
- One AWW noted that she just looks at the children and decides who should get double rations.
- Exclusive breastfeeding did appear to be common (according to women's reports) but the age of weaning was very high (8, 9, even 10 months). Knowledge of INHP interventions was good.

Implementation process

- THR was provided, but according to the definition of NHD (including supplementary feeding rations as well as ANC including immunizations, are not conducted as the ANM believes there are too many activities currently going on to include immunizations). When an AWW covered more than one village, it was not clear how she determined who would receive THR but distance seemed to play a role - this is not consistent with the idea that foods serves as an means for participation in the program.
- ANMs and AWWs do coordinate activities in terms of having the ANM being in the village during the THR distribution, only all activities are not undertaken.
- One site visited was adjacent to the sub-center and the AWW noted that she does not come over very often, but rather the AWW sends participants to the sub-center.
- One CDPO noted that immunizations were special and deserved a special day focused solely on their provision.

Community

There appear to be varying levels of community participation. According to the AWWs in many villages, women with young children are willing to come for spot feeding on a semi regular basis (and therefore don't get THR). The project has also spent a great deal of time working on developing community women's groups and working with the NGOs.

- In one village the AWW noted she was having a difficult time getting the women to contribute for the health fund. The women were saying that there was no need for them to be paying for the food as it was provided by the government.
- Panchayat was available in the villages we visited, but they did not appear to be overly interested in the activities of the AWC. One member noted that the pre-school education was not very good, but that the feeding and the immunizations were on going.

Behavior Change

AWWs report that knowledge and awareness has improved regarding child health practices over time. Weaning practices are late for both girls and boys.

- It is not clear whether adequate input is being provided for behavior change to be affected. The focus on NGOs and women's groups is to capacitate them to work with the AWWs to provide appropriate health messages. Coverage rates for basic services have improved, however some practices are still poor.

Support systems

CARE structure, roles staff and technical support

It is clear that the FCs have a strong hand on the FOs. FOs view their role as working with the NGOs and that the NGOs in turn will undertake many of the activities at the community level.

- State Director mentioned that he's not too sure what the role of the FC is.

Food

Food was usually available and transported by the CDPO to the AWC. AWWs noted that if a month was missed they were sent double the amount in the next month. However, the AWWs also noted that if a month was missed they would not provide double the ration to make up for what was missed. In general, most of the sites visited appeared to have relatively good storage facilities, though bags were often on the floor and against the wall and the integrity of the roof overhead was not clear at more than one site.

HMIS

Data is fed up the chain on a monthly basis. FOs are encouraged to try cover more than the 3% of AWCs per month. FCs note that they provided input into the development of the HMIS and noted how it helps them to understand the problems which the FOs are facing.

Organizational learning and diffusion

Internal: FOs and higher levels share experiences with each other in various fora.

External: The Project Manager noted that it was a long process to work with the NGOs but that it would pay off in the end. FOs noted that in one particular block where they had been working with women's groups, the group had come together and was able to get the contract to distribute the commodities from

the CDPO to the AWWs. Where it used to take 10-12 days for the entire block to receive the food, the women's group is able to cover the block in one day.

- Cross visits of women's groups have been undertaken to this block in order to see how these women have organized themselves.

Capacity building and sustainability (exit strategies)

The State Director noted that if they are able to continue to work with women's groups as they have been doing, and with the NGOs, then he believes in another 5 years they will be able to phase out their assistance. Discussions with a number of CDPOs suggested that a longer time frame would be necessary in order to bring about the level of awareness that could be sustained, however the ADM noted that they could not expect to receive external support indefinitely and that they would need to be able to continue the activities themselves.

Gender Equity Issues

Women do appear to be able to leave their homes on a consistent basis in order to collect the rations from the AWC, this could imply that there is a good level of empowerment among women such that they are able to control how they spend their time.

The balance of CARE State staff suggests that further effort needs to go into staff recruitment and retainment.

It is not clear to what extent the NGO activities will build up the status of women to the point where they are empowered to demand services, though some NGOs point out this should be their goal.

Innovations

One women's group that CARE worked with has requested and received from the CDPO the contract to distribute the food commodities across the block. They have been able to decrease the time from CDPO godown to AWC from 10-12 days to one day.

Recommendations

- Staff skills should be upgraded so that all FCs and FOs can provide technical input on all INHP interventions. This includes how to work different staff levels (AWW, Supervisor, ANM, and NGOs) on providing technical assistance at the community level.
- Staff time allocation should be reviewed with an eye toward allowing FOs to spend more time at the AWC level and less time at the District level.
- FCs may need to be re-trained on how to undertake supportive supervision of activities.
- Methods of providing training to AWWs, ANMs, Supervisors and CDPOs on the INHP interventions is critical, including how to undertake growth monitoring activities.
- INHP should assure that all AWCs have the appropriate equipment - particularly scales. Where GoWB input is slow, CARE should work with local women's groups to purchase scales locally (this does not mean that CARE should have to purchase the scales - women's groups may need assistance in identifying suppliers and in distributing stocks, but CARE should not purchase the supplies).