ICDS Systems Strengthening & Nutrition Improvement Project (ISSNIP)

Guidelines For
Implementation of Incremental Learning Approach (ILA)
For improving Programme Outcomes

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Ministry of Women and Child Development
Government of India

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CONTENTS

1. CONCEPT AND RATIONALE OF INCREMENTAL LEARNING AS AN APPROACH TO IMPROVE PROGRAMME OUTCOMES

The Integrated Child Development Services (ICDS) programme aims at achieving substantial improvement in outcomes from a range of maternal and child health and nutrition and pre-school education activities. As envisaged in the programme design, outcomes will be achieved if the *Anganwadi* Workers (AWWs) consistently and effectively execute these activities. The Lady Supervisor (LS) at the sector level is expected to provide the AWWs the necessary support and direction to ensure effectiveness and the Child Development Project Officer (CDPO) and District Programme Officer (DPO) in their turn are expected to provide the necessary managerial and leadership inputs to make this possible. While these roles are generally understood and acknowledged and the programme has well established ways of providing classroom training through the Training Centres/Institutes which imparts knowledge and develop skills, there are inherent challenges in translating knowledge into effective and consistent actions, *viz.*:

a. *the actions expected of the AWWs are apparently simple but are numerous and wide-ranging, demanding different skills in pre-school education, health and nutrition, accounting and coordination;*

b. *the range of beneficiaries is wide, from adolescents to mothers, young infants and preschool children, each requiring a different set of engagement skills and approaches; and*

c. *among the numerous tasks expected of the AWW, there are a few key tasks that are critical to achieving outcomes; the programme is likely to be effective only if the system manages to prioritize the effective implementation of these actions, many of which are soft interventions for behaviour change.*

Ensuring the development of such practical job skills and pragmatic grasp of priorities is not merely a function of '*training*', but one of effective, day-to-day '*programme management'*.

The ICDS Systems Strengthening & Nutrition Improvement Project (ISSNIP) which is under implementation in 162 districts across eight States[1] with financial assistance from the World Bank (IDA), envisages establishing a system where programme functionaries will become more effective by learning to plan and execute each task correctly and consistently through methodical, ongoing capacity building, called '*incremental learning approach (ILA)'*[2]. Such a system will use opportunities in the form of existing supervisory interactions at different levels, through which practical, guided learning may be accomplished. Since the range of skills and tasks to be learnt is quite substantial, and since adults naturally learn *by doing* rather than through theory alone, the proposed system envisages breaking down the total

[1] Andhra Pradesh, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Maharashtra and Uttar Pradesh

[2] Administrative Approval & Guidelines for implementation of IDA assisted ISSNIP (Component 6.1C), 10 January 2013, MWCD, Govt. of India

learning agenda into small portions of doable actions. *The approach is to build incrementally on small amounts of learning at a time, until all skills, understanding and actions have been put into regular practice, and have been internalized by the functionaries and finally a supportive supervisory mechanism is put in place*. By making such a system integral to routine programme implementation, it is possible for the programme to introduce new and complex content and skills at any time and expect its effective implementation in a predictable timeline. Such an approach has high potential in the context of a large and well-established programme, where most functionaries have already completed formal job and refresher training, and there is a need to quickly improve programme effectiveness. Specifically, it applies to the contexts of ICDS and health programmes as they stand today. The ISSNIP also supports organization of the sub-centre level meetings of ASHA, AWW and ANM for joint planning and implementation on pilot basis[3] which is another platform for incremental learning.

Different versions of this approach have been implemented in the past, involving the ICDS and health functionaries, with varying degrees of success[4]. Recently, a similar system has been successfully implemented[5] in eight districts of Bihar, and is currently being scaled up across all 38 districts in the State. The approach used in Bihar brings together all AWWs and ASHAs within a health sub-centre (HSC) for a monthly *review-planning-learning* meeting, co-facilitated by the concerned ANM and Lady Supervisor (LS), and utilizes the opportunity of the field visits of the ANM and LS for follow-up and *individualized supervision*. The National Health Mission (NHM) of Government of India has given budgetary support to this approach in Bihar through the Annual Programme Implementation Plan (PIP), recognizing this as an effective *supportive supervision and convergence mechanism*, and the two concerned Departments in Bihar (Health and ICDS) have issued joint directives to implement this. Outcomes, in terms of service coverage and behaviour change on a wide range of parameters related to maternal care, neonatal care, nutrition, immunization, family planning etc., have been measured *serially over time* and substantial change has been demonstrated in about two years of implementation at large scale[6]. Lessons from these experiences are available, and will be utilized to design and implement similar approaches under ISSNIP.

[3] Ref. Component 6.1D of ISSNIP Administrative Guidelines

[4] *Integrated Nutrition and Health Project* (INHP), in Andhra Pradesh and Chhattisgarh, 2007-2010. Through a system of District and Block level Resource Groups (DRGs/BRGs), thematic contents were successfully delivered incrementally every month to all AWWs in 15 districts of Andhra Pradesh and 6 districts of Chhattisgarh over a period of more than one year. This was facilitated by a small team of external facilitators at the district and State levels led by CARE India. The monthly sector meeting of ICDS was the main platform used, with ANMs participating in sector meetings as well as in VHNDs. The intention was to uniformly and effectively implement a set of good practices (including age-appropriate home visits, nutrition and health days, structured supervision through sector meetings and field visits). .

[5] *Integrated Family Health Initiative (IFHI) Project* , BMGF/Care India

[6] Outcomes measured in serial, LQAS-based large sample household surveys

2. GOAL AND OBJECTIVES OF THE INCREMENTAL LEARNING APPROACH (ILA)

The goal of the proposed system of *Incremental Learning* is, therefore, to supplement existing the training programmes with a structured method of supportive supervision at all levels which ensures that functionaries learn *how* to execute their roles and enable the programme to achieve desired outcomes. The specific objectives of the *Incremental Learning Approach* are:

- *Build skills and an understanding of priorities among frontline workers, through a learning-by-doing approach, over time;*
- *Strengthen supervisory structures and skills through a similar approach; and*
- *Enable coordinated functioning of ICDS and health programmes to achieve common goals*

While such a system can be implemented independently by health and ICDS programmes, coordinated implementation is likely to optimize the strengths of both, and yield better outcomes. The expected results are improved and sustained programme outcomes.

3. PROCESS FOLLOWED IN DEVELOPING THE GUIDELINES

Based on the experience of different attempted approaches, it was proposed under ISSNIP that the Incremental Learning Approach would be quickly piloted and taken to full scale by the third year of Phase 1 of the project, as a core approach to strengthening programme implementation to achieve desired outcomes. In the meanwhile, further refinements were made to the approach being followed in Bihar, and it was found to be scalable and effective in improving outcome level indicators. Keeping in view of this, a cross-learning workshop and exposure visits were organized under ISSNIP in Bihar during 16-18 January, 2014, for an initial exposure of the senior/mid-level officials of the project States, the World Bank Team and the Technical Assistance Agency Team to the Bihar model of health sub-centre based incremental learning approach. It was recognized that it may or may not be possible for all States to use an identical approach, but that the lessons and materials available from Bihar could be directly used by other States with due adaptation.

Following the above, individual consultations were also held by the Technical Assistance Team with the State Govt. officials in the States of Chhattisgarh, Andhra Pradesh, Bihar and Jharkhand to elicit their views on how the ILA can be implemented in their States. Based on their inputs and evidence from the Bihar model of ILA, draft guidelines for IL implementation were prepared; were discussed and deliberated upon with the selected State level Master Trainers (SLMTs) from the eight project States during a 2-day orientation training workshop on ILA held at Jaipur on 13-14 August 2014. The present guidelines have been finalized based on the aforesaid inputs.

This document outlines the key elements of ILA and provides guidance on how to implement it in all districts and blocks under ISSNIP.

4. KEY ELEMENTS OF THE INCREMENTAL LEARNING APPROACH (ILA)

A fully established incremental learning system under ISSNIP will consist of the following main elements:

i. *Structured supervisory interactions for ongoing learning, planning and review*
ii. *Planned learning agenda with clearly defined outputs and outcomes*
iii. *Use of evidence for learning and improving performance*
iv. *External facilitators/resource persons*
v. *Mechanisms for enabling convergent actions between ICDS and health programmes*
vi. *Cascading system of controlled monthly inputs*

These elements are first described in brief below, followed by suggested steps for implementation:

i. Structured supervisory interactions for ongoing learning, planning and review

Supervisory interactions take place regularly between different functionaries in the hierarchy. Currently, these interactions are largely ad-hoc and mostly restricted to administrative matters. These interactions can be strengthened by structuring them, specifying content and periodicity, as well as providing some tools and checklists to be used and data to be generated and used. Table-1 below provides basic details for the existing platforms for such interactions, which can be developed further according to local context. There are three main functions of all supervisory interactions: review, input and planning. Ongoing learning can be ensured by organizing these functions methodically. Supervisory interactions are the core elements of the IL system. They ensure that learning is translated into action.

ii. Planned learning agenda with clearly defined outputs and outcomes

All programme functionaries are learners under the ILA. Together they have to *learn to function effectively to achieve specific programme outcomes* in a range of different thematic areas. *Most of the learning is by doing*. The learning agenda is planned such that, typically, two small 'topics' are covered in each monthly cycle. Each topic has action points to be implemented over the next month. These actions are the expected outputs for that month, and can be monitored during supervisory interactions. Over a period of time, these actions are expected *to produce changes in specific outcome indicators* such as coverage of services and feeding and caring behaviours.

Any number of such topics can be covered over a period of time. An illustrative list of topics organized under different thematic areas (maternal care, neonatal care, child care, immunization, IYCF, etc.) may be found in *Annex-3*. For a given monthly cycle, one topic each can be selected from any two thematic areas. For the next cycle, it is useful to take up one topic that is from the same thematic area as was covered in the previous month, and select the second topic from a different thematic area. In this manner, both continuity and change are ensured. Other topics can be added to each thematic area, and other thematic areas can be added as well, for instance, preschool education and supplementary feeding.

While adding a new topic, it is important to remember that it must be short and practical so that it can be covered within the time available in the meeting platforms at each level and specific action points must be identified from the outset. These points must be included in the scope of supervisory interactions planned for the subsequent months.

The topics included in the illustrative list in Annex-3 are recommended because they are directly related to achieving desired programme outcomes. They follow the well-known '*window of opportunity'* approach of emphasizing critical points in the '*first 1000 days'* between conception and two years of age of the child, to maximize likelihood of impact with minimal but very sharp effort. One may choose to start with or prioritize any thematic area at any time. However, it is recommended that, within a thematic area, the sequence of topics covered over time should be as listed, since this is organized in a logical manner where each subsequent topic builds on the previous one. Separately, modules will be provided, including display materials and facilitator's guides, for most of the topics included in the illustrative list.

iii. Use of evidence for learning and improving performance

The IL process at every platform includes *a review of progress*. It is this process that should contribute most to *new learning*. The review will be most productive if it is based on evidence. The evidence can come from any reliable source – from verbal reporting and discussions during a platform meeting or other supervisory interaction, from data collected during supervisory field visits, data reported in monthly reports, or data from entirely independent sources. One such source of independent data could be LQAS-based household surveys by Lady Supervisors, which is one of the other innovations to be piloted under ISSNIP. The modules that will be provided separately contain some examples of how data and other evidences can be used during reviews. It is expected that, based on such evidence, supervisors at every level will take decisions about what is working or not working, and make minor changes to implementation approaches to achieve better or quicker outcomes. From the same process, it will also be able to identify factors that require higher level programmatic or policy decisions to make further progress.

iv. External facilitators/resource persons

It is recognized that only a few functionaries will have the capacity to run such a methodical system from the outset, and that many of them will require a lot of hand-holding for a long time. Under ISSNIP, there are several provisions for identifying and using resource persons external to the normal ICDS hierarchy of functionaries. This includes the District Resource Group (DRG) and the Block Resource Group (BRG), as detailed in later section, as well as District and Block Coordinators to be recruited under ISSNIP. Resource persons may also come from the Health department, from academic institutions as well as from reputed local NGOs. Budgetary provisions may also be used to hire on contract facilitators to support supervisory interactions in different platforms, such as sector, sub-centre or block. The IL approach recognizes that all such resource persons themselves are unlikely to bring in necessary technical expertise, and thus they are included among learners at various levels.

Table 1: Existing Platforms for Supervisory Interactions at the Sector and Block Levels

Level	***Supervisor / Facilitator(s)***	***Participants***	***Periodicity***	***Domains covered***	***Comments***
Sector Level Meeting	Lady Supervisor (LS) (+ANM) Additional external facilitator desirable until LS gains competence.	All AWWs of a sector	Monthly	Growth monitoring Supplementary Nutrition Preschool Education MCH including IYCF and malnutrition if HSC platform has not been activated for IL	Existing platform, currently being used mainly for administrative transactions. Experience from several states suggests that it is feasible to set aside 2-3 hours time for programmatic discussions. Alternatively, a second sector meeting during each month may be planned, dedicated to programmatic discussions. Concerned ANMs may participate in this meeting if the HSC platform is not being used for IL.
Health Sub-centre (HSC) Level Meeting	ANM + LS Additional external facilitator desirable until ANM/LS gain competence.	All AWW + ASHA of a given HSC	Monthly	All MCH, IYCF, malnutrition related issues (including immunization, FP, IMNCI as appropriate)	This platform does not exist in most States at present, and will need to be created jointly by the two departments. Experience in Bihar suggests that it is feasible to organize such a meeting for 2-3 hours each month, at a suitable location within the catchment area of the HSC. This enables ASHA and AWW to work together seamlessly, sharing the entire MCHN work.
AWC visits by LS	Lady Supervisor	AWW and ASHA of one village / AWC	At the recommended/ feasible frequency of centre visits of LS	MCHN with AWW and ASHA together, and ICDS-specific domains separately with AWW	Supervision by the LS includes making selective home visits by herself alone or in the company of the AWW/ASHA, to gather understanding and data about the interactions of the workers with families, and of service coverage and behaviour change.
VHND	ANM (+ LS)	AWW and ASHA of one village / AWC	Monthly	MCHN with AWW and ASHA together, and ICDS-specific domains separately with AWW (by LS)	This is seen as primarily a service delivery point. However, it is also a monthly opportunity for the ANM to interact with an ASHA and AWW individually.
ICDS Block review meetings	CDPO	All LS of the block	Weekly / Fortnightly / Monthly	ICDS-specific domains, + all MCHN domains if HSC platform not activated	Structuring these existing platforms will enable methodical review of progress of implementation. If HSC platform has also been activated, the agenda for this meeting can be ICDS-specific
Block PHC review meetings	MOIC / BHM / BPM + additional external facilitator	All ANM of the block	Weekly / Fortnightly / Monthly	All MCHN domains	Structuring these existing platforms will enable methodical review of progress of implementation. If HSC platform has also been activated, the agenda for this meeting will include the entire MCHN domain.

MCHN- Maternal Child Health and Nutrition

v. Mechanisms for enabling convergent actions between ICDS and health programmes

The mandate for achieving maternal and child health and nutrition outcomes through community level interventions is shared more or less equally by the ICDS and Health Departments, and specifically by the AWW and ASHA, and their supervisors - the LS and the ANM (or ASHA Facilitator). There are at least three interfaces between the two programmes that can be optimized for best results:

a. *The presence of two frontline workers, AWW and ASHA, in each village is an advantage that should be optimized.*

b. *Similarly, the presence of the ANM periodically in each village can be optimized if there is close coordination between her and the AWW/ASHA, and they all can use their individual skills and positional advantages to mutual benefit.*

c. *Finally, public health facilities that provide services are important service delivery points in the first 1000 days period. Before and after receiving facility based services, beneficiaries in the community are under the charge of frontline workers. The interface between services provided in the facilities and in the community can also be optimized.*

It is, therefore, important to include health functionaries within any IL process, with the specific objective of optimizing interfaces such as the above. The VHND (Village Health & Nutrition Day) is an existing platform where the two programmes are expected to converge. The proposed monthly HSC meeting is another platform with demonstrated advantages. Referral and feedback systems have been tried in several States, involving the frontline workers of the two departments. In addition, regular interactions between the respective programme leadership at the block and district levels are necessary to ensure smooth and mutually beneficial exchanges at all lower levels. Such mechanisms should be an integral part of the IL approach.

vi. Cascading system of controlled monthly inputs

The IL cycles require a central mechanism of coordination and control. Either at the State or at the District level, a small group of officials must take responsibility of conceptualizing and planning the entire IL process, and utilize appropriate resource persons with requisite expertise to do so. The TA Agency staff under ISSNIP and Consultants in the SPMUs will provide the necessary support and direction to this core planning group. At each subsequent level, programme leaders of that level should take charge. Overall, there are two key roles to be played at each level:

a. *Technical and training responsibilities*

   DRG and BRG members and other external and internal facilitators will ensure that detailed plans are made for each monthly cycle, related teaching-learning materials are created or made available in sufficient numbers, and the technical integrity of training and operational planning during the month is not compromised. Some of the members may have administrative responsibilities as well.

b. Administrative and managerial responsibilities

Supervisors and programme leaders at each level ensure implementation as planned, ensure that data becomes available for review, use data and evidence for review and monitor progress of outputs and outcomes as planned. They may also be resource persons and members of DRG and BRG, but their main responsibility is in ensuring that planned actions are executed. If they are not also members of DRG or BRG, they will require separate technical inputs to play their roles as leaders and managers effectively.

5. Steps for Implementing the ILS

This section describes steps and processes involved in successful implementation of the IL system using both, the sector (ICDS) and HSC platforms. While most processes are similar, there are significant differences in some aspects, which are described separately.

An illustrative plan for a monthly cycle of IL related processes and how they fit into various forums has been outlined in *Table-1* above. A monthly cycle will be initiated at the district level and will involve a sequence of planned interactions in each of the listed forums, similar to cascading training, and ending with the initiation of a new set of actions taken by frontline workers at the community level. This will repeat in the next cycle. In the process, all functionaries at all levels will have participated.

5.1 Two Optional Structures

This section describes how the monthly cycles of IL should be planned and how interactions at each platform should be structured. There are two optional structures for IL, of varying intensity of participation of the Health Department:

- *Model A:* Under this, monthly IL meetings are planned and organized both at the ICDS sector and health sub-centre levels. This is the most desirable option for success of the ILS.
- *Model B:* Under this, monthly IL meetings are planned and organized only at the ICDS sector.

Key features of these two options are described below:

Model A: Involving Monthly Health Sub-Centre (HSC) and ICDS Sector Meetings

- Requires full participation of the Health Department.
- Each month, IL occurs through both, HSC platform meetings as well as ICDS Sector platform meetings.
- At monthly HSC meetings, ANM is lead facilitator, and participants include all ASHAs and AWWs of the HSC catchment area; the LS attends as many HSC meetings in her catchment area as feasible; the agenda covers all aspects of maternal and child health and nutrition.
- At monthly Sector meetings, LS is lead facilitator, and participants include all AWWs of the Sector; the agenda is ICDS-specific, such as supplementary nutrition, preschool education, growth monitoring etc.

- At the block level, each month there are two separate platforms that the BRG facilitates: the ANM review meeting in the block PHC (or equivalent) run by the MOIC/BPM/BHM and the block level meeting of LS with the CDPO.
- During their respective village visits, both the ANM and LS engage with ASHA and AWW to track progress of individual women and children; potentially, both gather data that can then be shared between the departments and collated to inform programme reviews of both departments at the block level.

Model B: Involving ICDS Sector meetings alone

- Involvement of the Health Department is of lesser intensity than in Model A.
- At monthly ICDS sector meetings, participants are all AWWs of the sector, as well as ANMs concerned with villages in the sector; the ANMs do not have a major leadership role; the agenda includes the entire range of maternal and child health and nutrition topics, including ICDS-specific topics. Most of the coordination between the two departments takes place during these meetings.
- While the LS follows up closely with the AWWs during her AWC visits, the role of the ANM is limited, as at present (but can be expanded as feasible).
- At the block level, each month there is a single platform that the BRG facilitates: block level meeting of LS with the CDPO.

5.2 Key Steps

Following are the key steps to implement the ILS:

i. Identify the State level Master Trainers (SLMTs) from amongst the SPMU Team, Joint Project Coordinators (JPCs) under ISSNIP and State TA Team (State Team Leader and Regional Managers) and ensure their orientation training by the central team.

ii. Constitute DRGs and BRGs for all districts and blocks covered under ISSNIP (*described below*).

iii. Decide to adapt any of the two options of ILA i.e., Model A (both Sector and HSC level meetings)[7] or Model B (only sector level meetings).

iv. Issue instructions/directives (preferably jointly with health) to all districts/blocks about ILA.

v. Organize orientation training of DRGs on operational modalities involved in implementing ILA, as well as on the thematic modules for first 3-4 IL monthly cycles by the SLMTs, followed by cascading training of BRGs by the DRGs on the same issues. Ensure monthly orientations of DRGs/BRGs on next monthly cycle's modules.

vi. Develop district and block level micro plans for conducting IL sessions - schedules for meetings at the district, block and sector level (*separately for Sector and HSC levels, in case Model A is followed*).

[7] For implementation of HSC level ILA under Model A, the Health Department may be consulted for involvement of the health personnel at the district, block/PHC and sub-centre levels in the IL process and a joint directive may be issued to all districts. It may also be explored to mobilize additional resources through State PIP of National Health Mission (like in Bihar) for supporting ILA at the HSC level, since only limited allocation has been made for this, under ISSNIP (*Ref. Annex-2*).

vii. Inform the districts and blocks about financial norms, allocations, utilization certificates and reporting mechanism and ensure timely availability of funds at all levels.

viii. Ensure timely production and supply of materials (photocopy) for each IL session, up to all blocks.

ix. Deploy SPMU Consultants and the State TA Team for coordinating with individual districts.

x. Introduce programme management tools for Supervisors at each level, and ensure the generation and use of data and evidence to fine tune implementation[8].

xi. Develop and implement field monitoring plan to ensure quality of IL sessions.

xii. Organize periodic review of progress and initiate corrective actions at the State/district levels.

As pointed out above, frontline workers (AWW and ASHA in Model A, AWW alone in Model B), ANMs (in Model A), ICDS Supervisors, CDPOs, PHC officials (in Model A) and DPOs will be oriented incrementally on operational details of each technical intervention through District Resource Groups (DRGs) and Block Resource Groups (BRGs). Such IL sessions at district and block levels will mainly focus on actions to be taken, and will emphasize on the explanation of the content and technical rationale of all proposed actions. At each level, three kinds of action points will be conveyed through the designing of IL modules for each round:

a. how to 'run' the next lower level of IL meeting or interaction;

b. how to be an effective Supervisor, especially in the context of the intervention and actions being decided; and

c. how to execute individual responsibilities effectively, especially related to the intervention.

For instance, a BRG member would need to show how the next month's sector/HSC level meeting should be run (what the review/planning/training should be), how the Supervisor should support the AWWs during one-to-one interactions and what other actions independent of AWWs are expected of the supervisors (such as home visits, data collection). For AWW and ASHA, only the last type of action applies.

5.3 Formation of DRG and BRG

The important step in the roll out of ILA is formation of DRGs and BRGs, which will consist of members from the ICDS and Health programmes; staff of the development partners (wherever available) and other NGOs with experience of nutrition and health programmes as well as independent resource persons like district and block level master trainers who have been involved in earlier initiatives in ICDS or health[9]. Following is an indicative list of officials/other individuals who can be members of DRGs and BRGs. Their roles and responsibilities are also outlined below.

[8] Will be provided by the Central Project Management Unit (CPMU), MWCD

[9] A number of qualified and trained external master trainers may be found in most districts and they are often engaged by Health/ICDS for conducting cascade trainings or as resource persons for specific events.

A: District Resource Group (DRG)

Composition of DRG

Each project district constitutes a DRG following directives from the SPMU. Each DRG may consist of about 8-10 members (depending on size of the district, ensuring that at least one member takes responsibility of 1-2 blocks) with the following composition:

a) ICDS DPO/ DSW – 1 (lead)

b) CDPOs – 3

c) District Coordinator, ISSNIP – 1

d) District Public Health Nurse (DPHN) – 1 (*if available*)

e) Other Officials from Health Deptt.(District RCHO/ DIO/DPM) – 2-3

f) 3-4 external resource persons available in the district[10], like

- *Master trainers who have used in IMNCI/ Vitamin A/ RI programmes*
- *Staff of development partners or NGOs working in health/ nutrition areas*
- *Select staff of AWTC/ MLTC in the district and from other academic institutions*

Note: In States, where external resource persons are limited, all CDPOs can be part of DRGs and all LS can be part of BRGs, with very few or no external resource persons. However it is important to assess capacities of CDPOs and LSs to uniformly take content to next levels. District and Block Coordinators of ISSNIP and Regional Managers (RMs) of the TA Agency will have to ensure such consistency of quality.

At least 3-4 external resource persons need to be included in each DRG so that they can support block level sessions wherever required. As per directive from SPMU, DPO in consultation with the Regional Managers of TA Agency and District Coordinator of ISSNIP is responsible for constituting and notifying DRG. S/he is also responsible for getting BRGs constituted in all blocks of the district.

Roles and Responsibilities of DRG

a) Participating in full-day quarterly orientation on upcoming IL cycles, facilitated by SLMT;

b) Conducting full-day (6 hour) BRG orientations in assigned block/s monthly on upcoming IL cycles;

c) Support and monitor BRGs in the assigned block/s to conduct block level interactions as needed and feasible – on sample basis; and

d) Undergoing intensive training twice a year by SLMT to remain up-to-date.

B: Block Resource Group (BRG)

Composition of BRG

Each block in the project district will constitute a BRG. SPMUs will develop and circulate required directives to constitute BRGs. Each BRG will consist of about 8-9 members

[10] Essential criteria for all the external resource persons will be their ability to give at least 4-5 days for each monthly ILA cycle. Such external resource persons (who are not working on full time basis) may be paid honorarium and travel reimbursements for the days of work with the project.

(depending on the number of sectors in the block, ensuring that at least one member takes responsibility of 1-2 sectors) with the following composition:

a) CDPO (*lead*)

b) All Supervisors

c) Block Coordinator, ISSNIP – 1

d) Block Public Health Nurse – 1

e) 3-4 Master trainers/external resource persons available in the block like IMNCI/ Vit-A master trainers and staff of development partners or NGOs working in health/nutrition areas.

At least 3-4 external resource persons need to be included in each BRG so that they can support sector level ILA sessions, especially where Supervisors require additional handholding support. CDPO in consultation with the DPO, Regional Managers of the TA Agency and Block Coordinator of ISSNIP, is responsible for constituting and notifying BRG.

Roles and Responsibilities of BRG

a) Participating in monthly full-day orientation on upcoming ILA cycles, facilitated by the DRGs;

b) Conducting 3-4 hour monthly orientations of all LSs of the block and of block officials and ANMs (under Model A) on upcoming IL cycles;

c) Supporting LSs/ANMs in the assigned sector /HSC to conduct IL sessions as per design;

d) Undertaking additional joint trainings of ASHA, AWWs and ANMs on selected themes as per communication from the ISSNIP district team; and

e) Undergoing intensive training twice a year by DRG to remain up-to-date.

5.4 Organizing IL sessions at various levels

Engagement of groups of programme functionaries at each level in a cascading approach is the main driver of the IL approach. Table-2 below provides an outline of how this should be organized. The platforms at which functionaries gather to review, get trained and make plans for the subsequent month are indicated, along with facilitators for each platform.

As described earlier, at the most peripheral level, there are two platforms (*Ref*. Tables 1 & 2) – the Sector and Health Sub-Centre (HSC). If the approach adopted by a State is Model A (with intensive involvement of the Health Department and activation of health sub-centre meetings), careful attention needs to be paid to micro-planning for scheduling both HSC and Sector meetings in such a manner *that they do not overlap* (since AWW will need to attend both and there could be common facilitators for both). Under Model B, it may be decided to organize an *additional* sector meeting every month if the routine monthly sector meeting cannot be conveniently reorganized to accommodate a methodical programme management agenda (which is the essence of IL).

At higher levels, there are the BRG and DRG platforms, which require to be created under the project. It should be kept in mind that these bodies are not merely groups of trainers. Their main constituents are programme supervisors and officials (playing important roles as

managers and leaders) at each level, assisted by external resource persons as trainers or co-facilitators.

The frequency of engagement as recommended is designed to fit a monthly cycle[11]. At higher levels, above the districts, it may be impractical and unnecessary to meet monthly, hence a quarterly schedule is recommended. However, at the district level and below, the most practical and meaningful frequency will be monthly. The duration of engagement (meetings) at each level is indicated in Table 2.

Each cycle takes about one month to complete. This implies that while the community level implementation of a cycle is going on, the State, district and block levels will be already preparing for the next cycle.

An illustration on the cascade of monthly interactions is given in Box-1 below.

[11] In practice, due to holidays, and other interruptions, it will usually be difficult to complete 12 cycles a year. Hence, it is recommended to plan for 9-10 cycles per year, and schedule them anticipating times of the year when there will be breaks.

Box 1: Flow during a Monthly IL Cycle

The cascade of monthly interactions that are expected to methodically bring about predictable change in outcomes is conceptually as follows:

State level Master Trainers (SLMTs)

→ District Resource Group (DRG)

→ Block Resource Group (BRG)

→Block level platforms involving ANM/ and LS platforms

→ HSC/Sector meetings

→ AWW/ASHA

→ Families in the community

At each level, the interactions are two-way: the facilitators/supervisors obtain data and feedback which they take back as appropriate to the preceding higher level. Thus, the content and pace of each cycle is informed by the experience of past cycles.

Table 2: Recommended organization of IL at all levels

Level of engagement on ILA	***Trainees***	***Composition of Trainees***	***Batch size***	***Facilitators***	***Frequency and Time allocation***	***Remarks***
National	SLMTs	5-6 members per State: Joint Project Coordinators (JPCs) Technical Consultants-SPMU State Team Leader (STL) Regional Managers of TA Team	8 States X 5= 40	Central Team (from Central TA Agency, CPMU and World Bank)	2-3 days every quarter for 2-3 quarters, then as per need	Planning and visualization of entire implementation agenda, three months at a time. Note: *The first/inaugural IL training will be a thorough orientation during which all operational details as well as contents for first 4-5 rounds will be discussed . Thereafter, orientations will be only for actual content increments. A structured programme schedule for all orientations beyond national level will also be provided during the national level training.*
State	DRG	8-10 members per district: DPO, District Coordinator –ISSNIP CDPOs District RCHO/ DIO, DPM District Public Health Nurse, 3-4 Master trainers/external resource persons	@ 30 per batch (3 districts together)	2-3 SLMT members per batch	2 days every quarter	Planning and visualization of entire implementation agenda, three months at a time
District/ Block	BRG	8-9 members per block: ***Model A*** (HSC + Sector meetings) CDPO Selected Supervisors LHV/PHN BMO/MO/BPM/BHM External Resource Persons ***Model B*** (only Sector meetings) CDPO All Supervisors Block Coordinator ISSNIP Block public health nurse BMO/BPM	@ 30 per batch (3 blocks together)	DRG	1-2 days initially, followed by 1 day every month	This meeting will serve as a major programme management meeting, including review of data, and decisions about fine-tuning. It is recommended that a core group of one official each from ICDS/TA agency and Health Department, and 1-2 external resource persons is formed. This core group should take lead in content planning for the district and taking decisions based on local priorities. A half-to-one day meeting of the full DRG should be held every month, where the agenda for the next month is discussed in detail, members are fully oriented and materials for the month are

Level of engagement on ILA	***Trainees***	***Composition of Trainees***	***Batch size***	***Facilitators***	***Frequency and Time allocation***	***Remarks***
		3-4 Master trainers/ external resource persons				distributed. If there are block programme officers (MOIC, CDPO) who are not part of BRGs, such officers should be kept fully informed and engaged separately by the core group in the district, such as through routine monthly programme review meetings at the district level; the involvement of district programme leadership in this is crucial.
Block	Model A: ANM, LS Model B: None	Model A: All ANMs in Block PHC (or equivalent) Model B: All LS in block ICDS office	ANMs – could vary from 5-50, depending on size of PHC LS – usually 5-8 per block	Model A: ANMs engaged by BRG members from Health Dept, along with any other direct supervisors of ANM and external facilitators; LS engaged by BRG members of ICDS along with any external facilitators	At least half-day every month. Since ANMs and LSs report to their respective block offices at least once a week, there are more opportunities. In addition, initially, a special full-day orientation of all ANMs and LS together at the block level is recommended. This may be repeated quarterly or half-yearly as per need.	No need for separate engagement of any group at the block level in Model B, because all LS have already been engaged as BRG. Since this is a crucial level of engagement of supervisors and programme leaders, it is desirable to maximize frequency of engagement. For instance, if ANM and LS are in the block office every week, it would be optimal that some time be spent by their respective Supervisors each week with them. A schedule can be prepared for covering different thematic areas each week.

Level of engagement on ILA	***Trainees***	***Composition of Trainees***	***Batch size***	***Facilitators***	***Frequency and Time allocation***	***Remarks***
Sector	AWWs	Model A: All AWW in a given sector, as in routine sector meetings Model B: ANMs of the sector to be invited to sector meetings in addition to all AWW	As many AWW as in the sector	Supervisor In Model B, it would be desirable to have an external facilitator as co-facilitator for support.	Monthly, 3 hours for IL agenda	If a supervisor is in charge of more than one sector, separate meetings should be held for each sector. If it is not possible to reorganize the monthly sector meeting to accommodate the IL agenda, a separate sector meeting may be scheduled every month.
HSC	AWW & ASHA	(Only in Model A) All AWW and ASHA of the sub-centre	Usually, at least 4-5 ASHA and AWW each per HSC	ANM and Supervisor; External Facilitator may be used	Monthly, 3 hours	It is recommended that at least two facilitators are present in each HSC meeting. These may be ANM+LS, 2 ANMs (such as, when there are additional ANM posted in HSCs) or ANM+ external facilitator. To enable LS or an external facilitator to attend all HSC meetings, it is desirable to schedule the HSC meetings in the block such that they are spread out over many days of the month. It will still be desirable to complete all HSC meetings in a cluster at the beginning or end of the month.

5.5 Structure, Curriculum/Modules for IL Sessions

Each IL session at the Sector or HSC level will essentially comprise of the following three sessions:

a) **Review session:** Here status of implementation of actions decided in the previous IL round as well as any problems faced by the service providers during the last month will be discussed.

b) **Input session:** Here issues relating to selected technical interventions (like complementary feeding or Vitamin A supplementation etc) and the operational steps to deliver the interventions (e.g., what and how to tell mothers during home visits to promote age-appropriate complementary feeding; organizing special events/ community meetings etc) will be discussed. As indicated earlier, two such topics can be covered in each cycle.

c) **Planning session:** Here facilitators will help each AWW/ASHA to develop an action plan for delivering the new technical interventions to all relevant mothers/ children and families in the coming month through decided operational steps. This will involve identification of mothers/ families in the home-visit planner who will be met during the coming month to deliver IPC. Moreover, it will also include scheduling of community events to be organized (*Ref. Guidelines on organizing community events, MWCD, GOI, 30 July 2014*); and discussing problems faced in behaviour change communication with specific households.

Illustratively, contents to be delivered during the first five IL monthly cycles are indicated in Table-3 below. **Materials to facilitate running of each cycle will include hand-outs for participants, set of questions for facilitators to lead the discussion and facilitators' notes/ guide for each session.**

Along with these materials and facilitators' notes, the DRG and BRG members will also be provided **reference materials** on key technical contents. Modules will be kept dynamic to incorporate any changes needed.

The CPMU at the central level and the SPMUs at the State level along with the Technical Specialists of the TA Agency will jointly ensure *content integrity* of the modules and facilitators' guides.

Table 3: Suggested Content for the First Few Months of Incremental Learning

The table below illustrates how to systematically start the IL process at all levels of supervisory interaction simultaneously, and reach a point of consistent delivery of two learning topics each month by the fourth month from the start.

Months	***Contents for DRG/BRG***	***Contents for Sector/Health Sub-Centre Meetings***	***Follow-up Supervision*** *(during VHND or non-VHND field visits of Supervisor/ANM)*
Month 1	Concepts: • The nutrition and health goals of effective programme implementation • Introduction to Incremental Learning • How the linkages between DRG, BRG, Sector, HSC are going to work • The incremental learning plan for coming months. • Advantages of the health sub-centre as a platform for IL* • What is common between ICDS and NHM* • Vision of how ASHA and AWW can work together seamlessly* Action points: • Basics of mapping, enumeration and name based tracking • Use of Family Details Register (No.1) • Current status of revised ICDS MIS rollout in district/block	Concepts: • Introductions and listing of participants and the population numbers each participant represents. • Purpose of this platform/monthly meeting • Concept of incremental learning: review, planning and learning in small steps, building up over time Action points: • Status of demarcation of AWC areas • Status of family details register • Locating undistributed households and distributing them amongst AWCs • Identifying marginalized communities and ensuring inclusion plan: ▪ *Demarcate AWC clearly and update family details registers by next meeting*	• Supervisors to help identify AWC boundaries where required • Ensure complete updating of Family Details Register before next meeting
Month 2	Actions/Skills • Use of data transfer sheet • Use of Home Visit Planner (Register 8) • Use of other name-based tracking / service AWC Registers [Pregnancy (5), Immunization & VHND (6), Vitamin A distribution (7), Supplementary food distribution (3), Preschool attendance (4), Record of weights (11)]	Review: • Verifying AWC population totals • Creation/correction of Home Visit Planner (HVP) Action points: • Start making home visits to women likely to deliver next month before they deliver • Visiting them again immediately after they deliver • Recording visit dates in AWC Register No. 8	• Ensuring HVPs are correctly made

Months	***Contents for DRG/BRG***	***Contents for Sector/Health Sub-Centre Meetings***	***Follow-up Supervision*** *(during VHND or non-VHND field visits of Supervisor/ANM)*

Month 3	Concepts:
	• Purpose of IPC: details of first 1000 days
	• Indicators to move over the next 12 months
	  o *Proportion of families visited at home at the right time*
	  o *Proportion of visited families receiving correct advice.*
	• Full list of topics to be covered over the next 1-2 years
	
	Learning Topic M1[12]: Birth preparedness
	• *Why at least two visits in last trimester*
	• *Use of HVP to make these visits*
	• *Use of checklist of messages*
	
	Skills:
	• Basic principles of counselling
	• Use of role play and demonstration techniques for practicing counselling
		Review:
		• Has Family Details Register been fully updated?
		• Has Home Visit Planner been correctly made by all? (inclusion of all names, correct sequence of children and women)
		• Experiences from the home visits made since last meeting
		
		Learning Topic M1: Birth preparedness
		• *Why at least two visits in last trimester*
		• *Use of HVP to make these visits*
		• *Use of checklist of messages*
		Skills:
		• Calculating and noting due dates for home visits in HVP
		• Role play related to birth preparedness
		
		Action points:
		• Identify and visit all women in third trimester
		• Ensure preparedness for normal birth, including the eventuality of home delivery
		• Recording in HVP
			• Have due dates for home visits been correctly determined and entered?
			• Are women in third trimester being correctly identified and visited?
			• Are there any exclusions?
			• Experiences with birth preparedness counselling

Month 4	Review: • Experiences and challenges with initiating systematic home visits using HVP • Experiences with understanding birth preparedness concepts • Experiences with use of role-play	Learning topics M2 and F1 (Ref: Annex-3) (follow details from modules)	(follow structured supervisory tools)

[12] Refers to the theme and sequence (M1 is the first topic in Maternal Care) as in Annex-3

Months	***Contents for DRG/BRG***	***Contents for Sector/Health Sub-Centre Meetings***	***Follow-up Supervision*** *(during VHND or non-VHND field visits of Supervisor/ANM)*
	Learning Topics: • *M2: Emergency preparedness for mothers and neonates* • *F1: Initiating complementary feeding*		
Month 5	Learning topics: • *F2: Quantity and frequency of complementary feeding* • *N1: Care of newborn baby immediately at birth*	Learning topics F2 and N1 (follow details from modules)	(follow structured supervisory tools)

* *Important concepts to be covered, in case of Model A where close coordinated working between AWW and ASHA is being planned.*

5.6 Coverage Plan

As per the planned design of ISSNIP, IL approach is to be initiated in about 50% of districts during year 1 and to be scaled up to 100% in year 2. Now considering that the project is already in year 2, States are required to plan implementation of ILA in all project districts from current year (2014-15) itself.

5.7 Micro planning

Table-2 in previous section provides the basis for preparing micro-plans for all levels of IL interactions. The State TA Team will assist district officials prepare the micro-plans for the district and block levels. DPOs, assisted by project staff and DRG members can facilitate formulation of micro-plans within each block.

Important considerations during micro-planning should include:

a) Determining the requirement of additional/external facilitators (such as BRG members) and their availability at each level, particularly at the block, sector and HSC levels, and scheduling meetings of each platform to ensure convenient participation of these facilitators.

b) Considering the availability of health department staff and scheduling of health department programs. This will be very crucial in Model A, but even in case of Model B, the availability of ANMs in Sector meetings needs to be ensured.

c) Logistics of production and distribution of teaching-learning materials and data forms related to each cycle, to ensure that these are synchronized with the planned schedule of meetings.

d) The mode of use of facilitation materials at each platform (flipcharts, posters, etc).

e) Ensuring that every level of meeting at block and lower levels is planned for at least 2 hours, preferably 3 hours.

f) Venues of block, sector and HSC level meetings sufficient in size to seat all anticipated participants, and to ensure proximity to all /most participants.

g) Participation of Supervisors and ANMs in making micro-plans, to maximize realistic planning and ownership.

h) Refreshments to be included, to make the meetings attractive as per the approved norms.

6. BUDGETS AND FUNDS FLOW MECHANISM

Specific budgets (s*ee Annex-2*) with indicative cost norms have been provided in the administrative guidelines of ISSNIP for conducting different activities related to Incremental Learning *viz.* for:

- DRG and BRG trainings (semi-annual trainings)
- DRG and BRG orientations (6 weekly ILA orientations); and
- Sector level IL meetings (mainly to meet honorarium and travel of BRG members and refreshments/ other materials for participants)

While indicative cost norms for all these activities are provided in the administrative guidelines, actual budgets will be approved as part of the Annual Action Plans of ISSNIP.

Honorarium and travel reimbursements for external resource persons functioning as DRG and BRG members will be as per approved Annual Action Plans of the State. Travel reimbursements for other DRG/ BRG members, may be made for the days on which they undergo the trainings; and are engaged in IL activities.

Payments for DRG level activities will be made by DPO Office against submission of monthly invoice, and tour diary with signature of District Coordinator of ISSNIP and of CDPOs of blocks where they facilitated block level IL sessions. Similarly, payments for BRG level activities will be made by CDPO Office upon production of invoice and tour diary with signatures of Block Coordinator of ISSNIP and respective LS where they facilitated IL sessions at sector level. SPMUs will design and share formats for invoice and tour diary for all DRG and BRGs along with expenditure norms and approval procedures.

For sector level meeting costs, expenses related to BRG members will be reimbursed by the respective CDPOs upon submission of invoice and travel expenses by the BRG members, duly certified by concerned LS (supported by BRG member on that day). For the meeting expenses (like refreshments and other materials for participants), the Lady Supervisor (LS) of that sector will submit a meeting report (with attendance) and vouchers for expenses incurred to the CDPO. The CDPO will reimburse the amount. A system of providing advances to CDPOs and to LSs is to be established, with a condition of settlement before next IL cycle so as to enable timely implementation.

7. MONITORING, SUPERVISION AND EVALUATION

Along with ICDS officials (DPOs/CDPOs), the District and Block Coordinators of ISSNIP will be primarily responsible for supervision and review of the IL sessions. After every round of IL, structured review of process will be done in the subsequent rounds at the block, district and State levels. Officials/Consultants of the SPMU and the RMs of the TA Agency will undertake regular review of the process in the field and during review meetings at all levels.

Process monitoring and assessment of workers' knowledge and skills

As discussed in earlier sections, the BRG and DRG members who attend IL sessions respectively at the sector land block level will submit their report[13] capturing details about

[13] Reporting format will be shared in due course

attendance (against expected); content covered and highlights of issues/ discussions. These will be collated at block and district level. The DCs and RMs will be responsible for synthesizing the findings and use of it for programme refinement. Similarly, DRG and BRG orientations will be reported in an ongoing manner by the facilitation teams involved there. Through such reporting system process, monitoring will be undertaken to understand the rigor of implementation of IL activities and to know if the right content is being delivered or not.

Field visits to be undertaken by DCs, RMs and SPMU Consultants will be designed to include brief assessment of AWWs' knowledge and skills. Based on the analysis of findings from such assessments, improvements in AWWs' knowledge and skills related to themes being delivered in ILA will be understood. In case of any gap found in effective delivery of IL themes, actions will be taken for course correction during the subsequent IL rounds.

Note: Supervisory tools to be used during centre visits and to review reported data (MPRs) are being designed as part of ISSNIP's work related to strengthening ICDS monitoring system. Additional tools will be used to draw simple analysis that can be used for discussions in subsequent IL sessions and to improve delivery of relevant content. RMs and DCs will ensure availability of such information from supervisory tools to the SPMU, so that the content of upcoming IL rounds can be tweaked in each State as per the field situation.

Evaluation of Incremental Learning

Effectiveness of incremental learning will also be assessed through analysis of outputs (e.g., increase in mothers' reporting increased contacts by AWWs) and outcome data (e.g., increased behaviour change and service uptake) to be collected using rapid assessments[14] and LQAS[15] measurements. While process assessments will be done through the TA Team in selected districts, the effect of IL sessions on home visit frequency and focus as well as behaviour change at household level will be measured through LQAS and rapid assessments. Detailed guidelines and tools for LQAS based assessment of IL will be provided separately.

[14] To be undertaken at district level (select districts) through external agencies – which are planned and budgeted under ISSNIP annual action plans

[15] LQAS is being developed by TA Agency and CPMU (using lessons from Bihar) and is designed to be implemented through ICDS Supervisors. Bihar experience shows a direct link between theme focused in IL round and increase in related contacts and behaviors in subsequent LQAS round.

Annex-1

Role of SPMU, District ICDS and State TA Teams in implementing ILS

A. Role of SPMU

The technical consultants in the SPMU will support in adapting modules/materials for the State. They will eventually function as the main trainers and supporters of DRGs and provide monthly orientations to RMs and DRG members on the themes of upcoming IL rounds. Through regular field visits, the SPMU Consultants will monitor implementation on the ground and bring findings to refine the IL contents. They will also function as the resource pool that the DRG/ BRG members can access (over phone/ emails) in order to solve problems as and when required.

B. Role of District and Block ICDS Officials

The DPOs and CDPOs will provide the overall management and administrative leadership to the planning and implementation of IL in their area. They will be responsible for ensuring:

- ✓ Selection of appropriate DRG and BRG members and their participation in trainings
- ✓ Development of micro-plans for IL sessions at district, block and sector levels
- ✓ Assign external resource persons (members of DRG and BRG) to CDPOs and Supervisors that need facilitation support
- ✓ Monitor conduct of IL sessions in their programme areas and provide feedback to DRG and BRGs
- ✓ Manage the fund flow and payments to DRG and BRG members in a timely manner

The District and Block Coordinators and the Programme Assistants at district and block level under ISSNIP will also play a significant role in planning and implementation of ILA. They will perform some of the following roles:

- ✓ Conduct trainings and monthly orientations of DRG and BRGs
- ✓ Plan/schedule block level orientations of LSs by BRGs
- ✓ Monitor sector level IL sessions
- ✓ Block Coordinators will support the weak Supervisors at sector level (as being part of BRG)
- ✓ Help to develop micro plans for sector level IL meetings and coordinate with blocks/ districts to undertake any modifications in the micro plans as and when required (due to change in supervisors or modifications to DRG/ BRG member schedules)
- ✓ Ensure reporting on sector level IL sessions for consolidation and reporting
- ✓ Prepare reports of DRG and BRG trainings and monthly orientations
- ✓ Undertake field visits to understand difficulties faced by AWWs and their Supervisors and report upwards so that modifications in IL modules/tools can be made

C. Role of TA Team

While the role of TA Team has been indicated in appropriate sections above, at an overall level the STL's role is to coordinate with the SPMU to get the required guidelines, directives including establishment of fund-flow mechanisms developed and issued to all districts/ blocks. STL will also support the SPMU to identify SLMTs, and ensure their training plan, work schedule and establish systems to manage their logistic/financial aspects at the State level. They will also ensure that the SLMTs' support to districts is uninterrupted. Coordination with other Development Partners and getting their staff time as part of SLMT and DRG as required, is one of the key roles of the STL and the RMs. Additionally, select RMs will also function as part of SLMT and support in identification and training of DRGs, orientations of DRGs, and monitoring quality of implementation. RMs will review and analyse reports sent by DRG/ BRGs on a periodic basis and draw inputs for modifying IL modules/content, as required.

Annex-2
Phase I allocations and indicative cost norms for Incremental Learning Approach

A. During Phase 1 of ISSNIP, budgetary allocations made for implementation of IL approach and piloting sub-centre level meetings are as under:

(Rs. Lakh)

State	*Incremental Learning*	*Sub-Centre level meeting*
Andhra Pradesh	189.47	24.14
Bihar	361.71	45.89
Chhattisgarh	138.02	26.57
Jharkhand	151.21	28.98
Madhya Pradesh	384.59	72.45
Maharashtra	395.10	46.92
Rajasthan	264.75	45.89
Uttar Pradesh	663.00	99.02
Total	**2547.85**	**389.86**

B. Indicative cost norms for different activities under IL:

Activities	*Indicative Cost Norms*
a. Identification, formation and orientation training of Dist. Resource Groups (DRGs) and Block Resource Groups (BRGs) across all districts	@ Rs. 12,000 per district for DRG orientation @ 5,000 per block for BRG orientation
b. Training of DRG & BRG members along with all CDPOs and DPOs and health officials (on relevant themes)	@ Rs. 5,000 per training (district level) @ Rs. 3,000 per training (block level)
c. Conducting IL sessions at district level on identified theme	@ Rs.31,500 per district per theme
d. Conducting IL sessions at Block level on identified theme	@ Rs.3000 per block per theme
e. Conducting IL sessions at Sector level on identified theme	@ Rs. 500 per sector per theme

Annex 3
An Illustrative List of Thematic Areas for Monthly IL Cycles

Under each theme, there are a number of topics in a recommended sequence. For a given monthly IL cycle, one topic each from any two thematic areas may be selected. It is recommended that this selection is done in such a manner that one of the thematic areas is the same as one of the thematic areas covered in the previous month. While the sequencing of themes over months is flexible, the *sequencing of topics should not be arbitrarily changed*.

M. Maternal Care
M1 Initiation of home visits to women likely to deliver in the next month
M2. Preparation for institutional and home deliveries
M3. Preparation for maternal emergencies during pregnancy and delivery
M4. Immediate postnatal care: day of delivery
M5. First week postnatal care and postnatal emergencies
M6. Sub-centre-specific referral plans
M7. Preparing blood donors
M8. Antenatal care: IFA, check-ups
M9. Recording and reporting pregnancy outcomes
N. Newborn Care
N1. Preparedness during pregnancy for neonatal care
N2. Immediate neonatal care: day of birth
N3. First week neonatal care
N4. Observation of breastfeeding
N5. Identification and care of the weak newborn
N6. Skin-to-skin care
N7. Identification and referral of the sick newborn
N8. Breastfeeding support to the weak newborn
N9. Recording and reporting neonatal deaths, stillbirths and abortions
F. Infant and Young Child Feeding Practices (IYCF)
F1. Initiation of complementary feeding (CF): home visits at 6^{th} and 7^{th} months
F2. Increasing quantity of CF with age: 8^{th} to 12^{th} months
F3. Use of home-available variety in CF
F4. Food hygiene in CF
F5. Support to exclusive breast-feeding (EBF)
V. Vaccines and Immunization
V1. Ensuring complete inclusion in immunization register
V2. Recording immunization status
V3. Correct method of making and using due-lists and minimizing drop-outs
S. General Skills
S1. Mapping and enumeration: Survey and listing Family Details
S2. Use of transfer sheet to create service registers
S3. Use of Home Visit Planner to plan and record home visits
S4. Hand-washing at home

NOTES