No. PA/19/2018-CPMU
Government of India
Ministry of Women and Child Development
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3rd Floor, Jeevan Vihar Building,
Sansad Marg, New Delhi -110001
Dated 2nd November, 2018

To

The Chief Secretaries of all States/UTs of India,

Subject: - Convergence Action Plan Guidelines for effective implementation under POSHAN Abhiyaan.

Sir/Madam,

POSHAN Abhiyaan aims to reduce malnutrition, through a life-cycle concept, adopting a synergized and result oriented approach. The target of the mission is to bring down stunting in children in age group 0-6 from 38.4% to 25% by the year 2022. It also aims to reduce anemia among women and adolescent girls in the age group of 15-49 years and reduce low birth weight.

2. A key pillar of the POSHAN Abhiyaan is convergence of all Nutrition related Schemes on the target population. These include programmes such as the Anganwadi Services, Pradhan Mantri Matru Vandana Yojana, Scheme for Adolescent Girls of MoWCD; Janani Suraksha Yojana (JSY), National Health Mission (NHM), Anemia Mukt Bharat, Indradhanush of MoHFW; Swachh Bharat Mission of Ministry of Drinking Water & Sanitation (MoDWS); Public Distribution System (PDS) of Ministry of Consumer Affairs, Food & Public Distribution (MoCAFP&D); Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS) of Ministry of Rural Development (MoRD); Drinking Water & Toilets with Ministry of Panchayati Raj (MoPR) and Urban Local Bodies through Ministry of Housing & Urban Affairs (MoH&UA).

3. POSHAN Abhiyaan brings about Convergent Nutrition Action related schemes by identifying and bringing under one framework key nutrition related interventions, indicators and targets to be monitored and achieved by relevant line Ministries/Departments implementing the schemes. Convergence Action Plan Guidelines (Council/Committees) has to be constituted from the National level to the Block level to facilitate the operationalization of this framework.

4. At the National Level Convergence is addressed through the National Council under the Chairmanship of Vice-Chairman, NITI Aayog and Executive Committee under the Chairmanship of Secretary, Ministry of Women & Child Development. Both Committees have representation from all aligned Line Ministries, Partners, selected States and Districts. These Committees meet every 3 months. A progress report is to be submitted to the Hon'ble Prime Minister every 6 months.

5. The Convergence Action Plan Committees at the State, District and Block Level, are mandated to review progress, identify gaps and introduce effective interventions as required, based on specific targets. These Committees are required to meet at least once in each quarter. Now States level Convergence Committee needs to be chaired by Chief Secretaries as per the Guidelines.

6. A detailed Convergence action Plan Guidelines for effective implementation of POSHAN Abhiyaan are forwarded herewith for implementation.

Yours sincerely,

(Sanjiv Gajraj)
Executive Director, POSHAN Abhiyaan

Copy to

All Principal Secretaries/Secretaries, Department of Social Welfare/Women & Child Development, all States/UTs of India dealing with POSHAN Abhiyaan

Shri Alok Kumar, Adviser NITI Aayog,

Ms. Mohini Kak, The World Bank

Operational Guidelines for Convergent Action Plan

I. Introduction:

1.1 POSHAN *Abhiyaan* aims at reducing malnutrition, adopting a convergent, life-cycle and result oriented approach. It focuses on adolescent girls, pregnant women, lactating mothers and children from 0 to 6 years of age. The first 1000 days of a child are the most critical in addressing under nutrition, which includes the nine months of pregnancy, six months of exclusive breastfeeding and the period from 6 months to 2 years. Timely interventions during this period also contribute to improvements in birth weight and reduction in both Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR). An additional one year of sustained intervention (till the age of 3 years) would ensure that the gains of the first 1000 days are consolidated. Further, continued attention on children in the age group of 3-6 years would contribute to their overall development. While several services aimed at improving under nutrition are delivered through the Anganwadi Services (through Anganwadi Centres (AWCs)), the role of other programs is equally relevant. Health care, water, sanitation, hygiene, mother's education, poverty, are among some of the critical factors that contribute to improved nutrition and ensuring that all these services converge on a household is essential for reducing under nutrition in the country.

1.2 A key pillar of the POSHAN *Abhiyaan* is convergence of all Nutrition related Schemes on the target population. These include programmes such as the Anganwadi Services, Pradhan Mantri Matru Vandana Yojana, Scheme for Adolescent Girls of MoWCD; Janani Suraksha Yojana (JSY), National Health Mission (NHM), Anemia Mukt Bharat, Indradhanush of MoHFW; Swachh Bharat Mission of Ministry of Drinking Water & Sanitation (MoDWS); Public Distribution System (PDS) of Ministry of Consumer Affairs, Food & Public Distribution (MoCAFP&D); Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS) of Ministry of Rural Development (MoRD); Drinking Water & Toilets with Ministry of Panchayati Raj (MoPR) and Urban Local Bodies through Ministry of Housing & Urban Affairs (MoH&UA).

1.3 These Operational Guidelines detail the approach adopted under the POSHAN *Abhiyaan* to bring about this sectoral convergence for nutrition outcomes.

II. The Approach:

2.1 POSHAN *Abhiyaan* brings about convergence of various nutrition related schemes by identifying and bringing under one framework key nutrition related interventions, indicators and targets to be monitored and achieved by relevant line Ministries/Departments implementing the schemes. Convergence Action Plan

(Council/Committees) has been constituted from the National to the Block level to facilitate the operationalization of this framework. The role of these committees will primarily be three-fold.

(a) Development of Convergent Action Plans in discussion with the related line departments; based on issues, service delivery, gaps and interventions which have been identified and flagged as indicators.
(b) Monitoring and tracking progress along key indicators linked to these actions. The suggested list of key indicators to facilitate monitoring, evaluation and identifying gaps is attached as **Annexure A - District Review Guidelines for Nutrition** *(See Page Number 20-30).*
(c) Facilitating corrective actions based on periodic progress reviews and supporting line ministries address implementation gaps, where needed.

These committees will be responsible for carrying out all the work related to convergence such as plan development, conducting periodic review, work coordination, monitoring and evaluation, identifying gaps and suggesting measures to fill the gaps.

2.2 The primary purpose of monitoring and reviewing progress against identified multi-sectoral/multi-program actions and indicators will be to support better and effective delivery of nutrition related interventions to the targeted beneficiaries. In playing this role, the Committees will not impinge on the operational authority of any of the participating Ministry/Department or Autonomous body. During this process of convergent action planning and review, the identified gaps will be addressed by initiating interventions by the respective Department(s). These gaps could either be a financing gap for an existing intervention, an intervention which is relevant for nutrition but missing from the action plan, or an innovation that the state wants to undertake to address the nutrition challenge.

III. Constitution of Convergence Committees:

3.1 At the National Level Convergence is addressed through the National Council under the Chairmanship of Vice-Chairman, NITI Aayog and Executive Committee under the Chairmanship of Secretary, Ministry of Women & Child Development. Both Committees have representation from all aligned Line Ministries, Partners, selected States and Districts. These Committees are scheduled to meet every 3 months. A progress report is to be submitted to the Hon'ble Prime Minister every 6 months.

3.2 The Convergence Action Plan Committees need to be formed at State, District and Block Level, with a mandate to review progress, identify gaps and introduce effective interventions as required, based on specific targets and the mandate assigned as part of the

overall Convergence Action Plan. These Committees are required to meet atleast once in each quarter. The Constitution of the Committees is given at ***Annexure I*** *(See Page Number 9 - 10).*

IV. Convergence Action Plan Framework:

4.1 The primary goals of the POSHAN *Abhiyaan* are as under.

Sl.No	Objective	Target
1.	Prevent and reduce Stunting in children (0- 6 years)	By 6% @ 2% p.a.
2.	Prevent and reduce under-nutrition (underweight prevalence) in children (0-6 years)	By 6% @ 2% p.a.
3.	Reduce the prevalence of anemia among young Children(6-59 months)	By 9% @ 3% p.a.
4.	Reduce the prevalence of anemia among Women and Adolescent Girls in the age group of 15-49 years.	By 9% @ 3% p.a.
5.	Reduce Low Birth Weight (LBW).	By 6% @ 2% p.a.

4.2 Achieving this outcome requires improvement along multiple dimensions among the target population – which is adolescent girls, pregnant women, lactating mothers and children upto 6 years of age. With the vast canvas of beneficiaries, it is important to ensure timely service delivery, effective monitoring and interventions. The following Components will be considered while developing the Convergence Action Plans at various levels.

4.3 **Infrastructure:** Infrastructure in terms of Anganwadi Centre Building, availability of toilet and safe drinking water needs to be mapped. Emphasis should also be on Child Friendly Toilets, providing Smoke free Chulha/ LPG connections along with other key facilities at AWCs. A functional SPMU with the authorised manpower at State, District and Block level needs to be ensured. Gaps if any need to be identified and filled.

4.4 **Service Delivery & Interventions:** A framework outlining the key interventions and corresponding critical indicators addressing these dimensions has been outlined at ***Annexure II*** *(See Page Number 11 - 13).* The Action Plans will incorporate 'Baseline Data' and specific time bound 'Targets' to be achieved at each level. Convergence Committees will be expected to use this framework to track these key interventions and their progress. In addition to the key essential interventions outlined below, committees will have the

flexibility to add additional interventions, draft corresponding monitoring indicators and mechanisms to track progress.

4.5 **Supply Chain:** Availability of stocks, devices and material across AWCs, PHCs and other centres needs to be ensured. A suggested list for Supply Chain Monitoring is attached at ***Annexure III*** *(See Page Number 14).*

4.6 **Behavioural Change:** Behavioral Change is an important Component of POSHAN *Abhiyaan* and various activities need to be planned as part of it. An activity calendar will be created at State and District level for the same and progress reviewed as part of CAP. Detailed Guidelines on the subject have been issued as part of the Jan Andolan Guidelines.

4.7 **Feedback & Follow-Up:** The Committees will try and identify reasons for implementation gaps and provide both guidance and necessary support to the relevant line departments to address gaps and issues. Clear corrective actions will be documented during the reviews and shared with the relevant line department for their follow up and action. These would be reviewed in the next Meeting.

V. Convergence Action Plan Development and Approval Process:

5.1 All committees will use the framework outlined in Section IV for the development of the convergence action plan (CAP). The CAP will be developed for the period of one year and should be finalized and submitted as part of the Annual Program Implementation Plan by end January for the subsequent year. A bottom up planning process will be adopted in the development of the CAP, with block CAPs being consolidated to form district CAPs, and further consolidated to form the State CAP. To facilitate the bottom up approach of convergence plan adoption, it is suggested that the Block Resource Group and District Resource Group envisioned under the POSHAN *Abhiyaan* Guidelines may be given the responsibility of consolidating the convergence plans received from individual blocks and districts. As this will mostly be a one-time exercise conducted annually, representatives from multi-sector disciplinary, academicians and development partners may be invited to do the needful. A copy of the plans submitted by different Blocks and Districts may be shared prior with these representatives to facilitate a meaningful discussion. This exercise should be conducted at least one month prior to submission of one consolidated plan to district or state level.

The detailed plan development and approval process is outlined below:

5.2 **Block Convergence Action Plan (BCAP):** The Block Convergence Action Plan will be prepared by the Block Convergence Committee chaired by Sub Divisional Magistrate (SDM).

It will incorporate inputs from all relevant line departments, who are also committee members. The BCAP will be finalized by 15th of December for the consequent year, approved by the SDM and submitted to the District Convergence Committee. For Year 2018-19, the Plan should be implemented with immediate effect. The plan will be developed based on:

(a) An assessment of the status of key interventions at the Block level as outlined in the CAP framework outlined in Section IV

(b) Data informing this assessment will be provided by the relevant Block officials of the line departments, who will collate this information from their existing MIS and through information provided by their field functionaries

(c) Once block level baseline data is input into the framework an assessment of the gaps and lagging interventions will be undertaken by the Block Convergence Committee Members

(d) The Committee will discuss and identify specific reasons for these gaps, identify clear actions to be undertaken by the Department to address these gaps and set quarterly and annual targets to be achieved.

(e) If addressal of identified gaps requires assistance from the District/State or the Committee feels the need to add an additional intervention or innovation to strengthen efforts to achieve nutrition outcomes, the committee will recommend the addition of the intervention/innovation.

(f) The BCAP will be approved by the SDM and submitted to the District Convergence Committee for inclusion in the DCAP.

5.3 District Convergence Action Plan (DCAP): The District Convergence Action Plan will be prepared by the District Convergence Committee chaired by DM/DC/Collector. It will converge, consolidate and streamline all the BCAPs to form a DCAP. The DCAP will be finalized by 31st December for the consequent year, approved by the DC/DM and submitted to the State Convergence Committee. The plan will be developed based on:

(a) An assessment of the status of key interventions at the District level as outlined in the CAP framework outlined in Section IV

(b) Data informing this assessment will be collated from the BCAPs and be re-validated by the relevant District officials of the line departments

(c) Once district level baseline data is input into the framework an assessment of the gaps and lagging interventions will be undertaken by the District Convergence Committee Members.

(d) The Committee will discuss and identify specific reasons for these gaps, identify the blocks which are performing poorly and on which parameters, identify clear actions to be undertaken by the Department to address these gaps and set quarterly and annual targets to be achieved.

(e) If addressal of identified gaps requires assistance from the State or the Committee feels the need to add an additional intervention or innovation to strengthen efforts to achieve nutrition outcomes, the committee will recommend the addition of the intervention/innovation.

(f) The DCAP will be approved by the DC/DM and submitted to the state convergence committee for inclusion in the SCAP.

5.4 State Convergence Action Plan (SCAP): The State/UT Convergence Plan will be prepared by the State Convergence Committee chaired by Senior-most Principal Secretary of the line departments. It will converge, consolidate and streamline all the DCAPs to form a SCAP, however will include an annexure that details out district level plans, with district wise baseline information on key indicators as defined in the CAP framework. The SCAP will form part of the Annual Programme Implementation Plan (APIP) of the State/UT under the Anganwadi Services of Umbrella ICDS Scheme. It will be finalized by 31stJanuary for the consequent year and submitted to MWCD for consideration and approval. The plan will be developed based on:

(a) An assessment of the status of key interventions at the State level as outlined in the CAP framework outlined in Section IV

(b) Data informing this assessment will be collated from the DCAPs and be re-validated by the relevant State officials of the line departments

(c) Once state level baseline data is input into the framework an assessment of the gaps and lagging interventions will be undertaken by the State Convergence Committee Members.

(d) The Committee will review the identified reasons for these gaps (based on submissions in the DCAP), identify districts and blocks which need special attention and on which parameters, identify clear actions to be undertaken by the Departments to address these gaps and set quarterly and annual targets to be achieved.

(e) If addressal of identified gaps requires assistance from the Government of India or the Committee feels the need to add an additional intervention or innovation to strengthen efforts to achieve nutrition outcomes, the committee will recommend the addition of the intervention/innovation.

(f) The SCAP will submit this approved plan as part of the APIP to the MWCD for approval.

(g) On approval of the SCAP by the MWCD, the State Convergence Committee will ensure timely administrative and financial sanction of the plan along with the associated budget and communicate the same to the relevant line departments/districts.

(h) It will further ensure release of funds to the relevant department for action/implementation of the SCAP interventions.

(i) It will follow up with the concerned line department to ensure that funds for implementation of the outlined interventions have been released to the districts concerned, wherever required.

5.5 Role of Panchayati Raj institutions:

5.5.1 It is important for any field based programme to involve the community and the Panchayati Raj institutions. For preparing the Convergence Action Plans, the role of PRIs is very important. For this purpose, it is necessary that PRIs are not only active in their areas but are also aware about the Government programmes and their benefits.

5.5.2 Wherever PRIs are not active, an action plan for their capacity building should be included in CAP. Their training can be imparted through SIRDs wherein 5 to 8 Master Trainers can be trained who, in turn, can train the PRI members. Also, NIPCCD can prepare 4-5 training modules for On-line training of PRI members as well as field functionaries can be prepared. These modules can be developed regional languages to enhance the reach and effectiveness. The convergent action at village level can be enabled through VHSND.

5.6 **Village Health, Sanitation & Nutrition Day:** Under the Anganwadi Services of Umbrella ICDS Scheme VHSND is a very important tool for convergence. While framing the CAP, States/UTs should include number of VHSN days to be conducted, monitoring of such days, activities to be undertaken and the feed-back on such activities.

5.6.1 ***Promotion of VHSND as a Common Platform:*** Involvement of VOs, SHGs and Cluster Federations in VHSNDs should be promoted to strengthen Convergence and monitoring and management of Nutritional status of women and children. Additionally, can also refer the **Model VHSND Operational Guidelines** attached as **Annexure B** *(See Page Number 31 - 36).*

VI. Convergence Action Plan Monitoring:

6.1 The ICDS-Common Application Software (CAS) captures data based on Key Indicators (not all) which need to be monitored as part of CAP. Similarly, the State MIS and software's of other Line Ministries also provide data on the required indicators. Accordingly, States where ICDS-CAS has been rolled-out will utilize the data available on ICDS-CAS Dashboard to monitor, identify gaps and introduce interventions wherever required.

6.2 A few suggested formats incorporating baseline and target data for monitoring, across various indicators are at ***Annexure IV*** *(See Page Number 15 - 19).* States/UTs may use these as part of CAP monitoring mechanism. States/UTs need to endeavor to roll-out ICDS-CAS at the earliest to enable efficient monitoring.

VII. Additional Suggestion

7.1 In order to encourage local availability of diversified vegetables and fruits for HCM in AWCs, the practice of '***Nutri-Garden***' should be adopted (concerned Ministries & Departments – Panchayati Raj, Horticulture Departments and MoWCD).

7.2 A provision may be established to provide a sense of ownership to the community/society in order to scale up community based interventions and engagements of peer-groups including Mothers' Group to supervise the quality of HCM, THR etc.

7.3 Religious Leaders can be used as an Agent of Change in ensuring Convergence.

7.4 An initiative to promote contribution of CSR Agencies should be considered.

Annexure I

Convergence Action Committees

1. State/UT Convergence Committee *.

1. Chief Secretary	Chairperson
2. Secretary, Planning	Member
3. Secretary, Finance	Member
4. Secretary, Drinking Water and Sanitation	Member
5. Secretary, Health and Family Welfare	Member
6. Secretary, Rural Development and Panchayati Raj	Member
7. Secretary, Urban Development Department	Member
8. Secretary, Education	Member
9. Secretary, Food and Civil Supplies	Member
10. State Mission Director, NHM	Member
11. State NIPCCD Representative	Member
12. Secretary, Women and Child Development	Member
13. Director, Women and Child Development	Member-Secretary

***** State/UT may include Health & Nutrition experts, representatives from academia, and development partners from time to time as per the requirement. The State Convergence Committee may also incorporate representative members from Departments of Science & Technology and Information & Broadcasting. State Convergence Committee should have 3-5 representatives from District Convergence Committee also.

2. District Convergence Committee #.

1. District Magistrate/District Collector	Chairperson
2. Chief Executive Officer, ZilaParishad/DRDA	Member
3. Sub-Divisional Magistrate	Member
4. Chief Medical Officer, Health and Family Welfare	Member
5. District Program Manager, NHM	Member
6. District Education Officer	Member
7. District Planning Officer	Member
8. District Social Welfare Officer	Member
9. District officer, Rural Development/Rural Livelihoods Mission	Member

10. District officer, Water and Sanitation	Member
11. District officer, Food and Civil Supplies	Member
12. District Program Officer, ICDS	Member-Secretary

May also include Health & Nutrition experts, representatives from academia, and development partners from time to time as per the requirement. The District Convergence Committee should have 3-5 representatives of Block Convergence Committee and similarly the

3. Block Convergence Committee

1. Sub- Divisional Magistrate	Chairperson
2. Block Development Officer	Member
3. Block Medical Officer	Member
4. Panchayat Samiti Chairperson	Member
5. Block Education Officer	Member
6. Block Social Welfare Officer	Member
7. Block officer, Rural Development/Rural Livelihoods	Member
8. Block officer, Water and Sanitation	Member
9. Block officer, Food and Civil Supplies	Member
10. Child Development Project Officer, ICDS	Member-Secretary

May also include Health & Nutrition experts, representatives from academia, and development partners from time to time as per the requirement.

Annexure II

Service Delivery & Intervention Indicators

The focus of monitoring Convergence should be on various packages of services provided for the first 1000 days of child birth and pre and post-delivery support to mothers by different Departments / Ministries. In order to facilitate this, a set of key indicators has been attached as **Annexure A** which may be referred in addition to below mentioned indicators.

Department	Interventions/Services	Service delivered by/through	Indicators to track progress	Source/ Frequency	Baseline (%)
1. MWCD	1) Growth Monitoring and promotion	AWW (ICDS)	% of children 0 to 3 years who were weighed during the previous month	ICDS-CAS/ Monthly	
	2) Breastfeeding and complementary feeding counselling	AWW (ICDS) and ASHA	% home visits to households with children 0 to 24 months to counsel on appropriate IYCF	ICDS-CAS/ Monthly	
	3) Counseling on nutrition during pregnancy	AWW (ICDS) and ASHA	% home visits to household with pregnant mothers to counsel on appropriate practices during pregnancy	ICDS-CAS/ Monthly	
	4) Take home rations for pregnant and lactating women and children under 3	AWW (ICDS)	% PLW and children under 3 who received mandated THR in the previous month	ICDS-CAS/ Monthly	
2. MoHFW	5) Immunization	ANM (NHM)	% of children less than one year of age fully immunized	Monthly	
	6) Vitamin A	ANM (NHM)	% of children 6 to 59 months who received at least one dose of Vitamin A during the last 6 months	Quarterly	

	7) IFA supplementation	ANM (NHM) and AWW	% of pregnant women who received IFA tablets in the previous month	Monthly	
	8) Iron supplementation for children	ANM (NHM)	% of children 6 to 59 months who were provided recommended dose of the syrup during the previous month	Monthly	
	9) Deworming	ANM (NHM)	% of children 6 to 59 months who received at least one albendazole tablet during the last 6 months	Quarterly	
	10) ANC checkups	ANM (NHM)	% of pregnant women in their third trimester who received at least 3 ANCs	Monthly	
	11) Management of Acute Malnutrition	ANM (NHM)	% of SAM children treated appropriately at the health facility/community level	Quarterly	
	12) Diarrhea Management (ORS+Zn)	ANM (NHM)	% of children with diarrhea 0 to 60 month who received ORS during the previous month - % of children with diarrhea 0 to 60 who received the recommended dose of zinc tablets during the previous month	Monthly	
3. Ministry of Water and Sanitation	13) ODF villages		% of ODF free villages	Quarterly	

	14) Villages with safe drinking water supply		% of villages with safe drinking water supply	Quarterly	
4. Ministry of Rural Development and PRIs	15) SHGs to track no of children sent to NRC, discharged from the NRC 16) No of children supported through VRFs with transport to NRC /health facility t 17) IEC tools on health and nutrition disseminated at the village level. 18) Trainings and VHSND done in Panchayat or community centres		% of SHGs trained on a package of basic nutrition, health, sanitation and hygiene behaviours	Quarterly	
5. Ministry of Education	19) IFA supplementation for adolescents		% of adolescent girls who received IFA tablets in the previous month	Monthly	
	20) Deworming for adolescents		% of adolescent girls who received at least one albendazole tablet during the last 6 months	Quarterly	

Annexure III

Supply Chain Management & Monitoring

Sl. No.	Item	Parameters	Ministry
1.	Supplementary Nutrition (SNP)	Stock & Availability	MoW&CD
2.	Growth Monitoring Devices	Availability & Serviceability (Functional)	
3.	MCP Card	Availability & Stock	MoH&FW
4.	IFA Tablets	Availability & Stock	
5.	Viatmin A	Availability & Stock	
6.	Calcium	Availability & Stock	
7.	Deworming Tablets	Availability & Stock	
8.	ORS & Zinc	Availability & Stock	

Annexure IV

Sample Templates for Monitoring Progress

Sample Format : Promoting Sanitation

Indicator	Baseline (ICDS data)	2018	2019	2020
% of villages/wards which are open defecation free			100%	100%
% of Households with access to safe sanitation facilities				
% of Anganwadi with adequate and functional sanitation facilities				
% of health centres with adequate and functional sanitation facilities				

Key bottlenecks	Specific action	Indicator	Baseline	Target end year 1	Driven by (Department)

Further details as per national / state guidelines Swachh Bharat

Sample Format : **Iron and Folic Acid for Adolescents, Women of Reproductive Age and Pregnant Women**

Indicator	Baseline (NFHS-4/5, Health data)	2018	2019	2020
% of eligible adolescents 10-19 years who receive at least 4 blue iron folate tablets through WIFS program in last month	26% (HMIS)			
% of Women of reproductive age 20-24 years who received atleast 4 Blue IFA tablet in the last one month				
% of eligible pregnant women who received atleast 180 IFA tablets during antenatal period	80%			

Key Bottlenecks	Specific action	Indicator	Baseline	Target end year 1	Driven by (Department)

Further details as per national anemia free India guidelines to be issued soon

Sample Format : **Breastfeeding**

Indicator	Baseline (NFHS-4/5, ICDS/Health data)	2018	2019	2020
% of mothers with 4-months old baby that receive an ASHAs home visit and get counselling on continued exclusive Breastfeeding till 6 months	0	60%	80%	100%
% of mothers that deliver in health facilities who also start breastfeeding within 1 hour.	NFHS-4/5	70%	90%	100%

Key bottlenecks	Specific action	Indicator	Baseline	Target end year 1	Driven by (Department)
Further details as per national ICDS, VHSND and MAA guidelines					

Sample Format : **Behaviour Change Communication / Nutrition Literacy**

Indicator	Baseline (ICDS data)	2018	2019	2020
% of Anganwadi Centres that had at least three community based event (CBE) around nutrition in last quarter				
Calendar for nutrition advocacy at village level				
% of Anganwadi Centres that have a SHG or Mother support group to promote healthy eating				
% of Anganwadi centres that have other community/volunteer group' s in place to support Jan Andolan				
% of States where at least one mass media-campaign was operationalized during the last one year				
% of States where mid- media-campaign was operationalized during the quarter				

Key Bottlenecks	Specific action	Indicator	Baseline	Target end year 1	Driven by (Department)

Sample Format : **Supply Chain Management - Linked to ICDS**

Indicator	Baseline	2018	2019	2020
% of districts with no stock out of SNP			100	100
% of Anganwadi centres with no stock out of SNP				
% of districts where all Anganwadi Centres have functional growth monitoring devices (weighing scales infant, mother and child, infantometer and stadiometer			100	100
% of districts where all Anganwadi Centres have adequate availability of mother child protection (MCP) cards				
% of districts where all Anganwadi Workers have been provided a smart phone for CAS			100	100
% of districts where all supervisors have been provided a tablet			100	100

Key Bottlenecks	Specific action	Indicator	Baseline	Target end year 1	Driven by (Department)

District Review Guidelines for Nutrition

Malnutrition is a multidimensional problem which necessitates joint, coordinated & convergent Action by all relevant Ministries, Departments & Stakeholders.

These **Guidelines** for **Quarterly Review** have been devised with a view that broader Nutritional Objectives will organically be achieved if the indicators identified in these Guidelines are improved.

In order to keep the review exercise simplistic and avoid the burden of additional reporting, the number of Critical Indicators has been restricted to a certain minimum; with a focus on process rather than outcome indicators. It is firmly believed that regular monitoring of these Critical Indicators and Identified Focus Areas without any comprise on the quality of data will lead to the desired results.

1. INTRODUCTION

Investment in Nutrition is considered to be one of the most effective entry points for enhancing the overall development status of a country, with an estimated benefit cost ratio of about 16:1 for low and middle income countries.[1]

Despite multiple interventions on several fronts, India has not been able to overcome its nutritional challenges. With every 2nd women Anaemic, every 3rd child under 5 years Stunted and every 5th child under 5 years Wasted, malnutrition is a lived reality for many in this country.

As the underlying causes of malnutrition are multifaceted, multidimensional and rooted in economic and social factors, it is necessary that different Schemes/ Programmes of the Government which directly or indirectly impact the nutritional status of women and children are reviewed jointly. It is expected that a Common Review of these programs will trigger coherent and convergent action at the field level.

2. NEED FOR CONVERGENT ACTION

It is necessary to acknowledge the multidimensional nature of malnutrition. While the Anganwadi Services under the Umbrella ICDS largely focuses on the 'food' component, evidence has shown the dependence of nutrition indicators on a number of parameters including those linked to health and related services, hygiene and sanitation practices, prevalence of diseases among children, open defecation, availability of safe drinking water, and women's education.

In such a scenario, it is critical to address the challenge of malnutrition through a multi-pronged strategy, working on several fronts in a coordinated manner to enhance the overall status of nutrition among children and women.

3. CURRENT INITIATIVES OF DIFFERENT MINISTRIES

With the growing attention of the Government of India to improve the nutrition status of children and women, multiple initiatives are being undertaken simultaneously by different Ministries. The most recent example of this is the Joint Letter (Annexure I) issued by the Ministries of Women & Child Development, Health & Family Welfare and Drinking Water & Sanitation to all the States/ Districts to jointly work in improving this area by conducting Regular Reviews of the Progress (10th of every Quarter) made towards improving the overall nutrition status.

The key Departments identified to improve the status of nutrition are:

- Women and Child Development
- Health
- Education
- Rural Development

[1] Global Nutrition Report, 2015

- Drinking Water & Sanitation
- Panchayati Raj Institutions

4. OBJECTIVE

This document has been drafted for the District Collectors who will conduct Quarterly Joint Review of the performance of various Sectors & Schemes which have a direct or indirect impact on nutritional outcomes of women and children.

These Guidelines will support the District Officials to monitor the progress made on attaining Nutrition objectives in their Districts, once every 3 months.

5. PROCESS GUIDE

Step-wise process guide:

Prepation for Quarterly Review Meeting

- **Notify** all the concerned Oficials/ Functionaries
- **Set-up District Validation Committee** with representatives from NGOs, CSR Agencies, Development Agencies, Academic Institutions, etc
- Fix a **deadline** (minimum 15 days prior to the review date, i.e. 10th of every quarter) for receiving data on the fixed indicators

Data Validation & Quality Compliance

- Ensure the requried **data is submitted 15 days prior to the meeting**
- **Validate** the data submitted through **sample surveys** and **field visits** and ensure triangulation through other data sources.

Review Process

- Invite PRI Members, Reps of Different Departments & Members of the District Validation Committee to attend the Meeting
- Pointers for Review:
  - Invite **Presentations** by Concerned Departments
  - **Reivew** Progress over Process Indicators
  - Discussion on **Initiatives on Identified Focus Areas**
  - Review of **Supply Side Issues**
  - Identifying **Measures for Improvement**

6. INSTRUCTIONS FOR FILLING THE CONVERGENCE MATRIX

1.1. At the onset, fill out the Date, Name of the District and District Official.

1.2. The 'Validation' column is to validate the data through MIS and additional questions.

1.3. In case of unavailability of data for any particular indicator, please indicate so in the response column.

1.4. At the Block Level, the Block Level Officers of different Departments are responsible for the compilation of data of the select indicators and making it available to their Department heads.

1.5. The Action Taken on the provided feedback will be presented at the next Joint Review meeting.

7. QUALITY & VERACITY OF DATA

Section 9 presents a Matrix of Critical Indicators which must be reviewed on a quarterly basis. It is expected that the data inserted in this Matrix is provided by Frontline workers of different Departments, cross-checked at the Block Level and validated by the District Validation Committee.

It must be ensured during this process that the data which is entered is of high quality; as it undergoes multiple rounds of validation and verification. Some of the mechanisms to ensure credibility are through field visits to Anganwadi Centres (AWC), Public Health Centres (PHC), Sub-Centres etc, commissioning sample surveys for verification, cross-checking with other data sources/ programme data etc.

In addition, as Village Health, Sanitation, and Nutrition Days (VHSND) provide the platform for convergence of activities, periodic visits on such occasions are strongly recommended. They would provide an opportunity for direct feedback from beneficiaries regarding the quality of services currently being provided as well as enable identification of areas which require immediate action/ attention.

During this entire Review Process, it is suggested that all the functionaries/ officials who are likely to participate in this process be informed the actual purpose of this exercise- *which is to forge robust linkages between Departments and strengthen coordination among workers in view of the multidimensional nature of Nutrition while addressing nutritional & related challenges*. This would remove apprehensions towards the exercise and encourage enthusiastic participation, leading to enhanced data quality without instances of over & under reporting.

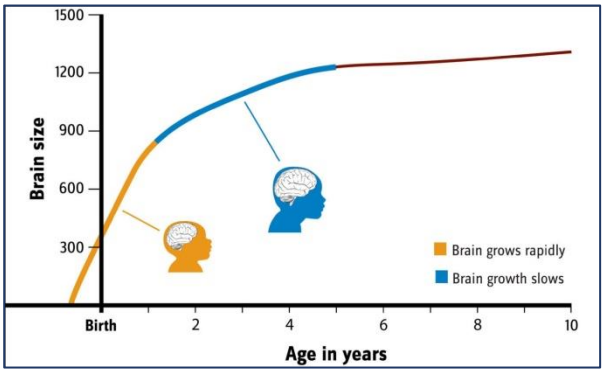
It must be ensured and accordingly conveyed to everyone that the purpose of this exercise is NOT to penalize accurate reporting. The field workers, at no point, must be put under pressure to improve certain indicators as it would simply lead to misreporting and data of questionable quality being fed into the system.

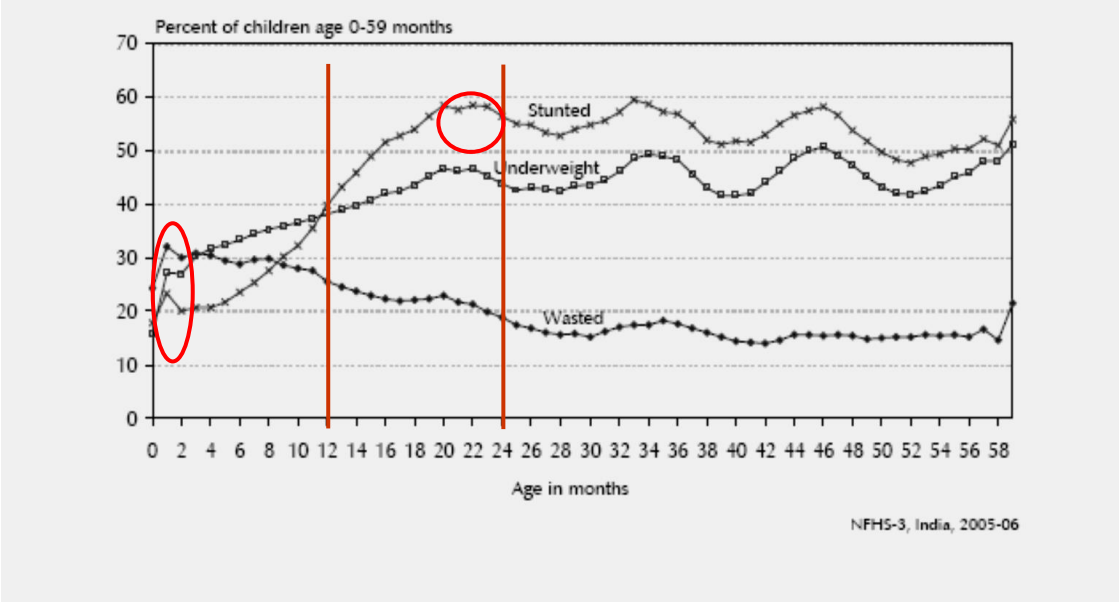
8. FOCUS AREAS

Our health and nutritional choices and practices are firmly embedded in our socio-cultural customs, practices and behaviours. Therefore, in order to change the nutritional status of women and children, an equal attention needs to be given in complimenting all programmatic and service delivery efforts with behavioural change campaigns.

Some of the possible areas/ activities be:

a) **Focus on first 1000 Days**: As evident in the adjoining figures, the 1st 1000 days of a child's life is critical to its health & nutrition well-being as it is the period of rapid brain growth. It is also during this time that a child is most likely to slip into malnourishment. While the ICDS programme primarily targets children in the 3-6 age groups, it is too late by then to take preventive measures.





Multiple measures can be introduced to prevent early onset of undernourishment, beginning with ensuring early initiation of breastfeeding. Despite a significant improvement in institutional deliveries (~80%), the rate of early initiation of breastfeeding is about 40%. This gap can be bridged easily. Further, home-visits by ASHA/ Anganwadi Workers can be used to disseminate knowledge regarding appropriate Infant and Young Child Feeding (IYCF) practices, growth monitoring of children, counseling on appropriate hygiene and sanitation behaviours, detection and prevention of diseases among others.

b) Using **Village Health, Sanitation and Nutrition Days (VHSND) as a Platform of Convergence**: The VHSNDs can provide the platform for convergence of multiple service delivery interventions such as vaccinations, growth monitoring/ weighting, counseling to mothers, organizing *Annaprashan* ceremonies, BCC Campaigns and so on. In fact, with the implementation of the National Nutrition Mission (NNM), it can be used for real time data feeding and monitoring purposes as well. Therefore, it is strongly recommended to organize and ensure regular, vibrant VHSNDs in every village.

During the Quarterly Review Meetings, a stock can be taken of the number of VHSNDs held, their popularity among beneficiaries measured on the basis of the attendance of beneficiaries, participation of functionaries, delivery of services etc. Visits to the VHSNDs by Officials are strongly recommended.

c) **Improving Infant & Young Child Feeding (IYCF) Practices:** As highlighted above, despite achieving a high rate of institutional deliveries (~80%), **early initiation of breastfeeding** remains a challenge as only about 40% of the children are breastfed within one hour of birth. Moving on, it is essential that **exclusive breastfeeding** continues for the first six months. The babies who are breastfed do not require any other additional food, supplements or fluids as beast-milk.

Post six months, along with breast milk, **complementary foods** are essential to address the growth needs of the baby. Presently, less than 10% children between 6-23 months receive adequate diet. The staple cereal of the family should be used to make the first food of the baby. Once the child starts eating the cereal, mixed foods including cooked cereals, pulses and vegetables can be given.

Most of the feeding practices are interlinked to the food and dietary patterns of the family. Measuring them can be a challenge. Changing them can take time and entail multiple rounds of counseling sessions. Therefore, it is suggested that VHNDs are used as a platform to promote and push the adoption of appropriate feeding practices. Additionally, it is also suggested to extend the bi-monthly home-visits of ASHAs once the child attains 4 months with an objective to ensure counseling for complementary feeding and growth monitoring.

d) **Extensive Behavioral Change Campaigns:** Based on context-specific challenges and opportunities, comprehensive BCC Campaigns are essential to change the health & nutrition status of women and children. *Therefore, it is suggested to devise an effective and comprehensive BCC strategy at the District Level which can be jointly implemented and reviewed during the review meetings.*

e) **Involving Self Help Groups (SHG) & Women's Groups:** Using SHGs and women's groups can be one of the strategies to change behaviours due to their networks and deep influential abilities. These groups can be used to disseminate information, mobilise people for VHSNDs, monitor service delivery, track high-risk babies, provide THR/ cooked meal services among other. Therefore, it is suggested to encourage their involvement to address nutrition related issues.

f) **Community Involvement:** World over, rapid decline in malnutrition trends has been conditional upon the involvement of communities in not only accelerating behavioral change but also

mobilizing additional resources to take care of children who lag behind. Excellent use has been made of Panchayati Raj Institutions in different parts of the country in the battle against malnutrition. You may like to mobilize PR Representatives and enlist their active support for this cause.

9. SECTOR WISE MONITORING INDICATORS

Sr. No	Indicator	Measurement	Source	Value	Validation	Response/ Action taken
			ADOLESCENT HEALTH			
1	Percentage of girls (6-12 class) provided at 4 IFA tablets in Schools	Total number of school girls provided at least 4 IFA tablets under WIFS v/s Total number of adolescent girls covered under WIFS in the district (Schools + AWC)	District Monthly Report WIFS/ HMIS		What is the total number of adolescent girls who were diagnosed with Anaemia in the district?	
2	Percentage of out of school Adolescent Girls (11-14 years) provided 4 IFA tablets at Anganwadi Centre	Total number of out of school girls provided at least 4 IFA tablets at the Anganwadi Centre v/s Total number of adolescent girls	ICDS			
			MATERNAL HEALTH			
3	Percentage of pregnant women who received 4 or more ANC	Total number of pregnant women who received 4 or more ANC v/s Total number of pregnant women registered for ANC	HMIS			
4	Percentage of pregnant women given 180 IFA tablets out of total ANC registrations	Total number of pregnant women who received 180 IFA tablets v/s Total number of pregnant women registered for ANC	HMIS		What is the stock availability status at SCs for IFA tablets?	

5	Percentage of pregnant women who gained at least 9-11 kgs during pregnancy	Total number of pregnant women who gained at least 9-11 kgs during pregnancy v/s Total number of pregnant women registered for ANC	HMIS/ MCTS			
6	Percentage of children between 6-12 months who were visited by the Anganwadi / ASHA Worker at least twice	Total number of households visited by the AWW/ ASHA worker with children between 6-12 months v/s Total number of	ICDS MPR		How many children under one year are registered at the Anganwadi Centre?	
CHILD HEALTH						
7	Percentage of institutional deliveries (public +private) out of the total reported deliveries	Total number of institutional deliveries (public + private) v/s Total number of reported deliveries	HMIS			
8	Percentage of children breastfed within 1 hour of birth out of reported live births	Number of children breastfed within 1 hour of birth out of reported live births v/s Total reported live births	HMIS		1. What was the percentage of C-section deliveries? 2. What are the reasons for gaps in the % of institutional deliveries and % of children breastfed in the first hour after birth?	
9	Percentage of live born infants with birth weight under 2.5 kgs	Total number of new-borns with weight less than 2.5 kgs v/s Total number of registered live babies that were weighed at birth	HMIS		What were the live births in the last month in the district? Percentage of new-borns weighted at birth	

10	Percentage of children fully immunized (9-11 months) (BCG, DPT3, OPV3, Measles1)	Total number of children aged 9-11 months who are fully immunized v/s Number of children completing 12 months during the month	ICDS MPR		What is the stock availability status for facility and VHND? (For each vaccine - BCG,DPT123,Penta123,OPV123,Measels)	
11	For Severe Acute Malnutrition (SAM): i. Percentage of children under 5 years Screened ii. Percentage of children under 5 years Diagnosed with SAM	i. Total number of children under 5 years screened v/s Total number of children under 5 years (as per estimates) ii. Total number of children under 5 years diagnosed with SAM v/s Total number of children screened for SAM	HMIS/ ICDS MPR		Please check against the NFHS Figures available for your District. If there are major discrepancies, you need to do an in-depth analysis of the cause.	
12	Percentage of Severely Underweight Children under 5 years: i. 0-1 years ii. 1-5 years iii. Total	Total number of children who are severely underweight (different age groups- in the Orange) /Total number of children in that age group	ICDS MPR		1. What steps were taken to improve child nutrition? 2. Were children referred to a health center/ NRC? 4. Were children given double ration? 5. Were families counselled about caring for children?	
13	Percentage of Children under 5 years with Diarrhoea treated with ORS	Total number of children Under-Five years with Diarrhoea treated with ORS in the last 2 weeks v/s Total number of Under-Five children with diarrhoea in the last 2 weeks	HMIS		What is the stock availability status for facility and VHND? (For zinc and ORS)	

14	Percentage of Children under 5 years with Diarrhoea treated with Zinc	Total number of children Under-Five years with Diarrhoea treated with Zinc v/s Total number of Under-Five years children with diarrhoea in the last 2 weeks	HMIS			
15	Percentage of children (9 months to 5 years old) administered 1st dose of Vitamin A (Dose-9)	Number of children (9 months to 5 years old) administered 1st dose of Vitamin A (Dose-9) v/s Total number of children under the age of 5	HMIS		What is the stock availability status for facility and VHND? (For Vit.A)	
16	Percentage of Children (1-19 years) administered Albendazole Tablets in the: (i) 2nd Quarter (ii) 4th Quarter	Number of Children (1-19 years) administered Albendazole Tablets v/s Total Number of Children (1-19 years)	HMIS			
SANITATION						
17	Percentage of ODF Villages	Total number of ODF Villages v/s Total number of Villages in the District	SBM(G) MIS		What is the status of toilets in Non ODF villages?	
18	Sanitation Coverage in Rural Area	Total number of households with access to toilets v/s Total number of Rural Households in the District	SBM(G) MIS			

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Operational Guidelines for Convergence in Village Health Sanitation and Nutrition Day (VHSND)

Village Health Sanitation and Nutrition Day (VHSND): VHSND is an existing platform where the programmes are expected to converge, considering the various determinants which are linked to outcomes of health and nutrition and can be used for achieving effective integration of the field machinery of relevant Departments.

The following action points will be adopted:

a) VHSND to be mandated in every village on a fixed date every month where participation of Health and Nutrition functionaries (ASHA, AWW and AWH) along with sanitation and PRI workers be ensured. Timings of the VHSND to be scheduled from 9 am - 4 pm.
b) A system of outcome linked joint incentives for field functionaries would be evolved primarily focusing on activating VHSND.
c) Recorded messages would be developed on critical issues related to nutrition, health and hygiene practices which would be used during the VHSNDs.
d) IEC campaigns at District/ Block level be organized to create awareness about the VHSND and encourage community participation.
e) In order to ensure community participation and desired behavioral changes, Panchayati Raj Institutions and Village Organizations should be involved in organization of VHSND.
f) The Joint Advisory dated 18th January 2018 clearly specifies the roles of VOs/SHGs in VHSND. The said Joint Advisory is attached.

The presence of all three 'AAA' frontline workers (i.e. AWW, ASHA and ANM) is critical for the provision of the intended package of services at VHSNDs.

- ASHA along with Aanganwari Workers (AWWs) are responsible for mobilising the community for VHSNDs, with support from Panchayati Raj Institutions (PRIs), and holding health education sessions.
- Auxiliary Nurse Midwives (ANMs) provide health services such as antenatal care (ANC), routine immunisations and other health services.
- AWWs provide growth monitoring services and referral of children with severe acute malnutrition in addition to distributing supplementary nutrition.

Some of the important ministries/ departments whose role is critical to roll out effective implementation of services through VHSND are as under –

- Rural development and Panchayati Raj
- Drinking water and sanitation
- Health and Family Welfare
- HRD and MoWCD
- Information and Broadcasting/ Department of Information & Public Relation

Focussed services envisaged in VHSND are as given below:

The components for convergence at different growth stages and inclusion in the Convergence Action Plan at State/UT, district and block level are:

S. No	Areas of convergence	Name of the component	Name of the concerned Department
1.	Antenatal Care	1.1. Early Registration 1.2. MCP Card filling 1.3. TT immunization 1.4. Abdominal check up 1.5. Haemoglobin testing 1.6. Identification of High risk Pregnancy 1.7. Urine testing 1.8. Blood sugar testing 1.9. Weight monitoring 1.10. IFA Supplementation 1.11. Deworming 1.12. Full ANC	Department of Health & FW, ICDS, Department of Education, Tribal Affairs
2.	Growth Monitoring	2.1. Weight by Age for measuring underweight 2.2. Height by Age for Measuring stunting 2.3. Weight by Height for wasting through scale 2.4. MUAC measurement for Screening wasting and further referral 2.5 MCP card filling 2.6 Identification of SAM & MAM children	Department of Health & FW, ICDS, Department of Education
3.	Supplementary Nutrition	3.1. Take home ration (THR) for Pregnant women, Lactating women and Children of 6 months to 36 months with counselling.	ICDS
4.	Immunization and other related services	4.1. Vaccination for BCG 4.2. Pentavalent 4.3. Measles 4.4. Polio drops 4.5. Vitamin A supplementation 4.6. Deworming 4.7. Zinc supplementation, Iron Supplementation to children above 6 months.	Health & FW, ICDS, Department of Education

S. No	Areas of convergence	Name of the component	Name of the concerned Department
5.	Health and Nutrition	5.1. Six steps hand washing 5.2. Diarrhoea management 5.3. Deworming, Early initiation of breastfeeding 5.4. Exclusive breastfeeding up to six months 5.5. Timely complementary feeding with dietary diversity through demonstration 5.6 Optimal IYCF practices	Health & FW, ICDS, Department of Drinking Water & Sanitation, Department of Education, Department of Rural Development (PRIs)
6.	Referral Services	6.1. Referral of high risk pregnancy, 6.2.SAM and Anaemic children screened to CHC, NRC and DH	Health & FW, ICDS, Department of Rural Development (PRIs), Tribal Affairs

Discussion on the Infrastructure and other aspects of IEC.

7.	Strengthening of AWC Infrastructure	Construction of AWC buildings under MNREGS including identification of gaps	Rural development and Panchayati Raj
8.	Provision of basic amenities at AWC	Drinking water, Electricity and Toilets	ICDS, Department of Drinking Water and Sanitation, Panchayati Raj Institutions
9.	Ensuring ECCE and IEC	Early childhood care and education	HRD and MoWCD
10.	Trans-media	Information and education Campaign	Information and Broadcasting/ Department of Information & Public Relation

Talk about the importance of CBE once a month for 1.5 hrs. The following activities will be included in this component.

a. CBE for Critical milestones in the 1000 days period.
b. IEC and advocacy to support nutrition behavior change.
c. Jan Andolan.

Normative Convergence Plan

Under the Anganwadi Services of Umbrella, ICDS Scheme VHSND is a very important tool for convergence. While framing the Convergence Action Plan, States/UTs should include number of VHSN days to be conducted, monitoring of such days, activities to be undertaken and the feed-back on such activities. This needs to be carried out in conjunction with the ILA activities.

State level leadership will infiltrate to grass root level with various administrative functionaries. In this regard as suggested under POSHAN Abhiyaan, State, District, Block, PRI level key stakeholders need to be mobilized with their specific roles. To achieve this, guidelines to be issued by Chief Secretaries of States under a convergence committee.

Composition and roles of Convergence committees:

I. State/UT Convergence Plan (SCP)

The State Convergence Committee shall consist of the following:

Senior most Principal Secretary of line Department (nominated by Chief Secretary).	Chairperson
Secretary, Planning	Member
Secretary, Finance	Member
Secretaries of line ministries (DW&S, Health, RD, PRI, Education & Food)	Member
Secretary, Panchayati Raj	Member
State Mission Director, NRHM	Member
F&NB representative	Member
State representative from NIPCCD	Member
Principals, MLTC	Member
Director, WCD	Member- Secretary

Role of State/UT Convergence Committee:

1) Consolidate and examine the requirements given in District Plans received from various Districts.
2) Segregate the item-wise requirements and seek the financial commitment before inclusion in the SCP.
3) Based on examination, determine the final requirement and prepare a State/UT Convergence Plan.
4) Indicate the roll-out plan, assign responsibilities of each department to avoid any over-lapping or consequent shifting of responsibility.
5) To submit the SCP for inclusion in State/UT APIP for approval by State/UT EPC before submission to the MWCD. The components which are to be funded from the State/UT budget need to be segregated and clearly mentioned in the APIP.
6) Ensure timely issue of sanction by each Department.
7) Prepare guidelines for release of funds for convergent actions directly to the DC

II. District Convergence Plan (DCP)

The District Convergence Plan Committee shall consist of the following:

DM/DC/Collector	Chairperson
Chief Executive Officer (Zila Parishad/DRDA)	Member
District level PRI members	Member
SDMs of the Districts	Member
CMO/DMO, Health & Family Welfare	Member
District Planning Officer	Member

District Social Welfare Officer	Member
District Officer, Rural Development/MGNREGS	Member
District level officers from Departments of Health, DW&S, RD, PRI, Education & Food	Member
Field representative of FNB	Member
CDPOs	Member
DPO, ICDS	Member- Secretary

Role of DCP Committee:

1) Examine the need assessment made by the BCP for essential interventions at the Village/AWC level and the availability of resources.
2) Consolidate requirement of interventions at the District level.
3) Considering the need, each line Department to prepare their action plan at the District level for delivering the interventions relating to them.
4) Take inputs from PRI members including on the extent of community participation, etc.
5) Submit the consolidated District Convergence Plan to the State Government for approval and for earmarking the financial provisions.
6) Wherever required, the DCP Committee may make physical inspections to assess the need projected.

III. Block Convergence Plan (BCP)

The Block Convergence Plan Committee shall consist of the following:

Sub Divisional Magistrate	Chairperson
Block Development Officer (BDO)/TDO	Vice-Chairperson
Block representatives of Health (BMO/MO in charge of PHC/CHC)	Member
Block representatives of Departments of Education, DW&S, RD, Food and Public Distribution	Member
Block representatives of Department of Planning Social Welfare Officers at the block level	Member
Representative of Block/Nagar/Taluka Panchayat	Member
Principal, Anganwadi Training Centre	Member
Block level officer of MGNREGS	Member
Supervisors (5) on rotation basis	Member
CDPO, ICDS	Member -Secretary

Role of BCP Committee:

1) Need assessment of essential interventions at the Village/AWC level i.e. water, sanitation, food, health interventions, immunization, ANC/PNC, Vitamin-A, IFA, Deworming tablets, functioning of VHSNC, etc. and the availability of resources.

2) The assessment at the Village level will be done by AWW and Supervisor in association with PRI representative under the supervision of concerned CDPO/DPO. CDPO/DPO would submit the inputs to the area SDM.
3) Consolidate and assess requirement of interventions at the block level.
4) Considering the need, each line Department at the block level to propose their action plan at the Block level for inclusion in the DCP
5) Involve PRI members actively in the assessing the need and seek their suggestions.
6) Submit the Block Convergence Plan to the District authorities for inclusion in the DCP and Approval of DM.

Role of Panchayati Raj Institutions:

1) It is important for any field-based programme to involve the community and the Panchayati Raj Institutions. For preparing the Convergence Action Plans, the role of PRIs is very important. For this purpose, it is necessary that PRIs are not only active in their areas but are also aware about the Government programmes and their benefits.
2) Wherever PRIs are not active, an action plan for their capacity building should be included in CAP. Their training can be imparted through SIRDs wherein 5 to 8 Master Trainers can be trained who, in turn, can train the PRI members.

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