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# Project Close-Out Report

## The Vistaar Project

*From Knowledge to Practice*  
(2006-2012)

April 2013

**SUBMITTED BY:**



## Project Description

<b>Project Name</b>	Vistaar
<b>Project Description</b>	The Vistaar Project is a six-year (2006-2012) project funded by the United States Agency for International Development (USAID) with the purpose “To assist the Government of India and State Governments of Uttar Pradesh and Jharkhand in taking knowledge to practice for improved maternal, newborn, and child health and nutritional (MNCHN) status”.
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<b>Project Funder</b>	USAID
<b>Duration</b>	October 1, 2006 to December 31, 2012
<b>Location</b>	India
<b>Agreement Type</b>	Cooperative Agreement # 386-A-00-06-00162-00
<b>Geographical Area</b>	Indian states of Uttar Pradesh, Jharkhand and Bihar
<b>Partners</b>	Abt Associates, Catholic Relief Services (CRS), MAMTA– Health Institute for Mother and Child, Vikas Bhakti, Child in Need Institute (CINI), Jut
<b>Budget</b>	\$ 24,965,393
<b>USAID Technical Office</b>	Office of Population Health and Nutrition

## List of Acronyms

AMTSL	Active management of third stage of labour
ANM	Auxiliary nurse midwife
APIP	Annual Program Implementation Plan
ASHA	Accredited Social Health Activist
AWC	<i>Anganwadi</i> centre
AWW	<i>Anganwadi</i> worker
CDPO	Child Development Program Officer
CSNSI	Coalition for Sustainable Nutrition Security in India
DFID	Department for International Development (UK)
DWCD	Department of Women and Child Development
DHFW	Department of Health and Family Welfare
GOI	Government of India
GOJH	Government of Jharkhand
GOUP	Government of Uttar Pradesh
HRIS	Human Resource Information System
ICDS	Integrated Child Development Services Scheme
IFA	Iron and folic acid
JH	Jharkhand
JRHMS	Jharkhand Rural Health Mission Society
LAA	Leadership Agenda for Action
MCH	Maternal and child health
MDG	Millennium Development Goal
MHFW	Ministry of Health and Family Welfare
MIS	Management information system
MMR	Maternal mortality rate
MNCHN	Maternal, neonatal, and child health and nutrition
MWCD	Ministry of Women and Child Development for Nutrition
NGO	Nongovernmental organization
NHSRC	National Health Systems Resource Center
NIHFW	National Institute of Health and Family Welfare
NIHP	National Integrated Health Program
NIPCCD	National Institute of Public Cooperation and Child Development
NRHM	National Rural Health Mission
PIP	Program implementation plan
PMP	Project Monitoring Plan
RCH	Reproductive and child health
RCH II	Reproductive and Child Health Program

SBA	Skilled birth attendant
SHSB	State Health Society of Bihar
SIHFW	State Institute of Health and Family Welfare
SLT	Senior Leadership Team
TA	Technical assistance
UNICEF	United Nations Children’s Fund
UP	Uttar Pradesh
USAID	United States Agency for International Development
USG	United States Government
VHND	Village Health and Nutrition Days
WFP	World Food Program
WHO	World Health Organization

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# 1. Project Overview

## 1.1. Genesis of USAID Support for the Vistaar Project

In early 2006, USAID designed the National Integrated Health Program (NIHP), which was later called the Vistaar Project. USAID stated that the key aspects of the mission strategy that influenced the NIHP design include:

- Transitioning the USAID/India program into a “last mile” phase, which focuses on providing technical assistance with the goal of scaling up proven practices (rather than supporting research, pilots, or stand alone/small scale service delivery efforts)
- Supporting GOI MNCHN activities and building GOI systems and capacities, in order to work at large scale and as a sustainable approach (an exit strategy is “built in from the start”)
- Leveraging the opportunities presented by the increasing GOI commitment and funding of MNCHN (especially through the NRHM)
- Fulfilling a USG commitment to support achievement of the MDGs
- Acting on the USAID commitment to promote evidence based interventions and the use of evidence in public health planning and programming
- Continuing the USAID focus on selected high needs areas (UP and Jharkhand)

## 1.2. The Project Purpose, Objectives and Strategies

### Purpose

The Vistaar Project’s purpose was “To assist the Government of India and State Governments of Uttar Pradesh (UP) and Jharkhand (JH) in taking knowledge to practice for improved maternal, newborn, and child health and nutritional (MNCHN) status”.

### Objectives

The Project sought to improve maternal, newborn, and child health and nutritional (MNCHN) status by assisting the Government to take proven practices to scale in their programs (taking knowledge to practice). The Project objectives were:

1. Technical Assistance: To provide strategic technical assistance (TA) to strengthen MNCHN programs of the GOI, Government of UP (GOUP) and Government of Jharkhand (GOJH), in selected priority areas and based on evidence
2. Evidence Generation: To generate needed evidence about effective, efficient and expandable MNCHN interventions based on TA experiences
3. Advocacy: To advocate with GOI, GOUP and GOJH for increased priority and improved evidence based programming in MNCHN

The Project contributed to Government initiatives such as the National Rural Health Mission (NRHM), the MOHFW Reproductive and Child Health Program (RCH II), the Universalization of Integrated Child Development Services (ICDS), and the Eleventh Five Year Plan and was expected to contribute to the achievement of the Millennium Development Goals (MDG) for maternal and child health in India.

**Objective One:** Working with the Government and other key stakeholders, the Project team selected several strategic technical assistance (TA) areas based on Government priorities and plans, Government interest and request for TA, evidence that these inputs could have a significant impact on MNCHN, and the Project’s comparative advantage (Figure 1). As per the Government’s NRHM approach and project design, most of the TA work was targeted at the district level (population between one to two million), although some complementary TA was at the state level.

**Figure 1. Key Technical Areas**



**Objective Two:** In addition to providing TA, the Project is carefully monitored these efforts to ensure they are effective, to make adjustments as needed, and to document lessons about which TA approaches were working at scale and which were not. This added a learning and evidence generation dimension to the TA effort. The learning was intended to contribute to the evidence base about operational issues and “how” to scale up better MNCHN approaches and practices in the Government system.

**Objective Three:** The Project team led efforts to improve attention and focused action on nutrition, at the national level. The NFHS 3 results, disseminated in 2007, showed the clear need for more focus and improved programming on nutrition, and the Project made significant contributions through national level consultations and by helping to form and support the Coalition for Sustainable Nutrition Security in India. The Coalition prepared and released a Leadership Agenda for Action (LAA) in late 2008 and worked to disseminate the

recommendations. The Project initiated a multi-sectoral approach to improve nutrition security in Gumla block of Jharkhand to operationalize the LAA recommendations.

## **Strategies**

The major overarching strategies of the Project included:

- Supporting Government MNCHN programming (primarily through TA)
- Leveraging existing opportunities and programs
- Fostering collaborative and participatory work processes
- Performance improvement for frontline workers (especially supportive supervision and motivation)
- Improved Government capacity in planning and program management (including use of evidence and data on program and human resources)
- Integrating equity and gender across all strategies
- Improving Knowledge Management

## **2. Project Implementation Details**

### **2.1 Project Timeline**

During the initial year, 2006-2007, the Project focused significant efforts in facilitating Evidence Reviews for various technical themes within MNCHN. During 2007-2008, the Project's focus was into the selection of districts and technical assistance areas based on state and district Government priorities, USAID priorities and the evidences. The Project team then developed technical assistance roll-out plans. The Project conducted baseline surveys in 2008/2009. During 2008-2011, the Project finalized and roll-out the district TA plans, using information from the baseline surveys and various needs assessments. The Project's activities during 2011-2012 focused on institutionalization and sustainability of its efforts, strengthening evidence and documentation, and advocacy for scale-up of systems improvements resulting from the technical assistance provided. The Project also actively pursued opportunities for advocacy and dissemination of successes and lessons learned at various forums. The Project conducted end line surveys by externally contracted agencies from January to April 2012.

### **2.2 Geographical Coverage**

The Project worked at large scale, supporting public sector health and nutrition programmes that serve 22 million people in eight districts (Azamgarh, Banda, Bulandshahr, Chitrakoot, Gonda, Kaushambi, Saharanpur and Varanasi) of Uttar Pradesh and 20 million people in 16 districts (Chatra, Deoghar, Garhwa, Giridih, Godda, Gumla, Hazaribagh, Jamtara, Khunti, Koderma, Latehar, Pakur, Ranchi, Ramgarh, Sahibganj and Simdega) of Jharkhand. In addition the Project provided targeted technical assistance to help the state of Bihar strengthen their human resources information.

## **2.3 Technical Assistance Partners**

IntraHealth International, Inc., a US based not-for-profit organization, led the Vistaar Project in partnership with two US-based organizations, Abt Associates which provided expertise in costing analysis and Catholic Relief Services (CRS) which provided field and technical experience in MNCHN. Vistaar also worked through Indian non-governmental organizations as subgrantees to facilitate technical assistance at the district level (MAMTA– Health Institute for Mother and Child in Uttar Pradesh and Vikas Bharti, Child in Need Institute (CINI), and Ekjut in Jharkhand. These partnerships offered capacity-building and technical assistance in several high priority technical areas.

## **2.4 Coordination and Collaboration**

Vistaar valued collaboration with other agencies and built relationships with a number of GoI departments and agencies, including the MHFW, MWCD, NIHF, NIPCCD, NHRDC, the Indian Council for Medical Research, the National Institute for Nutrition, the National Advisory Council, and the Planning Commission. Vistaar also worked regularly with a number of MNCHN stakeholders, including UNICEF, World Bank, DFID, and other nongovernmental organizations.

## **2.5 Leadership Approach**

The Project articulated a leadership approach as a part of (internal) start up and workshop planning which guided it through the Project period. Documents outlining the Project purpose, leadership approach, customer, community and other elements needed to build a strong foundation drafted by the entire Project team at the startup workshop and were reviewed and revised as needed about once a year. The leadership approach was designed to ensure achievement of the purpose of the Project and included:

- Clear articulation of the Government as the primary customer of the Project
- Supporting staff leadership and focus on the purpose at all levels
- Developing a culture that is flexible and able to deal creatively with change
- Fostering the ability to turn challenges into opportunities

The team defined the Vistaar Project Leadership approach as:

- Valuing consultative leadership within the limits of Project deliverables and timelines
- Encouraging, recognizing and respecting different ideas/inputs/styles/opinions
- Communicating clearly, especially about important decisions
- Mentoring emerging leaders
- Delegating responsibility with authority and accountability
- Fostering a supportive environment

This leadership approach led to a strong team that worked well together and was highly motivated. The Project developed an internal culture of consultation, which improved team work and extended the use of participatory processes in work with the Government and stakeholders.

## 2.6 Project Management

The Vistaar Project had offices in Delhi, Lucknow (Uttar Pradesh), and Ranchi (Jharkhand). The Vistaar Project valued team work and internal knowledge management and had several mechanisms for sharing critical information. An important tool was the intranet, which allowed all staff to access annual workplans, unit or individual workplans, district TA plans, project monitoring information, IntraHealth policies, job descriptions, and other important information. The project staffing was structured into technical and operations team. A senior leadership team (SLT) comprising the Project Director, Technical Director, the two State Directors the Contracts, Finance and Administration Directors met regularly to review progress and guide policy and program guidelines as required. Various units also held meetings periodically; the technical team met at least each quarter, and the full staff met once a year.

## 2.7 Project Monitoring and Evaluation

The Project team developed a Project Monitoring Plan designed to measure indicators across the Project, which was based on USAID's global monitoring guidelines and framework and was approved with the year one workplan. In year two, the USAID global monitoring guidelines and accompanying list of indicators changed and required some modification of the indicators used for the Project. Due to the nature of the Project, providing strategic TA to the Government, most of the indicators were systems or process indicators such as “# of improvements to laws, policies, regulations or guidelines related to improved access to and use of health services drafted with USG support (related to TA efforts).” In 2010, the Project developed a conceptual framework and included additional indicators in the Project Monitoring Plan (PMP), to evaluate the impact of its technical assistance at the district level. These included input, process, output and outcome level indicators, such as increased quality and quantity of VHNDs (indicated by increased number of VHNDs held as scheduled and increased # of services offered as per Government guidelines).

The Project designed and conducted baseline surveys in each district on key themes and, based on the data obtained, drafted reports and technical briefs for dissemination to district and state level officials and other stakeholders. The Project established an electronic Management Information System (MIS), with protocols for data collection and reporting, to capture process and output-level data during July 2009-March 2012 in all Project-supported districts. The Project also contracted an external research agency and experts to conduct qualitative studies from September to October 2011 to validate and better understand successful trends indicated from Project MIS data. In the final year, the Project contracted external agencies to conduct end line surveys in all eight Project-supported districts of Uttar Pradesh (Azamgarh, Banda, Bulandshahr, Chitrakoot, Gonda, Kaushambi, Saharanpur and Varanasi) and five districts of Jharkhand (Godda, Gumla, Khunti, Koderma and Sahebganj) and respondents included pregnant and recently delivered women, household decision-makers, DHFW and DWCD officials, supervisors and frontline workers from both departments.

## 3. Summary of Results

### 3.1 Process level results

The Vistaar Project exceeded the targets for the four Project Monitoring Plan (PMP) indicators:

- **Indicator: Number of improvements to laws, policies, regulations or guidelines**  
The Project's efforts resulted in 62 Government orders and guidelines related to improved access to and use of health services against the target of 47.
- **Indicator: Number of people trained**  
During the Project period:
  - 9,595 people were trained in child health against the target of 3,055
  - 688 participants were trained on FP/RH areas against the target of 470
  - 1,506 people were trained in nutrition against the target of 890
- **Indicator: Number of documents or tools generated and shared**  
The Project generated and disseminated 83 documents and tools against the target of 64.
- **Indicator: Number of MNCHN advocacy events**  
The Project contributed to 48 MNCHN advocacy events exceeding the annual target of 39

### 3.2 Outcome level Results

The Project, working in partnership with Government officials, achieved results in terms of systems improvements, increases in service quality, access and use, and positive changes in healthy behaviors, across the targeted states and districts. Highlights of the Project results are presented below and more details are available in thematic technical briefs:

Improved Newborn Health: In Uttar Pradesh, the majority of recently delivered women (90%) reported that their newborns received an initial check-up at the time of delivery at the facility (conducted by a doctor or ANM). There was a significant increase in the second newborn care visit conducted at home by an ASHA worker, with the percentage of mothers reporting a second visit increasing from 21% to 60%. The mothers receiving a third newborn care visit by an ASHA increased from 8% to 40%.

Improved Maternal Health and Skilled Birth Attendance: In Jharkhand, the average number of institutional deliveries conducted by SBAs in the six months prior to the survey increased from 8.7 to 33, among SBAs who provide services at Health Sub-Centres (evaluation survey conducted in Deoghar district in Jharkhand). The quality of delivery care improved as indicated by the use of active management of third stage of labour (AMTSL) (including the three key components of administering misoprostol, controlled cord traction and uterine massage). The use of AMTSL was non-existent during the baseline survey and at end line 98% of SBAs reported they follow AMTSL as standard practice in every delivery (evaluation survey in Deoghar district).

Improved Nutrition: In Jharkhand, around half of adolescents and one-third of mothers interviewed knew that iron and folic acid (IFA) supplementation could prevent or reduce

anaemia, an increase from the baseline. Adolescent girls received, on average, 47.3 tablets, and reported that they consumed most of the tablets (46.3 tablets), compared to receiving 10.8 tablets and consuming 6.1 at baseline. Further, 22 percent of the adolescents reported taking tablets to treat intestinal worms at end line, compared to three percent at baseline.

In Uttar Pradesh, the nutrition and anaemia related knowledge among pregnant and recently delivered women has improved. More women also knew the causes of anaemia and how to prevent it (such as by increasing consumption of green leafy vegetables) than at baseline. This suggests that nutritional counselling is reaching beneficiaries. Receipt and consumption levels of IFA also increased. However, consumption of foods that can prevent anaemia did not show any significant gains.

Delayed Age of Marriage: In Jharkhand, at end line, adolescent girls, their mothers and community leaders were much more knowledgeable about the legal age of marriage for girls. Almost all mothers (92%) and community leaders (99%) interviewed at end line considered it important to ask for the girl's consent about the age at which she would like to get married and the timing of her marriage. This represents a significant change in mothers' attitudes compared to baseline (54%).

Improved Services and Support Systems: In Uttar Pradesh, the quality of Village Health and Nutrition Days (VHNDs), increased, as indicated by the mean number of services offered during VHNDs increasing from 5.6 to 8.8 services. Support to the new ASHA cadre of workers increased significantly, as indicated by the quality and value of monthly ASHA meetings. The data show that capacity-building sessions were held in 93% of the ASHA meetings and ASHA attendance improved significantly from 53% in September 2009 to 74% in March 2012. In addition, other important review and planning meetings improved, such as interagency "convergence meetings" between the Department of Health and Family Welfare and the Department of Women and Child Development increased from 58% to 94% at block level.

### **3.3 Evidence Generation and Scale-Up Results**

The Project published six evidence reviews, four baseline and four end line briefs, eight technical briefs, three toolkits and six technical reports.

The Project worked strategically to disseminate successful approaches and advocated for their scale-up. Some examples of successful scale-up are provided below:

- In response to the request from Government of Jharkhand (GOJH) Vistaar provided technical assistance to improve the quality of SBA training in 2008, as a pilot initiative in Deoghar district. Based on the evidence of improved knowledge and practice of SBA skills and increasing institutional deliveries in Deoghar, GOJH decided to scale up the intervention in all 24 districts of the state in 2009, and asked the Project to provide technical assistance in 14 districts.
- The Project worked with the State Health Society of Bihar (SHSB) and the Jharkhand Rural Health Mission Society (JRHMS) to strengthen the Human Resources Information

Systems (HRIS) within department of Health. This work started with a pilot in one district in each state from mid-2010 through early 2012. Both state governments appreciated the data resulting from the pilots, and approved state-wide scale-up.

- The joint efforts of the Project and Department of Health and Family Welfare (DHFV) and Department of Women and Child Development (DWCD) in Uttar Pradesh to improve Village Health and Nutrition Days (VHNDs) contributed to increased access, use and quality of health and nutrition services at VHNDs. In May 2012, Government of Uttar Pradesh decided to replicate this strategy at scale in 28 high-burden districts (with high maternal mortality ratios) across six divisions of the state as an innovative effort under NRHM.
- The Vistaar Project supported the Integrated Child Development Services (Department of Women and Child Development), Government of Uttar Pradesh on areas like strengthening convergence through Village Health and Nutrition Days, improving counseling skills of Anganwadi Workers (AWWs) and improving their performance through supportive supervision, grading and reward and recognition system. These areas were incorporated in the final draft of the state's Annual Programme Implementation Plan (APIP) for FY 2011-12 and submitted to the Government of India for approval.
- In collaboration with the Government of Jharkhand, the Vistaar Project organized a knowledge sharing workshop in Ranchi on "Successful Approaches in Strengthening Skilled Birth Attendance". Apart from development partners in the state, the workshop was attended by senior health department, State Programme Management Unit (SPMU) and State Institute of Health and Family Welfare (SIHFW) representatives from seven high focus states - Assam, Bihar, Chattisgarh, Madhya Pradesh, Odisha, Uttar Pradesh and Uttarakhand and Karnataka. Dr. Dinesh Baswal, Deputy Commissioner (Maternal Health), Ministry of Health and Family Welfare, Government of India, encouraged the participating high focus states to replicate the intervention design, in at least one district of each state and scale it up gradually.

## **4. Finance Summary and Cost Sharing**

The Project spent 99% of the total budget. The Project's total cost share (in USD) was \$4,618,409 which exceeded the total cost share requirement of \$3,744,809 by \$ 873,600.

## **5. Overall Project Challenges and Lessons Learned**

### **Be Responsive to Government Priorities**

At the beginning of the Project, the team facilitated evidence reviews of approaches from India and the South Asian region (focusing on effectiveness, efficiency and expandability) to determine optimal interventions, and held consultations with government officials and other stakeholders to understand their priorities. The team also consistently used

participatory and consultative approaches, such as the whole person process facilitation and open space technology.

### **Provide High Quality and Credible Technical Expertise**

The Project focused on hiring staff with significant expertise and experience, as well as interest and willingness to work with the Government. The Project also partnered with international and local Indian organizations, selected based on local presence and appropriate experience. Since the Project team knew the Indian and state context well and were able to contextualize the technical assistance and capacity-building offered.

### **Promote the Programme Monitoring and Use of Data**

The Project promoted and demonstrated the use of (Project and government) data in regular meetings for progress reviews and problem-solving.

### **Strengthen existing Government Platforms and Systems**

The team worked with Government officials to strengthen existing platforms, such as regular monthly meetings of ASHAs and AWWs, which were enhanced to include capacity-building sessions, performance feedback and problem-solving. They also strengthened inter-agency collaboration meetings.

### **Adopt a collaborative shared leadership and team approach**

The Project faced significant hurdles, especially in working with vacancies and frequent change in Government leadership as well as challenging political and security situations, making strong team work and dedication to the Project and its purpose very important. The ambitious nature of the Project and challenging environment could have been very discouraging, but the staff has generally responded very positively and creatively.

## **6. Conclusion**

The Vistaar Project was successful in providing strategic technical assistance to the Governments of Jharkhand and Uttar Pradesh in taking knowledge to Practice at scale. The project produces new evidence in health systems strengthening and advocated for further scale up of successful approaches. The Project experience reinforced that improving performance of frontline workers and supervisors is critical for quality MNCHN services and simple and cost-effective systems improvements can have significant impact on district coverage and quality of MNCHN services. Further, district-level ownership needs to be backed by support at state and national level for sustainability and scale-up. The documents and tools developed by the Project can serve as useful resources for Government of India and the state Governments for improving the MNCHN status in India.