PD-AAX-972

A.I.D. EVALUATION SUMMARY PART I

(BEFORE FILLING OUT THIS FORM, READ THE ATTACHED INSTRUCTIONS)

A. REPORTING A.I.D. UNIT: USAID/India (Mission or AID/W Office)

(ES# 88/2)

B. WAS EVALUATION SCHEDULED IN CURRENT FY ANNUAL EVALUATION PLAN? yes ☒ slipped ☐ ad hoc ☐

Eval. Plan Submission Date: FY 87 Q 2

C. EVALUATION TIMING: Interim ☐ final ☐ ex post ☐ other ☒

D. ACTIVITY OR ACTIVITIES EVALUATED (List the following information for project(s) or program(s) evaluated; if not applicable, list title and date of the evaluation report)

Project #	Project/Program Title (or title & date of evaluation report)	First PROAG or equivalent (FY)	Most recent PACD (mo/yr)	Planned LOP Cost ('000)	Amount Obligated to Date ('000)
Grant No. 386-0000-G-00-5042	Catholic Relief Services' Targetted Maternal and Child Health Education Project	09/85	09/90	$400	$400

E. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR

Action(s) Required	Name of officer responsible for Action	Date Action to be Completed
1. A CRS/USAID Workshop to review the outcome of this evaluation and to formulate next steps	CRS/USAID	3/31/88
2. Consolidate CRS' program by reducing the total number of consignees (geographic consolidation)	CRS	9/30/88
3. Explore with CRS auditional staffing needs for both programs and mechanisms for funding staff development	CRS/USAID	9/30/88
4. Examine to what extent monetization could be attempted in order to ensure complementary cash funding	USAID	9/30/88
5. Render suitable training to all field programmers (including methodoligies)	CRS	9/30/88
6. Initiate discussion with CRS regarding training and technical assistance needs of TMCHEP program	CRS/USAID	12/31/88

(Attach extra sheet if necessary)

F. DATE OF MISSION OR AID/W OFFICE REVIEW OF EVALUATION: mo 08 day 12 yr 87

G. APPROVALS OF EVALUATION SUMMARY AND ACTION DECISIONS:

	Project/Program Officer	Representative of Borrower/Grantee	Evaluation Officer	Mission or AID/W Office Director
Signature				
Typed Name	Ronald E. Ullrich	J. DeHarpporte	K.K. Bablani	Robert N. Barkley
Date		7/4/88		

H. EVALUATION ABSTRACT (do not exceed the space provided)

A three member team contracted by USAID conducted an evaluation of CRS' Targeted Maternal/Child Health Education Project in June, 1987. The purpose was to assess program management and implementation of CRS' TMCHEP at all operational levels. Central issues were: whether monitoring and training were adequate and whether they could be accomplished given the geographical spread of the program.

CRS is in a difficult transition period. Its inherent strength is its outreach to the poorest through an existing infrastructure of highly committed and dedicated church counterparts. The scattered operational area, which resulted from this kind of request-response arrangement, is now a serious management problem.

CRS must consolidate in India. Even with additional staff, it would be an over-extended program. Continuing expansion of the government's MCH program--ICDS--into Blocks, in which there are counterpart sites, requires that CRS negotiate with the GOI and workout where their operational zones for TMCHEP should be. CRS would appreciate USAID support in this matter.

CRS recognizes the greatly increased planning, training and monitoring needs with TMCHEP implementation but cannot cope with these due to a lack of technical expertise, training design, audivisual aids, and sufficient staff to monitor the zones.

The most vital needs are:

- The resources to develop a technical cell with planning and training expertise at CRS/Delhi to serve the zones and to include membership of zonal-appointed technical staff;
- The resources to increase the technical field staff from the current 8-10 to 25 or 30;
- The resources to train or retrain staff, at all levels;
- The resources to pay full-time coordinators (from consignee offices in some instances as in the south; other would require CRS or USAID inputs)
- The cooperation of the church to make the most suitable consignees available to the program.

Because such technical inputs have not been available in sufficient quantity or quality, all of the program components lag. While the food supplement is delivered regularly, the efforts to target food to vulnerables through mother education have not yet altered family sharing of the food. Growth monitoring is inadequately carried out due to lack of training, materials, and clear guidelines on how to use the chart. Immunization coverage is not being verified systematically. Local Aides require guidance and should be at least literate to carry out this task. Coordination with government is improving but needs more encouragement. Mother education stresses general topics like personal hygiene and cleanliness. Some messages are understood, other only partially, some incorrectly. Local Aides require extensive training. They should be compensated for their work.

I. EVALUATION COSTS

1. Evaluation Team

Name	Affiliation	Contract Number OR TDY Person Days	Contract Cost OR TDY Cost (US$)	Source of Funds
Ms. Joyce King		386-0249-0-00-7153 Dt. June 1, 1987	$17,495	PD&S
Dr. P.Pushpamma		386-0249-0-00-7160 Dt. June 1, 1987	$ 7,457	PD&S
Dr. Usha Shah		386-0249-0-00-7159 Dt. June 1, 1987	$ 8,126	PD&S
			$33,078	

2. Mission Office Professional Staff Person-Days (estimate) _____

3. Borrower/Grantee Professional Staff Person-Days (estimate) _____

A.I.D. EVALUATION SUMMARY PART II

J. SUMMARY OF EVALUATION FINDINGS, CONCLUSIONS AND RECOMMENDATIONS (Try not to exceed the 3 pages provided)
Address the following items:

- Purpose of activity(ies) evaluated
- Purpose of evaluation and Methodology used
- Findings and conclusions (relate to questions)
- Principal recommendations
- Lessons learned

Mission or Office: USAID/India

Date this summary prepared: March 25, 1988

Title and Date of Full Evaluation Report: Evaluation of CRS's targetted Maternal Child Health Education Project in India July 8, 1987

FINDINGS AND RECOMMENDATIONS

Objectives
Findings:

(i) TMCHEP objectives are too general, optimistic and not measurable under the present monitoring system. CRS lacks a framework of phased targets over the first year period.
Showing a "reduction in infant mortality" is not possible, e.g. without baseline data on the areas where CRS operates.

(ii) CRS and counterparts are actually undertaking a TMCHEP program with wider objectives than those envisaged by AID for MCH.

Recommendations:

(i) CRS, with USAID or other technical assistance should refine its goals and include intermediate targets that can be measured by the existing evaluative structure (e.g., progress of III degree children under three years old).

(ii) The broader social objectives are valuable to the Maternal Child Health program and should be quantified.

SUMMARY

Geographical Spread; Overlap with ICDS/TINP
Findings:

(i) Thirty years of request-to-request program building throughout the church structure has resulted in a highly scattered program. With the new technical component of TMCHEP (requiring more monitoring, training and technical management) the enormity of the geographical distances poses even more implementation problems.

(ii) ICDS continues to expand into new Blocks and incidences of overlapping will increase unless CRS and GOI reach agreement on operational areas of CRS. CRS Centers in ICDS Blocks may be about 10%.

Recommendations:

(i) CRS must make a plan for consolidation of its program. One suggestion which CRS is considering is to reduce the total number of Consignees.
The team recommends that CRS should use the occasion of having to sort out frontiers of operation with the GOI to develop a consolidation operational area plan to be achieved in, say, three years (the average stay of Consignees). USAID should promote and encourage this effort as it is feasible.

4.3. **Adequacy of Staff for Training, Monitoring and Technical Direction**

Central and Zonal Level
Findings:

(i) CRS recognizes that greatly increased monitoring and training inputs are essential to carry out the TMCHEP program adequately but cannot cope due to lack of: technical staff; training design; and teaching materials such as audio-visual aids.
(ii) At the Zones, 1 or 2 nutritionists for these tasks is highly inadequate.
(iii) Present training programs are academic, loaded with basic subjects, usually presented in lectures, and lacking in practical hands-on experience.

Recommendations:
(i) A technical cell with planning and training expertise at the CRS/Delhi level should be established to serve the Zones (and include Zonal-appointed technical staff); it would be a technical support unit, not a policy-making body. In addition, the cell would encourage the exchange of technical information and facilitate uniformity of technical approaches.
(ii) One technical staff member (nutritionists, e.g.) for 80-100 Centers (as in ICDS) should be provided. This would mean 25-30 technical persons rather than the 8-10 slots now anticipated.
(iv) Existing staff should receive training in training methodologies suitable for field workers.

Consignee Level
Findings:
(i) Part-time TMCHEP coordinators are not able to carry out the program adequately due to lack of time and training.
(ii) Coordinator training has no emphasis on training skills (monitoring, practical and field experience).

Recommendations:
(i) Coordinators should be full time and the number of them at the Consignee level should be proportionate to the number of Centers served.
(ii) Task-oriented training programs with audio-visual aids and practical experience are needed.

Distributor/Center level:
Findings:
(i) Local Aides' qualifications and salary are highly variable and not commensurate with the job. Many are illiterate. Salaries range from zero to Rs. 800

Recommendations:
(i) Minimun education qualification should not be less than 8th standard and the minimum salary should be Rs. 150, both as for anganwadi workers. If cash is a constraint, payment should be made in kind.

4.4. Targeting: Selection of Beneficiaries

Findings:
(i) Since 1979, CRS has made considerable progress towards targeting under three year olds for growth monitoring. TMCHEP guidelines have only been issued recently, as late as a few months prior to this evaluation. Thus, the problems are just now

being faced at the Center level -- the difficulties of eliminating villages from the program and explaining that children over three who are not severely malnourished are no longer eligible. In that perspective, it is noted that the guidelines are not yet strictly adhered to, but they have been accepted (reluctantly in some cases).
(ii) Enrollment of mothers is low.

Recommendations:
(i) CRS should insist upon immediate implementation of the criterion that only under three year olds (except for severely malnourished over 3 years) be enrolled.
(ii) Phase-in of the new requirement should be given reasonable implementation time (two years maximum is suggested).

4.5. Availability of Commodities; targeting of rations

Findings:
(i) Delivery of full rations to program beneficiaries is highly regular.
(ii) Though efforts are apparent to target food to vulnerable groups, the program effects have not yet altered home consumption. Rations last 2-3 days for the most part and sometime up to a week.

Recommendations:
(i) None.
(ii) Motivation efforts for the mothers must be intensified to reserve foods for herself and the most vulnerable child, especially if requests on the part of CRS and counterparts for extra CSM rations for malnourished and under six months' infants are to be given a favorable hearing.

Mother Education:
Findings:
(i) Mother education stresses general topics like personal hygiene and cleanliness, rarely messages given on diarrheal management, ORS, feeding during diarrheal episodes, etc.

Recommendations:
(i) Local Aides need to be trained to convey specific, relevant simple messages, rather than talking to mothers on general topics in health and nutrition.

K. ATTACHMENTS (List attachments submitted with this Evaluation Summary; always attach copy of full evaluation report, even if one was submitted earlier)

Evaluation of Catholic Relief Services' Targeted Maternal Child Health Education Project in India - July 8, 1987.

L. COMMENTS BY MISSION, AID/W OFFICE AND BORROWER/GRANTEE

Mission endorses the Evaluation Team's belief that the TMCHEP program not only has potential but a firm basis of commitment and dedication to helping the poorest communities that cannot be matched in other programs.

TMCHEP is a very young program, but has a strong potential for developing into a highly relevant and need based program which improves the health and welfare of mothers and children. It has commitment and outreach structure, and urgently requires staff and training support. This also relates to one of our CDSS objectives, i.e., health care for rural population.

The Evaluation reinforces USAID contention that CRS urgently needs staff and training support. The Evaluation recommends that well designed orientation course be carried out for consignees to stimulate and encourage interest in the technical components of TMCHEP. Because technical inputs have not been available in sufficient quantity or quality, all of the program components lag. The team strongly recommends that CRS supply adequate number of reliable spring balances for weighing children and provide the required number of weight cards to each center. Growth cards should remain with the mothers so that it will be available to any person visiting the beneficiary. The Evaluation also recommends consolidation of CRS' program. One of the suggestions which CRS is considering is to reduce the total number of consignees.

USAID in coordination with CRS will organize a follow up workshop to discuss the strategies for the future direction of CRS' TMCHEP Program and also identify the possibility of cash resources.

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56702

EVALUATION

OF

CATHOLIC RELIEF SERVICES'

TARGETED MATERNAL CHILD HEALTH EDUCATION PROJECT

IN INDIA

Report Prepared by:

Joyce King, Team Leader
Dr. Pushpamma
Dr. Usha Shah
Ms. Ann Gowan

Assisted by:

Mr. N.K. Kotwaney

USAID/New Delhi

Draft: July 8, 1987

Acknowledgment

This report has been prepared by Ms. Joyce King, Team Leader, Nutrition/Food Program Evaluation Expert, Dr. P. Pushpamma, Dean of Home Science, Andhra Pradesh Agricultural University, Hyderabad, Dr. Usha Shah, International health consultant, Ex-Medical College Professor, Pune and Miss. Ann Gowan, AID-sponsored summer trainee, graduate student at Harvard University. Participating throughout the field work and assisting in the formulation of findings was Mr. N.K. Kotwaney of the Food and Development Resource Office of USAID/New Delhi. Mr. Joseph Perianayagam of the USAID Evaluation office also participated in some of the work. The evaluation was designed and directed by Ms. Christine Adamczyk, FDR, USAID/New Delhi and follow up after her departure was assured by Mr. Peter Amato, Evaluation Officer, USAID/New Delhi. Helpful guidance was provided by Dr. Richard N. Blue, Acting Director, and Mary Ann Anderson, Health and Nutrition office.

The field work could not have been carried out without the advance planning and assistance of CRS. Acting Director Mr. Mike McDonald of the Delhi office assured assistance and active cooperation by Zonal staff and contributed to the team effort, assisting them throughout their work in India. The team is grateful to Zonal staff for their guidance and outstanding helpfulness. Especially useful was their very valuable contribution made in the post field workshop held in Delhi to discuss preliminary findings and recommendations. Special thanks are due to the Zonal Directors, Nutritionists and Field Reviewers.

The team is indebted to the consignees, the MCH coordinators, the distributors/persons in charge of centers, the local aides and the mothers who shared their valuable time and thoughts with us.

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EXECUTIVE SUMMARY

Catholic Relief Services (CRS) began a family feeding program in India in 1951. By 1969 the first "MCH" program began operating. While program labels changed over the next 10 years, the Maternal and Child Health program in 1979 was still considered by a team of evaluators to be essentially a dole feeding program, unfocused, and except for 5 percent of its operations, not linked up with the health and nutrition education components capable of improving the health of its beneficiaries.

From the beginning, the CRS MCH program took the form of the responding church infrastructure in India. Priests and nuns around the country who were interested in beginning social programs with food aid assumed primary responsibility for receiving and accounting for the Title II foods.

Today priest consignees with MCH programs (now referred to as TMCHEP--Targeted Maternal Child Health Education Project) number 140. They reach 685,000 mothers and children in some 2,500 villages. Each of these beneficiaries receives monthly 2.4 kilograms of CSM, 1.5 kilograms of bulgur and .45 kilograms of oil. These foods provide a daily ration of 633 calories and 23 protein grams. For FY 1987, 30,000 tons of the three commodities were programmed for TMCHEP and were valued at $10.7 million plus 40% ocean freight. The present TMCHEP program has existed on paper since 1985, but guidelines have only recently been sent to the Zones. The two-year delay is attributed to centralized approval authority, and because of TMCHEP and other delays, CRS has moved to decentralize, reducing central staff while planning to add to zonal staff.

The evaluation core team, recruited to undertake an evaluation of CRS' TMCHEP program, included one American and two Indians; they worked from May 30 to July 8, spending the bulk of time on field work. They randomly selected a 12% sampling of consignees evenly spread in the three Zones to be concentrated upon--Bombay, Calcutta, and Madras. (Cochin had been intensively visited in previous months and was deliberately given but cursory attention). The team also visited 47 centers. Technical and other professional staff were interviewed at the levels of Zone, Consignee, Distributor/Center (sub-Center) and mothers. Questionnaires were used both as guides and as quantitative data collection instruments.

CRS is in a difficult transition period. Their inherent strength over the years has been their outreach to the poorest through an existing infrastructure of highly committed and dedicated church counterparts. The scattered operational area, which resulted from this kind of request-response arrangement, is now a serious management problem. The volunteer staff who have served the program are now insufficiently trained and have too little time to offer the program. There are

different expectations for a technical program like TMCHEP. What the staff has learned over the years--mainly maintenance of stock and account records--is only complementary or secondary for central program objectives about which most are neither oriented nor trained. The transition has not yet been completed

It has been evident throughout the world that voluntary agencies do not have sufficient resources of their own to effect similar programs successfully.

Unquestionably CRS must consolidate in India. Even with additional staff, it would be an over-extended program. They lack a rational plan for proceeding and are hard put to lop off Consignees indiscriminately. Continuing expansion of the government's MCH program--ICDS--into Blocks, in which there are counterpart sites, requires that CRS negotiate this issue as soon as possible. They would like to have USAID assistance and support to carry this forward. While no plan can be effected overnight, it is suggested that CRS use the occasion of having to negotiate with the GOI about the overlap issue with ICDS to work out where their operational Zones for TMCHEP should be in, say, two years and proceed toward that plan. New Consignee criteria might be considered, such as ensuring that all new TMCHEP Consignees be priests who are actively engaged in social development programs, and influencing replacements in the new "consolidated Zones" by soliciting support for such action at the Bishop level.

CRS recognizes the greatly increased planning, training, and monitoring needs with TMCHEP implementation but cannot cope with these due to a lack of technical expertise, training design, audio visual aids, and sufficient staff to monitor the Zones. When coupled with the other problems of part-time volunteer help at Consignee and Center level (TMCHEP Coordinators and Centers-in- Charge), they have resorted to attempts to reach out from the Zone to the Local Aide in the village, the mainstay of the mother education program. This is admirable but impractical and impossible to carry through. Currently many Centers are not monitored for two years or more, and when the visit occurs, it is essentially an auditing check of records.

The most vital needs are:

- The resources to develop a technical cell with planning and training expertise at CRS/Delhi to serve the Zones and to include membership of zonal-appointed technical staff.

- The resources to hire more technical field staff, a total of 25-30 rather than the 8-10 presently foreseen.

- The resources to train or retrain all staff, from the zonal nutritionists down to the Local Aides.

- The resources to pay full-time coordinators (from Consignee offices in some instances as in the south; others would require CRS or USAID inputs).

- The cooperation of the church to make the most suitable Consignees available to the program.

Because such technical inputs have not been available in sufficient quantity or quality, all of the program components lag.

- While the food supplement is delivered regularly, the efforts to target food to vulnerables through mother education have not yet altered family sharing of the food.

- Growth monitoring is a large time investment but inadequately carried out due to lack of training, materials, and clear guidelines and instruction in how to use the chart as a teaching tool.

- Immunization coverage is not being verified systematically; coverage is unknown. Local Aides require guidance and should be at least literate to carry out this task. Coordination with government is improving but needs more encouragement.

- Mother education stresses general topics like personal hygiene and cleanliness. Some messages are understood, others only partially, and some incorrectly. Local Aides require training in content and teaching techniques, and they should be compensated for their work, either in fees, when mothers can pay, or in food.

Finally, the team believes that the program not only has potential but a firm basis of commitment and dedication to helping the poorest communities that cannot be matched in other programs. If these human resources could be effectively harnessed and enhanced through training and technical direction, the program could be a highly successful one indeed.

A new USAID Food for Peace officer and a new CRS Country Director will shortly arrive in Delhi. It is proposed that this evaluation serve as a springboard to the formulation of an action plan for TMCHEP.

ABBREVIATIONS AND GLOSSARY

ANC	Ante Natal Care
CDPO	Child Development Project Officer
CIC	Center in-charge
CSM	Corn-Soya-Milk
FFW	Food For Work
FDR	Food and Development Resource (USAID)
FY	Fiscal Year
GOI	Government of India
ICDS	Integrated Child Development Service
MCH	Mother Child Health
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
P/L	Pregnant/Lactating
PNC	Post Natal Care
SOW	Scope of Work
TINP	Tamil Nadu Integrated Nutrition Project
TMCHEP	Targeted Maternal and Child Health Education Project
TT	Tetanus Toxoid
UPI	Universal Program for Immunization

Anganwadi	Literally a courtyard, a village pre-school child care center, focal point for delivery of services to an average 100 under 6 year old children and P/L women; usually covers a population of 1,000 in rural and urban areas, and 700 in tribal areas.
Anganwadi Worker	The Anganwadi is started by an Anganwadi worker usually selected from the community and paid Rs. 250 per month, and assisted by a helper.
CRS Zones	Bombay Zone - Maharashtra, Gujarat, Madhya Pradesh, Rajasthan, Haryana, Himachal Pradesh, Uttar Pradesh (partial), Karnataka, Punjab, Jammu and Kashmir and Delhi.
	Calcutta Zone - Assam, Arunachal Pradesh, Bihar, Manipur, Mizoram, Meghalaya, Nagaland, Orissa, Sikkim, Tripura, West Bengal and Uttar Pradesh (partial).
	Madras Zone - Andhra Pradesh, Tamil Nadu, Karnataka (partial), and centrally administered Pondicherry.
	Cochin Zone - Kerala and South West Karnataka.
Dai	Traditional birth attendant
Grade I	Mildly malnourished, according to weight-for-age Normal weight-for-age
Grade II	Moderately malnourished according to weight-for-age
Grade III/ IV	Severely malnourished according to weight-for-age
Scheduled Caste	Untouchables (considered unclean and with whom physical contact has been considered defiling by higher castes)
Tribals	Aboriginals (predominantly from hill areas)

Harijan	meaning children of God is the word coined by Mahatma Gandhi to change the conception of the "untouchable"
Mahila Mandal	Village Women's Association, a voluntary grassroots level organization of women registered as a Society with the Registrar of Cooperatives, and engaged in activities related to women and child welfare, including income - generating and savings activities for women.

1. EVALUATION OBJECTIVES AND APPROACH

1.1. Objectives

The objective of this evaluation of Catholic Relief Services' (CRS') Targeted Maternal Child Health Education Project (TMCHEP) is to assess program management and implementation of all CRS operational levels (headquarters, Zones, Consignee sites, Distributor and Center delivery points).

It should be noted that CRS' Food For Work program was being evaluated simultaneously and that there are some common management findings and recommendations.

1.2. Organization of the Report

This report is organized to reflect the emphasis placed on issues. It begins with a summary of conclusions and recommendations from the 1979 evaluation by Community Systems Foundation (Nelson, Sahn and Rogers) of particular relevance to the CRS TMCHEP program, notes the problems raised in the recent (May 1987) CRS internal audit, and addresses the issues identified in the Scope of Work (Annex A-1) as:

* Adequacy of the supervisory system at all levels;
* Appropriateness of geographical coverage in the context of goal and management capacity;
* the extent to which CRS selection criteria are reflected in targeting and project participation;
* Adequacy of training for job performance at all levels.

The team reclassified the issues as follows:

* Identification of TMCHEP objectives; compatibility with AID objectives.
* Feasibility of CRS operational area; overlap with ICDS.
* Targeting: Application of Selection Criteria.
* Adequacy of CRS Staffing for Training and Monitoring/ Supervisory Needs.

The team questioned the feasibility of completing two aspects of the SOW, namely:

o An analysis of Tasks and Time Allocation, and

o Comparing lists for CRS Overlap with ICDS.

The team was asked to attempt these assignments in any case, and did so. It was felt, however, that precious time was lost on trying to obtain details which were not central to the analysis of management issues.

Attempting to get precise details on how much time is devoted to the TMCHEP program was futile. First, TMCHEP is part of a wider activity for all of the counterparts. More important, it was an acultural assignment (Indian team members confirmed that awareness of time allocation for different tasks in one's job is a foreign concept). The team, however, did obtain a good idea of how much time was available to the program and how it is used. Detailed interviews were not prepared, but data are available on the separate questionnaires.

Attempting the second assignment was more frustrating, apparently due to a lack of understanding on the part of the person preparing the SOW. A list of ICDS Blocks cannot be compared with a list of CRS sites. One must have a list of Block sites which was not available to the team, and time constraints did not permit obtaining them from each State ICDS office. It seemed pointless to the team to compare lists of ICDS districts with CRS districts as any indication of "overlap." The team, instead, analyzed the work that had been completed in Bombay Zone. Upon receipt of the list of ICDS Blocks, they had asked each Consignee to determine whether or not any other Centers fell within ICDS Zones and to designate those. They then prepared a list. Even had the team acquired access to an ICDS list, they would have had to look through 100-150,000 ICDS sites to compare with CRS sites.

Information was compiled on matching ICDS names with CRS names and is available in the "evaluation Backup File" in USAID.

1.3 Methodology

1.3.1. **The Team:** The team consisted of five full-time members (King, Pushpamma, Shah, Gowan and Kotwaney). The team was enriched by part-time assistance from CRS staff members, one from the Delhi office during field testing in Ajmer (Rajasthan) and one or two persons from each of the Zonal offices during visits to the respective areas. In Cochin, the Zonal Director accompanied the team throughout their work. The evaluation team worked under the initial guidance and supervision of the Chief, Office of Food and Development Resource and made their report to the Evaluation Officer of USAID/Delhi.

1.3.2 **The Schedule:** After four days devoted to the selection of field sites, making field visit schedules, meeting with Mission and CRS staff, and developing field protocols, the team left for field testing and a first round of interviews in Ajmer, Rajasthan. Upon return, revisions were made in the questionnaires and the team left to complete the major portion of the field work (June 9-30) in the four CRS Zones.

(The States covered under CRS Zones are listed in the glossary). It was decided to give proportionately less time (and the Consignee sample was reduced accordingly) to the Cochin Zone which had been intensively visited over the previous two months by USAID for program review, by CRS internal auditing staff, and by external auditors.

Random selection of Consignees was made. It was planned that 15 out of 137 would be visited; in fact the team visited 17 Consignees (or a 12% sampling). Distributors/Centers were selected in random fashion at the Consignee level by the team members, some were eliminated due to knowledge of an absentee or new CIC, or due to time constraints for covering long distances. The team attempted to include more isolated areas (see Centers Visited, distances from Consignee in Appendix A-5) despite the limited time in the field.

Throughout most of the field work, team members worked together at the Consignee level, then split three ways for Center visiting. Two thirds of the way through, the team split at the Zonal and Consignee level. A midway seminar was held in Madras to meet with the CRS FFW evaluation team.

The team itinerary is included in Appendix A.8.

1.3.3.The Approach:

The evaluation approach was a combination of observation and interviewing at the four, and occasionally five, levels of operation:

* CRS Zonal staff
  - Director
  - Nutritionist(s)
  - Field Reviewer(s)

* Volunteer Consignee Staff
  - Consignee
  - TMCHEP Coordinator

* Distributor or Center
  - Center in charge
  - Local Aide

* Sub Center (occasionally)
  - Local aide

* Mothers

Field protocols served partially as guides, but portions were applied uniformly for quantitative data. Team members also completed observation sheets and checklists.

2. SETTING OF THE EVALUATION

2.1. CRS Infrastructure and MCH-TMCHEP Programs in India

CRS Structure: CRS operates its activities in India through an infrastructure which consists of a head office in New Delhi and four Zonal offices located in Bombay, Calcutta, Cochin and Madras. Recently the decentralization of operations has given considerable autonomy to the Zonal offices to implement their programs according to their pace. It has encouraged innovations and modifications in the programs to suit the socio-cultural and economic milieux of different parts of the country. Zones strongly believe that it has reduced administrative delays that may be inherent in a centralized organization. The negative effect of decentralization is that there is little dialogue/communication between the Zones resulting in duplication of efforts and lack of mutual reinforcement. The administrative and technical staff of the Zonal offices are totally responsible for selecting counterparts, training of project personnel, monitoring, supervision, technical guidance and commodity accountablity to donor agency. For implementation of the programs, CRS makes contractual agreements with Consignees who are sometimes directors of social service societies of dioceses. A local congregation participates in the activities by nominating their "sister" for implementation of the program (See Figure F.1 - for illustrative Diocesan Structure).

All priests and nuns working in the program are voluntary workers. Their motivation, dedication and commitment to work for the poor and needy, often in very remote areas, is the strongest asset of the CRS activities in the country.

History

CRS began its assistance to India in 1951 with a family feeding program which by 1969 had evolved into one of the few targeted Mother/Child Health (MCH) programs in operation. In 1974 a CRS Pilot Project reinforced the objectives of encouraging communities to adopt improved nutrition habits using locally available foods. Training of feeding center personnel in nutrition education so that they can share these messages with mothers was the principal concept implemented through this project.

The Pilot Project evolved into the 1977 Nutrition Education Program (NEP). The goal of this program was to upgrade 400 of the 2500 simple feeding centers, by adding staff at Zonal and field levels, with improved MCH training and community participation.

In response to the recommendations of the evaluation performed by USAID in 1979 (Community Systems Foundation Report) and subsequent internal program surveys, CRS developed the Targeted Maternal Child Health Education Program. This latest evolution of the program focuses on the most vulnerable segment, namely pregnant and lactating mothers (up to 6 months after child birth), all children below 3 years age and severely

malnourished children between 3-5 years age. It also offers a packet of services consisting of supplementary feeding, growth monitoring, immunization and health/nutrition education.

CRS is changing its orientation from "charity for the sake of charity" to "community development and self reliance through food programs". This change is reflected in their support for activities like organization of Mahila Mandals, income generation for mothers, and encouragement to prepare nutritious foods based on locally available ingredients.

TMCHEP is a very young program, but has a strong potential for developing into a highly relevant and need based program which improves the health and welfare of mothers and children. It has commitment and outreach structure, and urgently requires staff and training support.

2.2. 1979 Evaluation of Feeding Programs in India

Catholic Relief Services' MCH program in 1979 was essentially a feeding program with the purpose of humanitarian relief. The 1979 evaluation team reported that only 5% of the existing program had an integrated approach (combined food with health and educational inputs). One of the major conclusions was that despite the potential role of food as an incentive for bringing families into contact with health and education services, these were not available to beneficiary families.

While selection of needy families was appropriately made in the CRS program, the targeting of beneficiaries within the families was considered unsatisfactory. There were very few children under three years old enrolled. The report emphasized the need for higher immunization coverage and attention to environmental sanitation and hygiene to reduce infection and infestation, so that greater benefits might be derived from the food supplements. Sharing and substitution were identified as two diluting factors in the program.

Other key recommendations were: noting the desirability of providing suitable foods with a high caloric density for younger age groups; and the need for involvement and participation of communities which was minimal or non-existent.

2.3. April 1987 CRS Audit

An internal CRS audit was carried out from July 5 - October 5, 1986 covering operations from January 1980 through August 1986. It was completed in April 1987.

Concerns of the audit included:

* Shortcomings in planning ; the lack of AER planning based on documented Consignee needs;

* Lack of formal agreements: between the recipient country and CRS as required by Title II regulations;

* Lack of updated agreements with Consignees and Distributors;

* Insufficient monitoring of FFW stocks;

* Unmonitored disposition of unfit food stocks;

* Unauthorized expenditures from Fund #509 (mothers' fees).

Lastly, and of specific concern to the evaluation team as management issues, were findings that:

* Commodity accountability was inadequate. The auditors considered the system to be adequate on paper, but noted insufficient internal reviews and end-use checks at the three levels: CRS/Delhi review of Zones, Consignees and Distributors; CRS Zone level review of Consignees and Distributors; and Consignee-level review of Distributors.

* Delivery of only 63% of the MCH commodities programmed for FY 1986 (80% were delivered in FY 1985).

3. IMPLEMENTATION OF THE CRS TMCHEP PROGRAM

3.1. Feasibility of TMCHEP Objectives

The Key issues are:

Are CRS goals compatible with AID expectations for MCH programs?

Are they defined adequately? Are planning and strategy formulation adequate?

How can more emphasis on the developmental aspects of TMCHEP be achieved?

3.1.1. Health and Social Objectives

CRS perceives its goals for TMCHEP on a broad spectrum of health and social development, while USAID envisages more focused, undiluted health objectives for MCH activity. The team observed that Consignees, and especially those involved in social service organizations, had difficulty thinking about TMCHEP in isolation from other community activities. Those social programs undertaken by counterparts which are helping women to develop and improve their status in the family and community enhance the targeted mother concept, but are not health activities per se. Because these social programs are so intimately related to maternal health, and constitute the reality of what CRS counterparts are doing, the team's opinion is that these objectives are valuable and complementary, and should be quantified.

3.1.2. Definition of CRS Goals

The operation plan of CRS for FY 1987 clearly identifies the need for shifting the emphasis from relief and welfare to actual felt needs of the communities to move towards self reliance. As a consequence the MCH program which was conceived originally as an intervention program is gradually transforming into a developmental program. Another obvious development in CRS goals and objectives (Operation Plan FY 1987) is integrating MCH as a part of the total community development program. Such integration can speed up the program by providing supporting services and resources (like income-generating schemes, savings, kitchen gardens, adult education, etc.)

CRS objectives and strategy are not yet adequately defined, with verifiable indicators and time frame. E.g., an objective in the FY 1987 Program Plan is to "enhance the health consciousness of 70% of the families participating in the program". Other objectives are given a five year time frame without specifics of coverage to be attained each year, or the health improvements that will be responsible "for reducing infant mortality by 30%".

At a minimum, an estimate of expected coverage in each Zone over a five year period should be projected to show the effects of new criteria for graduating mothers from the program. More feasible than to measure reduced mortality would be to use information that should be available in the reporting system on third degree cases below three years and above three years. This could be used to assess intermediate targets of reduced malnutrition. Other indicators are needed to examine the social impact on women, e.g. number of new wage earners; number engaged in a specific Mahila Mandal activity; number of new savings accounts.

3.1.3. Planning and Decentralization

At the outset, it is important to note:

- CRS has only recently begun to decentralize; and
- Zonal personnel feel strongly that their efforts in the past have been greatly impeded by centralization and are extremely wary of placing any authority at the Delhi level.

At the same time, they recognize that there are areas of commonality - that there is but one TMCHEP program - and to avoid duplication of effort, some program activities should be given uniform treatment. Strong, timely national guidelines are needed in this respect.

Decentralization has meant that each Zone prepares its work plan for implementation of TMCHEP components and correlating training needs. Attention to planning and strategizing is adequate only when this task is prioritized. At best it is an ad hoc exercise fitted into a heavily burdened existing job.

A phased approach, with intermediate targets such as drafted for Bombay, is needed, together with specific indicators of achievement, planned time for evaluation and redesign, as necessary, on a continual basis. Parts of such an exercise could be generic at the national level so as to utilize planning expertise most efficiently, with Zones working out adaptations for their rate of program advancement with the central/Zonal planning experts, as is proposed further on.

A major constraint to effective planning at any level is the lack of multi-year commitment of food on the part of AID. CRS prepares its annual requests for food in April of each year for the Fiscal Year beginning in October. Planning levels (which are the total food CRS can expect to have approved) are often decided in March and have come later, making any meaningful planning exercise impossible.

While levels are predictable to some extent, multi-year commitments would facilitate and encourge better planning.

3.1.4. Emphasis on Development

CRS and counterparts are clearly moving away from the dole feeding operation documented in 1979 (Nelson, Sahn and Rogers) in the direction of development objectives. This changing emphasis for counterparts is quite recent and many counterparts were candid about the the fact that there is a continuing presence in their midst of those who think charity for its own sake is the way to use food aid. The evolution process is slowed, therefore, and the team believes, could be accelerated. The time seems right to support the development-oriented Consignee priests and bring along those with whom they work. This, they thought, could be accomplished through effective communication at the highest Church level - Bishops and Archbishops. The Bishop selects Consignees, and to a degree can influence commitment made for key TMCHEP personnel (the TMCHEP Coordinator).

3.2. Feasibility of CRS Operational Area: Nature of Church Structure; Stretch of Resources; Overlap of TMCHEP with GOI's MCH Program (ICDS)

Issues:

* How does the nature of the church infrastructure affect the program profile? What is the current program spread? Is there flexibility for consolidation?

* How has the question of overlap with ICDS been handled? What is the extent of overlap at present? What should be done to resolve the issue for the future?

3.2.1. TMCHEP Geographical Profile

In building its program in India over the years, CRS opened Consignee sites and Centers wherever willing counterparts were available. This has resulted in a highly scattered program with effective outreach to the poorest but which is extremely difficult to manage because of distances. This constitutes a major obstacle to achieving adequate supervision, especially for the Zonal offices. To a lesser degree but nevertheless a problem not yet surmounted, large distances and inadequacy of supervision are also found at the Consignee level.

Appendix A-7 summarizes the data on distances collected by the team. From Zonal office to Consignee, the average distances were 133 km for Cochin, the most densely programmed Zone, 476 km for Madras (recipient Zone of USAID grant). Longest distances between Zone and Consignee were 851 km and 937 km respectively for Bombay and Calcutta. An additional depiction of CRS stretch is shown in Figure 2, Map of delineated CRS Zones.
The team looked at average distances from Consignees to Distributors/ Centers in a sampling of 12 Consignees (also shown in Appendix A-8). Averages were similarly proportionate to those of the Zone: shortest, 15 km, for Cochin; longest, 130 km for Calcutta; 71 km, for Bombay; and while Madras fell in the middle with 49 km.

The implications for effective monitoring from the Zonal as well as Consignee level, are obvious and discussed further on.

CRS is fully aware that it is over-extended but has not yet found an acceptable rationale for consolidation. Understandably, they are unwilling to remove areas arbitrarily, eliminating the good Consignees along with others.

The team suggests that the concurrent need to look at ICDS frontiers, discussed later in this section, could constitute a propitious time to deal with the two inter-related questions. In the meantime, CRS should continue to reduce on the total number of Consignees and apply more vigorous demands for Consignee performance, terminating those who fail to meet those demands.

3.2.2. ICDC Overlap

The Government MCH program - ICDS - continues its planned expansion, and has now sanctioned for ICDS activities some 1600 of the total Blocks in India. Therefore, ICDS is increasingly moving into areas where CRS has been working over the years.

USAID has informed CRS that they must leave Blocks areas where the ICDS program has been sanctioned or is in operation, or negotiate for a defined area of operation in the Block. The deadline for such action has been set for June 1988.

Since the church organizational unit, the convent or school where the TMCHEP program (and frequently Sister in-charge) operates is fixed and is not a "moveable feast", the implication is that some good along with not so good Center programs will have to be discontinued. For the Consignees, there is less of a threat of being forced since the Consignee might cover three or four districts, which will likely have many unaffected Blocks. (A district has an average of 30-40 Blocks.) Nevertheless, Consignees for the most part resent having to deal with the overlap problem at the local level, believing it to be a policy matter that should be resolved in Delhi. They have frequently chosen to interpret "overlap" as simply that, real overlap or duplication at the village level. They do not find it easy to understand why an entire Block should be taken off their limits, especially when there is a considerable time gap between ICDS sanctioning and actual implementation, and they see people needing help in the interim. In other cases, they give Centers six months notice and feel harrassed by what they have been told is a GOI decision.

Extent of Overlap: The SOW called for a compilation of overlapping CRS Centers in ICDS Blocks. It should be noted that the Zonal offices have some confusion about which Centers are in these Blocks and have had to consult Consignees. Bombay Zone compiled such information more than a year ago. The Madras Zone's attempt left many blanks in place of Center names. In other Zones, names of the ICDS Blocks only were provided. The team was unable to match up lists of CRS Centers with Block lists, and had to be content with its own field study and the following analysis of the Bombay Zone data.

Affected	Total CRS/TMCHEP in Zone	Number in ICDC Blocks	Percent in ICDC Blocks
Consignees	43	19	44% *
Centers	368	40	9%
Beneficiaries	86,000	9,600	10%

* 44% means that many Consignees are affected by the question of overlap in their diocese; it does not mean that 44% of their program is affected.

The team studied the extent of "overlap" among the Consignees and Centers visited. From a sampling of 16 Consignees visited, we coincidentally found that seven (44%) had instances of "overlap" (of the area, not village overlap). Out of 39 Centers responding on the question of overlap, 21% reported ICDS in the same village while an additional 10% reported being in an ICDC Block without "overlap" in their village.

It is the team's impression that the "overlap" is a misnomer for CRS activity within an ICDS Block, especially since the Government does not cover 100% of Blocks as a rule.

Extrapolating from the Bombay Zone analysis of 10% chance of a site being within an ICDS Block, the possibility of CRS Center/ICDC Center overlap is 1:1000 there are (100 sites, or villages, within a Block).

Thus it seems that the problem is somewhat overdrawn, and the controversy has not led to a foreseeable resolution. CRS, informed of such a decisions, is less than eager to negotiate for any rights after being given what appears to be a rather arbitrary ultimatum.

CRS is unclear about USAID-GOI dialogue on this question, and would strongly welcome USAID assistance to get the matter resolved with the least hassle possible.

The team suggests that the pressure of having to negotiate with respect to overlap with ICDS should be used to advantage for delineating rational areas of CRS/counterpart operation that can assure:

- non-duplication with ICDS for a foreseeable period of, say, 10 years; and

- reasonable monitoring and training accessibility by the available administrative and technical field workers.

A central negotiation is urgently needed to clear the air and reserve energies for the right problems.

3.3. Targeting: Application of selection criteria

3.3.1. Consignee Site Selection

Issues:

At the Consignee level CRS depends on existing church or other voluntary agencies infrastructure. The Diocesan Bishop selects priest Consignees and requests the congregation Mother Superiors to nominate a suitable 'sister' to work as TMCHEP coordinator. The team found that when priests were Directors of Social Services for the Diocese, they were particularly suitable as TMCHEP Consignees. The team was convinced that effective, development-oriented priests, usually giving full time to social service work, could change the entire orientation of the program, percolating down to the field level. The CRS Zonal office has had no say in these appointments, but they have authority to suspend or terminate programs when guidelines are not followed. Use of the process of attrition is not going to result in a rapid modification of Consignee type. We observed three such exceptional Consignees out of 17. Because the influence of Consignee on the program is strikingly evident, the team suggests that CRS establish a dialogue with the Bishops to speed up the recruitment of more development-oriented priests and sisters to work on a full-time basis for the program.

3.3.2. Beneficiary Selection

The team had no question about the extent of need of CRS beneficiaries both on nutritional and economic grounds. The outstanding strength of the counterpart network is its outreach to the poorest, and the significance of this achievement should not get lost in our examination of selection criteria.

The TMCHEP criteria for selection of beneficiaries are not applied objectively, and the guidelines have not yet been understood and/or followed. While there has been a very definite trend toward increasing the proportion of enrolled children under three year old, not all Centers are following guidelines. In the reporting Centers we visited (39), a half of them showed 90% or more of the enrolled children to be under three. In four Centers, however, there were 50% or more of children over three years old. There are still instances of Centers providing services to all under-fives indiscriminately and where under-threes have been excluded because the 18-month limit, intended to apply to malnourished over-threes, was misunderstood as relevant to the youngest as well.

Mothers constituted on an average 12% of the beneficiaries (range being 0-39%), while the proportion of pregnant and lactating mothers in the total "eligible Population" is 30%.

The principal problem is that the new guidelines for selection require serious alteration of existing practices and those who must face the mothers and children to be turned away from the program in the future need extra help and guidance in making the transition. Written guidelines only are not sufficient.

To ensure higher enrollment of mothers, a separate quota (about 20%) may be reserved for mothers. In view of the lactating mothers' nutritional status, infants 0-6 months may also be registered for a ration of CSM for supplementary feeding.

The TMCHEP concept of "consolidation" of area by selecting a "cluster" of villages or slum area and covering all eligible families is a logical way to operate efficiently for management as well as impact on beneficiaries. Some counterparts felt they would not be concentrating as effectively as before on the poorest only. Others in the program considered this to be a justification for dole feeding. "Consolidation" need not adversely affect outreach to needy areas in the long run. TMCHEP guidelines foresee that when mothers are adequately educated/motivated about the health and nutrition needs for themselves and their children (in five years), the program shifts to other families and other locations. The team notes again the very short time TMCHEP guidelines have been out to the field (six months ago in Madras, 2-3 months elsewhere). The team suggests that transition time of one year is reasonable and that the TMCHEP objectives are a rational way for CRS and counterparts to improve the program.

3.3.3. Community Surveys

Distributors have made an effort to conduct surveys (required under the new guidelines) to identify needy beneficiaries. In Madras other professional staff have been hired. Others lack the technical expertise and time to carry out these directives. Bias, not necessarily harmful in any way (since the Distributors have good knowledge of the community), enters into the selection of the area/village to be surveyed. Sometimes three streets in a town or a nearby village is selected for survey which means a pre-selection process has been involved. The analysis of survey data is sometimes confusing e.g. only beneficiaries who are willing to join the program are classified as "eligible" thus indicating 100% coverage. In fact many eligibles by selection criteria may be unwilling to join even when 'needy'. The proportion of such eligible, needy but unwilling individuals in the area should be available to get the true picture of "coverage."

Registration Procedures

In some Centers new beneficiaries are enrolled throughout the year. However, in many areas selection of beneficiaries is done only once a year, usually in October, the beginning of U.S. fiscal year. This practice deprives a number of eligible pregnant and lactating mothers from the benefits of the program, while it allows others to continue in the program longer than the criteria would allow. This disadvantage can be obviated by filling up vacancies as and when they arise.

Graduation

Among the 54 mothers interviewed, 18% stayed in the program for more than 5 years. TMCHEP graduation criteria are designed with the objective of reaching more families and mothers are supposed to graduate after five years.

Upgrading of 25% Centers in Madras Zone

Madras Zone has selected 25% of its Centers for immediate (phase 1) upgrading. The selection of Centers we visited was based on:

- proximity as the most important criterion, and
- cooperation of the Center personnel and responsiveness of the community.

Since these Centers are pre-tests or pilots for application into remaining Centers, close supervision and monitoring is crucial. The criteria for upgradation decided upon by the Zonal office, are therefore reasonable for this phase of activity.

3.4. **Adequacy of CRS Staffing. Adequacy of Numbers and Training for: Monitoring, Technical Direction, and Training.**

Issues:

Are staff numbers adequate?
Are the staff trained adequately for the tasks required?
Is the training appropriate:
- o At the Zonal level, for monitoring, training, and/or technical direction?
- o At the Consignee level, for monitoring and training?
- o At the Center level, for teaching and motivating mothers?

What are the intermediate and long range options for meeting staffing and training needs?

3.4.1. Zonal Staffing. **Adequacy for Monitoring and Training/ Technical Direction**

Zonal Staffing. Technical staff positions in the Zones are:

Bombay Zone
- 1 Nutritionist
- 5 Field Reviewers

Madras Zone
- 2 Nutritionists
- 1 TMCHEP Program Reviewer
- 5 Field Reviewers (and one who does not deal with TMCHEP)

Cochin Zone
- 2 Nutritionists
- 1 Program Reviewer

Calcutta Zone
- 2 Nutritionists
- 4 Field Reviewers
- 1 Program Reviewer

Nutritionists are mainly responsible for planning TMCHEP implementation, training, and monitoring. Though the number of nutritionist slots is greater in Bombay Zone, presently only one of them is filled. The Zonal Office reported that poor response from qualified candidates was due to:

- Unattractive salary compared to similar work in other sectors, and
- Field visit requirements of the job, which constitute more than 15 days a month away from headquarters, and entail rigorous schedules of travel on trains and buses over long distances.

Once positions are filled, high turnover rate continues to diminish staff continuity and program efficiency. Bombay Zone is looking at the salary structure of other institutions in an attempt to arrive at fair salaries for technical staff.

The situation is similar in other Zones except that a second nutritionist (with relatively less experience) is in position in Calcutta and Madras Zones.

It is recommended that:

. Salaries of nutritionists be equivalent to those of their counterparts working in other government or non-government organizations.

. Clear job descriptions and tasks performed should be prepared for all the staff responsible for implementation of the TMCHEP program.

Adequacy of Zonal Monitoring

Nutritionists are charged with responsibility for both staff training and program monitoring; the current heavy load of training necessary to implement TMCHEP has diminished whatever little time was available for monitoring through field visits. Even if this is looked upon as a temporary setback only, needs are far beyond present capability. Supervision and field visiting to assure adequate technical monitoring for the TMCHEP program are seriously inadequate. Though CRS has a highly committed staff of nutritionists and field reviewers, expectations for their supervisory functions are unrealistic. For conducting regular training programs, monitoring and evaluation of the TMCHEP program, at least one technical person (nutritionist) for every 80 Centers would be a minimum requirement. (The parallel technical person in ICDS, the CDPO, is responsible for 80-100 Anganwadi Centers which are in a cluster in a single Block.) The ratio suggested here for CRS is arrived at, taking into consideration the geographical spread of Centers. It might take a minimum of one day and maximum of three days to visit one Center. This takes into account that several Centers might be visited during a field trip. To monitor each Center adequately, we think, requires a full day. To do that once a year would require 160 field days. The remaining 104 days (22 x 12: 264 working days) would be needed for other technical tasks.

Recommendations:

* To reduce the travel distances and avoid inconvenience to the nutritionist, the Zone might be divided into three or four smaller areas and one nutritionist might be located in each area (80-100 Centers per nutritionists) at one of the Consignee's offices centrally located for that area.

* Instead of requiring that all positions be held by nutritionists, one position might be filled by a training specialist.

The Field Reviewers in Zonal offices, in fact, supervise the TMCHEP program more regularly than do the nutritionists, but they have not been given technical training for this task and more often simply check

reports and perform a compliance function. Neither meets the schedules expected by CRS and stated in the Program Plan: i.e., visit to Consignee level once a year and visit to 25% of Distributors/Centers annually.

Over the past 12 months, nutritionists said they visited from 29-64% of Consignees and 10-16% of Distributors/Centers. (See Table T-2)

In 39 reporting Centers visited, 31% had received no supervisory visit (from nutritionists or field reviewers) for at least one year; the other 69% had received one or more visits. (See above referenced table of field visits).

3.4.2 Adequacy of Zonal Training

In order to achieve the targets set in their Program Plan, CRS recognized the need for reorientation and retraining of technical and field staff at all levels. Bombay Zone moved fast into action with a very ambitious training schedule to reorient and retrain all their 327 project holders, 43 Consignees, and all TMCHEP Coordinators and Local Aides.

By contrast with the massive efforts of Bombay Zone in training and reorientation prior to the implementation of TMCHEP, Madras Zone which began its TMCHEP implementation ahead of other Zones, has made no such training efforts. One training program was organized at Coimbatore (Avinashilingam College for Girls) for TMCHEP coordinators (in addition to the training programs organized for Local Aides).

The team looked at training capabilities and analyzed the adequacy of ongoing training programs from the perspective of health and nutrition targets set for the TMCHEP program as well as the quantitative indicators suggested for measuring program success.

Nutritionists are the technical experts at the Zonal level. They are responsible for planning, training, monitoring, and implementing the TMCHEP program. However, the practice in all Zones is that field reviewers share their responsibilities (especially supervision and training) because the number of nutritionists is highly inadequate for the size of the program. The inadequacy in number of available technical staff is the major constraint in meeting the training demands of the TMCHEP program. Whenever field staff devote more time to training, it is at the expense of other functions (monitoring and supervision).

Secondly, it is assumed that a nutritionist can automatically train nutrition workers. Thus no need is foreseen to train the Zonal nutritionist in training designs, training technology, monitoring, and evaluation of the nutrition program. This lacuna was highly evident to the team when they reviewed the training programs recently conducted. There is no health person, either at central or Zonal level, to provide technical guidance in the health component area. In TMCHEP considerable stress is given on growth monitoring,, immunization, and diarrheal management. Special training is essential for monitoring these activities and interpreting their impact on the beneficiaries.

These training programs are heavily loaded with subject matter on nutrition, which often tends to be academic. The principal training method used is lecturing, supported by a few demonstrations. Visual aids are usually limited to posters and charts.The efforts of Calcutta Zone in this regard are commendable. They have used CRS funds to carry out the production of audio-visual aids, especially slides. This beginning should be evaluated and shared with other Zones.

Zonal nutritionists who provide leadership to 30-40 TMCHEP coordinators have a greater role, not only in ensuring appropriate training, but also in monitoring the program. Monitoring is often misconceived as supervision and record checking. One of the well implemented components of the program is reporting. Monthly/quarterly reports are almost always prepared and dispatched (though not accurately or completely in many instances). The team observed that when reporting requirements were not met, corrective action was taken. However, the most disappointing aspect of the reporting system is that it is used almost exclusively for commodity accounting. Failure to use the reporting of health and nutrition information as a management tool emphasizes the need for training nutritionists in the purposes and techniques of monitoring. For the most part, due also to time constraints, monitoring consists of checking records and stocks. In Calcutta Zone where there is a training unit attached to the TMCHEP program at one Consignee site, the monitoring system was found to be more effective, and this is well reflected in the field reports of the MCH coordinator.

The team suggests two possible options to strengthen the training capabilities at the Zonal level:

Option 1

Establishment of a technical cell in CRS/Delhi. The functions of the proposed technical cell would be:

To develop training designs, manuals, and other supporting material for training the "technical" staff involved at each level (Zone, Consignee, Distributor).

To assist the Zones in developing a system for data reporting and analysis.

To consolidate Zonal data so that an overview of the country program is available.

To give technical support for training programs to be conducted by Zonal staff.

To train the trainers (nutritionists and TMCHEP coordinators).

A desirable composition of the technical cell would include:

- 1 nutrition and health planner
- 1 training expert (health trainer)
- 1 visual aids expert
- 1 artist, part time

Operational procedure:

This cell will be responsible for meeting the needs of Zones in program implementation, but will not have administrative or supervisory power over the Zones. Special funding to be administered by a committee of Zonal-appointed technical staff, meeting at least quarterly with the CRS Country Director, will monitor the program of the cell.

The team strongly recommends USAID support for this unit which has a vital role in supporting and upgrading the capabilities of Zones for implementing the technical aspects of the TMCHEP program. In light of anticipated delays in approval (NOCs) through country funding channels, this activity might be proposed for central Child Survival funding. It should cover a minimum of five years during which other funding sources should be sough, such as monetization of Title II foods.

Option 2:

Using services of a training expert as a consultant to develop task-oriented training designs or training modules specifically for each level and corresponding training manual.

Providing a suitable training for nutritionists and field reviewers to use the training material.

Strengthening the Zones by providing additional staff, especially in the areas of training and audio visual aids.

The Team Suggests:

A special trainers' training for Zonal nutritionists and field reviewers with emphasis on:

(i) Training technologies
(ii) Monitoring systems
(iii) Identification of indicators for continuous evaluation
(iv) Use of reports as management tools

3.4.3 Consignee Staffing: Adequacy for Monitoring and Training.

Consignee Staffing

TMCHEP coordinators are the only technical staff at Consignee level. Out of 17 Consignees visited, 13 of them have one TMCHEP coordinator while the remaining 3 Consignees have two TMCHEP coordinators, and one consignee is currently trying to fill the position. Centers under each Consignee varied from 5 to 82. The team thinks that the number of TMCHEP coordinators should correlate with the number of Centers. A key issue in staff capability for TMCHEP management is the available time for this program at this strategic level. TMCHEP coordinators, when appointed from outside the congregation, are usually full time workers; when they are nuns, they often have other responsibilities (running schools, working in dispensaries). The desire to have full time TMCHEP coordinators on the part of all Consignees was overwhelming. Lack of financial resources is the limiting factor, though the "honorariums" usually provided are small and range from 500 to 800 rupees monthly. The nuns are highly motivated and if they could give full attention to TMCHEP, this present weak link could become a central strength.

Options for consideration are:

> That the Diocese, especially better off ones in the South, might agree to find the resources, if the Bishop were in full support of the TMCHEP program. He might further decide that a full time coordinator ought to be made available.
>
> The other alternative is to include funding for TMCHEP coordinators in an AID grant. CRS/Delhi might be asked to match funds for two Zones with unused mothers' fees being held in a Delhi account (approximately 14 lakh) sufficient for the following, e.g.:

5 experts in nutrition training, visual aids, etc.@ 3000 Rs/mo x 3 years	5.4 lakh
Audio visual aids/mobile training unit	10.0 lakh

Consignee: Adequacy for Monitoring

Except in Bombay Zone, no specialized training is planned for Consignees. Often one or two days of meetings with Consignees, where administrative problems dominate, are interpreted as training programs. With few exceptions, Consignees limit their role to commodity accountability and record keeping. The exceptional Consignees for TMCHEP, by virtue of their role as Directors of Social Development programs and their own interest in health improvements in their communities, are not only knowledgeable but also resourceful. Such Consignees provide not only effective supervision but also motivate, promote, and support the implementation of the technical component of the program, which carries through to the Center level.

Coordinator: Adequacy for Monitoring and Training

Heterogeneity in education levels and backgrounds, of TMCHEP coordinators, means that the training needs are variable from Zone to Zone and within the Zone. Whenever nuns are TMCHEP coordinators, they are usually either trained nurses or teachers. This qualification is highly useful, but the TMCHEP program is a secondary activity for them. The turnover rate of these coordinators is high, often with no overlap time. Consignees, usually priests, have very little say in the designation of coordinators. As the Zones are not in a position to overcome this inherent constraint in the church system of hierarchy, they are resorting to the next best alternative, i.e., focusing on the Local Aides. Bombay Zone has already set its target to complete the training of all the Local Aides, with its sole nutritionist. Though their efforts are commendable, the strategy of skipping one level (Consignee) and taking the responsibility of training peripheral workers (Center level) of the entire Zone is stretching their personnel resources far beyond their capability.

TMCHEP coordinators who could be playing a vital role in training peripheral workers (Local Aides) and giving them supervision, technical guidance, and monitoring program implementation are not adequately trained to perform these tasks effectively. Those who are trained are not clear about basic knowledge and messages to be given on health and nutrition. Their monitoring skills are grossly inadequate (the task of monitoring again is understood as checking records and registers). Record keeping and reporting is carried out to fulfill requirements. Their training is not providing these necessary skills.

The Team Recommends That:

Well designed orientation courses be carried out for Consignees to stimulate and encourage interest in the technical components of TMCHEP. These would include training on the purpose and techniques for monitoring, including an understanding of key indicators to be used in the program.

Well designed, task oriented, pre-job training program for TMCHEP coordinators be carried out by Zonal staff with the help of the proposed technical cell. Training should be tailored to the specific health and nutrition goals of TMCHEP rather than be a broad coverage of technical subjects. Training should focus on:

(i) The methodology and skills necessary for training peripheral workers.

(ii) Use of key indicators in monitoring the program.

(iii) Record keeping and data reporting system.

In the FY 1987 Program Plan, the targets set include reducing mortality and incidence of diarrhea and particularly enhancing health consciousness of mothers. Data are not being collected in the existing reporting system to determine whether these targets are being or will be met.

The training program should provide the necessary skills and knowledge for collecting such information.

The team is of the opinion that entrusting the responsibility of training TMCHEP coordinators to any training institution outside the CRS system may not serve the purpose. To date, they have tended to be more academic and not specific to the tasks performed by the trainees (coordinators). This was particularly evident in the Coimbatore training program in Madras Zone, in which coordinators were taught more about physiology, food groups, basic nutrition rather than much needed guidance about growth monitoring and diarrheal management. This training failure is reflected in the confusion of Local Aides, e.g., about the ORS preparation. Often changes made in policies and methodologies to be used in implementing the program are communicated through circulars from the Zonal office. Despite excellent efforts made by some Zones to make their circulars clear and specific, in the process of percolation down the line, they become distorted. To avoid such confusion and misinterpretation, regular in-service training programs for TMCHEP coordinators will be necessary.

3.4.4. Center Level Staffing: Adequacy for Monitoring and Training

Center Staffing

Most Center-In-Charges are volunteer nuns with many other tasks in schools, hostels, and dispensaries, and they have very little time for TMCHEP.

Local Aides are the only "technical" staff available at the Center level. The honorarium for Local Aides varies from zero to Rs 800. The team observed both extremes in the Calcutta Zone. In other Zones it varied from Rs. 25 to Rs. 300. Most of the Distributors felt that a ratio of 1:100-150 beneficiaries was desirable. The educational background of Local Aides was also highly variable - from third grade to matriculate, with a considerable number of illiterates on the bottom end and an occasional graduate at the other end of the spectrum. Salary level, however, is not commensurate with their qualifications. Variations are due to available resources. More uniformity is observed in the qualification and remuneration of Local Aides in Madras Zone than in other Zones. Southern Zones are able to collect mothers' fees more readily because of less dire poverty. The collection of mothers' fees varies from Rs 2 to Rs 5, and the inland transport charges incurred by the Centers also varies, depending upon the distances. When the Centers are located in the interior, a large portion of the fees must be spent on

transportation, which cuts into the amount available for honoraria of Local Aides. Alternative sources of funding on the part of Consignees to compensate the high cost of food transportation would be necessary before implementing a policy of minimum standardized honoraria.

The team noted that Local Aides are the key persons working at the peripheral level. They are in direct contact with beneficiaries. The success of the program depends to a great extent on their performance. An illiterate Local Aide cannot do justice to the TMCHEP program with its emphasis on education of mothers and specific selection criteria, and expectations that the Local Aide will check immunization records, etc. The team recommends.

> A minimum educational qualification and honorarium for Local Aides. Though these Local Aides are not yet working regular, fixed hours every day like ICDS anganwadi workers, their job responsibilities are almost comparable to anganwadi workers. Therefore, similar qualifications and honoraria are suggested.
>
> (i) Educational Qualification: Not less than 8th standard, preferably matriculation.
>
> (ii) Honorarium: Minimum Rs 150/month
> Desirable Rs. 200-250/month
>
> If Centers are not in a position to implement the above recommendations due to genuine cash constraints, the team strongly recommends that USAID permit them to pay in kind as was in vogue earlier. The team was informed by CRS that this practice was discontinued due to audit objections of The Auditor General's Office AID. This provision would not only be a great incentive to Local Aides but would enable Centers to engage the required number of Local Aides for implementing TMCHEP.

It is suggested that such rations be equivalent to those given under FFW, i.e., 2.4 Kg. oil and 96 Kg. bulgur monthly. This would have a local market value of approximately Rs 228 (Rs 15/kg. oil; Rs 2/kg. bulgur).

3.4.5. Distributors/CICs: Adequacy of Training for Monitoring

Distributors/Center-In-Charges in most cases are priests and nuns of the local convent who are highly committed to serving the poorest of the community. Their potential to serve the program is painfully unexploited due to lack of orientation and training about the technical goals of the program. For the most part, their role is to provide secure storage space for food and to supervise food accounting. A motivational orientation on the developmental benefits for the community they serve could stimulate greater involvement of Distributors/CICs in the implementation of the program. As it is, Local Aides usually shoulder the major responsibility for the technical components of the program.

The TMCHEP program has ambitious targets to reduce mortality and morbidity in addition to educating mothers on health and nutrition; to attain them will require more time and involvement of the Distributor/CIC. Some exceptions are when Local Aides are well qualified, (matriculate-graduate) adequately trained, and in sufficient number. When Local Aides are illiterate, or just literate, and the Distributor or CIC devotes no time to the program management, it is unrealistic to expect adequate implementation of the program. Role and specific tasks to be performed by Distributor in implementing the program must be defined.

In order to enhance the role of the Distributor/CIC in the program, specially designed training program with emphasis on (a) program goals and objectives, (b) survey techniques, (c) monitoring skills and indicators to be used, and (d) reporting and record keeping will be essential. MCH coordinator's training capabilities should be built up to handle these training programs successfully.

Local Aides: Adequacy of Training for Educating Mothers

In all Zones training for Local Aides is conducted regularly. Except for one Center in Calcutta Zone where the Local Aide is a graduate, their education level is mostly matriculation and below, and often, in backward areas, they are even illiterate. Local Aide training programs should be determined against this background. They should not be expected to learn general subject matter related to health and nutrition. This is often ignored in the design of their training and training methodology. Presently, practical training is limited to a few demonstrations; field experience and hands-on learning are totally absent. Training design and methodology are inappropriate for the peripheral worker. The reason is poor design of trainers' training (TMCHEP coordinators). Whenever Local Aides are asked about the important messages they have given in the health and nutrition field, they mention only broad topics like cleanliness, nutrition, balanced diet, immunization. The concept of messages is not well understood either by Local Aides or TMCHEP coordinators. Supporting visual aids are totally inadequate. Recognizing this lacuna, Calcutta Zone got a project approved for developing slides useful for nutrition and health education. No printed material for literate mothers is yet available to reinforce the talks of Local Aides.

In the absence of a proper understanding of the need and use of the data they are collecting and reporting for management of the program, records and reports prepared at the Center level have very little meaning and the staff usually resent spending their time preparing them.

Often they fail to understand why the emphasis of the program has shifted and strategies have changed; e.g., the change in beneficiary selection and eligibility time in program.

The team recommends that training programs for Local Aides place more emphasis on:

(i) Articulation of goals and objectives of the program.

(ii) Need for survey to identify at risk groups of community and survey techniques - to achieve targeting goals.

(iii) Motivating techniques.

(iv) Specific messages in:

- Growth monitoring
- Care of severely malnourished (III-IV degree)
- Breast feeding
- Weaning and supplementary foods
- Preparation of special foods for malnourished children
- Diarrhea management
- Immunization schedule - importance of completing it
- Water and Food hygiene
- Vitamin A foods and deficiency symptoms
- Anemia - Iron rich foods
- Ante natal care

(v) Supply of specific lesson plans and supporting audio visual aids to deliver identified messages in the above listed areas.

(vi) Preparing reports and maintaining records.

(vii) Key indicators to be used in assessing the program effectiveness.

3.5. Commodity Availability

The principal issues are:

Are the rations regularly provided? Are they complete, adequate, appropriate?

Are the commodities stored properly and accounted for?

Availability of Food for Beneficiaries. Interruptions in the food supply at the Distributor/Center level have occurred though minimally. In the 47 sites visited, Center staff and beneficiaries reported highly regular distributions of all rations. The differences noted in the audit report between programmed and delivered foods for the TMCHEP program are due to discrepancies of planning and do not result in shortfalls to enrolled beneficiaries. Occasionally one commodity has been missing for a month or two. Most problems are caused by delayed shipments from the U.S.; others are due to inland transport problems. The latter are

particularly severe in Cochin Zone because the Cochin port is still closed, thereby necessitating lengthy overland shipment from Madras port. Frequently cars are held up on sidings, and especially during the rainy season, commodities are subject to damage.

The limited shelf life of CSM continues to be a problem in India. After a six months' journey to the port, inland travel, and storage in-country prior to distribution, the one-year expectancy for commodity integrity is about over. There were many reports of bitter taste and a few report of stocks changing color. No alternative foods appear feasible at this time.

The matter of ration adequacy and its relationship to health is discussed in the next section. Here it is sufficient to say that the team recommends extra CSM rations for III degree malnutrition children provided there is an assured way of targeting the food to the children.

The possibility of obtaining milk supplies in the future was discussed so that nutrient-dense foods could be made for severely malnourished children. CRS is aware that milk is not now available under Title II, but is interested in possibly reopening the subject at a future date. The team would recommend small amounts of milk for this purpose, again provided there is an assured way of targeting the food to the children.

It is unclear why oil must be distributed in 0.45 kg. group rations (rather than rounding off at 0.5), or why 2.4 kg of CSM instead of 2.5 constitute the ration. Distributions and accounting could be greatly facilitated by this small increase in daily rations, and the team recommends that the change be made on the next AER.

Adequacy of Storage and Stock Accounting. Distributor godowns were often impressively clean in solidly constructed buildings of church compounds where security was amply assured. Two Distributors complained about having to accept too great a volume of stocks because of overstocked Consignee godowns. Consignees, on the other hand, said they purposely sent stocks out to cover the monsoon period whenever feasible.

Consignee godowns were less well-maintained; the special caretaking at the local level was not present. Five out of six godowns carefully inspected by the team were poorly managed with one of several of the following failings: storing stocks next to walls, oil seepage, and exposure of grains to inclement weather; improper stacking of bags to threatening heights (more than 20 bags per stack), causing sacks to burst; failure to use pallets (even when visibly available); poor ventilation; poor use of available space (crowding into siderooms); and lack of passageways for making inventory checks feasible.

The team suggests that field reviewers give special attention to these godowns.

Stock Accounting. In an attempt to save time, CRS was given permission to replace monthly stock reports with quarterly ones. This may have

resulted in less attention to the interim maintenance of daily stock balances since these were not readily available in the same five godowns out of six which are poorly managed.

USAID/Delhi has interpreted Regulation 11 as a requirement that CRS (Field Reviewers) should inventory the Consignee godowns annually. (The usual semi-annual inventory requirement had previously been waived.) CRS has stated that this takes six to seven weeks of the Reviewers' time. (See elsewhere in the report comment that the FRs cannot possibly fulfil minimal supervisory functions.) CRS' internal auditors have made a recommendation that the inventories should be taken by CRS quarterly for a 12-month period. Obviously, neither demand can be met with available staff who have other equally important tasks.

The team is not undertaking accounting functions but is concerned with this issue as it closely affects performance of other program tasks. Therefore, we offer the suggestion that:

* CRS give special instructions to Consignees that they must put their godowns in order and keep up-to-date balances to faciliate FR checking.

* CRS set out a visiting plan to all Consignees in whatever time frame is feasible and that the problem of godowns identified in USAID field reviews and in this evaluation (details in Evaluation Backup File to be left with USAID/FDR) be given priority attention.

3.6. Potential Benefits of Program to Mother/Child Health and Welfare

The health components of TMCHEP are generally weak and are not sufficiently in place to assure the likelihood of program impact on beneficiaries. Lack of technical monitoring, both at Delhi and the Zonal levels, has resulted in a lack of knowledge about:

- what impact the program is achieving, and
- which components are making the difference.

As a result, there are considerable gaps in the understanding of the need and usefulness of the different health services - immunizations, and diarrheal disease management (including ORT). Implementation effectiveness varies, but, on the whole, the team observed that effective, overall education was not yet being imparted to mothers. No quantitative effort was made to check mothers' knowledge, but the ones interviewed confirmed the inadequacies noted at the educator level (Local Aides).

3.6.1 Health Services for P/L Women

The "mother" component of MCH is usually neglected even though its importance for child survival and development is well documented. The services intended to improve maternal health are:

- For pregnant women: Supplementary feeding and Nutrition and Health Education.
- For lactating mothers: Supplementary feeding and Nutrition and Health Education.
- Immunization against Tetanus
- Health Check-up.

Supplementary nutrition. CRS ration is distributed regularly and in prescribed amounts which supplies 633 calories and 23 gm. protein/day. The ration prescribed for pregnant and lactating mothers is the same, though the dietary needs of nursing mothers are greater than those of the pregnant women. The ration is not targeted; i.e., no efforts were observed to ensure that mothers consumed this ration; there was every indication that they did not eat the food for themselves.

Immunization against Tetanus by Tetanus Toxoid is most often given by the local health services staff. Occasionally, when the CIC is a nurse and facilities are available to store vaccine, immunization is given by the Centers. Data were not consistently available to determine the percentage of mothers immunized.

Health check-up relevant to pregnancy is not done.

Nutrition and Health Education is given through mothers' classes, usually held on days of distribution, but in Madras and Calcutta Zones, there were health/nutrition education sessions on days other than the distribution days. In these Centers the response was good, and mothers gave top priority to this activity among all the services offered and stated willingness to continue attending classes even if ration was discontinued. In this village, as in many others, the Mahila Mandal was active serving to identify community leaders and to build leadership, as were activities to enhance women's income and effect positive attitudinal changes about the role of women in the family and community.
From interviews with Local Aides, it was clear that topics, notably personal hygiene, environmental cleanliness, and "nutrition" were covered most often. Local Aides also gave talks regarding breast feeding, weaning, diet for children and mothers. Topics, not messages, are the rule. CIC and Local Aides did not know that the additional caloric and protein requirement during lactation is greater than in pregnancy. In our interviews, we found that mothers' knowledge about management of diarrhea, accurate preparation of ORS, need for vitamin A for prevention of blindness, and Fe for prevention of anemia to be the most inadequate. Comparatively, knowledge and understanding of the need for immunization, breast feeding, and supplementary feeding was good.

Recommendations:

The "mother" component needs to be strengthened. The first step in this direction would be to train the Local Aides to:

- Motivate more pregnant women to enroll. Once enrolled, they will hopefully remain during lactation also.

- Weigh mothers on alternate distribution day (once a month) in the first and second trimesters and on every distribution day (twice a month) in the last trimester.

Identify the following few 'risk factors' for referrals:

(i) First pregnancy.
(ii) Mothers' age less than 18 years or more than 35 years.
(iii) Pale conjunctiva and inside of lower lip (for anemia).
(iv) Swelling on feet and legs (for toxemia).
(v) Spotting/bleeding at any time during pregnancy.
(vi) History of still births, Caeserean.
(vii) Pregnancy weight less than 40 kg. at 20th week.
(viii) Weight gain less than 1 kg/month after 20th week.

- Organize health/nutrition classes for pregnant and lactating (up to 6 months after delivery) mothers separately and stress specific messages relevant to health of mothers and infants. Some of the most important messages are:

(i) Dietary needs. Nursing mother needs more food than the pregnant woman. Include leafy vegetables in the diet to get iron to prevent anemia.

(ii) Breast feeding is best for babies. It should be started 3-4 hours after birth and continued as long as the mother is able to lactate. However, after the 6th month, babies will need supplementary feeding.

(iii) Colostrum, the thick milk that is initially secreted, is nutritious and must not be thrown away. It also helps to protect the baby from infections.

(iv) Go to a hospital as soon as you notice any "Risk factors" (specified earlier).

3.6.2. Health Services for Infants and Children

Growth Monitoring is an important tool for identifying "at risk" children, taking timely action to check further deterioration in health and for education of the mothers.

(i) **Weighing Scales:**

In many Centers appropriate weighing scales for children are not available. Platform scales are used sometimes to weigh the babies, by taking the difference in the weight of the mother alone and later with the baby. Such weighing is totally inappropriate for growth monitoring. The most common reason given for non-availability of proper scales was that CRS had not supplied them.

(ii) **Weighing:** Weighing is almost always done on distribution days. With 200-400 children having assembled for collecting ration there is little time to devote to weighing of each child. Usually one person takes the weight and another records it in the register. At one Center, the Local Aide weighed the child and told the mother what the weight was. The mother passed on this information to the Center-in-charges when she went to pay her monthly contribution, and the CIC recorded it in the register. The possibility of error at one or more of the three levels through which the information passes cannot be overlooked. Note was taken only of weights at current weighing compared to last weighing. There is a total lack of understanding regarding the "trend in successive weights" over a period of time and its significance to child growth. As a result growth faltering was not identified for prevention of further deterioration.

Even when Grade III children remained in the same grade for months no action was taken to give special attention to them. This, in the team's opinion, was the most glaring inadequacy of the program.

(iii) **Weight Charts:** In Bombay and Madras Zones, some Centers were not supplied with weight charts. In these Centers the weight is recorded in a register, but it neither helps in understanding the trend of weight-gain nor in grading nutritional status for age. From discussions with nutritionists at the Madras Zonal office it was learned that they had specific instructions over the past 18 months not to print new cards as CRS/Delhi was waiting for UNICEF to finalize the new format of weight cards. (However recently Mr. McDonald gave clearance to Madras Zone to print the required number of cards and action is being initiated.) One of the observations made by the team at some Centers was use of cards donated by Glaxo with advertisement of 'Farex' baby food. This should be discouraged.

The charts were not used by field staff to determine priorities in their home visit schedules. Due to the lack of understanding of the concept of growth monitoring at all levels, it is taken more as a CRS requirement (of paper work) than as a monitoring and educational tool. An important opportunity to educate the mother, make her conscious of the pattern of her child's growth and effect behavioral change towards improved feeding of the malnourished child is lost.

Even when weight cards were available, they were often incorrectly marked and incomplete. Often weighing as well as marking the chart was done by Local Aides who were not adequately trained and sometimes not educated enough to carry out this responsibility. The Centers in charge themselves have confusion regarding how to maintain the card and rarely took time to scrutinize the charts marked by Local Aides. One common mistake was to start every year with January instead of the month of birth. This resulted in gross errors in estimation of nutritional status.

Usually the weight charts are kept in the Center, as there is concern that mothers will "spoil" the cards. Only in one Center the CIC had kept the charts of severely malnourished children separately and took them along during home visits to explain to the mother need for special attention to the baby. TMCHEP guidelines are that cards are to be kept with mothers.

Immunization: Immunization is another very important health component. In most Centers the actual administration of vaccines is done by the government health workers in the area. Immunization coverage of beneficiaries depends upon the coordination and cooperation between the TMCHEP Center workers and the field staff of health Centers. The immunization records are often not kept by the Centers, and when the team checked Center cards, found the data to be incomplete or unavailable. In one Center the staff ensured complete immunization of all beneficiaries by warning the mothers "no immunization, no ration" and checking the cards issued by health workers. Prior to making such an announcement they had made adequate arrangements with the local health Center for immunizations.

It would help to improve such horizontal linkage if the Consignee can discuss with the District/State level health officers in charge of UPI to ensure assistance to the Centers. There should be insistence by supervisory staff (for Consignee as well as Zonal office) that actual doses or specific doses of vaccines received be marked on the weight cards.

Nutritional Supplement: Rations are not provided for children below 6 months of age. Other children receive 2.4 Kg. CSM, 1.5 Kg. bulgur, and 0.45 Kg oil every month. In some Centers ration is distributed once a month and in others twice a month in divided portions.

3.6.3. Health and Nutrition Education

Though information regarding management of diarrhea and ORT is given by the CIC and Local Aides to the mothers, the specific messages given are not clear. Often instructions regarding preparation of ORS are not supplemented by demonstrations and mothers' participation in the preparation. The quantities of water, sugar and salt are rarely correct; confusion being specially in amount of water (one litre/one glass) to be used. Mothers were never asked to test the ORS to know how salty it should be!

Recommendations:

- The difficulty of individual Consignees to obtain child-weighing scales is obvious. It is strongly recommended that CRS supply adequate numbers of reliable spring balances for weighing of children.

- Required number of cards should be provided to each Center. It is important to ensure that all CICs and Local Aides have acquired the skills of accurate weighing and recording the weight correctly on the weight chart. Marking the weight on the chart should be done simultaneously at the time of weighing.

- Growth charts should remain with the mother so that it will be available to any person visiting the beneficiary. During the home visits the weight cards should be used to educate the mother regarding her child's growth pattern and what she needs to do to achieve/maintain normal weight for age.

- Growth charts need to be used as a monitoring tool by CICs and MCH coordinators. A list of severely malnourished children would help them to undertake follow-up home visits at regular intervals. A graphical presentation of total number (and %) of children with Grade II and III malnutrition and how they have progressed over successive months would help to focus attention on these most needy children. It would also help the Centers to assess the impact of their own efforts. Other incentives for Centers and mothers to improve Mother and Child Health are needed, such as baby shows (competition) and award days. Zonal nutritionists can help by organizing special orientation workshops for MCH coordinators to emphasize the importance of interpreting the "trend" in growth pattern and focusing on Grade II and III children by appropriate follow-up actions. If possible, mothers of all malnourished children should be called

on a separate day for food distribution, so that more time can be spent for nutrition education with each individual mother, as well as with the group.

- To avoid duplication of efforts as well as to ensure complete immunization coverage of beneficiaries, horizontal linkages need to be established with the local health staff responsible for EPI/UPI. It would help if the Consignee can make suitable arrangements by eliciting cooperation from District/State level officials in charge of EPI/UPI. If the health team cannot visit on a regular basis, 'pulse immunization strategy'1/ (recommended by UNICEF) can be used.

- If measles vaccine is not available with the Government, voluntary organizations like Rotary or Lions Clubs might be requested to donate the vaccine once or twice a year.

- Further emphasis should be placed on why there is a need for immunization and which vaccine protects against which disease. An enlightened mother, then, can be expected to seek immunization for her next child.

- The supervisory staff from Consignee and Zonal offices should insist that the dates of specific immunizations be recorded on the weight cards. The tendency is to tick off all blanks provided.
- Considering the poor health of lactating mothers and the documented caloric deficiency in their diets, it would be advisable to provide ration, if and when the ration is targeted, for breast fed babies also, rather than from six months of age as now provided.

- In Health/Nutrition Education emphasis should be on "specific messages" rather than general topics. There is need to ensure clarity of messages regarding breast feeding, supplementary feeding, foods rich in Vitamin A and iron, diet during an attack of diarrhea etc. Audio visual aids need to be supplied to the Centers and use of other communication methods like role playing, story telling, puppetry etc. should be encouraged.

  In many Centers, growth charts showed no improvement in nutritional status of severely malnourished children for 5-6 months or longer. It is generally accepted that considering the family sharing the ration, only a small proportion of the ration is in fact consumed by the beneficiary.

1/ Pulse immunization strategy. A team visits an area and immunizes all eligible children. The team visits at intervals required for the multi-dose schedules. The missed children in the area are covered in a mopping up operation. This strategy is most useful in areas where a routine , steady immunization activity by a stationary unit is not feasible.

Since time is important, in case of severely malnourished children, it is essential that these children get additional ration. It was generally observed that CSM is consumed mainly by the children. Hence an additional amount of CSM should be supplied to each Grade III children. This must be accompanied by intensive efforts to make the mother understand the gravity of the child's nutritional status, so that she will give it only to the target child. These mothers can also be encouraged to prepare their own dry nutritious food based on local ingredients at home (as is being done by mothers in Madras Zone).

The impact of the program on the health and welfare of mothers will not be seen unless the community is motiviated to undertake other developmental activities simultaneously. The following areas are already being covered:

- environmental sanitation
- Personal hygiene
- Clean water source
- Adult functional literacy for women
- Savings accounts for women
- Building leadership through the organization of Mahila Mandals
- Income generation activities for women such as the preparation of nutritions foods for sale to the weak and unwell, a doubly beneficial effort.

The Mahila Mandal is an excellent forum for initiating community participation and involvement. Members of Mahila Mandal, when adequately motivated and educated, can exert peer pressure on other mothers and help bring about a change in values and behavior conducive to better health. Calcutta and Madras Zones have made excellent progress in this area.

Every Zone has made a beginning in this direction. Progress has depended on the policy and interest of individual dioceses in supporting these activities. These valuable efforts should have further support and encouragement. It should be noted here that the very selection and training of Local Aides and the provision of employment and income for them is a major program benefit.

TMCHEP is very young - in some places only two months old. Given time and provided it progresses along the lines recommended, it is sure to improve the health and welfare of mothers and children.

4. FINDINGS AND RECOMMENDATIONS

4.1. Objectives

Findings:

(i) TMCHEP objectives are too general, optimistic and not measurable under the present monitoring system. CRS lacks a framework of phased targets over the first year period.

Showing a "reduction in infant mortality" is not possible, e.g. without baseline data on the areas where CRS operates.

(ii) CRS and counterparts are actually undertaking a TMCHEP program with wider objectives than those envisaged by AID for MCH.

Recommendations:

(i) CRS, with USAID or other technical assistance should refine its goals and include intermediate targets that can be measured by the existing evaluative structure (e.g., progress of III degree children under three years old).

(ii) The broader social objectives are valuable to the Maternal Child Health program and should be quantified.

4.2. Geographical Spread; Overlap with ICDS/TINP

Findings:

(i) Thirty years of request-to-request program building throughout the church structure has resulted in a highly scattered program. With the new technical component of TMCHEP (requiring more monitoring, training and technical management) the enormity of the geographical distances poses even more implementation problems.

(ii) ICDS continues to expand into new Blocks and incidences of overlapping will increase unless CRS and GOI reach agreement on operational areas of CRS. CRS Centers in ICDS Blocks may be about 10%.

Recommendations:

(i) CRS must make a plan for consolidation of its program. One suggestion which CRS is considering is to reduce the total number of Consignees.

The team recommends that CRS should use the occasion of having to sort out frontiers of operation with the GOI to develop a consolidation operational area plan to be achieved in, say, three years (the average stay of Consignees). USAID should promote and encourage this effort as it is feasible.

4.3. Adequacy of Staff for Training, Monitoring and Technical Direction

Central and Zonal Level

Findings:

(i) CRS recognizes that greatly increased monitoring and training inputs are essential to carry out the TMCHEP program adequately but cannot cope due to lack of: technical staff; training design; and teaching materials such as audio-visual aids.

(ii) At the Zones, 1 or 2 nutritionists for these tasks is highly inadequate.

(iii) Present training programs are academic, loaded with basic subjects, usually presented in lectures, and lacking in practical hands-on experience.

Recommendations:

(i) A technical cell with planning and training expertise at the CRS/Delhi level should be established to serve the Zones (and include Zonal-appointed technical staff); it would be a technical support unit, not a policy-making body. In addition, the cell would encourage the exchange of technical information and facilitate uniformity of technical approaches.

(ii) One technical staff member (nutritionists, e.g.) for 80-100 Centers (as in ICDS) should be provided. This would mean 25-30 technical persons rather than the 8-10 slots now anticipated.

(iv) Existing staff should receive training in training methodologies suitable for field workers.

Consignee Level

Findings:

(i) Part-time TMCHEP coordinators are not able to carry out the program adequately due to lack of time and training.

(ii) Coordinator training has no emphasis on training skills (monitoring, practical and field experience).

Recommendations:

(i) Coordinators should be full time and the number of them at the Consignee level should be proportionate to the number of Centers served.

(ii) Task-oriented training programs with audio-visual aids and practical experience are needed.

Distributor/Center level:

Findings:

(i) Local Aides' qualifications and salary are highly variable and not commensurate with the job. Many are illiterate. Salaries range from zero to Rs. 80.

Recommendations:

(i) Minimum education qualification should not be less than 8th standard and the minimum salary should be Rs. 150, both as for anganwadi workers. If cash is a constraint, payment should be made in kind.

4.4. Targeting: Selection of Beneficiaries

Findings:

(i) Since 1979, CRS has made considerable progress towards targeting under three year olds for growth monitoring. TMCHEP guidelines have only been issued recently, as late as a few months prior to this evaluation. Thus, the problems are just now being faced at the Center level -- the difficulties of eliminating villages from the program and explaining that children over three who are not severely malnourished are no longer eligible. In that perspective, it is noted that the guidelines are not yet strictly adhered to, but they have been accepted (reluctantly in some cases).

(ii) Enrollment of mothers is low.

Recommendations:

(i) CRS should insist upon immediate implementation of the criterion that only under three year olds (except for severely malnourished over 3 years) be enrolled.

(ii) Phase-in of the new requirement should be given reasonable implementation time (two years maximum is suggested).

4.5. Availability of Commodities; targeting of rations

Findings:

(i) Delivery of full rations to program beneficiaries is highly regular.

(ii) Though efforts are apparent to target food to vulnerable groups, the program effects have not yet altered home consumption. Rations last 2-3 days for the most part and sometime up to a week.

Recommendations:

(i) None.

(ii) Motivation efforts for the mothers must be intensified to reserve foods for herself and the most vulnerable child, especially if requests on the part of CRS and counterparts for extra CSM rations for malnourished and under six months' infants are to be given a favorable hearing.

Mother Education:

Findings:

(i) Mother education stresses general topics like personal hygiene and cleanliness, rarely messages given on diarrheal management, ORS, feeding during diarrheal episodes, etc.

Recommendations:

(i) Local Aides need to be trained to convey specific, relevant simple messages, rather than talking to mothers on general topics in health and nutrition.

4.6. Potential Benefits of TMCHEP

Growth Monitoring

Findings:

(i) Much time and effort (without adequate training) are spent on growth monitoring which is carried out in varying degrees of accuracy. Weight charts and proper scales have not been universally available. Little to no use is made of data collected. Growth monitoring charts are not being used as teaching tools for mother education.

Recommendations:

(i) Though it will be some time before the technical skills of TMCHEP coordinators and Local Aides can be strengthened, CRS Zonal nutritionists should give this matter the most urgent attention since so much time is invested in what is often useless activity.

Immunization:

Findings:

(i) Data are not yet available to determine the extent of immunization coverage.

(ii) Most Consignees lack resources for obtaining vaccines and do not have cold-chain facilities. They must depend on Government staff for immunization coverage.

Recommendations:

(i) Local Aides must be literate if they are expected to record and check records for immunization schedules and growth monitoring.

(ii) TMCHEP should continue to work toward the following to assure immunization coverage; by making every effort to coordinate with government teams; and eventually by verifiying records.

Table T-1 Distribution of mothers and children beneficiaries in 39 centers visited

Consignee Site	Total number of reporting centers	No. of Centers where Mothers as a % of total beneficiaries is: less than 13%	more than 13%	No. of Centers where children under 3 yrs. as a % of total children is: Less than 50%	50-90%	more than 90%
Bombay Zone						
Ajmer	3	3	0	1	0	2
Indore	5	2	3	1	1	3
Nadiad	6	4	2	0	0	5
Nagpur	6	5	1	0	4	2
Madras Zone						
Mysore	3	2	1	0	2	0
Trichy	3	1	2	0	0	2
Kumbakonam	1	0	1	0	0	1
Bangalore	2	1	1	0	2	0
Hyderabad/ Secunderabad	3	1	2	0	1	1
Cochin Zone						
Trivandrum (1)	2	1	1	0	0	2
Trivandrum (2)	1	0	1	0	0	1
Alleppey	0	NA	NA	NA	NA	NA
Calcutta Zone						
Seva Kendra	1	1	0	1	0	0
Khurda Road	1	1	0	1	0	0
Tezpur	1	0	1	0	0	1
Baruipur	1	0	1	0	1	0
Total	39	22	15	4	11	20

Table T-2

Field Visits in the Past Year

Zone	No. of Consignees	Nutritionist Visits to Consignees	Field Reviewer Visits to Consignees	No. of Centers	Nutritionist Visits to Centers	Field Reviewer Visits to Centers
Bombay	43	13 (29%)	9 (21%)	368	50 (14%)	100-110 (28%)
Madras	37	10/6 mos (54%)	12/6 mos (65%)	850	65-70/6 mos (16%)	60/6 mos (7%)
Cochin	25	4/2 mos (96%)*	8/2 mos (64%)*	1003	42/2 mos*	52/2 mos*
Calcutta	25	16 (64%)	21 (84%)	329	34 (10%)	21 (64%)

*Data available for 2 months only not used

Number of Visits Received by Centers from Nutritionist or Field Reviewer during past year

	Number of Visits			
	0	1	2	More than 2
39 Reporting Centers	12	18	6	3
	31%	69%		

Number of Visits Received by Centers from TMCHEP Coordinators

	None	1-2	3-6	More than 6
35 Reporting Centers	4	10	12	9
%	11%	29%	34%	26%

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Table T-3

Training Programs Conducted in 1986

Zonal Level

Zone	No. of Programs	Who Attended	No. Attended Each
Bombay	1	Local Aides	36
Madras	6	Local Aides	40
Calcutta	6	CIC's	10-12

Consignee Level

Zone	Consignee	No. of Programs	Who Attended	No. Attended Each
Bombay	Indore	1	Local Aides	46
	Nagpur	1	Local Aides	35
Madras	Mysore	1	Local Aides	55
	Trichy	12	Local Aides	30 (Attended 12 classes, 1 each month)
	Kumbakonam	1	Local Aides	40
	Secunderabad	2	Local Aides	30
Calcutta	Seva Kendra	3	Local Aides	20, 19, 21
		1	CIC's	19
	Tezpur	1	Local Aides	32
		1	CIC's	20

Training Programs Planned by the Zones for 1987

Zone	No. of Programs	Who Attended	No. Attended Each	Duration
Bombay	7	TMCHEP Coord./ Consignee & Local Aides	211	5 days
Calcutta	6	Local Aides	N.A.	N.A.
	1	MCH Coord.		
		Distributors (CIC)	N.A.	2days
Madras	3	Distributors	N.A.	N.A.
	1	MCH Coord.		

Number of Centers and MCH Coordinators Under Each Consignee

TABLE T-4

	NO. OF CENTERS	MCH COORDINATORS
Bombay		
Ajmer	5	1 Part time
Indore	17	1 Part time
Nadiad	10	1 Part time (just became full time)
Nagpur	11	1 Part time
Madras		
Hyderabad	8 (many subcenters)	1 Part time
Mysore	24	2 Full time
Trichy	36	2 Full time
Kumba	53	1 Full time
Bangalore	22	1 Full time
Secunderabad	43	1 Full time
Cochin		
Trivandrum (1)	72	1 Full time
Trivandrum (2)	89	1 Full time
Alleppey	35	1 Full time
Calcutta		
Seva Kendra	33	2 Full time
Barinpur	27	1 Full time
Tezpur	18	1 Part time
Khurda Road	9	None

NUMBER OF BENEFICIARIES PER LOCAL AIDE IN CENTERS VISITED

Table T-5

	C E N T E R S (C)							
	C1	C2	C3	C4	C5	C6	C7	C8
Bombay								
Ajmer	100	150	N/A	133				
Indore	75	50	60	80	150	200	50	60
Nadiad	75	75	N/A	56	125	100		
Nagpur	87	N/A	143	125	121	100		
Madras								
Hyderabad	154							
Mysore	150	116	150					
Trichy	300	200	200	160				
Kumbakonam	150							
Bangalore	75	150						
Secunderabad	150	91						
Cochin								
Trivandrum (1)	75							
Trivandrum (2)	150							
Calcutta								
Seva Kendra	167							
Baruipur	175							
Tezpur	175							
Khurda Road	N/A							

BENEFICIARIES PER LOCAL AIDES

	Less than 100	100-150	151-200	201-250	More than 250
Number of Centers	12	16	7	0	1

Total = 36

QUALIFICATIONS OF LOCAL AIDE

	Illiterate	3rd-9th Grade	10th-12th Grade	Graduate
Local Aides Interviewed	11	19	16	3

Total = 49

APPENDIX A.1: SCOPE OF WORK

CRS

TARGETTED MATERNAL CHILD HEALTH EDUCATION PROJECT (TMCHEP) EVALUATION

I. Evaluation Objective:

Assess the management tasks involved and the implementation of TMCHEP by quantitative and qualitative analysis at the field, CRS zonal and headquarter levels.

II. Background

CRS began its assistance to India in 1951, with a family feeding program which by 1969 had evolved into one of the few targetted Mother/Child Health (MCH) programs in operation. The dual objectives of combatting hunger and malnutrition, while encouraging communities to adopt improved nutrition habits using locally available foods, was a forerunner of the present worldwide MCH projects.

A 1974 CRS Pilot Project reinforced these objectives by training feeding center personnel in nutrition education, who in theory would share these messages with the target beneficiaries in community classes.

The Pilot evolved into the 1977 Nutrition Education Program (NEP). The goal of this program was to upgrade 400 of the 2,500 simple feeding centers, by adding staff at Zonal and field levels, improved MCH training and community participation.

The CRS/MCH was last evaluated by USAID in 1979 Community Systems Foundation (CSF). This evaluation examined four voluntary agencies' MCH programs and made the following general recommendations:

> Programs which provide food alone should be upgraded to include health and educational services, target children under threes, select beneficiaries on the basis of economic and nutritional need, utilize low bulk, high nutrient density food prepared on-site and focus community awareness on environmental sanitation.

Taking into account these recommendations and subsequent internal program surveys, CRS developed the Targeted Maternal Child Health Education Program (TMCHEP), to respond to the growing need for an integrated basic services program focussed on the vulnerable segment of the Indian population.

CRS's present goal is to upgrade its delivery system in all of its 2,500 MCH centers, to include not only the bi-weekly ration of take-home food, but a complete package of Child Survival services, vitamins, immunizations and health care follow-up.

CRS's main counterparts are the Social Action Departments of the 106 Catholic Dioceses. Its consignees are usually local priests who select social service agencies or parish centers to be the project holders distributing the Title II commodities. The Centers-in-Charge are ideally nurses or community development specialists, who provide health/nutrition education, weight recording, health records and conduct MCH activities. The In-Charge is assisted by a local aide who helps in food distribution, center activities and follow-up home visits to the beneficiaries.

In an effort to assist CRS, USAID awarded the Madras Zonal program a $400,000 grant in 1985, to allow for more rapid, intensive expansion of the TMCHEP program components. CRS hopes to soon have groundwork in place to request additional funding for the same purpose in the remaining three zones.

The current USAID evaluation will attempt to quantify the traditional CRS management apparatus and collect and analyze qualitative information on MCH program selection criteria, personnel training supervision, program implementation and effectiveness at all levels.

III. Issues

1. Has CRS developed a supervisory system at the field, zonal and Headquarter level sufficient to implement effectively this very large and administratively complicated project.

2. Has training been designed and carried out that has resulted in improved skills required for job performance on all levels.

3. Is the geographical coverage of the CRS/TMCHEP appropriate to its goals and management capacity.

4. To what extent are CRS selection criteria reflected in targetting and project participation.

IV. Indicators

1. Ascertain the number of consignees, project holders, centers and sub-centers in each TMCHEP zonal program.

2. In order to examine the issue of MCH program overlap, compare the list compiled in #1 to list of districts and blocks covered by TINP and ICDS. Compile a list of all such blocks where TMCHEP and TINP or ICDS are in dual operation.

3. Examine the management decision making process and criteria used for selection of TMCHEP centers.

4. In order to analyze program management logistics, determine closest and most distant TMCHEP centers from Zonal offices, taken from a sample of consignees and project sites for the current fiscal year.

5. In order to determine effectiveness of program supervision, prepare a list of Consignees and center level visits made by CRS Field Reviewers and Nutritionists during the past year. The team will visit a sample of these and analyze tasks commonly performed by Zonal staff during a routine visit.

6. Analyze the tasks and approximate time allocated to each which are performed over the course of a month by a representative sample of local aides, centers-in-charge and MCH Coordinators. Prepare a summary description for each interviewee.

7. Numerate TMCHEP training programs that have been held in the last year for and by zonal staff, consignees, project holders, centers in charge and local aides. Collect agenda or curricula used for each and assess the adequacy of the CRS training plan for achieving the TMCHEP objectives and effective program implementation.

8. To determine the extent to which eligible beneficiaries are covered in the villages served by the center, prepare a detailed description of beneficiary selection criteria based upon a survey in a representative sample of centers.

9. An evaluation of the following TMCHEP components in a sample of centers:

   a. Growth monitoring; weighing, plotting growth charts, interpretation of growth charts and counseling to mothers on child's growth progress.

   b. Nutrition education; materials, methods, themes, messages and frequency presented.

   c. Beneficiary coverage and availability of Vitamin A, iron and folic acid.

10. In a representative sample of centers ascertain:

   a. Adequacy of storage facilities at consignee and center level.

   b. Commodity availability and delivery from consignee to center and frequency of complete ration distribution.

c. Extent to which CRS is supervising food commodity distribution including accountability.

V. Statement of Work

A. Composition of Evaluation Team

An international contractor assisted by a two person in-country team will carry out the evaluation.

B. International Contractor's Scope of Work

The international contractor will be the team leader and will be responsible for reviewing the Targetted Mother Child Education Program (TMCHEP), developing the evaluation field protocol and instruments for the management and implementation assessment of the MCH program and writing the final report.

1. Upon arrival in India for the 7 week evaluation duration review the following documentation:

   An Evaluation Report of the PL 480 Title II Program In India: Community Systems Foundation. June 4, 1979.

   The Integrated Maternal and Child Nutrition Project in India: Recommendations Based on a Review of Past Experiences: David Sahn, Community Systems Foundation. November 1980.

   Annual Summary of Activities in India by CRS: 1985.

   CRS/India Operating Manuals

   CRS Current Program Plan

   USG Audit Report. March 27, 1984.

   FDR Review Reports of CRS Zonal Programs

   USAID files containing CRS/USAID correspondence and documentation

2. Design and field test evaluation protocol, data collection instruments and analysis plan with the assistance of the in-country team members.

3. Data will be collected, compiled and verified by the evaluation team with the assistance of CRS functionaries, if necessary. The data will be checked for accuracy and presented to team leader for analysis.

C. In-Country Team's Scope of Work

The in-country team, consisting of two persons will be responsible for carrying out the following tasks:

1. Review all documents listed in B 1.

2. Assist international contractor in developing and field testing the evaluation protocol and data collection instruments.

3. Using these instruments developed, conduct the data collection at each of the CRS zones. To facilitate collection, the team will each be assigned separate geographical areas. Each member will be accompanied by a USAID representative and/or team leader. At the discretion of CRS they may also be accompanied by CRS personnel.

4. Compile and review data, with the assistance of CRS to check for accuracy as needed. Organize data and collaboratively analyze if required by team leader.

5. Assist the International Contractor as required.

VI. Team Composition

A. International Contractor

The individual must have experience in development management programming. He/she must possess skills in designing and conducting quantitative and qualitative evaluations of PL 480 Title II, MCH or other food assistance programs. Proven analytical skills are required. Prior direct operational management experience with a PVO or work experience associated with Volag Mother Child Health programs is highly desirable. Ideally the candidate would have background in Nutrition, Public Health or related fields.

It is essential that the team leader possess the required evaluation skills, operational management experience and an awareness and sensitivity to PVO fields operations.

The individual must be available for travel to India commencing o/a June 8, 1987, and remain in country for a 7 week period (July 24). During this time the team leader will develop and test field protocol, conduct site visits, and write the final report.

B. In-Country Team

This two person team must be composed of individuals with proven evaluation and data collection experience. The incumbents must have direct experience or knowledge of PVO programs or development assistance projects in India. Specific MCH and food assistance programming is highly desirable. Proven experience as a team member on a research or evaluation effort is required. The individuals must have a flexible working style and be willing to work under the direction of an international contractor and in his/her absence the guidance of the Food For Peace Officer. The incumbents must be willing and able to keep the directives of the team leader in focus throughout the evaluation, including the data collection period when work may be conducted on an individual basis.

The incumbents should be available for approximately ten weeks beginning o/a June 8, 1987 through July 17, 1987. During this period the team members should be prepared to conduct field work for up to five consecutive week period.

VII. Reporting Requirements

A. Format of the Written Report

The final written report will contain the following sections:

1. Executive Summary: Not to exceed three single spaced pages. This section stands alone from the main document, and summaries in a concise, succinct way the major elements of the report. (Examples of how this section should appear will be provided during the international contractor's first visit).

2. Body of the Report: The report will describe the context in which TMCHEP in India is implemented, along with the specific environment and details for each of the three sections of the evaluation. The report will provide evidence and analysis,

including tables and graphs, to support conclusions and recommendations relative to each part of the evaluation. The report should not exceed 30 pages. Relevant qualitative or anecdotal information that is not used in direct support of a conclusion or recommendation may be added as appendices.

The report should end with a full statement of conclusions. Since many management and service delivery issues are common to both FFW and TMCHEP programs, the recommendation section will be drafted jointly with the FFW Team Leader. The section will incorporate TMCHEP specific recommendations, as well as CRS management issues that cross cut both programs. Recommendations should correspond to the conclusions, and should specify action to be taken by CRS, or as the case may be, by both CRS and USAID.

Appendices should include the following:

a. The evaluation scope of work.

b. Brief summary of the current fiscal year TMCHEP program in terms of the amount and value of PL 480 Title II commodities.

c. A bibliography of documents consulted.

d. Other appendices as cited above.

3. Submission of the Report: The final report will be submitted and found acceptable by USAID prior to completion of the international contractor's visit. The report will be reviewed by USAID and CRS while in draft form. A formal submission of a draft report will be replaced by interactive review of it by USAID and CRS as it is being prepared for final submission.

4. Debriefing: Formal submission of the report will take place at debriefing to be given by the team leader, and his/her in-country team members for the benefit of USAID and CRS executive-level staff officers. The debriefing will be scheduled to take place two days prior to the team leader's scheduled departure to allow time for any follow-up/follow-on actions or clarifications prompted by the debriefing that would require his/her presence.

5. A table will be developed by the International Contractor specifying major findings, conclusions and recommendations. Priorities will be established for all recommendations made by the Consultant.

6. The International Contractor, working with the Project Officer and counterpart staff, is responsible for preparing in draft according to Bureau guidelines the AID Evaluation Summary (ES), Part I ('Action Decisions' and 'Evaluation Abstract'), and Part II ('Summary of Evaluation Findings, Conclusions and Recommendations'). A samples outline of the above requirements is attached to this Scope of Work. The Project Officer will not approve the contractor's voucher until the required sections of the ES are prepared in draft.

7. Relationships - The Contractor will be responsible for drafting sections of the paper and reporting associated with the activities outlined in Section III and Section IV above. The team leader will be directly responsible to the Food For Peace Officer and will be expected to collaborate closely with the Evaluation Officer and with the Project Committee Members. A six-day work week will be expected.

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Appendix A-2

List of Persons Interviewed

Central Office/New Delhi

Mr. Michael McDonald	Acting Director
Ms. Usha Goel	Nutritionist

BOMBAY ZONE

Zonal Office Staff

Mr. Edwin L.D'Souza	Zonal Administrator
Miss Rajalakshmi Nair	Nutritionist
Mr. Babu Mathew	Field Reviewer
Mr. T.G. Ekande	Field Reviewer

Consignee Level

Indore	Fr. Joseph Thayil and MCH coordinator
Nadiad	Fr. Cyprian Andrade and MCH coordinator
Nagpur	Mr. D'Souza (admn.) and MCH coordinator
Ajmer	Fr. John Pais

Distributor/Center Level

Indore

Holy Cross Rural Health Center	Center-In-Charge (CIC), 1 Local Aide, and 4 Mothers
Fr. George Payatikat, Jhabua	CIC
Community Health Center Christian Hosp.	CIC and 2 Local Aides
Missionaries of Charity, Indore Slums	CIC
Ishgarh-Piplia	CIC and 3 Local Aides
Dhani	CIC and 2 Local Aides, 5 Mothers
Pauchkin Center	CIC
Meghnager	CIC and 1 Local Aide, 1 Mother

Nagpur

Karuna Niwas Health Center, Mansar	CIC, 1 Local Aide and 3 Mothers
Mrs. Leela Chitale (Dist. with 6 centers)	CIC and several local aides several mothers
St. Joseph's convent, Thana	CIC and 3 Mothers
Providence Convent, Phuttara	CIC, 4 Local Aides and Group of Mothers

Asha Bhavan	CIC, 1 Local Aide and 3 Mothers
Jaitala	CIC, 1 Local Aide and 3 Mothers

Nadiad

Eye Hospital, Chikodra	CIC
Umreth	Assistant to CIC
Our Lady of the Pillar Hospital	CIC and 3 Mothers
Matar	CIC, 1 Local Aide and 3 Mothers
Nirmal Samaj Kendra	CIC, 2 Local Aides and 2 Mothers
Gothada	CIC
Nadiad Urban Center	CIC and 1 Local Aide
plus 2 centers attempted*	

Ajmer

Jaipur, Sisters of Charity	CIC and group of mothers
Madal	CIC
Matikera	CIC
Pasupalnikal	CIC

MADRAS ZONE

Zonal Office Staff

Mr. Michael Frank	Zonal Director
Mrs. Usha	Nutritionist
Miss Sujata Amravati	Nutritionist
Mr. Rosario	Field Reviewer
Mr. Vincent	Field Reviewer
Mr. J. Aimen	Field Reviewer
Mr. Rajeshwar Reddy	Program Reviewer

Consignee Level

Kumbakonam	Fr. M.A.Sebastian and MCH Coordinator(2)
Mysore	Admn. MCH Coord.
Hyderabad	Mrs. Rhoda Mistery (former Consignee) and Mr. Hans Saxena, consignee
Secunderabad	Fr. Henry D'Souza and MCH Coord.
Bangalore	Fr. Saleema
Truchirapalli	Fr. Kulandaisamy and MCH Coord.

Distributor/Center Level

Kumbakonam

Papanasam+	MCH Coord. in place of CIC
Sacred Heart Leprosy Center	Observed distribution only
plus 1 center attempted	

Mysore

Vimalaya+	CIC and 1 Local Aide
Little Flower Center	CIC
Kalenhelli	CIC

Hyderabad

Shadnagar Distributor	Distributor and Program Director
1. Podagutta	Health Coordinator
plus 1 center attempted	

Secunderabad

St. Theresa's Hospital+	CIC
St. Francis of Assisi, Ramnagar+	Distributor (signatory), 1 Local Aide (runs program)
Plus 1 center attempted	

Bangalore

Mariam Nilaya	CIC
Chelikere+	CIC, 1 Local Aide and 4 Mothers

Trichy

Ammapettai	CIC and 2 Local Aides
Subramaniapuram+	CIC, 2 Local Aides, and4 Mothers
Keelamullaidudi+	CIC, 2 Local Aides and 4 Mothers
Anali Seva Illam	CIC and 1 Local Aide + 25% upgraded center

COCHIN ZONE

Zonal Office Staff

Dr. Yavrina	Zonal Director
Mrs. Subaida Moosa	Nutritionist

Consignee Level

Alleppy	Fr. Pius Mohan Parayakattil, and MCH Coordinator
Trivandrum (1)	Fr. M. Joseph
Trivandrum (2)	Fr. George Jacob

Distributor/Center Level

Trivandrum (1)

Udayan Kulangara	CIC, 1 Local Aide and 2 Mothers

Trivandrum (2)

Muttathara	CIC and 2 Local Aides
Balarampuram	CIC, 1 Local Aide and 2 Mothers

CALCUTTA ZONE

Zonal Office Staff

Ms. Vivian Marin	Zonal Director
Ms. Nirmala Gupta	Senior Nutritionist
Mr. Mikhil Mazra	Field Reviewer

Consignee Level

Seva Kendra Tezpur	Fr. John L. Noinha and MCH Coordinator
	Fr. Thomas Thottankara and MCH Coordinator
Khurda Road	J. Parichha and Program Coordinator
Baruipur	Fr. Charles Pollet

Distributor/Center Level

Sewa Kendar

Andul	Health Worker in charge of 1 subcenter, 1 Local Aide and 2 Mothers

Tezpur

Borgang	CIC, 1 Local Aide and 2 Mothers

<u>Khurda Road</u>	
Kadab	CIC and 2 Mothers
<u>Baruipur</u>	
N. Durgapur	CIC and 3 Mothers

Appendix A-3

Method:

Since recent CRS decentralization of administration in Zonal offices located at bombay, Calcutta, Cochin and Madras, the Zones have been responsible for TMCHEP in their respective geographical areas. The Zonal distribution of Consignees, Centers and beneficiaries served are:

Zone	Consignees	Centers	Beneficiaries
Bombay	43	368	86,000
Calcutta	25	329	115,000
Cochin	25	1003	202,223
Madras	37	850	286,417
Total	130	1550	689,640

To evaluate all aspects of the total program the team observed activities and studied the management of the program at four, and sometimes five, levels - Zonal, Consignee, Center, occasionally sub-center, and mothers. In view of the extensive geographical spread and the constraints of time, a random sample of 14 Consignees was taken (from a list of 139) with the objective of covering 10% of the total. Zonal lists of Consignees were used in selecting the random samples. Three extra Consignees were added during the field work so that 17 Consignees in all were visited or a 12% sample.

Most of the States where CRS has TMCHEP were represented in the sample thus obtained. However some of the Consignees in the original sample had to be replaced for reasons beyond the control of the team. These constraints were:

* Areas classified as "sensitive" by GOI, where no visitors are permitted.
* Remote areas, for which information regarding roads and travel time was not available during the planning stage.
* Disturbances of "law and order" in other areas.

Whenever a Consignee in the original sample had to be replaced, to the extent possible, the next Consignee in the list was selected. If that too was not feasible, another Consignee from the same State was selected.

As Cochin Zone was recently reviewed by USAID staff and extensive documentation was available, USAID suggested that the team visit a lesser percentage of Consignees in that Zone; finally, three were visited.

Center selection was made after discussions with the Consignee taking into consideration the travel time and availability of staff at the Center. Whenever possible, the team selected distant Centers along with those nearby. (See Appendix A-5.)

Instruments of Investigation:

To gather information on the delineated issues, three protocols were designed: One for the Zonal level, which included interviews of the Zonal Director, Nutritionist(s) and Field Reviewers; one for the Consignee level with interviews of the Consignee and MCH coordinator and one for the Center level with interviews for Centers-In-Charge Local Aides and mothers. (See Appendix A-4).

Each protocol contained a set of questions and observations made during the visits by the team members. These observations are essential in the qualitative analysis of the program components.

The team carried out **Pre-Testing** of the protocols in Ajmer area of Rajasthan and visited three out of four Centers in the area.

Based on the pre-testing, the questionnaires were accordingly modified for final use in the field.

Field Visits:

Considering the variety of backgrounds of the three team members, it was felt that each one would contribute a different perspective to the quality of data collected. The entire team, therefore, visited the Zonal offices (except for Calcutta) and the Consignees (except for team split in the last field week) and contributed to the observations. They then separated to visit different Centers under the same Consignee.

Due to the limited time and the restriction of travel by foreigners in the North-Eastern States, the evaluation team separated in 2 groups for the last week of visits. One team visited the Calcutta Zonal office and Consignees in Tezpur (Assam) and Bhubaneshwar (Orissa) while the other team visited Consignees in Karnataka and Andhra Pradesh.

Thus in a period of three weeks, the team visited four Zonal offices, 17 Consignees and Centers spread over Rajasthan, Gujarat, Maharashtra, Karnataka, Kerala, Tamil Nadu, Andhra Pradesh, Madhya Pradesh, West Bengal and Assam.

Z O N E L E V E L

ZONAL DIRECTOR (Policy)

Guide:

1. Discuss problems identified in recent audits, field reports, particularly the inadequacy of monitoring and supervision. Explain primary interest of team is to find causes and feasible solutions. What are zonal goals and strategy?

2. What are major problems in your zone:

   a) In getting foods delivered and accounted for?

   b) In educating mothers and keeping children well? Growth chart supply?.

3. OVERLAP AND/OR COORDINATION

   3.1 Are there other MCH programs in this zone? If yes, have there been instances of program duplication (ICDS, TINP)? [ ] yes [ ] no

   If yes,

   Examples: _____

   What do you do about it?

   Do you discuss with State(other officials?

   Do you impose any deadlines for ending such duplication? Who should do something about it?

   3.2 Do you promote/encourage MCH and FFW programs in the same village?
   [ ] yes [ ] no.
   Why?, why not? _____

4. SITE AND BENEFICIARY SELECTION

4.1 Who suggests/recommends new consignee sites: [ ] priest [ ] Zone Director [ ] Bishop [ ] CRS Field Officer Power of Zonal Director?_____

4.2 How is the decision made to approve new consignee sites? (what criteria, rationale, what evidence was provided?)

_____

_____

4.3. Do you think there is any advantage in consulting with the Government about this?_____

_____

4.4 How many new consignees have been approved in the last 12 months since May 1986? [_____]

4.5 Did some requests have to be refused? [ ] yes [ ] no. If yes, how many [_____] What were the reasons?

_____

_____

_____

_____

5. PERCEPTION OF STAFF ADEQUACY

5.1 What professional staff do you have? Indicate number.

Total [ ] Nutritionist [ ] Field Reviewers [ ]
Other, specify_____

5.2 What do you expect each to do for you?

Staff	Tasks

5.3 Can they supervise the Zone satisfactorily? [ ] yes [ ] no.

If no, what further strengthening is necessary_____

_____

5.4 Should there be greater numbers?

[____] yes [____] no

If yes, what would they do?

_____

_____

_____

5.5 Should they be given more training? Specify technical training, reporting, other_____

_____

_____

6. Task Analysis of Zonal Director

6.1 How long have you been in this job? [_____]

6.2 What are your main tasks?

Task	Time allocated
_____	_____
_____	_____
_____	_____
_____	_____

summarize % of time devoted to MCH [_____]

6.3 Do you think the MCH part of your job requires further training? If yes, specify:_____

_____

_____

_____

CRS FIELD REVIEWER

1. PROGRAM SIZE AND RELATIONSHIP AMONG FOOD PROGRAMS

1.1 Ask for list of consignees and centers with distances from zone to consignees.

How many consignee sites are there? [____]
How many centers [____]
How many sub-centers [_____]

1.2 How many have both MCH and FFW programs?
Consignees [____] Centers [____]
FFW only? consignees [_____]
MCH only? consignees [_____]

1.3 How many beneficiaries in all?_____
How many MCH beneficiaries?_____

1.4 Have consignees, centers and beneficiaries been increasing or decreasing in the last few years?

1.5 What is the farthest distance to which you must send food to consignees?
Farthest for all consignees [ ]
Farthest for MCH consignees [ ]
Average all consignees [ ]
Average MCH consignees [ ]

1.6 Have the distances increased or decreased over the past few years?

1.7 Do the distances pose problems (transport costs, monitoring logistical obstacles) for you that cannot be resolved at present? [ ] yes [ ] no.
If yes, discuss what changes would be required to ease the present situation_____
_____
_____
_____

2. TASK ANALYSIS OF FIELD REVIEWER

2.1 How long have you been working in this job? _____

2.2 What are your main tasks? (% of time)

_____ _____
_____ _____
_____ _____ _____
_____ _____ _____
_____ _____

(Prioritize by numbering on left side)

Which is most important to you?

2.3 What education and training have you had for yourself? (qualifications)

_____

2.4 Do you think the job you are doing requires additional training? [ ] yes [ ] no.
If yes, specify kind_____

2.5 (a) Do you make regular supervisory visits to consignees and centers? [_____]

(b) How many have the FR staff made in the last 12 months to consignees? [_____] to centers? [_____]

(c) How long do you spend in a visit?

(d) What do you do? [____] check stocks [____] check records [_____] answer questions [_____] deal with problem that has promoted the visit [_____] give instructions for filling out forms, other _____

Do you use a proforma checklist ? Others? ____

_____
_____

3. COMMODITIES: AVAILABILITY/ACCEPTABILITY

3.1 Have you had commodity shortages in the last year?
[ ] yes [ ] no
If yes, describe length and reasons, effect on program

3.2 Problems of accountability have been documented in audits and field reports. What do you think are the causes of these problems?_____

_____
_____

3.3 How could these be corrected?

3.4 What do you request and get from consignees inthe way of reports? _____

_____

_____

What do you do with them?

_____

_____

_____

3.5 What reports do you prepare?

_____

What is done with them?

_____

Is there feedback? Describe.

_____

_____

_____

3.6 Are the foods generally acceptable? Describe

_____

_____

_____

Zonal Level (Nutrionist)

1. What is your role in the MCH program?

2. What are its components?

(a) Maternal health service [ ] ANC [ ] TT Immun. [ ] Nutrition [ ] Other, specify_____
(b) Child health services [ ] Nutrition [ ] Growth monitoring [ ] Immun. [ ] Vit. suppl. [ ] ORT [ ] Rx of minor illnesses; [ ] Referral to health facility [ ] Other, (specify)

_____

3. Regarding the technical component of the MCH program what are your specific tasks? [___] Training, [___] Supervision, [___] Training material, [___] Data processing [___] Evaluation, Other (specify)_____

Total time allotted to MCH program in days/months_____
in % of total time _____

4. What are the training programs you conducted last year?

Number_____ Duration (days) _____ No. and category of trainees_____

5. Is there a curriculum for training each category of staff? [ ] yes [ ] no

If no, how do you ensure unformity of training?_____

_____

6. Training Methodology? [ ] Classroom [ ] Practical [ ] Field

7. Training aids used? [ ] Manuals [ ] Leaflets [ ] Memeographed notes [ ] Charts [ ] Slides [ ] Film strips [ ] Films [ ] Other,
specify_____

8. Supervision and support:

a. No. of visits made to each consignee during previous 12 months_____

b. No. of centers visited during previous 12 months?_____

c. What do you do during visits?

_____

_____

d. time spent on the average [____]

9. Nutrition material supplied to centers?

[ ] Written [ ] Charts[ ] Slides [ ] Other, specify_____

10. Who does the teaching in the centers?

11. Do you think they are sufficiently qualified? How do you know?

Observation Notes

1. Training program curriculum _____

_____

_____

_____

2. Reference material used for training _____

_____

_____

_____

3. Training aids _____

_____

_____

_____

4. Data processing system? _____

_____

_____

_____

5. Messages emphasized?

[ ] Growth monitoring [ ] ORS [ ] Suppl. feeding [ ] Nutritional requirements of pregnant women [ ] Lactating mothers [ ] Maintenance of Records [ ] Horizontal linkages.

6. Data reporting frequency? _____

7. Data use in [ ] Programming [ ] Training [ ] Nil [ ] Other, specify _____

Comments on zonal staff capability and attitude.

CONSIGNEE LEVEL

CONSIGNEE GUIDE

Purpose of team visit? What are the main problems you have?

1. PROGRAM OVERLAP/COORDINATION

1.1. Are there other MCH programs in your area?

[___] Yes [___] No

Have there been instances of program duplication (ICDS, TINP)? [] Yes [] No [] Unaware

If yes, what do you do in such cases?

[] Move out
[] Watch closely for village overlap
[] Discuss with State (others) officials
[] Other, specify_____

1.2 Do you promote/encourage/a combination of MCH and FFW in the same village? Are they complementary?

[] Yes [] No

Why?

Why not?

1.3 Is there a special orientation in this Diocese?

[___] education [___] Health [___] Social work

Priority?_____

2. SITE SELECTION (CENTERS)

2.1 How many new centers have been approved since 1 year ago - May 86 - May 87? [_____]

2.2 How do you decide where new centers are to be opened? (Criteria)?

2.3 (Madras only) How did you select the 25% of centers to be included in the upgraded program?

2.4 Were some requests refused?

[] Yes [] No

If yes, how many? [____]

Principal reason

2.5 Do you close down centers at times?

[] Yes [] No

If yes, what is the principal reason?

[__] ICDS [__] Lack of sufficient motivation

[__] Poor Functioning [__] Other_____

3. PERCEPTION OF STAFF

3.1 What monitoring is required for the MCH program?

_____
_____
_____
_____

Do you have enough staff to do the necessary monitoring at the centers?

3.2 Are they trained adequately?

Are they motivated?

3.3 How long do MCH Coordinators stay on the average? [____]

3.4 What are their qualifications?

_____
_____
_____

3.5 Who decides on the naming of MCH coordinators?

_____
_____
_____

4. TASK ANALYSIS OF CONSIGNEE

4.1 How much time (%) do you spend on the MCH program? [____]

4.2

What are your main tasks?	Time allotted to them?

What would you like to have the highest priority?

_____
_____
_____
_____

4.3 Have you been trained for this MCH work and reporting?

_____
_____
_____
_____

4.4 What do you think should be the consignee's powers and responsibilities in the MCH programs?

_____
_____
_____
_____

4.5 Do you have enough time to carry out your MCH responsibilities? - Enough decision making power?

[] Yes [] No

If no, what should be changed so that you would have enough time?

How would you use more time if you had it?

_____
_____
_____

5. COMMODITIES/AVAILABILITIES

5.1 Do you have a consignee godown? If yes, what volume of commodities do you normally carry? [_____]
To cover how many months? [_____]

5.2 What do you have now?
(Check storage & Stocks on hand)

5.3 Do you have interruptions in supply?

Yes [ ] No [ ] Length of time:_____

Specify causes?

5.4 Do you get quarterly reports? Are they correct and on time? What problems do you have in accounting for food?

What are causes?

6. SUPERVISION/MONITORING System

6.1 What reports do you prepare or approve?

_____
_____
_____

What use is made of them?

_____
_____
_____

CONSIGNEE LEVEL

MCH COORDINATOR

1. QUALIFICATION AND TASKS

1.1 How long have you been associated with the CRS/MCH program?

1.2 What education have you had?

1.3 What training for MCH job?

1.4 Is there further training that you consider necessary for yourself?

[] Yes [] No

If yes, specify _____

_____

1.5

Tasks performed	Time Allocation

2. TRAINING AND MONITORING TASKS

2.1 What training programs did you conduct last year (Since May 1986)?

Area of Training	How do you do training? (Methodology)	No. of Sessions	Duration	No. of trainees

2.2 Monitoring:

No of visits made to each center during the past 12 months [ ]

Tasks performed during visit		Time allocated
Stock checking	[]	[ ]
Scrutiny of records	[]	[ ]
Growth Monitoring	[]	[ ]
Supervising food distribution	[]	[ ]
Discussion/guidance with staff	[]	[ ]
Meeting beneficiaries in the center	[]	[ ]
in the home	[]	[ ]
Other	[]	[ ]

3. PROGRAM SIZE

3.1 How many MCH centers are there? [ ]

3.2 How many total MCH beneficiaries ? [ ]

3.3 What distance is it to the farthest MCH? [ ]

3.4 Most are how far? [ ]

3.5 Do the distances pose any problems? What could be done to improve the situation?

_____

_____

4. NUTRITION AND HEALTH PROGRAM COMPONENTS

4.1 Nutrition Education programs

How other do mothers group meet?

How many groups?

How many mothers attend

What messages are given

(1)_____
(2)_____
(3)_____
(4)_____

4.2 Do you make individual visits to homes?_____

No. of Mothers contacted last month?_____

What did you say during the visit?_____

_____

4.3 What 'health care' (if any) is given at the centers by the center staff?

4.4. How many centers in your area have your own health facility?

4.5 What referral facilities are used by the centers in your area?

4.6 How many were referred last month?

mothers_____ Children_____

4.7 Are there any guidelines issued to center staff regarding referrals?

[] Yes [] No

4.8 If yes, what are they?

4.9 Do you work with governmental or non-governmental agencies in your area to make health care services available to your beneficiaries?

Do they get immunizations, Vitamin A, Iron and Folic acid supplements?

4.10 Do you receive from the centers regular reports regarding "health care" activities (other then food ration distribution)?

[] Yes [] No

If yes, how do you use these reports?

If no, do you think such a system would help you?

OBSERVATIONS

1. Training program content:

2. Materials used for training:

3. Main messages in Nutrition

   Breastfeeding, Growth monitoring, ORT, Supplementary feeding, Nutritional needs of pregnant and lactating women

4901G

DISTRIBUTOR/CENTER LEVEL

Distributor/Center Name _____

Villages covered _____ Rural/Peri-urban _____

Population _____ Years of Center Operation _____

CENTER-INCHARGE

1. Education, Training and Tasks

1.1 What is your educational level? _____

1.2 a) Have you had training for MCH work? Yes ( ) No ( )
specify: _____

b) Any special training for this CRS program? ( ) Yes ( ) No
If yes, Specify _____

1.3 a) Total experience in this program ( )
b) Experience at this center ( )

1.4 a) How many days full time you devote to this programme ( )
b) How many days part time ( ) No. of days ( ) hrs/day

1.5 Task analysis of Center in charge

Principal Tasks	% of Time
a) Food distribution	
b) Weighing	
c) Growth charts	
d) Home visits	
e) Health & Nutrition Education	
f) Immunization	
g) ANC Care	
h) Records & other paper work	
i) Treatment of minor illness	
j) Any other	

2. Enrolment and Selection Criteria

2.1 What is the current enrolment? of Mothers _____ of Children _____

2.2 What % of children are under three? ( )

2.3 Do you make the selection of beneficiaries? Yes _____ No _____
If no, who makes the selection? _____

2.4 What factors are considered in selecting beneficiaries?

( )	( )	( )	( )	( )	( )	( )
Proximity to Center	Income	Nutrition Status	Mother in Program already	Tribal or caste	Religion	Age

Other_____

Which is given priority?

2.5 Are there beneficiaries waiting to enrol? ( ) Yes ( ) No
If yes, how many? ( )
and how long must they wait( )

2.6 When are new registrations made?_____

3. Program Overlap/Coordination

3.1 Are there other MCH/similar programs
in the village? ( ) Yes ( ) No
in the area? ( ) Yes ( ) No

3.2 What action is taken to avoid that beneficiaries attend two programs? _____

3.3 Is there a FFW program operating nearby? ( ) Yes ( ) No
(in the same village as MCH)

4. Stocks/Availabilities

4.1 How often do you have stock interruption?

( )	( )	( )	( )	( )
Rarely	Sometimes	Often	Regularly	Never

4.2 Longest interruption(s) over the last year since May 86 _____

4.3 What is available now? ( ) CSM ( ) Bulgur ( ) Oil
Check

4.4 How long will it last? ( ) CSM ( ) Bulgur ( ) Oil

4.5 On the average how much do you give as ration each month/benificiary

( )	( )	( )
(2.4 Kg) CSM	(1.5 Kg) Bulgur	(0.45) Oil
CSM	Bulgur	

4.6 What was given last month?

( )	( )	( )
CSM	Bulgur	Oil

4.7 How many times in a month do you distribute ration ( )

4.8 How long does the ration last (no. of days
specify by commodity

( ) CSM ( ) Bulgur ( ) Oil

5. Supervision

5.1 How many supervisory visits have you received during the past 12 months from:

MCH Coordinator ( )
Consignee ( )
Nutritionist ( )
Field Reviewer ( )
Oth r ( )

5.2 How long are these visits? ( )

5.3 What is done in the visit?

	Check Stocks	Check records	Give advice	Visit village	Discussion with local aides	Other
MCH Coord.						
Consingee						
Nutritionist						
Field Reviewer						
Other:						

6. Perception of Staff - Local aides

6.1 How many local aides do you have? ( )

6.2 What do you think should be the ratio between local aides and beneficiaries? _____

6.3 How many of your aides are local village women? ( )

6.4 How many of them have been trained? ( )

6.5 Who has trained them and for how long? ( ) ( ) ( )

6.6 What tasks do they perform?

( )	( )	( )	( )	( )
Home visits	Weighing	Wt. Charts	H & N talks	Other

6.7 What other occupation/employment do they have?

7. Training

Training program conducted for local aides and mothers since May 86:

	No. of Programs	Duration	No. of trainees
Local aides	( )	( )	( )
mothers	( )	( )	( )

8. Health & Nutrition Education

8.1 a) No. of meetings held for mothers at the center per month ( )
b) No. of home visits per month made by CIC ( ); or
No. of visits made to each beneficiary/month ( )

8.2 Topics covered under Nutrition & Health Education
1. _____
2. _____
3. _____
4. _____

8.3 What communication techniques do you use?

Talks	Discussion	Demonstration	Role-Play	Story	Charts	Films	Songs	Folk Love	Other
( )	( )	( )	( )	( )	( )	( )	( )	( )	_

9. Program implementation

9.1 What are the community activities that support MCH services that you undertake?

9.2 How many pregnant women have been registered since May 86?
How many children under 3 yrs. registered since May 86?
How many Gr. III & IV children registered since May 86?

9.3 Since May 1986
a) Services received by mothers. (Give No. of mothers)

TT	Fe&folic acid	Referrals	Rations
( )	( )	( )	( )

b) Services received by children / 3 yr. (No. of children)

Rations	Vit. A	Polio Vac.	DPT	Measels	BCG	ORT
( )	( )	( )	( )	( )	( )	( )

c) No. of discussions held with mothers on growth monitoring?_____

9.4 Were any special lectures/demonstrations on nutrition and health organized for local aides/mothers?_____
(Specify)

9.5 How much contribution (Rs.) do you collect/beneficiary/month ( )

9.6 Do you vary it depending on the ration ( )

9.7 How are these contributions used?_____

MOTHERS + OBSERVATION

	Mother 1	Mother 2	Mother 3	Mother 4	Mother 5	Mother 6
a) Time in Program	_____	_____	_____	_____	_____	_____
b) No. of children now enrolled?	_____	_____	_____	_____	_____	_____
c) No of children ever enrolled?	_____	_____	_____	_____	_____	_____
d) Do you always receive commodities in right amounts?	_____	_____	_____	_____	_____	_____
e) Have you been visited at home last month? How many times?	_____	_____	_____	_____	_____	_____
f) How often do you come to the center?	_____	_____	_____	_____	_____	_____
g) What service is most useful to you?	_____	_____	_____	_____	_____	_____
1. Understands the growth chart	_____	_____	_____	_____	_____	_____
2. Knows ORT formula	_____	_____	_____	_____	_____	_____
3. Understand the need for immunization	_____	_____	_____	_____	_____	

OBSERVATION

1. Storage Adequacy

Yes or No:

( ) Pallets	( ) Screens	( ) Ventilation	( ) Enough space
( ) Infestation signs	( ) Open torn bags	( ) Contaminated supplies in area	( ) Unclean room

Other _____

2. Record Keeping (Distribution & growth monitoring)
Validity _____

Duplication _____

3. Distribution of food if observed _____

_____

4. Growth monitoring skills, if observed or checked _____

	Poor	Fair	Good	V. good
a. Weighing Child	( )	( )	( )	( )
b. Plotting weight on chart	( )	( )	( )	( )
c. Interpretation of growth chart	( )	( )	( )	( )
d. Counselling mother on child growth	( )	( )	( )	( )

5. Determining grade of malnutrition: _____

6. Knowledge about important nutrition messages.

a. breast feeding _____ b. ORT _____

c. Child growth _____ d. Suppl. feeding _____

e. Additional food requirement for prognant & lactating mothers

_____

7. Materials available for training & health education.

_____

_____

8. Contact with mothers? _____

_____

9. Knowledge & skill of local aides in health & nutrition education? _____

LOCAL AIDE

1. EDUCATION, TRAINING AND TASKS

1.1 What is your educational level? _____

1.2 Have you had any training for your work? ( ) Yes ( ) No

a) Who gave the training, when and how long? _____ _____

_____

b) What was it? _____

1.3 What kind of (further) training would help you? _____

1.4 How long have you worked here? ( )

1.5 a) How many days full time? ( )
b) How many days part time? ( )
do you work each month

1.6 What are your main tasks?

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

How much time do you devote to each?

1.7 What other employment/occupation do you have? _____

2. SUPERVISION

2.1 Who supervises your work? _____

2.2 Describe how often, what kind, whether adequate

_____
_____

2.3 Do you feel you get adequate guidance and in your work? _____

who from? _____

3. SELECTION OF BENEFICIARIES

a) Do you recommend mother/children for inclusion in the program? ( ) Yes ( ) No

b) If yes, what criteria do you use for selection?
( ) Nutritional Status ( ) Income ( ) Other

Appendix A-5

Centers Visited and Distances

Zone	Consignee	Centers Completed	Dist. from Consignee KM
Bombay	Ajmer	1. Jaipur, Sisters of Charity	N.A.
		2. Madal	"
		3. Matikera	"
		4. Pasupalnikar	"
	Indore	1. Holy Cross Rural Health Center	22
		2. Jhabua, Fr. George Payatikat	150
		3. Community Health Center Christian Hospital	200
		4. Missionaries of Charity, Indore Slums	2
		5. Ishgarh-Pipla	158
		6. Dhani	120
		7. Panchkui Center	169
		8. Meghnagar	162
	Nagpur	1. Karuna Niwas Health Center, Mansar	40
		2. Mrs. Leela Chitale	10
		3. St.Joseph's Convent, Padri Thana	45
		4. Providence Convent, Phuttara	6
		5. Asha Bhavan	5
		6. Jaitala	11
	Nadiad	1. Eye Hospital,Chikodra	30
		2. Umreth	25
		3. Our Lady of the Pillar Hospital	1
		4. Matar	20
		5. Nirmal Samaj Kendra	60
		6. Gothada	65
		7. Nadiad Urban Center Plus 1 center attempted	
Cochin	Alleppey	-	
	Trivandrum (1)	1. Balarampuram	15
		2. Muttathara	20
	Trivandrum (2)	1. Udayankulangara	45

Madras	Mysore	1. Vimalalaya+	40
		2. Little Flower Center	5
		3. Kalenhelli, Mandya	40
	Trichy	1. Ammapettai	30
		2. Subramaniapuram+	7
		3. Keelamullaidudi+	10
		4. Amali Seva Illam	3
	Kumbakonam	1. Papanasam+	17
		2. Sacred Heart Leprosy Center (Observed dist. only) Plus 1 center attempted	2
	Bangalore	1. Mariam Nilaya	15
		2. Chelikere+	12
	Hyderabad	1. Shadnagar (Distributor has subcenters in 15 villages; we visited 2)	50
	Secunderabad	1. St. Theresa's Hospital	13
		2. St. Francis of Assisi, Ramnagar+ Plus 1 center attempted	5
Calcutta	Tezpur	1. Sacred Heart Convent, Borgang	102
	Bariupur	2. N. Durgapar	35
	Seva Kendra	1. Andul Center	20
	Bhubaneswar (Khurda Road)	1. Kadar	35

+ 25% upgraded center

A. CRS FY 1987 MCH PROGRAM

1. Beneficiaries by Zone, FY 87 1/

Bombay	88,335
Calcutta	115,000
Cochin	195,583
Madras	286,417
Total	685,335

2. Projected Metric Tonnages of Commodity by Type, FY 87 2/

Bulgur	12,361
CSM	20,004
Oil	3,738
Total	36,103

3. Dollar Value of Commodities 2/

	($000)
MCH Commodities	$ 10,680
Ocean freight @ 40% of value	4,272
Total	$ 14,952

B. CRS FY 87 Beneficiaries in Total Program 1/

	Madras	Cochin	Calcutta	Bombay	Total
MCH	286,417	195,583	115,000	88,335	685,335
N & C	14,632	12,288	450	7,630	35,000
SF	29,766	-	62,167	27,767	119,700
OCF	32,730	10,710	12,106	25,754	81,300
IHC	9,645	5,125	59,625	6,905	81,300
FFW	45,310	-	47,050	81,910	174,270

1/ Source: CRS/Delhi, June, 1987
2/ Source: USAID

Appendix A-7

Distances

Zone of Consignee
(100%)

Zone	No. of Consignees	Range of Distance	Range of Distance
Bombay	43	15 to 1035 km	851 km
Madras	37	6 to 934 km	476 km
Calcutta	25	14 to 1623 km	937 km
Cochin	25	0 to 307 km	133 km

Consignee to Centers

(from sample of consignees visited)

Zone	Sampling of 12 Consignees	Number of MCH Centers	Average Distance to Centers	Average per Zone
Bombay	Indore	18	134 km	
	Nagpur	11	28 km	
	Nadiad	10	50 km	71
Madras	Mysore	24	66 km	
	Bangalore	21	42 km	
	Tiruchirapalli	36	32 km	
	Kumbakonam	53	69 km	
	Hyderabad	8	30 km	
	Secunderabad	10	53 km	49
Cochin	Allepey	35	15 km	15
Calcutta	Tezpur	20	166 km	
	Seva Kendra	33	95 km	130

Appendix A-8

Travel Itinerary - Teams 1 and 2

Entire Team

DAY - DATE	TIME		DETAILS
Fri. June 5	0500 1400	Lv. Delhi by car Arr. Ajmer	Meet with consignees
		NIGHT HALT: AJMER	
Sat. June 6	1400 1600	Lv. Ajmer by car Arr. Jaipur	Visit 4 centers
		NIGHT HALT: JAIPUR	
Sun. June 7	0500 1100	Lv. Jaipur by car Arr. Delhi	Rest
		NIGHT HALT: DELHI	
Mon. June 8		NIGHT HALT: DELHI JUNE 7 & 8	
Tues. June 9	0635 0925	Lv. Delhi: IC 433 Arr. Indore	Meet with consignee; visit 2 centers
		NIGHT HALT: INDORE	
Wed. June 10	0800 2200	Lv. Indore by car to Dhani and Jhabua Arr. Jhabua	Observe distribution at Dhani; meet with CIC, Local Aides, MCH Coordinator
		NIGHT HALT: JHABUA	
Thurs. June 11	1440 2200	Lv. Jhabua by car Arr. Baroda	Visit 5 centers; meet with Nadiad consignee
		NIGHT HALT: BARODA	
Fri. June 12		Baroda, environs, by car	Visit 4 centers; attempt 2 others
		NIGHT HALT: BARODA	
Sat. June 13	2305 2355	Lv. Baroda IC 190 (flt. delayed) Arr. Bombay	Visit 3 centers

NIGHT HALT: BOMBAY

Sun. June 14	1735 1845	Lv. Bombay IC 270 Arr. Nagpur	Rest

NIGHT HALT: NAGPUR

Mon. June 15		Nagpur visits	Visit consignee; Visit 3 centers
Tues. June 16	1445 1605	Lv. Nagpur, IC 269 Arr. Bombay	Visit 3 centers

NIGHT HALT: BOMBAY

Wed. June 17			Meeting with Zonal Staff
	1730 1900	Lv. Bombay IC 107 Arr. Bangalore Drive to Mysore by Car	
	2000 2300	Lv. Bangalore Arr. Mysore	

NIGHT HALT: MYSORE

Thurs. June 18	1300	Lv. Mysore to Bangalore by car	Visit consignee; Visit 3 centers
	1900	Arr. Bangalore	
	2000	Lv. Bangalore IC 510	
	2050	Arr. Madras	

NIGHT HALT: MADRAS

Fri. June 19	0605 0650	Lv. Madras, IC 501 Arr. Trichy	Visit consignees; Visit 4 centers

NIGHT HALT: TRICHY

Sat. June 20		Drive to Kumbakonam by car Return Trichy	Visit consignee; Visit 1 center two others attempted
Sun. June 21	0715 0905	Lv. Trichy, IC 501 Arr. Madras	Rest

NIGHT HALT: MADRAS

Mon. June 22	1815	Lv. Madras by train	Meeting with FFW and USAID; meeting with Zonal Staff
Tues. June 23	0600	Arr. Cochin Drive to Trivandrum by car	Meeting with Zonal Staff Visit consignee
	1100	Lv. Cochin	
	1845	Arr. Trivandrum	

Team One

NIGHT HALT: TRIVANDRUM

Wed. June 24	1125	Lv. Trivandrum IC 530	Visit consignee
	1225	Arr. Bangalore	

NIGHT HALT: BANGALORE

Thurs. June 25	1405	Lv. Bangalore, IC 272	Visit 2 centers;
	1505	Arr. Hyderabad	Visit consignees

NIGHT HALT: HYDERABAD

Fri. June 26		Work in Hyderabad	Visit 1 center; two subcenters; visit consignee
Sat. June 27	2000	Lv. Hyderbad, IC 539	Visit 2 centers
	2200	Arr. Delhi	

NIGHT HALT DELHI

Team Two

NIGHT HALT - TRIVANDRUM

Wed. June 24		Work in Trivandrum	Visit 2 centers; Visit 2 consignees

NIGHT HALT - TRIVANDRUM

Thurs. June 25	1125	Lv. Trivandrum by IC-530
	1230	Arr. Madras
	2015	Lv. Madras IC-266
	2220	Arr. Calcutta

NIGHT HALT: CALCUTTA

Fri. June 26		Work in Calcutta	Meeting with Zonal Staff
Sat. June 27	1130 1330	Lv. Calcutta by IC-213 Arr. Tezpur	Visit consignee

NIGHT HALTH: TEZPUR

Sun. June 28	1335 1745	Lv. Tezpur by IC-213 Arr. Calcutta	Visit one center
Mon. June 29		Work in Calcutta and Bhubaneswar	Visit 2 consignees and 2 centers.

NIGHT HALT: CALCUTTA JUNE 28 & 29

Tues. June 30	1720 1950	Lv. Calcutta by IC-402 Arr. New Delhi	Visit one consignee and one center

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Appendix A-9

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5. Joyce King, Polly Harrison, Bonani Kakkar, Hope Sukin, Program Review of CARE MCH (ICDS and SNP) Title II Program in India, October, 1986.

6. David E. Sahn. The Integrated Maternal and Child Nutrition Project in India: Recommendations Based on a Review of Past Experiences, November, 1980.

7. United States Government Audit Report, March 27, 1984.

8. USAID/Office of Food and Development Resources, Recent Review Reports of Catholic Relief Services Zonal Programs.

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INDORE DIOCESE

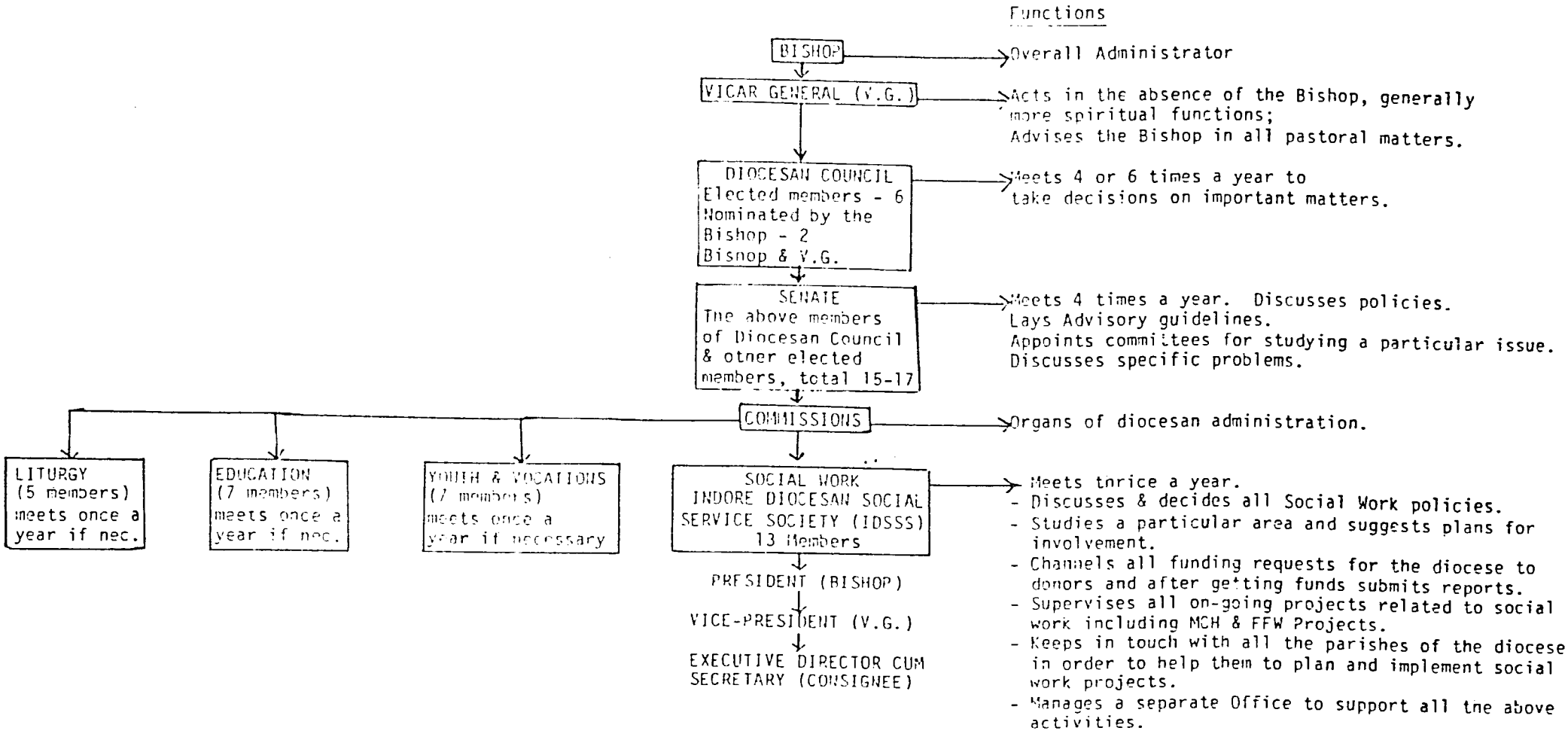
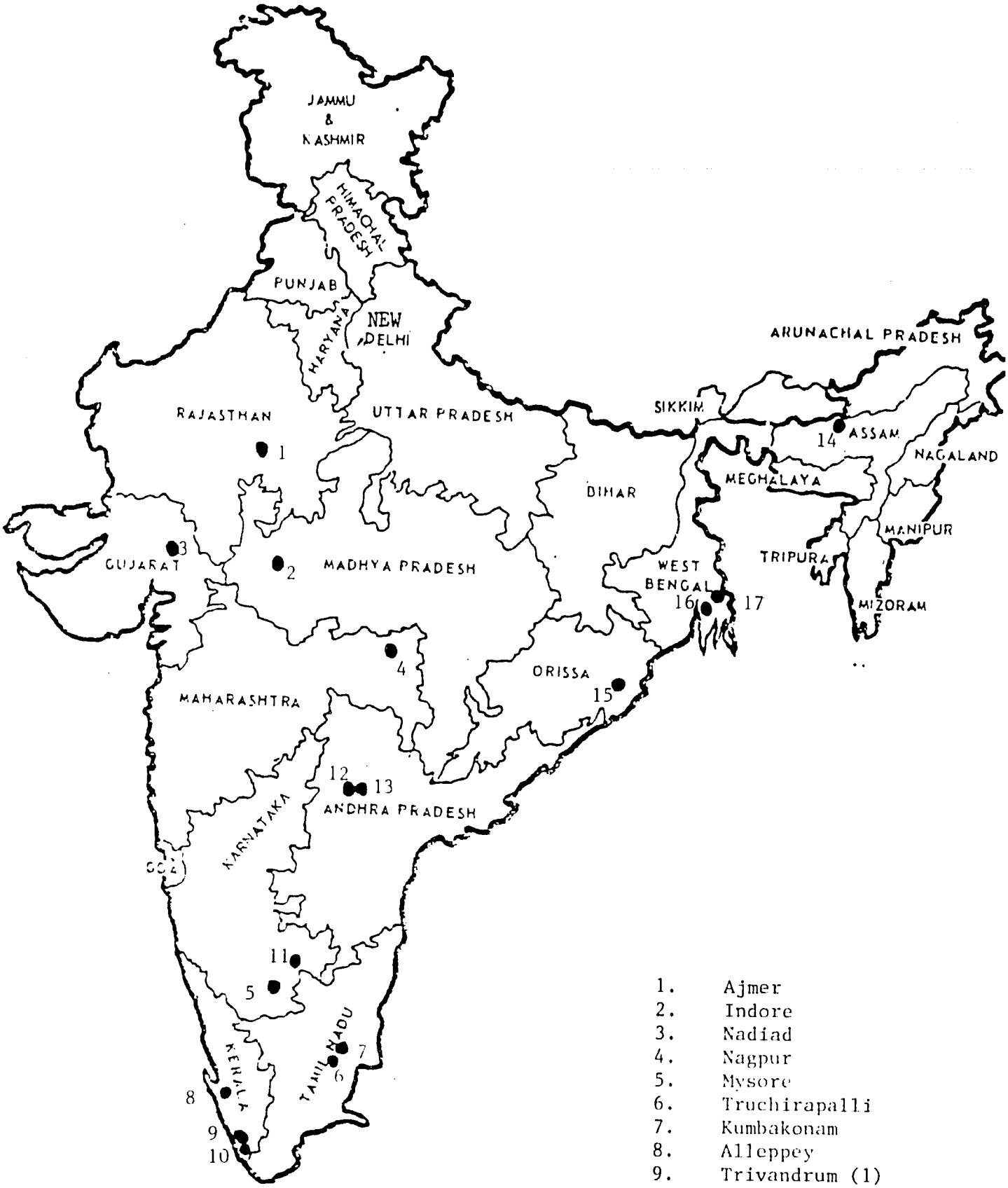


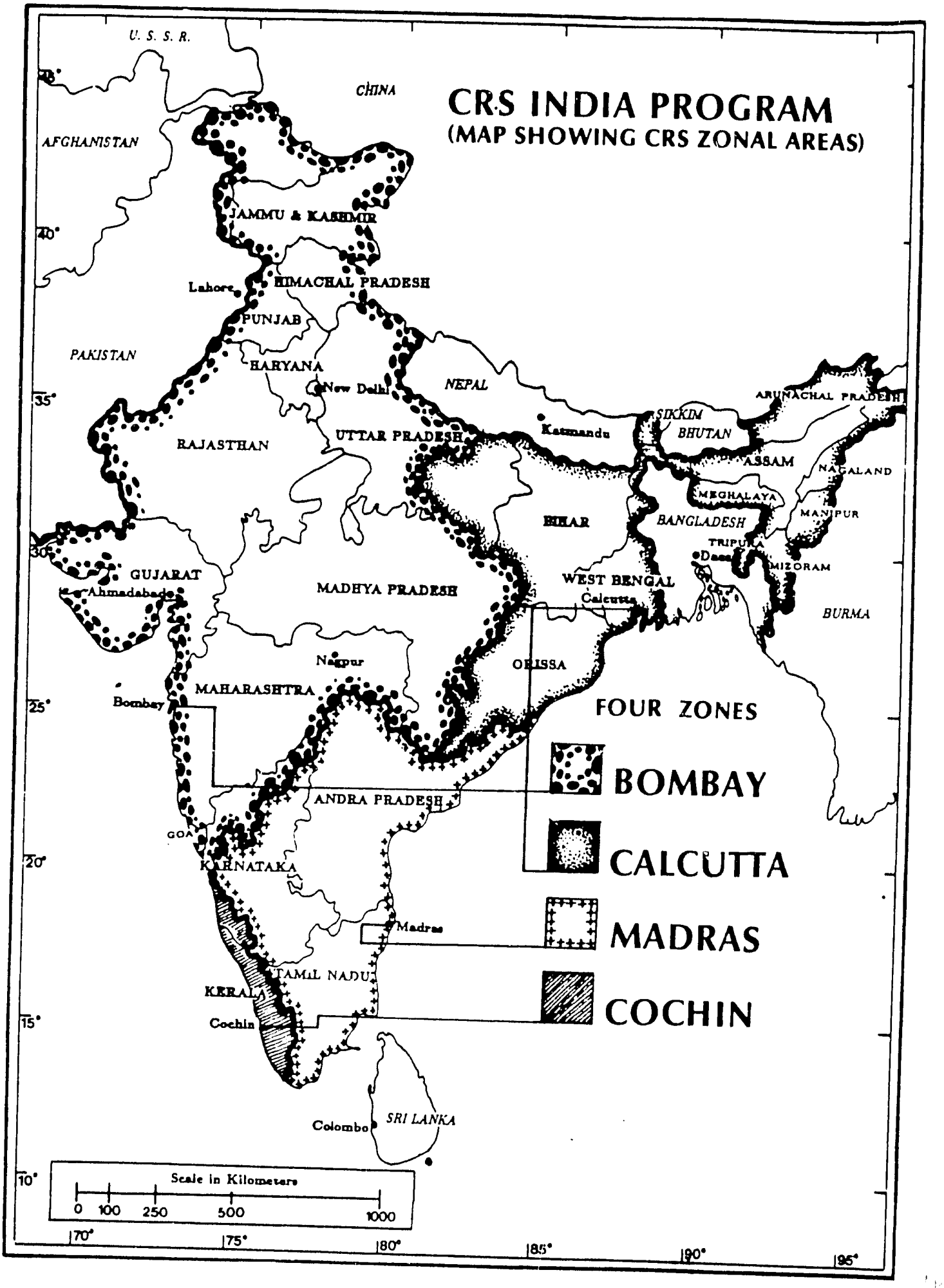
Figure F2

MAP OF CONSIGNEE SITES VISITED



1. Ajmer
2. Indore
3. Nadiad
4. Nagpur
5. Mysore
6. Truchirapalli
7. Kumbakonam
8. Alleppey
9. Trivandrum (1)
10. Trivandrum (2)
11. Bangalore
12. Hyderabad
13. Secunderabad
14. Tejpur
15. Khurda Road
16. Seva Kendra
17. Baruipur

Figure F.3


CRS INDIA PROGRAM
(MAP SHOWING CRS ZONAL AREAS)
U. S. S. R.
CHINA
AFGHANISTAN
JAMMU & KASHMIR
HIMACHAL PRADESH
Lahore
PUNJAB
PAKISTAN
HARYANA
New Delhi
NEPAL
Kathmandu
SIKKIM
BHUTAN
ARUNACHAL PRADESH
RAJASTHAN
UTTAR PRADESH
ASSAM
NAGALAND
MEGHALAYA
BIHAR
BANGLADESH
MANIPUR
TRIPURA
Dacca
MIZORAM
GUJARAT
Ahmadabad
MADHYA PRADESH
WEST BENGAL
Calcutta
BURMA
Nagpur
ORISSA
MAHARASHTRA
Bombay
FOUR ZONES
BOMBAY
ANDRA PRADESH
GOA
CALCUTTA
KARNATAKA
Madras
MADRAS
TAMIL NADU
KERALA
Cochin
COCHIN
Colombo
SRI LANKA
Scale in Kilometers
0 100 250 500 1000
40°
35°
30°
25°
20°
15°
10°
70°
75°
80°
85°
90°
95°