

**USAID/INDIA**  
**STRATEGIC OBJECTIVE CLOSE OUT REPORT**

**1. Basic Information**

SO Name: **Improved Child Survival and Nutrition in Selected areas of India**  
 SO Number: 3  
 SO Period: FY1994-2002  
 Geographic Area (Code): India (386)

States:

Andhra Pradesh, Assam, Bihar, Chhattisgarh, Dadra & Nagar Haveli, Gujarat, Himachal Pradesh, Jharkhand, Madhya Pradesh, Maharashtra, Manipur, Meghalaya, Nagaland, Orissa, Rajsathan, Uttar Pradesh, and West Bengal.

Total Cost of SO:

(In Dollars)

Type/source	CARE	CRS	Activities/Projects	Total
Title II commodities	400,195,159	156,604,800	-	556,799,959
Monetization	18,905,075	-	-	18,905,075
Farm Bill (202 e)	2,935,252	8,363,766	-	11,299,018
Container funds	372,789	-	-	372,789
World Food Program	219,659	-	-	219,659
Other DA funding	-	-	35,179,000	35,179,000
<b>Total</b>	<b>422,687,934</b>	<b>164,968,566</b>	<b>35,179,000</b>	<b>622,835,500</b>

**2. Principle Implementing Partners:**

Bilateral Projects and Title II:

1. CARE
2. Catholic Relief Services
3. CICI Bank Limited
4. Innovations in Family Planning and Services (IFPS)

Under Field Support

CARE/India and CRS/India, OMNI, MOST, Health Tech Program for Appropriate Technologies in Health (PATH) Commercial Marketing Strategies Project, The Futures Group

**3. Background to SO3:**

One-third of India's nearly one billion people lack adequate food. More than half of India's young children (73 million) are underweight and chronic maternal malnutrition is high one of every nine children dies before the age of five. Infant and child mortality rates are very high. Poor access to health care, high illiteracy rates and poor nutrition and health practices contribute to the high mortality and malnutrition. Because poor women and children, particularly in remote rural and tribal areas, have the greatest mortality risks, the purpose of this SO was to reduce the high levels of child mortality and malnutrition. The major activity that contributed to this SO was the P.L. 480 Title II program, implemented by CARE and Catholic Relief Services (CRS). The program reached more than seven million women and children by integrating Title II commodities and other Government of India (GOI) and non-governmental resources in the program. Through

the GOI's Integrated Child Development Services (ICDS) program, (India's equivalent of Head Start), CARE worked across 110,000 village centers, CRS worked through private registered social service societies including programs managed by Mother Teresa's and the Dalai Lama's organizations, reached those women and children, not reached by the GOI's ICDS program.

The Program for Advancement of Commercial Technology/Child and Reproductive Health (PACT/CRH) provided support for technologies aimed at improving child survival while increasing commercial marketing and distribution of quality child survival products and services, such as Oral Rehydration Salts (ORS). Nearly one-fifth of the child deaths are due to diarrhea, a substantial proportion of which can be prevented by the use of ORS.

USAID, along with the World Bank, funded a large Deworming and Enhanced Vitamin A (DEVTA) trial. The trial covered 8,000 villages and about one million children. The study results are awaited and will determine the impact of enhanced Vitamin A coverage and deworming on mortality and growth of children. It will also provide a sustainable model for improved delivery of micronutrient, including Vitamin A. USAID plans to fund additional research that will inform government policy on Vitamin A and anemia control programs.

### 3.1 Intermediate Results

This SO had three intermediate results (IR) as shown below.

a). **I.R.1:** Increased use of key child survival interventions:

**Indicators:**

1.1: Percentage of children 12-23 months old, in program catchment area, fully immunized by age one. This is reported during baseline, mid-term and final evaluations of the program

1.2: Average number of anganwadi centers (AWCs) or village feeding centers conducting at least one monthly, Nutrition and Health (NH) day with take-home ration and immunization/ante-natal check-up. This is reported annually.

b). **I.R. 2:** Improved maternal and child nutrition:

**Indicators:**

2.1: Percentage of pregnant women, in program catchment area, delivered in the past year, who received 90-100 IFA tablets. This is reported during baseline, mid-term and final evaluations of the program.

2.2: Number of counterpart personnel and community members given training in nutrition and health topics. This is reported annually.

c). **I.R.3:** Improved targeting of at-risk populations:

**Indicators:**

3.1: Percentage of children under two (6-23 months old) in program catchment areas, enrolled in the supplemental food program. This is reported during baseline, mid-term and final evaluations of the program.

3.2: Percentage of children 6-23 months old in program catchment area enrolled for take-home rations (THR). This is reported annually.

The Achievement of the IR indicators (at the end of the SO period) are:

Indicator	Target	Achieved
Percentage of children 12-23 months old, in program catchments area, fully immunized by age one.	34	57

Average number of AWCs conducting at least one monthly, NH day with THR and immunization/ante-natal check-up.	40	43
Percentage of pregnant women, in program catchment area, delivered in the past year, who received 90-100 IFA tablets	35	37
Number of counterpart personnel and community members given training in nutrition and health topics	79	92
Percentage of children under two (6-23 months old) in program catchments area, enrolled in the supplemental food program	40	64
Percentage of children 6-36 months old* in program catchments area enrolled for THRs	80	95

\*The indicator was modified to include children 6-35 months old. This was done to reconcile with the ICDS age group classifications.

### 3.2. Activities/Projects under the SO:

**Integrated Nutrition and Health Project (INHP):** The INHP of CARE/India worked with government and non-governmental counterparts to improve the health and nutritional status of women and children. Working within the broader mandate and scope of the Indian Ministry of Human Resource Development/Department of Women and Child Development's ICDS and the Ministry of Health and Family Welfare, the program focused on activities with the greatest potential to improve health and nutritional status of pregnant women, adolescent girls and children under two. The program interventions included, targeted supplementary nutrition to pregnant women, lactating mothers and children under twos, immunizations to children under two years and pregnant women and antenatal care. The program was implemented in 748 ICDS blocks of eight states (Andhra Pradesh, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh and West Bengal) and reached 6.9 million beneficiaries through a network of approximately 100,000 village level centers called AWCs. This activity is continuing under SO14 of the Mission current strategy.

**Safe Motherhood and Child Survival Program (SMCS):** CRS India implemented the SMCS program in 13 states across the country, serving 182,121 pregnant and nursing mothers and children of 0-3 years of age from around 3,169 villages. The SMCS program has been implemented through a network of around 600 local partner agencies, primarily the social service wing of the dioceses. This network enabled CRS to reach out to remote areas which are inaccessible and under-served. The ultimate goal of the program was to empower women to address their own health needs as well as those of their children and communities.

**PACT/CRH:** PACT/CRH is a twelve-year (1984-2007) \$29.8 million collaborative project with the ICICI Bank, which is one of the largest financial institutions in India. The goal of this project is to increase the use of reproductive and child health (RCH), and HIV/AIDS related products and services through the private sector. Objectives of the project are (i) Introduce and commercialize new RCH and HIV/AIDS technologies, and (ii) Improve quality and use of private sector, primarily commercial sector RCH and HIV/AIDS products and services. The project approaches are: (i) small grants for private sector activities (ii) concessionary loans for private firms; (iii) demand creation through commercial advertising; (iv) technical support for new technologies, marketing, and quality control; and (v) improvement of policy environment for commercial sector service delivery

Under the PACT project, the ORS campaign was successful in creating awareness both among mothers and doctors about the World Health Organization (WHO) formula ORS and increasing the market for WHO-ORS by 47% from 4 m liters in 2001 to 5.9 m liters in 2002, and the total ORS market by 17% 19.1 m liters in 2001 to 22.4 m liters in 2002. The use of ORS in the project area grew from 26% in 1998-99 to 29% in 2002.

**IFPS:** IFPS project complemented SO 3 efforts in the state of Uttar Pradesh (UP) after incorporating a 1998 midterm review recommendation to broaden its agenda to reproductive health approach. Key additional child health interventions were maternal iron-folic acid (IFA), tetanus (TT) immunization for pregnant women and provisioning of child immunization camp.

**Campaigns to provide Tetanus Toxoid (TT) and Iron Folic Acid (IFA) to pregnant women:**

Special six-monthly statewide drives were undertaken to identify and enroll all pregnant women for reproductive health services, particularly TT immunization and IFA supplementation. As a result, TT and IFA coverage among pregnant women increased significantly, maternal TT coverage in UP increased from 41% in 1998 to 63% in 2003, while IFA coverage has increased from 20% to 34% in the same period.

**Integrated services through reproductive and child health camps to provide:** Sterilization camps have been part of India's family planning program for many years, these camps under IFPS were expanded to provide integrated RCH services (i.e., gynecological check-up, child examination and immunization, family planning counseling and services). These camps:

- provided an array of maternal, child health and family planning services under one roof,
- assured services following a predetermined calendar, and
- combined the benefits of rural outreach and high quality services.

Nearly 48,000 RCH camps have been funded under the IFPS project over a six-year period from 1998. On an average, 100 clients attended each camp and more than half of these accessed integrated RCH services.

#### **4. Impact:**

The project activities funded under this SO have been evaluated. Title II results that contributed to the SO performance indicate success in integrating food aid resources with complementary health care services provided through the GOI and non-government organization (NGO) resources. The evaluation findings indicate that SO 3 has reached its objectives considerably. Refer to the data under 1.1 for impact.

#### **5. Changes in the Results Framework during the life of the SO:**

The Result Framework was revised during the implementation of the SO. Revisions were made to accurately reflect the SO progress.

#### **6. Prospects for sustainability and threats:**

The activities under the current SO are being continued in the new Mission Strategy under SO 14: Improved Health and Reduced Fertility in Targeted areas of India.

#### **7. Evaluations, Assessments and Lessons Learned**

##### **7.1 Evaluation:**

Results of the final evaluation of the five-year program (1997-2001) of CARE conducted during FY 2001 are encouraging. All indicators show an upward trend over the baseline and have exceeded targets. These indicators provide evidence that the program strategy of integrating food and ancillary health services to improve women's and children's health was successful. The strategy helped to institute processes and build capacities that have led to improved program implementation, coverage and community ownership. The program has influenced GOI's policy regarding the ICDS program. In the CARE program, the malnutrition rates were decreased by six percentile points. Immunization rates for children increased from 18% to 57%; iron-folate supplementation rates for pregnant women went from 13% to 37%; timely complementary feeding

rates for infants improved from 46% to 67%; and the supplementary feeding coverage of children under two years expanded from 40% to 64%.

In the CRS program, the malnutrition rates among children less than two years age group was reduced by two percentile points. Immunization rates for children (12-23 months) increased from 26% to 46%, timely complementary feeding rates for infants from 44% to 70% and the supplementary feeding coverage of less than two expanded from 68% to 84%.

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## **7.2 Achievements:**

CARE's THR strategy was successful in improving coverage rates of the priority target groups of children under three and pregnant and nursing mothers. 86% of the beneficiaries reached by the CRS program belonged to the most disadvantaged sections of society i.e. Scheduled Caste and Schedule Tribes.

The success of key strategies and processes under CARE's INHP has led to change in government ICDS policy in several states. Some examples are:

- All the state governments have issued orders for universalizing the THR concept to all INHP areas.
- Several state governments issued orders to institutionalize NH days, during which THR are distributed and health service providers are on-site to provide basic health services like immunizations and/or ante-natal care, including distribution of iron-folate (IF) tablets. Because of the success of the CARE/ICDS program, the government of Madhya Pradesh has asked CARE for help in expanding NH days to cover all ICDS projects.
- CARE instituted ICDS and Department of Health advisory committees at the state, district and the block levels. The committees are proving extremely effective in planning, problem solving and coordination between different GOI and state government agencies.
- CARE's INHP best practices and case studies are being incorporated into several state government training institutions' curricula for medical functionaries.

## **7.3 Lessons Learned**

### **Convergence:**

- Regular NH days held at village level lead to improved coverage of key services
- Joint training sessions to Department of Women and Child Development (DWCD) and Department of Health and Family Welfare (DHFV) service providers promote convergence and cooperation between functionaries of these two departments
- Block and district level working group meetings, involving key Government and community institutions, have been successful for promoting best practices and joint problem solving
- Block resource mapping and joint planning are useful approaches to improve service delivery

#### **7.4 Targeting and behavior Change:**

- Targeting only women of reproductive age with behavior change messages and health information limits impact, as these women are rarely key decision makers in households and communities, therefore men, mothers-in-law and other decision makers must be included
- Supplemental feeding through take-home rations (as opposed to on-site feeding at AWCs) is a critical strategy for reaching pregnant and lactating women and children under two
- Most service providers lack adequate counseling and behavior change skills and traditional approaches to sharing nutrition and health messages are not resulting in desired behavior changes
- Social mapping was found to be a useful tool in identifying and reaching community members who were eligible for but not participating in the DWCD and DHFW activities. Development of a cadre of volunteer village change agents can lead to improved household level practices as these individuals serve as a link between families and service providers
- Community groups are more sustainable when engaged in productive activities as well as health and nutrition activities; successful models include group involvement with grain banks, health financing and local food production models
- Community-based monitoring (including of food distribution) improves acceptance of new health practices and demand services

#### **7.5 Scale-up and Replication:**

- The District Collector can be a powerful ally and the district is a good level for promoting the replication of successful strategies
- Cross visits of key government staff to learn about successful models first-hand can significantly contribute to replication of best practices
- Joint DWCD and DHFW working group meetings at block, district and state levels facilitate joint planning and replication of successful strategies
- Advocacy efforts at the state and national levels, based on field level experience, are critical for promoting best practices
- There are significant government and donor resources which can be leveraged for capacity building and systems improvement efforts

#### **7.6 Project Management:**

- NGO partnership requires a significant investment of time and resources and therefore partners should be carefully selected and it should be considered as a medium to long term strategy
- The monitoring system should include process indicators that are closely tied to outcomes, management indicators and more agile techniques like mini-surveys because frequent collection of impact or outcome data through large surveys has proven costly, time consuming and unnecessary
- There is a need to develop better practices and models in key areas such as behavior change, reaching hard-to-reach populations, reaching adolescents, and improving gender equity



## **APPENDICES**

### **Appendix 1**

**(A list of evaluations and special studies conducted during the life of the SO, including Annual Reports)**

#### **CARE & CRS:**

Results Reports for five years (1997-2001)

Mid-term evaluation report (1999)

Final evaluation report (2001)

### **Appendix 2**

**(A list of instrument close out reports prepared for contracts, grants, and cooperative agreements)**

Close-out reports are maintained by Regional Contracting Office, USAID/India. For any information, please contact Mr. Marcus Johnson, Regional Contracting Officer, Marcus Johnson (mjohnson@usaid.gov)

### **Appendix 3**

**(Names and contact point of individuals who were directly involved in various phases of the SO (planning, achieving, and assessing and learning), and who would be good sources of additional information)**

Ashi K. Kathuria, Deputy Office Director, Office of Social Development, USAID/India

Ramesh Babu, Senior Program Manager, Office of Social Development, USAID/India

Sheena Chhabra, Division Chief – Health Systems, PHN Office, USAID/New Delhi

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If you wish to contact any of the above individuals or if you would like any additional information about this SO please contact Ms. Ashi K. Kathuria at Tel# 2419-8709 or e-mail: akathuria@usaid.gov