

**Midterm Review of the Reproductive, Child Health, Nutrition and
HIV/AIDS Program
(RACHNA)**

Written by

Jack Reynolds, Team Leader
Alfred Bartlett
Bruce Cogill
Harsh Mander
Subadra Seshadri
Sundararaman
Rajani Ved

Prepared for

CARE/India

March 2005

EXECUTIVE SUMMARY

RACHNA, INHP-II and Chayan . RACHNA (Reproductive and Child Health, Nutrition and HIV/AIDS) is CARE's new program umbrella that consists of two projects. The first is INHP-II (Integrated Nutrition and Health Project), which provides basic food, child health and nutrition information and services. INHP-II is underway in 78 districts in nine states (Andhra Pradesh, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh and West Bengal). The second is Chayan, a relatively new project that deals with reproductive health and HIV/AIDS. The rural component of Chayan provides reproductive health information and referrals in 29 districts in four of the same states as INHP-II: Chhattisgarh, Rajasthan, Uttar Pradesh and Jharkhand. The urban component of Chayan (which provides HIV/AIDS information and referrals for high-risk groups and youth) is underway in 21 cities in the four states, as well as in selected slums of Delhi.

The operational model of RACHNA consists of demonstrating practical problem-solving approaches for behavior change and improved service coverage in about 10 percent of the project AWCs and replicating lessons learned from these demonstrations in the remaining 90 percent of the AWCs.¹ Four "best practices" are replicated in INHP sites to facilitate demonstration and implementation: Nutrition and Health Days (NHDs), change agents, community-based monitoring systems (CBMS), and block level resource mapping (BLRM). Chayan has four best practices, also: reproductive health change agents (RHCA), peer educators, community stakeholder groups and youth resource centers (YRC). Both demonstration and replication activities are implemented through government systems (ICDS and RCH).²

RACHNA achievements to date. Overall, RACHNA has done very well, especially in helping ICDS and HFW to bring basic child survival interventions to scale in the majority of the 95,000 Anganwadi Centers (AWCs) in priority communities in 8 of the 9 project states. In doing so the program has had to overcome a number of unanticipated obstacles, the most significant of which was the loss of half of its Title II resources in 2003 and an accelerated graduation schedule. RACHNA has done remarkably well in helping the government transition from Title II to local food provision and is also on track to graduate 25 percent of its 747 blocks by the end of September 2006.

At the operational level the most impressive best practices in INHP-II have been the NHDs and the change agents, although as of the 2004 RAP surveys, only 50 percent of the AWCs had NHDs the previous month with THRs and immunizations/ANC, and only 30 percent of the AWCs had change agents. Overall achievements go well beyond replication and scaling up of the core best practices and include successfully addressing the food transition issue, encouraging community involvement, supporting self-help groups (SHG), promotion of local food models (LFM) to produce suitable local foods, engagement of government systems, improvements in behavioral change communication (BCC), improvement in program systems (logistics, M&E,

¹ INHP covers 747 blocks in the 9 states. Each block has about 100 AWCs

² Integrated Child Development Services, and Reproductive and Child Health.

capacity development, etc.), and improvements in coverage of project health interventions.

INHP-II achievements are seen in delivery, newborn care, immunization, nutrition and food supplementation. INHP-II has done particularly well in such areas as consumption of IFA (iron and folic acid) tablets adoption of the “five cleans,” in delivery, avoiding to put anything on the cord after it is cut, early breastfeeding, measles vaccination, fully-immunized children, exclusive breastfeeding to six months, introduction of semisolid food and supplementary feeding. Improvements can be made in such critical areas as consumption of Vitamin A, tetanus toxoid doses, ANC visits, birth planning, drying and wrapping of the newborn, BCG and DPT vaccinations. Delivery by skilled attendants, while not a project intervention, should be encouraged as much as possible, perhaps as part of birth planning.

Chayan achievements. Chayan has been operational for only 18 months, so there are no data yet on its outcomes, which cover birth spacing, RTI/STI screening and referral, and HIV/AIDS prevention for youth and high-risk groups.. So far, Chayan has met all of its milestones. However, this is a new project for CARE and represents some significant opportunities for CARE as well as some challenges. For example, the “best practices” need to be further refined and validated, the roles of community stakeholders and youth centers need to be clarified and procedures set up to enable them to work effectively. There are also significant differences between the rural and urban environments in which Chayan operates. The rural INHP “platform” is appropriate for the addition of birth spacing and STI referral. It could be further strengthened by mainstreaming gender and quality of care issues. The urban intervention, on the other hand, does not have a platform or a well-defined counterpart. The youth and HIV/AIDS components, in particular, need much more development work. The urban component also has to deal with the lack of a government health MIS and basic services. Finally, the urban program will need to establish relationships with new organizations, notably, the national and state AIDS control societies and develop a strategy for scaling up and handing over the models it develops. Nonetheless, Urban Chayan, has initiated intervention activities among high-risk population in most of the locations that were planned and has drawn in the communities that are being intervened. Evidently, these are one of the few interventions that are well conceived and initiated in urban areas where HIV prevalence still seems to be low.

Community participation, gender and social equity. RACHNA has a strong community participation component but it could be strengthened and made more explicit. RAP data show that women in the lower socio-economic classes (SES) are being reached, however, the integration of gender and social equity could be improved, as well, which would strengthen program coverage of the most vulnerable and needy sub-populations.

The overall observation of the MTR Team is that community workers, institutions and processes are in place in a majority of demonstration and replication sites, although their quality is not uniform. The expected graduation and sustainability targets may not be uniformly feasible by 2006, especially if there are gaps in change agents and NHDs. A longer phase of capacity building of community agents and institutions in community processes may be required to implement the various community participation initiatives set out in the strategic plan. Note that

only 20 percent of the CBOs and/or PRIs participated in NHDs in 2004.³ The team recognized the tradeoff that RACHNA faces in pursuing community participation, gender and social equity issues versus bringing the basic model to scale. However, the team also believes that if greater attention were given to these issues that could enhance both the impact and sustainability of RACHNA's approach.

Management is excellent. Although the team did not explore this in depth, it was able to conclude that the change to District Teams has worked out very well.

Monitoring and evaluation are also very good. The various M&E data sources (routine MIS, rapid assessments, and the neonatal evaluation research) are extremely valuable to national, state and district management staff. Improvements are needed, however, in standardizing the overall conceptual framework, including accompanying objectives and indicators, now that IHNP and Chayan are part of the same project. A MIS is needed for Chayan, especially in urban areas. Systems that can provide periodic outcome data at block and district levels would also be helpful. There is also a need to standardize the samples so that baseline, panel and endline data are comparable.

Prospects for 2006. The food transition is well underway and looks to be successful so far. RACHNA is on target for reaching its replication goals. The graduation goal is also on target. Some 25 percent of the blocks are expected to "graduate" from CARE support by the end of 2006. Graduation processes are underway but this area needs to be looked at carefully in terms of viability and schedules. Sustainability needs to be built into every block that is graduated to make sure that they are able to continue and conform to minimal service standards. In terms of its performance outcome targets, the project should easily reach seven of them (early breastfeeding, exclusive breastfeeding to six months, commencement of solid foods, and all four supplementary feeding indicators). Another two are possible (receipt of IFA tablets, timely completion of measles vaccinations). Four others look unlikely unless they receive a great deal more attention (birth plans, TT doses, drying and wrapping, and receipt of two doses of Vitamin A). INHP-II has already met one of its management objectives (training). The other six look to be within reach by the end of 2006.

Challenges for the current project. The Team identified eight broad challenges for the current program.

1. The first is **breadth vs. depth**. The Team believes that quantitative progress is being made (i.e., in achieving the numeric targets and milestones). However, only 30 percent of AWCs have change agents, one of the most critical and effective of the IHNP best practices. Qualitative progress is a challenge. Much needs to be done to improve, standardize, and monitor the quality of the replication sites. The challenge for CARE is to find the appropriate balance between achieving scale and ensuring the quality of the interventions that are taken to scale.
2. **Sustainable graduation** is a major challenge. CARE has developed a program that

³ The end-of-project target for this variable (Percent of NHDs where CBO and/or PRI participated last month) is only 30 percent.

- requires continued support including supervision, training, M&E and elements of commitment that are often difficult to sustain once graduation has occurred. The food transition has provided evidence that state governments and communities (including NGOs) are capable of supporting these programs. There is concern, however, that some blocks will be graduated prematurely and resources will be insufficient to maintain CARE's model. Although CARE may continue to provide indirect technical assistance by continuing to work with the district and state health and ICDS systems, the immediate challenge will be to determine how flexible to be in deciding when a given site is ready to graduate.
3. **Effective behavior change.** BCC is a major activity underlying the best practices and is the main pathway for influencing outcomes. CARE has done detailed work on BCC (including formative research and refinement of BCC messages with LINKAGES and others) but it was unclear if there is a process for determining which BCC measures/interventions actually result in the desired changes in behavior at the scale of the program in demonstration and replication sites. The challenge to RACHNA is to determine which BCC interventions work, which do not, and how to operationalize these processes in a large-scale program.
 4. **Outcome monitoring.** Process monitoring and panel assessments of outcomes are excellent and represent a model for both cooperating agencies and the Government of India. The flow of information from the implementers to Delhi and USAID is voluminous and comprehensive. However, local managers have expressed a need to have data that will tell them whether their inputs and processes are having the desired effect on outcomes in their blocks and districts. The challenge to the project is to determine how best to produce such data at a reasonable cost.
 5. **Health and Family Welfare ownership.** The success of the RACHNA model depends on involvement of HFW medical and paramedical providers and commitment by HFW officials at national, state and local levels. Although this seems to be going well in some districts and states, that is not the case throughout. CARE has done an excellent job of bringing HFW and ICDS together for joint planning and problem solving. The challenge to CARE is to use these convergence skills to co-opt HFW staff in all sites so that they accept RACHNA as their own project.
 6. **Effectiveness of the health systems.** Reliable health systems are critical to the success of RACHNA. This means reliable infrastructure, staff, medications, vaccines, information, logistics, and so on. The team found that INHP successes in mobilization and demand creation are negated when these elements of the health system are not provided as planned. Although the team realizes that CARE does not control the health system, the challenge is to find ways to improve the reliability of key HFW inputs needed to carry out RACHNA interventions.
 7. **Balance between community participation, content and technical support.** Community participation is another element that is critical to the success of the project. Although there are important community elements in RACHNA (e.g., change agents, self-monitoring, PRI, SHG, etc.) the program has put more emphasis on the technical

aspects of its interventions than empowerment of communities to take them over. To ensure community ownership of the interventions the challenge to CARE will be to balance its diverse components so that there is adequate support (both technical and community) to maintain, expand and sustain replication sites.

8. **Effective involvement of State AIDS Control Societies and the National AIDS Control Program.** Since the Urban Chayan is concentrating on the interventions among marginalized populations in low prevalence-high priority States, it poses an immense opportunity to build capacity for the State AIDS Control Societies and thereby preparing ground for scaling up. The challenge in catalyzing response of the State AIDS control societies depends on the level of involvement CARE seeks and solicits with the National AIDS Control Organization.

Recommendations for the current project. The following recommendations are quite broad. More specific recommendations will be found in the overview and the annexes. The team realizes that CARE will not be able to implement all of these recommendations. Thus, the team suggests that acceptance of any recommendation should be based on an assessment of the costs of implementing that recommendation and the expected benefits that would accrue to the project as a result.

1. **Continue INHP replication and graduation.** Rollout of the replication plan should be completed. Given the continuing changes in resource levels, CARE should review the replication and graduation strategies to ensure that phase-over plans will not only be realistic but will result in sustainable services.
2. **Continue to monitor the food transition,** including the continued provision of refined soybean oil (RSO) (this is the one which was approved by the GEAC), take home rations (THR) and adequate food for spot feeding under other funding sources.
3. **Fill critical gaps in the INHP health interventions** (e.g., ANC, inclusion of delivery by a skilled attendant in birth planning, cord care, immediate drying and wrapping, immunization availability, and Vitamin A). CARE should examine these gaps and the team's recommendations for closing them. It should then set priorities (based on cost and expected outcome improvement) to work on those gaps that when filled, will make the greatest difference.
4. **Fill critical gaps in demand, supply and enabling environment factors.** Priority areas are recruitment of change agents, BCC, more emphasis on practical capacity building, and routine collection of outcome data for managers.
5. **Strategic expansion of urban Chayan.**

Identifying and addressing the issue of SACS capacity through well planned capacity building measures, consolidation of program approaches through a structured process of problem identification and problem solving, contextualizing demonstration-replication and taking a call on implementation arrangements based on level of capacity and skill in each State, being there and showing the way forward for SACS to scale up and saturate in all urban locations in the State, strategic expansion by making strategic choices are well

worth investing in.

6. **Fill critical gaps in community participation, gender and social equity.** The RACHNA design calls for greater community participation than is happening at the moment. The same can be said for gender and social equity. In general, RACHNA needs to put more emphasis on both. The team believes that this will enhance outcomes and sustainability.
7. **Strengthen monitoring and evaluation systems.** Current procedures are excellent, but there are gaps that could be filled and opportunities for enhancing the phase over. These include providing relevant outcome data at the block and district levels, providing support to state governments in commodity monitoring systems, developing an MIS for Chayan, updating the project framework, adding more impact indicators, and desegregating data by gender and vulnerable groups (scheduled castes, tribes and the disabled). It would also be helpful to standardize the sampling procedures so that baseline, panel and endline data are comparable.

Future opportunities for CARE. CARE's leadership recognizes that it faces several critical choices regarding its long-term role and direction. The principal consideration is whether or not to expand its technical assistance role. The team identified seven options. Should CARE expand the current model to other sites; refine the current model; expand the health interventions; expand community participation interventions; increase policy and advocacy; provide TA in management; and/or provide TA in convergence?

The choices will depend, in part, on four factors: 1) CARE's organizational mission; 2) the mandate it is given by governments and donors; 3) available resources and the requirements that come with them; and 4) capacity requirements.

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal care
ANM	Auxiliary Nurse Midwife
AP	Andhra Pradesh
AWC	Anganwadi Center
AWW	Anganwadi Worker
BCC	Behavior change communication
BCG	Bacillus Calmette-Guérin vaccine
BLAC	Block Level Advisory Committee
BLRM	Block level resource mapping
CA	Change Agent
CARE	Cooperative for Assistance and Relief Everywhere
CB	Capacity building
CBMS	Community-based monitoring system
CBO	Capacity Building Officer
CBO	Community-based organization
CDPO	Child Development Project Officer
CF	Complementary feeding
CG	Chhattisgarh
CSB	Corn soy blend
DAP	Development assistance program
DDK	Disposable delivery kits
DHFW	Department of Health and Family Welfare
DLAC	District Level Advisory Committee
DPO	Demonstration and Partnership Officer
DPT	Diphtheria, Pertussis, Tetanus vaccine
DS	Demonstration site
DWCD	Department of Women and Child Development
EBF	Exclusive breastfeeding
ELP	Early learning phase
ELS	Early learning site
EOP	End of project
FY	Fiscal Year
GOI	Government of India
GPO	Government Partnership Officer
HFW	Health and Family Welfare
HIV	Human immunodeficiency virus
HMIS	Health management information system
HRBG	High-risk behavior group
ICDS	Integrated Child Development Services
IEC	Information, education, communication
IFA	Iron and folic acid
INHP	Integrated Nutrition and Health Project
IUD/IUCD	Intra-uterine device/contraceptive device

JH	Jharkhand
LFM	Local food model
LOA	Life of activities
LOP	Life of project/list of provisions
M&E	Monitoring and evaluation
MO	Monitoring Officer
MOHFW	Ministry of Health and Family Welfare
MP	Madhya Pradesh
MTR	Mid-term review
NFHS	National Family Health Survey
NGO	Non-governmental organization
NHD	Nutrition and Health Day
OR	Orissa
PHC	Primary Health Center
PRI	Panchayat Raj Institution
R1	Round 1
R2	Round 2
RA	Rajasthan
RACHNA	Reproductive and Child Health, Nutrition and HIV/AIDS
RAP	Rapid appraisal
RCH	Reproductive and child health
RH	Reproductive health
RHCA	Reproductive Health Change Agent
RS	Replication site
RTI	Reproductive tract infection
RVO	Refined vegetable oil
SACS	State AIDS Control Society
SHG	Self-help group
SMT	Self-monitoring tool
SN	Supplementary nutrition
SOW	Scope of work
STI/STD	Sexually-transmitted infection/disease
TA	Technical assistance
TBD	To be determined
THR	Take-home ration
TOT	Training of trainers
TT	Tetanus Toxoid
UNICEF	United Nations Children's Fund
UP	Uttar Pradesh
US	United States
USAID	United States Agency for International Development
WB	West Bengal
WHO	World Health Organization

Table of Contents

EXECUTIVE SUMMARY.....	I
ABBREVIATIONS AND ACRONYMS.....	VII
I. INTRODUCTION.....	1
A. BACKGROUND.....	1
B. THE MIDTERM REVIEW	2
II. PROGRAM ASSESSMENT	3
A. OVERALL ACHIEVEMENTS TO DATE	3
B. INHP PROGRESS TO DATE	9
C. CHAYAN PROGRESS TO DATE	15
D: COMMUNITY PARTICIPATION, GENDER, AND SOCIAL EQUITY.....	19
E. RACHNA ORGANIZATION AND MANAGEMENT ISSUES	20
F. MONITORING, EVALUATION AND RESEARCH	21
G. PROSPECTS FOR 2006.....	23
1. <i>Food Transition</i>	23
2. <i>Replication</i>	24
3. <i>Sustainable Graduation</i>	24
4. <i>INHP and Chayan Achievements Prospects by 2006</i>	25
H. CHALLENGES FOR THE CURRENT PROJECT	27
1. <i>Breadth versus Depth</i>	27
2. <i>Sustainable Graduation</i>	28
3. <i>Effective Behavior Change</i>	28
4. <i>Outcome Monitoring</i>	29
5. <i>Health and Family Welfare Ownership</i>	30
6. <i>Effectiveness of Health Systems</i>	30
7. <i>Balance between Community Participation, Content and Technical Support</i>	30
I. RECOMMENDATIONS FOR THE CURRENT PROJECT	31
1. <i>Continue INHP Replication and Graduation</i>	31
2. <i>Complete the Food Transition</i>	31
3. <i>Fill Critical Gaps in the INHP Health Interventions</i>	31
4. <i>Fill Critical Gaps in Demand, Supply and Enabling Environment Factors</i>	32
5. <i>Slow Down on the Expansion of Urban Chayan</i>	32
6. <i>Fill Critical Gaps in Community Participation, Gender and Social Equity</i>	32
7. <i>Strengthen Monitoring and Evaluation Systems</i>	32
J. FUTURE DIRECTIONS: OPPORTUNITIES AND CRITICAL CHOICES FOR CARE.....	33
ANNEX A: INHP PANEL DATA, ROUNDS 1 AND 2	35
ANNEX B: INHP	37
1. ANTENATAL CARE AND DELIVERY.....	37
2. NEWBORN CARE	39

3. IMMUNIZATION.....	43
4. NUTRITION.....	46
5. SUPPLEMENTARY NUTRITION.....	50
ANNEX C: CHAYAN.....	59
1. RURAL COMPONENT.....	59
2. URBAN COMPONENT:.....	67
ANNEX D: COMMUNITY PARTICIPATION, GENDER, AND SOCIAL EQUITY	74
1. FINDINGS.....	74
2. RECOMMENDATIONS FOR THE CURRENT PROGRAM.....	79
<i>a. Community Participation.....</i>	<i>79</i>
<i>b. Gender and Social Equity.....</i>	<i>81</i>
ANNEX E: SCOPE OF WORK.....	82
1. ABRIDGED SCOPE OF WORK.....	82
2. METHODOLOGY AND SCHEDULE.....	83
3. REPORT STRUCTURE AND OUTLINE.....	85
ANNEX F: PROSPECT TABLES FOR 2006 OUTCOME ACHIEVEMENTS.....	87
ANNEX G: DOCUMENTS.....	89

TABLES

TABLE 1: RACHNA STATES, DISTRICTS, CITIES, BLOCKS, AWCs AND PROJECT SITES*.....	1
TABLE 2: INHP-II INDICATOR PERFORMANCE TRACKING TABLE.....	5
TABLE 3: ANTENATAL CARE PERFORMANCE.....	10
TABLE 4: DELIVERY AND NEWBORN CARE.....	10
TABLE 5: IMMUNIZATION.....	12
TABLE 6: NUTRITION.....	13
TABLE 7: SUPPLEMENTAL FEEDING.....	15
TABLE 8: INHP-II PANEL DATA ROUNDS 1 AND 2.....	35
TABLE 9: RURAL CHAYAN –MILESTONES AND ACHIEVEMENTS -FY 2003 AND FY 2004	
MILESTONES-2003.....	65
TABLE 10: TEAM SITE ASSIGNMENTS.....	85
TABLE 11: INDICATORS MOST LIKELY TO SHOW SIGNIFICANT IMPROVEMENT BY 9/30/2006	87
TABLE 12: INDICATORS WITH A POSSIBILITY OF SHOWING IMPROVEMENT BY 9/30/2006.....	87
TABLE 13: INDICATORS UNLIKELY TO SHOW SIGNIFICANT IMPROVEMENT BY 9/30/2006.....	88
TABLE 14: MANAGEMENT INDICATOR PROSPECTS.....	88

I. INTRODUCTION

A. Background

Since 1950 CARE has collaborated closely with the Government of India (GOI) to implement a range of development and relief projects. Support from the USAID Title II Program began with food for work and school feeding programs and evolved into support for GOI nutrition and health programs. In 1984 CARE, with USAID support, started contributing to the world's largest community-based outreach program for vulnerable women and children – the Integrated Child Development Services (ICDS) program of the Government of India. In 1996 CARE, GOI and USAID initiated the Integrated Nutrition and Health Project (INHP), which transformed the Title II program support to the ICDS, from primarily provision of supplementary food into a maternal and child survival initiative. INHP-II, as the current project is called, ends September 2006.

INHP is implemented in partnership with the Ministry of Human Resources Development's Department of Women and Child Development and the Ministry of Health and Family Welfare's (MoH&FW) Department of Health and Family Welfare, local NGOs and community-based organizations. INHP-II is currently implemented in 78 districts in nine Indian states⁴ namely Andhra Pradesh, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttar

Table 1: RACHNA States, Districts, Cities, Blocks, AWCs and Project Sites*

States	Districts	Cities	Blocks	Grad 25%	AWC	DS 10%	RS 90%	Projects
Andhra Pradesh	8		70	18	10,130	1,019	9,111	INHP
Chhattisgarh	10	5	96	24	12,833	1,286	11,547	INHP & Chayan
Jharkhand	17	4	125	31	13,582	1,465	12,117	INHP & Chayan
Madhya Pradesh	3		29	7	4,682	464	4,218	INHP
Orissa	9		104	26	10,556	1,084	9,472	INHP
Rajasthan	7	5	64	16	8,769	889	7,880	INHP & Chayan
Uttar Pradesh	12	7	132	33	15,534	1,560	13,974	INHP & Chayan
West Bengal	9		91	23	13,444	1,344	12,100	INHP
Bihar	3		36	9	5,127	0	0	
Delhi		Slums	0	0	0	0	0	Chayan urban
Total 9	78	22	747	187	94,657	9,111	85,546	

*Grad refers to the 25% of the blocks that are expected to graduate. This column was computed by multiplying

⁴ Due to the request of the government of Bihar, INHP-II initiated its operations in three districts of Bihar during FY 04.

Pradesh and West Bengal (see Table 1).

An USAID/India-funded reproductive health and HIV prevention project called “Chayan ” (means choices or selection), got underway in 2003 and will end in 2006.⁵ It was designed to build upon the INHP program platform in four out of the nine INHP states, namely, Chhattisgarh, Rajasthan, Uttar Pradesh and Jharkhand. Chayan is operational in 29 districts. The urban part of Chayan, which deals with HIV/AIDS prevention, is operating in 21 cities, including selected slum areas of the city/state of Delhi.

In program year 2002-03, the INHP-II and Chayan projects were brought under CARE's new program umbrella called “Reproductive And Child Health, Nutrition and HIV/AIDS” (RACHNA). Currently IHNP-II and Chayan are operationally and managerially integrated under the RACHNA program umbrella at all levels.

B. The Midterm Review

The SOW calls for a mid-term review of INHP-II and a review of the effective integration of Chayan into INHP-II. The goal of the Midterm Review (MTR) is to analyze the progress made in INHP-II in line with the design of INHP-II towards achieving intended impact by FY 2006 and to make recommendations for improvement. The program has gone through some important changes over the past two and half years. Some of them include changes in the external environment, including sudden withdrawal of one of the two food commodities, organizational changes within CARE India, and the integration of reproductive health and HIV prevention interventions through Chayan .

The specific objectives of the MTR are to:

- analyze the progress made against the INHP-II plan
- assess the progress made against the Chayan plan⁶
- make recommendations for increasing program effectiveness to achieve expected outcomes and impact by 2006, and
- make recommendations to inform the next phase of RACHNA (both INHP-II and Chayan), i.e., beyond October 2006, considering the current operational context, global trends and evidence

The key-audiences for this review include CARE/India, FFP/Washington, USAID India, the Government of India’s Department of Women and Child Development the Department of Health and Family Welfare, respective state government agencies including National AIDS Control Organization, NGO partners, and CARE/USA.

The scope of work, methodology, schedule and team assignments for the MTR are found in

⁵ Originally, Chayan was to end 9/30/2007. As part of the DAP amendment, USAID and CARE agreed to end both projects at the same time to allow for comprehensive planning for the next phase.

⁶ While INHP-II is going through its mid-term review as planned, the Chayan review is advanced by a year from the original plan.

Annex E, along with a note on limitations of the panel data that are included in this report.

II. PROGRAM ASSESSMENT

A. Overall Achievements to Date

Milestones and targets. At mid-point, RACHNA has made significant progress towards meeting its targets for a range of outcome and management indicators reflected in its performance tables (see Table 2).⁷ Most performance targets are on track, such as supplemental food, measles vaccinations, and iron folic acid tablets for pregnant women, immediate breastfeeding, exclusive breastfeeding, and introduction of solid food. However, there are indicators that are not moving much, such as TT injections, and some that are very low, such as Vitamin A, birth planning, and newborns dried and wrapped immediately after delivery. Such management indicators as training appear to be on target. However, more attention is needed on recruiting change agents and involving CBOs and PRIs in Nutrition and Health Days. See section II C of this report for more details on INHP performance. No data are available yet for Chayan, but it has done well in terms of meeting all of its milestones to date.

Scale. To implement a program at the scale of RACHNA is significant, not only in the Indian context, but also globally. RACHNA is operating in 78 districts in nine states and selected areas of Delhi. It reaches into over 95,000 villages with a range of services from simple provision of refined and fortified Soybean oil along with Government of India provided grain to a comprehensive package of health interventions ranging from antenatal care to the prevention of HIV/AIDS. It does this through two principal projects: INHP-II and Chayan.

The RACHNA model. The core of both projects is a replicable model. The basic INHP model establishes a platform of health interventions around which food provisioning is essential. Given the scale of the program, CARE has developed a comprehensive replication strategy that relies on demonstration sites strategically located to provide support and evidence for the replication sites. The key operational approaches to achieve replication of these models are systems strengthening, capacity building and behavior change communication. The objective is to demonstrate practical problem solving approaches for behavior change and improving service coverage in about 10 percent of the AWCs in each block and replicating the lessons learned from these sites in the remaining 90 percent of the AWCs in each block. CARE works closely with government ICDS and RCH systems to bring about replication.

Best practices. The replication strategy relies on a set of interventions referred to as “best practices.” In INHP these are: Nutrition and Health Days (NHD), Change Agents (CA), Community-Based Monitoring Systems (CBMS), and Block-Level Resource Mapping (BLRM). In Chayan the best practices are Reproductive Health Change Agents (RHCA), Peer

⁷ The samples for Baseline and LOA are different from the samples of the Round 1 and Round 2 panel data. Thus, they should not be compared. The data are shown together for convenience and to summarize the available data for these performance indicators. The R1 and R2 data correspond roughly with FY 03 and FY 04 data and do suggest trends, or the lack thereof.

Educators (PE), Community Stakeholder Groups (CSG), and Youth Resource Centers (YRC). These best practices are seen by CARE as potential solutions to problems faced by ICDS and RCH in achieving their child health and nutrition objectives. The

Table 2: INHP-II Indicator Performance Tracking Table

Impact & Outcome Indicators	Baseline (January '01) ⁸		LOA		
	All	DS	All	DS	
Impact Indicators	All	DS	All	DS	
% of children age 12-23 months whose weight is more than two standard deviations below the median weight achieved by children of that age (%)	48	50	40	39	
1 % of pregnant & lactating women and children 6-60 months of age in program catchment area received supplemental food from AWC					
a. Pregnant Women	61	72	65	65	
b. Lactating Mothers	50	64	65	65	
c. Children 6-36 months	64	65	65	65	
d. Children 36-60 months	NA	NA	65	65	
2 % of children 12-23 months old in program catchment area receiving measles vaccine by age 12 months	51	66	62	77	
3 % of children 18-23 months who received at least two doses of Vitamin A by 18 months of age	3	2	26	38	
4 % of women in program catchment area delivered in past year who received at least 2 TT injections during pregnancy	74	83	82	89	
5 % of women in program catchment area delivered in past year who received 90-100 iron folic acid tablets during pregnancy	25	37	47	62	
6 % of women (with children 0-24 months of age) who report having made birth plans ¹⁰ during the third trimester of their last pregnancy	23	20	40	45	
7 % of newborns dried and wrapped immediately after delivery	69	69	80	85	
8 % of newborns put to breast within 1 hour postpartum	15	12	35	45	
9 % of children under 24 months of age who were exclusively breastfed till 6 months postpartum	37	43	57	65	
10 % of infants in program catchment area who received breast milk and solid-mushy foods at 6-9 months of age	60	65	67	77	
		FY 04	LOA		
	Baseline	Target ¹¹	Achieved	Target	Achieved
1 % of counterpart personnel and community members given training in nutrition and health topics as against planned to be	79	358390	119	100	
2 % of AWCs conducting at least one Nutrition and Health Day last month with Take Home Ration and immunization/or	36	50	48	60	
3 % of AWCs where immunization/or ante-natal check-up were provided on a scheduled NHD in the absence of THR last	NA	60	27	80	
4 % of pregnant & lactating women and children 6-36 months in program area enrolled for take home ration (THR)					
a. Pregnant & Lactating Women	71	50	113	75	
b. Children 6-36 months	76	50	106	65	
5 % of AWCs with change agents ¹⁴	12	30	36	50	
6 % Nutrition and Health Days where CBOs and/or PRIs participated last month ¹⁵	NA	20	27	30	

⁸ The baseline data for outcome indicators are based on the INHP I Final Evaluation quantitative survey that was completed in January 2001.

⁹ Though INHP II interventions work towards improvement in this indicator, mortality will not be measured because of sample size requirements, complexity and cost.

¹⁰ Birth plans include: identification of a skilled provider (trained ANM/TBA), obtaining/preparing a clean delivery kit and saving money in advance for the delivery

¹¹ Targets are taken from DAP II amendment.

¹² As per the discussion with USAID India, the absolute figures are reported.

¹³ This indicator is committed in DAP II amendment.

¹⁴ A Change Agent is an active, interested member from the community who acts as promoter and monitor of health and nutrition practices counsels 15-20 families on a voluntary basis to encourage them to adopt healthy behaviors. This indicator considers AWCs with 3 or more CAs.

¹⁴ Though INHP II interventions work towards improvement in this indicator, mortality will not be measured because of sample size requirements,

¹⁵ Calculation: CBO/PRIs participation on NHD taking all AWCs as the denominator.

practices, when adapted to local conditions, can help ICDS and RCH improve key behaviors and practices that are essential to achieving health and nutrition outcomes.

Graduation and sustainability. In addition to meeting most of its milestones for RACHNA, CARE has been active in launching a phase-over program where blocks will be “graduated.”¹⁶ Originally, INHP-II had planned to test models for graduation through the life of the project. However, the amendment to the DAP accelerated the graduation phase and INHP-II is now expected to graduate 25 percent of its blocks by September 2006. This amounts to roughly 25,000 AWCs. Making sure that these blocks, and the AWCs within them, can continue the program is a major sustainability issue for CARE.

Food transition. Progress is especially impressive given that the organization has had to deal with startling challenges in the past two years. Chief among these was the loss of approximately 50 percent of its USAID-provided Title II resources in the form of corn soy blend (CSB) beginning in 2003. This commodity was the basis for several key elements in the program. The most important were on-site or spot feeding, take-home rations and an incentive for participation at the NHDs. The Government of India’s cash contribution to CARE was tied to the quantity of commodity provided. The food transition has shifted the responsibility for providing a substitute for CSB (e.g. grain, lentils and blends) to the states. CARE continues to provide RSO through the supplementary nutrition component of the ICDS program and also monetizes oil for local currency proceeds. CARE has systematically and successfully brokered the food transition to ensure that food continues to be provided and that the relationship with the government at central and state levels has been strengthened. Sound and comprehensive audit and monitoring systems in place have enabled CARE to work with the government to detect supply breaks and to rectify the causes. This has been a major achievement.

The GOI and the state governments are already working with CARE to ensure that its valuable experience and presence are reflected at all levels. This includes an expansion by ICDS of over 200,000 AWCs in April 2005. Equally important is the government’s commitment to the extension of reproductive and child health (RCH) services to villages, so as to improve the lives of disadvantaged and vulnerable populations. Furthermore, recent rulings from the Indian Supreme Court to fight hunger and famine by providing food through AWCs and other initiatives makes this an especially important time to use CARE’s credibility and reach to transfer skills and accelerate the phase over of US government support.

Community involvement is significant in RACHNA and this is important, given the large scale of the program. That is because RACHNA is basically a community-level program. It bridges the gap between communities and facility-based government health and child development programs by using human, food and organizational resources to create demand, help rank or prioritize needs and carry out basic provisioning. CARE is an active, community-focused organization that brings several key components to villages, including the following, in diminishing order of effectiveness:

¹⁶ Graduation is defined as “sustainable, independent functioning of the health and nutrition activities without CARE’s intervention, where inputs and resources can be managed; quality and timelines of activities can be maintained and desired outcome and objectives met.” Reflections...p. 31.

- Knowledge transfer of basic health and nutrition messages
- Strengthening of community processes and resources with community-based organizations (CBO) and Panchayat Raj Institutions (PRI)
- Behavior change for improved newborn care, nutrition and immunization
- Community engagement and empowerment

The progress in achieving the transfer of knowledge and many key community processes has established the basis for changes in behavior and the type of community engagement and empowerment needed for more effective negotiation at the village, block, district and state levels. Still, more needs to be done to strengthen community ownership of RACHNA and community capacity to sustain program activities (see Annex D for details).

Convergence. A recurrent theme promoted by the government and civil society is convergence, the coming together of various organizations and programs to provide comprehensive services to target groups. CARE, through INHP-II, has significant and extensive experience in operationalizing convergence, especially between the MOH Health and Family Welfare (HFW) and ICDS. Under RACHNA convergence occurs at several levels, from the community level (where the ANM, AWW and change agents coordinate and work together in NHDs) to the block and district levels (where HFW and ICDS officials plan and solve problems together) and to the state level (where senior officials collaborate in policy development and resource allocation).

There is a genuine interest in ensuring that communities are served and are making appropriate demands on services. In some states and districts convergence has extended to include self-help groups, mothers' groups, and community political institutions, particularly the Gram Sabha and Panchayat. The cooperation, especially at the village level, among government services with direct links to local governing structures is seen as essential to providing the stimulus for village development. CARE has working models of convergence and its technical, organizational and managerial expertise is being sought out by government agencies seeking to promote collaboration and coordination in their own fields. CARE is widely seen as a strong technical agency in terms of its content, organizational and management skills. Information is key. For example, the ability to track and report on the supply of food for spot feeding and take home rations has empowered communities to refine targeting of beneficiaries, minimize supply breaks and employ creative means to produce and distribute food locally through local food models.

Challenges. Overall, the CARE model works. Challenges do remain on a range of issues, including the quality of the technical components, the reach of the program within existing communities, the resource demands, both human and financial as a result of the planned expansion of AWCs in response to the universalization of ICDS as mandated by the Supreme Court, and the competing demands from multiple funding sources. These challenges and opportunities are discussed in more detail later in this report. While CARE recognizes there is room for improvement, the scale of RACHNA and its achievements are impressive.

Data availability. CARE only began Chayan 18 months ago and the INHP-II will not be evaluated until late 2005 in accordance with Title II guidelines. Therefore, the full range of outcome and impact data were not available for this assessment. Management indicators are

available from regular reporting (see Project Year 1, 2 and 3 Results Reports) but are of limited use in assessing achievements. Fortunately, CARE has several impressive data sources that have produced information that the team was able to access. In late 2003, CARE began an ambitious program of collecting a wide range of population-based data from villages with replication sites in eight representative districts in eight INHP-II states. As mentioned in the methodology section (see Annex E: Scope of Work), differences in the sampling procedures between rounds one and two and the short interval between R1 and R2 (approximately 8-12 months) make it difficult to make definitive statements about changes in many of the outcome and process indicators, especially when the changes are small. However, the data are useful and provide some support for the observations made in the different technical sections.

B. INHP Progress to Date

INHP interventions cover the part of the life cycle from pregnancy to two years of age. This includes antenatal care, safe delivery, newborn care, immunization, nutrition, Vitamin A and food supplementation. Supplementary feeding extends to children up to six years of age. The following pages summarize progress to date in each of these interventions.

Antenatal care. Interventions related to ANC and delivery in INHP-II are designed primarily for improved newborn survival and care, rather than a focus on the woman. They are also significantly dependent on a well-functioning health system. Thus, the performance of the indicators is not just a function of the effectiveness of community-based approaches but also of service availability and quality. Review of the outcome indicators in the eight INHP states shows variable performance across states in respect of the key indicators.

Major components of INHP-II's ANC package include: early registration of pregnancy, ensuring three antenatal examinations by the auxiliary nurse midwife (ANM), administration of two doses of tetanus toxoid (TT), birth planning, and consumption of 90 tablets of iron and folic acid (IFA).

The change agents and the Anganwadi workers in demonstration sites and, to a lesser extent, in replication sites, have substantially facilitated access to pregnant women. The NHDs are an important focal point to encourage the ANMs to be present to provide such services as ANC and TT. The AWW serves as a depot holder for Vitamin A and IFA tablets. Self-monitoring tools (SMT) for keeping track of pregnancy and infant milestones are being tested in most states. Care is taken to make sure that the tools are culturally appropriate and locale-specific. Theoretically, these tools should help mothers and providers alike to keep up to date on such critical events as scheduled ANC visits, immunization dates, and so forth. In practice, CARE field staff noted that some women see them as more trouble than they are worth, forget to keep them up to date or find them intrusive. Panel data show that only about 1/3 of AWCs have a social map and at least one woman using an SMT. Given these concerns it may be useful for CARE to look into the value and utility of these tools.

Keeping the limitations of the RAP data in mind, it would seem that TT has been relatively high but that there has been no movement. If this is the case, then it may be difficult for the project to reach its target unless coverage is expanded significantly in collaboration with HFW interventions. Antenatal checkups are quite low and show no movement, either. IFA tablet distribution and

consumption are increasing steadily, but the percentage of pregnant women who make birth plans is extremely low.

Table 3: Antenatal Care Performance¹⁷

Antenatal Care Indicators	Baseline	Round 1	Round 2	Target
Receipt of two doses of TT during pregnancy ¹⁸	74	73.4	72.2	79
Prenatal checkups: 3 or more*		28.1	26.1	
Received at least 90 IFA tablets	23	36.2	39.8	47
Consumed at least 90 IFA tablets*		54.5	69.9	
Birth plans made during pregnancy	23/TBD	4.0	4.5	47

* No baseline or LOA targets set for these indicators.

Of all the eight states, only Chhattisgarh saw improvements in all five indicators. They were followed by Jharkhand (4), West Bengal and Uttar Pradesh (3), Andhra Pradesh, Orissa and Rajasthan (2), and Madhya Pradesh (1). See Annex A: INHP Panel Data, Rounds 1 and 2 for details.

Delivery and newborn care. The panel data show that all seven indicators improved between R1 and R2. The greatest improvements were in delaying the bath (an increase of 18.4 points) and the five cleans (14 points). Improvements in the five-point range were seen in the remaining indicators, except for the percent of women who delivered at home. The team hypothesized that increases in adoption of the “five cleans” may have been facilitated by increased promotion and availability of disposable delivery kits (DDKs). There was an assumption that DDKs are part of social marketing. However, CARE pointed out that DDK use is minimal across the program and that it is not part of social marketing. In any case, INHP-II appears to be demonstrating that substantial positive changes can be made in key outcomes related to essential newborn care. Aggregated data from replication sites in panel districts across the eight INHP-II states demonstrate the changes shown in Table 4.

Table 4: Delivery and Newborn Care

Delivery and Newborn Care Indicators	Baseline	Round 1	Round 2	Target
Women delivered at home*		76.9	69.9	
Followed the use of 5 cleans at birth*		27.2	41.5	
Applied nothing to the cord/umbilicus*		32.4	39.2	
Dried and wrapped immediately after birth	69	5.2	9.9	80
Delayed bath for at least 3 days*		9.7	28.1	
Early breastfeeding	15	38.2	46.7	35
Pre-lacteal feeds not given*		41.5	55.4	

¹⁷ The baseline and target data are shown for reference and do not necessarily identify trends. In addition, they are weighted averages, while the RAP data are not weighted. Finally, the baseline and target data are for all blocks and include DS as well as RS. The RAP data do not include DS.

¹⁸ Clean hands, surface, blade for cord-cutting, thread for tying the cord, and wrap for the infant.

* No baseline or LOA targets set for these indicators

The data show a slight decline in women delivering at home. Nevertheless, seven out of ten women surveyed said their last delivery was at home. The outcome indicators do not include data on the attendant at delivery. Data from other sources (NFHS-2 and DLHS) indicate that a mix of skilled and unskilled personnel attends most births in these states. However, the message for the five cleans is being targeted to the change agents and AWW, most of whom have no direct role in the delivery. (In one site visited by team members, the change agents began to consider themselves as birth attendants based on the training they received in the five cleans). In fact, other than the attendant, neither the change agents nor the AWW are present at the delivery in most cases. Panel data on processes show that only 17 (R1) to 19 (R2) percent of the AWW or ANM were present at the home on the day of the birth. The range was from 4-39 percent. Data from the Neonatal Evaluation Research showed that only 2-8 percent of delivered women arranged for a birth attendant. Thus, the observance of five cleans cannot be monitored, although reported data on the five cleans has increased over 14 percentage points, especially in Chhattisgarh, Madhya Pradesh, Rajasthan, Uttar Pradesh, and Madhya Pradesh.

The practice of applying nothing to the cord or umbilicus increased by five percentage points. However, six out of ten women still apply something.

Perhaps one of the most notable findings was keeping the infant warm. Very few mothers (or birth attendants) dry and wrap the child immediately after birth. Although the trend upward is encouraging, nine out of 10 do not follow this practice. The increase in delaying bathing of the child increased significantly. However, several of the team members pointed out that there is no scientific evidence that this practice has any benefit. In a discussion with CARE staff, the rationale for promoting this practice was to avoid hypothermia. Staff wants to discourage the bathing of newborns in cold water. As pointed out in the discussion, the point is to maintain the newborn's body temperature, which could include bathing in warm water followed by immediate drying and wrapping, or simply by drying and wrapping at birth.

Early breastfeeding also increased over six percentage points and averaged 45 percent of women interviewed. In some states the rates are quite high: Chhattisgarh (76 percent), West Bengal (77 percent), and Orissa (66 percent).

Overall, MP and RA showed improvement in all seven indicators. CG and UP improved in six; AP and WB in five; JH in four and OR in three.

The movement in these largely behavioral variables is potentially very important, since recent research has demonstrated that improvements in such essential newborn care can improve survival of newborns in low resource settings like rural India. While the progress in INHP-II is encouraging, it is important to note that improvement is variable across states (and probably communities) and that overall levels of some key practices (such as keeping the newborn warm by immediate drying and wrapping) are still very low. Thus, additional attention and learning in these areas will be important. The Newborn Evaluation Research being carried out in partnership with Johns Hopkins University and local researchers should give important additional insights. For example, the study shows that between the baseline and the second round of the

adequacy surveys there were substantial increases in contacts and advice from AWW or ANM related to ANC and newborn care. These represent significant effects of simple interventions and point out the value of promoting contacts.

Immunization. Most of the immunization indicators are relatively high but do not seem to be moving upward very much at all. This includes BCG and DPT 3. Measles vaccinations (card only) gained 10 percentage points and timely completion of measles vaccinations increased 13 points. Children fully immunized on time gained almost 11 points but is only at 48 percent coverage, quite a distance from the WHO standard of 80 percent. The only performance indicator (which has a baseline and target) is timely completion of measles vaccinations. The R2 value, while significantly higher than R1, is only four points over the baseline. However, because of sampling differences, the panel data probably underestimate coverage. Nonetheless, the project will have to increase its efforts in this area if it is to meet the target of 62 by mid-2006. There has been a slight decrease (four points) in dropouts, which is good news.

Table 5: Immunization

Immunization Indicators	Baseline	Round 1	Round 2	Target
Received immunization card*		76.0	73.3	
Retained immunization card*		60.2	59.6	
BCG vaccine received (card only) *		89.6	88.2	
BCG vaccine received (card + recall) *		85.2	82.0	
DPT 3 vaccine received (card only) *		79.5	80.0	
DPT 3 vaccine received (card + recall) *		65.7	60.4	
Timely completion of DPT 3 vaccine*		70.5	75.2	
Measles vaccine received (card only)		56.4	66.8	
Measles vaccine received (card + recall) *		59.5	60.5	
Timely completion of measles vaccine	51	42.2	55.2	62
Fully immunized (card only) *		53.0	60.9	
Fully immunized (card + recall) *		45.7	44.4	
Fully immunized on time*		37.2	47.7	
Dropouts from BCG to measles vaccination (card + recall)*		31.5	27.5	

* No baseline or LOA targets set for these indicators

Review of the state RAP results indicates that the sample district in Orissa shows improvement on the greatest number of immunization indicators (12 of 14). Orissa is followed by UP (11), WB (10), and AP, CG and MP (9 each). RA adopted 8 and JH adopted 7.

Observations on the ground and reports of informants uniformly indicate that the coordination of ANM and AWW through NHDs, together with the promotion and organization of immunization activities through community change agents (including identifying and “rounding up” children due to be immunized) have increased acceptance of and demand for immunization. However, one of the management indicators shows that only 30 percent of AWCs have change agents and CBO and PRI participation in NHD was only 20 percent. It would seem that CARE needs to get

more CAs mobilized in order to increase the immunization indicators.

On the systems side, several operational factors appear to contribute to continued inadequacies of immunization activities. These factors include overall weaknesses in management and logistics, periodic shortages of specific vaccines, and disruption of routine immunization and other services by multiple Pulse Polio campaigns. There are also more situation-specific system side problems, as when ANMs arrive late for NHDs because of logistic difficulties or because of having to travel to PHCs to get vaccines before traveling to communities. The block and district-level coordination processes put in place under INHP-II have enabled local officials to identify and resolve some such problems, for example by coordinated rescheduling of NHDs when ANMs are unable to participate because of polio activities or attending a birth.

Nutrition. Table 6 shows 12 nutrition indicators, three of which are performance indicators and, therefore, have baselines and targets. Of the 12 nutrition indicators, five show positive trends, one is negative and the rest are stable. Only one of the performance indicators shows positive performance. The indicator “exclusive breastfeeding until 6 months” is at high levels (almost 67 percent), but there was no movement between R1 and R2. It is also important to note that the panel indicator is not comparable with the indicator in the baseline survey or in the DAP, which measured exclusive breastfeeding through 6 months as reported for children 6-23 months. In contrast, the panel surveys measured breastfeeding among children presently aged 0-6 months. Since the prevalence of exclusive breastfeeding generally declines progressively during the first six months, the average prevalence among children during these months is quite different from the proportion of children exclusively breastfed through six months.

Table 6: Nutrition

Nutrition Indicators	Baseline	Round 1	Round 2	Target
Exclusive breastfeeding until 4 mo.*		73.8	73.3	
Exclusive breastfeeding until 6 mo.	37	67.5	66.7	57
Not started on liquids/solids until 6 mo. *		51.5	69.3	
Started giving solids between 6-8 mo.	60	52.1	62.3	67
Gave at least ½ quantity of semisolids (6-11 mo.) *		12.1	19.5	
Gave at least ½ quantity of semisolids (12-23 mo.) *		6.0	14.3	
Appropriate CF, 6-11 mo. *		29.8	30.9	
Appropriate CF, 12-23 mo. *		40.4	43.1	
Added oil or ghee to semisolid meal*		21.5	24.4	
Received at least 3 different food groups in last week*		72.1	79.0	
Received at least 1 dose of Vitamin A (care + recall) *		46.0	45.9	
Received at least 2 doses of Vitamin A by 18 months of age(care + recall)	3	20.6	14.0	26

* No baseline or LOA targets set for these indicators

“Started solids” has exceeded the baseline and only needs five more points to exceed the target. Some of the other related indicators are moving positively, as well. “Not starting” until 6 months increased almost 18 percentage points (parenthetically, this may be a better indicator of exclusive breastfeeding, although the way the information was elicited is not clear). “Started” between 6-8 months increased almost 10 points. Both of the groups labeled “Gave at least ½ of recommended solids” increased around eight percentage points. However, the levels for these last two indicators are very low, around 14-20 percent. Nevertheless, progress is being made. Observations in several states indicate that this improvement may be significant. In Orissa, for example, initiation of CF at six months has become nearly institutionalized by linking it to a traditional practice called *annaprasana*. The event was moved back from 12 months to 6 months and made into a celebration at the AWC where other potential targeted mothers would gather to witness the celebration.

The “appropriate complementary feeding” indicators increased only slightly and are relatively low, around 30-40 percent. The percentage of infants 6-11 months who receive at least half the quantity of recommended solid foods increased from 12 to 20 percent. For children 12-23 months the rate (which was very low at the baseline, just 6 percent) increased to 14 percent at R2. Although this is an improvement, the rate is still very low, and a cause for concern. CARE needs to reexamine its BCC strategy for adequate complementary feeding.

“Adding oil or ghee to semisolid meals” is very low and has barely increased. “Received three different food groups” was relatively high (72 percent) and increased almost 7 percentage points.

Vitamin A supplementation coverage was low. Between R1 and R2 one indicator didn’t move and the other actually declined. The percentage of children aged 18-23 months who had received two doses of vitamin A by age 18 months was 21 at R1 and 14 percent at R2. This was probably due, in part, to the withdrawal of supplies for a period of time, distribution problems, low levels of awareness about dosage requirements and the low priority that providers give to this intervention. In addition, India does not have a policy of postpartum Vitamin A supplementation.

Most AWW (80 percent) were aware that the correct age for introducing CF is six months. However, only 39 percent knew that five doses of vitamin A need to be taken by three years. Although there have been supply problems, the AWWs visited during the team’s field trips all had adequate supplies of vitamin A. It seems that low demand and the low priority that workers put on vitamin A are the main reasons for these low coverage rates.

Overall, five of the 12 nutrition outcome indicators are progressing in the right direction, except for vitamin A. However, the incremental changes are negligible for another five. This could be due, in part, to the short period (8-12 months) between R1 and R2. More effort may be needed in breastfeeding, complementary feeding and Vitamin A to bring about significant changes by the end of the project period.

Variation by states is a familiar theme by now. With respect to nutrition, Chhattisgarh and Jharkhand show 10 of 12 indicators improving. Next are AP and MP at 8 they are followed by

AP and UP (6), RA (5), and OR (4).

Supplementary food remains a major component of RACHNA. In addition to its value as an incentive, it is an important health/nutrition intervention in itself. **Error! Reference source not found.** summarizes the program indicators. All of these indicators show that coverage is in the 60-65 percent area. That is, roughly 2/3 of the target population is likely to be covered and that would meet project targets. However, it is worth noting that one of the indicators (receipt of supplementary food during pregnancy) declined six percentage points between R1 and R2.

Table 7: Supplemental Feeding

Supplemental food indicators	Baseline	Round 1	Round 2	Target
Receipt of supplementary food during pregnancy	61	69.2	63.3	65
Receipt of supplementary food for mother in first 6 mo.	50	62.7	64.7	65
Receipt of supplementary food after 6 (6-36) months of age*	64	54.3	60.4	65
Receipt of supplementary food 36-60 months of age*	NA	54	60	65

* The panel indicator is for “after 6 months;” while the performance indicators are for 6-36 and 36-60 months.

C. Chayan Progress to Date

Originally planned for 45 districts across 5 states, Chayan is currently being implemented in 29 districts and 21 cities (including selected areas of Delhi) in 4 states: Uttar Pradesh, Jharkhand, Rajasthan, and Chhattisgarh.¹⁹ The key goals of Chayan (2002-2006) are:

- Men and women in 29 districts across 4 states are better able to choose the number and timing of their children
- Men and women in 29 districts and 21 cities across 4 states and Delhi are better able to protect themselves from RT/STI and HIV infection.

Rural Chayan. Chayan strategies focus on providing information and services for birth spacing and management of RTI/STI. RHCAs (Reproductive Health Change Agent) are supposed to be a couple (a male and a female, not necessarily married). RHCAs are considered the mainstay of the Chayan program and currently provide information on oral contraceptives and condoms and refer those women in need of services to the public health system. Their primary task is to generate demand for services through identification, provision of information, motivation, and distribution of commodities or referral for services.

¹⁹ Chayan, too, was subject to resource reductions within a few months of start up, setting back the pace and reducing scale of the project, with negative consequences for human resources and systems.

Chayan interventions have been in place for about 12 to 18 months. Thus, it is too early to provide substantial comments on quantitative achievements. However, progress in setting up the program has been good.

- Overall it appears that most milestones, planned for FY 2004 have been achieved. Gaps remain in the areas of gender mainstreaming into Chayan components, capacity building, and behavior change communication strategies.
- Trends also indicate that in 2006, most milestones related to establishing demonstration and replication sites have been met. However, the quality of information and services, as well as capacity building, are in danger of being compromised in the push to ensure expanded coverage.
- INHP-II, and its four established best practices, has proved to be an effective platform for launching and integrating rural Chayan interventions for women and men at village and community levels. This is being carried out through the AWCs and convergence among the Anganwadi worker, the change agents and the auxiliary nurse midwife.
- For the birth spacing component, Chayan has partnered with social marketing (SM) agencies in all four states to ensure adequate supplies of commodities and increased brand choices. In all DS and some RS, the SM agencies have been able to supply oral contraceptive pills and condoms to change agents and commercial outlets. Chayan has also worked with the health system to ensure that free supplies are available, thus offering a choice to women and men in need, and ensuring uninterrupted supplies. The social marketing component has been slow to take off. One of the reasons identified by the SM partners and communities alike was the low purchasing power of rural communities. Currently shortages of free supplies do not appear to be a problem.
- Chayan's selection of improved care seeking for RTI/STI and increasing knowledge levels of HIV/AIDS in a low-prevalence setting could have positive implications for the AIDS scenario in the four states. As migration of men to cities increases, rural women become increasingly vulnerable to STIs and HIV. Ensuring the adoption of safe sexual behaviors and early care seeking are the only ways of ensuring that prevalence continues to remain low.
- Chayan's approach to improved care seeking for RTI/STI has largely been through training of change agents on signs and symptoms of RTI/STI and mapping referral sites in the private sector. Despite substantial formative research and the analysis of causes underlying recognition and care seeking for RTI, particularly in women, the focus remains on the identification of signs and symptoms. It is important to note here that the scientific community has concluded that this approach (syndromic management) should not be promoted; it is neither effective nor efficient. Chayan has not yet engaged change agents to facilitate referrals to providers that have been identified in the mapping exercise. There is little evidence of involving the private and public sectors in RTI/STI management, beyond just treatment of the condition.
- Based on the aforesaid points, a clear rural strategy being absent in containing

HIV/AIDS in general, the integrated approach may well be useful for determining the overall integrated rural strategy by the National AIDS Program for building a prevention focus in rural areas of the low prevalence States.

Overall prospects for Chayan to reach 2006 milestones are fairly high. With additional inputs in areas of capacity building and enhancing the involvement of health systems, quality could also be addressed. One of the most significant leverages that Chayan has is the launch of two major national level programs for women's health. These are RCH 2 and a community-focused primary health care program called the National Rural Health Mission (NRHM). CARE is well placed to support both projects in areas of convergence, community participation, and monitoring. Both of these projects offer the potential to significantly impact the service delivery components of both Chayan and INHP-II.

- **Urban Chayan:** The HIV prevention component of Chayan (Urban) focuses on interventions among High Risk Behavior Groups (HRBG). This group includes Female Sex Workers (FSW), truckers and migrants and unmarried youths (15-24 age group). The interventions are rolled out in 21 cities covering four of the nine INHP states including areas of Delhi. Majority of the States (excluding Delhi) are part of the Low Prevalence High Priority States for GOI. All the states have programs that are being implemented through the National AIDS Program and the implementing arm of the program is the State AIDS Control Societies (SACS). It is recognized that though INHP provided institutional linkages, complete integration with INHP has not been possible in Urban Chayan since the key ministry involved in program implementation is the Health and Family Welfare through specially set up Government run Societies (Government run autonomous program in the spirit of Non Government Organizations) Chayan interventions in urban locations have been in place from 15 months to one year and therefore too early to comment on quantitative achievements. However, the review has identified processes (qualitative) that offer high prospect of achieving goals is good.
- All urban locations where Chayan was planned have interventions begun and there is a good level of community participation given the fact that there is low level of interest in HIV prevention in general in low prevalence environment.
- Till date the emphasis on Urban Chayan has been on establishment of demonstration sites within the guiding principle of demonstration and replication. Therefore the project efforts have been in demonstrating already proven processes (from elsewhere) in low prevalence states so as to influence the State AIDS Control Societies and its partners to engage similar interventions to attain scale and coverage.
- In this regard it has to be mentioned that in all the States that come under coverage of Urban Chayan there has been a slow start (with regard to the respective SACS and State mechanism) and therefore the linkages with SACS is at varying levels.
- Chayan Urban strategies focus on implementation of best practices such as a) Peer education (as in change agent concept), b) community stakeholder groups and c) youth resource center.

- Apart from this Urban Chayan has geared itself to set up geographic interventions among specific risk population among the High Risk Behavior Groups and Youth as demonstration – learning ground to enhance the scope of engagement with the State Program.
- The mapping and enumeration leading to identifying populations to be reached is impressive and this has given local teams a good knowledge and understanding of locations where interventions need to be mounted, nonetheless, the service provision has been weak and requires a strategy development for reducing the STI in the marginalized communities.
- In deploying the best practice elements of peer education (change agent concept) all urban projects have been able to identify people from the community to be deployed as peer educators. There is variability in the quality and levels of capability among them. Though the concept of peer education itself is not new to the HIV sector, there is an attempt to build community cohesion that may well lead to a community response that conventionally lacks in the peer model.

The overall prospect of Chayan Urban to catalyze a response in the hitherto low prevalence states is high. There is a fair degree of connectivity to the State Specific government response but there is not strategic vision to catalyze a heightened response by the State. This may well be due to the poor state response itself . However, to be able to act as a lever, the Urban Chayan has to be careful not to scale-up by itself (which is a definitely a need) but to be able to provide technical assistance and capacity building to the State response through which a sustainable scaled up response can be attained. Therefore, strategies for augmenting scaling up rather than scaling up by CARE per se should be well thought out.

Youth Resource Centers

CARE based its **youth** interventions on past work in urban slums with adolescent boys and girls. Youth Resource Centers (YRC) in urban Chayan (there are no youth-related interventions in rural Chayan) are undertaken primarily through NGOs. CARE supports NGOs to engage peer educators to reach out to girls and boys, providing them with life skills education, vocational training, and expects that this will lead to overall youth development. The interventions are primarily targeted to youth from lower socio economic strata. Overall, the quantitative milestones for the youth component, including the establishment of YRCs, have been met.

The design and concept of the youth intervention *per se* may be appropriate, but the lack of perspective among NGO staff, a rather loose constellation of interventions, and lack of specific targeting and messages hamper them. Several of the youth-related interventions depend on linkages with initiatives beyond those that CARE has established. These include: the health system (which itself is not geared to adolescent health needs, much less issues of sexuality), the Department of Youth and Social Affairs, the Education Department and other large institutes that could provide opportunities for training of young people.

D: Community Participation, Gender, and Social Equity

Community-level data are very limited. There are two management performance indicators. One is the percent of AWCs with change agents. The baseline was 12 and the figure for FY 04 is 30. This is a significant improvement, but still very low. Panel data show that 36 percent of AWCs have at least three trained CAs.²⁰ The other performance indicator is about CBO and/or PRI participation in NHDs. No baseline is available and the FY 04 figure is 20 percent. The overall observation of the MTR Team is that although community workers, institutions and processes are in place in a many demonstration and replication sites, there is scope (and opportunity) for improvement. Full graduation and sustainability by 2006 as targeted may not be uniformly feasible without a longer phase of recruitment and capacity building of community agents and institutions in community processes. There are four principal community interventions in RACHNA: community workers, community institutions, and community processes.

The **community workers**, especially the change agents, are arguably the greatest asset and strength of the program. There are at least three strengths of the CA in the CARE model: 1) voluntary CAs whose morale is based on non-monetary rewards of social value and leadership; 2) the decentralized coverage of 15-20 family clusters; and 3) the emphasis on preventive and promotional health (including nutrition) rather than curative health.

This matches the general observations of the reviewers in various states, who found CAs in position, with high to medium levels of motivations, knowledge and community outreach. Service providers (AWWs and ANMs) valued them, because they extended their reach and helped to promote compliance with healthy behaviors and use of health services.

Especially good results were seen in Chhattisgarh, partly because of the convergence of the CARE CA strategy with a statewide “*mitanin*” program of the Chhattisgarh state government that places women health volunteers in every hamlet.

The other major community worker in RACHNA is the peer educator of Chayan, drawn from high-risk groups and youth. The internal RACHNA mid-term review reports 1,565 peer educators identified and trained, made up of 265 sex workers, 365 truckers, 267 migrants and 688 youth. This program is still at an early stage of development, but the levels of motivation among peer educators in some states impressed reviewers.

The most effective and vibrant **community institutions** that were observed during the review were of SHGs of women, many of which were constituted as part of the ICDS mandate. This linkage was strongest in places like West Bengal where the CAs are chosen and nurtured by the SHG itself.

The engagement of PRIs, as the data mentioned previously show, is low. Involvement may depend partly on the strength of these local institutions of government in various states. The Chhattisgarh team has made significant attempts to engage the Gram Sabha or the village

²⁰ This discrepancy is likely due to the former (30% of AWCs have CAs) being taken from service statistics and the latter (36% of AWCs with at least 3 trained CAs) from survey data.

assembly of all adult voters.

The most common **community process** that has been adopted as a “best practice” throughout the RACHNA program area is community-based monitoring systems (CBMS).

The first widely used CBM is a **self-monitoring tool** (SMT). The “flower pot” model is quite common but regardless of the tool, many women lack the motivation to keep them current. All in all, self-monitoring is problematic for many women and their families.

The other major community-monitoring instrument envisaged under RACHNA is the **social map** or village resource map. The maps were found everywhere but they seem to be more formalities than tools to stimulate community participation. They tend to be mechanical, pictorial representations of those eligible women and children that have been identified by functionaries and change agents, rather than a genuine participatory mapping by the entire community to identify resources, needs and barriers. The maps seem to be useful at the outset for planning and defining households for which CAs are responsible. Beyond that it is difficult to determine how useful they are. Several informants noted that they are not updated very often and do not provide much more relevant information than the CAs, in particular, already have.

Gender and equity data are also very limited. The panel data were desegregated by SES (low and high). The summary analysis indicates that changes are being seen among the poorer half of the target populations that are at least equal to, and sometimes greater, than those among the “high” SES group.²¹ The report also points out that all of the target groups are poor, including those in the “high” SES group. Gender analysis by CARE staff has also failed to find any significant difference in the way girls and boys are handled in the project or in their nutritional status.²²

One of the most pervasive gender/equity issues is the treatment of **women primarily as mothers**, rather than as women who have value and health needs in their own right. In part, RACHNA inadvertently reinforces that message by the very nature of the program, which is almost exclusively focused on the child and the mother’s childbearing and child-rearing role.

The social maps mentioned above do not always reflect social or geographical exclusion, much less a social diagnosis of the needs and status of women’s and child’s health and nutrition.

E. RACHNA Organization and Management Issues

The Scope of Work asked a limited number of questions with respect to district and headquarters reorganization. Information collected on these items was limited to interviews with headquarters and district-level teams.

District organization and management. Initially, one person was responsible for 4-5 blocks. The reorganization consists of a four-person team in each district for INHP. Everyone

²¹ Reflections on a Journey, Rachna Midway, November, 2004, p. 48.

²² Personal communication, 1/17/2004.

interviewed about this change agreed that it is much better than the initial system. Now, each team member specializes in a function: Government Partnership Officer (GPO), Demonstration and Partnership Officer (DPO), Capacity Building Officer (CBO) and Monitoring Officer (MO), which is seen as more effective and efficient than having each team member do the same thing. However, some issues were raised: 1) the need for more frequent supervision by the Regional Manager or the appointment of one of the district team members as the district supervisor; 2) consideration of appointing a state technical officer to provide more day-to-day assistance to the district teams; and 3) the need to have technical specialists in HIV, RH and gender at the state level, especially where CARE (as in Jharkhand) is increasingly being called upon for technical assistance to the HFW and the state AIDS control programs.

National reorganization was not addressed due to lack of time to look into this issue.

The INHP platform. The integration of INHP and the rural component of Chayan appears to be a good fit. The interventions, which are limited to messages about birth spacing, RTI/STI can easily be added to the INHP messages and no significant operational or management changes would seem to be required. The RHCA may be redundant as the INHP CAs seems quite capable of adding these messages to their basket of messages (birth spacing and STI prevention should be integrated into prenatal and postnatal services). In fact, the team met several CAs who were also taking on the role of RHCA. However, the contribution of the male RHCA needs to be assessed, since most INHP CAs are female.

The integration of urban Chayan is another issue. The INHP platform does not seem appropriate to this venture. INHP does not deal with youth or high-risk populations. In addition, the core partners are different (State AIDS Control Societies and the Department of Education). Finally, there is no public health structure in urban areas, nor is there a health information system. Urban Chayan will require the development of a completely different model, expertise and strategy that works in complementing, synergizing and augmenting State response.

Project framework. RACHNA is a relatively simple program operating at a large scale. However, it can be difficult to comprehend due to different descriptions and conceptual views of its structure, objectives, strategic approaches, and interventions. It appears that INHP has one conceptual framework and Chayan another. These have changed over time, which further complicates matters. It would help outsiders and staff alike to develop a single framework. One possibility would be to follow the USAID strategic objective model with standard indicators and targets. An alternative would be to use the “log frame” approach seen in several of the state-level “Reflections” documents, since several team members found this approach to be very clear and useful in understanding the program.

F. Monitoring, Evaluation and Research

Monitoring and Evaluation (M&E) are seen as very good, both in terms of comprehensiveness and quality. CARE, as well as NGO and government staff, use the information generated.

Data produced by the HMIS on every AWC are very useful to program managers at all levels. More non-food indicators have been added. However, links with the health side (RCH) have

not been strong enough to bring the health information system up to par with that of ICDS. That means that there are gaps in the HMIS that may be difficult to fill. As pointed out in the Reflections document, any change in the HMIS, no matter how small, requires a huge effort as all 95,000 AWWs in 78 districts have to be contacted and oriented/trained in the revision.

The lack of a uniform public health structure in urban areas means that similar data for Chayan cannot be collected. Chayan relies on data provided by NGOs. There is also a need to develop a MIS for high-risk groups and youth. These can be sizeable and costly activities for what is, at the moment, a small program. Whilst this may be the case, this provides an opportunity to build capacity for the SACS in developing a robust MIS.

BSS baselines have been conducted in the four Chayan states and endline surveys will be conducted to detect changes in behavior of targeted groups. These endline surveys will be conducted at the same time in 2006 as those for INHP and should be very useful for the EOP evaluation.

Rapid appraisals (including mini-RAPs and Early Learning RAPs) have produced valuable data on ANC, child health and nutrition care. As noted previously, the RAPs have limitations due to changes in sampling, in particular. But they have strengths, as well (see Annex E: Scope of Work). Although CARE states that the individual state RAPs were not intended to be aggregated to generate project-wide data, this would seem to be a very important use, especially for tracking project progress toward achieving key outcomes. A related concern is that only one more round of “panel district” RAPs is planned, and that will come near the end of the project. If it turns out that variations in present data do not indicate real trends and the next round of RAPs finds less than hoped-for progress, there will be little time left in RACHNA for additional corrective action.

Although the “panel” data are assumed to be representative of all of the project districts in each state, there is some concern that this may not be the case and that there is a need for measurement of outcomes in all project districts. Local managers have expressed a need to know whether their inputs and processes are having the desired effect on outcomes. Needed data might be collected through mini-RAPs, and/or from community monitoring data (such as the Orissa micro-planning tool).

CARE has repeatedly cautioned that the baseline/endline survey data should not be compared to the RAP surveys, as the sampling procedures were different. This leads to the question as to why the samples were not the same in the first place so that they could be compared. In the future, such samples should be standardized so that project-wide assessments can be made that are comparable to the baseline and endline surveys.

The “adequacy” surveys of the Newborn Care Package in UP are producing valuable data on antenatal and newborn care.

In some cases indicators are inconsistent, which affects the interpretation of trends. For example, several of the panel indicators do not match the corresponding indicators in the PTT. In other case there are no indicators for certain “goals” or “objectives.” For example, only one of the four “project goals” has an indicator. There is only one impact indicator. Others should be

added, especially if the project is moving into reproductive health and prevention of HIV/AIDS.

G. Prospects for 2006

Given achievements to date, what are the prospects for RACHNA achieving all of its goals and objectives by the end of the project (September 2006). In general, they look very good quantitatively. The real challenge is on the qualitative side.

1. Food Transition

The success of the substitution of CSB for a range of locally-procured and produced foods exceeded the expectations following the cessation of US supplied corn soy blend (CSB) in late 2002. CARE has worked with its partners to ensure that the vast majority of the program has continued and, in some cases, grown. A recent study by Vasant Cavale²³ and the various reports from CARE and the MTR team, the food transition or replacement of CSB with an array of locally supplied foods is largely successful. The food supply chain is critical to the support of such key best practices as NHDs. The results show that the system is functioning well. The state-prescribed rations are mostly meeting the energy and protein specifications set by ICDS.

Direct distribution of US-supplied, refined vegetable oil continues to decline in importance in the overall program. States have adapted well to the local procurement of alternative ration components to oil and CSB and are already preparing for a future when US-supplied oil will not be available. The financial demands of providing rations (and improving the technical content of the program) at the state level, however, could be a challenge in some states, especially as ICDS expands as a result of recent Supreme Court rulings. The situation will need to be monitored to ensure that supply interruptions do not jeopardize the key elements of the program.

CARE has developed a detailed supply chain to deal with US-supplied commodities as well as supplies from the GOI. The food transition has enabled CARE and the government to identify weaknesses in the system that CARE has the tools and organizational skills to address. CARE is respected for its information system as well as its training. In addition, the food transition has provided an opportunity for CARE to share these systems with the wider government-run ICDS. It is in a special position where it supports the GOI's efforts to strengthen state supply chain management. This has already happened in some states (Chhattisgarh, Rajasthan, and Andhra Pradesh). The experience gained by the ICDS in supply management at the village level could be useful for the supply of other essential goods provided through HFW programs, such as vaccines, micronutrients, etc.

There are some significant developments reflecting key elements of CARE's model where local-level procurement and processing of the food used for THR and spot feeding for AWCs have occurred. This was especially significant in some states (Madhya Pradesh, Chhattisgarh, Rajasthan and Andhra Pradesh). Local food models (LFM) provide local level employment for

²³ Cavale, VM. Review of ICDS Supply Chain Systems in the Nine CARE-assisted States. FANTA Project, Academy for Educational Development, Washington DC. Draft. November 22, 2004.

disadvantaged groups and women. They also promote the establishment of systems, local-level procurement, local production of foods, flexibility in the type of food used for the ration, and for meeting the energy and protein guidelines of ICDS. In some states, the food is precooked and prepared as a powder, thus reducing the preparation time for the AWW and the family. In Andhra Pradesh the contribution to the cost of the ration is shared by the beneficiary, the government, and CARE, thus providing local ownership of a key input and strengthening local accountability and governance. Further, implementation of the LFM is occurring in both government and NGO administered demonstration and replication sites. The experience of the LFM under these different settings suggests the potential for a post-phase-over model of sustainable procurement and provision of the ration. Documenting this experience, undertaking a cost study, and adapting it further should be considered before preparation of the next DAP proposal.

2. Replication

The strategy of having demonstration sites and then replicating them has proven to be an effective way to scale up services. Some states have already begun to expand replication sites on their own, based on their involvement in demonstration sites. In some cases the institutional partner of CARE is not an NGO but a state government. In Andhra Pradesh, CARE has supported the state government, which is now well poised to take over the program as part of the phase-over strategy.

Quantitatively, replication of INHP is well underway and appears to be proceeding according to plan. After setting up 9,111 demonstration sites the project established roughly 85,500 replication sites in the 747 blocks where it is underway.

Qualitatively, CARE needs to clarify the scope of replication. Replication currently refers to the four INHP best practices and the ancillary procedures to ensure that those practices are effective. For example, a change agent is one of the best practices to be replicated. However, as of 2004, only 30 percent of the AWCs have CAs. Having a change agent (yes or no) is not necessarily sufficient to ensure that the change agent carries out his or her functions, or that the change agent is effective in changing behavior.

There is also a question about standardization. For a program of this size, some variation is expected. What is easy to replicate in one district may be difficult and time-consuming to replicate in another. However, replication implies some sort of standardization. Although CARE has placed a good deal of emphasis on improving the quality of services, there are no procedures as yet to certify that a replication site meets certain standards. This is important because RACHNA could, theoretically, become a brand name assuring clients that each RACHNA site provides the same quality of care.

3. Sustainable Graduation

Sustainability and graduation are critical for RACHNA. The graduation pace has been accelerated recently as the US Government seeks to phase over parts of its program in India.

CARE has agreed to graduate 25 percent of its blocks (197) by 2006. The implication is that phase over will continue beyond 2006 until all CARE Title II-funded sites are managed by the GOI, its partners and the communities.

CARE has concentrated on negotiating criteria with its partners for selecting graduation sites and developing procedures for graduation. In some cases, the sites selected for graduation will receive additional resources to meet the graduation criteria and schedule. Actual graduation is expected to be a flexible process that will reflect the strengths and needs of individual sites. Ensuring that graduated sites are sustainable (and offer a package of quality services) will be an important challenge. This will include ensuring that needed training, supervision and technical assistance will be provided to the sites.

CARE does not plan to offer direct assistance to sites that need more help. It is planning to continue providing assistance, on an as needed basis, to district and state teams that work with graduated blocks. CARE is also contacting other programs and donors that might be willing and able to support needed assistance.

Whether the achievements made to date can be sustained or not is also a challenging issue. Much depends on the ability of CARE to secure long-term commitments from governments and communities to continue and expand the model. Given the likelihood that CARE food contributions will continue to decline, this may be a significant challenge, as food has served as both an important supplement as well as an incentive to adopt healthy behaviors.

4. INHP and Chayan Achievements Prospects by 2006

It is clear from the previous analysis and the available data that the prospects for reaching individual INHP outcome performance targets by September 30, 2006 are good for some indicators, possible for some others and unlikely for others. The same holds true for achievement of significant improvements in outcomes measured in the panel studies. The following is a subjective assessment of the likelihood of an indicator reaching its EOP target (or a RAP indicator exceeding its R1 level by 10 percentage points or more.²⁴) This assessment is based on the qualitative information gathered by the team as well as the R1 and R2 data and other reports.

The indicators have been divided into three groups: likely, possible, and unlikely to be achieved. Regardless of the values set, the point is to help CARE identify those services that may need additional effort to become successful. Overall, this analysis indicates that 17 indicators are likely to be achieved, 7 are possible, and 18 are unlikely. With respect to the 10 performance indicators the breakdown is 6, 2 and 4. Annex F: Prospect Tables includes the baseline, R1, R2 and targets for each indicator.²⁵

²⁴ Ten percentage points is less than the average improvement targeted for performance indicators. It is also the range of the sampling error (+/- 10 points). Some staff told the review team that they expected increases of 10 or more points for each RAP indicator.

²⁵ The SOW asked the MTR team to assess the prospects of the project meeting its 2006 targets. The Team Leader takes responsibility for preparing these estimates, which are based on qualitative judgments by individual team members and a "subjective quantitative analysis" of survey data and targets by the Team

As noted before, although some key variables (such as adequate feeding of semisolids during weaning, and drying and wrapping of newborns) demonstrate changes that are potentially significant, their actual levels are still quite low and not likely to have major public health or nutrition impact without substantial additional effort. Other indicators (such as supplementary feeding) may show little change but their levels are already high, even beyond targets.

a. Indicators most likely to show significant improvement by 9/30/2006²⁶

It seems clear that seven of the project performance indicators will exceed, or already have, exceeded their LOA targets. These are early breastfeeding, exclusive breastfeeding until six months, starting solids between 6-8 months, and all four of the supplementary food indicators. For example, the target for early breastfeeding is 35 percent. The R2 figure was already 45 percent. Supplementary food during pregnancy has a target of 65 percent. The R2 achievement is just under 65 percent.

Another 10 indicators used in the panel surveys also should reach or exceed significant gains by the end of 2006. These include consumption of IFA tablets, the five cleans, delayed bathing, four vaccination indicators (DPT 3, measles vaccination, fully immunized and fully immunized on time). In addition, three of the semisolid indicators should be reached (not starting on liquids/solids until six months and providing semisolids 6-11 months and 12-23 months). For example, fully immunized on time increased 10 percentage points between R1 and R2 (from 37 to 48 percent). If immunization efforts continue as they have, the LOA achievement will be even higher.

b. Indicators with a possibility of showing improvement by 9/30/2006

Two of the performance indicators fall into this category: received IFA tablets and timely completion of measles vaccines. The latter increased 13 points between R1 and R2 and should be able to improve another 7 points to reach the target of 62 percent by the end of 2006.

Five panel indicators are in this category, as well: not applying anything to the umbilicus (5 point increase so far between R1 and R2); no pre-lacteal feeds (6 point increase); timely completion of DPT3 (5 point increase); received 3 different food groups (7 point increase); dropouts from BCG to measles vaccination (4 point drop). All of these indicators are within striking distance and would only require a little additional effort to exceed their targets or the informal goal of a 10 percentage point improvement by 2006.

Leader. For the former, the technical experts based their judgments partly on the survey data, partly on their experience, and partly on the factors they identified that either favor or constrain achievements. For the latter, the Team Leader based his judgments on the likelihood of each indicator reaching its LOA target or an increase of 10 percentage points over the R1 level. CARE opposes this approach because it compares “the RAPS averages with the baseline and the target... which is misleading.” However, most of the indicators have no targets. For those that do (which is 10 of 42 indicators), the objective is only to give a rough idea of the probability of reaching that target, based on the criteria mentioned above. In most cases the conclusions are obvious.

²⁶ Performance indicators highlighted in bold.

c. Indicators unlikely to show significant improvement by 9/30/2006

These are the indicators that may not move without significant increases in effort. There are three performance indicators in this category. Two doses of TT (high at 72 percent but no movement between R1 and R2 – the target is 82 percent); dried and wrapped is only 10 percent at R2 and the target is 80 percent; birth plans (5 percent at R2 and the target is 47 percent); and Vitamin A (14 percent at R2, down from 21 percent at R1 and the target is 26 percent).

Among the 14 panel indicators in this category, the most important is ANC (only 26 percent at R1 and down 2 points at R2). Many of the other indicators are either already high or just don't show much movement. At one extreme is BCG vaccinations, which are high at 82-88 percent at R2, but dropped slightly from 85-90 percent at R1. Even if no movement is seen, coverage is still high. CARE may not need to worry about these indicators, even though they show no movement. About half of the indicators fall into this category. At the other extreme are those that are in the low or moderate range and don't show much movement. These make up the other half. ANC is an example. Another example is the two complementary feeding indicators. One went from 29-31 percent, the other from 40-43 percent. These indicators may need more attention and effort if they are to move upward.

d. Prospects for Management Indicators

Of the six indicators in this category, only training seems sure to reach its target without significant extra effort. Two indicators are on the borderline of having to gain ten percent increases over 2004 to meet their targets. These are the percent of AWCs conducting at least one Nutrition and Health Day last month with THR and immunization /or antenatal checkup; and the percent of Nutrition and Health Days where CBO and/or PRI participated, last month. The other three indicators would have to gain from 15-25 percentage points. These are AWCs with change agents, mothers enrolled for THR, and percent of AWCs where immunization and/or ANC checkup were provided on a scheduled NHD, in absence of THR, last month.

H. Challenges for the Current Project

1. Breadth versus Depth

It is tempting to suggest that RACHNA add one or more key interventions, such as the management of early childhood illnesses; or to recommend that more should be done to increase community participation, improve BCC or provide more training for AWWs and CAs.

At the same time, it is important to remember that RACHNA is intended to accomplish something that few USAID-supported programs do in such a short time frame, i.e., rolling out its program approach to reach roughly 7 million direct beneficiaries in about 95,000 communities in 9 high fertility/high mortality states of India. This fact implies that efforts to implement additional technical or program activities may come at the expense of reaching scale.

The RACHNA model that is being replicated is not complicated. It involves replicating four "best practices," problem-solving, and a limited number of community-based, reproductive and child health interventions. CARE has been very successful in rolling out that model. The project

is clearly on track for achieving its quantitative demonstration and replication objectives. The challenge is to go more in depth to strengthen quality, consistency and reliability. This could take more time and effort than the project has resources to invest. Thus, the question is, how much is enough? Should RACHNA continue to assist ICDS and RCH to improve the quality, coverage and impact of the replication sites (for example, by looking for ways to increase ANC visits and increase Vitamin A distribution)? Should it work with ICDS and RCH to set minimum standards of care for the interventions? Should it introduce quality assurance mechanisms? Or should it concentrate on scaling up, increasing the number of RS and speeding up the graduation process?

Given this tradeoff – scale vs. quality, breadth vs. depth – the team has identified a limited number of “challenges” facing the program, and provides a limited number of recommendations for the remainder of RACHNA. It would be prudent for CARE and USAID/India to analyze these recommendations, and any other potential technical or programmatic embellishments it would like to make, from a “cost-benefit” perspective. What would be the marginal cost of accepting a recommendation and what would be the marginal improvement as a result? Those recommendations that have a low marginal cost and a high marginal benefit would be worth accepting. An example might be the low cost and high improvement in coverage of expanding Vitamin A distribution.

2. Sustainable Graduation

Sustainable graduation is probably the most important issue facing RACHNA. If replication sites can continue indefinitely after graduation, then all of the key outcomes will also continue. The reverse is also true. If replication sites close down after graduation, then the investments will have been for naught.

Although graduation plans and selection criteria have been developed, the team is concerned about the viability of graduation sites. RACHNA staff inputs are critical to the operationalization of the interventions. Will the government and communities be able to sustain their replication sites once CARE withdraws its staff and consultants? Will CARE provide adequate inputs to ensure that each site continues to receive the assistance that it needs post graduation? Will CARE and the government approach sustainable graduation from other perspectives? For example, would it be sufficient only to sustain CAs and NHDs? Would it be sufficient to sustain only demonstration sites, or certain replication sites? Would it be sufficient to sustain only certain services? These are issues that CARE will need to address this next year. The team believes that it will be important for CARE, USAID and the government to be flexible in terms of graduation. Some sites may not be ready or able to graduate for years to come. It would be a shame to see them close down just because they cannot meet graduation schedules.

3. Effective Behavior Change

Since most INHP and Chayan interventions are promotive or preventive in nature, BCC is a critical element of the RACHNA model. RACHNA has engaged in a very impressive set of activities to set up its BCC approach, including formative research, early learning sites, development of state-specific BCC strategies and field testing of messages. However, CARE does not have a process for following up BCC messages to determine if they actually result in the

desired change.

The data coming in from INHP-II suggest that behavior changes associated with a commodity, such as vaccines associated with NHD, seem to be more readily adopted than changes not associated with a commodity, such as complementary feeding. The constraints to the adoption of desirable complementary feeding practices exist at different levels. These include inadequate knowledge and counseling skills among change agents and the AWWs, group communication instead of interpersonal communication, resource constraints at the household level, and lack of feedback from the mothers about adoption or non-adoption of the desired behavioral changes. Vitamin A is yet a different case, since its utilization appears to be affected by: 1) the availability of the commodity; 2) an effective, functioning health system; and also 3) the attitude and importance assigned to Vitamin A by ANMs, AWWs, and change agents.

The challenge to RACHNA is to figure out which BCC interventions are working and which are not. This would not only improve performance but also would save resources, since ineffective BCC interventions could be ended.

4. Outcome Monitoring

The project has an excellent set of approaches for process monitoring. These include tools for collecting and reporting data on key process and management indicators. Beginning at the community (AWC) level, these data are aggregated upward in monthly reports to the state level and consolidated at the central level in quarterly reports. It appears that, at essentially all levels, the monitoring information is also analyzed through a convergent, participatory process involving CARE, NGOs, ICDS and HFW counterparts. It also appears that in many cases this analysis leads to problem identification and action. Thus, the process monitoring system is a fairly exemplary, results-oriented management model.

However, the main approach to outcome monitoring is periodic surveys in panel districts (one per state). These districts have been selected as representative of the state as a whole. Thus, in the aggregate, they give CARE a reasonable sample of progress across the project (although the interpretation in the text of the “Reflections” report sometimes seems more optimistic than the data might support). The “Reflections” document and field visits also suggested that the outcome data in those panel districts was found important and useful for program analysis and corrective action in those districts.

Although the panel data are assumed to be representative of all of the project districts in each state, there is some concern that this may not be the case and that there is a need for measurement of outcomes in all project districts. Even if this were the case, local managers have expressed a need to know whether their inputs and processes are having the desired effect on outcomes. Needed data might be collected through SIP registers for AWCs, mini-RAPs, and/or from community monitoring data (such as the Orissa micro-planning tool).

Two other items need to be considered. First is the reluctance of CARE to aggregate the RAP data to get an overall picture of how the project (not the activities in individual states) is doing. The RAP data would appear to provide the data to do that. If they do not, then the design

should be modified to allow this type of analysis. Second is the different sampling approaches, which make it difficult to compare baseline, RAP and endline data. There should be one standard approach to data collection so that results can be tracked over time.

5. Health and Family Welfare Ownership

Several outcome and impact indicators of INHP-II and RACHNA rely on behavior changes at individual, household, and community levels. However, services for safe delivery, immunization, Vitamin A, care of sick newborns and children, management of RTI/STI, and some methods of family planning, need basic and referral health services delivered through an accessible and equitable health care system. Despite the impressive work done with community behavior change, two critical challenges threaten achievement. The first is related to low involvement of the medical and paramedical staff in convergent services. This stems primarily from their lack of belief that community participatory processes lead to improved care seeking, their reluctance to participate in such processes, and their consequent lack of accountability. Thus, the involvement of medical officers at the block level resource mapping (BLRM) and the advisory committees at block and district levels is sometimes perfunctory. The second is the lack of ownership of project activities by HFW, which sometimes sees community-level work as the responsibility of ICDS, not HFW. The challenge for CARE is to find ways to involve HFW state, district, block and PHC medical staff in the project to the point that they accept RACHNA as their own project.

6. Effectiveness of Health Systems

Another critical challenge comes from the poor functioning of health systems overall. Reliable health systems are critical for addressing the needs of the poor and marginalized. A range of issues hampers their effectiveness. These are related to the need for adequate infrastructure, functioning health systems, trained personnel distributed evenly, adequate drugs and supplies, management information systems that capture changes in the health of people, and logistics and supply systems that ensure uninterrupted services and products. Field observations indicate that the effectiveness of an NHD is defeated when there are inadequate vaccines, vitamin A, and food for THR. Frequent Pulse Polio campaigns disrupt the NHD and routine provision of services when skilled attendants are taken away from their jobs to work on the campaigns. Although it is too early to tell, the lack of drugs for RTI/STI management is likely to affect the RTI component as well. The challenge for CARE is to find ways to employ its convergent skills to co-opt key HFW officials and gatekeepers to address these problems.

7. Balance between Community Participation, Content and Technical Support

During the phase of the program when the major contribution of CARE was perceived to be of primarily food supplies, the skills of CARE that were most visible and valued within the system were those of logistical management. The withdrawal of food was both a challenge and an opportunity for CARE, and as a result, today most government officials at all levels and community members now perceive and value CARE primarily for its contributions to community processes, its technical knowledge of nutrition and public health, its contributions to capacity building, its management support systems and its policy advocacy. Community participation is

critical to the success of the project. Although there are important community elements in RACHNA (e.g., change agents, self-monitoring, PRI, SHG, etc.) some are quite low (e.g., only 30 percent of AWCs have change agents; PRI/CBO participation in NHDs is only 20 percent). In addition, the program has put more emphasis on the technical aspects of its interventions than empowerment of communities to take them over. To ensure community ownership of the interventions the challenge to CARE will be to balance its diverse components so that there is adequate support (both technical and community) to maintain, expand and sustain replication sites. The challenge for CARE in the future will be to accelerate community involvement (especially change agents, CBOs and PRIs) while balancing these diverse components to ensure that there is adequate support (technical and community) to maintain, expand and sustain project replication sites.

I. Recommendations for the Current Project

As promised, the recommendations listed here are broad. Details can be found in each of the respective annexes. Acceptance of any recommendation should be based on an assessment of the costs of implementing that recommendation and the expected benefits that would accrue to the project as a result. It may also be useful to assess the costs and consequences of not implementing a particular intervention. For example, what would happen if nothing were done about Vitamin A distribution?

1. Continue INHP Replication and Graduation.

The INHP model works and CARE should continue with its rollout replication plan, with everything that comes with that (capacity development, BCC, systems improvement, etc.). Special attention needs to be given to the graduation strategy. CARE should make a formal commitment to sustainable graduation and implement procedures to make sure that blocks and replication sites are not graduated before they are ready. This may require some negotiation with USAID regarding graduation criteria, sustainability criteria, the graduation schedule, and flexibility in the provision of additional technical assistance.

2. Complete the Food Transition

CARE has done remarkably well in dealing with the food crisis and has built up considerable political capital for its work in bringing about a smooth transition. In addition to continuing this work, CARE needs to work closely with USAID and Indian government agencies right away on the next phase of the food part of the program. The next DAP will be developed before the end of the INHP-II and a viable food strategy needs to be developed before then.

3. Fill Critical Gaps in the INHP Health Interventions

A number of gaps in ANC, delivery, newborn care, immunization, nutrition and supplemental feeding have been identified in earlier sections and are expanded in the annexes. CARE should examine these gaps and the recommendations for closing them. It should then set priorities (based on cost and expected outcome improvement) to work on those gaps that when filled, will make the greatest difference. Examples in newborn care are cord care, immediate drying and

wrapping, and early breastfeeding. In immunization the supply problems need to be addressed. In nutrition, delivery and utilization of Vitamin A needs attention. In supplemental nutrition, the expansion of LFMs should be considered. Appropriate complementary feeding also needs attention.

4. Fill Critical Gaps in Demand, Supply and Enabling Environment Factors

For example, BCC needs more attention throughout; especially in following up on BCC messages to determine which are leading to behavior change and which are not. Capacity building, while extensive, needs to be less procedural and more practical. There is a need to identify alternative methods for collecting outcome data for use by managers at the block and district levels. Again, specific adjustments need to be examined in terms of their cost and projected outcomes. More attention needs to be paid to the management indicators, in particular, recruitment of change agents, involvement of CBOs and PRIs, and ensuring the reliable provision of NHDs and the services that are to be provided on those days.

5. Strategic Expansion of Urban Chayan

The rural Chayan program fits the INHP “platform” quite well. However, there are issues that need to be addressed as to the practical integration of Chayan into INHP, the readiness of the RHCAs, the involvement of CBOs, and the development of referral mechanisms for STI/RTI treatment. The urban Chayan program does not fit the INHP platform and the “best practices” do not seem to be ready yet for replication. If CARE is going to continue working in HIV/AIDS, it needs to be building a model that relates to the state and national AIDS control societies, VCT centers and treatment facilities. Chayan should probably be limited to “demonstration” sites for the remainder of the project period, which would allow CARE to document and validate its best practices while developing replicable models.

6. Fill Critical Gaps in Community Participation, Gender and Social Equity

The RACHNA design framework calls for greater community participation than is happening at the moment. The same can be said for gender and social equity issues. The recommendations in

Annex D: Community Participation, Gender, and Social Equity call for greater community participation in the selection of change agents, setting up of more SHGs, especially those based on local food models, using mapping and monitoring tools more broadly to encourage communities to be more involved in planning, as well as monitoring. Other recommendations deal with revising IEC/BCC messages to treat women as individuals with their own needs, not just as mothers; helping to organize and increase representation of marginalized women (e.g., female sex workers); and revising messages to ensure that women get a fair share of THRs and other foods.

7. Strengthen Monitoring and Evaluation Systems

While M&E is very good in RACHNA, excellent, in fact, there are a number of gaps that could be filled. One already mentioned is the development of procedures for collecting outcome data

at block and district levels in order to help local managers in planning and implementation. Another is the standardization of surveys so that comparable data are collected. Also important is the desegregation of data by gender, and such other disadvantaged groups as scheduled tribes, castes and the disabled. Developing a MIS for urban Chayan is needed, but that might be deferred until CARE decides what role it will play in HIV/AIDS. The project framework needs to be standardized (perhaps to fit the USAID model), integrated (to include both INHP and Chayan) and appropriate indicators linked to strategic objectives and intermediate results. More impact indicators should be added to measure improvements in health, especially if the project is moving into reproductive health and HIV/AIDS.

J. Future Directions: Opportunities and Critical Choices for CARE

It is clear to the evaluation team that present priorities must be given to CARE continuing its current direction in completing the roll-out of INHP-II, the refinement and roll-out of rural Chayan , the definition of its approach to urban HIV/AIDS, the food transition in the states where it works, and implementation and evaluation of the graduation strategy.

At the same time, the team also strongly believes that CARE is facing important choices now regarding its longer-term role and direction. As the Country Director put it, CARE/India is at a crossroad and will need to decide which road to take.

Expanding its technical assistance role. One of these choices relates to how CARE will build upon and focus its role in technical assistance. CARE is widely seen as an effective facilitator and catalyst. The food transition underscored the value of this role to government at all levels. How should CARE build on that strength? The team believes that there are several viable options available to CARE.

1. **Expand the current model to other sites**, with and without food as an incentive. This could involve scrapping the current replication targets to help government, NGOs and the private sector expand the INHP model to the other blocks and AWC sites.
2. **Refine the current model** to place more emphasis on quality assurance, incorporation of additional best practices, ensuring sustainability and demonstrating cost-effectiveness.
3. **Expand the health interventions**: add malnutrition (including treatment), management of childhood illnesses and other high impact child survival interventions; consider expanding reproductive health interventions; consider adding key primary health care interventions; consider expanding HIV/AIDS prevention, treatment and support interventions.
4. **Expand community participation interventions**: put more emphasis on community mobilization, organization, and empowerment; focus more on overcoming discrimination, stigma, social exclusion and related barriers to health.
5. **Increase policy and advocacy** activities in nutrition and/or child survival; develop and build capacity at local, state and national levels.

6. **Provide TA in management** issues, including needs assessments, strategic and operational planning, monitoring, evaluation, logistics, capacity development, and BCC.
7. **Provide TA in convergence** at local, state and national levels, involving government, NGOs and private sector organizations.

Mission and mandate. In part, the choices made by CARE about its future direction have to be guided by its organization's mission. It may also depend upon the mandate(s) given it by state or national level governments. For example, in UP, CARE has been asked to provide technical assistance in expanding the RACHNA model across its 70 districts, while in other states CARE has been requested to assist in policy development for food and nutrition or for HIV.

Resources. Clearly, the direction that CARE goes in the future will depend in part upon the availability of resources. Application to USAID for a third stage of INHP/RACHNA may provide continuing resources, despite the food transition, allowing the completion of the graduation process. USAID may also be approached for continuing or expanded support for program and technical work in child survival, reproductive health, family planning, infectious diseases, or HIV/AIDS, although the availability and amount of these resources is difficult to predict in the longer term.

At the same time, the apparent credibility of CARE as a technical assistance resource, its long-standing relationship with state and national governments in India, the scale of its work, and the types of expertise it offers suggest that resources may also be available from other sources to support CARE's work. CARE could conceivably take on an important role in one or more of several important new initiatives in the health and WCD sectors in India. These include the new RCH 2 program, the universalization of ICDS under the recent Supreme Court order, the government's planned Rural Health Mission, and programs of the national and state AIDS control societies.

Other potential sources of support are CARE's own fund-raising campaigns; other donors, such as the World Bank and the Bill and Melinda Gates Foundation; private sector societies, commercial and manufacturing sectors; and the military.

Capacity. The choices made about directions to pursue will have implications for the types of capacity CARE needs to strengthen or develop. For example, if CARE moves toward greater engagement in strengthening service delivery at the primary and community levels under RCH 2, it will probably need additional expertise in the technical aspects of those services, as well as in primary health care delivery, monitoring, and management.

ANNEX A: INHP PANEL DATA, ROUNDS 1 AND 2

Table 8: INHP-II Panel Data Rounds 1 and 2

Indicators	AP		CG		JH		MP		OR		RA		UP		WB		Total		Change*
	R1	R2	R1	R2	R1	R2	R1	R2	R1	R2	R1	R2	R1	R2	R1	R2	R1	R2	
Antenatal care																			
Receipt of two doses of TT during pregnancy	83.0	80.6	62.3	72.0	68.9	71.4	67.8	67.6	77.3	76.0	51.9	44.8	71.3	66.0	97.0	98.5	73.2	72.2	-1.0
Prenatal check-ups: 3 or more	66.0	59.5	26.5	33.9	13.6	9.5	33.6	21.6	27.3	34.8	13.0	7.8	10.5	5.4	34.1	40.7	28.1	26.1	-2.0
Birth plans made during pregnancy	5.2	3.2	2.8	8.9	1.9	2.6	6.5	5.8	6.4	2.0	3.3	1.3	2.7	6.6	4.1	4.0	4.0	4.5	0.5
Received at least 90 IFA tablets	17.6	34.5	37.0	61.7	33.9	42.0	46.7	39.8	67.3	48.9	10.2	12.3	24.0	26.4	47.0	50.0	36.2	39.8	3.6
Consumed at least 90 IFA tablets	33.3	71.1	51.7	88.4	48.3	63.5	56.3	59.3	70.3	72.8	36.4	57.7	53.7	63.1	49.4	63.5	54.5	69.9	15.4
Outcomes: Newborn care																			
Women who delivered at home	50.3	35.6	87.7	85.4	87.6	65.7	80.9	84.9	93.3	75.5	84.3	88.4	86.0	85.1	45.1	38.3	75.5	73.0	-2.5
Followed the use of 5 cleans at birth	20.8	29.6	39.4	66.4	34.2	41.3	18.7	34.1	43.2	40.3	23.1	33.5	5.4	30.8	32.4	56.3	27.3	41.6	14.3
Applied nothing to the cord or umbilicus	19.5	32.8	57.7	75.6	56.8	45.5	30.9	38.4	32.0	22.7	12.1	25.7	4.1	16.5	45.9	56.3	33.6	38.5	4.9
Dried and wrapped immediately after birth	5.2	8.8	3.5	9.4	2.6	3.5	1.6	12.4	5.6	8.0	1.1	12.6	4.1	7.4	17.6	17.0	4.5	9.5	5.0
Delayed bath for at least 3 days	3.9	12.8	12.7	48.6	4.5	30.8	18.7	37.6	4.0	8.5	5.5	11.8	1.4	16.3	27.0	58.0	8.9	27.3	18.4
Early breastfeeding	41.6	37.6	64.1	75.6	31.6	27.6	44.7	48.1	59.2	65.6	17.6	25.7	12.9	16.8	33.8	76.7	38.7	45.2	6.5
Pre-lacteal feeds not given	44.2	77.6	79.6	93.4	52.9	56.3	47.2	62.2	50.4	47.2	15.4	26.0	10.9	18.3	31.1	62.5	43.2	49.1	5.9
Outcomes: Supplementary food																			
Receipt of supplementary food during pregnancy	78.5	73.6	91.9	92.3	54.1	46.1	86.2	84.3	64.4	73.3	26.3	34.8	52.9	48.2	82.1	50.3	69.2	63.3	-5.9
Receipt of supplementary food in first 6 months	75.6	72.8	93.0	93.0	48.1	50.1	85.3	77.7	76.9	82.3	22.5	28.8	52.2	49.2	33.4	59.0	62.7	64.7	2.0
Receipt of supplementary food after 6 months	76.8	61.8	78.5	89.8	19.0	36.7	75.0	59.3	80.1	84.1	24.2	22.3	45.3	46.5	25.0	74.7	54.3	60.4	6.1
Outcomes: Nutrition																			
Exclusive breastfeeding until 4 months	84.8	78.4	89.1	91.8	80.7	83.7	64.9	76.3	80.8	75.5	61.7	46.4	67.7	65.6	61.5	71.8	73.8	73.3	-0.5
Exclusive breastfeeding until 6 months	68.6	74.1	86.4	88.1	78.5	77.1	62.5	71.9	76.0	68.0	51.9	37.7	59.6	54.5	51.2	63.5	67.5	66.7	-0.8

Indicators	AP		CG		JH		MP		OR		RA		UP		WB		Total		Change*
	R1	R2	R1	R2	R1	R2	R1	R2	R1	R2	R1	R2	R1	R2	R1	R2	R1	R2	R2-R1
Not started liquids or solids until 6 months	26.9	91.6	70.2	84.0	57.4	80.5	55.3	79.9	51.8	53.2	48.1	44.3	48.5	66.0	51.8	58.2	51.5	69.3	17.8
Started giving solids between 6-8 months	32.4	78.4	44.7	63.2	58.5	64.8	48.5	52.2	60.4	63.5	45.6	50.8	48.0	40.4	75.1	85.3	52.1	62.3	10.2
	AP		CG		JH		MP		OR		RA		UP		WB		Total		Change*
Outcomes: Nutrition	R1	R2	R1	R2	R1	R2	R1	R2	R1	R2	R1	R2	R1	R2	R1	R2	R1	R2	R2-R1
Gave at least half the recommended quantity of semisolids (6-11 mo.)	29.2	28.2	11.5	26.2	2.0	21.3	4.8	12.1	22.1	20.6	7.2	16.5	2.2	0.6	16.8	34.6	12.1	19.5	7.4
Gave at least half the recommended quantity of semisolids (12-23 mo.)	9.0	11.6	3.8	9.4	4.9	27.7	1.5	8.9	16.0	15.7	3.2	10.9	0.3	2.5	8.3	27.8	6.0	14.3	8.3
Appropriate CF, 6-11 months	45.0	39.6	39.0	48.0	13.4	20.6	34.0	44.0	48.0	29.0	18.0	26.0	9.0	12.0	27.4	32.7	29.8	30.9	1.1
Appropriate CF, 12-23 months	42.9	43.4	59.8	50.6	27.1	43.8	58.9	58.4	47.4	35.3	28.2	45.4	23.6	23.6	30.6	42.8	40.4	43.1	2.7
Added oil or ghee to semisolid meal	44.0	54.5	15.8	34.2	12.5	7.1	22.6	15.9	7.5	9.6	41.1	48.8	15.4	20.2	24.1	11.0	21.5	24.4	2.9
Received at least 3 different food groups in last 1 week	88.8	90.3	73.7	78.6	46.7	64.3	73.8	76.6	67.9	67.2	85.7	87.5	71.2	82.5	77.4	84.8	72.1	79.0	6.9
Received at least 1 dose of Vitamin A - card plus recall	61.8	47.9	41.9	52.1	26.5	46.2	49.2	48.5	57.8	45.9	24.5	18.4	25.6	28.5	69.8	76.1	46.0	45.9	-0.1
Received at least 2 doses of Vitamin A - card plus recall	43.3	10.7	15.3	19.4	8.7	15.7	21.4	20.2	12.9	15.6	13.6	8.7	6.3	2.8	34.9	19.5	20.6	14.0	-6.6
Outcomes: Immunization																			
Received immunization card	90.7	88.8	65.6	79.7	78.8	74.6	84.0	71.0	45.3	57.7	54.8	45.7	76.8	72.5	98.5	97.2	76.0	73.3	-2.7
Retained immunization card	65.8	65.0	49.2	56.5	51.0	59.3	45.3	49.8	58.5	70.2	43.7	23.0	54.8	46.6	91.5	83.0	60.2	59.6	-0.6
BCG vaccine received (card only)	100.0	89.6	97.9	86.3	92.7	88.7	92.9	86.9	72.4	80.6	86.7	87.5	58.4	76.0	95.5	97.3	89.6	88.2	-1.4
BCG vaccine received (card + recall)	98.4	82.4	96.2	92.1	82.0	81.2	93.4	88.1	85.7	88.2	60.6	54.6	59.6	68.0	94.1	97.2	85.2	82.0	-3.2
DPT 3 vaccine received (card only)	87.0	87.0	77.7	77.1	75.6	65.2	69.8	82.2	69.7	80.6	80.0	46.9	62.4	62.5	90.8	93.2	79.5	80.0	0.5
DPT 3 vaccine received (card + recall)	83.5	68.2	72.2	69.4	52.3	56.9	68.3	60.4	59.6	63.7	42.6	31.3	48.8	45.1	86.7	84.4	65.7	60.4	-5.3
Timely completion of DPT 3 vaccine	83.3	80.5	61.7	74.5	67.5	55.7	47.6	80.4	67.1	76.9	57.8	37.5	52.8	55.2	86.3	89.8	70.5	75.2	4.7
Measles vaccine received (card only)	65.1	65.6	46.8	55.6	59.3	64.3	42.1	67.3	50.0	55.2	51.1	34.4	47.2	62.5	65.1	86.4	56.4	66.8	10.4
Measles vaccine received (card + recall)	73.3	58.1	64.3	69.1	51.3	58.8	65.9	70.6	67.6	63.1	35.1	32.2	42.8	46.1	64.8	81.7	59.5	60.5	1.0
Timely completion of measles vaccine	47.4	58.4	31.9	49.0	43.9	49.6	15.9	60.7	46.1	50.0	15.6	21.9	38.4	51.0	57.5	65.5	42.2	55.2	13.0
Fully immunized (card only)	64.6	55.8	43.6	53.6	56.9	53.9	40.5	65.4	44.7	50.7	44.4	25.0	38.4	53.1	62.0	81.8	53.0	60.9	7.9
Fully immunized (card + recall)	67.7	41.6	49.1	50.0	34.3	43.1	45.6	46.5	42.2	43.2	27.7	17.8	29.6	36.6	59.9	72.5	45.7	44.4	-1.3
Fully immunized on time	43.2	48.1	28.7	44.4	40.7	38.3	12.7	57.0	38.2	42.5	13.3	18.8	24.8	37.5	53.8	59.5	37.2	47.7	10.5
Drop outs from BCG to measles vaccination (card + recall)**	25.5	29.5	33.2	25.0	37.4	27.6	29.4	19.9	25.1	28.5	42.1	41.0	28.2	32.2	31.1	16.0	31.5	27.5	-4.0

ANNEX B: INHP

1. Antenatal Care and Delivery

Performance and prospects. Interventions related to antenatal care (ANC) and delivery in INHP-II are *designed primarily for improved newborn survival and care, rather than a focus on the woman*. They are also significantly dependent on a well-functioning health system. Thus, the performance of the indicators is not just a function of the effectiveness of community-based approaches but also of service availability and quality

The package of antenatal and delivery care interventions to improve newborn health and survival include: a minimum of three antenatal check-ups, TT vaccination, supplementary nutrition, increased dietary intake, reduced workload, rest, preparations for safe delivery, and clean childbirth.

ANC and delivery-specific indicators measured in the two rounds of the RAP districts include: receipt of two doses of TT, antenatal check up, birth preparedness, use of five cleans during delivery, contact by ANM/AWW in last trimester, contact by CA in last trimester, AWW/ANM present at time of birth, mean number of visits by ANM/AWW in the first week, mean number of visits by CA in the first week.²⁷ The outcome indicator related to nutrition and IFA includes: receipt and consumption of 90 IFA tablets, and receipt of supplementary food during pregnancy.²⁸

Data from panel districts indicate the following:

- Review of the RAP data from both rounds show that, except in Rajasthan, immunization with two doses of TT is high although the increase between the two rounds is not significantly high. For TT 2 the end FY 2004 value of 72 percent is below the target for the year, and not changed for Round I where the aggregate value is 73 percent.
- The picture with IFA is mixed. Receipt and consumption of IFA show significant increases in Andhra Pradesh, Chhattisgarh and Jharkhand. Smaller increases are seen in West Bengal, Uttar Pradesh and Rajasthan, though even here it appears that the data for consumption is improved. In Orissa and Madhya Pradesh there are declines in receipt, possible due to state level shortages of IFA.
- Antenatal care overall is still low. With the exception of Andhra Pradesh, which has about 60 percent coverage, the picture in the other states, particularly Uttar Pradesh, Rajasthan, and Jharkhand signifies that despite contact with the ANM, pregnant women are not being examined.
- One of the indicators measured by the RAP is contact in the last trimester by either an

²⁷ Table 3.1 a, Reflections on a Journey, Rachna Midway, November, 2004

²⁸ Ibid. Table 5.2 a.

ANM or AWW. This is quite high and has increased across the states (data from Jharkhand are not available), and provides an opportunity to educate the woman and family for birth preparedness, education on high-risk signs and the need for a skilled attendant at birth.

- The key outcome indicators for delivery that are being measured include: birth preparedness, (saving money, mapping facilities, and identifying transport), ensuring five cleans at delivery for home deliveries, and presence of ANM/AWW at time of delivery. Birth preparedness is low across the states, despite the fact that this is one of the key messages in the training curricula. Presence of AWW or ANM did show increases in 4 states, although still at low levels (the highest was 39 percent in Chhattisgarh); 5 of the states had essentially static, quite low, levels.
- An important constraint is the logistic and other issues of providing access to skilled birth attendants. Birth planning helps deal with the recognition of need for such an attendant if complications occur, but the Newborn Care Evaluation Research suggests that this component of birth planning is the least practiced. In Phulbani District of Orissa, the district is providing financial support to remove the cost barrier of transportation to hospital in case of need for emergency obstetric care. Families will be provided with compensation of Rs 150 if they have to travel less than 10 km. to reach a site where required delivery services can be provided, and Rs 200 if they live more than 10 km. away. The district has also procured enough DDKs to supply two years' projected births.
- Except in Andhra Pradesh and West Bengal, home deliveries appear to be the norm. Overall, there has been little progress in this area. The percent of home deliveries identified in the RAP surveys only declined slightly, from 76 percent in R1 to 73 percent in R2.

Effectiveness of strengthening activities. The change agents and AWW have been able to effectively mobilize pregnant women in order to ensure their presence at the NHD. However, it is unclear what level of behavior change was actually affected by the education provided at these meetings. The low levels of antenatal care raise further questions about whether women are adequately motivated for birth preparedness, or educated about high-risk signs and the need for referral and linkages to appropriate sites.

The project does not measure proportion of births conducted by skilled attendants.²⁹ This

²⁹ Delivery by a *skilled attendant at the community level* means that the attendant has the competence and skill to perform *obstetric first aid*, which includes active management of the third stage of labor, intramuscular oxytocin and antibiotics, and IV fluids. Even here, if the complication requires such interventions as blood transfusions, the skilled attendant cannot do much in the home setting and referral to an institution is critical. Institutional delivery refers to delivery taking place in an institution that is capable of providing BeOC or CemOC. There are eight signal functions defined in the Guidelines for Monitoring the Availability and Use of Obstetric Services, issued in 1997 by UNICEF, WHO, and UNFPA. Six of these signal functions can be performed at a facility that can then be defined as a Basic Emergency Obstetric Care (BEmOC) facility. These include: administering parenteral (intramuscular or intravenous) antibiotics, oxytocic drugs, and

indicator measures access of the pregnant woman to delivery services that have a positive effect on MMR and NMR. None of the messages to workers or the community focus on the need for a skilled attendant at birth, despite prevailing policy and programmatic efforts at state and national level in this direction. This gap urgently needs to be addressed.

Data from other sources (NFHS-2 and DLHS) indicate that most births in these states are attended by a mix of skilled and unskilled personnel. However, the message for the five cleans is being targeted to the change agents and AWW, most of whom have no direct role in the delivery. In fact, in one site in Uttar Pradesh, the change agents began to consider themselves to be birth attendants based on the training they received on the five cleans). The observance of five cleans cannot be monitored, although reported data on the five cleans has increased in Chhattisgarh, Madhya Pradesh, Rajasthan, Uttar Pradesh, and Madhya Pradesh.

The disposable delivery kit (DDK) has, until now, had limited success. The price of the kit (Rs. 15 per pack) is a deterrent to the buyer. In many sites, free DDKs were being provided. For example, officials in the district visited in Orissa had purchased DDKs to be provided for all expected births over the next two years.

Conclusions and Recommendations. Given that the focus is on a few key outcomes and processes, the targets for the end of project will likely be met, although it is not clear how they will improve maternal mortality or morbidity. Overall, prospects for achieving outcomes for TT are good. However, substantial effort will be needed to improve antenatal check ups, IFA administration and consumption (and nutrition education), and delivery care. Perhaps the variable that needs the greatest attention is births conducted by a skilled attendant, a variable that is not even measured by the project.

While many of the other inputs of INHP-II are primarily behavior related, those for ANC and delivery rely on a supportive environment, particularly effective services and well-functioning logistic and supply systems. Unless these are in place indicators like TT, IFA consumption, examination of the pregnant woman by the ANM, and skilled attendant at delivery are unlikely to improve.

On the other hand the project could use the CBOs and CAs to monitor the availability of these services and develop accountability mechanisms so that the system will be forced to provide quality services. Messages for communities (through CBOs, RHAs, and CAs) should include identification of complications and prompt referral to pre-decided sites. The message for safe delivery should include access to a skilled birth attendant.

2. Newborn Care

Performance and prospects. The newborn care-specific outcome indicators for which CARE has held itself accountable under INHP-II (DAP amendment) are “percent of newborns dried

anticonvulsants, manual removal of placenta, removal of retained products, and assisted vaginal delivery (vacuum extraction, forceps). The provision of Comprehensive Emergency Obstetric Care (CEmOC) includes all of these and two additional functions- facilities for C-section and blood transfusion.

and wrapped immediately after birth” and “percent of newborns put to breast within 1 hour postpartum.” Of these, baseline values and LOA targets were only available for early breastfeeding. The figures for wrapping were TBD (to be determined) in the amendment. However, there were figures from the earlier DAP.

Other variables in the panel district surveys reflect additional aspects of “essential newborn care,” including cord care (clean blade and thread [two of the “five cleans”] and applying nothing to the cord stump), avoidance of prelacteal feeds, and delayed bathing. The last variable, delayed bathing, appears to have received a lot of attention, but the evidence base for changing this practice is not clear – thermal control of the newborn is critical, but this is better represented by immediate drying and warming, and by maintaining the baby warm during the postpartum period.

The relevant aspects of “Essential Newborn Care” are important, since recent research indicates that these practices alone – even without detection and treatment of newborn infections – can result in measurable reduction of newborn illness and mortality.

Data from the panel district surveys indicate the following:

- Across the project, there appears to have been substantial positive movement in the variables related to appropriate newborn care.
- In relation to cord care, there has been only a slight increase in the specific practice of **putting nothing on the umbilical stump** (34 percent in Round 1 to 39 percent in Round 2). However, there has been a much greater positive change in **practice of the “five cleans”** as a set (27 percent in Round 1 to 42 percent in Round 2).
- **Immediate drying and wrapping of the newborn** is one of the most important newborn care practices. Across the states, this practice is very low. It has shown some positive change (from 4.5 percent in Round 1 to 9.5 percent in Round 2), but obviously needs much more effort.
- On the other hand, the practice of **delaying bathing of the baby** has enjoyed much more positive change, although its connection to newborn survival is not strongly supported by evidence; the practice increased from 9 percent across all states in Round 1 to 27 percent in Round 2. The rates doubled in MP, Orissa, Rajasthan, and West Bengal, tripled in AP, quadrupled in Chhattisgarh, and increased almost seven-fold in Jharkhand and more than ten-fold in UP (although it is still very low in UP).
- **Early breastfeeding** (colostrum feeding) is another of the most important protective practices for newborns, since it reduces their exposure to contaminated substances and provides direct immune protection. Across states, the practice increased modestly, from 39 percent in Round 1 to 45 percent in Round 2. Several states were essentially unchanged (slight positive or negative change between rounds), while the rate in West Bengal doubled (to 77 percent).
- **Avoidance of pre-lacteal feeds** increased by six percentage points overall, except in Jharkhand and Orissa, where it remained essentially flat.

- In terms of **postpartum visits**, (where the focus is on newborn care, and not on the mother either for postpartum morbidity or motivation for family planning use) there was wide variation among states. AP and Chhattisgarh, which already had an average of about 1 visit per newborn in the first week, increased that rate to 1.5 to almost 2. Orissa doubled its rate, reaching almost 1 visit per newborn in the first week. UP also substantially increased its rate, although reaching only an average of about 1 in 3 newborns visited in week one. The remaining states remained essentially flat (no data from Jharkhand), with between 2 of 3 to less than 1 of 3 newborns being visited in the first week.

In INHP-II, there already is a focus on ensuring that the delivery/or immediate postpartum period is attended by the AWW, CA, and ANM. It is possible to address postpartum care in several ways. It is important that the ANM visits the mother within the first three days of birth. The CA should be in touch with the mother during this same period to promote exclusive breastfeeding and advocate the use of condoms. Anecdotal evidence indicates that the customary period of eight to twelve weeks of postpartum abstinence is fast declining.

Early results from the Newborn Care Evaluation Research, being carried out by INHP with Johns Hopkins University support, largely corroborate the results of the larger panel district surveys, and add some detail. For example, they show that in the UP intervention area (Barabanki) advice regarding immediate drying and wrapping of the newborn substantially increased, but the practice did not. Since the overall panel district data also show little increase in this practice, this finding deserves more in-depth exploration in terms of finding appropriate BCC interventions. The evaluation research also suggests that – even in UP, where these practices are low – early breastfeeding (colostrum feeding) and avoidance of pre-lacteal feeding can be improved.

In terms of delivery and postpartum care, the UP evaluation research data confirm low levels of institutional deliveries and deliveries attended by trained personnel (as opposed to AWWs). Postpartum visits by ANMs, AWWs, and change agents all increased, although the increase was greater for community personnel (AWWs and CAs) than for ANMs. This finding suggests the potential contribution of community personnel in improving newborn care and potentially in detecting problems, if properly oriented.

Effectiveness of strengthening activities. It appears that most of the improvement of newborn care stems from INHP's inputs on the demand and behavior side. This is very important, since many of the key practices (like drying and warming newborns and practicing colostrum feeding) are almost purely behavioral, not dependent on service delivery. The fact that this advice was actually given at all to mothers and others involved in birth and newborn care is probably an important factor in the positive change observed, since this is an area that before had not been part of most programming. The training inputs (to AWWs, change agents, and *dais*), combined with the messages and materials provided to them appear to have supported the dissemination of this information.

Although the team understands that RACHNA does not include all supply-side interventions in its essential package, there are gaps that might be filled in the future. The most important of these is the availability and use of skilled attendants at birth. In some sites visited there were anecdotal

reports of increased participation of ANMs in birthing, but the data available do not yet support this. Since many ANMs do not reside at their sub-centers, it is logistically hard to involve them in many births at village level. Some states were trying to deal with this issue. For example, Jharkhand has undertaken to increase the number of trained ANMs through a contracting process. CARE has been asked to help in development and implementation of supplementary obstetric skill training for ANMs, an example of the sort of expanded role that CARE could take in the future. Another opportunity for CARE would be to use its experience and community perspective to help develop realistic guidelines and training for care and referral of complicated births, as well as emergency obstetric care.

What Worked, What Didn't. INHP's inputs at the community level that have worked include training of community personnel (AWWs, change agents, and *dais*) in essential newborn care; providing them with relevant messages and materials; and promoting home postpartum visits during the first week of life. These appear to have been effective in increasing awareness of the needs of the newborn infant and in changing relevant practices. However, as with immunization, INHP's inability to modify system-side inputs and overcome constraints continues to be a limiting factor. Most notables of these are the constraints on increasing attendance at birth by skilled attendants. There also appears to have been some difficulty at the field level in distinguishing and focusing on the most important newborn care behaviors (drying and wrapping, colostrum feeding) versus other behaviors (such as delayed bathing).

In UP, in one of the villages of Barabanki involved in the Evaluation Research on Newborn Care, some key issues presented themselves regarding understanding and reporting on newborn care variables by AWWs and others. One issue was a discrepancy between the records kept by the AWW and the research population-based surveys on such variables as "immediate drying and wrapping." The survey found (across Barabanki sample villages) that this practice was quite low (12 percent), while the AWW's records in the register provided to monitor maternal, newborn, and infant variables indicated virtually 100 percent practice.

Facilitating factors and constraints. As noted, an important facilitating factor is the general increase in awareness (especially by the health system and health authorities at all levels) of the importance of newborn survival and of the relevant care practices to improve it. This attention will hopefully add a "Hawthorne effect" (improvement of a health outcome once attention is paid to it) to the effects of the specific interventions. An important constraint is the logistic and other issues of providing access to skilled birth attendants, since this practice is substantially related to the rates of early neonatal mortality through adequate obstetric management.

Conclusions and recommendations.

- Across the project, it appears that important newborn practices are changing in a positive direction. This is an important result and has the potential to improve newborn survival and reduce overall infant and under-five mortality.
- Despite this improvement, levels of these important practices – especially those with potentially highest impact (cord care, immediate drying and wrapping, early breastfeeding [colostrum feeding]) – remain low. Continued monitoring and program effort will be required

to continue these positive trends.

- There is still substantial variability among states in regard to these practices, despite the purely behavioral nature of many of them. The reasons for these differences, and definition of effective approaches to promote these behavior changes in the lowest performing states, deserve additional BCC attention.
- For the highest impact practices, additional BCC efforts (including additional formative research and implementation and evaluation of new BCC approaches) are also likely to be required to achieve improvement to levels of public health significance.
- An important gap in the current program is promotion of using trained [skilled] birth attendants. This is a critical component because it is directly related to neonatal mortality. Again, the team recognizes that this is not a component of the current program. However, CARE might at least encourage CAs, AWWs and ANMs to convey this message to pregnant women, perhaps as part of the birth planning component. If this component is added to the essential package in the next program, it will also be important to include advocacy efforts to increase access to such trained attendants (since INHP itself does not control resources and programming that will directly increase such access).

3. Immunization

Performance and prospects. The immunization-specific outcome indicators for which CARE has held itself accountable under INHP-II (DAP amendment) are “percent of children 12-23 months old in program catchment area, receiving measles immunization by age 12 months” and “percent of women in program catchment area, who received at least 2 TT injections during pregnancy.” While data on additional immunization indicators are also collected in the panel districts, these two are appropriate choices, since they represent the highest impact immunization actions for child survival.³⁰

For measles immunization, “timely completion of measles vaccination (among mothers of 12-23 month children who have card),” the FY 2004 value of 55 percent aligns closely with the extrapolated DAP target for FY 2004 of 56 percent. However, other immunization variables show higher coverage figures for mothers having cards than for “card plus recall;” so this value may be overestimated. Overall measles coverage among all children surveyed (card plus recall) was 60 percent for FY 2004, virtually unchanged from the FY 2003 value of 59 percent.

For TT2, the FY 2004 (R2) value of 72 percent is below the extrapolated target of 77 percent and not substantially changed from the FY 2003 (R1) aggregate value of 73 percent.

For comparison, among mothers having immunization cards, aggregate DPT 3 coverage was 80 percent at the end of FY 2004. For all children, DPT3 coverage was 60 percent. Full immunization among all mothers of 12-23 month-old children surveyed (card plus recall) was 44 percent.

³⁰ *Lancet* series on Child Survival, July, 2003.

Overall observations from the data tables include:

- Immunization coverage varies somewhat from R1 to R2, with coverage going up in some states going up and down in others. In general, these deviations are not huge.
- The more impressive differences are the fairly consistent differences among states, with Rajasthan and UP tending to have lower performance.
- The variability within states from indicator to indicator, and the low levels of full immunization among children even after age 12 months, suggests that multiple and uneven problems exist with the immunization process.
- TT coverage began and has remained moderately high across the project states, although variability exists (West Bengal is consistently very high, Rajasthan is consistently mediocre).
- The “dropout” rate (between BCG and DPT 3) has diminished somewhat. In FY 2003, this rate was 31 percent, dropping to 27 percent by the end of FY 2004.
- The process indicator for immunization – mothers reporting having received advice on immunization during their last visit by a change agent, AWW, or ANM – is consistently fairly high (68-91 percent); this finding is consistent with the conclusion that most of the problem with immunization falls on the supply side (see discussion below).

Note that these conclusions are not quite as optimistic as the data interpretation that accompanies Table 3.3 in the “Reflections” report.

Effectiveness of strengthening activities. In general, the “demand side” activities carried out under INHP seem to have promoted demand for and acceptance of immunization. There is consensus among health authorities, community workers, and CARE staff that Nutrition and Health Days have helped organize the delivery of immunization to communities and increased community uptake. In addition, broadening the “denominator” for NHDs through registers of all children and their immunization requirements (rather than just the under-threes registered with the AWC) is assumed to have laid the groundwork for expanded coverage. Combining this approach with the active role of AWWs and change agents (often using “social mapping”) in identifying and bringing in children for immunization, and the focus on reducing “left-outs and dropouts” should increase the number of children reached in each community.

While INHP has apparently succeeded in increasing demand for immunization, it appears to be less successful at addressing the “supply side” issues, many of which lie within the health system. It is these issues that appear to underlie the slow progress in immunization and the variability in coverage from year to year and antigen to antigen. Examples include:

- **Vaccine stock-outs.** For example, UP was without DPT and BCG for three months.
- **Interruptions of ANM participation.** Some of these are systemic, especially related to pulse polio campaigns (up to eight planned for the year) in such polio-endemic states as

UP. Others are episodic (as when a delivery or other medical reason causes an ANM to miss an NHD). In addition, some are motivational (as when an ANM just doesn't show up).

- **Logistic and operational procedures**, including the fact that ANMs have to travel to PHCs to get vaccines and then get to villages for NHDs (often arriving late in the day, with the result that some mothers and children [especially non-food recipients] leave before being immunized). Another such factor is confusion or conflicting guidance on opening vaccine vials. In most states, like Orissa, BCG comes in 20-dose vials and the ANMs don't want to open a vial until there are "enough" children. The team heard that HFW is going to provide 5 dose vials soon.
- **Overall poor organization, management, and implementation** of routine immunization programs in some low-performing states or districts.

The convergent planning and problem-solving process introduced by INHP has been able to partially resolve some such problems. For example, when an ANM has to miss an NHD, in some cases the block or district-level coordinators have been able to adjust dates so that the NHD can be rescheduled and the community informed of the new date. However, most of these problems are systemic within HFW, and have been beyond the reach of INHP.

What Worked, What Didn't. INHP's inputs in community organization, mobilization, and demand generation for immunization all appear to be working. This includes increasing community demand for and participation in immunization activities through NHDs, establishing community registers and social maps of all children and their immunization requirements, carrying out BCC activities reinforcing the value of immunization, and having AWWs and change agents "round up" children needing to be immunized. On the other hand, these community-level inputs – and, in many cases, the ability to resolve problems at the block or even district level – were often not adequate to get the health system to overcome generic (e.g., vaccine supply, pulse polio) and episodic (ANM participation) interruptions in routine immunization services and participation in NHDs. These interruptions neutralize and, in some cases, undercut the increased community level demand for immunization generated through INHP.

Facilitating factors and constraints. As noted, pulse polio campaigns are reported in UP (and probably in other polio-endemic states) to have caused major disruptions in ANMs' participation in routine immunization activities and all other health services. Each pulse polio round requires 20 days of staff time. This has a detrimental effect on NHDs. In Orissa, the state level UNICEF office reportedly convinced state health authorities that there was a danger of unsafe immunization if it were carried out on the same day as food distribution (although there is no apparent evidence or reported incident to support this theoretical concern). As a result, NHDs can only include food distribution and antenatal care. There is a separate, fixed "Immunization Day" when the ANM is supposed to return to each village for routine immunization (without the food incentive, of course). The effects of this policy have not yet been evaluated, but it obviously complicates the logistics of immunization (especially in remote villages) and negates the incentive approach intrinsic in the NHD.

However, there have been some success stories in overcoming such constraints. For example, in Pali District, Rajasthan, ANMs often have to travel great distances to carry out immunization activities for NHDs. When this logistic problem is added to the requirement to travel to the PHC to get vaccines, the obstacles are often insurmountable. This problem was identified and discussed by the local health and ICDS authorities in BLAC and DLAC meetings. As a result, the block level health team worked out a system whereby HFW vehicles transport the required sterilized needles and vaccine in a cold box directly from the primary health center to the AWC. Thus, the ANM can come directly from her sub-center, and when she arrives the needed vaccines and immunization supplies are there.

Conclusions and Recommendations

- The community level activities of INHP have strengthened community organization and demand for immunization services.
- This improvement has not been enough to offset problems with the delivery of immunization by the health system. These problems are multiple, sporadic, and unpredictable, resulting in persistent inadequate levels of routine immunization coverage.
- To reach its LOA targets, and (more importantly) to assure increased immunization for all children, CARE will have to seek effective leverage with the HFW system to induce it to address its immunization problems. Doing this may be aided by careful documentation of the effects of these problems (possibly beginning with this evaluation), building stronger alliances with other stakeholders (PRIs, UNICEF, others), and influencing the investment of RCH 2 resources in ways that address the principal factors affecting immunization service delivery.

4. Nutrition

Performance and prospects. The INHP-II DAP amendment identified the following indicators for tracking performance and for each of these indicators targets to be achieved by the end of FY 2006:

- Percent of children under 24 months who were exclusively breastfed until six months of age (LOA target 57 percent)
- Percent of children 6-9 months who received solid mushy foods in addition to breast milk (LOA target 67 percent).
- Percent of children 18-23 months who received at least two doses of vitamin A by 18 months (LOA target 26 percent)

In addition to these indicators, new ones were added in the in the Round 1 and 2 panel surveys. There are no targets for these indicators.

Breastfeeding. The aggregated exclusive breastfeeding rate (EBF) was just under 68 percent in R1 and close to 67 percent in R2. This exceeded the LOA target but there was no significant change between R1 and R2. However, some problems exist in interpretation of these increased

rates. The baseline covered children from 6-23 months while the panel surveys covered children below 6 months. It is known that EBF rates drop progressively with age from birth to six months.

Initiation of complementary feeding. Appropriate complementary feeding along with control of infections is the most critical factor in sustaining the normal growth of infants beyond six months. However, in the Indian context complementary feeding (CF) has proved to be the most resistant to change. Focused BCC interventions addressed this variable in INHP-II.

The target for introduction of solid mushy foods at 6-8 months was set at 67 percent. That is, at least two thirds of all infants were to initiate CF at the age of 6-8 months. The baseline value was 60 percent. The panel data showed an improvement in this indicator from 52 percent at R1 to 62 percent at R2.

CF was lower than the target in all states and ranged from a low of 32 percent in Andhra Pradesh to 60 percent in Orissa. The only exception was West Bengal where the initial rate was quite high at 85 percent. Improvements were noticed in all states, many of them being highly significant. The only state where a decline occurred was Uttar Pradesh, which went from 48 percent in R1 to 40 percent in R2. Field level observations were consistent with these data.

Appropriate complementary feeding. The challenge to improving CF practices is one of introducing solid foods at the appropriate age, following that up with gradual increases in the quantity of food to meet energy needs, and at the same time including a variety of foods to take care of micronutrient requirements. The BCC addressed these issues as well although there were no targets set for these behaviors in the INHP-II proposal.

Mothers who gave at least half the recommended quantity of semi solids to their infants aged 6-11 months at R1 was 12 percent. This increased to almost 20 percent at R2. Corresponding figures for 12-23 month-old children were 6 and 14 percent. Although these trends are positive they are not enough to influence nutritional status significantly.

The percent of mothers who added oil or ghee to the semisolid meal was just under 22 percent at R1 and 24 percent at R2. The chief constraint was the availability of food.

The percent of infants who received at least three different food groups in the last week (among 6-11 month-old children being given semisolids) went from 72 percent in R1 to 79 percent in R2. The nutritional contribution of this improved practice may be minimal when viewed in conjunction with the findings on the quantity of foods fed.

Vitamin A supplementation. Vitamin A seems to be a serious problem. The baseline for receiving at least two doses for children 18-23 months was a meager three percent. The target is a not-very ambitious 26 percent. That was close to being met at R1 (21 percent) but apparently dropped at R2 (14 percent). It was uniformly low in all the states in both rounds. The lowest was 3 percent in UP in R2. The exception was AP, where receipt was relatively high in R1 (43 percent), but declined significantly in R2, falling to 11 percent. Even though the target is relatively low, movement toward it was not evident in most states. The drop from R1 to R2 makes it unlikely that this modest target will be met.

Field level observations showed that Vitamin A delivery was not a priority for the AWWs. Some AWWs were not even aware that five doses of Vitamin A were required. Performance was better for the first dose because of the link to measles immunization. This is amply reflected in the figures for receipt of one dose of vitamin A, which were much higher, 46 percent at R1 and R2. This tallies relatively well with the timely completion of measles vaccine, 37 percent at R1 and 51 percent at R2.

Effectiveness of strengthening activities. Some of the improvements noted in infant feeding practices appear to be due to the improved capacity building of the peripheral workers. This increased their knowledge base regarding healthy infant feeding behaviors. The AWWs who were aware that 6-7 months is the correct age for introduction of solid foods to young infants was high at both R1 and R2, (81 percent). AWWs advising mothers to add oil or ghee to the diets went up from 54 percent at R1 to 76 percent at R2. The mothers reportedly receiving advice on breastfeeding from the AWWs went up from 28 percent in R1 to 57 percent in R2. Regarding complementary feeding mothers reportedly receiving advice from AWWs increased from 33 percent at R1 to 62 percent at R2.

Community capacity-building, however, is still in the very initial stages. Our observations in the field revealed a notably large difference in the awareness of healthy behaviors among the AWWs and the mothers.

INHP-II has made substantial investments in innovative efforts to promote healthy infant feeding behaviors in the community. Extensive formative research was conducted to identify current feeding behaviors, optimum behaviors and barriers to these. Trials provided evidence regarding factors that affected acceptance or rejection of the desired behaviors. Based on these experiences behavior change communication materials have been developed and tested. Functionaries have been trained in the use of these materials. In addition, folk media and radio spots for diffusion of the messages to a larger audience have also been used. This capacity building is beginning to yield dividends in the form of improved behaviors, although the pace of change will need to be accelerated.

Supply side factors have played a role in improved feeding. The supplementary food was the main source of solids introduced to the infant around six months of age in some of the sites visited. Improved awareness about the role of supplementary food among the workers and take home rations on NHDs has facilitated this behavior.

An important enabling environment factor is the motivation of the AWWs. An innovative method of promoting the introduction of complementary foods is practiced in many of the Anganwadi in Orissa. The traditional practice of “annaprasana” has been converted into an opportunity for initiation of CF at six months by making a celebration of it in the Anganwadi and inviting a potential target audience to witness it.

What worked and what did not work well. Exclusive breastfeeding has worked. The rate in five of the eight States was higher than the EOP target of 57.5 percent. Even though the exclusive breastfeeding rate did not show any significant improvement from R1 to R2, except in two states, it still looks to be well over the target.

There was a marked improvement in the introduction of CF between 6-8 months in all states except Uttar Pradesh. Adequate complementary feeding poses a big challenge, however, in terms of quantity and quality.

Capacity building of functionaries, especially AWWs/CAs, was strong in terms of providing knowledge regarding appropriate infant feeding practices. Skill development for persuasive communication for behavior change, however, lagged behind.

Vitamin A distribution is not working well. AWWs do not have adequate knowledge about the five doses of vitamin A to be completed by three years of age and neither the AWWs nor the CAs seem to place much of a priority on Vitamin A.

Facilitating factors and constraints. The main facilitating factor is the improved awareness and knowledge of the AWWs, CAs as well as the supervisors regarding appropriate infant feeding practices. The main constraint is the limited skills of the workers in persuasive communication for behavior change. Lack of any feedback from the mothers is an impediment to taking suitable measures for promotion of healthy behaviors.

The absence of working mothers from home for prolonged periods of time was a constraint on both EBF and adequate complementary feeding. In some villages this is being addressed by adolescent girls who take on the role of feeding the infants in the absence of the mother. This practice, which was seen on field visits in some of the villages in Uttar Pradesh, is worth considering for replication elsewhere as this will not only facilitate the appropriate feeding of the infant but also equip the adolescent girl with knowledge about infant feeding for her future role as a mother.

With respect to vitamin A, demand and supply issues as well as the inadequate knowledge of AWWs, coupled with what seemed to be a low priority for this component are the key constraints. We observed on our field visits that the AWWs and the trained CAs were enthusiastically recalling the newborn care messages as well as some of the complementary feeding messages, but vitamin A was low on their lists. The percent of AWWs who were aware that five doses of vitamin A are due by third year of age was 46 percent at R1, and it declined to 39 percent at R2.

Conclusions and recommendations. Overall, across the states, some of the nutrition outcome indicators are progressing in the right direction and are showing an improvement. Although these changes have the potential to reduce malnutrition and improve child survival, levels of some of the important practices such as adequate complementary feeding remain low. Continued focus and program efforts are required to accelerate these improvements.

Of the four key healthy behaviors promoted, vitamin A delivery and utilization remains low initially and declined further at R2. The exclusive breastfeeding rate (for the first six months) was reasonably high to begin with but did not improve further at R2. The percent of mothers introducing solid foods at six months was relatively high at R1 and improved further by 10 percentage points at R2. Adequate complementary feeding of children between 6-23 months was low to begin with and showed no change at R2. Thus, the initial rates as well as improvements varied widely for different components.

While the knowledge levels of functionaries improved substantially in the area of appropriate infant feeding practices, their skills in persuasive communication for behavior change in the community need strengthening. Constraints on the adoption of adequate complementary feeding exist at different levels. Therefore, the BCC strategy needs to be revisited to modify it so that behavior change at the community level can be accelerated.

Capacity building for behavior change needs to include feedback from mothers on the adoption or non-adoption of the healthy behaviors, constraints for non-adoption and processes to overcome these constraints. Continued monitoring of these events will be required. Training and capacity building need to be strengthened at all levels starting with the CAs, AWWs, ANMs and going up to the block and district level functionaries. This can be done at the demonstration sites and then replicated at the RS.

To increase vitamin A coverage both demand and supply side factors have to be improved along with a focus on sensitizing the ANMs and AWWs on the importance of vitamin A supplementation as a critical strategy for improving child survival.

Capacity building for behavior change strategies and communications should be revisited and ways and means devised to accelerate adoption of desired healthy behaviors at the community level.

Improved awareness regarding the importance of vitamin A supplements has to be promoted among the workers. Also, community awareness on the need for vitamin A has to be strengthened.

5. Supplementary Nutrition

The provision of Supplementary Nutrition (SN) is at the root of the ongoing RACHNA program, excluding the urban component of Chayan. SN is characterized by the design, provision, and monitoring of an array of rations tailored to local needs and production/supply dynamics. The SN ration is targeted to pregnant and lactating women and children six months to six years of age. The rations can be in the form of ready to eat (RTE) powder or as an uncooked cereal blend produced at the state, district and local levels for both supplementary and therapeutic use. No vitamin-mineral premixes are added to the formulations with the exception of iron fortification of salt (for Chhattisgarh).

The ration has several purposes including closing gaps in intake for protein and energy (prevention), as a basis for the treatment of severe under-nutrition, and as an incentive for participation in ICDS and related programming. The ration is an important factor in encouraging attendance at ICDS and Nutrition and Health Days. It is integral to ensure that immunization is increased and various best practices are carried out. Further, the ration provides a programmatic foundation, facilitating staff motivation, monitoring, and accountability.

Rations provide important nutrients for the prevention of under-nutrition, either as take-home rations (THR) or on-the-spot feeding. An ICDS ration is required to meet a centrally-mandated requirement for energy (300 kcal/ration/day) and protein (10 g/ration/day).

The food basket consists of contributions from USAID in the form of refined and fortified vegetable oil (RVO) as well as locally procured foods, including wheat, rice, lentils, soy, jaggery, iodized and iron-fortified salt, and other foods.³¹ While the content of the rations vary as well as the production, supply and monitoring, the existence of spot feeding and THRs means this component is the common input in the CARE and various government-administered programs. Recent orders by the Supreme Court of India have made compulsory the provision of food by the ICDS to all children under six years, as well as pregnant and lactating women, coordination with the state health departments, and mid-day meals for all school age children. This has significant human and financial resource implications including the establishment of new centers and expanded reach in existing centers.

The remainder of this section is based on a review of documentation from CARE's program and incorporates observations from state visits by team members, including the author's visit to Chhattisgarh and Andhra Pradesh. An important focus for the comments is the ongoing replication process coupled with the graduation strategy both for this DAP period (through September 2006) and beyond.

Performance and prospects. Outcome and impact-level results have not been measured or reported yet except for the panel data from a representative district in each of the eight states. Supplementary nutrition is best represented by a limited series of management indicators as well as observations from mid-term team visits, the annual results reports, recent panel data and other project-related documentation. The management indicators include enrollment of target beneficiaries (pregnant and lactating women and children aged 6-36 months) in supplementary nutrition and NHDs with THRs.

The enrollment of 6-36 month-old children for THR is 75-174 percent against the target of 65% percent, with significant departures in Andhra Pradesh (around 5 percent) where the state government, in an effort to reduce short-term program costs, restricts THR to pregnant and lactating women only.

The enrollment of pregnant and lactating women for THR is approximately 113 percent against the target of 75 percent. Differences among states are significant but there are differences in pace of implementation and how enrollments are undertaken. In Andhra Pradesh the state government has capped AWC beneficiary numbers at 58 to contain costs, thus reducing its programmatic burden and raising concerns about the characteristics of the beneficiaries.

The impact of the Supreme Court ruling for ICDS expansion has yet to be felt but some states have begun to include all people in the community. The shifting eligibility criteria have implications for these indicators as well as program costs and, ultimately, the impact level results. A commitment on the part of the government and the Supreme Court rulings place CARE at an important juncture in the program. The experience gained in developing supply chains and the adjustments necessary due to the food transition have meant that CARE is in an excellent position to strengthen government systems to ensure that the NHD can continue, as well as ensure sustainability.

³¹ Op cit. Cavale, VM

Another indicator of supplementary nutrition is feeding continuity, which partly reflects the availability of SN. The indicator is stated as the percentage of AWCs with 22+ feeding days. The pattern over the past 4 years shows a dip in year 2 with the reestablishment in year 4 of around 67 percent. States with strong local-level provision and advance planning performed better.

The NHD best practice is monitored on a regular basis and appears to be on target, with some deviations. The program achieved 74 percent of the FY03 target, which was 50 percent of AWCs holding NHDs (THR plus immunization and/or ANC). This shortfall was due to feeding gaps caused by the transition from Title II CSB to government-provided substitutes. Other factors include challenges faced by the program matching CSB with government grain, and the decision by some state governments to revert to spot feeding in place of THR to compensate for food shortages. While most of these factors have been dealt with, there still is a challenge in meeting the target. The panel data results³² show an improvement in this indicator. Approximately 50 percent of panel data replication centers met the target in FY04. Some states show significant progress, reflecting the commitment on the part of state officials and close CARE-government relationship (e.g., Chhattisgarh) while others have shown declines due to problems with supply, restrictions on THR and other factors.

Shortfalls in NHDs had significant program implications and CARE has taken several approaches to improve this key management indicator. For example, CARE has provided technical assistance to state governments to improve supply chains, commodity supply management, information management; operational planning, and M&E mechanisms for program graduation.

The program's approach to graduation and the planned monitoring and evaluation of the graduation process and outcomes are innovative, not only for India, but also for other Title II programs that are planning and implementing graduation strategies. Specifically, CARE is building networks of change agents, making linkages to mother's groups, local government systems and community-based organizations. The community-based monitoring system appears to be a strong approach and is linked to community-based sustainability measures. The strong level of detail with which the graduation strategy and M&E have been planned is unusual.

CARE is proactively dealing with the changes in the programming environment at community, district, and state levels.

Effectiveness of strengthening activities. The strength of CARE in capacity building, reporting and general technical assistance is integral to the success of the program. The trust and goodwill CARE has been able to build up while implementing a large and operationally diverse program is unusual in Title II-funded programs. CARE has focused on a maternal and child health program using food as an entry point or incentive and leveraging these resources to build capacity with local institutions, government and with the very communities they serve. While the institutional role is critical, CARE is at a special point where there are some critical decisions to be taken with respect to its future role, technical content, coverage, and phase-over of replication

³² Reflections, p. 72.

sites.

What worked. Food transition worked. As confirmed by the recent review by Cavale, various reports from CARE, and the mid-term team's observations, the food transition or replacement of CSB with an array of locally supplied foods is largely successful. There is demand from some state government partners to improve on the smooth food transition by providing technical assistance to improve supply chains, commodity supply management, information management; operational planning, and M&E mechanisms for program graduation. This TA could be a part of CARE's overall support function and expanded to other states.

Local food models: There are some significant developments reflecting key elements of CARE's model where local level procurement and processing of the food used for THR and spot feeding for AWCs have occurred. This was especially significant in some states (MP, CH, RA and AP). LFM's provide local-level employment, group participation, help empower disadvantaged women, foster systems establishment, promote local-level procurement and use of local production. LFM's also exhibit flexibility in the type of food used for the ration and in meeting the energy and protein guidelines for ICDS. In some states, the food is precooked, thus reducing preparation time for AWWs and the families. In AP, the contribution to the cost of the ration is shared by the beneficiary (approximately six rupees per month for a child and 12 for an adult), the government, and CARE. Further, implementation of the LFM is occurring in both government and NGO-administered demonstration and replication sites. The experience of the LFM under these different settings suggests a potential role for CARE in promoting a post phase-over model of sustainable procurement and provision of the ration.

Commodity monitoring and management: CARE has developed a detailed supply chain to deal, not only with US-supplied commodities, but also with the supplies provided by the GOI. The food transition has enabled CARE and the government to identify weaknesses in the system that CARE has the tools and organizational skills to address. CARE is respected for its information system, level of training, monitoring and reporting. Further, the food transition has provided an opportunity for CARE to share these systems with the wider government-run ICDS. It is in a special position of supporting the GOI at the state levels in strengthening state supply chain management. This has already happened in some states (CH, RA, AP). The experience gained in the ICDS in supply management at the village level could be useful for the improvement of supplies of other essential commodities (such as vaccines, micronutrients and so on) distributed through HFW programs,.

Use of refined soybean oil: Oil continues to be provided in a range of CARE and non-CARE AWCs. The oil is not always considered essential to the ration by the partners but it provides a source of energy and Vitamin A. The ration allowance is eight grams per day and the oil is incorporated into spot feeding as well. Since the locally procured components for the ration are not fortified with vitamins or minerals, oil is one of the few sources of Vitamin A. (Salt is fortified with iodine and in Chhattisgarh, iron fortified salt is distributed to AWCs and in the THR).

Graduation: The approach taken by CARE to graduation and the planned monitoring and evaluation of the graduation process and outcomes are innovative not only for India but for other Title II programs that are planning and implementing graduation strategies. Specifically, building

networks of change agents, linkages to mother's groups and local government systems, and community-based organizations have been significant.

Systematic application of tools: Critical to the success of the replication and graduation strategy is the development of systems and their systematic application. CARE has demonstrated that this is possible with the development of program, commodity, technical, training, monitoring and related tools and approaches. From the mother's self-monitoring tools, local level commodity monitoring, block level mapping and problem identification to the overall program design, the program is grounded in a range of sound tools and approaches.

Information sharing from village to block to district: An important contribution of the program has been the sharing of information and transparency. The supply of food to the AWC, especially in villages where beneficiaries were paying for part of the ration, has been recorded and is the basis for active discussion and demand creation. Accountability for supplies is also evident at the block and district level where various tools have been employed, including block mapping and comprehensive monitoring systems. The sharing of best practices and innovations will be strengthened with the move to clustering AWCs and their proximity to demonstration and replication sites.

State ownership of the food component: The acceptance on the part of all levels of the government of the need to provide a replacement for CSB is significant. The results from the monitoring of the key indicators show that much of the program elements remain in place with a shift from CSB. This food transition is important as the program accelerates its phase over and as the Supreme Court instruction introduces new demands on the AWCs.

State level nutrition policies and plans of action. Partly recognizing CARE's technical and operational expertise, some states (CH, AP) have engaged CARE in developing state nutrition policies and plans of action. This reflects the value of the CARE-government partnership. The state plans are an outgrowth of the recognition of the importance of good nutrition and the national nutrition policy initiative.

Flexibility in its replication strategy. Despite the size and complexity of the program, CARE has been able to adapt the strategy to ensure expanded reach of its best practices and innovations. Some AWWs in replication sites are acting as good examples to others and are involved in cross visits and capacity strengthening. This recognition is a result of a well-motivated team of CARE and NGO/government partners.

What may not work

The use of food to prevent certain types of malnutrition: The THRs are an integral part of the incentive for NHD and for access to a range of important services and behavior change opportunities. The likelihood, however, is that the food taken home by the mother will be shared with the family and that she may place herself last in terms of feeding priority. While efforts to encourage the woman, adolescent girl, mother and child are commendable, the food will mostly be shared and have relatively little direct nutritional benefit for the target beneficiary. The shift from a fortified CSB to various combinations of cereals and lentils has likely reduced the micronutrients and minerals in the ration. It is evident that ICDS beneficiaries lack a wide range

of nutrients but the ICDS (and the health interventions) have prioritized iron for pregnant women and Vitamin A for infants. There are some notable gaps in vitamin A, iron and other minerals for all women and children. Counseling and such tools as the Essential Nutrient Actions make the case for a diversified diet but it is unlikely that children under three years are getting their full nutrients from local foods, including the ration. Also while iron and Vitamin A supplementation is improving more needs to be done. A more systematic review of the nutrient profile of the various rations and other sources of nutrients (e.g., iron-fortified salt, IFA, Vitamin A) should be conducted as it is unlikely that counseling and the ration will improve dietary diversity and quality. Measures of dietary diversity and quality also need to be included beyond exclusive breastfeeding. The needs of adults (and adolescents) should be separated from those of children.

Treatment of severe malnutrition: While CARE is to be commended for its programmatic shift from the severely malnourished to all children especially children under two-three years, the treatment of severe malnutrition in children (and poor weight gain in pregnancy and adult thinness) is weak or non-existent. Children classified as Grade 3 and 4 in India fall below -3 Z-scores using more widely accepted WHO/NCHS international standards. Severe malnutrition from the RAPS panel data using -3 Z-score as the cutoff for weight for age among children aged 12-23 months was approximately 22 percent, which is about 170 times greater than what would be found in a developed country (0.13 percent). The high prevalence of severe under-nutrition would be considered a crisis in countries in Sub-Saharan Africa. These children need to be rehabilitated and require nutrients and care that differs from the standards of care provided to mildly malnourished, or the preventative type activities reflected in the overall program (e.g., counseling, ration, Vitamin A). Improvements in the treatment of these cases can build on program components already used for prevention and remove the need for the existing ration to achieve these ambitious objectives. Furthermore, it can be linked with other practices that deal with the sick child, and which need to be incorporated into the program.

Low birth weight: Although the design of RACHNA does not commit to reduction of low birth weight, the RACHNA package does contribute to improving birth weight through nutrition interventions, improved diet, increased rest during pregnancy, supplementary nutrition and IFA. However, the results reflected in birth weight suggest that much more needs to be done. The average birth weight is 2.5 kg., which is the usual cutoff for classifying low birth weight. Since this is a key factor in child survival, the next program should consider putting more emphasis on this issue.

Variable composition of ration: Not all existing rations including those combined with RVO are meeting ICDS mandated requirements for energy and protein. The specification has also made some states use some components that are coming from other states. For example, broken wheat is brought from Punjab to Chhattisgarh to be used in the mix. The state is the rice bowl of India but the cost of wheat is lower and the protein levels in wheat are higher. Furthermore, systematic testing, or quality control of the various mixes and RTE rations is not systematic.

Problems with program implementation in the absence of food. Demand creation for the INHP health services in the absence of food is still uncertain. Supply interruptions experienced with the food transition did not provide much evidence that the community is in a position to

demand the types of services provided by the government ICDS and health functionaries. Some bright spots are evident, however, including the community mobilization for transparency and the direct contributions to the program by beneficiaries, local authorities and the states.

Recognition of the phase-over among counterparts with varying degrees of understanding and acceptance. Despite CARE's well-developed and detailed graduation strategy, acceptance and detailed planning for the phase over has not taken shape yet in the states, districts, and blocks. The challenge is to find ways to ensure that as much of the program as possible is sustainable and can, therefore, be phased over. There are examples where this is happening and CARE can use these as best practices to share with others. An example is AP's implementation of government administered AWCs with various food models including a LFM.

Targeting and eligibility: The Supreme Court instructions to expand ICDS represent a new challenge to CARE and its partners. As this becomes operationalized, the existing system falls short of reaching all eligible members of the community. Combined with state-to-state variations (e.g., AP has a cap on eligibility at 58 people per AWC). CARE will need to work closely with local partners to ensure that beneficiaries are selected along clear, transparent guidelines. Negotiations will be needed to ensure that exclusion and inequity are reduced.

Facilitating factors and constraints. Demand creation: CARE has been instrumental in moving the ICDS from a provisioning function to one where the community owns the program and is able to demand services to complement those of the AWW. The enabling environment for demand creation should be documented as a best practice and become the basis for future actions. In addition to documentation, better monitoring or process indicators are needed to reflect demand creation and community empowerment.

Food based (or SN) approach has been both a facilitating factor and a constraint. The reliance on food as an incentive is not likely to change in the near future. However, it would be prudent to examine other incentives that would attract people to seek basic child health services.

Other issues The idea of CARE becoming a TA agency in the future involves several considerations that need to be examined carefully. Increasing TA has cost and organization implications that will force CARE to make choices about its role and direction. Excellent case studies in this area can guide that process.

Conclusions and recommendations

Role of ration: The function of the ration is primarily to act as an incentive to encourage pregnant women and mothers to participate in health activities for small children. The ability of the ration to prevent and treat malnutrition is minimal and should be recognized as such. Once this is accepted, the incentive can be more flexible (RTE foods, for example). Thus, CARE, ICDS and HFW should recognize the role of the ration as an incentive for program participation and minimize the expectation that the ration will prevent or treat malnutrition.

Opportunities for different RTE foods including therapeutic and/or nutrient-dense foods: Recognizing that LFM is a relatively new activity, eventually, there will be a demand for ready to use therapeutic food (RUTF), which is part of community-based therapeutic care of severely

malnourished children and thin pregnant and lactating mothers. PMGY therapeutic foods are a start but a more systematic review of the program and food requirements needs to be undertaken. RUTF requires special formulations with vitamin and mineral premixes, hygienic production, storage and use. Furthermore, it needs to be linked to medical care for the severely malnourished.

The continuum of care: The program has experienced convergence and there is a growing recognition for a continuum of care from ICDS to health, early childhood education and more formal education. Prevention is important, but illness and malnutrition must also be treated using a range of tools and approaches including home-based or community therapeutic care.

LFM as model for phase over: While challenges remain in making community-owned production and distribution of the ration sustainable, the decentralization of procurement and manufacturing shifts the technical functions to the community and encourages ownership as well. Support will continue to be needed but the cessation of CSB has stimulated a wide range of positive effects that will continue to evolve. Documentation and costing of this component, which is directed to disadvantaged groups including women, should be undertaken.

Sharing of standardized commodity monitoring with HMIS and automation of information flows. CARE has made significant improvements in these systems and the experience gained can be shared with state government programs right away. Strengthened commodity management at CARE and within the government can also be applied to such non-food-related supplies as vaccines and micronutrients. As part of the “packaging” of the CARE model for supply management, etc., it would be useful to undertake a cost analysis of the program in different situations so as to guide program rationalization and ensure that delivery systems are competitive.

Capacity building among NGO and government partners: CARE has made progress in the development of systems and tools for its many levels of implementation. The need to build capacity among the partners to better assess problems and adapt local actions is still significant.

Management review and placing CARE in a position to take advantage of new opportunities. The shift in government policy to village level safety nets and food provisioning, together with the Supreme Court rulings, pose an opportunity for CARE to shift from a food aid technical assistance group to one that can be a national partner with central and state governments. Current management structures and operating systems, while relevant to its current role, should be reexamined to take advantage of these new opportunities. A review to examine current central and state level organization should be undertaken in the next year.

Review of indicator choices for monitoring and evaluation: The next year provides an opportunity for CARE to review its indicator collection, analysis, reporting and use. Before the next DAP proposal is prepared (late calendar year 2005), CARE should systematically review the indicators and incorporate some of the new developments in measuring complementary feeding, dietary diversity, etc.

Top down and bottom up improvements in policy. Nutrition policies and plans of action are needed for all states. Demand creation at the village level has clear advantages but local action needs high-level support and coordination. CARE has used its reputation as a technical and

logistics agency to gain access to policy development at local, state and national levels. In partnership with other stakeholders (e.g., UNICEF), CARE should be encouraged to engage state level officials in policy dialogue and implementation of plans of action. This is especially important given the future directions from the RCH2 and Supreme Court initiatives.

Complementary feeding: New opportunities, including RCH2 and the Supreme Court recommendations, make an emphasis on improved complementary feeding timely. The food and programming component needs strengthening. This could include more emphasis on nutrient-dense foods adapted to local needs and building on the experiences in the food transition, including the LFM.

ANNEX C: CHAYAN

Chayan consists of a rural component that operates in districts and an urban component that operates in cities. Originally planned in 45 districts across 5 states, Chayan is currently being implemented in 29 districts and 21 cities in 4 states: Uttar Pradesh, Jharkhand, Rajasthan, and Chhattisgarh and selected areas of Delhi.³³ The key goals of Chayan (2002-2006) are:

- Men and women in 29 districts across 4 states are better able to choose the number and timing of their children
- Men and women in 29 districts and 21 cities across 4 states, and in selected areas of Delhi are better able to protect themselves from RT/STI and HIV infection.

1. Rural Component

Chayan strategies focus on providing information and services for birth spacing and management of RTI/STI. The RHCA (Reproductive Health Change Agent) couple (a male and a female, not necessarily married) is considered the mainstay of the Chayan program. RHCAs currently provide information on oral contraceptives and condoms and refer those women in need of services to the public health system. Their primary task is to generate demand for services through identification, motivation, information provision, and distribution of commodities or referral for services.

Chayan interventions have been in place for about 12 to 18 months. Thus, it is too early to provide substantial comments on quantitative achievements. However, progress in setting up the program has been good.

- Overall it appears that most milestones, planned for FY 2004 have been achieved. Gaps remain in the areas of gender mainstreaming into Chayan components, capacity building, and behavior change communication strategies.
- Trends also indicate that in 2006, most milestones related to establishing demonstration and replication sites have been met. However, the quality of information and services, as well as, capacity building is in danger of being compromised in the push to ensure expanded coverage.
- INHP-II, and its four established best practices, has proved to be an effective platform for launching and integrating rural Chayan interventions for women and men at village and community levels. This is being carried out through the AWCs and convergence among the Anganwadi Worker, the change agents and the auxiliary nurse midwife.
- For the **birth spacing** component, Chayan has partnered with social marketing (SM) agencies in all four states to ensure adequate supplies of commodities and increased

³³ Chayan, too, was subject to resource reductions within a few months of start up, setting back the pace and reducing scale of the project, with negative consequences for human resources and systems.

brand choices. In all DS and some RS, the SM agencies have been able to supply oral contraceptive pills, condoms to change agents and commercial outlets. Chayan has also worked with the health system to ensure that free supplies are available, thus offering a choice to women and men in need, and ensuring uninterrupted supplies. The social marketing component has been slow to take off. One of the reasons identified by the SM partners and communities alike was the low purchasing power of rural communities. Currently free supplies do not appear to be a problem.

- Chayan's selection of improved care-seeking for **RTI/STI** and increasing knowledge levels of HIV/AIDS in a low-prevalence setting could have positive implications for the AIDS scenario in the four states. As migration of men to cities increases, rural women become increasingly vulnerable to STIs and HIV. Ensuring the adoption of safe sexual behaviors and early care seeking are the only ways of ensuring that prevalence continues to remain low.
- Chayan's approach to improve care-seeking for RTI/STI has largely been through training of change agents on signs and symptoms of RTI/STI and mapping referral sites in the private sector. Despite the substantial formative research and the analysis of causes underlying recognition, and care-seeking for RTI, particularly in women, the focus remains on the identification of signs and symptoms. Chayan has not yet engaged change agents to facilitate referrals to providers that have been identified in the mapping exercise. There is little evidence of involving the private and public sectors in RTI/STI management, beyond just treatment of the condition.

Effectiveness of strengthening activities

Demand creation. Substantial formative research has been conducted in the context of understanding community perceptions towards family planning, access and use of birth spacing, and reproductive tract infections. These findings have been used to inform the BCC strategy. Interpersonal communication appears to be the mainstay of the BCC program as far as Chayan is concerned. On the operational level, these findings are not reflected in reaching the target groups, choice of communication methods and material and proper targeting of messages. While some material exists on birth spacing methods and RTI/STI infections, this is not user friendly or particularly suitable for the largely non-literate female RHCAs.

The training of the RHCA focuses largely on technical information and not enough on practical BCC. The RHCAs ability to distinguish couples in need of spacing methods is limited. As a result their efforts are spread over all women and men in the eligible age group. They serve more as agents to spread information rather than as motivators. Only 20 percent of the training program is focused on building motivation skills. Their awareness of the social marketing (SM) component and the location of depots for SM products and free supplies are high. Among married RHCA, men are the more active partners. Issues of privacy and confidentiality have not been internalized. As a result there is open discussion about which contraceptives are being used by which couples.

Where RHCAs have been trained in the RTI/STI component, their own understanding of signs and symptoms, treatment compliance and partner notification is fairly high. However, as in the

birth spacing component, their ability to convey this to women and men appears limited. Contacts are based on chance, one-on-one meetings. There is little identification of opportunities to address this topic, and overall it appears that there is reluctance to discuss this issue. Information on sources of care for RTI/STI seems to emphasize private sector providers. RTI/STI referrals are not being monitored. Both RCH and the AIDS control programs have invested substantially in drugs and supplies for RTI/STI drugs. However, the public sector is not identified as a source of services.

Male participation in the program is limited to male RHCA promotion of condoms and occasional discussions with male self-help groups, where they exist.

Women's support groups to create demand. Substantial potential exists for this mechanism as a means to generate demand from a perspective of rights and entitlements from the state. Mahila Mandal members congregate at the AWC on the NHDs. The Anganwadi Worker, and to a lesser extent, the RHCA use this as an opportunity for group education. Participation of the ANM is questionable since she is quite busy on the NHD. Messages for all meetings span across early childcare, safe delivery, birth spacing and RTI/STI. The focus of these meetings appears to be passive information transfer.

Ensuring supply. Block level resource mapping (BLRM) has identified a network of private and public sector facilities for RTI/STI treatment, but beyond that there is little progress. The orientation and training of providers is scheduled for later. This aspect of the program will need acceleration to ensure that the demand created does not result in frustration.

Quality aspects. The concept of choice is fundamental to family planning service quality. The training of RHCA focuses on the IUD, condom and OCP, but sterilization and injectables are also covered. The Standard Days Method and lactation amenorrhea (a natural consequence of the focus of INHP-II on exclusive breastfeeding) are also covered in the module. Neglect of female controlled methods is one example that reflects the lack of attention given in Chayan to gender issues. Adoption of birth spacing and RTI/STI care seeking are inherently linked with issues of sexuality, low status of women, poor negotiating power and skills. However, these aspects are not included in either the training of change agents or AWWs through whom these components are implemented.

The focus on SM and free supplies is appropriate and based on differential purchasing capacity as well as to compensate for lacunae in the supply systems, particularly the free supplies. While the SM component is in place and the RHCAs (and in some cases the AWWs) stock the SM products (oral pills, condoms), off take is limited. Discussions reveal that the vendors and RHCAs are not prepared to pay up front for the SM supplies. When free supplies are available, it appears that the communities prefer these. Thus, the role of SM in improving access and use of pills and condoms is not very clear at this fairly early stage. Emphasis on SM products varies across states, being higher in UP than Jharkhand, possibly due to the prevailing policy and program environment in these states.

DDKs are available for sale in some centers. The cost of the DDK is quite high and a deterrent, even when free supplies do not exist. In one DS in UP, the RHCA sold three kits over a six-

month period. Two of these were to an untrained individual running a proxy nursing home.

Facilitating the enabling environment. Chayan interventions depend substantially on a well-functioning Health and Family Welfare (HFW) system.³⁴ Instances of large-scale absenteeism, lack of well trained human resources, infrastructure, drugs, equipment and supplies hamper service delivery.

CARE has established strong linkages with the HFW system and their collaboration is highly appreciated at all levels. Mechanisms such as BLAC and DLAC are effective monitoring mechanisms on coverage, absenteeism, lack of supplies, and provide an opportunity for redressing such issues at the local level, or advocating at district and state levels. However, in some jurisdictions there is little buy-in from block and district-level officials. As a result, their participation in these meetings is perfunctory. State level commitment is high, but the disconnect in the co-ordination at various levels, hampers effective performance of Chayan interventions as well as such INHP-II interventions as care of sick children needing facility-based care, ANC and safe delivery services.

Community stakeholder groups. Chayan's strategy at the community level is to engage a range of such community-based organizations as SHGs, Mahila Mandals, and other groups of women and men. This is expected to result in increasing diffusion of messages, greater involvement of community members in discussions of reproductive health, and most importantly, monitoring and assessment of public sector services. In many areas emergency health funds have been instituted, even in non-savings and credit groups, potentially increasing access to credit for poor women. An innovation, seen in some sites in UP, is village contributions to a grain banks, which are later monetized with the proceeds used to enable poor women and children to access care. CBO involvement is currently not geared to implement accountability mechanisms.

Recommendations. Beyond 2006, the content and form of Chayan will depend on the choices that CARE makes. However, one overall recommendation for the period beyond 2006 is that the package of RH components be significantly expanded to include a larger range of interventions that would have an impact on women's overall health, from puberty to the post menopausal stage, truly reflecting the life cycle approach.

Chayan has about 18 months left before the end of the project. Given this relatively short period of implementation and commitments to USAID's results framework, recommendations will perform be limited to strengthening current interventions. The recommendations in this section are aimed at strengthening existing Chayan interventions so that the quality aspect is ensured for the remaining 18 months of the project. Primarily the recommendations revolve around three major aspects:

- Strengthening the RHCA and other **change agents** so that the village level resources are equipped to better respond to community needs for information and referral,

³⁴ It requires functioning sub-centers with ANMs in place, block level and additional PHCs with the requisite team of medical officers, and lady health visitors, including supplies and equipment.

- Increasing capability and opportunities for **CBOs** to engage with village-level resources and providers to build their capacity for demanding accountability, and
- Sensitization of **providers** in the public and private sectors to Chayan and its provision of RH services within a gender framework.

Strengthening the Reproductive Health Change Agent

Recruitment of RHCAs: In some sites visited the RHCAs were former CAs and just added RH messages, supplies and referrals to their CA role. Since it may be advantageous to have CAs who trained in RH it might be useful to combine these two roles.

Increasing the focus of training on motivation and communication skills: Currently the content of RHCA training is substantially on technical issues. The training methodology should be readjusted so that the focus is on BCC skill building so that RHCA can effectively motivate women and men to adopt health-seeking behaviors. This would include effective communication to address prevailing perceptions, attitudes, and barriers to care seeking. This training would also need to include a component for the RHCA on gender and social equity issues that inhibit adoption of healthy behaviors.

Increasing male responsibility: The male RHCAs need increased input on addressing male attitudes towards birth spacing and STI/RTIs. They need skills and material to communicate with men about women's particular vulnerability and to create a positive environment for men to proactively modify behaviors and facilitate care-seeking for their wives.

Differential approaches for FP and RTI/STI care. RHCA orientation and training should differentiate between approaches to identify couples in need of birth spacing and creating an enabling environment for RTI care seeking. The RHCA should be able to focus on enabling newlyweds, first time parents, and multigravida who do not want to use limiting methods to access the birth spacing service of their choice. A useful tool developed by CARE for the RHCA in Uttar Pradesh is a community needs assessment form that could serve as a planning and monitoring tool for other areas as well. For RTI/STI, RHCAs should be trained to address smaller groups of women and men to discuss the causes, nature and consequences of RTI/STI and on high-risk behaviors that predispose people to STI and AIDS.

Improve referral environment and skills. The training content for RHCAs and other change agents should enable them to serve as resources in their communities to ensure that women and men are directed to appropriate providers for care and follow up. This could include participatory mapping of provider locations and facilities, including preferred providers (with a caveat that village-level providers may not necessarily have the skills to identify and diagnose some conditions) group interaction with providers, and listing of services and costs (where feasible) so that communities have a choice of providers.

In order to familiarize RHCAs and other change agents with services offered in primary and secondary government facilities, the CAs could be taken on guided tours and given the opportunity to interact with medical and paramedical staff. As their level of familiarity with these centers increases, they should become more confident about escorting village women to such centers when required.

Enhancing community stakeholder participation

Enabling meetings of CBOs beyond NHD: While NHDs are a good forum for women to meet, it is primarily a forum for pregnant and lactating mothers. These are only a sub set of the women who need information and services for BS/RTI/STI. Thus, other platforms will have to be created for the RHCAs to interact with women and men, without burdening either the RHCA or the community.

CBO orientation: The message for CBOs should be that they have the power to enhance services brought to their communities. Orientation of CBOs should include information about services provided by public and private sectors, entitlements and rights within the public sector. The training should also discuss issues of service quality, patient rights, and redress mechanisms. Chayan should promote increased interaction between providers and CBOs.

Visual aids to strengthen message delivery. RHCAs, CAs and CBOs need effective visual aids that serve as memory triggers for key messages, especially for the non-literate rural population in these states. A variety of aids needs to be available, including case studies, role plays, and skits so that there is variation and fatigue of trainers and audience is kept at bay.

Orient and sensitize health providers to be more responsive to RH and gender issues

Joint training of ANMs and AWWs are happening in some states. They need to be enhanced to focus on being responsive to community service needs and in monitoring outcomes through improved data recording and analysis. One aspect of the joint ANM-AWW training could include training in maintaining and providing feedback on NHD and other community services based on village level mapping.

The role of block and district-level providers can be enhanced through increased orientation, training, and exposure visits so that their ownership of the initiative is equivalent to that of the ICDS.

Chayan should support state level processes for enhancing service delivery through sub center and PC staff. For instance, where the trend is towards deliveries by ANMs, support could be provided through technical assistance and training to build essential obstetric skills among ANM. Jharkhand has requested this.

Chayan should also identify state resources for carrying out gender sensitization of providers: National and state-level programs have been conducting gender sensitization of providers at all levels. This has happened in Rajasthan and Madhya Pradesh. CARE could support attendance of its providers at these trainings. Where they do not exist, CARE should advocate for gender sensitization at the state level so that it becomes institutionalized.

Chayan should continue advocacy activities at the state level so that the health systems are responsive to the needs generated by intensive community processes.

Conclusions: Overall prospects for Chayan to reach its 2006 milestones are fairly high. With additional inputs in capacity building and enhancing of health systems, quality aspects could also be addressed. One of the most significant leverages that Chayan has is the launch of two major national level programs for women's health- the RCH 2 and a community-focused primary health

care program – the National Rural Health Mission. CARE is well placed to support both projects in areas of convergence, community participation, and monitoring. Both these projects offer the potential to significantly impact the service delivery components of both Chayan and INHP-II.

Table9: Rural Chayan –Milestones and Achievements -FY 2003 and FY 2004 Milestones-2003

Milestones-2004	Achievements	Observations
Human Resources in place	State offices have the required human resources for management and support in place. District teams have staff to support INHP-II and RACHNA interventions.	State teams and district staff have made substantial headway in liaising with counterparts and enjoy a good reputation across state, district, and block levels. They serve as resource persons to the ICDS, HFW and SACS in development and monitoring of programs at the state level. Issues of leadership at district level, significant liaison related responsibility for state leaders with ICDS, HFW and JSACS) and lack of technical resources hamper effective implementation, particularly for Chayan .
NGOs contracted for integrating Reproductive Health in Demonstration and Replication Sites (DS/RS)	In all 72 NGOs now include RH interventions and are responsible for implementing them in DS and facilitating in the RS.	Understanding and capacity of NGO staff for Chayan -related interventions is uneven.
District and Block Level Advisory Committees functional on Reproductive Health issues	Advisory Committees formed at block and district level and meetings are held.	Currently they need substantive facilitation by CARE- ownership is primarily from the ICDS system.
Operational Strategy Developed	Operational strategy manual developed and disseminated to all states.	
10 percent DS developed across blocks	All states have included Chayan in 10 percent demonstration sites	
Social Marketing Partnerships –financial and non financial established in all districts	Social Marketing partnerships established.	SM partner staff does not appear to share the program vision.
Private Provider Mapping completed in all states	Private provider mapping as part of Block Level Resource Mapping completed in all DS and in some RS.	Little progress beyond mapping.
Social Marketing Products and free supplies available in all DS	3230 DS, 11940 adjoining villages (RS?) in CH, JH and Raj. In UP where non- financial partnership exists, 96 percent of the DS have one depot holder for Social marketing. Free supplies available at most DS and RS.	Most AWC have supplies of free condoms and oral contraceptive pills. Availability of DDK from government supplies is problematic in some places.

10 percent of the villages have functional RH volunteers (CA/Others)	12 percent of the DS have Reproductive Health Change agents, trained as per the two phase five day CB module. In Replication Sites, RHCAs are just being trained.	
--	---	--

Milestones-2004	Achievements	Observations
HMIS design integrated with INHP	HMIS being field tested	Need to include indicators such as referral for RTI, institutional deliveries, mapping and use of Emergency Obstetric and newborn care.
DTT/BTT functional for CB on RH issues	Training of trainers (initial round) completed	Turnover of trainers is an issue. Competence and RH experience of trainers is an issue and is reflected in the knowledge and skills of CA and RHCA.
BCC designs and materials developed-roll out initiated	BCC strategy developed, based on baseline qualitative and quantitative studies. Booklets, calendars, pamphlets and posters developed	Currently IPC and education sessions during NHD are the key methods of communication. Little use is being made of visual aids particularly by CA and RHCA.
Gender/Underlying Causal Analysis components integrated in Best Practices, Capacity Building and BC plans	Ongoing	
Orientation of Chayan completed at state and district level, areas of convergence with RCH identified.	Completed in all districts.	Convergence most clearly observed at AWC and ANM level. While there is considerable understanding and appreciation at the state and district level, the health systems often do not support Chayan interventions. At the block level, the responsiveness of the HFW is variable and is reflected in program outcomes.

2. Urban Component:

Urban Chayan: HIV/AIDS.

The HIV prevention component of Chayan (Urban) focuses on interventions among High Risk Behavior Groups (HRBG). This group includes Female Sex Workers (FSW), truckers and migrants and unmarried youths (15-24 age group). The interventions are rolled out in 21 cities covering four of the nine INHP states including areas of Delhi. Majority of the States (excluding Delhi) are part of the Low Prevalence High Priority States. All the states have programs that are being implemented through the National AIDS Program and the implementing arm of the program is the State AIDS Control Societies (SACS). It is recognized that though INHP provided institutional linkages, complete integration with INHP has not been possible in Urban Chayan since the key ministry involved in program implementation is the Health and Family Welfare, through specially set up Government run Societies (SACS).

Till date the emphasis on Urban Chayan has been on establishment of demonstration sites though the guiding principle has been that of demonstration and replication. Therefore the

project efforts have been in demonstrating already proven processes in low prevalence states so as to influence the State AIDS Control Societies and its partners to engage similar interventions to attain scale and coverage. In this regard it has to be mentioned that in all the States that come under coverage of Urban Chayan there has been a slow start even with reference to the State mechanism and therefore the linkages with is at varying levels.

The States and urban areas currently under coverage by Urban Chayan are

Chattisgarh	Rajasthan	Uttar Pradesh	Jharkhand	Delhi
Raipur Durg Bhilai Korba Bilaspur	Udaipur Bharatpur Bhilwara Jhodpur Bikaner	Agra Allahabad Lucknow Ghaziabad Varanasi Sitapur Kanpur	Ranchi Bokaro Dhanbad Jamshedpur	Delhi

Performance and prospects

The following grid gives an understanding of the aspects committed during the period 2003/4 in addressing the High Risk Behavior Groups (Female Sex workers-FSW, Truck Drivers-TD, Migrant Workers-MW) and the Status.

2003/2004		
Committed	Status	
2003		
Coordination Mechanism with SACS	YES	SACS in different states are at varying degrees of implementation of interventions among HRBG. E.g. In Chattisgarh there are few interventions supported by SACS but there is no structure and functioning that can augment or scale up CAREs activities at the current level of their functioning. There is a greater degree of buy in from the Ministry of Health of Chattisgarh and the Secretary of Health has invited CARE to develop the State AIDS Policy.
Mapping	YES	In all the states the mapping exercise has been completed and urban locations for intervention roll out has been identified. But the mapping has not clearly given insight for fixing denominators for coverage for demonstrating impact. Moreover, the community involvement in mapping is not evident and therefore the contiguity of mapping and intervention going hand in hand has been a loss of opportunity.
HR structure	YES	All HR are in place and the key resource that provides back stop to the intervention implemented through the contracted local NGO is the pivot. There has been a difficulty in the overall human resource at the district level understand the guiding philosophy in working with marginalized communities. It has been challenging for HR of Care to relate to such communities as well as the staff that work with them.

Cluster for DS to be finalized	YES	All the cluster for DS have been finalized and criteria has been applied for finalizing the clusters.
		2004
BSS	YES	Baseline has been set and the behavioral information has been interpreted and internalized. There are clear evidence of high risk behavior as well as low level of health concern and condom use. It is not clear as to how the BSS data will be used in the construct of intervention as well as the strategies that will drive the intervention. This needs to be better understood location by location and state by state.
BCC Strategy	YES	The BCC strategy is in place and is provided to all the States. While there is an approach which is predominantly interpersonal through the peer educators and others who are part of the stakeholder community, some of the materials are not in sink with the “evoking health concern philosophy”.
CB Modules Development	YES	Modules are available and training completed (first round)
NGO Subcontract for implementation	YES	All NGOs in Urban areas have been contracted
NGO Training	YES	NGO training rolled out but at varying levels
Condom outlets establishment in DS	YES	Majority of the urban locations have condom outlets at the DS but the overall strategy of social marketing needs to be well articulated

		2004
Committed	Status	
Functional Peer Educators	YES	Peers have been selected from both the population under coverage as well as stakeholders.
Needs Assessment Stake Holder Analysis Micro planning	YES	Completed. It needs to be better used in local design and fed into the planning of interventions
HMIS	YES	In process and to be effected

2005		2006	
Committed	Prospect	Committed	Prospect
Private Public Health Service Providers Training and Linking in DS	Needs greater studying.	Chayan BP tools to be adopted by others	Effectiveness of tools to be captured
TI in all mapped sites through agencies including SACS	Roll out plan dependent on SACS plan	Common program monitoring with SACS and Partners	Highly dependent on the MIS established by NACO/SACS
Replication plans	Same as above	Private/Public health Care providers trained are linked in all sites	Depends completely on the 2005 outcomes
Advocacy and networking	Elements of this is in place already but outputs based on activity to be clarified	Linkage of PE/SH and Service Providers	Community Systems to be looked into for higher prospect
Short Learning Cycle for addressing underlying causes	High prospect in DS	HMIS in replication areas	Depends on NACO/SACS and on the commitment for TI resources

Observations:

- Program presence a one hundred percent
 - 100% roll out of Urban HIV prevention efforts among HRBG.
- High degree of variability
 - Though the program is on the ground in all locations, there is varying levels of understanding on the processes for intervention development leading to high degree of variability.
 - Varying levels of program maturity in different urban venues of program. This is seen both within and among interventions among female sex workers, truck drivers and migrant workers.
 - Varying levels of commodity availability and access
- Lack of effective service delivery for minimizing HIV transmission risk

Effectiveness of strengthening activities

Increasing demand:

- The key aspect of intervention is the integration of BCC into the program. The major part of BCC is through IPC and therefore the demand creation needs to be specific to enhancing health seeking behavior and initiating use of commodities like condoms. There are more local media IEC type activities than skills building among peer workers in providing IPC. The lack of IPC material has led to use of generic materials.
- There is high degree of peer cohesion and community mobilization. Therefore creative development of tools that will enhance the scope of communication is the challenge. There needs to be a clear purpose driven outreach that is able to periodically reach the population under coverage. Due to early stages the strategies and tactics that will best produce demand need to be developed and deployed.

Improving supply:

- The key aspect to risk reduction is the effective treatment of STI. The linkages to STI service providers is yet to be strengthened. The availability of free supply of condom is palpable but the social marketing needs to be more aggressive.

What worked / What didn't work

- Organizing the intervention through implementing partner NGOs seems to have given a good head start
- Mapping and enumeration has given good information but it has not lent itself to intervention development for coverage and saturation in that geographic area
- Condom Social Marketing (commodity for risk reduction) is not integral to the response
- Linkages with existing intervention or with the Government Program (lack of clarity of purpose)
- Innovation and demonstration are clear and purposeful, but replication and graduation as a strategy for urban areas is not clear to implementers.
- Since implementation is in different stages as well as different levels of capacity, communities served under the program is in varying degree of connectedness to the response. Nonetheless, mobilization has worked and needs to be strengthened.

Facilitating factors and constraints

- One of the major constraints is the level of engagement of SACS. This has been dependent on the nature of SACS response itself. While in some locations, the SACS is

implementing interventions and are engaged with civil society organizations, in some locations the SACS are slow in their overall response. Therefore, the major constraining factor to replication and scaling up will be because of the level of interest and involvement of State AIDS Control Societies.

Other questions/issues – The peer education model:

- In the urban areas, the peer educators are the interface between the community and the program.
- They have been identified both from the population under coverage (female sex workers, truck drivers and migrant workers as well as youth) as well as those population that are proximate to them (e.g. dhabawallas in truckers intervention).
- The concept of peer education itself is not an innovation but the way that the peer educators function as not just providers of information but providers of referral is the important element.
- Though the criteria for selection of peer educators is not clear, it is evident that these peers are able to take sexual health information as well as commodities closer to the practitioners of High Risk Behaviors.
- The inputs that are provided to enhance the credibility of the information that they give are not particularly behavior change focused and therefore the peer educators may remain at the level of information providers.
- Though they are expected to be promoting health seeking among those who need STI treatment there is not much of investment in skills building among the peer educators.
- There is an element of fear production by use of tools that are very graphic in showing genitals with disease which can often be deterrent since many individuals may not have the kind of presentation that are depicted.
- Moreover, there are anecdotal evidence for antibiotic abuse as well as inadequate treatment and therefore the kind of presentation that are shown as pictures may be related to by the population as “I don’t get those kind of diseases” and therefore chances of getting people who have moderate symptoms feeling “I don’t need any treatment”.
- The most critical demonstrability comes within the program addressing female sex workers. This is in the context of “taking responsibility and making choices”. The critical aspects of demonstration will probably take the path of “right to health” as well as local self organizations – “right to govern” with a high degree of gender based programming leading to “women are not transmission agents but women are indeed the ones that protect themselves”. There are palpable examples to this in places like Raipur, Bilaspur and Durg in the state of Chattisgarh. Therefore, the peer model can go beyond the conventional peer education which is predominantly as “show and tell” information driven to being community driven.

- The peer education coupled with condom promotion is to focus commodity as an important element in prevention but the synergy of social marketing and free distribution is low. Availability of condoms among peer educators for provision to the people engaging in HRSB is high but self reported condom use suggest that there is a creation of socially desirable responses from the community.
- All the community processes should culminate in risk reduction by improving the content that address STI and Condom use. In the void of a strengthened risk reduction approach, the primary intent for STI and HIV prevention could be compromised. (New insert)

Recommendations

- Address variability of program across the board and build a uniform response taking into consideration the local nuances. Therefore, utilizing uniform strategy and developing local tactic will be essential
- Saturate coverage in the areas of operation, consolidate and scale up through the involvement of the State AIDS Control Societies
- Capacity building within CARE, State AIDS Control Societies, partner NGOs and frontline personnel including the community members who are part of the response has to be well thought out and outlined as well as commissioned urgently.
 - Build capacity for the State AIDS Control Societies for scaling up and develop closer links for working with them including assisting in the development of State Plans, strategies and policies.
 - Develop core capacity and strengthen the same in-order to play a role of technical capacity builder in the State
- Go beyond conventional peer model and develop processes of community engagement and involvement that could mature to community taking the lead towards risk and vulnerability reduction
- Develop a coherent strategy for providing treatment of STI and therefore examine scope of referral as well as provision within the scope of the program
- Whilst all elements that go to catalyze community changes, that promote reduction of vulnerability are essential, the risk reduction part has to bring in “evidence based strategies” thereby strengthening the community response through a content driven approach that enhances the scope of addressing STI and Condom use.
- Develop strong linkage with other players including other NGOs towards building high quality intervention locally
- Move beyond BCC to IPC that will be easy for the community to use and therefore

production of materials in participation of the community is essential

- Develop a strong local monitoring process that could be community friendly so that the community is able to take stock of what is happening and therefore advise the project on “how to enhance outreach” and “how to improve referral” etc.
- In addressing quality and equity in the next phase of the program, community consultation process being set up can promote both. Therefore, building a community ownership is essential.
- The change agent concept in the context of peer education needs to be exploited well in the agency of the marginalized population. This can take shape in the form of community committees and working groups and self organizations that can be powerful change mechanisms in future.

Conclusion

In the short period of time, Urban Chayan has moved along in a positive direction. In the States where targeted intervention among marginalized population has not been a key thrust (since most of the states have a low prevalence), there has been ongoing dialogue established with the State mechanism that addresses HIV/AIDS. Since it is early days to comment on the quantitative achievements of urban Chayan the processes and the qualitative aspects of the project shows that progressive steps are being taken. The opportunities for augmenting intervention response in the Chayan States are present. The National Program has identified the very states as “high priority – high vulnerable” states and therefore the opportunities for enhancing capacity for augmenting response is evident.

Though expansion of such interventions is essential for scaling up and saturating, the strategies for such expansion should be well thought of. Whilst CARE may be the only opportunity in the State for expansion, there is a need to build capacity in the State for the Government supported program for attaining expansion, scale and coverage. This does not necessarily mean that Care should not attain full coverage in the geographic areas that they are currently engaged in.

With the National AIDS Control Organization currently undertaking the planning of the Phase 111 of the program, it gives an enormous opportunity for CARE to forge a synergy with GOI and the State in building a robust response in the low prevalence state both in urban and rural areas.

ANNEX D: COMMUNITY PARTICIPATION, GENDER, AND SOCIAL EQUITY

1. Findings

One of the major project goals of RACHNA is that “communities (will) sustain activities for improved maternal and child survival.” Among the key operational components of RACHNA listed in its documents, is to “identify and address exclusion and inequities based on gender and

other factors.”

Community-level data are very limited. There are two management performance indicators. One is the percent of AWCs with change agents. The baseline was 12 and the figure for FY 04 is 30. This is a significant improvement, but still very low. Panel data show that 36 percent of AWCs have at least three trained CAs. The other performance indicator is about CBO and/or PRI participation in NHDs. No baseline is available and the FY 04 figure is 20 percent.

The overall observation of the Review Team is that community workers, institutions and processes are in place in a majority of demonstration and replication sites, although there is scope (and opportunity) for improvement. Full graduation and sustainability by 2006 as targeted may not be uniformly feasible. A longer phase of capacity building of community agents and institutions in community processes may be required.

It is significant that all government officials whom we spoke to at various levels, and most locally-elected panchayat officials, valued CARE interventions despite the withdrawal of food supplies. They maintained that the relevance of CARE’s contributions would remain even if oil supplies were also withdrawn. The contribution of CARE is seen mainly in the identification and training of change agents, formation of SHGs and in community processes and capacity building. They would like to see CARE contribute these elements to the government health and nutrition programs over an even wider area.

In our field visits, we also found encouraging levels of knowledge about women and children’s health and nutrition in village communities, ownership and value for these services, and engagement with and support the service providers. Once again, these levels are not uniform, but their prevalence is a significant achievement of the program.

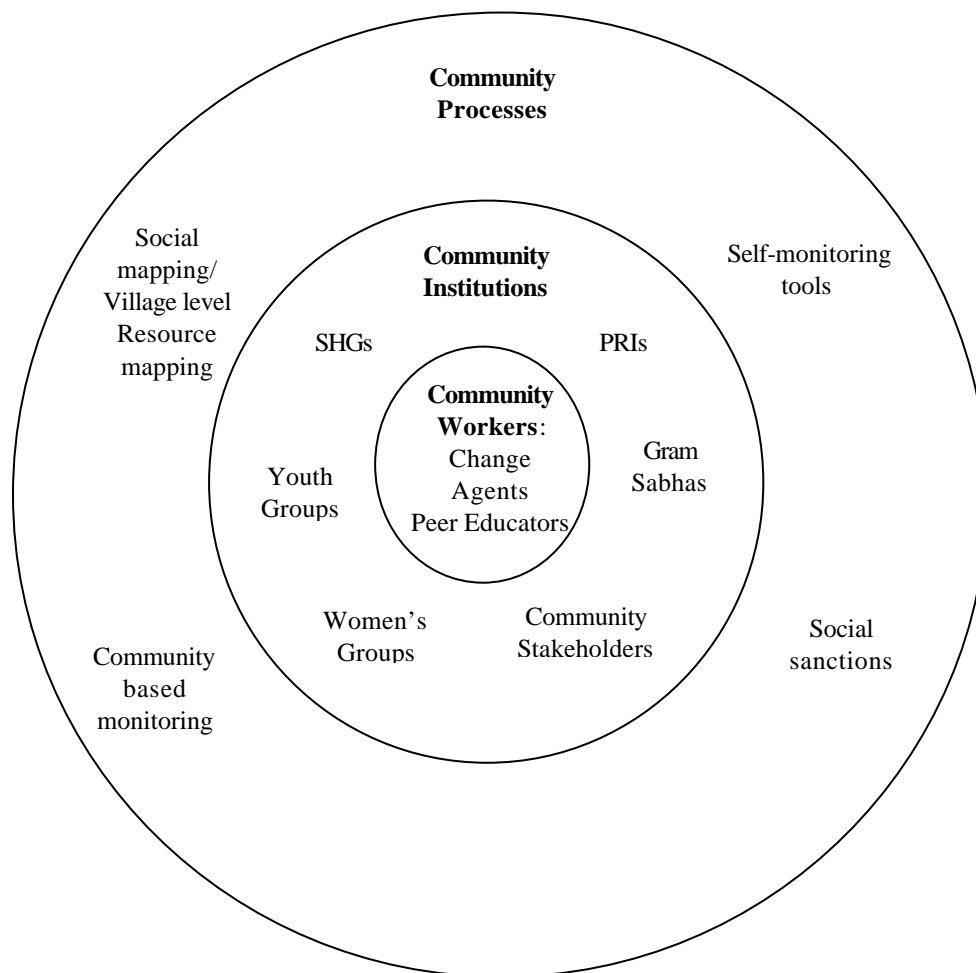
In the program design of RACHNA, CARE identifies a major underlying cause for food insecurity to be “a lack of community unity and organization for problem solving.” Among the program and system gaps that it acknowledges is the “lack of community participation and demand for quality health and nutrition services.”

The diagram on the next page (Figure 1) attempts to portray three levels of community participation and the RACHNA elements that fit into them. The three are community workers, community institutions, and community processes.

The RACHNA Program design framework describes the following rationale for community participation: “Mobilizing communities and building ownership about the importance of appropriate health, nutrition, reproductive health and sexual behavior would lead to sustained behavior change and ensure regular delivery and utilization of services.” This would happen through:

- Increased awareness among community groups and greater engagement of local governance;

Figure 1: Community Groups, Institutions and Processes



- Increased community capacity to analyze and address health and nutrition issues;
- Better program monitoring and problem solving at all levels;
- Increased community ownership and intervention in promoting behavior change at family and individual levels; and
- Faster behavior change by providing enabling environment at community and family levels.

The **community workers**, especially the change agents, are arguably the greatest asset and strength of the program. RACHNA defines a CA as an active, interested member from the community who acts as a promoter and monitor of health and nutrition practices for 15-20 families in the neighborhood. Change agents voluntarily counsel families to promote positive health behaviors in their catchment areas. This cadre of nutrition and health resource people at the community level is expected to serve as a link between service providers and communities. They are also expected to promote and monitor positive behaviors among their neighborhood households.

A number of organizations and some governments the world over have experimented with community volunteers in public health and nutrition, and the experiences have been generally positive. RACHNA attempts to build on the positive experience of INHP I. Community volunteers from the INHP I experience were found to be a good source of support for overloaded field functionaries of ICDS and RCH, particularly for maintaining contact with specific households on a regular basis. In addition, they were expected to form an important bridge between the systems and the community in terms of being able to positively influence both, behavior change and service delivery and uptake.

There are at least three strengths of the CA in the CARE model: 1) CARE has demonstrated that it is both feasible and desirable to work with voluntary CAs, whose morale is based on non-monetary rewards of social value and leadership; 2) the decentralized coverage of 15-20 family clusters; and 3) the emphasis on preventive and promotional health (including nutrition) rather than curative health.

A recent mid-term review undertaken internally by CARE found that more than 36 percent of the AWCs, at a national average, had at least three CAs. Statewide averages were uneven, with the highest ratios in Chhattisgarh (60 percent), high ratios in Madhya Pradesh, Andhra Pradesh and West Bengal, and lower ratios (15-25 percent) in Rajasthan and Orissa.

This matches the general observations of the reviewers in various states, who found CAs in position everywhere, with high to medium levels of motivations, knowledge and community outreach. They were valued by service providers (AWWs and ANMs), because they extended their reach and helped to promote compliance with healthy behaviors and use of health services. They were observed to have carved out for themselves a position of respect and credibility within their respective communities, which is remarkable in societies that remain patriarchal and unsupportive of public leadership roles for women. Anecdotal evidence gathered by the review team during field visits also suggests the positive influence of CAs on behavior and compliance among mothers and (less consistently) men, and other women (who were not mothers).

Service providers also appreciated the fact that they are voluntary workers from the communities. As one ANM in Chhattisgarh perceptively remarked, “People have greater trust in the same advice when it comes from the CA than from me. This is because, unlike me, she is an unpaid worker, and therefore, her advice is seen as more objective and, therefore, more credible and authentic.”

Especially good CA results were seen in Chhattisgarh, partly because of the convergence of the CARE CA strategy with a statewide “*mitanin*” program of the Chhattisgarh state government that places women health volunteers in every hamlet. There are also significant learning’s from West Bengal, where the CA is most organically linked with self-help groups (SHGs) of women from whom they derive considerable support. The experience of other CA programs (like the Saathin program in Rajasthan), have shown the dangers of isolated female CAs when they have to deal with socially sensitive practices.

The other major community worker in RACHNA is the peer educator of Chayan , drawn from high-risk groups and youth. The internal RACHNA mid-term review reports 1,565 peer

educators identified and trained, made up of 265 sex workers, 365 truckers, 267 migrants and 688 youth.

This program is still at an early stage of development, but reviewers were impressed by the levels of motivation among peer educators in some states. For stigmatized groups like sex workers, there were in some states positive spin-offs observed in terms of greatly enhanced self-esteem, hope and personal dignity.

The most effective and vibrant **community institutions** that were observed during the review were of SHGs of women, many of which were constituted as part of the ICDS mandate. Several of these groups became major allies of the efforts to promote behavior change and compliance with healthy practices. This linkage was strongest in places like West Bengal where the CAs are chosen and nurtured by the SHG itself.

The engagement of PRIs, as the panel data show, is low. Involvement may depend partly on the strength of these local institutions of government in various states. The RACHNA mid-term review mapped the attendance of PRIs and CBOs at NHDs in AWCs as a proxy of PRI involvement, and found high levels in AP, CG and MP and low levels in JH, UP, RJ and WB. The Chhattisgarh team has made significant attempts to engage the Gram Sabha or the village assembly of all adult voters.

There are a number of other official and voluntary formations (both based on functions such as forest protection, and identities such as caste) in the village, with which the program was mandated to engage. But there were fewer examples for the team to observe. One unusual example was observed in Chhattisgarh of a forest protection committee that was successfully drawn in as partners in women and child health and nutrition.

The most important **community process** that has been adopted as a “best practice” throughout the RACHNA program area is community-based monitoring systems (CBM).

The first widely used CBM is **self-monitoring tools** (SMTs). The most widely-used tool creatively adapts local cultural practices of wall drawings and embroidery, in which each line or drawing is assigned a symbolic value (e.g., the number of antenatal checkups completed, or the number of iron tablets consumed). The mother would learn how to draw (or embroider) the figure and the symbolic value of each element, and thus would be able to keep track of where she is in her pregnancy and the activities she needs to complete.

This was expected to serve as a reminder for the mother, and also an easy mechanism for dialogue between the service provider and the client. Review team members observed SMTs in a number of home visits. However, often these were drawn by AWWs themselves. The figures displayed on outer walls seemed directed more at program reviewers than the women themselves. All in all, this did not appear to be a robust instrument for self-monitoring the women or their families.

The other major community-monitoring instrument envisaged under RACHNA is the **social map** or village resource map. An ideal social map should depict, apart from the key landmarks of the village, every household in the village with household number marked on them. It should also

highlight the main resources of the village, which are listed in the RACHNA document to include CAs, dais, village pradhans, AWC sub-centres, *Panchayat Bhawans*, etc. According to the design document, the village social map needs to be developed through a participatory process involving key stakeholders in each village, such as women's group members, men, dais, change agents, AWWs, other opinion leaders and elders in the village. The maps seem to be useful at the outset for planning and defining households for which CAs are responsible. Beyond that it is difficult to determine how useful they are. Several informants noted that they are not updated very often and do not provide much more relevant information than the CAs, in particular, already have.

Gender and equity data are also very limited. The panel data were desegregated by SES (low and high). The summary analysis indicates that changes are being seen among the poorer half of the target populations that are at least equal to, and sometimes greater, than those among the "high" SES group.³⁵ The report also points out that all of the target groups are poor, including those in the "high" SES group. Gender analysis by CARE staff has also failed to find any significant difference in the way girls and boys are handled in the project or in their nutritional status.³⁶

One of the most pervasive gender/equity issues is the treatment of **women primarily as mothers**, rather than as women who have value in their own right. In part, RACHNA inadvertently reinforces that message by the very nature of the program, which is almost exclusively focused on the child and the mother's childbearing and child-rearing role.

The **social maps** mentioned above do not always reflect social or geographical exclusion, much less a social diagnosis of the needs and status of women's and child's health and nutrition.

2. Recommendations for the Current Program

a. Community Participation

1. The RACHNA design also provides for specialized **reproductive health change agents** (RHCAs) (who may be individuals or couples). The experience with this separate cadre of CAs as in Rajasthan, is less positive, especially in rural contexts because they have to deal exclusively with the more difficult and stigmatized elements of public health (birth spacing, RTI/STI and HIV/AIDS). It would seem to be a more effective strategy to integrate reproductive health concerns with other more generalized public health and nutrition duties of the CA.

2. From an equity perspective, the review did not find wide or scrupulous adherence to the prescribed process of **selecting CAs**. According to RACHNA norms, for identifying suitable CAs, one should use the social map technique to map the change agents and ensure that the CAs are drawn from all pockets of the village. Hamlets and marginalized caste groups will have to be given extra attention to ensure inclusion of CAs from their pockets. Separate meetings may have

³⁵ Reflections, p. 48.

³⁶ Personal communication, 1/17/2004.

to be held in such pockets to mobilize local leaders. The review suggests a strict adherence (and sensitization) to this critical requirement.

3. SHGs are primarily organized around **thrift and credit**, and many are unable to rise above these so-called “entry-point activities” to nurture consciousness, concern and skills about women’s and children’s health and nutrition, much less about gender equity. Efforts should be undertaken, therefore, to organize women’s group not just around thrift and livelihood but also more generally around women’s entitlement to health and nutrition.

4. Although social maps are described as “monitoring” tools, they are also envisaged in the RACHNA design as participatory planning tools as well, particularly to deal with **geographical and social exclusion**.

In practice, however, as with the use and application of other CBM tools, the use of these social maps was often more of a formality than to drive program. Social maps tend to be a mechanical, pictorial representation of those eligible women and children that have been identified by functionaries and change agents, rather than a genuine participatory mapping by the entire community to identify resources, needs and barriers. Thus, the maps do not always reflect social or geographical exclusion, much less a social diagnosis of the needs and status of women’s and child’s health and nutrition.

At the planning stage itself, we have observed that, contrary to its stated objectives, the social map is not used widely as a participatory instrument to identify and develop appropriate plans and strategies to address exclusion. The more obvious form of exclusion is geographical and spatial – of settlements that are excluded from nutrition and health services because of distance or natural barriers. However, the much more tenacious (and invisible) forms of exclusion are social, often hidden and nurtured within the very spatial groups that are theoretically fully covered by the AWC services.

Adjustments can be made during the current implementation period of the project to enhance the use of social mapping so that it identifies and addresses both geographical and social exclusions. Greater effort is needed, including the development and application of participatory instruments, program strategies and monitoring instruments, to reach those groups that are most marginalized and excluded (e.g. the disabled, dalits (backward castes), stigmatized groups, working children, and migrant workers). This is one of the most important mid-term corrections that should be undertaken in the program.

5. Participatory methods can also be used for more comprehensive community **nutrition and health planning**, based on a social diagnosis of reasons for and locations of preventable and treatable morbidity, mortality, malnutrition and hunger.

6. It is not just that social maps are rarely genuine participatory planning tools. Even as a **community monitoring** system, it is, at best, only monitoring program compliance. Community monitoring needs to be expanded to include program supplies, expenditures, objectives and outcomes.

A promising practice that was observed in Chhattisgarh is “monitoring committees” for each

AWC that are approved by the Gram Sabha or statutorily constituted and empowered village assemblies. The committees are made up of women and SHG group members, PRIs, representatives, CAs, service providers and other respected individuals. These committees review supplies, expenditures, program targets and achievements every month.

If these monitoring committees report back regularly to the Gram Sabha, it will greatly enhance the objectives of community monitoring, accountability of service providers and community problem solving. Such “social audit” processes can be introduced in the current project to enhance program transparency and accountability to communities.

7. Another community process that is advocated by RACHNA is “**social sanctions**.” This is a strategy to identify and secure the active support for program goals and strategies from influential opinion leaders within families, specific target groups and the wider community.

However, social sanctions seem to be a conscious strategy mainly in Chayan work. Social sanctions should be adopted as a much more conscious strategy in INHP-II, as well. A best practice observed in Chhattisgarh was that of engaging husbands and mothers-in-law in all aspects of the programs related to women and children’s health.

b. Gender and Social Equity

1. The messages from both communities and staff, constantly reinforce the value of a **woman primarily in her role as a mother**. She is encouraged to access better nutrition on health services, primarily in order to improve the health of her child. Even adolescent girls tend to be addressed either as “future mothers” or as potential sites of HIV infection. Thus, for instance, anemia in adolescent girls is combated primarily for the sake of the health of their future children. Even if RACHNA is programmatically focused on women in the reproductive age group, its messages can still be tailored more sensitively to advancing the value of women intrinsically in their role as human beings, as workers, as social and cultural agents, as community leaders etc. This cannot be overstated in a country characterized by an adverse and declining sex ratio, which signifies socially dispensable “missing women” who are lost because of social denial of their equal right to nutrition and health care.

2. In a similar vein, it was observed in Chayan that **groups of women in especially difficult circumstances**, like sex workers, are organized because of HIV vulnerability not because of gender discrimination and social vulnerability. Once again, care should be taken not to instrumentalize these highly disadvantaged women to advance social objectives, however, lofty.

3. There is **poor representation in RACHNA of women in senior and program positions** of the organization. This needs to be redressed right away. There should be a conscious diversity policy in staff recruitment, to also expand the involvement of people from socially disadvantaged castes, religious and ethnic groups, people from rural and non-English-speaking backgrounds, and persons with disabilities.

4. There is also a need for systematic and reliable collection and analysis of **gender desegregated data** at national, state, district and local levels on both process and outcome indicators. Strategies need to be developed and built into the M&E system to review and

analyze these data and respond with timely program corrections.

5. Program strategies and their implementation are often blind to the weak bargaining power, access and entitlements to health and nutrition of **women *within* the family**. For instance, THR's may enhance attendance and compliance with other aspects of the program, but because of cultural factors, women are unlikely to receive all or even a major share of the THR's when they are added to the family pool of food. Similarly, birth spacing and RTI/STI strategies do not consciously focus enough on those strategies that are within the power and control of women. Program strategies should be reviewed in the light of the low power, access and rights of women within families and mid-course corrections introduced.

ANNEX E: SCOPE OF WORK

1. Abridged Scope of Work

A draft scope of work was discussed in a preliminary team meeting in October 2004. It was found by the team to be overly ambitious for the amount of time available. CARE agreed to modify it but a formal revision was not prepared. Rather, CARE presented the following scope of work at the initial team meeting in November.³⁷

Goal: Analyze the progress, identify gaps and make recommendations for improvement for RACHNA to achieve the stated objectives by FY 2006.

Broad Questions: what has worked well and why? What did not work well and why? What can be done for improving the program effectiveness?

Objectives:

- **INHP-II:** Assess progress made, identify links between project strategies and the results achieved, and make recommendations.
- **Chayan :** Assess implementation progress against milestones for FY 03 and FY 04 and make recommendations. Assess effective utilization of INHP-II platform for Chayan and make recommendations.
- **RACHNA:** Assess the effectiveness of program management and monitoring. Assess integration of gender and equity issues.

The Review: Primary stakeholders: CARE/India, FFP/Washington, USAID/India, Government of India and other partners.

Key Questions from CARE: Are the thinking and planning of RACHNA adequate to achieve the impacts intended? Are the approaches and methods used, and appropriate? Is the pace of accomplishments justifiable? What needs to be improved to ensure achievement of end-of-

³⁷ Power Point Presentation: Scope of the Midterm Review, November 29-December 17,2004, Briefing for Midterm Review Team.

project outcomes and impacts?

Key Questions from USAID: Did the program achieve committed performance targets? Is the pace of implementation and monitoring and management systems adequate to ensure achievement of end-of-project results? Are the program inputs and utilization of resource consistent with the progress made? Is the project (INHP) progressing towards graduation as planned? How effectively the platform of INHP was used to integrate Chayan interventions? How effectively has the TA been utilized? What additional support may be required?

Questions potentially of interest to the Government: In what specific ways has RACHNA benefited ICDS, RCH and NACPII? What lessons does the RACHNA experience offer to ICDS and RCH programs to make them more effective? How can the partnership become more effective?

Information Sources: Desk Review (list of documents); Field Visits (list of key project staff to interview); Key Individuals (CARE, USAID, Government, Other Partners, technical support agencies, external agencies, social marketing partners).

Preparations needed: Review of critical documents at program level; development of tools and methodology to address the key questions; development of a work plan with roles and responsibilities at individual and team level; review and finalization of the field visit plan.

Logistics: 24-hour work and meeting facility with some critical documents for review and some references. All the information requests to be channeled through Dr. Rajesh Bhaskar, Manager M&E. Ruben Menon is the point of contact for any of the logistics/travel arrangements. RACHNA team members available for any individual consultations. All the field visit travel arrangements will be made by CARE India.

Team composition. Team members, who were recruited, in part, for their expertise in selected program areas of interest, prepared collected information and drafted sections for the overall assessment and annexes for the report. The members and their assignments were Jack Reynolds (Team Leader, management, M&E), Alfred Bartlett (newborn care and immunization), Bruce Cogill (supplementary nutrition), Harsh Mander (community participation, gender and social equity), Subadra Seshadri (nutrition), Sundararaman (HIV/AIDS), and Rajani Ved (antenatal care, delivery, STI/RTI and youth).

2. Methodology and Schedule

Documents. The MTR was based largely on documents prepared by the project staff, supplemented by field visits to selected districts in each of the eight primary project states and Delhi. The amount of documentation was large so, on the advice from CARE, the team concentrated on five-six key documents, the most important of which were the DAP, the amendment to the DAP, and “Reflections on a journey...RACHNA midway.” A complete list of the documents provided is in Annex F.

Data sources. Data reviewed were taken from annual reports and two surveys, called panel data or rapid appraisals (RAPs) that were carried out in 2003 (Round 1) and some 8-12 months

later in 2004 (Round 2). The districts were considered by CARE to be representative of the project districts in each state. Mothers of children 0-24 months were sampled along with service providers (AWW, ANM and change agents). These data were summarized in the “Reflections” document mentioned above and provided comparative outcome data for each state. The outcomes reported cover all of the key INHP-II interventions and are grouped in this report under the following categories: Antenatal care, Newborn care, Supplementary food, Nutrition, and Immunization. There are no comparable data for Chayan, although data were collected on Chayan in R2.

A Note on Panel Data Limitations. Although the panel data are impressive and informative, there are a number of limitations that need to be kept in mind when reviewing them. They are not exactly comparable with the baseline and endline targets in that they do not include demonstration sites (the baseline included demonstration and replication sites). Since demonstration sites are likely to have better outcomes than replication sites (they have been operational longer, have more project resources and receive more technical assistance) it is likely that baseline/endline data will show better results than the panel data.

There are no control groups in the project as the panel samples did not include non-project areas. The sampling method and sample size differed somewhat over the two rounds. The first round used a two-stage cluster sampling approach, the second only had one stage. In the first round, five AWCs from five blocks were sampled and this was substantially increased in round 2. The sample size for the 0-5 age group (150) was increased in the second round (to 460) to match that of the 6-23 age group. Statistical tests were run on each variable for each state and many of the results showed no statistical significance. Those that were statistically significant have a wide error range, plus or minus 10 percentage points.

On the other hand, both rounds were conducted in the same areas, which should strengthen reliability. The combined size of the samples of the eight states is large (4,800 for R1 and 7,360 for R2), which should enhance validity and reduce the sampling error. In addition, Round 2 data should be better than Round 1 data, not only because the sample was larger, but it was broader as well. There were 25 primary sampling units per district in R1 and 90 in R2. CARE notes that the sample for R2 is more evenly spread across the district and is likely to be more representative” than the sample for R1.³⁸

Interviews. Meetings were held in Delhi with CARE staff, USAID, HFW, ICDS, NACO and a number of donors, including UNICEF and the World Bank.

Site visits. The team split up to be able to cover more field sites. Two-three person teams visited one state each, spending most of their time in one or two districts where the project was active. The teams were reconstituted (one-two members) for the next visit, which was also to one or two districts in a project state. Interviews were held with RACHNA staff (district and

³⁸ Reflections, p. 46.

state levels), AWWs, ANMs, change agents, private health providers, representatives of HFW and ICDS, state and district level functionaries, self-help groups, local governance groups and clients. In Chayan states the team members also met with SACS, DACS, NGOs and others involved with RH, youth and HIV/AIDS. The following table summarizes the sites visited and team assignments.

The MTR field work was conducted over a three-week period from November 29-December 17. The first 3 days were spent in Delhi, the next 9 in field visits, and the last 7 days in Delhi preparing for and making debriefing presentations. Four debriefings were held: for CARE, USAID, HFW and IDCS.

Table 10: Team Site Assignments

State	INHP-II	Chayan	RACHNA	Team Member
Delhi		SR		AB: Al Bartlett
Rajasthan	SS, JR	JR	JR	BC: Bruce Cogill
Madhya Pradesh	JR			HM: Harsh Mander
Chhattisgarh	BC	SR	HM	JR: Jack Reynolds
Uttar Pradesh	AB, RV	RV		RV: Rajani Ved
Jharkhand	RV	RV		SR: Sundararaman
West Bengal			HM	SS: Subadra Seshadri
Orissa	SS, AB			
Andhra Pradesh	BC			

3. Report Structure and Outline

The initial report outline followed the principal categories in the above SOW. However, after returning from the field visits and making an initial presentation of findings to CARE, the team revised the format of its presentation for USAID. The team and CARE later agreed to use this format for the overview of the report. Material already prepared by team members on their assigned topics was to be included in the report as annexes. Thus, while these annexes follow the original SOW outline, the overview follows the outline of the presentation prepared for USAID. The principal components are summarized below:³⁹

- Achievements
- Prospects for 2006
- INHP-II Findings
- Chayan Findings
- Community Participation, Gender and Social Equity
- Challenges
- Opportunities and

³⁹ For details see Presentation for USAID.ppt

- What's Next (recommendations for this project; and critical choices for CARE in the future).

Most of the team members were able to provide a first draft of their assigned sections before they left Delhi. However, it was not possible to prepare a draft of the full report until after leaving India. The first full draft was completed December 26 and sent to team members for comment. A revised draft was sent to CARE January 4 for review. The final version of the report was sent to CARE on January 21.

ANNEX F: PROSPECT TABLES FOR 2006 OUTCOME ACHIEVEMENTS

Table11: Indicators Most Likely to Show Significant Improvement by 9/30/2006

Likely to reach target or 10 points above R1	Baseline	Round 1	Round 2	Target	Rating
1. Consumed at least 90 IFA tablets*		54.5	69.9		H
2. Followed the use of 5 cleans at birth ^{40*}		27.3	41.6		H
3. Delayed bath for at least 3 days*		8.9	27.3		H
4. Early breastfeeding	15	38.7	45.2	35	H
5. DPT 3 vaccine received (card only) *		79.5	80.0		H
6. Measles vaccine received (card only)		56.4	66.8		H
7. Fully immunized (card only) *		53.0	60.9		H
8. Fully immunized on time*		37.2	47.7		H
9. Exclusive breastfeeding until 6 mo.	37	67.5	66.7	57	H
10. Not started on liquids/solids until 6 mo. *		51.5	69.3		H
11. Started giving solids between 6-8 mo.	60	52.1	62.3	67	H
12. Gave at least ½ quantity of semisolids (6-11 mo.) *		12.1	19.5		H
13. Gave at least ½ quantity of semisolids (12-23 mo.) *		6.0	14.3		H
14. Receipt of supplementary food during pregnancy	61	69.2	63.3	65	H
15. Receipt of supplementary food in first 6 mo.	50	62.7	64.7	65	H
16. Receipt of supplementary food after 6-(36) mo.**	64	54.3	60.4	65	H
17. Receipt of supplementary food 36-60 months.*	NA			65	H

* No baseline or LOA targets set for these indicators

** Panel question is “after 6 months.” Performance indicators are 6-36 months and 36-60 months.

Table12: Indicators with A Possibility of Showing Improvement by 9/30/2006

Possible will reach target or 10 pts above R1	Baseline	Round 1	Round 2	Target	Rating
18. Received at least 90 IFA tablets	25	36.2	39.8	47	M
19. Applied nothing to the cord/umbilicus*		33.6	38.5		M
20. Pre-lacteal feeds not given*		43.2	49.1		M
21. Timely completion of DPT 3 vaccine*		70.5	75.2		M
22. Timely completion of measles vaccine*	51	42.2	55.2	62	M
23. Received at least 3 different food groups in last week*		72.1	79.0		M
24. Dropouts from BCG to measles vaccination (card + recall)*		31.5	27.5		M

* No baseline or LOA targets set for these indicators

⁴⁰ Clean hands, surface, blade for cord-cutting, thread for tying the cord, and wrap for the infant.

Table13: Indicators Unlikely to Show Significant Improvement by 9/30/2006

Unlikely will reach target or 10 pts above R1	Baseline	Round 1	Round 2	Target	Rating
25. Receipt of two doses of TT during pregnancy	74	73.2	72.2	82	L
26. Prenatal checkups: 3 or more*		28.1	26.1		L
27. Women delivered at home*		75.5	73.0		L
28. Dried and wrapped immediately after birth**	69/TBD	4.5	9.5	80/TBD	L
29. Birth plans made during pregnancy**	23/TBD	4.0	4.5	47	L
30. Appropriate CF, 6-11 mo. *		29.8	30.9		L
31. Appropriate CF, 12-23 mo. *		40.4	43.1		L
32. Added oil or ghee to semisolid meal*		21.5	24.4		L
33. DPT 3 vaccine received (care + recall) *		65.7	60.4		L
34. Received immunization card*		76.0	73.3		L
35. Retained immunization card*		60.2	59.6		L
36. BCG vaccine received (card only) *		89.6	88.2		L
37. BCG vaccine received (card + recall) *		85.2	82.0		L
38. Measles vaccine received (card + recall) *		59.5	60.5		L
39. Fully immunized (card + recall) *		45.7	44.4		L
40. Exclusive breastfeeding until 4 mo.*		73.8	73.3		L
41. Received at least 1 dose of Vitamin A (care + recall) *		46.0	45.9		L
42. Received at least 2 doses of Vitamin A (care + recall)	3	20.6	14.0	26	L

* No baseline or LOA targets set for these indicators

Table14: Management Indicator Prospects

Management Indicators	Baseline	FY 03	FY 04	Target	Rating
1. Percent of counterpart personnel and community members given training in nutrition and health topics as against planned to be trained	79	73	100	100	H
2. Percent of AWCs conducting at least one Nutrition and Health Day last month with Take Home Ration and immunization /or antenatal checkup	36	28	50	60	M
3. Percent of AWCs where immunization and/or ANC checkup were provided on a scheduled NHD, in absence of THR, last month	NA	NA	60	80	L
4. Percent of pregnant & lactating women and children 6-36 months, in program area, enrolled for take home ration (THR)					
a. Pregnant & lactating women	71	75	50	75	L
b. Children 6-36 months	76	86	50	65	L
5. Percent of AWCs with change agents	12	18	30	50	L
6. Percent of Nutrition and Health Days where CBO and/or PRI participated, last month	NA	100	20	30	M

ANNEX G: DOCUMENTS

CARE/India provided a large number of documents to the team, much more than the team was able to review and digest. The following is an abbreviated list of documents that CARE recommended as priority for this assignment.

CARE. Integrated Nutrition and Health Project: Development Assistance Program, October 2001-September 2006.

CARE. Integrated Nutrition and Health Project: Results Report. Achievement Against Plans for FY 03 (October 1, 2002 to September 30, 2003).

CARE. Integrated Nutrition and Health Project II: Development Assistance Program (October 2001-September 2006), Amendment (April 22, 2003).

CARE. Behavior Change Communication Strategy for INHP-II.

CARE. Assessment of Local Food Models in AP and MP: Summary of the findings and recommendations of an independent assessment – for reference by the RACHNA Mid-Term Team (Draft only).

Cavale, V.M. Review of ICDS Supply Chain Systems in Nine CARE-Assisted States. Food and Nutrition Technical Assistance Project. November 22, 2004.

CARE. RACHNA Operational Strategy Document. December 10, 2003.

CARE. The Chayan Project: A proposal to build on the Integrated Nutrition and Health Project and for the Reproductive and Child Health, Nutrition and AIDS (RACHNA) Program. Submitted to the United States Agency for International Development (USAID). November 2002.

CARE. Integrated Nutrition and Health Project II. Fiscal Year 2005 – Resource Request (October 2004 – September 2005. January 15, 2004.

CARE. Integrated Nutrition and Health Project. Results Report (FY 01) and Resource Request (FY 03 & 04).

CARE. Integrated Nutrition and Health Project. Results Report (FY 02) and Resource Request (FY 04 & 05).

CARE. Reproductive and Child Health, Nutrition and AIDS (RACHNA) Program: A proposal for Child survival, Family Planning & HIV Prevention Components. Submitted to USAID/India.

CARE. Reflections on a journey...RACHNA midway. November 2004.