A Qualitative Study of RACHNA Program Processes

RACHNA/INHP 2001-2006

Johns Hopkins University – IndiaClen Program Evaluation Network

These are the stories from the ground of the people implementing the program and those whom the program strives to serve.

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The QAT thoroughly enjoyed learning and understanding from the program managers, partners and the community. It was inspiring to see the efforts and commitment for improving child survival and malnutrition in the community across the length and breadth of this country. This report is intended to share some stories from the ground and contribute to ongoing efforts to make a difference for mothers and children in India and across the economically less developed parts of the world.

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ABBREVIATIONS AND ACRONYMS

ANM	Auxiliary Nurse Midwives
ASHA	Accredited Social Health Activist
BCC	Behavior Change Communication
BLAC	Block-level Advisory Committees
BLRM	Block Level Resource Mapping
BMO	Block Medical Officer
CA	Change Agent
CBMS	Community-based Monitoring System
CBO	Capacity Building Officer
CDPO	Child Development Project Officers
DAP	Detailed Activity Plan
DHFW	Department of Health and Family Welfare
DLAC	District-level Advisory Committees
DMO	District Medical Officer
DPO	District Partnership Officer
DS	Demonstration Site(s)
DT	District Team,
DWCD	Department of Women and Child Development
DWCDO	District Women and Child Development Officers
FP	Family Planning
GPO	Government Partnership Officer
GOI	Government of India
HIV/AIDS	Human Immunodeficiency virus/Acquired immunodeficiency syndrome
HQ	Headquarters
ICDS	Integrated Child Development Scheme
IEC	Information, Education, Communication
IFA	Iron-folic Acid
IMR	Infant Mortality Rate
INHP	Integrated Health and Nutrition Program
IPEN	IndiaClen Program Evaluation Network
LBW	Low Birth Weight
LHV	Lady Health Visitor
MO	Monitoring Officer
MOHFW	Ministry of Health and Family Welfare
MTR	Mid-term Review
NGO	Non-governmental Organization
NHD	Nutrition and Health Day
OCP	Oral Contraceptive Pills
PHC	Primary Health Centre
PHC	Primary Health Center
RAP	Rapid Assessment
RCH	Reproductive and Child Health

RH	Reproductive Health
RH-CA	Reproductive Health-Change Agents
RS	Replication Site
RTI	Reproductive Tract Infection
SMO	Social Marketing Officer
STI	Sexually Transmitted Infections
TBA	Traditional Birth Attendant
TC	Training Coordinator
THR	Take Home Ration
TT	Tetanus Toxoid
USAID	United States Agency for International Development

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Executive Summary

Introduction: The Reproductive and Child Health, Nutrition and HIV/AIDS (RACHNA) Program is an umbrella program of CARE-India consisting of several projects. The Integrated Nutrition and Health Project II (INHP II) and Chayan are the largest of them. They are operationally integrated, and designed to achieve measurable results at scale. INHP II is the second five-year phase (October 2001 – September 2006) of a ten-year project that began with INHP I (October 1996 – September 2001). Chayan (meaning choice) was conceived in 2002 and integrated with INHP II to address issues of reproductive health.

The objective of INHP II is to bring sustainable reduction in infant mortality and malnutrition in children across 78 districts spread over eight states in India, while Chayan aims to increase contraceptive use and safe sex practices in the target population. The RACHNA program has a broad package of interventions that is implemented through governmental and non-governmental partners across a large geographical area, aiming to potentially reach 100 million. The program contexts are diverse in terms of socio-demographic characteristics, cultural construct, political environment, governance, public health systems reach and quality of services. The 10-year period of the INHP/RACHNA program has seen marked changes in design, strategy and implementation processes.

Objective and Conceptual Model of Enquiry: The current study was undertaken to gain objective/confirmable and credible qualitative insights into key non-quantified processes that shaped the implementation of RACHNA and informed its Final Evaluation. The conceptual framework for qualitative enquiry was based on the impact hypothesis, program design, implementation and its subsequent translation at various levels. Primary inputs of RACHNA, as envisaged in its impact hypothesis and program design, were to help existing Systems enhance effectiveness in delivering critical services, and to help Communities become effective champions for their own change. This served to guide the study investigators through a process of identifying the broader areas of enquiry for the qualitative study. The areas of enquiry were juxtaposed on the Implementation Framework with emphasis on (but not limited to) the District as a key unit of implementation. This model served as a reference for qualitative enquiry of key processes to follow a systematic sequence across the implementation chain through to the final beneficiaries of the program in the community, over the life of the project.

Sampling: The sampling was purposeful and followed a mix of sampling techniques, i.e., Intensity sampling and Heterogeneous sampling. Three of the eight program states were selected for inclusion in the qualitative study through a joint meeting of investigators with USAID and CARE staff. Based on the above considerations, three states with two districts each were selected (Uttar Pradesh, Chattisgarh and Orissa). It was important to have informants representing different stages and levels of the implementation pathway, namely CARE, Non-governmental Organizations (NGOs), Systems and the Community, and importantly, the target group of the program. In other words, the informants were chosen to represent the "people who were implementing the

program" and "people whom the program was meant to serve." The qualitative study was done in 35 Anganwadi Centers, of which 55% were Demonstration Sites, 30% were Replication Sites and 15% were Non-Demonstration/Non-replication Sites (scaled-up sites). Remote Anganwadi Centers were excluded.

Study Design and Data Collection: This study used qualitative design in an attempt to provide independent insight into key program processes. The study employed non-reactive techniques, including use of an observer as an outsider, as opposed to participant observation. In-depth interviews were the mainstay of data collection in this study. Focus Group Discussions, General Group Discussions and Observations were also used. CARE was blinded to the identity of the specific study areas that would be visited and the informants who would be interviewed. Interviews with government officials were also arranged by the study investigators. All field visits were done without the presence of CARE/NGO staff. Data collection was conducted over a span of 10 days. During this time, 174 In-depth Interviews, 19 Focus Group Discussions and 15 Observation Sessions were held.

Data Analyses: The qualitative analysis was conducted in three stages due to the needs of the Final Evaluation Team. The Phase I analysis was an intensively expedited process lasting approximately 5 days, aimed at presenting preliminary impressions and insights to the Final Evaluation Team within a few days of the completion of data collection across the states. Phase II data analysis was equally intensive and also was restricted in the time-frame available to about 2 weeks, as the goal of Phase II was the presentation of a draft written report to the Final Evaluation Team in time for their use in preparing the RACHNA Final Evaluation Team Report. Phase III was a relatively protracted and systematic exercise and involved nearly a complete re-analyses and re-synthesis of all available data.

Limitations of the Study: The study was designed to provide insights into key program processes using qualitative research methods and tools. Necessary steps were taken to comply with requirements of a scientific study. The findings in this study should be seen in light of the methodology employed. Thus, caution needs to be exercised when comparing findings of this study with experiences from other sources. The program is spread over a large geographical area with wide-ranging diversity across several characteristics. Selection of the sample of informants was designed to be as representative and simultaneously as broad as possible, but does not adequately capture all possible variations, and this limitation needs to be factored when generalizing the findings to the entire program.

Most of the informants were from the District to the Community level, and few functioned at the State level. The findings have been reported after triangulation whenever possible, and attempts have been made to interpret them while keeping local contexts and constraints in mind. The study aims to report findings that are broadly applicable and avoids being too specific, and, therefore, results should be seen as indicative and not definitive. However, use of the qualitative information gained in this study may help to provide insights into hypotheses generated by quantitative program reports.

The formation of the District Team was a characteristics feature of INHP II. It is with this understanding that the investigators decided to focus on the District Team as one of the most critical determinants of program effectiveness. However, in no way does this suggests that other program levels are not critical. Given that the Final Evaluation Team was prepared to operate at the State and National levels in conducting their evaluation, it was decided that study of the program processes at the District level would make a unique contribution to the Final Evaluation.

Program Objectives: Since 1950, CARE has collaborated closely with the Government of India to implement a range of development and relief projects. The conceptualization and implementation of INHP in 1996 was a programmatic and institutional shift for CARE, and its main focus was to work within the broader mandate of Integrated Child Development Scheme (ICDS) and Reproductive and Child Health (RCH) programs of the Health System. INHP II had an objective of achieving sustainable improvement in health status of women and children. Building capacity of systems and communities was aptly identified as the two key sub-objectives of the program.

CARE had demonstrated various models of intervention in INHP I, had established specific Demonstration Sites with higher program inputs and had scaled-up a less intensive intervention to the rest of their program universe. Further extension of the Demonstration Sites for Best Practices to 10% of the program Anganwadi Centers and Replication of those Practices to the rest of the program by the government system was to be the mainstay of INHP II strategy.

Technical Package: The objective of INHP has remained the same over the decade, but the technical package has undergone multiple adaptations. There were broadly four distinct phases:

> **Phase IA** (First 3-3.5 years of INHP I): Differential implementation approach. There were four levels of intervention packages namely Food Monitoring, Basic Nutrition, Capacity Building and High Impact. The Block was the unit of implementation and each District had all four packages with variable coverage.
>
> **Phase IB** (Last 1-1.5 years of INHP I): Focus was on scale-up of one common minimum package across the entire District and development of Demonstration Sites in 10% of the Anganwadi Centers in every block, and thus, every District.
>
> **Phase IIA** (First 3-3.5 years of INHP II): Implementation of a broad package of interventions with additional inclusion of community-based newborn care and Vitamin A supplementation.
>
> **Phase IIB** (Last 1-1.5 years of INHP II): Scale-up of a minimal package of interventions.

The shift from one phase to another is an indication of the program's ability to adapt and adopt. The observations by the Mid-term Evaluation in both INHP I and INHP II have had a profound impact on the program, leading each time to scaling down of the intervention package components in the later part of the program, coinciding with geographical scale-up across the program universe. The reach of the program universe has remained almost the same in both INHP I and II. However, the transition in terms of the technical package has been more abrupt, both within INHP I and II, and between them.

The technical intervention package for INHP II underwent an extensive phase of development and incorporation of emerging evidence after the end of INHP I. The subsequent development of new training tools, methodologies and strategies for implementation took time and looked different than the previous generation of program tools. The time-lag and the introduction of a package with a new identity un-intentionally seemed to introduce a perceived discontinuity in the program, as evidenced by the lack of institutional memory. In the process, the momentum built during the scale-up period of INHP II appears to have withered, and the program was perceived to have begun afresh at the beginning of INHP II.

INHP's scale of operation makes it among the largest programs of its kind in the world. CARE facilitates the process but the implementation lies with the Anganwadi Worker (AWW) of the Integrated Child Development Scheme (ICDS) and the Auxiliary Nurse Midwife (ANM) of the Health System. The ratio of district CARE staff to an Anganwadi Worker is roughly 1:400 with several layers of hierarchy above them. This introduces a time-lag of several months for translation of strategies from the drawing board to implementation in the field. Adaptation to local realities has a shorter turn-around time, but program-wide changes that primarily emerge from the top down need much longer to penetrate to the grass-roots level where behavior change occurs and lives can be saved.

The process of refining or scaling down the technical intervention was driven by data generated through monitoring and evaluation of the program. The CARE team showed ingenuity in focusing on the most critical interventions at the critical time for both newborn care and nutrition. However, when the lag time in the scale-up phases of INHP I and II are factored in, insufficient time remains for exposure to, successful adoption of and increased effective coverage of the scaled-down package.

Implementation Approaches: In INHP II, the Demonstration Sites for Best Practices were to be developed with local NGOs in at least two Anganwadi Centers within an ICDS Sector. The Sector Supervisor was, therefore, strategically suited to be the Replicator. This approach is very well conceived, building on the principle of "seeing is believing," while providing scope for contextualization, local adaptation and innovation. The Best Practices were seen as potential solutions to operational problems. A Best Practices was defined as "one that has been innovated, demonstrated and validated in multiple contexts to produce results". The four Best Practices were Change Agents (CA), Nutrition and Health Days (NHD), Community-based Monitoring Systems (CBMS) and Block level Resource Mapping (BLRM).

By the end of INHP I, a majority of blocks had reached the target of 10% of Anganwadi Centers (AWCs) being Demonstration Sites. It is not clear, however, what happened to these Sites. Implementation time-lines for INHP II indicate an extended effort to establish Early Learning Sites and Demonstration Sites in the first two years or more in this second phase of INHP. During this time, the Demonstration Anganwadi Centers were chosen in consultation with ICDS counterparts, and in most cases they appeared to be well equipped, better manned and accessible than the Replication Sites. The degree, however, to which each of the Demonstration Sites was able to establish and demonstrate all the Best Practices was highly variable. The process of fresh identification and re-development of Demonstration Sites limited the program's ability to build on and consolidate gains made in INHP I. Similarly, the program was unable to capitalize on successes in non-demonstration areas or areas where the program had managed to scale up in INHP I.

The idea of having 10% of AWCs or more than two Demonstration Sites in each ICDS Sector, while aiming to capacitate the Sector Supervisors to replicate the program across other AWCs in their sector is an example of strategic sector engagement. Thus, this concept was integral not only to the later part of INHP II, but was promoted in INHP I as well. The Replication process in INHP II, however, did not meet the desired milestones nor the outcomes, and CARE's internal reflections and recommendations of the Midterm Review Team led to a change in implementation approach. Some of the possible factors that might have affected the process of Replication are:

- The buy-in of the concept of Best Practices by the Sector Supervisor may have been incomplete.
- The Sector Supervisor may not have been adequately engaged.
- The NGO worker effectively served as the "Change Agent" in the Demonstration Sites, mobilizing both the System and the Community, but there would be no such support in the Replication Sites.
- The Demonstration Sites had more intensive supportive supervision and may have been better equipped.

It therefore appears that the Replication of Best Practices was expected to occur in a different environment than in Demonstrations Sites, and the Sector Supervisor did not champion Replication. The "process gap" of taking the Best Practice from a Demonstration environment to a Replication environment needs to be better understood.

It was increasingly becoming apparent that with the current pace of Replication, it would not be possible to reach the entire program universe. The Best Practices were not yielding the expected results, and implementing them was resource and process intensive. Consequently, the program efficiently responded to this realization.

The process of adopting a faster, leaner approach was developed through an exhaustive process of consultations within CARE. The strategy to reach the entire program universe was to revolve around strategic use of NGO workers and Sector Supervisors. This scale-

up approach necessitated withdrawing the NGO workers from the Demonstration Sites and utilizing them to engage the Sector Supervisor and the Sector Meetings. This strategy required a combination of supportive supervision, data use, problem solving and sector-based training. The scale-up strategy, in essence, was to target and rely upon the Sector Supervisor to champion change, with the underlying assumption that this would trigger the Anganwadi Worker into action. The approach of targeting the same Sector Supervisor to Replicate by the same NGO worker that had focused on Demonstration in the first three and half years of the program (INHP II), however, did not yield expected results, and needs to be further explored. The emphasis on scale-up and the redistribution of NGO workers' responsibilities also meant cessation of Replication of Best Practices, with the exception of Nutrition Health Days. This approach also marked a departure from the principle of Demonstration with active involvement and enabling Replication through system strengthening. The scale-up approach brought more active engagement and mentoring of Sector Supervisors, as well as a higher level of monitoring, but suffered from limited community interaction. New tools were introduced for the Sector Meetings and for Home visitations by Anganwadi Workers. The scale-up/sectoral strengthening approach began in mid 2005 and action at the field level started towards the end of 2005. In several places the tools for Sectoral engagement were arriving at the time of qualitative data collection.

The program has a unique approach for 25% of the Blocks that would be graduated, meaning "transition to a sustainable independent functioning without CARE's oversight - inputs and resources can be managed, quality and timeliness of activities maintained and desired outcomes and objectives met". It is not uncommon for programs to adopt sustainability as a goal, and INHP II/RACHNA had a clearly defined road map and plan. The Graduation Blocks began to receive higher inputs in the later part of the program; for example, the NGO deployment is twice that of a Non-graduation Block. This is a unique experiment, and it would be interesting to assess the impact on sustainability, because unlike other sustainable models where the external inputs reduce with time, in this model the inputs have actually been increased in Graduation Blocks during the scale-up phase.

Program Management: The Program Management Structure now in place has evolved over the 10 years of the INHP program and its subsequent integration with Chayan in 2003 to become RACHNA. INHP I saw one major restructuring to effectively respond to the changed intervention strategy for scale-up. The inception of INHP II in 2001 saw the introduction of District Teams that had specialist functions based on the Demonstration of the Best Practices and their Replication by the ICDS and Health Systems. Each of the members of the District Team had thematic responsibilities across the District, for example, the District Partnership Officer directs development of Demonstration Sites through NGOs, the Government Program Officer guides replication through the system, the Capacity Building Officer strengthens capacity of service providers, and the Monitoring Officer monitors commodities. Subsequent positions were added to streamline integration of Chayan.

Based on the recommendations of a professional firm, senior level program management was restructured in 2003 with redistribution of authority and responsibility at the state

and national levels. Recommendations of the Mid-term Review of INHP II/RACHNA led to functional re-structuring in mid-to-end of 2005 to accommodate faster scale-up to the entire program universe. Each team member, besides their specialist/thematic responsibility for the entire district, was additionally responsible for implementation of the complete intervention across 20-25% of the blocks.

The RACHNA program necessitated large-scale recruitment for its country-wide positions, with the majority based in remote districts. The experience in filling up the positions and retaining them has been mixed. But from strictly an execution point of view in a human resource intensive sector, un-filled positions and higher attrition can pose a serious challenge to meeting program objectives. The Technical Director position remained open through the life of the program, which had repercussions at all levels in the implementation chain. It was not uncommon to see less than 50% of consistent man-days input through the entire program. This problem of staffing may not be unique to CARE, but appeared to affect the program because of the specialist nature of the individual team members and very steep CARE: Service Provider ratio (roughly 1:400).

The level of discipline, commitment and compliance is high at all level of the program structure. The program team members demonstrated very high levels of understanding in terms of the operational activities that they were supposed to perform, but were less clear on their roles and conceptual linkages to program objectives. The gulf between managerial competencies and appreciation of technical aspects of the intervention appeared to widen down the operational hierarchy, as the need and nature of technical assistance to existing Systems and NGOs grew further down the implementation chain. Horizontal and Experiential learning was the predominant mode of learning for the District Team. This mode of learning is excellent but may not necessarily provide sufficient scientific foundation to enable the District Team to imbibe the various technical and managerial aspects of the program.

The District Teams displayed high levels of coordination, NGO management, and supervisory, negotiation and persuasive skills. The investigators felt, however, that the District Teams were not adequately capacitated on issues of medical interventions, epidemiological data use, health information systems, capacity building, sustainability, community processes, principles of behavior change and organizational behavior. The program management structure is exceptionally well suited for supervised program implementation, but may potentially limit program effectiveness when technical input is a prerequisite at every stage and creative response to local problems is a regular need. Knowledge Management structure already exists within CARE and it presents an exceptional opportunity for harnessing technical competencies for more localized and de-centralized evidence-based programming.

System Partnership: Building Capacity of Systems and Service Providers has been aptly identified as one of the two key sub-objectives to help achieve sustained delivery of of services at high coverage and quality. However, the study team observed that this objective tended to migrate towards an emphasis on Building Capacity of Systems for Replicating the Best Practices. Thus, the focus seems to have been placed on replicating

the Best Practices, although the causal relationship between Best Practices and system efficiency and improved health status does not appear to have been well established.

The program adopted multiple approaches to Capacity Building, including Partnership, Top-down organizational, Bottom-up organizational and Community approaches, each of which had the potential to contribute to Capacity Building in its own right and in consort with the others. Evidence from the scientific literature suggests that multiple approaches improve the chances of Capacity Building, and this program wisely incorporated multiple opportunities into its program structure. The conceptual link between the various activities and achievement of Capacity Building, however, appears somewhat weak at the operational level, potentially allowing some activities, such as training, to overshadow other aspects of capacity building, thus failing to create the synergy needed for broad and sustained impact.

CARE's ability to identify partners in ICDS, Ministry of Health and Family Welfare (MOHFW) and Panchayati Raj Institutions is indicative of foresight and strategic alignment with national priorities, institutions and programs. CARE has successfully built strong and influential working relationship with ICDS at all levels. This was a uniformly observed phenomenon across all the states. The Anganwadi Workers felt that the training they received from CARE and at the Sector level meetings had served to refresh their knowledge and reorient their focus on key interventions.

The functioning of the Health System is a very significant factor in the ability of the program to achieve its objectives. The level of relationship of CARE with the MOHFW was relatively sparse compared with ICDS. The value that RACHNA could potentially bring to the mandate of the Health System was not communicated to Health System personnel in a way that engendered a sense of value in engaging with them. CARE has clearly demonstrated its capacity to build partnership with ICDS, but it could benefit from continuing to explore ways of establishing deeper working relationships with the Health System, and build District Team capacity to engage each of the partners meaningfully as well as constructively manage the network of partnerships that it has built. The partnership with the Panchayati Raj Institution is on the rise and multiple innovative instances were brought to the notice of the team.

One of the distinctive strengths of INHP/RACHNA has been the effort to bring two vertical government service delivery systems to converge with each other and continue to build bridges with others to reinforce the relationship and strengthen service delivery. There was almost universal acknowledgement from ICDS functionaries that CARE had helped to strengthen the convergence between the ICDS and Health at the community level. District-level Advisory Committees (DLAC) and Block-level Advisory Committees (BLAC) are two convergence and coordination forums at the District and Block level, respectively. The strength, density and effectiveness of these forums varied widely amongst the Districts and Blocks that were assessed. The ability of CARE to bring the different partners together through these forums needs to be commended. Further efforts to strengthen and institutionalize the process and bring qualitative improvement, however, will require strategic investment in strengthening of

organizational, technical and leadership skills combined with decentralized decision making in the District CARE Team.

Training emerged as the predominant Capacity Building strategy of RACHNA, both in terms of financial expenditure as well as magnitude of the exercise. Training had become synonymous with Capacity Building, and by the year 2004, almost 600,000 participants had been trained. Core to the training was the development of Training Teams at all levels, from the District up to the Sector. The Block Training Team was particularly successful. This concept of cascade training involving Health System and ICDS officials is reflective of a sustainability approach to development. Capacity of these teams was hampered, however, because of frequent transfers.

Training was conducted for officials at all levels, however, the most significant impact appeared to be at the level of the Anganwadi Workers and Change Agents. Their training began during 2002. This training was not accompanied by any formal module, nor was it guided by a defined methodology because these were still being developed and pre-tested when training began. For similar reasons, the training was not accompanied by job-aids or IEC materials, which reached several months later. The training content was very exhaustive, and two days did not seem sufficient to absorb the learning. The second round of training was methodical, participatory and useful. The logistics of supportive materials was better executed. The third round of training did not take place in most of the sites. The quality and impact of training needs close monitoring.

The scale-up mode necessitated a shift from classroom-based training to on-the-job interaction and mentoring. The NGO worker in charge of the Sector meetings has, in most cases, worked intensively in the Demonstration Sites with the Anganwadi Workers, and this skill is leveraged to bring value and direction to the Sector meetings. In most cases, however, the NGO worker has not interfaced with system level processes, and it was not clear how they were re-oriented towards system engagement within the very short time frame available in the later part of INHP II.

Most of the Sector Supervisors saw value to the Sector-level meeting. The NGO worker seems to have brought value in assisting the Supervisor in record keeping; helping them to focus on key interventions like supplementary nutrition, complementary feeding, delayed bathing, and early and exclusive breastfeeding; providing for joint monitoring of Anganwadi Workers; providing inputs to the Sector Supervisor on a regular basis; providing hands-on help to Anganwadi Workers, where possible; and discussing key issues in Sector meetings. There has been an increased emphasis on home visitations at critical points in time. It was generally felt that coordination of Anganwadi Workers and Auxiliary Nurse Midwives had improved. The involvement of the Auxiliary Nurse Midwives and other representatives from the Health System was found to be limited, but there were indications of improvement in the later months of the program.

The magnitude of the program poses huge logistical challenges, and, therefore, it was clear that strategy changes and subsequent development of Sector-level tools needed time to reach the intended audience. In most cases, at the time of Qualitative Assessment, the

tools had recently arrived, leaving little time for exposure to and use of these tools. Another additional constraint was the capacity of NGO workers to effectively help develop “problem solving abilities”, understand and interpret data for decision making and build capacity of Anganwadi Workers to do so. Fundamental issues of data acquisition, data quality and interpretation need review.

The Post Mid-term Strategy of taking data use down to the Sector level has been useful in provoking some grass root level workers on issues of infant mortality, changes in key practices and improvement in grades of malnutrition. The program has strategically invested in a computerized Health Management Information System (HMIS) which has the potential to be a very powerful tool that can help in program monitoring and execution. However, this has not been fully realized for various reasons:

- The primary data source for the HMIS System is the Anganwadi Worker, and the formats that she fills are primarily centered on food supplementation and Best Practices.
- CARE has worked hard to improve abilities of Anganwadi Workers for better record keeping, but quality of data needs to substantially improve.
- The Monitoring Officer collects data that offers an extremely narrow window of insight into service delivery and behavior change.
- The computer-based HMIS System has not adequately kept pace with newer data collection tools that have been introduced.
- The forms/tools introduced during the scale-up approach have not been integrated into the computer-based HMIS System, nor are they being utilized to acquire data from the Anganwadi Workers and Sector Supervisors.
- During the Sectoral approach, the NGO worker can only collect limited data from across the Block. The newer forms are better reflections of program outputs and outcomes.
- The software in the current mode does not allow sufficient analytical support for the District Team and the capacity of the team to analyze and interpret data needs strengthening.

Nevertheless, CARE has very effectively used data from Rapid Assessment Periodic Surveys (RAPS), and Johns Hopkins conducted Evaluation Research studies, in part to stimulate system accountability, efficiency and program refinement.

NGO Partnership: The NGO occupies a vital position in the implementation framework of the program. INHP-I set the precedence for engagement of the NGOs, and INHP-II concretized their role and responsibilities. The role of the NGO as originally envisioned in the RACHNA program design was centered on the development of Demonstration Sites for the system to replicate. The scale-up of the program marked a significant shift in the role of the NGO from Demonstration towards scale-up through Sector strengthening of ICDS.

The program has a wide geographical coverage across several States with varying capacity of local NGOs, particularly in the field of maternal and child health. In the early

phases, the program worked with several NGOs, sometimes each District having as many as 3 to 4 NGOs. The variable capacity of NGOs to work effectively helped influence the transition towards more focused engagement with the best performing NGOs in a process of implementing the program district-wide. As a consequence, coordination, monitoring and efficiency of NGOs have improved over time

Most of the NGOs in the program are small, and their association with the program has enabled them to expand their operations geographically and into newer areas like health, Reproductive Tract Infections (RTIs)/ Sexually Transmitted Infections (STIs), etc. Hands-on implementation; grant-for-training; interaction and guidance by the District Team, and increasing representation in the convergence forums at the Sector, Block and District levels; and cross field visits and learning opportunities have all served to strengthen their organizational, managerial and technical capabilities. Association with the program has also lent credibility and stature to the NGO vis-à-vis the community and the System. Likewise there was also acknowledgement by the District Team of the inherent strength that grass root level NGOs have brought to the program in terms of community processes. During the Demonstration Phase, the NGOs under the guidance of the District Team in general and the Demonstration Partnership Officer in particular led the development of Demonstration Sites, implementation of Best Practices and innovations of more effective tools.

The NGOs worked primarily with the Anganwadi Worker, the Change Agents, Community-based Organizations, Panchayati Raj Institutions and the community at large, with the objective of improving the quality and coverage of service provision. The essence of their objectives was social mobilization, sustained behavior change, community-based monitoring and appropriate demand generation. The geographical scope of the NGOs was confined to the 10% Demonstration Sites. The scale-up strategy began to be implemented from the mid and later parts of 2005. The responsibilities of the NGO workers shifted from the community to Systems. Their new responsibilities focused on the ICDS Sector as an avenue for System Strengthening. This strategy allowed the NGO worker to engage Anganwadi Workers during Sector level meetings, and thus influence a much larger number of Anganwadi Workers and potentially a larger population of beneficiaries.

NGO workers were found to share a good working relationship with their Sector Supervisor, who saw the benefits in terms of improved logistics, monitoring and program focus. The NGO worker utilized the Sector meeting to discuss the problems faced in the field by the Anganwadi Workers, share feed back from the field visits and introduce a health topic for discussion. In Orissa, there has been an increasing emphasis on monitoring of Grade I and Grade II malnutrition in children, and that is evolving into a District-level health audit. Cases of neonatal death are also being put to discussion. In the last several months, a tool has been introduced for conducting the Sector meetings and joint visits by the Sector Supervisor. The use of these tools was found to be limited but poised to improve.

Community Engagement: In the last several decades, there has been an increasing realization of the importance and opportunity of community engagement and community centered approaches. This in part is attributed to the growing recognition that lasting and wide-spread behavior change is best brought about by changes in norms of acceptable behavior at the level of the community as a whole. INHP I had recognized that building capacity of communities and individuals was as important as reaching short-term nutrition and health targets. INHP II continued to recognize that simultaneous engagement of the Health System and communities is foundational to achieving program objectives. The impact hypothesis of RACHNA also highlights the importance of complementary and synergistic interaction between the System and community processes for achieving the stated program objectives.

The **Best Practices** along with key processes like Behavior Change Communication, active engagement of Community-based Organizations and Local Governance had been identified to stimulate community processes. These Practices seem to have been chosen deliberately to complement the role of each other and steer the community towards improved capacity. Best Practices formed the cornerstone of the operational strategy of the program. They were envisaged as solutions to operational challenges in bringing the two key stake-holders -- systems and community -- together to improve infant survival and reduce malnutrition. The Best Practices were seen as specific processes that would help Systems improve the quality and coverage of services on one hand, and mobilize communities to demand improvements in service delivery and sustain behavior change on the other hand.

The objective of having a cadre of **Change Agents** was to create a resource of nutrition and health promoters at the community level to serve as a **link** between service providers and communities, and to positively influence both service delivery and behavior change. The Change Agents were seen by RACHNA as the "*Most potential Best Practice contributing to achievement of community level behavior change outcomes of INHP II and Chayan.*"

Maintaining rigor in the **selection process of Change Agents** was a monumental challenge given the magnitude of this operation. The process appeared to become more closely identified with subsequent training than with the role of the Change Agent as a volunteer and champion of change in the community. The time and process input estimates for selection of Change Agents seem to have been under estimated. Perhaps the process leading to the selection of the Change Agents could have been broken into a series of critical stages ultimately leading to their selection, and perhaps progress could have been monitored more closely; however, it seems that insufficient time and resources were available for such a process to be actualized. The time estimates and work loads could have been more realistically planned based on the experience of INHP I or Early Learning Sites from INHP II. The selection process by RACHNA very systematically addressed issues of social inclusion on a theoretical level, but departure from the established procedures during Change Agent selection potentially introduced a systematic exclusion of groups. It was not infrequent for the study team to come across hamlets that had no representation in terms of Change Agents.

The **training of Change Agents** becomes more important than any other cadre of worker because her/his role goes beyond service provision. She/He is a volunteer who does not have institutionalized supportive supervision and is expected to internalize the learning, become an advocate, promote healthy behaviors, monitor service provision, serve as a link worker between the System and Community, mobilize communities and make home-visits to provide technical intervention. It was not clear from the training modules if the needs of the various roles expected from the Change Agent were addressed in the two days of training. The roles and responsibilities of the Change Agents have undergone radical metamorphoses over the course of the 10 years of INHP. The concept was born in the early years of INHP I, modified during the later half and recommended for deliberate replication in INHP II. However, the last 18 months of programming in INHP II witnessed partial to complete departure from this approach, as the scale-up strategy steered away from the Change Agents.

The experience with Change Agents was variable across the different states. In some states, use of Change Agents continues; in some other areas, their use is still supported in principle by the implementation team; and, finally in some areas, this is not considered a feasible practice.

Nutrition and Health Days are a mechanism to ensure convergent service delivery, an intervention to reach the most marginalized sections of the community with health and nutrition services, and an event to provide a forum for community involvement in monitoring health and nutrition services. Ownership for Nutrition and Health Days is very high among program mangers at CARE as well as various levels of the Government System.

Nutrition and Health Day is a powerful innovation and is the only Best Practice that has been continued as part of the Sectoral Strengthening, Post-Mid Term Strategy. It is, however, important to understand that several intended benefits of Nutrition and Health Day were expected to be driven by other Best Practices. Nutrition and Health Day, in the opinion of the study team, only provides an opportunity, and lack of sufficient engagement of the community may result in these events not bringing about the intended qualitative improvement in services. Continued engagement of the Panchayati Raj Institutions and other Community-based Organizations could improve the level of convergence between Anganwadi Workers, Auxiliary Nurse Midwives, Lady Health Visitors and the Community. The Sectoral Strengthening approach by CARE is also an important innovation for convergence among these groups, and the effort to drive community participation to promote the strategy is highly commendable.

The **Village Resource Map** represents an excellent opportunity to bring community members and groups together in a continuing participatory process, while providing them a visual and monitoring tool. The team almost universally came across village Social Maps. Reducing social exclusion and tracking left-outs and drop-outs were some of the key benefits that were expected. In most cases the Village Maps were found neatly hung in Anganwadi Centers, but the maps had not been updated in recent times, as they

apparently had outlived their utility. The Village Map universally did not include the Hamlets that are generally where most of the excluded groups live.

The main objective of the **Community-based Monitoring System (CBMS)** is to mobilize and empower communities to manage the health and nutritional status of women and children. Community-based Monitoring System is a set of tools/visuals evolved through a participatory process that enables families and community groups to monitor their own health status and practices, and take action. The idea of having a set of tools to self-monitor on all critical parameters for care during the antenatal and newborn period is an example of CARE taking local innovation across the country. This approach can significantly enhance one's sense of empowerment and serve as a powerful starting point for increasing demand for services, seeking care at appropriate times, information sharing and monitoring both by self as well as by peers and other providers. Linking this with the Village Map to continuously track information on key parameters such as pregnancy, malnutrition, left-outs and drop-outs seems to be an important step towards development of a comprehensive tool for empowerment, self-regulation, development of social cohesion, reduction of social exclusion, and promotion of equity and public accountability.

Despite the strong theoretical basis for the Community-based Monitoring System, there seemed to have been a generalized lack of recognition of benefits, and a low level of acceptance of the Monitoring Tools, even in areas that have remained as Demonstration Sites since the inception of the program. Their eventual discontinuation potentially affects the ability of the program to address issues of community capacity building and to meet program objectives.

The program's recognition of the significance of Community-based Organizations and making them central to the community engagement strategy will continue to help institutionalize processes for better health within the community. Self-help Groups, Women's Groups and Village Health Committees are some of the examples of groups that the program has attempted to effectively engage. Different Community-based Organizations will bring different strengths and at times competing agendas and leadership. Identification of an organizational structure or network with clear leadership will be essential to power community capacity to engage in problem identification, problem solving and innovation.

Participation and Leadership are closely connected. Leadership requires a strong participant base just as participation requires the direction and structure of strong leadership. Both play an important role in development of groups for collective action. It is also important to have group organizational elements to enable people to come together and address their concerns and problems. It was not clear from review of program documents, field notes and interviews, how this issue was addressed in Demonstration Sites and Replication Sites as well as in the Sector-strengthening approach. While excellent tools for community engagement existed as part of the program, the required skills and know-how to help frontline workers negotiate through a participatory process and build other domains of community capacity like leadership, organizational structures

and dynamics of organizational change, resource mobilization and the authority to engage in reciprocal dialogue with the community were poorly developed. As a consequence, well conceived tools such as the Best Practices did not seem to have been widely accepted, negotiated, adapted and integrated within the community structures and value system.

Increasing community awareness has been one of the priorities of the program. Appropriate Behavior Change Communication Strategies was to be one of the defining aspects of INHP II, and a mix of strategies has been rolled out, namely Radio Spots, TV Spots, Magic Shows, Community Meetings, Baby Shows, Street Shows etc. CARE has also utilized these opportunities in innovative ways to bring convergence between the System and the Community. Awareness generation in the community on issues of newborn care, antenatal care of the mother and gender equity issues have been the focus of the Behavior Change Campaigns that have been universally rolled out in all the states with high intensity.

The common notion in the community is that the Anganwadi Workers are primarily responsible for pre-school education of children, and the distribution of food. The role of Anganwadi Workers in immunization is also widely accepted. The community's general perception about the Anganwadi Workers, however, continues to be affected by her association with food and oil distribution. This traditional suspicion needs to be taken into account when developing a communication strategy to convey messages that have traditionally come from authority figures. Intangible entities like behavior change counseling continue to be under-valued by the community.

Anganwadi Workers identified Take Home Rations during Nutrition Health Days as an important incentive, and irregularity in food supply adversely affected the meetings that she tried to convene during the distribution. However, both the frequency, density of beneficiaries and quality of interaction needs to be monitored and improved. Most of the women interviewed who had ever attended a meeting could not attribute sufficient value to the content. In some cases, the Anganwadi Worker confessed to transmitting a message to the community that she herself did not believe. The use of job-aids in these forums was highly limited.

Interviews with Anganwadi Workers and a review of the Training Module and accompanying job-aids suggested that behavior change messages were delivered in the context of a linear channel of communication between the provider of the information (Anganwadi Worker) and the recipient (beneficiary). Interviews with mothers and their family members suggested that interactions with the Anganwadi Worker tended to be instructional, prescriptive and highly limited in duration, lacking in reciprocal dialogue. The program might benefit from moving communications to a negotiation plank and equilibrating power-relations to allow communication to be established. Changing practices will depend on utilizing such opportunities to conduct further barrier analyses and supporting the community members through the process of change.

CARE's emphasis on home visitation has started taking roots and home-visitations could potentially improve. In the scale-up mode, the program has emphasized the need for improving home visitation at critical periods during the antenatal, neonatal and postnatal periods. The number of critical contacts through home visits varies from 8 to 13 during the neonatal period and infancy. On average, an Anganwadi Worker caters to a population spread across 4 to 5 hamlets and is expected to make 2 to 5 home visits per day. The Anganwadi Worker considers home visitations relatively difficult due to lack of conveyance to reach hamlets, and other competing responsibilities, including running the pre-school until mid-day and attending to other official/domestic duties.

The program has introduced the home visitation register that the Anganwadi Worker finds useful as a guide. These registers have been introduced in the last several months. In the majority of cases, the home visitation register was found to be in use. The register allows for recording the highlights of the visitation and forms the basis for discussion during Sector level meetings. The majority of the potential beneficiaries who were interviewed could not recall home visitations for counseling by the Anganwadi Worker. It is important to note, however, that home contacts have been emphasized more recently, and most of the respondents had availed of the services prior to the revised strategy. Amongst those who reported home contact, the most common messages recalled were immunization, early/exclusive breastfeeding, five cleans and delayed bathing. The recall of intervention messages varied widely amongst the beneficiaries.

1 INTRODUCTION

I Introduction

The **R**eproductive **A**nd **C**hild **H**ealth, **N**utrition and HIV/**A**IDS (**RACHNA**) Program is an umbrella program of CARE-India consisting of several projects. The **I**ntegrated **N**utrition and **H**ealth **P**roject **II** (**INHP II**) and Chayan are the largest of them (Figure 1A). They are operationally integrated, and designed to achieve measurable results at scale. **INHP II** is the second five-year phase (October 2001 – September 2006) of a ten-year project that began with INHP I (October 1996 – September 2001). The objective of INHP II is to reduce infant mortality and malnutrition in children across 78 districts spread over eight states in India. Chayan (meaning choice) was conceived in 2002 and integrated with INHP II to address issues of reproductive health in 29 districts and 22 cities across five states in India. The Chayan project is aimed to increase contraceptive use and safe sex practices in the target population.

FIGURE – 1-A: Characteristics of INHP and Chayan Programs

I N H P

Project objectives

- Service providers improve the quality and coverage of maternal and child health services and key systems
- Communities sustain activities for improved maternal and child health survival

Target groups

- Pregnant women
- Lactating mothers
- Children under three

Impact objectives

- Reduction in Infant Mortality Rate (IMR)
- Reduction in malnutrition in children

Technical interventions

- Antenatal Care: including tetanus toxoid (TT) immunization, food supplements, increased diet and rest, check-ups and preparation for clean child-birth
- Neonatal Care: including clean child birth, adequate warmth, early and exclusive breastfeeding, clean handling, clean cord care, recognition and extra care for the weak newborn (low birth weight and premature)
- Nutrition: early and exclusive breastfeeding until the age of 6 months, appropriate complementary feeding thereafter, food supplements until 6 years, Vitamin A supplementation
- Immunization: Improving coverage and quality of routine immunizations

Main partners

- Department of Women and Child Development of the Ministry of Human Resource Development, Ministry of Health and Family Welfare, local Non-governmental Organizations (NGOs), Panchayati Raj Institutions, and Community-based Organizations

C H A Y A N

Project objectives

- Men and women in program areas are better able to choose the number and timing of their children
- Men and women are better able to protect themselves from reproductive tract infections (RTI) / sexually transmitted infections (STI) and HIV infection

Target groups

- Men and women of reproductive age (15-45 years)
- Youth (males and females aged 15-24 years)
- High risk behavior groups (female sex workers, migrants, truckers and their associates)

Impact objectives

- Increase in contraceptive prevalence rate among men and women
- Increase in safer sex practices, especially among high risk behavior groups

Technical interventions

Men and women of reproductive age: Birth spacing, including informed choice and improved contraceptive supplies Prevention of RTI/STI and HIV/AIDS through safe sex practices and syndromic management of RTI/STI supported by referral networks

High Risk Behavior Groups in select cities: (not part of the qualitative assessment)

Main partners

- Ministry of Health and Family Welfare, local NGOs, Panchayati Raj Institutions, Community-based Organizations, National Aids Control Organizations, Social Marketing agencies, etc

The current study was undertaken to gain objective/confirmable and credible qualitative insights into key non-quantified processes that shaped the implementation of RACHNA and informed its **Final Evaluation**. This study was undertaken at the request of USAID, India Mission. The **Scope of Work** was developed through a consultative process between USAID, CARE, IndiaClen Program Evaluation Network (IPEN) and the Johns Hopkins University Bloomberg School of Public Health.

Scope of Work ANNEXURE I

II Purpose of the Study

INHP and Chayan projects are funded by USAID until September 2006. The Final Evaluation consists of:

- Population-based quantitative surveys providing state-wise estimates of intervention coverage rates
- Population-based evaluation research aimed at providing impact data on infant mortality and malnutrition in Uttar Pradesh
- Qualitative study (the subject of this report)
- Final review by a team of national and international experts informed by the above mentioned data sources and CARE's internal documentation

The goal of the **qualitative study** was to provide analytical inputs to the Final Evaluation Team based on an examination of the implementation processes of the RACHNA program at various levels and in varied contexts over the life of the program, within the program design framework, particularly regarding:

- Implementation and translation of the technical package
- Program management
- Advocacy
- Monitoring

Urban Chayan and Food Commodity Management were excluded from this study and emphasis was placed on complementing and informing the work of the Final Evaluation Team.

2 DESCRIPTION OF THE STUDY

I Introduction

The RACHNA program has a broad package of interventions that is implemented through governmental and non-governmental partners across a large geographical area aiming to potentially reach 100 million beneficiaries. The program contexts are diverse in terms of socio-demographic characteristics, cultural construct, political environment, governance, public health systems reach and quality of services. The 10-year period of the INHP/RACHNA program has seen marked changes in design, strategy and implementation processes. These factors make program understanding complex and its assessment challenging.

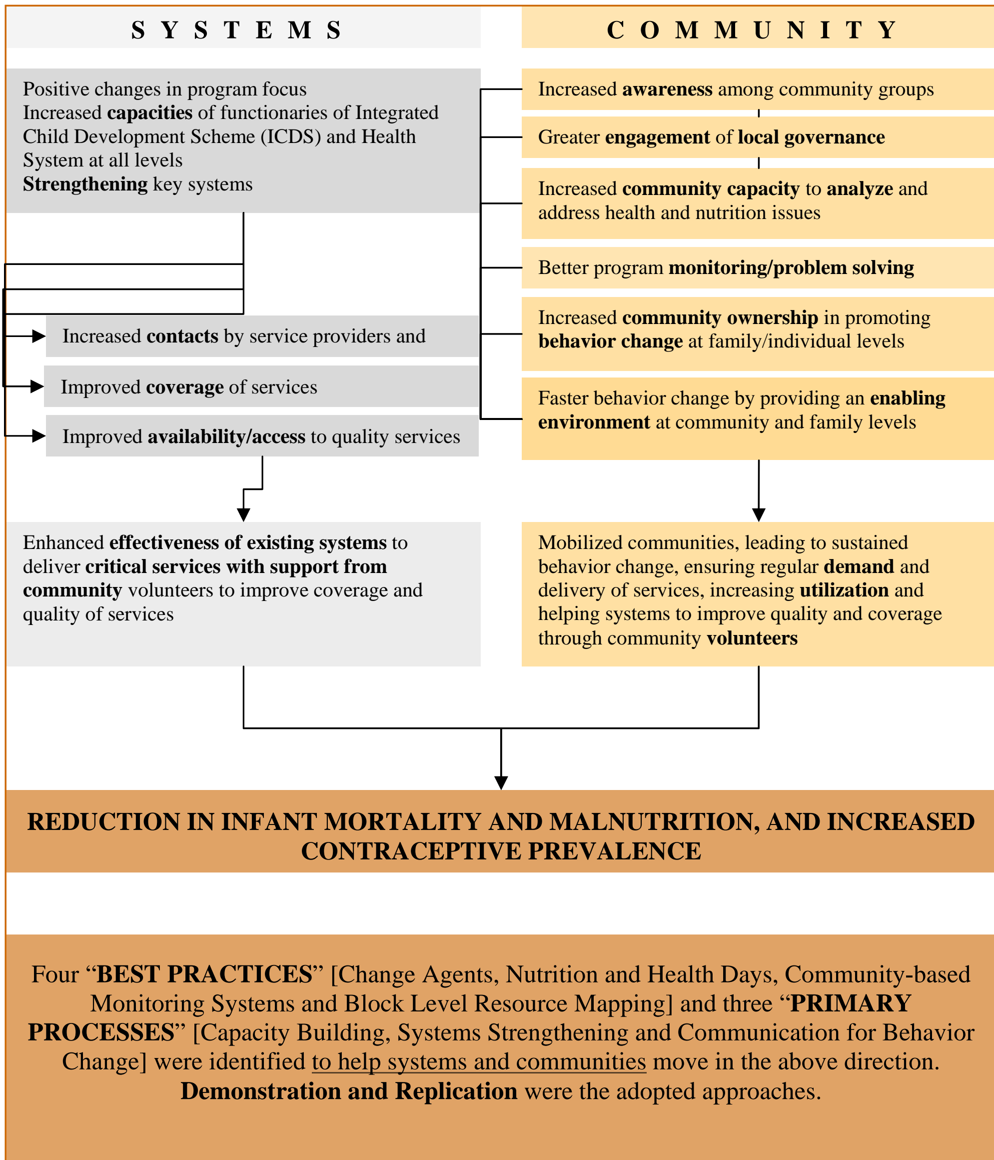
The qualitative study was developed by a team of experts drawn from various institutions, principally the IndiaClen Program Evaluation Network (IPEN), India, and the Johns Hopkins University Bloomberg School of Public Health, USA. The study was designed through a series of consultative meetings followed by a workshop of investigators to develop the **conceptual framework** for qualitative enquiry and guidelines for the field study. Inputs were taken from CARE and experts from other institutions. Steps were taken to maintain an independent and objective/credible character of this study.

II Conceptual Framework

The conceptual framework for qualitative enquiry was based on the impact hypothesis, program design, implementation and its subsequent translation of RACHNA/INHPII at various levels. The impact hypothesis of the program provided a sequence of defined inputs and processes that would lead to outputs and outcomes. The impact hypothesis served as a template for RACHNA program design. The program design framework provided a schematic representation of the operational strategy, and the inter-links between inputs, processes, outputs, outcomes and impacts. The implementation framework provided the systematic organization of "men and materials" for translating program design to achieve the impact objectives.

Primary inputs of RACHNA as envisaged in its impact hypothesis and program design, were to help existing **Systems** enhance effectiveness in delivering critical services, and to help **Communities** become effective champions for their own change. This served to guide the process of identifying the broader **areas of enquiry** for the qualitative study that are highlighted in **BOLD** in Figures 2-A and 2-B. The **Impact Hypothesis** of RACHNA/INHP II is schematically shown in Figure 2-A and **RACHNA Program Design** in Figure 2-B. These two figures provided the conceptual framework used by the Qualitative Assessment Team to design the qualitative study, and served as a reference throughout.

FIGURE – 2-A: RACHNA Impact Hypothesis

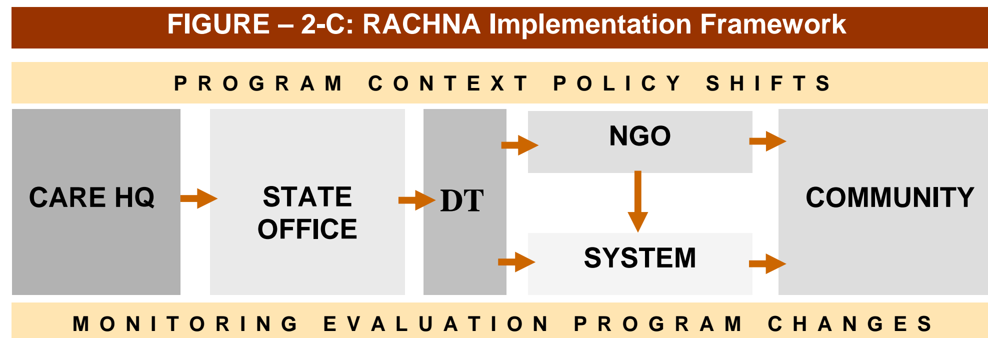


Four "**BEST PRACTICES**" [Change Agents, Nutrition and Health Days, Community-based Monitoring Systems and Block Level Resource Mapping] and three "**PRIMARY PROCESSES**" [Capacity Building, Systems Strengthening and Communication for Behavior Change] were identified to help systems and communities move in the above direction. **Demonstration and Replication** were the adopted approaches.

FIGURE – 2-B: RACHNA Program Design

The areas of enquiry were juxtaposed on the **Implementation Framework** (Figure 2-C) with emphasis on (but not limited to) the District as a unit of implementation. This model allowed qualitative enquiry of key processes to follow a systematic sequence across the implementation chain through to the final beneficiaries of the program in the community, over the life of the project. This model also allowed selection of key **informants**, the capture of views from multiple perspectives on key processes, and helped the study team to place in context program translation and mutation across the implementation chain.

FIGURE – 2-C: RACHNA Implementation Framework



(HQ – Headquarters, DT – District Team, NGO – Non-governmental Organization)

The areas of enquiry were juxtaposed on the Implementation Framework with emphasis on (but not limited to) the District as a unit of implementation. This model allowed qualitative enquiry of key processes to follow a systematic sequence across the implementation chain through to the final beneficiaries of the program in the community, over the life of the project.

III Study Site Selection

The INHP/RACHNA program is currently being implemented in 78 districts spread over eight states in India. The program consists of a standard package of interventions with room for local adaptation in consonance with the local conditions and priorities. The environment within which the program functions is highly diverse, which made selection of Districts for qualitative study complex. There was no single method of selecting the Districts, and no easy-to-arrive-at number of Districts that could sufficiently represent the program area and improve the internal validity of the study.

Selection of a sample of study sites from the vast program area was done *a priori*. The sampling was purposeful and followed a mix of **sampling techniques.**

I. **Intensity sampling:** purposeful sampling of predominantly Demonstration sites (see description below) which have higher intensity of program inputs.

II. **Heterogeneous sampling:** purposeful sampling of areas with tribal and non-tribal population, areas representing different linguistic groups (e.g., *Telugu, Oriya and Hindi speaking areas).*

Three of the eight program **states** were selected for inclusion in the qualitative study through a joint meeting of investigators with USAID and CARE staff. Some considerations that guided the selection were as follows:

- USAID priority state
- Priority state for Child Health and Nutrition Programs
- Representation of Tribal and Non-Tribal populations
- Representation of newly formed states
- Representation from better governed states
- Geographical representation

Based on the above considerations, three states were selected:

- Uttar Pradesh: INHP and Chayan
- Chattisgarh: INHP and Chayan
- Orissa: INHP only

Three of the eight program states were selected for inclusion in the qualitative study through a joint meeting of investigators with USAID and CARE staff. They were Uttar Pradesh, Chattisgarh and Orissa.

From each state, two districts were selected for the study. CARE prepared a list of districts within each state, barring a few that were excluded by them from the sampling frame. The districts were classified into two groups by CARE, based on certain program criteria. The investigators were to choose one district from each of the two groups within each state; thus, six districts were chosen for the study. The investigators first chose one Panel district (each state has one district, termed a panel district, that was chosen for serial evaluation through Rapid Assessment Surveys by CARE) each in Uttar Pradesh and Chattisgarh. By choosing Panel districts, qualitative information would be made available to enrich understanding and interpretation of data gained through the Rapid Assessment Surveys. The districts chosen within a state were geographically far apart, with an average distance of over 200 kilometers between them.

From each state, two districts were selected for the study. CARE prepared a list of districts within each state, barring a few that were excluded by them from the sampling frame. The districts were classified into two groups by CARE, based on certain program criteria. The investigators were to choose one district from each of the two groups within each state; thus, six districts were chosen for the study.

A total of eleven blocks, and a minimum of one block in every district, were then chosen for the study. The blocks consisted of Graduation Blocks (Blocks that have been chosen to graduate at the end of the program) and Non-Graduation Blocks. Graduation Blocks usually represent 25% of the program blocks and receive higher intensity of inputs. A Graduation Block is defined as having 'sustainable, independent functioning of the health and nutrition activities without CARE's interventions where inputs and resources can be managed; qualities and timelines of activities can be maintained and desired outcomes and objectives met'. Lists of Graduation Blocks were taken and every effort made to include them in the study. The qualitative assessment team collected information from the District Team or the State Office of CARE about program status and distance from the District Headquarters. The District Team was also asked for information on well performing and poor performing Blocks. In a few cases the District Teams already had a grading system in place while in others a discussion enabled them to arrive at a similar classification. Blocks that were considered poorly performing by the CARE District Team were excluded. Care was also taken to identify and exclude blocks that for any reason did not represent the typical case scenario. Maps were also collected and accessibility information collected. Blocks which were too close to the District Headquarters or too far were excluded. Security concerns were also factored and those deemed unsafe were excluded.

Based on these criteria, Blocks were chosen by the Qualitative Assessment Team with the final decision made by the respective Team Leader. The distribution of **Blocks** across the three states is shown in Figure 2-D.

FIGURE – 2-D: Sites selected for qualitative evaluation

STATE	DISTRICT	GRADUATION BLOCKS	NON-GRADUATION BLOCKS
CHATTISGARH	Surguja	0	2
	Kanker	1	0
ORISSA	Rayagada	0	2
	Bolangir	0	2

UTTAR PRADESH	**Raebareli**	**2**	**0**
	Pilibhit	**1**	**1**

A major proportion of informants from the System and the Community were based at the **Anganwadi Center** level, and therefore, the selection of Anganwadi Centers was important. Anganwadi Centers were classified as Demonstration, Replication and Non-Demonstration/Non-Replication Sites. Demonstration Sites represent 10% of the program area and had higher intensity and duration of inputs through the life of the program. Replication Sites represent almost 40% of the program area and had a relatively reduced level and shorter duration of inputs. Non-Demonstration/Replication Sites (scaled-up sites) represent almost 50% of the program universe and the least in terms of duration and quantum of inputs from INHP/RACHNA.

Demonstration sites represent 10% of the program area and had higher intensity and duration of inputs through the life of the program. Replication sites represent almost 40% of the program area and had a relatively reduced level and shorter duration of inputs. Non-Demonstration/Replication Sites (scaled-up sites) represent almost 50% of the program universe and had the least in terms of duration and quantum of inputs from INHP/RACHNA.

The study investigators felt that since the aim of the study was primarily to evaluate program processes of RACHNA and not the ICDS program of the government (although RACHNA works through them), we deliberately chose to sample areas with higher levels of program inputs. Thus, the majority of Anganwadi Centers selected were Demonstration Sites. It is, however, important to clarify that program inputs for Demonstration Sites and Replication Sites were reduced in the last 18 months or so of the program (after the Midterm Review and leading up to the Final evaluation) and increased in Non-Demonstration/Non-replication Sites because the mid-course corrections after the Mid-Term Review moved the program into a scale-up mode across all the program areas.

The qualitative study was done in 35 Anganwadi Centers, of which 55% were Demonstration Sites, 30% were Replication Sites and 15% were Non-Demonstration/Non-replication Sites (Scaled-up sites). Remote Anganwadi Centers were excluded.

The qualitative study was done in 35 Anganwadi Centers, of which 55% were Demonstration Sites, 30% were Replication Sites and 15% were Non-Demonstration/Non-replication Sites (scaled-up sites). Remote Anganwadi Centers were excluded.

IV Informants: Sample Selection and Sample Size

Selection of the informants was largely guided by the conceptual framework for qualitative enquiry. It was important to have informants representing different **stages** and **levels** of the implementation pathway, namely CARE, NGOs, Systems and the Community, and importantly, the **target group** of the program. In other words, the informants were chosen to represent the "people who were implementing the program" and "people whom the program was meant to serve."

Selection of a sample of respondents from a vast program area occurred at two broad levels:

I. **Selection of the study areas** (i.e., Districts, Blocks, Sectors, Anganwadi Centers), by default, narrowed the choice of Anganwadi Centers to those within them. Furthermore, selection of an Anganwadi Center automatically selected for the Anganwadi Worker in-charge of the center.

II. **Selection of a sample of informants:** The selection followed a **purposive sampling** strategy. This was applicable for those informants who were not selected through the process of study site selection.

The informants included Change Agents, Community members, Utilizers and Non-Utilizers. Among those who were eligible to receive services from the Anganwadi Center, those who utilized the services are referred to as Utilizer clients and while those who did not avail of the services are referred to as Non-Utilizer Clients (e.g., Pregnant woman who was not reached by the program), etc). They also included program management staff of CARE, NGO workers and Service providers at the community level like Anganwadi Workers, Outreach workers like Auxiliary Nurse-midwife (ANM) and Sector, Block and District level officials of Department of Women and Child Development and the Department of Health and Family Welfare.

Informants were chosen to represent the "people who were implementing the program" and "people whom the program was meant to serve."

The composition of informants is shown in Figure 2-E; this was generally uniform across the study sites.

FIGURE – 2-E: Composition of qualitative study informants

CARE	NGO	SYSTEMS	COMMUNITY
State Representative Regional Program Manager District Team	NGO Secretary NGO Block Coordinator NGO Sector Coordinator Other agency workers	State ICDS functionary District Magistrate District ICDS officials District RCH/Health officer Block ICDS/Health system officer Sector IDCS/Medical Officer AWW/ANM	Utilizer client Non-Utilizer client Change Agents Community-based Organization PRI members Depot Holder Community members

Sample size was largely opportunistic, starting with minimum samples representing key stake-holders. The underlying principle in helping teams decide the appropriate number of participants was when the information gained became saturated to the point of redundancy, and subsequent informants did not yield new information (i.e., saturation had been reached), interviewing could cease.

Some factors that guided the process of selection and the number of the informants were as follows:

- Representation from "implementers/facilitators" and "target group: utilizers/non-utilizers of the services" involved at different stages and levels of the implementation pathway, e.g., CARE, NGOs, Integrated Child Development Services (ICDS), Reproductive and Child Health (RCH) Program of MOH and Community.
- Some level of proportionate representation from different levels and stages of "implementers/facilitators" based on their numerical strengths. For example, a higher number of Anganwadi Workers were interviewed than Medical Officers, since more of the former were involved in the program.
- Significance of the informant in the implementation of the program. For example, CARE District Teams are at the frontline of program implementation, and

Anganwadi Workers around whom the program implementation revolves, gained precedence over other types of key informants.

- Changing role over the life of the program, e.g., Change Agents, whose role was de-emphasized in the Post-Midterm Review course correction of the program. The Change Agents, although de-emphasized in the later phase of the program, held key information about a very significant process in the program, and their current state and lessons learnt were considered crucial to understanding program processes.
- Shift in program focus: ICDS Sector Supervisors became important in sector strengthening in the Post-Midterm Review phase.
- Changing role of partners: Role of NGO worker gained prominence in scope in the Post-Midterm Review scale-up mode.
- Program input: Demonstration sites represent high inputs over longer periods of time and this characteristic has a bearing on the engagement of Community, Community-based Organizations, Change Agents, Panchayati Raj Institutions, etc., and thus the selection of informants from these areas was emphasized.
- Main village or Hamlets: This was factored in selection of Utilizer and Non-Utilizer clients from both the main villages and the hamlets.
- Quality of information gained from various cadres.
- Other agencies working in the same area with the same objectives: e.g., UNICEF, World Food Program Staff and Health Workers such as the *Mitanin* in Chattisgarh. In these areas, staff /community-based workers working with the various agencies/ government in a complementary or similar role were chosen for the study.

V Confidentiality

The study team, particularly those involved in data collection, data transcription and coding, were oriented on issues of confidentiality and ensuring protection of informants. Interview was taken after explaining to the informant the purpose of the study and assuring them of confidentiality.

VI Preparatory Phase for Data Collection

The development of the conceptual model for qualitative enquiry and the subsequent design of the process and operational strategies for data collection were critical to the study. A period of intensive study of RACHNA program design culminated with a 3-day workshop of study investigators to finalize the qualitative study design and study instruments. The preparatory process consisted of a team of investigators who first sought to understand the RACHNA program through intensive study of RACHNA program documents, formal presentations from CARE HQ, informal interactions with personnel involved at various levels of the program, officials of the government ICDS and the Health system, and field visits to Anganwadi Centers.

During the investigator workshop, the finer details of the data collection process, ethical issues, data processing, analysis plans and field logistics were worked out. Inputs from the preparatory phase, field visits, interaction with different stakeholders and consultations between the investigators formed the basis of the deliberations during the workshop. A topical guide was developed to be used by the Data Collectors. This consisted of broad topics based on the areas of enquiry. The topics and sub-topics were arranged in a logical sequence to guide the interview process to flow naturally and to serve as a check-list to ensure uniformity in terms of topics covered across the different sites where the study was being simultaneously conducted. The field guide thus developed was pre-tested in two phases in Uttar Pradesh and Chattisgarh. The pre-testing was done for community-based functionaries and community members. More details on the **methods** and **process** of **data collection** are discussed in the following sections.

VII Data Collection Methods

The RACHNA program has had several internal and external quantitative evaluations that have tracked program progress over the life of the program. This study, however, used qualitative design in an attempt to provide independent insight into key program processes, using the following methods for data collection.

Observations: The study employed non-reactive techniques, including use of an observer as an outsider, as opposed to participant observation. This approach was deemed important because we wanted to establish "how things happen" for ourselves rather than rely solely on how other people perceive it happening. This allowed the interviewers to gather first-hand impressions by direct observations through their own eyes. This was done by only key, more experienced interviewers. The interviewers took field notes and recorded (where possible) their observations and took photographs where possible. The number of observations possible was dictated by opportunities available within the duration of data collection by the study team.

Focus/General Group Discussions: Focus Group Discussions and General Group Discussions formed part of the data collections methods. Focus Group Discussions were moderated by senior investigators within the data collection team. The Focus Group Discussions were held with group of women who were potential beneficiaries of the program, District Implementation Team members, and members of the Panchayati Raj Institutions, etc. This provided breadth of information and wide range of perspectives. This opportunity allowed group interactions and helped participants build upon each others' ideas and comments in ways not attainable from individual questioning. It also allowed us to identify consensus and diversity of participants needs. Influence of group dynamics was an important observation that could be made with group discussion.

In-depth Interviews: In-depth interviews were the mainstay of data collection in this study. The study investigators deliberated on the extent of structuring that was to be introduced in the interview process. The suggestions put forward ranged from informal conversational to outline-guided or standardized open-ended interview. Based on the

assessment of relative strengths and weaknesses of each of the interview processes, the study objectives and time available for the study, a decision was made to have a mix of open-conversational/in-depth narrative style interviews in concert with a topical guide.

In-depth interviews were the mainstay of data collection in this study.

This strategic interface of open-conversational/in-depth narrative style interviews directed through use of topical guides has characteristic strengths and weaknesses. The open-conversational mode allows the data collector to explore, understand and expand on topics on which there is limited information. The informant is free to relate information in the form of a narrative or story, which helps to stimulate memory. This also allows scope for questions to emerge from the immediate context and circumstances, thus increasing the relevance of the questions. This, however, becomes time-consuming, less systematic and challenging if all interviewers are not uniformly experienced. The use of topical guides, in contrast, provides a minimum set of topics and issues to be covered, but may stifle memory and blunt flow of information. The interviewers in this study had the flexibility to sequence the topics as desired. The guide only served as scaffolding for the interview process. This improved the comprehensiveness and made data collection more systematic. However, individual interviews sometimes could sway from being more conversational to being more regimented and topical.

VIII Process of Data Collection

Data collection was conducted simultaneously in all three states included in the study. A Central Coordination Team was established in Lucknow to provide technical and logistical support. Each of the state teams was led by a senior investigator from IPEN. Other members in the state team included a senior investigator, 4 to 6 research associates and 3 to 4 locally recruited assistants and interpreters. Most of the investigators were conversant in the local language, and where necessary, interpreters were hired.

In keeping with the study objective of providing insight into the program implementation processes in real field-like conditions, the study investigators followed certain procedures that need to be factored when interpreting the findings of this study.

- The study investigators arranged all necessary field-based logistics themselves, including travel and local assistance.
- Local hiring was done independently by the study investigators.
- CARE was blinded from the identity of the specific study areas that would be visited and the informants who would be interviewed. Interviews with government officials were also arranged by the study investigators.
- All field visits were done without the presence of CARE/NGO staff.

- All interviews (except Focus Group Discussions) were held **individually,** with care being taken to ensure confidentiality and protection of informants from physical, social, psychological and professional harm. All possible steps were taken to ensure an environment wherein the informant would share his/her story without fear or favor.
- Interview was conducted only after building adequate rapport and an atmosphere of re-assurance.
- The interviews ranged in length from 30 minutes to over 14 hours in a few cases.
- The goal was to record all interviews on tape. Approximately 90% of the interviews were recorded.
- Conference calls between the three teams in the field were held regularly to update and keep all teams equally informed of progress, issues, challenges and solutions.
- One of the members of the investigating team reported a conflict of interest and dropped out.

CARE was blinded from the identity of the specific study areas that would be visited and the informants who would be interviewed. Interviews with government officials were also arranged by the study investigators.

Data collection was conducted over a span of 10 days. During this time, 174 in-depth interviews, 19 Focus Group Discussions and 15 observation sessions were held. The total hours of interviews exceeded 600. Interviews were subsequently transcribed *ad verbatim*, and transcriptions were used in data analysis (see below).

IX Quality Assurance

Quality Assurance was applied at each step in the study, from study conceptualization to data analyses. There was, however, no separate quality assurance team for this study. The various steps taken to ensure data quality included:

- Experienced senior investigators from across the country were pooled to help develop the study plan and execute it.
- Research Associates who have been qualitative researchers in similar settings were loaned from their current assignments to help with the data collection process and were evenly spread over the three states.
- Local facilitators were used to gain access and trust with the informants, particularly in the community.
- A team of investigators had been intensively collecting vital information on the program, partners and community processes, methodology used in other assessments, etc, for approximately 3 weeks preceding the formal protocol

development workshop. This input was critical to the design of the study and the operational strategy of data collection.

- A core team of investigators committed to the work from inception until the final report submission participated in the data analysis process. They were distributed evenly across the states for data collection and were involved at all stages of the study. This created continuity in efforts to achieve study goals.
- All state teams were closely supervised by a senior investigator.
- The team of data collectors (who led the data collection) received orientation on the program and the study for an average of 10 days duration.
- Over 90% of the interviews were recorded and transcribed by a separate team.
- The data collectors were grouped, to obtain an effective mix of skills, on the basis of their area of expertise, skill sets and local language proficiency. They were matched to optimize the operational efficiency and quality of the data. Within state teams, there were groups specialized to handle CARE, Systems and NGO staff, while another group specialized in Community processes.
- The following principles of qualitative research were applied throughout the study period to ensure its quality:
  - **Objectivist**: group discussions were held regularly with data collectors, field supervisors, core team, and investigators, and interview transcripts were thoroughly reviewed in order to reach consensus and reliability.
  - **Constructivist:** During interviewing and data analysis, we consistently sought to achieve data saturation. Meticulous field notes and extensive documentation was kept to allow steps in the research process to be retraceable, and field notes were compared with interview transcripts to confirm the validity of the information.
  - **Triangulation/saturation:** The study utilized multiple researchers (to document that informants said the same things to different researchers), multiple research methods (e.g., participant observation, Focus Group Discussions, and in-depth interviews that confirmed each other), and multiple respondents (e.g., to ensure that different types of respondents represented the issues from multiple sides).
  - **Member checking/validation:** After summarizing the findings, the study leadership went back to the data collectors and presented the findings to them to make sure they agreed with the findings and conclusions. All study investigators reviewed the written report for accuracy and provided explicit consent to be named on the report.

X Data Analysis

Data analysis was conducted by a team of ten members. The characteristics of the analysis team were as follows:

- All the members had been actively involved at every stage of the study from conceptualization to execution.
- All the lead data collectors from the three states were represented in the team.

- All the required areas of expertise, skill sets and language proficiency needed for analyses were covered between the various members of the team.

The qualitative analysis was conducted in three stages due to the needs of the Final Evaluation Team:

Phase I: The Phase I analysis was an intensively expedited process lasting approximately 5 days, aimed at presenting preliminary impressions and insights to the Final Evaluation Team within a few days of the completion of data collection across the states. At this point in time, most of the interviews had not been transcribed and therefore were not factored in the analysis nor presented to the Final Evaluation Team. This phase of analysis was based on minimal sets of data that were retrieved from the interviewers on a limited number of domains (program management, BCC, community mobilization, monitoring and evaluation, capacity building, system strengthening, Best Practices) broadly known to determine the course of large programs. This process culminated in an oral presentation to the members of the Final Evaluation Team, USAID and CARE officials.

Phase II: The Phase II data analysis was equally intensive and also was restricted in the time-frame available (to about 2 weeks), as the goal of Phase II was the presentation of a draft written report to the Final Evaluation Team in time for their use in preparing the RACHNA Final Evaluation Team Report. During this phase, most of the interviews were transcribed, domains established and basic analysis conducted. Since voluminous amounts of data had been collected, including over 600 hours of taped interviews, and during multiple sessions to brainstorm and synthesize the findings, the short time available to the investigators resulted in limited collation or integrated synthesis of information from across the various sources, and limited contextual interpretation of the findings in light of the program impact hypothesis and RACHNA program design. Moreover, quantitative qualifiers and appreciation of the constraints that large programs are expected to function in were not fully developed, nor was sufficient time available for all investigators to provide inputs to the report. This process resulted in a draft document of findings, solely for the purpose of aiding the Final Evaluation Team in preparing their final report. However, at this stage, the need to place data in the context of program understanding and program impact hypotheses as defined by CARE, was not realized. Thus, phase III was undertaken.

Phase III: Phase III was a relatively protracted and systematic exercise and involved nearly a complete re-analyses and re-synthesis of all available data. Each interview transcript was thoroughly read by the researchers, free-listed for range of responses, and a full set of domains were identified (Best Practices, NGO, Systems, Capacity Building, Community Mobilization, BCC, Capacity Building, Monitoring and Evaluation, Advocacy, Potential Utilizers of Services, Providers of Services, etc), coded in the transcript and recorded in a separate data sheet with coded identity tags. Each of the findings were recorded to enable use of semi-quantifiable qualifiers where possible and needed. Findings were also ranked (where applicable and possible), ranging on a scale from negative to positive based on their potential/perceived ability to improve/reduce the

probability of meeting program objectives. For example, ignorance of the Medical Officer about the program would be ranked negative while evidence that suggests otherwise would be positively ranked. Findings were further ranked on a scale of three for both positive and negative ends of the scale, depending on the intensity/strength of the findings for example, -2, -3 or +1 etc. This was done to identify outliers, use quantifiable qualifiers, assess range of responses of a particular finding, collate information from various regions, triangulate information from other stake-holders and respondents, assess patterns and potential interviewer and interviewee biases, identify potential biases during analyses and allow balanced interpretation of findings. The findings have now been presented following the impact hypothesis of the program and its subsequent translation based on the implementation framework of the program through the life of the program. The findings reported have been agreed after discussions with all members of the analyses team and have been further vetted with the entire team of investigators. Quotes have been extensively used through the report and have been carefully chosen to be representative. Wherever, there are variations to this rule, it has been duly reported.

At no stage has data collection or subsequent analyses attempted to explain findings emerging from other data sources, e.g., Periodic Rapid Assessment conducted by BASICS, Newborn Evaluation Report, Nutrition Evaluation Report, etc. The qualitative data collection centered on recording observations and reporting them after following due scientific process. The investigators were of the opinion that exposure to key indicators from quantitative findings could have potentially interfered with the objectives laid out for the study. However, it is anticipated that future correlation of qualitative findings of this study with other quantitative evaluations will further enrich the program learning that can be gained. This process has begun, but will be reported separately.

At no stage has data collection or subsequent analyses attempted to explain findings emerging from other data sources, e.g., Periodic Rapid Assessment conducted by BASICS, Newborn Evaluation Report, Nutrition Evaluation Report, etc.

XI Limitations of the study

This study has limitations which must be considered when drawing conclusions, making comparisons and seeking to generalize the findings of the study. Some of the limitations are as follows:

- The study was designed to provide insights into key program processes using qualitative research methods and tools. Necessary steps were taken to comply with minimum requirements of a scientific study that have been detailed in previous sections. The findings in this study, therefore, should be seen in light of the methodology employed. Caution needs to be exercised when comparing findings of this study with experiences from other sources.

> The findings in this study, therefore, should be seen in light of the methodology employed. Caution needs to be exercised when comparing findings of this study with experiences from other sources.

- All possible steps within the constraints of design, time and logistics have been taken to maximize the internal validity of the study, but caution needs to be exercised when generalizing/transferring the findings to the entire program. The program is spread over a large geographical area with wide-ranging diversity across several variables. Selection of the sample of informants was designed to be as representative and simultaneously as broad as possible, but does not adequately capture all possible variations and this limitation needs to be factored when transferring the findings to the entire program. Most of the informants were from the District to the Community level, and few functioned at the state level.

> All possible steps within the constraints of design, time and logistics have been taken to maximize the internal validity of the study, but caution needs to be exercised when generalizing/transferring the findings to the entire program.

- The study is purely qualitative in nature, and any attempts to quantify the findings and draw parallels with quantitative studies will lack scientific validity. However, use of the qualitative information gained in this study may help to provide insight into hypotheses generated by quantitative program reports.
- The qualitative study was aimed to provide insight to the Final Evaluation Team, and the sensitivity associated with such an exercise could have potentially affected informant's responses in some cases.
- Since the RACHNA program had set certain objectives and designed a program to achieve them, it is possible that the study investigators/analyzers were inadvertently making comparisons of "what they saw with what they were expecting to see", thus introducing observer bias.
- The data collection was highly skewed to favor areas with much higher than average levels and longer duration of program inputs (i.e., Demonstration Sites and Graduation Blocks). This selection bias should be factored.
- The findings have been reported after triangulation where possible and attempts have been made to interpret them while keeping local contexts and constraints in mind. The study aims to report findings that are broadly

applicable and avoids being too specific, and, therefore, results should be seen as indicative and not definitive.

The study aims to report findings that are broadly applicable and avoids being too specific, and, therefore, results should be seen as indicative and not definitive.

- The study has not collected data from comparison areas or other programs.

XII Timelines

FIGURE – 2-F: Timeline for the qualitative assessment

2006 **01st – 16th March**	Pre-assessment preparations and consultations with CARE India program team to understand the program design, develop tools and a detailed work plan for data collection
17th – 19th March	Investigators' workshop to finalize data collection strategies and guidelines
20th – 22nd March	Pre-testing of interview approaches, strategies and guidelines
23rd March – 2nd April	Data collection
07th April	Presentation of preliminary findings to Final Evaluation Team, CARE and USAID
20th April	Early Draft Report to Final Evaluation Team
23rd April	Early Draft Report to CARE and USAID
6th October	Pre-Final Report to CARE and USAID for internal circulation

3 Organization of Findings

The findings of this study are presented in line with the conceptual framework developed for this qualitative study. The domains for analyses were applied on the Implementation Framework with emphasis on (but not limited to) the District as a key unit of implementation. An attempt has been made to organize the findings in a way that allows for discussion of key approaches, best practices and key processes of the program in some detail. The Implementation Framework of RACHNA necessitated that some issues are also presented within the structural confines of the implementation framework and have been addressed separately, for example in the section on NGO Partnership. Thus, readers will encounter some redundancy as they go through the various sections; this is deliberate to ensure continuity and context to the discussion within the various sections.

The sections are organized under two basic broad approaches. The first approach follows the implementation framework and thus there are sections on Program Management by CARE, its implementation partners discussed under Systems Partnership and NGO Partnership. Community engagement is central to the study design and its objectives, and, therefore, this is addressed under Community Partnership. The distinctive strength of the RACHNA program has been its Best Practices, key processes and approaches. They have been discussed under the sections on Best Practices, Demonstration, Replication and Scale-up Approaches, while key processes like Capacity Building, System Strengthening and Behavior Change Communication are summarized under the section on System and Community Partnership.

The report supplements the RACHNA/INHP process documentation that has been undertaken regularly by CARE. The findings are meant to highlight some key issues as perceived by 1) those who are responsible for facilitating the provision of services, such as CARE District Implementation Teams and NGO workers, 2) direct providers of services such as Health and ICDS personnel, and 3) the intended beneficiaries like pregnant women. An underlying assumption being made is that perception shapes behavior, and thus presenting findings as perceived by the various stake-holders of the program becomes important.

Since this study is qualitative in nature, attempts have not been made to either generalize or draw inferences but provide indicative analyses based on data triangulation, leading to qualitative insights that enhance understanding of program processes. Quotes have been extensively used throughout the report. They have been selected very carefully to represent the majority view, and wherever exceptions have been made, it has been duly noted. The qualitative information may be used with other scientific data sources and provide insight to quantitative observations in the program; however, this was beyond the scope of this study. At no stage of the study was an attempt made to explain or justify quantitative findings. Recommendations were specifically excluded from the scope of this study.

4 Program Management

I Introduction

In the last two decades the scientific community has been able to demonstrate successful models and interventions for child survival in resource poor settings. They have been accepted, adopted and programmatically rolled out in several countries with varying degrees of success. The Health System initiative of the Government of India is one such example of programmatic implementation at scale across the country. The scientific validity of the intervention has seldom been questioned but variability in impact across states has also been attributed to differences in quality of program management. The role of program management in determining the success of a technically well thought out intervention becomes paramount.

The following section attempts to provide some constructive comments on some aspects of RACHNA program management, keeping constant other determinants, such as technical package, behavior change communication and impact hypotheses, which are important determinants of program success. The investigators were of the opinion that this analytical approach helps to de-construct and delineate the contribution of key determinants to program success.

The role of program management in RACHNA/INHP II assumes significance for two primary reasons:

- Program Management of RACHNA/INHP II as a primary managerial requirement, responsibility and determinant for effective execution of a large program in general.

- Program Management as a key managerial intervention to strengthen and improve the effectiveness of government Health and ICDS program management in delivering services, and thus, meeting specific RACHNA/INHP II program objectives.

II Program Management Structure

The Program Management Structure now in place has evolved over the 10 years of the INHP program and subsequent integration of INHP II with Chayan. It has successfully transitioned from being a commodity centered to a technical program management driven structure. This is not an easy process for a large program within a large organization working in multiple states in as diverse a setting as India. However, CARE has demonstrated its ability to respond to changing program needs as evidenced by major

Program Management restructuring in 2003 and integration of Chayan within the larger RACHNA program management umbrella.

National Level: The Project Management Team based at New Delhi under the leadership of the Senior Program Director has been driving the systematic implementation of RACHNA across the program universe, with assistance from highly qualified Regional Program Directors with several years of relevant programmatic experience. The concept of Program Management Teams at the national and state levels has been exemplary and so has high level of coordination within and between them. This has contributed to efficient control of activities across the program areas, and has contributed to disciplined implementation of instructions by the states and ensured generally standardized implementation of the intervention. The level of discipline, commitment and compliance is high at all levels of the program structure. The role of the Program Support Team that has been providing the administrative and human resource management framework for the program needs special mention in helping manage a complex program and stay true to mandatory requirements and established standard operating procedures. The delicate balance between needs of program managers and the parameters set by the Program Support Teams continues to evolve.

> The level of discipline, commitment and compliance appeared high at all levels of the program structure.

The RACHNA program also necessitates intensive technical inputs on Nutrition, Neonatal Health, Child Health, Reproductive Health, Behavior Change Communication, Community Mobilization, Training, System Strengthening, Monitoring, etc, to enable innovation, adaptation, validation and integration of technically sound interventions for programmatic implementation. The positioning of the Technical Director and other national level technical positions is well thought out. A senior manager suggested that, "*The program design has a significant community involvement component and a position for a specialist on community processes would definitely benefit the program.*" The assessment team also observed that consistent availability of in-house technical expertise seems to have been limited to Nutrition, Reproductive and Child Health. However, in order to guide the program towards sustainability, perhaps the penultimate goal during the later part of the program, the program design demands very high levels of expertise and skills in capacity building of systems and communities, behavior change communication and development of information systems and its subsequent use for supporting and guiding program implementation.

> *"The program design has a significant community involvement component and a position for a specialist on community processes would definitely benefit the program."*
>
> CARE Manager

The program's inability to fill the key Technical Director Position throughout the life of the program, and attrition in other mid-level technical positions may have hampered the program's ability to institutionalize improved core technical competencies among staff at various levels of program implementation. A concerned CARE official noted, "*We have not been able to fill key technical position and particularly the position of Technical Director. This has not stopped available specialist from contributing but lack of cohesion and direction has led to confusions."* The role of available technical specialists in attempting to cover the entire program area deserves special mention and credit.

"We have not been able to fill key technical position and particularly the position of Technical Director. This has not stopped available specialist from contributing but lack of cohesion and direction has led to confusions."

CARE Manager

Provision by BASICS II of close technical assistance to RACHNA was highly valuable at all stages of program design, implementation and monitoring; and at a functional level largely substituted for the absence of the Technical Director role in CARE. This partnership is evidenced in the close collaborative spirit that was fostered. The use of data dissemination as part of Newborn and Nutrition Evaluations Research served to propel a culture of evidence generation and information use for program refinement and dialogue with government partners. A senior CARE program official summarized, "*CARE could have better leveraged technical assistance from other agencies if they would have had core technical positions within the program, in place. This could have led to far greater improvement in overall institutional strength and re-enforcement of technical identity. Otherwise, external technical assistance is seen as external to the program and adversely influences buy-in of ideas and ownership by program staff for subsequent implementation."*

"CARE could have better leveraged technical assistance from other agencies if they would have had core technical positions within the program, in place. This could have led to far greater improvement in overall institutional strength and re-enforcement of technical identity. Otherwise, external technical assistance is seen as external to the program and adversely influences buy-in of ideas and ownership by program staff for subsequent implementation."

CARE Official

Program Support Team: The study team had very limited interaction with the Program Support Team, but had the opportunity to scrutinize the manuals, tools and

procedures that they developed. These were very detailed and meticulous and serve as a powerful resource for other organizations. The Program Support Team has had at various times, key personnel with advanced training in Management Sciences and particularly in Human Resource Management. Their expertise has been utilized in developing human resources and managerial practices within CARE and NGO partnership are admirable. The investigators are of the opinion that this is an important and key technical resource within CARE and could well have been core to the strategy of CARE program management structure going beyond serving a supportive role to the program staff. More specifically, this unit can play a pivotal role in providing technical know-how for managerial intervention for program managers within CARE as well as the Systems and NGOs that RACHNA works with. This strategy can potentially lead to better alignment of objectives, refinement of procedures and an execution plan that is centered on a common goal.

The human resource management practice encourages vertical movement of staff members to higher positions of authority. The investigators came across multiple examples of managers who have grown up through the ranks. This deserves credit and appreciation. The program has evolved and so has the nature of manpower requirements. The program has been accommodative and its initiative to absorb most of the staff from the commodity centered phase into the technical-program centered phase deserves appreciation. However, the investigators were not clear (based on the interaction with some staff members) if the commodity centered human resource pool underwent adequate orientation/de-learning to equip them to assume a technical-programmatic role at the outset of the RACHNA program and whether this may have weighed on organizational ability to make a faster transition.

The program has been accommodative and its initiative to absorb most of the staff from the commodity centered phase into the technical-program centered phase deserves appreciation. However, the investigators were not clear if the commodity centered human resource pool underwent adequate orientation/de-learning to equip them to assume a technical-programmatic role at the outset of the RACHNA program and whether this may have weighed on organizational ability to make a faster transition.

State Level: The program in the state is led by the State Program Representative assisted by Regional Program Managers who supervise several Districts, which is the functional unit of planning, implementation and monitoring. The State Program Management Team is led by the State Program Representative, who is the primary point of liaison with the state health and ICDS functionaries. State Program Representatives and Regional Managers without exception showed understanding, commitment and enthusiasm for the program and the objectives that it stood for. All the states showed very high levels of management control. The State Program Representatives were contributing with their own distinct style of leading and managing the program. In all cases, their role

was highly proactive and they enjoyed fairly high levels of autonomy in operational matters relating to program implementation. In all the three states, the investigators were of the opinion that the State Program Management team right through to the District could not have done better in terms of what they were asked to do and what they were equipped to do. They had pushed themselves beyond the operational limits and shown exceptional commitment, camaraderie and discipline.

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The gulf between managerial competencies and appreciation of technical aspect of the intervention appeared to widen further down the operational hierarchy, as the need and nature of technical assistance to existing Systems and NGOs grows further down the implementation chain. A State Program Representative quipped, "*Improving child survival is just a managerial issue and interventions require only common sense and technical inputs are neither necessary nor desirable.*" It is possible that most of the other program representatives may not agree, but taken together with the limitations the program faced in technical expertise noted above, this sentiment does indicate the need to bridge the chasm between "Managerial" and "Technical" intervention and view them as synergistic and complementary.

The lack of technical positions in the state seemed to create some level of discomfort in engaging the government system for providing technical assistance. This becomes more pronounced in scenarios where other agencies bring higher levels of technical specialization to the table. In the words of a State Program Representative, "*The Regional Managers are accountable for program implementation in the Districts and the State Program Representative maintains an oversight. The State Program Representative represents the program vis-à-vis the government and is expected to bring technical inputs to the table. This mis-match between roles and responsibilities makes him a poor program manager and a poor program representative*". He goes on to add "*When you don't have technical specialist at hand when others have, you loose the opportunity when it presents itself.*"

The gulf between managerial competencies and appreciation of technical aspects of the intervention appeared to widen further down the operational hierarchy, as the need and nature of technical assistance to existing Systems and NGOs grows further down the implementation chain.

"When you don't have technical specialist at hand (in the state) when others have, you loose the opportunity when it presents itself."

CARE Official

The study team came across Managers with technical background in health, nutrition and managerial sciences that were primarily performing supervisory functions at the state level. They could potentially be mentored to serve as specialists to work towards integration of technical and managerial sciences. The program management structure is exceptionally well suited for supervised program implementation, but may potentially limit program effectiveness when technical input is a prerequisite at every stage and creative response to local problems is a regular need. Knowledge Management structure already exists within CARE and it presents an exceptional opportunity for harnessing technical competency for more localized and de-centralized evidence-based programming.

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The Regional Program Managers are part of the State Program Management Team and supervise over two to three districts and in some cases more. They hold a strategic position in the operational chain. Their insight into program processes, limitations and possible solutions was exceptional. One CARE manager put it, "*Wherever the Regional Program Manager has been proactive, it has positively reflected in the performance indicators for those districts."* They serve as a technical-managerial hub for the implementation teams and efforts need to be made to strengthen this role; otherwise, they functionally become largely supervisory. Since they are part of the State Program Management Team, this provides an opportunity for cross learning and subsequent transmission to respective District Teams.

"Wherever the Regional Program Manager has been proactive, it has positively reflected in the performance indicators for those districts."

CARE official

The level of understanding and maturity displayed by the Regional Program Managers makes them ideal leaders for de-centralized and localized evidence-based programming and accountability. The current structure, however, does not seem to give them enough room and opportunity. The bounds are not clear regarding their role, responsibility, authority and accountability continuum, and needs careful attention. The roles, responsibilities, coordination and lines of authority between Regional Program Director, State Program Representative and Regional Program Managers are crucial. The supervisory and mentoring mix for each of the positions could be refined further.

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The synchronization of the role of the National Program Support Team at the State level vis-à-vis the State Program Management Team was less clear, and seemed to be a missed opportunity. According to a CARE staff member, "*In the pre-management re-structuring phase of 2003, the State Program Support Manager reported to the State Program Director. Subsequent to re-structuring the State Program Representative in reality reports to the Program Support Director at New Delhi and this has led to discomfort and confusion. This parallel vertical structure has led to better control and adherence to established practices but curtailed operational freedom of the State Program Representative, affecting accountability and efficiency.*"

Another senior manager goes on to add, "*The Program Support Team has developed very comprehensive operating procedures meant for a program that is continuously evolving but sometimes it becomes very bureaucratic and this leads to a progressive shift of loyalty and adherence of personnel, from program goals to program procedures.*" A CARE manager suggested that, "*The staff appraisal system does not adequately reflect program realities and therefore there is neither incentive nor disincentive for staff members' vis-à-vis performance leading to achievement of program objectives and requires refinement.*"

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CARE Official

III District Team: Program Understanding, Roles, Responsibilities and Coordination

The CARE team based out of the headquarters in New Delhi predominantly drives the content and direction of the program. However, most of the translation and implementation of program strategies are mediated through the CARE frontline implementation team based in the districts [i.e., the District Team (DT)] (Figure 2-C). The district is also the unit of program implementation and evaluation for RACHNA as well as for most of the government programs. The District Team occupies a strategic position and its role becomes very crucial vis-à-vis the CARE HQ/State office/program on one hand and implementation partners/impact on the other. The District Team consists of members with specialist and inter-dependant functions that cater to most key stake-holders of the program and influence almost all key program processes.

The formation of the District Team was a characteristics feature of INHP II. It is with this assumption that the investigators decided to focus on the District Team as one of the most critical determinants of program effectiveness, but in no way indicating that other program levels are not critical. However, given that the Final Evaluation Team was prepared to operate at the state and national levels in conducting their evaluation, it was decided that study of the program processes at the District level would make a unique contribution to the Final Evaluation.

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Program Understanding: The general understanding of program activities is very high, evolved, systematic and uniform across teams. Within teams, however, wide variations exist in interpretation of the program activities and the conceptual links to overall objectives of RACHNA. At least one team member in every District Team interviewed displayed far greater understanding of program processes than others. Some displayed a palpable urge to critically study different processes and relate them to the final outcome. The investigators recall at least two instances where District Team members happily conceded to request for technical documents and research papers on community-based health programs. At the same time, we observed relevant research papers and information sheets that were regularly sent across to the District Teams. One common suggestion was, "*We need to be guided to understand, interpret and apply the research findings. Otherwise, we end up just stacking the research papers and technical documents because we cannot intuitively draw relevance to our program.*" The role of

Regional Program Managers in filling this gap needs to be explored vis-à-vis their current role perceived to be primarily supervisory and ensuring compliance.

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"We need to be guided to understand, interpret and apply the research findings. Otherwise, we end up just stacking the research papers and technical documents because we cannot intuitively draw relevance to our program."

District Team member

The study investigators found it challenging to understand how the lessons of INHP I Phase had been integrated and applied to the 2nd Phase of the program. Most of the understanding of INHP I came from Senior Program Officials in New Delhi and only one source from the state level. Most of the respondents at the state level could not recall different aspects of the INHP I program. An interesting and commonly encountered justification was, "*Lets leave the past behind us. Lets look forward and it's not useful to look back at INHP I.*"

The investigators had the opportunity to interact with at least one senior CARE official who recounted in vivid detail the evolution of CARE from a commodity management to program-centered organization. This context needs to be factored when critiquing existing program processes and gains. In short, the evolution has been rapid and continues forward at present. This historical perspective can be useful information to share with ground staff. Otherwise, program changes are seen as reactionary and not perceived as a continuous process of program adaptation and evolution. A senior CARE official's remark finds echo in a majority of respondents, "*The program has been a series of experimentation. We have not been able to stabilize but keep changing from time to time. The system allows for lot of discussion but we should not let the program remain for discussion for ever. We should freeze it and work steadfastly towards the results.*"

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Most of the respondents were not part of the original design development team for INHP II, but the buy-in of program processes, particularly by District Staff, was credible. Most of the respondents who had been in position since the inception of INHP II recalled with enthusiasm how they had been looking forward to a successful implementation of Best Practices. In the words of a District Team member, "*There was no room to doubt the strategy. We were enthusiastic and driven to accomplish the goals set before us. We wanted to just go to the field, implement the processes. That's it. We were very excited about it.*" A few senior officials shared their reservations. One of them remarked, "*I attended the exhaustive workshop at the beginning of the program but couldn't quite understand it. We wanted to see for ourselves and convince ourselves by visiting the Demonstration Sites and see the Best Practices for ourselves.*"

"There was no room to doubt the strategy. We were enthusiastic and driven to accomplish the goals set before us. We wanted to just go to the field, implement the processes (Best Practices). That's it. We were very excited about it."

District Team member

Post-Midterm Review deliberations at all operational levels need to be commended. The response of CARE to the observations made by the Midterm Review Team and the subsequent series of planning and introspective activities was a powerful participatory activity in itself. Some found the exercise as redemption of what they had been feeling but never articulated in the established forums. A common feeling was, "*Processes are not sacrosanct and they can be questioned.*" Some, however, felt that it was probably too late into the program to make dramatic changes. The Midterm Review exercise, as

understood by the investigators, brought about a paradigm shift in the program management from being activity-centered to becoming impact-centered. The degree to which the Post-Midterm Review strategy was embraced by the staff at different levels needs special mention. On enquiry a CARE staff summarized, "*The Mid-Term Report reminded us that we would be evaluated on the bases of impact across the entire program universe and not just by process indicators in Demonstration and Replication sites. We were confronted with data and everything was open for question. Everything! We realized that activities were not paramount and we could try any strategy to come as close as possible to achieving the impact. This broadened the scope for involvement and ownership of the changed strategy.*"

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CARE official

The structural refinements and re-allocation of manpower in the post-Midterm Review phase was professionally executed. The investigators also observed that this shift was limited to the re-structuring within the District Team and did not appear to proceed further to include other levels of decision making and supervision.

Roles, Responsibilities and Coordination: Roles and responsibilities of program staff are diagrammatically presented in Figure 4-A

The District Team structure has been unique to INHP II and has undergone two major adaptations. The first adaptation stage was during the integration of Chayan with INHP II, which necessitated two additional positions of Social Marketing Officer and Training Coordinator. The second stage was in response to the observations of the Midterm Assessment that led to juxtaposition of geographical responsibilities (i.e., staff were assigned certain Blocks and were responsible for all the activities within those Blocks, in addition to their specialist functions that extended across the entire District) with existing thematic responsibilities.

The team structure, as originally conceived, was designed to address the strategy of Demonstration and Replication of Best Practices through key processes like Capacity Building, System Strengthening and Behavior Change Communication. The observations of the study team vis-à-vis each specific role will be covered in the relevant chapters and only general observations will be made in this section.

The team structure, as originally conceived, was designed to address the strategy of Demonstration and Replication of Best Practices through key processes like Capacity Building, System Strengthening and Behavior Change Communication.

FIGURE – 4-A: Descriptions of key positions

Position	Job Description
District Partnership Officer	NGO management Demonstration sites and assistance to Replication Post Mid-Term Review (MTR): # No more Demonstration and Replication
Capacity Building Officer	Capacity building of NGO, System and Change Agents through District Training Team and Block Training Team, BCC shows Post MTR: # No more classroom training, No more training of Change Agents
Government Partnership Officer	Interface with the system, convergence and convergence forums like District Level Advisory Committee and Block Level Advisory Committee, Replication Post MTR: # Scale-up mode
Monitoring Officer	Monitor Title II commodities, limited role in the Program Post MTR: # No significant change
Social Marketing Officer	Coordination with Social Marketing Agencies to develop Social Marketing outlets, Support Demonstration efforts through NGO Post MTR: #
Training Coordinator	Capacity building of Systems, NGO and Reproductive Health Change Agents on family planning and reproductive health interventions Post MTR: #

 # Result-oriented responsibility over 20-25% geographical areas.

Except for the District, all other levels had at least two tiers of functional hierarchy. All the program members interviewed demonstrated exceptional team spirit, coordination and

shared professional responsibility. Some felt that a team leader position would help the team make decisions more efficiently and conflict resolution easier. A Senior Manager remarked, "*Demarcation of roles and responsibilities needs further refinement. It is easier to step on another's toes without being aware of it. The team members have learnt to make adjustments but at times it leads to un-necessary conflicts. The Government Partnership Officer is considered the most senior of the team members but there are several instances where others are better suited for team leader's position."* The study team felt that the role of the Regional Program Manager could be strengthened further to serve as a techno-managerial support for the District Team. The potential benefits in terms of morale, motivation and efficiency could be substantial if there is shift in focus from supervision to mentoring. Technical skills need to be strengthened and continuously supported for all positions.

Post Midterm Review…there is a shift of roles from technical expertise in one area to output oriented tasks in all fields. This shift marks a significant departure from a process focus to results focus. It was not clear to the investigators, however, what additional training and skills were imparted to the District Team members to negotiate this rapid transition.

Post Midterm Review, each District Team member is assigned 25% of the program blocks within the district. It is now expected that the District Team will perform a broad range of results oriented tasks in 25% of the blocks, in addition to their already stated technical/thematic roles. In other words, each District Team member performs the duties of other team members along with his own. There is a shift of roles from technical expertise in one area to output oriented tasks in all fields. This shift marks a significant departure from a process focus to results focus. It was not clear to the investigators, however, what additional training and skills were imparted to the District Team members to negotiate this rapid transition. However, each team member now better appreciates the constraints and responsibilities of the other, even though role clarity may have been blurred. They do not seem to view the post-Midterm Review strategy, however, as a long-term strategy but rather a short term strategy to facilitate scale-up in the least possible time.

CARE has established various mechanisms and forums for streamlining communication of the District Teams with other levels of program implementation. One of the investigators has had the opportunity to participate in a quarterly review session. It was found to be highly participatory and intense, with representation from the CARE HQ as well. This serves as an excellent forum for stock-taking, sharing of ideas and planning forward. Despite the existence of such an institutional mechanism, there was a feeling among the majority that they are not core to the planning and execution process. One of the District Team members said, "*We meet, we talk, we discuss, but they have to be within fixed parameters. We have lots of ideas and concerns that we don't think is appropriate to discuss. Everyone is very strategic in what they say and what they don't. At the end, therefore, it is safest to do the activities that are told and move on."* Another

colleague suggests, "*We want to do and we can do more than we have so far. We have to develop strategies that are suited for the place that we work in. We can do it if appropriately guided.*"

These words need to be seen in light of the potential that is waiting to be unleashed, and, on the other hand, the cost of misplaced concerns that need to be addressed. A program as vast as RACHNA may not have the resources to do so, but it does indicate the need to continue with localized programming and continue to support and mentor District Teams to serve as units of planning and execution. Current levels of decentralization need to be improved. Some voices pointed out that funds earmarked for professional development of employees were largely un-utilized and if this is the case, then these opportunities could be exploited to move in the above direction.

The role of team members as a facilitator, implementer, supervisor and/or technical assistance provider vis-à-vis the System and Community needs to be further clarified and fortified.

The program team members demonstrated very high levels of understanding in terms of the operational activities that they were supposed to perform, but were less clear on their roles and conceptual linkages to program objectives. The communication of the larger vision and goal of RACHNA as it relates to the larger development agenda can bring additional value and clarity to the work that they are engaged it. The role of team members as a facilitator, implementer, supervisor and/or technical assistance provider vis-à-vis the System and Community needs to be further clarified and fortified.

IV District Team – Staff in-position, Orientation and Training

CARE has a systematic recruitment structure and the organization attracts some of the finest talents in its field. It has also been one of the key "sources" of trained manpower to other organizations. The RACHNA program necessitated large-scale recruitment for its country-wide positions with the majority being based in remote districts. The experience in filling up the positions and retaining them has been mixed.

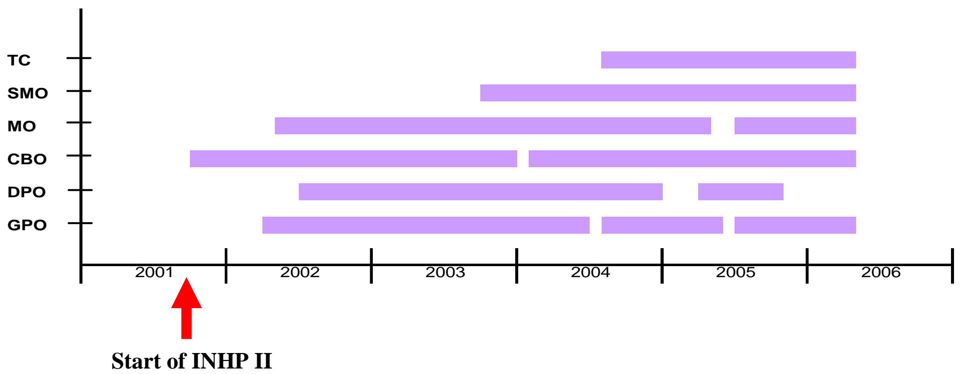
Staff in-position: Figure 4-B and Figure 4-C represent staff-in-position status from two of the six districts that formed part of the assessment. They represent the two extremes among the six districts. The names of the districts have been withheld because the intent is to present findings that represent a scenario without being critical of any particular program district or person. The figures are not to scale. It is important to note, however, that high staff turnover and inability to fill key positions is a universal challenge across programs, and is not unique to CARE. An added characteristic that potentially explains this scenario is CARE's insistence on a higher threshold of minimum qualifications for recruiting quality manpower and the subsequent challenge in retaining higher quality manpower also is not unique to CARE. But from strictly an execution point of view in a

man-intensive sector, un-filled positions and higher attrition can pose a serious challenge in meeting program objectives. The input in terms of man-days is an important program parameter and some districts did not have more than 30% of man-days input over the life of the program.

From strictly an execution point of view in a man-intensive sector, un-filled positions and higher attrition can pose a serious challenge in meeting program objectives.

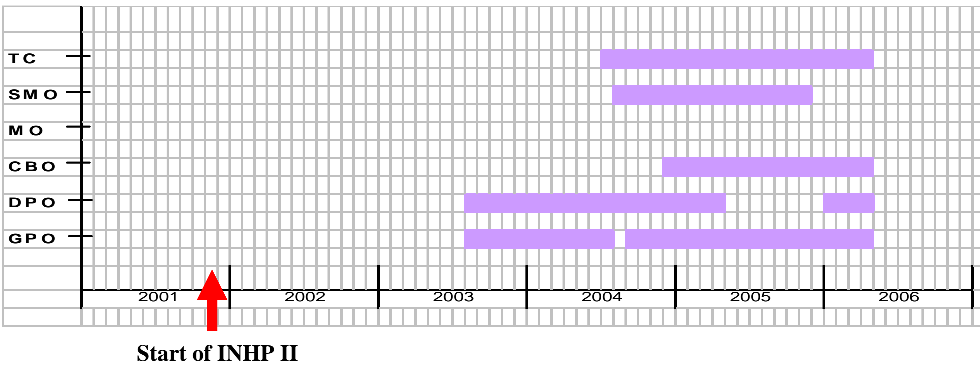
The District Team is structured to function as a team with specialized function for each member. Vacancies have variable impact on the momentum of the program. A State Program Representative emphatically observed, "*When I came in end of 2003, majority of the positions were vacant. How is the program expected to deliver? We worked very hard to fill-up position on a priority bases and the results are becoming evident in the field.*" However, the camaraderie and team spirit displayed by District Teams goes a long way in compensating for the absence of certain positions. In the words of a District Team member and echoed by most, "*We work together to compensate for the absence of some members of the team. We do not allow the work to suffer.*" Orientation and training, however, does become difficult to organize for individuals joining at varied points in time.

FIGURE – 4-B: Staff positions filled in District A



[TC: Training Coordinater**, SMO:** Social Marketing Officer**, MO:** Monitoring Officer**, CBO:** Capacity Building Officer**, DPO:** District Partnership Officer**, GPO:** Government Partnership Officer**]**

FIGURE – 4-C: Staff positions filled in District B



[TC: Training Coordinater**, SMO:** Social Marketing Officer**, MO:** Monitoring Officer**, CBO:** Capacity Building Officer**, DPO:** District Partnership Officer**, GPO:** Government Partnership Officer**]**

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CARE Official

"We work together to compensate for the absence of some members of the team. We do not allow the work to suffer."

District Team member

Orientation and Training of staff coming from varied educational and professional backgrounds towards the program goals and inducting them into the organizational culture is important. Recruitments during the initial years of the program afforded the opportunity to do so. The District positions in general demand basic technical, managerial, communication and organizational capabilities. Each of the positions also requires specialist skills that are not generally learned through formal educational systems in the country, but rather are learned on-the-job; the candidates are thus drawn from a wide array of disciplines. The Government Partnership Officer, for example, requires skills at conducting needs assessment of systems and identifying opportunities for synergistic collaboration, basic technical capacity to assist and advocate on health issues, institutionalization, organizational behavior, etc. The District Capacity Building Officer/Training Coordinator requires in-depth understanding of capacity building needs and strategies, training methodologies, etc. The District Social Marketing Officer's position demands social marketing skills as a prerequisite (Figure 4-A).

> *"I spent the first two weeks in another District observing and learning from a colleague. It was very useful, I was able to experience and learn what needed to be done."*
>
> District Team member

The program had provided orientation to District Team members on the program strategy and trained them on specialist areas. This was a mammoth exercise that was undertaken over several months and, therefore, definitely benefited those who had been recruited during the early months of the program. The study could locate only a few who had been through this formal training process and recalled how beneficial it had been to them; high staff turnover is a possible explanation for this finding. For staff members recruited later, there seemed to have been a shift from classroom to on-site training from peers. A District Team member recalled, "*I spent the first two weeks in another District observing and learning from a colleague. It was very useful, I was able to experience and learn what needed to be done."* This was a cost-effective strategy that evolved within the realities that the program faced, with high manpower attrition and reactive recruitment. Sustaining a formal extended training program in the classroom could not have been feasible. On-site training was efficient and enabled newcomers to quickly learn day-to-day functions, procedures and skills.

The Regional Manager serves as the supervisor and guide to help staff negotiate problems and issues as they emerge. A District Team member said, *"No training was organized but workshops have been conducted in which state level planning is done, what ever loopholes remain we discuss them with the RM (Regional Manager) during the monthly meeting."* The regular interaction with the Regional Manager and three-monthly state meetings attended by the Regional Program Director serves as an excellent institutional mechanism for sharing, learning and monitoring on a regular basis. However, technical guidance was a universally felt need. The study team felt that the District Team displayed tremendous zeal to learn and acquire new skills and knowledge. CARE necessitates a dedicated in-house training team for its large and diverse workforce to be able to respond to complex program needs.

> The District Team displayed tremendous zeal to learn and acquire new skills and knowledge.

As noted already, a majority of the team members received job orientation from their colleagues and have utilized every opportunity to learn from their day-to-day work in the field. A senior CARE official remarked, "*Our staff members learn first hand by getting their hands dirty in the field. This makes them valuable for other organizations."* This resonates with a District Team member who remarked, "*We learn through trial and error."* This is an extremely valuable form of learning and experiential learning emerges

as the predominant mode. However, high attrition bleeds the program and organization of precious accumulated knowledge. A team member put it succinctly as follows: "*If the organization depends only on people, the learnings are gone with people.*" In the course of discussion with some members of the District Team, it was felt that it is quite a while before the learning curve stabilizes and information can be used effectively for decision making in day-to-day program implementation. Changes in program strategies disrupt or limit the application of their accumulated learning for program implementation. A common refrain was, "*Frequent program changes are defeating.*"

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The qualitative team observes that horizontal and experiential forms of learning are an invaluable knowledge source. They are an excellent repository for helping staff do what others have been doing, but may not necessarily provide sufficient scientific foundation to all to enable them to understand the various technical and managerial aspects of the program. The District Teams displayed high levels of coordination, NGO management, and supervisory, negotiation and persuasive skills. The investigators felt, however, that the District Teams were not adequately capacitated on issues of medical interventions, epidemiological data use, health information systems, capacity building, sustainability, community processes, and principles of behavior change. These issues may require deliberately planned scientific orientation and continuing education over the course of the program. The experiential mode may not address these issues adequately.

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The District Teams displayed high levels of coordination, NGO management, and supervisory, negotiation and persuasive skills. The investigators felt, however, that the District Teams were not adequately capacitated on issues of medical interventions, epidemiological data use, health information systems, capacity building, sustainability, community processes, and principles of behavior change.

The program had developed a very detailed Operational Manual. The Manual details the activities envisioned in the program and in most cases offer a blue print for systematic program roll-out. A senior program official pointed out, "*The operational strategy document remained at a draft stage for a long time and it was too ambitious to serve as an operational manual."* The team found limited evidence of use of this manual to guide operations. Another probable reason was probably the evolving nature of the program which rendered parts of the manual obsolete. This piquant situation introduced some degree of uncertainty within the implementation team and presence of one or more road maps could have affected the sense of direction and cohesive action. A senior Program Manager observed, "*Discussions and brainstorming are common and allows inputs from various quarters. But, decisions are usually protracted and remain at draft stages for a long time. Changes are sometimes frequent and goal posts continue to shift. It is, therefore, not uncommon for managers to draw different interpretations and bring different 'take home messages' to the states."*

"The operational strategy document remained at a draft stage for a long time and it was too ambitious to serve as an operational manual."

CARE Official

"Discussions and brainstorming are common and allows inputs from various quarters. But, decisions are usually protracted and remain at draft stages for a long time. Changes are sometimes frequent and goal posts continue to shift. It is, therefore, not uncommon for managers to draw different interpretations and bring different 'take home messages' to the states."

CARE Official

There appeared to have been an activity-centered orientation as opposed to impact-centeredness among the team members. As a District Team member explained "*Before the MTR Review we were focused on completing sets of activities like number of training, number of change agents recruited etc and were not particularly guided by the impact. After MTR Review, we focused on impact as measured by changes in practices, mortality, malnutrition etc. We started focusing on things that work and making changes if they didn't."*

Systems and procedures continue to be put in place after post-Midterm Review findings and observations, and there is a deliberate shift towards impact centeredness. The "WHAT" was more prominently observed in operational as well as other CARE documents as opposed to "HOW", and this was universally evident during the course of interviews with team members across the different states. The Annual District Action Plan serves as the operational charter for the District Teams. It details the targets for

different activity for the year and as a District Team member put it, "*We are dictated by the activity outlined in the action plan and assessed against it.*" The District Activity Plan serves as a powerful mechanism to ensure adherence to program activities but also potentially introduces activity centeredness and limits flexibility and adaptability.

5 System Partnership

I Introduction

Since 1950, CARE has collaborated closely with the Government of India (GOI) to implement a range of development and relief projects. In 1984, CARE with USAID support began contributing to the world's largest community-based outreach program for vulnerable women and children – the ICDS program of the GOI, Department of Women and Child Development (DWCD). In 1996, CARE, GOI and USAID began INHP, which transformed the Title II program support of the ICDS from primarily the provision of supplementary food into a maternal and child survival initiative (INHP DAP 2001-2006). The INHP was designed as a ten-year effort between 1996 and 2006, with two distinct phases of five years each, INHP I (October 1996 - September 2001) and INHP II (October 2001 – September 2006). CARE India's main focus in the INHP program is to work within the broader mandate of the GOI's ICDS and RCH Programs.

CARE India's main focus in the INHP program is to work within the broader mandate of the GOI's ICDS and RCH Programs.

ICDS- a primer: Since independence, the GOI has remained committed towards care and welfare of deprived children. In 1975, the most important, multifaceted ICDS was launched by GOI. ICDS has been India's chief vehicle for improving the prospects for healthy physical, psychological and social growth of children. From a base of 33 pilot projects in 1975, the program has expanded rapidly to a network of 4200 projects covering nearly 75% of community development blocks and 273 urban slum pockets. The principal participants of the program are children below 6 years, expectant and nursing mothers and women in the reproductive age group of 15 to 45 years.

ICDS is designed to provide a comprehensive package of services for early childhood care and development, targeted to the poorest areas of the country. It consists of these basics components:-

I. Supplementary nutrition
II. Pre-school education
III. Immunization, health check-up and referral services
IV. Nutrition and Health Education (NHED) for women 15 to 45 years

The basic unit of the ICDS system is the network of Anganwadi Centers (AWCs). These centers provide a powerful mechanism for reaching mothers and their children. Anganwadi Centers are focal points of delivery of all basic services to women and children. Each center serves about 1000 population, less in tribal areas. The Anganwadi Centers are run by village volunteers (who are paid a nominal honorarium), known as

Anganwadi Workers and the Helpers (usually local village women). The Anganwadi Workers are supported by a cadre of supervisory staff beginning with the Sector Supervisor who each is responsible for 17 to 20 Anganwadi Centers. At the Block level, the ICDS project is managed by the Child Development Project Officers (CDPO). At the district level, the District Women and Child Development Officers (DWCDO) are responsible for all ICDS projects of the District.

RCH- a primer: The RCH program which was launched in October 1997 incorporated the new approach to population and development issues which emerged in the International Conference on Population and Development held in Cairo in 1994. The program integrated and strengthened the services under the Child Survival and Safe Motherhood Program and Family Planning Services, and added new areas on adolescent health and reproductive tract/sexually transmitted infections to the basket of services. The RCH Program is the umbrella program within which all the services being provided by the Ministry of Health and Family Welfare (MOHFW) are to be planned and delivered. It aims at providing need-based, client-centered, demand-driven, high-quality services to the beneficiaries with a view to enhancing the quality of reproductive life and enabling the country to achieve population stabilization.

In the current RCH Program, inter-sectoral linkages will be brought to bear upon the delivery of a wide range of services and is aimed to enhance the outcomes of reproductive services. Broadly the program aims to universalize immunization, antenatal care, and skilled attendance during delivery as well as treatment for common childhood illnesses. Greater stress will be laid on improving neonatal care at all levels, including the home and community so as to substantially reduce the infant mortality (drawn from: *Reflections RACHNA 2004).*

The Department of Health and Family Welfare is primarily responsible for providing Reproductive and Child Health services, hence forth to be referred to as Health System. The basic outreach health worker is the Auxiliary Nurse Midwife (ANM) who covers a population of approximately 6000 or more and is supervised by the Lady Health Visitor (LHV) who reports to the Medical Officer (MO) at the Primary Health Center (PHC). The MO reports to the Block Medical Officer (BMO) who works under the supervision of the District Medical Officer (DMO/CMO). RACHNA works with both the health system and ICDS functionaries to converge together for complementary programming of Reproductive and Child Health Services.

II Historical Perspective

INHP I (1996-2001): The conceptualization and implementation of INHP was a programmatic and institutional revolution for CARE and for USAID food support to ICDS. As informed by the Impact Evaluation of the Title II program in 1994, INHP design aimed to maximize the impact of Title II Resources through addition of complementary interventions to enhance the impact on maternal and child nutrition. While provisioning of supplemental food continued to focus on children under 6, INHP

placed greater emphases on pregnant women and children under two years, and on the delivery of a package of interventions known to contribute to reduction in child malnutrition and infant mortality. INHP I was implemented in seven states (Bihar and Madhya Pradesh were subsequently split into two states).

> The conceptualization and implementation of INHP was a programmatic and institutional revolution for CARE and for USAID food support to ICDS.

Introduction of INHP I demanded significant institutional and programmatic changes for CARE in transforming from a direct feeding program into a broad health and nutrition program. The CARE INHP I program worked with the ICDS, the RCH program and a range of NGOs and Community-based Organizations (CBOs). Prior to 2001, the block was the unit of intervention and there were four different intervention strategies (Food Monitoring, Basic Nutrition, Capacity Building and High Impact Strategy) with different intervention packages and modes of delivery. The emphasis was on supplementary feeding for children under two, and on targeting services for pregnant and lactating mothers for feeding through the ICDS system. The program included immunization, iron-folic acid (IFA) supplementation, complementary feeding, birth spacing and community management of childhood illnesses.

INHP I Mid-Term Review: The Mid-Term Evaluation of INHP I in 1999 recommended refinement of the program implementation strategy to focus on a narrower range of interventions delivered uniformly across the District as opposed to the block-level differential intervention strategy implemented to that point. It also recommended the development of Demonstration Sites (DS) across 10% of the Anganwadi Centers. The Demonstration Site was in some ways similar to the High Impact Strategy Blocks that had been part of the program until then. Anganwadi Centers where the program processes were better established with the ICDS and the chances of successful demonstration were higher were to be selected as DS. CARE responded enthusiastically to the suggestions of the Mid-Term Review. INHP successfully revised the program structure in order to more effectively channel resources and more efficiently move into a scale-up mode.

> The Mid-Term Evaluation of INHP I in 1999 recommended focusing on a narrower range of interventions and on the development of Demonstration Sites across 10% of the Anganwadi Centers.

INHP I Final Evaluation: The Final Evaluation Team observed that INHP I had succeeded in bringing together ICDS and Health Department policies, operations and service delivery, after decades of failed attempts made by government and other agencies. As a result, CARE and its partners had become more effective at reaching high coverage rates for health services. The Final Evaluation Team observed that CARE had been

impressive in systematizing, monitoring and strengthening processes and at rolling them out to scale. The management of commodity supply chains and use of social mapping for improved targeting of program interventions to the most vulnerable by the ICDS and program was note-worthy. INHP I effort to strengthen government service delivery while building community capacity were identified by the Final Evaluation Team as critical for improvement in health and nutrition outcomes, as well as for building sustainability and empowerment.

INHP I efforts to strengthen government service delivery while building community capacity were identified by the Final Evaluation Team as critical for improvements in health and nutrition outcomes, sustainability and empowerment.

INHP I had recognized that strengthening systems though capacity building was central to their strategy. The focus was on convergence, planning, monitoring, supervision, food commodity management, and nutrition and health education. The Final Evaluation Team, however, did not observe clear articulation of what specific types of capacities were necessary, and at what levels of functioning, in order to achieve the desired improvements in maternal and child health and nutrition. The team further observed, "*Although early in INHP documents refer to a broad range of potential actions for building capacity, perhaps unintentionally, training appears to have become the predominant approach explicitly stated as the INHP strategy for building capacity.*"

The collaborative working style of CARE that included joint planning, frequent field visits and joint reviews was observed to lead to increased capacity at all levels. The Final Evaluation Team, however, recommended using a broader approach to capacity building through a process of participatory planning, and urged that it be taken beyond training, and include close monitoring of indicators for activities and outcomes in terms of functions (not inputs and outputs alone). They also recommended linking Capacity Building activities to stages of INHP development, working towards the penultimate goal of Graduation of the program areas with defined outcome indicators.

"*Although early in INHP, documents refer to a broad range of potential actions for building capacity, perhaps un-intentionally; training appears to have become the predominant approach explicitly stated as the INHP strategy for building capacity.*"

INHP I Final Evaluation

Transition to INHP II: The Mid-Term Review, Final Evaluation, comprehensive problem analysis exercises with all stakeholders from the community to policy makers, and global lessons in reducing child mortality and malnutrition, all influenced the development of the INHP II strategy and the subsequent integration with Chayan to

become RACHNA. The final content of the intervention package was considered based on feasibility, cost and particularly the context of its primary implementing partner, the ICDS (RACHNA Program documents).

The geographical focus of INHP II was the same as INHP I, with changes being mainly determined by the redrawing of the state boundaries in the year 2000. Some fundamental changes in the implementation approach in the second phase of INHP included:

I. Demonstration of Best Practices
II. Replication of Best Practices through System **Strengthening and Capacity Building of Service Providers**.
III. Greater emphases on influencing **ICDS and Health systems** to improve the operational effectiveness in reaching the target groups.
IV. Establishment of a District Implementation Team

III INHP II: Introduction

Objective: Achieve sustainable improvement in health status of seven million women and children

Sub-objective: Service providers (Anganwadi Workers and Auxiliary Nurse Midwives) improve the quality and coverage of maternal and child health services and key systems including training, supply chain management and information management

Sub-objective: Communities sustain activities for improved maternal and child survival

CARE had demonstrated various models of intervention in INHP I, and had established specific Demonstration Sites and scaled-up the program based on less intensive intervention inputs in the rest of the program areas. Further extension of the Demonstration Sites to 10% of the program Anganwadi Centers and Replication of those to the rest of the program universe by the government system was to be the mainstay of the INHP II strategy. The role of system partnership was central to the Replication strategy. According to the Detailed Activity Plan (DAP) for INHP II, "*The Government has the largest and most important infrastructure dedicated to making nutrition and health improvements, and therefore influencing and supporting the Government System to adopt and replicate Best Practices is critical.*"

Further extension of the Demonstration Sites to 10% of the program Anganwadi Centers and Replication of those to the rest of the program universe by the government system was to be the mainstay of the INHP II strategy.

Capacity Building: The term "Capacity Building" has been used to refer to a wide range of strategies and processes which have the ultimate goal of improved health practices that are sustainable. This term is applied to interventions which change an organization's or community's ability to address health issues by creating new structures, approaches and/or values (Crisp et al. 2000).

In reality, "Capacity Building" as a term has been conceptualized in a diverse range of ways and is associated with a plethora of meanings (Selsky, 1991; Hawe, 1994) and open to differing interpretations by different organizations. It is, therefore, paramount that a cross-cutting critical process like Capacity Building and System Strengthening be first understood as conceptualized by the program and assessed accordingly. In this study, System Strengthening is considered a sub-set of Capacity Building and the terms are used interchangeably at times.

Capacity Building for Replication: Sharing information and demonstrating successes were considered powerful forces for change. To optimize chances for success, Program and System issues were identified that could impede effective replication, including:

- Poor staff motivation and inadequate recognition of good performance
- Vacant positions and frequent transfers
- Poor staff capacities and lack of supportive supervision
- Lack of coordination and convergence of GOI programs, especially the Department of Women and Child Development (DWCD) and the Department of Health and Family Welfare (DHFW), although they have overlapping goals
- Over-emphasis on a uniform central approach
- Lack of community demand
- Poor Information Systems for management

Capacity Building of the Government System was identified as the key step to effective replication and thus INHP II envisaged significant effort in this area, leading to a targeting of DWCD, DHFW and Training Institutions. Some of the key supporting activities that were proposed for INHP II are as follows:

- Positive Changes in Program Focus
- Strengthen ICDS/Health Training Institutions
- Support improved data quality and effective use of information for management decision making
- Establish mechanisms for convergence and coordination between DWCD and DHFW
- Advocacy for a supportive policy environment, Strategic Alliances and synergy with other projects

The program hypothesized that positive changes in program focus, convergence and increased capacities of functionaries of ICDS and Health system at all levels would lead

to increased contacts by service providers, improved coverage and improved availability and access to quality services. (CARE Program documents).

Capacity Building of Systems and Service Providers was recognized as the most "critical" process intervention for replication of Best Practices.

Discussion: NIHP II very clearly lays down its objective of sustainable improvement in health status of women and children. Building Capacity of Systems and Service Providers has been aptly identified as one of the two key sub-objectives to help achieve sustained delivery of high coverage of services with consistently high quality. However, the study team observed that this objective tended to migrate towards Building Capacity of Systems for Replicating the Best Practices. Thus, the focus seems to have been placed on replicating the Best Practices, although the causal relationship between Best Practices and system efficiency and improved health status does not appear to have been well established. The conceptual fallacy of this program approach seems to have been borne out, in that INHP II/RACHNA has abruptly shifted its object of Capacity Building, and means for achieving health and nutritional status gains, from "Best Practices" in the first three and one-half years to "Sector Strengthening with very limited Best Practices" in the last one and one-half years of the program. This shift has come about in part due to the increasing realization of the conceptual and logistical limitations of the Best Practices in the course of the program.

INHP II/RACHNA…has abruptly shifted the goal post of Capacity Building from "Best Practices" in the first three and one-half years to "Sector Strengthening, with very limited Best Practices", in the last one and one-half years of the program.

The Qualitative Assessment Team observed that System Strengthening and Capacity Building of Service Providers seemed to become both a means to an end, as well as an end in itself; it was both an objective as well as the means to the objective. It is not uncommon for evolving concepts like Capacity Building to be caught between means/ends dialectic but, clear articulation and consistency of objectives is primary to a synchronized sequential implementation of Capacity Building Strategies that are aimed to achieve sustained improvements in health and nutrition.

IV Capacity Building: Approaches

The assessment team observes that Capacity Building of Service Providers and System Strengthening, as defined in RACHNA, could both well be considered as Capacity

Building processes. Therefore, we consider them together, in order to allow better appreciation and recognition of Capacity Building efforts.

Approaches: The assessment team, based on the processes, structures and strategies that were reviewed, identified four major approaches to Capacity Building in the program. This conceptual model will enable identification of key Capacity Building processes and subsequent discussion.

I. Partnerships: Bringing together more than 150 NGOs in a partnership, strategic alliances with MOST for Vitamin A supplementation, as well as with Government partners and Social Marketing Organizations, among others, are indicative of a partnership approach to Capacity Building.

II. Top-down organizational approach: CARE's attempt to bring two vertical programs to converge at all levels is exemplified by initiatives like formation and/or strengthening of convergence forums like District level Advisory Committee (DLAC), Block Level Advisory Committee (BLAC) and Sector Meetings, Nutrition and Health Days at the community level, advocacy at the National and State levels for policy changes like gender issues.

III. Bottom-up organizational approach: Training has been the hallmark of the Capacity Building approach of RACHNA. An effort to develop technical expertise so that they can plan, implement and evaluate their program is part of this approach. An effort to develop District Training Teams, Block Training Teams, and training of service providers is indicative of this approach. Training of primary health care workers, including Anganwadi Workers and Auxiliary Nurse Midwives, along with their supportive supervision; and development of program monitoring home-visitation tools are all examples of a bottom-up organizational approach by RACHNA.

IV. Community organizing approach: this is discussed under the Community Partnership section.

It is evident that there were multiple approaches and each of those approaches had the potential to contribute to Capacity Building in its own right and in consort with others. Evidence from the scientific literature suggests that multiple approaches improve the chances of Capacity Building (McLaughlin et al, 1997), and this program wisely incorporated multiple opportunities into its program structure.

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Program Management Structure: The Program Management structure of INHP II at the Program Headquarters and at the State Headquarters did not give the study team a clear conception of the connection between Capacity Building activities, which were central to the program, and the achievement of the main program objective of sustained improvement in health status of women and children. Capacity Building is itself an evolving and challenging field, and for large programs like INHP II/RACHNA which aim to achieve sustainable impact through largely inflexible government systems, and in collaboration with multiple and heterogeneous partners and diverse communities, the issue assumes complex proportions. The approaches to Capacity Building identified by the program demand a high level of expertise on issues of organizational change, workforce development, institutionalization, community processes and leadership. It was not clear to the study team whether the Technical Director Position, a critical position that remained open through the life of the program, was meant to serve this responsibility. This systemic void needs to be addressed.

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Capacity Building Officer: The District Team had a dedicated position of Capacity Building Officer, an indication of structural commitment of the program to this objective. The Capacity Building Officers' commitment to training was unqualified and deserves sincere appreciation. Most of the Capacity Building Officers considered their primary responsibility to be the coordination of training activities across the districts. The overwhelming magnitude of this effort left little time for other activities. The job description of the Capacity Building Officer overwhelmingly revolves around training, although this position has also been described as the focal point for capacity building in the District. Based on the interviews with Capacity Building Officers, it seemed that the conceptual understanding of Capacity Building did not extend beyond the confines of training activities and joint field visits.

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Government Partnership Officer: The assessment team observed that the Government Partnership Officers have been playing a very important role that can be viewed as Capacity Building by helping to strengthen convergence forums, replication of best practices and advocacy at the District level. The Government Partnership Officers displayed good understanding of the government system and the challenges that it posed. They displayed high levels of commitment to scale-up the program by the government system, but their understanding of building systems capacity towards sustenance was limited. Their understanding of organizational behavior issues, change management, adoption and institutionalization needs to be nurtured and strategically directed towards meeting program objectives.

The Government Partnership Officers displayed good understanding of the government system and the challenges that it posed. They displayed high levels of commitment to scale-up the program by the government system.

The Community Organizational Approach is an important pillar of the Capacity Building model, and the role of INHP during the first phase was highly appreciated by the Final Evaluation Team of INHP I. INHP II continued this focus. Its objectives recognized sustained community capacity along with system capacity as complementary and prerequisite to achieving the goals of the program. Review of the function of all the positions across all levels, however, did not reveal a position that was designed to steer capacity building of the community towards sustained action.

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The assessment team identified activities/processes/opportunities of Capacity Building that have been presented as different approaches which potentially could create an impact at various levels. It also observed activities taking place at different levels and positions. However, these diverse and broad activities do not appear to have been knit together in a cohesive, concerted set of synergistic actions. The conceptual link between the various activities and the objective of Capacity Building appears somewhat dissociated at the operational level, potentially allowing some activities e.g. training to overshadow other aspects of capacity building, thus failing to create the synergy needed for broad and sustained impact.

V Partnership Management

The development of partnerships between organizations and groups of people is an approach to Capacity Building (Chavis, 1995; Marty, 1996). Partnership with ICDS, the Ministry of Health and Family Welfare (MOHFW), NGOs and other governmental departments is fundamental to the program design of INHP II/RACHNA. Equally significant is its role in strengthening partnerships between them, especially between the ICDS and the MOHFW. CARE's long association with ICDS in managing the supply chain and monitoring food delivery provides credibility within the Government System and ICDS is recognized as the primary partner of the program. INHP marks the transition to programming for improved antenatal care and child survival, necessitating increasing collaboration with the MOHFW. The program had also envisaged working in close partnership with Panchayati Raj Institutions (local self governments), and with the community.

Program Design Process: Review of INHP I documents indicates that it had been clearly recognized that CARE had the ability to bring the MOHFW and ICDS to converge, thus increasing the reach and impact of services. Program documents report active involvement of key officials from ICDS and Health System at the national and state levels during the design process of INHP II. According to the program documents, presentations and discussions centering on malnutrition and infant mortality were seen as powerful mechanisms in gaining attention and approval of government officials. The documents, however, were silent on the involvement of Panchayati Raj Institutions in the program design process though they have been included at other stages of program implementation. CARE's ability to identify partners in ICDS, MOHFW and Panchayati Raj Institutions is indicative of foresight and strategic alignment with national priorities, institutions and programs.

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The assessment team had very limited interaction with State level officials from the various partner departments and institutions. Thus, most of our observations are from interaction with officials at the District, Block and Community level.

ICDS Partnership: CARE has successfully built strong and influential working relationships with ICDS at all levels. This was a uniformly observed phenomenon across all the states. One of the investigators has had the opportunity to observe the close working relationship of one of the State Program Representatives of CARE with the State ICDS officials, and the close ties that were forged needs to be commended. The

investigators have reasons to believe that this observation could be safely extrapolated to the other states.

CARE has successfully built strong and influential working relationships with ICDS at all levels. This was a uniformly observed phenomenon across all the states.

The study team had multiple opportunities to interact with a range of ICDS functionaries at various levels of hierarchy within the Districts across all the states. Most of the functionaries were highly appreciative of the supportive nature of the program and its personnel. They were appreciative of the efforts by CARE and stated that they had helped activate the existing ICDS system as well as bring new components in the form of RTI and STI management. They all seemed to view RACHNA as being the same as their own program with additional inputs in the form of job-aids, IEC materials, BCC shows, Change Agents and training.

One sector supervisor, in sharing her opinion on capacity building done by CARE, observed that "*CARE has provided more detailed information about the pregnant women and newborn which we were not aware of earlier.*" The Sector Supervisors generally felt that record keeping abilities and monitoring of AWWs had improved compared to INHP I. They also saw an additional help in the NGO worker, particularly in the last several months of the program when Sector Strengthening improved. The Anganwadi Workers could not differentiate the technical intervention as distinct from what they had been oriented on by the ICDS or other agencies, but they felt that the training they received from CARE and the Sector level meetings had served to refresh their knowledge and reorient their focus on key interventions.

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ICDS worker

The Anganwadi Workers felt that the training they received from CARE and the Sector level meetings had served to refresh their knowledge and reorient their focus on key interventions.

There was a lack of clarity, however, among the various program partners in terms of perceptions of programs goals, objectives and the foundation of the partnership. One ICDS official explained "*CARE is an international NGO and has a program on mother and child. They have to work in the community where we work. They have to therefore*

take our help and we are happy to help them." Another official adds "*There is a Government Order that we have to help them and we follow the order. They provide oil and used to provide food and now they are also conducting training for the Anganwadi Workers."* There was also mention of lack of due acknowledgement to the partners as highlighted by an ICDS official, "*We brought the water to 90 degrees and CARE put in few things and brought it to boil and takes the credit."* This statement highlights the importance of resolving the conflict with the partners, but, on the other hand, is also an implicit acknowledgement of the value that CARE brings to the program.

"CARE is an international NGO and has a program on mother and child. They have to work in the community where we work. They have to therefore take our help and we are happy to help them."

ICDS worker

Most of the ICDS functionaries at the District and the Block levels could not vividly recall the process of joint planning, identification of priority areas, mapping existing capacities and identifying opportunities to work together towards a common goal. The District Team members could not recall such an exercise either, but did explain to the study team the process of sharing the program design and operational plans with the District and Block level ICDS and MOHFW functionaries during the early months of INHP II.

A District Team member recounted, "*The Implementation Strategy was ready and I received orientation. The government officials had lots of questions and doubts related to the program but we had to sensitize and begin the implementation. There was hardly any scope for their inputs."* The latter strategy, however, may have threatened the spirit of partnership, wherein an intervention and its operational strategy have already been finalized and the objective, therefore, remains to work towards getting the partner to comply with a predetermined plan. The partnership of Anganwadi Worker and the NGO worker in the Demonstration Site, as reconstructed through data available, appears to be an example of a more dynamic and healthy partnership.

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District Team member

In the views of the investigators, a continuity of relationships already established in INHP I could have been leveraged to propel discussion, debate and a co-shared strategy in the second phase of the program, based on past experience and current priorities.

Health System Partnership: The functioning of the Health System is a very significant factor in the ability of the program to achieve its objectives. The level of relationship of CARE with the MOHFW was relatively sparse compared to CARE's relationship with ICDS. The assessment team extensively interviewed MOHFW officials at various levels, but there was limited evidence of close partnership, especially at the District and Block levels. The general understanding of the program emerged from their involvement with training programs at the Block level. As one Medical Officer put it, "*CARE works with the ICDS and they are helping organize the Nutrition and Health Day.*" Involvement of the Health System creates a tremendous opportunities, that, in the view of the study team, remains relatively untapped. The partnership with Panchayati Raj Institutions, in contrast, is rapidly evolving, and there are some excellent instances of the potential benefits that this approach can bring.

The Health System views CARE as an NGO that primarily works with the ICDS system. They see CARE primarily engaged in IEC activities, assistance during health campaigns and immunization drives and provision of food and oil. Some associate CARE with birth-spacing and RTI and STI management from the posters hung in the health centers or the collection of contraceptive pills by the NGO workers. Some Medical Officers interviewed recall extending their help in training on health issues and interacting during convergence meetings.

> The level of relationship with the MOHFW was relatively sparse compared to CARE's relationship with ICDS.

The value that RACHNA could potentially bring to the mandate of the Health System was not found to be appropriately communicated and therefore the health system personnel did not perceive much value in engaging with them. The District Team's self-efficacy to engage the Medical Officers on technical aspects of the intervention needs to be developed.

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Program changes after MTR had to be made under difficult circumstances with very limited time to build consensus, and it didn't seem that close consultations with the partners at the District level were made. In the words of a CARE official "*The initial part of the program focused on integrating the idea of "demonstration" and "best practices" within the ICDS System…. There wasn't enough room for accommodating views of the*

Government at the District level." Regular review and re-evaluation of the level of cooperation among the partnership may be beneficial.

Panchayati Raj Partnership: This relationship is evolving and variable across the states. The study team had very limited geographical coverage for the assessment and this could have been the explanation for meeting fewer members of the Panchayati Raj Institutions involved with the program. However, it was made known to the assessment team of the increasing efforts being made to involve them. They are referred to in other relevant sections in the report.

CARE has clearly demonstrated its capacity to build partnership with ICDS but it could benefit from continuing to explore ways of establishing deeper working relationships with the Health System, and build District Team capacity to engage each of the partners meaningfully as well as constructively manage the network of partnerships that it has built. The role of Government Partnership Officers and their capacity to understand the phases of partnership development are critical. Building capacity towards this engagement would be potentially rewarding to the program.

> *"The initial part of the program focused on integrating the idea of "demonstration" and "best practices" within the ICDS System.... There wasn't enough room for accommodating views of the Government at the District level."*
>
> CARE official

Information Usage and Sharing amongst Partners: CARE has been very instrumental in investing resources in evaluation of the program, and equally responsible and strategic in sharing the findings with the partners. It is mainly true for Evaluation Research Districts (One program district in Uttar Pradesh and Andhra Pradesh each) and Panel Districts that represent one district in a state. The mini-RAPS have been an innovative exercise in utilizing the existing workers of the system to acquire and analyze data. This has been useful in stimulating the process of data review leading to evidence-driven action. A State Program Representative remarked, "*We have activated the system. We have presented them the figures of coverage and it is making them accountable.*" The Post Mid-term Strategy of taking data use down to the Sector level has been useful in provoking some grass root level workers on issues of infant mortality, changes in key practices and grades of malnutrition.

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The program has strategically invested in a computerized Health Management Information System (HMIS) which has the potential to be a very powerful tool that can help in program monitoring and execution. However, this has not been fully realized due to various reasons. It was introduced late into the program. Though CARE has been successful in establishing an extensive system of acquiring data from the Anganwadi Centers, there is limited data acquisition from the Health System. Additional efforts need to be made to improve the quality of acquired data. The Anganwadi Worker continues to fill more than twelve registers and efforts have been made by the program to strengthen record keeping but efforts to reduce and rationalize data collection are lacking.

The pre-MTR HMIS system was mainly centered around compilation of data on food and oil distribution and Best Practices and continues so far. The data was not compiled pertaining to malnutrition and infant deaths that are routinely collected by the ICDS and health systems. The Monitoring Officer conducts 3% checks in compliance with USAID regulations. This opportunity has been utilized to collect some information through interview of the beneficiaries. It provides a window on very limited aspects of program outputs.

Post-MTR some additional forms have been mandated by the program. The new forms that have been introduced post-MTR are better reflection of program activities. The logistics of introducing new forms are challenging in terms of orientation, data collection, compilation and information processing. The newer forms were at the time of the assessment still finding their way to the Anganwadi Centers but discussion with CARE and ICDS staffs who had been introduced to the newer forms were of the view that these forms bring a definite value to them.

The current computerized HMIS has not kept pace with the changes in reporting formats and therefore data compilation is partly manual and partly automated. The current monitoring system helps compile data and generate reports for different time periods within a short duration. However the software in the current mode does not allow sufficient analytical support for the District Team. The capacity of the team to analyze and interpret data needs strengthening.

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VI Convergence of Health and ICDS

Introduction: One of the distinctive strengths of INHP/RACHNA has been the effort to bring two vertical government service delivery systems to converge with each other and

continue to build bridges with others to fortify the relationship. The Operational Strategy Document outlines three key outputs under the INHP II sub-objective of Strengthening Health Systems and Building Capacity of Service Providers. The three outputs are:

- **Convergence and coordination between Department of Women and Child Development (DWCD) and Department of Health and Family Welfare (DHFW)**
- Increased capacity of service providers
- Better use of information for improvement of health supplies

> One of the distinctive strengths of INHP/RACHNA has been the effort to bring two vertical government service delivery systems to converge with each other.

Convergence: The Operational Strategy Document very clearly identifies different levels of convergence between the two vertical governmental structures, beginning from the National level and continuing to the State, District, Block and Supervisor levels until the Anganwadi Center and subsequently the community. Strengthening District-level Advisory Committees (DLAC) and Block-level Advisory Committees (BLAC) and setting these up where none existed was undertaken during the first phase of INHP I and continued into INHP II. According to CARE documents, DLACs and BLACs have always been seen to play key roles as locally mobilized groups comprising of stakeholders, including service providers, implementers and/or community leaders. According to the operational results of INHP I, most of the states already had these forums (i.e., DLAC, BLAC) in place by the end of INHP I and membership was expanded to include representation from other departments. The increasing effort to involve the Panchayati Raj Institutions will be taking convergence to greater strength.

> The operational strategy document very clearly identifies different levels of convergence between the two vertical governmental structures, beginning from the National level and continuing to the State, District, Block and Supervisor level, until the Anganwadi Center and subsequently the community.

According to program documents, CARE's experience of improving convergence has enabled them to influence the Health System to not only work with ICDS, but to furthermore recognize its strong potential to contribute to its objectives. The program recognizes that the use of these forums has been limited by the kind and quality of data available for discussion. The difficulties in improving completeness and accuracy of information and compiling data for meaningful analyses and interpretation, and lack of

information on aspects of behavior change and lack of accountability by the systems have been some of the major concerns of CARE during INHP II/RACHNA.

According to a Child Development Project Officer (CDPO) of the ICDS/DWCD, "*ICDS works towards better nutrition and reducing infant mortality. Working closely with the Health Department is important because our success also depends on them. If we have a good coordination, then all the tasks will be accomplished.*" According to a District Team member, "*Government has been aware of the need for convergence but we have worked towards ensuring that. However, we do not know how much we have reached……. perhaps 60%.*" It was an almost universal acknowledgement from the ICDS functionaries that CARE had helped to strengthen the convergence between the ICDS and Health at the community level.

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ICDS official

It was an almost universal acknowledgement from the ICDS functionaries that CARE had helped to strengthen the convergence between the ICDS and Health at the community level.

As one Medical Officer put it, "*Anganwadi worker helps the ANM in bringing the beneficiaries and it becomes easy for the ANM to administer the vaccines*". An NGO worker explains, "*Take Home Rations (THR) is one way of achieving convergence. On every Monday, beneficiaries come to the Anganwadi Centers and receive THR. The ANM also comes and administers the vaccines.*" The Anganwadi Workers see this as a mutually rewarding opportunity, as one related, "*It is about mutual understanding and coordination. We are helping each other and it benefits the community members*". Another ICDS official adds, "*There was some coordination before CARE came but they have acted as a catalyst.*"

"*There was some taal-mel (coordination) even before CARE came but they have acted as a catalyst.*"

ICDS worker

There were a few skeptics, however, and all from the Health System, particularly in states where joint meetings between the two governmental departments have been institutionalized, felt that, "*It has been our initiative and we have been having been*

regularly having joint meetings between the two departments at the Block level and at the District level. We do it for our own coordination and I don't think this has been facilitated by some other organization." A District officer opined, "*Frankly speaking, they are working and supporting but there is no strengthening."* Another Medical Officer, talking about the role of convergence, observed, "*CARE has helped in bringing the AWW and ANM together. But their role is limited because they mainly work with the ICDS and NGOs. They are less in contact with us."*

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Medical Officer

District-level Advisory Committees (DLAC) and Block-level Advisory Committees (BLAC): The DLAC and BLAC are two convergence and coordination forums at the District and Block level, respectively. The strength, density and effectiveness of these forums varied widely amongst the Districts and Blocks that were assessed. The study would particularly like to share its experience with DLAC in one of the tribal districts and the role of CARE and the leadership demonstrated by the Government Partnership Officer (GPO) of the CARE District Team. There were also Districts where DLAC meetings have happened only a few times since the inception of the program, and have not contributed meaningfully to coordination and convergence. According to a GPO, "*The District Magistrate keeps changing and so do officials in the other departments. They are all so busy that it's very difficult to bring them together. It is easier to meet them directly and get the work done."* A Medical Officer explained, "*You should take a look at the number of meetings that we are supposed to attend. It kills time and an extra burden. We cannot do our regular work because of these meetings. There are so many national programs that I have to coordinate and manage to attend only few of the meetings."*

The strength, density and effectiveness of these forums [District-level Advisory Committees (DLAC), Block-level Advisory Committees (BLAC)] varied widely amongst the Districts and Blocks that were assessed.

In the opinion of CARE District Teams, the BLAC is more functional than the DLAC. As one member explained, "*The Block Development Office has all the senior officers staying close to each other. It is easier to bring them together for meetings."* The frequency of BLAC was also found to be highly variable. In a few blocks, the Medical Officer could not confirm the existence of a BLAC, and in some there were only a couple of BLAC meetings until the time of the study. Scrutiny of the minutes of the meetings and subsequent discussions indicated a need for standardization and introduction of quality

concepts like quality circles to structure and manage the meetings. The representation from CARE District Team was found to be sparse and logistical challenges are obvious constraints which hinder them from contributing effectively to this process. The attendance of the NGO Block Coordinator was regular, but concerns were expressed about the ability of the NGO workers to effectively engage the Block officials and steer the agenda of the BLAC. The NGO worker's capacity and perceived role by the officials of the ICDS and Health system does not adequately empower him to constructively engage with the Block level officials and provide impetus to the BLAC. In the words of an NGO worker "*We are too junior to them. The Sector Supervisor listens to me but above that position is difficult.*"

The District Magistrate as well as numerous Block-level officials vividly recalled the initiative of the GPO in convincing the District Administration of the value of convergence and an active DLAC and BLAC. The DLAC in the district meets regularly every three months and is patronized by the District Collector who incidentally also happens to be a physician by training. The DLAC has representation from various departments, organizations and NGOs working towards improved child survival. The investigators had the opportunity to go through the minutes and the contents of the meetings.

Data compilation, neonatal death audit and epidemiological surveillance were cornerstones of the meetings, and served to guide active discussion, realization and subsequent engagement of all involved stakeholders. The coordination and pooling of expertise from different organizations towards strengthening this forum was exemplary.

One of the most credible examples of transparency, accountability and data integrity has been the rapid increase in Infant mortality that the District has registered subsequent to an active DLAC. Based on the interaction and perusal of documents with clearly laid out tables and figures, the increase could be attributed to better reporting. The District now also publishes an Epidemiological Report every month or so. The demand on the District Team to continue to respond to the changing needs of such a forum is critical and institutional mechanisms need to be put in place to capacitate the District Team so that they can continue to bring value and direction.

"The District Magistrate keeps changing and so do officials in the other departments. They are all so busy that it's very difficult to bring them together."

CARE GPO

The attendance of the NGO Block Coordinator was regular, but concerns were expressed about the ability of the NGO workers to effectively engage the Block officials and steer the agenda of the BLAC. In the words of an NGO worker "*We are too junior to them. The Sector Supervisor listens to me but above that position is difficult.*"

The assessment team also had an opportunity to directly observe a BLAC that had representation from Health, ICDS as well as Panchayati Raj Institutions. The ability of CARE to bring the different partners together on BLACs needs to be commended, but efforts to strengthen and institutionalize the process and improve quality require strategic investment of organizational, technical and leadership skills combined with decentralized decision making in the District CARE Team. CARE has recognized the need for these bodies to have more administrative powers and accountability that are outside the scope of CARE, and in the absence of same, the challenges will continue to confront the program.

The ability of CARE to bring the different partners together on Block-level Advisory Committees needs to be commended, but efforts to strengthen and institutionalize the process and improve quality needs strategic investment of organizational, technical and leadership skills combined with decentralized decision making in the District CARE Team.

The team scrutinized the minutes of BLAC meetings and saw increasing trend towards data use but in majority of cases the BLAC was not being effectively used to discuss, analyze and initiate corrective measures.

Sector Meeting: The Sector has been recognized as the most fundamental functional unit of replication and the Sector Supervisor was envisioned to be the Replicator of Best Practices. Discussions with CARE officials at various levels and personnel from the ICDS and Health System did not provide evidence of a strong sector engagement in the first three and one-half years of the program. The reason was not well understood, but in the last 18 months the program has seen the Sector emerge as the most strategic level of program intervention and means to reach scale.

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Sector meetings are slated to take place every month and are to be attended by the Sector Supervisor, Lady Health Visitor, ANM, and Anganwadi Workers. Efforts are being made to ensure participation of representatives from the Panchayati Raj Institutions. CARE has recently developed detailed guidelines for Sector-level meetings. The Sector-level meetings are facilitated by the NGO worker and are aimed to review: 1) select indicators from the previous Monthly Progress Report, 2) Health Monitoring Information System (HMIS) data from the Nutrition Health Day, 3) operational plans from previous meetings, and 4) observations from field visits. The NGO worker in charge of the Sector meetings has, in most cases, worked intensively in the Demonstration Sites with the Anganwadi Workers and this skill is leveraged to bring value and direction to the sector meetings. The NGO worker, however, in most cases has not worked with system level processes and it was not clear how they were re-oriented towards system engagement within the very short time frame available.

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The assessment team had the opportunity to extensively interact with Sector Supervisors, Anganwadi Workers and ANMs. Most of the Sector Supervisor saw a value to the sector level meeting. The NGO worker seems to have brought value in assisting them in record keeping; helping them to focus on key interventions like supplementary nutrition,

complementary feeding, delayed bathing, and early and exclusive breastfeeding; providing for joint monitoring of Anganwadi Workers; providing inputs to the Sector Supervisor on a regular basis; providing hands-on help to Anganwadi Workers where possible; and discussing key issues in sector meetings. It was generally felt that coordination with ANMs had improved since increased emphasis had been placed on the Sector post-Midterm Review, and so had immunization. They also felt that some processes like sector level meetings had been fine-tuned and thus had become more streamlined and organized. The involvement of the ANM and other representatives from the Health System was found to be limited but there were indications of improvement in coming months.

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This provided a shift from classroom-based interaction to on-the-job interaction and mentoring. The magnitude of the program places huge logistical challenges and therefore it was obvious that strategy changes and subsequent development of sector level tools will need time to reach the intended audience. In most cases, the tools had recently arrived, leaving little time for exposure to and use of these tools. The assessment team recognized and took into account this limitation.

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A District Team member, advocating the benefits of Sector-level engagement, said, "*In joint Sector meetings you will find participation of Lady Health Visitor with Sector Supervisor of ICDS and Anganwadi Workers and ANMs. You will find them meeting, sharing problems and solving them. Earlier they were aware of the problems but they never used to share it.*" An NGO Worker, talking about the process of organizing the

Sector-level meetings, describes, "*The agenda of the meeting is prepared jointly with the Sector Supervisor one day prior to the meeting containing issues on joint visit, action plan for the month and follow-up plans for the previous month. In the last meeting CARE officials had come."*

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District Team Member

Constraints to Sector Meetings: Competing priorities of the Lady Health Visitor and the ANM, and time management appear to be constraints to effective implementation of the Sector-level meetings. A District Team member described, "*The reporting by Anganwadi Worker to the Sector Supervisor is a day long process in which a lot of calculation is done. There are approximately 124 sector meetings in my District and it is not possible for us to reach. But NGO workers are able to cover most of the meetings. Vacant sector Supervisor position is a problem and also reaching far off sectors."* It is not uncommon for Anganwadi Workers to continue to reach the Sector at various times, compile her reports and head back home. NGO workers have, in the first stage, intervened to improve time management and thus also positively influenced the quality of interaction. In the words of a District Team member, "*Discipline in maintaining time was a problem. We began working to sensitize and improve this aspect and improvements are visible"*. Another additional constraint has been the capacity of NGO workers to effectively help develop "problem solving abilities", understand and interpret data for decision making and build capacity of Anganwadi Workers to do so. Fundamental issues of data acquisition, data quality and interpretation need review. The role of the NGOs vis-à-vis sustainability needs to be addressed too.

Another additional constraint has been the capacity of NGO workers to effectively help develop "problem solving abilities", understand and interpret data for decision making and build capacity of Anganwadi Workers to do so. Fundamental issues of data acquisition, data quality, data integrity and interpretation need review. The role of the NGOs vis-à-vis sustainability needs to be addressed too.

The Nutrition and Health Day (NHD) serves as another opportunity for convergence and coordination and has been discussed in detail under the section on NHD.

The different levels of convergence and coordination need to be strengthened at every level and strategically linked to each other to allow flow of information, instructions, transparency, positive competition and accountability. The role of GPOs in understanding the different stages of development of a forum like DLAC/BLAC/Sector Meetings, integration of problem solving paradigm and subsequent institutionalization is fundamental to developing these forums as powerful drivers of sustained change.

Joint Field Visits: Cross visits to demonstration sites has been characteristics of the pre-MTR phase of INHP II. The post-MTR saw the NGO worker shift focus from demonstration sites to engaging and strengthening the sectors. The process of active engagement of the sector supervisor during the sectoral meetings, joint visits to the Anganwadi Centers and helping build supervisory capacity, improved monitoring and on-job assistance to the Anganwadi workers in solving the problems. This process has been welcomed by the CARE team members but large area of operations has limited the inputs to each Anganwadi centers. This process has however, helped engage all the Anganwadi Workers in a sector simultaneously.

VII Training

Training was the pre-dominant capacity building strategy of RACHNA. The training accounted for over 40% of the program budget (RACHNA Final Evaluation Report, 2006) and by the year 2004, almost 600,000 participants had been trained. The training was conducted for all levels of workers, including the Change Agents and personnel from ICDS and Health as well as Panchayati Raj Institutions.

Training Teams/Institutions: The training was pre-dominantly class-room based and initially conducted for the Demonstration sites and subsequently for the Replication sites. The program had operationalized training with a view of strengthening existing capacities within the system and training institutions. It effectively collaborated with several institutions for this purpose. Core to the operational strategy was the formation of District Training Team and Block Training Teams and further down to engage the Sector. The training of the District Training and Block Training Team was conducted by the CARE District Team early on in the program. Since the program was taking off, the process was not accompanied with formal training modules and pre-defined methodology.

The District Training Team in general has not been effective and Block Training Team has played a significant role. The Block Training Team mainly consists of Block level officials and NGO worker. Transfer of officials is a common phenomenon and therefore the Block Training Team does not effectively function as predictable resource. In practice, the trainers were not generally equipped to train Community-based workers and use adult learning models. An NGO coordinator observed, *"The initial trainings did not focus on how to implement the interventions which we all wanted to learn; we wanted to be trained on certain tools and techniques to help us implement the interventions.*" The assessment team acknowledges the logistical challenge in Block level training and commends CARE's role in attempting to do the best by utilizing people within the system.

Training methodology and job-aids: The training was usually two days duration for Anganwadi Worker, ANMs and Change Agents. The list of topic to be covered was exhaustive requiring varied degrees of skills for e.g. danger sign recognition. It was generally felt that the topics were too exhaustive to be accommodated within two days for adult learners. The size of each training class was also reported to be large. The first round of training for Anganwadi Workers, ANMs and Change Agents could not be guided by any training manual, and apparently did not follow a standardized methodology. The development of the modules had not been completed by than. The class-room training were driven by the Best Practices and capacitating the community-based workers to implement them.

> The class-room training and the technical content were driven by the Best Practices and the aim was to capacitate the community-based workers to implement them.

The accompanying job-aids and supportive IEC materials were delayed by several months. However, the second round of training was conducted based on formal training guidelines accompanied by the required job-aids. The refresher training happened after almost a year or longer and the contents had undergone refinement and training manuals were available. Some of the trainers recalled, "*The training was participatory and the initial time was spent on sharing the experiences in the field since their first training and addressing the problems faced in implementation and discussions around it.*"

Based on the interaction of the study team with the District team and other CARE functionaries, it was felt that development of IEC materials and the Behavior Change Communication Strategy, as well as supply chain management of the IEC materials and job aids and supportive training of the service providers were not adequately synchronized.

> Initial training for Anganwadi Workers, Auxiliary Nurse Midwives and Change Agents could not be guided by any training manual and apparently did not follow a standardized methodology…. In most cases, the job-aids and IEC materials that were meant to accompany the trainings of the Anganwadi Workers and Change Agents were delayed by several months.

In talking to the Change Agents and Anganwadi Workers it was observed that they had difficulty in recalling the content of the trainings and had limited understanding of the use of job-aids and IEC materials. As one of the RACHNA program officials echoed, "*Quality suffered as a result of accelerated training.*" The training magnitude was huge

and coordinating training across the entire district and ensuring compliance to minimum standards is hard to accomplish by one District Officer.

"The initial trainings did not focus on how to implement the interventions which we all wanted to learn; we wanted to be trained on certain tools and techniques to help us implement the interventions."

NGO worker

Monitoring: Large scale training characterized the Pre Mid-term Phase of the program. The study team could not identify mechanisms in place, however, to track the potential benefits of the training. In the later part of the program, a very comprehensive checklist to monitor the quality of the trainings was introduced, but the study team cannot comment on its application given the limited available data.

The study team could not identify mechanisms in place, however, to track the potential benefits of the training. The "number of training" was the most visible indicator. In the later part of the program, a very comprehensive checklist to monitor the quality of the trainings was introduced, but the study team cannot comment on its application given the limited available data.

After the Midterm Review, classroom training was replaced by informal Sector-level meetings as a strategy for System Strengthening. It was felt that this changed strategy of applying a Sector-level focus, as opposed to the Demonstration Site – Replication Site mode that had only covered less than 50% of the program area, would allow easier and quicker scale-up across all program areas. The Sector became the unit of attention for strengthening. While interacting with a Capacity Building Officer of a District Team, he stated that, *"In the demonstration phase we used classroom training for capacity building of the Anganwadi workers but when the strategy changed, for 100% coverage we realized that it would take a long time to cover all the Anganwadi through classroom training. Hence we shifted …."*

The post-MTR Scale-up saw a refinement of the technical package. The technical intervention was narrowed down to fewer key interventions, de-emphases of Best Practices except NHD, focus on contact and increased home visitations by the Anganwadi Workers. The increased focus was palpable amongst the Anganwadi Workers.

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CARE Official

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The sector approach to capacity building has already been discussed. The sector approach has increased the opportunities for interactive learning. The assessment team observed that capacity building and strengthening are more abstract, making it difficult to intuitively appreciate the contributions to the system. Mutually agreed outcome indicators of different strategies and dimensions of capacity building need to be developed and jointly monitored. It can be used both as a tool for strategic communication of contributions of the program as well as for joint monitoring, critical appraisal and subsequent improvement. This participatory process in itself can be an important tool for empowerment of systems and help overcome communication and ownership issues.

6 NGO Partnership

I Introduction

The NGO occupies a vital position in the implementation framework of the program. Its roles and responsibilities have evolved over the life of the program. INHP-I set the precedence for engagement of the NGOs and INHP-II concretized their role and responsibilities. The role of the NGO as originally envisioned in the RACHNA program design was centered on the development of Demonstration Sites for the system to replicate. Mid-term Course Correction subsequent to receiving recommendations of the Mid Term Review saw a significant shift in the role of the NGO towards scale-up through System Strengthening.

II Roles and Responsibilities

The program has a wide geographical coverage across several States with varying capacity of local NGOs, particularly in the field of maternal and child health. The program in the early phases worked with several NGOs, sometimes each District having as many as 3 to 4 NGOs. The capacity of NGOs to deliver helped influence the transition towards more focused engagement with the best performing NGOs to help implement the program district-wide. As a consequence, coordination, monitoring and efficiency of NGOs have improved over time.

CARE: Most of the NGOs are small and their association with the program has enabled them to expand their operations geographically and into newer areas like health, RTI/STI, etc. Hands-on implementation; grant-for-training; interaction and guidance by the District Team and increasing representation in the convergence forums at the Sector, Block and District level; cross field visits and learning opportunities have all served to strengthen their organizational, managerial and technical capabilities. Association with the program has also lent credibility and stature to the NGO vis-à-vis the community and the System. Likewise there was also acknowledgement by the District Team of the inherent strength that grass root level NGOs have brought to the program in terms of community processes. The NGOs are responsible for organizing and implementing various group-based Behavior Change Communications, which encompasses activities such as theater, magic shows and other folk media.

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The formal partnership between the NGOs and CARE is operationalized through an eleven-month contract that could vary based on the local context, and can be renewed based on established criteria. The study investigators understand the administrative compulsions underlying such a policy but the NGOs felt that if this contract was for the duration of the program, it would allow them to view themselves as partners and thus bring higher levels of commitment and value to the program. A secretary of an NGO remarked, "*The eleven month contract is a problem.*" The respondents felt that improved job security through long term contracts would allow them to commit for longer periods of time to the program. The partnership with NGOs has refined over time but scope remains for further improvisation towards true participatory relationship.

Demonstration Phase: During the Demonstration Phase, the NGOs under the guidance of the District Team in general and the Demonstration Partnership Officer in particular led the development of Demonstration Sites, implementation of Best Practices and innovations of more effective tools. The NGOs worked primarily with the Anganwadi Worker, the Change Agents, Community-based Organizations, Panchayati Raj Institutions and the community at large, with the objective of improving the quality and coverage of service provision. The essence was social mobilization, sustained behavior change, community-based monitoring and appropriate demand generation. The geographical scope of the NGOs was confined to the 10% Demonstration Sites. The NGO workers typically made a weekly to fortnightly visit to the Anganwadi Center and also had the opportunity to make home visitations and conduct community meetings along with the Anganwadi Workers, wherever possible. The enthusiasm of the NGO workers and the District Team was highlighted by a Demonstration Partnership Officer in the following words, "*After the program allowed and encouraged innovations, they were flooded with ideas from all over the Districts.*"

A secretary of an NGO remarked, "*The eleven month contract is a problem.*" The respondents felt that improved job security through long term contracts would allow them to commit for longer periods of time to the program.

Scale-up (Sector Strengthening): After the Mid-term Review, the program saw major changes in the role and responsibility of the NGOs. Based on the information gathered by the study team, the Post Mid-term Strategy began to be implemented from mid and later part of 2005. The responsibilities of the NGO workers shifted from the community to Systems. Their new responsibility focused on the ICDS sector as an avenue for System Strengthening. This strategy allowed the NGO worker to engage Anganwadi Workers during Sector level meetings, and thus influence a much larger number of Anganwadi Workers and potentially a larger population of beneficiaries. The primary point of engagement was the Sector Supervisor with whom he makes joint supervisory visits. They also make their own visits to the Anganwadi Centers and help in better record keeping, and provide guidance and joint home visits with the Anganwadi worker to improve her capacity for effective counseling. Joint home visits with the NGO staff, though limited in number, are viewed by the Anganwadi Worker as helpful, as they feel that the beneficiaries listen more to an outsider, who is introduced by her, and is better qualified and often more articulate. However, one of the Anganwadi Workers thought that the NGO staff attend the Sector level meetings to collect information and not to build their capacity; in her own words, "*The NGO worker does not come to the sector meeting to give us some information rather he collects information from us.*"

Based on the information provided to the study team, the Post Mid-term Strategy began to be implemented effectively from July 2005. The responsibilities of the NGO workers shifted from the community to Systems. Their new responsibility focused on the ICDS sector as an avenue for System Strengthening.

Joint home visits with the NGO staff, though limited in number, are viewed by the Anganwadi Worker as helpful, as they feel that the beneficiaries listen more to an outsider, who is introduced by her, and is better qualified and often more articulate.

NGO workers also bring experience in community engagement for use by the larger community of Anganwadi Workers. The current geographical responsibility allows them to follow-up an Anganwadi Center every 2 to 3 months. The program has taken steps to increase their acceptability through orientation, changes in their job titles and closer interaction with the District Team, particularly with the member responsible for the Block.

NGO workers were found to share a good working relationship with their Sector Supervisor, who sees the benefit in terms of logistics, improved monitoring and program

focus. The NGO worker utilizes the Sector meeting to discuss the problems faced in the field by the Anganwadi Workers, share feed back from the field visits and introduce a health topic for discussion. In Orissa, there has been an increasing emphasis on monitoring of Grade I and Grade II malnutrition in children and that is evolving into a District-level health audit. Cases of neonatal death are also being put to discussion. In the last several months, a tool has been introduced for conducting the Sector meetings and joint visits by the Sector Supervisor.

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The use of these tools was found to be limited but poised to improve. An NGO area coordinator corroborated, "*A Sector Supervisor fills only 10-20% of the new tools given to her in the month of November-December 2005.*" The sector meeting is supposed to be attended by the ANM, but an NGO Area Coordinator in a State where the convergence between the ICDS and Health is relatively high, the NGO worker shared his concerns saying, "*The ANM comes to the joint meeting with Health and ICDS (it's a government initiative for bringing both the departments to meet every month), but she does not come to any of the Sector meetings in the Block, if she ever does it is only to reconcile the figures*". He further added that, "*I use the joint meetings to meet the Lady Health Visitor and the Medical Officer, which I did not do during the Demonstration Phase.*" The interaction of the NGO workers with the ANM and the Medical Officers was found to be limited. There were instances in which the NGO worker had good acquaintance with the Medical Officer, but in most of the cases his perceived role was unclear.

There is a need for engagement of Sector Supervisors on health issues, which requires some basic technical competence besides other skills. A secretary of an NGO articulated the need of NGO workers in this context using the following words, "*The technical abilities of the NGO worker need to be improved.*" The NGO Coordinator usually represents the program at the Block Level Advisory Committee (BLAC) meeting. Representation of the NGOs at the District Level Advisory Committee (DLAC) meetings has also been facilitated by CARE.

III Training and Capacity Building

The NGO workers in the Demonstration phase were initially trained by the District Team. The training introduced them to the objectives of INHP-II and the operational strategy that would unfold in the coming years. Since the program was in its early stages and multiple activities were being initiated simultaneously, the District Team neither had the opportunity to be specifically trained on how to train the NGO workers, nor did they have an NGO training module to guide them through the process of training.

According to an NGO worker, "*The training did not focus on 'how' to go about effectively implementing the intervention package.*" The NGOs receive funds for conducting in-house training sessions, however, post MTR, expectations for the NGO worker has undergone major changes, and there has been limited time to implement training strategies to upgrade their skills. In the post MTR phase, which emphasizes scale-up, the NGO worker's role has become very prominent. In most cases, they have been able to bring their experiences from the field, however, their current responsibilities demand additional skills that need to be systematically addressed, for example, data analysis and information use. As the roles and expectations of the NGO worker continue to evolve, it is important to ensure adequate technical support to help them continue to respond to the needs of the System and the Community.

In the post MTR phase, which emphasizes scale-up, the NGO worker's role has become very prominent. In most cases, they have been able to bring their experiences from the field, however, their current responsibilities demand additional skills that need to be systematically addressed, for example, data analysis and information use.

Low wages combined with inadequate financial support for making field visits affects the quality of NGO manpower. As one District Team member ventilated, "*It is very difficult to find qualified workers, especially when the salaries are so low; we have to largely compromise on quality and educational qualifications*"..

IV Monitoring and Information Use

In the post MTR/scale-up phase, there has been an increasing emphasis on the use of information to help guide the Anganwadi Worker. The NGO collects qualitative and quantitative information directly and through the ICDS systems. Use of this information forms the basis for the monthly meetings that their project coordinator has with their District Team. The re-organization of geographical areas between the District Team members has improved the probability of the NGO worker's interaction with the District Team members. There has been an increasing emphasis on vital statistics, including percentage of different grades of malnutrition in children, number of births, number of neonatal deaths, infant deaths and stillbirths. Data is also collected on key practices related to newborn care and service provision by Anganwadi Workers.

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Monitoring by the NGO workers has improved the focus and functioning of the Anganwadi Worker. The Sector Supervisors are also able to use the opportunity of independent monitoring to bring improved functioning of the Anganwadi Centers in her Sector. An Anganwadi Worker remarked, "*Previously what I used to postpone for the next day, now I try to complete the work on the same day.*"

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The role of the NGO worker as perceived by the Anganwadi Worker in the Demonstration Phase was that of a guide who helped her develop the Anganwadi Center by working with her and the community. In the scale-up mode, the perceived role has shifted to capacity building and supervision.

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FIGURE – 6 - A: Comparison of key activities of NGO workers Pre- and Post-MTR

Comment [GD1]: I don't find in the text where this figure is referred to?

Pre – MTR Phase	Post – MTR Phase
Focus on Demonstration Site	**Focus on Sector**
Community mobilization a critical component	**Limited interaction with community, confined to limited home visits**
Maximum of 10 Anganwadi Centers (AWC) visited by the NGO worker in a month **Approximately 5 visits in one AWC in one month**	**One Anganwadi Center visited once in 3 months.** **NGO staff visits 2 AWC/day for 10 days, (20 AWC in 10 days);10 household visits per AWC (20 home visits/day, 400 home visits in the block in a month, roughly 4 home visits per AWC)**
Covers approximately 50 to 100 households in one AWC in 3 months	**Covers only 4 to 5 households in one AWC in 3 months**
Classroom-based training as part of the Block Training Team	**Sector-level meetings by CO-NGO staff**
Perceived to be more focused around demonstration	**Perceived to be more focused around monitoring**
Best practices the crux of the program, implemented in the DS	**Best practices dropped, except for the NHD**
More regular meetings with the demonstration site AWW, thereby providing her additional help and information	**Sector Supervisor getting additional help and information due to regular meetings with the NGO staff**
Could see and observe change, which gave him an additional incentive to work. Could use community mobilization to make AWW more responsible	**NGO worker has to focus mainly on monitoring and therefore fails to see any change; has to cover much more area than previously.**

7 Community Engagement

I Introduction

In the last several decades there has been an increasing realization of community engagement and community centered approaches. According to Green and Kreuter, 1991, community has become the "center of gravity". This is part attributed to the growing recognition that lasting and wide-spread behavioral change is best brought about by changes in norms of acceptable behavior at the level of the community as a whole. The principles of participation, central to community based approaches to health, posits that change is more likely to occur when people it affects are involved in the change process (Riftkin et al, 1988).

INHP I: INHP I had recognized that building capacity of communities and individuals was as important as reaching short-term nutrition and health targets. Building capacity of communities and individuals was to assure that women and children would benefit from the ICDS and Health services in INHP and have the ability to continue to improve their nutritional and health status beyond the tenure of the project. The Final Evaluation Report of INHP I report very specifically commended CARE's role in community engagement and developing innovative community processes. The INHP I Final Evaluation team observed that INHP I link with self-help groups, village development committees and Change Agents had empowered village women who also became effective agents for behavioral change among their peers. The team also noted that "INHP's efforts to simultaneously strengthen government service delivery while building community capacity are critical for health and nutrition outcomes, sustainability and empowerment". Emphases on community approaches to behavior change as distinct from messages directed to individuals were among the key recommendations.

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>
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>
> INHP I Final Evaluation Report

INHP II/RACHNA: The program design of INHP II/RACHNA as originally envisaged was community centered in its approach. The program identified some key community based processes as essential to the success of RACHNA. They included increasing awareness, greater engagement of local governance, increasing community capacity to analyze and address health issues, improving community monitoring, problem solving and enabling environment within the community for faster behavior change. It was

hypothesized that this would lead to sustained behavior change, regular demand and delivery of services, increased utilization, community volunteers helping to improve the quality and coverage of the services eventually leading to a sustained reduction in child mortality, malnutrition and improved maternal care. It is schematically presented in Figure 2-A.

Objective of INHP II: Achieve sustainable improvement in health status of seven million women and children

Sub-objective: Service providers (AWWs and ANMs) improve the quality and coverage of maternal and child health services and key systems including training, supply chain management and information management

Sub-objective: Communities sustain activities for improved maternal and child survival

It is apparent that simultaneous engagement of system and communities are foundational to achieving program objectives. The impact hypothesis also highlights the importance of complementary and synergistic interaction between the system and the community processes to achieve the stated program objectives. In brief Community engagement and system engagement are the two pillars on which the programs impact hypothesis lies.

The Best Practices along with key processes like Behavior Change Communication, active engagement of community-based organizations and local governance had been identified to stimulate community processes supported by System strengthening and Capacity Building of Service Providers. They seem to have been chosen deliberately to complement the role of each other and steer the community towards improved capacity. Demonstration of these processes in 10% of the program Anganwadi Centers and Replication to the rest had been the chosen approach. However, subsequent to the process of internal reflection of program processes and recommendation of the Mid-Term Review Team, the program approach went subsequent modification and adoption of Sector Strengthening Approach towards reaching scale across the program universe. The following sub-sections will attempt to organize the findings of the qualitative assessment team around the impact hypotheses as well as key processes and approaches.

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II Program Management Structure and Capacity

Role of the community is primary to meeting the program objectives. It is therefore key that the Program Management Structure and its values be aligned to this goal to enable translation of strategies through an efficient operational framework and, guided by a clear vision. Full-time in-house expertise to specifically address and help negotiate the program through the complex maze of community processes could have benefited the program further. The program did not seem to have full time technical experts for community processes at the CARE Headquarter, nor at the State and neither at the District level. The program did have a position of a Technical Director that went un-filled through the life of the program. The assessment team is of the opinion that developing community capacity for sustained behavior change across a diverse and expansive geographical area primarily through the system on which they have limited control, calls for very high level of expertise and leadership, capacity at all levels and continuous monitoring and adaptation. This calls for a process of continuous and evolving engagement of the program with the community.

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The role of Capacity Building Officer was primarily centered on coordinating training of service providers and Change Agents. The role of District Partnership Officer was centered on engaging the NGOs for development of the Demonstration sites for establishment of Best Practices. The Government Partnership Officer was primarily engaging the Government to Replicate. However, there was no Community Partnership Officer. There was a Government Partnership Officer. There was an NGO Partnership Officer. But, there was no Community Partnership officer.

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Based on the interviews of the District Team it wasn't apparent what were the stages of change that the community was being taken through and how were these being monitored? What was the level and kind of training that the District Team received that helped them enhance their understanding of the process and nuances of leading community towards problem identification and more importantly problem solving. What were the supportive structures that were being put in place for such activities to evolve and capacities to manifest? With whom in the team did the primary responsibility lie and if it was distributed among the team how was it being coordinated and synchronized towards a defined direction?

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The training module of the Anganwadi Workers was more focused around the Technical interventions and the stages of life-cycle that needed to be targeted for intervention. These trainings have been short in duration of generally two rounds of two days each covering a wide range of intervention topics and emphases on approaches to community capacity building needs to be enhanced and continually supported. On job demonstration and support was a felt need by the community-based workers to enable them to acquire the skills and the confidence to effectively lead change in the community. The training of Sector Supervisors did not seem to have adequately addressed this need. The Sector Supervisors capacity to provide supportive guidance and leadership to the Anganwadi Workers effort to build community sustenance needs to be worked on. The Sector Strengthening approach affords a useful avenue for such an action but de-emphases of the Best Practices in the last 18 months potentially limit the Anganwadi Workers opportunity to engage through participatory tools.

The Sector Supervisors capacity to provide supportive guidance and leadership to the Anganwadi Workers effort to build community sustenance needs to be worked on.

Excellent tools for community engagement existed but the required skills and know-how to help frontline workers negotiate through a participatory process and build other domains of community capacity like leadership, organizational structures and dynamics of organizational change, resource mobilization and the authority to engage in reciprocal dialogue with the community needs to improve. As a consequence well developed concepts and tools like some of the Best Practices did not seem to have been widely accepted, negotiated, adapted and integrated within the community structures and value system. The District Team members have over the years developed a repository of key learning and better appreciation of the challenges that confront them.

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It is however, important to note that CARE's decision to engage local NGOs as a source for community capacity building is a strategic decision. Local NGOs bring local knowledge and know-how and CARE's ability to pool their learning has been very useful and needs to be more efficiently fed to inform local programming. Local NGOs may bring a good understanding of local context but analyzing local context to localize strategies for community capacity needs to be scientifically guided. The challenges for community engagement, however becomes bigger where the system is expected to replicate.

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Engaging community and building their capacity for sustained action across a large program universe with large variation in social, political and economic structures, cultural practices, degree of empowerment and equity, state of local self-governance and local priorities, is a big challenge. The ability of the program structure to allow higher degrees of freedom within certain acceptable parameters becomes necessary. The current state of decentralization was variable within the states and also found to be a function of the leadership and capacity within the District Teams. The operational team at the district

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III Community Participation

Participation is basic to community capacity. Only by participating in small groups or larger organizations can individual and community members better define, analyze and act on issues of general concern to the broader community (Labonte and Laverack, 2001). Participation helps create opportunities, remove barriers and build an enabling environment for behavior change.

Access is defined by stratifications (caste, class, gender, it would perhaps be right to say that these determinants imply differential access by different groups within the community. The Best Practice of Change Agents, Nutrition and Health Day (NHD) and Social Maps attempted to address this issue with varying degrees of success. They are discussed in detail under separate sections. The NGOs played a key role in mobilizing community participation in the Demonstration sites and by the Anganwadi Worker in the Replication Sites but the program did not leave enough flexibility to involve community members in the problem definition phase. The process of bringing the mandate of the program to synchronize with the priorities of the communities needs to be better addressed. Ensuring Community Participation for accepting an idea already formed may limit the benefit that might accrue from the community.

CARE has attempted to utilize opportunities for learning within the community and increase the incidence of such exposure. During the demonstration phase of the program the NGO worker was able to better mobilize women and beneficiaries, to congregate and discuss topics pertaining to maternal and child health. Participation of the members of the Panchayat was also solicited and ensured with varying degrees of success. Women who were interviewed in the village convened by the Anganwadi Worker identified barriers like household chores, work in the farm, distance from the hamlet, caste, practice of not going out when pregnant, confinement during the early weeks of delivery etc as barriers to attending the meetings.

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Beneficiaries belonging to the hamlets of the Anganwadi Center were not found to be proportionately represented. In the words of one of the potential beneficiaries "*Neither do they (Anganwadi Worker) come here neither do we go. They only call their own people."* It was not uncommon to come across accounts of male members, young girls or other family members going to collect the Take Home Rations from the Anganwadi Center. This was more common during the last months of pregnancy and early months after having delivered the baby. The Take Home Rations in most of the cases was shared and consumed by the whole family. A husband of a recently delivered woman said "The Anganwadi Helper comes to the village to announce when the food and oil has arrived. The oil is sweet and we make some preparations and we all have it"..

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CARE has also initiated a number of innovative means of mobilizing and sensitizing the community towards complementary feeding. Each of these innovations has been inspired by the local social and cultural values. The idea of distributing bowls for helping mothers understand the quantity to be fed was well received. Sustained local action is important and wherever follow-up by NGO has not been intensive, the momentum seems to have been gradually lost.

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Anganwadi Workers identified Take Home Rations (THR) during NHD as an important incentive and irregularity in food supply also affected the meeting that she tried to convene during the distribution. However, both the frequency, density of beneficiaries and quality of interaction needs to be monitored and improved. An Anganwadi Worker despaired "*what can we do, these people do not come and sit, if they do come they are always in a hurry, they don't even sit for ten minutes. We have to bribe them saying we will give them food.*"

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Most of the women interviewed who had ever attended a meeting could not attribute sufficient value to the content. In some cases the Anganwadi worker confessed to transmitting a message to the community that she herself did not believe. As an Anganwadi Worker recounted "*I tell mothers not to bathe the baby but I bathed my own baby and you see how healthy he is. If the baby is not bathed and something happens than everyone will blame me.*"

The use of job-aids in these forums was highly limited. The long time lag of several months between training and actual delivery of the job-aids could be one of the potential reasons. Since these jobs were not developed during the first phase of the training and thus not trained on them, it could have posed challenges for the Anganwadi Worker to comprehend. Besides, she had also been in possession of other similar job-aids provided by the government and other international organizations. She couldn't in most cases clearly distinguish between the distinctive values that the different job-aids apparently brought. It was not uncommon to find job-aids that had been very carefully concealed and never used.

The level of engagement of the learner with the learning process needs to increase and so does the self-efficacy of the Anganwadi Worker. Her current capacity needs to be improved with sufficient hands on training and the process needs to be more intensive and robust than then the inputs in the Demonstration phase. An Anganwadi Worker recalling the help of the NGO worker "*We used to go the home visits together. He is from outside so when he tells something people listen. He also knows how to convince. When people ask question he is able to answer. I learnt a lot from him. He also helped me in maintaining my registers."* An NGO worker sharing his experience said "*There are almost 50% of the Anganwadi workers who cannot fill the forms themselves. Most of the time it is filled by their husbands or some one else."*

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The study team interviewed a range of stake-holders in the community. An elderly member recalled "*I was called for the meeting initially when there was a talk on health issues. But nothing happened after that. We will help them whenever they ask for help"*. As one NGO worker described his meeting "*I ensure that the Pandit also participates in the meeting. He is important for improving the delay in breastfeeding."* Process of ensuring participation needs to be better understood and to improve inclusive participation. A stake-holder analysis that is informed by the local context is important and appreciated.

Community participation is a process that is time consuming and the team understands that it was not possible for a large program to ensure at such a large scale. This becomes more critical when building capacity of systems to replicate community participation. CARE has adapted its program strategy to move to a scale-up mode using Sectoral Strengthening instead of the Demonstration Replication Approach. This invariably increases the range of opportunities for System Engagement but the study team observed that community engagement had been dramatically reduced. Many of them thought that the program had closed down. The Best Practices are no more to be replicated in the scale-up mode except the NHD. The Best Practices like Chang Agents and Social Mapping are based in the community. Other avenues will need to be explored to address the void in the new approach. Ensuring increasing participation of Panchayati Raj Institutions that CARE is already doing and its impact on community participation as a whole would be interesting to look and document.

The use of home-visitation tools, joint supervisory field visits, supportive supervision by the NGO worker and sharing and sharing of problems encountered in the field should all work to increase the quality and coverage of contact.

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The study would like to specifically mention about the local Panchayati Raj Institution taking the leadership in replicating the program in Orissa. This is still at a pilot phase and the team is made to understand that multiple such initiatives are taking shape.

IV Community Leadership and Organizational Structures

Participation and Leadership are closely connected. Leadership requires a strong participant base just as participation requires the direction and structure of strong leadership. Both play an important role in development of groups for collective action. It is also important to have group organizational elements to enable people to come together and address their concerns and problems. Areas with few or ineffective internal organizations will generally be less able to mobilize internal or external resources, provide opportunities for social support or network influence decisions affecting health determining conditions (Labonte 2001)

It wasn't clear from review of program documents; field notes and interviews, how this issue was addressed in Demonstration Sites and Replication Sites as well as in the sector-strengthening approach. Review of Best Practices and observing from operational realities, there didn't appear to have been a concerted effort or plan to develop or identify a champion. The Change Agent didn't seem to have been conceptualized to serve the purpose as the selection criterion and scope of work did not seem to imply if community leadership was to be her domain. The study however heard stories from the District Teams of Change Agents assuming social and political leadership within the community. The Anganwadi Worker is another potential candidate. The engagement of the community was different in the Demonstration and Replication Sites primarily because of the intensity of inputs, the duration of inputs and involvement of an external facilitator in the form of the NGO. In the Demonstration Sites, the NGO worker though primarily

worked with the Anganwadi Worker but strategically engaged the community to drive accountability. An NGO worker explained "*Sometimes the Anganwadi Worker does not listen and I use the community to apply the pressure.*" In the Replication sites the Anganwadi Worker was supposed to drive both the supply side and the demand side of the services. The Best Practices tools were supposed to help her do so but in the Scale-up mode even the Best Practices tools except the NHD was de-emphasized. It isn't clear how this void was addressed and what structural adjustments were made.

It was not clear from review of program documents; field notes and interviews, how the issue of community leadership addressed in Demonstration, Replication as well as in the sector-strengthening approach.

The engagement of Panchayati Raj Institutions and community leaders seems to be on the rise. The Panchayati Raj Institutions being community based are also political institutions and may exclude community groups and thus effort needs to continue to bring more people within its fold. The need to have a champion identified and developed is imperative to sustained community processes for the program.

The program's recognition of the significance of Community-based Organizations and making it central to the community engagement strategy will continue help institutionalize processes for better health within the community. Self-Help Groups, Women groups and Village Health Committees are some of the examples of groups that the program has attempted to effectively engage. Different community-based organizations will bring different strengths and at times competing agenda and leadership. Identification of an organizational structure or network with clear leadership will be essential to power community capacity to engage in problem identification, problem solving and innovation.

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V Community Awareness and Behavior Change Communication

Increasing community awareness has been one of the priorities of the program and its significance need not be elaborated. Appropriate Behavior Change Communication Strategies was to be one the defining aspects of INHP II and a mix of strategies has been rolled out namely Radio Spots, TV Spots, Magic Shows, Community Meetings, Baby

Shows, and Street Shows etc. CARE has also innovatively utilized these opportunities for bring convergence between the system and the community.

Awareness generation in the community on issues of newborn care, antenatal care of the mother and gender equity issues have been the focus of the Behavior Change Campaigns that have been universally rolled out in all the states with high intensity. This has generally been conducted by the NGOs under the supervision of the District Partnership Officer. This has been a district-wide campaign and not limited to specific areas of the Demonstration Sites. The activities are conducted by local artistes from the region and have adapted it to suit local conditions. An NGO Worker offers some insight "*The artistes are usually from the region and know the local conditions well. Sometimes it is more effective to conduct the shows in the evening and so we do it than and more people get to watch it."* The strategy to enable *Anganwadi Workers* to mobilize the pregnant mothers, local community leaders for logistical support and ensure presence of local doctors etc is very helpful. These shows are usually organized in villages that are considered relatively more resistant and less aware of improved health behaviors. This potentially boosts the Anganwadi Workers confidence in promoting behavior change to a community that is being sensitized beforehand.

Some of these activities were utilized to bring convergence between health and ICDS, for e.g., healthy baby shows. The involvement of PRI is around facilitating logistic and ensuring community participation. The study team witnessed one such show. The show had representation from the department of health, ICDS, Panchayat and Block administration. Several activities had been organized centered around the healthy baby attended by women their husband and mother-in-law. This was utilized to convey key health messages by authority figures, recognize mothers who had practiced good behaviors and afford opportunity for discussion. The show was entertaining and that helped to hold the audience together.

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The attendance is usually high and as a District Partnership Officer analyzed "*In villages these kinds of events usually does not happen and when we organize them there is lot of excitement and lot of people come. The artists usually convey messages through entertainment for e.g. magic shows, drama etc. The impact is difficult to asses because the children take center stage and the women are pushed to one end."* The team was witness to two such shows in different states and the quality and level of local contextualization was very high but we didn't come across a monitoring system to assess the potential impact or feedback system to improve upon it. There was a general

sensitization of the mothers to "*not bathing the baby, immediate breastfeeding, consumption of IFA, Tetanus Immunization and Five Cleans.*"

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An NGO Supervisor observed "*These activities become more an entertainment than increase in awareness. Change in practice comes with one to one interaction.*" This was corroborated by a member of the Panchayat who said "*Home visits maintain confidentiality and we also feel that we are being given extra importance.*" CARE has attempted to spread awareness to a large geographical area and prioritizing them to more difficult areas of the program but the sheer size of the program areas limits the reach and frequency of such an intervention. But majority of CARE District Team were very optimistic of the impact that these activities can bring in terms of behavior change. The study team came across individuals who had been in the know of such activities but could seldom recall the content. A monitoring system to help analyze the feedback could be helpful for better understanding of the effectiveness if such an activity. These activities need to be supported by other supportive intervention to maximize the gains that could be made. In areas where multiple languages are spoken within the same village, incompatible language and dialects restricts potential impact. The team based on the interviews came away with the impression that most of the shows were organized in the main villages and hamlets were getting excluded. This needs to be corroborated.

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NGO supervisor

"*Home visits maintain confidentiality and we also feel that we are being given extra importance.*"

Panchayati Raj member

In the Demonstration Phase the NGO worker had the opportunity to visit an Anganwadi Center several times in a month. During this period he would help the Anganwadi Worker organize meetings with the Change Agents and other women group. Involvement of local government was also sought and this opportunity utilized to discuss specific topics on health. The Anganwadi Worker is expected to utilize the Nutrition and Health Day to raise the awareness and counsel the community groups. The challenges faced in counseling during this occasion are discussed under the Nutrition and Health day section. Based on very limited observation and interviews, it seems that the community's

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Interviews with Anganwadi Workers and a review of the Training Module and accompanying job-aids did not seem to have given much insight into some aspect and mechanism of Behavior Change. The approach is reminiscent of a linear channel of communication between the provider of the information (Anganwadi Worker) and the recipient (Beneficiary). An NGO Supervisor sharing his understanding on BCC says "*When we go to the Anganwadi Center we tell the Anganwadi Worker that we have to change the people. I feel that people are following them to an extent.*" Interviews with mothers and their family members were suggestive of an instructional and prescriptive interaction that was highly limited in duration. As one beneficiary recalled "*The interaction is limited to few minutes and she reminds me of few things that I should do.*" The communication needs to move to a negotiation plank and power-relations need to equilibrate to allow communication to be established. Changing Practices will depend on utilizing that opportunity to do further barrier analyses and supporting them through the process of change. Current level and quality of interaction with the beneficiaries during community meetings need to be reviewed.

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NGO Supervisor

Interviews with mothers and their family members were suggestive of an instructional and prescriptive interaction that was highly limited in duration. As one beneficiary recalled "*The interaction is limited to few minutes and she reminds me of few things that I should do.*"

The common notion in the community is that the Anganwadi Workers are primarily responsible for pre-school education of children and distribution of food. The role of Anganwadi Worker in immunization is widely accepted. Awareness in the community

particularly in the hamlets of the Anganwadi village, about the roles and responsibilities of the service provider needs to improve.

There are instances where the community is sensitized on issues like ANC, etc, but they get subordinated to issues that have a higher perceived importance and thus interfere with appropriate demand generation. One pregnant woman remarked, "*I have so much work to do, that I am not able to go in-spite of the Anganwadi Workers repeated request.*" On a similar note the Anganwadi helper also remarked that it is difficult to sensitize the community about the importance of these issues, "*Only if one puts pressure, will it go into their head properly.*"

The community's general perception about the Anganwadi Workers continues to be affected by her association with food and oil distribution. This traditional suspicion needs to be factored while developing a communication strategy to convey messages that have traditionally come from authority figures.

> The community's general perception about the Anganwadi Workers continues to be affected by her association with food and the more lucrative oil distribution.

The NGO area coordinator who had been associated with the program for several years and worked in the Demonstration Phase observed, "*Even if the Anganwadi Worker does not misuse her position for personal gains the community at large views her with suspicion.*" He further adds that "*The Anganwadi Worker is fully aware of this attitude and this tends to lower her self confidence*". He continues that "*during the Demonstration Phase they involved the Change Agents during food distribution, involved Panchayat members improve her counseling skills and quality of service provision.*" This in his view helped improve the acceptability and stature of the Anganwadi Worker in the community. The scale-up strategy does not allow him to provide the same level of inputs but his experiences gained during the Demonstration Phase helps him in engaging all the Anganwadi Workers through sector meetings. Involvement of Panchayati Raj Institutions in the different convergence forums should in due time lead to improved participation at the village level.

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>
> NGO Coordinator

CARE's attempt to improve linkages with ANM is helpful. Most of the key practices that are being targeted for change are closely linked with other aspects of their social and cultural construct. Mobilizing community support and leadership to help develop an enabling environment for mothers to change from behaviors that they see nothing wrong with into a new one that they have never tried is critical and the current level of engagement might not be sufficient.

VI Service Provision and Home visitation

CARE has helped sharpen program focus by utilizing data to target the most critical period. The strategy in the last 18 months to improve home visits during the newborn period is indicative of such an initiative. In the revised approach, the program has emphasized on home visits that roughly translates to making a couple of home visits every day. The Anganwadi Worker considers home visits logistically challenging since her catchment area is usually spread over a several kilometers. CARE's emphasis on home visitation has started taking roots and home-visitations could potentially improve.

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In the scale up mode the program has emphasized through sector meetings and visit to the Anganwadi Center by the NGO worker on the need for improving home visitation at critical periods during the antenatal, neonatal and post natal period. The number of critical contacts through home visits varies from 8 to 13. On an average an Anganwadi Worker caters to a population spread across 4-5 hamlets and expected to make 2-5 home visits per day. The Anganwadi Worker considers home visitations relatively difficult. The Anganwadi Worker runs the pre-school till mid day and combined with other official/domestic responsibilities, lack of conveyance to reach hamlets limits her ability to make regular and timely home visits. In the words of an Anganwadi worker, "*one has to remain at the center, run the pre school, and also fill a number of registers hence home visits are often neglected.*" The program has introduced the home visitation register that she finds it as a useful guide. These registers have been introduced in the last several months. In majority of the cases the home visitation register was found to be in use. The register allows for recording the highlights of the visitation and forms the basis of discussion during sector level meetings.

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Majority of the potential beneficiaries who were interviewed could not recall home visitations for counseling by the Anganwadi Worker. Contacts have been reported and those contacts have been utilized to convey important messages. A beneficiary recalled "*take the iron pills every evening, and come to the center for immunization."* The study team specifically sought to interview mothers who had recently delivered. Practices around newborn care and community practices and role appeared culturally entrenched and broadly similar across the study area. Confinement of the mother and the baby in the first weeks was similar while tribal areas had better breastfeeding practices. Reluctance to weighing and barriers to contact during the first weeks by Anganwadi Workers posed similar challenges across the different states.

Confinement of the mother and the baby in the first weeks was similar while tribal areas had better breastfeeding practices. Reluctance to weighing and barriers to contact during the first weeks by Anganwadi Workers posed similar challenges across the different states.

Generally food distribution along with immunization was found to be more or less regular. There is a higher value attached to the ration and potentially affects the up-take of other services like immunization, weight monitoring, etc. The ration attracts women and children to the Anganwadi Center and facilitates the provision of key services. On the other hand an inquiry from a non-Utilizer woman revealed "*When it comes to distributing food, the Anganwadi Worker calls her relatives and when it comes to immunization, she calls others.*" The study team came across families who did not consider collecting free ration respectable and did not avail services from the Anganwadi Center while there were also cases for non-utilization by a section of the community because collecting rations entailed immunization which went against their religious belief. In tribal areas in one of the states, exclusion of tribal groups was observed in the group discussion with community members and observation by the assessment team leader who was also a senior physician noted very high numbers of malnourished children who had not been weighed for a year, their family not counseled on nutritional behaviors and food supplementation not regularly distributed. The program has taken various steps to reduce exclusion and some of the Best Practices were designed to address that. Newer tools needs to be better utilized to include left-out groups.

There has been an improvement in the convergence between the ANM and the Anganwadi worker. The immunization coverage has improved. For instance in Chhattisgarh, it was observed that, there is an increasing trend towards self-declaration of pregnancy and taking initiative for immunization.

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The antenatal care provided at the Anganwadi Center mainly consists of weight measurement and abdominal examination. As a pregnant woman said, "*at the Anganwadi center they (ANM) conduct an abdominal examination and take the weight. Blood pressure is not taken, while in the hospital complete check up is done and we also get information.*" In Anganwadi Centers where weighing scales were available growth monitoring was usually done for children. The program has been emphasizing on tracking of Grade I and Grade II malnutrition in children that had so far not been stressed through the ICDS system. The Anganwadi Worker as well as the NGO workers were generally found lacking in issues of danger sign recognition, care of the premature/ low-birth weight babies and sick babies.

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The IFA distribution was found to be universal though the consumption levels were generally found to be low. One of the innovations encouraging complementary feeding once the baby was six months old is '*Annaprashan*'. Anganwadi Worker would arrange for '*kheer*' (rice pudding) that will be given to the six month old baby along with a bowl and a spoon. On the spot feeding was found in practice in majority of the Anganwadi Centers.

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The recall of intervention messages varied widely amongst the beneficiaries. The common messages recalled were, immunization, early/exclusive breast feeding, 5 clean and delayed bathing. The Change Agents could be located in most of the Anganwadi Centers that we visited predominantly belonging to the Anganwadi Center the main village. Some of the change agents have continued to play an active role and some of them have also been utilized by other programs and organizations. In one Anganwadi Center, in Orissa the Change Agent had taken upon the counseling responsibilities on herself and the respondents from the village valued her contribution even more than that of the Anganwadi Worker. The CARE Team in Rayagada District has made successful in-roads into institutionalizing rewards and recognition system for the Change Agents along with the Anganwadi Workers and ANM.

The recall of intervention messages varied widely amongst the beneficiaries. The common messages recalled were, immunization, early/exclusive breast feeding, 5 clean and delayed bathing.

The Reproductive Health Change Agents had been identified by the program to address issues on sexually transmitted diseases and HIV AIDS. They were difficult to track and the few who were identified confess honestly that "*it is not feasible for them to counsel others in the community on such issues.*" They recall attending the trainings and getting paid by the NGO staff. Some of them seem to have grievances on having to spend half of what they received from attending the training to buy contraceptives which they could not sell in the community. The general perception of the community, according to one of the Reproductive Health Change Agent and an Anganwadi Worker is, "*why should anyone buy the contraceptives from us when we also provide the ones that come free, after all it's the same thing in a different packet.*" One of the women in the community said that traditional methods are still found to be more effective, "*if one forgets to eat the contraceptive pills then she will conceive, however taking herbs provided by the elderly women of the village is more effective. People who ate it only once or twice have not conceived till they became old.*"

VII Community Monitoring and Problem Solving

The Community Based Monitoring System was a powerful tool for monitoring at the community level. The success and challenges is discussed under a separate section. In the sector strengthening approach attempts are being made to involve community participation during the sectoral meeting. This is innovative and the study did not have the opportunity to see their participation.

Problem solving abilities are indicative of an advanced stage of community capacity with mechanism to ensure regular community participation, commitment to program objectives, mechanism for conflict containment and accommodation, ability to establish formal means for representative input to decision making. It would be difficult to suggest that community did demonstrate problem solving abilities within the community especially after community engagement has been affected. All the Best Practices at the community level are theoretically aimed at ensuring community participation and collective monitoring and problem solving. The Scale-up sectoral approach is attempting to improve the participation of Panchayati Raj Institutions and there are examples emerging from across the program areas of the promise it holds. The study team did not specifically have the opportunity to observe them.

8 Best Practices: Introduction

The **Best Practices** has been central to the RACHNA program design framework. It evolved in the first phase of INHP (INHP I) and formed one of the key recommendations by the Final Evaluation Team for deliberate replication in the second phase of INHP (INHP II) considering the District as the most strategic level for replication efforts. It was defined as "*A Best Practice is one that has been innovated, demonstrated and validated in multiple contexts to produce results.*" Based on this rigorous eligibility criterion **four** **B**est **P**ractices were identified through a consultative process between CARE and the government counterparts. They are **C**hange **A**gents (**CA**)/**R**eproductive **H**ealth **C**hange **A**gent (**RHCA**), **N**utrition and **H**ealth **D**ays (**NHD**), **C**ommunity**-b**ased **M**onitoring **S**ystem (**CBMS**) and **B**lock **L**evel **R**esource **M**apping (**BLRM**).

These **B**est **P**ractices formed the cornerstone of the operational strategy of the program. They were envisaged as **solutions** to operational challenges in bringing the two key stake-holders: **systems and community,** together to improve infant survival and reduce malnutrition. The Best Practices were seen as specific processes that would help systems improve the quality and coverage of services on one hand and mobilize community to influence service delivery and sustain behavior change on the other hand.

Demonstration of **B**est **P**ractices in 10% of the program Anganwadi Centers and Replication of these best practices in the rest of the program areas was to be the **mainstay** of RACHNA. **Replication** represents the big shift in INHP II from INHP I, where an emphasis was on experimentation and innovation. INHP II places greater emphases on replication of the Best Practices. Replication is identified as a key strategy for scaling-up the INHP Best Practices through government partnership. Capacity building, systems strengthening and behavior change communication were seen as key approaches to ensure effective replication.

These Best Practices formed the cornerstone of the operational strategy of the program. They were envisaged as solutions to operational challenges in bringing the two key stake-holders: systems and community, together to improve infant survival and reduce malnutrition. The Best Practices were seen as specific processes that would help systems improve the quality and coverage of services on one hand and mobilize community to influence service delivery and sustain behavior change on the other hand.

9 Best Practices: Change Agents

I Definition

Change Agent (CA) is defined as an active, interested volunteer from the community who acts as a promoter and monitor of health and nutrition practices in a neighborhood of 15 to 20 households. Reproductive Health Change Agents (RH-CA) are a dyad of one man and one woman for every Anganwadi Center area within which the Change Agents reside. The RH-CA would counsel the target families specifically on birth spacing choices and RTI/STI referral.

The objective of having a cadre of Change Agents was to create a resource of nutrition and health promoters at the community level to serve as a **link** between service providers and communities, and to positively influence both service delivery and behavior change. They were deemed to be a good source of support for the overloaded field functionaries of ICDS and Health System, particularly for maintaining **contact** with specific households on a regular basis. It was also expected that having 5 to 6 Change Agents in a village would form a large resource base of volunteers to **mobilize** the community as well as to ensure that services were being provided.

The Change Agents were seen by RACHNA as the "*Most potential Best Practice contributing to achievement of community level behavior change outcomes of INHP II and Chayan.*" It therefore becomes imperative that key Change Agent processes be understood and assessed.

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II Selection Process

The selection of Change Agents is a key process that has potentially powerful bearing on the operational success and objectives that the Best Practices aim to fulfill.

Excerpt from the Operational Strategy Manual:

Change Agents would have clear allocation of 15 to 20 households each. The RH-CA dyad would have a much larger area and cover the entire Anganwadi Area. They would be selected through 1 to 2 community meetings in the village attended by active opinion leaders, AWW, ANM, Panchayat members and others as deemed appropriate. Ensuring participation of community members from all castes and class groups is essential. Adequate efforts need to be focused on including marginalized groups. Use of social map

techniques to ensure Change Agents are identified from all pockets of the village. Hamlets and marginalized caste groups will have to be given extra attention to ensure identification of Change Agents from their village. Once Change Agents start functioning, they could help identify and motivate more individuals to act as Change Agents.

> Ensuring participation of community members from all castes and class groups is essential. Adequate efforts need to be focused on including marginalized groups. Use of social map techniques to ensure Change Agents are identified from all pockets of the village. Hamlets and marginalized caste groups will have to be given extra attention to ensure identification of Change Agents from their village.
>
> CARE Operational Strategy Manual

Study Findings:

Selection: The selection of Change Agents was a gigantic exercise covering 10,000 Anganwadi Centers (10% of program areas) in the Demonstration Phase and almost 30,000 to 40,000 Anganwadi Centers in the Replication Phase. This translates into identification and selection of over 50,000 Change Agents and 10,000 Reproductive Health-Change Agents in the Demonstration Phase itself and 3 to 4 times that number in the Replication Phase. The selection process was facilitated by NGOs (in most Demonstration Sites) and led by Government partners, mainly the ICDS. The capacity of NGOs and the System to coordinate such a large effort and stay true to the laid out selection norms was a challenge and variable across the states. The selection of the Change Agents in the Demonstration Sites began in some districts as early as 2002 while in a few it was protracted and began by late 2003.

The selection of Change Agents was largely done by Anganwadi Workers and facilitated by the NGO staff in the Demonstration Sites. The Anganwadi Workers could largely recall the laid out criteria for selection but expressed their inability to follow the procedures in the face of local constraints. An Anganwadi Worker explained, "*We were told to select Change Agents and send them for training. It is very difficult to call a meeting in the village and then select someone. We don't have the time for it. We are forced to select those whom we know and will listen to us.*" The Anganwadi Workers selected Change Agents from among the women who were seen to be "active" during Nutrition Health Days or in *Mahila Mandal* (Women Groups). In places where the Self-help Groups were actively promoted by the government or other organizations, the Anganwadi Workers effectively utilized this forum to recruit Change Agents from among those attending. In some places, semi-literate women, adolescents, close relatives, friends or those who agreed for the training were selected by the Anganwadi Workers.

Maintaining rigor in the selection process of Change Agents was a monumental challenge given the magnitude of this operation. The process appeared to become more closely

identified with subsequent training than with the role of the Change Agent as a volunteer and champion of change in the community. The time and process inputs estimated for selection seem to have been under estimated. Perhaps the process leading to the selection of the Change Agents could have been broken into a series of critical stages ultimately leading to their selection, and perhaps progress could have been monitored more closely; however, it seems that insufficient time and resources were available for such a process to be actualized. The time estimates and work loads could have been more realistically planned based on the experience of INHP I or Early Learning Sites from INHP II. The perception of the community with regard to training and its synonymy with compensation and jobs seems to have greatly influenced Change Agent selection, and needs to be better understood and addressed.

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Social Exclusion: Representation of Change Agents from geographically excluded hamlets, and groups marginalized by religion/caste/ethnicity and gender was variable. Representation of Change Agents from hamlets far from the Anganwadi Center village was observed to be limited. In regions where the distribution of hamlets closely follows ethnic/caste/religious lines, exclusion of hamlets was also observed to affect their representation. The Anganwadi Workers could not recall using the Social Map as a tool to identify marginalized groups and select the Change Agents from within them. It was also observed that the Social Map in the Anganwadi Centers displayed the main village but representation of the hamlets was missing. The selection process by RACHNA very systematically addresses issues of social inclusion but departure from the established procedure during Change Agent selection potentially introduced a systematic exclusion of groups. It was not infrequent for the study team to come across hamlets that had no representation in terms of Change Agents.

The Anganwadi Workers could not recall using the Social Map as a tool to identify marginalized groups and select the Change Agents from within them. "…the Social Map in the *Anganwadi* Centers displayed the main village but representation of the hamlets was missing. The selection process by RACHNA very systematically addresses issues of social inclusion but departure from the established procedure during Change Agent selection potentially introduced a systematic exclusion of groups…"

The number of Change Agents recruited at the inception of the program was found to be consistently 4 to 5/Anganwadi Area across all the states and consistent with the set targets. The process of re-selection of Change Agents in case of drop outs was not addressed. According to a District Program Officer, "*We did not have a procedure in place and therefore did not know the next steps after the Change Agents were put in place. There were women who dropped out and there were also new ones who wanted to volunteer and become the Change Agent but we could not respond to them."* A process of follow-through of a well thought out strategy would have added further value. Sharing of case-studies from INHP I in terms of challenges and opportunities encountered vis-à-vis Change Agents to address day-to-day operational bottlenecks may have brought more efficiency and accountability to the process.

Post-MTR: The scale-up of selection of Change Agents in the Non-Demonstration/Non-Replication Anganwadi Areas representing approximately 50 to 60% of the program universe was suspended as part of the Post-MTR Operational Strategy. In districts where Change Agents were not effective, the suspension was greeted with enthusiasm. However, in Districts where intensive inputs had been made, Change Agents were largely seen as a winning strategy. A District Team member explained, *"Change Agents have been useful and their value has been recognized by others. Some of them have been recruited as ASHA by the government or by other agencies while some have stood for local elections and have won. We know that they are not part of the intervention but we have not informed them so far. It is very difficult to deal with such situations on the ground"*. A senior Program Manager corroborates, "*The fact that Change Agents were being dropped as part of the Post-MTR strategy was not clearly communicated to the government partners.*"

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District Team member

III Training of Change Agents:

The training of Change Agents was a very prominent activity and occupied large amounts of time and resources until 2004. Training was the most important Capacity Building strategy pre-MTR, and was coordinated by the Capacity Building Officer. In the words of a senior CARE official, "*Huge resources and time was allocated for training the Change Agents. It was a gigantic exercise. At one point it became the program itself."*

According to the Operational Strategy Manual, a w*ell thought-out process of structured capacity building was adopted in each community to effectively implement the Best Practice of Change Agents. Capacity building of Change Agents focused upon:*

- *Enabling them to internalize the technical aspects of the intervention areas, desirable positive behaviors.*
- *Develop communication, problem solving, counseling and negotiation skills to effectively perform their roles as promoters and monitors of positive health behaviors.*

Capacity building of Change Agents involved both structured training events and on-the-job support by supervisors (Capacity Building Officers), Anganwadi Workers, Auxiliary Nurse Midwives and NGO workers. The training events were planned in three rounds. The **first round** of training focused on the situational analysis of nutrition and health, roles and responsibilities of the Change Agents, technical issues, and orientation to the Community-based Monitoring System along with the development of an action plan for the Change Agents. The **second round** of training focused upon experience sharing of the Change Agents, resolution of technical problems and planning for monitoring the practices at the household level. The **third round** of training for the Change Agents was meant to mainly focus on refreshers (however, this round of training, although planned, did not take place in the areas we sampled).

The training of the Reproductive Health-Change Agents emphasized the technical aspects of contraception and RTI/STI and HIV/AIDS prevention. They were also trained in counseling and negotiation, social marketing skills and knowledge on needs assessment techniques specific to age and life cycle phases along with techniques of group formation.

Study Findings:

Training: The training of Change Agents was conducted primarily by the Block Training Team supervised by the Capacity Building Officer/Training Coordinater and Demonstration Partnership Officer. The Block Training Team activities were coordinated mainly by the Block ICDS officer and major contributions to training were made by the NGO workers. The training process did not apparently involve a process of local needs assessment and adaptation for training of the Change Agents. In some districts, free lance consultants were hired to train Change Agents. According to a long-serving NGO worker that also corroborates the observations of District Team members, "*The trainers had not known what the Change Agent was like. What her capabilities were? It would have been useful to have got the feel of who they were, what background they were from, what educational qualifications they came with and what expectations they had come with?*" Prior to the trainings, the interactions of the Change Agents were limited to the Anganwadi Workers and the NGO workers. The NGO worker continued, "*The trainers that I came across were not trained in imparting training to grass root level workers. It becomes difficult for them to make them understand and relate to practices and beliefs in the community.*" Since training was prolonged over several months to years, the assessment team has reasons to believe that capacity did emerge among the trainers who progressively perfected the art of training Change Agents. Cultural appropriateness as an important input during the Change Agent training could be useful if customized by the District Teams and based on some form of expedited ethnographic information; however, the challenge of achieving this at scale in a large program is acknowledged.

"*The trainers had not known what the Change Agent was like. What her capabilities were? It would have been useful to have got the feel of who they were, what background they were from, what educational qualifications they came with and what expectations they had come with?*"

NGO Worker

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The training of Change Agents becomes more important than any other cadre of workers because her/his role goes beyond service provision. She/He is a volunteer who does not have institutionalized supportive supervision and is expected to internalize the learning, become an advocate, promote healthy behaviors, monitor service provision, serve as a link worker between the System and Community, mobilize communities and make home-visits to provide technical intervention. It was not clear from the training modules if the needs of the various roles expected from the Change Agent were addressed in the two days of training.

The role of the Capacity Building Officer was perceived to be mainly coordinating Capacity Building activities. A Capacity Building Officer explaining her role, said, "*My job is to co-ordinate Capacity Building activities as per the District Action Plan. I am not supposed to be a trainer or an expert on that and therefore please do not ask me questions related to it. I have neither been trained on it.*" A cursory perusal of her monthly work plan clearly indicated that this role of Capacity Building coordination itself was very demanding and that it was being done with sincerity. It might have been helpful, however, to explore the possibility of expanding the technical capabilities of the Capacity Building Officer to play a more pro-active role in customizing, refining and leading the training process for Change Agents.

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Eligibility of a Change Agent was dependent on the completion of all rounds of training. According to a District Team member, "*To call Change Agents as Change Agents, we have two basic requirements most important being that s/he had three rounds of training*." But even in the Demonstration Sites, the Change Agents could not undergo a full three rounds of training because in many sites the program started in mid 2003 and the training modules were not ready until the second round of training itself. A District Team member recalled, "*We began training based on some information on program objectives and roles that Change Agents were supposed to play. The module wasn't ready but it came during the second round of training. Between the first and the second rounds the module was developed and pre-tested.*" It was not clear to the investigators whether the compression of training into two rounds instead of three was a decision based on logistical feasibility or a deliberate strategy to shorten the period of training. However, the logistical challenges are evident in rolling out the program across the country, and RACHNA sincerity to begin implementation as soon as minimum resources were mobilized, but before training materials were available, needs to be appreciated.

The on-the-job training of the Change Agents was primarily the responsibility of the supervisors, Anganwadi Workers, ANMs, Sector Supervisors and the NGO workers. The Change Agents frequently interacted with them in the community and could ask for their help and cooperation when they had any difficulty in performing their responsibilities. The Change Agents mostly sought help from the Anganwadi Worker and the NGO workers in bringing the community together for the Nutrition and Health Days. In some states, the Change Agents received flip charts and pamphlets after their training to aid them in recalling the technical intervention package, but the distribution of such IEC materials was not uniform across all states. Cross-visits and joint fairs had been used in some of the states to bring Change Agents, Anganwadi Workers, Sector Supervisors and

ANMs together to share and guide the Change Agents in meeting their expected responsibilities of counseling, negotiating, home visitations and group formations.

Logistical Support: Supply chain management and synchronization between activities and technical development of key training materials is one area that could be worked upon in future endeavors. Based on records of inventory and discussions, the study team observed that the program could benefit from synchronization of the development of training modules, job-aids to accompany the trainees and dispatch of succeeding and refresher materials to the recipients with CARE's supply chain and logistics management expertise to optimize availability and distribution of materials. The first of the two rounds of training could have been more productive if the training modules had been developed beforehand and the focus was on the "HOW" rather than the "WHAT" of intervention. An NGO worker who had served in various capacities and also served as master trainer with another organization on maternal and child health presented the following analysis, "*The training impressed on interventions like breastfeeding, etc, which for me was not new but was informative for others but the real issue was how do we communicate to other women? How do we negotiate resistance and get them to adopt new practices? How do we convince them and get them to listen to us? What do we do when other question arises or mother faces problems as a result of doing it? How do we assure them about avoiding doing something that is considered to be vital for survival?"* He goes on to add, "*In the first round, the trainers were themselves not very conversant with community beliefs and practices, and, therefore, communicating becomes difficult."* This was corroborated by several District Team members who were part of the training process.

The ability of trainers to relate to the cultural sensitivities and social paradigms seems to become important when training grass-root level volunteers. The second round of training was more interactive and followed a structured pattern based on the module. Several respondents could recall certain participatory activities from the training session. An NGO worker involved in the training as a trainer of Change Agents said, *"The second round was interactive and we first listened to them about their experience. They had very good questions and we helped answer them. They found it very helpful and interesting."*

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NGO worker

Quality Control: The quality control and standardization process for training activities seems to have evolved over the course of the program. The content of the program, including technical intervention aimed at a life-cycle approach with continuum of care from mother to the baby, community mobilization, behavior change communication, and monitoring, by-and-large was considered to be too exhaustive to be covered in a two-day curriculum. "*Absence of supportive materials for trainers and trainees makes*

comprehension more difficult," observed a NGO trainer. It was not clear if the training materials were standardized for content, duration, methodology and characteristics of trainees. It was observed that IEC materials for RTI/STI could not be distributed in the community in one of the districts because it was not considered culturally appropriate to do so. According to a team member, "*It is difficult even for us and if we take it to the community, we are definitely inviting trouble.*"

The role of the Capacity Building Officer/Training Coordinator also assumes significance when trying to create an optimal match of work-load with appropriate supervision. A common theme heard by the study team is illustrated in the following quote from a District Team member, "*Quality was casualty as a result of large scale training. It was not possible to spend time at each of the training sessions. The number of training assumed more significance.*" However, it appears that training of Change Agents was limited to two rounds, and no further refreshers were offered, which may have limited the ultimate impact of the training sessions that were held.

Recall: A majority of the Change Agents could not recall the contents of the trainings. They explained that a lot of time has elapsed since they were trained, almost one and one-half years, without any further refreshers. The dominant feature associated with the trainings that almost every Change Agent could recall was the amount of compensation they received for attending the two rounds of training.

The use of job-aids was observed to be highly restricted. It was not unusual to find job-aids that had been kept very carefully and never utilized for the purpose of counseling. However, where Change Agents were closely working with a pro-active Anganwadi Worker, their understanding on various issues of newborn health and maternal nutrition was highly commendable. The trainings conveyed the intervention package but left a lot of space for individual interpretation regarding the implications of this training for their future role and expectations of them. This highlights the need for "expectation negotiation" as an important part of such training and mobilization activities. This was further illustrated in a Demonstration Site where in the post-MTR phase they felt the program had stopped. A Change Agent recalled, "*Previously, the NGO brother used to come very often and we used to have a meeting and discuss different issues. Now he has stopped coming because the program has stopped.*" It is important to note that the strategy after the MTR called for the NGO workers to operate primarily through the Sector Supervisor and not through the Demonstration sites; however, the Change Agents seem to have not understood this.

IV Roles and Responsibilities

Excerpt adapted from the Operational Strategy Manual:

The volunteer Change Agent is limited to behavior change communication and counseling with specific contacts within their allotted area of 20-25 house-holds. All Change Agents are expected to keep contact with the house-holds having pregnant and

lactating women and children under two years and all eligible couples as target population. Identify program participants from them; facilitate birth planning, home visitations, and track and counsel the target population within the allotted area. Identify barriers and difficulties related to adopting new behavior practices, actively participate in Nutrition and Health Days, and act as depot holders for IFA and ORS and contraceptives (in case of RH-Change Agents). S/he is also expected to reach out to all the drop outs and the left outs in the community and enhance coverage within their allotted area. The Change Agents are primarily responsible for bridging the gap between the service providers and the community beneficiaries.

The Change Agents are not expected to maintain complicated registers, provide health care services like distribution of medicines, administering vaccines, undertaking health check-ups and play the role of a Change Agent as a full time employment. The Community-based Organizations, the Anganwadi Workers and the community members were responsible for pursuing the Change Agents as being volunteers they were not under any kind of formalized surveillance.

Study Findings:

The roles and responsibilities of the Change Agents have undergone radical metamorphoses over the course of the 10 years of INHP. The concept was born in the early years of INHP I, modified during the later half and recommended for deliberate replication in INHP II. Change Agents were central to the intervention strategy of both INHP II, prior to the MTR, and *Chayan,* in terms of responsibilities, resources, uniqueness and visibility of the program. However, the last 18 months of programming witnessed partial to complete departure from this approach, as the Post-MTR strategy steered away from the Change Agents. Nevertheless, the investigators would like to record their appreciation to CARE for having experimented with this idea that may not have contributed to outputs and outcomes during the project duration but has substantially contributed to the ongoing experimentation and understanding of volunteerism. The contribution of the program of Change Agents, therefore, should also be viewed through a larger social perspective and beyond the confines of the program's objectives.

The experience with Change Agents was variable across the different states. In some states, use of Change Agents continues; in some other areas, their use is still supported in principle by the implementation team; and, finally in some areas, this is not considered a feasible practice. The experience with Change Agents, in general, appears to have been better where there was an existing culture of self-help group movements, organizations working that utilize volunteers with some compensation, or where Change Agents have been institutionalized either as part of local governments or subsumed by the National Rural Health Mission. It was heartening to see that despite the program withdrawing active support to the Change Agents, the investigators found many who were still contributing in different ways to the cause of child and maternal health. The investigators met several Change Agents, and all of them had good things to recall of their association with the project, and some continued to identify themselves as Change Agents despite

having the view that the program had ended. Thus, the investigators felt that the "end" of the program should not be interpreted as cessation of services through RACHNA, but should be seen more in the light of cessation of active contact and participation in community activities of Change Agents through NGO workers.

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In general, however, the investigators came across very limited evidence of Change Agents playing the intended role that the program had envisioned. The Change Agents, in general, served the role of assisting the *Anganwadi* Workers. As a Child Development Project Officer put forth, "*Change Agents reside in the same village who can maintain contact with the beneficiaries for 24 hours. She is in charge of 10 families. She can maintain a more intensive relation with the community in comparison to the Anganwadi Worker or the Child Development Project Officer."* The same was substantiated by the Anganwadi Worker who said, "*Change Agents help in weighing of ration and I maintain the register.*" The study investigators did not come across any Anganwadi Worker who did not see value in the Change Agents. However, those who yet identify themselves as a Change Agent appear to have been self-selected over a period of time as others withdrew from this role. There were several instances where the Anganwadi Workers had developed a compensatory mechanism for sustaining the Change Agents. As one Anganwadi Worker honestly shared, "*I don't have an assistant and have been requesting for a long time but it has not happened. Thankfully the Change Agents were recruited. They are very helpful. I give them some ration when I distribute the Take Home Ration (THR) and they help in informing the beneficiaries and also assist in distributing them."*

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There was limited evidence of Change Agents making home visits in the hamlets but instances of Change Agents engaging with the households in main villages were notable. One of the investigators recalls from his field notes, "*We were deliberately looking for a family with a newborn baby and it wasn't long before village folks guided us to a partial brick household. We found the baby with the mother and grandmother, well wrapped and covered. On enquiry we learnt that the baby was 21 days old and had weighed 3 kilograms. On being asked precautions and care that was needed for the baby she recounted with ease what she was doing and how the elder sister in the neighborhood had been visiting her and guiding her. On enquiry we learnt that it was the Change Agent whom CARE had identified. We also learnt that the Change Agent had subsequently also been recruited by another organization and had received the "Best Change Agent" award in the district."*

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One Change Agent, in explaining what she does, said, "*We do not go for home visits; if we meet any pregnant women who we think will listen to us and those whom we like, we tell them about the new practices.*" In terms of the content of counseling, the Change Agents said that, *"We tell the pregnant women to eat 3 to 4 times, not to work too hard, take 1 to 2 hours rest after having the food, to consume 1 tablet (IFA) in the day…because proper diet ensures that both the mother and baby will be healthy. We advise the pregnant woman to take care of the following five cleans - clean surface, clean cloth, clean blade, clean hands, clean thread… and she should go to the hospital if the labor pain becomes unbearable.* "She went on: "*We ask lactating mothers to immunize their babies with the BCG vaccine after twenty days of birth and after that polio drops to be given."* A Reproductive Health-Change Agent explained her role as, **"***Making the villagers aware about the possibilities of family planning and also to make it available to them, telling them how to maintain gaps between children, the methods to be undertaken, telling them everything about family planning.***"** The latter, however, could not be corroborated by the members of the community she was working in.

The Change Agent's role as an "Agent or Champion of Change" needs to be more carefully assessed and analyzed. An NGO worker who had been working on a Demonstration Site since inception said, "*If the Anganwadi Worker did not respond to legitimate requests, I used to mobilize the community through the Change Agents and this method was very successful. I was able to bring both of them closer to each other. The Anganwadi Worker was becoming more accountable to the community and the community was also happy that they were receiving better services."* The Change Agents were under constant supportive supervision by the NGO worker in the Demonstration Sites but the strategy for Replication of this model in areas where there would be no NGO supervision did not seem to have been addressed. The study investigators were told

by District Teams about the increasing involvement of local governments, Panchayati Raj Institutions and local models of Replication were being developed. The study investigators did not have the opportunity to make specific visits to these places but based on conversations with members of the community and the members of the Panchayat, the void could potentially be addressed through strategic involvement of this institution to stimulate a process of community audit.

V Motivations and Constraints

Excerpt adapted from the Operational Strategy Manual:

Motivational support to the Change Agents was to be provided by the Anganwadi Workers, Auxiliary Nurse Midwives and the Community-based Organizations (CBO), since the presence of an active, skilled Change Agent can greatly facilitate their own work in terms of up-dation of records, counseling for behavior change, follow up of under nourished children and compliant mothers.

The Operational Strategy puts forth certain activities initiated by Community Based Organizations along with the Anganwadi Workers and the Auxiliary Nurse Midwives involving the Change Agents that facilitates the process of motivating them to perform their responsibilities better. Activities such as periodic fairs, where the Change Agents are encouraged, recognized and awarded for their contributions, or to institutionalize a reward system with the support of philanthropists, government and other institutions, should be initiated by the existing village institutions.

Study Findings:

The operational model for Change Agent motivation has been very comprehensively outlined in the Operational Strategy Manual of RACHNA. Identification of factors that have motivated the Change Agents is of immense value to the program as well as other similar efforts going on in the country and elsewhere in the developing world. The study investigators came across several Change Agents who had been working and contributing to the community. A Change Agent who now serves another program said, "*I come from a well–to-do family and have always wanted to contribute. This program allowed me to do so. I get respect from the people and I like helping them. Because of this I also got 15 days training on sanitation, diarrhea, etc, from another organization. Two ladies came from Japan to meet me."* On the other hand, the study found that the majority of the Change Agents had progressively reduced their contribution. Responding to the scenario, a Sector Supervisor had the following observation, "*Majority of the Change Agents who volunteered to undergo the CARE trainings were hoping to get a government job or some opportunities in the future and when nothing such happened they lost their motivation to work.*" Some of the Change Agents have been absorbed within the Government system, as ASHA workers as part of the National Rural Health Mission, and this has paradoxically served to dissuade a few others to give up. As one Change Agent put it, "*We became Change Agent together but she has been chosen as ASHA. She will get paid for it. I don't think there is any future. I rather stay at home."* Some continue to hope that

some opportunity would arise in the future while others have gone about contributing because the recognition and pleasure of serving the community continues to be enough reason for them.

"*Majority of the Change Agents who volunteered to undergo the CARE trainings were hoping to get a government job or some opportunities in the future and when nothing such happened they lost their motivation to work.*"

Some continue to hope that some opportunity would arise in the future while others have gone about contributing because the recognition and pleasure of serving the community continues to be enough reason for them.

Constraints: No monetary compensation emerged as the primary reason for discontinuing their work. In the words of a Change Agent, *"I will not do it [work as a Change Agent], I have many tasks to do at my home…I cannot do free service. I have 3 to 4 children to look after; I can not do it anymore."* The Depot Holders of contraceptives in the community, who were in some cases also the Reproductive Health-Change Agents, expressed difficulty in selling their stock because the community members are not willing to pay for the contraceptives that are generally available for free from the government workers, e.g., Anganwadi Worker, ANM. When the researcher asked a Reproductive Health-Change Agent (male) why he had not sold the contraceptives given to him, he said, "*Everybody prefers to buy from the government, and not from private Depot Holders, because the ANM gives it for free and so everyone prefer to take it from her, why should they pay for the same?*" He further added, "*We cannot pressurize them; people think that when they get the same thing free of cost why should they pay for it.*"

Frequently it became very difficult for the Change Agent to advocate for practices and broach sensitive issues in the community. As pointed by a Reproductive Health-Change Agent (female), when she tries to tell the community about contraceptive usage they say, "*I earn, my husband earns so what problem do you have with our children, you do not have to feed our children.*" Another adds, "*The people in the villages are mostly uneducated and do not want to listen to what I say and find these things un-useful…and if they are not willing to listen I have to stop.*" Some of them expressed their inability to adequately use the job-aids because they were semi-literate and in most cases there was a long gap between the training and the availability of the supportive take-home materials that were provided. A majority of them felt that trainings should have been more frequent. The need for supportive supervision was universally echoed by the Change Agents and also by several members of the District Team. As one Change Agent put it, "*Now no one visits to check or give us further training or something. It was in the initial period that we were trained and asked to spread awareness to the people…but in the past*

one year no one came to us to enquire about what we are doing…have we got something or not."

10 Best Practices: Nutrition and Health Day (NHD)

According to the Operational Strategy Manual: *Nutrition and Health Days are a* ***mechanism*** *to ensure convergent service delivery, an* ***intervention*** *to reach the most marginalized sections of the community with health and nutrition services, and an* ***event*** *to provide a forum for community involvement in monitoring health and nutrition services.*

Study Findings:

Ownership for Nutrition and Health Days is very high among program mangers at CARE as well as various levels of the Government system. An interesting observation was a consistent reiteration from both CARE program managers as well as government functionaries, claiming the Nutrition and Health Day as their innovation. The study team notes this phenomenon with equal appreciation and views this positively from the perspective of collaborative spirit and striking common ground.

The Best Practice of Nutrition and Health Days was seen as an opportunity for **convergence of services**. The various activities for the Nutrition and Health Days were summarized in the following words of a member of the District Team, "*In Nutrition and Health Days, the targeted beneficiary are educated on basic health services, the nutrition and health aspect is also covered as the Take Home Ration is distributed. The Anganwadi Workers also educate the mother on the nourishment content of the food being given and we are pursuing on several gradation of nourishment, grade I, II, III and IV as this is an easy forum where the mother can be educated about the growth of their children. The mother is educated using Behavior Change Communication messages. Change Agents also participate in these discussions and help in mobilizing the women. The major participants are the Auxiliary Nurse Midwife, Anganwadi Worker, Change Agents and the beneficiaries. All health service providers at the village level come together in one platform, reducing the gap between the beneficiary and service provider*."

District Team members pointed out that Nutrition and Health Days have been emphasized upon as a Best Practice and consistently advocated for. The program implementers have mobilized the village Panchayati members to attend these activities. To quote one of them, "*In the Graduation blocks, the Pradhan/Mukhiya and few women from the Panchayat are mostly present in the Nutrition and Health Days*". An NGO worker adds that, *"Earlier, Panchayat members did not come for Nutrition and Health Days, but now they have started coming due to which the number of beneficiaries has also increased."*

Some Anganwadi Workers said, "*The Nutrition and Health Days are conducted to ensure whether proper distribution of ration is taking place or not and also to look into the health of the pregnant women, like the consumption of chloroquin and Iron tablets and*

gradation (of malnourished children)." An Auxiliary Nurse Midwife, elaborating on the utility of the Nutrition and Health Days, said that, "*It serves as a common platform to gather women and children together for immunization. Earlier she had to tour the whole village to immunize them, now she can access all of them at one focal point which makes her work easy.*"

In most cases the Nutrition and Health Days are attended by the Anganwadi Worker, Auxiliary Nurse Midwife, pregnant and lactating women, children under 3 years and Change Agents (if functional) of the area. Sometimes the Sector Supervisor of the area and the NGO worker also come to review and monitor the activities on a Nutrition and Health Day. Such supervisory visits are rare, however, as pointed out by some ANMs, who commented, "*…I have not seen the ICDS Sector Supervisor come for any of the Nutrition and Health Days.*"

Community Perception: As the study team interviewed the various stakeholders and community members, they observed that the common perception associated with the Nutrition and Health Days was that the focus was on distribution of the Take Home Ration, Iron Folic Acid tablets or chloroquin tablets (wherever applicable) and immunization. Among these, the Take Home Ration was identified as the most crucial factor determining the success or failure of Nutrition and Health Days. One of the Anganwadi Workers said, *"On the immunization day, women come with their small children, madamji [Anganwadi Worker] distributes ration and sisterji [Auxiliary Nurse Midwives] administers the vaccines."* Some Anganwadi Workers also talked about weighing of the child and the pregnant woman. *"All children are gathered at one place, where the Auxiliary Nurse Midwife administers the vaccines and the Anganwadi Worker distributes the ration and the children are weighed."*

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The members of the community, however, also said that they would prefer to go to a hospital for a complete check-up, in preference to the care provided at Nutrition and Health Days, as "*At the Anganwadi Center they [Auxiliary Nurse Midwife] conduct an abdominal examination and take the weight. Blood pressure is not taken, while in the hospital complete check up is done by the doctor and we also get information. The main incentive for going to Nutrition and Health Days is the Take Home Ration.*" Most of the District Team members felt that the Take Home Ration was the essential factor and if discontinued it would seriously impede attendance. This seems to be borne out by the fact that in a lot of places the lack of availability of the Take Home Ration already seems to

have affected the regularity of Nutrition and Health Days. The study team had the opportunity to witness a planned NHD, but because ration was not available, the attendance was very limited.

Counseling Session: Perceptions regarding the counseling sessions, which are an important component of the Nutrition and Health Days, also varied greatly among the different stakeholders. As expressed in the words of a Change Agent, "*In Nutrition and Health Days, I call women and children and sit with them, spread awareness regarding early initiation of breastfeeding, postpone bathing the baby and advise adequate rest.*" Most of the beneficiaries revealed that often (especially in the case of a new bride having her first child) other family members went to collect the Take Home Ration. The target beneficiaries would go to get the vaccines and never stayed long enough to get the Ration and the IFA tablets.

On Nutrition and Health Days, the Anganwadi Workers and their helpers organize a session where they deliver the behavior change communication messages. However, such sessions are irregular since a number of activities (immunization, distribution of Take Home Ration, ANC, weighing of the baby/mother, record maintenance, etc.) take place simultaneously. As pointed out by an *Anganwadi* Worker, "*It becomes difficult to manage the children, the beneficiaries and to tell them to wait for the counseling sessions. Often the family members of the beneficiaries come only to receive the Take Home Rations and leave soon after, which hinders group participation.*"

Constraints: The major constraints to observance and effectiveness of Nutrition and Health Days that were identified by the various stakeholders were the unavailability of the Take Home Ration and the lack of adequate coordination between the Anganwadi Worker and the Auxiliary Nurse Midwife. Other secondary constraints are the lack of required materials like blood pressure measuring machines (sphygmomanometer) or a functional weighing machine, or even adequate supply of IFA or vaccines. Sharing their experiences on ANC, some of the NGO workers said, "*At places there are no blood pressure machines, no privacy to conduct abdominal examinations."* In the same vein, one Anganwadi Worker said, *"… in her Anganwadi Center, ANC is not being done; it is done in the hospital*."

Constraints in achieving 100% coverage of immunization (BCG) of children on Nutrition and Health Day were voiced by an Auxiliary Nurse Midwife as follows: "*Only when 4 to 5 children are collected, then the vaccination takes place so that the vaccines do not go to waste. But when less than the specified number, they wait for the next month. They [Anganwadi Worker] tell us that the children are less here or they call us to some other place. And if she (mother) wants the vaccination to be done then we refer her to the hospital*."

A member of the District Team, talking on the regularity of weighing the baby at Nutrition and Health Days, said, "*Not 100% of the babies are weighed as there are no weighing machines available or else they are not working properly*." As an NGO worker said, "*The chain of the weighing machine to weigh the baby is not available in the Anganwadi Center, hence, the babies cannot be weighed. But we have told them how to*

assess that the baby is less than 2.5 kilograms – like for instance by looking at the baby properly, whether the baby is active, etc, this can be understood on the basis of experience."

The quality of service being provided is another factor that prevents people from attending the Nutrition and Health Days, which again indirectly affects the services further. As a woman said, "*People of my cluster go out (to hospital) to avail the services because here they re-use the syringes, the medicines are old, and hence we prefer to go for private check-ups."* A similar perception was held by another beneficiary: "*If anyone is interested, they come for immunization, but all of them lead to some or other infection…moreover, the same needle is used to vaccinate everyone.*"

"*We prefer to go for private check-ups.*" A similar perception was held by another beneficiary: "*If anyone is interested, they come for immunization, but all of them lead to some or other infection…moreover, the same needle is used to vaccinate everyone.*"

Another significant fact that serves as a constraint for the community members is the lack of awareness about when the Nutrition and Health Days will be conducted and what activities will happen there. This is more pronounced in people residing in the hamlets where the coverage is low, as the Change Agents, Anganwadi workers or the Auxiliary Nurse Midwives make limited visitations to these places. As a woman from one of the 'tag villages' said, "*Neither do they come here nor do we go to the Anganwadi Center, they only call their own people*."

The aim of conducting Nutrition and Health Days was to serve as a forum for the convergence of services, thereby facilitating community processes. The NGO members and the Sector Supervisor and at times the members of the District Team were supposed to **monitor** the effective conduct of Nutrition and Health Days, to ensure that both the Anganwadi Worker and the Auxiliary Nurse Midwife provided the Take Home Ration, conducted counseling sessions, administered vaccines and performed the health check-ups respectively. As an Anganwadi Worker commented, "*Since CARE people have started pressurizing the Auxiliary Nurse Midwives to attend the Nutrition and Health Days, she cannot take off even if it's her child's wedding she still has to come for it.*" In contradiction, most Change Agents said that "*Neither CARE nor the NGO officials attend Nutrition and Health Day."* Similarly, some NGO workers indicated, *"We have inadequate time…sometimes we have less time and therefore enquire whenever possible whether the immunization was takes place or the women come [on NH])."*

> Nutrition and Health Day is a powerful innovation and …is the only Best Practice that has been continued as part of the Sectoral Strengthening (i.e., Post-Mid Term Strategy). It is, however, important to understand that several intended benefits of Nutrition and Health Day were expected to be driven by other Best Practices…. Nutrition and Health Day, in the opinion of the study team only provides an opportunity, and…lack of sufficient engagement of the community may result in these events not bringing about the intended qualitative improvement in the services. Continued engagement of the Panchayati Raj institutions and other Community-based Organizations could improve the level of convergence between Anganwadi Worker, Auxiliary Nurse Midwife and the Community. The Sectoral Strengthening approach by CARE is also an important innovation for convergence at the next level, and the effort to drive community participation to promote the strategy is highly commendable.

Nutrition and Health Day is a powerful innovation and affords an excellent opportunity for convergence at the implementation level in the community. The concept is well entrenched within the system and the ownership and potential value attached with it well known. Nutrition and Health Day is one of the most promising Best Practices and is the only Best Practice that has been continued as part of the Sectoral Strengthening (i.e., Post-Mid Term Strategy). It is, however, important to understand that several intended benefits of Nutrition and Health Day were expected to be driven by other Best Practices, e.g., mobilization for attendance, community participation for an enabling environment to accept and demand services, constructive demand for improved quality of services, social maps for reducing social exclusion and community monitoring for sustained service. Nutrition and Health Day in the opinion of the study team only provides an opportunity, and while a strategy may drive the regularity of Nutrition and Health Days, lack of sufficient engagement of the community may result in these events not bringing about the intended qualitative improvement in the services. Continued engagement of the Panchayati Raj institutions and other Community-based Organizations could improve the level of convergence between Anganwadi Worker, Auxiliary Nurse Midwife and the Community. The Sectoral Strengthening approach by CARE is also an important innovation for convergence at the next level and the effort to drive community participation to promote the strategy is highly commendable.

10 Best Practice: Community-based Monitoring System (CBMS)

Excerpts adapted from the Operational Strategy manual:

The main objective of the Community-based Monitoring System (CBMS) is to mobilize and empower communities to manage the health and nutrition status of women and children. Community-based Monitoring System is a set of tools/visuals evolved through a participatory process that enables families and community groups to monitor their own health status, practices and take action. The Community-based Monitoring System has two components:

- *The village-level Social Maps for tracking the progress of behavior change, left-outs, drop-outs, newborn deaths and child malnutrition.*
- *Family-based **Self-monitoring Tools** usually through visual depictions such as wall writing, Kantha, etc.*

*The Self-monitoring Tool is to be made on the walls of the house of a pregnant woman. The process starts with the tracking of the woman for which the **Village-level Resource Map** is used. The Village-level Resource Map is a map of the village made using a participatory process involving the stakeholders, members of the Panchayat, and other key people from the village. It should be ideally displayed at the Anganwadi Center and updated to facilitate the ability of Anganwadi Workers, the Change Agents and the Auxiliary Nurse Midwives to track the beneficiaries, Pregnant and Lactating women and check for proper coverage of Left-outs and Drop-outs.*

Study Findings:

The idea of having a set of tools to self-monitor on all critical parameters for care during the antenatal and newborn period is an example of CARE taking local innovation across the country. This can significantly enhance one's sense of empowerment and serve as a powerful starting point for increasing demand for services, seeking care at appropriate times, information sharing and monitoring both by self as well as by peers and other providers. Linking this with the Village Map to continuously track information on key parameters such as pregnancy, malnutrition, left-outs and drop-outs seems to be an important step towards development of a comprehensive tool for empowerment, self-regulation, development of social cohesion, reducing social exclusion, and promoting equity and public accountability.

Despite the strong theoretical basis for the Community-based Monitoring System, the experience of the Assessment Team vis-à-vis the practice of these tools was not particularly encouraging, even in areas that have remained Demonstration Sites since the inception of the program. Self-monitoring Tools were seen at several of the Anganwadi Centers visited, and in many cases they had undergone impressive local adaptation. In most of the cases, it was found to have been drawn by the Anganwadi Worker. However, as a mother of three month-old baby said, "*I am aware of it but see no use, no benefit in*

making it. Suppose someone comes to check and ask for the Self-monitoring Tool, then what will the Anganwadi Worker answer? If the houses are far off from the centre no one will go to see; since mine is near the Anganwadi Center, the Anganwadi Worker told me to make it…so I made it." In most of the cases, the tool depicted was not serving the purpose of a monitor and was observed to be an incorrect depiction of the true status of the beneficiary. Although speculation, the sense gained by the study was that this may have reflected 'Demonstration Bias', where the need to demonstrate a practice to others becomes paramount to the functionality.

There seemed to have been a generalized reluctance to embrace the benefits or applicability of the Monitoring Tools. This ran across beneficiaries, service providers and even CARE District Team members. As one of them shared his observation, "*The Self-monitoring Tool is good to demonstrate a unique, novel innovation to visitors but it does not make sense for the mothers. They don't see the need of a reminder. If they have taken 50 iron tablets, they remember it.*" According to a beneficiary, "We *can remember on our own and hence we did not make the Self-monitoring Tools."* On the other hand, some opined, "We *do not know how to draw it…. I did not make it, there is no use."* Most of the women who have heard or seen it in the Anganwadi Center perceive it as an indicator which would help the visitors to identify the house of a pregnant woman. The Anganwadi Worker explained, "*People in the village do not want to reveal their pregnancy and the Self-monitoring Tool makes it public. This is one of the major reasons people don't want to have it on their walls. Therefore, we have also tried having them behind the door within the home but then it becomes difficult to ensure that they are complying with it."* The mothers also found the tool complex and it required a certain level of training and skill for them to do it; this barrier needs to be further explored. The District Team members expressed their opinion on the implementation and success of Community-based Monitoring System as follows: "*Both Community-based Monitoring System and Block Level Resource Map are conceptually very good, but when it was taken to the field, a lot of other factors became important such as, community acceptance, their reaction, attitude and behavior, how well was the implementation monitored, ownership from the Anganwadi Worker and the community and others.*"

"The Self-monitoring Tool is good to demonstrate a unique novel innovation to visitors but it does not make sense for the mothers. They don't see the need of a reminder."

CARE District Team member

"People in the village do not want to reveal their pregnancy and the Self-monitoring Tool makes it public. This is one of the major reasons people don't want to have it on their walls."

Anganwadi Worker

Besides the cultural barriers and potential skill deficits, the acceptance of this Tool needs to be closely evaluated in the context of the Behavior Change Communication and Community Mobilization strategies practiced in the community. The Self-monitoring Tool is an excellent innovation, but it needs to be explored in-depth as to why its acceptance has been low, leading to it being de-emphasized in the last 18 months of the program.

Village Resource Map: It is yet another example of CARE's commitment to community participatory processes to meet its goal. The Village Resource Map represents an excellent opportunity to bring community members and groups together in a continuing process, while providing them a visual and monitoring tool. The team almost universally came across village Social Maps. Reducing social exclusion and tracking left-outs and drop-outs were some of the key benefits that were expected.

The village maps in most cases were found neatly hung in Anganwadi Centers. One of the study team observed, "*The village map was very neatly done and the list of pregnant mothers was matched with the register. It was found to be updated. More importantly, the Change Agent had taken on the responsibility of doing so entirely on a voluntary basis."* The study team did not, however, come across other village maps that had been updated in recent times, as they apparently had outlived their utility. The village map universally did not include the Hamlets that are generally where most of the excluded groups live. The tool in the initial periods of development had followed a participatory process with the community members but the study did not come across evidence suggesting continuing community monitoring and participation in the one year prior to the study. The supply of logistics for updating the maps was cited as one of the reasons. As one Anganwadi Worker put across, "*We don't have the stickers or pen to write on it."* The study team came across several instances where they had used ingenuous ways like use of'*Bindi'* to depict the pregnant women, children, malnourished kids, etc. A modified version of this tool was also observed in one of the states. They were introduced by an International Agency with the Government and appeared to have been well accepted. Supportive supervision, better logistical support and ownership of the system appeared to have been differentiating features in the greater acceptance of these alternative maps.

The Community-based Monitoring System is potentially a powerful participatory capacity building tool that, based on its design and intended purpose, potentially opens avenues for capacity building of the community through promotion of participation, reduces exclusion, promotes awareness, increases community capacity to analyze, develops ownership, drives accountability and develops problem identification and possibly problem solving skills. The low level of acceptance and use of this tool and eventual discontinuation, potentially affects the ability of the program to address the issues of community capacity building and to meet program objectives. This deserves further exploration.

The Community-based Monitoring System is potentially a powerful participatory capacity building tool…. The low level of acceptance and use of this tool and eventual discontinuation, potentially affects the ability of the program to address the issues of community capacity building and to meet program objectives.

11 Best Practice: Block Level Resource Mapping (BLRM)

BLRM was introduced with the aim of instating a robust participatory monitoring mechanism at the Block level. This involved engaging key personnel from both ICDS and Health System as well as from panchayat bodies to validate and supplement routine reports by the ANM and AWW to enable joint identification and resolution of operational problems at the Block level. This is a great innovation that enhances the robustness of the monitoring mechanism through mutual check and balance between the two systems. We found evidence that this scheme was kicked-off and an initial assessment was done by engaging all concerned parties. However, there was lack of follow-through and this best practice was not functional in any of the Blocks that we investigated.

ANNEXURE I

Qualitative Assessment of Reproductive, Child Health, Nutrition and HIV/AIDS (RACHNA) Program of CARE India, 2006

Background:

Reproductive and Child Health, Nutrition and HIV/AIDS Program (RACHNA) is an umbrella program of CARE India consisting of three health and nutrition projects. The USAID supported projects include the Integrated Nutrition and Health Project (INHP) and the *Chayan* Project.

CARE implements the Integrated Nutrition and Health Project (INHP) with support from USAID and in partnership with the Government of India's ICDS program of the Ministry of Human Resources Development (MOHRD) and the RCH program of the Ministry of Health and Family Welfare (MOHFW), local Non-Governmental Organizations (NGOs) and other partners. INHP II is the second five-year phase of the project.

INHP II is implemented in 78 districts across nine states and the *Chayan* project is implemented in a subset of 29 districts in four out of the nine INHP states. The INHP II project aims to contribute to reductions in child mortality and malnutrition, while the *Chayan* Project contributes to adoption of birth spacing practices and prevention and management of RTI/STI/HIV. The child health and nutrition, birth spacing and prevention and management of RTIs, are implemented primarily through the ICDS and Health System, predominantly in rural areas. The HIV interventions are implemented among high-risk behavior groups and youth in 22 cities.

While INHP II officially began in October 2001, the *Chayan* project began in July 2002 with a plan to layer reproductive health and HIV prevention interventions in 45 districts of the INHP II in four out of the nine states[1] in a phased manner. The following are the some of the major factors that happened over the life of INHP and Chayan that have influenced the program:

- GOI's decision to disallow the import of Corn Soy Blend resulted in reduction of about 50 M USD food resources of INHP II. The implications of the cut in food resources in middle of a financial year posed challenges to the program. The implications included negotiations with the respective state governments to put in local resources and repositioning CARE's role with the state governments. This also necessitated, an amendment to the INHP II design with reduced resources, which was approved in 2004 with some revisions in the performance targets.
- Reduction in family planning resources in year 2004 led to roll back of rural chayan interventions from originally planned 45 districts to 29 districts in four states. This called for a significant level of effort in reorganizing internal staff/processes,

[1] 12 districts of UP, 10 districts of CG, 7districts of RA and 16 districts of JH

discontinuation of partnerships with local NGOs and managing critical relationships with critical stakeholders.

- While INHP and Chayan initially conceived as two separate projects, they were operationally and managerially integrated in the year 2003 to ensure efficiencies in the program. This called for changes in structures and roles at different levels of the program.
- While Chayan was originally planned for a period of 6-years from 2002 to 2008, in order align the timings of both projects, it was jointly decided with USAID that Chayan will end along with INHP by September 2006. Accordingly Chayan performance targets modified.

As both INHP and Chayan projects are ending in September 2006, the final evaluation processes are underway. The final evaluation of RACHNA consists of the following:

- Population based surveys providing state wise estimates of coverage rates on the committed indicators conducted external agencies
- External qualitative assessment
- Final review by a team international and national experts informed by the quantitative assessments, external qualitative assessment, CARE's internal documentation and evaluation research findings

External qualitative assessment is one of the critical inputs into the final review team begin which will begin its work on April 3, 2006.

2 The External Qualitative Assessment and its Goal

The external qualitative assessment of RACHNA will be independent of CARE, India, and will be conducted by Johns Hopkins University (JHU), in partnership with India CLEN Program Evaluation Network, New Delhi. The program would be assessed in three states, namely Uttar Pradesh, Chattisgarh and AP (or Orissa). The Qualitative Assessment team will share their findings and analysis with CARE, USAID and the Final Evaluation Team but will not make any recommendations.

The Goal of the Qualitative Assessment is to provide analytical inputs to the Final Evaluation team on the likelihood of RACHNA's implementation strategies producing the desired or demonstrated results, based on an examination of the implementation of the RACHNA program at various levels and in different contexts, within the program design framework.

Since there are no other data sources on processes available for the FE team apart from the end-line survey, evaluation research (which is limited to two districts) and the internal documentation, this assessment has a critical role in providing an independent input on processes not quantified in the end-line survey. The assessment report should thus address some of the potential "why and how" questions of Final Evaluation team.

3 Key Areas of focus for the External Qualitative Assessment

A Implementation Framework

- Evolution of implementation strategies over the life of the program for taking interventions to full scale:
    - Transition from INHP I to II, and from Pre-Mid-Term to Post-Mid-Term – how these worked on the ground (Refer the presentation made on 11 March for a description of how these transitions were planned, and to the RACHNA Operational strategy document for a full description of strategy as elucidated at the beginning of the current phase, including operational descriptions of main approaches and Best Practices)
    - Integration of Chayan and INHP II (Refer RACHNA Midway Reflections document)
- Current program implementation:
    - Translation of technical interventions into implementation strategies
    - Influencing Systems: (Refer to the implementation framework for roles of functionaries Post-MTR)
        - Advocating for operational changes to make ICDS / Health System more effective in achieving stated objectives of RACHNA
        - Influencing and supporting focused effort by systems at sub-district levels for:
            - Ensuring behavior change
            - Improving service coverage
        - Streamlining supplies / distribution, including social marketing
        - Influencing generation and use of information within systems
        - Variations in different contexts
        - Roles of NGOs
        - Capacity building approaches
        - Flexibility and adaptability of strategies
        - Perceptions of the systems about feasibility / sustainability, effectiveness and desirability of changes sought by RACHNA
    - Community mobilization / involvement:
        - Communications strategies:
            - Design, approaches and implementation
        - Efforts at involving communities including change agents / CBOs / PRIs in monitoring and supporting behavior change activities

B Program Management Framework

- RACHNA Program Management Design, roles and relationships and their influence on program effectiveness (Refer RACHNA Midway Reflections document and Post-MTR implementation framework)
- Effectiveness of managing organizational change and change in program strategies (including food transition, Chayan integration, reduced funding, mid course changes in implementation strategies)

C Monitoring and Evaluation Framework

- Adaptation of ME systems to changes in implementation strategies
- Use and effectiveness of current ME systems, including RAPs and ER.

D Advocacy Framework

- Advocacy efforts at National and State levels (Request documents from CIHQ and states)

4 Methodology and Data source

The assessment will be qualitative in nature and qualitative tools will be developed for this purpose. The direction and focus of the assessment will also be guided by existing quantitative data from rapid assessments. Documentation existing with CARE will also be utilized for the purpose of the assessment. The criteria for selection of districts will be based on a set of criteria agreed between the assessment team, USAID and CARE. Assessment team will spend time with CARE India central team to familiarize with the program design, interpretation of the program design and program evolution. In addition, the assessment team will invite CARE’s participation in tool development. Program implementation framework will help define the limits, content and tools for the assessment.

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