PARTNERSHIP FOR SUSTAINABLE HEALTH IMPACT
(USAID Child Survival Grant XIV)

CARE India's partnership with
Parivar Kalyan Sansthan &
Tata Steel Rural Development Society

(October 1, 1998 – September 30, 2002)

MID-TERM REVIEW

July 2000

Contact person: Dr. Sanjay Sinho, CARE – USA headquarters

External evaluator: Dr. Mary Ruth Horner

TABLE OF CONTENTS

E. What is working well?
F. What is not working so well?
G. Mid-term Quantitative Survey

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ACRONYMS

ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
AWW (AWC)	Anganwadi Worker (Center)
BCC	Behavior Change Communication
CBO	Community-Based Organization
CBOP	Community-Based Operating Partner
CBW	Community-Based Worker
CHD	Community Health Day
CIHQ	CARE India Headquarters
CS	Child Survival
CSP	Child Survival Project
CSPW	Child Survival Project Worker
DIP	Detailed Implementation Plan
FEW	Field Extension Worker
GOI	Government of India
HMIS	Health Management Information System
ICDS	Integrated Child Development Services
IEC	Information, Education and Communication
IFA	Iron and Folic Acid
IMCI	Integrated Management of Childhood Illnesses
KPC	Knowledge, Practice and Coverage
M&E	Monitoring & Evaluation
MOH	Ministry of Health
MTR	Mid-Term Review
NGO	Non-Governmental Organization
OPV	Oral Polio Vaccine
PKS	Parivar Kalyan Sansthan
SRI	Social & Rural Research Institute
TSRDS	Tata Steel Rural Development Society
TT	Tetanus Toxoid
USAID	United States Agency for International Development

SUMMARY

1. Overview

CARE India has entered into a partnership with two corporate sector NGOs affiliated with the Tata Group to make sustainable improvements in selected Child Survival (CS) indicators in the 262 villages of East Singhbhum district of southern Bihar. The project, which operates from October 1, 1998, through September 30, 2002, is being implemented by Parivar Kalyan Sansthan (PKS) and Tata Steel Rural Development Society (TSRDS) in collaboration with CARE India and the Government of India. The two main objectives are:

- Improve coverage rates of health practices associated with reductions in infant mortality
- Improve the capacity of community-based operating partners (CBOPs) to make continuous and sustained improvements in those coverage rates of healthy practices.

Although CARE India has had experience working with NGOs (in health and other sectors), this CS project is the first time that CARE India is working with two NGOs that are sponsored by corporations. Results from this first experience will contribute to future efforts by CARE and its partners to promote models of corporate citizenship to advance "health for all" in India.

2. Main Accomplishments

Evolution of the partnership
Each one of the three partners that embarked on this joint undertaking started out with its own strong identity, philosophy, values, strategies and systems. Even though the two local NGOs (PKS and TSRDS) came to this project with their own wealth of resources and well-established infrastructure as inputs, the partners still had to develop new systems and new ways of working in order to engage communities in a participatory (not welfare) approach. For its part, CARE brought its approach to development, to be implemented through the structure of USAID's CS Program. As of the Mid-Term Review, the main accomplishments of this project can be summarized as follows:

Project start-up activities –laying a sound groundwork among CARE, TSRDS and PKS for developing the partnership.
Capacity Building – a wide variety of carefully selected activities was used to help introduce staff (management and frontline workers) to the new content and processes of the project.
Community mobilization – formation of Community-Based Organizations and promotion of their activities; raising awareness and creating demand for health services.
Expansion of Child Survival health services – through NGO-based clinics and Community Health Days.
Early adopters - initial evidence regarding changes in key health behaviors of the early adopters is promising vis-à-vis more widespread behavioral changes by the end of the project.
Linkages with government – Government health staff are becoming more involved in and committed to the project's objectives.
Development of a Child Survival partnership – major improvements have occurred in the interpersonal and inter-institutional relationships over the past two years; TSRDS and PKS are showing signs of a significant shift in their development thinking and operating.

Commitment from NGO management – senior and middle-level managers in both NGOs give high priority to this project.
Ability to adjust to a changing environment – all partners – PKS, TSRDS and CARE - have faced numerous constraints (some common and some individual) and, to a great extent, have overcome them successfully.

3. Overall Progress in Achieving Program Objectives

With regard to the specific CS interventions, major progress has been made (at least 33% or more towards the DIP goal) in six of the ten indicators: receiving three antenatal checkups; receipt of IFA tablets; consumption of IFA tablets; receipt of TT2; initiation of breastfeeding and immunization of children under two. With the exception of breastfeeding, these interventions are among the preventive services being offered to women and children through the NGOs clinics and the outreach activities of Community Health Days.

Much more difficult to change and just as difficult to measure, are the behaviors that mothers do in their own homes, without a health provider present – which correspond to the other four interventions. Results from the MTR either show little change or difficulties in measuring change in the following interventions: preparation of birth plans; use of a modern method of family planning; exclusive breastfeeding; and introduction of semi-solid foods.

MTR results showed that 39% of the women interviewed were aware of a CBOP operating in their village; 16% of these mothers reported some participation in CBOP activities and another 16% reported active participation. Given that the formation and development of CBOPs has only been underway for the past 18 months, these results are quite promising. Community mobilization and organization is a critical and difficult initial step in CS projects. PKS and TSRDS had little experience in these areas prior to the project, thus the considerable progress to date reflects very well on their institutional capacities.

4. Main Constraints, Problems and Areas in Need of Further Attention

The big challenge for the project is to turn the increase in awareness and knowledge into changed behaviors. For the most part, the difficulties being faced in this project are common to other CS projects. Behavior change is difficult to effect and the systems needed to facilitate this are complicated as well -i.e., working with community groups and keeping them engaged in health issues; understanding barriers (e.g., resource constraints; other family members) and helping mothers resolve them; training project staff how to be effective facilitators and trainers at each level of organizational structure; learning how to assess community groups in order to phase out at an appropriate time; and learning how to monitor the whole process in as streamlined a manner as possible.

In addition to the CS-type constraints noted above, this project has also faced other difficulties. The systemic human resource problems plaguing CARE India have affected this project, e.g., in its ability to produce a coherent and streamlined health monitoring system. While the CARE Jamshedpur CS team is understaffed, they have had too many visitors. This latter constraint is a result of the high expectations placed on this project to produce a model for working with

corporate sector NGOs. Still other constraints emanate from the corporate systems of the NGO partners, given their focus on vertical structures for communication and decision-making.

5. Summary of Capacity-Building Effects of the Program

The capacity building approaches of this project have had a significant impact on the evolution of developmental thinking and practice among the implementing NGOs as well as CARE.

- NGOs have shown significant shift from welfare (service delivery) to empowerment (behavior changes at the household level).
- NGOs have started recognizing and acting on the importance of partnerships and networking with the government, local NGOs and communities for sustainability of services.
- CARE is learning about Indian corporate culture and working systems and how these can be productively engaged for community development purposes.
- CARE has been able to test many of its macro strategies in this project in a controlled environment. This project serves as a type of efficacy trial for CARE, since these corporate partners can provide fairly steady and high quality services and supplies, which in other CARE projects are almost completely dependent on governmental resources.
- This CS project, unlike the majority of CARE India's activities, is not integrally connected with ICDS. As it is not food-based, this experience is breaking out of a decades-old approach that CARE and the government have traditionally taken towards improving health services and community empowerment for health in rural India.

6. Summary of the Prospects for Sustainability

Progress towards sustainability is evident on a number of fronts. Examples of behavioral sustainability are the willingness of communities to participate and the presence of early adopters. At the village level, the CBOPs that have been formed are raising awareness about the project's services and messages, creating community funds and forming linkages with other development schemes. With regard to CARE's implementing partners, they have shown tremendous progress as far as embracing the shift towards a more developmental approach in their thinking and operating. Some replication efforts have been undertaken in limited areas of both Potka and Patamda, through the work of other local NGOs. Strategies for increasing the government's role in sustainability are being promoted through specific events such as joint planning and facilitation of ANM and AWW participation in village-level activities such as clinics and Community Health Days. Financial sustainability is being explored by levying user fees on project services in one block. Although all of these examples are promising, these efforts will need constant support, monitoring, and adjustment as necessary and expansion to a greater number of villages before they can represent a significant force. Results from the MTR suggest that this is possible by the end of the project.

7. List of Priority Recommendations

For CARE India, in its role of supporting CARE Jamshedpur

Regarding program management:

- Allow the local staff (all partners) to focus more on program implementation and meeting CS objectives rather than on building a model for corporate NGO partnerships
- Re-evaluate all future visits to the project in terms of *support* to the project, not *attention*
- Review, revise and streamline HMIS to make it a more viable management tool

Regarding human resources management:

- Enlarge the CARE Jamshedpur CS team so that three, full-time employees work on the project

Apply CARE's own expertise to this Child Survival project:

- Review and apply relevant findings from INHP Mid-Term Review with regard to health monitoring information system, health communications and IEC materials
- Apply internal technical assistance from CARE's Reproductive Health Unit

For the three implementing partners – CARE-PKS-TSRDS

To continue to build their partnership:

- Identify issues that need more transparency (e.g., materials development) and reach consensus on mutually-acceptable norms for these issues
- Reduce the use of development jargon, in speaking and writing

Provide capacity building activities to relevant staff in:

- HMIS; community mobilization and development of CBOPs; development and use of a wider variety of IEC methods and materials; counseling; birth spacing; supportive supervision

To increase coverage and promote sustainability:

- Community Health Days – review rationale, design and implementation strategies
- Linkages with government – continue and expand efforts to engage in mutually-supportive joint planning, problem-solving and sharing of credit
- Local private health care providers (*khabiraj*) – develop effective ways to engage their support for the project's objectives

Many of the key aspects of this summary are also presented in Annexes E and F, respectively, through charts that present "What is working well?" and "What is not working so well?"

B. ASSESSMENT OF PROGRESS

1. Technical Approach

1.a. Brief Overview

This CS project is unique to CARE India with its partnership with two corporate sector NGOs, i.e., Parivar Kalyan Sansthan (PKS) and Tata Steel Rural Development Society (TSRDS). Project implementation is taking place in two blocks of East Singhbhum district in southern Bihar, near the city of Jamshedpur. PKS is working in 100 of the 252 villages of Potka block, while TSRDS is working in all 162 villages of Patamda block. PKS and TSRDS are well established NGOs with considerable past experience in health program implementation, especially in the provision of curative services.

During the period May – September 1999, both PKS and TSRDS introduced the concept of field-level clinics to increase the availability and accessibility of the key health interventions included in this project. For PKS, their 13 clinics in Potka were first operated once or twice weekly to cover their 100 villages and now they are being gradually reduced to fortnightly. In Patamda, TSRDS initiated 20 clinics, operating weekly or fortnightly, to cover the entire block.

In addition to the NGO management staff who are assigned part-time to the project, the implementation is carried out through 27 full time Child Survival Project Workers (CSPWs; predominantly men) in TSRDS and 18 Community Based Workers (CBWs; all women) and nine Field Extension Workers (FEWs; all men) working for PKS. The project aims to improve coverage rates and household-level behaviors in four areas: antenatal care (ANC), immunization of children under two, breastfeeding and birth spacing. The processes and activities through which the project engages communities in these interventions include:

- community mobilization through community-based operating partners (CBOPs) (predominantly mahila mandals, but also small local NGOs and individual volunteers);
- creation of demand and provision of services for ANC, immunization and birth spacing services through regularly-scheduled NGO-run clinics in rural areas; and
- development of linkages with government health providers, especially for preventive services to be delivered through Community Health Days.

1.b. Progress by Intervention Area

For the overall purposes of this Mid-Term Review, CARE undertook two separate, yet complementary activities. An external consultant coordinated a participatory qualitative assessment that involved key members of the management staff of PKS, TSRDS and CARE. The second component was a quantitative survey, for which CARE employed the Social and Rural Research Institute (SRI) - a specialist unit of Indian Market Research Bureau (IMRB). The two activities (quantitative survey and qualitative assessment) were implemented in July 2000, but not in the same villages on the same day (for more details on all MTR methods, see Annex C).

The SRI teams visited 10 villages in each block and interviewed only mothers with children under two years old - - 105 mothers in Potka and 102 mothers in Patamda. To supplement this work, the NGO, CARE staff and external consultant visited eight villages (four in each block) and interviewed a total of 109 persons (or groups), among them mothers, NGO field and clinic staff, ANMs, AWWs, village opinion leaders and CBOP members. Additional interviews were conducted with GOI Bihar MOH staff, and the management staff of TSRDS, PKS and CARE. For the purposes of this report, the term "MTR team" refers to those individuals who conducted the qualitative assessment.

Based on their own experience with the project and results of the field visits, the MTR team reviewed the performance of each intervention and explored reasons why they were or were not progressing well. Those deliberations were used to form the initial set of Conclusions and Recommendations and to aid in the interpretation of the quantitative results when they became available (July 25, after the MTR team completed their work in Jamshedpur). Thus, the external consultant performed the task of combining the quantitative results with those from the qualitative assessment in this document. Subsequently, the implementing partners – TSRDS, PKS and CARE – reflected further on the consistency of these two sets of results in the process of developing their joint Action Plan.

Progress Related to the Four Intervention Areas

The following discussion of progress in each intervention area uses data from the quantitative survey (with comparisons to the baseline results, if available, and DIP goals) and results from the qualitative assessment. Although the quantitative survey explored many dimensions of outputs and behavioral outcomes, the discussion below focuses only on the overall results for those 10 outcome indicators presented in the DIP, without making internal comparisons between PKS and TSRDS.

1. Maternal nutrition, antenatal care and safe delivery

Antenatal care (ANC) refers to pregnancy-related health care provided by a doctor or health worker in a medical facility or at home. ANC comprises health check-up, advice regarding correct diet during pregnancy, provision of Iron-folic acid (IFA) tablets and Tetanus Toxoid (TT) immunization.

Results:

Antenatal checkups

Indicator: % of women who receive at least 3 antenatal check-ups by delivery		
Baseline Survey	**MTR-Quantitative Survey**	**DIP**
30	41**	50

**Significant difference between baseline and MTR at 99% level of confidence

Receipt of IFA tablets

Indicator: % of women who received 100 IFA tablets (or more) by delivery		
Baseline Survey	**MTR-Quantitative Survey**	**DIP**
8	36**	60

**The figure 36% is the sum of results from two sub-categories, i.e., those women who received 100-119 tablets and those who received 120 or more tablets. The significant difference between baseline and MTR at 99% level of confidence occurred in the sub-category of women who received 100-119 tablets.

Consumption of IFA tablets

Indicator: % of women who consumed 100 IFA tablets by delivery		
Baseline Survey	**MTR-Quantitative Survey**	**DIP**
8	36	50

Receipt of TT2

Indicator: % of women who received TT2 by delivery		
Baseline Survey	**MTR-Quantitative Survey**	**DIP**
25	52**	60

**Significant difference between baseline and MTR at 99% level of confidence

Preparation of birth plans

Indicator: % of women who prepared a birth plan for a safe delivery		
Baseline Survey	**MTR-Quantitative Survey**	**DIP**
See text below	See text below	50

There are a total of seven different components of the safe birth plan. Results show that the percentage of women who had no components planned were 57% at the baseline and 58% at the MTR. One explanation for the apparent "no change" in this indicator is that the concept of birth plan is new and the phrasing in the quantitative survey might have introduced some confusion during questioning on this topic.

The quantitative results above are consistent with those obtained during the qualitative assessment. The ANC components that are improving the most dramatically are those which are dependent upon an external supply, e.g., the checkups and their accompanying TT injections and IFA tablets. The qualitative assessment also identified that *awareness* has improved for nutrition during pregnancy and that women report they are reducing the typical delay in starting to consume food after delivery.

Consistency between the two survey activities also exists regarding the fifth DIP antenatal outcome -results show no progress in encouraging mothers to develop a birth plan to deal with potential contingencies at the time of delivery. Discussions during the qualitative assessment revealed difficulties in pregnant women's ability to take rest during pregnancy and to increase their food intake during pregnancy and lactation.

2. Breastfeeding

Results:

Initiation of breastfeeding

Indicator: % of infants who are put to the breast within 8 hours postpartum		
Baseline Survey	**MTR-Quantitative Survey**	**DIP**
65	73	80*

*Note: the original DIP indicator was 65%; but after the baseline revealed 65% for this indicator, the goal was increased to 80%. However, the revised DIP (October 31, 1999) mistakenly includes the same figure, 65%, for the goal.

The project has progressed half-way towards the DIP goal of having 80% of the women give colostrum to their newborns within the first eight hours after birth. Findings from the qualitative assessment support this positive trend in that women reported giving colostrum to their latest child and often sooner than the penultimate child. The quantitative survey did not explore the issue of pre-lacteal feeding practices, but during the qualitative assessment, some change was noted in the prevalence of pre-lacteal feeds. This change is particularly successful where mothers can be convinced to modify their cultural practice and only wet the newborn's lips with goat's milk instead of giving a pre-lacteal feed. Nevertheless, project staff are well aware of the challenge faced in encouraging mothers to give up pre-lacteals prior to giving colostrum and the larger issue of convincing them that they have sufficient breastmilk to breastfeed exclusively, without the need for additional liquid of any kind.

Exclusive breastfeeding

Indicator: % of infants who are exclusively breast fed for 4 months		
Baseline Survey	**MTR-Quantitative Survey**	**DIP**
See text below	See text below	40

The baseline survey did not provide this indicator. For the MTR, the results are available for those children who were under four months of age at the time their mother was interviewed. All were breastfeeding and none was receiving any semi-solid foods at the time. However, 17% of the infants were also given water and 12% were also given another type of milk. Although these results show clearly that giving other liquids (besides breastfeeding) before four months is still a fairly common practice, it is not possible to compare these findings directly to the DIP indicator.

Introduction of semi-solid foods

Indicator: % of infants 6-9 months who consumed complementary semi-solid foods by age 6 months		
Baseline Survey	**MTR-Quantitative Survey**	**DIP**
See text below	See text below	75

The baseline survey did not report on this indicator and the MTR survey explored the weaning foods issue for a number of different foods. MTR results showed the following proportions of infants between 7-9 months consuming these foods:

- breastmilk – 97%; other milk – 11%; curds – 3%;

- soft cereal foods – 71%; fruits – 24%; yellow fruits and vegetables – 14%, green leafy vegetables – 34%;
- meat, fish, poultry – 21%; eggs – 13%, pulses – 37%
- sugar – 26%; fats & oils – 24%

It is difficult to draw specific conclusions to compare against the DIP indicator because the data collected refer to the present, while the DIP indicator refers to the situation of the child at six months of age. As expected, the highest rates of consumption are for liquids and soft cereals. The bigger challenges lie in convincing mothers of the need for giving their infants foods from the other groups and helping them to incorporate these foods into their daily routine of child care.

3. Immunization of children under 2

Results:

Immunization coverage

Indicator: % of children 12-23 months old completely immunized by age one		
Baseline Survey	**MTR-Quantitative Survey**	**DIP**
Not available	21	60

Results from the quantitative survey show considerable improvement in immunization rates of specific vaccines for all children under two years of age. The one exception was OPV1 (oral polio vaccine). Nevertheless, the percentage of children who are completely immunized by age one (excluding vitamin A) is still very low (21%) for the entire sample. Notable in the findings is that, on the whole, children are being brought for vaccination much later than that recommended age. One logical explanation for the apparently low coverage is that the clinics started full operation in May 2000 and the quantitative survey was implemented only three months later. Thus, the project continues to face the dual challenges of expanding the accessibility of vaccines to remote villages and maintaining regular schedules in all covered villages so that children can receive the full complement of vaccines. The administration of vitamin A is a fairly new phenomenon and should increase throughout the remaining two years of the project.

4. Birth spacing

Results:

Birth spacing

Indicator: % of non-pregnant, newly married women using a modern spacing method		
Baseline Survey	**MTR-Quantitative Survey**	**DIP**
9	11*	25

*Note: These results of this question on the quantitative survey showed that 8% of the women used wild herbs as a spacing method and 3% used homeopathic methods. These two categories were not reported in the baseline. Nevertheless, they are not considered modern methods and therefore these results are not included in the 11% figure shown above for the MTR.

All the NGO staff participating in the qualitative assessment agreed that, on the whole, the birth spacing intervention is proceeding the most slowly, for reasons they could easily articulate, including: difficulty in discussing the subject; need to communicate with both members of the couple; low and/or inconsistent availability of supplies; and rumors about negative results of individual cases.

1.c. New Tools or Approaches

Although CARE India has had experience working with NGOs (in health and other sectors), this CS project is the first time that CARE India is working with two corporate NGOs. In fact, this could be CARE's first experience of this type anywhere in the world. Some of the challenges embodied in this partnership are described below:

- *What is the overall advantage of this partnership compared to other CS projects?*

CARE has had 14 years of experience in USAID's Child Survival Program. Typically, CARE's CS projects work with governments and local community structures. So, which is harder for a CS project – to start from scratch and try to build new systems with the government and community **OR** start with two well-established and functioning institutions and try to change them to further the community development agenda? Consider what a challenge it would be for an NGO to partner with CARE India and to enter into that partnership with the objective of changing some of CARE's own deeply held attitudes, principles, institutional jargon and in-grained way of doing things!

- *How has the partnership begun to work together?*

The partnership has had to address change on two levels: at the institutional level as well as the household level in the intervention villages. The institutional changes which need to occur in the two local NGOs in order to make this project a success are a *prerequisite* for any other achievement along the way. Just as importantly, CARE has had to modify its expectations of NGO behavior to work effectively with two seasoned NGOs and their respective corporate management systems and practices.

- *Where can this partnership expect to be by mid-term?*

The partnership is fortunate to have enormous resources; the two NGOs are well known, experienced and well-respected, and bring highly professional and sophisticated staffs. The partnership will take a different route in this CS project, but the hardest challenge –with this project as with *all* CS projects- is how to interact at the village level to introduce and nurture the desired changes towards more healthy behaviors for mothers and children. The goal of changes in behavior at the household level, must remain the focus of the partners in spite of the potential to become distracted by the fact that this is a novel venture.

- *What are the unrealistic expectations associated with the partnership?*

CARE has developed this unique project with its characteristic enthusiasm and optimism for success. However, for the first time, CARE is facing the challenges of working in CS in rural Bihar (also see section D. OTHER ISSUES) plus the unknown challenges of developing a viable, productive and efficient relationship with *each* NGO partner, and among the group of three

institutions as a whole. Thus, the MTR provides a critical opportunity to reflect on all of the promises in the DIP and identify those which seem to be unrealistic for the resources (time, budget, staff) of the current project. The DIP not only includes goals in terms of progress for specific health indicators (discussed above in section 1.b), but others that warrant explicit reference and discussion as well. Some examples follow.

1) Enabling sustainable and capable institutions (DIP, p. 11)

The penultimate indicator in this list is: "Increased number of new NGOs replicating components or committing to social development activities."

TSRDS and PKS are identifying some NGOs (typically smaller than TSRDS and PKS) in Potka and Patamda that are beginning to make a major contribution to community mobilization and expanding and replicating the project's health services. These types of efforts should continue. However, *it is premature* for CARE to seek to identify other corporate NGOs (such as within the Tata Group) that are potentially capable of replicating the CS partnership as it is currently underway with PKS and TSRDS. CARE needs to focus its efforts on the *current partners* so that they can meet the CS goals.

The final indicator is this list is: "NGO practices adopted and applied by CARE to other corporate sectors."

While this indicator is appropriate for this type of partnership endeavor, it is unrealistic that it can be successfully achieved *within the first four years* of this project. In addition, while the results of this project will definitely *contribute* to CARE's new and evolving strategy for working with corporate sector NGOs, this strategy cannot be expected to be based solely on this one project. In developing this strategy, CARE needs to be very explicit within its own organization about how the strategy will be marketed, to whom and by whom, with what timeline (CARE's and other corporations), and on what terms, e.g., will grants be provided to the NGOs? If so, how much? By whom?, etc.

2) Policy Sustainability (DIP, p. 35)
"CARE will utilize lessons learned from this project to benefit the 937 blocks in the country where the large-scale INHP project is operational". While CARE has the obligation to adapt and apply new successful approaches from the CS project to all of its work in India, where relevant, it is unrealistic to project (as the DIP does) that this will happen in *all* 937 INHP blocks.

3) Business Plan for Sustainability of NGO Outreach Clinics (DIP, Annex E)
This Annex discusses plans to improve the financial viability of the 25 NGO outreach clinics in the project area. While this initiative is certainly worthwhile, *it practically constitutes a project in itself.* The resources of the four-year CS project are not adequate for seriously engaging in the types of activities described in this Business Plan.

2. Cross-cutting approaches

The discussion below focuses on those process outcomes that are presented in the DIP and specifically the four outcomes whose status at the end-of-project is expressed in numerical terms. The two remaining DIP outcomes, i.e., "NGO performance against plan" and "NGO practices institutionalized by CARE" are discussed in other sections of this report.

2.a. Community Mobilization

Activities undertaken in community mobilization and progress noted by the time of the MTR include:

1. Formation and development of women's groups (CBOP) as evidenced by
   - Regular meetings with or without projects grass root level functionaries
   - Norms of the group developed by them with little inputs from outside
   - Members of the group participating in organization of clinics and community health days
   - Funds being collected by the group as individual contributions by members of CBOP
   - Members keeping their own records about their community health funds
   - Funds being generated by CBOP by collecting users fees for services in the clinics in certain areas
   - Funds being dispersed without any disputes
   - Groups being linked with other schemes
2. Contributions from communities for clinic and community health days in form of space and food provided for the functionaries during CHDs (at certain places)
3. Communities are aware of role of project functionaries (CBW & CSPW) in promoting project messages.
4. Services (especially clinics) are attracting women from distant villages
5. Community demand for services is picking up, leading to initiation of informal community surveillance mechanisms, e.g., some CBOPs demand and report to the block if the ANM does not come for the CHDs

Additional results about community mobilization are provided by the quantitative survey and discussed below.

Presence of active Community-Based Operating Partners

Indicator: % of villages with active CBOP (individual or community group)		
Baseline Survey	**MTR-Quantitative Survey**	**DIP**
See text below	See text below	75

Neither the baseline survey nor the MTR survey reported on this indicator as such. However, the MTR provided results showed that 39% of the women interviewed were aware of a CBOP operating in their village; 16% of these mothers reported some participation in CBOP activities and another 16% reported active participation. Although TSRDS and PKS have been involved in CBOP formation for some time (TSRDS in Patamda and PKS in other blocks), the CS project's messages are new to the CBOPs. Given that TSRDS and PKS have only been

promoting these messages with the CBOPs for the past 18 months, the MTR results indicate a strong beginning. Formation and development of CBOPs is a major job activity of the project's frontline workers (27 CSPW who work with TSRDS; 18 CBWs and 9 FEWs with PKS) as guided by the NGOs' Block Coordinators and Project Officers. Among the first goals that these frontline workers have with CBOPs is building awareness among the communities regarding maternal and child health issues and creating a demand for the services provided by the project. Findings from the qualitative assessment pointed to the high degree of motivation and personal behavior change manifested in their performance. These frontline workers have a considerable number of villages (262) in their area of responsibility and by the time of the MTR, it was evident that they are making progress in becoming known by name in their villages.

Two specific activities around which communities are being organized are the creation of community health funds and Community Health Days. Results from the quantitative and qualitative assessments related to these activities are presented below.

Presence of community health funds

Indicator: % of villages with community health funds for emergencies & drugs		
Baseline Survey	**MTR-Quantitative Survey**	**DIP**
See text below	See text below	50

There were no community-managed health funds for emergencies and drugs at the beginning of the project. This indicator was not assessed directly at the MTR. However, when mothers were asked what they knew about the CBOP's activities, none of them mentioned this component explicitly, although this component may have been implied by those who responded that the CBOP's activities are to "motivate people to avail themselves of services provided by the project".

Community organization and mobilization are slow processes that must be handled very thoughtfully and sensitively, especially in villages where literacy is low and demands on adults' time for managing their families' basic survival are high. Results from the qualitative assessment show that the CBOPs that have formed are accepted by the community, and are now becoming more focused on health issues. Some CBOPs have started working for disseminating messages for behavior changes and service utilization. And, in certain areas, community funds are being generated and used for health purposes.

Implementation of institutionalized monthly health days

Indicator: % of villages with institutionalized monthly health days		
Baseline Survey	**MTR-Quantitative Survey**	**DIP**
See text below	See text below	75

Community health days did not exist before the project began. For the most part, ANM visits to rural villages were irregular and not according to a mutually agreed upon schedule. At the time of the MTR, only 5% of the women interviewed were aware of a community health day in her village. This low figure is understandable due to the fact that CHDs were just beginning to be discussed, organized and implemented before the MTR. CHDs require considerable

coordination among the NGO, ICDS and MOH staff for their external inputs. The activity's ultimate success, however, will be dependent on community participation and ownership.

Better known are the NGO clinics that PKS and TSRDS have been implementing in their operating areas. Of the MTR mothers interviewed, 42% were aware of these clinics. The two most commonly-cited activities at the clinics were ANC (81%) and immunization (78%). As noted during the qualitative assessment, the high acceptance of the clinics is attributable in large part to their high quality and well-organized services and record keeping.

On the whole, community mobilization is happening around the initial project activities. Difficulties regarding community mobilization well are as follows:

1. There is some confusion about the funds being collected by CBOP in the clinics (Potka). Therefore, there is a need for more transparency and community buy-in.

2. The strategy of CBOP has a lot of promise; however project leaders need to be more realistic in their expectations from CBOPs and their own NGO field staff in working with them (i.e., concentrate more on quality of CBOP development and less on numerical targets).

3. Community Health Days related concerns
   - Their ownership amongst community members
   - Commitment for implementing it among project leaders
   - Monitoring plan and supportive supervision for CHDs (NGO, govt. and community)

2.b. Communication for behavior change

Working for behavior change at the community and household level has been a new challenge for TSRDS and PKS. The NGOs are in the early stages of learning the underlying concepts of behavior change theory and how to apply these to effect new, positive and lasting behaviors in their implementation areas. Quite understandably, the approach to date has been directed towards the initial steps of increasing awareness and attracting mothers to health services for themselves and their children under two. For the remainder of the project, the challenge is to not *only* sustain these gains in awareness and coverage, but to bring about individual behavior changes in the target group, especially within the household, and entire normative changes in communities.

Qualitative achievements in the area of communication for behavior change, as noted in the MTR, include:

1. Project messages are reaching mothers through a variety of channels. Examples of the channels being used for dissemination of messages include:
   - ✓ wall paintings by commercial artists depicting project messages (Patamda),
   - ✓ wall writings of project slogans undertaken by communities (Potka)
   - ✓ a video show (Patamda),
   - ✓ handbills,
   - ✓ street theatres,

- ✓ audio cassettes,
- ✓ mother and child health cards,
- ✓ organization of health fairs (known as "melas") ,
- ✓ information dissemination sessions for participants while waiting to see doctors in the clinic,
- ✓ health education sessions during community health days,
- ✓ health education during meetings of CBOPs, and
- ✓ some limited one-to-one counseling during home visits .

2. The accuracy, completeness and consistency of project messages given by project staff (CSPW, CBW) and to a limited extent by CBOP members is indicative of good initial training as well as training refreshers and supportive supervision.

3. Blending cultural beliefs with healthy behaviors. The qualitative research activity provided excellent clues about the barriers to practice, points of resistance and key persons who influence decisions. One example of how this research is being put into practice:

Project staff have identified necessary compromises for adoption of project messages so that they do not conflict with prevalent cultural practices within the community – one excellent example is the message that instead of giving the newborn goat's milk (as per custom), just put a drop of goat's milk on baby's lip.

   More of these types of compromises need to be captured (where they already exist) or developed (where needed) and disseminated, using the recommendations of the qualitative research.

4. Use of role models. There are already many examples of early adopters, i.e., those persons who have quickly accepted and practiced the new behaviors promoted by the project. These early adopters, in the communities and among the project functionaries, can help their peers identify barriers to adopting the new practices.

Areas that need attention for the remainder of the project include:

1. The language used for **written** communication needs to be reconsidered. The overall low literacy levels in rural villages of Bihar (13% for adult women) demands that materials for village use be primarily pictorial, especially for counseling purposes. As for other persons, their comfort and ability in Hindi or Bengali need to be taken into account when determining which language to use in written communications.

2. The language used for **verbal** communication is a separate and equally important issue, especially at the village level. Project functionaries should be careful in assessing language facility in Hindi, Bengali, Santhali, or other tribal languages for different groups and finding translators as necessary.

3. The project needs to address its efforts to developing tools for measuring actual changes in behavior and then apply these tools in the field. Currently, the data gathered are highly focused on the delivery and use of services with little attention to tracking actual changes in behavior.

4. Application of additional findings from the qualitative research, with modifications in the BCC plan. For example, the qualitative research has shown that pregnant women often go to traditional local healers (*Khabiraj* or Rural Medical Practitioner [RMP]), and therefore there needs to be a concerted strategy to address this group of health providers .

5. Counseling versus Messaging: The word "counseling" has been accepted by the project as jargon such that almost every interaction is labeled "counseling". Most of these interactions are really lectures given to groups (CBOPs; mothers waiting in clinics) or messages delivered to individual mothers. Project field staff need to help all community change agents (CBOPs, dais, etc.) learn how to identify individual (and group) barriers to adopting the new behaviors and how to develop feasible and acceptable options.

6. IEC vs. BCC: Information, Education and Communication (IEC) is now being replaced in some project documents and in verbal communications with Behavior Change Communication (BCC). Project staff need to clearly understand the definitions of these two complementary concepts and to be very careful in their use of these terms (or their acronyms) with non-project staff and especially with villagers.

7. Multiplication of project messages: Results to date show that project messages are only just beginning to reach the key population via current strategies. Therefore, project staff must develop ways to disseminate the messages more widely and more often throughout participating communities. For example:
    - Each month, each CBOP member can be asked to reach out to five other women (e.g. her daughters, mother, mother-in-law, extended family members, neighbors) and then report back at the next CBOP meeting;
    - Pregnant women who are familiar with the project messages can be asked to carry and disseminate these messages if they travel to their mothers' villages for the birth of their children;
    - IEC activities (such as those listed at the beginning of this section) that are already being used need to be used *more* often and by *more* people who are disseminating project messages and in *more* villages; and
    - Additional IEC activities need to be added to those above.

In sum: The big challenge for the project is to encourage real gains in awareness and knowledge to be turned into changed behaviors. For example, according to project functionaries, many mothers identify barriers (resource constraints; other decision makers) that they find insurmountable to adopting the new behaviors. Project staff will benefit

from training in methods such as "Trials for Improved Practices" (TIPS) or "Positive Deviance" to equip them in helping mothers address their real concerns*.

2.c. Capacity building

Capacity building activities have encompassed a wide variety of structured trainings (see section C.2), informal interaction among groups (such as at monthly meetings) and one-to-one and "hands on" events (such as the MTR). By the Mid-Term Review, these activities have already produced a series of specific achievements and learnings across the entire spectrum of stakeholders.

Strengthening the PVO Organization - What CARE Has Learned

Corporate NGOs are a special type of NGO, so CARE cannot necessarily apply the same approaches it has used with other NGOs in India nor in other countries. It is a very different mindset for CARE to be working to modify and support the agenda of another institution (i.e., corporate NGOs) as opposed to finding other institutions to support CARE's agenda. CARE has learned that it needs to test its initial assumptions about the specific partners with whom it plans to work, as they all cannot be lumped into the general category of "local NGO".

This MTR has shown CARE that it cannot let the novelty of working with corporate NGOs replace a careful assessment of basic project management needs and ways to address these in a timely and satisfactory manner.

The high level of sophistication, interest, enthusiasm and capability of corporate partners to learn may be greater than CARE's ability to respond in a consistent manner given the resources of the current project.

Strengthening Local Partner Organizations

During the MTR, specific indicators of changes in the two local NGO partners were articulated

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* TIPS is a method designed for identifying, understanding, and addressing the reasons why mothers are unwilling and/or unable to adopt a new practice and then, through a trial and error process, determining a mutually satisfactory modified behavior that achieves the goal of the original new behavior being promoted. The concept of positive deviance is employed when project staff identify those community members (usually women), who, despite great limitations and constraints, are able to adopt the new behavior. Then these women, and the strategies they use, are promoted as positive examples in the community.
References:
For Positive Deviance:
Sternin M, Sternin J , Marsh D. *Designing a Community - Based Nutrition Program Using the Hearth Model and Positive Deviance Approach - a Field Guide.* Save the Children 1998; 85 pages, available in English only.
For TIPS:
Dickens K, Griffiths M , Piwoz E. *Designing by Dialogue. A program planner's guide to consultative research for improving young child feeding.* Prepared for the Health and Human Resources Analysis (HHRAA) project by SARA /AED 1997; 334 pages, available in English and French.

in terms of their:

Evolution of development thinking

1) Moving from a welfare (service delivery) to an empowerment approach (e.g., putting less focus on clinics, more on Community Health Days)
2) Becoming aware of the need for and difficulty in bringing about true behavior change in villagers' lives
3) Being concerned for sustainability of these new behavior changes and embracing community-level sustainability as a key programming principle
4) Appreciating the need for partnerships and networking, e.g., willingness to work on creating linkages with MOH to increase services and decrease dependence on the NGO; they know and recognize that government services can be sustainable and therefore they now try to support them where they exist
5) Expanding their understanding of their role from primarily being contributors to the public relations needs of their parent corporation to now seeing that they can be good development practitioners *as well*
6) Talking explicitly about behavior change, especially their own since joining the project
7) Being comfortable with the concepts of community development, for example discussing the four aspects of sustainability – a completely new topic for them

Evolution of development skills

1) Application of qualitative research techniques to developing their understanding of project populations
2) Application of qualitative research techniques to the MTR
3) Ability to serve as effective MTR team members in making observations and drawing conclusions from both project areas (their own block and the other block)
4) Willingness to share information and resources with one another; change in attitudes toward each other
5) Taking increased ownership of the project
6) Replicating tools, approaches, concepts from the CS project in other activities of their NGO

Capacity building of government staff

Government officials in Bihar work in an environment characterized by inadequate physical infrastructure and minimal support. Within this context, lack of mobility, high transfer rates, irregularity in salary/stipend disbursement and lack of regular supplies are the major constraints. Along with the work overload, constantly changing governmental priorities create a most challenging working environment.

The majority of government functionaries interviewed are appreciative of the project. As a result of their participation, they have learned the importance of joint action planning, and the need for micro-planning, regular monitoring and focusing on fewer issues. Government health officials at different levels (district, block) also serve on committees that have been established to plan, monitor and support progress of the project. On the whole, government health officials with

responsibilities for Patamda and Potka blocks would welcome even greater interaction with the project's activities.

On the negative side, certain concerns about sharing of credit and statistics about service delivery from the project have the potential of adversely affecting the relationship with government officials, and hence, need to be watched and addressed. Project staff, and particularly those who work at the block level and community level, can improve linkages with government by maintaining transparency, communicating more frequently and committing themselves to joint planning and monitoring of activities. As these types of collaboration increase, it is critical for all stakeholders involved to have a clear understanding of their own roles and responsibilities and those of everyone else involved.

Overall constraints faced in capacity building efforts to date include:

- Environmental factors such as transfer of trained government staff (prior to the MTR, 60 ANMs were transferred from the project area *all at once*) will result in loss of time whereby the new arrivals will have to be introduced to the project activities and motivated to participate actively.
- While the project's capacity building activities have reached to the level of grass root level functionaries (CSPW & CBW), the transfer of skills from them to members of CBOP is sub optimal.
- The transfer of knowledge and skills in the technical aspects of the interventions has been fairly successful throughout the NGO staff hierarchy. More difficult is the design and conduct of training related to increasing skills in communications and community mobilization. This is the area where CARE and the senior management of TSRDS and PKS need to review their progress to date and reinforce and expand their efforts.
- Grass roots level functionaries have significant differences in their levels of performance. Pairing them for specified duration will facilitate peer learning.

In conclusion, bringing three different institutions together to work on a CS project is an ambitious endeavor. USAID's Child Survival program could even be considered a fourth institution, in that it has 14 years of experience as of the beginning of this project in 1998. Over the past two years, CARE and its two NGO partners have taken a course that has confronted some basic institutional issues from the macro- to the micro- level. To their great credit, the partners have given these issues the priority they deserve so that they can work effectively towards the shared CS objectives in Patamda and Potka. These issues can be summarized as:

***Philosophy*:** corporate welfare vs. community development; how to make the switch.
Content: project management skills (e.g., development of indicators); upgrades on technical interventions; ways to engage NGO staff and communities in the development process.
Process: linkages with government; "horizontal" communication as well as vertical; looking outside of one's own agency for answers, especially looking to the other partners; it may be easier to "do it yourself", but this will not promote sustainable change in the long run.
Results: what can truly be expected at the village level by individuals and by communities as a whole; behavior change can happen at different levels, including among the NGO staff themselves.

2.d. Sustainability

Progress towards various components of sustainability was evidenced by the time of the MTR through the following examples:

1. Policy sustainability
   - Convincing the corporate NGO partners that sustainability is an important consideration, through their participation in the project
   - NGOs showing interest in developing community ownership of the project's activities
   - NGOs developing an understanding of the concept, helping the field staff to understand and appreciate it and implementing specific activities in the field to promote it

2. Institutional sustainability
   - Helping the community-based organizations develop management skills
   - Helping CBOP members to develop tangible shared interest and commitment amongst themselves, e.g., creation of a community fund, linkage with income generation activity, linkages with agriculture activities.
   - Helping CBOP to develop linkages with other governmental and non-governmental developmental schemes
   - NGOs developing an appreciation for the role of the government and ability to work with the government as a partner
   - The project has attempted to institutionalize CHD by joint planning with MOH and getting government circular issued for this purpose.
   - The project has made some progress in linking with government to develop joint action plans that facilitate ANM and AWW participation in activities like CHD and clinics
   - The project has fostered a major shift in thinking for the NGOs, with sustainability subsequently becoming a major discussion point for the project staff.

The comments above relate to CARE's partner NGOs, TSRDS and PKS. As a result of this project's activities, a few other corporate sector organizations have already expressed interest in replication. Given the challenges left for the current project in meeting its DIP goals, it will be advisable to approach the issue of replication with other corporate NGOs very cautiously and not prematurely.

3. Financial sustainability

Of the total budget of $1,655,241, the USAID portion is $850,000 and the contributions from CARE and the local NGO partners is $805,240. The matching contribution from the local NGO partners is as high as 44% in the first year and increases over time to 46% by the end of the project. Given their corporate sponsorship, the NGOs will continue to operate after the project is over. There is already firm evidence that suggests that they intend to continue to promote these CS interventions and strategies on their own. The extent to which this might happen can only be speculated at this point. Another type of evidence of financial sustainability concerns the practice of CBOPs in levying user fees. Finally, if time and resources (absorptive capacity of local implementers) allow, the project may explore possibilities of health insurance through linkages with health insurance companies. If conditions allow, the CS partners could test some

very small-scale activities in this area, based on the positive experience that INHP has had in other parts of Bihar.

4. Behavioral sustainability
In the project villages, there is considerable evidence of increased awareness, knowledge and changes in certain behaviors by the "early adopters" participating in the project. On a community level, there are already anecdotes of individual CBOPs demanding ANMs to come to their villages according to an agreed-upon schedule. Behavioral sustainability is also nurtured by developing alternative funding sources to the PKS and TSRDS-provided services. Examples of such alternatives are the ANM (for ANC checkups and vaccinations) and the CBOP (for the disposable delivery kit [DDK], IFA, guidance).

Areas where sustainability efforts need to be increased:

- Community ownership of the project needs to be reinforced, as currently the communities are generally availing themselves of the services as recipients but they do not control the process. This ownership will be vital for them in order to develop community surveillance mechanisms.
- The project needs to increase its efforts to share its credit and data with government and other stakeholders so that there is no real or perceived competition between or among any group (TSRDS has already initiated this).

Exit strategies

Both PKS and TSRDS will continue their development activities in Potka and Patamda, respectively, after the CS project ends. Therefore, although they will not exit their blocks of operation, they are developing strategies to help them exit from communities that no longer need their assistance. These strategies include:

- Reducing the frequency of clinics (run by the NGOs) and replacing them with Community Health Days (run by communities with government health workers) in more remote areas
- Developing CBOPs to be able to negotiate with government to demand health services
- Learning how to assess CBOP maturity in order to devote NGO resources to more needy areas
- Training other NGOs to replicate project activities

This final strategy is one of the outcomes contemplated in the DIP but was not assessed by the quantitative survey.

Replication of project activities

Indicator: 3 new NGOs replicating components or committing to social development activities		
Baseline Survey	**MTR-Quantitative Survey**	**DIP**
See text below	See text below	3

At the beginning of the project, TSRDS and PKS were operating their clinics in a series of well-defined locations without great concern for the more distant villages. Now, as PKS and TSRDS continue to expand the range of their activities, their growing ability to develop linkages with the

MOH and other NGOs will be even more crucial. Already, AWWs and ANMs are taking active roles in certain areas and some local NGOs (much smaller than TSRDS and PKS) are providing community-specific collaboration in the project area (not assessed by the quantitative survey).

C. PROGRAM MANAGEMENT

1. Planning

The NGO partners have been involved in program planning through developing the proposal, the first DIP and then the revised DIP, and through the monthly and quarterly meetings of the Core Team with CARE's Project Coordinator. All stakeholders involved commented that these meetings have been productive and support the project's development.

Overall, the work plan submitted in the DIP is on schedule with the exception of introducing IEC/BCC materials (for staff, CBOPs and communities) and making revisions in the project's health management information system (HMIS).

The program's objectives are well understood by CARE Atlanta, CARE India staff (Delhi, Patna, JRS) and the Core Team and Block Coordinators of PKS and TSRDS. CARE translated key aspects of the project design (objectives, indicators, etc.) into Hindi for the NGO field staff. For the most part, the frontline workers understand the objectives, although many are understandably challenged by the new community mobilization and communication skills needed to be successful in this project. Some CBOPs and community members are probably confused about the new role that TSRDS and PKS are taking in the community and how this relates to the clinics and Community Health Days they are implementing. Since PKS and TSRDS are well-established NGOs, it is difficult for communities who know them well to understand why they are now talking about phasing out their direct presence in these communities so that they can concentrate on needier and more remote areas.

2. Staff Training

The Annual Report FY'99 details a total of 31 different training events conducted by the partner NGOs during the first year of the project (October 98 - September 99). To these are added the events that CARE specifically designed and implemented on behalf of CARE and NGO participants. Since the onset of the project, the breadth and depth of the training undertaken by and for the staff of TSRDS, PKS and CARE has been quite impressive. Examples of staff training activities and an assessment of their timeliness and benefit are:

External technical assistance received in Jamshedpur:

1) To design project and write proposal (before official start date) – timely and beneficial
2) Preparation of DIP – initial participatory experience was timely and beneficial, even though major revisions were required as a result of the USAID DIP review
3) HMIS (from MACRO) – timely but ultimately not beneficial as many questions remain
4) Community empowerment – timely and beneficial
5) Project management – timely and very beneficial
6) Qualitative research – timely and extremely beneficial

External technical assistance received outside of Jamshedpur (all timely and beneficial)

1) Exposure trip to INHP blocks in northern Bihar (CARE Bihar)

2) Exposure trip to Gadchiroli, Maharastra, to learn new techniques in community-based newborn care (Dr. Abhai Bang)
3) Capacity building in CS technical interventions (CARE; in Delhi; this workshop was voted by CARE's Human Resources Department as the best training event offered by CARE in several years)
4) Training in partnership management (CARE; in Delhi)
5) Training on Integrated Management of Childhood Illnesses (IMCI) in Chandigarh, Punjab
6) CARE's annual international CS Conference (CARE; in Peru)
7) CARE's annual international CS Workshop (CARE; in Bangladesh)

While each one of these training events had a specific focus, they all contributed to increased knowledge and skills in:

Technical content areas – the Core Team trainees rapidly took on the newest concepts and techniques (e.g., in newborn care)
Community development processes – for the most part, the content was absolutely **brand new** to the trainees. They were quite familiar with village life from their prior work in Potka, Patamda and other rural parts of India, but they were not familiar with the concepts of working with villagers on mobilization, participation, communication, non-formal adult education, counseling, and empowerment –all for the purposes of sustainability. By their own accounts and by observations from others close to the project, the NGOs have shown keen interest in and great ability to absorb these concepts in the first two years.
Training methods – Once the Core Team members are trained, they are expected to disseminate that training within their organization. CARE has exposed the NGO partners to some new training methods. Discussions during the MTR indicated that internal cascade training approaches have been *more* successful when focused on increasing awareness and the demand for services and *less* successful when the frontline workers are expected to serve as trainers to help others translate new knowledge into changes in behavior at the household level.

Learnings from all of the above training activities have been shared in different ways within PKS and TSRDS. Both NGOs have regular monthly meetings with all of their field staff. These meetings provide an opportunity to discuss constraints in fulfilling their job responsibilities. During the month, the Block Coordinators and Project Officer spend the majority of their time in the field in direct contact with the field staff under their supervision. The MTR provided an opportunity to assess, in a semi-structured fashion, the performance of the NGO field workers by:

- Observing the community's response to clinics, functioning of the CBOPs and organization of Community Health Days (only started four months ago).
- Talking to mothers at clinics and learning that it was the CSPWs or CBWs who encouraged them to come.
- Hearing comments from the NGO block-level staff regarding their knowledge of the strong and weak performers among the government functionaries, their own frontline and clinic staff, village opinion leaders and CBOP members.

Prior to the MTR, performance of the NGO field workers had been weighted more in terms of reaching physical targets (how many CBOPs organized, how many meetings held) and less in terms of quality of the CBOPs' functioning. The concepts of "capacity building" and "counseling" are new and tend to be attributed to a wide range of interactions with community members. The NGOs realize that qualitative measures and tools are necessary for monitoring community activities and have requested CARE's assistance in this regard. CARE's Maternal and Infant Survival project in Madhya Pradesh has developed some interesting tools for monitoring the growth and development of community organizations and these could be reviewed for potential benefit for the CS project in Jamshedpur.

The MTR provided an opportunity for all partners to assess how far the field staff have progressed and to identify ways in which their initial training can be reinforced and refreshed in the future. Methods for undertaking this follow-up are: more deliberate pairing of field staff, more one-on-one between supervisor and supervisee, refresher training on selected topics and more overall on-the-job training. CARE will work with the partners to determine the sources of technical assistance (from within CARE or external) for continued capacity building in these crucial areas.

3. Supervision of Program Staff

Since CARE's implementing partners are well-experienced organizations, CARE does not become directly involved with supervision of NGO staff. Through review of progress reports coming from the NGOs, CARE has been able to help them determine if weaknesses in reporting are problems with the report itself (inadequate transfer of information) or reflect weaknesses in program implementation (e.g., lack of feedback from one month to the next). TSRDS and PKS have a structured meeting schedule for review of project progress with field staff and senior management. In fact, one of the strengths of this project is the investment that senior managers are making in keeping informed about progress, including frequent trips to the field. The Block Coordinators and Project Officer spend the majority of their time in the field with the CSPWs, CBWs and FEWs and are well-known throughout their implementing areas.

CARE's Project Coordinator role is one of facilitator and catalyst. Both NGOs have requested the Project Coordinator to increase his field visits. Currently, this is not possible due to staff turnover and shortage in Jamshedpur. However, CARE recognizes the value of increasing the opportunities for mutual skills transfer between CARE and the NGO field staff, whether this happens with the current Project Coordinator or a new coordinator of field operations or a combination of both. This need is addressed in the recommendations regarding human resources management.

Given that CARE is extremely interested in this new partnership with corporate NGOs, there has been a constant stream of visitors to Jamshedpur. A rough count (known to be an underestimate) of the number of persons who have visited the project during its first 22 months is no fewer than 25, in almost as many trips. These visitors have included consultants providing technical assistance and also representatives from all levels of CARE management (from CARE USA, CARE Delhi, CARE Bihar (in Patna) and the visits themselves reflect a wide range of need:

some mandatory, some not; some supervisory, some not; some scheduled, some not; some helpful, some not. They *all* have required logistics and programmatic support and almost all resulted in recommendations for follow-up.

This high frequency of visits, coupled with shortage of staff, for a new project trying to find its way in *terra incognito,* is extremely taxing and risks ultimately being counter-productive and detrimental. It is recommended that, for the next six months, that there be no more external visitors to the CS Project in Jamshedpur except visits related to specific recommendations in this MTR. And, none of these visits should occur before the full-time Project Assistant position is re-filled.

1. Human Resources and Staff Management

4.a. Personnel management system

Some of the human resources decisions made by CARE regarding the management of this project have hampered project performance. These include the original projections for project staff (insufficient in number and level) and subsequent decisions to address these insufficiencies. Now that the Project Coordinator is officially taking on the role of the Project Manager, this is a good opportunity to review and revise all job descriptions and staffing requirements. Based on the project's experience over the first 22 months, it appears that three full-time positions are needed to cover the following: one position for project management, macro issues and liaison with NGOs and government; one position for coordination of field-level activities and training; and one position for office administration and support for visitors. The functions of financial management, HMIS and communications with CARE Bihar and Delhi would be assigned to the most appropriate member(s) of this three-person team.

For some time, all of CARE India has been suffering from high levels of staff turnover with the resulting negative effects: e.g., the staff who remain are overworked; key staff time is diverted from program implementation to human resources functions to fill vacancies; many new staff require orientation and training and sometimes there is little time to do it adequately; some questions and issues (particularly coming from the field) get "lost in the cracks" with turnover in CARE's HQ in Delhi. The consequences of these human resource problems, as manifested in the CS project in Jamshedpur, are a reflection of an overall phenomenon plaguing CARE India. These problems are being addressed at the highest levels in CARE India.

4.b. Personnel policies and procedures in place

Even though the staff for the new CS project in Jamshedpur was small, they still needed adequate orientation to CARE India's personnel policies and procedures. This process is still on-going, with support provided from CARE's state office in Patna. The NGO partners are long-established and have their own personnel policies. However, these corporate systems can also present a constraint to the project when they work against the participatory processes CARE is trying to nurture for community development. CARE's NGO partners operate within a corporate environment typically characterized by a strong vertical approach to supervision,

communications and decision making. These systems can inhibit the more participatory approach needed for effecting sustainable changes in health behaviors at the village level.

4.c. Working relationships

One of the notable achievements in this project relates to improvements in the interpersonal and inter-institutional relationships over the past two years. Regular meetings, joint trainings and continued dialogue have facilitated the positive evolution of these relationships. Through the CS project, relationships between the NGOs and local government officials have been established at different levels. Prior to the project, the NGOs had not been used to coordinating their efforts with the government; now they are increasingly aware of and appreciate the importance of these linkages. This evolution in their day-to-day thinking is evidenced by the fact that "sustainability" has become a "buzz word" among the NGO staff.

Corporate NGOs, with their vertical management structures, are not used to the "lateral" sharing and participatory decision making which is common among other NGOs. In this regard, if one of the NGOs does not share its plans (ideas, drafts, etc.) for developing materials and tools to be used in the project, this can have very negative effects –on the partnership spirit, potential misunderstandings in community, and wasted time and resources if the materials have to be redesigned and reproduced (for example, to change from Hindi to Bengali).

4.d. Staff turnover

Staffing issues have been discussed in prior sections. One of the consequences of CARE's being short staffed is that inadequate attention is being paid to linking the CS project with CARE's other projects. For example, CARE is working in INHP in Patamda, yet there was little evidence during the MTR of coordination of communications (INHP and CS) with local government officials and of CARE's overall efforts in southern Bihar. In addition, there is a wealth of IEC materials available from INHP, yet these were not apparently discussed as potential inputs for the overlapping interventions of the CS project. CARE needs to set an example for PKS and TSRDS that it (CARE) is able to learn from itself and optimize its own resources.

4.e. Staff transition to other jobs at end of project

Most of the NGO staff working on this project have job security; although some of the field staff were hired specifically for the project. CARE will not be directly involved in succession planning for any NGO partner staff. As for CARE's CS staff positions, transition at the end of the project will depend on activities in Jamshedpur and vacancies throughout other locations of CARE India's operations.

5. Financial Management

CARE provides funds for capacity building and the two local NGO partners ultimately decide how to use them. PKS and TSRDS manage and account for their own sub-grants from CARE as well as their own matching contributions. They submit audited statements to CARE for the former but not the latter. Since the two partners already had their own accounting systems prior to working with CARE, they needed to make some internal adjustments in order to manage the CS sub-grants and to learn how CARE needed them to report on their matching contributions.

At the time of the MTR, there were no identified problems with the financial reporting from PKS and TSRDS to CARE. On CARE's side, there are several levels of management through which financial information flows –to Patna and then to Delhi. Several issues relating to financial reporting were resolved by a visit to Jamshedpur during the MTR by the CARE Patna accountant. An overall analysis of budget vs. expenditure for the project to date is underway and the results will be available to the Project Coordinator during the week of July 24.

6. Logistics

6.a. Status to date

The NGOs and government are responsible for supplies used in the field, and for the most part, supply problems are not an issue. At the beginning of the project, there were major supply problems caused by a strike of government staff that lasted more than three months. There are a few reports of stockouts of vaccines and some problems with birth spacing supplies in Potka.

6.b. Logistics challenges

Now that the NGOs are focusing more on outreach from their fixed clinics, the question of where to schedule the Community Health Days becomes relevant. Clinics have been located to maximize accessibility for the surrounding villages and to permit the arrival of the NGO vehicle. Since Community Health Days are to be implemented in individual villages, there will need to be a careful assessment of access, especially in the monsoon season. In addition, the NGOs are planning to disseminate IEC materials soon and this will require careful logistics planning. The DIP also forecasts the development of community-based depots for managing contraceptives and other supplies (e.g., disposable delivery kits). The MTR qualitative results suggest that some CBOPs have taken on this activity. When the project is able to focus more attention on the whole birth spacing intervention, then these logistics issues can be addressed in detail for a greater number of communities.

7. Information Management

Staff turnover has also had a negative effect on the development of a user-friendly HMIS for the CS project. At the time of the MTR, the system in place was reported to be unnecessarily

burdensome, especially for the field workers. In order to make adjustments in the current system, CARE needs to study the lessons learned from the INHP MTR.

In the CS context, the NGO partners and their respective community-based partners should manage most of the monitoring activities. Evaluation activities to actually calculate the outcome indicators are done via the Knowledge, Practices and Coverage (KPC) survey for the baseline (required), the quantitative survey at mid-term (optional) and the repeated KPC survey at the end of the project (required). This issue about *how often* to collect data to measure project activities and the outcome indicators for the CSP is the **same** as was found for INHP.

One very positive data collection activity relates to the skills gained in qualitative research. All project staff who participated in this activity found it very helpful in understanding household-level practices and applying these insights to their work.

The issues surrounding the HMIS and suggestions for addressing problems were discussed with CARE Jamshedpur and CARE India (CIHQ) staff. A summary of the HMIS recommendations follows:

- Study the INHP MTR section on monitoring and evaluation
- Determine how revisions in the INHP HMIS can assist the CSP
- Determine what data already being collected by the NGOs is needed for CS purposes; for example, the CSP is not responsible for measuring changes in vital statistics, so if these data are needed, it must be determined where, why and how
- Do not add any new formats or checklists – the net result of this revision should be a total *reduction* in data collected
- Apply the results of these discussions to a review of the KPC survey – many questions are not related to the project's outcome indicators
- Modify the Terms of Reference accordingly for the prospective HMIS consultant

8. Technical and Administrative Support

Technical assistance received to date is listed above in section 2. Anticipated technical assistance needs for the remaining life of the program include:

- HMIS – revise current system; then train all levels of staff
- Community mobilization and promotion of CBOPs – field staff
- Development and use of a wider variety of IEC and BCC methods and materials – for field staff
- Counseling – field staff
- Birth spacing – all levels of staff
- Supportive supervision (including pairing, on-the-job training, modeling) – Core Team and field staff

As discussed earlier, this project has received very high levels of interest and support from CARE USA's HQ (Atlanta), and CARE India's HQ and state office. In fact, this project is probably an exception to the rule in that it has received too much attention, from too many

sources. At this point, *attention* needs to be refocused as *support,* based on the needs of the project, *not* on the curiosity or interest of external audiences.

9. Conclusions about program management

This project's unusual partnership with corporate NGOs has given it quite a high profile within CARE. The attention, however, may have allowed CARE to forget that the project has basic management needs which must be attended to. The typical needs of a CS project seem to have been overlooked in part because the corporate NGOs were already well equipped (highly competent staff, vehicles, infrastructure) and due to the overall fascination and focus on the high expectations of developing a strategy for corporate NGO partnerships.

CARE needs to pay more attention to the fact that this is a CS project with explicit expectations and promises in terms of achieving quantitative changes in four intervention areas. If these intervention objectives and their underlying process objectives continue to be given less priority than the partnership objectives, then CARE will not succeed in this project. Most likely, the second part of the project will be more difficult than the first, for the following reasons. The project has succeeded in raising awareness and making progress in changing some key behaviors. Most progress is related to health services provided directly by the NGOs, supported by the community mobilization efforts of the NGO field staff. The NGOs now see that the more difficult job is ahead in changing household level behaviors with which they do not interact directly. Thus, the NGO management staff and their field staff are now facing the difficult job of effecting change in some very closely-held cultural beliefs and practices. This will not be easy for them and they will need all the help and encouragement they can receive from CARE. CARE cannot afford to be distracted from here on.

D. OTHER ISSUES

There is no doubt that CARE's choice to work in Bihar is based on a sound assessment of need. The socio-economic and health profiles of rural Bihar describe an area of extreme poverty, and therefore present CARE and its partners with an opportunity for making great improvements in the lives of poor families. Just a few examples illustrate the situation: in rural Bihar: 99% of the population reports routinely defecating in the open air; the female literacy rate is 15%; and before the project began, 63% of births were to mothers with *no* antenatal care and measles coverage was 7%. Of all the states in India, Bihar ranks second in total number of polio cases.

This picture of rural life is reminiscent of the general state of health statistics in many developing countries over 15 years ago when USAID initiated its Child Survival Program. Even though USAID, through its cooperating PVOs, has achieved considerable success in improving CS indicators around the world, the blocks of Potka and Patamda have not had the opportunity –until now- to benefit from this progress. Now that CARE, TSRDS and PKS have initiated the Partnership for Sustainable Health Impact project, the odds are much improved for greater availability, access and use of maternal and child survival health services and for communities to take charge of these health services.

In addition to the overall picture of poverty, the project area is highly political. News from Bihar is often carried on the front page of the nation's leading papers. During the MTR in July 2000, Bihar was featured in allegations that a government State Minister had beaten his driver to death and several days later, in reports of killings of religious leaders in the state. Although these types of activities are fairly commonplace in Bihar, there is a more significant issue that is causing political rumblings. The most recent contribution to the generally charged political environment is the legislative resolution passed by the Indian Parliament that divides Bihar into two new states. As expected, this situation is fraught with all the uncertainties presented by such radical political changes, among which are the uncertainties embodied in meeting the long-standing aspirations of communities in this area for separate statehood. The possibility of separate statehood is expected to lead to start up difficulties that could affect the Government of Bihar's support to the project. As it is, the government's fiscal state is quite weak, as in one of the blocks, the grass roots level functionaries have not received their salaries or stipends for a period of seven months.

E. CONCLUSIONS

1. Overall Progress

As of the Mid-Term Review, this Partnership for Sustainable Health Impact project has made considerable progress against its objectives and despite the somewhat excessive expectations derived from this being CARE's first experience working with corporate NGOs. The types of constraints being faced by this project, as noted in the MTR, are not unexpected and are fairly typical for CS projects throughout the world. Sometimes, in other projects, issues such as staff turnover or understaffing become such serious distractions that they are the overriding focus of the MTR. That could have happened in this project, but it did not. The collective ability to work around the constraints, keep on focus and make steady progress is largely due to the competence and commitment of *all* the members of this unique partnership. The MTR noted solid achievement in terms of the specific CS interventions, project support systems and the CARE-TSRDS-PKS partnership.

1.a. The Child Survival Interventions

This discussion is limited to those interventions for which there is a specific DIP indicator. In order to draw conclusions about overall progress, the interventions have been divided into four categories, based on the results of the quantitative survey, as confirmed by the qualitative assessment.

Interventions where progress achieved by the MTR are as follows.

1. At least **half-way, if not closer**, towards the final numerical DIP goal, are:
   - Receipt of TT2 vaccination
   - Receipt of IFA tablets
   - Consumption of IFA tablets
   - Number of health checks undergone during pregnancy
   - Initiation of breastfeeding.

2. Still positive, but **less than half-way** towards the DIP goal, is:
   - Immunization of children under two

3. Negligible, are:
   - Preparation of a birth plan
   - Birth spacing

4. Somewhat difficult to interpret, are:
   - Exclusive breastfeeding (indicator not measured definitively at MTR; qualitative data indicate improvement)
   - Introduction of semi-solid foods (indicator not measured definitively at MTR; qualitative data indicate improvement)

In sum, major progress has been made (at least 33% or more towards the DIP goal) in six of the ten indicators. High quality NGO clinic services has been a major facilitating factor in promoting the project interventions. It is not surprising that five out of six of the most successful interventions (immunizations, IFA tablets, check-ups) are connected to a specific service and/or supply offered by health providers outside the home. Much more difficult to change, and just as difficult to measure, are those interventions that reflect behaviors that mothers implement in their own homes, without a health provider present. Nevertheless, there is anecdotal evidence from early adopters about their positive experiences in embracing the project's messages and new behaviors. These early adopters have great potential for serving as models for the rest of their communities. As of the Mid-Term Review, the interventions in which progress has been documented in this project and the amount of progress measured is impressive given the constraints faced. The results are also consistent with the findings of many other CS projects around the world. Results of the qualitative assessment not only confirm those of the quantitative survey, they also provide insights into why some behaviors are easier to adopt than others.

1.b. Project Support Systems

The NGOs have taken part enthusiastically in a wide variety of activities to increase their awareness, knowledge and skills in the interventions themselves and the cross-cutting approaches for community-based development work. CARE has played a crucial role in ably facilitating these activities, i.e., through exposure visits, external technical assistance, and in-service trainings. As a result, the NGOs are implementing new activities (e.g., Community Health Days) and in new ways (e.g., through linkages with government).

2. Overall Constraints

2.a. The Child Survival Interventions

The quantitative and qualitative results from the MTR reinforced the staff's growing awareness that some of the interventions are much easier to introduce than others. It is not surprising to them that the hardest interventions to introduce are those that are:

- new concepts (e.g., birth planning); or
- complicated processes with deep-rooted beliefs (e.g., pre-lacteal liquids; delay of introducing semi-solids); or
- very sensitive topics (e.g., birth spacing); or
- stretching the family's limited resources (e.g., need for pregnant and lactating women to eat more).

Raising awareness and increasing access to supply-related interventions (ANC checkups, IFA, TT, immunizations for children) is much easier than addressing those interventions where behavior change is needed at the *household level* and where other family members can exert their influence. The NGO partners are now beginning to see the difference in these two distinct groups of health behaviors –

- behaviors requiring direct contact with a health provider, such as receiving TT; and

- behaviors mothers carry out on their own at home, usually under the watchful eye of a husband, mother or mother-in-law.

2.c. Project Support Systems

And, having developed this insight into the difficulties of changing certain *household level* behaviors, the NGOs are now re-examining the skills needed by their own field staff and the most effective methods for developing these skills. Prior to this project, the NGO field workers did not focus on community participation and behavior change. Now they are charged with: community mobilization (how to initiate and sustain interest in the project's activities; how to know when a CBOP needs more or less assistance); developing linkages with government health providers; training CBOP members to be change agents (to not only understand the messages, but to be the catalyst for these messages around the village); modeling (such as how to counsel mothers) and documenting the progress of their work without depending on numerical targets. All of these skill areas take serious effort to develop and require constant reinforcement once learned. Through the MTR, the NGOs have identified and confirmed that the areas noted above need more attention in the months to come.

As for its role in the partnership, CARE has faced some constraints that have prevented it from maintaining the high level of interaction with and support to PKS and TSRDS that was characteristic in the early months of the project. CARE's initial assessment of project needs was insufficient in terms of human resources and physical infrastructure. In addition, CARE's excitement about working with corporate NGOs has resulted in a high degree of visits to Jamshedpur and inevitable distraction from the day-to-day needs of the project. Finally, the persistent staff shortages that CARE India has faced for a couple of years have had an inevitable negative effect on providing consistent and high quality support to this project. One specific example of the consequences is that, despite technical assistance from several sources, this project has not yet developed its final health monitoring information system.

3. The Partnership

All partners have sensed that there is tremendous potential in such joint collaboration among three institutions that heretofore had no explicit reason to work together. Each partner has very tangible and critical contributions to make which do not necessarily stem from original assumptions about what each partner could, should or might contribute. Some organizational behaviors are much harder to change than others, e.g., participatory decision-making often requires an equal voice (or voices) from individuals at different levels and/or outside of one's own organizational structure.

All three partners, i.e., PKS, TSRDS and CARE, have undergone significant changes in their expectations about this project and for each other. The proposal stage was characterized by great optimism and somewhat unrealistic expectations about the breadth, depth and speed at which this partnership could operate effectively. By the MTR, the partners have shown their ability for considerable institutional growth and development. For its part, CARE is learning to adjust its

modus operandi to find a comfortable fit with that of corporate NGOs. For their part, TSRDS and PKS have realized the need for a significant shift in their thinking and operating. They have responded by embracing the community development approach whole-heartedly and enthusiastically, as evidenced by their openness for new knowledge, new ways of thinking and eagerness to develop new skills. Furthermore, as these new partners have adjusted to working with each other, they also have learned that building effective linkages with the government and MOH requires them to adjust the project's priorities and activities to the government schedule.

F. RECOMMENDATIONS

Recommendations for CARE India, in its role of supporting CARE Jamshedpur

1. Human Resources Management
   - **Consider seriously the need for a team of three full-time positions**
   - Fill two open positions as soon as possible (within 60 days maximum)
   - Revise Project Coordinator's job description accordingly, so that this position and its current incumbent take on the overall responsibilities of a project manager, including authority over hiring decisions and authority to negotiate visits from outsiders (CARE or otherwise)
   - Streamline communications with CARE Bihar (Patna) and Delhi by reducing the channels of information exchange (e.g, appointing point persons in these offices for communications with Jamshedpur; establishing schedule of weekly telephone calls to reduce on-site visits)
   - Give CARE Jamshedpur a breathing period of at least six months (free of all visitors and technical inputs unless explicitly requested) to hire and train new staff, to recover from recent managerial turnover, and to develop and implement the Action Plan which derives from this Mid-Term Review

2. Overall Expectations for Project to be a Model
   - Adopt a supportive approach, rather than a "let's look at this interesting model" approach to working with CARE Jamshedpur; put more focus on the concept and needs of a *Child Survival* project (which happens to be working through two corporate NGOs) and less focus on the expectations of developing a model of corporate NGO partnership
   - Consider that learnings from this project will *contribute to*, not *write*, CARE's corporate sector strategy
   - Suspend efforts to identify other corporate sector NGOs that can replicate this project until the options for replication are fully developed (e.g., through grants from CARE; on their own with technical assistance from PKS and/or TSRDS, etc.) *and* the project has had ample time to implement the Action Plan which stems from the Mid-Term Review Most likely it will not be possible to devote serious attention to NGO replication (outside of Potka and Patamda) until the last year of the project.
   - Be attentive to and explore promising opportunities to apply successful strategies from this project to INHP, beginning in Bihar. Remove DIP expectations to apply learnings to all 987 INHP blocks. (One current opportunity where learnings can be applied is in the development of the follow-on project to INHP).

3. Application of CARE's own expertise to this CS project
   - Review and apply relevant findings from the INHP Mid-Term Review, especially with regard to monitoring and evaluation (section VII.D and Annex F) and the process of Health Communications (section V.F and Annex D)
   - Review INHP IEC materials (manuals, flip books, scrolls, flash cards) to identify those that are adaptable to the CS project

- Identify opportunities for exploiting economies of scale with INHP's structure and activities in Patamda through more explicit coordination between the INHP Field Officer's activities and those of the CS project
- Develop appropriate opportunities for CARE India's Reproductive Health Unit to provide technical assistance with the birth spacing component and perhaps with improving field staff's skills in counseling
- Review the tools from CARE's Maternal and Infant Survival project in Madhya Pradesh for monitoring the growth and development of community organizations.

Recommendations for the three implementing CS partners

1. Concerning their partnership:
   - Openly negotiate and honor those issues that need to be more transparent to promote project success (e.g., development of all IEC and training materials for use by field staff and in communities; development of monitoring tools)
   - Be more sensitive about the inappropriate use of development jargon among staff, government functionaries, community members
   - Identify and develop more clarity among certain terms that have different meanings for different persons actually charged with "putting them into action" in the field (among these confusing terms are IEC/BCC, Community Health Days, capacity building, training, counseling, messaging)
   - In discussing and writing about the project, be careful not to take one example and unconsciously present it as a trend or, even more problematic, as the current norm "in most villages". These anecdotes are vital information and need to be documented and shared. They are most valuable as case studies for celebration, study, motivation and examples for replication.

2. Concerning the supporting strategies and activities in the field:
   - Communications strategies: need to expand the currently available options of IEC channels (currently focused principally on women with young children), messages and materials into a more comprehensive approach to IEC (to reach more people, more often, with more of the project's messages);
   - Project staff would benefit from training in methods such as "Trials for Improved Practices" (TIPS) or "Positive Deviance" to equip them in helping mothers address their real concerns.
   - Communications: need to consider locally-specific language requirements for written (in Bengali? Hindi?) and spoken (in Bengali? Tribal language?) messages
   - Frontline staff – develop additional means to increase skills in:
     a. **content areas** of their work (e.g., what are the stages of community mobilization and the ways to assess the maturity of CBOPs; what are the 5 components of counseling) and the
     b. **methods needed** to apply the content (becoming trainers of trainers; identifying positive case studies and/or "positive deviants" to promote; incorporation of Trials of Improved Practices (TIPS); modeling; pairing of stronger and weaker field staff; exposure visits among CBOP members, effective use of IEC materials, etc.)

    c. **management of the time available** to engage in community activities and efficient monitoring thereof
    d. **working with additional target groups** (mothers and mothers-in-law of pregnant and lactating women, each with their differing roles; husbands; other influential community leaders)
- CARE staff in Jamshedpur (the Project Coordinator in some combination with his other staff) need to spend more time in the field and less in reporting and visitor management

3. To increase coverage and promote sustainability:
    - Community Health Days – clarify rationale, roles, locations and methods and time needed to successfully mobilize communities to plan and carry out their own
    - Linkages with government – continue to advocate project's objectives and promote joint planning, problem-solving, disseminating reports, and sharing of credit; continue to adjust the project's priorities and activities as per government schedule as much as possible
    - Local private health care providers (including Rural Medical Practitioners -*Khabiraj*) - determine how project's services and messages can be more supportive to their work and less threatening; enlist their help in reinforcing project's messages and providing referral when appropriate

4. Monitoring and evaluation system
    - Determine the absolute *minimum* information to be obtained for calculating indicators and the *maximum* appropriate intervals. Make adjustments to the current system without introducing any new forms.
    - Examine all other data being collected to ascertain at what level it is crucial, and in what frequency (some data are only needed as spot checks; other data are needed on a fixed regular basis and still other data are needed only once a year)

5. For PKS
    - Develop improved communications to address community-level confusion (where present) about funds being collected by CBOPs in the clinics
    - Determine how to improve collaboration (in perception and in practice) with government health officials in Potka

6. For TSRDS
    - Involve other partners (PKS and CARE) from the beginning in developing IEC materials and other new strategies for use in communities

G. ACTION PLAN

The midterm review of the project has reported that the first 16 months of implementation (May, 1999 to Sept. 2000) have shown encouraging results in several areas. The mid-term review has put forward recommendations for the future. The CS Project Team, keeping in view the recommendations of the mid-term review as well as the experience of implementing the program, and focussing on the goal has developed an action plan.

The Process

The MTR results and recommendations were discussed with the implementing team from both NGOs and CARE and post-midterm Action Plan was developed. The participants in this process represented the core implementing group from both NGOs, essentially the same group as the one which was engaged in the MTR process. The process of developing the Action Plan was carried out at a two-day workshop facilitated by Siddharth and Sainath. The workshop began with a listing of the expectations by the participants, which was followed by discussion on *'what is working well?'* and *'what are the areas for improvement?'*. Comments from the discussion were organized into lists and used as reference points for developing the Action Plan. The major sections of the Action Plan were identified and the task of developing it divided between two groups, each having representatives from all the three partners. The final Action Plan was firmed up after discussion in the large group. Participants included: Drs. S.N. Jha & Neera Sachdeva and Mrs. Madhu Bansal from Parivar Kalyan Sansthan; Drs. P.C. Mahapatra & Pushpa Tiwari, Mr. Ashok Bharti and Ms. Mallika from Tata Steel Rural Development Society and Sainath Banerji (Project Coordinator), Siddharth (Technical Specialist back-stopping the Project at CARE India HQ) and Ms. Leena Rajan (Project Officer, HMIS, CIHQ). The salient aspects of the post-midterm Action Plan that emerged from the group are as hereunder.

Major issues that emerged following MTR:

1. CARE Corporate Partnership
2. Human Resource management
3. Strengthening technical project interventions
4. Enhancing skills of implementing team
5. Strengthening and refining project strategies
6. Monitoring system

CARE -Corporate Partnership

The three partners (CARE, TSRDS and PKS) have all benefited from the experience. It is heartening to note that the two corporate sector NGOs are getting involved in social and development motives. There has been a perceptible paradigm shift towards empowerment and sustainability. Significant progress has been made in the partners' ability to complement one another. This is particularly exciting given corporate sector organizations are involved. To further cement the partnership, periodic review meetings and joint field visits will be conducted with a renewed focus on objectives. To optimize the efficiency of the project, a working group comprised of functionaries from all the three partners has been formed. This working group has

four sub-committees to oversee the project activities in the four key implementation areas, viz., service delivery, capacity building and training, community mobilization and monitoring.

Human Resource Management

1. The recommendation for three, full-time positions at field level for the CS Project has been discussed by senior management at CARE- India head quarters (CIHQ). The selection process for the position of Program Assistant has been initiated by CARE- Bihar (Patna) .The need to create another position of a Field Officer has been agreed upon in principle and is awaiting final approval.

2. The current job description of the Project Coordinator has been revised in the light of his new roles and responsibilities towards the project and is in the process of finalization. The revised job description has covered all key components of the JD of the earlier position of Project Manager in order to have an adequate balance of responsibility and authority. This includes the authority to decide on cross visit or field exposure for the partner NGOs and project staff, visits to the project (both internal and external) and other decision-making authority related to Project Management.

3. In order to streamline communication flow, it was agreed upon that the Project Coordinator will directly report to the State Director, CARE – Bihar. The Project Coordinator will also maintain communication with the Health Sector Director, the key point person at CARE India headquarters, and with other personnel as per project needs and for issues related to donor compliance. In order to keep a check on the flow of visitors, it was decided that CIHQ as well CARE- Bihar would not encourage further visits to the CS Project unless it were aimed at value addition and until all the positions were filled.

Strengthening technical project interventions

The MTR has indicated that certain intervention areas are weak. This together with the field observations and experience of the implementing team were discussed and the following areas were identified for renewed focus during the coming months:

1. Maternal and Infant nutrition – The project will make serious efforts to translated knowledge regarding maternal and infant nutrition into real change in nutritional practices at the household level. This will be done through special focus during capacity building sessions.
2. Birth planning – The messages regarding this intervention need to be understood uniformly, for which some technical assistance will be useful. The agreed upon messages will be provided to frontline worker who in turn will encourage families to adopt birth planning. Criteria to define birth planning for monitoring and assessing results will also be set.
3. Newborn care – Technical input for this relatively new intervention will be sought and then messages and pictorial communication material already developed in the Maternal and Infant Survival Project could be adapted for use in the project.
4. Immunization – The immunization coverage of infants will be strengthened by a focus on Community Health Days (CHDs), strengthening of CBOPs so that they can ensure presence

of all infants at the CHDs and by promoting linkages between service providers (ANM and AWW) and CBOPs. The quality related issues (cold chain, use of properly sterelised needles and syringes) would also be addressed through capacity building of functionaries and CBOPs.

5. Birth Spacing – The field workers need to be given refresher training and practice in using the messages effectively in counseling of families/couples. Quality issues such as informed choice and appropriate counseling methods will be stressed.

Enhancing skills of implementing team

1. Communication and counseling skills – Technical assistance will be sought to orient the entire implementing team to effective communication techniques for behavior change, such as, Positive Deviance, Trial for informed Practices (TIPS), Appreciate-Affirm and Adapt and similar methods.
2. Community Mobilization – The implementing team will be trained in the use of Participatory Rural Appraisal and related techniques. The project implementers will also be trained to carry out focussed group discussion and report inferences.

Strengthening and refining project strategies

1. Service delivery and coverage- It was agreed that CHDs were an effective approach to enhance coverage rates and also for sustainability of efforts. As such the post –midterm action plan will concentrate on strengthening and scale-up of CHDs and progressively reducing the clinics.
2. Linkage with Government functionaries – It has been felt that dedicated efforts to promote improved coordination with the health service providers (ANM and AWW) will be useful. The project has already initiated these efforts and would strengthen the same during the post mid-term period.
3. Capacity Building -
    - CB of frontline workers: This is one of the most crucial cadres for the success of the project. The Action plan envisages progressive and regular capacity building of the frontline workers on the technical content areas as well as skill areas.
    - CB of CBOPs: The need to strengthen CBOPs has been widely recognized by all. The Action Plan focuses on this area to convert CBOPs into active CBOPs as per agreed upon criteria.
    - CB of ANM, AWW, TBAs and RMPs: The team has drawn out a plan to provide inputs to these key service providers, who are the ones approached by the community. They will be provided training on the project interventions.
4. Development and use of communication material – a core team formed; pictorial and local and folk media, aimed at mobilization of the community (bicycle rallies, use of village markets to reach to large sections of the community, aimed at intensified effort towards changing behavior (pictorial posters for homes). In keeping with the observation of the MTR, the project team has already obtained the pictorial communication material developed in other CARE India projects, namely, INHP and MISP.

5. Strengthening of CBOPs - The significance of the facilitator focussing on listening, learning, understanding the people's perspective and helping people own the project objective and hence the efforts is clearly understood. The project will strengthen efforts, with this approach in mind, to empower the CBOPs, so that they can make incremental contributions to improving health care delivery in the villages. In line with the MTR recommendation both implementing NGOs have reviewed the tools for monitoring growth and development of community based organizations developed by CARE India's Maternal and Infant Survival Project, and adapted the same to set parameters for measuring progress of CBOPs in CSP.

Monitoring System

A consultant has been hired to help the project team develop a system synergistic with the existing monitoring system used by the NGOs, and which better meets the needs of the partner NGOs as well as the project. There will be an effort to develop a system that does not overburden the project functionaries and is also owned by the implementers.

The Action Plan is described in further detail in the matrix on the following pages.

ACTION PLAN (October 2000 to September 2002)

Child Survival Project (Partnership for Sustainable Health Impact) Jamshedpur,India

Goal	Objective/Activity	Indicator	Timeline (Quarter wise) starting Oct.1, 2000								Agency Responsible	Remarks
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8		
A. Improve coverage rates and health practices associated with reductions in infant mortality (DIP)	**A1. Improve service delivery and coverage** a) Clinics	i)% of clinics gradually scaled down *(current status:PKS-15clinics;TSRDS-20clinics)*	10%	20%	35%	50%	65%	75%	75%	75%	NGO partners	The % denote proportion of clinics being gradually scaled down. Scaling down of clinics will follow scale up of CHDs.
	b) Community Health Day (CHD) -Strengthen linkage between ANM,AWW &CBOP -Enhance capacity of CBOP to take charge of CHD -Ensure regular flow of health supplies including communication materials	ii) % of villages conducting regular CHDs (Progressive increase) *(Criteria)	25%	35%	45%	50%	60%	75%	75%	75%	NGO partners	
	c) Convergence/linkages with govt. -Effective liaison with District officials -Effective liaison with Block officials	iii) District level coordination meetings for convergence iv) Block level coordination meetings	✔ ✔	✔ ✔	✔ ✔	✔ ✔	✔ ✔	✔ ✔	✔ ✔	✔ ✔	NGOs & CARE NGOs & CARE	District level coordination meetings are held once a quarter and block level coordination meetings are conducted once a month.
	-Close coordination among the triad of project frontline workers, service providers (ANM &AWW) and CBOPs	v) Cluster level (5-6 villages)meeting/capacity building session of ANM, AWW and CBOP covering X % of villages	25%	35%	45%	50%	60%	75%	75%	75%	NGO partners	

**Criteria for CHD* - Activity where CSP intervention related health services for mothers and infants are provided with active involvement of ANM, AWW and CBOP
Component of CHD -Services, health education, provision of health supplies, communication material, active role of CBOP
Clinic and CHD to pay special attention towards – birth planning, immunization, birth spacing, new born care, nutritional counseling for mother and infant
The project will attempt to try out alternative mechanisms for addressing gaps in services.

ACTION PLAN (October 2000 to September 2002)

Child Survival Project (Partnership for Sustainable Health Impact) Jamshedpur,India

B. To improve the capacity of operating partners to make continuous and sustained improvements in the coverage rates of healthy behaviors (DIP)	**B1.Capacity Building (CB)** a) Conduct CB sessions for : *CBOP* *Topics*-Scope & functions of CBOPs and project messages *ANM & AWW* *Topics*-CH days, project interventions *TBAs* *Topics*-Birth Planning, safe Delivery and New Born Care *RMPs/Kabiraj* *Topics*-primary intervention, secondary intervention, Emergency Obstetric Care, Birth Spacing and New Born Care *Middle level & Frontline workers* *Topics-* *Approaches*: Communication and Counseling, CHD, CBOP formation, strengthening, monitoring, -PRA/PLA *Technical content areas:* Maternal & Infant Nutrition, Birth Planning, New born care, Immunization, Birth spacing, community mobilization	% of CBOPs covered % of ANMs &AWWs covered % of TBAs covered % of RMPs covered % of frontline workers covered	30% 50% 50% 50% 100%	40% 100% 100% 100% 100%	50% 100% 100% 100% 100%	60% 100% 100% 100% 100%	75% 100% 100% 100% 100%	100% 100% 100% 100% 100%	100% 100% 100% 100% 100%	100% 100% 100% 100% 100%	NGO partners NGO partners and District Govt. NGO partners NGO partners NGO partners, CARE and External faculty	For the capacity building activities, the project will seek appropriate technical assistance as required. Capacity Building will be an on-going process, wherein inputs/messages will be periodically reinforced. Capacity building of frontline workers will be particularly vital since they serve as the critical change agents. Efforts will focus on helping them develop into effective facilitators.

ACTION PLAN (October 2000 to September 2002)

Child Survival Project (Partnership for Sustainable Health Impact) Jamshedpur,India

	B2. Communication Material -Development and use of pictorial & audio visual communication material (audio cassettes, flip charts, flip books, video cassettes, wall writing , wall painting, nukkad natak, cycle rally, folk media, home based health cards, posters and scrolls) -Dissemination of CSP messages to larger community	Communication materials developed Messages disseminated	✔ ✔	✔ ✔	✔ ✔	✔ ✔	 ✔	 ✔	 ✔	 ✔	NGO partners & CARE NGO partners, Govt. functionaries and CBOPs	A joint committee of all three partners will oversee the development of communication aids
	B3. Formation and strengthening of CBOPs	% of active CBOPs as per the following parameters - Participation in CHDs -Maintenance of records -Regular monthly meetings -Health Education -Collection and use of Health Funds	20%	30%	45%	60%	75%	75%	75%	75%	NGO partners	This will be done through village level contact meetings and cluster level CB sessions conducted by frontline workers

ACTION PLAN (October 2000 to September 2002)

Child Survival Project (Partnership for Sustainable Health Impact) Jamshedpur,India

C Assess-ment of results	**C1. Monitoring and review** -Develop uniform monitoring tools	i) Tools developed and owned by the entire project team	✔								NGOs & CARE.	
	-Institutionalize effective use of data	ii) Monthly review meetings held at										
		-core group level	✔	✔	✔	✔	✔	✔	✔	✔		Once a month
		-frontline workers	✔	✔	✔	✔	✔	✔	✔	✔		
	-Periodic review of project progress	iii) In depth quarterly program and technical review	✔	✔	✔	✔	✔	✔	✔	✔		
		iv)Data collected, analyzed and shared with all stakeholders	✔	✔	✔	✔	✔	✔	✔	✔		Project data shared with the AWWs and CBOPs by
	-Undertake qualitative research	v) Qualitative study report available	✔				✔				CARE	frontline workers
	C2. Reporting -Timely compilation and submission of report	vi) MPR	✔	✔	✔	✔	✔	✔	✔	✔	NGOs &	Once a month
		vii) QPR	✔	✔	✔	✔	✔	✔	✔	✔	CARE.	Once a quarter
	C3. Documentation and Dissemination of lessons learnt	viii) Annual Report available	✔				✔				CARE	
		ix) Minimum four lessons learnt papers prepared and disseminated at appropriate forum				✔		✔	✔	✔	NGOs & CARE.	
	C4. Endline project evaluation	x) Report of end-line evaluation available								✔	CARE	

ANNEX A
BASELINE INFORMATION FROM THE DIP
(page 1 of 4)

1. Field Program Summary (DIP page 2)

PVO/Country: India Program Duration: October 1, 1998 – September 30, 2002

Table 1. Estimated Program Effort and USAID Funding by Intervention

Intervention	**Percent of Total Effort**	**USAID Funds ($ US)**
Maternal & Newborn Care	40%	311,478
Breastfeeding Promotion	20%	155,739
Immunizations	20%	155,739
Child Spacing	20%	155,739
Total	**100%***	**778,695**

Table 2. Program Site Population: Women and Children

Population Age Group	**Number in Age Group**
Infants (0-11 months)	5,300
12-23 Month Old Children	5,300
24-59 Month Old Children	15,900
Total 0-59 Month Olds	**26,500**

Population Age Group	**Number in Age Group**
Women (15-49 years)	53,000

Estimated Annual Number of Live Births in the Site: 6,360

Sources of the Population Estimates Above: 1991 Census (GOI)

*****It is expected that $48,000 will be provided by the World Health Organization (WHO) for IMCI initiatives. This is in addition to technical assistance that WHO will provide.

Changes made in the above since approval of the second DIP: none

ANNEX A
BASELINE INFORMATION FROM THE DIP
(page 2 of 4)

2. Program Goals and Objectives (DIP page 11)

Antenatal care and preparation for safe delivery

- 50% of women receive 3 antenatal check-ups by delivery
- 60% of women receive and 50% consume 100 IFA tablets by delivery
- 60% of pregnant women receive TT2 by delivery
- 50% of women have birth plan, with contingencies for emergencies and birth kit, in preparation for safe delivery

Infant feeding

- 65%*of infants are put to breast within 8 hour postpartum (*this is a typographical error carried over from the first DIP; the revised DIP, dated October 31, 1999, should have 80% for this indicator)
- 40% of infants are exclusively breast fed for four months
- 75% of infants 6-9 months consume semi-solid foods

Childhood immunization

- 60% of children aged 12-23 months are completely immunized by age one

Family planning

- 25% non-pregnant married women use a modern contraceptive method

Enabling sustainable and capable institutions forms the basis of all program interventions

- Percentage of villages with active CBOP (community-based operating partners – individuals or community group)
- Percentage of villages with community health fund for emergencies or drugs
- Percentage of villages with institutionalized health days consisting of health fairs and other community-wide activities
- Partners have institutionalized systems to deliver services and provide basic supplies
- NGO match to budget increases over time
- Increased number of new NGOs replicating components or committing to social development activities
- NGO practices adopted and applied by CARE to other corporate sectors

Changes made in the above since approval of the second DIP: This Mid-Term Review recommends that CARE revise its expectations regarding the final two indicators in the above list (regarding NGO replication)

ANNEX A
BASELINE INFORMATION FROM THE DIP
(page 3 of 4)

3. Program Location (DIP page 3)

Program Area: The CS project will be implemented in Patamda and Potka, two community development blocks located in East Singhbhum district in the south of Bihar.
Target Groups: The primary target population of the project is pregnant and lactating women and mothers of children under two years of age.
Existing Health Infrastructure: A large proportion of the program villages in the two identified blocks are remote, isolated, and have limited access to health services and programs for maternal and child survival. There is one sub-center staffed by an Auxiliary Nurse Midwife (ANM) or other health worker for every five to six villages, one primary and one additional health center for every block, and one Anganwadi Center (AWC) and two workers (AWW and helper) in each village. However, a vast majority of these facilities lack sufficient supplies and staff and consequently are not utilized. In the majority of villages in Patamda, TSRDS provides excellent health services to communities. This includes one Health Center and two sub-centers which provide curative and preventive services. CBWs provide outreach services for immunization of children and doctors and paramedical staff conduct check-ups in the centers. In Potka block, PKS provides health services such as immunization, antenatal care, family planning, etc., through its mobile clinics in 17 villages.

Changes made in the above since approval of the second DIP: None

4. Program Design (DIP page 21)

The CS project seeks to reduce infant and child mortality by improving the health practices associated with reductions in mortality. The project will strengthen the capacity of the two local partners, PKS and TSRDS, who will in turn increase the capacity of village-level operating partners to make continuous and sustained improvements in these health practices. The total target population is about 79,500 mothers, pregnant women and children under two residing in 262 villages. To reduce mortality within the first year of life, the project will focus on four groups of interventions: antenatal care, breastfeeding, immunizations and child spacing. These services will be provided by PKS and TSRDS, who will be assisted by CARE to improve their capabilities to:

a. Develop and implement an effective IEC/BCC strategy
b. Increase community demand for health services
c. Ensure appropriate provision of services and supplies
d. Provide quality assurance with respect to service delivery of local health providers (ANM, AWW, birth attendants)
e. Monitor and evaluate project interventions accurately and use this information to guide the program
f. Serve as a model for other corporate houses in India to pursue socially responsible initiatives

ANNEX A
BASELINE INFORMATION FROM THE DIP
(page 4 of 4)

Changes made in the above since approval of the second DIP: The project is behind schedule with regard to developing the IEC/BCC strategy (a). Also, this Mid-Term Review recommends that CARE revise its expectations regarding the final component in the above list (f - developing a model for other corporate houses).

5. Partnerships (DIP page 30)

The CS project envisions an effective and cohesive partnership with various stakeholders and future role players. Both the NGO partners – PKS and TSRDS besides community and government Health & ICDS department will be the key partners of the project. To achieve greater sustainable impact, partnerships with other local NGOs will also be visualized. At the block level, the coordination committee (comprising representatives from block Health and ICDS, NGOs and CS) will prepare a monthly Joint Action Plan to promote effective coordination and avoid duplication of efforts. At the village level, the NGO field staff will work closely with the CBOPs to establish systems for increasing coverage rates of healthy behaviors. As for the public sector, CARE India has fifty years of experience working with the Government of India and has recently made concerted efforts to increase collaboration with the Government of Bihar through the broad INHP umbrella that operates in 157 blocks in Bihar.

Changes made in the above since approval of the second DIP: None

6. Health Information System (DIP page 40)

The basic monitoring and evaluation framework consists of a baseline survey, ongoing internal monitoring, mid term assessment and final evaluation. Under this framework, qualitative and quantitative methods will be used. The baseline survey activity was a joint effort by TSRDS and PKS, after extensive training provided by CARE. Ongoing process and service delivery data are collected, aggregated monthly and reported within the internal NGO management structure. Quarterly compilation for reporting and feedback of project achievement, financial results and human resources is addressed through the Core Team (comprising CARE and NGO representatives).

Changes made in the above since approval of the second DIP: The project is behind schedule with regard to making revisions in the project's health management information system (HMIS).

ANNEX B
TEAM MEMBERS

Representatives of PKS:
Mrs. Madhu Bansal, Project Manager
Dr. Shankar Nadh Jha, Senior Medical Officer
Dr. Neera Sechdeva, Senior Medical Officer
Mr. P. P. Mitra, Project Officer

Representatives of TSRDS:
Dr. Pravash Mohapatra, Project Coordinator
Dr. Pushpa Tiwari, Medical Officer
Dr. Mallika Mitra, Training Coordinator
Mr. Ashok Bharti, Block Coordinator

Representatives of CARE:
Dr. Sainath Banerjee, CS Project Coordinator, CARE Jamshedpur
Dr. Sanjay Sinho, Technical Specialist, Child Health, CARE USA

External Consultant:
Dr. Mary Ruth Horner

ANNEX C
ASSESSMENT METHODS
(page 1 of 3)

A. QUALITATIVE ASSESSMENT

Participatory evaluation within USAID/PVC/Child Survival framework

STEPS
1. Discussion of Terms of Reference among partners
2. Identification of MTR team leader
3. Refining Terms of Reference

Process at Jamshedpur – 12th July – 19th July
1. Creation of Review team (stakeholders)
2. Development of tools
3. Field level data collection
   a. Clinics
   b. Community Health Day
   c. Community visits (home visits)
   d. Meeting with CBOP
   e. Key informant interviews

Total – 109 people (and groups) interviewed

4. Project Management Review
5. Secondary documents Review
6. Synthesis and analysis of Review

B. QUANTITATIVE SURVEY

The complete report of this survey is available from CARE-India. The SRI interviewers visited 10 villages in each block and in the process, interviewed 105 mothers in Potka and 102 mothers in Patamda, all with children under two years of age.

Key questions were formulated for the various performance indicators pertaining to:
- Antenatal care during pregnancy in terms of receipt & consumption of IFA tablets, TT immunization, preparation of a birth plan before delivery
- Childbirth practices
- Breastfeeding practices
- Complementary feeding practices of the infant
- Immunization of the mother during pregnancy and the child during the first year
- Management of diarrhea in children under-two

- Management of ARI (acute respiratory infection) in children under two; and
- Utilization of birth spacing methods by mothers of under-twos

In addition, the MTR answered questions pertaining to involvement of mothers in the community-based health activities in the village. Specifically, these comprised:

- Presence of active Community Based Organization (CBO) or Change Agents (CAs) in the village
- Availability of health funds with the CBO/CA
- Awareness of existing CBOs/CAs among target beneficiaries
- Utilization of services offered by the CBO/CA
- Participation in Monthly Health Day activities held in the village

ASSESSMENT METHODS (page 3 of 3)

SCHEDULE OF CHILD SURVIVAL MID-TERM REVIEW
(Field portion only)

JULY 2000

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
9) consultant arrived in Delhi	10) CARE CIHQ planning, interviews	11) CARE CIHQ-Planning, Interviews, travel to Calcutta	12) Travel to Jamshedpur Orientation to MTR; overall presentation of project	13) Develop field protocol, instruments, logistics (Quantitative survey underway)	14) Field visits and processing (Quantitative survey underway)	15) Field visits and processing (Quantitative survey underway)
16) Begin developing key themes for report; DIP review of timeline (Quantitative survey underway)	17) Field visits and processing	18) Interviews – NGO partners, CDPOs, MOs	19) Discussion, interpretation, synthesis of key themes De-briefing for Jamshedpur partners	20) Travel to Delhi MTR Report writing	21) MTR Report writing	22) MTR Report writing
23) MTR Report writing; preparation of first draft	24) CARE de-briefing (am) USAID, GOI, TSRDS, PKS de-briefing (pm); Consultant leaves	25)	26)	27)	28)	29)

ANNEX D
PERSONS INTERVIEWED (page 1 of 2)

Villages visited and persons interviewed during field work in Potka and Patamda, July 14-17, 2000

Category of Person Interviewed								
Village	**Khursi**	**Kankidih**	**Pichli**	**Sahoda**	**Bodan**	**Jamdih**	**Dhusra**	**Sisda**
Mothers (Home Visit)	Renu Hira	Malti Gurumani Sumitra	Phoolmati Juvali Shivani Nirupama	Jeera Shandeh Gurbari	Malti Geeta	Malti Geeta	Malti Mangli Sukumari Shanti	Anurupa Paribala
Exit Interview for Clinic/ CH Day		Marmoo Phoolmati Bharti		Jahitri	Parul Pal Umapal	Samiyah Joba		
Field Staff	Manjari	Keshav	Sarveshwar Manjmala	Nisro		Behula Champa		
AWW		2			2		Savita Singh Manjari	
ANM					Gita			
Opinion Leader (including Dai, RMPs etc.)	Suruburi (Dail) Manjari's Husband	Subhash			Chattanja Nami (Dai)			Promila (Dai) Pasupati (Opinion Leader)
Community Member	Adolescent Girl							
CBOP Members	Whole Group	Whole Group		Payo	BK Mehto		Mansi Ramani and group	Gauri Bala Promila and group
Clinic Staff	Samantha Rubina Ajeet Vinay			J. Nandi Manoj Jamuna	Tejender Gopi Nath Doulen Upadhyay			

ANNEX D
PERSONS INTERVIEWED (page 2 of 2)

Other interviews:

PKS Management Staff:

1. Mrs. Madhu Bansal, Project Manager
2. Mr. D.K.C. Roy, Secretary
3. Dr. Neera Sachdeva, Sr. Medical Officer
4. Dr.Shankar Nadh Jha, Sr. Medical Officer
5. Mr. P.P. Mitra, Project Officer

GOI-Bihar Health Staff

1. Dr. S. K. Jha, Medical Officer in-charge Block PHC, Patamda
2. Mr. S. Bakshi, Project Manager Tagore Society for Rural Dev., Patamda
3. Mr. S. Thakur, CDPO, Patamda
4. Dr. D. N. Singh, Medical Officer in-charge Potka
5. Dr. Binay Siddhesh, First Medical Officer, Potka

TSRDS Management Staff:

1. Mrs. Shakti Sharma, Honorary Secretary
2. Dr. Pravash Mohapatra, Project Coordinator
3. Dr. Pushpa Tiwari, Medical Officer
4. Dr. Mallika Mitra, Training Coordinator
5. Mr. Ashok Bharti, Block Coordinator

CARE Management Staff:

1. Dr. Sainath Banerjee, Child Survival Project Coordinator, CARE Jamshedpur
2. Mr. Mukesh Kumar, INHP Project Manager & Acting State Director, CARE Bihar
3. Dr. Anubha Ghose, Director, Health, CARE India
4. Dr. Manish Subharwal, M&E Officer, CARE India
5. Mr. Nalin Johri, Manager, HMIS Unit, CARE India
6. Mr. Harry Sethi, Director of Coordination, Resource Mobilisation & External Relations, CARE India
7. Mr. Gurumani, ACD Program Support, CARE India

ANNEX E
WHAT IS WORKING WELL?

Specific Intervention	**Components**
1. Maternal nutrition	• Awareness has improved for nutrition during pregnancy; practice will be explored • Receiving and consuming IFA and deworming tablets • Awareness has increased for need to improve post delivery maternal nutrition
2. Breastfeeding	• Gave colostrum to the latest child • Some change in prevalence of pre-lacteal feeds
3. Antenatal care and safe delivery	• Going for 3 ANC checkups has greatly improved • Receiving 2 TT injections
4. Immunization of children under 2	• Coverage of scheduled immunization has increased • Vitamin A supplementation has improved

Supporting Strategies & Activities	**Components**
1. CBOP (Mahila Mandals & others)	• Accepted by community, now are becoming more focused on health issues • Some CBOPs have started working for disseminating messages for behavior changes and service utilization • Community funds are being generated and are being used for health purposes in certain areas
2. Project front-line workers (CSPWs, CBWs, FEWs)	• Frontline workers' role in reaching the communities – they are known in the villages • AWARENESS creation among communities • High degree of motivation and personal behavior change
3. Community Health Day	• Community Health Day initiated in certain areas and discussion on its importance and organization started to a *varying* degree (NGO/ICDS/Health) • Community's role and ownership recognized as key elements for success
4. Clinics	• High acceptance in communities and are well organized

	• Good quality services are being provided • Good record keeping and data generating activities
5. Linkages (Gov't – NGOs)	• AWW/ANM are taking active role in certain areas • Good collaboration with local NGOs by PKS & TSRDS
6. Capacity building	• Training and cross visits have been used in a major way • Technical upgradings related to project interventions has worked well • Percolation of trainings using cascade method has worked well when they involve building awareness and increasing knowledge
7. IEC/BCC	• Worked WELL for increasing knowledge and awareness to prepare project for launching in the phase where these can be converted to practice changes

Organizational Behavior	**Components**
1. NGO partners – PKS and TSRDS	• Significant shift in development thinking and operating • Welfare (service delivery) to empowerment approach • Community sustainability as key programming principle • Partnership & networking (govt, other NGO, and community) • Replication process in other project initiatives (outside the CS project) • New qualitative research skills making major contribution
2. CARE	• Understanding of corporate management systems • Learning role of facilitator and catalyst for others involved in direct service delivery
3. Government	• Partnership with govt developed • Initiated joint action planning in a few areas; represents good beginning

ANNEX F
WHAT IS NOT WORKING SO WELL?

Specific Interventions	**Why is this not working well?**
1. ANC & safe delivery	Knowledge not being translated into practice due to:
• Taking rest	heavy workload low family support low awareness
• Diet	lack of availability of food (poverty) lack of desire low awareness of family members (esp. mothers-in-law, husbands)
• Birth planning	concept very new CBOP not so strong transport (hard to arrange ahead of time) referral system not adequate
2. Infant feeding	Knowledge not being translated into practice due to:
• Colostrum feeding	Colostrum is now being given by more women but pre-lacteals are still being practiced
• Starting semi-solids	Lack of knowledge about quality, quantity, frequency

3. Birth spacing	Knowledge not being translated into practice due to: Lack of supplies (Potka) Fear of complications CSPWs, CBWs find it hard to discuss in community Lack of husband's support (for condoms) Where there is felt need, no supply

Constraints with the Supporting Strategies & Activities	How to overcome these constraints?
1. IEC and BCC constraints: a. need assessment/time gap b. language c. concept of IEC vs BCC not clear d. counseling vs messaging e. not convincing f. lack of fieldworkers' time	• Interpersonal pictorial counseling & learning aids • Focus on counseling • Focus on positive case studies and early adopters • Modeling • Practical time allocation
2. Transfer and development of skills from project functionaries to CBOP – constraints: a. CSPW/CBW – lack of training b. Lack of motivation of CBOP	• Continued motivation and skill development of CSPWs and CBWs, especially on community mobilization and counseling • Define role of CBOP • Skill development of CBOP • Pairing of CBW and CBOP
3. Community Health Days – constraints: a. relatively new concept for project functionaries & Govt. b. confused with clinic time c. community role is not very clear (CBOP & communities)	• Capacity building for everyone • Role clarity of community; build ownership • Commitment to operationalize the strategy by project leadership
4. Project linkages with Govt – constraints: a. transfer of trained staff b. personal rapport and contact c. mobility d. conflicts with other programs	• coordinate with govt priorities • joint schedule to be prepared and monitored • sharing of credit and publishing it • report to be shared widely • coordinate for the supplies and mobility • involvement in other programs
5. Monitoring – constraints: a. How do we detect true change at community level? b. Who needs what data at which level & how often? c. Clarity for the monitoring	• Continue to reinforce direct contact with mothers and others • Data collection and analysis at outcome level • Case studies (early adopters; positive deviants) to be collected from the community • Existing data system needs to be reviewed and reduced