USAID
FROM THE AMERICAN PEOPLE

MIDTERM REVIEW OF THE VISTAAR PROJECT FOR USAID/INDIA

November 2009

This publication was produced for review by the United States Agency for International Development. It was prepared by Carina Stover, Pradeep Deshmukh, Jenny Ruducha, and K V Ramani through the Global Health Technical Assistance Project.

MIDTERM REVIEW OF THE VISTAAR PROJECT FOR USAID/INDIA

MATERNAL, NEWBORN, AND CHILD HEALTH AND NUTRITION

This document (Report No. 09-001-228) is available in printed or online versions. Online documents can be located in the GH Tech web site library at www.ghtechproject.com/resources.aspx. Documents are also made available through the Development Experience Clearing House (www.dec.org). Additional information can be obtained from

The Global Health Technical Assistance Project
1250 Eye St., NW, Suite 1100
Washington, DC 20005
Tel: (202) 521-1900
Fax: (202) 521-1901
info@ghtechproject.com

This document was submitted by The QED Group, LLC, with CAMRIS International and Social & Scientific Systems, Inc., to the United States Agency for International Development under USAID Contract No. GHS-I-00-05-00005-00.

ACKNOWLEDGMENTS

The GH Tech assessment team thanks the managers and administrators of the Government of India and the state governments of Jharkhand and Uttar Pradesh, as well as other stakeholders, including the representatives of donors and nongovernmental and private organizations who helped the team to gather information in preparation for writing this report. We also thank the many health service personnel we interviewed in Delhi and in Jharkhand and Uttar Pradesh. In all cases there was enthusiasm and interest in the progress of Vistaar and in identifying ways to continue and improve its activities.

We also thank the GH Tech team—particularly Elsa Berhane, Hassantu Blake, Anne Shinn, and Julie Klement, Director of GH Tech—for their continued support. No evaluation is without challenges. For this one, home office support was particularly valuable in ensuring that field activities went forward with the fewest possible disruptions.

Thanks also to USAID/India, particularly Rajiv Tandon and Anchita Patil, who through their prescient vision and leadership have created and supported an innovative model for future USAID engagement in the health sector. Particularly notable was the interest and time given the mid-term review team by USAID leadership, both in the Population, Health, and Nutrition (PHN) Office and in Mission management. Thanks to your interest in Vistaar and the other PHN programs, India's health systems are being reinforced and human capacity built so that health and nutrition programming can be based on evidence and made sustainable for the people of India.

Last, and certainly not least, we underline our thanks to the Vistaar team led by Laurie Parker. The team was with us every step of the way. Their care for detail and their responsiveness to our needs was extraordinary. Special thanks to Hanimi Reddy, Manish Kumar, George Philip (Lucknow), Dharmendra Panwar (Varanasi/Lucknow), Nilesh Deshpande (Bulandshahr), Manju Shukla (Ranchi), and Kumar Madhusudan (Latehar), who obviously gave up a lot of their free time to prepare for and travel and work with us.

We have made every effort to capture the comments and opinions of stakeholders as they were provided to us. We have used all the quantitative and qualitative information we were able to collect to interpret the situation as best we can. The findings and recommendations are those of the GH Tech MTR Team alone, as are any errors or omissions.

Carina Stover
Pradeep Deshmukh
Jenny Ruducha
K V Ramani

ACRONYMS

ANC	Antenatal care
ANM	Auxiliary nurse midwife
ASHA	Accredited Social Health Activist
AWC	*Angan wadi* center
AWW	*Angan wadi* worker (a village-level functionary of ICDS)
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homoeopathy
BCC	Behavior change communication
BDO	Block development officer
BPNI	Breastfeeding Promotion Network of India
CB	Capacity building
CCSP	Comprehensive Child Survival Programme
CDO	Chief Development Officer
CDPO	Child Development Programme Officer
CHC	Community health center
CLICS	Community-led Initiatives for Child Survival Program
CMO	Chief Medical Officer
CRS	Catholic Relief Services
CRT	Core resource team
CSNSI	Coalition for Sustainable Nutrition Security in India
DAP	District annual plan
DFID	Department for International Development (UK)
DLHS	District-level household survey
DM	District Magistrate
DOM	Delayed age of marriage
DWCD	Department of Women and Child Development
ER	Evidence review
GHI	Global Health Initiative
GoI	Government of India
GoJH	Government of Jharkhand
GoUP	Government of Uttar Pradesh
HFW	Health and family welfare
HSC	Health subcenter
ICDS	Integrated Child Development Services Scheme
IEC	Information, education, and communication
IFA	Iron and folic acid
IGNOU	Indira Gandhi National Open University

IMR	Infant mortality rate
IndiaCLEN	Indian Clinical Epidemiology Network
IPC	Interpersonal communication
IPHS	Indian Public Health Standard
IYCF	Infant and young child feeding
JH	Jharkhand
JHU	Johns Hopkins University
JSY	*Janani Surakshya Yogana*, an NRHM incentive scheme
LHV	Lady health visitor
M&E	Monitoring and evaluation
MCH	Maternal and child health
MCH STAR	MCH Sustainable Technical Assistance and Research Project
MDG	Millennium Development Goal
MHFW	Ministry of Health and Family Welfare
MIS	Management information system
MMR	Maternal mortality rate
MNCHN	Maternal, neonatal, and child health and nutrition
MO	Medical officer
MoHFW	Ministry of Health and Family Welfare
MoWCD	Ministry of Women and Child Development for Nutrition
MPW	Multipurpose worker
MTR	Mid-term review
MWCD	Ministry of Women and Child Development
NBC	Newborn care
NFHS	National Family Health Survey
NGO	Nongovernmental organization
NHSRC	National Health Systems Resource Center
NIHP	National Integrated Health Program
NIPCCD	National Institute of Public Cooperation and Child Development
NLHS	National Level Household Survey
NMR	Neonatal mortality rate
NRHM	National Rural Health Mission
PATH	Program for Appropriate Technology in Health
PHC	Primary health center
PHN	Population, health, and nutrition
PI	Performance improvement
PIP	Program implementation plan
PPB	Program performance budgeting
ORS	Oral rehydration salts

RCH	Reproductive and child health
RCH II	Reproductive and Child Health Programme
RI	Routine immunization
SBA	Skilled birth attendant
SO	Strategic objective
SRS	Sample registration system
TA	Technical assistance
TAG	Technical advisory group
TBA	Traditional birth attendant (also referred to as *dais*)
TFR	Total fertility rate
TOR	Terms of reference
TOT	Training of trainers
TT	Tetanus toxoid
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNFPA	United Nations Family Planning Assistance
UP	Uttar Pradesh
USAID	United States Agency for International Development
USG	United States Government
VHND	Village Health and Nutrition Days
VHSC	Village Health and Sanitation Committee
WFP	World Food Programme
WHND	Weekly Health and Nutrition Days
WHO	World Health Organization

CONTENTS

ANNEXES

TABLES

EXHIBITS

EXECUTIVE SUMMARY

OVERVIEW OF INDIA'S HEALTH SYSTEM

India faces one of the most critical challenges of this century: keeping up with rising demands for basic health and social services for its women and children. Continued reductions in mortality and morbidity are made more difficult by the fact that India's 1.177 billion people represent one-sixth of the world's population.[1] However, this means that even small improvements in the percentage of people receiving health, education, and other social services will result in enormous improvements on a global scale and have a major impact on achievement of the Millennium Development Goals (MDGs). India's economic status—76% of Indians currently live on less than US$2 a day[1]—reflects the generally poor conditions in the country. India's health sector will need considerable assistance to augment its capacity for planning, implementation, and monitoring if greater numbers of people are to be brought out of a seemingly endless cycle of poverty, ill health, and poor education.

Child and Newborn Health: Over 57% of under-5 mortality occurs during the first year of life, and 60% of all infant mortality occurs in the first month.[2] The major causes of death among children under 5 are diarrhea, pneumonia, asphyxia, premature birth, measles, and malaria and other infections. In the neonatal period the major causes of death are sepsis, asphyxia, and premature birth; other causes are unknown.

Maternal Health: The national maternal mortality ratio is 254 per 100,000 live births and is higher in states like Uttar Pradesh (440) and Jharkhand (312).[3] The major causes of maternal deaths are hemorrhage, sepsis, abortions, and obstructed labor.[4] One of every 75 women of reproductive age dies from childbirth-related causes. Only 15% of mothers receive complete antenatal care (ANC), meaning that they complete at least three checkups, consume 100 iron and folic acid (IFA) tablets, and get two tetanus toxoid immunizations. Although 65.1% received or bought IFA, the percentage who actually consumed IFA for at least 90 days was only 23.1%. In addition, only 38.7% of deliveries take place in health facilities, and only 46.6% are assisted by a skilled health professional. The maternal health situation is also complicated by such socioeconomic factors as gender discrimination and violence, which contribute to poor maternal health.

Gender and Equity: There are significant differences in maternal and child mortality and morbidity between social, economic, and gender groups. For example, the highest rates of morbidity and mortality are found in the poorer northern states, particularly in Uttar Pradesh and Jharkhand, and in groups with less educational and economic opportunity. The inequities, including gender inequity, are closely linked with poor health status; improvements in maternal and child health will rely at least in part on addressing educational, economic, and social inequities. Girls aged 1–4 are 40% more likely to die than boys in the same age group, and the child mortality rate would drop by 20% if girls had the same mortality as boys.[5] Similarly, the nutrition levels of both children and women vary significantly by caste, wealth quintile, and education of mother.[6]

---

[1] Population Reference Bureau 2009 (http://www.prb.org).

[2] National Family Health Survey III (NHFS 3), 2005-06.

[3] Special SRS Bulletin on Maternal Mortality, 2004-06.

[4] Sample Registration System (SRS), 2007.

[5] *The Lancet*, 2003.

[6] NFHS 3, 2005-06.

Health Sector Organization: India has a relatively decentralized system of health service delivery, with state governments primarily responsible for public health. State governments find it difficult to ensure access to quality health services for the most vulnerable. Recognizing the importance of health to economic and social development and to the quality of life of its citizens, the Government of India (GoI) has launched the National Rural Health Mission (NRHM) to carry out necessary architectural corrections in the basic health care delivery system. The NRHM adopts a synergistic approach, relating health to its determinants, such as nutrition, sanitation, hygiene, and safe drinking water. The goal of the NRHM is to improve the availability of and access to quality health care for all people, but especially those residing in rural areas, the poor, and women and children.

Although in general GoI policies and plans are sound and the NRHM has significantly increased resources for public health, there are still major bureaucratic, administrative, and human resource capacity barriers to translating these resources into better maternal and child health.

INCEPTION OF THE VISTAAR PROJECT

The United States Agency for International Development (USAID) has recognized the huge gap between India's needs for improved access to quality health care and the health system's capacity to respond to those needs. In 2006 USAID designed the National Integrated Health Program (NIHP), now called the Vistaar Project, to help achieve its health strategic objective (SO) 14, "Improved health and reduced fertility in targeted areas of India," especially Intermediate Result 3: "Increased use of key child survival interventions."

Because USAID/India was advised at that time to transition its program into a "last mile" phase, it focused its maternal, newborn, and child health and nutrition (MNCHN) program on providing technical assistance (TA) to help scale up proven practices rather than supporting research, pilots, or stand-alone small-scale service delivery efforts.

OVERVIEW OF THE VISTAAR PROJECT

In response to India's critical needs, USAID entered into a cooperative agreement to provide TA in MNCHN over a 5-year period, 2006–10. Now called Vistaar (a Hindi word meaning "to expand"), the program works most closely with the NRHM, the Reproductive and Child Health Programme (RCH II), and the Universalization of Integrated Child Development Services (ICDS), which are all guided by the GoI's Eleventh Five-Year Plan and its commitment to achieving the MDGs for maternal and child health.

> The purpose of the project is to assist the Government of India and the State Governments of Uttar Pradesh and Jharkhand in taking knowledge to practice for improved maternal, newborn, and child health and nutritional status.

Vistaar is led by IntraHealth International, Inc., which has subagreements with two US-based organizations, Abt Associates and Catholic Relief Services (CRS). Vistaar also has numerous partnerships and subgrants with Indian organizations, including Mamta, CINI, Vikas Bharati, and Ekjut.

The Vistaar Project works in four major technical areas:

- Community-based newborn care (NBC)
- Nutrition (with a focus on anemia and complementary feeding)

- Delayed age of marriage (DOM)
- Skilled birth attendants (SBAs)

THE MID-TERM REVIEW: PURPOSE AND METHODOLOGY

The objectives of the mid-term review (MTR) are to

- assess the progress and achievements of the Vistaar Project relative to its stated objectives; and
- make recommendations for the remainder of the Vistaar Project and for other USAID-funded MNCHN projects.

To accomplish this, the mid-term review assesses the following major areas:

- Project results and achievements to date
- Project strategies and technical approaches
- Project management

The MTR team used a combination of quantitative and qualitative evaluation approaches, including examination of data sources, key informant interviews, and field-based interviews in two districts in Jharkhand and two in Uttar Pradesh, with a focus on MNCHN policy makers, program and planning supervisors, and front-line health workers. The MTR team reviewed a considerable number of historical and recent studies and reports on India's MNCHN, including other USAID-supported projects. The team analyzed critical findings and lessons learned from these documents, giving particular attention to the contribution of USAID-supported activities that identify gender and equity-related issues, particularly those reaching girls and women and underserved populations.

VISTAAR LINKS TO THE GLOBAL HEALTH INITIATIVE

Following on a long history of United States Government (USG) commitment to supporting health activities throughout the world, President Obama announced a commitment to global health of approximately $63 billion to address some of the most serious health problems facing the world's poorest people (May 2009). To guide this Washington has recently disseminated a draft framework for "Saving Lives, Strengthening Systems"[7] developed through the Global Health Initiative (GHI). The GHI focuses attention and resources on such health problems as HIV/AIDS, maternal and child mortality, tuberculosis, malaria, tropical diseases, unintended pregnancy, and undernourishment.

The challenge for the GHI is to integrate existing programs into a whole that delivers more than the sum of its parts by achieving synergy and sustainable outcomes. According to the GHI, achievements in the health sector "have largely not been driven by large investment or the sheer gravity of the situation." Therefore, it would seem that the USG's best investment in health would be to reinforce the systems that support improved health care and build capacity to manage these systems. India provides the ideal testing ground for demonstrating GHI success because it has both adequate local investment in the health sector and grave problems on a broad range of health status indicators, particularly MNCHN.

[7] FY2011 Senior Review, August 5, 2009.

CRITICAL FINDINGS AND RECOMMENDATIONS

1. Monitoring and Evaluation

Findings:

- Vistaar's current monitoring framework does not provide a sufficient high-level overview of what the project will accomplish.
- The current Vistaar evaluation design needs to be strengthened with rigorous criteria to better demonstrate the results of the SBA training program.

Recommendations:

- Vistaar staff should define appropriate, high-level quantitative and qualitative measures including service delivery and technical assistance indicators that will help track the key project level activities, especially those for health systems strengthening, over time. The project should communicate these well to program staff, the USG, USAID, and other stakeholders, particularly the GoI and state governments in JH and UP.
- As the value of adding assistance to GoI's health management information system (HMIS) was previously assessed, the MTR team did not consider this for Vistaar but did agree that Vistaar, in examining its own data collection system, should structure a process for regular review of project data with counterparts at all levels (sector, block, and district).
- Vistaar should ask a high-quality operations research group to review the evaluation design and develop a methodology for answering a key question of the program: What is the effect of the technical assistance for SBA training on maternal health outcomes?

2. District level Coverage

Finding: Vistaar has a formidable challenge in covering the 23 districts where it is now working.

Recommendation: Rather than expanding TA to new districts, Vistaar should consider consolidating and expanding its work in the 23 districts that it is currently working in. Also, the work that the project is doing at the state level will have an impact on health systems beyond those districts they are directly involved in.

3. Technical Assistance

Findings: Vistaar is working in four thematic areas (nutrition, newborn care, skilled birth attendance and delayed age at marriage). Within each area it is working on multiple TA topics, such as state and district annual planning, supportive supervision, and interpersonal communication skills of community-level functionaries, which are intended to improve outcomes in the theme areas. The current 23 districts have a variable mix of thematic and TA areas.

Recommendation: All (or most) of the districts should have programs that focus on all technical theme areas (NBC, nutrition, DOM, and SBA), because most of the project's TA efforts (such as improving supportive supervision or ensuring adequate service delivery through VHNDs) are cross-cutting and can help to achieve results in more than one thematic area.

Vistaar is working to influence the government planning process by using the evidence generated in the first year of the program, institutionalizing supportive supervision and improving the performance of frontline workers through improving their communication skills, and enhancing the effectiveness of Village Health and Nutrition Days (VHNDs). As the modalities are the same for all technical theme areas, modalities for one can easily be extended to the others.

4. Nutrition Advocacy

Finding: While the nutrition advocacy component of Vistaar got off to a good start centrally with broad national participation and interest, including active and visible champions on the Advisory Committee, government participation seems to be inconsistent, and government officials in the Coalition for Sustainable Nutrition Security in India (CSNSI) that Vistaar helped organize seem unclear about the purpose of and their role in the same.

Recommendations:

- The project should continue to engage the GoI as an active advocate for the nutrition platform. Perhaps hold a meeting(s) with all ministries in the coalition to outline roles for each ministry and discuss how coalition recommendations can be implemented.
- Vistaar should continue to engage other partners, including other donor organizations and other active advocates for the nutrition platform, and clarify roles for them as well.
- The project should work with the various partners to see how best to move the agreed upon recommendations in the "Leadership agenda for action" into practice.

5. Coordination

Finding: Many different stakeholders are working in the same districts on MNCHN and are not taking full advantage of each other's experiences and skills.

Recommendation: Vistaar and USAID should employ all means to strengthen collaboration and integration of efforts wherever they are working. This also applies to other USAID interventions that could benefit from an exchange of information and ideas, such as education, food security, and emergency assistance.

6. GoI Human Resource Needs

Finding: There is an overwhelming shortage of health providers and supervisory staff, at all levels within the government (more than 50% vacancy rates in many categories).

Recommendations:

- Vistaar should explore and document alternative supportive supervision approaches that could sustain motivation of health workers, including use of the open discussion format to facilitate sharing of experiences and strategies for solving problems.
- The project should also continue to advocate for human resource training and brainstorm with local government officials on how best to work on human resource management and support, including improved training and staffing patterns (such as quick filling up of vacancies, and more rational division of workloads).

7. Financial Management

Finding: As of June 30, 2009, 55% of Vistaar's five-year period has elapsed, and 37% ($8,157,333) of total project funding ($25 million) has been expended.

I. INTRODUCTION

MATERNAL, NEWBORN, AND CHILD HEALTH AND NUTRITION IN INDIA

India faces one of the most critical challenges of this century: keeping up with the rising demand for basic health and social services for its women and children. Continued reductions in mortality and morbidity are difficult considering that India's population of over 1.2 billion represents one-sixth of the world's population.[8] However, this means that even small improvements in the percentage of people receiving health, education, and other social services will result in enormous numerical improvements and impact on the Millennium Development Goals (MDGs). Despite its growing momentum as a global economic superpower, India's resource distribution (76% of Indians currently live on less than US$2 a day[1]) reflects its gross poverty. India's health sector will need considerable assistance to augment its management capacity (planning, implementation, and monitoring) if it is to ensure that many more people are brought out of the endless cycle of poverty, poor education, and related ill-health.

Although there are success stories in parts of India that show great achievements, India still carries a disproportionately high share of the world's health burden. With 20% of the world's births, India contributes 28% of neonatal deaths, 23% of infant deaths, and 40% of low-birth-weight babies. Similarly, with 20% of the world's children under 5, it also contributes 49% of children underweight, 34% of those stunted, and 46% of those wasting.[9]

Rates of maternal and child malnutrition in India are among the highest in the world. The prevalence of child wasting in India (20%) is twice as high as the average prevalence in sub-Saharan Africa (9%) and ten times higher than in Latin America (2%). The prevalence of child stunting in India (48%) is more than four times higher than in China (11%). More than half (55.3%) of Indian women aged 15–49 are anemic. It is particularly worrisome that the nutritional situation has not improved significantly for the last decade, despite impressive economic growth and achievement of national food security.

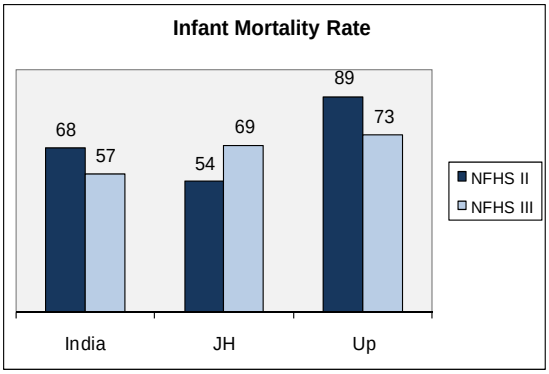
Child and Newborn Health Status: Over 57% of under-5 mortality in India occurs during the first year of life and 60% of all infant mortality occurs in the first month.[10] The major causes of death among children under 5 are diarrhea, pneumonia, asphyxia, premature birth, measles, malaria, and other infections. In the neonatal period major causes of death are sepsis, asphyxia, and premature birth.

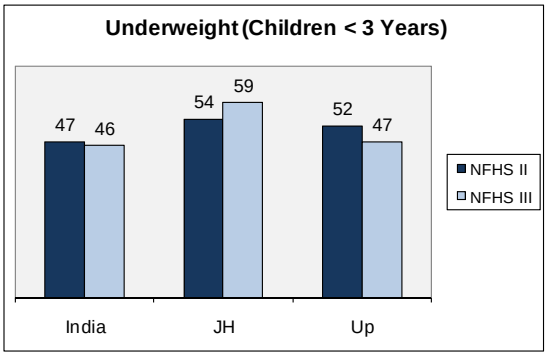
[8] Population Reference Bureau 2009 (http://www.prb.org).

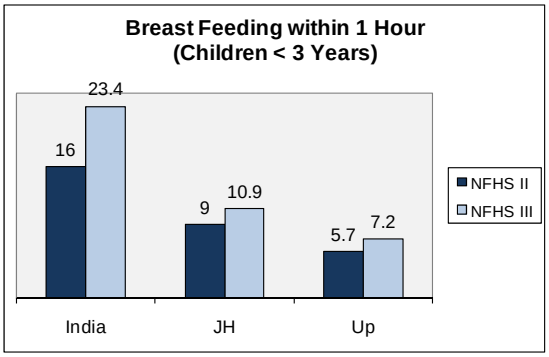
[9] UNICEF, *The State of the World's Children*, 2009.

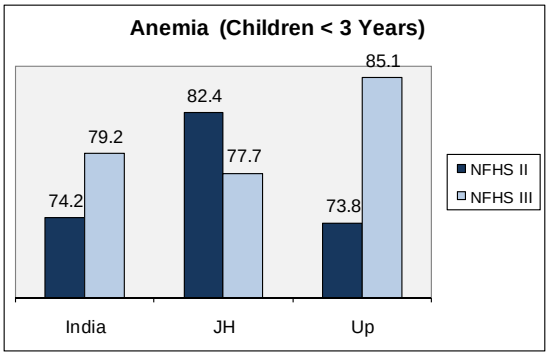
[10] National Family Health Survey III (NHFS 3), 2005–06.

TABLE 1: NEWBORN AND CHILD HEALTH INDICATORS FOR INDIA, UTTAR PRADESH, AND JHARKHAND (NFHS II, 1998–99 & NFHS III, 2005–06)





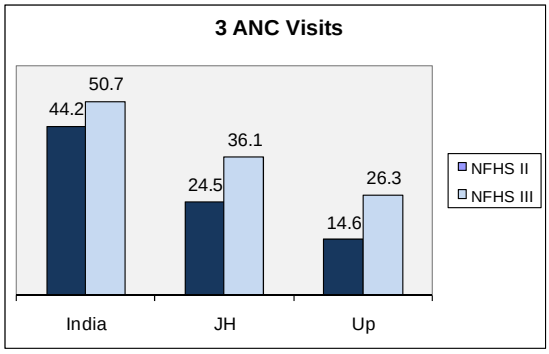


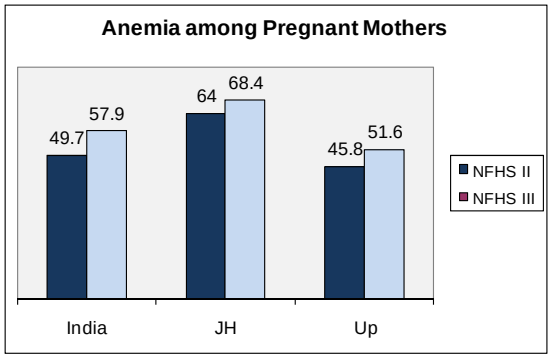


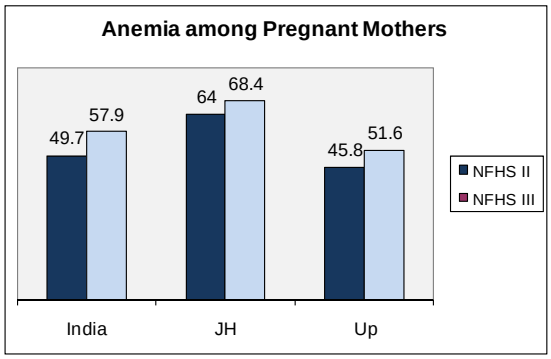
Maternal Health Status: Nationally the maternal mortality rate (MMR) is 254 per 100,000 live births, and it is higher in Uttar Pradesh (440) and Jharkhand (312).[11] The major causes of maternal deaths are, as they have been, hemorrhage, sepsis, abortions, and obstructed labor. One of every 75 women of reproductive age dies from childbirth-related causes. Only 15% of mothers receive complete antenatal care (ANC), meaning that they complete at least three antenatal checkups, consume 100 iron and folic acid (IFA) tablets, and get two tetanus toxoid (TT) immunizations. Although 65.1% received or bought IFA, the percentage of those who actually consumed it for at least 90 days was only 23.1%. Only 38.7% of deliveries take place in health facilities, and only 46.6% are assisted by a skilled health professional. In addition, numerous socioeconomic factors, such as gender discrimination and violence, undermine maternal health.

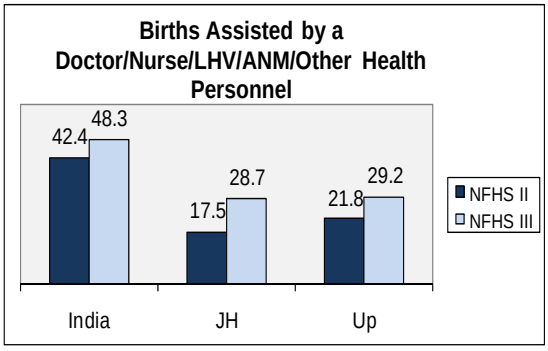
[11] Special SRS Bulletin on Maternal Mortality, 2004–06.

TABLE 2: MATERNAL AND NEWBORN HEALTH INDICATORS FOR INDIA, UTTAR PRADESH, AND JHARKHAND (NFHS II, 1998-99 & NFHS III, 2005-06)









Gender and Equity: There are significant differences in maternal and child mortality and morbidity between social, economic, and gender groups. For example, the highest rates of morbidity and mortality are found in the poorer northern states, particularly Uttar Pradesh and Jharkhand, and in groups with less educational and economic opportunity. The inequities are strongly linked with poor health status; improvements in maternal and child health will rely at least in part on addressing educational, economic, and social inequities. Girls aged 1–4 in India are 40% more likely to die than boys in the same age group. Child mortality would drop by 20% if girls had the same mortality rate as boys.[12] Similarly, nutrition levels of women and children women vary significantly by caste, wealth quintiles, and education of the mother.[13]

India's Health Sector: India has a relatively decentralized system of health service delivery, with the state governments primarily responsible for public health. The state governments face formidable challenges in ensuring availability of and access to quality health services for the most vulnerable. Recognizing the importance of health to economic and social development and a better quality of life for its citizens, the Government of India (GoI) has launched the National Rural Health Mission (NRHM) to carry out necessary architectural corrections to the basic health care delivery system. The NRHM adopts a synergistic approach by relating health to such determinants as nutrition, sanitation, hygiene, and safe drinking water. The goal of the NRHM is to improve the availability of and access to quality health care for all people, especially those residing in rural areas, the poor, and women and children. The NRHM Plan of Action includes

[12] *The Lancet*, 2003.

[13] NFHS 3, 2005-06

- increasing public expenditure on health
- reducing regional imbalances in health infrastructure
- pooling resources, integrating organizational structures, and optimizing health human resources
- decentralizing district management of health programs
- promoting community participation and ownership of assets
- introducing management and financial personnel into district health systems
- converting community health centers into functional hospitals that meet Indian public health standards in each block of the country.

The Ministry of Health and Family Welfare (MoHFW) provides most planning and policy guidance and funds special NRHM efforts. It seeks to foster collaboration with the Ministry of Women and Child Development for Nutrition (MoWCDN), which deals with children 0–6 years and adolescent girls through its Integrated Child Development Scheme (ICDS); the Ministry of Youth Affairs and Sports, for adolescent health; and so on. The MoHFW is the nodal ministry, and the largest component of NRHM implementation is currently focusing on its reproductive and child health (RCH) services.

Significant strengths of the government of India (GoI) public health system are the high-level political commitment and increasing funding for public health. There is also a vibrant private health sector that could potentially be a useful partner of the GoI in meeting the country's needs. Even so, the public sector faces numerous challenges: slow and inefficient management and financial systems, minimal capacity to implement plans and monitor programs, and numerous human resources challenges, such as low worker motivation, frequent changes in management personnel, and high staffing vacancy rates.

A few important components, among many, through which NRHM envisions achieving its goals are launching a new cadre of village health functionaries, accredited social health activists (ASHAs), strengthening primary health centers and first referral units, promoting development of district health plans, and introducing new health financing mechanisms. NRHM sees a clear role for nongovernmental organizations (NGOs) and other agencies in providing technical support for empowering and mentoring ASHAs; working on task forces; providing training, behavior change communications (BCC) support, and technical support for developing district health plans; functioning as health resource organizations, and supporting monitoring and evaluation (M&E).

Although in general GoI policies and plans are sound and national government resources intended for public health have increased significantly through the NRHM, there are still major bureaucratic, management, and human resource barriers to translating these resources into better maternal and child health.

INCEPTION OF THE VISTAAR PROJECT

Recognizing the huge gap between India's need for better access to quality health care and the health system's capacity to respond to that need, in 2006 USAID designed the National Integrated Health Program (NIHP), now called the Vistaar Project, to help achieve its health strategic objective (SO) 14: "Improved health and reduced fertility in targeted areas of India," and especially Intermediate Result 3: "Increased use of key child survival interventions."

Because USAID/India was then directed to transition its program into a "last mile" phase, it focused its maternal newborn and child health and nutrition (MNCHN) program on providing

technical assistance (TA) that would promote the goal of scaling up proven practices, rather than supporting research, pilots, or stand-alone and small-scale service delivery efforts. To do this the Mission created an exit strategy that emphasized

- fulfilling the U.S. government (USG) commitment to support achievement of the Millennium Development Goals (MDGs)
- leveraging GoI commitment to and funding of MNCHN activities (especially through the NRHM)
- strengthening systems and building local capacity to sustain MNCHN activities
- acting on the USAID commitment to promote evidence-based interventions and the use of evidence in public health planning and programming
- continuing the USAID focus on selected high-needs areas (UP and Jharkhand).

The Request for Applications (RFA) the Mission sent out set ambitious objectives for this project:

- "[NIHP will work to] significantly reduce maternal and childhood morbidity and mortality in rural and urban (areas of < 100,000 population) districts of Uttar Pradesh and Jharkhand."
- "NIHP will be integrated within the Mission's overall vision and strategy and serve as a catalyst for national programs by providing technical assistance and support for rigorous short-term operations research on models that can be scaled up by the Government through NRHM/RCH II."
- "NIHP will learn from past and current global and Indian programs, drawing on experience [with] programs supported by USAID and others, and seek to incorporate best practices on maternal, child health, and nutrition care."
- "NIHP is aimed at developing and rigorously evaluating a maternal, child health, and nutrition care demonstration and learning model that can be scaled up by the GoI. Hence, the model should be low-cost, use the Government infrastructure and personnel, and apply guidelines and recommendations stated under the Government's NRHM/ RCH II strategy. NIHP will not focus on new research questions but focus instead on testing a cost-effective, gender-integrated, scalable model."
- "NIHP's effectiveness with partners and stakeholders will be key to executing an integrated program to leverage and complement other major activities, to set priorities and supply stakeholders with valued information, and to establish and maintain the set of skills and experience necessary within the project."

OVERVIEW OF THE VISTAAR PROJECT

In response to the critical needs in the country, USAID entered into a cooperative agreement to provide TA in MNCHN over a five-year period, 2006–10. The program, now called Vistaar (a Hindi word meaning "to expand"), works most closely with the NRHM, the Reproductive and Child Health Programme (RCH II), and the Universalization of Integrated Child Development Services (ICDS), which are all guided by the GoI's Eleventh Five-Year Plan and its commitment to achieving the MDGs for maternal and child health.

> The purpose of the project is to assist the Government of India and State Governments of Uttar Pradesh and Jharkhand in taking knowledge to practice for improved maternal, newborn, and child health and nutritional status.

Vistaar is led by IntraHealth International, Inc., which has subagreements with two US-based organizations, Abt Associates and Catholic Relief Services (CRS). It also has numerous subgrants with Indian agencies, including Mamta, CINI, Vikas Bharati, and Ekjut.

The Vistaar Project works in four major technical areas:

- community-based newborn care (NBC)
- nutrition (with a focus on anemia and complementary feeding)
- delayed age of marriage (DOM)
- skilled birth attendance (SBA)

Vistaar objectives are to

- provide strategic evidence-based TA to strengthen the MNCHN programs of the GoI and the governments of Uttar Pradesh (GoUP) and Jharkhand (GoJH) in priority areas
- generate evidence about effective, efficient, and expandable MCNHN interventions based on TA experiences (previously called "demonstration and learning")
- advocate with the GoI, GoUP, and GoJH for increased emphasis on better evidence-based MNCHN programming, especially in the areas of nutrition and newborn care.

Vistaar also has two cross-cutting focus areas:

- *Equity and Gender*, to ensure that its efforts are directed to improving MNCHN for the most needy and vulnerable.
- *Knowledge Management*, to ensure that project work is based on evidence and that Vistaar actively promotes and shares evidence to improve MNCHN.

PURPOSE AND METHODOLOGY OF THE MID-TERM REVIEW

The objectives of the review are to

- assess the progress and achievements of the Vistaar Project relative to its stated objectives; and
- make recommendations for the remainder of the Vistaar term and for other USAID-funded MNCHN projects.

To accomplish this, the MTR assesses

- project results and achievements to date
- project strategies and technical approaches
- project management.

(See Annex A for the full scope of work for the MTR.)

USAID/India asked the Global Health Technical Assistance (GH Tech) Project to provide a team of consultants to conduct the MTR. The team provided comprised four members with extensive public health expertise: two from India, an American with extensive India experience, and a former USAID Population, Health, and Nutrition Officer.

The MTR team used both quantitative and qualitative evaluation approaches, including examination of data sources, key informant interviews, and field-based interviews of MNCHN

policy makers, program and planning supervisors, and front-line health workers. The team reviewed historical and recent studies and reports on MNCHN in India, including those from other USAID-supported projects. It identified and analyzed critical findings and lessons learned, paying particular attention to the contribution of USAID-supported activities that identify gender and equity-related issues, especially reaching girls and women and underserved populations.

Major Data Sources

Key Informants and Sites Visited

Informants selected for interviews represent major stakeholder organizations involved in MNCHN, including national and state program managers and policy makers, and district managers, NGOs, and donor organizations. The MTR team made a strategic decision to use a participatory process whenever possible and to seek and utilize inputs from village health workers (ASHAs, ANMs, and AWWs) and all levels of Vistaar staff and the public whenever possible to understand the context for Vistaar and the health sector.

To gain perspective on geographical variations, the MTR team scheduled site visits to cover all types of functionaries, including other development partners and the Vistaar team offices, in two districts in each of two states, UP and JH. (See Annex B for a list of informants and sites visited.)

Documents and Data Reviewed

To examine trends and patterns in MNCHN in India, particularly in the two target states, the team analyzed information from all National Family Health Surveys (NFHS), the Sample Registration System (SRS), service delivery statistics from the national management information system (MIS), Vistaar's monitoring plans, and interactions with project staff members. These data sources combined to provide a retrospective picture against which to understand where Vistaar would be best-advised to plan for and collect information in its remaining years. (See Annex C for a list of documents reviewed.)

VISTAAR AND THE GLOBAL HEALTH INITIATIVE

Building on a long history of USG commitment to supporting health activities throughout the world, in May 2009 President Obama announced an approximately $63 billion commitment to global health to address some of the most serious health problems facing the world's poorest people. To guide this, Washington has recently disseminated "Saving Lives, Strengthening Systems,"[14] which was drafted by the Global Health Initiative (GHI). The GHI focuses attention and resources on such global health challenges as HIV/AIDS, maternal and child mortality, tuberculosis, malaria, tropical diseases, unintended pregnancy, and undernourishment.

The challenge for the GHI is to integrate existing programs into a whole that delivers more than the sum of its parts by achieving synergy and sustainable outcomes. Because previously, the GHI says, achievements in the health sector "have largely not been driven by large investment or the sheer gravity of the situation, " the USG's best investment in health would be to reinforce the systems that support improved health care and build capacity to manage these systems. India provides the ideal testing ground because while it has adequate local resources to invest in the health sector, it is underperforming on a broad range of health status indicators, particularly MNCHN, that disproportionately impact health status and achievement of the MDGs.

While the GHI framework is still being developed and a full outline would be beyond the scope of this MTR, a select sample of areas where Vistaar is working that correspond to the GHI strategy is presented below:

[14] FY2011 Senior Review, August 5, 2009.

Equity and Gender

Vistaar is concentrating on creating an enabling environment for bringing health services to communities to increase services for women and adolescent girls and for infants and children at a critical stage in their physical development. Because these services will be primarily provided by women, Vistaar is helping districts to train and supervise female health workers in a supportive and reinforcing way. Its efforts to support DOM will ensure that young women have the opportunity to stay in the education system longer and have more employment opportunities before marriage and pregnancy. Sex-disaggregated data collected during the Vistaar-supported BCC campaign (discussed below) show that gender-related attitudes and practices are influencing behavior.

Government Ownership

USAID and the Vistaar team began with a strategy that showed flexibility and an understanding of the local environment. By talking with government stakeholders at all levels and with other technical advisors, Vistaar was able to help the GoI find consensus on the need for a more systematic way of setting priorities for the relatively new NRHM program and planning process. Vistaar has continued to focus its efforts not only on getting the government to own the activities the project supports but also to getting active participation from all stakeholders.

Sustainability and Health Systems Strengthening

Vistaar is not intended to be as a provider of services; rather, it is a facilitator, enabling the government to improve coverage and deliver services effectively. One aspect of the project is to build government capacity to support and maintain health care systems and to plan for long-term results.

II. PROGRESS TOWARD PROJECT OBJECTIVES

VISTAAR GOAL, OBJECTIVES, AND STRATEGIES

Goal: Vistaar goal's is to improve MNCHN status by helping the government to take proven practices to scale and thus better take knowledge to practice.

Objectives:

- **Provide strategic evidence-based technical assistance** (TA) to strengthen the MNCHN programs of the GoI, GoUP, and GoJH in priority areas.
- **Generate needed evidence** about effective, efficient, and scalable MCNHN interventions based on TA experiences (previously called "demonstration and learning").
- **Advocate** with the GoI, GoUP, and GoJH to give more priority to improving evidence-based programming in MNCHN.

Objective 1: Working with governments and other stakeholders, the project team identified several areas for strategic TA:

- Improving the performance of community health workers, especially through supportive supervision and motivation
- Improving the communication skills, especially interpersonal, of community workers
- Scaling up quality Village Health and Nutrition Days (VHNDs), a priority convergence activity identified in the NRHM
- Improving government capacity in planning and program management, especially use of evidence.

These TA areas were selected based on government priorities and plans, government interest and request for this assistance, evidence that inputs in these areas could have a significant impact on MNCHN, and Vistaar's comparative advantages. Like the GoI's NRHM approach, most of the TA is targeted at the district level (population between one to two million), although some is at the state level.

Objective 2: Besides providing TA, Vistaar will monitor those efforts to ensure they are effective, make adjustments as needed, and document which TA approaches are working at scale and which are not. While TA at the state and district levels began only recently, it will add evidence generation and a learning dimension to the TA effort that should provide useful feedback. The learning is intended to contribute to the (limited) evidence base about operational issues and how better to scale up effective MNCHN approaches and practices within the government system.

Objective 3: The Vistaar team has led efforts to focus national attention and action on nutrition. The NFHS 3 results, disseminated in 2007, showed a clear need for better nutrition programming. Vistaar's contribution has been national-level consultations on nutrition; it has helped form and supports India's Coalition for Sustainable Nutrition Security. (See below, Leveraging Action, for more on the coalition.)

Strategies: Vistaar's overarching strategies are to

- support government NCHN programming (primarily through TA)
- promote the use of evidence and improve knowledge management
- learn about and demonstrate scaling up proven practices in the GoI system
- foster collaboration and partnerships
- integrate equity and gender into MNCHN programs.

Supporting MNCHN programming: The Vistaar Project was specifically mandated to support large-scale national and state health and nutrition efforts rather than delivering services. Working with USAID, Vistaar therefore defined TA as *strategic and catalytic inputs to strengthen ongoing government efforts, not to become a substitute for them*. Vistaar also sought to plan and offer TA at the district level so that its efforts would be operating at a scalable level from the start (not at the traditional small-scale pilot level) and offer lessons about what works at scale.

Because government officials were used to donors and NGOs conducting small pilots, paying for training service providers, providing equipment or materials for clinics, and otherwise helping provide services, it took some time for Vistaar to work out the mandated TA plan and strategy, and it took considerable time and careful attention to operationalize the strategy.

Promoting the use of evidence and improving knowledge management: Taking knowledge to practice requires that knowledge be easily available for government leaders to use. Vistaar has conducted numerous activities to increase the amount of MNHCN evidence that is publicly available, especially on government web sites, and to promote the use of evidence in state and district government planning. Vistaar has been able to influence the annual MoHFW and MoWCD planning systems to improve their review of the current MNCHN situation; review data on past progress, lessons, and needs; and expand participation in the planning process. A number of state and district planning teams reviewed the MNCHN recommendations from the evidence reviews (ERs) and incorporated some into their plans.

Vistaar also modeled the ER process, which brought Indian experts together to consider the evidence on priority topics and use it as the basis for recommendations for programming. (See below, Evidence Reviews, for more on this subject.)

Demonstrating and learning: Donors and NGOs promote a number of models and approaches, generally based on small-scale pilots. However, there is limited evidence on whether these can work at scale and how to scale them up. The government often has concerns about the intensity, cost, and feasibility of scaling up models. The Vistaar strategy is to identify opportunities to introduce a promising or proven new approach (as recommended in the ERs) into the government system at scale, and to document the learning associated with it. Thus Vistaar is not only providing strategic TA to improve the GoI system at scale, it is also generating evidence about effecting change at scale and with scale-up potential. With expert advice, the Vistaar team has designed a monitoring system for each district that will provide information about the inputs, process, outputs, and outcomes of Vistaar work. The system uses government data when possible but also collects primary data as needed. However, the monitoring system needs to be strengthened to differentiate between planning and monitoring indicators; address information needs for making policy, planning, and monitoring decisions; design a smaller number of measurable indicators; and ensure that data collection and analysis are done routinely rather than ad hoc.

Fostering collaboration and partnerships: To work effectively with the government and other stakeholders, Vistaar has pursued highly collaborative processes of listening and learning from others, problem-solving, and building consensus. Vistaar trained its staff and a number of government partners and stakeholders in collaborative processes, such as whole-person process facilitation and open space technology, that facilitate communications in the work place and during meetings.[15]

Equity and gender: Vistaar is committed to addressing the significant equity barriers to improving the MNCHN. Its strategy has included building staff sensitivity and skills related to equity and gender and conducting rapid reviews and needs assessments to increase project and government understanding of these issues in each of the technical themes (nutrition, newborn care, DOM, and SBA). The joint Vistaar/government assessments used participatory methodologies, including focus group discussions and interviews. The Vistaar team and district officials used the resulting information to strengthen their plans for cooperative work, as is reflected in the district TA plans. Vistaar gathers and uses information on equity, including gender equity, from its baseline survey and MIS.

EVIDENCE REVIEWS

During the start-up phase (October to December 2006) Vistaar staff consulted with USAID, national, and state government officials, and other stakeholders (e.g., UNICEF, other USAID projects). They found there was no agreement on which MCNHN models or even best practices should or could be scaled up in India. Vistaar therefore needed to build consensus and a credible foundation in order to promote a model acceptable to the GoI and then offer TA to scale it up. Accordingly, Vistaar's Year 1 workplan focused on facilitating reviews of the evidence in priority MNCHN areas, to be conducted by recognized Indian experts with government leadership and involvement.

From the priorities identified in the national plans and objectives and input from USAID and other stakeholders, Vistaar selected six evidence review (ER) topics, four in technical areas and two in complementary process areas:

Technical

- Delaying age of marriage and first birth
- Iron deficiency anemia prevention and treatment
- Complementary feeding
- Community-based newborn care

Process

- Strengthening village health committees
- Improving the performance of community health and nutrition functionaries

The reviews were intended to benefit not only Vistaar's efforts to identify MNHCN models and select TA areas but also the MNHCN community by increasing access to and use of evidence and forging a consensus about how to translate this knowledge at scale into practice.

[15] For more information on this technology, see www.openspaceworld.org/ and www.genuinecontact.net/mtg_whole_person.html.

Vistaar named an ER leader from the staff, who first conducted a desk review of evidence from interventions related to each selected technical topic. The team leader also had to proactively seek evidence because little was available through public access. The leader selected information to present in the review based on whether it met an evidence standard. At first the standard was high and included such criteria as that the evidence should come from at least the block level (population of 100,000 or more), include an external evaluation, and have outcome (service delivery) data collected with a credible methodology, such as a baseline-endline or case-control design. However, very few research reports or studies met the population standard, so the Vistaar team revised the standard to allow evidence from smaller-scale interventions.

During the ERs experts from all over India were brought together to discuss each of the technical and process priorities. Vistaar used an open meeting format to facilitate free discussion and acceptance of differing opinions in a safe and organized environment. While Vistaar staff primarily organized, led, and synthesized the ERs, all participants interviewed (including one on the MTR team) found the ERs to be inclusive, allowing for the government and all other partners to buy into the results. Considerable effort has been made at various levels of government to use the ER highlights and cite reference materials used to support the ERs.

After the first two or three ERs, it was clear that trying to reach consensus on a certain package or model was not a viable approach. In these a model was interpreted as a larger package of interventions and approaches, and it was often associated with a certain organization. Most of the reviewers felt there was not enough quality evidence to be able to recommend a model, and some of the participants had vested interests in promoting a certain model (e.g., CARE RACHNA, CLICS, Dular positive deviance, SEARCH), so the approach of rating or selecting a best model became controversial. (Although Vistaar considered it, it was not feasible to exclude all persons or organizations that might have some association with an intervention or model being reviewed, and thus a possible conflict of interest.) Through this process, the Vistaar team learned that it was more appropriate to seek consensus on specific evidence-based practices, valuable lessons, or recommendations that would improve MNCHN in the government system rather than try to select one model. Lessons or recommendations were narrower, more focused, and less “branded.” For example, a recommended approach was to use regular block meetings more effectively for mentoring and in-service training and other supportive supervision activities. The recommendations then gave direction for Vistaar to work with government to select TA areas.

The Vistaar team published an Evidence Review Brief on each of the six ERs and shared these with national and state government ministries, departments, and stakeholders. The Vistaar team has also worked to ensure that the ER Briefs and the source documents used to conduct the review were in the public domain. For example, these documents are currently available through the web sites of the National Institute of Public Cooperation and Child Development (NIPCCD) and the National Health Systems Resource Centre (NHSRC). The directors of NIPCCD and the NHSRC both reported to the MTR team increases in hits to their web sites since adding this information (see also below, Generating Evidence).

Results to date: Outcomes of the ERs included (1) increased dissemination of, and access to, MNCHN evidence; (2) increased awareness and use of the data by experts as they consider programming implications and obvious gaps; (3) analysis and some consensus on recommendations from the evidence base; (4) an evidence-based foundation and menu of options for the Vistaar Project to use in working with governments to improve MNCHN; and (5) lessons about processes for conducting ERs.

Lessons learned: Vistaar found that MNCHN evidence is not easily accessible to policy or program leaders, especially through public access (e.g., the Internet). There was little information on the outcomes of interventions, and even less on the process for achieving outcomes or the costs of doing so. This finding reinforced the need for the Vistaar Project to (1) work on

expanding public access to evidence; (2) produce process documentation to contribute to the evidence about how to improve district MNCHN programs; and (3) capture the costs of the approaches selected (see Generating Evidence for more on costing).

Another lesson was that it can be challenging to interest the government (particularly the MoHFW and MoWCD) in reviewing or using evidence; generally they will engage only if the review is of a government high-priority area that they select and there is some opening or discussion within the government system about how to address it. (Government leaders selected all the Vistaar ER topics as priorities.) The ERs also worked well when there was a senior government "champion" who acted as the leader or sponsor of the review and the expert meeting. Despite some early skepticism, the government and other participants appreciated the review process and the resulting recommendations.

For a review of the ERs, please see the handouts prepared by Vistaar on each. See Annex F for a review of the newborn care ER based on an MTR team member's experience.

GENERATING EVIDENCE

A key objective in the Vistaar Project is to contribute to the evidence on MNCHN so that the information can be used to inform and improve performance (knowledge to practice). While the majority of the MTR discussion on generating evidence took place during the ERs and will take place at the district and state levels, some additional activities are underway.

Vistaar also worked to identify ways to share lessons nationally and beyond, such as presenting the lessons from ERs at national and international forums, as was done with the MCH STAR (a USAID-funded project) consortium of partners (April 2009); the USAID Population, Health and Nutrition Partner 'Meeting (June 2008); the Indian Science Congress (January 2008); and the regional Implementing Best Practices conference in Bangkok (September 2007).

Participatory process: Vistaar clearly recognizes the value of creativity, leadership, and problem-solving capacity in its staff and of fostering collaboration with other organizations. The Vistaar team applied these approaches in its core technical work—for example, in facilitating experts to conduct ERs and in generating ideas about how to address major challenges, like improving nutrition in India. Several persons interviewed mentioned that Vistaar's consistent use of participatory approaches set it apart from the many projects working in public health in India and enhanced its reputation as a team that could facilitate productive meetings, generate creative ideas, solve problems, and manage conflict.

Performance improvement: The objectives of Vistaar's work in performance improvement (PI) are to

- demonstrate that PI is an essential catalyst for technical interventions to achieve improved health outcomes at scale
- contribute to filling information gaps in the PI process
- generate lessons for future programming in improving human resources for health
- enhance organizational, national, and global knowledge of successful strategies for integrating performance factors into public health systems.

The PI framework used by IntraHealth International Inc. specifies five factors believed to influence performance outcomes: job expectations, performance feedback, environment and tools, motivation and incentives, and knowledge and skills.

After considerable analysis using the participatory process with other stakeholders, Vistaar prioritized requirements for strengthening performance in MNCHN:

- Making supervision more supportive
- Improving the quality of training and ensuring follow-up, especially through mentoring in the field
- Developing human resource policies that are gender-sensitive and support female frontline workers (critical to attract and retain workers in difficult and remote areas)
- Rewarding and recognizing good performance
- Building capacity to decentralize primary health services.

The experts also identified several gaps where additional knowledge needs to be generated.[16]

Program performance budgeting (PPB): PPB is an internationally recognized best practice using outcome budgets to inform investment. It substantially improves transparency and accountability by requiring public entities to describe their programs, identify their goals, demonstrate the results of their work, and identify their future objectives. When considering competing priorities, decision-makers can use this information to make a more effective and efficient allocation of scarce resources. As the states and districts become more experienced with this new approach to budgeting, citizens should expect more transparency, more effective budget allocations, and a more realistic understanding of the results of government spending. This new budgetary architecture is called for in the NRHM Vision Statement. [17]

PPB is a reform measure to improve transparency and accountability. Decision-makers use the information to allocate scarce resources more efficiently and effectively. Because this is a new approach to budgeting for states, development of the skills needed takes time. The methodology adopted in Jharkhand is based on the experience in Karnataka and Uttarakhand, as is reflected in the PPB manual used for implementation in Jharkhand. The methodology was developed by the REFORM Project, a USAID/India-funded project.

The GoJH has launched an initiative, implemented by Vistaar, to ensure use of PPBs in all 24 of its district health offices. The work plan calls for training secretariat-level NRHM budget and program officers and teams of 6–7 officers from each of the 24 district health resource centers. The PPB methodology will enable the Jharkhand NRHM program to better deliver health services by rationally distributing staff and work responsibilities across its offices. PPB makes this possible because it allows for the monthly mapping and tracking of budget utilization by programs, subprograms, and schemes, which in turn helps managers to identify those experiencing time and cost delays in budget and work execution.

Vistaar is currently working in five districts. Use of PPB will enable it to complete its inter-sectoral health plans for incorporation into the state health plan. At the state level, the PPB will help track budget delivery against specific programs, subprograms, and outcome indicators.

Achievements to date:

- Vistaar began working in five districts (Deoghar, Ramgarh, Khunti, Gumla, and Latehar) on a pilot basis in February 2009.
- A task force to ensure PPB implementation was constituted on February 19, 2009.

[16] For more information on the PI ER, see the Evidence Review Series #6, available at www.nipccd.net.

[17] NRHM: Framework for Implementation, page 11.

- Vistaar developed a tool kit, also in February.
- In four of the five districts task forces have been formed comprising the civil surgeon, district program manager, and other key health department staff.
- A workshop for the district task forces was conducted in May 2009.
- A PPB mentoring plan has been prepared in consultation with the five civil surgeons.
- Feedback on the draft plan has been provided to task force leaders.
- Districts are expected to submit the PPB by November 2009.

Costing: The ERs Vistaar carried out on MNCHN reported the inadequacy of information and analysis of the cost of services for maternal and child health and nutrition programs in India. While the ERs found that certain programs were effective in producing improvements in MNCHN outcomes, there was little data on what it would cost to replicate an intervention or to apply an intervention at scale. Often financial analysis was not included in assessments of the interventions, since provision is not usually made for generating data on intervention cost. This lack of evidence makes it difficult for governments to make informed decisions on how to effectively invest their resources in MNCHN.

The Vistaar Project intends to collect cost data for interventions introduced as a result of its TA support to districts in UP and JH so that policy makers and program implementers can have more comprehensive information with which to plan and implement MNCHN activities. The cost analysis will include prospective costing and a limited number of retrospective costing analyses using an incremental cost approach.

LEVERAGING ACTION

National Support for Nutrition Advocacy

Coalition for Sustainable Nutrition Security in India

We met on the eve of the 60th anniversary of India's Independence to continue the work to achieve Mahatma Gandhi's vision:

The first task of an independent India must be to eliminate hunger.

Sixty years after independence, national survey data (such as NFHS III) show that the nutrition situation has not improved as desired in some areas in India, with almost 50% of our children underweight and more than 70% of our women and children with serious nutritional deficiencies, such as anemia. Although there are success stories and parts of India which show what we can achieve, the level of malnutrition in India today is morally unacceptable and has enormous costs in terms of social and economic development.

Quote from the Chennai Declaration at the National Nutrition Conclave, August 14, 2007, when the Coalition for Sustainable Security in India was formed.

While there is a national nutrition plan that most nutrition experts consider complete, though it needs updating, the NRHM does not have a prominent focus on nutrition, and there is no clear national or state leadership for it. A lack of convergence between ministries is reflected in the fact that some consider that nutrition falls under the MWCD and its ICDS program is the government's main nutrition program. However, the ICDS is actually an early childhood development effort designed to provide replacement foods for the target group of 3–6-year-olds;

it does not cover all children aged 0–6 years. The 0–3 group has not received the kind of attention it deserves and neither the MWCD nor the MoHFW has a clear mandate to take responsibility for this issue. While there have been some efforts within ICDS to serve children under 3 and mothers, as well as interventions such as nutrition education, there is still a significant need for programs that focus on nutrition services and information, particularly in preschool settings and homes.

While most of the its work is at the state and district levels in UP and JH, Vistaar is also engaged in a high-profile advocacy effort (Objective #3) to bring attention to nutrition issues in India and to build consensus on how to improve nutrition security. The effort started with widespread consultations and led to the creation of the Coalition for Sustainable Nutrition Security in India, which is now a recognized national force in advocating for nutrition policies and programs. The coalition consists of senior policy, program, and political leaders serving as a Steering Committee and technical and program experts who work through task forces on activities sanctioned by the Steering Committee. The coalition is chaired by Professor M. S. Swaminathan, a globally recognized agricultural scientist, leader of the green revolution in India, and now leader of an "evergreen" revolution promoting sustainable food security. The Vistaar Project acts as the coalition secretariat.

Results to date: Vistaar has (1) built collaboration and communication between the many stakeholders in nutrition security through its support to the nutrition coalition; (2) supported the consensus document, the Leadership Agenda for Action; and (3) supported many related activities in support of the Leadership Agenda, such as the course offered through Indira Gandhi National Open University (IGNOU). The coalition work represents a breakthrough in collaboration between groups that did not work together or disagreed in the past, such as government departments (MHFW, MWCD, NIPCCID, NIHFW, NHSRC); bilateral donors and their projects (USAID, DFID); unilateral donors (UNICEF, World Bank, WFP, WHO); foundations (Bill and Melinda Gates Foundation); NGOs (CARE, Save the Children, M. S. Swaminathan Research Foundation, Nutrition Foundation of India**,** Dangoria Charitable Trust); and academic groups (National Institute of Nutrition, Indian Council of Medical Research). Vistaar was also able to influence the work of the task forces, as they prepared the Leadership Agenda, to include ERs and ensure that the recommendations made were supported by evidence, or if not were presented as expert opinions.[18]

IGNOU nutrition learning course: Working with the nutrition coalition to advocate for nutritional security, "The Indira Gandhi National Open University (IGNOU) has initiated a leadership program on Nutrition Security and Sustainable Development which seeks to review the current situation in India, analyze the complex causes of poor nutrition, and provide evidence of what works to improve it."[19] The program is intended to sensitize and guide policy leaders to rely on evidence-based programming for achieving nutritional security, is open to graduates, and can be completed in one to six weeks.

Behavior Change Communications Campaign

The national government wanted to enhance awareness of various NRHM programs and key MNCHN messages (e.g., JSY) and requested assistance from the Vistaar Project to create public service television and radio spots. The campaign aimed to promote key program areas and schemes and improve target audience attitudes and knowledge.

[18] Information about the coalition and all related documents are available on the coalition public access web site: (www.nutritioncoalition.in)

[19] From a letter written by the Assistant Commissioner (Child Health), August 4, 2009. More information on the program is available at http://www.ignouonline.ac.in/save/NSSD.htm.

Vistaar provided technical expertise to improve the messages and design (print, radio, and TV information and action messages) and selected the local contractor to do the work; the government paid for all printing and dissemination (air time, etc.).

USAID's MCH STAR project has evaluated the BCC campaign and favorable preliminary findings show evidence of best practices in the campaign. The evaluation objectives were to

- evaluate the extent of reach, visibility, and exposure of the target audiences to the campaign.
- evaluate target audience recall, comprehension, and appeal of the theme and specific spots.
- assess how the campaign affected the perceptions of policy-makers and program managers.
- provide feedback to MOHFW for improving the communication strategy.

The results should be disseminated shortly.

The following materials were produced as part of this MNCHN BCC campaign:

- ANC and Institutional Delivery (4 spots)
- Family Planning (5 spots)
- NRHM/Health Services (2 spots)
- Immunization (2 spots)
- Newborn Care (1 spot)
- Age at Marriage (1 spot)
- Nutrition and Breastfeeding (1 spot)

VISTAAR ASSISTANCE TO JHARKHAND AND UTTAR PRADESH

Although the MNCHN situation in some parts of India is quite good, other, primarily rural, parts of the country face major challenges. Working in the northern states of Uttar Pradesh and Jharkhand, Vistaar is addressing related issues. These two states are home to approximately 10 million pregnant women and 14 million children under the age of 5.

Vistaar has a clear mandate to assist the GoJH and GoUP by providing requested TA. By working to build the capacity of the GoI and the two state governments to implement the NRHM, Vistaar aims to improve maternal, newborn, and child health and nutritional status to help them achieve the MDGs.

Vistaar in Jharkhand

Introduction to the State

In 2000 Jharkhand became India's 28th state when Parliament passed the Bihar Reorganization Bill, carving 18 districts out of southern Bihar to form the Land of "Jungles" and "Jharis" (bushes), which currently contain 29% of total JH land area. The original 18 districts have been reorganized into the current 24. Because JH is rich in iron ore, copper, bauxite, coal, and uranium, it contains some of India's most industrialized cities, among them Jamshedpur, Ranchi, Bokaro, and Dhanbad. Tata Steel, which has its corporate office in JH, reported gross income of Rs.

204,910 million for 2005. Nevertheless, only 22% of JH is urbanized, and annual per capita annual income is only US$90.[20]

Such conditions have created fertile ground for the Naxalite insurgency that continues to plague the state. The Naxalites are a Communist group that started in Naxalbari, West Bengal, in response to oppression of the poor. They have grievances with the government about access and distribution of resources and inflict random terror and violence.

The population is diverse n language, religion, and cultural beliefs and practices, which creates another layer of challenge in crafting health messages and providing services. The current population of 32.2 million is 28% tribal (with 32 primitive tribal groups); 12% scheduled castes, and 60% others. There is substantial variation by district: three have a tribal population of over 50% and eight districts are 25-50%. The primary languages are Hindi and English, but 42% of the population speaks Bengali.

> Of the 32,620 villages in Jharkhand, only 14,667 (45%) have electricity and only 8,484 (26%) are reachable by road.

MNCHN Indicators and Status of JH Goals for MDGs 4 and 5

In an estimated JH population of 32.2 million, there are 1 million pregnancies annually.[21] The estimated number of births is 870,000, and infant deaths may be more than 41,500.[22] The sex ratio—941 females to 1,000 males—is better than in many states.

The main goal for mothers in Jharkhand is to reduce the maternal mortality rate (MMR) from 371/100,000 to 100 by 2012.[23] However, the most recent SRS released in 2009 for 2004–2006 places JH with Bihar with an MMR of 312.[24] The goal for reducing the infant mortality rate (IMR) is 30/1,000 live births, from the current 48, by 2012. The goal for the neonatal mortality rate (NMR) is 18 by 2012 (current level not stated). Surprisingly, using SRS statistics JH's IMR has been consistently lower than the India national average of 55.[25] Table 3 shows related MNCHN indicators and targets from the state NRHM Plan.

[20] Department of Health and Family Welfare, Government of Jharkhand, Programme Implementation Plan on National Rural Health Mission (2008-2009), Namkum, Ranchi, Jharkhand.

[21] State of Jharkhand, NRHM State Plan, 2009-2010.

[22] Using the estimates in the Vistaar Deoghar TA Plan, July 24, 2009, p. 2.

[23] State of Jharkhand, NRHM State Plan, 2009-2010.

[24] SRS, Office of the Registrar General, Special Bulletin on Maternal Mortality in India, 2004-2006, New Delhi, April 2009.

[25] The NRHM State Plan attributes these statistics to SRS data.

TABLE 3: MATERNAL, NEWBORN, AND CHILD HEALTH AND NUTRITION INDICATORS, 2009–10					
	Indicators	**Status Now**	**2012 Targets**		
	Maternal health	(%, NFHS-3)	09-10 (%)	10-11 (%)	11-12 (%)
1.	% institutional deliveries	17.8 (19.2)	35	60	75
2.	% births assisted by health personnel (doctor, nurse, auxiliary nurse midwife, lady health visitor)	25.0 (28.7)	70	80	80
3.	% mothers who received postpartum care from health personnel within 2 days of delivery (last child)	30.9 (17.0)	60	70	70
4.	% pregnant women receiving 3 ANC	30.5 (36.1)	70	80	80
5.	% pregnant women receiving any ANC	55.9	80		
6.	% pregnant women receiving tetanus toxoid injection	54.9	70		
7.	% pregnant receiving 100 IFA pills	19.1			
8.	% pregnant women age 15–49 who are anemic	70.4 (68.4)	60	50	40
	Newborn health				
1.	% newborns breastfed within 1 hour of birth	34.6 (10.9)	85	90	90
2.	% newborns provided newborn care at time of delivery and 1st week of postnatal period				
	Nutrition				
1.	% infants who were breastfed exclusively until 6 months	75.3 (57.8)	85	90	90
2.	% infants receiving complementary feeds apart from breastfeeding at 9 months	53.6 (65.3)	70	80	90
3.	% children aged 6–35 months who are anemic	77.7 (77.7)	60	50	40
4.	% children under 3 age with diarrhea in the last 2 weeks who received oral rehydration salts (ORS)	21.3	70	80	90
5.	% children under 3 who are underweight	59.2 (59.2)	50	45	40

Source: State of Jharkhand NRHM, Plan. It is not stated where these numbers in the NRHM Plan came from.

Extreme poverty, underdeveloped basic infrastructure such as roads and electricity, a population dispersed in hard-to-reach hamlets, and the Naxalite security threat have all contributed to JH's very low indicators for MNCHN.

The Jharkhand Health System

Lack of health infrastructure and human resources is a major problem that interferes with provision of basic coverage as well as quality of health services. Currently 194 community health centers (CHCs), 330 primary health centers (PHCs), and 3,938 health subcenters (HSCs) are functioning in the state. Applying Indian Public Health Standard (IPHS) norms, the numbers of

proposed CHCs, PHCs, and HSCs are listed in Table 4. The gap in infrastructure in any category varies by district but is on average more than 30% for HSCs and more than 50% for PHCs.

TABLE 4. GAPS IN INFRASTRUCTURE AND HUMAN RESOURCES IN JHARKHAND

Category	In-Place	Sanctioned / Required	% Short of Sanctioned /Required	Source of Data
Health infrastructure				
HSC	3,958	5,588[a, b]	29	Table 12, RHS Bulletin, MOHFW, GOI, March 2007 http://www.mohfw.nic.in/RHS%20Bulletin%20March%202007%20-%20Tables.pdf
PHC	330	891[a]	63	,,
CHC	194	223[a]	13	,,
AWC	31,074	32,097	3	http://wcd.nic.in/icdsimg/ICDS-vacancy%20position%20%200208-page%205.htm
Human resources				
Sahiyas (ASHA workers)	39,556	50,000	20	http://www.mohfw.nic.in/NRHM/Documents/ASHA_Training_Status.pdf
ANMs at HSC and PHC	4,372	5,549[b]	21	RHS Bulletin, MOHFW, GOI, March 2007 http://www.mohfw.nic.in/RHS%20Bulletin%20March%202007%20-%20Tables.pdf
LHV	278	461	40	,,
PHC Medical Officer	2,323	3,927[b]	41	,,
AWW	30,617	32,097[b]	5	http://wcd.nic.in/icdsimg/ICDS-vacancy%20position%20%200208-page%205.htm
Mukhya Sevika (Supervisor)	486	1,146	58	,,
CDPO	148	192	23	,,

a: Estimated requirement as per 2007 population (http://censusindia.gov.in/Census_Data_2001/Projected_Population/Projected_Population.pdf)

b: In place as on March 2007 as per Table 12- RHS Bulletin, March 2007, GoI (http://www.mohfw.nic.in/RHS%20Bulletin%20March%202007%20-%20Tables.pdf)

Health staffing gaps continue to be a major challenge in delivering public health services. According to the NRHM Program Implementation Plan (PIP) 2008–2009, "the actual scenario for health manpower (human resources) is pathetic." At present in CHCs and block PHCs, of the category of doctors (4 specialists, 2 MBBS [Bachelor of Medicine, Bachelor of Surgery] doctors, and 1 AYUSH [Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homoeopathy] practitioner), about 50% may be in position but they are not rationally distributed. According to staffing norms, each HSC should have 1 male multipurpose worker (MPW) and 2 auxiliary nurse midwives (ANMs), so there is a shortage of 3,236 MPWs and 4,222 ANMs. The NRHM plans for JH do not address the lack of direct supervisors of ANMs, namely lady health visitors (LHVs), and do not integrate the work plan of the ICDS system and its staff.

The lack of supervisors of frontline workers is a huge barrier to the ability of the health system to respond to quality concerns. Over 40% of LHV positions in the Health Department and 58% *Mukhya Sevika* positions in the ICDS dept are vacant.

The Naxalite insurgency throughout most of Jharkhand severely limits the ability of health workers to engage in outreach to villages, especially after dark. Women and families may not be able to risk traveling out of their villages even in an emergency for fear of violence, including sometimes landmines on roads—and 74% of the villages are not even connected by road. These two factors elevate the importance of village-based health care.

The recently recruited *Sahiyas* (ASHA workers) are considered a major resource for direct service delivery, enhancing BCC messages and promoting institutional deliveries. Other local practitioners, such as traditional birth attendants (*dais;* TBAs) and family members, continue to deliver most babies in Jharkhand and provide health advice and other services to mothers and families. In the most recent NRHM policy documents, some members of the GoI acknowledge the importance of TBAs, especially in hard-to-reach communities and areas where delivery in institutions is less than 50%. The NRHM framework document states:

> For those villages which are far away from the Sub-Centre, a TBA with requisite educational qualifications would be identified for training and support. She would assist the ANM at the Sub Centre. ASHAs willing to play this role would be given preference. In places [that] even an ANM's [auxiliary nurse midwife] services are not reaching and there is no accredited ASHA available, the RMPs (rural medical practitioners) would be identified for training so that they could upgrade their skills and get accredited. Efforts would also be made to regulate quacks and untrained dais.[26]

Other Development Partners Working in MNCHN

Many development partners, including NGOs, are working on MNCHN issues in Jharkhand. USAID alone has nine projects at different stages, among them the CARE INHP Program, Immunization Basics (now transitioning into MCHIP and working on routine immunization), and A2Z, which is working on micronutrients, especially vitamin A and childhood and maternal anemia. CARE's intensive training over 10 years of *Angan wadi* workers on supportive supervision and enhanced skills counseling in nutrition in 10 out of 15 of Vistaar's districts is a solid platform for enhancing further work. MCH STAR is part of the MNCHN work and is meant to complement the work of Vistaar by building the research and advocacy capacity and skills of local institutions.

UNICEF is also a major source of MNHCN support through its statewide IMNCI training, both community and facility-based. UNICEF has also begun implementing the Deogargh SBA training program in 10 districts. Some of Vistaar's state partners, such as Vikas Bharti, have been active

[26] MoHFW, GoI, *National Rural Health Mission: Meeting People's Needs in Rural Areas, Framework for Implementation, 2005-2012* (www.mohfw.nic.in/NRHM/Documents).

in Jharkhand for a long time working on development issues relevant to Vistaar's goals and objectives, such as delivering training and support to *Sahiyas* in many Vistaar districts. Likewise, current Vistaar partners CINI and Ekjut are very capable NGOs that have considerable experience in JH.

Vistaar in Jharkhand

The Vistaar program in Jharkhand reflects Vistaar Objective 1: Provide technical assistance to strengthen MNCHN programs. Objective 2 refers to the evidence generation needed for demonstrating "effective, efficient and expandable MCNHN interventions based on TA experiences."[27] This objective can only be met if Vistaar has in place a rigorous evaluation design so that changes in process and outcome indicators can be attributed to Vistaar TA. The criteria for what constitutes "evidence" need to be clearly spelled out to ensure that limited resources are not wasted on supporting strategies that have not been proven in the current donor rush to demonstrate scale-up. Objective 3 involves advocacy with government for "increased priority and improved evidence based programming in MNCHN." In JH, SBA training and PI and other MNCHN priorities advocated by Vistaar were included in the state NHRM State Plan and related Program Implementation Plan (PIP).

TABLE 5. VISTAAR TECHNICAL INTERVENTION BY DISTRICT IN JHARKHAND

District	SBA	DOM	NUT	NBC
Garhwa	x	x		
Latehar	x	x		
Chatra	x	x		
Hazaribagh	x	x		
Ramgarh	x	x		
Koderma	x		x	
Giridih	x			
Deoghar	x			
Jamtara	x			
Godda	x		x	
Sahebganj	x		x	
Pakur	x			
Gumla	x			x
Simdega	x			
Khunti				x

In a series of consultations the GoJH identified its priority work areas and allocated districts. Vistaar is now working in 15 districts on nutrition, community-based NBC, DOM, and SBA (see Table 5).

TA focuses on improving the performance of frontline workers and government officials in the district: supportive supervision, motivation and reward systems, improving interpersonal communication skills, scaling up VHNDs, and improving government capacity for planning and program management.

Alignment with government priorities: Vistaar also has a clear mandate to support the GoJH in providing TA in MNCHN areas. It serves on the task force preparing the state PIP and served as the secretariat for the MNCHN Technical Advisory Group. By working with the government to improve the performance of frontline workers by training them in interpersonal communication (IPC) skills and supportive supervision, Vistaar's work should ultimately strengthen subcenters and PHCs. It also has helped the government to draft communications strategies for improving newborn health and the nutritional status of children; reducing anemia in children, adolescent girls, and pregnant mothers; and DOM. It also has a new model for training SBAs, which has been taken up by the GoJH as the Deoghar model. All these activities align Vistaar with the GoI umbrella program, the NRHM.

27 The Vistaar Project Mid-Term Reviewers' Handbook, prepared by project staff, July 2009.

The GoJH in its PIP has acknowledged Vistaar as an important project for providing TA for capacity building. Vistaar has been successful in advocating the importance of supportive supervision and monitoring for system strengthening, which has been taken up by the state PIP. Other important areas where Vistaar was successful in influencing the state PIP are

- reorganization of the MPW work schedule
- development of job aids for ASHAs, AWWs, and ANMs
- institutionalization of reporting and feedback mechanisms.

See Exhibit 1 for a description of program roll-out in the state and the current status of implementation. See also Exhibit 2, organogram of state program, and Exhibit 3, Vistaar staff expression of factors affecting their work (supportive factors and barriers).

Progress in Technical Area: Skilled Birth Attendant

Importance of SBA training for reducing MMR: The lack of SBAs and a system for communication and transport to a functional health facility together contribute to the high MMR of 371 (although this is down from 400 in 2007–08).[28] Special attention to the *Janani Surakshya Yogana* (JSY), an NRHM incentive scheme that pays mothers and village health workers (ASHAs, known as *Sahiyas* in JH) for institutional deliveries is considered a significant way to reduce maternal mortality and morbidity.

A major input to improve quality of care for deliveries has been to train ANMs to conduct safe deliveries and also life-saving methods to deal with the most common complications for mothers and newborns, such as active management of the third stage of labor, using a partograph for early detection of obstructed or prolonged labor, and prompt referral and newborn resuscitation. The vision of the NRHM is to shift deliveries to a functional health facility, add an additional SBA/ANM, and expand the package of drugs that ANMs can administer in obstetric emergencies. Inherent in this vision is the training and recruitment of more SBAs/ANMs to address human resource gaps in plain numbers as well as skills, improve the availability and drugs and supplies, and upgrade facilities to IPHS.

History of SBA training in Jharkhand: Starting in 2006, the state PIP for NRHM envisaged an increase in institutional deliveries conducted by SBAs both at home and in facilities. According to an interview with Nidhi Khare, the state NHRM Director from 2006 until 2008, "Under NRHM, there was a need to bring in a global perspective and get technical support to augment the skills of ANMs, instill confidence in their abilities, and use the JSY incentive scheme to improve deliveries and reduce the MMR." With support from UNICEF, the GoJH launched a standard GoI three-week SBA training program (1 week classroom, 2 weeks clinical experience) to train 2–3 ANMs at a time. Using this approach, over a two-year period about 100 ANMs in three to four districts were trained as SBAs. Starting in 2007 USAID supported a pilot project in Dumka district implemented by CEDPA under the ACCESS Project with a 12-week training program; 37 ANMs were trained; afterward 75% of them were conducting 3–4 deliveries a month but only 25% increased their deliveries to 8–12 a month.[29]

The GoJH did not provide complete support of previous SBA training initiatives for numerous technical and logistical reasons. This led to exploration of other approaches to improve the quality and coverage of ANM deliveries. Although the CEDPA training module was based on

[28] State NRHM Plan, p. 8 (source of numbers unknown). The figure of 371 is listed in the GoJH document, "Improving Performance of Skilled Birth Attendants: Strategy for the State SRS 2003". It is much higher than the national average of 301.

[29] Based on comments by Dr. Bulbul Sood, Director of CEDPA.

global evidence, the limited participation of government in its planning and in the 12 weeks of training was viewed as "unrealistic." Because of the shortage of staff at PHCs and subcenters, district officials could not release ANMs for such a long period. An illustrative timeline of developments leading to the adoption and scale-up of the Deoghar SBA Model is presented in Exhibit 4.

Adoption of Deoghar SBA Training and the PI Package: The GoJH NRHM state director asked the Vistaar state program director for help in devising an SBA training curriculum and a follow-up plan to ensure that ANMs were using their enhanced skills and performing safe deliveries in community and facility settings. Based on the ER paper on "Improving Performance of Community-Level Health and Nutrition Functionaries," Vistaar concluded that improving the performance of ANMs beyond skills-based training was critical to enhancing the coverage, expansion, quality, and reliability of services. Early recognition of the increase in institutional deliveries by ANMs due to their "improved confidence, skills, and motivation" received high visibility in the state and at the national level with visits by the NRHM director of the MoHFW; this precipitated the scale-up and adoption of the Deoghar model in JH.

The "Deoghar difference" in improving the training of SBAs is attributed to a number of factors, among them the following:

- Within the 6-week SBA participatory training curriculum, 4 weeks are structured rotations through the labor and delivery rooms of a hospital (rotating through all three 8-hour shifts) as well as outpatient ANC, accompanied by one district SBA trainer/mentor. Each SBA participant observes five deliveries, assists in two, and performs three.
- Orientation is included on guidelines for emergency funds and use of checklists for planning.
- A minimum standard of achievement is established, and there is a post-training checklist for measuring knowledge and skills.
- Drugs and delivery kits are provided immediately to ensure use.
- Post-training mentoring is assured through rotational posting to PHCs and guidance from master trainers and medical officers (MOs).
- Vistaar uses five PI factors to ensure support for newly trained SBAs:
    1. Clear job expectations
    2. Feedback and supportive supervision
    3. Motivation and incentives
    4. Enabling environment (equipment and supplies)
    5. Continued updating of knowledge and skills

District Technical Assistance Plan for SBA: The MTR team was not able to visit Deoghar district because a major Hindu festival (*Shiva mela*) brought large crowds and congestion and front-line health workers were absent from their routine work. Therefore, direct exposure and interaction with trained SBAs was not possible. Most of the information obtained was from the State of Jharkhand Vistaar coordinator. The documents provided included the GoJH strategy,

which was almost identical to Vistaar's TA plan for building sustainable capacity of ANMs in SBA (see Exhibit 5):[30]

Delay of Marriage

Importance of DOM in promoting adolescent health and reducing high-risk pregnancy: Early age of marriage is inextricably bound to maternal and child health outcomes.[31] Worldwide, an estimated 16 million women aged 15–19 give birth every year; India is one of the seven countries that account for half of all adolescent pregnancies, many of which occur within an early marriage. Pregnancies before the mother is 16 carry four times the risk of maternal death than when the women are in their 20s, and the death rate for neonates is 50% higher.[32]

In Jharkhand, 61.2% of women are married by 18—and 80% of women with no education. The median age of first birth is 18.9, which means that 50% of young mothers had a baby before reaching 19.[33] Gender disparities are also obvious in women's physical mobility: Only 51% of women are allowed to go to the market alone, only 47% can go by themselves to a health facility, and only 40% are allowed to go to places outside their village.[34] These grim statistics portray the extremely disadvantaged status of adolescent girls in JH.

> The goal of the Delayed Age of Marriage focus of the Vistaar program: Reduce the proportion of adolescents getting married before 18 from 70% to 50% by 2011. The objective is to increase positive attitudes and behavior among adolescents and parents on delaying age at marriage for both girls and boys.

It will be very difficult for Vistaar to demonstrate progress on DOM within the brief time remaining. Moreover, an association between positive attitudes of parents and decisions to marry at an early age has not been substantiated. Well-conceived and well-executed research in this area could make a significant contribution to the evidence base on factors that influence decisions about early age of marriage that could lead to more effective programs.

Status of Vistaar's activities in DOM: The state of Jharkhand requested Vistaar's assistance on DOM, which suggests that it places considerable importance on this issue. Garhwa, Latehar, Chatra, Hazaribagh and Ramgargh districts have requested TA on DOM and adolescent anemia. In Latehar district the GoJH asked Vistaar to provide TA for implementing the adolescent health and empowerment component of the ICDS scheme. An NGO, CINI, is the lead agency for these interventions and has subcontracted to local NGOs Vikas Bharti, KGVK, and Prayas for implementation. These districts fall within the SBA training districts assigned to Vistaar.

The idea for this technical intervention category arose in the first year of project when the GoI suggested DOM as an important but often overlooked component of maternal health and mortality. An ER process was initiated for identifying interventions and best practices that could lay the groundwork for evidence-based interventions; it concluded that[35]

- Much of the limited information on this topic is not publicly available.

---

[30] The Vistaar Project Technical Assistance to the Government of Jharkhand, Deoghar District, Improving Performance of Skilled Birth Attendants, July 24, 2009.

[31] Strategic Health Communication for Delaying Age of Marriage and Reducing Anemia Among Adolescents, USAID, Vistaar, GoJH, July 13, 2009.

[32] Adolescent Pregnancy: A Culturally Complex Issue, Volume 87, Number 6, June 2009, 405-484.

[33] NFHS-3, Fact Sheet Jharkhand.

[34] The Strategic Health Communication for Anemia Control and Delaying Age of Marriage

[35] Community-Based Interventions to Delay Age of Marriage: A Review of Evidence in India, March 2008.

- Most of the 30 interventions identified did not collect outcome or impact data.
- Four of the five interventions selected for the review relied heavily on NGOs for implementation; however, there is little information on the effectiveness, efficiency, or expandability of this NGO strategy.

In late 2008 a gender and equity analysis was undertaken to try to better understand the complex interplay of social factors that might be contributing to the problem. Some of the main factors contributing to early marriage are

- family honor and safety (getting the girl married early helps avoid the danger of premarital sexual relations or pregnancy outside of marriage)
- the cost of education
- the difficulty of finding a groom for an educated girl
- the concept of a girl being *paraya dhan*—wealth that belongs to another
- from the perspective of the bridegroom and his family's, it is useful to have a young wife or daughter-in-law who can help with household chores and provide a dowry.

DOM is affected by context and spans multiple disciplines and program departments: access to education, vocational skills training, incentives to support adolescent nutrition and DOM, life skills training, and specific services and products, such as IFA and deworming (which according to Vistaar staff serves as an entry point for discussion of other sensitive topics). Vistaar has conducted a situation assessment and drew up a communications strategy that the MoHFW is reviewing. Approval is anticipated very soon.

Technical support for strengthening DOM marriage initiatives involves

- strengthening the health communication component of adolescent programs (community health awareness, KSY, and school health education)
- enhancing counseling skills of frontline workers and their supervisors
- building supportive environments at the district and subdistrict levels for adolescent health and empowerment programs.

Newborn Care

Importance of newborn health: Jharkhand's IMR is 69 per 1,000 live births (NFHS III), one of the highest in the country. It is 50% higher in rural than in urban areas. A child's risk of death is nearly 15 times greater in the first month of life than at any other time during the first year.

With the IMR declining in India, the proportionate contribution of newborn deaths has been increasing. To achieve the MDG for child survival, it is important to reduce neonatal mortality. The NRHM has set a target of reducing IMR to 30 per 1,000 live births by 2012. To achieve this will require reducing newborn deaths by over 50%.

Most neonatal deaths take place at home, underlining the problem of health care access.[36] The delay in access to health care involves problems with disease recognition, decision making, and transport to health care services. Hence, community-based NBC is essential to achieving the NRHM's IMR reduction target and ultimately the MDG for child survival.

[36] Save the Children, *Saving Newborn Lives Program, State of the World's Newborns: India,* 2001.

Priorities and activities of GoJH and other development partners: Newborn health is a priority area for the GoJH, and development partners like UNICEF and the Breastfeeding Promotion Network of India (BPNI) are working in the state to promote newborn health. UNICEF is supporting the training of IMNCI, and BPNI is working on infant and young child feeding (IYCF) through UNICEF.

The RCH-DLHS III findings were taken as the baseline. Table 6 summarizes the status of newborn health in the state as a whole and in two districts, Khunti and Gumla.

TABLE 6. STATUS OF NEWBORN HEALTH IN KHUNTI AND GUMLA DISTRICTS, JHARKHAND

No.	Indicator	Jharkhand*	Gumla*	Khunti/Ranchi**
1	% mothers who received PNC care from any health professional within 2 days of birth	30.9	27.5	38.4
2	TT immunization	54.4	62.6	67.1
3	% children under 3 breastfed within one hour of birth (%)	34.6	38.7	44.7
4	Exclusive breastfeeding	75.6	42.4	53.9

* DLHS III **New district – separate data not available; data are for old district (Ranchi)

District and sub-district TA plans for improved newborn care: Vistaar TA will

- Provide catalytic support to GoJH efforts to promote improved newborn care.
- Promote involvement of community leaders and champions from stakeholder groups in advocating for maternal and newborn care.

Outcome objectives:

- Increased knowledge among pregnant women and their family members about newborn care
- Enhanced knowledge and skills of mid-level managers and frontline health workers about newborn care

Strategies:

- Strengthen the health communication component of programs for promoting improved NBC: Develop a communications strategy focused on essentials of maternal and newborn care, five cleans at delivery, and immediate and exclusive breastfeeding. Vistaar will support design, testing, and development of user-friendly information, education, and communications (IEC) message tools and job aids.
- Build the NBC capacity of mid-level managers and frontline health workers: Strengthen the IPC skills of frontline workers, and encourage frontline worker use of job aids and communication materials on NBC.
- Build an intersectoral convergence strategy for improving maternal and newborn care. Form district and block support teams and facilitate their functioning.
- Enable supportive supervision by training district trainers for supportive supervision.

- Help District Health Departments and ICDS scale up and improve the quality of monthly VHNDs.

Roll-out and implementation activities:

- The baseline study was conducted in December 2008 and January 2009.
- The intervention has recently been rolled out in Khunti and Gumla.
- The dialogue with district health officers and ICDS has been established.
- The communication strategy has been developed but not yet implemented. It will roll out with training of district trainers, who will then train block officials, who will in turn train the frontline workers who will disseminate the messages during VHNDs and household meetings.
- As for capacity–building, state TOT for PI has been completed, and district TOT is planned. TOT for supportive supervision has been completed for Gumla district, and a performance needs assessment has been completed for Khunti.
- District and block convergence platforms have been created under the chairmanship of the Deputy Commissioner with all government departments deliberating on development issues and finding solutions to local problems. In villages convergence between ASHAs, AWWs, and ANMs is being promoted through Village Health and Sanitation Committees (VHSCs). Joint supervisory visits by ICDS and health system supervisors are also being promoted.
- VHNDs have been microplanned so that all villages are covered and all beneficiaries get services. This also makes closer supervision possible.

Nutrition

Importance of nutrition: The MDG target is to halve malnutrition in India. Nutrition is an important determinant of child survival: 54% of child deaths in developing countries have been attributed to poor nutrition. In Jharkhand, NFHS III has reported the prevalence of stunting to be 41%, wasting 31.1%, and underweight 59.2%.

In India as a whole about 70% of women aged 15–49 are anemic, with 50% suffering mild anemia, 19% moderate anemia, and 1% severe anemia.[37] Anemia is associated with compromised pubertal growth and cognitive development in adolescent girls, which contributes to 25% of maternal mortality. During pregnancy only 14.6% consumed IFA tablets for 90 days or more. In comparison, the anemia levels in men are just over half the rate for women (37%), demonstrating gender inequality in access to food. Anemia is highest for women residing in rural areas (74%) and for the least educated. These patterns also correspond to lack of participation in household decision-making; only 59% of women are "given a say" in their families, and 37% report having experienced spousal violence.[38] The powerlessness of poor and uneducated women has been linked to a variety of poor health and nutrition outcomes.

In Jharkhand anemia is also prevalent at 77.7% among children and 68.4% among pregnant mothers aged 15–49 years. Iron deficiency anemia is associated with impaired mental, physical, and cognitive performance in children. This makes the nutrition intervention a priority for the Government of Jharkhand.

[37] NFHS-3, Fact Sheet Jharkhand. The levels of anemia are extracted from: The Strategic Health Communication for Anemia Control and Delaying Age of Marriage paper (based on NFHS-3).
[38] NFHS-3.

Priorities and activities of GoJH and other development partners: UNICEF is providing support to the government to train frontline workers throughout the state on IYCF and IMNCI. Vistaar is providing TA on adolescent anemia in five districts (Garuhwa, Chhatra, Latehar, Hazaribagh, and Ramgarh), maternal anemia in two districts (Sahibganj and Godda), and child nutrition in one district (Koderma).

The NFHS III and RCH-DLHS II findings were taken as the baseline along with a Vistaar baseline survey on newborn care and nutrition. Table 7 summarizes nutritional status in Jharkhand and in Koderma, Sahibganj, and Godda districts.

TABLE 7: NUTRITIONAL INDICATORS FOR KODERMA, SAHIBGANJ, AND GODDA DISTRICTS, JHARKHAND

No.	Indicator	Jharkhand	Koderma	Sahibganj	Godda
1	% stunting in children < 3 years	41.0	NA	NA	NA
2	% wasting in children < 3 years	31.1	NA	NA	NA
3	% underweight children < 3 years	59.2	NA	NA	NA
4	% children under 3 breastfed within one hour of birth	10.9	26.6	19.5	44.8
5	% children age 0–5 months exclusively breastfed	57.8	52.3	64.2	70.1
6	% children age 6–9 months receiving solid or semi-solid food and breast milk	65.3	97.3	99.5	96.4
7	% children age 6–35 months who are anemic	77.7	NA	NA	NA
8	% pregnant women age 15–49 who are anemic	68.4	NA	NA	NA
9	% mothers who consumed IFA for 90 days or more when they were pregnant with their last child	14.6	NA	NA	NA

NA – Data not available

District and subdistrict TA plans to improve nutritional status (reduce anemia) of pregnant and lactating women:

- Vistaar TA is designed to
  - provide catalytic support to government efforts to improve the anemia status of pregnant and lactating women
  - improve knowledge about anemia prevention among pregnant and lactating women, their families, and the community
- Strategies for Vistaar TA to the district:
  - Strengthen the health communication component of programs for anemia prevention: Develop a communication strategy focused on causes and prevention of anemia. Vistaar will support design, testing, and development of user-friendly IEC message tools and job aids.

- Enhance IPC skills of frontline workers and their supervisors: Encourage frontline worker use of job aids and communication materials on newborn care.
- Build a supportive environment in districts and subdistricts for improving the nutritional status of pregnant and lactating women. Train district trainers for supportive supervision so that the supervisory cadre can mentor frontline workers and follow the PI principles.
- Increase the coverage of services through VHNDs.
- Build an intersectoral convergence strategy for improving nutritional status. Form district and block support teams and facilitate their functioning.
- Strengthen supply chain management and IFA and deworming programs like biannual catch-up rounds.

Status of program roll-out and implementation:

- The baseline study was conducted in December 2008 and January 2009.
- The intervention has recently been rolled out in Sahibganj, Godda, and Koderma districts.
- The dialogue with district health system officers and ICDS has been established.
- District and block convergence platforms have been created under the chairmanship of the Deputy Commissioner with participation by all government departments in deliberating on development issues and finding solutions to local problems. Convergence between village ASHAs, AWWs, and ANMs is being promoted through VHSCs. Joint visits by ICDS and health system supervisors are also being promoted.
- State TOT for PI has been completed and district TOTs are planned. A Performance Needs Assessment has been completed for Koderma, where TOT for supportive supervision has also been completed. An IYCF module has been prepared and is awaiting government approval. Once that is secured, training will begin in Koderma, which has child nutrition as a focus.
- VHNDs have been microplanned so that all villages are covered and all beneficiaries get services. This also makes supervision possible.

Major Findings and Recommendations for JH

Finding 1. Skilled Birth Attendance

In less than two years Vistaar has made a major contribution to SBA training by demonstrating the Deoghar model, which has been adopted and scaled-up to the entire state of Jharkhand. If implemented with a similar quality of training and post-training mentoring as in Deoghar, the model should make a huge impact on reducing maternal mortality and improving newborn health indicators. However, the current monitoring system for Vistaar staff is not structured to ensure that all HSCs are visited within a reasonable time to provide feedback to ensure timely intervention and support to the newly trained SBAs. The current visit schedule is completion of a minimum of three Vistaar checklists in a month and 9–12 in a quarter. This may not be sufficient to generalize the findings across as many as 200 HSCs in each district.

Recommendation:

Continue to roll out this model with a structured and proactive monitoring plan to ensure that the four strategies continue to be implemented, especially post-training mentoring and follow-up. Considering that 4–5 Vistaar staff and district subcontracting organizations are available where other thematic groups of work are being implemented (9 districts), they should be organized to administer the Vistaar checklists in at least one HSC every 2–3 months. This active assessment of

HSCs could be integrated with other review visits for VHND to assess supportive supervision and other PI activities at block levels and below.

Finding 2: Skilled Birth Attendance

Over 80% of deliveries are still conducted at home by TBAs. Less than 25% of the ANMs (17.4%) live in the HSC village; most are serving more than 10 villages, and the average distance from home to HSC is 10.8 km.[39] The Naxalite threat and the lack of roads deeply complicate the ability of ANMs to conduct deliveries at individual homes and subcenters outside normal working hours. It is not expected that these problems will be solved any time soon.

Recommendations:

- The continued lack of access to safe home deliveries requires attention, strategy development, and planning at the district and block levels. Working with TBAs to ensure safe management of home deliveries and knowledge about activating a continuum of care (recognition of complications, transport, and coordination with *Sahiyas* and ANMs) to facilitate timely and lifesaving interventions has to be part of the strategy in order to impact maternal and newborn health and survival. Vistaar could initiate a planning process that prioritizes training of SBAs in hard-to-reach areas with the highest rate of home deliveries.

- The role of TBAs in newborn care should also be recognized and building their capacity should be advocated along with that of ASHAs/*Sahiyas*.

Finding 3: Evaluation of the SBA Training Program

The current Vistaar evaluation design cannot withstand rigorous criteria for demonstrating a change or impact of the SBA training program. The credibility of the results of the SBA Deoghar model is essential if Vistaar plans to seriously improve maternal outcomes and envisions a trajectory for full scale-up in India.

Recommendation:

A high-quality research group should be asked to review the evaluation design and design a methodology that can answer the key question: How does SBA training affect maternal health outcomes? There is plenty of opportunity to create a rigorous evaluation design because SBA training has just started in Jharkhand. The random and staggered nature of the training offers an important natural experiment in which to develop a pre-post training design, especially since the entire state will receive the training so a control district will not be useful. It would be an important contribution for Vistaar to closely monitor inputs into post-training supportive supervision and other PI activities in order to demonstrate how these factors contribute to improved coverage, quality of services, and ultimately outcomes. Also, it would be important to cover UNICEF districts, because their post-training interventions may be different and perhaps have different outcomes.

Finding 4: Interpersonal Communications

The current training program does not appear to have social and cultural dimensions to its methodology and delivery practices, including IPC and other materials for communicating with mother and family to secure their trust and satisfaction with services, such as the use of different positions for delivery (i.e., squatting as opposed to lithotomy).[40]

[39] Based on the Deoghar district baseline survey administered by Vistaar.

[40] The position is perhaps most recognizable as the often used position for childbirth: the patient is laid on her back with knees bent, positioned above the hips, and spread apart through the use of stirrups.

Recommendations:

- Identify major social and cultural groups in the state and use knowledge of them in IPC to adjust basic care practices with methods for conducting delivery that demonstrate sensitivity and respect to subgroups and pave the way for continued health services utilization.
- Local feeding practices need to be understood through formative research, and the findings should be used in designing the communications strategy.

Finding 5: Provision of Adequate Human Resources

There is an overwhelming shortage of frontline health workers, supervisors, and infrastructure at all levels (more than 50% in many categories). The use of MOs as supervisors of SBAs/ANMs is essential in the short run for post-training support and follow-up due to the shortage of LHVs but may not be sustainable. In the government health system it is unusual for MOs to engage in outreach to ANMs, because there is a shortage of MOs, and a lack of commitment even within the PHC structure. The persistent stories of salaried MOs who do not work and do not seem to be accountable to anyone stress the health system. For example, the MTR team visited one district, where five MOs were posted to one PHC but the only one working did not know how many deliveries had been conducted at her PHC in the previous month (this was happening even though the civil surgeon and district commissioner had offices less than 1 km. away). Also, where there are LHVs, newly trained SBAs may have more skills and motivation than supervisors. This threatens the access to and quality of traditional supportive supervision for SBAs and other front-line health workers that frames Vistaar's model for one key PI aspect.

Recommendations:

- Explore other support structures that could sustain the motivation of SBAs and are grounded in openness and sharing of experiences and strategies for resolving problems. Examples might be setting up an SBA buddy system with peer support and feedback at the block level.
- Actively utilize other community workers and systems (*Sahiyas* and VHSCs) to learn about how SBA services are viewed and understood in the community and what SBAs need to do to improve quality and coverage of deliveries and other MNCHN services.
- Continue to advocate for training and deploy staff equitably. Addressing work accountability and motivation for block and district health personnel is also critical for improving delivery of services. Vistaar could initiate a planning process to develop supportive supervision and worker recognition for block and district service providers and officials.

Vistaar in Uttar Pradesh

Introduction to Uttar Pradesh

With 190 million residents UP is the most populous state in India. If UP were a country, it would be the 5th most populous country in the world. The population is also very diverse: 21% are scheduled caste, 0.1% are scheduled tribe, and 31% of the population lives below the poverty line. Administratively, UP is divided into 71 districts and 813 blocks, which have populations ranging from 150,000 to 250,000. The large population in each block presents even greater challenges for planning and managing service delivery.

MNCHN Indicators: The IMR in UP is 73/1,000 live births, and the MMR is 440/100,000 live births,[41] both of which are higher than the national averages (IMR: 58, MMR: 254). As part of its NRHM PIP, in 2007 UP launched the Comprehensive Child Survival Programme (CCSP) to

[41] SRS 2004–06.

reduce infant mortality to less than 40/1,000 live births and maternal mortality to less than 200/100,000 live births by 2012.

In UP 8.3 million children are malnourished, of whom 3.3 million are severely so. Nearly every third infant born in UP is a low birth-weight baby (less than 2,500 grams), and every other child under 3 is malnourished. Most of the growth retardation occurs by the age of 2 and is largely irreversible. In 2006 UP announced the Mission Poshan Program to reduce malnutrition among children aged 0–3 years to 40% by 2012. In general all MNCHN indicators in UP are very poor (see Table 8).

TABLE 8. CRITICAL MNCHN INDICATORS IN UTTAR PRADESH

Indicators	%
Maternal Health	
% institutional deliveries	22.0
% births assisted by SBA (doctor, LHV, ANM, nurse)	27.2
% mothers who received postnatal care within 48 hrs of delivery	13.3
% pregnant women who made three or more ANC visits	26.6
% who received two or more TT injections during pregnancy	64.5
% who consumed IFA for 90 days or more when they were pregnant with their last child	8.7
% women (15–49 years) who are anemic	49.9
Mean number of children born to women aged 40–49 years	5.6
Median age at first marriage among women age 20–49 years	16.2
Median number of months since the preceding birth (birth interval)	29.8
% of women age 15–19 years who were already mothers or pregnant	14.3
Newborn Health	
% children under 3 breastfed within 1 hour of birth	7.2
% of home deliveries where baby was immediately wiped dry and wrapped without being bathed	26.7
Nutrition	
% children age 0–5 months exclusively breastfed	51.3
% children 6–9 months breastfed and received complementary feeding	46.0
% children 6–35 months who are anemic	85.1
% children under 3 who are underweight	41.6
% children under 3 with diarrhea in last 2 weeks and received ORS	12.0
% children who had diarrhea in last 2 weeks and taken to a health facility	55.9
% children under 3 who had acute respiratory infection or fever in last 2 weeks and taken to a health facility	63.6

Source for all indicators – NFHS-3, 2005-06, Uttar Pradesh

The UP Health System: The state has less than half the health facilities it needs (see Table 9). The GoI norms for facilities are at least one HSC per 5,000 population in rural areas and one HSC per 3,000 population in tribal areas; at least one PHC per 30,000 population in rural areas and 20,000 population in tribal areas; one CHC per 100,000 population; and one hospital per district.

TABLE 9. FACILITIES IN THE UTTAR PRADESH HEALTH SYSTEM

Facility	In place	Needed
Health subcenters (HSC)	2,500	45,000
Primary health centers (PHC)	3,690	7,200
Community health centers (CHC)	515	1,800
District hospitals	70	71

* Source: Vistaar UP Team

Also, there is an acute shortage of staff for delivering services at these health facilities (Table 10). The shortages of ANMs (13%), LHVs (5.5%), and medical doctors (46%) are serious concerns that the GoUP needs to address urgently if HFW services are to reach the intended beneficiaries.

TABLE 10. STAFF REQUIREMENTS FOR HEALTH SERVICE DELIVERY IN UP

Post	In position	Needed	Shortage
Auxiliary nurse midwives (ANM)	21,000	24,200	13.0 %
Lady health visitors (LHV)	3,500	3,700	5.5 %
Medical doctors	2,000	3,700	46.0 %

*Source: Vistaar UP Team

The UP ICDS system: The MoWCD ICDS focuses on supplementary nutrition for children under 6, pregnant women, and lactating mothers. ICDS services are offered through 147,180 *Angan Wadi* Centers (AWCs) in the villages. The number of AWCs is insufficient—government norms require one for every 1,000 people. The GoUP also needs to address urgently the shortages (see Table 11) of *Mukhya Sevikas* (30%), chief development planning officers (CDPOs) (33%), and district planning officers (DPOs) (55%).

TABLE 11. STAFF REQUIREMENTS FOR ICDS SERVICE DELIVERY IN UP

Post	In Position	Required	Shortage
Angan wadi workers (AWW)	141,900	151,500	6.3%
Mukhya sevikas	3,840	5,800	30%
Chief development planning officers (CDPO)	580	900	33%
District planning officers (DPO)	24	57	55%

*Source: Vistaar UP Team

Development Partners in MNCHN: About 15 UN organizations, development partners, and NGOs are working on MNCHN in UP (Exhibit 6). UNICEF, WHO, SIFPSA, UPVHA, JHU, the Beti Foundation, and the A2Z project are active in Vistaar intervention districts. While there is good communication between Vistaar and these partners, the MTR team did not see any indication that there is systematic and routine coordination. It would be desirable for the Vistaar team to understand the contributions to the state from others so as to design effective TA interventions.

Vistaar Activities in UP

Evidence Reviews: Based on the results of the ERs Vistaar conducted in October 2006 and on input from USAID and other stakeholders, the GoUP asked Vistaar to work in two technical areas:

- Community-based newborn care (NBC)
- Nutritional status of pregnant and lactating mothers and ICYF with a focus on children under 2

Table 12 details where Vistaar is providing TA in these areas in UP.

At the request of the UP Department of Health and Family Welfare (DHFW), Vistaar is also undertaking capacity-building for the VHSCs in the district of Varanasi. Vistaar is mandated to integrate and support government MNCHN programs in keeping with evidence-based practices. The choice of NBC and nutrition as areas for Vistaar TA is critical for the UP government to address its MNCHN concerns.

TABLE 12. VISTAAR TA INTERVENTIONS IN UP

District	NBC	Nutrition
Azamgarh	x	x
Saharanpur	x	x
Bulandshahr	x	x
Banda	x	x
Varanasi		x
Kaushambi		x
Gonda		x
Chitrakoot		x

Technical Area: Community-Based Newborn Care

What has been done: Perhaps the most important of the initiatives the UP DHFW has taken to address the MNCHN challenges is the Comprehensive Child Survival Program (CCSP). The department launched the CCSP on April 25, 2007, to reduce neonatal and under-5 mortality. In the first phase, 17 districts, one from each division, were selected based on their IMRs and the availability of minimum infrastructure. All districts are expected to be covered by 2012.

A 10-day training program for MOs, ASHAs, ANMs/LHVs, and others was begun as the the state PIP for 2007–08 planned and is continuing. CCSP has budgeted for providing ASHAs with job aids. A three-day special clinical training package for district hospitals, CHCs, and PHCs on facility-based care has been initiated, and sensitization workshops are being conducted for state, district, block, and PHC service providers.

Vistaar strategy: It is evident from the CCSP objective of reducing the MMR and IMR that developing the capacity of frontline workers is essential to improving the health system for effective and efficient service delivery. The Vistaar process of building capacity in NBC started in October 2007 with sharing of evidence from the ERs and proceeded to roll-out through the following processes:

- Allotment of districts by GoUP DHFW for NBC TA to support roll-out of the CCSP in Azamgarh, Varanasi, Saharanpur, Bulandshahr, and Banda
- Advocacy for formation of a CCSP Core Group that led to formation of NRHM technical support groups
- Providing TA for conceptualizing and planning the CCSP sensitization workshops called for by the UP NRHM PIP
- Providing TA at the state level for conceptualizing and developing job aids for ASHAs, LHVs, and ANMs
- Preparing district-specific NBC TA plans in consultation with districts based on local needs, opportunities, and interest of leaders
- Award of a TA subgrant to MAMTA
- Developing MIS for TA on NBC
- Conducting a baseline survey in the Vistaar districts (Exhibit 7).

A comparison of the UP state indicators (NFHS 3 and DLHS 3) with the performance indicators of the eight Vistaar districts (Vistaar baseline survey, see exhibit 7) shows that NBC practices in those districts has been very poor. In response, Vistaar helped the GoUP to design a TA plan for NBC to address the following needs:

- Building the capacity of ASHAs
- Strengthening local networks (ANM, LHV) to support mentor ASHAs
- Encouraging convergence between the district health and ICDS departments
- Strengthening monthly VHNDs

To plan the TA the Vistaar team reviewed the CCSP training program and recognized that there was no provision for post-training follow up or on-job support, which are critical for practicing skills acquired during training. The Vistaar project therefore decided to pursue strategies and activities to address components missing from the CCSP in order to meet the planned goals.

Building ASHA capacity: As a link between the community and the public health system, an ASHA is envisioned as a community-based health functionary who will create awareness about health-related issues and generate demand for health services. She is seen as the first point of contact in the village for any health-related services, especially for the disadvantaged and for women and children who find it difficult to access health services. She receives performance-based compensation for her efforts. Part of her training and supervision is designed to engage her IPC skills.

***Strengthening local networks for mentoring and supporting ASHAs*:** Building the capacity of ASHAs alone is not sufficient to bring about the desired improvements in community maternal and newborn care practices. There is a need to strengthen the skills of their immediate supervisors, the ANMs and LHVs, who need to support ASHAs as they undertake their prescribed roles. ASHA supervisors are oriented on ways to assess the quality of work done and mentor ASHAs in improving operational aspects of their work, such as planning for VHNDs, maintaining the village health register, and ensuring that records for tracking service coverage are complete. Through field visits and informant interviews the tools and records already in use by ASHA supervisors will be critically assessed to ascertain their usefulness in supportive

supervision. Vistaar also enhances the capacity of district medical and health officers for supportive supervision.

***Encouraging convergence between the district Health and ICDS departments*:** The UP Directorate of Family Welfare issued a government order to all district CMOs on June 2, 2008, to organize monthly VHNDs for populations of 1,000. The order gave detailed guidelines for implementing VHNDs. Because a VHND can be a good platform for providing child health and nutrition services, the Vistaar Project has rolled out TA in the field for VHNDs to help with review and revision of their microplans, enhance convergence between HFW-ICDS and other stakeholders, facilitate in planning and roll-out of VHND sessions, facilitate quarterly reviews by the district DPO, CMO, and DHS, and help build a cadre of VHSC facilitators for better organizing VHNDs.

Monitoring and evaluation: There are far too many indicators for effective monitoring (Exhibit 8). Monitoring indicators should be fewer and evaluated more often to catch the immediate attention of block supervisors and trigger any intervention required. Planning indicators should be designed to meet the needs of district supervisors, and strategy and policy indicators should meet the needs of state supervisors.

The progress of TA: Most of the preparatory work for launching TA is over (Exhibit 9)**,** and Vistaar has had a fair amount of success in getting the UP DHFW to include project findings in the state PIP:

- The roll-out of TA for NBC started in May 2009.
- The GoUP has agreed with the Vistaar TA interventions for ASHAs in IPC skills and recognizes its value in improving the quality of home visits, as evidenced by inclusion of sessions on enhancing IPC skills in the state's new ASHA module.
- The GoUP has accepted the Vistaar approach of strengthening ASHA meetings, on-the-job capacity-building for ASHAs, and using monthly ASHA meetings for problem-solving and capacity-building, as evidenced by recent communication from the NRHM Director to the CMOs of all 71 districts in UP. The capacity-building areas and approach are in line with the Vistaar TA proposals. Recognizing the value of this platform, the NRHM has made a provision for ASHAs of Rs 30/- for local travel to attend meetings.
- The Vistaar-initiated reorganization of ASHA meetings into smaller groups is helping to reach out to ASHAs more directly and individual problem-solving, record–keeping, and payment of incentives are getting more attention. The improved interaction and quality of ASHAs meetings in smaller groups is already becoming standard.
- VHND microplans are now being finalized jointly by ICDS and the Health Department and are being expanding beyond just a routine immunization microplan to a VHND with many services, per NRHM guidelines. The convergence meetings initiated between the two departments are improving coordination and local decentralized decision-making. The key findings of observations of VHNDs in the eight Vistaar districts in UP (Exhibit 10) reflects the participation of frontline workers (ASHA, AWW, ANM) from the departments of Health and ICDS, and key services offered in VHND sessions.

Technical Area: Nutrition

What has been done: Perhaps the most important activity initiated by the GoUP Department of Women and Child Development (DWCD) to address nutritional challenges is Mission Posahn, which the department announced in 2006 to accelerate efforts to reduce malnutrition. The ICDS frontline workers (AWWs, *Mukhya Sevikas,* and CDPOs) have been given special training to

focus on children under 1, pregnant women, and lactating mothers. Mission Poshan emphasizes community participation by involving community mobilizers (*Bal Parivar Mitra*), mothers committees, and self-help groups in family and community counseling to create demand for health and nutrition services. DWCD's Weekly Health and Nutrition Days (WHND) every Saturday focus on growth promotion, nutrition health education, and establishing linkages with DHFW health services for routine immunization. WHND has been subsequently modified into the twice monthly Village Health and Nutrition Days (VHND) under NRHM.

Vistaar Strategy: The main objective of Mission Poshan is to reduce malnutrition in children aged 0-3 to 40% by 2012.[42] It is evident that the capacity development of the frontline workers is essential for effective and efficient service delivery to affect malnutrition rates. The process for capacity building in nutrition under Vistaar started in October 2007 with sharing of evidence from the ERs and the GoUP DWCD chose seven districts for nutrition TA to support Mission Poshan: Azamgarh, Saharanpur, Bulandshahr, Banda, Kaushambi, Gonda, and Chitrakoot districts.

A key component of ICDS is the decentralized planning in the form of district annual plans (DAPs) that highlight strategies and additional resource requirements for better implementing ICDS. The DWCD invited the Vistaar Project team to help draft the ICDS PIP for Vistaar districts. This involved the following activities:

- Helping the district magistrate to form a CRT consisting of the DPO, CMO, Basic Siksha Adhikari, and the district PRI officer (DPRO)
- Conducting a baseline survey on nutrition and health through the CDPO and DPO (Exhibit 7)
- Holding a workshop with block health officers, ICDS, primary educators, and PRI along with the CRT members
- Documenting the decisions and preparing the DAP per ICDS guidelines

The technical areas the ICDS team thus identified are discussed next.

***Help build the IPC skills of AWW*:** As the frontline worker**s** for the ICDS program AWWs are responsible for community mobilization, demand generation, and delivery of ICDS services. Their role also extends to household counseling on maternal and newborn nutrition and complementary feeding for infants. Evidence suggests that household counselling using good IPC skills is an effective way to influence community nutritional and dietary behaviors.

***Strengthen supportive skills of managerial and supervisory staff*:** The ER revealed that simply training frontline workers may not be enough. Regular mentoring by supervisory staff (*Mukhya Sevikas* and CDPOs) and observing worker IPC skills, especially negotiation skills during actual community interactions, is important. Because the proposed intervention of strengthening the skills of supervisors in line with the PI principles would complement this effort, Vistaar, in consultation with the district, is incorporating this element as part of TOT for lead trainers and into the checklist.

***Strengthen VHNDs*:** VHND under NRHM is an important tool for the convergence of activities and promises to be effective for providing first-contact primary health care in communities. VHNDs are to be organized once every month at the village AWC, which is identified as the hub for nutrition and health services for women and children and is also the point for intersectoral convergence. A VHND is recognized as an important interface between the community and the health and ICDS systems.

[42] Information provided by UP Vistaar Team.

Keeping in mind the significance of the VHND, the ICDS of the DWCD has guidelines for organizing and monitoring Mission Poshan health and nutrition education days. The roles of the ANMs, ASHAs, AWWs, and supervisory staff in organizing and monitoring VHNDs, are also well-defined. Vistaar's TA includes support to the district in reviewing VHND guidelines; drafting a VHND microplan using fixed-day, fixed-site approach; rolling out VHNDs; and monitoring.

***Help ICDS to initiate community-based monitoring through activation of mothers' committees*[43]:** To help achieve national standards for health and address the problem of malnutrition of children and pregnant and lactating women, the UP DWCD has constituted a mothers' committee at each AWC, and the GoUP has issued a detailed government order and guidelines for its operations. The mothers' committees will be linked to the AWC so that they are also part of the ICDS system. Mechanisms for recognizing high-performance mothers' committees are being created.

Monitoring and evaluation: As with NBC, there are far too many indicators for effective monitoring. Indicators should be fewer and evaluated more often to catch the immediate attention of block supervisors and trigger any intervention required. Planning indicators should be designed to meet the needs of district supervisors; strategy and policy indicators should meet the needs of state supervisors.

The Progress of TA

The Vistaar Project has achieved considerable success in getting the DWCD to invite Vistaar to help the government draft the state PIP.

- The roll-out of TA is scheduled for September 2009,[44] when the state will be ready to implement Mission Poshan.
- The state ICDS PIP includes improving the IPC skills of AWWs, strengthening home visits, building the capacity of mothers' committees, and organizing regular VHNDs.
- DHFW and DWCD have formed joint monitoring teams for VHNDs.
- ICDS sectors have been formed to serve as a platform for sectoral meetings.
- Regular sector meetings of ICDS staff have begun.
- ICDS and the Health Department have together finalized VHND plans that expand beyond just an RI microplan to provide many services, per NRHM guidelines. The convergence meetings are improving coordination and local decision-making. The summary of VHND observations (Exhibit 10) highlights greater participation of frontline workers from both the Health and ICDS/WCD departments.

Findings and Recommendations Specific to Uttar Pradesh

Finding 1: Planning and Monitoring–UP

With a population of 190 million spread over 71 districts and 813 blocks, planning and monitoring in UP is a challenge: The population of three or four UP blocks is roughly equal to that of a whole district in Jharkhand.

[43] Not yet operational in UP.

[44] Based on information provided by the UP Vistaar Team on nutrition TA.

Recommendation:

If TA is to be effective, all the planning and monitoring for it in UP has to be focused more at the block than at the district level.

Finding 2: ASHAs at the Block Level

Each block in UP has about 200 ASHAs (under the DHFW) and an equal number of AWWs (under the DWCD). As a result, TA and the monthly meetings of ASHAs and of AWWs with their supervisors are not very effective in addressing the problems ASHAs and AWWs face in the field.

Recommendation:

Each block should be further divided into four or five clusters so that TA modules for IPC and supportive supervision for frontline workers will be more effective. This seems to be working in Varanasi, where meetings of ASHAs consist of smaller groups of 40–50 people.

Finding 3: Strengthen Block Development Officers

Block development officers (BDOs) did not seem to be actively involved in the activities of DHFW and DWCD.

Recommendation:

Strengthen TA interventions for BDOs. As the government officer closest to the community, the BDO is accountable for all government services in the block. TA for BDOs will reinforce the TA for supportive supervision and also lead to better convergence between Health, ICDS, and other government departments for VHNDs, as the state PIPs envisage.

Finding 4: Health Infrastructure

UP has on average only one PHC for every 46,000 residents and only 515 CHCs for 813 blocks. As discussed, there is a shortage of staff at all levels in all facilities. As a result of the inadequate infrastructure and staff shortages in the DHFW and DWCD, the effectiveness and efficiency of MNCHN services is a major concern.

Recommendation:

Vistaar has to work more closely with the UP state government to fill all the vacant positions so as to facilitate its TA offerings to improve service delivery.

Finding 5: Vistaar TA

The block, district, and state government officers in Varanasi and Bulandshahr visited by the MTR team often commented that they look to Vistaar staff more to support service delivery than to develop government staff capacity.

Recommendation:

Vistaar district activity leaders and the staff of Vistaar subgrantees should be very clear about their responsibilities as TA—not service—providers, and communicate that role clearly to government officers.

Finding 6: Frontline Workers

ASHAs, ANMs, AWWs, etc. are trained to discuss all MNCHN issues (NBC, nutrition, SBA and DOM) with their community because they are all closely intertwined. Hence providing TA on only one or two technical areas (e.g., only NBC in Varanasi) limits the impact of Vistaar TA.

Recommendation:

Scale up by providing TA in all the technical areas in all current Vistaar intervention districts, rather than expanding TA into additional districts.

Finding 7: Development Partners

There are 15–20 development partners (including UN organizations, USAID implementing agencies, and international and local NGOs) working in UP on aspects of MNCHN. While Vistaar is working with 5–7 development partners in its districts, there seems to be a lack of routine and systematic communications between them.

Recommendation:

Strengthen coordination and collaboration among the various organizations and with the state government. This would reduce redundancies and ensure that all Vistaar inputs are aligned with GoUP needs and with the capacities and activities of UP's partners.

Finding 6: Management Information Systems

The current MIS system does not feed back into sector, block, and district structures (e.g., block and district monitoring committee meetings) for regular review of data and for use in problem-solving and systems improvement. The burdensome government HMIS requires that voluminous forms be filled out and aggregated at various levels. The resulting low-quality data are not used because of inaccuracies and contradictory information. The MTR team heard during an interview that ANMs and other front-line workers report accurately but the data keep changing as they go up the system to the district and state levels and are therefore not taken seriously.

Recommendation:

Reexamine Vistaar's data collection system and structure a process for regular data review with sector, block, and district counterparts. Use this opportunity to pull out indicators from the state HMIS to engage officials in a serious dialogue on ways to make the system more user-friendly. Insist on and reward accurate reporting, even if targets are not met.

Finding 7: District Technical Assistance Plans

Each district seems to have a TA plan, and they all seem very similar except for information on district-specific history and sociodemographic characteristics. TA plans are so long they read more like general strategy papers. The workplans attached also seem to be the same for all districts.[45]

Recommendation:

Review the profile of each district (infrastructure, human resources, other development partners, and history of past and current interventions, sociodemographics, Naxalite activity, tribal cultures) and adjust district TA to reflect the unique conditions of each district.

Finding 8: Delay of Marriage I

There is little evidence about what can be done to delay age of marriage, as is summarized in Vistaar's ER on the topic, and population diversity further complicates matters. The many government cross-sectoral programs have shown little or no demonstrable success.

Recommendation:

To help to build the evidence base about what works and the dynamics behind this intractable problem, Vistaar would need to refocus attention on refining the study design to capture family dynamics, community norms, and other social, cultural, and gender factors that affect the

[45] Based on review of Latehar and Chatra TA plans. Other districts for the same TA were observed.

acceptance of early marriage—areas the current baseline survey does not cover. There is also a need for Vistaar to refine its strategies for work that is specific to major sociocultural orientations (such as by tribe, caste, or religion). It is not known whether formative research is currently available or whether it should be initiated to customize strategies to increase the chance of success.

Finding 9: Delay of Marriage II

One major strategy to address DOM is to work through IPC channels with adolescent girls and their parents. Changing the attitude toward marriage of the adolescent girl is not sufficient, because usually she is powerless within her family. Hence, some of these strategies may not be enough to effect change in a patriarchal society, as evidenced by a lack of progress on this issue in many parts of India, especially the northern states.

Recommendations:

- Prioritize interventions to influence the power structures in the community to reshape the enabling environment by working through local men's and farmers' groups and cooperatives and with influential community leaders, both male and female, including religious leaders. There needs to be more grounded work on how marriages are arranged in different subgroups, and who loses and who benefits from various scenarios. The media campaigns have to be more insightful if they are to make a difference. Mere restatement that early age of marriage is illegal and causes poor health and even increases deaths in adolescents and their newborns has not been successful in effecting change.

- Continue to encourage Vistaar's excellent cross-sectoral approach in facilitating coordination with AWWs, ANMs, and *Sahiyas* through the VHNDs for out-of-school adolescent girls and in working with teachers in schools. These vehicles provide multiple opportunities for learning more about contraceptive methods; the value of delaying first birth, and limiting and spacing future births; nutrition counseling; provision of iron supplements; and deworming.

Finding 10: National Government Staff Training

The GoJH is training staff on IMNCI, with the help of UNICEF.

Recommendation:

Vistaar should capitalize on this opportunity to facilitate making IMNCI operational at the household, community, and facility levels by reinforcing the common MNCHN messages, supporting frontline workers to do their jobs more effectively, and promoting supply-chain management through district planning and effective monitoring.

Finding 13: Nutrition

Two districts are focusing on maternal anemia, one on child nutrition, and five on adolescent anemia.

Recommendation:

To improve nutritional status there is a need for a life-cycle approach focusing on critical age groups—children, adolescents, and pregnant women—so all target groups should be addressed in all Vistaar districts.

PROJECT MANAGEMENT: FINDINGS AND RECOMMENDATIONS

Vistaar Project Management

The Vistaar Project is led by IntraHealth International, Inc., a US-based nonprofit agency that has over 20 years of experience in health programming, primarily on USAID-funded projects. US-

based partners are Abt Associates, which provides expertise in costing analysis, and CRS, which provides field and technical experience in MNCHN. Until mid-2008 the JHU Center for Communications Programs was a partner, contributing to strategic health communications efforts, but there were problems in recruiting local seconded staff for the project.

Vistaar is also working through subgrantees to facilitate TA at the district level (MAMTA in UP and Vikas Bharati, CINI, and Ekjut in JH). The subgrantees are local NGOs; it is planned that working with Vistaar will build their capacity and thus may help keep project activities sustainable after Vistaar ends.

Staffing and Structure: Vistaar has offices in Delhi, Lucknow (UP), and Ranchi (JH). The project organizational chart illustrates the staffing of Vistaar structured into technical, finance, and procurement/administration teams. The state offices replicate this structure except that finance and procurement and administration units are combined (in Delhi they are separated for better checks and balances).[46]

Leadership Approach: The leadership approach Vistaar articulated at start-up during workshop planning has guided it ever since. The entire project team together drafted documents outlining the project purpose, leadership approach, customers, community, and other elements needed to build a strong foundation; the documents have been revised as needed about once a year. The leadership approach, designed to ensure that Vistaar achieves its purposes incorporates

- clear articulation that the government is the primary customer Vistaar (endorsed by USAID)
- support for staff leadership and focus on the purpose at all levels
- emphasis on a culture that is flexible and able to deal creatively with change
- commitment to fostering the ability to turn challenges into opportunities.

More discussion on Vistaar's leadership approach is available in the process documentation on participatory approaches.

Coordination and Collaboration: Vistaar has valued collaboration with other agencies and has built relationships with a number of GoI departments and agencies, including the MHFW, MWCD, NIHFW, NIPCCD, NHSRC, the Indian Council for Medical Research, the National Institute for Nutrition, the National Advisory Council, and the Planning Commission. Vistaar has also worked regularly with a number of MNCHN stakeholders, including UNICEF, World Bank, DFID, the Indian Clinical Epidemiology Network, the Institute for Applied Statistics, Urban Health Resource Center, Population Foundation of India, PATH, CARE, CEDPA, AED, and the International Center for Research on Women.

Policies and Procedures: IntraHealth has customized policies and guidelines for India and the Vistaar Project in the *India Project Office Policies and Procedures Manual*. All policies are available to staff through the internal web site, and a lead staff member is responsible for updating policies as needed (there is a process for requesting or suggesting changes).

Knowledge Management: The Vistaar Project values internal knowledge management and has several mechanisms for sharing critical information. An important tool is the intranet, which allows all staff to access annual workplans, unit or individual workplans, district TA plans, project monitoring information, IntraHealth policies, job descriptions, and other important

[46] See "The Vistaar Project Mid-Term Reviewers' Book – Overview Paper," prepared by project staff in July 2009, for an excellent summary of the staffing pattern and corresponding structures at Vistaar. See Annex C.

information. Various units also hold meetings periodically; the technical team meets at least each quarter, and the full staff meets once a year.

Vistaar Management Information System: Considerable information is collected, and enthusiasm and interest in the results were evident during discussions with Vistaar staff. Vistaar operates amid a large and diverse set of audiences for the information it plans to collect, which may result in over-collection as well as a loss of rationale about what should be collected to best present progress toward indicators of project success and established annual benchmarks. Vistaar must make evidence-based decisions on what it can accomplish between now and the end of the project and how it will measure progress so that it can guide where to site TA to best meet the needs of the GoI, GoJH, and GoUP and of its own and USAID's reporting requirements. It is hoped that external assessments of its progress will encourage interest in and replication of Vistaar's approach and strategies.

The MTR team spent a disproportionate amount of its time reviewing Vistaar MIS data and discussing ways to improve the system with Vistaar and USAID staff. The box contains a brief overview of some of the guidelines the team provided. It will be up to Vistaar and USAID to agree to the final MIS targets and benchmarks, but this is urgent (see Recommendation 1 in Chapter III and specific comments in the state-level discussions).

A Management Information System (MIS) provides information to support managerial functions: strategic planning, operational planning, and monitoring and control (interventions).

Level of decision making: Strategic decisions are taken at the policy level to set goals. Operational planning decisions are taken at the program/project planning level on resource allocations to address the stated objectives. Monitoring decisions are taken at the field level to trigger any required interventions.

Frequency of decision making: Strategic planning and operational decisions require information support at different times. Monitoring decisions are made most frequently. Planning decisions are made every 3–6 months, depending on the utilization of resources versus planned allocation in meeting strategic objectives. Policy decisions are made once a year based on the extent of annual target achieved.

Performance Indicators: Central to any MIS are the performance indicators for monitoring, and planning decision support. Performance indicators should be easily measurable, few in number for each decision maker, and at the desired frequency.

Data collection, validation, and analysis: Data collection and analysis are two very important components of any MIS. Measurement definitions of performance indicators would influence the type, source, and frequency of data to be collected. Data validation is critical before using any data for analysis and estimating performance indicators. It is essential that the design of data collection forms be simple and easily understood. Data collection and analysis should be routine rather than ad hoc.

The MTR team also spent a considerable amount of time discussing methods for developing the Vistaar Monitoring Plan. It was agreed that the MIS for Vistaar TA should support TA monitoring at the block level, planning at the district level, and strategies at the state level. (See Annex G: Vistaar Project Monitoring Framework, a draft Vistaar prepared after these discussions.)

It is necessary to identify easily measurable performance indicators to support monitoring, planning, and strategic decisions. Care should be taken to ensure that TA indicators are not the same as service indicators, even though TA indicators will influence service indicators. TA

indicators are process indicators (e.g., number of VHND sessions held in a block/cluster); service indicators are output indicators (e.g., number of pregnant women who received IFA tablets during VHND sessions).

Again, TA indicators should not be confused with HMIS indicators. The success of Vistaar TA projects must be measured through process indicators. Because the objective of the TA projects is to build management capacity, which in turn will impact service delivery, it would be useful to identify a few HMIS indicators on service delivery that can be influenced by TA to ensure that Vistaar TA is aligned with government programs.

A Few Important Steps:

The following suggestions would help streamline the work of the project:

- Organize geographically so that the same Vistaar team can cover all technical areas of work on a single visit.
- Reformat and simplify the monitoring plan to include indicators and their measurement.
- Consider whether the monitoring system can or should be a basis for a recognition and reward system for frontline workers and their supervisors.
- Draft a detailed monitoring plan for each block and district.
- Identify the purpose of each indicator, how it will be used, by whom, and at what intervals.
- Identify who is the end user of data (government officials).
- Define what gets monitored and its value.
- Identify who collects the information and how often.
- Identify who analyzes the data and when.
- Plan for how the information gets shared and at what venues.
- Be sure to identify how the information corresponds to the government HMIS.
- Identify a few government HMIS indicators to focus on, such as improving the number of deliveries and where conducted, births and deaths reporting, JSY expenditure – amount, and timeliness of reimbursement, etc.
- Note how and which actions result from information exchange between the Vistaar and Government information collection systems and feed this back positively into both.

USAID Management of Vistaar

Because Vistaar is a cooperative agreement, by definition it should not require extensive day-to-day USAID management or monitoring. However, USAID must insist that Vistaar set up an M&E plan immediately. It must clearly show target indicators and benchmarks for the remaining years of the project so that both Vistaar and USAID can demonstrate success.

Financial Management: As of June 30, 2009, 55% of Vistaar's five-year period had elapsed and 37% of total life-of-project funding had been expended ($8,157,333 of an expected $25 million). The first two years of the project were affected by

- the phasing-in of staff hiring,
- the decision to compete out four TA agencies (which took more time),

- the lower cost of TA agencies than expected,
- Vistaar's success with getting the GoUP and GoJH to support major activities from their own, not project, funds, and
- favorable changes in the dollar-rupee exchange rate.

The analysis that follows shows that the original funding could support project activities for an additional year. This would have a number of benefits for USAID; for instance:

- It would allow more time for TA inputs to show outcome results at scale. The core TA efforts began in Year 3 (after the ERs, assignment of districts, building trust and relationships in the districts, district TA planning, baseline survey and initial assessments, and identification and contracting with TA agencies). Since the areas covered, such as reducing child malnutrition and increasing the age of marriage, are complex, it would be preferable to have more than two years to document change.
- It increases the likelihood that change will be sustainable: The additional time will facilitate and solidify the desired systems-level changes.
- It increases the ability to advocate for wider scale-up: The additional time would allow Vistaar to document lessons learned from district TA and advocate for replication at the state level. It would also allow Vistaar to work to influence the planning for the next phase of NRHM and the XII Five-Year Plan.

TABLE 13. PROJECTED VISTAAR PROJECT EXPENDITURES IF THE PROJECT IS EXTENDED (US$)

	ACTUAL EXPENDITURE			PROJECTED EXPENDITURE			
	YEAR 1	YEAR 2	YEAR 3*	YEAR 4	YEAR 5	YEAR6	Total
Labor	493,058	806,386	1,130,000	1,200,000	1,260,000	1,000,000	5,889,444
Allowances	260,011	146,503	149,638	100,000	180,000	125,000	961,152
Consultants	60,059	69,572	123,052	130,000	120,000	85,000	587,683
Travel	184,120	188,133	280,000	300,000	375,000	250,000	1,577,253
Equipment >$5,000	45,264	65,218	-	-	-	-	110,482
Other direct costs	622,542	548,848	600,000	700,000	950,000	1,035,000	4,456,390
Fringe/ leave	109,817	99,036	100,000	115,000	132,250	126,500	682,603
Sub-contracts	84,538	211,787	600,000	1,000,000	1,350,000	1,150,000	4,396,325
Overhead	559,016	603,329	1,104,986	1,270,734	1,461,344	1,397,807	6,397,216
Total	**2,418,425**	**2,738,812**	**4,087,676**	**4,815,734**	**5,828,594**	**5,169,307**	**25,058,548**

* Year 3 data includes 3 quarters of actual and 1 quarter of projected expenses.

Finding: Vistaar Project Overview and Presentations

Numerous PowerPoint presentations, briefing notes and papers, web sites, and reviews contain different ways to describe Vistaar, which causes confusion for those aiming to learn from and guide Vistaar and even among Vistaar staff as to the objectives, goals, and language used to guide Vistaar implementation and reporting.

Recommendation:

Vistaar should collect all presentations project-wide and for each state and for each technical or strategic focus area and consolidate them into standardized formats and language. USAID and Vistaar staff should all be briefed on the result of this review so that they all use the same format in the remaining years of the project. As far as possible, use language that complies with the new, though still unofficial, guidance on the USG Global Health Initiative.

III. CRITICAL FINDINGS AND RECOMMENDATIONS

FINDING 1

Vistaar needs a monitoring framework that can provide an overview of what the project will accomplish and a measurement tool for assessing progress continuously. The evolving approach of the first two years of Vistaar and the diversity of audiences invested in Vistaar has led to a diffusion of focus even as the technical content and underlying strategies have continued to develop. The main goal of the Vistaar program is to strengthen government systems and performance to improve MNCHN outcomes across all districts in both target states. Because Vistaar has the potential to offer an effective model for global USAID TA programming, it needs to monitor, evaluate, and present itself more clearly.

RECOMMENDATIONS

- Vistaar staff should give priority to defining main goals and project focus (using quantitative and qualitative evidence-based measures) and to communicating them well to its own program staff; the USG, particularly USAID; and other stakeholders, particularly the GoI, GoJH, and GoUP. A clear presentation of project goals, objectives, process and outcome target indicators and annual benchmarks, and how they fit into the GoI, Vistaar, USAID/India, and USAID frameworks, is essential to moving forward with clarity, vision, and focus to achieve the goals.

- As the value of adding assistance to India's HMIS was previously assessed, the MTR Team agreed that Vistaar, in examining its own data collection system, should structure a process for regular data review with counterparts at all levels (sector, block, and district). It should use this opportunity to pull out indicators from the GoI, GoJH, and GoUP HMIS to engage officials in serious dialogue on ways to streamline their systems and make them more user-friendly, and to insist on and reward accurate reporting.

FINDING 2

Vistaar currently has a formidable challenge just to cover the 23 districts where it is already working. Considering the sheer numbers of people being served, overlaid with the distance between target regions and the diversity of needs of the populations served, the designation of these districts seems more than adequate for the funds and time that Vistaar has invested. Furthermore, each delivery area requires a different set of guidelines and interventions, which puts additional burdens on Vistaar management.

RECOMMENDATIONS

Vistaar should immediately determine how many districts it can reasonably expect to serve and modify its activities accordingly. Criteria for selecting districts should be based on currently demonstrated commitment and potential to achieve expected results, proximity to each other so that time spent traveling for TA is reduced, subgrantee locations, and Vistaar areas served by UNICEF and other development partners. If Vistaar deems this too time-consuming, the MTR team suggests that Vistaar not expand to other districts but expand the TA provided in all current districts to cover all four technical areas (nutrition, community-based NBC, DOM, and SBA) because the approaches are similar and are cross-cutting in all districts assisted and therefore should be integrated into all interventions.

FINDING 3

While the nutrition advocacy component of Vistaar is off to a good start at the central level, with broad national participation and interest, including active and visible champions on the Advisory Committee, government participation seems to be inconsistent and government officials in the Nutrition Coalition seem unclear about project direction.

RECOMMENDATIONS

- Continue to engage the government as an active advocate for the nutrition platform. Perhaps hold a meeting with all concerned ministries to outline roles for each in the coalition and in implementing its recommendations. The current attitude that it is some other ministry's responsibility to take care of nutrition is not acceptable if critical changes in nutritional status are to be made in India.

- Continue to engage other supporters and active advocates for the nutrition platform. Seek to discuss it with those who may have different views or experiences with nutrition, particularly those who are familiar with the food security and hunger agenda and those who stand to gain from improved and sustained nutritional status in the country, such as those who produce or market food. Continue to use evidence-based learning to engage participation from the state to the household level.

FINDING 4

Many different stakeholders are working in the same or similar districts on MNCHN and are not taking full advantage of each other's experiences and skills.

RECOMMENDATION

Vistaar and USAID should employ all means to strengthen coordination. collaboration, and integration of efforts where they are working, starting with other USAID interventions that could benefit from an exchange of information and ideas, such as education, food security, and emergency assistance, etc. To do this, organized and regular meetings and communications (one idea is to use an online listserv for staying in touch) should be scheduled and adhered to. To be fully effective this will need to occur at all levels of the system and geographically.

FINDING 5

Many of those interviewed for the MTR stated a personal or observed lack of ground-level understanding by political, program, or planning personnel. This has resulted in decisions that do not reflect the realities of information dissemination and utilization or planning, let alone service delivery.

RECOMMENDATION

Vistaar should continue to get people out to see what is actually happening by inviting functionaries and other stakeholders to visit district, block, and community sites to interview the people who work there and see the realities of where they work.

FINDING 6

Vistaar's objective of improving the performance of front-line health workers is critical to enhance the coverage and delivery of quality health services. Most programs focus on training in technical knowledge but do not offer ways to improve IPC for behavior change, leadership skills in meetings, understanding job descriptions and coordinating with other frontline workers, or using data for planning, time management, and supportive supervision. In the community, the ASHAs, AWWs, and ANMs have the most direct link with mothers, newborns, children,

adolescents, and families. They can offer a wide range of information and services covering all MNCHN programs under the NRHM umbrella.

RECOMMENDATION

All the districts should be immersed in all the technical theme areas (NBC, nutrition, DOM, and SBA) as Vistaar works to influence the government planning process by using the evidence generated in the first year of the program, institutionalizing supportive supervision, improving the performance of frontline workers by improving their communication skills, and strengthening implementation of VHNDs. As the modalities are the same for all technical areas, they can easily be extended from one area to the others.

FINDING 7

There is an overwhelming shortage of health staff, supervisors, and infrastructure at all levels—more than 50% in most categories. The use of MOs as supervisors of SBAs and ANMs is essential in the short run for post-training support and follow-up due to the shortage of LHVs, but this may not be sustainable. In the government health system it is unusual for MOs to engage in outreach to ANMs, considering that there is a shortage of MOs and a lack of commitment even within the existing PHC structure. The persistent stories of salaried MOs who do not work and do not seem to be accountable to anyone continues to stress the health system.

RECOMMENDATIONS

- Explore other types of support structures that could sustain continuous motivation of health workers, including the use of open discussions to facilitate sharing of experiences and strategies for resolving problems. Examples might be setting up a supervision system with peer support and feedback at the block level.

- Continue to advocate for human resource training and brainstorm with local government officials on how they could better use a more evidence-based approach to set staffing patterns and specify qualifications. Continuing to address work accountability and motivation for block and district health personnel is also critical for improving the performance of workers and their contribution to the delivery of health services. Vistaar could initiate a planning process to develop a structure for supportive supervision and worker recognition for block and district service providers and other officials.

FINDING 8

The current Vistaar evaluation design needs to be reinforced to meet rigorous criteria for demonstrating change or the impact of the SBA training program. The credibility of the SBA Deoghar model is essential if Vistaar plans to make a major contribution to improved maternal outcomes and envisions a trajectory for full scale-up in India.

RECOMMENDATION

Ask a high-quality research group to review the evaluation design and create a methodology to answer a key question about the program: How does SBA training affect maternal health outcomes? There are multiple opportunities to create a rigorous evaluation design because SBA training has just started. The random and staggered nature of the training offers an important natural experiment to closely develop a pre-post training design, especially since an entire state will receive the training so a control district will not be useful. It would be an important contribution for Vistaar to closely monitor inputs into post-training supportive supervision and other PI activities so as to demonstrate how these factors contribute to improved coverage, quality of services, and ultimately outcomes.

ANNEX A. TERMS OF REFERENCE

MID-TERM REVIEW OF THE VISTAAR PROJECT
USAID/INDIA

Last Revision: April 20, 2009

I. Background

This document outlines the purpose and plans for the Mid-Term Review of the Vistaar Project. The Vistaar Project is a five-year (2006–2011) technical assistance project funded by USAID with the purpose of assisting the Government of India and State Governments of Uttar Pradesh and Jharkhand in taking knowledge to practice in order to improve maternal, newborn, and child health and nutritional (MNCHN) status. The project contributes to the USAID mission's strategic objective of "Improved maternal, child, and newborn health and nutrition at scale in India." It also contributes to the GOI's National Rural Health Mission (NRHM), MOHFW's Reproductive and Child Health Program (RCH II), the universalization of ICDS, and the Eleventh Five-Year Plan, and further is expected to contribute to the achievement of the Millennium Development Goals for maternal and child health.

The project is led by IntraHealth International and has two US-based partners (Abt Associates and Catholic Relief Services) and a number of local Indian partner agencies. The primary role of Abt Associates is to contribute to cost analyses and the primary role of CRS is to share experience and technical expertise with the project and government about how to improve systems and services at the community level. The project is expected to have a funding level of $25 million over the five-year period.

The project objectives are

- Technical Assistance: To provide strategic technical assistance (TA) to strengthen MNCHN programs of the GOI, GOUP, and GOJH in selected priority areas and based on evidence.
- Evidence Generation: To generate needed evidence about effective, efficient, and expandable MCNHN interventions based on TA experiences (previously called "demonstration and learning").
- Advocacy: To advocate with GOI, GOUP, and GOJH for increased priority to improved evidence-based programming in MNCHN, especially in the areas of nutrition and newborn care.

The project also has two cross-cutting focus areas:

- Equity and Gender: Ensure that the project efforts focus on improving MNCHN for the most needy and vulnerable.
- Knowledge Management: Ensure that project work is based on evidence and that the project actively promotes and shares evidence to improve MNCHN.

II. Objectives of the Vistaar Mid-Term Review (MTR)

The objectives of the review are

- to assess the overall progress and achievements of the Vistaar Project relative to its stated objectives; and

- to make recommendations for the remainder of the project period and for other USAID-funded MNCHN projects.

Major Review Areas

To accomplish this purpose, the MTR will consider the following major areas:

1. Project results and achievements to date
2. Project strategies and technical approaches
3. Project management

The MTR team will base its assessment on the following primary sources of information:

- Annual workplans, progress reports, and results reports
- Project monitoring and evaluation plans and data; government and other monitoring data
- Project documentation of accomplishments, including process documentation
- Site visits
- Key informant interviews

Project Strategies and Technical Approaches

The MTR team will assess the degree to which project activities contribute to the objectives and review the project's core strategies and principles and the degree to which they have been effective. The core strategies include a focus on supporting GOI MNCHN programming, providing technical assistance (as against direct implementation), working at scale, using and applying evidence, and promoting collaboration and partnerships. This review will cover

- The soundness of the basic design and approach, whether the basic assumptions have proven correct (e.g., availability of models and best practices to scale up, government acceptance of technical assistance, government willingness to use evidence, project ability to catalyze change at scale with limited inputs, government funds availability, government capacity to change within this time frame)
- The robustness of the strategies, with respect to using available evidence, focusing on areas of shared GOI and USAID programming priority, and the project's ability to take advantage of programming opportunities
- The quality of the technical assistance and inputs
- The level of partnership and collaboration with the GOI and other key project stakeholders
- Major lessons learned to date, including how to operationalize technical assistance and advocacy efforts at a scale with the GOI (at national, state and district levels), the sustainability of the efforts and approach, and the effectiveness of the project in documenting and sharing lessons.

Project Management

The MTR team will assess the appropriateness and effectiveness of the project's management systems and approaches, including

- Leadership, shared leadership, ability to respond and manage change

- Technical work planning and workload assignment
- Staffing, performance management, quality assurance
- Budgeting, financial management, procurement, cost share
- Monitoring, evaluation, documentation, reporting, internal and external knowledge management
- Ability to work with GOI officials and within the GOI system (national, state, and district levels)
- Ability to provide technical assistance (rather than a pilot or stand-alone program effort)
- Use of participatory approaches, fostering partnering and collaboration (with GOI, other USAID-supported projects, and other key stakeholders)
- Relationship between the prime contractor (IntraHealth) and its subs (originally JHU CCP, Abt Associates, and CRS)
- Relationship between the project and USAID; USAID guidance and support for the project

In addition to the above, the review team should address the following key questions:

1. Has the Vistaar Project been able to adapt and respond to changes and opportunities? (Has the evolution from the RFP and proposal stage been appropriate?)
2. How should USAID measure the results in technical assistance projects such as Vistaar that are designed to work with the government at a large scale? Should the project be held accountable for service delivery outcomes at scale (e.g., increased IFA consumption by pregnant women or improved newborn care practices at community level)? Should it also be held accountable for systems or process improvements (e.g., improved supportive supervision of community level health functionaries)? Is this time frame adequate to produce outcome results at scale? Will projects like Vistaar be able to show plausible attribution if there are improvements in outcome indicators at scale?
3. Is "technical assistance" the way it is envisaged and being implemented by the project a good way to achieve concrete and sustainable results? (The team needs to compare the advantages and disadvantages of the TA approach versus the more direct implementation or pilot approach and make recommendations for future USAID programming in this respect.)
4. Are the major project lessons and successes of the project being adequately documented and shared? (If not, the team should give suggestions for improvement.)
5. Are there any important observations or recommendations related to the project's burn rate being lower than anticipated in the first half of the project?
6. Has the project been able to build a sufficient relationship with the government to achieve its objectives? What appear to be the relative advantages and disadvantages of the unilateral mechanism for this type of project (vis-à-vis a bilateral mechanism), especially with respect to the project's ability to collaborate or influence the government?
7. In an effort to be responsive to government, has the project's technical focus become too broad? Would it be advisable for the project to focus on fewer technical themes?

8. Does a project like Vistaar, working to provide TA to the government, need to have an "exit" or sustainability strategy? (If so, the review team should provide guidance regarding the same.)

III. Review Methodology

The final methodology and work plan will be developed as a product of the team planning meeting and shared with the Mission prior to application, for approval concurrence. It should include the following major components:

Document Review

Prior to arriving in country and conducting field work, the team will review various project documents and reports, including but not limited to annual project workplans, progress reports, and results reports; project monitoring and evaluation plans and data; government and other monitoring data; project documentation of accomplishments, including process documentation, USAID strategy documents, the original request for applications, and the final proposal from IntraHealth and its partners. A list of key documents is included in Annex I. The USAID/India team will provide the relevant documents for review at least a week in advance so that the team has enough time to review the documents.

Team Planning Meeting

A two-day planning meeting will be held, with the team members only, prior to official onset of meetings and work with USAID and others. This time will be used to clarify team roles and responsibilities, deliverables, development of tools and approach to the assessment and redesign, and refinement of agenda. In the meeting the team will

- share background, experience, and expectations for the assignment,
- formulate a common understanding of the assignment, clarifying team members' roles and responsibilities,
- agree on the objectives and desired outcomes of the assignment,
- establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion,
- develop data collection methods, instruments, tools and guidelines, and methodology, and
- develop an assessment timeline and strategy for achieving deliverables.

Formal Initiation of the Review with USAID/India

A one-day team meeting with USAID will be held in India before the review begins. This meeting will allow USAID to discuss the purpose, expectations, and agenda of the assignment with the team. During this meeting the team will

- share background, experience, and expectations for the assignment,
- formulate a common understanding of the assignment and how it fits into USAID's broader program and objectives,
- review the background of the Vistaar Project and its current status,
- identify various stakeholders to be involved in the review, develop a common understanding of their relationships and interests, and agree on an approach to working with them,

- agree on the objectives and desired outcomes of the assignment,
- clarify team members' roles and responsibilities,
- finalize assessment methodology,
- finalize the assignment timeline,
- finalize data collection methods, instruments, tools, and guidelines,
- review and clarify any logistical and administrative procedures for the assignment,
- develop a preliminary draft outline of the team's report, and
- assign drafting responsibilities for the final report.

Internal USAID/India meetings will include, at a minimum, one mid-point review meeting following the site visits to request additional information; share initial impressions about the findings, conclusions, and preliminary recommendations; or address any other outstanding issues or questions.

Field Visits/Key Informant Interviews

- Field visits and key informant interviews at state and district level (Uttar Pradesh and Jharkhand), visiting work in the four main programming areas of nutrition, community-based newborn care, delaying age at marriage, and skilled birth attendance
- Key informant interviews at national level with GOI and key partners (Nutrition Coalition members, such as the chairperson, UNICEF and IFPRI, other USAID project staff, partner agencies, and subrecipients). A list of key informants is included in Annex II.

Wrap-up and Debriefing

Two debriefing meetings will be held: (1) with USAID/India and (2) with Vistaar Project representatives and USAID/India. The objective of these meetings is to share the draft findings and recommendations, solicit comments and inputs, and clarify any remaining questions or issues.

IV. Proposed Composition of the Mid-Term Review Team

GH Tech will identify a list of possible candidates for each position, and a short list of candidates (multiple candidates for each position) will then be forwarded to the Mission for their selection. The Mission will then approve a final team for the assignment.

Overall, the MTR team members should have expertise and experience in areas of relevance to this project, including:

- Technical areas of nutrition, newborn and child health, maternal health (especially skilled birth attendance), and gender issues (especially delaying age of marriage)
- The systems and strategic areas of monitoring and evaluation, training and performance improvement, health communications and development of IEC materials, equity and gender, and advocacy
- Working at scale within government programs
- Familiarity with Indian Government health systems and the MNCHN context in India.

In addition, the team members should have experience in conducting similar reviews and working with USAID projects.

The team should include four to five full-time independent experts (not associated with USAID/India or the project). It is recommended that there be at least two members from within the country who have an understanding of the Indian context and systems. Government representatives can serve the purpose, and if they are unable to be present for the entire evaluation, they can participate at least part-time with the team. However, it is hoped that these government representatives would participate in the initial briefing and planning meetings, at least some of the field visits, preparation of the key recommendations, and the final briefing with USAID and the project team. The government representatives could be invited from the following suggested agencies:

- State representation from NRHM, MHFW, MWCD, SIHFW, and SIPPCD
- National representation from NRHM, MHFW, ICDS, NHSRC, NIPPCD, and NIHFW

In addition, the team may include selected staff from one or more key stakeholders in India, such as from UNICEF, DFID, or other development partners.

The team shall have a team leader who, apart from being an expert in the technical area(s) mentioned above, should have excellent oral and written communication skills. S/he should have past experience of leading a team for such project reviews. The team leader will be responsible for the overall planning, design, and implementation of the evaluation and work coordination among team members. S/he will be responsible for report writing and the organization of the debriefing presentations. It will be his/her responsibility to submit a satisfactory report to USAID within the agreed timelines. Thus, s/he will have the overall responsibility for management of the team and finalization of the completed review report to USAID.

V. Timeline and LOE

USAID/India anticipates that the period of performance of this review will take place on/about mid-July to mid-August 2009 for approximately four weeks (including approximately three weeks in-country). The complete duration allows for planning, desk review of documents, in-country meetings, field visits, and report preparation. The Vistaar Project team has proposed one week of state and district site visits, visiting both states at the capital and then visiting two districts in each state (four districts total). This would allow a visit to districts working in all four major themes of skilled birth attendance, delay of marriage, newborn care, and nutrition.

Illustrative LOE and Timeline

Task/Deliverable	Duration/LOE		
	Team Leader	Other Team Members Expatriate (n=1)	Other Team Members: Local Experts (n=2 to 3)
1. Review of background documents & offshore preparation work	3 days	3 days	3 days
2. Travel to India	2 days	2 days	-
3. Team planning meeting	2 days	2 days	2 days
4. Team planning meeting with USAID/India	1 day	1 day	1 day
5. Information and data collection. Includes interviews with key informants (stakeholders and USAID staff) and site visits*	7 days	7 days	7 days
6. Mid-term briefing meetings with USAID (and key stakeholders)	1 day	1 day	1 day
7. Discussion, analysis, and draft review report in-country.	4 days	3 days	3 days
8. Final debriefing with USAID and partners	1 day	1 day	1 day
9. Preliminary draft report due to USAID prior to departure from country	2 days		
10. Depart India/travel to US	2 days	2 days	
11. USAID and partners provide comments on draft report (out of country) – 5–10 working days			
12. Team revises draft report and submits final to USAID (out of country)	5 days	3 days	3 days
13. USAID completes final review			
14. GH Tech edits/formats report (one month)			
Total Estimated LOE	**30 days**	**25 days (x 1 person)**	**21 days (x 2 to 3 people)**

* A six-day work week is authorized when working in–country.

VI. Deliverables

The following deliverables will be required from the review team:

1. **Review Methodology and Workplan:** During the team planning meeting, the team will prepare a detailed work plan and a written methodological plan which will include the methodologies to be used in the review. These plans will be discussed and approved by USAID prior to implementation.

2. **Debriefings:** The team will conduct one mid-point and at least one final debriefing meeting. The mid-term debriefing will take place after the field visits to discuss preliminary findings with USAID. The final debriefing(s) will include a meeting with

USAID and with Vistaar Project representatives (either together or separately, based on decisions made during the Team Planning Meeting with USAID). The debriefing should present key findings and recommendations in a PowerPoint format and should occur before submission of the draft of the report that is due upon departure from the country.

3. **Draft Report:** The first draft of the review report will be due at the end of the team's country visit and describe findings, conclusions, and recommendations. This draft report should include observations in the three selected areas (i.e., project results and achievements to date, project strategies and technical approaches, and project management), along with recommendations based on these observations. The recommendations should include (a) recommendations on how to improve and strengthen the project work in its final years, and (b) recommendations to USAID for future programming efforts in MNCHN. The report should also specifically answer the questions that are laid out in this scope of work and any others decided during the initial briefing meeting with USAID.

USAID will provide comments on the draft report within five to ten working days of submission.

4. **Final Report:** The final report will be due within approximately five working days after the team receives comments from USAID/India. USAID/India requests both an electronic version of the final report (Microsoft Word or PDF format) as well as 10 hard copies of the report.

   After the final but unedited draft report has been reviewed by USAID, GH Tech will have the documents professionally edited and formatted and will provide the final report to USAID/India for distribution (8 hard copies and a CD ROM). It will take approximately 30 days for GH Tech to edit, format, and print the final document.

VII. Logistics

The review team will be responsible for the majority of the off-shore and in-country logistical support. This includes arranging and scheduling their internal meetings, international travel, working/office space, computers, printing, and photocopying. USAID will assist in arranging meetings with government officials and key stakeholders. Vistaar Project staff will assist in arranging logistics for the field visits. A local administrative/logistics assistant may be hired for additional logistics support if needed.

VIII. Reporting

The point of contact for this assignment is

Dr. Rajiv Tandon
Chief, MCH, Nutrition and Urban Health Division
Office of Population, Health & Nutrition
USAID/India

IX. List of Key Documents

Background Documents

Key data from the NFHS for India, UP, and JH

USAID Request for Applications

IntraHealth's BAFO proposal response (formerly known as the "National Integrated Health Project")

Project Documents

Annual Workplans for Project Years 1-3 (includes the project monitoring plans)

Semiannual progress reports to USAID

TA plans for districts to be visited (representative of each technical theme)

Monitoring (MIS) plans for districts to be visited (representative of each technical theme)

Job descriptions of key Vistaar positions

Equity and gender assessment summary document

TOR for Nutrition Coalition

History of Nutrition Coalition

Project Organizational Chart

Burn rate chart for life of project

Project Publications

Project brochure

Evidence review briefs (for six technical topics)

Nutrition Conclave Proceedings / Chennai Declaration

Leadership Agenda for Action (nutrition advocacy document)

Key government orders related to the Vistaar Project

Baseline survey thematic summaries

Process documentation reports

- Evidence review process
- Nutrition advocacy process
- District and state level annual planning process
- Participatory processes and consultative approaches
- Training and performance improvement (first phase, Deoghar)

X. List of Key Informants

(*The list below is only illustrative. A detailed one will be sent later*.)

- Government officials at national, state (UP and Jharkhand), and district levels
- USAID project staff
- USAID staff, especially those not directly related to Vistaar project.
- Staff of other USAID-funded health projects working in UP and Jharkhand
- Staff from agencies that are IntraHealth subs on Vistaar, i.e., CRS and Abt Associates

- Staff of local Indian partner agencies that have received sub-awards under the mechanism
- Staff of other donor agencies working on maternal, newborn, and child health and nutrition (e.g., DFID, WHO, UNICEF)
- Nutrition coalition members, especially the chairperson and members of the steering committee
- Individuals from local agencies, such as NHSRC, NIHFW, and NIPCCD

ANNEX B. KEY INFORMANTS AND SITES VISITED

USAID

Vistaar

Laurie Parket, Vistaar Director, and staff

Dr. Dharmendra Panwar, District Activity Leader, Vistaar

Ms. Vidhya Verma, MAMTA

GOVERNMENT, NGO, AND OTHER STAKEHOLDERS

Dr. Marta Levitt-Dayal, Chief of Party, MCH STAR

Prof. M.S. Swaminathan, Chairman, M. S. Swaminathan Research Foundation, Member of Parliament (Upper House)

Dr. A.K. Gopal, Director, NIPCCD, MWCD, GOI, National Institute of Public Cooperation and Child Development (NIPCCD)

Ms. Nidhi Khare, Director, Ministry of Social Justice and Empowerment

Dr. Deoki Nandan, Director, National Institute of Health and Family Welfare

Dr. Rajesh Khonna, Coordinator, Child Health Project

Ms. Srilekha Chakrabarty, IT Consultant

Dr. M. Hementa Meilei, Senior Lecturer, Statistics and Demography

Dr. Sangeeta Saxena, Assistant Commissioner, Ministry of Health and Family Welfare

Ms. Veena Rao, CH, Ministry of Health and Family Welfare Nutrition Advisory Committee

Ms. Purnima Menon, Research Fellow, International Food Policy Research Institute

Dr. G.N. V. Brahmam, Head of the Field Division, National Institute of Nutrition (telephone interview)

Dr. T. Sundararaman, Executive Director, NHSRC, MHFW, GOI, at the NHSRC Office, Munirka

Ms. S. Jalaja, Secretary, Department of AYUSH (Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homoeopathy), MHFW

Ms. Aradhana Johri, Joint Secretary, NACO, Ministry of Health and Family Welfare, GOI

Dr. Ram Saran Verma, Chief Medical Officer, MHFW

Dr. L C Yadav, Assistant Chief Medical Officer, Child Health, MHFW

Mr. Rajesh Sharma, Nodal Officer, NRHM

Ms. Gurmeet Gupta, District Program Officer, ICDS

Mr. Ripunjay Srivastava, District Program Manager, NRHM

Ms. Razia Khan, District Community Mobilizer NRHM

Mr. Ajay Upadhyay, District Magistrate

Ms. Deepti Pant, State Representative, CRS, Lucknow

Dr. Sunil Mehra, Executive Director, MAMTA Health Institute, New Delhi

OTHER DONORS

Dr. K. M. Sathyanarayana, National Program Officer, UNFPA India

Ms. Anne Philpott, DFID

Ms. Adele Khudr, State Representative, UNICEF, Lucknow

Dr. Marie-Claire Mutanda, Head, Health Section, UNICEF Lucknow

Dr. Gaurav Arya, Health Specialist, UNICEF, Lucknow

Dr. Gayatri Singh, Nutrition Specialist, UNICEF, Lucknow

UTTAR PRADESH INTERVIEWS

Dr. P. K. Bhagwat, Joint Director, Child Health and NRHM, Directorate of Family Welfare, GoUP

Dr. Manish Jain, State Representative, Immunization Basics

Ms. Pratibha Sharma, State Representative, CARE, India

Ms. Geetali Trivedi, Senior Program Officer, JHU, with the USAID-funded Integrated Technical Assistance Program (ITAP)

Ms. Deepti Pant, State Representative, CRS India

Dr. Sanjay Avinash Mall, State Representative, World Vision India

Mr. Pushpraj Kaushik, State Program Manager, AED, POUZN Project

Ms. Shilpa Nair, State Representative, PATH, Sure Start Program

Dr. Ravi Anand, State Program Manager, Abt Associates

Dr. Neelam Singh, Executive Director, Vatsalya

Mr. Anujesh Mathur, State Consultant, Urban Health Resource Center

Dr. Aruna Narain, General Manager, Child Health/Planning, SPMU/NRHM State Mission, GoUP

Dr. R. R. Bharti, Director General, Medical Health and Family Welfare, GoUP

Dr. Madhu Agarwal, Regional Director, National Institute for Public Cooperation and Child Development (NIPCCD), Lucknow, MWCD, GOI

Dr. A. K. Gupta, State Representative, A2Z Project

Dr. V. K. Srivastava, Convener, State Nutrition Resource Centre and Prof. of Community Medicine, KGMU/Member IndiaCLEN

Dr. Viswajeet Kumar, Director and Associate Faculty, JHU, Project on Child Survival

Mr. Chandra Prakash, Director, ICDS, GoUP

Dr. Nilesh Deshpande, District Activity Leader-Vistaar Project

Mr. Anil Dwivedi, District Representative, CRS

Mr. Tapas Kumar, District Representative, MAMTA Representative

Dr. B.R. Rathi, Chief Medical Officer

Dr. H.C. Pipal, Assistant Chief Medical Officer, Child Health and CCSP Training

Dr. A.K. Dwivedi, Nodal Officer, NRHM

Mr. Manoj Kumar Bharadwaj, District Program Manager, NRHM

Mr. Virendra Singh, District Community Mobilizer, NRHM

Mr. Sandeep Shukla, District Program Officer, ICDS

Mr. Girish Chandra Rajat., District Panchayat Raj Officer

Mr Vidhya Sagar Prasad, Chief Development Officer, ICDS

Mr. Shashi Bhushan Lal, District Magistrate

JHARKHAND INTERVIEWS

Mr. Islamul Haque, District Program Officer, ICDS

Mr. Samresh Singh, District Program Manager, NRHM

Mr. Rahul Purwar, IAS, Deputy Commissioner, Latehar

Mr. Ashok Bhagat, Secretary

Dr. N. N. Agarwal, Director, RIMS

Dr. Preeti Bala Sahay, HoD, Obstetrics and Gynecology

Dr. Shashi Bala Singh, Associate Professor

Dr. Prakash Gurnani, State Representative

Dr. Madhulika Jonathan, Programme Officer—Health

Civil Surgeons: Gumla, Hazaribagh, Koderma, Ranchi

District RCH Officers: Gumla, Hazaribagh

District Program Managers: Koderma, Hazaribagh

Mr. Shibaji Mandal, Director—Healthcare, Krishi Gram Vikas Kendra (KGVK) (CSR unit of Usha Martin Group)

Dr. Prasanta Tripathy, Secretary, Ekjut

Dr. Suranjeen Prasad, State Representative, CINI

Mr. J. Kandimalla, State Program Representative, CARE, India

Mr. Vikas Sinha, State Head, ITAP—Jharkhand

Mr. Soumitra Roy, State Coordinator, A2Z Project

Dr. Sumant Mishra, State Coordinator, Immunization Basics

Dr. Ashfaq, State Routine Immunization Officer, WHO-NPSP Programme

Dr. Dinesh Singh, State Program Officer, EngenderHealth

Ms. Ragini Sinha, State Program Officer, IRH

Mr. P. P. Sharma, Retd., IAS (Former Health and Chief Secretary, Jharkhand), now Chief Executive Officer, P. P. Sharma & Associates, Ranchi

Dr. V. S. N. Singh, State RCH Officer

Mr. Rajan Kumar, State Program Manager

Mr. Subir Kumar, State NGO Coordinator

Ms. Suchandra Panda, Consultant, Training

ANNEX C. KEY DOCUMENTS REVIEWED

Documents Supplied on CD Labeled Midterm Review Document – Vistaar Project

SECTION 1. INTRODUCTION TO THE VISTAAR PROJECT

- Vistaar Project Overview Paper (Vistaar – July 2009)
- State maps (indicating Technical Assistance Districts)
- Vistaar Project brochure
- Foundation document

SECTION 2. MNCHN SCENARIO IN INDIA

- NHFS: 3 fact sheets, for Uttar Pradesh, Jharkhand, and India (2005–2007)
- DLHS-3 data for Latehar, Varanasi, and Bulandshahr (2005–2007)
- MNCHN background data
- NRHM Mission Document
- ICDS IV Concept Note

SECTION 3. GENESIS OF USAID SUPPORT FOR THE VISTAAR PROJECT

- USAID MNCHN Strategic Program Framework (2005)
- USAID/India: Health Overview

SECTION 4. PROJECT OBJECTIVES AND STRATEGIES

Objective 1: Providing Technical Assistance

- Technical Assistance (TA) and Management Information System (MIS) Plans
  - TA and MIS Plan of Deoghar District, Jharkhand
  - TA and MIS Plan of Latehar District, Jharkhand
  - TA and MIS Plan of Bulandshahr District, Uttar Pradesh
  - TA and MIS Plan of Varanasi District, Uttar Pradesh
- Other documents
  - Equity and Gender Assessment
  - Cost Analysis of Technical Assistance – Concept Paper
  - Concept Note on Program and Performance Budgets (PPB)
  - TA Plan for PPB
  - Rapid Assessment of Supervision Mechanism in NRHM, Varanasi

Objective 2: Generating Evidence

- Process Documentation Guidelines

Objective 3: Advocacy

- TOR for Nutrition Coalition
- List of Task Force members
- Coalition Workplan

SECTION 5. RESULTS AND ACHIEVEMENTS TO DATE

Objective 1: Providing Technical Assistance

- Evidence Review Briefs
  - Community-Based Interventions to Delay Age of Marriage
  - Community-Level Interventions to Prevent and Treat Anemia
  - Improving Complementary Feeding Practices
  - Role of Village Health Committees in Improving Health and Nutrition Outcomes
    - Community-Based Interventions that Improve Newborn Health Outcomes
    - Improving Performance of Community-Level Health and Nutrition Functionaries
      - Illustrative Job Aids for ASHAs (Hindi)
      - IPC Training Module on Nutrition (Parts 1 & 2)
      - Draft IPC Counseling Guide
      - Draft Health Communication Strategy for DoM, Jharkhand
      - Checklist for Supervisors (SBA)
      - List of Material Developed for NRHM BCC Campaign (second phase)
      - NRHM BCC Campaign Evaluation Presentation
      - District Level PPB: Instructions for Completing the PPB Forms and Format
      - Draft Review of Interventions in Supportive Supervision and Worker Motivation
      - Government Order for Scaling Up SBA Training in Jharkhand
      - Government Order for Knowledge-Sharing Collaboration with NIPCCD
      - Government Order for District-Level Technical Assistance in Uttar Pradesh
      - Government Orders for Constituting MNCHN Technical Advisory Group in UP and JH

Objective 2: Generating Evidence

- SBA Process Documentation
- Participatory Approaches Process Documentation
- Nutrition Advocacy Process Documentation

- Performance Improvement Process Documentation
- Cost Analysis of SBA Theme

Objective 3: Advocacy

- Nutrition Conclave Proceedings and Chennai Declaration
- Leadership Agenda for Action
- Executive Summary 1 of Leadership Agenda for Action
- Executive Summary 2 of Leadership Agenda for Action
- Leadership Course on Nutrition Security and Sustainable Development

SECTION 6. MONITORING AND EVALUATION

- Workplans
  - Year 1 (2006–07)
  - Year 2 (2007–08)
  - Year 3 (2008–09)
- Results/Semiannual Progress Reports
  - Year 1 (2006–07)
    - Half-Yearly
    - Annual
  - Year 2 (2007–08)
    - Half-Yearly
    - Annual
  - Year 3 (2008–09)
    - Half-Yearly
- Baseline Survey Thematic Briefs
  - Nutrition and Newborn Care
  - Delay Age of Marriage
  - Skilled Birth Attendance
- Baseline Questionnaires and MIS Forms for Four Thematic Areas

SECTION 7. PROJECT MANAGEMENT

- Summary of TA Agencies
- Vistaar Project Organogram

OTHER DOCUMENTS SUPPLIED BY USAID AND VISTAAR

- Jharkhand and UP State PIP and District Plans
- Health Profile of UP
- Mapping of NGOs and Development Partners working in UP and Jharkhand

DOCUMENTS ACQUIRED INDEPENDENTLY

Links

http://www.usaid.gov/in/our_work/program_areas/health.htm

http://www.intrahealth.org

http://www.intrahealth.org/projects/20

http://www.usaid.gov/in/our_work/activities/Health/health_vistaar.htm

http://www.dalarinternational.com

www.openspaceworld.org/

www.genuinecontact.net/mtg_whole_person.html

Special SRS Bulletin on Maternal Mortality, 2004-06:
http://www.censusindia.gov.in/Vital_Statistics/SRS_Bulletins/MMR-Bulletin-April-2009.pdf

11th five year plan: http://planningcommission.gov.in/plans/planrel/fiveyr/welcome.html

NRHM JRM: http://mohfw.nic.in/NRHM/RCH/JRM.htm

NRHM PIP, MTR: http://mohfw.nic.in/NRHM/RCH/Index.htm

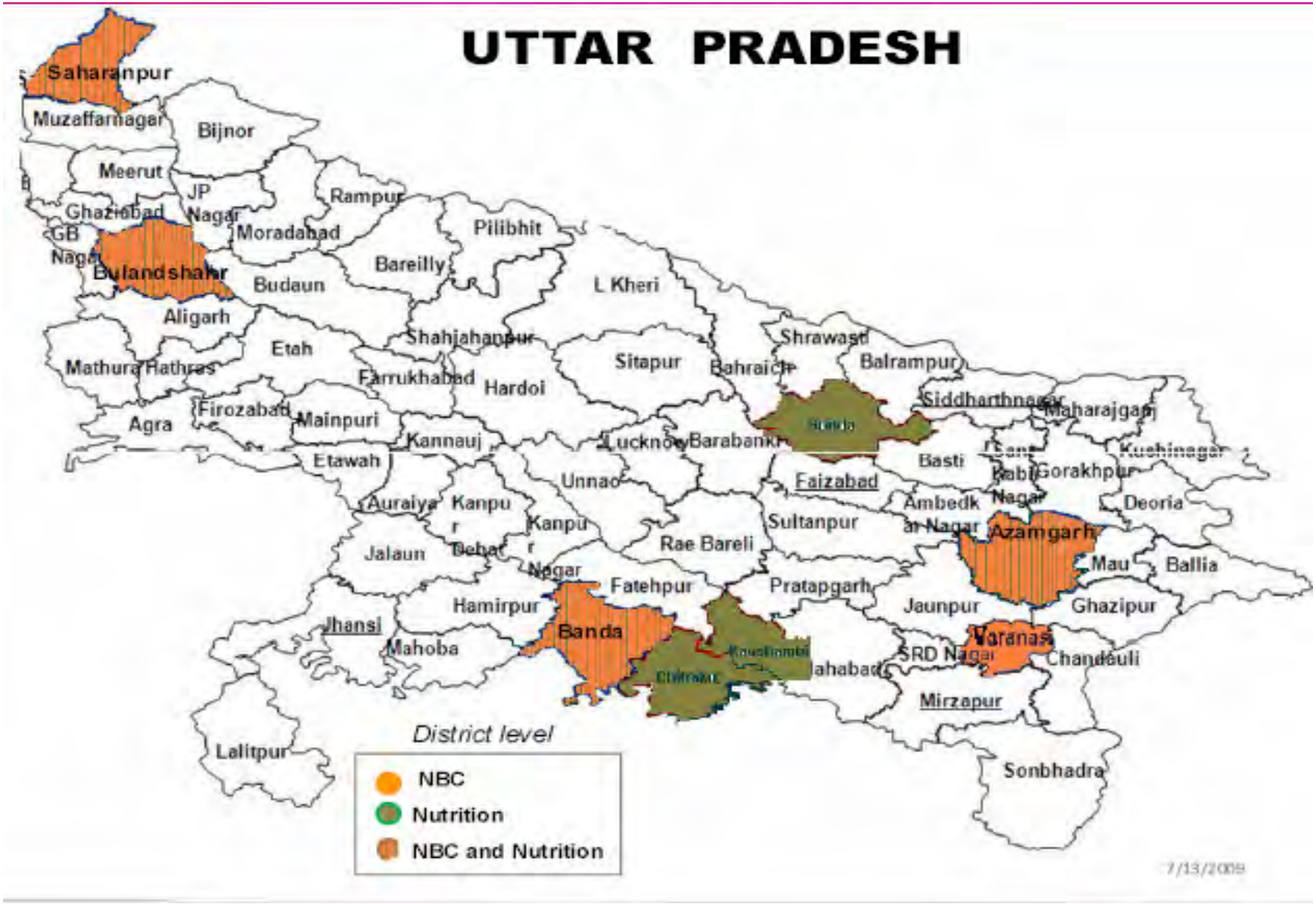
NRHM – CRM http://mohfw.nic.in/NRHM/CRM/CRM_files/Introduction_CRM.htm

World Bank-Supported ICDS IV/ Reforms Project http://www.wcd.nic.in/

Nutrition Coalition http://www.nutritioncoalition.in/

ANNEX D. MAPS OF VISTAAR PROJECT SITES

IN UTTAR PRADESH



VISTAAR PROJECT SITES IN JHARKHAND

ANNEX E. VISTAAR PROJECT MONITORING

Draft: August 14, 2009

PROPOSED INDICATORS

Illustrative Indicators from Monitoring System	Approaches	Goals
A1: % VHNDs held as planned **A2:** % newborns visited by a frontline worker within 24 hours (by sex, vulnerable group) **A3:** % women reporting nutrition counseling at household level (by vulnerable group) **B1:** Intended age of marriage for daughter **B2:** % correctly following complementary feeding practices (by sex, vulnerable group) **B3:** % women consuming IFA (by vulnerable group/ pregnant/ lactating, adolescents) **C1**: Annual change in % of VHNDs held as planned **C2**: Annual change in % newborns visited by a frontline worker within 24 hours **C3**: Annual change in % of births with skilled attendance **C4**: Annual change in % women reporting nutrition counseling at HH level	**Emphasis on primary/communication prevention and capacity of primary/community workers** **A. % increase in coverage in selected high-impact interventions by primary providers in project areas** **Increase behavior change** **B. % change in healthy behaviors in project areas** **Scale-up of high-impact interventions** **C. Over 10% annual increase in coverage of high impact interventions in selected districts** **Health systems strengthening** **D. # districts providing supportive supervision for frontline workers** E. **# districts with functioning planning and monitoring systems for VHNDs** **F. # government planning processes that included a data or evidence review step (district/state/national)** **Coordination and leveraging** **# joint products with government or other development partners (e.g., communication materials, advocacy papers)** **# high-impact interventions included in government plans, linked with project advocacy and influence efforts**	**Child Health: Save lives of children** **% newborns visited within 24 hours** **(by sex, vulnerable group)** **Maternal Health: Save lives of mothers** **% deliveries assisted by skilled providers (by home/other/type of provider)** **Nutrition: Reduce number of malnourished children** **% infants 6-11 months who are underweight (by sex, vulnerable group)** **Nutrition: Reduce anemia in women** **% of women who are anemic (pregnant, lactating/recently delivered/ adolescents)** **Family Planning: Improve birth spacing**

Illustrative Indicators from Monitoring System	Approaches	Goals
D1: % frontline workers reporting support form a supervisor (ASHA, ANM, SBA, AWW) **E1**: % VHNDs held as planned **E2**: Proportion of VHND services offered out of total 15 services **E3**: % districts preparing a VHND microplan **F1**: # districts/states that held data reviews before preparing a plan **F2**: # MNCHN evidence studies newly available for public access, linked with project efforts	**Focus on girls** **% of adolescent girls who are anemic** **Intended age of marriage (overall/vulnerable group)** **Integrate family planning with maternal and child health** **% of VHNDs offering FP information or supplies** **% of ASHA home counseling visits that include messages on healthy timing and spacing of births (HTSB)**	**Age of first birth**

Note: The monitoring system will provide information to feed into some of the approach-level indicators, as shown. The project is also collecting more monitoring indicators, especially to inform district TA efforts.

FORMS AND CHECKLISTS FOR MONITORING AND EVALUATION

The following are forms and checklists the Vistaar Project is collecting for each technical areas:

Technical Area	Forms / Checklists Used for Measuring the MIS Indicators
Skilled birth attendance	• Checklist for supervisors of SBAs • Checklist for Vistaar team visits
Newborn care	• Checklist for observing VHNDs – same for NBC and nutrition • Supportive supervision and home visit assessment tool: ASHA (same as the Field Work Form for *Sahiya* during Field Visit listed below?) • ASHAs block-level monthly meeting observation form • ANMs/LHVs monthly meeting observation form
Nutrition	• Checklist for observing VHNDs – same as for NBC • AWW feedback form and household visit form
Delay of marriage	• Rapid assessment tool: Adolescent • Rapid assessment tool: Parent

1. Field Work Form for *Sahiya* During Field Visit

   Section 1: Support and Supervision to *Sahiya* During Field Visits

   Section 2A: Household Visit 1 – Woman in 3rd trimester of pregnancy (*Sahiya* and monitoring person)

   2B: Household Visit 2 – Visit to a household with a newborn (*Sahiya* and monitoring person)

2. Field Work Form for AWW

   Section 1: Background Information (including numbers of visits by AWW in last month to pregnant women, pregnant women in last trimester, newborn < 1 month and sick newborn referrals)

   Section 2: Use of job aids and delivery of messages: (*Sahiya* and monitoring person)

   Household Visit 1 – Woman in 3rd trimester of pregnancy

   Household Visit 2 – Visit to a household with a newborn

3. Training Report Format (perhaps meant for day of training at district level): includes facilitator name, topic covered, duration, was it a TOT?, number of participants, type of trainees

4. SBA Monitoring

   2 forms: Annexure 6, which the supervisor of SBA fills out, and Annexure 7, which the Vistaar Team fills out

   – The number of questions is manageable for each.

- The total number of deliveries is a very important measure, and currently boxes on the form record deliveries at (1) home and (2) HSC; may need to add boxes for PHC / CHC or wherever the SBA is conducting deliveries to capture all deliveries.
- It is unclear who is the ANM supervisor who conducts monitoring visits (the trainer, who may be a medical officer [MO]?). If an LHV is posted, does she take over supervision? Does the frequency of supervision change as the SBA gets established and starts performing well? How is this information used?
- Having the MO supervise ANMs is not likely to be sustainable (since in many cases it is difficult to have the MO attend his own clinic duties at PHC / CHC)
- The number of questions in each category varies: Skills=4; Supplies=6; Support=3; Other PI related=3. The support questions need to be strengthened to reflect what kind of support the SBA would need from her supervisor, i.e., did the supervisor make sure she got her salary or supplies on time?
- The number of pregnancies registered at HSC during last month. It is unclear whether only pregnancies registered at HSC should be included or all pregnancies in the HSC area (meaning pregnancies that were registered at VHND, identified by *Sahiya*, etc.). The point is to have a listing of all registered pregnancies, perhaps by place of registration, to compare to total number of expected pregnancies.
- The monitoring visit schedule should be more frequent than 9-12 visits a month; there will not be enough variation with a denominator of 9 and it may not reflect what is happening in the field.
- Not sure how the information is collected on the number of SBAs trained. This should be available at block and subcenter levels to monitor progress.
- Segregate one-time observations, such as training site readiness and test scores of SBAs, from the quarterly monitoring format.
- Pick out a few most important drugs/supplies rather than monitoring all six.

5. Newborn Care and Nutrition Monitoring (many of the same forms are used, such as VHND, and observations will reflect variation as needed)
   - The VHND form is an excellent accounting of the level of coverage and the quality of services.
   - For supportive supervision overall, do not ask general questions (“was their supervisor supportive?”) because the majority may/will answer yes. Ask some specific questions, some of which are already listed, e.g., did the supervisor observe them conducting an IPC session?
   - Since VHND is a key NRHM and ICDS integration point and essential for service delivery across the board, it would be important to list a few indicators to compare and share with government HMIS and actively use at meetings for promoting MNCHN.
   - For VHND, consider creating a method to rate the VHND and then use that rating in meetings to recognize good work and motivate others to achieve the standards set.
   - For low-performing VHNDs, consider exchange visits to higher-performing VHNDs for extra learning, etc.
   - Many other comments about scrutinizing every indicator, setting up a process to know who collects what, how and for what purpose are referenced elsewhere.

- The monthly meetings observation forms for ANM/LHV and ASHA/*Sahiya* only count if the necessary training has taken place, but there is no assessment of quality of training, use of monitoring information for problem-solving and decision-making.

6. Delayed Age of Marriage Monitoring

   - The rapid assessment forms for both mother and adolescent focus disproportionately on listing signs of anemia and foods rich in iron and vitamin C.
   - There are no monitoring indicators on Vistaar's specific TA interventions: iron supplementation by AWW in the village, VHND for girls not attending school, and iron intake in school for girls still attending school.
   - What is the monitoring for already married adolescents (over 60% are in this category)? Is this form only for unmarried adolescents?
   - Indicators are needed to measure village norms about DOM and critical social/cultural attitudes and practices that affect DOM.

7. General Findings, Observations, and Recommendations

   - Organize geographically so that the same Vistaar team can cover all technical areas of work during the same visit.
   - Reformat and simplify the write-up of monitoring plans, including indicators and their measurement.
   - Consider whether this monitoring system can or should be a basis for a recognition and reward system for SBA's or other frontline providers.
   - Each district should develop a detailed monitoring implementation plan:
     - Identify the purpose of each indicator, how it will be used, by whom, and at what intervals.
     - Who is the end user of data (government officials)?
     - What gets monitored?
     - By whom, frequency of visits?
     - Who analyzes and when?
     - How does the information get shared, at what venues?
     - How does the information correspond to HMIS of government?
     - What few government HMIS indicators should be improved (number of deliveries and where conducted, births and deaths accurate reporting, JSY expenditure – amount and timeliness of reimbursement, etc.)?
     - How are actions resulting from information exchange taken?
     - Use the VHND information to develop a rating system that can be compared across VHNDs and their HSC and block areas for recognition and as a way to bring in some accountability for block officials to improve their performance.
     - There is no monitoring structure for policy and planning activities at the block, district, and state levels. There is a need to further define Vistaar TA at these levels beyond mere TOT.

- The quality of Vistaar TOT and the cascading process of further training is not monitored. This is the major input of Vistaar and needs a high level of attention.

EVALUATION

Separate baseline studies have been conducted by technical area: SBA, DOM, and combined nutrition and newborn care.

- There are 5–6 separate questionnaires for each technical area that can provide a comprehensive profile of the issue from different perspectives.
- The baseline should have a specific evaluation question that should be answered that could guide data collection and the instruments used.
- The lack of inclusion of comparison districts compromises the value of the data and inhibits any attribution of change to Vistaar. This is particularly the case because the government is implementing its programs in all districts.
- There needs to be a review of Vistaar's goals for the types of evidence it wants to produce, including the level of rigor to ensure that attribution of any change can be adequately detected and accepted for scale-up.
- The evaluation design and methods need to be reworked to achieve more rigor and provide enough evidence to assess program effectiveness.

ANNEX F. REVIEW OF THE NEWBORN EVIDENCE REVIEW

Newborn Care Evidence Review: From over 20 interventions identified on community-based newborn care (NBC), the Vistaar Project team selected 11 for review by Indian technical experts. The main selection criterion was that the interventions should have sound evaluation data that showed results at the outcome or impact level (e.g., improved newborn care practices). In addition, due to the need to identify lessons that have a good chance of working at large scale, interventions implemented in very small geographic areas (fewer than 30 villages or a population less than 25,000) were not included in the review. The 11 interventions selected were ANKUR project, Community-Led Initiatives for Child Survival, Saving Newborn Lives Initiative (Pakistan), Home-Based Newborn Care Project, Community-Based Participatory Interventions to Improve Essential Newborn Care Project, Projahnmo Project, RACHANA Program, Saksham Project, Saving Newborn Lives Initiative (Bangladesh), SMART Project, TBA Training, and Integration on Perinatal and Maternal Mortality (Pakistan).

The experts produced recommendations on "Components for Optimal Community-Based Newborn Care Package," which are:

1. Early and exclusive breastfeeding
2. Prevention and management of hypothermia (including "kangaroo" mother care at home)
3. Clean delivery
4. Tetanus toxoid immunization
5. Community-based pneumonia case management
6. Intermittent presumptive treatment of malaria in endemic areas[47]
7. Community-based resuscitation of newborns

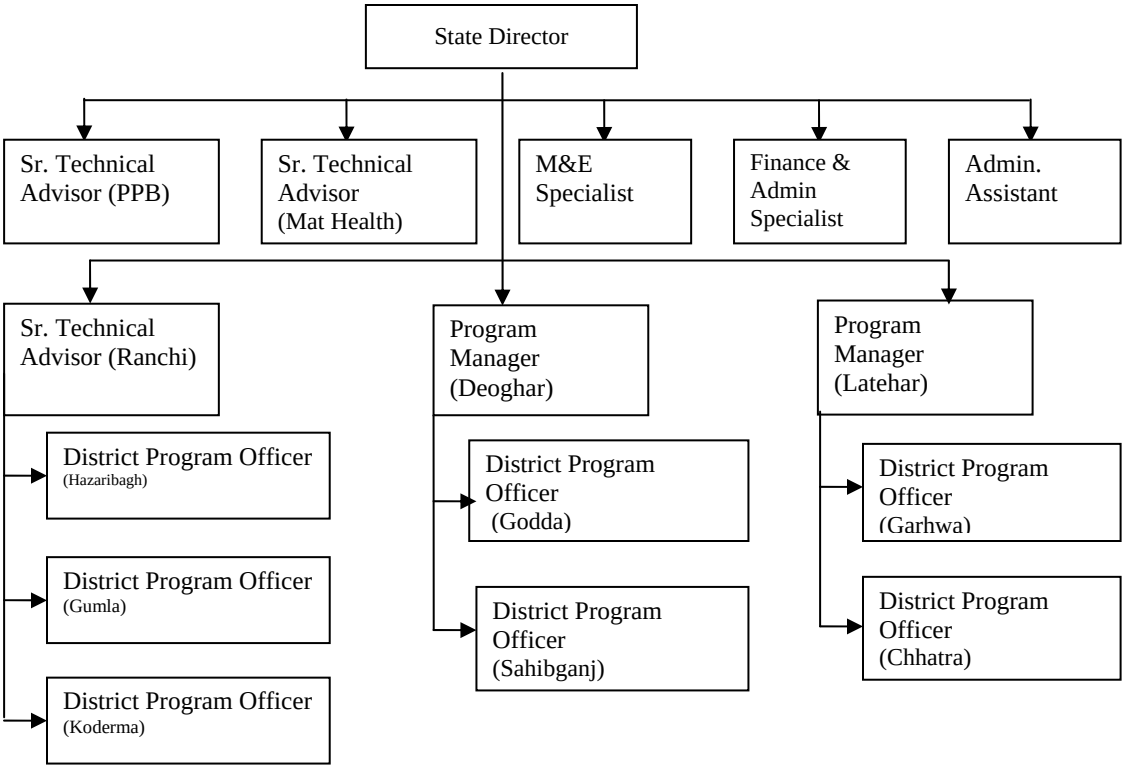
[47] There was consensus among the experts on interventions 1 to 5. For 6 and 7, although the majority of experts recommended their inclusion, there was no consensus on them for the short-term package.

EXHIBIT 1. PROGRAM ACTIVITIES IN JHARKHAND AND CURRENT STAGE OF IMPLEMENTATION

Month/Year Initiated and Major Activities	Roll-out and Implementation
November 2006 • Initial consultations with state government • State officials involved in Evidence Reviews (ERs)	State influenced project planning and ER topics. State officials involved in ERs (Performance Improvement ER held in Ranchi)
March 2007 • Support and advocate for collaboration mechanisms, including formation of MNCHN Technical Advisory Group (TAG), led by the MHFW	MNCHN-TAG begins with government leadership. Vistaar participates in other collaborative groups, such as the State Health Mission, IMNCI Task Force and task forces preparing the state MHFW Program Implementation Plan. TAG maps all government partners in JH.
May 2007 • TA planning for districts, based on ERs	State asked Vistaar to provide TA to 15 (out of 24) districts Consultative work to support district planning began Shared ERs, developed TA plans with district officials (required many reviews and an iterative process) Began planning for subgrants
April 2008 • Begin providing some TA at state level on nutrition and NBC.	Helped to develop job-aides for ASHAs, LHVs & ANMs. Conducted TOT for performance improvement at state level. Involved state officials in training on participatory processes and consultation. Vistaar served as secretariat to MNCHN-TAG in 2008.
February - April 2009 • Subcontracts awarded to three NGOs (Vikas Bharati, Ekjut, CINI) for work in JH.	Staff hired; workplan approved; initial consultations held. Needs assessments conducted (equity and gender, performance improvement).
February 2009 • Baseline survey in selected districts completed.	Findings shared with district health officials. Findings used to shape TA plans.
May 2009 • Ramped up TA activities.	TOT for supportive supervision at state and district levels Formative research conducted. Communications strategies drafted for DOM. District MIS finalized and data collection initiated .

*Note: Deoghar SBA roll-out and timeline are shown separately in Exhibit 8.

EXHIBIT 2. ORGANOGRAMS OF THE JHARKHAND HEALTH SYSTEM



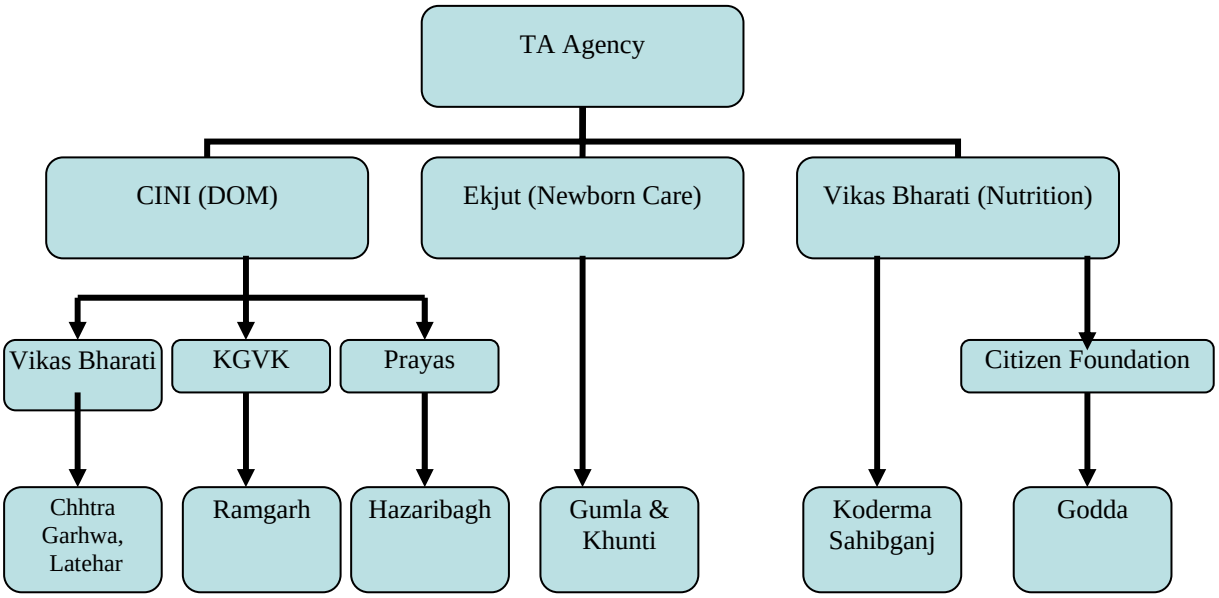


EXHIBIT 3. INTERACTION WITH THE VISTAAR STAFF AT RANCHI

Vistaar staff vision, goals, and aspirations for the end of the project:

The Vistaar Jharkhand staff met at Ranchi during the mid-term review visit to present the status of their TA in each district. Actual implementation has just started in the previous few months or was about to begin in some districts. Because the TA is evolving, staff were asked to identify their goals or aspirations for Vistaar. The responses spanned a range of levels of understanding but clustered around the following:

- Vistaar should help the government provide good and timely service to the population.
- Supervisors should be supportive.
- Improve nutrition to mothers, lactating mothers, and children 0–2.
- Increase iron intake.
- Increase institutional delivery.
- Help government analyze data.
- Support government microplans for VHND.
- Reduce malnutrition.
- Achieve goals of monitoring plan.
- Improve knowledge of AWW.
- What Vistaar is doing gets institutionalized and government takes ownership.
- All plans should go into PIP, government gets credit for their work, and they develop a habit of getting the work done.

This exercise pointed out the wide range of opinions about the goals for the Vistaar Project. At the end of the exercise the consensus around goals and results was:

1. Increase institutional delivery by SBA.
2. Improve newborn care and nutrition.
3. Increase IFA coverage in adolescent girls and reduce anemia.

Supporting Factors for Implementation:	Barriers to Project Implementation:
• Evidence base for program planning • Ownership by government • Participatory training methodology • Government officials welcoming the ideas • Technical assistance is a unique approach. • Work freedom and supportive officials • Excellent team leadership • Team commitment	• It is difficult for government officials to understand the technical assistance approach. • There are gaps in program implementation. • There are numerous vacancies at all levels of health system, and especially among ICDS and health system supervisor. • Many managers still believe in a traditional work/management environment. • Frequent transfers of the officials makes

Supporting Factors for Implementation:	Barriers to Project Implementation:
• Vistaar's rapport with government and other development partners • Good health communication strategies • Trainings on supportive supervision and performance improvement helping to change system's environment • Mind-set of government officials changing	continuum of dialogue difficult. • Health infrastructure is poor. • Government staff are less motivated. • The project has a short life span. • Government system has its own pace of working, which makes progress very slow; following up with them can be frustrating. • Demonstrating results is difficult.

EXHIBIT 4. SBA DEOGHAR MODEL TIMELINE

YEAR	Month	SBA Milestones
2006		GoJH launches GOI 3-week SBA training, with UNICEF support.
2007		CEDPA/ACCESS/Jhpiego starts 12-week training program in Dumka district.
	Nov	- **Vistaar begins planning with district officials.** - **GoJH NRHM Director asks Vistaar to develop SBA training program in Deoghar district.**
	Nov-Dec	SBA training design team (4 GoJH district officials, RCH, Civil Surgeon, Ob-gyn, Peds., 4 Vistaar staff, 1 consultant) meet three or four times.
2008	Jan	**Week 1**: Guidelines and curricula for SBA TOT, and ANM training are developed. **Week 2**: GoJH NRHM Mission Director approves SBA 6-week training model in consultation with team. **Week 3:** Orientation is held by Master Trainers from RIIMS. **Week 4:** First TOT for SBAs (18 people) is launched for the Deoghar district pilot. (Simultaneously: Deoghar District Hospital mandates use of comprehensive checklists (labor room supplies, meds, waste disposal).
	Mar	19 ANMs from Deoghar graduate from 6-week SBA training course.
	Sept	KGVK, which operates a commercial ANM school in Ranchi, adopts SBA training at the pre-service level.
	Oct	39 ANMs are trained in the 6-week SBA program in Deoghar.
	Nov-Dec	- The Vistaar baseline in Deogarh is completed (with Palamau as the control district). - Monitoring data reveal that after completing Deoghar training, SBAs increased their deliveries from 20 deliveries per PHC per month (2 deliveries only in 3 PHC, 0 in 5 others) to 100 per month per SBA per PHC; SBAs thus will be conducting approximately one-third (1,200) of the expected 3,300 deliveries a year if the trend continues). Deliveries in the District Hospital have more than doubled (from 200 to 450/500 per month) - Just under 100 ANMs are trained in the GoI 3-week program.
2009	Jan	- UNICEF, which supported the 3-week training, adopts Deoghar model because it is working—Vistaar shared all documents and materials. - The GoJH incorporates a new 6-week SBA training program into its state NRHM PIP.
	Feb	**The GoJH adopts the 6-week SBA training program for the entire state** by Government Order issued by the Secretary of HFW. Vistaar is allotted 14 districts and UNICEF 10.
	June	120 ANMs (out of a total of 299) are trained in SBA in Deoghar.
	Aug	- 4 batches of 22 TOT are trained at RIIMS (Vistaar Districts); the numbers are similar for the UNICEF districts. - SBA TOT is completed in 6 districts (Latehar, Hazaribagh, Koderma, Godda, Sahebjang).

EXHIBIT 5. SKILLED BIRTH ATTENDANT TRAINING AND PERFORMANCE IMPROVEMENT STRATEGIES

1. **Enhance the quality, comprehensiveness, and effectiveness of SBA training:**
   a) Facilitate the maintenance of quality SBA training sites.
   b) Help with selection of master trainers and strengthen their training skills (through a 5-day skill-building program).
   c) Assist in strengthening the SBA training strategy at the district level (facilitators guide, opportunities for hands-on experiential learning with three weeks in the labor room and one week in maternity ward/or ANC clinic).
   d) Create a 360-degree training feedback mechanism to reinforce training (develop training monitoring tools).
   e) Provide in-field support to SBAs for knowledge retention.
2. **Strengthen the provision of drugs and supplies to SBA's for continuity of services:**
   a) Provide safe delivery kits when SBAs complete training so that they are immediately equipped for deliveries.
   b) Help ensure that essential drugs are always available at facilities.
   c) Assist in monitoring.
3. **Enhance supportive supervision through mentoring and feedback on performance:**
   a) Develop tools for supportive supervision.
   b) Orient medical officers on how to perform supportive supervision.
   c) Monthly field visits and meetings with SBAs
   d) Offer on-the-job mentoring (regular visits by master trainers, rotational posting of ANMs trained, monitoring from Vistaar project).
4. **Institute a motivation and recognition system for SBAs,** consisting of
   a) Composite performance criteria
   b) Recognition at PHC levels
   c) Recognition at district levels.

EXHIBIT 6. GOUP MNCHN PARTNERS BY DISTRICT AND TECHNICAL AREAS

(as per NRHM PIP)
[Last updated on FEB 2008]
(Highlighted districts are those where Vistaar is working.)

Note: Only state-level key partners included in the matrix (district level agencies not included in the list)

Sl.	District	Newborn Care	Child Health	Maternal Health	Family Planning	Adolescent Health	Urban Health	Routine Immunization	Polio Eradication	Nutrition
1	Agra	CARE, MAMTA	CARE, MAMTA	CARE, MAMTA	CARE, SIFPSA	MAMTA, SIFPSA	CRS, UNICEF, MAMTA	CARE, UNICEF, MAMTA, NPSP/WHO	CARE , MAMTA, NPSP/WHO	CARE, MAMTA
2	Aligarh	UNICEF	UNICEF	UNICEF	SIFPSA	SIFPSA		UNICEF, NPSP/WHO	NPSP/WHO	UNICEF
3	Allahabad	CARE, UPVHA, MAMTA	CARE, A2Z, UPVHA, MAMTA	CARE, A2Z, MAMTA	CARE, UPVHA, MAMTA, SIFPSA	MAMTA, SIFPSA	MAMTA	CARE, UNICEF, UPVHA, MAMTA, NPSP/WHO	CARE, UPVHA, MAMTA, NPSP/WHO	CARE, MAMTA
4	Ambedkar Ngr	UPVHA	UPVHA		UPVHA	UPVHA		UNICEF, NPSP/WHO	NPSP/WHO	
5	Auraiya		CRS	CRS	SIFPSA	SIFPSA		CRS, UNICEF, NPSP/WHO	NPSP/WHO	CRS
6	Azamgarh	Vistaar, MAMTA	UNICEF, MAMTA	UNICEF, MAMTA	MAMTA, SIFPSA	UPVHA, MAMTA, SIFPSA		UNICEF, MAMTA, NPSP/WHO	MAMTA, NPSP/WHO	Vistaar, MAMTA
7	Badaun	UPVHA		JHU		Vistaar	UPVHA	UNICEF, NPSP/WHO,	UPVHA, NPSP/WHO	
8	Baghpat				SIFPSA	SIFPSA		UNICEF, NPSP/WHO	NPSP/WHO	
9	Bahraich	PATH, Beti Fnd., JHU, UNICEF	Beti Foundation UNICEF	PATH, Beti Fnd., JHU, UNICEF	SIFPSA	Vistaar, Beti Fnd., MAMTA, SIFPSA		UNICEF, NPSP/WHO	NPSP/WHO	UNICEF
10	Ballia	UPVHA			SIFPSA	SIFPSA		UNICEF, NPSP/WHO	NPSP/WHO	
11	Balrampur	PATH, Beti Fnd.	Beti Foundation	PATH	SIFPSA	Beti Foundation, SIFPSA		UNICEF, NPSP/WHO	NPSP/WHO	

12	Banda	Vistaar, UPVHA	UNICEF, UPVHA	JHU, UNICEF	UPVHA, SIFPSA	Vistaar, SIFPSA		UNICEF, UPVHA, NPSP/WHO	UPVHA, NPSP/WHO	Vistaar
13	Barabanki	CARE, Vatsalya, PATH, MAMTA	CARE, POUZN, Beti Fnd., MAMTA	CARE, Vatsalya, PATH, Beti Foundation, MAMTA	CARE, MAMTA	Beti Foundation, MAMTA	MAMTA	CARE, UNICEF, MAMTA, NPSP/WHO	CARE, MAMTA, NPSP/WHO	CARE, Vatsalya, MAMTA
14	Bareilly				SIFPSA	SIFPSA		UNICEF, NPSP/WHO	NPSP/WHO	
15	Basti	PATH, MAMTA	MAMTA	PATH, MAMTA	MAMTA, SIFPSA	MAMTA, SIFPSA	MAMTA	UNICEF, MAMTA, NPSP/WHO	MAMTA, NPSP/WHO	MAMTA
16	Bijnor							UNICEF, NPSP/WHO	NPSP/WHO	
17	Bulandshar	Vistaar, UPVHA	UPVHA		SIFPSA	SIFPSA	UPVHA, SIFPSA	UNICEF, NPSP/WHO	UPVHA, NPSP/WHO	Vistaar, UPVHA
18	Chandauli	UPVHA	UPVHA		UPVHA			UNICEF, NPSP/WHO	NPSP/WHO	
19	Chitrakoot					SIFPSA	SIFPSA	UNICEF, NPSP/WHO	NPSP/WHO	Vistaar
20	Deoria							UNICEF, NPSP/WHO	NPSP/WHO	
21	Etah	UPVHA			UPVHA			UNICEF, NPSP/WHO	NPSP/WHO	
22	Etawah					SIFPSA	SIFPSA	UNICEF, NPSP/WHO	NPSP/WHO	
23	Faizabad	JHU, UNICEF	POUZN, UNICEF	UNICEF				UNICEF, NPSP/WHO	NPSP/WHO	UNICEF
24	Farrukhabad							UNICEF, NPSP/WHO	NPSP/WHO	
25	Fatehpur	CARE, Vatsalya, UPVHA	CARE, UPVHA	CARE, Vatsalya	CARE, UPVHA	UPVHA	UPVHA	CARE, UNICEF, NPSP/WHO	CARE, NPSP/WHO	CARE, Vatsalya
26	Firozabad				SIFPSA	SIFPSA		UNICEF, NPSP/WHO	NPSP/WHO	
27	G B Nagar							UNICEF, NPSP/WHO	NPSP/WHO	
28	Ghaziabad							UNICEF, CARE, NPSP/WHO	CARE, NPSP/WHO	

29	Ghazipur	CARE	CARE	CARE	CARE, SIFPSA	SIFPSA	UNICEF	UNICEF, NPSP/WHO	NPSP/WHO	CARE
30	Gonda		Beti Foundation MAMTA	Beti Foundation, MAMTA	MAMTA, SIFPSA	Beti Foundation, MAMTA		UNICEF, MAMTA, NPSP/WHO	MAMTA, NPSP/WHO	Vistaar
31	Gorakhpur	CRS, PATH, JHU, UNICEF, UPVHA, MAMTA	CRS, UNICEF, UPVHA, MAMTA	CRS, PATH, UNICEF, MAMTA	UPVHA, MAMTA, SIFPSA	UPVHA, SIFPSA, MAMTA	MAMTA	CRS, UNICEF, UPVHA, MAMTA, NPSP/WHO	UPVHA, MAMTA, NPSP/WHO	UNICEF, MAMTA
32	Hamirpur	UPVHA	UPVHA		UPVHA			UNICEF, NPSP/WHO	UPVHA, NPSP/WHO	CRS
33	Hardoi	CARE, Vatsalya, PATH, MAMTA	CARE, MAMTA	CARE, Vatsalya, PATH, MAMTA	CARE, MAMTA	MAMTA	UPVHA	CARE, UNICEF, MAMTA, NPSP/WHO	CARE, NPSP/WHO, MAMTA	CARE, Vatsalya, MAMTA
34	Hathras	UPVHA			UPVHA			UNICEF, NPSP/WHO	NPSP/WHO	
35	Jalaun							UNICEF, NPSP/WHO	NPSP/WHO	
36	Jaunpur		A2Z	A2Z				UNICEF, NPSP/WHO	NPSP/WHO	
37	Jhansi	JHU, UNICEF	UNICEF	UNICEF	SIFPSA	SIFPSA		UNICEF, NPSP/WHO	NPSP/WHO	UNICEF
38	J P Nagar							UNICEF, NPSP/WHO	NPSP/WHO	
39	Kannauj	JHU, UNICEF	UNICEF	UNICEF				UNICEF, NPSP/WHO	NPSP/WHO	UNICEF
40	Kanpur Dehat	UPVHA, MAMTA	MAMTA	MAMTA	SIFPSA, MAMTA	SIFPSA, MAMTA	MAMTA	UNICEF, NPSP/WHO, MAMTA	NPSP/WHO, MAMTA	MAMTA
41	Kanpur Nagar	CARE, MAMTA	CARE, MAMTA	CARE, MAMTA	CARE, SIFPSA, MAMTA	SIFPSA (Trg. & AH Centre), MAMTA	MAMTA	UNICEF, NPSP/WHO, MAMTA, CARE	NPSP/WHO, MAMTA, CARE	CARE, MAMTA
42	Kaushambhi		A2Z	A2Z				CRS, UNICEF, NPSP/WHO	NPSP/WHO	Vistaar
43	Kushinagar		CRS	CRS				UNICEF, CRS, NPSP/WHO	NPSP/WHO	CRS
44	Lakhimpur Kheri	JHU, UNICEF, MAMTA	UNICEF, MAMTA	UNICEF, MAMTA	SIFPSA, MAMTA	SIFPSA, MAMTA		UNICEF, NPSP/WHO, MAMTA	NPSP/WHO, MAMTA	UNICEF, MAMTA

45	Lalitpur	JHU, UNICEF	POUZN, Beti Fnd., UNICEF	Beti Foundation, UNICEF		Beti Foundation		CARE, UNICEF, FPAI, NPSP/WHO	CARE, FPAI, NPSP/WHO	
46	Lucknow	CARE, UPVHA, MAMTA	CARE, Vatsalya, POUZN, Beti Fnd., MAMTA, FPAI	CARE, Beti Fnd., MAMTA, FPAI	CARE, SIFPSA, FPAI	Vatsalya, Beti Fnd., SIFPSA, MAMTA, FPAI	POUZN,MAMTA, UNICEF, FPAI	UNICEF, NPSP/WHO, MAMTA, CARE, FPAI	NPSP/WHO, MAMTA, FPAI	CARE, Vatsalya, UPVHA, FPAI
47	Maharajganj	UPVHA, MAMTA	MAMTA	MAMTA	UPVHA, SIFPSA, MAMTA	SIFPSA, MAMTA		UNICEF, NPSP/WHO, MAMTA	NPSP/WHO, MAMTA	
48	Mahoba		UPVHA		UPVHA			UNICEF, NPSP/WHO	NPSP/WHO	
49	Mainpuri			JHU		Vistaar		UNICEF, NPSP/WHO	NPSP/WHO	
50	Mathura				SIFPSA	SIFPSA		UNICEF, NPSP/WHO	CRS, NPSP/WHO	
51	Mau							UNICEF, NPSP/WHO	UPVHA, NPSP/WHO, CRS	
52	Meerut				SIFPSA	UPVHA, SIFPSA	UNICEF, UPVHA	UNICEF, NPSP/WHO	NPSP/WHO, UPVHA	
53	Mirzapur	JHU, UNICEF	UNICEF	UNICEF	SIFPSA	SIFPSA		Unicef, NPSP/WHO	NPSP/WHO	UNICEF
54	Moradabad	PATH, JHU, UNICEF	UNICEF	PATH, UNICEF	SIFPSA	SIFPSA	UNICEF, UPVHA	UNICEF, NPSP/WHO	UPVHA, NPSP/WHO	UNICEF
55	Muzzaffarnagar						UPVHA	UNICEF, NPSP/WHO	NPSP/WHO, UPVHA	
56	Pilibhit	CARE	CARE	CARE	CARE			UNICEF, NPSP/WHO, CARE	NPSP/WHO, CARE	CARE
57	Pratapgarh	JHU, UNICEF	A2Z, UNICEF, MAMTA	MAMTA, A2Z, UNICEF	MAMTA	MAMTA		UNICEF, NPSP/WHO, MAMTA	NPSP/WHO, MAMTA	UNICEF
58	Raebareli	CARE, PATH, MAMTA	CARE, JHU + SPM Dept., MAMTA	MAMTA, CARE, PATH	CARE, MAMTA	Beti Foundation, MAMTA		CARE, UNICEF, NPSP/WHO, MAMTA	CARE, NPSP/WHO, MAMTA	CARE, MAMTA
59	Rampur				SIFPSA	SIFPSA		Unicef, NPSP/WHO	NPSP/WHO	

60	Saharanpur	Vistaar			SIFPSA	SIFPSA		CRS, UNICEF, UPVHA, NPSP/WHO	UPVHA, NPSP/WHO	Vistaar
61	Sant Kabir Nagar		CRS	CRS		UPVHA		UNICEF, NPSP/WHO	NPSP/WHO	CRS
62	Sant Ravi Das Nagar							CARE, UNICEF, NPSP/WHO, CRS	CARE, CRS, NPSP/WHO	
63	Shahjahanpur	CARE, JHU, UNICEF	CARE, UNICEF	CARE, UNICEF	CARE, SIFPSA	SIFPSA		UNICEF, NPSP/WHO	NPSP/WHO	CARE
64	Shrawasti		Beti Foundation	Beti Foundation		Beti Foundation		UNICEF, NPSP/WHO	NPSP/WHO	
65	Sidharth Nagar	JHU, UNICEF, UPVHA, MAMTA	A2Z, UNICEF, UPVHA, Beti Foundation MAMTA	A2Z, Unicef, MAMTA	UPVHA, MAMTA	UPVHA, MAMTA		UNICEF, NPSP/WHO, MAMTA	NPSP/WHO, MAMTA	UNICEF, MAMTA
66	Sitapur	CARE, Vatsalya	CARE, Beti Fnd.	CARE, Vatsalya, Beti Fnd.	CARE, SIFPSA	Beti Foundation, SIFPSA		UNICEF, NPSP/WHO, CARE	NPSP/WHO, CARE, CRS	CARE, Vatsalya
67	Sonbhadra							UNICEF, NPSP/WHO	NPSP/WHO	
68	Sultanpur				SIFPSA	SIFPSA		UNICEF, NPSP/WHO	NPSP/WHO	
69	Unnao				SIFPSA	SIFPSA		UNICEF, UPVHA, NPSP/WHO	NPSP/WHO	
70	Varanasi	Vistaar, UPVHA, MAMTA	MAMTA, A2Z, UPVHA	MAMTA, A2Z	UPVHA, MAMTA, SIFPSA,	SIFPSA, MAMTA	MAMTA	UNICEF, UPVHA, MAMTA, NPSP/WHO	MAMTA, NPSP/WHO	MAMTA

#	Vistaar Project-related Indicators	State Level and Overall 8 Vistaar Districts				Vistaar District wise Estimation of Indicators							
		DLHS-3 (8 Vistaar Districts)	DLHS-3 (8 Vistaar Districts)	DLHS-3 (8 Vistaar Districts)	DLHS-3 (8 Vistaar Districts)	Kaushambi	Gonda	Chitrakoot	Varanasi	Banda	Saharanpur	Bulandshahr	Azamgarh
20	Infants aged 0–11 months for whom breastfeeding was initiated within one hour of birth (%)	7.2	15.4	14.3	10.0	9.9	5.1	13.7	9.6	22.0	5.2	3.0	10.6
21	Infants aged 0-5 months who were fed breast milk only during the previous one day (%)	51.3	NA	NA	40.4	42.6	37.9	46.0	35.6	44.3	38.1	35.4	40.5
22	Infants 6–11 months exclusively breastfed for at least 6 months (%)	12.3 (6-9m)	8.2 (6-35m)	NA	16.3	9.7	10.5	29.7	14.6	35.3	11.2	8.0	11.0
23	Infants aged 6–11 months who are currently breastfed and received food from 3 or more major food groups (%)	NA	NA	NA	30.0	35.4	21.1	30.1	28.6	38.6	29.1	28.8	28.4
24	Infants aged 6–11 months who are currently breastfed and received solid or semi-solid food in the previous 24 hours (%)	45.5	54.5 (6-9m)	NA	38.9	44.0	31.6	39.5	35.4	45.0	38.9	37.3	38.6
25	Infants aged 6–11 months who are breastfed and received semi-solid and/or solid foods in the previous 24 hours and who have two servings per day (%)	NA	NA	NA	25.7	35.7	17.8	22	20.9	30.8	26.1	25.7	25.2
	Newborn Health Indicators												
26	Home deliveries where nothing was applied after the cord was cut and before it fell off (%)	NA	NA	NA	38.3	42.3	37.2	45.3	34.0	38.5	46.4	28.1	27.5

#	Vistaar Project-related Indicators	State Level and Overall 8 Vistaar Districts				Vistaar District wise Estimation of Indicators							
		DLHS-3 (8 Vistaar Districts)	DLHS-3 (8 Vistaar Districts)	DLHS-3 (8 Vistaar Districts)	DLHS-3 (8 Vistaar Districts)	Kaushambi	Gonda	Chitrakoot	Varanasi	Banda	Saharanpur	Bulandshahr	Azamgarh
27	Home deliveries where newborns were dried and wrapped immediately after birth before placenta was delivered (%)	26.7	NA	NA	10.6	2.0	12.6	16.1	19.3	7.3	13.4	14.9	4.9
28	RDW who identified ASHA as a key source of information on newborn care (cord care and warmness of newborn and immediate breastfeeding) (%)	NA	NA	NA	1.7	2.4	0.4	1.3	1.3	4.6	1.6	0.8	1
29	Newborns visited by ASHA at least once within three days of birth (%)	NA	NA	NA	0.6	0.7	0.8	0.5	0.2	0.6	1.0	0.7	0.4
30	Low-birth-weight babies visited by ASHA more than three times during the neonatal period (%)	NA	NA	NA	1.1	1.9	0.9	0.2	0.1	1.0	1.2	1.1	0.1
31	Sick newborns identified and referred by ASHA (%)	NA	NA	NA	0.3	0.0	0.0	0.0	0.0	0.0	1.5	0.2	0.0

EXHIBIT 7: TOP-LINE FINDINGS OF BASELINE SURVEY CONDUCTED IN EIGHT DISTRICTS OF UP BY THE USAID/VISTAAR PROJECT (2008–2009)

#	Vistaar Project-related Indicators	State Level and Overall 8 Vistaar Districts				Vistaar Districtwide Estimation of Indicators							
		NFHS-3 (2005-06)	DLHS-3 (2007-08)	DLHS-3 (8 Vistaar Districts)	Vistaar Baseline (8 Districts Total)	Kaushambi	Gonda	Chitrakoot	Varanasi	Banda	Saharanpur	Buland shahr	Azamgarh
	Maternal care Indicators												
1	RDW who had at least 3 ANC visits during last pregnancy (%)	26.3	21.9	23.6	50.0	31.5	37.2	41.2	62.0	64.9	56.1	59.0	57.5
2	RDW who visited skilled provider 3 or more times during last pregnancy (%)	NA	NA	NA	43.0	27.9	34.2	39.1	58.7	42.5	55.7	49.0	47.1
3	RDW who received 2 or more TT injections during last pregnancy (%)	64.5	62.9	60.4	77.2	61.0	71.9	70.4	87.2	78.8	86.0	81.8	87.7
4	RDW who delivered at health facility (institutional births) (%)	22.0	24.5	27.8	50.7	36.0	31.1	49.3	64.8	60.9	51.8	51.2	67.4
5	Deliveries assisted by trained personnel (safe delivery) (%)	29.2	30.1	33.7	55.3	38.8	38.2	53.1	67.6	64.2	57.3	58.5	71.4
6	Home deliveries assisted by trained personnel (%)	NA	7.4	NA	11.1	10.4	10.4	8.3	10	9.1	14	15.6	12.8
7	RDW who were aware of financial assistance for delivery under JSY (%)	NA	NA	NA	90.4	90.6	82.7	95.4	88.7	96.5	87.8	92.3	89.0
8	RDW who received financial assistance for delivery under JSY (%)	NA	4.7	4.9	26.2	22.4	9.3	36.9	18.6	55.3	17.5	24.4	24.6

#	Vistaar Project-related Indicators	State Level and Overall 8 Vistaar Districts				Vistaar Districtwide Estimation of Indicators							
		NFHS-3 (2005-06)	DLHS-3 (2007-08)	DLHS-3 (8 Vistaar Districts)	Vistaar Baseline (8 Districts Total)	Kaushambi	Gonda	Chitrakoot	Varanasi	Banda	Saharanpur	Buland shahr	Azamgarh
9	RDW accompanied by husband at least for one ANC check-up (%)	26.9	NA	NA	34.0	22.3	37.5	32.8	43.8	31.7	41.6	35.9	32.1
	Nutrition-related indicators												
10	RDW who received 100+ IFA tablets/3 bottles of syrup during last pregnancy (%)	53.2 (any IFA)	NA	NA	18.8	12.7	9.5	23.0	26.8	32.8	20.6	11.9	17.0
11	RDW who consumed 100+ IFA tablets/3 bottles of syrup during last pregnancy (%)	8.7	7.7	NA	10.2	6.2	5.1	11.1	18.9	15.0	12.1	6.9	9.5
12	Pregnant women who are anemic (< 11.0 g/dl), using Hb count (%)	52.0	NA	NA	63.0	58.8	72.9	52.5	67.0	58.5	69.1	75.0	57.8
13	Lactating women who are anemic (< 12.0 g/dl), using Hb count (%)	58.0	NA	NA	75.0	73.0	80.2	68.4	77.8	72.3	74.4	78.4	73.5
14	Infants aged 6–11 months who are under nourished (weight-for-age, – 2 SD) per WHO growth standards (%)	36.6	NA	NA	30.3	40.0	33.1	32.6	28.5	43.0	15.4	24.3	23.8
15	Pregnant women who cited at least 3 nutritional practices to prevent anemia during pregnancy (%)	NA	NA	NA	32.3	42.3	33.0	26.6	39.0	27.7	34.8	30.2	26.3
16	RDW who cited at least 3 nutritional practices to prevent anemia during lactation period (%)	NA	NA	NA	28.0	31.6	23.8	26.9	38.0	24.0	31.8	28.8	23.2

#	Vistaar Project-related Indicators	State Level and Overall 8 Vistaar Districts				Vistaar Districtwide Estimation of Indicators							
		NFHS-3 (2005-06)	DLHS-3 (2007-08)	DLHS-3 (8 Vistaar Districts)	Vistaar Baseline (8 Districts Total)	Kaushambi	Gonda	Chitrakoot	Varanasi	Banda	Saharanpur	Buland shahr	Azamgarh
17	Pregnant women who have had one extra meal the previous day (%)	NA	NA	NA	6.7	10.1	3.9	4.8	6.6	9.7	8.5	3.6	6.5
18	RDW who have had one extra meal the previous day (%)	NA	NA	NA	14.9	37.9	21.2	14.6	3.1	5.6	22.4	8.7	0.8
	IYCF Indicators												
19	Infants aged 0–5 months for whom breastfeeding was initiated within one hour of birth (%)	7.2	15.4	14.3	14.4	12.9	7.5	21.6	13.3	29.7	7.7	5.2	15.2

EXHIBIT 8. INDICATORS TO BE COMPILED MONTHLY BY TA AGENCY–NEWBORN CARE

#	Indicator	Numerator	Source	Denominator	Source	Level of Data Collection
ASHA meetings						
1	Percentage of blocks where ASHA monthly meetings have been regularized *(sector-wide/batch-wide meetings agreed to and days finalized, written communication from MOIC/CMO)*	Number of blocks where ASHA monthly meetings have been regularized	Written communication from MOIC/CMO	Total number of blocks in the district	District health records	Block
2	Percentage of ASHA monthly meetings held as scheduled during the month	Number of ASHA monthly meetings held as scheduled during the month	ASHA block-level monthly meetings observation form & meeting records	Total number of ASHA monthly meetings planned at PHC and additional during the month	Plan for ASHA monthly meetings	Block
3	Percentage of ASHAs attending monthly meetings during the month	Number of ASHAs attending monthly meeting in the month	ASHA's block level monthly meetings observation form/meeting records/attendance sheet	Number of in-position ASHAs in the block *(figure updated in every quarter)*	District health records	Block
4	Percentage of ASHA monthly meetings attended and observed by project staff	Number of ASHA monthly meetings attended by project staff in the month	ASHA meeting forms	Number of scheduled ASHA monthly meetings project staff planned to observe during the month	Monthly activity plan of project staff	Block
Capacity Building (CB) Sessions of ASHAs and Supervisors						
5	Percentage of district facilitators trained on ASHA mentoring (IPC skills, VHIR & ASHA & CCSP drug kits)	Number of district facilitators trained on ASHA mentoring	Training form	Number of district facilitators identified	List of District Facilitators	District—Biannual
5.1	Percentage of district facilitators trained on IPC skills	Number of district facilitators trained on IPC	Training form	Number of district facilitators identified	List of District Facilitators	District—Biannual

#	Indicator	Numerator	Source	Denominator	Source	Level of Data Collection
5.2	Percentage of district facilitators trained on VHIR	Number of district facilitators trained on VHIR	Training form	Number of district facilitators identified	List of District Facilitators	District—Biannual
5.3	Percentage of district facilitators trained on ASHA and CCSP drug kits	Number of district facilitators trained on drug kits	Training form	Number of district facilitators identified	List of District Facilitators	District—Biannual
6	Percentage of block facilitators trained on ASHA mentoring (IPC skills, VHIR & ASHA & CCSP drug kits)	Number of block facilitators trained on ASHA mentoring	Training form	Number of block facilitators identified	List of Block Facilitators	Block
6.1	Percentage of block facilitators trained on IPC skills	Number of block facilitators trained on IPC	Training form	Number of block facilitators identified	List of Block Facilitators	Block
6.2	Percentage of block facilitators trained on VHIR	Number of block facilitators trained on VHI	Training form	Number of block facilitators identified	List of Block Facilitators	Block
6.3	Percentage of block facilitators trained on ASHA & CCSP drug kits	Number of block facilitators trained on drug kit	Training form	Number of block facilitators identified	List of Block Facilitators	Block
7	Percentage of ASHA monthly meetings in which on-the-job CB sessions were held during the month	Number of ASHA monthly meetings in which on-the-job CB sessions were held during the month	ASHA meeting form & meeting records	Number of ASHA monthly meetings in which on-the-job CB sessions were planned during the month	Plan for ASHA monthly meetings	Block
8	Percentage of ASHA monthly meetings in which on-the-job CB sessions were attended/observed by project staff during the month	Number of ASHA monthly meetings in which on-the-job CB sessions were attended/observed by project staff during the month	ASHA meeting form	Number of ASHA monthly meetings in which on-the-job CB sessions project staff planned to observe during the month	ASHA meeting form & meeting records	Block

#	Indicator	Numerator	Source	Denominator	Source	Level of Data Collection
9	Percentage of blocks where monthly meetings for CB of supervisory cadre (LHV/ANM) were fixed *(day for CB activity fixed and written communication in place from MOIC/CMO)*	Number of blocks where monthly meetings for CB of supervisory cadre were fixed	Written communication from MOIC /CMO	Total number of blocks in the district	District health record	Block
10	Percentage of supervisory cadre (LHV/ANM) meetings where on-the-job CB was undertaken during the month *(Session conducted as per quarterly plan for CB)*	Number of supervisory cadre (LHV/ANM) meetings where on-the-job CB was undertaken during the month	ANM/LHV meeting form	Total number of supervisory cadre meetings for CB planned for the month	Plan for Supervisory cadre meetings	Block
11	Percentage of supervisory cadre (LHV/ANM) meetings attended/observed by project staff during the month	Number of supervisory cadre (LHV/ANM) meetings attended/observed by project staff during the month	ANM/LHV meeting form	Number of supervisory cadre (LHV/ANM) meetings project staff planned to observe during the month	Monthly activity plan of project staff	Block
CCSP Training in the District						
12	Percentage of ASHAs who have undergone CCSP training	Number of ASHAs who received CCSP training	District Training Reports	Total number of ASHAs in position in the block	District health records	Block
13	Percentage of supervisors (LHV/ANM) who have undergone CCSP supervisory training	Number of supervisors (LHV/ANM) who received CCSP supervisory training	District Training Reports	Total number of supervisors (LHV/ANM) trained in basic CCSP training in the block	CCSP Training Reports	Block
Convergence for Village Health & Nutrition Days (VHNDs)						
14	Percentage of blocks where Health-ICDS convergence meetings were initiated *(day/date agreed upon by CDPO and MOI/C)*	Number of blocks where Health-ICDS convergence initiated	Letter from MOIC and /or CDPO	Total number of blocks in the district	District health records	Block

#	Indicator	Numerator	Source	Denominator	Source	Level of Data Collection
15	Percentage of Health-ICDS convergence meetings held during the month *(for review of VHND and other issues)*	Number of Health-ICDS convergence meetings held during the month	Minutes of meetings	Number of Health-ICDS convergence meetings planned in the month	District health records	Block
16	Percentage of Health-ICDS convergence meetings attended/observed by project staff during the month	Number of Health-ICDS convergence meetings attended/ observed by project staff during the month	Minutes of meetings	Number of Health-ICDS convergence meetings project staff planned to observe during the month	Minutes of the meeting	Block
17	Percentage of blocks where VHND microplans were reviewed and finalized	Number of blocks where VHND microplans were reviewed and finalized	Copies of VHND microplans	Total number of blocks in the district	District health record	Block
18	Percentage of VHND sessions attended/observed by project staff during the month *(out of total planned in the VHND microplan)*	Number of VHND sessions attended/observed by project staff during the month	VHND checklist	Number of VHND sessions planned per microplan for the month	VHND microplan	Block
19	Percentage of VHND sessions attended/observed by project staff during the month *(out of total planned by project staff)*	Number of VHND sessions attended/observed by project staff during the month	VHND checklist	Number of VHND sessions project staff planned to observe during the month	Monthly activity plan of project staff	Block
20	Percentage of VHND sessions held per the microplan based on sessions observed during the month	Number VHND sessions held per microplan during the month	VHND checklist	Number of VHND sessions observed by TA agency during the month	VHND checklist	Block
21	Percentage of blocks where VHND formats (1 & 2) are in use for reporting	Number of blocks where VHND formats (1 & 2) are in use for reporting	Health records	Total number of blocks in the district	District health record	Block

#	Indicator	Numerator	Source	Denominator	Source	Level of Data Collection
22	Percent of VHND sessions in which community groups *(e.g. VHSC/PRI/Trained dai)* participated	Number of VHND sessions participated by VHSC/PRI/trained dai during the month	VHND checklist	Number of VHND sessions observed by TA agency during the month	VHND checklist	Block
23	Mean number of services/activities provided at VHNDs *(out of 15 total services/activities)*	Number of services provided at a VHND (mean calculated per month)	VHND checklist			
24	Percent of VHND sessions where disadvantaged community members participated	Number of VHND sessions where disadvantaged community members participated	VHND checklist	Number of VHND sessions observed by TA agency during the month	VHND checklist	Block
NBC Indicators from Service Statistics/ Government HMIS						
25	Percentage of low-birth-weight newborns visited by ASHA more than three times during the neonatal period	Number of low–birth-weight newborns visited by ASHA more than three times during the neonatal period	CCSP-HMIS	Number of LBW newborns reported during the month	CCSP-HMIS	Block
26	Percentage of sick newborns identified by ASHAs during the month	Number of sick newborns identified by ASHA during the month	CCSP-HMIS	Number of live births reported during the month	CCSP-HMIS	Block
27	Percentage of sick newborns referred by ASHAs during the month	Number of sick newborns referred by ASHA during the month	CCSP-HMIS	Number of sick newborns identified by ASHA during the month	CCSP-HMIS	Block
28	Percentage of neonatal deaths reported by ASHAs during the month	Total number of neonatal deaths during the month	CCSP-HMIS	Total number of live births reported during the month	CCSP-HMIS	Block

#	Indicator	Numerator	Source	Denominator	Source	Level of Data Collection
29	Percentage of newborns for whom breastfeeding was initiated within one hour of birth during the month	Number of newborns breastfed within one hour during the month	Government HMIS	Total number of live births during the month	Govt.HMIS	Block
Other Key Government Decisions Facilitated in Support of TA Roll-out						
30	DHS meeting held and project staff participated	Held-Yes/ No Participated -Yes/ No				District
31	Key DHS decisions in support of NBC TA roll-out *(mention them briefly in bullets)*					District
32	Any important decisions *(e.g. circulars/ GO/ Meeting Minutes etc.)* taken at block/district level by **Government** in support of TA roll-out					Block
Field visit by TA Agency *(Through Checklist only)*						
33	Percentage of ASHAs using job aides and communication materials to promote birth planning or safe delivery	Number of ASHAs who reported using job aids/communication materials at least once in last three months to promote birth planning or safe delivery	Field visits by the TA agency to ASHAs with ASHA form	Total number of ASHAs visited during the month	Field visits by the TA agency to ASHAs with ASHA form	Block
34	Percentage of ASHAs using job aids and communication materials to promote newborn care	Number of ASHAs who reported using job aids/communication materials at least once in last three months to promote newborn care in pregnant/RDW	Field visits by the TA agency to ASHAs with ASHA form	Total number of ASHAs visited during the quarter	Field visits by the TA agency to ASHAs with ASHA form	Block

#	Indicator	Numerator	Source	Denominator	Source	Level of Data Collection
35	Percentage of ASHAs reporting at least one field interaction at ASHA's home or at VHND (not monthly meeting) with LHV/ANM	Number of ASHAs who reported at least one field interaction with LHV/ANM at her home or at VHND	Field visits by the TA agency to ASHAs with ASHA form	Total number of ASHAs visited during the quarter	Field visits by the TA agency to ASHAs with ASHA form	Block
36	Percentage of ASHAs reporting role of ANM or LHV as being supportive	Number of ASHAs who considered that their supervisor's previous visit was supportive	Field visits by the TA agency to ASHAs with ASHA form	Total number of ASHAs visited during the quarter	Field visits by the TA agency to ASHAs with ASHA form	Block
VHSC (District Varanasi only)						
37	Percentage of blocks where microplan for VHSC meetings has been developed	Number of blocks where microplan for VHSC meetings has been developed	VHSC Microplan	Total number of blocks in the district	District health record	Block
38	Percentage of *gram sabha* in the district for which VHSC facilitators have been identified (from Health and other departments)	Number of *gram sabha* in the district for which VHSC facilitators have been identified (from Health and other departments)	VHSC Microplan	Total number of *gram sabha* in the district	Block records	Block
39	Percentage of VHSC facilitators trained in the district	Number of VHSC facilitators trained in the block	VHSC facilitators training report	Total number of VHSC facilitators identified in the district	List of VHSC Facilitators	Block
40	Percentage of VHSC meetings held in the district during the month	Number of VHSC meetings held during the month	VHSC facilitators' review meeting records	Total number of VHSC meetings planned in the district during the month	VHSC Microplan	Block

#	Indicator	Numerator	Source	Denominator	Source	Level of Data Collection
41	Percentage of VHSC meetings project staff attended/observed during the month	Number of VHSC meetings project staff attended/observed during the month	VHSC meeting observation form	Number of VHSC meetings project staff planned to observe during the month	Monthly activity plan of project staff	Block

EXHIBIT 9. VISTAAR PROJECT TA FOR IMPROVING NEWBORN CARE IN FIVE DISTRICTS OF UP STATE AND DISTRICT-WIDE PROGRESS (AS OF JULY 31, 2009)

Sr.#	Activities/Subactivities	State	Azamgarh	Banda	Bulandshahr	Saharanpur	Varanasi
Development of Technical Assistance Plans and Job-aides							
1	Sharing of Evidence Review recommendations at state and district level **(HFW and SPMU)**	●	●	●	●	●	●
2	Formation of district resource group/core group to develop TA plan for the district	NA	●	●	●	●	●
3	Baseline survey on maternal and newborn care knowledge and practice among pregnant and recently delivered women	NA	●	●	●	●	●
4	RNA on IPC skills of ASHA, SS and VHNDs (all districts) & VHSC (Varanasi)	NA	●	●	●	●	●
5	Dissemination of RNA results	●	⊙	●	●	⊙	●
6	Performance Needs Assessment of ASHAs	NA	NA	NA	NA	●	●
7	Equity and Gender Needs Assessment on newborn care	NA	NA	NA	●	NA	●
8	Development of Technical Assistance plans	NA	●	●	●	●	●
9	Selection of TA agency and agreement for TA	●	NA	NA	NA	NA	NA
10	Recruitment of state and district teams by TA agency (MAMTA HIMC)	●	●	●	●	●	●

Sr.#	Activities/Subactivities	State	Azamgarh	Banda	Bulandshahr	Saharanpur	Varanasi
11	Orientation of and planning with state and district teams	●	●	●	●	●	●
12	Systems and mechanisms developed for review of project progress and finalization of MIS indicators at project and district level	●	●	●	●	●	●
13	Establishment of state and district project offices by TA agency	●	●	●	●	●	●
14	Dissemination of baseline results	●	⊙	●	●	⊙	●
15	TA for development of job aids (prototype) to strengthen ASHA's work related to MNCHN under NRHM with **SPMU**	●	NA	NA	NA	NA	NA
16	Printing and distribution of job aids to all CCSP districts by NRHM **(SPMU)**	NA	●	●	●	●	●
Strengthening Interpersonal Communication and Operational Skills of ASHAs							
1	Support Health Department for regularization of ASHA monthly meetings **with DPMU**	NA	⊙	●	⊙	●	●
2	Development and translation of training materials on IPC, drug kit, and VHIR **with SPMU**	⊙	NA	NA	NA	NA	NA
3	State TOTs for master trainers on IPC	●	NA	NA	NA	NA	NA
4	District TOTs for block facilitators on IPC, **with support from DPMU**	NA	●	●	●	X	●
5	Roll-out of CB sessions in ASHA monthly meetings, **with support from DPMU**	NA	⊙	⊙	⊙	NA as dist. TOT not held	⊙
Strengthening Supportive Supervision Network for ASHAs							
1	Facilitated regularization of monthly supervisory cadre meetings for CB	NA	●	●	●	●	●

Sr.#	Activities/Subactivities	State	Azamgarh	Banda	Bulandshahr	Saharanpur	Varanasi
	sessions						
2	Development of calendar on CB sessions for supervisory cadre, in consultation with Health Department	NA	⭘	⭘	⭘	⭘	⭘
3	Observation of supervisory cadre meetings	NA	⭘	⭘	⭘	⭘	⭘
4	Development of module on supportive supervision for ANMs, LHVs, HEOs, and MOs	⭘	NA	NA	NA	NA	NA
5	Development of checklist on supportive supervision of ASHAs	●	NA	NA	NA	NA	NA
6	Development of supportive supervision guidelines and checklist for ANMs and LHVs	⭘	NA	NA	NA	NA	NA
Convergence Through VHNDs							
1	Orientation of block and district government officials (ICDS, Health, and PRI) on VHND guidelines and reporting formats, **with DPMU**	NA	⭘	●	●	●	●
2	Facilitated preparation of VHND microplan jointly by Health and ICDS Departments for district and block, **with support from DPMU**	NA	⭘	⭘	⭘	⭘	⭘
3	Orientation of ANMs and ASHAs at monthly block meetings on VHND guidelines	NA	⭘	⭘	⭘	⭘	⭘
4	Promoted use of government VHND reporting formats, **with DPMU**	NA	⭘	⭘	⭘	⭘	⭘
5	Observation of VHND sessions by using VHND observation checklist	NA	⭘	⭘	⭘	⭘	⭘

Sr.#	Activities/Subactivities	State	Azamgarh	Banda	Bulandshahr	Saharanpur	Varanasi
6	Initiated convergence meeting between Health, ICDS, and PRI at district and block level for joint review of VHND	NA	⭘	●	⭘	●	●
7	Initiated sharing of findings from VHND analysis at state and district level, **with DPMU**	●	⭘	●	●	⭘	●
Strengthening VHSCs (Varanasi only)							
1	Initiation of development of microplans for VHSC meetings, **with DPMU**	NA	NA	NA	NA	NA	⭘
2	Development of module for orientation of VHSC facilitators (LHVs, ANMs & male supervisors), **with SPMU**	NA	NA	NA	NA	NA	⭘
3	Identification and training of state master trainers on VHSC	NA	NA	NA	NA	NA	⭘
4	Identification of VHSC facilitators, training, **with DPMU**	NA	NA	NA	NA	NA	⭘
5	Roll-out of CB sessions in VHSC meetings	NA	NA	NA	NA	NA	⭘
6	Institute system of follow-up meetings by MOIC/HEO, **with DPMU**	NA	NA	NA	NA	NA	⭘

EXHIBIT 10: BROAD OBSERVATIONS FROM THE ANALYSIS OF VHND OBSERVATION CHECKLIST (AUGUST 6, 2009)

VHND related Characteristics		Total (8 Districts)	Kaushambi	Gonda	Chitrakoot	Varanasi	Banda	Saharanpur	Bulandshar	Azamgarh
Sessions observed	**Number of VHND Sessions Observed**	**638**	**97**	**31**	**16**	**88**	**72**	**112**	**165**	**57**
	by MAMTA (#)	359	0	0	0	88	54	86	93	38
	by CRS (#)	279	97	31	16	0	18	26	72	19
Following microplans	Sessions held per microplan (%)	71	81	90	94	56	81	90	46	88
	Sessions NOT held as per microplan (%)	23	14	10	6	31	19	10	44	12
	Sessions not held (%)	5	5	0	0	14	0	0	10	0
Personnel present	ANMs (%)	93	88	100	100	84	94	100	90	100
	ASHAs (%)	85	73	52	75	84	89	99	85	89
	AWWs (%)	62	62	42	75	72	64	74	57	47
	VHSCs (%)	5	8	0	0	10	6	3	2	2
	Mothers Committee (%)	8	16	0	0	20	4	5	2	4
	Trained TBAs (%)	13	21	0	6	31	4	13	2	18
	Health supervisors (%)	12	8	13	19	8	21	18	8	7
	ICDS supervisors/MS (%)	5	11	19	25	1	6	1	3	0
Community awareness	Disadvantaged community aware of VHND (services, session date, and venue) (%)	29	32	19	19	72	13	35	16	9

VHND related Characteristics		Total (8 Districts)	Kaushambi	Gonda	Chitrakoot	Varanasi	Banda	Saharanpur	Bulandshar	Azamgarh
Source of information about VHND	ASHA (%)	60	62	8	56	72	56	66	53	84
	AWW (%)	33	27	28	40	26	41	69	8	44
	ANM (%)	6	9	0	17	3	3	7	3	19
Child health services	Updated list of beneficiary available from ASHA/ANM (%)	58	69	55	19	45	29	86	61	39
	Availability and use of RI Card (%)	72	66	58	75	80	33	96	67	91
	RI Tally Sheet used (%)	69	48	84	75	69	57	89	79	39
ANC services	Updated list of beneficiary available from ASHA/ANM (%)	53	47	68	6	44	40	80	56	32
	IFA given and usage explained (%)	60	66	65	69	68	28	76	60	40
	Weight taken (%)	14	11	19	0	18	25	21	7	11
	BP recorded (%)	4	2	10	0	6	0	9	3	5
	Separate place available for ANC check-up (%)	27	26	35	6	20	25	24	32	33
	Abdominal exam done (%)	20	21	32	44	22	21	17	18	11
Supplementary nutrition available	THR (take home ration) for children available at site (%)	41	33	10	25	49	54	67	38	9
	THR available for pregnant women (%)	39	32	10	6	47	53	68	35	9
Growth monitoring	Children weighed (%)	33	31	23	38	35	35	50	23	35
	Weighed & plotted on growth chart (%)	11	14	3	6	15	6	31	2	2
	Identification of malnourished	15	12	10	0	26	14	25	4	21

VHND related Characteristics		Total (8 Districts)	Kaushambi	Gonda	Chitrakoot	Varanasi	Banda	Saharanpur	Bulandshar	Azamgarh
	children (%)									
Group meeting	Group meetings conducted(%)	36	62	0	31	56	40	14	16	77
Referral of severely anemic pregnant women	Identified (%)	36	21	68	13	44	15	40	45	25
	Referred (%)	6	4	3	6	14	1	8	4	4
Recording deaths	Infant and maternal deaths recorded (%)	18	24	6	0	20	11	43	7	4
Reporting	Received reporting formats (%)	13	7	10	6	15	32	21	9	2
MIS indicators	% VHSC/PRI & trained TBA participated	16	25.5	0	6.3	38.6	9.7	15.3	4.8	17.5
	Mean number of services offered at VHND	5.4	5.4	4.4	4.4	6.1	4.9	7.1	4.7	4.9
	% disadvantaged community participated	51.4	64.3	80.6	62.5	58	44.4	49.5	35.2	59.6

EXHIBIT 11. ESTIMATED HEALTH INFRASTRUCTURE NEEDS IN JHARKHAND, 2001 AND 2009, PER IPHS NORMS

	Population	Population per HSC	Number of HSCs Required	Population per PHC	Number of PHCs Required	Population per CHC	Number of CHCs Required
In 2001							
Total population (Census 2001)	26,945,829	--	--	--	--	--	--
Rural population (77.8%)	20,952,088	--	--	--	--	--	--
Total tribal population (26.3% of total population)	7,087,068	--	--	--	--	--	--
Tribal population in rural areas (92% of total tribal population)	6,500,014	3,000	2,167	20,000	325	80,000	81
Nontribal population in rural areas	14,452,074	5,000	2,890	30,000	482	120,000	120
Total rural population	--	--	**5,057**	**--**	**807**	**--**	**202**
							In 2007
Projected total population in 2007	29,745,000	--	--	--	--	--	--
Rural population (77.8%)	23,141,610	--	--	--	--	--	--
Total tribal population (26.3% of total population)	7,822,935	--	--	--	--	--	--
Tribal population in rural area (92% of total tribal population)	7,197,100	3,000	2,399	20,000	360	80,000	90
Nontribal population in rural areas	15,944,510	5,000	3,189	30,000	531	120,000	133
Total rural population	--	--	**5,588**	**--**	**891**	**--**	**223**

JHARKHAND HEALTH INFRASTRUCTURE AND HEALTH HUMAN RESOURCE NEEDS

Category	In Place	Sanctioned/ Required	Shortfall in Sanctioned /Required	Source of Data
Health Infrastructure				
HSC	3,958[b]	5588[b]	29%	Table 12, RHS Bulletin, MOHFW, GOI, March 2007 http://www.mohfw.nic.in/RHS%20Bulletin%20March%202007%20-%20Tables.pdf
PHC	330[b]	891[b]	63%	,,
CHC	194[b]	223[b]	13%	,,
AWC	31,074[d]	32,097[d]	3%	http://wcd.nic.in/icdsimg/ICDS-vacancy%20position%20%200208-page%205.htm
Human Resources				
Sahiyas	39,556[c]	50,000[c]	20%	http://www.mohfw.nic.in/NRHM/Documents/ASHA_Training_Status.pdf
ANMs at HSC and PHC	4,372[b]	5549[b]	21%	RHS Bulletin, MOHFW, GOI, March 2007 http://www.mohfw.nic.in/RHS%20Bulletin%20March%202007%20-%20Tables.pdf
LHV	278[b]	461[b]	40%	,,
Medical Officers at PHC	2,323[b]	3927[b]	41%	,,
AWWs	30,617[d]	32,097[d]	5%	http://wcd.nic.in/icdsimg/ICDS-vacancy%20position%20%200208-page%205.htm
Mukhya Sevika (Supervisor)	486[d]	1146[d]	58%	,,
CDPOs	148[d]	192[d]	23%	,,

a. Estimated requirement as per 2007 population (http://censusindia.gov.in/Census_Data_2001/Projected_Population/Projected_Population.pdf).

b: In place as of March 2007, per Table 12- RHS Bulletin, March 2007, GoI (http://www.mohfw.nic.in/RHS%20Bulletin%20March%202007%20-%20Tables.pdf) .

c: Status as of January 2009, per NRHM ASHA Training reports, GoI. (www.mohfw.nic.in/NRHM/Documents/ASHA-Training).

d: Status as of February 2008, per Ministry of Women and Child Development, GoI (http://wcd.nic.in/icdsimg/ICDS-vacancy%20position%20%200208-page%205.htm).

For more information, please visit
http://www.ghtechproject.com/resources.aspx

Global Health Technical Assistance Project
1250 Eye St., NW, Suite 1100
Washington, DC 20005
Tel: (202) 521-1900
Fax: (202) 521-1901
www.ghtechproject.com