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USAID/INDIA MATERNAL AND CHILD HEALTH—SUSTAINABLE TECHNICAL ASSISTANCE AND RESEARCH INITIATIVE (MCH-STAR)

MID-TERM REVIEW

MAY 2010

This publication was produced for review by the United States Agency for International Development. It was prepared by Stephen Atwood, Janina Ruducha, Renu Khanna, S.K Chaturvedi, and Snehashish Raichowdhury through the Global Health Technical Assistance Project.

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CONTENTS

ACRONYMS v

EXECUTIVE SUMMARY ix

Overview ix

Origins, Structure, and Function of MCH-STAR ix

Results to Date x

Lessons Learned xi

Recommendations xi

Next Steps for MCH-STAR xiv

I. BACKGROUND 1

Overview of the MNCHN Situation 1

Government Needs and Demands 3

Research Institutions in India 4

Origins of the MCH-STAR Project 5

II. PURPOSE OF THE MID-TERM REVIEW 7

Objectives 7

Methodology 7

III. DESCRIPTION, STRUCTURE AND FUNCTION OF MCH-STAR 9

Goal and Objective 9

The USAID-funded MCH-STAR Initiative 9

MCH-STAR Structure 11

Relations with Donors and other Partners 16

Interactions with National and State Governments 17

Monitoring and Evaluation 17

Budget and Funding 18

IV. PROGRESS TOWARD ACHIEVING OBJECTIVES 21

Goals and Objectives 21

Technical Approach and Planned Activities 21

Monitoring 21

Achievement of Results 23

Challenges and Lessons Learned by the Participants 27
V. ANALYSIS OF GAPS 29
Demand for TA During the Program Lifecycle 29
Areas Still Requiring Support 30
Capacity Building and Institutional Strengthening 30
VI. FINDINGS AND RECOMMENDATIONS 33
Measure Significant Results 33
Introduce Healthy Competition 35
Take Measures to Increase Productivity 35
Streamline the Proposal Approval Process 36
Identify and Respond to Specific SSI Needs 39
Modify Ways to Secure Government Buy-in 39
Resolve Problems Within the Partnership 39
Work with National Government Counterparts in the Districts 40
Increase the Presence of MCH-STAR in the States 41
Revitalize SIFPSA in UP 42
Maximize the Partnership with IndiaCLEN at the State Level 42
Keep Gender and Equity at the Forefront of MCH-STAR 43
VII. ROADMAP FOR THE NEXT STEPS OF MCH-STAR 45

FIGURES

Figure 1. USAID/India MNCHN Strategic Program Framework 10
Figure 2. Use of Grants by SSI and Discipline 29
Figure 3. Use of Total Grants by Discipline 29
Figure 4. Current Cycle for Approval of SSI Proposals 37
Figure 5. Proposed Process for Approval of Proposals 38
Figure G1. Schematic Diagram Showing Current and Future Scope of Partnerships between Government, MCH-STAR, Development Partners, and SSIs 79
Figure H1. Suggested Model of Future Support by MCH-STAR to Government through TA 81

TABLES

Table 1. Maternal, Newborn and Child Health and Nutrition Indicators Compared 2

Table 2. Stages and Current Status of SSI Proposals 14

Table 3. MCH-STAR Budget 18

Table 4. MCH-STAR Budget Utilization 19

Table 5. USAID Operational Indicators (OPs) for MCH-STAR 23

Table 6. Summary of Progress of MCH-STAR Against Targets 23

Table 7. Technical Areas Needing Attention 24

Table 8. CB/IS Areas Needing Further Support 25

Table I.1 Road Map to Two-Year Extension of MCH-STAR and a Proposed Second Phase 83

ANNEXES

Annex A. Scope of Work 47

Annex B. Persons Contacted and Final Timeline 61

Annex C. References 71

Annex D. Findings from a Gender Review of Material Produced 73

Annex E. Typical Phases of a Donor-Financed Project and Potential of SSIs to Contribute 75

Annex F. Institutional Capacities in Government—Avenues for Future Technical Assistance 77

Annex G. Expansion Possibilities for MCH-STAR in Phase II 79

Annex H. Suggested Positioning of MCH-STAR Phase II in the Context of the NRHM 81

Annex I. Suggested Roadmap to Expansion of MCH-STAR 83

ACRONYMS

ADB	Asian Development Bank
ANC	Antenatal care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
BCC	Behavior change communication
BU	Boston University Center for Global Health and Development
CB	Capacity building
CCSP	Comprehensive Child Survival Program, Uttar Pradesh
CEDPA	Center for Development and Population Activities
CEO	Chief Executive Officer
CEU	Clinical Epidemiology Unit
CHC	Community health center
CINI	Child-in-Need Institute
COP	Chief of party
COTR	Contracting Officer's Technical Representative
DFID	Department for International Development, United Kingdom
DLHS	District Level Household Survey
DPMU	District Program Management Unit
EAG	Empowered Action Group
EMG	Emerging Markets Group, Cardno
EmONC	Emergency obstetric and newborn care
EUHP	Expanded Urban Health Program
FGD	Focus Group Discussion
FRU	First referral unit
GHI	Global Health Initiative, USA
GoI	Government of India
GoJH	Government of Jharkand
GoUP	Government of Uttar Pradesh
HMIS	Health management information system
HUP	Health for the Urban Poor
ICDS	Integrated Child Development Scheme
ICMR	Indian Council of Medical Research
IMR	Infant mortality rate

IndiaCLEN	India Clinical Epidemiology Network
ISPOT	Indiaclen Severe Pneumonia Oral Therapy
IS	Institutional strengthening
JH	Jharkand
JSY	Janani SurakshaYojana project
LHV	Lady Health Visitor
M&E	Monitoring and evaluation
MCH-STAR	Maternal and Child Health—Sustainable Technical Assistance and Research Initiative
MDGs	Millennium Development Goals
MIS	Management information system
MMR	Maternal mortality rate
MNCHN	Maternal, newborn, and child health and nutrition
MOHFW	Ministry of Health and Family Welfare
MOU	Memorandum of understanding
MPW	Multipurpose worker
MTR	Mid-term review
MWCD	Ministry of Women and Child Development
NFHS	National Family Health Survey
NGO	Nongovernmental organization
NHSRC	National Health Systems Resource Center
NIHFW	National Institute of Health and Family Welfare
NIPI	Norway India Partnership Initiative
NRHM	National Rural Health Mission
NUHM	National Urban Health Mission
P&A	Policy and advocacy
PFI	Population Foundation of India
PHFI	Public Health Foundation of India
PIP	Program implementation plan
PMP	Performance monitoring plan
QA	Quality assurance
R&E	Research and evaluation
RCH	Reproductive and child health
RCH II	Reproductive and Child Health II project
ROG	Results-oriented grant
SC/ST	Scheduled Caste / Scheduled Tribe

SIFPSA	State Innovations in Family Planning Services
SOW	Scope of work
SSI	STAR-supported institution
TA	Technical assistance
TAG	Technical advisory group
UHRC	Urban Health Resource Centre
UP	Uttar Pradesh
WHO	World Health Organization
WRAI	White Ribbon Alliance in India

EXECUTIVE SUMMARY

OVERVIEW

Maternal, newborn, and child health and nutrition in India: India holds the key to global achievement of the Millennium Development Goals (MDGs). The magnitude of India's population and its high mortality rates mean that every fifth child that dies in the world before reaching 5 is Indian, and every fifth woman who dies in the world from pregnancy-related causes is Indian.

The prevalence of maternal and child malnutrition in India is the highest in the world. It is a tragic failure that the nutritional situation has not improved over the last decade despite impressive economic growth, achievement of national food security, and the reach of longstanding national programs into each of the 600,000 villages across India. At the root of these problems are profound gender inequities, expressed in differences in educational, economic, and social opportunities and closely linked to poor health and nutrition and high mortality rates. A girl aged 1–4 in India is 40% more likely to die than a boy in the same age group[1]; child mortality would drop by 20% if girls had the same mortality as boys between the ages of 1 month and five years.[2]

The Government of India (GoI) has acknowledged the problem and initiated or accelerated many programs, such as the National Rural Health Mission (NRHM), the National Urban Health Mission (NUHM), and the Integrated Child Development Scheme (ICDS) to increase the rate of progress in reaching the MDGs to improve the lives of mothers and newborns. It acknowledges that these problems are worst in a group of eight states it terms the Empowered Action Group (EAG).[3]

MNCHN in Uttar Pradesh and Jharkhand: From this group, Uttar Pradesh (UP) and Jharkhand (JH) were chosen as the focus of the MCH-STAR project because they were among the worst off in terms of infant, child, and maternal mortality and had significantly worse health indicators than the Indian national average. Both states have outlined ambitious programs and plans to improve the situation. The MCH-STAR program was designed to support and supplement those plans.

ORIGINS, STRUCTURE, AND FUNCTION OF MCH-STAR

Rationale

MCH-STAR was designed to improve the capability of institutions to fill gaps in the effective implementation of maternal, newborn, and child health and nutrition (MNCHN) activities through the NRHM and the ICDS. This concept fit into USAID's plan to improve MNHCN at scale. It also reflected USAID's "last mile" strategy in that it planned to transfer technical and programmatic skills to Indian institutions before the project ended. Accelerating development of the capacity of Indian institutions for research, policy analysis, and technical assistance (TA) in MNCHN would provide the Indian government with a system for making continuous program improvements without a development partner.

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[1] Claeson M, Bos ER, Mawji T, Pathmanathan I. Reducing child mortality in India in the new millennium. *Bull World Health Organ* 2000; 78: 1192–99.

[2] Lancet, 2003*Victora, CG, Wagstaff,A et. Al., Lancet* 2003: 362: 233–41

[3] Uttar Pradesh, Jharkhand, Madhya Pradesh, Chhattisgarh, Rajasthan, Orissa, Uttarakhand, and Bihar.

Description

The main objective of MCH-STAR is to build the capacity of "sustainable Indian institutions [to] provide technical leadership and critical technical inputs to public and private sector programs in India in maternal, neonatal, and child health and nutrition matters through technical assistance to programs, policy analyses and advocacy and operations research, [and] applied and policy research." MCH-STAR is a five-year (2007–11) USAID-funded project led by Cardno Emerging Markets (USA), partnered with the Center for Global Health and Development, Boston University (BU) and the Center for Development and Population Activities (CEDPA). Its goal is to provide complementary expertise in capacity assessment, management and strategic planning, academic skills in research and writing, and moving research results into a policy and advocacy framework for action based on standards of evidence.

The program operates by facilitating, supporting, and enhancing the skill development of five Indian institutions known as the STAR-supported institutions (SSIs). The SSIs were selected based on their reputation for excellence, scope and scale of work, and potential to make a significant contribution to improving MNCHN in India. They are the Public Health Foundation of India (PHFI), Population Foundation of India (PFI), India Clinical Epidemiology Network (IndiaCLEN), the State Innovations in Family Planning Services (SIFPSA), and the Child-in-Need Institute (CINI).

The capacity-building (CB) approach was directed to developing the skills and technical leadership of the SSIs to global standards so as to serve health sector needs for evidenced-based program planning and activities. The concept of learning by doing was introduced in drafting applied research proposals and executing funded projects. operative model was to (i) establish government priorities; (ii) write concept notes that effectively translated the priorities into viable MNCHN research topics, (iii) write proposals from the concepts; and, through continuous quality review that ended with funding assured, (iv) carry out the research. The research results were then expected to be used to create a platform for advocating changes or improvements in GoI policies and programs to improve MNCHN in India, with a focus on UP and JH.

RESULTS TO DATE

A review of achievements of deliverables for technical components of the MCH-STAR Initiative at the end of Year 2 indicates that MCH-STAR achieved most of its targets. Only targets related to publication of research and evaluation and policy analysis were not met. The principal reasons for this were (a) the time it took the SSIs to build their capacities; (b) delays in completion of projects for various reasons (e.g., participation in capacity-building initiatives like workshops and proposal writing[4]); (c) resultant delays in analyzing data that made it impossible to publish findings at the end of the project year.

Activities related to task order management, capacity building, and institutional development were generally on track. The few exceptions mainly had to do with policy analysis and advocacy and writing of policy briefs and white papers. In technical areas, progress was satisfactory, with the exceptions detailed in the body of the report.

[4] Current projects are expected to be completed in the first quarter of Year 3 and SSIs are planning to submit for publication all of the studies that resulted from the TA provided. The focus will be on translating evidence into policies and program guidelines.

LESSONS LEARNED

- **Facilitating capacity building and process change for quality outputs of SSIs often slows deliverables.** There is a trade-off in the initial phases of CB between internalization of quality assurance (QA) processes and producing outputs. The alternative would be to not expect deliverables until the capacity development process has been completed, but this may contradict the learning by doing philosophy.

- **The emphasis should be on building capacity in SSIs as institutions rather than on individuals.** If institutional development is to be sustainable, efforts are needed to identify, in conjunction with the SSIs, ways to extend training from designated individuals who work on a project to a greater number of SSI staff.

- **Ensuring the buy-in of SSI chief executive officers (CEOs) for institutional change is important to sustainability**. Long-term structural changes and process improvements for better SSI governance and management require support and stewardship from top management. In the first two years of the project, interactions with CEOs were limited due to competing priorities, distances, and availability.

- **MCH-STAR itself needs to facilitate engagement with state and national governments.** At the state level the SSIs felt that MCH-STAR should take a more proactive role in engaging the government, at least until a transition could be made without inhibiting output.

- **Support for implementation in districts is required.** Engagement at the state level for policy and research-oriented assignments often led to slow-downs because of frequent transfers of government officials. Moreover, state government leaders have expressed a need for TA for districts, rather than engagement only with the state.

- **Having a business plan is important.** Staff of one SSI noted that it had learned the meaning and importance of having a good business plan—an emphasis they felt had been missing in the nonprofit community. The usefulness of the business plan extended to requests for more input on administrative and finance systems to enable the SSIs to be more efficient and responsive in leveraging funds from other donors.

- **Activism can support advocacy.** Some SSIs appreciated learning how to have an impact on government systems and programs through advocacy rather than solely relying on activism.

- **Competition is healthy.** Strategies are needed to introduce some healthy competition into the system, to improve output and generate a more real-life atmosphere in the project.

RECOMMENDATIONS

While appreciating the program's accomplishments in its first half, the mid-term review (MTR) team derived 12 major categories for improvement from the findings detailed in the report and recommended actions for each. Changing practices in these areas would require some deep changes in the management and practices of the project, but it was felt they could well guarantee greater and more visible success. The MTR team also noted that the MCH-STAR project was philosophically and programmatically compatible with the new U.S. Global Health Initiative (GHI) and could well become the vanguard for the practices it is advocating.

Measure significant results.

- In consultation with the SSIs, MCH-STAR should define broad outcome indicators that measure improvements in MNCHN (per the task order) so as to demonstrate how process

indicators now being used will eventually improve the health and nutrition of women and children.[5]

- Similarly, the SSIs and MCH-STAR should reduce the number of indicators to a manageable number so that CEOs could more frequently report on them and use them in making decisions on program direction.

Introduce healthy competition.

- Increase the value of individual MCH-STAR project grants to emphasize the project's importance and to encourage proposals that take on problems of greater significance. To do this:
  - Increase the amount of the MCH-STAR budget dedicated to funding proposals.
  - Fund only three or four major project proposals rather than a large number of smaller projects.
  - Encourage SSIs to collaborate on project proposals.
- Continue to have SSIs work with government counterparts to draft proposals that reflect the interest of the GoI and its commitment to implement the results once a project is completed, but agree with all parties that not all concept proposals will be accepted, not all proposals will be funded, and collaborative proposals will be considered first.

Work to increase productivity.

- Increase the incentives for project output by linking funding to the achievement of clear and measurable results-based indicators.
- Allow multiyear funding of grants to give SSIs sufficient time to execute more complex and more strategic projects.
- Intensify SSI-specific mentoring to improve communication with and troubleshooting between MCH-STAR and the SSI at the national and state levels and to encourage SSIs to implement the action plans they drafted as a result of the assessments of CB and institutional strengthening (IS) that MCH-STAR initiated.

Streamline the proposal approval process.

- USAID, MCH-STAR, and SSIs should form a joint working group to (i) analyze bottlenecks in the proposal approval process; (ii) design a system to reduce to no more than four months the turnaround time from proposal to funding; and (iii) set default timeline guidelines for each step to keep the process moving (e.g., no input from an individual or agency by the deadline means tacit approval, with the document moving to the next step).
- Delegate power to the MCH-STAR chief of party (COP) for either all proposal approvals or for a higher funding threshold.

[5] As an example, in the first referral unit (FRU) project, change the goal from process, " build capacity of government functionaries," to outcome, e.g., "reduce adverse delivery events for women and newborns." This goal could also organize inputs from other SSI proposals (e.g., the Janani SurakshaYojana [JSY] study).

Identify and respond to specific SSI needs.

- Graduate from the program SSIs that have shown capacity for generating funds for MNCHN on their own or for working collaboratively with partner institutions like BU to attract larger non-USAID funding.
- Implement activities that are responsive to the requests and identified needs of the individual SSIs and support participation in CB activities case by case using the expertise of Indian institutions, including SSIs, to plan and present workshops and training programs. Where necessary (e.g., finance and business processes), expand the mandate of MCH-STAR to cover topics that SSIs repeatedly request.

Modify ways to secure government buy-in.

- Develop strategies to establish longer-term agreements with government counterparts to ensure that priorities are set based on an information-based dialogue with the government.

Resolve problems within the partnership.

- The three partner organizations need to address issues the MTR team has raised. This should be done in an open forum with an external facilitator. Communication between the partners could be improved by creating a platform for regular meetings, trouble-shooting/problem solving, and setting agendas together.

Work with GoI counterparts in the districts.

- With National Health Systems Resource Center (NHSRC) and SSIs at the district level in JH and UP, draft joint proposals that maximize the comparative advantages of the SSIs to address priorities identified through a joint analytical exercise. Considered district by district (more than one district will apply), choose the proposal that is most competitive.
- Consider integrating NHSRC and the National Institute of Health and Family Welfare (NIHFW) into the MCH organizational structure as advisors and facilitators through whom TA requests could be coordinated while exploring the interest of other government departments central to MNCHN in becoming SSIs for CB.

Increase the presence of MCH-STAR in the states.

- Establish MCH-STAR satellite offices in UP and JH to develop better relationships with both governments, facilitate the work of the SSIs, and create synergy with other programs in the USAID's MNCHN framework (e.g., Vistaar). These offices should lead to the empowerment of state SSI representatives to make decisions on local issues with the backing of the state MCH-STAR office, which would be authorized to decide on and facilitate state TA needs.

Revitalize SIFPSA in UP.

- Use the output from a meeting, facilitated by an expert, with the current and previous executive directors of SIPFSA, USAID officials, and MCH-STAR to draw up a strategic action plan for SIFPSA (like the one done successfully for IndiaCLEN) that can serve as a basis for MCH-STAR assistance.[6]

[6] This action plan could include ways to transform SIFPSA into a State Health Resource Center, or ways to reintegrate it with the NHRM.

Maximize the partnership with IndiaCLEN in the states.

- Delhi-based IndiaCLEN members, with MCH-STAR support, should provide orientation workshops for to the state medical institutions to which IndiaCLEN representatives are attached to ensure: (a) more effective use of the institutional resources of the medical colleges; (b) access to logistics support; and (c) better use of their reputation for providing TA to state government.

Keep gender and equity at the forefront of MCH-STAR.

- A gender analysis of the range of technical issues related to MNCHN is needed; MCH-STAR could do this in a white paper or other position paper. It should define a common understanding of the gender perspective around each MNCHN issue and what gender and equity mean in the context of MCH-STAR; it could be used to move the SSIs beyond gender "considerations" to a genuine gender analysis as they draft proposal.
- Offer TA to state and district health administrators to enable them to look afresh at the concept of equity so they can better understand contextual definitions of vulnerable[7] groups or populations and put in place a health management information system (HMIS) that can monitor provision of services to these groups.

NEXT STEPS FOR MCH-STAR

The MCH-STAR initiative was forward-looking in formulating a conceptual framework that changed the approach to development assistance in India. It is not only aligned with the new GHI but could also be incorporated into USAID programs around the world.

The GHI offers a bold and integrated vision for USAID assistance in the health sector to tackle improvement in health outcomes for the most vulnerable groups. Its guiding principles are to

- Implement a woman- and girl-centered approach;
- Increase impact through strategic coordination and integration;
- Strengthen and leverage multilateral organizations, global health partnerships, and private sector engagement;
- Encourage country ownership and investing in country-led plans;
- Build sustainability through health systems strengthening; improve metrics, monitoring, and evaluation; and
- Promote research and innovation.[8]

MCH-STAR embodies most of these principles and can retool itself to live up to the great expectations of USAID, SSIs, and the GoI.

The observations of the MTR team suggest several recommendations for mid-term correction of MCH-STAR's operational and strategic parameters. A unique project like this could

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[7] For example, single women, disabled women, mothers of two daughters, and women subjected to domestic violence would be considered vulnerable groups, as would migrants, people working in hazardous occupations like stone crushing (silicosis-affected), sugarcane harvesting (leptospirosis), and so on.

[8] Implementation of the Global Health Initiative: Consultation Document http://www.usaid.gov/our_work/global_health/home/Publications/docs/ghi_consultation_document.pdf.

contribute significantly to strengthening Indian institutions and facilitate responsive TA to the national and state government through indigenous rather than foreign consultations. To significantly scale up MCH-STAR operations, the MTR team believes that it would be desirable to extend the project for two years beyond its remaining 2.5 years and add a follow-on second phase. While the remaining 2.5 years and the proposed extension can be used to streamline the project's vision and operative parameters, it can also offer an opportunity to prepare for MCH-STAR Phase II. That should maximize return on investment and consolidate the progress it has already made, paving the way to providing the TA increase that the GoI will need in a constantly changing global environment.

I. BACKGROUND

OVERVIEW OF THE MNCHN SITUATION

India as a Whole: India holds the key to global achievement of the Millennium Development Goals (MDGs). Its population of 1.2 billion and its high mortality rates mean that every year 2.1 million children under the age of 5 die. Since there are 9.2 million child deaths globally,[9] this means that every fifth child who dies in the world is an Indian child. While the country accounts for only 20% of all births, it suffers 28% of neonatal deaths and 23% of infant deaths; it also has 40% of low-birth-weight babies.[10] Many Government of India (GoI) efforts, such as the National Rural Health Mission (NRHM) and the Integrated Child Development Scheme (ICDS), have been initiated to accelerate progress toward the MDGs and save and improve the lives of mothers and newborns.

The pattern for maternal deaths is the same. Of the 500,000 women who die every year from pregnancy-related causes, about 100,000 are Indian. MDG 5 calls for a three-quarters reduction in maternal mortality by 2015, but progress everywhere has been slow. Despite a recent global reanalysis of mortality data that suggests that the maternal mortality rate (MMR) in India (as in the rest of the world) has been decreasing faster than expected (4% a year in India), the current reduced estimate of 68,300 deaths still places the MMR at 254 per 100,000 live births.[11]

A pervasive underlying condition that affects mortality rates is maternal and child malnutrition, which in India is again among the highest in the world. The prevalence of child-wasting in India (20%) is more than twice as high as the average in sub-Saharan Africa (9%) and 10 times higher than in Latin America (2%). Child stunting is more than four times higher in India (48%) than in China (11%). More than half (55.3%) of Indian women aged 15–49 are anemic. It is a national failure that the nutritional situation has not improved over the last decade despite impressive economic growth, the achievement of national food security, and the longstanding national ICDS with its reach into each of the 600,000 villages across India.

At the root of these statistics are profound gender inequities, expressed in differences in educational, economic, and social opportunities and closely linked to poor health and nutrition and high mortality rates. A girl aged 1–4 year in India is 40% more likely to die than a boy in the same age group; child mortality would drop by 20% if girls had the same mortality as boys.[12] Nutrition of children and women varies significantly by caste, wealth quintile, and education of mother.[13] Significant improvements in maternal and child health will only occur when these are addressed.

The GoI has acknowledged these problems and initiated or accelerated many programs, such as the NRHM, ICDS, and the National Urban Health Mission (NUHM) to speed up progress in

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

[10] Personal communication suggests that worldwide mortality in children younger than 5 years has dropped to 7.7 million deaths in 2010 (3.1 million neonatal, 2.3 million post-neonatal, and 2.3 million childhood). Under-5 mortality is declining faster than expected. The global decline from 1990 to 2010 is 2.1% annually for neonatal mortality, 2.3% for post-neonatal mortality, and 2.2% for childhood mortality.

[11] Hogan, Foreman, Naghavi, et al. Lancet. 2010 May 8;375(9726):1609-23. Epub 2010 Apr 9 Maternal mortality for 181 countries, 1980-2008: a systematic analysis of progress towards Millennium Development Goal 5. These numbers are published with an uncertainty interval of 41.6-106.2 per 100,000 live births.

[12] *Lancet*, 2003.op cit.

[13] NFHS 3, 2005–06.

reaching the MDGs to improve the lives of mothers and newborns. It also recognizes that these problems are worse in eight states, now termed the Empowered Action Group (EAG).[14]

MNCHN in Uttar Pradesh and Jharkhand: The MCH-STAR project chose to work in EAG states Uttar Pradesh (UP) and Jharkhand (JH) because of their inordinately high rates of infant mortality (UP = 73 per 1,000/live births; JH = 69/1,000; India = 57/1,000) and maternal mortality (UP = 440/100,000 live births; JH = 312/100,000; India 254/100,000), and health indicators that were significantly worse than the Indian national average. Both states are intent upon improving on these figures. As part of its NRHM Program Implementation Plan (PIP), UP launched the Comprehensive Child Survival program (CCSP) in 2007 to reduce the infant mortality rate (IMR) to less than 40/1,000 live births and the MMR to less than 200 /100,000 live births by 2012. JH's targets for 2012 are reducing the MMR 100 by 2012[15] and reducing the IMR from the current 48 to 30.

In UP, there are 8.3 million malnourished children, of whom 3.3 million are severely malnourished. This is more than 10% of the Indian total of 72 million malnourished children. Nearly every third infant born in Uttar Pradesh is a low-birth-weight baby (less than 2,500 grams) and half of all children under 3 are malnourished.[16] Most 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 3 and under to 40% by 2012, but it has not been activated. (See Table 1 for other MNCHN comparisons.) Both states have outlined ambitious plans to improve this situation.

TABLE 1. MATERNAL, NEWBORN AND CHILD HEALTH AND NUTRITION INDICATORS COMPARED

MNCHN Indicators	Status		
	UP (%)	JH (%)	India (%)
Maternal health			
Institutional deliveries	22.0	19.2	40.8
Births assisted by health personnel (doctor, nurse, Auxiliary Nurse Midwife (ANM), Lady Health Visitor (LHV)	27.2	28.7	48.8
Mothers who received postpartum care from health personnel within 2 days of delivery of last child	13.3	17.0	36.8
Pregnant women receiving 3 antenatal care visits	26.6	36.1	50.7
Pregnant women age 15–49 who are anemic	49.9	68.4	57.9
Total unmet need for family planning	21.2	23.1	12.8
Child and newborn health			
Children 12–23 months fully immunized	30.3	34.2	43.5
Newborns breastfed within 1 hour of birth	7.2	10.9	23.4

[14] Uttar Pradesh, Jharkhand, Madhya Pradesh, Chhattisgarh, Rajasthan, Orissa, Uttarakhand, and Bihar.

[15] State of Jharkhand, NRHM State Plan, 2009–2010.

[16] Vistaar Mid-Term Report, GH-Tech and USAID, 2009.

TABLE 1. MATERNAL, NEWBORN AND CHILD HEALTH AND NUTRITION INDICATORS COMPARED			
MNCHN Indicators	**Status**		
	UP (%)	**JH (%)**	**India (%)**
Children with acute respiratory infection or fever taken to a health facility	70.4	60.0	70.5
Nutrition			
Infants breastfed exclusively till 6 months	51.3	57.8	46.3
Infants receiving complementary feeds apart from breastfeeding at 9 months	46.0	65.3	55.8
Children 6–35 months of age who are anemic	85.1	77.7	78.9
Children under 3 who are underweight	41.6	59.2	40.4
Children under 3 who are stunted	52.4	47.2	44.9
Children under 3 who are wasted	19.5	35.8	22.9

Source: National Family Health Survey (NFHS) 3

India's Umbrella Program for Health: Recognizing the importance of health to the process of economic and social development, the GoI launched the NRHM in April 2005 to effect a major adjustment in public health care delivery. 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, women, and children. Despite its work, the public sector continues to face numerous challenges, including slow and inefficient management and financial systems, little capacity to implement plans and monitor programs, and numerous human resources challenges, such as low worker motivation, frequent personnel changes at the leadership and management levels, and high staff vacancy rates.

Pre-NRHM total public expenditure on health was less than 1% of GDP; it is now about 1.1% (2009–10)—less than half the 2–3% envisioned. To impact maternal and newborn mortality, funds were allocated to establish first referral units (FRUs) that could provide emergency obstetric and newborn care (EmONC) services coupled with an incentive scheme, the Janani SurakshaYojana (JSY), to promote institutional deliveries through a new community-based worker, the ASHA. Though these measures were well-intended, not enough attention has been given to their actual success or failure, or to the implementation of JSY policies, the management and functionality of health facilities, regulatory and information-feedback mechanisms, and equity of access and quality of care at different levels of the health services pyramid. For example, JH in 2007 still had no FRUs as defined in the National Reproductive and Child Health II Project (RCH II) PIP, and universal coverage of eligible pregnant women under JSY was only 24%.[17]

GOVERNMENT NEEDS AND DEMANDS

The combination of poor health indicators and the modest performance of even the largest of India's programs to safeguard the health of its citizens point to significant needs for improvements in MNCHN. There are numerous ways to assess these needs, such as

[17] Programme Implementation Plan on National Rural Health Mission (2007–08) Jharkhand.

government and stakeholder meetings, sharing quality research results to lay a foundation for informed dialogue, review of the GoI's 11th 5-Year Plan, and tapping into state and national planning and review processes, such as the PIPs and Common Review Missions.[18] For example, the NRHM/Reproductive and Child Health (RCH) II Common/Joint Review Mission comprising stakeholders, donor partners, and the GoI is a good basis for examining the missing links in NRHM program implementation. Through this process recommendations are formulated and accepted by the government but may need to be tailored to meet the needs of individual states and districts.

In general, a consistent theme in many assessments of the public health sector is that most health facilities are characterized by (i) poor infrastructure and human resources, especially at community health centers (CHCs) and district health hospitals; (ii) absence of referral systems; (iii) underutilization of services in some states; (iv) long delays and procedural complications; and (v) lack of trained personnel and literacy skills at the grassroots level. These proximate problems are manifestations of deeper issues: (i) lack of political will; (ii) poor management capacity in general; and (iii) inadequate governance and sectoral coordination throughout the health system. This has slowed progress in improving MNCHN indicators and effective implementation of program strategies.

Because there are a large number of development partners and no consistent knowledge about who is working on what, gaps and priorities must be revisited after a thorough understanding of the state and national MNCHN landscape. Specific inputs from the GoI in coordination with development partners and collaboration between projects within each partner's own health portfolio and beyond can lead to more effective programming and greater impact.

RESEARCH INSTITUTIONS IN INDIA

These persistent deficiencies have increased the demand for evidence-based health programs and policies that are more likely to succeed in India. This in turn has led to more recognition of the role that health and policy research must play in gathering the evidence for actions to achieve health and related goals, such as the MDGs. Among specific objectives of a health research system are setting health research priorities, generating knowledge, building capacity, developing standard procedures and mechanisms to ensure ethics, quality, accountability and transparency, mobilizing resources, and conducting advocacy for better partnership.[19]

In India, a variety of organizations are engaged in health research: research institutes, medical colleges, and nongovernmental organizations (NGOs) as well as government institutions. In 2007 the Indian Council of Medical Research (ICMR) and the WHO Country Office for India collaborated to map health research institutions and populate a database. An expert group meeting was held to define health research and health research institutions and to classify areas of research and who to access for information.

The study identified 432 institutions, with 57 in Delhi, 19 in UP, and 3 in JH. This was an essential first step in identifying the range of Indian institutions conducting health research. However, further work is required to determine the degree to which each institution identified and others not on the list are engaged in MNCHN research and whether they are able to support the GoI in its mission to improve programs that affect health outcomes. If building the capacity of Indian institutions is the way forward in sustainable development, then an extensive

[18] National and state PIP documents and the three Common Review Mission Reports can be found at http://india.gov.in/citizen/health/govt_welfare.php.

[19] WHO, Strategies or Health Research Systems in South East Asia Region, 2001.

needs assessment showing their current status must be the next step to quantify institutional needs and opportunities for further strengthening.

ORIGINS OF THE MCH-STAR PROJECT

Rationale

MCH-STAR was designed to fill an identified gap by supporting effective implementation of NRHM through evidence-based, sustainable MNCHN activities. This concept fit into USAID's commitment to improve MNCHN at scale. It also reflected the "last mile" strategy as USAID planned to leave India. Accelerating development of the capacity of Indian institutions for research, policy analysis, and TA in MNCHN would leave the Indian government with a sustainable system for making health program improvements without a key development partner.

Description

MCH-STAR was designed to build the capacity of "sustainable Indian institutions [to] provide technical leadership and critical technical inputs to public and private sector programs in India in maternal, neonatal, and child health and nutrition matters through technical assistance to programs, policy analyses and advocacy and operations research, [and] applied and policy research." It is a five-year (2007–11) USAID-funded project led by Cardno Emerging Markets (USA), with BU and the Center for Development and Population Activities (CEDPA) as partners. Its goal is to provide complementary expertise in capacity assessment, management and strategic planning, academic skills in research and writing, and moving research results into a policy and advocacy (P&A) framework for action based on standards of evidence. The program's core work is to facilitate, support, and enhance the skill development of selected Indian institutions, the STAR-supported institutions (SSIs). Four of the five SSIs were chosen based on their reputation, scope of work, and location: Public Health Foundation of India (PHFI), Population Foundation of India (PFI), India Clinical Epidemiology Network (IndiaCLEN), and the State Innovations in Family Planning Services (SIFPSA), which is based in UP. The fifth SSI, selected in a competitive process, is the Child-in-Need Institute (CINI).

The primary approach to building the capacity of Indian institutions was to develop an indigenous source of skills and technical leadership that met global standards in order to respond to health sector needs for evidenced-based planning and programs. The concept of learning by doing was introduced as a method to draft and execute applied research proposals. The operative model was to (i) establish government priorities; (ii) write concept notes on how to translate these priorities into viable MNHCN research topics; (iii) formulate proposals based on the concepts; and, through a continuous quality review process that ended with funding assured, (iv) carry out the research. It was planned that the research results would then be used to create a platform for advocating changes in GoI policies and programs to improve MNCHN in India. The initial focus was on two EAG states that had some of the worst health indicators and the most challenging needs in India: Uttar Pradesh (UP) and Jharkhand (JH).

II. PURPOSE OF THE MID-TERM REVIEW

OBJECTIVES

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

- Review the progress and achievements of the MCH-STAR project relative to its objective, principles, approaches, and approved work plan; and
- Make recommendations for the remainder of the project period.

METHODOLOGY

Team Planning Meeting

The MTR began with a two-day planning meeting during which team members clarified the objectives and scope of the review, drafted the interview guides, listed informants, reviewed the list of documents, outlined the report and divided work among themselves. Annex A gives the schedule followed by the MTR team.

Initial Briefings

The USAID MCH-STAR team made a brief presentation to the MTR team on key elements of the project. At the briefing, the MTR team was able to meet with some informants and members of the SSIs and used the opportunity to plan the interview and field visit schedule.

The MTR team also had a videoconference briefing with the USAID/India team members and the GH Tech team in the United States. This briefing clarified the relationship between the two clients (USAID/India and GH Tech) and the relationship of both to the MTR team: The role of GH Tech was to recruit the MTR team, give them logistical support to and from New Delhi, and provide formats for the team planning meeting agenda, a generic outline for the final report, and other standardized documents. USAID India explained its expectations for the review and elaborated on key elements of the scope of work (SOW).

Document Review

The team reviewed project documents and reports, including annual workplans, progress and results reports, project monitoring and evaluation (M&E) plans and data, project documentation and accomplishments, process documentation, USAID strategy documents, the original request for application, and the final task order with Cardno/Emerging Markets Group (EMG) and the consortium of partners. These documents not only provided background but also served as a source of quality assessment of program outputs. (Documents reviewed are listed in Annex C.)

Interviews

More than 55 interviews were done with individuals from (a) all three partners of the MCH-STAR consortium working in New Delhi and at their headquarters in the United States; (b) the SSIs in New Delhi and in JH and UP; and (c) USAID/India. There were also interviews with significant persons from the GoI, development partners, and other stakeholders, and with individuals who had helped design and initiate MCH-STAR but had since moved on. (Informants are listed in Annex C.) Key informants were generally interviewed by at least two members of the MTR team; on occasion two or three informants or entire teams were interviewed together when the MTR team felt there were no dominant participants who might inhibit open responses from others in the group.

Field Trips

For greater efficiency, the MTR team separately into two groups to visit UP and JH. These visits were used to assess not only MCH-STAR activities but also the context within which they happen. The JH trip included a visit to Chaibasa District to visit FRUs that were part of an MCH-STAR-funded project.

Wrap-up and Debriefing

Debriefing meetings were held with the SSIs, MCH-STAR, the USAID Mission Director, and the USAID/India team. The objective was to share draft findings and recommendations, solicit comments, and clarify any remaining questions.

Team Composition

The gender-balanced review team had five members (two foreign and three in-country professionals), all with experience in India but none with USAID/India or the project. Between them they had expertise with the Indian Government Health System and MNCHN in India and the region and had field experience and knowledge of operations research, project development, M&E, capacity development and institutional strengthening, gender and equity issues, and policy advocacy. They also had conducted similar reviews and worked with other USAID projects.

III. DESCRIPTION, STRUCTURE AND FUNCTION OF MCH-STAR

GOAL AND OBJECTIVE

Goal: The overall goal of MCH-STAR is to improve MNCHN child health and nutrition among poor and underserved Indian populations through effective programs that address priority issues and are guided by appropriate policies.

Objective: To develop sustainable Indian institutions capable of meeting international standards of technical leadership and providing critical technical inputs to public and private MNCHN programs in India through TA to programs, policy analyses and advocacy operations, and applied and policy research.

THE USAID-FUNDED MCH-STAR INITIATIVE

MCH-STAR—the Maternal and Child Health Sustainable Technical Assistance and Research initiative—is a five-year $13.8 million USAID TA task order designed to improve MNCHN among poor and underserved Indian populations by improving the capacity of premier Indian institutions (STAR-supported institutions–SSIs) to provide technical leadership and critical technical inputs to public and private programs. To do this, the project was designed to strengthen SSIs in critical areas so that they deliver TA that meets international standards. This initiative was designed to contribute to USAID/India's core MNCHN program and work closely with other USAID projects: Vistaar (formerly the National Integrated Health Program) and the Expanded Urban Health Program (EUHP).

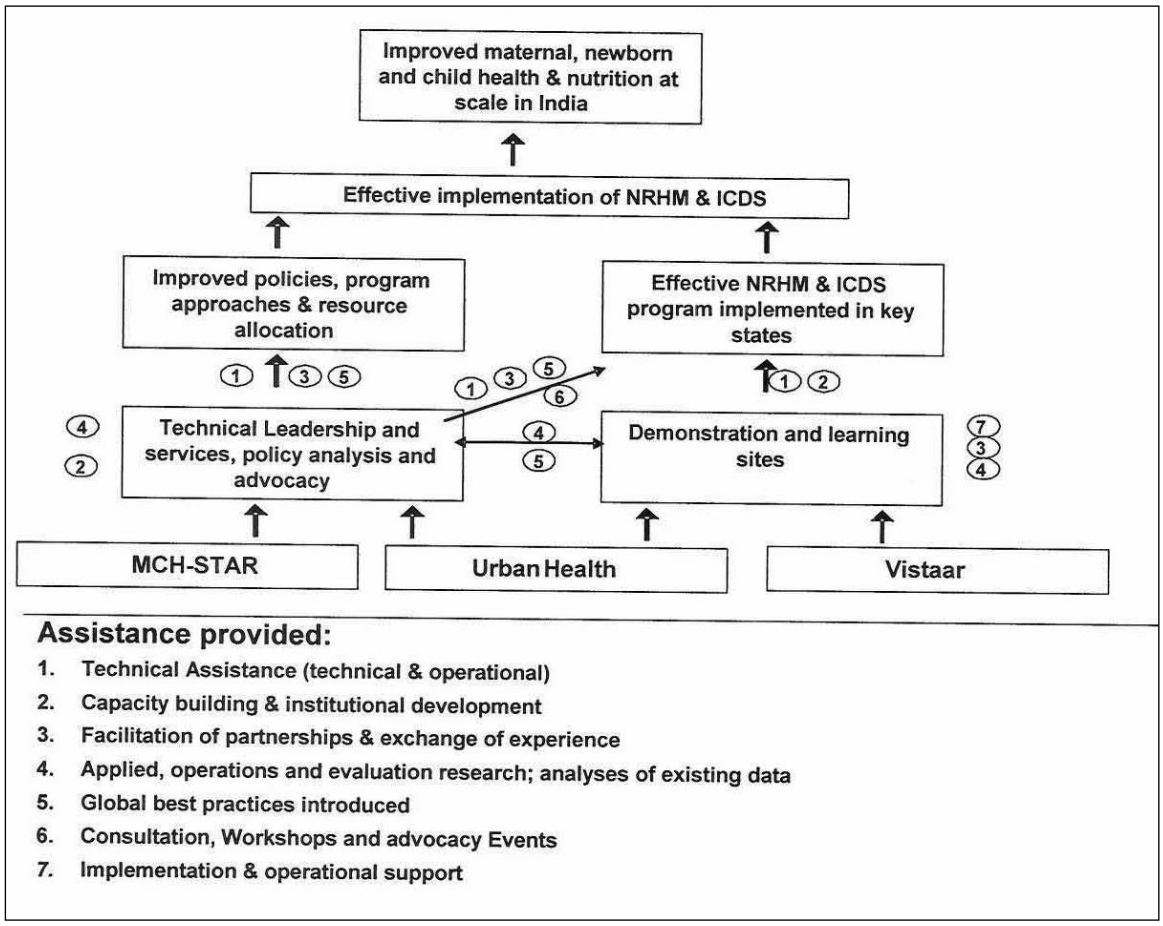
When MCH-STAR was conceived in early 2005-06, it was not clear whether USAID involvement in India would continue because the country no longer needed USAID financial assistance. The MCH-STAR project was designed as part of the Last Mile Initiative to transfer TA to indigenous nongovernment agencies that could then replace USAID in providing such assistance to agencies and departments of national and state governments in India. The Last Mile Initiative was contingent on discontinuation of future USAID support to India in health and nutrition as India's development proceeded rapidly. When this policy was reversed by USAID with the change of administration in the U.S., though consideration was given to discontinuing the project, ultimately it was believed to offer a model of development assistance that was more germane than ever as development proceeded apace. The objectives set at the inception of MCH-STAR and the need to build the capacity of Indian institutions were seen as aligned and highly relevant.

MCH-STAR is widely recognized as a challenging and innovative approach as USAID attempts to influence national MNCHN policy through evidence-based research and analysis in two of the largest and most needy states in India, UP and JH. Its outcome will determine how relevant it is to the national context, and more specifically to EAG states.

MCH-STAR is one of the USAID-supported projects that contribute to the agency's overall MNCHN goal. Closely related are Vistaar and the EUHP, now known as the Health for the Urban Poor (HUP) project. MCH-STAR was designed to interact and collaborate with Vistaar, EUHP, and others to achieve the goals set out in USAID/India's Results Framework (Figure 1). Vistaar had been launched in 2006 to support implementation of the NRHM and the ICDS program in the two key states of UP and JH. It was designed to support identification and scale-up of effective programs and successful state and local NRHM implementation. MCH-STAR was designed to provide high-level MNCHN technical inputs for effective NHRM policies and implementation. Ideally, Vistaar and EUHP would be able to use TA from and build alliances with

the institutions that MCH-STAR was strengthening. The interaction was to be managed by USAID, which is also involved in technical consultations, proposal review, facilitation of meetings with decision makers, and advocacy.

Figure 1. USAID/India MNCHN Strategic Program Framework



In September 2008, USAID amended the MCH-STAR task order to support its EUHP and build on USAID's leadership in jump-starting the urban health movement in India. As elaborated in the MCH-STAR Detailed Implementation Plan for Years 1 and 2, starting up EUHP and supporting organizational strengthening of the Urban Health Resource Centre (UHRC) then took center stage. UHRC had grown from a USAID-funded project initiated in 2002 into an independent organization institutionalized in 2005 that had as its mission bringing about sustainable improvement in the health conditions of the urban poor by influencing policies and programs and empowering urban communities. MCH-STAR's second major area of focus was to propel implementation of the NUHM, the city counterpart of the NRHM. Immediate action was directed at setting up projects to improve basic water, sanitation, and hygiene services for the urban poor. A 15-page MCH-STAR EUHP Quarterly Progress Report for January-March 2009 illustrates the degree of MCH-STAR financial and human resource involvement in EUHP.

As this program activity unfolded, unforeseen organizational, governance, and management barriers emerged at UHRC that USAID and MCH-STAR devoted considerable time and energy to resolving. In the end, complete resolution was not possible and UHRC was ended in October 2009. Because the progression was complex, a separate exercise had been undertaken to document the details, so it was decided not to assess the EUHP and UHRC in the MTR. Discussions with MCH-STAR senior staff confirmed that the initial EUHP program inputs

significantly distracted MCH-STAR attention to from its programs and undermined its ability to create opportunities for more significant achievements through the other SSIs.

MCH-STAR STRUCTURE

The MCH-STAR Team

The MCH-STAR Initiative has just five key personnel plus short-term technical advisors, including public health managers, researchers, and technical specialists in the U.S. at Cardno/EMG, BU, and CEDPA. Responsibilities have been assigned among the team in terms of SSI point person, geographic point person, technical components, thematic (MNCHN) specialization, and support roles and functions. The SSI point person is the liaison between the MCH-STAR team and the SSI. The geographic point person deals with routine communication in the states, liaison with government and development partners, relationship building, participation in technical advisory group (TAG) and partnership forums, coordinating SSI activity in each location, information-sharing, ensuring capacity building and institution strengthening (IS), providing weekly updates, and keeping abreast of the policy and political environment in UP and JH.

The team is led by a very accomplished chief of party (COP) with vast experience in India and other countries. She is ably supported by five persons with varied experience and qualifications. There is a good mix of junior and senior staff. Although there is general appreciation of the team and their professional experience, some informants suggested adding senior staff at core level to facilitate relations with the highly experienced and internationally recognized CEOs and other staff of the SSIs, though the expertise brought in from overseas (BU and other institutions) was acknowledged as adding to this capacity.

Consortium Partners

MCH-STAR is managed by a prime contractor (originally the Emerging Markets Group, now part of the Cardno Group) with two subcontractors (the Center for Global Health and Development of Boston University [BU], and the Centre for Development and Population Activities [CEDPA]). The prime contractor manages the project and reports directly to USAID.

MCH-STAR implementers provide high-level CB/IS to the SSIs in the areas of MNCHN-responsive TA, research and evaluation (R&E), and policy analysis and advocacy.

Cardno/EMG is an international consulting firm that serves donor agencies, governments, and private clients by applying business expertise to promote sustainable development. As prime contractor for MCH-STAR, Cardno/EMG provides project management and strategic leadership and ensures that the contract is complied with; in collaboration with all partners it facilitates strategic direction, development and management of work plans, and CB assessments and plans. In its technical role, Cardno/EMG provides long and short-term technical expertise and support to SSIs in CB/IS, responsive TA, and M&E. It also drafts and manages agreements with SSIs, monitors and evaluates MCH-STAR activities, and assures that milestones for deliverables are met. Cardno/EMG is dedicated to building stronger, sustainable, and responsive health systems by providing private sector solutions to build human capacity, implement public-private partnerships, strengthen public institutions, and design innovative financing mechanisms.[20]

BU is a university-wide applied research center. Its mission is to design, implement, and disseminate public health research that is relevant to the policies and programs of developing and transitional countries. It operates through a process that trains scientists in developing

[20] EMG web-site.

countries to participate in research of a quality that meets global standards. One full-time BU faculty member and one local specialist are located in the MCH-STAR office. BU provides technical expertise, IS, and mentoring in R&E. It shares global updates on MNCHN with SSIs, provides technical reviews of proposals, and offers guidance on project operational issues and report writing.

CEDPA is an international NGO that works with local partner and national organizations to design and implement programs dealing with reproductive health, HIV/AIDS, girls' education, youth development, gender, and governance. It is known worldwide for its advocacy and social mobilization expertise. It uses a variety of strategies (e.g., behavior change communication [BCC], community mobilization events, media campaigns, social marketing, and strategic advocacy) to reach collective solutions, support positive behaviors, and create social change. CEDPA brings its global experience in policy analysis and advocacy to the initiative.

Although national programs and policies are its remit, the MCH-STAR initiative concentrates in the northern Indian states of UP and JH, where the need for better services is great. UP alone accounts for one-quarter of all child deaths in India. The three partners function under the banner of MCH-STAR, and all staff members report to the COP but also maintain their individual affiliations There is a formal meeting every Monday to discuss made in the previous week and the program for the coming week.

STAR-Supported Institutions

In the original task order, MCH-STAR identified two premier Indian institutions to be part of this project: IndiaCLEN and PHFI. When the contract was awarded, Cardno/ EMG added the PFI. To select an SSI in JH, MCH-STAR in a competitive solicitation process chose the CINI. In August 2008, in consultation with the Secretary of Health for UP, MCH-STAR selected an SSI in UP, the State Innovations in Family Planning Services Agency (SIFPSA).

In the task order (pp. 22–23), USAID set out minimal institutional requirements for selection and additional criteria that were desirable but not limiting:

- Foreign Contribution Regulation Act clearance (for private organizations)
- An articulated institutional focus or mission that includes MNCHN or matters critical to improving MNCHN program effectiveness
- A history of funding from at least three sources
- A history of performance in some or all MCH-STAR technical support areas (e.g., R&E, TA to the NRHM)
- An institutional focus that goes beyond narrow technical issues and covers social, behavioral, systems, and community aspects of both treatment and prevention of MNCHN-related conditions.

Among the additional criteria were established credibility and a track record of working with the GoI and targeted state governments; an ability to influence the GoI and EAG state government programs and policies; demonstrated ability to secure required approvals and clearances for research studies within four months; and indicators of fundamental institutional strength, such as financial management systems, governance structures, and paid full-time staff in key positions.

No government institution was selected as an SSI, although consideration was given to working with NIHFW and with the NHSRC. The question of whether SSIs should be selected competitively has arisen and will be discussed below.

Reporting Relationships

To ensure compliance with USAID regulations, MCH-STAR oriented its SSIs to USAID regulations related to subgrants. The initiative works with SSIs to monitor and achieve deliverables established in the USAID/India MCH-STAR task order and benchmarks in SSI task orders. The following indicators are used to monitor achievement of deliverables:

- Desk reviews of quarterly reports submitted by SSIs
- Quarterly SSI-specific program reviews led by CEOs or senior managers with participation of the entire MCH-STAR core team, the USAID/India Contracting Officer's Technical Representative (COTR) and the Maternal and Child Health Nutrition and Urban Health Division Chief.
- Field visits and mentoring visits

In line with the dual objective of monitoring SSI grants and building their capacity, MCH-STAR core team members used field visits to gauge the quality and pace of project implementation and to mentor project teams. SSI focal persons on the MCH-STAR team also kept in regular contact and made regular visits to the offices of the SSIs for which they were responsible.

The MCH-STAR grants manager and director of finance conducted two Nuts and Bolts workshops where there were presentations on the differences between fixed-obligation and results-oriented grants (ROGs). These short workshops set out practical operational guidelines for effectively and efficiently implementing USAID-funded projects. The series included overcoming operational difficulties in complying with USAID regulations and putting together cost proposals that reflected estimated direct costs for all proposed activities. In the series, the MCH-STAR team shared budget formats and principles of budgeting and discussed the need for timesheets.

SSI Functions and Performance

SSI priorities were identified through a consultative process with the government. As outlined in MCH-STAR's "Criteria for MCH-STAR Funding," projects were chosen after the following extensive process: (a) consultative meetings that generated a list of ideas that were shared with government; (b) numerous discussions with policy makers, development partners, and USAID partners; (c) a survey of previous evidence reviews, gaps, demonstration, and learning; (d) outcomes of MNCHN TAG/partnership meetings; (e) PIP gaps as presented by state governments; (f) Joint Review Mission recommendations; and (g) the interests of the SSIs. Although setting priorities was often time-consuming, it also served as a CB exercise. SSIs that were initially reluctant to sit with government personnel to discuss programming needs were later actively engaged.

Once priorities were established, the SSIs wrote concept papers to present each idea as a possible project proposal. If the concept paper was accepted, the SSI wrote a full proposal and submitted it to MCH-STAR for review. MCH-STAR staff provided critical feedback on all proposals and also solicited feedback from technical experts associated with the project. In the iterative process, the proposal was rewritten and resubmitted. Once accepted by MCH-STAR, it was referred to the USAID/India mission for final critical review, approval, and funding. It is important to note that a conscious decision was taken to forego a competitive process in favor of one that emphasized supporting each SSI throughout the process to improve technical quality, with approval of funding guaranteed at the end, and building a system that responded positively to government priorities. The project matrix in Table 2 shows the evolution of proposals from concept paper to journal publication.

TABLE 2. STAGES AND CURRENT STATUS OF SSI PROPOSALS								
Name of Project	**Concept Paper**	**Full Proposal Returned to MCH-STAR with USAID Comments or Approval**	**Project Implementation**	**Project Completed**	**Project Final Report**	**White Paper/Policy Brief**	**Technical Dissemination**	**Publication in a Journal**
Population Foundation of India								
BCC evaluation	√	√	√	√	√	√	√	√
JSY	√	√	√	√	Work in progress (Likely to be completed in May 2010)	Work in progress	Main findings disseminated	Work in progress
BP/CR	√	√	√					
ASHA training needs assessment	√	√						
Gender consult, UP	√	√	√	√	√	√	√	√
CB/IS	√	√	√	√	√	N/A	N/A	N/A
Public Health Foundation of India								
FRU phase 1	√	√	√	√	√	√	√	√
FRU phase 2	√	√	√					
Maternal death audits in UP	√	√						
CB/IS	√	√	√	√	√	N/A	N/A	N/A
IndiaCLEN								
JSY	√	√	√	√	Work in progress (To be done May end)	Work in progress	Preliminary findings	Work in progress

TABLE 2. STAGES AND CURRENT STATUS OF SSI PROPOSALS								
Name of Project	**Concept Paper**	**Full Proposal Returned to MCH-STAR with USAID Comments or Approval**	**Project Implementation**	**Project Completed**	**Project Final Report**	**White Paper/Policy Brief**	**Technical Dissemination**	**Publication in a Journal**
Under-nutrition	√	√	√	√	Work in progress (To be done by May end)	Work in progress	Topline findings	Work in progress
Immuniza-tion logistics in UP	√							
Acute Respiratory Illnesses consultation	√	√	√	√	√	√	√	√
Gender consult, UP	√	√	√	√	√	√	√	√
ISPOT	√	√	√	√				
CB/IS	√	√	√	√	√	N/A	N/A	N/A
Child in Need Institute (CINI)								
Improving use of NRHM flexi-funds in JH	√	√	√	√				
CB/IS	√	√						
Account-ability consultation	√	√	√	√	√	√	√	

Although collaboration between SSIs was not the initial vision of the program, it evolved over time as SSIs established mutually advantageous partnerships with each other for particular projects. The partnerships developed synergistically around the comparative strengths of the SSIs. For example, PHFI invited IndiaCLEN members to collect data for the Operationalization of First Referral Units Project and to facilitate training on waste management for FRU staff. CINI connected with PHFI for FRU data collection, compilation, and monitoring progress. Another excellent example of partnership was the assistance IndiaCLEN and PFI gave to SIFPSA in designing and conducting the Gender and RCH Advocacy workshop in UP.

Factors Critical to SSI Functioning

SSIs were very proactive in responding to CB/IS initiatives but they often lost track of the basic goal and objectives of this initiative, i.e., to build the capacity of individuals *and* each institution as a whole so as to be able to efficiently and effectively respond to MNCHN requests from state and national governments and other clients. As a result, some of the initial capacity-building activities were limited to SSI staff assigned to MCH-STAR-funded projects. This is not necessarily a negative result for the long run because trained staff even when rotated to new jobs carry the lessons of the MCH-STAR initiative with them. It did, however, slow the progress of SSIs toward developing a critical mass of staff capable of moving project development forward more efficiently.

In some instances the lack of focus led to delays in project completion or deviation from the objectives of the initiative. Some SSIs requested funds for activities that were narrowly focused on a specific institutional need rather than aiming at building MNCHN capacity generally. Other requests for activities and funding were shortsighted and did not clearly spell out plans for sustaining these resources. The tendency of some SSIs to outsource technical work to contractors and consultants seems to contradict the CB/IS intent of the MCH-STAR initiative and should be examined in future project proposals.

A number of factors caused the delays in project initiation or completion that led to decreased productivity. The complex process of identifying priorities took a long time. At the outset, despite memoranda of understanding (MOUs) with government agencies, close relationships between SSI leaders and government members, and good working relationships between core team members and individual technocrats, the SSIs on the whole struggled to engage with government institution-to-institution.

RELATIONS WITH DONORS AND OTHER PARTNERS

MCH-STAR as a major USAID initiative has an established seat at the table at GoI and donor forums and is invited to participate in major national and state program and policy discussions. MCH-STAR expertise in CB/IS, its contribution to research skills through its partnership with BU, and its ability to take research to practice through the advocacy component supported by CEDPA are well-recognized.

The SSIs, except for the new PHFI, have a long history of work with other donors, local and international NGOs, and GoI counterparts. This relationship has been reinforced by MCH-STAR's MNCHN focus. The new area of interface for many of the SSIs is more substantive engagement with the state in UP and JH. The state advisory TAGs serve as a conduit for exchanging information, establishing more integrated programs, and identifying research and advocacy gaps that need to be bridged. State-level engagement has created opportunities for PHFI to initiate applied work within the MCH-STAR funding structure and to develop joint projects with UNICEF, such as reviewing the performance of sick newborn care units in four states (including Lalitpur, UP) and drafting a document for promoting strategies for health advocacy.

CEDPA is a major partner in MCH-STAR, providing expertise in advocacy issues. It has also been instrumental in developing and leading the White Ribbon Alliance in India (WRAI) to promote policies to improve the political, social, and health policy environment for improving maternal survival. This partnership has stimulated the SSIs to become more involved in addressing some critical issues related to reducing some of the main barrier conditions to effective intervention, such as upgrading the FRUs in JH to prevent deaths from postpartum hemorrhage and becoming involved in national advocacy campaigns.

MCH-STAR through the SSIs has also promoted partnerships on research projects, such as the undernutrition study led by IndiaCLEN in which the Ministry of Health and Family Welfare (MOHFW), Ministry of Women and Child Development (MWCD), the Norway India Partnership Initiative (NIPI) ,and WHO also participated; NIPI's role was to provide funding for WHO involvement. NIPI also has an agreement with PHFI to provide technical support in quantitative and qualitative research methods. NIHFW, as a GoI research and training institute has participated actively in many MCH-STAR meetings and workshops to improve the R&E skills of its own staff.[21] The director of NIHFW suggested that "MCH-STAR should become a more pro-active partner with NIHFW."[22]

INTERACTIONS WITH NATIONAL AND STATE GOVERNMENTS

It was envisaged that MCH-STAR and its partners would support the goals of the NRHM, the emerging NUHM, the ICDS, and the RCH II project through MNCHN research, policy, and responsive TA activities in UP and JH, and MNCHN priorities in other EAG states where the need is great.[23] The project has MOUs with government agencies, and many of the SSIs have close individual relationships with GoI counterparts. This has paid off in JH, where SSI involvement in district projects is well-regarded by the state. In UP, MCH-STAR and its partner SSIs are still trying to engage the government. It should be noted that in the states, the strategic approach of the MCH-STAR team has been to put the SSIs on the front line, keeping its own involvement less obvious but supportive.

There has been interest from the outset in MCH-STAR becoming involved with national and state CB organizations like NIHFW and the NHSRC. Although that did not happen in the first half of the project, both organizations and MCH-STAR remain interested. In its discussions with the MTR team, both NIHFW and NHSRC expressed interest in an expanded role with MCH-STAR, NIHFW as an SSI and NHSRC as a partner in district development.

Although the government of UP (GoUP) strongly advocated for the selection of SIFPSA as an SSI, the arrangement hardly moved beyond the MOU signed in 2008. MCH-STAR could not execute the activities specified in the MOU, including the CB/ARE assessment, perhaps because of miscommunication, differences in expectations, a limited response from SIPFSA to MCH-STAR's methods of engagement, or the frequent changes in SIFPSA leaders.

MONITORING AND EVALUATION

MCH-STAR reports progress and expenditures to USAID on a quarterly basis as required. It makes a quarterly progress report and semiannual reports on indicators, benchmarks, and deliverables. This implies that all SSIs should submit reports to MCH-STAR before the USAID quarterly submission dates. In addition, with the introduction of the Results Oriented Goals (ROGs), SSIs were asked to report monthly on finances. They report on benchmarks,

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[21] NIHFW has 35 assistant research officers to respond to GoI priority information needs.

[22] Dr. Deoki Nandan, *personal communication.*

[23] In addition to UP and JH, the EAG states are Madhya Pradesh, Chhattisgarh, Rajasthan, Orissa, Uttarakhand, and Bihar.

milestones, and indicators as their agreements with MCH-STAR specify. To ensure that the quality of reported data is high, MCH-STAR and SSIs have evolved a performance monitoring plan (PMP) that covers benchmarks, indicators, and means of verification; established a data collection and reporting system; and documented all activities leading to milestones and deliverables. MCH-STAR and SSIs give USAID access to all PMP-related documentation and data for data quality checks.

Other monitoring mechanisms are SSI quarterly reports, assessments and re-assessments, the participant database, deliverable trackers, the proposal development matrix, and a leveraging survey.

Although MCH-STAR has a lengthy list of internally used monitoring indicators, only two are used for reporting to USAID:

- Number of information-gathering and research activities
- Number of improvements to laws, policies, regulations, or guidelines related to improving access to and use of health services

Although the plan reflects both M&E, the evaluation component is not sufficiently developed or implemented.

BUDGET AND FUNDING

Budget

The initial budget for the task order was revised, diverting savings estimated from Other Direct Costs to Grants and Fixed Fee for Grants. Thus, the amount budgeted for Grants rose from $350,000 to $2,029,410, a percentage increase from 2.5% of the total five-year budget to 14.7%. However, even with the increase, the amount allocated for grants is still low with respect to the other budget headings (see Table 3).

TABLE 3. MCH-STAR BUDGET

Cost Element	Base Period Oct 07–Sep 09	Option Year 1 Oct 09–Sep 10	Option Year 3 Oct 11–Sep 12	Total Initial Budget	Revised Total Budget	Difference
Workdays ordered	$562,495	$302,309	$321,514	$15,00,688	$15,00,688	$0
Fixed fee	$293,931	$1,52,666	$1,63,362	$7,62,933	$7,62,933	$0
Other direct costs	$3,386,148	$1,741,512	$1,864,672	$8,716,469	$7,002,815	–$1,713,654
Grants	$175,000	$87,500	$17,500	$350,000	$2,029,410	$1,679,410
Fixed fee on grants	$3,500	$1,750	$350	$7,000	$41,244	$34,244
Indirect costs	$950,196	$500,609	$536,518	$2,498,388	$2,498,388	$0
Cost plus fixed fee ceiling price	**$5,371,270**	**$2,786,346**	**$2,903,916**	**$13,835,478**	**$13,835,478**	**$0**

Utilization of Budget

The amount obligated was on average 71% of the total annual budget, and utilization of the obligated amount was about 60%. Utilization of the five-year total budget is even lower at 43% (see Table 4).

TABLE 4. MCH-STAR BUDGET UTILIZATION

Cost Element	Budget Amount	Percentage Obligated Through 3-31-10	Oct 07-Mar 10 Cumulative Expense as of 03-31-10 (% of Obligated Amt.)	Oct 07-Mar 10 Cumulative Expense as of 03-31-10 (% of Budgeted Amt.)
Work days ordered	10.8%	57.6%	71.8%	41.4%
Fixed fees	5.5%	58.5%	64.9%	38.0%
Other direct costs	50.6%	73.2%	54.0%	39.5%
Grants	**14.7%**	**95.7%**	**69.9%**	**66.9%**
Fixed fee on grants	0.3%	95.8%	68.7%	65.8%
Indirect costs	18.1%	58.1%	63.0%	36.6%
Total cost + Fixed fee	**100.0%**	**71.3%**	**60.6%**	**43.2%**

IV. PROGRESS TOWARD ACHIEVING OBJECTIVES

GOALS AND OBJECTIVES

When the MCH-STAR project was conceived early in FY 2005–06, it was not clear how long USAID involvement in India would continue. As a last-mile initiative should USAID support be discontinued, the project set goals and objectives for both the national level and the states of JH and UP. USAID has continued its support in health and nutrition, and the objectives set at inception, the context, and the need to build the capacity of Indian institutions remain relevant.

Goal: The basic goal of MCH-STAR is to improve MNCHN among poor and underserved Indian populations through programs that address priority issues and are guided by appropriate policies.

Objective: Sustainable Indian institutions provide technical leadership and critical technical inputs to public and private sector MNCHN programs in India through TA to programs, policy analyses and advocacy, operations, and applied and policy research.

TECHNICAL APPROACH AND PLANNED ACTIVITIES

The approach detailed in the task order was to support an evidence-based approach to programming, with the focus on MNCHN. It was also designed to address critical gaps and constraints to success for MNCHN programs and to focus on areas that were likely to lead to measurable MNCHN improvements.

The "how" included leveraging resources, working with both public and private entities, building on Indian competencies, and providing a legacy of Indian institutional capacity to sustain technical support in MNCHN and urban health. The project would be linked to other USAID India Health programs geographically, programmatically, and strategically.

With MNCHN as the core and culmination of the project, the approaches and activities centered on the following:

1. Building the capacity of Indian institutions
2. Applied, operations, and policy research and program evaluation
3. Policy analysis, white papers, and advocacy
4. Technical assistance (supply and demand)
5. The Expanded Urban Health Program

MONITORING

Progress was to be monitored against a list of process indicators that demarcated the expected program achievements. The set of indicators was kept simple and standardized to ensure easy verification and tracking. Plans and grant progress have been reviewed quarterly. However, it was felt that such standardized indicators as number of reports written and disseminated and number of consultations on evidence-based policy development did not facilitate structured development of the SSIs based on their individual strengths and preferences. There were also concerns that the short interval between measurements did not give the SSIs time to make substantial and measurable progress, especially since it is expected that they will soon be involved in more strategic and time-consuming assignments.

Such frequent and regular monitoring by the MCH-STAR team is highly resource- intensive. Since the capacity and extent of work assignments have already increased substantially, a management information system (MIS) developed for (and with the input of) the SSIs would enable their senior managers to assess progress and make corrections as needed. This model would both strengthen management systems and reduce the burden and drudgery of frequent reviews by the MCH-STAR team. Needless to say, such a shift would require revision of the monitoring indicators.

Choice of Indicators

The PMP for the SSIs shows a long list of detailed input and output indicators, which have multiple parameters. The somewhat standardized model of activity charts, PMPs, and SSI CB served the project well at first. However, a reorientation of the process indicators would adjust the monitoring program in respond better to the

- Different strengths, aspirations, and foci of the SSIs (e.g., in research, R&E, implementation);
- The different status and maturity of these institutions;
- The need for a team of SSIs with complementary skill sets rather than a group of stand-alone SSIs that all fall into the same mould; and
- The changing context of an expanding NRHM with increasing demands to expand activities and inputs.

A standardized set of indicators serves well as a monitoring core that can differentiate between the performances of SSIs, regardless of their inherent strengths or weaknesses. If well-developed, the same set can be used to distinguish the individual strengths of each and rate them accordingly. The set can also be used to standardize expectations of output and performance from each SSI. As their capacities develop, however, consideration should be given to modifying the indicators to keep them abreast of institutional changes.

Of greater importance, however, is the need to reduce the number of indicators being measured so as to make data collection more efficient, and to improve the capacity of those dealing with the data to make decisions. The current long list of indicators is not only difficult to monitor but is also inflexible. A shortened list drafted in conjunction with the SSIs could improve data quality and program monitoring.

Institutional strengthening for SSIs should reflect their ability to take corrective decisions based on progress updates and use of data for decision making. Each needs a plan for upgrading its MIS. Decision support systems and executive information systems designed to provide quality data to top management are imperative for better planning and control. The current M&E indicators are mostly inputs and outputs and focused largely on MCH-STAR-related deliverables. Working with the SSIs, MCH-STAR could create indicators not only for operational parameters but also for strategic and tactical dimensions, perhaps including outcome indicators related to MNCHN.

ACHIEVEMENT OF RESULTS

Achievements against Targets

A review of targets and achievement of deliverables for technical components of the MCH-STAR Initiative at the end of Year 2 indicates that MCH-STAR achieved most of its targets (see Table 5). Only those related to publication of R&E and to policy analysis were not met. The principal reasons were (a) the time it took SSIs to build their capacities; (b) delays in completion of projects for various reasons, with the result that (c) at the end of the project year SSIs were still analyzing data and not yet ready a position to publish their findings; and (d) delays in implementation of technical work due to participation in CB initiatives like workshops, proposal writing, and allied tasks.[24]

TABLE 5. USAID OPERATIONAL INDICATORS (OPS) FOR MCH-STAR

Indicator*	Annual Target for Reporting Year 2009	Actual Cumulative Targets for Reporting Year
IIP. 1.6 MCH Number of information-gathering or research activities conducted by US government	13	18 (10 from MCH-STAR and 7 from EUHP)
IIP.1.8 CLEAN WATER AND SANITATION SERVICES Number of baselines or feasibility studies.	1	1 (Water activity to be carried out by EUHP)

Source: Annual Report 2008-09 (page 60)

The monitoring framework for the project, meant for quarterly review, consists of three reportable indicators for USAID (of which two are reported in Annual Reports) and of 59 indicators divided into three sections: (a) Technical Areas PMP for R&E, P&A, and TA; (b) CB/IS; and (c) MCH-STAR task order management. Only 13 of the indicators (out of 59) have either not started or are moving slowly. The summary table below shows the progress of indicators at a glance; indicators that have not met the target or are progressing slowly are described in the following paragraphs.

TABLE 6. SUMMARY OF PROGRESS OF MCH-STAR AGAINST TARGETS

Indicator Group	Total Number of Indicators	Number that Achieved Target	Number on Track	Number that Need Improvement	Number not yet Started	Number Reported Annually
MCH-Star USAID reportable indicators	3 (2 in Annual Report)	-	2	1	-	-
Technical Areas Performance Monitoring Plan for Research &	17	7	7	2	1	-

[24] Current projects are expected to be completed in the first quarter of Year 3, and SSIs are planning to submit publications for all the studies that resulted from the TA provided. The focus will be on publishing and translation of evidence into policies and program guidelines.

TABLE 6. SUMMARY OF PROGRESS OF MCH-STAR AGAINST TARGETS						
Indicator Group	**Total Number of Indicators**	**Number that Achieved Target**	**Number on Track**	**Number that Need Improvement**	**Number not yet Started**	**Number Reported Annually**
Evaluation, Policy & Advocacy and TA						
Capacity building and institutional strengthening	28	7	9	4	5	3
MCH task order management	14*	9	3	-	-	2*
Total	**62***	**23**	**21**	**7**	**6**	**5***

*Indicator on final evaluation of MCH-STAR project 6 months before project closure is not included.
Source: 10th Quarterly Monitoring Report (January-March 2010).

Achievement of Results in Technical Areas

Progress on technical areas per the PMP has been satisfactory except for the activities listed in Table 7.

TABLE 7. TECHNICAL AREAS NEEDING ATTENTION	
Planned Activity	**Performance**
5. Research priorities established & reviewed at the national and state levels in UP and JH through consensus building exercises	The SSIs did not hold consensus exercises.
6. Number of MNCHN-related program evaluations conducted by SSIs	This activity has not yet started.
7. Number of policies at the national and state levels designed to improve MNCHN that have been developed or modified and approved.	Insufficient number developed or modified and approved.

The activities listed have progressed slowly or did not start largely because

- The SSIs were slowly getting settled in the state and were going through a learning curve and a consolidation phase.
- In most cases the SSIs have yet to internalize MNCHN as a core thematic area for operation.
- Not all SSIs were oriented in the beginning to work on policies, especially on MNCHN, and required direction or agreement from government to proceed.

Results in Capacity Building and Institutional Strengthening

The indicators for tracking progress in CB/IS were not developed as deliverables but rather as measures for monitoring institutional commitment, leadership, and technical capacity; organizational sustainability; and diversification of resources for MNCHN. Therefore, no targets

are assigned. Progress is to be measured by comparing the performance of each SSI in these areas year to year, e.g., performance in Year 2 will serve as a baseline for subsequent years.

The 10th Quarterly Progress Report on capacity CB/IS shows mixed results. Many activities are proceeding as planned, but others (see Table 8) require further support.

TABLE 8. CB/IS AREAS NEEDING FURTHER SUPPORT

Planned Activity	Performance
10. Percentage increase of pre- and post-tests among participants of MCH-STAR-supported capacity strengthening workshops	Not yet started; proposal workshop did not include a pre-/post- test.
11. Changes in corporate mission, policies, strategies, systems, or procedures that indicate commitment to MNCHN	Only IndiaCLEN has done this.
12. The organization uses cost analysis for planning and developing proposals related to MNCHN areas	Three SSIs were targeted; none has done so.,
13. Number of times SSIs responded to the government's request for assistance, call for proposals, and bids on MNCHN issues	The target was 2 per SSI, CINI has done 4. Nothing is reported for the other SSIs.
14. Number of specific instances where technical assistance resulted in MNCHN policy or program change	None reported
15. Number of SSIs benefitting from a consultant/expert database to respond to the request for TA on MNCHN	None
16. Number of policy briefs on MNCHN issues produced during the reporting period by each SSI	1 cookstove consultation carried out, scope to improve.
17. Number of white papers on MNCHN issues produced during the reporting period by each SSI	Only IndiaCLEN, with one paper, has met the target.
18. Number of policy analyses and advocacy activities implemented by SSI leading to MNCHN policy or program change	None reported

Results in MCH Task Order Management

According to the 10th Quarterly Monitoring Report, MCH task order management activities were progressing well; some were even ahead of schedule. Most of the USAID MCH indicators were on track or had been delivered.

The only indicator under "needs improvement" in the 10th Quarterly Report (p. 26) was

- Number of improvements to laws, policies, regulations, or guidelines related to improved access to and use of health services drafted with USG support.

The reports in progress in those calendar quarters were all in JH: (i) untied funds guidelines; (ii) FRU accreditation guidelines; and (iii) improved guidelines for JSY. Reports being reviewed were in UP: (i) ASHA periodic training guidelines; and (ii) wheezing training guidelines.

Work on laws, policies, regulations, and guidelines is time-consuming and requires support from government officials at every point. The delays in meeting the indicators on policy development for technical areas and task order management are all related to the time-consuming process of

working within bureaucratic structures. This process is difficult for large donors and bilateral funding agencies, let alone for small indigenous NGOs. Given the length of the start-up period, the planned deadline for this type of deliverable may have been overly ambitious.

Results in Cross-Cutting Issues: Gender and Equity

Gender and equity are the source of many of the problems in meeting the MDGs and MNCHN goals and objectives. As in every USAID project, gender and equity issues were integrated into the task order of the MCH-STAR project: the higher child mortality rates in girls, the sharp decline in the child sex ratio for girls (i.e., 35 points between 1981 and 2001 censuses), and the lack of women's autonomy to make decisions about the health and well-being of their families and selves are noted. In the analysis of the causes of persistently elevated MMRs, low birth weight, undernutrition, and stunting, factors associated with inequity (caste, class, religion, age, geographical location, economic status, etc.) are all intensified by the single issue of gender inequity.

Activities to Promote Gender Equity

Within the MCH-STAR initiative, CEDPA, PFI, and CINI have a history of working to reduce gender and other inequities. In the MCH-STAR project, equity is reviewed through the collection and use of Scheduled Caste / Scheduled Tribe (SC/ST) data in all research studies.

The MCH-STAR initiative has promoted gender equity balance in a variety of ways:

- The protocol for writing proposals includes an item called Gender Considerations.
- Four studies were commissioned in UP, to (i) analyze gender aspects of mortality and nutritional status among children; (ii) health-care-seeking behavior for children under 5; (iii) reproductive and child health (RCH) service utilization; and (iv) violence and its effects on RCH service utilization.
- Findings from these studies were presented and action plans made at a regional advocacy workshop on gender and RCH was organized in UP in June 2009. Advocacy issues and audiences were also identified. As a result, MCH-STAR was able to demonstrate to its SSIs how to analyze secondary data and use it to identify advocacy issues and generate program recommendations. Yet challenges remain. Despite substantive hand-holding to SIFPSA on its gender advocacy activity, it did not yield the anticipated outcomes because SIFPSA changed leaders, and its limited human resources were unable to internalize the larger picture to influence policy. Neither SIFPSA as the SSI in UP nor MCH-STAR has pursued the gender and health agenda in UP.

QUALITY FROM A WOMAN'S PERSPECTIVE

Technical Quality of Care: As far as possible noninvasive; woman-controlled rather than provider-controlled; not over-medicalised, i.e., while alleviating symptoms also addressing social and psychological causes of the health condition

Client–provider relationship: Respecting all women—single, widowed, or married; demonstrating care and compassion; believing what women say; in couple counseling, responding in a way that will empower the woman and sensitize the man; maintaining strict confidentiality; ensuring that another woman is present if the health care provider is a man

Administrative: Enabling easy physical access to services, e.g., placing Ob-Gyn department on ground floor; providing understandable signage; exhibiting clearly a patient's/ citizen's charter of rights; ensuring privacy through provision of curtains, placement of windows and doors;, ensuring toilets for women with waste bins and running water in health care facilities; ensuring provision of good quality and affordable food for patients and attendants; enabling easy financial access.

Report of RCH II Midterm Review (2008)

- The MCH-STAR COP made a presentation to state medical officers on "Gender Issues in Ensuring Equity for Health Care" at IIPH Gurgaon on February 9, 2010, at a stand-alone session on gender and health that elicited an immediate positive response.

- A *Manual for Integrating Gender into Reproductive Health and HIV Programmes* has been sent to all SSIs to guide their gender mainstreaming efforts. While it remains unclear whether a gender analysis of the range of technical issues related to MNCHN has been done, chapter 5 of this manual, "A Process for Gender Integration Throughout the Programme Cycle," offers excellent guidance on how such an analysis can be done. Policy analysis by the SSIs should use the Gender Integration Continuum.[25]

Tools, Materials, and Gender Research Studies

Gender analysis of tools and publications has the potential to throw light on power relations and decision making within families and communities. The review of materials produced reveals those elements of the programs and publications where gender analysis has been incorporated and exposes many areas where integration of a gender perspective is incomplete or lacking. For example, a review of the gender research studies (Annex D) notes that the findings replicate those of many other published studies. Though this could reinforce those other studies, it could also limit the power and attention that a new voice with new offerings would generate. Still, four research studies on gender and health undertaken in a state where gender inequities are so pronounced is an excellent start that can be augmented by continued work on this topic. Further analysis may reveal previously unknown causal factors.

MNCHN as a Rights Issue

The NRHM has a strong foundation in human rights, including the right to health care. The GoI has drafted the National Public Health Bill, which aims to make the right to health care justiciable. While to some members in the MCH-STAR initiative, the rights violations in all these health issues are crystal clear, others have not taken a rights perspective. To strengthen TA to state and national health departments and align it with GoI initiatives, SSIs and MCH-STAR partners must build their understanding of the rights dimensions of MNCHN.

The focus of MCH-STAR on MNCHN affords it an opportunity to work with each SSI in defining gender bias factors in the quality of care of women and girls that have such a major impact on their health and nutrition. This may be one of the most important causes of the MNCHN problem in India and other countries of South and Southeast Asia. MCH-STAR is in a prime position to stimulate discussions among the SSIs on this substantive issue.

CHALLENGES AND LESSONS LEARNED BY THE PARTICIPANTS

MCH-STAR is a unique initiative in India and in interviews participants cited a number of lessons learned and challenges in implementation. Among them are the following:

- **Facilitating capacity building and process change for quality outputs of SSIs often slows completion of deliverables:** In the initial CB phases there is a trade-off between internalization of QA processes and producing outputs. This affects timely completion of projects by SSIs wishing to produce high-quality products. By streamlining systems and project management procedures and assigning highly qualified personnel at the outset to mentor project development, particularly at the state level, the SSIs would find it easier to learn new approaches *and* produce quality deliverables on time. The alternative

[25] The Gender Integration Continuum categorizes approaches by how they treat gender norms and inequities in design, implementation, and evaluation of programs and policies.

would be to reduce the expectation of deliverables until capacity has been built, but this may go against the learning by doing philosophy.

- **The emphasis should be on building capacity in SSIs as institutions rather than in individuals:** In the first two years inputs for capacity building in SSIs through MCH-STAR workshops and trainings were restricted to designated SSI staff working on the project. When these trained personnel moved to other projects or changed employment, the potential for institutional learning was curtailed. If sustainable institutional development is to be realized, efforts are needed, in conjunction with the SSIs, to identify ways to train more SSI staff.

- **Ensuring CEO buy-ins for institutional change in SSIs is important for sustained participation**. Long-term structural changes and process improvements for better SSI governance and management require stewardship from top management. In the first two years of the project, interactions with CEOs were limited due to competing priorities, distance, and availability. Use of a pre-award survey to review financial and administrative policies, systems, procedures and practices and to inform the CEO, board members, and senior management of the results worked well with IndiaCLEN in Year 2 and led to more solid plans and activities. This approach should be considered for all SSIs.

- **MCH-STAR needs to facilitate engagement with state and national governments:** In the first two years of the project, SSIs tried to establish themselves with the national and UP and JH state governments largely on the basis of their own reputations and relationships. MOUs with government agencies were not enough. Although this process was intended to build SSI confidence and skills in engaging with government, the process was inefficient and the results not always adequate. Consequently, SSIs have not progressed uniformly in initiating events for setting state priorities. The SSIs felt that MCH-STAR should take a more proactive role at the state level in engaging the government, at least until a transition could take place without inhibiting output.

- **Focus on district level implementation support is required:** Engagement at the state level for policy- and research-oriented assignments was often slowed by transfers of government officials. Moreover, state government leaders have expressed a need for TA in the districts, rather than engagement at the state level only.

- **A business plan is important:** Representatives of one SSI noted that they had learned the meaning and importance of having a good business plan—a concept they felt was missing in the nonprofit community. Recognition of the usefulness of the business plan precipitated requests for more input on administrative and finance systems to enable the SSIs to be more efficient and responsive. This is certainly congruent with other CB/IS elements, and although not presently part of the MCH-STAR mandate should be considered as an input to all SSIs in the remaining years of the project.

- **Advocacy can be as effective as activism:** Some SSIs appreciated learning ways to have an impact on government systems and programs through advocacy rather than relying solely on activism.

- **Competition is important:** MCH-STAR realized that since four of the five SSIs were preselected, they consider acceptance and funding of their proposals to be guaranteed. This may reduce their motivation to work long hours on drafting proposals. Strategies are needed to introduce healthy competition into the system to improve output and to generate a more realistic atmosphere in the project.

V. ANALYSIS OF GAPS

All SSIs were provided with standardized inputs in the form of workshops or training. CB/IS were based on assessments made for each of them when the program began. Based on the data available for the project, similar importance was given to TA, research, evaluations and other CB/IS elements. Figures 2 and 3 illustrate how the grant money was used.

The significant allocations to R&E reflect the preferences of the more research-based organizations like IndiaCLEN and PHFI. A review of proposals suggests, however, that even within this category, research is valued above program evaluation. However, TA should be given more importance by all SSIs because substate government functionaries express high demand for it.

Figure 2. Use of Grants by SSI and Discipline

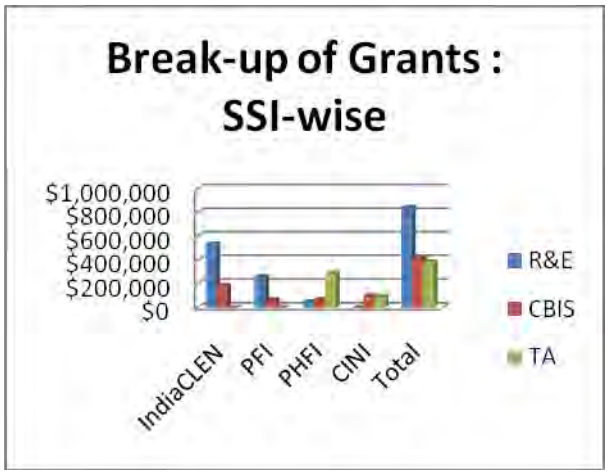
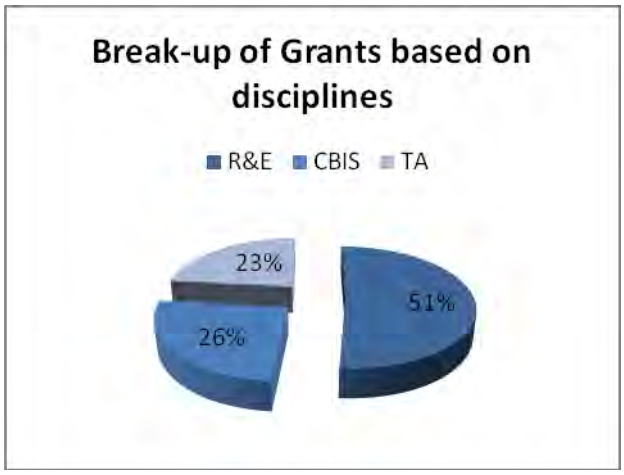


Figure 3. Use of Total Grants by Discipline



DEMAND FOR TA DURING THE PROGRAM LIFECYCLE

The project has attempted to design CB/IS processes to benefit the SSIs. However, based on interviews with representatives of national and state governments, donors and SSIs, the SSIs did not focus clearly for future assignments on development-partner-financed projects with national and state governments. Based on the various requirements of development projects, different SSIs could position themselves at different stages of the project cycle (see the diagram in Annex E) based on their strengths and preferences. A sound mechanism to integrate the SSIs with various donor networks seems necessary and MCH-STAR as well as USAID could provide the necessary platform. It also appears that creating a team of SSIs adaptable to issue-based consortiums, rather than each standing alone, might be a better approach for penetrating the donor-driven project market for consultancies and studies,.

The one area in which SSIs consistently request support is for upgrading finance and administrative systems to enable them to be more efficient and responsive. This is imperative if they are to corner a certain percentage of donor-driven project work, which often requires reporting on institutional and financial parameters. At present this is not within the MCH-STAR mandate. MCH-STAR has, however, worked with the SSIs to identify finance and administrative gaps. It would be very useful if MCH-STAR could respond to these needs in a more comprehensive way to increase SSI chances of qualifying for assignments in projects financed by big donors like the World Bank, DFID, and the ADB.

AREAS STILL REQUIRING SUPPORT

Responsive TA is a function of the quality of personnel in the agency providing it, an appreciation of the needs of the country, and demonstrated cutting-edge knowledge. TA from donors is usually supplied by outside consultants MCH-STAR aims to change that by building these capabilities in indigenous institutions. Its challenge is to match its institutional CB to the needs of its clients. Interviews with state and national government officials, in addition to representatives of the development partner community, indicate that there is an unmet demand for the following kinds of TA:

- *Implementation*: The government values more highly TA on implementation at the district level and below, rather than policy-related support in national or state capitals. This would mean, for example, TA to hospital administrators, supervisors, and primary health center staff through evidence-based support, planning exercises, guidelines, manuals, and other inputs that help improve day-to-day activities related to problems faced at the district level.
- *Evaluations*: Independent third-party evaluations of government or donor-financed programs are increasingly gaining ground in India. Most of the SSIs are well-suited to cater to this demand if they are properly trained and oriented.
- *Other areas*: These are summarized in Table in Annex F.

CAPACITY BUILDING AND INSTITUTIONAL STRENGTHENING

CB/IS are the foundation for development of institutions and viewed by MCH-STAR from its inception as a core activity to be developed with SSIs and government agencies (e.g., MOHFW, the government of JH [GoJH], GoUP, MOWCD/ICDS, NHSRC, and NIHFW).[26] The capacity of SSIs was assessed "to analyze current capacities against desired future capacities and to understand capacity assets and needs of these organizations." The scope of the assessment was limited to MNCHN issues related to R&E, P&A, and TA.

Specifically, CB was thought to be needed to enhance evidence-based expertise in MNCHN and skills in technical areas of R&E, P&A and TA, while IS was geared toward developing SSI institutional policies, systems, tools, resources and practice. Early on, MCH-STAR initiated the process by assessing all SSIs except SIPFSA using a very comprehensive quantitative instrument with some leeway for explaining responses. MCH-STAR senior technical staff conducted the assessments with SSI CEOs and key personnel. Data was analyzed by MCH-STAR staff, findings reviewed with each SSI, and reports finalized. During a retreat each SSI drafted a CB/IS plan. This process led to a call for proposals and by July/August all SSIs had submitted proposals and were awarded grants to address their MNCHN needs.

Observations

To probe further to understand the process and the inputs into it, the MTR team reviewed the Detailed Implementation Plan for Years 1 and 2 to reflect on MCH-STAR's own vision of how CB/IS would be operationalized; the Capacity Building Assessment and Reassessment Tools; and the Capacity Assessment and Reassessment Reports of two SSIs.

The CB/IS concept is critical to ensuring the sustainability of Indian institutions, governmental and nongovernmental. The parts of the dynamic strategy MCH-STAR proposed were not implemented equally. For example, the model did not include government institutions. Also, the idea of focusing CB/IS on building expertise and knowledge of the content area of MNCHN was part of program planning and operations but not activated in the first half of the project.

[26] MCH-STAR Detailed Implementation Plan for Year 1 and 2, October 30, 2008.

Revisiting CB theory and practice based on MCH-STAR's experience in the first few years will be critical to leveraging the strengths of MCH-STAR and the SSIs. Identifying the best CB/IS global models and practices is vital. For example, one CB model that seems to match MCH-STAR's aspirations rests on three pillars: knowledge generation, knowledge dissemination, and informed action.[27] Each pillar has unique CB needs yet each also depends on the support of the others to be sustainable and self-replicating. CB in support of all three pillars will be most effective in cases where strategic partnerships, based on optimizing complementary strengths between partners, are developed. An essential premise in the initial step of knowledge generation is that institutions and individuals need to have an in-depth knowledge of the latest state of the art research that would lead to more insightful observation of research gaps and opportunities for planning better projects.

The CB assessment tools are comprehensive. They can generate considerable knowledge and insight into multiple components of CB/IS, but they have the following limitations:

- The methodology for assessing capacity is not explained. Over the two years, the team members interviewed may have changed. The Year 1 report does not specify who was interviewed and who administered the questionnaire, but the Year 2 report identifies the persons interviewed. It is difficult to know whether it was the same or different persons and therefore the assessment of any temporal changes may not be valid and reliable.
- The response categories for the first assessment were Yes/No; the response categories for the reassessment are on a scale of 0–4. If the instruments were implemented this way, comparisons would not be valid.
- In data analysis and presentation, MCH-STAR reports do not incorporate most of the data from the interview instruments. Individual components are subsumed into broad categories that have been converted to scores that are difficult to interpret.
- There is a range of perception-style qualitative questions and more quantitative inquiries, such as whether the SSI has a budget for research, percent of funds from different sources and types of activities, and lists of articles and reports written three years before MCH-STAR and now. Both categories should be analyzed to assess the institutional changes.
- The methods used to calculate scores or percentages are not given.

SSI Assessment and Reassessment Reports and CB/IS Plans

- There is no evidence that MCH-STAR used previous institutional assessments to gain insight into why the recommendations, which still have relevance, have not been implemented. A critical understanding of barriers to progress could perhaps lead to a focus on implementation challenges rather than continued reassessments. Since there seems to be a history of little response to recommendations, it will be necessary to go beyond strategic planning and support to provide incentives and firm expectations for action.
- Scores for both the institutional and the R&E components decreased from the first to the second assessments. It was explained that in Year 1 respondents were generous in their scoring and in Year 2 they became more realistic. This suggests that the reliability of the instruments or the way they were used is problematic.

[27] START (the [global change] System for Analysis, Research and Training and UNESCO. August, 2009 Issue Paper on Capacity-building for Adaptation to Climate Change Presented to the World Climate Conference-3.

- The CB assessment data have sometimes shown that the perceptions of SSI members do not correspond to MCH-STAR report findings. This inconsistency should be investigated and action taken to better understand CB/IS processes and make improvements.
- The "shoulds" and the lack of progress need to be addressed in order to be proactive in helping SSIs move toward sustainability.
- Comparing the conclusions and recommendations in the MCH-STAR initial assessments with the CB/IS grant demonstrates good alignment between what were identified as institutional priorities and the strategic decisions made with the grant.

VI. FINDINGS AND RECOMMENDATIONS

While appreciating MCH-STAR's accomplishments in the first half of this project, the MTR team identified 12 categories of recommendations and related actions. The team felt the recommended changes would significantly improve ultimate project results. Changing practices in these areas would require deep changes in project management and practices, but the changes could well guarantee more, and more visible, success. The MCH-STAR project is philosophically and programmatically compatible with the new GHI and could well be in the vanguard in adopting practices advocated in that initiative.

The recommendations that respond to the findings are interconnected. They include measures to increase competition; increase productivity; streamline the proposal process; work better within the initiative and with SSIs and national, state, and district governments; expand the reach of the MCH-STAR initiative, and keep gender equity issues at the forefront of this project.

MEASURE SIGNIFICANT RESULTS

Findings

The concept of the MCH-STAR initiative was hailed without exception by all interviewees as being an innovative and exciting approach that modernized capacity development and offered a new way for a major donor to respond to the needs of a rapidly developing nation. Stakeholders reported what MCH-STAR has actually done in just two and a half years in a highly complicated environment:

- Manage two multipartner teams (the MCH-STAR collaborators—Cardno/EMG, BU, and CEDPA—and the five SSIs) with partners that each have a distinct identity in the U.S. and in India.
- Overcome time-consuming and preoccupying difficulties with an urban health project that faltered significantly in the second year.
- Established a trusted and mutually respectful relationship with an exacting donor, USAID .
- Sustained the interest of state and national governments.

Among other achievements, the project has led to changes in the philosophy and geographic focus of PFI and contributed to its confidence in applying for and winning a large competitive grant; it has helped to stabilize a major entity, IndiaCLEN, by working with it to draft a strategic plan that some believe has revived the organization; it brought global recognition and a modest degree of financial support to PHFI in its early stages, before its meteoric rise to international recognition, and catalyzed its entry into grounded research in the FRU project; and it has been embraced for its professionalization of organizational inputs to a grassroots organization, and contributed to its growing prominence on the state and national scene. It has also introduced these organizations to each other and offered them each a place on the greater global development stage.

Despite these achievements, however, the MTR team encountered an equally widespread disappointment at MCH-STAR's lack of significant achievements to date. This is in part because expectations were unrealistically high at the outset: too much was expected to change too quickly, given how innovative this project is. But the result is the same: the project has kept government interest but has yet to achieve full impact on government policy.

However, the project has not been without impact on some policies. The GoJH now incorporates labor room registrars in its FRUs. PFI undertook to evaluate the NRHM BCC

campaign through a subcontract with AC Neilson while the campaign was going on. PFI made a presentation of preliminary findings, shared with USAID and then the MOHFW, to the Joint Secretary of Health, technical officers, USAID representatives, MCH-STAR, Vistaar, and ITAP that appears to have influenced the Information Education and Communication strategy to focus more on TV than radio because there is wider access to and use of TV for entertainment and information delivery. These encouraging examples demonstrate how recommendations supported by evidence can lead to change.

MCH-STAR has had only modest results in terms of project briefs (2), white papers (1), reports (3), and a series of papers on gender issues (4). It has made progress in achieving its process indicators, though it has yet to yield significant results in terms of MNCHN goals and objectives. As noted, of the 59 indicators, only 13 are either moving slowly or have not started. This is a genuine achievement—one that can be enhanced by adding significant outcome indicators to the list.

Project staff interviewed were able to measure change in process indicators but were less clear about how to measure effect or attribution. Rigorous program evaluation could establish a new momentum in promoting evidence-based decision-making and setting standards for objective review of whether programs should be scaled up. It was also noted that project managers are not consistently using the data collected in making decisions.

A number of MTR findings seem to be linked:

1. Governments buy in to small-scale projects that are not yet having an impact on government policies.
2. There is no unifying theme that would allow synergy rather than fragmentation of SSI inputs. Treating each area of activity—CB/IS, R&E, P&A, and TA—independently leads to small projects with limited potential to contribute to the larger MNCHN dialogue in the country or in individual states (see Measuring Significant Results above).
3. Paradoxically, some SSIs feel that MNCHN is too large a theme to allow for a significant effect.
4. There is no mention of new developments in MNCHN content as being germane to the process-oriented inputs from MCH-STAR, which exacerbates the beliefs of some participants that MCH-STAR input could be used for any development sector and that MNCHN is secondary.

Few of the key informants were able to identify barriers to implementation of interventions that could have a major impact on MNCHN indices.

Recommended Actions [28]

Before other recommendations can be considered, the MTR team identified a critical gap in the ability of the project to measure change and to attribute change to inputs as well as a weakness in the definition of what results it would consider significant. The team therefore recommends the following:

1. In consultation with the SSIs, MCH-STAR should define broad outcome indicators that measure improvements in MNCHN (per the EMG Task Order) to demonstrate how the

[28] In what follows, recommendations in **bold** are prioritized as essential and immediate and should be implemented during the current project. Other recommendations are important but might be more relevant if the life of the project is extended.

process indicators now being used will lead to eventual impact on the health and nutrition of women and children.[29] Changes in outcome indicators may not be measurable in the short time remaining, but they would align MCH-STAR and SSI activities to MNCHN priorities.

2. In the same consultative way, SSIs and MCH-STAR should revise and reduce the number of indicators to a manageable number that would allow for frequent reporting and utilization by CEOs making decisions on program direction and implementation.

INTRODUCE HEALTHY COMPETITION

Findings

The choice of four of the five SSIs through a noncompetitive process and the decision to accept all proposals submitted for funding as long as they were generated with government buy-in have led to a degree of complacency in the SSIs. The certainty of funding has tended to devalue the MCH-STAR technical input and engendered in participants annoyance rather than appreciation for the proposal vetting process (see Improving the Proposal Process below). High-level technical input to documents in order to improve their quality is viewed as unnecessary when funding is certain and leads to a "just show me the money" attitude of entitlement. Even proposals suggested by government should be subjected to a competitive funding process if they are being submitted to an outside donor. The capacities of individuals and institutions as a whole will be strengthened so that they can efficiently and effectively compete for grants to answer MNCHN requests from state and national governments and other clients.

Recommended Actions

3. Increase the value of individual project grants being awarded through the MCH-STAR process to emphasize the importance of each project and to encourage proposals that take on broader problems of greater significance. To do this, for the next 2.5 years (i) increase the amount of MCH-STAR budget for funding proposals to 40% (or some proportion mutually agreed by all partners); (ii) fund a smaller number (e.g., 3-4) of major project proposals rather than a large number of smaller projects; and (iii) encourage collaborative project proposals from SSIs.

4. Continue to have SSIs work with their government counterparts on concept papers and proposals that reflect the interest of the government and its commitment to implement the results once completed, but agree with all parties that not all concept papers will move to the proposal stage, and not all proposals will be funded. Give funding priority to joint proposals related to issues of significance identified by the government.

TAKE MEASURES TO INCREASE PRODUCTIVITY

Findings

Contributing to the sense of disappointment in the project is the notably low level of output. As mentioned a number of reasons have been given for this: the time it took SSIs to gradually develop capacity; delays in the completion of projects, leaving SSIs at the end of the project year still analyzing data and not ready to publish the findings; and a possible slowdown in technical work due to participation in CB initiatives like attending workshops, writing proposals in a new way, and allied tasks. Though accurate, these reasons do not fully explain the problem; nor do

[29] As an example, in the FRU project, change the goal from process, "to build capacity of government functionaries to outcome, e.g., "reduce adverse delivery events for women and newborns." This goal could also organize the inputs from other SSI proposals (e.g., the JSY study).

they offer ways to overcome it. Not mentioned is the inordinately long and discouraging process of proposal generation and funding (see Proposal Process below) that diluted staff and government interest in the process; and the lack of full institutional participation in the CB workshops and activities, meaning that a smaller group were assigned to draft and follow up on project proposals.

The relatively low level of funding for projects also discouraged participation and reduced productivity, particularly as the investment in time and workload seemed disproportionate to the funding for the project itself. Fixed obligation grants to the SSIs had a ceiling of $250,000 and many were in the range of $60,000-$70,000. SSIs often saw the rigorous procedures required to access these small amounts as having an adverse cost-benefit ratio. Moreover, award of the grants was often delayed for various reasons (quality of proposals, procedural delays related to approval, multiple iterations, etc.). Often, the time available for the SSIs to deliver the outputs was not sufficient, since it is mandatory to use the grants within the MCH-STAR financial year.

Recommended Actions

Various steps can be taken to increase productivity, some of them mentioned in the recommendations above, particularly those on competition, and changing the significance of indicators. The MTR team also recommends the following:

5. Increase the incentives for productivity by linking funding to the achievement of clear and measurable results-based indicators.

6. Allow multiyear funding of grants to give SSIs time to produce more complex and more strategic outputs. With the use of results-oriented grants this should be easier to implement.

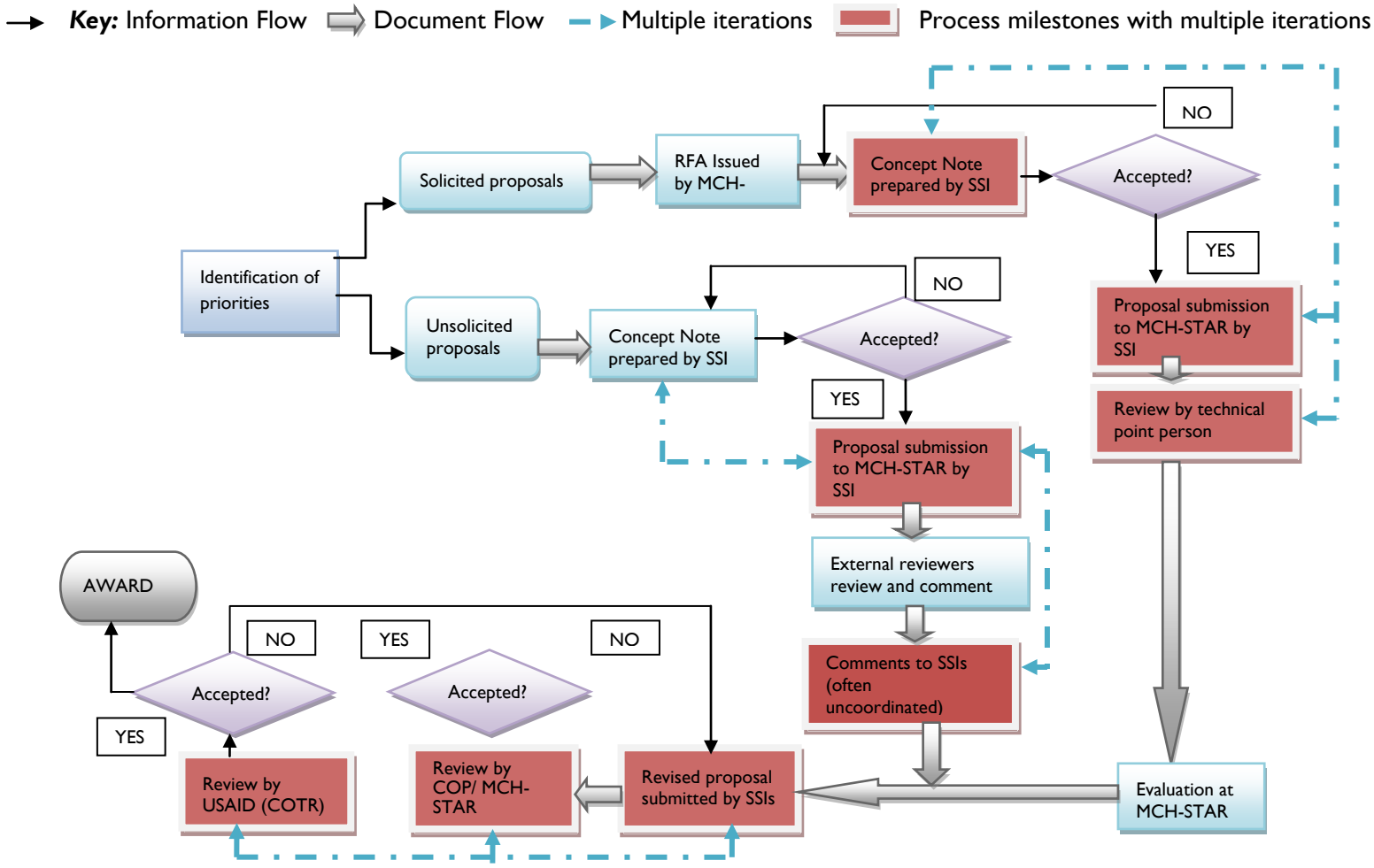
7. Intensify SSI-specific mentoring to improve MCH-STAR communication with and troubleshooting for the SSI at the national and state level and to encourage SSIs to implement the action plans they drafted as a result of the CB/IS assessments initiated by MCH-STAR. The causes of slow production are different for each SSI, and individual attention from the MCH-STAR technical staff may be necessary to help them solve their problems. This would require both the presence of MCH-STAR representatives in the states and more frequent exchanges with Delhi-based institutions. However, it is ultimately the responsibility of the individual SSIs to build up their internal management, governance, financial and human resource systems and policies so that they can function optimally in the new Indian and global health environment to create conditions for having more impact on improving MNCHN. Quarterly progress meetings should be more effectively used for finding solutions to problems identified.

STREAMLINE THE PROPOSAL APPROVAL PROCESS

Finding

The process MCH-STAR currently uses for approving concept notes and proposals is uniformly perceived as tedious, involving multiple iterations of comments and reviews. It generates frustration and decreases productivity. This is more pronounced for unsolicited proposals, where sending comments from external reviewers to SSIs is often uncoordinated, requiring increased time and effort for multiple revisions. Since unsolicited and often solicited proposals are not open to competition, such reviews are inevitable. Figure 4 illustrates the redundancies and bottlenecks in the present system. Note that there are eight steps (highlighted in red) that represent major inefficiencies in the process where frequent iterations, and therefore redundancies, occur.

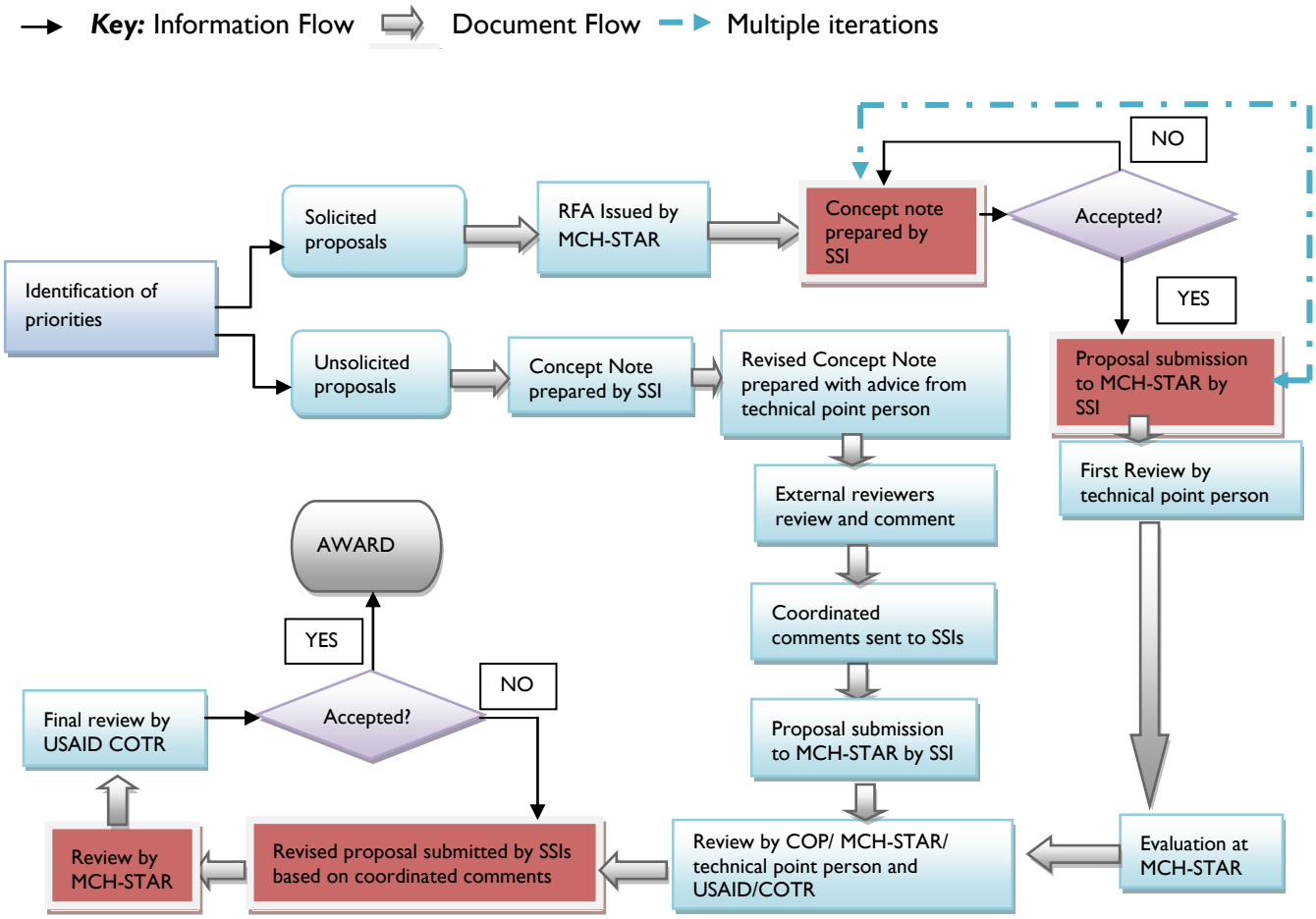
Figure 4. Current Cycle for Approval of SSI Proposals



Although a rigorous process assures quality, it was felt that the process could be made more reasonable in order to (i) reduce multiple iterations; (ii) coordinate review comments to reduce multiple revisions; (iii) give the COP of MCH-STAR (or the BU and CEDPA, depending on the proposal) final authority to approve projects; (iv) take USAID staff out of the individual proposal approval loop, leaving them to serve as advisors and for final approval only; and (v) ensuring that a QA process is still in place.

Figure 5 suggests a revised process with fewer stages, reducing iterations from eight to four. The steps are reduced by introducing a coordinated joint review involving the MCH-STAR representative, the technical point person, and the USAID COTR before a project is submitted to USAID for final approval.

Figure 5. Proposed Process for Approval of Proposals



Recommended Actions

8. USAID, MCH-STAR, and the SSIs should form a joint working group to (i) do a task analysis using the schematics as a guide; (ii) develop a system that will reduce the turnaround time from proposal to funding to no more than four months; and (iii) set default timeline business process guidelines for each step that will be used to keep the process moving (e.g., no input from an individual or agency by the agreed deadline means tacit approval, with the document moving to the next step).

9. Power should be delegated to the MCH-STAR COP for either all proposal approvals or for a higher funding threshold than the current one.

IDENTIFY AND RESPOND TO SPECIFIC SSI NEEDS

Findings

The goals established in the MCH-STAR program do not uniformly fit into the "arranged marriage" structure brokered for the SSIs. The SSIs have completely different histories both within India and with USAID and although many of their perceived core strengths are complementary, the CB/IS required to develop them into sustainable premier institutions is very different. The original capacity assessments, which were intended to provide the "needs foundation" for assistance from MCH-STAR, were conceived by some as being more assessments of resources than genuine analyses of needs. The results of the reassessments a year later were ambiguous, showing less capacity in many categories in some organizations. As a result, the project was unable to adapt training, workshops, and other assistance to changing SSI needs. Some staff felt that the standardized inputs provided in workshops and the rigid rules of the MCH-STAR project inhibited learning because the workshops were not field-oriented or customized to the Indian context.

Recommended Actions

10. After a dialogue with specific SSIs, graduate from the program those that have demonstrated capacity to generate funds for MNCHN on their own or to work more collaboratively with partner institutions like CEDPA to attract more non-USAID funding.

11. Implement activities that are responsive to the requests and identified needs of each SSIs and support participation in CB courses and workshops case by case, using the expertise of Indian institutions, including the SSIs, to plan and execute workshops and training programs. Where necessary, expand the mandate of MCH-STAR to cover topics (e.g., finance and business processes) repeatedly requested by the SSIs.

MODIFY WAYS TO SECURE GOVERNMENT BUY-IN

Findings

The process for establishing government buy-in has been taken too literally. The requirement for written government approval is inefficient and causes long delays. The government hierarchy centralizes decision-making authority, and the high turnover in senior posts creates a vacuum of leadership and direction and may invalidate the concept of what it means to address government needs. This is a difficult climate for MCH-STAR to operate in.

Recommended Action

12. Formulate strategies to establish longer-term agreements with government counterparts to ensure that priorities are set based on an information-based dialogue with the government.

RESOLVE PROBLEMS WITHIN THE PARTNERSHIP

Findings

MCH-STAR's three partners—Cardno EMG, BU, and CEDPA—have not yet found an optimal way of working together. Factors such as lack of a common vision for the program, distance, lack of sustained involvement and follow-through of senior staff, irregular communication, and procedural bottlenecks within MCH-STAR and USAID have all contributed to disjointed and at

times ad hoc implementation of the program. This has contributed to a climate of disengagement, as some senior staff members feel incapable of realizing the full potential of their input to the project, and to a reduced capacity for problem-solving, as members of the coalition do not seem empowered by its structure to act independently to overcome barriers that confront them.

Having been engaged in this type of project before, BU has an effective approach to providing TA and building research skills in countries around the world, but MCH-STAR leadership has not sufficiently tapped into its experience. For example, BU had to convince MCH-STAR to set deadlines and budgets for the research projects. Research proposals were written without knowing what the budget limits would be, creating a serious disconnect in terms of what could realistically be accomplished. Considering the increasing technical focus the GoI may demand from the SSIs, as well as improvements in the stature of SSIs due to inputs from and exposure through MCH-STAR, the roles of BU and CEDPA need to be increased in terms of management and budgeting freedom as well as their providing thematic leadership.

The MCH-STAR partners said that they "need a voice" on the MCH-STAR team and found themselves "reactive vs. proactive" in getting things done. The resource allocations established solely by Cardno/EMG are not based on the technical needs of programs and grants. This has led to a deep frustration and tension about the lack of transparency about how the money is being spent. All financial activities are managed by Cardno/EMG, to the extent that even taking a taxi across Delhi for a meeting has to be reimbursed by the lead contractor.

The control exercised by the lead and to some extent by USAID was a consistent theme in discussions with partners. For example, everyone was frustrated with the requirement that the partners were not allowed to have direct communication with USAID. There was also perceived interference with the approval of partner staff positions that resulted in delays in getting people on board and trained adequately to contribute to the project. More flexibility, such as allowing CEDPA to train its new staff in its Delhi office, would create efficiencies in accelerating the development of MCH-STAR staff competencies to support their roles in strengthening the SSIs in a particular technical domain.

Recommended Actions

13. The three partner organizations need to address these issues in an open forum with an external facilitator. The MTR team encourages the partners to use the findings of its discussions with project staff as a useful starting point to zero in on broader issues: more equal sharing and decision making about resource use, procedural questions, and ways to move forward more effectively in the next phase of the project. Communication between the partners could be improved by creating a platform for regular meetings, trouble-shooting/problem solving, and collective agenda-setting.

WORK WITH NATIONAL GOVERNMENT COUNTERPARTS IN THE DISTRICTS

Findings

At first, MCH-STAR made efforts to work with the NHSRC because it offered a new government model of TA with goals and objectives similar to those of MCH-STAR. However, as both programs were new and intent on establishing their unique identities, attempts at collaboration were premature. MCH-STAR focused on developing the capacity of private NGOs (the SSIs), which would then transfer technical support to government offices. MCH-STAR's commitment to working with NGOs meant there was no mandate to engage a GoI agency (NIHFW) in capacity development.

Now, at the midpoint of the project, both MCH-STAR and NHSRC have established their capabilities and identities and are poised to enter into a cooperative work mode that would be of benefit to all. NHSRC is concerned with the functioning of health systems at the district level. It has expressed an interest in engaging MCH-STAR to collaborate in providing TA and CB to improve the ability of district governments to deliver health care for MNCHN. Extending its work to government organizations could help make MCH-STAR project results more sustainable.

Recommended Actions

14. Work with NHSRC and multiple SSIs at the district level in JH and UP to do an analysis of bottlenecks that are preventing MNCHN objectives from being achieved. Examine these barriers at all levels of the causal pathway: proximate, underlying, and basic. Choose proposal priorities in conjunction with district governments that together have an aggregate and synergistic impact on MNCHN indicators. Develop joint proposals that maximize the comparative advantages of the SSIs around these priorities, and, considered district by district (more than one district will submit a concept paper or proposal) choose the joint proposal that is most competitive. In conjunction with the recommendations above, increase the funding level for this proposal and design and evaluate the entire approach for impact on higher-level indicators.

15. Consider integrating NHSRC and NIHFW into the MCH organizational structure as advisors or facilitators through whom future TA requests could be coordinated, while exploring the interest of other government departments central to MNCHN in becoming SSIs for CB.

INCREASE THE PRESENCE OF MCH-STAR IN THE STATES

Finding

At present, the state engagement of MCH-STAR is limited and sporadic. Partners and state staff of the SSIs expressed a need for a greater MCH-STAR presence in the field (which to them also meant USAID) in order to "open government doors" and coordinate with other development partners. SSI staff expressed an opinion that the "hand holding" that was common in the first year was stopped prematurely and should be resumed in a consistent way until their state programs were established and their reputation within the state was secure. There was acknowledgement of the value of the USAID/MCH-STAR approach to putting the SSI in front and support less conspicuously from behind, and a recognition that any state presence would have to be discreetly balanced to avoid overshadowing the primary role of the SSIs. However, UP and JH have been selected as priority states for USAID assistance because of their poor health indicators and their importance to the world in achievement of the MDGs. They offer distinct, complex, and challenging environments in which to work. The absence of an MCH-STAR state coordinator has inhibited the integration of its work with other USAID-funded entities (e.g., Vistaar). Rules of engagement with government and emphasis on process often result in delays in providing TA. Such "missed opportunities" are especially clear in the context of significant turnover in top government leadership, whose requests for assistance often need a prompt response to avoid risking loss of government ownership after transfers of key officials.

Recommended Actions

16. Establish MCH-STAR offices in UP and JH to develop better relationships with their governments, facilitate the work of SSIs, and create synergy with other USAID-funded MNCHN programs (e.g., Vistaar). This should empower SSI state representatives to make

decisions on local issues with the backing of the state MCH-STAR office, which would be authorized to decide on and facilitate TA at the state level.

REVITALIZE SIFPSA IN UP

Finding

USAID's long-term support of SIPFSA is slated to end in 2012. The GoUP has expressed in SIFPSA being selected as an SSI but has not moved beyond an MOU signed in 2008. It was selected in view of its history and unique positioning. However, SIFPSA was radically different from other SSIs due its constitution, history, and mandate. Although SIFPSA showed interest in IS through the MCH-STAR, had participated in workshops, and had worked on RCH and gender issues for the MCH-STAR program, it did not respond to MCH-STAR workplans. It is not clear whether this was because of miscommunication, different expectations, and SIPFSA's limited response to MCH-STAR's methods/processes of engagement. Frequent changes in leadership at SIFPSA may have contributed significantly to the slow start and consequent stalemate.

SIFPSA was not designed to work like other SSIs to build business from elsewhere and is funded adequately by USAID till March 2012. Many GoI and GoUP officials interviewed, as well as NGOs, credit SIPFSA with introducing many program innovations that the NRHM has adopted, such as translating the success of the community-based distribution workers into the Accredited Social Health Activist (ASHA) program and district action planning. Also, SIFSA trained many of UP's public health workers and current leaders.

The turning point for SIFPSA, as recounted by officials interviewed, was the establishment of NRHM with a mandate to take over some of the district functions that SIPFSA supported. Pre-NRHM, SIFPSA had offices in 40 districts; after, the number was reduced to 17 divisional offices. Not seizing the opportunity to become the official NRHM body to implement the District Program Management Unit (DPMU) has contributed to the current environment of uncertainty about SIFPSA's future. It was expressed that there is a "poor visualization of the role of SIFPSA, with 95% of the people not knowing its vision, objectives and output."

Recommended Action

17. Use the results of a high-level meeting with the current and previous executive directors of SIPFSA, USAID officials and MCH-STAR, with an expert facilitator, to draft a strategic action plan for SIFPSA, as was done successfully with IndiaCLEN, that can serve as a basis for MCH-STAR assistance.[30]

MAXIMIZE THE PARTNERSHIP WITH INDIACLEN AT THE STATE LEVEL

Findings

IndiaCLEN state representatives work as individual members for MCH-STAR. This often requires that they convince the medical institutions with which they are affiliated to contribute the time and effort required for consulting or catering to TA needs in the state. Often they do not have sufficient knowledge of MCH-STAR to perform this service effectively, resulting in drop-out or lack of participation by IndiaCLEN member institutions whose technical services are needed.

[30] This action plan could include ways to transform SIFPSA into a State Health Resource Center, or to re-integrate it with the NHRM.

Recommended Action

18. Delhi-based IndiaCLEN members, with MCH-STAR support, should offer orientation workshops to the state medical institutions to which IndiaCLEN representatives are attached to ensure (a) more effective use of medical college resources; (b) access to logistics support; and (c) better use of the reputation of the medical institutions in providing TA to state governments.

KEEP GENDER AND EQUITY AT THE FOREFRONT OF MCH-STAR

Findings

Gender analysis tells us whether and how socially constructed differences in women's and men's living conditions, roles, status, behavior, and perceptions affect a specific health dimension. It analyzes whether the phenomenon being studied is affected by power relations between men and women or other differences between them. Gender analysis tells whether a condition is due to a biological cause or social differences between women and men. The concept of gendered research in health—that it is more than only or necessarily collecting data for both men and women—needs more attention from the MCH-STAR program. The effect of MCH-STAR's gender integration efforts should be seen over time in the research done by PHFI and IndiaCLEN, and in an increase in the courses on gender and health and gendered research in health offered by individual SSIs. At the moment, the nuances of gender relationships are missing from or found piecemeal in SSI discussions and proposals—for example, that male involvement in RCH should not result in increasing men's control over women, or that campaigns against sex selection should not jeopardize women's access to safe abortion, and so on. The MTR team felt that these needed to be systematized.

Equity is an important concept that needs to be incorporated into the TA provided to the state and national governments, but equity is commonly understood as considering the health needs of SC/ST populations rather than the health needs of all vulnerable groups. State and district health administrators need TA that will enable them to look afresh at the concept of equity in order to understand contextual definitions of "vulnerable" groups as well as to develop HMIS to monitor provision of health services to them

Building on the four gender studies done in UP, an advocacy agenda could be to increase male involvement in women's health by, e.g., educating men on domestic violence issues. The MTR team sees a role for the male multipurpose workers (MPWs) in this area. NRHM funds could be used to reinforce the men's involvement component of the RCH program by creating more positions for MPWs and revising their job descriptions and their training. This is congruent with current thinking in the MOHFW.

Recommended Actions

19. A gender analysis of the range of technical issues related to MNCHN is needed and could be presented by MCH-STAR through a white paper or other position paper. It would define a common understanding of the gender perspective for each MNCHN issue and what gender and equity mean in the MCH-STAR context, and it could be used to move the SSIs beyond gender "considerations" to real gender analysis in their proposal development.

20. Provide state and district health administrators with TA that will enable them to look afresh at the concept of equity in order to understand contextual definitions of

"vulnerable"[31] groups and to develop a suitable HMIS to monitor provision of health services for them. A differential analysis of the health needs of each group and planning of strategies and financial allocations based on this will be necessary. Generation of disaggregated data on social groups, their coverage utilization, and their health outcomes will be necessary for monitoring and planning.

[31] For example, single women, disabled women, mothers of two daughters, and women who are subjected to domestic violence would be vulnerable groups in any context, as would migrants, people working in hazardous occupations like stone crushing (silicosis affected), sugarcane workers (leptospirosis),and so on.

VII. ROADMAP FOR THE NEXT STEPS OF MCH-STAR

The MCH-STAR initiative was forward-looking in developing a conceptual framework that changed the approach to development assistance in India. It not only fits into the new GHI but could prescribe a future direction for USAID programs around the world.

The GHI has a bold and integrated vision for how USAID development assistance in the health sector can tackle problems and improve health outcomes for the most vulnerable groups. Its key principles are to implement a woman- and girl-centered approach; increase impact through strategic coordination and integration; strengthen and leverage multilateral organizations, global health partnerships, and private sector engagement; encourage country ownership and invest in country-led plans; build sustainability through health systems strengthening; improve metrics and M&E; and promote research and innovation.[32] MCH-STAR embodies most of these principles and can retool itself with big ideas to live up to the expectations of USAID, SSIs, and the GoI.

From its findings, the MTR team have suggested recommendations for mid-term correction of MCH-STAR's operational and strategic parameters. A unique project like this has the potential to contribute significantly to strengthening Indian institutions and to facilitating responsive TA to national and state governments through indigenous rather than foreign consultants. To significantly scale up the operations of MCH-STAR, the MTR team believes that an extension of two years (beyond the 2.5 years remaining) and a follow-on second phase of the project are desirable. While the remaining 2.5 years plus the proposed extension can be used for streamlining both the current vision and the project's operative parameters, the extended time would also offer an opportunity to prepare for MCH-STAR Phase II. It is expected that this will maximizes the return on investment and consolidate the gains MCH-STAR has made, paving the way to providing the increase in TA that the GoI is likely to require in a constantly changing global environment.

[32] Implementation of the Global Health Initiative: Consultation Document http://www.usaid.gov/our_work/global_health/home/Publications/docs/ghi_consultation_document.pdf.

ANNEX A. SCOPE OF WORK

MATERNAL CHILD HEALTH SUSTAINABLE TECHNICAL ASSISTANCE AND RESEARCH

(MCH-STAR) Project
Mid-Term Review–Scope of Works

I. BACKGROUND

This document outlines the purpose and plans for the mid-term review of the Maternal and Child Health Sustainable Technical Assistance and Research (MCH-STAR) Project. The MCH-STAR is a five-year (2007-2012) technical assistance project funded by the United States Agency for International Development (USAID). USAID-funded maternal, newborn, and child health and nutrition (MNCHN) technical assistance (TA), which has historically been spread across many projects, was to be coordinated under one management structure, MCH-STAR. The project provides technical leadership and critical technical inputs to public sector programs in India in MNCHN matters through critical technical assistance to programs, policy analysis and advocacy and operations, and applied and policy research. The project contributes to USAID/India's MNCHN objective of "Improved maternal, child, and newborn health and nutrition at scale in India." It also contributes to the Government of India's (GOI) National Rural Health Mission (NRHM), Ministry of Health and Family Welfare's (MOHFW) Reproductive and Child Health (RCH) II Program, Integrated Child Development Services (ICDS) Scheme, and other flagship programs of the GOI, and further is expected to contribute to the achievement of the Millennium Development Goals (MDGs) for nutrition and maternal and child health. A hallmark of MCH-STAR is its focus on capacity building of Indian institutions to be the technical leaders in MNCHN, achieving long-term goals of the institutions providing services after USAID support ends.

The MCH-STAR project is led by Cardno Emerging Markets USA Ltd (formerly Emerging Markets Group [EMG] Limited). The other partners of the consortium are: (i) Boston University (BU) and (ii) The Centre for Development and Population Activities (CEDPA). The project is expected to have a funding level of $13.8 million over its five-year life. The project is being implemented through four Indian institutions, referred as Star Supported Institutions (SSI) further in the document. These are: (i) Public Health Foundation of India (PHFI); (ii) India Clinical Epidemiology Network (IndiaCLEN); (iii) Population Foundation of India (PFI); and (iv) Child in Need Institute (CINI). Although a Memorandum of Understanding has been signed between State Innovations in Family Planning Services Project Agency (SIFPSA) and MCH-STAR, only one activity has been implemented and frequent changes in the Executive Director have made it difficult to have a consistent strategy for capacity strengthening.

Project Objective

The objective of the project is 'sustainable Indian institutions provide technical leadership and critical technical inputs to public and private sector programs in India in MNCHN matters through critical technical assistance to programs, policy analysis and advocacy, operations, and applied and policy research,.

Project Principles

The following principles are guiding the MCH-STAR project in its planning and implementation:

1. Focus on major causes of maternal, neonatal, and childhood diseases and malnutrition, and their proximate determinants.
2. Promote evidence-based programs and policies to address MCHN needs.
3. Address critical gaps and constraints.
4. Focus on poor, vulnerable, and marginalized populations, including applying a gender lens to all activities and analyses.
5. Focus on program and policies that benefit populations with the worst health indicators.
6. Work with programs that will make a difference at scale in India.
7. Build the capacity of Indian institutions that can provide technical leadership in MNCHN and continue to make contributions of the nature of MCH-STAR's in a sustainable fashion in India.
8. Improve the coherence and management of USAID-supported MNCHN technical support activities.
9. Work closely and systematically with other MNCHN activities and partners.

Project Approaches

1. Capacity Building of Indian Institutions: Capacity building is the hallmark of MCH-STAR project. The project focuses intensively on working with the Indian institutions to build their capacity for sustainable technical leadership in MNCHN. The project will develop a detailed capacity building plan for each SSI. The capacity building activities will be closely linked to the provision of TA services. Specifically, the capacity building will focus on skills that will build SSI's capacity to provide high-quality, responsive technical support services in MNCHN, including the range of services provided by the project, conduct applied and policy-relevant research and program evaluations, analyze policies, and implement effective advocacy activities.
2. Technical assistance to programs that work at scale in MNCHN: Technical assistance will be provided to NRHM/RCH II and ICDS-related endeavors in select states and at the national level. Themes for technical assistance include all aspects of maternal, neonatal, and child health and nutrition and may include operational and systems issues that impede the effective implementation of MNCHN activities. The project also coordinates with other USAID-funded activities, i.e., USAID/India-funded urban health projects and the Vistaar project under the guidance of USAID to rationalize provision of technical assistance, avoid overlap or duplication, and maximize synergy among USAID MNCHN activities.
3. Operations, applied and policy-related research, analysis of existing data, and program evaluations: MCH-STAR supports improved programs and policies by providing new information through research, by re-analyzing existing data to answer key questions, and performing high-quality independent evaluations of existing programs. Priorities are established with the GOI, state governments, and other majorstake holders, and the activities are focused on producing high-quality results in a timely manner. MCH-STAR builds capacity of SSIs in generating new and reviewing existing evidence and applying data for improved policies and programs.

4. Policy analyses, advocacy, and white papers: The project mandates a consultative and consensus-building process with key stakeholders, including the state and central government officials, to identify evidence-based priorities and obtain buy-in on the outcomes. MCH-STAR builds capacity of SSIs to review and analyze policies, write white papers and policy briefs, and implement advocacy activities that influence changes in policies and programs.

Besides the above, the project has the following two cross-cutting approaches

1. Facilitation of partnerships and exchange of experience: In order for the project activities to be relevant, the project will never work in isolation. Activity priorities – from research to consultations to advocacy activities – will be established with the GOI and a wide array of important stakeholders in order to establish buy-in and ownership of the end users of information thus produced.

2. Leveraging other resources to achieve large-scale and long-term public health improvements: The GOI national programs are the key focus of the MCH-STAR activities, with an aim of improving programs operating at scale. The project-supported SSIs, as a result of the MCH-STAR support, will develop fundamental institutional and technical strengths and diversity of funding sources – from both public and private sector resources. This approach is strategically planned to apply limited USAID funds on the one hand and on the other hand as an indicator for longer-term sustainability of the SSIs.

Key Indicators and Expected Results

1. Applied, operations, and policy research priorities established for maternal, neonatal, and child health and nutrition in India.

    a. Consensus on research priorities established at the national level for maternal health, neonatal health, child health, maternal nutrition, and infant and child nutrition through a process that involves all stakeholders, including the GOI.

    b. Consensus on research priorities established at the state level in UP and Jharkhand.

    c. Consensus on research priorities are reviewed and updated with all stakeholders annually, including reviewing progress in addressing priorities, at both the national and state levels.

2. Results of key applied, operations, and policy research studies effectively disseminated to influence the national programs and policies.

    a. At least two major applied, operations, and/or policy research studies initiated annually.

    b. At least four small-scale applied or operations research studies initiated annually.

    c. Results documented and disseminated to all stakeholder organizations within four months of the end of field collection of study information.

    d. At least one national and one state consultation on new research findings held annually.

    e. At least one policy change annually to which a major contribution of MCH-STAR research can be attributed.

3. Information and platforms for evidence-based policy development are improved.

    a. At least two policy analyses or white papers produced annually.

b. At least one policy consultation annually addressing one or more MNCHN matters convened or cosponsored by MCH-STAR or its SSIs.

4. Programs are improved through the provision of well-informed and competent technical assistance at the national level.

   a. At least two MCH-STAR-supported institution members are asked to participate and contribute in each NRHM/RCH II Common Review Mission (CRM).

   b. MOHFW and MOWCD requests for specific technical assistance in MNCHN are fulfilled timely with high quality and responsiveness.

   c. State level requests for specific technical assistance in MNCHN are fulfilled timely, with high quality and responsiveness in UP and Jharkhand.

5. Programs are improved through authoritative independent evaluations.

   a. At least one major program evaluation is conducted by MCH-STAR-supported institutions.

   b. Evaluation scope, methodology and final interpretation of results are managed in collaboration with major stakeholders, including the GOI.

   c. Evaluation results are disseminated through a final report, peer-reviewed publication where appropriate, and a technical consultation.

6. MCH-STAR-supported Indian institutions, two to five in number, have the technical capacity, established relationships, and financial health to provide these MNCHN technical services in a substantial fashion.

   a. MCH-STAR-supported partners convene, cosponsor or their institutional representatives are invited as members of national and EAG state working groups, task forces, and similar forums where MNCHN are the subjects.

   b. Research reports are published in peer-reviewed publications.

   c. In the fourth year of the project, USAID funds constitute no more than one half of all funding for SSI-implemented MNCHN activities.

   d. In the fifth year of the project, no more than 10% of technical support provided through MCH-STAR will be provided from non-SSI sources.

The project's Project Management Plan (PMP) for years 1-3 is enclosed for reference.

Geographic Focus for Implementation

MCH-STAR provides technical support to the NRHM, RCH II, and ICDS programs, so it has some national influence. State-specific activities and on-the-ground research activities were to be focused in USAID's focus states of UP and Jharkhand. Overall, the project activities and approaches are being focused to improve MNCHN that are directly relevant in those areas of

India where need is greatest – the EAG[33] states with similar health problems and poor MNCHN indices.

II. OBJECTIVES OF THE MCH-STAR MID-TERM REVIEW (MTR)

The objectives of the review are to

- Assess the overall progress and achievements of the MCH-STAR project relative to its objective, principles, approaches, and approved workplan; and
- Make suitable recommendations for the remainder of the project period.

III. MAJOR REVIEW AREAS

To accomplish this purpose, the MTR will assess the degree to which project activities contribute to the project's objectives and review the approaches and principles and the degree to which they have been effective. The focus will be on *(these are illustrative examples to be reviewed and refined during the team planning meeting***)**:

- The effectiveness of the project design
- What has worked (set of strategies, approaches, and processes) well and why
- The choice of SSIs, their compatibility, and their effectiveness
- What did not work well and why
- What were the constraints that impeded potential approaches and processes? What were the facilitating factors in bringing results with variation across the implementation areas?
- How did the MCH-STAR activity influence national and state level MNCHN policies?
- Are the efforts initiated through the project sustainable at the SSI level?
- What are the lessons for stakeholders?
- What are the best criteria to assess the readiness level of the SSIs to support the government?
- How can this readiness be attributed to the project?

In addition to the above, the review will also focus on **project management.** The MTR team will assess the appropriateness and effectiveness of the project's management systems and technical approaches, including *(these are illustrative examples to be reviewed and refined during the team planning meeting***)**:

- Leadership and ability to respond in a timely manner

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[33] The EAG constituted by order dated March, 20, 2001 is an administrative mechanism that was established for the purpose of closely monitoring the implementation of family welfare programs in the EAG states to facilitate the preparation of area-specific programs to address unmet needs. The EAG is chaired by the Union Minister for Health and Family Welfare and consists of Secretaries of various related Departments, Advisor, Planning Commission, NGOs, and experts. Eight UP states – Madhya Pradesh, Bihar, Rajasthan, Orissa, Uttarakhand, Chhattisgarh, and Jharkhand – have been identified as EAG states. The EAG is a high-powered one-window clearance mechanism for approving schemes, finalize strategies, and address gaps in the ongoing programs, and also to facilitate inter-sectoral convergence.

- Technical work planning and workload assignment
- Staffing, performance management, and quality assurance
- Funds utilization against the plan
- Monitoring, evaluation, documentation, reporting, and internal and external knowledge management
- Ability to work with the government systems at the national and state level and with the SSIs
- Relationship between EMG and its consortium of partners and SSIs
- Relationship between the project and USAID: USAID guidance and support for the project

A list of proposed key questions for the convenience of the MTR team is given in Annex A. (These are illustrative examples to be reviewed and refined during the team planning meeting.)

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

- Annual workplans, quarterly progress reports, and annual results reports
- Project monitoring plan and data
- Project documentation of accomplishments, including the research studies, white papers, etc.
- Site visits
- Key informant interviews

IV. AUDIENCE

The key audience for the MTR is USAID/India. The others include MCH-STAR and its partner consortium, SSIs, USAID/Global Health Bureau, the GOI, the Governments of UP and Jharkhand, and other development partners.

V. METHODOLOGY FOR REVIEW

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

Document review: Prior to arriving in country and conducting fieldwork, the team will review various project documents and reports, including but not limited to annual work plans, progress reports, and results reports; project monitoring and evaluation plans and data; project documentation and accomplishments, including process documentation; USAID strategy documents; the original request for application; and the final Task Order with EMG and consortium of partners. A list of key documents is included in Annex B. The MCH-STAR team will provide all relevant documents to GH Tech for review at least a week in advance so that the team has enough time to review the documents.

Team planning meeting: The team will start its work with a planning meeting with the team members only either in the MCH-STAR office or any other suitable place prior to the outset of meetings and work with USAID and others. During this meeting and in the further meetings the time will be used to clarify team roles, responsibilities, deliverables, development of tools, and approach to the assessment and refinement of the team schedule. In the meeting the team will

- Share background, experience, and expectations of each of the team members 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.
- Revisit the assessment timeline and strategy for achieving deliverables.
- Finalize the assessment timeline and strategy for achieving deliverables.
- Develop and finalize data collection methods, instruments, tools, and guidelines.
- Develop preliminary outline of the team's report and assign drafting responsibilities for the final report.

Briefing on the project: MCH-STAR team will make a brief presentation to the team on arrival and USAID will participate in the meeting. The presentation will help the team understand the project and seek clarifications of any of the questions they came up during the documents review.

Formal initiation of the review with USAID/India: The MTR team will meet with the USAID team 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 and experience and learn about USAID's expectations of the assignment.
- Formulate a common understanding of the assignment and how it fits into USAID's broader program and objectives.
- Understand the background of the MCH-STAR initiative and its current status.
- Review the list of the key stakeholders to be involved during the review, develop a common understanding of their relationship and interest, and agree on an approach to working with them,
- Agree on the objectives and desired outcomes of the assignment.
- Share preliminary draft outline of the team's report.

Field Visits/Key Informant Interviews

Field visits and key informant interviews at the state level in UP and Jharkhand and district and subdistrict level in Jharkhand.

Key informant interviews at national level with the GOI and key partners. A list of key informants is given in Annex C.

Wrap-up and Debriefing

Two debriefing meetings will be held: (i) with USAID/India and (ii) with the MCH-STAR project team and SSIs. USAID will participate in this debriefing session also. The objective of these meetings is to share the draft findings and recommendations, solicit comments and inputs, and clarify any remaining questions or issues.

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

VI. TEAM COMPOSITION

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 India Mission for their selection. The Mission will then approve a final team for the assignment.

The team leader will lead the review process and serve as the lead writer. The review team is expected to bring global and national perspectives and understanding of issues around MNCHN. The review team will include five members (two expats and three in-country professionals) not associated with USAID/India or the project. They need to have expertise with the Indian Government Health System and MNCHN context in India and the region with sufficient field experience, operations research, project development, monitoring and evaluation, capacity development and institutional strengthening, gender and equity, and policy advocacy. Efforts need to be made to have gender balance within the team. In addition, one of the team members should have the experience of conducting similar reviews and working with USAID projects.

The team leader, apart from being an expert in the technical areas 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 planning, design, and implementation of the evaluation and work in coordination with team members. S/he will be responsible for report writing and the organization of different briefing presentations. It will be her/his responsibility to submit a satisfactory report to USAID within the agreed-upon timeline. Thus, s/he will have the overall responsibility for management of the team and finalization of the completed review report.

VII. TIMELINE AND LIFE OF THE ACTIVITY

USAID/India anticipates that the period of performance of this review will take place during May to June 2010 for about four weeks at a stretch (including approximately 18 days in the country). The complete duration allows for planning, desk review of documents, in-country meetings, field visits, and report preparation. The MCH-STAR proposed a week of state visits, visiting both the states at the capital.

Illustrative LOE and Timeline

Task/Deliverable	Duration/LOA		
	Team Leader	Other Team Members: Expatriate (n=1)	Other Team Members: Local Experts (n=2-3)
1. Review of background documents and offshore preparation work	4 days	3 days	3 days
2. Travel to India/Delhi	2 days	2 days	0.5 day
3. Team planning meetings	2 days	2 days	2 days
4. Team planning meeting with USAID/India	0.5 day	0.5 day	0.5 day

Task/Deliverable	Duration/LOA		
	Team Leader	Other Team Members: Expatriate (n=1)	Other Team Members: Local Experts (n=2-3)
5. Briefing on the project by MCH-STAR, SSIs, and USAID	0.5 day	0.5 day	0.5 day
6. Information and data collection. Includes interviews with key informants (stakeholders and USAID staff) and site visits*	6 days	6 days	6 days
7. Mid-term briefing meeting with USAID	1 day	1 day	1 day
8. Discussion, analysis, and draft report review in-county	3 days	3 days	3 days
9. Final debriefing with USAID and partners	1 day	1 day	1 day
10. Preliminary draft report due to USAID prior to departure from country	2 days	2 days	2 days
11. Depart India/Delhi travel to US	2 days	2 days	0.5 day
12. USAID and partners provide comments on the draft report (10 days)			
13. Team leader revises draft report and submits final report to USAID	4 days	2 days	2 days
Total estimated LOA	**28 days**	**25 days**	**22 days**

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

Before In-country Work Begins

Team leader:

- Complete review of the key documents shared by MCH-STAR and seek clarifications on the project from USAID/India and MCH-STAR
- Plan and coordinate with the team members

All team members:

- Complete review of the key documents shared by MCH-STAR
- Seek clarifications on the project from USAID/India and/or MCH-STAR
- Respond to any the team leader queries

VIII. DELIVERABLES

The following deliverables will be required from the review team:

1. **Review Methodology and Work Plan:** During the team planning meeting, the team will prepare a detailed work plan and a written methodological plan, which will include the methodologies and data collection tools to be used in the review. These plans will be discussed and approved by USAID/India 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 the India Mission Director on the executive summary and key recommendations and USAID and MCH-STAR 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 mentioned above along with the recommendations based on these observations. The recommendations should include how to improve and strengthen the project work in the remainder of the project life. The report should also specifically answer the questions that are agreed upon by the team together with USAID/India (some of which are provided as illustrations in the SOW), results and return on investment, and any others decided upon during meetings with USAID.

   USAID will provide comments on the draft report within 10 working days of receipt of the report.

4. **Final Report:** The final report will be due within approximately seven working days after the team receives comments from USAID/India and the MCH-STAR project. USAID/India requests both an electronic version of the field report (Microsoft Word) and a couple of hard copies of the report.

5. 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 business days for GH Tech to have the report edited, formatted, and printed.

IX. 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. MCH-STAR will assist in arranging meetings with government officials, SSIs, and key stakeholders. A local administrative/logistics assistant may be hired for additional logistics support and for arranging logistics for the field visits.

X. POINT OF CONTACT

The point of contact for this assignment is

V. Ramesh Babu
Project Management Specialist
Contracting Officer's Technical Representative
Office of Population, Health and Nutrition
USAID/India

ANNEX A TO SOW. PROPOSED KEY QUESTIONS FOR MID-TERM REVIEW OF MCH-STAR ACTIVITY

Focus Area	Suggested Questions	Sources of Information	Review Team Member(s)
1. Capacity building and institutional strengthening (CB/IS)	1. Is the project making progress in building the technical capacity and skills of the SSIs in MNCHN areas to meet their expected role and growing demands of the government? 2. How is the project responding to the felt needs expressed by the government? 3. How can the SSIs sustain and meet the growing demands of the government? 4. What are the factors that influenced achieving or not achieving the committed results under the CB/IS? 5. The relevance and effectiveness of the tools and approaches developed by the project team for the CBIS 6. The level of readiness of the SSIs for providing support to state and national governments	• Key respondent interviews • Field visits • Review of CBIS proposals, final reports • Review of capacity-strengthening assessments, workshops, and CB/IS activity reports	To be decided by the team leader
2. Policy analyses, advocacy, and white papers	1. How effective is the process followed by the project in identifying issues for policy advocacy and analysis? 2. Have the efforts resulted in policy changes? 3. What have been the key learnings and challenges from policy analysis/ advocacy activities?. 4. What has been the effect of USAID branding and marking requirements on and around policy advocacy and networking	• Field visits • Interviews with key stake holders at the government, project staff, and SSIs • Review of proposals of various studies; final reports, white papers, policy briefs produced and advocacy material developed	To be decided by the team leader

Focus Area	Suggested Questions	Sources of Information	Review Team Member(s)
3. Operations, applied and policy-related research, analysis of existing data, and program evaluations	1. What impact have the operations, applied and policy-research, data analysis and evaluations brought to national programs? • Have the MCH-STAR approaches been effective in developing research proposals by the SSIs and identifying researchers? • Are the research questions submitted by SSIs helpful in improving the efficiency of national programs? • Have the research results stimulated program policy debate and brought government ownership and changes to policies? • Are the protocols, implementation analysis, and dissemination approaches adequate to maintain and sustain government interest and buy-in?	• Field visits • Interview with key stakeholders from the government and SSIs. • Desk review of project documents, reports, presentations, and papers published and submitted for publication. • Review of the research proposals and protocols used.	To be decided by team leader
4. Technical assistance (TA) to programs that work at scale in MNCHN	1. How strategic are the SSIs in selecting the TA needs of the government? 2. How effective are the results of the TA in terms of sustainability? 3. Do the project and SSIs have a clearly articulated set of strategies for determining priorities for and providing technical support? 4. What is the halo effect of MCH-STAR activities on SSIs providing TA to state and national government? 5. Does the project have an exit strategy?	• MCH-STAR staff and SSI staff at different levels • Key informant interviews with officials in USAID, GOI, GoJH and SSIs • Project proposals and final reports and other documents	To be decided by the team leader
5. Relevance of the project for socially excluded and marginalized communities	What has been the impact of the program in improving nutrition and health outcomes for vulnerable groups? 1. Is the project contributing to the reduction of undernutrition, improving efficiency in delivery of MCH services, and improving interventions that reduce infant mortality and morbidity of the vulnerable target groups? 2. Were the strategies appropriate to improve access and coverage for the vulnerable groups? 3. Has the program contributed to addressing gender issues within the context of maternal and child health and nutrition?	• Desk review of the project documents • Field visits • Interview with stakeholders	To be decided by the team leader

ANNEX B TO SOW: LIST OF KEY INFORMANTS

Government Counterparts

Senior officials from the MoWCD and MoHFW at the national and state (UP and Jharkhand) levels, which will include the Health Secretary, Health Director, State Project Management Unit and their consultants, NRHM MD and NRHM cell. At the district and subdistrict level, the District Medical Officers and Primary Health Centers Medical Officers in Jharkhand, and representatives from State Health Resource Centers in UP and Jharkhand.

USAID Team

Mission Director, PHN Office Director, Program Support Office Director, Dr. Rajiv Tandon, Ramesh Babu, Dr. Sanjeev Upadhyaya (former COTR), ROAA representative

Massee Bateman (former USAID Health Officer) engaged in project design, Dr. Anchita Patil and Anand Rudra, COTRs of Vistaar and Health of the Urban Poor (HUP) Projects respectively.

USAID Partners

Staff from USAID-funded projects based in Delhi: Ms. Laurie Parker, COP Vistaar Project, and Vistaar staff based in Lucknow and Ranchi; Dr. Sanjay Pandey, COP, HUP Project.

Chief Executive Officers, Senior Staff, MCH-STAR-Supported Project Principal Investigators, and Their Staff

- PHFI: Dr. K. Srinath Reddy, CEO; Dr. Sanjay Zodpey, Dr. Sathpati, Dr. Raj Panda,
- Dr. Sangita Bhattacharya, Dr. PK Sahoo, Dr. Sunil Raj, Subhdra Menon, and key staff
- IndiaCLEN: Professor Niswade, President, IndiaCLEN; Dr. Kurien Thomas, former President; Dr. NK Arora, Dr. Manoj Das, Dr. Sanjay Rai, Dr. Siddarth Ramji, Dr. Gariyali, and key staff
- PFI: Mr. AR Nanda, CEO; Arundhati Mishra, Dr. Llitendu, Ms. Shalini, and other key staff
- CINI: Dr. Rajib Haldar, CEO; Dr. Suranjeen Prasad, and key staff

MCH–STAR Key Team

- Dr. Marta-Levitt Dayal, Chief of Party
- Mr. Sameer Wadhava, Director of Finance and Operations
- Dr. Ashok Patwari, Senior Technical Advisor, Research and Evaluation
- Dr. Avinash Ansingkar, Technical Advisor, Capacity Building
- Ms. Anju Dadhwal Singh, former Technical Advisor, Policy and Advocacy

MCH-STAR Partner Agencies

- CEDPA: Aparajita Gogoi, CEDPA/India, and Danielle Grant, CEDPA/Washington
- Boston University: Jonathan Simon and Deborah Maine

ANNEX C TO SOW: LIST OF KEY DOCUMENTS

Background Documents

1. EMG proposal in response to USAID solicitation
2. Special Task Order signed between USAID and EMG
3. Multi-year Work Plan, Annual Work Plans for Project years 1-3 (includes the project monitoring plans), progress reports
4. Job descriptions of key MCH-STAR positions
5. Project organization chart
6. Budget and burn-rate statement
7. Background reports on the SSIs, tools for their identification and finalization
8. Capacity assessment reports of each of the SSIs conducted by MCH-STAR

Project Publications

1. All study, consultation, and operations research reports conducted under the project (a few examples are behavioral change communication, use of untied funds under the NRHM, undernutrition study done by India-CLEN, and first referral unit study)
2. Project proposals being implemented by the SSIs
3. Urban Health Resource Center documents: KPMG study report, Dalar Baseline Report, Dalar report on organizational development, governance, capacity building, annual report and final report submitted by MCH-STAR.
4. Working papers and white papers

ANNEX B. PERSONS CONTACTED AND FINAL TIMELINE

SCHEDULE FOR THE MTR TEAM FROM MAY 5– 25, 2010						
Date	**Day**	**Activities**				
May-02	Sunday					
		Dr. Jenny Ruducha	Arrival by AF 226		ETA 10.35 p.m.	Transfer to Vasant Continental by the hotel
May-03	Monday					
		Dr. Renu Khanna				No accommodation
May-04	Tuesday					
		Dr. Steve Atwood	Arrival by TG 323		ETA 10.35 a.m.	Transfer to Vasant Continental by the hotel
		Mr. Snehashis Raichowdhury	Arrival by IT 604		ETA 11:10 p.m.	Transfer to Vasant Continental by the hotel
		Dr. S.K. Chaturvedi	Arrival by Car from Jaipur			Transfer to Vasant Continental by own car
May-05	Wednesday		Team 1	Team 2		
	Time	09:00-18:00	Team Planning Meeting			
May-06	Thursday					
	Time	09:00-18:00	Team Planning Meeting			
May-07	Friday					
	Time	09:00-14:30	USAID Briefing			

SCHEDULE FOR THE MTR TEAM FROM MAY 5– 25, 2010					
Date	**Day**	**Activities**			
		14: 30-15:00			
		15:00-16:00	Mr. Nanda Shalini	Arundhati	
		16:00-17:00	Shalini	Laltiendu	
		17:00-18:00			
May-08	Saturday				
	Time	09:00-10:00	Dr. Niswade, IndiaCLEN	Dr.Kurien Thomas, IndiaCLEN	
		10:00-11:00	Dr. Haldar, CINI	Manoj Das, IndiaCLEN	
		11:00-13:00			
		13:00-14:00	Marta, MCH-S	Kachina, MCH-S	
		14:00-15:00	Avinash, MCH-S	Naidu, MCH-S	
		15:00-18:00			
May-09	Sunday				
	Time	09:00-18:00			
May-10	Monday		PHFI		
	Time	09:00-10:00	Dr. Suni Raj	Dr. Raj Panda	
		10:00-1400	Dr. Sanghita K Bhattacharya	Dr. Subhadra Menon	
		14:30-15:30	USAID Meeting		
		17:00-19:00	Meeting with all PHFI staff with MCH STAR)		
			Dr. K.S. Reddy	Dr. Sanjay Zodpey	
May-11	Tuesday				
	Time	09:00-11:00	Dr. Ashok Patwari, MCH-STAR	Dr. Sanjay Panday, EHUP, PFI	
		11:00-12:00	Arti Bhanot, P&A,MCH-STAR	Dr. Piyush Gupta, Indian Academy of Pediatrics	

SCHEDULE FOR THE MTR TEAM FROM MAY 5– 25, 2010					
Date	**Day**	**Activities**			
		12:00-13:00			
		13:00-14:00			
		14:00-15:00	Ramesh Babu	Dr. Rajiv Tandon	
May-12	Wednesday		Lucknow Team	Ranchi Team	
	Time	09:00-10:00	Narendra Arora IndiaClen	2 interviews/ Leila Caleb	
		10:00-11:00	1 interview		
		11:00-12:00		Anju Dadhwal-Telephonic Interview (09923423331)MCH-STAR	
		12:00-13:00			
		13:00-14:00	2 interviews/ Laurie Parker-Vistaar	Dep for Ranchi IT 3347 1450 - 1640	
		14:00-15:00			
		15:00-16:00			
		16:00-17:00	Mr. P.K. Hota & Mr. K. Pappu, NIPI	16:45, Arrival from Delhi. Proceed to Hotel.	
		17:00-18:00			
May-13	Thursday			Ranchi Field	
	Time	09:00-10:00	4-5 Interviews	CINI Dr. Suranjeen/ Dr. Supriya	All meetings at CINI Office
		10:00-11:00	Prof. Deoki Nandan - NIHFW; Baba Gang Nath Marg, Munirka, New Delhi -110067	State NGO Coordinator. Mr. Subir Kumar (not confirmed)	
		11:00-12:00		PFI-Nikita Sinha / Sudhir	

SCHEDULE FOR THE MTR TEAM FROM MAY 5– 25, 2010					
Date	**Day**	**Activities**			
		12:00-13:00	11:30/12:00 –1300 Laurie Parker, COP, Vistaar, A2/35 Safdarjung Enclave phone - 01146019999	IndiaCLEN (Medical College): Prof. S Haider	
		13:00-14:00	Lunch	Lunch	
		14:00-15:00		IndiaCLEN:CEU,Dr. R Pancholi	
		15:00-16:00		PHFI: Abhijit Chanda	
		16:00-17:00	Dr. Loveleen Johri, USAID - 011-24198000, American Embassy, Shantipath, Chanakyapuri, New Delhi - 110021 Bring photo ID.	UNICEF: Dr. P Gurnani	Travel to UNICEF (30 min. drive)
		17:00-18:00			
May-14	Friday	5:50	05:50 departure from hotel for airport to arrive by 6:30 am - flight Dep Lucknow IT 3651 0725 - 0830	Field trip to Chaibasa / Khunti	Travel time – 3 hours one way Accompanied by Abhijeet (PHFI)
	Time	09:00-10:00	Lucknow Field: to be met at airport and accompanied by Mr. Dattatreya Gorkhale of PFI		
		10:00-11:00	SIFPSA: Ms. Savita Chauhan, Mr. MK Sinha, and Mr. RK Singh at SIFPSA, Om Kailash Tower, 19-A, Vidhan Sabha Marg, Lucknow - 226001 cell: 09415500771		

SCHEDULE FOR THE MTR TEAM FROM MAY 5– 25, 2010					
Date	**Day**	**Activities**			
		11:00-12:00	Dr Manju Mehrotra, SPMU: - General Manager, (Maternal health & FP),;Dr Hari Om Dixit-General Manager, (Community Processes), SPMU – Mobile: 09839171943; Dr Madhu Sharma, NRHM Location: in same compound as SIFPSA.		
		12:00-15:00			
		14:00-1500	Directorate of Family Welfare: Dr C.B. Prasad, Director General; Dr Jain, Director (MCH); Dr Bhagwat, Additional Director Directorate of Health Services, 509, Swasthya Bhawan,. Lucknow – 226001, Uttar Pradesh. Tel. Off. +91-522-2628937, +91-522-2262937, +91-522-2620560		
		15:30-16:30	3:30 Vikas Bhawan, Janpath, Sh. Pradeep Shukla, Principal Secretary (Health & FW), Department of Health & Family Welfare, Government of Uttar Pradesh, 5th Floor, Room No. 516, Vikas Bhawan, Janpath Market, Vidhan Sabha Road, Hazrat Ganj.Lucknow – 226 001, UP. Tel: +91-522-2627029		

SCHEDULE FOR THE MTR TEAM FROM MAY 5– 25, 2010						
Date	**Day**	**Activities**				
		17:00-18:00	UNICEF Office: Marie-Claire Mutanda, Health Advisor, UNICEF Office 3/194 Vishal Khand, Gomti Nagar, Lucknow Phone:0522-4093333 Mobile: 09005090058 mmutanda@unicef.org 3/194 Vishal Khand Gomti Nagar Lucknow 226 010 Uttar Pradesh, India			
May-15	Saturday			08:30 - Vistaar : Dr. Manju Shukla	Hotel Foyer	
	Time	09:00-10:00	Dr. George Philip, Project Director & Dr Panwar, Technical Advisor, Vistaar, The Vistaar Project. 1/55 A, Vipul Khand, Gomti Nagar Mobile: 09935585222 gphilip@intrahealth.org			
		10:00-11:00		MD _ NRHM (Past)- Dr. NM Kulkarni (yet to confirm)	Travel time to JEPC, Shyamli, 20 min.	

SCHEDULE FOR THE MTR TEAM FROM MAY 5– 25, 2010						
Date	**Day**	**Activities**				
		11:00-12:00	KGMU: Meeting with KGMU CEU members - Dr. Shalley Awasti 09839221244; shallya@rediffmail.com Dr. Srivastava 09215101095 Dr. Ahuja 09335907745 Dr G.K. Singh 09450579869 drgksingh@gmail.com - kgmcice@gmail.com CSM Medical University (go through gates and to the Dean's Office building. The CEU office is on the far left side of building)	11:30-Sec. Health Dr. DK Tiwari (yet to confirm)	Travel time to Nepal House- 20 min.	
		12:30-13:30	1230 Luncheon discussion with Mr Dattatraya Gokhale, PFI	12:45-SPM- NRHM (Mr. Ranjan Kumar)	Travel time to Nepal House:30 min.	
		13:00-14:00		Lunch: Hotel at Main Road	Travel time: 30 min	
		13:30-14:30	1:30 leave for airport for Lucknow - Delhi IT 205 15:20 – 16:25	15:00-Director, Social Welfare Ms. Pushpa Marandi	Travel time to HEC: 20 min.	
		15:00-16:00		Ranchi - Delhi IT 17:10 -20: 15		
		16:00-17:00				
		17:00-18:00				
May-16	Sunday					
	Time	09:00-10:00				
		10:00-11:00				

SCHEDULE FOR THE MTR TEAM FROM MAY 5– 25, 2010					
Date	**Day**	**Activities**			
		11:00-12:00	Dr. Renu Khanna, Arrival from Vadodara by 6 E 482, ETA 11.30 hrs		Transfer to hotel by Vasant Continental
		12:00-18:00			
May-17	Monday				
	Time	09:00-15:00	Team Meeting		
		15:00-16:00	2 interviews	2 interviews	
		16:00-17:00	Dr. Rajesh Mehta, WHO India Meeting Cancelled		
		17:00-18:00	Aparajita Gogoi, CEDPA, at hotel Jaypee Vasant Continental		
May-18	Tuesday				
	Time	09:00-10:00	4 interviews	4 interviews	
		10:30:11:30	Dr. Sunderaman, Dir., NHSRC: Baba Gang Nath Marg, Munirka, New Delhi -110067 011-26100057/26185696/26165959		
		11:30-12:00			
		12:00-16:00			
		16:00-17:00	Telephone Conference with Laurette Cucuzza, CEDPA, Washington		
		17:00 - 18:00			
May-19	Wednesday				
	Time	09:00-11:00			

SCHEDULE FOR THE MTR TEAM FROM MAY 5– 25, 2010					
Date	**Day**	**Activities**			
		11:00-12:00	Mr. Amarjeet Sinha, 242-A, Nirman Bhawan Maulana Azad Road New Delhi-110011. Tel: 011-23062157	Team Members: - Dr. Steve, Dr. Renu, Ramesh Babu	To be reconfirmed with his P.S (Mr. N. Satish)
		12:00-15:00			
		15:00-15.45	15:30- Mr. Mahesh Arora (Dir, ICDS), Shastri Bhawan Dr. Rajendra Prasad Road, New Delhi-22. Tel:011-23389434 Meeting cancelled	Dr. Steve	
		16:00-17:00	Henri Van Den Hombergh, Chief Health Section, UNICEF, India Country Office, 73, Lodhi Estate, New Delhi - 110 003, Tel: 011-24606205, Mob: 9810170167 - Dr. Steve		
		16:30-17:00	Ms. Aradhana Johri NACO (Former JS for RCH) National AIDS Control Organisation, Department of AIDS Control (DAC) MoHFW, Govt. of India, 6th & 9th Floor, Chandralok Building 36, Janpath, New Delhi-110001 Tel: 011-43509999, 011-23731778/ 23325343	Team Members - Dr. Jenny & Mr. Snehashish	
		18:30-19:30	Telephone Conference with Jon Simon, Boston University - MTR Team		
May-20	Thursday		Analysis and Writing		
	Time	09:00-10:00			
		10:30-12:00	Mid-briefing at USAID - MTR Team		

SCHEDULE FOR THE MTR TEAM FROM MAY 5– 25, 2010					
Date	**Day**	**Activities**			
		12:00-17:00			
		19:00-20:00	Telephone conference with Deborah Maine, Boston University - MTR Team		
May-21	Friday		Analysis and Writing		
	Time	08:30-09:30			
		10:00-16:00			
		16:30-17:00	Telephone conference call with Susan Otchere, Project Manager, & Leslie Finn, Health Director, Cardno		
		19:00-20:00			
May-22	Saturday		Analysis and Writing		
	Time	09:00-18:00			
May-23	Sunday		Analysis and Writing		
	Time	09:00-18:00			
May-24	Monday				
	Time	09:00-14:00	Briefing with SSIs		
		14:00-18:00	Briefing with MCH STAR		
May-25	Tuesday				
	Time	09:00-15:00	Presentation of Findings and Recommendations		
		15:00-16:00	Submission of Draft Report		
		16:30	Mr. Snehashish Raichowdhury	Departs by IT 603	ETD 18:10 hrs
		19:30	Dr. Jenny Ruducha	Departs by CO 083	ETD 22:50 hrs
		20:30	Dr. Steve J. Atwood	Departs by TG 316	ETD 23:30 hrs
MM			Marta Levitt-Dayal, cell: 995862 9740 Panchmani Vicent, cell: 9717096884 Sameer Wadhwa, cell : 9810102671		

ANNEX C. REFERENCES

Technical references can be found in the footnotes to the main report.

DOCUMENTS REVIEWED FOR BACKGROUND

- Capacity assessments and reassessments
- Websites of the partners
- Rationale and history of the project
- Descriptions of workshops
- District Level Household Survey, (DLHS), National Family Health Survey (NFHS) for Jharkand and UP
- Presentations
- Bio-data of staff
- Documents on NHRM, ICDS, NHSRC, etc.
- EMG proposal in response to USAID solicitation
- Special Task Order signed between USAID and EMG
- Multi-year workplan, annual workplans for Project years 1–3 (includes the project monitoring plans), progress reports
- Job descriptions of key MCH-STAR positions
- Background reports on the SSIs, tools for their identification and finalization
- Project organization chart

DOCUMENTS REVIEWED FOR APPRAISALS

- Proposals pre- and post-review
- Proposals accepted and rejected
- Evaluations of workshops
- Capacity assessments and re-assessments of the SSIs conducted by MCH-STAR
- Completed research reports conducted under the project
- Working papers and white papers
- Workplans and District Implementation Plans (DIPs)
- Monitoring indicators and MIS
- Budgets, disbursals, and utilizations
- Urban Health Resource Center documents: KPMG study report, Dalar Baseline Report, Dalar report on organizational development, governance, capacity building, annual report, and final report submitted by MCH-STAR.

ANNEX D. FINDINGS FROM A GENDER REVIEW OF MATERIAL PRODUCED

- In *Top Line Findings: Social Determinants of Undernutrition in India* with authors from IndiaCLEN, GOI, MCH-STAR and NIPI *India CLEN, and GOI–MCH-STAR, WHO NIPI,* there is no gender analysis of undernutrition in children in Jharkhand, nor of the causes for undernutrition in women.

- In *Project Brief: Concurrent Evaluation of the Reach, Effectiveness and impact of MMJSS A-JSY in Jharkhand: An IndiaCLEN and PFI study,* equity concerns have been integrated into the objectives of the study but there is no gender analysis in the study design.

- In *Social Determinants of Under Nutrition in Children and Assessment of Management at Different Levels of Health Care,* the objectives of the study do not specify gender as a social factor for undernutrition. There are good things in this paper, but the larger determinants of children's undernutrition—early marriage and childbearing, girls' undernutrition, etc.—have not been included in the issues to be explored or, if data have come out, they do not feature in the recommendations.

- The study on *Determinants of Under Nutrition in Children and Assessment of Management at Different Level of Health Care (Draft)* contains a section titled Gender Differences in Feeding Practices. A section of the Focus Group Discussions (FGDs) explored discrimination between girls and boys in feeding practices. However, this gender consciousness does not appear to have been universally present throughout the study. For example, when inquiring about feeding practices and treatment seeking behavior, children are disaggregated by "younger children" and "older children" but not also by "girls" and "boys." When siblings are mentioned as those taking care of younger children, once again this is treated as a non-gender -specific category—the reporting of data does not indicate whether probing was done on whether it is the elder girl sibling who is preferred to take care of the younger children; there is evidence from the Education sector that a major reason for dropouts among girls is care of younger siblings. The gender roles and the sexual division of labor are well brought out in the study, and roles of fathers- and mothers-in-law have been explored and reported upon. The Effects of Domestic Violence on Caring for Children has also been explored in the study. Working on this with a more critical perspective would make the paper's arguments about gender more complete and forceful and add to its impact.

- The *Training Manual for Quality Assurance for MNCHN (Draft)* does not include gender issues in QA.

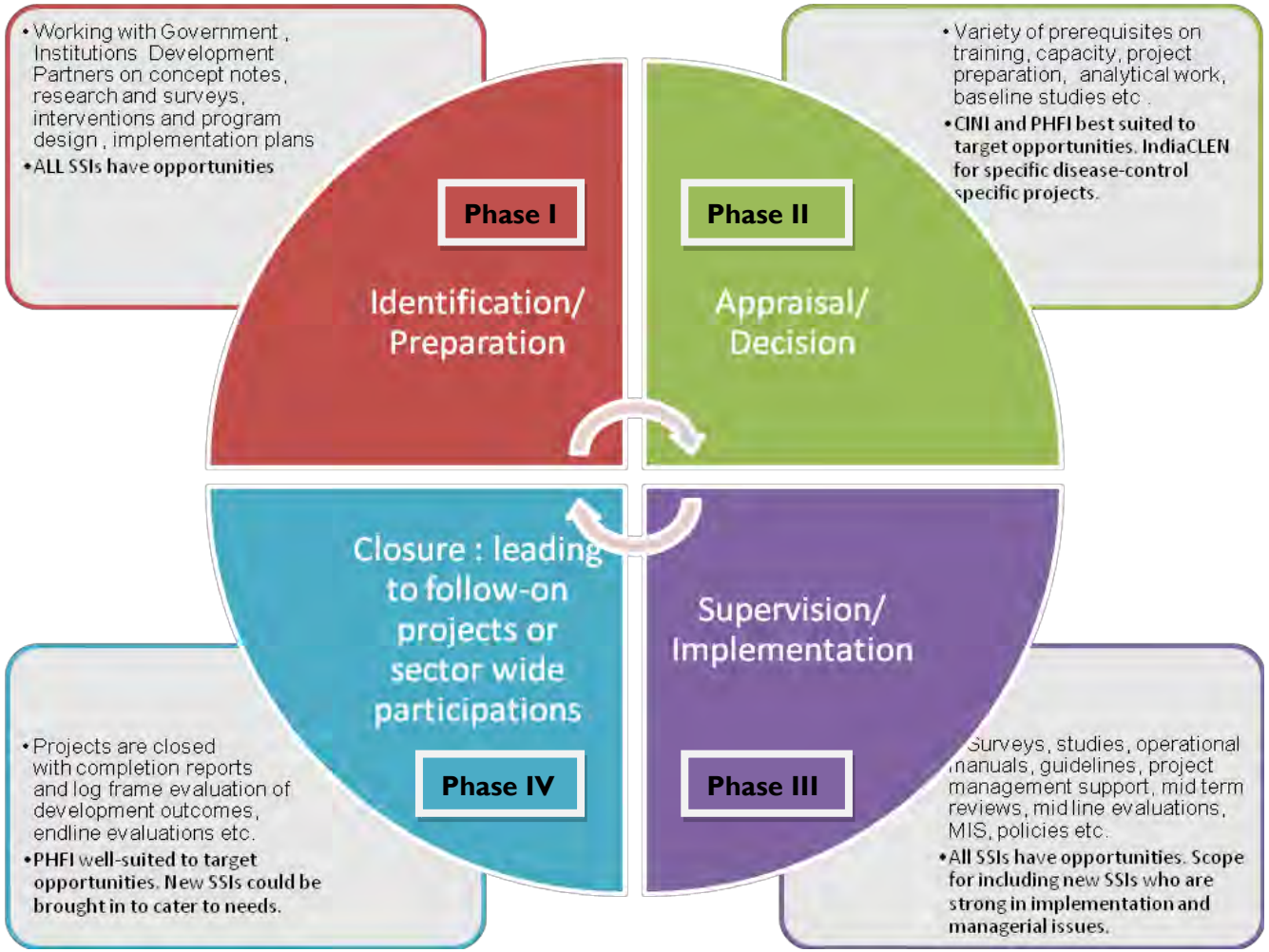
- *Maternal Death Audit proposal*. There is a section on Ethical and Gender Considerations that is quite comprehensive in its gender balance of investigators, gender balance of respondents, and implementation after study to promote gender equity. Of note: The proposal states that having a mix of male and female respondents will help them to look for gender-related factors. Even with single-sex respondents, researchers can look for/identify gender related factors.

A REVIEW OF THE GENDER STUDIES

- In the Literature Review for *Paper 2: Gender Differentials in HC-Seeking Behaviors for Under-5 Children,* there are seven references that show that girls are discriminated against; one questions the need for another paper on the same topic.
- In *Paper 4: GBV and its Effects on RCH Service Utilization in U.P.,* the abstract says, "Health systems can play a major role in addressing Intimate Partner Violence against women in [the] domestic sphere." But the paper does not really spell out **what** the role of the health system can be and how it can play this role. The study uses the language of "Sex selective abortion of female fetus"— women's health rights advocates are recognizing the world over that this kind of language compromises women's rights to safe abortion.

ANNEX E. TYPICAL PHASES OF A DONOR-FINANCED PROJECT AND POTENTIAL OF SSIS TO CONTRIBUTE

The diagram below shows the four stages of a typical donor-financed project and the opportunities for SSI involvement in each of these. An indicative guideline has been given regarding the possibilities of increased involvement of each of the SSIs in these phases based on their current strengths.



ANNEX F. INSTITUTIONAL CAPACITIES IN GOVERNMENT—AVENUES FOR FUTURE TECHNICAL ASSISTANCE

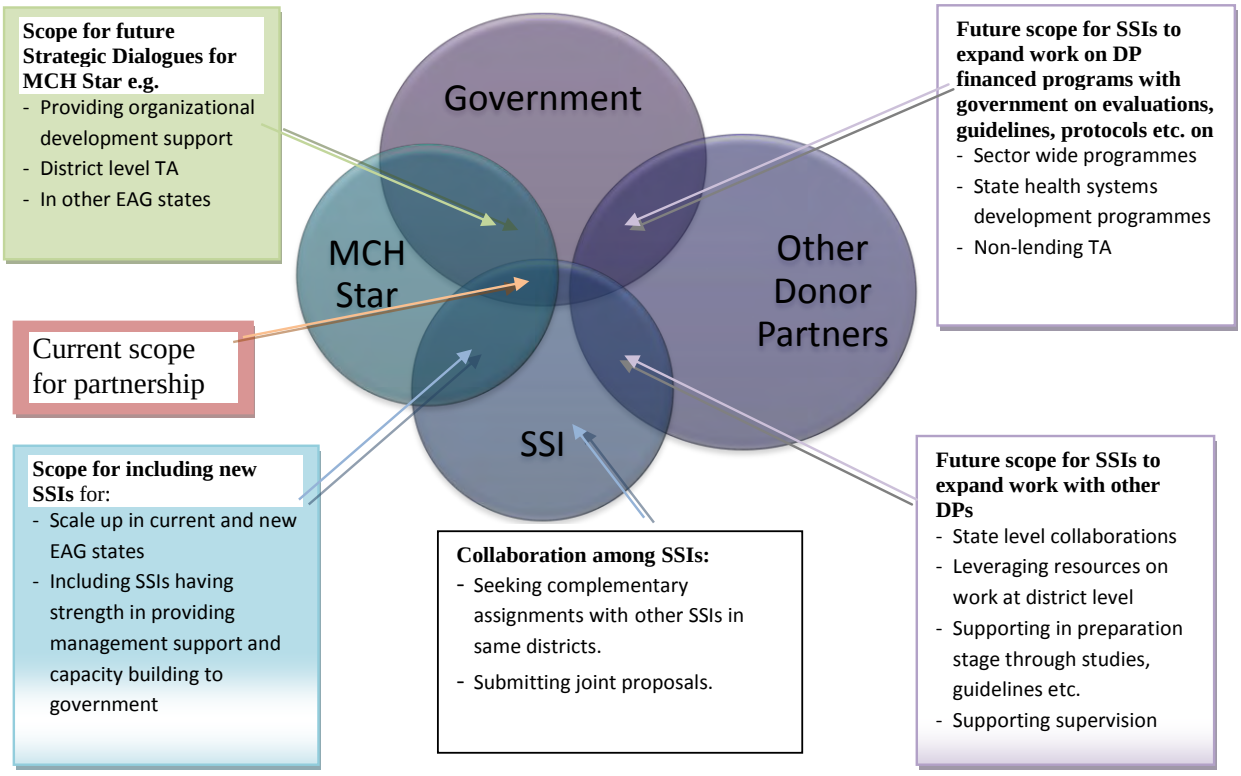
Level	Dimensions	Capacity Indicators	Areas Where SSIs are Present	Potential Areas of Support by SSIs
System	• Policy (systems have a purpose) • Legal/regulatory (rules, laws, norms, standards) • Management/accountability (who oversees and who implements) • Resources (human, financial, information)	• Health policies/legislation established • Sector-wide strategy articulated • Formal/informal coalitions and/or multisectoral collaboration in place • Specific focus on MNCHN issues.	Present: policies	Sector-wide strategies, collaboration in multiple sectors, systems issues related to human resources, information, etc.
Organizations	• Mission/strategy (e.g., role, mandate) • Culture (e.g., management values and styles) • Processes (e.g., .use of information for management; inter-relationships; planning and implementation, monitoring and evaluation) • Resources (human, financial, information)	• Strategic and operational plans in place • Trained/supported staff • Functional: management systems (e.g., available supplies; supervision undertaken); financial management systems (e.g., available resource); information systems (e.g., timely analysis of health information for decision-making); service delivery systems	Limited or none	Scope for contribution in all. May need inclusion of other SSIs with expertise in management and systems.
Individuals	• Education/training • Skills	• Years of education/training • Skill set of staff relating to management, health systems, MNCHN and related areas	Partial presence	Opportunities to scale up.

Adapted from Boffin, N. Health system capacity building: review of the literature. Antwerp, Institute of Tropical Medicine, 2002 report.

ANNEX G. EXPANSION POSSIBILITIES FOR MCH-STAR IN PHASE II

With strengthening of SSI capacities and increasing government demand for TA in numerous areas, MCH-STAR needs to scale up its operations by increasing SSI membership with institutions having complementary skills. Opportunities exist for expansion of MCH-STAR in multiple areas and possibilities for collaboration are apparent at inter-SSI levels and with development partners. In addition, extending MCH-STAR's support to other needy Empowered Action Group (EAG) states is likely to bolster its core objective of making a dent in MNCHN issues through support to Indian institutions. An illustrative schematic below shows the possibilities of expansion and strengthening of the MCH-STAR model for better efficiency.

Figure G1. Schematic diagram showing current and future scope of partnerships between government, MCH-STAR, development partners, and SSIs

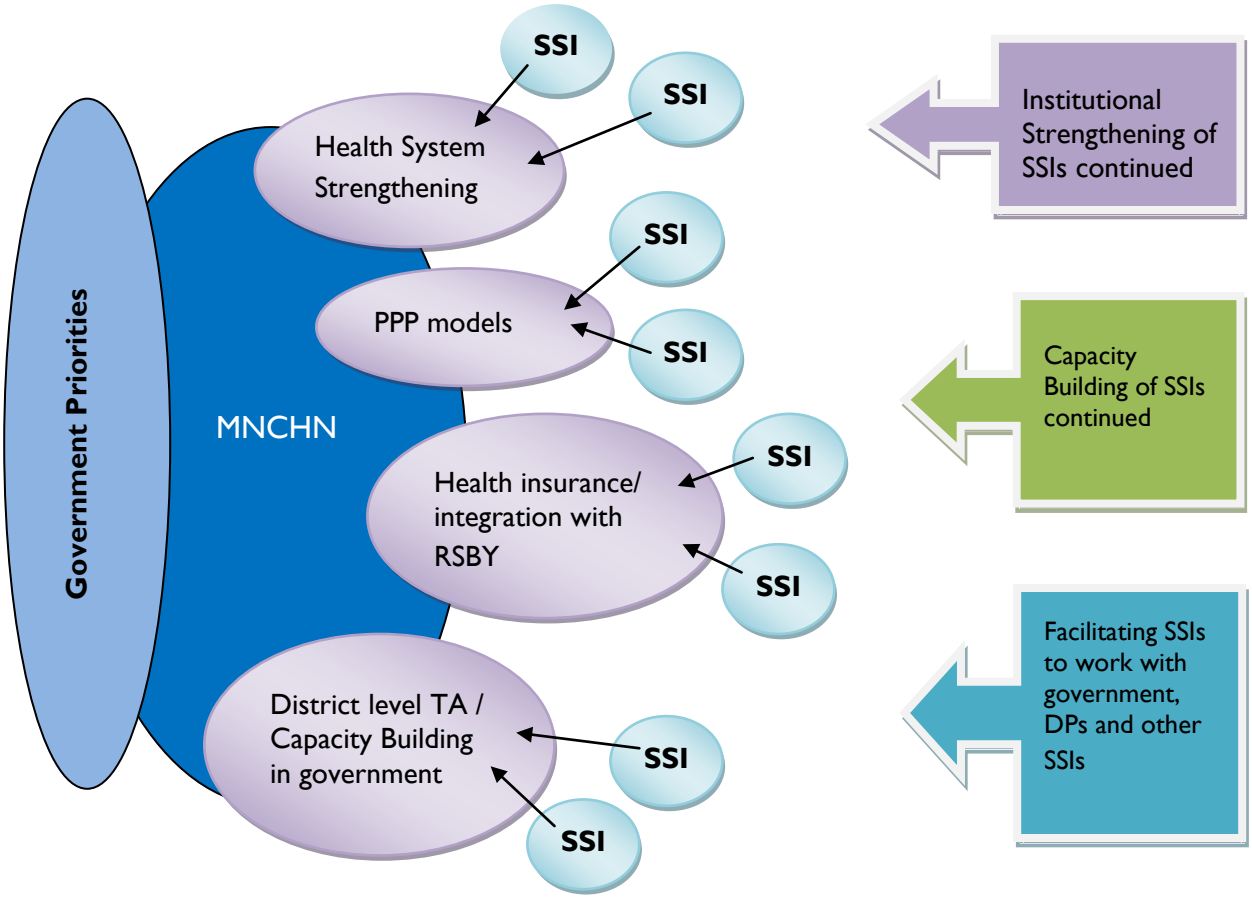


The current scope of MCH-STAR partnership is represented through the area formed by the intersection of the three circles representing government, MCH-STAR, and SSIs. Possibilities of expansion and consolidation of MCH-STAR in other areas are represented by the intersection of two or more circles pointed to by an arrow, including the addition of more SSIs under MCH-STAR.

ANNEX H. SUGGESTED POSITIONING OF MCH-STAR PHASE II IN THE CONTEXT OF THE NRHM

The advent of NRHM in 2005 has resulted in substantial funding for the healthcare sector in India, with focus on strengthening of state-level functions. However, states have not been able to spend the additional funds, to a large extent because of issues related largely to dearth of human resources, as well as weak governance and systems. Augmenting the spending capacities of states and supporting the national and state governments through responsive technical assistance in focus areas like health system strengthening, innovative approaches in public private partnerships, and health insurance, to name a few, is the need of the hour. In view of that, MCH-STAR Phase II could focus on some of these areas as a subset of MNCHN and position itself to facilitate delivery to the government of responsive TA through multiple SSIs of complementary skill sets. The diagram below suggests some areas that can be considered in future for providing TA, subject to agreement with the government. The areas are not prescriptive but are guidelines and may be altered based on the priorities set by the government.

Figure H1. Suggested Model of Future Support by MCH-STAR to Government through TA



An important area for future engagement by MCH-STAR could be capacity building, organization development, and change management of government institutions. In order to have a substantial effect on the MNCHN agenda, the capacity of the government needs to be augmented for both

service delivery and stewardship functions. However, this will mean expanding the team of SSIs beyond the current set and including organizations that are capable of providing management support and systems for capacity building of government institutions for service delivery.

Based on demand generated by the government, the SSIs could work together in newer areas with sufficient demand, viz. public-private partnerships (PPPs) in health, district level TA in lagging states like Jharkhand, health system strengthening, etc. The current inputs of MCH-STAR for CB/IS (represented by the boxes on the right of the figure) need to be continued, with additional efforts given toward facilitating SSIs to work with government, Development Partners (DPs), and other SSIs. Although MCH-STAR has consciously taken a back seat with respect to interactions with the government and DPs so far in generating opportunities for SSIs, the MTR team feels that higher involvement of MCH-STAR in facilitation with government and DPs would not contradict the project's original objectives and would possibly help in achieving the objective of strengthening the identified Indian institutions (SSIs) better.

ANNEX I. SUGGESTED ROADMAP TO EXPANSION OF MCH-STAR

In order to scale up the operations of MCH-STAR, a step-by-step approach is necessary to ensure that resources are committed in tune with evidence of success at each stage, in keeping with the "learning by doing" approach. Table I.1 provides a suggested road map to the extension phase of MCH-STAR and a proposed second phase of the project with revised objectives. The rationale for scaling up and extending MCH-STAR into a second phase is to keep it in the vanguard of USAID's Global Health Initiative. It is expected that this will result in maximizing the returns on investment and consolidating the gains made so far in MCH-STAR, paving the way to providing the increase in technical assistance that will be demanded by the government in a constantly changing global environment.

It is proposed that the MCH-STAR project be restructured per the recommendations of this report for the remaining 2.5 years, with extension for a further 2 years. The proposed second phase of the project can aspire to deliver TA of substantial scale to the government through a larger network of SSIs and with additional funding. This phase can have two stages:

Stage I: Provide structured CB/IS inputs to the larger network of SSIs with provision for delivering TA on a collaborative basis as a pilot. Not more than 20% of the total funding for Phase II (i.e., including Stage I and II) should be allocated to this stage. "Trigger indicators" may be designed to assess the progress of system strengthening of SSIs. SSIs would be allowed to graduate to Stage II only if they meet the triggers.

Stage II: Allocation of the remaining 80% of the total funding for a second phase of MCH-STAR may be planned at this stage. The larger TA delivery system may also be designed for SSIs at this stage.

Table I.1 gives detailed activities for the proposed extension and second phase.

TABLE I.1 ROAD MAP TO TWO-YEAR EXTENSION OF MCH-STAR AND A PROPOSED SECOND PHASE

Period/ Stage	Objective	Major Areas of Intervention	Actions Required	Exit Option
2010–2012 Current	Taking corrective actions at MTR to achieve MCH-STAR objectives	Partnerships: MCH partners; government at state and national levels Systems improvement at government and SSIs	Implement recommendations from the MTR. Start dialogue with other EAG states with intention for support. Offer workshops on technical and MNCHN areas: PPPs, health insurance, health systems, nutrition, etc. Encourage SSIs to leverage resources with government and donor funds. Identify additional SSIs for recruitment in next phase Start preparing project blueprint and implementation plan for Phase II	No

2012–2014 (Proposed extension phase of MCH-STAR)	Conducting evaluations of MCH-STAR project before and after MTR; preparing for MCH-STAR Phase II	Partnerships with SSIs, government of UP, Jharkhand, and at least two other EAG states Dissemination of evaluation of MCH-STAR Preparation of proposed Phase II of MCH-STAR	Continue partnership building with government, DPs, other Indian institutions, and the academic fraternity. Add at least 5 more SSIs. Disseminate evaluation results. Enter into MOUs with two additional EAG states and renew/revise MOUs with UP and Jharkhand. Finalize Concept Note and Project Implementation Plan, including detailed plan from each SSI for second phase. Continue TA at district level and in the areas of health system strengthening, PPP, health insurance, and integration with Rashtriya Swastya Bima Yojana national health insurance scheme.	Yes
2014–2016 Stage I of proposed MCH-STAR Phase II	Focusing on providing responsive TA at scale to state governments and national government around the central theme of MNCHN; gradual phasing out of CB/IS inputs	-Provide TA to district government on pilot basis -Offer organizational development of government institutions through SSIs on pilot basis - Systems strengthening in SSIs through CB/IS inputs against "trigger indicators" that need to be achieved by the SSIs to graduate to Stage II of the program with larger funding for providing TA.	Reorient SSIs for providing responsive TA at scale to government. Focus on districts for providing TA. Engage in organization development initiatives with government staff for better outputs through workshops, long-term capacity building exercises, and evaluations. Strengthen SSI base further and facilitate leveraging of resources with donors and government. Continue CB/IS inputs to SSIs as needed with focus on gradual phasing out of the inputs after evidence that SSIs are strengthened Monitor SSI achievement of "trigger indicators" for graduating to Stage II of program. Develop model for transferring skills and knowledge from strengthened SSIs to other potential SSIs. Facilitate strengthening of other potential Indian institutions through SSIs based on model developed for "trickle down" effect of institutional strengthening.	Yes

2016–2019 Stage II of proposed MCH-STAR II	Strengthening TA inputs; conducting evaluations of MCH-STAR II to evaluate return on investments	Consolidate TA inputs through larger funding and collaborations with government and donors Continue organizational development and change management inputs to government institutions and officials with focus on gradual phasing-out.	Scale up resources for larger TA needs. Consolidate SSI teamwork, including potential SSIs who can be trained by current SSIs for delivering strong TA. Continue facilitating SSIs to leverage funds and collaborate with each other. Ensure sustainability of SSIs and programs and rough out exit strategy. Conduct end-term evaluation.	No

The roadmap is indicative; it would need fine-tuning based on the context and ground realities at different points of time. The MTR team recommends gradual scaling-up of funding and resources to the project (for the current as well as the proposed phases) with exit options at several points to ensure that return on investment is evaluated at every major stage before committing further funds.

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