Pakur Mother and Child Survival Project

Annual Report for Fiscal Year 3

April 1st 2013 – March 31st 2014

Submitted by: HealthBridge Foundation of Canada
Date: May 21st 2014

Revised: June 25 2014

Table of Contents

List of Acronyms

ANC	Antenatal Care
ANM	Auxiliary Nurse Mid-wife
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BCC	Behaviour Change Communication
BTT	Block Training Team
CIDA	Canadian International Development Agency
CDPO	Child Development Program Officer
DPC	District Program Coordinator
DPM	District Program Manager
DPT	Diphtheria, Pertussis, Tetanus (vaccine)
EFICOR	Evangelical Fellowship of India Commission on Relief
FY-2	Fiscal Year 2
FY-3	Fiscal Year 3
HSC	Health Sub-centres
IEC	Information, Education and Communication
IFA	Iron-Folic Acid supplementation.
ITN	Insecticide-treated Net
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring and Evaluation (Officer)
MNCH	Maternal, Newborn and Child Health
MOIC	Medical Officer in Charge
NRHM	National Rural Health Mission
ORS	Oral Rehydration Salts
PIT	Project Implementation Team
PMF	Performance Measurement Framework
PMT	Project Management Team
TBA	Trained Birth Attendant
TAG	Technical Advisory Group
TT	Tetanus Toxoid (vaccine)
VHND	Village Health and Nutrition Day
VHSNC	Village Health, Sanitation and Nutrition Committee

Executive Summary

This Annual Report describes implementation of the Pakur Mother and Child Survival Project during Fiscal Year 3, comprising the period from April 1st 2013 to March 31st 2014. During FY-3, the project conducted a mid-term review to assess progress made towards achieving the expected outcomes. The report was submitted with the Semi-Annual Report in November 2013. Results showed improvements in many of the project indicators, including increases in the percentage of: a) mothers receiving ANC, b) consumption of iron tablets during pregnancy, c) births taking place in a health facility, d) children receiving 3 doses of DPT3 and measles vaccine, and e) care-seeking with children with suspected pneumonia.

The project team completed training of ASHAs and AWWs, and more than half of ASHAs and 80% of AWWs received re-fresher training. EFICOR developed a tracking format to improve ASHAs documentation and follow-up of household counselling visits, and now 560 ASHAs are using the tracking format.

Great strides were made in building local capacity to reduce gender barriers in maternal and child health. Block Training Teams, comprising EFICOR and Pakur government staff, were "trained to be trainers" on gender. These teams later conducted gender training with ASHAs, which marks the first time ever that frontline health workers in Pakur received this kind of training. Additionally, EFICOR developed a leaflet and video that promotes family communication and husband involvement in maternal and child health. The video will stay with the government after the project ends to enable further dissemination.

One of the main challenges experienced by the project is a district-wide stock-out of Vitamin A which has endured since Fiscal Year 2. EFICOR has brought this to the attention of district and state level officials, but the issue has not been resolved. EFICOR has been told that the problem is related to procurement at the state level.

Another challenge the project team incurred was the re-formation process of the VHSNCs which delayed capacity building activities to the beginning of Year 3. In the Semi-Annual Report for Year 3, EFICOR requested to reduce the number of VHSNCs trained by the project from 600 to 400 due to the shortened time period. To date, EFICOR has been able to train and mentor 384 VHSNCs, but has noted that sustainability of the project results would be strengthened by training all 600 VHSNCs and having more time to mentor the 384 that have already been trained.

Progress made in Fiscal Year 3 towards achieving the project's outcomes is described below:

Intermediate Outcome: *Implementation of more effective, gender-sensitive MNCH interventions and services.*

- The project reached its targets for the percentage of live births taking place in a health institution (50%) and percentage of mothers consuming 100 iron tablets during pregnancy (37%).

Immediate Outcomes:

100: *Increased capacity of EFICOR and local and government health institutions*

- 384 VHSNCs and 1277 members received training and mentorship on their roles and responsibilities. 40% of VHSNCs in the district now have a Village Health Plan.
- 213 convergence meetings held with frontline health workers from health and ICDS centres (ASHAs, AWWs and ANMs) to strengthen the delivery of services at the village level. EFICOR has noticed that these meetings are being held more regularly.
- 560 ASHAs are now using tracking format, developed by EFICOR, to improve documentation and follow-up of household counselling visits.

200: *Increased access to MNCH services*

- There has been a 50% increase in the percentage of HSCs with availability of iron-folic acid supplementation (IFA) and 59% increase in HSCs with availability of oral rehydration salts (ORS).
  A total of 1135 AWWs have been trained by the project (97% of 1168 in district).
- A total of 721 ASHAs have been trained by the project (86% of 839 in district).
- A total of 609 TBAs have been trained by the project (81% of 750 initial target).
- 1263 safe deliveries were conducted by trained TBAs and 1257 mothers were referred by TBAs to give birth in a health facility.

300: *Increased knowledge of appropriate MNCH practices amongst men and women in Pakur*

- Results from the mid-term review show a 14% and 9% increase in the percentage of mothers and fathers, respectively, with knowledge of maternal and newborn danger signs.
- 407 street theatre (Kalajathaa) events were organized, and 9500 educational leaflets were distributed.

400 & 500: *Increased acceptance of and ability to make shared decisions about MNCH*

- 467 Saas, Bahu, Pati Sammelan were conducted reaching 3288 pregnant women, 6899 lactating mothers, 4275 mothers in-law and 5138 husbands.
- 663 ASHAs were trained on gender which included the importance of counselling husbands and mothers in-law, and also behaviours men can do to support maternal and child health.

1. Operational Section

1.1 Narrative Sub-section

1.1.1 Completion of Outputs Compared to Annual Work Plan for FY-3.

Table 1: Progress made in completing key milestones in Fiscal Year 3 (FY-3)

Output	Expected Milestone	Progress
Project Evaluation	LQAS (Lot Quality Assurance Sampling) completed for mid-term internal performance review	LQAS survey was initiated in September and completed in October 2013.
Output 110 EFICOR & VHSNC Capacity Building	Training completed for 600 VHSNC	384 VHSNCs trained *Note there was an error in the Semi-Annual Report which indicated 388 were trained.
Output 120 Coordination of MNCH Programs	768 meetings held at the village level (VHNDs), 72 at block level and 12 at district level to strengthen coordination MNCH programs and services	1825 meetings done at village level (VHNDs), 72 (at block level and 12 at district level
Output 130 Gender sensitivity training	Gender sensitivity training completed with ANM, AWW, ASHA	663 ASHAs were trained on Gender.
Output 210 Health worker training	1.Training for all 600 TBA completed 2. Re-fresher training completed for 855 ASHAs and 1167 AWWs	1.609 TBA have been trained. 2. 431 ASHAs and 928 AWWs received re-fresher training.
Output 220 Facilitating Availability MNCH Supplies	24 meeting held with Health and ICDS officials	213 meetings held at 28 Health sub centers with health and ICDS frontline workers. One meeting was done with the District Malaria Officer and Medical Officer in Charge in the malaria prevalent blocks – Littipara and Amrapara
Output 230 Home and community counselling	25% of Mothers and Pregnant Women counselled on Nutrition and Growth Monitoring Chart in each of Semester 1 and 2	Semester 1: 73% of mothers and pregnant women were counselled on nutrition and growth monitoring chart.

Output	Expected Milestone	Progress
		Semester 2: This will be reported at endline.
Output 310 BCC activities MNCH practices	250 outreach events completed	407 outreach events completed
Output 410 IEC & media materials shared decision making	Materials distributed to 640 families in each of Semesters 1 and 2 (1280 in total)	9500 handouts were distributed
Output 510: Discussion groups shared decision making	336 Saas Bahu Pati Sammelan completed in each of Semesters 1 and 2 (672 in total)	475 Saas Bahu Pati Sammelan were completed.

Table 2: Progress made in completing project outputs in Fiscal Year 3 in comparison to Annual Work Plan

ACTIVITIES	DESCRIPTION OF WORK COMPETED
Administrative	
Dissemination meetings at district level	The dissemination meeting was postponed to first quarter of FY 4, due to busy schedule of Government Officials (March closing and Elections).
Monthly PIT Meetings	Six PIT meetings were conducted in Semester 1. Five PIT meetings were held in Semester 2. Activities were critically reviewed and planning was done for subsequent months.
Quarterly PMT Meetings	Four PMT meetings were held in FY-3. In the first quarter, the team discussed the project indicators and incorporating suggestions from the DFATD monitoring visit. It was here that the project team decided to implement kitchen gardens with 6 families, as per the recommendation of Mr. Sampath. In the second quarter, the team discussed project indicators, reporting, staff exposure visit, LQAS and budget expenditure. In the quarters three and four, the main issues discussed were: staff exposure visit, VHSNC exposure visit, VHSNCs coordination meeting, training materials and equipments, end-line evaluation, case studies, possibility of project extension and a new project focused on VHSNCs, updates on the kitchen garden, and availability of basic drugs with ASHAs.
Bi-annual TAG Meetings	One TAG meeting was held at Pakur project office on November 14 2013. Attendees included the HealthBridge Project Manager, NRHM District Program Manager (DPM) and District Program Coordinator (DPC), EFICOR Director Programmes, Manager Programmes, Project Manager, M&E Officer and Training & BCC Officer. The discussion focused on the mid-term LQAS findings and the situation of stock-outs of Vitamin A, IFA and MCP (maternal and child protection) card. The DPM informed us that the issue of Vitamin A stock-out was a problem at the state level, and they expect to receive it by February 2014 (although this is did not occur). He said that IFA has been distributed to block officials and should reach the village level soon, and that the MCP card will be distributed at the ground level in the next few days. EFICOR showed the video on shared decision making that was developed to promote male involvement and support for maternal and child health. The DPM and DPC suggested that the video should be contextualized so that it is more relevant to the tribal communities (e.g. Tribal clothing for the actors, use ANM instead of a doctor for the ANC check-up). EFICOR agreed to

ACTIVITIES	DESCRIPTION OF WORK COMPETED
	look into how these suggestions could be incorporated. EFICOR also explained the research they will be conducting on the perceptions of mothers of institutional deliveries. The DPM was interested in being involved in and learning of the findings of this research.
Monthly PM & Cluster Supervisor field visits	Field visits are on-going.
End of Year Meetings (HB & EFICOR)	The end of year meeting was held in March 2014. Three days of the meeting were held in New Delhi at EFICOR's Headquarters on March 5th to 7th. Day 1 focused on project achievements to date, the project budget and planned activities for the remainder of the project. Days 2 and 3 focused on planning for the endline evaluation, including a meeting on Day 3 with all of the consultants who will be involved in data collection and analyses. Subsequently, meetings and field visits were conducted in Pakur from March 10th to 13th. The main focus of the discussion was achievement to date, challenges, activities for the remainder of the project, and a discussion on what EFICOR and HealthBridge should focus on for future projects in Pakur. There was a consensus amongst the project team that there will still be challenges remaining beyond the scope of the Pakur project, and given their extensive knowledge and the strong rapport they have established in the district, they are well-suited to continue working to address these challenges in the future.
Project Evaluation	
Deliver training to EFICOR (LQAS)	Planning and training meetings were held with block coordinators and cluster supervisors towards proper execution of LQAS Survey,
Mid-term internal performance review (LQAS)	The midterm LQAS survey was conducted in September & October 2013
LQAS report submission	The report was submitted with the Year 3 Semester 1 report.
Activity 110: Train EFICOR & VHSNCs	
Deliver gender training to EFICOR (refresher)	In Semester 1, a two-day refresher training on gender was provided to the EFICOR staff. 36 staff attended the training. Some project staff also participated in the 'Training of Trainers' gender program to form the block level training teams.

ACTIVITIES	DESCRIPTION OF WORK COMPETED
Learning & exposure visit –EFICOR staff	In Semester 1, 36 project staff underwent a 4-day training on Maternal and Child Health issues. 10 staff went for an exposure visit to Rajasthan to learn about Village Health Sanitation & Nutrition Committees (VHSNC). Block coordinators and Cluster Supervisors were given training on HMIS (health monitoring and information system) formats and analysis, VHSNC Self scoring tools and tracking of ASHA time counselling. In Semester 2, 39 EFICOR staff went for an exposure visit to Gangtok (Sikkim). The objective of the visit was to learn the basic components of nutrition, type I and type II nutrients, and types and forms of malnutrition. The staff learned about food groups, categories of nutrients, micronutrients and macronutrients, types of malnutrition, acute malnutrition, chronic malnutrition, under weight and fortified food and therapeutic food.
Deliver training to VHSNCs- 600	384 VHSNCs and 1277 members were trained in Year 3 on their roles and responsibilities.
Activity 120: Coordination of MNCH services	
Quarterly meetings with VHSNCs	A total of 102 mentorship meetings were held with 384 VHSNCs in FY-3. The main issues discussed in these meetings were: Role of VHSNCs, Formation of VHSNC, Conducting VHSNC meetings, United fund, Sass Bahu Pati Sammelan, Mamta wahan (vehicle service provided by government for transportation for institutional births), JSY(Janani Sishu Suraksha Karyakram) incentive scheme for institutional births, Malnutrition Treatment Center, Maintaining meeting register and Village Health Plan.
Monthly mtngs with ICDS/ MOIC @ block & district	Semester 1: A total of 72 advocacy meetings were held with Health and ICDS departments at the block level at which EFICOR Block Coordinators met with the Medical officer in-charge (Health) and child development program officer (ICDS). The meetings enabled two-way sharing of information and updates between the government and EFICOR. A total of 12 meetings were held at the district level by the Project Manager and M&EO with the Civil Surgeon, District Program Manager and District Program Coordinator and block level program management unit (NRHM) for providing feedback as well as updating them on EFICOR activities. Major issues of discussion at these meetings were: • Shortage of Maternal and Child Protection (MCP) Cards, • Referrals of severely malnourished children to the malnourished treatment centre • Lack of Iron folic acid (IFA) tablets and vitamin A during VHND were discussed and brought to district officials attention • Placement of health and nutritional educational hoardings) at Health Sub-Centres (HSC)

ACTIVITIES	DESCRIPTION OF WORK COMPETED
	and ICDS Centres • Availability of malaria and pneumonia treatment and ORS at HSCs • Availability of weighing scales at Anganwadi Centres As a result of the meetings, the district level officials demanded the supply to be increased for IFA and MCP Card. IFA tablets are now available at the village level and MCP card will be available from May 2014 onwards. Unfortunately, the status of Vitamin A and Weighing scale has not changed – there is still a shortage in the district and, for Vitamin A, throughout the state. Regarding the Referral of malnourished children, the block / district level ICDS officials assured that they would support the identification and admission of such children. The government also agreed on placement of hoardings at HSCs and ICDS centres.
Supportive supervision to VHNDs	1825 VHNDs were supported and 97 (5.31%) met the minimum criteria. The main reasons that so few met the minimum criteria were lack of Vitamin A, MCP card and IFA tablets. Another issue addressed by EFICOR was the importance of weighing children during VHND for growth monitoring.
Exposure visits for VHSNCs	90 VHSNCs went on an exposure visit to a district named Dhanbad in Jharkhand state. The main purpose was to meet with VHSNCs that are performing well in regards to carrying out their roles and responsibilities, and developing and implementing the Village Health Plan. The Pakur VHSNCs learned about how the VHSNCs in Dhanbad prepared and are implementing their Village Health Plan. The knowledge gained will help the Pakur VHSNCs in preparing and implementing their own Village Health Plan.
Activity 130: Gender-sensitivity training	
Develop workshop content & logistics Deliver ToT training (BTT + Project Staff)	In Semester 1, 2 days Training of Trainers (ToT) was provided for some EFICOR project staff and the government Block Training Team (BTT). The purpose is to form a block level trainers team (team consist of two cluster supervisor and two government staff from each Block) to facilitate gender workshops with front-line service providers at the block level.
Deliver service provider workshops: (ASHA,AWW,ANM,MPW)	663 ASHA were given gender sensitivity training. The training covered the difference between sex and gender, how gender norms and beliefs impact women's health and status, Indian government policies related to gender equality, conceptions of masculinity and its impact on

ACTIVITIES	DESCRIPTION OF WORK COMPETED
	men and women, positive notions of masculinity and behaviours men can do to support women's health.
Activity 210: Health worker training	
Deliver ASHA workshops – Training & Follow up	In total 721 ASHAs have been trained (527 ASHA were trained in FY-2 & 194 in FY-3), 86% of the 839 in the district. Re-fresher training was conducted in Quarter 4 of FY-3 with 431 ASHAs.
Deliver AWW workshops – Training & Follow up	1135 AWWs were trained in total (FY-2 = 1093 & FY-3- = 42), 97% of the 1168 in the district. Re-fresher training was conducted with 928 AWWs in Quarter 4 of FY-3.
Deliver TBA workshops	In total 609 TBA have been trained by the project (FY-2 = 375 & FY-3 = 234). TBAs were trained on danger signs during pregnancy, referring mothers for institutional deliveries, clean and hygienic delivery practices and how to keep the newborn warm.
Activity 220: Facilitate availability of supplies	
Monthly meetings with PHCs (ANM,MOIC, EFICOR)	This is captured under Activity 120.
Monthly meetings with ASHAs, AWW & ANMs:VHNDs	213 meeting were held to increase the coverage of ANC, Immunization, Institutional Delivery, PNC, Weighing of children, using the Growth Monitoring Chart and referring Severe Malnourished Children to the Malnutrition Treatment Centre. The meetings provide a platform for sharing and joint planning between front-line health workers.
Annual meetings with District Malaria Officer/Unicef/Sub-centres to facilitate ITNs	A meeting was held with the Medical Officers in Charge of malaria prevalent blocks (Littipara and Amrapara). At the meeting, refresher training on Malaria was given by the Government for Multipurpose Workers, who are responsible for collecting malaria blood smear slides for diagnosing malaria at the village level.
Meeting with ICDS to avail scales and GMC	Advocacy is on-going – when EFICOR's Cluster Supervisors and Block Coordinators visit ICDS centres and notice stock-out, they contact the corresponding Child Development Program Officer (CDPO) to make him/her aware.

ACTIVITIES	DESCRIPTION OF WORK COMPETED
	Block coordinators meet monthly with the CDPOs to discuss shortages of supplies and inform CDPO if AWWs are practicing growth monitoring in the centres. EFICOR also discussed the shortage of scales with district level officials. The ICDS district level officials informed them that the scales can be procured only at the state level. Thus, the issue is lack of procurement at the state level, which is difficult for EFICOR to influence.
Activity 230: Home & community counseling	
Tracking of correct & timely counseling ASHA/AWW	A total of 9232 pregnant and lactating mothers were counselled in FY- 3. The counselling is done correctly with the help of EFICOR's flipbook. EFICOR developed a format to facilitate ASHA's in documenting the counselling visits and follow-up. The format tracks the number and timing of ASHA counselling visits for each pregnant woman and whether the pregnant woman avails ANC and institutional delivery after the counselling. 560 ASHA are now using the tracking format.
Tracking of safe delivery conducted by TBAs	A total of 1263 safe deliveries were conducted by trained TBAs and 1257 mothers were referred by TBAs to give birth in a health facility.
Activity 310: BCC activities MNCH practices	
Disseminate IEC materials	9500 leaflets on MNCH practices were distributed in FY-3.
Conduct outreach events	407 Kalajathaa were organized in FY-3.
Activity 410: IEC & media materials shared decision making	
Produce IEC materials	1 leaflet was developed to promote shared decision making and engagement of men in maternal and child health was produced. It was submitted with the Year 3 Semester 1 report (Annex D).
Disseminate IEC materials	5000 leaflets to promote share decision making and engagement of men were distributed in FY-3.

ACTIVITIES	DESCRIPTION OF WORK COMPETED
Conduct locally appropriate AV dissemination	A video promoting active involvement of men in maternal health education and support was developed by EFICOR. The video was shown to the ASHAs during the Gender Training. It will be shown to men and women in the villages in FY-4.
Activity 510: Discussion groups shared decision making (Saas, bahu, pati sammelan)	
Conduct group discussion/ SBPS	In Total, 467 Sass Bahu Pati Sammelan were conducted in FY-3 reaching 3288 pregnant women, 6899 lactating mothers, 4275 mothers in-law and 5138 husbands.

1.1.2 Problems/difficulties encountered

A transfer of the CMHO (chief medical health officer) occurred and created a challenge for the project team. It took time to orient the new CMHO to the project and to build a good rapport. However, given the strong reputation of EFICOR in the district and state, they were able to build a good relationship with the CMHO and gain his support for the project.

There is still a stock out of Vitamin A in the state, and it was reported by EFICOR that only around 25-30% of ASHAs have kits with basic drugs. EFICOR has informed the district officials of these issues. In addition, ASHAs have reported delays in receiving compensation for their work. Rather than receiving a salary, ASHAs work on an incentive system in which they receive pay for certain outputs, such as bringing pregnant mothers to ante-natal care, bringing pregnant mothers to health facilities for delivery, etc. The ASHAs have indicated that sometimes there are delays in receiving the incentives, or it is not received at all, which reduces their motivation to work. EFICOR will bring these issues to the attention of the district officials, although it may not be possible to develop solutions during the scope of this project.

1.1.3 Changes made to Project Management or Implementation Plans or Strategies

In Semester 2, Ms. MacDonald, HealthBridge Project Manager, and Mr. Prashant Missal, EFICOR Manager Programmes, participated in a sub-plenary symposium at the Canadian Conference on Global Health in Ottawa on October 28th 2013. The symposium titled "The social dimensions of maternal and child health: engaging men, families and communities" comprised four speakers including Ms. MacDonald, Mr. Missal, Dr. Gail Webber of the University of Ottawa and Ms. Elaine Hernandez of the Canadian Red Cross. Ms. MacDonald presented on the results of the Pakur project's barrier analysis which demonstrated the need to engage men and mothers in-law, described the strategies the project is using to do this, and presented lessons learned and challenges from the Pakur project as well as HealthBridge's previous projects. Mr. Missal described EFICOR's unique approach to engage husbands and mothers in-law called "Sass Bahu Patti Samellan", shared results achieved from using this approach in EFICOR's previous project in Sahibganj district, and the scale up of the strategy by the Jharkhand state government. The symposium was well attended and interesting questions and discussion followed the presentations. Ms. MacDonald was later contacted by an attendee for a copy of the presentation. The conference contributed to the project's communication strategy, enabling HealthBridge and EFICOR to share about the project approach and achievements to date with the broader global community. Additionally, the conference provided an excellent capacity building opportunity for Mr. Missal who was able to attend other sessions at the conference and network with other professionals from Canada and around the world.

In the Semi-Annual Report for Semester 1 the project team had planned to conduct a mid-term gender assessment to determine how to strengthen the projects' gender-related activities for the remainder of the project. Due to holiday closures, it took longer than anticipated to find the right Gender Evaluation Consultant for this task, and due to time restrictions, the project team decided to conduct the gender assessment at endline instead. Thus, the gender assessment will assess achievement of project results, and will also provide recommendations for strengthening the gender-related strategies in future projects.

As described in the Semi-Annual Report, the project team conducted a qualitative study to assess the perceptions of mothers on the quality and accessibility of institutional deliveries. The study was completed, and the report and findings will be submitted with the next report.

In December 2013, HealthBridge received approval from DFATD to conduct a nutrition assessment to explore barriers to improving infant and young child feeding practices given that mid-term LQAS results showed little improvement from baseline results. One component of this assessment was completed, and comprised a more detailed analysis of the baseline quantitative results. The report is attached in Appendix A. Good infant and child feeding practices require eating at least four food groups (minimum dietary diversity) 2-4 times per day (depending on the child's age and whether they are breastfed). The findings showed that dietary diversity was worse than feeding frequency and that feeding practices were worse for children 6-11 months old, compared to 12-23 months. This suggests that the project team should focus on clear messaging about the importance of a diverse diet and of starting complementary feeding at 6 months of age. Reasons for poor feeding practices will be explored in more detail through a qualitative assessment in June 2014.

As mentioned in the Semi-Annual Report for Semester 1, EFICOR developed a video to promote the engagement of men in MNCH which was shown to ASHAs during their gender training and will be shown to local communities in the next quarter. Similarly, EFICOR will develop health films to educate local people on the four key indicators with poor results at baseline: a) consumption of IFA tablets, b) institutional delivery, c) complementary feeding and d) care-seeking for malaria, diarrhea and pneumonia. These topics are currently being addressed through street-theatre education, but EFICOR decided to develop the videos to enhance sustainability of the education, as the videos will remain with the district health administration after the project. The videos will be developed in Hindi, Bangla and Tribal language so that they are contextually relevant.

1.1.4 Analytical comments on financial information as they relate to successes or problems encountered in implementing activities

See section 1.2.

1.1.5 Implementation of Gender Equality Strategy

Several achievements were made in Fiscal Year 3 towards implementation of the Gender Equality Strategy. First, EFICOR developed a leaflet with messages and images on how husbands can support their wife during and after pregnancy, including recognizing danger signs. The leaflet is distributed during the Sass Bahu Pati Sammelan, which brings together husbands, mothers in-law and pregnant and lactating mothers in joint education about maternal and child health. Secondly, using the same message in the leaflet, EFICOR developed a video to promote male involvement in maternal and child health. The video dramatizes the importance of husband's involvement and the various ways husbands can support their pregnant wives. It will be given to the district administration so that it can be used beyond the scope of the project.

Thirdly, gender training was conducted with selected government officials and project staff to form block level training teams. The training teams subsequently conducted gender training with 663 ASHAs throughout all six blocks of Pakur district. The training covered the difference between sex and gender, how gender norms and beliefs impact women's health and status, Indian government policies related to gender equality, conceptions of masculinity and its its impact on men and women, positive notions of masculinity and behaviours men can do to support women's health. The training particularly highlighted the importance of counseling the whole family during the household visits by ASHAs. EFICOR staff also received a two-day refresher training to reinforce the gender concepts they learned at the beginning of the project.

1.1.6 Implementation of UN Commission recommendations

Recommendation 2: Health indicators: By 2012, the same 11 indicators on reproductive, maternal and child health, disaggregated for gender and other equity considerations, are being used for the purpose of monitoring progress towards the goals of the *Global Strategy.*
As part of the mid-term evaluation, the project collected data on progress made towards achieving 6 of the 11 indicators (see mid-term LQAS report submitted with Semi-Annual Report for Year 3). The results were shared with the district level government and front-line health workers. In addition, EFICOR developed a tracking format for ASHAs to track ANC, skilled delivery and PNC received by the mothers. The tracking format will strengthen accountability at the Health Sub-Centre level through the collection of accurate data on utilization of maternal

health care, and enable ASHAs to identify gaps and barriers, provide timely follow-up and coordinate with the Auxiliary Nurse Mid-wife.

1.1.7 Updated Risk Register and Response Strategies:

There are no new risks to add to the Risk Register. The response strategy has been updated for Operational Risk 3: To deal with the delays in capacity building and mentorship with VHSNCs, EFICOR has decided to train only 400 VHSNCs, rather than 600. This will allow the capacity building to be more intense and focused. However, the project team has indicated that a longer mentorship process would have been more beneficial.

1.2Financial Sub-section

Table 3: Comparison for Forecasted and Actual Costs for Fiscal Year 3

2. Performance Section/Actual Outcomes

2.1 Project Context for Fiscal Year 3

External context:

As described in Section 1.1.2, the transfer of the CMHO was a challenge for the project team, but EFICOR has worked to establish a good rapport and has won his support. Aside from this, the project has received strong support from the Health and ICDS departments, which has enabled the project to run fairly smoothly. Both governments have expressed their appreciation to EFICOR for their support in strengthening the government's MCH services.

The continued stock out of Vitamin A, and shortages of vaccines in some areas, has created challenges in achieving the project results. Since the stock outs are at the state level, there is little EFICOR can do to amend this problem.

Internal context:

There were no major changes at EFICOR during this Fiscal Year. The project received quarterly visits from the Director Programmes and monthly visits from the Manager Programmes to review the work plan, finances and implementation.

The HealthBridge Field Project Manager went on maternity leave in February 2014 and will return in May 2014. Prior to this, due to the pregnancy, she was unable to travel to the quarterly project meetings in Pakur in quarters 2, 3 and 4. Consequently, the HealthBridge Headquarters Project Manager made two trips (in quarters 3 and 4, respectively) to Pakur to monitor the project and provide support.

2.2 Actual Outcomes

Table 4: Progress Made Towards Achieving Project Intermediate and Immediate Outcomes as of March 31st 2014

Expected Results[1]	Indicators[2]	Targets[3]	Progress made as of March 31 2014
Intermediate Outcomes (Medium Term) Implementation of more effective, gender-sensitive interventions and services related to MNCH in Pakur	1. % of women, and boys and girls aged 0-23 months utilizing maternal and child health services; % difference in utilization rates for boys and girls 2. Perceived accessibility and quality of government MNCH services..	Details in PMF narrative	1. Results of the midterm LQAS survey showed an increase in the utilization of the following maternal and child health services since baseline (see attached report for details). Indicators with an asterix have reached or surpassed the end of project target: • 19% increase in mothers whose received at least 3 ANC during pregnancy • 19% increase in mothers whose delivery took place in a health facility* • 34% increase in mothers who consumed 100 IFA tablets during pregnancy* • 15% increase in children who received 3 doses of DPT3 and measles vaccine 28% increase in children with suspected pneumonia who sought care from a skilled provider in 24 hours* During the HealthBridge Project Manager's visit to Pakur in March 2014, an ANM in Littipara block and the Medical Officer in Charge in Pakur block indicated that more women are coming to deliver in a health facility since the project has been in place.
Increased shared decision making at the household level about MNCH practices in Pakur	1. % of men and women who discussed MNCH plans with their spouse 2. % of men and women who say that MNCH decisions were made jointly 3. Perceptions of men and women regarding changes in communication and shared decision making about MNCH	1. 75% men; 90% women 2. 85% men; 90% women 3. Men & women indicate that inter-spousal communication about MNCH issues has increased, and both men and women feel their input is valued in the final decision making.	Results of the midterm LQAS survey showed an increase in the % of men and women who say that they discuss MNCH and make decisions jointly since baseline: 1. 90.7% men;90.8% women 2. 95.5% men; 94.1% women Cluster supervisors have noticed that husbands and mothers in-law are more supportive of pregnant and lactating women accessing health service. The gender evaluation at endline will provide more detail on this.
Immediate	1. Development		1.

Expected Results[1]	Indicators[2]	Targets[3]	Progress made as of March 31 2014
Outcomes ***(Short term)*** 100 Increased capacity of EFICOR and local and government health institutions to design and deliver effective, coordinated and gender-sensitive programs and services related to MNCH in Pakur	and/or implementation of solutions by block and district government officials in health plan to address identified gaps in MNCH service delivery and coverage; extent to which gender issues are addressed 2. % of VHSNCs with Village Health Plan 3. Demonstrated evidence by EFICOR staff of ability to effectively plan, implement and monitor MNCH initiatives	1. Plans/programs are developed at all levels; at least one gender issue addressed at the block and district level. 2. 40 % of VHSNCs with Health Plan 3. Progress & financial reports indicate effective project implementation, monitoring, and accounting	Due to EFICOR's baseline survey results and involvement in the VHNDs, in Year 2, the District Immunization Officer asked them to conduct an Urban Micro-planning Survey of Immunization with the purpose of preparing a district-wide list of beneficiaries for immunization (pregnant women and children 0-5). This list will help the government to improve their surveillance and coverage of immunization in the district. As a result of EFICOR's advocacy efforts, monthly block level convergence meetings were initiated between HSC and ICDS staff in Year 2 of the project. The meetings enable the front-line health workers to engage in joint planning to improve the accessibility and quality of their services at the village level. In Year 3,EFICOR has noticed that the coordination meetings are being held more regularly and have helped ANMs in monitoring pregnant mothers and malnourished children in their catchment area. In Year 3, The government agreed to place nutrition and growth monitoring hoardings at all Anganwadi Centres to help Anganwadi workers and lactating mothers identify signs of severe acute malnutrition and improve referrals to the malnutrition treatment centre. Also, in Year 3, EFICOR developed a format to facilitate ASHA's in documenting and following up on the counselling visits to pregnant women. The format tracks the number and timing of ASHA counselling visits for each pregnant woman and whether the pregnant woman avails ANC and institutional delivery after the counselling. It is now being used by 560 ASHAs. 2. As of the end of Year 3, 384 VHSNCs have a health plan (40% of the total 950 VHSNCs that have been formed). . The HealthBridge Project Manager met with one VHSNC during the field visit in March 2014 who had received support from EFICOR in using the untied funds from the government to purchase DDT spray, sanitizing powder to clean their wells and to clear a road for the Mamta Wahan (government ambulance) to reach the village. 3. Thus far, EFICOR has submitted all financial and progress reports in a timely manner, and is demonstrating effective project management.

<table>
<tr><th>Expected Results[1]</th><th>Indicators[2]</th><th>Targets[3]</th><th>Progress made as of March 31 2014</th></tr>
<tr><td>200 Increased access to MNCH care and counselling (maternal and newborn care, nutrition, prevention and treatment of infectious diseases) amongst women and children 0-23 months in Pakur.</td><td>1. % of villages with a Village Health & Nutrition Day (VHND) held each month over the past 1 year (FY-2); % VHNDs which satisfy minimum requirements
2. % of HSCs with adequate supplies of essential drugs(first line anti-malarials, ORS, Vitamin A, IFA, first-line pneumonia)
3. % of PHCs which offer institutional delivery services</td><td>1. 40%
2. 30% antimalarial, 40% ORS, 40% Vitamin A, 30% IFA, 30% pneumonia
3. 25%</td><td>1.
In Year 2, 30% of villages in the district had a Village Health & Nutrition Day each month over the past 1 year (Fiscal Year 2) (source: HMIS – 2012-13). EFICOR developed a tracking system to assess whether VHNDs satisfy the minimum requirements. The tracking system assesses whether the following services were available: ANC, IFA, Immunization, Vitamin A, growth monitoring charts, Nutrition Counselling for Pregnant & Lactating Mothers, and Malnutrition Counselling. In Year 3, out of the 1825 VHNDs that were supported by EFICOR, only 97 (5.3%) were found to satisfy the minimum criteria. The low percentage is due to stock outs of Vitamin A, Maternal and Child Protection Card and IFA tablets.

2. The table below provides the findings of the assessment on the availability of rugs at HSCs at different points throughout the project. It should be noted that the reduced availability of Vitamin A is due to stock out at the state level.

<table>
<tr><th>IFA %</th><th>ORS %</th><th>Vit – A%</th><th>Malaria%</th><th>Pneumonia%</th><th>Comparative Status</th></tr>
<tr><td>65</td><td>87</td><td>4</td><td>13</td><td>9</td><td>FY 3 - Dec/13</td></tr>
<tr><td>26</td><td>74</td><td>17</td><td>30</td><td>30</td><td>FY 3 – April/13*</td></tr>
<tr><td>41</td><td>50</td><td>46</td><td>37</td><td>37</td><td>Target 2014</td></tr>
<tr><td>15</td><td>28</td><td>23</td><td>10</td><td>10</td><td>Baseline 2012</td></tr>
</table>
*Please note that the mid-term data provided in the Year 2 Annual Report was incomplete, and was completed in quarter 1 of Fiscal Year 3. Thus, the correct data is reported here.

3. 56% of PHCs offer institutional delivery services (5 of 9). As well, 45% of HSCs offer institutional delivery services (54 of 121).</td></tr>
</table>

Expected Results[1]	Indicators[2]	Targets[3]	Progress made as of March 31 2014
300 Increased knowledge of appropriate MNCH practices amongst men and women in Pakur	**1. % of mothers and fathers with knowledge of maternal and newborn danger signs** **2 % of boy/girl newborns and infants fed with appropriate feeding practices; % difference for boys/girls** 3**. % of mothers and fathers who report use of practices to prevent and treat infectious disease in children and newborns**	1. 73% 2. 60% 3. 70%	Mid-term LQAS results: 1. There was an increase to 69.8% of mothers (baseline 66%) and 60.6% (baseline 51%) of fathers with knowledge of the 3 dangers signs during pregnancy, delivery and in the newborn. 2. Altogether, the % of newborns and infants fed with appropriate practices increased to 61.6%, surpassing the target of 60%. The percentage of newborns put to breast within one hour of delivery increased 6% to 59%, and the % of children 6-23 months fed according to minimum practices increased by 7% to 27%. Exclusive breastfeeding between 0-5 months has increased significantly to 99%. 3. Altogether, the % of mothers and fathers who report use of practices to prevent and treat infectious disease in children and newborns increased to 68% and 67% for mothers and fathers, respectively (baseline levels were 62% and 63%, respectively). This was primarily due to an increase of 16% in households who report using soap or detergent for hand washing.
400 Increased acceptance of shared decision making at the household level about MNCH amongst men and women in Pakur	Degree to which men and women indicate understanding of the importance and benefits of jointly discussing MNCH issues and taking a joint decision	Men and women are aware of the benefits and importance of discussing MNCH decisions together. More men indicate that they ask for their wife's input in MNCH decisions. Women indicate that ther input is asked for in MNCH decisions.	As noted above, EFICOR Cluster Supervisors have noticed that husbands and mothers in-law are more supportive of pregnant mothers accessing health care.
500 Increased perceived ability of men and women to make shared decisions about MNCH in Pakur	Degree to which men and women indicate they feel confident that they can discuss MNCH practices with their spouse	Counter to the results of the quantitative survey, qualitative results indicate that women feel they have little knowledge or	EFICOR Cluster Supervisors have noticed that more husbands and wives and making a birth plan together

Expected Results[1]	Indicators[2]	Targets[3]	Progress made as of March 31 2014
		power to counter their husbands in decision making. Women reported that even if they had knowledge, their input would not be heard. Men do not consider asking for their wives input.	

2.3 Crosscutting themes and Priorities

2.3.1 Gender Equality Strategy

See section 1.1.5

2.3.2 Environmental Strategy

The project's strategy of using electronic telecommunications (e.g. e-mail, skype) has again been utilized during the FY-3 and has resulted in efficient communication without the need for overly frequent international travel. The main environmental issues related to MNCH identified at baseline were poor use of soap/detergent for hand-washing and only two thirds of children 0-23 months were reported to sleep under a bed net. Information on the importance of proper hand-washing and use of bed nets for maternal and child health is being provided to mothers through the household counselling and the VHNDs. The mid-term LQAS findings showed that the percentage of households using soap or detergent for hand washing increased from 54% to 71%. However, there was a decrease in the percentage of households who slept under a bed net in the last 24 hours from 66% to 2%. One reason for this dramatic reduction could be that the baseline survey asked about use of any bed net, while the mid-term LQAS asked only about insecticide-treated nets (ITNs). Another reason may be that the baseline survey may have been done closer to the last distribution of ITNs. At the TAG meeting in November 2013, the District Program Manager indicated they have 25,000 ITNs in stock and will be distributing them to the malaria high prevalence blocks (Amrapa and Littipara). Cluster supervisors will follow-up to promote use of the ITNs by households.

Through the training and mentoring of the VHSNCs, EFICOR has helped to promote positive environmental changes. In addition to maternal and child health, VHSNCs also have the responsibility of addressing sanitation problems in their village. One VHSNC which was visited by the HealthBridge Project Manager in March 2014 had used the untied funds from the government to purchase DDT spray for reduction of mosquitoes and sanitizing powder to clean their wells.

2.3.3 Governance Considerations

Over the course of the project, EFICOR has established good rapport with the block and district officials as well as front-line health workers. Feedback from the government has been very positive with respect to the support they have received from EFICOR, and the positive results EFICOR has achieved in mobilizing the community to access services. EFICOR has received requests to continue the project from district and block officials, as well as Auxiliary Nurse Mid-wives. At meetings between the HealthBridge Project Manager and one of the Medical Officers

in Charge (MOiC) as well as the Regional Coordinator of UNICEF (Dr. Pritish Nayak), both commented on the achievements that have been made by the project and expressed the need for EFICOR to continue working in the district to support maternal and child health.

As described in Section 1.1.2, there are some issues in the governance of ASHAs, particularly in receiving their supplies and incentives. The problem needs to be brought to the attention of district officials to develop an appropriate solution. EFICOR will raise the issue but there might not be time to address it during the scope of this project.

2.4 Lessons Learned and Recommendations Applied

Several recommendations were applied during Fiscal Year 3. Upon the recommendations of Mr. Sampath, EFICOR purchased bicycles for Custer Supervisors to facilitate their travel between villages, and implemented Kitchen Gardens with six families in Littipara block and four families in Amrapa block. The gardens are growing local seasonal vegetables, including tomatoes, cabbage, spinach, lady fingers, brinjal, and pumpkins.

The MNCH consultant, Mr. Sanjeev Bhanja, also recommended that EFICOR develop a booklet that merges the MNCH and Gender materials together to distribute during the outreach activities. The booklet is given to pregnant and lactating mothers, and has a spot to put their names on it, increasing the sense of ownership.

.

3.0 Annexes

3.1 Annex A: Logic Model

<table>
<tr><td colspan="5">Project Title: Pakur Mother and Child Survival Project
Budget: $1,146,880 (CIDA contribution $860,160)
Duration: Three years</td><td colspan="5">Version: 2
Date: February 24th 2012
Team Leader: Lisa MacDonald, Project Manager, HealthBridge Foundation of Canada</td></tr>
<tr><td>Ultimate Outcome</td><td colspan="9">Reduced maternal, newborn and child morbidity and mortality in Pakur District, Jharkhand State, India</td></tr>
<tr><td>Intermediate Outcomes</td><td colspan="7">Implementation of more effective and gender-sensitive interventions and services related to MNCH</td><td colspan="2">Increased shared decision making at the household level about MNCH practices</td></tr>
<tr><td>Immediate Outcomes</td><td colspan="3">100 Increased capacity of EFICOR & local government health institutions to design & deliver effective, coordinated and gender-sensitive programs and services related to MNCH</td><td colspan="3">200 Increased access to MNCH services (maternal and newborn care, nutrition, prevention &treatment of infectious diseases) amongst women and children 0-23 months</td><td>300 Increased knowledge of appropriate MNCH practices amongst men & women</td><td>400 Increased acceptance of shared decision making at the household level about MNCH</td><td>500 Increased perceived ability of men and women to make shared decisions about MNCH</td></tr>
<tr><td>Outputs</td><td>110 Capacity building conducted for EFICOR & VHSNCs in design and delivery of effective MNCH interventions</td><td>120 Coordination of MNCH programs & services strengthened at the village block & district levels.</td><td>130 Gender sensitivity workshops conducted with health & government institutions at village, block & district levels</td><td>210 Health workers trained in MNCH counseling & care</td><td>220 Availability of MNCH drugs, health supplies and resources facilitated</td><td>230 Home and community counseling for MNCH delivered</td><td>BCC activities to promote proper MNCH practices conducted</td><td>410 IEC & media materials developed & delivered to promote shared decisions about MNCH at the household level</td><td>510 Discussion groups conducted with men & women to facilitate shared decision making about MNCH</td></tr>
<tr><td>Activities</td><td>110 Conduct capacity building for EFICOR & VHSNCs in design & delivery of effective MNCH interventions</td><td>120 Strengthen Coordination of MNCH services at the village, block & district levels</td><td>130 Conduct gender sensitivity workshops with health & government institutions at village, block & district levels</td><td>210 Train health workers in MNCH counseling & care</td><td>220 Facilitate availability of MNCH drugs, health supplies &resources</td><td>230 Deliver home &community counseling for MNCH</td><td>Conduct BCC activities to promote proper MNCH practices.</td><td>410 Develop & deliver IEC & media materials to promote shared decisions about MNCH at the household level</td><td>510 Conduct discussion groups with men & women to facilitate shared decision making about MNCH</td></tr>
</table>

3.2 Annex B: Performance Measurement Framework and Narrative

Project Title: Pakur Mother and Child Survival Project **Budget: $**1,146,880 (CIDA contribution $860,160) **Duration**: Three years	**Version:** 4 **Date:** Sept 30 2013 **Team Leader:** Lisa MacDonald, Project Manager, HealthBridge Foundation of Canada

Expected Results[1]	Indicators[2]	Baseline Data	Targets[3]	Data Sources	Data Collection Methods	Frequency	Responsibility
Ultimate Outcome ***(Long term)*** ***Reduced maternal, newborn and child morbidity and mortality in Pakur District, Jharkhand State, India***	1. Infant Mortality (deaths per 1,000 live births) with proportion of newborn deaths; 2. Under weight: % of boys and girls 0-23 months who are under weight (-2 SD for the median weight for age according to WHO reference); % difference in rates for boys and girls 3. Project changes in maternal mortality ratio (deaths per 100,000 live births)[1]	1. Infant: 58 per 1,000 (58/59 - M/F); Neonatal: 36) 2. 46% of children 0-23 months are underweight (43.4% boys and 48.4% of girls) 3. N/A	Actual improvements may not be measurable by the end of the project due to the short duration (3 years) and the fact that it requires a multi-sectoral effort. However, the project should be able to measure if the groundwork has been laid for such improvements through the intermediate and immediate outcome indicators.	1. Government Annual Health Survey 2. Children aged 0-23 months 3. LiST Tool	1. Document collection and review 2 .Household survey 3 LiST Tool	Beginning and end of project	EFICOR
Intermediate Outcomes ***(Medium term)*** Implementation of more	1. % of women, and boys and girls aged 0-23 months utilizing maternal and child health services; % difference in utilization	1. Overall usage of maternal and child health services is low. There were no	1. See PMF Narrative 2. Government MNCH services	1. Women who have children aged 0-23 months 2. Pregnant and	Household survey; interviews Focus groups,	Beginning and End	EFICOR

[1] Data on maternal mortality is not available at the district level. Projected changes in maternal mortality can be estimated using the LiST Tool (Lives Saved Tool). This computer program calculates projected changes in mortality rates based on demographic information and changes in the coverage of various MNCH services.

Project Title: Pakur Mother and Child Survival Project **Budget: $**1,146,880 (CIDA contribution $860,160) **Duration**: Three years	**Version:** 4 **Date:** Sept 30 2013 **Team Leader:** Lisa MacDonald, Project Manager, HealthBridge Foundation of Canada

Expected Results[1]	Indicators[2]	Baseline Data	Targets[3]	Data Sources	Data Collection Methods	Frequency	Responsibility
effective, gender-sensitive interventions and services related to MNCH in Pakur	rates for boys and girls 2. Perceived accessibility and quality of government MNCH services..	significant differences in utilization rates for boys and girls. Details can be found in the PMF Narrative. 2. Government MNCH services are perceived to be difficult to access due to geographical, functional and cultural reasons. Perceived quality of the services is poor due to poor treatment by health workers and perceived corruption. See PMF narrative for more detail.	are perceived to be accessible and reliable. Perceived quality of services has improved.	lactating mothers, husbands, mothers in-law			
Increased shared decision making at the household level about MNCH practices in Pakur	1. % of men and women who discussed MNCH plans with their spouse 2. % of men and women who say that MNCH decisions were made jointly 3. Perceptions of men and women regarding changes in communication and shared decision making about MNCH	1. 72.6% men; 87.8 % women 2. 81.5% men;84.0% women 3. This indicator is assessing men's and women's perceptions about <u>changes</u> in communication & decision making, and therefore was not assessed at	1. 75% men; 90% women 2. 85% men; 90% women 3. Men and women indicate that inter-spousal communication about MNCH issues has increased, and both men and women feel their input is	Women and men who have children aged 0-23 months ; ASHA & AWW	Household survey; focus groups; key informant interviews	Beginning and end of the project	EFICOR

Project Title: Pakur Mother and Child Survival Project **Budget: $**1,146,880 (CIDA contribution $860,160) **Duration**: Three years	**Version:** 4 **Date:** Sept 30 2013 **Team Leader:** Lisa MacDonald, Project Manager, HealthBridge Foundation of Canada

Expected Results[1]	Indicators[2]	Baseline Data	Targets[3]	Data Sources	Data Collection Methods	Frequency	Responsibility
		baseline.	valued in the final decision making.				
Immediate Outcomes ***(Short term)*** 100 Increased capacity of EFICOR and local and government health institutions to design and deliver effective, coordinated and gender-sensitive programs and services related to MNCH in Pakur	1. Development and/or implementation of solutions by block and district government officials in health plan to address identified gaps in MNCH service delivery and coverage; extent to which gender issues are addressed 2. % of VHSNCs with Village Health Plan 3. Demonstrated evidence by EFICOR staff of ability to effectively plan, implement and monitor MNCH initiatives	1. Many barriers exist in MNCH service delivery but there is lack of motivation and understanding amongst government officials, particularly gender-related barriers. 2. 0% of VHSNCs have a Village Health Plan 3. N/A	1. Plans/programs are developed at all levels; at least one gender issue addressed at the block and district level. 2. 40 % of VHSNCs with Health Plan 3. Progress & financial reports indicate effective project implementation, monitoring, and accounting	1 .Government health officials; Block & District Health Action Plan, PHC/HSC Plan 2. Cluster supervisors 3. Project Manager performance appraisal reports; EFICOR progress/financial reports	1. Key informant interviews; Document review 2. &3 Document review,	Annually	EFICOR & HealthBridge
200 Increased access to MNCH care and counselling (maternal and newborn care, nutrition, prevention and treatment of infectious diseases) amongst women and children 0-23 months in Pakur.	1. % of villages with a Village Health & Nutrition Day (VHND) held each month over the past 3 months; % VHNDs which satisfy minimum requirements 2. % of Health Sub-Centres (HSCs) with adequate supplies of essential drugs (first line anti-malarials, ORS, Vitamin A, IFA, first-line pneumonia)	1. 20% 2. 10% anti-malarial, 28% ORS, 23% Vitamin A, 15% IFA, 10% pneumonia	1. 60% 2. 30% antimalarial, 40% ORS, 40% Vitamin A, 30% IFA, 30% pneumonia	1. Cluster supervisor 2. Health Sub-Centre Staff (ANM, ASHA) 3. PHC staff	1. Progress reports 2 &3. Health Facility Assessment Survey	1. Annually 2, Semi-Annually 3. Beginning and end of project	EFICOR

Project Title: Pakur Mother and Child Survival Project **Budget: $**1,146,880 (CIDA contribution $860,160) **Duration**: Three years	**Version:** 4 **Date:** Sept 30 2013 **Team Leader:** Lisa MacDonald, Project Manager, HealthBridge Foundation of Canada

Expected Results[1]	Indicators[2]	Baseline Data	Targets[3]	Data Sources	Data Collection Methods	Frequency	Responsibility
	3. % of PHCs which offer institutional delivery services	3. 0%	3. 25%				
300 Increased knowledge of appropriate MNCH practices amongst men and women in Pakur	**1. % of mothers and fathers with knowledge of maternal and newborn danger signs** **2 % of boy/girl newborns and infants fed with appropriate feeding practices; % difference for boys/girls** 3**. % of mothers and fathers who report use of practices to prevent and treat infectious disease in children and newborns**	1. 56.3% mothers; 51.7% fathers 2. 42.6% (41.9% girls; 43.6% boys) 3. 62.5% mothers and 63.8% fathers	3. 73% 4. 60% 3. 70%	Women and men who have children aged 0-23 months	Household survey	Beginning and end of project	EFICOR
400 Increased acceptance of shared decision making at the household level about MNCH amongst men and women in Pakur	Degree to which men and women indicate understanding of the importance and benefits of jointly discussing MNCH issues and taking a joint decision	Counter to the quantitative results, qualitative results indicate that most couples do not discuss MNCH decisions, but rather blindly follow the cultural norms of their village. For decisions taken against the norm or an exceptional circumstance, the	Men and women are aware of the benefits and importance of discussing MNCH decisions together. More men indicate that they ask for their wife's input in MNCH decisions. Women	Women and men with children 0-23 months	Focus groups,	Beginning and end of project	EFICOR

Project Title: Pakur Mother and Child Survival Project **Budget: $**1,146,880 (CIDA contribution $860,160) **Duration**: Three years	**Version:** 4 **Date:** Sept 30 2013 **Team Leader:** Lisa MacDonald, Project Manager, HealthBridge Foundation of Canada

Expected Results[1]	Indicators[2]	Baseline Data	Targets[3]	Data Sources	Data Collection Methods	Frequency	Responsibility
		husband consults traditional service providers or his mother, and the woman's opinion is not asked. Women, however, solely make decisions about vaccinations, because men are typically away at work or not interested in this issue.	indicate that ther input is asked for in MNCH decisions.				
500 Increased perceived ability of men and women to make shared decisions about MNCH in Pakur	Degree to which men and women indicate they feel confident that they can discuss MNCH practices with their spouse	Counter to the results of the quantitative survey, qualitative results indicate that women feel they have little knowledge or power to counter their husbands in decision making. Women reported that even if they had knowledge, their input would not be heard. Men do not consider asking for their wives input.	More women report that they feel their input is listened to in MNCH decisions. More men and women indicate they feel comfortable initiating discussion about MNCH issues with their spouse.	Women and men with children 0-23 months	Focus groups ,	Beginning and end of project	EFICOR
Outputs 110 Capacity building conducted for EFICOR and village health committees in design and delivery of effective	1. # of VHSNCs trained; # of VHSNC members (M/F) trained 2. # of training sessions for EFICOR staff; # EFICOR project staff trained (M/F)	VHSNCs are responsible for planning, implementing and monitoring health initiatives at the village level but do not receive	1. 400 VHSNCs receive training: 2. 33 EFICOR staff trained; Year 1= 33 staff,	Project documents; Participant lists	Review of project documents	Annually	EFICOR

Project Title: Pakur Mother and Child Survival Project **Budget: $**1,146,880 (CIDA contribution $860,160) **Duration**: Three years	**Version:** 4 **Date:** Sept 30 2013 **Team Leader:** Lisa MacDonald, Project Manager, HealthBridge Foundation of Canada

Expected Results[1]	Indicators[2]	Baseline Data	Targets[3]	Data Sources	Data Collection Methods	Frequency	Responsibility
MNCH interventions in Pakur.		any formal training in Pakur.	Year 2= 33 staff, Year 3= 6 staff.				
120 Coordination of MNCH programs and services strengthened at the village, block and district levels in Pakur	1.# of advocacy/coordination meetings with block and district level government officials; # of service delivery issues brought forth at the meetings 2. # of coordination and planning meetings with VHSNCs; Evidence of improved planning of health initiatives (e.g. quality of planning meetings; establishment of bank accounts for untied fund management)	Block and district level officials are often not aware of service delivery issues at the village levels; VHSNCs often have poor planning and management of health funds and initiatives	1. 4 meetings per Q with block and district officials; 2. 1 meeting per Q with VHSNCs; discussions indicate improved planning	1. Minutes from meetings with block and district officials; Cluster superviser reports 2. VHSNC Health and planning documents; Cluster Supervisor monthly reports	Document review	Qly	EFICOR
130 Gender sensitivity workshops conducted with health and government institutions at the village, block and district levels in Pakur.	# of gender sensitivity workshops conducted; # and position of participants (M/F); nature of reaction to gender issues raised	There is currently no gender sensitivity training offered to health and government institutions in Pakur	6 workshops Year 2=3 workshop Year 3= 3 workshop	Participant lists; Workshop notes	Review of project documents	Annually	EFICOR
210 Health workers trained in MNCH care and counselling (maternal and newborn care, nutrition and infectious disease prevention and treatment) in Pakur.	# of ANM, ASHA and AWW trained and passed end of training exam # of Trained Traditional Birth Attendants trained (TBAs) and passed end-of-training exam	ANMs, ASHAs, AWWs and TBAs exist within the villages but have not been appropriately trained	2221: ASHA (800), AWW (1000) and TBAs(300), and ANMs (121) trained and passed final exam Fiscal Year 2=1100 Fiscal Year 3=1121 Fiscal Year 3=	Training attendance lists; pre/post training exam	Review of project documents	Annually	EFICOR

Project Title: Pakur Mother and Child Survival Project **Budget: $**1,146,880 (CIDA contribution $860,160) **Duration**: Three years	**Version:** 4 **Date:** Sept 30 2013 **Team Leader:** Lisa MacDonald, Project Manager, HealthBridge Foundation of Canada

Expected Results[1]	Indicators[2]	Baseline Data	Targets[3]	Data Sources	Data Collection Methods	Frequency	Responsibility
			refresher course for all.				
220 Increased availability of MNCH drugs, health supplies and resources facilitated in Pakur.	1. # of planning meetings with HSCs/PHCs/CHCs/District; 2. # of planning meetings with HSCs and ICDS staff at sub-centre level 3.# of advocacy meetings with District Malaria Officer and UNICEF to avail ITNs; degree of willingness to provide ITNs at subsidized cost	Inefficient planning at Health Sub-Centres and lack of coordination between ICDS (AWW) and Health (ASHA, ANM) Departments results ineffective service delivery at village level. Availability of affordable ITNs is currently inadequate at the village level due to lack of coordination and motivation from government.	1. 4 meetings per Q 2.. 4 meetings per Q 3. 1 meeting per Q with District Malaria Officer and UNICEF; willing to provide ITNs at subsidized cost	Cluster Supervisor Reports	Cluster Supervisor Reports	Qly	EFICOR
230 Home and community counselling and care for MNCH (maternal and newborn care, nutrition, and infectious disease prevention and treatment) delivered in Pakur.	1. % of women who received a visit from an ASHA during pregnancy 2. % of women and children (M/F) 0-23 months who received nutrition and growth monitoring counselling by AWW	1. 62% 2. 39% mothers; 38.3 % children (38.5% M; 37.5% F)	1. 75% 2. 50% mothers and children (M/F)	Women with children aged 0-23 months;	Household survey,	Beginning and end of project	EFICOR
310 BCC activities to promote proper MNCH practices (maternal and newborn care, nutrition, infectious disease prevention and treatment) conducted in Pakur	# of IEC/media materials produced; dissemination coverage; # of outreach events conducted; # of attendees (M/F)	Few or no initiatives have been implemented in the villages to address MNCH practices	More than 20000 IEC/Media materials produced and disseminated to a total of 2,80,666	Dissemination lists; project documents	Review of project documents	Qly	EFICOR

Project Title: Pakur Mother and Child Survival Project **Budget: $**1,146,880 (CIDA contribution $860,160) **Duration**: Three years	**Version:** 4 **Date:** Sept 30 2013 **Team Leader:** Lisa MacDonald, Project Manager, HealthBridge Foundation of Canada

Expected Results[1]	Indicators[2]	Baseline Data	Targets[3]	Data Sources	Data Collection Methods	Frequency	Responsibility
			people; 790 outreach events with 1,20,000 attendees 24 outreach events in a month				
410 IEC and media materials to promote shared decision making about MNCH at the household level developed and delivered in Pakur.	# and type of IEC and media materials produced; dissemination coverage	No initiatives have been implemented to address shared decision making about MNCH	20000 IEC/Media materials produced and disseminated to a total of 1200 families people 360 family targeted in each Q through IEC material.	Project documents; Dissemination lists	Review of project documents	Qly	EFICOR
510 Discussion groups conducted with men and women to facilitate shared decision making about MNCH in Pakur.	# of discussion sessions conducted; # of participants (M/F);	No initiatives have been implemented to address shared decision making about MNCH	24 of sessions conducted per Q 480 participants (M=240/F=240) in each Q.	Participant lists; Project documents; Notes from discussion groups	Review of project documents	Qly	EFICOR

PMF Narrative

Description of Outcome Indicators

Ultimate Outcome: *Reduced maternal, newborn and child morbidity and mortality:* Indicators will assess infant mortality and the percentage of children (M/F) 0-23 months who are underweight according to the WHO standard. Data on maternal mortality is not available at the district level through the government system and would be difficult to collect; therefore it will not be directly measured in this project. Changes in maternal mortality will be estimated using computer-based technologies (such as LiST) which predict the expected change in maternal mortality based on changes in levels of service coverage (such as institutional deliveries).

Intermediate Outcomes:

1. Implementation of more effective, gender-sensitive interventions and services related to MNCH: Quantitative indicators will measure changes in the use of MNCH services by women and children of 0-23 months. The assumption is that if MNCH services are being implemented more effectively at both the supply and demand sides of the health system, the usage of services will increase. Indicators for measuring access, government health planning and knowledge of the local population are included in the immediate outcomes. The types of MNCH services which will be measured are listed below. Qualitative indicators will measure beliefs and perceptions about MNCH services to gain insight into the reasons women choose not to use health services for themselves and their children.

Maternal and Newborn Care	Baseline	Mid-term	Target
% of live births taking place in a health institution/ home births attended by skilled birth attendant	30.3%/22%*	49.8%/0%	50%/34%
% of mothers who received ANC by a skilled health provider at least 4 times during pregnancy	7.3%	Not reported	30%
% of mothers who received ANC by a skilled health provider at least 3 times during pregnancy**	29.3%	48.3%	N/A
% of mothers who received two doses of TT vaccine prior to giving birth	86.3%	77.7%	90%
% of mothers who received postnatal care within two days of child birth	45.3%	47.7%	60%
% of mothers who consumed iron supplements for at least 100 days during their last pregnancy	3.0%	36.9%	30%

** Overall, 45.6% of births had a skilled attendant present (30.3% in a health facility and 15.3% at home)*

***3 ANC visits is the standard in India, although 4 times is the global standard. Thus, we have included this as a comparison.*

Nutrition and Childhood Feeding	Boys	Girls	% Var.	Baseline	Mid-term LQAS	Target
% of boys and girls aged 9-23 months who received at least one dose of Vitamin A supplementation	56.8%	60.7%	3.9%	58.9%	36.8%	70%
Infectious Disease Prevention and Treatment						
% of boys and girls 12-23 months who received 3 doses of DPT vaccine, and measles vaccine before 12 months*	38.9%	43.1%	4.2%	41.1%	56.2%	60%
% of boys and girls 0-23 months with suspected pneumonia who sought care from skilled provider within 24 hours	27.3%	22.1%	-5.2%	24.7%	52.4%	50%
% of boys and girls 0-23 months with suspected malaria who sought care from skilled provider within 24 hours	23.9%	19.7%	-4.2%	21.7%	24.2%	50%
% of boys and girls 0-23 months who received an accepted form of ORT when they had diarrhea	45.2%	44%	-1.2%	44.5%	Sample too small	65%
% of boys and girls aged 0-23 months who slept under a bed net in the last 24 hours	65.0%	66.2%	1.2%	65.7%	Not reported**	75%

Note: Since the differences between boys and girls was small and did not reach statistical significance, only one target was set for both boys and girls.
**55.6% received 3 doses of DPT and 43.5% received measles vaccine before 12 months*
***The baseline questionnaire asked about bed net use, while the mid-term questionnaire asked about ITN use, thus a comparison cannot be made*

Qualitative Indicator**:** Perceived accessibility and quality of government MNCH services

Baseline Results indicate that government health services are perceived to be fairly inaccessible and of poor quality, and this deterred women from using them. Reasons for inaccessibility were categorized as geographical, functional and cultural; this is described in more detail below. In addition, women perceived the government health services to be of poor quality due to perceived corruption within the system and poor treatment from health workers.

Inaccessibility of Services:

1. *Geographical*: Many of the villages in the district are remote and located far distances from the Health Sub-centres (HSCs) and Primary Health-centres (PHCs). Rough and hilly, poor road infrastructure and poor or costly transportation services make it very difficult to travel to the government health facilities.
2. *Functional*: Women reported that MNCH services are irregular and unreliable. For example, clinic operating times do not follow a schedule (often closed when supposed to be open), and essential medicines were often unavailable when they did seek health care.

3. *Cultural*: Particularly amongst Muslim communities, receiving care from a male doctor is deemed unacceptable. In certain tribes, women must be accompanied by their spouse when travelling long distances, who is often unavailable or uninterested. These factors were a barrier for women to access MNCH services from the government system.

2. Increased shared decision making at the household level about MNCH practices:

Quantitative indicators will measure two important aspects of decision making: inter-spousal communication and whether the final decision is made jointly by husband and wife. Both factors are important because spousal communication is necessary for joint decision making to occur and changing the balance of decision making power could take years to change. However, the starting point is increasing communication and there is evidence that just increasing spousal communication about these issues increases women's access to services and men's involvement in MNCH. Qualitative indicators will gain in-depth insight into men's and women's perceptions how the decision making process about MNCH has/has not changed.

Immediate Outcomes

Immediate outcomes 100 and 200 will measure changes in the supply side of the health system, while outcomes 300, 400, and 500 will measure changes in the demand side of the health system.

Immediate outcomes 100 and 200 will measure changes in the supply side of the health system, while outcomes 300, 400, and 500 will measure changes in the demand side of the health system. Sub-indictors of Outcome 300 *Increased knowledge of appropriate MNCH practices amongst men and women* are described below. The result given in bold is an average of the indicator sub-components.

Indicator	Baseline Mothers	Baseline Fathers	Mid-term LQAS Mothers	Mid-term LQAS Fathers	Target
1. % of mothers and fathers with knowledge of maternal and newborn danger signs	**56.3%**	**51.7%**	**69.8%**	**60.6%**	**73%**
a) % of mothers and fathers able to report at least 3 known maternal danger signs during pregnancy	68.7%	62.0%	78.3%	48.3%	80%
b)% of mothers and fathers able to report at least 3 known maternal danger signs during the post partum period	50.0%	45.0%	62.5%	63.9%	70%
c) % of mothers and fathers able to report at least 3 known newborn danger signs	50.3%	48.0%	68.5%	69.6%	70%

Indicator	Girls	Boys	% Var.**	Baseline	Mid-term LQAS	Target
2. % of boy/girl newborns and infants fed with appropriate feeding practices; % difference for boys/girls	**41.9%**	**43.6%**	**-1.9%**	**42.6%**	**61.7%**	**60%**
a)% of newborns (M/F) who were put to breast within one hour of delivery and did not receive pre lacteal feeds	56.7%	50.4%	6.3%	53.7%	59.0%	70%
b) % of boys and girls who were exclusively breast fed between 0-5 months	50.0%	59.5%	-9.5%	54.6%	99.1%	70%
c) % of boys and girls 6-23 months fed according to a minimum of appropriate feeding practices	18.6%	20.8%	-2.2%	19.6%	26.96 %	40%

Indicator	Baseline Mothers	Baseline Fathers	Mid-term LQAS Mothers	Mid-term LQAS Fathers	Target
3. % of mothers and fathers who report use of practices to prevent and treat infectious diseases in children and newborns*	**62.5%**	**63.8%**	**68.2%**	**66.6%**	**70%**
a) % of mothers and fathers of children 0-23 months who are able to report 3 danger signs of childhood illness	70.7%	73.3%	65.7%	62.6%	80%
b) % of households of children 0-23 months that use soap or detergent for hand washing	54.3%		70.6%		60%

* *3. Setting of Pr*oject Targets

In order to set realistic end of project targets, the project team considered program factors and utilized the following formula:

F = PI + ((1 – PI)* B) where:
F = Potential Final Target; B = Baseline level; PI = Performance Index

The Performance Index (PI) is a ratio of the absolute achievement in respect of the project indicators to the possible achievement, assuming a ceiling of 100%. PI for a given indicator A = (final levelA – baseline levelA) / (100 – baseline levelA)). The PIs for most indicators have been calculated from studying the performance of other maternal and child health projects around the world. For indicators in which a reference PI was not available, the project team used the results of the qualitative study and other baseline data to set the PI at an appropriate level. Program factors which were also taken into account include EFICOR's staff experience in achieving targets in similar projects, the project duration and the project location (size, level of development and current health infrastructure).

3.3 Annex C: Updated Risk Register and Response Strategies

Revisions are in yellow.

Project Title: Pakur Mother and Child Survival Project **Budget: $**1,146,880 (CIDA contribution $860,160) **Duration**: Three years			**Version:** 6 **Date:** March 31 2014 **Team Leader:** Lisa MacDonald,					
Organization's Name: HealthBridge Foundation of Canada			India/Jharkhand State/Pakur District					
Risk Definition		**Updated Risk Response Strategy**	**Residual Risk Level – Low/Very Low/High/Very High**					
			Initial Rating	Mar 31 2012	Sept 30 2012	March 31 2013	Sept 30 2013	March 31 2014
Operational Risks								
Op1	Implementation may be impeded due to delays in getting necessary ministerial approvals.	EFICOR's good relationships with the Jharkhand state government has helped with getting the necessary support and approvals for the project, and good rapport has been formed with the district government during the first Fiscal Year. The project team will regularly inform the government of the project activities and results to ensure continued support.	L = 2 I = 4	L = 1 I =4	L = 1 I = 4	L = 1 I = 4	L=1 I=4	L = 1 I = 4
Op2	Project partners may have weak project management skills which could hinder the implementation and completion of appropriate activities.	Capacity building of local partners in project management has been built into the proposal to minimize this risk. In addition, HealthBridge has in place a Qly technical reporting system with all its project partners. This reporting system captures not only activities in progress and achievements-to-date, but also allows a regular assessment of challenges and opportunities. This close monitoring by HealthBridge staff enables the project team to address weaknesses as soon as they arise and modify work plans as necessary.	L = 2 I = 4	L=1 I = 4	L=1 I = 4	L = 1 I = 4	L-1 I=4	L = 1 I = 4

Project Title: Pakur Mother and Child Survival Project **Budget: $**1,146,880 (CIDA contribution $860,160) **Duration**: Three years			**Version:** 6 **Date:** March 31 2014 **Team Leader:** Lisa MacDonald,					
Organization's Name: HealthBridge Foundation of Canada			India/Jharkhand State/Pakur District					
Risk Definition		**Updated Risk Response Strategy**	**Residual Risk Level – Low/Very Low/High/Very High**					
			Initial Rating	Mar 31 2012	Sept 30 2012	March 31 2013	Sept 30 2013	March 31 2014
Op3	Dissolved VHSNCs and long process of re-formation	EFICOR Cluster Supervisors will organize cluster level training for the VHSNCs, rather than village level, to speed up the training and ensure that it can be completed at the end of three years. EFICOR revised the number of VHSNCs to train from 600 to 400.	N/A	N/A	L=4 I = 3	L = 4 I = 2	L=1 I=3	L = 1 I = 3
Financial Risks								
Fin1	Partner organization may have weak financial management systems in place, which could hinder the ability to ensure appropriate spending.	Capacity building of local partners in financial management has been built into the proposal to minimize this risk. At the beginning of the project, the HealthBridge project team will send the local partner detailed instructions on how the process for financial management and reporting. Where necessary, field visits will be taken to project sites to go through the financial requirements one-on-one with partner staff. HealthBridge also has in place a Qly financial reporting system with all of its project partners which captures actual against planned expenditures and thus allows regular tracking and assessment of partner spending and discussions about variances. This close monitoring enables the project team to address weaknesses as soon as they arise.	L = 2 I =2	L = 1 I =2	L = 1 I =2	L = 1 I = 2	L=1 I=2	L = 1 I = 2
Fin2	Fluctuation in exchange rates could cause loss in project	In the case of extreme exchange rate variations, the budget and work plan will be	L = 2 I =	L = 2 I =	L = 2 I = 1	L =2 I = 1	L=2 I=1	L = 2

Project Title: Pakur Mother and Child Survival Project **Budget: $**1,146,880 (CIDA contribution $860,160) **Duration**: Three years			**Version:** 6 **Date:** March 31 2014 **Team Leader:** Lisa MacDonald,					
Organization's Name: HealthBridge Foundation of Canada			India/Jharkhand State/Pakur District					
Risk Definition		**Updated Risk Response Strategy**	**Residual Risk Level – Low/Very Low/High/Very High**					
			Initial Rating	Mar 31 2012	Sept 30 2012	March 31 2013	Sept 30 2013	March 31 2014
	revenues.	reviewed with CIDA.	1	1				I = 1
Development Risks								
Dev1	Women's low decision making power in the household may inhibit them from being able to access health services.	We will engage men, and mothers-in-law, in all project activities so that they are aware of and approve the proposed maternal health practices and services. A BCC campaign will be implemented to engage men and increase shared decision making about MNCH practices at the household level	L = 3 I = 3	L=3 I=3	L = 3 I = 3	L = 3 I = 2	L=2 I=2	L = 2 I = 2
Dev2	High levels of illiteracy and poor access to information may inhibit women from accessing health services.	Health information will be provided to women through direct counselling and community education campaigns (using non-written forms of media) to increase their awareness of maternal, newborn and child health services and practices. Educating men and encouraging them to accompany their wives to health services will also reduce barriers and support women in accessing services.	L = 3 I = 3	L=2 I = 3	L = 2 I = 3	L = 2 I = 3	L=2 I=3	L = 2 I = 3

Project Title: Pakur Mother and Child Survival Project **Budget: $**1,146,880 (CIDA contribution $860,160) **Duration**: Three years			**Version:** 6 **Date:** March 31 2014 **Team Leader:** Lisa MacDonald,					
Organization's Name: HealthBridge Foundation of Canada			India/Jharkhand State/Pakur District					
Risk Definition		**Updated Risk Response Strategy**	**Residual Risk Level – Low/Very Low/High/Very High**					
			Initial Rating	Mar 31 2012	Sept 30 2012	March 31 2013	Sept 30 2013	March 31 2014
Dev3	The government partners we wish to engage (WCD, H&FWD, VHSCs) may not be ready or willing to discuss how to improve coordination and coverage of MNCH services, integrate gender equality, or they may be unwilling to change their current practices to better coordinate services.	The project team already has established relationships with government partners. In addition, the project team will use an approach that focuses on supporting government partners, rather than challenging them. In HealthBridge's past projects, this type of approach has proven to be very successful in getting government partners on board. Training will also be conducted to increase awareness of the impact of gender inequality on MNCH.	L = 2 I = 3	L = 2 I = 3	L = 2 I = 3	L = 2 I = 3	L=1 I=3	L = 1 I = 2
Dev4	Difficult terrain (dense forests, remote areas) in the project districts may prevent health volunteers and service providers (AWWs and ASHAs) from being able to reach certain households and may prevent mothers from being able to access health services.	The trained community health workers will be members from the local community and thus, familiar with the landscape. Conducting home visits for counselling will minimize the need for women to navigate difficult terrain. Every effort will be made to identify and respond to transportation issues as they arise. The Project Implementation Team will identify transportation issues and identify solutions, as needed, making modifications to the project plan as required.	L = 2 I = 3	L = 2 I = 3	L=2 I = 3	L = 2 I = 3	L=2 I=3	L = 2 I = 3
Dev5	Poor governance may impact the performance of the health service providers. For example, delayed remuneration to ASHAs may inhibit their	The close collaboration with the government health officials will enable EFICOR to bring up such issues at the block and district level meetings and advocate/suggest appropriate solutions.	N/!	L = 2 I = 4	L = 2 I = 4	L = 2 I = 4	L=2 I=4	L = 3 I = 4

Project Title: Pakur Mother and Child Survival Project **Budget: $**1,146,880 (CIDA contribution $860,160) **Duration**: Three years			**Version:** 6 **Date:** March 31 2014 **Team Leader:** Lisa MacDonald,					
Organization's Name: HealthBridge Foundation of Canada			India/Jharkhand State/Pakur District					
Risk Definition		**Updated Risk Response Strategy**	**Residual Risk Level – Low/Very Low/High/Very High**					
			Initial Rating	Mar 31 2012	Sept 30 2012	March 31 2013	Sept 30 2013	March 31 2014
	performance at the local level.							
Dev 6	Stock out of Vitamin A and IFA in the district. This is beyond the control of EFICOR as the stock out is at the state level.	EFICOR has discussed the issue with the Civil Surgeon and other district official. The government is planning to purchase the drugs and will disburse at the district level.					L=4 I=4	L = 4 I = 4
Dev 7	Stock out of growth monitoring and weighing scale in many Anganwadi centres	EFICOR has brought this to the attention of the District Program Officer and Child Development Program Officer of the ICDS Department.					L=4 I=4	L = 4 I = 4
Reputation Risks								
REP1	EFICOR is a Faith Based Organization. Consequently, its beliefs and values may conflict with some individuals and groups in Canada and India. Also, vested interest groups may politicize the intervention for their own interests.	Emphasizing that the project objectives aim to improve maternal, newborn and child health amongst all individuals in the targeted district, regardless of religion, and that the EFICOR will not promote their religious beliefs as part of the current project. Transparency in the project activities and the project team's use of finances.	L = 1 I = 1	L = 1 I = 1	L =1 I =1	L = 1 I = 1	L=1 I=1	

Updated Risk Response Strategy

Revisions are highlighted in yellow.

Methodology for Monitoring of Project Risks:

The Project Management Team (PMT) will assess and revise the Risks Register on a Qly basis. Overall information on the status and level of project risks, the use and effectiveness of response strategies, and any modifications, will be reported on in the Qly progress reports.

Operational risks will be monitored using HealthBridge's Qly technical reporting system which captures actual versus planned activities, achievements to date and an assessment of challenges and opportunities. Similarly, financial risks will be monitored using HealthBridge's Qly financial system which captures actual against planned expenditures and thus allows regular tracking and assessment of partner spending and discussions about variances. This close monitoring by HealthBridge staff enables the project team to address weaknesses as soon as they arise and modify work plans as necessary.

Developmental risks will be monitored on a regular basis by the Project Implementation Team (PIT) and reported to the PMT in the monthly meeting reports and Qly progress reports. The PIT is located in the field and will work directly with the community health workers (ANMs, AWWs, TBAs) and village, block and district government health departments. This hands-on and collaborative approach will enable the PIT to identify and assess development risks on an on-going basis, and modifications to the project activities will be made as necessary.
Reputational risks will also be monitored by the PMT on a regular basis through documentation of individuals or groups who attempt to intervene on the project for their own interests or purposes. Such documentation will be included in Qly progress reports and appropriate responses will be implemented by the PMT, as necessary.

Strategies to Address, Mitigate and Prevent Risks

Operational Risks:

(1) Risk: Project implementation may be impeded due to delays in getting necessary ministerial approvals.
Response Strategy: HealthBridge's local partner EFICOR has already established a good relationship with the Jharkhand state government as a result of its project in the adjacent Sahibganj district. This has helped in getting the necessary support and approvals for the current project. Throughout the project duration, EFICOR will work in close collaboration with the government at all levels, which will help to sustain government support.

(2) Risk: Project partners may have weak project management skills which could hinder the implementation and completion of appropriate activities.
Response Strategy: Capacity building of EFICOR staff in project management has been built into the proposal to minimize this risk. The PIT meetings will allow for on-going discussion of weaknesses and training needs within EFICOR staff throughout the project duration. The presence of an in-country HealthBridge Field Project Manager will also enable direct support with project management. In addition, as described above, HealthBridge has in place a Qly technical reporting system with all its project partners which will enable identification of weaknesses as soon as they arise and modifications to the work plan as necessary.

(3) Risk: The VHSNCs were dissolved by the government and the re-formation process took longer than anticipated. This resulted in delays in capacity building of VHSNCs.
Response Strategy: EFICOR Cluster Supervisors will organize cluster level training for the VHSNCs, rather than village level, to speed up the training and ensure that it can be completed at the end of three years.

Financial Risks:

(1) Risk: Partner organization may have weak financial management systems in place, which could hinder the ability to ensure appropriate spending.
Response Strategy: Capacity building of EFICOR staff in financial management has been built into the proposal to minimize this risk. At the beginning of the project, the HealthBridge project team will send the local partner detailed instructions on how the process for financial management and reporting. Where necessary, field visits will be taken to project sites to go through the financial requirements one-on-one with partner staff. The presence of an in-country HealthBridge Field Project Manager will enable this direct support with financial management.

(2) Risk: Fluctuation in exchange rates could cause loss in project revenues.
Response Strategy: In the case of extreme exchange rate variations, the budget and work plan will be reviewed with CIDA.

Development Risks:

(1) Risk: Women's low decision making power in the household may inhibit them from being able to access health services and practice appropriate MNCH behaviours.
Response Strategy: Increasing the use of shared decision making at the household is central to the goals of this project and thus, strategies have been incorporated into the project activities to address this issue. As male authority in decision making is a long-held tradition which will take time to change, men will be engaged in all project activities, including being involved in household counselling and targeted by BCC campaigns. This will ensure that they understand and will support women in accessing health services and practicing appropriate MNCH behaviours. As mothers in-law tend to have a significant influence on MNCH practices at the household level in India, they too will be engaged in the project activities.

(2) Risk: High levels of illiteracy and poor access to information may inhibit women from accessing health services.
Response Strategy: Improving access to health information is central to the goals of this project. Health information will be provided to women through direct counselling in their homes by community health workers and through community education campaigns (which include use of non-written forms of media) to increase awareness of MNCH practices, services and how to access such services. The campaigns will also address myths and harmful cultural norms and traditions which inhibit women from accessing services.

(3) Risk: The government partners we wish to engage (WCD, H&FWD, VHSNCs) may not be ready or willing to discuss how to improve coordination and coverage of MNCH services, integrate gender equality, or they may be unwilling to change their current practices to better coordinate services.
Response Strategy: The project team has already established relationships with government partners through the consultations conducted during the project conception, and other projects implemented by EFICOR in the project area. These relationships will greatly facilitate collaboration with government partners in the current project. In addition, the project team will use a participatory approach that focuses on supporting government partners (rather than challenging them) and facilitating discussions to identify solutions from within, rather than from outsiders. In HealthBridge's past projects, this type of approach has proven to be very

successful in getting government partners on board. The gender-sensitivity training that will be conducted during the project will increase understanding of how gender inequality impacts MNCH and why it is important to address these issues.

(4) Risk: Difficult terrain (dense forests, remote areas) in the project districts may prevent health volunteers and service providers (AWWs and ASHAs) from being able to reach certain households and may prevent mothers from being able to access health services.
Response Strategy: The trained community health workers will be members from the local community and thus, familiar with the landscape. Conducting home visits for MNCH counselling will minimize the need for women to navigate difficult terrain, and women who cannot access health clinics will receive basic maternal and newborn care (including safe delivery care) directly in their homes. Every effort will be made to identify and respond to transportation issues as they arise. The Project Implementation Team will identify transportation issues and identify solutions, as needed, making modifications to the project plan as required.

(5) Risk: Poor governance may affect performance of service providers. For example, delayed remuneration to ASHAs may inhibit their performance at the local level.
Response Strategy: EFICOR will be working in close collaboration with the government health officials throughout the project, including attending monthly advocacy and networking meetings at the block and district levels. At these meetings, EFICOR will be able to inform the government of specific issues affecting service delivery at the local level, such as delayed remuneration of ASHAs, and advocate for appropriate solutions.

Reputation Risks:

Risk: EFICOR is a Faith Based Organization. Consequently, its beliefs and values may conflict with some individuals and groups in Canada and India. Also, vested interest groups may politicize the intervention for their own interests.
Response Strategy: All project communications will emphasize that the project objectives aim to improve maternal, newborn and child health amongst all individuals in the targeted district, regardless of religion. EFICOR will not promote their religious beliefs as part of the current project. A transparent approach will be used in all project activities and the project team's use of finances.