Pakur Mother and Child Survival Project

Annual Report

Nov 16th 2011 – March 31st 2012

Submitted by: HealthBridge Foundation of Canada
Date: May 16th, 2012
Revised July 3rd, 2012

HealthBridge
RESEARCH • POLICY • ACTION • DEVELOPMENT

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List of Acronyms

ANC	Antenatal Care
ANM	Auxiliary Nurse Mid-wife
ASHA	Accredited Social Health Activist
BCC	Behaviour Change Communication
CIDA	Canadian International Development Agency
DPT	Diphtheria, Pertussis, Tetanus (vaccine)
EFICOR	Evangelical Fellowship of India Commission on Relief
HFA	Health Facility Assessment (survey)
HFWD	Health and Family Welfare Department
HSC	Health Sub-centres
ICDS	Integrated Child Development Services
ITN	Insecticide-treated Net
JSY	Janani Suraksha Yojana
KPC	Knowledge, Practice, Coverage (survey)
M&E	Monitoring and Evaluation (Officer)
MNCH	Maternal, Newborn and Child Health
NRHM	National Rural Health Mission
PIT	Project Implementation Team
PMCSP	Pakur Mother and Child Survival Project
PMF	Performance Measurement Framework
PMT	Project Management Team
PRA	Participatory Rural Appraisal
Q1	Quarter 1 (April 1 – June 31st 2012)
RBM	Results-based Management
TAG	Technical Advisory Group
TAG	Technical Advisory Group
TT	Tetanus Toxoid (vaccine)
VHSC	Village Health and Sanitation Committee

Executive Summary

The Pakur Mother and Child Survival Project (PMCSP) officially started on November 16th 2011, at which time HealthBridge signed the Contribution Agreement with CIDA. The current Annual Report describes the implementation of the PMCSP during its first Fiscal Year, comprising the period from Nov.16th to March 31st, 2012, approximately one and a half quarters. Key accomplishments and challenges experienced during this first Fiscal Year are described below.

Administrative: A key achievement realized in the first Fiscal Year was approval from the Pakur government ministries for implementing the three-year project and conducting the baseline data collection. Some challenges were experienced regarding the administrative components of the project, namely staff recruitment and set-up of project offices. Many staff were recruited for the PMT and PIT, however six positions still needed to be filled at the end of the fourth quarter. The recruitment difficulties were due in part to the short time period and also a lack of qualified and suitable candidates who applied for the positions. It is expected that all positions will be filled in the subsequent quarter. The project head-office was set-up, however, set-up of the block-level satellite offices are still under-way due to difficulties finding appropriate and available venues.

Project Evaluation: The baseline data collection was successfully completed and a finalized PMF with the results and end of project targets has been included with this report. Such results will be formally presented to the Pakur government health officials in the subsequent quarter. The sex-disaggregated quantitative data allowed for clear analyses of differences in outcomes for boys and girls, although no significant differences were found.

Capacity Building of EFICOR: Training was conducted for the Project Manager, who attended a comprehensive training course on “Monitoring and Evaluation of Population, Nutrition and Health”. A project orientation was conducted with the recruited staff team and the 24 Cluster Supervisors received training on basics of MNCH issues and KPC survey data collection.

Relationship Building with Government: Building good rapport with Pakur government officials was a priority in the first Fiscal Year. In obtaining ministry approvals, the project team conducted extensive meetings to introduce the project to key government officials of the HFWD and ICDS. The responses were very positive and the team received assurance from the district administration for their cooperation and support to implement the project in Pakur. Relationship building will continue in the second Fiscal Year through regular networking and advocacy meetings, using strategies learned in EFICOR’s Parivartan Project in the adjacent Sahibganj district. Such strategies include: a) establishing personal, as well as business, relationships; b) using a supportive, non-confrontational approach, rather than challenging or criticizing; and c) conveying the feeling that EFICOR is part of the government.

1. Operational Section

1.1 Narrative Sub-section

1.1.1 Completion of Outputs Compared to Annual Work Plan

Table 1, below, provides an overview of progress made in completing the expected key milestones, in comparison to the Annual Work Plan. Subsequently, Table 2 provides an overview in completing project outputs, in comparison to the Annual Work Plan.

Table 1: Progress made in completing key milestones in Fiscal Year 1

Output	Expected Key Milestones	Progress
Administrative	1. Project management and implementation teams formed 2. Project office facility set-up completed 3. Technical Advisory Group formed	1. In progress 2. In progress 3. Deferred to Q1
Project Evaluation	1. Baseline data collection completed	Completed
Output 110 EFICOR & VHSC Capacity Building	1. First training course for 33 EFICOR staff completed: **Project Manager:** Monitoring and evaluation of population, nutrition and health **2 Block Coordinators & 24 Cluster Supervisors:** Project orientation and basic health issues	Completed for recruited staff
Output 120 Coordination of MNCH Programs	1. First meetings with ICDS (MWCD) and HFWD @ block and district levels	Completed
Output 220 Facilitating Availability MNCH Supplies	1. Meeting schedules developed with health facility staff and district officers	Deferred to Q1

Table 2: Progress made in completing project outputs in Fiscal Year 1

Fiscal Year 1: Nov 16th 2011 – March 31 2012		
	Progress	**Comments on Variances**
ACTIVITIES		
Administrative		
Sign agreement between HealthBridge and EFICOR	Completed	
Obtain Ministry Approvals	Completed	
Staff Recruitment	In Progress	As of March 31st 2012, EFICOR had not recruited qualified candidates for the M&E Officer, Training and BCC Specialist, 2 Block Coordinators, project accountant and administrative assistant. Since this time, EFICOR has recruited for all positions except for the 2 Block Coordinators and administrative assistant. EFICOR was aiming to recruit 2 female and 2 male Block Coordinator, but had difficulty finding suitable women candidates (the 2 hired are male). It is expected that all positions will be filled during the next quarter.
Set-up satellite offices	In Progress	The project head office in Pakur has been rented and a legal agreement has been signed with building owner. Set-up of the block level satellite offices is still under-way due to difficulty finding appropriate and available venues.
Set up of communication & project assets	In Progress	Office assets for the project head office in Pakur such as tables, chairs, etc. have been purchased. Purchasing of assets for the satellite offices is underway. Only 3 of the 7 two-wheeler bikes have been purchased as the PMT was focusing on hiring the project staff prior to purchasing the bikes. The remainder of the bikes will be purchased as the staff positions are filled.
Inaugural project launch meeting between EFICOR and HealthBridge	Completed	HealthBridge met with EFICOR project staff on January 10th 2012 to formally launch the Pakur Mother and Child Survival Project. Attendees included HealthBridge's Executive Director, Project Manager and Field Project Manager, EFICOR's Executive Director, Director Programmes, Program Manager, Grants Manager, Pakur Project Manager, Finance Manager and Project Manager from Sahibganj Child Survival Project.
Formation of TAG	In Progress	The PMT decided that it was preferable for the TAG to be formed after the official Project Launch in the district in April 2012.

Fiscal Year 1: Nov 16th 2011 – March 31 2012		
	Progress	**Comments on Variances**
ACTIVITIES		
Develop & Submit Annual Work Plan for 1st Fiscal Year	Completed	Annual Work Plan submitted to CIDA on February 24th 2012.
Monthly PIT Meetings	Completed	2 PIT meetings were held in February and March 2012. The topics discussed included orientation to the project and planning for the baseline data collection.
Quarterly PMT Meetings	Completed	The first PMT meeting was held on January 11th, 12th and 16th. The topics discussed included development of the PMF, Annual Work Plan and financial documentation and reporting requirements.
First TAG Meeting	Deferred to Q1	As mentioned above, the TAG will be recruited after the official project launch in April.
PM field visits and Cluster Supervisor field visits	Completed	
Project Evaluation		
Develop and finalize PMF	Completed	The PMF was submitted to CIDA along with the Annual Work Plan on Feb 24th 2012.
Develop data collection tools	Completed	
Baseline KPC survey	Completed	The KPC survey was conducted in March 2012 with a representative sample of 300 mothers and fathers of children 0-23 months. The process was lead by Dr. Arvind Kasthuri of St. John's Medical College with support from EFICOR Project Staff (Project Manager, Block Coordinators) and ten data collection teams of 3-4 persons each (one supervisor and 2-3 interviewers).
Baseline HFA survey	Completed	The HFA survey was conducted in March 2012 with 25 health centres across all 6 blocks of Pakur District. The process was lead by a Research Team from the Child In Need Institute and 5 data collection teams of 2 people each (1 Nurse professional and 1 assistant). The data collectors comprised staff from the SDA Mission Hospital and EFICOR project staff.
Baseline Qualitative data collection	Completed	Qualitative data collection was conducted in March 2012 and utilized PRA methods (Problem Tree, Venn Diagram) and Focus Groups, with participants from 10 villages across 5 blocks in Pakur district. The process was lead by an Independent Consultant (Mr. Ravindra Raj) with support from EFICOR Project Manager, Block Coordinators and Cluster

Fiscal Year 1: Nov 16th 2011 – March 31 2012		
	Progress	**Comments on Variances**
ACTIVITIES		
		Supervisors.
Final baseline report	Completed	Submitted to CIDA on April 6th 2012.
Activity 110: Train EFICOR and VHSCs		
Develop content & logistics for EFICOR staff training	Completed	
Deliver training to EFICOR	Completed	• The Project Manager attended a training course of "Monitoring and Evaluation on Population, Nutrition and Health". • The 24 Cluster Supervisors and 2 Block Coordinators were given a project orientation on the objectives, indicators, activities and results. • The 24 Cluster Supervisors received training on basics of MNCH issues which covered the following topics: a) Basics of MNCH; b) Systems and functioning of government health and ICDS departments; c) roles and expectations of Cluster Supervisors. • The 24 Cluster Supervisors were also part of the training on KPC survey data collection, which provided them with greater understanding of the project indicators and expected results.
Activity 120: Strengthen coordination of MNCH programs and services		
Monthly meetings with ICDS and HFWD at block & district levels	Completed	Initial introduction meetings were held with the ICDS and HFWD departments. The monthly meetings will commence in Q1.
Activity 220: Facilitate availability of MNCH drugs, supplies & resources		
Develop meeting schedules with ASHAs, PHCs, HSCs and District Officers	Deferred to Q1	The project team decided that it was best to wait until the project was official launched in the district before completing this activity.

1.1.2 Problems/difficulties encountered

As explained in the above table, some difficulties have been experienced in staff recruitment during the first Fiscal Year. The difficulties partly reflect the minimal time period, such that the first Fiscal Year was only one and half quarters in duration (approximately 4.5 months) and included Christmas holidays. In addition to the minimal time period, EFICOR also had difficulty finding qualified candidates for some of the positions including the M&E Officer, Training and BCC Specialist, two Block Coordinators and an administrative assistant. With respect to the Block Coordinators, EFICOR wanted to recruit two male and two female Block Coordinators, however, they had difficulty recruiting qualified female staff for this position. It was decided that EFICOR would hire the most qualified candidates for the position, regardless of gender, to prevent any further delays in the project. EFICOR expects they will find a suitable candidate for the administrative assistant in the next quarter.

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

The local employee remuneration fees were less than expected due to the delays experienced in hiring project staff. Positions were also filled over a period of time in the first Fiscal Year (not all at once at the beginning of the quarter), which resulted in less staff time spent on the project and thus, lower staff costs. The delays in hiring project staff also resulted in delays in setting up the project offices and purchasing the corresponding assets and equipment (e.g. computers, two-wheelers), and reduced travel expenses (as less staff were travelling than expected). It is expected that all positions will be filled and all assets purchased in the first quarter of Fiscal Year 2.

Meanwhile, Canadian remuneration fees were more than expected during the first Fiscal Year due to the significant amount of planning and technical support that was required with the local partner at the beginning of the project to establish sound procedures for narrative and financial monitoring, documenting and reporting, and also learning CIDA's RBM system. The time spent establishing these procedures with the local partner will help to ensure that documentation and reporting meet HealthBridge's and CIDA's standards throughout the project duration.

1.1.4 Implementation of Gender Equality Strategy

The first Fiscal Year focused on gathering in-depth information about gender issues through quantitative and qualitative baseline data collection. The sex-disaggregated quantitative data allowed for clear analyses of differences in outcomes for boys and girls, although no significant differences were found. Specific information on gender issues in the district were also identified

in the qualitative analysis. This information will be integrated into the gender sensitivity training provided to EFICOR staff, as well as into the project activities. This is discussed in more detail in Section 2.3.1.

1.1.5 Implementation of UN Commission recommendations

The project is utilizing 6 of the 11 indicators recommended by the UN commission for monitoring progress on maternal and child health. These include the following:

- % of boys/girls 0-23 months who are underweight for height and age
- % of live births taking place in a health institution/attended by skilled birth attendant
- % of mothers who received antenatal care by a skilled provider at least 4 times during pregnancy
- % of mothers who received postnatal care within two days of child birth
- % of boys/girls 0-5 months who are exclusively breast fed
- % of boys/girls 12-23 months who received 3 doses of combined diphtheria, pertussis and tetanus (DPT) vaccine and measles vaccine before 12 months of age

With respect to the recommendation "By 2015, all countries have taken significant steps to establish a system for registering births, deaths and causes of death, and have a well-functioning health information systems that combine data from facilities, administrative sources and surveys": The project will help to improve birth registration and tracking systems at the local level by through the supportive supervision provided directly to the health centre staff and VHSCs by the EFICOR team throughout the project. For example, EFICOR will be conducting coordination meetings with ASHAs and staff at the HSCs to improve immunization surveillance and tracking. Coordination meetings will also be with PHCs and VHSCs to improve birth registration and referrals to the JSY, which is India's national benefit scheme to promote institutional deliveries.

1.1.6 Updated Risk Register:

An updated risk register has been included in Annex C. A fifth developmental risk has been added to the register based on lessons learned from EFICOR's project in the adjacent Sahibganj district:

- Risk: Poor governance may impact the performance of the health service providers. For example, delayed remuneration to ASHAs may inhibit their performance at the local level.

The response strategy for this risk involves the project team working closely with the government health officials throughout the project and notifying the government of specific issues that affect service delivery at the local level (such as delayed remuneration) and advocating for appropriate responses and solutions.

1.2 Financial Sub-section

Please see Form E in the attached financial report for a comparison between forecasted and actual costs for Fiscal Year 1 and an updated forecast for Fiscal Year 2. Analytical comments on financial info concerning variances between forecasted and actual costs or Year 1 are described in Table 3 below. It should be noted that the column "Forecast for Year 1" in Table 3 below differs from the forecast included in section 7.3.1 of the Annual Work Plan for Fiscal Year 1, which was submitted in February 2012. The forecast in Table 3 is the forecast submitted in Form A at the time of signing the contribution agreement. Meanwhile, the forecast in the Annual Work Plan comprises the sum of *actual costs* for Quarter 3 (Nov. 16th – Dec. 31st. 2011) and the forecast for Q4 (Jan. 1st – Mar.31st 2012) submitted on Form A of the Quarter 3 Financial Report. This is due to the fact that the Annual Work Plan was submitted after the first quarter of the project (Q3) and thus, it was possible to make a more accurate forecast.

Overall spending in Fiscal Year 1 was 44% lower than originally forecasted. This under-spending is due to two main reasons: (1) Inaccuracies in the initial forecast; (2) Delays in staff recruitment. With respect to the former reason, the forecast made in Q3 was submitted prior to any major planning between EFICOR and HealthBridge, and it did not take into account the shorter time period (1.5 months vs. 3 months) or the Christmas holidays. For example, remuneration forecasts for Q3 were for 3 months (a full quarter), not 1.5 months and did not take into account office closures for Christmas holidays. In addition, the initial forecast anticipated that some project activities would begin in Q4, however, this period was used to complete the baseline data collection instead, and activities were deferred to Q1 of the second Fiscal Year. The forecast submitted in the Annual Work Plan for Fiscal Year 1 ($101,467) corrected this error by including actual costs for Q3 and thus, was much closer to the actual spending for the year, with only approximately a 14% variance. With respect to the latter reason, as explained in Section 1.13, the delays in staff recruitment resulted in lower remuneration expenses for local employees, and correspondingly lower travel costs and asset costs (as equipment and vehicles were not purchased for the staff who had not yet been hired). It is important to note that despite the delays in staff recruitment, the baseline data collection was completed in a timely manner, as EFICOR utilized outside consultants as well as expertise within their organization.

2. Performance Section/Actual Outcomes

2.1 Project Context for the Fiscal Year

External context:

The Pakur Mother and Child Survival project is being implemented in Pakur district of Jharkhand state, which has a population of approximately 899, 200 (Census, 2011). Pakur is a rural, tribal-dominated state with higher rates of poverty, illiteracy, and infant and under-five child mortality in comparison to national averages. Initial meetings with government health officials in the district were very positive and demonstrated support for the current project, however results from the baseline data collection revealed a relatively high amount of dysfunction within the government health system, contributing to the poor access of the local population to MNCH services. In addition, there is a high degree of distrust and dissatisfaction amongst the local population with the government health system, also contributing to the low usage rates and demand for MNCH services. While such findings demonstrate the great need for the current project, they also indicate the challenges that will be encountered in striving to achieve the project outcomes, and the importance of working at both the supply and demand sides of the health system to improve the coverage of MNCH services. The current project will address such challenges by working in close collaboration with the government health system to improve service delivery, and also raising awareness and knowledge amongst the local population to improve the demand for MNCH services.

Internal context:

At the time of the project start, EFICOR was nearing the end of implementing its five-year Parivartan Project in the Sahibganj district of Jharkhand state. The Parivartan Project has very similar objectives, expected results and methodology as the current project, and is taking place in a similar context. As a result, the current project benefitted from the lessons learned in the Sahibganj project during the development of the PMF, Annual Work Plan and when building rapport with the government. The experiences learned in the Sahibganj project, along with the mentoring by related staff, will significantly benefit the implementation of the Pakur project throughout its duration.

As explained in the Operational Section, there were delays in recruiting staff for the project team. Despite this, the baseline data collection was completed efficiently and effectively during the required time period. The fact that external consultants were utilized, as well as the organizational experience within EFICOR itself, helped to ensure that there were no delays or problems in completing this component of the project.

2.2 Actual Outcomes

Baseline data on the project outcomes was collected in the first Fiscal Year and is shown in the PMF and PMF Narrative in Annex B. The baseline results were used to set realistic targets to which the project will work towards achieving at the end of three years. Some key results are discussed below:

Results of the baseline assessment revealed that the coverage of most maternal and newborn services was quite low in the district, particularly for institutional delivery/skilled attendant (30.3%/22%) at birth and ANC (7.3% had received 4 check-ups). The only exception was TT vaccination, in which 86.3% of mothers reportedly received the recommended two doses before giving birth. The project team will conduct further investigation and analysis (of the baseline data and in the ensuing barrier analysis) to determine why uptake of TT vaccination was so high compared to the other services. Results of the qualitative analysis found that, unlike other forms of health care, women tend to be the sole decision makers regarding vaccinations, which could be one reasons that coverage for this service was higher than others.

In comparison to TT vaccination, child immunization was much lower at only 41.1% of children receiving 3 doses of DPT vaccine and measles vaccine within in the recommended time frame (12 months). In addition, while mother and father knowledge of the danger signs of childhood illness (diarrhea, pneumonia, malaria) was quite high (70.7% of women and 73.3% of men couple report 3 danger signs), the percentage of children with suspected illness who were taken to a skilled provider or received an acceptable form of treatment was low (24.7% and 21.7% of children with suspected pneumonia or malaria, respectively; and 44.5% of children with diarrhea received acceptable form of ORT). This suggests that additional barriers, besides lack of knowledge, are preventing children from receiving treatment. Qualitative results suggest that preference for traditional health providers (Jhola Chhap and Ojha) may be a factor as well as dysfunction within the health system itself (0% of HSCs had adequate supplies of drugs).

Baseline results pertaining to shared decision making about MNCH at the household level are discussed in section 2.3.1.

2.3 Crosscutting themes and Priorities

2.3.1 Gender Equality Strategy

As explained in Section 1.1.6, Fiscal Year 1 focused on gathering in-depth information about gender issues in the district. With respect to gender equality outcomes, sex-disaggregated analyses did not find any significant differences in outcomes for boys and girls. For outcomes related to shared decision making at the household level, quantitative results indicated that

approximately 73% of men and 88% of women discuss MNCH issues with their spouses, and approximately 84% of men and women make decisions jointly with their spouse. Qualitative results, meanwhile, indicated that women feel they have little power to counter their husbands in decision making, and that men typically do not ask for their wives input in decisions about MNCH (rather the mother in-law or village *ojha* are consulted). The discrepancy in quantitative and qualitative findings could reflect a limitation in the wording of the related survey questions, but regardless, it is clear that more work needs to be done to improve couple communication and shared decision making about MNCH issues. This will be addressed in the project through the BCC campaigns, discussion groups and through encouraging health service-providers to engage fathers during their counselling sessions.

Additional gender issues identified in the baseline qualitative results include the following:

- Pregnant women are expected to continue with domestic and agricultural tasks almost right up until the time of delivery and immediately after. This high work load compromises the health of the mother and infant.
- 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. This inhibits their access to health care.
- Strong preference for sons results in repeated pregnancies in an attempt to give birth to a son, resulting in inadequate child spacing. This negatively impacts the health of the mother and infant.
- Early (adolescent) marriage is common within some groups in the district and results in increased risk for complications and adverse outcomes during delivery.

Strategy: The scope of the project does not allow for all these issues to be addressed within the three year period. For example, the strong preference for sons is deep-rooted in the culture and it is unlikely that this can be changed in a three-year period. That being said, the project will be able to mitigate some of these issues through current gender equality strategies as follows:

- Engaging men and mothers in-law in the project activities (BCC campaigns and counselling) will ensure that they are aware of the health and nutritional needs of women during and after pregnancy and will be more supportive of women receiving the required health care and rest.
- Encouraging couple communication and shared decision making about MNCH will open doors for discussions about family planning and child spacing.
- The above issues will be raised with government health officials and health service providers at the gender sensitivity training and at the networking and advocacy meetings which will increase their awareness and encourage discussions about appropriate local solutions.

2.3.2 Environmental Strategy

The project's strategy of using electronic telecommunications (e.g. e-mail, skype) has been utilized during the first Fiscal Year and has resulted in efficient communication without the need for overly frequent international and local travel. Similar to the gender equality strategy collected information on environmental issues and threats to MNCH in the project district. Baseline results indicated that only 54% of households of children 0-23 months use soap or detergent for hand washing, and approximately 66% of children 0-23 months had slept under a bed net in the last 24 hours. Thus, information on the importance of these two behavioural practices for prevention of infectious diseases will be provided to the local population in the BCC campaigns and health worker counselling sessions. The baseline results also indicated that none of the HSCs assessed had supplies of ITNs. This issue will be raised in the advocacy and networking meetings at the block and district levels, and also at the coordination meetings with UNICEF and the District Malaria Officer, to ensure that adequate supplies of ITNs are made available. Continued monitoring of environmental threats will be conducted through the Barrier Analysis and also through the reports of Cluster Supervisors at the monthly PIT meetings.

2.3.3. Governance Strategy

The main focus of the first Fiscal Year was relationship building with key government officials in order to obtain support and approval for the project. In obtaining ministry approvals, the project team conducted extensive meetings to introduce the project to key government officials of the HFWD and ICDS including the Civil Surgeon, District Project Manager (NRHM), Project Director (ICDS), District Immunization Officer and District Magistrate/Collector. The responses were very positive and the team received assurance from the district administration for their cooperation and support to implement the project in Pakur. Permission was also granted for conducting the baseline data collection. An official Project Launch will be conducted in the next quarter to formally introduce the project and present the baseline results to government partners and key stakeholders. The relationship and rapport building with the government will continue in Fiscal Year 2 through the regular networking and advocacy meetings with the block and district officials, and supportive supervision provide provided to the government health workers at the local level. Specific lessons learned from EFICOR's project in the adjacent Sahibganj district for relationship building with government officials are discussed in Section 2.5 and will be applied into the Pakur project.

2.4 Updated Risks and Risk Response Strategies

An update on project risks and response strategies is included in Annex C.

2.5 Lessons Learned and Recommendations Applied

Consultation and mentoring by members of EFICOR's staff from their Parivartan Project in the Sahibganj district has provided insight into lessons learned which can be applied to the current project. One key lesson learnt is the importance of building a good rapport with the government health officials. This is vital for smooth implementation of the project and also for establishing trust, such that the government officials will be open to the changes suggested by the EFICOR project team. Recommendations made by members of the Sahibganj team for building good relationships with the government include the following:

- Establish personal, as well as business, relationships.
- Use a supportive, non-confrontational approach, rather than challenging or criticizing.
- Convey the feeling that EFICOR is part of the government by using government venues for training, and regularly updating officials on the latest news, statistics and reports related to MNCH

Another lesson learnt from the Sahibganj project is the importance of positive staff moral and team cohesion amongst the EFICOR project team. This will be maintained in the current project through the monthly PIT meetings and quarterly PMT meetings.

3.0 Annexes

3.1 Annex A: Logic Model

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

3.2 Annex B: Updated 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:** 2 **Date:** March 31st, 2012 **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 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	1. Overall usage of maternal and child health services is low. There were no significant differences in utilization rates for boys and girls.	1. See PMF Narrative 2. Government MNCH services are perceived to be accessible and reliable.	1. Women who have children aged 0-23 months 2. Pregnant and lactating mothers, husbands, mothers in-law	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.

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Expected Results[1]	Indicators[2]	Baseline Data	Targets[3]	Data Sources	Data Collection Methods	Frequency	Responsibility
	2. Perceived accessibility and quality of government MNCH services..	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.	Perceived quality of services has improved.				
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 baseline.	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 valued in the final decision making.	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
Immediate Outcomes	1. Development and/or			1 .Government	1. Key informant	Annually	EFICOR &

Project Title: Pakur Mother and Child Survival Project **Budget: $**1,146,880 (CIDA contribution $860,160) **Duration**: Three years	**Version:** 2 **Date:** March 31st, 2012 **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
(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	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 VHSCs 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 VHSCs 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. 50 % of VHSCs with Health Plan 3. Progress & financial reports indicate effective project implementation, monitoring, and accounting	health officials; Block & District Health Action Plan, PHC/HSC Plan 2. Cluster supervisors 3. Project Manager performance appraisal reports; EFICOR progress/financial reports	interviews; Document review 2. &3 Document review,		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 (VNHD) held each month over the past 3 months; % VHNDs which satisfy minimum requirements (immunization, Antenatal check up, distribution of IFA, counselling to pregnant and lactating mothers, counselling to mothers of malnourished children, administer Vitamin A and growth monitoring) 2. % of Health Sub-centres (HSCs) with adequate supplies of drugs; % of	1. 20% 2. 0% of HSCs have adequate supplies of drugs;	1. 60% 2. 25% of HSCs have adequate	1. Cluster supervisor 2. Health Sub-Centre Staff (ANM, ASHA) 3. Cluster Supervisors 4. PHC staff	1. Progress reports 2. Health Facility Assessment Survey; 3. Cluster Supervisor Reports 4. Health Facility Assessment Survey	1. Annually 2, Semi-Annually 3 Annually 4 Beginning and end of project	EFICOR

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Expected Results[1]	Indicators[2]	Baseline Data	Targets[3]	Data Sources	Data Collection Methods	Frequency	Responsibility
	HSCs who have been supplied with ITNs 3. % of villages with trained, well-performing ASHAs and AWW 4. % of PHCs which offer institutional delivery services	0% have ITNs 3. 15% 4. 0%	supplies of all drugs and ITNs 3. 60% 4. 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	1. 73% 2. 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,	Men and women are aware of the benefits and importance of discussing MNCH	Women and men with children 0-23 months	Focus groups,	Beginning and end of project	EFICOR

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Expected Results[1]	Indicators[2]	Baseline Data	Targets[3]	Data Sources	Data Collection Methods	Frequency	Responsibility
		but rather blindly follow the cultural norms of their village. For decisions taken against the norm or an exceptional circumstance, the 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.	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.				
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

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Expected Results[1]	Indicators[2]	Baseline Data	Targets[3]	Data Sources	Data Collection Methods	Frequency	Responsibility
Outputs 110 Capacity building conducted for EFICOR and village health committees in design and delivery of effective MNCH interventions in Pakur.	1. # of VHSCs trained; # of VHSC members (M/F) trained 2. # of training sessions for EFICOR staff; # EFICOR project staff trained (M/F)	VHSCs are responsible for planning, implementing and monitoring health initiatives at the village level but do not receive any formal training in Pakur.	1. 600 VHSCs receive training: 400 VHSC trained in year 2 and 200VHSC trained in Year 3. 2. 33 EFICOR staff trained; Year 1= 33 staff, Year 2= 33 staff, Year 3= 6 staff.	Project documents; Participant lists	Review of project documents	Annually	EFICOR
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 VHSCs; 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; VHSCs often have poor planning and management of health funds and initiatives	1. 4 meetings per quarter with block and district officials; 2. 1 meeting per quarter with VHSCs; discussions indicate improved planning	1. Minutes from meetings with block and district officials; Cluster superviser reports 2. VHSC Health and planning documents; Cluster Supervisor monthly reports	Document review	Quarterly	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	# of ANM, ASHA and AWW trained and passed	ANMs, ASHAs, AWWs and TBAs	2221: ASHA (800), AWW	Training attendance lists;	Review of project documents	Annually	EFICOR

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Expected Results[1]	Indicators[2]	Baseline Data	Targets[3]	Data Sources	Data Collection Methods	Frequency	Responsibility
counselling (maternal and newborn care, nutrition and infectious disease prevention and treatment) in Pakur.	end of training exam # of Trained Traditional Birth Attendants trained (TBAs) and passed end-of-training exam	exist within the villages but have not been appropriately trained	(1000) and TBAs(300), and ANMs (121) trained and passed final exam Fiscal Year 2=1100 Fiscal Year 3=1121 Fiscal Year 3= refresher course for all.	pre/post training exam			
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 quarter 2.. 4 meetings per quarter 3. 1 meeting per quarter with District Malaria Officer and UNICEF; willing to provide ITNs at subsidized cost	Cluster Supervisor Reports	Cluster Supervisor Reports	Quarterly	EFICOR
230 Home and community counselling and care for MNCH (maternal and newborn care, nutrition, and infectious disease	1. % of women who received a visit from an ASHA during pregnancy 2. % of women and children (M/F) 0-23 months	1. 62% 2. 39% mothers; 38.3 % children	1. 75% 2. 50% mothers and children (M/F)	Women with children aged 0-23 months;	Household survey,	Beginning and end of project	EFICOR

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Expected Results[1]	Indicators[2]	Baseline Data	Targets[3]	Data Sources	Data Collection Methods	Frequency	Responsibility
prevention and treatment) delivered in Pakur.	who received nutrition and growth monitoring counselling by AWW	(38.5% M; 37.5% F)					
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 people; 790 outreach events with 1,20,000 attendees 24 outreach events in a month	Dissemination lists; project documents	Review of project documents	Quarterly	EFICOR
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 quarter through IEC material.	Project documents; Dissemination lists	Review of project documents	Quarterly	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 quarter 480 participants (M=240/F=240) in each quarter.	Participant lists; Project documents; Notes from discussion groups	Review of project documents	Quarterly	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 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.

Type of MNCH Service	Indicators
Maternal and newborn care	• % of live births taking place in a health institution or home births attended by skilled birth attendant • % of mothers who received ANC by a skilled health provider at least 4 times during pregnancy • % of mothers who received two doses of TT vaccine prior to giving birth • % of mothers who received postnatal care within two days of child birth • % of mothers who consumed iron supplements for at least 100 days during their last pregnancy
Nutrition and child feeding	• % of boys and girls aged 9-23 months who received at least one dose of Vitamin A supplementation •
Infectious disease	• % of boys and girls 12-23 months who received 3 doses of DPT vaccine, and measles vaccine before 12 months

Type of MNCH Service	Indicators
prevention and treatment	• % of boys and girls 0-23 months with suspected pneumonia who sought care from skilled provider within 24 hours • % of boys and girls 0-23 months with suspected malaria who sought care from skilled provider within 24 hours • % of boys and girls 0-23 months who received an accepted form of ORT when they had diarrhea • % of boys and girls aged 0-23 months who used an ITN in the last 24 hours

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.

Outcome 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*: The capacity of EFICOR will be measured throughout the project through performance appraisals and progress reports. The capacity of local government health institutions will be measured through development, changes and/or additions to village, block, and district health plans which will demonstrate that they understand and are committed to addressing MNCH service gaps.

Outcome 200: *Increased access to MNCH care and counselling amongst women and children 0-23 months*: Access will be measured through the availability of quality, well-functioning MNCH services at the village level. This includes Village Health and Nutrition Days (which bring MNCH services such as ANC and immunization directly to the villages), Health Sub-Centres with adequate supplies, well-performing community health workers in the villages (ASHAs and AWWs) and Primary Health Centres with institutional delivery services. Criteria for assessing the quality of the services will be specified in the data collection tools.

Outcome 300: *Increased knowledge of appropriate MNCH practices amongst men and women*: We will measure knowledge of both men and women of key aspects of maternal and newborn care and practices for prevention and treatment of childhood illness (fever, diarrhoea, pneumonia). Knowledge of nutrition and feeding practices will be measured through practice indicators.

Outcome 400: *Increased acceptance of shared decision making at the household level about MNCH amongst men and women in Pakur*; Outcome 500: *Increased perceived ability of men and women to make shared decisions about MNCH in Pakur*: Acceptance will be measured through understanding of the importance and benefits of spousal communication and joint decision making, while perceived ability will be measured by assessing confidence. Both understanding and confidence are necessary for men and women to make actual changes in their decision making practices. Qualitative methods

Outputs

Output indicators measure the delivery of project activities and processes, and therefore correspond with the activities in the Annual Work Plan. The assumption is that the targeted outputs need to be achieved successfully in order for changes to occur in the project outcomes, and so the indicators were designed to assess this.

2. <u>Elaboration on Certain Baseline Results and Targets</u>

Intermediate Outcome: Implementation of more effective, gender-sensitive interventions and services related to MNCH in Pakur

<u>Quantitative Indicator</u>: % of women and children 0-23 months utilizing MNCH services; % difference in utilization rates for boys/girls

Maternal and Newborn Care	**Result**	**Target**
% of live births taking place in a health institution/ home births attended by skilled birth attendant	30.3%/22%*	50%/34%
% of mothers who received ANC by a skilled health provider at least 4 times during pregnancy	7.3%	30%
% of mothers who received ANC by a skilled health provider at least 3 times during pregnancy**	29.3%	N/A
% of mothers who received two doses of TT vaccine prior to giving birth	86.3%	90%
% of mothers who received postnatal care within two days of child birth	45.3%	60%
% of mothers who consumed iron supplements for at least 100 days during their last	3.0%	30%

pregnancy		

** 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.**	**Total**	**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%	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%	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%	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%	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%	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%	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*

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

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.

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

Indicator	Mothers	Fathers	Target
1. % of mothers and fathers with knowledge of maternal and newborn danger signs *	**56.3%**	**51.7%**	**73%**
a) % of mothers and fathers able to report at least 3 known maternal danger signs during pregnancy	68.7%	62.0%	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%	70%
c) % of mothers and fathers able to report at least 3 known newborn danger signs	50.3%	48.0%	70%

**Result given is average of indicator sub-components*

Indicator	Girls	Boys	% Variance**	Total	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%**	**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%	70%
b) % of boys and girls who were exclusively breast fed between 0-5 months	50.0%	59.5%	-9.5%	54.6%	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%	40%

**Result given is average of indicator sub-components*

***Differences for boys/girls not significant*

Indicator	Mothers	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%**	**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%	80%
b) % of households of children 0-23 months that use soap or detergent for hand washing	54.3%		60%

**Result given is average of indicator sub-components*

***3. Setting of Pro*ject 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 highlighted in yellow. Updated ratings for risk level and impact level have been included.

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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	Date3
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 = I =
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 quarterly 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	
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	L = 2	L = 1	L =

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			Initial Rating	Mar 31 2012	Date3
		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 quarterly 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.	I =2	I =2	I =
Fin2	Fluctuation in exchange rates could cause loss in project revenues.	In the case of extreme exchange rate variations, the budget and work plan will be reviewed with CIDA.	L = 2 I = 1	L = 2 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	
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	

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Risk Definition		**Updated Risk Response Strategy**	**Residual Risk Level – Low/Very Low/High/Very High**		
			Initial Rating	Mar 31 2012	Date3
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	
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	
Dev5	Poor governance may impact the performance of the health service providers. For example, delayed remuneration to ASHAs may inhibit their performance at the local level.	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.		L = 2 I = 4	
Reputation Risks					
REP1	EFICOR is a Faith Based Organization. Consequently, its beliefs and values may	Emphasizing that the project objectives aim to improve maternal, newborn and child health amongst all individuals in the targeted district, regardless of religion,	L = 1	L = 1	

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Risk Definition		**Updated Risk Response Strategy**	**Residual Risk Level – Low/Very Low/High/Very High**		
			Initial Rating	Mar 31 2012	Date3
	conflict with some individuals and groups in Canada and India. Also, vested interest groups may politicize the intervention for their own interests.	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.	I = 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 quarterly 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 quarterly progress reports.

Operational risks will be monitored using HealthBridge's quarterly 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 quarterly 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 quarterly 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 quarterly 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 quarterly 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.

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, 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.
Response Strategy: The project team already has 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.