WWJMRD 2020; 6(7): 80-89
www.wwjmrd.com
International Journal
Peer Reviewed Journal
Refereed Journal
Indexed Journal
Impact Factor MJIF: 4.25
E-ISSN: 2454-6615

Dr. Tridibesh Tripathy
Homoeopathic & Public Health Expert, Subject Expert, Master of Public Health (Community Medicine) Course, Lucknow University, Lucknow. India

Ms. Anjali Tripathy
Program Co-ordinator, Water Aid, Lucknow office, UP, India

Correspondence:
Dr.Tridibesh Tripathy
Homoeopathic & Public Health Expert, Subject Expert, Master of Public Health (Community Medicine) Course, Lucknow University, Lucknow. India
tridibeshtripathy@gmail.com

Geographic Focus- A strategy in 2002 for Title II based Safe Motherhood and Child Survival Program of Catholic Relief Services, Lucknow, UP, India

Dr. Tridibesh Tripathy, Ms. Anjali Tripathy

Abstract
The health program of Catholic Relief Services (CRS) known as the Safe Motherhood and Child Survival (SMCS) program of CRS/North India, Lucknow operated with 9 partners in 8 districts of Uttar Pradesh as in 2002. The program was operational in selected villages of 10 development blocks in these districts. Thus, the program operated in a scattered manner covering small geographic patches within the blocks. Due to this discrete spread, the impact of SMCS program remains visible only to CRS and its partners. The impacts of public health interventions are usually assessed by organizations in terms of geographic units such as blocks, districts, states and countries.
The current article written in a proposal format aimed to expand the scope of the SMCS program from a portion of the block to the entire block. It expected to bind the efforts of the program personnel in a whole block. This coverage was expected to derive measurable positive health outcomes in the program communities. The activities were expected to focus to improve vital health statistics of program communities especially people who were related to the safe motherhood and child survival program.
CRS/North India proposed that two of its potential Non-Governmental Organization (NGO) partners to expand their current program to cover entire blocks. These partners were 'GRAMIN VIKAS SANSTHAN' and 'LOKARPAN' working with SMCS in Raebarely and Auraiya districts since 1997 and 1998 respectively. Through this expansion, LOKARPAN expected to cover the BIDHUNA BLOCK while GVS expected to cover the SHIVGARH BLOCK.
As the expansion process planned to cover a large number of villages, the proposal incorporated the administrative, financial and various managerial issues to be dealt both at the partner and CRS, Lucknow level. The estimated program period was expected to be of 5 years duration. The program was expected to empower people especially women, so that demand is generated for quality health services from the government. This process is likely to ensure their own health needs through appropriate service delivery from the public health system. CRS and partners will strengthen their current linkages with government health departments to ensure quality health service delivery.

Keywords: Title I, II, III & IV, SMCS, NGO, PL 480, Food Aid, CRS,

Introduction:
The food situation in India was marked by severe shortages in early 1940s[1]. To overcome shortages, the Government of India felt the need for reserve of food grains as there was wide fluctuations in production of food grains. Secondly, the planned budgeting of activities in five- year plans was bound to put inflationary pressure in the food grain sector than elsewhere[2]. Thus, to create a buffer stock of out of imported food grains, the Indian Government entered into negotiations with the United States Government & signed an agreement in 1956 for import of agricultural commodities, mainly food grains under Public Law 480[3].
The Food for Peace program of the Government of United States operated under the Agricultural Trade Development & Assistance Act of 1954 (as amended), better known as the Public Law (PL) 480. The law authorized four types of special programs such as Title I, Title II, Title III & Title IV[4]. Title I focused on sale of surplus food grains, II on donations to governments for disaster relief, economic & community development, III on donations to voluntary agencies for distribution & IV on foreign buying of US farm products[4]. From

1956, Catholic Relief Services was engaged in Title III program in India[4].

The concept changed from food aid to food assistance in the period from 1990-2014. Use of food aid was more forthrightly in programs aimed at community development. These programs are best examples of United States efforts to reach people directly. Three-fourths of the food donations were administered by American Voluntary Agencies one of which was CRS[5]. To increase the flexibility of food aid, the United States Government allows sale of food in recipient countries to generate cash resources for other programs addressing the causes of hunger, a practice known as monetization & CRS also used the monetized food to address hunger in India & from 1991 to 2001, levels of monetization of the non-emergency Title II food increased from 10% to 70%[6].

The Agency for International Development office in India operated the Title II program as USAID was given the responsibility to implement the Title II programs[7]. The Title II program in India was at the time the single largest humanitarian food donation program in the world providing food commodities through CARE, CRS, Lutheran World Relief, UNICEF & others[8].

CRS implemented projects from 1997 to 2010 in three sectors such as maternal & child health & nutrition, agriculture (watershed development) & education. CRS devoted its last project cycle called the Phase out Plan (POP) to transitioning or phasing over their activities to Government of India programs[9].

The Safe Motherhood & Child Survival Program of Catholic Relief Services in India was operated in 13 states across the country serving 182, 121 pregnant & nursing mothers & children of 0-3 years of age from around 3169 villages. The program was operational through 600 social service wing of the dioceses as local partners thus reaching the inaccessible & the underserved. The goal of the program was to empower women to address their own health needs as well as those of their children & communities[10].

CRS India implemented baseline studies in the second project cycle in 2002 after the first Development Activity Project phase I (1997-2001) ended in 2001. The base line studies of SMCS program was done in 2002. The Development Activity Phase II was from 2002-2007. The current article is regarding the SMCS program in this phase. The baseline for the Phase out Plan (POP) was from 2007. End line evaluation for POP was done in 2010 for CRS, India. The end line evaluation was replicated in 2012 for CRS, India in a follow up quantitative survey implemented in a subset of the states in which the end line evaluations were conducted. Qualitative survey was also done. Uttar Pradesh was also one of the states in which the end line was done[9].

The end line evaluation of SMCS program reflected increase in institutional deliveries, immunization coverage, increase in prenatal & postnatal care. The underlying assumption was that improving maternal care practices would ultimately affect rates of malnutrition but the indicators on Early Initiation of Breast Feeding, Exclusive Breast Feeding, Complementary Feeding and continued breastfeeding & feeding during illness did not show any significant effect on the probability of a child being stunted[9]. This shows less effective implementation of these indicators as these are proved & effective interventions if done strategically[11]. However, the evaluation focused on identification of factors leading to the sustainability of those changes in activities, outcomes & impacts that were achieved by the project[9].

One such effort to augment the SMCS program in Shivgarh block of Raebareily district was done in the second DAP period in the year 2002. Shivgarh block was then a non-ICDS block as ICDS was not universalized in the Nation by that time[12]. The ICDS program was universalized through a order of supreme court in December 2006 where by the Government of India was asked to cover all the blocks of the country through the ICDS by 2008[12]. The other block Bidhuna of partner LOKARPAN mentioned below was also a non-ICDS block.

The approach was to implement the Safe Motherhood & Child Survival (SMCS) program in two development blocks where by the entire block is covered through the program. The program was already operational in UP since 1996. CRS works with Non-Governmental Organizations (NGO) to implement the programs & two such NGOs were GVS & LOKARPAN.

The current article has the simplified approach where the important contents of the program reaches all targeted communities in a geographic region. It was expected that the process is integrated into the SMCS program of other NGO partners of CRS Lucknow wherein they work in a contiguous geographic region & not work in patches. The benefits and impact of this approach can be gauged by going through the details mentioned in the proposal. The integration envisages such large-scale outcomes in the program areas of other program partners.

As the design of the SMCS program was based on the concept of child survival, it is prudent to discuss the progress of child survival programs in India. The following paragraph helps us to understand the rationale & the importance of the SMCS program.

Fig. 1: Milestones of child survival program In India[14, 15]

Child survival program progress in India

The current article is in the area of child survival and the stage right from the new-born to 5 years of age comes under the domain of child survival which is a part of Child Health. Hence, imperatively tracing the history of the child survival programs in India is essential. Needless to say, initially the entire child survival intervention was based on

the roll out of immunization programs in the country. Almost after a decade of introducing the immunization program at the national level, the child survival interventions became more focused. The National Neonatology Forum was formed in 1980 and formulated the first set of recommendations on neonatal care in 1980[15]. Therefore, in 1992 the program launched was Child Survival and Safe Motherhood (CSSM) program and this name was adopted by CRS in the late Nineties when the Safe Motherhood & Child Survival (SMCS) program was launched through DAP I in 1996. From CSSM, the new name became SMCS. The naming had a lot to do with the linkages established with the public health system in the implementation of the program as the health personnel could identify with the program. The program had the Essential New-born Care component included as an integral part[15]. This was followed by Reproductive and Child Health program in two phases from 1997 to 2005[16]. Since 2000, with the advocacy of the National Neonatology Forum the National New-born week was celebrated from 15th to 21st November each year[15]. The NRHM was launched in 2005 and the Home-Based New-Born Care (HBNC) strategy was launched in 2011[18] as the Neo-natal Mortality is difficult to reduce than the Infant & U5 mortality[14]. The RMNCH+A strategy were in place in 2013[16] and currently we have the India New-born Action Plan (INAP) since 2014[14].

Health Status of U.P.

The State of Uttar Pradesh (UP) is one of the poorest states of India, with 166 million people (2001) and ranks among the top ten populous area of the world. Hence there is enormous challenge on the public health system to deliver quality health services. This unmet challenge has contributed towards the poor health status in U.P. The table1 presents the evidence in details.

The enormous challenge on the public health system is also reflected when we see the available number of public health facilities in the state. There is a definite norm for health facilities in the state. Ideally, there should be one community health centre per 100,000 population. Similarly, one primary health center per 30,000 and one subcenter per 5,000. The data given below presents the number of public health facilities in the state. Thus the real situation tells us that there is one community health center per 721,968 population, one primary health center per 54,766 population and one sub center per 8,250 population.

Table 1: Health status of UP in 2001.

Health Indicators of U.P.	
Infant Mortality Rate (Per1000)	86.7
Under 5 Mortality Rate (Per1000)	122.5
Ante Natal Checkup	31%
Iron and Folic Acid	21%
Tetanus Toxiod	51
Non-institutional Delivery	83%
Complementary Feeding of infants (6-9 months)	17.3%
Anemia in women	49%
Anemia in children	71%
Fully immunized (12-23 months) Source- National Family Health Survey-2 reports of 1998-99.	21.2%
Maternal Mortality Rate (per 1000 PW)	6.2

Source: National Family Health Survey-2 reports of 1998-99 & UNICEF report of 1995.

Table 2: Health Infrastructure of UP in 2001.

District hospitals	83
CHC	230
PHC	3,032
SUB CENTERS	20,130

Source: Status of health of UP, Uttar Pradesh Voluntary Health Association.

The comparison clearly demonstrates the burden on each of these public health units to deliver quality health services. In India, health is a state subject. Hence, the poor health status can also be attributed to the health expenditure of the state government. There is a huge gap between the need and the budget allocation. The data of the annual plan of state planning commission, August 1999 regarding the medical and public health expenditure of last 3 years presents the picture.

Table 3: Medical & Health expenditure of UP from 1997-2000.

97-98	Rs 1,560.9 million
98-99	Rs 4,055.1 million
99-00	Rs 4,281.6 million

Source: State Planning Commission, UP, 1999

Although there is an increasing trend in the budget of 1998 to 2000, the allocation does not correspond with the huge demand.

CRS Health Program in UP

CRS commenced its Safe Motherhood and Child Survival (SMCS) program in UP since 1996. Through a network of 9 NGO partners, the health program reached 34,200 program participants. The program participants are dispersed in 250 villages spread over 8 districts covering population of 342,000.

The program provided Growth Monitoring and Promotion services, health education and intensive counseling to all pregnant women and mothers of children under 3 years of age. Participants receive five kilos of PL480 commodities as a strategy to get them out of their houses and as well as encourage them to participate in the program. The program facilitates linkages with the health providers of the state government. A set of micro targeting criteria is used to identify non-ICDS villages with 80 percent or more socially disadvantaged groups (ST, SC and OBC) and have minimal infrastructure. Villages thus identified are then surveyed and mapped to determine the demographic profile and other general attributes. All eligible participants are then enrolled in the program.

Prior to the food distribution, pamphlets are distributed in the village to inform the people regarding the program. Community meetings are held in the villages to aware the people regarding the programmatic activities. The selected health workers and supervisors are trained regarding the management information system of the program. They are also given a motivational training that highlights the importance of a health worker in the community. All these processes have contributed to improve program quality. People take about 6 months to actively participate in the program activities such as health education sessions and home visits.

The program participants assemble once a month at a common location in the village to avail health services and Title II commodities. The health services include weighing and immunization of children and pregnant mothers, identification of growth faltering children for follow up and counselling to their mothers. The date of food distribution is also synchronized with the visit of the Auxiliary Nurse Midwife from the local government health center. In addition to the above the village health workers visit the homes of pregnant women, recent deliveries, growth faltering children and children nearing 6 months of age for intensive counselling. They also conduct health education sessions with women and disseminate safe motherhood and child survival messages in the community.

The program staff includes locally identified health workers and supervisors. The community involvement is the real strength of the program. The program staff salaries and other operating costs are covered by the Title II funds generated through participant contribution. The participants contribute a fixed amount per month for the services availed from the program. As the program is community based and operates through the contribution of the people, they develop an ownership of the program.

The SMCS program faces resistance from communities during the initial 6 months of program implementation. Rumors spread in the villages regarding the Title II food commodities. People think that women may become sterile after consuming this food and the children will be forcibly immunized and taken away to America. It is also difficult to get women out of their houses to participate in the program activities like the distribution and health education sessions. This is because of the social stigma, which confines women only to their household. This is also a limiting factor for selection of female health workers.

Partners face difficulties to get educated health workers in every village (as per 2001 census, female literacy rate in UP is about 43%) to work in the program and even if they get some educated women, most of them are not encouraged to work by their family. To add to this, the various superstitions regarding immunization and IFA tablets act as obstacles towards acceptance of health services. Our experience of working in the villages of UP tells us that the level of health awareness among the people is very low. The prevailing caste system too is a barrier because the upper caste people dislike to mix with the lower caste people in performing any activity. They are usually reluctant to send the women to the food distribution centers where all are treated equal. Hence, the challenge lies in overcoming these social evils and to clear the myths regarding acceptance of the health services and commodities.

About The Two Partners

Gramin Vikas Sansthan (GVS)

GVS is a registered organization since 1984-85 under the Society Registration Act of 1860 and FCRA since 2000. The organization has its head office in village Kannawan of Raebareli district. Mr. Mohammed Attaulla heads the organization. Since inception, the organization continues to implement various developmental activities in Shivgarh block like running crèche center, women awareness on social issues, incense stick production unit for income generation supported by Central Social Welfare Board, New Delhi. The other activity is self-help group formation supported by Rashtriya Mahila Kosh, New Delhi. The SMCS program is implemented at the partner level since 1997. This shows that the partner has a long association with CRS/ North India. The partner has good managerial skills.

The SMCS program was started in Shivgarh block covering 19 villages catering to 1900 program participants. As the program was managed successfully for two years maintaining good quality standards, it was expanded in the year 1999. Currently, the program caters to 4500 program participants spread over 39 villages. According to the partner, unlike other programs, the SMCS program has helped to generate health awareness among the people through various health communication strategies like use of information, education and communication materials and puppetry shows. They find CRS as a supportive donor and during these years of partnership their staffs have been enriched through capacity building processes like training and supervision.

LOKARPAN

The partner is a registered organization since 1996 under the Society Registration Act of 1860 and FCRA since 2000. The organization has its head office in the village Malhausi of Auraiya district. Ms. Seema Singh is the head of the organization. The partnership with CRS started in the year 1997 with the implementation of education program in the selected villages of Bidhuna block.

The SMCS program started in the same villages in the year 1998. Other program of the partner includes the reproductive and child health program supported by state government in non-SMCS villages of Sahar, another block in the same district. This shows that the partner has good managerial skills and has the potential to develop effective linkage with the government. In fact, among all the SMCS partners, this partner has developed the best linkage with the government for availing health services. The program results like immunization coverage of this partner over the

last three years clearly depicts the benefits of the linkage.

The SMCS program was started in Bidhuna block in 26 villages catering to 3300 program participants. As the program was managed successfully for three years maintaining good quality standards, it was expanded in the year 2001. Currently, the program caters to 5300 program participants spread over 51 villages. According to the partner, the SMCS program has helped them to generate health awareness among the masses through various health communication strategies like the use of IEC materials and puppetry shows. They also find CRS a supportive and friendly donor and during these years of partnership, their staffs have enriched themselves through various capacity building processes like training and supportive supervision.

About The Blocks

Shivgarh

This block has 39 Gram Panchayats with a population of 96,590. Currently, the SMCS program covers 15 Gram Panchayats with a population of 45,000. Agriculture is the major occupation of the population. As per the block development office data, the female literacy rate of the block is only 14%. Our experience of working in the block for the last 4 years tells us that there is a great need to improve the health service delivery system.

Bidhuna

This block is larger than the Shivgarh block with 64 Gram Panchayats and a population of 164,456. Currently, the program covers a population of 53,000. The major occupation of the population is agriculture. As per the block development office data, the female literacy rate of the block is 42.4%. Our experience of working in the block for the last 3 years tells us that there is a great potential to improve the health service delivery system in order to meet the demand.

Reasons for Adopting These Blocks

- As the programmatic interventions will be concentrated in a well-defined geographic area, program management will be effective for CRS and the partners.
- Both the partners are already covering a portion of the blocks through the SMCS program. As they have the potential to manage the program effectively, there is an opportunity for them to run the program in the entire blocks. The attached maps show the area covered and to be covered (See Annexure II and III).
- Till now, the reporting system of SMCS program was based upon the number of program participants, which represents 10% of the population. Hence, the results of the program are not comparable with that of any national level data, as the denominators are different. The smallest unit to assess the health data by the government is the block. This project will ensure the participation of the whole population of the block in the program as everyone has the right to avail basic health facilities. This includes even those families who do not wish to receive the Title II commodities. Thus, the program will have visible impacts through the strategy of covering entire community of a whole block.
- Both these blocks are situated near by Lucknow. Shivgarh at a distance of 2 hours by road and Bidhuna at a distance of 5 hours' drive. Hence, CRS can monitor the program effectively.
- Unlike the previous strategy of working in a scattered manner, this strategy will help the partners to increase their capacity and also get recognition from the government for their work.
- This strategy is also likely to mobilize people to generate demand for health services and ensure proper service delivery from the public health system.
- The Shivgarh block is a non-ICDS block while Bidhuna block is covered by the state government funded ICDS program without involvement of CARE or WFP. Hence there is an opportunity for both CRS and the partner to implement the SMCS program in both the blocks while having an effective government linkage.

Project Framework

Goal:

To empower women to address their own health and development needs as well as those of their children and their communities in two entire blocks of UP.

Objectives:

To promote antenatal care, safe delivery and postnatal care.

Indicators

- Percentage of pregnant women and nursing mothers (up to 6 months lactation) in the program villages enrolled in the program
- Percentage of mothers receiving three antenatal check-ups.
- Percentage of mothers having delivery assisted by trained birth attendant.
- Percentage of mothers receiving 90-100 iron and folic acid tablets
- Percentage of mothers receiving 2 tetanus toxoid or Booster.
- Percentage of mothers with institutional deliveries who receive any post-natal service within two months of delivery.

To improve the nutritional practices of children, pregnant women and nursing mothers.

Indicators

- Percentage of children of 6-9 months age receiving complementary feeding.
- Percentage of mothers initiating breast-feeding within eight hours after giving birth.

To promote primary immunisation of all children against the six vaccine preventable diseases by the age of one year.

Indicators

- Percentage of children of 0-12 month's age receiving complete immunisation.

To reduce common childhood illnesses.

Indicators

- Percentage of children 6-23 months in the program villages enrolled in the program.
- Percentage of children under 3 years of age who are registered in the program growth monitored every

month.
- Percentage of growth faltering children treated and their mothers counselled.
- Percentage of children given oral re-hydration therapy.

To increase awareness among mothers and the community about health and nutrition issues related to safe motherhood and child survival.
Indicators
- Percentage of program villages that conduct monthly health and nutrition education sessions every month.
- Percentage of mothers attending health education sessions.
- Percentage of mothers following health practices.

To promote/ encourage the formation of women's groups for program sustainability.
Indicators
- Number of active women groups.

To encourage the participation of the community to take the initiative to meet its own health needs.
Indicators
- Percentage of all the health service providers who have correct knowledge about the program activities and expected outcomes.
- Community demands regular health service delivery from the public health system.

All the indicators are as per the findings and recommendations of the mid-term and final evaluation of the DAP I. The indicators of the DAP II are also captured.

Activities:
1. Baseline survey conducted in the whole block
2. Training to TBAs, RMPs, Health Workers and Supervisors.
3. Health workers and supervisors conduct growth monitoring and counselling of pregnant mothers and mothers of growth faltering children.
4. The partners develop effective linkage with the government.
5. Health workers and supervisors conduct health communication activities such as puppetry shows, street plays and health education sessions for mothers on health-related issues.
6. Health workers and supervisors conduct home visits for the priority cases and counsel them accordingly.
7. Partners initiate the formation of women groups.
8. Partners conduct community mobilisation activities in the community.

Strategies
Activity 1- Baseline survey conducted in the whole block
The partner and the SMCS team will do a detailed survey in the block. The survey format will be developed with the help of an external agency taking in to account all the socio-economic factors. These factors will be decided in consultation with the partners. The survey format will also capture the baseline status based on the indicators of DAP II. This base line data will help to measure the impact of the program during the MTR and the final evaluation.

Activity 2 – Training to TBAs, RMPs, Health Workers and supervisors
This activity will provide information on the key components of SMCS program activities to the traditional birth attendants, registered medical practitioners, health workers and supervisors. Using participatory and innovative training techniques such as group exercises, role-plays, demonstrations and problem solving exercises, the training will improve their skills. They will become more effective health service agents in the communities.
Besides the Management Information System training on maintaining child register, pregnant register, attendance register, mother child card and distribution card, the health workers and supervisors will be trained on the technical health aspects as per the health curriculum developed for the program. The Registered Medical Practitioners will be oriented regarding the basics of the program to ensure that they participate in the program. The practitioners who will be directly involved in the program will do the antenatal care of the pregnant women during the distribution. They will also provide curative services to the program participants The Traditional Birth Attendants will be trained regarding ante, pre and postnatal care.
The partners will identify the above mentioned service providers from the program communities. Need based refresher training will also be held for these trainees.

Activity 3 – Health workers and supervisors conduct growth monitoring and counselling of pregnant mothers and mothers of growth faltering children.
This activity will be done at the distribution centres every month. The growth faltering children will be identified from the plotted growth cards and the health workers will counsel their mothers. The pregnant mothers will also be weighed and counselled by the workers.

Activity 4 – The partners develop effective linkage with the government.
The partners will meet the district and block level authorities and apprise them about the program. This will ensure their cooperation to run the program. Linkage will also be developed with the public health system to avail various child and mother care services like immunization, IFA tablets, Vitamin A solution.

Activity 5 – Health workers and supervisors conduct health communication activities like puppetry shows, street plays and health education sessions for mothers of SMCS program.
The SMCS personnel will be trained to conduct puppetry and street play shows. The partners will plan this activity at their level and do these activities periodically. These entertaining activities will generate health awareness and help in the process of community mobilization.

Activity 6 – Health workers and supervisors conduct home visits for the priority cases and counsels them accordingly.
The supervisor and health worker will identify the priority cases and visit their homes to counsel them specifically based upon their need. The priority cases include growth faltering children, pregnant women, recently delivered

cases and children completing 6 months of age. They will record the details of the visits in the home visit diary.

Activity 7 – Partners initiate the formation of women groups.

Activity 8 - Partners conduct mobilization activities in the community.

The partners will follow the women group strategy developed by CRS/ North India for the formation of women groups. As the program will cover the entire population of the block, the people will be mobilized through the various program activities. These activities include the health education strategies, the regular services from the public health system, services provided by the doctors in the program and various confidence building measures for non-Title II people. This process of mobilization is expected to facilitate the formation of women groups.

Management at partner level

The pattern of management will be different from the current structure. The staffing pattern and implementation strategy will change, as the number of program communities

will increase. In order to have a good quality program, the block will be divided into zones. There will be a zonal supervisor in each zone to look after all the activities in the zone. In each zone, there will be about 6 supervisors and each supervisor will supervise about 6 health workers. Each health worker will provide services to 125 program participants on an average. All the zonal supervisors will report to the project co-ordinator.

The responsibility of the project co-ordinator will be to ensure the quality aspects of the program and give feedback to the Operating Partner NGO. The responsibility of the zonal supervisor will be similar to that of the current SMCS co-ordinator. The responsibilities of the supervisors and health workers remain the same as that of the current status. There will be a warehouse in charge who will be at the same level as that of the project co-ordinator. The only difference will be in their responsibilities. The responsibilities include planning the monthly distribution at the various centres, maintenance of the go-downs and all the activities related to commodity management at the partner level. The organogram of both the partners is also attached.

Program implementation

The program implementation includes the collective efforts of people, partner, government and CRS. The success of the program depends on the active participation of the people. They are expected to encourage mothers to attend the monthly distribution along with their children. The mothers are also expected to make their monthly contribution to the Title II fund while attending the health education sessions. This strategy will help the program participants to give priority to the health services and not to the Title II commodities.

Here the role of the mothers-in-law is crucial. They will be oriented about the program activities. They are expected to know the benefits of the program and discuss this within the family. As they have the power to take family decisions, their positive attitude is likely to generate interest about the program on all the family members. The co-operation of each family is needed to assist the health workers and supervisors in various activities like growth monitoring, antenatal check-ups, health education sessions and home visits.

The village panchayat is also expected to play an advocacy role in involving the senior citizens of the village to aware people about the benefits of the program and encourage them to participate in the program. They are expected to be the key informants of the program in every village. The progress of the program will be displayed in a black board so that people get the feedback about the program activities. This information will be updated every quarter. The community mobilization activities are expected to facilitate the formation of active women groups. These women groups carry on the activities of the program even after the Title II commodities are withdrawn from the villages.

The partner is expected to have a constant liaising with all the stakeholders of the program. They are the people, district administration and CRS. This process includes mobilization of the community about the program through the panchayats, periodic meeting with the district officials to aware them regarding the progress of the program. They are expected to send the relevant reports in time to CRS and get feedback from CRS regarding the programmatic activities.

Partners will ensure that the expected outcomes are met. The partner will hold quarterly meetings with CRS to plan for the activities of next quarter and evaluate the past quarter. In order to meet the expected outcomes, partners will assign well-defined job responsibilities to their staffs and monitor their performance. The partners will focus on the various capacity building initiatives for the staffs. Planning need based training for the staffs and percolating new information regarding public health to the SMCS personnel are the other activities that the partner is expected to do.

Primarily, the role of CRS will be to support the partner for effective program implementation. CRS/NI will depute one staff from health team to take responsibility for Block Coverage. The success of this initiative will be the sole responsibility of the staff. CRS is expected to give feedback on the program both externally and internally. The external player includes the state government. Efforts will be made not only to brief them about the program but also arrange exposure visits for government officials to enable them to see our program. The internal player includes the management of CRS/ North India, health technical advisors of CRS/India and CRS/Head Quarters Baltimore. The progress reports will also be shared with the health team of other zones. CRS should advocate on the progress of this initiative while sharing with other like-minded agencies like CARE and WFP.

Monitoring plan

- The supervisors provide monitoring support to the health workers regularly.
- The zonal supervisors provide monitoring support to all the supervisors every week.
- The project co-ordinator reviews the activities of the zonal co-ordinators every week.
- The commodity manager and the project co-ordinator report to the partner every week.
- CRS provides monthly support visits to each partner.
- Partners update CRS quarterly about the progress of the program.

Besides, the health workers and supervisors conduct a monthly meeting to discuss regarding programmatic issues. In addition, need based visits will be done by CRS, partners and the project co-ordinators.

Key assumptions and potential risks

The successes of this initiative lie with the combined efforts of various stakeholders like the people, partners, government and CRS. The basic assumption is that they all will play their roles as listed in the program implementation plan.

The program is community based and it operates with the help of the contribution of the people. Hence, the active cooperation of the people is solicited at all the levels. The potential risk is that people may not cooperate to the expected level and even if they do, they might take more time than the expected period of six years.

The partner is the link between the people and both CRS and the government. Through this initiative, the partner will be supported through various capacity building initiatives and as well as financially. We also assume that the partnership continues throughout the project period for effective implementation of the program. The potential risks are that the partners may not perform as expected and the partnership discontinues.

The program is a health awareness program coupled with community mobilization. It aims to sensitize people so that they demand regular services from the public health system. Hence, the assumption is that the public health system provides regular services to the people throughout the tenure of the program. The potential risk is that due to unfavorable political and social circumstances, the services and cooperation may not be up to the expected level.

CRS expects to involve the opinion of the like-minded agencies like Cooperative for American Relief Everywhere, World Food Programme and United Nations International Children Emergency Fund (UNICEF) in sharing the progress of the initiative. It is also expected that situations are favourable at the partner level and within CRS throughout the program period so that the objectives are achieved. The potential risk is that there might be some obstacles in this regard there by retarding the progress of the program.

It is expected that the Title II commodities will be made available regularly for the program participants throughout the project period. However, the potential risk is that due to unforeseeable circumstances there may be disruption in regular supply of commodities. Over all, these are the basic assumptions and risks.

Sustainability

The program is expected to operate on its own using only the Title II fund money by the end of 3rd year i.e. by 2003. It is expected to mobilize the people so that active women groups are formed by the end of 4th year i.e. by 2005. The active women groups are expected to carry on the health awareness activities like health education, growth monitoring and home visits by the end of year 2006. The awareness level thus developed in the people help them to regularly demand quality services from the public health system.

Midterm review and final evaluation

The progress of the program will be reviewed through the midterm evaluation due in 2004. The findings of the evaluation will help to identify the strengths and weakness of this initiative. This feedback will help to improve the program quality. The final evaluation of the program due in 2006 will help us to know the results of our efforts. Competent external agencies will be hired to undertake this task. CRS is expected to replicate this initiative in other blocks subsequent to the results of the midterm/final evaluation.

Compliance with Regulation 264 (Initial Environment Examination)

As the program aims to generate awareness and mobilize community towards betterment of health and nutrition services, it is not expected to extend any negative environmental impact. The aspects of food distribution and linkages with the government health services will also not have any negative impact on environment.

Budget

The budget of both the partners are as per the management structure at their levels. The expenditure pattern has both recurring and non-recurring expenditures. The non-recurring expenditures will be borne from CRS private sources and 202(e). The private sources expenditures include assets such as vehicles, computers, and office furniture, blood pressure and stethoscope machines for program doctors. Similarly, the 202(e) (a line item of CRS budgeting) expenditures include weighing machine for the main warehouse and dunnage both for the main and field warehouses of the partners.

The recurring expenditures will be borne from Title II fund and 202(e). Among these, the 202(e) expenditures include SMCS staff training, salary of the operating partner and staffs such as the project co-ordinator, zonal supervisors, ware house supervisors, storage in charge, accountant, logistician, clerk and driver. The other recurring expenditures to be borne from 202(e) are staff travel, office maintenance, transport and handling charges of the Title II commodities for the main warehouse.

The major source of income to the Title II fund includes collection of monthly contribution from program participants at the time of health education sessions. The income is calculated on the assumption that 80% of the program participants are expected to pay their monthly contribution on a regular basis in the first two years and 90% in the last three years of the program implementation. Ground realities and consultation with the partners on this issue has helped us to reach at these figures. Another source is the sale of empty containers of the oil tin and bulgur bags. The other sources include registration fees at the time of registration, yearly renewal of beneficiary cards, charge for issue of duplicate growth and beneficiary cards and charge for availing services from the program doctors.

The Title II fund expenditures include salaries of health workers, supervisors, transport and handling charges of the commodities for the field warehouses. The internal travel expenditures of the health workers and supervisors is also included in the Title II fund.

Title II commodities

Currently, LOKARPAN has 5,300 program participants and GVS 4,500. As a result of block coverage, LOKARPAN is expected to have 19,000 program participants and GVS 12,000. This amounts to an increase of 13,700 program participants for LOKARPAN and 7,500 for GVS.

The increase in the program participant level is directly related to the increase in the amount of Title II commodity at the partner level. Currently, GVS uses 266 metric tonnes of Title II commodities annually. With the expansion, the requirement is expected to go up to 709 metric tonnes i.e. an increase of 443 metric tonnes annually. Similarly, LOKARPAN uses 313 metric tonnes currently every year. This annual requirement is expected to go up to 1122 metric tonnes i.e. an increase of 809 metric tonnes annually.

This increase has direct implications on the Annual Estimated Requirement (AER) of CRS/North India zone. It is expected to increase by 21,200 program participants as a result of this block coverage. The commodity requirement is expected to increase by 1252 metric tonnes annually for CRS/North India.

The total program participants will be 57,800 for CRS/North India's SMCS program in FY02 (2002-2003). This also includes program participants for one new partner and natural increase at other partner levels. The total commodity requirement in FY02 for CRS/North India's SMCS program is expected to be 3413 metric tonnes.

A note

The proposal is presented as an article as it was written 18 years ago. It may be noted that the Village Health Workers (VHW) of the SMCS program led the foundation of the ASHAs that came into force in 2005 with the launch of the National Rural Health Mission (NRHM). Shivgarh block was a non-ICDS block during 2002 when the article was conceptualized. Using the ground made by the SMCS program, the Community Empowerment Laboratory, a project working in UP implemented its program on new-born care from 2003 when it started the baseline survey of the project. The Shivgarh block witnessed so many initiatives and academic visits as a result of the new-born care initiatives. When the new-born care initiative started in 2003, the block had already witnessed the SMCS program experience since 1997.

The MCH card that is used widely by the ASHAs currently had the foundation stone in the form of the growth cards that the SMCS program launched in the state of Uttar Pradesh. Many Traditional Birth Attendants were identified by the program and were trained through a joint effort of the program & the public health system. The importance of home deliveries is still relevant in UP & efforts are on to make these deliveries safe. The health education component of the SMCS program & the Inter Personnel Communication strategy through home visits is still a force to reckon with in the public health sector of UP. Mobilizing community & the process of forming Self Help Groups (SHG) & Mother Groups are still relevant through various SHG related programs & the hot cooked scheme using mother's groups in the Integrated Child Development Scheme (ICDS) that are operational currently. These are some of the platforms that the SMCS program gave back to the people of Uttar Pradesh. As the article is focussed in the state of UP, the related platforms are also related to the state of UP.

Current health program of CRS, Lucknow

After the Phase out Plan of SMCS program in 2010, CRS, Lucknow continued to work in the field of Maternal & Child Health. Since April 2011, CRS, Lucknow is operating the project named Reducing Maternal & New-born Deaths (ReMiND). The strategy of the project is entirely different from that of the SMCS program. The details of the project can be obtained from the site given in the reference[13]. The SMCS program can be called as the precursor of the current project.

Nostalgic Acknowledgement

The lead author was an employee of CRS from 1997 to 2012. The SMCS program taught the lead author the basics & intricacies of public health & community medicine. All the learning & activities were part of augmentation activities of SMCS program in which the lead author worked. The author duly acknowledges CRS, Lucknow for the contents of the article. The author thanks all the colleagues of CRS, Lucknow for their support. Special thanks are due for Mr. Alexander Mathew for his support as the manager of all the programs of CRS, Lucknow during that period. The lead author has retained his inputs through the original document & reproduced the document as the current article. The author has also retained his language as such written by him 18 years ago in 2002. The document sowed the seeds of proposal writing in the lead author which eventually culminated in enabling the lead author to complete his Ph.D. in public health after 18 years of conceptualizing the article.

Funding

Nil

Conflict of interest

Nil

Declaration

The authors declare that the contents are as of 18 years ago. There have been changes in the MCH program guidelines & nutrition strategy both at state & centre level since then. The contents can be categorized as a small step towards development of future strategies in Maternal, Neonatal & Child Health Nutrition (MNCHN).

Supplemental file

Given below is the internal note from the lead author to Mr. Alexander Mathew who was the director of all operations of CRS, Lucknow when the article was developed by the lead author. The forwarding note by Mr. Mathew is also given. His inputs & guidance shaped the proposal & the proposal was forwarded to the CRS headquarters of India operations in Delhi during 2002. The brief notes with the

signatures of Mr. Mathew & the lead author are given below as the supplemental files.
To: Alex

From: Dr. Tripathy, Program Executive, and Health

Date: 15.1.02

Sub: Block Coverage proposal

In order to send the hard copy of the block coverage proposal through proper channel, requesting you to forward the hard copy to CRS, Delhi through a note.

Regards

To
Deputy Regional Director, Program Quality
CRS, Delhi

15.1.02

Sub: Block coverage proposal

Attention: Dr. Goel, Heath Technical Advisor

The hard copy of the block coverage proposal of health sector of CRS, Lucknow to be implemented at partner GVS & LOKARPAN is being sent. The soft copy of the proposal has already been sent.

This is an effort to scale up the Title II program in two contiguous areas.

Waiting for a positive response.

Thanks & Regards

Alexander Mathew
Director, CRS, North

References

1. Bhatia B M, Famines in India, Analysis of food situation in India after independence, 1860-1965, Bombay, 1967, p 340 f.
2. GoI, Planning Commission, Second Five-Year Plan, 1956, New Delhi, pp39-40.
3. Hatti Neelambar, Impact of assistance under PL 480 on Indian Economy, 1956-1970, Economy & History, 20:1, 23-40, DOI: 10.1080/00708852.1977.11877475.
4. Mann J S, Food for Peace Program & India, Farm Business Notes, Institute of Agriculture, University of Minnesota, No.488, October 1966, Waite Memorial Book Collection, Division of Agricultural Economics, University of Minnesota.
5. Chaudhry, Praveen K; Snow, M V; From Food Aid to Food Assistance, 1990-2014, Chapter in the US & India- A history through Archives: The Later Years: Vol2, I2, Sage Publications, 2011. ISBN: 978-81-321-0477-3(HB).
6. Barret C B, Maxwell D G: PL 480 Food Aid: We Can Do Better, CHOICES, the magazine of food, farm & resource issues, American Agricultural Economics Association, fall of 2004. Available at http://www.choicemagazine.org.
7. United States Congress, Food for Peace, 19th Semi Annual Report on PL 480, op.cit, p 61.
8. Riley Barry, the Political History of American Food Aid: An Uneasy Benevolence, OUP, 2017. ISBN: 978-0-19-022887-3. E ISBN: 978-0-19-022889-7.
9. Beatrice R, Carisa K, Ameya B, Jamie F, Sustaining Development: Results from a study of sustainability & exit strategies among development food assistance projects-India country study. Washington, DC: FHI 360/Food & Nutrition Technical Assistance III Project (FANTA), 2017.
10. USAID India, strategic objective close out report, Strategic Objective # 3, improved child survival & nutrition in selected areas of India, FY 1994-2002, Geographic Area- India, Code-386.
11. GoI, WCD, National guidelines on IYCF, 2019. Department of WCD, Ministry of HRD, IYCF guidelines, 2004. https://wcd.nic.in/sites/default/files/nationalguidelines.pdf.
12. Supreme Court of India, Affidavit on behalf of people's union for civil liberties petitioner, union of India, Represented by Ministry of WCD, 13th Dec 2006, Uploaded on March 2007.
13. CRS, UP, Lucknow: The ReMiND Project: Reducing Maternal & New-born Deaths; Implementing the Principles for Digital Development, 2017. https://www.crs.org/sites/default/files/tool_research/a4_case_study_remind_final_online.pdf.
14. India New-born Action Plan, Ministry of Health and Family Welfare, GOI, September, 2014.
15. National Neonatology Forum teaching aids, newborn care, 2015. www.nnfi.org/index.php
16. GOI, RMNCH+A strategy document, January 2013.
17. National Family Health Survey, NFHS-3, IIPS, Mumbai, GOI, 2005-2006.
18. WHO bulletin; 2012; on Home Based New-born Care