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DETAILED IMPLEMENTATION PLAN
Ballia Rural Integrated
Child Survival Project
(BRICS)
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Child Survival Grants Program
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Acronyms

ADP	Area Development Program
AED	Academy For Educational Development
AFP	Acute Flaccid Paralysis
AIDS	Acquired Immune Deficiency Syndrome
ALRI	Acute Lower Respiratory Infection
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infection
APRO	Asia-Pacific Regional Office
BAM	Bachelor of Ayurdevic Medicines
BASICS	Basic Support for Institutionalizing Child Survival
BCC	Behavior Change Communication
BCG	Bacillus Calmette Guerin
BIMARU	Bihar Madhya Pradesh, Rajasthan, Orissa, Uttar Pradesh
BRICS	Ballia Rural Integrated Child Survival
CBDDS	Community Based Disease and Death Surveillance
CBO	Community-Based Organization
CDD	Control of Diarrheal Diseases
CDO	Community Development Organizer
CMO	Chief Medical Officer
CQI	Continuous Quality Improvement
CRS	Catholic Relief Services
CS	Child Survival
CSP	Child Survival Project
CSSM	Child Survival Safe Motherhood
DIP	Detailed Implementation Plan
DPT	Diphtheria, Pertussis, Tetanus
EPI	Expanded Program on Immunization
FGD	Focus Group Discussion
FRU	First Referral Unit
GIK	Gift in Kind
GOI	Government of India
GONGO	Governmental Organization
TBA	Trained Birth Attendant
HFA	Health Facility Assessment
HIS	Health Information System
HIV	Human Immune Deficiency Virus
HMIS	Health Management Information System
IASD	Institute For Applied Statistics and Development
ICDS	Integrated Child Development Program
IEC	Information Education Communication
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
IUD	Intra-Uterine Device
KII	Key Informants Interview
KPC	Knowledge Practice Coverage
LB	Live Birth

KPC	Knowledge Practice Coverage
LB	Live Birth
LCO	Lady Community Organizer
LHV	Lady Health Visitor
MBBS	Bachelor of Medicines Bachelor of Surgery
MCH	Maternal and Child Health
ME	Monitoring and Evaluation
MED	Micro Enterprise Development
MIS	Management Information System
MM	Mahila Mandals
MMR	Maternal Mortality Rate
MOA	Memorandum of Agreement
MOHFW	Ministry of Health and Family Welfare
NFHS	National Family Health Survey
NGO	Non Governmental Organization
OPV	Oral Polio Vaccine
ORS/T	Oral Rehydration Solution/Therapy
PATH	Program for Appropriate Technology in Health
PHC	Primary Health Center
PHN	Public Health Nurse
PLA	Participatory Learning for Action
PMP	Private Medical Practitioner
PSI	Population Services International
PVO	Private Voluntary Organization
RCH	Reproductive Child Health
RH	Reproductive Health
RMP	Registered Medical Practitioners
RTI	Reproductive Track Infection
SC	Sub Center
SCM	Standard Case Management
SIFPSA	State Innovations in Family Planning Services Agency
STD	Sexually Transmitted Disease
SWACH	Survival For Women And Child Health
TA	Technical Assistance
TBA	Traditional Birth Attendant
TOT	Training of Trainers
TT	Tetanus Toxoid
U5MR	Under 5 mortality rate
UNICEF	United Nation International Children Education Fund
USAID	Unites States Agency for International Development
VAD	Vitamin A Deficiency
VDV	Village Development Volunteer
VHAI	Voluntary Health Associates Of India
VHG	Village Health Guide
VHV	Village Health Volunteers
WHO	World Health Organization
WV	World Vision

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A. FIELD PROGRAM SUMMARY

PVO/Country World Vision/India

Cooperative Agreement # · FAO -A- 00-98-00041-00

Program Duration October 01,1998 to September 30, 2002

ESTIMATED PROGRAM EFFORT AND USAID FUNDING BY INTERVENTION

Intervention	% of total effort	USAID Funding in US$
Essential care of the sick child • Pneumonia Case Management • Diarrhea Case Management	30 (15) (15)	**74934** 37467 37467
Essential Care of the Newborn	5	**12489**
Increased Coverage of Immunization	15	**24978**
Prevention of Malnutrition and vitamin A deficiency	15	**37467**
Reproductive Health Coverage	35	**74934**
Others		

Program Site Population · Children and Women

Population Age Group	No in Age Group
Infant (0-11 months)	4167
12 - 23 months old children	5882
24 - 59 months old children	10342
Total 0 - 59 months old children	20391
Women 15 - 45 years	26065
Total beneficiaries	**46456**

- **Estimated annual number of live births in the site 4,277 (in direct impact area, Beruar Beri Block),**
- **Sources of the population estimates above** BRICS 1988 and CMO estimates house to house contact with the help of village pradhan selected youth members animators and the project field staff

B PROGRAM LOCATION

B 1 Maps

These are appended as Annex 1

B.2 Project Location/Demographics

The BRICS project has the challenge of poverty, culture, remoteness and lack of health resources It is located in remote and underserved Ballia district in the eastern part of Uttar Pradesh (UP) state, 20 km from the border with Bihar state Ballia district is 150 km or 4 hours' drive from Varanasi, the latter is 700 km or 70 minutes' direct flight time from New Delhi (please refer to maps in Annex 1) The *direct impact area will be one block, namely Beruar Beri Block*, consisting of 150,686 people (including 20,391 under-5 children) living in 83 villages spread over 77 9 sqkm The *indirect impact area will cover the other 16 blocks of Ballia district*, with 2,583,517 people (including 403,116 under-5 children) residing in 1,920 villages spanning 2,981 sqkm The furthest point of Beruar Beri Block from the Ballia district headquarters is about 30 km Beruar Beri Block is the largest block in Ballia district

Section A lists the BRICS/Ballia Chief Medical Officer (CMO) 1998 estimates of the potential beneficiary population (based on 1991 Census) in the direct impact area Eighty percent of the population are rural Population density averages 1,934 people per sqkm in the direct impact area, mirroring the rapid 21 6% population increase in the last 10 years

The sex ratio is 946 females for every 1,000 males Strong disparities persist the life expectancy of a girl born in UP state (54 years) is 20 years less that of a girl born in Kerala today The gender gap in education remains wide in Ballia a girl is 20% less likely to attend a primary school than a boy The median female age of marriage is about 16 years, well below India's legal minimum age for marriage of 18 years Only 23 7% of women are literate, compared to 59 4% for adult men About 79% of the population belong to the poorest of the poor, namely Scheduled Castes (SC) and 'Other Backward Castes' (OBC) who are mostly Hindus Sixty percent of these lower caste people are landless laborers who earn a living as rickshaw pullers or casual laborers The rest are involved in agriculture, animal husbandry, fishery, artisans and *Dhobi* (washer men) The land is rich and fertile, with the main agricultural products being rice, wheat, potatoes, maize, pulses, sugar cane, mustard and vegetables Seasonal unemployment is widespread, leading to a high degree of seasonal mobility, with whole families migrating as far as Punjab and West Bengal during the November/ December harvest season Household incomes average $20-30 monthly--well below the Government of India (GOI)-stipulated poverty level of 1,200 rupees ($33) (SIFPSA/1995) There is widespread discrimination against the girl child The November KPC survey revealed that 73 2% of women with under-2 children had no schooling, or were illiterate Caretakers of children other than the child's mother include relatives, older children, and fathers

<u>*Rationale for site selection*</u> WVUS and the WV Asia-Pacific Regional Office (APRO) approached WV India to consider a USAID-funded child survival and reproductive health (CS/RH) project because India's 5-UMR is above 100/1,000 LB, and WV India has proven capability in managing a large and innovative USAID-funded project Meanwhile, WV India senior management has been lobbying WVUS in the past year for add-on CS/RH grant funding

for one of its remote and underserved ADPs in the north zone Ballia district was selected because (a) the central Ministry of Health and Family Welfare (MOHFW), the UP State health authorities, WHO, UNICEF, UNDP and Population Council have all encouraged WV to choose a remote district in the northern UP state that is needy in terms of poverty, health service infrastructure and coverage, (b) the Ballia Area Development Program (ADP) team are keen to demonstrate impact on mortality and fertility from an add-on CS/RH component to it newly-established ADP, which commenced in Beruar Beri Block in October 1996, (c) the Ballia CMO has strongly welcomed WV India's partnership in launching an innovative program to increase health coverage and quality, and to demonstrate and document impact, (d) the potential strength and quality of 5 local NGOs/Governmental Organizations (GONGOs) which have requested WV's help in mentoring and building their institutional, technical and financial capacity, (e) the USAID/New Delhi mission has encouraged PVOs to consider their highest priority state, namely UP state, India's largest state with 150 million people, and also one of the North Indian "BIMARU" states which rank low among Indian states on most child survival indicators and high fertility rates, and because of (g) the opportunities for WV India to build synergistic linkages with the large USAID-funded State Innovations in Family Planning Services Agency (SIFPSA) in UP state, and to complement USAID-funded initiatives with WHO, UNICEF and Rotary International to eradicate polio

B 3 Causes of Infant, Child and Maternal Mortality, and Fertility Trends

Although India has achieved significant decreases in infant, child and maternal mortality rates over the last two decades, mortality rates are still high and have leveled off since 1993 Some northern states, labeled as 'BIMARU' (or 'sick') states, such as UP, where the proposed project will be located in Ballia district, are still home to IMRs (Infant Mortality Rates) and Under-5 Mortality Rates (U-5MRs) above 100/1,000 live births, as seen in the table below

Indicator	India	Uttar Pradesh State	Ranking among states
Infant Mortality Rate/1,000 live births	72	99 9	Second highest
Under-5 Mortality Rate/1,000 live births	109	141 3	Second highest
Neonatal Mortality Rate/1000 live births	37	59 9	Highest
Post-Neonatal Mortality Rate/1000 LB	29 9	40	Highest
Child Mortality Rate/1,000 live births	23	46	Second highest
Maternal Mortality Ratio/100,000 LB	437	570	Second highest
Total Fertility Rate children/woman at 45 yr	3 39	4 82	Highest
Sources UNICEF/1997, National Family Health Survey (NHFS)1992-93, No reliable mortality data available for Ballia district currently, data quoted represent that of UP state unless noted otherwise			

Infant mortality Seventy six percent of under-five deaths are infant deaths. *Neonatal mortality accounts for 60% of the IMR*, primarily from Acute Lower Respiratory Infections (ALRI), 40%, low birth weight, 29%, neonatal tetanus, 10% (mirroring the low 37 4% TT2 coverage of pregnant women in Ballia District), and prematurity and congenital malformations, 21% The remaining 40% of infant deaths are post-neonatal deaths contributed by ALRI, 20% (with 5 4% due to measles alone), diarrhea, 15%, and malnutrition 57%, (with low birth weight continuing to confer a higher mortality risk throughout the first six months of life)

Under-5 mortality The principal contributors are five preventable causes ALRI, 33 7%, malnutrition, 29%, diarrheas, 24 7%, fevers (including malaria), 7 7% and measles, 9 5% (UNICEF/WHO/Ballia CMO/1997)

Pneumonia (ALRI) is now the biggest single killer of the under-5 children in UP state and in Ballia District At highest risk are children under-two, and neonates The MOHFW estimates that nationally, (a) each under-5 child averages 3-6 ARI episodes annually, (b) the ALRI case mortality rate for children 0-5 years is 6/1000 LB, and (c) 40% of all neonatal deaths, 20% of post-neonatal deaths and 22% of all under-5 deaths are attributable to ALRI (1997) Seasonal infant and child mortality patterns are measles (July-August), diarrheas (post monsoon October/November), tetanus (September-December peak in newborns)

Sixty percent of under-fives are undernourished A recent (February 1999) nutrition survey conducted by BRICS revealed high degrees of undernutrition (severe 15%, moderate 28%, mild 35%), with a peak prevalence rate of wasting in children 12-23 months (11% < minus 2 standard deviations from the median wt/ht of the reference population) (please see Baseline Nutrition Survey report, submitted separately) This is related to adverse breastfeeding practices and delayed, inadequate supplementary feeding, as found in the November 1998 KPC survey of mothers with under-2 children, e g (a) only 25 8% of infants 5-9 months receive solids/semi-solids, (b) only 32 5% of mothers initiated breastfeeding within 8 hours of delivery and only 38% within 24 hours, (c) 74 2% of mothers do not feed their newborns with colostrum The NHFS/1983 showed that newborns are exclusively breastfed for an average of 2 5 months According to Pelletier et al, "the odds of dying increase at the compounded rate of 7 3% for each percentage deterioration in weight-for-age " Participatory Learning and Action (PLA) exercises indicate that nearly 60% of young children in Beruar Beri Block are left behind by mothers for the day this contracting of child care is a major risk factor for childhood undernutrition and vitamin A deficiency (VAD) More than 75% of undernutrition-related deaths in under-5 children in Ballia were linked not to severe undernutrition but to mild and moderate forms (WV & PHC/SC staff/1996)

Vitamin A deficiency (VAD) is still endemic and remains a threat to child survival in India, UP and in Ballia district today Nearly half of all under-5 children have inadequate intake of vitamin A. Biochemical studies showed that 47% of children screened within the framework of the 1992-93 NFHS had low serum retinol levels (<0 7 umol/L) Mild VAD signs in pre-school aged children are associated with a 4-fold mortality increase and a 2-3 fold incidence increase of diarrhea or ALRI Blindness and corneal lesions (xerophthalmia) caused by VAD afflicts 50,000 to 60,000 pre-school aged children per year in India In Ballia district, where systematic vitamin A coverage of children 9-35 months and of postpartum women has not started yet, xerophthalmia prevalence in children 9-59 months remains high 2 97% (see Annex 2/1999) PHC/SC staff in Beruar Beri Block have provided anecdotal reports of night blindness/xerophthalmia in under-5 children following measles, severe undernutrition, pneumonia and severe diarrhea PLA exercises

done by BRICS staff in 1998 revealed that between 15-30% of women reported having night blindness during their last pregnancy

Polio From April-July 1997, an outbreak of 203 cases of Acute Flaccid Paralysis (AFP) were reported in pockets of Ballia district and 10 other districts in eastern UP state, UNICEF estimates the AFP prevalence to be 1/150,000 population, with Ballia district averaging an expected reported 6-7 AFP cases annually

Malaria The CMO office reports 8,365 malaria cases for the first 10 months of 1997 in Ballia district, with a majority of vivax cases At least 10% of children reported to have malaria this year have died Chloroquine resistance is reportedly not yet a major problem Most cases occurred during the rainy season (May-September) No data are available for the proportion of (a) children with chronic or persistent malaria, or (b) of pregnant women with malaria

Maternal Mortality Between 100,000-125,000 Indian women die from pregnancy-related causes each year, accounting for 25% of all annual maternal deaths globally Although UP state has made strides in some districts in lowering fertility through family planning/birth spacing, maternal mortality remains high in Ballia district Seventy-seven percent of the MMR in Ballia is pregnancy-related (post-partum hemorrhage, puerperal sepsis, eclampsia, abortion and obstructed labor) The maternal malnutrition rate is 41% and 87% of pregnant women have nutritional anemia SIFPSA 1995 data indicate that 44 7% of pregnant women had at least one prenatal contact with a provider in Ballia, with only 29 5 % receiving iron/folate supplementation Eighty-one percent of deliveries are conducted at home by an untrained attendant (*dais* or traditional birth attendants (TBAs), family members or neighbors) Half of maternal deaths occur at home and 10-15% occur on the way to a referral facility Between 50-80% of women report symptoms of Reproductive Tract Infections (RTI) and up to 25% may be infected with Sexually Transmitted Diseases (STDs) (UNICEF/1997)

Fertility The 1992-93 NFHS found that 58 7% of women in Ballia practiced high-risk fertility behavior (i e gave birth at ages under 18 years or above 35 years, had 4 or more births, and had birth intervals less than 24 months) Population Council and SIFPSA 1996 data revealed (a) the desired family size is still large (3 or more children), (b) 33% of men and 70% of women were not aware of the legal age of marriage of girls, (c) over 50% of men reported no communication with their wives on their reproductive goals and acceptance of contraception when it occurred, it was initiated by the husband, and only after 2 or 3 children, (d) the contraceptive prevalence rate for modern methods is 18 8% in Ballia district (against a national average of 41%), (e) the use of contraceptives for spacing is still an alien concept--86% of acceptors were using family planning to *stop* childbearing and only 14% of family planning acceptors were adopting non-terminal methods (mostly IUDs), (f) most men who accept family planning do so to stop childbearing among these, 40% prefer to use non-terminal methods--this underlines the need for a wide range of contraceptive choices, as well as the option of changing from one method to another, if they so desire, (g) 39% of currently married women (against a national average of 19%) and 29% of married men reported an unmet need for family planning--this gap was mainly because few men expressed an unmet need for spacing, and (h) 19% of women reported at least one unintended pregnancy WV PLA exercises found 60-70% of married women reporting 1-3 abortions/ pregnancy terminations This practice of using abortion as a fertility control method has grave consequences WHO (1996) estimates that 1 out every 8 maternal deaths is due to unsafe abortions in UP state

HIV/AIDS PLA exercises (BRICS/1998) revealed that 70% men and women are involved in multi-partner sex However only about 1% of the population has ever heard of AIDS Sexually-transmitted diseases were very common in men, similar information from women was not yet forthcoming

B 4 Existing Child Survival and Reproductive Health Programs, Facilities and Activities in Impact Area

The UP State Government oversees all health programs in the 78 districts of UP state The Ballia District CMO has corresponding responsibility for health programming in the direct impact area (Beruar Beri block) and in the other 17 blocks of Ballia district Below is a summary of the potential health players to be impacted by the project

POTENTIAL HEALTH PARTNERS	DIRECT IMPACT AREA	INDIRECT IMPACT AREA
PUBLIC SECTOR HEALTH STAFF		
NO OF DISTRICT CMO STAFF	**8**	**12**
NO OF PRIMARY HEALTH CENTERS (PHCs)		
Current	1	17
New	2	65
TOTAL	**3**	**82**
NO OF PRIMARY HEALTH CENTER STAFF		
Doctors	3	82
Lady Health Visitors (LHVs)	3	82
Auxiliary Nurse Midwives (ANMs)	3	82
TOTAL	**9**	**246**
NO OF SUB-CENTERS (SCs)	15	366
NO OF SUB-CENTER STAFF (ANMs)	**15**	**366**
PRIVATE SECTOR HEALTH PROVIDERS		
NO OF TRADITIONAL BIRTH ATTENDANTS (*Dais*) (trained/untrained)	**173**	**?3,840**
NO OF REGISTERED MEDICAL PRACTITIONERS (RMPs), AYURVEDIC PRACTITIONERS & UNANI/ HOMEOPATHIC PRACTITIONERS	**71**	**?1,207**
NO OF VHGs (functioning/non-functioning)	**82**	**1, 852**
LOCAL NGOs/GONGOs		**5**
Rotary Club--Ballia		
Purvanchal Gramin Chetna Samiti		
Prathini Sansthan		
Naval Sikshan Sansthan		
SIFPSA		
VENDORS	**15**	**214**

Remote, underserved Ballia district has a three-tiered public health infrastructure sub-centers (SCs) and Primary Healthcare Centers (PHCs) in each of the 18 blocks, with the District Hospital in the District Headquarters serving as the First Referral Unit (FRU) for the entire district The PHCs are the GOI's most peripheral non-hospital clinical facilities providing technical and commodity support (ORT, vaccines, weighing scales, vitamin A and iron-folate supplements and contraceptives) to the SCs Each SC serves 5,000-7,000 people (approximately 5-7 villages) focused on center-based services (antenatal care, family planning, immunization) and anti-malarial campaigns

However, WV customer appraisal exercises using PLA have found that (a) 70-90% of all curative services for children and women in Beruar Beri block are delivered through private practitioners, most of whom lack regulation, standardization and training in quality case management of pneumonia, diarrhea, malaria and obstetric emergencies, (b) the met need for obstetric services (i e the proportion of women with obstetric complications) which reflects the utilization of the District Hospital, is extremely low at 4 3%, (c) there is no block-level FRU or postpartum center in Beruar Block, (d) a large number of maternal deaths are due to the lack of organized village-based transport for obstetric emergencies to the district hospital, to delays by pregnant women and their supporters (husbands, mothers-in-law and PHC/SC staff), and to delays in receiving appropriate care at the District Hospital due to inadequate equipment and skills of staff, (e) the PHCs and SCs do not have regular power supply, and vaccine cold chain maintenance is a challenge, (f) missed opportunities for immunization are numerous, as evidenced by the low 20 4% full immunization coverage of children 12-23 months by age 12 months (card only), (d) there is no systematic program for vitamin A supplementation of children 9-35 months or of post-partum women, and (e) the low ORT knowledge rate and low ORT usage rate (17 6%) of mothers with under-2 children

The 1996 SIFPSA survey in Ballia district revealed that family planning services were of poor quality in terms of access, choice, counseling and client-provider interactions, as evidenced by the following findings (a) non-existence of community-based distribution of contraceptives, (b) 86% of couples who have accepted a contraceptive use sterilization (almost exclusively vasectomy), indicating a heavy program bias towards permanent methods, (b) contraceptive choices offered to clients are limited, with only about 4% of sterilization acceptors told about IUDs, and only 11% of sterilization acceptors told of the surgical procedure, how the method works, and about side effects, (c) 85 9% of PHC/SC resources were focused on family planning, with private clinics, local NGOs and vendors committing only a minor proportion (12 5%, 18 9% and 22% respectively) of resources to family planning, (d) missed opportunities for child spacing services were significant, with only 55% of SCs having oral contraceptives on the day of the visit, and only 41% of SCs having condoms on the day of the visit

There is no community-based surveillance of AFP, only institutional surveillance of AFP has been initiated by the District Immunization Officer (please see Annex 3 on AFP surveillance reporting network)

In spite of the current constraints, the Ballia District CMO office has welcomed World Vision's technical assistance (TA) to build the capacity of the CMO, PHC and SC staff in Beruar Beri

Block and the other 17 blocks of Ballia district in the following areas district and PHC health management team-building, participatory appraisal and planning of health services, community-based disease and death surveillance (CBDDS), including AFP surveillance, continuous quality improvement (CQI) and integrated case management of childhood illness (IMCI), care of the newborn, and essential obstetric care

The Block Development Officer (BDO) of Beruar Beri Block has requested WV's help in establishing the ICDS (Integrated Child Development Services) program with the *Angawadi Wadi* workers (AWWs), commencing in calendar year 1999 There are currently no *angawadi* (childcare centers) for pre-schoolers

The Rotary Club (Ballia Chapter) has invited WV India to form a Polio Eradication Network with the 3 other local NGOs in Beruar Beri Block (Annex 4 summarizes the current activities of the local NGOs) The latter are expecting WV's assistance in their organizational development and participation in CS/RH activities in the impact area The USAID-funded SIFPSA, a UP state GONGO has agreed to provide TA, starting in January 1998, to the proposed project in partnering with vendors and local NGOs to expand contraceptive choices and initiate community-based contraceptive distribution services in Beruar Beri Block initially, and later, in all the other 17 blocks of Ballia District

C PROGRAM GOALS AND OBJECTIVES

C 1 Strategic Objective

The BRICS's strategic objective is to assist the Ballia District CMO and private sector and community partners to accomplish, sustain, document and replicate best practices to *reduce fertility and infant, child and maternal mortality through an innovative child survival and reproductive health improvement project* in one block (namely, Beruar Beri Block) of the remote Ballia District in eastern UP state over a four-year period

The project plans to go to scale by replicating best practices in child survival and reproductive health to (a) the entire Ballia District (17 blocks with 2,583,517 people), and (b) three other WV India ADPs in UP state impacting 221,418 people

The project will pilot-test with the MOHFW, WHO and UNICEF the following two prototype modules

(i) Community-based surveillance of
  (a) childhood diseases (polio, measles and neonatal tetanus), and
  (b) infant, child and maternal mortality,

(ii) "Integrated Approach in Management of Cough or Difficult Breathing, Diarrhea or Under-nutrition in Young Children" module with WHO/SEARO for basic health workers (PHC/SC staff, AWWs, VHGs)

WV India envisions that ***these two prototype modules will also be adapted and utilized in 100 districts where WV India's 100 ADPs are located*** across almost all the states of India As each ADP covers one block with an average of 100,000 people, ***a potential population of 10 million people and 245 local NGOs and community-based organizations may eventually be impacted through this proposed replication.***

Accomplishment of this strategic objective will be evidenced by the following ***impact indicators*** which reflect the Ballia District benchmarks which have been adjusted from the national and UP state targets set by the MOHFW for the year 2003

Impact Indicator #1 Reduction of Total Fertility Rate from 4 3 to 3 6 children born to a woman who lives up to 45 years
Measurement Method National Health Family Survey (NFHS),

Impact Indicator #2 Reduction of Under-5 Mortality Rate from 143/1000 live births to 115/1000 live births
Measurement Method NFHS, pilot-testing community-based death surveillance focusing on investigations of deaths in the children 0-28 days, children 1 month to 59 months

Impact Indicator #3 Reduction of Infant Mortality Rate from 99 5/1000 live births to 75/1000 live births
Measurement Method NFHS, pilot-testing community-based death surveillance focusing on investigations of deaths in the children 0-28 days, children 1 month to 59 months

Impact Indicator #4 Reduction of Maternal Mortality Ratio from 570/100,000 live births to 400/100,000 live births,
Measurement Method NFHS, pilot-testing community-based death surveillance focusing on investigations of deaths in women 15-45 years

Impact Indicator #5 Prevalence of reported case-based AFP reduced to zero
Active community and institutional surveillance, with zero reporting

Impact Indicator #6 Reduction in night blindness in children 9-35 months from a baseline 2 97% to under 0 1%,
Measurement Method Nightblindness survey during vitamin A distribution rounds

Impact Indicator #7 Reduction in the percentage of children 0-23 months who are moderately or severely wasted *(i e who fall below -2 Z score from the median weight for age of NCHS/WHO reference population)* from a baseline 43% to under 30%,
Measurement Method Sample nutrition survey of children 0-23 months

Intermediate Results The BRICS's strategic objective will be achieved through the accomplishment of the following ***five Intermediate Results (IRs)***

Intermediate Result #1 ***Increased use of high-impact child survival and reproductive health services by the target population*** (50% of program effort)

Intermediate Result #2 ***Strengthened local institutions through partnerships, coalitions and strategic alliances, leading to replication of best practices in child survival and reproductive health across the entire Ballia district and in three other WV ADPs in UP state*** (20% of program effort)

Intermediate Result #3 ***Enhanced capabilities of individuals, families and communities to protect and provide for their own health*** (10% of program effort)

Intermediate Result #4 ***Improved quality of training, supervision, information and service, leading to raised customer satisfaction*** (10% of program effort)

Intermediate Result # 5 ***Enhanced sustainability of child survival and reproductive health services and support systems*** (10% of program effort)

General Strategies: These are summarized by the following sub-results of each Intermediate Result

Intermediate Result #	**Sub-results (S R.)**
IR # 1	S R # 1a ***Increased Coverage of Essential Care of the Sick Child*** S R # 1b ***Increased Coverage of Essential Care of the Newborn*** S R # 1c ***Increased Coverage of Immunization*** S R # 1d ***Prevention of Malnutrition and Vitamin A Deficiency*** S R # 1e ***Improved Reproductive Health Coverage*** S R # 1f ***Improved Malaria Prevention and Control***
IR # 2	S R # 2a ***Capacity building of Public Sector staff*** S R # 2b ***Coalitions, capacity building and organizational development of local NGOs/GONGOs*** S R # 2c ***Capacity building of private sector health players*** S R # 2d ***Strengthening of WV ADP staff/partners in 3 ADPs in UP State***
IR # 3	S R # 3a ***Capacity building of community institutions***
IR # 4	S R #4a ***Continuous quality improvement initiated***
IR # 5	S R #5a ***Sustainability initiatives in place***

C 2 Objectives and Sub-Results: Child Survival Interventions

These are reflected in the sub-results of **Intermediate Result #1** *Increased use of high-impact child survival and reproductive health services by the target population* (in the direct impact area--Beruar Beri Block)

Sub-Result #1 ***Intervention-specific Coverage Increased***

Sub-Result #1a Increased Coverage of Essential Care of the Sick Child (30% of IR #1 Effort)
Pneumonia Case Management (15%):
70% of mothers/caretakers would be able to recognize at least two danger signs (cough and rapid or difficult breathing) of pneumonia that call for immediate referral and treatment (FY 99 65 %, FY 2000 65%, FY 2001 65%, FY 2002 70%,), *Indicator Proportion of mothers/caretakers able to recognize at least two danger signs of pneumonia that call for immediate referral and treatment,* *Measurement methods KPC survey*
65 % of mothers/caretakers would have sought appropriate antibiotic treatment for their children under 24 months with cough and rapid or difficult breathing in the past two weeks (FY 99 65%, FY 2000 65%, FY2001 65%, FY2002 65%,), *Indicator Proportion of mothers/caretakers who sought appropriate antibiotic treatment for their children under 24 months with cough and rapid or difficult breathing in the past 2 weeks,* *Measurement methods KPC survey*
Pneumonia Case Management
55% of children 0-23 months diagnosed as pneumonia would have been appropriately treated with antibiotics (FY 99 10%, FY 2000 25%, FY2001 40%, FY2002 55%), *Indicator Proportion of children 0-23 months diagnosed as pneumonia who were treated with antibiotics according to standard case management protocol,* *Measurement methods Baseline assessment of case management practices, use of on-site observation checklists, exit interviews*
Major Planned Activities (a) baseline assessment of pneumonia case management practices of health providers, (b) training/supervision in pneumonia case management protocol, (c) inventory system/logistics to monitor stock-outs and ensure supply of cotrimoxazole, (d) KPC survey, missed opportunity surveys and PLA exercises, (e) adapt different messages and train caregivers in recognition and care-seeking, (f) ensure referral completions, (g) monitor the quality of client-provider interactions regarding antibiotic compliance and home care for children with pneumonia, (h) promote measles and pertussis immunization, exclusive breastfeeding and improved weaning practices

Diarrhea Case Management (15%)
40% of children 0-23 months with diarrhea in the past two weeks were treated with ORT (FY 99 20%, FY 2000 25%, FY 2001 30%, FY2002 40%), *Indicator Proportion of children 0-23 months with diarrhea in the past 2 weeks who were treated with ORT,* *Measurement Method KPC Survey*
50% of children 0-23 months with diarrhea in the past two weeks were given the same amount or more fluids other than breast milk(FY 99 20%, FY 2000 30%, FY 2001 40%, FY2002 50%), *Indicator Proportion of children 0-23 months with diarrhea in the past two weeks who were given the same amount or more fluids other than breast milk,* *Measurement Method KPC Survey*
40% of children 0-23 months with diarrhea in the past two weeks were given the same amount or more food (FY 99 25%, FY 2000 30, FY 2001 35%, FY2002 40%), *Indicator Proportion of children 0-23 months with diarrhea in the past two weeks who were given the same amount or more food,* *Measurement Method KPC Survey*
Major Planned Activities (a) baseline PLA exercises, focus groups to identify causes of the ORT knowledge-practice gap, (b) train service providers in quality case management of childhood diarrheas/severe cases, including persistent diarrhea and dysentery, (c) train mothers/caretakers/mahila mandals in correct ORT mixing/administration methods, correct recognition/referral of serious cases of diarrheal dehydration, and dietary management of diarrhea, (d) social marketing of ORS (Oral Rehydration Salts), (e) establish ORT corners in balwadis (day-care center under the new ICDS scheme), SCs and PHCs, (f) establish depot holders of ORS packets, (g) use local songs/dramas to instruct mothers/caretakers to continue breastfeeding and, give the same or more amount of food and fluids to children with diarrhea , (h) promote (thru' mahila mandals) proper stool disposal of young children, latrine use, hand washing, personal hygiene, clean water for drinking, measles immunization and correct weaning practices (i) use of supervisory checklists to assess ORT competency of mothers/caretakers and to track referral completions of serious dehydration cases (j) training of ANMs, AWWs, NGO staff on "Integrated Approach in Management of Cough or Difficult Breathing, Diarrhea or Under-nutrition in Young Children" module with WHO/CMO (k) Promote high quality case management of pneumonia/diarrhea thru' demonstration sites, and by hosting "Best Practices/Lessons Learned" workshops

Sub-Result #1b Increased Coverage of Essential Care of the Newborn
(5% of IR #1 Effort)

40% of post-partum mothers were trained in care of their newborn (hypothermia prevention, low birth weight management, and establishment of exclusive breastfeeding) (FY 99 5%, FY 2000 15 %, FY 2001 25%, FY2002 40%),
Indicator Proportion of post-partum mothers who were trained in care of their newborn (hypothermia prevention, low birth weight management, and establishment of exclusive breastfeeding,
Measurement Method KPC Survey

Major Planned Activities

(a) Train 15 ANMs and 173 TBAs to teach post-partum mothers in essential care of their newborns Focus areas include management of asphyxia, hypothermia prevention, low birth weight management, and establishment of exclusive breastfeeding,
(b) Pilot project in 10 villages to introduce a simplified PATH weighing scale to the trained TBAs to identify and refer newborns with low-birth weight (<2,500 gm at birth) to the SCs /PHCs

Sub-Result #1c Increased Coverage of Immunization
(15% of IR #1 Effort)

50% of children (12-23 months) would have been fully immunized before their first birthday (FY 99 30%, FY 2000 35%, FY 2001 40%, FY2002 50%),
Indicator Proportion of children (12-23 months) who have received card-documented doses of BCG, OPV3, DTP3 and measles vaccines before age 12 months,
Measurement Method KPC survey

35% of mothers would have received two doses of tetanus toxoid (TT2) before the birth of her youngest child less than 24 months, (FY 99 10%, FY 2000 15%, FY 2001 25%, FY2002 35%),
Indicator Proportion of mothers would have received two card-documented doses of tetanus toxoid (TT2) before the birth of her youngest child less than 24 months),

Major Planned Activities

a) mobilize mahila mandals and VHGs to establish community EPI registers (one page for each month of birth) to increase EPI coverage of eligible children and track EPI defaulters,
b) establish ***Polio Eradication Network*** partnerships with the Rotary Club (Ballia Chapter) and 3 local NGOs,
c) Assist in National Immunization Days/Polio Pulse days,
d) training and utilizing TBAs and VHGs to refer all pregnant women to the ANMs in the SCs for TT immunization, and to ensure that all immunization referrals are completed
e) missed immunization opportunity surveys
f) cold chain survey,
g) introduce tools to monitor vaccine temperature twice-a-day in the PHCs,
h) field-test a EPI session Supervisory Checklist,

i) institute early control measures for EPI disease outbreaks
j) supplement cold chain equipment and standby generators for the 3 PHCs,
k) Pilot-test community-based surveillance of (a) childhood diseases (polio, measles and neonatal tetanus), and of (b) infant, child and maternal mortality—establish demonstration site for CBDDS for other 16 blocks of Ballia district,
l) Host "Lessons Learned/Best Practices" workshops,

Sub-Result #1d Prevention of Malnutrition and Vitamin A Deficiency
(15% of IR #1 Effort)

90% of infants 0-4 months exclusively breastfed in the last 24 hours (FY 99 80%, FY 2000 80%, FY 2001 85%, FY2002 90%),
Indicator Proportion of infants 0-4 months exclusively breastfed in the last 24 hours,
Measurement method KPC Survey

45% of infants 5-9 months are given solid or semi-solid foods (FY 99 30%, FY 2000 35 %, FY 2001 40 %, FY2002 45%),
Indicator Proportion of infants 5-9 months who are being given solid or semi-solid foods,
Measurement method KPC Survey

Major Planned Activities for prevention of undernutrition

(a) Introduce "positive deviant" model to promote community best practices in infant and child feeding,
(b) Host "lessons learned" seminars to share findings on breastfeeding and infant feeding practices from the USAID-funded AED Linkages Project at Dehra Dun in northern UP,
(c) Identify and test appropriate complementary foods thru' brief household trials with mahila mandals, incorporate findings into module on weaning counseling education module for mothers,
(d) Pilot-test child care centers and lobby for ICDS program to ensure that children 6-36 months get 5-6 feeds daily,
(e) Initiate demonstration nutrition education sessions for pregnant and lactating mothers,
(f) Disseminate key nutrition messages to mothers,
(g) Provide nutrition counseling in to mothers/care-givers in *sick child encounters*

90% of children 9-35 months will have received vitamin A doses semi-annually, (FY 99 60%, FY 2000 70 %, FY 2001 80 %, FY2002 90 %),
Indicator Proportion of children 9-35 months who received appropriate card-documented doses of vitamin A in the last six months,
Measurement Method KPC survey, community registers of vitamin A distribution rounds, child growth cards

30% of postpartum mothers would have received one high-dose vitamin A supplement within 4 weeks of delivery (FY 99 5%, FY 2000 10 %, FY 2001 20 %, FY2002 30 %),
Indicator Proportion of postpartum mothers who received one card-documented high-dose vitamin A supplement within 4 weeks of delivery,
Measurement Method KPC survey, maternal cards, TBA records

Major Planned Activities for Vitamin A

(a) Standardized six-monthly vitamin A distribution months at PHCs, SCs and balwadis for children 9-35 months and during NIDs,
(b) house-to-house distribution sweeps to distribute vitamin A to children 9-35 months,
(c) pilot-test postpartum vitamin A supplementation (200,000 IU) of women within one month of delivery by training and supplying 173 TBAs and ANMs to distribute vitamin A (200, 000 IU one-time dose) to postpartum women within 1 month of delivery,
(d) holding contests with the mahila mandals to test new vitamin A-rich food recipes for children,
(e) promoting exclusive breastfeeding in the first 4 months,
(f) initiating 83 village-based home gardening groups,
(g) conduct missed immunization opportunity surveys/workshops to increase measles coverage,
(h) train PHC/SC staff to provide measles immunization to children 9-35 months identified with malnutrition/severe diarrhea) irrespective of history of previous measles immunization,
(i) training of 83 VHGs, 173 TBAs and NGO staff to counsel mothers on the appropriate timing (9 months) of measles immunization for their infants,
(j) train PHC/SC staff, NGO staff and private sector practitioners in providing appropriate vitamin A supplementation/treatment (i) children with severe pneumonia, persistent diarrhea, severe undernutrition, (ii) children with measles, and (iii) children with xerophthalmia/nightblindness,
(k) Produce/disseminate a booklet on the safe use of high dose vitamin A

Sub-Result #1e Improved Reproductive Health Coverage (35% of IR #1 Effort)
At least 40 of 83 target villages would have functioning village-based emergency transport schemes for obstetric emergencies (FY 99 5 villages, FY 2000 15 villages, FY 2001 30 villages, FY2002 40 villages), *Indicator Number of target villages which have functioning village-based emergency transport schemes for obstetric emergencies,* *Measurement Methods Community/BRICS staff reports, on-site visits, key informant interviews*
20% or under of women with children less than 24 months reported at least one unintended pregnancy in the last 12 months (FY 99 35%, FY 2000 30 %, FY 2001 25%, FY2002 20%), *Indicator Proportion of women with children less than 24 months who reported at least one unintended pregnancy in the last 12 months,* *Measurement Methods KPC survey*
20% of mothers with children less than 24 months who desire no more children in the next two years, or are not sure, will be using modern contraceptive methods (FY 99 10%, FY 2000 12%, FY 2001 15%, FY2002 20%), *Indicator Proportion of women with children less than 24 months who desire no more*

children in the next two years, or are not sure, who are using modern contraceptive methods, *Measurement Methods KPC survey, CBD register, PHC/SC /ANM records,*
35% of women who delivered their youngest child in the last one year would have received at least 90 iron/folate tablet supplements during their last pregnancy, (FY 99 10%, FY 2000 15%, FY 2001 25%, FY02 35%), *Indicator Proportion of women who delivered their youngest child in the last one year who received at least 90 iron/folate tablet supplements during their last pregnancy,* *Measurement Methods KPC survey, review of pregnancy tracking forms/maternal cards, mahila mandal records,*
35% of mothers had at three or more antenatal visits before the delivery of her youngest child less than 24 months (FY 99 5%, FY 2000 15%, FY 2001 25%, FY2002 35%), *Indicator Proportion of mothers who had at three or more card-documented antenatal visits before the delivery of her youngest child less than 24 months,* *Measurement Methods KPC survey, review of pregnancy tracking forms/maternal cards*
25% of deliveries in the last 12 months would have been attended by a trained health provider or PHC/Sub-center ANM/staff (FY 99 18%, FY 2000 20%, FY 2001 22%, FY2002 25%), *Indicator Proportion of deliveries in the last 12 months who have been attended by a trained health provider or PHC/SC/ANM/staff,* *Measurement Methods KPC survey, review of tracking forms/maternal cards*
Major Planned Activities for Reproductive Health (a) mobilize and train 170 members of the youth clubs to form village-based referral management teams to initiate village-based transport schemes for obstetric emergencies in target villages, (b) Facilitate refresher training of PHC/SC staff emergency obstetric care, (c) train and equip 173 TBAs (*dais*) in prenatal care, nutrition counseling of pregnant women, referral of pregnant women for TT2 immunization, recognition and referral of high-risk pregnancies and obstetric emergencies, the use of TBA kits, in clean delivery, in essential newborn care, in iron-folate distribution during pregnancy, vitamin A distribution to post-partum women, in birth spacing education, in recording and reporting information of each pregnant women—to identify for TT and prenatal referral and tracking of pregnancy outcome (live births, neonatal deaths, and maternal deaths), (d) Mobilize ANMs, LHVs, TBAs, VHGs, local NGO staff and mahila mandals to distribute iron/folate supplements to pregnant women, (e) Introduce pregnancy tracking forms to ensure that pregnant women have at least three prenatal contacts
Major Planned Activities for Family Planning/Birth Spacing (a) Launch community-based advocacy program to highlight important linkages between child spacing and child survival--that child spacing patterns have a powerful effect on the survival chances of the Indian child in UP state and to promote longer pre-birth and birth intervals, data will be shared from the 1992-93 NHFS which found that infant and child mortality,

(b) Facilitate village-level health information system in each village, including two fertility-specific indicators for community tracking (i) women's age at first birth, (ii) percentage of active users of modern contraceptive methods (temporary/ permanent),
(c) Partner with the USAID-funded SIFPSA, 3 local NGOs, private sector vendors to promote community-based sale/distribution of contraceptives (oral pills and condoms),
(d) Facilitating COPE exercises to gather customer perception of family planning/birth spacing services),
(e) Increasing client satisfaction by training PHC doctors, LHVs and ANMs in interpersonal communications skills,
(f) Mobilize men's groups (*parush mandals*) to increase the demand for male family planning methods,
(g) Engage youth group members in a series of dialogues on family planning and spacing,
(h) Introducing an adolescent reproductive health curriculum for high school girls

C 3 Development Objectives

Please refer to (a) section H (Sustainability Action Plan) of the DIP body,
(b) Annex 5 on Assessment and Monitoring Tools for Capacity Building of Local NGOs

D BASELINE ASSESSMENTS

D 1 Types of Baseline Assessments Conducted/Planned by the Project

D 1 1 Baseline Assessments Conducted To Date

During the first five months of the project, the BRICS project core team jointly conducted the following *qualitative* and *quantitative* baseline assessments with CMO/PHC/SC/NGO/community partners

Qualitative baseline assessments that have been completed include baseline PLA exercises, focus group discussions (FGDs), in-depth interviews, and exit interviews for customer appraisal of CS/RH services in Beruar Beri Block These were used to gather qualitative data about caretakers' knowledge, attitudes, beliefs, practices, and local vocabulary regarding each of the CS/RH intervention, as well as of customer perception of CS/RH services provided by both public sector and private sector providers in the block (please see Annex 6 for a generic list of qualitative intervention-specific baseline exercises conducted and section D 2 for summary findings) These qualitative data were also used to customize the generic BHR/PVC-supplied questionnaire for the 30-cluster sampling KPC (Knowledge, Practice and Coverage) survey which was conducted in November 1998

Quantitative baseline assessments that have been completed include the following

a) KPC Survey in November 1998 (please see KPC survey report, submitted under separate cover)

The KPC survey training was facilitated by Dr Mary Lou Rorabaugh, Ph D , a JHU-certified KPC Survey Trainer, and currently the Project Manager of WV Cambodia's USAID/BHR/PVC-funded Kean Svay Child Survival Project
Methods The BRICS project customized, translated, back-translated and field-tested the generic KPC survey questionnaire of Johns Hopkins University PVO Child Survival Support Program A two-stage, 30-cluster sampling survey of 300 mother-child (< 24 months of age) pairs was conducted The findings were both manually tabulated as well as analyzed in EPI-Info, with focus on frequencies and cross tabulations

b) Baseline Night Blindness Prevalence survey of children 6-59 months in February 1999 (please see Annex 3),
c) Baseline Polio Vaccination Status survey of children 0-59 months in February 1999 (please see Annex 7),
d) Baseline Nutrition survey in February 1999 to assess the prevalence of children 0-23 months who are moderately or severely wasted (i e who fall below -2 Z score from the median weight for age of the NFHS/WHO reference population) (please see Baseline Nutrition Survey report, submitted under separate cover)

Planned Uses of Findings from Qualitative and Quantitative baseline assessments include

a) Revising the end-of-project targets and annual benchmarks for each of the intervention-specific coverage objectives (sub-results) listed in section C 1 during the DIP process/workshop with project partners in January 1999 (please see the DIP Workshop Report in Annex 8),
b) Identifying the knowledge-practice gap for essential household behaviors,
c) Designing appropriate audience-specific behavior change communications messages, materials and strategies to overcome these knowledge-practice gaps,
d) Designing training curricula and materials,
e) Enhancing the quality of training, supervision, information and service

D 1 2 Additional Baseline Assessments Planned

a) Health Facility Assessment

As part of the DIP preparations the BRICS project had planned a Health Facility Survey (HFS) This was also strongly recommended by USAID/BHR/PVC in their Technical Review of the BRICS proposal in June 1998 (please see Annex 9) As the proposed consultant was not available during the DIP preparation phase, the project has invited Dr Stan Foster of Rollins School of Public Health, Emory University, Atlanta, USA, to provide the technical assistance for this HFS Dr Heather Goldman of the USAID Mission in New Delhi/India also strongly supports Dr Stan Foster's consultancy This is now planned for late April and May 1999

It is envisaged that Dr Foster will assist the BRICS project staff and partners to assist to test the PVO CORE group's new module for NGO assessment of health facilities Through this proposed health facility survey, the current and future capacity of health facilities to provide essential services will be determined A cold chain survey will be incorporated into the HFS Based on the survey, there may be need for some readjustment to the DIP as to what can be done at the facility, by outreach and what needs to be done at the community level This will be communicated at the end of the facility survey (please see Dr Stan Foster's Scope of Work in Annex 10)

b) Baseline Study of the quality of home and private practitioner case management of childhood illnesses

Both the KPC survey and PLA exercises revealed that the majority of mothers seek *private* practitioners for *curative* care for their sick children *and public health staff* for *preventive* health services The project will therefore put special focus on private practitioners This focus is also supported by USAID/ BHR/PVC's recommendation in its Technical Review of the BRICS proposal to highlight private practitioners (please see Annex 11) The BRICS project will in FY 2000 recruit a local consultant to adapt the generic BASICS/Kurji Holy Family Hospital/Bihar PVO II Operations Research questionnaire/methodology to study the "Quality of Home and Private Practitioner Case Management of Childhood Illnesses" (please see Annex 11) Following the baseline study, the project plans several CQI exercises with private practitioners to improve the quality of their case management/service delivery CQI instruments will be jointly developed with them to measure and track improvements

c) COPE (Client-Oriented Provider-Efficient) exercise

This is a process and practical set of tools for quality improvement in family planning and other reproductive health services developed by AVSC International It is a technique clinics and hospitals can use to find out how to make their services more efficient and responsive to needs A simplified NGO-friendly version adapted from the USAID/Bangladesh-funded Quality Improvement Project (QIP) (of which World Vision Bangladesh is an implementing partner) will be used to supplement the HFS An AVSC local consultant will be recruited for this exercise in FY 2000

D 2 Summary Findings of Baseline Assessments

D 2 1 Findings of Qualitative Baseline Assessments

PLA exercises were conducted in 6 villages Intervention-specific issues were discussed

FGDs were conducted in 18 selected villages of Beruar Beri block of Ballia district by BRICS staff over a period of three days The FGDs focused on the influence of ritual practices on health, beliefs, customs, traditions and superstitions regarding nutrition and immunization, maternal and child health, family planning, sexual behavior, HIV/STDs, knowledge about appropriate age for marriage, their understanding and perception of disease and local treatment patterns

Key PLA findings include

1 Pneumonia case management

(a) 40% of the community members are willing to pay for antibiotics Most of the people spend up to 10% of their income on medicines However the remaining were not willing to pay for medicine as they were very poor
(b) Vocabulary related to pneumonia recognition, local beliefs and practices, care seeking and compliance with treatment In local vocabulary pneumonia is called *Haba Dhaba* or *lalmonia*, and some call it pneumonia as they have heard from doctors, if the child tends to cry a lot and refuses to eat, it is called *pasli chalna*, chest in-drawing is *sakkar sakkar*, *alasth* is physical restlessness, *hafna* is fast breathing, and *dam marna* is difficult breathing
(c) They believe that the difference in body temperature of lactating mothers who take baths in the evenings, or eat cold food such as curd and rice, will give the child pneumonia A child is also believed to contract pneumonia from being exposed to cold or playing in cold water They also believe it spreads from one child to another, and believe that it mostly affects children in the age group of 0-5 years of age
(d) For home treatment of pneumonia, there are several traditional remedies caretakers heat camphor and/or mustard oil and feed them to the child, they may also massage the body of the baby with heated mustard oil and garlic (a local oil, *nurani*, is also used), a paste of "Ajuvaine" (thymol) and mustard oil, or a paste made of dried peas and oil may be applied to the child's head, mothers may feed the baby heated cow's ghee (a semi-fluid clarified butter), and lactating mothers are given Ajuvaine (thymol) to eat as a preventive measure Mothers also stop feeding children cold food They usually seek care from unqualified "doctors" or traditional practitioners
(e) Children are usually affected with pneumonia in the months of November-March (winter months) Mothers are ready to obtain medicines for their children at any time of the day and any day of the week when their child is ill
(f) Caretakers/mothers provide initial treatment for pneumonia at their homes If the child does not improve they go to traditional healers/registered medical practitioner (RMP) If the disease still persists they will seek out a PHC provider and other 'good' hospitals

2 Diarrhea case management

Awareness in the project area about dehydration as a cause of death is limited Some caretakers give a mixture of sugar, salt and lemon to their children However, many do not have these in their homes Childhood diarrhea is also managed in the home by giving the child ground guava, mint leaves and *heeng* (asafetida) Financial constraints, and poor local hospital facilities and equipment prevent them from obtaining better health care

3 Prevention of Malnutrition

Causes of malnutrition, especially among children under 3 years, were identified by the community as the following 1) feeding the child warm breast milk, 2) evil eye, 3) vitamin A

deficiency, 4) lack of nutritious food, 5) inadequate production of breastmilk for child feeding, 6) feeding the milk of a weak and diseased mother, 7) liver enlargement Lack of immunizations after delivery of the child, and poor care of the mother during pregnancy were identified as causes of malnutrition

The following weaning foods are given by mothers to children according to age group

- For children 5-6 months of age mothers give biscuits, cow's milk, or rice water,
- For 6-7 months child, they give *dal* and rice, *halwa* (a sweet) made out of wheat For children 7-8 months they give *dal*, roti and rice,
- For 8-12 months of age, they give eggs and fish in addition to those food served at home

Causes of night blindness were identified by community members as 1) VAD, 2) lack of nutritious diet due to financial constraints, 3) frequent pregnancies that make mothers weak, 4) mothers eating mud and clay during pregnancy, 5) lack of protein in daily diet such as fish, eggs and meat etc 6) improper bowel movements (constipation)

4 Reproductive Health care

The major causes of maternal deaths mentioned by the community are

- cutting of umbilical cord with unsterilized instruments (rusted blade, axe) leading to tetanus
- excessive bleeding during delivery
- anemia
- obstructed labor
- poor ante-natal care and checkups,

In-addition the following reasons were given

- non-availability of vehicles to hospitals
- placenta not completely removed and cleaned
- frequent abortions
- rupture of the uterus
- loss of amniotic fluid during delivery
- fetal deaths

Marriage takes place at 10-15 years of age as it is believed the girl is pure at this age (pre-menarche) This "purity" is considered necessary, as during the marriage ceremony the girl has to sit on her father's lap She will not, however, go to her in-laws home until she is 17 -18 years of age Once she has attained adulthood, she cannot stay at her father's house any longer It is believed that girls who wait longer to marry will not be able to get a good husband

Regarding beliefs about contraceptives, many women believe oral pills cause excessive bleeding They also mentioned experiencing bleeding and back pain from IUDs Condoms are not preferred as they are believed to reduce sexual pleasure Participation of men in family planning is low, as they believe that surgical methods such as vasectomy reduce their sexual pleasure and their ability to work Though women prefer to space their births, their husbands threaten to find other sexual partners or to stop providing for household expenses if their wives use contraceptives Male

children are much desired, which results in frequent pregnancies Having several children is also desired as they can earn more income, many children are perceived to increase one's physical strength, and parents fear the children they have will die Usually mothers prefer to have a birth spacing of 2-5 years

Key Findings from FGDs

Maternal Care and Family Planning

Village-based transport systems presently exist in some villages, with the aid of tractors or jeeps owned by some of the villagers If there is no vehicle available, 4-5 people will carry the woman on a cot Youth clubs are willing to form village-based referral management systems to strengthen and expand the existing system They need accurate information on when mothers are expected to deliver in order to make the necessary arrangements of vehicles

Abortion is sometimes used as a method of birth spacing, as well as to terminate unwanted pregnancies due to illicit relations Some *dais* (TBAs) advise mothers to space births up to 2 years apart, and mothers with several children are advised to go for tubectomy

Most of the *dais* have limited knowledge e g , they say that pills must be consumed as well as inserted inside the body Contraceptive supply is also poor VHGs are the community-based distributors of pills and are selected by the Government However they are not being utilized properly and effectively for distribution

Most RMPs do not provide any family planning services They instead refer eligible couples to the PHC for sterilization Some RMPs who stock condoms supply them to their clients

D 2 2 Findings of Quantitative Baseline Assessments

D 2 2 1 Findings of KPC Survey (please see full separate report)

Infants were evenly distributed by age The gender breakdown showed more boys (56 9%) than girls (42 8%) Nearly 42% of mothers were young (15-24 years of age) Low educational status of mothers was evident, with 73 2% illiteracy

Only 35 5% of mothers took their children with them to the fields when they worked The rest left their children with their husbands (14 3%), older children (24 7%) or relatives (37 1%)

Pneumonia Case Management

- 46% (136/298) of mothers reported that their under-2 child had a history of cough difficult breathing in two weeks prior to the survey, which was conducted in November, the beginning of the cold winter season in the area
- 85 4% (117/136) of these children experienced rapid or difficult breathing, consistent with the diagnosis of pneumonia,
- 63 2% (189/299) of mothers were able to recognize 2 or more dangers signs/symptoms of respiratory illness/pneumonia that would prompt them to seek care,

- 66% (76/115) of mothers reported seeking treatment for their under-2 child with pneumonia signs/symptoms, these included the 57 4% (66/115) of mothers who sought care from private practitioners This finding is consistent with those from the qualitative PLA exercises which revealed that the majority of mothers went to private practitioners for curative care for their sick children and public health staff for preventive health services
- The KPC survey instrument was not able to capture what percentage of children 0-23 months receiving antibiotic treatment were treated according to standard case management protocol, a separate assessment will be done later However, additional studies described below show that most treatments received do not meet established standards

Diarrhea Case Management

- 48% (141/300) of mothers reported that their under-2 children had diarrhea in the two weeks prior to the survey
- 17 6% (25/141) of under-2 children who reportedly had with diarrhea in the past 2 weeks were treated with ORT
- 16 9 % (23/141) of under-2 children with diarrhea in the past 2 weeks were given same amount or more fluids other than breast-milk during their diarrheal episode,
- 20 4% (28/141) of under-2 children with diarrhea in the past 2 weeks were given the same amount or more food during their diarrheal episode,
- 67 6% (96/141) of under-2 children with diarrhea in the past 2 weeks were given same amount or more breast-milk during their diarrheal episode,
- 20 4% (23/137) of children under-2 children with diarrhea in the past 2 weeks were given same amount or more of solids/semi-solids in addition to breastfeeding during their diarrheal episode, 52 6% stopped solids/semi-solids completely, and 22 6% of children had reduced solids/semi-solids,
- 24 1% (34/141) of under-2 children with diarrhea in the past 2 weeks were not given any treatment for their diarrhea, yet 54 6% (77/141) received anti-diarrhea medicine Only 8 5% (12/141) received ORS, although 72 3% (102/141) of mothers sought medical care for their child's diarrhea These mothers included 41 8% (59/141) who went to a private clinic or private doctor—this correlates well with the high percentage of under-2 children who received anti-diarrheal medication as mentioned above Only 6 4% (9/141) of mothers sought the PHC/SC A relatively high percentage (18 6%) sought out relatives for help with care for their children with diarrhea, another 15 6% sought RMPs for diarrhea care for their children
- Signs and symptoms cited by mothers that would trigger care-seeking for their child's diarrhea included vomiting (20 9%), fever (33 3%), dehydration (15 5%), diarrhea of more than two weeks of duration (36 0%), and blood in the stool (6 7%),
- 37 0% (111/300) of mothers with under-2 children had no idea what to do when their children are recovering from diarrhea, only 29% (87/300) said that they would give smaller, more frequent feedings A smaller 4 7% (14/300) said they would give more food and 7 3% (22/300) said that they would give foods with high caloric content

Essential Care of the Newborn

- 61 7%(182/295) of mothers initiated breastfeeding for their last newborn 8 hours or more after delivery,

- Although the KPC survey did not capture the percentage of post-partum mothers trained in the care of their newborn (prevention of hypothermia, low birth weight management and initiation of exclusive breastfeeding) the BRICS project has learned that this is not taught in a systematic manner by any health provider in the block

Immunization

Childhood Immunizations

- Only 53 5% (69/134) of children 12-23 months had an EPI card, and mothers of another 34 3% (46/134) of these children had lost their children's EPI cards,
- 39 1% (27/69) of those 69 children 12-23 months with cards have been fully immunized before their first birthday,
- However, only 20 9% (28/134) of all 134 children 12-23 months had card-documented coverage of all the six EPI vaccines before their first birthday,
- Only 27 6% (37/134) of children 12-23 months received a card-documented measles vaccine dose by their first birthday,
- 53 6% (37/69) of children 12-23 months with cards had received a measles dose by their first birthday,
- 65 9% (197/299) of mothers did not know at what age their children should receive measles vaccine, only 4 7% (14/299) knew the correct age for measles immunization
- DPT1 coverage (91 3% [63/69] of cards) or (47% [71/134] of total) dropped by DPT3 (72 5% [50/69] of cards) or 37 3%[50/134] of total) The DPT dropout rate was high (20 6%{91 3-72 5}/91 3)
- OPV1 coverage (91 3% [63/69] of cards) or (47% [71/134] of total) dropped by OPV3 (71% [49/69] of cards) or (37 3% [50/134] of total) The OPV dropout rate was similarly high (20 6%{91 3-72 5}/91 3),

TT vaccinations

- Only 35 8% (107/299) of mothers knew that tetanus toxoid (TT) vaccines would protect both mother and child against tetanus, another 11 4% (34/299) knew that TT would protect the newborn against tetanus,
- 47 5% (142/299) of mothers did not know why pregnant women are vaccinated with TT,
- 79 3% of mothers knew that 2 or more TT doses are needed by a pregnant woman to protect her newborn infant from tetanus,
- Only 5 6% of mothers had two card-documented doses of TT before the birth of her youngest child less than 24 months,

Prevention of Malnutrition and Vitamin A Deficiency

Breastfeeding and Nutrition

- Only 25 8% (77/299) of mothers reported giving colostrum to their newborn,
- 32 5% (96/295) of mothers breastfed their last newborn within 8 hours of delivery,
- 38% of mothers started breastfeeding in the first 24 hours of birth, 62% did not,
- 76 6% (49/64) of infants 0-4 months were exclusively breastfed in the last 24 hours,
- 25 8% (17/66) of infants 5-9 months were given solid or semisolid foods,
- 74% (217/295) of mothers reported having started complementary foods after six months,

- High continuation of breastfeeding was reflected in the 90 3% (28/31) of children 12-23 months who were still being breastfed,
- 86% (258/300) did not know what to do during a baby's first four months to keep on breastfeeding,
- Only 36 6% (108/295) of mothers had added oil or fat to their child's diet in the last 2 days,
- Only 39 8% (119/299) of mothers had added iodized salt to their child's diet in the last 2 days,
- Only 14 3% (43/300) of mothers knew of the importance of adding vitamin A-rich foods to breastmilk for their weaning children,
- Only 11% (33/300) of mothers knew of the importance of adding iron-rich foods to breastmilk for their weaning children

Vitamin A Deficiency

- Only 5 8% (10/171) of children 9-23 months received vitamin A supplements within the past 6 months, after this, the first vitamin A round organized with the Polio Plus Day in February 1999 increased the vitamin A coverage of children 6-59 months to 63 5% (please see Annex 2),
- None of the mothers with under-2 children received any card-documented high dose vitamin A supplement within 4 weeks of delivery,
- 82 7% of mothers did not know any food which prevents night blindness,
- Reported foods that prevent night blindness include green leafy vegetables (13 7% of mothers), yellow fruits (6 7%), meat/fish (7 3%), egg yolk (2 7%), breast milk (4%)

Reproductive Health

- None of the village clusters had functioning village-based emergency transport schemes for obstetric emergencies,
- 31 8% (95/300) of mothers with under-2 children reported at least one unintended pregnancy in the last 12 months,
- 8 1% (24/282) of women who desire no children in the next 2 years or are not sure, are using modern contraceptives,
- Only 8 8 % (26/295) of mothers who delivered their youngest child in the last one year received at least 90 iron/folate tablet supplements during their last pregnancy,
- Sources of iron/folate tablets included the PHC (8 5%), ANM (11%), and SCs (3 5%),
- Only 7% (21/300) of mothers had *at least one card-documented antenatal* visit before the delivery of their youngest child less than 24 months,
- Only 1 7% (5/300) of mothers had at least *three card-documented antenatal visits* before the delivery of their youngest child less than 24 months,
- Only 17% (51/300) of deliveries in the last 12 months had been attended by a trained health provider or PHC/SC/ANM staff
- 33 3% (100/300) of mothers did not know of any food to prevent anemia in pregnancy, those who knew cited eggs (29 3%), and green leafy vegetables (26 7%)
- Only 4 7%(14/300) of mothers knew that a woman should gain at least 8-12 kilograms during pregnancy

Sanitation and water

- 83 3% of mothers and their families do not have access to a latrine,
- 71% of mothers do not purify their water

Discussion

The majority of mothers sought private practitioners for curative care for their sick children and public health staff for preventive health services

The first dose of vitamin A (at nine months) is tied with the measles vaccine dose, however, with the current low measles coverage, it will be difficult to increase coverage for children at nine months of age with the first vitamin A dose Tying vitamin A distribution to children with the NIDs (National Immunization Days) is not sustainable as the NIDs will be phased out after the year 2000 Some other mechanism for delivering vitamin A to children should be explored

Conclusions and Recommendations from the KPC Survey findings

a) Recruit a local consultant in FY 2000 to assist in adapting the BASICS/Kurji Holy Family Hospital/Bihar PVO II Operations Research questionnaire/methodology to study the "Quality of Home and Private Practitioner Case Management of Childhood Illnesses" (see Annex 11)
b) Plan several CQI exercises with private practitioners to improve the quality of their case management/service delivery related to childhood illnesses,
c) Explore with the MOHFW and the UP State health authorities pilot-testing a vitamin A supplementation program for post-partum women within 4 weeks of delivery,
d) Increase measles coverage at nine months, and thereby increase vitamin A coverage, meanwhile continue to tie in vitamin A distribution with the NIDs,
e) As measles immunization is possibly the single most effective intervention in this population, include measles coverage by 122 months and 12-23 months in future immunization KPC results
f) Include a question on maternal night blindness (current/during last pregnancy) in the next KPC survey questionnaire

D 2 2 2 Key Findings of Baseline Night Blindness Prevalence Survey of children 6-59 months (see Annex 2)

Of 11,627 children 9-35 years who were eligible for vitamin A supplementation during the planned Polio Pulse Day on February 21, 1999, 7,386 children (63 5 %) attended and received vitamin A Of these 7,386 children, 220 (2 97%) were night blind *The baseline night blindness prevalence was 2 97 percent*

D 2 2 3 Key Findings of Baseline Polio Vaccination Status Survey of children 0-59 months in February 1999 (see Annex 7)

Of 15,439 eligible children 0-59 months (December 1998 total population survey/BRICS/PHC)

- 15,418 children received the first OPV dose (99 86 percent coverage) on December 12, 1998,
- 14,957 children received the second OPV dose (96 8 percent coverage) on January 17, 1999,

The Polio Pulse campaign (third dose) on February 21, 1999 was called off because of polio vaccine shortage

D 2 2 4 Key Findings of Baseline Nutrition Survey of 326 children 0-23 months, from 30 villages of Beruar Beri block conducted in February 1999 with local consultancy group, VRIDDHI (see full report submitted separately),

- Twenty eight percent of children 0-23 months were moderately under weight (i e who fall below -2 Z score from the median weight-for-age of the NCHS/WHO reference population),
- Fifteen percent of children 0-23 months were severely underweight (i e who fall below -3 Z score from the median weight-for-age of the NCHS/WHO reference population),
- In total, 43% of the children 0-23 months were severely or moderately underweight (i e who fall below -2 Z score from the median weight for age of the NCHS/WHO reference population),

Other key findings of the nutrition survey were

- Prevalence of wasting among the target group is 16 5%, stunting 36 5% and underweight children is 42 9% All three indices indicate a high to very high prevalence of malnutrition in the area
- It should be noted that the survey was conducted in late winter, which is a relatively low risk season in terms of occurrence of diseases like diarrhea, dysentery, etc The situation is likely to worsen in high risk seasons, i e late summer and during the monsoons, when the occurrence of diarrheal and vector-borne diseases is greater
- The survey projects approximately 1,658 children 0-23 months would be severely wasted and need immediate corrective measures to restore normal levels of nourishment
- There is a probability of 4,321 underweight children, 65% of them severely underweight
- Approximately 4,200 children would be moderately underweight and wasted, and require immediate preventive intervention, as they are at a greater risk of slipping into the severely wasted and underweight category
- The survey projects an immediate target group of almost 6000 children who are malnourished, and require preventive and/or corrective care This is approximately 60% of the total number of children 0-23 months
- Caste groups where prevalence of malnutrition has been found to be high are Harijans, Mallahs, Rajbhars and Chauhans
- Malnutrition is prevalent in a cross-section of the population, irrespective of the economic status or sibling position of the children
- Villages which have a relatively better Nutritional Status are Deluah, Durgipur, and Sultanpur

E PROGRAM DESIGN

E 1 Overall Program Design

The BRICS project is designed with the following *three-pronged vision* in mind

E 1 1 The BRICS Project as a Capacity Builder for Child Survival and Reproductive Health Services

This is evident from the ***BRICS' strategic objective*** (as mentioned in section C) which is to *assist the Ballia District CMO and private sector and community partners to accomplish, sustain, document and replicate best practices to* ***reduce fertility and infant, child and maternal mortality through an innovative child survival and reproductive health improvement project*** *in one block (namely, Beruar Beri Block) of the remote Ballia District in eastern UP state over a four year period.*

The BRICS staff will primarily be facilitators and will provide or arrange for technical assistance for its partners in the primary impact area (Beruar Beri Block) They will work with and through the staff of the CMO, PHC and SC The BRICS staff will not be providing CS/RH services, except for special events such as Polio Pulse Days, National Immunization Days and during vitamin A distribution rounds, where they will assist their public and private sector and community partners The specific collaboration with health facilities and service providers is described under the Detailed Plans by Intervention (section M)

The project's strong capacity-building component is reflected in section F (Partnership)

E 1.2 The BRICS Project as Demonstration Site for Linking Quality Improvement, Impact Monitoring, Equity and Sustainability

The BRICS project's focus on the primary impact area (Beruar Beri Block) is to assist it to become a demonstration site/ "center of excellence" where innovative strategies and results related to quality, impact, equity and sustainability are carefully documented and disseminated It will also serve as a training and dissemination site for "Lessons Learned/Best Practices" for the entire Ballia district and WV India's ADPs in UP state

Some of the proposed innovations are summarized in section E 5

The BRICS project's strong *quality improvement* and *impact monitoring* components are described more fully in section J (Monitoring and Evaluation) The BRICS project's push for *equity* is reflected in the strong CS/RH coverage objectives listed under the sub-results in section C The emphasis on *sustainability* is evident from the beginning at the DIP Workshop (Annex 8), and the Sustainability Action Plan (SAP) that emerged from that workshop (Section H and Annex 16)

E 1 3 The BRICS Project as a Child Survival/Reproductive Health Multiplier for Scale-Up

As discussed in section C, the project plans to go to scale by replicating best practices in child survival and reproductive health in (a) the entire Ballia District (of 17 blocks with 2,583,517 people), and (b) in three other WV India ADPs in UP state impacting 221,418 people

The scale-up plan is summarized in Annex 12 and in the map with concentric circles (Annex 3) This scale-up plan will be coordinated with the Ballia CMO Office and the WV India North Zone Office in Delhi, and will be reviewed and revised accordingly by the Mid-Term Evaluation (MTE) team at the end of two years of project implementation

In addition, the BRICS project will pilot-test with the MOHFW, WHO and UNICEF the following two prototype modules

(i) Community-based Surveillance of
  a) childhood diseases (polio, measles and neonatal tetanus), and
  b) infant, child and maternal mortality,

(ii) "Integrated Approach in Management of Cough or Difficult Breathing, Diarrhea or Under-nutrition in Young Children" module with WHO/SEARO for basic health workers (PHC/SC staff, AWWs, VHGs)

WV India envisions that these two prototype modules will also be adapted and utilized in 100 districts where WV India's 100 ADPs are located across almost all the states of India As each ADP covers one block with an average of 100,000 people, a potential population of 10 million people and 245 local NGOs and community-based organizations may eventually be impacted through this proposed replication

E 1 4 Three-pronged Vision will be attained through the accomplishment of the Five Intermediate Results (IRs)

Intermediate Result #1 *Increased use of high-impact child survival and reproductive health services by the target population*

Intermediate Result #2 *Strengthened local institutions through partnerships, coalitions and strategic alliances, leading to replication of best practices in child survival and reproductive health across the entire Ballia district and in three other WV ADPs in UP state*

Intermediate Result #3 *Enhanced capabilities of individuals, families and communities to protect and provide for their own health*

Intermediate Result #4 *Improved quality of training, supervision, information and service, leading to greater customer satisfaction*

Intermediate Result # 5 *Enhanced sustainability of child survival and reproductive health services and support systems*

E 1 5 Process by which eligible women, children, and newborns will enter and participate in the program

The BRICS project will facilitate community empowerment by introducing *village-owned health registers* which will enroll eligible women, children, and newborns to participate in the program Together with PHC/SC staff, BRICS staff will facilitate and train the *mahila mandals* and VHGs to adapt and adopt two innovative village-owned registers from the USAID/BHR/PVC-funded Kean Svay Child Survival Project of WV Cambodia They have been very useful in the community and very effective in increasing CS/RH coverage of eligibles Dr Stan Foster of Emory University has declared the village EPI register as the "World's Best Buy" for immunization recording systems

The two village-owned registers are the
i) Community EPI (Immunization) Register,
ii) Community Pregnancy Register

Locally available register books will be used (See community surveillance forms in Annex 13 for these two registers)

The Community EPI Register
This is similar to the PHC/MOH EPI register, with the major (and crucial) difference being that children are entered by month/year birth, regardless of age at the time of first presenting for immunizations Hence there is *one page for each month of birth* This way, VHGs/*mahila mandals* know that all children on a given page are due for their immunizations at the next session, and that all empty spaces for children preceding that are children who are late They know that all children in pages for the preceding 9 months should have had their measles immunization In addition, newly born children will be listed by the VHG each month even if they do not present for immunization, and will be tracked down if they don't come

In contrast, the usual MOH/PHC/SC routine is to list the children sequentially as they present for immunizations In order to know how many defaulters there are, staff must look at each entry, calculate the age, and then determine whether or not they are behind

Community Pregnancy Register
The PHC/SCs have a TT register that lists all women (pregnant or not) receiving TT The BRICS project will keep this, but will add a pregnancy register in order to pick up neonatal and maternal deaths, and to make sure all surviving children have been listed in the Community EPI Register In this way, VHGs/*mahila mandals* can easily identify individuals in need of key preventive services By linking pregnancy registers with infants EPI registers, maternal and neonatal deaths can be identified

From WV Cambodia's experience, these two community-owned registers provide an effective and low-cost maternal and child health monitoring system that can be maintained and used by the villagers themselves to set their own priorities for health care These tools have been designed using materials that are available locally and at low cost, can be maintained by users with an

elementary reading level, are in a format compatible with government monitoring systems, and collect only that information that is actually useful for those collecting it

The development of the two registers will include periodic review and evaluation The MTE will also include a review of the village monitoring system Findings from sample surveys (such as the KPC survey) will be compared with village registers, and the BRICS staff and their PHC/SC and NGO partners will conduct focus group discussions with VHGs and *mahila mandals* regarding their understanding and use of the information

Reviews of WV Cambodia's Kean Svay CSP reveal that using these tools, community volunteers are able to maintain the monitoring system with minimal assistance, and are able to use the information for setting health priorities Communities have ongoing access to information such as current census, names of individuals in need key services, number of maternal and infant deaths, and migration patterns The communities using this system have made impressive gains in major health indicators The BRICS project hopes to replicate this success and community empowerment in Ballia and beyond in India

E 2 Process to Involve Partners and In-country Organizations in Program Design

From the beginning, WV India and the Ballia ADP staff consulted with the local USAID Mission in New Delhi, the MOHFW in Delhi and the UP State health authorities, the Ballia CMO, the PHC/SC staff, local NGOs, ICDS officers, private sector health providers, and community leaders and organizations in Beruar Beri Block before determining the project site, interventions, objectives and strategies

Most baselines assessments were jointly conducted with local partners Findings from baseline quantitative and qualitative assessments (please see section D) were shared with a broader constituency of local partners during the DIP Workshop in January 1999, and were used to revise project objectives, and annual benchmarks and targets

The project has also incorporated the recommendations from USAID/BHR/PVC's Technical Review of the proposal (See Annex 9) In-country technical agencies such as WHO, UNICEF, PRIME/INTRAH, VRIDDHI, SIFPSA, and other PVOs working in the area (CARE, Plan, SCF, and CRS) were also consulted The WV India North Zonal Office had major inputs to the design, as did the Ballia ADP staff A list of in-country advisors is given in Annex 14)

Process/Rationale for Selecting Country and Project Site

WVUS and the WV APRO approached WV India to consider a USAID-funded CS/RH project because India's 5-UMR is above 100/1,000 LB, and WV India has proven capability in managing a large and innovative USAID-funded project (please see section E 4 5) Meanwhile, WV India senior management has been lobbying WVUS for the past year for add-on CS/RH grant funding for one of its remote and under-served ADPs in the north zone

Ballia district was selected because (a) the central MOHFW, the UP State health authorities, WHO, UNICEF, UNDP and Population Council have all encouraged WV to choose a remote

district in the northern UP state that is needy in terms of poverty, health service infrastructure and coverage, (b) the Ballia ADP team are keen to demonstrate impact on mortality and fertility from an add-on CS/RH component to its newly-established ADP, which commenced in Beruar Beri Block in October 1996, (c) the Ballia CMO has strongly welcomed WV India's partnership in launching an innovative program to increase health coverage and quality, and to demonstrate and document impact, (d) the potential strength and quality of 3 local NGOs which have requested WV's help in mentoring and building their institutional, technical and financial capacity, (e) the USAID/New Delhi mission has encouraged PVOs to consider their highest priority state this is UP state, India's largest state with 150 million people, and also one of the North Indian "BIMARU" states which rank low among Indian states on most child survival indicators and have high fertility rates, and (g) the opportunities for WV India to build synergistic linkages with the large USAID-funded health and family planning services project with SIFPSA in UP state, and to complement USAID-funded initiatives with WHO, UNICEF and Rotary International to eradicate polio Annex 14 provides a list of persons from organizations consulted in-country, they have agreed to serve as project advisors within their areas of expertise

Program Design Process also incorporated USAID/India Mission's Strategic Objectives
The proposed project's strategic objectives, impact indicators, intermediate results and sub-results contribute to the Mission's Child Survival Strategic Objective #3 (*Increased Child Survival and Nutrition in Selected Areas of India*) and Population and Reproductive Health Strategic Objective #2 (*Reduced Fertility and Improved Reproductive Health in North India*) by focusing on impact and results The project site fits USAID's highest priority for UP state and affinity for under-served populations The Mission's preference for *innovative strategies* is reflected in the project's plan to pilot-test (a) the use of contraceptives for child spacing, (b) community-based disease and death surveillance to complement the current institutional surveillance of AFP, (c) essential care for the newborn to reduce neonatal mortality, (d) centers of excellence in quality case management of ALRIs and diarrheas, (e) essential care of the sick child by training AMNs, VHGs, TBAs and AWWs in IMCI, (f) team approaches and CQI tools to improve program quality in terms of access, choice, counseling and client-provider interactions, and (g) vitamin A supplementation of postpartum women

The project's plan to *replicate and scale up* best practices in CS/RH among 10 million people in 100 WV India ADPs eventually (as evidenced in Intermediate Result #2 in section E 5 2 and the 'ripple effect' diagram included in maps in Annex 1) underscores USAID's desire to sustain and promote multiplication of efforts The mission's emphasis on sustainability is mirrored in the project's Intermediate Results #2 and #5 which focus on strengthening local partners and *promoting voluntarism* among communities The project's co-location in the same state and district and issue-based partnerships/linkages with other large USAID-funded projects (SIFPSA, polio eradication, ICDS) will facilitate synergistic impact in reducing fertility and infant, child and maternal mortality The project's plan to have a strong health management information system, which is focused on quality and impact, will meet the Mission's requirement for a strong performance monitoring and evaluation system

Program Design Process also incorporated CS/RH policies of the Government of India
To ensure consistency with the GOI's CS policies, WV India sought the active participation of the MOHFW, the UP State Health authorities in Lucknow, the Ballia District CMO, and the BDO and PHC doctors, LHVs and AMNs in Beruar Beri District in the project design stage The project's strategic objectives and intermediate results are consistent with GOI's recently launched (1997) Reproductive and Child Health (RCH) Program The RCH program, with the 4 components of child survival, safe motherhood, family planning and women's reproductive health, is the centerpiece of its Family Welfare Program (FWP) in the Ninth Plan, involving a comprehensive reorientation of the Program Over the past 30 years, India's FWP's single objective had been to reduce fertility through a strategy based on contraceptive targets and cash incentives However these latter strategies resulted in inflated performance statistics and neglect of quality of services Inherent in the new RCH program is a paradigm shift from the previous top-down, target-driven, vertically-oriented and quantitative approach to a decentralized, participatory, client-centered, integrated and quality-focused program

This proposal's Intermediate Results #1, #2, #3 and #4, are in line with the following changes in program management that have resulted from the policy re-orientation under the new RCH program, namely (a) implementation of decentralized district planning to replace national and state targets, (b) improving quality and accessibility of services, (c) increasing utilization of services through increased community participation through the *Panchayat* (village leadership) system

The project also plans to assist the Ballia CMO to build the Ballia Health Management Team capacity in (a) decentralized participatory planning, and (b) the use of baseline PLA methodologies and KPC surveys for customer appraisal of CS/RH services

E 3 Choice of Interventions and Strategies

The project considered the following factors in the choice of interventions and strategies
(a) mortality and fertility patterns (please see section B 3),
(b) potential and constraints of the current health facilities (please see section B 4),
(c) community preferences (please see section D 2 on findings of baseline qualitative assessments),
(d) current potential and expertise of staff and local partners

The BRICS Project has ready-made grassroots and institutional relationships to facilitate a running start for this proposed add-on child survival/reproductive health project at the site of the current Ballia ADP

Already in place are the ADP Manager, one Community Development Coordinator, six Community Development Organizers (CDOs), two Lady Community Organizers (LCOs), and a trained accountant, all supported by private ADP funds A WV North India Zonal Office accountant, trained in USAID grant accounting staff by WVUS finance staff, will provide competent backstopping for the financial management of the project The financial software SUN system is installed in the Zonal Office, as well as in all 13 ADP offices, including the Ballia ADP

(please see Annex 15 for CVs and resumes of BRICS core team, and Annex 4, a descriptive summary of local NGOs)

BRICS has developed a comprehensive plan to upgrade the skills of its staff (Section I 4) It will also draw on the rich experiences of its previous USAID/BHR/PVC-funded Navapur Integrated Child Survival Project in Maharashtra which has now transitioned into a 15-year ADP

Rationale for choice of interventions and strategy

Child Survival interventions As neonatal mortality now accounts for 60% of the IMR, the project will address the emerging need for ***essential newborn care*** to reduce the number of neonatal deaths Because ALRI and diarrhea are principally identified causes of under-5 child mortality, the project will assist in building capacity in ***quality case management of ALRI (pneumonia) and diarrhea*** among public and private sector health providers in a district where only 10% of PHC staff have been trained in standard case management of pneumonia The project's *immunization component* will assist in increasing the extremely low full immunization coverage of infants and TT2 coverage of pregnant women in order to reduce neonatal tetanus mortality, to eradicate polio and eliminate measles The ***vitamin A intervention*** aims to improve the vitamin A status of vitamin A-deficient children 9-35 months and post-partum women, and thereby reduce child mortality by an average of 23%, decrease the duration and severity of childhood illnesses such as diarrheas and ALRI, prevent xerophthalmic lesions, reduce the prevalence of anemia when it co-exists with VAD, and increase serum and breastmilk retinol levels when vitamin A supplements are given to breastfeeding women shortly after delivery Other recent studies suggest a strong association between the vitamin A status of HIV-infected women and reduced transmission of HIV from mother to infant The nutrition education component seeks to correct adverse breastfeeding and infant feeding practices in Beruar Beri block

Reproductive Health Interventions The establishment of ***village-based transport for obstetric emergencies*** to the District Hospital will assist in reducing the principal cause of maternal mortality, namely post-partum hemorrhage The birth spacing component promotes the important linkages between child spacing and child survival the 1992-93 NHFS found that child spacing patterns have a powerful effect on the survival chances of the Indian child in UP state Infant and child mortality increase sharply as birth intervals decrease infant mortality is 3 times higher in children with a preceding birth interval of less than 24 months (IMR of 130/1,000 LB) compared to children with birth intervals more than 24 months (IMR of 42/1000 LB) UNICEF/1995 data reveal that only 28 9% of birth intervals exceeded 24 months in UP state The family planning/spacing component will also impact maternal mortality reduction by preventing abortions (another major cause of maternal mortality), especially in Ballia district, where the use of contraceptives for birth spacing is still an alien concept The prenatal component aims to reduce the high prevalence of pregnancy anemia and intrauterine growth retardation in Beruar Beri block, where the prevalence of low birth weight (<2,500 gm at birth) in newborns is 34% The project plans to institutionalize well-managed deliveries by TBAs and ANMs who are also trained and equipped to give newborn care, in Beruar Beri Block, more than 95% of the 173 TBAs are not currently trained in clean delivery techniques The project's plan to increase maternal education through non-formal literacy programs is critical in a country like India where, for example, the

infant mortality rate of babies whose mothers received primary education is half that of children whose mothers are illiterate (UNICEF/1996)

E 4 Interventions Removed/Deferred

The BRICS project has decided to

a) ***Remove the malaria component***, upon the recommendation of USAID/BHR/PVC Technical Review of the Proposal (Annex 9),
b) ***Delay the introduction of the IMCI component*** until the MTE (September 2000), upon the recommendation of USAID/BHR/PVC Technical Review of the Proposal (Annex 9) It will instead focus first on training PHC staff and basic health workers in using the *Integrated Approach in Management of Cough or Difficult Breathing, Diarrhea or Under-nutrition in Young Children* module from WHO/SEARO for basic health workers (SC staff, AWWs, and VHGs
c) ***Delay the introduction of post-partum vitamin A supplementation*** until additional vitamin A capsules are available from another donor source (like CIDA), as the CMO does not have any vitamin A supplies for this program,
d) ***Postpone the pilot project on vitamin A supplementation of pregnant women*** until the Lucknow-based State Health authorities have cleared it with the central MOHFW Meanwhile the project will collect baseline data on the prevalence of night blindness in pregnant women and women in general

E.5 Innovations, New Methods, Strategies or Materials

These include

1) *The Community-Owned EPI and Pregnancy registers* (described above in section E 2) which can help facilitate community empowerment
2) Joint development with WHO/SEARO and CMO of a training module on *Integrated Approach in Management of Cough or Difficult Breathing, Diarrhea or Undernutrition in Young Children* module for basic health workers (PHC/SC staff, AWWs, and VHGs),
3) Pilot-test with the MOHFW, WHO and UNICEF a prototype module on community-based surveillance of (a) childhood diseases (polio, measles and neonatal tetanus), and (b) infant, child and maternal mortality (WV India envisions that these two prototype modules will also be adapted and utilized in 100 districts where WV India's 100 ADPs are located across almost all the states of India As each ADP covers one block with an average of 100,000 people, a potential population of 10 million people and 245 local NGOs and community-based organizations may eventually be impacted through this proposed replication)
4) Introduction of postpartum vitamin A program WV will approach CIDA to provide the capsules As most deliveries occur at home, TBAs, VHGs, and Mahila Mandals will be trained by PHC/SC staff to distribute and document the vitamin to post-partum women within one month of delivery,
5) Pilot-test the PVO Core Group's new module for NGO assessment of health facilities with Dr Stan Foster in April/May 1999,

6) Use COPE exercises to improve the quality of reproductive health services A simplified NGO-friendly version adapted from the USAID/Bangladesh-funded Quality Improvement Project (QIP) (of which World Vision Bangladesh is an implementing partner) will be used to supplement the HFS An AVSC local consultant will be recruited for this exercise in FY 2000
7) Use of "positive deviance" to identify sustainable local practices which lead to healthy child nutritional status The BRICS project will draw from SCF/USA's experience in Vietnam to design village-based nutrition interventions

Operations Research The BRICS project will, in FY 2000, recruit a local consultant to adapt the generic BASICS/Kurji Holy Family Hospital/Bihar PVO II Operations Research questionnaire/ methodology to study the "Quality of Home and Private Practitioner Case Management of Childhood Illnesses" (see Annex 11) Following the baseline study, the project plans several CQI exercises with private practitioners to improve the quality of their case management/service delivery CQI instruments will be jointly developed with them to measure and track such improvements

F. PARTNERSHIP

F.1 Partnership with Public Sector

F 1 1 Current Capacity/Resources of the Public Sector Health Service Providers

The various categories of public sector health service providers in both the direct impact area (Beruar Beri Block) and the indirect impact area (the rest of the 16 blocks of Ballia District) are listed in section B 4 The BRICS staff will not be providing health services directly, instead, they will support the work of various PHC/SC staff and private sector health providers

<u>The staffing structure in Beruar Beri Block (Direct Impact Area)</u>
The 83 VHGs, one in almost every village, are volunteer health workers offering service for 4-10 hours weekly, on average They have been trained and are supervised by ANMs from the SCs to provide health and ORT education to the community, identify children for immunization, refer pregnant women for TT immunization and prenatal care, and promote best practices in infant feeding A VHG is responsible for an average of 1000-1400 people in a village Some VHGs are also TBAs, or *dais*, who number 173 Most of them have not been trained in clean delivery techniques The project plans to work with the SC-based ANMs to train and equip these TBAs with TBA kits

The 15 SCs are staffed by an ANM and multipurpose workers who are primarily involved in malaria control activities ANMs have 3 years' midwifery training and they provide midwifery services, TT immunization for pregnant women, immunization for infants, and Vitamin A supplements to children 9-35 months, prenatal and post-natal care, family planning services and reporting of SC activities They are paid by the MOHFW and are full-time ANMs report either to a Senior ANM or LHV who are based in the PHC One ANM serves an average population of 8000 people

The 3 PHCs are each staffed by a full-time government-paid doctor, a LHV and a senior ANM The PHC staff provide basic clinical care and CS/RH services, including IUD insertions and clinical contraception On average, a LHV or senior ANM supervises 5 SC-based ANMs Each PHC serves an average of 40,000 people

In addition, the Ballia District CMO office of 12 staff (including the CMO, Deputy CMO/District Immunization Officer, Statistician and District Malaria Officer) provide supervision to all PHC staff in Ballia district

F 1 2 BRICS Projects' Plans to increase the managerial and technical skills of Public Sector Health Staff

This is summarized in the project's Intermediate Result (IR) #2 which calls for *strengthened local institutions through partnerships, coalitions and strategic alliances, leading to replication of best practices in child survival and reproductive health across the entire Ballia district and in three other WV ADPs in UP state*

In line with IR #2, the BRICS project will develop the following Sub-Result #2a and Action Plans

Sub-Result #2a CAPACITY BUILDING OF PUBLIC SECTOR HEALTH STAFF

ACTION PLANS	FY 1999	FY 2000	FY 2001	FY 2002	TO-TAL
A BALLIA DISTRICT HEALTH MANAGEMENT TEAM STRENGTHENING					
Team Building Exercises facilitated for District CMO/PHC staff	1	3	0		3
District CMO staff trained in the use of PLA methodologies for customer appraisal	6	6			12
District-level Health Management Information System (HMIS) Review facilitated		1			1
District CMO staff trained in CBDDS, with initial emphasis on AFPsurveillance	8	4			12
District CMO staff trained in RH/CS management skills	2	2	2	2	8
District CMO staff trained in QA/CQI tools/techniques		6	6		12
District CMO staff trained in high quality pneumonia and diarrhea case management	4	4	4		12
District CMO staff trained in					
• Missed Opportunity Surveys for CS/RH interventions		6	6		12
• Assessing customers' timeliness of immunization-seeking behavior & treatment-seeking behaviors for major childhood killer diseases		6	6		12
• Assessing extent of immunization left-outs/drop-outs		6	6		12
District CMO staff trained in TOT skills		6	6		12
District CMO staff sent on cross-visits to other RH/CS Projects		3	3		6
B STRENGTHENING OF PHC MANAGEMENT					

TEAMS IN DIRECT IMPACT AREA					
Team-building exercise facilitated for 3 PHCs	1				1
PHC staff trained in PLA	9				9
PHC staff trained in QA/CQI tools/techniques		9			9
PHC staff trained in high quality pneumonia and diarrhea case management		9			9
PHC staff trained in					
• Missed Opportunity Surveys for CS/RH interventions		9			9
• Assessing customers' timeliness of immunization-seeking behavior & treatment-seeking behaviors for major childhood killer diseases		9			9
• Assessing extent of immunization left-outs/drop-outs		9			9
PHC staff trained in CBDDS with emphasis on AFP surveillance	9				9
PHC staff trained in KPC survey techniques and analysis	9				9
PHC staff trained in cold chain survey	3	9			9
PHC staff trained in TOT) skills		3	3	3	9
PHC staff trained in emergency obstetric care		3	3	3	9
PHC staff sent on cross-visits to other CS/RH projects		3	3	3	12

C. CAPACITY BUILDING OF SUBCENTER STAFF (ANMs) IN DIRECT IMPACT AREA	**FY 1999**	**FY 2000**	**FY 2001**	**FY 2002**	**TO-TAL**
ANMs trained in PLA methodologies for customer appraisal	5	5	5		15
ANMs trained in KPC survey techniques and analysis	15				15
ANMs trained in essential obstetric care and life-saving skills		10	5		15
ANMs trained in essential newborn care (management of asphyxia, hypothermia, low birthweight, exclusive breastfeeding)	5	5	5		15
ANMs trained in interpersonal communications (IPC) and face-to-face counseling skills		5	5	5	15
ANMs trained in supervisory skills	5	5	5		15
ANMs trained in					
• Missed Opportunity Surveys for CS/RH interventions	5	5	5		15
• Assessing customers' timeliness of immunization-seeking behavior & treatment-seeking behaviors for major childhood killer diseases	5	5	5		15
• Assessing extent of immunization left-outs/drop-outs	5	5	5		15
ANMs trained in high on quality case management of pneumonia and diarrheal diseases		5	5	5	15
ANMs trained in CBDDS, with emphasis on AFP surveillance	5	5	5		15
ANMs trained in vitamin A treatment/supplementation of the sick child (with severe undernutrition, or measles or pneumonia or severe diarrhea)	5	5	5		15
Please note. (D) will only take place if and when the ICDS scheme is introduced into Beruar Beri Block					
D. CAPACITY BUILDING OF AWWs IN DIRECT IMPACT AREA)					
AWWs trained in PLA methodologies	15	20	20	30	85
AWWs trained in KPC survey methodologies	15	20	20	30	85

AWWs trained in IPC and face-to-face counseling skills	15	20	30	30	85
AWWs trained in the 5-day WHO/GOI package on "Integrated approach in management of Cough or Difficult Breathing, Diarrhea or Undernutrition in Young Children"	5	20	30	30	85
AWWs trained in referral management skills	5	20	30	30	85
AWWs trained in CBDDS, with emphasis on AFP surveillance	5	20	30	30	85
AWWs trained in Missed Immunization Opportunity Surveys		25	30	30	85

E STRENGTHENING OF PHC STAFF IN THE INDIRECT IMPACT AREA (THE OTHER 16 BLOCKS OF BALLIA DISTRICT)	**FY 1999**	**FY 2000**	**FY 2001**	**FY 2002**	**TO-TAL**
PHC staff trained in workshops CBDDS, with emphasis on AFP surveillance					
• Doctors		20	35	34	79
• Lady Heath Visitors		20	35	34	79
• Auxiliary Nurse Midwives		20	35	34	79
PHC staff participating in "Lessons Learned " PHC-sharing seminars on KPC survey methodologies findings and applications					
• Doctors	20	35	34		79
• Lady Health Visitors	20	35	34		79
• Auxiliary Nurse Midwives	20	35	34		79
PHC staff participating in "Lessons Learned " PHC-sharing seminars on the use of PLA methodologies for customer appraisal					
• Doctors		20	35	34	79
• Lady Health Visitors		20	35	34	79
• Auxiliary Nurse Midwives		20	35	34	79
PHC staff participating in "Lessons Learned " PHC-sharing seminars on Missed Opportunty Surveys for CS/RH interventions, assessing customers' timeliness of immunization-seeking behavior & treatment-seeking behaviors for major childhood killer diseases, & assessing extent of immunization left-outs/drop-outs					
• Doctors		20	35	34	79
• Lady Health Visitors		20	35	34	79
• Auxiliary Nurse Midwives		20	35	34	79
PHC staff participating in "Best Practices" workshops on High Quality Case Management of Childhood Pneumonia and Diarrhea					
• Doctors		20	35	34	79
• Lady Health Visitors		20	35	34	79
• Auxiliary Nurse Midwives		20	35	34	79
PHC staff participating in "Best Practices" workshops on team approaches to the use of QA/CQI tools/techniques					
• Doctors		20	35	34	79
• Lady Health Visitors		20	35	34	79
• Auxiliary Nurse Midwives		20	35	34	79
PHC staff participating in "Best Practices" workshops on the use of Quality of Care (QOC) supervisory instruments					

• Doctors		20	35	34	79
• Lady Health Visitors		20	35	34	79
• Auxiliary Nurse Midwives		20	35	34	79
PHC staff participating in "Best Practices" workshops on the Reproductive Health					
• Doctors		20	35	34	79
• Lady Health Visitors		20	35	34	79
• Auxiliary Nurse Midwives		20	35	34	79

Please see the DIP workshop report (Annex 8) which spells out the roles and contributions of the different partners, and Annex 4 (agreements with Ballia CMO and UP State Health authorities)

F 1 3 Coalition building and partnerships with other organizations

Partners include
(a) The UP-based State Innovations in Family Planning Services Agency (SIFPSA), a GONGO funded by USAID, to assist local NGOs to promote expanded contraceptive choices and community-based contraceptive distribution, (b) the MOHFW at national and state levels, (c) the State EPI Director, (d) Surveillance Medical Officer (SMO) and Ballia District Immunization Officer, (e) WHO/SEARO, (f) UNICEF India Office, (g) the Population Council, and (h) USAID/Delhi

F 2 Partnership with NGOs

A descriptive summary of the three local NGOs (Puvanchal Gramin Chetna Samiti, Prathimithi Sansthan, Naval Siksan Sansthan) which BRICS will partner with, is found in Annex 4, along with agreements for planned partnerships with these 3 NGOs The willingness of these 3 local NGOs to be mentored by BRICS Project/WV India and the plans of these local NGOs to broaden their agendas and make resource commitments to initiate CS/RH activities in Beruar Beri Block provides reasonable evidence that these local NGOs will be able to sustain a sizable proportion of program activities

BRICS also plans to form a Polio Eradication Network with these three local NGOs and the Rotary Club (Ballia Chapter)

Sub-result #2a (below) summarizes the (a) coalitions, (b) capacity building plans to increase the skills of local NGO staff to sustain program activities, and (c) organizational development of local NGOs and GONGOs

Annex 5 provides the assessment and monitoring tools for capacity building of the three local NGOs in the following areas
1) Management Capacity
2) Financial Capacity
3) Service Delivery Capacity

These tools have been adapted from the Bangladesh Population and Health Consortium list

During the DIP workshop in January 1999, a block-level Sustainability Action Plan (SAP) was drafted where all partners will jointly define their roles and contributions (please see section H) Sustainability objectives, benchmarks and indicators under the SAP have been collectively developed, and these will be used to evaluate these partnerships and to assess the local partner resource commitments to the partnerships

Sub-Result #2b COALITIONS, CAPACITY BUILDING AND ORGANIZATIONAL DEVELOPMENT OF LOCAL NGOs/GONGOs

ACTION PLANS	FY 1999	FY 2000	FY 2001	FY 2002	TO-TAL
Polio Eradication Network established between BRICS & • *Puvanchal Gramin Chetna Samiti* • Rotary Club--Ballia Chapter • *Prathimithi Sansthan* • *Naval Siksan Sansthan,*	1				1
Family Planning/Birth Spacing Partnership established between BRICS with SIFPSA and local NGOs to promote • expanded range of contraceptive choices available to clients • community-based contraceptive distribution (oral pills & condoms) in relatively remote villages	1				1
Organizational Development (OD) exercises facilitated for 3 local NGOs					
• *Puvanchal Gramin Chetna Samiti*	1	1	1	1	4
• *Prathimithi Sansthan*	1	1	1	1	4
• *Naval Siksan Sansthan*	1	1	1	1	4
NGO staff trained in program management and technical oversight of RH/CS activities	3	3	3		9
NGO staff trained in financial management, accounting & costing skills		3	3		6
NGO staff trained in networking, fund-raising, proposal writing, and in English		3	3	3	9
NGO staff trained and functioning as Community Health/ Development workers	6	6	6	6	24
NGO staff trained in using PLA methodologies for customer appraisal	12	12			24
NGO staff trained in KPC survey techniques and analysis	12	12			24
NGO staff trained in supervisory monitoring and evaluation skills		6	6	6	24
NGOs trained in IPC and face-to-face counseling skills		6	6	6	18
NGO staff trained in TOT skills		6	6	6	18
NGO staff trained in the 5-day WHO/GOI package on "Integrated approach in management of Cough or Difficult Breathing Diarrhea or Undernutrition in Young Children"		6	6	6	18
NGO staff trained in referral management		6	6	6	18
NGO staff trained in CBDDS, with emphasis on AFP surveillance		6	6	6	18
NGO staff trained in the conduct of social autopsies		6	6	6	18

Partnerships with other non-governmental organizations include

(a) Issue-based partnerships with CARE in CS/RH, (b) participating in the NGO group advising UNICEF/India on its Health Section (RCH) Master Plan for Operations (1998-2002), (c) serving on impact evaluation teams evaluating USAID SIFPSA-partnered projects in Nainital District in UP state, (d) working with the G B Pant Nagar University on Agriculture to organize farmers' clubs and disseminate environmentally-sound integrated farm management techniques, (e) holding fora with VHAI (Voluntary Health Association of India), Christian Medical Association of India (CMAI), and SHARAN in HIV/AIDS/STDs initiatives, (f) EFICOR (a relief and development agency), (g) developing with Emmanuel Hospital Association a community-based rehabilitation package for the disabled in UP state, and (h) pilot-testing a training package on disaster mitigation with major NGOs

F.3 Partnerships with Community-Based Organizations

This is reflected in the project's Intermediate Result #3, which envisions *enhanced capabilities of individuals, families and communities to protect and provide for their own health*

Sub-Result #3a CAPACITY BUILDING OF COMMUNITY INSTITUTIONS

ACTION PLANS	FY 1999	FY 2000	FY 2001	FY 2002	TO-TAL
Village Health Management Teams (VHMTs) established and functioning	***15***	***30***	***30***	***8***	***83***
Panchayat members trained in using PLA methodologies	75	100	100	150	425
Panchayat members trained in KPC survey techniques and analysis	75	100	100	150	425
Panchayat members trained in effective use of data from CBDDS, including AFP surveillance	75	100	100	150	425
Panchayat members trained in developing 5-6 critical indicators that can be (i) visually represented, (ii) tracked regularly by themselves, (iii) result in action, and (iv) lead to improved health and decreased mortality of women and children	75	100	100	150	425
Panchayat members trained in developing Village Resource Development Plans (VDRPs)/Sustainability Action Plans	75	100	100	150	425
Panchayat members trained in facilitating social autopsies	75	100	100	150	425
Mahila Mandals revitalized and functioning	***15***	***30***	***30***	***8***	***83***
Mahila Mandal members trained in using PLA methodologies	45	90	90	30	255
Mahila Mandal members trained in KPC survey techniques and analysis	45	90	90	30	255
Mahila Mandal members trained to establish (with VHGs) two community-owned registers --Community EPI Register --Pregnancy Register	 ***15*** ***15***	 ***30*** ***30***	 ***30*** ***30***	 ***8*** ***8***	 ***83*** ***83***
Mahila Mandal members trained in CBDDS including AFP surveillance	15	60	90	90	255
Mahila Mandal members trained in promotion of household					

gardens growing vitamin A-rich vegetables	45	90	90	30	255
Mahila Mandal members trained in cooking and promoting appropriate weaning food recipes to mothers	45	90	90	30	255
Mahila Mandal members trained in promoting births spacing/modern methods of contraception	45	90	90	30	255
Mahila Mandal members participating in non-formal literacy programs	45	90	90	30	255
Trained Village Health Guides who are functioning	***15***	***20***	***20***	***27***	***82***
VHGs trained in using PLA methodologies for customer appraisal	15	20	20	37	82
VHGs trained in KPC survey techniques	15	20	20	27	82
VHGs trained to establish (with Mahila Mandal members) to establish two community-owned registers --Community EPI Register, --Pregnancy Register	 ***15*** ***15***	 ***30*** ***30***	 ***30*** ***30***	 ***8*** ***8***	 ***83*** ***83***
VHGs trained in IPC skills & face-to-face counseling skills		20	25	37	82
VHGs trained in role-modeling skills		20	25	37	82
VHGs trained in CBDDS, with initial emphasis on AFP surveillance		20	25	37	82
CAPACITY BUILDING OF COMMUNITY INSTITUTIONS (continued)	**FY 1999**	**FY 2000**	**FY 2001**	**FY 2002**	**TO-TAL**
Association for VHGs (AVHG) established and functioning in Beruar Beri Block		***1***			***1***
VHG networking meetings facilitated	2	3	3	3	11
VHGs sent on cross-visits to other RH/CS projects	5	5	5	5	20
Newsletters for VHGs documenting Lessons Learned/Best Practices in VHG RH/CS in Beruar Beri Block	1	2	3	4	10
Men's group (Parush mandal) members mobilized to promote active male involvement in birth spacing/family planning	30	40	60	60	170
Youth Club (Yuvak Mangal Dal/Nehru Youth Club) and NSS members mobilized and trained in CBDDS, with initial emphasis on AFP surveillance	***30***	***60***	***90***	***30***	***210***
Youth Club (Yuvak Mangal Dal/Nehru Youth Club) and NSS members trained in organizing village-based emergency transport schemes for obstetric emergencies	30	60	90	30	210
Families with WV sponsored children trained in CBDDS with initial emphasis on AFP surveillance	50	200	300	300	850
School teachers trained in CBDDS with initial emphasis on AFP surveillance		20	25	30	75
Annual contests held to promote ***Model/Healthy Child*** in • Each village • Beruar Beri Block	 15 1	 35 1	 65 1	 85 1	 200 4

The BRICS project will work with the village *panchayats* (leadership) to facilitate a smooth and phased implementation of the proposed capacity building activities PLA exercises, FGDs, key informant interviews and training needs assessments will be conducted in partnership with CMO and PHC/SC staff, local NGO staff and communities to decide on topics, content, methods and duration of training WHO, UNICEF and MOHFW will also be consulted in this participatory process A village resource development plan will be jointly facilitated with all project partners

Sustaining the Participation of Volunteers

BRICS plans the following initiatives to sustain the VHGs and other community volunteers and reduce their dropout and turnover

a) Upgrading knowledge and skills through cross-visits to other model CSPs in-country,
b) Selection, recognition and award-giving to the best VHGs/volunteer workers each year,
c) Ensuring that village *panchayats*, *parish mandals* and *mahila mandals* select the VHGs,
d) Establishing accountability relationships between the VHGs and their respective *panchayats*,
e) Arranging with PHC/SC staff and private practitioners to provide free medical treatment to VHGs/volunteers and their families,
f) Facilitating the formation of an association/cooperative of VHGs and establishing a revolving loan scheme for VHGs,
g) Training of VHGs in income-generation skills which will be jointly identified with them

F.4 Partnerships with Private Sector Health Providers

The project will conduct a baseline study on the quality of home and private practitioner case management of childhood illness in FY 2000 (please see section D and Annex 11 on this) The BRICS staff will meet with private practitioners to discuss ways to collaborate and to build their capacity CMO and PHC/SC staff and staff of the three local NGOs will be involved as resource persons and as trainers The VHAI group and SWACH will also be recruited as training organizations

A draft capacity building plan for private sector health providers is given below under sub-result #2c This will be reviewed and revised during the First Annual Review in September 1999

Sub-Result #2c CAPACITY BUILDING OF PRIVATE SECTOR HEALTH PROVIDERS

ACTION PLANS	FY 1999	FY 2000	FY 2001	FY 2002	TO-TAL
TBAs (Dais) equipped with TBA kits and functioning	***30***	***40***	***60***	***43***	***173***
Dais trained in clean delivery techniques (clean surface, clean hands & clean cord)	30	40	60	43	173
Dais trained in essential newborn care (management of asphyxia, hypothermia, low birthweight, exclusive breastfeeding)	30	40	60	43	173
Dais trained in screening and referring high-risk pregnant women	30	40	60	43	173
Dais trained in iron/folate distribution to pregnant women	30	40	60	43	173
Dais trained in CBDDS, including AFP surveillance	30	40	60	43	173
Dais trained in timely referral of obstetric emergencies	30	40	60	43	173
Dais trained in a new package on "Integrated approach in management of Cough or Difficult Breathing Diarrhea or Undernutrition in Young Children" (new package to be jointly developed & pilot-tested with WHO)		15	15	15	45
Dais trained in vitamin A supplementation of post-partum mothers (to be pilot-tested with MOHFW, DMS and UNICEF)		15	15	15	45

RMPs, Ayurvedic Practitioners, and Unani/ Homeopathic Practitioners trained in CBDDS, with emphasis on AFP surveillance		20	30	21	71
RMPs, Ayurvedic Practitioners, and Unani/Homeopathic Practitioners trained in quality case management of pneumonia and diarrheal diseases		10	15	20	45
Vendors mobilized to sell contraceptives (condoms/oral pills)	5	5	5		15

F 5 Partnerships with WV ADPs in Uttar Pradesh

To facilitate the multiplier vision and scale-up plan mentioned in sections E 1 and E 5, the BRICS project will embark on the following capacity-building action plans for staff of three WV India ADPs in UP State (please see map in Annex 1 for names/locations of the three ADPs)

The action plans are listed under sub-result #2d

Sub-Result #2d STRENGTHENING OF WV AREA DEVELOPMENT PROJECT(ADP) STAFF/PARTNERS IN FOUR ADPs IN UP STATE

ACTION PLANS	**FY 1999**	**FY 2000**	**FY 2001**	**FY 2002**	**TO-TAL**
ADP staff trained in ADP-sharing workshops on CBDDS/AFP surveillance	10	10	10	10	40
ADP staff trained in participating in "Lessons Learned " PHC-sharing seminars on the use of PLA methodologies for customer appraisal	10	10	10	10	40
ADP staff participating in "Lessons Learned " ADP-sharing seminars on KPC survey methodologies, findings and applications	10	10	10	10	40
ADP staff participating in "Best Practices" workshops on IMCI	10	10	10	10	40
ADP staff participating in "Best Practices" workshops on the RH/CS	10	10	10	10	40

G WORK PLAN

BRICS Project Year I Action Plan

Activity	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
HUMAN RESOURCES												
a Hire Project Manager	X											
b Hire other Key staff	X	X	X	X	X							
PROCUREMENT												
a Supplies	X	X	X	X	X	X	X	X	X	X	X	X
b Capital Expenditures		X	X	X								
MONITORING & EVALUATION												
a Design KPC (Sept 98)	(X)											
b Conduct KPC Survey		X										
c KPC Data Analysis			X	X								
d PLA	X											
e FGD	X		X									
f Key Inf Interviews				X								
g Design HFA							X	X				
h Conduct HFA							X	X				
i Design HIS					X	X						
j Routine Data collection and analysis						X	X	X	X	X	X	X
k Training & Testing of surveillance system						X	X					
l Development of Instruments for community surveillance with emphasis on AFP surveillance							X	X				
PARTNERSHIP LIAISON	X	X	X	X	X	X	X	X	X	X	X	X
a Meetings with Partners		X	X	X								
b Meetings with CMO/PHC							X	X	X	X	X	X
c NGOs network established	X	X	X	X	X	X	X	X	X	X	X	X
d Polio eradication network established with local NGOs	(X)					X	X	X	X	X	X	X
e Family Planning/ Spacing partnership established with SIFPSA												

STAFF DEVELOPMENT												
a CSP Orientation for staff	X					X						
b Team Building exercises			X									
c Accounts Training				X		X	X	X				
d CSP Component training for staff								X	X			
e Exposure trips (in country)					X			X				
f Exposure trip (International)												
TRAININGS												
a Gold standard for training/supervision reviewed							X	X	X	X	X	X
b Capacity building of CMO team				X	X	X	X	X	X	X	X	X
c Capacity building of PHC team				X	X	X	X	X	X	X	X	X
d Capacity building of Sub Center staff (ANMs)				X	X	X	X	X	X	X	X	X
e Capacity building of PHC team (indirect impact area)				X		X	X	X	X	X	X	X
f Capacity building of local NGOs		X				X	X	X	X	X	X	X
g Capacity building of private sector health provider				X		X	X	X	X	X	X	X
h Capacity building of people's organizations	X	X	X	X	X	X	X	X	X	X	X	X
TECHNICAL ASSISTANCE												
a Regional (Dr Chander)				X			X	X			X	
b Zonal (Dr Dutta)		X		X	X		X	X	X		X	X
c Others (Dr Anthony UNICEF)							X					
d Dr Nigam (IASD)						X						
e Dr Sheila Veir (UNICEF)						X						
f Dr Suresh Kumar												

(UNICEF)											X	
g Dr Stanley Foster (HFA)							X	X				
h Dr Sawat Ramaboot (WHO)												X
i Dr Neena Raina (SWACH)												X
j Mr David C Cantor Macro international (MIS)										X		
FIRST ANNUAL REVIEW												X

BRICS Year II Action Plan

Activity	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
STAFF DEVELOPMENT												
a Technical Trainings for staff	X		X		X	X	X		X		X	
b Exposure visits (in country)					X		X			X		
c Exposure visits (International)		X									X	
d Trainings/Workshop (International)												X
TRAININGS												
a Capacity building of CMO team	X			X			X			X		
b Capacity building of PHC team	X			X			X			X		
c Capacity building of Sub Center staff (ANMs)	X			X			X			X		
d Capacity building of PHC team (indirect impact area)	X			X		X		X		X		X
e Capacity building of local NGOs		X		X		X		X		X		X
f Capacity building of private sector health provider		X		X		X		X		X		X
g Capacity building of people's organizations		X		X		X		X		X		X

h Lesson learned/Best practices workshop for other ADPs and Partners											X	
OUTREACH												
a Outreach EPI Team	X	X	X	X	X	X	X	X	X	X	X	X
b Outreach Antenatal contacts	X	X	X	X	X	X	X	X	X	X	X	X
c Apex bodies formed	X	X	X	X	X	X	X	X	X	X	X	X
MONITORING & EVALUATION												
a Routine Data Collection and Analysis	X	X	X	X	X	X	X	X	X	X	X	X
b Mid Term Evaluation												X
PARTNERSHIP LIAISONS												
a Meetings of project advisory board	X	X	X	X	X	X	X	X	X	X	X	X
b Meetings with NGO partners	X		X		X		X		X		X	
c Meetings with district health units	X		X		X		X		X		X	X
TECHNICAL ASSISTANCE												
a Regional (Dr Chander)				X				X			X	
b Zonal (Dr Dutta)		X		X	X		X	X	X		X	X
c Others (Dr Anthony UNICEF)							X					
d Dr Nigam(IASD)						X						
e Dr Sheila Veir (UNICEF)						X						
f Dr Suresh Kumar (UNICEF)											X	
g Dr Stanley Foster(HFA)							X	X				
h Dr Sawat Ramaboot (WHO)												X
i Dr Neena Raina (SWACH)												X
j Mr David C Cantor Macro international(MIS)										X		

SUSTAINABILITY

H 1 Definition of Sustainability

World Vision agrees with Dr Stan Foster's definition of "developmentally-oriented" sustainability as the *"maintenance of individual, community, NGO, health system, private sector, and government* ***capacity to continue*** *essential promotive, preventive and case management services necessary* ***to achieve locally established targets*** *with the* ***minimal amount of external inputs"***

From World Vision's perspective, sustainability means that

i) skills transfer will have led partner institutions to acquire the resources and capacity to manage and deliver CS/RH services after the World Vision phases out or over,
ii) communities, families and individuals will have been empowered to institutionalize the adoption of essential health care-taking and health care-seeking behaviors,

From the program partners' perspective, sustainability means that they have the institutional, human (trained personnel), technical, material (logistics) and financial resources to fund, lead and manage CS/RH services,

From the perspective of beneficiaries, sustainability means that they are empowered to make decisions about their own health and take ownership of plans to improve and monitor their own health

Further discussion on sustainability is summarized in Annex 8 in the DIP Workshop Report

H 2 Sustainability Action Plan

H 2 1 The Project's sustainability goal

The project's sustainability goal is to improve the sustainability of the benefits of the child survival and reproductive services in Beruar Beri Block and Ballia district

The project has *six sustainability strategies* to achieve this goal

1) Transfer program responsibility steadily to indigenous players by facilitating consensus on sustainability goal and objectives,
2) Build public health sector capacity by equipping and training staff of the Ballia District CMO and PHC/SC staff in Beruar Beri Block and 16 other blocks in Ballia district in key technical/management skills,
3) Mobilize and strengthen entrepreneurship of key private sector actors in providing alternative CS services,
4) Strengthen community structures and build their capacity in CS/RH activities,
5) Promote self-financing of CS services through (a) Cost-recovery methods, (b) Resource generation methods, (c) Institute mechanisms to improve project cost-effectiveness, and
6) Initiate advocacy and policy formulation

These strategies are captured by the action plans and sub-result of the project's **Intermediate Result # 5** **Enhanced sustainability of child survival and reproductive health services and support systems**

To this end, a Block-level Sustainability Action Plan was developed as a follow-up to the DIP workshop in January 1999 with all public sector, private sector and community partners to jointly define the roles and contributions of partners and to develop sustainability objectives, benchmarks and indicators (see Annex 16 Sustainability Action Plan)

H 2 2 What the Program will Leave in Place

This is summarized in the Sustainability Action Plan (see Annex 16)

The BRICS Project will work with the village *panchayats* (leadership) to facilitate a smooth and phased implementation of the proposed capacity building activities PLA exercises, focus group discussions, key informant interviews and training needs assessments will be conducted in partnership with CMO and PHC/SC staff, local NGO staff and communities to decide on topics, content, methods and duration of training WHO, UNICEF and MOHFW will also be consulted in this participatory process A village resource development plan will be jointly facilitated with all project partners

Sustaining the Participation of Volunteers The BRICS Project plans the following initiatives to sustain the VHGs and other community volunteers and reduce their dropout and turnover

(a) Upgrading knowledge and skills through cross-visits to other model CSPs in-country,
(b) Selection, recognition and award-giving to the best VHGs/volunteer workers each year,
(c) Ensuring that village *panchayats*, parish mandals and *mahila mandals* select the VHGs,
(d) Establishing accountability relationships between the VHGs and their respective *panchayats*,
(e) Arranging with PHC/SC staff and private practitioners to provide free medical treatment to VHGs/volunteers and their families,
(f) Facilitating the formation of an association/cooperative of VHGs and establishing a revolving loan scheme for VHGs,
(g) Training of VHGs in income-generation skills which will be jointly identified with them

H 2 3 Financial Sustainability

At the end of 4 years of USAID/BHR/PVC funding, WV India plans to incorporate the CS/RH activities of the BRICS Project into the WV Ballia ADP for at least another 10 years, with private WV sponsorship funding through local fund-raising from individual sponsors, private companies and large corporations and from abroad This base funding of approximately $100,000 per year will ensure that the CS/RH benefits of USAID will be continued in Beruar Beri Block

The three partner NGOs have expressed interest in funding CS/RH interventions of their interest, which will be sealed in the form of resource commitments during the DIP workshop, when the SAP was finalized

The Ballia district CMO has committed itself to provide vitamin A for all children 9-35 months, but needs vitamin A supply for post-partum women The CMO also needs to ensure an uninterrupted supply of cotrimoxazole in the 3 PHCs and 15 SCs in Beruar Beri Block

It is envisaged that partnerships with local NGOs, GONGOs, the CMO, and technical agencies will allow more cost-sharing of at least 10% and help reduce the total program cost per beneficiary even further

The BRICS project will address the following issues

i) Financial Commitments of other organizations The Ballia Chapter of the Rotary Club has agreed to make a financial commitment to the Polio Eradication Network (the quantity will be decided at the DIP workshop), it is open to financing at least one additional CS or RH intervention after the polio eradication drive of Rotary by the year 2000 is completed WVUS is currently exploring Gifts-in-Kind (GIK) of vitamin A and cotrimoxazole from the United States

ii) Strategy for getting private sector support WV India has committed itself to raise up to 5% of the match from national resource mobilization efforts from the private sector The Kiwanis Club and the Ballia branch of the Indian Medical Association will also be approached to co-fund specific interventions Private pharmaceutical companies will be tapped to fund the sale of insecticide for the social marketing program for IMNs

iii) Improving Cost-Efficiency An integral part of the BRICS Project will be the rigorous tracking of costs and revenues, and relating them to program outputs and impact Annual budget reviews and budgeting exercises will be conducted Findings from the project's missed opportunity surveys will be shared with the BRICS core team, the local NGOs, and the CMO and PHC/SC staff, and action plans will be made accordingly to maximize CS/RH coverage and thereby reduce the cost per intervention/beneficiary even further The project will promote community advocacy to lobby for more rational resource allocation by the Ballia CMO for health promotion programs that focus on prevention of diseases, and thereby cut health care costs The BRICS Project will also train local NGOs and the CMO/PHC/SC staff to calculate costs per intervention beneficiary Once the community surveillance is installed, the project will begin to track the cost per death averted

iv) Cost-Recovery Methods The project will encourage the local NGOs involved in community-based distribution of contraceptives to charge a small fee for service

H 2 4 Process in Developing the SAP

This was initiated during the DIP workshop in January 1999 (see Annex 8 for report of DIP workshop) A small working group consisting of representatives of all partners was then convened to draft out the SAP over the next two weeks

I HUMAN RESOURCES

I.1 Organizational Chart

Please see Annex 17 for the updated organizational chart defining the relationships between the types of organizations, committees, and project staff

The BRICS core team consists of the following

Team Leader He will have management oversight of both the Ballia ADP team and the BRICS team The Team Leader's principal task will be to facilitate the strategic integration of both teams under the BRICS to ensure synergistic impact of CS/RH interventions and the development interventions in Beruar Beri Block He will ensure that the project will satisfy the high technical standards of both USAID and WVUS A statistical background and training in community health will be required He will also facilitate monitoring and evaluation of the Project

CSP Manager He will lead the BRICS team in the day-to-day implementation of the project He will supervise the work of the Technical Officer, the Monitoring and Evaluation Officer, the Training Officer and the Finance Officer He has several years of public health experience and has a Masters in Public Health

Technical Officer A medical doctor (MBBS) with a strong public health background who ensures that MOHFW policies, protocols and standards are attained and best practices are replicated He will supervise the ANMs who will be responsible to assist counterpart CMO and PHC/SC staff to assure the quality, coverage and impact of CS/RH services

Auxiliary Nurse Midwives (ANMs) They work with the PHC/SC ANMs responsible for providing CS/RH services in order to achieve project goals and maintain proper records and reporting system

Training Officer will be responsible for the capacity-building activities of the public sector, private sector, NGOs and the community organizations He will also coordinate other staff development activities of the Project He will be assisted by the Training Assistant

Monitoring and Evaluation Officer He will work with the District staff to establish the Health Information System (HIS) to track progress towards objectives He will also initiate the training modules for community-based disease and death surveillance, including AFP surveillance He will facilitate the launch the CQI initiatives of the project to monitor and improve program quality He will assist the CSP Manager in preparing the project technical report for submission to WV headquarters and USAID/BHR/PVC

Finance/Administrative Coordinator He is trained in USAID grant accounting and compliance and SunSystems He will report to the CSP Manager and will be responsible for financial management and ensure with WVUS's Finance Officer that project reporting standards and datelines are met according to USAID regulations

Development Coordinator will be responsible to mobilize and initiate with project partners the following (a) micro enterprises development (MED) component, and (b) facilitating the transfer of leadership, management, technical, fund-raising skills of partners, leading to the achievement of project sustainability indicators and project objectives

Accountant He will be responsible to keep all records of financial transactions

Administrative Assistant will be responsible for all clerical assistance required, quarterly newsletter, and file management

Field Staff There are 17 community development organizers (male and female) resident in the villages

Drivers are responsible for monitoring project jeeps, maintenance of office equipment, premises and surroundings

I 2 Working Relationships with Health Staff

The project will support the work of various PHC/SC staff and private sector health providers The 83 VHGs, one in almost each village, are volunteer health workers offering service for 4-10 hours weekly on average They have been trained and are supervised by ANMs from the SCs to provide health and ORT education to the community, identify children for immunization, refer pregnant women for TT immunization and prenatal care, and promote best practices in infant feeding A VHG is responsible for an average of 1000-1400 people in a village Some VHGs are also TBAs, or *dais*, who number 173 Most of them have not been trained in clean delivery techniques The project plans to work with the SC-based ANMs to train and equip these TBAs with TBA kits

The 15 SCs are staffed by an ANM and multipurpose workers who are primarily involved in malaria control activities ANMs have 3 years' midwifery training and they provide midwifery services, TT immunization for pregnant women, immunization for infants and vitamin A supplements to children 9-35 months, prenatal and post-natal care, family planning services and reporting of SC activities They are paid by the MOHFW and are full-time ANMs report either to a Senior ANM or LHV who are based in the PHC One ANM serves an average population of 8000 people

The 3 PHCs are each staffed by a full-time government-paid doctor, a LHV and a senior ANM The PHC staff provide basic clinical care and CS/RH services, including IUD insertions and clinical contraception On average, a LHV or senior ANM supervises 5 SC-based ANMs Each PHC serves an average of 40,000 people In addition, the Ballia District CMO office of 12 staff (including the CMO, Deputy CMO/District Immunization Officer, Statistician and District Malaria Officer) provide supervision to all PHC staff in Ballia district

This information is summarized in the table below

Type of worker (number)	Affiliation	paid/ volunteer	duties	time devoted
State MOH (Uttar Pradesh)	State Govt	Paid by Govt	Administrative Supervision and State level policy making	20%
District level Health officers (12)	"	"	Administrative supervision and implementation of government health policy	75%
PHC Medical Officer (3)	"	"	primary health care at block level	80%
Animas (Auxiliary Nurse Midwives) (15)	"	"	ANC, Immunization, Birth Spacing, deliveries at SC-level	100%
Health Inspector (2)	"	"	Field Supervision	100%
EPI Officer (1)	"	"	Immunization data and statistics compilation	100%
Basic Health Worker (6)	"	"	part time worker providing health education	100%
Lady Health Visitor (2)	"	"	Supervision of ANMs	100%
Male Supervisor (2)	"	"	Supervision of the work of basic health worker	50%
Health Assistant (4)	"	"	Health Education	50%

N B This includes only direct impact area (Beruar Beri Block) and not the indirect impact area (remaining 16 Blocks of Ballia District),

I.3 Ratio of Health Workers to Beneficiaries

The ratio of all government health workers to the number of beneficiaries in the direct impact area (Beruar Beri Block) is very low—(150,000/350 health personnel to 428 beneficiaries) The number of health personnel (350) includes the PHC/SC staff as shown in the above table, as well as 83 VHGs, 173 TBAs, and the 71 local RMPs

I.4 Program Strategy for BRICS Staff

This will include the following_

1 The CSP Team Leader and the Finance/Administrative Officer (along with the WV India North Zone Office accountant) participated in a training workshop in New Delhi in March

1999 in USAID grant accounting procedures and regulations It was facilitated by a USAID consultant

2 The CSP Manager and one Deputy CMO participated in the SEATS Workshop in Bangladesh in February 1999 The one-week workshop focused on the integration of Family Planning services into CS programs The CSP Manager remained for another week to participate in the TOT workshop,

3 The CSP Team Leader participate in 10-day public health management course in the Indian Institute of Management in Bangalore

4 The entire core team were trained in

a) conducting KPC surveys using customized questionnaires/methodologies field-tested by PVO CSSP of JHU by Dr Mary Lou Rorabaugh (JHU-certified KPC Survey Trainer) in KPC survey tools and techniques (November 1999),

b) the use of PLA exercises for customer appraisal and for facilitating community counterparts to develop village resource development plans, in October 1998 by a PLA trainer from the WV India North Zone Office,

c) developing a Detailed Implementation Plan and Sustainability Action Plan,

5 The entire core team will be trained in health facility assessment using the PVO CORE module on NGO assessment of health care facilities by Dr Stan Foster of Emory University in April/May 1999, an MPH student from Emory University's Rollins School of Public Health will assist as intern,

6 Two staff (CSP Leader and CSP Manager) will participate in the World Vision Asia-Pacific Regional Workshop on QA/CQI in December 1999, to be hosted by the USAID/BHR/PVC-funded Kean Svay Child Survival Project in Cambodia,

7 The entire core team will receive refresher's training in developing core competency in quality improvement and impact monitoring of CS/RH services in the following areas

a) in building team exercises/approaches to problem identification and problem solving,

b) in using QI assessment tools and problem-solving tools such as the use of on-site supervisory checklists, exit interviews, and in sending the best-performing health service providers to work with lesser performing health service providers for a short period,

c) in conducting missed opportunity surveys for CS/RH interventions, (g) assessing customers' timeliness of immunization-seeking behaviors and treatment-seeking behaviors for major childhood killers (pneumonia, diarrheal dehydration, malnutrition),

d) assessing the extent of immunization drop-outs/left-outs among eligible customers,

e) in conducting LQAS (Lot Quality Assurance Sampling),

f) in standard case management of pneumonia and diarrheal diseases and in IMCI,

g) COPE (Client-Orientated Provider Efficient) exercises to improve the quality of reproductive health services,

h) in monitoring/documenting impact of CS/RH services through the field-testing and institutionalizing of customer-driven disease and death surveillance for EPI diseases (for polio, neonatal tetanus and measles), with initial emphasis on AFP surveillance, and in conducting death investigations of neonatal, child and maternal deaths,

i) in training of trainer (TOT) and facilitation skills, and in inter-personal communications skills,

j) in cross-visits to other USAID-funded CSPs in India and to WV Bangladesh's Chittagong CSP,

k) in networking skills to build strategic alliances with counterpart institutions,
l) Two key staff will participate in the Global Health Council (formerly NCIH) conference in Washington DC in the third year Technical assistance will be obtained from WVUS, the WV/APRO, WHO, UNICEF, MOHFW, AVSC International and other in-country consultants

I.5 CVs/Resumes of Key PVO Headquarters Staff/In-Country Program Staff (see Annex 15)

Dr Sri Chander, MBBS, MPH, WV Asia-Pacific Regional Health Advisor, will provide regional technical backstopping to the project He will visit the project four times in the first year (DIP workshop, Health Facility Assessment Survey, Integration Workshop, and First Annual Review) and subsequently three times each year for the remaining three years Dr Fe Garcia MD, MPH, WVUS's Team Leader for Asia-Pacific, will be the principal headquarters technical backstopper She will visit the project at least once a year Ms Tracy Stueve, WVUS's Finance Officer, will provide the financial support to the project and ensure the project's compliance with USAID grant regulations She will visit the project in the first year to provide refresher training in USAID grant accounting systems for the project's Finance/Administrative Officer and the WV India Delhi North Zone Accountant Their CVs are appended (Annex 15)

The duration of Dr Chander's visit will 7 days on average, for years 2, 3, and 4, he will participate in the Midterm Evaluation, Third Annual Review, the Final Evaluation, as well provide technical assistance in CQI, CBDDS, and design of training curricula

J MONITORING AND EVALUATION

J 1 Monitoring and Evaluation Plan

The project will assist the Ballia district CMO to develop a strong Health Management Information System (HMIS) guided by 3 principles (1) avoid duplication of data collected, (2) collect data that can be use for immediate decision-making by the health worker who collects it, and (3) assist in prompt analysis and feedback to communities

J 1 1 Monitoring the Impact *of CS/RH Interventions*

The BRICS project will evaluate the accomplishment of its strategic objective with the following impact indicators which reflect the Ballia District benchmarks which have been adjusted from the national and UP state targets set by the MOHFW for the year 2003

Impact Indicator #1 Reduction of Total Fertility Rate from 4 3 to 3 6 children born to a woman who lives up to 45 years
Measurement Method NFHS,
Data Collectors NHFS enumerators (MOHFW),
Data Source Women 15-45 years,
Frequency of Data Collection every five years (for NFHS),

Impact Indicator #2 Reduction of Under-5 Mortality Rate from 143/1000 live births to 115/1000 live births
Measurement Method NFHS, pilot-testing community-based death surveillance focusing on investigations of deaths in the children 0-28 days, children 1 month to 59 months,
Data Collectors NHFS enumerators (MOHFW), Community/NGO (CBDDS)
Data Source Families with children under 5 years sampled by NFHS, Pilot CBDDS
Frequency of Data Collection every five years (for NFHS), on-going (CBDDS)

Impact Indicator #3 Reduction of Infant Mortality Rate from 99 5/1000 live births to 75/1000 live births
Measurement Method National Health Family Survey (NFHS), pilot-testing CBDDS focusing on investigations of deaths in children 0-28 days, children 1 month to 59 months
Data Collectors NHFS enumerators (MOHFW), Community/NGO (CBDDS),
Data Source Families sampled under NFHS, pilot CBDDS, Community Pregnancy Register,
Frequency of Data Collection every five years (for NFHS), on-going (CBDDS)

Impact Indicator #4 Reduction of Maternal Mortality Ratio from 570/100,000 live births to 400/100,000 live births
Measurement Method National Health Family Survey (NFHS), pilot-testing CBDDS focusing on investigations of deaths in women 15-45 years,
Data Collectors NHFS enumerators (MOHFW), Community /NGO (CBDDS)
Data Source Families sampled under NFHS, pilot CBDDS, Community Pregnancy Register
Frequency of Data Collection every five years (for NFHS), on-going (CBDDS)

Impact Indicator #5 Prevalence of reported case-based Acute Flaccid Paralysis (AFP) reduced to zero
Active community and institutional surveillance, with zero reporting
Data Collectors PHC/SC staff (MOHFW), Community/NGO (CBDDS)
Data Source PHC/SC staff (institutional surveillance), pilot CBDDS
Frequency of Data Collection zero-reporting of AFP by PHC/SC staff, on-going zero-reporting by community (CBDDS)

Impact Indicator #6 Reduction in night blindness in children 9-35 months from a baseline 2 97% to under 0 1%,
Measurement Method Nightblindness survey during vitamin A distribution rounds
Data Collectors PHC/SC staff (MOHFW), Community, BRICS staff, NGO staff
Data Source PHC/SC staff (institutional surveillance), pilot CBDDS
Frequency of Data Collection six-monthly vitamin A distribution rounds

Impact Indicator #7 Reduction in the percentage of children 0-23 months who are moderately or severely wasted *(i e who fall below -2 Z score from the median weight for age of NCHS/WHO reference population)* from a baseline 43% to under 30%,
Measurement Method Sample nutrition survey of children 0-23 months,
Data Collectors outside agency (VRIDDHI),
Data Source nutrition sample survey enumerators,
Frequency of Data Collection baseline, mid-term, and final evaluations

Pilot Community-Based Disease and Death Surveillance

The project will pilot-test with the MOHFW, WHO and UNICEF a prototype module on community-based surveillance of (a) childhood diseases (polio, measles and neonatal tetanus) with initial focus of AFP surveillance, and (b) deaths in neonates (0-28 days), children 1-59 months, and women 15-45 years This module will initially be tested in Beruar Beri Block, and then in the remaining 16 blocks of Ballia District After refinements, the use of this pre-tested module will be replicated in the 3 WV ADP sites in northern UP state, followed by up-scaling to all 100 WV India ADP sites, with potential impact population of 10 million people The project will draw from lessons learned in community surveillance from its USAID-funded CSPs in Bangladesh, Cambodia and Indonesia

The BRICS will not be creating a whole new HMIS, but will complement the national, state and district and block level surveillance, which is primarily institutional surveillance and heavily focused on AFP currently (please see annex V 11 current status in AFP surveillance (with maps) in India) The project will undertake with its partners the following steps in developing the CBDDS (see community surveillance forms in Annex 13, for "Steps in Community Surveillance" Annex 13 also includes the Data Flow Diagram for Community Surveillance)

Death Reporting The first contact worker (VHG, TBA, AWW or SC-based ANM) will report immediately any deaths to the PHC LHV, who will conduct a verbal autopsy/death investigation to determine the cause of death The BRICS project's LCOs will be trained to obtain notification of deaths in under-5 children and women 15-45 years from *panchayat*/religious leaders daily Any deaths will be reported immediately to the LHV The BRICS project will liaise with the Ballia District Hospital to obtain death notification among under-5 children and women 15-45 years from Beruar Beri block It will also arrange for maintenance of line listing of all neonatal, child and maternal deaths to facilitate summary and to prevent double-counting The project will discuss with community and NGO partners on possible strategies to raise the proportion of

neonatal, child and maternal deaths captured by the death surveillance system Annex 13 provides copies of community surveillance forms/algorithms

The project will also facilitate more effective use of surveillance data at

i) *the community level*--e g if there is a diarrheal or pneumonia death or neonatal tetanus death or maternal death, target all pregnant women in the cluster/compartment for intensive health education regarding ORT, pneumonia recognition and referral, TT or family planning/spacing,
ii) *program level*--map the geographical distribution of all identified neonatal, child and maternal deaths,
iii) *strategic/planning level*--recommend family planning as the single most important intervention to reduce neonatal mortality

J 1 2 Monitoring Coverage *of CS/RH interventions*

From the baseline, through the DIP (January 1999), the First Annual Review, (September 1999), the Midterm Evaluation (September 2000), the Third Annual Review (September 2001) and the Final Evaluation (September 2002), the project will track coverage indicators to track progress the towards achieving the EOP targets and annual benchmarks of the intervention-specific objectives listed in section C 1 (please see Annex 18 for list of indicators tracking Impact and Coverage of CS/RH Interventions)

The intervention-specific CS/RH coverage objectives are given below under **Sub-Result #1**

Sub-Result #1a Increased Coverage of Essential Care of the Sick Child (30% of IR #1 Effort)
Pneumonia Case Management (15%)
70% of mothers/caretakers would be able to recognize at least two danger signs (cough and rapid or difficult breathing) of pneumonia that call for immediate referral and treatment (FY 99 65 %, FY 2000 65%, FY 2001 65%, FY2002 70%,), *(Indicator Proportion of mothers/caretakers able to recognize at least two danger signs of pneumonia that call for immediate referral and treatment,* *Measurement methods KPC survey* *Data collectors Enumerators of KPC survey* *Data source sample survey of women with children 0-23 months,* *Frequency of data collection Baseline mid-term, and final evaluations*
65 % of mothers/caretakers would have sought appropriate antibiotic treatment for their children under 24 months with cough and rapid or difficult breathing in the past two weeks (FY 99 65%, FY 2000 65%, FY2001 65%, FY2002 65%,), *(Indicator Proportion of mothers/caretakers who sought appropriate antibiotic treatment for their children under 24 months with cough and rapid or difficult breathing in the past 2 weeks)* *Measurement methods KPC survey* *Data collectors Enumerators of KPC survey* *Data source sample survey of women with children 0-23 months,* *Frequency of data collection Baseline mid-term, and final evaluations*
Pneumonia Case Management
55% of children 0-23 months diagnosed as pneumonia would have been appropriately treated with antibiotics (FY 99 10% FY 2000 25%, FY2001 40% FY2002 55%) *(Indicator Proportion of children 0-23 months diagnosed with pneumonia who were treated with antibiotics according to standard case management protocol)* *Measurement methods Baseline assessment of case management practices use of on-site observation checklists exit interviews*

Diarrhea Case Management
40% of children 0-23 months with diarrhea in the past two weeks were treated with ORT (FY 99 20% FY 2000 25%, FY 2001 30% FY2002 40%) *(Indicator Proportion of children 0-23 months with diarrhea in the past 2 weeks who were treated with ORT),* *Measurement Method KPC Survey* *Data collectors Enumerators of KPC survey* *Data source sample survey of women with children 0-23 months* *Frequency of data collection Baseline mid-term and final evaluations*
50% of children 0-23 months with diarrhea in the past two weeks were given the same amount or more fluids other than breast milk (FY 99 20%, FY 2000 30%, FY 2001 40%, FY2002 50%), *(Indicator Proportion of children 0-23 months with diarrhea in the past two weeks who were given the same amount or more fluids other than breast milk)* *Measurement Method KPC Survey* *Data collectors Enumerators of KPC survey* *Data source sample survey of women with children 0-23 months* *Frequency of data collection Baseline mid-term and final evaluations*
40% of children 0-23 months with diarrhea in the past two weeks were given the same amount or more food (FY 99 25%, FY 2000 30, FY 2001 35%, FY2002 40%,) *(Indicator Proportion of children 0-23 months with diarrhea in the past two weeks who were given The same amount or more food)* *Measurement Method KPC Survey* *Data collectors Enumerators of KPC survey* *Data source sample survey of women with children 0-23 months* *Frequency of data collection Baseline mid-term and final evaluations*

Sub-Result #1b Increased Coverage of Essential Care of the Newborn(5% of IR #1 Effort)
40% of post-partum mothers were trained in care of their newborn (hypothermia prevention, low birth weight management, and establishment of exclusive breastfeeding) (FY 99 5%, FY 2000 15 % FY 2001 25%, FY2002 40%), *(Indicator Proportion of post-partum mothers who were trained in care of their newborn hypothermia prevention low birth weight management, and establishment of exclusive breastfeeding)* *Measurement Method KPC Survey* *Data collectors Enumerators of KPC survey* *Data source sample survey of women with children 0-23 months* *Frequency of data collection Baseline mid-term and final evaluations*

Sub-Result #1c Increased Coverage of Immunization (15% of IR #1 Effort)
50% of children (12-23 months) would have been fully immunized before their first birthday (FY 99 30%, FY 2000 35% FY 2001 40%, FY2002 50%), *(Indicator Proportion of children (12-23 months) who have received card-documented doses of BCG, OPV3 DTP3 and measles vaccines before age 12 months)* *Measurement Method KPC survey* *Data collectors Enumerators of KPC survey* *Data source sample survey of women with children 0-23 months Reproductive & Child Card (annex V 12)* *Frequency of data collection Baseline mid-term and final evaluations*
35% of mothers would have received two doses of tetanus toxoid (TT2) before the birth of her youngest child less than 24 months, (FY 99 10% FY 2000 15%, FY 2001 25%, FY2002 35%,), *(Indicator Proportion of mothers would have received two card-documented doses of tetanus toxoid (TT2) before the birth of her youngest child less than 24 months)* *Measurement Method KPC survey*

Data collectors *Enumerators of KPC survey* *Data source* *sample survey of women with children 0-23 months, Reproductive & Child Card (annex V 12)* *Frequency of data collection* *Baseline, mid-term, and final evaluations*

Sub-Result #1d Prevention of Malnutrition and Vitamin A Deficiency (15% of IR #1 Effort)
90% of infants 0-4 months exclusively breastfed in the last 24 hours (FY 99 80%, FY 2000 80%, FY 2001 85%, FY2002 90%), *(Indicator* *Proportion of infants 0-4 months exclusively breastfed in the last 24 hours* *Measurement method* *KPC Survey* *Data collectors* *Enumerators of KPC survey* *Data source* *sample survey of women with children 0-23 months,* *Frequency of data collection* *Baseline mid-term and final evaluations*
45% of infants 5-9 months are given solid or semi-solid foods (FY 99 30%, FY 2000 35 %, FY 2001 40 %, FY2002 45%), *(Indicator* *Proportion of infants 5-9 months who are being given solid or semi-solid foods)* *Measurement method* *KPC Survey* *Data collectors* *Enumerators of KPC survey* *Data source* *sample survey of women with children 0-23 months* *Frequency of data collection* *Baseline, mid-term, and final evaluations*
90% of children 9-35 months will have received vitamin A doses semi-annually, (FY 99 60%, FY 2000 70 %, FY 2001 80 %, FY2002 90 %), *(Indicator* *Proportion of children 9-35 months who received appropriate card-documented doses of vitamin A in the last six months)* *Measurement Method* KPC survey, community registers of vitamin A distribution rounds, child growth cards *Data collectors* *Enumerators of KPC survey* *Data source* *sample survey of women with children 0-23 months* *Frequency of data collection* *Baseline mid-term and final evaluations*
30% of postpartum mothers would have received one high-dose vitamin A supplement within 4 weeks of delivery (FY 99 5%, FY 2000 10 %, FY 2001 20 %, FY2002 30 %), *(Indicator* *Proportion of postpartum mothers who received one card-documented high-dose vitamin A supplement within 4 weeks of delivery)* *Measurement Method* *KPC survey, maternal cards, TBA records* *Data collectors* *Enumerators of KPC survey* *Data source* *sample survey of women with children 0-23 months, maternal cards, TBA records,* *Frequency of data collection* *Baseline, mid-term, and final evaluations*
Sub-Result #1e Improved Reproductive Health Coverage (30% of IR #1 Effort)
At least 40 of 83 target villages would have functioning village-based emergency transport schemes for obstetric emergencies (FY 99 5 villages, FY 2000 15 villages, FY 2001 30 villages, FY2002 40 villages), *(Indicator* *Number of target villages which have functioning village-based emergency transport schemes for obstetric emergencies)* *Measurement Methods* *Community/BRICS staff reports, on-site visits, key informant interviews,* *Data collectors* *BRICS staff* *Data source* *youth groups mahila mandals* *Frequency of data collection* *Baseline first annual mid-term third annual and final evaluations*
20% or under of women with children less than 24 months reported at least one un-intended pregnancy in the last 12 months (FY 99 35% FY 2000 30 % FY 2001 25%, FY2002 20%) *(Indicator* *Proportion of women with children less than 24 months who reported at least one unintended pregnancy in the last 12 months)* *Measurement Methods* *KPC survey*

Data collectors *Enumerators of KPC survey* *Data source* *sample survey of women with children 0-23 months maternal cards TBA records* *Frequency of data collection* *Baseline mid-term and final evaluations*
20% of mothers with children less than 24 months who desire no more children in the next two years, or are not sure, will be using modern contraceptive methods, (FY 99 10%, FY 2000 12%, FY 2001 15% FY2002 20%), *(Indicator* *Proportion of women with children less than 24 months who desire no more children in the next two years or are not sure who are using modern contraceptive methods)* *Measurement Methods* *KPC survey CBD register PHC/SC /ANM records*
35% of women who delivered their youngest child in the last one year would have received at least 90 iron/folate tablet supplements during their last pregnancy, (FY 99 10%, FY 2000 15% FY 2001 25% FY02 35%), *(Indicator* *Proportion of women who delivered their youngest child in the last one year who received at least 90 iron/folate tablet supplements during their last pregnancy)* *Measurement Methods* *KPC survey review of pregnancy tracking forms/maternal cards mahila mandal records* *Data collectors* *Enumerators of KPC survey* *Data source* *sample survey of women with children 0-23 months maternal cards TBA records* *Frequency of data collection* *Baseline mid-term and final evaluations*
35% of mothers had at three or more antenatal visits before the delivery of her youngest child less than 24 months, (FY 99 5%, FY 2000 15%, FY 2001 25%, FY2002 35%), *(Indicator* *Proportion of mothers who had at three or more card-documented antenatal visits before the delivery of her youngest child less than 24 months)* *Measurement Methods* *KPC survey review of pregnancy tracking forms/maternal cards* *Data collectors* *Enumerators of KPC survey* *Data source* *sample survey of women with children 0-23 months maternal cards TBA records* *Frequency of data collection* *Baseline mid-term and final evaluations*
25% of deliveries in the last 12 months would have been attended by a trained health provider or PHC/ Sub-center ANM/staff (FY 99 18%, FY 2000 20%, FY 2001 22% FY2002 25%), *(Indicator* *Proportion of deliveries in the last 12 months who have been attended by a trained health provider or PHC/ Sub-center ANM/staff)* *Measurement Methods* *KPC survey, review of pregnancy tracking forms/maternal cards* *Data collectors* *Enumerators of KPC survey* *Data source* *sample survey of women with children 0-23 months maternal cards TBA records* *Frequency of data collection* *Baseline mid-term and final evaluations*

Village-owned EPI/Pregnancy Registers

The BRICS project will facilitate community empowerment by introducing village-owned health registers which will enroll eligible women, children, and newborns to enter and participate in the program Together with PHC/SC staff, BRICS staff will facilitate and train the *mahila mandals* and VHGs to adapt and adopt two innovative village-owned registers from the USAID/BHR/ PVC-funded Kean Svay Child Survival Project of WV Cambodia They have been very useful in the community and very effective in increasing CS/RH coverage of eligibles Dr Stan Foster of Emory University has declared the village EPI register as the "World's Best Buy" for immunization recording systems

The two village-owned registers are the

i) Community EPI (Immunization) Register, (Annex 13)
ii) Community Pregnancy Register (Annex 13)

Locally available register books will be used Please see section E 1 for descriptions of these registers

Village-based HIS

In addition, the project will also assist the village *panchayats/mahila mandals* to choose 5-6 critical indicators that can be (i) visually represented, (ii) tracked regularly by themselves, (iii) result in action and (iv) lead to improved health and decreased mortality of women and children

a) Women's age at first birth--indication of pre-birth interval (women's age at first birth minus women's age at marriage)--to promote community/social norms for delayed age of marriage, longer pre-birth and birth intervals, and need for family planning/spacing,
b) Percentage of active users of modern contraceptive methods (temporary/permanent),
c) Pregnant women--identification for TT, prenatal care, and tracking of pregnancy outcome and post-partum Vit A supplementation,
d) Measles coverage of children aged 9-35 months--to identify leftouts and refer them for measles immunization,
e) Percent of newborns who are of low birth weight (<2500 gm at birth), to target their mothers for breastfeeding and intensive education in best practices in infant feeding and weaning,
f) Percent of girls finishing primary school,

For program management at PHC, SC or village level, BRICS will assist PHC/ANC staff to be coverage-oriented in micro-levels by focusing on 'spot maps' and graphs for visual representation of aggregate data on coverage, (rather than just on listings and registers of children immunized or given vitamin A or of women given TT or prenatal care)

J 2 Data Management

This has been described in section J 2 above All surveillance data and coverage data will inputted into the computer Back-up diskettes of all data files will be kept in a secure, locked cupboard along with all hardcopies of data, to ensure their confidentially The project will need the technical assistance of the monitoring and evaluation officer of the WV Bangladesh team in the USAID-funded Quality Improvement Project to establish a data quality control system and to provide training in EPI-Info data entry and analysis

J 3 Data analysis, use and dissemination

Data analysis

KPC data will be analyzed both by manual tabulation as well as by using EPI-INFO Surveillance data will also be analyzed using EPI-Info software

Data Use

This is described in sections J 1 and J 2

In addition, the BRICS project will also facilitate baseline training needs assessments of all target trainees along with a cold chain survey and facility needs assessment of the PHCs and SCs

Information from qualitative and quantitative baselines will be used to (a) identify the knowledge-practice gap for essential household behaviors, (b) design appropriate audience-specific behavior change communications messages, materials and strategies to overcome these knowledge-practice gaps, (c) design training curricula and materials, (d) improve the vaccine cold chain, (e) enhance the quality of training, supervision, information and service, and to (f) revise the end-of-project targets and annual benchmarks for each of the intervention-specific coverage objectives

Data Dissemination

Data will be presented at "Less Learned/Best Practices" workshops for the indirect impact area and WV ADP sites in UP State, and at national, regional (e g WV Asia-Pacific Regional QA/CQI Workshop in Cambodia) and international conferences (e g Global Health Conferences)

To raise US Public Awareness, WVUS will embark on the following

a) The WVUS marketing department will inform individual North American sponsors of WV-sponsored children in Ballia ADPs about USAID/BHR/PVC's Child Survival Grants Program and explain how low cost-per-beneficiary CSPs can make such impact in reducing infant, child and maternal mortality Case studies will be highlighted
b) Present to the US Congress evidence on the cost-effectiveness of BHR/PVC CSPs, just as Ms Penny Altman of PVO CSSP/JHU did of the WV India Navapur CSP a two years ago,
c) Feature USAID/BHR/PVC-funded CSPs in the WVUS Magazine, which has a circulation of 140,000,
d) Write and publish monographs on best practices and lessons learned from USAID-funded CSPs among the donor community, US Congressmen, Senators, prominent mayors and institutions

J 4 Monitoring and Improving Performance, Quality and Coverage

The project facilitate partner staff to (a) make more use of exit interviews, as they are an important tool for quality improvement, (b) arrange for the best workers to work with the less-performing workers for one week, (c) use monthly meetings with TBAs, VHGs, AWWs, *Parush mandals*, *mahila mandals* and *panchayats*, to discuss ways to improve the quality of training, supervision and service The project will tap WV Bangladesh's USAID-funded Quality Improvement Partnership to pre-test and develop a CQI Training Manual for local NGOs

Listed below are the Sub-Results and Action plans of **Intermediate Result #4** ***Improved quality of training, supervision, information and service, leading to raised customer satisfaction.***

Sub-Result #4a *CONTINUOUS QUALITY IMPROVEMENT INITIATED*

ACTION PLANS	FY 1999	FY 2000	FY 2001	FY 2002	TO-TAL
Health Facility Assessment (with Dr Stan Foster)	1				1
Center of Excellence established in Beruar Beri Block for					
• Quality case management of pneumonia			1		1
• Quality case management of diarrheal diseases			1		1
• Integrated management of childhood illnesses (IMCI)				1	1
Reviews for gold standards for training & supervision for					
• Child survival (CS) interventions	1				1
• Reproductive health (RH) interventions	1				1
Workshops for finalization of technical guidelines for					
• Child survival interventions	1				1
• Reproductive health interventions	1				1
Development of CS/RH standards & protocols for incorporation into materials & course design for					
• training & supervision	2	2			4
• service delivery	2				2
• evaluation			2		2
Adaptation/development of a PLA manual for customer appraisal for					
• PHC/sub-center staff		1			1
• NGO staff		1			1
Adaptation/development of IPC skills and face-to-face counseling skills training module for					
• ANMs		1			1
• AWWs		1			1
• NGO staff			1		1
• Village Health Guides			1		1
Adaptation/development of KPC survey manual for NGO staff		1			1
Adaptation/development of CQI/QA training modules using team approaches to build capacity in CQI/QA for CMO staff/PHC staff		1			1
Adaptation/development of Quality of Care (QOC) supervisory instruments for RH/CS interventions	1	2			3
Adaptation/development of instruments for CMO staff/PHC staff and ANMs for					
• Missed Opportunity Surveys for CS/RH interventions		3			3
• Assessing customers' timeliness of immunization-seeking & treatment-seeking behaviors for major child killer diseases		3			3
• Assessing extent of immunization left-outs/drop-outs		1			3
Development of instruments to assess extent of completed obstetric and family planning/birth-spacing referrals	1	1			2
Pilot-testing/development (with WHO) of new training package for *Dais* on "Integrated approach in management of Cough or Difficult Breathing, Diarrhea or Undernutrition in Young Children"		1			1
Adaptation/development of instruments for CBDDS, with initial emphasis on AFP surveillance	1				1

To help improve the quality of the cold chain the project will use (see Annex 19 for EPI forms)

- Protocol to monitor/record vaccine temperatures twice daily in the refrigerator,
- Supervisory checklist for cold chain monitoring,
- The quality of immunization sessions will be monitored using the EPI session supervisory checklist,
- To identify and minimize missed opportunities for immunization, the project will use a form to Identify Missed Opportunities for Immunization,
- To improve the competency of mothers and caretakers in ORT preparation and administration, the project will use ORT Competency checklist (see Annex 20 for treatment checklists and algorithms)

To improve the quality of training and supervision for case management of pneumonia, diarrhea and undernutrition in an under-5 child, the BRICS project will promote the use of the following

- Checklist for Monitoring Assessment, Classification, Treatment of Integrated ARI/CDD/ Under-Nutrition Skills Training of Basic Health Workers,
- Algorithm for AWWs/ANMs to Assess, Classify and Identify Treatment of a Child with Cough or Difficult Breathing, Diarrhea, or Under-nutrition,
- Algorithm for AWWs/ANms on age-specific feeding recommendations,
- Sheet on Counsel The Mother on Feeding/Growth Chart/Assess Feeding,
- Algorithm on solving feeding Problems

See Annex 20 for copies of these tools

K BUDGET

Please refer to the revised budget in Annex 30

L REFERENCE MATERIALS (see Annex 29 for list of technical references used in the development of this DIP

M DETAILED PLANS BY INTERVENTION

M 1 IMMUNIZATION

M 1 1 Incidence and Outbreaks

In Ballia District, neonatal tetanus accounts for 10% of neonatal mortality, and measles accounts for 5 2% of post-neonatal infant deaths and 9 5% of all under-5 deaths Ballia district was one of the 11 districts in eastern UP where a recent (April-July 1997) outbreak of polio saw a total of 203 reported cases of AFP AFP prevalence is estimated at 1/150,000 population with Ballia district averaging an expected reported 6-7 AFP cases annually (UNICEF/1997)

M 1 2 Baseline Coverage Estimates

a) The November 1998 KPC Survey (please see separate KPC survey report) revealed the following

Childhood Immunizations

- Only 53 5% (69/134) of children 12-23 months had an EPI card, and mothers of another 34 3% (46/134) of these children had lost their children's EPI cards,
- 39 1% (27/69) of those 69 children 12-23 months with cards have been fully immunized before their first birthday,
- However, only 20 9% (28/134) of all 134 children 12-23 months had card-documented coverage of all the six EPI vaccines before their first birthday,
- Only 27 6% (37/134) of children 12-23 months received a card-documented measles vaccine dose by their first birthday,
- 53 6% (37/69) of children 12-23 months with cards had received a measles dose by their first birthday,
- 65 9% (197/299) of mothers did not know at what age their children should receive measles vaccine, only 4 7% (14/299) knew the correct age for measles immunization
- DPT1 coverage (91 3% (63/69) of cards or 47% [71/134] of total) dropped by DPT3 (72 5% [50/69] of cards—or 37 3%[50/134] of total) The DPT dropout rate was high (20 6%{91 3-72 5}/91 3)
- OPV1 coverage (91 3% (63/69) of cards or 47% [71/134] of total) dropped by OPV3 (71% [49/69] of cards—or 37 3%[50/134] of total) The OPV dropout rate was similarly high (20 6%{91 3-72 5}/91 3),

TT vaccinations

- Only 35 8% (107/299) of mothers knew that tetanus toxoid (TT) vaccines would protect both mother and child against tetanus, another 11 4%(34/299) knew that TT would protect the newborn against tetanus,
- 47 5%(142/299) of mothers did not know why pregnant women are vaccinated with TT,
- 79 3% of mothers knew that 2 or more of TT doses are needed by a pregnant woman to protect her newborn infant from tetanus,
- Only 5 6% of mothers had two card-documented doses of TT before the birth of her youngest child less than 24 months,

b) Key Findings of Baseline Polio Vaccination Status Survey of children 0-59 months in February 1999 (please see Annex 7)

Of 15,439 eligible children 0-59 months (December 1998 total population survey/BRICS/PHC)

- 15,418 children received the first OPV dose (99 86 percent coverage) on December 12, 1998,
- 14,957 children received the second OPV dose (96 8 percent coverage) on January 17, 1999,

In comparison, 1998 PHC data indicate that full immunization coverage (card plus history) is more than 80%, and TT2 coverage (Card plus history) is at lest 50%,

M 1 3 MOH Policies and Current Services

a) The MOH immunization strategy, schedule, and policies are described in Annex 22
b) As frequent power outages occur in Beruar Beri Block (including the PHCs), cold chain maintenance of EPI vaccines is a challenge There is twice-a-day temperature recording of vaccines Public health facilities are not regularly providing vaccines, however There is poor rapport between the PHC/SCs and the community (as indicated by the high drop-out rates) Another challenge is getting the ANMs to the villages, they often do not want to go as it is too hot, too muddy, etc
c) Immunization services are only available in the PHCs, and not in the SCs There are no mobile team or outreach sessions, except during the Polio Pulse Days/NIDs The recent Polio Pulse campaign (third dose) on February 21, 1999 was called off because of polio vaccine shortage

M 1 4 Program Approach

The project's immunization component objectives and yearly benchmarks are listed under Sub-result # 1c under section C 1 Attainment of these objectives will help reduce neonatal tetanus mortality and neonatal mortality in general, and help to eradicate polio and eliminate measles

The BRICS project plans to facilitate (a) immunization of all infants with the six EPI vaccines (BCG, OPV3, DTP3, and measles) by their first birthday by using *mahila mandals* and VHGs to mobilize mothers of eligible children and track EPI defaulters, (b) partnerships with the Rotary Club (Ballia Chapter) and three local NGOs to establish a *Polio Eradication Network* to mobilize all community, private sector practitioners and NGO partners for National Immunization Days/ Polio Pulse days and for mass publicity events to promote polio immunization, (c) training and utilizing TBAs and VHGs to refer all pregnant women to the ANMs in the SCs for TT immunization, and to ensure that all immunization referrals are completed

The project will also help build the capacity of CMO, PHC and SC staff to (a) conduct missed immunization opportunity surveys, to assess caretaker's timeliness of immunization-seeking behaviors, and to assess the extent of immunization left-outs and drop-outs, (please see Annex 19 for forms to identify missed opportunities), (b) conduct of cold chain survey of 3 PHCs and 15 SCs in Beruar Beri Block during the health facility survey in April/May 1999), (c) maintain vaccine cold chain maintenance by using tools to monitor vaccine temperature twice-a-day in the 3 PHCs (please see Annex 19), (d) field-test a EPI session Supervisory Checklist, adapted from WV Bangladesh's Chittagong CSP (please see Annex 19), and to (e) institute early control measures for EPI disease outbreaks The Project will also supplement cold chain equipment and standby generators for the 3 PHCs (Annex 23),

The BRICS project will Improve Measles Immunization Coverage and Timeliness by (a) training of 8 CMO and 15 PHC staff in missed immunization opportunity surveys to assess (i) measles vaccine coverage, (ii) missed measles immunization opportunities, and (iii) timeliness of measles immunization among children 12-23 months, (b) hosting a Missed Measles Immunization Opportunity Workshop for 70 Ballia District health staff, (c) training 15 PHC staff, 82 VHGs and NGO staff in the MOHFW/WHO guidelines in providing measles immunization to children 9-35

months who are identified with severe malnutrition or severe diarrhea) irrespective of history of previous measles immunization, (d) training of 83 VHGs, 173 TBAs and NGO staff to counsel mothers on the appropriate timing (9 months) of measles immunization for their infants, (e) mobilization of VHGs, TBAs, *mahila mandals*, youth groups, families of WV sponsored families, school students and school teachers to identify, refer and follow-up measles immunization defaulters among children 9-35 months to the nearest PHC/SC for measles immunization

Following the Health Care Facility survey in April/May 1999, the BRICS project will (jointly with CMO/PHC/SC staff) plan the following steps to reach high-risk populations

a) map sites of fixed vaccine delivery with circles representing areas which have 95% access (3-5 km),
b) identify outreach sites to ensure 100% availability,
c) ensure continuous cold chain for one week a month,
d) assist to ensure that sufficient, in-date, potent vaccine is available,
e) set targets for immunization availability, access, quality and coverage

For instance, an *access target* could be that each community will have access to immunization (once a month or once every two months) within X km as measured by DPT1 coverage,

Two quality targets could be

i) Each immunization session will have adequate quantities of in-date, potent (polio marker), cold chain and diluent (as assessed with a checklist),
ii) Every injectable will be administered with a sterile needle and syringe (as assessed with a checklist)

A knowledge target could be by end-of project (EOP) at least 80% of mothers with children under 2 will know three messages on leaving the PHC/SCs (based on exit interviews),

As measles immunization is possibly the single most effective intervention in this population—*a coverage target* could be xx% of infants will be given measles vaccine by 1 year of age (based on village based registers and the KPC survey at the MTE and FE) The project will include measles coverage by 12 months and 12-23 months in future immunization KPC results

The project will also explore the provision of large cold boxes which can maintain the cold chain for one week a month Alternatively, solar or kerosene refrigerators will be explored

M 1 5 Individual Documentation

Currently during mass campaigns like the NIDs, individual immunization doses are not recorded However, with the project's planned introduction of Community EPI Registers, all immunizations during mass campaigns will be recorded Women's TT doses are currently recorded in the maternal card Cards are kept by women and mothers/care-givers The project will conduct PLAs and focus group discussions with *mahila mandals* to seek ways to minimize card loss Currently, the project is negotiating with the CMO and the PHC staff to increase the card supply reliability

See Annex 24 (Reproductive and Child Health Card) where children's immunization doses are recorded

M 1 6 Drop-outs and Missed Opportunities

In addition to the strategies listed in section M 1 4, the project will pilot test innovative ways to reduce the number of drop-outs and missed opportunities for child immunization and women's TT immunization Please see section J 1 2 for a description of village-owned health registers

M 1.7 Vaccine and Equipment Supply and Cold Chain Equipment

This has been discussed in section M 1 4

All vaccines will come from the CMO's office The BRICS project is currently working with the CMO's office to ensure priority and reliable allocation of vaccines to the primary impact area (Beruar Beri Block)

As part of the health facility survey planned for April/May 1999, the BRICS project will work with the CMO's office in developing a plan for safe disposal of equipment, including syringes

M 1 8 Vitamin A

Currently the first dose of vitamin A (at nine months) is tied with the measles vaccine dose However, with the low measles coverage currently, it will be difficult to increase coverage of children at nine months of age with the first vitamin A dose Tying vitamin A distribution to children with the NIDs is not sustainable as the NIDs will be phased out after the year 2000 Some other mechanism for delivering vitamin A to children needs to be explored

M 1 9 Involvement in Polio Eradication Efforts

This is discussed in section M 1 4, section D 2 and demonstrated in Annex 7 (baseline polio vaccination status of children 0-59 months)

M 1 10 Surveillance

According to WHO/SEARO, India uses institutional surveillance exclusively to track EPI vaccine-preventable diseases In fact, WHO and MOHFW recently trained 59 medical officers from UP state and other Indian states in institutional surveillance only As no systematic active community-based surveillance exists in UP state, WHO/SEARO is seeking partnership with an "umbrella NGO" and has requested WV India's active participation in field-testing with the MOHFW and UNICEF a prototype module on Community-based Surveillance of (a) childhood diseases (polio, measles and neonatal tetanus), and of (b) infant, child and maternal mortality WV India envisions that this prototype module will also be adapted and utilized in 100 districts where WV India's 100 ADPs are located across almost all the states of India As each ADP covers one block with an average of 100,000 people, ***a potential population of 10 million people and 245***

local NGOs and community-based organizations may eventually be impacted through this proposed replication.

BRICS will embark on this by assisting the Ballia CMO staff and the District Immunization Officer (DIO) to (a) pilot-test the use of community-based surveillance tools, adapted from that of WV Bangladesh's Chittagong CSP, to conduct EPI disease case investigations and death investigation (please see Annex 13 and section E 5 2), and to (b) track EPI coverage against EPI disease surveillance data (AFP, measles and neonatal tetanus) by pilot-testing community-based surveillance of these 3 EPI diseases, *initially focusing on active community AFP surveillance by fostering a climate where everyone in the community needs to report every case of AFP*

This proposed community-based surveillance will complement and feed into the institutional surveillance currently operating in Ballia district (Annex 3 summarizes the current status of AFP surveillance in India, in UP state and in Ballia District) Twelve CMO staff, 9 PHC staff, 15 ANMs, 85 AWWs, 18 NGO staff from 3 local NGOs, 173 TBAs, 71 private practitioners, 425 village *panchayat* members, 225 *mahila mandal* members, 82 VHGs, 210 Youth Clubs and NSS members, and 850 families of WV sponsored children in Beruar Beri Block will be trained in this community-based surveillance (Please see section J 1 for more details, and Annex 13 for community surveillance forms, Steps in Community Surveillance, and Data Flow for Community Surveillance)

The project will host "Lessons Learned/Best Practices" workshops and serve as a demonstration site for CBDDS for 70 PHC staff from the other 16 blocks of Ballia district

M 1 11 Knowledge, Practice and IEC

The baseline current knowledge and practices of mothers and families are discussed in section M 1 1

The plans for IEC for the immunization component are discussed in section M 1 4

The program will use qualitative methodologies (PLA, FGDs) to develop and test IEC messages and materials To monitor the quality of the communications effort, the project will use PLA, FGDs, exit interviews and the KPC survey

Key messages include

1) Vaccinate your child against measles at the ninth month,
2) Make sure you vaccinate you child with BCG, three doses of OPV, three doses of DPT, and measles vaccine by his/her first birthday,
3) Every pregnant women should receive at two doses of TT during her pregnancy,
4) TT immunization protects both the mother and the child from tetanus,
5) Keep the immunization (RCH) card in a safe place,
6) Even if your child has a mild illness, it is OK to have him/her immunized

About 4,277 newborns each year, 10,342 children 0-59 months and 26,045 women 15-45 years in Beruar Beri Block will be directly impacted About 90,164 newborns each year, 403,116 children 0-59 months and 357,479 women 15-45 years in all the 17 blocks of Ballia district will indirectly be impacted over the life of the project

M 2 NUTRITION AND MICRONUTRIENTS

M 2 1 Child Feeding Practices

M 2 1 1 Protein Energy Malnutrition (PEM) Status

a) Key Findings of Baseline Nutrition Survey of 326 children 0-23 months, from 30 villages of Beruar Beri block conducted in February 1999 with local consultancy group, VRIDDHI (please see full report submitted under separate cover),

- *Twenty eight percent* of children 0-23 months *were moderately under weight* (i e who fall below -2 Z score from the median weight for age of the NCHS/WHO reference population),
- *Fifteen percent* of children 0-23 months *were severely underweight* (i e who fall below -3 Z score from the median weight for age of the NCHS/WHO reference population)
- *In total, forty three percent* of the children 0-23 months *were severely or moderately underweight* (i e who fall below -2 Z score from the median weight for age of the NCHS/WHO reference population),

Other key findings of the nutrition survey were

- Prevalence of wasting among the target group is 16 5%, stunting 36 5% and underweight children is 42 9% All three indices indicate a high to very high prevalence of malnutrition in the area
- It is to be noted that the survey has been conducted in late winter, which is a relatively low risk season in terms of occurrence of diseases like diarrhea, dysentery, etc The situation is likely to worsen during high risk seasons, i e late summer and monsoon season, when the occurrence of diarrheal and vector-borne diseases is greater
- The survey projects approximately 1,658 children 0-23 months would be severely wasted and need immediate corrective measures to restore normal levels of nourishment
- There is a probability of 4,321 underweight children, 65% of them severely underweight
- Approximately 4,200 children would be moderately underweight and wasted, and require immediate preventive intervention, as they are at a greater risk of slipping into the severely wasted and underweight category
- The survey projects an immediate target group of almost 6000 children who are malnourished, and require preventive and/or corrective care This is approximately 60% of the total number of children 0-23 months
- Caste groups where prevalence of malnutrition has been found to be high are Harijians, Mallahs, Rajbhars and Chauhans
- Malnutrition is prevalent in a cross-section of the population, irrespective of the economic status or sibling position of the children

- Villages which have a relatively better Nutritional Status are Deluah, Durgipur, and Sultanpur

b) Findings from PLA exercises

i) Causes of malnutrition, especially among under-3 children, have been identified as the following "Feeding the child with warm breast milk, evil eye, vitamin A deficiency, lack of nutritious food, inadequate production of mother's milk for child feeding, milk of weak and diseased mother, liver enlargement No immunization after delivery of the child and poor care of the mother during pregnancy will cause malnutrition "

ii) Weaning foods are given by mothers with the following age groups,
   - For a child 5-6 months of age mothers give biscuits, cow's milk, rice water,
   - For children 6-7 months old, they give *dal* and rice, and *halwa* made out of wheat For children 7-8 months they give *dal*, *roti* and rice,
   - For 8-12 months of age, they give eggs and fish in addition to those food served at home

iii) Causes of night blindness are deficiency of Vitamin A, lack of nutritious diet due to financial constraints, frequent pregnancies that makes the mothers weak, mothers eating mud and clay during pregnancy Lack of proteins in daily diet viz fish, egg and meat etc Improper bowel movements (constipation)

iv) PLA exercises also indicated that nearly 60% of young children are left behind by mothers for the day this contracting of child care has been identified as a risk factor for childhood under-nutrition and VAD in Beruar Beri Block (WV/1997) More than 75% of undernutrition-related deaths in under-5 children in Ballia district were linked not to severe under-nutrition but to mild and moderate forms (WV/ PHC/SC staff/1997)

M 2 1 2 Current Beliefs and Practices

The November 1998 KPC survey of mothers of children 0-23 months revealed the following *breastfeeding and nutrition profile*

- Only 25 8% (77/299) of mothers reported giving colostrum to their newborn,
- 32 5% (96/295) of mothers breast-fed their last newborn within 8 hours of delivery,
- 38% of mothers started breastfeeding in the first 24 hours of birth, 62% did not,
- 76 6% (49/64) of infants 0-4 months were exclusively breast-fed last 24 hours,
- 25 8% (17/66) of infants 5-9 months were given solid or semisolid foods
- 74%(217/295) of mothers reported having started complementary foods after six months,
- High continuation of breastfeeding was reflected in 90 3% (28/31) of children 12-23 months who were still being breastfed,
- 86% (258/300) did not know what to do during a baby's first four months to keep on breastfeeding,
- Only 36 6% (108/295) of mothers added oil or fat to their child's diet in the last 2 days,
- Only 39 8%(119/299) of mothers added iodized salt to their child's diet in the last 2 days,

- Only 14 3% (43/300) of mothers knew of the importance of adding vitamin A-rich foods to breastmilk for their weaning children,
- Only 11% (33/300) of mothers knew of the importance of adding iron-rich foods to breastmilk for their weaning children,

Low educational status, ignorance, poverty, superstitions, peer pressure and pressure from mothers-in-law are all factors influencing the lack of accurate knowledge and beliefs regarding correct breastfeeding infant and breastfeeding practices The recent KPC survey found nearly 42% of mothers were young (15-24 years of age) Low educational status of mothers was evident, with 73 2% illiterate Only 35 5% of mothers took their children to their work fields The rest left their children with their husbands (14 3%) or older child (24 7%) or relatives (37 1%)

M 2 1 3 MOH Policies and Activities in the Area

The GOI's ICDS program has not yet reached Beruar Beri Block Therefore, the people of Beruar Beri Block are not yet able to avail themselves of the nutrition programs offered under the ICDS The ICDS focuses on preventing malnutrition in the under-2 child, with emphasis on infants (see Annex 25 for MOH protocol on nutrition in children)

a) Universal early registration of pregnancy-enabling utilization of key services, i e antenatal care, TT immunization, iron/folate (IFA) supplementation, and improved care and counseling of pregnant women, to ensure appropriate and adequate food and rest This is also likely to reduce the incidence of low birth weight
b) Promoting the practice of exclusive breastfeeding from birth to four to six months of age, timely immunization and counseling for appropriate care of low birth weight babies,
c) Promoting appropriate and timely complementary feeding, with the use of local household resources, starting among infants at four to six months of age (with continued breastfeeding up to two years),
d) Improving coverage of nine month old children with measles and vitamin A supplementation, and checking that each nine-month-old child receives at least four complementary feeds a day,
e) Improving the management of diarrheal diseases (with ORT and continued feeding) and ARIs at home, through *Aganwadi* centers and through health facilities,
f) Strengthening growth monitoring and promotion of young children (especially under two years of age), with participation of mothers/communities,
g) Promoting consumption of only iodized salt

Under the ICDS program, supplemental feeding support for 300 days a year is provided to identified low income families, deprived under-6 children, pregnant women, nursing mothers and adolescent girls AWWs (child care center workers) provide food supplements of 300 calories (with 8-10 grams protein) per day (which is doubled to 600 calories/day if the child is malnourished) Home gardens are also promoted, although fortification of local foods is not yet occurring on a significant scale Iodized salt is not widely consumed Until the ICDS program begins in Beruar Beri Block, malnutrition will mostly likely continue to be widespread, given the socio-economic context of the area

Exit interviews of women in PHC/SCs and on-site observation reveal that PHC/SC staff are not well equipped to provide counseling on child feeding and nutrition, dietary management of diarrhea and other childhood illnesses

M 2 1 4 Program Approach

The intervention-specific objectives and their annual benchmarks are listed under Sub-result #1 d in section C 1

BRICS will collect findings from seminars on breastfeeding and infant feeding practices from the USAID-funded AED Linkages Project at the WV Jagriti ADP in Dehra Dun in northern UP state, through cross visits and lessons learned Appropriate complementary foods will be identified with *mahila mandals*, tested in brief household trials to assure their acceptability, and then incorporated into effective nutrition counseling through the development of an effective weaning counseling education module for the mahila mandals

The project will aggressively use the findings of the baseline nutrition survey to lobby with the DDO (District Development Officer), BDO (Block Development Officer), *panchayats* and various community groups to provide child care under the *Anganwadi* of the proposed ICDS to ensure that children 12-59 months get 5-6 feeds daily

BRICS will partner with the BDO, village *panchayats*, *mahila mandals*, NGO staff, AWWs, VHGs and TBAs to

a) initiate demonstration nutrition education sessions for mothers and pregnant and lactating mothers (exit interviews will be conducted randomly and regularly by PHC/SC and BRICS staff to assess the quality and impact of each session),
b) disseminate key nutrition messages to mothers

The LHVs, ANMs, VHGs, TBAs, NGO staff and private sector practitioners will also be trained in interpersonal communications and face-to-face skills to impart the following nutrition messages focusing on essential household behaviors

- exclusively breastfeed for at least 5 months,
- introduce solid or semi-solid foods from the fifth month,
- add oil, sugar, groundnuts and/or appropriate animal products and yellow and green vegetables and fruits of foods from 6 months,
- continue breastfeeding through at least 24 months,
- add oil or fat to their child's diet if he/she is more than 6 months old,
- add iodized salt to their child's diet if he/she is more than 6 months old,
- add vitamin A-rich foods to breastmilk for their weaning children,
- add iron-rich foods to breastmilk for their weaning children,

The AWWs, VHGs, ANMs, NGO staff, TBAs and LHVs will be trained in *sick child encounters* to train mothers/caretaker to give same amount or more of fluids other than breastmilk to a child with diarrhea or other illness, give same or more amount of foods to a child with diarrhea or other illness, continue breast-feeding during an illness, give more foods after an illness, give 5-6 feeds

daily to a child aged 12-59 months daily, weigh a child 0-23 months quarterly in the *balwadi*, seek help in identifying growth faltering, and aim for catch-up growth The project's proposed training of ANMs (and later of AWWs) in integrated management of children with cough/rapid breathing, diarrhea or undernutrition (see Annex 20) will focus significantly on nutrition counseling

The BRICS project will introduce "positive deviance" to identify sustainable local feeding and child care practices which lead to healthy child nutritional status, as key to designing village-based interventions

M.2 2 Growth Monitoring

This is not a component of the BRICS project

M 2 3 Maternal Nutrition

M 2 3 1 Maternal/Newborn Nutritional Status

SIFPSA (1995) data reveal that the maternal malnutrition rate is 41% and 87% of pregnant women have nutritional anemia (with mean hemoglobin levels among pregnant women as low as 9 2 g/dl--Agrawal/1987) and 20% are deficient in folic acid The 1992-3 NFHS found that only 29 5% of births were to mothers who had been receiving iron/folate supplementation

There are no baseline data on height/weight distribution or BMI for women in the direct impact area The November 1998 KPC survey revealed that

- 33 3% (100/300) of mothers did not know of any food to prevent pregnancy anemia, those who knew cited eggs (29 3%), and green leafy vegetables (26 7%)
- Only 4 7%(14/300) of mothers knew that a woman should gain at least 8-12 kilograms during pregnancy,
- Only 8 8 %(26/295) of mothers who delivered their youngest child in the last one year received at least 90 iron/folate tablet supplements during last pregnancy,
- Sources of iron/folate tablets included the PHC (8 5%), ANM (11%), and SCs (3 5%),

There are no data on the percent of women who consume vitamin C-rich food or iodized salt during pregnancy There is no program for vitamin A supplementation during pregnancy or during the post-partum period

The prevalence of low birthweight newborns is not known However NFHS data show that low birth weight contributes to 29% of neonatal mortality Fifty seven percent of post-neonatal deaths are due to malnutrition, with low birth weight continuing to confer a higher mortality risk throughout the first six months of life

M 2 3 2 Current Beliefs and Practices

Most women believe that food intake should be restricted during pregnancy to prevent a large fetus from obstructing labor Other beliefs and practices are found in section M 2 1 1 Most women are confident they are breastfeeding successfully No special precautions or changes in work habits are made by mothers during pregnancy, except in diet (section M 2 1 1)

M 2 3 3 MOH Policy and Activities in Area

Current policies related to ICDS are given in section M 2 1 3, which proposes the provision of supplementary food support of 500 calories per day for 300 days a year for pregnant and nursing mothers However, the women in the direct impact area (Beruar Beri Block) do not have access to this food supplementation, as the ICDS program is not yet introduced to this Block

M 2 3 4 Approach

The project will mobilize ANMs, LHVs, TBAs, VHGs, local NGO staff and *mahila mandals* to *distribute iron/folate supplements to pregnant women* (1 tablet/day for at least 90 days for all pregnant women, and 2 tablets/day for at least 90 days to those clinically anemic, as per MOHFW guidelines), and provide nutrition education to pregnant and lactating mothers through *mahila mandals*, VHGs, TBAs and ANMs
Key nutrition messages will include

- Eat eggs and green leafy vegetables to prevent pregnancy anemia,
- A woman should gain at least 8-12 kilograms during pregnancy,
- Take at least 90 iron/folate tablet supplements during last pregnancy,
- KPC surveys will be conducted to assess the impact of the behavior change messages
- The program will reach high-risk groups through the introduction of community-owned pregnancy registers (please see section E 1)

M 2 4 Micronutrients

2 4 1 Micronutrient Status

Vitamin A Deficiency

i) Key Findings of *Baseline Night Blindness Prevalence Survey* of children 6-59 months (see Annex 2),

Of 11,627 children 9-35 years who were eligible for vitamin A supplementation during the planned Polio Pulse Day on February 21, 1999, 7,386 children (63 5 %) turned up and received vitamin A Of these 7,386 children, 220 (2 97%) were night blind ***The baseline night blindness prevalence in children 6-59 months was 2 97 percent.***

ii) The November 1999 Baseline KPC Survey found that

- Only 5 8% (10/171) of children 9-23 months received Vitamin A supplements within the past 6 months, after this, the first vitamin A round organized with the Polio Plus Day in February 1999 increased the vitamin A coverage of children 6-59 months to 63 5% (see Annex 2),
- None of the mothers with under-2 children received any card-documented high dose vitamin A supplement within 4 weeks of delivery,
- 82 7% of mothers did not know any food which prevents night blindness,
- Reported foods that prevent night blindness include green leafy vegetables (13 7% of mothers), yellow fruits (6 7%), meat/fish (7 3%), egg yolk (2 7%), breast milk (4%)
- *Vitamin A deficiency is still endemic and remains a threat to child survival* The prevalence of milder eye diseases associated with vitamin A deficiency is at least 10 times higher than the prevalence of vitamin-A deficiency blindness in under-5 children in the project area Many Indian parents in Beruar Beri block continue to associate the dangers of vitamin A deficiency with blindness (WV/PLA/1997) Convincing parents and health workers that VAD remains a threat to their children is a challenge, now that blindness is no longer an everyday reminder of vitamin A's importance This situation requires an important thematic shift emphasizing vitamin A's role in strengthening the immune system and reducing childhood mortality from several causes

The majority of mothers sought private practitioners for curative care for their sick children and public health staff for preventive health services

Iron Deficiency this is discussed in section M 2 3

Iodine Deficiency--currently, the project is not directly addressing this component.

M 2 4 2 MOH Policy for Vitamin A

The MOH policy on vitamin A is attached (Annex 26) The first dose of vitamin A (at nine months) is tied to the measles vaccine dose, however, with the low measles coverage currently, it will be difficult to increase coverage of children at nine months of age with the first vitamin A dose Tying vitamin A distribution to children to the NIDs is not sustainable as the NIDs will be phased out after the year 2000 Some other mechanism for delivering vitamin A to children should be explored

The MOHFW, armed with evidence of widespread VAD, and studies showing the positive impact of vitamin A supplementation upon child mortality and morbidity has, in its Ninth Plan, committed itself to adopt the global goals of the World Summit for Children, seeking the virtual elimination of VAD and its consequences, including blindness, by the year 2000 Its three-pronged national strategy to reduce VAD in children 9-35 months consists of (a) expanding semi-annual megadose (200,000 IU) vitamin A distribution through PHCs and SCs into a multi-level national program, (b) a long-term strategy to increase target audience consumption of vitamin A foods including dark green leafy vegetables, fruits and fish, and (c) fortifying selected foodstuffs with vitamin A There is increasing recognition by MOHFW that food-based approaches are fundamental to long-term prevention of VAD

M 2 4 3 Approach

The project's overall goal for the vitamin A interventions is *to expedite the elimination of Vitamin A deficiency and accelerate child mortality reduction* by enhancing the capacity of the Ballia District CMO and Beruar Beri Block PHC/SC staff and that of private health care providers to *deliver four integrated quality-oriented interventions* (1) *improved vitamin A coverage* of children 9-35 months and of postpartum women, (2) *increased target audience consumption of vitamin A-rich foods,* (3) *improved measles immunization coverage and timeliness*, and (4) *improved coverage of Vitamin A supplementation/treatment for the sick child* (children with measles, pneumonia, severe diarrhea, severe undernutrition and xerophthalmia/ nightblindness) The project will facilitate the following intervention-specific activities

(i) Improving vitamin A coverage of children 9-35 months and of postpartum women through
(a) Standardized bi-annual vitamin A distribution at PHCs, SCs and *balwadis* for children 9-35 months (200,000 IU per dose) to create an "umbrella" Vitamin A program at the block level, (b) house-to-house distribution sweeps to distribute vitamin A to children 9-35 months by mobilizing staff of the BRICS and its 3 partner local NGOs as well as *panchayats, mahila mandals*, youth groups, and families of WV sponsored children during the bi-annual vitamin A distribution, (c) training and supplying 173 TBAs to distribute vitamin A (200,000 IU one-time dose) to postpartum women within one month of delivery

(ii) Increased Target Audience Knowledge/Consumption of Vitamin A-rich Foods by (a) facilitating PLA exercises to assist communities to explore causes and identify appropriate solutions to issues related to VAD and undernutrition, (b) jointly conducting a baseline KPC survey of mothers with under-2 children in Beruar Beri Block to ascertain the proportion of them who know that vitamin A prevents nightblindness, who are able to name any vitamin A-rich food, and who can say that vitamin A-rich foods should the added to breast milk for their children, (c) careful market and audience research to select 5 "right" vitamin A-rich foods after careful market and segmented audience research, (d) holding contests with the mahila mandals to test new recipes (using vitamin A-rich foods) with children, (e) promoting exclusive breastfeeding in the first 4 months, and (f) initiating 83 village-based home gardening groups to motivate pregnant and lactating women to raise home gardens and consume vitamin A-rich foods

(iii) Improving Measles Immunization Coverage and Timeliness by (a) training of 8 CMO and 15 PHC staff in missed immunization opportunity surveys to assess (i) measles vaccine coverage, (ii) missed measles immunization opportunities, and (iii) timeliness of measles immunization among children 12-23 months, (b) hosting a Missed Measles Immunization Opportunity Workshop for 70 Ballia District health staff, (c) training 15 PHC staff, 82 VHGs and NGO staff in the MOHFW/WHO guidelines in providing measles immunization to children 9-35 months who are identified with severe malnutrition or severe diarrhea) irrespective of history of previous measles immunization, (d) training of 83 VHGs, 173 TBAs and NGO staff to counsel mothers on the appropriate timing (9 months) of measles immunization for their infants, (e) mobilization of VHGs, TBAs, *mahila mandals*, youth groups, families of WV sponsored families, school students and school teachers to identify, refer and follow-up measles immunization defaulters among children 9-35 months to the nearest PHC/SC for measles immunization

(iv) Improving Coverage for Vitamin A Supplementation/Treatment of the Sick Child by (a) training PHC/SC staff, NGO staff and private sector practitioners in the WHO guidelines for providing appropriate vitamin A supplementation/ treatment (irrespective of history of previous vitamin A supplementation in the last 6 months) to (i) children with pneumonia, severe diarrhea, severe undernutrition (one dose of vitamin A upon diagnosis), (ii) children with measles (one dose of vitamin A upon diagnosis and second dose of vitamin A the next day), and to (iii) children with xerophthalmia/nightblindness (one vitamin A dose upon diagnosis, second vitamin A dose the next day, and the third vitamin A dose 2 weeks later) [Age-related VAC dose units are Children over 1 year 200,000 IU, Children under 1 year 100,000 IU], and (b) dissemination of a booklet on the "safe use of high dose vitamin A" to assuage possible fears among health practitioners (including PHC/SC) about toxic vitamin A overdose

The Ballia CMO has suggested that WV pilot-test post-partum vitamin A supplementation (200,000 IU) of women within one month of delivery, as this is not yet a national program The project is currently exploring with the UP State Institute of Family Welfare and UNICEF the possibility of pilot-testing low-dose supplementation of pregnant women in Beruar Beri Block, where the prevalence of maternal nightblindness is as high as 10% of pregnant women (UNICEF/ 1997) This follows the UNICEF/WHO statement (at the September 1997 XVIII IVACG Meeting in Cairo, Egypt) on policy implications of a well-conducted, Johns Hopkins University-sponsored, large scale prospective study in rural Nepal The study showed that (a) weekly doses of 25,000 IU of vitamin A, or beta-carotene, significantly reduced maternal mortality rates, (b) pregnant women who suffer nightblindness have a greatly increased risk of reproductive morbidity and dying compared to women who might not be night blind, and (c) vitamin A supplementation to pregnant women did not increase the risk of any kind of birth defect--in fact, the evidence was presented that vitamin A supplementation may have decreased the incidence of ocular birth defects

About 4,277 newborns each year, 20,391 children 0-59 months (including 8,541 children 9-35 months) and 26,045 women 15-45 years, including 4,277 post-partum mothers in Beruar Beri Block will be directly impacted

M.2 5 Supplementary Foods

There is no plan to provide weaning foods.

M 2 6 Home Gardens

This component is discussed under section M 2 4 3

M 3 BREASTFEEDING PROMOTION

M 3.1 Current Beliefs and Practices

The November 1998 KPC survey of mothers of children 0-23 months revealed the following breastfeeding nutrition profile

- Only 25 8% (77/299) of mothers reported giving colostrum to their newborn,
- 32 5% (96/295) of mothers breastfed their last newborn within 8 hours of delivery,
- 38% of mothers started breastfeeding in the first 24 hours of birth, 62% did not,
- 76 6% (49/64) of infants 0-4 months were exclusively breastfed last 24 hours,
- High continuation of breastfeeding was reflected in 90 3% (28/31) of children 12-23 months who were still being breastfed,
- 86% (258/300) did not know what to do during a baby's first four months to keep on breastfeeding

The KPC survey also found nearly only 35 5% of mothers took their children to their work fields The rest left their children with their husbands (14 3%), older child (24 7%) or relatives (37 1%) PLA exercises also indicated that nearly 60% of young children are left behind by mothers for the day this contracting of child care has been identified as a risk factor for childhood under-nutrition and VAD in Beruar Beri Block (WV/1997)

PLA exercises and FGDs revealed that pre-lacteal feeds are common--especially with honey and water Colostrum is considered "dirty" Often lentils (*Dhal pani*), vegetables and porridge (*Kitchedi*) are given as complementary foods There are no reliable data on the practice of bottle-feeding, but PLA exercises show that it is not a common practice--more among the affluent families

The majority of mothers delay putting their newborns to the breast until after a few days after birth Most of them do not know the benefits of colostrum, or the benefits of breastfeeding to themselves, the child or for birth spacing Less than 12% of mothers know how to continue breastfeeding in the first 4 months

Most health staff, family members, *mahila mandal* members, and village *panchayat* leaders acknowledge that breast milk is best, but vary in their beliefs regarding exclusive breastfeeding, supplementary foods and liquids and breastfeeding duration

Poverty has forced most mothers to go to the fields, and one-third bring their infants along Hence, exclusive breastfeeding for the first six months is difficult In spite of this, 90% of mothers continue to breastfeed through the second year

M 3 2 MOH Protocols and Related Activities in the Area

As discussed in section M 2 1 3 the ICDS focuses on preventing malnutrition in the under-2 child, with emphasis on infants

a) promoting the practice of exclusive breastfeeding from birth to four to six months of age, timely immunization and counseling for appropriate care of low birth weight babies,
b) Promoting appropriate and timely complementary feeding, with the use of local household resources, starting among infants at four to six months of age (with continued breastfeeding up to two years),
c) disseminate key nutrition messages to mothers

The national MOH policy discourages breastmilk substitutes, but the enforcement of such a policy is difficult in a remote and underserved area such as Ballia District

Currently, there are no concerted PHC/SC plans to promote breastfeeding aggressively, neither are there any local programs or policies that encourage the use of breastmilk substitutes The Ballia District Hospital is not yet enrolled in the Baby-Friendly Hospital initiative Breastfeeding is often considered a private matter for the mother Most deliveries are conducted at home, hence a Baby Friendly Hospital initiative is less likely to impact a large percentage of post-partum mothers WV's policy does not allow for distribution of infant formula in its programs

M 3 3 Approach

The LHVs, ANMs, VHGs, TBAs, NGO staff and private sector practitioners will also be trained by BRICS/CMO staff in interpersonal communications and face-to-face skills to impart the following nutrition messages focusing on essential household behaviors

- put the child to the breast within one hour of birth,
- feed colostrum to the newborn--do not discard it,
- do not give any other liquids to the newborn--give only the breast
- exclusively breastfeed for at least 5 months,
- introduce solid or semi-solid foods from the sixth month,
- continue breastfeeding through at least 24 months,

The AWWs, VHGs, ANMs, NGO staff, TBAs and LHVs will be also be trained in *sick child encounters* to train mothers/caretakers to give same amount or more of fluids other than breastmilk to a child with diarrhea or other illness, give same or more amount of foods to a child with diarrhea or other illness, continue breastfeeding during an illness, give more foods after an illness

The BRICS staff will explore with the *mahila mandals* strategies to assist mothers of young infants who work in the fields to continue breastfeeding

The project does not plan to promote LAM

M 3 4 IEC and Counseling

The breastfeeding behavior change objectives are given in section C 1 The IEC plans for breastfeeding are mentioned in sections M 2 1 4 and M 2 4 3 The project will use IEC messages and materials on breastfeeding and infant feeding developed from the USAID-funded

AED Linkages Project at the WV Jagriti ADP in Dehra Dun in northern UP State Besides the KPC survey to track impact on caretaker knowledge and practice, checklists will be developed to monitor the interpersonal communications skills and face-to-face counseling skills of PHC/SC staff, VHGs and TBAs in breastfeeding promotion

M 4 CONTROL OF DIARRHEAL DISEASES

M 4 1 Incidence and Distribution

No data are available on the number of episodes of diarrhea, per year, per child for the direct impact area Anecdotal data from PHC/SC staff indicate that an under-5 child has between 4-6 diarrheal episodes per year

Diarrhea contributes to 20% of post-neonatal infant deaths (with 5 4% due to measles-related diarrhea) and 29% of under-5 child mortality in Beruar Beri block (Ballia CMO and UNICEF/1997) PLA exercises revealed that diarrhea is more common in the months of June, July, August and September which are the rainy seasons for the region Dysentery in the impact area is not resistant to antibiotics

MOH 1994 data of the National Child Survival and Safe Motherhood Program, reveal that the distribution of diarrheal deaths in under-5 children are as follows acute watery diarrhea (65%), dysentery (15%), persistent diarrhea (20%) The 1992-1993 NFHS reported that diarrhea of any type contributed to 8 9% [1] of under-5 child mortality and bloody diarrhea contributed to 1 5 % of under-5 child mortality

The November KPC Survey (please see separate KPC survey report) revealed that

- 48% (141/300) of mothers reported that their under-2 children had diarrhea in the two weeks prior to the survey,
- 83 3% of mothers and their families do not have access to a latrine,
- 71% of mothers do not purify their water,

M 4 2 MOH Protocols and Current Practices

The MOH protocol for standard case management of childhood diarrheal diseases is appended as Annex 27, and include the MOH protocols for the management of acute watery, dysentery and persistent diarrhea

MOH-recommended home available fluids are rice water, pulse water, salt, butter milk with salt, lemon water and coconut water

There is no MOH policy for vitamin A supplementation for children with diarrhea The project is currently negotiating with the CMO and the UP State authorities to allow for vitamin A supplementation of children with persistent (>14 days) diarrhea and measles-related diarrhea

[1] Include diarrhea in the past 24 hours

The November 1998 KPC survey of mothers of under-2 children revealed

- 24 1% (34/141) of under-2 children with diarrhea in the past 2 weeks were not given any treatments for their diarrheal episode, yet 54 6% (77/141) received anti-diarrheal medicine Only 8 5% (12/141) received ORS,
- 72 3% (102/141) of mothers sought care for their child's diarrhea, these mothers included 41 8% (59/141) who sought a private clinic doctors—this correlates well with the high percentage of under-2 children who received anti-diarrheal medicines mentioned above Only 6 4% (9/141) of mothers sought the PHC/sub-center A relatively high 18 6% sought relatives for diarrhea care for their children, another 15 6% sought RMPs for diarrhea care for their children

An estimated 70-90% of all curative services for children in Beruar Beri Block are delivered through private practitioners, most of whom lack regulation, standardization and training in standard case management of and diarrheas in under-5 children Polypharmacy is rampant especially among private sector health providers, with frequent misuse/overuse of antibiotics (including cephalosporins), intravenous fluids, and metronidazole for children with persistent diarrhea or dysentery The ORT knowledge rate and the ORT usage rate by mothers of under-5 children with diarrhea are low *Heeng* and *jafar*[2] are prescribed by traditional healers Drugs such metronidazole and nalidixic acid are often not given in appropriate doses

With the exception of PHC staff, most other health workers are only able to distinguish between two types of diarrhea such as acute watery diarrhea and dysentery Health workers do not receive regular any training or supervision in quality case management of diarrhea Currently there are no strategies in place to improve the diarrhea case management practices of drug retailers and traditional healers Although such training are being organized for *dais* by the ANMs from the SC, often they lack practical exposure

M 4 3 Knowledge and Practice

The November 1998 KPC survey of mothers with under-2 children found that

- 17 6% (25/141) of under-2 children who reportedly had with diarrhea in the past 2 weeks were treated with ORT
- 16 9 % (23/141) of under-2 children with diarrhea in the past 2 weeks were given same amount or more fluids other than breast-milk during their diarrheal episode,
- 20 4% (28/141) of under-2 children with diarrhea in the past 2 weeks were given the same amount or more food during their diarrheal episode,
- 67 6% (96/141) of under-2 children with diarrhea in the past 2 weeks were given same amount or more breast-milk during their diarrheal episode,
- 20 4% (23/137) of children under-2 children with diarrhea in the past 2 weeks were given same amount or more of solids/semi-solids in addition to breastfeeding during their diarrheal

[2] local herbal medicine

episode, 52 6% stopped solids/semi-solids completely, and 22 6% of children had reduced solids/semi-solids,

- Signs and symptoms cited by mothers that would trigger care-seeking for their child's diarrhea included vomiting (20 9%), fever (33 3%), dehydration (15 5%), and diarrhea of more than two weeks of duration (36 0%), and blood in the stool (6 7%),
- 37 0% (111/300) of mothers with under-2 children had no idea what they would do when their children are recovering from diarrhea, only 29 0% (87/300) said that they would give smaller, more frequent feedings A smaller 4 7% (14/300) said they would give more food and 7 3% (22/300) said that they would give foods with high caloric content,
- 36% (107/297) of mothers recognized various forms of diarrhea such as dysentery as blood in stool, thin stool with water as acute watery diarrhea, and diarrhea with frequent stools and diarrhea of at least 14 days as persistent diarrhea,
- 15 5% (46/297) of mothers recognized dehydration as sunken eyes, dry mouth, sunken fontanelles, or decreased urine output

PLA exercises and FGDs among community groups

- Local words for diarrhea are *Patla Pekhana* or *Pet Jharna*[3] meaning "frequent stool with water, abdominal cramp, dry mouth are the signs and symptoms of diarrhea "
- Diarrheas are perceived to be due to
  --eating contaminated food and drinking contaminated water,
  --breastfeeding the child soon after coming from work on hot sunny days,
  --eating oily foods and eating food without clean hands,
- Awareness about dehydration as cause of death among the people is limited
- Home treatments for diarrheas included giving a mixture of sugar, salt and lemon to their children, however, many do not have these in their homes Others give grounded guava, mint leaves and *heeng* to the child,
- Financial constraints, poor local hospital facilities and equipment do not allow them to obtain better health care
- Hygienic practices are not practiced at home though they are aware that not practicing them are a risk factor for diarrhea,
- Most mothers have no perception of diarrhea severity,

During one field visit, a mother was found not being able to recognize that green stool that her child had passed was diarrhea

M 4 4 Approach

The project will focus in the first 2 years on improving the quality of case management of pneumonia and diarrhea in under-5 children

The BRICS project facilitated baseline PLA exercises, FGDs and a KPC survey of mothers of under-2 children to identify causes of the ORT knowledge-practice gap, and the obstacles to maternal/caretaker adoption of essential household behaviors regarding prevention and

[3] local term for diarrhea

management of childhood diarrheas These findings were factored into the Detailed Implementation Plan (DIP)

These finding show that for case management of diarrhea

- health facilities (PHC/SCs) are not always open,
- health facilities don't always have the correct drugs or ORS packets,
- people have little trust in the public health service,
- people predominantly use other providers,
- people unlikely to leave their villages for care

The project will also conduct

a) *Health Facility Assessment* in April/May 1999 Dr Stan Foster of Rollins School of Public Health, Emory University, Atlanta, USA, will provide the technical assistance for this HFS It is envisaged that Dr Foster will assist the BRICS project staff and partners *to assist to test the PVO CORE group's new module for NGO assessment of health facilities* Through this proposed health facility survey, the current and future capacity of health facilities to provide essential (including CDD services) will be determined Based on the survey, there may need for some readjustment to the DIP as to what can be done at the facility, by outreach and what needs to be done at the community level This will be communicated at the end of the facility survey (See Dr Stan Foster's Scope of Work in Annex 10)

b) *Baseline study of the quality of home and private practitioner case management of childhood illnesses (including diarrheal diseases)*
Both the KPC survey and PLA exercises revealed that the majority of mothers seek *private* practitioners for *curative* care for their sick children with diarrhea The project, therefore, will pay special focus on private practitioners The BRICS project will, in FY 2000, recruit a local consultant in adapting the generic BASICS/Kurji Holy Family Hospital/Bihar PVO II Operations Research questionnaire/methodology to study the "Quality of Home and Private Practitioner Case Management of Childhood Illnesses" (please see Annex 11) Following the baseline study, the project plans several CQI exercises with private practitioners to improve the quality of their diarrhea case management/service delivery, CQI instruments will be jointly developed with them to measure and track such improvements

The project will focus on

Priority 1 Strengthen public health facilities (PHCs/SCs) in relation to opening hours, staff availability, drug/ORS availability, and rapport,

Priority 2 Identify community providers in each community (with CMO permission) who will provide high quality case management of diarrhea Selection criteria for such community providers include

- available in village most of the time,
- able to keep simple records, even pictorial,
- has the respect of villagers,

The project will follow the following steps to facilitate this strategy

- Identification of current providers in the community,
- Identification of criteria for selection,
- Discussion of criteria for selection with the community,
- Selection, training and support of these community providers

The project will also

a) Re-train PHC doctors, LHVs and ANMs and the private practitioners in Beruar Beri Block in quality home management of childhood diarrheal diseases and in the management of severe cases, including persistent diarrhea and dysentery, (Annex 20 gives the algorithm for AWWs, AMNs to Assess, Classify and Identify for Treatment of a Child with Cough of Difficult Breathing, Diarrhea, or Undernutrition, as well as a checklist for Monitoring Assessment, Classification, Treatment of Integrated ARI/CDD/Undernutrition Skills Training for Basic Health Workers (AWWs, ANMs),

b) Train VHGs, AWWs, TBAs, school children and teachers to teach mothers/caretakers and *mahila mandal* members correct ORT mixing/administration methods, correct recognition and referral of serious cases of diarrheal dehydration, and dietary management of diarrhea,

c) Work with vendors to promote social marketing of ORS,

d) Establish ORT corners in *anganwadis* (day-care centers once the new ICDS scheme is established in the impact area), SCs and PHCs,

e) Encourage AWWs, VHGs, TBAs and school teachers to be depot holders of ORS packets,

f) Use local songs and dramas to instruct mothers/caretakers to continue breastfeeding and, give the same or more amount of food and fluids to children with diarrhea , and

g) Promote diarrhea-specific preventive activities through *mahila mandals*, such as proper stool disposal of young children, latrine use, hand washing, personal hygiene, use of clean water for drinking, measles immunization and correct weaning practices

The project will assist the CMO and PHC staff to adapt and use supervisory checklists to assess the ORT competency of mothers/caretakers and to track referral completions of serious dehydration cases

Issues to be discussed with the CMO and PHC/SC staff include

- Who will be the master trainers?
- Who will provide support to trained community providers and private practitioners?
- Who will provide the ORS packets and drugs?
- Annual refresher training and re-certification,

- Wile the project plans to train all private providers with basic diarrhea assessment, classification and treatment, it will discuss with the CMO/PHC/SC staff on limiting the management of danger signs/severe dehydration to PHC/SC staff,

Key hygienic behaviors that the project will promote are the following

1 Proper sanitation, safe drinking water and personal hygiene (wash hands before and after defecation/urination, and before eating or cooking)
2 Protection of food from flies
3 Demonstrate the need of proper disposal of sewage, including construction of drains, toilets and soak pit

About 4,277 newborns each year and 10,049 children 0-23 months in Beruar Beri Block will be directly impacted over the life of the project

Centers of Excellence/Demonstration Site From the third year of the project, 1 PHC and 2 SCs will be developed as 'centers of excellence' (COE) or demonstration sites, hosting 'Lessons Learned/Best Practices' PHC-sharing workshops on quality case management of diarrheal diseases in under-5 children for PHC staff from the entire 17 blocks of Ballia district and 40 staff of 3 other WV ADPs in UP state The WHO/SEARO and UNICEF/Delhi will provide TA for this These sites will also eventually in the fourth year become a COE for Integrated Management of a Child with Cough or Rapid Breathing, Diarrhea or Undernutrition for the entire Ballia district

About 4,277 newborns each year and 20,391 children 0-59 months in Beruar Beri Block will be directly impacted, and about 90,164 newborns each year and 403,116 children 0-59 months in all the 17 blocks of Ballia district will indirectly be impacted over the life of the project

M 4 5 ORS and Home Available Fluids

The BRICS project will promote use of ORS packets Adequate supply of ORS packets with the help of district CMO office will be ensured These packets will be available at PHC, SC, selected shopkeepers (one per village) and with the RMPs ORS supply will be free from government Vendors will be encouraged to sell them at low cost

The program will monitor mothers'/caretakers'/health workers' skills in ORS preparation with the help of supervisory checklist for ORS (Annex 20)

The project will promote the use of home available fluids as rice water and legume/lentil water (e g , *dhal pani*)

M 4 6 I E C

The project will provide feedback to communities on the findings of the KPC survey/PLAs/FGDs a feedback of our findings of diarrheal in their villages, the prevalence of diarrheal diseases and death caused The IEC plans are described in section M 4 4

The media used for IEC will include video, posters, charts, flash cards, and counseling cards, adapted from organizations such as CARE, CRS, VHAI, UNICEF and translated into the local language Field testing of the IEC materials will be done first

M.4 7 Prevention

The project will

1) Install 20 hand pumps (in addition to 10 already installed) to provide safe drinking water to the poorest communities, installation of similar hand pumps by other NGOs and the Government in most of the villages is being initiated

2) Construct low-cost toilets for disposal of sewage or excreta and to inculcate habits of using toilets

PLAs in target villages have revealed villagers' felt needs for water and toilets, with construction plans being developed by the villagers Communities participate by financing 40% of the cost and contributing physical labor Selected community youths will be trained to repair hand pumps, allowing them to be skilled potential job seekers Community-raised funds will be used for the maintenance of toilets, drainage and hand pumps

M 5 PNEUMONIA CASE MANAGEMENT

M 5.1 MOH ARI case management policies

Doctors, nurses and ANMs are allowed to give antibiotics RMPs, drug vendors and other private practitioners also routinely prescribe antibiotics Traditional healers or VHGs may have "illegal" access to antibiotics Currently, no ARI/IMCI training programs available in the impact area

The MOH policy/protocol for pneumonia case management (please see Annex 28) recommends cotrimoxazole tablets and syrup for mild cases of pneumonia (for dosage/duration of treatment see Annex 28) For severe cases, hospitalization is usually necessary, with intramuscular antibiotics (Benzyl penicillin or ampicillin) or intravenous Chloramphenicol (please refer to Annex 28)

For children less than two months with pneumonia, the MOH-recommended antibiotic treatment is injection of benzyl penicillin or ampicillin plus injection of gentamycin

M 5 2 Use of case management services in the program area

The types and numbers of health providers who treat pneumonia in Beruar Beri Block (direct impact area) are as follows

Government PHC Doctors	ANMs	RMPs	Private Doctors MBBS/BAMS	Traditional Healers
4	17	62	10	30

Government PHC Doctors They are qualified and trained in the MOH protocol on pneumonia case management,
ANMs They are trained and can treat mild cases of Pneumonia
RMPs They are not trained and provide treatment by experience,
Private Doctor They are qualified doctors, probably not knowing or practicing the latest MOH ARI case management,
Traditional healers They are not qualified

According to November 1999 KPC survey of mothers with children under 2, the relative utilization of health care providers for the children who had pneumonia signs/symptoms in the past two weeks are as follows

Facility	% who utilized	Numerator/Denominator
District hospital	1 7	2/115
Health center	7 0	8/115
Private doctor clinic	57 4	66/115
Pharmacy	4 3	5/115
Village health volunteer	0 9	1/115
Traditional Healer	13 9	16/115
Relatives and friends	0 9	1/115
Home treatment	11 4	13/115
Did not seek treatment	11 4	13/115

The KPC survey finding also show that for pneumonia standard case management (SCM)

- health facilities (PHC/SCs) are not always open,
- health facilities don't always have the correct antibiotics/correct drugs,
- people have little trust in the public health service,
- people predominantly use other providers,
- people unlikely to leave their villages for care

The PHC in Beruar Beri Block has 4 beds, the number of in-patients is nominal No data are available for the number of pneumonia cases treated in the impact area

M 5 3 Quality of case management services in the program area

An estimated 70-90% of all curative services for children in Beruar Beri Block are delivered through private practitioners, most of whom lack regulation, standardization and training in standard case management of pneumonia in under-5 children The PHC doctors, LHVs, and ANMs have been trained in SCM of pneumonia Less than 10% of the private sector practitioners in Beruar Beri Block are trained in SCM of pneumonia None of the health providers are trained in the IMCI protocol Regular supervision of pneumonia SCM does not take place at all in the direct impact area

The findings of knowledge and practice of providers regarding pneumonia case management are as follows

- The PHC doctors and private qualified trained doctors have been trained in pneumonia SCM, although no refresher training has been conducted to upgrade their knowledge and case management skills
- The PHNs and the ANMs have been trained to identify and refer all cases of severe pneumonia, yet no refresher training in pneumonia SCM has been provided for them for the past several years
- The RMPs are not trained in recognizing danger signs and symptoms of pneumonia and do not have (let alone follow) the MOH protocol on SCM of pneumonia They often treat mild cases of pneumonia with third generation antibiotics (and no standard dosage is followed)

There are frequent, long stock-outs of antibiotic supply for pneumonia SCM in PHCs and SCs The RMPs purchase from the local chemists who have abundant supplies of cotrimoxazole and third generation antibiotics

M.5.4 Monitoring, improving and sustaining the quality of case management

The project will focus in the first 2 years on improving the quality of case management of pneumonia and in under-5 children The project's initial priorities will be

Priority 1 ***Strengthen public health facilities (PHCs/SCs)*** in relation to opening hours, staff availability, antibiotic availability, and rapport,

Priority 2 ***Identify community providers in each community (with MOH/CMO permission)*** who will provide quality case management of pneumonia These could include VHGs, TBas or AWWs (once ICDS is introduced to Beruar Beri block) Selection criteria for such community providers include

- available in village most of the time,
- able to keep simple records, even pictorial,
- has the respect of villagers,

The project will follow the following steps to facilitate this strategy

- Identification of current providers in the community,
- Identification of criteria for selection,
- Discussion of criteria for selection with the community,
- Selection, training and support of these community providers

Priority 3 — The BRICS project will conduct a *baseline study of the quality of home and private practitioner case management of childhood illnesses (including pneumonia)*

Both the KPC survey and PLA exercises revealed that the majority of mothers seek *private* practitioners for *curative* care for their sick children with pneumonia The project, therefore, will pay special focus to private practitioners The BRICS project will, in FY 2000, recruit a local consultant in adapting the generic BASICS/Kurji Holy Family Hospital/Bihar PVO II Operations Research questionnaire/methodology for the to study the "Quality of Home and Private Practitioner Case Management of Childhood Illnesses" (please see Annex 11) Following the baseline study, the project plans several CQI exercises with private practitioners to improve the quality of their pneumonia case management/service delivery, CQI instruments will be jointly developed with them to measure and track such improvements

The project will also conduct Health Facility Assessment (see Section M 4 3 4 for details) in April/May 1999 Through this proposed health facility survey, the current and future capacity of health facilities to provide essential (including pneumonia SCM services) will be determined

(To lobby support from the MOH/UP State health authorities to train community providers in pneumonia SCM, the BRICS project will provide the following literature review In a meta-analysis of 9 community-based trials of case management of acute respiratory infections by S Sazawal and R Black, a substantial reduction in total and ALRI-specific neonatal mortality was found This demonstrates that simple pneumonia case management, usually delivered at home, can have an effect in this age group In Bang's study in Gadchiroli, India, training of TBAs to diagnose and treat suspected pneumonia resulted in a 20% reduction in neonatal mortality and a 44% reduction in pneumonia mortality)

(The BRICS project is considering replicating The Innovative Community Level Intervention for Control of Pneumonia Operations Research Project of the MOH in nearby Nepal with technical assistance of John Snow, Inc One of the project's objectives was to expand appropriate pneumonia case detection and treatment beyond the health facilities to the level of the community health worker (CHW) level In this project, two intervention models were tested

i) Treatment model (where CHWs diagnose and treat using "pneumonia" using only cotrimoxazole and refer all "severe pneumonia and very severe disease,"
ii) Referral model (where CHWs only diagnose and refer all pneumonia cases)

(Both intervention models provided home care advice and follow-up)

Subject to MOH/CMO clearance, the BRICS project is planning to take up WHO/SEARO's offer to collaborate in a pilot project to develop a training module for these community providers BRICS and WHO will adapt from and simplify further the training modules developed by GOI/CARE/WHO for Basic Health Workers (please refer to Annex 20 which gives the algorithm for Basic Health workers (AWWs, AMNs) to Assess, Classify and Identify for Treatment of a Child with Cough of Difficult Breathing, Diarrhea, or Undernutrition)

Good continuing assessment, classification, and treatment practices Annex 20 gives a checklist for Monitoring Assessment, Classification, Treatment of Integrated ARI/CDD/Undernutrition Skills Training for Basic Health Workers (AWWs, ANMs) These can be used for PHC/SC staff re-trained in pneumonia SCM and can be further simplified for use with community providers trained in pneumonia SCM

A supervisory checklist (combining on-site *observation* of client-provider interactions and *exit interviews* of mothers/care-givers) will also be developed

The *observation part* of the checklist will monitor

A) ASSESSMENT
1 Whether the child's respiratory rate (RR) was assessed,
2 The degree of agreement with supervisors' count of the RR,
3 Whether pneumonia was diagnosed correctly,

B) CLASSIFICATION
Whether pneumonia classification was correct,

C) TREATMENT
1 Whether the choice of treatment was correct, based on the classification,
2 Whether children with "cough or cold only" were given antibiotics,

D) ADVICE ON ANTIBIOTIC TREATMENT OF PNEUMONIA
Whether the provider explained to the mother/caretaker the following
1 Dosage correct,
2 Times per day,
3 Duration of treatment,
4 Told to return in 2 days,

The *exit interviews part* of the checklist will monitor

A) RECALL OF ADVICE ON ANTIBIOTIC TREATMENT OF PNEUMONIA
Whether the mother/caretaker recalled advice correctly on the following
1 Dosage correct,
2 Times per day,
3 Duration of treatment,
4 Told to return in 2 days

B) RECALL OF HOME CARE ADVICE

Whether the mother/caretaker recalled advice correctly on the following

1 Return if breathing fast,
2 Return if breathing difficult,
3 Breastfeed frequently,
4 Feed during illness,
5 Give more fluids

Issues that will be discussed with the CMO/MOH/PHC/SC staff and WHO/SEARO include

- Who will be the master trainers?
- Who will provide support to trained community providers and private practitioners?
- Who will provide the antibiotics?--the CMO has assured the project of adequate supplies for the PHCs/SCs, but who will provide cotrimoxazole for the community providers?
- Annual refresher training and re-certification,
- While the project plans to train these providers with pneumonia assessment, classification and treatment, it will discuss with the CMO/PHC/SC staff on limiting the management of danger signs/severe pneumonia to PHC/SC staff and trained private MBBS/BAMS doctors,
- Recognition, e g putting flag with happy baby over house of provider trained in pneumonia SCM

The pneumonia case management objectives are given under Sub-Result #1a in section C 1

The BRICS project will focus on *improving quality case management of pneumonia* by

1) Conducting base-line assessment of pneumonia case management practices of both public sector and private sector health providers in Beruar Beri Block through on-site observation, questionnaires and exit interviews of clients,
2) Initially training and supervising the PHC doctors and LHVs, and the sub-center ANMs in the latest MOHFW pneumonia case management protocol,
3) Initiating an inventory system to monitor stock-outs, and working out a logistics plan with the CMO's office to ensure adequate supply of cotrimoxazole (the antibiotic of choice) is readily available at the PHCs and SCs year round (the CMO has already committed to ensure this),
4) Training the private sector practitioners (RMPs, Ayurvedic practitioners, and Unani/ Homeopathic practitioners or NGO staff) in the latest MOHFW pneumonia case management protocol

The project will also conduct missed opportunity surveys to *assess the level of access* on different days of the week and different times of the day or the year that mothers/care-givers have to get prompt antibiotic treatment for their children with pneumonia signs/symptoms

The project will also conduct qualitative PLA exercises to ascertain community willingness and ability to pay for antibiotics for pneumonia treatment CMO staff will be trained to develop and use tools to assess caretakers' timeliness of treatment-seeking behaviors for pneumonia in under-2 children

To *institutionalize essential household actions*, the BRICS project will

1) Conduct baseline PLA exercises and the KPC surveys to understand local beliefs, practices, vocabulary related to pneumonia recognition, care-seeking and compliance with treatment,
2) Adapt different messages emphasizing recognition and care-seeking for neonates/young infants and for older infants/children with pneumonia signs/symptoms,
3) Train VHGs, TBAs, AWWs, mahila mandals and ANMs to teach mothers and child care-givers to recognize, name and refer children with life-threatening pneumonia signs/symptoms, especially in neonates and in young infants (the groups at risk of death from pneumonia),
4) Equip health providers/volunteers to track all childhood pneumonia referrals and ensure referral completion,
5) Develop role-plays and observation checklists to assess the face-to-face counseling skills of the health providers and volunteers and to monitor the quality of client-provider interactions regarding antibiotic compliance and home care for children with pneumonia, and
6) Train health volunteers and providers to promote preventive steps such as measles and pertussis immunization, exclusive breastfeeding and improved weaning practices

The project will use technical staff from Ballia district CMO and the State MOHFW Directorate for retraining PHC and SC staff in standard case management of pneumonia The VHGs, AWWs and TBAs will be the principal communications channels for pneumonia referral and treatment The PHC and SC staff will be trained to refer all complicated pneumonia cases to the Ballia District Hospital

About 4,277 newborns each year and 7,922 children 0-23 months in Beruar Beri Block will be directly impacted over the life of the project

Centers of Excellence From the third year of the project, 1 PHC and 2 SCs will be developed as 'centers of excellence' (COE) or demonstration sites, hosting 'Lessons Learned/Best Practices' PHC-sharing workshops on quality case management of pneumonia in under-5 children for PHC staff from the entire 17 blocks of Ballia district and 40 staff of 3 other WV ADPs in UP state WHO/SEARO and UNICEF/Delhi will provide TA for this These sites will also eventually in the fourth year become a COE for IMCI for the entire Ballia district

About 4,277 newborns each year and 20,391 children 0-59 months in Beruar Beri Block will be directly impacted, and about 90,164 newborns each year and 403,116 children 0-59 months in all the 17 blocks of Ballia district will indirectly be impacted over the life of the project

The drugs from The PHC and SCs are supplied to the patients free of cost The drugs available from RMPs cost US$ 1-2 for five days' treatment for mild pneumonia The project is currently working out with the CMO to ensure round-the-year access of antibiotics for pneumonia

M 5 5 Involving workers who do not currently treat pneumonia

This is discussed in section M5 4

The number of health workers to be trained in pneumonia SCM is given in section F 1, F 2 and F 3

M 5 6 Program protocol for pneumonia case management

The MOH protocol on pneumonia SCM is attached as Annex 27 Annex 20 provides the GOI/CARE/ WHO algorithm for Basic Health Workers (AWWs/ANMs) to assess, classify, identify treatment of a child with cough of difficult breathing, diarrhea or undernutrition The project plans to simplify with WHO/GOI the latter for community providers once clearance is given

Children will be assessed for breathing with UNICEF-supplied timers (for all providers trained in pneumonia SCM) which the project is currently negotiating Counting of respiratory rate for full one minute using wrist watch having seconds needle or a ARI timer will be emphasized

Health workers will be trained to recognize chest indrawing through the use of WHO-supplied videos in Hindi and through actual clinical visits to the Ballia District Hospital and to clinics with a high case load id children presenting with rapid or difficult breathing Examination will include looking at the abdominal or lower chest movement in exposed condition in a calm or asleep condition

There is no prevalence of *falciparum* malaria, and the project will drop the malaria component

M 5 7 Counseling for antibiotic use, home care and referral

PHC doctors, LHVs, ANMs and RMPs will be trained to provide counseling regarding antibiotic use and home care of pneumonia at the time of consultation The list of advice to be given is provided in the proposed supervisory checklist mentioned in section M 5 4

The project will introduce a referral completion form to ensure prompt referrals of pneumonia cases Health workers will decide on feasibility of the referral based on the following criteria

- Socio-economic situation
- Support of family members
- Availability of transport
- Supplies/services available at the referral center, such as antibiotics, oxygen, medical specialists

The same village-based obstetric emergency transport scheme will be used if the family is having financial problems Funds generated by the apex bodies will be used in such cases where referral is not feasible If there is no elder in the family to support, youth groups will take responsibility for the mothers/caregivers of such children

Monitoring of the counseling will be done using a supervisory checklist mentioned in section M 5 4 and by the KPC during the MTE and FE

Quality of the counseling will be improved in the following ways

- Role-plays, using peer critique and checklists,
- Feed back to the counselors (ANM, VHGs),
- Refreshers training for the counselors,
- Face to face counseling skills to the counselors

M 5.8 Follow-up of children treated for pneumonia

For early or mild pneumonia, a follow-up consultation is recommended within two days after initial consultation Home follow-up visits will be made immediately by the health workers for those who fail to come for the follow-up consultation within two days

Mother/caregiver recall (of advice on antibiotic use) during exit interviews will be conducted with checklists to assess whether they know how to give oral antibiotics correctly (see section M 7 4) The caregiver will be asked to demonstrate how she measures and gives a dose of antibiotic to the child

Compliance failure is defined as failure on the part of the mother or caretaker to complete the treatment of the child when they see some improvement in the signs and symptoms of the child To check compliance failure the BRICS staff and SC staff will make random home visits to check whether the child has received complete treatment It can be cross-verified with the number of bottles, tablets or doses consumed during the period between consultations The mothers/ caretakers will also be interviewed to check the dosage and the number of days the child has been given medicine The caretaker will also be asked to demonstrate how they gave the doses

Treatment success will be measured by knowing the doses given, the number of days given and the type of drugs given In addition, other factors such as whether the mother has followed the recommended regimen will also determine the treatment success The success of treatment is determined by general improvement in the condition of the child and the disappearance of the signs and symptoms of pneumonia Treatment failure occurs when an assessment of the child is done 2 days after the initial consultation and found to have no improvement, or the child's condition has worsened (more difficult breathing, unable to drink and has other danger signs) In the case of a worsened condition, compliance will be checked and necessary referral and its completion will be ensured with the help of BRICS staff

M 5 9 Assessment of current access

From the remotest village in Beruar Beri Block, it takes 3 hours to reach the Ballia District hospital in the daytime, and about 5 hours at night, depending on the mode of transport An average of Rs 40/- (about US$ 1) per person or a total of Rs 120/- (US$ 3) for 3 people (who accompany the pregnant women) is typically spent by a villager in seeking treatment Transport facilities are usually available in the daytime, but at night they have to arrange for their own vehicles, such as tractors, jeeps, rickshaws or even carrying the child on foot

The fees charged varies from provider to provider average $3 to $5 for the cost of antibiotics The waiting time depends on the number of patients At the PHC, waiting time is about 30 minutes At the RMPs' clinics, waiting time is 15-30 minutes

The main constraint to obtaining treatment services is poor economic status Prompt care-seeking is often constrained by mothers-in-law beliefs, referral first to a traditional healer, and the unwillingness among women to make a decision if the husband is away

M 5.10 Definition of adequate access

Access can be defined in terms of physical, financial and availability of antibiotics Prompt medical services within a distance of 5 kms and the necessary transport are available to take the child and the family to the health care center Treatment is given free of charge at the PHC, but for access to private clinics families will have to pay $1, and all essential antibiotics will have to be available

M.5 11 Increasing access

To increase access to pneumonia SCM, the project plans to train community providers The project is exploring whether village pharmacies with antibiotic available can be established with community organizations and local NGOs

A recent PLA exercise found that 76% of the target population have access to treatment from some provider Around 20 of the 83 villages in Beruar Beri block are not linked to the main road, hence they do not have access to such services

If this plan succeeds, it is estimated that least 90% of the target villages will have access to pneumonia SCM This is critical, because even in the villages where there are proper roads and services available, the schedule caste and the "backward classes" do not have access to these services due to social restrictions

Severe cases of pneumonia will be taken to the PHC/District hospital using the emergency transport system to be established in the villages Social issues of caste will be addressed through development programs planned for the project such as MED and community mobilization

The project in collaboration with RMPs will introduce the 'free coupon' system Mothers will be given 5 green coupons depicting a child with pneumonia, along with the project logo Mothers will be required to bring the coupon together with the immunization card to the clinic to receive treatment for their child This will also ensure that the cards are kept safe

M 5 12 Beliefs, practices and vocabulary

Key PLA findings include

1) 40% of the community members are willing to pay for antibiotics Most of the people spend up to 10% of their income on medicines However the remaining were not willing to pay for medicine as they were very poor

2) Vocabulary related to pneumonia recognition, local beliefs and practices, care seeking and compliance with treatment In local vocabulary pneumonia is called *Haba Dhaba* or *lalmonia*, and some call it pneumonia as they have heard from doctors, if the child tends to cry a lot and refuses to eat, it is called *pasli chalna,* chest in-drawing is *sakkar sakkar,* a*lasth* is physical restlessness, *hafna* is fast breathing, and *dam marna* is difficult breathing *Tej Sans lena*[4], *sans phoolana*[5], *Pasli Chalna*[6], *Dood kum peena*[7] are some of the local terms for pneumonia signs and symptoms Chest indrawing and fever are recognized by caretakers and are considered serious

[4] Local term for fast breathing
[5] Difficult breathing
[6] Chest indrawing
[7] Breastfeeding poorly

They believe that the difference in body temperature of lactating mothers who take baths in the evenings, or eat cold food such as curd and rice, will give the child pneumonia A child is also believed to contract pneumonia from being exposed to cold or playing in cold water They also believe it spreads from one child to another, and believe that it mostly affects children in the age group of 0-5 years of age

3) For home treatment of pneumonia, there are several traditional remedies caretakers heat camphor and/or mustard oil and feed them to the child, they may also massage the body of the baby with heated mustard oil and garlic (a local oil, *nurani*, is also used), a paste of "Ajuvaine" (thymol) and mustard oil, or a paste made of dried peas and oil may be applied to the child's head, mothers may feed the baby heated cow's ghee (a semi-fluid clarified butter), and lactating mothers are given Ajuvaine to eat as a preventive measure Mothers also stop feeding children cold food They usually seek care from unqualified medical practitioners or traditional practitioners

4) Children are usually affected with pneumonia in the months of November-March (winter months) Mothers are ready to obtain medicines for their children at any time of the day and any day of the week when their child is ill

5) Caretakers/mothers provide initial treatment for pneumonia at their homes If the child does not improve they go to traditional healers/registered medical practitioner If the disease still persists they will seek out a PHC provider and other 'good' hospitals

Findings of November 1998 KPC Survey (please see report submitted under separate cover) revealed that

- 46% (136/298) of mothers reported that their under-2 child had a history of cough difficult breathing in the last two weeks to the survey, which was conducted in November, the beginning of cold winter season in the area
- 85 4% (117/136) of these children experienced rapid or difficult breathing, consistent with the diagnosis of pneumonia,
- 63 2 %(189/299) of mothers were able to recognize 2 or more dangers signs/symptoms of respiratory illness/pneumonia that would prompt them to seek care,
- 66%(76/115) of mothers reported seeking treatment for their under-2 child with pneumonia signs/symptoms, these included the 57 4% (66/115) of mothers who sought private practitioners This finding is consistent with those from the qualitative PLA exercises which revealed that the majority of mothers sought private practitioners for curative care for their sick children and public health staff for preventive health services
- 59 5% of mothers (178/299) said fast breathing, 32 1%(96/299) said difficult breathing, chest indrawing 14% (42/299), loss of appetite 11% (33/299), fever 40% (121/299), and cough 42 1% (125/299) as the signs they look for in taking their child to the health center for treatment Initially try home treatment, and if there is no improvement they go to a private clinic 57% (66/115)
- Decisions at the household level in seeking care are made by the husbands and mother in law

(The KPC survey instrument was not able to capture what percentage of children 0-23 months receiving antibiotic treatment were treated according to standard case management protocol, a separate assessment will be done later However, additional studies described below show that most treatments received do not meet established standards)

The barriers to seeking prompt recognition and prompt care are illiteracy among mothers/caretakers, although the majority of the mothers know one or another symptom Even though the mothers/caretakers seek treatment, this treatment is from untrained private practitioners, as they are easily accessible at any time of the day or night Other community-based health providers do not have training in pneumonia SCM, hence they are not available to the mothers seeking treatment

M.5 13 Communications for recognition and care seeking

The project will provide feedback to mothers, mothers-in-law and fathers on the findings of the PLA exercises and KPC survey on childhood pneumonia and its treatment The following media will be used for information and education video, posters, charts, flash cards, and counseling cards

The following matrix is a guide to the proposed IEC program

Groups to be targeted	Key messages	IEC activity to be conducted	Communicators	Time	How often
Mothers caretakers RMPs Animators ANMs VHGs	For children 3-11 months • Fever • Fast breathing (50-60 resps per minute) • Restlessness • Difficult breathing • Coughing (may or may not) For children 12-35 months • Fever • Fast breathing • Coughing • Difficult breathing For children <2 months • Chest indrawing • Difficult breathing • Inability to drink • Respiratory grunting • Drowsiness	• House hold visits of the mothers 0-5 years of age • Group meetings held by *Mahila Mandals* • Videos/demonstration • Trainings	• RMPs • Animator • ANM • PHN • Training personnel • VHG	• Noon hour • Noon hour • training session held	• Daily • monthly meetings • one time

The project will adapt IEC materials developed by organizations such as CARE, CRS, VHAI, UNICEF, WHO and translate into local language and use appropriate messages with the help of technical expertise from UNICEF Field testing of the IEC materials will be done prior to adaptation with the target groups

The quality of communication will be monitored taking into account the following

- Mode of communication
- Materials used
- Language of communication
- Methods in which materials used
- Message shared
- Time of communication
- Target audience served (15-45 years of age)

The mothers/caretakers will listen to the messages, discuss with their peers and put into practice the learnings The mothers will seek prompt care, take standard antibiotic regimen and reduce treatment non-compliance

M 6. MATERNAL AND NEWBORN CARE

M.6 1 Baseline Information

The *maternal mortality rate* for the UP state is 570 per 100,000 live birth (NHFS 1992-93/UNICEF 1997) No reliable data are available for the Ballia district or the direct impact (Beruar Beri Block) Although UP state has made strides in some districts in lowering fertility through family planning/spacing, maternal mortality remains high in Ballia district Seventy seven percent of the MMR in Ballia is pregnancy related (post partum hemorrhage, puerperal sepsis, eclampsia, abortion and obstructed labor In the direct impact area, the maternal malnutrition rate is 41%, and 87% of pregnant women have nutritional anemia (with mean hemoglobin levels among pregnant women as low as 9 2 g/dl--Agrawal/1987) and 20% are deficient in folic acid The 1992-3 NFHS found that only 29 5% of births were to mothers who had receiving iron/folate supplementation The November KPC 1998 found that only 7% of pregnant women had at least card-documented prenatal contact with the trained health provider, and only 8 8% had received iron/folate supplementation High fertility is related to 58 7% of maternal mortality

Eight-one percent of deliveries are conducted at home by an untrained attendant Half of maternal deaths occur at home and 10-15% occur on the way to a referral facility

Baseline PLA exercises with women exploring the major causes of maternal deaths revealed the following community perceptions

- Cutting of umbilical cord with unsterilized instruments (rusted blade, axe) leading to tetanus
- Excessive bleeding during delivery
- Anemia

- Obstructed labor
- Poor ante-natal care and checkups
- In-addition the following reasons were given
- Non-availability of vehicles to hospitals
- Placenta not completely removed and cleaned
- Frequent abortions
- Rupture of the uterus, loss of amniotic fluid during delivery, and fetal deaths

Neonatal mortality accounts for 60% of the IMR Main causes of neonatal mortality are ALRI 40%, low birth weight 29%, neonatal tetanus 10% (mirroring the low 5 6% TT2 card-documented rate), and pre-maturity and congenital malformations, 21% Based on an unpublished review by Barbara Stoll, infection from ALRI appears to be a more important cause of *late* neonatal death (8-28 days) than *early* neonatal death (0-7 days) Once a newborn has survived early causes of mortality related to congenital malformations, preterm birth and asphyxia, infection from ALRI becomes even more important proportionally as a cause of death As such, the project will address the emerging need for essential newborn care to reduce the number of neonatal deaths

M.6 2 MOH Policies, current public and private services

The Reproductive and Child Health (RCH) program, with the 4 components of child survival, safe motherhood, family planning and women's reproductive health, is the center-piece of its Family Welfare Program (FWP) in the Ninth Plan, involving a comprehensive re-orientation of the Program Over the past 30 years, India's FWP's single objective had been to reduce fertility through a strategy based on contraceptive targets and cash incentives However these latter strategies resulted in inflated performance statistics and neglect of quality of services Inherent in the new RCH program is a paradigm shift from the previous top-down, target-driven, vertically-oriented and quantitative approach to a decentralized, participatory, client-centered, integrated and quality-focused program

The following changes in program management have resulted from the policy re-orientation under the new RCH program, namely (a) implementation of decentralized district planning to replace national and state targets, (b) improving quality and accessibility of services, (c) increasing utilization of services through increased community participation through the *Panchayat* (village leadership) system

a) National maternal health policies and programs

The MOH protocol on Essential Maternal Care and Mmanagement of Normal Labor and Essential Newborn Care are appended in Annex 29 These call for

1 *Early registration* All pregnant women should be registered early during pregnancy so that monthly monitoring can be done With early registration, the annual estimation of the pregnant women to be followed up can be done for each SC and PHC, as well as for the district level It could also show the number of pregnant women not yet receiving essential maternal care

2 *Three antenatal checkups* during pregnancy to assess the normal progress of the fetus, and to detect and manage abnormal pregnancy The appropriate times for all three antenatal checkups are

First at 20 weeks' gestation or as soon as pregnancy is known
Second at 32 weeks' gestation,
Third at 36 weeks' gestation

3 *Antenatal counseling*

a) Pregnant women need to take an extra meal every day, to meet the increased nutritional demand Rest for at least 8 hour a day Heavy work should not be done or should be reduced,
b) Consumption of 100 iron/folate tablets (each tab contain 100 mg of elemental iron) during pregnancy in three months to meet the increased demand of iron
c) TT2 immunization to protect mother from tetanus and the fetus from neonatal tetanus,
d) Preparing for labor pregnant mother is advised to keep a new blade and thread for delivery The thread is to be boiled in water for 20 minutes She is also advised to keep ready a clean cotton cloth for herself and the newborn, she is also advised to initiate breastfeeding and continue it through the second year

For newborn care

a) During delivery the following clean procedures should be implemented clean hands before attending delivery, clean surface, clean razor or blade(clean cut), clean cord tie, clean cord stump, no application over it
b) The cord should be tied with a clean thread 2-5 inches from umbilicus The cord stump should be inspected for bleeding, if bleeding continues, apply another cord tie No application of any medication or dressing of the cord should be made

Breast Feeding

a) All newborns who cry soon after birth and are normal
b) The mother has to keep the newborn with her to put to the breast soon after birth
c) Breast feeding should be initiated within first hour of birth
d) No glucose water, honey, *jaggery*, or *ghuti* (herbal extract) should be given

Assessment of birth weight

Birth weight should be recorded soon after the birth by a spring balance with color-coding, but not later then 2 days Management of the newborn should be based on the following

BIRTH WEIGHT	COLOR CODE	WHERE TO MANAGE
more than 2 500 gms	Green	home
2 000 - 2,500 gms	Yellow	home
less then 2 000 gms	Red	referral

Prevention of hypothermia

a) To prevent hypothermia, the mother should keep the baby in close physical contact, wrapped in several layers of cotton or woolen clothes depending on the environmental temperature

b) If hypothermia persists in spite of above management, the baby should be kept under a lamp with a 200 watt bulb placed 45 cm above the baby If there is no improvement in 30 to 45 minutes the infant will be referred to PHC or District hospital

Low birth weight management

Newborns with a birth weight of 1,800 gm - 2,500 gm can be managed at home as follows if they have no signs of illness

a) provide warmth
b) exclusive breastfeeding
c) prevent infection (see below)
d) teach the mother to recognize danger sign for seeking help refusal to feed, increased drowsiness, difficult breathing, cold to touch, yellow staining of skin, convulsions

Referral

a) All newborns weighing less than 1800 gm should be referred for special care at the district hospital
b) Signs indicating a need for referral Poor suckling, hypothermia, lethargy, fast breathing, apnea, abdominal distention, cyanosis, diarrhea, convulsion, jaundice

Care of eyes

Clean eyes with a soft clean cloth or cotton swab using one for each eye Clean the eye from medial to lateral side Do not apply any eye drops or *kajal* (Indian remedy) to eyes

Care of skin

The skin should be cleaned with a dry and clean cotton or cloth, and not by water in cold weather In hot weather, the skin can be cleaned with lukewarm water after some time

Prevention of infection

Infection should be prevented by

1 Suction of secretions from the respiratory tract, if any
2 OPV and BCG vaccination within one month of in-home delivery, and at discharge in hospital and PHC delivery

Presently, the MOH is fully committed to safe motherhood as indicated by its new RCH program

b) Public/Private health facilities and services

Below is a summary of the potential health players to be impacted by the project

POTENTIAL HEALTH PARTNERS	DIRECT IMPACT AREA	INDIRECT IMPACT AREA
PUBLIC SECTOR HEALTH STAFF		
NO OF DISTRICT CHIEF MEDICAL OFFICE STAFF	**8**	**12**
NO OF PRIMARY HEALTH CENTERS (PHCs)		
• Current	1	17
• New	2	65
• **TOTAL**	**3**	**82**

NO OF PRIMARY HEALTH CENTER STAFF		
• Doctors	3	82
• Lady Health Visitors (LHVs)	3	82
• Auxiliary Nurse Midwives (ANMs)	3	82
• **TOTAL**	**9**	**246**
NO OF SUB-CENTERS (SCs)	15	366
NO OF SUB-CENTER STAFF (ANMs)	**15**	**366**
PRIVATE SECTOR HEALTH PROVIDERS		
NO OF TBAs (*Dais*)	79 (identified)	
(trained/untrained)	173 (reported)	?3,840
NO OF RMPs, AYURVEDIC PRACTITIONERS &		
UNANI/ HOMEOPATHIC PRACTITIONERS	71	?1,207
NO OF VHGs (functioning/non-functioning)	82	1, 852
LOCAL NGOs/GONGOs	5	?
• Rotary Club--Ballia		
• *Purvanchal Gramin Chetna Samiti*		
• Center for Rural Development		
• Public Support Group		
• SIFPSA		
VENDORS	15	214

Remote, underserved Ballia district has a three-tiered public health infrastructure Sub-centers (SCs) and Primary Health Centers (PHCs) in each of the 18 blocks, with the District Hospital in the District Head-quarters serving as the First Referral Unit (FRU) for the entire district The PHCs are the GOI's most peripheral non-hospital clinical facilities providing technical and commodity support (ORT, vaccines, weighing scales, vitamin A and iron-folate supplements and contraceptives) to the SCs Each SC serves 5,000-7,000 people (approximately 5-7 villages) focused on center-based services (antenatal care, family planning, immunization) and anti-malarial campaigns

However, WV customer appraisal exercises using PLA have found that (a) 70-90% of all curative services for women in Beruar Beri block are delivered through private practitioners, most of whom lack regulation, standardization and training in quality case management of obstetric emergencies, (b) the met need for obstetric services (i e the proportion of women with obstetric complications) which reflects the utilization of the District Hospital, is extremely low at 4 3% (c) there is no block-level FRU or post-partum center in Beruar Block, (d) a large number of maternal deaths are due to the lack of organized village-based transport for obstetric emergencies to the district hospital, to delays by pregnant women and their supporters (husbands, mothers-in-law and PHC/SC staff) in seeking assistance, and to delays in receiving appropriate care at the District Hospital due to inadequate equipment and skills of staff, (e) the PHCs and SCs do not have regular power supply and cold chain maintenance for TT vaccine is a challenge, (f) missed opportunities for TT immunization are numerous, as evidenced by the low card-documented 5 6% TT2 immunization coverage of pregnant women, and (g) there is no MOH policy or program for vitamin A supplementation of post-partum women

The three PHCs are supposed to be equipped to handle essential obstetric care They have the following in various stages of disuse or in need of repair, replacement or replenishment obstetric

table, gloves, delivery forceps, vaginal inspection specula, oxitocin, Methargin, IV saline sets None have a blood bank

The ANMs in their field visits are supposed to register the pregnant women, provide iron folate tablets, TT2 and follow up counseling to pregnant women on safe delivery and the birth spacing However, many of the SCs visited by BRICS staff in the past three months reportedly had run out of iron/folate tablets for pregnant women for more than six months Yet most of the ANMs run their own private practice and provide supplies for a fee

On the other hand, many private qualified doctors (MMBS/BAMS)[8], provide fee-for-service prenatal services (physical check-up and laboratory tests), and have a ready supply of iron/folate tablets, and TT vaccines for paying clients They also manage minor prenatal "abnormalities "

Drug retailers (local chemists) sell iron/folate tablets Some local unqualified "doctors"[9] administer injection of oxitocin and TT vaccine and manage minor ailments during pregnancy

There are total of 79 *dais* (TBAs--both trained and untrained) It is difficult to differentiate them On average, *dais* attend 45 deliveries (based on personal discussion with some dais) each per annum An ANM conducts approximately 40-45 deliveries per annum Other family members (mothers-in-law) conduct approximately 10-15 per annum

From the remotest village in Beruar Beri block, it takes 3 hours to reach Ballia District Hospital in the daytime and about 5 hours at night depending on the mode of transport An average of Rs 40/- (about US$ 1) per person or a total of Rs 120/-(US$ 3) for 3 people (who accompany the pregnant women) is spent by a villager for such emergency transportation Transport services are usually available in the daytime, but at night a villager has to arrange his/her own vehicle such as tractors, jeeps, rickshaws, or even manual transportation on a make-shift stretcher An estimated 35-45% of the population currently have access to essential obstetric care (EOC) Around 20 villages in the block are not linked to the main road, hence they do not have access to such services Even in the villages where proper roads and services available, the people from "scheduled castes" and the "backward classes" do not have social access to these services

The main constraints for obstetric emergency services are poor economic status, non-availability of transportation, and distance to the District Hospital, where EOC and blood transfusion services can be arranged

M 6 3 Knowledge and Practice

a) Barriers to prompt care seeking for obstetric emergencies include

1 Lack of emergency village-based transport services, especially at night
2 PHCs and SCs not adequately equipped for EOC in terms of trained staff, equipment and supplies

[8] Registered MBBS, BAMS with the Medical College
[9] RMPs (non MBBS, but certified by the Government based on experience)

3 Delay in decision making, as pregnant women do not have much say in how their deliveries are managed
4 Poor socio-economic status
5 Illiteracy and lack of health education

b) Knowledge of women and families regarding danger signs

The FGDs conducted in the community showed the knowledge of women and families about the dangers signs that indicate the need for prompt care-seeking during pregnancy, labor and delivery and post partum

During pregnancy Cessation of fetal movement, Edema, Vaginal discharge (bleeding)
During labor Prolonged labor
Delivery Rupture of membrane (premature)
Post-partum Hemorrhage, Odorous discharge

Usually cessation of fetal movement, prolonged labor, rupture of membrane (premature), and postpartum hemorrhage are signs that would lead women and the families in the project's target area to promptly seek outside care The decision about when and from whom to seek care outside the home is made by mothers-in-law and husbands The nearest referral center for attention to these signs is the Ballia District Hospital

The November 1998 baseline KPC survey found the following

TT vaccinations

- Only 35 8% (107/299) of mothers knew that tetanus toxoid (TT) vaccines would protect both mother and child against tetanus, another 11 4% (34/299) knew that TT would protect the newborn against tetanus,
- 47 5% (142/299) of mothers did not know why pregnant women are vaccinated with TT,
- 79 3% of mothers knew that 2 or more TT doses are needed by a pregnant woman to protect her newborn infant from tetanus,
- Only 5 6% of mothers had two card-documented doses of TT before the birth of her youngest child less than 24 months,

Reproductive Health

- None of the village clusters had functioning village-based emergency transport schemes for obstetric emergencies,
- 31 8% (95/300) of mothers with under-2 children reported at least one unintended pregnancy in the last 12 months,
- Only 8 8 %(26/295) of mothers who delivered their youngest child in the last one year received at least 90 iron/folate tablet supplements during last pregnancy,
- Sources of iron/folate tablets included the PHC (8 5%), ANM (11%), and SCs (3 5%),
- Only 7% (21/300) of mothers had *at least one card-documented antenatal* visit before the delivery the delivery of her youngest child less than 24 months,

- Only 1 7% (5/300) of mothers had at least *three card-documented antenatal visits* before the delivery the delivery of her youngest child less than 24 months,
- Only 17% (51/300) of deliveries in the last 12 months had been attended by a trained health provider or PHC/SC/ANM staff
- 33 3% (100/300) of mothers did not know of any food to prevent pregnancy, those who knew cited eggs (29 3%), and green leafy vegetables (26 7%)
- Only 4 7%(14/300) of mothers knew that a woman should gain at least 8-12 kilograms during pregnancy,

M.6 4 Approach

a) The BRICS project's maternal care component will focus on pre-pregnancy and antenatal care, delivery care, postpartum care, and newborn care

The maternal and neonatal component objectives and annual benchmarks are listed under Sub-result # 1 e and #1 b under section C 1 The maternal care component will support the MOH's new Reproductive and Child Health package in 5 ways

i) *The BRICS project's Community Development Organizers (CDOs) will mobilize and train 170 members of the youth clubs (Yuvak Mangal Dal/Nehru Youth Club) and the NSS to form village-base referral management teams to initiate village-based transport schemes for obstetric emergencies* initially in 40 of the more remote villages of Beruar Beri block, where half of maternal deaths occur at home and 10-15% occur on the way to the FRU--namely Ballia Hospital These transport schemes will help reduce maternal mortality from its principal cause, post-partum hemorrhage Introductory information exchange visits between convenors of these referral management teams and staff of the Ballia District Hospital and PHC will be facilitated by the BRICS project to accept women with obstetric emergencies The *mahila mandals* and *Parush mandals* (men's groups) in each village will also be mobilized to educate pregnant women and their immediate relatives in preparing for obstetric emergencies The project will also facilitate refresher training of PHC/SC staff (doctors, LHVs and ANMs) in identification, management and appropriate of obstetric emergencies (please refer to sections F 1 and F 2) Supplemental equipment will be provided to the PHC and SCs (see Annex 23) It is envisaged that at least 60% of the population of the direct impact area (Beruar Beri Block) will have access to an emergency obstetric health facility at the end of the 4-year project

ii) In Beruar Beri Block, 88% of deliveries are conducted at home by an untrained attendant and 77% of the high maternal mortality is pregnancy-related More than 95% of the 173 TBAs are not trained in clean delivery techniques currently To institutionalize well-managed deliveries by TBAs, the BRICS team, together with PHC/SC staff, *will initially train and equip 79 TBAs (dais)* in (a) prenatal care, (b) nutrition counseling of pregnant women, (c) referral of pregnant women for TT2 immunization, (d) recognition and referral of high-risk pregnancies and obstetric emergencies, (e) the use of TBA kits, (f) in clean delivery, (g) in essential newborn care, (h) in iron-folate distribution during pregnancy, (i) vitamin A distribution to post-partum women, (j) in birth spacing education, (k) in recording and reporting information

of each pregnant women--to identify for TT and prenatal referral and tracking of pregnancy outcome (live births, neonatal deaths, and maternal deaths)

iii) The project will mobilize ANMs, LHVs, TBAs, VHGs, local NGO staff and *mahila mandals* to *distribute iron/folate supplements to at least 35% of pregnant women* (1 tablet a day for at 100 days for all pregnant women, and 2 tablets a day for at 100 days to those clinically anemic, as per MOHFW guidelines)

iv) The project will also assist the PHC/SC staff in *pregnancy tracking to ensure that at least 35% of all pregnant women have at least three prenatal contacts* This will be done by introduction of community-owned pregnancy registers to allow systematic follow-up by pregnant women by TBAs, VHG and mahila mandals to ensure completion of referrals This is critical in Beruar Beri district, where only 7% of pregnant women have at least one card-documented prenatal contact with a provider All prenatal contacts, TT immunizations will also be recorded in a home-based maternal card (See section E 1 for a description of this innovative community-owned pregnancy register and Annex 13 for the pregnancy register form) Community use of these registers will facilitate VHGs, TBAs and *mahila mandals* to make post-partum visits within 4 weeks of delivery Any identified post-partum problems will referred by the VHGs, TBAs or mahila mandal members to the ANM in the nearest SC

v) *Vitamin A supplementation of post-partum women* The project is currently negotiating this pilot project with the MOH/CMO, including the logistical requirements of such a program (please see sections M 2 4 2 and M 2 4 2) As it is not yet a national program of the MOH, the project has postponed the possibility of pilot-testing low-dose supplementation of pregnant women in Beruar Beri Block, where the prevalence of maternal nightblindness is as high as 10% of pregnant women (UNICEF/ 1997)

vi) *Essential Care of The Newborn* The project plans to train 15 ANMs and in 173 TBAs (initially 79) in Beruar Beri Block to teach post-partum mothers in essential care of their newborns Focus areas include management of asphyxia, hypothermia prevention, low birth weight management, and establishment of exclusive breastfeeding

The project plans to conduct with the Ballia CMO a pilot project in 10 villages to introduce a simplified PATH weighing scale to the trained TBAs to identify and refer newborns with low-birth weight (<2,500 gm at birth) to the SCs and PHCs The project will facilitate dais to use colored beads to record weights

The BRICS project will

i) Re-assess the need to use eye drops With STDs rates likely to be high in the direct impact area, the project will assess the need for and the feasibility of antibiotic treatment of the newborns' eyes
ii) Review whether the quality of referral services for LBW newborns is sufficient to justify referral
iii) Explore the possibility of an OR study to pilot-test the application of antibiotics to the umbilical cord at birth

The BRICS project will track the impact of this intervention by pilot-testing community-based death surveillance focusing on investigations of deaths in the children 0-28 days, children 1 month to 59 months, and deaths in women 15-45 years The project will work with WHO/SEARO to adapt death investigation forms and the surveillance system from WV Bangladesh's CIDA-funded Chittagong CSP and the USAID-funded Dhaka Urban Integrated CSP (please see section M 1 10)

About 4,277 newborns and 4,277 post-partum mothers each year in Beruar Beri Block will be directly impacted, over the life of the project

b) *Training Curricula*

i) The BRICS project will use the MOH RCH training curriculum for *dais* The master trainers will train ANMs and LHVs The project will procure local technical assistance from SWACH for these training programs

ii) The components of training for the obstetric first aid will be comprised of the following
   a Management of prolonged labor by external manual manipulation for mal-position and mal-presentation,
   b Management of first degree cord prolapse,
   c Management of distress due to blood loss,

iii) TBA training kits The BRICS project will explore delivery packs (for all identified pregnant women) which have been used successfully by NGOs like SWACH in India Preparation of these packs is a potential income generation scheme for *mahila mandals* The kits will be supplied for the *mahila mandals* for the first 3 rounds free of charge These delivery kits will be given to the proposed attending TBA, and will each consist of clean cloth, thread, blade, forceps, and a pair of gloves The ANMs will also receive supplementary equipment to assist them in deliveries (see Annex 23)

iv) TBAs will use physical examination of fetal presentation and the fetoscope to assess any complications the need to refer Cases of prolapse of cord, mal-position/mal-presentation will be referred to the ANMs or jointly managed with the ANMs Any obstetric emergencies will be referred directly to the Ballia District Hospital To get help the cases will be directly referred to the District hospital There is no formal chain of referral

   Assessment tools used by the *Dais* and the ANMs for assessing the need for referral will include
   a Using fetoscope for determination of fetal distress
   b Premature rupture of membrane
   c Second and third degree of cord prolapse
   d Prolonged labor
   e

v) Birth attendants will be trained in the following for immediate care of the newborn
   a Clean cord cut
   b Clean cord tie
   c Clean Cord stump
   d Clean hand
   e Clean surface
   f Clearance of respiratory pathway

c) Sustainability
Activities to facilitate the technical, financial, and organizational sustainability of the selected activities are discussed in sections F 1, F 2, F 3, and H 1 and Annex 16, the Sustainability Action Plan

d) Program documentation method for the maternal care component

These include the maternal card and the community-owned pregnancy register (Annex 13) and TBA registers

e) Monitoring quality of services

This will done jointly with CMO/PHC staff through the use of supervisory checklists which will be developed in the next three months for TBAs, ANMs and PHC staff Intervention-specific indicators (annex 18) will be used to track progress toward objectives Repeat KPC surveys (MTE/FE), exit interviews, FGDs and PLAs will also be conducted by BRICS staff, PHC staff, local NGOs and other partners to assess the quality of services

M.6 5 IEC

ANMs, PHNs, trained *Dais* and project LCOs will contact all married women in the reproductive age group and conduct classes for them

Among the messages to be delivered during these IEC sessions are given in the matrix below The program will use audio-visual materials promoting TT immunization and maternal care developed by UNICEF, CRS, CARE and VHAI The messages will be adapted in the local language and will be mainly pictorial, as more than 70% of women are illiterate The materials will be tested in the community, with mothers obtaining professional assistance from UNICEF's communication consultants

Groups to be targeted	*Key messages*	*IEC activity to be conducted*	*Communicators*	*Time*	*How often*
• Mother with children 0-23 mos • Pregnant women • Mothers-in-law • *Dais* • Husbands	• Birth-spacing • Delay pregnancy up to age 20 • Have 3 ANC checkups • Take 100 iron folic tablets • Take at least 2 doses of tetanus toxoid	• House hold visits of the mothers 0-23 months of age • Group meetings held by *Mahila Mandals* • *Dais* Group training • Folk songs	• CDOs • ANMs • PHNs	Noon hour Noon hour	Daily monthly meetings

The quality of communication effort will be done by constant supervision at the field level done with the help of PVOs, PHNs, technical officers, and LHVs and will be monitored using the following framework

- Mode of communication
- Materials used
- Language of communication
- Methods in which materials used
- Message shared
- Time of communication
- Target audience served (15-45 years of age)

M 7 CHILD SPACING

M 7.1 Current status of family planning

Fertility
The 1992-93 NFHS found that 58 7% of women in Ballia practised high-risk fertility behavior (i e had births at ages less than 18 years or more than 35 years, had 4 or more births, and had birth intervals less than 24 months)

Population Council and SIFPSA 1996 data revealed (a) the desired family size is still large (3 or more children), (b) 33% of men and 70% of women were not correctly aware of the legal age of marriage of girls, (c) over 50% of men reported no communication with their wives on their reproductive goals and acceptance of contraception when it occurred, it was initiated by the husband, and only after 2 or 3 children, (d) the contraceptive prevalence rate for modern methods is 8 1% in Ballia district (against a national average of 41%), (e) the use of contraceptives for spacing is still an alien concept--86% of acceptors were using family planning to stop childbearing and only 14% of family planning acceptors were adopting non-terminal methods (mostly IUDs), (f) most men who accept family planning do so to stop childbearing among these, 40% prefer to use non-terminal methods--this underlines the need for wide range of cintraceptive choices as well as the option of changing from one method to another, if they so desire, (g) 39% of currently married women (against a national average of 19%) and 29% of married men reported an unmet need for family planning--this gap was mainly because few men expressed an unmet need for spacing, and (h) 19% of women reported at least one unintended pregnancy

WV PLA exercises found 60-70% of married women reporting 1-3 abortions/pregnancy terminations This practice of using abortion as a fertility control method has grave consequences WHO (1996) estimates that 1 out every 8 maternal deaths in UP state is due to unsafe abortions

The 1996 SIFPSA survey in Ballia district also revealed that family planning services were of poor quality in terms of access, choice, counseling and client-provider interactions, as evidenced by the following findings (a) non-existence of community-based distribution of contraceptives, (b) 86% of couples who have accepted a contraceptive use sterilization (almost exlusively vasectomy), indicating a heavy program bias towards permanent metrhods, (b) contraceptive choices offered to clients are limited, with only about 4% of streilization acceptors told about IUDs, and only 11% of sterization acceptors told of the surgical procedure, how the method works, and about side effects, (c) 85 9% of PHC/SC resources were focused on family planning, with private clinics, local NGOs and vendors committing only a minor proportion (12 5%, 18 9% and 22% respectively), of resources to family planning, (d) missed opportunities for child spacing services were significant, with only 55% of SCs having oral contraceptives on the day of the visit, and only 41% of SCs having condoms on the day of the visit

The KPC survey conducted in November 1998 revealed that

- 74 98 % (206/275) women did not want any more children for the next two years,
- 31 8% (95/300) of mothers with under-2 children reported at least one unintended pregnancy in the last 12 months,

- Only 8 1% (24/282) of women who desire no children in the next 2 years or are not sure, are using modern contraceptives

There are no reliable data available on contraceptive drop-out rates

Other baseline PLA exercises showed the following

a) Misconceptions regarding contraceptives such as oral pills causing excessive bleeding Women also mentioned experiencing bleeding and back pain from IUDs Condoms are not preferred as they are believed to reduce sexual pleasure

b) *The participation of men in family planning* is low as they believe that methods such as vasectomy reduce their sexual pleasure and their ability to work Though women prefer birth spacing they are pressured by their husbands who threaten to seek other sexual partners or stop providing for household expenses if their wives use contraceptives They long for a boy child which results in frequent pregnancies Families also prefer to have several children, as they are a source of additional income for the family, believe they have increased physical strength from having numerous children, and they fear the children they have will die Usually mothers prefer to have a birth interval of 2-5 years

c) Most of the *Dais* have limited knowledge they say that pills have to be consumed as well as inserted inside the body Supplies of contraceptives is also poor VHGs are the community-based distributors of pills and are selected by the Government However they are not being utilized properly and effectively for distribution

d) Most RMPs do not provide any family planning services They say that they refer eligible couples to the PHC for sterilization Some RMPs who stock condoms supply them to their clients

M 7 2 MOH Policies, Current Services, Knowledge and Practices

(a) *MOH Policies*

The Reproductive and Child Health (RCH) program, with the 4 components of child survival, safe motherhood, family planning and women's reproductive health, is the center-piece of its Family Welfare Program (FWP) in the Ninth Plan, involving a comprehensive re-orientation of the Program Over the past 30 years, India's FWP's single objective had been to reduce fertility through a strategy based on contraceptive targets and cash incentives However these latter strategies resulted in inflated performance statistics and neglect of quality of services Inherent in the new RCH program is a paradigm shift from the previous top-down, target-driven, vertically-oriented and quantitative approach to a decentralized, participatory, client-centered, integrated and quality-focused program

The following changes in program management have resulted from the policy re-orientation under the new RCH program, namely (a) implementation of decentralized district planning to replace national and state targets, (b) improving quality and accessability of services, (c)

increasing utilization of services through increased community participation through the *Panchayat* (village leadership) system

The Ballia CMO has made the improvement of family planning/birth spacing services his top priority

(b) *Current Services and Facilities*
The PHCs in Beruar Beri Block provide sterilization services (tubectomies/vasectomies), Norplant, oral contraceptive pills and condoms The SCs provide oral contraceptives and condoms Some ANMs provide IUD insertions The PHCs and SCs are the main depot holders The contraceptives are easily available with regular and continuous supply In several villages, VHGs provide community-based distribution (CBD) of oral pills and condoms None of the contraceptive service providers had had refresher training in the recent past and almost none provide systematic IEC and counseling services

The November 1998 KPC survey found that modern methods preferred by couples were pills 4 9% (12/245), tubal ligation 2 4% (6/245), condoms2% (5/245)

Women have ready access to condoms and oral pills in the SCs and PHCs, except in the more remote villages, where CBD of oral pills or condoms has yet to commence Condoms are also readily available from vendors and local chemists

Main constraints to family planning
Though family planning service is high on the MOH/CMO agenda, its success is limited because it lacks three essentials (a) adequate supply (b) trained providers and (c) counseling Supply of oral pills and condoms in remote villages is limited or non-existent There are tremendous socio-cultural barriers as outlined in section M 7 1 above There is an urgent need to increase male participation in child spacing PLA findings indicate that community members perceive that they are deprived of their client rights to privacy of services, comprehensive and accurate counseling, and quick referrals of complications

M 7.3 Approach

The BRICS Project will introduce a range of innovative Family Planning (FP)/Birth Spacing (BS) activities to increase access, improve the quality of services and increase demand Under the new RCH program of the MOHFW, a paradigm shift is in process from the previous top-down, target-driven, vertically-oriented and quantitative approach to a decentralized, participatory, client-centered, integrated and quality-focused program for FP/BS The UP State government has withdrawn contraceptive method-specific targets from Ballia district To increase the contraceptive prevalence rate among couples with under-2 children from the current 8 1% to 20%, the BRICS project will facilitate the following activities

1 *Client identification* The *panchayats* willl be encouraged to establish a village-level health information system in each village, focusing on a few critical indicators that can be 1) visually represented, 2) be tracked regularly by themselves, 3) result in action, and 4) lead to improved

health, reduced fertility and reduced mortality The project will recommend two fertility-specific indicators for community tracking (i) women's age at first birth--indication of pre-birth interval (women's age at first birth minus women's age at marriage) to promote community/social norms for delayed age of marriage, longer pre-birth intervals, and need for family spacing, and (ii) percentage of active users of modern contraceptive methods (temporary/permanent) BRICS staff, working with village *panchayats*, *mahila mandals*, ANMs, VHGs and TBAs will identify the couples who desire the family planning services These workers will be trained by the PHC doctors and LHVs

The community-owned pregnancy register that the project plans to introduce (please section E 1 and Annex 13) will also be another source for identifying and targeting women after delivery for child spacing or family planning *Mahila mandals*, VHGs and TBAs will be trained for this by BRICS staff

After eligible couples have been identified, the next step would be to follow them with intensive IEC on modern contraceptives (condoms and oral pills) at the community level, with demonstrations on their usage Those who indicate interest will then be referred to the nearest SC or PHC for contraceptive services

2 *Commodity Management*

The BRICS project will

a Help increase access to FP/BS services by partnering with with the USAID-funded SIFPSA (State Innovations in Family Planning Planning Agency), and 3 local NGOs to promote community-based distribution of contraceptives (oral pills and condoms) in 30 relatively remote villages where public health facilities (PHC/SCs) do not exist or are far away,

b Mobilize 15 private sector vendors in 9 underserved villages to sell condoms and oral pills in Beruar Beri, and

c Train and utilize 71 private sector practitioners to provide contraceptives

SIFSA will work with both public and private sector service providers in coming up with a contraceptive logistics monitoring system to ensure that the procurement of contraceptives by a couple will be gauranteed over time

d Test alternative strategies to strengthen the public sector family planning with SIFPSA, the Ballia District CMO, and PHCs and SCs in Beruar Beri Block (i) improving contraceptive choices at the PHC and SC level, where staff will be encouraged to promote spacing methods such as oral pills and condoms, and (ii) meeting unmet need by ensuring that PHCs and SCs have at least 3 months' supply of contraceptives at any one time,

3 *Training*

The project will recruit SIFSA's technical assistance in increasing client satisfaction by training PHC doctors, LHVs and ANMs in interpersonal communications skills as family planning/spacing counselors to counsel clients on family planning/spacing methods, their effectiveness and side-effects A supervisory instrument will be pre-tested to assess the quality of the client-provider

interactions and mointor the stock-out rate of contraceptivers in PHCs and SCs (This is especially critical in Beruar Beri Block, where a 1996 SIFPSA survey found that most men who accept family planning do so to stop childbearing--among these, 40% preferred to use non-terminal methods, thus underlining the need for wide range of contraceptive choices as well as the option of changing from one method to another, if they so desire The same survey also revealed that 39% of currently married women and 29% of married men reported an unmet need for family planning--this gap was mainly because few men expressed an unmet need for spacing) *Essentials of Contraceptive Technology* from the Johns Hopkins School of Public Health, Population Information Program, will be used as a family planning training curricula for the different types of health worker

4 *IEC*

The BRICS project will facilitate

i) *The launching of a large-scale community-based advocacy program* in Beruar Beri block where the use of contraceptives for spacing is still an alien concept, and where 86% of acceptors use family planning to stop childbearing and only 14% of family planning acceptors adopt non-permanent methods (mostly IUDs)

   The village *panchayats, parush mandals* (men's groups), *mahila mandals*, VHGs, TBAs, and private sector practitioners, youth groups aand adolescent girls will be mobilized through community assemblies, villages dramas and songs, PLA exercises and FGDs The advocacy program will highlight the important linkages between child spacing and child survival--that child spacing patterns have a powerful effect on the survival chances of the Indian child in UP state To promote the need for longer pre-birth and birth intervals, data will be shared from the 1992-93 NHFS which found that infant and child mortality increase sharply as the length of the preceding birth interval decreases, that infant mortality is 3 times higher in children with a preceding birth interval of less than 24 months compared to children with birth intervals more than 24 months, and that only 28 9% of birth intervals exceed 24 months in UP state The advocacy program will also promote community/social norms for delaying the age of marriage, especially in Beruar Beri Block, where 33% of men and 70% of women are not correctly aware of the legal age of marriage of girls Efforts will be made to promote a smaller desired family size (three or fewer children) from the current desired family size which is still large (3 or more children) The project will also highlight the need for reduced high-risk fertility behavior currently 58 7% of women in Ballia District practise high-risk fertility behavior (i e have births at ages less than 18 years or more than 35 years, have 4 or more births, and have birth intervals less than 24 months)

ii) *The BRICS project will mobilize the men's groups (parush mandals) in FP/BS and increase the demand for male family planning methods* The project will use focus groups and PLA exercises to encourage men to allow their wives to communicate with them about their reproductive goals and acceptance of contraception,

iii) The BRICS project will assist in impacting maternal mortality reduction by *discouraging the practice of using abortion as a fertility control method.* In Beruar Beri Block, 19% of women report at least one unintended pregnancy and 60-70% of married women report 1-3 abortions/ pregnancy terminations,

iv) The BRICS Project will *increase awareness among youth of reproductive issues* by engaging male youth group members in a series of dialogues on family planning and spacing, and by introducing an adolescent reproductive health curriculum for high school girls

v) The BRICS project will work with NGO partners and PHC/SC staff to adapt IEC materials developed by organizations such as CARE, CRS, VHAI, and UNICEF into the local language and use appropriate messages with the help of technical expertise from SIFPSA Field testing of the IEC materials will be done prior to adaptation

The IEC activities can be summarized in the following matrix

Behavior change objectives	*Groups to be targeted*	*Key messages*	*IEC activity to be conducted*	*Communicators*	*How often*
Men/women with children less than 24 months/or are not sure will be using modern contraceptive methods	• women • men • adolescent youth	• one is fun • small family, happy family • *Bebi rakho tip top ek ke badd full stop*	• Household visits of couples with children <24 mos • Group meetings held by *Mahila Mandals* • Adaptation of materials • Demonstrations • Social marketing of contraceptives	• CDOs • Animators • ANMs/PHNs • RMPS • VHGs	• During daily vists • Monthly meetings • Monthly camps • When mothers seeks treatment for sick child

The quality of the IEC messages will be monitored according to the following categories

- Mode of communication
- Materials used
- Language of communication
- Methods in which materials used
- Message shared
- Time of communication
- Target audience served (15-45 years of age)

Repeat KPC surveys during the MTE and FE will be used to monitor the impact of the IEC messages on behavior and practices

The IEC materials currently available are video, posters, charts, flash cards, and counseling cards

5 *Quality improvement*

In FY 2000, the BRICS project will procure local technical assistance from AVSC International India office facilitate COPE (Client-Oriented Provider-Efficient) exercises in the direct impact area with all program partners and SIFPSA These COPE exercises are a process as well as a tool to improve the quality of family planning and other reproductive services

The four COPE tools that make up the main body of a COPE exercise are

Self-assessment guides focusing on

Clients' rights to	Information, Access, Choice, Safety, Privacy, Confidentiality, Dignity, Opinion, Comfort and Continuity
Staff needs for	Good supplies and site infrastructure, Good management and supervision, Information, Training and Development,

Client Interviews Done by PHC/SC staff with the aid of a Client-Interview Form,

Client-Flow Analysis (CFA) a "low-tech" method of tracking clients through a clinic or Subcenter from the time they enter to the time they leave,

Action Plan Prepared by PHC/SC staff using the three other tools, which describes the problems that staff have identified, recommended solutions and the persons responsible for it

The COPE tools will also look at the missed opportunities for family planning/child spacing, stock-out rates of contraceptives, and procedures for prevention of infection

6 *Sustainability*

The project's efforts to assure the technical, financial and organizational sustainability are reflected in sections F 1, F 2, F 3 and section H 2 and in Annex 12 (Sustainability Action Plan)

7 *Linkages to Other Partners*

A key strategy of the child spacing component is to build *strategic alliances* with SIFPSA (a GONGO), the CMO/PHC/SC staff, private practitioners and local NGOs and community as mentioned in sections F 1, F 2, F 3 and section H 2 and in Annex 12 (Sustainability Action Plan)

8 *Documentation Method*

The monitoring indicators tracking the impact and coverage of the child spacing component are listed in Annex 18

Other instruments will be developed after the COPE exercises

N TECHNICAL ASSISTANCE PLANS

The qualifications and experience of the key PVO Headquarters, country and program site staff are appended in Annex 15 Steps to increase intervention-specific skills are listed in section I 4 The technical assistance schedule and source are listed in the workplan (section G)

ANNEXES

DETAILED IMPLEMENTATION PLAN

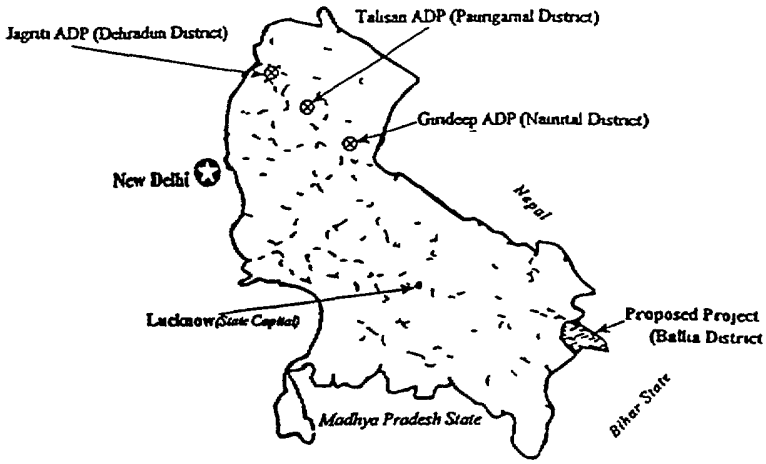
WORLD VISION INDIA
Ballia Rural Integrated
Child Survival Project
(BRICS)

March 31, 1999

Annex 1

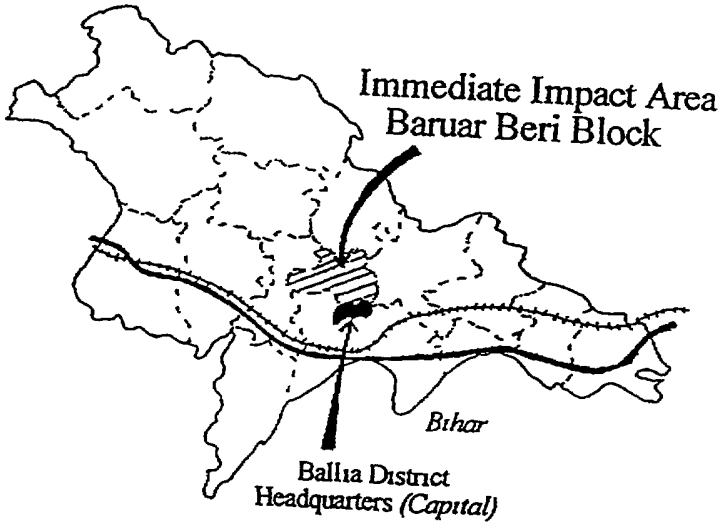
Map of India

Map of Uttar Pradesh State

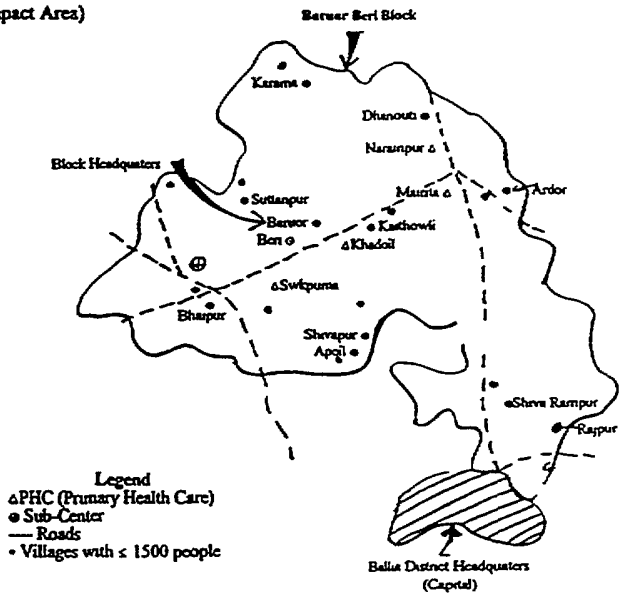


⊗ Sites of three other World Vision ADPs (Area Development Projects) in Uttar Pradesh State

Map of Ballia District (*with 17 Blocks*)

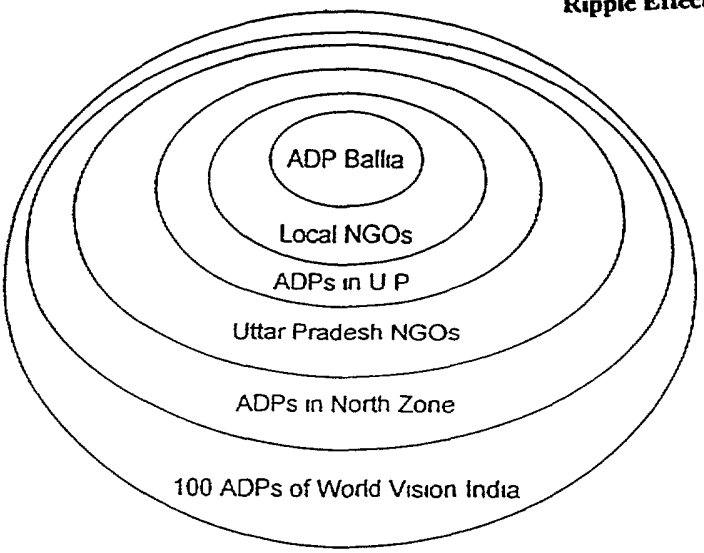


Map of Baruar Beri Block
(Direct Impact Area)

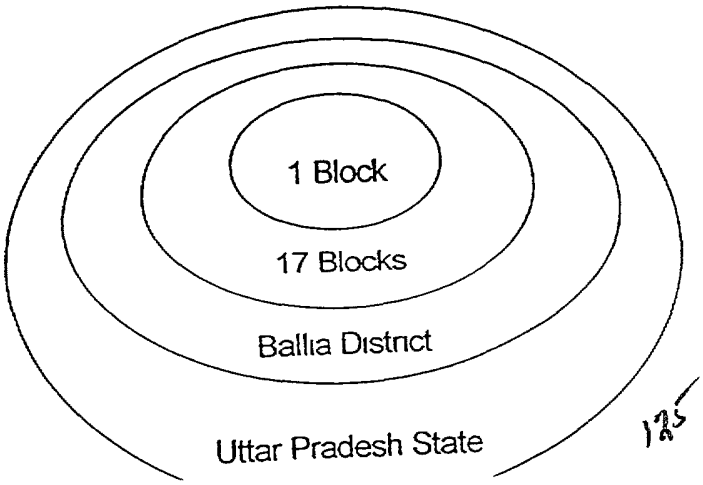


Institutionally

Ripple Effect Diagram



Spread of Impact Geographically

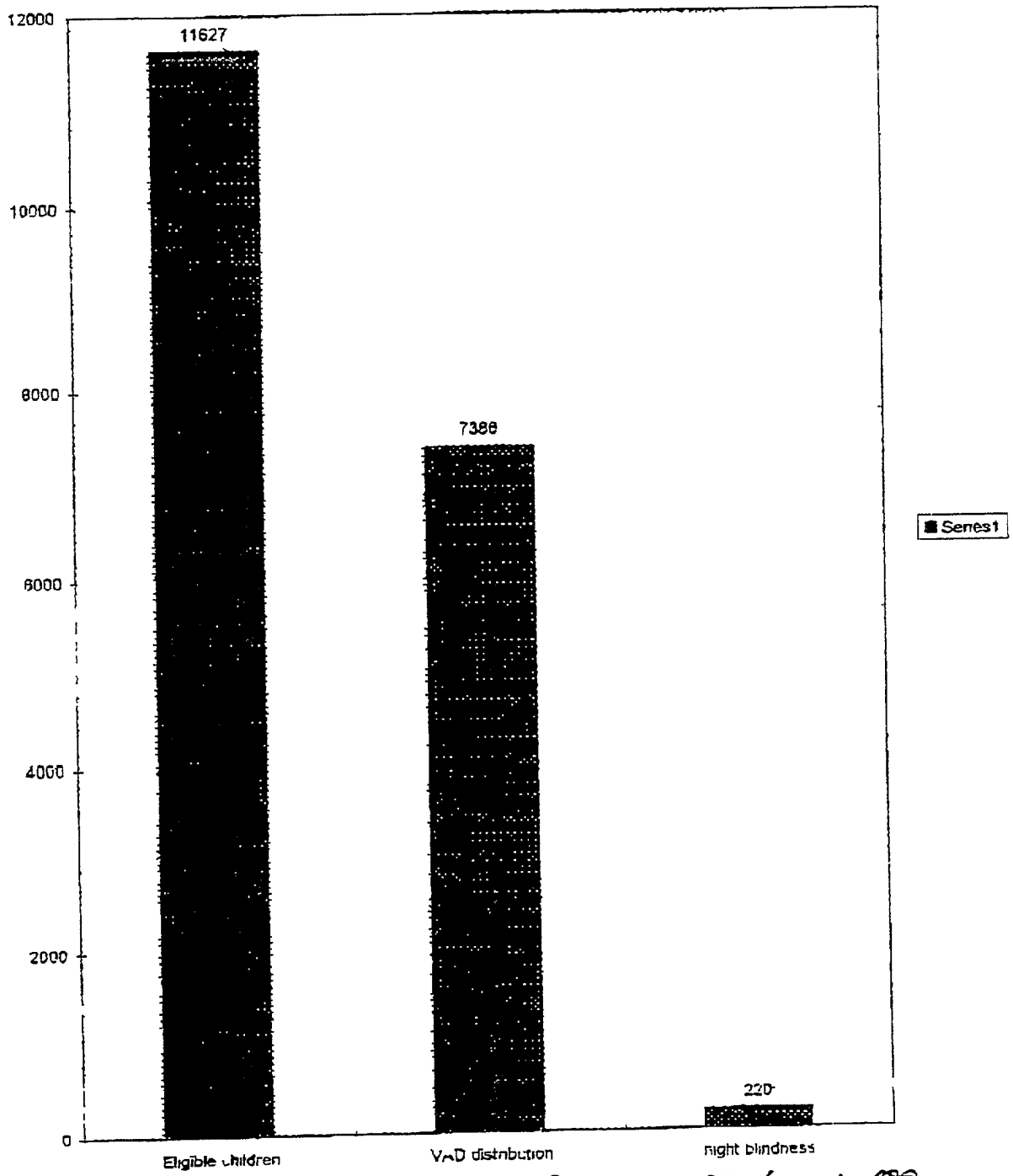


Annex 2

(1)

BALLIA RURAL INTEGRATED CHILD SURVIVAL PROJECT

NIGHT BLINDNESS SURVEY (Feb, 21, 1999)



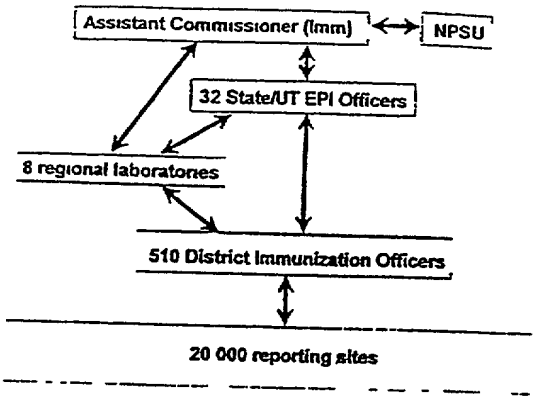
Coverage on Feb 21, 1999

220/7386 × 100 = 2.97% Nightblindness Prevalence Rate

Annex 3

Data Flow

AFP Surveillance in India

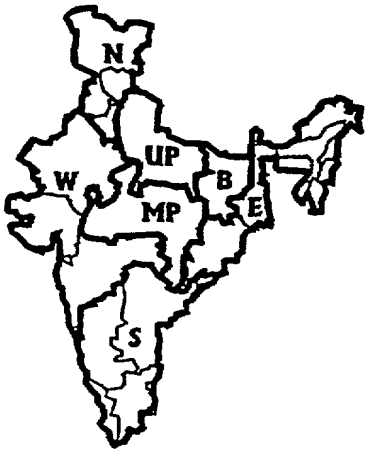


Current Status of AFP Surveillance

India, September 1997

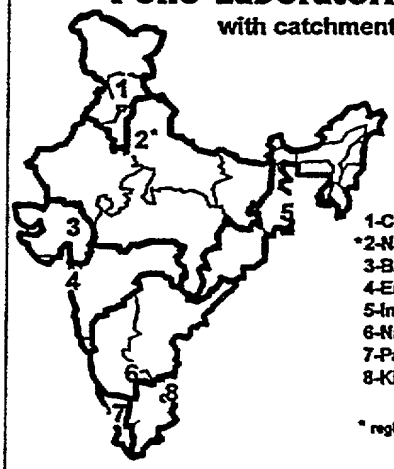
- only clinical polio cases are reported
- no standard case definition
- no linkage to lab specimens
- intensity of surveillance varies
- age, sex, OPV status, date of onset reported for <50% of cases

7 Regions of India for AFP Surveillance



Polio Laboratories in India

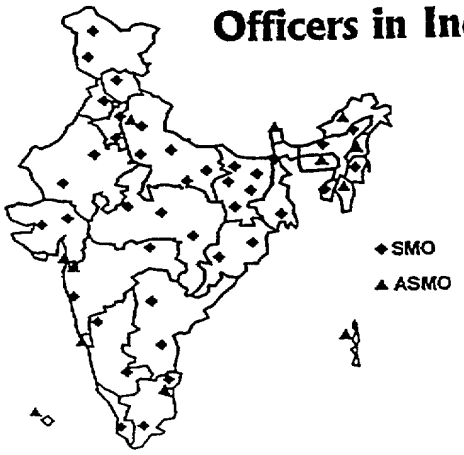
with catchment areas



1-Central Research Institute, Kasauli
*2-Nat'l Inst. for Communicable Dis., Delhi
3-B.J Medical College, Ahmedabad
4-Enterovirus Rsch. Ctr., ICMR, Mumbai
5-Institute of Serology, Calcutta
6-Nat'l Institute of Virology Bangalore
7-Pasture Institute of India, Coonoor
8-King Institute, Chennai

* regional reference lab

Distribution of Surveillance Medical Officers in India



District Immunization Officer Activities

for AFP Surveillance in India

- identify and enroll reporting sites
- weekly report to State EPI Officer
- weekly monitoring of timeliness and completeness
  - quarterly report to State EPI Officer
- active searches of reporting sites
  - monthly x3, then at least quarterly
- immediate investigation & follow-up of cases
- feedback

Annex 4

Centre for Rural Development, Raghopur, Athilapura P O ,
Rasra, Ballia, 221 712, Utter Predesh, India
March 4, 1999

Partnership with World Vision

We are ready to share our resource on following areas

1 Orientation programme for the village level animators and village leaders on People's organization

2 Micro enterprise training programme for

3 We have well formed community organization of women and men

4 Training for village level health workers on mother and child health care

Areas we would like to get help from World Vision

1 Specialized training in community health
2 Training on PRA
3 Training on Tuberculosis
4 Financial assistance to train our Health workers and Animators
5 Cooperation in world heath day celebration
6 Introducing our organization to the government and other organizations

Joseph
Director
Centre for Rural Development
Athilapura Raghopur
Ballia 221712

Purvanchal Gramin Chetana Samiti
Centre for Rural Development
Raghopur Rasra Ballia

Short History The organization was established in the year 1979 for Social Animation of the poor, oppressed farmers, laborers and unemployed villagers of Varanasi diocese at present consisting 7 districts The infant steps of it were in the villages of Katayan and Lahasani of Gazhipur and Ballia respectively Rt Rev Patrick D'Souza bishop of Varanasi was the main inspiration and Rev Fr Ivan Josepn was the pioneer to begin this noble task It began under the project of Animation and Community Building The organization was registered under Indian Society registration Act in 1983 having its office at St Pushpa Ashram, Jamwoan, Ballia In 1985 it was shifted to Center for Rural Development, Raghopur, Rasra, Ballia Since then it has been reaching out to more than 500 villages of this diocese It has formed more than 400 village groups through animation and Community Building Each village unit has 15 to 20 members totaling about 7 000 altogether Almost 300 units have established small savings and credit unions There is a total of 8,00,000 Rs in various saving accounts

Aim - Self reliance, self-governing and united development

People's animation, people s organization and peoples revolution for a structural change

Through nonformal education, adult education and school education marching towards a better society

Objectives - Economical, social educational hygienic instructions and animation of the villages through meetings
Educating people in leadership for developmental works
Causing discussions and debates on social problems and bad social systems and their effects and helping the community to find solutions for them
Finding people and finance force for social welfare
Building a common fund for community development
Educate people to march towards progress through hard work and united efforts
Teach cleanliness and preventive measures in health matters

Activities - Organize meetings of villagers twice a month
Form men and women groups for developmental works
Encourage small savings and credit unions for economic progress
Encourage literacy through nonforml education adult education and school education
Find alternatives for economical development through mincroenterprise small scale industry, home industry, tailoring, etc
Health awareness through health camps consientaization, immunization and preventive care
Help women and youth to get employed through microenterprise training etc

4-2

Aim and objectives for 1999 - Force all the grown up children to go to school
Regularize Anganwadi schools in the villages
Get all the benefits from ANMs regarding health and hygiene
Find all the alternatives for employment of women and youth
Bring awareness about new economic policy and its bad effects on poor and farmers
Implement all the development programs of Government available for the area
Help the ration and retail price shops function better
Help the Grampradhan to get all the benefits from the government

4-3

H Q 5/149 Bechala Pokhara Belthara Road Distt Ballia 221715 U P
प्र0 का 5/149 विचला पाखरा बल्थरा रोड जिला – बलिया –221715 उ0प्र0 ।

प्रतिनिधि
PRATINIDHI
MEDIA FOR DEVLOPMENT

Ref No

Dated

We are ready to share other resources in following areas

1 Training community on Pachayat Raj issue

2 Assisting BRICS to work with Panchyat

3 Sharing of expertised in PRA and convergence

4 Need based partcipatory Training programme

We would like to get help from world vision

1 Organisational development

2 Process documentation and managment information system(M I S)

3 Proposal writing

4 Health experties sharing

THANK YOU FOR YOUR NICE CO- OPRATION & HOPE IN FUTUR

ENVIRONMENTLY YOUR'S

Dr MAZHAR A RASHIDI
(Secretary)
Secretary
Pratinidhi Sansthan
5/149 Bichala Pokhara
Belthara Road, Ballia-221715 (U P)

A Civil Society of Working for Development through Empowerment

4-4

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ABOUT THE PRATINIDHI

Pratinidhi a centre for partcipatory learning and action is a ragistered civil society working as a support organisation for local institution (such as panchayat,youth club,self help group[SHG] and community orgnisation) on empowement related issues through training, workshop , study circles and dissemination of information and action oriented works (dimonstration) beside capicity building organisation PRATINIDHI also carries out process documentation, partiapatory research and studies, evaluation , participatory training etc on various issues of funding agency & small civil society

keeping in view of objective PRATINIDHI organises various training programe for local institution(such as panchayat,SHG,community organisation)chief functionries middle level functionrise focusing on leadership development

for all the progarams,booklets manuals learning materials taeching aids are being produced and dissemination There in four quarterly bulletins are also being published to provide timaly to community and panchayat repersentative

VISION Empowerment through people centred development

MISSION Building capicities of community organisation through and approch where people are placed in the centre of all the development initiative

OBJECTIVE -

- To ensure the community participatiory in development process strengthen local institution to ensure enable to panchayat
- To encourage participation of women and deprived classes in panchayats
- To promote intrection of local instituation ,community and adminstration through the convergence process
- To facilitate flow of news views and information
- To orgnisation programme one structured around health do education community development resources and skil development

Strategy -

To operationalise the objective PARTINIDHI has adopted specifice strategy and plan depending on the focus of each centre and the nature of its constitucncies

- Community Organisation
- System Development
- Convergence Community Action
- Participatory Learning & Action

OUR PROGRAMME AREA -

1 Panchayat Streangthing

2 SHG Formation & Streangthing

45

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3 Helth & Nutration

4 Community Oraganisation

OUR PROJECT -

1 Rural Empowerment in Panchayat Groups

2 Environment & Helth Education Programme

3 Joint Forest Management

4 Awareness motivation in rural people through agricultural labour

5 Particepatary development & self employment programme

OUR KEY INTRERVENTION ON PANCHAYAT INSTITUTION

Seventy thirdd and seventy fourth amendments to the constitution are aimed at revitalising institution to local self governance in rural and urban areas respectively Accepting the challenges posed by the two amendments, PRATINIDHI dicieded to work to strengthen panchayat instituation In the present time PARTINIDHI selected 10 Gram Panchayat for direct intervetion We have also developed the two micro plaining by panchayat member and follow up through conervegence convergence community action is a forum of solving the problum wiht the community

OUT COME / IMPECT -

Through our intervention panchayat emerged as important issue in the community Panchayat realised that opportunities like reservation for women and deprired classes of the society could be tapped for improving the standard of living in the villages They also realised that withour involment with the rural communities, keeping in viewthe changes taking place in development process

PRATINIDHI has been able to reach the information about new lows, rules and order to the village & Panchayat It has published qurterly news letter is easy hindi for community & panchayat repersentatives

OUR TEAM -

We are team professionals drawn from varied disciplines, Our programme staff is aided bg the ifficient support four devision with library etc

'भारत सरकार द्वारा प्रायोजित' S T D No 05498
SPONSORED BY GOVERNMENT OF INDIA No-21324

नवल शिक्षण एव शोध संस्थान
NAWAL EDUCATIONAL & RESEARCH INSTITUTE
पजीकृत गैर सरकारी सगठन
REGISTERED NON-GOVERNMENTAL ORGANISATION
प्रधान कार्यालय : मुहल्ला-मिड्ढी, जिला-बलिया (उ० प्र०) 277001
Head office Mohalla-MIDDHI, District-BALLIA, Pin 277001

Reg No ..... /NERI/ .. ... / Date . ...

To

The Project Officer
WORLD VISION OF INDIA
A D P Ballia

Sub **About Organisation & the activities**

Dear Sir,

With reference to your letter dated 8 3 99, regarding the N G O network under banner of BRICS Project of jointly develop the roles, responsibilities and capacity strengthening plans on the basis partnershi In this reference I draw your kind attention towards the following points as desired by you

Organisation - Nawal Shikshan Evam Shodh Sansthan (Nawal Educational & Research Institute) Ballia is a registered NGO under Society Registration Act 21,1860 vide Reg No 854 dt 25 3 91 & renewal No 135/97 dt 2 8 97

Working Areas - Urban & Rural Areas of the District Ballia, specially in Block-Dubahar & Hanumanganj, Beruarbari

Objectives - The summary of the objectives of the organisation area-

1 Technical/Vocational - Learning & Training

2 Adult & Non-formal Education

3 Coaching - Teaching/ Training

4 Health Education & Training

5 Integrated Development Programmes Income Generating Programmes for the peoples - which belongs to low income group & below poverty line

6 Survey & Research work on Socio-Economic Problems

7 To established the Library & Reading room

8 Panchayat Training Programmes

9 To organising educational Awareness, workshop, seminar programme on Health, Population Control, Environment & Pollution Aids Drug Abuse Prevention, Immunization, Family Welfare Safe Child Motherhood, (Mother & Child health care) Malnutrition etc

10 Community organisation at village level 4-7

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'भारत सरकार द्वारा प्रायोजित' S T D No 05498
SPONSORED BY GOVERNMENT OF INDIA No-21324

नवल शिक्षण एवं शोध संस्थान
NAWAL EDUCATIONAL & RESEARCH INSTITUTE

पंजीकृत गैर सरकारी संगठन
REGISTERED NON-GOVERNMENTAL ORGANISATION
प्रधान कार्यालय : मुहल्ला-मिड्ढी, जिला-बलिया (उ० प्र०) 277001
Head office Mohalla-MIDDHI, District-BALLIA, Pin 277001

Reg No .. . . /NERI/ . . .. / Date .. ...

Recognised by-

1 Ministry of Welfare, Govt of India
2 Ministry of Environment & Forest, Govt of India
3 Ministry of HRD (ICSSR)
4 Labour (Central Workers Education Board)
5 U P Voluntary Health Association
6 Family Planning Association of India
7 U P Control Board- Women & Child Deptt
8 Gandhuan Institute of Studies
9 Prayag Sangit Samity
10 Land Use Council
11 Regional Rural Development Institute
12 Labour Deptt
13 Drug Abuse Deptt
14 Central Pollution Control Board
15 Environment Deptt
16 Bachapan Bachao Andolan
17 Indian Animal Welfare Board
18 Human Rights Commission

Pulse Polio International

Nehru Yuva Kendra Sangathan
FINGO DAP
The Society for Capital Market Research Development
E C I U P Chapter & others
Staff Health worker 2
Social worker 13
O C 1
Class IV 1
Doctor Consultant 3
Annual Budget Rs 1,13,500 00

48

135

'भारत सरकार द्वारा प्रायोजित' S T D No 05498
SPONSORED BY GOVERNMENT OF INDIA No-21324

नवल शिक्षण एवं शोध संस्थान
NAWAL EDUCATIONAL & RESEARCH INSTITUTE

पंजीकृत गैर सरकारी संगठन
REGISTERED NON-GOVERNMENTAL ORGANISATION
प्रधान कार्यालय : मुहल्ला-मिड्ढी, जिला-बलिया (उ० प्र०) 277001
Head office Mohalla-MIDDHI, District-BALLIA, Pin 277001

Reg No .. .. /NERI/ .. .. / Date .. ...

Supports provided by organisation to BRICS

1 Organising Training /Workshop on safe child Motherhood Project

2 Organising Health Melas

3 Organising Community awareness programmes

4 Organising Panchayati Raj Training

Supports Required from World Vision

(A) For Training Workshop / Health Melas/ Awareness Programmes - Survey, PRA
(B) Learning materials
(C) Training & planning for integrating family planning into our existing programme
(D) Training our staff in primary health care

Sushil Kishore Srivastava
SECRETARY
Nawal Educational & Research Institute
BALLIA

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unicef
United Nations Children's Fund

UNICEF FIELD OFFICE
14 B Mall Avenue
Lal Bahadur Shastri Marg
Lucknow 226 001
Tel 211196 239317
239318 239481 239527
Fax 0522 239566
Cable UNICEF LUCKNOW

Luc/101/B4/278

3 March 1999

Dear Dr Kumar,

Technical support for community based Disease and death surveillance

Thank you for your letter dated 1 March 1999 inviting me to Ballia for the training of functionaries on community based disease and death surveillance

As discussed with you, Dr Dennis T Cherian and Dr Rakesh K Singh earlier, UNICEF shall support technically the initiative of World Vision of India in strengthening Mortality and Morbidity surveillance in Eastern U P , specially, Baruarbari Block of Ballia district

We wish you all the best in strengthening the district health system to improve MIS and disease surveillance

Thank you and with best regards

Yours sincerely,

Dr K R Antony
Project Officer (Health)

Dr Subodh Kumar
CSP Team Leader
Ballia Rural Integrated Child Survival Project
Post Box No 25
Distt Ballia
U P 277 001

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AGREEMENT BETWEEN

DISTRICT MEDICAL AUTHORITIES, PRIMARY HEALTH CENTER

&

BALLIA RURAL INTEGRATED CHILD SURVIVAL PROJECT

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FROM 138
PHONE NO
Mar 27 1999 04 32PM P5

Agreed Roles & Contributions between Primary Health Center and Ballia Rural Integrated Child Survival Project.

INTERVENTIONS	ROLE OF PHC	ROLE OF BRICS
Pneumonia	⇒ Adequate supply of drugs ⇒ Treatment on ARI diseases as per MOH policies	⇒ Educating Communities ⇒ Training to PHC staff / RMPs / NGOs on latest MOH Pneumonia Case Management ⇒ Assisting PHC in communications and referral management
Diarrhea	⇒ Organizing medical camps ⇒ Supply of drugs and ORT stock ⇒ Treatment for persistent Diarrhea & Dycentry	⇒ Training to PHC staff/ RMPs/ VHGs on latest MOH policies ⇒ Establishing ORT corners ⇒ Educating communities on ORT / ORS intake , hygienic conditions that should be maintaned, proper stool disposal, safe / clean drinking water ⇒ Assessment of ORT competency throguh Supervisory checklists ⇒ Educating mothers on food intake during diarrhea and the initiation of breast feeding
New Born Care	⇒ Adequate supply of	⇒ Training PHC staff on

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FROM PHONE NO Mar 27 1999 04 33PM P6

	medicines / clinical management of Asphyxia and hypothermia	management of Asphyxia and Hypothermia ⇒ Educating post-partum mothers on the importance of exclusive breast feeding ⇒ Training TBAs in indentifying and in referral management
Immunization	⇒ Vaccine supplies ⇒ Cold Chain Maintenance ⇒ Organizing Pulse Polio / mass immunization programs ⇒ Organizing Immunization camps at the time of outbreaks of EPI diseases	⇒ RCH cards ⇒ Mobile Team ⇒ Community mobilization ⇒ Training to PHC staff on cold chain maintenance and Vaccine storage ⇒ Training RMPs/ VHGs / TBAs on immunization referrals ⇒ Assisting PHC in conducting mass immunization camps ⇒ Role- Workshops on CBDDS for PHC staff and the community ⇒ Missed opportunity surveys & trainings ⇒ Educating community on the importance of immunization

Mar 27 1999 04 33PM P7 PHONE NO FROM 140

Malnutrition & Vitamin A deficiency	⇒ Supply of Vitamin A Supplementation ⇒ Health Education	⇒ Assisting in supply of Vitamin A supplementation to communities ⇒ Educating communities on night blindness in children and in pregnant women ⇒ Educating communities on rich local food recipe and early initiation on exclusive breastfeeding ⇒ Train PHC staff / TBAs / VHGs/ NGOs on malnutrition and Vitamin A supplementation ⇒ Supply of documentation cards
Reproductive Health Coverage	⇒ Health Education on Family Planning ⇒ Organizing family planning camps ⇒ Supply of contraceptives ⇒ Supply of Iron / Folic tablets ⇒ IEC ⇒ Counseling ⇒ Strengthening of CBDs	⇒ Educating Communities on family planning ⇒ Educating communities on using modern contraceptives ⇒ Training PHC staff / VHGs / TBAs on safe and hygienic delivery practices ⇒ Educating youth and the community on obstetric emergency ⇒ Train the PHC staff on essential of family

FROM PHONE NO Mar 27 1999 04 34PM P8

		planning and different methods ⇒ Strengthening of CBDs through various trainings ⇒ Educating communities on birth spacing ⇒ Training RMPS on hygienic delivery practices ⇒ Ensuring that all the PHC staff and TBAs are trained to attend deliveries ⇒ Ensuring TBAs on delivery kits

This was discussed and finalized in the DIP workshop on 18th & 19th January, 1999, and follow up meetings This was witnessed by Mr Naresh Kumar, Collector, Ballia District & Dr O P Singh, Chief Medical Officer, Ballia

Medical Officer PHC Umesh Kumar
(Dr Umesh Kumar)
Medical Officer
P H C Barh
Ballia

CSP Team Leader Subodh Kumar
(Mr Subodh Kumar)

Add Dr Umesh Kumar
Medical Officer
Primary Health Center
Beruai bari
Ballia Distt
U P

Add Mr Subodh Kumar
CSP Team Leader
World Vision
Post Box no 25
Ballia - 277 001
U P

Phone/ fax - (05498) 23014
E mail - adp_ballia@wvi org

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SIHFW
राज्य स्वास्थ्य एवं परिवार कल्याण संस्थान, उ० प्र०
इन्दिरा नगर, लखनऊ-226016
State Institute of Health & Family Welfare, U. P.
Indira Nagar, Lucknow-226 016 ☎ 382201, 384147. Fax 0522-[illegible]201
Dr. V. K. Srivastava
Director

D.O.No.9A-335/SIHFW/([illegible]H)/96
No.

Date 18 Nov., 1997

Subodh Kumar,
Manager
World Vision of India
Post Bag 2, Lajpat Nagar II.
New Delhi 111 024

Dear Sir,

I acknowledge with thanks the receipt of your letter date 17 November, 1997 and to know about your project Ball Integrated Child Survival Project which is being taken-up one of the Blocksof Ballia District. This effort on the part of World Vision is really commendable as Ballia being one the remotest districts of U.P. I hope that the project wil make a dent on the RCH services in the area and will lead certain fruitful recommendations.

State Institute of Health and Family Welfa U.P. at Lucknow is a premier institute in the field training and research in the health sector. We will be hap to extend all the support and technical expertise for t success of the project. I will appreciate if you writeto the role that this institute has to play in this project

With kind regards,

Yours sincerely,

(V.K. Srivastava)

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FROM

PHONE NO

Mar 26 1999 08 55PM P5

Appendix II

भारत सरकार
GOVERNMENT OF INDIA
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
MINISTRY OF HEALTH & FAMILY WELFARE
क्षेत्रीय स्वास्थ्य एवं परिवार कल्याण कार्यालय
Regional Office for Health & Family Welfare
सी-2, सी-ब्लाक, महानगर, लखनऊ, उ०प्र० C-2, B-Sec, Mahanagar Lucknow, U.P.

तार : Telegram
परिवारकल्याण : Parivarkalyan
दूरभाष : Tel.-
फैक्स : Fax-

No - 4531
दिनांक : Date : 19.11.97

Shri Subodh Kumar,
Manager, ADP-Ballia,
World Vision of India-North Zone,
B-3, Lajpat Nagar, II,
New Delhi - 24

Sub: Ballia Integrated Child Survival Project.

Dear Sir,

I am extremely thankful to you for taking up the Child Survival Intervention Project in district Ballia. You have sought technical expertise in this regard. I agree with t Project Proposal on the following interventions:-

1. Organization of the community partners for sensitization about reproductive and Child Health Problems prevalent in the community, as well as capacity building so they may act as effective partners in implementation of the R.C.H. Programme.

2. Convergence of the health infrastructure as well as community partners at the grass root level for effective planning, implementation and monitoring of the RCH programme.

Further, it is advised that you may please discuss your proposal with the Chief Medical Officer, Ballia so duplic of the efforts may be avoided.

I wish you all success in your endeavour.

Yours faithfully,

(P.L. Joshi),
REGIONAL DIRECTOR(H&FW)

Copy to:
1. The Director General, F.W., U.P., Lucknow.
2. The Addl. Director, H&FW, Azamgarh Mandal, Azamgarh.
3. The Chief medical Officer, Ballia.

(P.L. Joshi),
REGIONAL DIRECTOR(H&FW

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Annex 5

Assessment and Monitoring Tools
For
Institutional Capacity Building of NGOs

BALLIA RURAL INTEGRATED CHILD SURVIVAL PROJECT

Adapted From Paper June 1998
Jointly Developed by IPHC and its Funded NGOs

DEFINITION OF MANAGEMENT CAPACITY

प्रबन्धन क्षमता की परिभाषा-

Management Capacity refers to the ability of the NGOs to effectively plan implement and evaluate their own MCH and FP programmes with increased participation form both community and government

प्रबन्धन क्षमता का आशय अशासकीय सगठनों के क्षमता का विकास जिससे वे प्रभावशाली नियोजन, क्रियान्वयन तथा मूल्याकन कर अपने गर्भावस्था तथा शिशु स्वास्थ्य तथा परिवार नियोजन के कार्यक्रमों मे समुदाय तथा सरकारी सहभागिता प्राप्त कर वृद्धि करना है।

Criteria *श्रेणी*	*Measurable Indicators* *अनुमापक सूचकाक*	*Means of Verification* *प्रमाणीकरण का औसत*
The NGO is able to develop its own project proposal for Donars and GOI with specific Objectives and Goals स्वय सेवी सस्था अपना प्रकल्प प्रस्तावना वनाने में समर्थ जो दाताओ व भारत सरकार हेतु सुस्पष्ट उद्देश्य व लक्ष्य युक्त हो।	The organisation is able to prepare a project proposal with realistic Goals and Objectives सगठनस प्रकल्प प्रस्तावना बनाने मे समर्थ हो जिसमे वास्तविक लक्ष्य व उद्देश्य का समावेश हो	Project Proposal प्रकल्प प्रस्तावना
Capable to manage project personnel प्रकल्प कामिको के प्रवन्धन में योग्य	Service rules are approved by Executive Committee (EC) and shared with staff सेवा नियमों को शासन सबधित समिति अनुमोदित कर कमचारियो सग वाटेगी	Service rules सेवा नियमावली
	Personnel records are maintained व्यक्तिगत लेखा प्रमाणों को सभाला जाये	Personal files व्यक्तिगत फाइल (बन्धियॉ)
	Recruitement of staff is done according to job specifications and recruitment policy कार्मिको की भर्ती तथा कार्य व्याख्या भर्ती सबधी नीतियों के तहत होगी	Copies of relevant certificates and documents within personnel files प्रमाण-पत्र की प्रति तथा दस्तावेज व्यक्तिगत फाइलो में होगी
Personnel is being developed accroding to project needs प्रकल्प के आवश्यकतानुसार कर्मचारियो का विकास होगा	Staff development plans are prepared and implemented कार्मिक विकास योजना बनाये तथा क्रियान्वयित होगे	Staff appraisal record कार्मिक मूल्याकन लेखा Staff development plan कार्मिक विकास योजना
Good leadership is developed अच्छा नेतृत्व का विकास	A participatory planning decision making process is in place एक सहभागी नियोजन तथा निर्णय लेने वाली प्रक्रिया का निर्माण	Minutes of staff meetings कमचारी वेठक का विवरण

Criteria *श्रेणी*	*Measurable Indicators* *अनुमापक सूचकाक*	*Means of Verification* *प्रमाणीकरण का औसत*
	Delegation of responsibility with authority is in place प्रतिनिध मडल की जिम्मेदारी प्रभुत्व सम्पन्न के साथ स्थान विशेष मे	Staff job descriptions, office memos/circulars कर्मचारी कार्य विवरण कार्यालय मेमो/सर्कुलर
	Staff are satisfied and motivated कार्मिक सतुष्ट एव प्रोत्साहित	Staff turn over record कार्मिक लाभाश लेखा
The NGO is able to supervise supervise, monitor and evaluate the programme effectively अशासकीय सगठन पर्यवेक्षण, निर्देशन तथा मूल्याकन मे प्रभावशाली रूप मे योग्य होगी	Regular supervisory mechanisms are in place नियमित पर्यवेक्षण तत्र उस स्थान विशेष में होगी	Progress Reports उन्नति वृतान्त Workplans कार्य योजनायें
	Programme is monitored and evaluated periodically कार्यक्रम का निर्देशन तथा मूल्याकन निश्चित समयान्तराल मे होगा	Programme meeting minutes कार्यक्रम बैठक विवरण Supervisory checklists पर्यवेक्षण जाच सूचिया Supervisory reports पर्यवेक्षण वृतान्त Evaluation reports मूल्याकन वृतान्त
Co-ordination and networking of the project between GOI, NGO and other agencies exist भारत सरकार तथा अन्य अशासकीय सस्थाओ के साथ प्रकल्प का समन्वय व जानकारियो को अन्त करण होगा	The organisation coordinates with other agencies सस्था का समन्वयक अन्य सस्थाओं के साथ	Meeting minutes बैठक विवरण Metting records बैठक लेखाये
	The organisation mobilises and utilises local/non-local resources सगठन स्थानीय तथा अस्थानीय ससाधनो को उत्प्रेरित तथा उपयोग करेगी।	Project reports प्रकल्प वृतान्त

Criteria *श्रेणी*	*Measurable Indicators* *अनुमापक सूचकाक*	*Means of Verification* *प्रमाणीकरण का औसत*
	The organisation participates in GOI/NGO programmes and activities सगठन भारत सरकार तथा अशासकीय सगठनो के कार्यक्रमो तथा गतिविधियो मे सहभागी होगी	Project records and reports प्रकल्प लेखा एव वृतान्त
An effective Management Information System is in place एक प्रभावशाली प्रबन्धन सूचना प्रणाली स्थान विशेष में होगी	Data collected by individual worker/staff are being used for developing their own future workplans in achieving targets set समको का सग्रहण व्यक्तिगत कार्यकर्ता /कर्मचारियो द्वारा जिसका उपयोग उनके भविष्य कार्ययोजना का विकास तथा लक्ष्य प्राप्ति हेतु होगा	Data collection forms, sample surveys, monitoring and evaluation reports, workplans समक सग्रहण प्रपत्र, निर्दशन सर्वेक्षण, निर्देशन तथा मूल्याकन वृतान्ते, कार्य योजनाये
	Cummulative data is effectively compiled analysed and used for planning, implementing and evaluating the programme at project level सचयी समक का प्रभावशाली सग्रहण, विश्लेषण तथा उपयोग, नियोजन, क्रियान्वयन तथा मूल्याकन जो कि प्रकल्प स्तर के कार्यक्रम के लिए होगा	Monthly reports, annual reports, strategic plans मासिक वृतान्त, वार्षिक वृतान्त नीति योजनाये
An active participation of the Executive Committee in the decision making process of the project is in place शासन सबन्धित समिति प्रकल्प स्थान पर निर्णय बनाने की प्रक्रिया मे सक्रिय सहयोगी होगा	The Executive Committee is selected or elected and is functioning as per constitution शासन सबन्धी समिति चयन या चुनाव करेगी तथा परिस्थितियों के अनुसार कार्य होगा	Executive Committee election record शासन सबन्धित समिति चुनाव लेखा
Logistic and supplies are managed effectively हटाने की विधा तथा आवश्यक सामग्री का प्रभावशाली प्रबधन	Appropriate utilisation of supplies and transport is in place योग्य रीति से आवश्यक सामग्री का उपयोग तथा सचार उस स्थान पर	Stock register सचय पजिका Health sevice delivery records प्रदत्त स्वास्थ्य सेवा लेखा

DEFINITION OF FINANCIAL CAPACITY

वित्तीय क्षमता की परिभाषा-

Financial capacity refers to the NGOs ability to effectively utilise funds for stated programme activities through planning, forecasting and controlling their finances as per GOI standard guidelines

वित्तीय क्षमता का आशय अशासकीय सगठनो के योग्यता में विकास जिससे वे राशि का प्रभावशाली प्रयोग कार्यक्रमो को आरम्भ करने तथा उसकी गतिविधियो का नियोजन कर भविष्यवाणी वित्तीय नियत्रण करने मे योग्य हो जो भारत सरकार के मापक मार्गदर्शिका के अनुरूप हो।

Criteria *श्रेणी*	*Measurable Indicators* *अनुमापक सूचकाक*	*Means of Verification* *प्रमाणीकरण का औसत*
The NGO has suitable project financial guidelines acceptable to donors and GOI अशासकीय सगठन के पास उपयुक्त प्रकल्प वित्तीय रूपरेखा जो दाताओ व भारत सरकार को स्वीकार हो	NGO's own Financial guidelines are in place स्थान में अशासकीय सगठन का स्वयम् का वित्तीय रूपरेखा	Financial guidelines वित्तीय रूपरेखा
The NGO is ablek to forecast expenditure according to programme needs अशासकीय सगठन कार्यक्रम आवश्यकता के आधार पर व्यय सवन्धी भविष्यवाणी करने मे योग्य होगे	An annual projected expenditure plan is prepared within the organisation वार्षिक व्यय विचार जो कि प्रकल्प से सबन्धित होगा सगठन मे बनेगा	Annual expenditure plan वार्षिक व्यय योजना
The NGO is able to prepare and and justify its own budget according to programme needs अशासकीय सगठन अपना आय-व्यय सबन्धी अनुमान कार्यक्रम के आवश्यकता-नुसार बनाने तथा उसका उचित कारण बतानें मे सक्षम होगी	The organisation is able to prepare its own budget and justify it सगठन अपना आय-व्यय सबन्धी अनुमान (बजट) बनाने तथा उचित कारण बताने में सक्षम	Prepared budget आय-व्यय सबन्धी अनुमान बनाना
The NGOI is able to control and monitor financial expenditure अशासकीय सगठन वित्तीय सबन्धी खर्च को नियत्रण तथा निर्देशन करने मे योग्य	The expenses remain within the organisation's budget सगठन के आय-व्यय अनुमान में खर्च बचेंगे	Quarterly and annual expenditure reports, cashflow plan, annual audit तिमाही तथा वार्षिक व्यय वृतान्त, व्यय राशि विचार,वार्षिक लेखाकन
The NGO is able to maintain and record all financial transactions अशासकीय सगठन समस्त वित्तीय हस्तान्त-रण का उल्लेख तथा लेखा रखने मे सक्षम	Ledgers/cash books and other relevant documents are maintained correctly बही/नगद पुस्तिका तथा अन्य उचित कागजात का सही उल्लेख	Ledger, cash books and relevant books of accounts बही/नगद पुस्तिका तथा लेखा से सबन्धित उचित पुस्तके
The NGO is able to prepare financial reports and statements as and when required अशासकीय सगठन वित्तीय लेखाओ तथा कथन वनाने मे समर्थ है जव आवश्यकता हो	All financial reports are completed according to the agreed proforma on time समस्त वित्तीय लेखा निर्धारित प्रारूप से तथा समयानुसार पूण होगी	Annual audit reports, quarterly and annual financial reports वार्षिक लेखाकन वृतान्त तिमाही तथा वार्षिक वित्तीय वृतान्त

DEFINITION OF SERVICE CAPACITY-

प्रतिपादित सेवा क्षमता की परिभाषा-

Service Delivery Capacity refers to the NGOs ability to achieve its objectives and targets through delivering quality MCH and FP services

प्रतिपादित सेवा क्षमता का आशय अशासकीय सगठन के क्षमता का विकास जिससे वे अपने उद्देश्यो तथा लक्ष्यो को प्राप्त कर सके जो कि प्रदत्त गुणवत्ता गर्भावस्था तथा शिशु स्वास्थ्य तथा परिवार नियोजन सेवाओ से सबन्धित होगा।

Criteria *श्रेणी*	*Measurable Indicators* *अनुमापक सूचकाक*	*Means of Verification* *प्रमाणीकरण का औसत*
Project objectives and targets are being achieved प्रकल्प, उद्देश्य तथा लक्ष्य को प्राप्त करेगी	All staff are aware of project purpose and output सभी कर्मचारी प्रकल्प के उद्देश्य तथा अपेक्षित परिणाम के प्रति जागरूक	Documentation of purpose and output अभिप्राय तथा अनुमानित परिणाम का दस्तावेजीकरण
	The output and target are being fulfilled in the proposed time निर्धारित समय में अपेक्षित परिणाम तथा लक्ष्य प्राप्त	Progress report मूल्याकन वृतान्त
	Progress reviewed and annual implementaion plan developed उन्नति सबन्धी पुन परीक्षण तथा वार्षिक क्रियान्वयन विचार का विकास	Annual implementaion plan वार्षिक क्रियान्वयन विचार
		Quarterly and annual reports तिमाही तथा वार्षिक वृतान्त
The provision of quality services is in place स्थान विशेष में गुणात्मक सेवाओ का प्रावधान	Increase in the number of people using the services सेवा प्राप्त करने वाले लोगो के सख्या में वृद्धि	Client register सेवार्थी पजिका

MANAGEMENT

प्रबन्धन

CAPACITY ASSESSMENT CHECKLISTS
क्षमता निर्धारण जॉच सूचियॉ
MANAGEMENT
प्रबन्धन

INDICATOR - 1

सूचक १

The organisation is able to prepare a project proposal with realistic Goal and Objectives

सगठन प्रकल्प प्रस्तावना बनाने मे समर्थ होगा जिसमे वास्तविक लक्ष्य तथा उद्देश्य का समावेश होगा।

	Checklist जॉच सूची	Yes/No हॉ/नही	Comments समालोचना
1	Are the Following skills available within the organisation? क्या उल्लेखित क्षमता सगठन में ही उपलब्ध है?		
a	Ability to do a situational analysis and needs assessment परिस्थितिक विश्लेषण तथा आवश्यक्ता निर्धारण की योग्यता		
b	To set priorities प्राथमिकता तय करने में		
c	To set goal, purpose and outputs लक्ष्य, अभिप्राय तथा अपेक्षित परिणाम तय करने में		
d	To set indicators (Quality, Quantity, Timebound) and targets सूचकाक (गुणात्मकता, सख्यात्कमता तथा समयान्तराल) तथा लक्ष्यों को तय करने में		
e	To identity and design future strategies भविष्य के नीति निर्धारक प्रारूप बनाने तथा पहचान करने में		
2	Does the PP contain the following क्या प्रकल्प प्रस्तावना में निम्नलिखित तथ्य है?		
a	Goal that addresses the organistion s mission लक्ष्य जो सगठन के कार्यो का (उद्देश्य) व्याख्यान दें		
b	Goal and purpose that are consistent with the GOI plan लक्ष्य तथा अभिप्राय जो भारत सरकार के योजना के अनुकूल हो		
c	Measurable Indicators and realistic targets अनुमापक सूचकाक तथा वास्तविक लक्ष्य		
d	Planned activities and strategies for each output नियोजित गतिविधिया तथा कार्यनीति प्रत्येक अपेक्षित परिणाम के लिए		
e	Allocated working area and target group defined विभाजित कायक्षेत्र तथा लक्षित समूह का व्याख्या		
3	Have all the relevant staff read/shared and understood the PP? क्या सबन्धित कमचारी प्रकल्प प्रस्तावना को पढ/चचाकर/समझ सकते है?		

INDICATOR - 2

सूचक २

Service rules are approved by Executive Committee (EC) and shared with staff

सेवा नियमो का अनुमोदन शासन सबन्धी समिति द्वारा किया गया तथा कर्मचारियों में वितरित किया गया।

Checklist जॉच सूची	Yes/No हॉ/नही	Comments समालोचना
1 Are service rules available? क्या सेवा सम्बन्धी नियम उपलब्ध हे?		
2 Are skills available to prepare the service rules? क्या क्षमताये उपलब्ध है जो सेवा सबन्धी नियमों का निर्माण कर सके?		
3 Are the rules appropriate and gender rules? क्या नियम अनुकुल तथा लैंगिक आधार पर उपयुक्त है?		
a Rules and procedures include नियम तथा कार्यरीति समाहित		
❖ Working hours कार्य किये गये घण्टे		
❖ Leave and public holidays छुट्टी तथा लोक अवकाश		
❖ Recruitment and selection procedures भर्ती तथा चयन प्रक्रिया		
❖ Staff incentive/salaries/overtime/benefits/increments regulations कर्मचारी उपहार/वेतन/अतिरिक्त समय/लाभाश/वृद्धि पुनरावृत्ति		
❖ Promotion plans पदोन्नति योजनायें		
❖ Disciplinary and grievance procedures अनुशासनात्मक तथा क्षतिपूर्ति कार्यरीति		
❖ A mechanism for amending and reviewing the policy एक यत्र रचना वृद्धि के लिए जो नीतियों पर पुन विचार करे		
b The rules have been approved by EC नियमों का अनुमोदन शासन सबन्धी समिति द्वारा किया गया		
4 Is there a policy in the organisation to encourage/develop women staff? क्या सगठन में महिला कर्मचारियों को प्रोत्साहित/विकास करने की नीति है?		
5 Has the organisation increased women representaion in the EC committee for last two years? क्या विगत दो वर्षो में सगठन के महिला प्रतिनिधिकत्ताओं का शासन सबन्धी समिति में वृद्धि हुई?		
6 Do all staff have access to the service rules? क्या सभा कर्मचारी का प्रवेश सेवा नियम के तहत हुआ हे?		

Checklist जॉच सूची	Yes/No हॉ/नही	Comments समालोचना
7 Is the policy in operation and are the rules followed? क्या नातियॉ क्रियाशाल हे तथा नियमों का अनुसरण कर रही हे?		

INDICATOR - 3

सूचक ३

Personnel records are maintained

व्यक्तिगत लेखाये उल्लेखित

Checklist जॉच सूची	Yes/No हॉ/नही	Comments समालोचना
1 Are the personal files of all staff available? क्या सभी कर्मचारियों के व्यक्तिगत फाइल उपलब्ध है?		
2 Do the personal files contain the following? क्या व्यक्तिगत फाइल में निम्नलिखित तत्व हे?		
a Job application form कार्य आवेदन प्रपत्र		
b Interview/selection record साक्षात्कार/चयन लेखा		
c Jointing letter ससग पत्र		
d Appointment letter, service contract नियुक्ति पत्र, सेवा सविदा		
e Renewal of contract सविदा का नवीनीकरण		
f Job description कार्य व्याख्यान		
g Leave documents अवकाश दस्तावेज		
h Appraisal records मूल्याकन लेखायें		
i Copy of educational/training certificates certified by Executive Director (ED)/authorised person शैक्षणिक/प्रशिक्षण सवन्धी प्रमाण-पत्र की प्रति जिसका सत्यापन शासन सबन्धी निर्देशक /प्रमाणित व्यक्ति द्वारा किया गया हो		
j Any other documents related to the staff concerned अन्य काइ दस्तावेज जो कमचारी विशष मे सबधित हा।		

INDICATOR - 4

सूचक ४

Recruitment of staff is done according to job specifications and recruitment policy

कर्मचारी की भर्ती, कार्य विस्तार व्याख्या तथा भर्ती नीतियों के अनुरूप की गई

Checklist जॉच सूची	Yes/No हॉ/नही	Comments समालोचना
1 Is recruitment done as per service rule? क्या भर्ती सेवा नियमों के तहत की गई?		
2 Do job specifications contain the following job specification क्या कार्य विस्तार व्याख्या में निम्नलिखित तत्व मौजूद है?		
a Required educational qualification भर्ती योग्य शैक्षणिक योग्यता		
b Required skills and experience needed to accomplish the task भर्ती योग्य निपुणता तथा अनुभव की आवश्यकता जो कि कार्य निष्पादन में आवश्यक है		
3 Are staff recruited according to job specification? क्या कर्मचारी की भर्ती उनके कार्य विस्तार व्याख्यान के अनुरूप हुई ह		

INDICATOR - 5

सूचक ५

Staff development plans are prepared and implemented

कर्मचारी विकास योजनायें बनाये तथा क्रियान्वित किये गये

Checklist जॉच सूची	Yes/No हॉ/नही	Comments समालोचना
1 Are skills available to prepare a staff development plan? क्या दक्षतायें उपलब्ध है जो कर्मचारी विकास योजना बना सके?		
2 Is a staff development plan available? क्या कर्मचारी विकास योजना उपलब्ध है?		
3 Does the staff development plan contain the following? क्या कर्मचारी विकास योजना में निम्नलिखित तत्व है?		
a Yearly staff appraisal वार्षिक कर्मचारी मूल्याकन		
b Skills available to identify training needs प्रशिक्षण आवश्यकता की पहचान करने की निपुणता उपलब्ध		
c Training plan (including in service training) प्रशिक्षण योजना (सेवाकाल में प्रशिक्षण)		
d Provision for staff to participation in workshops, seminars forum meetings regularly कमचारी हेतु प्रावधान कि कायशालाओं में सहभागिता, सेमिनारों तथा सस्थागत नियमित वेठकों में भाग लें		

Checklist जॉच सूची	Yes/No हॉ/नही	Comments समालोचना
4 Is the staff development plan implemented according to the time frame? क्या कर्मचारी विकास योजना का क्रियान्वयन समयानुसार हुआ?		

INDICATOR - 6

सूचक ६

A participatory planning and decision making process is in place

एक सहभागी नियोजन तथा निर्णय लेने की प्रक्रिया उस स्थान मे बनेगी

Checklist जॉच सूची	Yes/No हॉ/नही	Comments समालोचना
1 Are the staff involved in reviewing the project targets and strategies क्या सभा कर्मचारी ने प्रकल्प लक्ष्य तथा कार्य नीति के नवीनीकरण में भाग लिया?		
2 Are the problems of the project solved in a participatory way? क्या प्रकल्प के परेशानियों का समाधान सहभागी रूप में हुआ		

INDICATOR - 7

सूचक ७

Delegation of responsibility with authority is in place

जिम्मेदारियों की चाह प्रभुत्व के साथ उस स्थान मे

Checklist जॉच सूची	Yes/No हॉ/नही	Comments समालोचना
1 Are the staff members clear about their job descriptions? क्या सभा कर्मचारी अपने कार्य विस्तार व्याख्या के प्रति स्पष्ट हे?		
2 Are delegation documents available? क्या प्रतिनिधि मण्डल सबन्धी दस्तावेज उपलब्ध हे?		
a Did the preparation involve the financial staff and the concer ned senior staff? क्या तैयारी के समय वित्त सवन्धी कर्मचारी तथा सवन्धित वरिष्ठ कर्मचारियों को समाहित किया गया?		
3 Is the projected expenditure plan followed? क्या प्रकल्पित व्यय योजना का अनुसरण हो रहा है?		
4 Are the expenses reviewed monthly against the expenditure plan? क्या मासिक व्यय योजना के अनुरूप दृष्टिगत हो रहा हे?		

INDICATOR - 8

सूचक ८

The organisation is able to prepare its own budget and justify it

सगठन अपने आय-व्यय का विवरण तथा उसका उचित कारण बताने में समर्थ

	Checklist जॉच सूची	Yes/No हॉ/नही	Comments समालोचना
1	Do the organisation's staff members have the skill (training) to to prepare a budget? क्या सगठन कर्मचारीगण के पास दक्षता (प्रशिक्षण) है कि वे आय-व्यय विवरण बना सके?		
2	Is the previous expenditure trend reflected in the new budget? क्या पूवाद्ध की व्यय पद्धति नवीन आय-व्यय विवरण को प्रभावित करेगी?		
3	Is the budget broken down by line item? क्या आय-व्यय विवरण रेखा तत्वों के द्वारा टूटेगी?		
4	Are the line items well specified? क्या रेखा तत्वों को सुस्पष्ट किया गया है?		
5	Does the budget serve all the needs of the programme activities? क्या आय-व्यय विवरण कार्यक्रम के सभी गतिविधियों की आवश्यकता को पूरा करता है?		
6	Are the financial staff and the concerned senior staff involved in preparing the budget? क्या आय-व्यय विवरण के तैयार करने में वित्तीय सबन्धी कर्मचारी तथा सबन्धित वरिष्ठ कर्मचारियों को समाहित किया गया		
7	Is the financial contribution of the organisation reflected in the budget? क्या सगठन की वित्तीय भागीदारी आय-व्यय विवरण से प्रभावित है?		
8	Are the financial contributions of other donors reflected in the budget? क्या अन्य दाताओं का वित्तीय भागीदारी आय-व्यय विवरण को प्रभावित करेगी?		

INDICATOR - 4

सूचक ४

The expenses remain within the organisation's budget

सगठन के आय-व्यय विवरण में खर्च बचेगे

	Checklist जॉच सूची	Yes/No हॉ/नही	Comments समालोचना
1	Do the expenses remain within the agreed budget? क्या तय किये हुए आय-व्यय विवरण में खच वचेंगे?		
2	Is within approval obtained when over expenditure is higher than the 15 percent limit? क्या लिखित स्वीकृति है जब अति व्यय की सीमा १५ प्रतिशत से अधिक होती है?		
3	Are there written justifications for alterations in the line items within the 15 percent limit क्या लिखित स्पष्टीकरण विकल्प के लिए जो रेखित सामग्री के १५ प्रतिशत के सीमा के अन्दर है?		
4	Does the organisation review monthly expenditure statements? क्या सगठन मासिक व्यय कथन पर पुन विचार करती है?		
5	All the expenses approved by the authorised persons? क्या सभी खर्चो की स्वीकृति प्रमुख व्यक्तियों द्वारा किया गया?		
6	Are reports on expenditure prepared on time? क्या व्यय सवन्धी वृतान्त समय पर पूरे किये गये?		

INDICATOR - 5

सूचक ५

Ledgers/cash books and other relevant documents are maintained correctly

बही/नगद पुस्तिका तथा अन्य उचित दस्तावेजों का सही देखभाल

	Checklist जॉच सूची	Yes/No हॉ/नही	Comments समालोचना
1	Is the accountant skilled to maintain books of accounts? क्या लेखापाल दक्ष हे कि वह लेखा सबन्धी पुस्तकों का सही देखभाल करे?		
2	Are the vouchers क्या ये साधन-पत्र		
	a Written in the proforma agreed in the guidelines? उस प्रारूप में लिखा हे जो पथ दर्शिका द्वारा मान्य हे?		

Checklist जॉच सूची	Yes/No हॉ/नही	Comments समालोचना
b Prepared as per line items? रेखाकित सामग्री के अनुसार बनाया गया		
c Approved by the authority? प्रभुत्व सम्पन्न द्वारा अनुमोदित		
d Supported by relevant documents उचित दस्तावेजों द्वारा सहारा दिया हुआ		
3 Is the format for the cash book as per the accounting manual? क्या राशि पुस्तिका का प्रारूप लेखाकन सक्षिप्त पुस्तिका के अनुरूप है?		
4 Are the vouchers consistent with the cash book? क्या साधन पत्र (हिसाब की लिखित रसीद) सक्षिप्त पुस्तिका के अनुरूप है?		
5 Does the opening balance of the current month match with closing balance of the previous month? क्या वर्तमानिक माह का आरम्भिक शेष राशि विगत माह के समाप्ति शेष राशि से मेल खाता है?		
6 Are the calculations in the cash book correct? क्या नगद पुस्तिका में की गई गणना सही है?		
7 Are the bank statements collected and verified with the cash book? क्या बैंक कथन सग्रहित तथा राशि पुस्तिका से सत्यापित की गई?		
8 Is the cash book maintained on a weekly basis? क्या नगद पुस्तिका की देखभाल साप्ताहिक आधार पर की?		
9 Is the cash book closed, checked and signed by the concerened authority on a monthly basis? क्या नगद पुस्तिका का समापन, जाच तथा हस्ताक्षर सबधित प्रभुत्व सपन्न व्यक्ति द्वारा मासिक आधार पर किया गया?		
10 Are all cash transactions within the cash ceiling? क्या सभी राशि हस्तातरण राशि परिसीमा के अदर है?		
11 Are approval for cash transactions above the cash ceiling (if any) available क्या सभी राशि हस्तातरण का अनुमोदन राशि परिसीमा से अधिक (यदि कोई) उपलब्ध है?		
12 Do figures in the cash book correspond with the ones in the ledger? क्या आकडे जो नगद पुस्तिका के पत्राचार बही में से एक है?		
13 Are columns in the ledger completed correctly? क्या वही के सभी खड सही रूप में पूर्ण किये गये?		
14 Is the ledger maintained according to the line items in the budget? क्या वही की देखभाल आय-व्यय विवरण के रेखा सामग्री के अनुसार है?		

	Checklist जॉच सूची	Yes/No हॉ/नही	Comments समालोचना
c	Are supplies labelled and organised in an accessible way? क्या वितरण श्रेणी तथा सगठन सही रूप में हे?		
d	Is the store well ventilated with enough light? क्या भण्डार में पयाप्त रोशनदान तथा रोशनी का व्यवस्था हे?		
28	Is there a person responsible for store management? क्या एक व्यक्ति भण्डार प्रबन्धन के लिए जिम्मेदार हे?		
29	Are stock/inventory registers maintained properly? क्या भडारण/चल सपत्ति की विवरण सूची पजिका उचित देखभाल हे?		
a	Each item listed with a balance प्रत्येक सामग्री समान रूप से सूचीबद्ध की गइ		
b	Identification mark given पहचान चिन्ह प्रदान किया गया		
c	Updated regularly नियमित रूप से पूरा किया हुआ		
d	Is the stock physically verified? क्या भण्डार भोतिक रूप में सत्यापित हुआ?		

INDICATOR - 6

सूचक ६

All financial reports are completed according to the agreed proforma on time

सभी वित्तीय वृतान्त निश्चित प्रारूप तथा समय पर पूर्ण किये गये

	Checklist जॉच सूची	Yes/No हॉ/नही	Comments समालोचना
1	Is there a agreed form for financial reporting? क्या वित्तीय वृतान्त के लिए कोई स्वीकृत प्रपत्र हे?		
2	Is the financial report prepared and distributed on time? Monthly/quarterly/six monthly/annually क्या वित्तीय वृतान्त समय पर बनाया तथा वितरित किया गया? मासिक/तिमाही/छमाही/वार्षिक		
3	Does the project management verify the financial reports based on क्या प्रकल्प प्रबन्धन में वित्तीय वृतान्त को [illegible] आधार पर सत्यापित किया?		

Checklist जॉच सूची	Yes/No हॉ/नही	Comments समालोचना
a The agreed budget मान्य आय-व्यय विवरण पर		
b Accuracy of calculation क्या भण्डार में पयाप्त रोशनदान तथा रोशनी की व्यवस्था हे?		
c Support documents सहायक दस्तावेज		
— Bank Statements बैंक कथन		
— Bank reconciliation certificates बैंक समाधान प्रमाण-पत्र		
— Cash and bank balance certificates नगद तथा बैंक के शेष प्रमाण-पत्र		
d The closing balance of the last financial report विगत समापन शेष की वित्तीय वृतान्त		
4 Are the project accounts audited annually? क्या प्रकल्प की लेखाओं का वार्षिक जाच होती है?		
5 Are terms of Reference (TOR) prepared for audits? क्या सदर्भ की पारी लेखा परीक्षण हेतु बनाई गई?		
6 Is the audit report distributed to the following person/organisations? क्या लेखा परीक्षण वृतान्त निम्नलिखित में वितरित की गई		
a Government सरकार		
b Executive Committee and concerned project staff शासन सबन्धी समिति तथा सबन्धित प्रकल्प कर्मचारियो को		
c Donors दाताओं को		
7 Are the audit recommendations addressed? क्या लेखा परीक्षण की सिफारिशों को पूरा किया गया?		

SERVICE DELIVERY

सेवा प्रतिपादन

CAPACITY ASSESSMENT CHECKLISTS
क्षमता निर्धारण जाँच सूचियाँ
SERVICE DELIVERY
सेवा प्रतिपादन

INDICATOR - 1

सूचक १

All staff are aware of project purpose and output

सभी कर्मचारी प्रकल्प के अभिप्राय तथा अपेक्षित परिणाम के प्रति जागरूक

	Checklist जॉच सूची	Yes/No हॉ/नही	Comments समालोचना
1	Are the purpose and output of the project shared with all concerned staff क्या प्रकल्प से अभिप्राय तथा अपेक्षित परिणाम सबन्धित कर्मचारियों के साथ बाटे गये		
2	Can the concerned staff describe the purpose and output of the project? क्या सबन्धित कर्मचारी प्रकल्प के अभिप्राय तथा अपेक्षित परिणाम की व्याख्या कर सकते है?		
3	Do the staff fell that the targets set for them are realistic/achievable क्या कर्मचारी महसूस करते है कि जो लक्ष्य निर्धारित किय गये हैं वे वास्तविक/उपलब्ध करने योग्य है?		

INDICATOR - 2

सूचक २

The output and targets are reached in the porposed time

अपेक्षित परिणाम तथा लक्ष्य प्रस्तावित समय में प्राप्त हो

	Checklist जॉच सूची	Yes/No हॉ/नही	Comments समालोचना
1	Does the project management compare achievement against targets? क्या प्रकल्प प्रबन्धन उपलब्धियों की तुलना लक्ष्यों से कर सकता है?		
2	Are the output and targets reached in the proposed quarter? क्या अपेक्षित परिणाम तथा लक्ष्य, प्रस्तावित तिमाही में प्राप्त हुआ?		
3	If no, are the targets reviewed and reset? यदि नहा, क्या लक्ष्य का पुन निरीक्षण तथा उसे दोवारा तय किया गया?		

INDICATOR - 3

सूचक ३

Progress reviewed and annual implementation plan developed

उन्नति पुनरीक्षण तथा वार्षिक क्रियान्वयन योजना विकसित

	Checklist जॉच सूची	Yes/No हॉ/नही	Comments समालोचना
1	Is there any mechnism to review the progress of services provided? क्या कोई पद्धति हे जो उपलब्ध करवाइ गई, सेवा की उन्नति का पुन अवलोकन कर सके		
2	Do the project staff have the skills to review the progress of services provided? क्या प्रकल्प कर्मचारी के पास दक्षता है जो प्रदान की गई सेवा की उन्नति का पुन अवलोकन कर सके?		
3	Are the review findings being used for revising staff work plans? क्या पुन अवलोकन में पाई गई खोज का प्रयोग कर्मचारी कार्य योजना में दोहरायी जायेगी?		
4	Do all staff participate in the process of reviewing and in the development of annual implementation plan? क्या सभा कर्मचारियों ने पुन अवलोकन की प्रक्रिया तथा वार्षिक क्रियान्वयन योजना के विकास में भाग लिया?		
5	Is the annual implementation plan adhered to? क्या वार्षिक क्रियान्वयन योजना सुदृढ है?		
6	Do the staff have the skills to priortize activities? क्या सभी कर्मचारियों के पास गतिविधियों को प्राथमिकता प्रदान करने की क्षमता हे?		
7	Do the staff initiate alternative measures when faced with problems क्या कमचारी परेशानियों का सामना करते समय मापक विकल्प का सूत्रपात करते है?		

INDICATOR - 4

सूचक ४

Increase in the number of people using the services

सेवाओ को प्राप्त करने वाले लोगो की सख्या मे वृद्धि

Checklist जॉच सूची	Yes/No हॉ/नही	Comments समालोचना
1 Are there records of clients using the services? क्या सेवार्थियों का लेखा है जो सेवाओं को ग्रहण करते है?		
2 Are the rate of clients using the following services increasing? क्या सेवार्थियों का दर निम्नलिखित सेवाओं को उपयोग करता है?		
a Contraceptive users गर्भ निरोधक का उपयोग करने वाल		
b Utilization of TBAs (Traditional Birth Attendant) for home delivery परम्परागत दाईयों का प्रयोग घर में प्रसव के लिए		
c Pregnant women गर्भवती महिला		
d Women in post partum गर्भकाल की महिलायें		
e Immunization of children वच्चों का टीकाकरण		
f Immunization of 15 49 years old women (Tatanus) १५-४८ आयु वर्ग की महिलाओं का टीकाकरण (टेटनस)		
3 Is the drop out rate of clients decreasing क्या छोडे गये सेवार्थियों की दर में कमी आई?		
a Contraceptive users गर्भ निरोधक के उपयोग करने वाले		
b Immunization of children वच्चों का टीकाकरण		
c Immunization of 15 49 years old women (Tatanus) १५-४६ आयु वर्ग की महिलाओं का टीकाकरण		

Annex 6

LIST OF QUALITATIVE BASELINE EXERCISES CONDUCTED THAT ARE SPECIFIC FOR CHILD SURVIVAL/REPRODUCTIVE HEALTH INTERVENTIONS

A) ***PARTICIPATORY LEARNING FOR ACTION (PLA) EXERCISES***

1) ***Pneumonia Case Management***

   a) to ascertain *community willingness and ability to pay* for antibiotics for pneumonia treatment,

   b) to understand local beliefs, practices, vocabulary related to pneumonia recognition, care-seeking
   and compliance treatment,

2) ***Diarrhea Case Management***

   a) to identify causes of the ORT knowledge-practice gap and the obstacles to maternal/caretaker adoption of essential household behaviors regarding prevention and management of childhood diarrheas,

3) ***Prevention of Malnutrition***

   a) Causal diagram of undernutrition in under-5 children, especially in under-3 children

   b) Identify appropriate complementary (weaning foods) with women's groups,

   c) Causal Diagram to look at the causes of night blindness,

4) ***Reproductive Health Care***

   a) Causal diagram of maternal deaths,

   b) Community/social norms for delayed age of marriage pre-birth intervals and need for family planning,

   c) Assess women's need for spacing

5) ***Customer Appraisal***

   a) assess the level of access on different days of the week and at different times of the day or the year that mothers/care-givers have to get prompt antibiotic for their children with pneumonia signs/symptoms

   b) assess caretakers' timeliness of treatment-seeking behaviors for pneumonia in under-2 children

B) ***FOCUS GROUP DISCUSSIONS***

   a) explore the willingness of village leaders and various community leaders to provide child care in
   day care centers to ensure that children 12-59 months get 5-6 feeds daily

b) identify causes of the ORT knowledge-practice gap and the obstacles to maternal/care-taker adoption of essential household behaviors regarding prevention and management of childhood diarrheas,

c) different messages emphasizing recognition and care-seeking for neonates/young infants and for
older infants/children with pneumonia signs/symptoms

d) explore willingness and ability of panchayats and parish mandals to establish village-based referral management teams to initiate village-based transport schemes for obstetric emergencies

e) gauge the knowledge and attitude (of the village panchayats, parish mandals (men's groups) mahila mandals, VHGs, TBAs, private practitioners, and youth groups) toward the use of contraceptives for birth spacing

f) explore awareness among youth of reproductive health issues (family planning/birth spacing HIV/AIDS, STDs),

g) engaging male youths youth group members in a series of dialogues on family planning and spacing,

h) probe the practice of using abortion as a fertility control method

C) *OBSERVATIONAL STUDIES*

1) Develop role-plays and observation checklists to assess the face-to-face counseling skills of the health providers and to asssess caretakers' timeliness of treatment-seeking behaviors for pneumonia in under-2 children,

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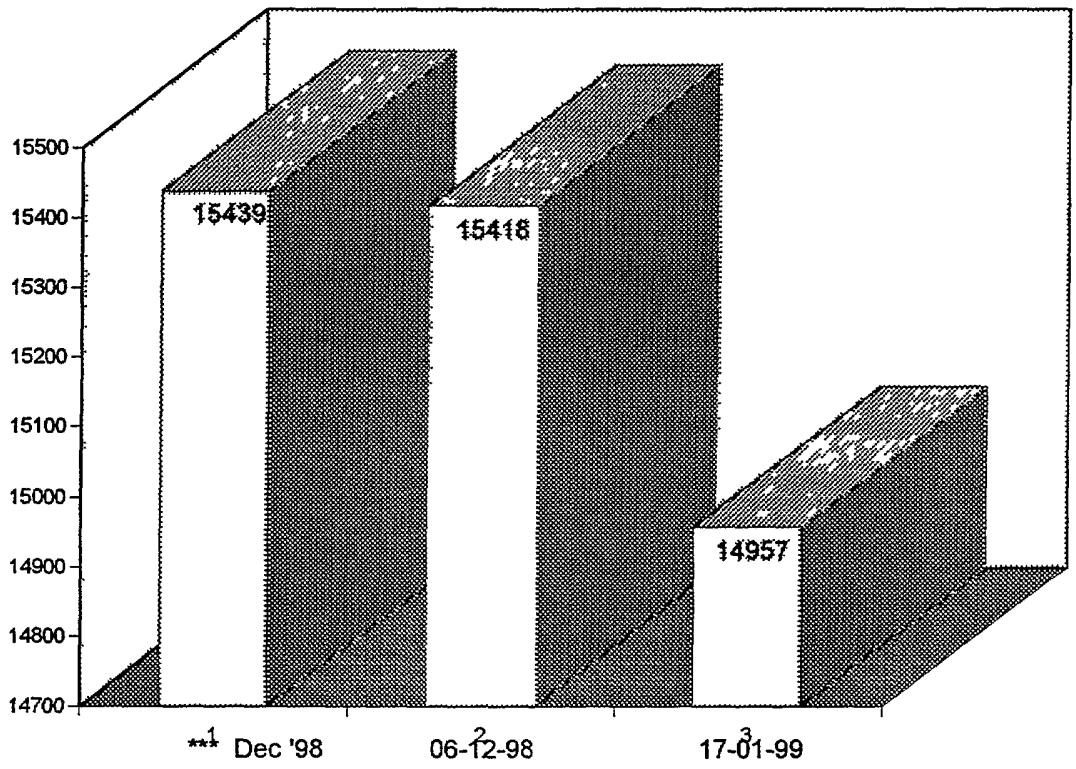
Annex 7

PULSE POLIO VACCINATION STATUS BERUARBARI BLOCK



*** Total No of Children (0-59 months) Total population survey - PHC, Sub-centre - Beruarbari block

BALLIA RURAL INTEGRATED CHILD SURVIVAL PROJECT (BRICS)

Annex 8

SCHEDULE FOR DETAILED IMPLEMENTATION PLAN (DIP) WORKSHOP

January 18 to 19, 1999

(A) PROPOSED OBJECTIVES

1 Share project background/milestones with clients/partners of the project

2 Present findings of project baselines (KPC Survey, PLA Exercises, FGDs, and Health Care Facility Assessment, etc) with client/partners

3 Promote a shared understanding of sustainability issue

4 Finalize DIP project goals, objectives, benchmarks and targets

(B) ANTICIPATED RESULTS

1 Revised agreed DIP project goals, objectives, benchmarks and targets

2 Agree on written roles and contributions of various project partners/clients

3 Selection of Working Group of the Sustainability Action Plan (SAP)

(C) PROPOSED PARTICIPANTS

1 District Magistrate, Ballia

2 MOH staff - CMO and district/block level health staff (from all 17 blocks), including doctors, Lady Health Visitors and ANMs

3 Assistant BDO of Beruarbari block

4 Village Panchayat / Samiti leaders from Beruarbari block

5 Community representatives - both men, mahila mandals, village health guides, youth clubs - and NSS members from Beruarbari Block

6 Dais (TBAs) from Beruarbari block

7 Families of World Vision sponsored children from Beruarbari block

8 Private practitioners, including RMPs, Aryuvedic practitioners, Unani/Homeopathic practitioners from Beruarbari block

9 Project (ADP/CSP) staff

10 Local NGO staff (Rotary Club, Purvanchal Gramin Chetna Samiti, Public Support Group)

BALLIA RURAL INTEGRATED CHILD SURVIVAL PROJECT
(BRICS)

(2)

SCHEDULE FOR DETAILED IMPLEMENTATION PLAN (DIP) WORKSHOP

January 18 to 19, 1999

MC - S K Samson

Monday (January 18, 1999)

9 00 to 9 10 AM	Introduction speech (project background)	Mr Subodh Kumar
9 10 to 9 30 AM	Share baseline findings	Dr Dennis T Cherian
9 30 to 10 45 AM	Speech by District Magistrate Ballia	Mr Naresh Kumar, IAS
10 45 to 11 00 AM	Speech by Distict Development Officer	Mr Hira Lal
11 00 to 11 15 AM	Speech by Chief Medical Officer	Dr O P Singh
11 15 to 11 30 AM	Speech by USAID official	
11 30 to 1 00 PM	Finalization of DIP Project goals, objectives, benchmarks and targets	Dr Shantanu Dutta
1 00 to 2 00 PM	Lunch break	
2 00 to 3 30 PM	Sustainability Issues	Mr J S J Sujeevandas
3 30 to 4 15 PM	Group discussions on sustainability	Mr J S J Sujeevandas
4 15 to 5 00 PM	Group Discussions & synthesis *Output No 1* = revised agreed DIP project goals, objectives, benchmarks and targets	Dr Shantanu Dutta/Subodh

Tuesday (January 19, 1999)

9 00 to 9 15 AM	Short Recap of previous day	Dr Rakesh Kumar SINGH
9 15 to 1 00 PM	Work on respective roles and contributions	partner working groups
1 00 to 2 00 PM	Lunch break	
2 00 to 4 00 PM	Come together, share and agree on roles, contributions of each partner	
4 00 to 5 00 PM	*Output No 2* = Written agreement on roles and contributions of various project partners and clients	

Thursday (January 28, 1999)

Working groups meet to develop the Sustainability Action Plan

8-2

Detailed Implementation Plan Workshop

January 18, 1999

The first day of the DIP workshop was attended by 62 local participants, including the District Magistrate, the Chief Medical Officer (CMO), the doctors of the 16 PHCs, the ANMS, the community and the World Vision staff The workshop was held at Vikas Bhavan of Ballia District, and was organized by the BRICS project under the guidance if Dr Sri Chander and Dr Shantu Dutta

The morning session commenced with a brief introduction of the BRICS project, its objectives and strategies by the Project Manager, Mr Subodh Kumar This was followed by a presentation of the KPC Survey finding by Dr Dennis T Cherian of WV India The initial part of the day was marked by speeches given by the District Magistrate, the CMO, the chief Development Officer and the block Development Officer

The District Magistrate, Mr Naresh Kumar, pointed out that economic progress was possible through effective interventions in the villages of India He also remarked that economic development meant that the common man who lived in the villages could enjoy the fruits of his labor All the speakers reiterated the importance of the role of NGOs in development work, and commended the work of World Vision and its implementation of the planned child survival project in Ballia District

The lack of hospital facilities and competent staff in remote villages was felt by the participants, and was considered a constraint to improving health conditions in the village communities

Dr Shantanu Dutta briefly introduced the work of World Vision in general, and in Uttar Pradesh in particular He reiterated the organization's child focus in all its activities and programs Following this session, Dr Dutta initiated discussion and opened the floor for comments from the participants on the KPC survey findings The main objective of the discussion was to arrive at a consensus regarding the annual targets of the 4-year project

The groups discussed the targets for the six intervention programs

Pneumonia Case Management The government medical officers who were present debated on the medicine that was currently administered by the RMPs ("barefoot doctors") to communities, which was not prescribed in the government protocol When cases became serious, they were then referred to the PHC who had to administer other antibiotics After some debate, the whole group arrived at a consensus on the yearly target, and the target for the final year was raised from 70% to 90%

Following the briefing, the participants were asked to break into 8 groups and the representatives of each group were asked to make presentations based on three questions

1 Definition of Sustainability
2 Factors working towards sustainability
3 Factors working against sustainability

8-3

17'

The group responses were impressive Some of the points were

1 Definition of Sustainability

- Sustainability is a never ending process
- Sustainability is the ability of the community to continue the programs and their benefit to the community in the same manner, with proper monitoring, even after the project closes

2 Factors working towards sustainability included

- Health education awareness
- Involvement of community
- Regular source of income
- Leadership / responsibility
- Proper coordination and integrity
- Training for capacity building
- Formation of village societies
- Acceptance of the community
- Corruption-free and interesting
- Accessible, affordable and beneficial
- Government support

3 Factors working against sustainability

- Illiteracy
- Traditions and superstitions
- Policies and social discrimination (catechism)
- Poverty
- Lack of income generation program
- Maternal / social calamity
- Corruption
- Non-cooperation
- Dependency
- Ineffectiveness of basic structure
- Lack of cooperation from Government

Diarrhea Case Management It was discussed that to encourage mothers to continue breastfeeding their children who suffer from diarrhea, a behavior change among the mothers was needed The other issue was that the ORS supply did not meet demand The final target of 70% was brought down to 40%, as the need to set realistic targets was recognized

Immunization Immunization workers refuted KPC baseline data, and claimed that immunization rates in Beraurbari were double the stated percentage TT2 coverage was claimed to be 90% These claims were based on card history documentation and other reliable sources, while the KPC data was based on card documentation only

Essential Care of the Newborn Doctors said that there were no facilities available at the PHC for newborn care--only in the Medical College

Prevention of Malnutrition and Vitamin A Deficiency The government did not have a plan for providing a supply of vitamin A for post partum mothersm, and the inadequacy of the supply of vitamin A capsules was pointed out It was affirmed that the supply would come through in the near future The final target of 60% was increased to 80%

Reproductive Health Coverage The CMO stated that the emergency transport schemes could be made effective to achieve goals Targets were specified

The afternoon session was taken by Sujeevandass, who spoke on sustainability He said that regarding sustainability we have to keep 5 points in mind

1 Perceived project effectiveness

- should deliver goods and services effectively
- should promote responsibility and well-being

2 Development of a funding mechanism, livelihood security

3 Strong training component

4 Mutually respectful negotiation process and equity

5 Integration with existing structures

The second day of the DIP workshop started off with a recap of the previous day's sessions by Dr Rakesh Singh Mr Subodh Kumar took over the next session, where the role of the BRICS project was dealt with The following points were presented, according to which BRICS would make their contributions

- Training
- Supportive joint supervision
- Appropriate timely logistics
- HMIS (Monitoring, Evaluation and Community Surveillance)
- Community Empowerment
- Safe drinking water
- Sanitation
- Income Generation Programs (MED)
- Literacy
- Early childhood care and development

The participants then broke into 5 groups

1 Beruar Beri PHC staff
2 Other PHC staff
3 NGO partners

8-5

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4 Community members
5 ADP Ballia staff

The groups were asked to discuss their contributions towards the BRICS Project objectives in terms of manpower, money (time) and material A representative of each group then came forward to make their presentations

The Beruar Beri Group shared a list of requirements for their PHC, namely staff, equipment, emergency and life-saving medicines, higher salaries, vehicles, diesel to run generators, freezers to maintain cold chain for vaccines etc The Project Manager intervened by stating that their expectations were incongruent with the actual requirements and anticipated collaboration

At this point, other medical officers demanded a clarification from the BRICS project staff about their role, contribution, and expectations, and the strength of the job descriptions of the ADP Ballia Staff and their contribution to the program After some interruption the presentation resumed

The second group emphasized training, optimum utilization of funds, quality assurance and concrete monitoring and evaluation patterns

The next group, which consisted of community members, was represented by a Youth Club President who was quite vocal about the inadequacy of the existing government health machinery He stressed the promotion of literacy, effective obstetric emergency services, and provision of ANMs in every village

The other NGO listed the areas in which they were ready to contribute primary health education, public health training, promotion of and education in the usage of medicinal herbs, and training in cottage industries They also assured help in developing a core team for the work

The ADP Ballia team presented their first year action plan which included
1 Capacity-building in terms of training of various groups
2 Community empowerment - development of Women's Saving Groups in 5 villages
3 Vocational training would be given to unemployed youths from 20 villages
4 Safe drinking water - installation of 10 handpumps and their regular maintenance, and distribution of chlorine for water purification
5 Sanitation facilities - construction of two toilets in two villages
6 Income Generation Programs - Animal husbandry
7 Literacy programs
8 Distribution of vitamin A and a survey on night blindness and malnutrition with the help of UNICEF
9 Training programs for pregnant women between the ages of 15-35 years regarding pre-natal and post partum care

Towards the end of the afternoon session Dr Dutta once again clarified the contribution of the BRICS Project, in response to the demand for clarification by some of the participants He also expressed the project's limitations in terms of manpower, money and material

To this the other participants agreed and assured their cooperation Each group nominated a person who would serve on the working group for further discussions and planning

8-6

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The CMO formally closed the workshop with a speech He pointed out the challenges involved in the accomplishment of the stipulated targets, and encouraged the participants to work zealously to fill the gaps in the existing system

The workshop ended after a vote of thanks by Mr Girish

Documented on 20th January 1999

Documented by Hannah Masih
Manju
Mamta Kumar

BALLIA RURAL INTEGRATED CHILD SURVIVAL PROJECT
DETAILED IMPLEMENTATION PLAN WORKSHOP

Indicator	TARGETS				
	Baseline Survey November 1998	Year 1 Sept 1999	Year 2 MTE	Year 3	Year 4 FE
A. Pneumonia Case Management					
1 % mothers/caretakers able to recognize a least two danger signs of pneumonia that call for immediate referral and treatment	63 2%	65%	65%	65%	70%
2 % mothers/caretakers who sought appropriate antibiotic treatment for their children under 24 months with cough and rapid or difficult breathing in the past two weeks	66%	65%	65%	65%	65%
3 % children 0-23 months diagnosed with pneumonia who were treated with antibiotics according to SCM protocol	?	10%	25%	40%	55%
B Diarrhea Case Management					
1 % of children 0-23 months with diarrhea in the past 2 weeks who were treated with ORT	17 7%	20%	25%	30%	40%
2 % of children 0-23 months with diarrhea in the past two weeks who were given the same amount or more fluids other than breast milk	16 9%	20%	30%	40%	50%
3 % of children 0-23 months with diarrhea in the past two weeks who were given the same amount or more food	20 4%	25%	30%	35%	40%
C Increased Coverage of Essential Care of the Newborn					
1 % of post-partum mothers trained in the care of their newborn (hypothermia prevention, low birth weight management and the initiation of exclusive breastfeeding	?	5%	15%	25%	40%
D Increased Immunization Coverage					
1 % infants 0-11 months who have received card-documented doses of BCG OPV3 and measles vaccines before age 12 months.	20 9% (card)	30%	35%	40%	50%
2 % of mothers with two card-documented doses of tetanus toxoid (TT2) before the birth of their youngest child < 24 months	5 6% (card	10%	15%	25%	35%

* The KPC (Knowledge Practice and Coverage) survey was conducted from 13-15 November 1998 Thirty stratified cluster samples of 10 mothers each with children 0-23 months were interviewed using WHO standard 30-cluster methodology

Indicator	TARGETS				
	Baseline Survey November 1998	Year 1 Sept 1999	Year 2 MTE	Year 3	Year 4 FE
D Prevention of Malnutrition and Vitamin A Deficiency					
1 % infants 0-4 months exclusively breastfed in the last 48 hours	76 6%	80%	80%	85%	90%
2 % of infants 5-9 months who are being given solid or semi-solid foods	25 8%	30%	40%	40%	45%
3 % children 9-23 months who received appropriate card-documented doses of VAC semi-annually	5 8%	60%	80%	80%	90%
4 % of post-partum mothers who received one card-documented high dose vitamin A supplement within 4 weeks of delivery	0	5%	20%	20%	30%
D Improved Reproductive Health Coverage					
1 Number of target villages which have functioning village-based emergency transport schemes for obstetric emergencies	0	5	15	30	40
2 % women with children < 24 months who reported at least one intended pregnancy in the last 12 months	31 6%	35%	30%	25%	20%
3 % of women with children less than 24 months who desire no more children, or who are not sure, who are using a modern method of contraception	8 1%	10%	12%	15%	20%
4 % women who delivered their youngest child in the last year have received at least 90 iron/folate tablet supplements during their last pregnancy	8 8%	10%	15%	25%	35%
5 % mothers who had three or more card-documented antenatal visits before the delivery of her youngest child < 24 months	1 7% *	5%	15%	25%	35%
6 % deliveries in the last 12 months who have been attended by a trained health provider or PHC/SC/ANM staff	17% **	18%	20%	22%	25%

* Card-documented only
** Excludes trained *Dais*

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DIP Workshop Jan 18-19, 1998

SN.	Name	Designation	Signature
1	जानकी देवी	B.H.W.W.W. बाटी स्वास्थ्य विभाग	जानकी देवी
2	MR. Devendra prasad	Field officer	Centre for Rural Development
3	Usha Pandey	इन्डोर्स्च BLV दाई (स्वास्थ्य विभाग)	Usha Pandey
4.	शिवदुलारी देवी		शिवदुलारी देवी
5.	Dr B. P. Singh.	MO i/c P.H.C. Nagara	
6	Dr P.C. Upadhyay	Supdt. C.H.C. Rasra Balia	
7	Fr Aloysius Lund	Father in-charge Social Service Centre	A. [illegible]
8	Dr R P. Singh	MO i/c PHC Sonwan BLA	
9	Dr Satish Chandra Chaudhary	Dy CMO (Imm) Ballia	
10	उरमिला देवी	का. आपरेटर	उरमिला देवी
11	Dr. D P Singh	M.O. (Health)	18/1/99
12	Dr UMESH KUMAR	M.O i/c Bairia Balia	
13	Dr. J R Singh	Sahli cum Babu Sahli	18/1/99
14	Sunil Sekhar Srivastava	Rural Educational & Research Institute	
15	शिवावती उपाध्याय	A.N.M. स्वास्थ्य विभाग	शिवावती उपाध्याय
16	Dr R K. Ambasht	M. उपकेन्द्र प्रभारी M.O. i/c PHC Dibiyapur	
17	Hira lal	ADS.	
18	Dr L N Singh.	Dy CMOJ	
19	DR S K SINGH	DYCMO II	
20	Dr. R. K. Sitaram	SMO [illegible]	

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DIP WORKSHOP Jan-18-1999

S NO	NAME	DESIGNATION	SIGNATURE
21	राजकिशोर दीक्षित	वरि॰ कैशवकी स्वास्थ्य विभाग	राजकिशोर
22	Dr. P.K. Singh	Y MO/C PHC Maunath	PK
23	किरण चौबे	बाल विकास टीचर	किरण चौबे
24	डा० मनोज कुमार	चिकित्साधिकारी	Manoj
25	श्रीमती दुर्गावती देवी	ग्राम॰ हरपुर स्टाफ नर्स	दुर्गावती देवी
26	V.K. Singh	Manager Amul/S.V.E.L	
27	उमा राम B.H.W (S)	स्वा० केन्द्र बीरवारी	उमा राम
28	[illegible]	CHO Ballia	
29	Naresh Kumar	D.M, Ballia	18/1/99
30	[illegible]	[illegible]	[illegible] 18/1/99
31	मनोज कुमार यादव	[illegible]	
32	सत्य प्रकाश वर्मा	सचिव [illegible]	
33	अमरेश नन्दन राय	परियोजना निदेशक	18/1/99
34	सन्तोष कुमार	टीचर, ग्रा॰ नरायनपुर	
35	रमेश कुमार	उपाध्यक्ष	
	[illegible]	[illegible]	8-11

	देवमणी	प्रचार करमपुर	देवमणी
38	Shela Singh	A.N.M करमपुर	Shela
39	Dr R.K. Panday	Subst CHC Searaha	
40	[illegible] Lal Kumar	Nodal PHC Raoli	
41	[illegible] Nath	Rajpur	
42	राजेन्द्र कुमार		
		बाबा [illegible]	
43	Dr. Vijay Kumar	P.H.C. Mulichapra	राजेन्द्र कुमार
44	Dr Sanjay Kumar	Mobile PHC RATSAR	
45	Nirendra Kumar		
46	Sachi Sharma	Anganbari Rajpur Karampur	
47	[illegible]	Beldari Rajpur Karampur	
48	[illegible]	जिला पंचायत बलिया	
49	[illegible]	जिला जनसंपर्क	
50	[illegible]	[illegible]	
51	[illegible]	[illegible]	Nirendra Kumar
52.	Santosh Rai,	PRATINIDHI Belthara Road	Santosh
53	[illegible]	[illegible]	
54	Jay Prakash Singh	युवक समिति जयंतीपुर	J P Singh
55	[illegible]	ग्राम प्रधान हरिपुर	
56	Dr J.K. Singh	Mobile P.H.C KOTWA	
57	Sri [illegible] M.	[illegible]	
58	V K Tiwari	Marketing officer, KRIBHCO	
59	श्री राजराज तिवारी	संपादक [illegible]	
60	ATUL KUMAR	A Secretary - Zila Bakshachi	
61	Dr A [illegible]	Superintendent CHC Sahatwar	
62			
63			

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S.No.	NAME	DESIGNATION	SIGNATURE
1	जानकी देवी	B.H.W.	जानकी देवी
2	शीला सिंह	A.N.M. & वि० कर्मी	शीला सिंह
3	mo. Devendra prasad	field officer	C.R.S.
4	Usha Pandey	इण्डो इंच B.L.V.	Usha Pandey
5	शिव दुलारी देवी	दाई	शिवदुलारी देवी
6	किरण चौबे	बाल विकास मित्र	किरण चौबे
7	DR S.C Chaudhary	Dy CMO (Im)	[illegible]
8	Dr. L. N. Singh.	Dy CMO I	[illegible]
9	Dr. R. P. Singh	MO i/c PHC Sonwar	[illegible]
10	Satya Prakash Verma	Secretary, Sunrise youth club	[illegible]
11	Pramod Kumar	President of Sun Rise club.	[illegible]
12	Sr. Jaya	Service	[illegible]
13	Fr Alonsius	Fr Incharge Social Service Centre Ballia	[illegible]
14	Dr. Umesh Kumar	M.O. P.C. Ba	[illegible]
15	Rajendra Prasad	SA Office of CMO	[illegible]
16	DR D P Singh	D.C.O. e.H.c. Ballia	[illegible] 19.1.2
17	Sachchidanand Tiwari	प्रधानाध्यापक कस्बापुर	सच्चिदानन्द
18	राजेन्द्र प्रसाद	बाबा नवयुवक संघ राजपुर	राजेन्द्र प्रसाद
19	इन्द्रजीत त्रिपाठी	T.E.S. [illegible]	[illegible]
20	Naresh Kumar Srivastava	Bisunpur Ballia	Naresh Kumar
21	Dr. S. R. Singh	S/o PHC Dadri	[illegible]
22	Dr. B.P. Gupta	MO i/c PHC Hapapur 643	[illegible]

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23	चामती देवी	ग्राम प्रधान हीरपुर	चामती देवी
24	Dr P. C. Upadhyay	Supdt. CHC Rosra	
25	Dr. P K Singh	MO/C PHC Manina	
26	शिवालीउपाध्याय	3 वार्ड मेम्बर	शिवालीउपाध्याय
27	Dr S-K सिंघ	DCMO..	
28	Raskishori	Kathauli (Da	राज कीशोरी
29	उमा राम	पंचायत समिति सदस्य	उमा राम
30	गिरिश दत्त	कैस पुर	गिरिश दत्त
31	दिनेश कुमार यादव	ग्राम शिवराजपुर	दिनेश यादव
32	देवमुनी	अकबरपुर गांव	देवमुनी
33	Dr Sanjay kumar	MO I/C, PHC Rotsar	
34	Dr A N Ra	Supdt CHC Sirsaganj	
35	Dr J. K Singh	P. H. C KOTWA	
36	Santosh Kumar	Teaching	Kumar
37	Kamal Ram	"	Ram
38	Dr Anil Kum	MO I/C PHC Rach	
39	Dr. S R Gupta	Administration	

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Annex 9

RESPONSE TO USAID/BHR/PVC's TECHNICAL REVIEW COMMENTS OF THE BRICS PROJECT PROPOSAL

CONCERNS AND RECOMMENDATIONS	*PROJECT'S RESPONSE*
*1 **Project Design***	
• *"Overly ambitious to include components on IMCI malaria bednets and possible vitamin A supplementation during pregnancy"*	The BRICS project has decided to drop the malaria bednets component. It will wait for the MTE Team to recommend whether or not to introduce the IMCI component from the third year of the project As vitamin A supplementation during pregnancy is not yet a GOI MOHFW policy, the project will wait until MTE to recommend whether it should do a pilot project with the UP State health authorities
• *"Too many activities at the different levels"*	We have streamlined our action plans, dropped some of the activities, and re-scheduled and consolidated others
• *'Complex management plan"*	The organogram has been simplified The revised management plan is discussed under the section I - Human Resources
• *"Phasing needed*	The annual bench marks for each year of the project have been re-set (please see DIP section C 2 "Objectives and Sub-Results")
• *'Slow start in year 1*	Year 1 will now cover 20 villages instead of 15 villages Other activities have been stepped up in year 1 Please refer to intervention-specific sections and the project work plan
*2 **Families of sponsored children***	
• *'Looks like WV intends to give them special attention at the expense of the rest of the community Are we going to involve other families too?*	WV policy disallows discrimination of any kind WV does not discriminate between families of WV sponsored children and families of non-WV sponsored children The BRICS project will engage all families
*3 **MOH Involvement***	
• *Unclear—need to spell out clearly the activities of the MOH"*	The DIP/Sustainability Action Plan (SAP) workshop was held in January 1999 The roles and contributions of the different partners were clearly spelt out Please refer to section H on Sustainibility and Annex 12 on the SAP
• *"Who will superrvise quality?"*	As the BRICS project is primarily a capacity-building project, BRICS staff will support and assist MOH, NGO and private sector and community partners to initiate and supervise continuous quality improvement (CQI) activities

Annex 10

PROPOSED SCOPE OF WORK FOR DR STAN FOSTER'S CONSULTANCY FOR BALLIA RURAL INTEGRATED CHILD SURVIVAL PROJECT, WORLD VISION INDIA

RATIONALE

As part of the DIP preparations for World Vision's USAID/BHR/PVC-funded Ballia Rural Integrated Child Survival Project (BRICS) in Uttar Pradesh, the project had planned a health facility survey This was also strongly recommended by USAID/BHR/PVC in their Technical Review of the BRICS proposal in June 1998

As the proposed consultant was not available during the DIP preparation phase, it is proposed that we invite Dr Stan Foster of Rollins School of Public Health, Emory University, Atlanta, USA to lead the assessment team for 15 days between April 24 and May 29, 1999 Dr Heather Goldman of the USAID Mission in New Delhi/India strongly supports Dr Foster's consultancy

It is envisaged that Dr Foster will assist the BRICS project staff and partners to test the PVO CORE group's new module for NGO assessment of health facilities

Through this proposed health facility survey, the current and future capacity of health facilities to provide essential services will be determined Based on the survey, there may be need for some readjustment to the DIP as to what can be done at the facility, by outreach and what needs to be done at the community level This will be communicated at the end of the facility survey

SCHEDULE OF ACTIVITIES

April 24-May 1

1) Assist in orienting the BRICS core team/partners to the process, and refining the questionnaire currently being developed by CORE
2) Plan with BRICS staff/partners the field work and data entry to be carried out over the following three weeks

May 23-29

1) Work with BRICS staff/partners to analyze results
2) Develop action plan to address identified gaps between standards and performance

An Emory University MPH student (self-paid) will assist Dr Stan Foster in the training, will work in the field with the teams, assist in teaching data entry and data cleaning, and participate in

anlaysis

CONSULTANCY COSTS

As Dr Stan Foster will be in India for the CARE ICDS evaluation around the same time, his USA-Delhi-USA trip will be paid by CARE

Dr Foster's domestic air travel and land transport costs, accomodation, food and incidentals and consultancy fees for the 15 consultancy days will be paid out of the BRICS Project's DIP budget

Annex 11 ___

BALLIA RURAL INTEGRATED CHILD SURVIVAL PROJECT
PROPOSED FORMAT

STUDY OF THE QUALITY OF HOME AND PRIVATE PRACTITIONER
CASE MANAGEMENT OF CHILDHOOD ILLNESSES
DATA ENTRY FORM FOR EPI-INFO *

Date of data entry or most recent revision of data record <today/yy>
(entered automatically by EPI-INFO using current date on computer)
Name and ID number of investigator {invname}_____ {invID}##
(from last page of form)

RESPONDENT INFORMATION

ID NUMBER {ID} #######
{Dist}rict # {CD Bl}ock # {Vill}age ## Household {HH} ###
2 1 {Resp}ondent's {name} _____
Is she the mother (1) or guardian (2) or other {relat}ionship to sick child (3) or no ans (9) #
2 2 {Fath}er's {name} _____
2 3 {Resp}ondent's {age} in years ## 99 = no ans
2 4 {Resp}ondent's {edu}cational level (coded) #
code 1 = illiterate 2 = literate 3 = primary 4 = middle 5 = matric and above 9 = no ans
2 5 {House} type (coded) #
code 1 = mud house 2 = khapra 3 = concrete roof 9 = no ans

CHILDREN
3 1 Number of living children 0 - 59 months in the family {numU5} #
Number of U5 children sick in last 2 weeks {numsick} #
If more than one has been sick, which child is this record about? #
(use serial no from item 3 2)
3 2 The sick child's name {sickname}_____
-- age in months {sickage} ## 99 = no ans
-- male or female? {sicksex} <A> M or F
3 5 Type of symptoms / illness USE CODE
CODE Y = Yes N = No D = Don t know or no answer on form
1 Fever? {sfever} <A>
2 Diarrhea? {sdiar} <A>
3 Cough/cold/trouble breathing? {sresp} <A>
4 Other {sothr} <A>
if yes, description {sothrd}_____
4 1 {Days sick} ## 99 = no ans
4 2 {Still} sick? <A>

* SOURCE · BASICS PVO II OR/KURJI HOLY FAMILY HOSPITAL

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RECOGNITION OF ILLNESS

4 3 What signs made you recognize that the child was sick?

ENTER Y = YES, N = NO, OR D = DONT KNOW/REMEMBER OR NO ANS

1	Change in appetite	{mappet}	<A>
2	Change in activity - play less	{mactiv}	<A>
3	Feel tired - lie down - no play	{mtired}	<A>
4	Fever	{mfever}	<A>
5	Change in consciousness, fits/convulsions	{mconvuls}	<A>
6	Persistence of symptom or sign	{mpersist}	<A>
7	Vomiting	(mvomit)	<A>
8	Change in stool color	{mstlcol}	<A>
9	Change in stool frequency, volume	{mstfrvol}	<A>
10	Blood in stool	{mstblood}	<A>
11	Cough	{mcough	<A>
12	Nasal discharge	{mnoserun}	<A>
13	Earache/ear discharge	{mear}	<A>
14	Trouble breathing	{mtbreath}	<A>
15	Fast breathing	{mfbreath}	<A>
16	Other symptoms or signs	{mosym}	<A>

5 HOME TREATMENT

1 Liquids/fluids {hfluid} # (use code)

Code 1 = increase volume 2 = same volume

3 = decrease vol 4 = withhold fluids 9 = no answer

2 Breastfeeding (BF)

-- BF before illness 1 = did 2 = Did not {bbf} # 9 = no ans

-- If Bfed, change in BF while sick {sbf} # (use code)

Code 1 = same BF as before sick 2 = more BF 3 = less 4 = stop BF

8 = not BF before illness 9 = no answer

3 Diet

-- Usual diet before illness {udiet} # (use code)

code 1 = not yet taking food (taking only BF) 2 = already taking food 9 = no ans

-- If taking food, change in diet while sick {sdiet} # (use code)

code 1 = diet/food NOT changed while sick 2 = diet/food changed

8 = not taking food before illness 9 = no answer

Diet components use code Y = takes, N = not take, D = don t know or no answer

	Before sick		During sickness	
1 Rice	{brice}	<A>	{srice}	<A>
2 Bread/roti	{broti}	<A>	{sroti}	<A>
3 Pulses/dhal	{bdhal}	<A>	{sdhal}	<A>
4 Milk	{bmilk}	<A>	{smilk}	<A>
5 Rice water	{bricwat}	<A>	{sricwat}	<A>
6 Curry	{bcurry}	<A>	{scurry}	<A>
7 Other {fother}_____	(write name of food)			
	{bother}	<A>	{sother}	<A>

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③

Diet frequency, number of feedings per day

-- Did number of feedings/day change during illness? {chfreq} # (use code)
code 1 = no change 2 = fed less frequently 3 = fed more frequently
8 = not feeding before sick 9 = no answer

-- What was the actual frequency of feedings before and during illness?
(give actual number of feedings per day, or 99 if no answer)
-- before sick {bfreq} ##
-- during illness {sfreq} ##

6 1 HOME FEVER CARE

2	Gave tepid bath (warm water)	{fbathwarm}	<A>
3	Gave bath/sponged with cool water	{fbathcool}	<A>
4	Removed clothing	{fclothoff}	<A>
5	Gave pain tablets (aspirin, etc)	{fpaintab}	<A>
6	Gave fever tablets (paracetemol, etc)	{ffevtab}	<A>
7	Gave malaria medicine	{fmalmed}	<A>
8	Gave antibiotic	{fbiot}	<A>
9	Gave herbal/traditional medicine	{fherb}	<A>
10	Gave other type of medicine	{fother}	<A>
	Name of other med	{fothern}_____	

6 2 HOME DIARRHEA CARE

2	Gave ORS	{dORS}	<A>
3	Gave sugar-salt solution	{dSSS}	<A>
4	Gave antibiotic	{dbiot}	<A>
5	Gave herbal/traditional medicine	{dherb}	<A>
6	Gave other type of medicine	{dother}	<A>
	Name of other med	{dothern}_____	

6 3 HOME CARE OF COUGH - COLD - TROUBLE BREATHING

2	Gave cough medicine	{rcough}	<A>
3	Gave fever med (paracetemol etc)	{rfever}	<A>
4	Gave pain med (aspirin, etc)	{rpain}	<A>
5	Gave herbal/traditional meds	{rherb}	<A>
6	Gave other local/traditional treatment	{rtrad}	<A>
7	Gave other med/treatment	{rother}	<A>
	Name of other med/treatment	{rothern}_____	

7 CARE OUTSIDE THE HOME

1 1 Advice sought? {advice} # (use code)
codes 1 = yes 2 = no 9 = no answer

1 2 If yes, from whom? {whoadv} # (use code)
codes 1 = own mother 2 = neighbor 3 = community health worker 4 = other 9 = na
-- for those answering 4, describe {whoadv4}_____

2 1 Medicine gotten outside home? {outmed} # (use code)
codes 1 = yes 2 = no 9 = no answer

2 2 If yes from whom?

Source 1	{medsourc1}	##	(use code)
Source 2	{medsourc2}	##	(use code)
Source 3	{medsourc3}	##	(use code)

codes 1 = allopath practitioner 2 = ayurved pract 3 = homeopath pract
4 = other practitioner 5 = shopkeeper 6 = govt health facility
7 = comm health worker 8 = other type than types 1 thru 7 9 = ANM, anganwadi worker 10 = source named but can't tell type 99 = no answer

2 3 Medicines obtained from each source of meds

Source 1 names of meds given	{s1mednam1}	_____
	{s1mednam2}	_____
	{s1mednam3}	_____
Source 2 names of meds given	{s2mednam1}	_____
	{s2mednam2}	_____
	{s2mednam3}	_____
Source 3 names of meds given	{s3mednam1}	_____
	{s3mednam2}	_____
	{s3mednam3}	_____

Cost of meds obtained (in rupees) from each source 999 = no ans

Source 1	{s1medcost}	###
Source 2	{s2medcost}	###
Source 3	{s3medcost}	###

8 HEALTH CARE PROVIDERS DOCTORS, NURSES, COUMPOUNDERS COMMUNITY HEALTH WORKERS, TRADITIONAL HEALTH WORKERS

For first practitioner consulted

8 1 1 1 Practitioner type {practype1} #

Codes

1 = allopath	5 = jharphunk
2 = homeopath	6 = djha-guni
3 = ayurved	7 = other
4 = jantar-manter	8 = shopkeeper
	9 = no answer

8 1 1 2 Name of practitioner {pracname1} _____

8 1 1 3 Address of Practitioner Village name {pracvill1}_____
Village number {pvillno1} ###

What is relationship of practitioner's village to patient's village? {relavill1}#
Code 1 = same village 2 = next village 3 = more than one village away

8 1 1 4 Payment to practitioner {pracpay1} total Rs ### 999 = no ans

8 2 1 Reasons for choosing practitioner 1

USE CODE Y =Yes, N = No D = Don't remember or no answer marked on form

1 previously treated children	{prevtreat1}	<A>
2 easy to reach	{easyreach1}	<A>
3 always available	{always1}	<A>
4 medicines always available	{hasmeds1}	<A>
5 not costly	{notcost1}	<A>
6 gives credit/loan	{credit1}	<A>

5

7 someone recommended {layrec1} <A>
8 doctor/CHW recommend {hwrec1} <A>
9 other reason {otherrea1}_____

IF SECOND PRACTITIONER CONSULTED, DESCRIBE SIMILARLY BELOW

8 1 1 2 Practitioner type {practype2} #

Codes
1 = allopath
2 = homeopath
3 = ayurved
4 = jantar-manter
5 = jharphunk
6 = djha-guni
7 = other
8 = shopkeeper
9 = no answer

8 1 2 2 Name of practitioner {pracname2} _____

8 1 2 3 Address of Practitioner Village name {pracvill2}_____
Village number {pvillno2} ###

What is relationship of practitioner's village to patient's village? {relavill2} #
Code 1 = same village 2 = next village 3 = more than one village away

8 1 2 4 Payment to practitoner {pracpay2} total Rs ###

8 2 2 Reasons for choosing practitioner 2

USE CODE Y =Yes, N = No, D = Don't remember or no answer marked on form

1 previously treated children {prevtreat2} <A>
2 easy to reach {easyreach2} <A>
3 always available {always2} <A>
4 medicines always available {hasmeds2} <A>
5 not costly {notcost2} <A>
6 gives credit/loan {credit2} <A>
7 someone recommended {layrec2} <A>
8 doctor/CHW recommend {hwrec2} <A>
9 other reason {otherrea2}_____

8 3 1 Did you consult other doctors besides local Health Practitioners?
{consult} <A> (code = Y, N, D)

Give reason for seeking consultation
{whyconsult}_____

8 3 2 Signs/symptome of child which were reasons for seeking consultation

USE CODE Y =Yes, N = No, D = Don't remember or no answer marked on form

1 poor appetite {cappet} <A>
2 reduced activity, listless {cactiv} <A>
3 high fever {cfever} <A>
4 convulsions, fits {cconvuls} <A>
5 changes in sleep pattern {csleep} <A>
6 persistence of symptoms {cpersist} <A>
7 vomiting {cvomit} <A>
8 stool color & character change {cstlcol} <A>
9 blood in stool {cstblood} <A>
10 coughing severely {ccough} <A>
11 nose running {cnoserun} <A>
12 earache, discharge {cear} <A>
13 trouble breathing {ctbreath} <A>

14 fast breathing {cfbreath} <A>
15 chest trouble {cchest} <A>
16 Other symptoms or signs {cosym} <A>

9 Socio-Economic Status of Respondent
-- {house}number ### 999 = no answer

9 1 Family description 99 = no ans
-- Total family members including sick child & respondent {totfam} ## (99 = no ans)
-- Total {males} ## (99 = no ans)
-- Total {females} ## (99 = no ans)
-- Total children under 5 years of age {u5} # 9 = no ans
-- {Religion}of the majority of family members #
Code 1 = Hindu 2 = Muslim 3 = Buddhist 4 = No religion 5 = Other 9 = no ans
-- Occupation of the top three money earners in the family {job1} # {job2} # {job3} #
Codes 1 = agriculture, farming 2 = laborer, daily wage earner 3 = animal raising
4 = skilled laborer/artisan 5 = shopkeeper market seller 6 = other 9 = no ans
-- Total family monthly {income} Rs ##### (99999 = no ans)

9 2 Family expenditures
-- monthly expenditures
-- for food {foodcost} Rs ?? <A____> no of Rs or NA = No Answer
-- for meds/treatment {Rxcost} Rs ?? <A____> no of Rs or NA = No Answer
-- tobacco/alcohol/etc {sincost} Rs?? <A____> no of Rs or NA = No Answer
-- annual expenditures
-- house construction/repair {housecost} <A____> no of Rs or NA = No Answer
-- education {educost} <A____> no of Rs or NA = No Answer
-- clothing {clothcost} <A____> no of Rs or NA = No Answer
-- conveyance {ridecost} <A____> no of Rs or NA = No Answer
-- entertainment {joycost} <A____> no of Rs or NA = No Answer

10 Inventory of Other Health Providers
(will be analyzed separately)

11 QUALITY OF PRACTITIONER SERVICES PROVIDED TO CHILDREN
11 1 Practitioner's name {NAMEPRAC} _____
-- Which of the practitioners mentioned in question 8 1 is this? # (coded)
1 = practitioner 1 in question 8 1 2 = practitioner 2 5 = neither 1 or 2
Did the practitioner
USE CODE Y =Yes, N = No, D = Don't remember or no answer marked on form
1 {touch} the child as part of his examination? <A>
2 use a {thermo}meter to check for fever? <A>
3 {weigh} the baby <A>
4 use watch or {timer} to calculate breathing rate? <A>
5 ask about the {history} of the illness? <A>

11 2 In the practitioner s examination did he/she

USE CODE Y =Yes N = No D = Don t remember or no answer marked on form

1 ask about what care you gave at home {homecare} <A>
2 ask you for the child s immunization care {immcard}<A>
3 recommend immunization of the child {immrec} <A>
4 {exam}ine the child <A>
5 take the child's {cloth}ing {off} to examine it <A>
6 look into and examine inside the child's {throat} <A>
7 use a {stetho}scope on the child's chest <A>
8 feel the child's {abd}omen <A>
9 ask about history of vomiting {hvomit} <A>
10 ask about history of diarrhea {hdiar} <A>

12 TREATMENT GIVEN OR PRESCRIBED

USE CODE Y =Yes N = No, D = Don t remember or no answer marked on form

12 1 1 Gave injection? {ginj} <A>

12 1 2 If yes, what was it? {whatinj} # (use code)

code 1 = don't know 2 = antibiotic 3 = for fever 4 = other 9 = no ans

12 1 3 Gave tablets? {gtab} <A>

(use Y N, or D as above)

12 1 4 If yes, what were they for? {whattab} # (use code)

code 1 = don't know 2 = for diarrhea 3 = vitamin
4 = for digestion 5 = for strength 6 = for breathing trouble 8 = other
9 = no ans

12 1 5 Gave syrup? {gsyr} <A>

(use Y, N, or D as above)

12 1 6 What was it for? {whatsyr} # (use code)

code 1 = don't know or no ans 2 = for diarrhea 3 = vitamin
4 = for digestion 5 = for strength 6 = for fever 7 = for resistance to cold
8 = cough syrup 9 = other

12 2 RECOMMENDATIONS BY PROVIDER

USE CODE Y =Yes N = No, D = Don't remember or no answer marked on form

			each time	times per day	no of days
1	Chloroquine/{mal}aria {med}	<A>	{mal-e} ##	{mal-t} #	{mal-d} #
2	Paracetamol/{fev}er med	<A>	{fev-e} ##	{fev-t} #	{fev-d} #
3	Aspirin/{pain} med	<A>	{pain-e} ##	{pain-t} #	{pain-d} #
4	Tepid bath {wmwater}	<A>			
5	Increase fluids {morfluid}	<A>			
6	ORS {ORS}	<A>	{ORS-e}_____	{ORS-t} #	{ORS-d}____

(instructions for ORS are likely to be 1 glass/stool, at each diarrhea time, until diarrhea stops)

7 Continue regular diet {regfood} <A>
8 Special diet {spfood} <A>
9 Increase food quality {qufood} <A>

10	Antidiarrheal medicine	{dmed}	<A>	{dmed-e}##	{dmed-t} #	{dmed-d} #
11	Antibiotics	{abiot}	<A>	{abiot-e} ##	{abiot-t} #	{abiot-d} #
12	Vitamin A	{VitA}	<A>	{VitA-e} ##	{VitA-t} #	{VitA-d} #
13	Other medicine	{Omed}	<A>	{Omed-e} ##	{Omed-t} #	{Omed-d} #
14	Go to other care source	{refer}	<A>			
15	Other suggestion	{Osugg}	<A>			

FURTHER INSTRUCTIONS BY PROVIDER OR HIS/HER ASSISTANT

USE CODE Y =Yes, N = No, D = Don't remember or no answer marked on form

12 3 Did the practitioner or assistant tell you

1 How to administer medicine {howmed} <A>
2 What and how to give food {howfood} <A>
3 What/how to give fluids {howfluid} <A>
4 How to give breastfeeding {howbreast} <A>
5 Signs to look for as indicator {looksign} <A>
child is getting worse and needs more help
6 How to mix ORS? {N6HOWMIXOR} <A>
7 How to prevent illness in future {howprev} <A>
8 Did the practitioner or assistant {anyques} <A>
ask you if you had any questions?

SATISFACTION & DIFFICULTIES

12 4 Level of {satisf}action # (code)

code 1 = very happy/satisfied 2 = happy 3 = somewhat dissatisfied 4 = very dissatisf
9 = no answer

12 5 Possible practitioner actions to improve service & increase satisfaction

{Improv1}_____

{Improv2}_____

12 6 Patient difficulties in carrying out treatment

USE CODE Y =Yes, N = No, D = Don't remember or no answer marked on form

1 Did {not purch}ase prescription <A>
2 {Purch}ased only {part} of prescription <A>
3 Child would {not take} medicine <A>
4 Child would not eat or drink {noeatdr} <A>
5 Child {want}ed {food}s restricted by practitioner <A>

APPENDIX —

PROPOSED FORMAT FOR PRE- & POST-INTERVENTION ASSESSMENT OF PRIVATE PROVIDERS' CASE MANAGEMENT PRACTICES FOR ARI, DIARRHEA & FEVER*
BALLIA RURAL INTEGRATED CHILD SURVIVAL PROJECT

Type of Case Management Practice	Pre-Test	Post-Test (12 months later)	Percentage Point Increase
EXAMINATION PRACTICES			
Asked the mother about care given at home			
Asked about child s immunization cards			
Took child s clothing off to examine the child			
Asked about care given at home			
Asked about the history of illness			
Used a thermometer to check temperature			
Used a watch or timer to calculate breathing			
Looked in and examined the child s throat			
Felt the child s abdomen			
Asked about the child s history of vomiting			
COUNSELING PRACTICES			
Recommended breast-feeding			
Mentioned signs to look for as an indication the child is getting worse			
Recommended how to prevent illness in the future			
Asked the mother if she had any questions			
Described how to administer the medicine			

* ADAPTED FROM BASICS

Annex 12

BALLIA RURAL INTEGRATED INTEGRATED CHILD SURVIVAL PROJECT

Criteria and Plan for Scaling Up

STRATEGIC OBJECTIVE The BRICS' strategic objective is to assist the Ballia District Chief Medical Office and private sector and community partners to accomplish, sustain, document and replicate best practices to ***reduce fertility and infant, child and maternal mortality through an innovative child survival and reproductive health improvement project*** in one block (namely, Beruar Beri Block) of the remote Ballia District in eastern Uttar Pradish state over a four year period

The project plans to go to scale by replicating best practices in child survival and reproductive health to
(a) the entire Ballia District (of 17 blocks with 2,583,517 people) , and
(b) three other WV India's Area Development Projects (ADPs) in UP state impacting 221,418 people

The project will pilot-test with the MOHFW, WHO and UNICEF the following two prototype modules
i) ***Community-based Surveillance of*** (a) childhood diseases (polio, measles and neonatal tetanus), and of (b) infant, child and maternal mortality,
ii) ***Integrated Management of Childhood Illnesses (IMCI) at the community level*** by PHC/sub-center staff, Anganwadi Workers (AWWs), VHGs (Village Health Guides) and traditional birth attendants(TBAs)

WV India envisions that these two prototype modules will also be adapted and utilized in 100 districts where WV India's 100 ADPs are located across almost all the states of India As each ADP covers one block with an average of 100,000 people, *a potential population of 10 million people and 245 local NGOs and community-based organizations may eventually be impacted through this proposed replication*

To clearly reflect intentionality to scale up (while ensuring that quality is maintained), the BRICS project will, during the first annual review in September 1999, consider the following

(1) **Establish criteria for scaling up** which will then be used at the mid-term evaluation/final evaluation to assess the BRICS project's readiness for scaling up in the next phase,

(2) **Produce a Scale-up Plan** detailing when, how and where the BRICS project will scale up in the next 3 years of its current USAID funding The following points will be used to help develop the Scaling up Plan
(a) state the type of scaling up that is planned for each year/phase, e g
- *quantitative program spread* with growth in the number of beneficiaries,
- *functional increase* in the number of program *sectoral components*,
- *organizational increase in program sustainability* through partnering and integration with local players, or nurturing and mentoring of local NGOs or people's organizations,
- *cultural diffusion of an innovation/behavior change* to CSP beneficiaries through dissemination of best practices,
- influence on the program environment through *policy reform or policy introduction*

(b) Describe steps to integrate impact, sustainability and scaling up

*** (please see map with concentric circles)*

Annex 13

EPI CASE IDENTIFICATION FORM
BALLIA RURAL INTEGRATED CHILD SURVIVAL PROJECT

Notification date ___/___/___ By _____ Cat _____

Interview date ___/___/___ By _____ Title _____

Name of the child _____ Date of birth ___/___/___

Address _____ Compartment _____ Ward _____

Illness onset date ___/___/___ First treatment date ___/___/___

Is the infant child alive now ?

Was the infant more than 28 days of age at the onset of illness Y ( ) _____ Polio
N ( )

Suspected Neonatal Tetanus

1 Was the infant able to suck and cry normally from birth until the illness started ? Y ( ) N ( )

2 Is the infant able to suck now? Y ( ) N ( )
3 Is the infants body stiff ? Y ( ) N ( )
4 Has the infant had convulsions or spasms ? Y ( ) N ( )

Suspected Polio

1 Is (child) the child less than 25 years of age ? Y ( ) N ( )
2 Does (child) the child have rash ? Y ( ) N ( )
3 Is the child paralyzed part of his/ her body loose of stiff? Y ( ) N ( )

Suspected measles

1 Is the child more than 90 days of age ? Y ( ) N ( )
2 Does (did) the child have rash ? Y ( ) N ( )
3 How many days did the rash lasted (did the rash last) _____ days
4 Where is (was) the rash ?
a Face Y ( ) N ( )
b Trunk Y ( ) N ( )
c Arms Y ( ) N ( )
d Legs Y ( ) N ( )
5 Does (did) the child have a fever ? Y ( ) N ( )
6 How many days has the fever lasted (did the fever last) ? _____ days
7 Does (did) the child have red eyes ? Y ( ) N ( )
8 Does (did) the child have cough ? Y ( ) N ( )

Final Diagnosis from case Identification Form

1 Suspected neonatal tetanus ( )
2 Suspected polio ( )
3 Suspected measles ( )
4 None of the above ( )

(2)

INVESTIGATION OF THE DEATH OF NEW BORN, 28 OR FEWER DAYS OLD
BALLIA RURAL INTEGRATED CHILD SURVIVAL PROJECT

Notification date ___/___/___ By _____ Cat _____

Interview date ___/___/___ By _____ Title _____

Name of the child _____ Date of birth ___/___/___

Address _____ Compartment _____ Ward _____

Illness onset date ___/___/___ First treatment date ___/___/___

Treatment place _____ Date of death ___/___/___

1 CALCULATE THE DAYS BETWEEN DEATH AND BIRHT

Was the infant 28 or fewer days of age at the death ? Y ( ) N ( )— end

2 Please describe the circumstances of (child's) death

_____

_____

_____

_____

_____

3 Did (child) breath or cry during or after the birth ? Y ( ) N ( ) _ end

4 Did (child) die of injury ? Y ( ) - 5

5 Did the injury occur during or after birth during ( )- end after ( )- end

6 Was (child) blue after the birth ? Y ( ) N ( )

7a Was (child) born 1 month or more before the due date ? Y ( ) N ( )

7b Was (child) very thin at birth ? Y ( ) N ( )

8 Was (child) malformed at birth ? Y ( ) N ( )

9 Did (child) have fever during the illness that led to death ? Y ( ) N ( )- 11

10 How many days did the fever last ? _____ days

13 b _ 1

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(3)

11 Was (child) able to suck and cry normally from birth until the illness started Y ( ) N ( )

12 Did (child) stop sucking with the illness that led to death ? Y ( )- 14 N ( )

13 How many days was the old infant when he/she stopped sucking ? _____ days

14 Was (child s) body stiff during illness that led to death Y ( ) N ( )

15 Did (child) have convulsions or spasms during the illness ? Y ( ) N ( )

16 Did (child) have cough during the illness that led to death Y ( ) N ( )-18

17 How many days did the cough last ? _____ days

18 Did (child) have difficult breathing during the illness that led to death ? Y ( ) N ( )-20

19 How many days did the breathing last ? _____ days

20 Did (child) have breathing during the illness Y ( ) N ( )-25

21 How many days did the rapid breathing last ? _____ days

22 Did (child) have loose or watery stools during the illness that led to death ? Y ( ) N ( )

23 For how many days did he/she have loose or watery stools ? _____ days

24 How many loose or watery stools did child have in one day ? _____ stools

25 Did (child) have blood in the stools during illness that led to death ? Y ( ) N ( )

Thank you for your help

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Appendix 11 Criteria for Diagnosis by verbal Autopsy (death investigation)

Investigation of the death of a new born (28 days or less)

PROBABLE DIAGNOSIS	DIAGNOSTIC CRITERIA
Prematurity	Neonate who was < 37 weeks (259 days) gestation (" yes " to Q # 3 and appropriate gestational age specified in Q#4)
Still birth	Neonate with no signs of life after birth ("no " response to Q # 5)
Birth trauma	Neonate who died of injury sustained during birth ("yes" response to Q # 7)
Other Injury	Neonate who died of an injury sustained after birth ("Yes " response to Q # 6 and after response to Q # 7)
Birth Asphyxia	Neonate who was slow to begin breathing and had poor color after birth (" Yes" response to Q # 8 and Q # 9)
Low birth weight	Neonate who was very light or small at birth (" Yes" response to Q # 10, LWB may be suspected to be due to prematurity if answer to Q # 3 is "Yes'
Congenital Malformation	Neonate who was malformed at birth (" Yes" response to Q # 11)
Neonatal sepsis	Neonate who had a fever without other causes of death (" Yes" response to Q # 12 with out satisfaction of criteria for diagnosis of other infections, such as tetanus, pneumonia, or diarrhea)
Neonatal tetanus	Neonate who was at least two days old at the time of onset of illness and was able to suck and cry normally prior to the onset of illness and who stopped sucking prior to death and who had either stiffness or convulsion prior to death (At least 2 days as response to Q # 16, and "Yes to Q # 14 and Q # 15, and a "yes" response to either Q # 17 or Q # 18), the diagnosis of the neonatal tetanus should not be made in the presence of a diagnosis of birth asphyxia, birth trauma, or congenital defects
Pneumonia	Neonate who had cough or difficult breathing for two days or more days, and rapid breathing for at least one day (24 hours) prior to death (" Yes" response to Q # 19 or Q # 21 with duration of two days or more days and "Yes" response to Q # 23 with duration of at least one day)
Diarrhea	Neonate who had at least three loose or watery stools per day for more than 24 hours prior to death (" Yes" response to Q # 25, and appropriate duration and number of stools in Q # 26 and Q # 27
Dysentery	Neonate who meets the criteria for diagnosis of diarrhea (above) and has blood in stool (" Yes " response to Q # 28)

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(4)

Investigation of the Death of a Child From 1 Month to 5 Years
[redacted] Integrated Child Survival Project

Notification date: ___/___/___ By. _____ Cat: _____

Interview date: ___/___/___ By: _____ Title: _____

Name of infant: _____ Date of Birth: ___/___/___

Address: _____ Compartment: _____ Ward. _____

Illness onset date: ___/___/___ First treatment date: ___/___/___

Treatment place: _____ Date of death: ___/___/___

1. CALCULATE THE DAYS BETWEEN BIRTH AND DEATH

   At death, was the child between 28 days and 5 years of age? — Y [ ] / N [ ] - end

2. Please describe the circumstances of (child's) death

   _____

3. Did the (child) die of an injury? — Y [ ] - end / N [ ]

4. Was (child) thinner than other children of his/her age before the illness that led to death? — Y [ ] / N [ ] - 7

5. Did (child) have a cough during the illness? — Y [ ] / N [ ] - 7

6. How many days did the cough last? — _____ days

7. Did (child) have difficult breathing during the illness that led to death? — Y [ ] / N [ ] -

8. How many days did the difficult breathing last? — _____ days

9. Did (child) have rapid breathing during the illness that led to death? — Y [ ] / N [ ] - 11

10. How many days did the rapid breathing last? — _____ days

11. Did (child) have loose or watery stools during the illness that led to death? — Y [ ] / N [ ] - 14

12. For how many days did he/she have loose or watery stools? — _____ days

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13. How many loose or watery stools did (child) have in one day during the illness? _____ stools

14. Did (child) have blood in the stools during the illness that led to his/her death? Y [ ] N [ ]

15. Did (child) have a rash during the illness that led to his/her death? Y [ ] N [ ]

16. How many days did the rash last/ _____ days

17. Where was the rash?

    a. Face Y [ ] N [ ]
    b. Trunk Y [ ] N [ ]
    c. Arms Y [ ] N [ ]
    d. Legs Y [ ] N [ ]

18. Did (child) have a fever during the illness that led to his/her death? Y [ ] N [ ]

19. How many days did the fever last? _____ days

20. Did (child) have a new paralysis during the illness that led to death? Y [ ] N [ ]

21. Was the paralyzed part of his/her body loose or stiff? Loose [ ] Stiff [ ]

Thanks you for your help.

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(7)

Appendix (continued)

Algorithms for Diagnosis based on Death Investigations

Investigation of the death of a child (1 to 59 months)

PROBABLE DIAGNOSIS	*DIAGNOSTIC CRITERIA*
Injury	Child reported to have died of injury ("Yes" response to Q # 3)
Malnutrition	Child who had weight loss or who was thinner than other children of his/her ("Yes" response to Q # 4)
Pneumonia	Child who had cough or difficult breathing for two or more days, and rapid breathing for at least one day (24 hours) prior to death ("Yes" response to Q #5 or Q #7)with duration of two or more days and ("Yes" response to Q # 9) with duration of at least one day
Diarrhea	Child who at least had loose or watery stools per day for than more than 24 prior to death ("Yes" response to Q # 11and appropriate duration and number of stools in Q # 12 and Q # 13)
Dysentery	Child who meets the criteria for diagnosis of diarrhea (above) and has blood in stool ("Yes" response to Q #14)
Measles	Child who is at least 4 months of age who had illness with fever and rash lasting 3 or more days ("Yes" response to Q #15 and Q #18 and duration of at least 3 days for Q # 16 and Q # 19, Location of the rash can help to make the diagnosis more certain)
Polio	Child who has a new flaccid paralysis prior to death ("Yes" response to Q # 20 and Q #21)

8

Investigation of death of a woman, Aged 15 - 45 Years
Ballia Rural Integrated Child Survival Project

Notification date ___/___/___ By _____ Cat _____

Interview date ___/___/___ By _____ Title _____

Name of the child _____ Date of birth ___/___/___

Address _____ Compartment _____ Ward _____

Illness onset date ___/___/___ First treatment date ___/___/___

Treatment place _____ Date of death ___/___/___

1 Could you describe the circumstances of the woman s death ?

_____

_____

_____

_____

_____

2 Did the woman die of an injury ? Y ( ) - end
N ( )

3 Did the women have an abortion shortly before she died Y ( )
N ( ) - 6

4 When was the abortion ? ___/___/___

5 CALCULATE THE DAYS BETWEEN ABORTION AND DEATH
Is this less than 43 days ? Y ( ) - end
N ( )

6 Was the woman known to be pregnant at the time of her death ? Y ( ) - 9
N ( )

7 When did the woman last give birth ? ___/___/___

8 CALCULATE THE DAYS BETWEEN BIRTH AND DEATH
Is this less than 43 days ? Y ( )
N ( ) - end

9 Dud the woman have bleeding during the pregnancy (after birth) ? Y ( )
N ( ) - end

10 Did the woman have a high fever during the pregnancy (after birth) ? Y ( )
N ( )

11 Did the woman have obstructed labor ? Y ( )
N ( )

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(7)

Appendix continued

Algorithms for Diagnosis Based on Death Investigations

Investigation of the death of a woman (15 to 44 years)

PROBABLE DIAGNOSIS	*DIAGNOSTIC CRITERIA*
Maternal Death	Any woman who dies while pregnant or less than 42 days after abortion or delivery ("yes" response to Q # 7, and " Yes response to Q # 6 or Q # 9, or " Yes" response to Q # 3), even if another cause of death is evident
Injury	woman reported to have died of an injury ("yes" response to Q # 2)
Abortion	Woman who had abortion less than 42 days prior to death ("yes" response to Q # 7and Q # 9)
Maternal Hemorrhage	Woman who had heavy bleeding during the pregnancy or during or after delivery / abortion ("yes" response to Q # 10)
Maternal Sepsis	woman who had high fever during the pregnancy or during or after delivery / abortion ("yes" response to Q # 11)
Eclampsia	Woman who had seizures during or after delivery / abortion ("yes" response to Q # 12)
Obstructed Labour	Woman who had reported to have obstructed labor ("yes" response to Q # 13)

STEPS IN COMUNITY SURVEILLANCE

The project will undertake with its partners the following steps in developing the community-based disease and death surveillance (CBDDS)

Community Surveillance of 3 vaccine-preventable disease cases (polio, measles and neonatal tetanus)

To facilitate Case Identification/Reporting, the project will

1) Develop simplified simplified definition of a "suspect" case for popular use in the project area in the detection of each target disease (i) polio new paralysis in a child or adolescent, (ii) measles fever and rash in a child, (iii) neonatal tetanus stiffness or inability to suck in a newborn,
2) Field test/adapt all CBDDS forms to assure that design is optimal
3) Train BRICS staff, CMO/PHC/SC staff, NGO staff VHGs, TBAs, AWWs panchayats, parish mandals, mahila mandals, youth groups, private practitioners family members of WV sponsored children WV sponsored children and school teachers in the above-mentioned simplified case definitions that should detect most of the cases of polio, measles and neonatal tetanus
4) Conduct community education through community meetings schools and home visits to ensure that health workers and community members will be able to detect suspect cases
5) Adapt and distribute promotion mateials including 'memory aids' and posters within project area,
6) Instruct community members to immediate report suspected cases of the 3 EPI target diseases to their first contact health worker (VHG, AWW or PHC/SC staff or to their closest contact in the BICSP)
7) ***Create a climate where everyone needs to report every case of AFP (Acute Flaccid Paralysis)***--zero-reporting of AFP will be instituted on a monthly basis
8) As the community definitions are very general, this will result in more reported cases (e g reported AFP cases) than actual cases (e g case-based AFP with stool positive for polio virus 8)--the first contact health worker will be instructed to report every suspected case immediately to the SC/PHC staff
9) Train the PHC staff (Doctor/LHV/senior ANM) or SC-based ANM to promptly (within hours) investigate any suspected cases by filling out a "Suspected Case Identification Form which is submitted to the Ballia District Immunization Officer (DIO)
10) Conduct a full investigation in collaboration with the PHC doctor or the Ballia DIO using the national case report form for suspected polio and neonatal tetanus cases
11) Arrange with the Ballia DIO for stool specimens from suspected polio cases to be taken and sent on ice or in specialaly designated "reverse cold chain" to the designated polio laboratory at the National Insitute of Communicable Diseases
12) Assist the Ballia DIO in weekly monitoring of timeliness and completeness ot reports

Community Surveillance of deaths in neonates (o-28 days), children 1-59 months, and women 15-45 years The project will

1) Finalize 3 types of death investigations forms for field investigation of (a) neonatal deaths (b) children 1-59 months, (c) maternal deaths (15-45 years)
2) Finalize diagniostic criteria for classifying cause of death by death investigation (verbal autopsy)
3) Train BRICS staff CMO/PHC/SC staff NGO staff VHGs TBAs AWWs panchayats parish mandals mahila mandals youth groups private practitioners family members of WV-sponsored children WV sponsored children and school teachers in the management of the communuty based death surveillance

Death Reporting

The first contact worker (VHG TBA AWW or SC-based ANM) will report immediately any deaths to the PHC LHV who will conduct a verbal autopsy/desath investigation to determine the cause of death The BRICS s LCOs (Lady Community Organizer) will be trained to obtain notification of deaths in

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under-5 children and women 15-45 years from panchayat/religious leaders daily Any deaths will be reported immediately to the LHV The BICSP will liaise with the Vballia district hospital to obtain death notification among under-5 children and women 15-45 years from Beruar Beri block It will also arrange for maintenance of line listing of all neontal, child and maternal deaths to facilitate summary and to prevent double-counting The project will discuss with community and NGO partners on possible strategies to raise the proportion of neontal, child and maternal deaths captured by the death surveillance system

The project will also facilitate more effective use of surveillance data at
(i) *the community level*--e g if there is a diarrheal or pneumonia death or NNT death or maternal death , target all pregnant women in the cluster/compartment for intensive health education regarding ORT, Pneumonia recognition and referral, TT or family planning/spacing;
(ii) *program level*--map the geographical distribution of all identified neonatal, child and maternal deaths,
(iii) *strategic/planning level*--recommend family planning as the single most important intervention to reduce neonatal mortality

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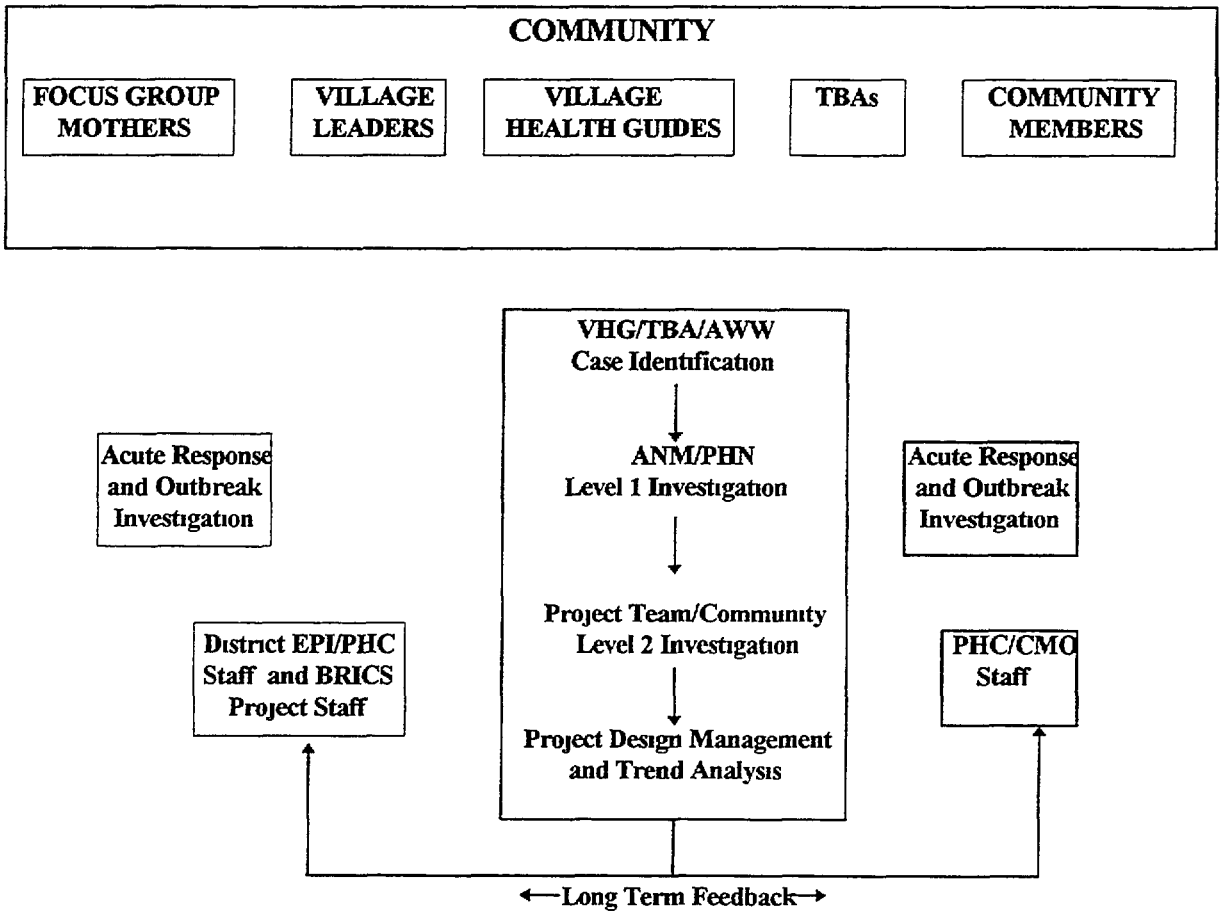
BALLIA CHILD SURVIVAL PROJECT
DETAILED IMPLEMENTATION PLAN

DATA FLOW DIAGRAM
COMMUNITY BASED SURVEILLANCE SYSTEM



VILLAGE PREGNANCY REGISTER

LMP	name	age	address	# children	ANC 1	ANC 2	ANC 3	TT1	TT2	TT3	TT4	TT5	date delivery	who delivered	born dead/ alive	post partum VAC	1 mo f/u mother	1 mo f/u child	name in EPI book	enrolled in birth spacing book

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VILLAGE EPI REGISTER

date of birth	name	sex	mother s name	father s name	address	BCG	OPV0	OPV1	OPV2	OPV3	DPT1	DPT2	DPT3	measles	complete	other

13K

Annex 14

LIST OF IN COUNTRY ADVISORS

NATIONAL LEVEL

1 USAID/New Delhi
Dr Heather W Goldman, Ph D (Director, Office of Social Development)
Dr Rajani Vaid (Project Officer, Health Services Division, Office of Population, Health and Nutrition)
Ms Ashi Kohli (Program Management Assistant, Office of Social Development)

2 WHO/Southeast Asia Regional Office/New Delhi
Dr T Walia (Public Health Administrator)
Dr Irnam Moceny (Chief of EPI)
Dr John Fitzfommons (Administrator & Program Officer)
Dr Oratin (Medical Officer Safe Motherhood)
Dr Vijar Kumar (Director Integrated Management of Diseases)
Dr Sanvati (M O Integrated Management of Childhood Illnesses)

3 UNICEF
Dr K Swesh (Medical Officer, Epidemiology)
Dr K.R.Anthony (U P State Health Officer, UNICEF, Lucknow)

4 UNDP
Tim Mckaye (Regional HIV/Development Project Director)
Ms Geeta Sethi (Senior Project Officer)

5 POPULATION COUNCIL
Dr M.E Khan (Country Advisor)

6 PLAN INTERNATIONAL
Dr Nalini Abraham (Advisor Health)

CENTRAL GOVERNMENT
Dr Vimte Umar (Director, Reproductive and Child Health)

UTTAR PRADESH STATE GOVERNMENT
1 Dr S D Trupathi (Additional Director EPI)
2 Dr Gayatri Sharma (Additional Director MOHFW)
3 Dr V K Srivaritara (Director State Institute of Health and Family Welfare)
4 Dr P C Joshi (Director MOH and Family Welfare)
5 Dr A Z Rizvi (Director General Family Welfare Govt of U P)

DISTRICT
Dr A K Snraiteva (Chief Medical Officer, Ballia)

LOCAL NGOs
Annpam Khatri (President Rotaract Club of Ballia)

Annex 15

FE D GARCIA
4940 SW 319th Lane #H303
FEDERAL WAY, WA 98023
(206) 874-3064

Objective

To contribute to the Achievement of the ministry goals of a Christian humanitarian organization which has global operations by providing leadership to the GrantsTraining and Evaluation division of World Vision, Inc

Background Summary

Nineteen years of successful experience in managing Primary Health Care/Child Survival projects internationally, with a strong record of achieving results in complex political environments

Specific Responsibilities

Principal activities include program design and development, grant management, training, fund raising, and evaluation Current responsibilities include management (planning, coordination, reporting, budgeting, quality maintenance of the work of the division) and strategic (capacity-building, resource acquisition, evaluation, marketing and reporting)

Career History and Accomplishements

GTE Programs and Evaluation Manager, WVRD — Jan 1995-present

Responsible for the procurement of new funds from USAID for microenterprise programs and provides technical assistance to selected staff at WVRD, egional, and national offices to enable them to negotiate, design, implement, and evaluate parternship-supported programs

- Accelerated the development and completion of training docuemnts and materials related to GTE initiatives
- Successfully facilitated a SED design workshop in collaboration with headquarters, regional, and national offices
- Drafted guidelines and workplans for implementation of the assessment of WVRD secondments to the field, customer satisfaction survey, midterm review of the ISG

Primary Health Care/Child Survival Manager — 1993-1994

Responsible for the production of quality proposals, fund raising, grant management, evaluation, field capacity-building and evaluation Annual budget of projects in over 20 countries is estimated at $6million WVRD became the US-based PVO with the most USAID grants

Education Attainment

Master of Public Health, School of Public Health, University of Hawaii in Manoa, Honolulu, HI, USA (1975)
Doctor of Medicine, Far Eastern University, Dr N Reyes Medical Foundation (FEU-DNRMF), Manila, Philippines, (1971)

Completed Training Programs

Lactation Specialty, Mercy Hospital and Medical Center, San Diego, California, USA (1984)
Pediatric Residency, Children's Medical Center, Philippines (1972-1974), Quezon City, MetroManila, Philippines (1976-1977)
Family Planning Specialty, Institute of Maternal and Child Health, Quezon City, MetroManila, Philippines (1972)

Work Experience

Senior Project Officer, World Vision Relief and Development, Inc , 34834 Weyerhauser Way S, Federal Way, WA 98001 1988 to present

Technical Consultant for USAID-funded Child Survival Project, World Vision Haiti, Port-au-Prince, Haiti 1988 (4 months)

MCH/FP Consultant, World Health Organization, Western Pacific Region 1984 (1 month)

Project Specialist and Field Medical Supervisor, Institute of Community and Family Health, Quezon City, Metro Manila, Philippines 1976-1986

Consultant in Primary Health Care and Family Planning, Population Center Foundation, Metro Manila, Philippines 1979-1986

Affiliate Consultant, Department of Family Medicine and Community Health, Fatime College of Medicine, Valenzuela Metro Manila, Philippines 1980-1986

Assistant Professor, Dept of Medical Biochemistry, Institute of Medicine, Far Eastern University-DNRMF, Manila, Philippines 1977-1986

Research and Teaching Fellow, as above 1971-1972

Assistant Professor, Dept of Medical Biochemistry and Dept of Medicine (Clinical Nutrition), Fatima College of Medicine, Valenzuela, Merto Manila, Philippines 1980-1986

Post-graduate Courses Attended/Audited

Crash Courses in Biochemistry (4-5 days/year) College of Medicine, University of the Philippines, Manila, Philippines 1978-1986

Teachers' Training Courses, National Teachers' Training Center, College of Medicine, University of the Philippines 1978-1986

Doctoral level courses in Nutrition (18 units), College of Home Economics, University of the Philippines, Diliman, Quezon city, Philippines 1983-1984

Clinical Nutrition, Institute of Human Nutrition, Columbia College of Physicians and Surgeons, New York, USA 1980 (1 month)

Special Summer Training Program in Social Research, Institute for Social Research, Ann Arbor, MI, USA 1975 (2 months)

Public Health/Scientific Papers Authored/Co-authored

Author "The Physician as a Trainer/Facilitator A Challenge " Presented during the International Consultation on Health sponsored by WVI in Geneva, November 2-9, 1989

"The NBT (Nitro Blue Tetrazolium) Dye Test to Differentiate Bacterial from Nonbacterial Infections Among Filipino Children "

Senior Author "Utilization of Mothers for Some Aspects of Primary Health Care in Philippine Barangays (Villages)" from Primary Maternal and Neonatal Health A Global Concern New York, Plenum Press, 1983, pp 495-501

Co-author "Practical Proposal Writing", presented during the International Consultation on Heath held in Geneva, November 2-9, 1989

"Guidelines for Trainers of Mother Health Workers" by the Institute of community and Family Health (ICFH)

"Private Efforts in the Preparation of 550 Mothers as Community and

Family Health Workers in 41 Philippine Barangays (Villages)" by ICFH

A Training Manual for the Hilot* Aide by ICFH

"The Botika sa Barangay (Village Drugstore) and its Relevance to Primary Health Care in Remote Philippine Communities "

"Traditional Birth Attendants as Hilot MCH/FP Aides in Philippine Rural Communities "

"A Ten-Year Study of Abdominal Tumors Among Filipino Children "

"Presenting Manifestations in Acute Lymphocytic Leukemia as Prognostic Parameters in 56 Filipino Children (ten-year period) "

Fellowships/Awards

- USAID Fellow, Lactation Specialist, San Diego, California, USA 1984
- Diplomat, Philippine Pediatric Society 1983
- FEU Medical Alumni Association Fellow, course/audit observation tour of US medical schools 1980
- UDAID Fellow, Master of Public Health, University of Hawaii, Honolulu, Hawaii 1974
- Most Outstanding Faculty in Biochemistry awarded by the Graduating Class of 1985, FEU-DNRMF, Manila, Philippines 1985
- Most Outstanding Faculty in Basic Science Category awarded by the Institute of Medicine FEU-DNRMF, Manila, Philippines 1980

Memberships in Organizations

- Member, American Public Health Association 1989 to present
- Secretary (1st), Philippine Association of Academic Biochemists (medical schools) 1984
- Chairperson, Committee on Family Life, Philippine Pediatric Society, Manila, Philippines 1985-1986
- Co-chairperson, Committee on School Health, Philippine Pediatric Society, Manila, Philippines 1983-1985
- Member, Board of Judges in Clinical Research, Dr Jose Fabella Memorial Maternity Hospital, Manila, Philippines 1984-1985
- Member, Philippine Pediatric Society, Manila, Philippines 1977-1986
- Member, Maternal and Child Health Association of the Philippines 1976-1986
- Member, Faculty Club(s), Institute of Medicine, FEU-DNRMF and

Fatima College of Medicine, Metro Manila, Philippines 1971-72, 1977-86

Projects Managed

- Manager, NOVIB (Netherlands)-funded project Development of a Simplified Health Care System in 15 Philippine rural villages 1983-1986
- Manager, MEMISA (Netherlands)-funded project Nutritional Enrichment Program in Isolated Philippine Villages 1982-1984
- Manager, APPA (Association of Philippine Practicing Physicians in America)-funded project Training of Primary Health Care Workers in Philippine Villages 1981-1983
- Manager, WHO-funded project Health Service Research for Primary Health Care 1979-1981
- Co-Manager, IDRC (Canada)-funded project Training of Hilot Aide 1977-1979

Also Guest lecturer/trainer for other medical schools, medical societies, and NGOs involved in health and health-related activities

*Traditional Birth Attendants

CURRICULUM VITAE

(I) PERSONAL PARTICULARS

NAME SRI CHANDER S/O TIKAMDAS NEBHRAJ
SEX MALE
NATIONALITY SINGAPORE CITIZEN
MARITAL STATUS MARRIED WITH ONE SON
ADDRESS WORLD VISION INTERNATIONAL SINGAPORE
1 SOPHIA ROAD #04-05 PEACE CENTRE SINGAPORE 228149
TEL (65) 785-7679 FAX (65) 334-5848

(II) CURRENT POSITION IN WORLD VISION INTERNATIONAL

Regional Health Adviser Asia Region

(III) PROFESSIONAL TRAINING

MAJOR	DEGREES/QUALIFICATIONS	YEARS COMPLETED
1 Public Health	Master s in Public Health (MPH) (Johns Hopkins Univeristy)	1year(1982-1983)
2 Medical/Surgical	Bachelor of Medicine/Bachelor of Surgery (MBBS) (University Singapore)	5 years(1968-1973)
3 Epidemiology	Certificate (Dept of Epidemiology Johns Hopkins School of Public Health and Hygiene)	Three weeks(1990)
4 Occupational Health	Certificate (Industrial Health Division/National Productivity Boards Singapore)	Six months/part time (1987)
5 Tuberculosis Control	Certificate (National Asthma Research Center/National Jewish Hospital, Denver Colorado, USA)	One week (1983)
6 Leprosy Control	Certificate (National Hansen s Disease Center, Carville, Louisianna USA)	Two weeks(1983)
7 Leprosy Control	Certificate - Schoeffelein Leprosy Research & Training Institute Karigiri India)	Ten weeks (1982)

(IV) WORK AND EXPERIENCE

(MONTH/YEAR)	TYPES OF WORK
1991 Now	Regional Health Advisor, Asia Pacific Region World Vision International Singapore (Provides technical backstopping to 41 health-development and HIV/AIDS Prevention & Control projects funded by USAID/AUSAID/ODA/CPHA/etc in Asia Pacific)
1990 - 1991	Director of Health, South Asia Region World Vision International (Bangkok Thailand/Singapore)
1987 - 1989	Primary Health Care Advisor Asia & Middle East Region World Vision International (Singapore/ Bangkok Thailand)
1985 - 1986	Primary Care Physician Singapore
1983 - 1984	Medical Officer Refugee Camp, Singapore
1981 - 1982	Rural Primary Health Care/Leprosy Work, India
1978 - 1980	Primary Health Care/Refugee Medical Work in Indonesia South China Sea Singapore Kampuchea and Somalia
1974 - 1978	Medical Officer in various hospitals and medical centres in Singapore

(V) AREAS OF EXPERTISE

1 Conduct of feasibility studies and writing of project proposals for specially-funded integrated health and development projects (both rural and urban) in Asia Regional countries
2 Assistance in baseline surveys and developing detailed implementation plans for specially-funded health and development projects (USAID/AUSAID/ODA/CPHA/etc)
3 Assistance in the conduct of mid-term and final evaluations of specially funded health and development projects and HIV/AIDS prevention projects (USAID/AUSAID/ODA/CPHA/etc)
4 Assistance to World Vision field offices in the development of a specific country strategy for health and development of innovative and holistic models of health projects
5 Assistance in the development of training modules/materials for health workers
6 Conduct of country-wide surveys on health and development of national health profiles
7 Design and conduct of Child Survival/Safe Motherhood training workshops/learning events
8 Review of Health Management Information Systems
9 Assistance to health projects in development of community-based Disease and Death Surveillance Systems (CBDDS)
10 Conduct Quality Assurance exercises involving Child Survival projects

(VI) ADDITIONAL QUALIFICATIONS

Extensive experience throughout Asia/S E Asia in training primary health care workers facilitating and organising workshops for health workers and performing evaluations of Primary Health Care programs and Health Information Systems Also attended conferences and workshops on Participatory Rural Appraisal Quality Assurance STD/AIDS Immunization and other regional/international health/child survival workshops and conferences

Tracy D. Stueve

[redacted]
(202) 608-1855 (W) ([redacted]

Professional Experience

World Vision , Inc

Grant Accountant, Finance/Corporate Services Department 10/95 to present

Responsible for managing the financial reporting for the Asia region and Child Survival Headquarters grants Duties include preparing grant budgets in cooperation with the field offices for submission to donor agencies, submitting monthly drawdown requests for grant expense reimbursement, preparing quarterly financial reports to A I D and other donor agencies and monitoring field expenditures Additional responsibilities include provision of grant accounting and compliance training to Asia regional staff

Project Coordinator, Innovative Programs 10/92 to 9/95

Managed all World Vision workplace giving and payroll deduction programs, coordinated the use of prepackaged "Fly-Away Kits" for emergency disaster response, prepared and monitored departmental operating budgets , coordinated all Monrovia-based volunteer initiatives, and provided backstopping to all domestic disaster response activities

Administrative Coordinator, International Relief 4/90 to 9/92

Assisted in proposal writing and editing, acted as primary liaison to professional medical volunteers for WV Romania program, coordinated all international and domestic travel for program review and evaluation

World Vision Inc

Administrative Support Specialist, Donor Services Division 1/85 to 4/90

Provided direct managerial support, maintained inventory of office supplies and written materials, assisted in annual budget preparation and monitoring and prepared departmental payroll

C Itoh and Co (America) Inc

Credit/Legal Secretary 10/84 to 1/85

Education

Bachelor of Science in Business Administration, University of Phoenix, 1996

Bachelor of Arts in Management, University of Phoenix 1996

University of Wisconsin Disaster Management, Four courses 1985 to 1986

Personal

Organizational and interpersonal skills demonstrated by successful performance of duties as discussed above Team player with solid communication skills and community involvement (e g youth director wedding coordinator and Church council member)

CURRICULUM VITAE

Address ADP Ballia P O Box 25 District Ballia Uttarpradesh-277001
Name Dennis T Cherian **Age** 32 years **Marital status** Single
Profession Public health specialist/project manager

Skills Project designing and planning Qualitative research designing Report writing & Financial management Community Based Programme designing & implementation Knowledge of MS word Excel, Wordstar Wordperfect

Professional Qualification

Masters in Health Administration	*Tata Institute of Social Sciences, Mumbai, 1995-1997*
M S (Counselling Psychotherapy)	*I B M S, Chittor, A P 1995*
Bachelor of homeopathic medicine and surgery (BHMS)	*M G university, Kerala, 1984-1992*

Work experience

1992-1993 Physician at a private clinic managed self at Cochin Kerala

1993-1995 Worked as a medical officer in -charge for CSI Mission Hospital, Warangal Provided clinical care and health education on nutrition and health care for approximately 100 villages

Professional experience

May 1997-September 1998

As project officer for an Action cum research programme " Infant feeding practices " Helped in facilitating the project, designing the project proposal, qualitative research and conducting a socio- behavioral study of feeding practices of children less than 1 year of age Assisted in providing an outline for materials development for health communication, which would cater to a community which is illiterate and semiliterate

Trained on

- Project designing and project proposal writing (World Vision, New Delhi-1997)
- PRA techniques (PRIA New Delhi-1997)
- Use of Qualitative research Technique with focus on "Infant feeding Practices & Nutrition" (AED,1998)
- Review of IMCI training package for basic health workers (WHO,Chandigarh-1998)
- KPC survey designing (Trainer certified by John Hopkins School of public health 1998)
- Use of EPIINFO package in data analysis (1998)
- Reproductive health Integration Initiative & TOT (SEATS USAID Bangladesh,1999)

Trainings conducted

- Trained grass root level staff of 12 NGOs on monitoring and evaluation
- Trained grass level staff on qualitative research techniques
- Designed a package and trained barbers on HIV/AIDS
- As resource person for ICDS Lucknow workshop organised on Dec 8th&9th 1998 presented paper on (a) Socio-cultural aspects and beliefs of feeding children less than 1 year of age and its impact on nutrition (b) Socio-cultural practices and beliefs-A communication barrier in use of ORS and its possible reasons for failure at the community level
- As resource person for Prathinithi Sansthan a local NGO to train community leaders on safe drinking water nutrition and family planning (1999)

Studies conducted and proposals developed

- "Role of CMAI in supporting community health programme of member institutions"
- Developed a proposal for "Infant feeding programme"
- Assisted in developing a project proposal for "Truckers interim HIV/AIDS project"
- Utilization pattern of health services in an urban slum
- Part-time community health workers and their role in implementing TB programme
- Arches Rural Hospital a step towards community participation
- An evaluation of training programmes of Haryana State Health services

CURRICULUM VITAE

Subodh Kumar,
Shanti kunj, Tagore Nagar,
Ballia, Uttar Pradesh
India - PIN 277 001
Tel 05498 23267

Personal Information

Age	28
Nationality	Indian
Status	Married
Profession	Statistician and Front Line Leadership Trainer
Spouse	Mamta Kumar
Children	None

Office Address

Ballia Area Development Program,
Near U P Setu nigam Office,
Post - Tikhampur, District - Ballia
Uttar Pradesh - PIN 277 001
Tel/Fax 0091-5498-23014
email balliaadp@wvi org

Professional Objective

Management oversight of BRICS and Area Development Program Also to facilitate the strategic integration of both teams under the BRICS project to ensure the synergetic impact of child survival/reproductive health interventions

Education and training

- Masters in statistics, Dr B R Ambedkar University Agra. U P (1993-95)
- Short course in community Health Management, Xavier Institute of Management, Bhubeneshwar, Orrisa. (1997-98)
- Certified Zenger Miller Facilitator (1998)
- Short course and workshop on Team Building (XLRI, Gurgaon 1998)
  proposal Writing (New Delhi, 1997)
  Training of Trainers (Konark, 1997)
  CEDC (Madras, 1997), Children in high risk (Bangalore 1997)
- Trained in KPC Survey methodology by trainer certified by John Hopkins University School of Public Health (1998)
- Trained on Grand Funding with USAID standards by WV International finance consultant of Bangladesh
- Trained on AID Funding rules and regulations for US government funds by association of PVO Financial Managers, USA (1999)

Work History

October 1998 Present Team Leader, BRICS Project, World Vision India. Major responsibility includes Over all Facilitation of the BRICS interventions, and ensure the strategic integration of BRICS and Ballia ADP team

July1997-Sept'98 Manager, Ballia Area Development Project World Vision of India. Major responsibilities included set up the ADP, provide leadership for the ADP interventions in Health and development program

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Oct' 96-June'97 Associate program support, Major responsibilities included Supervising Special projects like Child Abuse prevention project, Street children project, etc Assist in training and designing

April' 96- Sept'96 Research Associate, Kanpur Street children Project World Vision of India. Major responsibilities was to conduct a research study among the children of Kanpur and plan project interventions

Oct' 95-March'96 Assistant Pastor and Principal, City Church/ School, Church of North India.

Languages Fluent in oral and written English and Hindi
Survival level Punjabi, Bhojpuri, and Sanskrit

Other Board Member Shalom Children's Home Dehradoon
Member All India pulse Polio Immunization Task Force
Member Rotract Club Ballia (present)
President Rotract Interact Club Roorkee (1987-90)
Participated in Mid Term Evaluation of USAID funded Kean Svay Child Survival Project in Cambodia.

Publications - Research paper on Probability Model on couple Fertility (Sankhya 1995)
- " The Dead End Kids" published by World Vision of India.

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BIO-DATA

Name SHANTANU DUTTA
Father's Name [redacted]
Date of place of birth [redacted]
Nationality & Religion INDIAN, CHRISTIAN

EDUCATIONAL QUALIFICATIONS

1 MBBS from Armed Forces Medical College, Pune (1984)
2 Post Graduate Diploma in Community Health Management from Christian Medical College, Vellore (1992)

COURSES IN HEALTH/DEVELOPMENT

1 Drug Abuse and Alcoholism (National Institute of Social Defence, New Delhi [1990])
2 Project Formulation (National Institute of Public Co-operation and Child Development, New Delhi [1993])
3 NGOs and Rural India (Indian Social Institute, New Delhi [1993])
4 Gender and Development (Madras [1994])
5 Relief and Disaster management Workshop (Dhaka/Bangladesh [1994])
6 Transition from Relief to Sustainable Development (Colombo/Sri Lanka [1995])
7 South East Asia Regional Health Workshop (Phnom Penh/Cambodia [1995])
8 Course on Managerial effectiveness from Tata Management Training Centre, Pune [1996]
9 Transformational Leadership Course (Zenger Miller Modules [1996-97])
10 KPC survey training conducted by trainer certified by John Hopkins University School of Public Health (1998)

EMPLOYMENT AND EXPERIENCE:

January 1999 Till Date Operations Manager in an International NGO

Responsibilities Include Providing Managerial And Technical Supervision To A Cluster Of Projects In U P And Meeting Donor Accountability Standards The Projects Receive Multiple Funding From Private And Government Sources Also Required Conducting Regular Monitoring And Evaluation And Mobilizing Additional Resources As Necessary By Liaison And Dialog With Various Donor Agencies

October 1995 to December 1998. Manager for Programme Support in an International NGO

Responsibilities included

1) Assessing training and staff development needs facilitating in house or external training
2) Monitoring and evaluating projects implemented by the organisation
3) Providing technical backstopping to CEDC and Health/ nutrition projects (currently totalling 8 projects)
4) Identifying and responding to emerging trends and writing project proposals / designs
5) Documentation
6) Carrying out operational research on relevant subjects
7) Negotiating and operationalizing projects with assistance from USAID,DFID,CIDA, AUSSAID and other international and Indian donors

PROFILE OF PROECTS SUPERVISED

a) children of sex workers
b) CBR project for physically disabled
c) Sexual exploitation of tribal girl children
d) street children project
e) child labour (supported by AUSSAID)
f) refugee children of war (supported by AUSSAID)
g) infant nutrition (supported by USAID)
h) Child survival(supported by USAID)

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PROJECT UNDER NEGOTIATION

a) Law as a tool for development.
b) HIV/ AIDS project with truck drivers
c) CBR initiative for the mentally handicapped
d) Street children initiatives in two more centres due to start by Dec 98

September 1993-'95 Manager for North India for an International Relief and Development Agency Major responsibilities include overseeing the execution of more than 50 child care Health and Development Projects in 8 North Indian States, identifying and selecting new projects, liaison with national and international agencies

August 1992-'93 Field Program Director for NIRPHAD, an integrated Rural Development Project in Mathura District of UP Project has interventions in areas of Health, Family Welfare Agriculture, Animal Husbandry Women's' Development, Income Generation, Los Cost Housing, Social Forestry, Community Eye Programme and other with funding from National and International Agencies

1990-1991 Employed with Emmanuel Ministries, Calcutta, and a registered Trust. Along with my wife pioneered the "Tapuriaghata Community Development Project" an integrated Social and Health upliftment project in the suburbs of Calcutta Also involved in the treatment, counselling and rehabilitation of Drug addicts and alcoholics during this time

1984-1989 Medical Officer in the Indian Air Force in the rank of Flight Lieutenant. Duties involved General practice attending emergencies promotion of high health standard at Air Force bases implementation of all National Health programmes and a wide range of administrative duties

MEMBERSHIP OF PROFESSIONAL SOCIETIES

1 Indian Public Health Association
2 Indian Society of Health Administrators
3 Christian Medical Association of India

LANGUAGES KNOWN

Read, Write and speak English, Bengali and Hindi

Computer literacy: Windows 95, MS Office

Others:

1 Part of the Evaluation Team for Canadian Public Health Association funded Child Survival Project in Kandal Stung (Cambodia) – 1997
2 Presented paper at First India Public Health Congress organised by Indian Public Health Association at Calcutta – 1997
3 Member of a Regional Relief Action Team for the Asia Pacific Region for rapid response to major disasters—since 1995
4 Participated in Asia Regional Workshop on Micro Nutrients organised by Helen Keller International—Manila 1997
5 Attended 4th International Conference on AIDS in Asia/Pacific—Manila 1997
6 Attended the 51st Regional committee meeting of the World Health Organisation (SEARO), New Delhi, and September 1998 as an NGO observer

ADDRESS FOR CORRESPONDENCE

World Vision-India
B-III, Bali Bhavan, 2nd floor
Lajpat Nagar- II
New Delhi - 110024
Tel 011-6831168
Fax 011-683117

CURRICULUM VITAE

NAME **Mamta Kumar**

ADDRESS

DATE OF BIRTH

HUSBAND'S NAME Subodh Kumar

ACADEMIC QUALIFICATIONS

B A Jesus & Mary College Chanakyapuri New Delhi Delhi University 1993
XII , Kendriya Vidyalaya, Andrews Ganj, N Delhi , C B S E 1990
X Kendriya Vidyalaya Andrews Ganj N Delhi C B S E - 1988

TECHNICAL QUALIFICATIONS

Diploma Course in Executive Secretarial Practice - Y W C A of Delhi with the following subjects - Shorthand Typewriting English for Business Communication Steno-Typing, Gerundi, Computer Applications, Secretarial Practice

WORK EXPERIENCE

May 1996 - October 1998 worked as Administrative Assistant with ITC Limited, Janpath, New Delhi

July 1995 - March 1996 worked as a secretary at the Business Centre of the Taj Mahal Hotel Mansingh Road New Delhi

On the Job training at Perfect Relations Jangpura, New Delhi

LANGUAGES PROFICIENCY Very fluent in English, Hindi

HOBBIES Reading, Writing, Travelling

EXTRA CURRICULAR ACTIVITIES Actively participated in Declamation and debates at school level, Active Member of United Nations, Educational, Social, Cultural Organisation (U N E S C O)at school NCC Cadet at College Level

Mamta Kumar

MAMTA KUMAR

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CURRICULUM VITAE

Name	**Hannah Masih**
Husband's Name	Akbar masih
Date and place of Birth	[redacted]
Nationality and religion	Indian, Christian
• ***Educational qualifications***	(B A) Graduate in Economics, English and Sociology from HNB university Dehradoon 1997 Masters in Sociology from Annamalai University Delhi(Continuing) Previous year. Diploma course in Family Life Education from Marie Stopes, Delhi (Parivar Seva Sanstha) Continuing
• ***Technical Skills***	Computer literacy Windows 95 MS Office One Month Crash in typing KPC survey training conducted by the trainer certified by John Hopkins University School of Public Health
• ***Work Experience***	Worked as Lady community Organizer in ADP DISHA, Rajasthan for 8months 1997 (a project of World vision) Worked in ADP Ballia (a project of World vision) in Ballia for 6 months as a Lady community Organizer 1998 Presently executing my job with BRICS (Ballia Rural Integrated Child Survival Project, a project of World Vision) as an Administrative Assistant
• ***Language Skills***	Can read, write speak English, Hindi,

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CURRICULAM VITAE

BENJAMIN N JESURUN
S/o N Israel
BRICS
A D P Ballia - Project of World Vision India
BALLIA U P

PROFESSIONAL TRAINING	Diploma in Public Health And Hygiene
EDUCATIONAL QUALIFICATION	Intermediate (Board of Intermediate Education, Hyderabad)
WORK EXPERIENCE	Worked with FIRST BAPTIST MISSION as Coordinator
	Worked as Community Development Organiser in A D P Pauri Garhwal (A project of WV India)
	Prepared a House Hold Survey Format which is feasible for all kinds of data collection
PRESANT OCCUPATION	Working as Training Assistant in BRICS

(Benjamin N Jesurun)

CURRICULUM VITAE

FRANK FRANCIS
C/o Dr J P N Singh
Tagore Nagar, District - Ballia
Uttar Pradesh - PIN 277 001

Personal Information

Age 24 years Nationality Indian Marital Status . Single

Educational Qualification

(1) B Com from Lucknow University (1995)

(2) PGD in Rural Development from IGNOU (research on Child survival & safe motherhood with special reference to Beruarbari block, District Ballia, Uttar Pradesh) (1998)

(3) Masters in Sociology from Annamalai University (Previous year continuing)

Technical Qualification

(1) FA (Financial Accounting) & DTP (Desk Top) in computer basics from IICE, New Delhi (1995)

(2) Through with MS-Office & Internet environment

(3) Knowledge of Sun System & Manual Accounting according to WV standards

(4) Trained in grand funding with USAID standards by WV international finance consultant of Bangladesh (1998)

(5) Trained on KPC survey methodology by trainer certified by John Hopkins University School of Public Health (1998)

(6) Trained on AID Funding rules and regulations for US government funds by Association of PVO Financial Managers, USA (1999)

Work Experience

1 Worked as a Computer Instructor in IICE (Indian Institute of Computer Education) New Delhi for one year (1996)

2 Worked with ADP Bharpur, Kullu (Project of World Vision for 2 years as an countant cum EDP (1997-98)

3 Presently executing my job with BRICS (Ballia Rural Integrated Child Survival Project, a Project of World Vision) as a Finance/Administration Coordinator

BALLIA RURAL INTEGRATED CHILD SURVIVAL PROJECT (BRICS)
JOB DESCRIPTION

JOB TITLE: **CSP Project Manager**

REPORTS TO: **Operations Manager**

JOB PURPOSE: *To lead the project team in the day to day implementation of the BRICS activities in achieving its goals and objectives, control the service delivery and also coordinate the work of Technical Officer and Training Officer*

DUTIES AND THE RESPONSIBILITIES:

- Keep abreast of the latest developments in public health through systematic reading and research
- Facilitate project interventions and provide overall direction to the BRICS team in pursuit of program objectives
- Plan and lead day-to-day implementation and operations of the project
- Maintain good working relationships with other NGOs, and coordinate and collaborate with District Health Official to build capacity for quality services
- Submit monthly and quarterly reports to the Operations Manager in accordance with the reporting requirements of USAID (in consultation of CSP Team Leader)
- Supervise the work of the Technical Officer and Training Officer
- Ensures the formation of the local advisory board in Ballia ADP through networking activities
- Discuss, plan and implement sustainability strategies with the community and other partners in Ballia District
- Finalize the project plans in consultation with CSP Team Leader for each quarter
- Develop specific plans of action for the second, third and fourth year of the project in light of the findings of periodic surveys, assessments and evaluation reports
- Perform any other duties as assigned by the Project Team Leader

QUALIFICATIONS

- Must be a graduate from a recognized medical college or have a Masters of Public/Community Health/Health Administration degree, with a considerable amount of experience in community health programs (RCH/CS is preferable)
- Experience in management of community health programs
- Fluency in both written and spoken English

BALLIA RURAL INTEGRATED CHILD SURVIVAL PROJECT (BRICS)
JOB DISCRIPTION

JOB TITLE: **CSP Team Leader/ADP Manager**

REPORTS TO: **Operations Manager**

JOB PURPOSE *Responsible for the management oversight of the both BRICS and the Ballia ADP Team. Principal task will be to facilitate the strategic integration of both teams under the BRICS project to ensure the synergistic impact of Child Survival/Reproductive Health interventions*

DUTIES AND THE RESPONSIBILITIES

- Manages the overall programs, financial operations and interventions of the BRICS project and the Ballia Area Development Program
- Coordinates and collaborates with top level officials of the Health Department in Ballia, UP State and the international organizations in the implementation of the BRICS project
- Work with Zonal Health Coordinator by seeking his guidance in managing program interventions, and ensuring program objectives are met and implemented with quality
- Ensure that National MOH guidelines are followed in implementation of the interventions of the CS/RH program
- Ensure that project satisfies the high technical standards of both USAID and WVUS and honors its basic thrust
- Initiate strategic alliances with the key partners/potential donors
- Lead the BRICS Core Team and identify, provide and institutionalize capacity-building programs for all the personnel in the BRICS team
- Call the monthly staff meeting of the BRICS and the ADP Team
- Submit the monthly and the quarterly reports to ADNZ, for forwarding to USAID/WVUS/WVAPRO office, in accordance with the reporting requirements of USAID
- Maintain good working relationships with representatives of USAID, and ensure that changes in the budget and the implementation plan are communicated to and approved by USAID through WVUS
- Carry out annual performance appraisals of staff under BRICS project and the Ballia ADP
- Perform other duties as assigned

QUALIFICATIONS

- Must be trained in public health or statistics, with sufficient field experience in community health

- Ability to work in a team
- At least two years of proven managerial experience in managing health projects
- Demonstrated management experience in the area of training
- Excellent communication skills both in verbal and written English and Hindi
- Strong interpersonal and leadership skills
- Strong analytical skills

BALLIA RURAL INTEGRATED CHILD SURVIVAL PROJECT (BRICS)
JOB DESCRIPTION

JOB TITLE· **Training coordinator**

REPORTS TO **Project Manager**

JOB PURPOSE: *Responsible for organizing all the training for the BRICS team, government health sector, private sector and at the grass-roots level*

DUTIES AND THE RESPONSIBILITIES

- Be responsible for carrying out training needs assessment, and developing innovative, competency-based training curricula/materials relevant to project activities
- Liasie with UNICEF, USAID,VHAI, WHO, MOHFW and other agencies to collect, develop and utilize different training materials
- Develop yearly training calendar, quarterly newsletter, notebooks, and health messages for various target groups
- Prepare reports of annual/quarterly meetings of TBAs, VDWs, various trainings, special seminars and workshops
- Maintain copies of all relevant training materials and other project documents such as video, slides etc and make them available when required
- Help develop, organize and coordinate training needs assessments, curriculum development and schedules
- Conduct training sessions from time to time for project staff and grassroots participants
- Liaise with mass media in consultation with Project Manager/CSP Team Leader
- Perform other duties as assigned by the Project Manager/CSP Team leader

QUALIFICATIONS:

- TOT skills and facilitation skills
- Masters degree in Social Science or Communications
- Fluency in both written and spoken English
- Preferably two-three years experience working with any PVO in the field of training
- Ability to communicate ideas

BALLIA RURAL INTEGRATED CHILD SURVIVAL PROJECT (BRICS)
JOB DESCRIPTION

JOB TITLE: **Training Assistant**

REPORTS TO: **Training Coordinator**

JOB PURPOSE: *Assist training Coordinator in organizing all training for the BRICS team, government health sector, private sector and at the grassroots level*

DUTIES AND THE RESPONSIBILITIES:

- Assist Training Coordinator in training needs assessment and in developing innovative competency-based training curricula/materials relevant to project activities
- Assist Training Coordinator to liaise with UNICEF, USAID, VHAI, WHO, MOHFW and other agencies to collect, develop and utilize training materials
- Assist Training Coordinator to develop the yearly training calendar, provide diaries for field staff, prepare quarterly newsletter, notebooks and health message folders for the different beneficiary groups
- Assist Training Coordinator to prepare/publish reports on annual/quarterly meetings of TBAs, VDWs, various training sessions, special seminars, and workshops
- Assist Training Coordinator in maintaining a stock of all relevant training materials and other project documents such as photographs, video, slides etc and make them available when required
- Maintain the project resource center
- Assist Training Coordinator to develop, organize, and coordinate training needs assessments, curriculum development and schedules
- Assist Training Coordinator to conduct training sessions from time to time for project staff and grassroots participants
- Perform other duties as assigned by the Project Manager

QUALIFICATIONS:

- TOT skills and facilitation skills
- Masters degree in any subject
- Fluency in both written and spoken English
- Preferably two to three years experience working with any PVO in the field of training
- Ability to communicate ideas

BALLIA RURAL INTEGRATED CHILD SURVIVAL PROJECT (BRICS)
JOB DESCRIPTION

JOB TITLE. **Finance/Administrative Coordinator**

REPORTS TO **CSP Team Leader**

JOB PURPOSE: *Responsible for the financial management of the BRICS project and ensuring that project reporting standards and deadlines are met according to USAID regulations*

DUTIES AND THE RESPONSIBILITIES:

- Collect and maintain all necessary financial information
- Liaise with government departments or general administration (post office, electricity etc)
- In charge of EDP and related work ???
- Ensure compliance with financial requirements of World Vision India, WVUS and USAID Establish financial system to include fund requests, bank transfers, disbursements, record keeping, reporting and forecasting of financial needs
- Ensure that funds utilization follows the agreed budget plan as reflected in the Detailed Implementation Plan
- Prepare monthly, quarterly and annual financial reports, pipeline analyses and other reports required by World Vision India, WVUS and USAID
- Provide feedback and technical support in the area of financial planning analysis to the Project Manager and CSP Team Leader
- Perform other functions as requested by the CSP Team Leader
- Help in daily administration, i e maintenance of log book

QUALIFICATIONS:

- Must be a commerce graduate with sufficient experience in WV accounting system
- Two to three years of experience in managing accounts of a development project of any PVO
- Preferred experience in grant accounting
- Good interpersonal, analytical and integrative skills
- Good communication skills
- Can work under pressure with minimum supervision

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BALLIA RURAL INTEGRATED CHILD SURVIVAL PROJECT (BRICS)
JOB DESCRIPTION

JOB TITLE: **Technical Officer**

REPORTS TO: **CSP Project Manager**

JOB PURPOSE: *Responsible for ensuring that MOD & HFW protocols and standards are attained, and best practices are follwed Assuring the quality, coverage and impact of the CS/RH activities*

DUTIES AND THE RESPONSIBILITIES

- Facilitate the work of four Public Health Nurses
- Work with the counterpart PHC Medical Officer in assuring the quality, coverage and impact of the CS/RH activities
- Ensure that the proper registers are maintained by the PHNs for coverage of CS/RH interventions, and immunization and maternal cards are safely kept by mothers
- Facilitate the identification, registration and tracking of all the pregnant women and pregnancy outcomes
- Facilitate the education of pregnant women and adolescent girls in proper antenatal and postnatal care
- Train mothers and members of the Mahila mandal in the identification of symptoms of ARI and CDD
- Develop training programs for TBAs along with the Training Officer
- Provide counseling to mothers on Family Planning/birth spacing and the management of STDs
- Launch large-scale program on Family Planning/Birth Spacing
- Work with the CSP Manager in implementing other CS/RH interventions and ensuring the quality of the program
- Perform other duties as assigned by the Project Manager

QUALIFICATIONS:

- A medical doctor with MBBS degree from a recognized medical college
- Ability to work under pressure with minimum supervision
- Good interpersonal communication skills
- Experience of working in community health

BALLIA RURAL INTEGRATED CHILD SURVIVAL PROJECT (BRICS)
JOB DESCRIPTION

JOB TITLE. **Monitoring and Evaluation Officer**

REPORTS TO: **Project Manager**

JOB PURPOSE. *Responsible for establishing the Health information System, establishing and maintaining an effective monitoring and evaluation system, initiating CBDDS including AFP surveillance Launch CQI initiative to monitor and improve program quality*

DUTIES AND THE RESPONSIBILITIES

- Establish and maintain a systematic and decentralized recording and reporting system that will provide consistent, accurate and timely information to the BRICS Project Manager/CSP Team Leader at all levels
- Coordinate the collection and data analysis related to rogram goals and objectives
- Ensure periodic assessment to measure performance in accordance with program goals and indicators
- With the Project Manager, build strategic alliances with the District CMO office in establishing the HIS system to track progress towards the project objectives
- Evaluate training related to HMIS and share recommendations for improvement of training
- Train CDOs and Community Volunteers in establishing CBDDS with
    1. School children
    2. School teacher
    3. Members of the Mahila Mandal
    4. Members of the youth club
- Ensure that accurate and relevant data are gathered, aggregated, entered into the computer (backup copies stored securely), and analyzed, and provide feedback to the appropriate staff
- Develop, field-test and refine formal instruments needed for tracking progress of project
- Ensure accuracy of qualitative and quantitative data (through PLA, Focus Group Discussions, KII, health care facility assessment and KPC surveys) and properly document the same
- Work closely with the core team and provide support in the area of field assessments and surveys
- Ensure that all deaths and births in the community are registered with the District Registrar's office

- Ensure along with PHNs that identification of pregnent women, immunization, vitamin A supplementation, TT2 and iron folate distribution are properly documented through cards and registers
- Perform other duties as assigned by Project Manager

QUALIFICATIONS:

- Bachelor/Masters degree in Statistics/Bio-statistics
- Good working knowledge of the following software MSWord, WordPerfect, MSExcel, Power Point, EPI-Info, and Harvard Graphics
- Fluency in verbal and written English and Hindi
- Considerable experience in the filed of HMIS
- Strong analytical skills and interest in research

BALLIA RURAL INTEGRATED CHILD SURVIVAL PROJECT (BRICS)
JOB DESCRIPTION

JOB TITLE: **Monitoring and Evaluation Assistant**

REPORTS TO: **Monitoring and Evaluation Officer**

JOB PURPOSE: *Assist the Monitoring and Evaluation Officer to establish the Health Information System, to establish and maintain an effective monitoring and evaluation system, and initiate CBDDS including AFP surveillance Launch CQI initiative to monitor and improve program quality*

DUTIES AND THE RESPONSIBILITIES:

- Assist M&E Officer in establishing and maintaining a systematic and decentralized recording and reporting system that will provide consistent, accurate and timely information to the BRICS Team Leader
- Assist M&E Officer to perform periodic assessments of performance in achieving program goals and indicators
- Assist M&E Officer in coordinating the collection and analysis of data related to program goals and objectives
- Assist M&E Officer to build strategic alliances with the District CMO office in establishing the HIS system to track progress towards objectives
- Assist M&E Officer to evaluate training related to HMIS and make recommendations for improvement of training
- Train CDOs and Community Volunteers in establishing CBDDS with
  1. School children
  2. School teachers
  3. Members of the Mahila Mandal
  4. Members of the youth club
- Assist M&E Officer to ensure that accurate and relevant data are gathered, entered into the computer (with back-up copies stored securely), analyzed and fed back to the appropriate staff
- Assist M&E Officer to develop, field test and refine the forms/instruments needed for tracking the progress of the program
- To be responsible for accuracy of qualitative and quantitative data gathered through PLA, FGD, KII, health care facility assessment and KPC surveys, and properly document the same
- Assist M&E Officer in working closely with the core team and provide support in the area of field assessment, surveys, monitoring and evaluation of progress toward project objectives

- To ensure along with the PHNs/ANMs that identification of pregnant women, immunization, vitamin A supplementation, TT2 and iron folic distribution are properly documented through cards and registers
- To be available for any other duties assigned by the CSP Team Leader

QUALIFICATIONS:

- Graduate in Statistics/ Bio-Statistics/ Social Work/ Public Health
- Good working knowledge of the following software MSWord/Word Perfect, Excel, Power Point, EPI-Info, and Harvard Graphics
- Fluency in verbal and written English and Hindi
- Considerable experience in the field of HMIS
- Strong analytical skills and interest in research work

BALIA RURAL INTEGRATED CHILD SURVIVAL PROJECT (BRICS)
JOB DESCRIPTION

JOB TITLE: **Public Health Nurse/ANM**

REPORTS TO: **Technical Officer**

JOB PURPOSE: *To provide operational as well as mechanical services in order to achieve project goals and maintain proper records and reporting system.*

DUTIES AND THE RESPONSIBILITIES:

- Work with relevant project staff and community partners to accomplish project objectives for assigned working area
- Facilitate the work of LCOs under her care and also build up their technical skills on project interventions
- Assist in facilitating high quality care management among partner health care providers
- Assist in pre-service and on-the-job training of community development volunteers
- Be responsible for all technical logistical arrangements and inventory records needed to accomplish project activities
- Assist in developing supervisory mechanisms, tools and schedules
- Assist in all surveys and evaluations
- Assist in preparing and maintaining regular technical reporting system in relation to assignments
- Work with the government ANM in EPI coverage and to maintain proper records
- Work with the PHC ANM in promoting family planning measures, and maintain the proper records
- Assist in EPI disease identification, help in conducting missed opportunity surveys and verbal autopsies both of children and women on receipt of information from VDW/TBAs or LCO
- Perform other tasks as assigned by Technical Officer/CSP Manager

QUALIFICATIONS

- Nursing certificate in Public/Community health from a reputable nursing school
- At least 2-3 years working experience in community health

BALLIA RURAL INTEGRATED CHILD SURVIVAL PROJECT (BRICS)
JOB DESCRIPTION

JOB TITLE: **Development Coordinator**

REPORTS TO: **CSP Team Leader**

JOB PURPOSE *To organize and mobilize different partners of the project, including Public Sector agencies and NGOs initiating microenterprise development programs, and developing the leadership and management skills necessary to achieve project sustainability and have a positive impact on health.*

DUTIES AND RESPONSIBILITIES

- To ensure that targeted number of VDWs are recruited and trained to promote the project's child survival interventions, and to strengthen the existing people's organizations
- To ensure sustainable, preventive CS services by creating a demand among the community for PHC services, and preparing them to take over of the project activities during the project life or after the project function cases
- To assist the community in their efforts to develop micro enterprises initiatives (MED) by means of access to technical assistance in market research, production management and marketing , so as to sustain the economic condition of the community
- To help in integrating the Area development program and the BRICS
- To address the community demand on environmental hygiene and sanitation by working closely with concerned agencies
- To organize and support the potential community resources for the establishment of sustainable health infrastructure that may lead to the continuation of health care services delivery after the project phases over
- To build capacity of partner organizations, including people's organizations
- To be responsible for any other duties assigned by CSP Team Leader

QUALIFICATIONS:

- Masters degree in social work
- Fluency in Both written and spoken English
- Fluency in Bhojpuri preferable
- 4-5 years of working experience with the grassroots preferable
- Has an interest in business management and small scale development program

BALLIA RURAL INTEGRATED CHILD SURVIVAL PROJECT (BRICS)
JOB DESCRIPTION

Job Title: **Community Development Organizer**

Reports To: **ADP Manager/CSP Team Leader**

Job Purpose: *To assist in ensuring good rapport with target communities and to facilitate the community in becoming self-reliant by involving them in the planning, implementation, and evaluation of ADP-Ballia*

JOB RESPONSIBILITIES

- To visit target communities regularly to build and maintain good relationships
- To obtain and submit all necessary information from the target cluster as needed
- To work consistently towards organizing core groups, such as committees, women's associations, and youth clubs and to assist them in developing effective leadership
- Assist core groups to register with the registrar of societies
- Asssit community leadership to identify real needs through PRA/PEP, and encourage high level of participation and ownership among them
- Assist as a member of the recruitment team for animators, *basti sevikas*, and volunteers within and outside the community
- Maintain high standard of stewardship and accountability
- Inculcate team spirit through demonstrating active team membership
- Establish and nurture healthy inter-personal relationships among staff members, local churches, and among community members by example
- Facilitate monthly meetings with the core group and ensure minutes are kept properly
- Provide the community with information about various government and NGO schemes for their community's development
- Assist in monitoring the teachers, animators, *basti sevikas*, and instructors, and facilitate periodic follow-up meetings for teachers/parents etc
- Organize awareness-building programs/training in the community through internal and external resources
- Assist Sponsor Relation Services staff at the time of APR, CHS, Christmas Card preparation, Head Counting etc
- Periodically ensure the presence of sponsored children in their target communities
- Maintenance of distribution register, field staff (grass-roots level) attendance register, daily house visit registers and sponsored children visit register, write in diaries regularly, and prepare their monthly plan of action in consultation with Program Coordinator and other staff
- Accompany visitors to the project

- Write monthly reports including highlights, accomplishments, constraints, and success stories from their respective target clusters and submit in a timely fashion
- Work toward fulfilling ADP objectives in the planned time-frame
- Be available for ADP-related work as and when needed

Annex 16

ANNEX SUSTAINABILITY ACTION PLAN

OVERALL SUSTAINABILITY GOAL *To improve the sustainability of the benefits of the child survival and reproductive services in Beruar Beri Block and Ballia district.*

Sustainability Strategy	Sustainability Objective/Target	Sustainability Activities	Time Frame	Sustainability Indicator
1) *Transfer program responsibility steadily to indigenous players by facilitating consensus on sustainability goal and objectives,*	*1) Block-level Sustainability Action Plan developed,* *2) Village Resource Development Plans (VDRPs) developed for all 83 target villages in Beruar Beri Block*	*1) Block-level Sustainability Action Plan workshop facilitated with all public sector, private sector and community partners to jointly define roles and contributions of partners and to develop sustainability objectives, benchmarks & indicators,* *2) PLA exercises facilitated to develop Village Resource Development Plans (VDRPs) with panchayat and community members,* *3) Semi-annual meetings of multi-sectoral Project Advisory Committee (PAC)* (consisting of representatives of USAID/WV/CMO/ NGOs/ GONGO/community/private sector) established to advise project on sustainability initiatives	*1) January 1999* *2) # of VDRPS developed FY 1999 15 VDRPs, FY 2000 20 VDRPs' FY 2001 20 VDRPs, FY 2002 17 VDRPs* *3) Semi-annually*	*1) Development of a Block- level Sustainability Action Plan with all public sector, private sector and community partners to jointly define roles and contributions of partners and to develop sustainability objectives, benchmarks & indicators.* *2) # of VDRPs developed per year,* *1) # of Semi-annual meetings of multi-sectoral Project Advisory Committees conducted,*
2) Build public health sector capacity by equipping and training staff of the Ballia District CMO and PHC/SC staff in Beruar Beri Block and 16 other blocks in Ballia district in key technical/management skills,	2a One Ballia District Health Management Team established, equipped and functioning;	2a 1) 1 Team building exercise facilitated for CMO staff, 2) 1 District-level HMIS review	2a —On going over 4 years, (Please see section F 1)	2a 1) Presence of functioning and equipped Health Management Team, 2) District-level HMIS

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		facilitated, 3) 12 CMO staff trained in ♦ PLA exercises, ♦ CBDDS, ♦ CS/RH management skills, ♦ QA/CQI tools/techniques, ♦ high quality case management of pneumonia and diarrhea, ♦ Missed Opportunity Surveys, ♦ TOT skills, ♦ Health facility assessment, ♦ COPE exercises		review report, 3) # of staff trained in ♦ PLA exercises, ♦ CBDDS, ♦ CS/RH management skills, ♦ QA/CQI tools/techniques, ♦ high quality case management of pneumonia and diarrhea, ♦ Missed Opportunity Surveys, ♦ TOT skills , ♦ Health facility assessment, ♦ COPE exercises
	2b One Health Management Team in Beruar Beri Block for 3 PHCs established, equipped and functioning,	4) 6 CMO staff sent on cross visits, 2b 1) 1 Team building exercise facilitated for staff of 3 PHCs, 2) 9 PHC staff trained in ♦ PLA exercises, ♦ KPC survey tools/tecniques, ♦ CBDDS ♦ QA/CQI tools/techniques, ♦ high quality case management of pneumonia and diarrhea, ♦ Missed Opportunity Surveys,	2b —On-going over 4 years, (Please see section F 1).	4) # of CMO staff sent on cross visits, 1) # of Team building exercises facilitated for staff of 3 PHCs, 2) # of PHC staff trained in ♦ PLA exercises, ♦ KPC survey tools/tecniques, ♦ CBDDS, ♦ QA/CQI tools/techniques, ♦ high quality case management of pneumonia and diarrhea, ♦ Missed Opportunity

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	2 c Capacity of Subcenter staff (ANMs) enhanced	♦ cold chain survey ♦ TOT skills , ♦ emergency obstetric care 3) 9 PHC staff sent on cross visits, 2 c 15 ANMs trained in ♦ PLA exercises, ♦ KPC survey tools/tecniques, ♦ CBDDS, ♦ QA/CQI tools/techniques, ♦ high quality case management of pneumonia and diarrhea, ♦ Missed Opportunity Surveys, ♦ cold chain survey ♦ TOT skills , ♦ emergency obstetric care, ♦ essential newborn care; ♦ interpersonal communications skills, ♦ supervisory skills, ♦ vitamin A supplementation of the sick child,	2 c —On-going over 4 years, (Please see section F 1),	Surveys, ♦ cold chain survey ♦ TOT skills , ♦ emergency obstetric care 3) # of PHC staff sent on cross visits, 2 c # of ANMs trained in ♦ PLA exercises, ♦ KPC survey tools/tecniques, ♦ CBDDS, ♦ QA/CQI tools/techniques, ♦ high quality case management of pneumonia and diarrhea, ♦ Missed Opportunity Surveys, ♦ cold chain survey ♦ TOT skills , ♦ emergency obstetric care, ♦ essential newborn care, ♦ interpersonal communications skills, ♦ supervisory skills, ♦ vitamin A supplementation of the sick child,
	2 d Capacity of PHC staff in the indirect impact area (the other 16 blocks of Ballia district) enhanced,	*2 d 79 PHC staff in indirect impact area (the other 16 blocks of Ballia district) will participate in "Lessons Learned/ Best Practices" work-shops in*	2 d —On-going over 4 years, (Please see section F 1),	*2 d # of PHC staff in indirect impact area (the other blocks of Ballia district) who participated in "Lessons Learned/ Best Practices" work-*

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		♦ PLA exercises, ♦ KPC survey tools/tecniques, ♦ CBDDS, ♦ QA/CQI tools/techniques, ♦ high quality case management of pneumonia and diarrhea, ♦ Missed Opportunity Surveys, ♦ Reproductive Health		*shops in* ♦ PLA exercises, ♦ KPC survey tools/tecniques, ♦ CBDDS, ♦ QA/CQI tools/techniques, ♦ high quality case management of pneumonia and diarrhea, ♦ Missed Opportunity Surveys, ♦ Reproductive Health,
3) Mobilize and strengthen entrepreneurship of key private sector actors in providing alternative CS services;	3a Organizational development(OD) and capacity of 3 local NGOs facilitated and enhanced,	3a **Local NGOs,** 1) 3 OD exercises facilitated one each for the 3 local NGOs, 2) 24 local NGO staff trained in ♦ program management and technical oversight ♦ financial, management, accounting/costing skills,	3a On going over 4 years, (Please see section F 2),	3a **Local NGOs** 1) # of ***assessment & monitoring tools for institutional capacity building of the three partner NGOs*** • Criteria/measurable indicators for management, financial & service capacity • Capacity assessment checklists for management, financial & service capacity, 2) # of local NGO staff trained in ♦ program management and technical oversight ♦ financial, management, accounting/costing skills, ♦ networking, fund- [illegible]

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		♦ networking, fund-raising, proposal writing skills, - as community development workers, ♦ Missed Opportunity Surveys ♦ PLA exercises, ♦ KPC survey tools/techniques, ♦ supervisory, monitoring and evaluation skills, ♦ interpersonal communications skills, ♦ TOT skills, ♦ CBDDS, ♦ QA/CQI tools/techniques, ♦ high quality case management of pneumonia and diarrhea, ♦ referral manage-ment skills, ♦ conduct of social autopsies,		writing skills, - as community development workers, ♦ Missed Opportunity Surveys ♦ PLA exercises, ♦ KPC survey tools/techniques, ♦ supervisory, monitoring and evaluation skills, ♦ interpersonal communications skills, ♦ TOT skills, ♦ CBDDS, ♦ QA/CQI tools/techniques, ♦ high quality case management of pneumonia and diarrhea, ♦ referral manage-ment skills, ♦ conduct of social autopsies,
	3b Capacity of TBAs enhanced,	3b 173 TBAs trained in ♦ clean deliver techniques, ♦ essential newborn care, ♦ iron-folate distribution to pregnant women, ♦ timely referrals of obstetric emergencies, ♦ vitamin A distribution to post-partum women, ♦ CBDDS, ♦ QA/CQI tools/techniques,	3b On-going over 4 years (Please see section F 2),	3b # of TBAs trained in ♦ clean deliver techniques, ♦ essential newborn care, ♦ iron-folate distribution to pregnant women, ♦ timely referrals of obstetric emergencies, ♦ vitamin A distribution to post-partum women, ♦ CBDDS, ♦ QA/CQI tools/techniques, -- high quality case management of

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	3c Capacity of private practitioners enhanced,	♦ high quality case management of pneumonia and diarrhea, 3c 45 private practitioners trained in ♦ CBDDS ♦ high quality case management of pneumonia and diarrhea,		pneumonia and diarrhea 3c # of private practitioners trained in ♦ CBDDS ♦ high quality case management of pneumonia and diarrhea,
4)Strengthen community structures and build their capacity in CS/RH activities,	4a 83 Village Health Management Teams (VHMTs) established and functioning, 4b 83 women's groups (Mahila Mandal) will be formed and functioning as basic units of women empowerment,	4a 425 Village panchayat leaders trained in ♦ PLA exercises, ♦ KPC survey tools/tecniques, ♦ developing VDRPs, ♦ CBDDS, ♦ conduct of social autopsies, ♦ Village-based Health Information System (HIS) established in 83 target villages 4b 225 Mahila mandal members trained in ♦ PLA exercises, ♦ KPC survey tools/tecniques, ♦ CBDDS, ♦ home gardens promotion,	4a On-going over 4 years, (Please see section F 3), 4b On going over 4 years, (Please see section F 3),	4a i # of Village panchayat leaders trained in ♦ PLA exercises, ♦ KPC survey tools/tecniques, ♦ developing VDRPs, ♦ CBDDS, ♦ conduct of social autopsies, 4a ii # of Village Health Management Teams (VHMTs) established and functioning, 4a iii # of target villagers with Village-based Health Information System (HIS), 4b i # of women's groups (Mahila Mandal) will be formed and functioning as basic units of women empowerment, 4b ii # of Mahila mandal members trained in ♦ PLA exercises, ♦ KPC surv

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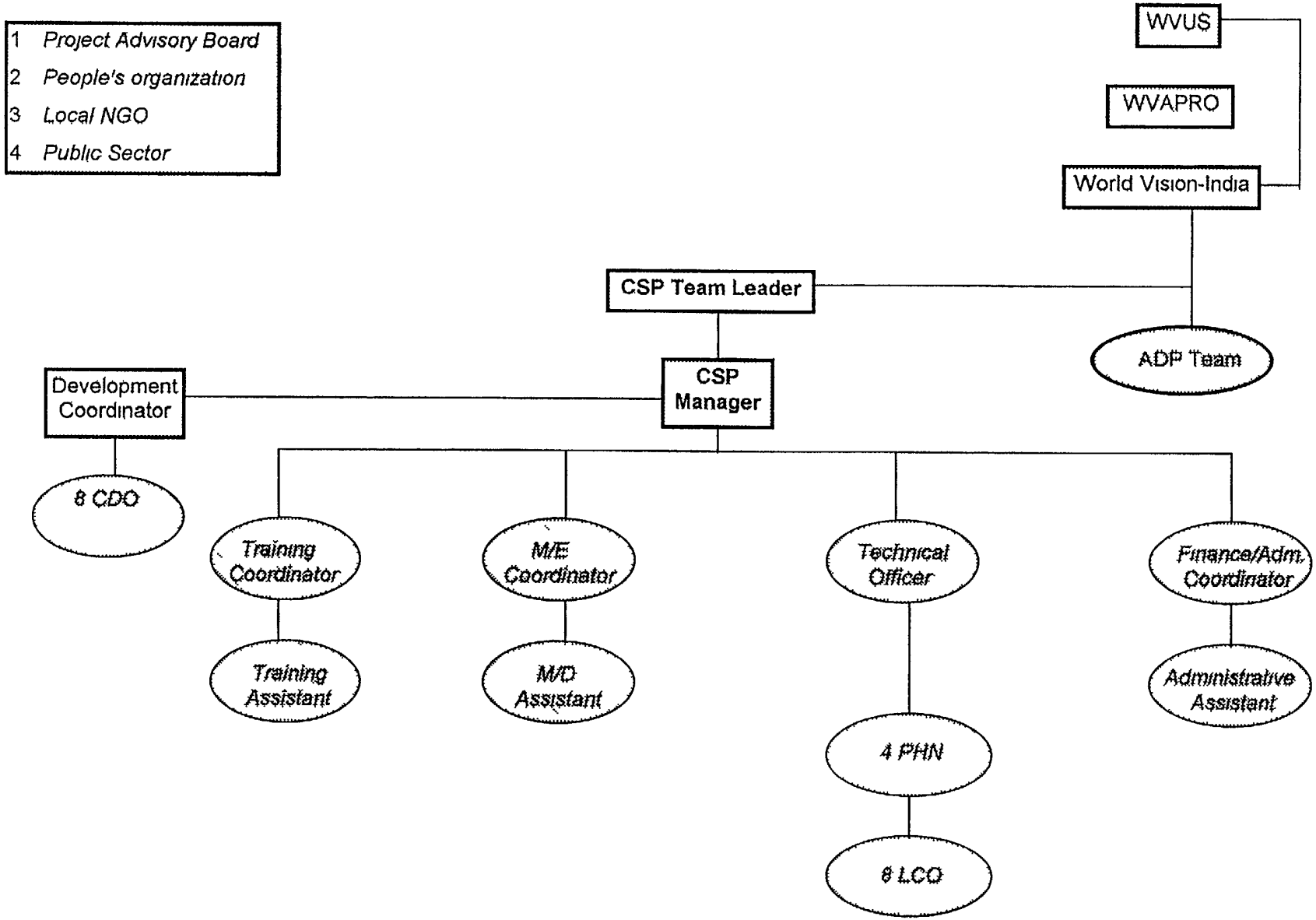
		♦ establishing two community-owned registers (EPI/Pregnancy), ♦ appropriate weaning food recepies, ♦ birth spacing/family planning,		tools/tecniques, ♦ CBDDS, ♦ home gardens promotion, ♦ establishing two community-owned registers (EPI/Pregnancy), ♦ appropriate weaning food recepies, ♦ birth spacing/family planning,
	4c 83 Youth clubs would be formed and functioning,	4c 210 youth club members trained in ♦ CBDDS, ♦ organizing village-based transport systems for obstetric emergencies,	4c On-going over 4 years, (Please see section F 3),	4c i # of Youth clubs would be formed and functioning 4c ii # of youth club members trained in ♦ CBDDS, ♦ organizing village-based transport systems for obstetric emergencies
	4d Association of VHGs formed and functioning	4d 83 VHGs trained in ♦ PLA exercises, ♦ KPC survey tools/techniques, ♦ interpersonal communications skills, ♦ CBDDS, ♦ establishing community-owned registers (EPI/Pregnancy), ♦ role-modeling skills, ♦ cross-visits, ♦ high quality case management of pneumonia and diarrhea,	4d On-going over 4 years, (Please see section F 3),	4d i Presence of Association of VHGs that is functioning 4d ii # of VHGs trained in ♦ PLA exercises, ♦ KPC survey tools/techniques, ♦ interpersonal communications skills, ♦ CBDDS, ♦ establishing community-owned registers (EPI/Pregnancy), ♦ role-modeling skills, ♦ cross-visits, ♦ high quality case management of pneumonia and diarrhea,

5)Promote self-financing of CS services through (a) Cost-recovery methods, (b) Resource generation methods, (c) Institute mechanisms to improve project cost-effectiveness, and	5 1 Three types of financial ***sustainability initiatives*** in place,	5 1 ♦ 5 Cost-recovery mechanisms to increase revenue generation in the delivery of CS/RH services in the public/private sector, • 7 Mechanisms to improve the cost-efficiency of providing CS/RH services, ♦ 4 Resource commitments by counterpart institutions made,	5 1 On-going over 4 years,	5 1 # in place ♦ Cost-recovery mechanisms to increase revenue generation in the delivery of CS/RH services in the public/private sector; • Mechanisms to improve the cost-efficiency of providing CS/RH services, ♦ Resource commitments by counterpart institutions made
6) Initiate advocacy and policy formulation.	6 1 State Health Department facilitated to officially ***endorse po-licy for vitamin A supplementation of post-partum mothers***	6 1 ***National "Lessons Learned/Best Practices in RH/CS"*** work-shop facilitated with MOHFW, USAID and partners	6 1 FY 2000	***6 1 # of National "Lessons Learned/Best Practices in RH/CS"*** workshop facilitated with MOHFW, USAID and partners

ORGANOGRAM

BALLIA RURAL INTEGRATED CHILD SURVIVAL PROJECT



Annex 17

Annex 18

INDICATORS TRACKING IMPACT & COVERAGE OF CS/RH INTERVENTIONS

Impact Indicator #1 Total Fertility Rate number of children born to a woman who lives up to 45 years
Impact Indicator #2 Under-5 Mortality Rate number of under-5 deaths per 1000 live births
Impact Indicator #3 Infant Mortality Rate number of infant deaths per 1000 live births
Impact Indicator #4 Maternal Mortality Ratio no of deaths in women 15-45 years per 100,000 live births
Impact Indicator #5 AFP Prevalence no of reported case-based Acute Flaccid Paralysis (AFP)/100,000 population
Impact Indicator #6 Vitamin A deficiency prevalence no of reported cases of VAD in children 9-35 mo
Impact Indicator #7 % of children 0-23 months who are moderately or severely wasted *(who fall below -2 Z score from the median weight for age of NCHS/ WHO reference population)*

Sub-Result #1a Increased Coverage of Essential Care of the Sick Child

Pneumonia Case Management

--Proportion of mothers/caretakers able to recognise at least two danger signs of peumonia that call for immediate referral and treatment
--Proportion of mothers/caretakers who sought appropriate antibiotic treatment for their children under 24 months with cough and rapid or difficult breathing in the past 2 week
--Proportion of children 0-23 months diagnosed as pneumonia who were treated with antibiotics according to standard case management protocol

Diarrhea Case Management

--Proportion of children 0-23 months with diarrhea in the past 2weeks who were treated with ORT
--Proportion of children 0-23 months with diarrhea in the past two weeks who were given the same amount or more fluids other than breast milk
--Proportion of children 0-23 months with diarrhea in the past two weeks who were given the same amount or more food

Sub-Result #1b Increased Coverage of Essential Care of the Newborn

--Proportion of post-partum mothers who were trained in care of their newborn (hypothermia prevention low birth weight management and establishment of exclusive breastfeeding

Sub-Result #1c Increased Coverage of Immunization

--Proportion of infants (0-11 months) who have been received card-documented doses of BCG OPV3 DTP3 and measles vaccines before age 12 months
--Proportion of mothers would have received two card-documented doses of tetanus toxoid (TT2) before the birth of her youngest child less than 24 months

Sub-Result #1d Prevention of Malnutrition and Vitamin A Deficiency

-- Proportion of infants 0-4 months exclusively breastfed in the last 24 hours
-- Proportion of infants 5-9 months who are being given solid or semi-solid foods
-- Proportion of children 9-35 months who received approporiate card-documented doses of vitamin A semi-annually
-- Proportion of post-partum mothers who received one card-documented high-dose vitamin A supplement within 4 weeks of delivery)

Sub-Result #1e Improved Reproductive Health Coverage

--Number of target villages which have functioning village-based emergency transport schemes for obstetric emergencies
--Proportion of women with children less than 24 months who reported at least one un- intended pregnancy in the last 12 months
--Proportion of women with children less than 24 months who desire --no more children in the next two years or are not sure who are using modern contraceptive methods
--Proportion of women who delivered their youngest child in the last one year who received at least 90 iron/folate tablet supplements during their last pregnancy
--Proportion of mothers who had at three or more card-documented antenatal visits before the delivery of her youngest child less than 24 months
--Proportion of deliveries in the last 12 months who have been attended by a trained health provider or PHC/ Sub-center ANM/staff)

CONCERNS AND RECOMMENDATIONS	PROJECT'S RESPONSE
4 Monitoring and Evaluation	
• *Objectives/indicators listed only capture the CS/RH service delivery component not capturing fully all what you plan to do*	Please refer to DIP for the project's development component objectives, work plans and annual benchmarks
• *"Need to highlight objectives/indicators to capture capacity building measurements '*	Please see Annex 5 on the "Assessment and Monitoring Tools for Institutional Capacity Building of NGOs"
• *At the end of the day need to ask 2 questions* *--What do you want to be accountable for?* *--What is measureable that can be measured?*	Please refer to i) Annex 18 on "Indicators tracking Impact and Coverage of CS/RH Interventions" ii) Annex 5 on "Assessment and Monitoring Tools for Institutional Capacity Building of NGOs"
• *' Include monotoring/evaluation of care takers*	This is included in the intervention-specific sections
• *' Include health facility assessment*	A HFA exercise was planned before this DIP was written However the consultant was not available earlier and is scheduled to facilitate this exercise only in late April/May 1999 A separate HFA report with recommendations will be submitted after that, and factored into the DIP
• *Need to measure health worker performance based on protocol of observation measurement ' What is the QA monitoring plan?"*	The project will assist facilitate the training of CMO staff PHC and subcenter staff in a CQI exercise in FY 2000 following which observation and supervisory tools will be developed to improve the quality of training supervision and service Some prototype CQI tools are included Annex 19 (EPI Session Supervisory Checklist, Twice-a-Day Vaccine Temperature Recording Chart Missed Opportunity Survey Forms) Annex 20 (Checklist for monitoring assessment classification and treatment for health workers trained in integrated ARI CDD and Undernutrition skills)
5 Care Givers	
a) Focus also on care takers other than children *b) Need to highlight private practitioners* • *How/Why we are going to help them participate in the program?* • *Assess their market share* • *What proportion of sick children/women seek their service in comparison to government health care providers?* • *Assess the quality of their case management/service delivery* • *Assess them to improve the quality of their case management/service delivery* • *Measure such quality improvements*	a) The project will also focus on mothers-in-laws and fathers b) The project will recruit a local consultant in FY 2000 to assist in adapting the BASICS/Kurji Holy Family Hospital/Bihar PVO II Operations Research questionnaire/methodology to study the "Quality of Home and Private Practitioner Case Management of Childhood Illnessess" (please Annex 11) Both the KPC survey and PLA exercises revealed that the majority of mothers seek private practitioners for curative care for their sick children and public health staff for preventive health services Following the baseline study the project plans several CQI exercises with private practitioners to improve the quality of their case management/service delivery, CQI instruments will be jointly developed with them to measure and track such improvements

6 Interventions	
• *"Drop the bed-net component"* • *"Check the target age group of children receiving vitamin A supplementation - is it 9-35 months, 6-71 months or 6-59 months?* • *"CDD-some technical errors need a design strategy"* • *"Screening for high risk pregnancy - out of date* • *"OR - need new methods/materials*	• The project has already decided to do this • The MOH protocol is for VA supplementation of children aged 9-35 months (please see Annex 26), • Please see CDD-specific interventions in section M, • This has been excluded • Besides the planned OR on private practitioners described above, the project will explore others in the next 6 months,
7 Partnership / Capacity Building	
• *"Need a management plan to improve the quality of local NGOs* • *What funds / resources are going to the local NGO s*	• Section F 2 describes this, and the Sustainability Action Plan (Annex 12) • No funds will go to local NGO's but will be used for training and other equipment

CONCERNS AND RECOMMENDATIONS	*PROJECT'S RESPONSE*
8 Sustainability	
• *'Donated drugs undermine sustainability who is going to be responsible for sustainability of antibiotic supply of CSP funding ends ? Donated drugs need to be for the short time only"* • *"Local fund raising--How are we going to get community involved ? '*	• The project willm not solicit any donated drugs but will access the supply from the CMO office, the project will use its private funds to meet shortfalls, and plans to work out with partners a cost-recovery plan, • The BRICs project is an add-on to the Ballia ADP, which plans income generation/resource generation activities

Annex 19

BALLIA RURAL INTEGRATED CHILD SURVIVAL PROJECT

PROTOCOL TO MONITOR / RECORD VACCINE TEMPERATURES TWICE DAILY IN REFRIGERATOR WHERE OPV AND MEASLES VACCINES ARE KEPT

PHC
~~Participant~~ Name _____ Impact Area : _____

Date	Temperature at 8 30a m	Temperature at 2 p m	Remarks

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(2)

Appendix

BALLIA RURAL INTEGRATED CHILD SURVIVAL PROJECT

SUPERVISORY CHECKLIST FOR COLD-CHAIN MONITORING

Staff Name _____ Area _____

No.	Checklist Item	Yes	No
1	Inventory of equipment (location and condition)		
2	Refrigerators and freezers in working condition and well maintained		
3	Vaccines carriers and cold boxes clean and well maintained		
4	Vaccines properly stored (placement and orderly)		
5	Thermometer in refrigerator (functioning properly)		
6	Temperature recorded every day (two times—8 a.m and 2 p.m)		
7	Temperature monitor present		
8	Temperature monitors placed and recorded properly		
9	Vaccines with expiration date		
10	Voltage stabilizer present and working		
11	Frozen ice packs sufficient for next day's outreach session with reserve		
12	Vaccines taken care of when electricity fails for more than three hours		
13	The stand-by generator is in good condition		

Signature of Supervisor _____

Designation _____

Date._____

CHECKLIST FOR STERILIZATION	Yes	No
Each child injected using a sterilized syringe / needle (steam boiled for 20 - 30 minutes) 1 Clean the syringes and needles with mild soapy water and rinse them with plain water 2 Place barrels, pistons and needles in the holes of the syringe rack 3 Rack to lid on the loaded rack and press the clip so that it fixes on the rack 4 Fill water in the sterilizer based up to the mark 5 Place the loaded sterilizer rack into the sterilizer 6 Put a pair of forceps on the rack lid 7 Put the sterilizer base, matching the arrow marks on the base and the lid and turn it clockwise to close it 8 Put the sterilizer on the stove 9 As steam starts coming out of the pressure valve, wait for 5 minutes reduce the flame 10 Keep it on flame for another 15 minutes 11 Remove the sterilizer from the stove and allow it to cool 12 Open the lid only when the syringes and needles are required 13 Turn the lid upside down and keep the forceps on it 14 Use to forceps to assemble the syringe		

Appe

BALLIA RURAL INTEGRATED CHILD SURVIVAL PROJECT

EPI SESSION SUPERVISORY CHECKLIST

1 Date __/__/__ 2 District _____ 3 Village _____ 4 Block_____

Vaccination team members present

5 AMNs present Y[ ] N[ ]
6 ANM data forms present Y[ ] N[ ]

Vaccines/cold chains

7 One ice pack on the table Y[ ] N[ ]
8 Needle rack in sterilizer Y[ ] N[ ]
9 Vaccines on solid ice Y[ ] N[ ]

Record Keeping

10 ANM EPI register includes names/birth dates of all children 0-11 months old Y[ ] N[ ]
11 ANM VAC register includes names/birth dates of all children 12-59 months old Y[ ] N[ ]
12 ANM pregnancy register includes names of all pregnant women Y[ ] N[ ]
13 ANM FP register includes names of all women with an under 2 child Y[ ] N[ ]
14 EPI tally marks =number of syringes used Y[ ] N[ ]
15 Number of vials used is appropriate to number of doses given Y[ ] N[ ]
16 VAC tally marks =number of capsules used Y[ ] N[ ]
17 ANM registers are correctly filled out at the end of session Y[ ] N[ ]

Health Education

18 Used visual aids Y[ ] N[ ]
19 Includes question/answer session Y[ ] N[ ]

PATIENT MANAGEMENT

M/I Pair (1)	Infant Vaccination Technique				Mother Given Needed TT (7)	Health Education Exit Interview									Knows Deaths (25)
						Immunization			FP(12)	Nutrition (14)		Diarrhea(17)		Pneumonia	
	Clean Site (3)	Not Touch (4)	Correct Site (5)	Correct Dose (6)		Side Effect (8)	Next Vacc (10)	Illness OK (11)	Knows Benefits (13)	Understands Chart (15)	Knows Weaning Foods (16)	Knows when Give ORS (18)	Knows how to give ORS (19)	Knows Two Signs (21)	
1	Y/N	Y/N	Y/N	Y/N	Y/N/NA	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
2	Y/N	Y/N	Y/N	Y/N	Y/N/NA	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
3	Y/N	Y/N	Y/N	Y/N	Y/N/NA	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
4	Y/N	Y/N	Y/N	Y/N	Y/N/NA	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
5	Y/N	Y/N	Y/N	Y/N	Y/N/NA	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

Comments

(2)

General Information Sheet
Identify Missed Opportunities

Date assessed _____ Health facility _____ Conducted by _____	Location of facility *(check one)* _____urban _____other _____rural
Type of session assessed *(check one)* _____paediatric clinic _____MCH clinic _____fixed immunization session _____antenatal clinic _____outreach immunization session _____other *(describe below)*	Number attending daily _____children _____women

On the day of the assessment use the checklist below to review the preparations

_____1 Cold chain equipment is used appropriately so that vaccine is kept between 0°C to 8°C

_____2 Vaccines are accessible to the health workers

_____3 The following vaccines are available today

- _____BCG
- _____OPV
- _____DPT
- _____Measles
- _____TT

_____4 The health workers are trained to

- _____use the recommended immunization schedule
- _____observe appropriate contraindications
- _____screen children and women at every contact and immunize them as necessary
- _____open a vial of vaccine even if only one eligible child or woman is present for immunizations
- _____use one sterile needle and one sterile syringe for each injection
- _____tell patients when to return for the next dose and whether there will be any side effects

_____5 Sufficient questionnaire forms are available for all the children and women who will be assessed today

_____6 Any additional interviewers are trained to conduct the interviews and complete the questionnaires

_____7 The supervisor has explained the assessment to the health workers so they know what is taking place

Comments *(about preparation for the assessment or the situation at the health facility)* _____

_____

_____

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5

Identify Missed Opportunities
Child's Questionnaire

Health facility _____ Today's date _____ Interview Number _____

What is your child's age or date of birth?

age: _____ months _____ weeks

date of birth: ___ day ___ month ___ year

If the child is less than 2 years old go to question 2.
If the child is more than 2 years old go to the women's questionnaire

2 Does the child have an immunization card? _____ YES _____ NO *If YES go to question 3* *If NO, go to question 4B*

3 Have you brought the card with you today? _____ YES _____ NO *If YES go to question 4A* *If NO go to question 4B*

4A May I see the card please? *(Copy from card dates immunizations received in space below.)*

4B Which immunizations has your child received? *(Tick each dose mother says child received and record approximate date below.)*

Vaccine	*If card available record* Day	Month	Year	*If card not available record each reported dose and approximate date*	*Doses missed today*
BCG					
OPV Zero					
OPV 1					
OPV 2					
OPV 3					
DPT 1					
DPT 2					
DPT 3					
Measles					

5 Decide Did the child receive all the immunizations for which he or she was eligible today? _____ YES _____ O
If YES go to question 7, and mark NO missed opportunity *If NO go to question 6*

6 Your child was eligible to receive an immunization today. Do you know any reason why your child did not receive the immunization?
Listen to the mother's reply. If her answer is listed in the first column mark it. If she reports any other reason, write it down in the second column.

Column 1	*Column 2*
_____ Child has clinical AIDS _____ Child had severe reaction to previous dose of DPT _____ Child is being admitted to hospital _____ Mother declined immunization which was offered because _____	OTHER REASONS _____ _____ _____ _____
If any answers are marked in this column go to question 7. Mark NO missed opportunity	*If any answers are marked in this column go to question 7. Mark YES. There was a missed opportunity*

7 Was there a missed opportunity? ☐ YES _____ NO
If YES ask the mother to go back to the health worker to receive the immunization
If NO go to women's questionnaire if any women have accompanied this child

ANSWER ANY QUESTIONS THE RESPONDENTS MAY HAVE ABOUT IMMUNIZATION. THANK THEM FOR THEIR COOPERATION.

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Identify Missed Opportunities
Woman s Questionnaire

6

Health facility _____ Today's date _____ Interview Number _____

1 What is your age ?

If the woman is between 15 - 44 years, go to question 2
If the woman is NOT between 15 - 44 years end the interview and thank her

age _____ years

2 Do you have your own immunization card? _____ YES _____ NO *If YES, go to question 4A* *If NO, go to question 3*

3 Are your immunizations recorded on your child's card? _____ YES _____ NO *If YES go to question 4A* *If NO, go to question 4B*

4A May I see the card please? *(Copy from card dates immunizations received in space below)*

4B How many times have you received a tetanus immunization? When did you receive each dose?
(Tick each dose woman reports received and record approximate date below)

Vaccine	If card available record			If card not available, record each dose and approximate date	Recommended minimum interval	Doses missed today
	Day	Month	Year			
TT 1						
					4 weeks	
TT 2						
					6 months	
TT 3						
					12 months	
TT 4						
					12 months	
TT 5						

5 Decide: Did this woman receive the dose of TT for which she was eligible today? _____ YES _____ NO
If YES go to question 8 and mark NO missed opportunity If NO, go to question 6

6 Did the health worker offer you TT immunization today? _____ YES _____ NO

If YES go to question 7 If NO go to question 8, and mark YES missed opportunity

Record any comment the woman makes about why immunization was not offered

COMMENT _____

7 Did you decline TT immunization when it was offered? _____ YES _____ NO

If YES go to question 8, and mark NO missed opportunity . If NO, go to question 8, and mark YES missed opportunity

8 Was there a missed opportunity? [ ] YES _____ NO

If YES ask the woman to go back to the health worker to receive the immunization

ANSWER ANY QUESTIONS THE WOMAN MAY HAVE ABOUT IMMUNIZATION THANK HER FOR HER COOPERATION

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BALLIA RURAL INTEGRATED CHILD SURVIVAL PROJECT

MONTHLY TIME REPORT

Employee Name _____ Employee No _____ Month / Year _____

Hours worked		Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
Project name	Project No	Total Hrs																
BRICS		Date	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		Total Hrs																
Total Hours worked in month (A)																		

Paid Leave

Weekend / Vacations																		
Holiday as ADP holiday list																		
Personal (Casual leave)																		
Personal (Privilege leave)																		
Personal (Sick leave)																		
Personal (Maternity leave)																		
Other (Explain Below) *																		
Total Paid Leave (B)																		

Payroll / Personal summary

Total paid hours (A & B) (C)																		
Regular Hours/Day (7 8 hours a day) (D)																		
Unpaid leave (D>C) (E)																		

Report time to nearest half hour in decimals

* Remarks _____

_____

_____

Employee Signature _____ Date ___ / ___ / ___

Checked by Supervisor _____ Date ___ / ___ / ___

Approved by _____

BALLIA RURAL INTEGRATED CHILD SURVIVAL PROJECT

DAILY TIME LOG SHEET

Employee Name _____ Employee No _____ Month / Year March 1999

DATE	TIME (IN)	SIGNATURE	TIME (OUT)	SIGNATURE	NATURE OF WORK
01-03-1999					
02-03-1999					
03-03-1999					
04-03-1999					
05-03-1999					
06-03-1999					
07-03-1999					
08-03-1999					
09-03-1999					
10-03-1999				19-9	

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FORM 4 (रूप पत्र–४)

A N M Activity Report for the month.. .. ... .Subcentre Population . .
SC (उपकेन्द्र) PHC (प्रा० स्वा० केन्द्र). . . . .
No of Ecs (पात्र दम्पतियो की संख्या) .. .. .
Current usess of I -P (प्र० क० कार्यक्रम की विधि अपनाने वाले की संख्या) .. . . . —

Sl No क्रम संख्या	Activity (कार्य गतिविधि)	Service Need (कार्य भार)		Performance (उपलब्धियाँ)		%
		Annually (वार्षिक)	Monhtly मासिक	Monthty मासिक	Comulative (क्रमिक)	
		1	2	3	4	5
1	A N C Regestration (Total) (कुल पंजीकृत गर्भवती महिलायें)					
2	Early Registration (Lessthan 16 weeks) (16 हफ्ते से पहले पंजीकृत)					
3 (a)	A N C Recieved T T 1 गर्भवती महिलाओं को टी टी (प्रथम)					
3 (b)	A N C Recreved T T 2/Booster गर्भवती महिलाओं को टी टी (द्वितीय)!					
4	A N C s recived Complate (पूर्ण खुराक वाली गर्भवती महिलायें)					
	(a) I F A Prophylures (बचाव हेतु) (b) I F A Therapy (उपचार हेतु)					
5	A N C s Examined (गर्भवती की जाच)					
6.	A N C s Completed 3 Visits (गर्भवती जिनकी ३ बार विजिट की गयी)					
7	A N C clinics conducted (ए एन सी क्लीनिक जो कराये गये)					
8	High risk A N Cs reffered (गम्भीर खतरे के रोगी जो सन्दर्भित किये गये)					
9 (a)	Insti tutional Delivery (संस्थागत प्रसव)					
9 (b)	Dellvery by Trained person (प्रशिक्षित व्यक्ति द्वारा प्रसव) (i) ए०एन०एम/एल०एच०वी० द्वारा (ii) प्रशिक्षित दायी द्वारा					
9 (c)	Delivery by untrained Dai/other (अप्रशिक्षित व्यक्ति/अ य द्वारा)					

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Mar 27 1999 04 30PM P1 PHONE NO FROM

	1	2	3	4	5
10 Birth weight Recorded (जन्म के समय वजन लिया गया)					
11. B W below 2 5 Kg (२ ५ कि०ग्रा० से कम वजन के बच्चे)					
12 High risk new born Refered (गंभीर खतरे वाले नवजात शिशु जो सन्दर्भित किये गये)					
13 No of PN CS Completed 3 visits (प्रसवोपरांत ३ बार देखे गये रोगी)					
14. M T P Referred (चि०ग० समापन हेतु सन्दर्भित)					
15. No Immunisation Sesson conducted (प्रतिरक्षण सत्र सम्पादित)					
16 No of Children Immunised (बच्चो की संख्या जिन्हे टीके लगाये गये)					
a B C G (बी० सी० जी०)					
b (i) D P. T 1 (डी० पी० टी० प्रथम)					
b (ii) D P T 2 (डी० पी० टी० द्वितीय)					
b (iii) D P T 3 (डी० पी० टी० तृतीय)					
c (i) O P V 1 (पोलियो प्रथम)					
c (ii) O P V 2 (पोलियो द्वितीय)					
c (iii) O P V 3 (पोलियो तृतीय)					
d Measles (खसरा)					
17 Children fully Immunised (पूर्ण प्रतिरक्षित बच्चे)					
18 (a) Children given Vit A doses (बच्चो की संख्या जिन्हें विटामिन 'ए' दिया गया)					
18 (b) Children Completed 5 doses of Vit A (बच्चों की संख्या जो ५ खुराक विटामिन 'ए' पूर्ण किये)					
19 Adverse events for I Imm. (प्रतिरक्षण में प्रतिकुल क्रिया)					

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FROM PHONE NO Mar 27 1999 04 30PM P2

	1	2	3	4	5
20 (a) Joint Sesson with A W W (आगनबाडी कार्यकर्मियों के साथ सयुक्त सत्र)					
20 (b) Joint Sessons with Dais (दाइयो के साथ सयुक्त सत्रो की सख्या)					
20 (c) Joint Sesson with women group (महिलाओ के साथ सयुक्त सत्र चलाये गये)					
21 (a) Users of pmt methods (स्थायी विधि अपनाने वाले)					
(i) Vasectomy (पुरुषो की नसबन्दी)					
(ii) Tubectomy (महिलाओं की नसबन्दी)					
21 (b) Acceptor of spacing methods समयान्तर विधि अपनाने वाले)					
(i) I U D (आई० यू० डी०)					
(ii) O P users (ओ० पी० यूजर्स)					
(iii) Condom users(निरोध प्रयोग कर्त्ता)					
(iv) Traditional/Indegenous method (परम्परागत देशी पद्धति अपनाने वाले					
(v) Natural Method (प्राकृतिक तरीका)					
22 No U FP Discontinued [illegible] केस जो (i) निकाले गये (ii) निकल गये					
23. No of F P Cases followed up (प०क०अपनाने वाले जिनका फालो अप किया गया					
24 Complication Due to Contracepteve कन्ट्रासेप्टिव पेचिदगी					
25 Sterilization failure (वन्ध्याकरण असफल हुए)					

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FROM PHONE NO Mar 27 1999 04 31PM P3

	1	2	3	4	5
26 (a) No of Cases of (रोग ग्रस्त)					
Polio (पोलियो)					
Measles (खसरा)					
N N Tetnas (नवजात टेटनेस)					
ARI US treated					
(५ वर्ष से कम उम्र के श्वसन तन्त्र के रोगी)					
ARI US refered (ए आर आई सन्दर्भित)					
Diarr US treated					
(५ वर्ष के दस्त के बच्चे उपचारित)					
Diarr US refered					
(५ वर्ष के दस्त के बच्चे सन्दर्भित)					
26. No of Cases of Reproductive problems					
(प्रजनन समस्याओ सम्बन्धित व्यक्तियों की संख्या)					
RTI/STD referred (सन्दर्भित)					
Other Gyn Prob referred					
(स्त्री रोग सम्बन्धित केस जो सन्दर्भित किये गये)					
27 Vital events Recorded					
(जन्म मृत्यु पजीकृत)					
Live Births (जीवित जन्म)					
Neo natal deaths/28 d)					
नवजात शिशु मृत्यु = २८ दिन)					
Infant death (under 1 Yr)					
१ वर्ष के कम उम्र के मृत शिशुओं की सख्या					
Maternal deaths (मातृ–मृत्यु					
Marriages (विवाह पजीयन)					
Marriages of girl below 18 yrs					
(१८ वर्ष से कम उम्र के विवाहित लड़कियाँ)					

हस्ताक्षर महिला स्वास्थ्य कर्मी

उप केन्द्र का नाम—

प्राथमिक स्वा० केन्द्र—

जनपद–बलिया

19h-4

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Annex 20

CHECK-LIST FOR MONITORING ASSESSMENT, CLASSIFICATION, TREATMENT

Participant's Name			
Age of the child (months)			
General Danger signs			
Cough			
Severe disease or Severe pneumonia			
Pneumonia			
Cough or cold			
Diarrhoea			
Dysentery			
Persistent			
Severe dehydration			
Dehydration			
No dehydration			
Undernutrition or Anaemia			
Severe undernutrition Severe anaemia			
Undernutrition			
Anaemia			
Not undernourished or anaemic			
Fever High			
Treat			
- ORS			
- Cotrimoxazole			
- Home care - diarrhoea			
- Home care - cough or cold			
Counsel			
Feeding - ask questions			
identify problems			
advise			
When to return			

INTEGRATED ARI, CDD, UNDERNUTRITION SKILLS MONITORING OF TRAINING COURSE

Location: _____ District: _____ State _____		No of Participants _____
Dates: From _____ To _____		No of Facilitators _____
Duration _____		Type of Participants _____ *(indicate number)*
		Anganwadi Workers _____ ANM _____ LHV _____ Anganwadi Supervisor _____
Course Material Used	Learner's Guide Trainer's Manual	Video Photographs
Clinical Practice	No of days _____ *Location* Hospital - Inpatient Clinic - OPD Community	No of hours each day _____ Urban / Rural
No of Cases	Severe Disease _____ Severe Pneumonia _____ Severe Undernutrition ____ Severe Dehydration _____ Persistent Diarrhoea _____ Dysentery _____	Pneumonia ____ Dehydration ____ Undernutrition ____ Anaemia _____ Cough or Cold ____ Diarrhoea ____ Fever ____
No of Children:	ORS Used _____ Cotrimoxazole Advised ___ Feeding Advised _____ Mothers Advised _____	
Teaching Methods	Drills Group Discussion Role Plays	

Course Monitoring:

2 Best Trainers

2 Best Participants

3 Suggestions for Improvement

3 Best Features of Course 20-9-2

GROUP CHECK-LIST OF CLINICAL SIGNS

Not able to drink or breast feed	Lethargic or unconscious
Chest indrawing	Fast breathing
Very slow pinch	Slow skin pinch
Eager to drink	Drinks poorly
Blood in stools	Diarrhoea more than 2 weeks
Severe visible wasting	Oedema both feet
Severe pallor	Some pallor
Very low weight for age	High fever

20-a-3

MONITORING OF FEEDING PROBLEMS

Child below 4 months age gets water other fluids or foods	Child above 6 months of age is not given complementary foods	Child not actively fed
Complementary food is very thin	Food stopped during illness	Animal milk is diluted
Child not given family food at 3-5 years age	Child 1-2 years of age is given only breast milk or animal milk and no solids	Child between 6-12 months given complementary food less than 3 times daily
Child is given complementary food without added oil	Child is not breast fed at night	

20-a-4

ASSESS, CLASSIFY AND IDENTIFY TREATMENT OF A CHILD WITH COUGH OR DIFFICULT BREATHING, DIARRHOEA OR UNDERNUTRITION

ASSESSMENT	SIGNS	CLASSIFICATION	IDENTIFY TREATMENT
CHECK FOR GENERAL DANGER SIGNS *ASK* "Is the child able to drink or breastfeed? *LOOK* • See if the child is lethargic or unconscious	Child not able to drink OR Is lethargic or unconscious	Severe Disease	Refer to the hospital
THEN ASK. "Does the child have cough or difficult breathing? If yes - • Look for chest indrawing • Count the breathing rate in one minute Breathing rate is___/minute **Fast Breathing** Below 2 months - 60 or more 2 months up to 12 months - 50 or more 12 months up to 5 years - 40 or more	Child not able to drink OR Lethargic OR Chest indrawing	Severe Disease OR Severe Pneumonia	Refer to the hospital
	Fast Breathing	Pneumonia	Treat with Cotrimoxazole provide home care
	None of the above signs	No Pneumonia	Home care only
THEN ASK. "Does the child have diarrhoea? If yes ASK.- • "Is there blood in the stool? • Is diarrhoea of more than two weeks duration? Offer the child a fluid to drink - Drinks poorly - Drinks eagerly - Drinks normally • Pinch the skin over the abdomen - Very slow - Slow - Normal	Diarrhoea for more than 2 weeks	Persistent Diarrhoea	Refer to the hospital
	Blood in the Stool	Dysentery	Refer to the hospital
	Not able to drink OR drinks poorly OR lethargic OR Very Slow Skin Pinch	Severe Dehydration	Refer to the hospital
	Slow Skin Pinch OR Drinks eagerly	Some Dehydration	Treat with ORS Provide Home Care
	None of the above signs Diarrhoea - less than 14 days No blood in stools	No Dehydration	Home care
Then check for undernutrition and anaemia • Look for visible severe wasting • Look for oedema of both feet • Look for palmar pallor - Severe Pallor - Some Pallor - No Pallor • Determine weight for age	Visible Severe Wasting OR Oedema in both feet OR Severe Pallor	Severe Undernutrition OR Severe Anaemia	Refer to the hospital
	Very Low Weight For Age OR Some Pallor	Undernutrition or Anaemia	Feeding advice Iron Home Care
	No wasting, no oedema Not Very Low Weight For Age OR Pallor	No Undernutrition OR Anaemia	Feeding advice if child below 2 years age, Home Care
Then check for other problems Does the child have fever?	High Fever	High Fever	Refer if no improvement in 1 day Give Paracetamol Refer if child below 2 months age

Then check the child s immunization status

___	___	___	___	___	___	___
BCG	DPT 1	DPT 2	DPT 3	Polio 1	Polio 2	Polio 3
___		___				
Measles		Vitamin A				

20-b-1

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BEST AVAILABLE COPY

AGE SPECIFIC FEEDING RECOMMENDATIONS

Up to 4 Months of Age

- **Breast feed only**
- Breast feed as often as the child wants day and night at **least 8 times in 24 hours**
- **Do not give** water food or other fluids for any reason unless advised by a health worker
- Contact a health worker if you are not able to breast feed your infant

Breast feed only
Give no other fluids or food

4 Months up to 6 Months

- **Continue breast feeding** as often as the child wants day and night at **least 8 times in 24 hours**

- Give complementary foods only if the child
  shows interest in semisolid foods
  appears hungry after breastfeeding or is not gaining weight adequately
- Give special and household complementary foods **1 or 2 times per day** after breast feeding such as mixed rice and dal khichari mashed banana potato and carrot

- Complementary foods should be mashed thick pasty and have some added oil Examples of special complementary foods to give are dalia rice kheer suji kheer

Continue breast feeding

6 Months up to 12 Months

- **Continue breast feeding** as often as the child wants and **also give** semi solid foods

Give adequate servings of mashed foods such as rice dal mashed chapati milk yoghurt seasonal fruit (such as banana papaya guava mango etc) vegetables (such as potatoes carrots green leafy vegetables pumpkin etc) meat fish eggs

- Give semi solid foods **5 times per day if the child is not breastfed**

Continue breast feeding and also give semi-solid foods

12 Months up to 2 Years

- Give adequate servings of foods such as rice dal chapati biscuits milk yoghurt seasonal fruit (such as banana guava mango etc) vegetables (such as potatoes carrots green leafy vegetables etc) meat fish and eggs

- **Also give** family foods
- Continue breast feeding as often as the child wants

- Feed the child 5 times per day

Give family foods and continue breast feeding

2 Years up to 5 Years

- Give family foods

Give adequate servings of family foods such as rice dal chapati biscuits milk yoghurt seasonal frut (such as banana guava mango etc) vegetables (such as potatoes carrots green leafy vegetables etc) meat fish and eggs

- Give family foods 3 times each day

- Also give nutritious snacks twice a day between family meals

Give family foods and snacks

Good Feeding Practices

- Exclusive breast feeding up to 4-6 months age.
- Breast feeding on demand more than 8 times/ day and night
- Complementary foods are thick with oil added.
- Baby fed by cup/katori/spoon.
- Mixed foods are given.
- The child is actively fed

Feeding Problems

- Child is given very diluted feed
- Child is fed by a bottle
- Food given is inadequate
- Complimentary feeding is delayed
- Complimentary food is too thin
- Feeding is stopped or restricted during illness
- Animal milk given is inadequate
- Baby is not actively fed
- Child is given very diluted powdered milk
- Complimentary foods are started too early
- Breast fed less than 8 times during day and night
- Problem in breast feeding the baby

Solutions (see guidelines on solving feeding problems)

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2 TREATMENT AT HOME FOR

A PNEUMONIA

Determine the dose of Cotrimoxazole for treatment of pneumonia

COTRIMOXAZOLE DOSAGE

⇨Give two times daily for 5 days

AGE (WEIGHT) OF CHILD	PEDIATRIC TABLET 20 mg trimethoprim + 100 mg sulphamethoxazole
Under 1 month* (< 4 kg)	1/2 tablet
1 month up to 2 months (< 4 kg)	1 tablet
2 months up to 12 months (4 - < 10 kg)	2 tablets
12 months up to 5 years (10 - 19 kg)	3 tablets

*avoid cotrimoxazole in infants less than one month of age who are premature or jaundiced

ADVISE THE MOTHER

⇨Tell the mother the reason for giving the drug to the child

⇨Explain how much to give to the child

⇨Show the mother how to crush and mix the tablet with fluid or food

⇨Explain carefully how to give the drug.

⇨Mother should give first dose in your presence

⇨Explain that **all** the tablets must be used to finish the course of treatment even if the child gets better before the medicine is finished. Child must be seen after 2 days

B DIARRHOEA (some dehydration)

Determine the amount of ORS for treatment of dehydration

HOW MUCH ORS TO GIVE DURING THE FIRST 4 HOURS

ORS	AGE OF CHILD			
	Up to 4 months	4 months up to 12 months	12 months up to 2 years	2 years up to 5 years
In ml	200 - 400	400 - 700	700 - 900	900 - 1400
In Cups	2 cups	3-4 cups	5-6 cups	6-8 cups

ADVISE THE MOTHER

- If the child wants more ORS than shown give more
- For infants under 6 months who are not breast fed also give them 100-200 ml plain clean water in addition to ORS during the first 4 hours

⇨ **SHOW THE MOTHER HOW TO GIVE ORS SOLUTION**

- Give frequent small sips from a cup For small infants tell the mother to give one teaspoon every minute
- If the child vomits wait for 10 minutes Then continue giving ORS but more slowly
- Continue breast feeding whenever the child wants

⇨ **AFTER 4 HOURS**

- Reassess the child (see over # 1) and
- Select the appropriate treatment (see over # 1)
- Begin feeding the child

3 COUNSEL THE MOTHER ON HOME TREATMENT FOR

C COUGH OR COLD (No Pneumonia)

⇨ **TELL THE MOTHER**

1 **Feed the child**
- Feed the child during illness -

2. **Give increased fluids**
- Increase breast feeding
- Offer the child extra to drink. (See home fluids listed at # 3D)

3 Soothe the throat and relieve the cough with a safe home made cough remedy (made into tea) such as
- sugar ginger lemon, tulsi leaves ,
- sugar ginger, lemon, mint ;
- sonf elachi ginger

4 If the child s nose is blocked and interferes with feeding, clean the nose by putting in nose drops (boiled and cooled water mixed with salt) and by cleaning the nose with a soft cotton wick.

5 **Keep the young infant warm.**

6 Watch for the following signs and **return quickly** if they occur
- Fast breathing
- Difficult Breathing
  Child becomes sicker
- Not able to drink or breast feed

D DIARRHOEA (No Dehydration)

⇨ **TELL THE MOTHER**

Give extra fluid (as much as the child will take) such as: ORS milk, yoghurt drink, shikanji, rice, kanji mand (peech), dal soup vegetable soup, fruit juice, plain clean water (or other locally available fluids, e g ——————————)

1. - **Breast feed frequently** and for longer at each feed
   - If the child is not exclusively breastfed give one or more of the above home available fluids (such as water or ORS)

2. Show the mother **how much fluid to give after each stool** in addition to the usual fluid intake:
   - Up to 2 years - half cup Give more if the child wants more.
   - 2 years or more - full cup. Give more if the child wants more

3 - **Give frequent small sips** from a cup. For small infants, give one teaspoon every minute
   - If the child vomits, wait for 10 minutes. Then continue but more slowly
   - **Continue giving extra fluid** until the diarrhoea stops.

4 **Continue feeding**

5 **When to return** Tell the mother to return to the health worker if
   - the child is not able to drink or breastfeed,
   - the child becomes sicker;
   - there is blood in stool
   - the child is drinking poorly

4 TREATMENT OF

E FEVER

Paracetamol Tablets

Age	Dose
2 months up to 3 years	1/4
3 years up to 5 years	1/2

F ANAEMIA

Iron Folate Tablets

Age	Dose
2 months up to 1 year	1/4 daily
1 year up to 3 years	1/2 daily
3 years up to 5 years	1/2 daily

G VITAMIN A PROPHYLAXIS

Vitamin A Syrup

Age	Dose
6 months up to 1 year	100 000 units (IV)
1 year up to 5 years	200 000 units (IV)

COUNSEL THE MOTHER ON FEEDING

WEIGHT FOR AGE CHART

Assess Feeding

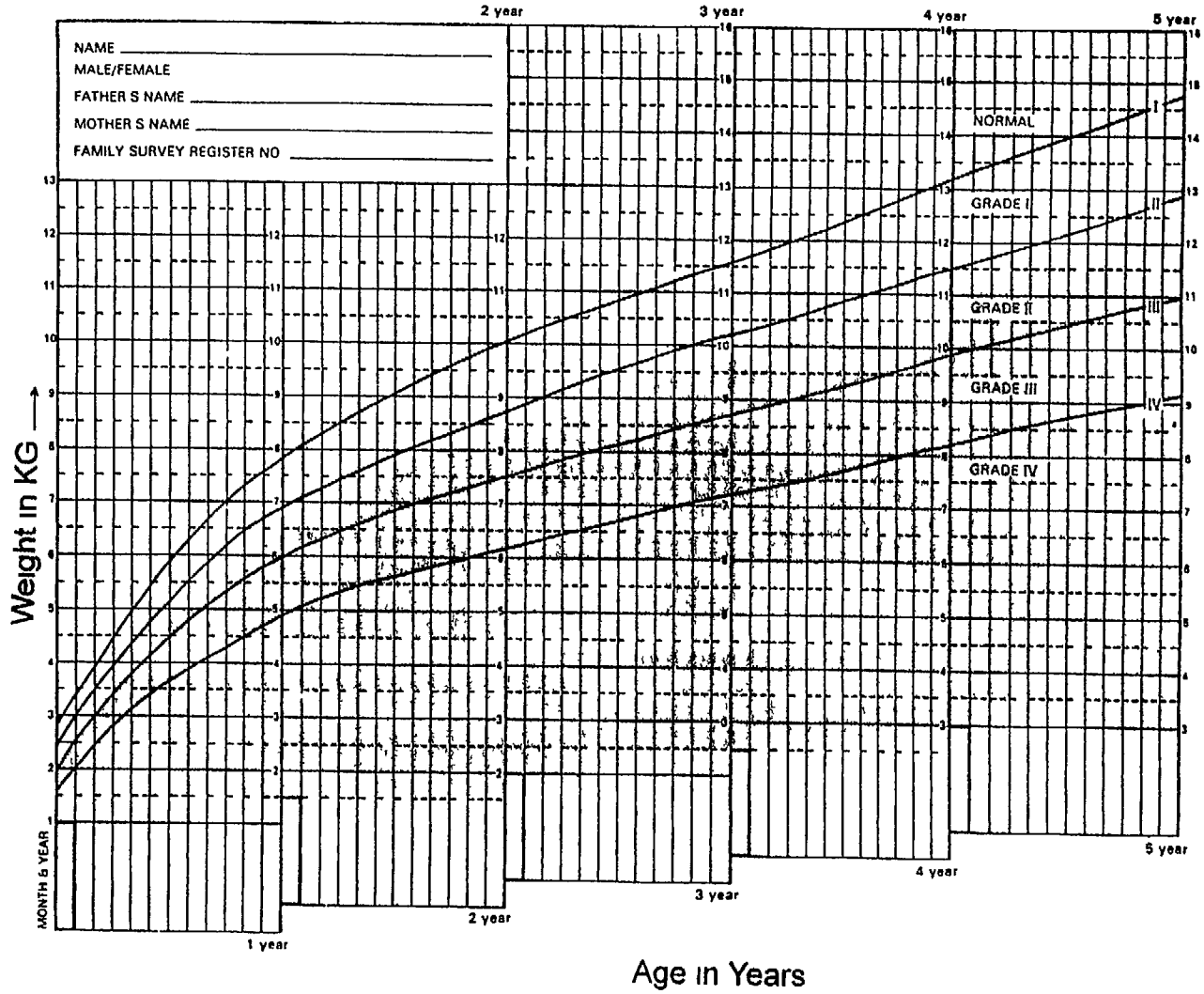
All children up to 2 years,
all children who are undernourished or anaemic

Do you breast feed the child?
How many times in a day?
Do you also breast feed at night?

Does the child take any other foods or fluids?
What foods or fluids?
How many times per day?
Are the foods thick or thin?
What do you use to feed the child?

In case of undernutrition or anaemia
How large are the servings (Katoris, Tea Spoons)?
Does the child receive separate serving?
Who feeds the child and how?

Ask if the child's feeding has changed during this illness?
If yes how?



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SOLVING FEEDING PROBLEMS

Feeding Problems	Solutions
	Age group Up to 4 months
1 Mother is not breast feeding exclusively	♦ Breast feed at least 8 times during day and night ♦ Do not give glucose water tea animal milk porridge and even water This will reduce the protection provided by breast milk
2. Mother feels she does not have enough breast milk.	**To increase her breast milk supply** ♦ She should breast feed the baby more often and for longer period at each feed ♦ Breast feed during the day and at night ♦ Mother should eat more and drink more liquids
3 Mother goes out to work and is not able to feed the baby	♦ Mother should breast feed the baby often before going to work after returning from work, and at night ♦ If possible she should take the baby to work and she must take brief breaks from work to feed the baby
4 Mother has flat or inverted nipples and cannot feed the baby	♦ Teach the mother to gently pull the nipples and massage them with oil (**do not use mustard oil**) This should be done 3-4 times per day ♦ **Refer the child** to a doctor if the problem does not improve in 2-3 days
5 Mother has very sore nipples or swelling on the breast	♦ Refer to a doctor ♦ Breast milk should be expressed regularly every 2 hours ♦ If the breast is infected throw away the expressed breast milk.
6 Child is fed by a bottle	♦ Advise the mother to stop bottle feeding This can be very harmful ♦ Put the baby to breast every time baby is hungry and feed for as long as the baby suckles ♦ Since breast milk may take 3-4 days to improve feed the animal milk by a cup
7 Baby is not able to breast feed	♦ There may be problem in suckling position or attachment Refer to a doctor/health worker who can solve the problem
	Age group 4 months up to 6 months
1 Complementary food given is very thin	♦ Prepare suji rice dalia' with undiluted animal milk (add butter/ghee) ♦ Give mashed banana or potato with butter or ghee ♦ Give thick dal with added oil
2 Child is given very small amount of complementary food	♦ Increase the cooked food amount by 1 tea spoon at each meal until the baby takes 1/2 katori/cup ♦ If the baby cannot eat large amount feed the baby more often
3 Child is given milk by a bottle	♦ Try and increase breast feeding ♦ If animal milk must be given then give it by cup or katori
4 Child is given diluted animal milk	♦ Try and increase breast milk feeding by increasing the frequency and by feeding longer ♦ Animal milk must never be diluted ♦ If mother is very worried that animal milk is too strong advise her to give plain clean water after a feed
	Age group 6 months up to 12 months
1 Mother has discontinued breast feeding She considers child is too old to breast feed	♦ Breast feeding can be done up to 2 years age ♦ Ask mother to resume breast feeding by putting the baby to breast every 2-3 hours ♦ Breast milk will come back after 3-4 days

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SOLVING FEEDING PROBLEMS

Feeding Problems	Solutions
2 Complementary foods not started	♦ Tell the mother that only breast milk is not sufficient for the child ♦ Introduce soft mashed but thick food like ✱ cooked in oil/ghee ✱ mashed potato with butter and ✱ mashed cooked vegetables (peas carrots) with oil ♦ Mashed seasonal fruit (banana chiku mango guava papaya) ♦ Khichari with oil or cooked dal and rice with oil
3 Complementary food is very small in amount	♦ Increase complementary food by 1 tea spoon per feed until the child takes 1/2-1 cup or katori ♦ If the child cannot take large amount of food feed 3-5 times/day instead of 3 times per day
4 Child takes breast milk and animal milk only	♦ Continue breast feeding but stop animal milk ♦ Replace animal milk feeding by complementary foods ♦ **For what foods to advise, consult problem No 2**
5 Child does not want to eat complementary foods	♦ Offer the child its most favourite food ♦ Play with the child or distract him while feeding ♦ If ill child may be fussy mother will have to be more patient and persistent while feeding the child
6 Child spits out the food given	♦ Do not place the food on tip of the tongue ♦ All children will spit out the food if placed on tip of the tongue ♦ Place the food inside the mouth
Age group 12 months up to 2 years	
1 Child is not actively fed	♦ Mother or somebody in the family who is responsible should feed the child ♦ The food for the child should be separate from rest of the family ♦ Some food should be left behind when the child has finished the meal
2 Child does not take family foods	♦ Make sure that family foods like dal vegetable meat eggs rice are soft and mashed ♦ Do not add any chilies or spice in the child's serving ♦ Offer what the child likes ♦ Give snacks (biscuit chikki besan laddoo chiku fried potato)
Age group 2 years up to 5 years	
1 Child is not hungry	♦ Determine the most favourite food and offer it ♦ Give snacks the child likes (biscuits chana ground nut chikki besan laddoo chiku fried potato) ♦ Increase the frequency of food to more than 5 times daily if the child cannot eat enough at one meal
2. Child is not actively fed	♦ **Refer to the age group 12 months up to 2 years (problem No 1)**
3 Family is poor and cannot give snacks between meals	♦ Get snacks from Anganwadi centre and give to the child ♦ Increase the frequency of family foods to 5 times per day instead of 3 times
4 Child is under nourished	♦ Increase the food amount by 2 tea spoons at every meal ♦ Give foods which are thick and have oil added ♦ Give food more often ♦ Include snacks (procured from Anganwadi Centre or biscuits chikki chana ground nut laddoo panjiri fried potato seasonal fruit) in between 3 meals

Developed by WHO, CARE, GOI

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Annex 21

Immunization

MOH IMMUNIZATION PROTOCOL

- [illegible] in all districts to achieve the goal of neonatal tetanus elimination and at least 90% reduction in the incidence of measles by 1995. By the end of 1997 all districts must become polio free zones.

4 STRATEGY

4.1 The strategy of the Immunization Programme is to make routine immunization services available on a regular basis on fixed days at readily accessible fixed sites. A cancellation of an immunization session is a breach of trust with the community and should be avoided at all costs. Sessions on an unscheduled day should be held only in case of an emergency such as an outbreak or for conducting supplementary activities for polio eradication. The community should be informed of these sessions in advance.

4.2 All health facilities will provide immunization services on fixed days. The periodicity of the services (daily, weekly, fortnightly or monthly) will depend on the number of children immunized in these centres. Outreach visits will be made to all large villages at least once a month by the ANM of the subcentre covering these villages. The place of the immunization site in the village should be fixed.

4.3 Efficacy of the vaccines in preventing disease is optimal if the full course of the potent vaccine is given at the right age. Efforts would be made to start the immunization of children at 6 weeks of age and complete the three doses of OPV and DPT by 14 weeks or as soon as possible, thereafter. Measles vaccine is to be given between 9-12 months. It will be aimed to cover all infants before they reach their first birthday. Children born in the institutions will be given a dose of BCG and OPV before discharge. The dose of OPV '0 dose' will be additional and the primary series of three doses will start at 6 weeks of age.

Older unimmunized children will be given vaccines ON DEMAND if brought to the sessions. Older children in high risk pockets may be vaccinated in anticipation of an outbreak or during the supplementary activities for polio eradication.

4.4 Minor illnesses, including mild fever, coughs and colds as well as malnutrition, are not a contra-indication to immunization. Immunization should be deferred only if the children are seriously ill or have high fever as any aggravation in the condition of the child may be attributed to immunization. The children should, however, be immunized as soon as they recover. The longer the immunization is delayed the longer the child is exposed to the risk of infection. Case fatality rates, especially following measles, are high in malnourished children. In case of history of convulsions DT vaccine should be given in place of DPT vaccine. All vaccines can be given to a child with diarrhoea. The dose of OPV should, however, be repeated during the next immunization session.

MALNUTRITION, LOW GRADE FEVER, MILD RESPIRATORY INFECTIONS, DIARRHOEA AND OTHER MINOR ILLNESSES ARE NOT A CONTRA-INDICATION TO IMMUNIZATION

4 5 All the vaccines will be available at an immunization session and the child should not be made to return due to non-availability of any vaccine A child can be given more than one vaccine at the same session, such as DPT and OPV If vaccines are being given by injection such as BCG and DPT or DPT and measles, the sites of the injections should be different The vaccines should be injected by using a separate sterile syringe and needle for each injection

4 6 Vitamin A should be given along with measles vaccine at 9 months of age If the schedule for OPV has not been completed, a dose of OPV can be given at the same time along with vitamin A solution

NATIONAL IMMUNISATION SCHEDULE	
FOR PREGNANT WOMEN	
❖ Early in Pregnancy	TT-1 or Booster
❖ One month after TT-1	TT-2
FOR INFANTS	
❖ At birth *	BCG and OPV-0 dose
❖ At 6 weeks	BCG DPT-1 and OPV-1
❖ At 10 weeks	DPT-2 and OPV-2
❖ At 14 weeks	DPT-3 and OPV-3
❖ At 9 months	Measles
❖ At 16 - 24 months	DPT and OPV
❖ At 5-6 years	DT
The second dose of DT should be given at an interval of one month if there is no clear history or documented evidence of previous immunization with DPT	
❖ At 10 and at 16 years	TT
The second dose of TT vaccine should be given at an interval of one month if there is no clear history or documented evidence of previous immunization with DPT, DT or TT vaccines	

* For Institutional Deliveries

4 7 If the sessions are held regularly, quality of the services are satisfactory, mothers informed of the immunization schedule the attendance at the immunization sessions are likely to be in the estimated range. If fewer than expected number of children turn up for any session

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vaccine vials should be opened and the children immunized. Children should not be returned unimmunized to keep 'wastage rates' of vaccines low. If the attendance is routinely low, reasons for poor acceptance of services should be identified and corrected.

5 ROLE OF MEDICAL OFFICERS

5.1 The medical officers of the PHCs must ensure universal immunization of children in their areas and must monitor the programme to sustain quality of services

5.2 The medical officers must also ensure that the distribution of essential supplies are regular and that all subcentres have adequate supplies. Sufficient number of syringes and needles should be available at each subcentre

5.3 They must provide additional assistance to pockets of low coverage. The type of assistance will depend on area-specific problems. If the low coverage is due to a long-term vacancy, special immunization camps may have to be organized by mobilizing resources from other areas. If the coverage is due to poor acceptance of services, IEC activities may have to be stepped up

5.4 The PHC medical officer must also monitor performance and analyze surveillance reports

5.5 The peripheral health staff must receive support from the medical officer if there is any adverse reaction following immunization. Monitoring of adverse events following immunization is important to detect programmatic lapses. Adverse events should be reported and investigated immediately. Serious adverse events including death following immunization must be reported within 24 hours. Other children vaccinated in the session should be examined to check for reactions and to provide treatment, if required. Cluster of cases (more than one case) is expected if the reaction was due to a programmatic error. Clustering of cases can also occur if the cause of the symptoms was due to incidental causes such as an infection. Other non-immunized children of the same age-group in the neighbourhood of the affected child should also be examined to rule out temporal relationship between reported adverse effect and immunization

5.6 The vaccine issue register must be checked periodically to ensure that the vaccines are being taken out only on scheduled days. The temperature record forms of the ILR and the freezer must be checked weekly

5.7 **Medical Officers must ensure**

- Universal immunization coverage to all infants starting at 6 weeks of age or as early as possible thereafter
- That the children receive full course of the vaccines by reducing dropout rates

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II ERADICATION OF POLIOMYELITIS

1 Among the vaccine preventable diseases poliomyelitis is a well recognized and feared disease in the community due to the atrophy of the affected muscles that results following the disease Prior to the immunization programme poliomyelitis was the cause of lameness in two out three children with the physical handicap

2 Poliomyelitis is caused by three types of polio viruses Type I polio virus is predominantly isolated in children with paralysis It is estimated that for every child with paralytic poliomyelitis, at least 100 other children are affected who have either no symptoms or have only non-specific symptoms of a mild illness These children also excrete polio viruses and contaminate the environment Man is the only host for polio viruses

3. Oral polio vaccine is effective in preventing poliomyelitis Many countries have successfully become polio free zones by immunizing all susceptible children through high immunization coverage levels and by eliminating foci of infection by organizing supplementary activities in addition to sustaining high levels of immunization coverage In 1993, 141 countries reported zero cases to the WHO, including 106 countries which reported zero cases for three consecutive years The World Health Assembly in May 1988 adopted the goal of global eradication of poliomyelitis by the year 2000 The goal of polio eradication means not only the absence of clinically identifiable cases of poliomyelitis, but also the elimination of the wild polio viruses from the environment so that future generations are free of the risk of the disease without immunization

4. Oral polio vaccine provides immunity to vaccinated children The viruses in the vaccine also multiply in the gut and are excreted in the environment This ability of the vaccine viruses to multiply in the guts of the children is used in the strategy for 'mop-up' rounds By immunizing close to 100% susceptible children in an area, wild polio viruses which cause paralytic poliomyelitis, are replaced by vaccine viruses The larger the number of children immunized and the larger the size of the area covered, the higher the likelihood of the replacement of the wild viruses Also, all pockets of 'high-risk' in the PHC area or the district should be covered, otherwise foci of infection will remain with the potential of spread to the areas where the 'mop-up' rounds have been successfully conducted The mop-up rounds are in addition to, and not a substitute to routine immunization services

5. Since the purpose of these rounds is to replace the wild polio viruses with the vaccine virus the effectiveness of the rounds increases if these are conducted in the low transmission season (months during which the number of reported cases is minimum) In India the number of cases start increasing from May to October, with a peak in July - August The mop-up rounds should be organized before or after the seasonal peak during the period October to April The organization of the rounds therefore require careful

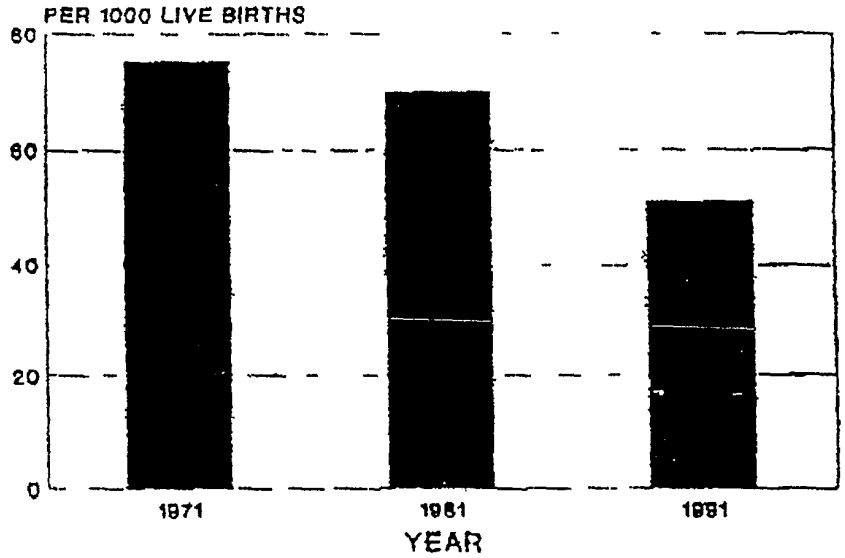
VIII NEONATAL TETANUS ELIMINATION

1 Prior to the national immunization programme an estimated 0 35 million children died annually due to neonatal tetanus The baseline surveys conducted in 1981 confirmed that 25 to 33% of neonatal deaths were due to tetanus The problem of neonatal tetanus is usually under-estimated as the children die within a few days of birth often without being brought for treatment Unless there is active surveillance, deaths due to neonatal tetanus may not be recorded or reported

2 Two doses of TT vaccine, at an interval of one month, provide adequate protection against tetanus If there is history of previous immunization, one dose (booster) is sufficient However, in case of any doubt, two doses should be given Pregnant women are immunized to protect them and the newborns against tetanus Immunization should not be delayed. The first dose is given at the first contact during pregnancy and the second after an interval of one month The last dose should be given at least one month before the expected date of delivery

3 In 1993-94, 81% of the pregnant women were immunized, although there was a wide variation between states and within districts 44% of the deliveries in 1990 were either institutional or by trained personnel, while 56% were conducted by untrained personnel In Rajasthan, Madhya Pradesh, Bihar, Orissa, Assam and Uttar Pradesh more than 70% of the deliveries were by untrained personnel

NEONATAL MORTALITY RATE



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'Iv CONTROL OF MEASLES

1 All children are susceptible to measles infection unless protected by immunization Measles has a wide range of clinical severity In malnourished children, case fatality rates of post-measles complications are high if appropriate treatment is not started early after the onset of symptoms Deaths due to measles are preventable by immunization between 9 to 12 months of age and by appropriate and early treatment of post-measles complications

2 One dose of measles vaccine provides life-long immunity Since the median age for measles infection is around 24 months of age, it is important that children receive measles vaccine at 9 months of age or as soon as possible thereafter and are immunized before they are exposed to the risk of infection Coverage with measles vaccine has increased from 1 3% in 1985-86 to 86 9% in 1993-94 The rapid increase in measles immunization coverage levels has saved many lives However, each year about 15% of the 25 million infants or 3 75 million children remain unimmunized and are potentially at risk of measles infection

3 As a result of the vaccination programme the reported incidence of measles has declined substantially The reported average annual number of 179,000 cases during the period 1985-89 has declined to around 80,766 during the period 1990-93 According to provisional data for 1993, 63409 cases have been reported A 75% decline in the incidence of measles has been recorded in 1993 as compared to 252940 cases reported in 1987

4 Measles immunization coverage levels, although relatively high, are not uniform with wide variations between the states and the districts Within districts, the unimmunized children are clustered in pockets of 'high-risk such as urban slums, peri-urban areas and remote, difficult to approach rural areas Some districts are yet to reach high coverage levels These areas are at risk of measles outbreaks Although reports of large outbreaks of measles are becoming increasingly rare, several relatively small outbreaks were reported in the last few years, largely in the tribal and remote areas Case fatality rates are generally much higher during outbreaks than the average rates due to relative inaccessibility to health facilities and other socio-economic factors Anticipatory action taken in the high risk pockets can minimize the risks of outbreaks and reduce mortality rates Early identification of outbreaks is also important in controlling the spread of the outbreak and in minimizing mortality rates

5. The treatment facilities and the health staff must immediately report any sudden increase in cases Even a single case from far-flung, difficult to approach and tribal areas should be treated as an outbreak and necessary investigations and follow action must be initiated immediately to prevent deaths due to measles

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VI THE COLD CHAIN SYSTEM

1 INTRODUCTION

1 1 The cold chain is a system of transporting and storing vaccines at recommended temperatures from the manufacturer to the point of use The cold chain is essential as vaccines lose their potency if exposed to temperatures above 8°C Once the vaccines lose their potency, it cannot be restored even if these are put back in the refrigerator

1.2 The loss of potency is dependent on the temperature and the duration of exposure At high temperatures, even short periods of exposure can be detrimental to the vaccines Vaccines are also sensitive to direct sunlight

1 3 During the transportation of vaccines there are a large number of levels and personnel involved in the cold chain system A break in the chain at any level will affect the vaccines

1 4 Vaccines also have a limited shelf life and must be used within the expiry date Large stocks should not be maintained in the peripheral health facilities and the principle of first-in first-out' should be followed

1 5 It is essential that the equipment are handled properly and the preventive maintenance is undertaken from time to time Equipment which are used properly, function for a longer time However, in anticipation of a breakdown of the equipments, contingency arrangements for storing vaccines must be made

1.6 Since the vaccines must be kept at temperatures between 2 to 8°C (or below for some vaccines), the proper storage, handling and transportation of the vaccines is critical for the success of the immunization programme

2. VACCINE REQUIREMENT

2.1 Estimation of vaccine requirement at various level is essential for proper implementation of the programme This will help to indent the right quantity so that there is no over or under stocking and that no session is cancelled due to shortage of vaccines While calculating the requirement following factors are to be considered

- number of beneficiaries
- number of doses of each vaccine
- wastage multiplication factor
- number of sessions

For example, in a PHC with a population of 30,000, birth rate of 29/1000 population, estimated beneficiaries would be

β MONITORING VACCINE SUPPLY AND UTILIZATION

3 1 It is essential that vaccine issue is regularly monitored to see that the vaccines are issued on the day of session and that the vaccines issued tally with the estimated number of beneficiaries likely to attend the session Monitoring of vaccine utilization will help to assess service delivery

FOLLOW FIRST-IN FIRST-OUT RULE
Vaccines received earlier or with short expiry date should be used first

3 2 Vaccine utilization should be periodically tallied with the number of children immunized If a subcentre reports high vaccine utilization rates, further investigation should be done to rule out

- false reporting of immunization performance
- reuse of opened vials of vaccines
- duplication of reported performance

3 3 Vaccines should be issued only in cold chain

3 4 Vaccine stock and issue register must be kept up to date

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- ☐ [illegible] immediate action if the equipments f[illegible]
- ☐ [illegible] kept in cartons make holes on the [illegible] or cold air [illegible] circulate

DONTs

- ☐ Do not keep any object on these equipments
- ☐ Do not store any other drug
- ☐ Do not open unless necessary
- ☐ Do not keep food or drinking water in them
- ☐ Do not keep more than one month's requirements at PHC level and 3 months requirement at district level
- ☐ Do not keep date expired vaccines

RECORDING AND MONITORING OF STORAGE TEMPERATURE

Temperature of the ILR and the Deep Freezers should be recorded twice a day This is done to ensure that at no time the temperature has risen above 8°C of has fallen below 2°C Therefore it is necessary to adjust the thermostat in different seasons so that the temperature is maintained within prescribed limits

4.4 Cold Boxes

Adequate numbers of Cold Boxes have been supplied to all peripheral centres These are mainly to be used for transportation of vaccines In emergency they can also be used to store vaccines Before the vaccines are placed in the cold boxes fully frozen ice packs should be placed at the bottom and sides The vaccines should be placed in cartons or polythene bags and then placed in the cold box Cover the vaccines with a layer of fully frozen ice packs and close the cold box The vials of DPT, DT and TT vaccines should not be placed in direct contact with the frozen ice packs

4 5 Vaccine Carriers

Vaccine Carriers are used to carry small quantities of vaccines (16-20 vials) for the outreach sessions 4 fully frozen Ice packs are to be used for lining the sides and the carrier must be closed tightly The vials of DPT, DT and TT vaccines should not be placed in direct contact with the frozen ice packs

4 6 Day Carriers

Day carriers are used for carrying small quantities of vaccines (6-8 vials) to a near by session Two fully frozen ice packs are to be used Day carriers are can maintain the temperature for for a few hours only and hence vaccines in day carrier should be only issued on the day of immunization

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5 1 Checklist for Preventive Maintenance

A External	
1 The exterior is clean	
2 It is firm on the floor	
3 It is properly levelled	
4 Its sides are atleast 10 cm away from walls	
5 It is away from direct sunlight	
6 Room is well ventilated	
7 It is opened only when necessary	
B Internal	
1 Lid seals properly without gap	
2 Lid seal is clean	
3 Ice lining tubes/ice packs are in proper position	
4 Ice lining tubes/ice packs filled water to proper level	
5 Thickness of frost formation is less than 6 mm	
6 Vaccines are neatly placed with space for air circulation	
7 DPT,TT and DT are kept in the basket in the ILR and not touching the cooling surface	
8 Thermometer has been kept among the vaccines	
9 Temperature is recorded twice a day	
C Technical	
1 Temperature within prescribed limit (if not set the thermostat)	
2 Voltage stabilizer is working properly and equipments are connected through it	
3 Plug of the voltage stabilizer is fitted properly to the power line	
4 Connection of equipments to voltage stabilizer are not lose	
5 There is no abnormal noise	
6 Compressor mounting bolts are tight	

5 2 Defrosting and Cleaning

The temperature in the ILR/Deep Freezer can rise if there is a thick layer of ice on the walls or at the bottom Therefore periodically defrosting should be done if the layer of frost is more than 6mm

- Vaccines need to be shifted to cold boxes which has already made ready by lining the walls and bottom with frozen ice packs
- Incase of deep freezer shift the frozen ice packs to cold box

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When administering vaccine to expectant mothers and infants at the site of immunization care must be taken not to expose the vaccines to heat or direct sunlight To do this the health workers must be instructed

- Select a site that is cool as possible preferably inside a room If a room is not available carry out immunization in the shade and not in direct sun
- Open the carrier only when necessary
- Remove vaccine and diluent from the vaccine container ONLY when you need it
- Take out only one vial of vaccine from the container at a time Do not take the second vial from the carrier until it is needed
- Secure the lid tightly after opening as soon as possible
- Wrap the BCG ampoule in a foil or a dark paper to protect them from heat and light
- When vaccine is taken out of the vaccine carrier, vials must be placed on an ice pack If no mothers or children are waiting vials must be put back into the vaccine carrier until a beneficiary arrives

Records on vaccine use must be updated regularly A record of the vaccines administered must be kept It is important to record the batch numbers and expiry dates of the vaccines used If any vaccine is returned to the PHC the reasons for non use must be ascertained and corrective action taken There should be no reason for returning of unopened vials from the outreach sessions if the sessions are well planned and vaccine issue is based on the estimated number of beneficiaries likely to attend the session If such vials have been returned in cold chain, these vial should be used first If there is any doubt about the quality of the reverse cold chain **DO NOT** use the vial

6 2 PHC Level

Vaccines are delivered to the PHC from the district stores It is best that vaccines be supplied at regular monthly intervals This is because a **PHC MUST NOT HOLD MORE THAN ONE MONTH'S STOCK NO VACCINE SHOULD BE STORED AT THE SUB-CENTRES.**
Vaccine requirements must be estimated so that every infant and pregnant women is immunized, and that adequate supplies are available

It is important that the right quantity of vaccine is indented Too little vaccine will result in poor performance If too much vaccine is obtained, some of them may expire or it may remain for a longer than the recommended time The longer the vaccines are kept at the PHC, the greater is the risk of a cold chain failure

WHILE DISTRIBUTING VACCINES FROM THE DISTRICT STORE

- Choose cold box of appropriate size In general a cold box (5 litres)

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(12

carrier to accommodate one month's supply of PHC of 40 to [illegible] population and a cold box (20 litres) for CHC for 1 lakh population

- ☐ Check that the types and amount of vaccine and diluent are the same as indented
- ☐ No vaccines beyond expiry date is to be issued
- ☐ Pack the vaccine in a cold box quickly to avoid exposure to heat and light Diluent need not be kept in a cold box
- ☐ Use the shortest route to the health centre
- ☐ Transfer vaccines to ILR immediately on arrival at the health centre

WHILE DISTRIBUTING VACCINES FROM THE PHC STORE

While the vaccines are issued it is important to check the indent to ensure that the demand is based on the estimated beneficiaries likely to attend the session This will cut down the wastage rate and that the health worker would not have to come back to the PHC to return unused vials

- ☐ Vaccines with nearest expiry date should be issued first
- ☐ Vaccines supplied earlier should be issued first
- ☐ Date expired vaccines should not be issued
- ☐ Check that DPT DT or TT vaccines have not been frozen If these have been frozen, do not use them You can confirm the shake test Shake the vial so that the sediment is completely mixed into the vial If the vaccine is not uniformly mixed, or the sediment settles down at the bottom of the vial completely within 15 minutes, then do not use it
- ☐ Diluent must be kept in ILR and issued to the field in Vaccine Carriers
- ☐ The diluent should not be frozen as the ampoule are likely to crack when frozen
- ☐ For the same reasons BCG ampoule should not be frozen
- ☐ The ice packs used for lining the vaccine carriers should be fully frozen

7. MONITOR COLD CHAIN AND USE OF VACCINES

It is essential to regularly monitor cold chain for effective and efficient implementation of the programme

You will need to monitor

- ☐ Supplies
- ☐ Storage temperature
- ☐ Potency tests

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7 1 Supplies

Regular and smooth flow of vaccines and their proper utilization will help to distribute vaccines evenly to all units Care must be taken to see that there are no over stocking at peripheral units The PHCs are not to keep vaccines more than the requirement for one month Similarly district should only keep stock for three months

The vaccines supply should be based on the estimates, demand and utilization This information can be easily be obtained from the monthly monitoring format

Physical check of vaccine stock during supervisory visits should be made It is necessary to see that the records are properly maintained

The stock register should be checked in order to assess

- Whether more vaccines are issued than estimated for the session,
- If vaccines have been issued more than 1 day prior to the session,
- Whether all the antigen were available and issued

7 2 Storage Temparature

Temperature of ILR/Freezer should be recorded twice daily This should be done by the identified person responsible for storage and issue of vaccine The Medical Officer should check the record regularly The break in the cold chain is indicated if temperature rises above +8°C or falls below +2°C

7.3 Potency Tests

Of all the vaccines OPV is the most thermolabile and the potency can be checked by relatively simple laboratory tests The potency of OPV at the point of use and at various storage points has been taken as indicator of the quality of cold chain

The samples should be collected in vaccine carrier with fully frozen ice packs and rushed to the assigned laboratory

If delay is anticipated in transmitting the samples for testing, such samples should be kept in the ILR It is critical the reverse cold chain at a temperature between 2°C - 8°C is maintained during the transportation of the sample from the site of collection to the laboratory

Facilities for OPV potency testing are currently available at the following centres

1 Central Research Institute, Kasauli, H P
2 National Institute of Communicable Diseases, Delhi
3 Enterovirus Research Centre, Bombay
4 School of Tropical Medicine Calcutta
5 B J Medical College, Ahmedabad
6 Institute of Preventive Medicine Hyderabad

Annex 22

BALLIA RURAL INTEGRATED CHILD SURVIVAL PROJECT

Appropriate timely logistics for 3 PHCs in Beruar Beri Block

1 Obstetric bed
2 Suction machine (low pressure)
3 Operating lamp
4 Thermometer for monitoring vaccine temperature
5 Minor surgical set
6 Sterilizer
7 Vaginal speculum
8 Baby scale
9 Salter scale
10 Otoscope

Supplies

a Vitamin A for postpartum mothers
b Iron folate tablets
c Cotramoxazole
d Vaccine monitoring temperature chart
e RCH cards
f Tongue depressor

BALLIA RURAL INTEGRATED CHILD SURVIVAL PROJECT

Supplementary equipment for 17 Sub-Centers

1 High pressure steam sterilizer (Cooker)
2 Blood pressure set
3 Stethopscope
4 Fetoscope
5 Weighing scale for newborns
6 Long forceps
7 Gloves
8 Baby scale
9 Obstetric bed
10 TBA kit

Supplies

a Vitamin A
b Iron folate tablets
c Cotromoxazole
d Deworming medicines
e Thermometers
f RCH cards
g Pregnancy tracking forms
h Conctraceptive supplies

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MOTHER AND CHILD CARE CARD

जच्चा-बच्चा रक्षा कार्ड

II-III दूसरे से तीसरे साल तक (12-36 महीने)

II-III Second to third year (12-36 months)

Date तिथि	Date तिथि	Date तिथि
डी पी टी ब DPT. (B)	पोलियो ब Polio	विटामिन ए 2 Vitamin A-2
Date तिथि	Date तिथि	Date तिथि
विटामिन ए 3 Vitamin A-3	विटामिन ए 4 Vit-A-4	विटामिन ए 5 Vit-A-5

क्रम सख्या Serial Number

जच्चा का नाम Name of ~~child~~ mother

पति का नाम Husband's Name

शिशु होने की सम्भावित तिथि Expected date of delivery

घर न० House No. गाँव/वार्ड Village / ward

पी एच सी /नगर PHC / Town

उप केन्द्र/क्लिनिक Subcenter / clinic

शिशु का नाम Name of child

लडका/लडकी male / female जन्म तिथि Date of birth

This part of card will remain with Health Worker.

● कार्ड का यह भाग स्वास्थ्य कार्यकर्ता के पास रहेगा।

स्वास्थ्य कार्यकर्ता के हस्ताक्षर

Signature of Health Worker

कार्ड यहाँ से अलग करें Remove card from here

II - III second to third year (12-36 months) MOTHER AND CHILD CARE CARD

II-III दूसरे से तीसरे साल तक (12-36 महीने)

Date तिथि	Date तिथि	Date तिथि
डी पी टी ब DPT (B)	पोलियो ब Polio (B)	विटामिन ए 2 Vit A 2
Date तिथि	Date तिथि	Date तिथि
विटामिन ए 3 Vit-A-3	विटामिन ए 4 Vit A-4	विटामिन ए 5 Vit A-5

उचित टीकाकरण सूची

गर्भवती महिलाओं को – For pregnant mothers	
गर्भावस्था में जितनी जल्दी हो सके As soon as possible during pregnancy	टेटनस 1 का टीका TT, Vaccine
टेटनस 1 के 1 माह बाद	टेटनस 2 या बूस्टर का टीका TT2 Vaccine or booster
बच्चे के लिए – For child	
1½ माह पर on 1½ month	बी सी जी व डी पी टी 1 के टीके और पोलियो 1 की खुराक
2½ माह पर 2½ month	डी पी टी 2 का टीका और पोलियो 2 की खुराक
3½ माह पर 3½ month	डी पी टी 3 का टीका और पोलियो 3 की खुराक
9 माह पर 9 month	खसरे का टीका measles Vaccine
16 से 24 माह के बीच में between 16-24 months	डी पी टी और पोलियो की बस्टर टीका/खुराक DPT and Polio booster Vaccine dose

- यदि किसी टीके/खुराक के लिए आपको देरी हो जाए, तो भी आप इसे जरूर लगवाइये। इस विषय में आप अपने स्वास्थ्य कार्यकर्ता से सलाह लें।
- इस कार्ड को अपने पास सभाल कर रख।
- आप जब भी स्वास्थ्य केंद्र आये, इस कार्ड को अपने साथ जरूर लाए।
- टीकाकरण के बाद इस कार्ड मे टीके/खुराक लेने की तारीख जरूर दर्ज करवाएँ।
- * यदि बच्चे का जन्म अस्पताल/क्लिनिक मे हुआ है, तो उसे ज म के समय ही बी सी जी का टीका लगाएँ।
- ● कार्ड का यह भाग जच्चा/बच्चे की माँ के पास रहेगा।

कार्ड यहाँ से अलग करें Remove card from here

जच्चा-बच्चा रक्षा कार्ड

क्रम सख्या Serial Number

जच्चा का नाम Name of ~~child~~ mother

पति का नाम Husband's Name

शिशु होने की सम्भावित तिथि Expected date of delivery

घर न० House Number गाँव/वार्ड Village / ward

पी एच.सी/नगर PHC / Town

उप-केन्द्र/क्लिनिक Subcentre / clinic

शिशु का नाम child's Name

लड़का/लड़की male / female जन्म तिथि Date of birth

राष्ट्रीय टीकाकरण मिशन

भारत सरकार

National Vaccination Mission Indian govt

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CHECK UP/CARE DURING PREGNANCY AND VACCINE DETAILS

गर्भावस्था मे जॉच और टीकाकरण का ब्यौरा

स्थिति Date तिथि	स्थिति Date तिथि	स्थिति Date तिथि
Visit 1 जाच 1	Visit 2 जॉच 2	Visit 3 जॉच 3
Date तिथि	Date तिथि	Date तिथि
Iron आयरन	आयरन Iron	आयरन Iron
Date तिथि	Date तिथि	
TT_1 टेटनस 1	टेटनस 2 (बूस्टर) TT_2 (Booster)	

- गर्भवती महिला को स्वास्थ्य कार्यकर्ता से मिलकर अपने स्वास्थ्य की नियमित जाच कराते रहना चाहिए।
- याद रह गर्भावस्था में, टेटनस के दो टीके अथवा टेटनस का 1 बूस्टर टीका लगवाना और तीन महीनों में आयरन की 100 गोलिया लेना बहत जरूरी है।
- याद रखिए कि टेटनस 2 (बूस्टर) का टीका शिश होने की सम्भावित तिथि से कम से कम 1 माह पहले दिया जाना चाहिए।

NATIONAL VACCINATION MISSION
राष्ट्रीय टीकाकरण मिशन
भारत सरकार
INDIAN GOVERNMENT

CHILD CARE VACCINE DETAILS

शिशु रक्षक टीको का ब्यौरा

I पहले साल में (0-12 महीने)
I in first year (0-12 months)

Date तिथि		
BCG बी सी जी		
Date तिथि	Date तिथि	Date तिथि
DPT_1 डी पी टी 1	DPT_2 डी पी टी 2	डी पी टी 3 DPT_3
Date Polio 1 तिथि	Date Polio 2 तिथि	Date Polio 3 तिथि
पोलियो 1	पोलियो 2	पोलियो 3
Date तिथि	Date तिथि	
Measles खसरा	और विटामिन ए।	Vit A 1

- सभी टीके सही समय पर लगवाएँ और उन्हे यहा दर्ज करवाएँ।
- याद रखिए, डी पी टी और पोलियो की हर टीका/खराक के बीच में एक महीने का अतर होना चाहिए।

स्वास्थ्य कार्यकर्ता के हस्ताक्षर
Signature of Health Worker

राष्ट्रीय टीकाकरण मिशन
भारत सरकार

कार्ड यहाँ से अलग करें

CHECK UP/CARE DURING DELIVERY AND VACCINE DETAILS

गर्भावस्था मे जॉच और टीकाकरण का ब्यौरा

Date तिथि	Date तिथि	Date तिथि
जॉच 1 Visit 1	जाच 2 Visit 2	जॉच 3 Visit 3
Date तिथि	Date तिथि	Date तिथि
Iron आयरन	Iron आयरन	आयरन Iron
तिथि	तिथि	
टेटनस 1 TT_1	टेटनस 2 (बूस्टर) TT_2 (booster)	

DETAILS OF CHILD CARE VACCINES

शिशु रक्षक टीकों का ब्यौरा

I पहले साल में (0-12 महीने)
I in first year (0-12 Months)

Date तिथि		
बी सी जी BCG		
Date तिथि	Date तिथि	Date तिथि
डी पी टी 1 DPT 1	डी पी टी 2 DPT 2	डी पी टी 3 DPT 3
Date तिथि	Date तिथि	Date तिथि
पोलियो 1 Polio 1	पोलियो 2 Polio 2	पोलियो 3 Polio 3
तिथि	तिथि	
खसरा	और विटामिन ए।	
measles	and Vit A-1	

राष्ट्रीय टीकाकरण मिशन
भारत सरकार

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Annex 24

INFANT FEEDING

1 EXCLUSIVE BREASTFEEDING

Breastmilk is the ideal food for the newborn child It contains all the nutrients that a child needs. It also contains sufficient amounts of water so that a child does not require anything else, **including water,** upto the age of 4 months Exclusive breastfeeding protects children from infections including diarrhoea and pneumonia in early infancy **Exclusive breastfeeding can save many lives by preventing malnutrition and reducing risks of infections during early infancy when fatality rates are high** No child should be denied the benefit of exclusive breastfeeding due to lack of information to the mother

1 1 What is Exclusive Breastfeeding

Exclusive breastfeeding means that except for breast milk no other food or fluids, including water and prelacteal feeds, should be given to a child from birth to 4 months

Breast milk has enough water in it to meet the hydration requirements of babies under 4 months of age even in hot and dry conditions

Feeding anything other than breastmilk [illegible] unnecessary but is also harmful It decreases milk flow and increases risk of infections

1 2 When to Start Breastfeeding

Breastfeeding should be initiated within the first hour of birth It should be given frequently and on demand

It is important that the baby gets the initial breastmilk called colostrum as the first feed Colostrum is rich in nutrients including vitamin A and also contains antibodies to protect the child against infections Giving colostrum has been called the 'first immunization' of the child

1 3 Advantage of Breastfeeding

- **Breastmilk is the ideal food for young infants**
  It contains all the nutrients needed for the first 4 months of life

- **Prevents malnutrition**
  Mothers produce enough milk for adequate nutrition of their babies In exclusively breastfed babies chances of undernutrition are rare

- **Protects Against Infections**
  Breastmilk is clean and free from bacteria It contains protective antibodies and other anti-infective factors which help to fight infection During the first six months of life, the risk of having diarrhoea requiring hospitalization can be 30 times greater for non breastfed babies than for those who are exclusively breastfed

- **Bonding**
  Breastfeeding creates a close bond between a mother and the child and helps in the emotional, intellectual and social development of the child

- **Benefits to the Mother**
  Exclusive breastfeeding has contraceptive effect in the first 4 months after delivery Other benefits to the mother include early involution of uterus and protective effect against breast and ovarian cancer

1 4 Role of Medical Officers

Majority of mothers in our country breastfeed However, lack of knowledge or misconceptions about the quantity and quality of breastmilk leads to unwarranted top feeding As a medical officer it is your duty to advise mothers about the benefits of breastfeeding

Mothers must be assured that they are capable of providing adequate milk for the growth of their babies and that true lactation failure is rare The best stimulus of successful lactation is frequent suckling by the baby The baby should take the areola and nipple into the mouth and should not suck only from the nipple When breastfeeding is done in correct position the baby takes slow deep sucks and there is audible swallowing and it causes no pain to the mother

Feed the baby on one breast initially so that it gets the benefit of energy rich hind milk Alternate the breast for subsequent feeding [illegible] baby gets older she may need to suck from both the breasts

Contact with the women during the antenatal period and immunization sessions provides you with an opportunity to advise them regarding the benefits of exclusive breastfeeding

During Antenatal check up

- ✓Inform about benefits of exclusive breastfeeding
- ✓Encourage the mother to eat extra food and take rest
- ✓Promote and monitor intake of IFA tablets
- ✓Examine breast and nipples

After Delivery

Put the child to the breast within the first hour of birth
Ensure feeding of colostrum
Discourage prelacteal feeds
Do not give any fluids including water
Demonstrate correct positioning
Assure anxious mothers
Encourage frequent feeding on demand

During immunization sessions (at the time of giving the three doses of DPT and OPV)

Confirm exclusive breastfeeding
Provide help, if there is any practical problem
Give advice about weaning

In the rare instances when breastfeeding is not possible like death or severe illness of the mother, undiluted cow, buffalo or dairy milk can be used. In such cases feeding should be done with a cup and spoon Children who are fed with animal milk need to be given water, which has been previously boiled and cooled, in between feeds Even very small children learn to drink from a spoon Bottle feeding should be strongly discouraged as it increases the risk of infections

BOTTLE FEEDING SHOULD BE STRONGLY DISCOURAGED

1 5 How Long should Exclusive Breastfeeding be Continued

Exclusive breastfeeding should be practised for at least first four months After this age, semi solids (weaning) must be started Breastfeeding must also be continued for as long as possible but preferably until the baby is at least 1 to 2 years old

1 6 Normal Weight Gain

It is important to monitor the weight for assessing whether the baby is getting adequate nutrition

- A normal newborn looses weight in the first few days after birth This loss of weight is regained by the 10th day
- The expected weight gain of the baby is

During the first 3 months	200 gms per week
During the next 3 months	150 gms per week.

BABY DOUBLES BIRTH WEIGHT BY 5 TO 6 MONTHS AND TREBLES IT BY 1 YEAR

- Weight increases by 2 5 kg per year between 1-2 years and by 2 kg per year between 3 to 5 years

Breast milk alone is not enough to meet the nutritional requirements of the baby after 4 to 6 months of age At this time semi solids should be added to the diet of the infant Breastfeeding, however, must be continued for as long as possible Adequate weight gain in the first year of life is very important for the future healthy growth of the child

2 ADDITION OF SEMI SOLIDS (WEANING)

Weaning is the process of gradual and progressive transfer of the baby from breastmilk to the usual family diet **Weaning does not imply discontinuation of breastfeeding.** Delayed or improper weaning results in malnutrition which predisposes the infants to higher risk of infections and mortality

2 1 When to Start Weaning

[illegible] of exclusive breastfeeding it is essential to add semi solids in the diet of the baby as after this age breastmilk alone may not satisfy all her nutritional needs If at this age, weaning is not introduced the baby will not gain weight adequately

The period between 6 months to 2 years of age is critical for the healthy growth of the child Children are often not given the right type and full amount of food even when it is available in the house due to lack of information with the mother Malnutrition which is common in this age group can be prevented to a large extent by informing the mother of the need to feed the children semi solids frequently and in sufficient amounts Every contact with the health personnel should be utilized for this purpose as malnutrition predisposes the children to higher risk of infections

2 2 What is a Good Weaning Food

In babies the stomach capacity is very small A good weaning food should therefore provide as many calories as possible in small volumes

DESIRABLE QUALITIES OF WEANING FOODS

- High in energy density
- Easy to digest
- Semisolid in consistency
- Low in bulk and viscosity(not too thick)
- Fresh and clean
- Affordable and easy to prepare
- Culturally acceptable

Weaning foods should not be excessively diluted (example dal water) This reduces the energy density of the food Small babies can easily tolerate semisolid foods Introduce one weaning food at a time for the child to get used to it

2 3 What Foods can be Given

Cereals, legumes, oils and fats, sugar and jaggery, vegetables and foods of animal origin can all be given to young infants and can be mixed with the staple food (rice, wheat or millet) The nutritive value can be greatly enhanced by mixing different types of foods Addition of a little oil increases the energy value The food that the family normally eats must be given to the child Breastfeeding should be continued as long as possible

WEANING
AGE RELATED GUIDELINES

- **4 TO 6 MONTHS**
  - Start with 1-2 teaspoons for each feed
  - Feed frequently, 5-6 times a day
  - Over 3-4 weeks, increase to half a cup or one banana a day
  - Mash all food
  - Give semisolid food, do not over dilute
  - Continue breastfeeding
- **6 TO 9 MONTHS**
  - Give foods normally taken by family
  - Mash all food
  - Feed frequently, 5-6 times a day
  - Continue breastfeeding
- **9 TO 12 MONTHS**
  - Can eat everything cooked at home but without adding spices and condiments
  - Food need not be mashed but should be soft
  - Feed about half cup, 5-6 times a day
  - Continue breastfeeding
- **12 TO 18 MONTHS**
  - Can eat all foods cooked in the family
  - Needs about half the amount the mother eats daily
  - Feed 4-5 times a day
  - Continue breastfeeding, especially at night

3 FEEDING DURING ILLNESS

Food intake can decrease due to poor appetite when the child is ill In addition children are often not fed during an episode of illness, especially diarrhoea Energy requirements of the child, however, are increased during illness

Children should continue to be fed during an episode of illness Feeding is physiologically sound and prevents or minimizes the deterioration of nutritional status that normally accompanies illnesses

Children who come to the health institutions are usually malnourished The contact with the mother should be used for advising her about appropriate feeding If the child is under one year of age, she should be advised about breast-feeding and proper weaning **It is important that the mother understands that the child should be fed during an episode of illness**

The child should be given the diet which is appropriate for her age and to which she is accustomed As the child may have a poor appetite food should be given in small volumes but more frequently Breast-feeding should be continued uninterrupted

Mothers should be advised to increase the frequency of feeding including breastfeeding for a few days following an episode of illness

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MOH VITAMIN A PROTOCOL

II CONTROL OF VITAMIN A DEFICILNCY

Annex 25

1 INTRODUCTION

Vitamin A deficiency increases case fatality due to common childhood diseases and is particularly marked following measles Reduction in prevalence and degree of Vitamin A deficiency levels are important for reducing childhood mortality and preventing irreversible blindness in children

Surveys indicate that the intake of Vitamin A is, on an average, about half the recommended dietary intake It is important that the dietary practices are improved and intake of Vitamin A rich foods be actively promoted Advice on nutrition, starting with exclusive breastfeeding and weaning, is an important measure for promoting healthy growth and for reducing morbidity and mortality rates

Night-blindness is an easily recognizable sign of Vitamin A deficiency However, when clinical signs appear, the degree of Vitamin A deficiency is severe A child with night-blindness needs immediate treatment with Vitamin A Since other children in the area may also have Vitamin A deficiency (although overt clinical signs may not be apparent), coverage with Vitamin A should be assessed in the area from where a case of night- blindness has been reported Coverage with Vitamin A should similarly be checked following outbreaks, particularly measles, since infections deplete vitamin A reserves and mortality rates are high in children with Vitamin A deficiency

1 1 Goal

Prevent vitamin A deficiency-associated blindness in children under 5 years of age by 1997

1 2 Strategy

- Provide vitamin A supplementation to children between 9 months to 3 years of age at six monthly intervals
- Promote exclusive breastfeeding and feeding of colostrum
- Promote intake of balanced food, including green leafy vegetables and yellow fruits
- Increase coverage with measles vaccine
- Provide additional attention and monitor areas with identified cases of night-blindness in children and areas where measles outbreaks have occurred

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2 VITAMIN A PROPHYLAXIS

Prevalence of Vitamin A deficiency is maximum between 6 months and 3 years In addition to the risk of blindness the children with Vitamin A deficiency are at a higher risk of dying due to infections It is therefore imperative that all children in this age group be given Vitamin A prophylaxis

Every child between 9 months to 3 years is to be given five doses of Vitamin A

- The first dose of 100,000 IU will be given at 9 months along with measles immunization
- The second dose of 200,000 IU will be given at 16 months with booster dose of DPT/OPV
- Three more doses of 200,000 IU will be given at 6 monthly intervals

3 VITAMIN A DEFICIENCY

3.1 Diagnostic Criteria

In children who have Vitamin A deficiency the surface of cornea becomes dry and rough, and may ultimately break down partially or completely This may lead to ulceration and permanent scarring or irreversible damage and loss of sight Ocular signs which are associated with Vitamin A deficiency are

Night Blindness
The child cannot see after dark

Xerophthalmia
This is the drying of the conjunctiva and cornea followed by destruction of the cornea and blindness

Bitot's Spots
These are accumulation of foamy, cheesy material on the conjunctiva, often in association with other signs such as night blindness.

Corneal Xerosis/Ulceration
The cornea becomes dry (xerosis) and wrinkled, devoid of the shine or gloss If it is not treated, xerosis can progress within hours to form an ulcer of the cornea

Keratomalacia
If the disease is not treated, a corneal ulcer can lead to "melting" or "wasting" of the cornea (keratomalacia)

Corneal Scar

Keratomalacia can lead to perforation of cornea resulting in a scar The sooner the disease is treated the smaller the ulcer and smaller the scar If treated early corneal scars and blindness can be prevented

3 2 Treatment

In a child with symptoms of night blindness therapeutic doses of Vitamin A should be administered

- ☐ Give 200,000 IU of Vitamin A immediately after diagnosis
- ☐ Give one more dose of 200,000 IU four weeks later (NOTE · Dose in infants is 100,000 IU)

- Children who have an eye lesion must be given the first therapeutic dose of Vitamin A, and **REFERRED URGENTLY FOR SPECIALIST CARE.**
- Infants and young children suffering from diarrhoea, measles or acute respiratory infections must be monitored closely In case signs of deficiency are present treat with therapeutic doses of Vitamin A
- Children should be encouraged to consume Vitamin A rich food.

> Vitamin A solution is available in the PHC and subcentres in the form of a liquid preparation Each ml of this contains 100,000 IU of Vitamin A
>
> A spoon / measure with 1 ml and 2 ml markings is provided with every bottle
>
> Vitamin A should be kept in a cool dark place and should not be exposed to direct sunlight

4. SERVICE DELIVERY

- The health worker(F) and other functionaries working in the Primary Health Centres (PHC) are responsible for administering Vitamin A to children under three years Coverage levels should be regularly monitored
- Services of Integrated Child Development Services (ICDS) functionaries may be utilized for the distribution of Vitamin A to children in the ICDS Blocks and for the education of mothers on prevention of Vitamin A deficiency

MANAGEMENT OF DIARRHOEA IN CHILDREN

MOH DIARRHEA PROTOCOL

1 INTRODUCTION

Annex 26

One in four deaths in children under the age of 5 years are estimated to be due to diarrhoea The mortality rates can be significantly reduced by the early use of oral rehydration salts (ORS) and home available fluids (HAF) and by continued feeding Standard case management of diarrhoea in children is a major intervention under the Child Survival and Safe Motherhood (CSSM) Programme for the reduction of infant and child mortality rates

1 1 Goal

Reduce diarrhoea associated mortality in children under the age of 5 years, by 30 percent by 1995 and by 70 percent by 2000

1 2 Strategy

- Ensure standard case management of diarrhoea (including dysentery and persistent diarrhoea) by training medical and other health personnel
- Promote standard case management practices among private practitioners
- Improve maternal knowledge on home management of diarrhoea and recognition of danger signs for seeking immediate medical care
- Increase availability of ORS by providing free ORS packets at the health facilities and outreach depots Increase accessibility by marketing ORS through the Public Distribution System and commercial outlets
- Monitor hospital based data on ORS use, case fatality rates and other parameters
- Promote exclusive breastfeeding for the first 4 to 6 months, proper weaning, infant immunization (including measles immunization and Vitamin A prophylaxis)

2 DEFINITION OF DIARRHOEA

2 1 What is Diarrhoea

Diarrhoea is the passage of loose liquid or watery stools These liquid stools are usually passed more than three times a day However, it is the recent change in consistency and character of stools rather than the number of stools that is more important Passage of even one large watery stool in a young child may constitute diarrhoea

DEFINITION OF DIARRHOEA

- Three or more loose or watery stools in a day
- Change in consistency and character of stools

2.2 WHAT IS NOT DIARRHOEA

- Passage of frequent formed stools
- Passage of pasty stools in breast-fed infants
- Passage of a stool during or immediately after feeding due to initiation of gastrocolic reflex
- Transitional stools on the third to seventh day of life

In most cases the mother knows what is an abnormal stool for her child

2.3 TYPES OF DIARRHOEA

CLASSIFICATION OF DIARRHOEA
(by clinical syndromes)

- Acute watery diarrhoea
- Dysentery (blood in the stools)
- Persistent diarrhoea

2.3 1 ACUTE WATERY DIARRHOEA

Acute watery diarrhoea starts suddenly and is characterized by passage of loose watery motions Most episodes of acute diarrhoea recover within three to seven days More than three fourths of all diarrhoeal episodes in the community are acute watery episodes

2 3 2 DYSENTERY

This is diarrhoea with visible blood in faeces The presence of blood may also be accompanied with abdominal cramps, fever, anorexia and rapid weight loss

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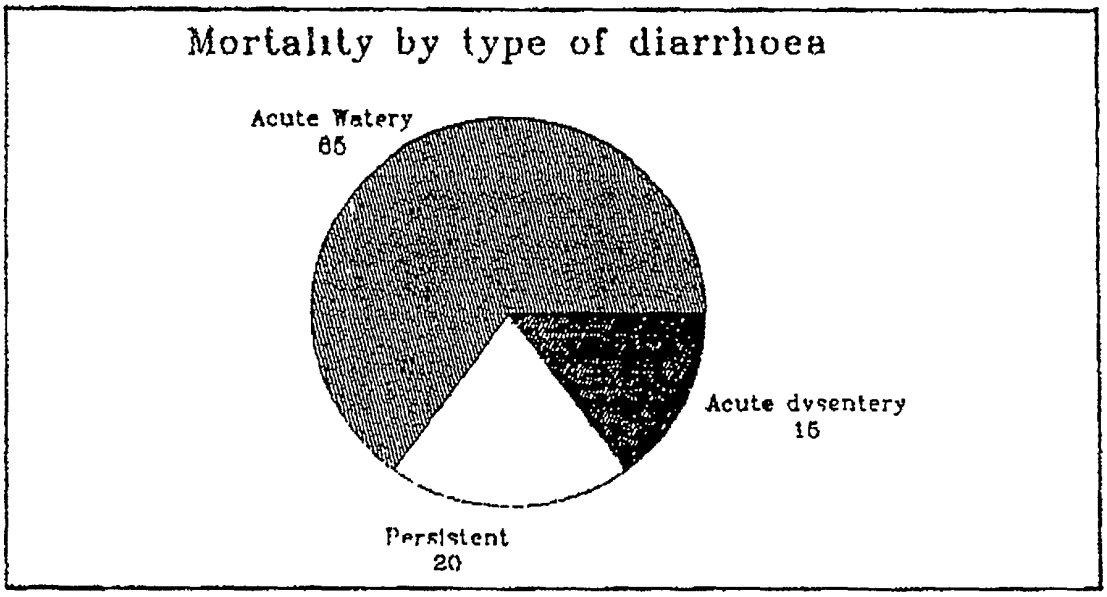
2 3 3 Persistent Diarrhoea

An acute episode of watery diarrhoea or dysentery may last upto 14 days If it persists longer it is classified as persistent diarrhoea These cases require careful management

PERSISTENT DIARRHOEA

- Acute watery diarrhoea and dysentery
- Lasts for more than 14 days
- Associated with weight loss

The relative contribution to diarrhoea-associated mortality in children under 5 years of age by each type of diarrhoea is shown in the figure below



2.3.4 Cholera

Cholera is a form of acute watery diarrhoea Recognizing cholera early is important in order to start treatment promptly If treatment is delayed or is inadequate, death may occur quickly from dehydration and circulatory collapse

- **Cholera should be suspected**
  - when a patient older than 5 years of age develops severe dehydration from acute watery diarrhoea (usually with vomiting)
  - in any patient who comes with symptoms of acute watery diarrhoea from an area where there is an outbreak of cholera

The pathologic consequences of diarrhoea are dehydration and malnutrition

2 4 1 Dehydration

Diarrhoea leads to loss of water and electrolytes (sodium, chloride, potassium and bicarbonates) from the body Dehydration occurs when these losses are not replaced adequately This can lead to shock and death

SIGNS OF DEHYDRATION
(two or more signs including at least one marked *)

- **Restlessness, irritability***
- **Increased thirst***
- **Decreased skin turgor***
- Dry mouth and tongue
- Tears absent
- Sunken eyes

SIGNS OF SEVERE DEHYDRATION

- Lethargic or unconscious, floppy
- Unable to drink

2.4 2 Malnutrition (undernutrition)

Diarrhoea has a significant negative impact on nutritional status of the child Even a brief episode of diarrhoea leads to the loss of 1 to 2 per cent of body weight Undernutrition in diarrhoea occurs due to loss of nutrients and because children are not given enough food during the episode

3. CLINICAL ASSESSMENT OF CASES

The clinical assessment of the child is done to determine whether the child has diarrhoea or not, type of diarrhoea, degree of dehydration (no signs of dehydration, signs of dehydration and signs of severe dehydration) and whether there are any other associated problems The age of the child, weight (if possible) and nutritional status of the child should be noted

soft drinks, sweetened fruit juices and sweetened tea should not be used These have a high osmolarity and can lead to worsening of dehydration

B Oral rehydration salts (ORS) is a balanced mixture of glucose and electrolytes for use in treating and preventing dehydration, potassium depletion and base deficit due to diarrhoea Glucose in ORS helps in transporting sodium and water across the intestinal membrane during diarrhoea

The ORS supplied under the national programme has a light blue colour and the national LOGO If ORS from other sources are used, the packet should be checked to confirm that it has the right composition Packets with a high glucose content (more than 20 gm per Litre), should not be used as these can lead to osmotic diarrhoea and worsen the condition of the child Packets containing colouring and sweetening agents like saccharine should also not be used

COMPOSITION OF ORS (Net Weight = 27 9 gm)	
Ingredient (gm)	Weight
Sodium chloride IP	3 5
Potassium chloride IP	1 5
Sodium citrate IP	2 9
Glucose anhydrous IP	20 0

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4 PRINCIPLES OF THE MANAGEMENT OF ACUTE DIARRHOEA

4 1 Fluid Replacement

Watery diarrhoea requires fluid and electrolyte replacement irrespective of the etiology ORS is the best solution available for fluid and electrolyte replacement In the early stages of diarrhoea or when ORS packets are not immediately available, home available fluids (HAF) and water can be used

4 2 Feeding

Feeding must be continued during all types of diarrhoea to the extent possible, and should be increased during recovery so as to avoid any adverse effects on the nutritional status

4 3 Rational Use of Drugs

ORS is the drug of choice for all cases of diarrhoea It is life saving when used timely, in adequate quantities

- Only a small proportion of the cases of diarrhoea (dysentery, cholera and associated illnesses) need specific antimicrobials (Table 5)
- Amoebiasis and giardiasis are rare in children and drug therapy should be started only when trophozoites of *E histolytica* or *Giardia* are seen in the faeces
- Anti diarrhoeals (anti-motility drugs, binding agents, stimulants, steroids and other drugs) have no place in the treatment of diarrhoea and must not be used Since anti-diarrhoeals have no clinical benefits and are potentially dangerous, their marketing has been banned in India

5 FLUID THERAPY

Fluid and electrolyte replacement is necessary for all types of diarrhoea and is the mainstay of the treatment of a case with diarrhoea ORS is the best available solution for fluid and electrolyte replacement In the early stages of diarrhoea or when ORS packets are not immediately available, home available fluids (HAF) and water can be used

PURPOSE OF FLUID THERAPY

- Provides for normal daily intake
- Replaces on-going losses
- Corrects deficits

5 2 Cases With Signs of Dehydration

Children who have dehydration should be kept under observation in the hospital/health centre for a few hours and given a prepared ORS solution during this period

- The purpose of fluid therapy in such cases is to correct fluid deficit and to provide for ongoing losses and normal daily requirement
- **During the first 4 hours, the child should receive 100 ml per kg of body weight of ORS** The quantities of ORS solution to be given by age and weight of the child is shown in Table 2

TABLE 2

REHYDRATION THERAPY
Approximate amount of ORS solution to be given in the first 4 hours*

Age**	<4 months	4-11 months	12 23 months	2 4 years	5-14 years
Weight (kg)	<5	5 8	8-11	11-16	16-30
ORS (ml)	200-400	400 600	600-800	800-1200	1200-2200
Measure (glass)	1-2	2-3	3-4	4 6	6-11

* If the child wants more ORS than shown, give more
** Inform mother to give the child breast milk in between the feeds of ORS
*** For infants who are not breastfed, also give 100-200 ml clean water during this period

- If the child **vomits**, wait for 10 minutes and then continue to give ORS, but more slowly
- If the child develops **puffiness of the eyelids**, stop ORS, Continue to give plain water (or breastmilk) Give ORS as for maintenance therapy (Table I) after the puffiness disappears

After 4-6 hours of treatment with ORS solution, the child should be reassessed for signs of dehydration If the child has improved (as will happen in most cases), put the child on maintenance therapy as indicated in Table I

If the child has some signs of dehydration after 4 hours of ORS therapy with ORS then continue therapy with ORS solution for another 4 hours However before starting therapy

- Inform mother to give the child breastmilk in between the feeds of ORS
- **If the child is not breastfed, give 100 - 200 ml of water, before starting the therapy with ORS** After rehydration has been achieved, ORS must be continued for replacement of ongoing losses (maintenance therapy) as indicated in Table I

If the condition of the child improves with therapy but the mother has to leave before the child is fully recovered, then

- Give enough of the prepared ORS solution to feed the child on the way home

Before the mother leaves the hospital two packets of ORS should be given and the mother told how to use the packet DO NOT FORGET TO ADVISE THE MOTHER TO GIVE ORS, HAF,TO CONTINUE FEEDING THE CHILD AND TO LOOK FOR EARLY DANGER SIGNS OF DEHYDRATION

HOW TO PREPARE ORS SOLUTION FROM A ONE LITRE PACKET

Mothers must be taught on how to measure one litre of water It is important that **a measure which is commonly available in the houses is identified and the mothers told the exact number of such measures that will make 1 litre**

There is no need to boil the water for preparing the ORS solution Clean water which the household normally uses for drinking purposes can be used

Hands must be washed with soap before making the ORS solution

Full packet of ORS must be used Generally the mothers will tend to save a part of the packet in order to use it later It is important to emphasize that the whole packet is to be mixed in one litre of water

The container should be kept covered The solution can be used for 24 hours and should be discarded if not consumed within this period Fresh solution should be prepared if required

further therapy should be continued with ORS as given at [illegible] as 5 1 and 5 2

Before the mother leaves the hospital two packets of ORS should be given and the mother told how to use the packet DO NOT FORGET TO ADVISE THE MOTHER TO GIVE ORS HALF, TO CONTINUE FEEDING THE CHILD AND TO LOOK FOR EARLY DANGER SIGNS OF DEHYDRATION

TABLE 3

RATES AND QUANTITIES OF IV INFUSION FOR CORRECTING SEVERE DEHYDRATION			
AGE	FIRST GIVE 30 ML / KG IN	THEN GIVE 70 ML / KG IN	TOTAL 100 ML/KG
Infants	First hour	Next 5 hours	6 hours
Older Children	First 30 minutes	Next 2½ hours	3 hours

Note -

- During IV therapy, the patient must be reassessed every 1-2 hours If hydration is not improving, give IV infusion more rapidly
- If the patient can drink, administration of ORS solution must also be started along with the IV Infusion
- The patient must be evaluated after the completion of the therapy (100 ml/kg body weight) If signs of severe dehydration have disappeared, continue treatment with oral therapy If signs of severe dehydration persist, IV fluid therapy must be continued
- If it is not possible to start the IV infusion for some reason, the patient can be given ORS solution through a naso-gastric tube

6 FEEDING IN DIARRHOEA

Children should continue to be fed during diarrhoea Feeding should also continue while the child is being rehydrated with ORS solution

- Feeding is physiologically sound and prevents or minimizes the deterioration of nutritional status that normally accompanies such illness

TABLE 5

ANTIMICROBIAL USED IN THE TREATMENT OF SPECIFIC CAUSES OF ACUTE DIARRHOEA IN CHILDREN		
CAUSES	DRUG(S) OF CHOICE	ALTERNATIVE
Cholera	Doxycycline 6 mg/kg/day in a single dose x 3 days OR Tetracycline 50 mg/kg/day in 4 doses daily x 3 days	Erythromycin 30 mg/kg/day in 3 doses x 3 days
Shigella dysenter	Paediatric cotrimoxazole 1 tablet twice a day x 5 days (under 2 months) 2 tablets twice a day x 5 days (2 12 months) 3 tablets twice a day x 5 days (1-5 years of age)	Nalidixic Acid 55 mg/kg/day in 4 doses x 5 days
Acute intestinal amoebiasis	Metronidazole* 30 mg/kg/day in 3 divided doses x 5-10 days	
Acute giardiasis	Metronidazole* 15 mg/kg/day in 3 divided doses x 5 days	

* Tinidazole can also be used

8 PERSISTENT DIARRHOEA

If acute watery diarrhoea or dysentery lasts for 14 days or more, the diarrhoea is classified as persistent

The important causes of persistent diarrhoea are

- Persistent infection with some intestinal pathogens

- Malabsorption particularly of carbohydrates and fat following mucosal damage by pathogens or malnutrition
- Rarely dietary protein intolerance

The treatment of persistent diarrhoea is similar to acute watery diarrhoea and dysentery as described earlier Diet forms an important part of the treatment of a child with persistent diarrhoea Mothers should be advised on appropriate feeding of the child

8.1 Diet in Persistent Diarrhoea

Diet is the most important part of the management of cases of persistent diarrhoea Since the child may not be able to take food in adequate amount, it is necessary to give small amounts of energy rich food, frequently Food given to the child should contain cereals, legumes, milk or curd and some oil. Eggs (boiled and mashed added to the basic cereal) are a good source of energy and protein and may be included in the food of the child

With adequate intake of food the child should gain weight In case this does not happen or any of the following signs appear, it suggests treatment failure

- Dehydration
- Severe abdominal distension or other intestinal complication
- Severe weight loss continues for several days despite adequate intake
- Diarrhoea persists after 6 days of treatment with poor weight gain

Children in whom the above signs appear and children less than 6 months old with persistent diarrhoea should be hospitalized

DIETS FOR PERSISTENT DIARRHOEA	
1	**Low Milk Diet** Cereal + milk (or curd) + oil
2	**Animal milk free diet** Cereal + legume + oil
3	**Starch free diet** Glucose + oil + protein*

* egg, pureed chicken

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MOH ARI PROTOCOL

3 2 2 Chest indrawing

Chest indrawing is defined as a definite inward movement of the lower chest wall while breathing IN (inspiration)

- The child should be observed lying flat in the bed or in the mother s lap
- A child is said to have a definite chest indrawing only if it is persistent If in doubt, chest indrawing should be observed in different postures
- Intercostal or supraclavicular retractions in which only the soft tissues between the ribs or above the clavicle goes in is NOT chest indrawing A normal child under 2 months of age may have mild chest in-drawing because of soft chest wall

TABLE -1

CLINICAL CLASSIFICATION OF PNEUMONIA AGE 2 MONTHS - 5 YEARS		
	Therapy	Where to treat
PNEUMONIA Respiratory rate Age (per minute) (months) o 50 or more 2 12 o 40 or more 12 60	Cotrimoxazole Oral	Can be treated at home/ health facility
SEVERE PNEUMONIA o Chest Indrawing	Antibiotics Intramuscular	Patient should be hospitalized
VERY SEVERE ILLNESS o Inability to drink o Excessive drowsiness o Stridor in calm child o Respiratory grunting o History of apnoea cyanosis convulsions o Severe malnutrition o Hypothermia	Chloramphenicol Intramuscular	Must always be admitted and treated at a health facility with provision of oxygen

NOTE Children less than two months who have fast breathing are always treated as for severe pneumonia and their assessment and management is discussed separately

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4 MANAGEMENT OF A CASE OF PNEUMONIA

4 1 Pneumonia (child with cough and fast breathing)

Although viral pneumonia are known, they are relatively less frequent in the developing countries Majority of the cases of pneumonia in children are bacterial *Streptococcus pneumoniae* and *Hemophilus influenzae* are the most common organisms in cases of pneumonia, among children aged 2 months to 5 years These organisms are sensitive to cotrimoxazole

Cotrimoxazole is the drug of choice for the treatment of pneumonia. Studies carried out in India have confirmed the efficacy of cotrimoxazole to be similar to ampicillin and procaine penicillin and cure rates of up to 95% have been recorded Cotrimoxazole is less expensive with few side effects and can be used safely by health workers at the peripheral health facilities and at home by the mothers Cotrimoxazole has been included as one of the drugs provided to the sub-centres in the drug kit 'A' under the CSSM Programme and health workers are being trained in the CSSM districts, for recognition of signs of pneumonia, treatment of simple cases and referral of severe cases

Children who have pneumonia should be treated with cotrimoxazole in the doses recommended in Table 2 for 5 days

- The condition of the child should be assessed after 48 hours Cotrimoxazole should be continued for another 3 days in children who show IMPROVEMENT in the clinical condition
- If there is no significant change in condition (NEITHER IMPROVEMENT NOR WORSENING), cotrimoxazole should be continued for another 48 hours and condition reassessed
- If at 48 hours or earlier the condition WORSENS, chest indrawing or other signs of severe illness (inability to drink, excessive drowsiness, convulsions or cyanosis) appear, the child should be hospitalized immediately

The mothers must be told to look for signs of severe pneumonia and to bring the child for assessment for further treatment

- ☐ Difficult breathing
- ☐ Chest indrawing
- ☐ Not able to drink
- ☐ Excessively drowsy and difficult to wake
- ☐ Condition gets worse than before

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TABLE 2

TREATMENT OF PNEUMONIA Daily dose schedule of COTRIMOXAZOLE for five days		
AGE / WEIGHT	Paediatric tablet Each tablet Sulphamethoxazole 100 mg and Trimethoprim 20 mg	Paediatric syrup Each spoon (5 ml) - Sulphamethoxazole 200 mg and Trimethoprim 40 mg
< 2 months* (Wt 3-5 kg)	One tablet twice a day	Half spoon (2 5 ml) twice a day
2-12 months (Wt 6-9 kg)	Two tablets twice a day	One spoon (5 ml) twice a day
1-5 years (Wt 10-19 kg)	Three tablets twice a day	One and half spoon (7 5 ml) twice a day

NOTE ·

a If Paediatric tablets are not available the daily dose of adult single dose tablet (containing Sulphamethoxazole - 400 mg and Trimethoprim - 80 mg), is a quarter, half and three-fourths of a tablet, per dose, to be given twice a day, for the three age-groups, respectively

b* In a child less than two months, cotrimoxazole is <u>not</u> routinely recommended These children are to be treated as for severe pneumonia However, in case of delay in referral cotrimoxazole may be initiated

c Cotrimoxazole should not be given to premature babies and cases of neonatal jaundice Such children when seen by a health worker must be referred to a health facility

d In small children the tablet should be crushed and mixed with milk or other fluids The mixture should be given to the child with a spoon.

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4 2 Severe Pneumonia (chest indrawing)

Children with severe pneumonia should be treated as inpatients with intramuscular injections of benzyl penicillin (after test dose) ampicillin or chloramphenicol The condition of the child MUST be monitored every day and REVIEWED after 48 hours for antibiotic therapy

- If there is IMPROVEMENT
  - Change to one daily injection of procaine penicillin, if the child was initially put on benzyl penicillin (after test dose)
  - In case the child was initially put on IM ampicillin or chloramphenicol change to oral administration of the same antibiotic
- If the condition WORSENS OR DOES NOT IMPROVE after 48 hours
  - Switch over to chloramphenicol IM, if benzyl penicillin was used initially
  - If chloramphenicol IM was used as the initial antibiotic, then change to intramuscular injections of cloxacillin and gentamicin

Antibiotic therapy must be given for a minimum of 5 days and continued for at least 3 days after the child gets well In case the child is put on cloxacillin and gentamicin the treatment should be continued for at least 3 weeks, since in such cases the child may be suffering from staphylococcal infection

- Treat fever and wheezing if these symptoms are present
- Fluid and food intake should also be carefully monitored
- On discharge of the child from the hospital the mother should be advised on home care

4.3 Very Severe Illness

Children with signs of very severe illness are in imminent danger of death, and should be treated in a health facility, with provision for oxygen therapy and intensive monitoring, as these cases require supportive therapy in addition to specific treatment of pneumonia Chloramphenicol IM is the drug of choice in all such cases The therapeutic efficacy of chloramphenicol IM in the recommended dose equals that achieved with IV administration of chloramphenicol

TREAT FOR 48 HOURS

- If condition IMPROVES
  Switch over to oral chloramphenicol Chloramphenicol should be given for a total of 10 days
- If condition WORSENS or DOES NOT IMPROVE after 48 hours
  Switch to IM injections of cloxacillin and gentamicin Treat with these antibiotics for 3 weeks

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TABLE - 3

TREATMENT OF SEVERE PNEUMONIA (2 months-5 years)			
Antibiotics	Dose*	Interval	Mode
A First 48 hours			
Benzyl penicillin	50000 IU per KG/dose	6 hourly	IM
or			
Ampicillin	50mg/KG/dose	6 hourly	IM
or			
Chloramphenicol	25 mg/KG/dose	6 hourly	IM
B 1 If condition IMPROVES, then for the next 3 days, Give			
Procaine penicillin	50000 IU/KG (maximum 4 lac IU)	Once	IM
or			
Ampicillin	50mg/KG/dose	6 hourly	Oral
or			
Chloramphenicol	25 mg/kg/dose	6 hourly	Oral
B 2 If NO IMPROVEMENT, then for the next 48 hours CHANGE ANTIBIOTIC ❖ If ampicillin used change to chloramphenicol IM ❖ If chloramphenicol used change to cloxacillin 25mg/kg/dose every 6 hours along with gentamicin 2 5 mg/Kg/dose every eight hours ❖ If condition improves continue treatment orally			
C Provide symptomatic treatment for fever and wheezing, if required			
D Monitor fluid and food intake			
E Advise mother on home management on discharge			

* The doses can be rounded off to the nearest administrable dose

Treat with antibiotics for at least 5 days Continue treatment for at least 3 days after the child recovers If cloxacillin and gentamicin are used the treatment should be for at least 3 weeks

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4 4 Pneumonia in Young Infants under 2 Months of Age

Cough may not be a presenting symptom in children less than 2 months of age Pneumonia in this age group is recognized by fast breathing and/or chest indrawing as in the older infants and children

In this age group pneumonia must always be considered to be severe as the condition of the child can deteriorate very quickly Many of the cases may have added risk factor of low birth weight Such children are very susceptible to temperature changes and even in tropical climates, deaths due to cold stress or hypothermia are common

It is difficult to differentiate between severe pneumonia, sepsis or meningitis in this age group, as the clinical presentation is very similar The treatment in these conditions is, however, basically the same

These children must be HOSPITALIZED Treatment with cotrimoxazole may be started by the health worker before referring the child

If pneumonia is suspected in young infants, they should be treated with intramuscular injections of Benzyl penicillin or Injection Ampicillin, along with Injection Gentamicin Chloramphenicol is not recommended as the first line of treatment in young infants

TABLE - 4

TREATMENT OF PNEUMONIA IN CHILDRENAGED LESS THAN 2 MONTHS			
ANTIBIOTIC	DOSE	FREQUENCY	
		Age < 7 days	Age 7 days to 2 months
Inj Benzyl Penicillin	50000 IU/kg/dose	12 hourly	6 hourly
or			
Inj Ampicillin	50 mg/kg/dose	12 hourly	8 hourly
AND			
Inj Gentamycin	2 5 mg/kg/dose	12 hourly	8 hourly

Besides antibiotics, therapy for the associated conditions, if any, must be instituted immediately The children must be kept warm and dry

Breastfeeding must be promoted strongly as children who are not breastfed are at a much higher risk of ARI and diarrhoea In such children the illness is more severe and case fatality rates are higher

II ESSENTIAL MATERNAL CARE AND MANAGEMENT OF NORMAL LABOUR

Annex 28

1 ESSENTIAL MATERNAL CARE

All women need additional care during pregnancy They need to eat and rest more than they did when they were not pregnant All women must be given TT immunization and the full course of IFA tablets All women need to be advised on the preparations they must make for delivery

All pregnant women must be given periodic health check-ups so that maternal complications or risk factors are identified in time, treatment started early and the women counselled to deliver in a hospital

1.1 Early Registration

- It is important that all pregnant women are registered early during pregnancy The urgency for doing so must be emphasized on the paramedical staff The number of women registered subcentre-wise should be monitored monthly
- The annual estimated number of pregnant women must be worked out subcentre-wise and the total number in the PHC area can be added up The estimated number of pregnancies and the number registered should be monitored to determine how many women are not receiving the essential services

An estimated 160 pregnancies will occur annually in a subcentre area with a population of around 5000 and a birth rate of 29 per 1000 population The estimated number of pregnant women is calculated by multiplying birth rate x population and dividing by 1000 Add 10% as some woman have spontaneous abortions and others may have still births (children who are born dead)

ESTIMATION OF PREGNANT WOMEN

- Birth rate x population / 1000
- Add 10%

Example

29 x 5000 /1000 = 145
145 + 15 = 160

(2

state (or district birth rate if available) and the project population of the area If the population of the area is more than 5000 or if the birth rates are higher (as in Assam Bihar Haryana Madhya Pradesh Rajasthan and Uttar Pradesh) the number of pregnant women will be more

1 2 Antenatal Checkup

Pregnancy is divided into three trimesters of 3 month periods The first trimester is from the first day of the last menstrual period (LMP) to 12 weeks, second trimester is from 13 weeks to 28 weeks and the third trimester is from 29 weeks to 40 weeks

The duration of a normal pregnancy is 280 days from the first day of the last menstrual period (LMP) or 40 weeks or 9 calender months plus 7 days The expected date of delivery (EDD) is calculated by adding 9 calender months and 7 days to the first day of LMP For example if the first day of the LMP was 3 March, the EDD would be 10 December

The purpose of antenatal check up is to monitor the progress of pregnancy and identify and treat maternal complications early Women who have had no antenatal examination are at risk as they may have an underlying complication or high risk factor Some women can even develop complications without any warning It is essential therefore that **all pregnant women** receive antenatal care and advice on where to deliver It is important that they and their families are aware of the nearest hospital (FRU) and have made advance arrangements for transportation in anticipation of an emergency Blood transfusion is often required as a life saving measure Family members and friends who can donate blood should accompany the woman to the hospital if there is an obstetric emergency

A pregnant woman must get at least 3 check-ups during pregnancy

- First at 20 weeks or as soon as the pregnancy is known and registered.
- Second at 32, and
- Third at 36 weeks

She should be encouraged to visit more often, especially in the third trimester of pregnancy

Clinical Assessment

Antenatal check up involves careful history and physical examination to determine whether the pregnancy is progressing normally Complications which can adversely affect a woman's health or the outcome of pregnancy can also be identified

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- Palpate for foetal lie (whether vertical transverse or oblique) and foetal presentation (vertex or breach)
- Auscultate for foetal heart rate This can be done either with a stethoscope or a foetoscope Normal foetal heart rate is 140 per minute Heart rate more than 160 or less than 120 indicates foetal distress

> X-Ray examination should be avoided in pregnancy During first trimester it is contraindicated
>
> Drugs should not be used in the first trimester unless required for a life threatening emergency

The antenatal examination should enable you to decide whether the pregnancy is progressing normally or some maternal complication is present Management of maternal complications have been discussed in section III of this manual

1 3 Advice to Mothers

Food and Rest

Pregnant women need to take an extra meal every day of the family food No special foods are required and no food that is normally taken should be restricted Alcohol and tobacco are prohibited The mother needs to rest on her side for about two hours in the afternoon and get at least 8 hours of sleep at night Short periods of rest in between periods of physical work are useful She must not do heavy work and must rest as often as she can The paramedical staff must be aware that food and rest are important and should advise the women and other family members in their area so that family responsibilities are shared and pregnant woman gets the rest she needs

Anaemia Prophylaxis

Explain the increased requirements of iron and the dangers of anaemia to the pregnant woman

All pregnant women must be given 100 tablets of Iron & Folic Acid(IFA-Large) during pregnancy **Many pregnant women can be saved by giving 1 tablet of IFA (100 mg elemental iron or 330 mg ferrous sulphate) daily for 3 months Women with visible signs of anaemia should be given two tablets daily for atleast 3 months**

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TT Immunisation

Explain to the pregnant woman that TT immunisation protects her and her newborn baby against tetanus which is a serious disease with high case fatality

Preparing for Labour

All pregnant women must make necessary preparations for delivery They should be provided with a disposable delivery kit (DDK) In case the DDK is not available they should be advised to buy a new blade and thread themselves and keep them handy The thread should be boiled for 20 minutes and sun dried before delivery

They should be advised to keep ready cotton cloth for themselves and for the newborn It is important that these are clean to prevent infection Clothes should be washed with soap and sun dried and kept away from dust

All women who are pregnant must be informed regarding the nearest hospital so that they can be taken there immediately if there is an emergency The family and the community must also make some arrangements in advance for transportation so that no time is lost if the woman has to be rushed to a hospital Blood transfusion is often required for obstetric emergencies and family members and friends must be prepared to donate blood

All pregnant women must also be advised on exclusive breastfeeding and care of the newborn

2. NEONATAL TETANUS ELIMINATION

Prior to the immunization programme, tetanus was a major cause of neonatal deaths An estimated 3 5 lakh deaths due to neonatal tetanus occurred annually As a result of high immunization coverage levels and improvement in the clean delivery practices, neonatal tetanus has been virtually eliminated in large parts of the country The goal is to reach an incidence of 1 or less per 1000 live births in all the blocks in the country by the end of 1995 Since a safe and effective vaccine is available and the recommended 'clean techniques are simple (hands washed thoroughly, a new blade used for cutting the cord and no dressings applied on the cord stump) can be adopted for all deliveries, case of neonatal tetanus is a failure of the system to reach the community with simple messages and to provide basic services

Symptoms of neonatal tetanus are easy to recognize A child, apparently normal at birth, stops suckling and has convulsions The symptoms usually appear three to five days after birth Most children die within a few days The health staff should be asked to report all neonatal deaths and suspect cases neonatal tetanus in their areas If no cases or deaths have occurred a nil report should be submitted

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TT immunisation must be given to all pregnant women and there are no contraindications

- The first injection is given at the first contact with the pregnant woman
- The second injection is given after one month If the woman had received tetanus toxoid during a previous pregnancy, only one injection is sufficient However, in case of doubt give 2 injections
- The injections must be completed at least one month before delivery There may be slight pain at the injection site for a day or two

High TT immunization coverage levels must be sustained and clean delivery practices continued even if there are no cases The tetanus spores are widespread in the environment, especially in the rural areas where there are a large number of animals living in close proximity

If a case of neonatal tetanus is reported, follow-up in the area of residence is necessary to prevent cases in the future Registration of pregnant women and immunization coverage levels must be assessed Training of dais must be given high priority

3. MANAGEMENT OF NORMAL LABOUR

3 1 Conduct of Normal Labour

Labour starts with the beginning of pains and ends with the delivery of the placenta Labour is divided into three stages

- The first stage is from the time the pains start to the time cervix is fully dilated
- The second stage lasts from full dilatation of cervix to the delivery of the baby.
- The third stage starts after the delivery of the baby and ends with the delivery of the placenta
- The three stages of labour together usually take up to 12 to 13 hours for the primigravida (first delivery) and about half the time for subsequent deliveries

□ First Stage of Labour

- The labour pains are regular and become progressively stronger The intervals between pains gets shorter The uterus becomes hard during the pains and cervix dilates
- This period is usually about 10 hours after the pains start (for the first baby) and about 5 hours (for subsequent births)

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REFERRAL OF AN OBSTETRIC EMERGENCY

- **Position of Patient**
  - Women should be kept in the left lateral position during transportation In this position
    - The weight of the pregnant uterus does not press the aorta and the vena-cava
    - The tongue does not fall back and asphyxia is prevented
    - The risk of inhalation of vomitus is also reduced
  - In case the woman is unconscious or has any signs of imminent eclampsia put a soft mouth gag is put in between her teeth This will prevent tongue bite in case she develops fits

- **Medication**
  - Start IV Fluids
    - Ringers lactate/ normal saline or 5% glucose can be used **Do not** give dextran as it can interfere with grouping and cross matching of blood
  - Sedate the patient before transport
  - Give first dose of a broad spectrum antibiotic
  - Give other specific medication indicated for the patient as given in the text

- **Referral Note**
  - Give salient points about the history, main clinical findings and medication (dose, route and time of administration) In case telephone facilities are available the referral hospital should be alerted about the arrival of the patient so that necessary preparations can be started immediately

- **Advice to Family Members**
  - Most obstetric emergencies require operative management and blood transfusion A responsible member of the patients family should accompany her for giving consent for surgery Relations and family friends who can donate blood should also accompany the patient
  - The patient should be transported by the quickest mode of transport

Mr. for New Born care

ESSENTIAL NEWBORN CARE

1 INTRODUCTION

More than half of the infant deaths occur in newborns (first 28 days of life) Most of these deaths take place in the first week of life due to birth asphyxia, hypothermia and infections Babies born with a low birth weight (less than 2500 gm) are at a higher risk of dying due to these causes Care of the mother during antenatal period and delivery provision of essential care to the newborn at birth and during the neonatal period will have a significant impact on neonatal and infant mortality rates

1 1 Goal

Improve essential newborn care in institutional and domiciliary deliveries to reduce perinatal and neonatal mortality rates

1.2 Strategy

- Ensuring antenatal care to all pregnant women
- Promoting safe delivery practices
- Providing essential care to all newborns
- Identification and referral of newborns "at risk'

2 CARE DURING ANTENATAL PERIOD

Care of the pregnant woman is vital for improving neonatal survival Anaemia, undernutrition and obstetric complications have an adverse influence on the foetus and the newborn Adequate rest and nutrition during pregnancy are essential for the health of the mother and the newborn During pregnancy particular attention should be given to

- Early registration and regular antenatal check ups
- Nutrition advice and anaemia prophylaxis
- Anaemia detection and treatment
- Tetanus immunization
- Early identification and treatment of maternal complications

Women with previous obstetric complications or where complications are expected should be advised to deliver in a health facility

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3 CARE AT BIRTH

The room where the delivery takes place should be clean well ventilated and adequately lighted

Ensure the following during delivery

- Clean hands
- Clean surface
- Clean razor blade
- Clean cord tie
- Clean cord stump (no applicant)

The newborn should be received at birth in a dry, warm and clean cloth After drying the newborn, the wet cloth should be discarded (to prevent hypothermia) and the baby wrapped in a clean and dry cloth The head of the baby should be wiped first

3.1 Cord Care

The cord should be tied with a clean cord tie 2 5 inches or less from the umbilicus and cut with a new razor blade or autoclaved scissors Inspect the stump for bleeding If bleeding is detected apply another cord tie Do not apply any medication or dressing to the cord

3 2 Eye Care

Clean the eyes with a soft clean cloth or cotton swab using one for each eye Clean the eyes from the medial to the lateral side Do not apply any eye drops or kajal to the eyes

3 3 Bath

Do not bathe the newborn after birth Bathing can lead to hypothermia which may be fatal Instead, wipe the newborn with a soft moist cloth to keep her clean Ensure that the room is warm and free of draughts during this procedure Bathing is not recommended till the child is atleast one week old

3.4 Assessment of Birth Weight

Weight should be recorded soon after birth, but not later than 2 days Health workers and traditional birth attendants are being provided with a spring balance for use during domiciliary deliveries Teach them how to weigh the newborn using this balance The spring balances have a colour code corresponding to different weight categories Green (2500-4000 gm), Yellow (2000-2500 gm) and Red (less than 2000 gm) Management of the newborn based on birth weight is indicated in the table

Birth weight	Colour Code	Where to manage
More than 2500 gm	Green	Home
2000 2500 gm	Yellow	Home
Less than 2000 gm	Red	Referral*

* Newborns with birth weight above 1800 gms who are sucking well and do not show any signs of illness can be managed at home

Newborns including low birth weight infants who show any signs of illness must be referred to an institution which has facilities for newborn care

3 5 Breastfeeding

All newborns who cry soon after birth and do not show any signs of illness must be kept with their mothers and put to the breast soon after birth This will ensure warmth, initiation of breastfeeding and emotional bonding Breast feeding should be initiated within the first hour after birth. This ensures establishment of lactation and early involution of the uterus No prelacteal feeds such as glucose water, honey, gur, ghutti, etc should be given

AFTER WIPING DRY AND WEIGHING GIVE THE BABY TO THE MOTHER IN THE LABOUR ROOM ITSELF FOR BREASTFEEDING

Exclusive breastfeeding will save lives of many babies by preventing malnutrition and infections like diarrhoea and pneumonia Case fatality rates due to these infections are high in early infancy

4 PREVENTION OF HYPOTHERMIA

The newborn is at risk of hypothermia because of poor thermal control mechanism. This is due to factors that increase body heat loss and its inability to generate sufficient body heat to match heat loss

Hypothermia can be prevented in newborns by keeping the baby in close physical contact with the mother The baby should be wrapped in several layers of cotton/woollen clothing depending on the environmental temperature The room where the baby is kept must be warm enough for an adult to feel just uncomfortable The room should be free from draughts

Hypothermia can be fatal for the child A child with hypothermia feels cold when the dorsum of the hand is placed on its body The baby becomes lethargic and refuses feeds Hypothermia is an emergency and must be treated promptly The baby can be rewarmed rapidly by keeping her under a lamp

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with a 200 watt bulb placed 45 cms above the baby If baby fails to improve within 30 40 minutes of initiating rewarming REFER immediately to a health facility using the quickest mode of transport for further management The mother must be advised to keep the baby wrapped and close to her body during transport

5 PREVENTION OF INFECTION

Prevention of infection is very important as the newborn infants are susceptible to infection and succumb quickly The risks are higher in low birth weight babies, especially pre-terms

- The prevention of infection begins with TT immunization of the mother Clean delivery practices are very important to minimize risks of infection Labour rooms must be clean and if the delivery is taking place at home the dai and the health workers must ensure that the place of delivery is clean The attendant at birth must wash hands thoroughly with soap and water Presterilised gloves should be used by the attendant

- The cord should be cut with a new blade or autoclaved scissors The cord should be tied with a clean cord tie It should be kept clean and dry Application of medication or dressing the cord does not prevent umbilical cord infection Dressing of the cord stump is not recommended

- Hand washing with soap and water for at least 1 min before handling the baby is the most effective method of preventing infection in the newborn, because hand transmission is a common mode of infection in the newborn

- A common source of infection is the prelacteal feeds and water given to the child, even if she or he is being breastfed A non-breastfed child is at a higher risk of infection Bottles should NEVER be used for feeding due to the high risk of contamination Exclusive breastfeeding must be strongly promoted

- Personnel with skin infections, respiratory infections or diarrhoea **must not handle the baby** till their infection is under control

- The baby should not be taken to a place where there are other sick children such as the OPDs They should preferably not be taken to any place with a large gathering and should be handled by as few persons as possible

- In case of institutional deliveries, the zero dose of OPV and BCG should be given to the baby before discharge The mother must be informed of the immunization schedule and advised to bring the baby for the first dose of DPT and OPV at six weeks

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- [illegible] where there is peripheral circulatory [illegible] by the [illegible] cyanosis absent pulse and/or capillary [illegible] more [illegible] give volume expanders

  Dose 10 ml/kg of Ringers lactate
  or 0 9% saline IV

7 4 1 Sites for establishing intra-venous access

Dorsum of hands or feet	Antecubital fossa
Long saphenous vein	Veins on the scalp

7.4.2 Technique

Clean the skin with alcohol Puncture the skin over the vein with a cannula or scalp vein needle of size 22G or 23G Infuse normal saline through the cannula or needle to check whether it is in the vein Tape the cannula securely Do not cover the skin overlying the tip to enable observation for extravasation Immobilize the cannula with a splint

8 LOW BIRTH WEIGHT

Newborns with a birth weight of less than 2500 gm are known as low birth weight newborns One-third of all newborns are LBW These newborns are at a higher risk of hypothermia, infection and death It is possible save most of these babies with simple interventions

8 1 Management of LBW Newborns

- Provide warmth
- Exclusive breastfeeding
- Prevent infections
- Teach mother to recognise danger signs for seeking help
  - ☐ Refusal of feeds
  - ☐ Increased drowsiness
  - ☐ Difficult breathing
  - ☐ Apnoea
  - ☐ Cold to touch
  - ☐ Yellow staining of skin
  - ☐ Convulsions

8 2 When to Refer LBW Newborns

- Babies between 1800-2500 gm, can be managed at home provided they have no signs of illness However they will need special care at home

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- All [illegible] less than 1800 gm should be referred for specialist care
- LBW [illegible] who are sucking poorly at the breast, are hypothermic or have any of the following signs of illness should also be referred for specialist care
  - ☐ Lethargy
  - ☐ Fast breathing and/or chest indrawing
  - ☐ Apnoea
  - ☐ Abdominal distension
  - ☐ Cyanosis
  - ☐ Pathological jaundice
  - ☐ Diarrhoea
  - ☐ Convulsions

9. CARE OF SICK NEWBORN

CLASSIFICATION OF A SICK NEWBORN

SEVERITY	SYMPTOMS	PLACE OF MANAGEMENT
Mild Illness	Umbilical discharge Conjunctivitis Pyoderma	Home
Severe Illness	Diarrhoea Fast breathing /Chest Indrawing Feeding poorly Decreased activity Fever	Inpatient care in a Health Facility
Very Severe Illness	Inability to feed Hypothermia Abdominal distension Imperforate anus No urine for 48 hrs Cyanosis Apnoea Convulsions Bleeding Pathological jaundice	Must be admitted in a health facility for specialist care

Mild Illness

These babies can be managed at home with the use of appropriate [illegible]biotics

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Annex 29

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Discription of Item	Year I USAID	Year I WVUS	Year I Total	Year II USAID	Year II WVUS	Year II Total	Year III USAID	Year III WVUS	Year III Total	Year IV USAID	Year IV WVUS	Year IV Total	USAID Total	WVUS Total	G Total
I Salaries and Benefits															
1 CSP Team Leader@191/m	2411	0	2411	2652	0	2652	2917	0	2917	3209	0	3209	11189	0	11189
2 CSP Manager@247/m	3040	0	3040	3344	0	3344	3679	0	3679	4047	0	4047	14110	0	14110
3 Technical Officer@175/m	2183	0	2183	2401	0	2401	2641	0	2641	2905	0	2905	10130	0	10130
4 Finance/Adm Coord@109/m	1391	0	1391	1530	0	1530	1683	0	1683	1851	0	1851	6455	0	6455
5 Monitoring/Eva Coord @114/m	1451	0	1451	1679	0	1679	1839	0	1839	2015	0	2015	6984	0	6984
6 Development Coord @114/m	1451	0	1451	1679	0	1679	1839	0	1839	2015	0	2015	6984	0	6984
7 Training Coord @104/m	1340	0	1340	1474	0	1474	1621	0	1621	1783	0	1783	6218	0	6218
Other Personnel															
1 Community Dev Organiz @86/m	8920	0	8920	20960	0	20960	24384	0	24384	28144	0	28144	82408	0	82408
2 Auxillary Nurse Midwife@91/m	4700	0	4700	5170	0	5170	5687	0	5687	6256	0	6256	21813	0	21813
3 M/E Assistant@86/m	1115	0	1115	1310	0	1310	1524	0	1524	1759	0	1759	5708	0	5708
4 Training Asst @86/m	1115	0	1115	1310	0	1310	1524	0	1524	1759	0	1759	5708	0	5708
5 Administrative Asst /@86/m	1115	0	1115	1310	0	1310	1524	0	1524	1759	0	1759	5708	0	5708
6 Drivers(2) Illyr (3)@86/m	2230	0	2230	3930	0	3930	4572	0	4572	5277	0	5277	16009	0	16009
7 Accountant @ 114/m	1451	0	1451	1679	0	1679	1839	0	1839	2015	0	2015	6984	0	6984
Total Salaries/benefits	**33913**	**0**	**33913**	**50428**	**0**	**50428**	**57273**	**0**	**57273**	**64794**	**0**	**64794**	**206408**	**0**	**206408**
II Travel/Per diems															
1 Local Travel (within India)															
a Site visits by Project partners	1000	0	1000	1000	0	1000	1000	0	1000	1000	0	1000	4000	0	4000
b Site visits by Project staff	3000	0	3000	3000	0	3000	3000	0	3000	3000	0	3000	12000	0	12000
c Program/Training related travel by partners	2000	0	2000	2000	0	2000	2000	0	2000	2000	0	2000	8000	0	8000
d Program/Training related travel by staff	3000	0	3000	3000	0	3000	3000	0	3000	3000	0	3000	12000	0	12000
e Administrative travel	500	0	500	500	0	500	500	0	500	500	0	500	2000	0	2000
f Incountry travel for Consultants	500	0	500	500	0	500	500	0	500	500	0	500	2000	0	2000
2 Regional Travel (within Asia Pacific)															
a Baseline consultant Airfare/per diem	400	0	400	0	0	0	0	0	0	0	0	0	400	0	400
b Regional PHC consultant Airfare/per diem lyr 3trips 2nd Yr onwards 4 trips	3420	0	3420	5000	0	5000	5333	0	5333	5666	0	5666	19419	0	19419
c Community base EPI surveillance consultant	0	0	0	1250	0	1250	0	0	0	0	0	0	1250	0	1250
d Cost Recovery consultant	0	0	0	0	0	0	1250	0	1250	0	0	0	1250	0	1250
e Regional Conferences/ Workshops															
(3 person including partner)	0	0	0	3750	0	3750	3750	0	3750	0	0	0	7500	0	7500

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3 International Travel															
a Mid term Evaluation Consultant	0	0	0	2500	0	2500	0	0	0	0	0	0	2500	0	2500
b Final Evaluation Consultant	0	0	0	0	0	0	0	0	0	2500	0	2500	2500	0	2500
4 Transport Cost															
a Fuel for 2 Wheelers 340/m	4080	0	4080	4280	0	4280	4480	0	4480	4680	0	4680	17520	0	17520
b Fuel for 4 wheelers 104/m	2447	0	2447	3271	0	3271	3471	0	3471	3671	0	3671	12860	0	12860
c Vehicle maintenance	4800	0	4800	4944	0	4944	5092	0	5092	5245	0	5245	20081	0	20081
d GIK Transport Ocean	0	0	0	0	0	0	6000	0	6000	0	0	0	6000	0	6000
e GIK Transport Internal	0	0	0	0	0	0	1000	0	1000	0	0	0	1000	0	1000
															0
Total Travel	**25147**	**0**	**25147**	**34995**	**0**	**34995**	**40376**	**0**	**40376**	**31762**	**0**	**31762**	**132280**	**0**	**132280**
III Trainings															
a Training for CMO staff	1190	0	1190	1000	0	1000	700	0	700	600	0	600	3490	0	3490
b Training for PHC staff	1200	0	1200	1000	0	1000	800	0	800	600	0	600	3600	0	3600
c Training for ANMs	2700	0	2700	3200	0	3200	3200	0	3200	500	0	500	9600	0	9600
d Capacity building (local NGOs)	2000	0	2000	6000	0	6000	5500	0	5500	5000	0	5000	18500	0	18500
e Capacity building (private sector)	2000	0	2000	4400	0	4400	6200	0	6200	5500	0	5500	18100	0	18100
f Capacity building people s															
organization	5000	0	5000	10000	0	10000	12500	0	12500	10000	0	10000	37500	0	37500
g DIP Workshop	1208	0	1208	0	0	0	0	0	0	0	0	0	1208	0	1208
h KPC Survey	4698	0	4698	500	0	500	500	0	500	500	0	500	6198	0	6198
i First Annual review	1208	0	1208	0	0	0	0	0	0	0	0	0	1208	0	1208
j Mid term evaluation	0	0	0	1500	0	1500							1500	0	1500
k Third Annual review	0	0	0	0	0	0	1300	0	1300	0	0	0	1300	0	1300
l Final Evaluation	0	0	0	0	0	0	0	0	0	2000	0	2000	2000	0	2000
m Host regional QA workshop	0	0	0	0	0	0	18000	0	18000	0	0	0	18000	0	18000
n Best practices workshops	0	0	0	640	0	640	1120	0	1120	3000	0	3000	4760	0	4760
o Sustainability workshop	120	0	120	0	0	0	0	0	0	0	0	0	120	0	120
p RCH Workshop	200	0	200	0	0	0	0	0	0	0	0	0	200	0	200
q Development of Training material	0	0	0	2000	0	2000	0	0	0	0	0	0	2000	0	2000
r HFA	595	0	595	0	0	0	0	0	0	0	0	0	595	0	595
s Lesson learnt workshop	0	0	0	850	0	850	1150	0	1150	1150	0	1150	3150	0	3150
t Project Staff Training	12700	0	12700	13200	0	13200	13200	0	13200	10000	0	10000	49100	0	49100
															0
Total Training	**34819**	**0**	**34819**	**44290**	**0**	**44290**	**64170**	**0**	**64170**	**38850**	**0**	**38850**	**182129**	**0**	**182129**
IV Professional fees															
Evaluation Consultant															
a Baseline															
consultant(15day@59/day)	885	0	885	0	0	0	0	0	0	0	0	0	885	0	885
b Mid term															
Evaluation(20days@750/day)	0	0	0	15000	0	15000	0	0	0	0	0	0	15000	0	15000
c Final Evaluation(20dys)@750/day										15000	0	15000	15000	0	15000
d Auditor@750/year	750	0	750	750	0	750	750	0	750	750	0	750	3000	0	3000
e HFA Consultant @ 750x14days	10500	0	10500	0	0	0	0	0	0	0	0	0	10500	0	10500

f Consultancy Zonal advisor(48dys@100/day)	4800	0	4800	4800	0	4800	4800	0	4800	4800	0	4800	19200	0	19200
External Consultant															
a Regional PHC Consultant(I yr 21 days@275/yr 2nd Yr onwards 28days@275/yr)	5775	0	5775	7700	0	7700	7700	0	7700	7700	0	7700	28875	0	28875
b Sustainability/Cost Rec Consult 14days@500/day	0	0	0	0	0	0	7000	0	7000	0	0	0	7000	0	7000
c Community Based EPI consultancy 6days@225/day	0	0	0	1350	0	1350	0	0	0	0	0	0	1350	0	1350
Total professional fees	**22710**	**0**	**22710**	**29600**	**0**	**29600**	**20250**	**0**	**20250**	**28250**	**0**	**28250**	**100810**	**0**	**100810**
V Procurement															
Supplies															
1 G I K pharmaceuticals	0	350000	350000	0	0	0	0	0	0	0	0	0	0	350000	350000
2 Basic medicines	0	1000	1000	0	1000	1000	0	1000	1000	0	1000	1000	0	4000	4000
3 Office supplies@ 70/mo	900	0	900	900	0	900	900	0	900	900	0	900	3600	0	3600
4 Training materials (cards charts work books vedio cassettes)	1450	0	1450	1450	0	1450	1450	0	1450	1450	0	1450	5800	0	5800
5 Computer Supplies (Stationery & software)	1450	0	1450	1500	0	1500	1500	0	1500	1500	0	1500	5950	0	5950
Equipments															
# Photocopy Machine	3278	0	3278	0	0	0	0	0	0	0	0	0	3278	0	3278
# TV/ VCR	541	0	541	0	0	0	0	0	0	0	0	0	541	0	541
# Computers (3)@1666	5000	0	5000	0	0	0	0	0	0	0	0	0	5000	0	5000
# Overhead projector	1011	0	1011	0	0	0	0	0	0	0	0	0	1011	0	1011
# Slide projector	2000	0	2000	0	0	0	0	0	0	0	0	0	2000	0	2000
# Hand microphone	100	0	100	0	0	0	0	0	0	0	0	0	100	0	100
# Fax machine	976	0	976	0	0	0	0	0	0	0	0	0	976	0	976
# Vehicles (3)@8300	0	16600	16600	0	8300	8300	0	0	0	0	0	0	0	24900	24900
# Obstetric bed (20)@35	700	0	700	0	0	0	0	0	0	0	0	0	700	0	700
# Suction machine (low pressure elect (3))@76	228	0	228	0	0	0	0	0	0	0	0	0	228	0	228
# Operating lamps (3)@74	222	0	222	0	0	0	0	0	0	0	0	0	222	0	222
# Thermometer for monitoring vaccine temperature (3)@2	6	0	6	0	0	0	0	0	0	0	0	0	6	0	6
# Minor Surgical set (3)@16	48	0	48	0	0	0	0	0	0	0	0	0	48	0	48
# High pressure steam sterlizer (17)@28	476	0	476	0	0	0	0	0	0	0	0	0	476	0	476
# Veginal Speculum (3)@3	9	0	9	0	0	0	0	0	0	0	0	0	9	0	9
# Baby Scale(20)@11	220	0	220	0	0	0	0	0	0	0	0	0	220	0	220
# Salter scale(3)@8	24	0	24	0	0	0	0	0	0	0	0	0	24	0	24
# Otoscope(3)@12	36	0	36	0	0	0	0	0	0	0	0	0	36	0	36

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# Blood pressure set (20)@17	340	0	340	0	0	0	0	0	0	0	0	0	340	0	340
# Stethscope(17)@3	51	0	51	0	0	0	0	0	0	0	0	0	51	0	51
# Fetoscope(17)@1	17	0	17	0	0	0	0	0	0	0	0	0	17	0	17
# Weighing scale for the new born	187	0	187	0	0	0	0	0	0	0	0	0	187	0	187
# Long forceps(17)@5	85	0	85	0	0	0	0	0	0	0	0	0	85	0	85
# Gloves(17)@7for 50 pcs	119	0	119	0	0	0	0	0	0	0	0	0	119	0	119
# TBA kits(17)@16	272	0	272	0	0	0	0	0	0	0	0	0	272	0	272
# Sterlizer(3)@9	27	0	27	0	0	0	0	0	0	0	0	0	27	0	27
# Tables 15@22	330	0	330	0	0	0	0	0	0	0	0	0	330	0	330
# Chairs(35)@11	385	0	385	0	0	0	0	0	0	0	0	0	385	0	385
# Almirah(5)@65	325	0	325	0	0	0	0	0	0	0	0	0	325	0	325
# Filing Cabinets(6)@92	552	0	552	0	0	0	0	0	0	0	0	0	552	0	552
# Digital Camera	500	0	500	0	0	0	0	0	0	0	0	0	500	0	500
Total Procurement	**21865**	**367600**	**389465**	**3850**	**9300**	**13150**	**3850**	**1000**	**4850**	**3850**	**1000**	**4850**	**33415**	**378900**	**412315**
VI Other Direct Costs															
1 Communications															
a Postage/ Courier telephone fax/ telex@150/m	1800	0	1800	1854	0	1854	1910	0	1910	1967	0	1967	7531	0	7531
2 Facilities (Rental & Util)															
a Rent for Project Office@159/m	1911	0	1911	2102	0	2102	2312	0	2312	2543	0	2543	8868	0	8868
b Rent for sub centers Yr I=4 Yr 2=6 Yr 3=8 Yr 4=8	571	0	571	857	0	857	1142	0	1142	1142	0	1142	3712	0	3712
c Honorariam to animators Yr 1=20 Yr 2=40 Yr 3=82 Yr 4=82	2000	0	2000	4000	0	4000	8200	0	8200	8200	0	8200	22400	0	22400
													0	0	0
Total Other Direct Costs	**6282**	**0**	**6282**	**8813**	**0**	**8813**	**13564**	**0**	**13564**	**13852**	**0**	**13852**	**42511**	**0**	**42511**
VII Other Costs															
a Printing of RCH(300000) cards	21428	0	21428	0	0	0	0	0	0	0	0	0	21428	0	21428
b Printing of Training material after adaptation	0	0	0	5000	0	5000	0	0	0	0	0	0	5000	0	5000
															0
Total Other costs	**21428**	**0**	**21428**	**5000**	**0**	**5000**	**0**	**0**	**0**	**0**	**0**	**0**	**26428**	**0**	**26428**
VIII Sub Total Direct Costs	**166164**	**367600**	**533764**	**176976**	**9300**	**186276**	**199483**	**1000**	**200483**	**181358**	**1000**	**182358**	**723981**	**378900**	**1102881**
IX Local contribution by WVIndia		25000	25000	0	25000	25000	0	25000	25000	0	25000	25000	0	100000	100000
X MSC		13408	13408		13408	13408		13408	13408		13408	13408		53632	53632
XI Indirect Costs@20%	33233	0	33233	35395	0	35395	39897	0	39897	36272	0	36272	144796	0	144796
XII A17Grand Total	**199397**	**406008**	**605405**	**212371**	**47708**	**260079**	**239380**	**39408**	**278788**	**217630**	**39408**	**257038**	**868777**	**532532**	**1401309**