CARE in India

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October 1, 1998 to September 30, 2002

Detailed Implementation Plan

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A FIELD PROGRAM SUMMARY

PVO/Country India Program Duration October 1, 1998 – September 30, 2002

Table 1 Estimated Program Effort and USAID Funding by Intervention

Intervention	Percent of Total Effort	AID Funds ($ US)
Maternal & Newborn Care	40%	311,478
Breast-feeding Promotion	20%	155,739
Immunizations	20%	155,739
Child Spacing	20%	155,739
Total	**100%***	**778,695**

Table 2 Program Site Population Women and Children

Population Age Group	Number in Age Group
Infants (0-11 months)	5,300
12-23 Month Old Children	5,300
24-59 Month Old Children	15,900
Total 0-59 Month Olds	26,500

Population Age Group	Number in Age Group
Women (15-49 years)	53,000

ESTIMATED ANNUAL NUMBER OF LIVE BIRTHS IN THE SITE 6,360

SOURCES OF THE POPULATION ESTIMATES ABOVE 1991 CENSUS (GOI)

* It is expected that $48,000 will be provided by the World Health Organization (WHO) for IMCI initiatives This is in addition to technical assistance that WHO will provide

B PROGRAM LOCATION

Program Area

The state of Bihar is one of the poorest and least developed Indian states With a population of 86,374,465 (1991 census), it is the second most populated state in the country and has the lowest literacy and per capita income levels, along with one of the highest mortality rates Approximately 87% of the population reside in rural and tribal areas, isolated from information, services, and supplies, which support survival The Child Survival Project will be implemented in Patamda and Potka, two community development blocks located in East Singhbhum district in the south of Bihar (see attached maps - ANNEX A) East Singhbhum was carved out of an undivided Singhbhum district in 1991 and Jamshedpur became the district headquarters While Jamshedpur is well developed due to the presence of large corporate industries (primarily the Tata group), the rural and tribal areas in the district lack available resources, services, and infrastructure Geographically, the district is part of Chottanagpur plateau, a vast undulating land studded with mountains, which was once covered with dense forest

Target Group

The primary target population of the project is pregnant and lactating women and mothers of children under two years in age The role of the mother in determining the health status of her child is well established, both, as a result of her own health status, as an outcome of her caring capacity The project target population is defined in terms of the women who can influence child survival rather than the infants who actually benefit from such actions To achieve the overall project goal of reducing infant mortality and, thereby, enhancing child survival, project efforts will focus on providing health information, services, and supplies to pregnant women and mothers of infants to support the practice of healthy behaviors most often associated with mortality reduction Particular emphasis will be placed on reaching those who are not adequately reached or not presently served by existing health programs Additionally, the Government of India, CARE's NGO project partners, TSRDS and PKS, and USAID prioritize the tribal project target group

Women are aware of the risks of pregnancy, childbirth, and neonatal death and many are particularly receptive to options for safe delivery, neonatal care, and family spacing options during pregnancy The importance of reaching women during pregnancy is increasingly recognized as critical to improving maternal health, birth weight, and birth outcome, which would lead to improve neonatal survival Hence, reaching women and providing support for healthy practices during pregnancy, delivery, and the post-partum period is seen as a primary mechanism to reduce neonatal mortality Pregnant women represent approximately 3% of the population at any point in time In other words, any village of 1,000 will include about 30 pregnant women Thus the number of pregnant population to be served by the Child Survival Project is estimated to be 6,360 During the first six months of the project, efforts will focus on early registration of pregnant women and establishing systems to improve information, services, and supplies provided to these women

Mothers of the neonates who are identified and registered will receive focused attention to reinforce the behaviors promoted during pregnancy Assistance will be provided to solve problems mothers encounter while trying to practice promoted behaviors, especially as related to motivation and ANC attendance obstacles After the initial six-month start up of the project, a more concerted effort to register all children under two will be implemented

Mothers of children under two years of age will be prioritized for health information, counseling, and receiving essential services These mothers will also be encouraged and supported in the practice of project targeted healthy behaviors Children under the age of two represent approximately 5% of the population A village of 1,000 would have approximately 50 children under two years old and an equal number of mothers with children less than two years old An estimated 10,600 children under two years of age reside in the project area

Although women are the primary source of care for their children, they are also responsible for the health and nutrition of their families Unfortunately, these mothers do not always have the authority to make decisions for practicing healthy behaviors In CARE-India's experience, family members including mothers-in-law, sisters-in-law, and husbands play important roles in determining the health behaviors of their families The project will try to reach influential family members and provide them with health information related to family health needs and their personal role in supporting the practice of healthy behaviors These family decision-makers are considered secondary participants in the project and consist of approximately 12,000 individuals

Socio-Economic Characteristics

The entire population of the project area can be divided into two broad categories tribals and non-tribals The tribal population is an indigenous one, while the non-tribals have largely migrated into the region for employment In Patamda and Potka blocks, the prominent tribal population consists of the Santhal, Bhumij (Sardar), Savar (Kharia), Mahali, Paharia and Birhore The Santhal are the major tribal ethnic group followed by the Bhumij, Sawara and Mahali The non-tribals, attracted to the area by the industrialization process, are made up by the Mahato, Khumbhakar, Gope, Patra, and Karmakar communities All of these non-tribal groups are officially designated as "backward communities" by the GOI and are called scheduled castes

Agriculture and related activities are the economic base in these two blocks Major crops include rice, wheat, grams, legumes, oil, seeds, and a variety of vegetables Selling agricultural produce in nearby markets or Jamshedpur is a common practice among the villagers A significant number, especially those who reside near Jamshedpur, are employed by factories run by the Tata group of companies as skilled or unskilled laborers Others are employed as day laborers in nearby brick kilns or infrastructure development activities such as bridge or road construction The sale of forest products such as firewood, fruits, gums, leaves, etc represents an additional source of income for tribal populations Traditional crafts such as pottery, bamboo works, weaving, and fisheries provide income for other families

The tribals of Patamda and Potka worship "Nature" as the principal God Generally, the community members believe in the existence of a supernatural power that controls all the events of life They believe that "Life" does not end with death and superstition plays a significant role in their lives The proximity of non-tribals to tribals and the continuous interaction between groups has resulted in some tribals celebrating Hindu festivals The majority of the non-tribal population is Hindu, but there are villages inhabited by Christians and those of the Islamic faith

A very low literacy rate in both blocks reflects the non-availability or under utilization of facilities for basic education The general literacy rate is comparable to the rest of the nation (see Table 3), but the female literacy rate is very low (15%) Education is sometimes seen as too expensive or meaningless, especially for women and among tribal ethnic groups inhabiting isolated places Females who reside closer to Jamshedpur show higher literacy rates, particularly in Potka Block

Traditionally females perform household work while males are engaged in outdoor work The industrialization process has changed this because an increasing number of women are engaged in activities outside their homes Although non-tribal communities are patriarchal and share most socioeconomic characteristics, there are differences in the status of women Unlike the non-tribals, tribal women do take part in village meetings and play a crucial role in various decision-making processes at the household level

The most common work in for women is agricultural activities, i e , field preparation, planting, harvesting, or selling of agriculture products A number of women work in unskilled or semi-skilled occupations, including construction-related activities Other women are involved in processing and selling articles for household use Family or household members (usually older siblings, husbands, or grandparents) assume childcare responsibility where the mother works outside of the home and the child does not accompany her

People in both blocks are generally deprived of basic infrastructure for communication, drinking water, education, and health services The government's ability to provide basic facilities is limited Community Based Organizations (CBOs) and NGO communities in the region seek to improve the quality of life but are limited by resource constraints The health status of the community is generally poor, but worse for the Birhore and Paharia tribal areas because they are both primitive and nomadic in nature

The Child Survival Project has been designed to transfer basic skills, knowledge, and practices to rural communities Specifically, community-based operating partners (CBOPs), mahila Mandals (a village women's group), and birth attendants (both trained and otherwise) form a core group that will be agents of change A capacity building training session is planned to teach local partners appropriate health behavior counseling techniques and exposure visits to areas where successful maternal and child health (RCH) activities are currently taking place have also been scheduled For immunization and related activities, a program where community partners will work towards demand generation, encourage community participation, and ensure access and availability of appropriate items has been envisioned and articulated For breast feeding promotion, working with birth attendants to promote breast-feeding soon after delivery has been identified as a key strategy to enhance behavioral change They will educate the mother about proper positioning of the child, switching breasts during feeds, and maintaining certain levels of hygiene As the majority of deliveries in the area take place with birth attendants, leveraging their accessibility and acceptability become crucial to this intervention

Many of the proposed ANC activities are not feasible for a community to perform The communities can be responsible for health counseling (including when to go for ANC check-ups, how many a woman should receive, etc), but the actual delivery component will be with the government or the NGOs However, birth attendants will be trained to know how safe deliveries should be conducted, recognize complicated pregnancies, and take appropriate action as necessary Finally, both NGOs plan to work with CBOPs to "socially market" birth control devices such as oral pills, condoms, and Copper T Initially, supplies will be procured from government sources, but when these supplies fall short, community-groups themselves will be mobilized to offset and supply with their own resources While this list is by no means exhaustive, it does show how responsibilities for certain activities will be transferred to communities

The behavioral change counseling will be primarily be taken up by the 60+ field workers that the NGOs have committed to hire These field workers are either current NGO staff that will have their assignment changed such that their efforts are 100% dedicated for Child Survival or villagers who have been trained

NGOs have previously trained and conducted services in rural areas, or assisted influential villagers who have a good relationship with their community Extensive efforts will be made to motivate the AWW to promote specific behavioral changes as well

Community mobilization, IEC/BCC, and capacity building activities have been described at the onset of the Detailed Plans by Intervention (Section M) Also the program approach for each intervention describes the specific activities that field-workers will implement for immunizations, breast-feeding, ANC, and birth spacing

Levels and Causes of Mortality

Interventions with the greatest potential to reduce infant mortality will also have the greatest impact on child survival in Bihar Infant mortality reduction is directly related to neonatal mortality, which accounts for 62% of all infant deaths in rural Bihar Neonatal mortality is most often associated with maternal health and nutrition and care during the delivery and post-partum period However, the health and nutrition status of women in Bihar is particularly poor and their capacity to care for their infants is limited by poor access to health services, nutrition information and prevention services

In rural Bihar, the infant mortality rate is 94/1000 live births, the neonatal mortality rate is 55/1000 live births, and the maternal mortality ratio is 1490/ 100,000 live births [1] These rates are high in comparison to the national average and to most countries in the world Within Bihar, mortality statistics are highest and coverage rates for health outcomes worst in rural areas with high proportions of scheduled tribe and scheduled caste populations The project is oriented to reach these high-risk groups, as the site area is one in which the population is 91% scheduled caste or scheduled tribe Based on NFHS estimates, IMR in this area will be higher than those estimates for rural Bihar (between 97-129 per 1000 live births)

Neonatal tetanus is one of the major causes of neonatal deaths in rural Bihar, 27% (KPC) of women do not even receive a single dose of TT Secondly, deaths among women who did not receive care during pregnancy and delivery were almost twice high as for women who received services, making a strong argument to improve access to care during pregnancy, delivery, and postpartum Thirdly, a strong association exists between maternal nutrition and anemia status, low birth weight, and high infant mortality [2] In the project area only 10% receive the required 100 iron tablets and only 9% consume 100 or more of such tablets during pregnancy (as per BLS which did not seek any documentation to verify either claim) Finally, the association between child spacing and child survival is well established However, the unmet need for family planning in Bihar (women who do not want a child and not using a modern method) is estimated to be 82 14% and current use of a modern spacing method is estimated to be 8 7% Improvements in care during pregnancy, delivery, and postpartum will contribute to maternal as well as infant survival

Access to infant care services is less than optimal Vaccine-preventable diseases continue to make a significant contribution to infant mortality in Bihar A disease survey conducted in August 1997 in East Singhbhum district noted 94 cases of diphtheria, 12 cases of whooping cough, and seven cases of measles among children under five The KPC Baseline measles immunization coverage is less than 12% in rural Bihar and measles outbreaks are still reported[3] Another notable factor is infant feeding practices A large

[1] CARE India, Bihar State Office Report - 1998
[2] The World Health Report 1997 - Report of The Director-General, Geneva 1997
[3] KPC Cluster Survey conducted 2/99 by PKS, TSRDS and CARE India

percent received some form of pre-lacteal feed, and 85% (BLS) did not initiate semi-solid complementary food by six months of age

The low coverage rates for healthy practices during pregnancy, delivery, and the post-partum period is commonly attributed to government facilities, which lack sufficient staff, equipment, or supplies Innovative strategies are required to expand successful NGO and community efforts to complement existing government services and improve access to health services in the state [4]

Related Activities, Facilities, and Programs

A large proportion of the program villages in the two identified blocks are remote, isolated and have limited access to health services and programs for maternal and child survival According to the government guidelines for the state of Bihar, there is one sub-center staffed by an Auxiliary Nurse Midwife (ANM) or other health worker for every five to six villages, one primary and one additional health center for every block, and one Anganwadi center (AWCs) and two workers (AWW and helper) in each village However, a vast majority of these facilities lack sufficient supplies and staff and, consequently, are not utilized A review of the ICDS activities in the program area revealed that the Anganwadi centers are non-functional in many villages The Central Technical Committee (CTC), Integrated Child Development Services (ICDS) has been in existence since 1975 The "Red Book " of the ICDS has been very popular since the ICDS system was initiated It contains chapters on Monitoring, Evaluation, Continuing Education, Evaluation and Research, and Training systems The Red Book has a section covering health and nutrition education which is very well done and remains more timely than the UNICEF *Facts for Life* publication

In a majority of the villages in Patamda, TSRDS provides excellent health services to communities This includes one Health Center and two sub-centers, which provide curative and preventive services CBWs provide outreach services for immunization of children and doctors and paramedical staff conduct antenatal check-ups in the centers In Potka block, PKS provides health services such as immunization, antenatal care, family planning, etc through its mobile clinics in 17 villages

A few NGOs are involved in community mobilization and group formation for income generation and adult education programs as well as for health promotion activities in selected villages This offers an opportunity for partnering with community groups wherever possible and for promoting maternal and child survival interventions Traditional Birth Attendants (TBAs) are present in most villages and they typically attend to deliveries in their villages and sometimes even in two or three nearby villages Both TSRDS and PKS have trained TBAs in the program area to conduct safe deliveries TSRDS has also trained local youth as community mobilizers for vaccinations and as family planning motivators The investments made by TSRDS and PKS, as well as other smaller NGOs and the government in building local capacities lay a critical foundation to implement the Child Survival Project in the area

With the exception of the activities of the government and both NGOs, no other organization is promoting the same behavioral changes as the Child Survival project The MOH Protocol and Current Activities (under Interventions) sections describe what activities take place under the status quo and what is actually planned to occur CARE is aware that the government is the only agent in the area that makes any attempt to promote the four Child Survival interventions that the project will implement Specific details and quantitative data will be provided when program activities begin and a more formal survey of government activities in the area takes place

[4] The State of the World's Children 1998 UNICEF Oxford University Press

The Project Proposal discusses the key recommendations made for CARE-India's Title II programs, specifically, 1) focus on pregnant and lactating women and children under two, 2) community-based health programs in addition to food provisions, and 3) increased attention on birth spacing and women's nutrition This detailed implementation plan was specifically designed to address these issues

The Child Survival Project interventions are a subset of those promoted in INHP High-Impact areas Specifically, while HI areas promote ten interventions, the Child Survival Project will promote only four ANC, infant feeding, immunizations, and birth spacing Consequently, the program is not advocating any behavioral changes that are not already being encouraged in nearby areas

However, this initiative is very different from other programs in the state since two NGO partners will execute it, whereas CARE will only provide technical assistance and support In other sub-contract agreements in Bihar, and other states in India as well, NGOs pick up a number of villages in the project area in which CARE already works In this Child Survival project, CARE has no plans to begin activities in Potka or Patamda blocks and the four interventions will be promoted exclusively by the partner NGOs (TSRDS and PKS) Additionally, the size, and scope of this NGO partnership dwarfs that of other collaborative efforts Finally, this venture is unique in that it marks one of CARE's few partnerships with an industrial house NGO The project will target changes in health behaviors (and reductions in infant mortality), the process will attempt to solicit other corporate NGOs to become actively engaged in socially responsible behaviors Both NGOs (and the corporations that back them) play leadership roles in the Confederation of Indian Industries (CII), the Federation of Industry and Chambers of Commerce–India (FICCI), and Associated Chambers of Commerce (ASSOCHAM) These forums will be a platform by which CARE can demonstrate successful collaborative efforts between an international PVO and local NGOs – and persuade other entities to replicate such efforts

An additional CARE India project in Ranchi (approximately 3 hours from Jamshedpur) is the Linkages project, as described below

> CARE-India has collaborated with the Academy for Educational Development (AED) to test and document a strategy for improving breast-feeding and maternal nutrition in Bihar, India, under the rubric of the Linkages project The project is implemented in only one block of Ranchi district of Bihar State, but the project process and results will inform a number of health and nutrition projects These include the large scale USAID-funded Integrated Nutrition and Health Project (INHP) and maternal and child health projects of AED and CARE worldwide This project will be implemented in a phased manner which will include a formative research, baseline, an intervention phase, an end point using both qualitative and quantitative methods and the final analysis, documentation and planning for incorporation and replication The intervention will also include the design of context-appropriate communication materials, which may have wider coverage This project will be implemented in partnership with community-based organizations, local and State government counterparts, private providers, and possibly a local NGO

The project partners are both dedicated to strengthening government facilities and to avoiding creation of a parallel health delivery structure Both NGOs have clearly articulated in Section M the activities they plan to initiate to improve the government's ability and to have a positive impact on child mortality These efforts include assessing current capabilities and training needs, capacity building exercises, logistical arrangements, procuring supplies, etc If government efforts prove to be inadequate (which is quite likely), then the NGOs will promote behavioral changes themselves

The primary data which an AWW records in her register includes commodities distribution, immunization records, IFA distribution, registration of pregnant women, ANC visits, growth monitoring and the names of those who have opted for permanent sterilization In the event that the government machinery is not functioning and the NGOs record this data themselves, the need for the government counterparts to possess this information does not diminish Therefore, it has been proposed that a monthly meeting be held with PKS, TSRDS, CARE, and the ICDS functionaries present to discuss how collaborative efforts can be enhanced During this forum, both NGOs can present updated records and data sets to the appropriate officials to maximize the use of data in the project implementation The ICDS can present this information to AWWs as they become activated

The community pharmacies (or revolving drug funds) will follow the model that has been successfully pioneered in the CARE INHP areas Activities begin when a group is formed to take on the responsibility of operating the drug fund and appoints one or two villagers (accompanied by the local AWW or some other health official) to discuss with the PHC doctor what drugs and medicines would be appropriate for such a program If the doctor is agreeable to such a program, he or she provides a list of basic drugs that are suitable for villagers to dispense At the same time, the group generates funds (usually through member contributions or community donations) to purchase a limited quantity of a few (typically no more than 10) season-specific drugs and medication from the list the PHC doctor has provided Before purchasing drugs, the villagers undergo basic training, which includes matching particular medicines with certain illnesses and dispensing appropriate amounts of drugs After the training, the group purchases a few medicines, explains to the larger village community that a drug fund activity has been initiated and makes the case that it would be more convenient for people to take advantage of their medicines than to make the trek to the nearest pharmacy The group then appoints one person to keep the medicines in her home and to keep track of the appropriate information with respect to the illness and dispensing of drugs (the appointment can be on a rotating basis) Once someone approaches the drug fund for medicine, the proper information is recorded and the drugs supplied The funds are kept on hand to periodically replenish the depleted stock of drugs or to purchase a different batch of drugs for the upcoming season

Table 3 Project Area Profile[5]

Information Profile	Patamda block	Potka block	East Singhbhum district
Area in sq km	51,153 43	1,20,582 52	41,8,025 13
Number of households	21,421	27,946	144 682
Number of residential houses	20,989	27,245	141 114
Total population	113,877	147,570	763,172
Total male population	58,069	74,993	389,521
Total female population	55,808	72,577	373,651
Scheduled Caste - Male	2,890	3,178	16,929
Scheduled Caste - Female	2,698	3,115	16,530
Scheduled Tribe - Male	23,252	39,945	196 311
Scheduled Tribe - Female	23,068	39,786	192,195
Literate Males	24,087	34,686	174,583
Literate Females	6,564	12,845	65,760
Agriculture Laborers	13,030	19,819	103,109
Cultivators	24,382	26,966	131,127
Total Male (0-5 yr)		13,024	68,140
Total Female (0-5 yr)		12,528	65,856
IMR	-	-	94
CMR	-	-	133
MMR	-	-	500

[5] District Gazette, 16th September 1994

C PROJECT GOALS AND OBJECTIVES

The overall goal of the project is to reduce infant and under-two mortality by improving coverage rates of health and curative practices associated with reduction in mortality, and to improve the capacity of operating community partners and NGOs to make continuous and sustained improvements in these coverage rates through healthy practices

The project will focus on interventions to reduce mortality within the first year of life by improving coverage rates of 10 healthy behaviors during pregnancy and infancy that have a proven association with child survival These ten areas form an integrated approach to healthy pregnancy and infancy and are divided into four intervention areas 1) Antenatal care and practices, 2) Infant feeding, 3) Immunization, and 4) Family spacing oriented toward infant survival Specific objectives are articulated below

The end of the project expects the following coverage rates

Antenatal care and preparation for safe delivery

- 50% of women receive 3 antenatal check-ups by delivery
- 60% of women receive and 50% consume 100 tablets of IFA by delivery
- 60% of pregnant women receive TT2 by delivery
- 50% of women have birth plan, with contingencies for emergencies and birth kit, in preparation for safe delivery

Infant feeding

- 65% of infants are put to breast within 8 hours postpartum
- 40% of infants are exclusively breast fed for four months
- 75% of infants 6-9 months consume semi solid foods

Childhood immunization

- 60% of children aged 12-23 months are completely immunized by age one

Family spacing

- 25% non-pregnant married women use a modern spacing method

Enabling sustainable and capable institutions forms the basis of all program interventions

The indicators to measure progress towards achieving this goal are articulated below

- Percentage of villages with active CBOP (community based operating partners - individual or community group)
- Percentage of villages with community health fund for emergencies or drugs
- Percentage of villages with institutionalized health days consisting of health fairs and other community-wide activities
- Partners have institutionalized systems to deliver services and provide basic supplies
- NGO match to budget increases over time
- Increased number of new NGOs replicating components or committing to social development activities
- NGO practices adopted and applied by CARE to other corporate sectors

Interventions such as the appropriate management of ARI and diarrhea, which enhance child survival, may be added by the collaborating agencies in the same project area

Figure 1 Project Logframe

The following Logframe describes how planned activities and inputs are expected to result in improved coverage rates and healthy practices associated with mortality reduction and sustainable institutions capable of making continuous improvements in these coverage rates

Objectives	Inputs	Outputs	Outcomes	Measurement
To improve coverage rates and health practices associated with reductions in infant mortality	Plans and timeline developed and documented Staff hired, trained, and placed with clear job description and scope of work Community based partners selected Learning aids procured and distributed Capacity IEC/BCC building events Monitoring systems implemented	% Pregnancies registered before 24 weeks gestation Staff performing within their Job Description CBOPs actively implementing activities Learning aids in use for counseling and information IEC/BCC information and local capacities to practice healthy behaviors applied Monitoring systems used for decision making	• 50% of women receive at least 3 antenatal check-ups by delivery, • 60% of women receive, 50% consume 100 tablets of IFA by delivery, • 60% of pregnant women receive TT2 by delivery, • 50% of women have birth plan, with contingencies for emergencies and birth kit, in preparation for safe delivery • 65% of infants are put to breast within 8 hours postpartum • 40% of infants are exclusively breast fed for four months • 75% 6 to 9 months children consumed complementary semi-solid foods by age 6 months • 60% of children aged 12-23 months are completely immunized by age one • 25% non-pregnant newly married women use a spacing method	Baseline, Mid-term, and Final Evaluation (External) Quarterly monitoring and review (Internal)
To improve the capacity of operating partners to make continuous and sustained improvements in these coverage rates of healthy practices	CBOPs selected CB inputs on how to establish village fund Liaisons with appropriate partners including regular supply of essentials	CBOPs actively implementing Funds initiated Registers of targeted population and household visits Improved availability of basic supplies and services	• 75% of villages with active CBOP (individual or community group) • 50% villages with community health fund for emergencies & drugs • 75% of villages with institutionalized monthly health days • NGO performance against plan • 3 new NGOs replicating components or committing to social development activities • NGO practices institutionalized by CARE	Baseline, Mid-term, and Final Evaluation (Externally led) Quarterly review (Internal)

1 ANTENATAL CARE AND PREPARING FOR SAFE DELIVERY

Current status

Child survival is directly related to maternal health and nutrition Adequate and appropriate care of women during pregnancy, delivery, and post-partum will contribute to improved maternal and infant survival In rural Bihar, NFHS found 63% of the births were to mothers who did not receive any antenatal care and the median gestational age for the first antenatal care visit was 5 3 months Deaths among women who did not receive care during pregnancy and delivery were almost twice as high compared to women who received services, making a strong argument to improve access to care during pregnancy, delivery, and post-partum Limited access and utilization of services and supplies during pregnancy, delivery and the postpartum period results in 91% (BLS by self-account) not consuming the recommended 100 IFA tablets, 34% (BLS) not receiving TT vaccines, 81% experiencing maternal anemia, and 55 neonatal and 14 9 maternal deaths per 1000 live births

Target population

The target population is pregnant women in the program area, estimated to be approximately 6,360 women at any given point of time Secondary beneficiaries targeted for supporting pregnant women in the practice of healthy behaviors includes husbands, mothers-in-law, and sisters-in-law

Activities

Generating demand	Ensuring supply
Identify, form and strengthen community-based operating partners who • Identify and register pregnant women early & follow up • Promote TT immunization, IFA consumption, ANC check-ups, treatment for complications, preparing birth plans and birth kits, referral to Anganwadi workers • Use learning aids and materials to promote healthy practices Develop a systematic approach to health promotion activities (calendars, role definitions, etc) Develop learning aids and materials Identify or provide technical assistance to the community-based operating partners	Identify, form and strengthen community-based operating partners who • Organize community health days / mobile clinics • Identify and procure medicines and essentials EPI supplies (antigens) from government, NGOs, and the private sector • Establish community-based funds for emergencies and drugs Provide training to on timely identification and restocking required supplies Community funds may be used to supplement immunization coverage Provide basic services and supplies through NGO clinics and improve linkages with government services where possible Identify or provide technical assistance to the community based operating partners (CBOPs)

2 INFANT FEEDING

Current Status

Breast-feeding confers a number of benefits to the mother and the child Colostrum feeding immediately after birth strengthens the infant's immune system, clears the gastro-intestinal tract, prevents infection-causing pre-lacteal feeds, and facilitates the delivery of the placenta Exclusive breast-feeding for six months prevents diarrheal, gastro-intestinal and respiratory infections optimizes the nutritional status and growth of the infant, and prolongs the period of postpartum infecundity Appropriate initiation of complementary supplemental foods by six months of age is required for the optimal growth of the infant after six months

Target Population targeted for the intervention

The target population is composed of pregnant and lactating women in the program area These are estimated to be 8,480 women Secondary beneficiaries include family members such as husbands and mothers-in-law who play an important role in influencing the practice of certain behaviors

Activities

Generating demand	Ensuring supply
Identify, form, and strengthen community-based operating partners who • In preparation for newborn care, promote optimal infant feeding during pregnancy and follow-up during the postpartum period These include providing colostrum, exclusive breast feeding for 4 to 6 months, and the introduction of semi-solid foods by 6 months • Register new births and track breast-feeding practices • Support lactating women in nursing and nurturing their infants • Promote supplemental food for lactating women and children above 6 months, and inform people of the availability of food at the Anganwadi centers	Orient service providers to promote optimal breast feeding practices during antenatal contacts Capacity building of project staff on optimal infant feeding practices and strategies for its effective promotion Strengthen linkages with Breast Feeding Promotion Network of Bihar and India, if appropriate Draw on and adapt experience from the USAID Linkages project (implemented in Bihar state)
Develop systematic approach to promote activities (calendars role definitions, etc) Develop locally suitable learning aids and materials Identify or provide technical assistance to the community based operating partners	Identify or provide technical assistance to the community based operating partners

3 CHILDHOOD IMMUNIZATION

Current Status

Child survival is closely related to the success in extending immunization coverage As part of the National Health Policy, the Universal Immunization Programme (UIP) has prioritized achieving total immunization coverage against six diseases tuberculosis, diphtheria pertussis, tetanus, polio and measles Additionally, five doses of Vitamin-A are administered to children at six-month intervals starting at the measles immunization contact at nine months However, complete immunization (for all antigens) rate by the age one is less than 4% (BLS) in rural Bihar, with measles immunizations particularly low These rates are too low to break the transmission chain of vaccine-preventable diseases Improving coverage rates and reducing dropout rates will require community-based monitoring and follow-up of all eligible children, and improved systems for ensuring vaccine supplies NGO counterparts have already established systems to procure supplies when there is a shortfall in the government system, but there is room for improvement in the identification and targeting of infants for immunization Increasing demand and facilitating the availability of supplies will be imperative to reduce morbidity and mortality from immunization-preventable diseases in Bihar

Target population

All children less than one year of age are eligible for immunization and Vitamin A This population is estimated at 6,360 The project will promote early immunization, education and motivation for complete immunization Mothers and other family members of these children will be contacted and reminded of pending immunization needs for their children

Activities

Generating demand	Ensuring supply
Identify, form, and strengthen community based operating partners who • Inform mothers and family members of the importance of immunization, and where and when to get immunization for their child and themselves during pregnancy • Follow up pregnant women through delivery to identify and register new births • Promote immunization and Vitamin A supplementation • Use learning aids and baby tracking materials to promote immunization Develop systematic approaches to identify and register children for immunization (Calendars, home-based health cards, role definitions, etc) Develop learning aids and materials	Identify, form, and strengthen community based operating partners who • Organize community health days / mobile clinics, where vaccinators and vaccines are reliably available Procure vaccines and cold chain equipment from the government and the private sector Provide vaccine for a fee if free supplies are not available (and within the context of MOH policy) Provide training to project staff to determine requirements, timely indents, and maintenance of the cold chain Provide basic services and supplies through existing NGO clinics and improve linkages with existing government services

4 BIRTH SPACING

Current Status

The relationship between birth spacing and child survival is clearly established The mortality of neonatal and post-neonatal infants and children is positively correlated with women giving birth too young too old, too close together, or too many times Short birth intervals are also associated with maternal depletion and reducing the number of pregnancies will certainly reduce maternal deaths Closely spaced births also compromise a family's ability to feed and care for its children The fertility rate of 2 4 (BLS) children per woman in the area is below the national average of 3 6 children However, it must be added that those interviewed, during the baseline survey, had a mean age of 24 1 years and were currently reproductively active, thus understating fertility rate per lifetime

Target Population

Initially, the project will target pregnant women with information on postpartum contraceptive choices and will follow-up with counseling and information after the pregnancy outcome After the first year of the project, the promotion of family spacing will also target mothers of children under two and subsequently all married women between the ages of 15 and 45 who want to postpone the birth of their next child or choose not to have additional children A special project to reach newly married women may be field-tested as part of this project Up to 30,640 newly married women may be targeted for birth spacing interventions, depending on the unmet needs

Activities

Generating demand	Ensuring supply
Identify, form, and strengthen community based operating partners who • Inform women of post-partum contraceptive options during pregnancy and provide follow-up postpartum • Identify eligible women in the reproductive age group and promote family spacing • Provide accurate information regarding where to get, how to use, and when to use birth spacing methods • Use learning aids and materials to promote birth spacing Develop systematic approaches to identify and follow-up with the eligible population (role definitions, etc) Develop locally suitable learning aids and materials Identify or provide technical assistance to the community based operating partner	Identify, form, and strengthen community based operating partners who • Organize community health days/mobile clinics where spacing methods are made available • Identify and procure modern contraceptive supplies such as condoms and pills from the government NGOs, and the private sector • Establish a community depot and distribution point for contraceptives Provide training to functionaries to determine requirement and make timely indents Provide basic services and supplies through NGO clinics and improve linkages with government services Identify or provide technical assistance to the community based operating partners

D BASELINE ASSESSMENT

The purpose of the India Knowledge Practice and Coverage (KPC) Survey was to prepare the CARE India Child Survival Core Team and to conduct a quality 30-cluster baseline KPC survey Survey results from two KPC surveys were used in the preparation of a Detailed Implementation Plan (DIP) for a CARE India CS XV USAID-funded project

CARE India staff, representatives from TSRDS and PKS, senior technical advisors and consultants from CARE HQ reviewed the baseline-screening instrument The survey followed the Johns Hopkins KPC 30-cluster format and utilized their training materials The questionnaire employed 72 questions, which covered all areas needed for three interventions as outlined in the CS XV Child Survival DIP Mothers with living children up to two years of age were selected for interview The target population of the project involved different ethnic and language target groups Therefore two complete 30-cluster KPC surveys were conducted

Over 600 interviews were conducted and entered into the EPI INFO software database (developed by CDC and WHO) for analysis Nine CORE team members from CARE India, and both NGO partners (PKS and TSRDS) were trained as trainers over a three-day period Ten supervisors and 40 interviewers and recorders were also trained A KPC Survey three-day training course was completed, ending with a field training exercise A total of 20 teams conducted the two 30-cluster surveys over a three-day period KPC survey data were entered daily These data were analyzed in three data sets The first consisted of the PKS 30-cluster KPC Survey, the second set included the TSRDS survey and the third set was done through a compilation of data from both surveys, consisting of more than 600 records Results were remarkably similar (See Annex B - KPC Survey results)

Supervisors audited questionnaires to assure accuracy and to validate the records while still in the community Interviewers were performance trained through multiple practice interviews and feedback sessions

Significant KPC Survey Findings

Mothers' mean age was 23 5 for PKS, 24 2 for TSRDS and 24 1 years in the combined data set The mean age by child distribution was 9 95 months for PKS, 9 83 months for TSRDS and 10 0 months for both sets In both surveys gender of children was evenly distributed The age distribution favored those younger that 12 months in both surveys The TSRDS cohort showed 60% (181/302) to be 11 months or less in age while the PKS group was 58% (175/302) The "less than six month" group represented between 55% and 60% of the children less than one year in age

The overall OPV dropout rate is 48 8% between OPV1 and OPV3 (418-214/418) Measles immunization coverage is 12 2% for all age eligible children (43 by combined UIP card and mother's memory - out of 353 children age 9 months or older) Children ages nine months and older represented 58 3% (353/606) of the total The 12 2% of measles-immunized children showed a surprisingly high return rate for the second measles dose By mother's memory and UIP card documentation, 30 2% (13/43) returned for a second measles immunization

For knowledge regarding weaning age, 38 3% of mothers (230/600) gave correct responses on adding foods between the age of four and six months However, 50 3% of the mothers interviewed thought that weaning should occur after age seven months This finding may reflect the interviewer's interpretation of

the question or some cultural norm for weaning The actual practice findings were less clear as 57 1% (343/600) of the mothers interviewed indicated they began giving their child additional foods between 6 and 18 months of life This finding may also represent problems in language, interviewer technique or the screening instrument There are, obviously, ethnic and cultural factors that affect these findings KPC Survey results indicate there is real a need for carefully framed qualitative surveys and focus group discussions before full implementation of the Detailed Implementation Plan (DIP) The full data set include cross tabulations done on diarrhea, pneumonia and malaria Higher risk assessments are highlighted with the most significant related to water source, child caretakers and post partum care (See Annex B - KPC Survey results)

The prevalence rate for diarrhea was found to be 21 5% overall (130/606) CARE staff reported that the current rate was normally low during this season It is not known what effect this factor would have on the actual rate ALRI prevalence rate was thought to be low at 19 5% (118/604), point prevalence

Many mothers could produce an UIP card for their child 214/606 (35 4%) An additional 6% of mothers reported a lost UIP card There were 353/606 children age nine months or older (58 3%) Mothers of children 9 months or older displayed UIP cards for 148/353 children (141 9%) and of these 31/148 (20 9%) were immunized with measles antigen Based on 148 UIP cards for children nine months or older, the coverage rate for BCG was 70%, OPV1 89% and for DPT3 the coverage was 34 5% The dropout rate for children 9 months or older with a UIP card (DPT2 - DPT3/DPT1 * 100) was 46 5% The overall dropout rate (OPV1 – Measles/ OPV1 * 100) was determined to be 83 8% for children age 9 months and older with UIP cards The measles coverage rate changes very little even when mother's history of measles immunization is included Measles coverage by card and mother's history was 7 1% for the total cohort Tetanus Toxoid coverage was 16 2% (98/606) for one dose only, 32 0% for two doses and 25 4% for three or more The TT coverage rate was 57 4% for two or more doses (348/606)

Iron/folate tablets were given to 328/606 (54 1%) women in varying amounts Two hundred seventy-eight out of 606 (44 9%) did not receive iron tablets Additional study needs to be conducted on iron/folate coverage, compliance and practices One ANC visit was made by 10 4% of mothers (63/606), 17 7% made two visits, 30 9% went three times, while 240 did not attend any ANC clinic session (49 6%) The number of pregnant women was 31/606 (5 1%) Among those mothers questioned, 214/606 (35 3%) want to have a child in the next two years, while 392 mothers do not Of the mothers who did not want to have a child in the next two years, only 51 (13%) indicated they were using some method to avoid/postpone the pregnancy

About 25% of pregnant women stated that their first ANC visit should occur in the first trimester of pregnancy (153/606) Another 222/601 women (36 6%) indicated the second trimester was the appropriate time Most significantly, 193/601 (31 8%) did not know when to visit an ANC clinic

This rapid KPC survey is an excellent tool for planning and developing the Detailed Implementation Plan Questionable areas for interventions can be elaborated and targeted based on valid findings and further applications of qualitative assessment tools Rates of projected change elements can be made and management aspects improved There are identifiable limitations

Cross tabulations have been performed for a number of factors Frequencies will continue to be analyzed by age of the mother and other variables Findings will be further analyzed during the project implementation phase Factors related to the behavior of mothers could and should be explored in detail through focus groups and PRA techniques Knowledge doesn't automatically translate into improved

health protection or prevention practices Continued assessment of how knowledge and prevention improve practice has yet to be defined Another consideration is sustainability and durability The four-year cycle will certainly help these projects achieve sustainability potential and a reasonable effort will be made to assess costs and explore cost recovery mechanisms

Additional Findings of Interest

The mean age of children was about 10 months, which indicates a good baseline cohort for most child survival interventions The range of mothers' age was 16 to 42 There were 27 mothers in the 35 and older age group (27/606), which may indicate a small risk group because of the upper age curve The combined extremes of high and low age women included 100 mothers (17%) These may represent the high-risk cohort of pregnancy in populations who are either too young or too old Six hundred and six mothers were asked about the total number of children born that lived long enough to cry and how many of these were still living There were 1,548 children born (mean 2 55 children per household) and 1,438 still living (crude Child Mortality Rate of 7 1%)

The KPC survey estimated ratio of male infants to females was 1 02 to 1 (304 to 299) Only 33 7% of the PKS survey participants had completed primary school or higher Overall literacy was 30 9%, but the variation ranges from 33 7%% in the PKS target area to 28 1% in the TSRDS site There were 42 secondary educated persons in both surveys (6 9%)

Few mothers reported working in income-generation activities in the TSRDS target area (67 out of 348 multiple selection possibilities) The PKS site found 186 women who did not leave the home for income-generation activities There were 115 mothers who took their child when leaving the household in the TSRDS location, while 149 traveled with their mothers when they went out Relatives, siblings and husbands were the most frequent child care provider when mothers went out alone A three-fold higher diarrhea risk was associated to family and sibling caretakers over parents

More than 90% of respondents in both surveys used tube wells and draw wells as their primary source of water Nearly 100% (596/606) of interviewees used open-air means of defecation

Breast-feeding/Nutrition

Ninety-seven percent of mothers reported breast-feeding Mothers also indicated they changed breasts four or fewer times per feeding (464/605) Mothers put the child to the breast in the first hour 18 5% of the time (111/600) and 47 2% attached the infant within one to eight hours One hundred eighty-six mothers waited longer than eight hours and 20 mothers just couldn't remember These findings were consistent in both surveys Mothers' weaning knowledge about the proper age to start weaning was found to be 38 4% (230/606) Half of the mothers interviewed (50 3%) thought that weaning should occur after 6 months (302/606) of life There are, obviously, ethnic and cultural factors, which affect these findings Qualitative means of assessing the problems associated with weaning and approaches to the implementation of correct weaning habits will be diligently researched during the early phases of this project

E PROGRAM DESIGN

Design Overview

The Child Survival Project seeks to reduce infant and child mortality by improving the health practices associated with reductions in mortality The project will strengthen the capacity of the local NGO partners, PKS and TSRDS, who will in turn increase the capacity of village-level operating partners to make continuous and sustained improvements in these health practices The target population consists of pregnant women (3% of the population), mothers of children under two (5% of the population) and, as secondary targets, families of pregnant women and children under two (about 12,000 people) The total target population is about 79,500 people residing in 262 villages Entry into the project for pregnant women and mothers of under-twos will occur when project health workers identify and register pregnant women and follow them through the birth and early life of their newborns As registered participants, these women (and the decision-makers in their lives) will be included in health education activities, receive home visits and be counseled on an individual basis, and receive services in the intervention areas mentioned below

To reduce mortality within the first year of life, the project will focus on four interventions

1 Antenatal care and safe delivery, which includes maternal nutrition, among pregnant women, and micro-nutrient supplementation
2 Infant feeding, which includes breast feeding promotion and introduction of complementary semi-solids at 4-6 months of age, and appropriate nutrition during diarrheal/ARI episodes
3 Immunizations
4 Child birth spacing

These services will be provided by PKS and TSRDS The project will increase these NGOs' capacities and enable them to

1 Develop and implement an effective IEC/BCC strategy
2 Increase community demand for health services
3 Ensure appropriate provision of services and supplies
4 Provide quality assurance with respect to service delivery of local health providers (ANM, AWW, birth attendants)
5 Monitor and evaluate project interventions accurately and use this information to guide the program
6 Serve as a model for other corporate houses in India to pursue socially responsible initiatives

The Child Survival Project will complement GOI's efforts to combat malnutrition and prevalent disability and death by increasing the number of women and children who practice healthy behaviors The proposed activities endorse the priorities of the Ministry of Health's Reproductive and Child Health (RCH) Project through implementation of selected interventions that have a proven association with mortality reduction among women and children The proposed project will complement the Government of Bihar's efforts to improve the health and nutritional status of women and children, as articulated in the State Plan of Action (1995)

Community Mobilization

The community mobilization strategy will first assess the needs of the community by preparing a village profile through social mapping This will include information about existing health facilities, assessment of the problem, details about cultural beliefs and practices, socioeconomic condition of the villages, and

existing social institutions/individuals It will also provide information about gaps in service delivery mechanisms, supporting structures and institutions

Using the information gathered during the social mapping and community assessment exercises, a communication strategy will be developed that is adapted to the local beliefs and customs The next step would be to seek support from the community through village-level meetings In these meetings, the existing situation and gaps would be discussed with the community, and the roles and responsibilities of each stakeholder will be determined The most active, respected and influential community-based institutions and individuals would be identified and chosen as potential community-based operating partners After this, the capacity building process will start for them, which would include training, community awareness, identification of target population, generation of awareness for adopting better nutrition and health practices, institution building, sustainability, etc These capacity-building measures will facilitate the CBOPs to access and manage health and nutrition-related interventions in their area The community-based organizations will be responsible for developing an action plan for achieving desired behavior change Monthly group meetings will be organized by NGO staff to identify barriers to behavior change, find appropriate solutions to constraints identified, and monitor the action plans All the messages regarding health and nutrition in the community will be channeled through the CBOP, who will be taught to adapt these messages to their cultural beliefs and setting NGO staff will assist the CBOP by providing technical and logistic support

CBOPs will be responsible for organizing village health community mobilization activities During the health days, participants will be expected to pay a token fee for services rendered, which will be channeled into a village fund These funds are known as a "Gram Kosh" The Gram Kosh will be used to finance various village health activities on a scale determined by the community Funds for emergency purposes will be maintained in the community while surplus funds will be deposited in a bank or post office account managed by two or more CBOP members CBOPs will be further strengthened through the NGOs' efforts to develop certain local groups into saving and loan institutions These S&L institutions would then be able to seek or access various funds available through government and non-government channels or start their own income generation activities for their institutional and financial sustainability

Relationship with Other Facilities

The Ministry of Human Resources, Women, and Child Development operates the Integrated Childhood Development Services (ICDS) program in the project area The services provided in the Anganwadi center (AWC) include supplementary nutrition, Vitamin A and iron-folate tablet distribution, pre-school education for 3-6 year-olds, immunizations, treatment for minor illnesses, referral services, and health and nutrition education of mothers Two people (an AWW and her helper) work in every village and are responsible for providing basic nutrition and health services for children up to six years of age as well as pregnant and lactating women of the disadvantaged poor class The AWW is a community volunteer who gets a nominal honorarium from the government yet is the focal point for these services She is typically a non-technical health intermediary and does not perform any immunizations, instead, she organizes communities so that the MOH nurse is able to vaccinate the eligible population expeditiously One health department sub-center, staffed by an ANM, is supposed to exist for every 5-6 villages, yet these structures are typically very weak due to a lack of basic materials and supplies, training and support

The project plans to work with the local Block Medical Officer (BMO) and Community Development Project Officer (CDPO) to strengthen their capacity to address various bottlenecks that are detrimental to child survival Through the NGO partners, this project will seek to improve the provision and quality of child survival services by capacity building of the ANMs and Anganwadi Workers The NGO partners

will organize training opportunities for the ANMs, AWWs, NGO health workers and community-based health workers Following the training, will provide follow-up to these health promoters to assess appropriate application of the knowledge and skills

Project health workers (CBWs) will coordinate their community-level activities with the ANMs and AWWs operational in their area and share such information as the pregnant women's register baby-tracking obstacles and vaccination data The MOH will assist the project through the provision of vaccines, immunization cards, and other supplies needed for vaccination All pregnant women will receive information on the importance of breast-feeding, the importance of a balanced diet during lactation, and how to maintain an adequate supply of breast milk Paramedical officers and physicians will provide the education sessions during the ANC clinics Women attending postpartum clinics will receive information and education on the process of breast-feeding, proper weaning age, and how to prepare semi-solid food The frequency and methodology of feeding infants semi-solid food and the disadvantages of bottle-feeding will also be explained Mothers with any medical or non-medical problems associated with breast care or breast-feeding will be referred and provided with appropriate counseling

The NGO partners will implement pre-pregnancy education activities for adolescent girls, prospective mothers and other family members in a "Plan Your Baby" campaign The project will also encourage women to seek antenatal care and physical examinations including blood pressure measurement and weight check Other "Plan Your Baby" services will include

- Iron-folate tablet distribution (100 tablets)
- Safe Delivery Kit supply to pregnant women
- Basic health investigation, which includes urine analysis, hemoglobin and blood typing
- Nutrition and diet counseling
- Two or more Tetanus Toxoid injections

Birth and delivery care will also be improved through capacity building of TBAs and ANMs in high-risk identification, counseling and referral for medical assistance in difficult pregnancy cases These interventions are consistent with government policy, except that clinics and community-based workers will be supervised by CBOPs Neonatal mortality will be addressed through capacity building of TBAs and ANMs Specifically community-based people will be empowered through

- Training on neonatal care for Community based workers (CBWs)
- Structured follow-up visits within 48 hours to mothers by CBWs to nursing mothers
- Structured follow-up visits within 48 hours to homes of mothers by doctors or paramedics

TSRDS will procure all commodities from the government supply sources, which are already certified or recognized as quality products by the MOH When surgical services are required (as for some FP methods), all cases will be attended by a NGO medical professional adhering to NGO-enforced standards of sterilization and hygiene Infection prevention measures will be rigidly followed After surgery, patients will be followed up in their homes and provided with medical assistance as indicated PKS will assure a quality control mechanism for patient follow up as well Emphasis will on complicated pregnancies, maternal services and high-risk cases In all cases quality control will be exercised for materials and services provided under the CS XIV project mechanism Capacity building through training will include 30 ANMs and paramedical staff, laboratory technicians, medical officer associates, block coordinators and community-based operating partners Training will be continued annually for community staff, and semi-annually for clinical service personnel Computer training will be established

as part of capacity building NGO clinics have a long-term stable track record in the project area It is anticipated that these clinics will continue after the CS XIV project closes

Participation in Project Design

The project has sought input from three groups of stakeholders into the project design process government officials (MOH and ICDS staff), community leaders, and community members The project's NGO partners have met with key government officials in the project area, including the Block Medical Officer and Child Development Project Officer, to better understand the constraints faced and strategies by which the project can best direct its assistance The results of these meetings are reflected in the project design for each intervention NGO partners have also met with various community leaders, before and during the baseline data survey Discussions have focused on the identification of priority problems and potential community-based operating partners, such as women's and youth groups Community members were actively involved in the baseline data survey and educated village women served as interviewers and recorders for the KPC survey As such, over 30 community members were trained in interview and recording techniques and through that experience gained a clearer understanding of the maternal and child health situation in their communities

Choice of Interventions and Strategies

1) The project has chosen to focus on the four intervention areas that are related to cause of death and therefore are most likely to have a significant impact on child survival, given the current maternal and infant health status in the project area These interventions are maternal and newborn health care, birth spacing, breast and infant feeding, and immunizations (see Table 4 below)

TABLE 4[6]
RISK FACTORS FOR MORBIDITY AND MORTALITY

INDICATORS	INDIA	RURAL BIHAR
MORTALITY & ANEMIA / HEALTH IMPACT		
Neonatal mortality	48 6	54 8
Infant mortality	78 5	94 to 127
Under-five mortality	109 3	127 5
Maternal mortality ratio	500	1490
Maternal anemia rate	60%	81 0
COVERAGE RATES/HEALTH OUTCOMES		
% who received any ANC contact from doctor	31 1	16 7
% who received 100 tablets of IFA before delivery	19 4[1]	9 0[2]
% immunized with TT2 before delivery	55 3	26 4
% infants given only breast milk for 4 months	51 0	34 2
% completely immunized by age 1	30 9	5 5
% immunized with measles by age 1	37 7	8 5
% eligible using modern spacing method	3 4	2 0
% eligible using any family planning method	36 9	18 6

[6] NFHS data, except for ICMR and INHP Baseline, 1995 (CARE India)

2) The project strategies will focus on improving access to maternal health services such as ANC and safe delivery, improving infant feeding practices through community-level health education and improving immunization coverage rates

3) The strengths and weaknesses of existing health services in the area According to the government guidelines for the state of Bihar, there is one primary health center for every block and a sub-center, staffed by an ANM for every five to six villages The ICDS system works with one Anganwadi center with one AWW and a helper in each village About 20-25 AWCs are supervised by a sector supervisor and there are usually 5-6 supervisors who report to a Child Development Project Officer stationed in every block The vast majority of these facilities, however, lacks sufficient supplies and staff, and are not utilized A review of the ICDS activities in the program area revealed that the Anganwadi centers are non-functional in most villages The project will actually serve as one of the mechanisms for furthering the ICDS structure in the tribal area The project would enhance the ICDS model of services related to nutrition, immunization, reduce the incidence of mortality and morbidity, and improve the health status of children less than six years of age Coordination and collaboration with all partners represent the guiding principal of this Child Survival project

PKS and TSRDS both provide some health services in the project area through fixed facilities and mobile clinics The strategies adopted by the project will strengthen the capacity of partner NGOs to identify and work effectively with community-based operating partners in an effort to increase population-based coverage The CBOPs will promote healthy behaviors, including service-seeking, among the target populations and will provide some services directly to beneficiaries, such as breast-feeding counseling, ANC promotion, nutrition education and postpartum assessments The CBOPs will also serve as a link between the communities and the NGO partners and MOH fixed facilities for improved service utilization Start-up activities are evenly shared, with coordinated tasks for staffing, facilities, equipment and other procurement functions IEC/BCC planning and materials development will also be shared Social mapping, pharmaceuticals, and office set up will be completed early on, as will specific essentials such as cold chain equipment

CARE-USA has a number of professionals with excellent technical, training, and management skills and experience to provide technical as well as management support from Atlanta One program staff person will be assigned the Child Survival Program portfolio to insure adequate headquarters support and monitoring of grant activities CARE-USA staff will finalize the DIP and make preparations for the mid-term and final evaluations

CARE-India Headquarters will directly monitor the management of the project in accordance with the plan, identify and arrange required technical inputs, liaise with the donor, the Confederation of Indian Industries, to expand corporate collaboration, and finalize reports as required CARE-India Headquarters will also coordinate the arrangements and required national contracts for baseline, mid-term and final evaluations The monitoring and evaluation officer will assist CARE-Bihar and the two NGOs to set up the CARE population-based monitoring and reporting system, the grant officer will monitor expenditures against budget

CARE-Bihar is primarily responsible for coordinating with the two NGOs for the management and implementation of the grant CARE-Bihar will do joint planning, quarterly or semi-annual reviews, make recommendations for mid-course corrections, and identify technical inputs and resources to guide NGO implementation CARE-Bihar is also responsible for informing CARE Delhi of any

problems encountered in implementing the project according to the time-line Finally, CARE Bihar will identify other potential corporate partners to expand health sector activities in Bihar

4) Health is generally a low priority in the program area, but mother and child health is the area in which communities feel greatest concern Access to quality services in the RCH area is also a major concern

5) In relation to the expertise of the staff of the CS XIV, the program and its local partners, the choices for meaningful interventions were clearly consistent with the KPC findings The choice of interventions and strategies complements the respective experience and expertise of CARE and the partner NGOs, PKS and TSRDS Both partner NGOs have expertise and experience in facility-based service delivery in the project area, and CARE brings its years of experience in community organization, health education and counseling for behavior change and institutional strengthening of community-based organizations and NGOs The project design takes advantage of each partner's relative strength and seeks to share its expertise with each partner as well as with government departments and CBOPs PKS has years of experience in child spacing and will use this expertise to the advantage of the project CARE will help the partner NGOs strengthen their monitoring and evaluation skills Presently NGOs have a good facility-based monitoring system of inputs provided and services availed CARE will assist in developing a population-based monitoring system to track outcome level changes in the project population CARE has also chosen to work through Indian corporate NGOs so that a model for social and industrial responsibility projects can be developed, shared and promoted in other areas of the country

Human Resource

The CARE-India project personnel include two professionals that will be based in Jamshedpur, Bihar, who will secure technical inputs and resources and provide training and oversight for project activities This staff will immediately be supported by a project manager who will provide strategic direction to the Child Survival Project and assist integrating lessons from another maternal nutrition projects located in the vicinity Tertiary support for the Child Survival project will come from the CARE offices in the state and national capitals, Patna and New Delhi, respectively

Both TSRDS and PKS have recruited, collectively, 63 field-based staff responsible for implementing project activities such as mobilizing groups, imparting health education, counseling behavioral changes, etc at the grassroots level These personnel will be supported by the TSRDS and PKS management structures, respectively, that are based entirely in Jamshedpur, Bihar These supervising structures include professionals with formal training in medicine, rural development, and management and include the active participation by the heads of both organizations

Project personnel details and responsibilities are listed in the Human Resources section

THE CHILD SURVIVAL PROJECT

Project Management Structure

Jamshedpur, Bihar

USAID
(Donor)

	TSRDS (NGO)		**CARE-INDIA** (PVO)		**PKS** (NGO)	
	Hon'y Secretary		Country Director		Vice-Chairman	
	Sr Manager		ACD Programs	CARE-Bihar	ACD Program Support	Secretary
Block Coord (3)	Medical Officer	Driver	Director Health	State Director		Jt Secretary
Village Level Worker (18)	Paramedic Staff			Manager CS & Linkages		Senior Medical Officer
	Project Coord		Project Officer Child Survival	Coordinator Child Survival	Program Officer	Medical Officer / Driver
				Program Asst Child Survival	Project Supervisor	Lab Technician
					Village Level Worker (27)	

Changes in Child Survival interventions

There have been no major changes in the choice of Child Survival interventions The KPC survey provided information on intervention needs to the extent that focus was expanded on nutrition maternal and childcare, breast-feeding, immunization coverage and childbirth spacing Nutrition and breast-feeding were merged, with distribution shared between maternal and newborn care and breast-feeding

Innovations, New Methods, Strategies or Materials

Collaborating with these Tata-affiliated organizations to implement the Child Survival Project in Bihar, represents the first time CARE-India has partnered with a corporate house to carry out program activities This venture will prove to be a symbiotic relationship with both CARE and the Tata entities benefiting from the partnership The NGOs will primarily benefit by gaining access to technical inputs to initiate, operate, and evaluate the project, resources that otherwise may not have been available Whether it's conducting a 30-cluster sample to gather baseline indicators or creating monitoring and evaluating tools to quantify project impact, the NGOs will have developed the capacity to carry out development activities in a scientific manner, an asset that will extend beyond the contractual life of the project CARE will gain by capitalizing on Tata's membership in various bodies such as the Confederation of Indian Industries (CII), the Federation of Industries and Chambers of Commerce – India (FICCI), and the Association of Chambers of Commerce (ASSOCHAM) to spread the ethic of "corporate social responsibility" The collaboration with the Tata group provides CARE the visibility and voice necessary to promote such an agenda to industrial houses, as well as a model demonstrating the successful collaboration between the corporate and development sectors To complement these advocacy efforts, a filmmaker has been secured to document the impact of the Child Survival Project with respect to both individuals and communities over the course of the project life

A comprehensive health and nutrition day will be organized monthly in all villages, when a package of health services, i e , antenatal check-ups, immunizations, health and nutrition education and counseling, IFA distribution, deworming tablets, Vitamin A, will be made available to the community Other services, which could be made available to the community through existing ICDS programs, include growth monitoring, take home ration distribution, first aid and treatment of minor illnesses CBOPs will mobilize communities to better utilize these comprehensive health and nutrition days and will encourage communities to become involved in surveillance, ultimately leading to total community management of such events Social events will be combined with health awareness messages and information While the services and supplies provided by the GOI are free of cost, the project plans to build the ethic whereby communities will make contributions on this health day for the convenience of having a Nutrition & Health Day (NHD) at a fixed place and time every month These funds will be retained in the community as a Village Health Fund which can be accessed to address health or related needs

Community day activities will include focus on

- Pregnancy information, birth plans/kits, and safe delivery and family participation
- Neo-natal and post-natal care issues
- Breast-feeding practices, child and maternal nutrition sessions
- All aspects of family planning and counseling services
- ANC visits and benefits
- Infant feeding and weaning practices
- All vaccine-preventable diseases and their association with malaria and pneumonia
- Diarrhea control, home care, prevention and treatment

- Respiratory recognition and appropriate care seeking within 24 hours for children 2 months or older and within 12 hours for infants less than two months in age
- Community mobilization for disease prevention and health promotion

F PARTNERSHIPS

The Child Survival Project envisions an effective and cohesive partnership with various stakeholders and future role players Both the NGO partners – PKS and TSRDS besides community and government Health & ICDS department will be the key partners of the project To achieve greater sustainable impact, partnerships with other local NGOs are also visualized

Based on its fifty years of working experience in India, CARE-India has realized that partnering with the regional or local agencies in addition to Govt is must to cater to the neediest group Over the last decades a major paradigm shift has taken place in Indian corporate sector whereby they had started looking at these activities from perspective of corporate social responsibility rather than philanthropic activities The Tata Group of Companies is a major advocate of the policy of corporate social responsibility amongst all the major corporate sector players in the country Both PKS and TSRDS, which are NGOs linked with TATA companies, have been active in their respective operational blocks for more than a decade PKS has an orientation towards health and thus focuses on family planning and other health related issues through clinics while TSRDS' strength lies in community mobilization with emphasis on holistic development, with health, sanitation and drinking water program being components of it The rationale behind partnering with both the NGOs is to utilize their relative strength, and test the model of promoting child survival interventions through NGO with different strategic missions and maturity It is expected that experimenting with more than one NGO will lend credibility to CARE's advocacy with other corporate sector partners CARE-India is committed to creative collaboration with corporate bodies and governments and realizes that project success is a function of effective mobilization of the different skills that these respective organizations possess

CARE is in a position to provide development strategies and paradigms while the resources and outreach of the Government of India is simply unmatched However, one of the most exciting aspects of the project is in leveraging corporate business practices, perspectives, and processes and transferring them into the development sector Key business processes, such as increasing efficiency and optimal utilization of resources along with becoming results and impact-oriented are lessons are jargon that is typically reserved for the boardroom The Child Survival Project will work towards internalizing and exhibiting these very same characteristics

The age-old relationship with Govt will be maintained to gain maximum mileage In the project area, especially at Patamda and other blocks near Jamshedpur, CARE-Bihar is already working very closely with Welfare Department through INHP program The CSP project would utilize the credibility and respect that the program has already created along with the local public administration The other reasons for partnering with Govt department is to ensure the smooth supply of medicines, vaccines, FP materials and ensure & enlist support and active involvement of ICDS and Health workers & officials to achieve sustainable results Attempt would also be made to involve the key block & district level officers of ICDS and Health to improve coverage rates and reinforce the monitoring systems

At block level, a coordination committee had been formed with representatives from block Health and ICDS, NGOs, along with the core members of the CSP The committee will hold monthly meetings at the block level to discuss on Anganwadi centres related supply and stock issues, distribution of IFA and vaccines, immunization status, identification and follow-up of drop outs for immunization or high-risk pregnancy cases The committee would prepare a monthly Joint Action Plan to enable effective coordination between AWW, ANM and CSP field staff to avoid the duplication effort towards the CSP

interventions The JAP will explicitly clarify the roles and responsibilities of each role player and specific tasks assigned to the members with respect to time The committee will closely monitor the progress of the program on monthly basis to resolve the issues pertaining to CSP activities and would also highlight flagship issues for the intervention of the higher level authorities In order to develop a sense of ownership and establish accountability, regular technical skill up gradation for the interventions and IMCI would be provided to the field level workers Opportunities would also be created for exposure visits for the field workers from the concerned Public Department to retain their interest and motivation The group, besides being be trained on maintenance of records and data, would also provide inputs during the preparation of IEC/BCC materials, so that they can act as a facilitator / motivator to disseminate the knowledge through IEC/BCC

At district level a similar committee would be formed in which the key government officials of the district along with the core committee of CSP would be the members The committee will primarily review the progress of the project on quarterly basis and act as a catalyst to increase the synergies of the government programme and CSP activities It will also fulfill all the logistical requirements of the project and address the flagship issue(s) raised by the block committee

In addition to these fixed meetings, CARE-field staff has a very positive working relationship with both NGOs which is reinforced during frequent interactions While deliberate care has been taken to ensure that daily interaction with the NGOs is not the norm (to avoid micromanagement of project activities), multiple exchanges occur weekly via ad-hoc meetings, joint-community visits, common training programs, various field-exercises, or other such events This frequent contact serves to ensure that project activities progress smoothly, obstacles are quickly identified, addressed, and resolved, and that field-level functionaries benefit from regular and routine on the job support Moreover, these interactions serve to cement the belief that this effort is truly collaborative in nature and that the CARE, PKS, and TSRDS are all equal partners in this initiative

NGOs

Corporate Philosophy

"A Tata company shall be committed to be a good corporate citizen not only in compliance with all relevant laws and regulations but also by actively assisting in the improvement of the quality of life of the people in the communities in which it operates with objective of making them self reliant "

The Tata code of conduct recognizes social responsibility as a key business process The other areas being market development, order generation and fulfillment, planning, control and risk management, investment management, operations (production and maintenance), supply management and human resource management In doing this it is propelled by the thought that fulfillment of social responsibility is as important as the pursuit of its business goals

The Tata group is not limited to supplying quality goods and services at reasonable cost It goes beyond to work for the well being of the people, and the economic and social progress of the nation, with whatever resources the group can spare It appreciates that general social and economic benefits result from the recognition of broader social goals in business decisions

The Tatas aim at making a fair profit with which the enterprise can expand and be of greater service to a greater number of people Underlining this is the belief that profits are a source of prosperity for the society and the role of a business is not only to respond to the expectations of shareholders, but also to the

societal needs around the region within which it operates The Tatas follow the motto that justice and concern for employees can and does harmonize with the interests of business

Aside from the philanthropic motive with which the Tatas approach the communities, they believe collective interests of the society naturally constitute a part of one's self-interest Thus they strive for efficient utilization of resources to ensure a qualitatively high degree of outcome in terms of products and services Also, the Tata group reaches out and shows that it deserves to belong to the society and draws its sustenance from it for its legitimacy In the words of J N Tata "wealth and means of generating wealth are not ends in themselves, but a means to an end, for the increased prosperity of India"

Future expectations

The specific expectations that both NGOs have beyond the 4-year agreement with CARE is very clear by all parties involved After the Child Survival Project period has lapsed, both TSRDS and PKS would like to be in a position where they can create, implement, evaluate, and document development initiatives in a modern, development framework While allowing (and even welcoming) collaboration and external expertise, after 4 years these development agencies do not want to rely on CARE to teach them how to perform a Baseline Survey or create IEC/BCC training material Instead, both agencies want to be in a position where they can create development initiatives independently, execute such a vision, measure the impact of project activities, and document the initiative for dissemination purposes While CARE would look forward to potential collaborations with either (or both) NGOs in the future, there is no understanding - implicitly or explicitly - that this would be the case

To evaluate the success of the partnership a few basic indicators have been established

a) Number of similar projects initiated by corporate houses as a result of CARE's presentations at apex bodies
b) Ability of partner NGOs to perform qualitative and quantitative survey for their other projects (i e a baseline survey for a tubewell project independent of CARE)
c) Number of villages beyond the project area in which partners are carrying out similar projects

Ability of partner NGOs to carry out M&E on their own, an area that both NGOs expressed specific interest

Community-based Organizations

The program will work with community-based operating partners to facilitate and sustain the program inputs and efforts The field staff will work closely with the CBOPs to establish systems for increasing coverage rates of healthy behaviors that will last beyond the Child Survival project The rationale for working with CBOPs is that a community-managed program is critical to achieving health impact and that communities will continue to practice healthy behaviors once supportive systems have been established The capacity building strategy and activities will determine the roles and responsibilities of each individual in facilitating program impact

A needs assessment conducted in the first six months of the project will determine the skills and level of information required by the field staff to support program implementation CARE and NGO experience in health programming will be useful for developing capacity-building plans, including content, methods, and duration of sessions Participatory, adult-learning methodologies will be applied in all situations The project will also work with non-paid volunteers, wherever possible, to assist in the delivery of services This strategy is consistent with TSRDS's current success in motivating community action through non-financial incentives

Upon the formal completion of project activities, communities would expect the community-based operating partners to continue to serve as a resource for pregnant and lactating women and mothers of children under 2 While the community-based workers may or may not continue to operate in the field area (this is up to NGOs to decide), the advice, counseling, and referral skills of the CBOPs should continue Furthermore, as the concept of Community Health Funds will be introduced in all villages, it is expected that it will continue to be a resource for individuals who have emergency health ailments Additionally, a specific plans for making the sustainability of the outreach clinics has been made and is attached as an Annexure

Public Sector

In addition to its fruitful history of working with the Government of India (GOI), CARE-India has recently made concerted efforts to increase collaboration with the Government of Bihar, specifically, the Integrated Nutrition & Health Program (INHP) which operates in 157 blocks within 24 districts in Bihar along with the Linkages Project (in Angra block in Ranchi district)

Under the broad INHP umbrella (which subsumes all interventions within the Child Survival Project) the Government of Bihar has agreed to work with CARE, TSRDS, and PKS in implementing the Child Survival Project The Integrated Childhood Development Services (ICDS) program has recently been sanctioned in one of the blocks in which project activities will take place, bringing innumerable resources (human and otherwise) CARE-India enjoys a positive and productive relationship with senior district government officials, such as the District Collector and Block Development Officer, who are experienced in administering the INHP program in Jamshedpur & E Singhbhum district with local government support The Child Survival Team would form a part of the district level committees that will meet on a regular basis, to effectively engage ICDS functionaries by creating a routine and dependable supply of vaccines, contraceptive commodities, IFA, and other supplies essential for enhancing child survival In addition to the Joint Action Planning previously described, IEC/BCC workshops and Capacity building sessions have been designed with these key functionaries in mind The idea is to share ideas, strategies, and resources with the ICDS personnel such that they have a personal stake in the outcome of the project If this ethic can be established, than a vigil watch can be kept on quality control The project area has a history of impotent vaccinations being administered and effectively working with the ICDS can increase the propensity for quality goods and services to be delivered and administered

Additionally, the extensive collaboration with the ICDS will serve to prevent a parallel health service delivery system from being created The ICDS mandate, outreach, and potential to positively effect health status in the project area should not be underestimated Therefore, the project will avoid creative duplicative structures wherever possible

CARE-India will work with NGO partners to identify training needs of government health intermediaries ANMs and AWWs in order to increase their managerial and technical abilities CARE and the NGO partners will then train them to improve skills and provide the appropriate knowledge necessary to enhance intervention efforts A detailed Work Plan is included in Section K the following section

G Work Plan

H SUSTAINABILITY

CARE's Nutrition and Health Sector defines sustainability as lasting and sustained change in behaviors, institutions, and policies which has a positive effect on health and nutritional status It implies enabling individuals, communities, and institutions to create and continue the process of positive change, and to adopt behaviors and systems that endure This includes enhanced capacity to procure and utilize needed resources The NGO partners have a long established history and track record for initiating and conducting activities on a sustainable scale Both NGOs have guaranteed sustainability through fiscal and institutional commitments

Behavioral Sustainability
Project strategies are designed to motivate and sustain the practice of health behaviors that reduce the risk of disease and death among women and children The strategies are based on the premise that people sustain behaviors that clearly reduce deaths so long as they continue to have access to quality services that make the behavior possible For example, women (and their daughters) continue to seek tetanus vaccine without health education and promotion once the practice is associated with reduced tetanus deaths, as long as the vaccine is accessible The primary strategy of working with mobilized community groups as key change agents is founded on the principle that peers and community members can influence behavior if supported by health providers in the promotion and provision of related services

Institutional Sustainability
Sustained behavior change may not be achieved in a single four-year period and institutions must be enabled to develop and sustain systems for promoting lasting changes in positive health behavior Institutional sustainability will be addressed at two levels, that of the community-based operating partners and that of the NGOs

The Child Survival project will work closely with the CBOPs to plan, implement, and monitor the program and will develop plans for phasing out from the program area after the life of the project The first year will be spent in mobilizing communities and forming community groups These critical initial investments will ensure community ownership of the program and contribute to the sustainability of the activities as well as the community-based organizations themselves In addition, CARE will assist the NGOs to link CBOPs with existing and available resources not currently tapped Lessons learned during this start up period will be applied throughout implementation

The institutional sustainability of the corporate NGOs is also well established as they have strong and capable management systems from which to launch additional child survival activities and the potential to influence similar organizations to adopt community heath projects CARE will transfer skills in project planning, monitoring, management, and evaluation, through the process of joint planning and review Systems that are useful to the NGO will be adopted and institutionalized Project strategies will enhance the capacity of the partnering NGOs to assume responsibility for the project and services beyond the life of the project

Financial Sustainability
Financial sustainability of CBOPs will be built on already established systems that require fees for services However, these systems need to be reviewed and strengthened to ensure financial viability as well as access for the poorest of the poor

The funds generated by the community may be used to pay community-level health promoters, procure basic drug supplies, or create an insurance fund for medical emergencies The use of the funds would be determined by each individual community and may be used for different purposes in different villages This will enable the communities to recognize and address their own needs, and will contribute towards community ownership of the program Assistance from a health-financing expert will assist the project to develop financially viable health financing options for CBOPs Furthermore, a specific business plan has been created which outlines the process by which the project hopes to achieve financial viability for the outreach clinics that form a vital means of health service delivery for project activities The business plan is enclosed as an Annex to this report

The financial sustainability of the two partnering NGOs was carefully considered before entering into the partnership Both are well grounded with a long track record of attracting a diverse portfolio of donors and contributions, and continuing program initiatives The NGO and community match is significant and gradually increases through the life of the project

Policy Sustainability

The project plan includes resources for the documentation and dissemination of achievements and lessons learned that may inspire other industries, NGOs, or the government to replicate the experience CARE will utilize lessons learned from this project to benefit the 937 other blocks in the country where the large-scale INHP project is operational

Sustainability Plan

Objectives	Indicators	Activities
Behavioral Sustainability 1 Pregnant women and mothers of children < 2 practice healthy behaviors 2 Functional system to ensure EOC	In communities with reduced* project inputs 60% of pregnant women are identified and registered during the early stages of pregnancy 50% of pregnant women seek ANC during their first trimester, 60% of pregnant women receive TT vaccinations, 60% of children 12-24 months are completely vaccinated, 85% of all deliveries are attended by a trained health worker, 40% of all deliveries were followed by a post natal visit, In communities where an EOC system has been established, it is used effectively * quarterly visits per community	- Training of CBOPs as community mobilizers and service providers, - Health and nutrition education of pregnant women, mothers and decision makers, - Provision of ANC/PPC and immunization services
Institutional/Program Sustainability In communities with reduced* project inputs - CBOPs are able to generate demand for services within the communities - CBOPs continue to encourage pregnant women for registration	In communities with reduced* project inputs - CBOPs formed in 80% of project communities continue to function, - 50% of pregnant women are registered by CBOPs, - 65% of CBOPs continue health education and	- CBOPs formed, trained, supported and supervised - Capacity building activities with NGO partners, - Technical assistance provided to NGO partners, - Effective partnering

- Trained CBOPs provide services to community members, - CBOPs facilitate community access to services and resources previously untapped or underutilized - NGO partners demonstrating skill in project planning, monitoring and management	community mobilization efforts, - Trained TBAs deliver 80% of children, - A trained health worker visits 50% of neonates within 24 hours of delivery - Villages have institutionalized monthly health days - 2 NGO partners effectively training and supporting CBOPs, - 2 NGO partners develop and implement action plans with MoH to overcome barriers to increasing coverage rates - Both NGOs maintain outreach clinics in the project area	approaches modeled
<u>Financial sustainability</u> - Community members covering a portion of health costs, - NGO partners providing match to project funds,	- 50% of communities have an emergency transportation fund established that is functional, - 50% of communities have created a fund that is used to cover costs related to some health care services, - NGO partners are covering a significant (%) portion of the costs of the CS project	Community education of need for emergency health funds Training CBOP for health fund management including formation of rules and norms
<u>Policy Sustainability</u> - MoH guidelines/policies are being more consistently followed in the project area, - Other Corporate NGOs express interest in initiating social responsibility projects	- MoH personnel vaccinate 50% of all children under 24 months in the project area with reduced project support, - Ten corporate NGOs attend a workshop on lessons learned regarding the project - Two corporate NGOs develop concept papers for the initiation of social responsibility projects - Two corporate adopt child survival activities	75% of immunizations performed by MoH personnel Project results regularly shared with government officials Projects experiences shared with CII, FICCI, and ASSOCHAM Workshop on lessons learned conducted

I HUMAN RESOURCES

CARE Staff associated with the Child Survival Project

Project Coordinator, Child Survival, and Bihar (100%) Based in Jamshedpur, s/he will report to the Nutrition and Health Manager for CARE-Bihar Job responsibilities include preparation and submission of project reports, coordination with NGOs for technical assistance and strategy development, monitoring implementation against plans, identification of partners to replicate the model in Bihar, and monitoring expenditure against budget Required qualifications include master's degree in public health medicine or nutrition with 2-5 years experience in planning, managing, and implementing community-based nutrition and health programs

Manager, Child Survival and Linkages, Bihar (67%) He reports to the State Director of CARE-Bihar He is responsible for planning, monitoring, and supervision of Child Survival project in Bihar, as well as liaison and representation with CIHQ, NGOs and government Required qualifications include master's degree in medicine, public health or nutrition with 3-10 years experience in planning, managing, and implementing community-based health programs Communication skills for liaison with international, national and local counterparts are required

Program Assistant, Child Survival, and Bihar (100%) Based in Jamshedpur, s/he will report to the Project Coordinator, CS, in CARE-Bihar S/he will provide programmatic and administrative support to the Project Coordinator to prepare reports and budgets, coordinate with NGOs, etc Qualifications include degree in social science or health, with experience in documentation, budgeting, and reporting

Project Officer, Child Survival, New Delhi (100%) Based in New Delhi, s/he reports to the Director of USAID projects This position entails coordination with CARE-Bihar for technical assistance, documentation, report submission, and grant management, coordination with the TSRDS, PKS and Confederation of Indian Industries for national level expansion of corporate NGO collaboration, and coordination with CARE-USA and USAID on all aspects related to the project Qualifications include master's training in health or management, with 3-5 years experience in conceptualization, planning and managing of community-based health programs

Director, USAID Projects, New Delhi, (20%) Based in CARE-India headquarters at New Delhi, he provides overall supervision for all USAID-funded projects for the mission, and reports to the Nutrition and Health sector Director for CARE-India This position will supervise the project officer of the CS project to manage the completion of activities according to plan and oversee the preparation and submission of reports and documents to meet grant obligations The director of USAID projects has 17 years of related management and health experience, including experience with Child Survival Projects (see attached CV)

Director, Nutrition and Health Sector (7%) Based in New Delhi, she provides the overall programmatic direction for all health projects She has 13 years of experience in planning, managing, monitoring, and evaluating community based health projects, including child survival projects in 7 countries (see attached CV)

Other programmatic and administrative support staff (7%)
Monitoring and evaluation officer, grants officer, and the finance, administration, and human resource units of CARE-India will support the child survival project

PKS Staff associated with the Child Survival Project
Secy - Masters degree with 30 years of experience in rural project management, including project planning, staff supervision, fund raising and financial management of the projects This position will be responsible for overall project administration and promoting other organizations to adopt corporate sector community health activities

Joint Secy - Postgraduate in Labor and Social Welfare with 15 years of experience in project planning, monitoring, staff Supervision, networking with state Govt counterparts and NGOs Primary responsibility will be project planning and administration including financial management

Senior Medical Officer - Bachelor of Medicine with 10 years of experience in hospital based health services and 5 years of experience in community based health project, supervision of staff, providing technical inputs and project monitoring Primary responsibility will be to supervise MO and project officer to ensure project implementation on time, reporting and providing technical inputs

Project Officer - Post graduate in rural development with experience in child survival activities and training Primary responsibilities include supervision of project supervisor, activity monitoring, data compilation analyses and feedback

Project Supervisor - Rural development professional with field experience in child survival This position will be responsible for training, technical support to CBWs, supervision and monitoring of project activities at the village level, coordination with AWCs and reporting to project officer

Medical Officer- Primary responsibility includes antenatal check ups, immunization, referrals and TBA training

CBWs (25) - One CBW will be responsible for 4 villages Primary responsibility includes identification and strengthening of community-based operating partners and community mobilization to increase the practice of healthy behaviors

TSRDS Staff associated with the Child Survival Project
Hon Secy - Masters in Social Anthropology with 12 years of experience in project management, coordination & planning, networking with State Govt and NGOs This position will be responsible for overall project administration and for liaison with other corporations to replicate the model

Senior Project Manager - Health professional (MBBS) with 16 years of experience in Community health project management, including implementation and overall project administration at District level, providing technical inputs and staff supervision Primary responsibility will be project planning and administration including financial management and technical guidance

Project Coordinator - Masters in Social Science with 14 years of experience in rural development including project implementation and monitoring at block level, liaison with district and block level

government counterparts and NGOs Primary responsibility will be to supervise block coordinators to ensure project implementation according to plan, monitoring, data compilation, analysis and feedback

Block Coordinators (3) - Rural development professionals with experience in child survival activities and training One coordinator will work with 54 villages and will be responsible for training and technical support to CBWs, supervision and monitoring of project activities at village level, coordination with AWCs and reporting to project coordinator

NGO medical personnel - Medical professional whose primary responsibilities will include antenatal check-ups, training of dais, health check-ups of children under 1, immunization and referral

CBWs (27) - One CBW will be responsible for 6 villages Primary responsibilities include community mobilization, identification of CBOPs, formation of Mahila Mandals /or active functional groups and conducting village-based activities such as health and nutrition education

J MONITORING AND EVALUATION

Data for decision-making under the Child Survival Project in Jamshedpur will be collected through a monitoring and evaluation system jointly devised by CARE-India and the two NGO partners The basic monitoring and evaluation framework consists of a baseline, ongoing internal monitoring, mid term assessment, and final evaluation Under this framework, recourse will be taken to both qualitative and quantitative methods

In this spirit of collaboration, a joint baseline was undertaken by both PKS and TSRDS after extensive training provided by CARE Both NGOs have existing staff structure and placement extending down to the community level This has facilitated the involvement of communities in the project implementation and monitoring through community-based organizations CARE has worked with both the NGO partners to introduce suitable modifications in their scope of data collection as also the methodology to better reflect the priorities of the Child Survival project These changes are captured in the Monitoring and Evaluation framework that follows

Ongoing collection of process level data at the community level is prescheduled on a monthly basis This is supplemented with outcome level data collected through home-visits and attendance at clinics and health camps Current data analysis is limited to frequency counts and totaling by different target groups Such data is aggregated monthly for reporting and internal feedback in the NGO structure Quarterly compilation for reporting and feedback of project achievement, financial results and human resources is addressed through the Core Team (comprising CARE and NGO representatives)

CARE-India's Health Management Information System has been requested by both NGO partners to facilitate the computerization of collected data at the PKS and TSRDS office Collected data would be data entered in EPI INFO (version 6 02) Earlier, on the request of the NGO partners and as a part of the preparation for the baseline, the use of this software by NGO partners was facilitated by CARE This will allow for preliminary analysis such as frequency counts, cross-tabulation and time series analysis required for decision-making Further analysis as required would be handled by CARE-India through importing data into SPSS (version 9) A record format to aid data entry and a program to help analysis is under preparation

Both NGOs are enthused by the possibilities that Geographic Information system holds to aid their effort in more effective decision-making for project implementation and refinement As a first cut, the map of the block with village boundaries would be digitized through EPIMAP to locate Gram Panchayats, clinics and the distribution of populations and baseline coverage on select indicators Once capacity for use of this software is built up, monitoring data will be represented through this software to better aid decision-making

The project's M&E dissemination methods will be broadly similar to those of other CARE-India projects Specifically, information will be made available to NGO partners, CARE, USAID, and government officials on a quarterly / six monthly basis An annual report listing project achievement, comparing plan with progress made, listing reasons for deviations, if any, financial and human resources report, and other contextual and anecdotal information would also be prepared and shared with key stakeholders CARE staff located at Jamshedpur and staff from PKS and TSRDS will be collectively responsible for communicating information with respect to M&E activities to the community at large

K BUDGET

No substantial changes have been made in the budget

L REFERENCE MATERIAL

Please see Annex C for copies of reference material currently used by both NGOs

M DETAILED PLANS BY INTERVENTION

This section contains specific details as to how the Child Survival Project will enhance Child Survival through ante-natal check-ups, immunizations, infant feeding, and family spacing interventions Although each section discusses particular strategies with respect to an intervention in detail a common approach has been used in preparing the IEC/BCC, Capacity Building, Training Needs Assessment, Quality Assurance, and Qualitative Data Collection sections, as briefly described below

IEC/BCC

The NGO partners will focus their IEC/BCC activities on increasing knowledge and understanding of maternal and child health and promoting sustainable healthful behavior changes among the target populations The partners' capacity to develop and execute an effective IEC/BCC strategy will be strengthened through technical assistance provided by CARE and other agencies IEC/BCC activities at the individual level will focus on counseling about identifying and overcoming barriers and at the community level activities will be directed towards action planning, reviewing the plan regularly, finding problems and re-addressing them At the level of project functionaries, IEC/BCC activities will focus on community mobilization, improving service quality, and strengthening delivery mechanisms to make them more responsive to community concerns Training of trainers will also improve the supervision of project staff Interactive learning aids will be developed and used by the project Key messages of project are identified in the sections on individual interventions

The IEC/BCC strategy has been created with the end result of transferring key information and processes under a broad framework in which the project target groups and intermediaries can effectively be engaged Matrixes for each Child Survival intervention have been prepared and specific objectives for engaging a particular target group (i e family members, CBOP members, etc) along with activities for the same have been detailed Additionally, these outlines provide supplemental information including who will conduct specific IEC/BCC sessions, the methods that will be used to transfer the relevant information, and how we will check progress to ensure a certain level of quality in our activities

Furthermore, a filmmaker has been secured to create several films that educate the local population about health practices related to the project, myths and misconceptions about such interventions, and means by which individual homes can practice healthy behaviors These films will be created in both Hindi and Bengali and will also be made available to other CARE projects as well as other agencies that are promoting similar interventions

Capacity Building

The Capacity Building plan for all Child Survival Project interventions follows a similar paradigm as that of the IEC/BCC section in that it addresses the specific capacity building needs of the project target group and the various spheres of influence that have the potential to influence their health and health seeking behavior, namely family members, CBOP members, government functionaries, NGO staff, and CARE The curriculum for the various trainings have been outlined in collaboration with TSRDS and PKS and the tentative training contents have been segregated into "Knowledge" or "Skill" based categories so that the workshops, cross-visits, group meetings, Nutrition and Health Day, and other training methods can blend both theory and practice As all aspects of the training schedule will not be applicable to all

trainees, we have assessed technical background, experience, and relevance of particular intervention information to prepare the Capacity Building Schedule

Training Needs Assessment

A Training Needs Assessment prototype was developed for a Technical Capacity Building Workshop that CARE-India hosted for certain CARE-India staff and NGO partners The assessment schedule aimed to identify training needs of field-level workers and was tested over the last month The primary comments to the prototype were 1) do not rate their current skills, rather focus on what they want to learn, 2) rephrasing certain phrases to make it more user-friendly, and 3) have few questions on the form As a result, the Training Needs Assessment form has been revised and a copy is enclosed in as an Annexure to this document

Quality Assurance

The Child Survival Project realizes that providing health services to the population at large means little if the quality of such services is inadequate Consequently, a Joint Action Planning (JAP) meeting has been initiated in which both NGOs, ICDS, CARE, and the Health Department come together on a monthly basis to coordinate activities and discuss progress to date as well as activities necessary to strengthen the project, including quality assurances Furthermore, a monthly meeting where both NGOs come together to discuss with CARE project goals occurs as well to coordinate the same on a more detailed basis with more accountability given to the parties than the JAP meetings This is in addition to the internal monthly NGO meetings that both NGOs have begun Additional activities to enhance and ensure quality service delivery are capacity building training for the CBW cadre along with the government AWWs and ANM Separate training will be held for the personnel with a more technical background, i e paramedical staff and Block Medical Officers This training include topics such as how to maintain and check the cold chain, ensuring commodities have not expired, etc The project also plans to cross-check the administered vaccines and commodities with mothers and other beneficiaries to ensure the quality of supplies A recent innovation that TSRDS has initiated which PKS plans to replicate is the creation of quality circles This is a mechanism by which the each of the 3 block coordinators is assigned one area of specialization (children, pregnant women, or CBOPs) and leads other field staff at identifying problems and resolving such conflicts vis-a-vis promotion and practice of healthy behaviors On a quarterly basis, the General Manager of Social Service (TISCO) will have a meeting with the 3 block coordinators to provide support to the quality circle leaders and assess performance The idea of quality circles derives from TISCO's own experience in using quality circles in improving the quality of steel they produces using this mechanism on the shop floor, reflecting the synergy in bringing corporate paradigms to development initiatives Finally, as the project is instigating an IMCI component, a detailed facility assessment has been prepared to ensure health service delivery mechanisms maintain a high standard of integrity

Quality of care indicators have been developed to assess quality of care issues at the individual, NGO, and clinic levels

a) % of women who feel their latest visit to the PHC or sub-center was satisfactory
b) Number of issues which have been identified and resolved by quality circles
c) Number of clinics that score above the minimum requirement with respect to the facility assessment

Qualitative Data Collection

To identify gaps in the BLS and create interventions appropriate to overcome such gaps, a qualitative training and data collection will occur in a phased manner between October - December, 1999 Burt Pelto, a leading qualitative surveyor will lead the training activities while Dr Ravi Verma, from the Indian Institute of Population Studies will play the primary role in spearheading the data collection and analysis efforts Additionally, MACRO will provide its input with respect to the study plan for the qualitative survey A copy of the Scope of Work for the qualitative survey is included in the Annexure H

CAPACITY BUILDING OF CBOPs AND CONSEQUENT ACTIONS IN THE COMMUNITY

The community-based operating partners and AWW will be the main agents for promoting activities at the community level Hence the program will try to address their knowledge and beliefs so that they can effect changes

CAPACITY BUILDING OF CBOPs (including AWW) ACTION IN THE COMMUNITY
CBOPs and other community workers work with families

Capacity Building	Action in Community
1 ORIENTATION Orientation to CSP Define roles of project functionaries Teach community-based operating partner to implement the program	Community meetings Generating interest Identifying and selecting best community-based operating partners to implement program in community
2 SETTING GOALS Define goals and indicators Educate communities about importance of health information and data Use information to meet project goals Define action plan and commit to implementation	Community meetings Begin making or updating household registers Community commitments towards joint action plans
3 LEARNING ABOUT COMMUNITIES Geographic maps and household locations (PRA) Community calendars/food calendar Community resources, groups, leaders and women	Mapping, household numbering Identifying community resources with communities Season-specific local food calendar
4 LEARNING ABOUT PEOPLE Registration and verification Tracking vital events	Household registry or verifications Improved vital events tracking
5 IDENTIFY THE TARGET GROUP Use rosters/AW registers to identify eligible women and children	Establishing/updating rosters of women and children Identifying project participants
6 IDENTIFY COMMUNITY BELIEFS AND PRACTICES FOR CHILD FEEDING PRACTICE Identify the normal practices and beliefs of infant feeding, Acknowledge the positive beliefs and support their continuity Address the impacts of the negative beliefs	Beliefs identified Community-level enabling/inhibiting factors for healthy practices identified Action plans developed based on identified factors
7 ROLE OF BETTER NUTRITION IN INFANT HEALTH Relationship between good infant feeding practices and health of the child Define dietary interventions to prevent illness related to malnutrition, such as diarrhea, ARI, malaria	Identify growth faltering and the possible reasons for it Dietary management for diarrhea and prevention of infections
8 SESSION ON INFANT FEEDING PRACTICES Educate about frequency, portion size, consistency, calorie density, hygiene in food preparation and feeding, Promote cultivation and consumption of locally available, low cost foods, especially those rich in Vitamin A and iron Demonstrate of cooking and feeding	Creating awareness about importance of Vitamin A and iron in the diet Increased local cultivation Recipe demonstrations
9 SERVICES AVAILABLE IN THE AW CENTRE Session on importance of the supplementary nutrition at the AWCs	Generate awareness about SNP at the ICDS Needs of the severely malnourished child Recipe and feeding demonstrations

CHILDHOOD IMMUNIZATION

Incidence and Outbreaks

There are no statistics available on incidence of disease and outbreak of epidemics in the area The immunization coverage rate is too low to prevent the transmission of vaccine-preventable disease and cases are seen throughout the year PKS, which acts as a polio surveillance center, reported four cases of acute flaccid paralysis last year in Potka, one of which was found to be seropositive for poliomyelitis

Baseline Coverage Estimates

According to the Population Coverage Survey of INHP Bihar (1997), 52% of children between 12-23 months were immunized for DPT1, 29% received OPV3, and 17% were provided with measles immunizations The dropout rate for DPT immunization was 20% for this 1997 survey, the percentage of children 12-23 months who were completely immunized was 15%, and the percentage of women who received two doses of TT was 54%

Drawing from the current KPC cluster survey only, the pool of children 9 months or older with UIP cards (148/353), DPT1 coverage was found to be 81% (120/148) OPV3 rates for the same population were found to be 61 5% (91/148) The dropout rate between OPV1 and OPV3 was found to be 31% (132-91/132) Measles coverage rates stand at 21% (31/148) An in-depth qualitative analysis of reasons for poor access and utilisation of services are being undertaken(see appendix G)

It is important to note that while coverage rates as reported by UIP cards are deemed accurate and reliable, they are not reflective of the population as a whole Rates as reported by UIP cards are higher than those for the entire population are because individuals who possess a card are statistically more likely to also be immunized (if number of UIP cards is used as the denominator) In an attempt to control for this, coverage rates as reported through UIP cards were pooled with coverage rates reported through the recollection of mothers The following table reports on these findings (See Annex B for KPC results)

IMMUNIZATION FOR CHILDREN AGE 9 MONTHS TO 23 MONTHS

ANTIGEN	NUMBER DOSES GIVEN	PERCENT n=353
BCG	158	44 8%
OPV1	261	73 9%
OPV2	229	64 9%
OPV3	146	41 4%
DPT1	181	51 3%
DPT2	136	33 5%
DPT3	116	32 9%
MEASLES 1	41	11 6%

MOH Policies and Current Services in the Area

The MOH's goal is to immunize all infants against six vaccine-preventable diseases The GOI's Universal Immunization Program (UIP) strategy is to immunize every child according to the following schedule BCG within a month of birth, three doses of DPT and polio at an interval of one month each, starting at 6

weeks and a measles dose between 9-12 months of age To assess the extent of immunization coverage children aged 12-23 months are taken as denominator by USAID, CARE-India child survival project will do the same Children who have received all these immunizations upon reaching their first birthday are deemed completely immunized Vitamin A supplementation beginning at nine months also is included in the Government's UIP protocol, according to which 9 months to 5 years age group is covered with focus on children below 3 years Children under the age of one year are given 100,000 International Units (IU) and older children are given 200,000 IUs of Vitamin A in a syrup form at six-month intervals

Only technically certified people in either the private or public sector can give immunizations In practice, ANMs immunize children in their area on a fixed day at a fixed place throughout the year The government specifies that ANMs conduct immunizations once a month in their villages Other certified providers are also encouraged to perform vaccinations The village level worker (AWW) of the ICDS program is responsible for IEC/BCC and community mobilization activities for immunization compliance In reality, the number of children who have received all immunizations (as called for by the UIP) is very low, due to the low performance of the GOI's immunization program

Barriers to achieving requisite coverage include the population's lack of knowledge about the necessity of immunizations, traditional taboos with respect to injections, the poor quality of services due to inadequate number of ANMs, sub-optimal training procedures, erratic supply of government vaccines, poor services for post-vaccination complications, and inadequate access to rural communities Collectively, these issues discourage communities from seeking appropriate immunizations

Program Approach

The project will focus on demand generation, improved community participation, including baby tracking, and ensuring accessibility and availability of quality services to the community

For demand generation, the NGOs will work through CBOPs, who will be responsible for

- Identifying the target group
- Early registration of pregnancy and following the life of the newborn until he or she reaches two years of age
- Registering deaths of children under two
- Informing mothers and other select family members about the importance of immunizations (including how and where to access such services)
- Mobilizing community groups and other opinion leaders to demand immunization services
- Using training aids to facilitate individual and group counseling and education
- Developing action plans at the community level for developing norms for prevention of disease and health promotion

The project will strengthen the existing government vaccine administration system by coordinating with MOH counterparts at the block and district level during regular monthly meetings While ANMs are expected to make monthly visits to villages, transportation often hinders such plans The project will facilitate ANMs transportation to villages by providing them an option to travel with project staff when NGO staff persons visit their areas In villages a comprehensive nutrition and health day will be organised providing complementary RCH services ICDS community mobilization services in the project area will be strengthened with project field staff especially CBW taking a lead in it ICDS in the Potka block has recently been sanctioned, but has not yet become operational

Government system breakdowns can be anticipated in the area To alleviate the impact NGOs will also provide vaccination services at fixed clinics within the project area on a set day PKS plans to operate seven service clinics and TSRDS plans to institutionalize 18 such clinics to serve the community once every a week These clinics will be manned by a medical doctor and licensed paramedical staff

To improve the availability and quality of Govt immunization services, specific training and capacity-building activities for MOH supervisory staff will be organized Individual health cards and registers will be maintained to monitor and ensure the quality and utilization of services in the NGO facility Every other week, the Medical Officer will check all the documents filled out by the clinic workers and suggest remedial steps Once a month, project supervisory staff will check documents and suggest appropriate amendments and changes

The ICDS workers along with the project CBW will identify the high-risk population with the help of the CBOP Identification will be carried out using available records, PRA techniques for resource mapping, and other health risk assessment tools Criteria will include inaccessibility (living more than two km away from vaccination sites), severe malnourishment (grade III and IV as per AWW records), low birth weights, and cases of post-vaccine complications or failures These high-risk groups will be individually counseled for vaccinations and rigorously followed up by the CBW to ensure compliance In case of service delivery failures, separate door-to-door immunization reminder visits will be organized by CBOPs

Individual Documentation

The GOI immunization card is retained by approximately 45% of the community, as determined during the BLS Half of the card is kept by the ANM, while the mother keeps the remaining half The project will continue to promote use of this card, as well as a comprehensive mother and child health service register designed by MOH TT given to mother will be entered in the same register Mothers in the PKS area will also be given maternal cards Clinic staff will retain one portion of the card and the other portion will be handed over to the mother In the TSRDS area, cards will be made in duplicate These NGO cards have sections for recording hemoglobin, blood pressure, and other illnesses related to high-risk pregnancies Cards will be given in a plastic cover, which can be hung up to minimize the potential for loss The plastic cover will be printed with a picture of something valued, thus reinforcing the importance of the card to the mother and serving as a further check against misplacement

During the 36th-38th week of pregnancy, the main card, which is kept at the clinic, will be handed over to the mother so the health provider attending to the woman's delivery can ascertain pregnancy history and take appropriate action GOI cards are usually in good supply, but each NGO will print 20% of its own cards in case shortages do occur In case cards are lost, duplicate cards will be prepared from the register and given to project participants The cards and immunization registers will be used to monitor immunization compliance and counseling of eligible populations during home visits Examples of the card will be provided in the first annual report During the monthly women's group meetings, information on immunizations will be shared and action plans developed with all group members Additionally, there will be monthly meetings in which CARE, TSRDS, PKS, and ICDS officials discuss the current status of immunization coverage and methods to enhance collaborative efforts (including analyzing and assessing content and quality of training for ANMs to conduct immunizations)

Type of Card	Information recorded	Recorded by	Retained by
GOI immunization cards	• Vaccinations (mother and child) • Vitamin A • Hb%	ANMs	• Half by mother • Half by ANM
Mother's Card (ANC)	• # of ANC visits to center • Pregnancy weight gain	NGO staff at facility level	• Half by mother (PKS) • One copy at clinic (TSRDS)
Mother and Child Health Service Register	• Consolidated RCH services • Demographic information	Community based workers	• Village level worker or ANM

Dropout and Missed Opportunities

Major causes of high dropout rates include lack of knowledge about the need to complete the immunization schedule, high prevalence of sickness among mothers and children, migratory habits of the local population, past vaccination complications, and difficulty in accessing immunization services (location and scheduling difficulty) Dropouts will be identified individually and counseled by community based workers to get services In cases of persistent dropouts or missed vaccinations, separate mop-up campaigns, outreach, or doorstep vaccinations will be organized by the NGO

The major service delivery obstacles include lack of vaccinations and vaccine supply, poor cold chain maintenance, shortage of syringes and needles, and inadequate transportation Vaccinators' indifference, overcrowded facilities, distance, workload, and lack of recognition, support, and supervision of workers, also contribute to difficulty in service delivery

The project will supplement and support government programs by improving the cold chain, ensure availability of potent vaccines and needed equipment, increase the number of vaccinators, and assist in transportation of vaccinators to the populations that need them

Vaccine and Equipment Supply and Cold Chain Maintenance

Vaccines will be supplied by the MOH In cases of contingency, vaccines will be procured from matching grants of the NGOs Disposable needles will be used to administer the vaccines Attempts will be made to procure disposable syringes and needles from government sources, but in case of shortages, NGOs will procure them from matching grant funds All attempts will be made to use disposable syringes, but in exceptional situations sterilized glass syringes may be used

Erratic electricity supplies and malfunctioning refrigerators at the block level are one of the important cause of non-maintenance of the cold chain The program intends to seek assistance from corporate facilities to make logistic arrangements for vaccine storage Ice liners, refrigerators, and ice boxes are already utilized by both NGOs and any additional equipment will be procured either by the government or from the open market itself

Another area that adversely effects immunizations is the vaccinators' lack of training in handling vaccines Training for ANM, NGO staff, and vaccinators will be organized to impart appropriate

knowledge and facilitate suitable practices for administering vaccines, with follow-up training after six months and ongoing supervision for most workers

For the safe disposal of syringes, needles, and other equipment, all disposable items will be brought to the main center and a corporate facility will dispose of waste materials

PKS is in the process of negotiating with the MOH to open a storage facility at the PKS campus, which will reduce logistic bottlenecks in conducting immunizations The store in charge and Medical Officer will be trained to maintain cold chain standards

Vitamin A Five doses of Vitamin A will be administered starting at nine months of age (along with measles vaccination) and continue at six-month intervals Supplies will be received from the GOI NGOs, AWWs, CBW, and CBOPs will be responsible for community mobilization and administration of Vitamin A following GOI guidelines

Polio Eradication Efforts The NGOs will be involved in Pulse Polio programs for community mobilization and will support transportation and administration of vaccine if required

Surveillance PKS is currently operating as a surveillance post for polio PKS may become involved with tetanus surveillance as well PKS has joined with UNICEF to send samples of suspect cases of polio to the National Laboratories in Lucknow and Delhi for serological investigations

Information, Education, and Communication (IEC/BCC)/Behaviour Change Communication (BCC)

While the IEC/BCC strategy for immunizations is part of the project's overall IEC/BCC strategy, several key messages will be promoted to encourage immunizations of infants and young children "Complete immunizations by one year of age and save your child from six childhood killers" will be the primary message ICDS messages will also be utilized

Behaviour Change Communication (BCC/IEC/BCC) – Childhood Immunization

IMMUNIZATIONS					
Target Group	**Objective**	**Activity**	**Frequency**	**Intervenors**	**Evaluation**
Pregnant/Lactating women	Provide immunization education to promote practice of healthy behavior on sustainable	Individual and peer counseling	Ongoing	Community-based workers CBOP members	Maternal and Child Immunization cards
Mothers of children <2	Promote compliance with immunizations against six major diseases	CBOP meetings Nutrition and Health Day Pulse Polio Campaigns	Fortnightly or monthly Fortnightly or monthly as deemed by GOI	Mothers of immunized kids ANMs, CBWs ANMs, CBWs	Home visit questionnaires Exit interviews Exit interviews
Family members, opinion leaders influential people	Provide PLU2 supportive atmosphere vis-a-vis Seeking immunizations	Village level meetings Awareness campaigns Audio/visual demonstration	Monthly Quarterly Semi-annually	CBWs, CBOPs CBOPs ANMs, AWWs	
CBOP Members	Mobilize community Identify children that have not been immunized	Group counselling Maintenance of records	Quarterly Ongoing	CBWs CBWs	Observation by staff, ANM Observation by staff, ANM
CBWs	Assist CBOPs in arranging logistics and aid ANMs in health delivery activities Provide outreach for un-immunized children	Community meetings Door-to-door surveillance	Quarterly Ongoing	Child Survival Project Staff Child Survival Project Staff Service Providers	CBOP, ANM, AWW feedback UIP cards
Service Providers ANMs, AWWs, etc	Improve skills in order to enhance quality of care Ensure ability to provide routine immunization services on health days	Distance education Small group and individual training and retraining Review meetings Cold chain spot-checks	Semi-annually Monthly Quarterly	Child survival project staff Child survival project staff	Direct observation by staff Exit interviews UIP cards/NHD records Direct observation by staff
Core Team (CARE TSRDS, PKS)	Develop skills to enhance supportive supervision and quality service delivery	Capacity building workshop Refresher training course	One time activity Annually	External consultant CIHQ technical staff	Training Evaluation Mid-term review

Capacity Building Plan for Childhood Immunizations

The capacity building plan for immunization activities encompasses the entire spectrum of project participants - ranging from Pregnant/Lactating Women of Children Under Two (PLU2) to senior personnel within the Child Survival project (from CARE, TSRDS, and PKS) While course content will include basic vaccination information for all trainees (i e what is a vaccine, vaccination schedules, eliciting immunisation history in lieu of UIP card etc) the depth of the lessons will vary based on trainee backgrounds Additionally, for those with management responsibilities within the project, the capacity building plan will also address issue related to utilization of secondary information to enhance immunization coverage (such as cold chain maintenance, quality assurance of immunisation services etc) and improving supportive supervision skills

Joint discussions with government service providers and NGO partners, in addition to CARE's experience in immunization activities, has yielded a tentative list of contents that the capacity building activities will seek to convey A detailed needs analysis of project functionaries is being undertaken to finalize the contents proposed (see Annexure H for Needs Assessment format)

Training content for Childhood Immunization

Knowledge (K)

1 What is a vaccine
2 The importance of immunizations
3 Potential side-effects of immunizations
4 Immunization schedule and doses
5 Validity of indicators
6 Significance of pulse polio

Skills (S)

1 Ensuring the quality of vaccines, and optimal administration procedures
2 Eliciting immunization history sans UIP card
3 Behavioral counseling skills
4 How to maintenance the cold-chain

Capacity Building Schedule for Childhood Immunization

CARE, TSRDS, PKS, Gov of Bihar, med off , paramedics, CDPO	External consultants CIHQ technical staff	K 1-6, S 1-4	Semi-annual workshops Cross-visits
ANMs, AWWs ICDS supervisor	Core group members	K 1-6, S 1-4	Workshop Refresher training seminars
CBW's	Core group members	K 1-6, S 1-4	Workshop Refresher training seminars Cross-visits
CBOP members	CBWs	K 1-6, S 1-4	Joint home visits Work sharing on NHDs
Family members, opinion leaders, influential people	CBOP members, AN AWWS	K 2-4, 6 S-3	Group meetings NHDs
Pregnant/Lactating wome Mothers of children < 2	CBOP members, CB	K 2-4, 6 S-3	Individual counselling Peer group counselling

BREAST FEEDING PROMOTION

Baseline information

The Baseline data reveals that nineteen percent of women put their child to breast in the first hour after delivery About forty seven percent initiated breast-feeding within one to eight hours Breast-feeding was initiated within eight hours by 68 4% of mothers in Patamda Block and 62 8% of mothers in Potka Block The data points to the fact that in most of the cases colostrum is discarded and there exist the practice of giving pre-lacteal (mainly goats milk) during initial days In addition to breast milk, herbal concoctions are also given because of cultural belief that it helps in digestion of milk and prevents abdominal discomforts Mothers also indicated they switched breasts four or fewer times per feeding (76%)

Thirty-eight percent of mothers interviewed started weaning at the correct age Whereas half of the mothers reported that weaning should start at six months The prevailing ethnic and cultural environment influence the current beliefs and practices of the community

An in-depth study of the prevailing practices is being undertaken through a qualitative study This study will focus on assessing the problems associated with starting of complementary feeding and approaches to the implementation of optimal breast feeding practices as per the Annexure G

MOH Protocols and Related Activities in the Area

According to the MOH, exclusive breast-feeding should continue up to the age of 4-6 months Government guidelines define exclusive breast-feeding as offering a child nothing other than breast-milk (with the exception of medically prescribed drugs)

Approach

A) Household level

Project community based workers along with ICDS AWW's will visit households to motivate women for colostrum feeding and exclusive breast-feeding until age of 4-6 months These visits will be initiated during the pregnancy so as to emphasize early initiation, its benefits for both mother and child During these visits other family members, especially mothers-in-law, will also be counseled These visits will provide the opportunity to identify problems faced by mothers while breast-feeding and specific counseling will be provided with focus on technique of breast feeding and insufficient milk Also, continued breast-feeding during diarrhea and ARI will be promoted TBAs will specifically be used for bringing behavioral modification and maternal support related to early initiation of breast-feeding

B) Community level

1 Training of Traditional Birth Attendants and Rural Health Providers about the importance of breast-feeding and its components Special attention will be given to women who do not seek or have access to the information

2 Comprehensive Nutrition and Health Days will be organized in collaboration with TBAs, ANMs, RHPs by the CBW and AWW's for pregnant and lactating mothers as well as fathers, community

leaders and others to address possible cultural barriers against colostrum and exclusive breast-feeding CBOP's will provide active assistance and support to organization of these NHD's

3 Women's groups will be used for peer education, counseling and monitoring breast- feeding

Although a network of trained counselors, health promoters and health workers is at the heart of community based support activities, but there is no one model A combination of individual, group and peer counseling will be utilized

At the community level breast-feeding support will be provided through

- Community participation and mobilisation
- Interpersonal counseling (Home visits, Informal contacts and contacts with health workers)
- Breast-feeding support groups
- Network of trained, supervised breastfeeding counselors/health promoters
- Supportive Supervision
- Program monitoring and evaluation

C) Clinical Level

During ANC clinics, medical and paramedical officers will explain to all pregnant women the importance of breast-feeding and technique of breast-feeding, increased maternal nutritional requirement during lactation Women attending postnatal clinics will learn about the process of breast-feeding, age of weaning and preparation of semi-solid food The frequency and method of feeding semi-solid food and disadvantages of bottle-feeding will also be explained Women with any medical psychological problems which can adversely affect optimal breast feeding practices will be appropriately treated in the project clinics and referred as needed

IEC/BCC

Information, education and communication activities will be targeted to pregnant and lactating women Family members, especially mothers-in-law, and other community members will be the secondary target group Messages will include

- Early initiation of Breast Feeding
- Importance of giving colostrum
- Exclusive breast-feeding up to 4-6 months
- Continue breast-feeding for as long as possible
- Breast-feeding during diarrhea and ARI as part of home care for sick children

IEC/BCC activities will follow the approach previously described and the primary message for this intervention will be to "initiate breast-feeding as early as possible after birth and to exclusively breastfeed for 4-6 months"

BEHAVIOUR CHANGE COMMUNICATION (BCC/IEC/BCC) – BREAST-FEEDING PROMOTION

BREAST-FEEDING PROMOTION						
Sl No	**Target Group**	**Objective**	**Activity**	**Frequency**	**Intervenors**	**Evaluation**
1	Pregnant/Lactating women	To promote early initiation of breastfeeding (within eight hours of birth) To promote Exclusive breast-feeding (4-6 months) To continue breastfeeding during illness To identify myths and misconceptions related to breast feeding and address them	Individual and peer Counseling Mahila Mandal meetings Nutrition and Health Day Home visits within 48 hrs of delivery	Fortnightly/weekly Monthly Monthly At the time of birth	CBWs, CBOPs, AWW, ANMs and TBAs	Observation of Individual/Group meetings Home Visit Questionnaires, NHD records Monthly monitoring formats
2	Family members, opinion leaders, influential people	To solicit support and promote optimal breastfeeding practices To create an enabling environment for the promotion of exclusive breastfeeding To encourage their participation in community action planning	Mahila Mandal meetings Awareness campaigns Audio/visual demonstration Individual counseling	Monthly Quarterly Semi-annually Fortnightly	CBWs, ANMs, AWWs	Observation of Individual/group meeting7 NHD records Monthly monitoring formats
3	CBOP members	To enhance their knowledge and skills for the promotion of optimal breastfeeding practices and addressing the identified barriers for the same	Workshops	Semi annually	AWWs, ANMs and CBWs	Observation by staff
4	CBWs	To enhance their knowledge and skills for the promotion of optimal breastfeeding practices and addressing the identified barriers for the same	Workshops	Semi-annually	Core group	CBOP ANM, AWW feedback Monthly monitoring format HVQ
5	TBAs	To promote early initiation of breastfeeding To address issues related to giving of pre-lacteals To promote optimal breastfeeding practices greater emphasis on exclusive breastfeeding	Workshops Mahila Mandal meetings	Semi-annually Monthly	Core group	Observation of mahila mandal meetings Monthly monitoring formats

6	Service providers ANMs, AWWs, etc	To improve their knowledge and skills for promoting and supporting optimal breast feeding practices in the community To enable them to identify medical and psychological problems related to breastfeeding and appropriately address them either through counseling or referral	Workshops Cross visits	Annually Annuallyq	Core group	Direct observation by staff Exit interviews
7	Core Team (CARE, TSRDS, PKS)	To build the capacity of service providers for the promotion and support of optimal breastfeeding practices in the community Treat and counsel referred cases of breastfeeding failure	Workshop	Annually	CIHQ technical staff External resource persons	Training evaluation Mid-term review

CAPACITY BUILDING PLAN

Capacity Building Plan for Breast feeding

The capacity building plan for optimal breast feeding practices will encompass the entire spectrum of project participants - ranging from PLU2, TBAs to senior personnel within the Child Survival Project (from CARE TSRDS, and PKS) While course content will include early initiation of breast feeding importance of colostrum feeding, exclusive breast feeding up to 4-6 months and breastfeeding during illness, etc The depth of the lessons will vary based on trainee backgrounds Additionally, for those with management responsibilities within the project, the capacity building plan will also address effective communication and counseling skills supportive supervision and the medical staff will be trained to handle medical causes of breast feeding failure

Joint discussions with government service providers and NGO partners, in addition to CARE's experience in promoting optimal breast feeding, has yielded a tentative list of contents that the capacity building activities will seek to convey A detailed needs analysis of project functionaries is being undertaken to finalize the contents proposed (see Annexure H for Needs Assessment format)

Training content for Breast Feeding

Knowledge (K)

1 Initiation of breastfeeding
2 Prelacteals
3 Colostrum feeding
4 Exclusive breastfeeding
5 Anatomy of breasts and composition of breast milk
6 Lactation failure, prevalent myths possible medical causes and their treatment
7 Insufficient milk
8 Breastfeeding during illness
9 Attachment

Skills (S)

1 Breast feeding Counseling
2 Correct technique of breast-feeding
3 Identification and treatment of medical/psychological causes of BF failure

Capacity Building Schedule for Breastfeeding

Trainees	Trainers	Content	Method
CARE, TSRDS, PKS, Govt of Bihar, Med officers, paramedics, CDPO	External consultants CIHQ technical staff	K 1-9, S 1-3	Workshops, Cross-visits
ANMs, AWWs, ICDS supervisor, LHV's, and NGO paramedics	Core group members	K 1-9, S 1-3	Workshops and refresher trainings
TBAs	Technical resource persons, ANMs, LHV's, NGO and project staff	K 1-9, S 1-2	Workshops and demonstrations
CBWs	Technical resource persons, ANMs, LHV's, NGO and project staff	K 1-9, S 1-2	Workshops and demonstrations
CBOP members	CBWs, ANMs AWWs	K 1-4, 6-9, S1-2	Joint home visits, work sharing on NHDs
Family members, community influential	CBOP, CBWs, AWW, ANMs and project staff	K 1-4, 6-9, S-2	Group meetings, NHDs, Clinic days, Home visits
Pregnant and lactating women	TBAs, NGO CBWs, AWW, ANMs	K 1-4, 6-9, S-2	Individual counseling, Clinic, NHDs, Group meetings

CHILDHOOD FEEDING PRACTICES

Protein Energy Malnutrition (PEM) Status

Data for prevalence of malnutrition was collected in the baseline using weight for age criterion The figures available show

Malnutrition rates among children under 2 years (%) in Potka Block

Grade N=	**Boy** 146	**Girl** 144	**All** 290
Normal	40	38	39
Under Nourished*	60	63	61
Severely Undernourished**	28	28	28

* Percentage below –2 SD (includes – 3 SD)
** Percentage below –3 SD

According to the Baseline Survey conducted by CARE in August-September 1996 and available NFHS (National Family Health Survey) data of 1993, prevalence of malnutrition in Rural Bihar is as follows in children below two years of age

Grade	**Baseline CARE (1996)**	**NFHS (1993)**
Normal	39%	36%
Undernourished*	60%	64%
Severely undernourished**	28%	32%

* Percentage below –2 SD (includes – 3 SD)
** Percentage below –3 SD

The above data show that the baseline reflects rates similar to those of the INHP baseline and very close to those of the NFHS

In recent years, growth monitoring and survey data from a number of South East Asian countries found that the process of growth faltering was completed by 2 years of age This suggests that a child becomes malnourished mostly between six months and 18 months of age and remains so thereafter (Ray Yip 1998 UNICEF) Delayed and improper introduction (quality/quantity) of semi-solids, lack of awareness about child feeding practices, poor socioeconomic conditions, poor availability and access to food and low agricultural yield or output are some of the common causes of malnutrition Hence the intervention should be focused on younger children

Past clinical experience from partnering NGOs shows that the incidence of malnutrition increases during the rainy and summer seasons Outbreaks of diarrhea and associated diseases are higher in the rainy season, while access to food and income are reduced during the summer season--all factors leading to malnutrition A high prevalence of worm infestation in the area is another cause of concern

Qualitative surveys is being carried out to further explore reasons for poor childhood feeding practices and help refine the intervention strategy

MOH Policies and Activities

One of the most significant achievements on the nutrition scene in India was the adoption of the National Nutrition Policy in 1993 It advocates a comprehensive, integrated and inter-sectoral strategy for alleviating the multi-faceted problem of malnutrition and achieving the optimal state of nutrition for the people Some of the objectives are as follows

* Start breast-feeding as early as possible
* Exclusive breast feeding for four to six months
* Complementary food to start from six months onwards
* Supplementary feeding program for children aged six months to six years via ICDS for disadvantaged groups, providing 300 calories and 10 to 12 grams of protein, with a double ration for children in grades 3 and 4 of malnutrition
* Vitamin A supplementation every six months from 9 months-5 years with focus on children under 3 years of age (100,000 IU till the age of 1 year and 200,000 subsequently)
* IFA for children suffering from anemia
* Fortified food (CSB is available from ICDS)
* Mandatory iodination of processed salt

The supplementary nutrition program is managed by ICDS, while Vitamin A and IFA is managed through the Ministry of Health Due to inadequate supplies and infrastructure, government programs are not functional and are underutilized

ICDS infrastructure as described in the strategy section is nominally functional in Patamda Block and sanctioned but non-operational in Potka Block Rural health service providers are available in almost every village Actual figures will be available after collection of data during program implementation

The AWW provides advice about feeding during childhood and the traditional birth attendant provides advice about initiation of breast-feeding The Rural Health Service Provider provides advice about feeding

during sickness which is usually restricting food during diarrhea and ARI AWWs and trained TBAs are the only ones who have received any type of nutritional training, but they still have inadequate knowledge The others have never been trained on any nutritional issues, but because of their proximity and rapport with the communities, they have immense potential to be effective in this area

Current Beliefs and Practices

Social and cultural taboos that prevent the mothers from feeding the children certain types of food tend to hinder normal growth and development In Bihar a common cultural practice is to start complementary feeding with a ritual, whereby complementary foods are introduced for male children at the age of five months and females at six months

According to the Baseline Survey conducted by CARE, the current practice in this area is to feed the child with locally grown and available seasonal food items There is no special weaning food The child is given whatever the mother consumes Mothers give cereals, like semolina, fruits, vegetables, pulses and animal proteins about 50% of the time Dense lipids, honey, jaggery and sugar are also frequently given, while eggs, yogurt, and iodized salt are given less frequently

Only about 38% of mothers added supplementary foods to the child's diet at six months Interestingly, more than half (51%) the mothers believed that introduction of supplementary food should occur at six months These results highlight the fact that lack of knowledge about proper child feeding practices is a major barrier, making it imperative to focus on educating mothers During episodes of diarrhea, 11% of mothers were found to be giving more food than usual, while 50% continued to give the same amount and 29% reduced the amount of breast milk

Approaches

In the initial project implementation phase, the project via qualitative research is exploring cultural practices and beliefs related to child feeding practices, such as the roles of different family members in initiation of complementary feeding, feeding frequency, portion size, caloric dense food, inclusion of important nutrients like iron and vitamin A, and modifications during common illnesses like diarrhea and ARI, utilization of locally available foods Strategies based on these explorations will be designed to address specific problems in various target groups

The project will approach child-feeding practices by modifying behavior at household, community and AWC levels Mother of children will be the primary target of counseling and behaviour change communication efforts Family members and operating partners will become involved to support optimal child feeding practices Since the community is the macro environment that directly influences the mothers' behaviors, CBOPs and Mahila Mandals will be used as the primary counselors and synergists in modifying the child feeding practices Availability and utilization of supplementary nutrition in the AWC will also be streamlined

Household Level CBOPs, community based workers and AWWs will follow the mothers from pregnancy onward During antenatal and postnatal visits, optimal feeding practices will be advocated, including proper breast-feeding and introduction of semi-solid foods by six months Messages will specify quantity and nutritional content of food, feeding frequency, increasing caloric density by adding oils, foods that are rich in Vitamin A and iron, and dietary management of diarrhea and ARI Household barriers to practicing these behaviors will be identified during individual sessions with the mothers, and a

feasible action plan to address them will be designed The role of the other family members (i e , husband and mother-in-law) will be taken into consideration

Community Level The community has a vital role in influencing mothers and family by positively reinforcing child feeding practices The project will focus on developing and institutionalizing ideal community norms of feeding practices The community members, CBOPs, and *mahila mandal* members will be involved/trained in the following

- Develop food calendars for the area, emphasizing locally grown products that can be incorporated as complementary foods for the child according to their seasonal availability
- Explore the beliefs and taboos associated with specific foods and develop action plans to alleviate the negative ones
- Inform and educate people about availability of supplementary food at the AWC and its importance for the child
- Provide community groups with nutrition education about low cost, high calorie, locally available foods, which are culturally acceptable and suitable for supplementary feeding of children
- Demonstrate cooking and complementary feeding with locally available foods
- Promote cultivation and consumption of locally available, low cost, nutritious foods especially those rich in Vitamin A and iron
- Utilization of community health funds for nutritional rehabilitation in case of grade III or IV malnutrition cases
- Inform and educate the community about the risks of diarrheal diseases and the need for adequate dietary management at the household level

AWC level

- Improve availability and distribution of supplementary food and ORS at the AWC with assistance from CBOPs and mahila mandal members
- Organize monthly comprehensive Nutrition and health days, which will provide a package of services for child health including nutrition education, ration distribution, immunization, deworming and treatment of minor illnesses Growth monitoring will not be a specific project focus, but it would be strengthened as a regular component of ICDS

IEC/BCC/ BCC

The approach adapted for IEC/BCC will be the same as described earlier, but it will focus on pregnant women and mothers of children under the age of two The key message will be to add mushy, semi-solid, locally available foods to the diet of children after 4-6 months of age

CHILDHOOD FEEDING PRACTICES						
Sl No	Target Group	Objective	Activity	Frequency	Intervenors	Evaluation
1	Lactating women	To promote optimal complementary feeding practices To address barriers/myths related to complementary feeding To improve their access to information To combat malnutrition by focusing on optimal quantity, quality and age of introduction of complementary foods	Individual and peer counseling Mahila mandal meetings Nutrition and Health Day Awareness campaigns Audio/visual	Fortnightly/weekly Monthly Monthly Quarterly Quarterly	CBWs, CBOP ANMs, AWWs	Individual/Group meetings Monitoring visits Home visit questionnaires (HVQs) NHD records
2	Family members, opinion leaders, influential people	To provide support and enabling environment for the promotion of optimal complementary feeding practices at household and community level To improve their access to information on correct complementary feeding practices	Mahila Mandal meetings Campaigns Audio/visual demonstration Individual counseling	Monthly Quarterly Semi-annually Fortnightly	CBWs, CBOPs ANMs, AWWs	Observations of individual/group meeting NHD records Monthly monitoring formats HVQs
3	CBOP Members	To enhance their knowledge and skills so as to promote optimal feeding practices Remove the prevailing myths and barriers in the community with respect to complementary feeding	Workshops Campaigns	Quarterly Quarterly	ANMS, AWWs, CBWs	Observation by staff
4	CBWs	To enhance their knowledge and skills so as to promote optimal complementary feeding practices To remove the prevailing myths and barriers with respect to childhood feeding amongst CBOP members	Workshops Campaigns	Semi-annually Quarterly	Core group members	CBOP ANM, AWW feedback Monthly monitoring format HVQs

5	Service providers ANMs, AWWS, etc	To improve their skills for the promotion and support of optimal complementary feeding practices in the community To enable the community in identifying and reducing cases of malnutrition due to faulty complementary feeding practices Ensure ability to remove the taboos and myths related with childhood feeding practices	Workshops Cross visits	Annually Annually	Core group	Direct observation by staff Exit interviews
6	Core Team (CARE, TSRDS, PKS)	To build capacity of service providers for the support and promotion of optimal childhood feeding practices To identify treat and counsel children with nutritional problems To develop skills to enhance supportive supervision	Workshops	Annually	External consultant CIHQ technical staff	Training Evaluation Mid-term review

CAPACITY BUILDING PLAN

Capacity Building Plan for childhood feeding practice

The capacity building plan for complementary feeding will encompass the entire spectrum of project participants - ranging from PLU2 to senior personnel within the Child Survival project (from CARE, TSRDS, and PKS) While course content will include correct feeding practices, right age of introduction of food, maintaining energy and nutrient balance in diet, consistency of food, and diet demonstration etc The level of information and skill imparted will be contingent on the knowledge level of the trainees Additionally, for those with management responsibilities within the project, the capacity building plan will also address interpersonal and communication skills

On the basis of the of the review of initiatives taken by CARE, other organizations and government counterparts a tentative list of technical areas on which capacity will be built, has been developed A detailed needs analysis of project functionaries is being undertaken to finalize the contents proposed (see Annexure H for Needs Assessment format)

Training content for childhood feeding practice

Knowledge (K)

1 Age of introduction of complementary feeding
2 Correct feeding practices (quality, quantity and feeding technique)
3 Common feeding problems
4 Constraints in improving child feeding practices
5 Energy requirement of children
6 Problem nutrients (Iron, zinc, calcium and Vitamin A)

Skills (S)

1 Interpersonal counseling
2 Communication skills
3 Diet demonstration

Capacity Building Schedule for childhood feeding practice

Trainees	Trainers	Content	Method
CARE, TSRDS, PKS, Govt of Bihar, Med Off , paramedics, CDPO	External consultants, CIHQ technical staff	K 1-6, S 1-3	Workshops
ANMs, AWWs, CBWs, ICDS supervisor, LHVs and NGOs	Core training group	K 1-6, S 1-3	Workshops , refresher training's and cross visits
CBOP members	Core training group, CBWs ANMs and AWWs	K 1-6, S 1-3	Workshops and refresher training
Family members (mother-in-laws, husbands), influential community members	CBOP, CBWs, AWW, ANMs and project staff	K 1-4, , S-3	Group meetings NHDs, Clinic days, Home visits
Pregnant and lactating women	TBAs, NGO CBWs, AWW, ANMs	K 1-4, , S-3	Individual counseling, Clinics, NHDs, Group meetings

Training will be reinforced and expanded in subsequent sessions Order of sessions will vary with context Emphasis is on the result of the session or consequent action not on training or knowledge gained

MATERNAL AND NEWBORN CARE

Baseline Information

Baseline information related to maternal mortality and morbidity in the program area is not available though the NFHS and ICMR survey reveals that the rate is as high as 1490 deaths per 100,000 live births in rural Bihar Recent data and experience have identified the following major causes of maternal mortality

- Inadequate and poor quality of obstetric care in the program area
- Use of traditional birthing procedures and non-compliance with aseptic methods
- Repeated pregnancies
- High rates of anemia and malnutrition
- Non-immunization against tetanus
- Severe worm infections
- Early age of pregnancy, usually before 20 years of age

The TT coverage rate is 57 4% for two or more doses (348/606) Tetanus Toxoid coverage is 16 2% (98/606) for one dose, 32% for two doses, and 25 4% for three doses or more

The Baseline Survey data shows that in the overall project area 38 8% of women reduce the amount of food consumed during their pregnancies Other reasons for malnutrition are insufficient consumption of locally available nutritious food, inadequate rest, poverty, and worm infection A high fertility rate also has an impact on maternal mortality because repeated pregnancies increase anemia in women An in-depth qualitative analysis of reasons for poor access and utilisation of services are being undertaken (see appendix G)

Data on neonatal mortality in the project area are not available, but according to the NFHS survey (1995) the rate is 54 8/1000 live births in rural Bihar Among the main causes are low birth weight and other causes of neonatal septicemia

MOH Policies

According to MOH policy one Auxiliary Nurse Midwife (ANM) caters to a population of 3000 Facility based services, inclusive of beds for delivery, are available at Primary Health Centre (PHC) which is manned by 1-2 Medical Officers and caters to 30,000 population For every developmental block, there should be one Community Health Centre (CHC) with 4 -5 specialist doctors and paramedical staff to provide health services

The baseline data show that in Potka 68% of deliveries are conducted by traditional birth attendants or by family members Inadequate health facilities and poor quality of services, particularly from the government institutions, have forced the population to get medical assistance from rural health practitioners, quacks, or Ojhas Medical equipment and obstetric care supplies are in a dismal state Both blocks have primary health centers and subcenters, but services rendered by the government health institutions are not high quality Government health services are considered so poor that the community does not use them unless there is no other option In Patamda, there are 137 Anganwadi centers and 30 trained ANMs who are supposed to deliver health assistance to the villagers In Potka, administrative license for Anganwadi centers has been given and they should be operational soon

A limited number of villagers in Potka have access to other nearby public health institutions i e Uranium Corporation of India Ltd (UCIL) Some of the residents of the area work in UCIL and receive obstetric and associated health care from its hospital

Overall the economic condition of the target population is poor Only a very small proportion of villagers have a regular source of income through permanent employment Even fewer have access for medical services, mostly those living near medical institutions

As per the Baseline Survey, only 21% of the population in Patamda and 41% of the population of Potka have gone for three ANC visits, which means 79% of Patamda's population and 59% of the population in Potka does not have routine access or does not participate in obstetric care

The main constraints to adequate maternal and newborn care are the population's poor financial condition, difficult accessibility to health facilities, insufficient knowledge about the safe motherhood, over-dependence on TBAs and poor transportation

Knowledge and Practices

Major barriers to seeking prompt care during obstetric emergencies are lack of knowledge about danger signs, dependence on TBAs to handle emergencies, lack of trained personnel in the area, lack of money, lack of transport and lack of qualitative obstetric care centers

Ignorance of danger signs and symptoms during pregnancy and labor is high The in-laws or husband usually makes the decision to seek emergency medical care, in consultation with the attending TBA

Abdominal pain and bleeding per vaginum are two reasons for which families seek outside help Prolonged labor, swelling and edema, hyperpyrexia and acute pain also lead families to seek medical help sometimes Initially, they seek advice from rural health practitioners Bleeding and fever are two main reasons why families to seek medical care in the post partum period The reasons for seeking care for a neonate (which may be septicemia, low birth related issues, hypothermia or asphyxia, jaundice, feeding related problems etc) and the barriers to it will be explored in the qualitative survey which would be undertaken in the project area

Approach

The MOH routinely implements these interventions NGOs will make all efforts to enhance the quality of the government service delivery mechanisms and will supplement the government's efforts by enhancing skills and capacity of government staff, such as ANMs and doctors, to provide quality service

To improve access to services NGO's will also open 25 fixed day clinics, which will open once or twice in a week and will be attended by NGO doctors and paramedical staff for a fixed duration Monthly Nutrition and Health Days (NHDs) will be organised in all the villages by NGO and Govt staff

The project will implement the following activities

<u>Pre-pregnancy</u>

Project intends to involve adolescent girls and perspective mothers apart from the pregnant and lactating mother as secondary target beneficiaries These group are usually more educated and

amenable to behaviour change than the primary target group of the project, hence project will form group of adolescent girls and perspective mother so that it can induce sustainable behaviour change in them and encourage them to act as change agents These groups will be trained into counselling techniques in addition to the technical content as detailed in the Capacity Building section

Another strategy adopted to address family size as well as early pregnancy will be "Plan Your First Baby Campaign" In this campaign focus would be towards the high risk population from the age group of 15-25 With this group special emphasis will be laid on this campaign which targets newly wed couples and provide access to suitable birth spacing information and supplies to them Adolescent girls will be used to access the women and the couple with these information and supplies

Antenatal Care

All women need at least three antenatal checkups during pregnancy, need to eat and rest more The outreach of the services would be ensured by organizing NHD's (Nutrition and Health Days) in every village (population about 700 – 1000) for provision of comprehensive Ante Natal Care along with other services

Available services in any village on a NHD will include registration of pregnancy, ANC checkups, IFA distribution, T T vaccination, supplementary nutrition distribution, Nutrition and health education modeled around Behaviour Change Communication strategies, counseling and distribution and distribution of commodities for birth spacing All pregnant women in a village will be registered during first trimester of the pregnancy First registration will be promoted as a social festive occasion when their husbands will be encouraged to accompany them to the NHD's During NHD's the mothers will be informed about the fixed day clinics (day, date, venue and site) and will be promoted to attend them for 3 ANC check ups

Project proposes 25 fixed day clinics providing ANC/PNC services, (each clinic will cater to about 8-10 villages covering a total population of about 7000-8000) which will be manned by teams comprising of a doctor and a paramedic These clinics will open either once a week or once a fortnight for either a half or a full day On that day following ANC services would be available to pregnant women

Doctor will be responsible for

1 Physical exam and ANC check up including BP measurement and treatment of complications
2 Paramedic (trained nurse) would be responsible for distributing IFA tablets and explaining how to consume it, administer T T vaccine, counsel her for diet and collect sample for pathological test
3 Community based worker would be responsible for early identification and motivating women for getting registered and availing these services, weight recording and also for ensuring compliance of pregnant women regarding counselled behaviour with CBOP support

Project also envisages capacity building for identification of danger signals during pregnancy at all levels Project will target its capacity building efforts regarding the identification of danger sign and action required towards pregnant women as well as family and community members who influences help seeking behaviours for obstretic problems

Capacity Building of CBOP members will be done so that they can help in identification, follow-up of compliance and capacity building of secondary target group (family members, husbands and influential community members)

Birth Planning enhances the wellbeing of women during pregnancies and the outcomes thereof This is possible when the barriers to the obstetric care during emergencies namely- delay in problem recognition, delay in seeking care, delay in reaching the first level referral facility, and delay in actually receiving care after arriving at the facility are addressed Every pregnant woman will be helped to develop a birth plan Birth planning will include the knowledge of the delivery date, self care during pregnancy, recognition of danger signs and complications during pregnancy, child birth and post-partum and mobilize materials for clean birth (disposable delivery kit) In addition, they will be encouraged to identify and use a skilled provider to attend to their delivery identify a health facility or a First Reference Unit (FRU), identify and arrange for transport and expenses to reach the FRU in the event of complication, ensuring availability of an escort to accompany the woman to the FRU The post partum components of the plan include understanding the importance of immediate and successful breast-feeding, danger signs for a newborn and the available post partum spacing methods

Delivery care

A large proportion of births (87% source NFHS for Bihar) are domiciliary deliveries being assisted by untrained personnel (i e TBA's and /or family members) with no previous planning for birth and are unable to recognise danger signs and complications and where to refer the cases for appropriate emergency obstetric care

Wide prevalance of domiciliary deliveries underlines the need to build the capacity of TBA's and family members for birth planning, use of disposable delivery kit, identifying danger/warning signs, appropriate action to be taken in case of emergency, basic neonatal resuscitation and post partum care Separate training with focus on hands on experience will be devised for it TBA is a prevalent profession in certain families and social groups, hence an attempt at pairing of a senior TBA with a junior within the same family or outside to facilitate peer learning will be done

Project will distribute/socially marketed Clean Birth Kits (CBKs) These kits would be given to pregnant women in last trimester of pregnancy so that they can be used by anyone (TBA or family member) who is conducting the deliveries Some contingency supplies will be made available to TBAs so that she can use them if CBK is not available with the pregnant mother In the beginning of the project these products might be provided free of cost but over a period of time to sustain this effort even after the project period CBOPs would be involved in social marketing of CBKs and would act as a depot holders for CBKs to make access to supplies easy for pregnant women This would not only increase the accessibility of CBKs once demand is generated but would become a regular source of funds for CBOPs which can be used for emergency transportation

Once a decision is made that a complication needs medical intervention, the factors that cause a delay in reaching the facility are lack of transport and easy accessibility to a facility with EOC capabilities (distance and unavailability of transportation), condition of the roads (travelling on bad roads itself can cause hemorrhage), lack of resources to pay for travel costs and treatment forcing women to go to a traditional practitioner closer by The strategy of birth planning and use for the community health funds will help overcome this barrier

One of the barriers to seeking emergency obstetric care is the delay in receiving care after arriving at an EOC facility This delay can be attributed to cumbersome administrative processes, lack of medicines, supplies, equipment, staff and effective management information systems To prevent these delays facilities in the area will be assessed for the services and the quality of services available through them The gaps identified thus would help form an action plan for addressing the issue of delay in receiving care The assessment would include a facility management survey, antenatal record or client review and interviews with health care providers (See Annexure K)

Postpartum/Neonatal care

Capacity building of TBAs, ANMs, family members and influential community members will go hand in hand for providing quality post-partum and neo-natal care Project will focus on expanding the access to the services through, enhancing the skills of service providers at different levels, out reach clinics and by establishing linkages with referral hospitals of both the partner organisations as well as government hospitals in time of emergencies

The protocol followed for this will include visit to post partum mother by Community based worker within 48 hours of delivery In this visit she will

- Screen for danger signs of puerperal and neonatal sepsis
- Provide maternal nutrition and breast feeding advice
- Weigh baby
- Provide birth spacing advice
- Refer if needed

The project will strengthen the capacity of the community to provide immediate neonatal care The CBWs, TBAs, CBOP members and the pregnant women will be trained and counseled on the essential components of neonatal care In collaboration with the Neonatology forum guidelines for community/village based neonatal care have been developed The TBAs would be taught to ensure warmth, by drying and wrapping the neonate in a clean wrap, clear the mouth of secretion, method of resuscitation, prevention of infections and early initiation of breast-feeding The CBOPs and mothers will be made aware of the signs of concern in a neonate viz cold baby, baby unable to suckle, low birth weight baby and signs of septicemia The community level worker's capacity will be built deal with these situation at the village level, identify the need for referral and refer to an appropriate facility The mother along with the child would be encouraged by CBWs to attend the fixed day clinic within 15 days of post partum period and followed by at least one more post natal visit within next 30 days of the first visit

The interventions are in line with government policies, CBOPs will support and assist clinic and CBW's activities The program will develop referral linkages with established hospitals such as UCIL, TCIL, PKS, MGM and Telco Maternity for emergency obstetric cases

Access to Emergency Service

The project will use MOH facilities for improving the access to emergency obstetric care (EOC) However at the same time possibilities of utilizing services of TSRDS/PKS and their parent hospitals, other hospitals and existing health units in case of emergency would also be explored to increase the access and improve quality of care and shortening of time required for rendering services Key role players would be identified (i e family members and influential community members, village level service providers including TBAs, Anganwadi workers, project community based workers) and trained in identifying need for emergency obstretic care and to provide assistance for transportation, escort, money and identifying place and doctor for services At the same time efforts would be made for making the referral links optimally functional to ensure quality services for the referred cases This will help in improving quality of EOC The percentage of beneficiaries who will benefit from EOC is uncertain but using nationwide projections we can expect up to 10% of mothers to utilize it The project will also train and motivate community members to practice positive health seeking behaviors and to generate surplus funds to be used to finance emergency obstetric care, work with government intermediaries to improve the quality of care

Postpartum Care Services

The project intends to provide postpartum care by community level activities and counseling during health days for postpartum women and making CBWs responsible for rendering these services PNC services will be provided in the fixed day clinics run by NGO's also

The CBWs will visit the mother within 48 hours after the birth to provide education on

- Danger signs of puerperal sepsis, neonatal sepsis
- Keeping baby warm
- Maternal nutrition and breast feeding
- Baby weighing
- Family Planning advice
- Referral, if needed

In case the community-based worker finds it necessary he will inform the paramedic for making a visit Generally in case of referral need patient will be accompanied to the doctor On a random basis doctors will make visits to the household for providing support to the paramedics and providing them on the spot training about what constitutes an effective post partum visit

Community Based Workers (CBWs) and CBOP members would be primarily responsible to ensure a routine post-partum visit of mother's to clinic within 15 days of delivery The PNC check up will be done along with ANC in the same fixed day clinics

These PNC visits will be used to provide counseling on birth spacing, various contraceptive methods, usage, benefits and contraindications and how to access them, maternal and new born check up, immunizations, and counseling about maternal nutrition, breast feeding and neonatal care Primary source of contraceptive commodity available through these PNC clinics would be from government however, project would also encourage social marketing adopting cafeteria approach Community based workers would be responsible for the distribution of condoms and oral pills to the interested clients, whereas for clinical methods i e IUD insertion, doctor or paramedics services would be solicited IUD insertions will be carried on initially in the main hospitals but the possibility of the insertion in the fixed day clinic will be pursued If demanded, sterilization services would be provided at base clinics / hospitals of both the organization

IEC/BCC (Information education and communication)/ BCC (Behaviour Change Communication)

Behavioral change communication strategies will be focussed on project participants to promote positive health seeking behaviour using health belief model The approach adapted for BCC will be the same as described earlier, but it will focus on pregnant women and lactating women Mothers of children under the age of two, adolescent girls and perspective mothers will be the secondary target audience The key behaviour focussed will be the danger signs and action required in case of emergency / high risk cases, birth planning and safe delivery to bring women closer to care, nutritional counselling, right age of child bearing, care during pregnancy/ neonatal care and post-natal care

MATERNAL AND NEWBORN CARE						
Sl No	**Target Group**	**Objective**	**Activity**	**Frequency**	**Intervenors**	**Evaluation**
1	Pregnant/Lactating women	Practice healthy behaviour* on sustainable basis Access quality services as and when required	Individual and peer counseling Nutrition and Health Day Awareness Campaigns	Ongoing Monthly Monthly	Community-based workers CBOP members Local cultural groups	Individual/Group meetings Monthly monitoring formats of mothers counselled by CBOP members
2	Adolescent girls and prospective mothers	Provide access to information to enhance their knowledge	Interpersonal counseling Peer counseling Group meetings Demonstration Awareness Campaigns	On regular basis Fortnightly or monthly monthly	CBOPs Service providers	Individual/Group Meetings
3	Family members, opinion leaders, influential people	Provide PLU2 supportive atmosphere vis-a-vis seeking ANC/PNC and emergency services and practice healthy behaviour	Village level meetings Group meetings Awareness campaigns Audio/visual	Monthly Monthly Quarterly Semi-annually	CBWs, CBOPs CBOPs ANMs, AWWs	Individual/group meetings Quarterly reports
4	TBAs	To promote and support healthy behavioural practices Provide access to information to enhance their knowledge Imporve skills in order to enhance quality of care	Orientation and refresher trainings Review meetings maintenance of records	Semi-annually Monthly/quarterly Ongoing	Child Survival project staff CBWs other village level	Observation by staff, ANM Quarterly reports NHD records
5	CBOP members	Mobilize community To promote and support healthy Behavioural practices Create enabling environment for service providers	Group counseling Maintenance of records	Ongoing Ongoing	CBWs/other village level service providers	Observation by staff, ANM Observation by staff ANM CBOP's records
6	Service Providers, TBA's CBWs, ANMs, AWWs, etc	Improve skills of order to enhance quality of care Knowledge and skills enhancement Strengthen support system and access to supplies for providing quality services	Distance education Orientation and refresher Review meetings	Semi-annually Monthly/quarterly	Child survival project staff Child survival project staff	Direct observation by staff NHD records
7	Core Team (CARE, TSRDS, PKS)	Develop skills to enhance supportive supervision and quality service delivery	Capacity building workshop Refresher training course	One time activity Annually	External consultant CIHQ technical staff	Training Evaluation Mid-term review

*Healthy behaviors include Receive 3 ANCs, consume 100 IFA tablets receive two TT immunizations consume supplementary nutrition, seek care for maternal and neonatal complications at health facility, have a birth plan, deliver using a Disposable Delivery Kit / Five cleans, deliver with the help of a trained birth attendant

Capacity Building Plan for Maternal and Newborn Care

The capacity building plan for maternal and newborn care activities encompasses the entire spectrum of project participants - ranging from Traditional birth attendants (TBAs) to senior personnel within the Child Survival project (from CARE, TSRDS, and PKS) While course content will include information relating to care required during pregnancy, importance of birth planning, preparation for birth and emergency obstretic care for all trainees (i e warning signs, information about next level of care/health facilities referral and follow up etc) The depth of the lessons will vary based on trainee backgrounds In addition to these distant education program for the project staff in collaboration with IGNOU is being explored Apart from skill building at least one opportunity for every project functionary to visit a successful RCH project in the NGO scenario is visualized

Additionally, for those with management responsibilities within the project, the capacity building plan will also address secondary information to ensure quality of care indicators

Joint discussions with government service providers and NGO partners, in addition to CARE's experience in maternal and child health projects, has yielded a tentative list of contents that the capacity building activities will seek to convey

Training content for Maternal and Newborn Care

Knowledge (K)

1 Care during pregnancy (diet,rest,periodic check ups, TT immunisation, IFA tablets)
2 Birth Planning and safe delivery practices (including disposable delivery kit and infection prevention)
3 High-risk cases, danger/warning signs, referral and follow up
4 Emergency Obstretic Care
5 Post partum maternal Care
6 Neonatal care practices (components of immediate neonatal care, danger signs in a neonate, importance of weighing neonates and time for referral)
7 Post delivery contraception
8 Age of marriage and child bearing
9 Expectations from TBAs and their role

Skills (S)

1 Behavioral counseling skills
2 Community birth planning
3 Community level action planning
4 Identification and registration of pregnant women through PRA/PLA technique
5 Identification and early registration of pregnancy
6 Prevention/identification/management of postpartum maternal sepsis
7 Prevention/identification/management of low birth weight, hypothermia
8 Prevention/identification/management of neonatal septicemia

Capacity Building Schedule for Maternal and Newborn Care

1)	CARE, TSRDS, PKS Gov of Bihar, med off, paramedics, CDPO	External consultants CIHQ technical staff	K 1-9, S 1-8	Semi-annual workshops Cross-visits
2)	ANMs, AWWs CBWs ICDS supervisor	Core group members	K 1-8, S 1-8	Workshop Refresher training seminars
3a)	Senior TBA's	Core group members	K 1-9, S 1-8	Workshop Refresher training seminars
3b)	New recruit TBAs	Core group members	K 1-9, S 1-8	Workshop Refresher training seminars
4)	CBOP members	CBWs	K 1-7, S 1-8	Joint home visits Work sharing on NHDs
5)	Family members, opinion leaders, influential people	CBOP members, ANM AWWS	K 1,3,4-8 S-1	Group meetings NHDs
6)	Adolescent girls and Perspective mothers	CBOP members, ANM AWWS	K 1,3,4-8 S-1	Group meetings/Home visits NHDs
7)	Pregnant/Lactating women	CBOP members, CBWs	K 1,3,4 - 8 S-1	Individual counselling Peer group counselling

Sustainability

All technical training workshops and visits will enhance the capacity of the service providers, and thus work inroads towards sustainability For financial sustainability, the project proposes to have a village level health fund, or "Gram Kosh " A users fee will be charged for services provided by the NGOs The money thus generated will be ploughed back into quality improvement and continuation of activities beyond project life

The organizational sustainability of the CBOPs will be ensured through regular meetings, group dynamics to provide inputs into their operation, taking up health-related responsibilities and other holistic developmental activities

Apart from above to sustain the effort even after the project period CBOPs would be involved in social marketing of CBKs and would act as a depot holders for CBKs to make access to supplies easy for pregnant women This would become a regular source of funds for CBOPs, which can be used for emergency transportation Project would also encourage social marketing of Family Planning commodities, IFA tablets adopting cafeteria approach

Project Documentation

The project aims to distribute antenatal cards to all pregnant women Part of the card will be given to the pregnant women and the remainder will be retained at clinic In addition, a register will be maintained by CBWs, which will record ANC, TT, IFA and the child immunization schedule of that village

Monitoring the Quality of Services

A double check system has been envisaged to monitor the quality of services using ANC cards A portion of card will remain with the clinics The records will also be cross-checked with the CBWs register CBWs will monitor IFA consumption at the village level

In the clinics hemoglobin levels of pregnant women will be measured thrice during pregnancy At the project level, a senior project functionary would cross check it quarterly through reports and random checks at the household level

CHILD SPACING

Current Status of Family Planning Usage

Knowledge of family planning methods is widespread among the target population However, the percentage of couples in Bihar who have ever used FP methods is only 22% (BFHS 1993) There are a host of issues associated with the acceptance and use of modern family planning practices Two important parameters influencing fertility behavior are the low rate of female literacy and early marriage Further, the high rate of infant mortality and the desire to have a male heir to the family who would carry the family's tradition into the future and inherit traditional family property inhibits acceptance of family planning programs

The current rate of family planning users as obtained from the Baseline Survey is 10% in PKS and 7% in TSDRS This relatively low percentage of contraceptive use could be explained by the mean age of children In both the blocks, the mean age of children whose mothers were surveyed was ten months The fact that lactating mothers are not menstruating may inhibit them from using contraceptives Sixty-five percent of mothers in both Potka and Patamda reported that they did not want another child within two years Among the contraceptive users, permanent sterilization (tubal ligation) is very popular, followed by the pill, condoms and IUDs Information on dropouts and unmet needs were not gathered through the baseline survey However, a qualitative study is being undertaken in order to get more insight into these issues (See Annexure G)

MoH Policies, Current Services, Knowledge and Practices

The MOH policy on family planning programs stipulated that 85% of eligible couples would be able to adopt any modern contraceptive by the year 2004 The current services from government institutions are available up to sub-center level ANMs and AWWs are the main propagators and service providers of the family planning program at the grass root level The ANM, who is responsible for the service component of the program, delivers contraceptives at villagers' doorsteps Anganwadi workers are allowed to supply non-clinical family planning services

In the project area, there are about 30 ANMs currently delivering the services for family planning in Patamda and 20 ANMs in Potka In addition, 137 Anganwadi workers in Patamda are involved in FP (Family Planning) services informally Condoms, oral pills and IUDs are the main temporary FP commodities supplied by the government

Women who wish to adopt any one of the family planning methods usually contact their Anganwadi worker, ANM or Primary Health Center For permanent methods and IUDs, the services are available at PHCs The main constraint associated with FP programs in the region is temporary unavailability of

FP commodities, especially condoms Side effects associated with consumption of Oral Pills or IUD insertion are also identified as constraints The problems of ANMs and AWWs in the field conditions related to place of stay, mobility and travelling expenses hamper the service delivery Also, their training is inadequate for the difficult tasks of motivation and systematic provision of the range of services that are within their ambit Further social and physical distance between the project participants and the providers of service constraints the reach and effectiveness of health services for this group

Therefore people usually prefer private assistance for better quality and service Residents of Potka access PKS and Uranium Corporation of India Limited (UCIL) hospital for family planning services whereas inhabitants of Patamda seek help from TSRDS, PKS or Center for Family Initiatives (CFI), Tata Steel

Approach

Client Identification

The "primary target population" for birth spacing comprises of newly wed couples, currently pregnant women, mothers of children within two years of age and couples who have already completed their desired family size "Plan your first baby" will be a key component of approach to address newly weds and perspective parents by quality supplies and services Family members, relatives and influential persons of the community, who are involved in decision making, form the "secondary target population" The identification of potential FP users will be done both at the clinic and village levels through CBOP's and CBWs The ANMs or Anganwadi workers will support the process of locating the target groups Appropriate training will be given to community based workers and CBOPs by MOH officials, TSRDS, PKS and other resources persons to identify potential clients

Technique

The identified couple will be counseled about adopting proper FP devices through informed choice In addition, counseling for potential side effects and contraindications will be done Easy accessibility of quality services will be ensured through formation of CBOP's organisation of Nutrition and Health days and improvement of the outreach of clinical/door to door services Further, local level institutions/individuals will be identified to motivate the people either individually or collectively for generation of demand for family planning services In order to give a wider choice new contraceptives shall be introduced and gradually promoted under the program after studying their acceptance This would include a broader range of safe and effective contraceptive methods as well as incorporation of services that address the special needs of adolescents and services that recognize the special needs of males In addition, the community will be involved in articulating user concerns and thus bringing a method into widespread use Suitable linkages will be developed at the delivery level with ICDS functionaries, ANMs to deliver health, nutrition and family planning services as a package

Commodity Management and Contingency Plan

For commodity management, the PKS envisages that oral pills will be supplied at the clinics initially and from the second cycle onwards CBOP will deliver commodities through monthly NHDs The condoms will be supplied by the CBOP, while the doctor will supply IUDs at the center The FP commodities will be procured from government supplies and a back up of 20% of the total demand will be procured from a matching grant

The TSRDS will ensure the timely and qualitative supply of commodities such as Oral Pills, condoms and copper T through existing government mechanisms All Anganwadi workers and ANMs will also be encouraged to carry Oral Pills and other birth spacing commodities during their home visit In case

of a shortfall of government supplies, TSRDS will supply the same through the proposed clinics and project functionaries All CBOP members and CBWs will also be provided with sufficient supplies so that the chain will be maintained

The CBOPs in Potka and Patamda will serve as community based depot holders generating demand and facilitating supply of quality family planning services by expanding the menu of temporary methods available to the recipients

IEC/BCC

IEC/BCC will focus on bridging the communication gap with the people and take the message of small family and maternal and child health to them in the language they understand The goal is to find a mix of channels that can reach large segments of the audience with adequate frequency The messages would be positive with thrust on quality of life issues and removal of ignorance, apathy and misgivings about family planning programs A community-specific strategies for behavior change will be developed since in a mixed community there are different behaviors relating to birth For example, tribal groups feel uncomfortable getting assistance for family planning from non-tribal health providers The key message for birth spacing will be *"Keep Births Spaced and Have a Healthy Mother and a healthy baby"* or *"A Minimum Gap of Three Years Between Two Babies"* and *"Plan your first baby"*

Different IEC/BCC strategies will be adopted for different levels At the household level, the CBOP and CBWs will convey the messages through personal interaction Posters, handbills and wall writing in local languages will be used for mass education Since the literacy level is low, greater emphasis would be on audiovisual methods, street plays and local cultural or religious festivals The CBOP and CBWs will be the key person for IEC/BCC under the guidance and supervision of core team members of the project The IEC/BCC material would be distributed and made available at Anganwadi centers, CBOP groups and at the clinics At the individual level, IEC/BCC activities would be ongoing, while village level activities will be organized it quarterly Periodic feedback will be gathered at the village level by CBOP/CBWs in order to test the efficacy of strategies The data will also be counter-checked through the demand of the target population Regular training of staff at different levels would be undertaken on latest BCC techniques, for improving their motivation and administrative/managerial abilities

BEHAVIOUR CHANGE COMMUNICATION (BCC/IEC/BCC)-CHILD SPACING						
Sl No	**Target Group**	**Objective**	**Activity**	**Frequency**	**Intervenors**	**Evaluation**
1	Pregnant/Lactating women Mothers of children <2	To disseminate birth spacing related information To generate awareness regarding risks of repeated pregnancy To remove myths and misconceptions To generate demand for quality services and create enabling environment for service providers	Individual and peer counseling Through satisfied acceptor CBOP meetings	Ongoing Fortnightly Monthly	Community-based workers CBOP members Adolescent girls Local cultural groups	Individual/Group meetings Monthly monitoring formats Home visit questionnaires of mothers counseled by CBOP members Exit Interviews
2	Adolescent girls and newly married women	To improve knowledge and access to make informed choice Practice healthy behaviour on sustainable basis	Interpersonal counseling Peer counseling Group meetings Demonstration Awareness Campaigns	On regular basis Fortnightly or monthly Monthly	Community-based workers CBOP members Peer group/informed village women Audio visual aids	Individual/Group Meetings Observation by staff, ANM
3	Husbands	To ensure male responsibility and a male involvement Solicit support for acceptance of child spacing methods To remove myths and misconceptions	Village level meetings NHD's Audio/visual Awareness campaigns	Monthly Monthly Quarterly Semi-annually	CBWs,/other village level service providers Local cultural groups	Individual/group meetings Observation by staff ANM HVQ's Exit Interviews
4	Family members, opinion leaders, influential people	Develop supportive environment for service provisions Promote male responsibility Demand generation for quality services	Village level meetings Group meetings Awareness campaigns Audio/visual	Monthly Monthly Quarterly Semi-annually	CBWs, CBOPs CBOPs ANMs, AWWs	Individual/group meetings Quarterly reports

5	CBOP members	Mobilize community for generating demand To promote and support healthy behavioural practices Remove myths and misconceptions Create enabling environment for service providers	Village level meetings Group counseling Maintenance of records NHD's Promoting contraceptive social marketing	Monthly Ongoing Ongoing Monthly Ongoing	CBWs/other village level service providers	Individual/group meetings Observation by staff, ANM CBOP's records
6	Service Providers, TBA's CBWs, ANMs, AWWs, etc	Improve skills and knowledge in order to improve quality of services Strengthen support system for uninterrupted supplies	Orientation and refresher trainings Infection prevention Workshops Review meetings	Semi-annually Quarterly	Child survival project staff Child survival project staff	Direct observation by staff CBOP records and other records Exit interviews NHD records
7	Core Team (CARE, TSRDS, PKS)	Develop skills to enhance supportive supervision To build capacity of service providers to support optimal child spacing practice in community	Capacity building workshop Refresher training course	One time activity Annually Semi-annually	External consultant CIHQ technical staff	Training Evaluation Mid-term review

CAPACITY BUILDING PLAN AND TRAINING

TSRDS, PKS and CARE staff working for CSP would give in-house training as well as training through government institutions The main emphasis would be on the importance of FP counseling and usage of child spacing commodities Besides CBOP members, AWW and other village level health workers will also be trained through village level workshops and training Integrated training modules for training and re-training of medical and paramedical personnel, ANMs, AWWs, and field level project staff involved in the delivery of family planning services will be developed As motivation is a key factor in improving the quality of delivery of services it will form a key element in the training modules Networking arrangements of training at different levels would be developed with a view to ensure uniformity in training modules, avoid duplication and bring about effective coordination Training manual and materials will be provided in first annual report

The capacity building will be conducted for the project staff as per the matrix suggested below Apart from skill building training at least one opportunity for every project functionary to visit a successful RCH project in the NGO scenario is visualized

Training content for Child Spacing

Knowledge (K)

1 Appropriate age for marriage and child bearing
2 Post delivery contraception and LAM
3 Various contraceptive methods, usage, benefits and contraindication
4 Health benefits of spacing/contraception
5 Cafeteria approach/informed choice
6 Importance of screening of perspective client
7 STD/RTIs treatment
8 Infection prevention measures
9 Importance of male participation
10 Myths and misconceptions associated with contraception
11 Contraceptive social marketing
12 Quality of care indicators
13 Participatory training techniques and quality of a good trainer

Skills (S)

1 Behavioral counseling skills
2 Interpersonal communication skills
3 Identification and syndromic approach for management of STDs
4 Training techniques (PRA/PLA)
5 IUCD insertion

Capacity Building Schedule for Child Spacing

1)	CARE, TSRDS, PKS, Gov of Bihar, med off, paramedics, CDPO	External consultants CIHQ technical staff	K 1-13, S 1-5*	Semi-annual workshops Cross-visits
2)	ANMs, AWWs, CBWs ICDS supervisor	Core group members	K 1-13, S 1-5*	Workshop Refresher training seminars
3)	TBAs	Core group members	K 1-13, S 1-4	Workshop Refresher training seminars
4)	CBOP members	CBWs	K 1-5, 8-12 S 1-3	Joint home visits Work sharing on NHDs
5)	Family members, opinion leaders, influential people	CBOP members, ANM AWWS	K 1,3-5,9,10 S-3	Group meetings NHDs
6)	Adolescent girls and Newly married women	NGO CBWs/AWW/ ANM's/CBOP members & informed family members	K 1-5,7-11	Individual counselling Peer group counselling
7)	Pregnant/Lactating women Mothers of children < 2	CBOP members, CBWs/AWWs/ANMs	K 1-5,7-11 S-3	Individual counselling Peer group counselling

* IUCD Insertion training would be for medical officers and paramedics

** IUCD Insertion would be AWWs

Quality Maintenance

NGOs will procure all commodities from government supply, which is already certified to be a quality product by the MOH but at community level it is sometimes not perceived as a quality product Community education in this regard will be taken up and other spacing commodities will be made available by social marketing to provide option to clients to chose For permanent methods, all cases would be brought to clinics sponsored and maintained by corporate groups, where all possible infection prevention measures are used CBOP and CBWs will simultaneously follow up on all operated cases for further medical assistance Post-operative complication redressal will be done at the village level In case of complications, attention will be given to material and services A strict quality control process will also be followed, especially for commodities procured from the market by tracking their expiry dates and ensuring proper storage facilities at the clinic and community levels

Both NGOs would strengthen their organizational capacities to plan and manage activities in terms of product procurement, distribution, logistics management and communications support A regular monitoring and evaluation system will be developed to assess changes in knowledge, attitudes, beliefs and practices of target audience Improved supervision at all levels will focus on problem identification, finding solutions thereon and improving understanding and capabilities of key functionaries involved in service delivery Emphasis on competency based training and encouragement of providers to conduct better counseling and follow-up by increasing frequency of home visits would ensure quality assurance of family planning services

Sustainability

Sustainability is one of the key factors in implementing child survival activities, especially for child spacing The CBOP will be a vital component once the project has withdrawn from the region During and after project implementation, the CBOP will keep in close contact with local ANMs to ensure regular flow of birth spacing materials for the target population In case of a shortage of government supply, the CBOP will use "Gram Kosh" (village fund) to procure or provide birth spacing commodities and other strategies suggested in general sustainability section will be applied

Maternal Nutrition

Maternal Nutritional Status

The Baseline Survey conducted by CARE for INHP, showed that women of reproductive age in the area were anemic and energy deficient The prevalence of anemia among pregnant women is 81% in rural Bihar The project will collect data on anemia within six months through ANC clinics Height and weight data for the women in the project site is not available Although ANC data has not yet been analyzed, but it appears that weight gain is around 4-5 kg during nine months of pregnancy

Since 63% of deliveries in Potka and 87% of deliveries in Patamda (BLS data) were handled by TBAs, it was very difficult to assess the extent and prevalence of low birth weight (<2 5 kg) at present

The IFA consumption rate (100 tabs or more) was only 9%, but the receipt of IFA varied from 30 - 70 tabs of 100 mg iron tablets during pregnancy Only 45 % of pregnant women consumed vitamin C-rich foods (KPC Survey)

The most likely causes of nutritional problems in program area are

- Poor purchasing power to buy staple foods
- Lack of knowledge about the consumption of various edible parts of locally available nutrient rich crops For example drumstick leaves consumption could be promoted besides the habitual consumption of drumsticks
- Poor food preparation and consumption practices
- Worm infestations
- Inadequate maternal diet during prolonged lactation
- Repeated pregnancies and lack of optimal birth spacing practices

Current Beliefs and Practices

To prevent morning sickness, pregnant women in this area generally consume less food during the first and third trimesters of pregnancy Awareness of optimal weight gain required during pregnancy is absent Food restrictions/ taboos are prevalent, for example women are not encouraged to consume drumsticks Post partum fasting is observed for the first three days and a general meal pattern of one meal per day is observed for the next 21 days High-energy foods are consumed only after six weeks of delivery (BLS)

A detailed qualitative data collection is being undertaken to assess community perceptions on mothers feeding practices before and after delivery as per the annexed scope of work (Annexure G)

MoH Policies and other Activities Section

As per MOH guidelines, Pregnant women working in the formal sector get three months maternity leave MOH recommendations includes an extra meal everyday of the normal family food, no food restrictions, rest for about 2 hours in the afternoon and at least 8 hours of sleep at night, and avoiding strenuous activity i e lifting heavy objects and drawing water from the well Focus on maternal nutrition has also been incorporated into the new Reproductive and Child Health Approach (RCH) which aims to reach up to 75% of pregnant and lactating women The ICDS provides 600 calories and 25 grams of protein to pregnant and lactating women Fortified food supplements such as Corn Soya blend and refined vegetable oil (RVO) is given in ICDS areas in collaboration with CARE Pregnant women should receive 100 IFA tablets from the second trimester and deworming in the third trimester for anemia prophylaxis Women with moderate to severe anemia are recommended to consume 200 tablets of IFA

Program Approach

The project will begin with a system of early registration whereby the CBWs will identify a pregnant woman, and register her for antenatal checkups The pregnant woman would be weighed at least three times, once in every trimester to ascertain weight gain during pregnancy and the information will be recorded on the ANC card for future analysis To promote three ANC visits and keep visual record, incentives in the form of orange, green and white bangles will be given signifying completion of protocol Hemoglobin estimation of pregnant women will be undertaken during three ANC visits

The project will introduce the weighing of babies in the home by CBW within 48 hrs of birth The ANC/MCH card will be analyzed to ascertain the weight gain during pregnancy (Proposed Card is Annexed)

Prevalence of night blindness and anemia is high in the project area The local term for night blindness is "Rataundhi and Ratkana " A sample survey will be conducted to assess clinically the vitamin A and iron status Elicitation of history of night blindness will be done by using its local terms Food frequency tables will be used to assess the intake of various important micronutrients

Pregnant women will receive folic acid (5mcg/d), calcium (500 mg/d) and B1, B6, B12 supplements at the time of their registration along with their first ANC checkup Elemental iron (100 mg/day) in the form of ferrous sulfate will be given from second trimester of pregnancy for 100 days for prophylaxis A requisite dose of Mebendazole or Albendazole tablets will be provided to all pregnant women in their third trimester for deworming Activities that would be undertaken will include

- Early registration of pregnancy
- Detailed analysis of seasonal availability of various food groups along with their consumption patterns by pregnant and lactating women will be conducted
- The laboratory analysis of locally available foods will be done to have nutritional information on them in case it is not available
- Nutritious locally available foods will be promoted for consumption by demonstrations of day's diet for pregnant and lactating women to create awareness of the types and amounts of food they need to consume through the CBOPs
- Promote consumption of additional food during pregnancy and lactation
- Promote the importance of adequate rest during pregnancy

- Promotion of Iron, Calcium and Vitamin A, C rich foods for cultivation and consumption by adolescent, pregnant, lactating women and discourage the exchange of highly nutritious low-cost food for high prestige foods
- Addressing of food taboos/ restrictions during pregnancy and lactation
- Monitoring weight gain during pregnancy
- IFA compliance tracking will be undertaken Women will be encouraged to consume IFA with meals which include enhancers for Iron absorption like citrus foods (individual compliance chart)
- Facilitate a community action plan for improving community norms for improving maternal nutrition not only during pregnancy but even before pregnancy
- Enrolling adolescent girls and newly married women, monitoring/improving their nutritional status by giving all the above mentioned nutrient supplements
- Study the barriers for receiving the supplementary food from Anganwadi Centres and facilitate their removal Promote generation of demand for the supplementary food provided by government through ICDS and PDS for those who are below the poverty line and reduce if not eliminate the sharing of the food supplement provided to pregnant women by family members
- Extensive capacity building sessions will be conducted for the communities on good cooking and food handling practices for preservation of nutrients This training program will help the CBW educate CBOPs about the importance of cooking and consumption behavior Every village will be given cooking demonstrations on the types of foods with their amounts which need to be consumed to meet nutritional requirements of pregnant/ lactating women along with good cooking practices at least twice a year CBOPs will be actively engaged in organizing these demonstration To encourage community participation, a cooking competition at a central location once a year may be arranged for preparing recipes suited for pregnant and lactating women using locally available food
- The information level of in-laws, husbands, and parents will be enhanced on maternal nutrition by organizing meetings at suitable time and place in the village where the participation of these groups could be maximum
- Birth attendants will also be given short-term training on pre and postpartum counseling on importance of maternal nutrition, early initiation of breast feeding etc
- A series of joint meetings will be held with district, block and government officials, CARE and NGO staff based at Jamshedpur to ensure regular supplies and supervision of personnel implementing the ICDS program
- Meetings will be held quarterly with the Block Development Officer, Block Coordinator and the Medical Officer in charge of PHC to improve registration of pregnant women so that they will receive the services for which they are eligible
- The high-risk groups suffering from chronic diseases such as tuberculosis, malaria and respiratory infection will be dealt with at the clinic level Mahila Gram Kosh will provide support in whatever it can to help pregnant women reach referral facility in case of any emergency

IFA is routinely supplied through the government, if supply fails efforts will be made to ensure regular intake of IFA by promoting alternative supplies i e social marketing, health funds etc Distribution will be done monthly on the NHDs by community health workers, local pharmacy etc The monitoring and evaluation of iron supply and its consumption will be done through CBW registers and hemoglobin levels will be estimated at the clinic level, and corrective action will be taken

Ongoing

Qualitative studies will be conducted through outreach clinics to estimate HB levels of the pregnant women and appropriate actions to improve their iron status

IEC/BCC /BCC

Behavioral change communication strategies will be focussed on project participants to promote positive health seeking behaviour using health belief model The approach adapted for BCC will be the same as described earlier, but it will, focus on pregnant women and lactating mothers

Detailed description of the IEC/BCC activities is given below

MATERNAL NUTRITION						
Sl No	**Target Group**	**Objective**	**Activity**	**Frequency**	**Intervenors**	**Evaluation**
1	Pregnant/Lactating women	To adopt healthy nutritional practices To improve access to information regarding nutritious foods (quality and quantity) and correct cooking practices to optimize the availability of nutrients To identify and address food taboos during pregnancy	Individual and peer counseling Mahila Mandal meetings Nutrition and Health Day Diet Demonstration Campaigns	Fortnightly/weekly Monthly Monthly As necessary Quarterly	CBWs, CBOP, ANMs AWWs	Observation of Individual/group meetings Monitoring visits Home visit questionnaires (HVQs) NHD records
2	Lactating women	To adopt healthy nutritional practices to improve access to information regarding nutritious food (quality and quantity) and correct cooking practices to optimize the availability of nutrients To identify and addrss food taboos and sub-optimal practices of fasting after delivery	Individual and peer counseling Mahila Mandal meetings Nutrition and Health Day Diet Demonstration Campaigns	Fortnightly/weekly Monthly Monthly As necessary Quarterly	CBWs, CBOP, ANMs AWWsand TBAs	Observation of Individual/group meetings Monitoring visits HVQs
3	Family members, opinion leaders, influential people including adolescent girls	To provide support for improving the nutritional status of pregnant and lactating women through providing and access information about nutritionally rich foods To support nutritional behaviour change (including cooking practices) by Pregnant/Lactating women	Individual and peer counseling Mahila mandal meetings Nutrition and Health Day Diet Demonstration Campaigns	Fortnightly/weekly Monthly Monthly As necessary Quarterly	CBWs, CBOP, ANMs AWWs and TBAs	Observation of Individual/group meetings Monitoring visits HVQs

4	CBOP Members	To enhance their knowledge and skills for improving the nutritional status of pregnant lactating women To mobilize the community towards adopting nutritionally rich eating habits To identify and address taboos regarding maternal nutrition	Workshops Campaigns	Quarterly Quarterly	CBWs, ANMs, AWWs TBAs	Observation by staff HVQs
5	CBWs	To enahnce their knowledge and skills for the promotion of optimal maternal nutritioin practices To remove barriers/food taboos amonst the community	Workshops Campaigns	Quarterly Quarterly	Core group	Feedback from CBOPs ANMs and AWWs HVQs
6	Service Providers, ANMs, AWWs, etc	To improve their knowledge and skills in order to promote and support optimal nutritional practices and address prevalent food taboos in the community	Workshops Cross visits Refreshers	Annually Annually Semi-annually	Core group	Direct observation by staff Exit interviews
7	TBAs	To improve their knowledge and skills in order to promote and support optimal nutritional practices and address prevalent food taboos in the community especially focussing on the practice of fasting by women after delivery	Workshops Cross visits Refreshers	Annually Annually Semi-annually	Core group	Direct observation by staff Exit interviews
8	Core Team (CARE TSRDS, PKS)	To develop capacity of service providers for improving the nutritional status of pregnant and lactating women To identify, treat and counsel pregnant and lactating women for nutritional problems	Workshops Refresher	Annually Semi-annually	External consultant CIHQ technical staff	Training Evaluation Mid-term review

CAPACITY BUILDING PLAN

Capacity Building Plan for Maternal Nutrition

The capacity building plan for maternal nutrition encompasses the entire spectrum of project participants - ranging from to senior personnel within the Child Survival project (from CARE, TSRDS, and PKS) Course content will include basic information on the importance of optimal nutritional status on the outcome of pregnancy and maternal health for all trainees (i e what is optimal nutritional status, how it can be achieved through locally available foods, misconceptions/ taboos regarding intake of various types of food during pregnancy, importance of optimal weight gain during pregnancy etc) The depth of the lessons will be based on trainee backgrounds Additionally, for those with management responsibilities within the project, the capacity building plan will also include mapping of the various types of food available in different seasons, getting the foods analyzed for nutritional composition and giving specific guidelines for promotion of nutrient rich foods etc Regular supply of supplementary food will be assured and efforts or strategies to reduce sharing of the food by family members will be addressed

Joint discussions with government service providers and NGO partners, in addition to CARE's experience in the field, has yielded a tentative list of contents that the capacity building activities will seek to convey A detailed needs analysis of project functionaries is being undertaken to finalize the contents proposed (see Annexure H for Needs Assessment format)

Training content for Maternal Nutrition

Knowledge (K)

1 What is good nutritional status
2 Importance of good nutritional status
3 Consequences of malnutrition during conception, pregnancy and lactation
4 Method to enhance nutritional status
5 Indicators to measure nutritional status
6 Importance of optimal weight gain and adequate rest during pregnancy
7 Importance of consuming full ration of supplementary nutrition during pregnancy and lactation
8 Importance of consuming IFA during pregnancy
9 Methods to increase iron intake
10 Ensuring IFA consumption
11 Side effect of IFA
12 Stages, consequences and methods to combat anemia
13 Seasonal calendar of locally available foods
14 Nutritional status of locally available foods
15 Importance of a balanced diet
16 Planning of low cost nutritious diet
17 Providing information on nutrition composition analysis of locally available foods
18 Healthy cooking practices for retaining the nutrients

Skills (S)

1 Mapping of seasonal availability of local foods

2 Planning and demonstration of balanced diet (Normal and for pregnancy/lactation)
3 Behavioral counseling skills
4 Measuring nutritional status (weight, elicitation of history of night blindness, pallor for anemia etc)
4 Preparing seasonal calendars as ready reckoners for planning of balanced diets in all seasons

Capacity Building Schedule for Maternal Nutrition

Trainees	Trainers	Content	Methods
CARE, TSRDS, PKS, Govt of Bihar, med Off , paramedics, CDPO	External consultants CIHQ technical staff	K 1-18, S 1-5	Semi-annual workshops Cross-visits
ANMs, AWWs, ICDS supervisor CBW	Core group members	K 1-18, S1-4	Workshop Refresher training seminars
CBOP members	CBWs	K 1-18, S 1-4	Joint home visits Work sharing on NHDs
Family members, opinion leaders, influential people	CBOP members, AN AWWs	K 1-18, S 1-4	Group meetings NHDs
Pregnant women	CBOP members, CBWs	K 1-18, S 1-4	Individual counseling Peer group counseling
Lactating Women	CBOP members, CBWs	K 1-18, S 1-4	Individual counseling Peer group counseling

INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS (IMCI)

MoH Strategies, activities and training materials

Ministry of Health of the GOI under its Child Survival and Safe Motherhood Programme (CSSM) which has now been replaced by the Reproductive and Child Health Programme (RCH) addresses various issues affecting the child survival, specifically dealing with illnesses The interventions viz ARI control, Diarrhea prevention and management and immunization are primarily vertical national and do not lead to an integrated management of the sick child Separate vertical programs address malaria and malnutrition The strengthening of the health system and the family/community practices are not focussed well in the existing programs

IMCI is implemented in any country in a phased manner, beginning with the introduction, to initiation of activities in selected districts, and finally, expansion of activities and geographic coverage India is in the first phase of implementation, the process of

introducing IMCI to the stakeholders viz senior MOH officials, leading National Health Training Institutions, academicians and pediatricians has been initiated The response of this group has been enthusiastic and concerns for adapting the package to suit the local needs have been voiced

A large number of sick children in India are brought to the Basic Health Workers (BHWs) who often are the first contact for the sick child in the community and provide services through health posts and/or on a domiciliary basis There are a large number of different categories of grassroots level workers who can be classified as Basic Health Workers They consist of Auxiliary Nurse Midwives, Health Assistants, Aanganwadi Worker and the Multi-Purpose Worker (male and female) form the government cadre The NGOs also have their own cadre of basic health workers, i e Community Based Worker in this project They play a vital role in child health by basic curative treatment for diseases like acute diarrhea, ARI including pneumonia and fever, BHWs have different degree of responsibilities for preventive care like providing iron tablets, vitamin A prophylaxis, immunizations, and treatment of worm infestations which makes their role vital in overcoming childhood morbidity and mortality

The BHWs are presently trained through different curricula developed by leading training institutes of the Government, based on their job requirements The training curriculum of the health is focussed on treatment related issues, while that of the Aanganwadi worker is focussed on nutritional issue These pre-service and inservice training programs stress on information as opposed to development and improvement of counselling skills and especially lacks hands-on component of training The approach to training has been disease specific, which has resulted in the inability of the worker to deal with a sick child in a comprehensive manner

CARE India in joint collaboration with WHO/ SEARO and MOH/GOI worked to adapt, develop and field-test an IMCI package and training course for BHWs and their supervisors The IMCI strategy has three components viz strengthening capacity through the training, strengthening systems and structure and community level interventions The BHW course is a 5 days capsule fully compatible with the 11-days course for facility level functionaries The package has simple language and a large number of illustrations, is focussed on actual skill development by incorporating hands-on sessions in hospital and community A variety of interactive training methods for incremental learning have been incorporated to reinforce the skills and enhance the capacity of the workers to identify and solve a problem CARE's experience of field-testing provided grounds for optimism that the package could improve the ability of BHWs to manage or refer sick children and to counsel caretakers However, no formal evaluation of the efficacy or effectiveness of the package has been performed

Follow-up supervision is an integral part of the training effort and is done with the purpose of strengthening the skills learned during the course for managing the sick child at the community level The trainers of the course preferably the natural supervisors visit each trainee at their natural work place to correct any errors in assessment, classification,

treatment and advice within 4-6 weeks of completion of the training The supervisor makes a joint home visit with a trainee to a mother and provides feedback to the BHW in order to improve their interpersonal communication This opportunity is utilized to observe the facility, identify and correct any deficiencies in the supplies equipment, training material and record keeping The supervisor is expected to reinforce the training specifically in technical and communication skills

WHO/SEARO has initiated the process of orienting the MOH and training institutes to the BHW package, which will initiate the incorporation of the package into the pre-service and in-service training of the health workers Although the MOH has no existing implementation plan, the MOH is keenly observing the IMCI initiative in the Child Survival Project for lessons, learnings and to provide guiding principles for the development of an action plan

Role of IMCI in Child Survival Program

The project is being implemented through the formation and strengthening of community based structures i e CBOPs and Community Based Workers The capacity building of the Basic Health Worker, hailing from that community would continue the momentum of positive change during and after the project life Both TSRDS and PKS provide clinical outreach to the community This is done through 25 fixed day clinics, which is manned by a team of Doctor, paramedics and CBWs In addition, CBWs reach out to the village and provide outreach services to the community The clinics and the outreach is supported and complemented by two tertiary level hospitals, which provide referral and specialized services to the population The community receives health services through the governmental health care delivery system through PHCs, CHCs and the tertiary care hospitals and outreach through ANMs While the CS project works on looking at strengthening and supporting the governmental delivery system, it also views the corporate partnership as an opportunity to succeed at IMCI interventions The service delivery by PKS and TSRDS are relatively devoid of infrastructural defects and ensures good quality of care

I IMCI Training

Series of 11-day (first referral level) and BHW training will be held for various stakeholders in the project These include the core NGO team, the Medical Officers, paramedical staff, ANMs, AWWs and the community based workers The Medical officers at the referral level would be trained in the 11-day IMCI package, to complement the activities of the community and the BHW at the grass root level The role of the referral unit in addition to providing referral services to the community would be to act as a supervisory structure and provide follow up for the BHW in the community

A team of master trainers will be formed who will be responsible for training the BHWs and their supervisors in the BHW package The trainees will include the ANM, AWW, LHVs, ICDS supervisor, CBWs and paramedics

The CBWs and the AWWs who have a village presence, will actively seek children of the community in need of attention, classify and manage them through the IMCI protocol The algorithm will be applied to any and every child the CBW /AWW The algorithm will encourage the timely referral of needy cases by the BHW Children will be assessed for illnesses and nutritional problems, classified and treated as per the protocol They will assess the immunization status as well and children requiring vaccination would be encouraged to attend the NHDs where the ANM would vaccinate the children

Nutrition and Health days will be looked as an opportunity to provide children with integrated management All children attending NHDs will be assessed in an integrated manner using the IMCI protocol Children found to have any of the IMCI illnesses would be classified by and treated with the first line drugs available with the CBW or ANM, children requiring nutritional management will be classified, treated and counseled accordingly and children requiring immunization would be vaccinated by the ANM

Sick children requiring referral would be referred to the nearest fixed day clinics/ PHC, where a team of Medical Officer and paramedics would provide referral care For specialized care the children will be referred to the appropriate tertiary facility These are the Tertiary hospitals run by the two NGOs, UCIL, and another corporate run hospital in the vicinity and the government medical college hospital

II Supplies and services

The issue of supplies and logistics of implementing the IMCI interventions will be ensured by the NGOs The issues of supplies of vaccines, IFA, ORS and drugs prescribed under IMCI will be a responsibility shared by the NGO partners Issues of gap in services and supplies will be addresses in the Coordination committees at the district and block level, through joint action planning Any existing gaps will be identified and filled as required The health care delivery system of PKS and TSRDS has a provision for 20% as contingency funds, which could be utilized for filling gaps This complementarity of supplies will support the IMCI interventions to be effectively implemented The referral hospitals of both NGOs will provide quality referral care

III Community level interventions

Capacity building of BHWs in IMCI will equip them to improve family/community practices The skills learned during the course will prepare the BHW to carry out the instructions and provide advice for actions by mother They will make use of the mother's card to give the mothers practical feeding advice and develop action plan to deal with feeding problems This component of family/community action will be an important additional step not only towards increasing access to treatment, and counseling but also decentralizing health care responsibilities The quality of care provided by the BHW and the outcome of this intervention will be monitored throughout the life of the project

Specific components of the child survival program's IMCI strategy

Specific interventions under the IMCI strategy has been covered under the relevant section of the DIP

Evaluation of the BHW package An Operational Research

The efficacy and effectiveness of BHW package will be evaluated by the project as an separate operational research component The evaluation will help negotiate and accelerate the incorporation of IMCI into the national curriculum CARE collaborated with WHO and has grants to the tune of $ 48000 US Dollars in cash and additional technical assistance

The evaluation aims to assess the extent to which implementation of the BHW IMCI package can improve the health care received by children at the peripheral level The specific objectives are

- To revise and improve the existing simplified IMCI guidelines and the associated BHW training course materials
- To determine the validity of the assessment, classification and treatment guidelines upon which the BHW IMCI package is based
- To evaluate the ability of BHWs to assess, classify, and provide appropriate health care to children 6 months after undergoing the BHW IMCI package
- To quantify the extent to which the BHW IMCI package results in increased identification by BHWs of illness and opportunities to offer preventive and curative care

Evaluation findings may provide an assessment of the merits and demerits of the package and can consequently help Ministry of Health to decide about its implementation and nation wide scale up The draft proposal document and the outline of the methodology is attached in Annexure F

The results of the evaluation would be widely published and disseminated to key players in the GOI Sharing this along with successful implementation would provide an opportunity for advocating the strategy at a larger, national and international platform to pave path for wider replication

Capacity Building Plan IMCI

The capacity building plan for IMCI encompasses the various levels of health care providers- from tertiary level health staff to the basic health workers In addition, it involves the orientation of core group and counterparts While a representative staff from the referral-level facilities will be trained in the 11-day generic protocol of IMCI all the Basic Health Workers, inclusive of ANMs, LHVs, MPWs, CBWs, Paramedical staff and AWWs will be trained in the 5-day BHW package developed by CARE India in collaboration with WHO

Training in IMCI will be inclusive of imparting information and knowledge regarding illnesses and conditions responsible for morbidity and mortality in children and clinical and counseling skills to identify and address these illnesses and conditions and the community level actions that can be undertaken

Training content for IMCI

Knowledge (K)

1 Orientation to IMCI
2 Importance of IMCI strategy
3 Illnesses and conditions covered under IMCI
4 The IMCI protocol
5 Treatment schedules
6 Nutritional requirements
5 Immunization schedules

Skills (S)

1 Ability to use the protocol to identify, classify and choose the treatment
2 Clinical skills **a)** taking temperature, **b)** counting respiratory rate, **c)** determining chest indrawing, **d)** assessing dehydration, **e)** weighing the child, **f)** assessing palmar pallor, **g)** identifying signs of severe malnutrition, **h)** identifying measles and complication of measles, **i)** identifying ear discharge and mastoiditis, **j)** assessment of an early infant
3 Counseling skills **a)** nutritional counseling **b)** negotiating skills in advising nutritional modifications **C)** counseling the mothers in the use of drugs **d)** advising the mothers when to return, **e)** pre referral advice
4 Skills to improve community involvement in IMCI initiative

Capacity Building Schedule for Integrated Management of Childhood Illnesses

	Trainees	Trainers	Content	Methods
1)	CARE management,, NGO core Gr Members Key GOB officials at district level	External consultants CIHQ technical staff	K 1-4	Orientation to IMCI through and initial workshop
2)	Referral hospital & clinic select staff (both NGO & government hospitals)	Master Trainers from WHO and identified Paediatricians	K1-7, S 1-4	11-day generic IMCI workshop
3)	select medical officers and NGO medical officers	Master Trainers from	K 1-7,S 1,2a-g S3-4	BHW package training of trainers
4)	Basic Health Workers ANM, LHV, MPW, CBWs, Paramedical staff	Trainees of 3)	K 1-7,S 1,2a-g S3-4	Series of BHW training in batches of 20-25
5)	CBOP members	ANMs, AWWs, CSPWs	K1-3 6-7, S 3-4	Group meetings NHDs
6)	Community members	CBOP members, ANMs, AWWS	K 1-3, 6-7 S-4	Group meetings/Home visits NHDs Individual counselling Peer group counselling

N TECHNICAL ASSISTANCE

Technical Support for the Child Survival Project will come from several sources The CARE mission will provide technical support vis-a-vis Geographical Information Systems (GIS) and work on this matter has already begun at the CARE-India headquarters in Delhi Additional support on the issue will be sought from MACRO Other areas where CARE will provide technical support to the project implementers includes, baseline survey including analysis plan (CARE Atlanta), creation of M&E tools, technical capacity building workshops on intervention topics and training materials

CARE-USA hosts an annual Child Survival Workshop which serves to introduce new concepts to CARE Child Survival Projects in addition to allowing CS projects from around the world to share best practices with one another This year, 4 CARE professionals participated in a one week workshop held in Dhaka, Bangladesh entitled "From Community Participation to Community Empowerment "

In addition to the CARE support, there have already been several other areas in which technical assistance has already been provided For developing capacity of project personnel for ongoing qualitative data collection and analysis and conducting a baseline qualitative study, Dr Ravi Verma from the Indian Institute of Population Studies (IIPS) in Bombay along with Burt Pelto will begin the qualitative study from October 99 MACROs assistance (specifically the inputs and advice of Stanley Yoder) had been sought to assess the qualitative instruments and review the study plan In addition to the above mentioned inputs the project will seek MACRO technical inputs as necessary

A WHO consultant Simon Cousines, technical assistance was sought to design the IMCI related operational research componant of the project Consultant visited the project area designed the study and provided operationalization advice for the IMCI initiative

Dr Abhay Bang hosted a visit from the Child Survival Team (3 CARE personnel, and one representative each from both NGOs) in Gadchiroli Maharashtra The team saw his approach of community based neonatal care using community based health workers which had produced commendable results for reduction of neonatal mortality by about 60% in operation In addition to sharing some field-level tools used in collecting child health indicators (i e verbal autopsies formats), he has agreed to be a resource person for Child Survival initiatives aimed at improving community based neonatal care component of the project

Lovelock & Lewis, an India-based financial consultancy, has reviewed both TSRDS and PKS' financial management system It was found that the systems in place, including the software in use and the checks and balances, were fundamentally sound for project needs they had provided suggestions for some improvements

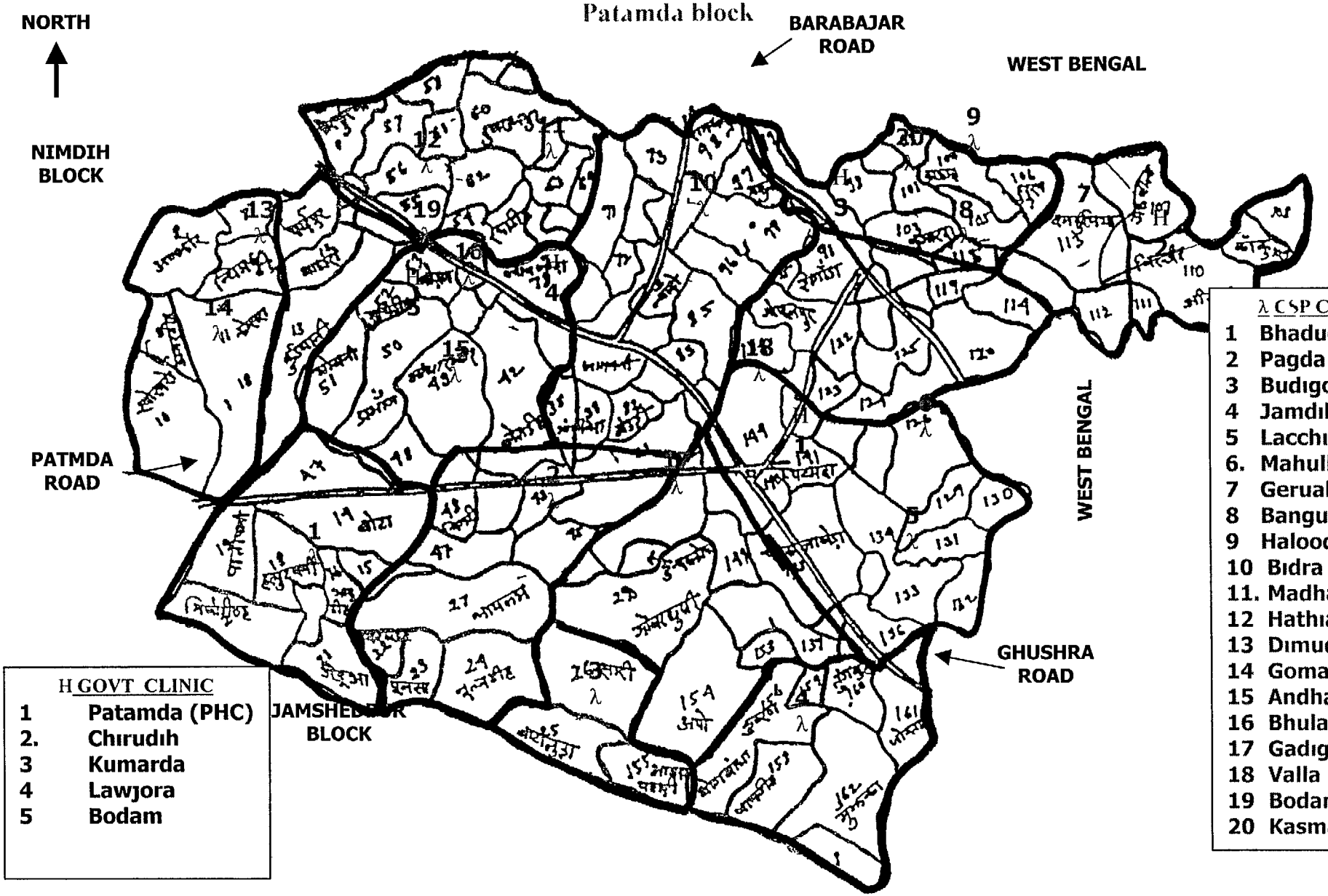
Penultimately, a group known as Participatory Rural Assessment, Xavier Institute of

Science (PRAXIS) has been contacted to coordinate and conduct PRA training workshops for field-level officers PRAXIS is based in Ranchi Bihar and thus have intimate understanding of the project area and needs of field level functionaries in the project area CARE has a good working relationship with PRAXIS and hopes to continue its relationship with PRAXIS vis-a-vis the Child Survival Project

Finally, CARE-India is a member of an interagency network agency working in nutrition and health in India, which includes UNICEF, the World Bank, UNDP, WFP, CRS, and others This interagency working group provides a forum for review and exchange of strategies, technical information, and resources These meetings represent a concerted effort by the members to complement existing inputs and to ensure consistency of information

Annex A - Location of TSRDS's Child Survival Project Clinics

Patamda block



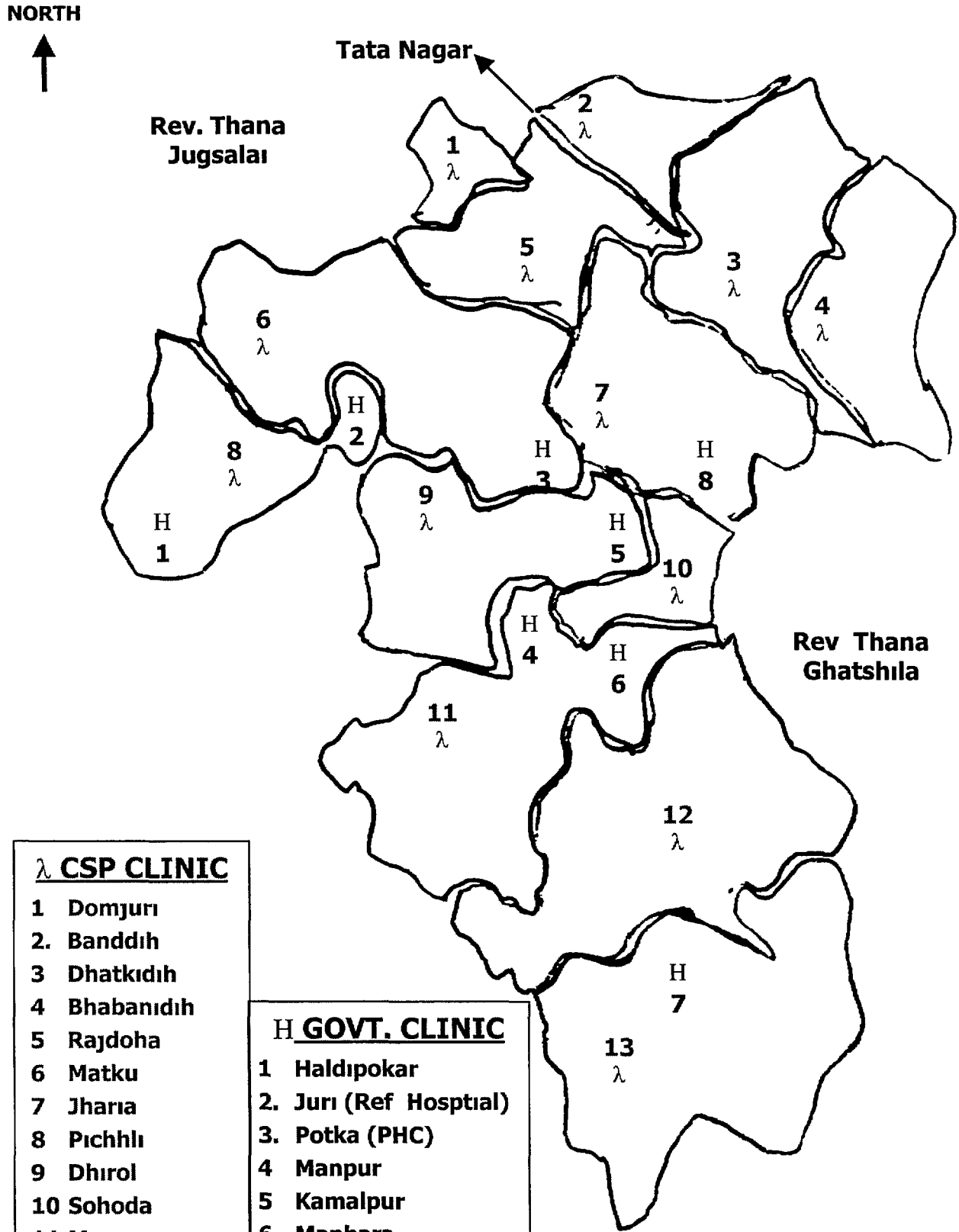
H GOVT CLINIC

1 Patamda (PHC)
2. Chirudih
3 Kumarda
4 Lawjora
5 Bodam

λ CSP CLINIC

1 Bhadudih
2 Pagda
3 Budigora
4 Jamdih
5 Lacchipur
6. Mahulbana
7 Geruala
8 Bangurda
9 Haloodbani
10 Bidra
11. Madhabpur
12 Hathiadih
13 Dimudih
14 Gomandih
15 Andharjor
16 Bhula
17 Gadigram
18 Valla
19 Bodam
20 Kasmar

Annex A (con'd) Location of PKS's Child Survival Project Clinics
Potka block*



λ CSP CLINIC

1 Domjuri
2. Banddih
3 Dhatkidih
4 Bhabanidih
5 Rajdoha
6 Matku
7 Jharia
8 Pichhli
9 Dhirol
10 Sohoda
11. Manpur
12 Goelketa
13 Jamdih

H GOVT. CLINIC

1 Haldipokar
2. Juri (Ref Hosptial)
3. Potka (PHC)
4 Manpur
5 Kamalpur
6 Manhara
7 Jamdih
8 Kalikapur

* Part of POTKA block showing CSP area only

Annex B – KPC Results

Demographics

Frequencies for standard KPC questions

DEMOGRAPHICS	PKS Survey Results		TSRDS Survey Results		All Survey Results	
Mother's Age	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
15 to 19	37	12 2%	36	12 2%	73	12 2%
20 to 24	131	43 2%	115	38 9%	246	41 1%
25 to 29	101	33 3%	99	33 4%	200	33 4%
30 to 34	22	7 3%	31	10 5%	53	8 8%
35 to 39	11	3 6%	14	4 7%	25	4 2%
40 to 44	1	0 3%	1	0 3%	2	0 3%
	303	99 9%	296	100 0%	599	100 0%
Mean	23 5		24 25		24 1	

Note Selected for Women >12 yrs

Child's Age (months)	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
0 to 5	82	26 8%	88	29 1%	166	27 5%
6 to 11	97	31 7%	93	30 8%	190	31 5%
12 to 17	80	26 1%	77	25 5%	157	26 0%
18 to 23	47	15 4%	44	14 6%	91	15 1%
	306	100 0%	302	100 0%	604	100 0%

Literacy/ Education	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
Illiterate	201	65 0%	217	71 9%	418	69 0%
Primary School	48	15 5%	45	14 9%	93	15 3%
Middle	34	11 0%	29	9 6%	63	10 4%
Secondary	20	6 5%	11	3 6%	31	5 1%
Unknown	6	2 0%	0	0 0%	1	0 2%
	309	100 0%	302	100 0%	606	100 0%

Income Generation	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
Nothing	186	60 2%	67	22 2%	253	41 7%
Handicrafts	7	2 3%	8	2 6%	19	3 1%
Agricultural Work	27	8 7%	136	45 0%	163	26 9%
Sale of Produce	34	11 0%	75	24 8%	109	18 0%
Sale of Foods	3	1 0%	1	0 3%	4	0 7%
Domestic Service	7	2 3%	0	0 0%	6	1 0%
Vendor	1	0 3%	1	0 3%	2	0 3%
Salaried	9	2 9%	24	7 9%	33	5 4%
Other	56	18 1%	36	11 9%	87	14 4%

Alternative Care Giver	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
None (with Mother)	149	48 2%	115	38 1%	264	43 6%
Father/Husband	40	12 9%	31	10 3%	71	11 7%
Siblings	0	0 0%	56	18 5%	98	16 2%
Relatives	93	30 1%	110	36 4%	202	33 3%
Neighbors/Friends	4	1 3%	3	1 0%	7	1 2%
Maid	0	0 0%	1	0 3%	1	0 2%
Nursery School	1	0 3%	0	0 0%	1	0 2%
Other	11	3 6%	4	1 3%	12	2 0%
Unknown	11	3 6%	0	0 0%	11	1 8%

DEMOGRAPHICS	PKS Survey Results		TSRDS Survey Results		All Survey Results	
Water Source	Frequency	Percent	Frequency	Percent	Frequency	Percent
Piped Water	3	1 0%	6	2 0%	9	1 5%
Tube Well or Hand Pump	105	34 0%	162	53 6%	267	44 1%
Draw Well	184	59 5%	126	41 7%	310	51 2%
Lake Water	10	3 2%	5	1 7%	15	2 5%
Pond Water	10	3 2%	10	3 3%	20	3 3%
River Water	3	1 0%	1	0 3%	4	0 7%
Spring Water	1	0 3%	0	0 0%	1	0 2%

Note Several people use mutiple sources of water

Sanitation	Frequency	Percent	Frequency	Percent	Frequency	Percent
Open air	295	95 5%	301	99 7%	596	98 3%
Latrine	8	2 6%	1	0 3%	9	1 5%
Unknown	6	1 9%	0	0 0%	1	0 2%
	309	100 0%	302	100 0%	606	100 0%

Demographics

Frequencies for standard KPC questions

DEMOGRAPHICS	PKS Survey Results		TSRDS Survey Results		All Survey Results	
Mother's Age	Frequency	Percent	Frequency	Percent	Frequency	Percent
15 to 19	37	12 2%	36	12 2%	73	12 2%
20 to 24	131	43 2%	115	38 9%	246	41 1%
25 to 29	101	33 3%	99	33 4%	200	33 4%
30 to 34	22	7 3%	31	10 5%	53	8 8%
35 to 39	11	3 6%	14	4 7%	25	4 2%
40 to 44	1	0 3%	1	0 3%	2	0 3%
	303	99 9%	296	100 0%	599	100 0%
Mean	23 5		24 25		24 1	

Note Selected for Women >12 yrs

Child's Age (months)	Frequency	Percent	Frequency	Percent	Frequency	Percent
0 to 5	82	26 8%	88	29 1%	166	27 5%
6 to 11	97	31 7%	93	30 8%	190	31 5%
12 to 17	80	26 1%	77	25 5%	157	26 0%
18 to 23	47	15 4%	44	14 6%	91	15 1%
	306	100 0%	302	100 0%	604	100 0%

Literacy/ Education	Frequency	Percent	Frequency	Percent	Frequency	Percent
Illiterate	201	65 0%	217	71 9%	418	69 0%
Primary School	48	15 5%	45	14 9%	93	15 3%
Middle	34	11 0%	29	9 6%	63	10 4%
Secondary	20	6 5%	11	3 6%	31	5 1%
Unknown	6	2 0%	0	0 0%	1	0 2%
	309	100 0%	302	100 0%	606	100 0%

Income Generation	Frequency	Percent	Frequency	Percent	Frequency	Percent
Nothing	186	60 2%	67	22 2%	253	41 7%
Handicrafts	7	2 3%	8	2 6%	19	3 1%
Agricultural Work	27	8 7%	136	45 0%	163	26 9%
Sale of Produce	34	11 0%	75	24 8%	109	18 0%
Sale of Foods	3	1 0%	1	0 3%	4	0 7%
Domestic Service	7	2 3%	0	0 0%	6	1 0%
Vendor	1	0 3%	1	0 3%	2	0 3%
Salaried	9	2 9%	24	7 9%	33	5 4%
Other	56	18 1%	36	11 9%	87	14 4%

Alternative Care Giver	Frequency	Percent	Frequency	Percent	Frequency	Percent
None (with Mother)	149	48 2%	115	38 1%	264	43 6%
Father/Husband	40	12 9%	31	10 3%	71	11 7%
Siblings	0	0 0%	56	18 5%	98	16 2%
Relatives	93	30 1%	110	36 4%	202	33 3%
Neighbors/Friends	4	1 3%	3	1 0%	7	1 2%
Maid	0	0 0%	1	0 3%	1	0 2%
Nursery School	1	0 3%	0	0 0%	1	0 2%
Other	11	3 6%	4	1 3%	12	2 0%
Unknown	11	3 6%	0	0 0%	11	1 8%

DEMOGRAPHICS	PKS Survey Results		TSRDS Survey Results		All Survey Results	
Water Source	Frequency	Percent	Frequency	Percent	Frequency	Percent
Piped Water	3	1 0%	6	2 0%	9	1 5%
Tube Well or Hand Pump	105	34 0%	162	53 6%	267	44 1%
Draw Well	184	59 5%	126	41 7%	310	51 2%
Lake Water	10	3 2%	5	1 7%	15	2 5%
Pond Water	10	3 2%	10	3 3%	20	3 3%
River Water	3	1 0%	1	0 3%	4	0 7%
Spring Water	1	0 3%	0	0 0%	1	0 2%

Note Several people use mutiple sources of water

Sanitation	Frequency	Percent	Frequency	Percent	Frequency	Percent
Open air	295	95 5%	301	99 7%	596	98 3%
Latrine	8	2 6%	1	0 3%	9	1 5%
Unknown	6	1 9%	0	0 0%	1	0 2%
	309	100 0%	302	100 0%	606	100 0%

Breastfeeding

Frequencies for standard KPC questions

BREASTFEEDING	PKS Survey Results		TSRDS Survey Results		All Survey Results	
Breatfeeding	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
Yes	295	95 5%	294	97 4%	589	97 2%
Child < 6 months	76	92 7%	108	99 1%	205	98 6%
Child > 6 months	217	96 9%	186	96 9%	384	96 5%
Breastfeeding Position	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
Change breast >5 times	73	23 6%	246	81 5%	118	19 5%
Hold close to breast	141	45 6%	45	14 9%	280	46 2%
Head up to breast	138	44 7%	139	46 0%	304	50 2%
Child in lap	62	20 1%	166	55 0%	147	24 3%
Full nipple in mouth	97	31 4%	67	22 2%	164	27 1%
Other	6	2 3%	5	1 7%	7	1 2%
Child to Breast	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
First hour after delivery	59	19 1%	52	17 2%	111	18 3%
1 to 8 hours after delivery	129	41 7%	154	51 0%	283	46 7%
More than 8 hours after	99	32 0%	87	28 8%	186	30 7%
Do not know	12	3 9%	8	2 6%	20	3 3%
Increase Breastmilk	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
					410	67 7%
Change Diet	63	20 4%	63	20 9%	126	20 8%
Breastfeed immediately	6	1 9%	3	1 0%	9	1 5%
Care for breasts/nipples	2	0 6%	2	0 7%	4	0 7%
Suckle often	2	0 6%	6	2 0%	8	1 3%
Exclusively breast feed for 4 months	8	2 6%	3	1 0%	11	1 8%
Avoid bottle feeding or other liquids	1	0 3%	4	1 3%	5	0 8%
Relactation	1	0 3%	2	0 7%	3	0 5%
Complementary Feeding	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
Begin before 4 months	7	2 3%	1	0 3%	8	1 3%
Between 4 to 6 months	118	38 2%	112	37 1%	230	38 3%
After 7 months	138	44 7%	164	54 3%	302	50 3%
Do not know	35	11 3%	25	8 3%	60	10 0%

Mean age (months)	6 7	
Before 4 months	5	2 6%
Between 4 to 6 months	88	45 8%
After 7 months	99	51 6%

Food & Nutrition

Frequencies for standard KPC questions

FOOD AND NUTRITION	PKS Survey Results		TSRDS Survey Results		All Survey Results	
Foods & Nutrition	Frequency	Percent	Frequency	Percent	Frequency	Percent
Water given	213	68 9%	205	67 9%	418	69 0%
Child < 6 months	18	22 0%	34	31 2%	66	31 7%
Milk given	98	31 7%	80	26 5%	178	29 4%
Child < 6 months	18	22 0%	22	20 2%	43	20 7%
Semi-solids given	185	59 9%	175	57 9%	360	59 4%
Child < 6 months	4	4 9%	17	15 6%	30	14 4%
Fruits given	143	46 3%	127	42 1%	270	44 6%
Child < 6 months	3	3 7%	8	7 3%	18	8 7%
Sugars (honey, jaggery, sugar)	189	61 2%	173	57 3%	362	59 7%
Child < 6 months	17	20 7%	26	23 9%	54	26 0%
Vit A rich foods given	154	49 5%	127	42 1%	280	46 2%
Iron rich foods given	159	51 5%	163	54 0%	322	53 1%
Protein rich meats given	134	43 4%	131	43 4%	265	43 7%
Protein rich vegetables	170	55 0%	164	54 3%	334	55 1%
Eggs	133	43 0%	113	37 4%	246	40 6%
Yogurt	47	15 2%	42	13 9%	89	14 7%
Dense lipids	138	44 7%	132	43 7%	270	44 6%
Iodized salt	150	48 5%	44	14 6%	194	32 0%

Prevention of Night Blindness	Frequency	Percent	Frequency	Percent	Frequency	Percent
Shell fish	3	1 0%	2	0 7%	5	0 8%
Green leafy vegetables	12	3 9%	18	6 0%	30	5 0%
Yellow fruits	5	1 6%	7	2 3%	12	2 0%
Dark yellow vegetables	2	0 6%	2	0 7%	4	0 7%
Breast milk	1	0 3%	4	1 3%	5	0 8%
Egg yolks	1	0 3%	7	2 3%	8	1 3%
Do not know	261	84 5%	268	88 7%	529	87 3%

Weight in kg	Frequency	Frequency	Frequency
0	2	40	40
1	1	1	2
2	2	1	3
3	11	5	1
4	26	6	32
5	42	21	63
6	60	46	106
7	74	8	154
8	51	40	91
9	23	26	49
10	4	10	14
11	0	0	0
12	0	1	1
Unknown	13	25	50

mean 6 04
st dev 3 34
median 7

Diarrhea

Frequencies for standard KPC questions specifically on diarrhea

DIARRHEA	PKS Survey Results		TSRDS Survey Results		All Survey Results	
Child had diarrhea in the last 2 weeks	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	56	18 1%	74	24 5%	130	21 5%
No	253	81 9%	228	75 5%	476	78 5%
			302	100 0%	606	100 0%
Breastfeeding during diarrheal episode	Frequency	Percent	Frequency	Percent	Frequency	Percent
More	7	12 5%	8	10 8%	15	11 5%
Same as usual	26	46 5%	39	52 7%	65	50 0%
Less	15	26 8%	21	28 4%	36	27 7%
Did not feed	4	7 1%	4	5 4%	8	6 2%
No longer breastfeeding	4	7 1%	2	2 7%	6	4 6%
			74	100 0%	130	100 0%
Fluids given during diarrheal episode	Frequency	Percent	Frequency	Percent	Frequency	Percent
More	2	3 6%	5	6 8%	7	5 4%
Same as usual	11	19 6%	23	31 1%	34	26 2%
Less	6	10 9%	15	20 3%	21	16 2%
Withheld breastmilk	3	5 4%	3	4 1%	6	4 6%
Exclusively breastfeeding	32	57 1%	28	37 8%	60	46 2%
			74	100 0%	128	98 5%
Feeding during diarrheal epidode	Frequency	Percent	Frequency	Percent	Frequency	Percent
More	1	1 8%	2	2 7%	2	2 7%
Same as usual	6	10 7%	20	27 0%	20	27 0%
Less	7	12 5%	16	21 6%	16	21 6%
Withheld breastmilk	4	7 1%	4	5 4%	4	5 4%
Exclusivley Breastfeeding	32	57 1%	32	43 2%	32	43 2%
			74	100 0%	74	100 0%
Sought advice about diarrhea	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	39	69 6%	53	71 6%	92	70 8%
No	17	30 4%	21	28 4%	38	29 2%
Where advice was sought	Frequency	Percent	Frequency	Percent	Frequency	Percent
General Hospital	4	7 1%	0	0 0%	4	4 3%
Health center or post	11	19 6%	1	1 9%	12	13 0%
Private clinic or doctor	12	21 4%	20	37 7%	32	34 8%
Pharmacy	2	3 6%	1	1 9%	3	3 3%
Village Health Worker	5	8 9%	12	22 6%	17	18 5%
Traditional Healer	3	5 4%	1	1 9%	4	4 3%
Relative, friend or family	5	8 9%	13	24 5%	18	19 6%
Quack	1	1 8%	3	5 7%	3	3 3%
Other	2	3 6%	2	3 8%	7	7 6%
			53	100 0%	100	108 7%

DIARRHEA	PKS Survey Results		TSRDS Survey Results		All Survey Results	
Treatment given for Diarrhea	Frequency	Percent	Frequency	Percent	Frequency	Percent
ORS sachet	6	10 7%	14	18 9%	20	21 7%
Sugar-salt solution	5	8 9%	12	16 2%	17	18 5%
Infusions	0	0 0%	1	1 4%	1	1 1%
Anti-diarrheal medicines	16	28 6%	10	13 5%	26	28 3%
Antibiotics	4	7 1%	0	0 0%	4	4 3%
Other	6	10 7%	2	2 7%	9	9 8%
Nothing	14	25 0%	24	32 4%	38	41 3%

Indications to seek advice or treatment	Frequency	Percent	Frequency	Percent	Frequency	Percent
Vomitting	126	40 8%	146	48 3%	272	44 9%
Fever	43	13 9%	43	14 2%	86	14 2%
Dehydration	16	5 2%	41	13 6%	57	9 4%
Prolonged duration	20	6 4%		0 0%		0 0%
Blood in stool	6	1 9%	5	1 7%	11	1 8%
Loss of appetite	6	0 6%	8	2 6%	10	1 7%
Weakness or Tiredness	12	3 9%	12	4 0%	24	4 0%
Other	58	18 8%	41	13 6%	140	23 1%
Do not know	119	38 5%	119	39 4%	238	39 3%

Actions when child is recovering	Frequency	Percent	Frequency	Percent	Frequency	Percent
Smaller, more frequent feeds	75	24 3%	126	41 7%	201	33 2%
More food than usual	1	30 0%	2	0 7%	3	0 5%
High energy foods	13	4 2%	9	3 0%	22	3 6%
Other	162	52 4%	13	4 3%	73	12 0%
Do not know	52	16 8%	143	47 4%	305	50 3%

Frequencies for standard KPC questions specifically on ARI illness

PKS Survey Results | TSRDS Survey Results | All Survey Results

40 Has the child had a cough or difficulty breathing the the last month?

Cough or difficulty breathing	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	51	16 5	70	23 2	118	19 5%
No	258	83 5	232	76 8	488	80 5%
	309	100 0	302	100 0	606	100 0%

41 Did the child experience rapid or difficult breathing?

Rapid or difficult breathing	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	21	41 2	52	74 3	73	61 9%
No	30	58 8	18	25 7	45	38 1%
	51	100 0	70	100 0	118	100 0%

42 What are the signs or symptoms of ARI that would cause you to take the child to a health facility?

Signs and symptoms of ARI	Frequency	Percent	Frequency	Percent	Frequency	Percent
Unknown	7	13 7	5	7 1	9	7 6%
Fast/Difficult breathing	8	15 7	19	27 1	27	22 9%
Chest Indrawn	0	0 0	1	1 4	2	1 7%
Loss of Appetite	0	0 0	0	0 0	0	0 0%
Fever	8	15 7	10	14 3	18	15 3%
Cough	9	17 6	30	42 9	39	33 1%
Other	3	5 9	2	2 9	4	3 4%

43 Dirıng the child's respiratory distress did you offer the child ?

Given to child during ARI	Frequency	Percent	Frequency	Percent	Frequency	Percent
Home herbal remedies	2	3 9	26	37 1	28	23 7%
Exclusive breastfeeding	9	17 6	14	20 0	23	19 5%
more fluid/food than usual	3	5 9	2	2 9	2	1 7%
same fluid/food as usual	1	2 0	0	0 0	1	0 8%
less fluid/food than usual	1	2 0	4	5 7	5	4 2%
withheld breastmilk	0	0 0	0	0 0	0	0 0%
other including doctor (1) honey (1) medicine (	9	17 6	8	11 4	1	0 8%
No Response	26	51 0	16	22 9	58	49 2%
	51	100 0	70	100 0	118	100 0%

44 Did you seek treatment when the child was ill with respiratory distress?

Sought treatment for ARI	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	15	29 4	32	45 7	47	39 8%
No	36	70 6	38	54 3	71	60 2%
	51	100 0	70	100 0	118	100 0%

45 Did you seek treatment within 24 hours?

ought treatment for ARI within 24 hour	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	9	17 6	21	30 0	30	25 4%
No	42	82 4	49	70 0	88	74 6%
	51	100 0	70	100 0	118	100 0%

46 From whom did you seek advice for the child when ill with respiratory distress ?

Sought treatment from whom for ARI	Frequency	Percent	Frequency	Percent	Frequency	Percent
General Hospital	3	5 9	0	0 0	3	2 5%
Health Clinic	5	9 8	0	0 0	5	4 2%
Private clinic or doctor	4	7 8	13	18 6	17	14 4%
Village health worker	1	2 0	6	8 6	7	5 9%
Traditional birth attendant	0	0 0	0	0 0	0	0 0%
Traditional healer	0	0 0	1	1 4	1	0 8%
Pharmaist, chemist shopkeeper	0	0 0	0	0 0	0	0 0%
Relatives, friends	4	7 8	11	15 7	15	12 7%
Quacks	0	0 0	0	0 0	0	0 0%
Other	2	3 9	1	1 4	3	2 5%

47 From whom did you receive treatment for the childs illness ?

Received treatment from whom for ARI	Frequency	Percent	Frequency	Percent	Frequency	Percent
General Hospital	1	2 0	3	4 3	4	3 4%
Health Clinic	5	9 8	0	0 0	5	4 2%
Private clinic or doctor	6	11 8	24	34 3	30	25 4%
Village health worker	2	3 9	3	4 3	5	4 2%
Traditional birth attendant	0	0 0	0	0 0	0	0 0%
Traditional healer	0	0 0	0	0 0	0	0 0%
Pharmaist, chemist shopkeeper	0	0 0	1	1 4	1	0 8%
Relatives, friends	4	7 8	1	1 4	5	4 2%
Quacks	0	0 0	0	0 0	0	0 0%
Other	0	0 0	1	1 4	1	0 8%

Frequencies on KPC questions specifically related to immunizations

IMMUNIZATIONS | PKS Survey Results | TSRDS Survey Results | ALL Survey Results

48 Does your child have a UIP card?

UIP Card	Frequency	Percent
Yes	123	39 8
No	186	60 2
	309	100 0

Frequency	Percent
91	30 1
211	69 9
302	100 0

Frequency	Percent
214	35 31
392	64 69
606	100 0

49 Is the card lost?

Card lost	Frequency	Percent
Yes	14	4 5
No Response	295	95 5
	309	100 0

Frequency	Percent
22	7 3
280	92 7
302	100 0

Frequency	Percent
36	5 94
570	94 06
606	100 0

Vaccinations	UIP CARD	MEMORY	TOTAL	PERCENT
BCG	94	39	133	43 04
OPV1	141	87	228	73 79
OPV2	109	77	186	60 19
OPV3	2	25	27	8 74
DPT1	109	32	141	45 63
DPT2	79	21	100	32 36
DPT3	68	15	83	26 86
Measles 1	22	6	28	15 82
Measles 2	10	1	11	6 21
Vitamin A 1	17	1	18	5 83
Vitamin A 2	8	0	8	2 59
Vitamin A 3	5	0	5	1 62
Vitamin A 4	2	0	2	0 647249

UIP CARD	MEMORY	TOTAL	PERCENT
62	36	98	32 45
91	102	193	63 91
78	90	168	55 63
56	45	101	33 44
75	40	115	38 08
59	29	88	29 14
49	21	70	23 18
11	2	13	7 56
2	0	2	1 16
10	2	12	3 97
3	1	4	1 32
1	1	2	0 66
0	3	3	0 99

UIP CARD	MEMORY
156	86
232	202
187	176
142	79
184	78
138	55
117	39
34	11
12	2
27	5
11	2
6	2
2	4

Frequencies for standard KPC questions specifically on malaria

PKS Survey Results | TSRDS Survey Results | ALL Survey Results

69 Did you suffer from malaria during this pregnancy?

Malaria during pregnancy	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	65	21 0	44	14 6	109	18 0%
No	244	79 0	258	85 4	497	82 0%
	309	100 0	302	100 0	606	100 0%

70 Did you receive any tablets for malaria during this pregnancy?

Malaria meds during pregnancy	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	27	41 5	24	54 5	58	53 2%
No	38	58 5	20	45 5	51	46 8%
	65	100 0	44	100 0	109	100 0%

71 From whom did you receive the malaria medicine ?

Where received malaria meds	Frequency	Percent	Frequency	Percent	Frequency	Percent
Anganwadi worker	0	0 0	0	0 0	0	0 0%
Nurse midwife	1	3 7	3	12 5	4	6 9%
Gov,t doctor	7	25 9	5	20 8	12	20 7%
Private doctor	2	7 4	20	83 3	6	10 3%
Dai	0	0 0	0	0 0	0	0 0%
Drug shop	0	0 0	0	0 0	0	0 0%
NGO worker	1	3 7	0	0 0	1	1 7%
Quack	2	7 4	0	0 0	2	3 4%
Don't know	0	0 0	0	0 0	0	0 0%
Other	0	0 0	0	0 0	1	1 7%

Frequencies for standard KPC questions

MATERNAL CARE	PKS Survey Results		TSRDS Survey Results		ALL Survey Results	

50 Why do pregnant woment need TT vaccine ?

TT vaccine in pregnancy	Frequency	Percent	Frequency	Percent	Frequency	Percent
Protect baby/mom from tetanus	55	17 8	97	32 1	152	25 1%
Protect mom from tetanus	35	11 3	32	10 6	67	11 1%
Protect baby from tetanus	41	13 3	19	6 3	60	9 9%
Don't know or other	157	50 8	155	51 3	312	51 5%
	288	93 2	303	100 3	591	97 5%

51 How many TT injections does a pregnant woman need ?

Number of TT vaccines needed	Frequency	Percent	Frequency	Percent	Frequency	Percent
One	20	6 5	10	3 3	30	5 0%
Two	95	30 7	87	28 8	182	30 0%
More than two	85	27 5	104	34 4	189	31 2%
None	74	23 9	58	19 2	132	21 8%
Unknown	157	50 8	144	47 7	312	51 5%

52 Record how many TT injections the woman has had

Number of vaccines given	Frequency	Percent	Frequency	Percent	Frequency	Percent
One	70	22 7	28	9 3	98	16 2%
Two	97	31 4	97	32 1	194	32 0%
More than two	68	22 0	86	28 5	154	25 4%
None	55	17 8	85	28 1	140	23 1%
Unknown	19	6 1	6	2 0	20	3 3%
	309	100 0	302	100 0	606	100 0%

53 How many iron tablets did you receive during your pregnancy ?

Number of iron tablets received	Frequency	Percent	Frequency	Percent	Frequency	Percent
0 to 19	32	10 4	130	43 0	159	26 2%
20 to 39	37	12 0	43	14 2	79	13 0%
40 to 59	3	1 0	2	0 7	5	0 8%
60 to 79	48	15 5	49	16 2	97	16 0%
80 to 99	42	13 6	34	11 3	76	12 5%
100 to 119	18	5 8	1	0 3	19	3 1%
120 to 139	9	2 9	5	1 7	14	2 3%
140 to 159	2	0 6	6	2 0	8	1 3%
160 to 179	1	0 3	0	0 0	1	0 2%
180 to 199	0	0 0	5	1 7	5	0 8%
200 to 219	1	0 3	4	1 3	5	0 8%
220 to 239	0	0 0	0	0 0	0	0 0%
240 to 259	1	0 3	1	0 3	2	0 3%
260 to 279	2	0 6	1	0 3	3	0 5%
280 to 299	0	0 0	0	0 0	0	0 0%
300 to 219	0	0 0	2	0 7	2	0 3%
360 to 379	0	0 0	1	0 3	1	0 2%
other	113	36 6	18	6 0	130	21 5%
	309	100 0	302	100 0	606	100 0%

MATERNAL CARE | NKS | TRNDS | ALL

54 How many of these tabs did you take ?

Number of tablets consumed	Frequency	Percent	Frequency	Percent	Frequency	Percent
0 to 19	41	13 3	142	47 0	180	29 7%
20 to 39	34	11 0	46	15 2	80	13 2%
40 to 59	11	3 6	5	1 7	16	2 6%
60 to 79	41	13 3	35	11 6	76	12 5%
80 to 99	38	12 3	29	9 6	67	11 1%
100 to 119	16	5 2	0	0 0	16	2 6%
120 to 139	8	2 6	4	1 3	12	2 0%
140 to 159	2	0 6	6	2 0	8	1 3%
160 to 179	1	0 3	1	0 3	2	0 3%
180 to 199	1	0 3	5	1 7	5	0 8%
200 to 219		0 0	4	1 3	5	0 8%
260 to 279	2	0 6	1	0 3	3	0 5%
300 to 219		0 0	2	0 7	2	0 3%
360 to 379		0 0	1	0 3	1	0 2%
other	114	36 9	21	7 0	133	21 9%
	309	100 0	302	100 0	606	100 0%

55 How many ante-natal visits did the mother receive ?

Number of ante-natal visits	Frequency	Percent	Frequency	Percent	Frequency	Percent
One	29	9 4	34	11 3	63	10 4%
Two	48	15 5	59	19 5	107	17 7%
More than Two	121	39 2	62	20 5	183	30 2%
None	96	31 1	145	48 0	240	39 6%
No Response	15	4 9	2	0 7	13	2 1%
	309	100 0	302	100 0	606	100 0%

56 Are you pregnant now?

Currently pregnant	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	11	3 6	20	6 6	31	5 1%
No	298	96 4	282	93 4	575	94 9%
	309	100 0	302	100 0	606	100 0%

57 Do you want another child in the next two years?

Desire for chidren in next two years	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	108	35 0	106	35 1	214	35 3%
No	201	65 0	196	64 9	392	64 7%
	309	100 0	302	100 0	606	100 0%

58 Are you currently using any method of birth control?

Use of birth control	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	33	10 7	20	6 6	53	8 7%
No	276	89 3	282	93 4	553	91 3%
	309	100 0	302	100 0	606	100 0%

59 What is the main birth control method you are using ?

Birth control method	Frequency	Percent	Frequency	Percent	Frequency	Percent
Tubal ligation	14	42 4	10	3 3	24	45 3%
vasectomy	0	0 0	0	0 0	0	0 0%
Norplant	0	0 0	0	0 0	0	0 0%
Inections	0	0 0	0	0 0	0	0 0%
Pill	11	33 3	3	1 0	14	26 4%
IUD	1	3 0	0	0 0	1	1 9%
Barrier method	0	0 0	0	0 0	0	0 0%
Condom	4	12 1	0	0 0	4	7 5%
Foam	0	0 0	0	0 0	0	0 0%
Lactation	0	0 0	2	0 7	2	3 8%
Rhyhm	0	0 0	0	0 0	0	0 0%
Abstinence	0	0 0	6	2 0	8	15 1%
Coitus Interruptus	0	0 0	0	0 0	0	0 0%
other	14	42 4	0	0 0	0	0 0%
None or no response	265	85 8	281	93 0	553	91 3%

60 When should a pregnant woman see a health professional ?

When to seek healthcare	Frequency	Percent	Frequency	Percent	Frequency	Percent
First Trimester	78	25 2	75	24 8	153	25 2%
Second Trimester	122	39 5	100	33 1	222	36 6%
Last Trimester	8	2 6	8	2 6	16	2 6%
No need to see health worker	1	0 3	7	2 3	8	1 3%
Don't know	84	27 2	109	36 1	193	31 8%
No answer	16	5 2	3	1 0	14	2 3%
	309	100 0	302	100 0	606	100 0%

61 What foods are good for pregnant woment to eat ?

Good foods for pregnant women	Frequency	Percent	Frequency	Percent	Frequency	Percent
Don't know	58	18 8	138	45 7	196	32 3%
Green leafy vegetables	193	62 5	107	35 4	300	49 5%
Fruits	164	53 1	106	35 1	270	44 6%
Meat	167	54 0	84	27 8	251	41 4%
Eggs	154	49 8	82	27 2	236	38 9%
Fish	15	4 9	68	22 5	219	36 1%
Dal	161	52 1	75	24 8	236	38 9%
Other	103	33 3	47	15 6	154	25 4%

62 Since delivery of your child have you gone for a checkup?

Post partum checkup	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	44	14 2	32	10 6	76	12 5%
No	265	85 8	270	89 4	530	87 5%
	309	100 0	302	100 0	606	100 0%

63 Since giving birth to your child have you taken them for a checkup?

Well baby checkup	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	51	16 5	35	11 6	86	14 2%
No	258	83 5	267	88 4	520	85 8%
	309	100 0	302	100 0	606	100 0%

MATERNAL CARE	PKS		TSRDS		ALL	

64 During your pregnancy with your child was the amount of food you ate ?

Food consumed during pregnancy	Frequency	Percent	Frequency	Percent	Frequency	Percent
More than usual	49	15 9	24	7 9	73	12 0%
Same as usual	116	37 5	173	57 3	289	47 7%
Less thant usual	34	11 0	101	33 4	235	38 8%
No answer	110	35 6	4	1 3	9	1 5%
	309	100	302	100	606	100 0%

65 What birth preparations did you make ?

Preparations made for birth	Frequency	Percent	Frequency	Percent	Frequency	Percent
Safe birth kit	32	10 4	1	0 3	33	5 4%
Identified trained birth attendant	60	19 4	9	3 0	69	11 4%
Funds for emergency use	57	18 4	69	22 8	126	20 8%
Transport in case of emergency	17	5 5	7	2 3	24	4 0%
Escort in case of emergency	24	7 8	5	1 7	29	4 8%
None	126	40 8	218	72 2	343	56 6%
Other	26	8 4	4	1 3	29	4 8%

66 Who cut and tied the cord of your child ?

Person who cut umbilical cord	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yourself	2	0 6	0	0	2	0 3%
Family member	11	3 6	2	0 7	13	2 1%
Traditional birth attendant	193	62 5	262	86 8	455	75 1%
Trained birth attendant	60	19 4	9	3 0	69	11 4%
Health professional	27	8 7	10	3 3	37	6 1%
Doesn't know	4	1 3	0	0 0	5	0 8%
No reply	12	3 9	19	6 3	25	4 1%
	309	100 0	302	100 0	606	100 0%

67 What instrument was used to cut the cord ?

Instrument used to cut cord	Frequency	Percent	Frequency	Percent	Frequency	Percent
Razor blade	258	83 5	291	96 4	549	90 6%
Bamboo blade	0	0 0	1	0 3	1	0 2%
sickle	0	0 0	4	1 3	0	0 0%
Spearkead	3	1 0	0	0 0	7	1 2%
Other	48	15 5	6	2 0	49	8 1%
	309	100 0	302	100 0	606	100 0%

68 During delivery what are signs of danger indicating need to seek healthcare?

Danger signs during pregnancy	Frequency	Percent	Frequency	Percent	Frequency	Percent
Bleeding	17	5 5	4	1 3	21	3 5%
Cramping	31	10 0	43	14 2	74	12 2%
Swelling in legs	14	4 5	12	4 0	26	4 3%
Pain in abdomen	142	46 0	84	27 8	226	37 3%
Prolonged labor	24	7 8	156	51 7	269	44 4%
Don't know	21	6 8	45	14 9	36	5 9%

DIARRHEA CROSS TABULATIONS

Data from each positive case of diarrhea was cross tabulated with data from variables known or suspected to be associated with an increased risk of diarrheal disease Notable risk ratios are highlighted Variables used as the denominator (control) for risk ratios are in italics

WATER SOURCE	cases		risk	risk ratio
Pipewater	1	9	11 11%	0 68
Tubewell	69	267	25 84%	1 57
Drawwell	51	310	16 45%	1 00
Lake water	7	15	46 67%	2 84
Pond water	7	20	35 00%	2 13
P-value	0 004695			

EDUCATION	cases		risk	risk ratio
Illiterate	92	418	22 01%	1 00
Primary School	16	93	17 20%	0 78
Middle	17	63	26 98%	1 23
Secondary	5	31	16 13%	0 73
P-value	0 434357			

CAREGIVER	cases		risk	risk ratio
Mother	43	264	16 29%	1 05
Father	11	71	15 49%	1 00
Siblings	22	98	22 45%	1 45
Relatives	51	202	25 25%	1 63
P-value	0 071297			

POST PARTUM	cases		risk	risk ratio
Yes	19	76	25 00%	1 19
No	111	530	20 94%	1 00
P-value	0 420421			

BABY CHECKUP	cases		risk	risk ratio
Yes	21	86	24 42%	1 16
No	109	520	20 96%	1 00
P-value	0 469392			

FOODS	cases		risk	risk ratio
Water given	108	418	25 84%	2 31
Water not given	21	188	11 17%	1 00
P-value	0 000045			
Milk given	53	178	29 78%	1 66
Milk not given	77	428	17 99%	1 00
P-value	0 001287			
Semisolids given	95	360	26 39%	1 85
Semisolids not given	35	246	14 23%	1 00
P-value	0 000342			
Meat given	60	265	22 64%	1 10
Meat not given	70	341	20 53%	1 00
P-value	0 529497			
Eggs given	63	246	25 61%	1 38
Eggs not given	67	360	18 61%	1 00
P-value	0 039296			
Yogurt given	26	89	29 21%	1 45
Yogurt not given	104	517	20 12%	1 00
P-value	0 053462			
Fruits given	67	270	24 81%	1 32
Fruits not given	63	336	18 75%	1 00

ARI CROSS TABULATIONS

Data from each positive case of ARI was cross tabulated with data from variables known or suspected to be associated with an increased risk of ARI Notable risk ratios are highlighted Variables used as the denominator (control) for risk ratios are in italics

DPT	cases		risk	risk ratio
DPT 1	49	255	19 22%	0 97
DPT 2	41	188	21 81%	1 10
DPT 3	36	153	23 53%	1 19
None	69	349	19 77%	1 00
P-value	0 702352			
BCG	53	231	22 94%	1 32
None	65	375	17 33%	1 00
P-value	0 387237			

CAREGIVER	cases		risk	risk ratio
Mom	41	264	15 53%	1 00
Father	16	71	22 54%	1 45
Siblings	15	98	15 31%	0 99
Relatives	48	202	23 76%	1 53
P-value	0 089269			

EDUCATION				
Illiterate	85	418	20 33%	1 00
Primary	14	93	15 05%	0 74
Middle	15	63	23 81%	1 17
Secondary	4	31	12 90%	0 63
P-value	0 397658			

VITAMIN A				
Yes	51	280	18 21%	1 00
No	67	326	20 55%	1 13

Annex C – Principal Documents

TSRDS

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Annex D – Contract and NGO Background

Executive Summary

Parivar Kalyan Sansthan (PKS), an NGO promoted by TATA ENGINEERING & LOCOMOTIVE CO LTD , in the year 1993-94, is ready to take up a Four-year Child Survival Project in collaboration with CARE-INDIA.

Backed by the strength of Telco's commitment to the society at large,and Telco's perepheral areas in particular, PKS took up the issue of population as its main plank of services Over a decade of relentless drive in Family Planning made it evident that the alarming level of mortality and morbidity in infant and pregnant mother population in the outreach areas beyond the Eastern periphery of Jamshedpur demanded equal priority and thrust, if not more It is always the rural outback which suffer most due to lack of insfrastructure as also fund It is a huge and one rous task to service the basic needs of pregnant mother and infant which PKS or any agency alone, including the government, is not able to do Hence a partnership with and International agency like CARE, involving both public and government department concerned is considered to be ideal and capable of implementing a child Survival Project effectively

The proposed project area is 50 villages in Potka Block, East Singhbhum , with a population size of over 50,000 The specific target groups are pregnant mothers (3%), children in 0-24 months (5%), and couples in the reproductive age-group (17%)

The CARE - PKS project will address the problem of mother & child survival by designing & implementing a sustainable community-based program of health care for pregnant mothers & children upto 24 months

The Project will aim at specific tangible results like reduction in maternal mortality, which is 1490 per 1,00,000 live births (as against 500 for India), infant mortality to be reduced from 89 per 1000 (as against 79/1000), atleast 3 antenatal care visit to ANC clinics of the Project by 50% of women in Project are in the first year and take TT injections, Inform, and ensure practice of colostrum feeding within 6 hrs of birth of a child, ensure parental initiative in having the child completely immunised by 24 months

The strategy for implementation keeps in view the sustainability factor when Project support will be withdrawn after the four year term Right from the beginning therefore community based organisations like Mahila Mondals, youth club or even Panchayat executives will be involved through motivation and orientation programs Members of these local organisations would enable identifying & encouraging pregnant women with family elders & adolescents to attend Health Days and practice preventive health measures as advised at the clinics and group discussions

The Project will lay focus on attitudinal change in the target community towards health culture the services rendered by the Project will be chargeable, albeit a token amount, which will help negating any feeling of dependancy from the very beginning The collections from service delivery would help constitute local level fund which will be managed by each local group

The Project will ensure close monitoring of the programs through visits, interaction, formats and response of the Target Community participating at Health Days

The experience and results will be shared with other corporate houses as also NGOs in the Potka Block area and generate interest & concern for collaboration or replication in their works vicinity

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Institutional Capacity

PKS is backed by a track record of over 15 years of family planning & health services in the rual Singhbhum The Tata Engineering & Locomotive CO. Ltd , Jamshedpur (TELCO), the leader in Commercial vehicles manufacturing in the country for decades, provides PKS fund, infrastructure and managerial support, During the first ten years, 70% to 80% of fund was mobilised for family planning operation programme which led to achievement of over one lakh operations This drive had stong impact in decelerating the growth rate of the rural and semi-urban population around Telco despite a steady stream of new settlers in these areas From 1996 shift of focus from sterilisation to awareness, training, mother & child health and local-lvel initiatives was affected, keeping sterilisation as secondary thrust area.

Funds & infrastructure - Telco channelises funds to PKS through its Community Services Dsivision Fund approval is provided on the basis of annual budgetary plan Telco has provided a large building complex to PKS which comprises of a Ward to accommodate 50 beds, a fully-equipped Operation Theatre for Lap TT, VT & Cataract surgery, medicine store, Training & Waiting Halls, Eye Clinic & a small Path Lab Two mobile Medical Vans and one hired vehicle constitute PKS's fleet of regular transport

As for manpower, there are six MBBS doctors, 4 paramedical staff and 22 other support staff

Associate Agencies - PKS has to its program support other similar NGOs promoted by Telco -

(i) Gram Vikas Kendra, Jamshedpur for rural development services in Jamshedpur, Potka and Chandil Blocks of East & West Singhbhum.

(ii) Nav Jagrat Manav Samaj for relief and rehabilitation of leprosy affected people, mostly migrated population living in small settlements in the city

(iii) Shiksha Prasar Kendra for providing support & guidance to the educational institutions in and around Telco Town

(iv) GVK-Family Helper Project - A unit of Gram Vikas Kendra, conducting child & family development in the remote rural base with fund from Christian Children's Fund Inc

(v) Community based Rehabilitation Project for the Blind, an organ of PKS with fund from Sight Savers international

(vi) Community Development - takes care of welfare & human development programs in the bastees around Telco township

Policy guidelines - PKS is governed by the guidlines drawn up by the PKS Governing Body, which comprises of 11 Telco execvutives The Coordinator and Secretary are nominated by this group at its Annual General Meeting and their services are loaned to the society Besides the Governing Body a number of medical professionals from Telco Medical Services provide consultancy to PKS on Community Health issues

Recognistion

PKS and Nav Jagrat Manav Samaj, the two health care NGOs received FICCI Awards in 1994-95 and in 1997-98 respectively for outstanding services in Family Welfare

On going Interventions

The present interventions cover a population of over 1 50 lakh in JmahsedpurBlock & Chandil Block of East & West Singhbhum.

Thus with the available manpower, experience, expertise and infrastructure, PKS is capable of implementing the child survival project in Potka Block, beginning with 50 villages

* Antenatal clinics (11 Nos)
* Primary Immunisation
* General Clinics (11 Nos.)
* Eye Care Clinic (1 No)
* T B Clinic (2 Nos)
* Cataract Surgery camps
* Lap TT/VT Surgery Camps (1 to 4 per month) & Routine program (once a week)
* Training of Traditional Dai/Midwifery Training for educated women/Firstaid Training for rural youth.
* Preventive measures & Campaign in Diarrhoea/Malaria-prone rural areas
* Water Testing Kit and Bleaching powder distribution.
* School Health checkup
* School Eye Checkup
* Pulse Polio drive
* Observance of National & International Health Days
* Awareness & Education program

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6470254 6470258 6470299 6471527
Fax 91 11 647 3098 91 11 648 3007
EMail CARE IN@cared ernet in

[redacted]

AGREEMENT

THIS AGREEMENT is made on the 8th day of January, One thousand nine hundred and ninety nine between CARE, voluntary agency incorporated in USA and carrying on its activities in India under the name and style of CARE-India and having its office at B-28 Greater Kailash-I New Delhi - 110 048, through its Country Director Tom Alcedo based at New Delhi, India (hereinafter called CARE which term shall include its heirs, assigns) party of the First Part, and Pavivar Kalyan Sansthan NGO, a Society registered under the Societies Registration Act and having its office at Plaza Dispensary Complex, Telco Colony, Jamshedpur, Bihar 831 004 through its Coordinater, Mrs Pankaj Khullar wife of Mr S M. Khullar, resident of Jamshedpur, Bihar (hereinafter called NGO which term shall include its heirs, assigns) party of the Second Part,

CARE
INDIA

WHEREAS CARE is a charitable organization engaged in relief and development activities to help the weaker sections of the society and to ameliorate their conditions and to uplift their standard of living, and is operating in India since 1950 under an agreement with the Government of India (hereinafter called the Indo-CARE Agreement), AND

WHEREAS the NGO is a charitable society registered under the Societies Registration Act, 1860 (Act No 21 of 1860) bearing Registration No 498 8384 and also the Foreign Contribution Regulation Act, 1976 (Act No 49 of 1976) bearing Registration No 031260032, and as such the NGO confirms that they are fully competent to enter into this Agreement and receive Foreign Grants and that they have the requisite permission to receive the Foreign contributions under this Agreement as contemplated under the project proposal, AND

WHEREAS the parties have had negotiations and have arrived at the following Agreement -

NOW, THEREFORE, THIS AGREEMENT WITNESSETH AS UNDER -

1 That the parties to this Agreement have discussed, mutually agreed and accepted the project, a copy of which is appended as Schedule 'A' to this Agreement The Project Implementation Plan, and Financial Plan have also been agreed to, by the parties, a copy of each of these is annexed as Schedules 'B' and 'C' respectively, to this Agreement

2 CARE has obtained government and donor approval for its Integrated Nutrition and Health Project (INHP) The present project, to be implemented by the NGO, is in conformity with CARE's INHP

Bk.

3 NGO undertakes and Covenants with CARE as under

(a) that the project as detailed in Schedule 'A' shall be carried out in jointly selected 100 villages in block Potka in East Singbhum district of Bihar state

(b) that the beneficiaries under the said project would be the children under the age of two years, and pregnant and lactating women as mentioned in the said project at Schedule 'A' in the selected villages

(c) that the project will be carried out by the NGO in conformity with sound financial practices within the time schedule as mentioned in the said project and the project implementation plan

(d) that any deviation and/or change in the agreed areas, targets and/or time schedule will be carried out by the NGO only with the consent in writing of CARE

(e) that the NGO will be responsible for the implementation of the project and will, therefore, be responsible for administering the funds received from CARE exclusively for the project

(f) that the NGO will use the funds in accordance with the agreed financial plan outlined in Schedule 'C' No variances will be made from the budget without CARE's prior approval in writing Any funds which are not utilized in accordance with this Agreement shall be returned to CARF

(g) that the NGO will use funds received under this Agreement exclusively for the purpose of the project as agreed under this Agreement, and will not use CARE funds directly or indirectly for the following goods or activities pharmaceuticals (including vaccines and vitamins), pesticides, rubber compounding chemicals and plasticizers, government-owned excess property, fertilizers, party politics, alcoholic beverages, military equipment, surveillance equipment, commodities in support of police or other law enforcing activities, abortion equipment and services, luxury goods and gambling equipment, weather modification equipment, agricultural commodities, motor vehicles, and immovable property purchases

(h) that the NGO will not use CARE funds for activities financed by another donor/agency, and will not use funds from other donors/agencies for activities funded by CARF

(i) that the NGO will segregate the funds received under the project in its accounts Receipt and expenditure of such funds should be shown separately in the NGO accounting records

(j) that the NGO will maintain separate records and vouchers in support of funds claimed and expended under this Agreement for the inspection by CARF officials/nominees as and when required Such records shall be maintained by the NGO till the NGO is released in writing from this requirement

(k) that the NGO will submit quarterly project progress reports to CARE as per the mutually agreed schedule and prescribed format

(l) that the NGO will furnish to CARE the quarterly statement of the amounts received and expended as per the format and schedule prescribed by CARE along with a utilization certificate of the same

(m) that for purposes of this Agreement and implementation of the project, the financial year may be taken as starting on the first day of October and closing on the 30 day of September of the succeeding year

(n) that the NGO will get its project accounts audited and furnish audited financial statements including receipt of the amounts as well as expenses to CARE within 60 days of the close of every financial year (October - September) This shall be further supported by the NGO's own Audited Balance sheet within three months of the year closing

(o) that the NGO will tulfil all its responsibilities under the Foreign Contribution Regulation Act (FCRA) and Rules thereunder, and will hold CARF free of any obligations under the said Act and Rules

(p) that the NGO will depute a minimum of 31 workers (animators, supervisors, coordinators, etc), as mentioned in the said project, for the implementation of the planned activities These staff will be dedicated to the project implementation as defined in the said project plan

(q) that the NGO will not place sub-contracts with other organizations, firms, institutions, or individuals for completion of activities for which the NGO has been provided funds by CARE, without prior approval and written authorization by CARE, unless these have been planned and described in the said project proposal

(r) that the NGO will employ competitive bidding in all procurements required for the project and agreed to by CARE Competitive bidding requires that three or more qualified suppliers be solicited for written quotations Exceptions will be made when the value of purchase falls below Rs 2000/- The NGO will offer the contract to the best overall offer (lowest cost for the required quality and quantity) The record of all such transactions to be maintained for inspection by CARL on demand.

(s) that the NGO will be responsible for the safe-keeping and return, in good condition and order of all CARE's property, if any, which may be issued or assigned to the NGO or as may have been purchased from funds under this Agreement.

(t) that the interest earned out of CARE funds, if any, will belong to the project and its use will be decided jointly by the NGO and CARE with CARE having final say of its disposition

(u) that the NGO shall bear all costs, levies or expenses as may result in the legal execution of this Agreement or in the enforcement by CARE of any provisions in the Court of Law

(v) that the NGO of their own accord shall promptly inform CARE of any and all circumstances precluding or seriously jeopardizing the implementation, the operation or the purposes of the project.

Ok.

(w) that the NGO further agrees

i) that if any of the provisions of this Agreement is invalid, all other provisions shall remain unaffected thereby, any gap resulting therefore shall be filled by a provision consistent with the purpose of this Agreement

ii) that amendments of this Agreement that effect only the legal relations between CARE and the NGO shall not require the consent of the NGO

(x) that, as a condition of award of this contract, and notwithstanding the conditions of any clause appearing thereon, CARE shall have unlimited rights in and to the technical data that emerges from this project.

(y) The logos, trademarks, printed material, communications and training aids, intellectual property, and software developed using these project funds and under this project cannot be copywritten by the NGO, or any agent, individual, or subcontractor hired by the NGO Copyrights, registered logos etc, that are already with the NGO before this Agreement would, however, be exempt CARE encourages the NGO to use and freely distribute the material developed during this project without claiming any copyright on the said material

4 CARE Covenants with the NGO as under

(a) to provide funds (subject to the availability) to the NGO for the project activities as mentioned in the project, a copy of which is appended as Schedule 'A' to this Agreement, subject to satisfactory progress of the project and receipt of timely progress and financial reports

(b) to provide technical/managerial support to the office bearers/staff of the NGO, if required, and resources are available for the same

(c) to provide a consolidated amount of US $177 206 as per the approved budget for the project life, subject to terms and other clauses as in this Agreement All payments by CARE to the NGO will be made by way of crossed cheque/bank draft in favor of the NGO

(d) The funds would be released to the NGO in Indian currency denominated installments, at the prevailing release date's US dollar to rupee exchange rate, subject to the satisfactory completion and acceptance thereof by CARF of activities, according to the following schedule

i) Initially, 50% of the annual current year's budgeted amount will be released as an advance on the signing of the agreement.
ii) In the following quarter, 25% of that current year's annual budget will be released
iii) In the following quarter, an additional 25% of that current year's annual budget will be released.
iv) In the following quarter, 25% of the following year's annual budget will be released.
v) Next, the process outlined in steps ii - iv above shall be repeated and continued until the total consolidated budget amount has been funded
vi) The quarterly advance of funding is subject to the timely and thorough completion of project activities carried out according to plan

O.K.

vii) Accounting will be done at the end of each year, and any surplus funds will be carried over to the following year's budget Upon completion of the project, a final accounting will be done and the NGO will reimburse to CARE any unused funds after CARE's review of the report and statement of expenses for the project

5 Allocation and release of funds to the NGO is contingent upon performance in the previous year, and availability of funds with CARE for conducting their activities in India or under this project

6 The NGO agrees to provide a consolidated in-kind contribution amount of Rs 1,24 39,686, the equivalent of US $296,183 at the current exchange rate of Rs 42 per US $1, towards the project, with both its own contribution and community match, as per the approved budget for the project life, subject to terms and other clauses as in this Agreement

7 The monitoring plans will be developed jointly by CARE and NGO CARE will organize an independent and external baseline, mid-term and final evaluation of the project, if required The NGO will modify the project or any part thereof, if warranted by the monitoring/appraisal studies, etc Such modification(s) will be by mutual agreement The NGO agrees to maintain openness for monitoring visits to project area by CARE, Donor(s) and Government officials, whenever required, such plans of visits will be coordinated/ facilitated by CARE

8 CARE will assume no responsibility or liability for any injuries death or any legal action in respect of office bearers/employees/agents/functionaries of the NGO arising out of any activity related to the project

9 The need for modifications/changes, if any in this Agreement, during its life will be jointly assessed by CARE and NGO CARE's discretion in this regard is final

10 This Agreement will remain in force, unless terminated earlier, as provided under Clause '11' below, during the life of the project i e until the four-year anniversary from the date of signing by both the parties

11 Early termination, suspension of disbursement, and repayment thereof

CARE may not suspend disbursements unless

a. Obligations under this Agreement or the project proposal and other agreed plans pertinent to the Agreement have been violated by the NGO
b The NGO fails to meet the standards referred to in the project and/or expected of it, as determined by CARE
c The NGO is unable to prove that the financial contribution has been used for the stipulated purpose
d Extraordinary circumstances arise that preclude or seriously jeopardize the implementation, the operation, or the purpose of the project
e Funds with CARE for the purpose of this project are no longer available

If any of the conditions as specified in (11a & 11b) occur, and has not been rectified within a period of 30 days or as determined by CARE, then CARE may demand immediate repayment from the

NGO, the entire disbursed amount. However, in the case specified in 11 (c), demand the immediate repayment of such amount as the NGO is unable to prove to have been utilised for the stipulated purpose

WAIVER OF BREACH
The failure of either party to this Agreement to object to or take affirmative action with respect to any conduct of the other which is in violation of the terms of this Agreement shall not be construed as waiver of such conduct

ARBITRATION
Any dispute which is not settled by mutual agreement shall be at the option of either party and, upon written notice to the other party, be settled by arbitration The arbitration shall be conducted in accordance with the rules then prevailing of the American Arbitration Association. Arbitration shall take place in New Delhi and the proceeding shall be held in English language In any such arbitration, there shall be appointed three arbitrators, one appointed by each of the parties and the third arbitrator unless selected by agreement between the other arbitrators, shall be appointed by the American Arbitration Association

NATURE OF DISBURSEMENTS
The nature of disbursements under this Agreement by CARE are financial contributions / technical inputs to the approved project The financial contributions may therefore be in kind, convertible Foreign Currency or Indian Rupees at the discretion / availability of CARE and as such among other Acts and Regulations is specifically covered under the Foreign contribution (Regulation) Act 1976 in India as amended from time to time

IN WITNESS WHEREOF, the parties have signed on the day mentioned above

ON BEHALF OF CARE (1)

P. Khullar 8.1.99
ON BEHALF OF NGO (2)

Witnesses
1 (3)
2 (4)

2 Mrs Pankaj Khullar
3 D K C. Roy
1 Tom Alcedo
4 Sanjay Sinho

Attachments
Schedule "A" Proposal
Schedule "B" Implementation plan
Schedule "C" Financial plan

CARE INDIA
B 28 Greater Kailash 1
New Delhi 110048
Phones 6221726 6418421 6418422 6441948
6470254 6470258 6470299 6471527
Fax 91 11 647 3098 91 11 648 3007
EMail CARE IN@cared ernet in

AGREEMENT

THIS AGREEMENT is made on the 8th day of January, One thousand nine hundred and ninety nine between CARE, voluntary agency incorporated in USA and carrying on its activities in India under the name and style of CARE-India and having its office at B-28, Greater Kailash-I, New Delhi - 110 048, through its Country Director Tom Alcedo based at New Delhi, India (hereinafter called CARE which term shall include its heirs, assigns) party of the First Part, and Tata Steel Rural Development Society NGO, a Society registered under the Societies Registration Act and having its office at E Road, Jamshedpur, Bihar 831 001 through its Honorary Secretary, Mr Viraf Mehta son of Mr Meher Mehta, resident of Jamshedpur, Bihar (hereinafter called NGO which term shall include its heirs, assigns) party of the Second Part,

CARE
INDIA

WHEREAS CARE is a charitable organization engaged in relief and development activities to help the weaker sections of the society and to ameliorate their conditions and to uplift their standard of living, and is operating in India since 1950 under an agreement with the Government of India (hereinafter called the Indo-CARE Agreement), AND

WHEREAS the NGO is a charitable society registered under the Societies Registration Act, 1860 (Act No 21 of 1860) bearing Registration No 438 of 78-79 and also the Foreign Contribution Regulation Act, 1976 (Act No 49 of 1976) bearing Registration No 031120004, and as such the NGO confirms that they are fully competent to enter into this Agreement and receive Foreign Grants and that they have the requisite permission to receive the Foreign contributions under this Agreement as contemplated under the project proposal, AND

WHEREAS the parties have had negotiations and have arrived at the following Agreement.-

NOW, THEREFORE, THIS AGREEMENT WITNESSETH AS UNDER -

1 That the parties to this Agreement have discussed, mutually agreed and accepted the project, a copy of which is appended as Schedule 'A' to this Agreement The Project Implementation Plan, and Financial Plan have also been agreed to, by the parties, a copy of each of these is annexed as Schedules 'B' and 'C' respectively, to this Agreement

2 CARE has obtained government and donor approval for its Integrated Nutrition and Health Project (INHP) The present project, to be implemented by the NGO, is in conformity with CARE's INHP

3 NGO undertakes and Covenants with CARE as under

(a) that the project as detailed in Schedule 'A' shall be carried out in jointly selected 167 villages in block Patamda in East Singbhum district of Bihar state

(b) that the beneficiaries under the said project would be the children under the age of two years, and pregnant and lactating women as mentioned in the said project at Schedule 'A' in the selected villages

(c) that the project will be carried out by the NGO in conformity with sound financial practices within the time schedule as mentioned in the said project and the project implementation plan

(d) that any deviation and/or change in the agreed areas, targets and/or time schedule will be carried out by the NGO only with the consent in writing of CARE

(e) that the NGO will be responsible for the implementation of the project and will, therefore, be responsible for administering the funds received from CARE exclusively for the project

(f) that the NGO will use the funds in accordance with the agreed financial plan outlined in Schedule 'C' No variances will be made from the budget without CARE's prior approval in writing Any funds which are not utilized in accordance with this Agreement shall be returned to CARE

(g) that the NGO will use funds received under this Agreement exclusively for the purpose of the project as agreed under this Agreement, and will not use CARE funds directly or indirectly for the following goods or activities pharmaceuticals (including vaccines and vitamins), pesticides, rubber compounding chemicals and plasticizers, government-owned excess property, fertilizers, party politics, alcoholic beverages, military equipment, surveillance equipment, commodities in support of police or other law enforcing activities, abortion equipment and services, luxury goods and gambling equipment, weather modification equipment, agricultural commodities, motor vehicles, and immovable property purchases

(h) that the NGO will not use CARE funds for activities financed by another donor/agency, and will not use funds from other donors/agencies for activities funded by CARE

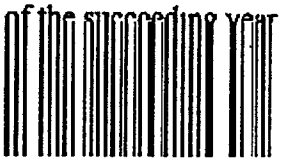
(i) that the NGO will segregate the funds received under the project in its accounts Receipt and expenditure of such funds should be shown separately in the NGO accounting records

(j) that the NGO will maintain separate records and vouchers in support of funds claimed and expended under this Agreement for the inspection by CARE officials/nominees as and when required Such records shall be maintained by the NGO till the NGO is released in writing from this requirement

(k) that the NGO will submit quarterly project progress reports to CARE as per the mutually agreed schedule and prescribed format

(j) that the NGO will furnish to CARE the quarterly statement of the amounts received and expended as per the format and schedule prescribed by CARE along with a utilization certificate of the same

(m) that for purposes of this Agreement and implementation of the project, the financial year may be taken as starting on the first day of October and closing on the 30 day of September of the succeeding year



(w) that the NGO further agrees

i) that if any of the provisions of this Agreement is invalid, all other provisions shall remain unaffected thereby, any gap resulting therefore shall be filled by a provision consistent with the purpose of this Agreement.

ii) that amendments of this Agreement that effect only the legal relations between CARE and the NGO shall not require the consent of the NGO

(x) that, as a condition of award of this contract, and notwithstanding the conditions of any clause appearing thereon, CARE shall have unlimited rights in and to the technical data that emerges from this project

(y) The logos, trademarks, printed material, communications and training aids, intellectual property, and software developed using these project funds and under this project cannot be copywritten by the NGO, or any agent, individual, or subcontractor hired by the NGO Copyrights, registered logos, etc, that are already with the NGO before this Agreement would, however, be exempt CARE encourages the NGO to use and freely distribute the material developed during this project without claiming any copyright on the said material

4 CARE Covenants with the NGO as under

(a) to provide funds (subject to the availability) to the NGO for the project activities as mentioned in the project, a copy of which is appended as Schedule 'A' to this Agreement, subject to satisfactory progress of the project and receipt of timely progress and financial reports

(b) to provide technical/managerial support to the office bearers/staff of the NGO, if required, and resources are available for the same

(c) to provide a consolidated amount of US $313,767 as per the approved budget for the project life, subject to terms and other clauses as in this Agreement All payments by CARE to the NGO will be made by way of crossed cheque/bank draft in favor of the NGO

(d) The funds would be released to the NGO in Indian currency denominated installments, at the prevailing release date's US dollar to rupee exchange rate, subject to the satisfactory completion and acceptance thereof by CARE of activities, according to the following schedule

i) Initially, 50% of the annual current year's budgeted amount will be released as an advance on the signing of the agreement

ii) In the following quarter, 25% of that current year's annual budget will be released

iii) In the following quarter, an additional 25% of that current year's annual budget will be released

iv) In the following quarter, 25% of the following year's annual budget will be released

v) Next, the process outlined in steps ii – iv above shall be repeated and continued until the total consolidated budget amount has been funded

vi) The quarterly advance of funding is subject to the timely and thorough completion of project activities carried out according to plan

vii) Accounting will be done at the end of each year, and any surplus funds will be carried over to the following year's budget Upon completion of the project, a final accounting will be done and the NGO will reimburse to CARE any unused funds after CARE's review of the report and statement of expenses for the project

5 Allocation and release of funds to the NGO is contingent upon performance in the previous year, and availability of funds with CARE for conducting their activities in India or under this project

6 The NGO agrees to provide a consolidated in-kind contribution amount of Rs 1,81,39,422, the equivalent of US $431,891 at the current exchange rate of Rs 42 per US $1, towards the project, with both its own contribution and community match, as per the approved budget for the project life, subject to terms and other clauses as in this Agreement

7 The monitoring plans will be developed jointly by CARE and NGO CARE will organize an independent and external baseline, mid-term and final evaluation of the project, if required The NGO will modify the project or any part thereof, if warranted by the monitoring/appraisal studies, etc Such modification(s) will be by mutual agreement. The NGO agrees to maintain openness for monitoring visits to project area by CARE, Donor(s) and Government officials, whenever required, such plans of visits will be coordinated/ facilitated by CARE

8 CARE will assume no responsibility or liability for any injuries, death or any legal action in respect of office bearers/employees/agents/functionaries of the NGO arising out of any activity related to the project

9 The need for modifications/changes, if any, in this Agreement, during its life will be jointly assessed by CARE and NGO CARE's discretion in this regard is final

10 This Agreement will remain in force, unless terminated earlier, as provided under Clause '11' below, during the life of the project i e until the four-year anniversary from the date of signing by both the parties

11 Early termination, suspension of disbursement, and repayment thereof

CARE may not suspend disbursements unless

a Obligations under this Agreement or the project proposal and other agreed plans pertinent to the Agreement have been violated by the NGO
b The NGO fails to meet the standards referred to in the project and/or expected of it, as determined by CARE
c The NGO is unable to prove that the financial contribution has been used for the stipulated purpose
d Extraordinary circumstances arise that preclude or seriously jeopardize the implementation, the operation, or the purpose of the project
e Funds with CARE for the purpose of this project are no longer available

If any of the conditions as specified in (11a & 11b) occur, and has not been rectified within a period of 30 days or as determined by CARE, then CARE may demand immediate repayment from the

NGO, the entire disbursed amount However, in the case specified in 11 (c), demand the immediate repayment of such amount as the NGO is unable to prove to have been utilised for the stipulated purpose

WAIVER OF BREACH:
The failure of either party to this Agreement to object to or take affirmative action with respect to any conduct of the other which is in violation of the terms of this Agreement shall not be construed as waiver of such conduct

ARBITRATION.
Any dispute which is not settled by mutual agreement shall be at the option of either party and, upon written notice to the other party, be settled by arbitration The arbitration shall be conducted in accordance with the rules then prevailing of the American Arbitration Association Arbitration shall take place in New Delhi and the proceeding shall be held in English language In any such arbitration, there shall be appointed three arbitrators, one appointed by each of the parties and the third arbitrator, unless selected by agreement between the other arbitrators, shall be appointed by the American Arbitration Association.

NATURE OF DISBURSEMENTS:
The nature of disbursements under this Agreement by CARE are financial contributions / technical inputs to the approved project The financial contributions may therefore be in kind, convertible Foreign Currency or Indian Rupees at the discretion / availability of CARE and as such among other Acts and Regulations is specifically covered under the Foreign contribution (Regulation) Act 1976 in India as amended from time to time

IN WITNESS WHEREOF, the parties have signed on the day mentioned above

ON BEHALF OF CARE

ON BEHALF OF NGO

8/1/99.

Witnesses

1

2

Attachments
Schedule "A" Proposal
Schedule "B" Implementation plan
Schedule "C" Financial plan

1 Tom J Alcedo
2 Viraf M Mehta
3 K Gopalan
4 Sanjay Sinha

1 EXECUTIVE SUMMARY

Tata Steel Rural Development Society in collaboration with CARE INDIA proposes to make sustainable improvement in mother and child survival rates to advance "health for all" in India The institutes of this project will complement existing government services and enhance Govt of Bihars and government of India s national goal for reproductive and child health The duration of "child survival project" will be of four years 1998-2002"

Patamda Block of Singhbhum East district in Bihar is one of the most neglected block in terms of people residing in the area has the lowest literacy rate per capita income and amongst the highest rate of mortality The infant mortality rate is 94 per live births and the child mortality rate is 133, maternal mortality rate is 1490 The 56% of population residing in Patamda Block are tribals who are isolated from safe / healthy medical practices and supplies to influence the survival rates

Mother and child survival in Patamda Block will rest on reduction of infant mortality rate, child mortality rate, neonatal mortality rate and maternal mortality rate The IMR, NNR and MMR can be reduced to a large extent if we check the neonatal mortality as neonatal mortality is prime cause of less survival Approximately 62% of deaths in rural Bihar is only due to this The reduction of neonatal deaths will heavily depend on maternal health care of post-partam and spacing During the course of implementation of this project emphasis will be given to strengthen community operating partners to deliver the desired facility to target population

Child survival project will focus on initiatives to reduce mortality rate The important steps to be taken to achieve this will be as follows

* Healthy behaviour during pregnancy
* Antenatal care
* Preparation for safe delivery
* Consumption of Iron / folic acid
* Tetnus Toxoid Immunisation
* Use of safe birth kit
* Timely medical care
* Breast feeding (colostrum feeding)
* Complementary food consumption
* Immunisation of child
* Spacing of birth
* Strengthening of community based operating partners
* Creation of community health fund

All above mentioned parameters will be integrated and accordingly implemented in 162 villages of Patamda through community based operating partners CBOP The CBOP members will identify the target population and motivate them to attend monthly health days in their own village During the monthly health days TSRDS alongwith its field workers and technical team will provide essential services at doorstep To create community health fund will also be a prime job during such occasions

The achievements would be determined by involving outside agency to evaluate the progress during the project cycle and after completion of project The recommendations of the project will be shared amongst like minded corporate sectors/NGOs for replication

Health Care Services rendered by TSRDS is a integral part of TSRDS s development programmes Focus is given on providing preventive curative and specific health care services to far flung villages that are beyond the reach of other agencies These villages are covered through static and mobile medical units within the villages

The initiatives by TSRDS under Health and Hygiene cover followings activities

HEALTH AND HYGIENE

Preventive Health Care	Immunisation with triple antigen OPV, measles & BCG
	Prevention of night blindness Antihelmenthic programme
	Prevention of gastro intestinal disease through chlorination of wells
	Anti-Malaria interventions
Treatment for general ailments	Communicable diseases
	Skin
	Respiratory
	Gastro-Intestinal disorders
	Nutritional deficiency diseases
Treatment for specific ailments	Antenatal / Postnatal care
	Tuberculosis
	Leprosy
	Vasectomy / Tubectomy and adoption of temporary methods of family planning
	Aids and appliances for physically handicapped
	Rehabilitation for handicapped

Besides general health care we also net work with a vast array of like minded national and international organisations to solve specific health problems of rural people These ranges from visual, audio and orthopedic disorders to socially dreaded diseases such as Leprosy and Tuberculosis Eye care services mainly cataract operation is also a routine activity TSRDS has collaborated with following agencies to provide health services to rural people

S No	Name of Agency	Particulars
01	Sight Savers International, Mumbai	Eye Care Services and Community Based Rehabilitation
02	Impact India, Indian Railways UNDP, UNICEF & WHO	Life Line Express
03	Tata Council for Community Initiatives, Mumbai	Eye Care Services
04	NIRTAR Bhubneshwar	Aid Appliances for physical disorder

In Family Welfare and Mother and Child Care Programme TSRDS has been able to bring 3,400 couples opting to adopt Family Planning methods (97-98 only) A total of 23, 312 children were immunised under Pulse Polio Programme (97-98)

In 97-98 under Hygiene and Sanitation programme TSRDS has constructed 100 Low Cost Sanitary Toilets 500 existing drinking water wells in 157 villages wer renovated

Training to village level health workers, ANM's is also priority of our health interventions in the rural area The coverage of different activities carried out in the year 1997098 is given below

During the year 1997-98 our medical interventions has benefited around 1 8 lakh villagers from 723 villages

S No	Activities	Villages covered	No of Cases
01	General Treatment	723	1,35 919
02	Tuberculosis	283	735
03	Leprosy	332	2 605
04	Family Planning	427	3 405
05	Eye Care	058	1,045
06	Children Immunised	500	23,312
07	Low Cost Sanitary Toilets	023	100
08	Paramedical Training	054	170 Beneficiaries

2 INSTITUTIONAL CAPACITY

Promoted by the Tata Iron & Steel Co Ltd , the Tata Steel Rural Development Society was formally registered under the Societies Registration Act-1860 in 1979 The principal aims and objectives of the Society is to undertake promote, sponsor, assist or aid directly or in any other manner, any activity for the promotion and growth of rural economy and rural welfare or any other programmes for the promotion of socio-economic development and welfare or upliftment of the people in the rural areas in proximity to the company s establishments Over the years, Tata Steel Rural Development Society, has expanded its area of operation to include the villages surrounding Tata Steel's major business locations in the states of Bihar, Orissa and Madhya Pradesh

In implementing its rural development initiatives, Tata Steel Rural Development Society seeks to involve the local community in the various stages leading to project implementation and this is increasingly validated by the growing levels of community participation and sense of stakeholding in such projects Towards this end, Tata Steel Rural Development Society seeks to mobilise human, technical and financial resources from a wide range of national and international, governmental and non-governmental agencies involved in community development work

TSRDS mission is to work as an enabler To provide effective development programme to the local community through their active involvement, participation and to work in partnership with all sectors involved in developmental work

The following Thrust areas have been identified for Tata Steel Rural Development Society

- Drinking Water Project
- Rural Health and Hygiene
- Agriculture extension and Irrigation
- Education, Literacy and Awareness building
- Women's Development Activities
- Youth Development
- Income Generation Programmes

The scope of activities of Tata Steel Rural Development Society ranges from building rural infrastructure to promoting of art and culture and spotting and nurturing sporting talents in the villages, construction of link roads, culverts, developing water resources both for irrigation and domestic use, drilling tube-wells, assisting farmers to adopt improved methods of cultivation, animal husbandry, repairing, construction of school buildings and community halls, promotion of rural industry and entrepreneurship adult literacy, empowerment of women and youth medical services, rural sanitation and promotion of rural handicrafts It also operates regular mobile medical services, conducts family planning and eye-cure camps at the regular intervals

at different village sites It has embarked upon scientific programmes for the rehabilitation of the visually and physically disabled and for the protection and preservation of endangered tribes such as the Birhores, Sabars etc

TSRDS also firmly believes that the task of rural development for a country like ours is not an easy one and it cannot be left solely to the Government nor can it be delegated to some enlightened industries or a few voluntary organisations It needs much greater interaction and widespread participation TSRDS has received their support in various forms such as land, labour, manpower, money or materials Sometimes this participation is manifested in the sharing of knowledge or skills

During the year 1997-98 TSRDS as a whole has worked in 723 villages spending Rs 3 10 crores from its own budget, Rs 0 18 crores from contribution received from Community and Rs 0 83 crores mobilised through different resources The budget for 1998-99 fiscal year is Rs 3 31 crores and target for resource mobilisation is Rs 1 crore Besides harnessing fund from community through their contribution 288 TSRDS employees and 66 Tisco employees are engaged in rural development activities Following given is detail of other activities carried out by TSRDS for enrichment of Rural People

1 AGRICULTURE & IRRIGATION

- Assistance to farmers for agricultural equipments
- Community-based lift Irrigation projects
- Construction of irrigation infrastructure
- Training & demonstration to farmers

2 DRINKING WATER

- Construction of wells
- Drinking water improvement programmes
- Installation of tubewells
- Repair of tubewells
- Repairs of wells

3 EDUCATION

- Assistance for Literacy Programmes
- Construction & Repair of Educational infrastructure
- Provision of educational aids & material assistance
- Skill development training for teachers

4 FORESTRY / AFFORESTATION PROGRAMME

- Formation of Save Forest Groups
- Motivation & awareness on forestry & afforestation
- Raising of saplings

5 YOUTH DEVELOPMENT & SPORTS

- Conducting Meets/Competition (in Athletics Archery Cycling, Football)
- Coaching (general/specialized in Athletics Archery Cycling Football)
- Formation of teams (in Athletics, Archery, Cycling, Football)
- Participation in competitive tournaments

6 ANIMAL HUSBANDRY

- Assistance for construction & repair of animal sheds
- Assistance for procurement of animals/birds/ducklings/fingerlings
- Treatment & vaccination of animals
- Veterinary training to farmers

7 IMPROVING QUALITY OF LIFE .

- Assistance for Gobar gas plants
- Construction of low cost toilets
- Construction of rural sanitation infrastructure (drains, culverts)
- Construction & repair of link roads

8 WOMEN'S DEVELOPMENT PROGRAMME

- Formation of Women Groups
- Mahila Vikas Melas & Workshops
- Training (Kushal grihani, Literacy, Sewing, Embroidery, Fabric, Painting, Good House Keeping etc)

9 VOCATIONAL TRAINING / INCOME GENERATION SCHEME

- Assistance for income generation programmes (Nursery raising, Shops, Poultry etc)
- Training (Handloom, Tubewell & Pumpset repairing Paraveterinary, Leaf plate making etc)

Performance Highlights for 1997-98 is as follows

TSRDS

PERFORMANCE HIGHLIGHTS

APRIL 1997 - MARCH 1998

	Activities	Particulars Beneficiaries	Villages covered
1	**AGRICULTURE EXTENSION & IRRIGATION**		
	• Field crop demonstration plots	258 nos	76
	• Training to farmers	4234 beneficiaries	144
	• Pumpsets distributed	13 nos	12
	• Delivery pipes distributed	1252 ft	3
	• Community based lift irrigation projects	22 nos	21
	• Land brought under cultivation (rabi & zaid)	391 8 acres	25
2	**DRINKING WATER PROJECT**		
	• Tubewells installed	59 nos	52
	• Tubewells repaired	262 nos	134
	• Open/ring wells constructed	29 nos	29
	• Wells repaired	44 nos	29
3	**HEALTH & HYGIENE**		
	• Treated through mobile & static clinics for General ailments	135919 Cases	723
	• Special focus on specific health		
	Tuberculosis	735 cases	283
	Leprosy	2604 cases	332
	Family planning methods adopted	3405 cases	427
	Eye-care services	1045 cases	458
	Help to physically handicapped	22 cases	12
	Preventive health		
	Children immunized	23312 children	500
	Vaccines administered (BCG TT Measles Vit 'A')	11105 doses	501
	Construction of low cost toilets	100 nos	23
	Para-medical training	170 beneficiaries	54

	Activities	Particulars Beneficiaries	Villages covered
4	**ANIMAL HUSBANDRY**		
	• Animals / birds treated / vaccinated	14368 nos	447
	• Animals / birds / ducking distributed	2162 nos	22
	• Veterinary training	1756 beneficiaries	99
5	**EDUCATIONAL PROGRAMME**		
	• Schools constructed	8 nos	29
	• Schools repaired	41 nos	37
	• Education material assistance to	28 schools	112
	• Assistance for pre / adult literacy classes	29 nos	29
6	**FORESTRY / AFFORESTATION PROGRAMME**		
	• Saplings raised	665532 nos	33
	• Acreage brought under plantation	192 24 acres	147
	• Material assistance for gobar gas plant	20 nos	2
7	**SPORTS & CULTURAL ACTIVITIES**		
	• Meets / tournaments / coaching camps conducted	59 nos	431
	• Participation in outside meets / tournaments	21 nos	28
	• Cultural programmes	17 nos	104
8	**WOMEN'S DEVELOPMENT PROGRAMME**		
	• Training (Good housekeeping, sewing, embroidery, kitchen garden, kushal grihani, literacy, fabric painting etc)	942 beneficiaries	58
	• Mahila samities formed	28 nos	35
9	**VOCATIONAL TRAINING / INCOME GENERATION SCHEME**		
	• Training (Ascence stick & leaf plate making, tractor, television, tubewell and pumpset repairing, smokeless chullhas, para-veterinary, motor driving handloom)	202 beneficiaries	34
	• Assistance for income generation programmes (Nursery raising, band party formation flour grinding stone, betal shop, vegetable selling, tubewell repairing toolkits)	338 beneficiaries	26

Award conferred to TSRDS is as follows

YEAR	AWARD	CONFERRED UPON
1983	Federation of Indian Chambers of Commerce and Industry (FICCI) Award for outstanding achievement in Rural Development	TATA STEEL RURAL DEVELOPMENT SOCIETY
1989	Federation of Indian Chambers of Commerce and Industry (FICCI) Award for outstanding achievement in Rural Development	TATA STEEL RURAL DEVELOPMENT SOCIETY
1997	Hong Kong Foundation International Award by Rehabilitation Co-ordination India (RCI) for outstanding performance with multiple handicaps (RCI is the National Chapter of Re-habilitation International, New YorK, USA)	TATA STEEL RURAL DEVELOPMENT SOCIETY
1997-98	Federation of Indian Chambers of Commerce and Industry (FICCI) Award for outstanding achievement in Rural Development	TATA STEEL RURAL DEVELOPMENT SOCIETY

Annex E – Business Plan

Overview

The Child Survival Project is a 4-year collaborative effort between CARE-India and two Tata-sponsored NGOs in 262 villages in the E Singbhum district of southern Bihar This USAID-financed initiative seeks to address high childhood mortality through four primary interventions with a proven association in enhancing child survival – antenatal care, immunizations, infant feeding, and family spacing

The primary objective of this business plan is to outline the process by which CARE-India, Tata Steel Rural Development Society (TSRDS), and Parivar Kalyan Sansthan (PKS), respectively, can improve the financial viability of the 25 outreach clinics that form a key means of health service delivery in the project area While both NGOs have experience operating health clinics and collecting fees-for-services rendered, no attempts have been made to create a framework that could quantify the potential impact that community funds can have vis-a-vis the long-term feasibility of such clinics

Initial Steps

Quantifying Costs and Identifying Expenditures to be Recovered

The costs that should be financed at the community level should include variable costs (as opposed to fixed costs) less salary expenditures The rationale for excluding the wage component is that the personnel-line item can often account for over 50% of business expenses and it would be unrealistic for poor communities to be able to assume this financial burden within the project period Parenthetically, the Bamako Initiative (BI) assumed a similar framework for many of its community financing objectives

In order to quantify costs, we would 1) look at historical expenses with respect to operating rural clinics as evidenced in operating expenses over the last three years and adjust such figures to take account for economies of scale, 2) analyze the projected clinic budget for the life of the project, and 3) attempt to identify the costs that other rural service providers incur for similar activities After establishing total costs necessary to operate the clinics, fixed costs and wages and salaries (as previously mentioned) would be subtracted in order to reach a final figure This figure would be the amount that the project would seek to recover Additionally, as the outlays for medicines often account for a significant amount of variable costs, we would pay careful attention to items related to the procurement of drugs and supplies to identify if these were acquired free of cost (via GOI channels) or if expenses were borne for them

Identifying Potential Revenue Streams and Projected Annual Revenue Mobilization

After quantifying the amount of funds that communities would need to generate to make sustainability a reality, the Child Survival Team would seek to assess the potential proceeds that various revenue streams may be able to generate on an annual basis These revenue streams would primarily be functions of the number of participants, contribution amount, and number of contributions per annum Emphasis would be placed on understanding these components

While the outreach health clinics have charged fees-for-service (or user-fees) without any historical resistance, the project would attempt to enhance this amount over a period of time by 1) increasing the fee beyond a minimal token amount to something more substantiative (for example, raising the fee from Rs 1 to Rs 5), 2) offering additional services for which a separate contribution would be required (i e STD tests), 3) requiring payment (fully or partially) for some medications, and 4) creating other such services which would require a financial outlay

Apart from fee-for-services, the other major source of contributions that is envisioned would come from community health funds Under CARE-India's Integrated Nutrition and Health Program (INHP) individuals contribute Rs 5 to take part in a monthly village Nutrition & Health Day (NHD) in which immunizations take place, health education provided, ANC check-ups occur and corn soya blend and vegetable oil distributed The key to the success of such NHDs is that the service providers (including the AWW and ANM) converge at a fixed place, at a set time, within the village itself in order to become a very convenient (not to mention regular) service An identical process is envisioned for the Child Survival Project and such funds could serve to subsidize the costs of operating the rural clinics

While fees-for-service and community health funds should make up the bulk of community contributions, PKS has explored the option of providing rural health insurance to project participants While this initiative has to be further explored, it is conceivable that a portion of any premium would go to the clinics for providing tertiary-level treatment, thus augmenting sustainability Finally, community donations or matching funds (from NGOs, donors, or interested individuals) – which may not be a recurring phenomenon – could also serve to enhance the viability of the clinics

After cost and revenue schedules have been created, a way to measure the sustainability of the outreach clinics needs to occur We have defined the financial viability of clinic activities to be the aggregate revenue collection with respect to non-salary recurring costs necessary to operate all outreach clinics in a given year, as expressed in a percentage form For example, if the total revenue realized for operating the clinics is Rs 200,000 and the non-salary variable costs are Rs 300,000, then the initiative will be defined to be 67% sustainable Under this given definition, the project would seek to become 100% sustainable by the end of 4 years

Community Mobilization

Both TSRDS and PKS have years of experience working in E Singhbhum district and have established tremendous credibility in these communities Concurrent with analyzing revenues and costs Child Survival community-based workers (CBWs) will discuss with communities the services which the mobile clinics will provide and the communities' responsibility in engaging in these activities While a fee-for-service concept is nothing new for many of these communities, three benefits of fee-for-services will be heavily promoted – enhanced government service, improved quality of care, and sustainability

Government Services – the concept of user-fees will be described as a means to improve government health services A recent World Bank paper states the "By charging fees for services that primarily benefit the user, such as tertiary-level curative care, governments can free up and reallocated tax-finance health expenditures to activities that yield benefits that extend beyond the individual These include public health services directed to community health, immunizations, and communicable diseases [7]" While program participant are, justifiably, cynical to claims that the only bottleneck preventing better health services is a lack of funds, the point remains that user-fees increase the likelihood of this possibility

Quality of Care – while enhancing government services is not an area that the NGOs can directly affect, it can most certainly have an impact on the quality of care Issues such as shorter waiting times, adequate stock of medicines, professionalism enhanced services, etc , can improve as a result of these fees A study in Africa categorically states that "any endeavor to boost local-level revenues is likely to have a positive

[7] World Bank Discussion Papers, Africa Technical Department Series # 294 *Financing Health Services through User Fees and Insurance - Case Studies from Sub-Saharan Africa*, edited by R Paul Shaw and Martha Ainsworth Article entitled *User Fees in Sub-Saharan Africa Aims Findings Policy Implications* by R Paul Shaw, p 7

impact on the quality of care," and this thought will not be lost among the participants or the service providers P-18

Sustainability – attempts to finance some health activities at the grassroots level will insulate such projects from funding shocks that occur as a result of political expedience, economic sanctions, donor priorities, and other such whims "Revenue generation, through higher prices, is usually necessary to finance higher quality services on a sustainable basis P 118)" and "improving basic services such as vaccinations, child care and the availability of drugs is likely to have a significant effect on demand for health care" thus reinforcing financial viability

Corporate Philosophy – As both NGO project partners are sponsored by corporate houses, we feel that promoting user-fees will only serve to make the clinics more effective health service delivery vehicles Specifically, because user-fees are usually retained at the local level, community contribution tends to increase efficiency and a more vigil watch is kept on expenses In Zimbabwe, it was found that fees "enhance efficiency by deterring consumers from seeking unnecessary "fee" care, and by encouraging hospital and clinic managers to be more cost conscious (p 43) " Furthermore, as with most other services, enhanced quality of service delivery tends to increase the number of people seeking to access that service – i e it leads to a broadening of customer base - thereby increasing potential revenue Collectively, increased efficiency and more participants should serve to increase the likelihood for success in meeting this business plan's objectives Additionally, as sustainability (as some level) is realized corporate houses can choose to decrease their own financial outlay to maintain the same level of services or contribute the same amount for development activities but over a larger population base Either way, community contributions should serve only to make the mobile health clinics more efficient

Annex F – IMCI Package

An evaluation of the 5-day IMCI package for Basic Health Workers in India

Executive Summary

Of the 25 million children born in India every year, approximately 2 7 million die before completing five years of age 70% of these deaths can be attributed to five cause -pneumonia, diarrhea, malaria, measles and malnutrition or some combination of them The lessons learned from disease-specific control programs have been used to develop a single efficient and effective approach to managing childhood illnesses-The integrated Management of Childhood Illnesses A large number of sick children in India are brought to the Basic Health Workers (BHWs) who often are the first contact for the sick child in the community CARE India, in collaboration with WHO and other partners, in 1996, developed simplified guidelines for IMCI together with a 5-day training package However, no formal evaluation of the efficacy or effectiveness of the package has been performed Under the present proposal the BHW package will be reviewed and revised in the light of these experiences and developments, an assessment of its validity in the Indian context will be made, and its effectiveness in improving the quality of care and counseling provided by BHWs will be evaluated

Background

The Integrated Management of Childhood Illnesses (IMCI) is a strategy to improve child health based on the recognition that some 70% of child deaths in developing countries can be attributed to five causes (pneumonia, diarrhea, malaria, measles and malnutrition) or some combination of them and that in the past some opportunities to prevent or treat these conditions have been overlooked About 12 4 million children under the age of 5 years die every year in developing countries Countries in South East Asia Region (SEAR) contribute to nearly 40% of these deaths More than 9 out of 10 of these deaths occur in five countries of the region, which include Bangladesh, India, Indonesia, Myanmar and Nepal Besides mortality, the infections and malnutrition drain the meager resources by contributing to the morbidity statistics in these countries Of the 25 million children born in India every year, approximately 2 7 million die before completing five years of age Of these, nearly two thirds, close to 2 million children die before reaching the age of one India has the unfortunate distinction of having nearly 75 million malnourished under five children In terms of proportion, 63% of under-five children are undernourished in India Compared with the risks facing a well-nourished child, the risk of death from common childhood diseases is doubled for a mildly malnourished child, and may be eight times for a severely malnourished child

As part of this strategy, The WHO Division of child health and development in collaboration with ten other WHO programs, UNICEF and International Institutions developed an integrated case management training course for the first level care providers called Integrated Management of Childhood Illnesses (IMCI) which provides guidelines to assist health workers to assess, classify and treat children The course was pre-tested in Gondar, Ethiopia in 1994 and the first international course was organized in Tanzania in 1995 The final generic version of the course was established in 1996 These guidelines prompt health workers to check for all of the important conditions listed above and to refer or treat the child as necessary They also prompt the health worker to immunize children who are not fully up-to-date, and to counsel the caretaker with respect to the child's feeding, with respect to fluid intake during illness and with respect to when the child should return to see the health worker

A large number of sick children in India are brought to the Basic Health Workers (BHWs) who often are the first contact for the sick child in the community and provide services through health posts and/or on a domiciliary basis There are a large number of different categories of grassroots level workers who can be

classified as Basic Health Workers, although a standardized definition of who constitutes this group is not available They consist of Village Health Workers, Midwives, Community Health Workers, Auxiliary Nurse Midwives, Health Assistants, Anganwadi Worker or the Multi-Purpose Worker The NGOs also have their own cadre of basic health workers

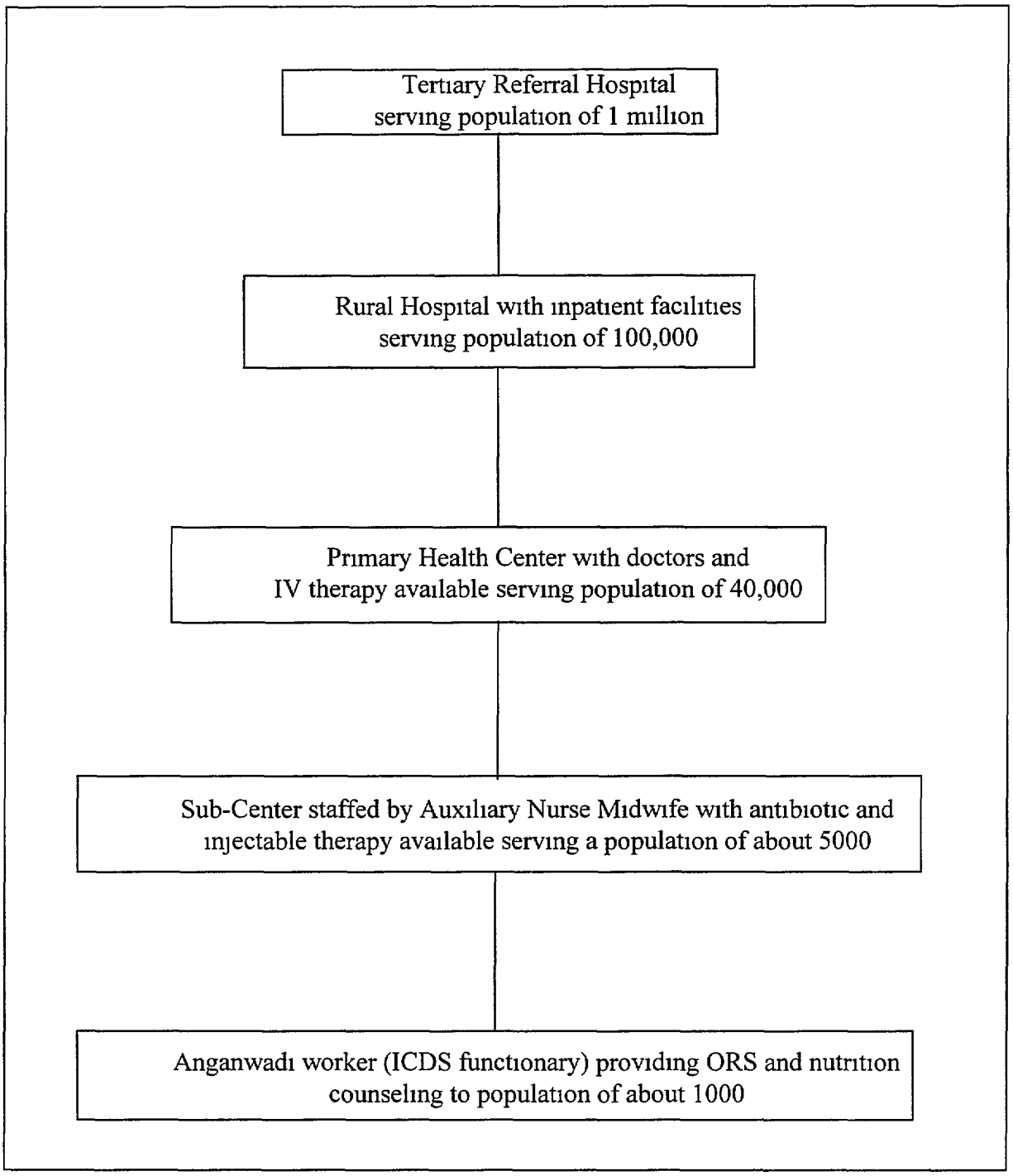
In theory, the Government of India (GOI) health services that are available to the rural population have a number of levels and are free of charge In practice, staffing problems mean that posts are not filled and not all of these levels are fully functional In addition to GOI services, there are numerous private health care providers with variable levels of training and skills

In the GOI system the tertiary referral hospitals are located in urban areas (Figure 1) Each such hospital serves a large population (between 0 6 to 1 million people) but may be many hours distant from a large proportion of that population Below the tertiary referral hospitals are rural hospitals with inpatient facilities, located in the rural areas themselves and typically serving populations of about 100 000 Below the rural hospitals lie the Primary Health Centres (PHCs) Each PHC serves a population of 30-40,000 and includes doctors on the staff However, these doctors may not live in the village in which the PHC is based, preferring to commute from the local town Facilities for intravenous therapy are available at this level along with a small number of beds

The most peripheral fixed health facilities are called Sub-Centers Each Sub-Center serves a population of around 5,000 (5-6 villages) An Auxiliary Nurse Midwife (ANM) with 18 months initial training staffs most Sub-Centers ANMs can prescribe and provide antibiotics, and deliver injections including immunizations, although because of problems with the cold chain ANMs receive supplies of vaccine only once a week and must then use these by the next day

More peripheral still than the ANMs are Anganwadi or Community-Based Workers (one per village), who are members of the ICDS system and not the health system Typically, these are local women with primary school education who have been trained to focus on child development, deliver ORS to children with diarrhea, to assist ANMs with immunization (but not to perform immunization themselves), and to counsel mothers on child feeding In some states, Anganwadi workers have also been trained to identify children with pneumonia and to prescribe antibiotics to such children

Figure 1 Structure of government health services in India



The 11-day IMCI training package developed by WHO is appropriate, in the Indian context, for staff working in PHCs The guidelines are, however, too complex for staff working at a more peripheral level (ANMs, Anganwadi Workers) (In addition, an 11-day course is considered too costly in terms of the total amount of training time available) Yet, in the public sector, these are the workers with whom the majority of sick children and children at risk will first come into contact In India (and other Asian countries) there is, therefore, a need for a more basic package for these, based on simplified guidelines

CARE India, in collaboration with WHO/South East Asian Regional Organization, the National Institute of Public Cooperation and Child Development (NIPCCD), the National Institute of Health and Family Welfare (NIHFW) and Society for Woman and Child Health (SWACH), in 1996, developed simplified guidelines for IMCI together with a 5-day training package The process of simplification involved series of workshop attended by stakeholders and field testing in six different of states of India

The most important simplifications made were the following

Reducing the number of general danger signs explicitly checked for from 4 to 2 (omitting questions concerning vomiting and convulsions),

Omitting the assessment of stridor for children with cough

Reducing the number of signs of dehydration examined for in children with diarrhea (retaining skin pinch and eagerness to drink and dropping examination for sunken eyes and assessment of restlessness/irritability)

Prescribing only Paracetamol for children with fever

Omitting the section on ear complaints

Between August 1996 and March 1997 this 5-day package was field tested in workshops in 7 different locations of six states (Bihar, Madhya Pradesh, Orissa, West Bengal, Uttar Pradesh and Rajasthan) of India More than 150 BHWs and 50 supervisors attended these workshops The experience of these workshops provided grounds for optimism that the 5-day package can improve the ability of BHWs to manage or refer sick children and to counsel their caretakers However, no formal evaluation of the efficacy or effectiveness of the package has been performed Furthermore, areas of improvement were identified

The language level of the written material needs to be simplified further to be appropriate to the literacy skills of many BHWs,

More pictorial aides could improve the printed material, particularly in the assessment, classification and treatment chart,

BHWs had difficulty distinguishing between "slow skin pinch" and "very slow skin pinch" and between "some palmar pallor" and "severe palmar pallor"

In addition, WHO/SEARO has developed further the guidelines for the treatment of fever cases to include treatment for malaria

Under the present proposal the BHW package will be reviewed and revised in the light of these experiences and developments, an assessment of its validity in the Indian context will be made, and its effectiveness in improving the quality of care and counseling provided by BHWs will be evaluated Ministry of health in India has been oriented to the generic 11-day version and there is a keen interest to adopt it to the local needs The utility of the integrated strategy at the community level is well appreciated by the government The length of the course may create impediments for incorporation into the national

health curriculum Positive findings from such an evaluation would provide powerful support for the argument that the package merits the allocation of scarce Ministry of Health training resources

Aim
To evaluate the extent to which BHW package can improve the health care received by children at the peripheral level

Objectives
To revise and improve the existing simplified IMCI guidelines and the associated 5-day training course materials

To determine the validity of the assessment, classification and treatment guidelines upon which the 5-day IMCI package is based

To evaluate the ability of BHWs to assess, classify, and provide appropriate health care to children 6 months after undergoing the 5-day IMCI package

To quantify the extent to which the 5-day IMCI package results in increased identification by BHWs of illness and opportunities to offer preventive and curative care

Study Description
Objective 1 To revise and improve the existing simplified IMCI guidelines and the associated 5-day training course materials

The revisions will be based on the recommendations which emerged from the Echo workshops and on a review of the package by 4-5 external experts In preparing the materials particular attention will be paid to the level of language used Pictures will be used wherever possible The revised material will be translated from English into Hindi and/or Bangla and then back-translated by independent translators to check the quality of the translation

Objective 2 To determine the validity of the simplified assessment, classification and treatment guidelines upon which the 5-day IMCI package is based

This component of the study will be performed by practicing pediatricians working in a tertiary referral hospital A referral hospital is chosen for this purpose to ensure that an adequate number of severely ill children are included, enabling an assessment to be made of the adequacy of the referral criteria to be made The rationale underlying the IMCI strategy and the simplified guidelines and the purpose of the study will be explained to the participating pediatricians Only pediatricians with an understanding of the strategy will be invited to participate For each child examined the pediatrician will record on a standard form the presence/absence of all the signs and symptoms included in the simplified IMCI guidelines In addition, she will record her own diagnosis, based on her clinical experience, and the treatment prescribed for the child These data will be entered onto microcomputer using Epi-Info (?) The classification and treatment recommended under the simplified IMCI guidelines will be identified and compared with pediatrician's diagnosis and treatment choice Based on this comparison the sensitivities and specificities of the referral and diagnostic criteria will be estimated using the indicators shown in the box below A minimum of 200 children will be included in the study

This approach differs somewhat from studies conducted in The Gambia, Kenya and Ethiopia (reference) using the generic IMCI guidelines These studies compared IMCI assessments made by trained health workers with diagnoses and treatment decisions made by pediatricians In these studies the sensitivities and specificities calculated are a compound measure of the validity of the guidelines and of the ability of the health worker to apply them (The rationale underlying the approach that we propose to use is that we wish to establish the validity of the guidelines) We shall assess the ability of the BHW to apply the guidelines in another component of the study

Indicators for assessing the validity of the simplified guidelines

proportion of children needing referral who are correctly classified as such,

proportion of children not needing referral who are correctly classified as such,

proportion of children needing antibiotic therapy who are correctly classified as such,

proportion of children not needing antibiotic therapy who are correctly classified as such,

proportion of children with severe dehydration who are correctly classified as such,
indicator for anemia

Objectives 3 and 4 To evaluate the ability of BHWs to assess, classify, and provide appropriate health care to children after undergoing the 5-day IMCI package, to quantify the extent to which the 5-day IMCI package results in increased identification by BHWs of illness and opportunities to offer preventive and curative care

These objectives will be addressed in a randomized, controlled trial involving the implementation of the simplified IMCI package in a fashion as close as possible to that in which it might be implemented nationally Thus, the trial aims to evaluate the effectiveness of the package rather than its efficacy In outline, 100 randomly selected, literate BHWs and their supervisors (Lady Health Visitors - LHVs) will attend 5-day IMCI courses run by medical officers trained in IMCI After approximately 6 weeks, the LHVs will perform the recommended follow-up supervisory visit Approximately 6 months after attending the 5-day course, BHWs will be visited by trained assessors who will observe the BHWs at work, record information on the activities performed by the BHW, make their own assessment of the children seen by the BHWs according to the simplified IMCI guidelines, and conduct exit interviews with the child's caretaker These assessors will also visit 100 randomly selected, literate BHWs who have not attended the 5-day IMCI course and perform the same assessment

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Activity Description

Stage 1 training of trainers, supervisors and trainees
Initially a workshop will be held to train 8-10 medical officers who would usually train BHWs "Master Trainers" will perform this training An independent observer will attend the course to document the training process These medical officers will form two training teams who will then hold workshops with randomly selected, literate BHWs and their supervisors at which the 5-day IMCI package will be used An independent observer who will document the training process will also attend these workshops The Medical Officers would also be trained to carry out the final evaluation two months and six months after the training All the training will be conducted in the

Stage 2 follow-up, supervisory visits
Approximately 6 weeks after attending the 5-day IMCI workshop, BHWs will be visited by their supervisor (LHVs) for the standard follow-up, supervisory visit prescribed under the IMCI strategy

Stage 3 assessment of BHW performance
Approximately 6 months after completion of the 5-day IMCI course, the trained BHWs (the intervention group) will be visited by a trained assessor (These assessors will be individuals with good clinical skills who have received training in IMCI and training in the assessment of BHWs using the study instrument) They will spend a day with each BHW observing their performance, making an independent assessment of the children seen by the BHW and performing an exit interview with caretakers to check the caretaker's understanding of any counseling provided by the BHW and to assess "caretaker satisfaction" with the service provided Over the same period the assessors will visit a control group of 100 BHWs who did not undergo the 5-day IMCI course and record the same information for the intervention group Health worker performance will be assessed through a number of indicators shown in the box below

Objective 3 (to evaluate the ability of BHWs to assess, classify, and provide appropriate health care to children after undergoing the 5-day IMCI package) will be achieved by estimation of the indicators below for the BHWs in the intervention group Confidence intervals around these point estimates will be derived using Huber's sandwich estimator to take into account the 'repeated measures" nature of the data (each BHW may see several children)

Objective 4 (to quantify the extent to which the 5-day IMCI package results in increased identification by BHWs of illness and opportunities to offer preventive and curative care) will be achieved by a comparison of the intervention and control groups with respect to the key indicators These analyses will be conducted use the Generalized Estimating Equations (GEE) approach to take account of the repeated measures

Indicators of BHW performance

Process indicators

% of children checked for cough, diarrhea and fever,
% of children with cough whose respiratory rate is measured,
% of children with diarrhea assessed for dehydration,
% of children weighed and checked against a growth chart,
% of children under 2 years of age whose caretakers receive feeding advice,
% of mothers who receive advice on when to return,
% of children whose vaccination status checked,

Quality indicators

% of children needing antibiotic therapy who are correctly classified as such,
% of children not needing antibiotic therapy who are correctly classified as such,
% of children with dehydration who are treated with ORS,
% of very low weight-for-age children who are identified as such
% of children identified as having more than one of the following complaints, cough, fever, diarrhea, low weight-for-age,
% of sick children who are incompletely immunized for their age who are identified as such,
% of caretakers receiving feeding advice who can recall the advice received,
% of caretakers receiving advice on when to return who can recall the advice,
% of caretakers receiving "good quality" counseling
% of caretakers rating the quality of the service as "good" or "very good"

Sample size

The table below indicates sample sizes required to detect a difference in proportions between two groups

Table Sample sizes required to detect a difference in proportions between two groups (assuming 5% level of significance and 80% power)

		Control group					
		1%	5%	10%	20%	30%	40%
Intervention Group	1%						
	5%	332					
	10%	121	474				
	20%	50	88	219			
	30%	30	43	71	313		
	40%	20	27	38	91	376	
	50%	15	18	24	45	103	407
	60%	11	14	17	27	48	107
	70%	9	10	12	18	28	48
	80%	7	8	9	13	18	27

The choice of sample size is complicated by two factors First there is little information on the current levels of the indicators among BHWs Furthermore, the structure of the data is complex, with two levels At one level (the BHW) the observations are independent However, observations of different children seen by the same BHW will not be independent The chosen sample size (100 BHWs in each group) will provide a minimum of 100 independent observations within each arm With several children observed per BHW, the effective sample size may be somewhat larger than this The table indicates that 100-120 independent observations in each group would be sufficient to detect changes from 1 to 10%, from 5 to 20%, from 10 to 30%, from 30 to 50%, etc The choice of sample size is thus based on practicality (such a trial size can be managed) and on the basis that it will enable the study to detect important changes in the indicators of interest

Monitoring and Evaluation

The process of package evaluation would be monitored for the quality of training, participation, data collection and analysis

Timetable

Revision and translation of training materials	3 months
Training of trainers, BHWs and their supervisors	2 months
Supervisory follow-up visits to trainees	2 months
Delay between supervisory visit and assessment during this period assessors will be trained	4 months
Revision and translation of training materials	3 months
Training of trainers, BHWs and their supervisors	2 months
Supervisory follow-up visits to trainees	2 months
Delay between supervisory visit and assessment during this period assessors will be trained)	4 months
Assessment of BHW performance	3 months
Data entry, analysis and report writing	4 months
Total	18 months

Annex G – Qualitative Survey Plan

Scope of Work for Ravi Verma and Burt Pelto– IIPS

The consultant's role shall be conducted in five phases commencing October 1, 1999 and ending December 31, 1999 as described below

Phase I – October 1999

- Identify gaps between Child Survival Base-Line Survey data and health seeking behaviors in order to discuss with Child Survival staff which specific issues vis-a-vis four health interventions (ANC, breastfeeding, immunizations, and family spacing) the qualitative research should seek to address Research should be limited to no more than two specific sub-issues with respect to any one particular intervention and should be confirmed by the Director – Health, CARE-India

Phase II – November 1999

- Co-conduct a training for Child Survival personnel (CARE, TSRDS, PKS, and Govt of Bihar staff) which includes

    1 Rationale for qualitative research
    2 Various data collection methods and processes (i e transcriptions, focus group discussions, in-depth interviews, direct observations, verbal autopsies, etc)
    3 Introduction to data analysis and documentation

- Finalize a study plan and prepare interviewer guides for field researchers Interviewer guides should be created in English

- Conduct field-based research to demonstrate the practical application of training curriculum

- Observe trainees' field-based data collection as a precursor to the actual survey

Phase III – November 1999

- Initiate field-based research and supervise the entire data collection process

Phase IV – December 1999

- Teach researchers about data analysis procedures (including orientation to appropriate computer software) and documentation of qualitative research findings

- Act as team leader in reviewing qualitative data analysis and manage the documentation of findings

Phase V – December 1999

- Prepare a Final Report with assistance from Child Survival personnel Although the Final Report will be a collaborative effort, the consultant remains ultimately responsible for the document (including text, analysis, layout, etc)

Annex H – Needs Assessment Form

TRAINING NEEDS ASSESSMENT - Field Officers

Note This questionnaire is not a personal test but an evaluatory tool to assess the extent of your understanding and knowledge to the given responsibilities The outcome of this assessment will enable program planners in providing opportunities for staff capacity building to meet the health program and organizational needs

Name Age

State Project

I PERSONAL DATA

1 How long have you been working with the project?

S No	Title	Location	Duration

2 Your educational qualifications

S No	Educational qualifications received	Duration	Year	Subject Specialities

3 Any other technical qualifications received? Yes/No

If yes, kindly give details

S NO	Educational qualifications received	Duration	Year

II KNOWLEDGE/PERCEPTION OF ORGANIZATIONAL OBJECTIVES

4 Are you aware of the paradigm shift of the project towards attaining sustainable behavioral change? Yes/No

5 If yes, are you appreciative of this shift? Yes/No

6 If no, give reasons

7 Do you feel competent enough to deal with the shift towards improving maternal and child health? Yes/No

8 If no, what are the limitations?

(i) Lack of technical know-how
(ii) Lack of managing abilities
(iii) Lack of job specifications
(iv) Absence of vertical support from above and below
(v) Any other (specify) _____

9 Can you specifically state the technical and strategic objectives of Health program of the project?

4	3	2	1	0
able to list 4-5 objectives definitely	able to list 3 objectives definitely	able to list at least 2 definitely	but not able to list definitely	unable to list

III ASSESSING TECHNICAL/MANAGEMENT SKILLS

10 Among the following, what areas would you like to learn more about

FUNCTIONS	TASKS	Tick where applicable
A Ante-natal care	• Components • Case finding • Physical examination	
B Essential Obstetric Care (EOC)	• Rationale • Components • Barriers to timely and appropriate EOC • Best Practices • Complications	
C Maternal Nutrition	• Factors contributing to maternal mortality • Maternal malnutrition • Role of vital nutrients and consequences of their deficiency	
D Newborn Care	• General danger signs • Asphyxia & its management • Hypothermia and its management • Care of low birth weight	
E Breast feeding	• Exclusive breastfeeding • Prelacteals • Anatomy of breast • Mechanism of breast milk production-role of prolactin and oxytocin	
F Integrated Management of Childhood illness	• Objectives and Strategy • Training of Basic Health Workers (BHWs)	
G Immunization	• Immunization eligibility & requirements • Methodology of Immunization • Precautions • Cold Chain • Adverse reaction • Monitoring of immunization session in community	
H Complementary Feeding	• Energy and nutrient requirements of young children • Problem nutrients • Supplementary nutrition	

11 Under the functions mentioned below, kindly indicate your tasks

Sl No	FUNCTIONS	TASKS

1	Planning	i) ii) iii) iv)
2	Liaison/Coordination/Net working	i) ii) iii) iv)
3	Supportive supervision	i) ii) iii) iv)
4	Monitoring	i) ii) iii) iv)
5	Accounting	i) ii) iii) iv)
6	Reporting/Documentation	i) ii) iii) iv)
7	Any other	

12 How do you perceive your relationship with the government health functionaries of your area

i) Supportive
ii) Hindering your work
iii) Nothing to do with them
iv) Any other (specify) _____

13 How do you view your present relationship with your supervisor?

i) Very co-operative/supportive
ii) Only technical in nature
iii) Strained relationships
iv) Any other (specify)_____

14 How do you view your present relationship with your colleagues

i) Very co-operative/supportive
ii) Only technical in nature
iii) Strained relationships
iv) Any other (specify) _____

15 How do you perceive your role in the project

i) Very important
ii) Not so important
iii) Time consuming
iv) Any other (specify) _____

18 Do you build the capacity of field-workers, supervisors, ANMs & local partners? Yes/No

19 If yes indicate your methodology?

i) Through lecturing
ii) Through individual/group exercises
iii) Through audio-visuals
iv) Participatory approach
v) Any other (specify) _____

IV TRAINING STATUS AND NEEDS

20 Have you received any in-service training? If yes, then please give details below

Sl No	Nature of Training	Year of Training	Duration	Trainer
1				
2				
3				
4				
5				
6				

21 Which of the following methods were frequently used during the training

S No	METHODS	FREQUENCY ORDER
1	Lectures	
2	Group/Individual exercises	
3	Field visits	
4	Audio visuals	
5	Role Play	
6	Case Studies	
7	Simulation	
8	Skit	
9	Presentation	
10	Games	
11	Self administered	
12	Questions and Answers/Quiz	
13	LGD/SGD	
14	Demonstration	

22 How do you view the impact of these training's in your ability to conduct your job

i) Increase your technical know-how
ii) Increase your managing abilities
iii) Increased your motivation
iv) Improved your communication skills
v) Improved inter-personal relations
vi) Made you a better trainer yourself
vii) Made no substantial impact
viii) Any other (specify) _____

23 What possible gaps do you visualize between your present knowledge/skills and performance level and the essential level?

i) Lack of knowledge of intervention technical information
ii) Lack of managerial abilities
iii) Lack of ability to communicate
iv) Lack of leadership
v) Lack of financial management abilities
vi) Lack of control over sub-ordinates
vii) Lack of monitoring and analysis
viii) Any other (specify) _____

24 Other comments

25 What subject areas should trainings discuss

i) MCH technical know-how
ii) Nutrition
iii) Program management
iv) All the above
v) Other (specify) _____

26 If a training program is organized, what methodology would you suggest

i) It should be short and concise
ii) It should not have much lectures
iii) It should be participatory
iv) Trainer should be co-operative
v) More audio-visuals should be used
vi) Any other (specify) _____

27 Are there any other suggestions you would like to make?

TRAINING NEEDS ASSESSMENT - Field-level Functionaries

Note This questionnaire is not a personal test but an evaluatory tool to assess the extent of your understanding and knowledge to the given responsibilities The outcome of this assessment will enable program planners in objectively scheduling a training calendar to meet the project and your needs

Name Age

Designation ANM/AWW/CBOP/CWB

State Project

District

Village/Organization

I PERSONAL DATA

1 How long have you been working in the field?

(i) Less than one year
(ii) 2-3 years
(iii) 3-4 years
(iv) 4-5 years
(v) 5 years or more

2 Your educational qualifications

S NO	Educational qualifications received	Duration	Year

3 Any other technical qualifications received? Yes/No

If yes, kindly give details

S NO	Educational qualifications received	Duration	Year

II ASSESSING TECHNICAL/MANAGEMENT SKILLS

4 Amongst the list provided below, what areas would you like to learn more about?

FUNCTIONS	TASKS	(Tick where applicable)
A Ante natal care	• Components • Case finding • Physical examination	
B Essential Obstetric Care (EOC)	• Rationale	

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	• Components • Barriers to timely and appropriate EOC • Best Practices • Complications	
C Birth Spacing	• Various contraceptive methods Benefits/contraindications • Screening and referral • Follow up • Male participation	
D Maternal Nutrition	• Factors contributing to maternal mortality • Maternal malnutrition • Role of vital nutrients and consequences of their deficiency	
E Newborn Care	• General danger signs • Asphyxia & its management • Hypothermia and its management • Care of low birth weight	
F Breast feeding	• Exclusive breastfeeding • Prelacteals • Anatomy of breast • Mechanism of breast milk production role of prolactin and oxytocin	
G Integrated Management of Childhood illness	• Objectives and Strategy • Training of Basic Health Workers (BHWs)	
H Immunization	• Immunization eligibility & requirements • Methodology of Immunization • Precautions • Cold Chain • Adverse reaction • Monitoring of immunization session in community	
I Complementary Feeding	• Energy and nutrient requirements of young children • Problem nutrients • Supplementary nutrition	

5 Under the functions mentioned below, kindly indicate your tasks

Sl No	FUNCTIONS	TASKS
1	Planning	i) ii) iii) iv)
2	Liaison/Coordination/Net working	i) ii) iii) iv)
3	Counseling	i) ii) iii) iv)

4	Supportive supervision	i) ii) iii) iv)
5	Monitoring	i) ii) iii) iv)
6	Accounting	i) ii) iii) iv)
7	Reporting/Documentation	i) ii) iii) iv)
8	Any other	

6 How do you perceive your relationship with the government functionaries/ CS personnel

i) Supportive
ii) Hindering your work
iii) Nothing to do with them
iv) Any other (specify) _____

7 How do you view your present relationship with your supervisor?

i) Very co-operative/supportive
ii) Only technical in nature
iii) Strained relationships
iv) Other (specify)_____

8 How do you view your present relationship with your colleagues

i) Very co-operative/supportive
ii) Only technical in nature
iii) Strained relationships
iv) Any other (specify) _____

9 How do you perceive your role in the Child Survival program

i) Very important
ii) Not so important
iii) Time consuming
iv) Any other (specify) _____

III TRAINING STATUS AND NEEDS

10 Have you received and training earlier?

Sl No	Nature of Training	Year of Training	Duration	Trainer
1				
2				
3				
4				
5				
6	No Training received			

11 Which of the following methods were frequently used during the training

Sl No	METHODS	FREQUENCY ORDER
1	Lectures	
2	Group/Individual exercises	
3	Field visits	
4	Audio visuals	
5	Role Play	
6	Case Studies	
7	Simulation	
8	Skit	
9	Presentation	
10	Games	
11	Self administered	
12	Questions and Answers/Quiz	
13	LGD/SGD	
14	Demonstration	

12 How do you view the impact of these training's in your own functioning

i) Increase your technical know-how
ii) Increase your managing abilities
iii) Increased your motivation
iv) Improved your communication skills
v) Improved inter-personal relations
vi) Made you a better trainer yourself
vii) Made no substantial impact
viii) Any other (specify) _____

13 Indicate the methodology that you use while building the capacity of community?

i) Through lecturing
ii) Through individual/group exercises
iii) Through audio-visuals
iv) Participatory approach
v) Any other (specify) _____

14 What possible gaps do you visualize between your present knowledge/skills and performance level and the essential level?

i) Knowledge of MCH-technicalities
ii) Community Health Financing
iii) Managerial abilities
iv) Ability to communicate

v) Leadership
vi) Lack of monitoring
vii) Any other (specify) _____

15 Do you need more trainings?

16 If yes, such training should be oriented towards which of the following

i) MCH technical know-how
ii) Nutrition
iii) Program management
iv) All the above
v) Other (specify) _____

17 If a training program is organized for you what methodology would you suggest

i) It should be short and concise
ii) It should not have much lectures
iii) It should be participatory
iv) Trainer should be co-operative
v) More audio-visuals should be used
vi) Any other (specify) _____

Are there any other suggestions you would like to make?

TBA TRAINING PROGRAM

Day I	Time/Duration	Session	Objective of the session	Venue	Methodology/ training aids	Resource Person
	One hour	Registration Introduction of self	Rapport building		Ice breaker	
	One hour	Role of TBA and importance of their role	How they perceive themselves and the practices that they adopt		Participatory session Flip charts can be used	
	Lunch					
	One and half hour	Female Reproductive system Process of conception Signs and symptoms of pregnancy	Refresher		Models charts	
	Break					
	One and half hour	-Causes of maternal morbidity/ mortality ANC -Registration, TT, IFA - Identification of problems during pregnancy	-Clarity in terms of what activities are covered under ANC, how do they perform it - How do women handle it and what is TBAs involvement		Role play Group discussions	

Day II	Time/Duration	Session	Objective of the session	Venue	Methodology/ training aids	Resource Person
	One hour	Recapitulation of previous day's sessions	Get to know their level of understanding in terms of modifying the sessions, if required		Ice breaker	
	One hour	Maternal Nutrition during pregnancy	- Amount of food required - Foods recommended during pregnancy (reasons) - Foods that are to be avoided during pregnancy (reasons) - - Information about locally available foods		Participatory session Role play Flip charts can be used	
	Lunch					
	One hour	TT	Importance of TT		Role play	
	Break					
	One hour	Problems in Pregnancy	To create an exhaustive list of these with the help of TBAs List out the serious and the non-serious ones Management of those and best ways of preventing them		A song can be developed to remind them of cases that need referral	

Day III	Time/Duration	Session	Objective of the session	Venue	Methodology/ training aids	Resource Person
	One hour	Recapitulation of previous day's sessions	Get to know their level of understanding in terms of modifying the sessions, if required		Ice breaker	
	Two hours with break in between	Preparation for Birth	-Five cleans -What advice is given to mothers - D Kits How do they use the items, what are the advantages and disadvantages of them		Participatory session D Kits	
	Lunch					
	Two hours	Stages of labour I, II, III	Recognize the signs of labour, danger signs during labour, first aid, referral cases		Role play Plastic bag and water Plastercine	
	Break					
	One hour	Care of mother and baby	-Clarity in terms of what activities should be conducted For eg Care of the cord, Care of breasts etc		Posters, models, dolls	

Day IV	Time/Duration	Session	Objective of the session	Venue	Methodology/ training aids	Resource Person
	One hour	Recapitulation of previous day's sessions	Get to know their level of understanding in terms of modifying the sessions, if required		Ice breaker	
	Two hours with break in between	Breastfeeding Share local breastfeeding practices	- Early initiation of Breast milk - Colostrum feeding - Avoiding pre-lacteals - How to ensure adequate production of milk(suckling)		Participatory session Dolls	
	Lunch					
	One hour	Maternal nutrition during Lactation	- Amount of food required - Foods recommended during lactation (reasons) - Foods that are to be avoided during lactation (reasons) - - Information about locally available foods		Exhibition of Locally available foods Flip Charts	
	Break					
	Two hours	Lessons learnt by the Dais	What has been the level of improvement in the knowledge part		Participatory	

Annex I – Monitoring & Evaluation Reporting Format

Monitoring & Evaluation Plan (Parivar Kalyan Sansthan & Tata Steel Rural Development Society)

Narrative Summary	Indicators	Data needed	Data Sources	Data Method	Frequency of collection	Responsible person(s)
Goal Reduce Infant and u2 mortality	• Reduced number of deaths in infants • Reduced number of deaths among children under two	• # of children • Deaths in children	CBW survey records	Routine survey	Monthly	CBW
Objectives To improve coverage rates of health practices associated with reductions in infant mortality	*Antenatal care* • 3 or more ANC by delivery • Receipt of 100 IFA tablets by delivery • Receive TT2 by delivery • Birth plan	• # pregnant • Receipt of ANC • Elements of Birth plan	Clinic records CBW records ANC card	Routine survey Attendance at clinic Homevisit	Attendance at clinic Monthly Homevisits	Medical Officers Para Medical Staff CBW
	Infant feeding • Initiation of breastfeeding within 8 hours post partum • Exclusive breastfeeding for four mos • Complementary feeding in 6-9 mos	Newborns Children under two years Breastfeeding practices	CBW register	Records	Attendance at clinic Monthly Homevisits	Para Medical Staff CBW
	Immunization • Complete immunization by age one	Children U2	Imm Card	Records	Attendance at clinic Monthly Homevisits	Para Medical Staff CBW
	Family Spacing • Use of modern spacing method	Women Use of contraception	CBW register	Records	Attendance at clinic Homevisits	Para Medical Staff CBW
Process	• Formation of CBOPs	CBO formation Attendance and meetings	CBO register	Records	Monthly meeting	CBO CBW
	• Capacity Building sessions using IEC	CB of community CB of NGOs CB of CARE staff	CBO register	Records	Monthly Quarterly	CBW MO / Co ord CARE PO
	• Establishment of village health funds	Contributions	CBO register	Records	Monthly	CBO
Outputs	• Distribution of Learning Aids	Learning Aids	Register	Records	Quarterly	MO / Co ord
	• Supply of essential drugs	Stock register	Register	Records	Quarterly	MO / Co ord
	• Clinics organized	# of clinics held	Daily Report	Records	Daily	MO / Co ord
Inputs	• Staff hired	NGO records	Register	Records	Quarterly	Secretary
	• Funds as per budget	NGO financial records	Financial Records	Records	Quarterly	Secretary

Annex J Facility Assessment

Data entry sequence number	Data entry initials

Facility Management

Facility name		Facility code		District code	
Type of facility (enter P=PHC, C=CHC, M=Maternity)					
Facility administration (enter G=Government, M=Mission P=Private)					
Date today		Team code		Surveyor code	

After initially meeting with the officer in charge of the facility to ask questions on pages 1-3 explain that you would like to be shown the facilities to gather the remaining information Complete one survey form for each facility

{FAC1A}	WHAT IS THE ESTIMATED POPULATION SERVED BY THIS FACILITY? *Enter population if not known enter 0*	
{FAC1B}	HOW MANY BEDS ARE THERE AT THIS FACILITY (INCLUDING MATERNITY) *Enter number*	
{FAC1C}	HOW MANY MATERNITY BEDS ARE THERE AT THIS FACILITY (BEDS FOR USE BEFORE, DURING AND AFTER DELIVERY) *Enter number*	
{FAC1D}	WHAT IS THE ANTENATAL CARE COVERAGE RATE FOR THIS FACILITY? *Enter percentage if not known do not calculate enter 0*	%
{FAC1E}	WHAT IS THE DELIVERY COVERAGE RATE FOR THIS FACILITY? *Enter percentage if not known do not calculate enter 0*	%

	AT THIS FACILITY HOW MANY FULL-TIME AND PART-TIME OCCUPIED POSTS ARE THERE FOR	Enter number of posts occupied	
		Full-time	Part-time
{FAC2A}	REGISTERED MIDWIVES AND NURSE/MIDWIVES (FULLY QUALIFIED)		
{FAC2B}	ENROLLED MIDWIVES AND NURSE/MIDWIVES (LIMITED QUALIFICATIONS)		
{FAC2C}	LADY HEALTH VISITORS		
{FAC2D}	PHYSICIANS (BOTH GENERALIST AND OBSTETRICIAN/GYNAECOLOGIST)		
{FAC2E}	ANAESTHETISTS AND NURSE-ANAESTHETISTS		
{FAC2F}	PHARMACISTS		

(Fac2G)	PAEDIATRICIANS		

	WHICH OF THE FOLLOWING SERVICES HAVE BEEN PROVIDED WITHIN THE PAST **SIX MONTHS** AT THIS FACILITY? *Ask about each service separately*	*Tick one box for each item*	
{FAC3A}	ANTENATAL CARE	☐ 1 Yes	☐ 0 No
{FAC3B}	TETANUS TOXOID IMMUNIZATION	☐ 1 Yes	☐ 0 No
{FAC3C}	MANAGEMENT OF SEXUALLY TRANSMITTED DISEASES	☐ 1 Yes	☐ 0 No
{FAC3D}	NORMAL DELIVERY CARE	☐ 1 Yes	☐ 0 No
{FAC3E}	VACUUM EXTRACTION DELIVERY	☐ 1 Yes	☐ 0 No
{FAC3F}	"ROOMING IN ' FOR POSTPARTUM CARE OF MOTHER AND BABY	☐ 1 Yes	☐ 0 No
{FAC3G}	POSTPARTUM CHECK UP	☐ 1 Yes	☐ 0 No
{FAC H}	FAMILY PLANNING SERVICES	☐ 1 Yes	☐ 0 No
{FAC3J}	VOLUNTARY TERMINATION OF PREGNANCY	☐ 1 Yes	☐ 0 No
{FAC3k}	BLOOD TRANSFUSION OR REPLACEMENT	☐ 1 Yes	☐ 0 No
{FAC3L}	CAESAREAN SECTION	☐ 1 Yes	☐ 0 No
{FAC3M}	IMMUNIZATION FOR INFANT	☐ 1 Yes	☐ 0 No
	WHICH OF THE FOLLOWING COMPLICATIONS HAVE OCCURRED AND HAVE BEEN MANAGED AT THIS FACILITY WITHIN THE PAST **SIX MONTHS?** *Ask about each service separately*	*Tick one box for each item*	
{FAC4A}	SEVERE ANAEMIA	☐ 1 Yes	☐ 0 No
{FAC4B}	ANTEPARTUM HAEMORRHAGE	☐ 1 Yes	☐ 0 No
{FAC4C}	PRE-ECLAMPSIA	☐ 1 Yes	☐ 0 No
{FAC4D}	ECLAMPSIA	☐ 1 Yes	☐ 0 No
{FAC4E}	POSTPARTUM HAEMORRHAGE	☐ 1 Yes	☐ 0 No
{FAC4F}	ABORTION COMPLICATIONS	☐ 1 Yes	☐ 0 No
{FAC4G}	RETAINED PLACENTA	☐ 1 Yes	☐ 0 No
{FAC4H}	BREECH/ABNORMAL PRESENTATION/DELIVERY	☐ 1 Yes	☐ 0 No
{FAC4J}	SEPSIS	☐ 1 Yes	☐ 0 No
{FAC4k}	ECTOPIC PREGNANCY	☐ 1 Yes	☐ 0 No
{FAC4L}	RUPTURED UTERUS	☐ 1 Yes	☐ 0 No
	ARE THE FOLLOWING SERVICES PROVIDED EVERY DAY THAT THIS FACILITY IS OPEN?	*Tick one box for each item*	

	Ask about each service separately		
{FAC5A}	ANTENATAL CARE	☐ 1 Yes	☐ 0 No
{FAC5B}	FAMILY PLANNING SERVICES	☐ 1 Yes	☐ 0 No
{FAC5C}	CHILD HEALTH SERVICES	☐ 1 Yes	☐ 0 No

	WHICH OF THE FOLLOWING LABORATORY SERVICES HAVE BEEN PROVIDED AT THIS FACILITY WITHIN THE **PAST WEEK?** *Ask about each service separately*	*Tick one box for each item*	
{FAC6A}	SYPHILIS TESTING	☐ 1 Yes	☐ 0 No
{FAC6B}	HAEMOGLOBIN MEASUREMENT	☐ 1 Yes	☐ 0 No
{FAC6C}	URINE TESTING – PROTEIN MEASUREMENT	☐ 1 Yes	☐ 0 No
	Emergency services and referral		
{FAC7A}	ARE MATERNITY SERVICES AVAILABLE AT NIGHT AND AT WEEKENDS?	☐ 1 Yes	☐ 0 No
{FAC7B}	ARE ON-CALL SERVICES FOR CARE OF COMPLICATED DELIVERIES AVAILABLE AT NIGHT AND AT WEEKENDS?	☐ 1 Yes	☐ 0 No
{FAC7C}	ARE ON-CALL SERVICES FOR CAESAREAN SECTION AVAILABLE AT NIGHT AND AT WEEKENDS?	☐ 1 Yes	☐ 0 No
{FAC7D}	ONCE YOU DECIDE TO REFER AN OBSTETRIC EMERGENCY CASE ABOUT HOW LONG DOES IT TAKE FOR HER TO ARRIVE AT THE REFERRAL FACILITY AND RECEIVE CARE? *Enter number of hours* *Enter 0 for referral centre/hospital*		
{FAC7E}	HOW FAR IS THE NEAREST REFERRAL FACILITY, IN KILOMETRES? *Enter number of kilometres one way* *Enter 0 for referral centre/hospital*		
{FAC7F}	WHO, APART FROM THE DRIVER, USUALLY ACCOMPANIES AN EMERGENCY REFERRAL PATIENT TO THE HOSPITAL? *Tick one box*	☐ 0 Patient is not accompanied (driver only) ☐ 1 Nurse/Midwife ☐ 2 Other health personnel ☐ 3 Family member ☐ 4 Other – specify	
{FAC7G}	HOW DOES THE PATIENT TRAVEL TO THE HOSPITAL? *Tick one box*	☐ 1 Own conveyance ☐ 2 Public transport ☐ 3 Ambulance ☐ 4 Other – specify	
	Infrastructure and equipment		
	WHICH OF THE FOLLOWING ITEMS ARE AVAILABLE AND IN SATISFACTORY CONDITION? *Ask about each item separately Code as unsatisfactory items which in your judgement are not functional have missing parts are unhygienic or otherwise sub-standard Be sure to* ***look*** *at each item*	*Enter correct number below* 0 = Not available 1 = Available but not satisfactory 2 = Available and satisfactory 9 = Not applicable for this facility	
{FAC8A}	EXAMINATION ROOM OR AREA PROVIDING CLIENT PRIVACY (ROOM FOR SCREENING, COUNSELLING AND EXAMINATION)		
{FAC8B}	TABLE AND STOOL FOR GYNAECOLOGICAL EXAMINATIONS		
{FAC8C}	STORAGE AREA OR CUPBOARD FOR DRUGS AND OTHER SUPPLIES		

{FAC8D}	TOILET FACILITIES OR LATRINE	
{FAC8E}	DELIVERY OR LABOUR ROOM WITH BED AND LIGHTING	
{FAC8F}	REFRIGERATOR	
{FAC8G}	WATER SUPPLY	
{FAC8H}	TELEPHONE	
{FAC8J}	AMBULANCE OR VEHICLE TO REFER AN OBSTETRIC EMERGENCY	

	WHICH OF THE FOLLOWING ITEMS ARE AVAILABLE AND IN SATISFACTORY CONDITION? *Ask about each item separately Code as unsatisfactory items which in your judgement are not functional have missing parts are unhygienic or otherwise sub-standard Be sure to* ***look*** *at each item*	*Enter correct number below* 0 = Not available 1 = Available but not satisfactory 2 = Available and satisfactory 9 = Not applicable for this facility
	Registers	
{FAC9A}	DELIVERY REGISTER	
{FAC9B}	ANTENATAL CARE REGISTER	
{FAC9C}	OPD REGISTER	
{FAC9D}	FAMILY PLANNING REGISTER	
{FACe}	IMMUNIZATION REGISTER	
{FAC9F}	INDOOR REGISTER	
{FAC9G0	STOCK REGISTER	
{FAC9H}	BIRTH REGISTER	
{FAC9I}	DEATH REGISTER	
	Basic equipment	
{FAC10A}	BLOOD PRESSURE APPARATUS (SPHYGMOMANOMETER)	
{FAC10B}	STETHOSCOPE	
{FAC10C}	INFANT WEIGHING SCALE	
{FAC10D}	FETAL STETHOSCOPE	
{FAC10E}	STERILIZER	
{FAC10F}	CLINICAL ORAL THERMOMETER	
{FAC10G}	MANUAL VACUUM ASPIRATOR (MVA)	
{FAC10H}	PROTECTIVE CLOTHING (SHOES APRONS)	
{FAC10J}	SPECULUM (VARIOUS SIZES)	
{FAC10K}	VACUUM EXTRACTOR	
{FAC10L}	OBSTETRIC FORCEPS	
	Absolute minimum equipment for delivery	
{FAC11A}	SCISSORS	
{FAC11B}	SUTURE NEEDLES AND SUTURE MATERIAL	
{FAC11C}	NEEDLE HOLDER, LONG	
	Absolute minimum for care of neonate	
{FAC12A}	CLOTH OR TOWEL TO DRY BABY	
{FAC12B}	BLANKET TO WRAP BABY	
{FAC12C}	BAG AND MASK FOR NEONATAL RESUSCITATION	
	Educational materials	

{FAC13A}	ON WARNING SIGNS OF COMPLICATIONS IN PREGNANCY	
{FAC13B}	ON POSTPARTUM OR NEWBORN CARE OR BREAST-FEEDING	
{FAC13C}	ON FAMILY PLANNING	
{FAC13D}	ON SEXUALLY TRANSMITTED DISEASES / HIV/AIDS	
{FAC13E}	ON ANTENATAL NUTRITION OR ANAEMIA	

{FAC14A}	IS ALL EQUIPMENT THAT YOU REQUIRE FOR FAMILY PLANNING/CONTRACEPTIONAVAILABLE? *If equipment is not available or unsatisfactory please specify below*	☐ 1 Yes	☐ 0 No
{FAC14B}	IS ALL EQUIPMENT THAT YOU REQUIRE FOR CAESAREAN SECTION AVAILABLE? *If equipment is not available or unsatisfactory please specify below*	☐ 1 Yes	☐ 0 No

	Essential drugs and consumable supplies	
	For essential drugs and consumable supplies it is sufficient to look for and see that a particular item is available regardless of condition or expiration date	*Enter correct number below* 0 = Not seen at facility 1 = Seen at facility 9 = Not applicable for this facility
{FAC15A}	GLOVES	
{FAC15B}	DISPOSABLE SYRINGES AND NEEDLES	
{FAC15C}	IV KIT	
{FAC15D}	BLANK "LABOURGRAPHS" OR "PARTOGRAPHS"	
{FAC15E}	BLANK ANTENATAL CLIENT CARDS OR MATERNAL RECORDS (AS APPROPRIATE)	
{FAC15F}	CORD TIES/DDK	
{FAC15G}	BLOOD GIVING SETS	
{FAC15H}	SYPHILIS TEST KITS	
{FAC15J}	URINE DIP STICK / PROTEINURIA TEST SUPPLIES	
	Anaesthetics general	
{FAC16A}	NITROUS OXIDE OR OTHER GENERAL ANAESTHETIC AGENT	
{FAC16B}	DIAZEPAM (INJECTION)	
{FAC16C}	KETAMINE (INJECTION)	
	Anaesthetics local	
{FAC17A}	LIDOCAINE 2% OR XYLOCAINE 2% OR OTHER	
	Analgesics	
{FAC18A}	PETHIDINE OR PENTAZOCIN	
	Anti-infective drugs antibacterial (mother)	
{FAC19A}	AMPICILLIN (CAPSULES OR INJECTION)	
{FAC19B}	BENZATHINE BENZYLPENICILLIN **OR** PROCAINE BENZYLPENICILLIN (INJECTIONS)	
{FAC19C}	CEFTRIAXONE (INJECTION) **OR** CIPROFLOXACIN (CAPSULE)	
{FAC19D}	GENTAMICIN (INJECTION)	
{FAC19E}	KANAMYCIN (INJECTION)	

{FAC19F}	SULFAMETHOXAZOLE+TRIMETHOPRIM(400 mg + 80 mg TABLETS)	

	For essential drugs and consumable supplies it is sufficient to look for and see that a particular item is available regardless of condition or expiration date	Enter correct number below 0 = Not seen at facility 1 = Seen at facility 9 = Not applicable for this facility
	Anti-infective drugs antibacterial (neonate)	
{FAC20A}	TETRACYCLINE OR CHLOROMPHENICOL (OINTMENT) **OR** SILVER NITRATE (EYE DROPS)	
	Anti-infective drugs antimalarials	
{FAC21A}	CHLOROQUINE (TABLETS)	
{FAC21B}	QUININE (INJECTION) **OR** CHLOROQUINE (INJECTION)	
	Antianaemia drugs	
{FAC22A}	FERROUS SALT+FOLIC ACID (IN COMBINED FORM OR SEPARATELY)	
Deworming tablets		
{FAC23A}	MEBENDAZOLE OR OTHER DEWORMING TABLETS	
	Antihypertensive drugs	
{FAC24A}	RESARPINE **OR** PROPRANOLOL **OR** ANY OTHER ANTIHYPERTENSIVE	
{FAC24B}	HYDRALAZINE (INJECTION)	
	Anticonvulsive drugs	
{FAC25A}	MAGNESIUM SULFATE (INJECTION) **OR** DIAZEPAM (INJECTION)	
	Contraceptives	
{FAC26A}	ORAL CONTRACEPTIVES (ANY TYPE)	
{FAC26B}	INJECTABLE CONTRACEPTIVES (ANY TYPE)	
{FAC26C}	CONDOMS	
{FAC26D}	IUCDS/IUDS	
	Immunologicals Vaccines	
{FAC27A}	TETANUS TOXOID (INJECTION)	
{FAC 7B}	BCG VACCINE (INJECTION)	
{FAC27C}	DPT VACCINE (INJECTION)	
{FAC27D}	MEASLES (INJECTION)	
{FAC27E}	POLIO (DROPS)	
	Oxytocics	
{FAC28A}	ERGOMETRINE (INJECTION) **OR** OXYTOCIN (INJECTION)	
	Disinfectants and antiseptics	
{FAC29A}	SURGICAL SPIRIT **OR** SAVLON **OR** ANY OTHER	
	Intravenous solutions	
{FAC30A}	SALINE SOLUTION **OR** SODIUM LACTATE COMPOUND SOLUTION **OR** ANY OTHER	

Delivery registry and presentation of maternal complications

Ask to see the delivery records or log book Tally information on the number of cases of various conditions from the delivery registry or other relevant records ***for the past 12 months*** *Space is provided under each condition for tallying the number of cases After completion enter numerical totals in the right hand column Exclude cases in which the baby was born before arrival at the facility*

		Use space below for tally	*Enter number below*
{FAC30A}	TOTAL NUMBER OF BIRTHS (FOR PAST 12 MONTHS) *(Count tally here e g IIII)*		
{FAC30B}	INSTRUMENTAL DELIVERIES (VACUUM EXTRACTION OR FORCEPS)		
{FAC30C}	ABNORMAL VAGINAL DELIVERIES (BREECH, FACE, SHOULDER DELIVERIES)		
{FAC30D}	CAESAREAN SECTIONS		
{FAC30E}	MATERNAL DEATHS		
{FAC30F}	STILLBIRTHS (FRESH AND MACERATED)		
{FAC30G}	EARLY NEONATAL DEATHS		

Family planning register

Ask to see the family planning register or log book Tally information on the number of users of various contraceptive methods ***for the past 3 months*** *For sterilization it might be necessary to look at the operating theatre register Space is provided under each family planning type for tallying the number of clients After completion enter numerical totals in the right-hand column.*

		Use space below for tally	*Enter number below*
{FAC31A}	ORAL CONTRACEPTIVES/PILL *(Count tally here e g IIII)*		
{FAC31B}	INJECTABLE (E G DEPOT-MEDROXYPROGESTERONEACETATE/DEPO-PROVERA, NORETHISTERONEENANTHATE/"NORESTAT")		
{FAC31C}	CONDOMS		
{FAC31D}	DIAPHRAGMS		
{FAC31E}	IUCD OR IUD		
{FAC31F}	SUBDERMAL IMPLANTS (E G NORPLANT®)		
{FAC31G}	SPERMICIDE (E G FOAM TABLET FOAM, CREAM, JELLY)		
{FAC31H}	STERILIZATION FEMALE		
{FAC31J}	STERILIZATION MALE		

26 October 1999

Annex K – Response to Technical Reviewer Comments