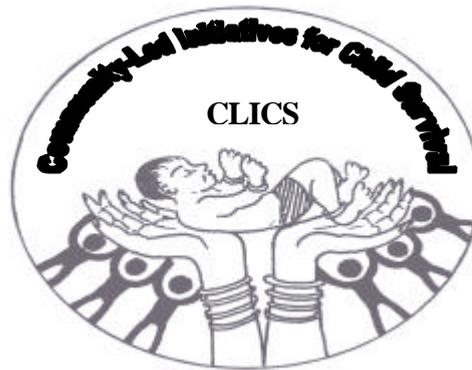


# COMMUNITY LED INITIATIVES FOR CHILD SURVIVAL PROGRAM – (CLICS)



## ANNUAL REPORT

**Report prepared for:** The United States Agency for International Development

**Name of PVO:** Aga Khan Foundation, USA

**Primary Partner:** Department of Community Medicine, Mahatma Gandhi Institute of Medical Sciences, Sewagram

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## LIST OF ACRONYMS

AKDN	Aga Khan Development Network
AKF, India	Aga Khan Foundation, India
AKF USA	Aga Khan Foundation United States of America
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infection
AWC	Anganwadi Center
AWW	Anganwadi Worker
BCC	Behavior Change Communication
CARE	Cooperative for American Relief Everywhere
CLICS	Community-led Initiatives for Child Survival
CO	Community Organizer
CSTS	Child Survival Technical Support Group
DCM	Department of Community Medicine
DIP	Detailed Implementation Plan
ECD	Early Childhood Development
FGD	Focus Group Discussion
GoI	Government of India
GoM	Government of Maharashtra
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
IMCFSC	Integrated Model of Communication for Social Change
ICDS	Integrated Child Development Services
IEC	Information Education Communication
IFA	Iron Folic Acid
IMCI	Integrated Management of Childhood Illnesses
IMI	Institutional Maturity Index
IMR	Infant Mortality Rate
IR	Intermediate Result
ISA	Institutional Strengths Assessment
KAP	Knowledge, Attitude & Practices
LHV	Lady Health Visitor
LoE	Level of Effort
LOGFID	Logical Framework for Institutional Development
LQAS	Lot Quality Assurance Sampling
MCH	Maternal and Child Health
MGIMS	Mahatma Gandhi Institute of Medical Sciences
MIS	Management Information System
MMR	Maternal Mortality Rate
MoH	Ministry of Health
MoHFW	Ministry of Health & Family Welfare, India
NFHS II	National Family Health Survey II (1998-1999)
NMR	Neonatal Mortality Rate
NGO	Non Government Organization
ORS	Oral Rehydration Solution
PHC	Primary Health Center
PHC MAP	Primary Health Care Management Advancement Program
PNC	Post Natal Care
PRI	Panchayati Raj Institution

PVO	Private Voluntary Organization
QA	Quality Assurance
RCH	Reproductive and Child Health
RH	Reproductive Health
RTI	Reproductive Tract Infection
SHG	Self Help Group
SO	Strategic Objective
SRS	Sample Registration System
STD	Sexually Transmitted Disease
TIPs	Trials of Improved Practice
TNA	Training Needs Assessment
TST	Technical Support Team
TT	Tetanus Toxoid
UNFPA	United Nations Fund for Population
USAID	United States Agency for International Development
VCC	Village Coordination Committee
VHW	Village Health Worker
WHO	World Health Organization

### LIST OF LOCAL TERMS

Bal aahar or posh aahar	Energy dense food for children
Bal Suraksha Divas	Child Survival Days
Gram Panchayat	Local Self Governing Body
Gram Swasthya Kosh	Village Health Fund
Kisan Vikas Manch	Farmer's Development Forum
Kishori Panchayat	Adolescent Girls Forum
Kosh Adhyaksha	Treasurer
Mulgi Wachawa Mohim	Save the Female Child Campaign
Panchayat member	Members of Local Self-Governing Body (Panchayat)
Suraksha Aaichi Aani Balachi Mohim	Safe Motherhood and Child Survival Campaign
Suraksha Aaichi Mohim	Safe Motherhood Campaign
Anganwadi Worker	Female worker, under the 'Integrated Child Development Services Scheme', responsible for managing the Anganwadi Center and related activities: pre-school education, growth monitoring, supplementary nutrition, etc.

## EXECUTIVE SUMMARY

The *Community Led Initiative for Child Survival (CLICS)* is a five-year program (2003-08) supported by United States Agency for International Development (USAID). The total budget is \$ 2,034,681 of which USAID cost share is \$ 1,386,480 (68%) and Aga Khan Foundation (AKF) cost share is \$ 648,201 (32%). The program is managed by the Aga Khan Foundation and implemented by the Department of Community Medicine, Mahatma Gandhi Institute of Medical Sciences (MGIMS), Sewagram. AKF and MGIMS are integral parts of institutional networks committed to improving people's lives through building and maintaining long-term partnerships and generating knowledge for wide applications. CLICS operates in 67 villages of Wardha District, Maharashtra State, India and serves a total population of 88,128 residents in three sectors, Anji, Gaur and Talegaon. CLICS seeks to facilitate a 'community-ownership' of a package of health services by refining and applying a 'social franchise model' that is demand-driven and sustainable. To ensure long-term sustainability, the selected villages are part of the field practice area of MGIMS, where medical and nursing students can obtain community-focused training and conduct community-based research.

This annual report covers the first year of program operations, from October 1, 2003 to September 30, 2004.

At the start of the program, health indicators in the program area reflected a decline in health gains to a level only marginally better than the national average, despite Maharashtra's high overall human development index. A neonatal mortality rate of 59/1000 live births was two-thirds that of the infant mortality rate and the child sex ratio was 936 females to 1,000 males. Wardha District is a rural area of low socioeconomic status, limited community resources and high rates of morbidity and mortality among its most vulnerable groups: newborns, infants and their mothers. The program will have 32,962 direct beneficiaries comprising children under three (5,067), women of reproductive age (20,685) and adolescent girls (7,210).

### **Program Goals, Objectives, Major Strategies**

The goal of the CLICS project is *"sustainable improvement in the health status and well being of children under the age of three and women of reproductive age (15-44 years)."*

The objectives of the program are to: (i) provide affordable, high-quality health care through effective partnerships at the village level; (ii) build the capacity of coalitions of local partners to sustain child survival activities and health gains; (iii) refine and test a social franchising model for the delivery of child survival interventions; and (iv) document, disseminate and share key program lessons and results so as to facilitate adaptation and replication of the model and advocate for policy changes.

The major strategy of CLICS is to refine and scale-up the collaboration between the Aga Khan Foundation and the Department of Community Medicine, Mahatma Gandhi Institute of Medical Sciences (DCM/MGIMS) in order to build the capacity of the target communities so they can develop, manage and ultimately achieve "ownership" of village-based child survival and health services. This scaling up will be accomplished by applying the principals of "social franchising" to the processes

undertaken by CLICS to change communities' health behavior and demand for healthcare. DCM (the "Franchiser") will mobilize villages and enter into a contractual arrangement with representative coordinating committees (the "Franchisees") to build capacity to develop, manage and sustain a package of high quality, affordable child survival and health services that address priority health problems (the "Social Product").

**Level of Effort (LOE) to Each Intervention:**

New-born care with a focus on reducing neonatal mortality: 25% LOE

Safe Motherhood: 15% LOE

Breastfeeding and Nutrition: LOE 15%

ARI, prevention, early detection, case management: 12% LOE

Diarrhea, prevention, early detection, case management: 12% LOE

Early Childhood Development: 6% LOE

Immunization, quality improvement: 5% LOE (coverage rates are high at 90%)

RTI/STI and HIV/AIDs, primary prevention: LOE 5%

Birth spacing: 5% LOE

The governor of the state of Maharashtra, His Excellency Shri Mohammad Fazal, officially inaugurated the CLICS program on November 28, 2003. Most of the start up activities, such as procurement of equipment and vehicles, recruitment of personnel, and the establishment of Central and Sector Offices, were completed. In order to have a clear picture of the health status of the program area, a baseline survey, including quantitative and qualitative assessments, was also undertaken.

Key project activities during the current reporting period included start-up activities and community mobilisation. Community mobilization was achieved through the formation of 249 women's self help groups (SHGs), 71 Kisan Vikas Manchs (Farmer's Development Association) and 62 Kishori Panchayats (Adolescent Girls Forum). The program also initiated the process of forming Village Coordination Committees (VCCs). By the end of the reporting period, VCCs were formed in 8 villages in the program area. Orientation of the VCC members to the CLICS program is happening through monthly meetings, and a health needs assessment has been conducted in all villages with VCCs.

Orientation on the CLICS program for program staff and partners has been completed. A training needs assessment (TNA) exercise has been conducted for all program staff, as well as the Anganwadi workers and auxiliary nurse midwives of the Talegaon and Anji Sectors, and the Anganwadi workers of Gaul Sector. Training for program staff on Participatory Rural Appraisal & Community Mobilization has been completed, while training is currently underway on Quality Assurance and technical interventions.

The plan for documenting program progress has been developed, and publication and distribution of a monthly newsletter, *Samvedana*, began in March of 2004. In addition, financial systems have been put in place, which include routine internal audits of quarterly expenditures and timely submission of quarterly financial reports. Institutionalization of MIS is underway with development of quantitative and qualitative reporting formats & formats for Mother & Child registers.

## 1. Introduction

The strategy for the Community Led Initiatives for Child Survival Program (CLICS) has evolved through the “Partnering for Child Survival” project, a collaborative pilot between DCM and AKF India in the Talegaon area. It introduced the concept of “community ownership” of a health clinic in villages without Government of India facilities, as a model ensuring sustainable delivery of quality health services. To strengthen community participation, DCM actively promoted the formation of self-help groups (SHGs), notably women’s groups, and partnerships with public and private practitioners. Results have been encouraging: “community ownership” seems to be a valid approach to engaging a village to take responsibility for its own health. DCM’s knowledge about ways to achieve community ownership has helped define the “social franchise principle” proposed by CLICS. In the same way, DCM’s understanding of new behavior change communication techniques to improve the existing package of child survival interventions has been refined.

CLICS represents an opportunity for DCM, with AKF and USAID support, to build its capacity and that of its partners to implement new methods and techniques for both *organizing communities* and *addressing their health needs* in ways that are effective and sustainable. Furthermore, this program offers DCM and AKF an opportunity to *increase the scale of collaboration* and to monitor and evaluate the manner in which services selected by villagers are implemented, financially supported and sustained. The intention is to *generate lessons* about the delivery model and the package of child survival interventions for *dissemination and replication through networks* of which both DCM and AKF are a part.

## 2. Goal, Objectives & Strategy

The overall *goal* of the program is “*sustainable improvement in the health status and well being of children under the age of three and women of reproductive age (15-44 years).*” The aim is to develop a community-led approach that ensures the provision of high quality and affordable child survival and health services for rural families.

The objectives of the CLICS Program are:

- To provide affordable, high-quality health care through effective partnerships at the village level;
- To build the capacity of coalitions of local partners to sustain child survival activities and health gains;
- To refine and test a social franchising model for the delivery of child survival interventions;
- To document, disseminate and share key program lessons and results to facilitate adaptation, replication and policy advocacy.

The CLICS program is managed by AKF and implemented by DCM/MGIMS in 67 villages of Wardha District, Maharashtra State, India (Annex 1). Detailed maps of the three sectors depicting the villages of the program area are included as Annexes 1a-1c. To ensure long-term sustainability, the villages selected are part of the field-practice area of MGIMS. The field-practice areas are used to train medical and nursing students on community-focused techniques. The areas are also used for conducting community-based research. The CLICS program will serve 88,128 residents in three sectors: Anji, Gaur and Talegaon. The list of villages in the program area, along with their populations, is given as Annex 2.

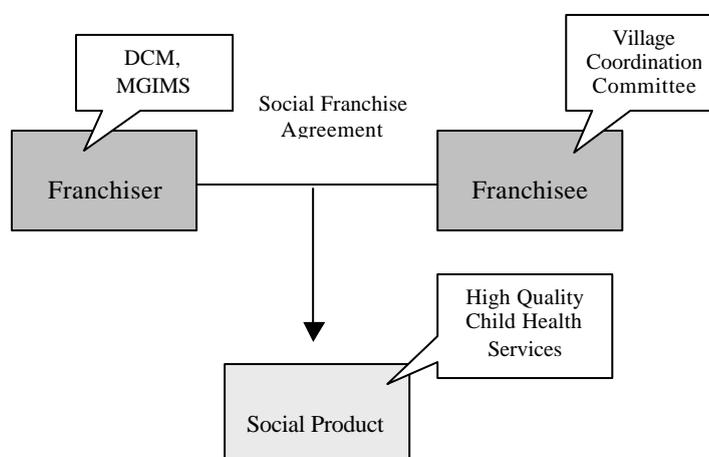
## Beneficiaries as per the baseline survey

As per the baseline survey, the program will serve a total population of 88,128 residents in three sectors: Anji, Gaur and Talegaon (Table 2.1). There are an estimated 32,962 direct beneficiaries comprising of children under the age of three, women of reproductive age, and adolescent girls. The decrease in population from that which was quoted in the proposal can be attributed to the reorganization of the Gaul PHC, and the incorporation of a few villages from Anji PCH under urban Wardha, which were subsequently excluded from the project.

Description	Anji	Gaul	Talegaon <sup>1</sup>	Total
Villages (under project area)	23	21	23	67
Population (under project area)	31482	18700	37946	88128
Total Households (under project area)	7783	4429	8699	20911
Beneficiaries: children (0-3 years)	1839	1039	2189	5067
Beneficiaries: women of reproductive age (15-44 years)	7524	4206	8955	20685
Beneficiaries : adolescent girls	2516	1492	3202	7210
<b>Total beneficiaries</b>	<b>11879</b>	<b>6737</b>	<b>14346</b>	<b>32962</b>

The major strategy of CLICS is to refine and scale up the collaboration between the Aga Khan Foundation (AKF) and the Department of Community Medicine, Mahatma Gandhi Institute of Medical Sciences (DCM/MGIMS). The purpose of this is to build the capacity of the target communities so they can develop, manage and ultimately achieve “ownership” of village-based child survival and health services. This scaling up will be accomplished by applying the principals of “social franchising” to the processes undertaken by CLICS to change communities’ health behaviors and demand for healthcare services. As illustrated in Figure 1, DCM (the “Franchiser”) will mobilize villages and enter into a contractual arrangement with representative coordinating committees (the “Franchisees”). The Franchiser and Franchisees will work together in building their capacity to develop, manage and sustain a package of high quality, affordable child survival and health services that address priority health problems (the “Social Product”).

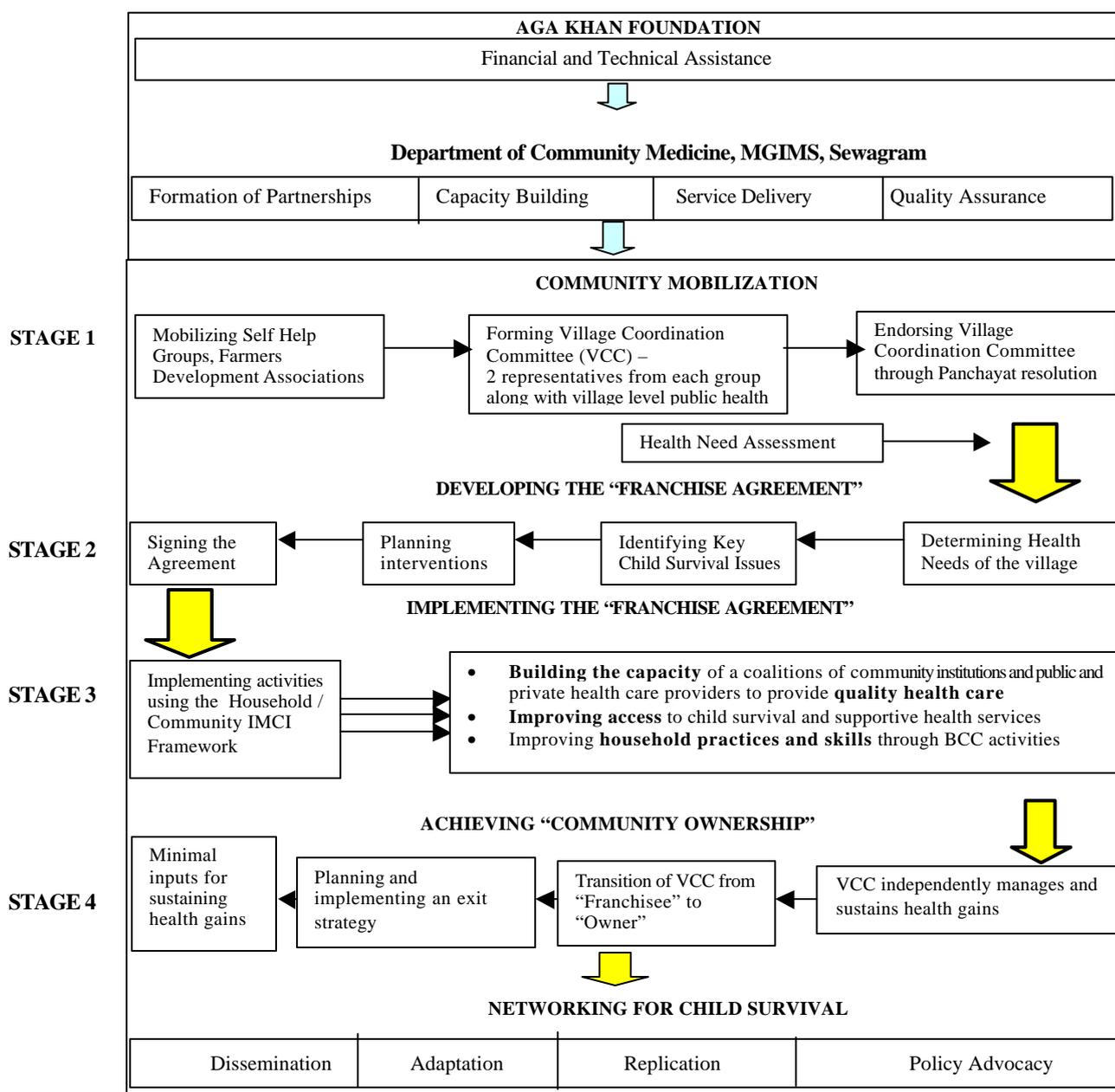
**Fig. 1 Social Franchise model**



<sup>1</sup> AKF has been supporting DCM’s work in Talegaon since 2001. This program builds on that experience.

A framework for describing the implementation of the CLICS Program appears below in Figure. 2. As illustrated, AKF will supply financial and technical resources to DCM to strengthen and build its capacity for working with local partners to achieve the program’s objectives. The four stages of the program include: (1) Mobilizing communities to form Village Coordination Committees (VCCs) to function as nodal agencies responsible for decentralized health care delivery at the village level; (2) Developing with each VCC a “Social Franchise Agreement”, a document that outlines a clear set of health priorities and the means by which to address them; (3) Implementing the Franchise Agreement through the VCC; and (4) Achieving “community ownership” whereby the VCC is able to independently manage key health activities and sustain health gains without intensive inputs from DCM.

**Figure 2: CLICS Program Framework**



Under the current reporting period, the program activities focused mainly on stage 1, community mobilization.

### 3. Progress made towards achieving objectives of the project

The progress made towards achieving objectives in the current reporting period is summarized in Table 3.1. A more detailed description of progress achieved against different activities as envisaged in the work plan is given in Annex 3.

**Table 3.1 Progress made towards achieving objectives of the project**

Objectives	Progress towards achieving objective on target Yes/No	Comments
To provide affordable, high quality health care through effective partnerships at the village level	Yes	<ul style="list-style-type: none"> <li>• Community Mobilization through formation of community based institutions (SHGs, KVMs &amp; KPs) has been completed.</li> <li>• Village Coordination Committees have been formed in 8 villages.</li> <li>• Under the QA plan, checklists have been developed.</li> <li>• Training for Program level staff on QA has been completed.</li> </ul>
To build the capacity of coalitions of local partners to sustain child survival activities and health gains	Yes	<ul style="list-style-type: none"> <li>• Program staff, CBOs, Health care providers (public &amp; private) in all three sectors have been oriented to CLICS.</li> <li>• Training Needs Assessment has been completed for program staff &amp; public health care providers.</li> </ul>

To refine and test a social franchising model for the delivery of child survival interventions	Yes	<ul style="list-style-type: none"> <li>• Draft Social Franchise agreement prepared.</li> <li>• Newly formed VCCs have been introduced to the concept of 'Social franchise'</li> </ul>
To document, disseminate and share key program lessons and results to facilitate adaptation, replication and policy advocacy.	Yes	<ul style="list-style-type: none"> <li>• Documentation plan has been developed.</li> <li>• Publishing of monthly newsletter "Samvedana" has begun.</li> <li>• Progress of program activities has been shared with program partners.</li> </ul>

### **The key activities in the current reporting period included:**

#### **3.1 Launch of CLICS program:**

The CLICS program was officially inaugurated by the Governor of Maharashtra state, His Excellency Shri Mohammad Fazal on November 28, 2003. The launch function was attended by the village leaders (Sarpanchs) for all villages in the program area, and representatives of partners in the CLICS program. Public health providers such as PHC Medical Officers, Auxiliary Nurse Midwives and Anganwadi workers were also invited. The Governor stressed, in his inaugural address, the importance of involving communities in the provision of health care services and the unique role of the CLICS program in enhancing child survival in the program area. The function was given wide coverage and publicity by the media.

#### **3.2 Start up activities:**

**The finalization of contractual procedures (AKF/DCM)** was undertaken in the first quarter. This included the finalization of grant flow mechanisms, reporting formats as well as determining deadlines for reports.

**The establishment of Central and Sector Offices** is almost complete. In October 2004, the final Sector Office will open in Telegaon Sector. At this point, all offices will be operational.

**The procurement of equipment/furniture and vehicles** is also almost complete. One computer, one printer and one generator remain to be purchased in the fourth

quarter (Oct-Dec) of 2004. Procurement was done in accordance with procurement guidelines of USAID, AKF USA and MGIMS.

**The Recruitment of Personnel** has also been completed and candidates have been selected for all positions, except two MIS Assistants and one Medical Officer. The delay in filling these positions is a result of the challenge in finding suitable candidates with the requisite qualifications, in consideration of the job requirements. Recruitment for all positions was done in accordance with MGIMS recruitment guidelines. The selection process involved screening of candidates and conducting skills tests and personal interviews.

**Appointment of Program Advisors** has been completed. The program advisors include:

- Dr. Vinod Paul, a neonatologist with special interest in home-based management of newborn care, is currently serving as Additional Professor and Head of the WHO Collaborative Centre for Neonatal Health at the All India Institute of Medical Sciences in New Delhi.
- Dr. Subash R. Salunke, a public health physician with 25 years of experience as a medical teacher and health administrator, is currently the Director General of Health Services in Maharashtra, Mumbai.
- Dr. Abhay Bang is physician and an expert in the health of tribal populations in Gadchiroli district, Maharashtra. Dr. Bang is director of the Society for Education, Action and Research in Community Health (SEARCH), an organization that has drawn international repute for developing a home-based management strategy to reduce neonatal mortality.
- Dr. Rajesh Kumar is an experienced medical professor and head of the Department of Community Medicine at the Post Graduate Institute of Medical Research and Education in Chandigarh.
- Dr. Dinesh Paul is the Joint Director and head of the Division of Child Survival at the National Institute for Public Cooperation and Child Development, which is the central body for training of personnel under the Integrated Child Development Services Scheme.

### 3.3. Development of Detailed Implementation Plan (DIP)

#### 3.3.1 Conducting the Baseline survey:

In order to have a clear picture of the health status of the program area a baseline survey was undertaken, including quantitative and qualitative assessments.

To establish a sampling frame, DCM conducted a house-to-house survey in all 67 villages for CLICS. To conduct this survey, the villages were first mapped. Based on the village maps, the households were numbered and each household was visited, taking care not to miss any of the households. The data collected at this stage included identification information, family composition, and information related to any deaths in the household during the preceding 12 months.

Next, a baseline survey was conducted, which included a census survey of all households in the program area with mothers having a child aged 0-35 months and a sample survey of women of reproductive age group (15-44 years), husbands, and

adolescent girls (12-19 years). The minimum sample size required to estimate the indicators in a sector was 384 for each category of respondents. This determination of the sample size was based on Lwanga & Lemeshow<sup>2</sup>, keeping in mind the anticipated population proportion  $p=50%$ ,  $CI=95%$ , and absolute precision= $5%$  ( $45% - 55%$ ). Thus, 1152 respondents in each category were required from all the sectors. To overcome the non-responses (approximately 10%), a total of 420 households were taken for each type of target respondent in a sector. The respondents for the sample survey were selected, adopting a random procedure from the sampling frames proposed from the house listing.

Type of schedules, key respondents and the broad areas on which information was gathered are given in Table 3.3.1.

Table 3.3.1: Type of instruments and information covered

S. No.	Type of Schedule	Purpose/ Information areas	Respondent	Sample coverage
1	Woman & Child	Knowledge & Practice: Safe motherhood RTI/ STI Birth Spacing Practice, knowledge & utilization of services with respect to : Newborn Care ARI/ Diarrhea Breastfeeding & Nutrition ECCD Immunization	Mother (women with child <36 mths)  Mother (Women with child <36 mths)	All households with child <36 mths  All households with child <36 mths
2	Woman Schedule	Knowledge & Practice: Safe motherhood RTI/ STI Birth Spacing	Women in reproductive age group (married women 15-44 yrs)	Sample of households
3	Adolescent Girls	Practices, knowledge & utilization of services with respect to: Personal & menstrual hygiene RTI/ STI & HIV Birth Spacing Child Care Questions Nutrition	Adolescent (unmarried girls 12-19 yrs)	Sample of households
4	Fathers/ Men	Knowledge: Safe motherhood RTI/ STI Birth Spacing Child Health Care	Husbands of women with child <36 mths)	Sample of households
5	Public Providers	Knowledge & Practice: Child Care Maternal Care Management Systems Facility Assessment	Lady Health Visitors/ Auxiliary Nurse Midwife(s)/ Medical Officers/ Anganwadi Workers/ TBAs	Sample of health providers

Data regarding the Rapid CATCH indicators disaggregated by sector is provided in Annex 4.

<sup>2</sup> Source: Sample size determination in Health Studies. A Practical manual by SK Lwanga & S Lemeshow, World Health Organization (1991)

In addition, in-depth interviews of medical officers and a facility survey of three Primary Health Centers were also conducted. A similar exercise was also conducted at the sub-centers in the program area. The checklist used for the interviews and facility surveys, and a brief report on the results, are included as Annexes 5 and 6, respectively. Data from the Health Facility Assessment reveal that both infrastructure and quality are in need of attention. Facilities lack utilities such as drinking water and basic sanitation. In addition, medical waste is not being appropriately disposed of. While basic equipment is available and functional, aids such as gloves and speculums are missing. Even where some equipment exists (one Primary Health Center had a baby warmer) it is not optimally utilized. Moreover, none of the Primary Health centers practiced any quality assurance standards.

### **3.3.2 Generation of DIP:**

The development of the Detailed Implementation Plan included conducting a partner's meeting at the Department of Community Medicine, and a DIP planning workshop. The DIP preparation was undertaken according to the guidelines in *Guidance for Detailed Implementation Plans (DIPs) for PVO Child Survival and Health programs FY 2004, Child Survival & Health Grants Program, USAID, (revised September 2003)*. A brief description of the steps taken in the DIP preparation is provided in Annex 7.

## **3.4. Systems development**

**3.4.1 Financial:** The financial system has been refined and improved to bring it in tune with the grant requirements. This was facilitated by Mrs. Rohini Gambhir, Financial Controller, AKF, India, who visited the Program area in the month of March 2004 and reviewed the financial systems and made suggestions for improvement. The staff was also familiarized with the *sf424* & *sf424a* financial reporting formats required by USAID. Procedures and periodicity of audits were also discussed, in line with grant requirements. Currently, expenditures of all quarters are subjected to an internal audit and all quarterly financial reports have been submitted within the stipulated deadlines.

**3.4.2 Human Resource:** Procedures for selection of Program personnel were decided in the first quarter. Job requirements and reporting mechanisms for each position were identified and conveyed to selected candidates. Contract assignment letter for each position was prepared keeping in view the program requirements. For all positions, the selected candidates were kept on three months probation period. Further extension of service was based on performance during probation period. An HR manual has also been prepared, which includes all job descriptions, required competencies, human resource management policies regarding performance, responsibilities of all parties, pay, incentives, allowances and other procedures relating to discipline and equal opportunity. The program staff has since been subjected to a series of capacity-building exercises.

Annex 8 lists all personnel contributing to achieving the results of CLICS by position title, number of workers, main responsibilities and level of effort (LoE) devoted to the Program as a percent of time.

### 3.4.3 Management Information System:

CLICS intends to develop a Management Information System (MIS), based on *Information Equity*<sup>3</sup>, a practice which ensures that the level of awareness and knowledge of an issue, health problem or program is shared among different individuals within a group and among different groups in a community. The practice also ensures that the community has access to corresponding information sources. In general, communities in India have little or no access to reliable health information. CLICS will ensure Information Equity by involving community institutions in the design, collection and use of data from the MIS. This will enable community institutions to monitor and understand changes in health status, which is crucial for the sustainability of program gains. The program strategy for MIS will be developed in the next quarter with the help of an external consultant. However, routine data collection for monitoring performance has begun. A comprehensive monthly progress report for Community Organizers (Annex 9) has been developed and is currently being used to collect data. Besides this, qualitative data is also collected from field staff at periodic intervals using qualitative reporting formats or case studies.

A prototype of the record on “Mother and Child” to be maintained by the village-level staff has been developed and tested (Annex 10). Records for mothers include information on demographics and obstetrics, antenatal care visits, post-natal services, post-delivery information, and an RTI/STI record. The records for children aged 0-3 years include birth records, newborn care, immunizations, vitamin A, growth monitoring, and record of childhood morbidities.

## 3.5 Implementation

**3.5.1 Community Mobilization:** Community mobilisation was implemented through the formation of 249 women’s self help groups (SHGs), 71 Kisan Vikas Manchs (Farmer’s Development Association) and 62 Kishori Panchayats (Adolescent Girls Forum). The sector wise break up of existing groups in the program area is given in Table 3.5.1

Based on experience, DCM fully appreciates the critical link between women’s empowerment and maternal and child health status and considers the involvement of *women’s self-help groups* (SHGs) to be key to the success of the Program. Ultimately, the CLICS Program envisages the formation of at least 3-4 SHGs per village. Drawing from the Freedom from Hunger Model of “Credit with Education”, DCM will assist SHGs to add a health action agenda to their current functions to empower women to determine health priorities and to play a proactive role in health care delivery in their villages. Other groups, already operational in some villages will be invited to join the VCC. These include the *Kisan Vikas Manchs* (Farmers’ Development Association) and *Kishori Panchayats* (Adolescent Girls Forum).

<sup>3</sup> Figueroa EM, et al: *Communication for Social Change: An Integrated Model for Measuring the Process and its Outcomes*, Communication for Social Change Working Paper Series: No. 1, Johns Hopkins University’s Center for Communication Programs for the Rockefeller foundation, 2002.

**Table 3.5.1 Existing groups in the Program area (as on Sept 30th, 2004)**

<b>Groups</b>	<b>Anji Sector</b>	<b>Gaul Sector</b>	<b>Talegaon Sector</b>	<b>Total</b>
Self Help Groups	59	73	117	249
Kishori Panchayats	20	19	23	62
Kisan Vikas Manch	21	26	24	71

For SHGs, activities for economic empowerment of women were actively pursued. 156 out of the 249 SHGs (63%) are linked with banks, 90% of the SHGs have updated member account books. The total monthly collection of all the SHGs amounted to INR 84,154 in the month of September 2004. While INR 86,500 was distributed amongst the SHG members by internal lending, INR 20,812 was the total amount of repayment of loans.

### **3.5.2 Orientation of CBOs:**

All the groups in the area have been oriented to the CLICS program during monthly meetings attended by Community Organizers. Moreover, any other community function was also utilized as an opportunity to orient the VCCs on the CLICS program. VCC formation activities were initiated only after it was ascertained by the Community organizers and the respective Assistant Program Officer that all the CBOs in the village were oriented to CLICS.

### **3.5.3 Orient Health Care providers (Public, Private, ICDS, NGOs)**

All the Auxiliary Nurse midwives, Anganwadi workers (ICDS functionaries), PHC staff, PHC Medical Officers, Private Practitioners, and local NGOs have been oriented to the CLICS program through partner's meetings and routine monthly meetings of PHC & Anganwadi staff.

### **3.5.4 Formation of VCCs**

After formation of CBOs, the next activity taken up was the formation of VCCs. The VCCs were formed by members nominated by the CBOs and the Gram Panchayat. VCCs were formed only in villages where the CO & APO (Social Mobilization) had ascertained that the groups were stable and that they had been oriented to CLICS. To ensure the viability of the VCC, a checklist and set of guidelines were developed (Annex 11). The checklist had to be followed by the village CO as a prerequisite for VCC formation.

Following the completion of the checklist, three meetings were held:

- 1) First meeting: The first meeting was held with CBO members to educate them about the VCC, its roles and responsibilities, and the method for nominating members to the VCC.
- 2) Second Meeting: A second meeting was held with members nominated from the CBOs that included more information about the VCC and assessed their motivation to work for the common good of the village.
- 3) Third meeting: This was the first official gathering of the VCC. At this meeting a president and secretary were elected and a name for the VCC was chosen.

A total of 8 VCCs have been formed in the program area. The distribution of villages where VCCs have been formed is given by sector in Table 3.5.4.2

**Table 3.5.4.2 Villages with VCCs**

Sector	Village
Anji	Pawnar, Chakha – Majra
Gaul	Wabgaon, Bhidi
Talegaon	Aajgaon, Bhiwapur, Padegaon & Dhotra (R)

### 3.5.5 Quality Assurance

The development of a quality assurance plan is in progress and will be completed in the fourth quarter (Oct-Dec) of 2004. Checklists (Annex 12) have been developed to ensure the quality of services provided by the Medical Officer, Private Practitioner, Health Assistant, ANM, Assistant Program Officer, Community Organizer, VCC, and for services such as Growth Monitoring, Antenatal care, Immunization, and OPD services in community owned health clinics. Program-level staff has been provided with training on quality assurance. This one-day interactive training course was coordinated by the Program Director. Training for Sector-level staff on quality assurance and work planning will be completed in October 2004.

### 3.5.6 Capacity Building Activities:

A training needs-assessment exercise was conducted and training needs of all CLICS staff, as well as public healthcare providers, like ANMs & ICDS functionaries, has been identified. However, due to delayed formation of VCCs, a training needs assessment for VCC members could not be completed.

A comprehensive training plan based on identified training needs is being developed and will be completed in fourth quarter (Oct-Dec) 2004. Core trainers have been identified, and a two-day training program has been planned for them on “Leadership” and “Training Technology.”

A detailed list of the training sessions conducted under the CLICS program at Central and Sector levels is given as Annex 13. Training included:

- Training programs for Community Organizers included a week-long training in March, and is being followed-up by monthly one-day trainings. Topics include skills required for community mobilization, and formation and maintenance of village-based institutions.
- Training programs were also carried out for Anganwadi workers and Auxiliary Nurse Midwives in all the three sectors.
- Training of program staff has been completed. Topics include: Community Mobilization and PRA, CLICS Program Technical Interventions, MIS & Documentation, and formation of VCCs.
- For Kisan Vikas Manch members, two single-day trainings were organized at the central level. The topics included: Innovations in Farming, Use of Natural Pesticides and Organic Farming, as well as selected health topics.
- Kishori Melas (gathering of adolescent girls) were held in all three sectors in the second quarter (April-June) 2004.
- Village Health Workers of Talegaon Sector were trained on IMCI and, at the end of training, knowledge and skill evaluation exercises were undertaken.
- External trainings included an 11-day training program (September 1-11, 2004) on “Behavior Change Communication” at the Institute of Health Management, Pachod. Six community organizers, three Auxiliary Nurse Midwives, and the Program Officer for BCC & TRAINING attended the training.
- Training programs for CBOs focused on relevant health topics. All CBOs were imparted with training on “Breastfeeding and its Advantages” during World Breastfeeding Week (September 1-8, 2004). Training on “Balanced Diet for Children and Adults” and “Diet during ANC and PNC,” were taken up in CBO meetings in recognition of Nutrition Week (September 1-7, 2004). In addition, the Community Organizers discussed important health issues with CBO members during monthly meetings.

Exposure visits were also held and program staff visited other Child Survival Programs for cross-learning, such as the Pragati Child Survival Program of World Vision, India at Balia, UP and the Jeevandan Child Survival Program of Counterpart, India at Ahmedabad, Gujarat. A one-day exposure visit for all program staff was also organized to the Bureau of Nutrition, Nagpur, where they were imparted with training on Nutritional Practices. Details of Exposure Visits are given in Annex 14.

One-day training for Panchayat members was organized in all three sectors. A set of guidelines (Annex 15) for training of Panchayat members was developed and provided to all the three sectors. The training mainly focuses on the role of PRIs and covers CLICS program issues and interventions as well as government health policy and relevant national health programmes.

### **3.5.7 Formative Research & Health needs assessment**

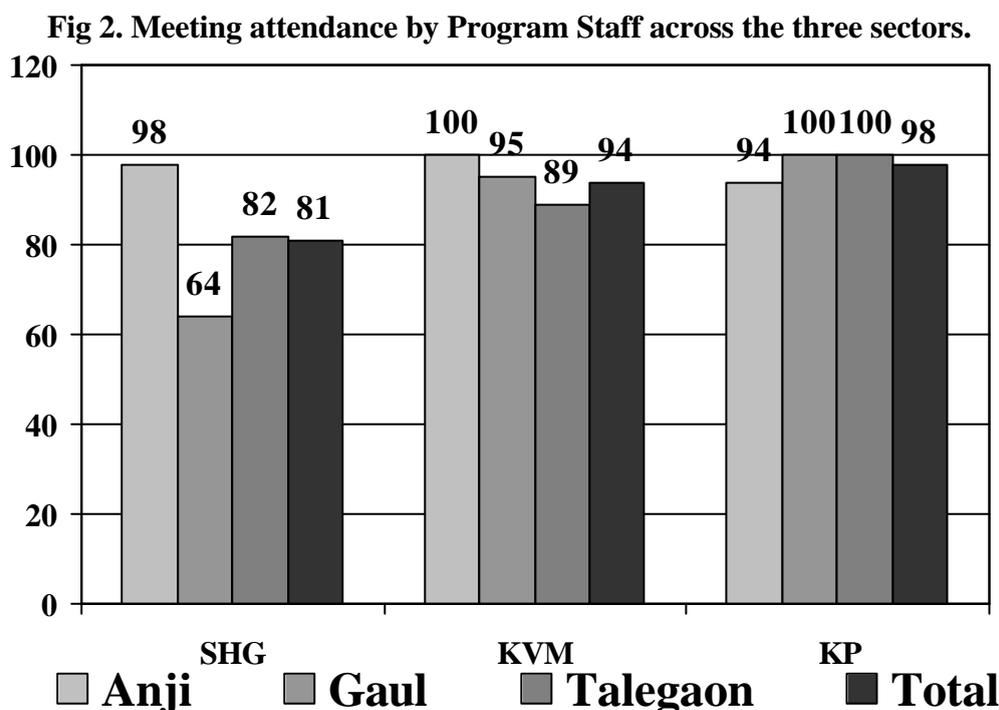
The formative research exercise has been ongoing since the third quarter of 2004 and is currently in progress. This exercise includes:

- Social Mapping (mapping of health resources) in all the program villages
- Daily activity charting of mother and child in sample villages
- Seasonal analysis in sample villages
- Treatment seeking diagram in sample villages

Planning for a health needs assessment has also begun. The program officer of MIS has been involved in the disaggregating of data for individual villages for important health indicators from the baseline survey. A sample of this exercise has been provided as Annex 16, Baseline data for village Pawnar.

### CBO meetings:

Monthly meetings are held for SHG, Kishori Panchayat & Kisan Vikas Manch members. During these meetings, the SHG women discuss relevant issues, as well as pool their monthly contributions and disburse loans. In August-September 2004, 345 (91%) of the CBOs held a monthly meeting. Of these, the program staff attended 296 (85%) of the meetings. These meetings are used by community organizers as an opportunity to deliver key health messages related to CLICS technical interventions. Every month, the sector coordinators provide training to the community organizers on key health messages to be delivered to CBOs during their meetings in the next month. Figure 3 gives a comparative picture of meetings attended by program staff across the three sectors of Anji, Gaul, and Talegaon.



### 3.5.8 Bal Suraksha Diwas

Steps have been taken toward establishing Bal Suraksha Diwas, although this activity was not scheduled for this reporting period. The program staff has started attending the Immunization Days of the district health system with the PHC staff in 12 villages of the program area. This approach has led to a sense of mutual cooperation and teamwork between the Primary Health Center and program staff.

### 3.6 Monitoring & Review

For routine monitoring and review of program activities, a steering committee has been formed, comprised of the Dean of MGIMS, the Program Director and Program Coordinator, AKF India's Health Program Manager, the Wardha District Health Officer, the District ICDS Officer, and a Chartered Accountant. This committee will meet twice a year to review progress against objectives, address unexpected barriers to implementation, and provide strategic advice and direction. The first meeting of the Program Steering Committee was held on November 28, 2003 at MGIMS, Sewagram (see Annex 17). The meeting began with a short presentation of the CLICS program by Dr. B.S. Garg, which provided a brief outline of the programme, activities, organogram and work plan. Following this, the committee discussed various issues regarding program implementation. The second meeting of the Program Steering Committee was held on June 1, 2004 (see Annex 18).

An external Program Advisory Group, consisting of eminent technical experts, has been convened to work with the program director. The advisors will work with DCM to enhance knowledge and skills in state-of-the-art interventions. The first meeting of the Program Advisory Group was held at Aga Khan Foundation, New Delhi on December 23, 2003 (see Annex 19). The purpose of the meeting was to orient the advisors to the CLICS program, and finalize roles and functions of the Program Advisory Group, based upon the evolving needs of the program. The second meeting of the Program Advisory Group was held at the AKF, New Delhi on May 7, 2004 (see Annex 20).

The Technical Support Team meets once a month. During this monthly meeting, the team gives reviews program activities, gives direction, and identifies areas for technical support to the program staff. A Program Implementation Committee has been formed to ensure smooth functioning of the program and for monitoring the progress achieved on a routine basis. This committee is headed by the Program Director and includes the Program Coordinator, Program Officers, members of the Technical Support Team, and the Sector Coordinators. Special participants may also be invited to join the committee from time to time in support of program activities.

A meeting of all the program staff members from all the sectors is held at the program Central Office once a month. This meeting serves as an opportunity for the central and sector staff to present their achievements in the past month and work plan for the next month. This helps in the coordination of the activities for the next month. During this meeting, the field staff members also share with the others their experiences and problems faced during implementation of program activities.

### 3.7 Research, Documentation & Dissemination

The following research topics have been proposed based on DCM's experience in the program area for operations research. These will be explored and refined further during the next quarter.

- *Reaching the Unreached:* According to the baseline study, immunization coverage is lower than expected. Of the 78% of the children aged 12-23 months who are card-documented, only 62% are fully vaccinated (Wardha: 90%; Maharashtra:

62%). The residual of children who are not immunized is therefore higher than expected. This study would attempt to profile this unreached group for immunization in order to arrive at an understanding of the barriers and facilitating factors at play. The Trials of Improved Practice (TIPS) would be the principal methodology employed. The object of the study will be to increase immunization coverage.

- *Compare the effectiveness of a social franchise model in the program area to the effectiveness of the health services in a control area.* The CLICS proposal review team suggested that an operations research study could be designed according to the 'gold standard' of social science research. CLICS partners would be willing to identify staff and resources required for such a study if additional funds were made available for these purposes. The mid-term program would be a suitable juncture at which to commence this study.
- *Home-Based Births vs. Maternity Hut Deliveries:* DCM will test the efficacy of a component of the National Population Policy (2000) that encourages the establishment of village-based maternity huts to increase the number of safe deliveries and promote newborn survival. This will be investigated through research that will compare maternity hut operations with alternatives, such as home-based births attended by trained and qualified attendants.

In addition, a study has been planned to test the overall effectiveness of the Social Franchise Model by comparing the effectiveness of interventions in the project area against those in a government-operated control area. A study has also been planned to look at the use of parenting workshops as a tool to enhance child survival.

**Documentation and dissemination** is being seen as the "*Window to Child Survival*" ensuring information equity among all partners through a multi-channeled approach, as well as between CLICS and the world beyond Wardha. At the village level, through its monthly newsletter, *Samvedana*, DCM enables the community institutions to share and learn from each other. The publication and distribution of *Samvedana* has been occurring since March 2004.

A single-day training program aimed at improving documentation and reporting was carried out in the last quarter. At the sector level, the essence of documentation was discussed among the CO's. Exercises were conducted on report writing so as to capture the process and the focus of the program. For effective documentation, checklists have been developed at the program level. Sector-level workers have been apprised of aspects of documentation and reporting, such as the objective, target audience, program, and lessons learnt. All program staff members have also been provided with daily diaries where they can keep a day-to-day record of their activities.

Issues that are being documented include: Process of activities such as the formation of VCCs; progress made by CBOs; rates of acceptance, involvement and responsibility sharing; and the key stages of forming groups, issues taken up, difficulties faced and strategies drawn. Case studies are also being documented so they can be used as for lessons learned.

Monthly qualitative reporting formats are currently being developed for effective documentation at the sector level.

### 3.8 Reporting

Quarterly financial reports and biannual narrative reports have been prepared and submitted as scheduled, and prepared according to reporting guidelines.

### 3.9 Communication Materials

A program brief is currently under development and will be printed in the next quarter (Oct-Dec 2004). A pamphlet about the CLICS program has been developed and widely circulated. The pamphlet mainly informs people about the activities of the CLICS program and invites them to join in the efforts for VCC formation in their village.

### 3.10 Participation in Conferences and Workshops

The program and DCM staff members have participated in a number of conferences and workshops in the current reporting period. A list has been provided in the table below.

**Table 3.10.1 Participation in Conferences & Workshops**

Name of Conference/Workshop	Dates	Venue of conference	Name of participants
XXXI Annual Conference of the Indian Association of Preventive & Social Medicine	27-29 <sup>th</sup> February 2004	PGI, Chandigarh	Dr BS Garg Dr. Subodh Gupta Dr. PR Deshmukh Dr. Sherin Varkey
Child Survival & Health Mini University II	7 <sup>th</sup> -11 <sup>th</sup> June 2004	Johns Hopkins Bloomberg School of Public Health, Baltimore, Atlanta USA	Dr. BS Garg Ms. Terri Lukas Ms. Nemat Hajeebhoy Dr. Sherin Varkey
National Workshop on methodologies for assessment of Vitamin A Deficiency, Iodine Deficiency Disorders & Iron Deficiency Anemia.	13-15 <sup>th</sup> September 2004	AIIMS, New Delhi	Dr. PR Deshmukh

## 4. Problems Encountered and Lessons Learned

There were no major problems in program implementation in the current reporting period. However, local village elections (Panchayat Elections), which were held in February and March 2004, caused a delay in implementation of certain program activities. Due to the anticipated change in leadership, orientation of Panchayat members was intentionally postponed. This was undertaken once the village bodies were in place. The upcoming state assembly elections are scheduled for October 13. As the whole of the government machinery is geared up for the State Assembly elections, VCC formation has been delayed at some politically sensitive areas.

Though Panchayat functionaries have been a part and parcel of the ongoing VCC formation, endorsement had to be deferred until after the elections.

Program personnel also faced problems of political rivalry between factions during the formation of VCCs in the villages of Padegaon in the Talegaon Sector and Kolona in the Gaul Sector. This problem was resolved by inviting all factions to participate in the process of VCC formation. Women were encouraged to take up the positions of president and secretary of these committees. All positions are selected unanimously and elections are avoided, as far as possible. The process of VCC formation in the village of Wabgaon has been included as a case study (see Annex 21)

In Dhotra (R) village VCC of Talegaon Sector, it was observed that the Sarpanch was dominating the proceedings and not allowing other members to express their views. He had also expressed his desire to become president of the VCC. This problem was resolved by encouraging the Sarpanch to give others an opportunity to play an active role in the development of the village, and rather than take a head role, to act as the chief advisor to the office bearers. This approach has avoided conflict and has facilitated the smooth functioning of the VCC.

Having gone through the process of VCC formation, program personnel have observed that membership to the VCC has been carefully considered in order to avoid future problems or conflicts, and to ensure sustainability of the VCC. With this end in mind, a set of criteria and guidelines has been developed. The guidelines are (see table 4.1):

- The VCC should be, at maximum, 25 people.
- In case the number of SHG is less than 5, then with the recommendation of the Community Organizer/Assistant Program Officer, the Sector Coordinator can nominate a SHG member to the VCC.
- Two representatives must be from KVM and KP.
- Anganwadi Worker and ANM & Gram Sewak & Community organizer would be the ex-officio members.
- 3-4 members of repute from the village involved in developmental activities may also be included, such as a schoolteacher or motivated youths (to be co-opted by VCC in their first formal meeting)
- Community Organizer will be committee's Convener for first two years

**Table 4.1 Constitution of VCC**

<b>Representative from</b>	<b>No. of Members</b>
SHGs	1(from each)
KVM	2
KP	2
Gram Panchayat	2
Influential leader (co-opted)	4
Ex-officio	
1. AWW	All
2. ANM	1
3. Gram Sewak	1
4. Community Organizer	1
<b>Total strength of VCC</b>	<b>25 (maximum)</b>

The unavailability of a suitable consultant has led to the delay in the development of BCC & Communication Strategies, and activities related to the MIS plan & formative research. These processes will be expedited in the next year.

Another problem faced by the project is the staff turnover for the position of Program Officer (Documentation & Communication). This has led to a delay in implementation of the documentation plan and development of communication products. These activities will be completed over the next year.

A favorable development for CLICS was the handing over of technical control of the three primary health centers to DCM by the State Government.. This has led to greater collaboration between CLICS staff and the primary health center staff and has provided an opportunity for smooth implementation of collaborative activities such as the Bal Suraksha Diwas and making the sub-centers functional.

## 5. Plans for the next year

The work plan for the next year is given in Annex 22. Plans for the near future include:

- A *formative research* exercise will be conducted in the next quarter. This will elaborate qualitative benchmarks such as community norms regarding the role of women and community perceptions regarding the quality of health services. It will provide a basis for a behavior change communication strategy.
- Strengthening of Self Help Groups, Kisan Vikas Manchs and Kishori Panchayats will continue.
- Formation and orientation of VCCs will be completed in all the program villages.
- Health needs assessment will be done for all villages with VCCs.
- Capacity building of VCCs.
- Identification and training of village health workers and trained birth attendants from the program villages.
- Capacity building of program staff in quality assurance, technical interventions, BCC and MIS.
- Development of BCC and communication strategies.
- BCC activities at village level.
- Family Life Education for adolescent girls.
- Setting up community-owned health clinics, maternity huts and making sub-centers functional.

## 6. Financial Management

Out of the total budget of \$ 373,244 for the period October 1, 2003 to September 30, 2004, an expenditure of \$193,167 has been incurred, resulting in a variance of 48%. This has been on account of the various reasons discussed below.

#	Category/Line-Item	Budget US\$				Actual US\$				Variance %			
		USAID	AKFUSA	Others	Total	USAID	AKFUSA	Others	Total	USAID	AKF USA	Others	Total
a.	Personnel	58,904	-	15,953	74,857	40,759	-	14,708	55,467	31	-	8	26
b.	Fringe Benefits	7,295	-	-	7,295	4,351	-	-	4,351	40	-	-	40
c.	Travel	15,860	-	-	15,860	9,918	-	-	9,918	37	-	-	37
d.	Equipments	1,532	83,150	-	84,682	-	36,381	-	36,381	100	56	-	57
e.	Supplies	-	20,127	-	20,127	-	10,160	-	10,160	-	50	-	50
f.	Contractual	79,958	-	-	79,958	49,572	-	-	49,572	38	-	-	38
g.	Construction	-	-	-	-	-	-	-	-	-	-	-	-
h.	Other	36,970	42,982	10,513	90,465	16,163	5,157	5,998	27,318	56	88	43	70
<b>Total Project Cost</b>		<b>200,519</b>	<b>146,259</b>	<b>26,466</b>	<b>373,244</b>	<b>120,762</b>	<b>51,698</b>	<b>20,706</b>	<b>193,167</b>	<b>40</b>	<b>65</b>	<b>22</b>	<b>48</b>

### Reasons for under-utilization of budget:

**Personnel** - This being the first year of implementation of the project, there have been delays in hiring of personnel. Most of the staff is now in place. The delay in hiring of personnel has resulted in a variance of 26%.

**Travel** - There has been a variance of 37% in travel costs due to planned travel not being undertaken.

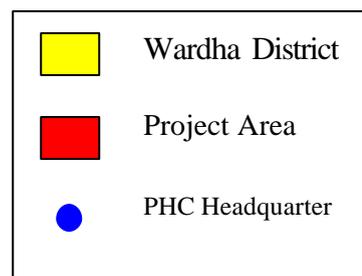
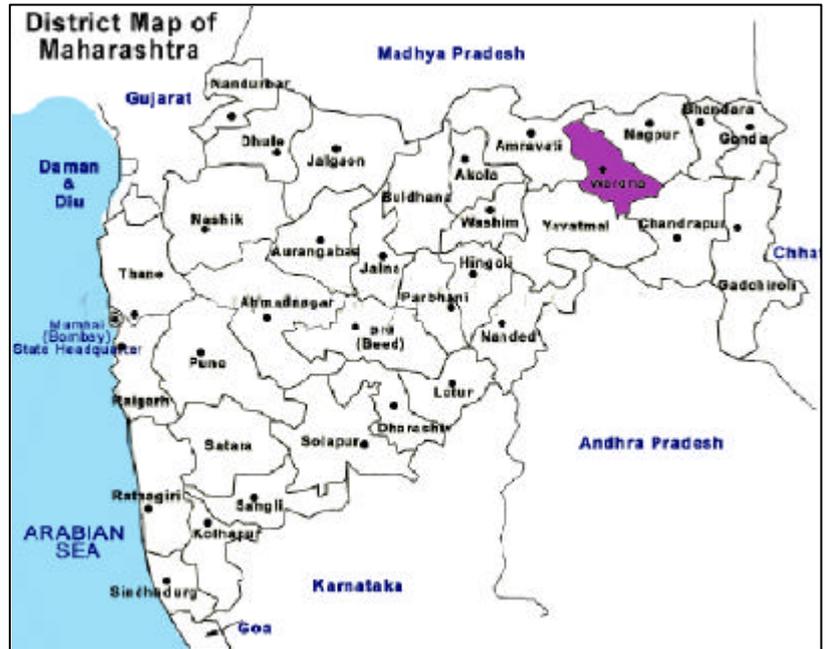
**Equipment and supplies** - Reported variances of 57% and 50% for equipment and supplies, respectively. For equipment, expenditures for maternity huts and health clinics will be undertaken next year. In addition, the time required for collection of quotations for purchase of equipment has been longer than anticipated. Supplies, such as software, medical kits for staff, and training materials, have not been purchased.

**Contractual** – There has been a variance of 38% under the contractual line item. This has been largely due to the unexpended amounts for formative research and audits. The audit line item will be expended in the next year.

**Other** – There has been a variance of 70% under this line item, which essentially consists of operating costs. The rent for one of the sector offices was to be borne under the USAID contribution. However, suitable premises for the Talegaon sector office could not be identified in the first year and therefore no expenditures for rent were made. Further, the other costs such as electricity, fuel for vehicles, insurance, and annual maintenance, have not been incurred to the extent anticipated.

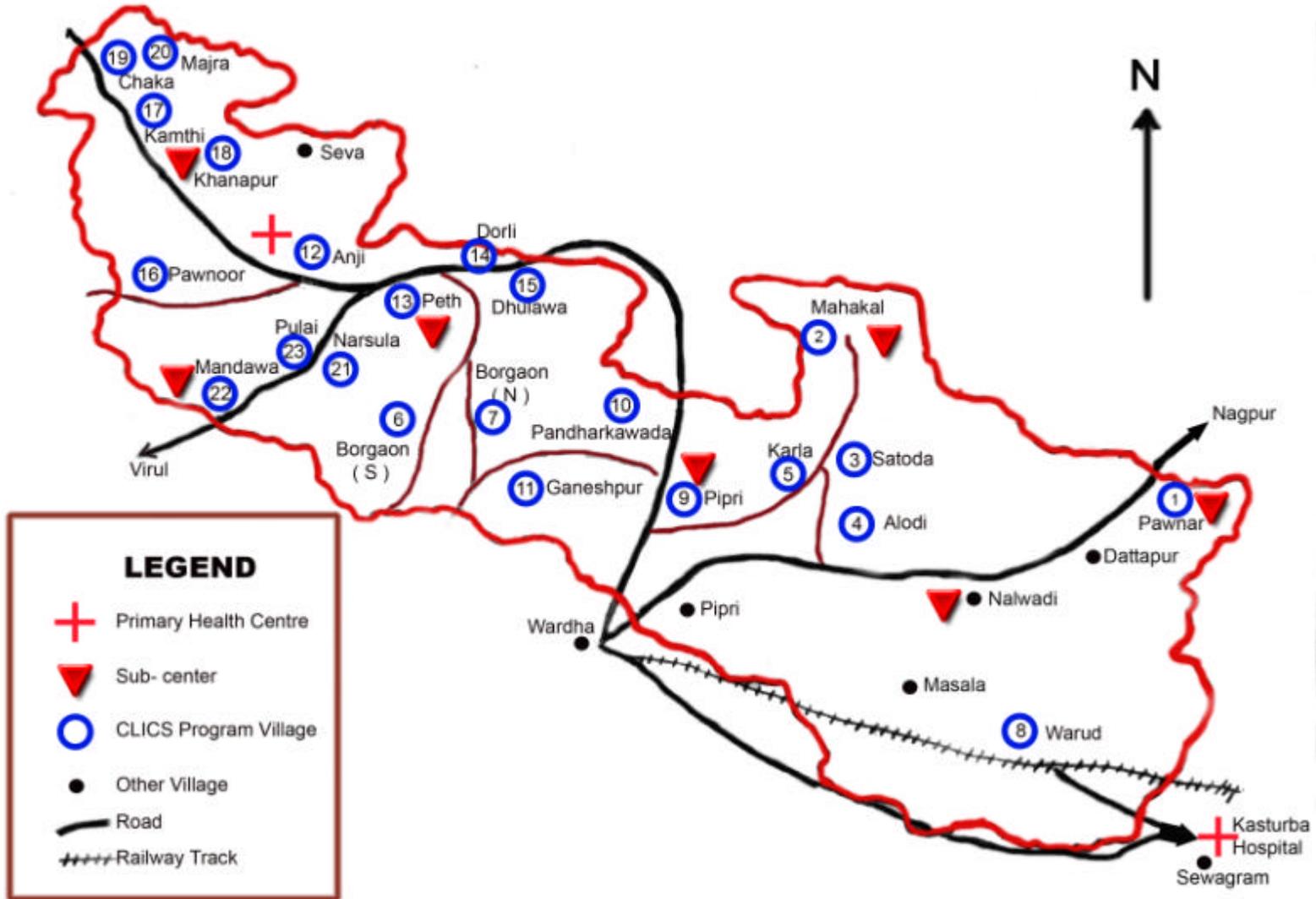
The preparation of the Detailed Implementation Plan (DIP) also took up considerable time of the program staff, and had a corresponding negative impact on the pace of activities during the first half of the year. Implementation picked up in the second half of the year, but not sufficiently to cover the gaps in activity for the entire year. It is expected that the program will report timely expenditure of funds for the years ahead.

### Annex 1



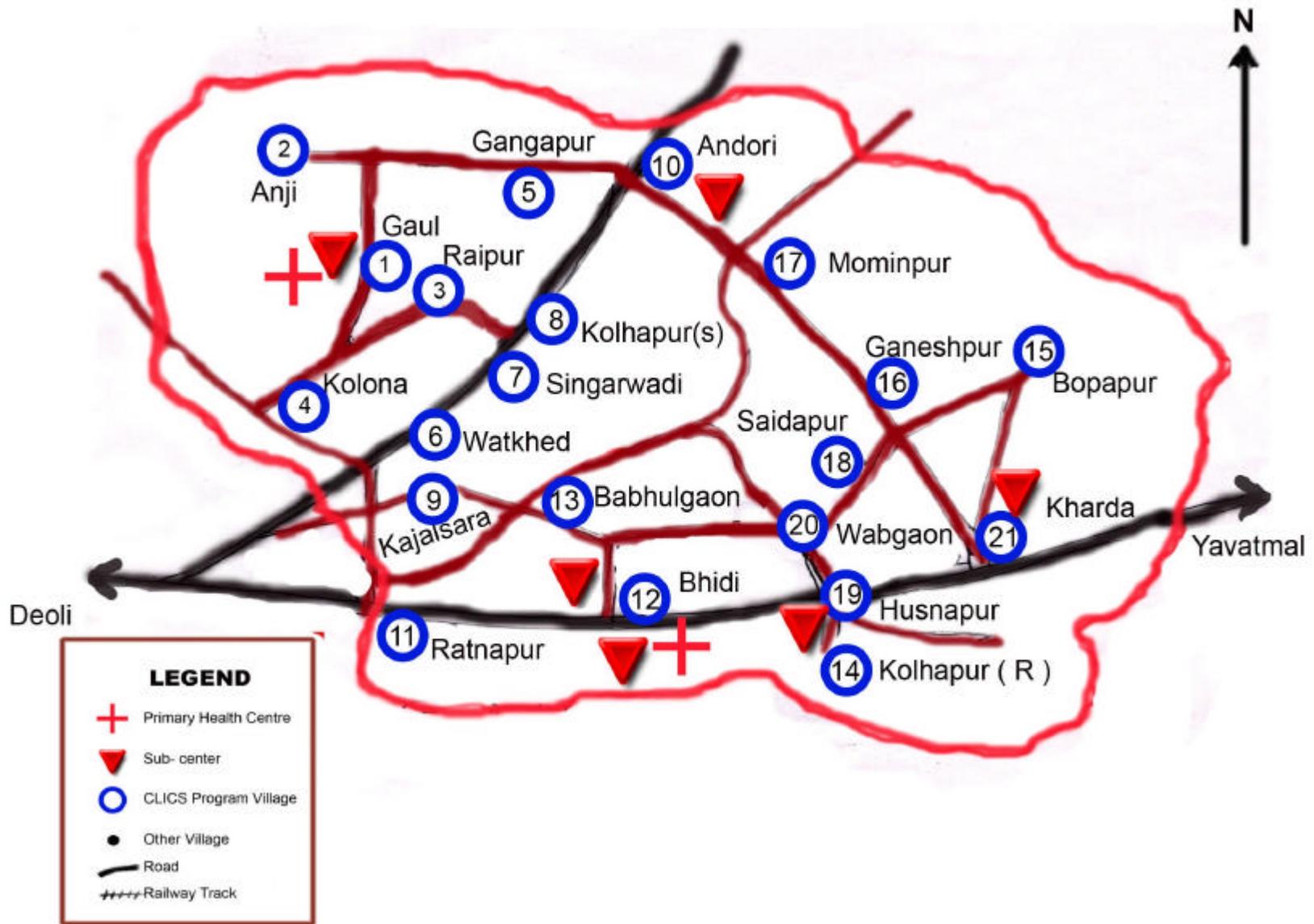


**Annex 1a. Map of Anji Sector**

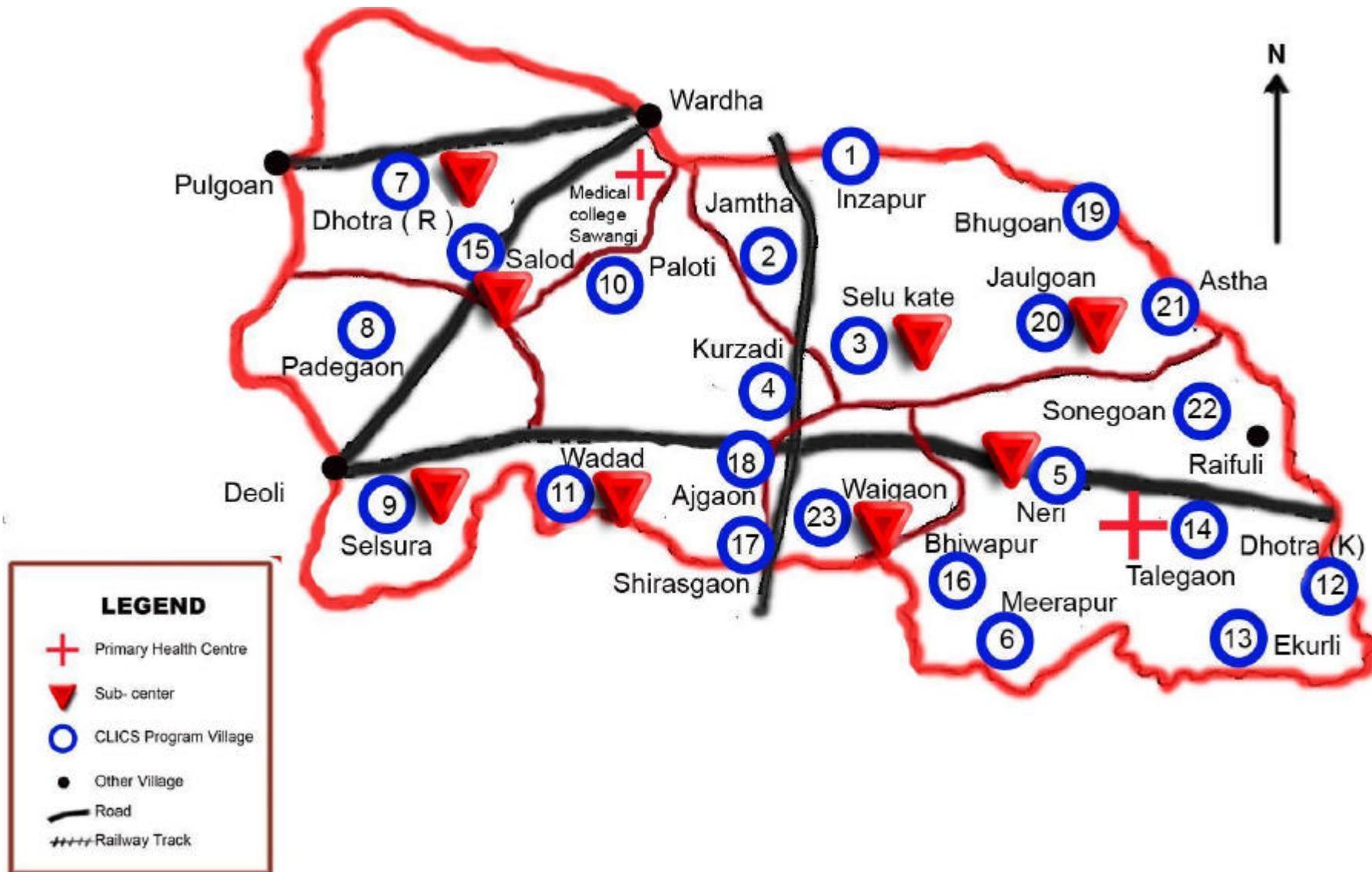


Annex

**Annex 1b. Map of Gaul Sector**



**Annex 1c. Map of Talegaon Sector**



## Annex 2: List of Villages and their Population

Sector	Village Code	Village Name	Total Population
<b>Anji (Mothi)</b> Sector 1	1	Anji (Mothi)	5550
	2	Dhulava	379
	3	Dorli	124
	4	Mahakal	1809
	5	Satoda	1017
	6	Aalodi	1422
	7	Peth	543
	8	Narsula	344
	9	Borgaon(Sa)	832
	10	Borgaon(Na)	488
	11	Mandava	1848
	12	Pulai	827
	13	Warud	2140
	14	Kamthi	312
	15	Khanapur	768
	16	Majara/Chaka	854
	18	Pavnoor	1293
	19	Pavanar	7261
	20	Pipri (Meghe)	2051
	21	Karla	720
	22	Ganeshpur	524
	23	Pandharkawada	377
			<b>Sub-total</b>
<b>Gaul</b> Sector 2	24	Gaul	1581
	25	Kolona	1186
	26	Watkhedda	998
	27	Andori	2268
	28	Anji (Andori)	1660
	29	Babhulgaon	817

Sector	Village Code	Village Name	Total Population
	30	Bhidi	3172
	31	Bopapur	383
	32	Ganeshpur	183
	33	Gangapur	183
	34	Husanapur	374
	35	Kajalsara	969
	36	Kharda	902
	37	Kolhapur Rao	486
	38	Kolhapur (Singarwadi)	550
	39	Mominpur	322
	40	Raipur	101
	41	Ratnapur	731
	42	Saidapur	219
	43	Singarwadi	234
	44	Wabgaon	1381
		<b>Sub-total</b>	<b>18700</b>
<b>Talegaon</b> Sector 3	45	Talegaon (Talatule)	3698
	46	Ekurli	957
	47	Dhotra (K)	1016
	48	Sonegaon	1318
	49	Jaulgaon	594
	50	Ashtha	1130
	51	Bhugaon	1446
	52	Salod	6039
	53	Padegaon	1848
	54	Dhotra (Rly)	799
	55	Selsura	1197
	56	Paloti	1844
	57	Jamtha	398
	58	Inzapur	803

Sector	Village Code	Village Name	Total Population
	59	Wadad	1278
	60	Kurzodi	1283
	61	Waigaon	6692
	62	Neri (M)	769
	63	Mirapur	601
	64	Aajgaon	381
	65	Shirsgaon	1354
	66	Seloo-Kate	1806
	67	Bhivapur	695
		<b>Sub-total</b>	<b>37946</b>
<b>Total</b>			<b>88,128</b>

**Annex 3 Workplan**

Line Items	Activity Focus	Year 1				Personnel	Benchmarks	Achievements as of September 30th 2004
		October 2003-September 2004						
		Oct 2003- Dec 2004	Jan- Mar 2004	Apr- Jun 2004	Jul- Sep 2004			
		Qtr 1	Qtr 2	Qtr 3	Qtr 4			
<b>Start-up Activities</b>								
Finalize Contractual Procedures (AKF/DCM)		X					Contractual procedures finalized	
Establish Office		X	X	X		Office Established	All offices established, except Talegaon Sector Office, which will be operational from the month of Oct 04	
Procure equipment/furniture/vehicles			X	X			Procurement completed, except for one computer, one printer and one generator, which will be completed in the quarter Oct-Dec 04	
Recruit Personnel			X			All personnel appointed	All positions in place except for MIS assistants (2) & Medical Officer (1) due to unavailability of suitable candidate. Will be completed in Quarter Oct-Dec 04	
Appoint Program Advisors		X				PA appointed	PA appointed	
<b>Objective 1 : To provide affordable high quality health care through effective partnerships at the village level</b>								
<b>Key indicator : Proportion of villages with VCC</b>								
<b>Key indicator : Proportion of VCCs with Franchise Agreement</b>								

Line Items	Activity Focus	Year 1				Personnel	Benchmarks	Achievements as of September 30th 2004
		October 2003-September 2004						
		Oct 2003- Dec 2004	Jan- Mar 2004	Apr- Jun 2004	Jul- Sep 2004			
		Qtr 1	Qtr 2	Qtr 3	Qtr 4			
<b>Key indicator</b> : Quality Assurance and affordability								
<b>1.1 Develop effective partnerships</b>								
Mobilize communities	A	X	X	X	X	Community Organizer	VCCs formed in 40% of Gram Panchayat villages by end of year 1. VCCs formed in 100% of Gram Panchayat villages by end of year 2.	249 SHGs, 71 KVMs & 62 KP formed in the program area.
Orient Community Based Organizations	A	X	X	X	X	Community Organizer + Asst. Program Officer		All CBOs have been oriented to CLICS
Orient Health Providers (Public, Private, ICDS Functionaries, NGOs)	A		X	X	X	Sector Coordinator + Asst. Program Officer		All Health Providers (Public, Private, ICDS Functionaries, NGOs)
Form VCCs	A			X	X	Community Organizer (CO)		VCCs formed in 15% of Gram Panchayat villages by end of year 1.
Orient VCCs	A				X	Asst. Program Officer+CO	All VCCs oriented	All VCCs oriented
Gram Panchayat Resolutions					X	Asst. Program Officer	All VCCs endorsed by Panchayats	VCCs could not be endorsed by Gram Panchayat due to State level Elections.
Conduct health needs assessment	A					Community Organiser + Asst. Prog. Officer+ Medical Officer	Health Needs Assessment conducted in all villages with VCCs	
Plan child survival interventions	A					Community Organiser + Asst. Prog. Officer+ Medical Officer	Franchise Agreement developed with all VCCs	
Develop Franchise Agreement	Q&A					Community Organiser + Asst. Prog. Officer+ Sector coordinator		
<b>1.2 Plan and provide affordable high quality care</b>								

Line Items	Activity Focus	Year 1				Personnel	Benchmarks	Achievements as of September 30th 2004
		October 2003-September 2004						
		Oct 2003- Dec 2004	Jan- Mar 2004	Apr- Jun 2004	Jul- Sep 2004			
		Qtr 1	Qtr 2	Qtr 3	Qtr 4			
Develop QA Plan	Q			X	X	Program Director	QA plan developed	Checklists have been developed for quality of services provided by Medical officer, Pvt. Practitioner, Health Assistant, ANM, Asst. Program Officer, CO, VCC and for services such as Growth Monitoring, Antenatal care, Immunization, OPD services in COHP
Build Capacity in QA Staff	Q				X	Core Trainers	Training in QA completed	Program level staff have been provided training on Quality Assurance. Training for Sector level staff will be completed in the month of October 2004.
Health Care Provider (HCP)	Q					Core Trainers	Training in QA completed	
ICDS Functionaries	Q					Core Trainers	Training in QA completed	
VCC	Q					Core Trainers	Training in QA completed	
Operationalise QA system	Q							
Village Level	Q					VCC + HCP	QA system operationalized	
Facility Level	Q					HCP+ Medical Officer	QA system operationalized	

Line Items	Activity Focus	Year 1				Personnel	Benchmarks	Achievements as of September 30th 2004
		October 2003-September 2004						
		Oct 2003- Dec 2004	Jan- Mar 2004	Apr- Jun 2004	Jul- Sep 2004			
		Qtr 1	Qtr 2	Qtr 3	Qtr 4			
<b>Objective 2: Build the capacity of coalition of local partners to sustain child survival activities and health gains</b>								
<b>Key Indicator:</b> % Improvement in capacities (task specific) of Program staff & Partners								
<b>Key Indicator:</b> % VCCs with sustainability plan								
<b>2.1 Build the capacity of coalitions of partners</b>								
Conduct Appreciative Inquiries, Org.Capacity Assessment for DCM	Q&A		X	X	X	External Consultant	Areas for Capacity building of DCM staff identified	Could not be done due to unavailability of suitable consultant.
Conduct Training Needs Assessment for Staff, Providers and VCC	Q&A		X	X	X	Prog Officer (BCC & Training)	Training needs of personnel identified.	Training needs of personnel, except VCC members identified.
Develop Training Plan (task-specific)	Q		X	X	X	Prog Officer (BCC & Training)	Training plan (task - specific) identified.	Process has been initiated. Will be completed in Quarter Oct-Dec 04
Identify and train core trainers			X	X	X	Prog Officer (BCC & Trg.) + Behavioral Sciences Expert	Core Trainers identified and trained	Core trainers identified, Training will be completed in Quarter Oct-Dec 04
Conduct training (task-specific) on	Q							
Community Mobilisation & PRA	Q		X	X	X	Prog Off (BCC & Trg) + Behavioral Sciences Expert+Astt. Prog. Officer		Training on Community Mobilization & PRA completed.
Technical Interventions				X	X	Prog. Officer (BCC & Trg) + Child Survival Exp+Technical team		Process has been initiated. Will be completed in Quarter Oct-Dec 04
Behaviour Change Communication	BC					Prog Officer (BCC & Trg) + Behavioral Sciences Expert+AKF	Training (task-specific) completed	

Line Items	Activity Focus	Year 1				Personnel	Benchmarks	Achievements as of September 30th 2004
		October 2003-September 2004						
		Oct 2003- Dec 2004	Jan- Mar 2004	Apr- Jun 2004	Jul- Sep 2004			
		Qtr 1	Qtr 2	Qtr 3	Qtr 4			
Management Information System	Q				X	Prog Officer (MIS)+External consultant		Staff has been sensitized to the need for a good MIS and training has been provided for the various formats. Will be completed in Quarter Oct-Dec 04
Quality Assurance	Q					Program Director		
Documentation						Prog Officer (Documentation & Communication)+AKF		
Continuing Education (Refreshers)	Q					Prog. Officer (BCC & Trg)	Monthly refresher training sessions held regularly	
<b>2.2 Determine Child Survival interventions &amp; develop BCC strategy</b>								
Conduct baseline assessments								
Survey		X	X			Contractual	Baseline Assessment completed	Baseline Assessment completed
Facility Assessment	Q		X	X		Sector Coordinator		Baseline Assessment completed
Planning workshop for DIP			X			CLICS Team +Partners	Planning workshop completed	Planning workshop completed
Develop Detailed Implementation Plan			X	X		CLICS Team	DIP developed	DIP developed
Conduct Formative Research	BC			X	X	Contractual	Formative Research conducted	Process has been initiated. But could not be completed due to unavailability of suitable consultant. Will be completed in Quarter Oct-Dec 04

Line Items	Activity Focus	Year 1				Personnel	Benchmarks	Achievements as of September 30th 2004
		October 2003-September 2004						
		Oct 2003- Dec 2004	Jan- Mar 2004	Apr- Jun 2004	Jul- Sep 2004			
		Qtr 1	Qtr 2	Qtr 3	Qtr 4			
Develop BCC Plan	BC				X	Prog. Officer (BCC & Trg.)+AKF	BCC plan developed	Process has been initiated. Will be completed in Quarter Oct-Dec 04
Develop BCC tools & materials	BC					Prog. Officer (BCC & Trg.)+Contractual	BCC tools and materials developed	
<b>2.3 Implement Child Survival Activities</b>								
Generate Village Health Fund	A					VCC+CO	Village Health fund generated in all VCCs	
Select VHWs & TBAs	A					VCC+CO	TBAs (1/Village) & VHWs (1:1000) selected.	
Initiate intervention specific activities								
<b>Home</b>								
VHW Home Visits	A and BC					VHW	More than 90% of VHWs conduct all the required home visits	
Trained Birth Attendant (TBA)	A and BC					TBA	100% of home deliveries conducted by TBAs	
<b>Community</b>								
CBO meetings	A and BC	X	X	X	X	Community Organizer	80% of CBO meetings conducted in a month	90% of CBO meetings conducted in a month, 85% of meetings were attended by program staff.
Bal Suraksha Divas	A and BC					Community Organizer + Medical Officer + ANM	90% of VCCs conducted Bal Suraksha Divas in any given month	
Parenting Workshops	A and BC					Asst. Prog. Officer+Sector Coord.	1 Parenting workshop conducted	

Line Items	Activity Focus	Year 1				Personnel	Benchmarks	Achievements as of September 30th 2004
		October 2003-September 2004						
		Oct 2003- Dec 2004	Jan- Mar 2004	Apr- Jun 2004	Jul- Sep 2004			
		Qtr 1	Qtr 2	Qtr 3	Qtr 4			
						in all villages		
Campaigns	BC							
Suraksha Aichi aani Balachi (Safe Motherhood and Child Survival Campaign)	BC				All sector level Program Staff+ Prog Officer (BCC & Trg)	Campaigns conducted in 90% villages in a year		
Mulgi Wachawa Mohim (Save the Female Child campaign)	BC							
Facility								
Community Health Clinics	Q & A				Medical Officer+ANM	Functional Community Health clinics in 25 villages		
Sub-centre labor rooms	Q & A				ANM (Govt.)	50% of subcentres with functional labor rooms		
Maternity Huts	Q & A				TBA	Maternity Huts in 15 villages		
Anganwadi center	Q & A				Anganwadi worker	50% of Anganwadi centers utilizing ECD tools.		
<b>2.4 Provide community access to services and health related products</b>								
Identify product basket required for franchises					Community Organiser+Asst. Programme Officer	Franchise agreement		
Define partnership with Government to ensure supply					Programme Director+Programme Coordinator	partnership documents		
Determine pricing policy for products and distribution points					Community Organiser+Asst. Programme Officer	Franchise agreement		
Monitor utilisation of products and cost recovery					Programme Officer (MIS)	Monitoring system operationalise		
<b>2.5 Develop system for sustaining child survival activities &amp; health gains</b>								

Line Items	Activity Focus	Year 1				Personnel	Benchmarks	Achievements as of September 30th 2004
		October 2003-September 2004						
		Oct 2003- Dec 2004	Jan- Mar 2004	Apr- Jun 2004	Jul- Sep 2004			
		Qtr 1	Qtr 2	Qtr 3	Qtr 4			
Adapt & refine LOGFID for VCC	Q					Program Coordinator + Behavioral Sciences Expert+AKF	LOGFID for VCC developed	
Assess institutional maturity of VCCs	Q					Asst. Program Officer + VCC	Institutional Maturity of all VCCs assessed	
Develop and initiate sustainability plan	A					Asst. Program Officer + VCC+CO	Sustainability plan initiated in 70% of VCCs	
Express 'ownership' intent	A					VCC	70% of VCCs express 'ownership' intent	
Second Agreement (Establishing VCC "ownership")	A					Asst. Program Officer + VCC	70% of VCCs achieve "ownership".	
<b>2.6 Institutionalise Monitoring and Financial Systems</b>								
MIS				X	X	Prog officer (MIS)	MIS developed and operationalized	Routine monitoring formats have been developed. MIS system will be developed in next quarter with the help of External Consultant.
Financial reports			X	X	X	Finance & Administrative Officer	Financial systems developed and operationalized	Financial systems developed and operationalized
Narrative				X		Program Coordinator + Prog officer (Docum. & Communication)	Timely preparation & dispatch of reports	Timely preparation & dispatch of reports
Audits						Contractual	5 Annual audit reports	
<b>Objective 3: Refine &amp; test social franchise model for delivery of child survival interventions</b>								
<b>Key Indicator:</b> % of VCCs with instituted annual reviews								
<b>Key Indicator:</b> % difference between CLICS and GOI facilities								

Line Items	Activity Focus	Year 1				Personnel	Benchmarks	Achievements as of September 30th 2004
		October 2003-September 2004						
		Oct 2003- Dec 2004	Jan- Mar 2004	Apr- Jun 2004	Jul- Sep 2004			
		Qtr 1	Qtr 2	Qtr 3	Qtr 4			
<b>3.1 Refine &amp; define the social franchise model</b>								
Institute review systems at VCC level					Asst. Program Officer	90% of VCCs have instituted annual reviews		
Program Steering Committee meetings		X		X	Program Director	Meetings held as per schedule.	Meetings held as per schedule.	
Program Advisory Committee meetings		X		X	Program Director		Meetings held as per schedule.	
Formal Reviews & Assessment								
<b>3.2 Test feasibility of social franchise model</b>								
Conduct pre-post project assessments					Contractual	Assessments completed as per schedule		
Baseline		X	X		Contractual		Assessments completed as per schedule	
Mid-term					Contractual			
End-term					Contractual			
Annual Reviews							X	
Operations Research for comparison of Gol facilities					Contractual	Operations Research completed	Both sector & program level review will be undertaken in the Quarter Oct-Dec 04.	
<b>Objective 4: Document, disseminate &amp; share key program lessons &amp; results to facilitate adaptation, replication &amp; policy advocacy</b>								
<b>Key indicator:</b> Communication strategy developed								
<b>Key indicator:</b> # of workshops/meetings participated and papers presented								
<b>4.1 Document key programme lessons &amp; results</b>								
Develop documentation plan				X	X	Prog officer (Doc. & Comm) + AKF	Documentation plan developed	
Develop & operationalise systems							Documentation plan developed	
<b>4.2 Disseminate &amp; share lessons</b>								

Line Items	Activity Focus	Year 1				Personnel	Benchmarks	Achievements as of September 30th 2004
		October 2003-September 2004						
		Oct 2003- Dec 2004	Jan- Mar 2004	Apr- Jun 2004	Jul- Sep 2004			
		Qtr 1	Qtr 2	Qtr 3	Qtr 4			
Develop communication strategy				X	X	Prog officer (Docum. & Communication) + AKF	Communication strategy developed	Communication strategy could not be developed due to unavailability of consultant and turnover for position Prog. Officer (Doc & Comm)
Develop communication products								
Newsletter/ Samvedna				X	X	Prog officer (Docum. & Communication)	Regular printing & distribution of newsletter	Regular printing & distribution of newsletter since March 2004
Project Briefs				X	X	Prog officer (Docum. & Communication) + PO+AKF	Project Briefs prepared	Draft brief has been prepared. Final version will be printed in the Quarter Oct-Dec 2004.
Child Survival Website						Contractual	Child survival website developed	
Others (as identified)								
Organise information sharing workshops/meetings						Program Director & Program Coordinator	2 information sharing workshops/ meetings organized	
Organise advocacy workshops/meetings						Program Director & Program Coordinator	2 advocacy workshops/ meetings organized	
Participate in conferences & network meetings				X		CLICS	Participation in 2-4 conferences/ network meetings each year	CLICS & DCM staff have participated in conferences.
Other						Asstt. Officer +AKF		
Operations Research								

Line Items	Activity Focus	Year 1				Personnel	Benchmarks	Achievements as of September 30th 2004
		October 2003-September 2004						
		Oct 2003- Dec 2004	Jan- Mar 2004	Apr- Jun 2004	Jul- Sep 2004			
		Qtr 1	Qtr 2	Qtr 3	Qtr 4			
Plan Operations Research			X	X		Program Coordinator & Technical Support Team	Will be completed in the quarter Oct-Dec 2004	
Implement Operations Research						Program Coordinator & Technical Support Team		



**Annex 4. RAPID CATCH INDICATORS**

Indicator	Sector			Total
	Anji	Gaul	Talegaon	
Sentinel Measure of Child Health and Well-being				
1. Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for age, according to the WHO/NCHS reference population)	23.4	26.4	24.1	24.3
Prevention of Illness/Death				
2. Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	68.7	64.8	66.3	66.9
3. Percentage of children age 0-11 months whose births were attended by skilled *health personnel	84.1	80.1	81.8	82.2
4. Percentage of mothers with children age 0-11 months who received at least two tetanus toxoid injections before the birth of their youngest child	83.1	80.5	84.8	83.3
5. Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours	78.3	81.3	80.8	80.1
6. Percentage of children age 6-9 months who received breast milk and complementary foods during the last 24 hours	49.7	34.1	56.7	50.0
7. Percentage of children age 12-23 months who are fully vaccinated (against the six vaccine preventable diseases) before the first birthday	70.6	79.0	77.9	75.5
8. Percentage of children age 12-23 months who received a measles vaccine.	75.4	86.2	84.5	81.6
9. Percentage of children age 0-23 months who slept under an insecticide treated net (in malaria risk areas) the previous night	1.9	1.3	0.8	1.3
10. Percentage of mothers with children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	21.2	14.2	21.5	20.1
11. Percentage of mothers with children age 0-23 months who report that they wash their hands with soap/ash				
Before food preparation	10.1	6.1	9.9	9.1
Before feeding children	17.3	6.1	15.4	14.0
After defecation	91.2	81.9	87.5	87.6
Management/Treatment of Illness				
12. Percentage of mothers of children age 0-23 months who know at least two signs of childhood illness that indicate the need for treatment	36.6	21.6	30.0	30.5
13. Percentage of sick children with cough and or/ difficult/ rapid breathing during the past two weeks who received				
i) Increased fluids (7-23 months)	1.6	0.8	1.3	1.3
ii) Continued feeding (0-23 months) among those who were breastfeeding	97.5	94.2	97.0	96.5
Percentage of sick children with watery or loose motion during the past 2 weeks who received				
i) Increased fluids (7-23 months)	2.1	0.0	0.9	1.2
ii) Continued feeding (0-23 months) among those who were breastfeeding	83.5	86.5	82.8	84.0

\* Trained health personnel (Doctor, ANM/nurse and trained dai)

**Annex 5**  
CLICS Programme  
Department of Community Medicine  
MGIMS  
SEVAGRAM

**CHECKLIST FOR SERVICE DELIVERY CENTRE**

Name of the Centre

Name of Respondent

Designation

Date of Interview

Name of Interviewer

Signature of Interviewer

(Please Reply in Yes-1, NO-2)

**1 Are clinic timings displayed in the local language clearly out side?**

2. Does the key service provider stay at centre?

**3. Waiting area**

- a) Is the area sheltered from weather conditions (sun/rain)?
- b) Is their adequate seating space for clients while waiting?
- c) Is drinking water available for clients while waiting?

**4. Counselling & examination room**

- a) Is there adequate privacy for client
  - i) Is there screen available
  - ii) Are their curtains available?
- b) Is electricity available?
- c) Is running water available?
- d) Is there at least one toilet for clients and outpatients?

If yes,

- i) Dose it appear clean?
  - ii) Dose it have adequate water supply
- e). Does the examination room have the following items?
- i) Examination table
  - ii) BP instrument
  - iii) Stethoscope
  - iv) Speculums
  - v) Antiseptic solution
  - vi) Gloves
  - vii) Source of light

- f) Does the examination room appear clean?  
( examine the fly and dust )

#### 5. IUD insertion room

- a) Is the IUD insertion room being used exclusively for IUD insertion only?
- b) Is the floor of the room washable?

#### 6 .Operation theatre

- A) Floor Pukka (Cement /tile)?
- B) Washable floor?
- C) Washable walls?
- D) Is dust present in the OT?

(INS: Run your finger on following 3 surfaces far corner, floor away from door or window slate, floor under instrument/operation table)

- f) Are there flies present in the OT?
- g) Are windows kept open or cannot be closed?
- h) Is electricity present?
- i) Is an inverter or generator available for standby power?
- j) Scrub room /Hand washing area
  - i) Is running water present?
  - ii) Is there a wash basin/sink?
  - iii) Is the tap elbow /foot operated?

#### k) Sterilization

- i) Is a functional autoclave present?
- ii) Is a sterilizer present?
- iii) Are autoclave drums present?

#### l) Are the following equipment/supplies present in the OT?

- i) Number of operating tables?
- ii) Functional Boyle s apparatus
- iii) Light source: Functioning pedestal Lamp- 1,  
Shadow less Lamp-2, Torch Emergency light -3,
- iv) Instrument trolley
- v) BP apparatus
- vi) Stethoscope
- vi) Ambu bag with its connection
- viii)Laryngoscope
- ix) Suction Machine
- x)Oxygen cylinder with key and flow meter
- xi)Antiseptic solution tube
- xii)Adequate linen

## 7. Stores, supplies and inventories

- a) Is there a clean and dry store for contraceptives and other supplies?
- b) Is it protected from sun/rain/pests (rats)?
- c) Is storage space adequate?
- d) Are they maintain the stock register

## 8. Lab equipments

- a) Are the following items available in functioning condition?

- 1) Haemoglobinometer
- 2) Spirit lamp
- 3) Test tubes
- 4) Benedicts reagents
- 5) RPR test kits
- 6) Grams stain
- 7) Crystal water
- 8) Autoclave
- 9) Saffarin
- 10) Cider wood oil
- 11) Normal saline
- 12) Microscope
- 13) Refrigerator

- b) Is there a person to perform the following tests at this facility?

- i) Haemoglobin
- ii) Urine albumin
- iii) Urine sugar

## 9. Cold chain equipment's

- a) ILR
- b) DF
- c) Vaccine Carrier
- d) Generator /Alternative to power supply
- e) Neonatal Care /Baby warmer

## 10. a) Are the following IEC materials available at the centre?

- |                | Available | Displayed at adequate place |
|----------------|-----------|-----------------------------|
| 1. Wall charts |           |                             |
| 2. Booklets    |           |                             |
| 3. Pamphlets   |           |                             |
| 4. Models      |           |                             |
| 5. Flip books  |           |                             |

- b) Does this centre have Audio /Video equipment's? Yes/ No/out of order

- i) Audio
- ii) Video

11. Are the following services regularly available at the centre?  
(Exclude FP camps conducted at the clinic)

- a) IUD insertion
- b) MTP/MR
- c) Services for RTI/S.T.D.
- d) Immunization of children
- e) Natal Care
- f) Basic emergency obstetric care

12. Record Keeping

No. of records (Available --1, Not available-2) (Maintained properly-1, Not maintained---2)

(Check for printed format) Available Maintained/Not maintained

Eligible Couple Register  
(ECR )

Service Delivery Register  
(SDR)

Monthly progress Report  
(MPR)

Stock Register

13. Whether the Centre has the Quality assurance Standards for the Health Care Delivery?

14. Infection control open ended

a) How disposal items are collected?

---

b) Is it separated out? Yes No

c) What is the method of disposal?

- i) Dumping
- ii) Chemical infusion
- iii) Burning in open Air
- iv) Other -----(Specify)

## Annex 6

### REPORT ON FACILITY ASSESSMENT OF SUBCENTRES UNDER CLICS

#### Introduction

A survey to assess the facilities at the subcentres in the CLICS project area was conducted in the month of June 2004. The main aim of this survey was to focus on the working of these subcentres and the existing deficiencies there, so that they could be improved upon later.

There were a total of seven subcentres in Anji sector, six subcentres in Gaul and eight in Talegaon sector. All of them were visited. The following were the villages where the subcentres were located.

Table 1: Subcenters under the Program area

Sector	ANJI	GAUL	TALEGAON
Names of subcenter villages	Peth	Gaul	Waigaon
	Kamthi	Bhidi	Wadad
	Pawnar	Bhidi (HQ)	Jaulgaon
	Nalwadi	Andori	Selukate
	Mandwa	Kharda	Neri
	Pipri	Husnapur	Dhotra
	Mahakal		Salod
			Selsura
Total no. of villages served	24	23	20

#### Methodology

A list of all the subcentres in Anji, Gaul and Talegaon PHC areas was prepared, and the areas were subsequently mapped. A plan was formulated to visit a certain number of subcentres on a particular day during working hours, when the ANM of the subcentre was expected to stay. The subcentres were visited on those particular fixed days and the ANMs were interviewed using a pre-designed questionnaire. When the ANM was not available, the attendant was interviewed.

The ANMs were informed about the purpose of the survey. Information was collected on infrastructure, services provided, and supplies and logistics in the subcentres. In areas where there was no subcentre building, the ANMs were interviewed in their homes.

The data thus collected was analyzed using ePInfo.

#### Observation

The findings of this assessment have been tabulated under suitable heads for easy interpretation.

**Table 2: Sector-wise availability of facilities in the subcenters of CLICS Program area**

Indicator	ANJI		GAUL		TALEGAON	
	Number	Percentage	Number	Percentage	Number	Percentage
Time displayed	1	14.3	1	16.7	1	12.5
Service provider stays at subcentre	2	28.6	4	66.7	5	62.5
<b>Waiting area for patients</b>						
Sheltered from weather conditions	7	100	6	100	8	100
Waiting space adequate	4	57.1	4	66.7	4	50
Drinking water present	2	28.6	2	33.3	5	62.5
Electricity present	4	57.1	3	50	4	50
Running water present	0	0	2	33.3	2	25
<b>Examination room items</b>						
Examination table	5	71.4	2	33.3	5	62.5
BP instrument	7	100	4	66.7	8	100
Stethoscope	7	100	1	16.7	7	87.5
Speculum	6	85.7	4	66.7	8	100
Antiseptic solution	3	42.9	2	33.3	5	62.5
Gloves	6	85.7	1	16.7	6	75
Source of light	2	28.6	0	0	1	12.5
Cleanliness	5	71.4	2	33.3	4	50
<b>Floor of the subcentre</b>						
pucca	6	85.7	6	100	7	87.5
washable	7	100	6	100	7	87.5
Washable walk	4	57.1	0	0	2	25
dusty	5	71.4	3	60	4	50
Flies present	0	0	0	0	0	0
Windows open	2	28.6	1	16.7	1	12.5
Deliveries conducted	3	42.9	2	33.3	3	37.5
vaccination	7	100	5	83.3	8	100
Equipment for sterilizing needles present	2	28.6	3	50	6	75
<b>Stores</b>						
Clean	2	28.6	2	33.3	3	37.5
Protected from pests etc.	1	14.3	1	16.7	1	12.5
adequate	3	42.9	3	50	3	37.5
Stock register maintained	5	71.4	1	16.7	4	50
<b>Lab. Equipment</b>						
Haemoglobinometer	5	71.4	3	50	1	12.5
Spirit lamp	0	0	1	16.7	4	50
Test tubes	4	57.1	2	33.3	5	62.5
Benedict's reagent	0	0	0	0	2	25
<b>Availability of staff for performing tests/ providing services</b>						
Hb	4	57.1	4	66.7	1	12.5
Urine albumin	3	42.9	0	0	3	37.5
Urine sugar	1	14.3	0	0	3	37.5
Cold chain- vaccine carrier	2	28.6	3	50	4	50
Baby warmer	0	0	0	0	0	0
Weighing scale	7	100	3	50	8	100
<b>IE C Material</b>						
Wall chart	7	100	5	83.3	8	100
Booklets	1	14.3	1	16.7	3	37.5
Pamphlets	1	14.3	1	16.7	3	37.5
Flip books	0	0	0	0	3	37.5
<b>Services</b>						
IUD insertion	4	57.1	3	50	6	75
RIT/STD	5	71.4	4	66.7	7	87.5
Immunization	7	100	6	100	8	100
Natal care	2	28.6	4	66.7	6	75
Emergency obstetric care	0	0	0	0	1	12.5
Records available	7	100	5	83.3	8	100
Records maintained	4	66.7	0	0	3	37.5
Quality assurance	0	0	0	0	0	0
<b>Infection control</b>						
Separate collection of waste	0	0	1	16.7	0	0
Disposal by burning	3	42.9	2	33.3	6	75

## **Infrastructure**

Timings are clearly displayed in local language in one subcentre each in Anji and Talegaon, and two subcentres in Gaul sector.

The service provider stays at the center in two subcentres in Anji, four in Gaul and five subcentres in Talegaon sectors. In rest of the subcentres, they have fixed days of visit.

The waiting area is sheltered from weather conditions in all the subcentres. The seating space was adequate for clients in only four subcentres in each sector, and drinking water during waiting was available in only two subcentres each in Anji and Gaul, and five subcentres in Talegaon sector.

Electricity was present in four subcentres in Anji and two subcentres in Gaul PHC areas. Though available in four subcentres in Talegaon, electricity was not present in two subcentres.

Running water was available in only two subcentres each in Gaul and Talegaon sectors, whereas it was present in none of the subcentres in Anji sector.

Most of the subcentres in Anji and Talegaon sectors had an examination table, BP instrument, stethoscope, speculums and gloves, but these items were grossly deficient in Gaul PHC subcentres. Antiseptic solution and a source of light was, however missing in most subcentres in all the three areas.

The examination room was satisfactorily clean in five subcentres in Anji, four in Talegaon and only one subcentre in Gaul sector. The floor of all these subcentres was pucca and washable except one in Anji. Washable walls were present in four subcentres in Anji, two in Talegaon and none in Gaul.

Though about half of the subcentres in each of the sectors were found to be dusty, flies were not present in any of the subcentres.

The windows could not be closed in two subcentres in Anji and one each in Gaul and Talegaon sector.

Items for disposal were collected indiscriminately and dumped outside in most subcentres. Only in a few were they burnt away.

## **Services**

Deliveries were conducted in four subcentres in Anji, two in Gaul and three in Talegaon sectors.

Vaccination was carried out in all subcentres in all the sectors. Problems, if any, were encountered in administrative areas. Similarly, facilities for IUD insertion and RTI/STI management were present in most of the subcentres. Natal care was not available in few subcentres whereas emergency obstetric care was not provided in any.

Facility for Hb estimation of pregnant women was present in four subcentres in Anji and Gaul sectors, and only one subcentre in Talegaon due to close proximity and easy access to tertiary care institutions. Urine albumin and sugar was not performed in any of the subcentre due to non availability of Benedicts reagent. Rough assessment was,

however done using urostix. The former was available in two subcentres in Talegaon where the tests were performed.

### **Supplies and logistics**

There was seemingly no problem in supply of vaccines in most of the subcentres, barring a few cases (30%), but equipment for sterilization of needles was missing in most of the subcentres in Anji and Gaul, and two in Talegaon.

Stores for keeping contraceptives and other supplies were available but not essentially clean and dry or protected from moisture and pests. The storage space was also found to be inadequate in most subcentres.

Registers were properly maintained in five subcentres in Anji, one in Gaul and four in Talegaon.

The haemoglobinometer and spirit lamps were functional in very few subcentres. Test tubes were available in four subcentres in Anji, two in Gaul and five in Talegaon, but tests were not carried out due to lack of Benedicts reagent.

Two subcentres in Anji, three in Gaul and four in Talegaon sector had their own vaccine carrier. The rest borrowed them from PHCs on immunization days. Baby warmer was not found in any of the subcentres. The weighing scale was functional everywhere, except for three subcentres in Gaul.

IEC materials like booklets, pamphlets and flip books, though available, were not properly displayed. Only wall charts were adequately displayed in all the subcentres.

Records were available in printed format in almost all subcentres but they were either not or ill maintained almost everywhere.

There was no system of quality assurance in any of the subcentres.

### **Other observations**

Most of the subcentres in Anji and Talegaon were functioning individually, though not up to the mark. In Gaul sector, a significantly different picture was seen. Bhidi and Andori subcentres had no separate buildings, but they had merged their services with that of RH, Bhidi.

The subcentre of Husnapur (Gaul) was under construction and the ANM provided the services to her area sitting in Bhidi HQ. Also, she was found to be on leave since the last six months.

In Kharda (gaul) the subcentre building had not been handed over by the Govt., and the ANM was providing services from her home in the village. So, most of the facilities were missing.

Each subcentre had different immunization days that were fixed in advance for each village under the subcentre. The ANMs got vaccines from supervisors.

Thus, from the above observations, it can be concluded that there is lot of scope for improvement in the facilities at the subcentres in Anji, Gaul and Talegaon sectors for better quality of service delivery to the villages in these areas.

## Annex 7

## DIP preparation process

Month	Process	Partners and stakeholders involved
November 2003	DIP Guidelines reviewed and discussed DIP process discussed with Program Steering Committee	AKF/DCM
December 2003	DIP Process discussed with Programme Advisory Committee	AKF/DCM
January 2004	DIP writing responsibilities assigned	AKF/DCM
February 2004	Internal discussions and draft outline created	DCM
March 2004	Participatory DIP development workshops  Writing of draft DIP  DIP refinement	DCM/CLICS program staff, public providers, CBOs and NGO partners  DCM/CLICS program staff  AKF/DCM
April 2004	Finalization of draft DIP Discussion with AID Mission Office Submission of draft DIP to AID	AKF/DCM AKF AKF
May 2004	Incorporate feedback from AID Present DIP to Advisory and Steering Committee Prepare for Mini-University	AKF/DCM DCM AKF/DCM
June 2004	Attend DIP Mini-University  Finalize DIP and re-submit to AID (as required)	AKF/DCM

**Annex 8**

<b>Human Resources</b>			
<b>Position</b>	<b>No.</b>	<b>Main Responsibility</b>	<b>LOE %</b>
<b>Aga Khan Foundation USA</b>			
Program Officer (Health)	1	Reviews implementation of the program, ensures compliance to grant requirements, provides technical input to the program, maintains contact with USAID/HIDN, participates in CORE and interacts with CSTS on behalf of AKF and partners.	25
<b>Aga Khan Foundation, India</b>			
Program Manager (Health)	1	Reviews overall program implementation from India. Serves as primary AKF link to DCM/MGIMS, USAID/New Delhi. Coordinates inputs from AKF USA.	20
Program Officer (Health)	1	Monitors implementation of program. Coordinates reporting with AKF USA. Coordinates technical assistance to the Program. Reports to the Health Program Manager.	70
Program Assistant (Health)	1	Assists Program Manager and Program Officer (Health). Provides financial & administrative assistance.	20
<b>Dept. of Community Medicine (MGIMS)</b>			
Program Director (Professor and Head, DCM)	1	Provides overall technical leadership/ management guidance for the Program at DCM. Coordinates with AKF to plan/implement operations according to USAID guidelines. Maintains external relationships with partners and networks on behalf of the Program.	10
Technical Support Team	4	Comprises of DCM personnel with core skills in the areas of Child Survival, Health Management, Behavioral Sciences, Biostatistics and Community Mobilization. Work with the Program Director to provide inputs as required on technical issues quality assurance.	25
Social Worker	1	Assists in Social Mobilization activities of the Program	20
Program Coordinator, CLICS	1	Coordinates development of DIP. Has overall responsibility to plan, implement, monitor and evaluate performance of field offices and supervise staff. Coordinates Program Officers' input to field program. Maintains communications with partners as delegated by Program Director. Ensures quality of program activities. Reports to Program Director.	100
Program Officer – MIS, CLICS	1	Provides technical assistance on MIS design and use to field Program, VCC, and community groups, public and private providers. Monitors data quality. Prepares periodic reports. Trains Program staff in use and maintenance of MIS. Reports to the Program Coordinator.	100
MIS Assistant	1	Assists the Program Officer MIS in data Management. Reports to Program Officer (MIS)	100
Program Officer – BCC & Training, CLICS	1	Provides technical assistance on all aspects of BCC within the Program, including developing messages, materials, delivery formats, and ensuring the quality of each. Monitors BCC activities, data collection and reports Conducts Training Needs Assessments and organizes training for staff, public and private providers, VCC and community institutions. Reports to Program Coordinator.	100
Program Officer – Documentation & Communication, CLICS	1	Plans and does documentation for all the Program activities. Trains staff in documentation skills and mentors them on-the-job. Prepares periodic reports according to program requirements. Develops content for child survival portal and other program dissemination materials. Reports to the Program Coordinator.	100
Finance & Administrative Officer, CLICS	1	Manages program funds and tracks costs. Prepares financial reports according to grant requirements. Coordinates with AKF Program Assistant as required. Reports to Program Coordinator.	100
Office Assistant	1	Assists the Program staff to carry out their responsibilities. Reports to Program Coordinator	100
Office Attendant	1	Responsible for Office errands, maintenance & security	100
<b>Program Sector Office</b>			
Sector Coordinator	3	Each Sector Coordinator manages one field office and supervises respective field staff. Plans, coordinates and supervises program implementation, monitoring and evaluation activities at sector level. Assures technical quality; calls on Program Officers for technical assistance as required. Reports to Program Coordinator. Member of Technical Support Team	25
Assistant Program Officer (Social Mobilization)	3	Provides technical guidance to Community Organizers for Social Mobilization and conflict resolution. Guides formation of VCC and allied institutions. Facilitates development of the Social Franchise agreement. Reports to Sector Coordinator.	100
MIS assistant	3	Collates Sector level MIS data and monitors data quality. Reports to Sector Coordinator.	100
Medical Officer	5	Operates community clinics. Provides curative care. Monitors, supervises and trains nurses and other health providers. Assists in managing field offices. Reports to Sector Coordinator.	100
Nurse	6	Under supervision of medical officer, treats diseases, attends deliveries, makes referrals, provides counseling, antenatal/postnatal care. Implements household/ community IMCI. Assists medical officer in the community clinics. Reports to Medical Officer.	100
Community Organizer	15	Mobilizes self-help groups and networks with the Gram Panchayat and village level public and private health providers to form VCCs. Builds capacity of community institutions. Conducts	100

		community level BCC activities. Provides supportive supervision to VHWs. Uses MIS data for community planning. Reports to Sector Coordinator.	
Office Attendant	3	Responsible for Office errands, maintenance & security	100
Village Health Worker	90	Visits households and negotiates BCC messages. Practices household and community IMCI and minor ailment treatment. Maintains health records. Reports to Community Organizers.	40
Trained Birth Attendant	50	Provides antenatal, natal and postnatal care.	20
<b>COMMUNITY Supported</b>			
Private Sector Providers	67	Provide quality, curative care in collaboration with the VCC & other village-based care providers.	N/A
Community Health Center Manager	25	Registers community health plan clients and collects fees. Ensures proper dispensing of medicines at the clinics. Maintains records.	10
<b>GoI Supported</b>			
Anganwadi workers	120	Follows ICDS protocols: assists in immunization, monitors child growth, collects data.	N/A
Auxiliary Nurse Midwives	18	Follows GoI protocols for implementing reproductive and child health activities.	N/A
School Teachers	18	Assists implementation of Family Life Education curriculum in schools.	N/A
<b>Others</b>			
Program Advisors	5	Eminent technical experts in areas vital to successful operations of CLICS. Work with the Program Director to identify capacity building requirements and ensure technical accuracy.	N/A
Steering Committee Members	7	An internal advisory group limited to key personnel from AKF, DCM/MGIMS and GoI. Also includes a Chartered Accountant. Meet once in six months to monitor implementation as per DIP and ensure compliance to program and financial grant regulations.	N/A

**Annex 9**  
**COMMUNITY LED INITIATIVES FOR CHILD SURVIVAL**  
**(A USAID/AKF USA Funded Program)**  
**Department of Community Medicine**  
**MGIMS, Sewagram**

Monthly Progress Report (Quantitative)

Community Organizer ID: \_\_\_\_\_

Name of Community Organizer:

\_\_\_\_\_

Sector No.: \_\_\_\_\_

Sector Name:

\_\_\_\_\_

Month: \_\_\_\_\_

Year:

S.No	Activity	Village Name →								Total
		Village No. →								
<b>I.</b>	<b>Formation &amp; Monitoring of Self Help Groups</b>									
1.	No. of new SHGs formed during the month									
2.	Total no. of SHGs existing (Old + Newly formed)									
3.	No. of monthly SHG meetings held									
4.	No. of monthly SHG meetings attended during this month									
<b>II.</b>	<b>Formation &amp; Monitoring of Kisan Vikas Munch (KVM)</b>									
1.	No. of Kisan Vikas Munch (KVMs) newly formed									
2.	Total no. of KVMs in the village (Old + Newly formed)									
3.	Number of KVMs meetings held									
4.	Number of KVMs meetings attended									
<b>III.</b>	<b>Formation &amp; Monitoring of Kishori Panchayat</b>									
1.	Is Kishori Panchayat formed? (1=Yes, 0=No)									
2.	Number of Kishori Panchayat meetings held									

3.	Number of Kishori Panchayat Meetings attended									
4.	Number of members attended the meeting									
5.	Any "Health Talk" Conducted? (1=Yes, 0= No)									
6.	On what topic?									
7.	Is any activity conducted? (1=Yes, 0= No)									
8.	What activity?									
<b>IV.</b>	<b>Monitoring of Community Health Clinic</b>									
1.	Number of clinics held during the month									
2.	Number of persons availed treatment from CHC									
3.	CHC has following records maintained regularly?									
	Patient Record (1=Yes, 0= No)									
	Drug Stock Record (1=Yes, 0= No)									
	Accounts (1=Yes, 0= No)									
<b>V.</b>	<b>Monitoring of Village Coordination Committee</b>									
1.	No. of introductory meeting conducted?									
2.	No. of exploratory meeting conducted?									




**Detailed Information of Every Kisan Vikas Munch in the Village**

	Village No.												
1	KVM ID No.												
2	Meeting held or not?												
3	Meeting attended or not?												
4	No. of members attended the meeting												
5	Is "Health Talk" conducted? (1=Yes, 0= No)												
6	On what topic?												
7	Is any "Activity" conducted? E.g. Visit to model NGO/ Act. Initiated by KVM (1=Yes, 0= No)												
8	What activity?												

**Detailed Information of Every Self Help Group in the Village**

1	Village No.												
2	SHG ID No.												

3	Total Number of members													
4	Meeting held or not?													
5	No. of members attended meeting													
6	SHG meeting attended by CO or not? (1=Yes, 0= No)													
7	SHG updated Member Account Book													
8	SHG opened Bank Account													
	Date of last up date													
9	SHG took loan from Bank													
	For SHG utilization													
	For Individuals													
10	Total monthly collection													
11	Amount disbursed as loan to SHG members													
	From SHG fund													
	Purpose													
	From Bank Loan													
	Purpose													
12	Repayment of loan by SHG members													
	From SHG funds													
	From Bank Loan													
13	Details of SHG activities													
	“Health Talk” conducted? (1=Yes, 0= No)													

	On what topic?												
	Any Activity conducted? (1=Yes, 0= No)												
	What activity?												





**(Annex 10 continued) Maternal Services Record**

POST DELIVERY INFORMATION										POSTNATAL SERVICES								
Date of Delivery	Place of Delivery	Whether DDK used?	Attended by	Pregnancy Outcome	Sex of child	Complications during delivery	Time of initiation of breast feeding (in hrs.)	FP Status	Ref. No in '0-3 Child Record'	At end of 1st week			At end of 4th week			At end of 6th week		
										No. of visits	Complication	Advice	No. of visits	Complication	Advice	No. of visits	Complication	Advice
(48)	(49)	(50)	(51)	(52)	(53)	(54)	(55)	(56)	(57)	(58)	(59)	(60)	(61)	(62)	(63)	(64)	(65)	(66)

















**Annex 11**

**REQUEST FOR CONDUCT OF EXPLORATORY MEETING FOR VCC  
FORMATION AT VILLAGE \_\_\_\_\_.**

To,

Date:

Sector Coordinator, \_\_\_\_\_

Sir/Madam,

You are requested to kindly consider conducting first exploratory meeting at village \_\_\_\_\_ for VCC formation. I have ensured the following:

- According to the requirement all community-based organizations i.e. SHG, KP and KVM are formed and functioning smoothly at least for last 3 months. Yes/ No
- Exploratory meetings have been conducted with CBOs and they have been explained in detail about CLICS program. This has been done over a period of 2 months in two or more meetings. Yes/ No
- The nominations for VCC are capable in terms of literacy, devoting time and motivation towards improving health services and health status of the community. Yes/ No
- The CBOs have documented the process of selection and name of representatives in meeting record book. Yes/ No
- SHG members have been nominated as per guidelines. Yes/ No
- The VCC has representation from all sections of the village. Yes/ No

Thanking you,

Yours faithfully,

(Community Organizer)

Comments of Asst. Program Officer

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**Annex 11 (continued)**

Confidential document: only for use by CLICS program staff

Guidelines for formation of VCC

Checklist for formation of Village Coordination Committee

There are three stages involved in the VCC formation process

<b>Activity</b>	<b>Expected time period</b>
Explain to the groups about CLICS, VCC etc.	2 months
Groups nominate representation to VCC	1 month
Exploratory Meeting with selected representatives and finalizing committee	1 month

**General instructions :**

1. Ensure that according to the requirement all community-based organizations i.e. SHG, KP and KVM are formed and functioning smoothly at least for last 3 months.
2. Conduct exploratory meetings with different CBOs and explain in detail about CLICS program. There should be at least two sessions with the one-week gap.
3. Though it is a voluntary representation from CBOs, Community Organizer should ensure the representative's capability in terms of literacy, devoting time and motivation towards improving health services and health status of the community.
4. CBOs should document the process of selection and name of representatives in meeting record book.
5. Each SHG will nominate 2 members; one will be member of VCC while other will act as standby in case of absence of first member. In case SHGs are less than 5, then remaining members will be nominated by Sector Coordinator on the recommendation of Asst. Program Officer / Community Organizer.
6. It will be the Community Organizer's Responsibility to ensure representation from all sections of the village in VCC. For this social maps of villages may be used. In the villages of Anji, Pawnar, Salod, Waigaon, Talegaon, Bhidi & Andori, it must be ensured that the VCCs have representation from all wards in the village.
7. Anganwadi Worker, Govt. ANM, Gram Sewak & Community Organizer will be ex-officio members of VCC.
8. 3-4 members of repute from the village will be coopted by the VCC in their first formal meeting. (eg. Teacher, ex- Sarpanch, ZP member (if any), Panchayat Samiti member (if any), MLA (if any), motivated youth etc.)
9. Exploratory meeting will be held only after the Community Organizer submits a completed checklist (format attached) to the Sector Coordinator.

10. Ensure that at the time of exploratory meeting all ex-officio members are invited, except ANM and AWW. However, ex- Sarpanch, ZP member (if any), Panchayat Samiti member (if any), MLA (if any) have to be invited.
11. In exploratory meeting discuss about the roles and responsibilities of Village Coordination Committee

The final body of VCC would consist of as mentioned below:

- Total strength of the VCC would be maximum 25.
- In case the number of SHG is less than 5, then with recommendation of Community Organizer/Assistant Program Officer, Sector Coordinator can nominate SHG member to VCC.
- Two representatives from other groups i.e. from KVM and KP.
- Anganwadi Worker and ANM & Gram Sewak & Community organizer would be the ex-officio members
- 3-4 members of repute from the village involved in developmental activities may also be included. e.g. schoolteacher, motivated youths (to be co-opted by VCC in their first formal meeting)
- Community Organizer will be committee's Convener for first two years

Representative from	No. of Members
SHGs	1(from each)
KVM	2
KP	2
Gram Panchayat	2
Influential leader (co-opted)	4
Ex-officio	
7. AWW	All
8. ANM	1
9. Gram Sewak	1
10. Community Organizer	1
Total strength of VCC	25 (maximum)

**Please Note:**

- **The final VCC will be established only after the Sector Coordinator has approved the constitution.**
- **In case of any problem in the implementation of the above, the Sector Coordinator should be consulted.**

**Annex 12****CHECKLIST FOR MO (PHC)**

Name of PHC: -

Name of Medical Officer (MO): -

Observer: -

Date:-

**OPD Services:**

1. Did the M.O. ask the chief complaints?
2. Did s/he ask the history of present illness?
3. Did s/he ask the relevant past history?
4. Did s/he conduct general physical examination and assess vital signs?
5. Did s/he conduct systemic examination?
6. Did s/he order investigations to confirm diagnosis?
7. Did s/he write to provisional diagnosis?
8. Did s/he explain the prescription to the patient?
9. Did s/he give health education to the patient?
10. Did s/he ask if the patient had any question?
11. Did s/he give the next appointment?
12. Did s/he refer the patient for specialist care?

**Training**

13. Did s/he organize training of Dais, AWW & ANM?
14. Did s/he participate in training process?
15. Did s/he evaluate the outcome of training?

**Supervision (During visit to MCH clinic / Sub-Centre Clinic / Monthly meet)**

16. Did s/he check the records of the ANM?
17. Did s/he check the FP records?
18. Did s/he comment on the records?
19. Did s/he discuss if the ANM had any problems?
20. Did s/he assess the outcome of activities in the community?
21. Did s/he organize and attend staff meetings with a definite agenda?
22. Did s/he make recommendations based on meetings proceedings?

**Annex 12 (Continued)**  
**CHECKLIST FOR PRIVATE PRACTITIONER**

Village: \_\_\_\_\_ Name of Practitioner: -

Observer: - Date:-

1. Is the waiting space adequate?
2. Is the waiting space sheltered from weather conditions?
3. Is there drinking water available?
4. Is there electricity available?
5. Is there general cleanliness at the facility?
6. Is there a screened area for examining patients?
7. Is IEC material adequately displayed in the OPD room as well as waiting area?
8. Did the doctor ask the chief complaints of the patients?
9. Did s/he ask the history of present illness?
10. Did s/he ask the history of past illness?
11. Did s/he ask the complete history?
12. Did s/he have a working BP apparatus, Stethoscope and Weighing Machine for the patients?
13. Did s/he examine?
 

a. Pulse	b. B.P.
c. RR.	d. Temperature.
e. Eyes for pallor & jaundice.	f. Lymph nodes.
14. Did s/he auscultate?
 

a. RS	b. CVS.
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15. Did s/he do per abdominal examination?
16. Did s/he write the provisional diagnosis?
17. Did s/he order investigations to confirm the diagnosis?
18. Did s/he wash hands after examining the patient?
19. Is a antiseptic lotion available for hand wash?
20. Did s/he explain the prescription to the patient?
21. Did s/he provide health education to needy patients?
22. Did s/he provide nutritional counseling, if indicated?

23. Did s/he confirm if the patient understood the messages?
24. Did s/he discuss if the patient had any questions?
25. Did s/he refer patients for specialist care beyond his / her competence?
26. Did s/he give appointment for next visit?
27. Does s/he maintain records for the patients?

**Annex 12 (Continued)**  
**CHECKLIST FOR SUPERVISORY VISITS FOR HA**

Name of Health Facility: -

Name of Health Assistant: -

Observer: -

Date: -

1. Is there a schedule for supervisory activities?
2. Does the Health Assistant meet the ANMs atleast every month?
3. Is the supervision schedule or any change communicated to ANMs?
4. Did the Health assistant do house visiting?
5. Did s/he demonstrate any technical skills to the ANM?
6. Does she help the ANM to organize or plan her work?
7. Did she make any comments on
  - a. improving service quality?
  - b. improving counseling or health education?
8. Did she guide ANM to establish depot holders for distributes of conventional contraceptives?
9. Did she conduct MCH & FP Clinics?
10. Did she organize & utilize women's groups in Family Welfare Program?
11. Did she review records supplies and condition of the facility?
12. Did the following areas receive adequate attention?
 

Household visits	ORT
ANC	ARI
Delivery	Post Natal Care
Immunization (0-1 yrs)	RTI / STD
Care of New Born	
13. Does s/he conduct regular staff meetings?
14. Is the health committee or VCC given adequate support through supervisory system?
15. Did the Health Assistant ask if the ANM had any problems?
16. Does s/he have a good rapport with the ANM?
17. Does s/he praise good performance or criticize?
18. Does s/he indent, procure and supply the needed materials to the ANMs in due time?

19. Does s/he maintain supervisory records?
20. Does s/he record problems identified and actions taken?
21. Are these records used for follow-up?
22. Does s/he submit progress reports to M.O., PHC in time?

**Annex 12 (Continued)**  
**CHECKLIST FOR ANM.**  
 (To be filled during sub-centre clinic)

Health facility                    :-  
 Name of ANM                    :-  
 Observer                         :-  
 Date                                :-

Primary Health Care:

1. Did the ANM register all children under 3?
2. Did she review the immunization status of all children under 3?
3. Did she vaccinate or arrange for vaccination of children?
4. Did she review vaccination status and dates for further immunizations with mother?
5. Did she ask if the mother had any questions?
6. Did she review growth cards of all children under 3?
7. Did she weigh children or refer them for growth monitoring?
8. Did she discuss changes in weight and give nutritional advice to mother?
9. Did she answer mothers questions about growth monitoring and nutrition?
10. For malnourished children, did she ensure that nutritional counseling food supplementation  
     and / or medical attention are being received?
11. Did she ask if any children had diarrhea?
12. Did she recommend the use of ORI and help mother prepare and administer it?
13. Did she answer mother's questions on ORI?
14. Did she ask about water storage practices and give appropriate advice?

Ante Natal Care:

15. Did she review obstetric record or family health card?
16. Did she update obstetric information?
17. Did she ask about risk factors in reproductive history?
18. Did she conduct a physical examination?
  - a. Pulse
  - b. BP
  - c. Weight

- d. Height
  - e. S/o edema
  - f. Anemia.
19. Did she give:-
- a. Inj. TT (if not given earlier) as per schedule.
  - b. IFA tabs. as per schedule.
20. Did she refer high risk pregnancies for medical attention?
21. Did she refer for urine sugar & Hb.
22. Did she counsel the pregnant woman about:
- a. balance diet.
  - b. nutritional supplements.
  - c. delivery by trained worker.
  - d. danger signs which require immediate attention.
  - e. family planning / birth spacing.
23. Did she ask if the pregnant woman had any questions.

Safe Delivery:

24. Did she have a disposable delivery kit?
25. Did she prepare a clean birthing space?
26. Did she assess potential complications?
27. Did she monitor the woman in labour?
28. Did she assist with (N) delivery?
29. Did she provide immediate care to new born?
30. Did she monitor mother after delivery?
31. Did she advise to initiate breast feeding soon after delivery?
32. Did she refer obstetric complications to FRU?
33. Did she advise the mother for after call.
- a. clean cord stump.
  - b. return if bleeding does not stop.
  - c. return if mother develops fever / foul smelling lochia.
  - d. feed colostrums to baby.
  - e. proper breastfeeding position of baby.
  - f. child immunization.

Post Natal Care.

34. Did she ask mother if she developed any problems after delivery?
35. Did she examine.
  - a. abdomen
  - b. genital
  - c. breasts.
36. Did she assess vital signs & weigh the mother?
37. Did she assess vital signs & weight the baby?
38. Did she examine umbilicus?
39. Did she record the findings?
40. Did she give BCG vaccination?
41. Did she give DPT & OPV immunization as per schedule?
42. Did she advice mother for birth spacing? Child nutrition?
43. Did she ask if the mother had any questions?

Family Planning:

44. Did she refer interested women / couples for FP services?
45. Did she ask about the client's preference?
46. Did she verify correct usage?
47. Did she counsel for:
  - a. side effects & their m/m.
  - b. when & where to go for re supplies?
  - c. when & where to go for follow-up?
48. Did she ask if the client had any questions?

To be asked for ANM:

49. Does she supervise TBAs in her area?
50. Does she guide the AWW and VHW in their activities?
51. Does she assist in the activities at COHP?
52. Does she check stock at COHP?
53. Does she attend staff meetings?
54. Does she maintain records & prepare necessary reports?

**Annex 12 (Continued)**  
**CHECKLIST FOR ASSESSMENT OF PROCESS QUALITY OF  
 GROWTH MONITORING IN ANGANWADIS**

Name of village:-

Name of Service Provider (AWW):-

Observer:-

Date:-

1. Did the Anganwadi Worker ask the age of the child from the person accompanying the child for growth monitoring?
2. Did she record the age correctly?
3. Did she have growth charts?.
4. Did she have a working Salters scale (for 0-1years) & bathroom scale (for > 1 year up to 5 years)?
5. Were the weighing machines in proper condition?
6. Did she look for zero error in both the scales before weighing?
7. Did she remove the child's extra garments and shoes before weighing?
8. For 0-1 year aged children, look for the following.
  - a) Was the Salters scale suspended correctly from a firm support?
  - b) Was the weighing bag (to suspend the child) in proper condition?
  - c) Was the child suspended from the scale correctly?
  - d) Was the reading noted correctly (nearest to 100 grams)?
9. For > 1 year up to 5 years aged children, look for the following.
  - a) Was the bathroom scale placed on a flat surface?
  - b) Was the child placed correctly on the scale?
  - c) Was the weight recorded correctly?
10. Was the weight plotted correctly on the growth chart?
11. Was it connected to the previous growth point?
12. Did the AWW inform the person accompanying the child regarding the current status of the child?
13. Did she inform the date for next weighing?
14. Did she refer malnourished children for medical attention?
15. Did she follow the children who had not come for growth monitoring on the previous date?

16. Did she ask the mother if she understood how to take proper care of her child and ensure proper nutrition?

17. Did she ask if the person accompanying the child had any questions?

18. Did she arrange for counseling of mothers of malnourished children / underweight children,  
and motivating them to accompany their children for growth monitoring?

**Annex 12 (Continued)**  
**CHECKLIST FOR ASSESSMENT OF PROCESS QUALITY OF  
IMMUNIZATION IN PHC**

Name of PHC :-

Name of Service Provider (ANM) :-

Observer :-

Date :-

1. Is the day and time of immunization clearly displayed outside the PHC?
2. Is there adequate waiting space for the clients?
3. Is the waiting area sheltered from weather conditions?
4. Is drinking water available for the clients while waiting?
5. Is IEC material properly displayed in the immunization room?
6. Did the ANM determine what immunizations are needed?
7. Did she wash her hands before the immunization session?
8. Did she check the label for correct vaccine & expiry date?
9. Did she use a sterile needle and syringe for each injection?
10. Did she use chitel forceps to take out sterile needles and syringes from the auto claved drum?
11. Did she load the syringe properly?
12. Did she maintain cold chain in between?
13. Did she prepare the area for injection?
14. Did she give vaccine at the right level? (BCG-i.d., Measles – s.c., DPT/TT – i.m.)
15. Did she dispose the needle and syringe properly?
16. Did she give all vaccinations needed on the same day?
17. Did she recommend vaccination for sick children?
18. Did she provide paracetamol tablets for children having fever?
19. Did she record vaccination on the child's health card?
20. Did she record in her register?

21. Did she inform the mother about the following.

- a) current status of the child's vaccination?
- b) possible side-effects of vaccination?
- c) when to return for next vaccination?

22. Did she ask if the mother had any questions?

**Annex 12 (Continued)**  
**CHECKLIST FOR ASSESSMENT OF PROCESS QUALITY OF**  
**ANTE NATAL CARE IN PHC**

Name of PHC :-

Name of Service Provider (ANM) :-

Observer :-

Date :-

1. Type of Patient :- Primi / Multi gravid

2. Nature of visit :- First / Repeat.

3. Did the ANM check the mother baby card of all pregnant women?

3. If first visit.

- a) Did the ANM ask the history of present pregnancy?  
(Age of the woman, LMP, complaints).
- b) Did she ask the obstetric history (in multigravida)?  
(last delivery, no. of previous pregnancies with outcome, complications, H/o breastfeeding).
- c) Did she ask for risk factors?  
(Bleeding per vaginum, burning micturition, foul smelling vaginal discharge, diabetes, cardiovascular disease, renal problems)
- d) Did she order or examine blood for hemoglobin and urine for sugar.
- e) Did she refer the woman for blood grouping?
- f) Did she calculate & inform EDD?

4. If repeat visit.

- a) Did the ANM review obstetric record?
- b) Did she ask for risk factors?
- c) Did she test urine for sugar?

5. Did she ask the history of treatment? (including Inj. TT & IFA tablets).

6. Did she examine for.

- a) anemia
- b) edema
- c) record weight
- d) record B.P.

7. Did she perform.

- a) Abdominal examination.
- b) Breast examination.

8. Did she do the following:-

- a) Immunize with Inj. TT (if not given earlier) as per schedule?
  - b) Use a separate sterile needle and syringe for giving the injection?
  - c) Give 100 tablets of IFA as per schedule?
  - d) Motivate and counsel the pregnant women to take the IFA tablets?
  - e) Advice regarding diet & nutrition?
  - f) Advice regarding danger signs?
9. Did The ANM treat or refer the woman for pregnancy related complaints?
10. Did she refer high risk patients for medical attention?
11. Did she give appointment for next visit?
12. Did she advice regarding family planning methods (during late pregnancy)?
13. Did she inform the woman about the use of Disposable Delivery kit for delivery (during late pregnancy)?
14. Did she ask if the pregnant woman had any question?
15. Did the ANM know about –
- a) complications of pregnancy?
  - b) atleast two conditions for referral of pregnant woman?
  - c) the nearest referral facility / FRU?

**Annex 12 (Continued)****CHECKLIST FOR VCC.**

Name of Village :-

Observer :-

Date :-

1. How many members are there in the VCC?
2. Does the VCC meet atleast once a month?
3. Are women actively involved in the VCC?
4. Has VCC a member from the marginalized community?
5. Does the VCC participate in creating awareness regarding,
  - a. safe drinking water
  - b. personal hygiene
  - c. basic sanitation.
  - d. breastfeeding.
  - e. immunization.
  - f. nutrition.
  - g. growth monitoring
  - h. new born care
  - i. care during ARI / diarrhea.
  - j. safe motherhood.
  - k. birth spacing
  - l. prevention of RTI/STI/HIV/AIDS.
6. Is the VCC playing a role in curative services?
  - a. delivery of primary health care through VHW & CHC.
  - b. identify & appropriate t/t for ARI, diarrhea, malnutrition & anemia.
  - c. identify & Syndromic m/m of RTI/STI.
  - d. appropriate referral linkages with secondary & tertiary health care providers.
7. Does the VCC do,
  - a. plan & participate in education and clinical sessions?
  - b. mobilize resources to the programme?
  - c. mobilize Gram Swasth Kosh funds to support the programme?
8. Whether VCC is aware / oriented about PRA tools?

9. Whether VCC has been oriented in basic health management?
10. Does the VCC play a leadership role in health activities?
11. Does the VCC have relationship with other agencies?



children or handling refuse?

4. Records:

- a. Are the records for home visits maintained?
- b. Are all 0-1 yr children (infants) registered?
- c. Are all 0-3 yr children recorded?
- d. Are the records of pregnant women maintained?
- e. Are all births and deaths of the village recorded and records maintained?

**Annex 12 (Continued)**  
**CHECKLIST FOR SUPERVISORY ROLE OF APO**

Name of Sector: -

Name of APO: -

Observer: -

Date: -

1. The APO submits regular work plan.
2. Is there a schedule for supervisory activities?
3. Does the APO meets the CO & ANMs at least once every week?
3. Is the supervision schedule or any change communicated to COs?
4. Did the APO accompany COs during village visits?
5. Did s/he demonstrate any technical skills to the COs?
6. Does s/he help the CO to organize or plan the work?
7. Did she guide COs to constitute VCC?
8. Did s/he make any comments on:
  - a. Improving service quality?
  - b. Improving counseling or health education?
  - c. Improving SHG performance?
  - d. Improving KP functioning?
  - e. Functioning of VCC?
9. Did she guide COs to establish CBDS?
10. Did she conduct BCC session during BSD/with CBOs?
11. Did she organize & utilize women's groups in CLICS activities?
12. Did she review & verify the COS records periodically?
13. Did she review records supplies and condition of the facility-CHC/SC/AWW?
14. Did the following areas receive adequate attention?
 

MIS	Documentation & Communication
BCC	Technical interventions
15. Does s/he attend regular sector level meetings?
16. Is the VCC given adequate support through supervisory system?
17. Did the APO ask if the CO had any problems?
18. Does s/he have a good rapport with the COs?
19. Does s/he praise good performance or criticize?

20. Does s/he indent, procure and supply the needed materials to the COs/ANMs in due time?
21. Does s/he maintain supervisory records?
22. Does s/he record problems identified and actions taken?
23. Are these records used for follow-up?
24. Does s/he submit progress reports to sector coordinator in time?

**Annex 12 (Continued)**  
**CHECKLIST FOR COMMUNITY ORGANIZER**

Name of Village: \_\_\_\_\_ Name of Community Organizer: \_\_\_\_\_

Observer: \_\_\_\_\_ Date: \_\_\_\_\_

1. Does the community organizer (CO) have a map of the service area?
2. Are the beneficiary to be served clearly known?
3. Does the CO know how many people overall are to be served through his / her activities?
4. Does s/he have current information about the health status of the people?
5. Does s/he have information about the key health practices in the area?
6. Does s/He have the information from formative research?

**Self Help Groups**

7. Was the SHG aware of the COs visit?
8. Does s/he have a good rapport with the SHG members?
9. Did s/he have a plan for this visit?
10. Did s/he check the cashbook and ledger book?
11. Did s/he provide advice or comment on the records?
12. Did s/he review the income generating plan or activities?
13. Did s/he deliver 'health talk'?
14. Did s/he discuss the problems encountered by the SHG?
15. Did s/he fix the date for next meeting?
16. Has the joint activity for SHG ever organized at village level?

**Kishori Panchayat (KP)**

17. Does s/he have a good rapport with the members of KP?
18. Did the members know about his/her visit?
19. Did s/he have a plan for this visit?
20. Did s/he prepare adequate material to facilitate?
21. Did s/he deliver health talk properly?
22. Did s/he discuss any problems encountered or queries?
23. Did s/he fix the date for next meeting?

## VCC

24. Did the VCC members know about the COs visit?
25. Did s/he have an agenda for this meeting?
26. Was the agenda presented adequately well before the VCC?
27. Did s/he guide the members on the agenda?
28. Did s/he assess the outcome after the meeting?
29. Did s/he help to finalize the recommendations of the meeting?
30. Did s/he record the proceedings?
31. Did s/he fix the date for next meeting?

## COHP

32. Did s/he make all the necessary arrangements for the clinic?
33. Did s/he make arrangement to communicate the day of clinic to the villages?
34. Did s/he provide health education at the clinic?

## **Community Based Distribution System (CBDS)**

35. Does s/he have a list of items to be dispensed under CBDS?
36. Does s/he have a list of depot holders?
37. Does s/he visit the depot holders regularly?
38. Does s/he guide the depot holders to dispense the items properly?
39. Did s/he enquire if they have any problem and suggest solutions?
40. Did s/he provide material to the depot holders for the month?

## Planning & Supervision

41. Did s/he plan the activities for the month in advance?
42. Did s/he supervise: -
  - (a) Records of VHW.
  - (b) Stock maintained by VHW.
43. Did s/he interview patients to assess client satisfaction?
44. Did s/he try to solve the problems encountered involving the VCC and SHGs?

## BCC

45. Did s/he organize and conduct BCC sessions for women, men and adolescents?
46. Did s/he develop & use appropriate material for BCC?
47. Did s/he record the effects?

## Records & Report

48. Did s/he maintain the following records: -
  - a. Pregnant mothers & Lactating mothers

b. Children in 0-3 yrs.

c. Activity Record of VCC / SHG / KP / Panchayat.

49. Is his / her daily diary maintained?

50. Did s/he prepare & submit the reports in time?

**Annex 12 (Continued)****CHECKLIST FOR ASSESSMENT OF QUALITY OF OPD SERVICES IN  
COHP**

Name of Village: -

Name of Service Provider (M.O.):-

Observer:-

Date:-

1. Is the day and time of OPD clearly displayed outside the clinic?
2. Is the waiting area for patients adequate?
3. Is there provision of drinking water for the patients?
4. Is there a toilet available for the patients?
5. Is there a separate space / screen for examining the patients to ensure privacy?
6. Is IEC material available in the clinic?
7. Is it properly displayed?
8. Is the following equipment available in working condition?
  - a)stethoscope
  - b)BP instrument
  - c)weighing machine
8. Did the service provider (M.O.) ask the chief complaints?
9. Did s/he ask the present and past history?
10. Did s/he determine the complete history related to the condition of the patient?
11. Did s/he check vital signs? (BP, Pulse, RR, Temperature).
12. Did s/he conduct a related local examination?
13. Did s/he conduct a related systemic examination?
14. Did s/he write a provisional diagnosis?
15. Did s/he order any diagnostic or preliminary test?  
(Laboratory tests, X-rays etc.)
16. Did s/he explain the prescription thoroughly?
17. Did s/he give related dietary instructions?
18. Did s/he give health education?
19. Did s/he give appointment for next visit?
20. Was antiseptic solution bowl available for the M.O. to clean hands after examination of  
patients?

21. Was the M.O. aware of conditions which needed referral to a higher centre / specialist care?

22. Did s/he ask if the patient had any questions?

23. Time – In  
Time – Out

### Annex 13 Training Sessions Conducted under CLICS At Program Central level

Training Dates	Duration	Persons attended	Trainers	Location of training	Topics covered
10-15/02/2004	6 day	Community Organizers	Dr. Garg Dr. Gupta Dr. Sherin Dr. Deshmukh Dr. Amol Dr. Madhavi Dr. Enakshi Ms. Alka Mr. Bhusari Mr. Yenukar Mr. Jaiswal Ms. Sharada	Dept of Community Medicine, Sevagram	Concept of SHG, Maintenance of accounts, Work responsibilities and expectation, safe Motherhood, Care of Newborn, concept of parenting workshop
24/02/2004	1 day	Community Organizers	Dr. Garg Dr. Sherin Dr. Gupta Dr. Deshmukh Ms. Vandana	Dept of Community Medicine, Sevagram	Development through SHG, Anganwadi and child development and Child Health
27/02/2004	1 day	Anganwadi Workers	Ms. Deepali Ms. Jyoti Ms. Vandana	Panchayat Office, Talegaon	Anganwadi and material development, Mother and child nutrition
03/03/2004	1 day	Village Health Workers	Dr. Madhavi Ms. Vandana	Dept of Community Medicine, Sevagram	Illness of the under 3 years child, Health education and communication
11/03/2004	1 day	Anganwadi Workers	Dr. Gupta Dr. Chetana Ms. Vandana	Training center Bhidi	Training Needs Assessment of Anganwadi Workers
20/03/2004	1 day	Community Organizers	Dr. Sherin Ms. Vandana	Dept of Community Medicine, Sevagram	Orientation on CLICS Discussion on community mobilization and CBO formation
11/04/2004	1 day	Community Organizers	Dr. Sherin Ms. Vandana	Dept of Community Medicine, Sevagram	Monthly Progress Report

23/04/2004	1 day	Community Organizers	Ms. Vandana	Dept of Community Medicine, Sevagram	PRA – Village mapping
03-07/05/2004	5 days	Community Organizers	Dr. Gupta Dr. Madhavi Dr. Deshmukh Mr. Bahulekar Dr. Sherin Ms. Vandana Ms. Narula	Dept of Community Medicine, Sevagram	IMNCI, Work planning, Management of CBOs, PRA and Adolescent health
19/05/04	1 day	Community Organizers	Ms. Neemat Dr. Sherin Ms. Vandana	Dept of Community Medicine, Sevagram	Qualitative Assessment
24/05/04	1 day	Community Organizers	Ms. Vandana	Dept of Community Medicine, Sevagram	PRA- village mapping and seasonal analysis
07/06/2004	1 day	MO and ANM	Dr. Garg Dr. Sherin Ms. Vandana	Dept of Community Medicine, Sevagram	Introduction to CLICS, job responsibilities of MO and ANM, Training Needs Assessment
17/06/2004	1 day	Chief Volunteer of Kisan Vikas Manch	Dr. Dhotre Mr. Kombe Mr. Tallar	Dept of Community Medicine, Sevagram	Livestock development, Organic farming and credit linkage to the bank

23-24/06/04	2 days	Community Organizers	Mr. Rishi, Mr. Atul Ms. Vandana	Dept of Community Medicine, Sevagram	Documentation skills, MIS , health Education
21-22/07/2004	2 days	Community Organizers	Dr. Deshmukh Dr. Gupta Dr. Enakshi	Dept of Community Medicine, Sevagram	Women health
4-5/08/2004	2 days	Community Organizers	Mr. Atul Mr. Aparajit Dr. Madhavi Mr. Rishi Mr. Bahulekar Dr. Sherin Dr. Gupta Ms. Vandana	Dept of Community Medicine, Sevagram	MIS, Credit linkage with bank, IMNCI, Documentation, management of CBO, formative research, child malnutrition and health message delivery
26/08/2004	1 day	Chief Volunteer of Kisan Vikas Manch	Dr. Peshkar Mr. Ingale Mr. Kamble	Dept of Community Medicine, Sevagram	Integrated pest management, organic farming, different government schemes
15-16/09/2004	2 days	Community Organizers and ANM, MIS assistant and MO	Mr. Bahulekar Mr. Bharambe Mr. Atul	Dept of Community Medicine, Sevagram	Reporting new MIS format, documentation, social mobilization
21/09/04	1 day	Program Staff including Program Coordinator, Technical Support team members, Sector Coordinators & Program officers	Dr. BS Garg	Dept of Community Medicine, Sevagram	Various aspects of Quality Assurance, Purpose & Methods of Quality Assurance, use of tools & exercises like checklists, Fish bone diagram, 5-whys and use of the Quality Assurance Kit.

**Annex 13 (continued) Program Sector level trainings****Sector: Anji**

<b>Training Dates</b>	<b>Duration</b>	<b>Persons attended</b>	<b>Trainers</b>	<b>Location</b>	<b>Topics covered</b>
23/03/2004	1 day	CO and ANM(DCM)	Dr. Deshmukh Dr. Amol	KRHTC, Anji	Daily diary and record keeping
13/04/2004	1 day	CO and ANM(DCM)	Dr. Deshmukh Dr. Amol	KRHTC, Anji	Interview skills, group discussion and home visit
20/04/2004	1 day	CO and ANM(DCM)	Dr. Deshmukh Dr. Amol	KRHTC, Anji	Behavior change communication, body language
27/04/2004	1 day	CO and ANM(DCM)	Dr. Deshmukh Dr. Amol	KRHTC, Anji	BCC and health problems in community
18/05/2004	1 day	CO and ANM(DCM)	Dr. Deshmukh Dr. Amol	KRHTC, Anji	Planned pregnancy
27/05/2004	1 day	CO and ANM(DCM)	Dr. Deshmukh Dr. Amol	KRHTC, Anji	Food and nutrition
15/06/2004	1 day	CO and ANM (DCM+ Program)	Dr. Deshmukh Dr. Amol	KRHTC, Anji	Balanced diet, cooking method
06/07/2004	1 day	CO and ANM (DCM+ Program)	Dr. Deshmukh Dr. Amol	KRHTC, Anji	Vitamins and minerals
13/07/2004	1 day	CO and ANM (DCM+ Program)	Dr. Deshmukh Dr. Amol	KRHTC, Anji	Nutritional deficiency disorders
19/07/2004	1 day	CO and ANM (DCM+ Program)	Dr. Deshmukh Dr. Amol	KRHTC, Anji	Malnutrition and growth monitoring
03//08/2004	1 day	CO and ANM (DCM+ Program))	Dr. Deshmukh Dr. Amol	KRHTC, Anji	Breast feeding
10/08/2004	1 day	CO and ANM (DCM+ Program))	Dr. Deshmukh Dr. Amol	KRHTC, Anji	Diet of pregnant and lactating mothers
17/08/2004	1 day	CO and ANM (DCM+ Program)	Dr. Deshmukh Dr. Amol	KRHTC, Anji	Diet of children
14/09/2004	1 day	CO and ANM (DCM+ Program)	Dr. Deshmukh Dr. Amol	KRHTC, Anji	Antenatal care
13/07/2004	1 day	Panchayat members	Dr. Garg	KRHTC, Anji	Introduction to CLICS program
21/08/2004	1 day	Panchayat members	Dr. Deshmukh	KRHTC, Anji	Malnutrition in Anji PHC area, new born care

			Dr. Amol Dr. Shyamkuwar		
21/09/2004	1 day	Panchayat members	Dr. Deshmukh Dr. Amol Mr. Anup Khavade Mr. Arvind Bhoskar	KRHTC, Anji	Safe motherhood, RCH Components, nutrition, VCC orientation, poisonous snakes demonstration with first-aid
13/02/2004	1 day	Anganwadi workers and PHC staff	Dr. Madhavi	KRHTC, Anji	IMCI
24/02/2004	1 day	Anganwadi workers and PHC staff	Dr. Madhavi	KRHTC, Anji	IMCI
27/02/2004	1 day	Anganwadi workers and PHC staff	Dr. Deshmukh Dr. Amol	KRHTC, Anji	Orientation on CLICS program
27/03/2004	1 day	Anganwadi workers and PHC staff	Dr. Amol	KRHTC, Anji	International Women's Day celebration
27/04/2004	1 day	Anganwadi workers and PHC staff	Dr. Amol	KRHTC, Anji	World Health Day celebration
27/05/2004	1 day	Anganwadi workers and PHC staff	Dr. Sanjay	KRHTC, Anji	Smokeless chulha and ARI
28/06/2004	1 day	Anganwadi workers and PHC staff	Dr. Deshmukh Ms. Vandana	KRHTC, Anji	TNA of PHC staff , IMCI
27/07/2004	1 day	Anganwadi workers and PHC staff	Dr. Amol Dr. (MO, PHC)	KRHTC, Anji	Breast feeding
27/08/2004	1 day	Anganwadi workers and PHC staff	Mr. and Mrs. Burande	KRHTC, Anji	Nutrition, games and action songs for children
18/09/2004	1 day	Anganwadi workers and PHC staff	Dr. Garg	KRHTC, Anji	Orientation on CLICS program and technical control
27/09/2004	1 day	Anganwadi workers and PHC staff	Ms. Ruikar Dr. Amol Mr. Nitin	KRHTC, Anji	Songs for children, nutritional recipes, pulse polio planning, different days of this months and its importance

**Sector Gaul:**

<b>Training Dates</b>	<b>Duration</b>	<b>Persons attended</b>	<b>Trainers</b>	<b>Location</b>	<b>Topics covered</b>
11/10/2003	1 day	Anganwadi workers	Dr. Chetana Dr. Rashmi Mr. Haresh	RHTC, Bhidi	ICDS
11/11/2003	1 day	Anganwadi workers	Dr. Gupta Dr. Chetana	RHTC, Bhidi	Folk songs, role play, cancer, TB
11/12/2003	1 day	Anganwadi workers	Dr. Gupta Dr. Chetana	RHTC, Bhidi	AIDS
13/01/2004	1 day	Anganwadi workers	Dr. Chetana Dr. Rashmi Mr. Haresh	RHTC, Bhidi	Smoking and its hazards, leprosy
11/03/2004	1 day	Anganwadi workers	Dr. Gupta Dr. Chetana Dr. Rashmi Ms. Vandana	RHTC, Bhidi	TNA
24/04/2004	1 day	Anganwadi workers	Ms. Deepali Ms. Jyoti Ms. Sathe Mr. Bawane	RHTC, Bhidi	Prayer, play, songs for children
23/06/2004	1 day	Anganwadi workers	Dr. Gupta	RHTC, Bhidi	IMCI
27/07/2004	1 day	Anganwadi workers	Ms. Deepali Ms. Jyoti	RHTC, Bhidi	Game for children
23/08/2004	1 day	Anganwadi workers	Dr. Chetana Dr. Rashmi	RHTC, Bhidi	Malnutrition
23/09/2004	1 day	Anganwadi workers	Dr. Enakshi Mr. Vinod Ms. Sushama Ms. Sathe	RHTC, Bhidi	Behavior Change Communication, Malnutrition
26/07/2004	1 day	Panchayat members	Dr. Gupta Dr. Sherin Dr. Chetana Dr. Rashmi Mr. Rishi	RHTC, Bhidi	Activities of RHTC, Bhidi, Jamkhed project, introduction to CLICS, role of VCC and Panchayat in CLICS project, importance of VCC

18/08/2004	1 day	Panchayat members	Dr. Chetana Dr. Rashmi Mr. Atul Ms. Geeta Mr. Manoj Mr. Haresh	RHTC, Bhidi	Tobacco chewing and its hazards, new born care, rights and responsibilities of Sarpanch
29/09/2004	1 day	Panchayat members	Dr. Chetana Dr. Enaskhi Mr. Haresh Mr. Manik Ms. Sushma Ms. Sathe Ms. Geeta	RHTC, Bhidi	RCH program, role and responsibilities of VCC, safe motherhood, Iodine Deficiency day, pulse polio
29/10/2003	1 day	Health workers(PHC)	Dr. Chetana Dr. Rashmi Mr. Haresh	RHTC, Bhidi	Cancer
27/11/2003	1 day	Health workers(PHC)	Dr. Chetana Dr. Rashmi Mr. Haresh	RHTC, Bhidi	Obesity
27/12/2003	1 day	Health workers(PHC)	Dr. Rashmi Mr. Haresh	RHTC, Bhidi	Polio and pulse polio immunization
27/02/2004	1 day	Health workers(PHC)	Dr. Chetana Dr. Rashmi Mr. Haresh	RHTC, Bhidi	Introduction to CLICS program
27/03/2004	1 day	Health workers(PHC)	Dr. Rashmi Mr. Haresh Mr. Bawane	RHTC, Bhidi	Tuberculosis
27/04/2004	1 day	Health workers(PHC)	Dr. Rashmi Mr. Haresh Mr. Bawane	RHTC, Bhidi	Prevention and control of Malaria
27/05/2004	1 day	Health workers(PHC)	Dr. Chetana Dr. Rashmi Mr. Bawane	RHTC, Bhidi	Prevention and control of Filaria
28/06/2004	1 day	Health workers(PHC)	Dr. Gupta Dr. Chetana	RHTC, Bhidi	Technical control of Gaul PHC

			Dr. Rashmi		
27/08/2004	1 day	Health workers(PHC)	Dr. Chetana Dr. Rashmi	RHTC, Bhidi	MCH activities
27/09/2004	1 day	Health workers(PHC)	Dr. Chetana	RHTC, Bhidi	Bal Surakshya Diwas

**Sector Talegaon:**

Training Dates	Duration	Persons attended	Trainers	Location	Topics covered
15/10/2003	1 day	ANM	Dr. Sherin Dr. Amol Mr. Wankhede Mr. Yenurkar	PHC Talegaon	Plus Polio Dengue and treatment
29/10/2003	1 day	Anganwadi workers	Dr. Gupta, Mr. Yenurkar Ms. Deepali Ms. Jyoti	Panchayat Office, Talegaon	Anganwadi and material development, Child Development
27/11/2003	1 day	Anganwadi Workers	Mr. Yenurkar Ms. Alka	Panchayat Office, Talegaon	Maternal Mortality
27/01/2004	1 day	Anganwadi Workers	Ms. Deepali Ms. Jyoti Ms Alka	Panchayat Office, Talegaon	Anganwadi and material development, RTI/ STD
27/02/2004	1 day	Anganwadi Workers	Ms. Deepali Ms. Jyoti	Panchayat Office, Talegaon	Anganwadi and material development, songs and games for children
27/03/2004	1 day	Anganwadi Workers	Ms. Deepali Ms. Jyoti Ms. Vandana	Panchayat Office, Talegaon	Child development, Anganwadi material development
27/04/2004	1 day	Anganwadi Workers	Dr. Madhavi Ms. Deepali Ms. Jyoti	Panchayat Office, Talegaon	IMCI, activities of anganwadi
27/05/2004	1 day	Anganwadi Workers	Dr. Madhavi	Panchayat Office,	IMCI, activities of anganwadi

			Ms. Deepali Ms. Jyoti	Talegaon	
28/06/2004	1 day	Anganwadi Workers	Dr. Mehendale Dr. Savinder Dr. Madhavi	Panchayat Office, Talegaon	Overall activities of anganwadi
27/09/2004	1 day	Anganwadi Workers	Ms. Alka	Panchayat Office, Talegaon	Ante Natal Care, high risk factors in pregnancy
2/11/2003	1 day	Sarpanch and Panchayat Members	Dr. Deshmukh Dr. Anchita Mr. Yenurkar	Dept. Of Community Medicine, Sevagram	Health Insurance, New born care, Vector control
28/07/2004	1 day	Panchayat members	Dr. Sherin Dr. Savinder	Dept of Community Medicine, Sevagram	Introduction to the CLICS program
11/08/2004	1 day	Panchayat members	Mr. Bahulekar Dr. Sherin Dr. Savinder Mr. Bhursari Ms. Vandana	Dept of Community Medicine, Sevagram	Panchayati Raj and health, information on CBOs in village, newborn care
08/09/2004	1 day	Panchayat members	Dr. Sherin Mr. Bahulekar Ms. Alka Ms. Nanda	Dept of Community Medicine, Sevagram	RCH program, orientation on VCC, safe motherhood
30/10/2003	1 day	Village Health Workers	Dr. Sherin Dr. Madhavi	Dept of Community Medicine, Sevagram	Record checking and Non Communicable diseases
29/11/2003	1 day	Village Health Workers	Dr. Sherin Dr. Madhavi	Dept of Community Medicine, Sevagram	Record checking Integrated Management of Child Illness
21/01/2004	1 day	Village Health Workers	Dr. Sherin Dr. Anchita Dr. Madhavi Dr. Deshmukh	Dept of Community Medicine, Sevagram	Maternal Nutrition and Child Death, Child development and malnutrition
03/03/2004	1 day	Village Health Workers	Dr. Madhavi Ms. Vandana	Dept of Community Medicine, Sevagram	IMCI, Health education
03/04/2004	1 day	Village Health Workers	Dr. Madhavi Dr. Sherin Ms. Vandana	Dept of Community Medicine, Sevagram	IMCI, Health communication

03/05/2004	1 day	Village Health Workers	Dr. Madhavi Dr. Sherin	Dept of Community Medicine, Sevagram	IMCI, Record keeping
31/05/2004	1 day	Village Health Workers	Dr. Madhavi Ms. Vandana	Dept of Community Medicine, Sevagram	IMCI, Malaria
05/07/2004	1 day	Village Health Workers	Dr. Deshmukh Dr. Sherin Dr. Madhavi Ms. Vandana	Dept of Community Medicine, Sevagram	FGD on work hours, reporting IMCI
29/07/2004	1 day	Village Health Workers	Dr. Sherin Dr. Madhavi Ms. Vandana	Dept of Community Medicine, Sevagram	Record checking, doses of medicine, report writing
30/08/2004	1 day	Village Health Workers	Dr. Savinder Mr. Nitin Ms. Savita	Dept of Community Medicine, Sevagram	Breastfeeding, bal surakshya divas
29/09/2004	1 day	Village Health Workers	Dr. Madhavi Ms. Vandana Mr. Bharambe Dr. Sherin	Dept of Community Medicine, Sevagram	Skill assessment, Training Needs Assessment, new reporting format

**Annex 14**  
**Exposure Visits**

<b>Visit to</b>	<b>Participants</b>	<b>Period</b>	<b>Learnings</b>
Child Survival program, entitled "Pragati" implemented by World Vision at Balia, UP	Dr. SS Gupta Dr. Amol Dongre Dr. Sherin Varkey Mr. Atul Gandhi Mr. P Bhusari	16 <sup>th</sup> –19 <sup>th</sup> August 2004	Training of adolescents on Family Life Education, Training of TBA, Community Based Distribution System, Program MIS
Bureau of Nutrition, Nagpur	Dr. Amol Dongre All Community Organizers, APOs & ANMs (CLICS Program Staff)	23 <sup>rd</sup> September 2004	Malnutrition – causes and its prevention, Diet during Ante Natal & post Natal period and diet of children, Demonstration of low cost nutritious recipes, Simple methods for identifying food adulteration.
Final Participatory evaluation workshop of Jeevandan Child Survival Program of Counterpart India at Ahmedabad	Dr. PR Deshmukh Mr. MS Bharambhe	2-7 <sup>th</sup> September 2004	Participatory Evaluation, Strategy for BCC, Developing key messages for Behavior Change.

### Annex 15

## GUIDELINES FOR TRAINING OF PANCHAYAT MEMBERS

- Panchayat training program will be held on fixed weekday of every month for eight months, starting from July 2004.
- Two members from each Gram Panchayat (One Sarpanch & one other Gram Panchayat member) will be invited for the training.
- Each invited member who attends the training session will be given fixed TA of Rs. 50/-.
- The training will last for a maximum of three hours.
- The trainees will be provided with tea & snacks.

### Training Content:

- Training topics will be mainly related to health and development subjects.
- Some of the training topics will be finalized in discussion with training participants.
- Arrangement of the resource persons will be done at sector level with consultation of Sector Supervisor.
- Each topic should last for not more than 30 minutes.
- The sessions should be interactive as far as possible
- The structure of each training program will be as follows:

Topic 1: As suggested by participants in previous training

Topic 2: Health System

Topic 3: CLICS program issues

Topic 4: Mother and child health

Kindly Note: The topics should only include information & issues relevant for Panchayat members

Session	Training	Topic 2	Topic 3	Topic 4
1	July 04	Introduction & orientation to CLICS		
2	August 04	Panchayati raj & Health (Discussion)	Information about SHGs, KVM & KP	Newborn Care
3	Sep 04	RCH Program – Key points	VCC	Safe Motherhood
4	Oct 04	NHP-2002, NPP-2000, Maharashtra PP (Key Points)	Bal Suraksha Diwas	Breastfeeding & Nutrition
5	Nov 04	Structure of District Health System, PHC	Community Health Clinic	Diarrhea
6	Dec 04	Subcenter	Maternity Hut	ARI
7	Jan 05	Anganwadi	Village Health Worker	Early Childhood Development, Immunization,
8	Feb 05	Health Insurance Schemes for rural households.	Trained Birth Attendant	RTI/STI, HIV & AIDS, Birth Spacing

**Learning Objectives:****Session 1:**

By the end of session 1, participants should:

- Be oriented to the goals, objectives, beneficiaries, program partners, strategy & interventions of CLICS program
- Have a clear understanding of the role and responsibilities of Gram Panchayat in the CLICS program.

**Session 2:**

By the end of session 2, participants should:

- Have a clear understanding of the role and responsibilities of Gram Panchayat in the delivery of health care at the village level.
- Have a clear understanding of the activities, roles & responsibilities of SHGs, KVM & KP in CLICS
- Have a clear understanding of the importance and approaches (home based management) of newborn care.

**Session 3:**

- Have a clear understanding of Government RCH program.
- Have a clear understanding of constitution, role and responsibilities of Village Coordination Committee.
- Have a clear understanding of role and responsibilities of Gram Panchayat in ensuring safe motherhood.

**Session 4:**

- Have a clear understanding of National Health Policy, National Population Policy and Population Policy of Maharashtra State
- Have a clear understanding of activities of Bal Suraksha Divas and roles and responsibilities of Gram Panchayat in Bal Suraksha Divas.
- Have a clear understanding of importance of breast-feeding and nutrition and role and responsibilities of Gram Panchayat in promotion of breast-feeding and nutrition.

**Session 5:**

- Have a clear understanding of structure of District Health System and functions /services provided by Primary Health Center
- Have a clear understanding of Community Health Clinic, role and responsibilities of Gram Panchayat in collection of funds and management of Community Health Clinic
- Have a clear understanding of diarrhea in 0-5 years aged children and its management at village level.

### **Session 6:**

- Have a clear understanding of functions of ANM & services provided by Subcenter at community level
- Have a clear understanding of importance of maternity hut and role of Gram Panchayat in management of maternity hut.
- Have a clear understanding of Acute Respiratory Infection in 0- 5 years aged children and its management at village level.

### **Session 7:**

- Have a clear understanding of functions of Anganwadi worker & services provided by Anganwadi.
- Have a clear understanding of method of selection & services provided by Village Health Worker at community level.
- Have a clear understanding of importance & role and responsibilities of Gram Panchayat in early childhood development and immunization program

### **Session 8:**

- Be oriented to health insurance schemes for rural households
- Have a clear understanding of method of selection & role and responsibilities of trained birth attendant in ensuring safe delivery at village level.
- Be oriented to the causes, complications, treatment & methods of prevention of RTI/ STI and sexually transmitted diseases like HIV/AIDS
- Have a clear understanding of different birth spacing methods and role and responsibilities of Gram Panchayat in ensuring adoption of birth spacing method by eligible couples.

**Annex 16****Community Led Initiatives For Child Survival**

Department of Community Medicine

M.G.I.M.S., Sewagram

**Village Profile**

Village: <b>Pavanar</b>	Village ID: <b>19</b>
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1	No of Households in the village	1721
2	Population	7261
3	Sex Ratio (Female / Male)	904
4	Children (0-3 years)	373
5	Adolescent girls (12-19 years)	555
6	Women (15-44 years)	1235
7	Age at marriage	19
8	Age at first pregnancy	20.5

**Health Situation & Hygiene Practices in the Village****Mothers**

1	Percent women who received at least one Antenatal Care	32.30%
2	Average number of Antenatal Checkups received (Out of Total)	1.35
3	Average duration of pregnancy at first ANC	2.98
4	No. of TT injections received	32% - Received Two 5% - Received One 67% - NA
5	Full ANC/ Package ANC (100 + IFA, 3 ANCs, 2+ TT)	5.60%
7	Percent women who received at least 3 PNC in 42 days of child birth	59.70%
8	Place of delivery (Home)	17.90%
9	Who attended the delivery in case of home delivery	85% TBA / DAI
10	DD kit use, in case of home delivery	42.90%

**Children**

1	Percent children born at least 36 m after the last surviving child	
2	Initiation of breast feeding	52.4 % - AOH

		40 % - ATH
3	Immunization (Full)	9.50%
4	Percent mothers (0-23 m) with immunization cards (Yes)	78.80%
5	Malnutrition	31% - M 13 % - S
6	Percent children (0-5 m) weighed within 24 hours of birth	75.70%
7	Percent low birth weight babies	28.00%
8	Percent children (0-5 m) breastfed within 1 hour of birth	50.00%
9	Percent children (6-9 m) given breast milk and complimentary food in the last 24 hours	
10	Percent children (12-35 m) given Vit. A dose in last 6 months	49.10%
11	Percent children (12-35 m) given IFA in last 14 days	2.80%
12	Percent mothers of children (6-35 m) who named at least 3 iron rich foods	
13	Percent children (0-35 m) suffering from diarrhea received Home available fluids/ORS	4.80%

#### Adolescent Girls

1	Percent Adolescent Girls who are still studying*	77.20%
2	Percent Adolescent girls using sanitary pads during menses*	5.50%

#### Personal Hygiene Practices

	Percent woman (15-44 ) who wash their hands with soap/ash	2.40%
1	Before feeding children*	1.00%
2	After defecation*	91.60%

#### RTI/STD and HIV/AIDS

1	Percent woman (15-44 yrs) who reported at least one symptom of RTI / STD in last 3 months*	15.20%
2	Percent woman (15-44 yrs) who sought treatment from a skilled provider for of RTI / STD in last 3 months*	55.20%
3	Percent mothers with children (0-35 m) who can cite at least two known ways of reducing risk of HIV/AIDS infection	32.00%
4	Percent fathers with children (0-35 m) who can cite at least two known ways of reducing risk of HIV/AIDS infection*	64.20%

\* The values of indicators are at Sector level.

**Annex 17**  
**MINUTES OF THE STEERING COMMITTEE MEETING**  
**28<sup>th</sup> November 2003**

The first meeting of the Steering Committee of the CLICS programme was held on the 28<sup>th</sup> November 2003 in the Seminar Room of the Dean Office at 3:30 pm. The meeting was attended by:

- 1) Shri Dhirubhaiji Mehta – President, Kasturba Health Society
- 2) Shri S R Halbe - Member, Kasturba Health Society
- 3) Ms. Suma Subanna – Secretary, Kasturba Health Society
- 4) Dr. (Mrs) P Narang – Dean, MGIMS
- 5) Dr. A P Jain – Medical Superintendent, Kasturba Hospital
- 6) Dr. B S Garg – Professor & Head, Department of Community Medicine
- 7) Ms. Nemat Hajeebhoy - Programme Manager (Health), AKF (India)

The proceedings of the meeting were as follows:

- The Meeting began with a short presentation of the CLICS programme by Dr. BS Garg, which provided a brief outline of the programme, the activities involved, organogram and the work plan.
- The issue of Office space was discussed in detail. Dr. Garg informed the members that the offices of Anji and Gaur sectors would be set up at the respective Rural Health Training Centres. The Talegaon sector office would be set up at Waigaon as it had a central location. The space at Waigaon would be hired and the staff of DCM is in the process of identifying a suitable space. The staff would not be provided accommodation and would have to arrange for the same themselves in the locality of the project office. Dr (Mrs.) P Narang reminded the members of the plot owned by the Society at Talegaon. After discussions, it was concluded that the plot would not be suitable for setting up the project office due to its inconvenient location. Shri Dhirubhaiji stressed on the fact that the Central Programme Office located at the DCM should have independent space in order to avoid the mixing of papers and interference with routine department activities.
- The members also discussed issues regarding the recruitment of manpower for the programme. Shri Dhirubhaiji stated that all the terms of the contract should be appropriately mentioned in the appointment letter, including period of employment, benefits and salary. He also directed Dr. Garg to consult Shri Tapadiya and a lawyer for matters related to recruitment of personnel and their benefits.
- Shri Dhirubhaiji also enquired about the procedure for payment of Provident Fund and said that according to present norms, all workers (including those on contract) have to be paid Provident Fund. He suggested registering the Programme with the Provident Fund Commissioner for the same. Shri Halbeji suggested that upto 3% of the Benefits could be distributed as performance based incentive. He also added that utilizing the services of a private firm for recruitment of personnel could decrease the burden and workload of the programme staff. Shri Dhirubhaiji

intervened and said that relying on a private firm would lead to a compromise on the quality of staff, which would be detrimental to the implementation of the programme. Shri Dhirubhaiji added that the Finance Officer should be recruited as soon as possible and until then Mr. Khode could be asked to help in managing programme finances.

- The members then discussed the issue of procurement of vehicles for the programme. Dr. Garg suggested that Bajaj M 80s would be ideal for use in the programme. Shri Dhirubhaiji added that there are many two wheelers currently available in the market ranging from M 80s to motorbikes and an appropriate vehicle could be chosen. He also said that the four wheelers could be hired from a private firm but special care should be taken to ensure that the driver is qualified and has a valid driving license.
- Ms. Nemat Hajeebhoy stated that since the funding involved a large amount of money underspending could be a problem. Shri Dhirubhaiji however assured her that in the current programme efforts would be made to avoid the same and the situation would only arise in case of delay in sanctioning of grant.
- Following this, Ms. Nemat Hajeebhoy formally handed over the agreement letter to Shri. Dhirubhaiji, which was greeted by a round of applause by the other members. Shri. Dhirubhaiji read the agreement while Dr. (Mrs.) Narang signed the agreement on the behalf of MGIMS, Sewagram.
- Shri. Dhirubhaiji advised that the programme activities should be started as soon as possible and by 31<sup>st</sup> December 2003 the procurement should be completed as per plan. Dr. Garg informed the members that the first Programme Advisory meet would be held by the end of December 2003.
- Dr. Garg also informed the member about the development of the Detailed Implementation Plan (DIP) after the completion of baseline survey by external agency. A workshop would be organized for preparing the DIP, which would be presented in the next steering committee meeting. At this juncture Shri. Dhirubhaiji stated that other activities like developing procurement & human resource manual should be taken up simultaneously. Shri. Halbeji added that a daily cashbook should be maintained till the process of financial accounting of the programme is streamlined. Dr. Garg assured members that the department was already using Tally – 6.3 Software for accounting of current project finances.
- Ms. Neemat informed the members on the procedure of release of funds. The funds would be released after receipt of a written request six weeks in advance. This would require an accurate foresight of estimated expenditure. Dr. Garg said that the programme also required periodic financial reports, which was already being done in the previous AKF project. He also added that the quality of the report would improve with the inputs of the Financial Officer.
- Shri. Halbeji asked the members whether any other programmes (blindness control activity) could be associated with the activity of the CLICS programme in order to save resources. Dr. Garg said that it would be possible as long as the additional activities would not interfere with the programme activities. Shri.

Dhirubhaiji however cautioned the committee that the additional activities should not be implemented in first six month as they could delay the CLICS programme activities.

- Dr. (Mrs.) Narang enquired whether the CLICS programme activities could adversely effects the ongoing activities of the Govt. Health system (e.g. immunization). Dr. Garg assured the committee that current Govt. activities would not be adversely affected; on the contrary he stated that the programme envisaged the strengthening of these activities. Shri. Dhirubhaiji stated that certain dogmatic communities have always resented immunization. It would be important for the programme to identify such communities and find out why they do not immunize their children. Ms. Neemat informed the members that the programme would focus on three aspects of immunization i. e. reaching the un-reached, quality of immunization and early childhood care and development. Dr. Garg added that some activities are already being undertaken in the Talegaon area.
- Ms. Neemat suggested that the recruitment of programme staff should be done on the basis of experience and merit only. However, Shri. Dhirubhaiji said that even a young person if capable enough could be employed.
- The Committee members discuss the Organogram of the CLICS programme. Shri. Halbeji voiced his concern about the position of Sector Coordinator and enquired whether the Sector Coordinator being an employee of MGIMS would be able to fulfill his responsibilities towards the programme. Dr. Garg assured the members that the sector coordinator would be given backup support by the existing staff of DCM posted at the Rural Health Training Center. Shri. Halbeji suggested that the Sector Coordinator should be made answerable for the activities in their respective sectors.
- Shri. Dhirubhaiji conveyed his best wishes for the implementation of the programme and expressed his hope that in the next Steering Committee Meeting a report on the implementation would be presented.
- In conclusion, Ms. Neemat thanked the committee members on behalf of Aga Khan Foundation (India) for all the help & support received from MGIMS. She also informed the members that AKF(I) had great interest in the programme due to its innovative strategies and the results of the CLICS Programme would help in improving the health component in other AKF(I) projects.

The meeting was concluded after vote of thanks.

## Annex 18

### Minutes of Steering Committee Meeting

Date : 1<sup>st</sup> June 2004; Time: 3:30 p.m.  
 Venue : Seminar Room, Dean Office  
 Attended by : Dr. (Mrs.) P. Narang – Dean, MGIMS  
 Dr. B.S. Garg – Professor & Head, DCM, MGIMS  
 Mr. Prabodh Bhambhal – Program Officer, AKF  
 Dr. Ashok Panbude, Civil Surgeon, Wardha  
 Dr. P.R. Dhakte, Asst. DHO, Wardha  
 Dr. Sherin Varkey – Prog. Coordinator, CLICS

The key proceedings of the meeting were as follows:

- The meeting began with the discussion on the minutes of the previous Steering Committee meeting. Dr. Panbude raised the issue of possibility of inclusion of National Health Program in the CLICS program. In response Dr. Garg said that this could be incorporated only after the CLICS program implementation gets streamlined and stabilised.
- Dr. Garg informed the Dean and other committee members about the recruitment of program personnel for CLICS. Giving details on this the committee was informed about the appointments of program officers, finance officer, medical officer and community organizers for various program functions.
- Further to the above, Dean asked about insurance cover for all the recruited personnel. To this Dr. Garg apprised her and other committee members of the insurance policy being provided to all the staff hired for CLICS. Dean also asked to confirm the need for provident fund for program staff members.
- On program logistics, Dr. Garg informed the members about hiring of vehicles. While Tata Sumos (3) have been hired for the office, Bajaj M 80s (10) have been provided community organizers working in the three sectors. Log Book is maintained for all the vehicles.
- Presentation on CLICS Program Progress:

Dr. Sherin Varkey, Program Coordinator (CLICS) made a presentation on CLICS program activities and progress made till date. Members were presented facts and figures related to various activities like baseline survey, community mobilization, Detailed Implementation Plan (DIP) generation, organization structure, program work plan and implementation etc.

Commenting further on DIP, Dr. Garg described about 5-year work plan chalked out for the program, stage-wise objectives and activities. He said that the foundation for the program has been created with completion of recruitment, procurement and trainings. Dr. Panbude enquired about the MIS to be used by CLICS program. In response, Dr. Garg emphasised that CLICS will use a MIS similar to that of the government, but will make certain improvisations. He added about the development of competent MIS plan to be implemented for the effective functioning of the program.

While explaining the logframe analysis, the Dean asked about the monitoring mechanism for true evaluation of the success of program. To this Dr. Garg informed about multi-tier assessment plan including mid-term, end-term and half-yearly ad hoc assessments.

- Dr. Garg informed the members that Dr. S.R. Salunke, DGHS, Maharashtra has accepted the chairmanship of the advisory committee. Dr. Garg also informed the committee that each member would be provided with a copy of the final DIP as soon as it is available.
- A decision was taken to organise the next steering committee meeting at one of the sector offices when the members will have opportunity to also visit the field. The meeting concluded with Dean lauding the role of program functionaries and hard work put into the program so far.

**Dr. B. S. Garg**

## Annex 19

### Minutes of Advisory Committee Meet of CLICS on 23-12-2003

The advisory Committee meet of the CLICS was held on 23-12-2003 at 10.30AM at Aga Khan Foundation, New Delhi. The followings attended:

1. Dr. S.R. Salunke, DGHS, Maharashtra, Mumbai
2. Dr. Vinod Paul, AIIMS, New Delhi
3. Dr. Dinesh Paul, NIPCCD, New Delhi
4. Dr. Arvind Mathur, NPO, WHO WR Office, New Delhi
5. Ms. Nemat Hajeebhoy, Programme Manager (Health), AKF (I)
6. Dr. B.S. Garg, Program Director, CLICS

Besides all the above the CEO of Aga Khan Foundation (AKF), Mr. Nick McKinlay also addressed the members & participated in the discussion. Dr. Abhai Bang showed his inability due to prior commitment while Dr. Rajesh Kumar cancelled his programme due to urgent institutional commitment.

The meeting officially commenced with a brief welcome to the Programme Advisory Committee members by the CEO of Aga Khan Foundation (AKF), Mr. Nick McKinlay, who stressed the critical importance of forming such a group of eminent health professionals to provide technical inputs and engage in policy advocacy for the *Community Led Initiatives for Child Survival* (CLICS) programme.

This was followed by presentations by Ms. Nemat on the work managed by the Aga Khan Foundation in India and subsequently by Dr. Garg on CLICS program including presentation on MGIMS Sewagram.

A notable point raised in response to the latter presentation regarding policy advocacy was that the government of India is keenly interested in rural community-based insurance schemes, which MGIMS is successful in implementing as a part of CLICS, and should make efforts to capitalize upon to further the gains made to date.

Concerns were raised with respect to the level of inclusion of health education activities in project interventions, to which it was clarified that such an approach will be present across all interventions at least to a 20% level, as laid out in Element 3 of the project.

Dr. Vinod Paul raised the issue that it may be in the project's interest to pursue a more ambitious approach to training community-based health workers; he suggested that they should be trained on the line of proposed RCH village level worker with exception of midwifery and therapeutic injections. This would be with the aim of strengthening the abilities of health workers mobilized in the project's interventions as a model to test and learn from, for wider application in RCH programme. It was further suggested that the Department of Community Medicine (DCM) of MGIMS could possibly link up with the RCH programme to receive training paid for by the government to align CLICS interventions with the future direction of national policy with respect to RCH service provision at the village level. However, Committee members did not reach consensus on this matter.

Dr. Subhash Salunke brought into discussion the issue of sustainability of community-owned interventions. All those present for the meeting were aware that community

participation and ownership of activities are not automatic processes and require vast amounts of attention both during project implementation and in the years after project termination. It is necessary to look at the viability of a village-level female health worker linked to CLICS and how the dynamics of reimbursement of her work play into the community's perception of ownership of activities/services in the long term. Solely leaving accountability of the village health worker to the Village Coordination Committee (VCC) is insufficient in that it assumes total transparency of the VCC and over-estimates the power of such a village-level body to take the necessary and appropriate action. One suggestion was to make it mandatory that the village health worker be a female employed on a temporary, contractual basis and to commit to both of these factors in the actual implementation of project activities from the outset.

Dr. Salunke requested that CLICS should develop collaboration with the Mumbai-based Directorate of Health Services, Maharashtra & with the District Health System at local level in order to identify the areas of mutual collaboration to avoid overlapping. A plan of action can be drawn up during the first year of implementation and be coterminous with the project. Particular emphasis would be on avoiding duplication of efforts and ensuring partnership of project health workers (VHWs & ANMs) with the health system to impress upon them that their work is valued and appreciated not only at the village-level but also at higher levels within and beyond the project's management structure. He also desired that DHO & Dy CEO (ICDS) should be member of steering Committee.

Dr. Vinod Paul suggested to change the project's name to include the RCH components which are present as part of the overall project. He in addition asked that documentation and dissemination design should take into account the production of publications in peer reviewed International/National Journals for dissemination, advocacy & replication.

Mr. Arvind Mathur stated with respect to safe institutional delivery that it must be specified that whether we have the skilled attendants or qualified Traditional Birth Attendants (TBAs). As a separate point he mentioned about developing RCH service package at different levels and associated costing would be a major contribution to the child survival community and RCH service delivery at multiple levels. A review of maternal mortality would give an indication of where maternal deaths are occurring (household or sub-centre/PHC, cause(s) of death and how such information is obtained, i.e. facility-based or verbal autopsy, etc). IMNCI materials that have recently come out would be worthwhile for project to look at, which Mr. Mathur will provide to the program. WHO could potentially serve as a link between the project and government in this respect, though Maharashtra is not part of the 5-state wide testing of the IMNCI protocol.

#### Review and discussion of the 6-month work plan

Prior to a discussion of the project's 6-month work plan, it was mentioned that the second launch of the project, which will occur either in January or February 2004, could serve as an opportunity for Committee members to visit CLICS the project area if they have not already done so. The members will be informed the dates well in advance. Similarly, the next Programme Advisory Committee meeting could be held in Sewagram in 1<sup>st</sup>/2<sup>nd</sup> week of April 2004 to orient the members to the project in the field.

**Review and discussion of the Terms of Reference for the Programme Advisory Committee:**

It was agreed that under the role and function section of the Terms of Reference, Points 1,2,5 and 6 would be critical contributions from Committee members

Lastly, and with respect to the option of awarding an honorarium to Committee members for their contribution to the project, it was left to Program Director to finalize it as per the program norms accordingly.

## Annex 20

### CLICS Programme Department of Community Medicine, MGIMS, Sewagram, Wardha Proceedings of Second Advisory Committee

The meeting of Advisory Committee was held on 7-5-2004 at 11AM in AKF office New Delhi. The followings were present:

1. Dr. Vinod Paul
2. Dr. Subhash R. Salunke
3. Dr. Rajesh Kumar
4. Dr. Dinesh Paul
5. Ms. Nemat Hajeebhoy
6. Dr. B.S. Garg

Mr. Probodh Bhambal, Programme officer (Health) AKF (I) & Ms. Aliya Karmali, Intern, AKF (I) were also present.

In start with Dr. Garg proposed that Dr. Salunke be appointed as Chairman which was accepted & thereafter the meeting was conducted by Dr. Salunke as per agenda:

1. There was no comment on the minutes of the last meeting.
2. Dr. Garg presented the activities of last 6 months including the Base Line survey. The followings issues & concerns were made:
  - A. Dr. Dinesh Paul and Dr. Subhash Salunke remarked that the adolescent age cohort should include 10-19 years as per WHO norms & not the 12-19 years age group. The project's goal statement should also be revised to include this target group & so for the activities.
  - B. Committee members expressed numerous queries and concerns regarding the validity and import of data during the presentation of baseline findings on key indicators. In particular, members requested that data for ever-married women (15-44 years) be divided into 10-year age cohorts so as to facilitate trends analysis over time. It was also suggested that the data obtained for deliveries attended by skilled health personnel be disaggregated by type of personnel specially for TBA & ANM, as well as that for ANC by sub-component (urine sample, hemoglobin test, blood pressure, tetanus toxoid injection, iron-folic acid consumption, etc.). Data for exclusive breastfeeding and malnutrition must also be re-analysed, as the former ought to be looked at over a 5-month period and the latter gathered using nutritional anthropometry in EPI-INFO. The action on these suggestions was agreed upon
  - C. Dr. Kumar requested that data from the Partnering for Child Survival project (2001-2003) be obtained from the project and also the government at the district level, so as to more accurately analyse the baseline findings with respect to gains achieved in the Talegaon sector. Dr. Dinesh Paul at this point suggested that the district level information is available in SHISHU INFO, which may also be utilized along with two RCH surveys.
  - D. Dr. Salunke also suggested that MIS might be developed in consultation of Dr. Satish Pawar, Nodal officer at DGHS, Mumbai.

3. Dr. Garg presented the plan for next six months. The followings concerns were raised:

- A. Ms. Nemat highlighted the importance of tailoring the project's operations research studies so that results may feed into RCH II and the GOI 10<sup>th</sup> Five Year Plan, etc. Such policy advocacy entails that PAC members leverage their professional networks to serve as a platform for disseminating key project impacts and findings.
- B. Dr. Vinod Paul strongly recommends the project team closely consider and possibly revise its package of interventions in terms of long-term desired impacts in the project area, which is to be followed by a further refinement of strategies, training materials, etc. This ought to be done with a view to create a truly innovative child survival project model that will yield lessons for replication in Maharashtra and similar Indian states.
- C. The Members collectively agreed that before research and documentation initiatives are planned and carried out, a broad survey of the information gaps in the child survival community should be undertaken so as to avoid duplication of efforts. Moreover, the documentation plan ought to include a cost-effectiveness component with respect to the efficacy of using the Social Franchise Model to deliver child survival and supportive health services at the community-level. Another method of generating lessons learned can start at the mid-term, with an in-process analysis of select indicators chosen to yield results according to a specific intervention or theme. It would be in the team's interest to consider holding two workshops on the package of technical interventions once finalized and community mobilization aspects of the project. Discussions at these workshops would inform the selection of operations research and documentation initiatives and contribute to well-defined goals and objectives of both.
- D. Dr. Vinod Paul voiced concern that marginalized groups (i.e. BPL families) appear to be excluded from the project's focus, and suggests that equity be mainstreamed across all socio-economic groups in the project area. Doing so would inform best practices in the scaling up of child survival projects amongst such populations in other parts of the country. He also cautioned about using 10 PNC visits as an indicator in normal delivery where it is neither recommended nor practical.
- E. Dr. Rajesh Kumar emphasized that the uniqueness of the project is to build up & develop community Led model & not the interventions. Similarly Dr. Salunke said that we have an opportunity to develop a model in partnership of the health system. He also informed the members that MGIMS would soon get technical control of the project PHCs that will again open an opportunity to develop a model.

4. Thereafter Ms. Nemat briefed the members about DIP. She informed Committee members that the Draft DIP was submitted to USAID for preliminary comments on 30<sup>th</sup> April, and that their inputs on the work plan and log frame are requested in first week June 2004 prior to the formal DIP review and 30<sup>th</sup> June deadline for finalizing

the document. The members desired that the GOI has planned decentralization to the local level and PRIs assuming increased ownership of financial and operational control of development initiatives, the Social Franchise Agreement must be amended to include greater detail on the role and responsibility of PRIs in achieving project objectives.

**5. Future Action Plan:**

- A. Dr. B.S. Garg to send a formal invitation letter to the Secretary, Family Welfare, GOI to visit the project area, and in reference to the Mr. Hota's conversation with Dr. Salunke.
- B. AKF India to receive draft baseline report on 15<sup>th</sup> May, subsequent to which further analysis and revisions will be made and included in the final DIP.
- C. Draft DIP to be shared with all PAC members in both hard and soft copy as soon as it is made available to AKF India and DCM.
- D. Dr. Dinesh Paul to provide MIS software package used by UNICEF/DOWCD.
7. Dr. Garg proposed that the next PAC meeting should be held in September/October in Sewagram when the members will have the opportunity to see the field activities also.

The meeting was concluded after passing the vote of thanks to the chair.

(B.S.Garg)



## Annex 21

### Case study on VCC formation

**Name of the village :** Wabgaon  
**Name of the Sector :** Gaul PHC  
**Name of the VCC :** Ektaa

Under the CLICS program a total no. of six SHGs has been formed in the village of Wabgaon. Besides this one SHG formed by a local NGO is also functioning. In the monthly SHG meeting, C.O. apprised the SHG members about CLICS and the need of forming a VCC. The members of the SHG's had taken a leading role in organizing all the meetings. SHG's has been an appropriate platform for the women to realize their needs through discussions and decisions. The women who bear the burnt of gender bias are always neglected and deprived of the common social rights. In regard to matters pertaining to Reproductive Health where the health concern lies with the mother and the child, women have been bereaved of their just right. Buying time from the household chores, sitting with the fellow women has enabled them to voice their concerns and rights. Economic independence in manner of the support they get from the monthly deposit has prompted them in the quest for avenues to make life healthier. To realize this goal they have formed groups and they have found CLICS as a new trusted ally. Managing cash, familiarizing with the bank transaction has made them vocal in their everyday life. Members were asked to nominate one member from each group to the VCC.

Similarly members of KVM and KP were to select two members each for the VCC. In these monthly meeting, the members agreed to the fact that the person who is selected should have genuine interest in the program. SHG members were also keen to be a part of the program and nominated one member each from their group. Some of the SHG members did express apprehension about neglecting their household chores for the program. But the majority of them voiced their conviction that they are ready to work for the development of their village. As one of the SHG members said, **"Keeping aside the trivial matters we should dream for bigger goals. CLICS has enabled us to recognize our problems, health status and how we can carve a healthy life for us and our children"**.

CLICS program objectives and the formation of VCC was also taken up in the monthly meeting of the Gram Panchayat. PRI members wanted to know about their role in the VCC. It was made clear to them that VCC as a body will be responsible for all matters pertaining to health status of the village. It was decided that the lady Sarpanch and another member of the Panchayat will be nominated to VCC.

Second exploratory meeting for the nomination of President and Secretary was held in the temple premises. Besides the members of the VCC, several village elders were also present in the meeting. The silent congregation was expectant as in an event. Men, women, youth sitting at a common platform is indeed a rare sight in the villages. The marked enthusiasm was hard to be missed.

One elderly person quipped **"for the sake of our village, we are all here to build a society for the betterment of our village"**. The session for VCC formation began with the CLICS functionaries giving an over view of the health status of the **district, state and the country**. The primary need which warrants attention is the health of mothers and children. Malnutrition, High IMR and MMR are the present day threats to the mankind which mars human development. The answer is community ownership of health care facilities which is the appropriate way for meeting all social and health problems. Sector Coordinator addressing the assembled, laid down the greater objective of the CLICS, issues addressed and apprised them about the roles and responsibilities of the VCC and its relevance in the present context. VCC as a body will function as a mouth piece of the villagers and will cater to the health needs and will facilitate the same. The criteria for the VCC formation, members, modalities and its significance were also discussed. The responsibilities are meant to make the health care practices a model. Other decentralized health care outlets like, PHC, health workers like ANM's, AWW's had been also enlisted to be part of the Village Coordination Committee. The purpose of forming groups is development in the health status. To coordinate these groups a centralized body is required which will strive for the improved health facility on the village.

Consent and consensus were called for, to which all the group members agreed.

The discussion in regard to nominating the office bearers was initiated. Commending the CLICS objective, Sarpanch, Gram Panchayat suggested that the concern revolves around the women and child for which the women should take up the challenge. Thus twenty-one member VCC was formed. The break up is as follows: SHG- 7, KVM- 2, KP- 2, G.P.- 2 (1- Sarpanch+1 Member, F), Opinion moulders- 4(1- School Teacher, 3- village elders), Gram Vikas Adhikari- 1, AWW-1, ANM-1, C.O.-1. Then followed the nomination of the President and Secretary of the VCC.

Two member of the group proposed the name Ms. Pramilla bhiyogi Chiore, to be the President of the VCC. The KVM and SHG members supported her candidature and all the members gave their consent. For the post of Secretary the name of Ms. Sangita Rupchand Patil came up. Every body unanimously agreed to her candidature. While discussing the possible name of the VCC, The KP members proposed the name " Ektaa Gram Samunaya Samiti (Kasturba Vilage Coordination Committee) which was finalized .

Record keeping, date for the monthly meeting were also finalized in the group meeting. The meeting concluded with Mr. Haresh Bondre, Community organizer Gaul Sector proposing the vote of thanks.



## Annex 22- Detailed work plan for Year II

Line Items	Activity Focus	Year II												Personnel	Benchmarks	
		October 2004 to September 2005														
		Oct 2004	Nov 2004	Dec 2004	Jan 2005	Feb 2005	Mar 2005	Apr 2005	May 2005	June 2005	Jul 2005	Aug 2005	Sept 2005			
<b>Start-up Activities</b>																
Finalize Contractual Procedures (AKF/DCM)																
Establish Office		X														Office Established
Procure equipment/furniture/vehicles		X														
Recruit Personnel		X														All personnel appointed
Appoint Program Advisors																PA appointed
<b>Objective 1 : To provide affordable high quality health care through effective partnerships at the village level</b>																
<b>Key indicator</b> : Proportion of villages with VCC																
<b>Key indicator</b> : Proportion of VCCs with Franchise Agreement																
<b>Key indicator</b> : Quality Assurance and affordability																
<b>1.1 Develop effective partnerships</b>																
Mobilize communities	A	X	X	X	X	X	X	X	X	X	X	X	X	X	Community Organizer	VCCs formed in 40% of Gram Panchayat villages by end of year 1. VCCs formed in 100% of Gram
Orient Community Based Organisations	A				X	X	X	X	X	X	X	X	X	Community Organizer + Asst. Program Officer		

Line Items	Activity Focus	Year II												Personnel	Benchmarks
		October 2004 to September 2005													
		Oct 2004	Nov 2004	Dec 2004	Jan 2005	Feb 2005	Mar 2005	Apr 2005	May 2005	June 2005	Jul 2005	Aug 2005	Sept 2005		
Orient Health Providers (Public, Private, ICDS Functionaries, NGOs)	A													Sector Coordinator + Asst. Program Officer	Panchayat villages by end of year 2.
Form VCCs	A	X	X	X	X	X	X							Community Organizer (CO)	
Orient VCCs	A	X	X	X	X	X	X	X	X	X				Asst. Program Officer+CO	All VCCs oriented
Gram Panchayat Resolutions		X	X	X	X	X	X	X	X	X				Asst. Program Officer	All VCCs endorsed by Panchayats
Conduct health needs assessment	A	X	X	X	X	X	X	X	X	X	X	X	X	Community Organiser + Asst. Prog. Officer+ Medical Officer	Health Needs Assessment conducted in all villages with VCCs
Plan child survival interventions	A	X	X	X	X	X	X	X	X	X	X	X	X	Community Organiser + Asst. Prog. Officer+ Medical Officer	Franchise Agreement developed with all VCCs
Develop Franchise Agreement	Q&A	X	X	X	X	X	X	X	X	X	X	X	X	Community Organiser + Asst. Prog. Officer+ Sector coordinator	
<b>1.2 Plan and provide affordable high quality care</b>															
Develop QA Plan	Q	X												Program Director	QA plan developed
Build Capacity in QA	Q														

Line Items	Acti vity Foc us	Year II												Personnel	Benchmarks
		October 2004 to September 2005													
		Oct 2004	Nov 2004	Dec 2004	Jan 2005	Feb 2005	Mar 2005	Apr 2005	May 2005	June 2005	Jul 2005	Aug 2005	Sept 2005		
Staff	Q	X	X											Core Trainers	Training in QA completed
Health Care Provider (HCP)	Q	X	X	X										Core Trainers	Training in QA completed
ICDS Functionaries	Q	X	X	X	X	X	X							Core Trainers	Training in QA completed
VCC	Q							X	X	X	X	X	X	Core Trainers	Training in QA completed
Operationalise QA system	Q														
Village Level	Q										X	X	X	VCC + HCP	QA system operationalized
Facility Level	Q				X	X	X	X	X	X	X	X	X	HCP+ Medical Officer	QA system operationalized
<b>Key Indicator:</b> % Improvement in capacities (task specific) of Program staff & Partners															
<b>Key Indicator:</b> % VCCs with sustainability plan															
<b>2.1 Build the capacity of coalitions of partners</b>															
Conduct Appreciative Inquiries, Org.Capacity Assessment for DCM	Q&A													External Consultant	Areas for Capacity building of DCM staff identified
Conduct Training Needs Assessment for Staff, Providers and VCC	Q&A	X	X	X										Prog Officer (BCC & Training)	Training needs of personnel identified.

Line Items	Activity Focus	Year II												Personnel	Benchmarks
		October 2004 to September 2005													
		Oct 2004	Nov 2004	Dec 2004	Jan 2005	Feb 2005	Mar 2005	Apr 2005	May 2005	June 2005	Jul 2005	Aug 2005	Sept 2005		
Develop Training Plan (task-specific)	Q													Prog Officer (BCC & Training)	Training plan (task-specific) identified.
Identify and train core trainers														Prog Officer (BCC & Trg.) + Behavioral Sciences Expert	Core Trainers identified and trained
Conduct training (task-specific) on	Q														
Community Mobilisation & PRA	Q													Prog Off (BCC & Trg) + Behavioral Sciences Expert+Astt. Prog. Officer	
Technical Interventions		X	X	X										Prog. Officer (BCC & Trg) + Child Survival Exp+Technical team	
Behaviour Change Communication	BC				X	X	X	X	X	X				Prog Officer (BCC & Trg) + Behavioral Sciences Expert+AKF	Training (task-specific) completed
Management Information System	Q	X	X	X	X	X	X						Prog Officer (MIS)+External consultant		
Quality Assurance	Q	X	X	X									Program Director		
Documentation		X	X	X	X	X	X						Prog Officer (Documentation & Communication)+AKF		

Line Items	Acti vity Foc us	Year II												Personnel	Benchmarks
		October 2004 to September 2005													
		Oct 2004	Nov 2004	Dec 2004	Jan 2005	Feb 2005	Mar 2005	Apr 2005	May 2005	June 2005	Jul 2005	Aug 2005	Sept 2005		
Continuing Education (Refreshers)	Q	X	X	X	X	X	X	X	X	X	X	X	X	Prog. Officer (BCC & Trg)	Monthly refresher training sessions held regularly
<b>2.2 Determine Child Survival interventions &amp; develop BCC strategy</b>															
Conduct baseline assessments															
Survey														Contractual	Baseline Assessment completed
Facility Assessment	Q													Sector Coordinator	
Planning workshop for DIP														CLICS Team +Partners	Planning workshop completed
Develop Detailed Implementation Plan														CLICS Team	DIP developed
Conduct Formative Research	BC	X	X	X										Contractual	Formative Research conducted
Develop BCC Plan	BC	X	X	X										Prog. Officer (BCC & Trg.)+AKF	BCC plan developed
Develop BCC tools & materials	BC	X	X	X	X	X	X							Prog. Officer (BCC & Trg.)+Contractual	BCC tools and materials developed
<b>2.3 Implement Child Survival Activities</b>															
Generate Village Health Fund	A	X	X	X	X	X	X	X	X	X	X	X	X	VCC+CO	Village Health fund generated in all VCCs

Line Items	Activity Focus	Year II												Personnel	Benchmarks
		October 2004 to September 2005													
		Oct 2004	Nov 2004	Dec 2004	Jan 2005	Feb 2005	Mar 2005	Apr 2005	May 2005	June 2005	Jul 2005	Aug 2005	Sept 2005		
Select VHWs & TBAs	A	X	X	X	X	X	X	X	X	X	X	X	X	VCC+CO	TBAs (1/Village) & VHWs (1:1000) selected.
Initiate intervention specific activities															
<b>Home</b>															
VHW Home Visits	A and BC	X	X	X	X	X	X	X	X	X	X	X	X	VHW	More than 90% of VHWs conduct all the required home visits
Trained Birth Attendant (TBA)	A and BC	X	X	X	X	X	X	X	X	X	X	X	X	TBA	100% of home deliveries conducted by TBAs
<b>Community</b>															
CBO meetings	A and BC	X	X	X	X	X	X	X	X	X	X	X	X	Community Organizer	80% of CBO meetings conducted in a month
Bal Suraksha Divas	A and BC	X	X	X	X	X	X	X	X	X	X	X	X	Community Organizer + Medical Officer + ANM	90% of VCCs conducted Bal Suraksha Divas in any given month
Parenting Workshops	A and BC	X	X	X	X	X	X	X	X	X	X	X	X	Asst. Prog. Officer+Sector Coord.	1 Parenting workshop conducted in all villages
Campaigns	BC														

Line Items	Acti vity Foc us	Year II												Personnel	Benchmarks
		October 2004 to September 2005													
		Oct 2004	Nov 2004	Dec 2004	Jan 2005	Feb 2005	Mar 2005	Apr 2005	May 2005	June 2005	Jul 2005	Aug 2005	Sept 2005		
Suraksha Aichi aani Balachi (Safe Motherhood and Child Survival Campaign)	BC				X	X	X				X	X	X	All sector level Program Staff+ Prog Officer (BCC & Trg)	Campaigns conducted in 90% villages in a year
Mulgi Wachawa Mohim (Save the Female Child campaign)	BC				X	X	X				X	X	X		
Facility															
Community Health Clinics	Q & A	X	X	X	X	X	X	X	X	X	X	X	X	Medical Officer+ANM	Functional Community Health clinics in 25 villages
Sub-centre labor rooms	Q & A			X	X	X	X	X	X	X	X	X	X	ANM (Govt.)	50% of subcentres with functional labor rooms
Maternity Huts	Q & A			X	X	X	X	X	X	X	X	X	X	TBA	Maternity Huts in 15 villages
Anganwadi center	Q & A			X	X	X	X	X	X	X	X	X	X	Anganwadi worker	50% of Anganwadi centers utilizing ECD tools.
<b>2.4 Provide community access to services and health related products</b>															
Identify product basket required for franchises			X	X	X	X	X	X	X	X	X	X	X	Community Organiser+Asst. Programme Officer	Franchise agreement
Define partnership with Government to ensure supply					X	X	X	X	X	X	X	X	X	Programme Director+Programme Coordinator	partnership documents

Line Items	Activity Focus	Year II												Personnel	Benchmarks
		October 2004 to September 2005													
		Oct 2004	Nov 2004	Dec 2004	Jan 2005	Feb 2005	Mar 2005	Apr 2005	May 2005	June 2005	Jul 2005	Aug 2005	Sept 2005		
Determine pricing policy for products and distribution points				X	X	X	X	X	X	X	X	X	X	Community Organiser+Asst. Programme Officer	Franchise agreement
Monitor utilisation of products and cost recovery							X	X	X	X	X	X	X	Programme Officer (MIS)	Monitoring system operationalise
<b>2.5 Develop system for sustaining child survival activities &amp; health gains</b>															
Adapt & refine LOGFID for VCC	Q				X	X	X	X	X	X				Program Coordinator + Behavioral Sciences Expert+AKF	LOGFID for VCC developed
Assess institutional maturity of VCCs	Q													Asst. Program Officer + VCC	Institutional Maturity of all VCCs assessed
Develop and initiate sustainability plan	A													Asst. Program Officer + VCC+CO	Sustainability plan initiated in 70% of VCCs
Express 'ownership' intent	A													VCC	70% of VCCs express 'ownership' intent
Second Agreement (Establishing VCC "ownership")	A													Asst. Program Officer + VCC	70% of VCCs achieve "ownership".
<b>2.6 Institutionalise Monitoring and Financial Systems</b>															
MIS														Prog officer (MIS)	MIS developed and operationalized

Line Items	Activity Focus	Year II												Personnel	Benchmarks
		October 2004 to September 2005													
		Oct 2004	Nov 2004	Dec 2004	Jan 2005	Feb 2005	Mar 2005	Apr 2005	May 2005	June 2005	Jul 2005	Aug 2005	Sept 2005		
Financial reports		X			X			X			X			Finance & Administrative Officer	Financial systems developed and operationalized
Narrative		X												Program Coordinator + Prog officer (Docum. & Communication)	Timely preparation & dispatch of reports
Audits		X												Contractual	5 Annual audit reports
<b>Objective 3: Refine &amp; test social franchise model for delivery of child survival interventions</b>															
<b>Key Indicator:</b> % of VCCs with instituted annual reviews															
<b>Key Indicator:</b> % difference between CLICS and GOI facilities															
<b>3.1 Refine &amp; define the social franchise model</b>															
Institute review systems at VCC level								X	X	X				Asst. Program Officer	90% of VCCs have instituted annual reviews
Program Steering Committee meetings			X						X					Program Director	Meetings held as per schedule.
Program Advisory Committee meetings			X						X					Program Director	
Formal Reviews & Assessment															
<b>3.2 Test feasibility of social franchise model</b>															

Line Items	Acti vity Foc us	Year II												Personnel	Benchmarks	
		October 2004 to September 2005														
		Oct 2004	Nov 2004	Dec 2004	Jan 2005	Feb 2005	Mar 2005	Apr 2005	May 2005	June 2005	Jul 2005	Aug 2005	Sept 2005			
Conduct pre-post project assessments														Contractual	Assessments completed as per schedule	
Baseline													Contractual			
Mid-term													Contractual			
End-term													Contractual			
Annual Reviews		X											X			
Operations Research for comparison of Gol facilities											X	X	X	Contractual	Operations Research completed	
<b>Objective 4: Document, disseminate &amp; share key program lessons &amp; results to facilitate adaptation, replication &amp; policy advocacy</b>																
<b>Key indicator:</b> Communication strategy developed																
<b>Key indicator:</b> # of workshops/meetings participated and papers presented																
<b>4.1 Document key programme lessons &amp; results</b>																
Develop documentation plan														Prog officer (Doc. & Comm) + AKF	Documentation plan developed	
Develop & operationalise systems																
<b>4.2 Disseminate &amp; share lessons</b>																

Line Items	Activity Focus	Year II												Personnel	Benchmarks
		October 2004 to September 2005													
		Oct 2004	Nov 2004	Dec 2004	Jan 2005	Feb 2005	Mar 2005	Apr 2005	May 2005	June 2005	Jul 2005	Aug 2005	Sept 2005		
Develop communication strategy														Prog officer (Docum. & Communication) + AKF	Communication strategy developed
Develop communication products		X	X	X	X	X	X								
Newsletter/ Samvedna														Prog officer (Docum. & Communication)	Regular printing & distribution of newsletter
Project Briefs		X	X	X										Prog officer (Docum. & Communication) + PO+AKF	Project Briefs prepared
Child Survival Website		X	X	X	X	X	X							Contractual	Child survival website developed
Others (as identified)															
Organise information sharing workshops/meetings														Program Director & Program Coordinator	2 information sharing workshops/meetings organized
Organise advocacy workshops/meetings														Program Director & Program Coordinator	2 advocacy workshops/meetings organized
Participate in conferences & network meetings		X		X		X		X		X		X		CLICS	Participation in 2-4 conferences/network meetings each year
Other														Asstt. Officer +AKF	
Operations Research															

Line Items	Acti vity Foc us	Year II												Personnel	Benchmarks	
		October 2004 to September 2005														
		Oct 2004	Nov 2004	Dec 2004	Jan 2005	Feb 2005	Mar 2005	Apr 2005	May 2005	June 2005	Jul 2005	Aug 2005	Sept 2005			
Plan Operations Research			X	X											Program Coordinator & Technical Support Team	
Implement Operations Research				X	X	X	X	X	X	X	X	X	X	X	Program Coordinator & Technical Support Team	