Jeevan Daan (Gift of Life)

Maternal and Child Survival Program, Ahmedabad, India.

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Annual Report

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COUNTERPART

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1. Abbreviations

AMC	=	Ahmedabad Municipal Corporation
BCC	=	Behavior Change Communication
BF	=	Breastfeeding
CDD	=	Control of Diarrheal Disease
CBO	=	Community Based Organizations
CHT	=	Community Health Team
CO	=	Community Organizers
CHP	=	Community Health Promoter
DCM	=	Diarrhea Case Management
DIP	=	Detailed Implementation Plan
FAO	=	Finance and Administrative Officer
FGD	=	Focus Group Discussion
FWC	=	Family Welfare Clinic
HES	=	Health Education Specialist
HFA	=	Health Facility Assessment
HMIS	=	Health Management Information System
IMCI	=	Integrated Management of Childhood Illness
IEC	=	Information, Education and Communication
ISDP	=	Integrated Slum Development Project
LNRA	=	Learning Need Resource Assessment
MOH	=	Ministry of Health
MPW	=	Multipurpose Worker
MSH	=	Management Sciences for Health
NGO	=	Non Government Organization
ORS	=	Oral Rehydration Solution
ORT	=	Oral Rehydration Therapy
PCM	=	Pneumonia Case Management
PCC	=	Program Coordination Committee
PD	=	Program Director
PUA	=	Participatory Urban Appraisal
SRFD	=	Sabarmati River Front Development
TBA	=	Trained Birth Attendants
UNDP	=	United Nations Development Project
UNICEF	=	United Nations Children’s Fund
USAID	=	U. S. Agency For International Development
WHO	=	World Health Organization
WLCC	=	Ward Level Coordination Committee

2. Background and Overview of the Program

The **Jeevan Daan Maternal and Child Survival Cost Extension program 2004-2009 (CS-XX)** is being implemented by Counterpart International-India in partnership with a local NGO Saath and the local Ministry of Health, the Ahmedabad Municipal Corporation (AMC), in the 5 target areas (Raikhad, Jamalpur, Raipur, Dariyapur, 5 and Danilimda) from Counterpart International-India's (CPI) original **Jeevan Daan Child Survival Program 2000-2004 (CS-XVI)** funding cycle. In addition, to these 5 original areas CPI has expanded its program to 5 additional municipal wards, Vasna, Bapunagar, Saraspur, Kankariya, and Maninagar.

The major causes of under-five mortality in the targeted slum areas are poor neonatal care and premature births, diarrhea, pneumonia and tetanus. Contributing to these factors are low birth weight, malnutrition, repeated infections and poor access to health care. The under-five mortality rate for Gujarat State is 85, the IMR of Ahmedabad city is 76, 28% of all child mortality is due to Diarrhea; ARI accounts for 22% of all deaths and 50% of deaths are due to poor sanitation and lack of access to clean drinking water. The Final Evaluation Knowledge, Practice and Coverage (KPC) 2004 for the CS-XVI program revealed that significant improvements have been made during the programs previous funding cycle, which have resulted in the significant reduction of infant, and maternal mortality within the target slum areas as outlined in the program goals and objectives.

The survey population for the Baseline KPC 2005 for the CS-XX program was a combination of the CS-XVI target areas, as well as the additional four areas that are to be targeted during the CS-XX program. The Baseline KPC 2005 for the CS-XX program revealed that within the additional program area there is an extensive need for health education to improve home case management since only 15.9% of mothers knew how to prepare ORS correctly; 9% of mothers could cite fast or difficult breathing as a danger sign of Pneumonia. The Baseline KPC 2005 for the CS-XX program also revealed that in the survey areas of the new slum areas 52.3% of children 0-5 months were exclusively breastfed, and 24.7% of children where fed within the first hour of delivery. It was shown that 22.7% of children 0-23 months were moderately malnourished. Of those children who were shown to have a vaccination card 32% were fully immunized. The Health Facilities Assessment (HFA 2004) revealed that with the CS-XVI program there have been tremendous improvements in regards to the health facility staff and services, however with the addition of wards there is significant need for training and improved case management at the facility level in the additional slum areas.

CPI will be implementing five interventions to address child and maternal mortality in the urban slums of Ahmedabad, Gujarat State, India, through the CS-XX program: Diarrheal Disease (25% effort), Pneumonia Case Management (15% effort), Nutrition and Micronutrients (20% effort), and Immunization (10%) and a new intervention area, Maternal and New born Care (30% effort). With the Ahmedabad Municipal Corporation/Ministry of Health and a local partner NGO Saath, Counterpart International will continue its participatory tripartite relationship. As these relationships grow during the CS-XX program, CPI will play a facilitative role as Saath continues to monitor the activities of the Anganwadis and the CBOs in partnership with the AMC which is the prime public

health provider in the city, and is responsible for managing the hospitals, dispensaries and health centers as well as sanitation activities and facilities.

The total number of beneficiaries for the Cost extension program will be 308,445. This number has increased by over 60% from the original number of beneficiaries in the Child Survival-XVI Program, this Cost extension will allow CPI to affect the lives of 91,519 Mothers and 108,817 Children in the urban slums of Ahmedabad and allow CPI to continue to work on CS-XVI's two main goals which will be enhanced with the addition of the maternal and newborn care component: (1) Sustainable reduction of maternal and new born and infant mortality and morbidity in the urban slums if the AMC. (2) Capacity strengthening if partnering agencies to sustainably carry out selected maternal and child survival activities after the life of the program.

The objectives for the current program include:

Objective 1: Strengthened caregiver, family and household knowledge and decision-making skills related to improved maternal and child health and prevention, recognize and manage diarrhea and pneumonia through adoption and practice of positive health behaviors.

Objective 2: Enhanced community capacity to form groups, association and institutions that sustain health initiatives.

Objective 3: Improved quality and accessibility of services provided by AMC personnel and AMC health facilities/services and established critical linkages among community organizations (Community Health Teams - CHTs) and public and private health providers.

Objective 4: Strengthened capacities of AMC and Saath to plan, implement, and evaluate maternal and child survival programs in the targeted urban slums:

The key program strategies which have proven to be most successful through our original program Jeevan Daan program cycle include: Community mobilization through the formation of Community Health Teams, Innovative BCC, Hanging Gardens and PD/Hearth approach to malnutrition, Partnering with both the MOH and local NGOs, and HH-CIMCI approach.

The Jeevan Daan program is increasingly involving the participation of husbands and mother in laws in MCS activities.

3. Annual Report Chapters

A. Main Accomplishments of the Program

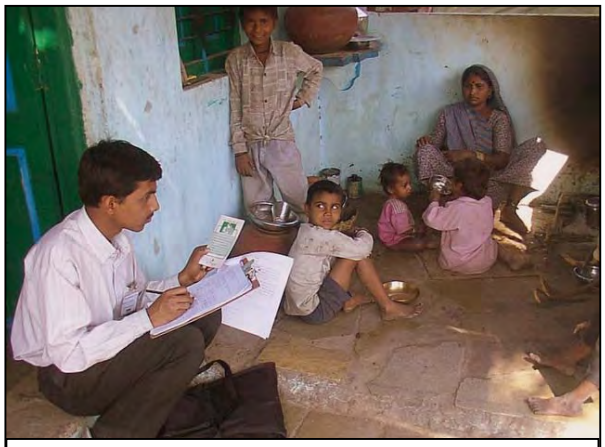
A.1. Baseline Assessments

The baseline assessments comprised of both quantitative as well as qualitative data collection methods, which included the old program areas and the new areas. The baseline assessment was conducted in the months of January- March 2005. Under the quantitative assessment, the Knowledge Practice Survey (KPC) and a part of Health Facility Assessment (supplies and equipments) were carried out. And under the qualitative assessment, tools such as the focus group discussion (FGD), key informant interview (KII), mappings, Preference ranking, force field analysis and doer and non-doer analysis were carried out for data collection.

Knowledge Practice and Coverage (KPC) Survey

Background

The prime objective of the baseline KPC Survey was to ascertain existing levels of knowledge, practices, and coverage of health services in Maternal and New born care, Diarrheal diseases, Acute Respiratory Infection/Pneumonia, Nutrition and Immunization, since these are specific intervention areas that are of most interest to the program and the AMC. The findings of the survey are then used to conceptualize program design, implementation, monitoring and evaluation. The baseline survey process has also been focused to enhance the capacity of the local partner NGO Saath staff members to collect, analyze, and use data for decision making. In addition, the KPC survey process helped build consensus between Counterpart, Saath, the AMC/MOH, and other stakeholders in terms of health programming priorities for the ten Municipal wards that comprise the program area.



Mother with children under two being interviewed during the KPC survey.

Objectives of the KPC Survey:

- To strengthen Counterpart/India's and Saath's capacity to collect, analyze and use KPC information for decision making in the future.
- To gather baseline data on the CS-XX program indicators, this data will be of interest to stakeholders and serve as a point of reference for measuring change during the final evaluation. This data will also allow Counterpart and Saath to identify and prioritize problems in the program area.
- To gather information on mothers' knowledge and practices for use in developing educational messages especially for the new intervention of Maternal and Newborn Care and for modifying intervention strategies.
- To help build consensus between Counterpart, Saath, the AMC/ MOH, and other stakeholders in terms of health programming priorities for the urban slums in the 10 AMC wards that comprise the CS-XX program area

Process:

The KPC 2000+ questionnaire was pre-tested for the correlation of the local verbatim and phrasing of the questions for all of the questions on the technical interventions of Pneumonia Case Management, Control of Diarrheal Diseases, Nutrition and Immunization as well as for the Rapid CATCH section covered under the CS-XVI program. Counterpart has in-house expertise to carry out large surveys including KPC.

The Core Team for the KPC survey for the baseline assessment of the CS-XX program was led by the India office staff Mr. Ramesh Kumar Singh, Program Director; Monitoring and Evaluation Specialist from India office and Counterpart Headquarters' India Program backstop Ms. Darshana Vyas, Director of Health and Child Survival Programs, who provided technical guidance and backstopping for the KPC survey including pre-KPC preparations, questionnaire review and finalization, training, data collection, data analysis and the finalization of the Baseline KPC Survey Report. Other members in the KPC Core Team from Counterpart India included the Health Information Systems Manager, BCC Specialist, and Program Coordinator and the Program Coordinator from the partner NGO Saath.

The training for the KPC Survey was carried out across two levels:

Level 1: Training of Supervisors: The first round of training was carried out for the Supervisors of the KPC Survey for a period of 4 days. These are the CS-XX program personnel and comprise of the Community Organizers of Counterpart and Saath.

Level 2: Training of Investigators: external investigators were rained in conducting KPC Survey through the understanding of the basis of the KPC survey, ability to select the first household in a given cluster, administration of the KPC questionnaire to a mother with a child 0-23 months of age, and good and bad interviewing techniques. Additionally practice sessions were carried out in three slum sites for a period of two days on February 3, 4 2005 to familiarize the investigators with the process of administering the questionnaire in an actual slum set-up. Role-plays were liberally used, and the training was designed to be as participatory as possible, with more and more emphasis on practice sessions.

Data collection was spread over three days, with 10 clusters being covered each day. The team was divided into 10 interview teams of one supervisor and 2 investigators each. Each team of investigators completed 10 interviews each day in a selected cluster. The duration of the interview varied between 25 and 35 minutes.

The data analysis was computer based and was carried out using a combination of a tailor made software package made on a VB6-MS Access platform. The front end was created using Visual Basic as the programming language, whereas the data was entered into a Microsoft Access database. All analysis programs were made through VB and run on the Access database. The program's MIS Assistant, who is formally trained in computer-based programming and was validated by the Health Information Systems Manager, created the front-end, backend and related programs.

Health Facility Assessment (HFA)

Since April 2004 AMC has been implementing an EU funded Urban RCH 2 Project, which has brought about changes in the health facilities and delivery of health services in the Municipal area of Ahmedabad city. Under this project Urban health Centers under the RCH 2 project have not only combined the preventive and curative types of services provided by the Family Welfare Clinic (FWC) and the Municipal Dispensary into one geographical location, but have also added to the convenience of the population it served by making it possible for them to access only one point of contact within a ward as far as all their primary health needs are concerned.

Under the Jeevan Daan CS XVI program, the detailed Health Facility Assessments adapted four tools[1] as per the BASICS Integrated Health Facility Assessment Manual. These tools were conducted during the Baseline, Midterm Evaluation and Final Evaluation. Thus, Counterpart has developed in-house capacity in conducting the Health Facility Assessment and using the tools effectively for informing the design of the program activities, including:

- Planned improvements in the quality of care at AMC outpatient health facilities, including staffing, clinic organization, equipment requirements, drug and material supplies, and case-management practices.
- Pre- and in-service training for AMC outpatient health workers.
- Improved supervision and monitoring of AMC health worker performance over time.

The HFA survey process during CS XVI has also been used to train AMC and the partner NGO health workers in survey techniques, in collection and analysis of survey data, and in the use of data to improve the quality of case management and the integration of services.
The baseline Health Facility Assessment for the *Jeevan Daan* Maternal and Child Survival Cost Extension Program was carried out using both qualitative and quantitative research methods in two parts:

First Part: A detailed and in-depth assessment including both qualitative and quantitative tools with regards to the Urban Health Centers present in the Jeevan Daan Maternal and Child Survival Cost Extension Program area, viz. 10 municipal wards namely Behrampura, Danilimda, Raikhad, Raipur, Jamalpur, Dudheshwar, Maninagar, Kankariya, Bapunagar and Saraspur

Focus group discussion with AMC link workers about MCS issues and health services during the HFA.

Second Part: An assessment of the equipment and supplies status for all of the 43 urban health centers present in the city of Ahmedabad using the Equipment and Supplies Checklist adapted from the BASICS Integrated Health Facility Manual, and the same tool that has been used during the baseline, midterm and final evaluation Health Facility Assessments carried out under the Jeevan Daan CS XVI Program.

As part of the **HFA preparation process,** discussions were carried out with senior AMC officials including the Medical Officer Health, and the Family Welfare Officer/ RCH Coordinator, in order to determine the health facilities that should be covered for the assessment, to better understand the existing health delivery and data monitoring systems of the AMC, to obtain a list of medications that the AMC requires to be present in each health facility, to prepare the qualitative tools that are to be used for the HFA in a participatory way with the AMC senior officials, and to explain the purpose of the HFA and obtain letters of support for the survey teams. Focus group discussions were also carried out in the Jeevan Daan Maternal and Child Survival Cost Extension Program areas in order to help determine where slum residents prefer to seek care.

[1] The four tools are Sick child Observation Checklist, Exit interview of mothers/caregivers, Health Worker Interview and Equipment and Supplies Checklist.

Qualitative Assessment

Qualitative assessments are an integral part of any research/survey, giving in-depth and rich data that supplement the quantitative data and give details of the factors that affect the findings from the quantified data. The Jeevan Daan program has a wide experience in using qualitative assessments to supplement quantitative data and provide an understanding into the lives of urban communities, challenges they face, positive deviant practices that they make possible, myths, beliefs and awareness about health issues.

The key objectives for conducting the baseline qualitative assessments were to:

- Appraise the "*Why's*" of the results of the quantitative KPC survey, which will perform an in-depth detail analysis of the facilitating as well as the behavioral obstacles and barriers to Behavior Change.
- Provide insight into knowledge, practices, attitudes and beliefs related to Maternal and Newborn Care and Child Survival issues in the current and new program areas.
- Provide the results of the Qualitative Assessments, which will also be the formative research for development of Behavior Change Communication messages and material for the program.
- At the Program Baseline design a more in-depth qualitative assessment methodology, building upon the strengths of Counterpart staff's capacity in conducting Focus Group Discussions and Key Informant Interviews, that imbibed from the essence of the following approaches namely Appreciative Inquiry, Positive Deviance, Participatory Urban Appraisal, Adult Learning Principles

Tools and Methods Used for Data Collection were:

Focus Group Discussions- this classical qualitative research tools was used in the baseline to obtain deeper insights into community practices, knowledge, resources, beliefs and myths.

Key Informant Interviews and/or Semi Structured Interviews- Interviews were planned in the baseline qualitative assessments to understand current knowledge, practices, challenges, innovative local behaviors, beliefs, myths, etc of various key community stakeholders and health system staff.

Seasonality Mapping - this participatory tool was used to obtain the seasonal trends of childhood illnesses and their severance among children under the age of five.

A preference ranking for MCS services involving pregnant women, mother in laws, Traditional Birth Attendants and grand mothers

Preference Ranking- this tool was used to understand the community's predilection for health services for maternal and child health.

Force Field Analysis- this tool was used to determine the various forces or elevating factors and factors that act as depressors for the low rate of institutional deliveries.

Doer- Nondoer Analysis- this tool was used to assess the key factors affecting various behaviors and practices. Data gathered from this tool is the key for developing and refining Behavior Change Communication materials for the *Jeevan Daan* program.

Interview with gatekeepers like husbands during qualitative assessment.

Data Collection was done in four teams (staff of Counterpart, Saath and External data collectors) of 5-6 participants who visited one community each to collect data on various themes, using different tools. Out of the four teams one team went to an area where the Jeevan Daan program was being implemented since 4 years, the other three teams went to three new communities where the program is proposed to expand. In this way the data collection team was able to collect the data in 6 days.

Participatory Data Compilation: The strove of qualitative data was complied in large and small group activities under the categories of: Key issues/ challenges/ difficulties; Current Beliefs and practices; Knowledge levels; Decision-making; Preferred health services; Felt needs of the community; Suggestions from the community for each intervention; Special note/ quotes of community member or health staff and Community best practices and resources.

A team of data collectors categorize the information on Post-its and paste them onto the charts where all other teams add their findings

Results:

The results of the baseline assessment were compiled and are part of the Detailed Implementation Plan. (Please see annexure 1 for Summary of Baseline Assessments).

A.2 DIP Development

After the baseline assessments were over and data compiled to form a situational analysis of the program area in relation to the program's intervention areas, the program team began the process of developing a Detailed Implementation Plan. The various stages that went into the formulation of the DIP are mentioned below.

A two day (March 4th and 5th, 2005) Baseline Dissemination and DIP Development Workshop was held in Ahmedabad to disseminate the Baseline Results and seek recommendations and suggestions, based on that design work plan and activities from the various stake holders of the CS-XX program that included: several community Health Team members; Medical officers of all the 10 wards of the CS-XX program and other CBO staff working in the program slum pockets; AMC officials including Dr. PK.

Members of the TAC, Medical Officer Health of AMC, at the workshop.

Makwana Medical Officer (Health); Dr. NK Patel (Immunization Officer); Dr Kinnariben Mehta Family Welfare Officer; and In charge of the EU Funded RCH Program in Ahmedabad, staff of urban health centers; Technical Advisory Committee members; Ahmedabad Municipal Corporation private practitioners; link workers form the urban RCH 2 project; and influential community members. During the workshop the findings of the Baseline Assessments were presented and the consultations, panel discussions and small group work were organized to facilitate the discussion in the most fruitful way and keep it focused towards the outcome—Program plans designing and refining the activities and strategies. A preliminary task analysis and list of roles and responsibilities was developed for each of the stake holders, as well as a timeline for implementing program activities. Meetings with the AMC included health facility staff as well as senior officials, in order to help determine the feasibility of program strategies. Also through joint discussion, involvement of various stakeholders for coming five years was discussed and task analysis was done for the different activities.

Involvement of Technical Advisory Committee:

The program Technical Advisory Committee (TAC) was formed at the beginning of the CS-XVI program to provide technical guidance and advice to the program. Several TAC meetings were held to provide technical input into the DIP development process. Members include: the Medical Officer of Health for AMC; the Health Commissioner of Gujarat , Gandhinagar; Dr. Rani Bang and Dr. Abhay Bang from Maharashtra, who are both very well known for their child survival and Home Based Life Saving Skills in the area of Maternal health efforts in India; Professor Sudarshan Iyengar from Centre for Social Studies, Surat , Dr. Dileep Mavalankar from the Indian Institute of Management; Prof. Arbind Sinha, from Mudra Institute of Communication expert of health communication and Prof. KV Ramani, the Chairman of the Public Systems Group, Indian Institute of Management, Ahmedabad, Mr. Ashok Bhargav and Dr . Lata Shah from IDEAL, known for their popular science based health trainings on CS and maternal health. The TAC is responsible for overseeing program activities and providing overall technical support to the program. The TAC members have individually reviewed the program design and provide their input. Also during the DIP development workshop most of them participated in the panel discussion and consultation and provided critical input for the program strategy and design.

Involvement of the partners and stakeholders:

The local Partner NGO Saath staff participated actively in all stages of the DIP development process, and also served as trained interviewers and supervisors for the baseline survey assessments. The KPC and HFA and qualitative survey were conducted jointly by Counterpart and Saath field teams. In addition, Saath's Program Coordinator was involved in all consultation meetings and discussions used for the designing of BCC strategies. Several community-level meetings were held jointly by Counterpart and Saath, to discuss the findings of the baseline surveys and discuss their implications for CS program activities. Saath staff and officers also participated in all DIP planning meetings with the AMC, and helped to build an even stronger partnership between the AMC, Saath, and Counterpart program staff. Saath's experience with community-based integrated development programs in the targeted slums has been an important asset to the CS-XX program and the DIP development process.

Ramesh Singh– Program Director Counterpart and Rajendra Joshi- Managing Trustee Saath chairing the baseline Dissemination and DIP planning workshop.

Consultation with the USAID India Mission:

Before the baseline started a primary consultative meeting was held at USAID Washington where the program design was discussed. Since USAID Officials from the local mission could not participate in the DIP development in March 2005, Ms. Darshana Vyas, Director of Health and Child Survival Programs and Program Director Ramesh Kumar Singh met with USAID Mission staff Dr. Meenakshi in New Delhi, and in order to debrief and discuss the outcomes of the DIP development workshop and future strategies for the program. Dr. Meenakshi provided valuable suggestions regarding the course of DIP development. The draft DIP was also shared with her to solicit USAID mission's suggestions.

Other Consultations and deliberations:

A series of workshops, consultations and meetings were held with the local partner organization, Saath, and AMC officials, to design program interventions and activities, and to clarify the partners' roles in the program. Ms. Darshana Vyas also met with the Municipal Commissioner of Ahmedabad, Mr Anil Mukim to discuss the future strategies of CS-XX and how the lessons learned in this program can be mainstreamed into the health delivery system of Ahmedabad Municipal Corporation, and involved senior MOH officials in the program design process.

Participatory designing of program strategies and activities based on seasonal and festival calendar.

The DIP was primarily prepared by Mr. Ramesh Kumar Singh, Program Director; Ms. Darshana Vyas, Director Health and Greater India Initiatives; Ms. Heer Chokshi, Behavior Change Communication Specialist; and Saath Managing Trustee, Mr. Rajendra Joshi; Program Coordinator Dr. Neeta Shah and the Manager Health Management Information System. The Counterpart headquarters office provided on-going technical support for the DIP development process. Editing and logistic support was given by Ms. Natasha Rodney, Program Officer. In February 2005, Ms. Darshana Vyas traveled to Ahmedabad to provide oversight and technical assistance for the DIP process. During this visit, she also facilitated training for the qualitative assessments and met MOH/AMC representatives, and Hygiene Improvement Program USAID Washington representatives and Saath representatives. She also assisted with the development of the program training plan and work plan, and provided full technical input for the DIP after returning to the Counterpart headquarters office. The DIP draft was also shared with an external technical reviewer Mr. David Pyle whose technical input was incorporated into the DIP.

The DIP is being used as the key program tool for implementation. It will be shared with all stakeholders and program staff. The DIP is a stand-alone document, providing a reference point for all interventions and activities. It will be referred to and used as a guidepost during quarterly staff meetings, Technical Advisory Committee meetings, partner meetings and will serve as a key document during the midterm and final evaluations.

A.3 Integration of Program Areas of the CS-XVI and CS-XX Jeevan Daan program.

Objective:

'Phase-in' the new program areas of the CS-XX, with ongoing activities in the CS-XVI program areas, to ensure equitable development in the entire program area.

Rationale:

The CS-XVI program was being implemented in six Municipal wards of the Ahmedabad city covering approximately 183,130 slum populations. The CS-XX program includes four additional wards (total 10) and approximately 308,445 beneficiaries and the program is expected to serve 108,817 children under the age of five and 91,519 women of reproductive age. This number has increased by over 60% from previous program beneficiaries. Therefore it was essential to 'phase-in' into the new program area, with ongoing activities in the CS-XX program areas, to ensure equitable development in the entire program area.

Modus operandi:

- **Establishing a rapport with the community** and orienting them with the Jeevan Daan program and its various components was the first step in the integration of the existing and additional program areas. This process began from October 2004. The phasing-in was initiated through **Community Mapping** which involved developing an understanding of the dynamics of the community and also carrying out a general situation analysis to define the status of the community regarding maternal and child health. This exercise was done using various **Participatory Urban Appraisal (PUA)** techniques like Social mapping, focus Group Discussions (FGDs), Time Line development, Venn Diagram development, Semi Structured Interviews, etc. These activities were conducted with mothers and pregnant women, local leaders, gatekeepers and elder members from the community. The process was intensive and resulted in developing an insight into the knowledge, practice and coverage of MCS interventions that the Jeevan Daan program is addressing. The exercise also facilitated an understanding of the social dynamics, health behaviors, myths, barriers to behaviors and issues specific to the slum pockets, these were compiled as formative research data for the development of IEC materials and BCC activities.

Social mapping in progress involving local leader, religious leader and the male folk of the community.

- **Extensive Rapport Building Process:** Post community mapping, an extensive rapport building process was initiated which involved initiating contact with all potential beneficiaries, community institutions such as Anganwadis, schools and trust-run hospitals, community based organizations, other field based NGOs implementing various social development programs, Urban Health Center staff in each ward etc. These meetings aided in initiating the scope for collaboration of efforts and coordination for maximum impact in the communities.

Community members share with the program staff issues related to health, employment, and community infrastructure during a FGD.

- **BCC activities:** mass campaigns of puppet shows and street plays were organized to introduce the program and create awareness about the significance of good health. This was followed by a campaign of displaying Information, Education and Communication (IEC) posters in all slum pockets to appurtenance the health messages created by individual contact, puppet and street play campaigns. (For details on the activities please refer to table on key program activities for year 1 on page 24)

Key Results:

- **In the New program area:** At the end of May 2005, all key community stakeholders in the new program areas were contacted, as a result the program has identified more than 300 potential CHT members identified and established a relationship with beneficiary groups. The details of each community were compiled in the Area Profile Format that is comparable to a slum directory with details important for program management.
- **In the Old Program area:** Ongoing activities, such as Behavior Change Communication activities, community mobilization to increase access to quality health services, capacity strengthening of community health team members in improving their efficiency and linkages with key stakeholders, coordination at the ward level to ensure improved access of health services offered by the Urban Health Centre and private providers, etc were continued in the old program area.

A.4. Community Participation- Key to Sustainability

Community mobilization has been the moving force at the grassroots level, for the success of the CS-XVI program through the formation of CHTs.The CS-XVI program has created a cadre of 400 volunteer women from the communities who have become the spearheads of the community making way for positive change in health.

Formation of Community Health Teams (CHTs): CHTs comprise of a few community women who possess leadership skills, are respected by most people, have some standing in the community, are well known, take initiative, fast in understanding health messages and the one who is able to voice her say. CHT members are identified over a period of six months through interaction with the community members during BCC activities. The age group of the CHT is also varied, ranging from 16-60 years of age.

It has been the CS-XVI program's experience that adolescent girls have been effective in understanding new concepts and adopt positive behaviors faster than women of other age groups. In some areas young women have been successful CHT members because they act as peer educators to other women and are keen on learning positive heath messages to put to use even on a personal level. In some area middle aged women whose children have grown up, and are waiting to become mothers-in-law have been the best CHT members because they are respectable by newly wed women, young mothers and other mother in laws as well. This age factor and experience of life cycles make them more reliable in the urban communities. Thus selection of CHTs has been very flexible and has been tailored to community needs and experience.

The structure and function of a CHT: The structure of the CHTs varies from community to community given the diversity of each slum's sociological scenario, population size, number of children under five, etc. in a slum pocket of about 200-300 households a team of 4-5 women is sufficient and in a pocket of 400-600, 8-12 members form the health team to increase outreach of health messages.

The CS-XVI program has formed CHTs offering voluntary services for health awareness, improving access, ensuring quality of health services and trained them in the program interventions, communication and counseling techniques, representation skills to deal with various people who have helped CHTs in improving the health status of women and children through health awareness and home based care, formed linkages with key community stakeholders, and have demanded for quality health services. Many CHTs have displayed interest and are also undertaking CS activities, plus activities of sanitation, garbage

At the monthly CHT meeting, CHTs and link workers share their work, key community issues and activities to address them.

disposal, street management and advocating/lobbying with local officials for better facilities CHTs maintained community data relating to the incidence of illnesses, births, deaths, pregnancies, next due date for children's vaccination, etc. they also have started visiting private practitioners regularly, apprising them of WHO protocols, and monitoring whether they are practicing them as well. In addition to this CHT members have issued referral chits to increase access to AMC health centers.
The Final Evaluation of the CS-XVI program also indicated that the purity of volunteerism should be maintained for sustainability[1]. Under the CS-XX program, the collective strengths of the CHTs will be harnessed to sustain the program impact by creating a confederation of CHTs, registered as a CBO and recognized by AMC. The concept of a city-wide confederation of CHTs is an example of "taking to scale" a CS intervention, and empowering its advocacy role and will continue under CS-XX.

Objective:

Identification of potential CHT members and youth groups in the new areas and involvement of members of existing CHTs of the old areas in phase-in.

Rationale:

Community participation in health programming is one of the core strategies of the Jeevan Daan program. Community participation is also the first step towards sustainability of program efforts at the community level. This participation from the community is a sustained "community investment" for long-lasting partnerships between young mothers and elderly members of the community and enabling the community people to take leadership roles as well as a method to initiate development 'from within'.

Modus Operandi:

- **Participation of CHT members in phase in process:** CHT members played a vital role in the design and detailing of culturally appropriate program interventions and strategies.

CHT members assisted the program staff during visits to the UHCs of the new program wards to share their experiences after the strong linkages formed between the community and the health delivery system.

- **CHTs become the champion for social development and health promotion:**

Most of the members of the CHTs were involved in the phase-in process to motivate community members and establishment a relationship. CHT members also spoke for the program and their work to motivate women with leadership skills to volunteer their time for the program and initiated the process of formation of CHTs in the new program area.

- **Participation of community youth in social development:**

The Jeevan Daan program has established a rapport with youth of the community who are either out of school or were unemployed who have shown a deep interest in participating in program activities. The program sees this as an investment in future parents who act as responsible and informed caretakers. It is also established that young people are more open to new and evolving concepts of healthcare and hygiene rather than mothers–in-law and older women. They are also more informed given the access to information through media such as television, internet and cinema.

Results:

By the end of September potential CHT members were identified and the CHTs were formed and were functional. Mentioned below is the current status of health teams and potential members:

[1] Ms. Donna Sillan- Final Evaluation report-Jeevan Daan CS-XVI program- September 2004

Status of Community Health Teams in the Program Area

Area type	Ward Name	Population	CHTs already Formed	CHT Formation in the Process	No. of Potential Members
CS-XVI program area that are also part of the CS-XX program	Danilimda	38850	11	3	81
	Jamalpur	21860	7	0	30
	Raipur	2,125	1	0	0
	Dudheshwar	49920	9	4	63
	Raikhad	36125	4	2	57
Additional areas in the CS-XX program	Kankariya	29710	0	6	22
	Bapunagar	24415	0	1	13
	Saraspur	32670	0	2	51
	Vasna	49210	0	2	107
	Maninagar	23560	0	3	52
TOTAL		**308445**	**32**	**23**	**476**

Potential CHT members identified:

476 Potential CHT members have been identified through routine program activities such as BCC activities, during social mapping, rapport establishment activities etc in the last year. These identified individuals, shall be assessed for the next 4-6 months through involvement in program activities and will be integrated into existing CHTs or will form new CHTs. In the old program areas potential members have been identified to cover up for dropouts or members who have left town due to shifting of residence or marriage.

Potential CHT member identified during a seasonal mapping exercise during phase-in.

Strengthened existing CHT:

The process of capacity strengthening of CHTs has resulted in strengthened skills of CHTs in communication, counseling and representation. Additional inputs were given to some CHTs after innovative methods of Learning needs and Resource Assessment (LNRA) such as CHT quizs and games. CHT members have been imparted skills on communication so as to conduct activities such as Health Education Sessions, counseling and also organizing and managing small community level BCC events. CHTs have been trained in written communication to assist them in drafting request letters and fill documents to appeal for sanitation, garbage disposal services to other AMC departments. About 50% of the existing CHT members have approached Water and Sanitation departments, Muster Stations of the AMC for hygiene and sanitation related issues it their respective slum clusters.

Broadening and strengthening linkages between CHTs and stakeholders:

Efforts have been made to improve coordination between other stakeholders (Private Practitioners, Anganwadi workers, CBO members, other NGO, School Teachers, etc) and key community members (TBA, Local leaders, traditional healers, Linkworkers vendors) with the CHT members to improve the quality of services offered by AMC staff and private providers and increase access to AMC health services. An increased interaction was facilitated between Anganwadi workers and Link workers and the CHTs of communities to improve coverage of services like nutrition, immunization, counseling and medical supplies such as ORS and Iron Folic Acid because these members are based in the communities. CHT members use Anganwadi space as a centralized location for conducting various activities and conduct joint activities like health education, nutritional supplementation and immunization camps. CHTs have increasingly involved local Link workers in their monthly meetings ensuring joint planning and co working.

CHT members lighting the sacred ceremonial lamp at the beginning of the Sneh Milan activity.

Establishing the solidarity of CHTs:

CHTs from different communities, but from the same wards were brought to a common platform where the teams of community volunteers of different clusters come and update each team on their activites, share and plan for priority issues jointly for their respective clusters. On these lines, two **Sneh Milan** (get together of CHTs) were organized for CHTs of the Danilimda and the Jamalpur ward where over 80 CHT members participated and realized their combined strength. The Sneh Milan was an opportunity for the members to individually share their experiences and vision for the development of their communities and their teams. Most CHT members felt that there is a dire need to work on maternal and new born care interventions, hygiene improvement and birth preparedness in the community. The Sneh Milan will be replicated for all the other wards and in the next stage all the CHTs will be confederated, as is planned for sustainability.

Involving Youth/Adolescent:

The program has formed youth groups of boys and adolescent girls, of ages varying from 12 to 17 years, in five communities who assist the community organizers in BCC activities, community mobilization during immunization camps, ORS rallies, etc.

After three rounds of discussions with youth from various slum pockets, youth groups have identified key areas that they would like to contribute their effort to:

- Assisting program staff in mobilizing and controlling audiences during mass BCC activities and in the preparation of PD/Hearth.
- Conducting individual and or group health education sessions with mothers on nutrition, hygiene improvement, and point of use and

Youth group members present a skit on hygiene and hand washing at a health education workshop for community women organized by UHC.

management of pneumonia.

- Adolescent girls volunteered to help mothers understand the importance of nutrition during pregnancy, and the importance of colostrum against prelacteals.
- Some youth were interested in performing street plays and puppet shows for the Jeevan Daan program. These talented youth were then trained in performing arts and health interventions and have started performing shows in the communities.

A.5. Behavior Change Communication Activities

BCC was one of the most successful approaches under the CS-XVI program and involved extraordinary community participation and impacted positive behavior change. Over the past five years the CS-XVI program has been conducting the BCC activities using the BEHAVE Framework with INFOTAINMENT as its approach and the local epidemiological calendar as its tool. The BCC strategy is innovative and has successfully used a mix of multiple mediums, including: street-plays, posters, flip books, exhibitions, games, as well as the traditional cultural mediums for promotion of health messages and targeting individual, household and community level audiences. The INFOTAINMENT approach is supported by formative research and pre-testing, which resulted in the promotion of gender balanced, culturally appropriate and 'urban context' specific health messages.

A street play on maternal and new born care with loads of laughter, song and dance- the perfect INFOTAINMENT.

The lessons learnt from the CS-XVI program are being applied to the CS-XX program in designing effective BCC strategies. These activities have been thoroughly analyzed in the CS-XVI for their strengths in reaching specific audiences and to disseminate specific messages and thus a range of activities have been designed through careful audience segmentation to reach each level. The CS-XX program is using its successful, urban specific, gender sensitive, culturally sensitive and feasible BCC activities to promote positive maternal and child health behaviors at the household and community levels through its innovative BCC strategies and improve the practices of health care providers at the facility level.

Objective:

Dissemination of community and culture specific health messages for Behavior Change, increased demand for quality health services and adoption of positive health behaviors by the community related to program interventions.

Rationale:

The CS-XVI program developed an efficient Behavior Change Communication strategy to address programmatic interventions that are urban specific, cultural and gender sensitive with the approach of infotainment[2]. The success of the CS-XVI program was supported by its strong BCC component and the extensive use of cost effective, innovative media forms and messages that were developed through formative research, pre-tested with various audiences and reviewed by experts in the field of public health. The successful BCC strategy of the Jeevan Daan program needs to be extended to address issues of Maternal and Newborn Care.

[2] Ms. Donna Sillan- Final Evaluation Report September 2004.

Modus Operandi:

The CS-XX is addressing maternal and childs survival issues through the continuation of successful core BCC activities and seasonal BCC activities. The **Core BCC activities** are Individual Counseling, Health Education Sessions, Street Plays, Puppet Plays, Pregnancy Hearths; Video and Slide Shows and **Seasonal activities** are Garba, Mela, Henna Decorations, Torans and Kites.

Core BCC activities are consistent and ongoing through out the year. These activities are a mix of multi media approaches ranging from the interpersonal level to mass level activities. (For details of activities please refer to Tables on page 24)

Individual counseling has been the best way to reach mothers and pregnant women because of the personal attention provided, and the mother or woman is able to open up and talk freely about issues related to maternal and child health. Its interactive nature allows the mother to ask questions for which answers are provided, then and there. This has helped to establish a rapport with mothers and allows CHT members to gain their confidence and as results it is easy to communicate health related messages and discuss their problems. This approach also gives chances for reluctant mothers who cannot open-up in large group settings. Given the urban situation where there is a constraint of space due to over crowded and congested spaces and because most women are either working at home or out of home it becomes difficult to get them together for group activities.

Health Education Sessions (HES): Even though the slum situation poses space constraints in conducting group activities, group based activities have been possible with community support in terms of provision of space within ones homes or in their courtyards. Based on the experiences of the CS-XVI program group health education sessions has been a good activity to reach a group of people with similar characteristics.

Street plays: have been an excellent medium to communicate to large audiences; almost the entire community participates actively and are apprised on key issues at once. The CS-XVI program has effectively used this medium to reach out to all of the communities where ever community offered spaces such as courtyards, school playgrounds, temple grounds etc. and over 350 street plays were performed during the life of the program. The entire community enjoys this popular media since it offers social entertainment with health messages. Counterpart has identified traditional performing groups, has trained community youth members in performing arts and in MCS messages, who have performed street plays in the program. These efforts have been very effective and have created a lasting effect. In the last year the program trained 20 youth groups and talented CHT members in dramatics, who have performed over 50 street plays in the community on diarrhea prevention and nutrition promotion during the summers and monsoon seasons.

Puppet plays: have been effective in disseminating health messages and addressing myths, false beliefs and superstitions through fun-filled puppet plays that also offer a large scope for improvisation and modification based on the kind of community thus making it culture, caste and community specific. These low cost, colorful mediums were very effective in reaching out to children, men and adolescent girls and have been used in the program. The CS-XX program performed over 75 puppet shows to promote AMC health services, immunization and participation in the Anganwadi program. Some members of the youth group who were trained in performing in the previous year were involved in these puppet shows.

Video and slide shows- The program is using video and slide shows to show images of childhood illnesses, processes of digestion, immunization, menstrual cycle, etc which have been very successful. The urban audiences are exposed to video and cable television on a day-to-day basis, many homes also have VCD players and television thus they are comfortable with audiovisual

A large group of pregnant women attend a video and slide show on maternal and new born care organized by the idstaffwith Urban Health Centre staff.

mediums. The CS-XX program is using video in health education sessions with different audiences and is highly effective. In some areas CHT members have learnt to conduct HES using video and are successfully carrying them out even when the program staff is not present. The program is in the process of finalizing scripts for making of docudramas, public service advertisements, and short story formats, , which will be shared with local cable operators to show between other cable programs.

Results:

- BCC activities have been extensively conducted during the phasing-in period in the new areas of the program so as to introduce the program objectives to the community at a mass level and also to familiarize the community members with the program staff.
- The responsiveness of the communities has helped in assessing the level of inputs to be made in order to accomplish program activities.
- Over all such activities have made a great impact in the community and has helped to establish the visibility of the program amongst the key community members.
- Post phase-in period, more and more stake holders like Local leaders, Anganwadi workers, private practitioners, link workers are extensively involved in these activities.
- There has been a greater demand of these activities from AMC link workers and NGOs managing the Anganwadis as they have also helped in enhancing rapport amongst the community members.
- In the older areas BCC activities like Infotainment Quiz, street plays and puppet shows have proved to be a strong medium for giving the CHT and the youth groups a visibility and respect in the community.
- Other core BCC activities like interpersonal counseling, Health Education Sessions, family Counseling, Street Plays, Puppet shows, variety competition programs, posters, songs etc have been conducted at full scale to take the health messages to the community.

A.6. Capacity Strengthening

Participatory and on-going training for capacity strengthening based on: needs assessments, the latest national and WHO protocols, Technical Reference Materials and updated information provided through CORE and CSTS, and feed-back has been the CS-XVI programs winning approach. Through this staff have been trained in PCM, CDD, Nutrition, BCC and counseling, PD/Hearth, EPI, M&E, KPC, HFA and qualitative assessment techniques using the adult learning principles, audio visuals, demonstrations, and learn-by-doing approaches, to better address the issues related to any intervention. The CS-XVI program has successfully developed an in-depth and appropriate training plan, which will be continued in planning trainings for the new intervention of Maternal and Newborn Care in the CS-XX program.

a. Program Level Trainings and workshops:

The program organized Core trainings (Mentioned in the table below) in technical interventions using adult learning principles and participatory approach to the strengthen capacity of Jeevan Daan staff members. These Core trainings help program staff to address MCS interventions and in using various approaches and strategies to achieve program targets and promote positive Behavior Change, improve quality of services and increased access to services. The content of these trainings draw largely from WHO protocols, TRMs, National policies and resource materials from CORE

Counterpart COs who have been trained in CS interventions in the CS-XVI program demonstrating the effect of ORS over Anti-diarrheals during the training on CDD.

and CSTS. These Core trainings have also been Training of Trainers for the Jeevan Daan staff where in they then transfer their skills to community level functionaries through community level trainings. Most of the trainers are members of the Core training Group of Jeevan Daan have the technical expertise to provide training in CS interventions and have been trained by members of the TAC and external consultants in the previous program.

The Jeevan Daan program has also developed a clear and precise Learning Needs and Resource Assessment (LNRA) form to assess training needs of program staff in technical interventions and methodologies preferred. All program level trainings on technical interventions have been conducted based on the findings from the LNRA. The following table indicates the program level trainings conducted in the last year that are also defined in the work plan and training plan of the DIP. There has been no delay or change in the planned trainings from the DIP.

Sr. No.	Trainings	Month/ Year	Trainers	Participants
1.	Program Orientation Workshop	Nov 2004	Counterpart India – Core Training Group	11 Counterpart, 7 Saath
2.	Quantitative Survey methods (KPC, HFA)	February 2005	Counterpart Program Director and HISM	10 Counterpart, 11 Saath
3.	Qualitative Survey methods	February 2005	Counterpart Program Director and HISM	10 Counterpart, 11 Saath
4.	Pneumonia Case Management	June 2005	BCC and Training Specialist& Program Coordinator	10 Counterpart, 11 Saath
5.	Control of Diarrheal Disease	June 2005	BCC and Training Specialist& Program Coordinator	10 Counterpart, 11 Saath
6.	Immunization	June 2005	BCC and Training Specialist& Program Coordinator	10 Counterpart, 11 Saath
7.	Nutrition and Breastfeeding	June 2005	BCC and Training Specialist& Program Coordinator	10 Counterpart, 11 Saath
8.	Monitoring and evaluation techniques	June 2005	HISM and Program Coordinator	10 Counterpart, 7 Saath
9.	Orientation on Maternal and Newborn Care	July 2005	Program director and Core training group	12 Counterpart, 7 Saath
10.	Finance and HR	December 2004	Finance and Admin. Manager	2 Saath

b. <u>Drip Trainings:</u>

The CS-XVI program also developed the concept of Drip Trainings, that are small scale, practical problem-solving and action-oriented short refresher training, where the trainees are updated about innovations in the field of MCS, discuss functional problems and find solutions jointly, use their new learning immediately in contrast to a conventional days-long intensive session with lower potential for retention and limited use during the work. These Drip trainings have been very successful, effective and popular and the Final Evaluation Recommendations have been to continue these drip trainings in the CS-XX program for capacity strengthening of the Jeevan Daan program staff[3].

[3] Jeevan Daan CS-16 Program Final Evaluation Report-September 2004, Ms. Donna Sillan

The CS-XX program conducted various drip trainings for the Jeevan Daan team of community organizers in the last year, from time to time, based on evolving needs and issues in implementation:

- Rapport Building and Community Mobilization
- Effective Planning
- The art of Multi Tasking
- Becoming a Community Organizer – roles, responsibilities and challenges
- Identification of potential CHT members
- Motivating CHT members and youth in the spirit of volunteerism
- CHT- Key to Sustainability
- Marketing of Social messages- Social and Behavior Change Communication approach
- Conducting Specific BCC activities (Health Education Session, Individual Counseling, Activities with children, communicating with gatekeepers, etc)
- Dealing with difficult stakeholders
- Conducting Family Counseling
- Kitchen/hanging Garden

A.7. Health Management Information System

The established Health Management and Information System of the CS-XVI program has used a participatory, bottom-up approach, which involves the partner NGOs, AMC/MOH staff, and community members at various levels. It has inbuilt mechanisms to ensure accuracy in data collection, easier comprehension of data because of its simplicity, easier validation of data due to effective quality assurance and quality control mechanisms, and more importantly usage of data for action. The most important component of the system is that it utilizes the systems already existing to the best possible extent, avoiding the duplication of data collection. An emphasis is placed on feeding results directly back into the planning process and adapting them immediately. Through monitoring, Counterpart has ensured that the CS-XVI Program stays on course by facilitating an on-going verification. This ensures that the activities are implemented within the framework of set the objectives, continuously measuring progress towards these objectives, identifying problems as they arise, identifying strengths that can be built upon, and adapting to changing circumstances.

The objectives of the program M&E system are as outlined below:

1. Improving the coverage of population for the delivery of RCH related services by the AMC facilities, by ensuring a 100% registration and coverage of the target population
2. Improving the quality of data collection at the community and facility level by the AMC personnel.
3. Increased use of data for program effectiveness and decision making through ongoing sharing, feedback and feeding results back into the system to make corrective actions

Modus Operandi:

Revisions and Finalization of HMIS framework:

At the program start up phase the entire HMIS frame was revisited for the changes or development as per the new cost extension program strategy to incorporate the additional component of maternal health was discussed and finalized. During the revisions attention was paid towards sustainability of data flow and analysis, thus increasing the scope for further strengthening of the MIS systems of AMC was discussed and the strategy for strengthening community based MIS was given prime focus.

Data Management Software: EPI Info that was used during the CS-XVI program was replaced by Visual Basic 6.0, with VB as backend and Ms Access as front end for data entry and analysis. Although EPI Info has been one of the most widely used platforms for health programs but has certain limitations as per the cost extension program needs. It can only compile and analyze quantitative data that too for one tool at a time. It is a DOS based software and one needs to develop skills for its usage. Where as VB 6.0 can compile both qualitative as well as quantitative information at the same time and can be analyzed. In addition, its user friendly and has the ease to share data to a number of users at the same time. It also has the facility to do analysis from multiple tools at the same time. In the first year of the program all M&E tools of the system were piloted and finalized.

Revisions of the MIS Tools/Checklists

The tools and formats of the CS-XVI program were upgraded as per the evolved program strategy with the incorporation of the new component of Maternal and Newborn Care. With the beginning if the Urban Reproductive and Child Health–2 program of the AMC and an entire cadre of Link workers at the community level and the resurgence of the Anganwadis in the communities resulted in the addition of key health stakeholders. Thus the MIS formats increased segments on joint activities with these stakeholders and the scope of their involvement and targeted beneficiaries for each activity have been much more refined and defined as to monitor the outreach of the program.

- A new checklist has been developed to monitor BCC activities with additional components to monitor Family Counseling, activities with youth groups, training related to BCC, etc.
- Components of Maternal health have been included in the Household Visit checklist.
- The Area profile format has also been designed to incorporate further details and contacts of key community stakeholders.
- A new checklist has been developed, piloted and finalized to ensure supportive supervision and supportive feedback for Community Organizers performance by Supervisor.
- As the program does not create a parallel system with the AMC, the Jeevan Daan MIS system systems has been designed on VB 6.0 so as to incorporate their data and compile a joint report that can be shared with AMC officials each month to monitor the health status of the community and the gaps or success in program interventions. This MIS has been appreciated by the AMC officials, who have also requested Counterpart to help and strengthen their data compilation mechanisms. A training program has been proposed and is planned in the coming months.

Community based HMIS strengthening:

As the program strategy, the focus has been on increasing the access and enhancing the quality of the health delivery system. It has been identified from the previous program, that unless the gap is bridged between the community and the health delivery institutions and the stakeholders equally participate in the process, the program efforts would be short lived. In the CS-XVI CHT members were the key points for data collection on child health related issues like illnesses, births and deaths etc that has been very effective. CHT members have increased the community's access to quality health services through the distribution of referral Chits and announcements on Community Boards.
The Jeevan Daan program's community HMIS has taken a step ahead in the first year of the program through the designing and piloting of a pictorial CHT activity card to record the regular activities like family counseling, individual counseling, health education session, etc that they perform. (Please see Annexure 4& 5 for details)
CHTs of few areas have identified and divided catchment areas amongst themselves and are tracking households that fall in that area. The data of their catchment is shared with all of the CHT members, Link workers and Anganwadi workers for access to medical supplies or services and follow-ups.

Other Monitoring Mechanisms

Technical Advisory Committee (TAC) Meeting:

TAC has been an exemplary feature of the CS-XVI program for increasing the scope of program sustainability and replicability. It is responsible for overseeing program activities and providing overall technical support to the program. Members include experts in the public health arena who are influential in public policy. This committee has provided invaluable advice to steer the CS XVI program. The CS-XX program will continue to involve the TAC for technical review and advocacy, and evaluate program performance and effectiveness at regular intervals.

The TAC was involved in the program orientation workshop and in the process of DIP development. Based on the results of the baseline assessments, the TAC offered valuable suggestions to design an emphatic and simple program and have conducted various trainings for program staff on MCS interventions.. (TAC inputs are mentioned in detail in the DIP).

Program Coordination Committee (PCC) Meetings:

PCC has been a successful approach in the current program and has stimulated effective discussions on an ongoing basis on the program performance review, HIS data sharing for decision making, lessons learned in implementation, encountered problems that need attention, identify strengths and weaknesses in the program and provide information to key decision makers in order to continually improve the quality of implementation. Chaired by the Program Director of Counterpart, and includes the senior members from Saath, Counterpart and AMC.

In the last year, the PCC meeting was held thrice to orient the partners in detail about the program design, strategies and outline ways in which each can contribute to program success.

The PCC also met to design the program during the DIP development process, finalize and review the DIP and make necessary updates. The managing trustee of Saath and Medical officer Health of AMC-Dr. P K Makwana attended the Mini DIP along with Ramesh K Singh, program director Counterpart India and Darshana Vyas- director Health Programs, Counterpart HQ.

Ward Level Coordination Committee (WLCC) Meetings:

WLCC is a ward level monitoring mechanism to facilitate smoother implementation of the program and promote synergy in the activities implemented by Counterpart and its NGO partners with the AMC health workers. WLCC meeting facilitate joint planning and sharing of findings of the past month with the ward based health facility staff and to help establish linkages between community and public service providers.

The process of Ward Level Coordination Committee (WLCC) is being initiated in the entire 10 wards of the Jeevan Daan program. The WLCC includes AMC health facility staff, ICDS Anganwadis, private practitioners, CHT members, local area cooperators, heads of local NGOs working in the field and community representatives so as they can jointly share and update information with each others and also are able to conceive a joint working plan so as to attain synergies of efforts.

WLCC meeting with participation of MOs, MPWs, Private Practitioners and program staff. in progress in the Danilimda ward.

This process involved three rounds of meetings with Medical Officer Health of AMC, Officer Health and Family Welfare and RCH Coordinator to initiate the idea of WLCC, design its structure and processes. Parallel to the WLCC, under the RCH II program, AMC started from August 2005, monthly monitoring meetings of its entire UHC and ICDS Anganwadi staff for all the Municipal wards to ensure smooth health delivery. WLCC

was thus integrated with the AMC ward level monitoring meetings to avoid creating a parallel coordination mechanism. At present, three rounds of meetings have been conducted. The first two meetings were focused on orienting the UHC and Anganwadi worker so as they can conceptualize the functioning of the WLCC. The WLCC then went on to include community participation of CHT members, TBAs and Private Practitioners, etc.

Counterpart and NGO partners' All Staff Action Planning and Review Meeting:
This meeting stimulates an environment of information sharing on successful approaches followed in implementation, Peer education and jointly drafting the Tools for Improved Practices for improved future planning and implementation. Such meetings in the current program have helped to integrate the activities in the areas that have been phased in the first year with the areas where phasing in has happened in the second or third year. These meetings are regularly organized and are a platform to monitor ongoing activities, plan for drip trainings to enhance program staff performance.

A.8. Status of Program based on program objectives and activities.

Technical Interventions	Key Activities (as outlined in the DIP)	Target	Status of Activities	Comments
Control of Diarrheal Diseases	**Core BCC Activities**			
	Individual Counseling	**1800**	**198**	**More focus on group activity to reach the masses as Diarrhea was at rise during summer and monsoon**
	Health Education Sessions Street Plays /Puppet show	**300**	**358**	
	Family Counseling	**500**	**120**	
	Referral Chits	**1000**	**1080**	**CO, CHT, AMC Staff distributing jointly.**
	Demonstration & ORS Corner / ORS rallies	**50 Slum communities**	**40 Slum Communities**	**Youth Groups involved extensively in this activity**
	Hygiene improvement and promotion, Point of Use interventions at personal level and household level	**100 slum communities**	**100 Slum Communities**	**Initial orientation and counseling of CHT and key community members have started**

Technical Interventions	Key Activities (as outlined in the DIP)	Target	Status of Activities	Comments
	Promotion of AMC "90 x 10" Toilet Building scheme	**100 slum communities**	**All the Slum Communities**	**Community mobilization and linkages with Saath's SNP has been initiated**
	Doer Non-doer Analysis to develop a comprehensive BCC strategy taking into account community beliefs and care-seeking behavior	**1 in Year 1**	**1**	**Incorporated in the baseline assessment**
	Counseling of Vendors for hygienic preparation and selling of foods, and ORS promotion	**100 each year**	**125 Vendors**	
	CHT/ CBO linkage with ward level Water and Sanitation and Solid waste management departments of AMC for timely collection of garbage from the community, provision of public toilet facilities and addressing issues of ensuring supply of clean drinking water	**5**	**Linkages initiated with 7 CHT**	**Meetings with Muster Station staff for linkage strengthening initiated**
	Personal Hygiene promotion among children through AMC and other NGO schools/ Anganwadis	**10**	**Activities initiated in 7 schools**	
	AMC Link Workers/ CHT Members/ Vendors/ Anganwadi workers distributing ORS packets to caregivers	**75% of Communities**	**All communities,**	**Primarily Linkworkers are responsible for the distribution.**
	Displaying and distributing posters/ Pamphlets/ flipbooks, booklets/ games like snakes and ladders etc. on Diarrhea through vendors/ Anganwadis/ CHT members and AMC Link workers	**In all the slum communities**	**In all the slum communities**	
	Health Facility Related Activities			

Technical Interventions	Key Activities (as outlined in the DIP)	Target	Status of Activities	Comments
	AMC Health facility Staff counseling caregiver on correct preparation of ORS, usage of ORS/ORT, home case management etc. during a diarrheal episode	**50% Cases**	**30%**	**Heavy out patient load on UHCs**
	Private practitioners counseling caregiver on correct preparation of ORS, usage of ORS/ORT, home case management, avoiding usage of anti-diarrheal	**30% Cases**	**20%**	**New area private practitioner still practice prescribing anti diarrheal pills**
	Displaying and distributing posters/ Pamphlets/ flipbooks, booklets/ games like snakes and ladders etc. on Diarrhea through AMC Health facilities and private practitioners	**All 10 facilities**	**All 10 facilities**	
	District/ Project Area Level/ Policy Level			
	Collaboration with Partner NGO Saath/AMC on the Slum Networking Project, for development of water and sanitation infrastructure in the target communities	**Exploratory research in year 1,**	**Initiated**	**Coordination with the SNP program staff initiated, exposure visit of COs to SNP project areas, and community mobilization initiated.**

Technical Interventions	Key Activities (as outlined in the DIP)	Target	Status of Activities	Comments
Pneumonia Case Management	**Core BCC Activities**			
	Individual Counseling	**1800**	**158**	**Pneumonia incidence was low in summer**
	Health Education Sessions, Street Plays /Puppet show	**300**	**125**	
	Family Counseling	**500**	**115**	

Technical Interventions	Key Activities (as outlined in the DIP)	Target	Status of Activities	Comments
	Displaying/distributing posters/ Pamphlets/ flipbooks, booklets/ games like snakes and ladders etc through Anganwadis/ CHT members/ AMC Link workers and vendors	**2 Campaigns**	**1 Campaign**	**and monsoon seasons. More focus will be given during winter season.**
	Displaying and distributing posters/ Pamphlets/ flipbooks, booklets/ games like snakes and ladders etc. on ARI/ Pneumonia through AMC Health facilities and private practitioners	**All 10 AMC Facilities and 50 Private Practitioners**	**All 10 AMC Facilities and 70 Private Practitioners**	
	UHC Staff Counseling Caregivers on completion of dosages.	**50% Cases**	**30-35%**	**Heavy Out-Patient Loan on UHC**
	Doer Non-doer Analysis to develop a comprehensive BCC strategy taking into account community beliefs and care-seeking behavior	**1 in year one**	**1**	**Done along with Baseline Assessment**
	District/ Project Area Level/ Policy Level			
	Improved linkages and referral mechanisms between private practitioners and AMC Facilities for avoiding deaths due to severe cases of pneumonia through WLCC meetings.	**Monthly meetings**	**2 meetings**	**WLCC initiated in August 2005**

Technical Interventions	Key Activities (as outlined in the DIP)	Target	Status of Activities	Comments
Nutrition & Breast Feeding	**Core BCC Activities**			
	Individual Counseling	1800	**198**	
	Health Education Sessions, Street Plays /Puppet show	**300**	**265**	
	Family Counseling	**500**	**222**	
	Referral Chits	**1000**	**810**	
	Promotion of buying nutritious foods from clean vendor through BCC	**4 Special Promotional Campaigns**	**4 Campaign**	

Technical Interventions	Key Activities (as outlined in the DIP)	Target	Status of Activities	Comments
	Doer Non-doer Analysis to develop a comprehensive BCC strategy taking into account community beliefs and care-seeking behavior	**1 in Year 1**	**1**	**Done along with Baseline Assessment**
	Promotion of participation in ICDS Anganwadis by pregnant and nursing mothers and children	**All Communities**	**Continuing in all communities**	
	Distribution of IFA tablets and de-worming medicine to mothers and children through Anganwadis	**All Communities**	**Continuing in all communities**	
	Promotion of Iodized salt consumption	**All Communities**	**Continuing in all communities**	
	Promotion of hanging gardens for growing nutritious foods within the community	**10 slum Communities**	**Slum pocket identification being done**	

Technical Interventions	Key Activities (as outlined in the DIP)	Target	Status of Activities	Comments
Immunization	**Core BCC Activities**			
	Individual Counseling	**1800**	**119**	
	Health Education Sessions, Puppet shows/street plays	**300**	**163**	
	Family Counseling	**500**	**166**	
	Issuance of Referral Chits	**1000**	**1080**	
	Doer Non-doer Analysis to develop a comprehensive BCC strategy taking into account community beliefs and care-seeking behavior	**Once in the year 1**	**Done**	**Done along with Baseline Assessment**
	Distribution of Mother and Child immunization card to all mothers who have not been issued one.	**In all the slum communities**	**Continued**	**AMC Linkworker are primarily responsible**
	Participation of community in National Immunization Days	**In all the slum communities**	**Regular Participation**	

Technical Interventions	Key Activities (as outlined in the DIP)	Target	Status of Activities	Comments
	CHT/ CBO linkage with ward level AMC Health facility for regularity of community based immunization camps	**In all the slum communities**	**In all communities**	**Linkages being strengthened in all slum communities with CHT**
	Health Facility Related Activities			
	AMC Health facility Staff counseling caregiver on immunization schedule and next due date to all mothers who visit the facility for seeking healthcare	**50% Cases**	**35%**	**Heavy Out-Patient Loan on UHC**
	Private practitioners counseling caregiver on immunization schedule and next due date to all mothers who visit the facility for seeking healthcare	**30% Cases**	**10%-15%**	**Prefer going to AMC for Immunization**

Technical Interventions	Key Activities (as outlined in the DIP)	Target	Status of Activities	Comments
Maternal & Neonatal Care	**BCC Activities**			
	Individual Counseling	1800	**198**	
	Health Education Sessions, Street Plays /Puppet show	300	**265**	
	Family and Gatekeepers' Counseling on birth preparedness, recognition of danger signs during pregnancy and promotion of institutional deliveries	200	**222**	
	Issuance of Referral Chits	600	1890	
	Doer Non-doer Analysis to develop a comprehensive BCC strategy taking into account community beliefs and care-seeking behavior	**1 in year one**	**Completed**	**Done along with Baseline Assessment**

Technical Interventions	Key Activities (as outlined in the DIP)	Target	Status of Activities	Comments
	Distribution of IFA tablets and de-worming medicine to pregnant women through Anganwadis	**All slum communities**	**In all slum communities where Anganwadi is present**	**Linkworker are doing where Anganwadi is not present**

A. Factors Impeding Progress of the Program

Since the beginning of the program in October 2004, there have been some impending factors that have come in the way of smooth program implementation and meeting of proposed targets. Mentioned below are the broader socio- economic and natural conditions that have hindered program activities:

Mega-city Development Program

Ahmedabad is the seventh largest city in the country and recently has been designated as Mega city status by the State Government. In view of this, large-scale infrastructure development projects have been initiated by AMC that include improvement in civic facilities, water and sanitation, reducing air pollution levels, broadening of roads through demolishing illegal structures and residences that include slum settlements. Thus many slum settlements that were part of the Jeevan Daan program have been evicted to other areas and those who are yet to vacate live in constant threat of eviction. Under such circumstance it's difficult to conduct program activities these areas and news areas were then identified to compensate the beneficiary loss.

Sabarmati River Front Project

Ahmedabad city is situated on the banks of the Sabarmati River that passes through the center of the city. Owing to the increasing migration and urbanization, many a slum settlements began to reside along the banks of the river that went unmonitored. The Government of Gujarat and Ahmedabad Municipal Corporation have initiated Sabarmati River Front Development (SRFD) project with the primary objective of city beautification, improving the environment, infrastructure development, provision of adequate public amenities and land development in the city of Ahmedabad. The project proposes to develop both sides of the Sabarmati River, which is about a 20.4 km stretch. About 20% of the population under the program area is situated on the bank of the Sabarmati River

The River front project bulldozers in process viewed from a slum located on the banks of river Sabarmati.

AHMEDABAD: In this aerial view taken from a helicopter on Saturday, an empty highway between Baroda and Ahmedabad is surrounded by water. At least 123 people have died and about 25 million have been affected by heavy rains and flooding in the western Indian state of Gujarat this week. Large stretches of property near rivers, tributaries and dams in the state, which has a population of 50 million, were under water. Almost 900 villages have been cut off by the flooding.

and falls under the SRFD project. Most of the population under this area has started migrating and issues of residence; livelihoods and eviction have taken priority against the programs objectives to improve maternal and child health. The program had to thus identify additional slum areas to begin work under the extended program due to which the program lost three months of implementation time.

Highest rainfall in 15 years reported leading to Flooding

Ahmedabad falls under dry and arid climates with average yearly rainfall of around 450 mm from June to August. This year, the rainfall data crossed all records and there was a heavy downpour of more than 900 mm in the monsoon season and the monsoon was extended from June to September. The city is not equipped to handle such heavy rains and as due to the major construction projects under the mega city development and Sabarmati development projects, there was flooding and incidences of heavy water logging condition in most parts of the city. The conditions were much worse for slum communities given the lack of drainage facilities and the fact that most slums are situated on the banks of the river. Due to heavy loss to life and property, the program had to reinitiate the process of phase-in and rapport establishment in these communities leading to a considerable loss of time. It took time for the community to come out of it and delayed the process of starting full-scale activities in the area which has been compensated through intensive activities involving Link workers, Anganwadi workers, local leaders, CHT members and youth groups.

AMC: Shortage of Staff (MPWs) and Staff Turn Over (Link worker)

Joint activities and co-working with AMC staff is the signature approach of the Jeevan Daan program. The program began operations in October 2004, during the months of July and August 2005, AMC was undergoing a shortage of almost 32 MPWs in the Urban Health Centers, which affected the service delivery of the Urban Health Centers on the whole thus many efforts targeted towards mobilizing communities to Urban Health Centre for referral went without treatment. This led to disappointment among the communities, in the AMC services. Since September 2005, AMC has recruited muli MPWs for most of the UHCs and joint activities have been revived in the respective areas. There is also a large turn over amongst the link workers in program areas, given the low wages, lack of motivation from supervisors and low capacity in accomplishing targets. Thus, re-establishing rapport, reorienting new batches of link workers about the program and its strategies, building their capacity in community mobilization and counseling and communication has also reduced the pace of the program.

B. Technical assistance required in the program

The Jeevan Daan program has a well-defined training plan in place that has been on target since October 2004. There have been constant technical inputs from Counterpart HQ under the leadership of Ms. Darshana Vyas, Director Health Programs that has gone a long way in program achievements. The program is well linked with organizations like MICA, IDEAL, CORE group, etc and members of the TAC who offer technical assistance in the form of trainings or review of program strategies and interventions.

In addition, the program envisages technical assistance to enhance the program for technical issues like Home Based Life Saving Skills (HBLSS), Rational Drug Therapy for private providers, in conducting Operations Research for Maternal and Newborn Care interventions. Though these are spelt out clearly in the training plan, these are some of the areas for technical assistance and will continue to tap resources from SEARCH-Abhay Bangs project in India, IDEAL and Foundation of Research for Health Studies (FRHS) as well as will use technical assistance and materials from the American Nurses and midwives.

C. Change in the Program from the program Description & DIP

There are no significant changes from the DIP to be reported.

D. Sustainability Plan and Progress

As a part of the sustainability plan, Counterpart has planned a phase over strategy in relation with its partner NGO Saath. The foundation of the phase over strategy rests on the Counterpart and Saath's approach towards decentralization and handing over the activities to the local groups and communities. This convergence of ideas has led to a revised phase over strategy and plan. This phase over strategy plans a gradual handing over of all the field related activities and necessary skills plan, implement and evaluate MCS programs to the partner NGO Saath and strengthen a team of technical staff capacities right from the beginning.

It is also planned that Saath with assistance from Counterpart would strengthen the community based groups ie CHTs that are majorly involved in the Self Help Groups that are mandated beyond health and take up other developmental activities in the area and are known as Community development Teams (CDTs). However health remains the central focus. These CDTs are then linked strongly with the AMC development activities and form a Confederation of CDTs as a way of empowerment.

E.1. Organizational Sustainability at Community Level

a. <u>CHT Capacity Strengthening</u>

The Jeevan Daan program rests on the firm belief that for a sustainable and lasting impact the program should have a detailed roadmap for strengthening the community based groups and strategically places them in a way that they survive, thrive and become a critical link in the AMC's key developmental activities. The phase over strategy for the sustainability plan to hand over the program activities to the community based groups. In this direction, CHTs were being strengthened and potential CHTs were being identified in the new program area (for details please refer to section A.4). The extended monsoon, which caused substantial water logging and city development projects after the phasing-in caused a great loss of life and property in the slum communities and it took time for people to recover from mental and physical agonies post monsoon. This led to dropouts in several of the CHTs and led to diminished motivation in regards to community based health activities. However, the constant interaction of COs and activities such as Sneh Milan, CHT quizs, involvement of CHTs in WLCC and BCC activities have helped in enhancing motivation and overcome stresses of daily life by offering CHTs social gratification and a feeling of accomplishment.

In addition, activities like WLCC and Sneh Milan are also steps to evolving CHT groups in to Community Development Teams through increasing their scale of operation and increased number of stakeholders to work with. This has helped CHTs understand larger social issues and the inter linkages among these key stakeholders.

<u>CHTs have also been integrated with MCS + activities</u> such as savings, credit and enterprise development. The Jeevan Daan program has facilitated the interface among Saath's savings and credit groups called the Sakhi Mahila Mandal[1]. Sakhi Members presented their last 15 years journey and also shared their lessons learned. The sharing sessions acted as a motivator and also facilitated the evolution of the CHT members into a Community development team. In the coming months such sharing sessions have been planned with CHTs of other wards. Further, the CHT has also been

[1] Group of Voluntary women in Vasna Ward, slum areas who since last 15 years have been working towards their slum development. Sakhi Mandal has emerged as an institution who is operating a Bank in the community, conducting savings and credit activities, conducting health initiatives, and also have a successful livelihood program for the women of the slum communities.

promoted to participate in other NGOs activities, like CHTs of Dudheshwar ward participated in a joint event by AMC and Ahmedabad Red Cross Society.

Drip trainings on Control of Diarrheal Diseases, Pneumonia Case Management, Maternal health and breast-feeding were conducted with the CHT members. A total of 16 drip trainings have been done with the CHT. Besides technical interventions focus has also been placed on cross cutting interventions. In an effort to enhance the new CHT members capacity in community mobilization related issues, during the phasing-in, in the new areas older area CHTs have been involved in jointly conducting group meetings, FGDs and mapping along with the Community Organizers. The practical experience has helped in greater understanding of the different aspects of the crosscutting activities. CHTs have also been given drip trainings on communication related aspects so as to facilitate communication with different stakeholders, especially with Private Practitioners, health facility Staff and Muster Station Staff[2]. These trainings have been mostly add-ons to the trainings given to them in the previous program. More structured training programs are planned for the coming year.

b. Organizational Sustainability for partner NGO-Saath

One of the goals of the Jeevan Daan program is to strengthen the capacity of the local partner NGO Saath in the planning, implementation and evaluation of MCS programs. The programs' sustainability plan has a well-designed stratagem for a smooth exit of counterpart as an implementing partner and through planned transfer of skills to Saath to manage the CS-XX program.

Technical and Crosscutting capacity Strengthening For Saath program Staff

As planned and recommended, program level training on all technical interventions and drip trainings have been conducted for Saath and Counterpart staff jointly. (For details refer to section on capacity strengthening in section A.5)

Joint planning, Supervision and Monitoring

From the beginning of the program in September 2004, Counterpart and Saath teams have been working jointly in planning, managing, monitoring and supervising field based activities. This has led to co-working at all levels and led to on the job skill development. Community organizers of Counterpart worked closely with Community Organizers of Saath during the baseline assessment, phasing in, rapport establishment and in some BCC activities conducted at the field level. The program coordinators from both organizations jointly develop field plans, trainings, conduct joint monitoring visits, and provide supportive feedback for COs during joint monthly meetings. Sharing of technical documents related to the CS-XX programs interventions, cross cutting approaches and strategies and BCC material, learning from larger CS community, etc has lead to cross learning and capacity strengthening and team solidarity.

These developments in mutual capacity strengthening are the steps towards organizational sustainability planned and smooth exit strategy.

E. Issues/ Recommendation raised During DIP Consultation

There were several valuable comments and suggestions from the USAID and other peer reviewers from PVOs, CSTS and USAID Mission in India. The CS-XX program responded to the comments and suggestions and incorporated appropriate changes in the DIP. (Refer for details to the Annexure 3)

[2] Zonal officers of the AMC are responsible for sanitation services. Each zone in Ahmedabad has a Muster(Monitoring) Station from which sanitation is monitored.

F. Indicators: Flexible Fund Guidance for Grantees

Not applicable for the Jeevan Daan program

G. Program Management System

a. Financial Management System

A sound financial management system that has been in the previous program is in place and for the smooth implementation of the program. Fund transfers are made from the HQ on a quarterly basis based on the funds request made by the field office. Partner NGO receives funds from the field office on a quarterly basis. The accounts are sent to the HQ on a monthly basis and "quick Book Pro" software is used to process the accounting procedure. Program Director and Manager Finance has been trained in July 2001 in the Counterpart standard financial and internal control procedure and USAID regulations. Partner NGO accountant is also trained by the Manager Finance in the accounting systems in line with the USAID guidelines.

Annual pipeline analysis is done at the HQ and is shared with the field to maximize the adherence to the planned spending patterns. Annual auditing is done at the HQ for the finance as well as the HR, inventory

b. Human resource

Counterpart has a well-defined HR policy for the field offices and a "personnel manual" has been in place and deployed for guiding the HR policies for the national employees in the program. Annual appraisals for all the staff is done on a participatory manner using the standard "*Employees Performance Tracking Format*".

From the HQ the Director of Health and Child Survival Programs is the main technical and administrative backstopping person for the program. In the field, a line of command and communication system has been created following the "smart management" with clear lines of communication, reporting, supportive supervision, regular timesheet management and smooth systems for material procurement and flow of policy and principle of skills and knowledge management. In addition to this, the program has established monthly General Body Meeting to discuss and address common issues related to admin and finance; weekly Core Management Team meetings to jointly review and update weekly activities and plan for forthcoming weeks. There has been little staff turnover since the cost extension program began with the departure of the HIS Manager to another Country and one Community Organizer went of maternal leave who has been replaced by another Co for the time.

c. Communication System and Team Development

There is a transparent, speedy and efficient communication system in place since the Cost Extension program began. There is day today contact between the field office and the HQ via emails and periodic and as and when necessary through phone. A brief in house team building exercise based on the "appreciative inquiry" and adult learning principles was conducted and also related drip activities are being done as per need and in an on going basis since there is a established system of communication for the field team as well with supportive supervision.

d. Local partner relationship (How is the PVO doing as assessed by the local partners)

(Please refer to Annex. 2 for details)

e. PVO coordination/collaboration in country

There has been excellent PVO coordination in the program in country as well as regionally. Cross visits from Concern Worldwide urban CS project in Bangladesh, World vision team, CRS, Agakhan Project in Maharashtra. Also USAID mission has started a 6 monthly partners meet which is attended by all the health programs running in country and provides a good opportunity for coordination and cross learning from each other project. The Program Director has been encouraged by the Director of Health and Child Survival Programs to attend these meets for collaborative opportunities. So far 3 such meetings have been organized and attended by the Program Director and 2 by the Director of Health and Child Survival Programs, while traveling in the region.

If an organizational capacity assessment of any kind has been conducted during the LOP, including a financial or management audit, described how the PVO program has responded to the findings.

At the project start up a participatory Capacity Strengthening Baseline been conducted to assess and determine the Capacity Strengthening Targets during the LOP. (Refer to the Annexure 7 for details) The program has devised the training and technical assistance plan based on that.

H. Collaboration with USAID

There has been constant collaboration with the USAID local mission in India to contribute towards the strategic objectives of the mission in India under the framework of the CSHGP. This has been continued in the cost extension phase as well. There were two visits by the local mission representatives last year.

DIP Review and Presentation at USAID Mission: A debriefing presentation was made after the DIP review at the mission to seek suggestions and incorporate in the program. Also as discussed in the section: e above Counterpart is an active participant in the USAID meetings and initiatives as it enriches the program technically and gives more opportunity for collaboration and visibility.

I. Timeline of Activities

Mentioned below is a detailed timeline of program activities beginning from October 1 2004 till September 30 2005.

J.1. Program Start Up (Sep 2004- March 2005)

Program Start Up and Planning Meetings: Initial three rounds of meetings were conducted with partners (Saath and AMC) for coming to a common understanding of the program and planning for starting the same	**September-October 2004.**
Program Orientation and design dissemination workshop was conducted with partner NGO Saath	**November 2004**
Recruitment of Community Organizers by Saath who will be the front-runners at the field level for the program and will devote 100% of their time for the cost extension program.	**November 2004**
Finalization of MOU and signed with the partner organization in December 2004. Also an addendum to the existing MOU (2000-2004) was signed with AMC to extend the partnership incorporating the new interventions, strategies and areas.	**December 2004**
Identification of new areas, mapping and contacts with the key community members like local leaders, Medical Officers (UHC) were made	**December 2004**
Detailed baseline assessment including both quantitative (KPC) and qualitative (PUA) methodology	**January to March 2005**
DIP development workshop with Saath and AMC	**March 2005**
DIP Draft Submitted	**April 2005**

J.2. Field based Activities

I. Phasing-in in the New Program Areas

Rapport Building with the community (101 slum clusters), through intensive group meetings, FGDs and individual level meetings	**March-May 2005**
Poster campaign conducted to introduce the community about its various components, objective and also information on the organization partnering.	
Social mapping of all the slum clusters	
Two rounds of meetings with the staff of Urban health Center (UHC) of all the 10 wards was conducted to update and orient regarding the cost extension program and its design. Discussions also included scope of coordination and co-working for quality and access of the health services provided by the AMC	
About 70 Private Practitioner was identified in the program areas and subsequent meetings were conducted to orient them about the program and discuss scope of coordination with them.	
Different stakeholder at field level were identified and through various joint meetings with the partner NGO staff strategy paper defining the level of involvement and scope of coordination of each was developed	
300 potential volunteer Community Health Team (CHT) members were identified	

II. Post Phasing-in Activities

All targeted activities started and regularized at full scale in the program areas (CHT meetings, Household Visits, Health education Sessions, family Counseling, other Behavior Change Communication activities, group meetings, stakeholder meetings.)	**May-Sep 2005**
Post phasing-in the focus has been shifted to strategic and extensive involvement of Stakeholders in program activities as part of addressing the sustainability of the efforts. E.g ICDS Anganwadis is being promoted in the community and being used as central location for conducting activities like group meetings HES and also scope is being identified to integrate approach of PD/Hearth with them	
Extensive CHT strengthening started to evolve them as Community Development Teams who will be the key body in all development aspects of their respective slum clusters	
Additionally, as a strategy youth amongst the communities are being identified who will evolve as a strong group assisting or adding to the cause in coordination with the CHT.	
Process of formation of potential CHT has been initiated in all the new areas.	
For establishing linkages with AMC linkworkers and ICDS Anganwadi NGO, rounds of meetings have been conducted in the entire 10 wards.	
Ward Level Coordination Committee (WLCC), for formalizing coordination for joint planning, sharing, updating progress and discussions of issues at each ward level has been initiated and two rounds of meetings have been held with participation from AMC UHC staff, ICDS Anganwadi Worker and representation from other NGOs at the field level	

J.3. Behavior Change Communication Activities (Oct 2004-Sep 2005)

I. BCC Activities (Phasing-in Period)

Identification of youth group (4) done and first round of BCC trainings to perform BCC activities (puppet show, street plays) initiated	**Oct 2004 - May 2005**
Poster Campaign for introducing the program in the community (new areas)	
Initiation of health Education Sessions and Individual Couseling by trained CHT members of the previous program areas. About 250 CHT members had initiated this activity at their slum pocket level.	
Reprint of the essential IEC materials.	
Infotainment activity like Quiz was done with about 24 CHT so as to assess the level of knowledge and also as an motivational activity	
About 120 youth who have been engaged in the program in promoting hygiene and ORS for diarrheal cases participated in drawing competition**.**	

II. BCC Activities Post Phasing-in

Reprinting of Pamphlets and Posters for mass distribution in slum communities.	**May 2005-**

Mass distribution of BCC materials to all the stakeholders (Private Practitioners, UHC, Anganwadis, Muster Station, TBA, etc)	**Sep 2005**
Round of CHT quiz as an infotainment activity completed with all the CHT of previous program area	
Training of the youth groups (4) has completed and mass level campaign initiated	
For continuation of rapport establishment in the new areas BCC campaign initiated and completed.	
Health education Session using audio-video aids at a mass level started	
Scope for linkages with the local cable network for broadcasting the health education programs have been initiated	

J.4. Capacity Strengthening

Extensive training on qualitative and quantitative research methodologies imparted to the program staff.	**Jan 2005-Sep2005**
Training and drip training on rapport building and community mobilization have been imparted to the program staff	
Training and drip training on all the technical interventions (CDD, PCM, Nutrition and Maternal and New Born Care) have been imparted to the program staff.	
An extensive MIS training focusing on the MIS design for the program, its various tools and methodology for collection of data for action was conducted for the entire program staff	
Training and drip training for the COs for conducting various field level activities (household visit, family counseling, health education sessions, CHT meetings, meetings with different stakeholders, etc) effectively was imparted. The training included role-plays along with practical exposure at field to have a better understanding of the all the components of each activity	
More drip trainings on effective organization of monthly targets were imparted the COs. The training covered ways and methods of planning, prioritizing, following time limits, etc for implementing day-to-day activities at field level.	
Program staff was given exposure to partner NGO's (Saath) other projects (Integrated Slum Development Programs) and jointly discussed the scope of integration of its various components (hygiene and sanitation program, savings and credit program and other livelihood programs) with Cost extension program.	

J.5. Health Monitoring and Information Systems

Based on the proposed HMIS, review and finalization of framework was done	**Nov 2004-Sep 2005**
New software (Visual Basic) for data compilation and analysis has been developed. The new system is more easy to use as its user friendly and runs on all available Window platforms	
Revisions of all field based monitoring formats have been done and are now in place.	
To enhance supportive supervision of field based activities tools for field based performance assessment has been developed which will help the supervisors to strengthen the weak areas and replicate the proven initiatives	
Monthly Joint planning and review meetings with partner have been revised and now in place	
Integration of Ward Level Coordination Committee has been done with AMC's Urban Health Center Coordination meetings. Orientation on the concept of WLCC was given to all the AMC health facility staff and common understanding on the functioning of the WLCC has been laid out.	

J.6. Coordination

Rounds of meetings with AMC/MOH conducted to share program updates and discuss avenues for better coordination with Linkworkers and Anganwadi NGO have been conducted. A formal support letter from AMC/MOH has been circulated to all the Anganwadi and Linkworkers managing NGOs to support the cause of the *Jeevan* Daan Cost extension program.	**May-Sep 2005**

Rounds of meetings have also been conducted with the Ahmedabad city RCH Coordinator to share updates, discussions on WLCC and other field related issues. Such meetings have enhanced the AMC and program coordination at field level.	
Meetings with the MOs (Medical Officer) of the Urban Health Center of all the 10 wards have been conducted to ensure smooth coordination and solving of field related issues	

J. Key Issues, Results or Successes

a. Integration with Saath's ISDP (Integrated Slum Development program)

Saath has been working towards slum development since 1989 with a vision to facilitate participatory and sustainable development processes that would make human settlements equitable living environments, especially for vulnerable groups. To attain this goal, Saath's conceptualized Integrated Slum Development Program (ISDP), which comprises of four, sectors namely, Services, Livelihood, Physical Infrastructure and Community participation and partnerships. The Services sector programs include projects related to health and education, Livelihood, savings and credit and other income generation activities. Physical up-gradation through Slum Networking project (SNP) which includes provision of infrastructure for improvement of hygiene, sanitation, drainage and lightning and over all community empowerment.

Visit to Saath's' Slum Networking project.

Since the slum areas lack basic civic facilities especially hygiene and sanitation, and livelihood options especially for women are very less, Saath recognized the need for integration of approaches for a sustained development process. The Jeevan Daan program has initiated the process of collaborating with Saath's ISDP for over all community development initiatives.

As the first step, the program team underwent a detailed exposure visit to Saath's Slum Networking Program. The SNP's major focus is on development of roads, drainage lines and toilets under 90 X 10 scheme of AMC which is an area of need in the urban slums under the Jeevan Daan program area. The very approach of the SNP is to develop community participation and ownership of the infrastructure created so as it later maintained by the community itself. In the program area awareness regarding SNP has been generated through CHT members and later the group is linked with the SNP coordinators.

b. Hearth- Anganwadi Interface

PD/Hearth and the ICDS Anganwadi program differ in approach but both converge on the objective to address the malnutrition among the children in the communities. ICDS is a food supplementation program to reduce malnutrition whereas the PD/Hearth is a community managed program, where the food is brought through participant contribution from the mothers or caregiver of the malnourished child that is cooked together, ensuring Behavior Change among the

CHT members showing Anganwadi workers the ways to improve the nutritional value of foods with simple techniques.

participant care givers. The interface between the two programs is explored in the CS-XX program to maximize the synergy between the two programs and building upon the existing resource of ICDS and harnessing that more strategically in the community cost extension CS-XX to address the malnutrition. Following are the possible areas of collaboration:

Saath the partner NGO will be responsible for running almost 120 Anganwadis and there is the possibility of exploring ICDS and PD/Hearth interface in the CS-XX. At a pilot basis in the selected 20 Anganwadis of Saath, the core and selected principles of PD/Hearth for example community contribution and ownership and behavior change of the mothers of the malnourished children would be applied for improved cooking, feeding, hygiene and care practices. In these 20 experimental "Anganwadi-Hearth hybrid demonstration model" the community mothers will also be encouraged to bring in their contribution, attend the BCC sessions and participate in the cooking and feeding sessions for at least five days.
The dialogue for the PD/Hearth and Anganwadi interface has begun with Saath and the first step towards it is a detailed training on the PD/Hearth approach to address malnutrition that is planned in December 2005.

c. <u>Kitchen/Hanging Gardens</u>

The Jeevan Daan program has proposed to kick start the growing of hanging garden in at least three slum communities on a pilot basis and based on the success, this will be continued in to remaining target areas. In the urban situation all commodities essential for living have to be purchased because everything is based on a cash economy. Mothers have to buy foods, vegetables and fruits by paying a price and this detours them from buying nutritious foods for themselves and for their children. The concept is being tried in the congested slum setting; the community can grow iron and Vitamin A rich food in hanging pots, old boxes and large containers at home and include it in their diet.

Pots of local herbal plants are growing on rooftops due to space constraint.

A learning needs resource assessment was done and accordingly a TOT was designed. The training was conducted for the COs using demonstrations the training comprised of basic information on local seasonal vegetable crops and their intercultural operations. At the community level the CHT member; youth groups and adolescent girls facilitate the hanging gardens with support form local leaders. Largely and supported by youth groups of the community. The benefits of the Hanging Gardens are that families will not need to buy nutrition rich foods from the market, can include it in their diets, and can exchange them with their neighbors for a different vegetable or fruit. Hanging gardens ensure that families use their organic waste as manure, reducing garbage near their homes and thus reduce infestation off flies and mosquitoes and will increase the green cover in the slums. The program promotes growing vegetables such as pumpkins, bottle gourds, cucumbers, tomatoes, egg plant, chilies, fruits like muskmelon, lemon, greens like, spinach, fenugreek, mustard and medicinal herbs such as Aloe Vera, Tulsi, turmeric, ginger, mint, garlic, ajwain etc.

d. <u>PPTCT workshop</u>

From May 16-20, 2005, the **CORE Group and Counterpart International** held a workshop to field test two draft CORE Group

Palm prints of PPTCT and VCT workshop participants.

guides on '**Community-based programming for prevention of mother-to-child transmission (PMTCT) of HIV, and HIV counseling and testing'**. The workshop took place at Hotel Pride, Ahmedabad, Gujarat, India, with support from the U.S. Agency for International Development (USAID). Twenty-seven nongovernmental organization (NGO) participants attended the workshop, together with two US-based facilitators and nine expert presenters. Thirteen Indian partner organizations were represented.

Technical presentations addressed issues such as the role and function of HIV/AIDS counseling and testing centers and strategies for PMTCT; the value and quality of pre- and post-test counseling; infant feeding options in the post-natal period; and legal and ethical issues related to community-level HIV/AIDS programs. Participants also took part in field visits that included one-on-one sharing with HIV-positive clients. The workshop provided participants an opportunity to study the CORE Group field guides, and to discuss ways to tailor the guides for local use in Indian communities.

Participants agreed early in the workshop to use the term "prevention of parent-to-child transmission" of HIV, or PPTCT, in place of PMTCT, to correspond to changes in Indian national HIV/AIDS .

Counterpart India subsequently launched a new web site to promote collaboration among workshop participants.

The workshop received wide media coverage in newspapers, television and radio outlets. The Gujarati daily *Divya Bhaskar* interviewed Darshana Vyas, Dr. Amarjit Singh and Dr. Saxena about government interventions to reduce and prevent the spread of HIV/AIDS, and the purpose of the workshop. Similarly, ETV Gujarati telecast proceedings from the workshop during its evening newscast.

For its web-based news service aimed at non-resident Indians, Voice of America interviewed facilitators Darshana Vyas and Phil Moses, and two workshop participants. The *Indian Express* (an English language daily) covered the workshop for its May 17, 2005 edition; another English language daily, *Asian Age*, ran a story about the workshop in its May 20, 2005.

E.1. Summary of the Baseline and other Assessments

A. Program Site Information

Background

In the year of 2000 Counterpart International received a grant under the CSHGP funding from the USAID to implement a **CS-XVI** (CS) program in Ahmedabad, Gujarat, India in partnership with Ahmedabad Municipal Corporation[1] and partner NGO Sanchetana. **The Jeevan Daan Child Survival Program 2000-2004 (CS-XVI Please use this everywhere)** funded by USAID/ GHDN began implementation in October 2000 covering 6 out of the 43 Municipal wards in Ahmedabad city. The program covered a slum population of approximately 177,400 and included the four key technical interventions of Control of Diarrheal Diseases, Pneumonia Case Management, Nutrition and Immunization.

Based on the successful and proven strategies of the ***CS-XVI*** program, and with respect to; a) the unmet maternal and child health needs of the slum population, 2) Community's demand and; c) prioritized by the Ahmedabad Municipal Corporation, Counterpart International proposed a Cost Extension program for the period of 2004-2009 with Local NGO Partner Saath and Ahmedabad Municipal Corporation and adding Maternal and New born Care as a technical intervention. For the cost extension program it was proposed to phase-in in the additional needy slums located in the other four adjoining wards of Ahmedabad to scale up to cover a population of **324,235.** The proposal has been awarded for funding for five years, with the period of implementation being October 2004 to September 2009.

Program Location

The ***Jeevan Daan*** **Maternal and Child Survival Cost Extension Program 2004-2009 (CS-XX)** is being implemented in ten wards: Raikad, Jamalpur, Raipur, Dudheshwar, Saraspur, Bapunagar, Danilimda, Vasna, Maninagar and Kankaria. (program map: Annexure 5). There is almost a 83% increase in the population (324235) and target beneficiaries from the additional five new wards as compared to the CS-XVI Program..These additional neighborhood slums/program areas have been selected on the basis of the priority recommendation by the Ahmedabad Municipal Corporation and the CS-XVI Program's Technical Advisory Committee, recommendations of the NGO partners, and by in-depth consultations with the community leaders. The additional wards are also in close proximity to the current program area and the CHT members and local leaders of the current program have offered local support, and work related participation in the new program areas. These selected slums have similar characteristics in terms of languages, cultural beliefs and other infrastructures to the CS-XVI program areas.

The CS-XX Program area has a total population of 324,235 including 213,069 of total beneficiaries (children <5 and WRA) of which approximately 58,362 children under fiveand approximately 84,301 women of reproductive age in the CS-XX Cost Extension Program area. As each year brings a new cohort of infants, there will be an additional 58,362 children over five years. Likewise an additional 12,043 women of

[1] The Ahmedabad Municipal Corporation, the local institution of self-government for Ahmedabad city, is responsible for the provision of health and hygiene services. It provides health care in the form of preventive and promotive services, curative services, medical education, and other services including the registration of births and deaths.

reproductive age will enter the cohort during the five years of the CS-XX Cost Extension Program. The CS-XX Cost Extension Program is expected to serve, therefore, 116,724 children and 96,344 women of reproductive age.

Details of the population covered under the *Jeevan Daan* Maternal and Child Survival Cost Extension Program (CS-XX)[2]

Sr. No.	Municipal Wards	Population/JDCSP 2000-04	Population JDMCS Cost Extension Program 2004-09	Children <5 years; JDMCS Cost Extension Program		WRA; JDMCS Cost Extension Program		Total Beneficiaries; WRA & Children < 5 served during LOP; JDMCS Cost Extension Program
				Current Estimate	Estimated addition During LOP	Current Estimate	Estimated addtion During LOP	
	OLD AREAS							
1	Danilimda	41300	**38850**	6993	6993	10101	1443	**25530**
2	Raikhad	25500	**36125**	6503	6503	9393	1342	**23739**
3	Raipur	3000	**2125**	383	383	553	79	**1396**
4	Jamalpur	15000	**21860**	3935	3935	5684	812	**14365**
5	Dudheshwar	37600	**49920**	8986	8986	12979	1854	**32805**
	NEW AREAS							
6	Vasna	-	**65000**	11700	11700	16900	2414	**42714**
7	Bapunagar	-	**24415**	4395	4395	6348	907	**16044**
8	Saraspur	-	**32670**	5881	5881	8494	1213	**21469**
9	Kankaria	-	**29710**	5348	5348	7725	1104	**19524**
10	Maninagar	-	**23560**	4241	4241	6126	875	**15482**
	TOTAL	**122400**	**324235**	**58362**	**58362**	**84301**	**12043**	**213069**

Gujarat State, located in the western part of India, occupies approximately 6% of India's total area (or 196,000 km^2) and ranks seventh in area and tenth in population among all the states of India[3]. According to the 2001 census[4], the population of Gujarat is 50,596,992. Approximately 40% of the total population lives in urban areas.

[2] The program uses the formula that is used by the AMC to determine the health needs of the city and calculate the target beneficiaries for the program. The number of children below 5 years is calculated as 18% of the total population and the each year new cohorts join the program and the number of each year new cohorts is calculated as 1/5 of the total population of children under 5. Similarly number the women of reproductive age (WRA) is determined as 26% of the total; population and the each year new cohorts is estimated at 1/35 of the total number of WRA.

[3] Registrar, General and Census Commissioner of India, New Delhi.

[4] Census of India 2001,*Totals*, Gujarat

Ahmedabad is the seventh largest city in India and is home to the second largest textile industry in India. The city has an area of 190.15 sq. km and has well-developed commercial and industrial centers. The population of urban Ahmedabad[5] is 3,515,361 making it one of the most densely populated cities in the state. Since Ahmedabad is an industrial city, people migrated to the city in search of employment from other states including Uttar Pradesh, Bihar, Rajasthan, Karnataka and West Bengal. There is a Hindu majority with a substantial Muslim minority. The over all work-force in the city is 30.43%, out of which 51.01% is of males and 7.17% is of females. The figures will be high if only slum situation is considered. The population of the city has grown by an average of 37.6% every decade since 1901, mainly due to continuous immigration.

Ahmedabad city has 2,432 slum pockets, with a population of over 1.5 million. Slums, as defined by the United Nations Development Programme, are *"Buildings, groups of buildings, or areas characterized by overcrowding, deteriorating, unsanitary conditions or the absence of facilities or amenities, which because of these conditions endanger the health, safety or morals of its inhabitants or the community."* Local conditions however, should be taken into account while defining 'Slums', as this term needs to be defined in the context of the general economic and housing conditions in the area. When large populations are residing in hut-like structures in urban areas, care has to be taken to identify the areas where conditions are relatively poor, and in greater need for community-based interventions. The Ahmedabad Municipal Corporation defines *Slums* as any structure that meets the following three criteria[6]:

1. It should be an unauthorized construction on a government, municipal or private plot.
2. It should be devoid of basic civic amenities (i.e. water supply, drainage, water closets, etc.)
3. It should not be in accordance with the building bylaws of the Municipal Corporation (such as the required plinth level and room size, etc.)

In addition to these types of housing, a *Chawl* is another form of structure, which has been identified as a slum by the Municipal Corporation. A *Chawl* is generally defined as a row of rooms with no individual sanitary conveniences or adequate community facilities. *Chawls* were originally constructed for housing textile labor. Over a period of years, condition in many of these *Chawls* have become as bad as in the slums, due to over-population and a lack of basic services. These *Chawls* do have some basic infrastructural services, such as water supply and community latrines, but they are generally inadequate. The community latrines are not sufficient to meet the needs of the current population in the *Chawls*, which is more than three times greater than the population when the *Chawls* were originally constructed. In addition, the condition of public facilities has deteriorated to the extent that many public toilets cannot be used. The community and *Chawl* owners rarely provide the necessary funding for maintenance of these facilities, leading to deteriorating conditions and health problems in many *Chawls*. Therefore, for the purpose of health programs, most *Chawls* should also be included in the definition of urban slums. Both categories of people living in huts and *Chawls* are therefore, identified as urban poor. It is estimated that 1.19 million people have been living in these huts and *Chawls*.

[5] Urban Reproductive and Child Health and Primary Care Project in the city of Ahmedabad, Gujarat, India. August 2003 and as per the 2001 Census

[6] Urban Reproductive and Child Health and Primary Care Project in the city of Ahmedabad, Gujarat, India. August 2003

The city of Ahmedabad has 697,869 dwelling units of which 175,447 units are situated in 1023 slum pockets having an estimated population of 824,601 people. Similarly, the city has 1409 *Chawls* having 154,199 dwelling units and an estimated population of 724,735 people. The population of slums and *Chawls* put together is 1,549,342, which forms 45% of the population of the city. This is the most vulnerable group of the society needing special attention[7]. Most of the slums do not have adequate drinking water facilities, health care infrastructure, or wastewater and sewage disposal systems. Diversity in culture, caste, and traditions is present in all the proposed slum pockets with respect to customs, traditions, languages, dialects, religions, and eating habits.

Ahmedabad has been divided into five zones, namely the South zone, East zone, West zone, North zone and Central zone. For administrative effectiveness and better management of the city, it has been further divided into 43 administrative units called Municipal Election Wards, on the basis of population; with a population range of 80,000 to 90,000 per ward. The CS-XVI program was being implemented in the slums (including hutments and *Chawls*) of six such municipal wards belonging to the South and Central zones; *Baherampura*[8] and *Danilimda* wards forming a part of the South zone, whereas *Raikhad, Raipur, Jamalpur* and *Dudheshwar* belonging to the Central zone. Under the CS-XX program, out of the five new wards added; *Bapunagar* and *Saraspur* form a part of the Central Zone, *Vasna* form part of West Zone, whereas *Kankariya* and *Maninagar* form a part of the South Zone.

The civic affairs of the city are governed by the Ahmedabad Municipal Corporation; a statutory local self-government body, deriving authority from the provisions of the *Bombay Provincial Municipal Corporation Act, 1949*. Apart from providing basic civic amenities to the people such as water supply, wastewater disposal, collection and disposal of waste, construction and maintenance of roads, provision of street lights etc., Ahmedabad Municipal Corporation provides several other services to the urban poor such as schools for primary education, city transport, construction and maintenance of public hospitals and dispensaries, medical services and medical education through teaching hospitals and undergraduate and postgraduate medical colleges and other programs for public medical relief. The demographic profile of women and children in India, Gujarat and Ahmedabad is described in more detail in the table below:

Table 2: Demographic Profile of Gujarat and India[9]

Indicators	**Gujarat**	**India**
Population (2001) in million	50.6	1027
Adolescent population (10-19 years) (%), 2001	22.0	21.5
Elderly population (60+ years) (in crore)	0.48	10.00
Decadal growth rate 1991-2001	22.66	21.34
Sex ratio	920	933

[7] Urban Reproductive and Child Health and Primary Care Project in the city of Ahmedabad, Gujarat, India. August 2003 and as per the 2001 Census

[8] Baherampura has been phased out from CS-XX, please see Revision from original draft chapter for details.

[9] ***Directorate of Economics & Statistics of respective State Governments (As on March 26, 2004), Ministry of Health and Family Welfare, Govt. of India***

Indicators	Gujarat	India
Population density	258	324
Urban percent	37.36	27.8
Proportion of child population to percent of 0-6 years of total population	14.19	15.42
Literacy rate	69.97	65.37
Male	80.50	75.85
Females	58.60	54.16
Percent of Scheduled Caste (2001)	7.09	
Percent of Scheduled Tribes (2001)	14.76	
Work participation (Total)	40.20	
Male	52.57	
Female	26.75	
Birth rate (SRS 2002)	24.6	25.0
Rural	26.5	26.6
Urban	20.5	19.9
Death rate (Total)	7.6	8.1
Rural	8.3	8.7
Urban	6.3	6.1
Infant morality rate (Total)	60	64
Rural	68	69
Urban	37	40

Table 3: Comparative demographic and Health profile on women and children in India, Gujarat and Ahmedabad[10]

Parameter / Indicator	India	Gujarat	Ahmedabad Municipal Corporation (all Municipal Wards)
Area	11,95,600 sq. km	1,96,000 sq. km	190.15 sq. km
Total population Male Female	1,027,015,247 531,277,078 495,738,169	50,596,992 26,344,053 24,252,939	3,515,361 1,863,886 1,651,475
Density (per sq. km)	324	258	18,488
Total number of districts	593	25	1

[10] Census of India 2001, Gujarat, and Statistical Department, Ahmedabad Municipal Corporation.

Parameter / Indicator	India	Gujarat	Ahmedabad Municipal Corporation (all Municipal Wards)
Literacy[11] rate Persons Male Female	65.38 75.85 54.16	69.97 80.50 58.60	83.03 89.27 76.10
Population 0-6 years Total Male Female	15.42% 15.47% 15.36%	14.19% 14.51% 13.85%	11.63% 12.24% 10.94%
Sex Ratio (No. of females per 1000 males)	933	921	886
Number of women of reproductive age (15-45 years old)	46.4%	48.8%	48.8%
Crude Birth Rate	26.1	25.5	21.9
Infant Mortality Rate per 1000 live births	73	63	64
Maternal Mortality Rate per 100,000 live births	45	39	14

Literacy for women aged 15-49 was 48.7% in 1998-99 in Gujarat State according to the Macro International, Inc. India NFHS, 1998-1999, whereas it was 59% according to the Census of India 2001, Gujarat, and Statistical Department, Ahmedabad Municipal Corporation. Women's literacy was lower (32.9%)[12] in Ahmedabad's urban slums, with generally lower rates for women married at a younger age. Unemployment is high in the proposed target slums and the majority of the population lives below the poverty line, with a per capita income estimated to be $272, which is much lower than that for the state of Gujarat at $487[13]. Most of the residents are engaged in unskilled labor such as vending, burrow pulling, and flower and vegetable selling, whereas the daily laborers mainly work in factories, in construction and as garage mechanic operators with low incomes. The majority of the women are engaged in home-based activities such as quilt making, garlic peeling, kite making, embroidering, incense-stick making, the selling of vegetables and Rakhi, or they work as maidservants or as construction workers.

[11] A literate as defined by The Census of India, *"A person who can read and write in any language is literate. A person who can merely read but cannot write is not literate. It is not necessary that the person should have received any formal education or should have passed any minimum educational standard."*

[12] Sample registration System Bulletin, Registrar General of India, 2001.

[13] Source: Directorate of Economics & Statistics of respective State Governments (As on March 26, 2004), Ministry of Health and Family Welfare, Govt. of India; Rs. 21276 equal to $487 @ 1USD = Rs. 43.70

Health Status in the *Jeevan Daan* Maternal and Child Survival Cost Extension Program (CS-XX) Area

Though the Ahmedabad City Corporation has a wide network of health and medical services[14], it still has a high prevalence of infant and maternal mortality rates, high fertility rate and high morbidity and mortality due to communicable diseases. Declining infant and maternal mortality rates, increasing life expectancy at birth and gradual diminishing of fertility rates are some of the highlights of the recent years, but the pace of improvement is slow and the growing population is nullifying the achievements. The slum population is increasing rapidly in Ahmedabad and glaring inequality is seen between the services available to the privileged elite and the underprivileged slum dwellers. A lot is therefore required to be done to reduce the inequality. The basic health services and essential services have not reached the urban poor to the desired extent. Concentrated efforts, backed by adequate funds and technical support are essential to reach the goal.

Overview of the on Ministry of Health and Family Welfare, India's Maternal and Child Health Services in Gujarat and India

In continuum to the Reproductive and Child Health Phase 1, is the implementation of RCH 2 that is now being implemented in the state. Earlier in the RCH phase 1, the focus was mainly on the rural areas, but with the RCH phase 2 project since April 2004, there has been a renewed focus on urban slums for all towns having a population of more than 50,000[15]

Nutrition services for children under six and pregnant and lactating mothers are provided under the Integrated Child Development Scheme (ICDS). Currently there are 88 ICDS Anganwadi[16] Centers in the CS-XX program area, staffed with one Anganwadi worker each. Earlier under the CS-XVI program, there were only 21 Anganwadis in the program area, when the program began in October 2000, and most of them stopped functioning during the first year of program implementation due to administrative and budgetary problems. Since April 2004, the ICDS has made renewed efforts to start Anganwadis in all slum areas, and has plans to initiate 900 Anganwadis in the city of Ahmedabad, 200 out of which are planned in the CS-XX program area. Each center functions as a part-time day care facility as well as a nutrition resource center providing health education and supplementary, locally available food. The AWWs are responsible for screening growth-faltering children and providing nutritional supplementation. AWWs also assist the ANMs and MHWs in providing immunization services.

Women and Child Health and Family Welfare Services in Ahmedabad and in the *Jeevan Daan* Maternal and Child Survival Cost Extension Program (CS-XX) area

The health facilities of the Ahmedabad Municipal Corporation are classified into three categories based on the level of health care services that they provide. Primary health care

[14] The entire paragraph has been adapted from the Report *"Urban Reproductive and Child Health and Primary Care Project in the city of Ahmedabad, Gujarat, India*, August 2003".

[15] State Program Implementation Plan, Reproductive and Child Health 2, Department of Health and Family Welfare, Government of Gujarat, January 2005

[16] The ICDS was launched in 1975 to provide an integrated package of services for holistic development of the child including early childhood care, nutritional supplementation, and early stimulation, micronutrient supplementation like Vitamin A, Iron Folic Acid, ORS promotion and hygiene promotion. This central government funded program has been reinitiated in Gujarat in a massive scale from 2004 by the setting up of Anganwadi centers in urban slums in Ahmedabad. The Anganwadi centers are run through NGOs, who provide either cooked foods or food supplies that are cooked at the center.

services are provided through Urban Health Centers, which are present in each of the 43 municipal wards and Maternity Homes, which are currently 10 in the city of Ahmedabad. The secondary-level health facilities are generally better equipped, and include Referral Hospitals and General Hospitals. Currently there are 4 Referral hospitals and 3 General hospitals in Ahmedabad. Specialized hospitals form the tertiary level of health care, and cater to specific health care requirements, such as curative care for TB, malaria, and other infectious diseases, eye hospital etc. Currently there are 3 specialized hospitals in Ahmedabad; one TB Hospital, one Infectious Disease Hospital and one Eye Hospital. The secondary and tertiary level facilities are intended to provide services for the entire population of Ahmedabad.

Table 4: Health Facilities in the *Jeevan Daan* Maternal and Child Survival Cost Extension Program (CS-XX) area

Sr. No.	Type of AMC Health Facility	Total No. in the *Jeevan Daan* Maternal and Child Survival Cost Extension Program area	Municipal Ward name where the facility is located
1.	Urban Health Centers	10	All wards
2.	Maternity Homes	4	Danilimda, Maninagar, Saraspur, Dudheshwar
3.	Referral Hospital	1	Behrampura
4.	General Hospital	2	Maninagar, Saraspur
5.	Specialized Hospital: Infectious Disease Hospital	1	Behrampura

Primary Health Care Services delivered through the Urban Health Centers (UHCs): These are the first point of contact for primary health care in the urban areas. There are 43 UHCs in Ahmedabad City, of which 10 are in the CS-XX program area. They provide reproductive and child health and family welfare services including registration of births and deaths, registration of eligible couples, registration of antenatal mother, organization of antenatal clinics and antenatal care, distribution of IFA tablets to pregnant women and children and also to malnourished children through ICDS anganwadis, postpartum care of women and neonatal care of children, children immunization, etc. They also provide medical services like active and passive surveillance of fever cases, general out patient department (OPD), special management of diarrhea, ARI/ pneumonia and fever/ malaria cases. UHCs also provide outreach services to the urban slum areas, primarily for vaccination and family welfare services.

The following personnel staff the in each of the 43 UHCs:

- A Medical Officer (MO), with overall responsibility for the UHC; conducts general O.P.D. clinic and provide family welfare and RCH services to the population covered under the urban health centre
- A Lady Health Visitor/ Health Supervisor, who supervises Multipurpose Workers, assists in minor operations, supervises in/outpatient clinics, compiles local health data, supervises and guide the health workers in the delivery of RCH and Health Care Services to the community;

- 4-5 Multipurpose workers, who assists principally in pregnant women and children immunization and delivery of reproductive and child health to the population covered;
- 15-18 Link Workers; Each Link worker covers a population of almost 2000 residing in his/her own as well as the adjoining slum communities. The key function of the link workers is to increase the outreach of the Urban Health Centers and ensure that the entire slum population in that ward is covered and registered for all health services delivered through that health center.

Overview of the Women and Child Health Status in the *Jeevan Daan* Maternal and Child Survival Cost Extension Program (CS-XX) Area

According to the 1998-1999 NFHS/DHS, the under-five mortality rate for India is 94.9 and urban Gujarat is 68.5 of which 28.8% deaths occur within the first year and 19.3% within the first month. It is note worthy that the NFHS/DHS data largely provides data of the entire urban population, whereas the situation in the urban slums is more stark and pronounced and is not reflected in the overall figure. The under-five mortality rate for Gujarat State is 85, compared to 101 nationally from Gujarat Institute of Development and Research. The IMR of Gujarat state is 64[17], while as per the UNDP formula (i.e. mortality in the urban slum are 1.8 times than that of the overall IMR) the IMR of targeted slums id estimated to be 115.2, which is quite high.

According to the State Program Implementation Plan, Reproductive and Child Health 2, Department of Health and Family Welfare, Government of Gujarat, January 2005; 48% of children less than 5 years in Ahmedabad district had Pneumonia as per the data available from the district level household survey conducted at the end of RCH Phase 1 in 2002-2003, 30% of the children had diarrhea and only 1.3% of these children were given ORS. Thus, major Cause of child mortality and morbidity in the slum areas is due to Diarrhea and Pneumonia. Poor sanitation and lack of access to clean drinking water further adds to cause of child mortality and morbidity.

Inadequate and contaminated water supplies, poor sanitation, and sewage disposal lead to outbreaks of dysentery, and diarrhea. Low levels of literacy and cultural and traditional beliefs/behaviors contribute to poor preventive and care-seeking behaviors. The primary causes of under-five mortality in the urban slums are poor neonatal care, diarrheal disease, and respiratory infections (including pneumonia), followed by measles. Pneumonia is the leading cause of death among children under five, according to the AMC/MoH. A study conducted by the AMC showed that diarrhea accounted for 20% of child deaths in the urban slums.

Malnutrition and Anemia: 1998-1999 NFHS/DHS indicates that in Gujarat State, the extent of malnutrition is 45%, among children less than 3 years of age, only including severe and moderate degrees of malnutrition 37.0% mothers have low body mass index, and 19.9% babies born have low birth weights. Only 36.6% of infants are breastfed within one day of birth, and 10.1% of infants are breastfed within one hour of birth and the KPC baseline survey indicates, only 24.7% of mothers breastfeed their child within the first hour of delivery in the program area. These figures are lower than the national average. In addition, 61.1% of mothers do not feed their child the first milk from the breast, and only 46.5% of children 6-9 months receive appropriate complementary foods as well as

[17] NFHS 1999

breast milk.[18] Malnutrition under 2 years, in the targeted slums according to weight for age[19] was 46%, 23.3% children were mildly, 4.0% moderately and 8.7% severely malnourished.

Complementary feeding is delayed often until nine to twelve months of age. Children in families with six or more children are most disadvantaged in terms of nutrition, and children born after a short birth interval are more likely than other children to be stunted or underweight. Anemia among urban women is 39.5% and 50.4% children aged 6-35 months suffer from moderate or severe anemia (NFHS 1998-99). Similar results have emerged from FGDs conducted, with women, TBAs and mother in laws in the new proposed slum areas, revealing that anemia was high among women and adolescent girls.

According to the State Program Implementation Plan, Reproductive and Child Health 2 (RCH 2), Department of Health and Family Welfare, Government of Gujarat, January 2005; Percentage of women seeking three Ante Natal Care checkups in Ahmedabad district is 47.1% as per the data available from the district level household survey conducted at the end of RCH Phase 1 in 2002-2003. Furthermore, as per the same report, for the Gujarat state, percentage of women undergoing complete Antenatal Care, including 3 ANC Checkups, at least one TT injection and 100 or more IFA Tablets is 23%.

The reports also states that as far as institutional delivery is concerned for the state of Gujarat, the utilization of public facilities was only 13% while in 44% of cases the child was delivered in a private facility. Regarding maternal morbidity, 19% of the women reported of post delivery complication, 42% mentioned of delivery complication and 32% reported pregnancy complication.

However, the number of registered pregnant women having completed the course of IFA tablets was 83% in urban Ahmedabad[20] indicating an increase in access to iron supplementation. Recurrent bouts of diarrhea and ARI combined with poor food availability and poor child feeding practices lead to high levels of malnutrition. The growth monitoring data from the CS-XVI program indicates that girls are 35% more likely to be malnourished than boys. A strong gender bias against girls leads to high levels of female malnutrition leading to maternal malnutrition and anemia that ultimately contribute to a significant number of low birth weight babies.

The CS-XVI program baseline (KPC) January 2001 in the intervention area, found only 29% of children between 12-23 months were fully immunized (based on cards), and only 11% had received measles vaccination. There was 55% coverage at the MTE. The EPI and the Polio Plus programs have created broader awareness of the need for EPI in communities, but immunization rates should be higher. In the 2 weeks preceding the CS-XVI program baseline KPC, 37% of children 0-23 months old had diarrhea. Of these, only 18% of children with diarrhea received some form of ORT. Mothers of 22% of the children reported signs of rapid and difficult breathing in the 2 weeks prior to the BL survey. Only over half (54%) of the mothers could name two danger signs indicating a child with acute respiratory infection required immediate care.

[18] NFHS 1998-1999
[19] *Jeevan Daan* Child Survival Program –Growth Monitoring data-KPC survey July 2003.
[20] Consolidated Monthly Report. AMC , March 2003.

B. Types And Methodology Of The Baseline Assessment

The baseline assessments comprised of both quantitative as well as qualitative data collection. Under Quantitative assessment Knowledge Practice Survey (KPC) and a part of Health Facility Assessment (supplies and equipments) were carried out and under qualitative assessment tools like focus group discussions (FGD), key informant interview (KII), mappings, Preference ranking, force field analysis and doer and non-doer analysis were carried out for data collection.

1. Knowledge Practice and Coverage (KPC) Survey

A. Background

The prime objective of baseline KPC Survey was to ascertain existing levels of knowledge, practices, and coverage of health services in Maternal and New born care, Diarrheal diseases, Acute Respiratory Infection/Pneumonia, Nutrition and Immunization, since these are specific intervention areas that are of most interest to the program and the AMC. The findings of the survey are then used to conceptualize program design, implementation, monitoring and evaluation. The baseline survey process has also been focused to enhance the capacity of local program and partner NGO Saath staff to collect, analyze, and use data for decision making. In addition, the KPC survey process helped build consensus between Counterpart, Saath, the AMC/MOH, and other stakeholders in terms of health programming priorities for the ten Municipal wards that comprise the program area.

B. Objectives of the KPC Survey: Quantitative assessment for the Jeevan Daan Maternal and Child Survival Cost Extension Program (CS-XX)

The four main goals of the KPC survey were:

(1) To strengthen Counterpart/India's and Saath's capacity to collect, analyze and use KPC information for decision making in the future.

(2) To gather baseline data on the CS-XX program indicators, this data will be of interest to stakeholders and serve as a point of reference for measuring change during the final evaluation. This data will also allow Counterpart and Saath to identify and prioritize problems in the program area.

(3) To gather information on mothers' knowledge and practices for use in developing educational messages especially for the new intervention of Maternal and Newborn Care and for modifying intervention strategies.

(4) To help build consensus between Counterpart, Saath, the AMC/ MOH, and other stakeholders in terms of health programming priorities for the urban slums in the 10 AMC wards that comprise the CS-XX program area.

B. Survey Methodology

1. Questionnaire Development

Under the CS-XVI program, between October 2000 to September 2004, full-scale KPC Survey was carried out thrice, once each during the Baseline, Midterm and Final

Evaluations. Additionally Rapid KPC Surveys were carried out twice. The KPC questionnaire was thus pre-tested for the correctness of local verbatim and phrasing of the questions for all the questions on the technical interventions of Pneumonia Case Management, Control of Diarrheal Diseases, Nutrition and Immunization as well as for the Rapid CATCH section covered under the *CS-XVI* program. Counterpart has in-house expertise to carry out large survey including KPC.

For the KPC questionnaire to be developed for the Baseline KPC survey of the CS-XX program, the generic KPC 2000+ and RapidCATCH questionnaire developed by CSTS were modified and used as part of the final assessments of the CS-XVI program and were used as a starting point. The CS-XX program proposal and indicators were used to modify this basic format. The modules that were included in the questionnaire design were:

1. The informed consent and cover page;
2. Child spacing table (from the RapidCATCH);
3. Questions on Prenatal care
4. Place of delivery and delivery attendants/ delivery practices
5. Questions on post-partum care
6. Questions on breastfeeding and nutrition;
7. Sick child questions;
8. Questions on diarrhea management;
9. Questions on ORS preparation;
10. Questions on ARI management;
11. Questions on immunizations; and
12. Questions on growth monitoring;
13. Other RapidCATCH questions on use of mosquito nets and knowledge of AIDS prevention;
14. Questions on prevention of diarrhea (hand washing and hand washing station observation);

Out of all the above modules, except for Maternal and Newborn Care (3,4,5) the other sections have been used in the questionnaire and pre-tested at least thrice in the baseline, midterm and final evaluation KPC Survey of the CS-XVI program. Hence all these sections have been put in the current KPC Questionnaire for the CS-XX program without any modifications.

2. Core KPC Survey Team

The Core Team for the KPC survey for the baseline survey of the CS-XX program was led by the India office staff Mr. Ramesh Kumar Singh program director, Jaydeep Mashruwala monitoring and evaluation specialist form India office and Counterpart Headquarters' India Program Backstop Ms. Darshana Vyas, Director of Health and Child Survival Programs, who provided technical guidance and backstopping for the KPC survey including pre-KPC preparations, Questionnaire review and finalization, Training, Data collection, Data Analysis and the finalization of the Baseline KPC Survey Report. Other members in the KPC Core Team from Counterpart India included Program Director, Health Information Systems Manager, Health Education Specialist, and Program Coordinator and the Field Coordinator from the partner NGO Saath. The Core Team was involved in the **Pre-KPC preparations** from January 5 to January 29, 2005. The core team was also responsible for conducting the KPC training, selecting the Field Data Collection Coordinators and Database Management Coordinators.

3. Questionnaire review

Once the draft questionnaire was prepared, it was sent for review to an external consultant Dr. Arvind Kasthuri[21] and to Counterpart HQ Director of Health and Child Survival Programs, Ms. Darshana Vyas[22] to seek their suggestions. Dr. Arvind Kasthuri provided his suggestions through email, whereas Ms. Darshana Vyas provided her suggestions question by question over a series of conference calls from Counterpart HQ in Washington DC. Ms. Vyas provided her suggestions in two stages; STAGE 1: First round of basic suggestions, after which the questionnaire was pre-tested in non-program areas where the KPC survey data collection was not supposed to take place; STAGE 2: After incorporating the changes arising out of the field pretest, finally reviewing the questionnaire to finalize it. Both the reviewers provided their suggestions especially on the following aspects:

1) Review the draft questionnaire and Provide technical guidance for the development and finalization of the Questionnaire for the Baseline CS-XX program KPC Survey

2) Correct sequencing of the questions, especially for the initial three sections on **pre-natal care, place of delivery and delivery practices, and post-partum care.** Also suggestions about the overall sequencing of the other sections and questions within the other sections, in general.

3) Correct again, specially for these three MNC sections, correctness about the phrasing of the questions, use of local lingo that is understood by the primary target audience without changing the meaning of the question, coding categories as per the Indian context, and if there is a need to further add/modify a few questions.

Once the questionnaire was reviewed, it was translated from English to Gujarati and then again back translated to English to ensure accuracy and ensure that the meaning of the questions asked did not change during the translation. The final questionnaire was administered in Gujarati due to the fact that all of the respondents in the targeted slums spoke Gujarati.

4. Personnel for the KPC Survey

To carry out the survey a total of 10 survey teams were formed; each team having three people, one Supervisor and two Investigators. The investigators for the survey were externally selected whereas the supervisors were the Community Organizers of Counterpart and Saath. The 22 external investigators were graduates, well conversant with

[21] Dr. Arvind Kasthuri, MBBS, MD and Professor St. John's Medical College, Bangalore, India; has carried out the KPC Survey twice for the *Jeevan Daan* CS Program; during the Rapid Impact Assessments in October 2002 and for the Final Evaluations in June 2004.

[22] Ms. Darshana Vyas, MSW, MPH has more than 22 years of experience in the are of Women and Child Health in various countries including India and has been the principal Backstopping person for the Jeevan Daan CS XVI Program as well as for the Jeevan Daan Maternal and Child Survival Cost Extension Program. She is well acquainted with the local verbatim and phrases used by the primary target audience (Women of reproductive age) living in the slums where the Jeevan Daan Maternal and Child Survival Cost Extension Program is being implemented for the various women and child health issues and has from time to time provided guidance for the development of the KPC questionnaires during the Baseline, Midterm and Final Evaluation of the Jeevan Daan CS XVI Program.

the local Gujarati language, and all of them had prior experience of working some of them working with the research institutions and NGO in slums for more than 1 year. Six out of the ten supervisors had a prior experience of participating in at least two KPC surveys as a part of the CS-XVI program between January 2001 to June 2004 as investigators as well as supervisors and were acquainted with the process in totality.

5. Pre-testing of questionnaire

The questionnaire was pre-tested in select non-program field areas, for a period of three days from January 17-19, 2005 and a few changes were made in the phrasing of the questions, in a way that was more clearly understood by the community. Final copies of the survey questionnaire in both English and Gujarati can be found in KPC document Annexures. Once the questionnaire was finalized, the related programs and software for the database management of the data generated through the survey were prepared.

6. Sampling

Although Census lists exist in the CS-XX program area, their completeness and whether they are up-to-date or not cannot be assured. For the same reason all the KPC Surveys carried out for the CS-XVI program used the 30-cluster sample survey methodology. This survey, therefore, also followed the 30-cluster sample survey method in which the population is organized into "clusters" and several individuals within each cluster are selected to reach the required sample size. The population covered under the CS-XX program is divided into ***Slum Clusters***, with the smallest definable unit being taken as the slum pockets. The urban slum pockets are groups of houses, which are present within a geographically definable boundary, which are in some cases as small as even 50 houses (approximately 250 people) and in some cases as large as 1000 houses (approximately 5000 people). If the smallest definable unit is taken as one slum pocket, then at times it becomes difficult to find ten households within such slum pockets, which have children less than 2 years for the survey. For this reason, the slum pockets that are located in geographical proximity to each other are clubbed to form a slum cluster. In the slum clusters thus formed there is a sizeable population within these units making it possible to select 10 children less then two years from within one slum cluster. Care is taken to avoid the grouping of such slum pockets within one cluster that have significantly different behaviors and practices, and which belong to different socio-economic strata of the society.

There are 101 such "clusters" with population ranging from 1,165 (Saraspur Cluster 9) to 11,000 (Behrampura Cluster 10, Khodiyarnagar) each. These slum clusters are formed from 338 small slum pockets located within the program area. 30 clusters were randomly selected from this list. Maps were prepared of the selected clusters, to enhance effectiveness of random selection of the first household for survey in each cluster. Ten mothers with children less than 2 years were interviewed in each of the selected clusters, with the first household for interview being selected randomly. See cluster identification form in Appendix.

The following selection protocols were used in the survey:

a. "Household" was taken to represent a dwelling with an independent kitchen.
b. "Mother" was a woman with her youngest child less than 24 months of age at the time of survey, who plan to be residing in the area for at least a period of six months after the survey. In the event of two mothers in the same household, the investigators were asked to ascertain first if the household had one kitchen used by both mothers.

If this was so, they were asked to randomly pick one of the two mothers for interview.

If the mother had more than one child under the age of 24 months, investigators were asked to randomly pick one child as the subject for interview, so as not to bias the survey towards younger children.

In the case of cluster sampling for a KPC survey, a sample size of 300 (10 mothers per cluster) is generally used so as to ensure that sub-samples are large enough to obtain useful management type information. This, therefore, was the final number of interviews performed in the survey:

7. KPC Survey Training

The training for the KPC Survey was carried out across two levels:

Level 1: Training of Supervisors: The first round of training was carried out for the Supervisors of the KPC Survey for a period of 4 days. These are the CS-XX program personnel and comprise of the Community Organizers of Counterpart and Saath. The Community Organizers of Counterpart have had previous experience of carrying out the KPC survey, whereas the team members from Saath did not have any experience regarding the supervision of the KPC survey. A participatory training for a period of four days was carried out for all the Supervisors from January 10-13, 2005, which involved the reviewing of questionnaire, preparation of the cluster frame and selection of the 30 clusters through random sampling, visiting the 30 clusters identified to prepare the boundary maps to enable the selection of the first household, field practice of the KPC Questionnaire in non-program areas where the KPC survey data collection was not supposed to take place, and discussions on roles and responsibilities of the Supervisors and Investigators. The pre-testing of the questionnaire took place during January 17-19, 2005 and was followed by practicing of the KPC questionnaire in selected field areas for a period of two days on January 20-21, 2005.

Level 1: Training of Investigators: The main KPC survey training for the Supervisors as well as the investigators was carried out for a period of total of 5 days; including a 3-day training at the Training Venue from January 31, 2005 to February 2, 2005, and a 2-day field based practice sessions in non-program areas where the KPC survey data collection was not supposed to take place on February 3, 4 2005. The KPC Survey training mainly included the understanding of the basis of the KPC survey, ability to select the first household in a given cluster, administration of the KPC questionnaire to a mother with a child 0-23 months of age, and good and bad interviewing techniques. Additionally practice sessions were carried out in three slum sites for a period of two days on February 3, 4 2005 to familiarize the investigators with the process of administering the questionnaire in an actual slum set-up. Role-plays were liberally used, and the training was designed to be as participatory as possible, with more and more emphasis on practice sessions.

8. Data collection

Data collection was spread over three days February 5, 2005 to February 7, 2005, with 10 clusters being covered each day. The team was divided into 10 interview teams of one supervisor and 2 investigators each. 10 interviews were completed by each team of

investigators each day in a selected cluster. The duration of interview the varied between 25 and 35 minutes.

9. Interviewee Selection and Precautions Taken to Avoid Selection Bias

Interviewers asked an adult in each household the ages of the children that live in the household. If one child under two lived in the household, the interviewer proceeded with the consent form and determined the age of the child. If more than one child under two was found, one mother was chosen for the interview at random by assigning a number to each child and drawing lots or flipping a coin. If no children were found under two in a given household, the interviewer proceeded to the next nearest door to find the next mother to be interviewed. If no one was at home, the interviewer asked a neighbor about the composition of the household to determine if a mother of a child under two lived in the house. If there was a mother under two, but she was not in, the interviewer asked what time she would most likely be in, and planned a return visit if the mother would be returning before the end of the survey. Interviewers were instructed to finish their cluster of ten mothers even if several mothers were not at home and they would need to be interviewed later. When these interviews were finally completed, the extra interviews (above the ten per cluster) were deleted from the data set in order to avoid biasing the data towards areas where mothers are not at home.

Interviewers notified supervisors of any households where mothers were not at home. Very few interviews were not completed those that were not completed were due to the fact that the mother was not at home -- this did not happen more than once per cluster. Interviewers kept track of mothers who refused to be interviewed, as well. No mothers refused to be interviewed in this survey.

10. Quality control procedures in data collection

The following were the procedures to ensure quality of data collected:

- Supervisors selected the first household to survey in all clusters using an approved random technique
- Supervisors observe at least 2 interviews for each of the interviewer each day.
- Supervisors checked all completed questionnaires at the cluster prior to leaving the cluster
- Survey trainers checked all completed questionnaires prior to data entry

In homes where the mother of a child under two years of age lived, but the mother chose not to answer a few of the questions/or had to leave before the survey was completed, an additional interview of another mother were carried out. This situation was encountered in two of the clusters where a total of 11 mothers were interviewed in each of the cluster. However the data for those extra households was also included in the analysis.

11. Data Analysis

The data analysis was computer based and was carried out using a combination of a tailor made software package made on a VB6-MS Access platform. The front end was created using Visual Basic as the programming language, whereas the data was entered into a

Microsoft Access database. All analysis programs were made through VB and run on the Access database. The front-end, backend and related programs were created by the program's MIS Assistant, who is formally trained in computer-based programming and was validated by the Health Information Systems Manager.

The four data entry personnel were organized into two teams of one caller and one recorder, who would record into the computer based questionnaire file as the caller called out the responses to each question.

During data entry, a 20% random sample of records were checked for correct entry by comparing the actual questionnaires with the entries made on the computer by the Health Information Systems Manager and the MIS Assistant. This was done for every lot of 50 questionnaires entered. The rule used was that any error found in the 20% checked would mean that the entire lot of 50 would have to be re-entered. An error was found in the first lot checked, and this was re-entered. The subsequent lots were found to be accurately entered. Simple programs were created for the analysis of selected indicators, with frequency distributions being adequate for most of the other indicators and questions for which analysis was done.

2. Health Facility Assessment (HFA)

A. Background

Since April 2004 AMC is implementing EU funded Urban RCH 2 Project, which has brought about changes in the health facilities and delivery of health services in the Municipal area of the Ahmedabad city. Under this project Urban health Centers under the RCH 2 project have not only combined the preventive and curative types of services provided by the FWC and the Municipal Dispensary into one geographical location, but have also added to the convenience of the population it served by making it possible for them to access only one point of contact within a ward as far as all their primary health needs are concerned.
Under the Jeevan Daan CS XVI program, detailed Health Facility Assessments adapting four tools[23] as per the BASICS Integrated Health Facility Assessment Manual were conducted during the Baseline, Midterm Evaluation and Final Evaluation. Thus, Counterpart has developed in-house capacity in conducting the Health Facility Assessment and using the tool effectively for informing the design of the program activities, including:

- Planned improvements in the quality of care at AMC outpatient health facilities, including staffing, clinic organization, equipment requirements, drug and material supplies, and case-management practices.
- Pre- and in-service training for AMC outpatient health workers.
- Improved supervision and monitoring of AMC health worker performance over time.

The HFA survey process during CS XVI have also been used to train AMC and the partner NGO health workers in survey techniques, in collection and analysis of survey data, and in the use of data to improve the quality of case management and the integration of services.

[23] The four tools are Sick child Observation Checklist, Exit interview of mothers/caregivers, Health Worker Interview and Equipment and Supplies Checklist.

The baseline Health Facility Assessment for the *Jeevan Daan* Maternal and Child Survival Cost Extension Program was carried out using both qualitative and quantitative research methods in two parts;

First Part: A detailed and in-depth assessment including both qualitative and quantitative tools with regards to the Urban Health Centers present in the Jeevan Daan Maternal and Child Survival Cost Extension Program area, viz. 10 municipal wards namely Behrampura, Danilimda, Raikhad, Raipur, Jamalpur, Dudheswar, Maninagar, Kankariya, Bapunagar and Saraspur

Second Part: An assessment of the equipments and supplies status for all the 43 urban health centers present in the city of Ahmedabad using the Equipments and Supplies Checklist adapted from the BASICS Integrated Health Facility Manual, and the same tool that had been used during the baseline, midterm and final evaluation Health Facility Assessments carried out under the Jeevan Daan CS XVI Program.

Under the **First Part** of the detailed Health Facilities Assessment of the 10 Urban Health Centers present in the 10 municipal wards covered under the Jeevan Daan Maternal and Child Survival Cost Extension Program; tools like Key Informant Interviews, Focus Group Discussions, Force Field Analysis, and detailed interview guides[24] were used with all the key stakeholders in that center for all the ten Urban Health Centers; including the Medical Officer in-charge, the Multipurpose Workers, the Link Workers and the pharmacist. It could not be feasible to conduct 'Exit Interviews' of the patients during the assessment as the facilities are generally overloaded with patients during OPD and its rather not possible to make the patient wait specifically for the interview. The primary purpose of this assessment was to acquaint the program in detail with the key services delivered through these health centers with regards to their quality, access and delivery. The key objectives of this assessment are as outlined below:

1. Assessing the services delivered through the Urban Health Centers and identifying the further needs with respect to improving quality, access, services and management of health services delivered through the center.

2. Training and Needs Assessment for all levels of staffing across Maternal and Child Survival Interventions and other cross cutting theses like communication and community development.

3. Understanding the organization of health service delivery through various levels of Medical Officers, Multipurpose Workers, and Link Workers; giving clarity about the actual roles and responsibilities being carried out by these stakeholders.

4. Assessing the current knowledge and practices of all health workers including the Medical Officers at AMC Urban Health Centers regarding the assessment and management of sick children and pregnant women.

5. Assessing the frequency, repetition and regularity of vaccination sessions at centers, and at the various outreach locations and the integration of vaccination with other services to avoid "missed opportunities"

[24] For details on the frequency of each of these qualitative tools together with the target audience, refer to the following section on methodology.

The purpose of the **second part** of the assessment was to understand the status and availability of equipments and medical supplies present in the entire network of urban Health Centers present in the city of Ahmedabad. The objective for the same was:

1. Assessing the availability of pharmaceuticals, vaccines and equipment in all urban health centers through the Equipments and Supplies Checklist, adapted from BASICS' Integrated Health Facility Manual.

The Jeevan Daan Maternal and Child Survival Cost Extension Program will use the Baseline HFA survey results extensively for the following key issues, :

- *Prepare separate trainings module and a training plan for all the key staff levels in the AMC health centers, as per the training needs.*
- *Refine and redefine coordination and joint planning mechanisms with the MOs, MPWs and Link Workers, for implementing BCC and other community mobilization activities at the community level.*
- *Ensuring the availability of equipments as per the requirements, continuity and regularity in drug and material supplies etc.*
- *Planned improvements in the quality of care at AMC outpatient health facilities, including staffing, clinic organization, equipment requirements, drug and material supplies, and case-management practices.*
- *Improved supervision and monitoring of AMC health worker performance over time.*

B. *Methodology*

The methodology of Health Facility Assessments adapting four tools[25] as per the BASICS Integrated Health Facility Assessment Manual has been tested three times (baseline, mid-term and final evaluation) under the Jeevan Daan CS XVI. During all these three assessments the team was trained meticulously to conduct, analyse the outcome and also to effectively utilize the outcomes in program designing. The previous experiences have equipped the team and have built their capacities to conduct the exercise in-house.

As mentioned earlier the First Part of the Health Facility Assessment was conducted in all the 10 AMC Health Facilities present in the Jeevan Daan Maternal and Child Survival Cost Extension Program area. The survey included all the AMC health facilities present in the vicinity of the targeted urban slums under the Jeevan Daan Maternal and Child Survival Cost Extension Program. Additionally as mentioned above, the Second Part of the Health Facility Assessment was conducted in all the 43 ward based AMC Health Facilities, present in the city of Ahmedabad.

As part of the HFA preparation process, discussions were carried out with senior AMC officials including the Medical Officer Health, and the Family Welfare Officer/ RCH Coordinator, in order to determine the health facilities that should be covered for the assessment, to better understand the existing health delivery and data monitoring systems of the AMC, to obtain a list of medications that the AMC requires to be present in each

[25] The four tools are Sick child Observation Checklist, Exit interview of mothers/caregivers, Health Worker Interview and Equipment and Supplies Checklist.

health facility, to prepare the qualitative tools that are to be used for the HFA in a participatory way with the AMC senior officials, and to explain the purpose of the HFA and obtain letters of support for the survey teams. Focus group discussions were also carried out in the Jeevan Daan Maternal and Child Survival Cost Extension Program areas in order to help determine where slum residents prefer to seek care.

The facilities were assessed in this way for the following reasons:

1. Since the Jeevan Daan Maternal and Child Survival Cost Extension Program is going to be implemented in 10 out of the 43 wards of Ahmedabad, it was suggested by the AMC officials that the Health Facilities Assessment in these facilities should be carried out in a detailed manner. Based on the discussions between the Jeevan Daan Maternal and Child Survival Cost Extension Program team members and the AMC officials, it was also decided that in the 10 Urban Health Centers present in the program area, a qualitative assessment will also be carried out using detailed interview guides with all the key stakeholders at the facility including the Medical Officer, Multipurpose Workers as well as the Link Workers.

2. It was strongly recommended by the AMC officials to carry out an assessment of all the 43 primary health care facilities of Ahmedabad with respect to the status of equipments and supplies that are present in these facilities, and that of the cold chain maintenance, so that it can be used as a benchmark for the Jeevan Daan Maternal and Child Survival Cost Extension Program as well as for the AMC to work together to improve the scenario during the life of program.

3. Prior to conducting the survey, Jeevan Daan Maternal and Child Survival Cost Extension Program team discussed and reviewed the tools; both qualitative and the quantitative, schedule and methodology for conducting the baseline HFA with the AMC, and AMC authorities recommended the usage of various tools as per the following frequency:

Tool Description	**Target Audience**	**Total Frequency**	**No. of Target Audience present in each**
Focus Group Discussion	Multipurpose Workers present in each of the 10 Urban Health Centers present in the Jeevan Daan Maternal and Child Survival Cost Extension Program area	10	3-5
Focus Group Discussion	Link Worker Workers present in each of the 10 Urban Health Centers present in the Jeevan Daan Maternal and Child Survival Cost Extension Program area	10	6-12
Key Informant Interview	Medical Officers/ Health Supervisors present in each of the 10 Urban Health Centers present in the Jeevan Daan Maternal and Child Survival Cost Extension Program area	10	1-2

Tool Description	Target Audience	Total Frequency	No. of Target Audience present in each
Equipments and Supplies Checklist	Medical Officers/ Health Supervisors/ Pharmacist present in each of the 43 Urban Health Centers present in the city of Ahmedabad	43	1-2
Force Field Analysis	Maternity Home Staff including Nurses, ANM and Doctor present in the five maternity homes in the Jeevan Daan Maternal and Child Survival Cost Extension Program area	5	3-5

4. After discussions with AMC officials and private practitioners in the urban slum areas, the Jeevan Daan Maternal and Child Survival XX Cost Extension Program staff also decided that private practitioner's clinics should not be included in the survey. Including these clinics might lead to a bias in the survey results, as many of them lack basic equipment and supplies, and private practitioners often lack adequate formal training. Most of the private clinics located in the slum areas are very small, and lack waiting areas. These facilities are visited by a small number of patients, sometimes 8-10 per day. It is also difficult to get permission from all the private practitioners or charitable organizations present in the Jeevan Daan Maternal and Child Survival Cost Extension Program area, to include their facilities in the assessment. Even if some of the private practitioners indicated their willing ness to participate, some private practitioners in the Jeevan Daan Maternal and Child Survival Cost Extension Program area refused to participate, which could lead to a bias in the sampling of facilities, as not all facilities would be available for assessment.

For these reasons, it was decided to include only AMC-administered health facilities in the assessment. Private clinics will continue to be included in the operations research for the Jeevan Daan Maternal and Child Survival Cost Extension Program, like they had been actively involved in the program's health education and training activities under the *Jeevan Daan* CS XVI Program.

Schedule and Process of conducting HFA

i. Presence of in-house expertise for conducting the HFA Survey

Health Facility Assessment tools had been used as Standard Facility Assessment tools that are used in a participatory way with the involvement of stakeholders from Counterpart, Partner NGOs and AMC personnel, under the Jeevan Daan CS XVI Program. Because of this, majority of the team members in the Jeevan Daan Maternal and Child Survival Cost Extension Program are well acquainted and trained with the use of these tools. Under the Jeevan Daan Maternal and Child Survival Cost Extension Program also, use of HFA tools has been proposed to be a primary tool for on ongoing assessment of the facility level program indicators on an annual basis. The program is fortunate to have a continuation of human resource pool and has developed sufficient in-house expertise, especially with respect to three key staff for conducting the HFA Survey: 1) Counterpart HQ

backstopping person Ms. Darshana Vyas[26], Director of Health and Child Survival Programs for providing technical guidance and support for the overall process, 2) Counterpart India Program Director, Mr. Ramesh Singh, who can lead and guide the HFA Survey training process and 3) Health Information Systems Manager, Mr. Jaydeep Mashruwala, who can effectively supervise the data collection and data management for the HFA Survey.

In addition to these key members, there are many other team members from the Jeevan Daan CS XVI Program including the logistics supervisors, translators, field supervisors, and data entry personnel, who have continued in the Jeevan Daan Maternal and Child Survival Cost Extension Program and have experience of participating in the HFA Surveys carried out earlier under the Jeevan Daan CS XVI Program.

All the above listed people have been involved in all the three earlier HFA Surveys for the Jeevan Daan CS XVI Program, and are all well trained and have a sufficient expertise in HFA Survey Methodology, conducting the HFA survey training, supervising the data collection, data management and data analysis and producing the final report. For the same reason it was decided to conduct the baseline HFA Survey for the Jeevan Daan Maternal and Child Survival Cost Extension Program utilizing the in-house technical capacity and expertise.

ii. Development of Tools

The Qualitative Assessment tools were prepared in a participatory way involving all the program stakeholders from Counterpart, and Saath and key officials from AMC on February 10 & 11, 2005. The tools developed included;

1. Semi-structured Interview Guides for Medical Officers

2. FGD Guides for MPWs and Link Workers

3. Force Field Analysis with the Maternity Home Staff including Nurses, ANM and Doctor; inquiring the facilitating and restraining factors faced by the population to seek the services of the maternity homes.

All these tools were made in the local (Gujarati) language, as all of the interviewers and the respondents in the targeted facilities understood Gujarati better.

Additionally the Equipments and Supplies Checklist that was used during the baseline, midterm and final evaluation HFA of the *Jeevan Daan* CS XVI Program was reviewed and finalized. This tool was also prepared during the Jeevan Daan CS XVI Program with the involvement of the AMC officials, who had reviewed it and suggested changes with respect to the medical supplies that are usually mandatory to be available in the AMC health facilities.

[26] Ms. Darshana Vyas, MSW, MPH has more than 22 years of experience in the are of Women and Child Health in various countries including India and has been the principal Backstopping person for the Jeevan Daan CS XVI Program as well as for the Jeevan Daan Maternal and Child Survival Cost Extension Program. She is well acquainted with the process of Health Facility Assessment as per the BASICS Integrated Health Facility Assessment Manual, and has from time to time provided guidance for the development of both qualitative and quantitative HFA research Tools during the Baseline, Midterm and Final Evaluation of the Jeevan Daan CS XVI Program.

Once the questionnaire was reviewed, it was translated from English to Gujarati and then again back translated to English to ensure accuracy and ensure that the meaning of the questions asked did not change during the translation. The final questionnaire was administered in Gujarati due to the fact that all of the interviewers and the respondents in the targeted facilities understood Gujarati better.

iii. Training for the Health Facility Assessment

The training for all the tools was carried out simultaneously with the process of tools development, involving all the program stakeholders from Counterpart, and Saath and key officials from AMC on February 10 & 11, 2005. Training included sessions on the purpose and methodology of the HFA, reviewing the both qualitative and quantitative tools that are to be used for the HFA, interview and observation techniques, and correct recording of data.

iv. Formation of teams and collection of data from health centers

The collection of both qualitative and quantitative data from the 10 urban health centers in the program area was carried out from February 12- February 15, 2005. Four teams were formed with 3 people in each team, and each team visited 2-3 facilities (two of the teams visited two facilities each and the other two teams visited three facilities each) for carrying out the assessments.

For the remaining 33 urban health centers, the collection of data through the Equipments and Supplies Checklist took place from February 24- February 25, 2005. Six teams were formed with two individuals in each team, and each team collected the data from 5-6 facilities. (three teams collected from five facilities and the rest of the three teams collected from 6 facilities each)

3. Qualitative Assessment

A Background

Qualitative assessments are an integral part of any research/survey, giving in-depth and rich data that supplement the quantitative data and give details of the factors that affect the findings from the quantified data. The *Jeevan Daan* CS-XVI program has a wide experience in using qualitative assessments to supplement quantitative data and provide an understanding into the lives of urban communities, challenges they face, positive deviant practices that they make possible, myths, beliefs and awareness about health issues. The *Jeevan Daan* CS-XVI program conducted qualitative assessments as part of the Baseline assessment in **January 2000, Mid Term Evaluation in July 2003, Final evaluation in September 2004 and during two Rapid Impact Assessments (October 2002, April 2004) during the Life of the program.** The entire *Jeevan Daan* team is well trained in conducting qualitative assessments using Focus Group Discussions and Interview techniques of data collection. Based on the rich experience of the *Jeevan Daan* CS-XVI program the qualitative assessments for the *Jeevan Daan* Maternal and Child Survival Cost Extension program baseline was designed in a participatory way with the involvement of partners in planning, implementing and analyzing the qualitative data.

The key objectives for conducting baseline qualitative assessments was to:

- Appraise the "*Why's*" of the results of the quantitative KPC survey, which will perform an in-depth detail analysis of the facilitating as well as the behavioral obstacles and barriers to Behavior Change.

- Provide an insight into knowledge, practices, attitudes and beliefs related to Maternal and Newborn Care and Child Survival issues in the current and new program areas.

- Results of Qualitative Assessments will also be the formative research for development of Behavior Change Communication messages and material for the program.

B. Methodology

1. Approaches for Qualitative Assessment

The *Jeevan Daan* CS-XVI program used participatory methods like focus group discussions and key informant interviews extensively in qualitative assessments. When planning for the Qualitative Assessments for the *Jeevan Daan* Maternal and Child Survival Program Cost Extension Program Baseline a more in-depth qualitative assessment methodology was designed, building upon the strengths of Counterpart staff's capacity in conducting Focus Group Discussions and Key Informant Interviews, that imbibed from the essence of the following approaches:

a. Appreciative Inquiry
b. Positive Deviance
c. Participatory Urban Appraisal
d. Adult Learning Principles

These approaches were used in the *Jeevan Daan* CS-XVI program and were selected for the Qualitative Assessments for the following proven strengths of these Social Action theories:

a. Participation of the people and the community
b. Respecting and tapping peoples' innovations and coping capacities
c. Highlighting and mainstreaming the best practices in the community;
d. Respecting the respondents as adult-rational beings

2. Tools and Methods Used for Data Collection

With the above approaches the following tools were proposed for use in the baseline:

1. Focus Group Discussions- this classical qualitative research tools was used in the baseline to get deeper insights into community practices, knowledge, resources, beliefs and myths.
2. Key Informant Interviews and/or Semi Structured Interviews- Interviews were planned in the baseline qualitative assessments to understand current knowledge, practices, challenges, innovative local behaviors, beliefs, myths, etc of various key community stakeholders and health system staff.
3. Seasonality Mapping - this participatory tool was used to arrive at the seasonal trends of childhood illnesses and their severance among children under the age of five.
4. Preference Ranking- this tools was used to understand community's predilection for health services for maternal and child health.

5. Force Field Analysis- this tool was used to arrive at the various forces or elevating factors and factors that act as depressors for the low rate of institutional deliveries.
6. Doer- Nondoer Analysis- this tool was used to assess the key factors affecting various behaviors and practices. Data gathered from this tool is the key for developing and refining Behavior Change Communication materials for the *Jeevan Daan* program.

3. Process For Baseline Assessments

The *Jeevan Daan* CS-XVI program's experiences in conducting qualitative assessments were heavily drawn in designing the baseline qualitative assessments plan for the *Jeevan Daan* Maternal and Child Survival Cost Extension program. The process was led by the Technical backstopping by **Ms. Darshana Vyas- Director Health Programs and Child Survival from Counterpart International H.Q**[27] and the participation of the entire *Jeevan Daan* team were key to the qualitative assessments of the *Jeevan Daan* Maternal and Child Survival Cost Extension program.

The baseline qualitative assessments for the *Jeevan Daan* Maternal and Child Survival Cost Extension program saw a month of planning, conducting in-depth and detailed assessments of the current situation, beliefs of the community, concerns of the family and health providers, needs and barriers to access from various community and health facility members and compiling the rich data from various tools into a formal qualitative assessment report.

The following steps were involved in the Baseline Qualitative Assessments:

a. Preparations for the Baseline Assessments
b. Training of program staff and external researchers in conducting qualitative assessments.
c. Data Collection in small teams
d. Participatory data compilation

Dates	Plan
15 January- 8 February 2005	Planning for qualitative assessment, Review of approaches, methodology and development of baseline qualitative assessment training plan
9-12 February 2005	Training in Qualitative Assessments and Tool Development
14-21 February 2005	Data collection in four teams
22-25 February 2005	Participatory Data Compilation in small groups

Preparations for the Baseline Assessments

[27] Ms. Darshana Vyas, MSW, MPH has more than 25 years of experience in the area of Women and Child Health in various countries including India and has been the principal Backstopping person for the *Jeevan Daan* CS XVI Program as well as for the *Jeevan Daan* Maternal and Child Survival Cost Extension Program. She is well acquainted with the local verbatim and phrases used by the primary target audience (Women of reproductive age) living in the slums where the *Jeevan Daan* Maternal and Child Survival Cost Extension Program is being implemented for the various women and child health issues and has from time to time provided guidance and conducted training for qualitative assessments the during the Baseline, Midterm and Final Evaluation of the *Jeevan Daan* CS-XVI Program.

The preparations for qualitative assessments in the *Jeevan Daan* Maternal and Child Survival Cost Extension program involved planning of approaches, methodology and tools for qualitative assessments led by Ms**. Darshana Vyas- Director Health Programs and Child Survival from Counterpart International H.Q,** and the CORE Training Team of the *Jeevan Daan* Program namely Mr. Ramesh K. Singh- Program Director-Counterpart India, Heer Chokshi-Behavior Change Communication Specialist-Counterpart India, Jaydeep Mashruwala-Health Information Systems Manager- Counterpart India and Ashish Yadav-Program Coordinator-Counterpart India.

The baseline qualitative assessments plan was then reviewed by Mr. Rajendra Joshi-Managing Trustee of partner NGO Saath, Dr. Neeta Shah, Program Coordinator- Saath and Dr. P K Makwana, Medical Officer-AMC who offered inputs on issues that need to be looked in further detail in the health delivery system, quality of services, community awareness, myths and beliefs related to health issues, etc.

The members of the Core Training Team and **Ms. Vyas** finalized on the approaches, methodology and tools to be used in the Baseline Assessment and developed a training module for the same. The training was largely conducted by **Ms. Vyas** based on her vast experience in using participatory qualitative techniques for assessments for over 25 years, her experience in conducting qualitative assessments in the *Jeevan Daan* CS-XVI program, in local language and in the urban slum communities. **Mr. Ramesh Singh** co-facilitated the training and conducted session on Participatory Urban Appraisal (PUA) based on his wide experience of using PRA and PUA techniques in both rural and urban setting for Child Survival Programs.

The Core Training Team developed the training module with details of each session, methods to be used, games and exercises required for the same and duration of sessions.

Training of Program Staff and External Researchers in Conducting Qualitative Assessments.

Counterpart India conducted the training on "Qualitative Assessments" between February 9 and 12, 2005 at its Ahmedabad Office to equip the baseline data collection team with skills in research methodology with the understanding that imparting such skills would contribute to collecting factual and quality data.

The Counterpart Core Training Team prepared an intensive four-day training module for its Community Organizers and external interviewers who were going to be the data collectors of the qualitative assessments. The content for each session were meticulously prepared. The training incorporated a well-defined methodology, tools and medium of instruction to make the sessions meaningful[28].

Personnel for the Qualitative Assessment:

The Participants of the qualitative assessments training included Counterpart's and Saath's Community Organizers, (having 1-5 years of field work experience) external Data Collectors, selected through a meticulous process particularly for the baseline study. Program Coordinators, Behavior Change Communication Specialist and Manager Health Information Systems were also part of the training. Of this mixed group the Community Organizers of Counterpart were trained in qualitative assessments methods in the *Jeevan Daan* CS-XVI program. The Community Organizers of Saath had little experience in

[28] For a detailed report on training on Baseline Qualitative Assessment refer to Baseline Qualitative Report.

conducting qualitative assessments but not with the approaches that were planned for the baseline of the *Jeevan Daan* Maternal and Child Survival Cost Extension program.
Most of the external interviewers were those who participated in the baseline KPC survey January 2005 and were aware of the *Jeevan Daan* maternal and Child Survival Cost Extension program. All the training participants were well versed in Gujarati and Hindi language for use in conducting qualitative assessments.

Facilitators:

The training was led by **Ms. Darshana Vyas**-Director Health Programs, Counterpart International, Washington DC, assisted by Ramesh Singh-Program Director, Counterpart India were the lead facilitators and were assisted by Heer Chokshi- Behavior Change Communication Specialist, Ashish Yadav Program Coordinator, Jaydeep Mashruwala-Manager Health Information Systems.

It was absolutely essential to mention that the language skills of the facilitators remained the barometer to check whether the training objectives were being met. Interpreting complex processes like group dynamics, focus group discussions, etc. into lucid Gujarati /Hindi and explaining the relevance of the processes with illustrations which the participants could relate to, was a striking attribute common to all facilitators.

In addition, the facilitators included a mix of locally and globally experienced development professionals along with a fairly long association with Counterpart's Health Program in Ahmedabad (India).

Training Methodology:

Refining the experiences of conducting qualitative assessments from the *Jeevan Daan* CS-XVI program the training methodology for the *Jeevan Daan* Maternal and Child Survival Cost Extension program baseline qualitative assessments made optimum use of the four approaches that were also to be the approaches used in the qualitative assessments.

Presentations through PowerPoint slides, lectures, mock sessions, small group work, etc were the various methods employed in the training. Each session of the training was systematically divided into the following broad framework:

- Understanding the term/words of a theory/concept and arrive at its definition.
- The need for using a theory in qualitative assessment.
- Understanding the concept with examples.
- Relating the concept and its relevance to qualitative assessments subsequent to the baseline surveys.
- Refreshing of the learning / transfer of skills at the end of each break and at the end of the day.
- Assessing the training objective by evaluating group's participation during mock sessions and if required administering a formal test.

The above methodology largely ensured:

- Participant's involvement throughout the modules.
- Scope to immediately check the Theory with Practice.
- A mechanism to reinforce new terms, definitions, concept through illustrations/examples.
- Every module conducted delivers the training objectives.

The use of such tools was strategic to the overall training of participants, in the sense that along with imparting skills and transferring knowledge about Qualitative Assessment Techniques, the sessions also included aspects on self-development of the participants.

The Participants got an opportunity to perfect their Public Speaking skills through Presentation Sessions, Speech Modulation and Articulation through Mock Sessions, Brainstorming and Mental Activation through Group Activities.

The Medium

The training mainly done in local language Gujarati with use the use of second language Hindi as the medium of instruction that was the local acceptable language in the *Jeevan Daan* Maternal and Child Survival Cost Extension program area.

Training Out comes:

- The team members understood the approaches, tools and methods to be used to collect data.
- Developed questionnaire guides for Focus Group Discussions and Interviews and Questionnaires for Doer and Non-Doer Analysis.
- Developed a data collection and logistics plan in four teams.
- Collected in-depth and rich data, compiled it in manageable form for further analysis.

4. Data Collection in Small Teams

Data was collected in four teams (staff of Counterpart, Saath and External data collectors) of 5-6 participants who visited one community each to collect data on various themes, using different tools. Out of the four teams one team went to an area where the *Jeevan Daan* program was being implemented since three years, the other three teams went to three new communities where the program is proposed to expand. In this way the data collection team was able to collect the data in 6 days.

The following table mentions the teams, areas they collected data from and the health facilities they assessed.

Team	Members	*Area*	Health Facility (ward)
1	Dr Neeta, Nirali, Veena, Keyur, Anupama, Sandhya, Priti Oza	Jamnanagar – Bapunagar Ward	Saraspur, Bapunagar
2	Ashish, Priti, Nimisha, Gosia, Binita, Mandakini,	Vasudev Dhanji Ki Chali- Kankariya	Jamalpur, Dudheshwar, Maninagar
3	Heer, Shahin, Sayra, Asha, Geeta, Pratima	Site And Service-Danilimda	Danilimda, Behrampura
4	Jaydeep, Hiren, Seema, Neeta Rawal, Neeta Patel, Rajshree	Milatnagar, -Maninagar	Raikhad, Kankariya, Raipur

Ms. Vyas and Mr. Ramesh Singh participated in data collection process in all the four areas from time to time to ensure the quality of data collection and provided key inputs in the data collection process.

5. Data Collection – Process and Out comes

Each team visited one area during the six days of data collection and was able to collect in-depth data, from various community members and stakeholders. These six days saw an intense input into four communities (one from the old and 3 from the new program area) and rich data emerging from the participatory approaches used.

- This exhaustive exercise of data collection began with the use of participatory tools to build rapport with the community.
- Once this was done the teams made appointments for Interviews and organizing Focus Group Discussions.
- Some teams split into two dividing the task of conducting the Doer and Non Doer Analysis.
- The teams met with various community members like mothers, pregnant and lactating women, mother in laws, husbands, vendors, local leaders, TBAs, private practitioners, etc bringing their perspectives on the program interventions, health issues and health services.
- The teams also conducted in-depth interviews with the AMC- Urban Health Center staff. Medical officers, multi purpose workers, link workers, maternity home staff etc who provided inputs on health status of communities, issues of access, and quality of health services.
- The entire data collection saw an increasing rapport with the communities during the period of six days. Community members had started taking interest in the program and offered support in the future as well.

The data collected from each tool can be reviewed in detail in Annexure 3.

6. Participatory Data Compilation

The strove of qualitative data was complied in large and small group activities. Data collected from focus group discussions, interviews, preference ranking, force field analysis, seasonality mapping from multiple respondents were reviewed, and participatory compiled through large group activity where team members made slips of issues from all the tools and put them under specific sections as mentioned below:

- Key issues/ challenges/ difficulties
- Current Beliefs and practices
- Knowledge levels
- Decision-making
- Preferred health services
- Felt needs of the community
- Suggestions from the community for each intervention
- Special note/ quotes of community member or health staff
- Community best practices and resources

A separate laundry list was also put up to incorporate those issues indirectly related to maternal and child survival E.g. gender bias among children, lack of women's education, working women issues, etc. Information from the Doer and Nondoer Analysis was put together and key factors that emerged were compiled separately.

Data Triangulation: The data from various tools were triangulated to check for validity of data to get a holistic perspective for each intervention.

- The tools were triangulated from the audience responses E.g. Women, Gatekeepers, Health facility staff for access to health services.
- From the beneficiary, decision maker and health provider perspective E.g. mother, private practitioner, health center staff for childhood illnesses
- Triangulation of tools e.g. data from FGD and Interviews, Force Field Analysis, Preference Ranking and doer- non-doer analysis were compared.

Data Analysis: The compiled findings were then analyzed under three main categories:

- Situation of the Urban Communities- Facilitating Factors and Challenges
- Access to Health Services and Facilities - Facilitating factors and Challenges
- Quality of Current Health Services- Facilitating Factors and Challenges

B. Baseline Findings Vis-À-Vis Current Country Context

The *Jeevan Daan* Maternal and Child Survival Cost Extension Program 2004-2009 (CS-XX) has added to a 83% increase in the population (**324,235**) from the CS XVI program. The baseline was conducted in all the ten Municipal Wards, Danilimda, Jamalpur, Baherampura[29], Dudheshwar, Raipur, Raikhad, Saraspur, Maninagar, Kankaria and Bapunagar

The data collected through qualitative tools and methods have provided in-depth analysis of the current health scenario related to maternal and child health in the urban slums of Ahmedabad. The outcomes are briefly discussed

MATERNAL AND NEWBORN CARE

Antenatal Care

- The baseline KPC survey indicates a very low coverage of Maternal Health card in the program area. Almost 70% (68.5%) of the mothers do not have a Maternal Health card, which verifies the status of antenatal visits, IFA tablets and TT coverage.

- TT Coverage: Only 19.5% women in the target population could confirm at least two tetanus toxiod vaccinations through a maternal card. But as per mother's report the figure is about 89.1%. As per NFHS/DHS the national data for TT coverage is 66.8% and for Ahmedabad 83.7%[30].

- The correct knowledge of the number of Iron Folic Acid (IFA) tablets to be taken during pregnancy is amongst only 17.2% of the women in the target area. However, only 46% take at least 90 tablets or for a period of up to three months during pregnancy. The NFHS/DHS data shows that the national coverage for IFA tablets is 47.5% and as per population census data 2001 for Ahmedabad the figure is 29.1%.

- Knowledge of Pregnancy Danger Signs: Correct Knowledge of being able to cite a danger sign during pregnancy that indicates the need to visit a doctor is very low among mothers residing in the target area.

[29] Baherampura has now been phased out and Vasna Ward is now included in the CS-XX program.
[30] Population census data 2001

A. Fever **12.3%**
B. Shortness of breath **1.7%**
C. Bleeding **13.6%**
D. Swelling of the body/hands/face **9.6%**

- Only 31.5% could cite at least one of the above dangers signs, that means more than 68% of women in the program area do not have the knowledge of important pregnancy danger signs.

- As per the mother's report about 90% have received at least one antenatal visit from a qualified provider, viz. an AMC Doctor, Private Doctor, Nurse/ Midwife, or an AMC Auxiliary Nurse Midwife/ Multipurpose Worker. For the district of Ahmedabad the figure is 83.1%[31].

- When a Maternal card is used to verify the status of antenatal visits, only 23.5% mothers have received at least three antenatal visits by a qualified provider out of which a meager 17.2 % mothers have received at least three antenatal visits from an AMC Doctor, ANM or MPW.

- Almost only half (51.7%) of the mothers reported taking at least three antenatal visit from the AMC facility during their pregnancy with youngest child. For the district of Ahmedabad the figure for full ANC is 47.1%[2], which is quiet comparable to the baseline KPC findings. 79.1 % of mothers reported that they received at least 3 antenatal visits by a qualified provider (AMC and Private Facilities) during their pregnancy with the youngest child.

Place of Delivery and Delivery Attendants/ Delivery Practices

- Almost 60% (59.6%) of the childbirths in the targeted slum population do not take place at an AMC hospital or maternity home. In other words one fourth (24.2%) of the deliveries in the target area take place at homes, whereas out of the remaining roughly half (53.3%) were carried out at the Public/AMC hospitals/ maternity homes, whereas the remaining 46.7% of the deliveries were carried out at private hospitals/ maternity homes. As per the population census data of Ahmedabad district 2001 there were 35.5% of home deliveries. The government of Gujarat, ministry of health and family welfare statistics (January 2005) stated 65.9% of Institutional deliveries in the district.

- In case of the deliveries that were carried out at home, either by a TBA or by a relative, a Disposable Dai Kit was used in only 32.4% of cases. In cases where a Disposable Dai Kit was not used, a new razor blade was used to cut the cord in only 60.4% of the cases.

- Placement at birth: in the program area there is a practice of taking the child for a bath or given to relatives immediately after its birth which results in delaying of breastfeeding and also leads to problems related to delayed or less milk coming from the mother's breast. The baseline KPC survey outcome indicates the only 21.5% of the newborn children were placed with the mother immediately after birth. 57.6% of the newly born children were bathed after their birth. If the placement of child at birth is compared

[31] RCH 2 State Implementation Plan, Department of Health And Family Welfare Gujarat, January 2005

between home and institutional deliveries, an interesting outcome comes by. 28.8% of children delivered at home are placed with the mother as compared to 19.2% of institutionally delivered children. In other words there is a 50% increased likeliness of a child being placed with the mother in case it is delivered at home as compared to when its birth takes place in a health facility.

Postpartum Care

- The percentage of women in the target slums receiving at least one post partum checkup from AMC provider is 41.4%, which is very low. If post partum care is considered from a qualified provider the figure is 64.9%.

- Out of the total target population only half (54.6%) of the women receive a PP check from a qualified provider that also includes the checkup of the new born. The indicator is further low, 33.1% if only AMC service providers are considered.

- Further only half of the mothers (49%) who received the first PP Checkup from a qualified provider also received a second PP visit or visited a qualified provider for their second checkup i.e. less than a third (31.8%) of mothers in the program area received a second PP checkup also from a qualified provider (including medical and paramedical staff), during the delivery that took place in the last 2 years. This further comes down to 17.2% if only the AMC service providers are considered in this analysis.

- Moreover when the checkup of the newborn child is also included as a criterion during this second checkup, then less than one fifth (19.5%) of the women in the target population received two post partum checkups from a qualified provider that also included the checkup of the newborn child. Less than one tenth (9.9%) of the women in the target slums are covered by quality post partum services (PP services that include two checkups both for the mother and the newborn child) through a Public/ AMC facility or AMC field personnel.

- Knowledge of Maternal and Neonatal Danger Signs: Correct Knowledge of being able to cite a danger sign in women during the post partum period, that indicates the need to visit a doctor, is:

A. Fever **20.5%**
B. Excessive bleeding **19.9%**
C. Smelly vaginal discharge **3.6%**

Alarmingly, 92.7% of the women in the target slums stated that they do not recognize any two of the above stated important danger signs.

- Correct Knowledge of being able to cite neonatal danger signs that indicates the need to visit a doctor, is very low among mothers residing in the target area.

A. Poor feeding **26.2%**
B. Fast breathing **6.6%**
C. Not active **10.3%**
D. Redness around the cord **3.0%**
E. Red/Discharging Eye **4.0%**

Adding to it, about 89.7% of the women in the target slums stated that they do not recognize any two of the above stated important neonatal danger signs.

- Postpartum Vitamin A Coverage: The coverage of Maternal Vitamin A supplementation in the two months after delivery is very poor in the target communities. Only 6.3% of the mothers received a Vitamin A dosage within two months after the delivery of their child less than 2 years.

NUTRITION AND BREASTFEEDING PROMOTION

Nutrition and breastfeeding is central to maternal and child health where in globally, 60% of child deaths are attributable to malnutrition. More than 80 percent of malnutrition related deaths occur in children who are mildly or moderately underweight. Age pattern of growth faltering occurs mainly during infancy[32].

- A very few mothers, about 24.7% breastfeed their child within the first hour of delivery, and a total of 61.7% of children are put to the breast within eight hours of their birth. (This is somewhat better than the NFHS-2[33], which reported 10% had breastfed within one hour of birth.).

- About 45% of children in the community are not fed with colostrums, which enhance their susceptibility for serious childhood illnesses.

- The baseline KPC survey indicates that 57.4% of children 0-3 months were exclusively breastfed whereas 52.3% of children 0-5 months were exclusively breastfed in the program area.

- The survey depicted that the diet of children over five months of age appears not to be balanced in terms of different kinds of foods. Counting each type of solid or semi-solid food mentioned by the mother as given to her child during the last 24 hours, one finds:

- 9.2% of children 6-23 months of age received none of the solid or semi-solid foods,

  - 38.5% of children received two of the food categories or less,
  - 62.1% received three types of foods or less, and
  - 79.5% received four types of foods or less.

- 78.4% of children 6-9m of age had received both breast milk and complementary foods the previous day of the survey, and a full 16.4% of children 6-23m of age received no semi-solid (mashed or pureed) foods during the previous day. (The NFHS-2 found that 47% of children 6-9m of age in Gujarat State had received both breast milk and complementary foods the previous day.)

- The average number of times per day that children 6-23 received these foods was 1.6. This added to one of the main reason of rampant malnutrition in the target program area.

- Only 2% of mothers stated that their children 6-9 months of age were eating Vitamin A vegetables and an equally 2% eating Vitamin A fruits the day before the survey. For all children 6-23 months only 9.2% of mothers stated that their children 6-23 months of age ate vitamin A vegetables and only 7.2% ate Vitamin A fruits the day before the survey.

[32] Technical Reference Material (TRM)-2004.
[33] National Family Health Survey, 1998-1999, International Institute for Population Sciences (IIPS), Mumbai, India; ORC Macro, Calverton, Maryland, USA and the East-West Center, Honolulu, Hawaii, USA

- The National Reproductive Child Health program of the Government of India recommends Vitamin A doses to be initiated at 9 months with the measles vaccine, and then repeating it every 6 months. Only 24.3% of mothers of children 9-23m of age said that the child had received a vitamin A supplement in the past six months. This is very close to the NFHS-2 figures, which state that 26.3% of children had received at least one dose in the past 6 months.

- In terms of growth monitoring, 67.9% of children were weighed at birth, but only 3.3% of mothers had a card for the child available for the interviewer to see. 82.1% of mothers said that the child never had a card. Only 6.6% of children were participating in the AWW nutrition program in Ahmedabad city.

- Only 10.9% of the children over 11m of age had been de-wormed in the last six months, which further adds to the problem of poor health and nourishment among children in the program area.

- 61.6% of children had had an illness in the two weeks prior to the survey, and **only 4.7% of mothers claimed to give their children more fluid and only 3.6% (mothers of children 6-23 months) continued to give more foods during that illness**. 35.8% of the illnesses suffered by these children were diarrheal diseases, and 31.5% were febrile diseases.

- **Prevalence of Malnutrition:** The prevalence of malnutrition based on weight for age as the indicator is reasonably high in the program area in the children 0-23 months. The weights are taken based on the Growth Monitoring Card followed by the Integrated Child Development Scheme of the Government of India. The prevalence of malnutrition in the target slums in different age groups, as an aggregate and separately for males and females is as per the tables presented below:

- Weight for age for all children 0-23 months

	Normal	Grade1/ Mild Malnutrition	Grade2/ Moderate Malnutrition	Grade3/ Severe Malnutrition
Children 0-23 months	**66.4**	**22.7**	**8.5**	**2.4**
Male	**72.3**	**22.9**	**3.6**	**1.2**
Female	**58.9**	**22.5**	**14.7**	**3.9**

- Across all age groups, the prevalence of malnutrition is 33.6%[34], which is as high as 41.1% in case of female children whereas it is 27.7% in case of male children. Thus the proportion of female malnutrition in the target slums is almost 50% higher than their male counterparts.

CONTROL OF DIARRHEAL DISEASES

- 35.8% of children had diarrhea in the two weeks prior to the survey, which is over 82% higher than the 19.7% of children 0-23m of age in Gujarat State found to have diarrhea

[34] If we follow the weight for age standards, as recommended by the WHO/ NCHS, the prevalence of malnutrition in children 0-23 months is 57.3%, with moderate and severe malnutrition being 30.5%, and mild malnutrition being 26.8%. For Details of comparison between malnutrition as per ICDS and WHO/NCHS standards, refer the Baseline KPC Survey Report, 2005

during the past two weeks in the 1998-99 National Family Health Survey.[35] (The urban rate for diarrhea of children 0-35m was even lower in that study 17%)

- 2.3% of mothers stated that their child had blood in their stool in the past two weeks. (This is quite comparable to the 1.3% found for Gujarat State in the NFHS-2.)

- Only 28.7% of the children with diarrhea were given some form of oral rehydration therapy (this is much lower than the 42.2% using ORT found in the NFHS-2 for Gujarat State.). A very few children, only 16.5% of children with diarrhea were given ORS from the packet, and homemade fluid (e.g. Rice water, lentil water, lemon water, glucose water etc.) was given to 14.6% of children. Nothing at all was given to 27.8% of children.

- Exactly two thirds of the children having a diarrheal episode (66.7%) were offered same or more amount of liquids during the illness. 24.1% of mothers offered less fluids to the child (cf: 26% in the NFHS-2), 6.5% offered the child nothing to drink at all.

- Feeding during diarrhea was quite poor. Only 37.8% of children greater than 5 months of age were offered same or more amount of foods during the diarrheal episode. For children 6-23 months having a diarrheal episode:

    - 25.7% offered the child less to eat,
    - 37.9% offered the child the same or more amount to eat as usual,
    - 33.8% offered the child nothing to eat.

- 64.8% of mothers said that they sought treatment for their child when the child had a recent diarrheal episode, which is comparable to the 63% found for Gujarat State in the NFHS-2. 98.6% sought care from a qualified health care provider (AMC/MOH Center/ Hospital or a Private Clinic/ Hospital). Although this figure seems high, the quality of several private practitioners in the program area is a question, since many of them are untrained providers and do not have the right kind of qualifications needed. Mothers most often sought care from a private/ trust practitioner (74.3%), followed by private/ trust hospitals (17.1%), AMC Hospitals (5.7%) and AMC Urban Health Centers (2.9%). Only 1.4% mothers said that they sought care from Traditional/ Ayurvedic healers.

- Out of the 51% mothers who said that they could make ORS, only 64.3% could explain the process correctly when asked to do so. This means that only 32.8% of mothers in the program area actually knew how to correctly make ORS. As per the population census data 2001 for Ahmedabad district the awareness of ORS amongst the mothers was 2.5% and the Government of Gujarat, Ministry of Health and Family Welfare January 2005 data shows 1.3% of the children were given ORS during diarrheal episode in Ahmedabad district which is very low.

- Only 9.6% of mothers claimed to have an ORS packet in the house.

- Only 34.8% of mothers stated that they washed their hands before food preparation, before eating, before feeding children, after defecation and after attending to a child that has defecated. This is besides the fact that 68.5% had soap/ash, water, and a place for hand washing.

[35] International Institute for Population Sciences (IIPS) and ORC Macro, 2000. National Family Health Survey (NFHS-2): 1998-99, India, Mumbai: (IIPS).

ACUTE RESPIRATORY INFECTIONS/ PNEUMONIA CASE MANAGEMENT

- 17.9% of mothers claimed that their child had an illness with a cough and faster breathing than usual (with short, fast breaths) during the two weeks prior to the survey. (This is almost 60% more than the 11% found in the NFHS-2 for Gujarat State.). 48% of the child had pneumonia in the Ahmedabad district according to ministry of Health and Family welfare, Gujarat, 2005 data.

- Only 32.5% of the mothers could cite fast or difficult breathing as a danger sign of pneumonia. And 73.8% of mothers could state at least two correct signs[36] of childhood illness that indicated the need for treatment.

- Hydration and feeding practice during pneumonia is also extremely poor in the target slum area. More than half the children suffering from ARI (55.6%) were offered less to drink or nothing to drink at all. 44.5% of the children (6-23m) were offered same or more amount than usual to drink.

- Feeding practice during pneumonia is extremely poor, as well. Of children 6-23m with signs of pneumonia:

    - 35.7% of were offered less to eat,
    - 26.2% were offered the same amount to eat,
    - 2.4% were offered more to eat, and
    - 35.7% were offered nothing to eat.

Therefore, about 71.4% of children 6-23 months, who had cough with fast breathing in the last two weeks were offered less to eat or nothing at all during the illness.

- The survey indicates that very few mothers, 37% of mothers of a child with symptoms of pneumonia seek care, the same day, which adds to the high mortality and morbidity of the children. 35.2% of the mothers stated that they sought care the following day and 27.8% of mothers waited two or more days after they noticed the cough and difficult breathing to seek treatment.

- 87% of mothers had sought care from a qualified provider, including an AMC/MOH Center/ Hospital or a Private Clinic/ Hospital (The NFHS-2 found that 71% of mothers in Gujarat State sought care when their child had signs of pneumonia.) The 2001 census data for Ahmedabad district shows 51.2% of the mothers sought treatment of children for pneumonia. Although this figure seems high, the quality of several private practitioners in the program area is a question, since many of them are untrained providers and do not have the right kind of qualifications needed. Mothers most often sought care from a private/ trust practitioner (74.5%), followed by AMC/MOH Hospitals (12.8%), private/ trust hospitals (6.4%), and AMC Urban Health Centers also (6.4%). Only 2.1% mothers said that they sought care from Traditional/ Ayurvedic healers.

IMMUNIZATION

- 69.2% (209/302) of mothers of children 0-23 months had a vaccination card for the child that was shown to the interviewer. 22.2% of mothers said that they had a card but it

[36] Signs included as correct were based on international IMCI protocols.

was either lost or misplaced, whereas 8.6% of mothers said that they never had a card. Moreover, 66.4% (85/128) of mothers of children 12-23 months had a vaccination card for the child that was shown to the interviewer. The EPI coverage for children, of Gujarat as per 1998-99 NFHS/DHS states that only 53 percent of the children have been fully immunized within one year.

- Using the immunization card for verification, only 48.2% of children of age 12-23 months with card have been fully immunized before their first birthday. However if all the children of age 12-23 months who are fully immunized before their first birthday irrespective of if they have a card or not is seen, the figure reduces to only 32%.

- If immunization with in first year of life is not considered then the immunization coverage amongst the children of age 12-23 months with card is 72.9%, and without card is 48.4%.

- Immunization based on card or mother's report**:** In addition to the card confirmed children, if the mother's report is considered as a valid confirmation about the child's full immunization status, then the proportion of children 12-23 months who have been fully immunized is 64.8%.

- Immunization coverage by each vaccine**:** The coverage of immunization for children 12-23 months, by each vaccine is as shown in the table below. The denominator for all the ratios is taken as the total no. of children 12-23 months that got selected as a part of the survey (128).

Vaccine Name	% of children 12-23 months getting the vaccine before their first birthday (Card confirmed)	% of children 12-23 months getting the vaccine, irrespective of the time of getting (Card confirmed)[37]	% of children 12-23 months getting the vaccine, (card confirmed or mother's report)
BCG	56.3	63.3	89.1
POLIO 1	57.8	65.6	97.7
POLIO 2	52.3	63.3	96.9
POLIO 3	48.4	58.6	95.3
DPT 1	57.8	65.6	92.2
DPT 2	53.1	63.3	89.1
DPT 3	46.9	57.8	80.5
MEASLES	32.8	50.8	70.3

(According to the census 2001 figures for Ahmedabad district the status was 60.7% full immunization, BCG 93.3%, DPT three injections 74.4%, polio three dosages 72.4% and measles 76.7%)

- EPI Access**:** EPI Access can be defined as the proportion of children 12-23 months in the program area that have received DPT1. This figure varies from 57.8% to 65.6% to 92.2% as per different definitions as per the table above. The most correct seems to be 65.6%, which is the proportion of children 12-23 months who have received the DPT1 vaccine, and have a proof of it on a vaccination card.

[37] The difference between the figures in the previous column and this column is mainly because of the date not being recorded on the vaccination card, rather then necessarily the child having received the vaccination after its first birthday.

- Drop out rate**:** The drop out rate or the percent of drop out between DPT1 and DPT3 can be defined as the difference between the no. of 12-23 month children who received DPT1 and the no. of 12-23 month children who received DPT3, divided by the total no. of children aged 12-23 months with cards who received DPT1. This comes out to be 11.9% ((84-74)/84). Furthermore if we compute the drop out rate from DPT1 to Measles, it comes out to be at 22.6%.

C. Constraints In Achieving The Program Objective

Cultural diversity

Ahmedabad once being a home for textile industries attracted lot of people from all over the country who migrated here in search of livelihood. These people were unskilled laborers and resided in slum areas of the city most of which are now the target population of the current program. The vast cultural diversity of the target area is characterized by people from different communities, speaking different language, different food habits and also different believes and norms. In this situation it's a great challenge to mobilize communities because of the group dynamics within some of the target communities. The *Jeevan Daan* CS-XVI program successfully addressed the challenge through forming Community Health Teams (CHT) within the communities and mobilizing people by using local language and culture specific BCC material and health education messages. Also the trainings for the key community members (CHT, local leaders, etc) were developed and designed keeping in mind the cultural barriers. The current CE program will follow the lessons learned from the *Jeevan Daan* CS-XVI and will further improvise on the previous strategies. The Linkworkers who are from within the community itself will be one of the central of focus, who will be trained in all the strategic intervention to reach out to the target population.

As in the *Jeevan Daan* CS-XVI program in the current CS-XX program also the trainers would be not only having strong technical knowledge base of program interventions but also will have a fair understanding of the beliefs, practices and customs of the local communities will be selected for imparting various trainings.

Counterpart will be closely working with its local partner Saath who has years of experience in developing effective strategies for addressing the social and cultural differences in the urban slum.

PD/Hearth using the positive deviance approach for malnutrition have been very effective in *Jeevan Daan* CS-XVI to address specific cultural difference among ethnic and religious group together, even in the times of violence will be expanded in terms of number and its scope of intervention (e.g. for pregnant mothers) in the current program. Also its probable integration with the ICDS program will be ventured out.

Logistical Constraints

Though with five years of advocacy under the Jeevan Daan CS-XVI and now with commencing of RCH 2 project the availability of ORS and other essential drugs has improved. But the baseline assessment at community as well as the facility level indicated that the availability is there but still reach of ORS and IFA tablets has not gone far as expected, a few essential drugs are still being prescribed to be purchased from outside chemist shops. More than 90% of the facilities do not have a functional ORT corner. Also,

in around 70% of the facility weigh scale is not available for children, most of the facility lack in mass media equipment and behavior change communication material.

Due to the lack of emergency facilities like ambulance in many communities people prefer to go to private providers. This is very specific in the case of emergencies during pregnancy. Also for many slum communities the AMC facilities are not in the local vicinity thus they refrain to spend transportation cost and instead visit a nearby private provider.

In *Jeevan Daan* CS-XVI program to make the availability of ORS and IFA at doorstep CHT was trained and being given the stock to provide it to the needy as and when required, also there was a wide use of referral chit to promote and motivate the patient to visit AMC facility, and ensure a better service to them. Similar strategies will be utilized and expanded in the current program to overcome the logistical constraints. Linkworkers will be promoted to keep stocks of essentials like ORS and IFA. They will also be given referral chits to motivate the patients to seek care from AMC facility. The CHT will be linked with the Linkworkers so as to logistically help them to identify the cases in the community.

Unemployment and Associated Problems

The industrial development of the city lead to a large scale migration into the city resulting in a wide unplanned expansion of the city. By 1980, many of the textile mills which had offered employment to the slum residents had to close due to market competition, financial instability and other political reasons, leaving behind a huge force of unskilled or semiskilled unemployed people. Most of the people of the slum communities are engaged in smaller livelihood options like pulling carts, daily wage laborer, fruit and vegetable vendors, domestic servants, begging, etc which are uncertain, involves lots of physical work, have risk of health hazards and have very fewer returns.

In the *Jeevan Daan Jeevan Daan* CS-XVI program this had been a greater challenge in implementation of the program. But the lessons learned suggest that in spite of the economic difficulties people show willingness and concern for adopting healthy behaviors. Therefore, using strategies like networking and integrating the program with the other livelihood generation program in the program area by other Voluntary Organizations provided a holistic approach of sustainable development of the target area. The CS-XX program will focus to replicate and expand the strategies with a greater force by exploring, linking and providing opportunities for a better income generation of the slum communities. The program will try to bring in more and more of existing unemployed youth in the slums, mobilize them, organize them and facilitate the existing opportunities.

Working Mothers

The issue of working mothers has been a great challenge in the last four years of program implementation. The challenge was strategically addressed in the *Jeevan Daan* CS-XVI program by focusing on the caregivers who are generally the elder sibling or the elders of the house as an informal support group who looks after the child. The poor socio-economic condition forces the mother to go out in search for income opportunities which pose a serious challenge as there is a missed opportunity for vaccinating her child or visiting health facility for either ANC or PNC check up/ counseling in case she is pregnant and other issues like if her child is not well. It also is a missed opportunity for the health

workers who are attempting to provide health education to the mothers. Also, the time availability to attend the Hearth is greatly limited. . The current strategy will continue to utilize the same strategy with more vigor. Counseling of the whole family together and forming adolescent support group will be done at a larger level. This will ensure reaching the decision makers of the family and also the future mothers of the community and generating critical awareness amongst them regarding the health issues of mother and child. Specific BCC activity will be designed to reach these audiences.

Health Seeking Behaviors

The economic condition of the slum dwellers has a lot to say in their health seeking behavior. The environmental risks and lack of services contributes to severe illnesses, which lead to costs for continuing medical treatment, as well as reduction of workdays and economic loss. Economic loss further limits community's ability to invest in health care and sanitation. Moreover, the low level of education and false cultural practices contributes to misunderstandings and inaccurate beliefs regarding health care. In many slum areas, this has contributed to incomplete immunization coverage, insufficient gynecological check up during pregnancy, unsafe deliveries at home and improper post-natal care. Inappropriate or incomplete treatment for tuberculosis (TB) and malaria often lead to recurrences and relapses. There is a general view that expensive treatment from private practitioners is good treatment, because of its higher cost. Conventional treatments from AMC facilities are often seen as slower or less effective.

The *Jeevan Daan* CS-XVI through its various BCC activities at individual and mass level was able to mobilize people regarding the culturally determined health seeking behavior vis-à-vis correct behavior. The process involved rigorous learning's regarding the cultural, social and economical aspect of the communities, which influences their health seeking behaviors. Mass campaigns at larger level were done to promote the new RCH 2 program by AMC. The CHT was trained in the program intervention aspects that also in turn facilitated the community for adopting a better health care seeking practice. The current CS XX program on the basis of the previous lessons learned will design similar BCC campaigns to address the issue. Also, rigorous skill building of the CHT and the Linkworkers will be done so as they can mobilize the people and bring awareness in them.

Health Facility Related Challenges

Continuous advocacy by means of constant formal and informal discussions, counseling and trainings and by other strategic means the Jeevan Daan CSXVI program facilitated the issues regarding quality and delivery of the services and outreach of the Ahmedabad Municipal Corporation Health Facilities. The rigorous efforts brought about many remarkable improvements but there still a wide scope for betterment. There is a large section of people in the slum communities who still prefer to visit a private provider than AMC facility. The hygienic condition of many of the facilities needs improvement, almost half of the center lacks a proper toilet for the patients, and there is also a dearth of sitting space for the patients waiting for their turn. Many of the center lack space for minor operation e.g. family planning. The maternity homes lack adequate equipments for conducting deliveries. Adding to it there is also a perception amongst the slum communities that the private health providers are more customers friendly than the Corporation health facilities.

In some of the centers as due to inadequate counseling and attention, the patients feel that they should have rather gone to a private health facility instead. In many cases this

becomes all the more pertinent for them, as the patients are prescribed medicines to be bought from outside rather then providing them for free at the center itself. It's also perceived by the slum communities that the doctors and MPWs are not sensitive to their culture and poverty, as they are often not examined properly by the doctors, which demotivates and discourage them and instead they prefer going to private clinics.

With the onset of RCH 2 project changes and improvement in certain areas has started. There has been improvement in availability of pharmaceutical, shortage of human resource and geographical coverage of the health center. The Linkworkers are the primary contact persons at field level but they lack skills like leadership, community mobilization, communication, and counseling and also skills regarding technical aspects of various mother and children related issues. The deployment of Linkworkers has started improvement in the geographical coverage of the health facility but many of the slum communities particularly in the new areas there is lack of awareness of the presence of the health center in their ward. In spite of improvement in the availability of ORS and IFA tablets there is still lack of awareness amongst the mothers regarding it. The *Jeevan Daan* CS-XVI program has carried out several training programs on key program interventions in the past especially for the MPWs. The baseline assessment outcome reflects a gap in the existing skills and the skills requirement of the facility staff. The MOs/doctors needs to develop skills on communication, particularly in client servicing, leadership, supervision and on the management of the health center to make it more effective and client friendly also, there is a need for MPWs and Linkworkers to develop their skill on community mobilization/development, counseling, MIS and on the technical interventions of the program.

There is different in the number of patients visiting the various health centers in the city. All the wards have a health center each and each one is staffed in a similar way. However, there are some wards, which have a significantly higher slum population as compared to the other wards, leading to more population visiting a particular center as compared to the other ward. For example, on one hand there is a daily patient load of about 35-40 patients in Saraspur Health Center, which goes as high as 200 patients in the Dudheshwar Health Center. This does not translate in a similar ratio as far as the deputation of Medical Officers in these two health centers is concerned. In other words the MO placed in a center where the patient load is higher tends to be overburdened and cannot carry out the activities more efficiently. Under the Jeevan Daan Maternal and Child Survival Cost Extension Program, Counterpart and its NGO partner will continue to discuss such critical issues through Special meetings and reviews with the Medical Officer Health and senior AMC/MOH officials on a quarterly basis to share field findings, provide feedback, and advocate for policy change or adaptation to address community needs, as under the Jeevan Daan CS XVI Program. Also, it is proposed that Counterpart will conduct a Health Facility Management Mapping along with the Indian Institute of Management (IIM), Ahmedabad.

E. MOH Policies/Strategies

The Ahmedabad Municipal Corporation is implementing EU funded RCH 2 project in the city of Ahmedabad. Its a state level program and is being implemented various district of Gujarat state. The program is output based and its vision is to accelerate the progress

towards the achievement of goals set in the State Population policy. Under this program the key strategies[38]are defined as:

- Improving access to family Welfare (FW) and maternal and Child Health (MCH) services through renovation, up-gradation and re-organization of existing facilities.
- Enhancing the supervisory, technical and interpersonal skills to all levels of health Functionaries to improve the quality of FW and MCH services.
- Involving of NGOs and private sector in various aspects of urban primary health care delivery.
- Increasing the demand of the FW and MCH services through IEC activities and enhancing the participation of communities and municipal leaders in the design, implementation and supervision of the services.
- Promoting convergence of efforts among multiple stakeholders, including the private sectors to improve health of the urban poor.
- Developing linkages with the communities.
- Strengthening the monitoring and evaluation mechanism.

Intervention Wise Policies/Strategies

Maternal And New Born Care

1. All pregnancies cases are to be registered by health workers (60% of the case before 12th week of pregnancy).
2. All registered pregnant women are…
    a. Provided 3 antenatal checkups, which includes checking their blood pressure and ruling out complications.
    b. Given 2 dosages of Tetanus Toxoid vaccination
    c. Given iron folic acid tablets (100) for the prevention and treatment of anemia.
    d. Deliveries by trained by trained health personnel in safe and hygienic surroundings are encouraged.
3. Institutional deliveries are encouraged.
4. In case of complication referrals are made to First Referral Units for management of obstetric emergencies.
5. Essential newborn cares like keeping the baby warm, checking the baby's weight and giving baby mother's first milk (colostrum).
6. Three postnatal checkups are given to mothers after deliveries. Which will be primarily dome by Linkworkers at the community level.
7. Spacing of at least three years between children is encouraged.

To ensure the above-mentioned policies, RCH 2 project has stated following key strategy:

- Have regular ANC clinics and link up with private practitioners
- Increase awareness in the community on the need for timely ANC
- Increase the percentage of institutional deliveries
- Increase comprehensive and basic emergency obstetric care in public health facilities.
- Ensure availability of Skilled Birth Attendants for home deliveries
- Undertake need-based facility up gradation
- Ensure capacity building of medical officers and staff nurses for BEmOC services
- Identify and train specialists (Gynecologists, anesthetists, pediatricians) for CemOC services
- Increase awareness in the community on the need for timely ANC

[38] Urban Slum Health Projects, Guidelines for Development of city level projects, Ministry of Health and Family Welfare, Government of India

- Increase the number of contacts by ANM, AWW, and LHV to women who have delivered within three days of delivery and then within six weeks
- Increase in percentage of newborn babies weighed at birth

Nutrition and Breastfeeding Promotion

The Government of India MOH has several initiatives to reduce child mortality, including the child Survival and safe Motherhood program, which now falls under the broader structure of Reproductive and Child Health program. The program emphasize the breast feeding and nutritional practices of mothers including:

1. Immediate breastfeeding within one hour of delivery.
2. Exclusive breastfeeding for first six months
3. Weaning or starting the baby on semisolid food are advised from six month onwards the fourth month
4. Vitamin A prophylaxis for children 6-60 months of age on a biannual basis.
5. Prevention and treatment of anemia.

The MOH is responsible for implementing the Integrated Child Development Scheme (ICDS), which integrates all child development related services. The key strategies under this scheme are:

- To improve the nutritional and health status of pre-school children in the age-group of 0-6 years;
- To lay the foundation of proper psychological development of the child;
- To reduce the incidence of mortality, morbidity, malnutrition and school drop-out;
- To achieve effective coordination of policy and implementation amongst the various departments to promote child development; and
- To enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education.

Under this program, for the slum children the Anganwadis are suppose to provide Supplementary Nutrition, Immunization, Health Check-up, Referral Services, Non-formal Pre-school Education and Nutrition & Health Education. The program provides an integrated approach for converging basic services through community-based Anganwadi Workers and helpers, supportive community structures/women's group - through the Anganwadi Centre, the health system and in the community. Besides this, the Anganwadi is a meeting ground where women's/mother's group can come together, with other frontline workers, to promote awareness and joint action for child development and women's empowerment

Control of Diarrheal Disease

The Government of India MOH has several policies to reduce infant and child mortality due to diarrheal disease. The RCH 2 program component for children features diarrhea as a major cause of infant and child mortality, and the strategies to reduce diarrhea related deaths were developed in accordance with WHO protocols. The program emphasize on educating the mother/caregiver about Oral rehydration Therapy and management of sick children affected with diarrhea. The RCH 2 program also provides integrated services for CDD and aims to promote demand for ORS packets through its wide awareness creation in the community with the help of the Linkworkers and making ORS available in all health centers.

Pneumonia Case Management

The RCH 2 program component for children features acute respiratory infections as one of the major causes of infant and child mortality. The strategies to reduce ARI and pneumonia related deaths are in accordance with the WHO protocols (partially), and emphasize health education for caregivers on the following topics:

- Early detection of danger signs of pneumonia.
- Immediate referral to the nearby health facility and compliance with referral.
- Correct assessment and classification and treatment with cotrimoxazole tablets.

Immunization

The MOH initiated the Expanded Program on Immunization (EPI) in 1978, and the Universal Immunization program (UIP) was introduced in 1985-86, with the goal of covering at least 85 percent of all infants against the six vaccine preventable disease by 1990. Pulse polio Immunization campaigns began in December 1995 as part of a major national effort to eliminate polio. Under the RCH 2 special emphasis has been given for increasing the coverage of immunization, which will be done majorly through extensive on field campaign reaching the un-reached.

F. Status of Existing Health Services

Previously AMC was providing the preventive services through the network of Family Welfare Centre (FWC) and Municipal Dispensaries. There were 37 FWCs and they used to be the first point of contact for primary health care in the urban areas. They used to provide facilities for minor surgery and deliveries, registration of pregnant women, vaccines for children, treatment of childhood illnesses like fever, cough/cold, diarrhea/vomiting, pneumonia etc. and a small number of beds for inpatient treatment. In addition, they provided family planning services. FWCs were also responsible for providing outreach services to the urban slum areas, primarily for vaccination and family welfare services. In addition to the FWCs, there were 19 Municipal Dispensaries present in Ahmedabad, which catered as the most basic urban health care centers. Dispensaries used to have outpatient departments, which provided health care services to the slum population and also distributed free medicines. They also provided free services for general illnesses such as fever, cough/cold, diarrhea/vomiting, pneumonia, malaria etc.

The EU funded Urban RCH 2 Project since April 2004, changed the organization of health facilities and delivery of health services for the Ahmedabad city. There has been an improvement as far as the geographic distribution and location of health services within the city is concerned, by creating a link between the ***Health Centers*** and the ***Urban Wards,*** which is the smallest administrative unit in a city. The city of Ahmedabad has 43 such Municipal wards, with the population of each being in the range of 70,000 to 100,000. Under this new structure each of this ward has an Urban Health Center (UHC) located within, which caters to both preventive and curative types of health needs of the people residing in that ward.

The UCH under the RCH 2 project have not only combined the preventive and curative types of services provided by the FWC and the Municipal Dispensary into one geographical location thereby increasing the assess to the people especially to the slum communities of the respective ward.

Additionally as a part of the staffing of the Urban health Centers, there has been an introduction of an additional level in the organization structure, which was not present in the earlier existing Family Welfare Centers. This additional level has been defined as the ***Link Workers*** who are literate and willing people from the slum communities itself. The primary purpose of this cadre is to create a link between the slum communities and the Urban Health Centers. The key function of the link workers is to increase the outreach of the urban health centers and ensure that the entire slum population in that ward is covered and registered for all health services delivered through that health center.

To acquaint the program with the existing access, quality delivery of health service provided by the Municipal Corporation HFA was conducted under baseline assessment. A detailed and in-depth assessment using qualitative tools was conducted with regards to the urban health centers present in the program area and also an assessment of the equipments and supplies status for all the 43 urban health centers present in the city of Ahmedabad based on the BASICS Integrated Health Facility Manual.

Summary of Quantitative Results through Equipment and Supplies Checklist

Equipment and Supplies

43 Urban Health Centers were assessed for Equipment and Supplies. Of these facilities:

- 92.9% of the Urban Health Centers had no Ambulance or any other emergency transportation vehicle available.
- 47.6% of the facilities did not have potable drinking water for the patients, whereas 31% of the facilities had no functional latrine available for the patients.
- 23.8% of the facilities did not have health education posters displayed in the local language.
- Only 4.8% of the facilities had a functional ORT corner
- Mass communication media were grossly inadequate; Megaphone was available in only 11.9% facilities, Flip charts in only 38.1% facilities, Counseling cards or pamphlets in 64.3% facilities and TV/ Video in only 9.5% facilities.
- 69% of the facilities lacked a weigh scale for children, whereas only 14.3% had a Salter.
- Although the regular stethoscope was available in 95.2% of the facilities, only 35.7% of the facilities had an Obstetrical stethoscope, and only 21.4% had an otoscope.
- The condition of cold-chain equipment was generally good. 95.2% of the health facilities had a working refrigerator, 83.3% had a working thermometer, and 85.7% had a temperature chart present. 76.2% of the centers had the temperature chart maintained up to date in the last 30 days. The condition of ice packs and vaccine carriers was even better; 95.2% of the facilities had ice packs, and 97.6% of the facilities had vaccine carriers in good condition.

Antibiotics and other Supplies

- Ampicillin/ Amoxicillin/ Ciprofloxacin was available in 90.5% of the facilities.
- Cotrimoxazole was available in 52.4% of the facilities.
- Chloroquine tablets were available in 95.2% of the facilities, and Paracetamol was available in 97.6% of the facilities visited for assessment.
- Iron tablets, Mebendazole and Vitamin A tablets were available in 97.6% of the facilities assessed.
- ORS packets were available at 92.9% of facilities. IV solution for severe dehydration was available in 28.6% of facilities.
- The availability of life saving vaccines in the facilities was excellent; 97.6% of the facilities had BCG, OPV, DPT, Measles and Tetanus Toxoid vaccines. 7.1% facilities had frozen vials of DPT or TT in the refrigerator, whereas none of the facilities had expired vaccines.
- The availability of needles and syringes in the facilities was also good with 97.6% of the centers having these supplies.
- None of the health facilities had experienced a stock-out of ORS in the previous month, whereas 14.3% of the facilities had experienced a stock-out of essential drugs.

Summary of Qualitative Results through use of Qualitative Assessment tools at the 10 Urban Health Centers located in the Program area

After the onset of the EU funded RCH2 project in April 2004, the following changes have taken place in the health delivery system of Ahmedabad:

- With the coming up of ward based Urban Health Centers (UHC), the accessibility of the target population for curative and preventive health services for women and children have improved. Services like registration of births and deaths, immunization, OPD, family planning for the population of one ward has come under one roof, resulting in an improved management of the health services.
- With the addition of Link Workers as a level in the health system organization structure, the linkage between the slum communities and the health facility in terms of coverage has improved.
- Specialist doctors, viz. a gynecologist and a pediatrician have been allotted to each urban health center on a part time basis, who visit the center on fixed days and at fixed times, and cater to these special health needs of the target population (especially women and children) covered.

Based on the detailed qualitative Health Facility Assessment of the ten wards covered by the program, and the detailed interaction with the key health facility personnel, following can be noted about the current status of the health services provided through the urban health centers.

- The RCH2 has increased the outreach of the coverage of health services delivered through the UHC. The patients records at the facility suggests that now more population now access the public health delivery system then they used to earlier. However, still in many areas there is a lack of awareness amongst the slum communities of the presence of these health centers, their location and the services delivered through them.

- Link Workers have been key in reaching out to the communities but in many areas they have not been able to penetrate and establish the desired rapport with them quite effectively. There is scope for their skill building regarding community development, leadership and communication skills. Also the current on the job supervisory support needs strengthening up to ensure the quality of the activities carried out by them.

- In many of the health centers, the specialized doctors do not visit them at regular schedules. Which results in over burdening of the Medical Officer doing the job of the general practitioner as well as taking care of the specialized needs. It has been observed that the centers where the Gynecologist and the Pediatrician have regular visits, more population access these facilities and the coverage of the center is higher.

Facility Infrastructure, Status and Regularity of Supplies and Equipments

- The facility infrastructure has improved quite significantly after the coming up of Urban Health Centers. The availability of space within the center, the organization of services/ facilities within the center, provision of waiting area, storage of medicines etc. has improved considerably.

- The supplies are now more regular and a significant reduction in the occurrence of stock-outs in the health centers. There has been a systemic improvement, and on a monthly basis a list of medicines required is sent to the centralized store directly from the health center, which are then made available at the earliest.

- No emergency medical services are available for the population covered, especially in cases where a maternity home is also present within the premises of the UHC (five of the 10 centers Baherampura[39], Danilimda, Dudheshwar, Saraspur and Maninagar).

- In some of the facilities there is a lack of enough space for carrying out the family planning operations and for the same have to be referred to other facilities. In many of such referral cases, there is an increased likeliness that the patient will opt out of the idea of getting an operation done.

- In most of the health centers, proper hygiene and cleanliness are significantly lacking.

- Different wards differ in their population size and all the wards have a health center each and each one is staffed in a similar way. This causes a greater inequality in the patient load. In other words the MO placed in a center where the patient load is higher tends to be overburdened and cannot carry out the activities more efficiently.

Facility Staffs' attitude towards Clients

- The facility staff, (Medical Officer in-charge of the center and the Multi Purpose Workers) has shown a considerable improvement in their attitude towards the patients

[39] Baherampura has now been phased from the CS-XX program. Please see Revision from original draft chapter for details

during the last 4 years, since the *Jeevan Daan* program began. However there is still a lot of scope of improvement in order to make these center more patient friendly leading to improve in performance and coverage of the center even further.

- Some of the doctors also carry out field visits to the slum communities covered by that center. This brings them closer to the communities and increases the level of trust among the slum population for the doctors. This was initiated during the time the CS XVI program was being implemented, and this will now be further made more institutionalized for all the urban centers covered by the cost extension program.

- In some of the centers, there is still not enough counseling of the patients, at times making the patients feel that they should have rather gone to a private health facility instead. In many cases this becomes all the more pertinent for them, as the patients are prescribed medicines to be bought from outside rather then providing them for free at the center itself.

- It is perceived by the slum communities that the doctors and MPWs are not sensitive to their culture and poverty, as they are often not examined properly by the doctors. Thus many of them still prefer to go to a private facility more, as they very strongly perceive that the attitude of the health staff at the urban health center is demotivating and discourage them from going there.

<u>Trainings</u>

The *Jeevan Daan* CS program has carried out several training programs on key program interventions in the past especially for the MPWs. Also the MOs have been part of many trainings that CS program carried out with the community members (CHT) and MPWs. The content and the participatory methodology of these training were well appreciated and the AMC health center staff are now looking forward to receiving more such trainings in future and especially for the Linkworkers. The Linkworkers have not received any formal training so far, the trainings so far received by them have been only in the form of guidance provided to them by their supervisors, viz. MPWs

Following training needs were evolved while conducting HFA:

- **Medical Officers/ Doctors**

  - ✓ Training on Supervision, Communication and Leadership skills
  - ✓ Management of Health Centers in a client friendly environment
  - ✓ A detailed program overview of the *Jeevan Daan* MCS program, including participatory designing of means of supervision, coordination and linkages on a regular basis

- **MPWs and Link Workers**

  - ✓ Community Mobilization and Community Development
  - ✓ Leadership, Communication and Counseling skills
  - ✓ MIS for the RCH 2 project (especially link workers who had difficulty in filling the MIS formats properly)

- ✓ On all maternal and Child health program interventions (maternal and newborn care, diarrhea, pneumonia, and immunization)

- ✓ TB, Malaria and HIV/AIDS

BCC Materials

- All the facilities that were covered under the *Jeevan Daan* CS Program have the program's BCC posters displayed adequately and at appropriate locations within the health center. Both the doctors and the MPWs have given a very positive view about the quality of the posters and the role that they have played in successfully communicating the health behaviors to the patients visiting the facility. The simplicity of the posters and the very clear pictorial presentations have made it possible even for the illiterate population to comprehend the posters easily.

- Not all the new centers that will now be covered under the MCS program have got the program's BCC materials displayed. Many of them had received the posters in the past but have not been replaced after they got wiped out in the last year's rainfall.

- There is a greater demand from all the centers for BCC materials including posters, flip charts and pamphlets that the Link workers can use to make their activities more effective.

- Moreover there is a strong demand from the health center staff, that the planning of BCC activities that are to be carried out in the community, should be carried out jointly as used to happen in the past under the *Jeevan Daan* CS Program, and the Link workers of the respective area will make sure to be present and facilitate the program staff when the BCC activity is going on.

Supervisory Support; Current and Future possibilities

- The link workers in most of the areas feel that they receive appropriate supervisory support from the MPWs at the health center for filling the reports, but it does not translate well to the field based activities. The link workers do not receive adequate support in community mobilization and strengthening rapport with the community.

- The linkworker feels demotivated as at times there is a shifting of priorities for the link workers from their usual RCH work to other priorities like emphasis on collecting malaria slides and finding TB patients. This often leads to inefficiency in achieving the RCH targets.

Scope of increasing access

- There has been a gradual increase in the coverage of health services through the urban health centers, especially for the areas where the *Jeevan Daan* program is being implemented. Otherwise also there has been an increase in the number of patients seeking health services from the health centers after the onset of the RCH 2 project.

- Furthermore, the Link workers have been successful so far to increase the outreach of the AMC services, and in many cases have been able to motivate the population to seek services from a urban health center. There is a great scope with the mix of the *Jeevan Daan* cost extension program and the RCH 2 project, which by working in conjunction can greatly increase the access of the AMC health facilities.

However there are still a good number of areas, where the Link workers are not yet well known and the urban health centers are also not well acquainted with. There is a need of carrying out a mass campaign to create awareness about the link worker and the health center location and services offered in the target population.

G. Rapid Catch Indicators

RAPID CATCH FINDINGS

- Child Spacing**:** 61.2% of mothers maintained adequate spacing (at least 24 months) between their two youngest children.

- Malaria**:** During the survey, it was found that 28.8% of mothers claimed to have a bednet in the house. Of those who had a bednet, mothers stated that the following people slept under it:

  - In 34.5% cases no one slept under the bednet.
  - 65.5% of the youngest children slept under the net the night before the survey (which is low season for malaria),
  - 10.3% of the respondents (mothers) slept under a net;
  - 12.6% were other individuals (e.g., husbands);
  - 12.6% said that they did not know who slept under the net.

Of the 28.8% of households that had a net, only 3.4% had ever been dipped in a liquid to repel mosquitoes or bugs. Thus only 1% of children in the study slept under an insecticide-treated bed net the previous night.

- HIV/AIDS**:** Only 42.7% of mothers claimed to have heard of AIDS before. Of those, only 18.6% could cite two or more ways to reduce HIV infection. However if this indicator is seen from all the mothers that took part in the survey, the figure reduces to 7.9%.

Annexure : 2

Capacity Strengthening Assessment with Saath

As per the recommendation from the USAID under the sustainability plan a capacity strengthening assessment has been conducted in a participatory way with the partner NGO Saath, which details out the Baseline, Mid term and final Targets. It has also been determined based on the consensus that 100% transition of any programmatic subcomponent to Saath would be determined if following factors are followed:

1. Saath staff/MCS team trained by Counterpart
2. There has been orientation by Counterpart about how to plan a program sub component
3. There has been joint implementation of that program component
4. There has been supervisory support provided by Counterpart to Saath during the implementation
5. There has been joint activities to monitor and evaluate that particular program component for its quality and impact
6. Counterpart shares all the literature, reports and manuals crucial to that program sub component

No	Indicator	BASELINE 2004	MID TERM 2007	TARGETS (FE) 2009
	Planning, Implementing and evaluating maternal and child survival programs TOTAL SCORE	3350/64 = **52.34%**	5310/64 = **81.69%**	6380/64 = **99.68%**
	Technical Interventions skills and knowledge, "what and how" pf Programming	370/10 = 37%	770/10 = 77%	100%
1.	Community and household Integrated Management of Childhood Illnesses (C-HHIMCI)	20	70	100
2.	Maternal and Newborn Care	20	70	100
3.	Active Management of third stage of labor	20	70	100
4.	Home Based Life Saving Skills	20	70	100
5.	IMNCI framework for Neonatal care	20	70	100
6.	C-HHIMCI framework for Control of Diarrheal Diseases	60	80	100
7.	Hygiene Improvement Framework	50	80	100
8.	C-HHIMCI for Pneumonia Case Management	30	80	100
9.	Nutrition and Breastfeeding	50	80	100
10.	Expanded Program on Immunization	80	100	100
	Behavior Change Communication	470/12= 39.16%	890/12= 74.16%	100%
11.	The BEHAVE framework	20	70	100
12.	Conducting formative research,	50	70	100

	Pretesting of materials and activities			
13.	Conducting Doer Non Doer Analysis and Audience Segmentation	20	70	100
14.	Developing Posters, Pamphlets, Flipbooks, Booklets, games for Health education, songs and parodies with health messages	60	80	100
15.	Developing video programs for health education	30	70	100
16.	Making puppets, props, costumes; developing scripts and puppet plays and street plays	30	70	100
17.	Organizing and managing large scale puppet and street play campaigns	30	70	100
18.	Developing kites with health messages, use Henna, Melas, exhibitions, rallies, demonstrations for health education,	50	80	100
19.	Conducting Individual counseling, Health education Sessions, activities with Children,	60	80	100
20.	Designing and organizing Breast feeding support groups	60	80	100
21.	Monitoring and improvising BCC activities	40	80	100
22.	Process Documentation of developing IEC materials and BCC activities	20	70	100
	Training and Capacity Strengthening	220/8=27.5%	580/8=72.5%	100%
23.	Conducting TOT for technical interventions and cross cutting approaches	20	70	100
24.	Developing training modules and facilitating trainings	20	70	100
25.	Using LNRA to design training content	20	70	100
26.	Planning, organizing and managing program and community level trainings and workshops (logistical and thematic)	50	80	100
27.	Evaluating trainings and workshops	50	80	100
28.	Documenting and developing training reports	20	70	100
29.	Monitoring training impact and developing new/ refresher trainings	20	70	100
30.	Conducting DRIP trainings	20	70	100
	Monitoring and Supervision	230/6=38.3%	440/6=73.3%	100%
31.	Developing, applying and using MCS specific monitoring systems	30	70	100

32.	Developing monitoring and supervision formats like community activity based report, household visit checklist, area profile, referral chit, reminder system, monthly case identification (birth and death report), quarterly health facility report,	50	70	100
33.	Developing community based monitoring formats like CHT registers, exit interview checklist, community boards, catchment area maps	50	80	100
34.	Compiling and analyzing data using EPI Info	20	70	100
35.	Develop and analyzing Health Worker performance assessment formats	50	80	100
36.	Developing MCS based monitoring softwares	30	70	100
	Evaluations	480/6=80%	560/6=93.3%	100%
37.	Conducting, analyzing and compiling population based Knowledge Practice and Coverage Survey (KPC)	40	80	100
38.	Conducting, analyzing and compiling Health Facility Assessment (HFA)	100	100	100
39.	Designing, conducting and analyzing Qualitative Assessments using Adult Learning Principles, focus Group Discussions, Key informant Interviews	90	100	100
40.	Designing, conducting and analyzing Qualitative Assessments using Participatory Urban Appraisal techniques	100	100	100
41.	Appreciative Inquiry	100	100	100
42.	Positive Deviance Approach	50	80	100
	PD/Hearth	40/2=20%	140/2=70%	100%
43.	Designing, planning, managing and evaluating PD/Hearth for children	20	70	100
44.	Designing, planning, managing and evaluating PD/Hearth for pregnant women	20	70	100
	Community Mobilization	400/4= 100%	400/4= 100%	100%
45.	Social mapping	100	100	100
46.	Rapport establishment with community members and stakeholders	100	100	100

47.	Rapport establishment, conducting regular appraisal meetings, motivating and supervising stakeholders like: Private Providers, Anganwadi workers, Local leaders, Traditional healers, TBAs, Vendors, CBOs	100	100	100
48.	Establishing linkages, between community stakeholders for community development activities	100	100	100
	CHT	480/6= 80%	600/6=100%	100%
49.	Identification of CHT members and formation of CHTs	80	100	100
50.	Organizing and facilitating CHT meetings	80	100	100
51.	Organizing and conducting CHT monitoring activities like quiz	80	100	100
52.	Conducting CHT activities for motivation and skill building	80	100	100
53.	Mentoring CHTs and providing on the job support	80	100	100
54.	Conducting ward level CHT activities/meetings like Sneh Milan	80	100	100
	Working with AMC	300/4=75%	380/4=95%	100%
55.	Rapport establishment with AMC staff members	70	100	100
56.	Conducting and facilitating meetings with AMC staff on health services issues	80	100	100
57.	Organizing, facilitating and reporting WLCC meetings	50	80	100
58.	Jointly planning and conducting activities like immunization camps, health days, Polio campaigns with AMC	100	100	100
	Partnership and Linkages	220/3= 73.3%	280/3= 93.3%	280/3= 93.3%
59.	Partnering with local Ministry of Health	60	80	80
60.	Partnering with community level CBOs and NGOs	100	100	100
61.	Partnering with national level NGOs and PVOs for sharing of lessons learnt, advocacy and capacity strengthening	60	100	100
	Others	140/3= 46.6%	270/ 3= 90%	100%
62.	Conducting health based operations	50	100	100

	research			
63.	Developing working papers on health issues and lessons learnt	60	100	100
64.	Proposal development for USAID programs	30	70	100

Annexure 3

Reviewers' comments/suggestions/clarifications for DIP and Program Response

Reviewer's Name: Sujata Ram
Intervention(s) Reviewed: Maternal and Newborn Care, Control of Diarrheal Diseases, Pneumonia Case Management, Nutrition and Breastfeeding, and Immunization

1. It is not clear how the project's current beneficiaries were calculated. Does the final figure incorporate Ahmedabad's annual population growth rate? If so was the revised figures based upon a mid-point calculation of the growth rate over the project's life? As the urban population is highly transitory, how was this incorporated in the beneficiary numbers?

   Program Response: It has been clarified in the DIP document that the program uses the formula that is used by the AMC to determine the health needs of the city and calculate the target beneficiaries for the program. The number of children below 5 years is calculated as 16% of the total population and the each year new cohorts join the program and the number of each year new cohorts is calculated as 1/5 of the total population of children under 5. Similarly number the women of reproductive age is determined as 26% of the total; population and the each year new cohorts is estimated at 1/35.

2. It is not clear if malaria is endemic in the project area. The baseline survey found extremely low levels of bednet use during the dry season and corresponding low season. Additional research could be undertaken to determine bednet use and malaria incidence during the high transmission period.

   Program Response: Malaria is not endemic in the area and it is addressed by AMC under the National Malaria Eradication Program.

3. Although the project has a training program in place for AMC personnel there is no mention of training AMC personnel to be trainers and subsequently holding joint sessions. Training AMC personnel to be trainers will ensure a greater level of sustainability and also strengthen capacity to extend training opportunities to other personnel outside of the project area. AMC trainers should also be involved in the development of materials and curriculum.

   Program Response: It is clarified that the program follows a cascading model of training plan and that requires that all the training has the component of the TOT, including the community based trainings designed for the community health workers so that they can carry forward the knowledge and train the mothers in healthy behaviors.

4. It is not clear what the status of clinical IMCI services are in the project area. Have AMC or any private providers received clinical IMCI training, follow-up and supervision? How will project activities strengthen referral links?

Program Response: The government of India has just launched the Reproductive Health and Child Health program which is a close to $9 billion effort over 5 years. This program went through a very rigorous design process of which all development partners were a part. The program looks at IMNCI (Integrated Management of Neonatal and Childhood Illnesses) approach. UNICEF has piloted this in select areas. Though the results of the pilot are not fully available there are some early lessons. At the AMC level IMNCI has neither been piloted nor has it been included in the implementation plan. Counterpart is exploring with the local UNICEF the possibility of including the AMC for the IMNCI. Technical intervention trainings are based on the Protocols of IMCI at the health facility level and C-IMCI protocols at the community level.

5. The monthly ward meetings are an excellent mechanism to share and disseminate local surveillance data that have been collected by CHTs and Linkworkers. A representative of the private provider network should also attend the monthly ward meeting. Data disseminated at these meetings can help formulate new AMC policies.

   Program Response: This component is inbuilt. CHT, Link workers, Medical Officers, MPWs, Maternity home staff, Link workers, CBO representatives, and Private Providers will be part of the WLCC.

6. How will the project motivate and maintain the interest and energy of the CHTs and Linkworkers? Are there any incentives planned?

   Program Response: Some of the incentives are planned that are described below:
   - Training and Skill building.
   - Self esteem enhancement - certificates, ID cards, medals and trophies.
   - Representing communities at AMC and other forums - CHT Confederation.
   - Social Incentives – recognition from community, CHTs are facilitators of community health increasing access and quality of health and hygiene related services.
   - Roping CHTs into SHG and/or Micro credit based groups with partner NGO Saath's other programs

7. It might be useful to have additional operations research studies on myths and cultural beliefs that are prevalent so that clear messages can be developed in all intervention areas. Also, how will the project address gender bias?

   Program Response: All BCC activities and materials developed have undergone Formative Research using participatory methods to identify myths and cultural beliefs; these are continued in the CE program.

8. It will be useful to have a more details on the project's exit strategy that also includes a clear sustainability plan and description on how activities will be scaled-up.

   Program Response: Based on this comment and also the priority comments from the USAID Washington Program has further elaborated the exit/phase over plan for Counterpart and Saath. This plan's theoretical foundations rest on the core approach of decentralization and handing over to the local stakeholders. Counterpart and Saath very much converge on this issue, where Counterpart has a commitment to build the capacity of the partner by the end of the program and gradually hand over the activities and technical expertise, Saath has shown commitment to work in conjunction with Counterpart towards a community hand over plan whereas the activities and the expertise to locally run the activities are transferred to the community base organizations and groups.

   A more detailed action plan for this has been chalked out, documented and included in the DIP Management section.

9. Overall, the document was difficult to follow and has a great deal of duplication.

   Program Response: Although the program team determined that a very detailed implementation plan is good for its own reference it has been difficult to some of the reviewers to follow. As a response several sections has been cross referenced to make it lean and remove redundancy. Also following the suggestion from USAID Washington a one or two page executive summary has been added in the interventions.

Reviewer's Name: Monique Mosolf Intervention(s) Reviewed: Nutrition

10. There is quite a bit of redundancy in the DIP, making it a little difficult to gain an understanding of the overall plan for implementation. Perhaps the sections could be tightened up and shortened a bit to reduce redundancies.

    Program Response: Please refer point 9.

11. The DIP includes many interventions and describes collaboration and incorporation of many community groups – CHT's, Link Workers, Anganwadi workers, private providers, AMC. While exploiting these synergies is important, the DIP does not present a coherent plan that describes how the project will feasibly and systematically be able to work with all these groups. How will they ensure quality, regular supervision, overall monitoring? A clear management plan, written concisely and presented up front in the DIP, is needed if the project is going to realistically be able to take advantage of all of these opportunities. The management plan should address training and supervision, including a schedule for implementation and the organization responsible.

Program Response: A Partners table is included that will list all the partners, the description of the partner, nature of partnership and their role in the program and linked activities.

12. The DIP's description of plans and strategy for improving organizational development of institutions and partners could be better developed so as to go beyond training of NGO staff and AMC staff. (pg 6-7)

    Program Response: As per the DIP guidelines, plans and strategies for improving organizational development of institutions was requested for entry and new grants only. However for cost extension grants this is not applicable.

13. The indicator for VAS coverage on page 148 should include children up to age 59 months.

    Program Response: This was a typing error and has been corrected and included as recommended.

14. It seems that training in CDD and ORS preparation should be included in training for all staff, including AMC urban health centre staff, Link Workers, Private practitioners. Perhaps this is assumed, but since it is clearly stipulated as part of training for Anganwadi workers, it should definitely be included in training for other staff as well (Page 155)

    Program Response: It is elaborated on in various sections of the DIP as per DIP guidelines especially training plan clearly indicates it., however there shall be further elaboration and a separate table shall be provided at the time of final submission, including various stakeholders .

15. Training has been well addressed on pg 155; however, further elaboration on plan for supervision is needed.

    Program Response: Counterpart is coordinating with the State Institute of Family Health and Welfare using our in house capacity and expanding upon the existing "buy-in" by local authorities. Also JD is expanding beyond our program area and beyond the state of Gujarat under the RCH program.

    As a response to the recommendation regarding the supervision a detail supervision plan linked with the capacity strengthening and training plan can be found in Annexure 8

16. **Vitamin A Supplementation:** Clear strategy for increasing VAS coverage is needed. Page 156 states that increased referrals will be made for VA, however, the strategy for ensuring higher coverage is lacking.

Program Response:

17. Employing Anganwadi workers to mobilize or administer VAS may be a good strategy for improving VA coverage, particularly as these workers are identified as responsible for working in area of nutrition. The DIP should maximize opportunities through Anganwadi workers to distribute vitamin A supplements – not just limit use of Anganwadi workers to distribution of food.

    Program Response: Program has already includes it and is using it.

18. The project should not consider consumption of micronutrient rich foods (in vitamin A, iron) as an adequate substitution for supplements.

    Program Response: Jeevan Daan does not consider the consumption of vitamin A rich foods a substitution for VAS. JD advocates the consumption of vitamin rich foods in addition to VAS.

    Post Partum VAS is not at present GOIs priority. USAID mission has confirmed that VAS is not a priority for the GOI. Under the RCH program AMC is implementing VAS and therefore the Jeevan Daan program will not address this issue so as to not duplicate RCH efforts.

19. The "Institution of Excellence" represents a good idea for increasing local ownership and perhaps for enhancing local capacity with other NGOs. The DIP should further describe this concept, i.e. will the center provide health services or will it serve as a training institution; who will have responsibility for ongoing costs and sustainability.

    Program Response: CPI is preparing ToR with AMC and SAATH which will be subjected to AMCs review and approval and shall be submitted by the end of December. However the centre will be a living university and will provide services and will be used as working model to for training and replication.

20. Opportunities for promoting nutrition interventions while delivering other health services, i.e. pneumonia, diarrhea, immunizations, maternal health services should be maximized.

    Program Response: Nutritional counseling is an integral part of all of the program intervention areas, and has been an integral part of the first program cycle of Jeevan Daan. This form of integrated nutritional management will be continued during the new cycle of JD.

Reviewer's Name: Dr. Meenakshi Intervention(s) Reviewed: Overall DIP

The suggestions offered are only to align the project with the mission and government priorities and are not reflective of any deficiencies in the DIP.

21. Due to the large size of the states in which the mission health programs are implemented, the mission has taken the approach of demonstrating state specific models of achieving results and working with the state governments to take these to scale with their resources. This allows us to leverage resources to achieve larger public health impacts in our focus states.

    Counterpart has worked very closely with AMC and has influenced its systems to adopt the best practices that the project has demonstrated to work. We would encourage Counterpart to work more with the Department of Health and Family Welfare of the Government of Gujarat to do the same. The cost extension phase would be the most appropriate in terms of timing this effort as the DIP does look at an exit strategy. Working with the government would allow the best practices to be picked up by the state for its larger programs, more so for the urban programs which are getting increasing attention by the Central as well as the state governments.

    Program Response: State government is already a strategic partner to the program. Through the institution of excellence state government can be advocated with evidence base what is ailing the public heath system and how it can be managed better with no extraordinary resources.

22. The DIP mentions efforts towards introducing Postpartum Vitamin A. This is not a part of the Government of India (GOI) policy. This change would require working with the GOI. Effort at the state level is not very likely to be successful. The MOST project and other efforts that the mission is making at the central level would be most suited to bring about this change, particularly because the Vitamin A has been episodically an issue of controversy and there are some strong opinion groups on the issue.

    Program Response: The program will not work on post partum Vit A and is coordinating with the help of mission to get involved and give its input for any such initiative.

23. The government of India has just launched the Reproductive Health and Child Health program, which is a close to $9 billion effort over 5 years. This program went through a very rigorous design process of which all development partners were a part. The program looks at IMNCI (Integrated Management of Neonatal and Childhood Illnesses) approach. UNICEF has piloted this in select areas. Though the results of the pilot are not fully available, there are some early lessons. We would suggest that the Counterpart program also adopts and works on the IMNCI approach. This would allow us to have lessons from an urban program on how this approach can be implemented in the urban context.

Program Response: The program is in active contact with the UNICEF and AMC on this issue. The Gujarat State implementation plan for the RCH do mention training on the IMNCI but the AMC does not have any plan on that right now, it also is not part of the implementation plan. The Jeevan Daan program is exploring the possibility of AMC health personnel training by the UNICEF on IMNCI.

Reviewer's Name: Janet Meyers Intervention(s) Reviewed MNC

24. There are a number of new evidence-based practices being promoted to reduce maternal mortality that I do not see mentioned and might be included in the strategy under the objective #3 "Improved quality and accessibility of services provided by AMC personnel and AMC health facilities/services and established critical linkages among community organizations and public and private health providers":

    - Promotion of active management of the third stage of labor (AMTSL) and the project might investigate the possibility of collaborating with the POPPHI project (based out of PATH) for technical support and / or whatever support they can provide to integrate this.
    - Ensuring the use of MgSO4 for pre-eclampsia instead of ergometrine which is the second drug of choice but not highly recommended as it is contraindicated if a woman has elevated blood pressure.

    Program Response: It has been clarified in the DIP presentation AMC Maternity facilities follow the protocols for Active Management of Third Stage of Labor under the RCH and MgSO4 is the drug of choice for pre-eclampsia.

25. In the health facility assessment report, there was no documentation of drugs, supplies and equipment that would be needed for Basic EmOC and Comprehensive EmOC. It appears that only AMC UHCs were assessed yet the project will be encouraging women to deliver at the AMC maternities. It would be useful then to have included the maternities at a minimum in the HFA as well (better yet the referral hospital as well). Based upon the information provided it is unclear whether or not the UHCs do provide delivery services or not. It seems that with the EU project, some if not all of the UHCs do or will have that capacity as well. Basic EmOC is generally recommended at a fairly well established health center where deliveries are normally conducted such as the maternities and probably many of the private facilities and maybe the UHCs. The comprehensive EmOC is normally provided at the hospital level or wherever c-sections are performed. At a minimum, the DIP should clearly present which facilities have the capacity to conduct deliveries and rationale for why women will be encouraged to deliver at the AMC maternities is needed or maybe the message of where women should deliver needs to be different.

Program Response: Presently there are 4 maternity homes that are housed by the Urban Health Centre and four major hospitals with multi specialties in program target area. Currently the Maternities are underutilized and the hospitals are overcrowded because community think that if at all there is a complication then instead of running for the hospitals in the last moment why not go to hospital itself so that there is nothing to worry and are assured that the pregnant mother will get all the possible medical help including the **EmOC.** But that defies all the referral systems because of the urban situation where the distance is not that prohibitive for access compared to rural area. In addition to that of almost 50% of all 75% of the institutional deliveries are conducted at private clinics which may not be essentially more equipped than the AMC maternities but are better managed as a health care provider business. Even the poor families have to pay good amount some times borrowed. If they access the maternities with improved facilities then this can be avoided. Neither the poor and vulnerable families have to pay and fall in debt nor are the big hospitals crowded. Only the referred deliveries take place there. Therefore JD program has planned to conduct a EmOC mapping, improve birth preparedness, HBLSSS, improve the facility attitude towards client and conduct OR on the underutilization of the maternity homes and promote the maternity homes for all the normal deliveries, so that there is a good use of existing infrastructure.

26. The focus of this project is community-based; however, in order to effectively have an impact on maternal morbidity and mortality reduction, one needs to consider the household to health facility continuum and ensure that services are provided all along that continuum. The community members can only do so much and they need to have quality services to refer to otherwise their efforts at the community level will not achieve a reduction in maternal deaths. This project may not be able to supply equipment, drugs, etc… at the maternities and hospital but the project talks of training maternity staff in EmOC and so they will need to have the supplies and equipment to do their work. The DIP refers to the EU project as supplying drugs and equipment necessary for the MNC component but the project needs to be clear on what those items are. The WHO IMPAC manual is an excellent resource and guidance for training in EmOC. The AMDD project in collaboration with JHPEIGO, also developed a number of training materials and modules for midwives, doctors and anesthetists and these are available on their website. The operations research planned for mapping EmOC services is not well explained and needs further explanation.

    Program Response: The Jeevan Daan program is using the expertise of its TAC members - such as Dr. Dileep Mavlanker, who has been also associated with the AMDD project and Dr. Abhay Bang - who are recognized by the AMC, USAID mission and GOI for their EmOC training. GOI has also commissioned Dr. Bang to conduct a pilot study in HBLSSs The JD is using the TAC members as our resource for EmOC.

27. Training of TBAs, LHVs, CHTs, MPW to maternity staff and a number of other paraprofessional staff is planned but the project needs to think through more carefully who will be trained in what. What will be their role for each of the interventions. For example, the DIP states that TBAs will be trained in HBLSS and EmOC. EmOC training is not appropriate for TBAs, it is dangerous and the purpose of the HBLSS training is to fill that gap in services at the community level when it exists. The TBAs and other key community members comprise a critical mass of people who can quickly respond to obstetric and neonatal emergencies by providing very basic care and facilitating quick referral, they cannot replace the skilled attendant able to manage obstetric complications. The training table in the appendix clarifies this somewhat but the body of the DIP is confusing on the training aspect. The training table includes the curricula to be used but the project should be sure to use curricula developed in India whenever possible. For example, the AMDD project did a lot of training in India and they probably have a number of useful health provider training materials. The project should try to use the country materials as much as possible before going outside for other curricula and this will promote greater "buy-in" by local authorities as well as improve the sustainability of the activity.

    Program Response: TBAs will be receiving ONLY HBLSS training and Counseling and Communication.
    Maternity staff trained in EmOC, Customer Relationship Management, Counseling and Communication.

28. On p.31 under place of delivery and delivery attendants, the presentation of the data is confusing and needs to be better explained. There are also inconsistencies in the KPC findings in the document as well as when compared with the data entered into the information system. These need to be corrected.

Program Response: This was an editing error and has been corrected as
UUPlace of delivery - (24.2%) of the deliveries in the target area take place at homes.
The remaining 75.8% of the deliveries take place at hospitals or health centers; either private or public.
Out of the institutional deliveries 53.3% were carried out at the PUBLIC/AMC hospitals/ maternity homes.
The remaining 46.7% of the deliveries were carried out at PRIVATE hospitals/ maternity homes.

29. In follow-up to the training, supervision is mentioned but a more well thought out plan for supervision that includes technical support, on-the-job mentoring, refresher training etc… might be better developed.

    Program Response: Please refer to point # 15 and Annexure 8

30. Data collection should include the number of maternal deaths in addition to the number of infant and child deaths already planned in the data collection. There are plans to do verbal autopsies for infant and child deaths but no plans to investigate maternal deaths. I suggest the project consider doing maternal death or "near miss" investigations to assist them in determining where the problems are in women receiving EmOC in a timely way. There is a well-known model applied to maternal mortality and morbidity reduction programs called the "three delays" (sometimes 4 delays). The first delay is a delay in decision to seek care at the household level, the second delay is in arriving at the health facility and the third delay is in receiving appropriate, adequate, timely and quality treatment at the health facility. This is also applicable to neonatal deaths. The interventions might be developed within this framework. For example, there are almost no ambulances at the UHC and transportation for emergencies appears to be a challenge, yet this is not directly addressed in the activities proposed. The project might develop a strategy within the community for ensuring timely and efficient transportation for all obstetric emergencies. The project might also look at the feasibility of supporting an emergency transport system from the UHC although that is usually laden with challenges in sustainability.

    Program Response: Counterpart has experienced that it is culturally not appropriate to conduct a verbal autopsy for maternal death, however CPI will explore other appropriate methodologies. Cause of maternal death is recorded at health facilities under the RCH through the AMC at the clinical level however at the community level link workers are recording maternal deaths and identifying the causes of death.

    Preparedness – Emergency transport committees at the community levels.
    Involvement of CHTs, local leaders, CBOs and male members in the transport committees are planned to be ensured.
    Committees will be a key part of house hold birth preparedness (transport, money).
    Emergency response mechanisms exist in the communities; these will be explored and linked with families, especially after the communal carnage.
    Urban situation - Transport facilities are available and are used for various emergency purposes.

31. Since it appears there is dissatisfaction on the part of the community with the health facility staff, the project might use the Partner Defined Quality (PDQ) approach to improving quality of services based upon the community's wishes and therefore improve use of the maternities for delivery.

    Program Response: The JD program has planned training on client relationship management for the facilities staff in this regard that is to be based on the expectations of the community and the possible actions within the given resources. It is the same thing only the name is different.

32. There is a focus on training TBAs, what about other influential women in the community (mother-in-laws, aunts, etc…) – did the baseline assessments reveal any other key decision makers related to maternal newborn health that might need to be targeted specifically?

    Program Response: CHT members, Link Workers and mother inlaws are the influential women and of course the husband and adult male members and these sets of people are targeted.

33. While the emphasis on postpartum care is key, the document might better elaborate how they plan to improve utilization of the service as well as ensure that quality visits are being conducted.

    Program Response: The program plans following strategies:
    - Promote PP care at the community and house hold level.
    - To use its private providers network for increased counseling of mothers
    - Increased PP home visits by the link workers and referral if needed

34. In summary, the document needs a lot of tightening up in order for it to be a document that program staff may use for implementation. There is a lot of useful information but the presentation of the information is very confusing and at times inconsistent. What will be done to achieve the objectives needs to be presented much more concisely and would be more easily understood with simple tables.

    Program Response: Refer to the point # 9.

<u>USAID Comments by Susan Youll</u>

35. Streamline the DIP Document- Take out the redundancy and refer to the important/relevant sections

    Program Response: The lot of extra information has been removed and important sections are cross referred.

36. 1 page executive summary for each technical intervention area- including "what" and "why"

    Program Response: Accordingly attached with the DIP document.

37. Include a partner table with roles and responsibilities ; linked activities and key staff

    Program Response: A partner table is prepared and attached in the management section, which explains the nature of partnership the description of the particular partner and their role/linked activities.

38. Summary/ table of phase over strategy of activities to SAATH; include plan for capacity building and skills transfer to NGO. Management plan should reflect transition.

    Program Response: A detailed summary of phase over/ exit strategy is prepared and attached in the management section. The phase over and exit strategy rests on the foundation o the core approach of counterpart and Saath about decentralization and handing over to the local groups and communities.

39. Consider increasing MNC component's LOE.

    Program Response: After discussion with program team and the key partners and stakeholders the LOE for the PCM has been reduced from 25% to 15% and the LOE for the MNC has been increased from 20% to 30%.

40. Document all feedback received from stakeholders including TAC, EHP, Mission, etc and explain how feedback was incorporated in project design (or not).

    Program Response: Documented and attached with DIP.

41. Revised budget submitted.

    Program Response: Submitted as suggested including all the changes.

42. Ensure project data form is included.

    Program Response: Included as suggested.

43. CDD- Zinc and POU need to be addressed.

    Program Response: Zinc not a part of the protocols of MOH India and Gujarat. USAID mission also views it out of scope of this project. However program will be open to participate in any national/state level advocacy initiative on Zinc for CDD. The POU is addressed at a pilot level in the program

HIP Suggestions for Counterpart CDD DIP *"JDMCS Cost Extension"* (April 18, 2005)

Program Response: All the following additions and suggestions have been included in the CDD section of the DIP as appropriate.

A. POSSIBLE ADDITIONS

1. Add to "Intervention Specific Objectives" – page 2

It might be best to differentiate between Treatment and Prevention in presentation, intervention, and impact. Consider adding something like the following:

The JDMCS Cost Extension program will continue to focus on:

Treatment Interventions – reduce deaths due to diarrhea by:

- Improving standard case management of diarrhea based on the C-IMCI framework
- Promoting ORS and ORT
- Promoting nutritional management of diarrhea
- Promoting breastfeeding

Prevention Interventions – reduce diarrheal disease by:

- Increasing hygiene improvement through the three key hygiene behaviors – hand washing, feces disposal, and improving quality of water:
    - *Then here restate the HIF elements, remember that all elements of the HIF are to change behavior surrounding the 3 key hygiene practices. Promotion alone does not imply the behaviors, promotion implies types of interventions (communication, training, social mobilization, etc.) just as access (latrines, water sources, POU packets, ORS packets, etc) and enabling environment (institutional strengthening, financing schemes, policy, etc.) imply certain types of interventions.*

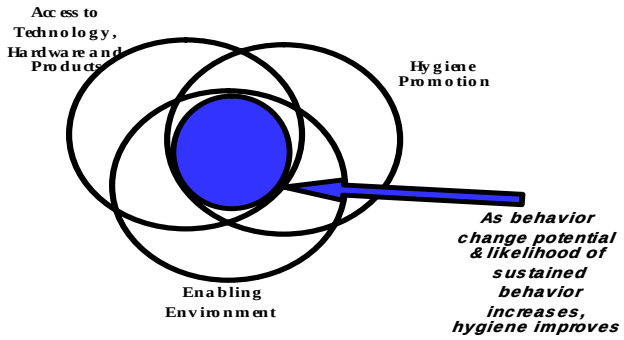
2. Add to "C.3" – page 3 right at the beginning, right before C.3.a

As I mention several times throughout these suggestions, behavior is the overarching element of any hygiene improvement effort. All needs to be seen through this behavioral lens and all should flow from this behavioral focus. If it doesn't, we run the risk of developing programs, designing BCC materials, improving elements of quality, and ensuring access to services or products that will have no effect on the behaviors that they need to and in turn no positive health impact. Considering adding something like the following:

Too often, the impact of environmental health interventions has been limited by the failure to understand and influence human behavior. Introducing a new technology is rarely sufficient to solve an environmental problem. In many instances people who have received latrines, improved water systems, or water treatment options but have not used them as intended. To have an impact on public health, the problem must truly be an important cause of ill health. The technology must address the problem effectively and should be selected based on knowledge of current behavior and user preferences. The environment in which the technology is promoted must be conducive to its use and availability, and the technology must be used appropriately.
Considering "behavior first," allows you to (1) identify, promote and facilitate improved behaviors that have significant positive impact on health and are feasible for users to do,

i.e. people both willing and able to make changes; (2) design program interventions that motivate and facilitate these improved behaviors; and (3) eliminate preconceived program designs.

Based on experiences in environmental health and in other areas of public health, technologies such as latrines, water pumps, soap, improved water containers, water treatment options, etc. should be considered one component of a behavior change strategy. Enabling environment issues such as policy change, advocacy, financing schemes, etc. should be considered as another component of a behavior change strategy. And hygiene promotion such as communication, training, community mobilization, social marketing, etc. should be considered as the third component of a behavior change strategy. In summary, a behavior change strategy is made up of all three of these components – (1) access to hardware, products and technologies, (2) hygiene promotion, and (3) creation of an enabling environment – and of an appropriate combination of these components' sub-interventions as appropriate and needed for the behavioral context. When all three components are addressed more thoroughly and frequently in the same communities, the potential for changing and sustaining behavior increases as does the positive health impact.



3. Add to "Collaborations with NGOs and PVOs" - page 29

Counterpart International has had initial discussions with the follow-on project to EHP, the Hygiene Improvement Project (HIP). This new USAID-funded project focuses on hygiene behavior change at-scale and has, within its mandate, a task to develop the capacity of NGOs and PVOs. HIP and Counterpart are discussing ways in which HIP could strengthen Counterpart's behavior change skills, competencies, and tools. One way might be to participate in sequenced behavior change training sessions focused on hygiene with other teams of PVOs. Thus, some participants may be from Counterpart's urban health program in India, in which case the skills developed would enhance the implementation and outcomes of the JD-MCS cost extension program.

Program Response: All the suggested additions were discussed and reviewed with partners and were accepted in the draft for the CDD.

B. SUGGESTIONS TO CONSIDER AND/OR QUESTIONS

1. Correction "Reference to HIP"- pag 2 & 14,

It is stated *"JD...collaborated with the HIP which was known as EHP for promotion..."* This is incorrect, we are not an extension of EHP. See addition 3 above for best way to discuss HIP and please delete these references. Counterpart has worked with EHP and now wants to work with HIP.

2. ***Suggestion "Statistics"***

Use statistics clearly, e.g., page 1 is the 28.8% of urban or of overall, is the 19.3% of the 28.8% or of urban or of overall? Just be sure everywhere you use stats, that you use them clearly and to prove your point, whatever that point might be.

3. Suggestion "Rationale" – page 2

How is this cost extension different from the original project? Is it just a continuation of the same things, but with more time and more money? Or are you doing some new things as well? If so, state them very clearly? Why is this cost extension necessary? It does not come through clearly.

4. ***Suggestion "Treatment and Prevention" (T&P)***

More clearly distinguish between and then delineate activities, successes, etc. for treatment and prevention. Your tables (pages 8 - 13) would be much clearer if there was clarity between treatment and prevention for outcomes, audiences, and activities. As well if your original successes were broken down between T&P, it would be easier to link them to what you intend to do next and why, as well, what is required in terms of BC, quality and access can change from prevention to treatment.

5. Suggestion "Use of BCC

Just a question, do you intend to use only BCC as a means of behavior change? If you look at BC in a broader context (see addition 2 above), communication would be but one intervention to use in conjunction with other interventions.

6. Suggestion "Analysis from All Baseline Data" – page 6-7

There seems to be a mix of analysis and strategy in this section. Maybe consider breaking it up between what you found and what you want to do about what you found, e.g., (page 7)

Analysis – It appears that, in the community, there is a lot of self-medication or irrational use of drugs, antibiotics, and pills to control diarrhea, especially in the new areas.
Strategy to Address – Design, develop and conduct two bi-annual, special BCC campaigns utilizing traditional methods such as street plays, etc.

7. Suggestion "Program Strategy and Intervention Framework" – page 8-13

While we understand why you structured the table using the Guideline Headers, i.e. behavior change, quality, and access; behavior change is and should be the overarching element here. All else falls under behavior change (see addition 2 above), i.e. why do we carry out BCC – to change behavior, why do we want to improve quality – to change behavior, why do we want to ensure access – to change behavior. BC should be the overarching principle here, yes?

Maybe first describe target audiences and behavioral targets, and then illustrate how the activities/interventions will achieve these. Visually, you might want to consider adding rows and not repeating information that is the same from one column to the next, simply making it all the same row. As well, sometimes you have presented activities in the columns, sometimes you have presented audiences, it is a bit of a challenge to follow.

8. Suggestion "Program Successes"

Though you repeatedly refer to previous program successes, it was difficult to see exactly what those successes were. Maybe consider, right upfront, stating these in bullet form, e.g.,

- *Trained ## AMC staff in communication skills which have been reportedly well-received by their clients*
- *Developed ## BCC materials on DD handwashing that have resulted in a decrease of %% DD in ## communities.*

We know that you might not yet have stats such as this, but you do have qualitative results that should indicate some initial trends in how it has impacted on your audiences and you could easily use that for the present. This kind of format would also give you a behavioral starting point to use to compare against in the next report.

Technical Advisory Committee (TAC) Comments/Suggestions

1. Consider developing Institution of excellence without putting extra ordinary resources and demonstrate to all the stakeholders how a public private solution is possible and document and disseminate all the lessons

Program Response: It has been incorporated that the NGO-PVO combine of Saath and Counterpart would explore with the MOH.

2. Involvement of youth, children and adolescent groups has been appropriate and need to have special focus in all the interventions

Program Response: This suggestion has also been found special focus under all the interventions and crosscutting themes.

3. Community Health Teams and its volunteerism is a unique achievement and should be consolidated with CS + activities

Program Response: Based on this suggestion it has been conceptualized that all the CHTs would finally become Community development Teams and based on the needs

of the community would engage and manage other non health developmental initiatives. A confederation of the CDTs is also planned to consolidate the strengths. For more detail see the Phase over strategy section.

4. Consider special focus on the video based BCC material products keeping the urban population

Program Response: This suggestion has been accepted and incorporated in the BCC planning process.

5. Increased advocacy in this cycle:

Program Response: The program will have a special focus on advocacy from the year 2 and has planned several Lessons learned Dissemination workshops.

Annexure 4. CHT Monitoring Format for Group Meetings

Work of CHT Members : Area:

Name: Month:

Date	Link Worker	A.M.C.	Private Doctor	ICDS Angan Wadi	Vender	Community Leader	Traditional Birth Attendant	Traditional Healer	Youth

Annexure 5. Referral chits for different stakeholders

REFERRAL CHIT

Serial No:_____

Jeevan Daan Maternal and Child Survival Program

Date:_____

To:_____

Health Facility:_____

Patients name:_____

Care giver's Name:_____

Slum Pocket/ Ward:_____

Referred by: _____Sign:_____

Purpose:_____

COUNTERPART Saath AMC

REFERRAL CHIT

Jeevan Daan Maternal and Child Survival Program

Counterpart India/ Saath/ AMC

Serial No:_____

Date:_____

To:_____

Health Facility:_____

Patients name:_____

Care giver's Name:_____

Slum Pocket/ Ward:_____

Referred by: _____Sign:_____

Purpose:_____

COUNTERPART Saath AMC

Serial No:_____

REFERRAL CHIT

Jeevan Daan Maternal and Child Survival Program

Date:_____

To:_____

Health Facility:_____

Patients name:_____

Care giver's Name:_____

Slum Pocket/ Ward:_____

Referred by: _____Sign:_____

Purpose:_____

COUNTERPART Saath AMC

REFERRAL CHIT

Jeevan Daan Maternal and Child Survival Program

Date:_____

To:_____

Health Facility:_____

Patients name:_____

Care giver's Name:_____

Slum Pocket/ Ward:_____

Referred by: _____Sign:_____

Purpose:_____

Serial No:_____

Serial No:_____

COUNTERPART Saath AMC

REFERRAL CHIT

Jeevan Daan Maternal and Child Survival Program

Date:_____

To:_____

Health Facility:_____

Patients name:_____

Care giver's Name:_____

Slum Pocket/ Ward:_____

Referred by: _____Sign:_____

Purpose:_____

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SAATH
Initiatives for
Urban Equality

28th October 2005

Mr Ramesh Singh,
Programme Director,
Counterpart India
Ahmedabad.

Dear Ramesh,

Greetings from Saath!

It is almost a year since we started implementing the Jeevan Daan Extension Program as a partnership between Counterpart India and Saath.

At Saath, we are quite satisfied with the quality of the partnership. Saath has been involved with the program from the planning stage and this involvement has continued during the needs identification, DIP preparation, implementation at the ground level and in the monitoring and supervision on a regular basis. We feel that Saath is seen as a valuable partner and our capacities for implementing the program are being enhanced.

This complementary partnership is reflected at the leadership and team levels resulting in timely implementation of the Jeevan Daan Program.

I am also satisfied with the progress of the program from an implementation viewpoint. The Saath team has understood the program and has been able to undertake various activities during the pre-phase, phasing-in and post-phase stages satisfactorily.

My detailed comments on the various aspects of the program are attached.

I am looking forward to a long term association with Counterpart India.

With warm regards

Yours sincerely

Rajendra Joshi,
Managing Trustee

Detailed comments from Saath on Saath – Counterpart India partnership in Jeevan Daan Program

1. Overall Progress of the program

A. The following Pre Phase-In Activities have been completed

- Formation of program coordination committee, selection of areas, selection of staff, baseline KPC survey, DIP preparation and submission were completed by April 2005

B. The following Phase-In Activities have been completed

- Collection of ward level information from Urban Health Centers.
- Introduction of Jeevan Daan program to all community stakeholders
- Preparation of maps of all slum clusters
- Identification of potential CHT members

C. The following Post Phasing In Activities have been completed in all six wards

- Individual and family counseling
- Health education sessions
- BCC activities
- Household visits
- Coordination with urban health centers and anganwadis
- Meetings with all stakeholders

D Saath is satisfied with the progress of the Jeevan Daan program and has a healthy partnership with Counterpart .

2. Communication

Communication processes and timeliness.

A. There is regular communication in the form of joint meetings, preparation and sharing of reports, regular meetings of PCC, joint planning and feedback procedures.

3. Training and Capacity Strengthening

a. Trainings on technical and crosscutting aspects

Training on all technical interventions consisting of KPC survey, control of diarrheal diseases, pneumonia case management, immunization, nutrition and breast feeding , and maternal and neo-natal care have been completed. Similarly training on crosscutting aspects of MIS consisting of CBAR, household checklist and area profile have been completed.

b. Training process (need assessment, medium, tools/methods, module)

Training needs were identified through LNRA, methods used included video shows, practical demonstration, IEC, quizzes, and presentation to bring about a theoretical understanding.

c. Follow-ups

Follow-ups have not been required since this is the first year of the program and the trainings are still fresh.

4. Finance Systems and Funds Disbursement

Funds have been regularly disbursed; Saath's financial systems have been made congruent to Counterpart and program requirements. Expenditures meet budget requirements

5. Program Coordination (Monitoring and supervision)

a. Joint planning and co-working aspects

This is basic to the program and all aspects of the program have been developed jointly. Meetings with partners and stakeholders are held jointly.

b. M&E joint review development of tools and checklist

This is done regularly during fortnightly meetings

c. Joint monitoring and supervision processes

CBAR report sharing and review is done regularly on a monthly basis. Although, supervision is separate for the differing geographical areas, review and corrective measures are decided jointly.

d. Program activity information compilation and sharing data for action

Presently all data is compiled by Counterpart and shared with Saath. It is planned that soon MIS officer from Saath will join joint data compilation activity.

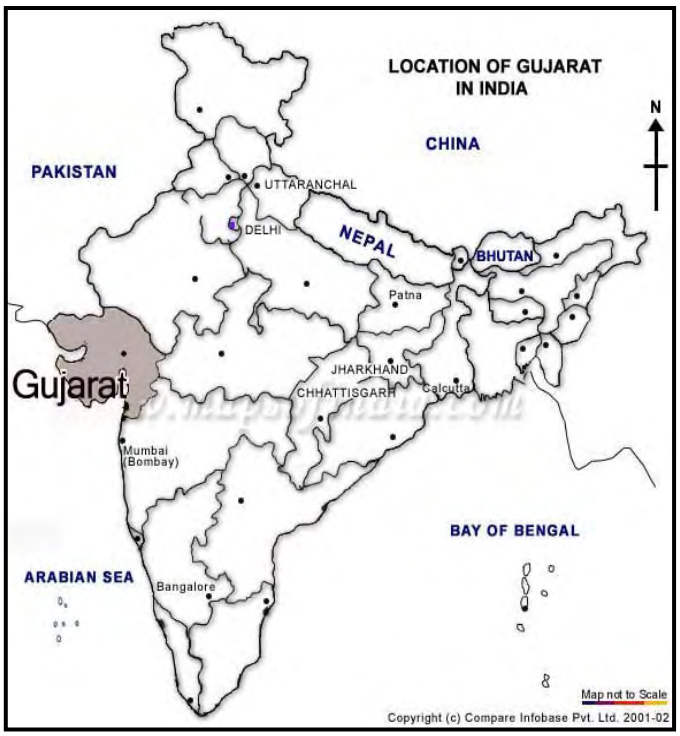
6. Progress towards sustainability

a. Training and capacity strengthening for Saath in technical interventions, crosscutting approaches, HMIS, planning and implementing MCS programs based on the organizational assessment

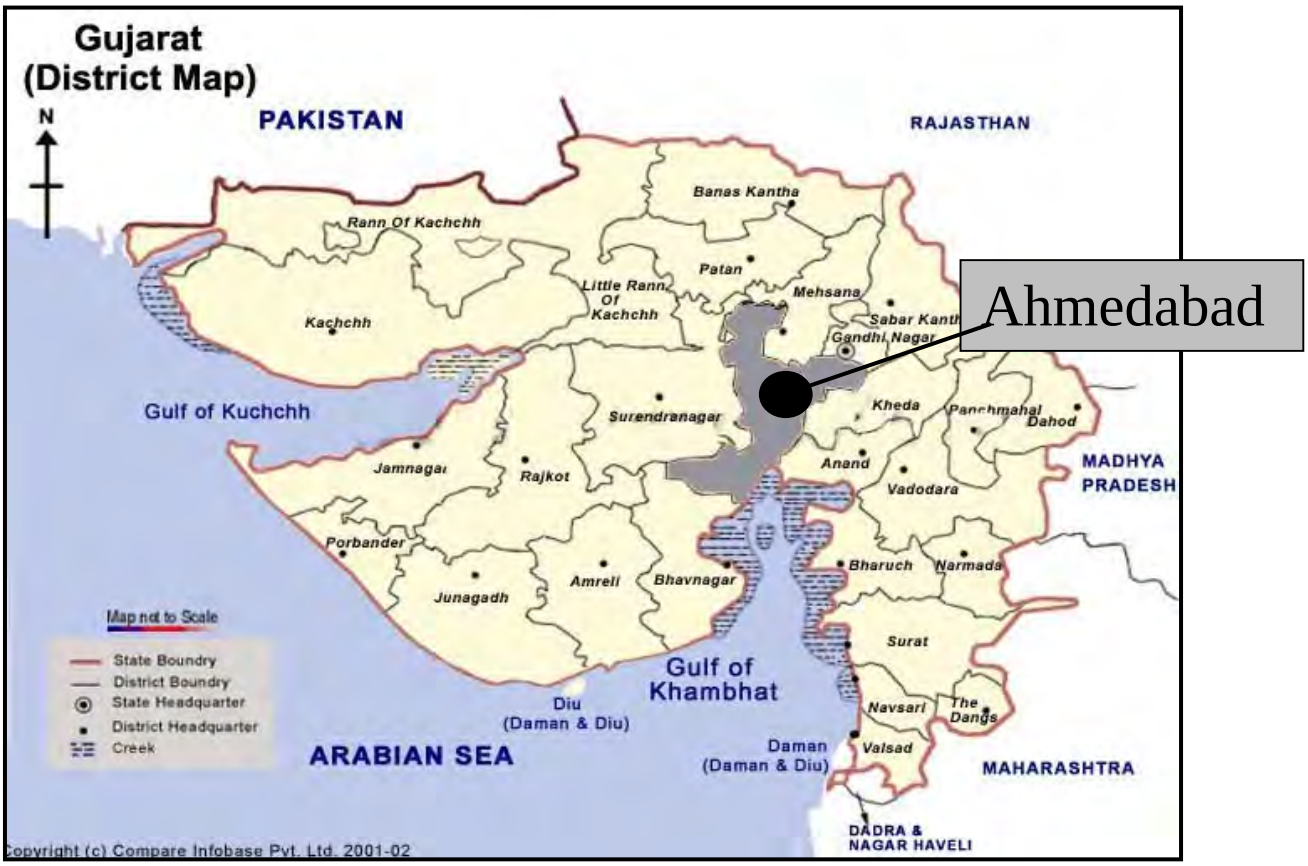
b. Recruitment of two additional technical staff 1) MIS and documentation Officer and 2) BCC and training officer at the level 50% time

Annexure 4

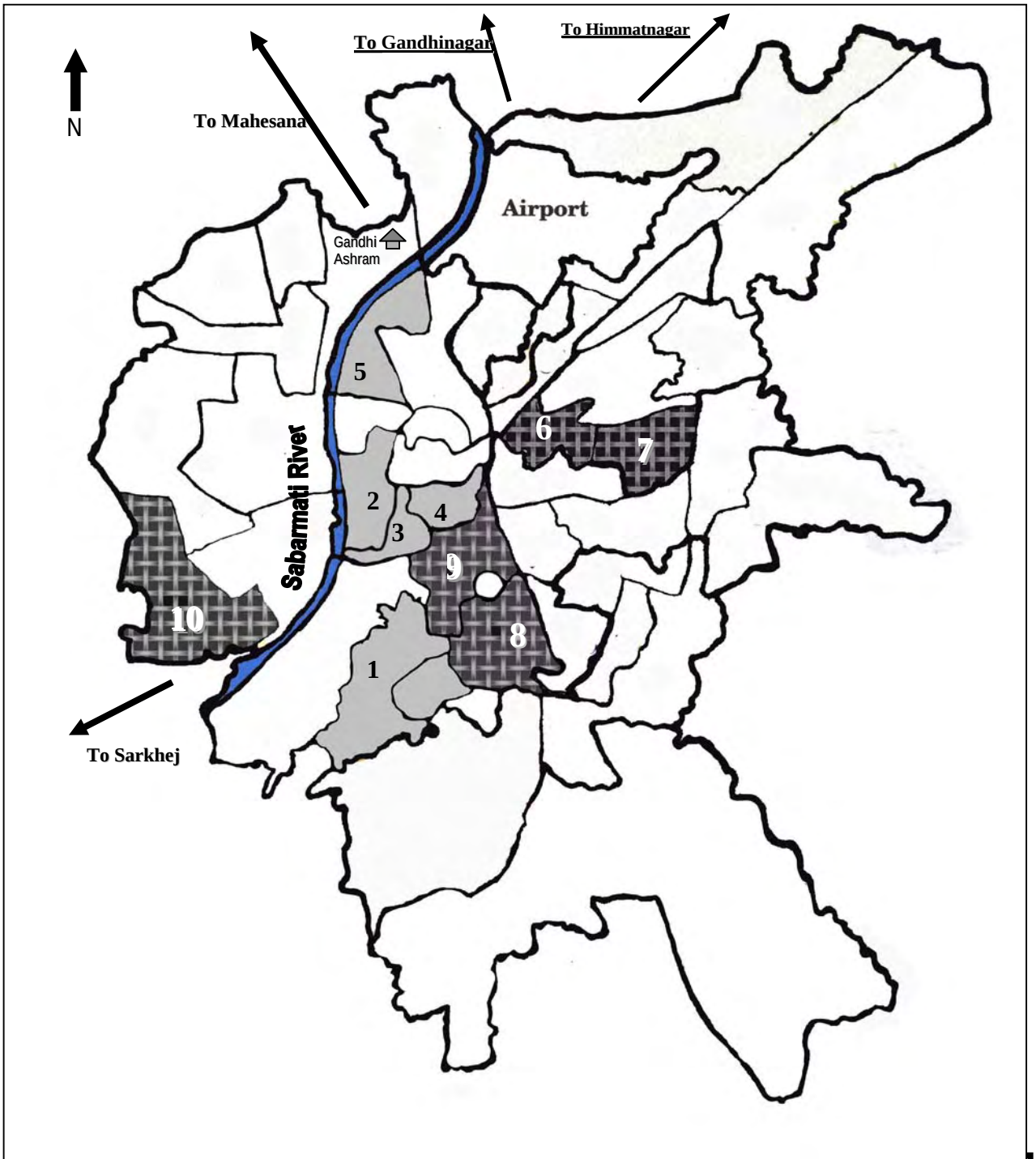
Map of India



Map of Gujarat State, India



Map of Ahmedabad under Ahmedabad Municipal Corporation city limits, delineating the 43 municipal wards



The Jeevan Daan Maternal and Child Survival Cost Extension Program Area (CS-XX)

CS-XVI Wards-1-Danilimda; 2 -Raikhad; 3-Jamalpur; 4-Raipur; 5-Dudheshwar;

Additional Wards in the CS-XX program-6-Saraspur; 7- Bapunagar; 8- Maninagar; 9 -Kankariya ; 10-Vasna