World Vision, Inc.

DETAILED IMPLEMENTATION PLAN

PRAGATI

Child Survival Project

Location:
Ballia, Lalitpur, and Moradabad Districts
Uttar Pradesh, India

Cooperative Agreement Number:
GHS-A-00-03-00018-00

Beginning Date: October 1, 2003
End Date: September 30, 2007

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Submitted to:

Child Survival and Health Grants Program
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ACRONYMS

AC	Accountant
ACOLES	Adaptation, Co-learning, Experimentation and Scaling Up
ADP	Area Development Program
ANC	Antenatal Clinic
ANM	Auxiliary Nurse Midwife
APRO	Asia Pacific Regional Office
AWW	Anganwadi Worker
BCC	Behavior Change Communication
BRICS	Ballia Rural Integrated Child Survival Project
CBD	Community-Based Distribution
CD	Capacity Development
CDC	Community Development Coordinator
CDO	Community Development Officer
CDPO	Child Development Project Officer (ICDS)
CEDPA	Center for Development and Population Activities
CHW	Community Health Worker
CMO	Chief Medical Officer
CSHGP	Child Survival and Health Grants Program
CSSA	Child Survival Sustainability Assessment
CSP	Child Survival Project
CSPO	Child Survival Project Officer
CSTS+	Child Survival Technical Support Project
DIP	Detailed Implementation Plan
DPT	Diphtheria/Pertussis/Tetanus vaccine
DPO	District Program Officer (ICDS)
ELCO	Eligible couples for family planning
EPI	Expanded Program on Immunization
FAR	First Annual Review
FG	Field Coordinator
FGD	Focus Group Discussion
GOI	Government of India
GSS	Gramin Swasthya Sevikas (WV-trained volunteer CHWs)
HIS	Health Information System
HMIS	Health Management Information System
HWPA	Health Worker Performance Assessment
ICDS	Integrated Child Development Scheme
IO	Immunization Officer
IDI	In-Depth Interviews
IFA	Iron Folic Acid tablets
KPC	Knowledge, Practice & Coverage

LAM	Lactational Amenorrhea Method
LHV	Lady Health Visitors (Supervisors of ANMs)
LOE	Level of Effort
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring and Evaluation
PME	Performance Monitoring and Evaluation
PMO	Program Monitoring Office
MTE	Mid-Term Evaluation
MOIC	Medical Officer in Charge
MOH	Ministry of Health
MS	Mukhya Sevikas (Supervisors of AWWs)
MWRA	Married Women of Reproductive Age
NCHS	National Center for Health Statistics (United States)
NFHS	National Family Health Survey
NGO	Non-Governmental Organization
OPV	Oral Polio Vaccine
PEI	Polio Eradication Initiative
PHC	Primary Health Center
PME	Performance Monitoring & Evaluation
PVO	Private Voluntary Organization
RH	Reproductive Health
RMP	Registered Medical Practitioner
SDM	Standard Days Method
SHG	Self-Help Group
SIFPSA	State Innovations in Family Planning Services Agency
SNID	Sub-National Immunization Day
TA	Technical Assistant
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
TOT	Training of Trainers
UP	Uttar Pradesh
WHO	World Health Organization
WV	World Vision
WVUS	World Vision United States

A. EXECUTIVE SUMMARY

The Protecting and Advancing Gains (PRAGATI) Project is a four-year cooperative agreement between USAID/Washington and World Vision US, awarded under the Expanded Impact category of the Child Survival and Health Grants Program, FY 2004-2007. This project will be implemented in Ballia, Lalitpur and Moradabad districts of Uttar Pradesh (UP). PRAGATI brings to scale the strategies, methods and tools developed and tested in the Ballia Integrated Rural Child Survival (BRICS) project, FY 1998-2002.

Problem Statement: Uttar Pradesh is the most populous of India's 29 states, with an estimated total population of 166 million and a growth rate of 2.4% per year. Nearly all child health, reproductive health and nutrition indicators of UP are well below national averages. Access to, and utilization of, health and information services is limited and the quality of these services is poor. The state's health services system is understaffed and the associated problems of inadequate compensation, training and supervision contribute to impaired performance and motivation. Within UP, there are disproportionately greater needs in the eastern, western and southern regions where the program districts are located.

End of Project beneficiaries will include an estimated 1,133,295 children 0-5 years of age and 1,609,280 women of reproductive age. The total population of the three districts is 7,555,303.

The *Objective (Key End Result)* of the project is to scale up a wellness package of critical child survival and family planning interventions in Ballia, Lalitpur and Moradabad districts of UP state.

The following *Intermediate results (IR) and Sub-results* (SR) will contribute to the achievement of this objective:

IR 1: Increased use of key interventions: Immunization, Family Planning, Maternal and Infant Nutrition, and Vitamin A supplementation	**IR 2:** Strategies, methods and tools from BRICS scaled up
SR 1a: Increased access to Child Survival and Family Planning services **SR 1b:** Increased quality of Child Survival and Family Planning services **SR 1c:** Increased knowledge and interest of Child Survival and Family Planning services	**SR 2a:** BRICS project site becomes an ACOLES (Action, Co-Learning & Scale Up) Center **SR 2b:** Strategies, methods and tools from BRICS documented and adopted **SR 2c:** Three operations research studies completed

The overall strategy of PRAGATI is to build capacity of and strengthen operational linkages between its key partners: the Integrated Child Development Scheme (ICDS) project, the government health services and the local partner NGOs. The Anganwadi Workers (AWW) of the ICDS, who are close to the communities, will ensure that all beneficiaries participate in the program. Three specific strategies critical to the success of BRICS will be adapted and scaled up under PRAGATI: (1) early registration of pregnant women and eligible couples; (2) targeted and timed BCC; and (3) creation of an enabling environment for the AWWs.

Although the progression of the coverage of activities in each district will be adapted to local contexts, all AWWs in the three districts will be trained in project interventions by the end of the third year (September 2006). The health system at the district, block and village levels will provide immunization and family planning services. The PRAGATI project will train the Auxiliary Nurse Midwives in sub-health centers and other selected health workers involved in program activities. The project will also strengthen the supply systems for contraceptives, vaccines, IFA tablets and vitamin A. For family planning, the PRAGATI project will collaborate with State Innovations in Family Planning Services Agency (SIFPSA) and receive technical assistance from CATALYST/India. In each district, PRAGATI will collaborate with local NGOs who will be trained and empowered to work with AWWs and their communities.

The proportionate level of effort allocated to each PRAGATI intervention in the proposal is as follows:

Intervention	Level of Effort
Immunization	40%
Family planning	30%
Breastfeeding and nutrition	20%
Vitamin A supplementation	10%

With resources from USAID's Flexible Fund (Flex Fund), the family planning intervention has been extended to married women of reproductive age instead of only mothers of children under two. Preliminary analyses of the level of effort by interventions to be completed by the First Annual Review may lead to a revision of this allocation.

The project will conduct community-level operations research on at least three topics: (1) Introduction of LAM and SDM to expand contraceptive choice; (2) Evidence-based advocacy for immunization services; and (3) Use of pregnancy and infant tracking registers for sentinel fertility and mortality surveillance. In addition, several innovative approaches will be assessed, documented and disseminated.

The PRAGATI Project started on October 1, 2004 and will end on September 30, 2007. Grant funding from USAID for this project is $2,499,771, and World Vision matching funds amount to $945,422, for total funding of $3,445,193 over the five-year period.

The first, as well as subsequent, drafts of the DIP have been discussed in detail with Samaresh Sengupta, PVO Liaison Officer (who recently left this role) and Dr. Meenakshi, Reproductive Health Advisor, of the USAID Mission in Delhi.

The main contributors to this document are Beulah Jayakumar, Jeshurun Rajan, Clement Timothy, Rajini Thambudorai, Marc Debay, David Grosz, Susan Larson and Lyndon Brown.

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B. CSHGP DATA FORM

Child Survival Grants Program Project Summary

DIP Submission: April 30, 2004
World Vision US

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Project Description:	The PRAGATI Project (initially called BRICS 2 SCALE), is funded by a four-year (2004-2007) cooperative agreement between USAID Washington and World Vision US awarded under the Expanded Impact Category of the Child Survival and Health Grants Program. This project is being implemented in Ballia, Lalitpur and Moradabad districts of Uttar Pradesh (UP) state, and 19 other Area Development Programs of World Vision India, thereby bringing to scale the strategies, methods and tools developed and tested in the Ballia Integrated Rural Child Survival Project (BRICS). The goal of PRAGATI CSP is to "To scale up a package of preventive and promotive child survival interventions in Ballia, Lalitpur and Moradabad districts of UP state and in 19 other WV's ADPs over four years." This goal will be achieved through two Intermediate Results (IR): IR 1 "Increased use of key CS and FP interventions", including immunization, breastfeeding, vitamin A supplementation, and family planning; and IR 2 "Strategies, methods and tools from BRICS I scaled

	up". IR 1 of PRAGATI CSP is similar to other child health and survival projects in terms of its general strategy to increase access, quality and demand for specific technical interventions. IR 1 will be achieved through three Sub-Results (SR): SR 1a "Increased access to CS and FP services in communities"; SR 1b "Increased quality of CS and FP services"; and SR 1c "Increased knowledge and interest of CS and FP services". Indicators for IR 1 and its sub-results are common CS and FP indicators. All nine core indicators required by the Flexible Fund are included in the framework. Under IR 2, PRAGATI CSP will develop, test and document focused approaches for scaling up these interventions. PRAGATI CSP not only seeks to gain the health impact specified under IR 1 results, but to achieve this by bringing to scale specific strategies, methods and tools that have been developed, tested and documented on a pilot basis in the Direct Impact area of BRICS. The indicators for IR 2 will measure the extent to which strategies, tools and methods have been scaled up and are likely to have contributed to the achievement of IR 1. These indicators are critical to the assessment of PRAGATI's scale up component. IR 2 of PRAGATI CSP will be achieved through three SRs: SR 2a "BRICS I project site becomes Action, Co-Learning and Scale Up (ACOLES) Center"; SR 2b "Strategies, methods and tools from BRICS 1 documented and adopted"; SR 2c "Three operations research studies completed". Ten overall strategies will give structure and direction to implementation of the project's four key interventions: (i) Performance improvement of AWW & ANM; (ii) Early registration of all pregnant women; (iii) Targeted and timed behavior change communication for families (iv) Improved block and village level planning and use of data; (v) Creation of an enabling environment for the AWW; (vi) Phased coverage of villages and blocks; (vii) Partnership and capacity building; (viii) Planning for sustainability; (ix) Demonstration, documentation and operations research; (x) Coordination and management.
Partners:	In each district, World Vision's partners in the implementation of PRAGATI CSP include Health Services, the ICDS Project and selected local NGOs. The health system will be the principal provider of all services in the projects intervention areas. The Chief Medical Officer and his team provide management and leadership to the district public health care system. There is a Primary Health Center (PHC) for every 100,000 people and a sub-center for about 5000 to 8000 people. The PHC is staffed by two medical doctors, a pharmacist, an Immunization Officer (IO), Auxiliary Nurse Midwives (ANMs) and administrative staff. It offers curative and preventive services such as immunization, antenatal and postnatal care. Sub-centers, each staffed by an ANM, offer basic curative care, immunization, family planning, antenatal and postnatal care. Specific activities being conducted to support this strategy include: ANM and AWW performance improvement, further strengthening of HIS and supervision systems; linkages among staff of health services and ICDS

	and both groups with communities; and for NGOs, identify areas of potential capacity building through NGO self-assessment score sheets; support for NGO staff in promoting closer linkage between AWWs and their communities; support for household surveys and increased service coverage.
Project Location:	Uttar Pradesh State, the most populous of the country's 29 states, is located on the Ganges plain in northern India. With a population of 166 million, the state is divided into 70 districts in four regions, each having distinct dialect, culture and traditions. The project districts are diverse and widely separated: Ballia district is located in the eastern (Purvanchal) region, close to the border with Bihar state. The predominantly agrarian economy benefits from fertile alluvial soil and abundant water supply. However, an estimated 60% of the population is landless. Moradabad district is in the western part of UP, close to Delhi. A majority of the population is employed in the brass industry, for which this district is renowned. Moradabad has a predominantly Muslim population (70%). Only 24.7% of the population is literate. Moradabad is one of the four districts in UP that have been a particular challenge to the country's polio eradication campaign, with a high proportion of families refusing OPV immunization and continued transmission of wild poliovirus. Lalitpur district is one of the 7 districts in the southwestern (Bundelkhand) region of UP, and is located close to the border with Madya Pradesh state. The district has vast forestlands. Most people work on their own small farms and supplement their income by working in stone quarries. Urban migration is minimal.

Grant Funding Information:

USAID Funding:(US $)	$2,499,771	**PVO match:(US $)**	$945,422

Target Beneficiaries:

Type	Number
Infants (0-11 months):	304,240
Children 12-23 months:	289,028
Children 24-59 months:	540,027
Children 0-59 months:	1,133,295
Women 15-49 years:	1,609,280
Estimated Number of Births:	271,990

Beneficiary Residence:

Urban/Peri-Urban %	Rural %
6%	94%

General Strategies Planned:

Advocacy on Health Policy
Strengthen Decentralized Health System
Information System Technologies

M&E Assessment Strategies:

KPC Survey
Health Facility Assessment
Organizational Capacity Assessment with Local Partners
Lot Quality Assurance Sampling
Community-based Monitoring Techniques
Participatory Evaluation Techniques (for mid-term or final evaluation)

Behavior Change & Communication (BCC) Strategies:

Interpersonal Communication
Support Groups

Capacity Building Targets Planned:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
US HQ (General) US HQ (CS unit) Field Office HQ CS Project Team	Local NGOs	(None Selected)	District Health System Health Facility Staff ICDS Staff & Anganwadi Workers	CBOs CHWs

Interventions:

Immunizations 40 %
** CHW Training
** HF Training
*** Polio
*** Classic 6 Vaccines
*** Vitamin A
*** Cold Chain Strengthening

*** Injection Safety
Breastfeeding 20 %
** CHW Training
** HF Training
*** Promote Exclusive. BF to 6 Months
*** Intro. or promotion of LAM
Nutrition/Micronutrients/Vit A (Combined) 10 %
** CHW Training
** HF Training
*** Complementary Feeding from 6 mos.
*** Continuous BF up to 24 mos.
*** Supplementation
*** Integrated with EPI
*** Iron Folate in Pregnancy
Family Planning & Reproductive Health 30 %
** CHW Training
** HF Training
*** Knowledge/Interest
*** FP Logistics
*** Community-Based Distribution
*** Quality Care
*** Human Capacity Development
*** Community Involvement
*** Access to Methods
*** Policy

Indicator	Numerator	Denominator	Estimated Percentage	Confidence Interval
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	**814**	1800	45.2	±3.7
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	439	811	54.1	±4.1
Percentage of children age 0-23 months whose births were attended by skilled health personnel	194	900	21.6	±3.7
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	619	900	68.8	±3.1
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	282	562	50.2	±5.8
Percentage of infants age 6-9 months receiving breast milk and complementary foods	68	237	28.7	±8.1
Percentage of children 12 months of age2-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	72	218	33.0	±8.8
Percentage of children 12 months of age2-23 months who received a measles vaccine	129	218	59.2	±6.5
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	107	1792	6.0	±1.5
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	1227	1814	67.6	±3.6
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an	**7**	1164	0.6	±6.2

illness in the past two weeks				
Percentage of mothers with children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	153	1795	8.5	±1.8
Percentage of mothers with children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	601	1781	33.7	±3.1

C. DESCRIPTION OF DIP PREPARATION PROCESS

Upon announcement of the award for the PRAGATI project, World Vision India held a series of meetings both internally and with key stakeholders in Delhi, Lucknow and the three project districts. These meetings continued the discussion begun during the proposal development process in the fall of 2002. WV India has undergone major re-structuring over the past year. In this context, the project's organizational structure was revised. Project staff was recruited accordingly.

One of the project's first steps in preparing for the DIP was design and preparation of baseline KPC surveys to be undertaken in the three program districts. These were conducted in October and November 2003. Data entry, processing and analysis were done centrally in Ballia. Survey reports were completed at the end of April 2004.

During the early project startup period, PRAGATI sought and received technical assistance from the Child Survival Technical Support Plus (CSTS+) Project on application of the new Child Survival Sustainability Assessment (CSSA) tool.[1] This technical assistance provided an opportunity to bring key project stakeholders together to develop a common vision for maternal and child health in Uttar Pradesh; to discuss proposed interventions, methods and approaches; and to begin the process of sustainability assessment. A first round of meetings w held in the three districts in January and were followed by a project-wide workshop held in Lucknow in February. The workshop brought stakeholders from the three districts along with UP state officials, World Vision health staff from PRAGATI project, WV India, WV APRO and WV US, as well as three colleagues from USAID (one from USAID/GH/PRH/SDI plus two from USAID/Nepal) and one CSTS+ consultant. In March and April, the outcome of this workshop was reported in the three districts and baseline assessments were conducted using the methods and tools developed during the workshop.

Discussions were also held with USAID/GH/PRH/SDI and CATALYST/India colleagues regarding the Flexible Fund, which contributes 30% of the Project's grant. This funding required that the initially proposed birth spacing intervention be expanded to a broader range of family planning services and specific indicators be adopted for monitoring and evaluation of related activities. A baseline survey of Married Women of Reproductive Age was carried out in March 2004. Flex Fund is also providing technical assistance in family planning for the project through CATALYST and CEDPA/India. The Terms of Reference and Work Plan for this assistance were defined and agreed upon in April 2004 (see Annex 18).

Also during the DIP preparation, the results framework included in the proposal was reviewed, and minor changes were made in the scope and targets for the family planning and the nutrition interventions (see section D). Proposed operational linkages with the ICDS project and other partners were discussed with the USAID mission and with the partners themselves. This required several rounds of discussions to adapt the strategies from BRICS and spell out the roles

[1] See CSTS+ website www.childsurvival.com for more information about the CSSA.

and responsibilities of the Anganwadi Workers (AWWs). The HMIS currently used by ICDS was reviewed and the BRICS registers, designed for early registration and tracking of pregnant women and eligible couples for timely communication of behaviors, were adapted.

Project launch meetings were held in the three project districts during February and March, 2004. District magistrates and representatives from the MOH, ICDS, SIFPSA and local NGOs were invited to attend briefings on the project. In each district, the participants to the launch meetings also discussed the targets to adopt for each project indicator. The list of persons participating in these meetings is found in Annex 2.

Also in February, four PRAGATI project team members, one representative from CATALYST/India, and two ICDS state officials participated in a DIP-writing workshop held in Delhi from March 1 to 6 and facilitated by one external consultant. This group reviewed all information available, identified remaining gaps, and began outlining various sections of the DIP according to USAID CSHGP and Flexible Fund guidance. They also discussed the various activities to be conducted by each partner and met with staff of the USAID mission. A first draft of the DIP was distributed on March 19 for review within World Vision India, APRO and WVUS, and by selected stakeholders including Chief Medical Officers of the three districts, state-level ICDS officials, CEDPA/India, USAID/India and USAID/GH/PRH/SDI. Further drafts were then distributed internally and externally until the submission to USAID on April 30, 2004.

The PRAGATI CSP Project Manager, WV Asia-Pacific Regional Health Advisor, WVUS Advisor for Child Health and the project's Baltimore-based consultant, participated in the 2nd Mini-University, held in Baltimore June 7th-11th, 2004. They presented the PRAGATI DIP and discussed the reviewers' comments of the draft DIP submitted April 30th with USAID CSHGP and Flex Fund representatives. They also presented specific aspects of the project in a total of four panel and roundtable discussions - one related to family planning, and three on various aspects of sustainability. The PRAGATI DIP was approved by USAID, with the understanding that three pending assessment reports (ANM performance assessment, FP surveys and NGO capacity assessment) would be included in the final document.

D. REVISIONS (FROM THE ORIGINAL APPLICATION)

Change in name

The name of the project was changed to PRAGATI. This is an acronym for "Protecting and Advancing Gains." In Hindi, *pragati* means advancement, further achievement, acceleration, a gain in momentum. As originally proposed, the project was called "BRICS 2 SCALE Child Health Project" signifying our intention to build on and scale up earlier successes from the Ballia Rural Integrated Child Survival (BRICS) Project. The new name will help to impart a favorable identity to the project; more familiar to the people we serve, and more effectively convey the idea of *expanded impact*.

Minor changes in objectives

The original goal of the project was "To scale up a comprehensive 'wellness' package of preventive and promotive child survival interventions in Ballia, Moradabad and Lalitpur districts of UP state, and in 19 World Vision ADPs." This has been modified as follows: "To scale up a wellness package of critical child survival and family planning interventions in Ballia, Lalitpur and Moradabad districts of UP state." PRAGATI interventions are only a subset of what a comprehensive package would include. The proposed scale and rapid expansion of the project has been a major consideration in our decision to focus on a limited number of interventions. World Vision India still intends to scale up BRICS strategies, methods and tools within 19 ADPs of the North Zone. Apart from the operations research studies to be carried out by PRAGATI CSP, as described below, World Vision intends to utilize other non-grant resources to fund scaling up activities.

IR 2 was changed from "Scale up strategies and tools documented and disseminated to local and international agencies." to "Strategies, methods and tools from BRICS I scaled up." This new formulation better supports the goal of PRAGATI CSP to build on the success of BRICS in scaling up the implementation of its specific strategies, method and tools.

Scope and LOE of the interventions

The birth spacing intervention described in the proposal is supported with funding from the Flexible Fund, recently established by the Office of Population and Reproductive Health/Service Delivery Improvement Division. With this funding, World Vision will be able to expand family planning services, with potential coverage of all married women of reproductive age (MWRAs), rather than mothers of children under 2 years old - the focus of birth spacing interventions. In terms of field activities, this expansion translates into the introduction of quarterly visits to eligible couples and use of a new register for eligible couples by the AWWs. The AWWs will primarily provide targeted and timed counseling on family planning, non-clinical contraceptives (pills, condoms, SDM/LAM) and referral services for all MRWAs. Recent analysis of LOE by intervention during detailed planning of PRAGATI field activities suggests that original estimates of proportional effort and resource allocation included in the proposal. In particular, the level of effort required to meet new family planning coverage targets appears considerably

greater than originally proposed, while the proportional LOE for immunization may be lower than anticipated. These analyses will be completed for the FAR, and LOE allocations may need to be formally revised at that point.

The exclusive breastfeeding intervention described in the proposal has been expanded to include improved nutrition for pregnant women, and appropriate complementary feeding for infants 6-11 months of age. As one key activity, the project will help AWWs identify pregnant women as early as possible after conception, monitor their progress through gestation and delivery, and track mothers and infants to ensure that they receive appropriate care through each stage. This offers a valuable opportunity to communicate messages related to maternal nutrition in pregnancy as well as breastfeeding and complementary feeding for infants. During the year between final evaluation of BRICS and the launch of PRAGATI, in Ballia District, World Vision introduced BCC strategies for improved infant feeding practices developed and adapted in collaboration with LINKAGES. These strategies and related tools will be integrated into the PRAGATI training and Behavior Change Communication (BCC) materials and into the AWW activities. AWWs will also be supported in distributing Iron and Folic Acid (IFA) tablets and in counseling pregnant women on antenatal care, birth preparedness, and the importance of taking one extra meal a day.

Additional surveys and assessments

To meet the monitoring and evaluation requirements of the Flexible Fund for the family planning intervention, an additional survey of Married Women of Reproductive Age (MWRAs) was conducted in the districts of Ballia and Lalitpur as part of the project baseline assessment. This survey will be repeated at midterm and at the final evaluation of the project.

Building on the CSSA workshop in February, two additional assessments will be conducted in the three project districts. The NGO capacity assessments were conducted in May and June 2004, and the Community Competence Assessment will be completed by the FAR.

Relocation of main project office

Following World Vision India's recent restructuring, the PRAGATI field office was relocated from Ballia to Lucknow in April 2004. This change will facilitate travel of the project management team to Lalitpur and Moradabad districts but may reduce the time they spend in Ballia and in the ACOLES Center. The proximity of state-level government health service, ICDS officials, and staff from USAID Cooperating Agencies including CATALYST/India will strengthen the project coordination and collaboration with these agencies - an added advantage of moving the office to Lucknow.

Revised budget

The PRAGATI budget and narrative were revised to reflect the changes in international and regional travel costs (less than the amount proposed in the application) and in capital assets (also less than the amount earlier proposed).

E. DETAILED IMPLEMENTATION PLAN

PRAGATI builds on two phases of the BRICS project that successfully developed and tested strategies, methods and tools to implement a set of six interventions in a direct impact area with a population of 150,000. Two of the six interventions were then scaled up to cover an indirect impact area with a population of 2,752,412. PRAGATI will contribute to further expansion, implementing four interventions in three districts (7,555,303 total population), and adapting the strategies, methods and tools developed under BRICS.

Table 1 shows the interventions scaled up during BRICS and PRAGATI. PRAGATI will scale up four main interventions that were implemented during BRICS: immunization, family planning, maternal and infant nutrition (particularly exclusive breastfeeding, complementary feeding and iron & folic acid supplementation) and vitamin A supplementation.

Table 1: Scaling Up Interventions under BRICS and PRAGATI Projects

Project/Phase	Total population	Period (FY)	Interventions					
BRICS:								
Direct Impact	150,000	99-02	Imm	ANC	EBF	Vit A	BS	MSC
Indirect Impact	2,752,412	01-02	Imm	ANC	-	-	-	-
PRAGATI:								
Three districts	7,555,303	04-07	Imm		MIN	Vit A	FP	-

Acronyms: Imm: Immunization; ANC: Antenatal Care; EBF: Exclusive breastfeeding; Vit A: Vitamin A supplementation; BS: Birth Spacing; MSC: Management of the sick child; MIN: maternal and infant nutrition; FP: family planning.

Three strategies were critical to the success of BRICS and will be adapted and scaled up under PRAGATI:

- Early registration of pregnant women and eligible couples
- Targeted and timed BCC: *timed* with the stage of pregnancy, age of the infant and fertility intentions of eligible couples; *targeted* for decision makers in the family.
- Creation of an enabling environment for the Anganwadi Worker (AWW), a grassroots workforce of nearly 5000

To scale up these key BRICS strategies and their related methods and tools, PRAGATI will implement the following strategies:

- Improved block and village level planning and use of data
- Health worker performance improvement (ANMs and AWWs)
- Partnership and capacity building
- Phased coverage of blocks and AWWs
- Planned sustainability
- Demonstration, documentation and operations research
- Coordination and management

The partners of PRAGATI in the three project districts are:

- Government health services
- Integrated Child Development Scheme (ICDS) project
- Local NGOs

PRAGATI will also collaborate with State Innovations in Family Planning Services Agency (SIFPSA) for the family planning intervention.

The key end result and intermediate results of PRAGATI are:

Objective (Key End Result): To scale up a wellness package of critical child survival (CS) and family planning (FP) interventions in Ballia, Lalitpur and Moradabad districts of UP state.	
IR 1: Increased use of key interventions: immunization, family planning, maternal and infant nutrition, and vitamin A supplementation	**IR 2:** Strategies, methods and tools from BRICS scaled up
SR 1a: Increased access to child survival and family planning services **SR 1b**: Increased quality of child survival and family planning services **SR 1c:** Increased knowledge and interest of child survival and family planning services	**SR 2a:** BRICS project site becomes an ACOLES (Action, Co-Learning & Scale Up) Center **SR 2b:** Strategies, methods and tools from BRICS documented and adopted **SR 2c**: Three operations research studies completed

Section E is the primary section of the PRAGATI DIP and is structured as follows:

Section E.1 summarizes the general characteristics of the three project districts and presents the methodology and findings of the various baseline assessments conducted since the beginning of the project in October 2003. The MOH policies relevant to the project interventions and the main constraints to the achieving the project objectives are summarized.

Section E.2 presents the results framework of PRAGATI, and the overall crosscutting strategies that will be implemented. The first strategies discussed are those developed under BRICS that will be scaled up under PRAGATI. The others detail how these BRICS strategies will be scaled up.

Section E.3 summarizes the monitoring and evaluation approaches of PRAGATI.

Section E.4 is the PRAGATI work plan.

The numerous annexes to this document are important components of the DIP that can be used separately: baseline assessments reports, results framework, sustainability framework, templates for the ICDS Health and Management Information System, BCC job aids for the AWWs, PRAGATI staffing structure and job descriptions, et cetera.

E.1. Summary of Baseline And Other Assessments

E.1.a. General characteristics of project districts

Uttar Pradesh, the most populous of India's 29 states, is located in the northern part of the country, on the Ganges plain. With a population of 166 million,[2] the state is divided into 70 districts in four regions - each with distinct dialect, culture and traditions (see map in Annex 3). The proposed project districts are located in three different regions of the state. **Ballia district** is located in the eastern (Purvanchal) region, close to the border with Bihar state. The predominantly agrarian region is fueled with fertile alluvial soil and abundant water supply, but an estimated 60% of the population is landless. **Lalitpur district** is in the southwestern (Bundelkhand) region of UP, located close to the border with Madya Pradesh state. The district has extensive forest. Most people work on their own small farms and supplement their income by working in stone quarries. Urban migration has been minimal. In **Moradabad district,** in western UP 150 km from Delhi, the majority of the population is employed in the brass industry, for which the district is renowned. Moradabad's population is predominantly Muslim (70%). Only 24.7% of the population is literate. Moradabad is among four districts in UP that are a challenge to the country's polio eradication campaign. Until recently it was the major source of the wild poliovirus in Northern India.Table 2 presents selected demographic data on the three project districts. The total population of the three project districts is 7.5 million inhabitants, that is, 4.5% of the population of Uttar Pradesh. Moradabad has the largest population and highest population density of the three project districts. Lalitpur, by contrast, is quite sparsely populated in some areas.

Table 2: Population, project beneficiaries and admin units in PRAGATI districts

Indicator	PRAGATI District			PRAGATI Total
	Ballia	Lalitpur	Moradabad	
Total Population, 2001	2,752,412	970,135	3,832,756	7,555,303
Children Under One Year	77,067	17,270	126,480	220,817
Children Under Three Years	266,983	94,103	371,777	732,863
Children Under Five Years	412,862	145,520	574,913	1,133,295
Women of Reproductive Age	586,264	206,639	816,377	1,609,280
Number of Blocks	17	6	14	37
Number of Villages	2517	689	1540	4746

Source: Population figures: 2001 General Census and CMO office records in the respective districts. Women of reproductive age calculated from corresponding distribution in the NFHS 98-99 (21.3%).

[2] Census 2001, Govt of India.

E.1.b. Baseline assessment methods

i. KPC surveys of mothers with children under two

Knowledge, practice and coverage (KPC) surveys of mothers with children 0-23 months were done in Ballia, Lalitpur and Moradabad in October and November 2003 in cooperation with the respective district Chief Medical Office, local NGOs and community leaders. These surveys consisted of quantitative household surveys and qualitative studies involving Focus Group Discussions (FGDs) and In-depth Interviews (IDIs). The project staff in Ballia did the data entry, processing, and analysis. The report was completed by the end of April. See Annex 4.

1. Quantitative household survey

The methodology included in the questionnaire was adapted from the KPC 2000+ Field Guide (two-stage 30-cluster sampling with parallel sampling of mothers with children aged 0-11 months and mothers with children aged 12-23 months). The total number of children sampled was 1800 (2 parallel samples of 300 in each of three districts).

The survey covered the areas of tetanus Toxoid (TT) vaccination in pregnancy: skilled attendance at birth; breastfeeding (initiation; feeding of colostrums; prelacteals; style of breastfeeding; current breastfeeding; frequency of breastfeeding and breastfeeding during child's illness;, 24 hour food recall; knowledge of mothers about signs of childhood illness; giving food and fluids during illness; malaria prevention (use of insecticide treated bed nets); hand washing practices; knowledge of mothers on HIV risk reduction; child spacing; knowledge of source of FP methods; use of modern family planning methods; method mix and duration of use; possession of vaccination card; vaccinations given and mothers' recall of vaccinations in the absence of card; vitamin A supplementation; and anthropometrical measurements. The priority child survival indicators (Rapid CATCH) were included in both questionnaires.

2. Qualitative studies

Objectives of the qualitative studies were to gain in-depth understanding of the family practices and norms related to breastfeeding; birth spacing and immunization; the decision making processes within families; the belief structure behind these practices; the sources and content of information provided to families; and the feasibility of related behavior change interventions. Five blocks were selected in each district: one in a central location, and the other four in outlying areas, at a distance from each other.

In each block, one *Focus Group Discussion* (FGD) was held with village-based private practitioners (RMPs—Registered Medical Practitioners), with traditional birth attendants (TBAs), with mothers-in-law and with married men (5 FGDs per type of participant and per district, that is, a total of 60 FGDs). The first two target groups are the most frequent sources of information and counseling for mothers and families. The latter two have a critical role in decision making within families. Participants were drawn from different villages in the block. The size of the groups ranged from 8 to 16.

In depth interviews (IDI) were held with mothers with children aged 0-11 months of age. In each block, two mothers were selected from a location close to a health center and two from a location far from these services (20 mothers per district, that is, a total of 60 IDIs). These interviews also

covered the entire range of interventions planned for this project, with a focus on the experience of mothers and the feasibility of behavior change interventions. Beliefs and taboos and major sources of information and support were explored.

ii. FP surveys of married women of reproductive age

Family planning (FP) surveys of Married Women of Reproductive Age (MWRA) were conducted in March and April 2004 in Ballia and Lalitpur, the two districts where the FP intervention will be implemented. The WHO two-stage 30-cluster survey sampling methodology was used in these surveys. Respondents were MWRAs (rather than all women of reproductive age) because Government of India family planning programs target only *married* women aged 15 to 49 years. As the median age at marriage is 17 years, a relatively small proportion of women 15-49 years of age are excluded from the survey and, consistent with GOI policy, from access to family planning services.

The FP surveys, in contrast to standard KPC surveys, were intended to assess the family planning needs and practices of a different target group, married women 15-49 years of age, and to examine a broader set of family planning-related questions and indicators. These indicators will be used by other projects supported by the Flexible Fund, and this will allow for comparisons among projects. The decision to conduct these FP surveys was made after data collection for the KPC surveys was already completed, so they were of necessity carried out separately. For the project's mid-term and final evaluations, these surveys will be planned and conducted together.

Flex Fund and CSTS+ developed the survey questionnaire and the tabulation plan (see Annex 5) and PRAGATI was the first CSHGP project to test this tool in the field. This questionnaire enquires into the contraceptive usage practices of MWRAs, their access to FP methods, and the quality of service they receive. The questionnaire and tabulation plan proposed by the Flexible Fund were adapted slightly and used for the surveys. The data collection, data entry, and analyses were done by an agency (TNS MODE) contracted by CATALYST/India.

The two surveys were successfully completed and the results for the main indicators are included in the DIP. As PRAGATI received the results from TNS Mode just before the final submission of the DIP and as these results of this new survey raised questions that need careful examination, PRAGATI decided to complete the report of these two surveys by the time of the FAR.

iii. Health Workers Performance Assessments

Health Workers Performance Assessments (HWPA) will be carried out as part of the performance improvement plans of the two main types of health workers involved in PRAGATI: the ANMs and the AWWs (see section E.1.b.iii) and to provide baseline information for project monitoring and evaluation.

Assessments of the performance of the ANMs were conducted in the three project districts in May 2004. These assessments covered their knowledge in project interventions; their skills in delivering related services and in counseling beneficiaries; their concerns for improving the quality of their services; and supply and stock issues. The tools used for these assessments are included in Annex 6. They consist of a checklist for the systematic observation of the clinical services provided, the client-provider interaction, or specific elements of the environment in which the services are provided (cleanliness; confidentiality; availability of equipment and supplies); a guideline for interview services of providers; a questionnaire to interview

clients/beneficiaries after they received services; and guidelines to extract data from the records. No assessment of the physical facilities will be made since the activities expected from the ANMs do not rely on facilities and SIFPSA plans to assess and refurbish these facilities.

The list of all ANMs in each district was used as sampling frame. Criteria to exclude the ANMs listed but not functional were used to ensure that the sample was representative of those actually providing services. All the ANMs included in the sampling frame were selected using stratified random sampling with two strata based on the range of services provided at the center where the ANM is posted. The first stratum included ANMs in the post-partum center, primary health center, new PHC and community health center and the second stratum included all the ANMs posted at the sub-health centers. The first group of facilities serves a larger population and handles a greater client load. ANMs posted in these centers constitute about 20% of the total number.

A total of 25 to 30 ANMs were sampled with the sample size of each stratum proportionate to the size of that stratum. This sample size is considered optimal for this type of assessment when taking into account the necessary precision and quality of data.[3] For the data on immunization practices, this sample would provide a sample of about 125 observations.[4] The 95% confidence interval on estimates of 20% and 50% for these two sample sizes (30 and 125) are provided in the table below. When comparing estimates using such sample size of 30 ANMs, the probability of observing a statistically significant difference (power) of 30% with a confidence level of 95% is 80% when the estimate is 50% and higher for any other value of the estimate.

Estimate	95% Confidence interval	
	N = 30	N = 125
50%	± 20%	± 9%
20% or 80%	± 15%	± 7%

Between the baseline and final assessments, Lot Quality Assurance Sampling (LQAS) will be used to assess whether performance of ANMs is acceptable or whether corrective action or further investigation is warranted. Using a priori decision rules for a limited number of key variables, this approach will provide the information needed (average performance acceptable or not) by observing a much smaller number of ANMs. If less than 50% of ANMs performing a specific task according to standard is found unacceptable (lower threshold), for instance, and that a provider error of 10% and a consumer error of 5% is found acceptable, the assessment could be stopped as soon as 1 out of 8 ANMs is found not performing according to standard (or 2 out of 10, or 5 out of 19). The use of the tables such as those generated by the SampleLQ calculator are helpful in applying this approach. If there were an interest to know whether more than 80% of ANMs perform according to standards, a higher number of observations would be needed.

AWWs constitute a far larger group than the ANMs, and PRAGATI will be focusing its support on them. Their performance assessment will begin with a qualitative survey of their level of knowledge in key intervention areas, and related skills such as counseling; their understanding of their own job, as well as their experience and motivation. One critical omponent of the AWWs'

[3] See BASICS Health Facility Assessment guidelines.

[4] The tool for observation of immunization sessions include collection of data on the immunization of 5 children and the sample size for this indicator is therefore N=25*5=125.

performance assessments will be determining their actual workload, and the feasibility of carrying out the tasks expected of them. These initial assessments will be used to clarify and specify their roles and responsibilities, technical and managerial standards and expected competencies. Results of these qualitative assessments will be used to develop training materials and tools for quantitative assessment and monitoring of their performance. Assessment tools for AWWs will be similar to those described for ANMs: observation checklists, in-depth interviews, interviews with clients and records review. For AWWs, the LQAS sampling unit will be the block, the individual supervision area or any other unit found relevant to program management. Given the large number of such units and the phased approach of the training program, a unique sample size of 19 ANMs in each unit might be used to simplify training and supervision for data collection and management.[5] These data will also be used to calculate estimates of average coverage across various units of investigation, as appropriate. Both qualitative and quantitative assessments of AWWs performance are likely to be completed by the time of the FAR.

iv. NGO and community capacity assessments

The Child Survival Sustainability Assessment (CSSA) tool and its six-stage assessment process were introduced to the PRAGATI project and its partners in January and February 2004 through technical assistance from CSTS+ (see section C and E.2.b.viii).

During the February project-wide sustainability workshop in Lucknow, the need to build the capacity of the NGO partners, who are critical to developing networks, mobilizing communities and strengthening the existing health systems, was evident to all participants. A self-assessment tool was developed with the NGO staff to assess the following areas of organizational capacity:

1. Organizational governance and leadership.
2. Human resources management.
3. External relations.
4. Finance management and administration.
5. Financial viability (resource mobilization)
6. Implementation capacity.

Specific elements within each theme are to be assessed using a 3-point scoring system. This tool was used by the PRAGATI staff and six partner NGOs in Ballia and Lalitpur in May 2004. The results of these assessments and the NGO Score Sheet and the NGO scoring system are included in the NGO Capacity Assessment report in Annex 7. These first results will help PRAGATI and its NGO partners to define the activities and support needed to build their capacity to support AWWs and community groups. The same assessments will be conducted with additional NGO partners as they join the project, and will be repeated on annual basis. All the NGOs involved with PRAGATI will be expected to repeat these self-assessments on an annual basis.

Community competence, related to Dimension III in the Child Survival Sustainability Assessment framework, was discussed with officials and staff of partner organizations from each district during the sustainability workshop. Several key elements of this dimension were identified as critical for sustaining the wellness of children, and gains being made in child survival. These elements were validated with community leaders in each of the three districts

[5] This sample size is commonly proposed as the best compromise between acceptable consumer and provider errors (2% and 4%, respectively).

during April and May 2004. They will be assessed using the World Vision Transformational Development Indicator (TDI) methodology and related qualitative methods.[6] The TDIs are a set of quantitative and qualitative indicators being introduced in over 80 countries where World Vision has ongoing programs, in order to measure progress toward "transformational development – wholeness of life with dignity, justice, peace and hope." The TDIs reflect World Vision's ethos of development: people caring for each other, emergence of hope in communities, community participation in development programs, and social sustainability of development programs. PRAGATI will adapt TDI measurement methods and tools to assess changes in community competence in the project districts. Baseline assessments will be completed in each of the three project districts by September 2004. Findings will be included in the FAR report.

E.1.c. Baseline assessment findings

The results of the various baseline assessments described above are included in the respective reports in the annex and presented in this section by project intervention. Each section begins with a table presenting selected indicators from the KPC and FP surveys in the three districts. An abbreviated expression of the indicators is used in these tables for simplicity. The complete statement of the indicators and the number of observations can be found in the reports. One table of results from the performance assessments of ANMs is presented in the section on immunization; other results from this assessment are provided in the relevant intervention sections. Findings of all the assessments are discussed together for each intervention as it best fits. This section on the baseline findings ends with the results and a discussion of the NGO partner assessments.

i. Immunization

Table 3: Baseline indicators for immunization in PRAGATI districts

Indicator (%)	Ballia	Lalitpur	Moradabad
Pregnant women			
* Two or more TT injections (maternal recall)	78	68	59
Children 12-23, all			
Possession of a vaccination card	43	14	15
* DPT1	37	12	12
Measles, any age			
Card documented	28	7	8
Maternal recall, no card	30	32	33
Total	58	39	40
Full immunization by age one	14	4	5
Children 12-23 with a vaccination card			
DPT1	86	86	76
* DPT1-III dropout rate	15	35	31
Measles, any age	66	49	50
* Full immunization by age one	33	30	33

Source: Baseline KPC survey report.
* Indicator included in the Results Framework

[6] See Transformational Development Indicators Field Guide. World Vision Development Resource Team, December 2002.

The prevalence of pregnant women with at least two injections of tetanus toxoid based on mother's recall appears relatively high in the three project districts, with a slightly higher coverage in Ballia, quite likely related to BRICS. This prevalence in Ballia may have decreased somewhat from the level achieved by the end of BRICS.

The possession of a vaccination card by mothers for their child 12-23 month of age is very low in the three districts but higher in Ballia (43%) than in Lalitpur (14%) and Moradabad (15%), presumably as a result of BRICS. The coverage of DPT1 (card-documented) among all children 12-23 months of age, commonly used as indicator of access to immunization services, is slightly lower than the card retention rates in each district. Although card-documented measles immunization coverage is quite low, when coverage based on mother's recall for children without immunization card is taken into account, measles coverage for all children 12-23 months reaches 58% in Ballia, and 39% and 40% in Lalitpur and Moradabad.

Among children 12-23 months with an immunization card, DPT1-DPT3 dropout rate is high in Lalitpur and Moradabad: roughly a third of children who received DPT1 did not receive DPT3. This rate is lower in Ballia, although it may well have increased since the end of the BRICS project. In the three project districts, only a third of children with an immunization card achieve full immunization by 12 months of age. As a result of the low card retention rates and the high drop out rates, the coverage of children 12-23 months with card-documented full immunization by 12 months of age is only 14% in Ballia and 4% and 5% in Lalitpur and Moradabad. Table 4 shows that the quality of the immunization services is not satisfactory in the three districts.

Stockouts of vaccine are common: more than two-thirds of sub-health centers in Moradabad had stockouts during the six-month period prior to the assessment. In Lalitpur, only 16% of the sub-health centers had DPT vials on the day of the survey. The cold chain indicators also suggest serious weaknesses. In Lalitpur, only half of the vaccine carriers on the day of the survey contained frozen ice packs, and none of the observed ANMs appropriately packed the DPT vials in the vaccine carriers. In Moradabad, on the other hand, most vaccine carriers contained frozen ice packs. None of the DPT vials showed signs of having been frozen and becoming ineffective (using the Shake Test).

In Ballia, 21% of the vaccine carriers did not have frozen ice packs and 11% of the DPT vials showed signs of having been frozen. In Lalitpur, nearly half of the vaccine did not have frozen ice packs the day of the survey. The injection practices in the three districts do not appear satisfactory as only between 40% and 60% of the observed ANMs administered the correct doses of vaccine and used the appropriate routine, and only 60% of them checked and marked the immunization cards in Lalitpur and Moradabad (80% in Ballia).

Some 20% of sub-health centers in Lalitpur still sterilize their needles and syringes, and therefore do not comply with the new MOH policy of using only disposable syringes. The exit interviews conducted during these assessments show that ANMs do not systematically counsel mothers on when to return to the center, on family planning methods, or on maternal and infant nutrition. Finally, observation of the case management practices in the sub-health centers show that ANMs do not always check the immunization status of the sick children.

Table 4: Quality of immunization services in PRAGATI districts

Indicator (%)	Ballia	Lalitpur	Moradabad
Vaccine supply			
* ANMs without stockout in past six months	16	3	28
ANMs with DPT vials on day of the survey	89	16	100
Cold chain			
ANMs who packed DPT vials and diluents in vaccine carriers appropriately	75	16	78
ANMs with vaccine carriers with frozen ice packs on day of the survey.	62	23	67
ANMs with frozen DPT vials on day of the survey	10	--	0
Injection practices and safety			
* ANMs who practice the correct dose and routine for immunization	39	57	52
ANMs who practice no touch technique, do not reuse syringes and sterilizes needles and syringes	7	20	3
ANMs who check and mark immunization cards	82	57	59
Integration with health services			
ANMs who missed an opportunity to check immunization status when managing a sick child	13	7	34
Counseling			
Mothers who recall having been counseled about when to return	60	62	45
Mothers who recall being counseled on FP	53	57	50
Mothers who recall being counseled on maternal and infant nutrition	46	52	24

Source: Health Worker Performance Assessment, 2004

* Indicator included in the Results Framework

-- Less than five observations

All FGD participants in the three project districts knew the benefits of immunization. Discussions on the availability and access of immunization services covered a wide range of issues including erratic hours of operation for sub centres, vaccine stockouts, lack of geographic access for some villages, and high fees for service. Illiteracy, lack of awareness and remoteness of certain hamlets were mentioned as the major barriers for utilization by families. Some groups also mentioned that if the head of the family was not at home on vaccination day, no decision could be made on taking infants for immunization. Lack of knowledge about the full course of immunization is seen as the major cause for dropouts. Experiences of, and knowledge on side effects, were generally low across all groups. Respondents appear to have very little awareness of the importance of the quality of the vaccines and related services (temperature maintenance, sterilization of equipment, etc.), and this may be a disincentive for accountability of service providers towards the beneficiaries of health services. One additional prevalent false belief is that polio vaccine is a measure to curtail fertility through male sterilization and impotence. This is an important constraint to the progress of the polio eradication initiative in the three project districts.

Program Implications:

- Apparently high coverage of pregnant women with tetanus toxoid, but very low coverage of fully immunized children
- Low rates of immunization card retention and high dropout rates
- Families not sufficiently aware of the importance of immunization and of the recommended immunization schedule.
- Poor accessibility and erratic hours of immunization services
- Quality of immunization services unsatisfactory, including vaccine supply, cold chain management, injection safety, and counseling.

ii. Family Planning

Table 5: Baseline indicators for family planning in PRAGATI districts

Indicator (%)	Ballia	Lalitpur	Moradabad
Mothers of children 0-23 months			
Not pregnant and does not want child in next 2 years or not sure	88	89	93
Know 1 contraceptive method source	26	26	30
* Use modern contraceptive method[1]	12	9	17
Method Mix:			
Condoms	*40*	*50*	*58*
Pills	*23*	*16*	*31*
Female sterilization	*32*	*32*	*5*
Copper T	*4*	*2*	*5*
Male sterilization	*2*	*0*	*1*
Birth spacing at least 24 months	57	47	57
Married Women of Reproductive Age			
Unmet need for FP	50	75	--
* New Acceptors [FF2]	46	34	--
Use modern contraceptive method[2]	12	3	--
LAM Use	0	0	--
Continuation	48	43	--
Postpartum initiation of FP	9	8	--
Birth spacing at least 24 months	54	60	--
* Discuss FP with spouse/partner in past year	47	39	--
* Discuss FP with health worker	18	12	--
* Adequate counseling	8	1	--
FP message recall	49	33	--
* Proximity to FP service delivery point	63	34	--
Travel time to FP service delivery point	83	88	--

Source: Baseline KPC surveys (mothers of 0-23 months) and FP survey (MWRA) reports.

[1] If not pregnant and does not want a child in next two years or are not sure.

[2] If not pregnant or unsure.

In the three project districts about 90% of mothers with children 0-23 months are not pregnant and do not want a child in the next two years or are not sure. However, only 12% in Ballia, 9% in Lalitpur, and 17% in Moradabad of these women use a modern method of contraception. This

data suggests an unmet need for family planning of about 80% among mothers with children under two. Also, only a third of mothers with children 0-23 months know at least one source of modern family planning method, and this suggests both a lack of services and a lack of information about their existence. The relatively higher level of expressed need for and of actual use of family planning in Moradabad is unexpected for an area otherwise portrayed as attached to traditional values of high fertility.

The FP survey shows that the unmet need for family planning is 50% in Ballia District, and 75% in Lalitpur. Of MWRAs who are not pregnant or not sure if they are pregnant, only 12.3% use a modern method of contraception in Ballia District, and an extremely low 2.7% in Lalitpur. Overall, the other FP indicators presented in Table 5 for Ballia and Lalitpur are consistent with these low levels of contraceptive prevalence, and with the differences between these two districts. Family planning continuation rate, postpartum uptake, discussion about FP with spouse/partner and with health workers, adequacy of counselling, message recall, as well as the proximity and time required to reach an FP service delivery point are all lower in Lalitpur than in Ballia. Estimates of contraceptive prevalence from the FP surveys seem much lower than those reported by SIFPSA. PRAGATI will investigate factors contributing to this situation in cooperation with SIFPSA and other partners.

The FGD and IDI showed that all participants recognize birth spacing of at least two years as beneficial to maternal and child health. Sufficient spacing is also perceived as beneficial as it allows older siblings to take care of younger ones and because of the need to stabilize population growth. However, the desire for boys prevents families from limiting births. The FGD and IDI showed openness between husband and wife to discuss issues related to family size and birth spacing, although this typically occurs only when the family has already many children and there is a strain on family's economy. Discussions about family planning are common among women in the family and in the neighbourhood. Decisions on birth spacing and family size are generally made by the husband and older family members including the mother-in-law, but the views and desires of the daughter-in-law are definitely taken into consideration. There seems to be some resentment among older women that the younger women tend to make decisions about these issues on their own. Almost all groups mentioned the positive effect that literate women have on these decisions within families.

The KPC survey shows that among mothers with young children using modern contraception,[7] about half report using condoms and the remaining report using the pill or having been sterilized. The proportion of mothers reporting having been sterilized is lower in Moradabad than in Ballia and Lalitpur. Copper T and male sterilization represent only a small percent of the method mix in all three districts. In general, modern contraception is perceived as effective and beneficial but a wide range of harmful effects and myths[8] are commonly mentioned and there seems to be little knowledge about their non-contraceptive benefits to health.

The KPC survey and the FGD and IDI clearly indicate the need for complete information on all methods and services available to families. House visits and family counseling is another area of reported need. Greater use of mass media, mobility for service providers, and advocacy by

[7] The denominators for the method mix indicators are 57, 44, and 84 for Ballia, Lalitpur and Moradabad, respectively.

[8] The Baseline assessment report includes detailed information on the various method-related false beliefs, taboos and myths that will be used to develop training and communication materials.

village leaders and community groups are other perceived ways of improving availability and utilization of FP services.

Among well-known social and cultural factors influencing the attitude towards, and the use of, family planning services are the pressure and need to prove fertility within one year of marriage, and the fact that women often cannot go out, even to the health center, without permission.

In addition to the three FP surveys to be conducted over the course of the project, PRAGATI staff will strengthen the FP information system in Ballia and Lalitpur through the development and support of the use of the family planning registers and related reports by AWWs (see section E.2.b.i) and by strengthening the HIS of the health services (see section E.2.b.iv). PRAGATI will also work with the health services, ICDS and SIFPSA to make sure that all the available data on service statistics from the AWWs to the ANMs and other service providers are available to estimate the number of users and couple-year protection in each district.

ANM performance assessments conducted in March and April 2004 provide limited information on the quality of family planning services. This is not surprising, since these assessments focused mainly on immunization services, before the project's decision to give greater attention to family planning. One FP indicator in this assessment shows that only half of mothers interviewed can recall having received counseling about family planning during immunization sessions (see Table 4). AWW Performance Assessments, consisting of qualitative and quantitative components, will be implemented between July and September 2004. They will provide an opportunity to assess AWWs' knowledge, attitudes and practices with respect to family planning. These assessments are likely to demonstrate the very limited involvement of AWWs in the provision of family planning services, even though their current job description includes distribution of non-clinical family planning methods. Issues related to the supply of pills and condoms to AWWs are also expected.

Program Implications:

- Large unmet need among mothers with children under two
- Unexpectedly higher contraceptive prevalence among mothers with young children in Moradabad as opposed to the other two projects districts
- Wide reliance on condoms (40% to 60% of CPR), followed by sterilization and pill
- Families unaware of benefits of birth spacing and of choices available; need for complete information on all methods available and on their source
- Interpersonal communication between husbands and wives is limited.

iii. Maternal and infant nutrition

Table 6: Baseline indicators for maternal and infant nutrition in PRAGATI districts

Indicator	Ballia	Lalitpur	Moradabad
Current breastfeeding (0-11 months)	95	100	92
Early initiation of breastfeeding (< 1 hour after birth)	21	7	2
Feeding colostrum	50	17	12
Feeding prelacteals	34	44	75
*Exclusively breastfeeding (0-5 months)	66	23	57
Breastfeeding during illness (same or more)	18	11	20
Timely complementary feeding (6-9 months)	38	15	35

Source: Baseline KPC surveys report.
* Indicator included in the Results Framework

Breastfeeding is very common in the three project districts and is practiced by more than 90% of mothers with children 0-11 months. However, the breastfeeding pattern is not always optimal. Only 21% mothers in Ballia, and 7% and 2% in Lalitpur and Moradabad breastfed their newborn during the first hour of life, and only 50% of mothers in Ballia, and 17% in Lalitpur and 12% in Moradabad, gave colostrum to their newborn. Also, up to 75% of mothers give prelacteals in Moradabad, and 44% in Lalitpur and 34% in Ballia.

The FGD and IDI clearly confirm these findings. In Ballia, breastfeeding is usually initiated within the first few hours after birth. Discarding at least some colostrum is the norm in other places and initiation of breastfeeding is delayed by up to 2 days. Some older women and TBAs report continuing with this practice despite having been trained in the benefits of colostrum and early initiation. Apart from ghee and water, goat's milk, sugar – water and honey are also commonly given as prelacteals. These are meant for cleaning up grime from the baby's stomach and are not considered to have any nutritive value. The RMP groups counseled against discarding colostrum but they also counsel on giving prelacteals (clarified butter or cow's milk). Frequency of feeding ranged from three to eight times during the day and is usually continual at night. Most mothers fed a little from each breast during each feed. Very few waited for one breast to be emptied before switching to the other. Most of the information on breastfeeding was gained from mothers-in-law. In Ballia, the role of counseling done by the GSS workers was evident.

The proportion of infants 0-5 months of age who are exclusively breastfed is 66% in Ballia and 57% in Moradabad, but only 23% in Lalitpur. About 20% of mothers in Ballia and Moradabad, and only 11% in Lalitpur continued breastfeeding during a child's illness. The introduction of complementary feeding after six months of age is low at about a third in Ballia and Moradabad and even lower in Lalitpur at 15% of the infants aged 6-9 months. These findings of poor breastfeeding practices in Lalitpur can be explained by the fact that a larger proportion of mothers of young infants in Lalitpur work out of home work in the stone quarries. Low and erratic rainfalls preclude a fairly steady income from agricultural labor in this area.

During the FGD and IDI, there was a range of responses about feeding of a child up to 6 months, and some described exclusive breastfeeding and continuation of breastfeeding during child's illness. Most RMPs counsel giving lentil water, animal milk and water. Initiation of semisolid food was generally encouraged between 8 to 10 months. Mothers continue to breastfeed during

the child's illness, but elders in the family typically dissuade a sick mother from feeding her child. The indicators show more favorable breastfeeding practices in Ballia, a likely result of the BRICS project.

Program Implications:

- Better practices of breastfeeding in Ballia, poorer practices of early breastfeeding in Moradabad, and poorer practices of exclusive breastfeeding in Lalitpur. Differences in pattern of breastfeeding across districts may need further investigation before designing district-specific training and BCC strategies
- Common practices of delayed initiation of breastfeeding, expulsion/discarding of colostrum and giving prelacteals in three districts
- Continued feeding during illness and introduction of complementary food inappropriate
- Families unaware of benefits of early initiation and feeding of colostrum
- RMP, TBAs and mothers-in-law providing inappropriate advice and counseling.

iv. Vitamin A supplementation

Table 7: Baseline indicators for vitamin A supplementation in PRAGATI districts

Indicator	Ballia	Lalitpur	Moradabad
Children 12-23 months, all:			
Possession of a vaccination card	43	14	15
Supplementation in the last six months			
* Card documented	8	1	2
No card, mother's recall	5	NA	NA
Total	13	NA	NA
Children 12-23 months, with a vaccination card:			
Supplementation at any time (at least one dose)	37	40	22

Source: Baseline KPC surveys report.

* Indicator included in the Results Framework

The KPC survey shows that the card-documented vitamin A supplementation to children 12-23 months old in the last 6 months is very low in the three project districts, although slightly higher in Ballia, presumably as a result of the BRICS project. The KPC survey also includes data on the prevalence of this intervention based on mother's recall among children 12-23 months of age who do not possess an immunization card. Adding these two indicators together in Ballia, suggests that vitamin A supplementation rate of 13% of all children 12-23 months of age. This is consistent with the fact that there has not been regular mass distribution of vitamin A in any of the three districts in the last six months before the survey and that supplementation is often not systematically recorded on the vaccination cards. Nevertheless, this low coverage is worrisome and PRAGATI staff will further investigate this issue.

Among children 12-23 months old with a vaccination card, the prevalence of vitamin A supplementation at any time (at least one dose) is higher than that for the last six months. These higher rates parallel those for measles immunization coverage, suggesting that the policy of the MOH to provide vitamin A at the time of measles immunization has been implemented.

Both families and service providers are often unaware of the importance of vitamin A supplementation, and providers are often unclear about the exact protocol of administration and the side effects of vitamin A.

Stockouts of vitamin A syrup in peripheral health centers were frequently observed under BRICS.

Program Implications:

- Low coverage of vitamin A supplementation, probably mainly provided through routine immunization services.
- Low awareness of benefits of vitamin A by families and health workers.
- Missed opportunities for counseling on vitamin A supplementation during measles immunization.
- Poor health service logistics leads to frequent stockouts of vitamin A.

v. NGO capacity

The primary value of NGO capacity assessments is to give NGO staff an opportunity to review strengths and weaknesses with some external support, provided in this case by the PRAGATI staff, and to discuss the issues and results of the initial assessment in order to develop plans for capacity building. Follow-up assessments will assist in monitoring progress and adjusting these plans as needed.

Annex 7 presents a summary of results from the capacity assessment of six NGO partners. The overall capacity scores[9] range between 93% and 62%. The relative scores of each theme of the assessment show enough variation across NGOs to encourage the development of plans for capacity building specific to each NGO. The theme with the highest average score (88%) is Organizational Governance and Leadership, while the theme with the lowest average score is Implementation Capacity (76%).

Program Implications:

- Promising NGO Capacity Assessment tool, process and results on which PRAGATI and its NGO partners can build to define specific capacity building and action plans to support the achievement of the project objectives and sustainability.
- New NGO partners must be identified soon to assist in the rapid expansion of project activities. Assessment of NGO capacity will be crucial in selecting the right partners, and in supporting them effectively thereafter.

E.1.d. MOH policies

The National Health Policy (NHP) 2000 includes the following goals:

- Reduce IMR to 30/1000 by 2010
- Reduce MMR to 100/100,000 by 2010
- Eradicate Polio and Yaws by 2005
- Achieve zero level growth in HIV/AIDS by 2007

[9] Calculated as the sum of the scores obtained for each element relative to the sum of the maximum scores.

- Increase public health expenditures by the central government from 0.9% to 2% of GDP by 2010
- Establish an integrated system of surveillance, national health accounting and health statistics by 2005.

NHP 2000 mandates the following:

Equity: Increased allocation (55%) of total public health investment for the primary health care sector.

Delivery of National Public Health Programs: NHP 2000 envisages that apart from the exclusive staff in a vertical structure for disease control programs, all rural health staff be available for the entire gamut of public health activities at the decentralized level.

Public Health Infrastructure: NHP 2000 envisages reviving the primary health care system by providing some essential drugs under the central government funding.

Use of generic drugs and vaccines: NHP 2000 envisages that no less than 50% of the requirement of vaccines/sera will be procured from public sector institutions.

The MOH document Reproductive and Child Health (RCH 1) includes the key policy elements relevant to the PRAGATI project. These are summarized below.

Immunization

The MOH policy is to immunize infants and pregnant women according to the following schedule:

Infants					
Age	At birth	6 weeks	10 weeks	14 weeks	9 months
Antigen	BCG OPV0	DPT1 OPV1	DPT2 OPV2	DPT3 OPV3	Measles Vitamin A
Pregnant women					
Stage	Early pregnancy	4 weeks later			
Antigen	TT1	TT2			

Routine immunization services are provided free by the MOH health services including the sub-health centers that typically receive their vaccines on the immunization day (Wednesday) from the health center where vaccines are refrigerated.

The GOI strategies for the polio eradication initiative (PEI) are:

1. Increase routine immunization coverage to 90%.
2. Organize national and sub-national immunization days (NIDs and SNIDs) to increase booth coverage to 50%.
3. Subsequent A and B team house-to-house activities to reduce proportion of resistant households to zero.
4. Acute flaccid paralysis surveillance and stool testing
5. Outbreak response immunization (mop up rounds).

Family planning

The MOH policy is to provide the following family planning methods in the government health system:

- Clinical methods:
  - Male sterilization: vasectomy and non-scalpel vasectomy (NSV) are provided at district hospitals and community health centers and primary health centers. In the primary health centers, the surgeries are performed during camps by trained surgeons from other blocks or from the district.
  - Female sterilization (minilap and laparascopy) is also conducted in camps by trained surgeons/gynecologists.
  - IUD (CuT): all ANMs in the districts have been trained in IUD insertion and infection prevention by SIFPSA.
- Non clinical methods:
  - Condoms (NIRODH) and combined oral contraceptives (COCs) (Malay N).
  - Non-clinical methods from the government's supplies are provided by the ANMs as well as by the AWWs.

In 2003, the MOH adopted LAM and SDM as family planning methods supported in health services. Specific guidelines, training materials, and research are needed to support the introduction of these two methods.

Maternal and infant nutrition

The MOH antenatal care (ANC) package consists of:

- At least three ante natal checkups by the ANMs
- Consumption of at least 100 IFA tablets
- 2 TT vaccinations (as above)

The policy to provide at least 100 IFA tablets to each pregnant woman is relevant where anemia is highly prevalent. ANMs and AWWs are expected to distribute IFA tablets to pregnant women but there are often shortages in the sub-centers and at the level of the AWWs.

The MOH policy on infant nutrition consists of:

- "Exclusive on-demand breastfeeding up to about 6 months of age"
- "Introduction of semisolid foods beginning at about 6 months along with on-demand breastfeeding."

This policy is adequate and very few related activities are implemented in the three project districts.

Vitamin A supplementation

The policy of the MOH is to provide vitamin A syrup[10] to all children according to the following schedule:

9 months	100,000 IU (along with measles vaccine)
18 months	200,000 IU
24 months	200,000 IU
30 months	200,000 IU
36 months	200,000 IU

Shortages of vitamin A syrup in health services are frequent. In addition to routine administration of vitamin A by health services, the MOH organizes bi-annual rounds of mass distribution and the ICDS and the AWWs play a major role in the implementation of this policy by registering the beneficiaries and gathering them for distribution.

Post-partum vitamin A supplementation is not approved by the GOI yet but it may be in the near future.

E.1.e. Constraints to achieving project objectives

This section identifies and clarifies the main constraints to the implementation of the project. The responses and strategies to address or alleviate them are included in the design and detail planning of the activities of the project.

Project design

- The project recognizes the challenge of addressing competing priorities;
  - To reach the poorest and most vulnerable and to expand coverage;
  - To maintain the focus on mothers and children and to address the health system issues;
  - To improve community involvement and to address strong beliefs and practices that adversely affect the child's and family's well being
- The scale of the project is its purpose and a challenge at the same time. The total population of the three project districts is 7,500,000, that is, three times more than the indirect impact area of BRICS (Ballia district, 2,700,000 population) and 50 times more than the direct impact area (Beruarbari block, 150,000 population) where the interventions to scale up where developed (see Table 1). In addition, the project is implemented in three different districts within UP but far from each other.[11]

AWWs

- Working through AWWs will make scaling up the results of BRICS possible and potentially sustainable, but is a significant departure from the experience under BRICS where community health workers were Gramin Swasthya Sevikas (GSS).

[10] Vitamin A is not provided in capsule because they are made of animal products.

[11] The choice of three districts in distant and different areas of UP was a decision made with the MOH to ensure the maximum opportunities to learn from the PRAGATI project and its scaling up approach.

- The limited number of AWWs in certain areas makes it impossible to reach all families even if all AWWs are trained and provide the expected services.
- The load of responsibilities of the AWWs might already be overwhelming and adding the expected project activities might not be feasible. Many tasks such as the identification of beneficiaries and the reinforcement of positive behavior may have to be offloaded to community groups.

Health Services

- Health services in remote areas are often understaffed and the available staff is often not present on a regular basis.
- Appropriate MOH policies often exist at the national and state level but they are not implemented at the grassroots level. There is a lack of political will for essential interventions such as family planning and safe motherhood. The hierarchical structure of the MOH makes it difficult to introduce innovations.
- The government health system has generally avoided public-private partnerships.
- The unique role of NGOs and other private sector agencies has often been undermined or unrecognized.
- Data collection systems often make meaningful interpretation difficult.
- There is a lack of local and district level technical expertise related to the project interventions and their implementation.

Governance

- Frequent change in government and heavy turnover of administrative staff disrupt and rob precious institutional memory, which is crucial for administrative support to community-based projects.
- The feudal nature of local governing structures and political hierarchy pose potential barriers to mobilizing communities to assess needs, plan and implement health activities for their villages.
- Corruption exists at all levels and adds to delays, and often complicates lines of authority, while dealing with the Government machinery for the project's implementation details.

Cultural norms and behaviours

- Discrimination against girls and women and denial of equal opportunities in nutrition and education perpetuate the intergenerational cycle of malnutrition. Low literacy precludes women from their meaningful contribution to their own health care and that of their children. Preference for boys by families has been a major deterrent to the increased utilization of contraception.
- Misconceptions and myths challenge the promotion of positive health behaviors. For example, people consider pregnancy and childbirth to be natural processes, requiring little or no assistance and care. People also believe that polio vaccine is a measure to curtail fertility, male sterilization, and increase impotence.
- General animosity towards the public health care system and providers due to negative encounters and experiences in the past has led the majority of the population to seek health care from unqualified village-based practitioners and traditional sources like traditional birth attendants (TBAs) or dais and healers.

- Poverty and illiteracy combined with strong feudal structures have led to vast sections of the population being denied access to health information and services.

E.2. Program Description

E.2.a. Results framework

Annex 8 presents PRAGATI's Results Framework and indicators. Annex 9 presents the Performance Monitoring and Evaluation Table that includes the definition of these indicators, the baseline results, and the annual project benchmarks.

The goal or key end result of PRAGATI is "To scale up a wellness package of critical child survival and family planning interventions in Ballia, Lalitpur and Moradabad districts of UP state."

The goal of PRAGATI will be achieved by two intermediate results (IR) at the end of the project:

IR 1	Increased use of key child survival and family planning interventions, including: 1. Immunization 2. Family planning 3. Maternal and infant nutrition 4. Vitamin A supplementation
IR 2	Strategies, methods and tools from BRICS scaled up

Table 8 shows that IR 1 and IR 2 of PRAGATI will contribute directly to IR 1 and IR 3 of the USAID/GH/HIDN PVO Child Survival and Health Grant Program (CSHGP).[12] The particular emphasis placed on planning for sustainability since the inception of PRAGATI will contribute to CSHGP's IR # 2.

Table 8: Contribution of PRAGATI to CSHGP Intermediate Results

CSHGP Intermediate Results	*Contribution of PRAGATI*
IR 1: Increased use, coverage and quality of child and maternal health, nutrition and infectious disease programs implemented by PVOs and their local partners.	**IR 1**: Increased use of key child survival and family planning interventions (in Ballia, Lalitpur and Moradabad districts).
IR 2: Increased sustainability of child and maternal health, nutrition and infectious disease programs/interventions initiated by PVOs and their partners.	**IR 2:** PRAGATI initiated a sustainability assessment process at the inception of the project that will be used to plan for and measure progress toward sustainability of project initiatives.
IR 3: Child and maternal health, nutrition and infectious disease program strategies, tools and approaches developed/adapted, tested and applied.	**IR 3:** Strategies, methods & tools from BRICS scaled up.

[12] See USAID/GH/HIDN guidelines for the preparation of proposals for the PVO Child Survival and Health Grant Program, FY 2003.

IR 1 of PRAGATI is similar to other child health and survival projects in terms of its general strategy to increase access, quality, and demand for specific technical interventions. This IR will be achieved through the three following sub-results (SR):

SR 1a	Increased *access* to child survival and family planning services in communities
SR 1b	Increased *quality* of child survival and family planning services
SR 1c	Increased *knowledge and interest* of child survival and family planning services

These sub-results and activities to achieve them are specified for each of PRAGATI's four technical interventions in section E.2.c. Indicators for IR 1 and its sub-results are standard child survival and family planning indicators. The nine core indicators required by the Flexible Fund are also included in this component of the framework.

IR 2 of PRAGATI characterizes the project as an innovative initiative to develop, test and document the process of scaling up interventions through a systematic approach. PRAGATI not only seeks to achieve the health impact results specified for IR 1 but also to achieve these by bringing up to scale specific strategies, methods, and tools developed, tested and documented on a pilot basis in the direct impact area of BRICS and subsequently in the ACOLES center (see section E.2.b.ix). The indicators for IR 2 measure the extent by which these strategies, methods, and tools are scaled up and contribute to the achievement of IR 1. These measures are critical to the assessment of the scale-up component of PRAGATI, as opposed to a standard child survival project.

IR 2 of PRAGATI will be achieved through three SRs:

SR 2a	BRICS project site becomes Action, Co-learning and Scale-Up Center (ACOLES)
SR 2b	Strategies, methods and tools from BRICS documented and adopted
SR 2c	Three operations research studies completed

Setting up the BRICS project site as an ACOLES center (SR 2a) will provide the environment for the full documentation and dissemination of strategies, methods, and tools developed and tested under BRICS. The documentation and adoption of steps in the process of scaling up interventions (SR 2b) are tangible sub-results necessary to the achievement of IR 2. In addition, the results of three operations research studies (SR 2c) will contribute to further defining the strategies, methods, and tools to scale up.

E.2.b. Overall strategies

PRAGATI will take to scale the strategies, methods and tools developed and tested during BRICS. The section below describes the overall strategies of PRAGATI. The first three strategies are those developed and tested under BRICS and that PRAGATI will scale up. The

other strategies are those used to scale up the strategies developed under BRICS. The specific activities that PRAGATI will conduct to support each strategy are provided at the end of their respective description.

i. Early registration of all pregnant women and eligible couples

One key lesson learned from BRICS is that identifying and registering pregnant women early in their pregnancy is crucial to ensuring provision of all pregnancy and infancy related services at the appropriate time. PRAGATI builds on this lesson and works with the ICDS officials at the UP and district levels to introduce this strategy and the related tools in the services provided by the AWWs under ICDS. Part of the responsibility of AWWs within the ICDS project is to conduct bi-annual "household surveys" to identify pregnant women, children under the age of 6, and couples eligible for family planning (ELCOs). The survey is a comprehensive census of all household members and includes income level and sources (to identify the recipients of nutritional supplements), as well as other data used to prepare the lists of beneficiaries of the ICDS current programs. The template of the form used by ICDS for the household surveys is provided in Annex 10.

Using the data from the household survey, the AWW is able to prepare three beneficiary listings and related tracking registers: one for eligible couples, one for pregnant women and one for infants. The household survey form does not contain all the information needed for the 3 registers but enough to begin the enumeration of ELCOs, pregnant women and infants, following which on going identification of beneficiaries and follow up are critical. The PRAGATI team and ICDS state officials already examined the tools used by the AWWs and identified the changes needed to ensure that the information collected during these household surveys is suitable to the new BCC and other activities to be conducted by the AWWs. The proposed templates for the three registers are in Annex 13, 14 and 15 respectively. PRAGATI will also assist the ICDS in the final design and field-testing of these tools. PRAGATI will also print, distribute and implement the new registers for one year in the three project districts. These registers will then be reviewed for their contribution to improving data quality and timeliness within ICDS and mainstreamed as appropriate.

The revised beneficiary registers to be used by the AWWs are a unique contribution of the PRAGATI to the ICDS. The *Family Planning Register* lists all eligible couples from the household survey. During her first visit to these couples, the AWW categorizes them on the basis of their fertility intentions and provides appropriate counseling as per the BCC plan. The couple's decision with respect to the use of a contraceptive method and the supplies provided are also recorded. During each subsequent quarterly visit, the fertility intentions are reviewed and the continuous use of the method and other outcomes are tracked.

All pregnant women identified during the household survey are entered in the *Pregnancy Register*. Further ongoing identification is done through regular home visits and through community groups between the bi-annual household surveys. Each pregnant woman is paid at least 4 visits: one at fourth/fifth month of pregnancy, the second at sixth/seventh month, the third at eighth/ninth month and the fourth within 2 days of delivery. There are specified tasks and counseling issues to be completed and addressed during each visit. During the post-partum visit, the outcome of the delivery is recorded.

After delivery, the live newborn's name is entered in the *Infant Register* and the mother's name into the ELCO register. Each infant should be visited at least four times before the first birthday, excluding visits to the ANM for immunization. The first visit follows-up on the post-partum visit, the second should occur in the first week after birth, the third at five months, and the fourth at eight months of age. As with the Pregnancy Register, the Infant Register serves as a reminder to AWWs that there are specified tasks to be accomplished during each visit. The purpose, timing, and contents of each home visit of the AWWs are discussed below (see E.2.b.ii).

While the Pregnancy and Infancy Registers have already been tested under BRICS, the ELCOs Register is new. The whole system, comprised of the household survey form, three registers and a monthly progress report (MPR) will be tested for three months in the initial BRICS project site in Beruarbari block, where the ACOLES Center will be located.

Specific activities to be conducted in support of this strategy:

- Final design and field testing of tools to be used by the AWWs: household survey form, three registers and monthly reports (see Annexes 11-14).
- Training and supervision of AWWs to ensure adequate use of the tools, including monthly reports (see section E.2.b.v).
- Analysis of the data collected by the AWWs at the AWW, ANM, block and district levels (see section E.2.b.iv).

ii. Targeted and timed behavior-change communication for families

The PRAGATI strategy for behavior change focuses on communicating well-defined sets of behaviors related to the project's interventions to mothers and married women of reproductive age and to the other family members at the time when they are most relevant. Targeting key decision makers in the family, primarily husbands and mothers-in-law, in the counseling sessions is essential as most decisions relating to practicing the behaviors rest with them. Timing counseling sessions during home visits made at determined stages of pregnancy, age of the infant, or fertility intentions of eligible couples ensure that the messages are received with interest and can be practiced right away. The BCC strategy also includes purposeful tracking and reinforcement of key behaviors that provide opportunities to discuss specific aspects or difficulties.

Annex 15 and Annex 16 present BCC plans that the AWWs will use for planning and conducting visits to eligible couples, pregnant women, and mothers of young children, respectively. The AWWs will also use job aids that describe the behaviors to be communicated during each of these visits. Home Visit Cards already developed for the pregnancy and infancy BCC plan under BRICS are presented in Annex 17. They will be adapted and new home visit cards for family planning will be developed. The intervention-specific content of these BCC plans (key behaviors, messages, timing, etc) is further described and discussed in the respective Technical Interventions sections.

Specific activities to be conducted in support of this strategy:

- Design and production of job aids for AWWs (BCC plan, home visit cards, flipchart, demonstration materials, etc.)
- Development of the related training and supervisory materials
- Training of AWWs and their supervisors in BCC plans and content and communication skills
- Supportive supervision of AWWs by MOH and ICDS staff

iii. Creating an enabling environment for behavior change

The behavior change approach of PRAGATI extends beyond the one-to-one activities conducted by the AWWs and described above. The approach includes the creation of a social environment that enables individuals to adopt and practice new behaviors.

PRAGATI will partner with local NGOs and support NGO Promoters to form and strengthen Community Groups to assist the AWWs with the bi-annual household survey and with the ongoing identification of pregnant women by the fourth month of pregnancy. These community groups can be modeled after the Self-Help Groups (SHG)[13] or support groups, depending on the local situation. One specific activity of the community groups women volunteers will be to help identify pregnant women early in pregnancy and reinforcing key behaviors especially in families where there is resistance to the adoption of these behaviors. These typically older women have better access to the older, decision-making members of families than AWWs. Whenever feasible, the community groups will help the AWWs in achieving and maintaining 100% coverage in registration and in all project interventions at the hamlet (tola) level.

NGO Promoters will also facilitate communication between ANMS and AWWs and between the health services and ICDS officials at the block level so that all health workers are fully aware and supportive of the work of the AWWs. They will also facilitate joint supervision of AWWs by health services (LHV) and ICDS (MS) staff. The CMO and the ICDS officials in each district have indicated that they wanted PRAGATI to facilitate and strengthen this collaboration between health services and ICDS.

Specific activities to be conducted in support of this strategy:

- Training of NGO promoters and other selected NGO staff in community mobilization and formation of community groups
- Creation and strengthening of community groups
- Informal training of community group members through regular meetings
- Facilitation of joint meetings at block level between MOIC and CDPO and at community level between community groups and AWWs

iv. Improved block and village level planning and use of data

This strategy aims at optimizing the flow and use of data collected by the AWWs at each level of the ICDS and health services in each district. PRAGATI staff at all levels, starting with the NGO promoters and field coordinators, will ensure that the AWWs collect and report accurate and quality data and that thesereports are shared with and used by the ANMs. This will be ensured by monitoring the timeliness, completeness and quality of the data in the registers and in monthly progress reports. Data analysis and presentation templates will be developed, tested and distributed to health workers and ICDS staff at each level. Assistance will be provided until the process of using data for decision-making is fully integrated into their current activities.

In addition, PRAGATI will strive to improve the timeliness and completeness of data reported from the ANMs to the PHC and the CMO, with a focus on improving the availability of supplies of commodities at the ANM and AWW levels. Most commodities needed for the PRAGATI interventions such as contraceptive methods, vaccines or vitamin A are available at the state

[13] Microcredit-based community groups of women volunteers supported by the Government of India or PVOs including World Vision.

level but stockouts are frequent at the local level. Once accurate and reliable data will become available, PRAGATI will use this information to address the most critical issues related to the supply of commodities and the related decision-making during various meetings at the block, district, and state levels.

Specific activities to be conducted in support of this strategy:

- Develop and test templates for analysis of AWW data to be used at the AWW, ANM, block and district levels
- Train NGO promoters and health services and ICDS staff in analysis and graphic presentation of data
- Facilitate district and block level meetings of health services and ICDS workers to discuss coverage and supply of commodities

v. Health worker performance improvement

The success of the strategies scaled up under PRAGATI depends heavily on the work of the ANM and AWWs. PRAGATI will assist the health services, the ICDS project, and its stakeholders in establishing performance improvement plans that ensure that ANMs and AWWs have all the competencies, support and environment conducive to performing their work optimally. PRIME II and other USAID CAs based in Lucknow[14] and Delhi will provide technical assistance to the PRAGATI team for these activities.

The health worker performance plans will follow the performance improvement cycle:

1. Define expected standards of services and required competencies
2. Assess actual performance through quantitative surveys and standardized tools
3. Define critical gaps between expected and actual performance
4. Identify root causes of poor performance (i.e., inappropriate job expectations, lack of clear standards and guidelines, lack of performance feedback, insufficient knowledge and skills, poor motivation for the job, poor communication skills, deficient management systems and leadership, and inadequate supply of commodities)
5. Select most effective and feasible solutions to poor performance (i.e., training, development and dissemination of guidelines and job aids, supervision, improvement of working conditions, creation of an enabling environment, etc.)
6. Implement selected solutions
7. Assess changes in performance and identify new opportunities for improvement

Although PRAGATI has already planned to provide training to ANMs and AWWs, the specific objectives and content of this training will be defined and adapted according to the general framework above. The design of the initial training curricula and materials will use the results of the systematic performance assessments of the ANMs and the AWWs (see section E.1.b.iii). CATALYST India will work closely with the project staff to revise the existing training modules and develop new ones.

The training plan will follow three levels of training. At the first level, a team of Master Trainers from WV India and CATALYST will be trained. At the second level, these Master Trainers will

[14] Several USAID Cooperating Agencies including CATALYST, DELIVER, JHUCCP, and PRIME II, are based in Lucknow and grouped in the Prema Population Resource Center (PPRC).

train Lead Trainers (all ICDS staff members, Lady Health Volunteers--LHVs and Mukhya Sevikas--MS). At the third level, the Lead Trainers will train AWWs. Potential trainers will be selected from within the project and from government health services and ICDS. Their training abilities will be assessed using role-playing and practice rounds, and by reviewing their previous training experience.

Table 9 presents the total number of trainers and trainees that will be trained throughout the duration of the project. These estimates are made on the basis of the official number of positions, which are typically lower than the recommended numbers in terms of ratio of health workers per population and higher than the number of these positions than are actually filled.

Table 9: Number training participants in the three PRAGATI districts

Participants		Ballia	Lalitpur	Moradabad	Total
Master Trainers:	WV staff				10
Trainers:	LHV	40	18	31	89
	MS	93	28	101	222
	NGO-Promoters	50	15	40	105
	Total:	*183*	*61*	*172*	*416*
Trainees:	ANM	426	145	375	946
	AWW[1]	1888	568	2286	4742

[1] Number of "sanctioned" positions (see Table 11)

Source: ICDS district-level records

Acronyms: LHV: Lady Health Volunteers; MS: Mukhya Sevikas; ANM: Auxiliary Nurse Midwives; AWW: Anganwadi Worker.

The training of ANMs will be conducted entirely during the first year of the project (FY04). Training of AWWs, on the other hand, will be conducted in a phased manner, varying from one district to the other, due to the specific environment. The progressive training of all AWWs in three district areas will determine the beginning of their actual activities and the achievements of the results of the project. This phased coverage of the three districts by the project activities is further described in section E.2.b.vii.

In addition to training ANMs and AWWs, PRAGATI will strengthen the supervision system existing within the health services and ICDS. The supervision system will be revised using the results of the HWPAs and the agreed upon performance standards for the ANMs and AWWs. The supervision system will combine supportive supervision approaches with objective measurement tools such as direct observation, review and cross verification of registers, and exit interviews. Supervision will focus on early registration of pregnant women, timeliness of the home visits, quality of the counseling session and coverage of all the beneficiaries in the AWW area. The LHVs, MS, MOIC and NGO Promoters will be trained to use these supervision tools. A refresher course will be tailored for each district during the course of the project using the results of the supervision visits and continuous tracking of the performance of the ANM and AWW, described in the program monitoring and evaluation section (see section E.3).

Specific activities to be conducted in support of this strategy:

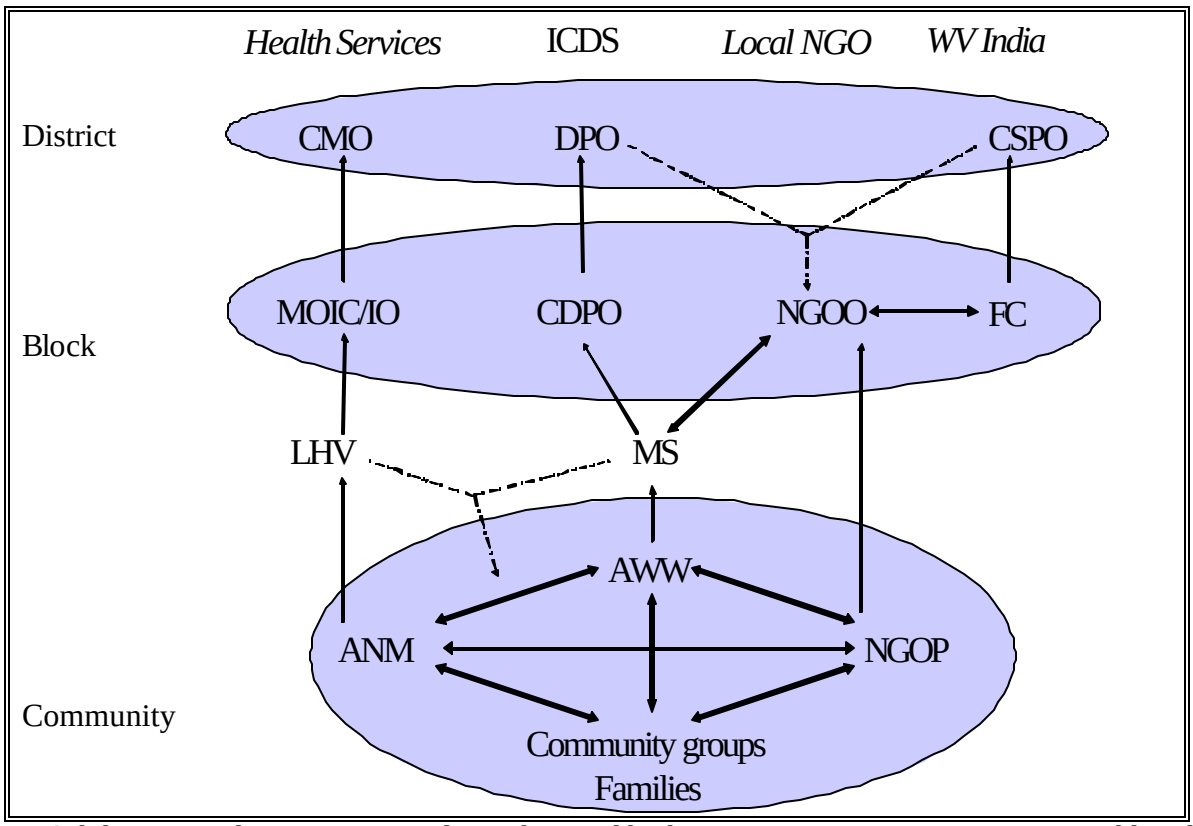
- Performance assessments of ANMs and AWWs (see section see E.3)
- Design and implementation of training programs to reach all ANMs and AWWs in three project districts (see section E.2.b.vii)
- Implementation of other solutions to poor health worker performance (to be defined)

vi. Partnership and capacity building

In each district, World Vision's main partners in the implementation of PRAGATI are the Health Services, the ICDS project, and selected local NGOs. This section provides overall descriptions and data on each PRAGATI partner that are used in the DIP when describing activities that they will implement. PRAGATI will build the capacity of its partners by supporting them in the implementation of these activities.

Figure 1 represents the relationships between these partners at the level of the health services and the ICDS in the districts. These relationships and the characteristics, terms of partnership, and the capacity building activities for each partner are further discussed below.

Figure 1: Relationships between PRAGATI partners at the district level



Note: Solid arrows indicate reporting relationships and broken arrows supervisory patterns. Double sided arrows indicate collaborations. Shaded areas indicate the levels and linkages that PRAGATI would facilitate and strengthen.

Acronyms: All acronyms represent staff from the PRAGATI partner organization. Health Services: CMO: Chief Medical Officer; MOIC/IO: Medical Officer In-Charge/Immunization Officer; LHV: Lady Health Visitor; ANM: Auxiliary Nurse Midwife. ICDS: DPO: District Program Officer; CDPO: Child Development Project Officer; MS: Mukhya Sevikas (AWW supervisor); AWW: Anganwadi worker. Local NGO: NGOO: NGO Officer; NGOP: NGO Promoter. WV India: CSPO: Child Survival Project Officer; FC: Field Coordinator.

Health services

The District Chief Medical Officer (CMO) and his team provide management and leadership to the district public health care system. Each district also has a 100 to 200 bed public hospital that provides secondary level curative care. In each block, an administrative unit of about 100,000 people, there is a primary health center (PHC) and one sub center for 5,000 to 8000 people. The PHC is staffed by two medical doctors, a pharmacist, a Medical Officer In-Charge (MOIC)/Immunization Officer (IO), Auxiliary Nurse Midwives (ANMs) and administrative staff. A PHC offers curative and preventive services such as immunization, antenatal and postnatal care. The sub center, manned by an ANM, offers basic curative care, immunization, family planning methods, antenatal and postnatal care. Nationally, and in UP in particular, the number of basic health workers has not kept pace with the increase in population. Table 10 shows the number of basic health workers in each PRAGATI district.

Table 10: Number of Basic Health Workers in PRAGATI Districts

Basic Health Worker	Ballia	Lalitpur	Moradabad	Total
Chief Medical Officer	1	1	1	3
Medical Officers	96	70	78	244
Immunization Officers	15	13	30	58
Lady Health Volunteers	40	23	31	94
Auxiliary Nurse Midwives	426	145	375	946

Source: ICDS and MOH records

In addition to the lack of manpower, the main constraints to the use health services include:

- Lack of motivation and support for service providers
- Large catchment areas and poor transportation, severely limiting access to health services
- Poor quality of services, with no enforced standards or protocols
- Low coverage of the poorest population
- Frequent assignment of ANMs to non-routine duties like leprosy detection campaigns and National Immunization Days of the Polio Eradication Initiative, leading to the closure of sub centers even on immunization and clinic days and failure to take time for administrative duties such as reporting and ordering supplies

The Integrated Child Development Scheme project

The Integrated Child Development Scheme (ICDS) is an early childhood care and development project implemented by the Department of Women and Child Development in about a 100 districts in the country. In UP, the project is currently in its third funding cycle (ICDS-III). Before 1999, 510 blocks had been covered by this project when the World Bank took over the funding and added another 110 blocks (along with strengthening 190 already existing ones). Recently the GOI sanctioned the inclusion of 187 more blocks (with government funding), thus making the total to 807 blocks in 60 districts.

The grassroots level workers of the ICDS are called the Anganwadi Workers (AWWs). A total of 80,000 AWWs have been recruited so far in UP and another 20,000 will soon be appointed. Each AWW is expected to cover a population of about 1,000 with one AWW helper. The AWW reports to a supervisor called Mukhya Sevikas (MS), who is expected to supervise 25 AWWs.

At the block level the child development project officer (CDPO) oversees the work of all the MS, and at the district level the district program officer (DPO) provides managerial and administrative oversight to all the project operations.

The AWWs are volunteer workers who receive an honorarium of US$ 20 a month. In principle, they undergo a 12-day induction training, and a subsequent 45-day on-the-job training spread over several months. Refresher training is also given every 5 years. Training curricula are developed centrally by the GOI, but 25% of the curriculum can be changed by the states. There are 71 Anganwadi Training Centers in UP. Training of the AWWs has not always been uniformly implemented by ICDS in the districts, and most of the current AWWs have had only minimal training.

The main roles of the AWWs are the provision of informal preschool education, distribution of supplementary food to children and pregnant/lactating mothers, growth monitoring of children 0-6 years, identification of beneficiaries for immunization, antenatal and FP services, distribution of non-clinical FP methods and provision of individual (house-to-house) and group health education. The ICDS Job Description for AWWs is found in Annex 20.

The state and central governments have attempted to form and strengthen operational linkages between ICDS and the health services, but these are still poorly defined and poorly functioning. Also, the training package, the supervisory mechanism, and the reporting system within ICDS are inadequate.

PRAGATI endeavors to provide ICDS with a model that is feasible and scaleable beyond the three program districts. The main role of ICDS in the PRAGATI project will be:

- Identify, assess and improve the AWW competencies;
- Clarify the tasks to be accomplished by the AWWs with respect to PRAGATI interventions in terms of frequency and timing of house visits, behaviors to communicate, and record keeping and reporting;
- Set up and implement a system of supportive supervision of AWWs in collaboration with the LHVs and the communities;
- Streamline the HMIS of AWWs in terms of accuracy and timeliness of reports and compatibility with that of the health system

The functions of ICDS that PRAGATI does not plan to address or support:

- Distribution of nutrition supplements
- Group nutrition and health education (NHE)
- Pre school activities (balwadi)
- Night blindness surveys
- Growth monitoring
- Kishori Shakti Yojana[15]

Table 11 shows the number of AWWs and MS expected according to the ICDS norms, the number "sanctioned" by ICDS so far, and the actual number of AWWs "positioned" in the three project districts. The table also shows the gaps between the expected and the actual numbers of

[15] Translated, this means "Program for Empowering adolescent girls" – adolescent girls are trained in local crafts. Family life and nutrition education are given as part of these classes.

AWWs and MS in all three districts. Once "sanctioned," the AWWs positions are usually quickly filled and therefore PRAGATI can reasonably plan on the number of sanctioned positions as an estimate of the actual number of AWWs to train and who will provide the expected services to the program beneficiaries. The gap between the expected and the sanctioned positions, however, is of a greater concern because it shows that PRAGATI may not be able to cover the entire population of the three districts as expected. PRAGATI may play an advocacy role at the district and state levels to increase the number of sanctioned AWWs in the project areas.

Table 11: Expected, sanctioned and posted AWWs and MS in PRAGATI districts

Status	Ballia	Lalitpur	Moradabad	Total
AWW:				
Expected1	2700	970	3800	7470
Sanctioned	1888	568	2286	4742
Gap (%)	*-30%*	*-41%*	*-40%*	*-37%*
Positioned	1849	483	1238	3570
Gap (%)	*-2%*	*-15%*	*-46%*	*-25%*
Total Gap (%)	*-32%*	*-50%*	*-67%*	*-52%*
MS:				
Expected2	110	39	153	302
Sanctioned	93	28	101	222
Gap (%)	*-15%*	*-28%*	*-34%*	*-26%*
Positioned	66	23	44	133
Gap (%)	*-29%*	*-18%*	*-56%*	*-40%*
Total Gap (%)	*-40%*	*-41%*	*-71%*	*-56%*

Source: District ICDS records
Note: The expected number of AWWs is 1 AWW per 1,000 population and the expected number of MS is 1 per 25 AWWs.

One of the constraints listed in section E.1.e is that the workload of the AWWs might be too heavy, and that the AWWs might lack the commitment, energy and motivation to carry out all the tasks expected from them. PRAGATI will carefully investigate this issue in the initial and subsequent performance assessments of the AWW. In the meantime, PRAGATI staff considers that the new tasks proposed consist more of a clarification and rationalization of the work that they are already supposed to do without much guidance. AWWs are already supposed to conduct home visits on two "Visitation Days" per week, for instance. According to the PRAGATI schedule of home visits, one AWW covering a population of 1000 would be expected to conduct 2 pregnant and infant visits[16] per Visitation Day, which seems acceptable. Similar calculations for the number of visits to eligible couples provide estimates of up to 8 visits per Visitation Day,[17] which seems high. However, these estimates may be too high, and the visits to eligible couples may not require as much time on average as visits to pregnant women and mothers with infants.

[16] Assuming 35 births per year and 6 visits per birth, or roughly 210 visits per year, with 2 visits per Visitation Day.
[17] Assuming 20% MWRA coverage and up to 4 visits per year, or roughly 8 visits per Visitation Day.

Local NGOs

In Ballia district, a forum of NGOs for Child Survival took BRICS operations to scale from one block to all the 17 blocks of the district. The NGOs in this forum will continue to function as PRAGATI partners in further expansion of the BRICS intervention package in that district. NGOs in other project districts have been identified and will play a similar role.

Each NGO partner will be expected to provide one or several promoters to work on PRAGATI activities as discussed in section E.2.b.iii. Overall, it is expected that about two promoters will be available in each block, which corresponds to a ratio of about one NGO promoter per 50 AWWs and 10 ANMs.

At the time of the proposal, the following NGOS were identified as available to partner with PRAGATI:

In Ballia:

- *Nawal Education and Research Center* – Headed by a professor in a local university, its strength includes advocacy in child labor and research. It operates BRICS interventions in 3 blocks of the district.
- *Solanki Gramodhyog Sewa Samiti* – Operated by an ex-student leader, the organization was involved in women's empowerment issues when they joined the network. They work in 4 remote blocks of Ballia and their grassroots acceptance and credibility is strong.
- *Subhash Memorial Manav Uthan Sewa Sansthan* – This NGO has capable supervisors working in two blocks. They also operate in 4 other districts in areas like alternative power sources.
- *Purvanchal Gramin Chetna Samiti* – Run by the social wing of the local Catholic diocese, this NGO has formed strong community groups who are involved in micro enterprise programs in one block. They also have a popular folklore team, which BRICS used to communicate its interventions.

In Lalitpur:

- *Harriet Benson Memorial Hospital* – the community health wing of this hospital has been active in providing primary preventive and curative care in rural areas of Lalitpur district.
- *Navchetna Community Services and Development Society* – this NGO works primarily on preventive health activities in rural areas of the district and has technically qualified staff.

In Moradabad:

- *Harpal Gramodhyog Vikas Kendra* – This NGO works at the grassroots level to form micro credit groups and to link them with rural and national banks. They also work with unemployed youth in the Government's Employment Program. The Pulse Polio campaign has benefited from its ability to mobilize communities during NIDs.
- *Jeeshan Gramodhyog Vikas Kendra* – Apart from mobilization activities during NIDs, this NGO conducts awareness campaigns in the area of birth spacing and conducts seminars on women's rights. It has 5 permanent staff and 50 volunteers working in 25 villages.

The NGOs in Ballia and Lalitpur are sufficient to carry out the field activities in the area that the project is to phase in during the first year. More NGOs will be identified and selected in Moradabad when the project will move beyond one block.

PRAGATI will provide support to its local NGO partners in the form of grants to cover project-related costs such as, office space, office utilities, stationery, communication, honoraria and travel expenses for the promoters, and NGO director travel.

Section E.2.b.viii describes PRAGATI plans for sustainability and capacity building with respect to local NGOs.

Specific activities to be conducted in support of this strategy

Health services:

- Performance improvement of ANMs, including training and supervision of ANMs
- Improvement in HIS, particularly with respect to supply of commodities
- Linkage with ICDS and the communities

ICDS:

- Performance improvement of AWWs, including training, supervision and provision of job aids, tools, and guidelines
- Linkages with communities and ANMs
- Improvement in HIS
- Provision of monetary incentives to AWWs for travel

Local NGOs:

- Provision of grant support for NGO officers and promoters to create enabling environment for AWWs and to assist in various project activities such as household surveys and identification of beneficiaries (see E.2.b.i)
- Support to strengthen specific areas of organizational structure as identified though NGO self-assessment score sheet (see sections E.1.b.iv and E.2.b.viii)

vii. Phased coverage of blocks and AWWs

To plan the expansion of the coverage of PRAGATI interventions, each ANM and the 3 to 5 AWWs in her area are considered a service delivery unit through which a set of preventive, behavior changes and referral services are made available to mothers and children. As the AWWs are the ultimate contact with the project beneficiaries, the proportion or coverage of trained AWWs in each district is a key output indicator of the PRAGATI project.

While the estimated 946 ANMs in the three project districts will be trained during the first year of the project, the more than 5,000 AWWs will be trained according to a phased approach to ensure the quality of the training and follow up. The progression of the training of AWWs will be different in each district to allow for their specific constraints. This progression is determined by the pace of entry of the AWWs training program into the blocks and by the pace of the training program within these blocks. It is described below and represented graphically in Figure 2 by six-month period or semester.

- *In Ballia,* where the total population is 2.7 million and there are 17 blocks and 1888 AWWs, the AWW training program will start in 10 blocks at the same time. The coverage of the AWWs will reach 50% of each block in the second semester of the first year and 100% of each block in the next semester. The training program will begin in the seven remaining

blocks and will cover 50% of the AWWs in these blocks during each of the two following semesters. All the 1888 AWWs in Ballia will be trained by March 2006. The progression of the coverage of AWWs in Ballia is more rapid than in the other project districts because of the presence of the WV ADP and the previous achievements of BRICS, including the strong network of NGO's.

- *In Lalitpur,* where the total population is 1 million and there are 6 blocks and 568 AWWs, the training program will start in 3 blocks in which the coverage of trained AWWs will reach 50% in the second semester of the first year and 100% in the following one. The training program will begin in the three remaining blocks and cover 50% of the AWWs in these blocks during each of the two following semesters. All the 568 AWWs in Lalitpur will be trained by March 2006. The progression of the coverage of the AWW training program in Lalitpur is justified by the location of the competent NGOs and by low density of the population in that area.
- *In Moradabad*, where the total population is 3.8 million and there are 14 blocks and 2286 AWWs, PRAGATI will only work in one block during the first year of the project during which all the AWWs in that block will be trained. Then 50% of the AWWs of 5 other blocks will be trained in one semester and the other 50% in the following semester. The training program will begin in the eight remaining blocks and cover 50% of the AWWs in these blocks during each of the two following semesters. The coverage will progress more slowly in this district because of the absence of a WV ADP and because the district is considered as a sensitive area. However, all the 2286 AWWs in the district will be trained by March 2006. A recent addition of 6 blocks to the district of Moradabad initiated discussions between WV India, the CMO and DPO of the district and the USAID Mission. After considering the PRAGATI resources, and the geographic spread of these additional blocks, it was decided that PRAGATI would only be implemented in the 14 initial blocks.

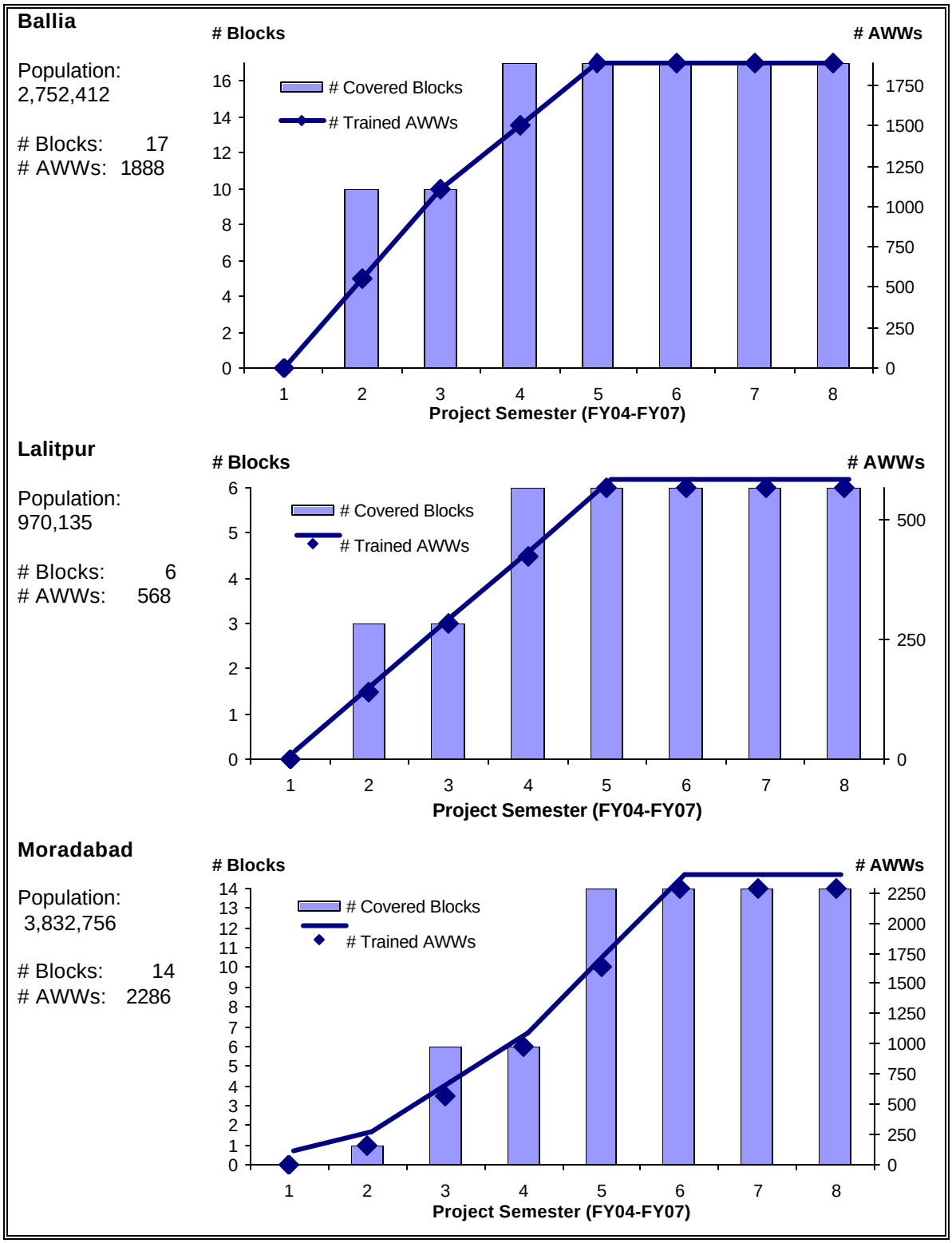
The progression of the PRAGATI activities into the blocks and the coverage of trained AWWs are critical dimensions of the implementation of the project. As such, they constitute two output indicators that are not included in the project results framework but will be tracked by the PRAGATI staff in each district using the annual targets represented in the graphs in Figure 2. The performance of AWWs is a related output indicator that is included in the results framework and that will be measured through regular performance assessments (see section E.2.b.v).

A weekly schedule of the training of master trainers, lead trainers and AWWs is proposed in Annex 19 for each district. After one master trainer's workshop scheduled in May 2004, each training of trainers workshop is followed by 3 or 6 workshops to train AWWs in the following week.

Specific activities to be conducted in support of this strategy:

- Training of Master Trainers, training of Trainers, and training of AWWs
- Monitoring of the number of trained AWWs and their performance

Figure 2: PRAGATI coverage of blocks and AWWs by semester and district



Note: Time axis is divided into six-month periods or semesters to represent PRAGATI's four-year period of implementation, from FY 2004 to FY 2007. Bars represent the number of blocks in which the AWW training program is implemented. Dots on the lines represent the number of AWWs that are trained.

viii. Planning for Sustainability

The Child Survival Sustainability Assessment framework, introduced during the February 2004 sustainability workshop, describes three dimensions of sustainability for child survival projects: health services, partner capacity and community competence. Prior to the workshop, PRAGATI staff discussed these dimensions with project partners in the three districts. During these discussions, the health services dimension was divided into health status and health services to account for the fact that health status can change without change in health services during or after the project. Specific elements were also defined to characterize each dimension. Finally, immediate and distant stakeholders were identified and a vision and goals were formulated for the four dimensions of the sustainability framework.

The sustainability workshop was held with representatives from immediate stakeholders of the three project districts who are also state level decision makers but not necessarily representative of the community. Staff from WV US, APRO and India, from USAID and from CSTS+ also participated. During the workshop, the project-wide vision and goals were developed and the elements of the four dimensions of the sustainability framework were defined and prioritised based on the preliminary work previously done in the three project districts. The elements identified for the health system and the partner capacity dimensions were divided into services and capacity issues. The project-wide sustainability framework resulting from the workshop is included in Annex 25.

Since only proxy representation of communities was possible in the workshop, participants recognized that there should be a further round of consultation with communities in the three districts before adopting the project-wide sustainability framework. They also recognized the need to assess the performance of health workers (ANMs and AWWs), the capacity of the NGO partners and the competence of communities, and discussed the tools and the plans for doing so. In the meantime, PRAGATI staff already included a series of indicators in the project result framework that link it to the sustainability framework. Besides the health and health services indicators already included in the initial results framework, the following indicators were included:

- #13: % AWWs who report active support from community groups
- #15: % Communities with at least 80% of AWWs receiving adequate support from community groups
- #35: % NGO partners that are capable of providing adequate support to AWWs
  #36: % Communities competent in child survival techniques

These new indicators will be confirmed and the data sources and methods of calculation defined by the time of the FAR.

Overall, the PRAGATI approach of training and empowering grassroots-level workers supported by a well-established, long-term governmental program providing quality maternal and child health has good potential for sustainability. Community groups trained and empowered by local NGOs to actively promote demand for these services and accountability of service providers, will ensure the continuation of these activities. ANMs, trained in providing quality services, will help to establish and maintain an effective link between AWWs and referral services. Together, the ANMs and AWWs will ensure that immunization, family planning, and other basic health services are being provided in the community. PRAGATI will also help to strengthen logistics and reporting systems, which will also contribute to the sustainability of health services.

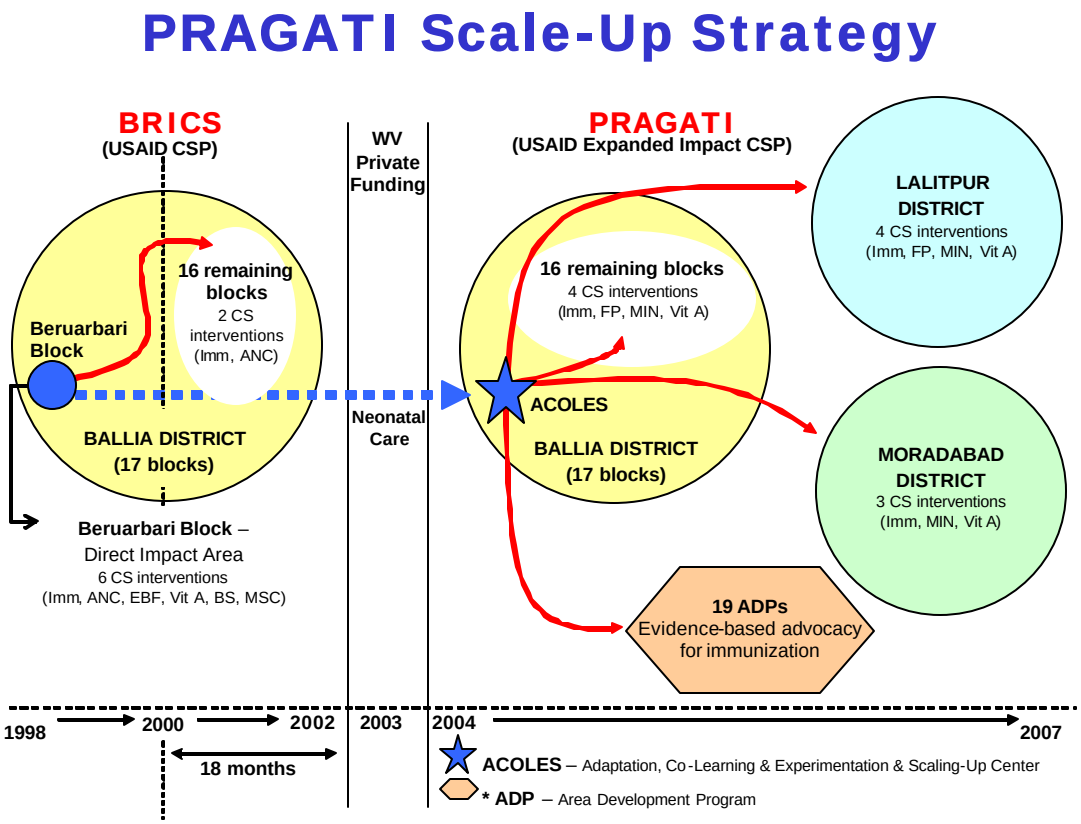
Specific activities to be conducted in support of this strategy:

- Follow-up meetings in each district and further discussion of linkages between the project's Results Framework and Sustainability Framework.
- Formulation and implementation of sustainability action plans and confirmation of sustainability indicators and data sources.

ix. Demonstration, documentation and operations research

Figure 3 summarizes the overall PRAGATI scale-up strategy from the initial phase of BRICS in Beruarbari block (six interventions implemented) to the remaining blocks of Ballia District (2 interventions scaled up) and to all three PRAGATI districts (4 interventions).[18]

Figure 3: PRAGATI Scale-up Strategy



Source: Adapted from PRAGATI proposal (2002)
Acronyms for interventions: Imm: Immunization; ANC: Antenatal Care; EBF: Exclusive breastfeeding; Vit A: Vitamin A supplementation; BS: Birth Spacing; MSC: Management of the sick child; MIN: maternal and infant nutrition; FP: family planning.

PRAGATI was designed according to the SEED-SCALE model[19], whereby communities that achieve better health outcomes through a local empowerment process involving the collection and use of data for their own planning become a center for learning for going to scale and larger

[18] See also Table 1.
[19] Taylor-Ide, Daniel and Taylor, Carl E. *Just and lasting Change: When Communities Own Their Futures.* Johns Hopkins University Press 2000. SEED-SCALE stands for Self-Evaluation for Effective Decision-making and Systems for Communities to Adapt, Learn and Expand.

impact. To that effect, PRAGATI will create and support the Adaptation, Co-Learning, Experimentation and Scaling-Up (ACOLES) Center in the Beruarbari block of Ballia district, the original site of BRICS. The ACOLES Center will provide the infrastructure where all project partners (communities, health services, ICDS, NGO partners, and World Vision) will meet to develop, test and document effective child survival and family planning strategies, methods and tools. While most of the tools are already developed and used in Ballia (registers, BCC plans, home visit cards, training manuals), they may need to be adapted to the other districts. New tools, mostly related to family planning, will need to be developed and tested. Also, the process of scaling up interventions will be made explicit and documented in the ACOLES center. This process will involve various training programs and cross visits that PRAGATI will support through the ACOLES Centre. PRAGATI will provide technical and financial resources to build the capacity of the ACOLES Center.

Given the rich environment for learning created in Beruarbari during BRICS and through the ACOLES Center, PRAGATI will also support operations research through the ACOLES Centre. Three main topics have been selected during the DIP preparation:

1. Expanding Contraceptive Choice

The aim of this study is to assess the operational feasibility of expanding the current contraceptive choice at the community level by introducing two technically proven family planning methods: the Lactational Amenorrhea Method (LAM) and the Standard Day Method (SDM). Inclusion of new contraceptive methods, natural methods in particular, serves not only to meet the particular needs of certain sections of communities but it also adds to the range of methods available to all couples. Although the MOH adopted SDM and LAM and studies have been conducted in India that show their acceptability, there is no well-documented experience of the introduction of SDM or LAM in health services and there is a need for fully developed protocols and tools for their implementation at the community level.

After a review of the international and national literature on research of and programs implementing SDM and LAM, the specific and locally adapted protocols, training manual, communication materials, supervisory tools, and data collection system[20] will be developed. Training, introduction and follow up of the two methods will be conducted in three different sites as follows:

Site 1: Block manned by GSSs
Site 2: Block manned by AWWs
Site 3: Block manned by AWWs but where SDM/LAM is not introduced

In each study site, 25 GSS or AWWs will be selected fto particpate or participating in the study in consultation with grassroots level workers.[21] The first two sites represent two different contexts in which LAM and SDM will be introduced. Site 1 represents a situation where World Vision has a more direct relationship with the community through the existence of an ADP and where the community health workers (GSS) are WV's volunteers. It is believed this represents the potential for greatest success. Site 2 represents the more usual situation in which the

[20] Data collection will be carefully monitored for the purpose of the research but also to avoid the over-reporting problems experienced in a few pilot projects in India in the past.

[21] Assuming that one AWW covers a population of 1,000, this sample size corresponds to approximately 30 births per year (potential clients for LAM) and 110 eligible couples (potential clients for SDM) per AWW.

intervention would be scaled up and where the community health volunteers are AWWs. Site 3 will serve as a control area where the contraceptive uptake will be carefully monitored but the SDM and LAM will not be introduced. The three sites will be chosen as comparable as possible with respect to all non-intervention related factors.

The study will assess the introduction of SDM and LAM in terms of:

- Operational constraints to adding natural methods in a rural north India setting
- Cultural acceptability
- Uptake of LAM and SDM
- Determinants of acceptance of LAM and of SDM
- Determinants of satisfaction and continuation of the use LAM and SDM
- Overall increase in contraceptive prevalence (as opposed to method switching)
- Increase in prevalence of exclusive breastfeeding
- Increase in the quality of exclusive breastfeeding and in the timeliness of the introduction of complementary food[22] among LAM acceptors

The time span for the study will be about 18 months for the first phase and 18 months for the second phase. The results of interventions in all ADPs will be monitored for a year to ensure sustainability or undertake remedial action if needed.

2. Evidence-based advocacy for immunization

The aim of this study is to provide the justification and the procedures for the creation and promotion of the use of a data bank at the community level. Adequate and useful data are often available at the community level but are only used to feed the health services HMIS. The present HIS of the health services and the ICDS does not allow for feedback of the data collected to the communities from where it originates, and communities are not empowered to use this information to their advantage.

The first phase of the study will identify the data needs of the community and specify how to process data in ways that interest the community using graphical representations, audiovisual aids, and other appropriate communication means. Community groups will be enlightened about the potential benefits of such information and how to take it back to the people where it can be used. The study will also define how AWWs and ANMs can use the data that they collect and compile to provide feedback to the community and how the NGO promoters can facilitate the process. The data bank will include, at a minimum, the registration of births and deaths and the immunization status of each child within the supervisory purview of each AWW. The existence of such data bank will enable the AWWs to better track the missed births and deaths, especially girl child, and enable community members to advocate for immunization of all infants and women at the block level.

The following outcomes expected from the creation and use of a relevant data bank at the community level will be assessed:

[22] In previous LAM pilot projects in India, a tendency by LAM acceptors to extend exclusive breastfeeding beyond 6 months has been observed.

- Increased accountability of health workers through better definition of expected services and standards in consultation with the AWWs and the community
- Improved relationship between health workers and communities evidenced by trust, transparency, and collaboration
- Improved quality of immunization services
- Improved competence of the community in areas like team building, decision-making, leadership, holistic development of the child, etc
- Successful community-led advocacy activities at the block-level.

The entire process of empowerment of the communities to use their own EPI data will be carefully documented. During the second phase of the study, the approaches defined and tested during phase 1 will be scaled up to the 19 ADPs in the World Vision North Zone that are not part of the three project districts. The appropriate community groups, AWWs, ANMs and NGO promoters will be trained on creating community data banks and on the use of the data for advocacy purposes. The outcome of this second phase will be the feasibility and benefits of empowering communities to use their own EPI data as a mainstream intervention of any ADP.

The time span for the study will be about 18 months for the first phase in the Ballia ADP (including some 6 months of participatory preparation and 12 months of implementation), and 12 months for the second phase in 19 other ADPs (including about six months of introduction of the HIS in the all ADPs and 12 months of implementation and monitoring). The last year of the project will be used to ensure sustainability, undertake remedial action, if needed, and documentation and dissemination of the results of the research.

3. Sentinel Measures of Fertility and Mortality

The aim of this study is to develop the methods and tools for measuring mortality and fertility using data routinely collected by community health workers in their pregnancy and infant tracking registers. These aggregate measures are important impact indicators of child survival and family planning programs but require data of sufficient completeness and quality from relatively large populations.

The first phase of the study will assess the completeness and quality of the fertility and mortality data collected by community health workers (GSS) during BRICS and later in the former "Direct Impact" area of the project. This area is also where the ACOLES Center will be established under PRAGATI. The outcome of this study will be (1) an assessment of the quality of the data available during the years of project implementation; if the data warrant it, (2) estimates of rates and trends; and (3) recommendations on the feasibility and approaches to using such data on a sentinel basis in the project districts.

The second phase of the study will pilot-test the system recommended after Phase 1 to calculate meaningful fertility and mortality measures in one sentinel area in each project district. This system will involve reporting births and deaths data already collected by the AWWs in the pregnancy and infant tracking registers adopted by ICDS, and building the capacity at the block and district level for managing, analyzing and disseminating this information. During the second phase of this study, various features of the system might be tested so that further recommendations can be made at the end of the project. One such feature of the system to list pregnant women by the month of their expected delivery date and newborns by their birthdate, a procedure that allows the AWW to quickly look at all the women who are at the same stage of

their pregnancy or all infants of the same age and easily know which women are due for delivery during the current month or which infants are due for which visits or which immunization. The feasibility and benefits of investigating causes of infant and child deaths may also be assessed in the ACOLES area.

The first phase of the study will be completed in December 2004, and the second phase, if the recommendations from phase 1 warrant it, will be implemented throughout the remainder of the project, with the expectation that measurement of trends will be feasible and well established by the end of the project.

Other potential topics of operations research or documentation have been considered during the DIP preparation and may be further developed and implemented under PRAGATI:

- ***Effectiveness of the three models of implementation used in BRICS:*** Detailed analysis of available data (BRICS records and MOH HIS) on the process and results of using three types of community health workers under the second phase of BRICS: (1) GSS supported by World Vision; (2) AWWs supported by ICDS; and (3) CBD agents supported by SIFPSA. This analysis should be done while the institutional memory is still present and the lessons learned from such analysis could be applied to the implementation of PRAGATI.

- ***Quality and utilization of TBA data:*** As noticed during the BRICS final evaluation, trained Dais collect data on small notepads using pictorial representations of their activities and birth outcomes that seem to be of sufficient quality to conduct aggregate analyses. The ACOLES staff could collect Dais records over a period of one year and possibly data on the characteristics of Dais and their communities. This research would involve Dais in the process of gathering these data and interpreting and validating the results of the analyses. These analyses may provide valuable epidemiologic and programmatic information and lead to practical recommendations on future collection and analysis of data from Dais.

- ***Complementarities and synergies between PRAGATI and other USAID-funded projects in Uttar Pradesh:*** Since PRAGATI will be working in three districts of UP where USAID already supports family planning activities through SIFPSA, there is both need and opportunity to assess and compare the results of each program, and identify complementarities and synergies between them. It may be worthwhile to compare the results obtained in areas where community-based distributors (CBD) are active in family planning services (typically one or two blocks per district) with those where AWWs are active, and those where both type of agents are active. USAID/India has expressed interest in such an assessment.

- ***Collaboration between the MOH and ICDS to supervise community health workers (AWWs):*** ANMs are MOH staff supervised by LHVs while AWWs are staff of the ICDS, a long-term multi-lateral health program, and supervised by MS. This situation makes it

difficult to foster a collaborative relationship between ANMs and AWWs. PRAGATI will link LHV and MS and support joint supervision of AWWs to ensure and improve technical complementarity and competence and to establish a sustainable collaboration.

x. Coordination and management

The PRAGATI coordination and management team will be based in Lucknow. This change from the initial proposal was necessary because of the organizational changes that have taken place in World Vision India early in 2004. This location change will make it easier for the coordination team to travel to Lalitpur and Moradabad, the two additional districts, but will decrease their presence in Ballia and in the ACOLES Center. Organizational and financial modifications have been made to take advantage of this new situation.

The organizational chart of PRAGATI is presented in Annex 21 and the status of staffing at the time of the preparation of the DIP is provided in Annex 22. The job descriptions of all the PRAGATI positions are included in Annex 23.

The APROl and the WVUS offices of WV will support PRAGATI. Dr. Sri Chander will provide technical assistance as the Regional Health Advisor. He has more than fifteen years of experience in several Asian countries supervising child health projects. At WVUS, the Technical Resources Team's Advisor for Child Health, Lyndon Brown, will provide technical oversight and support to the project. David Grosz, India Program Officer, will serve as a liaison between USAID and PRAGATI in administrative matters. Warren Wright, WVUS Finance Officer, will be responsible for the project's financial reporting. An organizational chart of World Vision and PRAGATI CSP can be found in Annex 25.

The Flexible Fund contribution to PRAGATI will facilitate technical assistance from CATALYST/CEDPA for the family planning intervention. The terms of reference for this assistance include:

- Provision of a full-time Family Planning Coordinator June 2004-June 2005.
- Organization and delivery of a contraceptive technology update workshop for WV India staff and technical staff from selected partners.
- Development and integration of family planning into PRAGATI technical references and activities including training and BCC materials, performance monitoring and evaluation (FP survey, HWPA), etc.
- Training of master trainers (WV staff and others) and supervision of the training activities.
- Assistance in the design, implementation and analysis of the expansion of contraceptive choice study.
- Documentation of PRAGATI FP experience, including: (1) collaboration between CATALYST and World Vision; (2) impact of sustainability planning on the family planning component of the project, and (3) links between health services and ICDS.

CATALYST/India will provide technical assistance to PRAGATI according to the work plan in Annex 18. Since CATALYST/India will end in June 2005, PRAGATI and CATALYST staff will prioritize the activities supported by Flex Fund to ensure that those requiring significant TA are completed before that time.

PRAGATI will be planned and implemented in close partnership with other USAID-funded FP agencies such as SIFPSA and its collaborating agencies in UP. PRAGATI and SIFSA representatives in the three project districts and in Lucknow have initiated discussions on coordination. In addition, discussions have begun on the need and the opportunity to carefully document project implementation, results, and potential synergies between the activities of the various partners. This will allow drawing lessons for future FP projects in UP and elsewhere (see section E.2.b.ix).

E.2.c. Technical interventions

This section describes the specific aspects of the four technical interventions of PRAGATI in terms of behavior change communication, quality and access. It builds on the baseline findings presented in section E.1.c. by intervention and on the crosscutting strategies described is section E.2.b. Each section begins with a summary of the intervention-specific baseline and annual benchmarks listed in the performance monitoring and evaluation table in Annex 9.

i. Immunization

Table 12: Annual benchmarks for immunization in PRAGATI districts

Sl. No	Indicator statement	District	Baseline	Annual Benchmarks		
				FY05	FY06	FY07
2	% Children aged 12–23 months who were fully immunized by their first birthday	Ballia	33	30	60	70
		Lalitpur	30	40	50	70
		Moradabad	33	40	50	70
3	% Children aged 12–23 months of age who received a measles vaccine	Ballia	66	70	75	80
		Lalitpur	49	55	60	70
		Moradabad	50	60	70	75
4	% Mothers of children aged 0–11 months who received two or more TT vaccinations when pregnant with youngest child	Ballia	79	80	85	90
		Lalitpur	68	70	75	80
		Moradabad	59	65	70	80
16	% children aged 12–23 months who have received at least one DPT vaccination	Ballia	37	60	80	95
		Lalitpur	12	30	60	80
		Moradabad	12	30	60	80
21	% Infants who received correct dose and route of vaccinations from an ANM	Ballia	39	70	80	90
		Lalitpur	57	70	80	90
		Moradabad	52	70	80	90
25	# Sub-centers which had no stockout in the past 6 months	Ballia	16	25	35	50
		Lalitpur	3	10	20	50
		Moradabad	28	35	45	70
26	% DPT1 – III drop out	Ballia	15	13	10	5
		Lalitpur	35	30	25	20
		Moradabad	31	25	20	15

Behavior Change Communication

Given the low awareness of the benefits and timing of childhood immunization, the AWWs will provide specific counselling on immunization to pregnant women as soon as they are registered and will continue throughout the pregnancy and first year of the child. The behavioral change communication plan in Annex 16 shows that the need to get TT immunizations is one of the key messages of the first visit around the fourth or fifth month of pregnancy, during which specific

arrangements for the next opportunity to do so are discussed. Follow up on the immunization status and reinforcement of the need to get the proper injections is provided during the two other visits before delivery. Immunization of the baby is also addressed during the last visits at the eighth or ninth month of pregnancy, and soon after delivery arrangement to obtain BCG and the dose of polio vaccines are discussed. The need to comply with the remaining immunization schedule and to keep the immunization card is emphasized during the post-partum visit. Follow up of the completeness of the DPT/OPV immunization is ensured during the home visit at the fifth month of the child, at which time remedial action can be taken. At seven or eight months, the importance of measles immunization and the specific arrangements necessary to obtain the injection are discussed.

One critical activity of the AWWs to increase and maintain high immunization coverage will be the biannual household survey to identify and list all the beneficiaries in her area. This is already part of her tasks for the ICDS project where all pregnant women identified during that survey are listed in the pregnancy tracking register as beneficiary of nutritional supplementation program. This register will be adapted to include the features of the pregnancy register used in BRICS. Annex 12 provides a template of the new register as it has been agreed upon by ICDS and PRAGATI staff (see section E.2.b.i). This new register allows for recording the specific BCC activities and follow-up actions for each visit as described above for immunization but also for other health concerns such as nutrition, birth preparedness and birth spacing. The pregnancy tracking register also includes information on the status of specific interventions such as TT immunization and IFA supplementation, and the outcome of the pregnancy (live birth, stillbirth, died after birth). At the time of the post-partum visit, the AWW transfers the data on the newborn into the Infant Register that is designed like the Pregnancy Register to allow for recording BCC activities and the status of selected interventions, including immunization.

In addition to the above one-to-one education and counseling activities conducted by the AWWs, PRAGATI and its NGO partner will form and strengthen community groups that will assist the AWW in their tasks to register all pregnant women and infants (see section E.2.b.iii). PRAGATI will also build the capacity of the ICDS and health services in the project district to use the available EPI data to plan for effective immunization services and achieve high coverage levels (see section E.2.b.ix).

Training of both ANMs and AWWs will include general principles of immunization and the specific aspects of the national immunization program including the related HIS and cold chain and supply system. For ANM, the focus will be on the technical aspects of administering the oral and injectable vaccines and the related safety procedures and standards, and the counseling approaches and skills at the health center. For AWWs, the focus will be on counseling at the household level, including the skills needed to facilitate communication and involve the other decision makers in the family, and the use of the registers and related information. As LHV and MS will be trained as trainers and will conduct all the training of ANMs and AWWs, they will be fully aware of the content of this training. LHVs and MS will also be trained and supported in conducting supervision using well defined checklist based on the agreed upon standards of performance.

One topic of operations research of PRAGATI is “Evidence based advocacy for immunization.” (see section E.2.b.ix) This study will assess the effectiveness of the availability and use of relevant health data such as birth, death and immunization status on the accountability of health providers and community involvement for health.

Quality

The baseline qualitative assessment showed that families perceive many issues with the quality of immunization of services, and the performance assessment of ANMs confirmed that the quality of immunization services is not satisfactory.

To address these concerns, the health worker performance improvement plan of PRAGATI (see section E.2.b.v) will include various elements critical to the quality of the immunization services: maintenance of the cold chain, including the specific QA system; injection safety; immunization techniques; and logistics at the ANM level primarily, but also to certain extent at the district level.

The sustainability of the support that PRAGATI will bring to immunization services relies on the following factors: establishment of a new and effective registration and tracking system, and establishment of a training and supervision system, including quality control, and the creation and involvement of community groups.

Access to Services and Commodities

Although the high rates of TT immunization among pregnant women suggest a relatively good accessibility to immunization services, irregularity of services remain a primary concern for families and communities. The performance improvement plan for ANMs in each district will partially address this concern by improving the number of ANMs providing quality services.

The existence of shortages of vaccines and weaknesses in the cold chain in terms of equipment and operations affect the accessibility and overall quality of immunization services. The supply of vaccine is particularly worrisome at the peripheral level even though it appears that the quantity of vaccines needed for the project districts is available at the district and state levels. PRAGATI will therefore work to improve the logistics system and particularly the reporting and ordering system from ANM to the district and the state. One of the constraints of this approach might be the difficulty to access and discuss these logistics issues with the health services officials. PRAGATI will only strengthen the existing logistics and information systems of the health services and not create new, parallel ones, so that the improved systems will be maintained beyond the end of the project.

During the PRAGATI Project, ANMs and other government health staff will be trained on accurate forecasting and will be followed for timely submission of reports. Sharing of AWW monthly reports on a regular basis will also facilitate logistics and management at the Sub-Center and PHC levels, and thus help reduce stockouts.

ii. Family planning

Given prevailing cultural and religious norms and practices in Moradabad, World Vision and its partners considered that implementing a family planning program in that area would face resistance and may be detrimental to the polio eradication efforts supported as a priority by various government and donor agencies. At this time, PRAGATI will implement family planning interventions only in Ballia and Lalitpur districts. However, this decision may be reviewed in consultation with other partners, if there is evidence that Moradabad District can be included without disrupting other programs during subsequent years of project implementation.

Table 13: Annual benchmarks for family planning in PRAGATI districts

#	Indicator statement	District	Baseline	Annual Benchmarks		
				FY05	FY06	FY07
5	Couple years of protection provided by ANM/AWW [FF1] [1]	Ballia Lalitpur				
6	% Mothers of children 0-23 months using modern contraceptive method	Ballia Lalitpur	12 9	15 11	20 13	25 15
7	% MWRA using modern contraceptive method [FF3]	Ballia Lalitpur	12 3	24 7	25 12	26 15
18	% MWRA who report having discussed FP issues with a health worker or promoter (AWW/ANM) in the past 12 months [FF6]	Ballia Lalitpur	18 12	30 30	40 40	50 50
19	% Population who live within 5 km of a family planning/reproductive health service delivery point [FF7]	Ballia Lalitpur	63 34	65 40	70 50	80 60
20	# Beneficiaries reached by the FP program [FF9]	Ballia Lalitpur	? ?			
23	% FP clients who received adequate counseling from AWWs [FF5]	Ballia Lalitpur	8 1	20 15	40 30	50 40
24	% MWRA who started using a method of FP at least 12 months ago who are still using the method	Ballia Lalitpur	48 43	60 60	70 70	80 80
27	% MWRA who know at least one source of FP method	Ballia Lalitpur	? ?			
28	# of acceptors new to family planning [FF2]	Ballia Lalitpur	46 34	? ?	? ?	? ?
29	% MWRA who report discussing FP issues with their spouse in the past 12 months [FF4]	Ballia Lalitpur	47 39	60 60	70 70	80 80

[1] The nine core indicators of the Flexible Fund are identified in the table with the sign [FF#].

Behavior Change Communication

The FP component of PRAGATI will place its major focus on targeted and timed counseling (see section E.2.b.ii) to address the prevailing false beliefs and myths about family planning and because the family decision-making structure is strongly biased in favor of husbands and other family members rather than women. AWWs will be trained to identify eligible couples and conduct regular home visits to ensure that all women are reached. Each visit will be planned according to pre-established criteria and schedules and conducted following guidelines specific to the target groups and the particular need and reproductive intentions of the couples. The AWWs will be trained to identify and facilitate appropriate interpersonal communication between all decision-makers in the family.

The BCC plans for eligible couples shown in Annex 15 defines four target groups for which specific behaviors and behavior change messages are planned, recognizing and consistently observing principles of informed choice. Visits to newly-married couples will address the pressure typically placed on young wives to prove their fertility. The benefits of delaying birth of the first child, and the various temporary methods available, will be presented. Visits to couples with 1 or 2 children will focus on the importance of three-year spacing between births. When couples already have 2 children, the counseling focuses on the advantages of limiting the

size of their family and discusses options for contraception, including CT 380 and NSV, two methods that have recently become available through government health services. Motivation for having more children, such as a son preference and resistance toward contraception will be addressed as appropriate. House visits are also made to women within 6 weeks post-partum in order to highlight the importance of timely initiation of family planning with an appropriate method, and the importance of limiting the number of children, with discussion of methods available for this purpose, as well. For all these target groups, a household visit is recommended every quarter or earlier if there is any need such as follow-up on users of LAM and their breastfeeding practices, or for additional counseling and support to women at higher risk of discontinuation of birth control or risk of unwanted pregnancy.

The behavior change communication plan for pregnancy and infancy in Annex 16 also addresses the benefits of birth spacing and contraceptive methods available to postpartum and lactation mothers depending on their reproductive intentions. This topic is introduced at the sixth of seventh month of pregnancy and is re-addressed at each subsequent visit.

To support the AWW in her work on FP and to provide the necessary information for the management of the program (performance monitoring and estimation of demand in contraceptives), PRAGATI will introduce the use of a new register (see proposed template in Annex 10). This register will be integrated into the current ICDS HIS system. During the bi-annual surveys, the AWW will identify all eligible couples and list them (or update the list) in the FP register. A new list will be developed every six months and new eligible couples will be added to that list after a quarter. Names of eligible couples will be crossed out when the list is updated if the woman becomes pregnant, dies, or leaves the area for more than a quarter. The information available for couples previously registered will be transferred to the new list. At each quarterly visit, information is recorded about the counseling provided, the FP method adopted for the coming quarter, the amount of commodities provided, and the behavior needing follow-up. The design of the register allows for easy tallying of this data by the AWW at the end of the quarter. A monthly report compiling this information is kept by the AWW and copies are sent to the ANM and to the MS (see Annex 14). This and the other registers and related reports to be used by the AWWs under the PRAGATI will be reviewed after three months and the appropriate modifications will be made before engaging in their large scale production and distribution.

Family planning will be integrated into the health worker performance improvement plan of PRAGATI (see section E.1.b.iii). At the beginning of the project, CATALYST/CEDPA will organize and conduct a contraceptive update workshop for WV India staff and technical staff from selected partners and develop the family planning training. CATALYST will also conduct the family planning aspects of training for all trainers who will eventually train ANMs and AWWs. One topic of operations research of PRAGATI is expansion of contraceptive choices (see section E.2.b.ix).

Quality

PRAGATI will design and implement all the AWW and ANM training and supervision within the framework of a larger performance improvement plan (see section E.2.b.v). The initial AWW qualitative performance assessment will provide the opportunity to specify the roles and responsibilities of the AWWs with respect to family planning. Specific standards will be adopted and the related competencies to implement them defined. PRAGATI will collaborate

with SIFPSA and obtain technical assistance from CATALYST for the implementation of its health worker performance improvement plan including the improvement of the quality of the family planning services that they provide.

Access to Services and Commodities

The success of the FP interventions of PRAGATI relies on the availability and accessibility of pills and condoms at the levels the ANMS and the AWW works. In the three project districts as elsewhere in UP, the supply of contraceptives comes to the district from the state-level store. From the district store, these commodities are distributed to the primary health centers (PHCs) and then to the sub-centers. The PHC and chief medical officer are trained in forecasting and planning but due to incomplete listing of eligible couples and users at the sub center and PHC levels and the irregular orders of supplies from the sub-centers, frequent and prolonged stockouts occur.

PRAGATI will strengthen the contraceptive logistics and supply system by ensuring timely reporting of demands for contraceptives especially at the ANM and PHC levels and by facilitating health and ICDS meetings to compile these demands at the block and district levels. PRAGATI will also advocate with the Reproductive and Child Health department of Family Welfare for the uninterrupted supply of contraceptives.

iii. Maternal and Infant Nutrition

Table 14: Annual benchmarks for maternal and infant nutrition in PRAGATI districts

#	Indicator statement	District	Baseline	Annual Benchmarks		
				FY05	FY06	FY07
8	% Children aged 0–5 months who were exclusively breastfed in the 24 hours preceding the survey	Ballia	66	70	75	80
		Lalitpur	23	30	40	50
		Moradabad	57	60	65	70
9	% Children 6–9 months who were given semi solids and breast milk in the 24 hours preceding the survey	Ballia	38	45	50	60
		Lalitpur	15	25	30	50
		Moradabad	35	40	55	70
10	% Mothers of children 0-11 months who report having 1 extra meal a day most of the days during last pregnancy	Ballia	?			
		Lalitpur	?			
		Moradabad	?			
11	% Mothers of children 0-11 months who report they took 100 IFA tablets during last pregnancy	Ballia	?			
		Lalitpur	?			
		Moradabad	?			

Behavior Change Communication

The baseline assessments confirmed that there are many false beliefs about maternal and infant nutrition, particularly with respect to early initiation of breastfeeding. Inadequate knowledge is also common among private health workers (RPMs and TBAs) and public health workers (ANMs and AWWs).

In the same way as for the two previous interventions, early registration and purposeful tracking of all pregnant women and newborns constitutes the main strategy of PRAGATI to change sub-optimal or adverse behaviors related to maternal and infant nutrition. During the first visit at the

fourth or fifth month of pregnancy, the importance of increasing the number of meals and of increasing the amount of food at each meal during pregnancy and the lactation period is emphasized. The systematic supplementation with at least 100 tablets of iron and folic acid (IFA) during the course of the pregnancy and lactation period is also recommended. The AWWs then follow-up on the compliance with these two key behaviors at each subsequent visit.

Education on proper nutrition of the baby begins at the eighth or ninth month of pregnancy with an emphasis on the initiation of breastfeeding within an hour after birth, of feeding of colostrum and of avoiding any prelacteals. The importance and proper techniques for successful breastfeeding are taught. Breastfeeding practices are reviewed and corrected as needed during the postpartum visit. When the child is five months old, the AWW teaches the importance of initiating complementary foods at 6 months of age and the recommended frequency, consistency and type of foods. Breastfeeding practices are also reviewed and corrected as needed. At 7 or 8 months of age, the AWW reviews feeding practices and discusses the need and the best way to increase the quantity of semi-solid foods.

In addition to the education and one-to-one counseling of pregnant women and mothers with young children, PRAGATI and its NGO partners will form and strengthen community groups whose members will reinforce adoption of key behaviors among resisting families. These support groups will gather women at the same stage of their pregnancy or lactation period to focus on specific nutrition issues of interest to that particular group.

The overall approach to training and improving performance of ANM and AWW is described elsewhere (see section E.2.b.v). In terms of nutrition, the focus will be on messages and skills needed to effectively communicate and support adequate nutrition behavior. ANMs and AWWs will also be trained to identify malnourished children and refer them to appropriate services. LHVs and MSs will be trained as trainers and supervisors of AWWs.

Quality

Pregnancy and infant nutrition will be a critical component of the health worker performance improvement plan (see section E.1.b.iii) developed at the beginning of the project. The specific competencies required from the ANM and AWW will be defined and used to prepare the appropriate training and supervision materials. The introduction and use of the pregnancy and infancy registers will provide not only a powerful tool to help AWWs focus on the right message and counseling at the right time, but will also help their supervisors to obtain reliable information on the level and quality of their activities. These methods and tools, once successfully implemented in the project zone, are expected to be adopted by the ICDS.

Access to Services and Commodities

The main contribution to improving access to pregnancy and infant nutrition services will be the training and support provided to AWWs to conduct targeted and timely counseling during regular home visits.

According to the MOH policy, the ANMs and the AWWs provide IFA tablets to pregnant women free of charge. However, there are common shortages and this makes it difficult to maximize coverage of this intervention. This situation had been experienced during BRICS.

The quality of the supply of IFA tablets will be ensured through training about and supervision of the ordering and storage practices of this commodity. These issues will be included in the training materials, the supervision checklists and reports of the ANMs and AWWs.

During PRAGATI, all the ANMs and AWWs in the three project districts will be trained to implement the pregnancy and infant nutrition policy of the MOH. The practical tools and training and BCC materials developed during BRICS will be introduced within the MOH and ICDS services, thereby strengthening their capacity to implement the MOH policy. PRAGATI will also strengthen the HIS system allowing the ICDS and MOH to better plan and manage their pregnancy and infant nutrition services. This capacity building effort and the simultaneous activities undertaken with local NGOs and at the community level will ensure continuous support and demand for these services and thereby sustainability.

iv. Vitamin A supplementation

Table 15: Annual benchmarks for vitamin A supplementation in PRAGATI districts

#	Indicator statement	District	Baseline	Annual Benchmarks		
				FY05	FY06	FY07
12	% Children aged 11–23 months who received a dose of vitamin A supplement in the 6 months preceding the survey	Ballia Lalitpur Moradabad	8 3 2	20 10 25	40 30 40	60 60 60

Behavior Change Communication

Given the low awareness of the benefits of vitamin A, the AWWs will systematically emphasize the importance of obtaining vitamin A supplements during their visits with mothers of eight to nine month old children. They will explain the recommended schedule starting at the time of the measles immunization and every six months thereafter. They will inform families about the two sources of vitamin A supplementation, in health services at the time of measles immunization in particular, and during the bi-annual campaigns.

AWWs play a major role in the organization of vitamin A supplementation campaigns (listing of all 9-36 month old children a few days before the campaign) and during the campaign days for gathering children and for door-to-door distribution of the supplements.

The training and supervision of ANMs will also include the importance of vitamin A supplementation for children 9 to 36 months old, the appropriate protocols of supplementation and recording, and the need to regularly check for the supplementation status at each contact with the child.

No research is planned for this intervention.

Access to Services and Commodities

Given the known issue of shortage of vitamin A in health services, PRAGATI will include vitamin A syrup as one the key foci of its logistics and supply strengthening activities including training, information management, stock management, and forecasting.

E.3. Program Monitoring and Evaluation Plan

E.3.a Routine health information system

There are two streams of health and management information (HMIS) in the project area–one for the health system and the other for ICDS. The HMIS of the Health System includes information generated by the ANMs and provides statistics on all services provided at the sub center level. The ANMs' reports are compiled at the PHC (block) level along with the data from the PHC. These compiled reports and the supply requests are sent to the district level and then to the state level. The information flow in the ICDS follows a similar pattern, with the AWWs preparing monthly progress reports (MPR) based on the data generated from tracking infants and pregnant women, distributing nutrition supplements, and conducting preschool classes and bi-annual vitamin A supplementation. These reports are compiled at the block and district levels. There is a clear overlap between the two HMIS systems in areas of immunization, vitamin A supplementation, and IFA consumption. Wide discrepancies in the respective statistics have been noted at every level.

PRAGATI will use the HMIS of the ICDS rather than set up its own system. The ICDS and PRAGATI staff has already compared the current ICDS registers with those used under BRICS and developed and agreed upon new templates. The foci of the BRICS registers are communication of sets of behaviors at set intervals during pregnancy, infancy and in at the various couple's stages of fertility, and timely provision of key preventive services. The key advantages of the BRICS registers that will be incorporated into the ICDS registers are: (1) defining the various tasks of AWWs by the visits during which they must be performed, and (2) tracking the beneficiary over time for changes in behaviors and for provision of services. After incorporating the elements of the BRICS registers, the AWW registers will have four sections:

1. Bi-annual household survey

The AWWs conduct bi-annual household surveys of all family members, their income status (to identify recipients for nutrition supplements) and other demographic details. These exercises precede vitamin A supplementation. Annex 10 presents the form for the household survey template.

2. Family planning register

The eligible couple register is an addition made by the project for its FP intervention and will be tested for a period of 4 to 6 months and revised before being printed for long-term use. This register begins with a list of all eligible couples constructed from data from the household survey. The AWWs will be expected to visit each eligible couple once a quarter and to perform specific tasks. The register will help the AWW to provide the services appropriate to the specific needs of each eligible couple (counseling, distribution of pills or condoms, or referral for clinical FP methods) and to track their contraceptive use or the changes in their reproductive intentions. The register also enables the AWW to calculate on a quarterly basis the number of current and new acceptors by method and the quantity of contraceptives distributed.

3. Pregnancy register

Pregnant women will be enumerated during the bi-annual household surveys and through regular house-to-house visits, and listed in the pregnancy tracking register. At least three

visits are mandatory during pregnancy – one at fourth/fifth month of pregnancy, another in the sixth or seventh month, and a third during the eighth month, with a post-partum visit no more than 2 days after delivery.

4. Infant register

After delivery, the name and details of each birth are entered into the infant tracking register and at least three visits are required to provide information to the mother at the appropriate times. The first visit is an extension of the post-partum visit, the second occurs when the infant is about 5 months old and the third at eight months.

The various sections of the AWW register have been described in detail in section E.2.b.i and their use by the AWWs has been described in section E.2.b.ii. The templates for these tools are located in Annex 10, Annex 11, Annex 12 and Annex 13, respectively.

Data from these registers will be compiled by the AWW in a monthly progress report (MPR) that will be sent to and aggregated at the block and district levels. Annex 14 contains the proposed template for the MPR. In addition, PRAGATI will collect selected FP and behavior data related to young child feeding as an annex to the MPRs. The project and NGO staff will work with the ICDS staff (supervisors, CDPOs and DPO) to ensure completeness and timeliness of reporting. Copies of these reports will be sent from the project to the state ICDS office where officials will be able to compare the quality of data coming from the three project districts with that from the rest of the state. Comparisons will also be done with the data generated from the government health system. Any significant improvement in data quality and timeliness will serve as a strong case for scaling up the revisions made in the registers of AWWs by the project.

In addition to the HMIS of the AWWs, PRAGATI will also strengthen the quality, timeliness and completeness of the HMIS of health services, working with the ANMs as well as with the staff at the block and district levels who are involved in the project interventions. PRAGATI will also work with the health services and community representatives to improve the use of the health data and decision-making. This important project strategy is described in section E.2.b.iii

E.3.b. Project level monitoring and evaluation activities

In addition to the data collected through the ICDS and health services HMIS, PRAGATI staff in each district will systematically collect information on the following project activities:

Training:	Number of seminars and participants, by types of participants and topics.
Supervision:	Number of supervisory visits and number of ANMs and AWWs supervised; data from the supervisory checklists.
AWWs activities:	Number of registered eligible couples and pregnant women; number of completed visits.
Other activities:	Meetings, special events, etc.
ACOLES:	Number and outcomes of exchange visits; documentation and operations research activities and outputs.

This data will be compiled in monthly, quarterly and annual activity and financial reports from each project district, and in project-wide quarterly activity and financial reports

The various other sources of data that PRAGATI will collect and use for performance and evaluation purposes are described in section E.1.b. The baseline KPC survey was done in October and November 2003 and will be repeated at the midterm and final evaluations in the three districts. The baseline FP survey was done in March and April 2004 and will be repeated at midterm and final evaluations in Ballia and Lalitpur. The ANMs' baseline performance assessment was done in March and April 2004 in the three districts and will be repeated at the midterm and final evaluation and possibly at another time during the project implementation as the need and opportunity arise.[23] The AWWs' baseline performance assessment will be conducted between July and October 2004 and repeated at midterm and at the end of project. Various qualitative studies involving FGDs and IDIs were conducted in October and November 2003 and will be repeated and adapted to the needs for specific information at midterm and at the end of the project. Partner NGOs will conduct self-assessments during the first year of the project and these will be repeated on an annual basis until the end of the project. PRAGATI will also conduct community capacity assessments in each district using the methodology developed by World Vision International based on Transformational Development Indicators.

PRAGATI staff will organize participatory annual reviews and evaluations of the project in each district. These reviews will involve key officials and regular staff from the key partners and stakeholders (health services, ICDS, NGO, SIPFSA and Panchayats) as well as external reviewers. Selected data collection may be made in addition to the project record reviews during the first and third annual reviews but most special data collection efforts will be made to prepare for the midterm and the final evaluation at the end of the second and fourth years of the project. A revised action plan will be one of the main outcomes of the annual reviews while the final evaluation will focus on lessons learned and documentation of the project.

E.3.c Building PM&E capacity of partners

The revision and implementation of the PRAGATI routine information system will be conducted by the health services and the ICDS staff who will have many opportunities to develop skills and expertise in monitoring and evaluation. All assessments involving special data collection efforts like household surveys and various qualitative assessments will be done with the PRAGATI partners (ICDS, Health Services, local NGOs) from the development of tools to the collection and analysis of data. The ICDS middle level managers will be trained in the use of LQAS as a monitoring method. Selected staff from health services, ICDS and WV India will attend the monitoring and evaluation course offered in Mahidol University in Thailand. The operations research to be carried out under PRAGATI is described in section E.2.b.ix).

[23] Such occasional and rapid assessment will primarily use LQAS approaches to answer specific questions to support project management decision-making, such as identification of low performing ANM or AWWs in specific areas, etc.

E.4. Work Plan

Activities	Focus [1]	Personnel	FY - 04				FY - 05				FY - 06				FY - 07			
	A/BC/Q		I	II	III	IV	I	II	III	IV	I	II	III	IV	I	II	III	IV
Project management																		
Staff recruitment																		
KPC surveys (qualitative and quantitative)																		
Family Planning Survey																		
Performance Assessment of ANMs																		
Performance Assessment of AWWs																		
NGOs selection and assessment																		
Discussion on project progress with state and district officials																		
Sustainability Assessment																		
DIP preparation and writing																		
Purchase of assets																		
Project launch in 3 districts																		
Review HMIS, adapt and test																		
Design training curriculum and materials																		
Design and test supervisory checklists																		
FAR / MTE / TAR / FE																		

Activities	Focus [1]	Personnel	FY - 04				FY - 05				FY - 06				FY - 07			
	A/BC/Q		I	II	III	IV	I	II	III	IV	I	II	III	IV	I	II	III	IV
IR # 1 Increased use of key CS and FP interventions																		
Training																		
Training of master trainers (WV staff)																		
Training of trainers (LHV and MS)																		
Training of AWWs																		
Training of ANMs																		
Refresher training for AWWs																		
Household level by AWWs																		
House to house survey																		
Identification and registration of pregnant women and eligible couples																		
Counseling and referral of MWRA, pregnant women and mothers																		
Community level																		
Creation and strengthening of CGs																		
Joint meetings of ANM, AWW, CGs																		
Ongoing supervision using checklists																		
Refresher courses designed on LQAS findings -																		
Health Sub center (ANM)																		
Immunization and counseling																		
Provision of clinical FP services to MWRA																		
Visits to the AWW center																		
Block and district level																		
Joint supervisory visits by MOH and ICDS																		
Regular supervisory visits by MS and LHV																		
Cross visits between service delivery units																		

Activities	Focus[1]	Personnel	FY - 04				FY - 05				FY - 06				FY - 07			
	A/BC/Q		I	II	III	IV	I	II	III	IV	I	II	III	IV	I	II	III	IV
IR # 2 Approaches, methods & strategies for child health from BRICS scaled up																		
ACOLES																		
Cross visits from other project districts																		
Cross visits from other ADP's																		
Lessons learned workshop																		
Documentation																		
Methods and tools from BRICS																		
Catalyst/WV collaboration on FP																		
ACOLES																		
Sustainability planning																		
Operations Research																		
Expanding Contraceptive Choice																		
Evidence based advocacy																		
Sentinel Mortality and Fertility Measures																		

[1] **Activity Focus:** A = Access; BC = Behavior Change; Q = Quality.

F. Annexes

Annex 1 Response to Application Debriefing

Summary Score Sheet

GH/HIDN Child Survival and Health Grants Program
Debriefing Summary Sheet
FY 2003

Application Contact in GH/HIDN/CSHGP Sheila Lutjens (202) 712-5734

PVO: WV
Country: India
Category: Expanded

Categories	Entry	Mentoring	Standard	Cost Ext	Expanded
Number reviewed	8	3	32	10	11
Number funded	1	1	9	2	2
Highest score	91.16	88.00	95.09	93.87	93.85
Lowest score	37.91	80.52	57.74	65.31	58.84
Funded upward	88.00	88.00	88.00	90.00	90.00
PVO Rank					2
PVO Score					90.03

Individual Category Scores: (Maximum Points in Parentheses)

Budget	Executive Summary	PVO Applicant	Situational Analysis	Program Strategy and Interventions	Organizational Development	PM&E	Management Plan	Collab. w/ USAID Mission	Total Points
(3)	(5)	(5)	(20)	(22)	(10)	(15)	(15)	(5)	(100)
2.79	4.60	4.80	18.56	19.00	9.20	12.93	13.35	4.80	90.03

USAID Internal Application Review Team:

Div/Bureau:	**Number of Reviewers:**
GH/HIDN/CSHGP	2
GH Bureau	1
Regional Bureau	0
Mission	1
External	1

Applicant's Comments
on Summary Score Sheet

The percentage scores below show the sections of the proposal on Program Strategy and Interventions, Performance Monitoring and Evaluation, and Management Plan as the weakest.

Budget	Executive Summary	PVO Applicant	Situational Analysis	Program Strategy and Interventions	Organizational Development	PM&E	Management Plan	Collab. w/ USAID Mission	Total Points
3	5	5	20	22	10	15	15	5	100
2.79	4.6	4.8	18.56	19	9.2	12.93	13.35	4.8	90.03
93%	*92%*	*96%*	*93%*	*86%*	*92%*	*86%*	*89%*	*96%*	*90%*

The PRAGATI strategy has been substantially developed with the partners during the preparation of the DIP. The DIP details ten overall strategies for the implementation of the four technical interventions of the project:

i. Early registration of all pregnant women
ii. Targeted and timed behavior change communication for families
iii. Creating an enabling environment for the AWW
iv. Improve block and village level planning and use of data
v. Health Worker Performance Improvement
vi. Partnership and capacity building
vii. Phased coverage of blocks and AWWs
viii. Planning for Sustainability
ix. Demonstration, documentation and operations research
x. Coordination and management

The description of the four technical interventions and the related activities are also detailed according to the USAID guidelines sections of Behavior Change Communication, Quality and Access. The overall Performance Monitoring and Evaluation plan is described in detail in the third section of the DIP. The methodology of each baseline assessment is described in detail in the Summary of Baseline and Other Assessment of the DIP and in the various reports on these assessments placed in the Annexes. The management plan of the PRAGATI was described as one of the overall strategies of the project. The organizational chart of the project staff in relation to World Vision India and the ADP staff is clarified and job descriptions have been written for all the project positions.

External Reviewers' Comments

Budget Information

STRENGTHS

WV match is 27.5% of total budget and HQ portion of federal direct costs is 14.6%. Both annual and all-year budget figures are given in detail. WV should be commended for putting in its own funds toward HQ salaries and for including their travel costs in the HQ section. The resources requested in the proposal have been adequately detailed and justified to be able to achieve the results expected in the project.

WEAKNESSES

There appears to be a lot of travel to/from India e.g. HO, IFO, IPO, CSTO, RHA, JHU, PhD, DIP consultant, NCIH (4 persons), regional conferences (12), international conferences (14), cost-recovery consultant, process documentation consultant, technical interventions consultants (2 are identified but not sure why these are needed in addition to the CSTO, RHA and other consultants). Internal staffing seems appropriate. Is there some way to use the expertise within India rather than having so many people coming and going? When will the work get done?

It is unclear why 1,490 AWWs need financial incentives ($3/month). How is this sustainable? What will happen to results once the project ends and financial incentives disappear? Is this what is meant by "empowering communities"? The application correctly identifies AWWs as the backbone "change agents" however financial incentives are more than supportive training and supervision (pg 13) and change the dynamics of the project.

ICDS brings its own resources for training (World Bank). Immunization officers are being trained by WHO and UNICEF (USAID and other donors). How will activity costs be shared among partners with resources?

Executive Summary and Overall Application

STRENGTHS

The executive summary provides a clear insight into the rationale for the project, the strategies to be used and the interventions to be put in place and gives a clear perspective to the details that follow in the later sections.

Applicant demonstrates a good understanding of the differing situations in the three districts chosen which led to decisions about choice of interventions. Interventions to be scaled up have been carried out effectively by WV in one district. There are several attractive innovative features, such as the ACOLES.

WEAKNESSES

Description of the PVO Applicant

STRENGTHS

Excellent presentation of goals for this proposed expanded impact program clearly demonstrating congruence with PVO's vision and expertise. This very experienced PVO has strong connections to the communities and areas where they work. WV has been a recipient of CS grants before, both for India and other countries. They also have integrated development projects with long-term commitments to several areas.

The description of the organization reflects that they are a premier organization in the field of Holistic Development and have a proven track record of diverse activities in the field in India. They have been extensively involved in working with local Indian partners and contributed to their capacity building for long term gains. The backbone of their efforts across the world is Area Development Programs that begin with one small unit and expand scaling up activities and achievements. This integration of the CSP into a comprehensive development package is likely to increase impact exponentially.

WEAKNESSES

Situational Analysis

STRENGTHS

Good strategic reasoning is evident, especially in section on rationale for selection of program sites. They have selected areas with high IMRs and poor access. Total of about 950,000 children 0-2 and 1.79 million women 15-45 are potential direct beneficiaries.

The proposal gives a very concise yet comprehensive description of the core issues in the districts of operation that would have relevance to this child survival activity. There is a deep understanding of the concurrent programs by the public and private health sector. The program is well aligned to the SOs of fertility reduction and child survival of the local mission.

WEAKNESSES

Program Strategy and Interventions

STRENGTHS

Again, the approach has been carefully thought out and seems to take into account variability among areas. For example, there is careful consideration of the attitudes in one district that could create resistance to birth spacing, which leads to a decision not to plan to promote it in that area, and possibly jeopardize the polio program, in an area with cases. Several wise decisions are made, such as about trade-offs between effectiveness and cost, and phased introduction of a tested MNC approach. Applicant plans adequate supportive supervision to PHC and sub-center staff, as well as AWWs and community health workers is planned.

The objectives of the program are timely and realistic and the proposed activities are bound to achieve them in the time frame of the project. There is a strong emphasis on

learning from the precursor of the current project and hence a clear understanding of the opportunities and constraints. The project centers on developing an enabling environment for utilization of existing services for preventive and promotive care. The program is consistent with the MOH policies. Issues of scale up have been dealt with in view of the latest available knowledge globally.

Proposal recognizes disparate geographical location of sites as a constraint but sees this as part of the strategy for scale up.

WEAKNESSES

BRICS 1 and the proposed plan for BRICS 2 are described very well, however clarification is needed about the objectives of the project. If the purpose of the project is to improve key health indicators while the project is operational and pays for key items like pharmaceuticals, medical supplies, honorariums, and transport, the interventions proposed will succeed. If the purpose of the project is to improve key health interventions in the long term, without funding things the government ought to be funding (e.g. pharmaceuticals, medical supplies, honorariums and transport), then the benefits will be short-lived. The interpretation is that the benefits of BRICS1 are fully dependent on World Vision's support for these key items and this is what the PVO proposes to replicate. This may be acceptable as children's lives will be improved while the project is active, but it should be realized it at the start and base expectations of sustainability on these critical assumptions.

One sustainability concern was that the proposal does not discuss how the honorarium to AWWs will be continued after the project.

The project is unclear about how it will recruit more Muslim women as AWWs. Few health workers are Muslim, fewer are Muslim women, and the poorest health care is in Muslim and low caste areas.

The links with some of the other projects working in the area are weak. There is no mention of the CORE group Polio Secretariat and the role they play in providing technical guidance to the partners. While funding for BRICS 2 is intended to "complement" the CORE funding, the role of the Secretariat is critical for quality control and linkages with the national program so as not to create parallel programs. The Global Health Bureau supports polio activities to World Vision in UP and the USAID Mission has provided funds for add-on activities in child health. USAID also supports WHO surveillance officers throughout UP who are charged with surveillance for vaccine-preventable diseases and much of the planning and training related to polio, including the use of data at all levels. USAID supports UNICEF's activities in UP as well. It isn't clear how BRICS 2 will interact with other partners that may have the lead in these areas, although WV does have an important role to play especially at the Panchayat level.

Organizational Development

STRENGTHS
Various assessments, plans for capacity building by each NGO, and support from WV are provided for. WV mentions a collaborative link with other CS CAs to complement their capacity buliding approach. The use of public forums to bring together various stakeholders, including community members, periodically to discuss child survival progress, disseminate information, and enhance ownership and partnership is an innovative idea.
WEAKNESSES

Performance Monitoring and Evaluation

STRENGTHS
The processes for collecting and using data for management decisions on a continuing basis and also by sample surveys at the beginning, middle and completion of the project have been clearly articulated. Both quantitative and qualitative methods will be used, and used appropriately. It may not be necessary to do surveys every year, but if the LQAS method is used it is not as much of a burden. The indicators used reflect the current thinking in measuring performance in Child Survival and Reproductive Health programs.
WEAKNESSES
It is unclear how data gathered through this program will support or comply with MOH HIS requirements.

Management Plan

STRENGTHS
World Vision has a long and successful presence in India and has developed good organizational abilities. There is a clear description of the roles and responsibilities and evidence of sufficient backstopping from the regional office and headquarters. WV seems to be well equipped to handle contingencies in an effective manner.
WEAKNESSES
The proposal contains a work plan for first year, but there is no general work plan for the life of the project.

Collaboration with USAID Field Mission

STRENGTHS
There appears to have been active participation of the Field Mission at every stage in the conceptualization and formulation of the project. The project will help the Mission in moving towards its Strategic Objective of promoting child survival.
WEAKNESSES

Applicant's Response to External Reviewer's Comments

Below are the key external reviewers' comments that should be addressed in the DIP. They are presented by issues (in italics) and followed by the applicant's comments and suggestions on how to deal with this:

International travel:

1. *There appears to be a lot of travel to/from India e.g. HO, IFO, IPO, CSTO, RHA, JHU, PhD, DIP consultant, NCIH (4 persons), regional conferences (12), international conferences (14), cost-recovery consultant, process documentation consultant, technical interventions consultants (2 are identified but not sure why these are needed in addition to the CSTO, RHA and other consultants). Internal staffing seems appropriate. Is there some way to use the expertise within India rather than having so many people coming and going? When will the work get done?*

Regional and international travel has been reduced to 18 round trips within the region and 8 trips outside the region. Planned round trips in the region are for the 3-week M&E course at Mahidol University (total 5 trips for this purpose over the life of the project) and mid term and final evaluation of CSPs in the region (total 9 trips) and for other conferences (total 4 trips) related to the Project's interventions. Planned round trips outside the region are for the DIP review – the Mini University (1 trip), planning for the ACOLES set up (2 trips), presentations on the project's lessons and best practices (8 trips). These trips will be for the CSP staff as well as for the National Office backstops.

Sustainability issues:

2. *It is unclear why 1,490 AWWs need financial incentives ($3/month). How is this sustainable? What will happen to results once the project ends and financial incentives disappear? Is this what is meant by "empowering communities"? The application correctly identifies AWWs as the backbone "change agents" however financial incentives are more than supportive training and supervision (pg 13) and change the dynamics of the project.*

3. *One sustainability concern was that the proposal does not discuss how the honorarium to AWWs will be continued after the project.*

4. *Clarification is needed about the objectives of the project. If the purpose of the project is to improve key health indicators while the project is operational and pays for key items like pharmaceuticals, medical supplies, honorariums, and transport, the interventions proposed will succeed. If the purpose of the project is to improve key health interventions in the long term, without funding things the government ought to be funding (e.g. pharmaceuticals, medical supplies, honorariums and transport), then the benefits will be short-lived.*

The interpretation is that the benefits of BRICS1 are fully dependent on World Vision's support for these key items and this is what the PVO proposes to replicate. This may be acceptable as children's lives will be improved while the project is active, but it should be realized it at the start and base expectations of sustainability on these critical assumptions.

AWWs are volunteers, receiving an honorarium of US$ 20 per month from ICDS, a long-term project funded by the World Bank, UNICEF, USAID and the GOI. As a matter of policy, PRAGATI will not add to this honorarium amount. However, World Vision will pay for all transport and living expenses related to training activities.

World Vision will not pay for items like vaccines, contraceptive and vitamin A capsules that are critical to the interventions but are provided by the Government. As there are documented frequent shortages in these commodities, World Vision will work with the health services to improve the related HIS and logistics.

The general approach and planning for sustainability of PRAGATI has been developed during the preparation of the DIP through a series of workshops with stakeholders in each project districts followed by a project-wide workshop that resulted in a project Sustainability Framework.

Collaboration and partnership:

5. *ICDS brings its own resources for training (World Bank). Immunization officers are being trained by WHO and UNICEF (USAID and other donors). How will activity costs be shared among partners with resources?*

The purpose and the topics of training to be provided by PRAGATI are different from those of the training provided by ICDS. This is detailed in the DIP.

6. *The links with some of the other projects working in the area are weak. There is no mention of the CORE group Polio Secretariat and the role they play in providing technical guidance to the partners. While funding for BRICS 2 is intended to "complement" the CORE funding, the role of the Secretariat is critical for quality control and linkages with the national program so as not to create parallel programs. The Global Health Bureau supports polio activities to World Vision in UP and the USAID Mission has provided funds for add-on activities in child health. USAID also supports WHO surveillance officers throughout UP who are charged with surveillance for vaccine-preventable diseases and much of the planning and training related to polio, including the use of data at all levels. USAID supports UNICEF's activities in UP as well. It isn't clear how BRICS 2 will interact with other partners that may have the lead in these areas, although WV does have an important role to play especially at the Panchayat level.*

The World Vision India Director for Health and HIV/AIDS Initiatives is a member of the CORE Polio Secretariat and will ensure that the PRAGATI project staff is up-to-date with its activities and directives, particularly in Moradabad. The support that World Vision will provide to the Panchayat will be the main mechanisms through which PRAGATI activities are coordinated with other partners in each district.

Work with AWWs:

7. The project is unclear about how it will recruit more Muslim women as AWWs. Few health workers are Muslim, fewer are Muslim women, and the poorest health care is in Muslim and low caste areas.

This concern is valid, and the challenges involved are acknowledged by project staff. However, WVI has had remarkable success in gaining the trust, commitment and genuine participation of Muslim communities in activities that are recognized to be of local benefit, including those that involve mothers of infants and small children. The progress World Vision has been able to make in Moradabad District over the past year as a partner in the CORE Polio Eradication Initiative is one recent and striking example.

HIS and PME:

8. It is unclear how data gathered through this program will support or comply with MOH HIS requirements.

This concern is addressed in section E.3.vi. of the DIP.

Workplan:

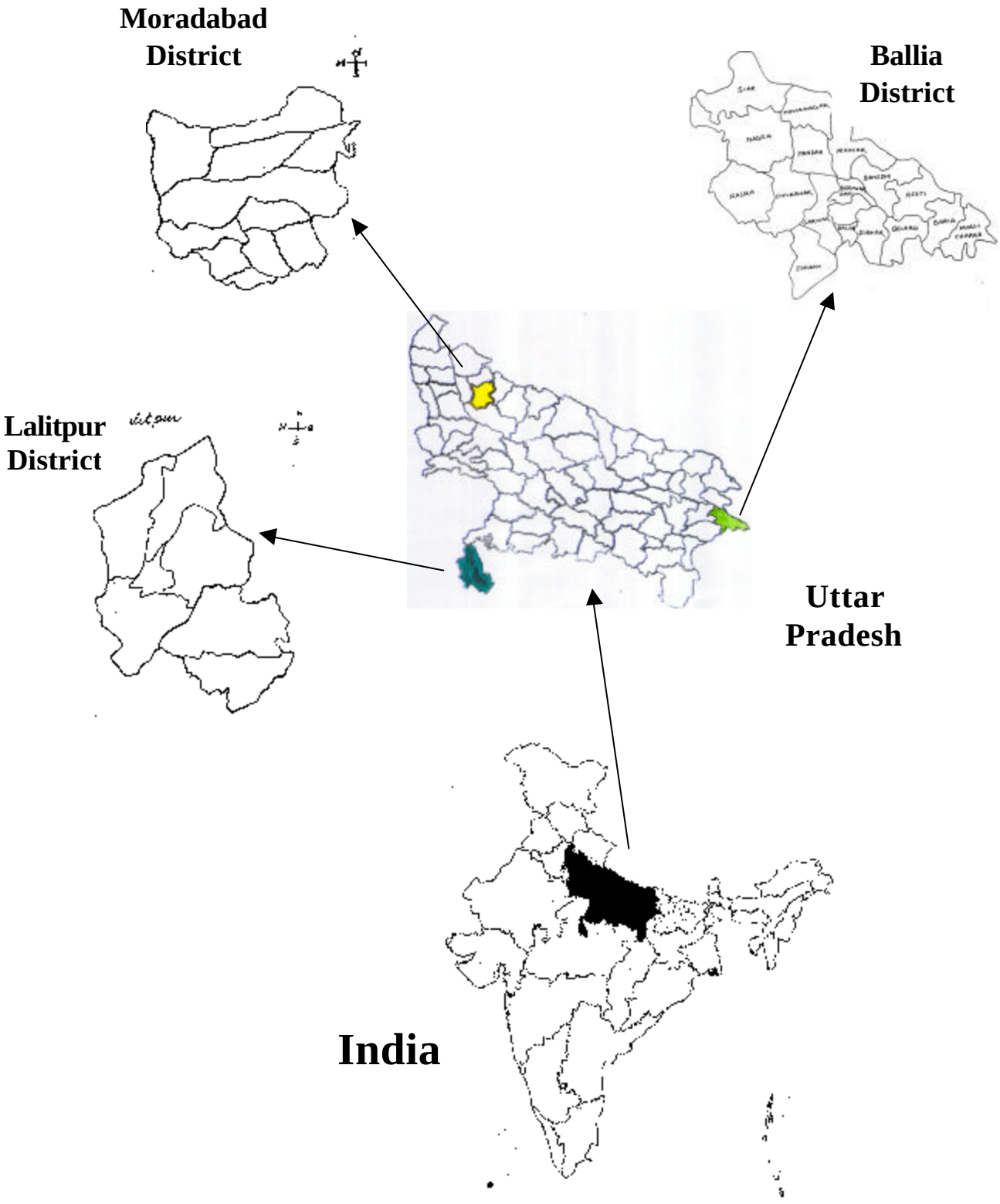
9. The proposal contains a work plan for first year, but there is no general work plan for the life of the project

The DIP includes a workplan for the four years of the project that build upon the first year work plan requested in the grant application proposal.

Annex 2 List of participants in key stages of DIP development

	Name	Designation
Ministry of Health	Dr Aruna Narayan	Assistant Joint Director
	Dr. Agarwal	MOIC
	Dr. Sashi Kumar	DMO
	Dr. Sevaram	AMOH
	Dr. R. C. Kumar	Deputy CMO
	Dr. Abdul Haleed	CMO
	Dr. Nanak Chand	Deputy CMO
	Dr. Bek	Ret. Deputy CMO
	Dr.Nanak	Deputy CMO, Moradabad
ICDS	Dr. A.K. Sinha	Joint Director
	Dr. Amita Jain	Deputy Director
	Mrs. Pushpa Verma	DPO, Lalitpur
	Mrs. Renu Jain	DPO, Moradabad
	Mr. Shailendar Rai	DPO, Ballia
	Mrs. Saroj Agarwal	CDPO, Lalitpur
	Mrs. Kamala Tiwari	CDPO, Moradabad
	Mrs. Asha Srivastav	CDPO, Ballia
	Mrs. Amita Takur	CDPO
	Ms. Uma Gupta	CDPO
	Mrs. Rani Batnagar	CDPO
	Mrs. Pramila Gupta	CDPO
	Mrs. Faridha Aftab	CDPO
	Mrs. Roopwala Sharma	CDPO
SIFPSA	Mr. Arvind Pandey	DPM, Ballia
	Mr. Mishra	DPM, Moradabad
	Mr. Saleem	DPM, Lalitpur
	Dr. C.K. Mishra	Project Manager
NGO Partners	Mr. S.K. Srivastav	
	Mr. Ghanshyam Singh	
	Fr. Mathew Cayany	
	Mr. S.P. Srivastav	
	Mr. Antony Swami	
	Dr. S.K. Mathur	Executive Director
	Mr. Malay	
	Johri Sing	Treasurer
	Mrs. Neha Sharma	Secretary
	Rev. Brijesh	
	Rev. Paul Sarasvath	
CEDPA/CATALYST	Dr Ravi Anand	RH Specialist
PRAGATI CSP	Dr. Beulah Jayakumar	CSP Manager
	Mr. Jeshurun Sunil	CB & D Officer
	Mr. D. Clement Timothy	M & E Officer
	Mr. Shibbu	Project Officer, Moradabad
	Mr. Surender	Accountant
	Mr. Philip	Field coordinator
	Mr. Nirmal	Accountant, Polio
	Mr. Selvina	BMC, Polio
	Mr. Amith	BMC, Polio
	Mr. S.K. Samson	SMC, Polio

Annex 3 Map of Project Area



Annex 4 KPC Surveys and Qualitative Studies

WORLD VISION, Inc

PRAGATI Child Survival Project

Cooperative Agreement # GHS-A-00-03-00018-00
1 October 2003 to 30 September 2007

BASELINE

QUANTITATIVE SURVEY
&
QUALITATIVE STUDIES

Conducted In PRAGATI Districts
(Ballia, Lalitpur & Moradabad)

February 2004

Field Contact
Dr. Beulah Jayakumar
Project Manager
WV Child Survival Project
PO Box 25
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91-5498-223014

World Vision India Contact
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Director Health
World Vision India
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Kodambakkam,
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TABLE OF CONTENTS

ACKNOWLEDGEMENTS

The BRICS 2 Project records its deep appreciation for the guidance and support provided by the Chief Medical Officers of Ballia, Lalitpur and Moradabad districts in conducting these surveys.

We are also grateful to the survey trainers and qualitative data collectors from other Area Development Programs of World Vision who invested their time and effort in this exercise.

The support provided by World Vision senior management was invaluable for the completion of this survey in time. The Project managers of the ADPs in Ballia and Lalitpur and that of the PEI Project in Moradabad were of immense help in planning and executing the surveys. Our heartfelt thanks to all of them.

We are thankful to the faculty of women's colleges in each district who deputed their students for data collection.

Above all, we are grateful to the mothers of children, other family members, TBAs and RMPs in these three districts, who came forward to participate in the surveys.

Child Survival Project Team
Ballia

February 2004

LIST OF ABBREVIATIONS

ADP	Area Development Program
ANM	Auxiliary Nurse Midwife
AWW	Anganwadi Worker
BCC	Behavior Change Communication
BCG	Bacillus Calmette Guerin
BRICS	Ballia Rural Integrated Child Survival Project
CMO	Chief Medical Officer
DPT	Diphtheria, Pertussis, Tetanus
EPI	Expanded Program on Immunization
FGD	Focus Group Discussion
GOI	Government of India
KPC	Knowledge, Practice, Coverage
LQAS	Lot Quality Assurance Survey
ICDS	Integrated Child Development Scheme
IDI	In depth Interviews
IMCI	Integrated Management of Childhood Illness
M&E	Monitoring and Evaluation
MOH	Ministry of Health
NFHS	National and Family Health Survey
NGO	Non Governmental Organization
OPV	Oral Polio Vaccine
PHC	Primary Health Center
PVO	Private Voluntary Organization
RMP	Registered Medical Practitioner
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
UP	Uttar Pradesh
USAID	United States Agency for International Development
WHO	World Health Organization
WV	World Vision

EXECUTIVE SUMMARY

The BRICS 2 project is a USAID funded Child Survival Project implemented by World Vision of India from October 2004 to September 2007. Its focus is to scale up a "wellness" package of child health interventions in Ballia, Lalitpur and Moradabad districts – Immunization, Family Planning, Nutrition in Pregnancy and Infancy and Vitamin A supplementation.

These baseline surveys were done using the WHO multistage 30 cluster sampling methodology and parallel sampling of children aged 0 – 11 months and those aged 12 – 23 months. A sample of 300 children was taken from each parallel group in each district, taking the total sample size to 1800 interviews. The surveys collected population based information on the above areas of intervention as well as others that are critical for child survival – malaria prevention, sick child management, mothers' knowledge of HIV/AIDS and hand-washing practices. Data was entered, processed and analyzed in EPI Info software version 6.04d.

- 42.2% mothers in Ballia can read and write, while only 24.2% mothers in Lalitpur and 24% mothers in Moradabad are literate. 11% mothers in Ballia go out of the home for work. The proportion is similar in Moradabad (10.2%) but is much higher in Lalitpur (34.8%).
- 95.4% of mothers of children aged 0 – 11 months (95% confidence limits - 92.2 to 97.4%) in Ballia report current breastfeeding of their children. The proportion is 100% in Lalitpur and is much lower at 91.8% in Moradabad. 20.7% mothers in Ballia initiated breastfeeding within one hour of birth, only 6.7% in Lalitpur and 1.7% (0.6 – 4.0%) in Moradabad.
- In Ballia, 49.7% of mothers report having not squeezed/discarded colostrum after birth. In Lalitpur, only 17% mothers report having fed colostrum, and in Moradabad the figure is 12.2%.
- In Lalitpur where 65% of those who had initiated breastfeeding within the hour of birth had boys.
- 66.0% (59.1 – 72.5%) of children aged 0 – 5 months in Ballia were exclusively breastfed in the 24 hours preceding the survey. The exclusive breastfeeding rate in Lalitpur is 22.6% (16.5 – 29.7%), and that for Moradabad is 57.4%
- 37.9% of children aged 6 – 9 months were given semisolid food along with breast milk in the 24 hours preceding the survey. 15.1% is the corresponding figure for Lalitpur and 35.3% for Moradabad.
- 69.1% mothers of children aged 0 – 11 months in Ballia, 76.4% in Lalitpur and 65.3% in Moradabad report having received 2 doses of tetanus toxoid before the birth of their youngest child. TT2 coverage for rural UP is 46.5%, for the three years preceding NFHS II. Card documented full immunization completed before the first birthday is 33.3% in Ballia. In Lalitpur and Moradabad, the corresponding figures are 30.2% and 32.7% respectively. In rural UP, 13.4% children 12 – 23 months were fully immunized before their first birthday.
- 7.5% children aged 12 – 23 months in Ballia have had a card-documented dose of vitamin A supplementation in the 6 months preceding the survey. This figure for Lalitpur and Moradabad are 2.6% and 2.3% respectively and it is 8.7% for rural UP (for children aged 6 – 35 months).
- 7.4% mothers of children aged 0 – 23 months in Ballia, 11.4% in Lalitpur and 12.4% in Moradabad were pregnant at the time of survey.

- Among the mothers who did not want any more children in the next two years or were not sure, 11.7% in Ballia, 9.3% in Lalitpur and 17.3% in Moradabad are using a modern contraceptive method. 11.5% in Ballia, 52.8% in Lalitpur and 26.4% in Moradabad have been continuously using the methods for the 12 months preceding the survey or longer.
- 56.7% of children 0 – 23 months in Ballia, 47% in Lalitpur and 57.3% in Moradabad were born at least 24 months after the previous surviving child. The corresponding figure for the state of UP is 71%.
- 36.3% children aged 0 – 23 months in Ballia, 52% in Lalitpur and 47.3% in Moradabad are underweight, and in the state of UP, the proportion of underweight children aged 6 – 35 months is 41.5%.

The qualitative study methods used were – Focus group discussions with RMPs , TBAs, Grandmothers and Married Men (total of 5 each across the districts) and in depth interviews with mothers of children 0 – 11 months of age (total of 60).
Initiation of breastfeeding ranged from a few hours of birth to 2 days. At least a few drops of colostrums are expelled, except in Ballia where practice of key behaviors was more widespread. A range of prelacteals is used, mainly to clean up the baby's stomach. Semisolids are introduced at 9 months to up to a year. However, water and other liquids are begun at even 3 months. Knowledge on immunization and vaccines is wide spread, and responses on services ranged from erratic and undependable to satisfactory and regular.

The opinions on optimum spacing between children range from 2 to 5 years. The effect of adequate spacing on children's and mothers' health is generally well perceived. Husbands and wives discuss reproductive intentions and FP methods more commonly now than a few years back. Many methods related concerns emerged from the discussions, like tearing of condoms, "heating" effect of OC pills and physical weakness after vasectomy.

These perceptions, norms, and gaps in knowledge would be adequately and systematically addressed in the behavior change communication plan that will be designed for the AWWs.

SUMMARY OF RESULTS

Sl. No	Indicator	Ballia	Lalitpur	Moradabad
BACKGROUND INFORMATION				
1.	Gender distribution of children aged 0 – 23 months	M - 56.8% (341/600) F – 43.2% (259/600)	M – 53.5% (321/600) F – 46.5% (279/600)	M – 54.3% (326/600) F – 45.7% (274/600)
2.	% Mothers of children aged 0 – 23 months who can read	42.2% (253/600)	24.2% (145/600)	24% (144/600)
3.	% Mothers of children aged 0 – 23 months who go out for work	11% (66/600)	34.8% (209/600)	10.2% (61/600)
SKILLED BIRTH ATTENDENCE AT DELIVERY				
4.	% Mothers of children aged 0 – 11 months whose births were assisted by a skilled birth attendant	35.3% (106/300)	13.7% (41/300)	15.7% (47/300)
INFANT NUTRITION				
5.	% Mothers of children aged 0 – 11 months who are currently breastfeeding	95.4% (290/304)	100% (300/300)	91.8% (279/304)
6.	% Mothers of children aged 0 – 11 months who initiated breastfeeding within 1 hour of birth	20.7% (61/294)	6.7% (20/300)	1.7% (5/286)
7.	% Mothers of children aged 0 – 11 months who did not discard colostrums	49.7% (146/294)	17% (51/300)	12.2% (35/286)
8.	% Mothers of children aged 0 – 11 months who fed prelacteals to their child in the first 3 days after birth	33.7% (99/294)	43.7% 131/300)	75.2% (215/286)
9.	% Mothers of children aged 0 – 11 months who report emptying one breast before switching over to the other	44.7% (134/300)	24.3% (73/300)	20.3% (58/286)
10.	% Mothers of children aged 0 – 5 months who report to have exclusively breastfed their children in the 24 hours preceding the survey	66% (136/206)	22.6% (38/168)	57.4% (108/188)
11.	% Mothers of children aged 0 – 11 months who were ill in the past 2 weeks who report having breastfed their child during illness	18.2% (30/165)	11.3% (12/106)	20.1% (35/175)
12.	% Mothers of children aged 6 – 9 months who fed breast milk and semisolids to their children in the 24 hours preceding the survey	37.9% (25/66)	15.1% (13/86)	35.3% (30/85)

IMMUNIZATION AND VITAMIN A SUPPLEMENTATION				
13.	% Mothers of children aged 0 – 11 months who received at least 2 TT immunizations before the birth of their youngest child	78% (237/304)	68% (204/300)	58.5% (178/304)
14.	% Mothers of children aged 12 – 23 months who have a vaccination card for the child	43% (129/300)	14.3% (43/300)	15.3% (46/300)
15.	% Children aged 12 – 23 months who are fully immunized before their first birthday (card documented)	33.3% (43/129)	30.2% (13/43)	34.7% (16/46)
16.	% Children aged 12 – 23 months who were given Vitamin A supplementation in the 6 months preceding the survey (card documented)	7.5% (23/304)	2.6% (8/302)	2.3% (7/301)
FAMILY PLANNING / BIRTH SPACING				
17.	% Mothers of children aged 0 – 23 months who know a source of family planning methods	25.8% (153/593)	20% (119/594)	30.5% (181/592)
18.	% Mothers of children aged 0 – 23 months who are currently pregnant	7.2% (43/597)	11.2% (67/597)	12.2% (73/597)
19.	% Mothers of children aged 0 – 23 months who do not want a child for the next two years or are not sure and are using a modern contraceptive method	11.7% (57/486)	9.3% (44/473)	17.3% (84/486)
20.	**Method Mix**			
	Condoms	40.4% (23/57)	50% (22/44)	58.3% (49/84)
	Pills	22.8% (13/57)	15.9% (7/44)	31% (26/84)
	Copper T	3.5% (2/57)	2.3% (1/44)	4.8% (4/84)
	Male sterilization	1.8% (1/57)	0%	1.2% (1/84)
	Female sterilization	31.6% (18/57)	31.8% (14/44)	4.8% (4/84)
21.	% Mothers of children aged 12 – 23 months who are using a modern contraceptive method continuously for the past 12 months or longer	11.5% (3/26)	52.8% (19/36)	26.4% (26.4)
22.	% Children aged 0 – 23 months who were born at least 24 months after previous surviving child	56.7% (147/259)	47% (113/240)	57.3% (179/312)

MALARIA PREVENTION				
23.	% Children aged 0 – 23 months who slept under an insecticide treated bed net the night preceding the survey	11.5% (69/601)	2.5% (15/595)	3.9% (23/596)
MANAGEMENT OF SICK CHILD				
24.	% Mothers of children aged 0 – 23 months who fed their children increased fluids and continued feeding during child's illness in the past 2 weeks	1.3% (5/392)	0.3% (1/336)	0.2% (1/436)
SIGNS OF ILLNESS				
26.	% Mothers of children aged 0 – 11 months who can identify at least 2 danger signs of illness	47.7% (145/304)	57.3% (172/300)	71.7% (218/300)
27.	% Mothers of children aged 12 - 23 months who can identify at least 2 danger signs of illness	66.8% (205/307)	77.8% (235/302)	83.7% (252/301)
HAND WASHING				
28.	% Mothers of children aged 0 – 23 months who wash their hands with water and soap/ash on all four instances (a. before food preparation b. before feeding children c. after defecation d. after attending to a child who has defecated)	8.7% (52/597)	30.8% (182/591)	61.9% (367/593)
KNOWLEDGE ON AIDS				
29.	% Mothers of children aged 0 – 23 months who have heard about AIDS	26.7% (157/588)	10.1% (60/597)	20.2% (120/594)
30.	% Mothers of children aged 0 – 23 months who know at least two ways to avoid being infected by HIV	9.4% (56/598)	5.5% (33/599)	10.7% (64/598)
BIRTH SPACING				
31.	% Children whose WAZ is < = 2	36.3% (218/600)	52% (312/600)	47.3% (284/600)

BACKGROUND

Project Overview

The BRICS 2 project is implemented through a cooperative agreement between USAID Washington and World Vision United States, under the Expanded Impact category of USAID's Child Survival and Health Grants Program, from October 2004 to September 2007.

The focus of BRICS 2 is to scale up a "wellness" package of preventive and promotive child health interventions in Ballia, Lalitpur and Moradabad districts. To achieve this objective, BRICS 2 will take to scale the strategies and methods from its precursor, the BRICS Project which had a wide margin of success in improving key child health outcomes in Ballia district.

The two intermediate results that will contribute to the above objective are:
IR #1: Increased use of key CS and FP interventions – Immunization (40%), Family Planning/Birth Spacing (30%), Exclusive Breastfeeding (20%) and Vitamin A supplementation (10%)
IR #2: Scale up strategies and tools documented and disseminated.

The strategies employed by BRICS 2 would be:

1. Performance assessment and Improvement of AWW & ANM
   Identify key competency areas critical for quality services and assess proficiency levels of the providers in these areas.
2. Ensure early registration of all pregnant women. This is key to ensuring provision of all services in time.
3. Targeted and timed behavior change communication for families. As opposed to group health education, this involves communicating "sets" of behaviors related to the project's intervention areas, to the mother/MWRA and the decision makers in her family, at appropriate times, and tracking changes in the communicated behaviors.
4. Improve block and village level planning and use of data. This involves taking data back to those from whom it was collected and process the data to optimize its use at each level. Create an enabling environment for the AWW to function efficiently
5. Phased coverage of blocks in each district, and of villages within each block

Project Location and Demography

Uttar Pradesh State, the most populous of the country's 29 states, is located north in India's fertile Gangetic plain. Its population of 166 million[20] is spread over 70 districts. These 70 districts are grouped into 4 regions, each with a distinct dialect, culture and traditions. The proposed project districts are located in three regions of the state – Ballia district is located in the Eastern region, Moradabad in the Western region and Lalitpur in the Southern region.

Ballia district is located in the eastern (Purvanchal) region of UP, close to the border with Bihar state. The district's estimated total population is 2.7 million, with a population density of 945 people per sq km. The district has 17 blocks. The predominantly agrarian economy is fueled with fertile alluvial soil and abundant water supply. However, an estimated 60% of the population is landless.

To the western part of UP is **Moradabad district** which has an estimated total population of 3.8 million--a population density of 688 people per sq km. The district has 14 blocks. The majority is employed in the brass industry for which this district is renowned. Unlike Lalitpur and Ballia, Moradabad has a predominant Muslim population (70%). Only 24.7% of the population is literate. Moradabad is one of the 4 districts in UP that are a challenge to the country's polio eradication campaign, as it was until recently, the major source of the wild poliovirus in Northern India.

Lalitpur district is one of the 7 districts in the southwestern (Bundelkhand) region of UP, and is located close to the border with Madya Pradesh state. The district has vast forestlands, and the total population is 970,135, spread over 6 blocks. The population density is 189 people per sq km. Most people farming their own small farms, and supplement their income by working in stone quarries. Urban migration is minimal.

QUANTATIVE SURVEYS

SURVEY METHODS

The surveys were done in cooperation with the respective district Chief Medical Office and local NGOs and community leaders.

Sampling Design

These surveys in each district, were done using the WHO two stage, 30 Cluster sampling methodology. Parallel sampling was also employed, based on the guidelines from the KPC 2000+ Field Guide from CSTS Project. In essence, three separate surveys were conducted.

Two parallel samples were chosen, one for mothers of children aged 0 – 11 months and another for those of children aged 12 – 23 months.

Sample Size Calculations

The population data of the 1991 census was used as the sampling frame and these were obtained from the district statistics offices. In each of the three districts, the villages were listed block-wise and cumulative population calculated. The first cluster was chosen using random numbers. Subsequent clusters were selected by adding the sampling interval to the random number.

In each cluster, 10 children were sampled from each of the two age groups, taking the total number of samples to 300 children aged 0 – 11 months and 300 aged 12 – 23 months. Thus the total sample size in a district was 600.

Protocols For Household Selection & Interview

In each cluster, one tola (hamlet, with about 50 households) was randomly selected.
In the selected tola, a direction was randomly selected from a central location.
In the selected direction, the houses were counted and the first household was randomly selected from them.
Subsequently, the household, which is nearest to the first, was selected and so on.
This protocol was followed as listing or door numbers of houses were unavailable.

Only one interview was conducted in one household. If there were two or more mothers with children aged less than 24 months, one of them was selected randomly. If a mother had more than one child less than 24 months, one of them was selected randomly.

Survey Tools

Separate questionnaires were designed for mothers of children aged 0 – 11 months (Questionnaire A) and for those of children aged 12 – 23 months (Questionnaire B). These were adapted from the generic questionnaire modules provided in the KPC 2000+ Field Guide. The priority child survival indicators, (Rapid CATCH) were added to both tools. Furthermore,

questionnaire A contained detailed sections on Tetanus immunization in pregnancy, breastfeeding, and complementary feeding. Questionnaire B contained sections on child immunization. Other sections were common to both tools.

Information on immunization was collected based on vaccination card as well as from the mothers' recollection.

The tools were designed in English and translated into Bhojpuri dialect in Hindi script. Field-testing was done for comprehension and flow and changes made accordingly.

SCOPE OF THE SURVEYS

The following were the topics covered:

Questionnaire A:

1. Background information – mothers' age, educational level, literacy, caregiver profile.
2. Spacing of children
3. TT vaccination in pregnancy
4. Skilled birth attendance at birth
5. Breastfeeding – initiation, feeding of colostrums, prelacteals, style of breastfeeding, current breastfeeding, frequency of breastfeeding and breastfeeding during child's illness
6. 24 hour food recall
7. Knowledge of mothers on signs of childhood illness
8. Giving of foods and fluids during illness in the past 2 weeks
9. Malaria prevention – use of insecticide treated bed nets
10. Hand washing practices
11. Knowledge of mothers on HIV risk reduction
12. Knowledge of source of FP methods
13. Use of modern family planning methods, method mix and duration of use.

Questionnaire B:

1. Background information – mothers' age, educational level, literacy, caregiver profile.
2. Spacing of children
3. Possession of vaccination card, vaccinations given, and mothers' recall of vaccinations in the absence of card
4. Vitamin A supplementation
5. 24 hour food recall
6. Knowledge of mothers on signs of childhood illness
7. Giving of foods and fluids during illness in the past 2 weeks
8. Malaria prevention – use of insecticide treated bed nets
9. Hand washing practices
10. Knowledge of mothers on HIV risk reduction
11. Knowledge of source of FP methods
12. Use of modern family planning methods, method mix and duration of use.

TRAINING OF SURVEY STAFF

As the surveys had to be conducted in three districts a team of survey coordinators were first trained in the following:

1. Types of quantitative surveys
2. Cluster sampling methodology – merits and limitations
3. Sample size calculations and selection from sampling frame
4. Protocols in household selection and interviews
5. Interview methods
6. Detailed discussion on the tools
7. Logistics management

The team members practiced in mock sessions before training the data collection staff.

Data collection personnel were taken from National Service Scheme members in local colleges. Ten teams of three each – one supervisor and two interviewers were made from these staff. The teams completed interviews in one cluster per day and completed the entire set of interviews in three days. Local male guides accompanied the teams each day.

All data collection personnel were women graduates and were trained in household selection and interview methods for three days. Calculation of age of the child and anthropometrical measurement methods were the other major topics. Training also included mock rounds and pre tests in the field.

Separate local teams were used for the three districts. The coordination team traveled from one district to another to train data collection personnel and to conduct the surveys.

The last day of the survey was allotted for completion of incomplete/incorrect information.

DATA ENTRY, PROCESSING AND ANALYSIS

A team of WV staff as well as hired personnel did data entry in EPI Info version 6.04d.

CSP Coordination team members based in Ballia did data processing and analysis. These staff were given hands on training on the use of the EPI program in detail. Each step in the process was written out in the form of protocols and cross-verified. Meticulously written check program files helped reduce errors during data entry and performed many calculations during the entry process itself. Program files were written and cross-verified before proceeding with analysis.

Analysis on Child Spacing and Underweight indicators were also done using MS Excel package.

DISCUSSION ON RESULTS

Age of Mothers

The age range of mothers is from 18 to 40 years in Ballia, 15 to 40 in Lalitpur and 16 to 45 in Moradabad. Most mothers fall within the 20 to 30 year age bracket.

Gender Distribution of Children

Gender distribution of children aged 0 – 23 months is fairly uniform across the districts – 56.8% of these children are boys in Ballia, 53.5% in Lalitpur and 54.3% in Moradabad.
This corresponds to the sex ratio in the state of UP for this age bracket, which is 973 girls for every 1000 boys.

Literacy and School Attendance of Mothers

57.5% of mothers of children aged 0 – 23 months in Ballia have never attended school. The corresponding figures for the other districts are higher – 74.7% mothers in Lalitpur and 79% in Moradabad have never attended school. 42.2% mothers in Ballia can read and write, while only 24.2% mothers in Lalitpur and 24% mothers in Moradabad are literate. The literacy rate is slightly higher than the proportion of mothers who ever attended school in Ballia, evidently due to the efforts towards adult literacy in the district. The literacy rate for women for UP is 36.2% (NFHS II India, 1998).

Caregiver Profile

11% mothers in Ballia go out of the home for work. The proportion is similar in Moradabad (10.2%) but is much higher in Lalitpur (34.8%). These figures reflect the pattern of income sources across the districts (the major source of income is unskilled labor in stone quarries) and the related compulsions that get reflected in families' decision to add to the income by getting mothers to return to work early after delivery.

The majority of women in all three districts work in others' fields (78.8% in Ballia, 82.2% in Lalitpur and 78.7% in Moradabad).

41% of mothers who go out of the home for work in Lalitpur take their young child with them. 33% leave their children with the grandparents, and 14.8% with older siblings. In Ballia, only 15% mothers take their children with them; 43.9% leave the child with the grandparents, and 24.2% with older siblings. Mothers who go for work in Moradabad also follow a pattern similar to Lalitpur – 36% take their infants with them, 24.6% leave them with the grandparents and 23% with older siblings. Though the proportion of mothers who stay away from their infants during the day is higher in Ballia compared to the other districts, most of these children are under the 12 – 23 age bracket and the total proportion of mothers who go out of the home for work is very small.

Skilled Birth Attendance

35.3% mothers of children aged 0 – 11 months in Ballia report having had skilled attendance during the delivery of their youngest child. 13.7% mothers in Lalitpur had skilled attendance at delivery and 15.7% in Moradabad. Assistance by TBAs was not included for skilled attendance, in keeping with MOH norms. According to NFHS II, 22.3% of births in the 3 years preceding the survey were assisted by a skilled attendant.

Breastfeeding

Current Breastfeeding: 95.4% of mothers of children aged 0 – 11 months (95% confidence limits - 92.2 to 97.4%) in Ballia report current breastfeeding of their children. The proportion is 100% in Lalitpur and is much lower at 91.8% in Moradabad.

3.3% (1.7% - 6.2%) mothers never breastfed their child in Ballia and 5.9% (3.6 – 9.4%) in Moradabad.

Initiation of Breastfeeding: 20.7% mothers in Ballia initiated breastfeeding within one hour of birth, only 6.7% in Lalitpur and 1.7% (0.6 – 4.0%) in Moradabad.
In Ballia, 49.7% of mothers report having not squeezed/discarded colostrum after birth. In Lalitpur, only 17% mothers report having fed colostrum, and in Moradabad the figure is 12.2%. Initiation of breastfeeding does not vary with the sex of the newborn, except in Lalitpur where 65% of those who had initiated breastfeeding within the hour of birth had boys.

The timely initiation of breastfeeding rate for rural UP (during the 3 years preceding the NFHS is 6.2%)

Colostrum: Of those mothers (48.6%) in Ballia who discarded colostrums, 17.5% discarded all colostrums before beginning to breastfeed. In Lalitpur, 80% mothers discarded colostrum, and out of these, 20.0% discarded all of it. In Moradabad 87.4% mothers discarded colostrum and out of these, 20.4% discarded all of it. Literacy of mothers does not seem to have a significant relationship with this behavior as seen in the cross tabulation.

Prelacteals: 65.6% mothers of children aged 0-11 months report that no prelacteals were fed to their children during the first three days after birth. In Lalitpur the figure is 56.3% and for Moradabad, 24.5%.

Appropriate Nutrition for the Newborn: In all, 2.3% mothers of children aged 0 – 11 months in Ballia initiated breastfeeding within the hour of birth, and fed all colostrums and did not feed any prelacteals after birth. The corresponding figures for the other districts are 0.3% for Lalitpur and 0.3% for Moradabad.

Exclusive Breastfeeding: 66.0% (59.1-72.5%) of children aged 0 – 5 months in Ballia were exclusively breastfed in the 24 hours preceding the survey. The exclusive breastfeeding rate in Lalitpur is 22.6% (16.5 – 29.7%), and that for Moradabad is 57.4% (50.0 – 64.6%). The exclusive breastfeeding rate obtained in one block of Ballia in February 2003 was 77.7%. It is worth noting that both these surveys were conducted in winter months. The figures could be lower in summer when the practice of feeding water to young infants becomes prevalent.

34.7% children aged 4 – 6 months are exclusively breastfed in UP (NFHS II)

Style of Breastfeeding: 44.7% mothers of children aged 0 – 11 months in Ballia report emptying one breast before switching to the other during breastfeeding. Corresponding figures for Lalitpur and Moradabad are 24.3% and 20.3% respectively.

Initiation of Complementary Feeding: 37.9% of children aged 6 – 9 months were given semisolid food along with breastmilk in the 24 hours preceding the survey. 15.1% is the corresponding figure for Lalitpur and 35.3% for Moradabad.

Breastfeeding during illness: Out of those children aged 0 – 11 months who were ill in the 2 weeks preceding the survey, 16.4% children in Ballia were fed the same amount of breast milk during illness, as before, and 1.8% were fed more. In Lalitpur, 9.4% were fed the same amount and 1.9% were fed more. In Moradabad 17.2% were fed the same amount and 2.9% were fed more than before the illness.

Immunization And Vitamin A Supplementation

TT2 In Pregnancy: 69.1% mothers of children aged 0 – 11 months in Ballia, 76.4% in Lalitpur and 65.3% in Moradabad report having received 2 doses of tetanus toxoid before the birth of their youngest child. Another 22.4% mothers in Ballia report having received 3 TT doses, and 6.5% in Lalitpur and 18.3% in Moradabad have also received 3 TT doses.

TT2 coverage for rural UP for the births in the three years preceding NFHS II is 46.5%

Vaccination Card 43% children aged 12 – 23 months in Ballia have a vaccination card. Only 14.3% in Lalitpur and 15.3% in Moradabad have cards.

In the whole of rural UP, 19.4% children aged 12 – 23 months possess a vaccination card.

Full Immunization by First Birthday: 33.3% children aged 12 – 23 months have card documented full immunization completed before their first birthday in Ballia. In Lalitpur and Moradabad, the corresponding figures are 30.2% and 32.7% respectively. This is the proportion of children having a vaccination card, who are fully immunized.

The figure for full immunization of children by first birthday for rural UP is 13.4%

Measles Coverage: Card documented measles coverage rates for the three districts are – 28.3% in Ballia, 7.0% for Lalitpur and 7.6% for Moradabad. Measles coverage figures based on mothers' recollection are – 29.8%, 32.3% and 32.8% respectively.

Drop from BRICS I final levels: The TT2 coverage in Ballia district during the last year of BRICS I was 97% and this drop (by about 28%) over the 18 months when there was very little child survival activities in the community level, is a strong argument for planning for sustainability (of child health gains) from the very start of the project.

Vitamin A supplementation: 7.5% children aged 12 – 23 months in Ballia have had a card-documented dose of vitamin A supplementation in the 6 months preceding the survey. This figure for Lalitpur and Moradabad are 2.6% and 2.3% respectively. These figures based on mothers' recollection are 8.2%, 10.0% and 10.2% respectively.

In rural UP, 8.7% of children aged 12 – 35 months had received a dose of vitamin A supplement in the 6 months preceding NFHS II.

Family Planning[21]

Knowledge on Source of FP Methods: 25.8% of mothers of children aged 0 – 23 months in Ballia, 20.0% in Lalitpur and 30.5% in Moradabad know at least one source of FP methods.

Current Pregnancy Rate: 7.4% mothers of children aged 0 – 23 months in Ballia, 11.4% in Lalitpur and 12.4% in Moradabad were pregnant at the time of survey.

Desire for More Children: The proportion of mothers who did not want a child in the next two years or are not sure are 60.4% in Ballia, 59.0% in Lalitpur and 67.6% in Moradabad.

Contraceptive Usage: Among the mothers who did not want any more children in the next two years or were not sure, 11.7% in Ballia, 9.3% in Lalitpur and 17.3% in Moradabad are using a modern contraceptive method. The most prevalent method being used in Ballia is condoms (40.4%) followed by female sterilization (31.6%) and OC Pills (22.8%). In Lalitpur, condoms again are most prevalent (50.0%), female sterilization (31.8%) and OC Pills (15.9%). In Moradabad though condoms are prevalent among users (58.3%), permanent methods are not. 18.3% of currently married women in rural UP currently use a modern method of FP (NFHS II).

Continuous Use: Among those mothers of children aged 12 – 23 months who are using a modern contraceptive method, 11.5% in Ballia, 52.8% in Lalitpur and 26.4% in Moradabad have been continuously using the methods for the 12 months preceding the survey or longer.

Child Spacing: 56.7% children in Ballia, 47.0% in Lalitpur and 57.3% in Moradabad were born at least 24 months after the previous surviving child.
29% of births in UP occur within 24 months of the previous one and the median birth interval is 30 months.

[21] These indicators have also been collected as part of another population based survey for Married Women of Reproductive Age (MWRA) for the Family Planning component of the Project.

Other Indicators

The following indicators were collected as part of providing information on Rapid CATCH indicators. The Project does not intend to work in these intervention areas.

Managing the Sick Child

Fluids During Illness: 20.9% of children aged 0 – 23 months in Ballia, who had an episode of illness in the 2 weeks preceding the survey, were given the same amount of fluids as before; another 3.3% were given more fluids than before. In Lalitpur, 25% children were given the same amount of fluids and 2.1%, more than before illness. In Moradabad, the corresponding figures are 25.5% and 1.4%. **Feeding During Illness**: In Ballia, of the children aged 0 – 23 months who were ill in the 2 weeks preceding the survey, 18.1% were given the same amount of food, and 0.3% were given more food than before. In Lalitpur and in Moradabad, the corresponding figures are: 26.2% & 1.8% and 22.2% & 1.8% respectively.

Knowledge of Signs of Childhood Illness: In Ballia 47.7% of mothers of children aged 0 – 11 months[22] and 66.8% of mothers of children aged 12 – 23 months know at least 2 signs of childhood illness. In Lalitpur 57.3% of mothers of children aged 0 – 11 months and 77.8% of mothers of children aged 12 – 23 months know at least 2 signs of childhood illness. In Moradabad the figures are 71.7% and 83.7% respectively.

Malaria Prevention: 11.5% of children aged 0 – 23 months in Ballia slept under an insecticide treated bednet during the night preceding the survey. Only 2.5% children in Lalitpur and 3.9% in Moradabad slept under a bed net treated with insecticide. It is unclear if the respondents fully comprehended the concept of treated bed nets, especially in Ballia and Moradabad where malaria is not a major public health problem.

Hand washing:

8.7% mothers in Ballia, 30.8% and 61.9% in Moradabad washed their hands with water and soap/ash before food preparation, before feeding the child, after defecation and after attending to a child who had passed stools.

Knowledge On HIV/AIDS

26.7% mothers in Ballia had heard of AIDS. Only 10.8% in Lalitpur and 20.2% in Moradabad had heard of AIDS. Out of those who had heard of AIDS 9.4% mothers in Ballia, 5.5% in Lalitpur and 10.7% in Moradabad knew of at least 2 methods of avoiding HIV infection.

Weight for Age

36.3% children aged 0 – 23 months in Ballia were underweight (2SD or less than the reference population for that age and sex). Corresponding figures for Lalitpur and Moradabad 52% and 47.3% respectively. NFHS II figures for the proportion of children (6-35 months) underweight is 41.4%

[22] Unlike the other indicators, data for this one could not be MERGEd in EPI Info. Therefore data from the two parallel samples is given separately

QUALITATIVE STUDIES

METHODOLOGY

Survey Objectives

The objectives of the qualitative studies were –

1. To gain in depth understanding of family practices and norms related to breastfeeding, birth spacing, and immunization as well as decision making processes in families; the sources and content of information that is provided to families
2. To acquire insight into the belief structures behind these practices
3. Assess feasibility of these behaviors to change

These studies were complementary to the quantitative surveys carried out in the same program areas with the same study topics. These were carried out in October and November 2003, about the same time as the quantitative surveys.

Study Design and Methods

Focus Group Discussions: These discussions were held for village based private practitioners (RMPs), traditional birth attendants (TBAs), Mothers in law and for Married men. These groups were chosen on their ability to provide information on the study topics – the first two groups are the most frequent sources of information and counseling for mothers and families and the latter two are critical for decision making in families. **In depth interviews**: Semi structured interviews were held with mothers of children aged 0 – 11 months of age. These interviews also covered the entire range of interventions planned for this project, with a focus on the experience of mothers and feasibility of these behaviors to change. Beliefs and taboos were explored, as well as major sources of information and support.

Sample Size and Distribution

The same team of data collectors carried out these qualitative studies sequentially in the three districts. In each of the three districts, five blocks were selected, one in a central location and the other four in the far corners of the district. In each of the five selected block, one FGD each was conducted with RMPs, Grandmothers, TBAs and Married Men. Participants for these FGDs were drawn from different villages of the block. In addition to the FGDs, four in depth interviews were conducted with mothers of children aged 0 – 11 months, in each block. Two of these mothers were selected from locations close to a sub center/PHC and the other two, far from these service delivery points. Twenty interviews were held in each district.

		Total Sample Size:	
Method	**Participants**	**In each district**	**Total for Program**
FGD	RMPs	5	15
FGD	Grandmothers	5	15
FGD	TBAs	5	15
FGD	Married Men	5	15
IDI	Mothers	20	60

Study Topics

Method	Topics
Focus Group Discussion RMPs	**Client load and profile** Counseling on infant feeding practices (and reasons for each) • Initiation of breastfeeding, colostrums, prelacteals • Feeding up to 6 months of age • Initiation of complementary feeds – quantity, quality, age at which to begin • Breastfeeding during mother's and child's illness Birth Spacing/Family Planning • Perceptions, knowledge on optimum birth interval • Effect of birth interval on mother's and child's health • Decision making patterns and norms in families • Methods – knowledge on benefits and limitations, side effects • Availability, stock issues • Perceptions among men and women on contraception, methods Immunization • Knowledge on vaccines, schedule, side effects • Services – quality, regularity • Utilization by families • Drop outs, reasons for the same • Participation of fathers, leaders
Focus Group Discussion Grandmothers	Birth Attendance, Newborn Care • Profile of birth attendance, place of delivery • Care of the newborn right after birth, counseling on the same • Counseling, practices on initiation of breastfeeding, feeding of colostrums, use of prelacteals, reasons, decision making processes Birth Spacing/Family Planning • Perceptions, knowledge on optimum birth interval • Effect of birth interval on mother's and child's health • Decision making patterns and norms in families • Methods – knowledge on benefits and limitations, side effects • Availability, stock issues • Perceptions among men and women on contraception, methods

	Immunization • Knowledge on vaccines, schedule, side effects • Services – quality, regularity • Utilization by families • Drop outs, reasons for the same
Focus Group Discussion TBAs	Birth Attendance, Newborn Care • Profile of birth attendance, place of delivery • Care of the newborn right after birth, counseling on the same • Counseling, practices on initiation of breastfeeding, feeding of colostrums, use of prelacteals, reasons, decision making processes Birth Spacing/Family Planning • Perceptions, knowledge on optimum birth interval • Effect of birth interval on mother's and child's health • Decision making patterns and norms in families • Methods – knowledge on benefits and limitations, side effects • Availability, stock issues • Perceptions among men and women on contraception, methods
Focus Group Discussion Married Men	Practices, beliefs, decision making in the following areas: Birth Spacing/Family Planning • Perceptions, knowledge on optimum birth interval • Effect of birth interval on mother's and child's health • Decision making patterns and norms in families • Methods – knowledge on benefits and limitations, side effects • Availability, stock issues • Perceptions among men and women on contraception, methods Immunization • Knowledge on vaccines, schedule, side effects • Services – quality, regularity • Utilization by families • Drop outs, reasons for the same
In depth Interviews – Mothers	Practices, experiences and support/objection related to • Early initiation of breastfeeding • Feeding of colostrums • Breastfeeding during mothers' and infant's illness • Discussion about and use of spacing methods • Immunization of children, special emphasis on dropouts

FINDINGS & CONCLUSIONS

Participation of Study Members

In all FGDs there was active and enthusiastic participation from all or most members, and a wide range of experiences and perceptions were collected during the course of the discussions. The size of the groups ranged from 8 to 16. Most groups were homogenous in terms of social and cultural variables. In some FGDs with grandmothers in Moradabad district there was a certain resentment that questions pertaining to family planning were being posed to a group and not to individuals.
Interviews with mothers were more challenging, with most of these young women requiring much probing, especially in questions related to family planning.

In terms of content, there was little difference between the districts except for evidence of changed practices related to newborn feeding practices in Ballia. This is evidently due to the presence of BRICS I in these areas.

There are considerable variations between Districts in perception, norms and knowledge in colostrums and breastfeeding. 50 to 80 % of deliveries take place at home, attended by a TBA or a relative. The mother in law, husband and older women in the family decide about the place of delivery and mode of assistance. After birth the child is cleaned and placed next to the mother.

Young Child Feeding

Initiation of breastfeeding & Colostrums: In Ballia breastfeeding is usually initiated within the first few hours after birth; some older women consider colostrums to be " life giving nectar " in earlier days if people used to discard the same out of ignorance.
Initiation of breastfeeding is delayed in other places by up to 2 days as the mother is exhausted and others are needed to care to the new born. In other instances initial milk is considered insufficient and so feeding is delayed 2 to 3 days.
Feeding colostrums also makes the mother and baby "relaxed ". There is a general and widespread concern about the newborn's mouth 'drying up'. Colostrums is also believed to aid brain development & capacity to fight. In certain areas, a few drops of colostrums are expressed and discarded.
Initiation of breastfeeding was usually advised after cutting the cord.

> Milk does not form until the mother begins to eat, and this, is only after 24 hours. Giving honey makes the baby calm
> - *a grandmother.*

Perceptions, norms and knowledge on newborn care are different in the districts. Colostrums is considered to have been stored during the entire pregnancy and hence has the potential for causing sepsis , it is also considered to cause 'clots ' and loose stools in the baby. Discarding at least some colostrum is the norm. Expressing at least some drops of colostrum is also meant to ' open up the source of milk' in the mother.

Some older women and TBAs report continuing with this practice despite having been trained in the benefits of colostrums and early initiation.

> I threw my colostrum out; elders told me that it was nine months old and dirty
> *– a mother*

A few drops of colostrums are expressed and dropped on the earth and the rest is fed to the new born. Colostrums was generally fed to the newborn after 2-3 spoons of the same were sacrificed to the tulsi plant or to ash, according to the mothers.

Prelacteals: Apart from ghee and water, goats milk, sugar – water and honey are also given as prelacteals. These are meant for cleaning up grime from the baby's stomach and are not considered to have any nutritive value.

The child is then given ghee (clarified butter) in very small amounts, the child 'gains life' by licking ghee. In some places boiled cooled water is given in a cotton ball.
Hot water is meant for removing grime collected in the baby's stomach over the 9 months of gestation. Tea is also given to calm the baby.
These are age- old customs and have been handed over to these women by previous generation.

The RMP groups counseled against discarding of colostrums. But they also counsel on giving of prelacteals (clarified butter or cow's milk)
Most mothers who were interviewed initiated breastfeeding within 1- 2 hours after birth. But initial flow of milk is almost universally considered insufficient and hence water ghutti tea, honey and animal milk are given. Ghee was also given to the newborns milk flow is considered sufficient for the child from the third day.
Ghutti believed to clean up the "black stools".
Those mothers who delivered by caesarean section also delayed initiation of breastfeeding sometimes for up to 2 days.
Most of the information on breastfeeding was gained from mothers in law. In Ballia district, the role of counseling done by the GSS workers was evident in the form of recollection by mothers.

Feeding Up to 6 months/Introduction of Semi Solids: There was a range of responses about feeding of a child up to 6 months of age – some described exclusive breastfeeding and continuing to breast feed during child's illness. Most RMPs counseled giving of lentil water, animal milk and water.

Initiation of semi-solid food was encouraged generally at 10-12 months of age. It is believed that the digestive system of the child begins to function by that age, and that the teeth also start to develop. Most mothers started their babies on liquids like lentil water, animal milk and plain water. Semi-solid mashed foods were introduced by 8-10 months.

Feeding During Illness: Mothers continue to breast feed during the child's illness. When mothers themselves feel ill, they stopped or reduced breastfeeding owing to malaise and other painful conditions.

Elders in the family also dissuade a sick mother from feeding the child.

Frequency and Style of Feeding: Frequency of feeding ranged from 3 to 8 times during the day and usually continual at night. Most mothers fed a little from each breast during each feed. Very few waited for one breast to be emptied before switching to the other.

Immunization

Women get together but the ANM does not reach there, and the whole day gets wasted – a Pradhan

All the groups of respondents were aware of the need for immunizations and its protective effects on children's health; as well as its availability pattern. Discussions on **availability and access** of this service covered a wide range if issues including irregular timings of sub-centers, erratic supply of vaccines, lack of geographic access for some villages (the resultant loss of wages) and having to pay for the services, knowledge on vaccine quality is inadequate. **Utilization**: Lack of awareness and illiteracy are mentioned as major barriers for utilization by families. Remoteness of certain hamlets was mentioned in some groups as another contributing factor. Some groups also mentioned that the head of the family is not at home on vaccination day, a decision cannot be made on taking infants foe immunization. Lack of knowledge about the full course of immunization is seen as the major cause for dropouts. **Side effects**: experiences of and knowledge on side effects was generally low across the groups. These side effects are considered "minor effects" affecting the utilization pattern.

Birth Spacing and Family Planning

Optimum spacing: Wide-ranging responses were obtained on optimum space between children but across the groups there is consensus on a minimum of 2 years gap.
Some mentioned that when a child becomes capable of caring for oneself, the family is ready for the next child. Spacing for at least 3 years is perceived to contribute to both the mothers and the child's health. The need for a child to have breast milk is another reason quoted for children to be born well spaced. The desire to have boys prevents families from limiting births. Such families are considered ignorant and inconsiderate on women. Sufficient spacing is also beneficial in allowing older siblings to take care of the younger ones. The effect of spacing on mother's health is also uniformly perceived across all groups. Men groups also expressed the need for spacing to stabilize population.

If there are fewer children, all of them will be able to learn and write – a grandmother

Discussions / decisions on family size and spacing: All the groups were of the opinion that there is greater openness between the husband and wife to discuss issues related to family size and spacing. However these discussions are seen to happen only when the family has already had many children and there is a strain on the family's economy. Discussions are also common among women in the family and in the neighborhood. There is a feeling of resentment among older women that the younger women in their families make decisions on their own in these issues. In other instances the mother-in- law is seen to have a greater influence on her daughter-in-law than her son. Decisions on family size and spacing are generally made by the husband and older family members, but the views and desires of the daughter-in-law are definitely taken into consideration. Almost all groups mentioned the positive effect that women's literacy has on these decisions within families.

Daughters-in-law are cleverer these days; they discuss these things (FP methods) with their husbands
– a mother in law

Method related Issues: All groups had heard of the contraceptive method range available at PHCs/Sub-Centers, the range of perceived harmful effects is very broad and varies between groups and between districts. Condoms are considered to be safe and effective, few drops knew about the protection offered from STIs and HIV. There is a disproportionately large fear of condoms tearing up and remaining in or getting sucked into the woman's body. Oral pills are considered an effective method, but replete with ill effects, ranging from bloating, peptic symptoms, reduction in milk flow in lactating mothers, "heating up" of the body and weight gain. Similar ideas were obtained on IUD's. Increased menstrual bleeding and infection of the reproductive tract are the most commonly noted ill effects. Other uncommon effects mentioned are the risk of cancer, risk of getting sucked into the body, migrating internally, causing decay in the uterus and enlarging the cervix. Female sterilization is considered safe, common and advantageous. It is perceived to contribute to a small happy family and healthy children. Many side effects are mentioned, including weight gain, peptic symptoms, loss of appetite, numbness, and weakness. All groups mentioned many and varied ill effects for male sterilization, including impotence, general weakness. (with specific mention of inability to lift heavy weight)

Availability of methods: Many groups mentioned the need for complete information on all available methods being made available to families. House visits and family counseling is another area of felt need. Greater use of mass media, mobility for service providers and advocacy by village leaders and community groups are other ways of improving availability and utilization of FP services. Some groups also noted that the poor quality of products hampered utilization.

END OF REPORT

ANNEX I

LIST OF SURVEY STAFF: QUANTITATIVE SURVEYS

Co-ordination Team: Dr. Beulah Jayakumar, Elizabeth Dayal, Sanjay Masih, Deepak Kumar, Rajesh.

	Ballia		**Lalitpur**		**Moradabad**	
S.no	***Interviewers***	***Supervisors***	***Interviewers***	***Supervisors***	***Interviewers***	***Supervisors***
1	Sangeetha	Rasmiya Sukhla	Nasarina	Swetha jain	Nutan	Mehnaj
2	Urvasi	Kiran Tiwari	Hemalata sahu	Pinky sahu	Salim praveen	Anita Sharma.
3	Abhilasha Singh	Shobha	Rajani	Neha	Reetu	Sahenaj.
4	Sweetha Singh.	Anju Rai	Smiriti.	Rekha sony.	Kumkum chaudhari	Frahat jahan.
5	Saveetha	Jyothi Singh	Anita	Indu	Najrina.	Shahnaj
6	Ranjana Rai	Jyothi Singh	Preethi	Lavely jain	Shabnam.	Tanbasun
7	Monica Pandey	Seema Singh	Preethi Khere	Rameshwari	Swati	Rama Sharma
8	Manisha Singh	Pooja Raj	Chandra Prabha	Priyanka Modi	Preti	Anita
9	Mamta Singh	Poonam	Kamalesh	Mona Chaubey	Rajani	Sheetal
10	Roma Singh	Sonal Singh.	Manisha	Jyothi	Abina Singh	
11	Neelam Tiwari	Priyanka Pandey	Rani Sahu		Neeraj	
12	Anshu Dubey		Geeta Sharma		Ruchi Gupta	
13	Pragya Singh		Arthi Namdey		Sneha	
14	Sneha		Ankita Yadey		Reetu	
15	Aradhana Tiwari		Sanju Sony		Bidasha	
16	Priyanka Srivastava		Sangeetha		Sangeetha	
17	Suchita Saurabha		Ranjana Sahu		Rajani.	
18	Ranju Singh		Versha		Sheetal	
19	Priyanka Upadhaya		Shilpi		Swetha khan	
20	Reena Pandey		Swati		Neetu	

Data Entry, Processing & Analysis

Clement Timothy	Issac
Jeshurun Sunil Rajan	Along with hired personnel

LIST OF SURVEY STAFF: QUALITATIVE STUDIES

Training and Coordination: Beulah Jayakumar

Data Collectors

Anita Doonga
Anita Matthews
Manoj Kumar
Renu Umesh
Sylvans Patel
Philemon Masih
Anita Doonga

ANNEX II

Timeline for Qualitative and Quantitative Baselines

23 to 25 October 03	Training of Qualitative Study data collectors
27 to 31 October 03	Data collection in Ballia – qualitative
27 to 31 October 03	Planning and pretesting for baseline surveys
6 to 8 November 03	Training of survey coordinators.
10 to 14 November 03	Training of Survey staff, Ballia
	Data collection in Ballia – quantitative
	Data Collection in Lalitpur – qualitative
17 to 22 November 03	Training of KPC survey staff, Moradabad
	Data collection in Moradabad – quantitative.
	Data collection in Moradabad – qualitative
24 – 29 November 03	Training of Survey staff, Lalitpur
	Data collection in Lalitpur.
20 – 25 November 03	Creation of EPI info files.
26 Nov to 10 Dec 03	Data Entry – EPI Info
10 Dec to 20 January 04	Data processing and Analysis – quantitative
12 – 24 January 04	Transcription of qualitative data
2 – 6 February 04	Data Synthesis and reporting – qualitative

ANNEX III
QUANTITATIVE SURVEY TOOLS

QUESTIONNAIRE A

{IDNum}ber: ####
{Date} of {Inter}view: <dd/mm/yyyy>
Name of {Cluster}: <A >

1. What is your name? {moname} <A >
2. What is your age? (years){moage} ##
3. How many of your children are under the age of five?{childnum} #
4. Can you tell me their names and ages, starting from the youngest?
i. {namea} <A > {doba} <dd/mm/yyyy> {agea} ## {sexa} #
ii. {nameb} <A > {dobb} <dd/mm/yyyy> {ageb} ## {sexb} #
iii.{namec} <A > {dobc} <dd/mm/yyyy> {agec} ## {sexc} #
iv. {named} <A > {dobd} <dd/mm/yyyy> {aged} ## {sexd} #
v. {namee} <A > {dobe} <dd/mm/yyyy> {agee} ## {sexe} #

Sampled child
Name:{chname} <A >
DOB:{chdob} <dd/mm/yyyy>
Age:{chage} ##
Sex:{chsex} #

5. Till what have you {studied}? #
i. Never attended school
ii. Primary school
iii. High/middle school
iv. Intermediate
v. Diploma/Degree

6. Can you {read} this sentence please? (Show the mother the sentence)
i. Able to read
ii. Unable to read

7. Do you {work} {out}side the home to earn money?#
i. Yes
ii. No - go to question 10

8. {What} {work} do you do? #
i. Work in field
ii. Work in others' homes
iii. Work in construction sites
iv. Salaried job
v. Other{OWHATWORK} <A >

9. Who {takes} {care} of(----------) when you are away? #
i. Child's father
ii. Child's grandparents
iii. Child's older sister
iv. Other relatives (sister - in - law etc)
v. Neighbors
vi. I take the child with me for work

10. Before you gave birth to (--) did you receive {tetanus} injection?
i. Yes
ii. NOGO TO Question 12
iii. Do not knowGO TO Question 12

11. How {many} {tet}anus injections did you get?
i. One
ii. Two
iii. More than two
iv. Do not know

11a. Do you have {your} {imm}unization {card} with you?
i. Yes, seen by interviewer
ii. Lost, misplaced, not at home GO TO Question 12
iii. Never had a card GO TO Question 12
iv. Do not know GO TO Question 12

11b. RECORD INFORMATION EXACTLY AS IT APPEARS ON THE CARD.
{TT1} <dd/mm/yyyy>
{TT2} <dd/mm/yyyy>
TT2 complete but dates not recorded {notrecord} <Y>

12. Who {assisted} you with the delivery of (-----)?
i. Doctor in PHC
ii. Doctor in district hospital
iii. Doctor in private hospital {asspvt} <A   >
iv. ANM/Nurse
v. Dai{assdai} <A   > (name of dai)
vi. Chamain
vii. Relative{assrel} <A   >
viii. Other{oass} <A   >
ix. No one

Skilled{SBA} birth attendance at delivery <Y>

12a. After the birth, did you get a {check} up?#
i. Yes
ii. No go to question 13
iii. Dont know go to question 13

12b. Who did the checkup {whocheck}#
i. TBA
ii. ANM Govt
iii. Private nurse
iv. RMP
V. Govt doctor
vi. Private hospital----{hpcheck} <A   >

12c. How many days after birth did you get checked? {whenchk}
after ---- days

13. Did you ever breastfeed (---)?{everbf} #
i. Yes
ii. No Go to Question 25

14. How long after birth did you {first} {put}(------) to the breast? #
i. Immediately/Within First Hour After Delivery
ii. After The First Hour

15. Did you {squeeze} out any colostrum from the breast? #
i. YES
ii. NO GO TO Question 17
iii. Do not remember GO TO Question 17

16. {How} {much} colostrum did you squeeze from the breast before? #
i. A Few Drops
ii. Most/All
iii. Do not remember

17. During the first three days did you give anything else?{prelact} #
i. Yes
ii. No GO TO Question 19
iii. Do not know/remember GO TO Question 19

18. What did you give (------) during that time?
i. {powder}ed milk <Y>
ii. {animal} milk <Y>
iii. {plain} water <Y>
iv. {sugar} or glucose water <Y>
v. {ajwain} water <Y>
vi. {ghutti} <Y>
vii. fruit {juice} <Y>
viii. infant {formula} (cerelac/ farex) <Y>
ix. {tea} <Y>
x. {honey} <Y>
xi. Other{oprelact} <A >
xii. Do not remember{dkprelact} <Y>

19.Do you first empty one breast?{bfstyle}#
i. empty one breast before switching to the next
ii. use both breasts at each feed
iii. Do not know

20. Are you currently breastfeeding (------)?{currentbf}#
i. Yes GO TO Question 22
ii. NO

21. How many months old was(------) when you stopped?{stopbf}##
i. ---- months G0O TO Question 23
ii. Do not remember GO TO Question 23

22. How many times did you breastfeed in the last day and night?
Day ---------- times{daybf}##
Night ------- times{nightbf}##

23. In the past 2 weeks was (---------) ill?{childill}#
i. Yes
ii. No GO TO Question 25
iii. Do not remember GO TO Question 25

24. When (----------) was ill, did you breastfeed{childillbf}#
i. less than usual
ii. same as usual
iii. more than usual
iv. stopped completely
v. never breastfed/ had stopped breastfeeding by then
vi. don't remember

25. I would like to ask you about the types of liquids and foods
Breastmilk?{bm} <Y>
Plain water?{water} <Y>
Other liquids?{oliquid} <Y>
Mashed, pureed, solid, or semi-solid food{food} <Y>
Anything else--{ofood} <A   >

26a. Do you have any bednets in your house?{havenet}#
1. YES
2. NO GO TO Question 29
3. DON'T KNOW GO TO Question 29

27. Who slept under a bednet last night?{sleepnet}#
i. Child
ii. Respondent
iii. Other Individual{osleep} <A   >
iv. No one

28. Was the bednet ever soaked or dipped{IBN}#
i. Yes
ii. No
iii. Don't Know

29.What are the signs of illness?
i. Don't Know{dksigns} <Y>
ii. Looks {Unwell} Or Not Playing Normally <Y>
iii. Not Eating Or Drinking{noteat} <Y>
iv. {Lethargic} Or Difficult To Wake <Y>
v. High {hfever} <Y>
vi. Fast Or Difficult Breathing{fastbr} <Y>
vii. {Vomits} Everything <Y>
viii. {Convuls}ions <Y>
ix. Other{osign1} <A > Other{osign2} <A > Other{osign3} <A >

30. Did (-------------) experience any of the following?
i. {Diarrhea} <Y>
ii. {Blood} In Stool <Y>
iii. {Cough} <Y>
iv. Difficult Breathing{dbreath} <Y>
v. Fast Breathing/Short, Quick Breaths{fbreath} <Y>
vi. {Fever} <Y>
vii. {Malaria} <Y>
viii. {Convulsion}s <Y>
ix. Other{osick} <A   >
x. None Of The Above Go To Question 33{nosick} <Y>

31. "When (-----) was sick, was he/she offered{sickfluid}#
i. less than usual
ii. same amount
iii. more than usual

32. When (------------------) was sick, was he/she offered{sickfood}#
i. less than usual
ii. same amount
iii. more than usual
iv. Has not begun eating food

33. Have you ever heard of an illness called AIDS?{heard}#
1. YES
2. NO GO TO Question 35

34. What can a person do to avoid getting AIDS
i. Nothing{naids} <Y>
ii. {Abstain} From Sex <Y>
iii. Use Condoms{usecon} <Y>
iv. Limit Sex To One Partner/Stay {Faithful} To One Partner <Y>
v. {Limit} {Num}ber Of Sexual Partners <Y>
vi. Avoid Sex With {Prostit}utes <Y>
vii. Avoid Sex With Persons Who Have {Many} {Part}ners <Y>
viii. Avoid Intercourse With Persons Of The {Same} {Sex} <Y>
ix. Avoid Sex With Persons Who Inject {Drugs} Intravenously <Y>
x. Avoid Blood {Transfus}ions <Y>
xi. Avoid {Injections} <Y>
xii. Avoid {Kissing} <Y>
xiii. Avoid {Mosquito} Bites <Y>
xiv. Seek Protection From Traditional {Healer} <Y>
xv. Avoid Sharing {Razors}, Blades <Y>
xvi. Do not know{dkaids} <Y>
xvii. Other{oaids1} <A >
Other{oaids2} <A >
Other{oaids3} <A >

35. When do you wash your hands with soap/ash?
i. {Never} <Y>
ii. {Before} Food {Prep}aration <Y>
iii. {Before} {Feed}ing Children <Y>
iv. {After} {Def}ecation <Y>
v. {After} {Att}ending To A Child Who Has Defecated <Y>
vi. Other{owash1} <A >
{owash2} <A >

36. Do you know of a place from obtain family planning methods?{knowfp}#
i. Hospital{hospfp} <A >
ii. PHC
iii. Sub center (ANM Center)
iv. RMP doctor
v. Kirana Shop
vi. Medical Shop
vii. Other{ofp} <A >
viii. Do not know

37. Are you pregnant now?{pregnow}#
i. Yes GO TO Question 43
ii. No
iii. Do not know

38. Do you want to have another child?{wantchild}#
i. Yes
ii. No GO TO Question 40
iii. Do not know GO TO Question 40

39. When do you want to have another child?{whenwant}#
i. Within the next two years
ii. After two years
iii. Do not know

40. Are you currently using any method{currentuse}#
i. Yes
ii. No GO TO Question 43

41. What method are you using?{method}#
i. Abstinence
ii. Condoms
iii. Pills
iv. Copper T
v. Male Sterilization
vi. Female Sterilization
vii. Other-{omethod} <A   >
viii. Not using any method{nomethod}

42a. From when are you using{whenfp}##
   ..... months

42b. from where did you obtain{wherefp}#
   1. PHC
   2. ANM Centre
   3. RMP Doctor
   4. Provision shop
   5. Drug shop
   6. Hospital {hospfp1} <A   >
   7. Other{wofp} <A   >
   8. Dont know

43. Before I end, may I measure the height and weight of{hw}#
1. YES
2. NO END

{Height}: ###.#
{Weight}: ##.#

THAT'S ALL! WELL DONE!!

QUESTIONNAIRE B

{IDNum}ber: #### {Date} of {Inter}view: <dd/mm/yyyy>
Name of {Cluster}: <A > Name of {Interv}iewer: <A >
1. What is your name? {moname} <A >
2. What is your age? {moage} ##
3. How many of your children are under the age of five?{childnum} #
4. Can you tell me their names and ages,
i. {namea} <A > {doba} <dd/mm/yyyy> {agea} ## {sexa} #
ii.{nameb} <A > {dobb} <dd/mm/yyyy> {ageb} ## {sexb} #
iii.{namec} <A > {dobc} <dd/mm/yyyy> {agec} ## {sexc} #
iv.{named} <A > {dobd} <dd/mm/yyyy> {aged} ## {sexd} #
v. {namee} <A > {dobe} <dd/mm/yyyy> {agee} ## {sexe} #

Sampled child
Name:{chname} <A >
DOB:{chdob} <dd/mm/yyyy>
Age:{chage} ##
Sex:{chsex} #

5. Till what have you {studied}? #
i. Never attended school
ii. Primary school
iii. High/middle school
iv. Intermediate
v. Diploma/Degree

6. Can you {read} this sentence please? (Show the mother the sentence) i. Able to read
ii. Unable to read

7. Do you {work} {out}side the home to earn money?
i. Yes
ii. No GO TO Question 10

8. {What} {work} do you do? #
i. Work in field
ii. Work in others' homes
iii. Work in construction sites
iv. Salaried job
v. Other {Owhatwork} <A >

9. Who {takes} {care} of (----------) when you are away?
i. Child's father
ii. Child's grandparents
iii. Child's older sister
iv. Other relatives (sister - in - law etc)
v. Neighbours
vi. I take the child with me for work

10. I would like to ask you about the types of liquids and foods
Did (----------) have
Breastmilk? {bm} <Y>
Plain water?{water}<Y>
{O}ther {liquids}? <A >
Mashed, pureed, solid, or semi-solid {food}? <Y>
Anything else?{ofood} <A >

11. Do you have a {v}accination {card} for (-----)? #
i. Yes, seen by interviewer
ii. Lost, misplaced, not at hom GO TO Question 13
iii. Never had a card GO TO Question 13
iv. Do not know GO TO Question 13

12. RECORD INFORMATION EXACTLY AS IT APPEARS ON THE VACCINATION CARD.

{BCG}	<dd/mm/yyyy>	{ABCG} ##
{POLIO1}	<dd/mm/yyyy>	{APOLIO1} ##
{POLIO2}	<dd/mm/yyyy>	{APOLIO2} ##
{POLIO3}	<dd/mm/yyyy>	{APOLIO3} ##
{DPT1}	<dd/mm/yyyy>	{ADPT1} ##
{DPT2}	<dd/mm/yyyy>	{ADPT2} ##
{DPT3}	<dd/mm/yyyy>	{ADPT3} ##
{Measles}	<dd/mm/yyyy>	{AMeasles} ##
{VitaminA}	<dd/mm/yyyy>	{avitaminA} ##

{Immu}nization {comp}leted before first birthday <Y>
Immunization completed but dates not recorded {notrecord} <Y>

13. Did (-------) receive BCG vaccine (look for scar)?{hBCG} #
i. Yes
ii. No GO TO Question 15
iii. Do not know GO TO Question 15

14. At how many months did (----) get BCG injection? {hmBCG} ##
i. ---- months
ii. Do not remember

15. Did (------) receive DPT1njections {hdpt} #
i. Yes
ii. No GO TO Question 19
iii. Do not know GO TO Question 19

16. How many DPT1njections did (-----) receive? {hmanydpt} #
i. ---- times
ii. Do not remember

17. At how many months did (---) get the last DPT1njection? {hlastdpt} i. ---- months
ii. Do not remember

18. Did (-----) get polio drops with each DPT1njection? {hpolio} ##
i. Yes
ii. No
iii. Do not know

19.Did (---) get polio drops during {pulsepolio} #
i. Yes
ii. No
iii. Do not know

20. Did (-------) get measles injection?{hmeasles} #
i. Yes
ii. No GO TO Question 22
iii. Do not know GO TO Question 22

21. At how many month(---------------) get the measles injection? {hmmeasles}

i. ---- months
ii. Do not remember
Immunization completed before first birthday {himmucomp} <Y>
Yes
No

22. Did (----------) vitamin A doses? {hvita} #
i. Yes
ii. No GO TO Question 24
iii. Do not remember GO TO Question 24

23. How many months ago was the last dose given?{hlastvitA} ##
i. ------ months
ii. Do not remember
Vitamin A given in the last 6 months {hvitA6} <Y>

24. Do you have any bednets in your house?{havenet} #
1. YES
2. NO GO TO Question 27
3. DON'T KNOW GO TO Question 27

25. Who slept under a bednet last night?{sleepnet} #
i. Child (----------)
ii. Respondent
iii. Other Individual(S){osleep} <A   >
iv.no one sleeps.

26. Was the bednet ever soaked or dipped?{IBN} #
i. Yes
ii. No
iii. Don't Know

27 What are the signs of illness that would indicate?
i. Don't Know{dksigns} <Y>
ii. Looks {Unwell} Or Not Playing Normally <Y>
iii. Not Eating Or Drinking{noteat} <Y>
iv. {Lethargic} Or Difficult To Wake <Y>
v. High {hfever} <Y>
vi. Fast Or Difficult Breathing{fastbr} <Y>
vii. {Vomits} Everything <Y>
viii. {Convuls}ions <Y>
ix. Other{osign1} <A > Other{osign2} <A > Other{osign3} <A >

28. Did (----------) experience any of the following
i. {Diarrhea} <Y>
ii. {Blood} In Stool <Y>
iii. {Cough} <Y>
iv. Difficult Breathing{dbreath} <Y>
v. Fast Breathing/Short, Quick Breaths{fbreath} <Y>
vi. {Fever} <Y>
vii. {Malaria} <Y>
viii. {Convulsion}s <Y>
ix. Other {osick} <A   >
x. None Of The Above Go To Question 31 {nosick} <Y>

29. "When (------) was sick, was he/she offered{sickfluid} #
i. less than usual

ii. same amount
iii. more than usual

30. When (--------) was sick, was he/she offered{sickfood} #
i. less than usual
ii. same amount
iii. more than usual
iv. has not begun eating food

31. Have you ever {heard} of an illness called AIDS? #
1. YES
2. NO GO TO Question 33

32. What can a person do to avoid getting AIDS or the virus that causes AIDS?
i. Nothing{naids} <Y>
ii. {Abstain} From Sex <Y>
iii. Use Condoms{usecon} <Y>
iv. Limit Sex To One Partner/Stay {Faithful} To One Partner <Y>
v. {Limit} {Num}ber Of Sexual Partners <Y>
vi. Avoid Sex With {Prostit}utes <Y>
vii. Avoid Sex With Persons Who Have {Many} {Part}ners <Y>
viii. Avoid Intercourse With Persons Of The {Same} {Sex} <Y>
ix. Avoid Sex With Persons Who Inject {Drugs} Intravenously <Y>
x. Avoid Blood {Transfus}ions <Y>
xi. Avoid {Injections} <Y>
xii. Avoid {Kissing} <Y>
xiii. Avoid {Mosquito} Bites <Y>
xiv. Seek Protection From Traditional {Healer} <Y>
xv. Avoid Sharing {Razors}, Blades <Y>
xvi. Do not know{dkaids} <Y>
xvii. Other{oaids1} <A > Other{oaids2} <A   > {oaids3} <A   >

33. When do you wash your hands with soap/ash?
i. {Never} <Y>
ii. {Before} Food {Prep}aration <Y>
iii. {Before} {Feed}ing Children <Y>
iv. {After} {Def}ecation <Y>
v. {After} {Att}ending To A Child Who Has Defecated <Y>
vi. Other{owash1} <A   > {owash2} <A   >

34. Do you know of a place from where you can obtain family planning{knowfp}
#
i. Hospital{hospfp} <A   >
ii. PHC
iii. Sub center (ANM Center)
iv. RMP doctor
v. Kirana Shop

vi. Medical Shop
vii. Other{ofp} <A   >
viii. Do not know

35. Are you pregnant now?{pregnow} #
i. Yes GO TO Question 40
ii. No
iii. Do not know

36. Do you want to have another child?{wantchild} #
i. Yes
ii. No GO TO Question 38
iii. Do not know GO TO Question 38

37. When do you want to have another child?{whenwant} #
i. Within the next two years
ii. After two years
iii. Do not know

38. Are you currently using any method?{currentuse} #
i. Yes
ii. No GO TO Question 40

39. What {method} are you using? #
i. Abstinence
ii. Condoms
iii. Pills
iv. Copper T
v. Male Sterilization
vi. Female Sterilization
vii. Other{omethod} <A   >
viii. Not using any method

39.A. From when are you using {whenfp} ##
      .....months
39.B.From where did you obtain {wherefp} #
     1. PHC
     2. ANM Centre
     3. RMP Doctor
     4. Provision shop
     5. Drug shop
     6. Hospital {hospfp1} <A   >
     7. Other{wofp} <A   >
     8. Dont know

40. Before I end, may I measure the height and weight of?{hw} #
1. YES
2. NO END

{Height}: ---------.--- cm ###.#
{Weight}: ---------.--- kg ##.#

THANK THE MOTHER FOR HER TIME

ANNEX IV
QUALITATIVE STUDY TOOLS

Tool for Focus Group Discussion with Grandmothers

Informed Consent

Namaste, I am ---------- and my companions are ---------- and ----------, and we are working with an organization called World Vision.

We would like to know from you the practices in your village related to the health of young children in your village. As you are experienced and respected members of your village, you are the best people to help us know more about these practices. This information will be used by World Vision to plan better programs for your villages.

This discussion will take approximately 45 minutes to complete. We would want all of you to take part in the discussions. The information you give us will be noted down by ---------- but will not be shared with others in your community.

Do any of you wish to ask us more about this survey?

Facilitator to sign here after oral consent of the participants----------

FGD Team
Facilitator:----------
Recorder:----------
Observer:----------
Name of Village ID Number:

Focus Group Characteristics
Number of Participants: ----
Age Range: ----------

A brief description of the participants

A brief description of the participation

Any comments on Facilitation

To begin with let us discuss about the customs and practices related to childbirth and breastfeeding. Let us suppose that 10 women in this village had deliveries in the past one month. Of these, how many would have been assisted by a dai, how many by the mother in law or other family member, and how many would have gone to the PHC / Ballia hospital?

Dai –
Family Member –
PHC/Hospital –
Other –

Who in the family decides about this, and what factors/reasons are considered while making this decision?

After the birth of the baby, can you describe what is done to the child?
(Probe: What do you do to the child right after birth, who does this, what next, who does that, etc)

What are the reasons behind these practices?
(Probe: How are these practices supposed to benefit the health of the mother/child?)

How long after birth do mothers put the baby to the breast? When you assist deliveries, what do you advise mothers in this regard?

What are the reasons why you advise mothers to put the child to the breast after --------?

What advise do you give mothers regarding colostrums?

What are the reasons behind doing so?

What do you think will happen to the mother or to the child if the colostrum is given to the baby?

What do you think might happen to the mother or to the child if the colostrums is not given to the baby?

Are any other fluids given to the baby after birth?

What are the reasons why these are given? What benefits?

In all the above advise you give mothers after childbirth and in all the things that are done to the baby soon after birth, is there any difference in what you would do to a girl baby from what you would do to a boy baby?

Next we would like to listen to your ideas and opinions about another topic.
In your opinion, what should be the time interval between births of children?

Do family members discuss about this? (Husband and wife, Husband and his mother, Daughter

in law and mother in law etc)

Who in the family take part in deciding this time interval?

Will this affect the health of the mother? How?

Will this affect the health of her children? How?

Do women discuss issues related to the number of children, time interval between children, with anyone? With whom?

What do you think about contraceptive methods?

What are the benefits of these methods? What are the side effects?
Condoms
Pills
Copper T
Female Sterilization
Male Sterilization

How can we help families decide about the time interval between children?

How can we help them obtain the contraceptive methods regularly?

Lastly, let us talk about immunization of children and pregnant women. There are vaccinations available in the govt hospitals and PHCs and Sub-centers against six killer diseases. What are your ideas about these immunizations?

Quite often we find children not taken for the full course of immunizations. What are the reasons behind this?

Have you seen children with side effects of vaccinations? What advise do you give to the mothers regarding this?

Thank the participants for their time

Tool for Focus Group Discussion with TBAs

Informed Consent

Namaste, I am ---------- and my companions are ---------- and ----------, and we are working with an organization called World Vision.

We would like to know from you the practices in your village related to the health of young children in your villages. As you are experienced and respected members of your village, you are the best people to help us know more about these practices. This information will be used by World Vision to plan better programs for your villages.

This discussion will take approximately 45 minutes to complete. We would want all of you to take part in the discussions. The information you give us will be noted down by ---------- but will not be shared with others in your community.

Do any of you wish to ask us more about this survey?

Facilitator to sign here after oral consent of the participants----------

FGD Team
Facilitator: ----------
Recorder: ----------
Observer: ----------
Name of Village ID Number:

Focus Group Characteristics
Number of Participants: ----
Age Range: ----------
A brief description of the participants

A brief description of the participation

Any comments on Facilitation

Thank the participants for having decided to participate.

To begin with let us discuss about the customs and practices related to childbirth and breastfeeding. Let us suppose that 10 women in this village had deliveries in the past one month. Of these, how many would have been assisted by a dai, how many by the mother in law or other family member, and how many would have gone to the PHC / Ballia hospital?

Dai –
Family Member –
PHC/Hospital –
Other –

Who in the family decides about this, and what factors/reasons are considered while making this decision?

After the birth of the baby, can you describe what is done to him/her?
(Probe: What do you do to the child right after birth, who does this, what next, who does that, etc)

What are the reasons behind these practices?
(Probe: How are these practices supposed to benefit the health of the mother/child?)

How long after birth do mothers put the baby to the breast? When you assist deliveries, what do you advise mothers in this regard?

What are the reasons why you advise mothers to put the child to the breast after --------?

What advise do you give mothers regarding colostrums?

What are the reasons behind doing so?

What do you think will happen to the mother or to the child if the colostrum is given to the baby?

What do you think might happen to the mother or to the child if the colostrums is not given to the baby?

Are any other fluids given to the baby after birth?

What are the reasons why these are given? What benefits?

In all the above advise you give mothers after childbirth and in all the things that are done to the baby soon after birth, is there any difference in what you would do to a girl baby from what you would do to a boy baby?

Next we would like to listen to your ideas and opinions about another topic.
In your opinion, what should be the time interval between births of children?

Do family members discuss about this? (Husband and wife, Husband and his mother, Daughter in law and mother in law etc)

Who in the family take part in deciding this time interval?

Will this affect the health of the mother? How?

Will this affect the health of her children? How?

Do women discuss issues related to the number of children, time interval between children, with anyone? With whom?

What do you, and the women of your village think about contraceptive methods?

What are the benefits of these methods? What are the side effects?
Condoms
Pills
Copper T
Female Sterilization
Male Sterilization

How can we help families decide about the time interval between children? How can we help them obtain the contraceptive methods regularly?

Thank the participants for their time

Tool for Focus Group Discussion with Married Men

Informed Consent

Namaste, I am ---------- and my companions are ---------- and ----------, and we are working with an organization called World Vision.

We would like to know from you the practices in your village related to the health of young children in your village. As you are experienced and respected members of your village, you can help us know more about these practices. This information will be used by World Vision to plan better programs for your villages.

This discussion will take approximately 45 minutes to complete. We would want all of you to take part in the discussions. The information you give us will be noted down by ---------- but will not be shared with others in your community.

Do any of you wish to ask us more about this survey?

Facilitator to sign here after oral consent of the participants----------

FGD Team
Facilitator:----------
Recorder:----------
Observer:----------
Name of Village ID Number:

Focus Group Characteristics
Number of Participants: ----
Age Range: ----------

A brief description of the participants

A brief description of the participation

Any comments on Facilitation

Let us begin with immunization of children and pregnant women. There are vaccinations available in the govt hospitals and PHCs and Sub-centers against six killer diseases. What are your ideas about these immunizations?

Can you describe the immunization services in your area (PHCs, Sub-centers)?
Ask about regularity of services, quality of services, availability of vaccines, etc

How much do families utilize these services?
(Ask – what are the possible reasons why so few children get vaccinations, are there any beliefs about these vaccinations?)

Quite often we find children not taken for the full course of immunizations. What are the reasons behind this?

Have you seen children with side effects of vaccinations? What do the families do when such side effects occur to their children?

What can community leaders do to improve these services (making them regular, improve quality etc)

Next we would like to listen to your ideas and opinions about another topic.
In your opinion, what should be the time interval between births of children?

Do family members discuss about this? (Husband and wife, Husband and his mother, Daughter in law and mother in law etc)

Who in the family take part in deciding this time interval?

Will this affect the health of the mother? How?

Will this affect the health of her children? How?

Do women discuss issues related to the number of children, time interval between children, with anyone? With whom?

What do you think about contraceptive methods?

What are the benefits of these methods? What are the side effects?
Condoms
Pills
Copper T
Female Sterilization
Male Sterilization

How can we help families decide about the time interval between children?

Describe the services being provided by the PHCs and Sub-centers with regard to Contraceptives.

How can we help them obtain the contraceptive methods regularly?

Thank the participants for their time

Tool for Focus Group Discussion with RMPs

Informed Consent

Namaste, I am ---------- and my companions are ---------- and ----------, and we are working with an organization called World Vision.

We would like to know from you the practices in your village related to the health of young children. As you are experienced and respected members of your village, you are the best people to help us know more about these practices. This information will be used by World Vision to plan better programs for these villages.

This discussion will take approximately 45 minutes to complete. We would want all of you to take part in the discussions. The information you give us will be noted down by ---------- but will not be shared with others in your community.

Do any of you wish to ask us more about this survey?

Facilitator to sign here after oral consent of the participants----------

FGD Team
Facilitator:----------
Recorder:----------
Observer:----------

Name of Village ID Number:

Focus Group Characteristics
Number of Participants: ----
Age Range: ----------

A brief description of the participants

A brief description of the participation

Any comments on Facilitation

How many patients do you see per day on average?

Do mothers bring their babies to you for treatment and/or advise?

What advise do you give mothers soon after childbirth, regarding putting their baby to breast?
How long after delivery should they put their baby to the breast?

What are the reasons behind this advise?

In your opinion, what all should be given to an infant to eat or drink, up to 6 months of age?

When a mother becomes sick, what advise do you give her regarding breastfeeding her child?

Would this advice depend on what sickness the mother has?

What are the reasons for this?

When a child becomes sick, what advise do you give the mother regarding breastfeeding her child?

Would this advice depend on what sickness the child has?

What are the reasons for this?

In your opinion, at what age should a mother start giving her child fluids other than breast milk?

What are the reasons for this?

In your opinion, at what age should a mother start giving her child semisolid/mashed foods?

What are the reasons for the same?

In all the above advise you give mothers after childbirth and in all the things that are done to the baby soon after birth, is there any difference in what you would do to a girl baby from what you would do to a boy baby?

Next we would like to listen to your ideas and opinions about another topic.
In your opinion, what should be the time interval between births of children?

Will this affect the health of the mother? How?

Will this affect the health of her children? How?

What do you think about contraceptive methods?
What are the benefits of these methods? What are the side effects?
Condoms

Pills
Copper T
Female Sterilization
Male Sterilization

Do patients who come to you ask for advice on contraception?

If they do, what advise do you give?

Do you stock/dispense contraceptive material?

What do men, women think about contraception?
Men
Women

How can we help families decide about the time interval between children?

How can we help them obtain the contraceptive methods regularly?

Lastly, let us talk about immunization of children and pregnant women. There are vaccinations available in the govt hospitals and PHCs and Sub-centers against six killer diseases. Do you counsel mothers and families on getting children and pregnant women immunized?

How do they respond to your advise?

Quite often we find children not taken for the full course of immunizations. What are the reasons behind this?

Have patients ever come to you with problems after vaccinations?

Thank the participants for their time

Tool for In Depth Interview with Mother of a child 0 – 11 months
Informed Consent

Namaste, I am ---------- and my companions are ---------- and ----------, and we are working with an organization called World Vision.

We would like to know from you the practices related to the health of infants. As you have a young child, you are experienced in this regard, you are the best person to help us know more about these practices. This information will be used by World Vision to plan better programs for your villages.

This discussion will take approximately 45 minutes to complete. The information you give will not be shared with others in your community.

Do any of you wish to ask us more about this survey?

Interviewer to sign here after oral consent of the participants----------

Name of Village: ---------- ID Number:

Name of Interviewer---------- Name of Mother: ----------

Name of child:---------- Sex: Boy/Girl

Date of Birth: ---/---/------ Age in months: --------

Brief Description of Mother:

I want you to think back to the time when (----------) was born. Can you recollect and tell me how long after birth you put (----------) to your breast and who helped you in doing so?

Can you tell me the reasons why you put (----------) to the breast ---------- after birth?

How and through whom did you get to know of these reasons? Did you yourself decide to start breastfeeding ---------- after birth or was it someone else?

Who would have approved if you had started to breast feed (----------) soon after, maybe within one hour of birth?

Who would have objected/disapproved?

What all was (----------) given to drink before you put him/her to your breast? Can you describe them please?

Why were the above given to (----------) to drink? What are the benefits of giving them to a child?

After (----------) was born, what did you do with the first milk ? Did you feed that to your child, or squeeze it out?

If you had fed the first milk to (----------), would someone have disapproved of that?

Would someone have approved?

In the past day and night, what all did you give (----------) to eat or drink?
(Probe: and then? And then?------)

How often do you normally breastfeed (----------) during the day?
(How do you know he/she is hungry?)

During the night? (Where does (----------) sleep?)

Can you describe each breastfeed? Do you feed him/her from both breasts each time, or do you alternate breasts for each feed?

How do you know when to switch from one breast to the other?

How do you know that (----------)'s stomach is full?

Please think of the last time when you were ill, after (----------) was born. Was there a change in feeding your child during that time? What changes?

Did you decided to do so by yourself, or did someone advise you to do so?

What are the reasons for doing so?

If you had continued to breastfeed (----------) when you were sick, what would (the above person) have felt/reacted?

Did (----------) ever become ill ?

Was there a change in breastfeeding at that time? Can you describe the changes?

Why did you make these changes? Who decided that you should do so?

How, in your opinion did that benefit the child?

Have you heard about breastfeeding from others outside you own family? Please describe. (regarding when to put the child to the breast, how long to give only breastmilk, etc.

Next, we would like to listen to your ideas and opinions about another topic.
In your opinion, what should be the time interval between births of children?

Do your family members discuss about this? (Husband and wife, Husband and his mother, Daughter in law and mother in law etc)

Do you discuss this with anyone? How did discussing with that person help?

Who in the family decides what this time interval should be?

Will this affect your health? How?

Will this affect the health of your children? How?

What do you think about contraceptive methods?

What are the benefits of these methods? What are the side effects?
Condoms
Pills
Copper T
Female Sterilization
Male Sterilization

How can we help you and other families decide about the time interval between children?

How can we help you and other women obtain the contraceptive methods regularly?

Lastly, let us talk about immunization of children and pregnant women. There are vaccinations available in the govt hospitals and PHCs and Sub-centers against six killer diseases. What are your ideas about these immunizations?

Quite often we find children not taken for the full course of immunizations. What are the reasons behind this?

Have you seen children with side effects of vaccinations? What did you or the other mothers do then? Who advised them to do so?

ANNEX VI Population Sampling Frame and Cluster Selections

AVAILABLE AT THE PRAGATI CSP OFFICE.

ANNEX VII Logistics Plan

AVAILABLE AT THE PRAGATI CSP OFFICE.

ANNEX VIII EPI-Info Analysis Tables

AVAILABLE AT THE PRAGATI CSP OFFICE.

Annex 5 Family Planning Survey Questionnaire and Tabulation Plan

Population based surveys of Married Women of Reproductive Age (MWRA) were conducted in Ballia (between 13th to 17th March) and in Lalitpur (between 21st to 26th April). The methodology and main results are presented in the DIP. The full report is still in preparation and will be included with, and discussed in, the First Annual Review report. This annex includes the Questionnaire and the Tabulation Plan developed by Flex Fund and adapted in cooperation with CATALYST for use in these surveys.

USAID OFFICE OF POPULATION AND REPRODUCTIVE HEALTH
FLEXIBLE FUND FAMILY PLANNING SURVEY
WOMAN'S QUESTIONNIARE

REVISED VERSION MARCH 11, 2004 FOR WORLD VISION INDIA

IDENTIFICATION

PLACE NAME_____

..
CLUSTER NUMBER.....

HOUSEHOLD NUMBER.....

RECORD NUMBER .....

REGION……

URBAN/RURAL (URBAN = 1, RURAL =2)……

NAME OF HEAD OF HOUSEHOLD_____

NAME OF WOMAN_____

INTERVIEWER VISITS

	1	2	FINAL VISIT
DATE			DAY
INTERVIEWER'S NAME			MONTH
NEXT VISIT:			YEAR
DATE			
TIME			
RESULT CODE			

RESULT CODES:
1= COMPLETED
2 = NOT AT HOME
3 = POSTPONED
4 = REFUSED
5 = PARTLY COMPLETED
6 = INCAPACITATED

SUPERVISOR	FIELD EDITOR	OFFICE EDITOR	KEYED BY
NAME_	NAME		
DATE	DATE		

SECTION 1: RESPONDENTS BACKGROUND

INTRODUCTION AND INFORMED CONSENT

Hello. My name is _____ and I am working with (NAME OF ORGANIZATION). We are conducting a survey about the health of women and children. We would very much appreciate your participation in this survey. I would like to ask you about your health and family life. This information will help the government Ministry of Health and other organizations to plan local health services. This survey will take about ___ to ___ minutes to complete. Whatever information you provide to (NAME OF ORGANIZATION) will remain confidential. We will not pass on your name or the information you provide to any other parties. We will contact you again only if we have a question (or questions) that need(s) to be clarified.

Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. However, we hope that you will participate in this survey since your views are important.

At this time, do you want to ask me anything about the survey?

May I begin the interview now?

Signature of interviewer:_____ Date:_____
(day, month, year)

CIRCLE ONE:

RESPONDENT DOES NOT AGREE TO INTERVIEW…….1 → END; DO NOT INTERVIEW WOMAN

RESPONDENT AGREES TO INTERVIEW……2 → BEGIN INTERVIEW

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
101	**RECORD THE TIME**	**HOUR……..**+-------+ MINUTES……+-------+	
102	**How old were you at your last birthday?**	**AGE IN COMPLETED YEARS……..**+-------+	
103	**Have you ever attended school?**	**YES……1** **NO……..2**	→ **107**
104	**What is the highest level of school you attended: primary, secondary, or higher?**	**PRIMARY……...1** **SECONDARY……2** **HIGHER……..3**	
105	**What is the highest grade or year you completed at that level?**	**GRADE…….....**+-------+	
106	**CHECK 104: HIGHEST LEVEL OF SCHOOL:** **PRIMARY (CODE 1)** ☐⇩	**SECONDARY OR HIGHER (CODE 2)** ☐⇨	→ **108**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
107	Now I would like to you to read this sentence to me. SHOW CARD TO RESPONDENT IF RESPONDENT CANNOT READ WHOLE SENTENCE, PROBE: Can you read any part fo the sentence to me? NOTE: EACH CARD SHOULD HAVE FOUR SMIPLE SENTENCES (FOR EXAMPLE, “PARENTS LOVE THEIR CHILDREN”, “THE CHILD IS READING A BOOK”, ETC)	**CANNOT READ AT ALL……1** **ABLE TO READ ONLY PARTS……2** **ABLE TO READ WHOLE SENTENCES……3** **NO CARD WITH REQUIRED LANGUAGE……4** **BLIND/VISUALLY IMPAIRED……..5**	

PROCEED TO NEXT SECTION→

SECTION 2: REPRODUCTION AND CHILD SPACING

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
201	**Now I would like to ask about all the births you have had during your life. Have you ever given birth?**	**YES……..1** **NO……2**	**→ 208**
202	**How many children have you given birth to? Include any children born alive, including those who cried or showed signs of life but did not survive.**	**TOTAL NUMBER OF CHILDREN EVER BORN** **ALIVE……+-------+**	
203	**How many children living in this household are under five years of age?**	**NONE……..0** **ONE CHILD…….** **.....1** **TWO CHILDREN……..2** **THREE OR MORE……..3**	**→ 208**
204	**How many of those children are your biological children?**	**NONE……0** **ONE CHILD…… 1** **TWO CHILDREN……2** **THREE OR MORE……3**	**→ 208**
205	**What is the sex and date of birth of your youngest child?**	**YOUNGEST CHILD** **SEX** **MALE…… .....1** **FEMALE…… 2** **DATE OF BIRTH** **DAY i__i__i** **MONTH i__i__i** **YEAR i__i__i__i__i**	
206	**CHECK 204: NUMBER OF BIOLOGICAL CHILDREN:** **TWO OR MORE (CODE 2)** ☐ ⇩ **ONE (CODE 1)** ☐ ⇨		**→ 208**
207	**What is the sex and date of birth of your second youngest child?**	**SECOND YOUNGEST CHILD** **SEX** **MALE…… .....1** **FEMALE…… 2** **DATE OF BIRTH** **DAY i__i__i** **MONTH i__i__i** **YEAR i__i__i__i__i**	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
208	From one menstrual period to the next, are there certain days when a woman is more likely to become pregnant if she has sexual relations?	YES……1 NO…… 2 DON'T KNOW……..8	 → 210 → 210
209	Is this time just before her period, during her period, right after her period has ended, or halfway between her two periods?	JUST BEFORE HER PERIDD BEGINS……..1 DURING HER PERIOD……...2 RIGHT AFTER HER PERIOD HAS ENDED……..3 HALFWAY BETWEEN TWO PERIODS……4 OTHER ……..5 (SPECIFY) DON'T KNOW……8	
210	In the past 12 months, have you experienced a miscarriage or a pregnancy termination?	YES……..1 NO……2 DON'T KNOW/ REFUSED……8	

PROCEED TO NEXT SECTION→

SECTION 3: KNOWLEDGE AND EVER USE OF CONTRACEPTION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP

Now I would like to talk about family planning—the various ways or methods that a couple can use to delay or av oid a pregnancy.

ASK THE QUESTION 301 (FIRST COLUMN):

Which ways have you heard about?

FOR EACH METHOD LISTED MENTIONED SPONTANEOUSLY, CIRCLE "1" (YES) IN THE COLUMN 301 TO INDICATE THAT WOMAN HAS HEARD OF METHOD. THEN PROCEED DOWN THE LIST OF METHODS, READING THE NAME AND DESCRIPTION OF EACH METHOD NOT MENTIONED SPONTANEOUSLY. CIRCLE CODE "1" IN COLUMN 301 IF THE METHOD IS RECOGNIZED, AND CODE "2" IF NOT RECOGNIZED.

THEN, FOR EACH METHOD WITH CODE "1" IN COLUMN 301, ASK **BOTH** QUESTIONS 302 AND 303 "DO YOU KNOW OF A PLACE YOU COULD OBTAIN (METHOD)?" AND "HAVE YOU EVER USED (METHOD)?" FOR BOTH THESE QUESTIONS, CODE "1" IF THE ANSWER IS "YES" AND CODE "2" IF THE ANSWER IS "NO".

	METHOD	301	302	303
	Which ways have you heard about? PROBE: Have you heard of (METHOD)?		Do you know where to obtain (METHOD)?	Have you ever used (METHOD)?
A	FEMALE STERILIZATION Women can have an operation to avoid having any more children	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2
B	MALE STERILIZATION Men can have an operation to avoid having any more children	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2
C	PILL Women can take a pill every day to avoid becoming pregnant	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2
D	IUD Women can have a loop or coil placed inside them by a doctor or nurse	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2
E	INJECTABLES Women can have an injection by a health provider which stops them from becoming pregnant for one or more months	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2
F	IMPLANTS Women can have several small rods placed in their upper arm by a doctor or nurse which can prevent pregnancy for one or more years	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2

	METHOD	301	302	303
	Which ways have you heard about? PROBE: Have you heard of (METHOD)?		Do you know where to obtain (METHOD)?	Have you ever used (METHOD)?
G	CONDOM Men can put a rubber sheath on their penis before sexual intercourse	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2
H	FEMALE CONDOM Women can place a sheath in their vagina before sexual intercourse	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2
I	DIAPHRAGM Women can place a thin flexible disk in their vagina before intercourse	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2
J	FOAM OR JELLY Women can place a suppository, jelly, or cream in their vagina before intercourse	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2
K	LACTATIONAL AMENORRHEA (LAM) Up to 6 months after childbirth, a woman can use a method that requires that she breastfeeds frequently, day and night, and that her menstrual period has not returned	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2
L	STANDARD DAYS METHOD A woman who is sexually active abstains (or uses a condom) on days 8 through day 19 each menstrual cycle	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2
M	RHYTHM OR PERIODIC ABSTINENCE Every month that a woman is sexually active can avoid pregnancy by not having sexual intercourse on the days of the month she is most likely to get pregnant	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2
N	WITHDRAWAL Men can be careful and pull out before climax	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2
O	EMERGENCY CONTRACEPTION Women can take pills up to three days after sexual intercourse to avoid becoming pregnant	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2
P	Have you heard of any other ways or methods that women or men can use to avoid pregnancy?	YES……1 → …… (SPECIFY) NO……2	YES……1 NO……2	YES……1 NO……2

PROCEED TO NEXT SECTION→

SECTION 4: ACCESS TO FAMILY PLANNING

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
401	Now I w ould like to ask you about family planning services in your community. Do you know of a place where you could obtain a method of family planning? IF NO, CIRCLE "Z" [DON'T KNOW] IF YES, ASK "Where is that?" [1] PROBE: "Are there any other places where you could obtain a method?" RECORD ALL MENTIONED. IF A SOURCE IS A HOSPITAL, HEALTH CENTER, OR CLINIC, WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE)	PUBLIC SECTOR: GOVT. HOSPITAL……A GOVT. HEALTH CENTER……..B FAMILY PLANNING CLINIC……..C MOBILE CLINIC…….. D FIELDWORKER…….. E OTHER PUBLIC……..……..F PRIVATE MEDICAL SECTOR: PRIVATE HOSP./CLINIC……G PHARMACY…….. H PRIVATE DOCTOR……I MOBILE CLINIC……..J FIELDWORKER……..K OTHER PRIVATE MEDICAL…….L OTHER SOURCE: SHOP……....M CHURCH…….... N FRIEND/RELATIVE……O DON'T KNOW……Z	→ 501
402	How far away from your home is the place you can obtain a method of family planning: 5 kms or less or more than 5 kms?	5 KMS OR LESS ……1 MORE THAN 5 KMS……..2 DON'T KNOW…… 8	
403	How long does it take you to get to the place where you can obtain a method of family planning?	LESS THAN 1 HOUR…..…….. 1 1 HOUR UP TO TWO HOURS…….2 2 HOURS UP TO 4 HOURS…….3 MORE THAN 4 HOURS……4	

PROCEED TO NEXT SECTION→

SECTION 5: DESIRE FOR FUTURE CHILDREN

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
501	CHECK QUESTION 303A: WOMAN NOT STERILIZED ☐ ⇩ (CODE 2)	WOMAN STERILIZED ☐ ⇨ (CODE 1)	→ 602
502	CHECK QUESTION 303B: MAN NOT STERILIZED ☐ ⇩ (CODE 2)	MAN STERILIZED ☐ ⇨ (CODE 1)	→ 602
503	Are you currently pregnant?	YES……1 NO……2 UNSURE ……8	→ 801
504	Do you want to have a/another child?	YES……1 NO……2 DON'T KNOW……8	→ 601 → 601
505	When do you want to have your next child?	WITHIN 2 YEARS ……1 MORE THAN 2 YEARS FROM NOW……2 UNSURE WHEN…… 8	

PROCEED TO NEXT SECTION→

SECTION 6: CURRENT USE OF FAMILY PLANNING

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
601	Are you currently doing something or using any method to delay or avoid getting pregnant?	YES……1 NO…….. 2	→ 606
602	Which method are you (or your husband/ partner) using? CHECK RESPONSE PROVIDED IN 602 AGAINST 303: EVER USE OF METHOD. IF A METHOD IS CURRENTLY USED, THAT METHOD SHOULD ALSO BE CODED AS 'EVER USED' IN 303. IF WOMAN IS STERILIZED, CIRCLE A. IF MAN IS STERILIZED, CIRCLE B. IF MORE THAN ONE METHOD IS MENTIONED, FOLLOW SKIP INSTRUCTION FOR HIGHEST METHOD ON LIST	FEMALE STERILIZATION……A MALE STERILIZATION……B PILL……..C IUD……D INJECTABLES……E IMPLANTS……F CONDOM……G FEMALE CONDOM……H DIAPHRAGM……I FOAM/JELLY……J LACTATIONAL AMEN. METHOD……K STANDARD DAYS METHOD……L PERIODIC ABSTINENCE (OTHER THAN STANDARD DAYS)……M WITHDRAWAL……N OTHER……X (SPECIFY)	
603	For how long have you (or your husband/partner) been using (CURRENT METHOD) now without stopping? PROBE: In what month and year did you start using (CURRENT METHOD) continuously? IF STERILIZED, ASK: In what month and year was the sterilization performed?	MONTH…… ☐☐ YEAR…… ☐☐☐☐ DON'T KNOW……Z	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
604	Where did you obtain (CURRENT METHOD) when you started using it? IF THE WOMAN OR HER HUSBAND/PARTNER WAS STERILIZED, ASK: Where were you (your partner) sterilized? IF THE WOMAN IS USING LAM OR THE STANDARD DAYS METHOD, ASK: Where did you learn to use your method?	PUBLIC SECTOR: GOVT. HOSPITAL……A GOVT. HEALTH CENTER……..B FAMILY PLANNING CLINIC……..C MOBILE CLINIC…….. D FIELDWORK ER…….. E OTHER PUBLIC……..……..F _____ (SPECIFY) PRIVATE MEDICAL SECTOR: PRIVATE HOSP./CLINIC……G PHARMACY…….. H PRIVATE DOCTOR……I MOBILE CLINIC……...J FIELDWORKER……..K OTHER PRIVATE MEDICAL…….L _____ (SPECIFY) OTHER SOURCE: SHOP……....M CHURCH…….... N FRIEND/RELATIVE……O OTHER _____ X (SPECIFY) DON'T KNOW……Z	
605	Before using (CURRENT METHOD), did you ever use another method of family planning?	YES……1 NO…….. 2	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
606	CHECK 501: NOT PREGNANT OR UNSURE ☐ ⇩ (CODE 2)	PREGNANT ☐ ⇨ (CODE 1)	→ 801
607	You have indicated that you are not using a method of family planning. Can you please tell me the reason you are not using a method? RECORD ALL MENTIONED	NOT MARRIED……A FERTILITY-RELATED REASONS NOT HAVING SEX……B INFREQUENT SEX ……C MENOPAUSAL/HYSTERECTOMY…D SUBFECUND/INFECUND……E POSTPARTUM AMENORRHEIC.....F BREASTFEEDING……G FATALISTIC…...……H OPPOSED TO USE RESPONDENT OPPOSED……I HUSBAND/PARTNER OPPOSED….J OTHERS OPPOSED……K RELIGIOUS PROHIBITION……L LACK OF KNOWLEDGE KNOWS NO METHOD……M KNOWS NO SOURCE……N METHOD-RELATED REASONS HEALTH CONCERNS……...O FEAR OF SIDE EFFECTS…… …… P LACK OF ACCESS/TOO FAR……Q COSTS TOO MUCH……R INCONVENIENT TO USE……S INTERFERES WITH BODY'S NORMAL PROCESSES…… ……T OTHER_____X (SPECIFY)_____ _____	

PROCEED TO NEXT SECTION→

SECTION 7: QUALITY OF COUNSELING FOR CURRENT USERS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
701	CHECK 602 (CURRENT METHOD). CIRCLE METHOD CODE. IF MORE THAN ONE METHOD USED, CIRCLE CODE FOR HIGHEST ON LIST IF NO METHOD CURRENTLY USED, CIRCLE Z	FEMALE STERILIZATION……A MALE STERILIZATION……B PILL……C IUD……D INJECTABLES……E IMPLANTS……F CONDOM……G FEMALE CONDOM……H DIAPHRAGM……I FOAM/JELLY……J LACTATIONAL AMEN. METHOD……K STANDARD DAYS METHOD……L PERIODIC ABSTINENCE (OTHER THAN STANDARD DAYS)……M WITHDRAWAL……N OTHER……X (SPECIFY) NO METHOD……Z	→ 702 → 703 → 704 → 704 → 704 → 704 → 708 → 708 → 708 → 708 → 708 → 708 → 801 → 801 → 801 → 801
702	Before your sterilization, were you told that you would not have any (more) children because of your operation?	YES……1 NO……2	→ 704 → 704
703	Before the sterilization operation, was your husband (or partner) told that he would not be able to have any (more) children because of the operation?	YES……1 NO……2 DON'T KNOW……3	→ 801 → 801 → 801
704	At the time you first started to use (CURRENT METHOD), were you told about side effects or problems you might have with the method? IF STERILIZED, ASK: At the time you were sterilized, were you told about side effects or problems you might have with the operation?	YES……1 NO……2	→ 706
705	Were you <u>ever</u> told by a health or family planning worker about side effects or problems you might have with the method?	YES……1 NO……2	
706	Were you told what to do if you experienced side effects or problems?	YES……1 NO……2	
707	Were you told when you should return for follow-up (or when someone should be back to see you?)	YES……1 NO……2	

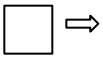
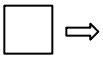
708	When you obtained (CURRENT METHOD) from (SOURCE OF METHOD) were you told about other methods of family planning that you could use? IF USING LAM OR STANDARD DAYS METHOD, ASK: "When you first learned (METHOD) were you told about other methods of family planning that you could use?"	YES……..1 NO……2	→ 801
709	Were you <u>ever</u> told by a health or family planning worker about other methods of family planning that you could use?	YES……..1 NO……2	

SECTION 8: DIFFUSION OF FAMILY PLANNING MESSAGES

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
801	In the past 12 months, have you discussed family planning with your husband or partner, friends, neighbors, or relatives?	YES……1 NO……..2	→ 803
802	With whom? Anyone else? RECORD ALL PERSONS MENTIONED	HUSBAND/PARTNER……A MOTHER……..B FATHER…… C SISTER(S)……D BROTHER(S)…… E DAUGHTHER……..F SON…… G MOTHER-IN-LAW……H FRIENDS/NEIGHBORS……I OTHER……..J	
803	In the past 12 months, have you discussed the number of children that you want with your husband or partner?	YES……1 NO……..2 DOES NOT HA VE HUSAND/PART….3	
804	In the past 12 months, were you visited by a community health worker or promoter who talked to you about family planning?	YES……1 NO……..2	
805	In the past 12 months, have you visited a health fac ility for care for yourself (or your child?)	YES……1 NO……..2	→ 807
806	Did any staff member at the health facility speak to you about family planning methods?	YES……1 NO……..2	
807	In the past month, have you seen or heard any messages about family planning from the following?	**<u>YES</u>** **<u>NO</u>**	
	RADIO	1 2	
	NEWSPAPER.....	1 2	
	TELEVISION	1 2	
	HEALTH FAIR..……	1 2	

PROCEED TO THE NEXT SECTION→

SECTION 9: POSTPARTUM FAMILY PLANNING

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
901	CHECK 204: DOES WOMAN HAVE A LIVING (BIOLOGICAL) CHILD? YES (CODE 1) 	NO (CODE 2) 	→ 1001
902	CHECK 205: AGE OF YOUNGEST LIVING CHILD: LESS THAN 12 MONTHS:  (CODE 1)	12 MONTHS OR OLDER:  (CODE 2)	→ 1001
903	Now I would like to ask a few questions about the time while you were pregnant with your youngest child. Did you see anyone for prenatal care while you were pregnant with (NAME)? IF YES, Whom did you see? Anyone else? PROBE FOR THE TYPE OF PERSON AND CIRCLE ALL PERSONS MENTIONED.	HEALTH PROFESSIONAL DOCTOR……A NURSE/MIDWIFE……B AUXILIARY NURSE……C OTHER PERSON TRADITIONAL BIRTH ATTENDANT……D COMMUNITY HEALTH WORKER…..E OTHER_____ F (SPECIFY) NO ONE…… Z	→ 905
904	During your prenatal check, were you counseled on the following?	YES NO Breastfeeding? 1 2 Lactational Amenorrhea Method? 1 2 Family planning? 1 2	
905	After the birth of (NAME) did anyone check on your health?	HEALTH PROFESSIONAL DOCTOR……A NURSE/MIDWIFE……B AUXILIARY NURSE……C OTHER PERSON TRADITIONAL BIRTH ATTENDANT……D COMMUNITY HEALTH WORKER...E OTHER_____ F	

		(SPECIFY) NO ONE…… Z	→ 907
NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
906	During your postpartum check, were you counseled on the following? Breastfeeding? Lactational Amenorrhea Method? Family planning?	YES NO 1 2 1 2 1 2	
907	After (NAME) was born, did you start to use a method of family planning?	YES……..1 NO……2	→ 909
908	Did you start to use the method within the first 6 weeks of after the first 6 weeks following (NAME's) birth?	6 WEEKS OR EARLIER……1 7 WEEKS OR LATER……2 DON'T KNOW……8	
909	CHECK AGE OF YOUNGEST CHILD (SEE 205) CHILD LESS THAN 6 MONTHS ☐ ⇩ YES (CODE 1)	CHILD 6 MONTHS OR MORE ☐ ⇨ NO (CODE 2)	→ 1001
910	Did you ever breastfeed (NAME?)	YES……..1 NO……2	→ 1001
911	Are you still breastfeeding (NAME?)	YES……..1 NO……2	→ 1001
912	Did (NAME) receive any liquids yesterday during the day or at night besides breastmilk?	YES……..1 NO……2	→ 1001
913	Did (NAME) eat solid, semi-solid or soft foods yesterday during the day or at night?	YES……..1 NO……2	→ 1001
914	When did your last menstrual period start? DO NOT COUNT BLEEDING WITHIN THE FIRST 6 WEEKS POSTPARTUM _____	DAYS AGO…… …1_ ☐☐ WEEKS AGO ……..2 ☐☐ MONTHS AGO……...3 ☐☐ BEFORE BIRTH OF (NAME)...4 HAS HAD HYSTERECTOMY..6	

PROCEED TO NEXT SECTION→

SECTION 10: SEXUAL ACTIVITY

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
100 1	When was the last time you had sexual intercourse? RECORD NUMBER OF DAYS AGO IF LAST INTERCOURSE WAS WITHIN 1-6 DAYS AGO; RECORD IN WEEKS IF LAST INTERCOURSE WAS FROM 7 DAYS UP TO 27 DAYS AGO; RECORD IN MONTHS IF LAST INTERCOURSE WAS FROM 4 WEEKS UP UNTIL 12 MONTHS AGO; RECORD IN YEARS IF LAST INTERCOURSE WAS 12 MONTHS AGO OR LONGER AGO.	DAYS AGO……1 ☐☐ (1-6) WEEKS AGO……..2 ☐☐ (1-3) MONTHS AGO……..3 ☐☐ (1-11) YEARS AGO……..4 ☐☐	

PROCEED TO NEXT SECTION→

SECTION 11: HIV/AIDS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1101	Have you ever heard of an illness called AIDS *(or the local term for AIDS)*?	YES .....1 NO.....2	 → END
1102	Is there anything a person can do to avoid getting AIDS or the virus that causes AIDS?	YES .....1 NO.....2 DON'T KNOW 8	 → 1104 → 1104
1103	What can a person do? Anything else? RECORD ALL MENTIONED.	ABSTAIN FROM SEX ..... A USE CONDOMS ..... B LIMIT SEX TO ONE PARTNER/STAY FAITHFUL TO ONE PARTNER ... C LIMIT NUMBER OF SEXUAL PARTNERS ..... D AVOID SEX WITH PROSTITUTES .....E AVOID SEX WITH PERSONS WHO HAVE MANY PARTNERS .....F AVOID SEX WITH PERSONS WHO INJECT DRUGS INTRAVENOUSLY..G AVOID CONTACT WITH CONTAMINATED BODY FLUIDS (BLOOD, SECRETIONS, ETC.) . . . . H AVOID UNNECESSARY INJECTIONS/ INJECTIONS BY TRADITIONAL HEALERS AND NON HEALTH PROFESSIONALS……..…I AVOID GETTING TATOOS ……. . . . .J AVOID SHARING RAZORS, BLADES .. K FOR MEN, AVOID HAVING SEX WITH OTHER MEN.....L AVOID KISSING.....M AVOID MOSQUITO BITES ..... N	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
		SEEK PROTECTION FROM TRADITIONAL HEALER ..... Q OTHER ..... X DON'T KNOW ..... Z	
1104	Can the virus that causes AIDS be transmitted from a mother to a child? During pregnancy? During delivery? During breastfeeding?	**YES NO DK** DURING PREGNANCY .....1 2 8 DURING DELIVERY .....1 2 8 DURING BREASTFEEDING 1 2 8	
1105	If a mother is infected with the AIDS virus, is there any way to avoid transmission to the baby?	YES .....1 NO .....2 DON'T KNOW 8	
1106	Can a person who has AIDS be cured?	YES .....1 NO .....2 DON'T KNOW 8	

USAID PVO/NGO Flexible Fund
Tabulation Plan / Definition of Indicators
Flexible Fund Family Planning Survey
To be Used with April 1, 2004 Version of the Survey

This document is designed to assist Flexible Fund Grantees who are conducting a population-based survey using the Flexible Fund Family Planning Survey Instrument. This Tabulation Plan with assist those analyzing the survey results to construct the core and optional indicators correctly. These instructions relate to the April 1, 2004 Version of the Survey. Please check the Child Survival Technical Support Plus (CSTS+) website for the most recent versions of all documents related to the USAID Office of Population and Reproductive Health (PRH) Flexible Fund.

Key End Result (Strategic Objective): Increased Use of FP and Improved FP/RH Practices	
Core Results Level Indicators 1, 2	**How to Calculate the Indicator**
New Acceptors **R2: % of WRA (15-49) who report being a 'new user' of a modern method[3] of family planning** Note: This indicator is related to the actual core indicator: "Number of WRA (15-49) who report being a 'new user' of a modern method of family planning (per time interval)." The core indicator is typically collected through service statistics, not through population-based surveys.	Number of women 15-49 who report being a 'new user' (Q 605 = 2 (never used a method prior to current method)) AND who report using a modern method (Q 602 = A – L) ÷ Number of women 15-49 who report using a modern method (Q 602 = A – L) X 100
Contraceptive Prevalence **R3: % of women married or in union 15-49 years who are not pregnant or are unsure, who are using a modern family planning method[2, 3]**	Number of women 15-49 married or in union (Q 1001 = 1 (currently married) or 2 (living with a man)) AND who are not pregnant (Q503=2) or unsure if they are pregnant (Q 503 = 8) AND who are using a modern method of family planning (Q 602 = A – L) ÷ Total number of women 15-49 married or in union (Q 1001 = 1 (currently married) or 2 (living with a man)) AND who are not pregnant (Q503=2) or unsure if they are pregnant (Q 503 = 8) X 100

Key End Result (Strategic Objective): Increased use of FP and improved FP/RH practices	
Optional Result Level Indicators4	**How to Calculate the Indicator**
Continuation **R4: % of WRA who started using a method of family planning in the past 12 months who are still using the method**	Number of women 15-49 (or their partner) currently using a method (Q 601 = 1 (yes)) AND who started using that method within the past 12 months and are continuing to use it: (date of interview minus the date of starting to use current method (Q 603) is ≤ 12 months) **———————————** Number of women 15-49 who (or their partner) started using a method within the past 12 months: (date of starting current method (Q 603) minus Date of Interview is ≤ 12 months) PLUS the number of women (or their partner) who stated using a method of family planning within the past 12 months and discontinued (Q 606 = 1 (yes)) X 100
LAM Use **R5: % of mothers with infants less than 6 months who report using LAM** *Note: Using Questions 909-914, you may check to see if the criteria for LAM is being met by those who report using LAM (Q 602 = K). In addition, you may determine the percentage of women who meet the criteria of LAM but may not be aware that they are at low risk of becoming pregnant ('passive LAM use').*	Number of women 15-49 who have a child < 6 months. (Q 909 = 1 (yes)) AND who report using LAM (Q 602 = K) **———————————** Total number of women 15-49 who have a child < 6 months (Q 909 = 1 (yes)) X 100 *The criteria for LAM use have been met if:* *If the child is less than 6 months (Q 909 = 1 (yes)) AND* *The woman is still breastfeeding (Q 911 = 1) AND* *The baby is only being fed breastmilk and nothing else (Q 912, 913 both = 2 (no) AND* *The mother has not returned to menses (Q 914 = 4)*
Post-partum Initiation of FP **R6: % of postpartu m mothers who report initiating use of a modern method of FP within 6 weeks after birth**	Number of women with children < 12 mos. (Q 902 = 1(yes)) AND who started to use a method of FP within 6 weeks of birth (Q 908 = 1 (6 weeks or earlier)) **———————————** Number of women with children < 12 mos. (Q 902 = 1(yes)) X 100

Key End Result (Strategic Objective): Increased use of FP and improved FP/RH practices	
Optional Result Level Indicators4	**How to Calculate the Indicator**
Adequate Child Spacing **R7: % WRA who have a child < 12 months who report that the youngest child was born at least 24 months after the previous surviving child** *Note: Programs being implemented for five years or longer may also elect to consider birth intervals of 36 months*	Number of women 15-49 who have at least two biological children < 5 years (Q 204 = 2 or 3) AND the youngest child was born at least 24 months after the next youngest child: (date of birth of second youngest child) (Q 207) minus the date of birth of youngest child) $\geq$ 24 months) --- Total number of women15-49 who have at least two biological child < 5 years (Q 203 = 1 or 2 or 3) X 100
Condom Use with Non-Regular Partner **R8: % of women who report that they or their partner used a condom during last intercourse with non-regular partner**	Number of sexually active women 15-49 (Q 1002 date of last intercourse < 12 months since date of interview) AND who report that they or their partner used a condom during last intercourse (Q 1004 = 1 (yes)) AND last intercourse was with non-regular partner (Q 1003 = 3 or 4 or 5 or 6 (other friend, casual acquaintance, relative, other)) --- Number of sexually active women 15-49 (Q 1002 date of last intercourse < 12 months since date of interview) AND who report having a non-regular partner (Q 1003 = 3 or 4 or 5 or 6 (other friend, casual acquaintance, relative, other)) X 100
Key End Result (Strategic Objective): Increased use of FP and improved FP/RH practices	
Optional Result Level Indicators4	**How to Calculate the Indicator**
Unmet Need for Family Planning **R9: % of WRA (15-49) currently married or in union who are fecund (not pregnant and not**	Number of women 15-49 married or in union (Q 1001 = 1 (currently married) or 2 (living with a man)) AND who are not pregnant (Q 503 = 2 (no)) AND who are not sterilized (Q 501 = 2) AND do not want any more children at all (Q 504 = 2 (no) or 8 (unsure)) OR do not want any more children for at least two

pregnant and not sterilized) who desire to have no more or postpone childbearing, but who are not currently using a method of family planning	more years (505 = 2 (more than two years) or 8 (unsure)) AND who are NOT using a method of family planning (Q 601 = 2 (no)) Total number of women 15-49 married or in union (Q 1001 = 1 (currently married) or 2 (living with a man)) AND who are not pregnant (Q 503 = 2 (no)) AND who are not sterilized (Q 501 = 2) AND do not want any more children at all (Q 504 = 2 (no) or 8 (unsure)) OR do not want any more children for at least two more years (505 = 2 (more than two years) or 8 (unsure))	X 100

Intermediate Result 1 2,11: Increased knowledge and interest in FP services through NGO/PVO involvement		
Core Indicator Intermediate Results Level5	**How to Calculate the Indicator**	
Discussion of FP with Spouse/ Partner **IR1.1 % of sexually active respondents who report discussing FP issues with their spouse or (cohabitating) sexual partner in the past 12 months.2**	Number of sexually active women 15-49 (Q 1002: date of last intercourse < 12 months since date of interview) AND who have a husband or a cohabitating partner (Q 1001 = 1 or 2 (yes)) who report discussing family planning in the past 12 months with their spouse or regular partner (Q 802 = A) Number of sexually active women 15-49 (Q 1002: date of last intercourse < 12 months since date of interview) AND who have a spouse or regular partner (Q 1001 = 1 (spouse) or 2 (co-cohabitating partner))	X 100
Optional Indicators Intermediate Results Level	**How to Calculate the Indicator**	
FP Message Recall **IR1.2 % of WRA (or other target group) who recall hearing or seeing a specific FP-related message being promoted by the program (message recall)**	Number of women 15-49 who report having seen or heard a message about family planning (Q 807 = 1 for one or more of the media sources: radio, newspaper, television, or fair) Number of women 15-49 who are interviewed	X 100

Intermediate Result 2:
Improved quality of FP service delivery in facilities and i n the community

Core Indicator Intermediate Results Level	How to Calculate the Indicator				
	IF CURRENT METHOD, Q701 =				
	Female Sterilization (A)	**Hormonal Methods (C-F)**	**Male Sterilization (B)**	**Barrier or Education-based (G-L)**	
Adequate Counseling **IR2.1 % of FP clients who receive adequate counseling** Note: This indicator is related to the core indicator of the same name. Adequate Counseling' is typically assessed through direct observation or exit interviews, not through population-based surveys. The Flexible Fund is field testing questions relating to this indicator. ***To determine the numerator: calculate the numbers for each column, then add the column totals*** *The numerator of this indicator is based upon combining 'correct' answers as appropriate for each method (see Qs 701 – 708). See skip patterns for each method. For example, to meet all relevant criteria relating to 'adequate counseling' for pill use, the responses to the following questions must all be 1 (yes): Q 704, Q 706, Q 707, 708. To meet all the relevant criteria for 'adequate counseling' for LAM, only a 'yes' response for Q 708 is necessary.*	Number of women 15-49 who were sterilized (Q 701 = A) AND were told that they would not have more children (Q 702 = 1 (yes)) AND who were told at the time of the procedure about potential problems (Q 704 = 1 (yes)) AND who were told what to do if she experienced side effects Q 706 = 1 (yes)) AND who was told when to return for follow-up (Q 707 = 1 (yes)) AND who was told about other methods (Q 708 = 1 (yes))	Number of women 15-49 who are current users of the pill, IUD, injectables, or implants (Q 701 = C-F) AND who were told at the time they received the method about side effects (Q 704=1 (yes)) AND who were told what to do if she experienced side effects (Q 706 = 1 (yes)) AND who was told when to return for follow-up (Q 707 = 1 (yes)) AND who was told about other methods (Q 708 = 1 (yes))	Number of women 15-49 whose partner is sterilized (Q 701 = B) AND whose partner was told that he would not be able to have any (more) children (Q 703 = 1 (yes))	Number of women 15-49 who are current users of the condoms, diaphragm foam/jelly, LAM, or SDM (Q701=G-L) AND who was told about other methods (Q 708 = 1 (yes))	
	Number of women 15-49 (or their partners) who are current users of family planning methods (Q 701 = A – L)				X100

Intermediate Result 3: Increased FP access in communities	
Core Indicator Intermediate Results Level	**How to Calculate the Indicator**
Proximity to Family Planning Service Delivery Point6 **IR3.1 % of population [of WRA] that lives within 5 km of a family planning service delivery point (SDP), [among women who know where to obtain a method]** Note: This core indicator is typically collected by program staff, and not through population-based surveys. The Flexible Fund is field testing questions relating to this indicator. Phrases in brackets have been added to the indicators for population-based surveys.	$\frac{\text{Number of women 15-49 who are interviewed AND who live within 5 km of a family planning service delivery point (Q 402 = 1) AND who know where to obtain a family planning method (Q 402 NE Z)}}{\text{Number of women 15-49 who are interviewed AND who know where to obtain a family planning method (Q 402 NE Z)}} \times 100$

Intermediate Result 3: Increased FP access in communities	
Core Indicator Intermediate Results Level	**How to Calculate the Indicator**
Discussion of Family Planning with Health Worker **IR3.2 % of respondents of reproductive age who report discussing family planning with a health or family planning worker or promoter in the past 12 months2**	Number of women 15-49 who have discussed family planning within the past 12 months with a health worker (Q 804 = 1) OR (Q 806 = 1) / Number of women 15-49 who are interviewed X 100
Optional Indicator Intermediate Results Level	**How to Calculate the Indicator**
Travel Time to Family Planning Service Delivery Point **R3.3 % of women 15-49 who report that the travel time to nearest SDP6 is within 2 hours (geographical access)**	Number of women 15-49 who live within 2 hours of a family planning service delivery point (Q 403 = 1 or 2 (two hours or less)) / Number of women 15-49 who are interviewed X 100

Intermediate Result 4: Improved social and policy environment for FP/RH services and behaviors
Note: No core or optional indicators for IR4 are measured using the Flexible Fund Family Planning Survey

Endnotes

[1] The Core Indicators relate directly to the Results and are designed to measure to what extent the Results (Objectives) are being met.

[2] Flex Fund grantees are required to report on this core indicator if they are conducting a population-based survey(s).

[3] 'Modern' family methods include injectables (Depoprovera, Noristerat), IUDs, Norplant, tubal ligation, vasectomy, condoms, diaphragms, spermicides, Lactational Amenorrhea Method, and the Standard Days Method (SDM).

[4] Optional Results may be selected/developed depending upon the aims of the specific program. R4-R9 are some examples of program specific Results. The ordering of the Optional Results does not reflect Flex Fund priority or emphasis.

[5] The Intermediate Results Indicators relate to Intermediate Results (IRs) and are designed to measure to what extent the IRs are being met.

[6] A Service Delivery Point (SDP) is a place where contraceptives are distributed or sold, including health centers and posts, kiosks, or persons whose role it is to dispense contraceptives (for example, a community-based distribution agent (CBDA).

Annex 6 Performance Assessment of ANMs

WORLD VISION INDIA

PRAGATI
Child Survival Project

Report on
Health Worker Performance Assessment

Ballia, Lalitpur, and Moradabad Districts
Uttar Pradesh, India

ACKNOWLEDGEMENTS

The BRICS 2 Project records its deep appreciation for the guidance and support provided by the Chief Medical Officers and District Program Officers (ICDS) of Ballia, Lalitpur and Moradabad districts in conducting these surveys.

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The support provided by World Vision senior management was invaluable for the completion of this assessment in time. The Project managers of the ADPs in Ballia and Lalitpur and that of the PEI Project in Moradabad were of immense help in planning and executing the surveys. Our heartfelt thanks to all of them.

Above all, we are grateful to the ANMs, who actively participated and co-operated in the assessment.

PRAGATI Child Survival Project Team
Lucknow

May 2004

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LIST OF ABBREVIATIONS

ADP	Area Development Program
ANM	Auxiliary Nurse Midwife
AWW	Anganwadi Worker
BCC	Behavior Change Communication
BRICS	Ballia Rural Integrated Child Survival Project
CMO	Chief Medical Officer
DPT	Diphtheria, Pertussis, Tetanus
EPI	Expanded Program on Immunization
FGD	Focus Group Discussion
GOI	Government of India
KPC	Knowledge, Practice, Coverage
LQAS	Lot Quality Assurance Survey
ICDS	Integrated Child Development Scheme
IDI	In depth Interviews
IMCI	Integrated Management of Childhood Illness
M&E	Monitoring and Evaluation
MOH	Ministry of Health
NFHS	National and Family Health Survey
NGO	Non Governmental Organization
OPV	Oral Polio Vaccine
PHC	Primary Health Center
PVO	Private Voluntary Organization
RMP	Registered Medical Practitioner
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
UP	Uttar Pradesh
USAID	United States Agency for International Development
WHO	World Health Organization
WV	World Vision

EXECUTIVE SUMMARY

Health Workers Performance Assessments (HWPA) was carried out to guide the preparation of the performance improvement plan for ANMs and provide baseline information for project monitoring and evaluation. The assessment of the performance of the ANMs will cover their knowledge in project interventions; their skills in delivering related services and counseling beneficiaries; their concerns to be addressed for improving the quality of their services; and supply and stock issues. The assessment of the performance of the AWWs was their knowledge level in key intervention areas, their skills like counseling, and motivational factors and levels.

The same type of tools was used for ANMs and AWWs, with the appropriate modifications to reflect the specific aspects of their respective practices. These tools are a checklist for the systematic observation of the clinical services provided, the client-provider interaction, or specific elements of the environment in which the services are provided (cleanliness; confidentiality; availability of equipment and supplies); a guideline for interview services of providers; a questionnaire to interview clients/beneficiaries after they received services; and guidelines to extract data from the records. The following is a summary of the results obtained from this survey:

SUMMARY OF RESULTS

No	Indicator	Ballia	Lalitpur	Moradabad
Service Provider - Training				
1.	% ANMs who received at least a years pre service training	96.8% (30/31)	100% (30/30)	93.1% (27/29)
2.	% ANMs who received at least one in service training in the past one year	83.9% (26/31)	80% (24/30)	55.5% (16/29)
Service Provider – Cold Chain				
3.	% ANM centers which had a vaccine carrier on the day of survey	100% (31/31)	100% (30/30)	93.1% (27/29)
4.	% ANMs who packed DPT and diluents vials appropriately	66.7% (18/27)	16% (4/25)	77.8% (21/27)
5.	% ANM centers which had vaccine carriers with solid icepacks on the day of survey	62.1% (18/29)	23.3% (7/30)	66.7% (18/27)
6.	% ANM centers which had frozen DPT vials on the day of survey	10% (3/30)	0% (0/21)	0% (0/27)
Service Provider – Missed Opportunities				
7.	% ANMs who do miss an opportunity for immunizing a child on account of the child's illness	12.9% (4/31)	6.7% (2/30)	34.5% (10/29)
Service Provider – Knowledge				
8.	% ANMs who have knowledge about giving all due vaccines	14.8% (4/27)	33.3% (10/30)	0% (0/29)
9.	% ANMs who are able to tell appropriate infant feeding behaviors	32.3% (10/31)	73.3% (22/30)	10.3% (3/29)
10.	% ANMs who are able to tell appropriate Vitamin A dosage for children	19.4% (6/31)	56.7% (17/30)	6.9% (2/29)
11.	% ANMs who provide appropriate FP counseling	64.5% (20/31)	36.7% (11/30)	69% (20/29)
Service Provider - Immunization Practices				
12.	% ANMs who practice the correct dose and route for immunization	39.3% (11/28)	56.7% (17/30)	51.7% (15/29)
13.	% ANMs who practice no touch technique, does not reuse syringe and sterilize needle and syringe	7.1% (2/28)	20% (6/30)	3.4% (1/29)
14.	% ANMs who checked for vaccination card	82.1% (23/28)	56.7% (17/30)	58.6% (17/29)
Facility – Stockouts				
15.	% ANM centers which had no stockouts in the past six months	16.1% (5/31)	3.3% (1/30)	27.6% (8/29)
Exit Interview - Beneficiaries				
16.	% Women who recall being counseled on follow up	66% (33/50)	61.8% (34/55)	44.8% (13/29)
17.	% Mothers who recall being counseled on infant and maternal nutrition	51% (26/51)	52% (26/50)	24.1% (7/29)
18.	% Women who recall being counseled on FP	52% (26/50)	57.4% (31/54)	50% (14/28)

BACKGROUND OF PROJECT

Project Overview

The BRICS 2 project is implemented through a cooperative agreement between USAID Washington and World Vision United States, under the Expanded Impact category of USAID's Child Survival and Health Grants Program, from October 2004 to September 2007.

The focus of BRICS 2 is to scale up a "wellness" package of preventive and promotive child health interventions in Ballia, Lalitpur and Moradabad districts. To achieve this objective, BRICS 2 will take to scale the strategies and methods from its precursor, the BRICS Project that had a wide margin of success in improving key child health outcomes in Ballia district.

The two intermediate results that will contribute to the above objective are:
IR #1: Increased use of key CS and FP interventions – Immunization (40%), Family Planning/Birth Spacing (30%), Exclusive Breastfeeding (20%) and Vitamin A supplementation (10%)
IR #2: Scale up strategies and tools documented and disseminated.

The strategies employed by BRICS 2 would be:

6. Performance assessment and Improvement of AWW & ANM
   Identify key competency areas critical for quality services and assess proficiency levels of the providers in these areas.
7. Ensure early registration of all pregnant women. This is key to ensuring provision of all services in time.
8. Targeted and timed behavior change communication for families. As opposed to group health education, this involves communicating "sets" of behaviors related to the project's intervention areas, to the mother/MWRA and the decision makers in her family, at appropriate times, and tracking changes in the communicated behaviors.
9. Improve block and village level planning and use of data. This involves taking data back to those from whom it was collected and process the data to optimize its use at each level. Create an enabling environment for the AWW to function efficiently
10. Phased coverage of blocks in each district, and of villages within each block

Project Location And Demography

Uttar Pradesh State, the most populous of the country's 29 states, is located north in India's fertile Gangetic plain. Its population of 166 million[23] is spread over 70 districts. These 70 districts are grouped into 4 regions, each with a distinct dialect, culture and traditions. The proposed project districts are located in three regions of the state – Ballia district is located in the Eastern region, Moradabad in the Western region and Lalitpur in the Southern region.

Ballia district is located in the eastern (Purvanchal) region of UP, close to the border with Bihar

state. The district's estimated total population is 2.7 million, with a population density of 945 people per sq km. The district has 17 blocks. The predominantly agrarian economy is fueled with fertile alluvial soil and abundant water supply. However, an estimated 60% of the population is landless.

To the western part of UP is **Moradabad district** which has an estimated total population of 3.8 million--a population density of 688 people per sq km. The district has 14 blocks. The majority is employed in the brass industry for which this district is renowned. Unlike Lalitpur and Ballia, Moradabad has a predominant Muslim population (70%). Only 24.7% of the population is literate. Moradabad is one of the 4 districts in UP that are a challenge to the country's polio eradication campaign, as it was until recently, the major source of the wild poliovirus in Northern India.

Lalitpur district is one of the 7 districts in the southwestern (Bundelkhand) region of UP, and is located close to the border with Madya Pradesh state. The district has vast forestlands, and the total population is 970,135, spread over 6 blocks. The population density is 189 people per sq km. Most people farming their own small farms, and supplement their income by working in stone quarries. Urban migration is minimal.

SURVEY METHODS

The list of all ANMs in each district was used as sampling frame. Criteria to exclude the ANMs listed but not functional was used to ensure that the sample is representative of those actually providing services. All the ANMs included in the sampling frame were selected using stratified random sampling with two strata based on the range of services provided at the center where the ANM is posted. The first stratum includes ANMs in Post-Partum Center, Primary Health Center, New PHC and Community Health Center and the second stratum will include all the ANMs who are posted at the sub-health centers. The first group of facilities serves a larger population, and handle a greater client load. ANMs posted in these centers constitute about 20% of the total number.

For the baseline assessment, a total of 25 to 30 ANMs were sampled with the sample size of each stratum proportionate to the size of that stratum. This sample size is considered optimal for this type of assessment when taking into account the necessary precision and quality of data. For the data on immunization practices, this sample would provide a sample of about 125 observations.[24]

[24] The tool for observation of immunization sessions include collection of data on the immunization of 5 children and the sample size for this indicator is therefore N=25*5=125.

RESULTS AND DISCUSSION

Background information

Experience

The mean years of experience of an ANM is 17.9 in Ballia, 15.5 in Lalitpur and 18.5 in Moradabad.

11.2, 9.5 and 12.7 are the mean number of years an ANM has worked in her center at Ballia, Lalitpur and Moradabad respectively

Training

In Ballia 96.3% of the ANMs have received at least one year of pre service training while Lalitpur leads with 100% and Moradabad has only 93.1%.

83.9% of the ANMs in Ballia have had at least one in service training in the past year and is closely followed by Lalitpur (80%) but Moradabad has the least with 55.5%

The trainings were mostly on Cu-T, FP, Immunization, Leporesy and Sterilization at Ballia. AIDS, RCH and Infection prevention at Lalitpur and Cu-T, ANC, PNC, Polio and Leprosy at Moradabad.

23% of these trainings were conducted by MoH and 80% by SIFPSA in Ballia, 65.2% by MoH and 41.7% by SIFPSA in Lalitpur and 37.5% by MoH and 68.8% by SIFPSA in Moradabad. There were few joint programs conducted in all three districts.

Immunization

Cold chain

In Ballia and Lalitpur all the ANM centers surveyed had vaccine carriers on the day of survey but in Moradabad only 93.1% had vaccine carriers.

66.7% of the ANMs in Ballia packed the DPT and vials correctly but only 16% in Lalitpur and 77.8% in Moradabad.

In Ballia 62.1% of the ANM centers had vaccine carriers with solid ice packs, Lalitpur had the least with only 23.3% and Moradabad had the most 66.7%

10% of the DPT vials in ANM centers of Ballia were frozen while 0% in Lalitpur because DPT vials were not available through out the district during the survey and 0% in Moradabad

Missed oppurtunities

53.3% of the ANMs in Ballia had refused immunization for children, out of this 68.8% had done so due to non availability of vaccines and 6.3% due to non availability of needles and syringes.

46.7% of the ANMs in Lalitpur had refused immunization for children, out of this 78.6% had done so due to non availability of vaccines and 7.1% due to non availability of needles and syringes. 53.6% of the ANMs in Moradabad had refused immunization for children, out of this 26.7% had done so due to non availability of vaccines and 6.7%% due to non availability of needles and syringes

In Ballia 12.9% of the ANMs had missed an opportunity to immunize a child due to the child's illness while only 6.7% of the ANMs had done so in Lalitpur and as many as 34.5% in Moradabad

Safe injection practices

The mean for children observed during an immunization schedule are 4.4 in Ballia, 3 in Lalitpur and 4.6 in Moradabad

In Ballia only 39.3% of the ANMs follow the correct dose and route for immunization while it is 56.7% in Lalitpur and 51.7% in Moradabad

Only 6.1% of ANMs in Ballia practice no touch technique, does not reuse syringe and sterilize needle and syringe while a maximum of 20% Lalitpur and only 3.4% in Moradabad
82.1% of the ANMs in Ballia check for vaccination cards while 56.7% in Lalitpur and 58.6% in Moradabad
In Ballia 77.8% of the ANMs sterilize the needles and 33.3% recap needles after use while it is 72.4% and 65.5% in Lalitpur, 44.4% and 17.9% in Moradabad respectively
Only 14.8% of the ANMs in Ballia had knowledge about giving all due vaccines while 33.3% knew in Lalitpur and 0% in Moradabad
19.4% of ANMs in Ballia could tell the appropriate Vitamin A dosage for a child and 56.7% in Lalitpur and only 6.9% in Moradabad

Stockouts

16.1% of the ANM centers in Ballia had no stockouts in the past six months while only 3.3% in Lalitpur and 27.6% in Moradabad had no stockouts

Family Planning

In Ballia 96.8% of the ANMs have provided FP counseling during the past two weeks, while it is 86.7% in Lalitpur and 85.7% in Moradabad
96.8% of the ANMs in Ballia counsel clients on the various FP methods and 64.5% explain in detail regarding the chosen method. 66.7% of the ANMs in Lalitpur counsel clients on the various FP methods and 63% explain in detail regarding the chosen method. 93.1% of the ANMs in Ballia counsel clients on the various FP methods and 75.9% explain in detail regarding the chosen method.
64.5% of ANMs in Ballia know appropriate FP counseling while only 367% in Lalitpur and 69% in Moradabad
In Ballia 52% of beneficiaries recall being counseled on FP, 57.4% in Lalitpur and 50% in Moradabad.

Nutrition

Just one third (32.3%) of the ANMs in Ballia could tell appropriate infant feeding practices, maximum of 73.3% in Lalitpur and a minimum of 10.3% in Moradabad could do so
66% of beneficiaries in Ballia and 61.7% in Lalitpur recall being counseled regarding follow up while only 44.8% in Moradabad
51% of beneficiaries in Ballia and 54% in Lalitpur recall being counseled on infant and maternal nutrition compared to only 24.1% in Moradabad

ANNEXES:

Distribution of Samples

Stratified Random sampling - Ballia

Stratum	Number of ANMs	%of Total	Number of Samples
Stratum 1 – PHC/NPHC/CHC	81	20	20% of 30 = 6
Stratum 2 – SC (SubCenter)	349	80	80% of 30 = 24
Total	430	100	30

Stratified Random Sampling - Lalitpur

S. No	No.of ANMs	Total %	Total Sample
Stratum 1	21	14.5	4
Stratum 2	124	85.5	26
Total	145	100	30

Stratified Random sampling - Moradabad

S.no.	Level	No. Of ANMs	% of total	No. of samples
1.	Stratum 1	26	7%	2
2.	Stratum 2	326	93%	28
3.	Total	352	100%	30

QUESTIONNAIRES

Service Provider - Interview schedule

{Name} of {center} <A >

{ID} {Number} ####

{Block} <A >

{District} <A >

{Name} of ANM <A >

{Date} of assessment <dd/mm/yyyy>

Assessor 1:{a1} <A > Title:{t1} <A >

Assessor 2:{a2} <A > Title:{t2} <A >

1. For how many years have you been working as an ANM?
   i. --- years {wyrs} ##
   ii. --- months (if less than a year){wmths} ##

2. For how many years have you been working in this center?
   i. --- years {wcyrs} ##
   ii. --- months (if less than a year) {wcmths} ##

3. What was the duration of the training you received before appointment?
   i. --- months {trgmhs} ##
   ii. --- days (if less than a month) {trgdays} ##

4. Did you receive any training in the past year? {trgpastyr} #
   i. Yes
   ii. No - Go to question 7

5. {What} were you {train}ed on? #
   i. ---------- {train} <A >
   ii. Do not remember

6. Who organized the training?
   i. Health department {trgmoh} <Y>
   ii. SIFPSA {trgsifpsa} <Y>
   iii. Other {otrg} -------- <A >

7. {Vac}cine {carrier} present #
   i. Yes
   ii. No - Go to question 10

8. {DPT} and {dilu}ents are kept away from the icepacks in the vaccine carrier #
   i. Yes
   ii. No

9. {Ice} {packs} #
   i. Solid ice
   ii. Half ice, half water
   iii. Fully water (cold)
   iv. Fully water (lukewarm)

10. DPT {vial} {shake} test #
   i. Flaky deposits
   ii. No deposits
   iii. No DPT supply on the day of survey

11. In the past one month, did you have the following available in your center

{BCG}	Y/N	<Y>
{DPT}	Y/N	<Y>
{OPV}	Y/N	<Y>
{Measles}	Y/N	<Y>
{TT}	Y/N	<Y>
{Ice} packs	Y/N	<Y>
{Vitamin} A	Y/N	<Y>
{IFA} tablets	Y/N	<Y>
{Condoms}	Y/N	<Y>
{OCPs}	Y/N	<Y>
{CuT}	Y/N	<Y>

12. Did you {ref}use {immu}nization to any child today/last session? #
   i. Yes
   ii. No - Go to question 14

13. What is the {reason} why you {ref}used? #
   i. The child was sick
   ii. The required vaccine was not vailable
   iii. Syringes/needles were not available

iv. Other {oreason} -------- <A >

14. How {many} {vac}cinatons (injections) can a child get in a day? #
i. Only one - Go to question 16
ii. Two
iii. More than two
iv. Do not know - Go to question 16

15. What vaccines can be given together?
i. BCG and DPT {bd} <Y>
ii. DPT and Measles {dm} <Y>
iii. BCG and Measles {bm} <Y>
iv. All three {all} <Y>

16. What {nutrition} (feeding) should a four-month-old infant receive? #
i. Only breastmilk
ii. Breastmilk and other fluids
iii. Breastmilk and other foods
iv. Other {onutri} -------- <A >
v. Do not know

17. What is the {dose} of {Vit}amin A that should be given to a child who is one and a half years of age? #
i. 1 spoon (1,00,000 IU)
ii. 2 spoon (2,00,000 IU)
iii. Other {odose} ------- <A >
iv. Do not know

18. If someone approaches you for {info}rmation/services on {FP} what all will you tell them?
i. Ask about the womens {menstrual} cycles <Y>
ii. Ask if her {husband} is with her or stays away <Y>
iii. Enquire about the number of {living} {ch}ildren <Y>
iv. Enquire about how many more {ch}ildren they {want} and when <Y>
v. Inform about all {methods} that are provided by the government health system (condoms, pills, CuT, male and female sterlization) <Y>
vi. Explain in detail about the method they {choose} <Y>
vii. Others ------- {ofp) <A >

19. In the past 2 weeks did you {counsel} any woman/couple on {FP} or birth spacing? #
i. Yes
ii. No
iii. Do not remember

Thank the ANM for her participation

Immunization Session - Observation schedule

{ID} {Number} ####

1. Child observed {chobs} #
   a. Dose correct {dc} #
   c. Cleans injection site {cis} #
   d. Uses no touch technique {ntt} #
   e. Site correct {sc} #
   f. Route correct {rc} #
   g. Checks for vaccination card and marks in the same {vcard} #
   h. Reuse of equipment {reu} #

2. Needle and syringe are boiled for atleast 20 minutes or sterilized in a pressure cooker {needleboil} <A>
   a. Yes
   b. No
   c. Sterilized once at the start of the day and later kept reusing

3. Needle recapped after injection {recap} <A>
   a. Yes
   b. No
   c. Sometimes

Exit Interview - Questionnaire

{ID} {Number} <A >

1. {Why} did you {come} to the center today? #
   i. Vaccination for myself
   ii. Vaccination for my child
   iii. Treatment for my sick child
   iv. To obtain FP services
   v. Others---------- {ocome} <A >

2. Did you {rec}eive what you {came} for? #
   i. Yes
   ii. No
   iii. Don't know

3. What {vac}cine was {given} to you (your child)? #
   i. ---------- {vac} <A >
   ii. Don't know

4. Were you told when to {return}? #
   i. Yes
   ii. No
   iii. Do not remember

5. Were you given advice on {what} to {eat}/feed your child? #
   i. Yes
   ii. No
   iii. Do not remember

6. Were you counseled on birth spacing/family planning {fpcounsel} #
   i. Yes
   ii. No
   iii. Do not remember

Annex 7 NGO Capacity Assessment

WORLD VISION INDIA

PRAGATI
Child Survival Project

Report on
NGO Capacity Assessment

Ballia and Lalitpur Districts
Uttar Pradesh, India

NGO assessment

Local NGOs are key partners in the Pragati Child Survival Project. In the earlier BRICS project, the scale up of operations to the district of Ballia was made possible through operational partnerships with local NGOs.

These NGOs are indigenous, registered entities, run by local leaders, and come with the specific and unique strength of having identity and credibility at the grassroots level. They operate programs in women's development, curative care, and microcredit and savings. The last of these programs has given these NGOs opportunities to create, strengthen community groups and to link them with agencies like the Regional Rural Bank.

Furthermore, working in partnership with BRICS offered opportunities for increased visibility and recognition for these otherwise block level organizations. Many of BRICS' partner NGOs now are part of district level task forces and committees.

The following is a summary of the local NGOs who will partner with Pragati in implementing its activities. Owing to revisions in the Home Ministry's stipulations regarding micro grants from foreign sources of funds, some of the NGOs who propose to work in partnership with Pragati are required to acquire permission from the Ministry in the form of Foreign Contributions Regulatory Act (FCRA) registration number. Such NGOs are not profiled here. Moreover, NGO partnerships in Moradabad will only begin in the latter half of FY 05 and recruiting, profiling and selection of NGOs in that district will be done after the First Annual Review.

The Assessment Tool

The need to build the capacity of the NGO partners who are critical to developing networks, mobilizing communities and strengthening the existing health systems appeared to all participants very clearly during the Sustainability assessments at the start of the Project. As part of the process of assessing the capacity of the NGOs, a self-assessment tool was developed with the NGO staff using the areas identified during the Workshop to characterize the capacity of the partners' dimensions of the Sustainability framework. The tool is built on the following areas:

1. Organizational governance and leadership
2. HR Management
3. External relations
4. Finance management and administration
5. Financial viability (resource mobilizing)
6. Implementation capacity

Specific elements were identified in each area for assessing with a three point scoring system. The tool was used to assess the NGOs in Ballia and Lalitpur districts. The results are analyzed and weighed against the total score, and the capacity building areas will be further identified.

The Assessment Process: The assessment tool was given a few days prior to the assessments for the NGOs to reflect on the elements and gather illustrative descriptions on each element. Later, the Pragati team (the Capacity Development Officer and the Project officer of the district, along

with other staff) sat down with each NGO director/staff and walked through the tool with them. In certain elements, there was ambiguity about what score should be assigned, and in such cases, the one that gets closest to describing the NGO in that area, was chosen. Many NGOs expressed their desire to conduct this assessment at least once a year. No consensus has been reached about the frequency of future assessments.

Overall NGO capacity score: Although the analysis and interpretation of the score for each element is most meaningful for the users of the Assessment, it is probably useful to calculate an overall NGO score to easily compare NGOs among themselves and monitor change. Two simple methods have been used at this point. The simplest method is to calculate the total absolute or relative score for all elements. As the number of elements under each theme of the assessment tool is unequal, this method assumes a relative importance of each theme that is proportional to the number of elements that it contains. Another method is to assume an equal importance to each theme and calculate the average relative score across themes. Other methods may be developed later after the PRAGATI staff and its NGO partners have gained practical experience with this new assessment tool.

Response Bias: Despite this assessment being a guided self-assessment process, it was inevitable that each partner scored quite high in each element. The fact that the subsequent assessments would result in lesser scores owing to improved understanding of the elements, has been kept in mind. The Pragati team is also working with the partners to look beyond score 3 in each element and where each NGO would like to reach. Discussions are also on regarding the frequency and timing of subsequent assessments.

Table 1 presents selected information on the six NGO partners who completed the assessment. **Table 2** presents the summary results of these assessments and the two overall NGO score discussed above. The NGO CAPACITY SCORE SHEET and the NGO CAPACITY SCORING CRITERIA are presented at the end of the report.

Table 1 Identification and characteristics of six PRAGATI NGO partners

#	Name & Address the Director	FCRA and Organization Registration position	Years in Operation	Funding Sources (Past and Present)	Major Programs	Partnership in Pragati. Names of the Block
Nawal Education and Research Centre						
1.	Dr. Sushil Kumar Srivastava Mohalla Middi District Ballia	Registered under UP societies and has been registered under FCRA.	13 years	Govt Agencies, World Vision	Prime Minister Rojgar Yogana	Dubhar and Belhari Blocks in Ballia District
Purvanchal Gramin Chetna samiti						
2.	Fr. Matthew Ragavpur, Rasara District Ballia.	Registered under UP societies and has been registered under FCRA.	25 Years.		TB , Programmes on disability, SHGs.	Rasara, Nagra, and Sohaon blocks in Ballia District
Solanki Gramodyog Sewa Samiti						
3.	Mr Ghanshyam Singh	Registered under UP societies and has been registered under FCRA.	10 years	NABARD and World Vision.	Immunization, Safe Motherhood, Family Planning	Murli Chapra, Garwar and Hanuman Ganj Blocks in Ballia District
Navbharti Nari Vikas Samiti						
4.	Mr. Ajhar Ali Baheri, District Ballia	Registered under UP societies and has been registered under FCRA.	11 years	Govt agencies, State Govt and World Vision.	Women Empowerment, Watershed Management, SHG's, Environment, Vocational Training, Pulse Polio, Family Planning, Disaster Management.	Baria Block in Ballia District

#	Name & Address the Director	FCRA and Organization Registration position	Years in Operation	Funding Sources (Past and Present)	Major Programs	Partnership in Pragati. Names of the Block
Harriet Benson Memorial Hospital						
5.	Mr. Antony Samy Community Health and Development Department. Civil Lines Lalitpur	Registered under UP societies and has been registered under FCRA.	28 Years.	AFPRO, CBR, PFI, CRS, and Oxfam	HIV/AIDS awareness, community health development, water development programs.	They would work in 3 Blocks of Lalitpur District.
Nirman Samajottan Seva Samiti						
6.	Mr. Shrivastav 152, Prashanti Vidya Campus, Milan road, Govind nagar, Lalitpur. (UP).	Organization has been Registered under UP societies act in June 2002	7 years	Contributions from Community Members, Governing Body, and World Vision India.	Prashanti Education Institution and Polio program.	Coordinated qualitative surveys in all 6 Blocks and Quantitative survey in 5 blocks for the Baseline KPC survey. Would work in 3 blocks of Lalitpur District.

Table 2 Summary Results of Capacity Assessment of six PRAGATI NGO partners

Theme	Max Score	NGO					
		Navbharti Nari Vikas Samiti	Harriet Benson Memorial Hospital	Solanki Gramodyog Sewa Samiti	Purvanchal Gramin Chetna Samiti	Nirman	Nawal Education and Research Centre
Absolute score							
Org Governance/Leadership	12	12	11	10	11	9	10
HR Management	12	12	9	10	10	11	10
Ext relations	6	6	5	6	5	4	6
Finance Mmt and Admin	15	14	15	15	13	14	9
Financial Viability	9	6	9	7	6	6	8
Implementation Capacity	15	13	13	12	13	9	8
Total	69	63	49	48	45	44	43
Relative score (%)							
Org Governance/Leadership		100.0%	91.7%	83.3%	91.7%	75.0%	83.3%
HR Management		100.0%	75.0%	83.3%	83.3%	91.7%	83.3%
Ext relations		100.0%	83.3%	100.0%	83.3%	66.7%	100.0%
Finance Mmt and Admin		93.3%	100.0%	100.0%	86.7%	93.3%	60.0%
Financial Viability		66.7%	100.0%	77.8%	66.7%	66.7%	88.9%
Implementation Capacity		86.7%	86.7%	80.0%	86.7%	60.0%	53.3%
Total		91.3%	71.0%	69.6%	65.2%	63.8%	62.3%
Average across themes		91.1%	89.4%	87.4%	83.1%	75.6%	78.1%

Notes:

Only total score per theme are presented in this table. Score per elements available at the PRAGATI office.

Absolute score: total score per theme.

Relative Score (%): 100 * Absolute score / Maximum score.

Average across them: Sum of Relative Score / 6.

NGO listed in the table per descending order of Total Relative Score.

NGO CAPACITY SCORE SHEET

#	Elements	Description/ Examples	2004	2005	2007	2010
1	***Organizational Governance and Leadership***					
1.1	Leadership and office bearers					
1.2	Legal Status					
1.3	Vision / Mission / Goals of organization					
1.4	Board					
		Total				
2	***Human Resources Management***					
2.1	Recruitment and Selection.					
2.2	Staff Development/ Growth					
2.3	Working environment					
		Total				
3	***External Relations***					
3.1	Visibility					
3.2	Tapping of Resources					
	Total					
4	***Financial Management and Administration***					
4.1	Accounting					
4.2	Budgeting					
4.3	Integrity					
4.4	Audit					
4.5	Record Keeping					
	Total					

NGO CAPACITY SCORE SHEET

#	Elements	Description/ Examples	2004	2005	2007	2010
5	***Financial Viability (Resource Mobilization)***					
5.1	Contingency Plan for crisis.					
5.2	Technical competence for accessing resources					
5.3	Resource Diversification					
	Total					
6	***Implementation Capacity***					
6.1	Knowledge					
6.2	Program Quality					
6.3	Establishing Local Linkages					
6.4	Community mobilization Grassroots level identity					
	Total					

NGO CAPACITY SCORING CRITERIA

#	Elements	Score = 1	Score = 2	Score = 3
1	***Organizational Governance and Leadership***			
1.1	Leadership and office bearers	No selection process in place. Women not represented. Staff are not briefed about changes or reasons for the same.	Office bearers are replaced at regular intervals, staff are kept informed of the leadership decisions .No representation of women in the leadership.	Democratic process of selection and replacement of office bearers and leaders; mutually accountable relationships among staff; participatory decision-making and adequate representation of women in leadership.
1.2	Legal Status	Registered as a society in UP but not obtained FCRA registration	Registered as society / co-operative and process for registration under FCRA begun	Registered as society / co-operatives. Registered under FCRA.
1.3	Vision / Mission / Goals of organization	There is no written vision or mission for the NGO. Broad Goals & objectives have been laid down	Long-term Vision and Mission statements exist. Goals & objectives do not fully contribute to the vision.	Long term Vision and Mission exist, staff subscribe to the same. Goals & objectives are clear and contribute to the vision.
1.4	Board	The NGO has a list of Board members/office bearers; does not meet regularly	A Board exists and meets once a year and makes policy level discussions. Minutes not available	Board exists, meets twice a year and makes policy level discussions, minutes available, key decisions discussed with staff.
2	***Human Resource Management***			
2.1	Recruitment and Selection.	All recruitments and selections are at the discretion of Director or there are no proper HR policies	Selection policies and criteria are in place. No indication of a fair recruitment process (advertising, short-listing and interviewing).	A recruitment and selection policy is in place which is fair and contemporary
2.2	Staff Development/ Growth	There is no opportunity for growth within NGO and development activities. access to state of art resources is also less.	There is limited scope for growth within the organization. Staff performance is not assessed.	There is scope for growth within the organization. There is also an annual Performance assessment for all workers and latest resources are made available to staff.

#	Elements	Score = 1	Score = 2	Score = 3
2.3	Working environment	There are no clear Job Descriptions or grievance redressal system in place	There is a system of grievance redressal / corrective actions. Staff do not have clear job descriptions	There are clear Job Descriptions and system for grievance redressal and correction in place.
3	***External Relations***			
3.1	Visibility	Members/Leaders are not part of any District task Force/ Forum and other Networks. The NGO is not known beyond the blocks where it implements PRAGATI programs	Members have had the opportunity to be part of at least one District task Force/ Forum and other Networks, related to child survival.	Members are a part of more than one District task Force/ Forum and other Networks, both health and non-health. They are also part of Inter Agency Coalitions within the district
3.2	Tapping of Resources	The only technical resource made available to the staff is from PRAGATI.	NGO was able to identify and tap resources in at least one instance in the past year, apart from those available through PRAGATI	NGO was able to identify and tap resources for a range of technical issues - at least 3 instances in the past year.
4	***Financial Management and Administration***			
4.1	Accounting	Accounting and book keeping procedures not in place.	Books of accounts are maintained and an accounting system exists but staff is not trained in accounting procedures.	NGO has staff that is well versed in accounting and bookkeeping and reporting procedures of various donor Agencies. Staff versed in at least one accounting software.
4.2	Budgeting	Last year's total budget: <= Rs 50,000	Last year's total budget: > 50,000 and <= 1,50,000	Last year's total budget exceeded Rs 1.5 lakh
4.3	Integrity	Issue of integrity is not addressed.	The issue of integrity is reported to have been discussed with staff, but there are no policies or checks	NGO has various check systems in place to ensure integrity and transparency at all levels.
4.4	Audit	Books of accounts have not been audited in the past 3 years or in a regular basis.	External auditors audit books of accounts at least annually.	Books of accounts are Audited at least biannually by internal and annually by external auditors.
4.5	Record Keeping	NGO has no maintenance of records and reports.	NGO has established filing and maintenance of records and reports of 1 to 3 years, but has had difficulty retrieving records.	NGO has well-established filing system and maintains records and reports of preceding three years in easily retrievable fashion. All staff are required to follow the system

#	Elements	Score = 1	Score = 2	Score = 3
5	***Financial Viability (Resource Mobilization)***			
5.1	Contingency Plan for crisis.	NGO has not addressed the issue of crisis.	NGO has a fund to be used in crisis, but no clear policies on access to and use of the same.	NGO has contingency plan, a fund to be accessed in times of crisis and clear rules on the use of this fund.
5.2	Technical competence for accessing resources	NGO has not submitted any proposal or is in the process of preparing proposal.	NGO has prepared and submitted at least one proposal to state / national dept/ agencies.	NGO has prepared and submitted more than two proposals to state / national dept/ agencies, of which at least one was funded.
5.3	Resource Diversification	PRAGATI is the only source of funding for the NGO	NGO has at least 2 sources other than the current project.	NGO has multiple and diverse funding sources - govt/private, health/non health, district/state/national levels
6	***Implementation Capacity***			
6.1	Knowledge	Training of newly inducted staff and on the job support for existing staff are not given priority	Current staff is trained in maternal and child health interventions. No system for refreshers on the Job.	NGO has a system for training newly inducted staff in current thinking in maternal and Child Health and survival, as well as on the job training for existing ones
6.2	Program Quality	The NGO has no system to monitor and evaluate the project's activities on its own.	The NGO has a system to monitor and evaluate the activities, but they are not regularly used.	NGO has a system to monitor and evaluate the timeliness and effectiveness of implementation of project activities, which is over and above BRICS 2 requirement.
6.3	Establishing Local Linkages	The NGO has not been successful in establishing working relationships at any of the three levels - Community - AWW, AWW - ANM and at the block level	The NGO has concentrated on the formation of linkages at one level at the expense of focusing on the other two.	NGO has been effective in establishing linkages at all three levels - community - AWW, ANM - AWW and at the block levels
6.4	Community mobilization Grassroots level identity	The staff are in the process of forming community based groups	The NGO staff have formed Community based groups and strengthened at least 25 % of the assigned field.	NGO staff have formed Community based groups and strengthened at least 50 % of the assigned field.

Annex 8 Results Framework

<table>
<tr><td colspan="6">Objective (Key End Result)
To scale up a wellness package of critical child survival (CS) and family planning (FP) interventions in Ballia, Lalitpur and Moradabad districts of UP state.</td></tr>
<tr><td colspan="3">IR 1
Increased use of key CS and FP interventions:
1. Immunization
2. Family Planning
3. Maternal and Infant Nutrition
4. Vitamin A supplementation</td><td colspan="3">IR 2
Strategies, methods and tools from BRICS scaled up</td></tr>
<tr><td>SR 1a
Increased and continued access to CS and FP services in communities</td><td>SR 1b
Increased quality of CS and FP services</td><td>SR 1c
Increased knowledge and interest of CS and FP services</td><td>SR 2a
BRICS project site becomes Action, Co-learning and Scale Up Center (ACOLES)</td><td>SR 2b
Strategies, methods and tools from BRICS documented and adopted</td><td>SR 2c
Three Operations Research studies completed</td></tr>
</table>

Objective (Key End Result)

To scale up a wellness package of critical child survival (CS) and family planning (FP) interventions in Ballia, Lalitpur and Moradabad districts of UP state.

Indicators

1. Number of districts that achieved IR 1 and IR 2

IR 1 Increased use of key CS and FP interventions	**IR 2** Specific strategies, methods and tools from BRICS scaled up
Indicators 2. % Children 12–23 months who were fully immunized by their first birthday 3. % Children 12–23 months who received a measles vaccine 4. % Mothers of children 0–23 months who received two or more TT vaccinations when pregnant with youngest child. 5. # Couple years of protection provided by ANM/AWW [FF1][1] 6. % Mothers of children 0–23 months using modern contraceptive method 7. % MWRA using modern contraceptive method [FF3] 8. % Children 0–5 months who were exclusively breastfed in the 24 hours preceding the survey 9. % Children 6–9 months who were given semi solids and breast milk in the 24 hours preceding the survey 10. % Mothers of children 0-11 months who report having 1 extra meal a day most of the days during last pregnancy 11. % Mothers of children 0-11 months who report they took 100 IFA tablets during last pregnancy 12. % Children aged 12–23 months who received a dose of vitamin A supplement in the 6 months preceding the survey	**Indicators** 13: % Communities with at least 80% of AWWs who registered and provided adequate counseling to at least 80% of mothers of children under two 14: % Communities with at least 80% of AWWs who registered and provided adequate counseling to at least 80% of eligible couples 15: % Communities with at least 80% of AWWs receiving adequate support from Community Groups

SR 1a Increased & continued access to CS & FP services in communities	**SR 1b** Increased quality of CS and FP services	**SR 1c** Increased know-ledge and interest of CS and FP services	**SR 2a** BRICS project site becomes ACOLES Center	**SR 2b** Strategies, methods & tools from BRICS documented & adopted	**SR 2c** Three Operations Research studies completed
Indicators 16.% Children 12–23 months who have received at least one DPT vaccination 17. % Mothers of children 0-11 months who received the last expect-ed home visit by an AWW 18. % MWRA who re-port having discussed FP issues with a health worker or promoter (AWW/ANM) in the past 12 months [FF6] 19. % Population who live within 5 km of a family planning / re-productive health service delivery point [FF7] 20. # beneficiaries reached by the FP program [FF9]	**Indicators** 21. % infants who received correct dose & routine of vaccinations from an ANM 22. % Pregnant women or mothers of an infant who received adequately targeted & timed counseling from an AWW 23. % FP clients who received adequate counseling from AWWs [FF5] 24. % MWRA who started using a method of FP at least 12 (or six) months ago who are still using the method 25. # Sub-centers that had no stock-outs in the past 3 months	**Indicators** 26. % DPT1 – III drop out 27. % MWRA who know at least one source of FP method 28. # of acceptors new to family planning [FF2] 29. % MWRA who report discussing FP issues with their spouse in the past 12 months [FF4]	**Indicators** 30. # Cross visits of ADPs and project districts to ACOLES 31. # Strategies, methods and tools satisfactorily documented	**Indicators** 32. # Blocks that have adopted documented strategies, methods and tools from BRICS	**Indicators** 33. # Operations Research studies conducted, documented, and shared with partners

Capacity building and sustainability indicators
34. Program has sustainability plan in place [FF8]
35. % of NGO partners that are capable of providing adequate support to AWWs
36. % of communities competent for child survival

[1] The nine Flex Fund core indicators are identified in the table with "FF#".

Annex 9 Performance Monitoring and Evaluation Table

#	Indicator	Description	Partners Using Data	Data Source	District	Annual Benchmarks / Achievements			
						FY04	FY05	FY06	FY07
1	Number of districts that achieved IR 1 and IR 2 at the end of the project	Qualitative assessment of the results of all indicators for IR 1 and IR 2	USAID WVI	FE	Ballia	NA	NA	NA	1
						NA	NA	NA	
					Lalitpur	NA	NA	NA	1
						NA	NA	NA	
					Moradabad	NA	NA	NA	1
						NA	NA	NA	
2	% Children aged 12–23 months who were fully immunized by their first birthday	N = # children aged 12–23 months who were fully immunized by their first birthday (card documented) D = # children aged 12–23 months with a card	USAID WVI ICDS MOH	KPC	Ballia	NA	30	60	70
						33			
					Lalitpur	NA	40	50	70
						30			
					Moradabad	NA	40	50	70
						33			
3	% Children aged 12–23 months of age who received measles immunization	N = # children aged 12–23 months who received measles vaccine (card documented) D = # children aged 12 – 23 months with a card	WVI ICDS MOH	KPC	Ballia	NA	70	75	80
						66			
					Lalitpur	NA	55	60	70
						49			
					Moradabad	NA	60	70	75
						50			

#	Indicator	Description	Partners Using Data	Data Source	District	Annual Benchmarks / Achievements			
						FY04	FY05	FY06	FY07

4	% Mothers of children aged 0–11 months who received two or more TT vaccinations when pregnant with youngest child	N = # mothers of children aged 0–11 months who received two or more TT vaccinations when pregnant with youngest child (card documented)
		D = # mothers of children aged 0–11 months
			USAID
			WVI
			ICDS
			MOH
				KPC	Ballia	NA	80	85	90

						79			
					Lalitpur	NA	70	75	80
						68			
					Moradabad	NA	65	70	80
						59			
5	Couple years of protection provided by ANM/AWW [FF1]	Sum of CYP for methods offered by ANM/AWW CYP = quantity of method distributed over 12-month period x conversion factor for that method	USAID WVI ICDS MOH	ICDS and MOH HIS	Ballia	NA			
					Lalitpur	NA			
					Moradabad	NA			

6	% Mothers of children 0-23 months using modern contraceptive method	N = # mothers of children 0-23 months who do not want a child in next two years or are not sure who report using a MCM
		D = # mothers of children 0-23 months who do not want a child in next two years or are not sure
			USAID
			WVI
			ICDS
			MOH
				KPC	Ballia	NA	15	20	25

						12			
					Lalitpur	NA	11	13	15
						9			
					Moradabad	NA	18	20	22
						17			

7	% MWRA using modern contraceptive method [FF3]	N = # MWRA who report using a MCM
		D = # MWRA
			USAID
			WVI
			ICDS
			MOH
				FP Survey	Ballia	NA	24	25	26

					Lalitpur	NA			
					Moradabad	NA	NA	NA	NA
						NA	NA	NA	NA

#	Indicator	Description	Partners Using Data	Data Source	District	Annual Benchmarks / Achievements			
						FY04	FY05	FY06	FY07

8	% Children aged 0–5 months who were exclusively breastfed in the 24 hours preceding the survey	N = # children 0–5 months who were exclusively breastfed in the 24 hours preceding the survey
		D = # children 0–5 months
			WVI
			ICDS
			MOH
				KPC	Ballia	NA	70	75	80

						66			
					Lalitpur	NA	30	40	50
						23			
					Moradabad	NA	60	65	70
						57			

9	% Children 6–9 months who were given semi solids and breast milk in the 24 hours preceding the survey	N = # children 6–9 months who were given semi solids and breast milk in the 24 hours preceding the survey
		D = # children 6–9 months
			WVI
			ICDS
			MOH
				KPC	Ballia	NA	45	50	60

						38			
					Lalitpur	NA	25	30	50
						15			
					Moradabad	NA	40	55	70
						35			

10	% Mothers of children 0-11 months who report having 1 extra meal a day most of the days during last pregnancy	N = # mothers of children 0–11 months who report having 1 extra meal a day most of the days during last pregnancy
		D = Mothers of children aged 0 – 11
			WVI
			ICDS
			MOH
				KPC	Ballia	NA			

						NA			
					Lalitpur	NA			
						NA			
					Moradabad	NA			
						NA			

11	% Mothers of children 0-11 months who report they took 100 IFA tablets during last pregnancy	N = # mothers of children 0–11 months who report they took 100 IFA tablets during last pregnancy
		D = # mothers of children aged 0–11 months
			WVI
			ICDS
			MOH
				KPC	Ballia	NA			

						NA			
					Lalitpur	NA			
						NA			
					Moradabad	NA			
						NA			

12	% Children aged 11–23 months who received a dose of vitamin A in the 6 months preceding the survey	N = # children aged 11–23 months who received a dose of vitamin A in the 6 months preceding the survey (card documented)
		D = # children aged 11–23 months
			WVI
			ICDS
			MOH
				KPC	Ballia	NA	20	40	60

						8			
					Lalitpur	NA	10	30	60
						3			
					Moradabad	NA	25	40	60
						2			

13	% Communities with at least 80% of AWWs who registered & provided adequate counseling for at least 80% of mothers of children under 2	N = # AWW who report active support from Community Groups
		D = # AWW
			WVI
			ICDS
			WVI
			ICDS
			MOH
				AWW Registers	Ballia	NA	20	30	55

					Lalitpur	NA	20	30	55
					Moradabad	NA	20	30	55

14	% Communities with at least 80% of AWWs who registered and provided adequate counseling to at least 80% of eligible couples	N = # AWWs who registered and provided adequate counseling to all beneficiaries in the last quarter
		D = # AWWs
			WVI
			ICDS
			MOH
				AWW Registers	Ballia	NA	20	30	55

					Lalitpur	NA	20	30	55
					Moradabad	NA	20	30	55
15	% communities with at least 80% of AWWs receiving adequate support from community groups	N = Number of communities with NGO providing adequate support to AWWs D = Number of communities	WVI ICDS MOH	HWPA	Ballia	NA	20	-	60
					Lalitpur	NA	20	-	60
					Moradabad	NA	20	-	60

16	% children aged 12-23 months who have received at least one DPT vaccination	N = # children aged 12–23 months who have received at least one DPT vaccination (reported)
		D = # children aged 12–23 months
			WVI
			ICDS
			MOH
				KPC	Ballia	NA	60	80	95

						37			
					Lalitpur	NA	30	60	80
						12			
					Moradabad	NA	30	60	80
						12			

17	% Mothers of children 0-11 months who received the last expected home visit by an AWW	N = # mothers of children 0-11 months who received the last expected home visit by an AWW
		D = # mothers of children 0-11 months
			WVI
			ICDS
			MOH
				KPC	Ballia	NA			

					Lalitpur	NA			
					Moradabad	NA			

18	% MWRA who report having discussed FP issues with a health worker or promoter (AWW/ANM) in the past 12 months [FF6]	N = # MWRA who report having discussed FP issues with a health worker or promoter (AWW/ANM) in the past 12 months
		D = # MWRA
			USAID
			WVI
			ICDS
			MOH
				FP Survey	Ballia	NA			

					Lalitpur	NA			
					Moradabad	NA	NA	NA	NA
						NA	NA	NA	NA

19	% Population who live within 5 km of a family planning / reproductive health service delivery point [FF7]	N = # MWRA who report living within 5 km of a family planning / reproductive health service delivery point
		D = # MWRA
			USAID
			WVI
			ICDS
			MOH
				FP Survey	Ballia	NA			

					Lalitpur	NA			
					Moradabad	NA	NA	NA	NA
						NA	NA	NA	NA
20	# Beneficiaries reached by the FP program [FF9]	See and contextualize FF definition	USAID WVI ICDS MOH	Project Records	Ballia	NA			
					Lalitpur	NA			
					Moradabad	NA	NA	NA	NA
						NA	NA	NA	NA

21	% Infants who received correct dose and route of vaccinations from an ANM	N = # infants who use correct dose and route of vaccinations from an ANM
		D = # infants who received immunization from an ANM
			WVI
			MOH
				HWPA	Ballia	NA			

						39			
					Lalitpur	NA			
						57			
					Moradabad	NA			
						52			

22	% Pregnant women or mothers of an infant who received adequately targeted and timed counseling from an AWW.	N = # pregnant women or mothers of an infant who received adequately targeted and timed counseling from an AWW
		D = # pregnant women or mothers of an infant who received counseling from an AWW
			WVI
			ICDS
			MOH
				HWPA	Ballia	NA			

					Lalitpur	NA			
					Moradabad	NA			

23	% FP clients who received adequate counseling from AWWs [FF5]	N = # FP clients who received adequate counseling from AWWs
		D = # FP clients who received counseling from AWWs
			USAID
			WVI
			ICDS
			MOH
				HWPA	Ballia	NA			

					Lalitpur	NA			
					Moradabad	NA			

24	% MWRA who started using a method of FP at least 12 (or six) months ago who are still using the method	N = # MWRA who started using a method of FP at least 12 (or six) months ago who are still using the method
		D = # MWRA who started using a method of FP at least 12 (or six) months ago
			WVI
			ICDS
			MOH
				FP Survey	Ballia	NA	20	30	50

						12			
					Lalitpur				
						53			
					Moradabad				
						26			
25	# Sub-centers which had no stockouts in the past 6 months	# Sub-centers which had no stockouts in the past 6 months (vaccines; condoms, pill, CuT, Vitamin A syrup)	WVI MOH	HWPA	Ballia	NA	25	35	50
						16			
					Lalitpur	NA	10	20	50
						3			
					Moradabad	NA	35	45	70
						28			

26	% DPT1-III drop out rate	N = # children 12-23 months who received DPT1II immunization (card documented)
		N = # children 12-23 months who received DPT1 immunization (card documented)
			WVI
			ICDS
			MOH
				KPC	Ballia	NA	13	10	5

						15			
					Lalitpur	NA	30	25	20
						35			
					Moradabad	NA	25	20	15
						31			

27	% MWRA who know at least one source of FP method	N = # MWRA who know at least one source of FP
		D = # MWRA
			WVI
			ICDS
			MOH
				FP survey	Ballia	NA			

					Lalitpur	NA			
					Moradabad	NA	NA	NA	NA
						NA	NA	NA	NA
28	# of acceptors new to family planning [FF2]	# of acceptors new to family planning [FF2]	USAID WVI ICDS MOH	ICDS Reports based on AWW Registers	Ballia	NA			
					Lalitpur	NA			
					Moradabad	NA	NA	NA	NA
						NA	NA	NA	NA

29	% MWRA who report discussing FP issues with their spouse in the past 12 months [FF4]	N = # MWRA who report discussing FP issues with their spouse in the past 12 months
		D = # MWRA in the survey
			USAID
			WVI
			
			ICDS
			MOH
				FP survey	Ballia	NA			

					Lalitpur	NA			
					Moradabad	NA	NA	NA	NA
						NA	NA	NA	NA
30	# Cross visits of ADPs and project districts to ACOLES	# Cross visits of ADPs and project districts to ACOLES	WVI	Project Records	Ballia	NA			
					Lalitpur	NA			
					Moradabad	NA			
31	# Strategies, methods and tools satisfactorily documented	# Strategies, methods and tools satisfactorily documented	WVI ICDS MOH	Project Records		NA	2	4	5
						0			
32	# Blocks that have adopted documented strategies, methods and tools from BRICS	# Blocks that have adopted documented strategies, methods and tools from BRICS	WVI	Project Records	Ballia	17	17	17	17
					Lalitpur	3	6	6	6
					Moradabad	1	14	14	14
33	# Operations Research studies conducted, documented, and shared with partners	# Operations Research studies conducted, documented and shared with partners	WVI ICDS MOH	Project Records		NA			
						0			
34	Program has sustainability plan in place [FF8]	Existence of a sustainability plan, with FP component, in each district	USAID WVI	Project Records	Ballia	NA	1	1	1
					Lalitpur	NA	1	1	1
					Moradabad	NA	1	1	1

35	% of NGO partners that are capable of providing adequate support to AWWs	N= NGO partners that are capable of providing adequate support to AWWs D = Number of NGO partners	WVI	NGO Capacity Assessment MTE & FE	Ballia				
					Lalitpur				
					Moradabad				
36	% of communities competent for child survival	TO BE DETERMINED	WVI	Community Capacity Assessment MTE & FE	Ballia				
					Lalitpur				
					Moradabad				

Annex 10 Template for ICDS Household Survey

Form 1: Details of the Family

Fam. No.	Fam. Memb No.	Name of the head of family	Name of other family members	Relation to head of family	Gender M/F	Age Year / Mths	Put a tick Mark (✓) in the Appropriate Column							
							< 6 mths	6-8 mths	9-11 ms	1-3 yrs	3-5 yrs	5-6 yrs	10-19 yrs Adol. Girl	Pregn. Woman
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15

Form 1, continued

Religion or Caste (SC/ST/ OBC/GN)	Literacy Level	Occupation/ Service/ Farmer/ Labourer etc.	Monthly Income of Family		Unmarried/ Married/ Widow/ Widower	Type of Physical Disability	Weight of Child below 6 yrs (Kg)	Nutritional Level (Grade) General I/II/III/IV	Other details like birth, death etc.
			BPL	APL					
16	17	18	19	20	21	22	23	24	25

Annex 11 Proposed Template for Family Planning Register

FAMILY PLANNING REGISTER
Village:

General Information						Planned /Actual visit date	Quarter 1 Visit								
										Method to be used during next three months					
H.H. No.	Name of Woman	Name of Husband	Age	# Live children	Age of youngest child		User Y/N	New User Y/N	Drop Out Y/N	Pill # given	Condom # given	IUD	Fem. Steril	Male Steril	None[1]

[1] If no method will be used during the next three months, indicate one of the following possible reasons: Pregnancy; Desires a child; Side effect; No partner; Other.

FAMILY PLANNING REGISTER, Continued

COUNSELING PLAN USED Behaviors to follow up/ Comments	Planned /Actual visit date	Quarter 2 Visit									COUNSELING PLAN USED Behaviors to follow up/ Comments
		User Y/N	New User Y/N	Drop Out Y/N	Method to be used during next three months						
					Pill # given	Condom # given	IUD	Fem. Steril.	Male Steril.	None[1]	

[1] If no method will be used during the next three months, indicate one of the following possible reasons: Pregnancy; Desires a child; Side effect; No partner; Other.

Annex 12 Proposed Template for Pregnancy Register

PREGNANCY REGISTER
Village:

FIRST VISIT(4-5 months)										SECOND VISIT(6-7 months)			
Name	**Name Husband**	**Age**	**LMP**	**EDD**	**Date of this visit**	**PLAN 5**	**Behaviors to f/up**	**Date for Next Visit**	**TTI/IFA50 due/given dates**	**Date of this visit**	**PLAN 5 Review**	**PLAN 6**	**Date for III visit**

PREGNANCY REGISTER, Continued

TT II/IFA50 due/given dates	THIRD VISIT(8-9 months)			POST-PARTUM VISIT(within 2 days of delivery)			GO TO INFANT REGISTER If infant's name is not transferred to infant register, cite reason →
	Date of this visit	PLAN 6 review	PLAN 7	Date of this visit	Date of Delivery	Livebirth/Stillbirth/ Died after birth (# days)	

Annex 13 Proposed Template for Infant Register

Death of infants to be noted with date, age and probable cause of death

INFANT REGISTER
Village:

POST-PARTUM VISIT (Continued from Pregnancy Register)								BCG - Due / Given dates	FIRST WEEK VISIT		
Name Father	Name Mother	Sex	Date of Birth	Date of this visit	Weight	PLAN 8	Date Next visit		Date of this visit	PLAN 9	Date for Next Visit

INFANT REGISTER, Continued

DPT/OPV I Due/Given Dates	DPT/OPV II Due/Given Dates	DPT/OPV III Due/Given Dates	FIFTH MONTH VISIT				EIGHTH MONTH VISIT			Measles/Vit A Due/Given Dates
			Date of this visit	PLAN 10	Agreed behaviors	Date for Next visit	Date of this visit	PLAN 11	Agreed Behaviors	

Annex 14 Proposed Template for AWW Monthly Progress Reports

Monthly Progress Report

Name of AWW : **Month:**

Centre : **Year:**

No. of Houses visited this month:

PLAN 1	**PLAN 2 :**	**PLAN 3 :**	**PLAN 4 :**
PLAN 5 :	**PLAN 6 :**	**PLAN 7**	**PLAN 8 :**
PLAN 9:	**PLAN 10:**	**PLAN 10:**	**PLAN 11:**

Family Planning

No. of Users :

No. of New Users :

Method	No. of Clients	Drop-out	Drop-out Returned	Method Switch		No. of Packets Supplied
				In	Out	
Pill						
Condom						
LAM						
SDM						
IUD						
Injection						
Female Sterilization						
Male Sterilization						
Total						

Monthly Progress Report, Continued

Safe Motherhood

No. of Pregnant women identified this month :

Total No. of Pregnant women :

	No. Due:	No. Given:
TT-1		
TT-2		
IFA		

No. of Deliveries : **By trained :** **By Untrained :**

Institutional : **Others :**

Live Births :

Still birth/Died after birth :

Immunization

	No. Due:	No. Given:
BCG/OPV0		
DPT/OPV1		
DPT/OPV2		
DPT/OPV3		
Measles/Vitamin A		

Annex 15 BCC Plan: Eligible Couples

Targeted Audience	Behavior Change Messages	Behaviors to Follow Up
Newly Married (0-Parity) couples **PLAN 1**	Users: Follow up on method Non Users: Inquire about reproductive intentions Advantages of: - Delaying birth of first child - Spousal communication Appropriate FP methods (include SDM in OR areas)	Users: Follow up on method, supplies Non users: Decisions made, referral
Couples with 1-2 children (Low parity women) **PLAN 2**	Users: Follow up on method Non Users: Inquire about reproductive intentions Advantages of: - At least 3 year birth interval - Spousal communication Appropriate FP methods (include SDM in OR areas as well as LAM where appropriate)	Users: Follow up on method, supplies Non users: Decisions made, referral
Couples with 2 or more children **PLAN 3**	Users: Follow up on method Non Users: Inquire about reproductive intentions Advantages of: - At least 3 year birth interval - Limiting # children - Spousal communication Appropriate FP methods (include SDM in OR areas) and LAM where appropriate	Users: Follow up on method, supplies Non users: Decisions made, referral
Pregnant Women and Post Partum Mothers **PLAN 4**	Inquire about reproductive intentions Advantages of: - Early post partum initiation of FP methods - At least 3 year birth interval - Limiting # children - Spousal communication Appropriate FP methods (include SDM in OR areas) Introduce LAM to pregnant women in OR areas (2 blocks of Ballia)	Follow up on decision made – supplies, counseling, referral plan

Annex 16 BCC Plan: Pregnant Women and Mothers of Infants

Visit	Behaviors, Messages to communicate	Behaviors to follow up
Fourth/Fifth month of pregnancy **PLAN 5**	Nutrition - increased number of meals and increased amount at each meal Rest At least 100 IFA tablets TT2 vaccinations Vaccination card	
Sixth/Seventh month of pregnancy **PLAN 6**	PLAN 4, plus Preparing for Birth - Skilled attendance - Money - Transport	PLAN 1
Eighth/Ninth month of pregnancy **PLAN 7**	Initiation of breastfeeding within 1st hour. Colostrum Dissuade use of Prelacteals Drying and Wrapping No bath	PLAN 4 PLAN 6
Post-partum-For mother and Newborn **PLAN 8**	Exclusive Breastfeeding for 6 months	PLAN 4
First Week Visit **PLAN 9**	Vaccinations for the Baby	PLAN 4
Fifth month of child **PLAN 10**	Initiation of complementary feeds at 6 months of age – frequency, consistency, types of foods Continuation of breastfeeding	Immunizations – three DPT/OPV FP/BS decision/follow up Referral for methods
Seventh / Eighth month of child **PLAN 11**	Vitamin A Measles Immunization Increase in quantity and frequency of feeds	

Annex 17 Household Visit Card

Pregnancy Register							
First Visit			**Second Visit**			**Third Visit**	
Timing:	Fourth/Fifth month of pregnancy	TT1	**Timing**	Sixth/Seventh month of pregnancy	TT2	**Timing**	Eighth/Ninth month of pregnancy
Name and Age	Fill the woman's name, name of husband and the woman's age		**Date this visit**	Write today's date		**Date this visit**	Write today's date
LMP	Write the first day of the last menstrual period		**Review of BCC1**	Enquire about BCC1 Behaviors - One extra meal a day, IFA consumption and TT1		**Review of BCC2**	Enquire about BCC2 messages - Reproductive intentions, birth preparedness
EDD	Add 9 months and 7 days to the last menstrual period		**BCC2**	Reproductive intentions, benefits of spacing, methods available, birth preparedness		**BCC3**	Initiate breastfeeding within the hour of birth, Feed colostrum, dissuade use of prelacteals, warmth/no bath for baby, immunizations
Date this visit	Write today's date		**Date next visit**	Write date for next visit (about 2 months from now)			
BCC1	One extra meal a day, 100 IFA tablets, TT2						
Behaviors	Note behaviors to follow up						
Date next visit	Write date for next visit (about 2 months from now)						

Pregnancy Register, Continued			Infant Register				
Post-partum Visit						**First week visit**	
Timing	Within 2 days of delivery	**GO TO INFANT REGISTER**	**Names**	Write names of father and mother	**BCG**	**Timing**	Within the first week after delivery
Date this visit	Write today's date		**Sex**	Write sex of the baby		**Date this visit**	Write today's date
Date of delivery	Write date of delivery		**Date of Birth**	Write date of birth of the baby		**BCC4**	Reinforce behaviors communicated during post-partum visit, include DPT/OPV vaccinations
Details	Livebirth, stillbirth or died after birth, sex of baby		**Weight**	Weigh and note the weight in KG		**Date next visit**	Write the date of next visit, about 5 months from now
			Date this visit	Write the date of this visit. Should be the same as the visit date in post-partum visit in Pregnancy Register			
			BCC4	BCG, vaccination card, exclusive breastfeeding for 6 months, FP decisions, referral for clinical FP			
			Date next visit	Write the date of next visit - one week from now			

Infant Register, Continued

			Fifth Month visit			Eighth Month Visit		
DPT/OPV I	DPT/OPV II	DPT/OPV III	**Timing**	When the infant is about 5 months old		**Timing**	When the infant is about 8 months old	Measles/ Vitamin A
			BCC6	Initiation of complementary feeds - frequency, consistency, types of food, continue breastfeeding, FP decisions, follow up		**Date this visit**	Write the date of this visit	
			Agreed behaviors	Enquire about what feeding practices mother/care giver agree to do, and note them		**BCC7**	Increase in quantity and consistency of foods, FP decisions, Measles and vitamin A	
			Date for next visit	Write date of next visit, about 3 months from now		**Agreed behaviors**	Enquire about what feeding practices mother/care giver agree to do, and note them	

Annex 18 CATALYST/ India Technical Assistance Work Plan

PROGRAM	ESSENTIAL ACTIVITIES	ASSIGNED RESPONSIBILITY	DATE
Develop PRAGATI management plan, work plan and monitoring and evaluation plan with WV	Project planning meeting DIP workshop	CATALYST India WV India	March 2004
Support for a full-time FP Coordinator	A full time coordinator will be appointed by CEDPA by March 2004 Posted in Delhi and based in the WV/Delhi office, with travel to the two districts (Ballia and Lalitpur) of Uttar Pradesh, India	Day to day guidance from Beulah Jayakumar Managerial and technical support from Ravi Anand	Beginning of project to September 2005
Assist in preparation and Baseline family planning survey in Ballia and Lalitpur	Develop survey guidelines and questionnaires Support a portion of the field testing of the FP questionnaire	MODE to collect and enter data, with TA and funding from Catalyst	April 2004
Health Facility Assessment	TA to WV/India to incorporate a small number of select FP items into tool that will be used to assess facilities.		April 2004
Contraceptive Technology Update (CTU) for WV/I technical staff and technical staff from select partner organizations	Design, develop relevant training materials and facilitate training CTU Training (one batch) for a minimum of three days in Ballia or Lucknow	Ravi Anand FP coordinator	April 2004

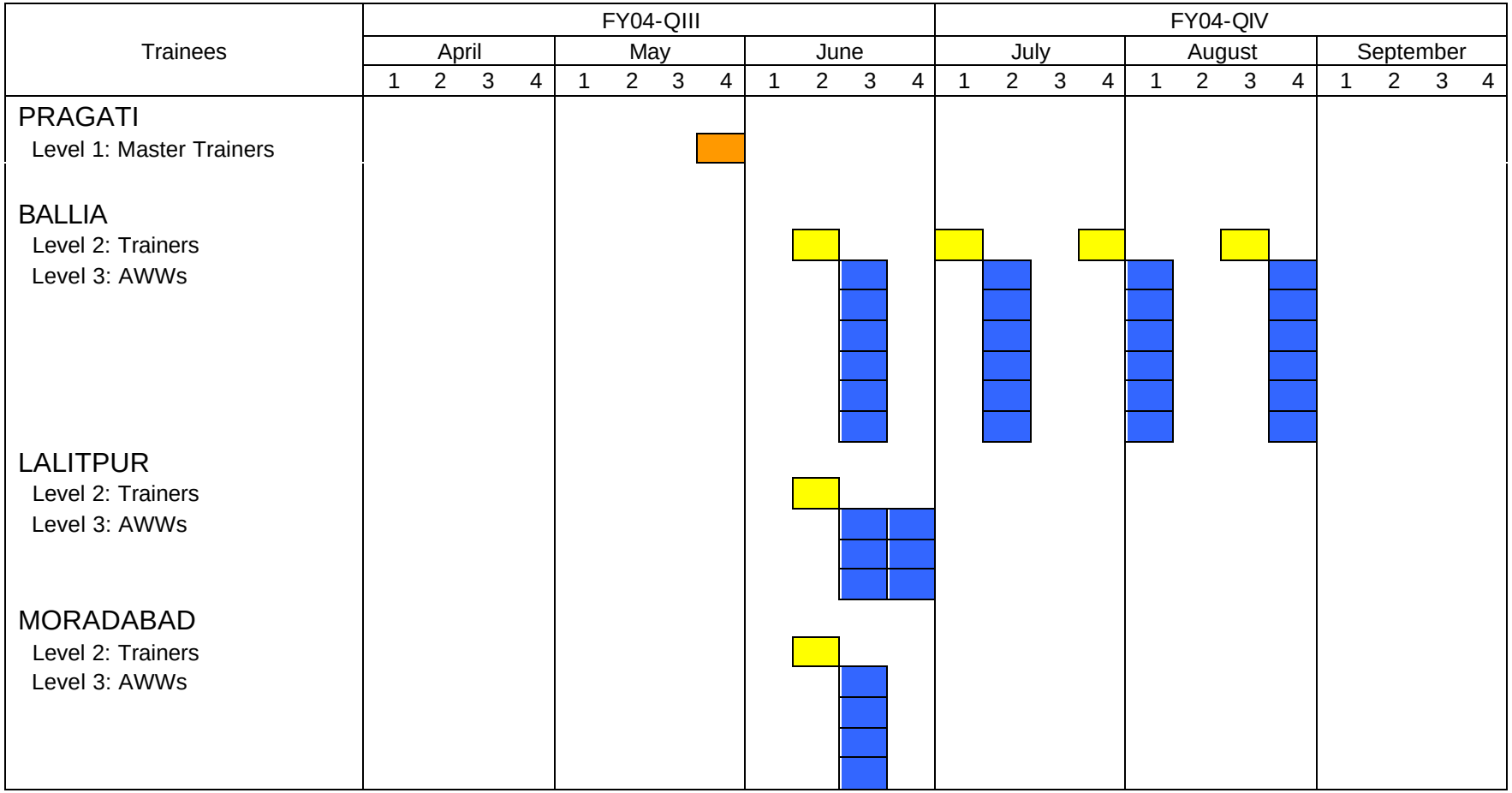
PROGRAM	ESSENTIAL ACTIVITIES	ASSIGNED RESPONSIBILITY	DATE
Development and integration of family planning components into World Vision/India's Program Implementation Manual and Training Guide.	Review and update FP components of Program Implementation Manual and Training Guide. Review and update/revise other materials like flipbook, handbook for Anganwadi Workers. Development of training package for supervisors (NGO personnel) with FP and Supportive Supervision components.	Ravi Anand	June 2004

PROGRAM	ESSENTIAL ACTIVITIES	ASSIGNED RESPONSIBILITY	DATE
Training • Master Trainers (MTOT) • Trainers (TOT) • NGO personnel (Orientation) • AAnganwadi Workers • Supervisors	Design and develop relevant FP materials to be included in Training package that WV/India is going to use for training Anganwadi Workers. Includes FP training objectives, and sessions on FP methods, FP counseling and record keeping of FP clients. Design TOT for trainers and developing relevant material for them Facilitate MTOT (6 days for one batch of 6-8 participants in Ballia). Orient approximately 34 NGO personnel in one batch for 5 days in Ballia. Mentor Master trainers during Training of Lead Trainers (TOT in three batches for 68 participants from Ballia and Lalitpur.) Monitoring training of AWWs (a few batches out of the total 55 batches) Facilitating FP sessions during Training of Supervisors	Ravi Anand FP coordinator Others from Catalyst as and when required	Based on PRAGATI training program in the DIP

PROGRAM	ESSENTIAL ACTIVITIES	ASSIGNED RESPONSIBILITY	DATE
Documenting Lessons Learned	Documenting collaboration between Catalyst and World Vision (partnership between a CA (Catalyst) and a high functioning PVO; how the relationship started, the mission's involvement, the existing capacity of the PVO and what was added) Documentation of the process of program design to increase the likelihood of programmatic activities continuance beyond the program. Documentation of the attempt to link the MoH with the Integrated Child Development Scheme (ICDS) at the community level		End of 2005

Annex 19 AWW Training Schedule

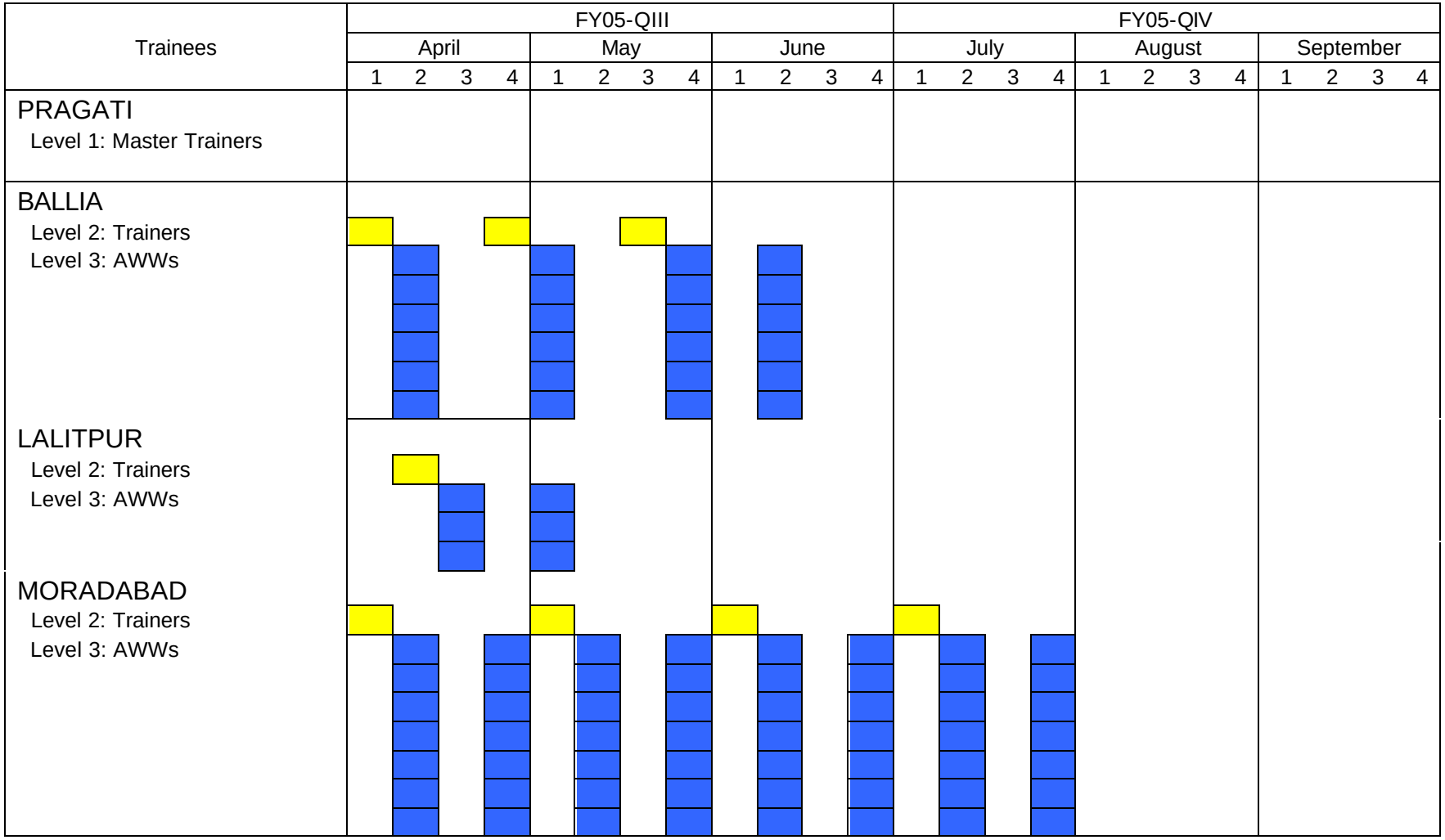
Semester 1



Semester 2

Trainees	FY05-QI												FY05-QII											
	October				November				December				January				February				March			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
PRAGATI Level 1: Master Trainers																								
BALLIA Level 2: Trainers Level 3: AWWs																								
LALITPUR Level 2: Trainers Level 3: AWWs																								
MORADABAD Level 2: Trainers Level 3: AWWs																								

Semester 3


Trainees
FY05-QIII
FY05-QIV
April
May
June
July
August
September
1 2 3 4 1 2 3 4 1 2 3 4 1 2 3 4 1 2 3 4 1 2 3 4
PRAGATI
Level 1: Master Trainers
BALLIA
Level 2: Trainers
Level 3: AWWs
LALITPUR
Level 2: Trainers
Level 3: AWWs
MORADABAD
Level 2: Trainers
Level 3: AWWs

Annex 20 Agreements

(Translated from Hindi)

LETTER FROM MOH

From
The Director General,
Directorate of Family Welfare
Uttar Pradesh, Lucknow

To
The Chief Medical Officers
Ballia, Lalitpur and Moradabad

Letter #: RCH/5/2003-04 Date: 14.01.2004

Sub: Reg the USAID funded Child Survival Project implemented in Ballia, Lalitpur and Moradabad districts by World Vision.

Respected Sirs,

World Vision has been awarded a four year Child Survival Project by USAID, to be implemented in the above three districts.

This Project will work on various activities and operations related to routine immunization, birth spacing, nutrition and vitamin A.

It is requested that you offer all support to the Project's staff and its activities in your districts and also keep the undersigned informed of all the programs.

Sincerely
(signed)
Dr Chittaudia
Joint Director, RCH
For Dr LB Prasad, Director General, FW

Cc: Project Manager, WV Child Survival Project

(translated from Hindi)

LETTER FROM ICDS

Directorate
Child Development and Nutrition, UP
Third Floor, Indira Bhawan
Lucknow

Letter #: C-8148/ICDS/2003-04 Date: 23.01.04

To
District Program Officers
Ballia, Lalitpur, Moradabad
Sub: Reg. Child Survival Project implemented by World Vision

The Child Survival Project referred to above, will be implemented in your districts by World Vision. This Project will implement the following interventions:

1. Immunization
2. Birth Spacing
3. Breastfeeding
4. Vitamin A

You are directed hereby to establish and continue good working relationships with this Project in your districts so that the ICDS program may be strengthened through the activities of this Project and beneficiaries may receive maximum gains through this effort.

At the Directorate, Dr Amita Jain, Deputy Director (IEC) will be the coordinator for you regarding this Project.

(signed)
Chandra Prakash
Director

Cc: Dr Beulah Jayakumar, Manager, World Vision Child Survival Project

(Received in English)

STATE PROJECT MANAGEMENT UNIT
ICDS III PROGRAMME
III Floor, Indira Bhawan
Lucknow UP
Ph: 0522-2287056, 2287057

Ref No: 8447/ICDS III/2003-04 Dated: 27 March 04

To:
Dr Beulah Jayakumar
Project Manager
World Vision
Post Box – 25
NCC Chouraha, Harpur
Ballia – 277 001, UP

Madam

This has reference to your letter dated 6 March 2004 on the subject noted.

We have already accorded our consent to the Project vide our letter no C-8148 dated 23.01.04.

We have also gone through the proposed roles, received vide your afore said letter and we have found nothing objectionable to it. We will do the needful at our end, in accordance with it.

Yours sincerely

(signed)

Chandra Prakash
State Project Director

Annex 20 Job Description for Anganwadi Workers

The main tasks of the Anganwadi Workers are defined by ICSD as:

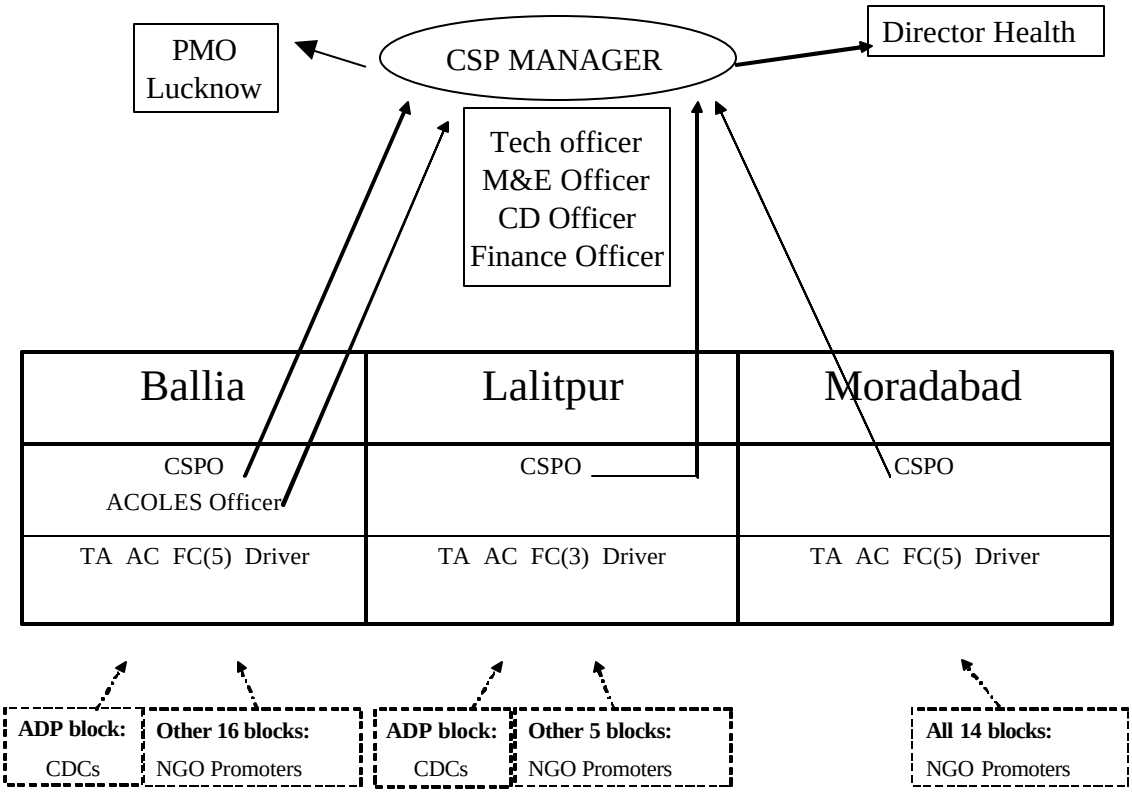
I. Identification of beneficiaries

- Conduct the survey in her respected area twice in a year.
- Compile survey results.
- Identify and list the target beneficiaries.
  i. Pregnant Women
  ii. Lactating mothers (0 – 5 months)
  iii. Adolescent girls
  iv. Children (up to 5 years)

II. Preparing and distributing of complementary food

- Growth monitoring of children up to 5 years (monthly monitoring up to 3 years)
- Identify severely malnourished and high risk pregnant women and refer to Primary Health Centre, Community Health Centre, District hospitals and others
- To motivate and provide awareness about immunization and assist ANM.
- Preschool education to the children of (3- 5 years)
- To conduct Mahila Mandals and organize NHE (Nutritional Health Education)
- To conduct home Visits

Annex 21 PRAGATI Organizational Chart



Acronyms:

AC	Accountant
CD	Capacity Development
CDC	Community Development Coordinator
CSP	Child Survival Project
CSPO	Child Survival Project Officer
FC	Field Coordinator
M&E	Monitoring and Evaluation
PMO	Program Monitoring Office (World Vision)
TA	Technical Assistant

Annex 22 PRAGATI Current Hiring Status

PRAGATI staff positions and hiring status as of June 2004

#	Position	Number of positions	
		Available	Filled
1.	Project manager	1	1
2.	Monitoring and evaluation officer	1	1
3.	Capacity building and documentation officer	1	1
4.	ACOLES officer	1	1
5.	Family planning coordinator	1	1
6.	Finance officer	1	1
7.	Technical officer	1	1
8.	Project officer (one in each district)	3	3
9.	Technical assistant (one in each district)	3	2
10.	Accountant (one in each district)	3	3
11.	Field coordinator (5 in B, 3 in L, 5 in M)	13	3
12.	Driver (one in each district)	3	0

Annex 23 Job descriptions for PRAGATI staff

PRAGATI Child Survival Project

JOB DESCRIPTION

Position: Child Survival Project Manager (1)

Category: Leadership. The National Child Survival Coordinator is seconded 100% to this Position.

Location: Lucknow

Reporting to: Director, Health and HIV/AIDS Initiatives

Summary of Responsibilities
Provide overall direction and lead the entire CSP team in achieving project goals and objectives.

Job Details:

- Keep abreast of developments in public health, child survival and health in particular, through systematic research and reading.
- Design and implement the Project's strategy and workplan along with the Project teams.
- Ensure cohesive functioning of the coordination team and the three project teams in day-to-day implementation details.
- Ensure that all reporting requirements of USAID's CSHGP are met in a timely and accurate manner.
- Establish and nurture good working relationships with the Project's public and private partners at the state and district levels.
- Liaise with national and international agencies in accessing state of the art technical resources for the Project.
- Ensure that adequate and relevant capacity development opportunities are made available to and are used, for the entire CSP II team.

Requirements of Knowledge, Skills and Abilities

- Postgraduate in medicine/public health
- At least 3 years experience in leading a community health project
- High standards of stewardship and accountability
- Excellent interpersonal and communication and presentation skills
- Ability to nurture and build the project team.
- Excellent in written and spoken English and spoken Hindi. Writing ability in Hindi a plus
- Knowledge of MS Office and DOS applications. Good typing speed
- Sensitiveness to the political and cultural context in which the project operates.
- Travel 30 – 50% of the time to the three program districts.

PRAGATI Child Survival Project

JOB DESCRIPTION

Position: Monitoring and Evaluation Officer (1)

Category: Technical

Location: Lucknow

Reporting to: CS Project Manager

Summary of Responsibilities
Set up the Project's information system; ensure that timely and accurate information is available for all levels.

Job Details:

- Keep abreast of developments in the field of M&E in public health, through systematic research and reading
- Work with the Project's public and private partners in designing the PME plan and work plan, in accordance with the guidelines from CSHGP.
- Develop, field test and update appropriate supervisory and monitoring tools to track progress towards objectives.
- Coordinate collection and analysis of routine data at population and service levels in the three program districts.
- Design and conduct non-routine qualitative and quantitative surveys in the three program districts.
- Work with the Capacity Building Officer in designing and conducting MIS related training for project staff and for partners.
- Ensure timely reporting of data to PMO/NO and to WV US and USAID.
- Ensure use of data at the community level
- Ensure proper storage of electronic and hard copies of all data.
- Any other responsibilities as delegated by the CS Project Manager

Requirements of Knowledge, Skills and Abilities

- Postgraduate in social sciences
- At least 2 years experience in MIS in a community health project
- High standards of stewardship and accountability
- Strong analytical and interpretative skills
- Excellent interpersonal and communication and presentation skills
- Ability to work in a multicultural team.
- Excellent in written and spoken English and spoken Hindi. Writing ability in Hindi a plus
- Knowledge of MS Office and DOS applications. Good typing speed
- Sensitiveness to the political and cultural context in which the project operates.
- Travel 30-50% of the time to the three program districts.

PRAGATI Child Survival Project

JOB DESCRIPTION

Position: Capacity Building and Documentation Officer (1)

Category: Technical

Location: Lucknow

Reporting to: CS Project Manager

Summary of Responsibilities
Develop and implement a systematic capacity development plan for personnel and organizational development of the Project's staff and partners.

Job Details:

- Keep abreast of developments in the field of public health, child survival in particular, through systematic research and reading.
- Identify training needs of staff and partners and incorporate capacity development plans into the Project's design and work plan.
- Work with the Project Manager, Technical Officer and agencies providing TA, in designing training modules, curricula and QI tools.
- Access resources on child survival, adapt and use them in the Project's implementation.
- Document the processes, lessons learned and promising practices of the Project.
- Maintain the Project's central resource center and the Project's key documents.
- Coordinate on site trainings at the three program districts for its public and private partners.
- Prepare the Project's monthly and quarterly program reports, quarterly newsletter and other material.
- Any other responsibility as delegated by the CS Project Manager.

Requirements of Knowledge, Skills and Abilities

- Post graduate in social sciences, with specialization in personnel development
- At least two years' experience in a community health project
- High standards of stewardship and accountability
- Excellent interpersonal and communication and presentation skills
- Ability to work in a multicultural team.
- Excellent in written and spoken English and spoken Hindi. Writing ability in Hindi a plus
- Knowledge of MS Office and DOS applications. Good typing speed
- Sensitiveness to the political and cultural context in which the project operates.
- Travel 30 – 50% of the time to the three program districts.

PRAGATI Child Survival Project

JOB DESCRIPTION

Position: ACOLES Officer (1)

Category: Technical

Location: Ballia

Reporting to: CS Project Manager

Summary of Responsibilities
Facilitate the development of BRICS site into a Center for Adaptation, Co-learning and Experimentation for Scale Up (ACOLES) where project partners from all three program districts learn delivery models, scaleable strategies and tools hands on.

Job Details:

- Keep abreast of developments in the field of public health, child survival in particular through systematic reading and research
- Work with JHU and with the CSP team in designing the conduct of ACOLES as an Operations Research Project, and at least two other ideas for case study/OR in Ballia district**.** Develop and test analysis templates for use of EPI and other data for community level decision making, in other WV ADPs in North India
- Draw up annual and monthly workplans for the Ballia program district with all partners.
- Ensure quality at every step of implementation by effective monitoring of field
- Convene regular meetings of all partners and discuss progress of the project and provide feedback
- Provide regular feedback on field activities to the ADP Manager and CS Project Manager
- Liaise with district and block level health and other departments for effective field implementation.
- Monitor field activities for quality and coverage.
- Send monthly and quarterly program and finance reports to Coordination team.

Requirements of Knowledge, Skills and Abilities

- Postgraduate in medicine/public health/social sciences with training in research
- At least 3 years experience in leading a community health/research project.
- High standards of stewardship and accountability
- Excellent interpersonal and communication and presentation skills
- Ability to nurture and build the project team.
- Excellent in written and spoken English and spoken Hindi. Writing ability in Hindi a plus
- Knowledge of MS Office and DOS applications. Good typing speed
- Sensitiveness to the political and cultural context in which the project operates.
- Travel extensively within and outside Ballia district.

PRAGATI Child Survival Project

JOB DESCRIPTION

Position: Family Planning Coordinator (1)

Category: Technical

Location: Lucknow

Reporting to: CS Project Manager / Reproductive Health Advisor, CEDPA

Note: The FP Coordinator will be employed by Catalyst/India and seconded to World Vision/India

Summary of Responsibilities:
Provide technical oversight and assistance related to Family Planning

Job Details:
- Keep abreast of developments in the field of public health especially Family Planning through systematic research and reading
- Access resources on Family Planning and Reproductive Health and adapt them for the project's implementation
- Work with the project's public and private partners in designing and implementing the FP component of the DIP
- Assist in data entry and preparation of report of FP survey
- Identify training needs of World Vision staff and partners and incorporate capacity development plans into the project's design and work plan
- Review and update WV's training materials, adding FP component in each of them
- Design training curricula, develop relevant training modules and QI tools and facilitate trainings related to the project
- Develop, field test and update appropriate supervisory and monitoring tools to track progress towards objectives in FP
- Work with World Vision's Child Survival team in designing and conducting non routine qualitative and quantitative surveys in program districts
- Coordinate collection and analysis of routine data at population and service levels in the program districts
- Monitor implementation of FP component in the program districts
- Document the processes, lessons learnt an promising practices of the project
- Any other assignment as delegated by the Supervisor

Requirements of Knowledge, Skills and Attitudes
- Post Graduate in Social Sciences/Medical Graduate with complete knowledge of Family Planning and its various Methods
- FP Trainer with at least two years experience
- At least two years experience in community health project

- High standards of stewardship and accountability
- Excellent interpersonal communication and presentation skills
- Ability to work in a multicultural team
- Excellent written and spoken English and Hindi
- Knowledge of MS Office and DOS Applications. Good typing speed. Equally competent on the Computers in English & Hindi.
- Sensitiveness to the political and cultural context in which the project operates
- Travel 30-50% of the time to the program districts

PRAGATI Child Survival Project

JOB DESCRIPTION

Position: Finance Officer (1)

Category: Technical

Location: Lucknow

Reporting to: CS Project Manager

Summary of Responsibilities
Responsible for financial management of the Project and ensuring adherence to USAID's requirements.

Job Details:

- Ensure smooth and effective, two way flow of financial information between the program districts and the PMO/NO & WV US.
- Train staff of all three program districts in USAID requirements especially cost allocations and labor distribution.
- Conduct sample checks on book keeping in program districts and with partners and ensure quality and integrity in all financial dealings.
- Prepare monthly, quarterly and annual financial reports in a timely and accurate fashion.
- Provide feedback and support the CS Project Manager in financial planning, projections and analysis and keep spending on track.
- Any other responsibilities as delegated by the CS Project Manager.

Requirements of Knowledge, Skills and Abilities

- Graduate/Postgraduate in commerce
- Trained in USAID grant regulations.
- Conversant in SUN accounting system. Knowledge of MS Office and DOS applications. Good typing speed
- High standards of stewardship and accountability
- Strong analytical and interpretative skills.
- Excellent interpersonal and communication and presentation skills
- Ability to work in a multicultural team.
- Excellent in written and spoken English and spoken Hindi. Writing ability in Hindi a plus
- Sensitiveness to the political and cultural context in which the project operates.
- Travel 30 – 50% of the time to the three program districts.

PRAGATI Child Survival Project

JOB DESCRIPTION

Position: Technical Officer (1)

Category: Technical

Location: Lucknow

Reporting to: CS Project Manager

Summary of Responsibilities
Provide technical oversight to the Project and keep the technical interventions from drifting.

Job Details:

- Keep abreast of the developments in the field of public health, child survival in particular, through systematic research and reading.
- Work with M&E and Capacity Building officers in designing/updating tools, manuals and curricula.
- Access resources on child survival, adapt and use them in the Project's implementation.
- Provide technical inputs into the training plans designed by the Capacity Building Officer
- Coordinate the activities of Technical Assistants in the three program districts.
- Monitor on site trainings for technical soundness
- Any other responsibilities as delegated by the CS Project Manager

Requirements of Knowledge, Skills and Abilities

- Medical/Public Health graduate
- At least two years' experience in a community health project
- High standards of stewardship and accountability
- Excellent interpersonal and communication and presentation skills
- Ability to work in a multicultural team.
- Excellent in written and spoken English and spoken Hindi. Writing ability in Hindi a plus
- Knowledge of MS Office and DOS applications. Good typing speed
- Sensitiveness to the political and cultural context in which the project operates.
- Travel 30 – 50% of the time to the three program districts.

PRAGATI Child Survival Project

JOB DESCRIPTION

Position: Child Survival Project Officer (3)

Category: Leadership

Location: Moradabad / Lalitpur districts, UP

Reporting to: CS Project Manager/ADP Manager

Summary of Responsibilities
Provide overall direction to field activities in the respective program district and lead the field team in day-to-day implementation

Job Details:

- Draw up annual and monthly work plan for the district with
- Supervise and coordinate the work of the Technical Assistant, Field Coordinators, and CSP Accountant.
- Convene regular meetings of all partners and provide feedback on the progress of the project.
- Provide regular feedback on field activities to the ADP Manager and to the CSP Manager.
- Liaise with district and block level health and other departments for effective field implementation.
- Monitor field activities for quality and coverage.
- Send monthly and quarterly program and finance reports to the Coordination team.
- Other responsibilities as delegated by the CS Project Manager.

Requirements of Knowledge, Skills and Abilities

- Postgraduate in social sciences
- At least two years' experience in leading a community health/development project.
- High standards of stewardship and accountability
- Excellent interpersonal and communication and presentation skills
- Ability to work in a multicultural team.
- Conversant in English. Excellent written and spoken Hindi.
- Knowledge of MS Office.
- Sensitiveness to the political and cultural context in which the project operates.
- Travel extensively in the program district.

PRAGATI Child Survival Project

JOB DESCRIPTION

Position: Technical Assistant (3)

Category: Technical

Location: Ballia / Moradabad / Lalitpur

Reporting to: CS Project Officer of the respective district.

Summary of Responsibilities
Responsible for technical soundness of all field activities in the respective program district

Job Details:

- Work with the CS team of the district in drawing up a training plan for the staff and partners of the district.
- Coordinate all training programs in the district.
- Monitor on site trainings for quality and provide feedback.
- Maintain stock of all training related material.
- Maintain the project's resource center.
- Monitor the day-to-day field activities and provide support and supervision to field staff and grassroots volunteers in improving quality of field activities.
- Facilitate good working relationship between the different partners at the community level.

Requirements of Knowledge, Skills and Abilities

- Diploma/Degree in Nursing/Public Health
- At least two years' experience in community health project.
- High standards of stewardship and accountability
- Excellent interpersonal and communication and presentation skills
- Ability to work in a multicultural team.
- Conversant in English. Excellent written and spoken Hindi.
- Sensitiveness to the political and cultural context in which the project operates.
- Travel extensively in the program district.

PRAGATI Child Survival Project

JOB DESCRIPTION

Position: Accountant (3)

Category: Technical

Location: Ballia, Moradabad and Lucknow

Reporting to: CS Project Officer

Summary of Responsibilities
Responsible for financial management and ensuring adherence to USAID's requirements in the program district.

Job Details:

- Ensure smooth and effective, two way flow of financial information between the program district and the CS Coordination team.
- Supervise CS staff of the program district in USAID requirements especially cost allocations and labor distribution.
- Conduct sample checks on book keeping in program districts and with partners and ensure quality and integrity in all financial dealings.
- Prepare monthly, quarterly and annual financial reports in a timely and accurate fashion.
- Provide feedback and support the CS Project Officer in financial planning, projections and analysis and keep spending on track.
- Any other responsibilities as delegated by the CS Project Officer

Requirements of Knowledge, Skills and Abilities

- Graduate/Postgraduate in commerce
- Training in USAID grant regulations a definite plus.
- Conversant in SUN accounting system. Knowledge of MS Office and DOS applications. Good typing speed
- High standards of stewardship and accountability
- Strong analytical and interpretative skills.
- Excellent interpersonal and communication skills
- Ability to work in a multicultural team.
- Conversant in English. Excellent written and spoken Hindi. Knowledge of local dialect a distinct advantage.
- Sensitiveness to the political and cultural context in which the project operates.
- Travel at least 20% of the time within the district.

PRAGATI Child Survival Project

JOB DESCRIPTION

Position: Field Coordinator (13)

Category: Development

Location: Ballia, Moradabad and Lalitpur

Reporting to: CS Project Officer/ACOLES Officer

Summary of Responsibilities
Ensure timeliness and quality in Child Survival field activities in the assigned area.

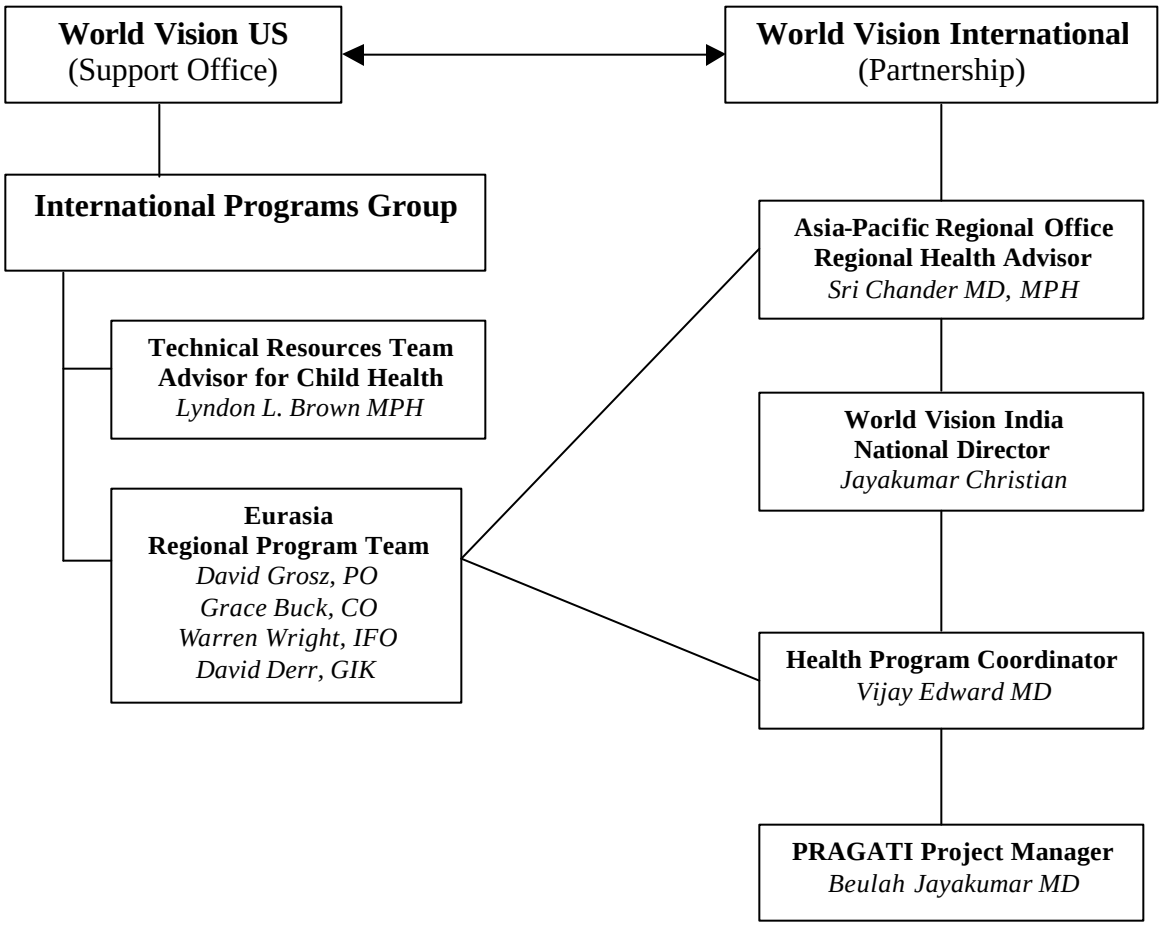
Job Details:

- Assist the CS Project Officer in drawing up annual and monthly workplans
- Support and supervise ADP and NGO staff and grassroots workers in the field activities in order to continuously improve quality and coverage
- Ensure that routine data and reports from the field area are timely and accurate
- Facilitate/nurture relationships between the project's workers and the private and public partners.
- Supervise on site trainings for quality
- Provide regular feedback on field activities to NGO partners, and ADP/CS Team
- Network with the block level health and administration departments for implementation of CS activities.

Requirements of Knowledge, Skills and Abilities

- Graduate
- At least two years' experience in leading a community health/development project.
- High standards of stewardship and accountability
- Excellent interpersonal and communication and presentation skills
- Ability to work in a multicultural team.
- Conversant in English. Excellent written and spoken Hindi. Knowledge of local dialect a distinct advantage.
- Computer literacy.
- Sensitiveness to the political and cultural context in which the project operates.
- Travel extensively in the assigned area.

Annex 24 World Vision / PRAGATI Organizational Chart



Legend:
CO = Contracts Officer
GIK = Gift In Kind
IFO = International Finance Officer
PO = am Officer

Annex 25 Sustainability Framework

Immediate Stakeholders: Health services ICDS WV CSP SIFPSA Communities, mothers, groups	**Distant Stakeholders:** Panchayats (local governance structures) NABARD, Rural Bank. UNICEF (total Hygiene Drive) District Rural Development Authority. Deputy Labor Commissioner Basic Education Officer

VISION
All children survive their first five years and all mothers survive their pregnancy, delivery and post-partum period. Health services and information are of good quality, are timely and reach all children. Community groups, families and service providers work together to bring services and the beneficiaries closer to each other. Mothers are empowered to act on the information to care for their children. Communities know and exercise their rights to quality health services.

HEALTH STATUS	HEALTH SERVICES	CAPACITY OF PARTNERS	COMMUNITY COMPETENCE & SOCIAL ENVIRONMENT
GOALS			
• Maternal and infant mortality rates are reduced • Mothers know and practice critical child health behaviors • All children are well-spaced and well-nourished and receive timely preventive services & appropriate immunization & micronutrients • Mothers know & practice appropriate feeding behavior for their children	• All beneficiaries are identified and reached with timely information and services that are of improved quality.	• Health services and ICDS workers are motivated, capable, confident, and enabled to provide timely and quality services. Co-ordination between health services, ICDS and communities is improved. • Local NGO's are competent, resourceful and recognized.	• Communities create an enabling environment for ANMs & AWWs to work together in providing timely & quality services. • Communities mobilize beneficiaries for utilization of services. • Communities are able to ensure that services are provided to the poorest and most vulnerable • Communities are aware of key health behaviors for mother & child health & incorporate them into their belief systems

HEALTH STATUS	HEALTH SERVICES	CAPACITY OF PARTNERS	COMMUNITY COMPETENCE & SOCIAL ENVIRONMENT
ELEMENTS			
• Full immunization of children by first birthday & of pregnant women with at least two doses of TT • Supplementation of pregnant women with 100 IFA • Exclusive breastfeeding until 6 months & initiation of complementary feeding later on. • Vitamin A supplementation of children 6-59 months. • Good nutrition of children (no stunting or wasting). • Institutional deliveries of children. • Adequate birth spacing • Improved knowledge of mothers/caregivers on key health behaviors. • Low maternal mortality ratio	**Health Services** • Adequate & timely supply of drugs/vaccines/other supplies • Availability/mobility of ANM • Complete beneficiary listing • Practice of safety procedures • **ICDS** • Early & complete registration of beneficiaries • Complete geographic reach of the AWW services • Regular provision of health services & information by AWWs. • AWWs reside in the communities they serve, or are sufficiently mobile • Volunteer women leaders are role models for & communicate health messages to the community. • **NGOs** • Co-ordination of Government services through advertisement, propaganda,	**Health Services** • Technical knowledge & skills appropriate • Supervision & motivation. • Sub Center rent & infrastructure • Improved cold chain at PHC level • Equipment • On the Job training. • Micro level planning at sub centre/village level. • Improved confidence of ANMs in providing services • **ICDS** • Improved communication skills of AWWs, availability & utilization of communication materials • AWW able to plan their work • Improved technical capacity and skills of AWWs. • Role clarification/coordination between AWW/ ANM, MS, LHV & other levels.	• Access to information • Participation • Empowerment • Leadership • Changed perception towards preventive services. • Community groups actively assist the AWW/Local NGO's in mobilizing beneficiaries. • Point persons (women) in each village/hamlet support the work of the ANM and AWW. • Improved knowledge on key behaviors in the community groups. • Improved village level hygiene (solid & liquid waste disposal) use of latrines. • Groups contribute significantly to dissemination of knowledge on caregiver behavior. • Monitoring of health worker performance (ANM & AWW)

HEALTH STATUS	HEALTH SERVICES	CAPACITY OF PARTNERS	COMMUNITY COMPETENCE & SOCIAL ENVIRONMENT
	• Demand creation & fulfillment of community needs	• Increased timeliness, relevance, & completeness of reporting by AWWs • Support from community groups • Availability of district forum for AWWs to discuss grievances & suggestions for improvements. • Improved infrastructure for AWW • Improved timeliness & regularity of AWWs services. • **NGOs** • Technical knowledge & supervision capacity of workers • Improved leadership capacity • Improved local organizations (SHGs, Mahila Mandals) • Increased fund raising capacity • Networking capacity (Government / NGO/ Dept/ Organization)	