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World Vision Relief & Development, Inc.

**SPECIAL EVALUATION
NAWAPUR
INTEGRATED CHILD SURVIVAL PROJECT
DHULE DISTRICT
MAHARASHTRA, INDIA**

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Submitted to:

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GLOSSARY OF TERMS AND ABBREVIATIONS

ANM	Auxiliary Nurse Midwife
AWW	Anganwadi Worker
BCG	Baccilus Calmette Guerin
BDO	Block Development Worker
CHW	Community Health Worker
DHO	District Health Office
DPT	Diphtheria, Pertussis, Tetanus
EPI	Expanded Program of Immunization
GOI	Government of India
ICDDR	International Center for Diarrheal Disease Research in Bangladesh
ICDS	Integrated Child Development Services
IMR	Infant Mortality Rate
KAP	Knowledge Attitude Practice
MCH	Maternal and Child Health
MOHFW	Ministry of Health and Family
NGO	Non-Governmental Organization
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
PHN	Public Health Nurse
TBA	Traditional Birth Attendant
UNICEF	United Nations Children's Fund
VAC	Vitamin A Capsule
VDW	Village Development Worker
VHG	Village Health Guide
VHW	Village Health Worker
WHO	World Health Organization
WV	World Vision

NAWAPUR CHILD SURVIVAL SPECIAL EVALUATION

AUGUST 1995

I. PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED

I.A. Project Accomplishments

This project was begun in 1989 and was scheduled to be completed at the end of FY 92. Two years of no-cost extension were granted and this evaluation was conducted at the end of that period to assess achievement for the extension period and to focus particularly on sustainability issues in consideration of World Vision's plans for establishing an Area Development Project (ADP) at this site. The end-of-project evaluation done in 1993 chronicles the achievements during the scheduled life of the project. This report will concentrate on the extension period, particularly the last year's activities conducted since the annual report of 1994.

I.A.1 Comparison to Objectives

The achievements of this project will be presented here in terms of the outputs or services delivered and in terms of effectiveness and coverage. The objectives stated were divided into two main types: development and health. Table 1 highlights the achievements of the two-year extension period. Table 2 summarizes similar information on child survival objectives but is based on both survey and service records and compares achievement to the objectives stated in the plan of action for the extension period. Section I.A.3 containing Table 3 is a report of the Key Child Survival indicators based on the 30-Cluster survey conducted just prior to the evaluation visit.

Table 1 shows that during FY94 maternal and child health services were emphasized and very high levels of coverage were provided for antenatal care and education of mothers. Immunization services reached a large number of children in the entire project area by 1993 and continued high through FY95. These outputs are congruent with survey findings in Section I.A.3 and with the percent coverage figure presented in Table 2.

The achievements presented in Table 2 are based on the survey and on service records in some cases. They are largely the same indicators as the "Key Child Survival Indicators" but vary slightly from those to reflect the objectives written for the project and modifications which were made following the midterm and EOP evaluations. The source of data will be described where it is other than the 30-cluster survey.

Table 1
Summary of Measurable Outputs (In absolute numbers)

Outputs	FY 91 Achieve ment	FY 92 Achieve ment	FY 93 Achieve ment	FY 94 Achieve ment	FY 95 Achieve ment
No. of children 12-23 months fully immunized with DPT3, OPV3, BCG & measles vaccine.	302	344	571	579	592
No. of women 15-45 yrs. who delivered in the last 12 months immunized with two doses of Tetanus Toxoid.	254	332	471	632	514
No. of mothers trained to be competent in ORT usage.	2,219	690	1,264	4,884	3,821
No. of children 12-71 months given appropriate doses of Vitamin A once every 6 months.	1,279	3,583	3,040	2,858	3,529
No. of children 0-11 months given appropriate doses of Vitamin A along with their immunization doses.	NA	NA	NA	NA	592
No. of women 15-45 yrs. who delivered in the last 12 months who received a Vitamin A dose within two weeks after delivery.	270	464	531	732	549
No. of mothers with children 0-23 months trained to know correct and appropriate weaning and infant feeding practices.	268 (0-11mos only)	192 (0-11 mos only)	765 (0-11 mos only)	1,639 (0-11mos only)	1,090 (0-11mos only)
No. of women 15-45 years who delivered in the last 12 months who received 2 antenatal & 1 postnatal checkup by a trained health person.	NA	NA	NA	534	398

Data displayed in Table 2 shows that immunization coverage was extraordinarily high. Survey forms were re-tallied and service records reviewed and appeared to be in agreement with this outstanding level of coverage for the childhood vaccinations. Immunization levels for mothers are less clear and will be explained below. Competence in ORT usage was not measured directly by the survey but is based on the record of those trained in its use. The figures given for ORT use for cases of diarrhea during the previous two weeks are survey data. Ninety-seven of the 296 children surveyed (32.8%) were reported to have had

diarrhea within the previous two weeks. This survey was done shortly after the onset of a delayed monsoon, peak season for diarrhea as run-off water is heavily contaminated and pollutes the potable water sources.

Indicators related to VAC coverage were assessed through the survey except that records were used to measure the percent of those to whom VACs were given in conjunction with immunizations. Again coverage is outstandingly high, but is congruent with service records.

The indicator considered here for maternal care is the percent of women who had at least two prenatal visits during their pregnancy occurring during the previous 12 months. Based on the survey, 94.2% reported having had such care.

Based on service records (registers maintained by the CHWs) the number of women receiving this antenatal care was 534 during FY94 and 398 during FY95. (See Table 1.) Similarly the number of women who received TT2 was 632 in FY94 and 514 in FY95, suggesting fewer pregnancies occurred in FY95. (This is corroborated by the data in Table 3). However the number of pregnant women who received at least two antenatal visits (398) in FY95 is only 77% of those who received TT2 (514) according to the service records reported in Table 1 and 73% of all live births (533) reported in Table 3 based on CHW registers. This is a difference of 21% between the service records and the survey results which reported 94.2% of women who had delivered during the last 12 months having had at least two visits.

Some difference between service records and survey data is to be expected and may arise from incomplete service records and/or sampling error. The much lower number of births in FY95 as compared to the previous year is consistent with some incompleteness in the FY95 records. The very high coverage figures of the survey would also be consistent with a sample which does not accurately represent the entire population served. Taken together these two factors (incomplete service records and a somewhat unrepresentative sample) are the most likely explanation for the discrepancy between the service records and survey data.

Table 3 represents the efforts of this project to maintain records documenting the impact of its maternal and neonatal care. In examining this table it is important to bear in mind that during the first two years the area served by the project was expanding. It was only during FY 93 that the entire project area was served. FY94 saw maximum emphasis on maternal care in the project and data is probably most complete for that period. Qualitative reports from CHWs and mothers groups tend to support a decline in the number of births during FY95 but continued tracking of this trend is necessary to confirm a decline of 36% (from 834 to 533) in one year in the number of live births.

Table 2
A Summary of Project Targets and Achievements

Objectives	FY 1993 Achievement 8/93	EOP Achievement 8/95	EOP Target 8/95
IMMUNIZATION			
Percent of children 12-23 months fully immunized by age 12 months with DPT3, OPV3, BCG & measles vaccines.	88% (card)	96.7% (card)	85% (card)
Percent of women 15-45 years who delivered in the last 12 months and were immunized with two doses of Tetanus Toxoid.	62.2% (card)	95.2% (card)	85% (card)
ORT			
Percent of household with children 0-59 months (with at least one person per household competent in ORT usage).	84.8%	97.7%	90%
Percent of children 0-23 months with diarrhea in the past two weeks who were given ORT.	78.7%	94.8%	90%
NUTRITION (PLUS VITAMIN A)			
Percent of mothers with children 0-23 months know correct weaning and infant feeding practices.	87.3%	96.2% (5-9 months)	85%
Mothers should start complementary foods between fourth and sixth months).	NA	96.2%	
Percent of children 0-11 months given appropriate doses of Vitamin A along with their immunization doses.	NA	80.2%	90%
Percent of children 12-71 months given appropriate doses of Vitamin A once every 6 months.	99.8% (children 12-59 months)	99.9% (children 12-59 months)	90%
MATERNAL CARE			
Percent of women 15-45 years who delivered in the last 12 months and who received at least two antenatal checkups by a trained person.	NA	94.2%	85%

Table 3
Pregnancy Outcome Data FY 91-95

INDICATOR	FY 91	FY 92	FY 93	FY 94	FY 95
Number of Pregnancies	442	447	797	888	548
Number of still birth/abortions	4	2	38	45	15
Number of live births	392	337	555	834	533
Number of neonatal deaths (0-28 days)	31	16	23	26	22
Number of post neonatal deaths (1-11 months)	NA	NA	NA	6	8
Number of maternal deaths	NA	NA	NA	0	3

In FY 94 and FY 95 collection of data on the impact of the immunization component of the project was attempted. The results shown in Table 4 are insufficient to warrant drawing any conclusions but the attempt was a fruitful exercise in developing this kind of expertise within World Vision.

Table 4
EPI Disease & Death Surveillance Data FY 91-95

INDICATOR	FY 91	FY 92	FY 93	FY 94	FY 95
Neonatal tetanus deaths	NA*	NA*	NA*	1	0
Measles cases in children 0-59 months	NA*	NA*	NA*	7	4
Measles related deaths 0-59 months	NA*	NA*	NA*	3	0
Number of reported cases of lameness in children 0-59 months	NA*	NA*	NA*	0	0

An additional factor which confounds the data on any of the indicators of coverage or impact is the migration of people to and from the project area. There are a number of factors involved in this migration, but much of it seems to be seasonal in nature and the destinations of most of the out migrants are the cities of Gujerat where these rural people try to find temporary work outside the agricultural season. Table 5 presents data on migration and suggests that more people are moving in than are leaving. That too is a

* NA = Not Available

trend which bears further monitoring and some inquiry into the reasons for moving back to this rural area.

Table 5
Migration to and from the Project Area

No.		FY 91	FY 92	FY 93	FY 94	FY 95
1.	Number of in-migrations	NA*	NA*	129	194	134
2.	Number of out-migrations	NA*	NA*	97	101	105

* NA=Not Available

A very important component of this project since its inception and increasingly as it has evolved toward becoming an ADP has been its community development activities. These have included a broad range of activities from organization of Women's Clubs (Mahila Mandals) to installing hand pumps. Some of these activities have been locally initiated and supported, others have involved extensive liaison with government agencies in which WV/CS staff played a facilitative role to access government resources. See Appendix D.

Table 6
FY 95 Development Component Targets and Accomplishments

DEVELOPMENT OUTPUT	FY 95 TARGET	FY 95 ACCOMPLISHMENTS
Number of Health Camps organized	10	10
Number of girls trained in vocational skills	10	8
Number of adult literacy classes initiated	10	18
Number of health education film shows held	10	10
Number of Mahila mandal members sent on visits to other model development projects	150	120
Number of district level veterinary camps held	1	1
Number of village level veterinary camps held	10	7
Number of animals (buffaloes, cows, goats, poultry) vaccinated semi annual	-	17,423

Table 6
FY 95 Development Component Targets and Accomplishments

DEVELOPMENT OUTPUT	FY 95 TARGET	FY 95 ACCOMPLISH MENTS
Number of buffaloes procured from the governments tribal scheme by VDWs for beneficiaries	50	78
Number of diary cooperative initiated	1	1
Number of farmers facilitated with training/exposure visits to initiate kitchen gardens and new vegetable farming techniques	1,000	888
Number of new compost pits dug by trained farmers	400	834
Number of farmers trained in planting of fruit trees and forest tree saplings	400	415
Number of new hand pumps installed	15	26
Number of handpump repair and maintenance training sessions held	--	13
Number of hand pumps repaired	--	13
Number of new recurring deposit (savings) accounts opened by tribal families	300	232

Achievements include outputs directly related to the objectives of the project as well as collaborative activities with community and government agencies that relate more to the sustainability of the project and were not specified as objectives. Outputs related to specific targets are presented in Table 6 and those more related to sustainability in the sections on community support and governmental involvement in community development.

The numbers related to each development activity are derived from service records and qualitative assessments made through interviews of community leaders and groups by evaluation team members. A couple of the outputs recorded here were not specifically targeted but are included since they fit in the category of an output very well and represent significant achievements of the project. These are the repair of hand pumps, accompanied by training, and animal vaccinations.

The emphasis on agriculture is seen in the targets exceeded for procuring buffalo from government schemes for tribal development, initiation of a dairy cooperative, compost pits dug, training of farmers in tree-planting and vaccination of farm animals. These activities

exemplify the collaboration established between the Project and various government agencies with schemes for tribal development.

Health camps were a new intervention initiated through collaboration with the Chinchpada Christian Hospital. They appear to have been quite successful in building confidence in both the Hospital and the Project's health interventions. More will be said about the Mahila Mandals in later sections of this report, but their interaction with other model projects was short of the target. They are critically important to making this into a successful ADP but seem not to have grown as much as might be hoped. Training in vegetable production came somewhat short of the target, but significant work was done in this vital area. It was related to the digging of compost pits and shows promise.

A major part of both the health and development components of this project has been training of staff and community members. Table 7 below lists training activities in which

Table 7
Training Conducted in 1995

TOPIC	PARTICIPANTS	DURATION	RESOURCE PERSON(S)
General Health	Nurses	5 days	District Health Office, Dhule
Handpump repair & maintenance	VDWs	5 days	AFPRO, Ahmednagar
Goal Accounting	AO/Accnt.	3 days	World Vision India
Leaf plate making	All staff	1 day	Local businessmen
Income Generation	VDWs/CHWs	1 day	ICSP team
Communication Skill	VDWs/CHWs	1 day	ICSP team
Better Animal Care	Community	3 days	Government/ICSP
Buffalo rearing	Community	1 day	ICSP team
TOST	Project Manager	7 days	Johns Hopkins Univ.
Management Development	Accounts Officer Project Manager	5 days	World Vision India
Exposure trips	Community	1 day	BAIF/Ralegoan Sid
Participatory Rural Appraisal (PRA)	All staff	5 days	World Vision India
Appropriate Technology	VDWs/DC/AO	5 days	Ryan Foundation
Sun System	AO	5 days	World Vision India
Cold Chain	PHA/MEC	½ days	District Health Office, Dhule

Note: This table does not include the periodic training given by the project for the VDWs, CHWs and the VHWs on health and development.

WV staff or community representatives participated during FY95. Two events stand out as having a major impact on staff competence. The first is the TOST training in Nepal in which the Project Manager, Mr. Jebaraj participated and the Participatory Rural Appraisal workshop conducted at Nawapur in May by Dr. Ravi Jayakaran of World Vision India. Both of these events are referred to often by staff and the skills learned are part of project staff's repertoire of ways to monitor their progress and understand the communities in which they work. Regular training of CHWs and VDWs is a regular part of the program as funded by USAID and WVRD. As the move is made toward an ADP, means must be found to maintain this vital function even if at a reduced level.

The number of deposits to savings plans is less than targeted but is surprisingly high given that a Post Office employee absconded with a significant amount of deposited money and recovery of these deposits is likely to be delayed.

Overall achievements in the development components of the project are considerable and, as subsequent sections will illustrate, have moved the project in the direction of sustainability.

I.A.2 Unintended Effects

In addition to the achievement of stated objectives, this CS project has encountered a number of opportunities to go beyond the usual activities and extend its reach into other areas of development and form linkages with other agencies that facilitated access to government benefits and other possibilities for project participants. Listed below are some specific outcomes which illustrate the unintended effects of the project:

- ◆ Extensive resource and referral linkages facilitated by the project have enhanced the communities' ability to tap both public and private resources for development. In particular, government programs for tribal peoples have become increasingly accessible to project participants.
- ◆ There is anecdotal evidence of decreased alcohol use and domestic violence in some segments of society who have actively participated in the project, but overall these remain serious public health problems. Implementing the CS project has made WV more aware of these problems and the need to deal with them as part of any family health project.
- ◆ The PRA training workshop was not originally planned to be part of this project but it has helped project staff to understand the survival strategies of villages and to assess the qualitative improvement of life there. It also has made the Nawapur ADP a site for future training which can be expected to influence WV's institutionalizing PRA methodology.
- ◆ Prophylactic distribution of 30,000 tetracycline capsules to potentially exposed people in the project area during the September 1994 plague was opportunity to

assist local health authorities in a crisis thus building more collaborative relationships.

- ◆ The project's credibility in CS achievements has won widespread press acclaim in the district and in Nawapur block. Public awareness and goodwill are always intended outcomes of a WV project, but the degree of acclaim which has come to this project exceeds planned outcomes.
- ◆ The DHO plans to establish a fully staffed and fully equipped Family Planning Center in Nawapur and is seriously considering placing it under the technical oversight of the WV/ADP in Nawapur. This is a spin-off resulting from the credibility and good relationship the project has built with local health authorities
- ◆ The daughter of the local member of parliament who is also the chairperson of the Panchayat Samiti when interviewed said that, "it is our (the Panchayat Samiti's) project" indicating an unexpected level of goal ownership of the project. An example of this cooperation is the planting of 300,000 trees/saplings with community help since the project's commencement.
- ◆ A community ethic of active care seeking seems to be evolving among mothers regarding the referral of children with symptoms/signs of pneumonia and signs/symptoms of severe diarrhoeal dehydration. This is pointed out by staff of Chinchpada Christian Hospital (CHC) and PHC staff.
- ◆ Health camps in partnership with Chinchpada Hospital staff (private) and PHC staff (public) demonstrates the project's effective networking and utilization of resources. These camps are viewed by CHC staff as mutually beneficial, contributing to their own marketing efforts and building goodwill for them in the community, on one hand, and strengthening the project on the other.

I.A.3 Survey Indicators

The results of the survey will be reported in more detail in an accompanying document to be prepared by the survey team leader.* What is presented in Table 8 is only the "Key Indicators" applicable to this project's activities. The first eight indicators relate to practice and cannot be triangulated with any other service record data. The findings suggest excellent communication of the key messages of child survival in the areas of breast feeding and CDD with one exception. Water was reported to be included along with breastmilk during the first four months by more than half of the mothers surveyed. Only 41.5% reported strictly exclusive breastfeeding during the first four months.

As mentioned in Section I.A.2, the survey findings for indicators 10 and 11 (TT2 and antenatal visits) are higher by more than 20% over what surveillance records (based on village registers) would support for the population as a whole. When either the records (See Tables 1, 2 and 3) or the survey are taken to represent reality for the population, excellent coverage has been achieved. It is probably best to consider both the records, where these measure a similar indicator, and the survey to assess coverage.

* See Appendix B1 and B2

The use of modern contraceptive methods was quite high (66.8%) for a traditional society such as this. Seventy-nine of the 101 users reported having been surgically sterilized, 71 women and 8 men. In keeping with this, women's groups interviewed expressed strong preference for no more than two or three children and, except for a few older women, reported having only that many. A recent study (Oct. 5, 1995) published by the Population Reference Bureau by Leela and Pravin Visaria entitled India's Population in Transition reported that total fertility rate has fallen from 5.3 children per woman in 1970 to 3.6 in 1992 and that decline was steepest in the most recent years. Government policies followed in the Nawapur area provide incentives to health workers and other government employees as well as parents to limit family size and these policies seem to have been very effective.

Table 8
KPC Survey Results (August 1995)

	INDICATORS	PERCENT (P)	N = Numerator D = Denominator P = Percent
1.	<u>Appropriate Infant Feeding Practices: Initiation of Breast feeding</u> Percent of infants/children (less than 24 months) who were breastfed within first eight hours after birth.	P = 96.2%	N = 285 D = 296 P = 96.2%
2.	<u>Appropriate Infant Feeding Practices: Exclusive Breast feeding</u> Percent of infants under four months, who are being given only breast milk.	P = 41.5%	N = 17 D = 41 P = 41.5%
3.	<u>Appropriate Infant Feeding Practices: Introduction of Foods</u> Percent of infants between five and nine months who are being given solid or semi-solid food	P = 96.2%	N = 52 D = 54 P = 96.2%
4.	<u>Appropriate Infant Feeding Practices: Persistence of Breastfeeding</u> Percent of children between 20 and 24 months, who are still breastfeeding (and being given solid/semi-solid foods).	P = 89.4%	N = 34 D = 36 P = 89.4%
5.	<u>Management of Diarrheal Diseases: Continued Breastfeeding</u> Percent of infants/children (less than 24 months) with diarrhea in the past two weeks who were given the same amount or more breast milk.	P = 87.6%	N = 85 D = 97 P = 87.6%
6.	<u>Management of Diarrheal Diseases: Continued Fluids</u> Percent of infants/children (less than 24 months) with diarrhea in the past two weeks who were given the same amount or more fluids other than breast milk.	P = 89.6%	N = 87 D = 97 P = 89.6%

Table 8
KPC Survey Results (August 1995)

	INDICATORS	PERCENT (P)	N = Numerator D = Denominator P = Percent
7.	<u>Management of Diarrheal Diseases: Continued Foods</u> Percent of infants/children (less than 24 months) with diarrhea in the past two weeks who were given the same amount or more food.	P = 89.6%	N = 87 D = 97 P = 89.6%
8.	<u>Management of Diarrheal Diseases: ORT Usage:</u> Percent of infants/children (less than 24 months) with diarrhea in the past two weeks who were treated with ORT.	P = 94.8%	N = 92 D = 97 P = 94.8%
9.	<u>Maternal Care: Maternal Card:</u> Percent of mothers with a maternal card	P = 97.9%	N = 290 D = 296 P = 97.9%
10.	<u>Maternal Care: Tetanus Toxoid Coverage: (Card)</u> Percent of mothers who received two doses of tetanus toxoid vaccine (card)	P = 95.2%	N = 282 D = 296 P = 95.2%
11.	<u>Maternal Care: Antenatal Visits (card):</u> Percent of mothers who had at least two antenatal visits prior to the birth of the child (card + history)	P = 94.2%	N = 279 D = 296 P = 94.2%
12.	<u>Maternal Care: Modern Contraceptive Usage:</u> Percent of mothers who desire no more children in the next two years, or are not sure, who are using a modern contraceptive method.	P = 66.8%	N = 101* D = 151 P = 66.8%
13.	<u>VAC :</u> Percent of children 12-23 months who received appropriate doses of VAC semi-annually.	P = 95.9%	N = 154 D = 167 P = 92.2%
14.	<u>VAC :</u> Percent of women 15-44 years months in the last 12 months who received a Vitamin A dose within one month of delivery.	P = 98% (recall only)	N = 147 D = 150 P = 98%
15.	<u>Immunization Coverage: Completed Series</u> Percent of children 12-23 months who received BCG, OPV3, DPT3 & measles vaccine.	P = 96.7%	N = 166 D = 167 P = 99.4%

* Of these 101 users of modern methods, 79 had been surgically sterilized--71 women and 8 men.

I.B Project Expenditures

I.B.1 Pipeline Analysis (See Appendix E)

I.B.2 Comparison of Expenditures to Budget

The Nawapur CSP has a combined budget of \$786,518 - 57 percent A.I.D. funds (\$448,967) for three years initially (FY 91-93) but was heavily underspent. the project received two no-cost extensions (one year each time); this is the second no-cost extension year (August 31, 1994 to August 31, 1995).

In spite of these no-cost years, the project is still way underspent; this year at the time of the evaluation,, the project is underspent by 50% after 10 months of implementation.

A breakdown of budget expenditures by line item (Direct Cost only) shows the following:

Line Item	YTD Expenditure (Aug. - July) US\$	FY95 Budget (Aug. - Aug.) US\$	%Spent
Procurement	\$3,331	\$9,650	35%
Evaluation	182	2,800	7%
Personnel	42,412	94,554	45%
Travel/Per Diem	3,244	14,350	27%
Communications	4,508	5,000	34%
Facilities	1,819	4,354	42%
Other Direct Cost	5,832	17,000	34%

Most line items except evaluation, travel and per diem are heavily underspent (>35% in all cases). Items which could dramatically experience accelerated spending before the end of the project are travel, communications, and facilities because of the final evaluations. The evaluation line item should be overspent as soon as the evaluation expenditures come in.

This project was meant to go through an underspending mode because of these reasons:

1. The project was approved for a shorter time frame (three years instead of four) and was awarded slightly more money than requested.

2. The rupee went through a series of devaluations against the dollar.
3. There was a delay in filling staff positions and construction of staff houses and training center; throughout the life of the project, it went through staff turnovers without immediate replacements.
4. Charges made to U.S.A.I.D. to pay for renovation and construction costs of the project facilities were reverted back to WVRD, increasing A.I.D. funds available for other project activities. These facilities are privately owned by Team Trust, hence once the project is over, the facilities will be returned to them. Because of this reversal of charges, WVRD has contributed more funds than originally planned in the cooperative agreement.
5. As the project matures, fiscal management became more stringent and the project tended to use local resources as replacement for budget allocations. Most of the trainings were conducted in situ, hence travel costs, hotel lodging, and other training needs were reduced considerably.

I.C. Lessons Learned

The process of distilling lessons learned from this project involved lengthy discussions with field staff, community groups and leaders, and representatives of government and NGOs working in collaboration with WV in Nawapur. The learnings of individual team members and their notes on discussions with various groups are included in Appendix A. What follows here is a synopsis of those materials and of team discussions. Recommendations relevant to future programming in this project area and in similar situations elsewhere are also included.

1. Sustainability is greatly enhanced by a PVO with a long standing presence in the area and a mission which includes a continuing presence. WV has plans to continue its work in the Nawapur area with funding from its private donors to maintain basic operations and initiate what in World Vision parlance is known as an Area Development Project (ADP). This basic support from the PVO provides other donors exceptional opportunities to enhance the impact of their resources when invested here.
2. Continuity of vision and project focus are vitally important to achieving the objectives of a CS project. In the case of WVRD's project in Nawapur these were provided by 27 technical assistance visits by Dr. Shri Chander of the WV/Asia office during the five-year project life span and by community-level project personnel who stayed with the project throughout. There were three project directors during the five years with quite different styles and backgrounds. There were also changes of managerial personnel at the WV/India office which might have been expected to change the focus of the project. However it remained remarkably on-course throughout, due in large part, to the continuous guidance of technical staff from WV/Asia and WVRD.
3. Interventions which are viewed by the community as important services delivered to them build the credibility of the PVO and provide opportunity to do community mobilization and go on to create a more enabling environment for development. In this project providing potable and irrigation water systems, delivering immunization services in the community by mobile teams and assisting farmers to access government-provided benefits stand out as effective means of creating credibility and gaining community support.
4. CS staff here has learned to work in very close cooperation with government agencies that deliver services to tribal peoples. The staff has learned to provide effective liaison services to tap government resources for the communities in which they live and work. This is particularly so for agricultural inputs and training. They have also learned that this activity requires a degree of political acumen which they are still acquiring. It is not evident that staff perceives any danger of creating dependency through reliance on these resources.

5. Recent (May '95) training in Participatory Rural Appraisal techniques has done much to sensitize staff to the wisdom of the community and to provide direction for future ADP programming. Where CS projects have a development component which allows for flexible response to community needs this approach should be more widely used.
6. The combining of CS interventions with their specified target groups and activities with a broader range of development activities which are designed with input from and participation by the communities has prepared the way for an ADP. This combination can well be expected to work in other situations where the PVO plans to continue to work in the area and its effectiveness can be the basis for operation of the ADP at Nawapur.

Recommendations

1. The immunization program (including TT for pregnant women) should be continued with mobile teams to be used only for remote villages (more than approximately five km. from a government PHC). WV staff has developed good working relationships and has received substantive support from these centers. The PHC centers are often inadequately staffed and supplied, however it will not be feasible for WV to provide all immunization services within the budget of the ADP. It is appropriate that this project should now move toward a support role, promoting immunization and other PHC services, for those communities within reasonable distance of a center rather than delivering services throughout the entire area. Details of which communities will be served by mobile teams need to be negotiated with PHC staff, Panchayat leaders, and WV field staff as soon as possible. Moves to strengthen the Mahila Mandals to promote and facilitate active demand for this service by the families in the community need to take priority in the early stages of the ADP.
2. The best hope for sustaining ORT usage, promoting breastfeeding and child spacing practices and VAC distribution lies in strengthening the Mahila Mandals and providing training and supervision for the VHWs. Monetary incentives for the VHWs which are now provided by WV should be shifted to a combination of state government funding, which exists for this purpose, and community support. This will require further liaison with the District Health Office and substantial strengthening of the Mahila Mandals. There has been considerable progress made in organizing these women's groups and it is important that this impetus not be lost as the transition to the ADP is made. Giving them greater responsibility for health interventions provides an immediate *raison d'être* for them and focus for their energies. A community contribution toward the support of the VHWs can also be expected to increase ownership in the health program. Liaison with the PHCs to provide contraceptives will remain a responsibility of project staff.
3. As the project transitions to an ADP mode and project staff reduce their operational

role creative strategies for CS delivery will be needed. i.e.:

- a) Mahila Mandals can take responsibility for stocking, distributing and documenting Vitamin A in their respective villages.
 - b) Train VHWs to take increasing responsibility for the proposed community-based disease and death surveillance system, and for health education (see Recommendation #2 above).
 - c) Step up the already good referral and networking linkages with the Chinchpada Christian Hospital, Nawapur Hospital and the government run PHCs.
4. Explore all avenues for expanding participation in the FCs and MMs, including encouragement from the Panchayat Samiti and incentives such as IGA loans and non-formal literacy classes.
 5. Use the project as a field-based training center for WV India's Western Zone, slated to include 20 ADPs in Maharashtra, Gujarat, and Karnataka.
 6. Make the ADP an underpinning for obtaining other special-funded grants. Areas of obvious need include: reproductive health, STD/HIV/AIDS, girl child welfare and education, and development of quality assurance methods for wider application in WV.
 7. Convert objectives which focus on the inputs and activities of the project to practice objectives which focus on changes in the community in its behavior and/or condition. This will shift project focus toward improving quality of service and documenting impact.
 8. Maintain the dramatic gains made in health care and changes in health-related behavior that are the essential elements of a child survival project. Please see the attached list of indicators for the irreducible minimum for CS elements in an ADP in Appendix C2.
 9. Conduct an HIS review ASAP with a view to providing information for immediate action at the community and project level and to synchronizing the WV HIS and report forms with that of the DHO.
 10. Use PRA findings to design village-specific sustainable projects, combining the rich insights these methods provide with the "hard-nosed" emphasis on results learned in CS project operation.

II PROJECT SUSTAINABILITY

II.A Community Participation

This project was marked by extensive collaboration with other organizations, both governmental and non-governmental. Table 9 catalogs the more substantive collaboration with NGOs and estimates a monetary value for the services rendered by them. Most of this collaboration was directed toward training project staff or community members. The major exceptions are the contributions of Chinchpada Christian Hospital for use of their facilities and patient subsidies, and Team Mission for use of their facilities at Nawapur. Collaboration with Government agencies will be discussed in the next section and forms a larger part of hopes for ongoing sustainability. The other piece of the sustainability puzzle is the local village level participation in development. This was largely concentrated in the Mahila Mandal and Farmers Club organizations.

In terms of rupee value, the contribution of the TEAM mission which provides the project with a base site is the most substantial. Other churches in the area which lend support to the goals of the project in a variety of ways also represent significant resources provided to the project. The collaboration facilitated by this project's staff with numerous local NGOs may not represent large amounts of money but does seem to have created widespread awareness of the project and introduced people in the project area to a range of potential resources that can be expected to enhance their development in the long term.

Interviews with Mahila Mandal and Farmers Club groups were conducted by team members and additional time was spent with a number of leaders of these groups. Notes on these meetings are included in Appendix D. In addition group interviews were done by team members with small groups of four or five Village Development Workers and Community Health Workers. Summaries of the Lessons Learned by these groups are included in Appendix A.

These groups have been organized and, generally, meet fairly regularly, the women's group more so than the men. The women's groups have served as very good educational forums. Communication of health and family planning messages and transmitting information regarding availability of government benefits available to tribals have been the principal functions of these groups. The Farmers Clubs had experienced some disruption in connection with recent political campaigns but VDWs were helping them to regroup and initiate further development. Table 6 catalogs the activities of the Farmers Clubs and shows the particular strength they have built in the area of agriculture and animal husbandry during this project, particularly in the past year as the ADP was planned.

The role of the Mahila Mandals and the Farmers Clubs as mobilizers and health promoters is a little less clear. One dairy cooperative was formed which demonstrates a fairly high degree of community organization. Some limited cooperative work has been done by these groups in the way of irrigation wells but the predominant form of development project has been at the level of the family. Health promotion by the volunteer health workers has been met with a good degree of response from the members of the Mahila Mandals but

further work will need to be done to see these clubs as supporters of the village level workers. The Farmers Club meetings are often attended by larger numbers of men than actual consider themselves to be members of the clubs. Some of those who participate occasionally in FC meetings work through the VDWs to access government programs but cannot be said to be active in community mobilization.

The paid staff (particularly VDWs and CHWs) are the principal initiators of community activity, and with the establishment of an ADP at Nawapur, will be able to continue to interact with the MM's and FC's. This continued support for community level organization is clearly still needed and will be available through World Vision's ongoing involvement. This is the key ingredient to sustainability for this project.

An important support to the health activities of the project has been the referral services of the Chinchpada Christian Hospital which has been particularly active during the extent phase of the project. They have fielded mobile teams to conduct "Health Camps" (See Table 6) and recognize a benefit to the hospital in terms of increased community confidence and utilization of their services. Interviews with the Medical Director of CHC and a few other key staff confirm their commitment to working with the Nawapur project and their perception of the project as complimentary to their own interests.

The Mahila Mandals with their VHWs are probably the most critical community level organization in sustaining the Child Survival interventions. They have been and must continue to be the focal point of communication of key CS messages and the contact between health services such as immunization and families who need to access these services. This will require strong leadership by the volunteer workers with somewhat less support from project staff as the ADP takes shape. The other part of this equation is the increased role of the Nawapur Primary Health Centers. There have been good relations with these and they have provided a good deal of the antenatal care. The Dhule DHO has consistently supplied vaccines and been generally supportive however the ICSP has taken a very active service-delivery role the responsibility for which will have to shifted to government services while community level mobilization for participation in the health program is taken over to a greater extent by the Mahila Mandals.

Another local entity with government backing is the balwadi or anganwadi program. These are similar to a creche with a feeding program. Their staff have actively assisted the ICSP in growth-monitoring (in the early stages of the project), EPI activities and nutrition education. This collaboration is likely to continue as anything the PVO does is viewed as a help[to their own program.

The workshop on Participatory Rural Appraisal conducted in May, 1995 by Dr. Ravi Jayakaran had left a profound impression on the staff and gone far to build a team more skilled in community mobilization and grass roots development. This was mentioned repeatedly by the VDWs and CHWs in the "lessons learned" groups facilitated by team members. (See Appendix A.) This skill was already demonstrated in networking with NGO and government agencies but gained impetus through the PRA training.

Table 9
Non-government Organizations Collaborating with ICSP

ORGANIZATION	TYPE OF ASSISTANCE	1989 - 91 Aprox. Value	1992 Aprox. Value	1993 Aprox. Value	1994 Aprox. Value	1995 Aprox. Value	TOTAL IN INDIAN RS
Chinchpada Christian Hospital, Chinchpada Taluka, Dhule Dist.	CHC provided quarters, offices, vehicles & guest rooms. Subsidy for patients.	48 months Rs. 48,000	31 May 92 Health checkup Rs. 1,600	Patient subsidies Rs. 4,000	Patient subsidies Rs. 3,000	7 Health camps Rs. 3,500	60,100
Dr. Raj Arole Comprehensive Rural Health Project, Jamkhed, Maharashtra	CRHP trained 6 VDWs & 1 Social Worker	1989 Rs. 2,000	---	---	---	---	2,000
ADPRO Action for Food Production, Amednagar, Maharashtra	5 days training hand pump repair training (16 people)	---	---	---	---	---	13,000
Ryan Foundation, Shrinagar Colony, Sayadya Peth, Madras	10 VDWs, 1 Development Coordinator & 1 Accounts Officer, training in appropriate technology	---	---	---	---	---	2,500
BAIF : Bahrtiya Agro Industrial Foundation Vansada, Dist: Balsad Gujerat.	They gave training to our farmers and provided mango grafting at concession rate.	---	80 farmer visit Rs. 1,600	173 farmer & mahilas 3,460	135 farmers training Rs. 2,700	120 farmers training Rs. 2,200	14,060
Mahatma Phule Krishi Veedyapith, Rahuri, Dist: Ahmadnagar.	Trained 66 people at Rahuri	---	22 Rs. 2,200	24 Rs. 2,400	10 Rs. 1,000	10 Rs. 1,000	6,600
Anna Hazari Ralegoan, Sidhi	Free Accommodation	---	---	10 Rs. 1,000	---	10 Rs. 1,000	2,000

Table 9
Non-government Organizations Collaborating with ICSP

ORGANIZATION	TYPE OF ASSISTANCE	1989 - 91 Aprox. Value	1992 Aprox. Value	1993 Aprox. Value	1994 Aprox. Value	1995 Aprox. Value	TOTAL IN INDIAN RS
Pabal Veedyan Ashram Mandir Pabap, Rajgurunagar, Dist: Pune	Trained 3 persons in testing (ground water investigation)	1 Rs. 1,000	---	2 Rs. 2,000	---	---	3,000
Jan Seva Mandal Taloda Road Nandurbar, Dist: Dhule	Training 6 days Nandurbar (7 people) Herbal Medicine, free accommodation	Rs. 7,000					7,000
Puppet Vellya Karjat, Dist: Raigad	Training on puppet shows, puppet making	2 people Rs. 3,000	---	---			3,000
Puppet Abhiyanti less Lee Sahani Centre Dealali Camp Nasik	Media of communication training 6 days			Nov 93 4 people Rs. 2,400			2,400
RAIN (Rahuri Agricultural-Institute Narayangaon)	On Goat farming						100
TASK (Tapti Agro Service Kendra), Nizar Taluka, Surat District, Gujerat	They gave whole day vehicle & other project visit. They help on installation of submersible pump.	2 days Rs. 2,000	4 days Rs. 4,000	3 days Rs. 3,000	4 days Rs. 4,000	4 days Rs. 4,000	53,000
PRINCIPAL Art & Commerce & Science Collage, Nawapur	On Survey 4 days, 20 students & professor (Mid term evaluation)	---	Rs. 1,600	---	---	---	1,600
Krishi Vigyan Kendra, Dhule District, Maharashtra	Agricultural Training on different topics	1 day visit program Rs. 1,000	Training FC/MM Rs. 1,000	---	---	---	2,000

Table 9
Non-government Organizations Collaborating with ICSP

ORGANIZATION	TYPE OF ASSISTANCE	1989 - 91 Aprox. Value	1992 Aprox. Value	1993 Aprox. Value	1994 Aprox. Value	1995 Aprox. Value	TOTAL IN INDIAN RS
Father Albert, Adivasi Vikas Kendra Vyara, Surat. Gujrat	Animal husbandry training (Buffalo) (15 people)	15 people Rs. 750	100 people Rs. 1,100	---	---	---	1,850
INSA	1 Social worker trained in Utility of local resources	Rs. 1,200	Rs. 1,200	---	---	Rs. 1,500	3,900
Adgoan Visit Vijay Borade Adgoan Rachod Dist : Aurangabad	Training consultancy on water shed development	Rs. 1,000	---	---	---	---	1,000
ICSA Pantheon Road Madras. Nandurbar, Dist : Dhule	They provided accommodation at concession rate. Free Accommodation	Rs. 600 per day (5 days)	---	---	---	---	7,000 3,000
Inter Churches. (Indirect Value)	40 Churches give support to our work						160,000
Chinchpada Church	15 days used jeep, 96 days used hall, rate 350 per day	10 days @ 500 48 days 2,400	5 days @ 250 48 days 2,400	---	---	---	4,800
Team Mission, Team Mission Compound, Wakipada, Nawapur, Dist : Dhule 425418	We using their property 2 acre land banglow water		7 months Rs. 42,000	12 months Rs. 72,000	12 months Rs. 72,000	12 months Rs. 60,000	246,000
Pachod Health Centre	One nurse training on Nutrition		1 month Rs. 1,000				1,000
Seventh-day Adventist Mission Hospital, Surat	They sent nursing students for field training and program assistance		20 girls for 3 months Rs. 6,000	20 girls for 4 months Rs. 6,000	20 girls for 1 month Rs. 2,000	---	14,000

II.B Ability and Willingness of Counterpart Institutions to Sustain Activities

The ICSP with its development components has networked very effectively with a wide range of government agencies. Several of the most active were contacted by the evaluation team and the summaries of these conversations are included in Appendix A. In further summary it must be said that the project has gained stature with many local government offices and the press. Interviews with the Block Development Officer and others suggest a high degree of confidence in the WV personnel and respect for their ability to work with the communities. This confidence is reflected in the resources made available to people in the project area as summarized in Table 10. These are very wide range of resources, many of substantial value.

Further the process of obtaining these resources has led both project staff and community leaders to a much better acquaintance government officers and the procedures to be followed to access these resources. Health resources directly related to the CS interventions have also been accessed. From the beginning of the project the Dhule District Health Officer has supplied vaccines and cold chain equipment which have in turn been provided by UNICEF. The PHC center resources are stretched as it is and the project was a very welcome enrichment to their efforts. Relations with them vary among the centers in the area but are generally quite collaborative. A conversation with medical staff of the Nawapur PHCs provided assurance of their willingness to assume greater responsibility for EPI and antenatal care services but also highlighted their need to have organized community support for communication and education.

The kinds of support provided to the communities under the auspices of the ICSP by government agencies will provide substantial enhancement to the ADP now taking shape. The support from the DHO in the form of vaccines, VAC and cold chain equipment will help to sustain the CS interventions as will the service delivery role of the PHCs and the referral support of the Chinchpada Christian Hospital. However WV will be needed for the foreseeable future to initiate and bolster community organization and health education activities. They will probably also need to continue to deliver immunization services to the most remote areas which have difficulty in reaching the PHCs for services. To coordinate this combination of resources and insure coverage for the most remote and disadvantaged communities while going forward with development programs designed to increase income and enable communities to address their own problems will challenge the ADP staff for some years to come.

Table 10
Development Resources of Government Accessed in ICSP Target Area

Activities	Unit Cost in Rs.	1991	1992	1993	1994	1995	Total in Rs.
Jivandhara Well	30,000	2	36	14	18	9	227,000
Biogas	15,000	86	39	76	4	44 @10,000	309,000 440,000
Toilet Construction		---	---	---	---	14	56,000
Dairy Buffalo Scheme		8	---	17	98	75	1,980,000
Animal Husbandry Camp			1 @ 15,000	4 @ 10,000	10 @10,000	4 @15,000	205,000
Oil Engines	7,000	6	---	---	---	1	49,000
Electric Motor Pumps	5,500	3	22	31	17	6	434,500
Fruit Trees Plantation		8	132	71	116	154	865,000
Small Grocery Shops	5,000	2	5	12	19	13	255,000
Sewing Machines	1,500	---	2	9	7	3	37,800
Roof (Tin Sheets)	110	---	---	---	---	---	13,200
Ghar Ghanti (Big)	8,000	---	---	---	4 1 @ 20,000	3	56,000 20,000
Feeds for Milk Animals	165				7		1,155
Forest Trees Plantation		67 32,000	410 125,092	307 112,600	560 156,000	261 26,600	425,292 Trees 226,146
Goat Rearing		---	20	130	55	103	154,000

Table 10
Development Resources of Government Accessed in ICSP Target Area

Activities	Unit Cost in Rs.	1991	1992	1993	1994	1995	Total in Rs.
Hand Pumps	18,000	4	14	14	8	17	1,026,000
Bullock Pairs Bullock Carts		---	---	---	16 BP 2 BC	15 BP 1 BC	217,000 24,000
Compost Pits	50	12	30	126	---	---	8,400
Rabbit Keeping	100	---	13	20	---	---	3,300
Cycle Repair Shop		16	8	---	24	16	64,000
Carpentry	1,500					2	3,000
Loud Speakers	5,000	1	6	3	2	1	65,000
Sewing Bamboo Basket	6,000			17			102,000
Govt. Nursery			75,000				75,000
Photographer Studies in Village					1		8,000
Tempo Trax for Transportation					1		210,000
Tractors for Land Leveling					4 275,000	2 290,000	1,390,000
Film Publicity Officer, Navapur	Free film and Use of Jeep	5,000	9,000	3,000	3000	1000	19,000
Hand Pumps Materials	6,500			91,000			91,000

II.C Sustainability Plan

The previous sections have discussed much of the strategy that has been followed during the life of the project to ensure its sustainability as external funding was withdrawn. Fortunately USAID has had a partner in WVRD that has a long term interest in continued support to health and development activities in the project area. This commitment, while not at the level of funding provided during the CS project and having goals that are more comprehensive than CS programming, is the basis for sustainability at Nawapur. Government resources to support ongoing health care are also committed but represent less than the amounts needed to sustain the outstanding coverage that the project has achieved. The local communities and other NGOs have likewise committed resources and abilities as they were able and seem ready to continue to support development in the area.

The ICSP has been an effective catalyst in mobilizing the resources of government and NGOs but the coalition they have built will require their continued leadership. That role is perhaps the principal function of the ADP which is now emerging. Insuring that the solid gains made in coverage and health communication during the CS project are maintained as the ADP takes on broader development issues. The team discussed this aspect of sustainability at some length and developed a "minimum standard" for the health component of the ADP. This is included in Appendix C1 and incorporates most of the child survival interventions and indicators.

Critical to implementation of this ongoing health program is cooperation between the PHC centers, the ADP health workers and community level leadership, particularly the Mahila Mandals. This will require the ADP management to take a lead role bringing the players together and providing uninterrupted service until such time as the other entities assume responsibility and have the capacity to continue. This depends very much on the level of staffing in the PHC centers and development of community level leadership. That kind of development of leadership has been part of the project plan from its inception and must continue to be an important element of the ADP. Appendix C2 also contains detailed recommendations for the next phase which spell out some of the steps to be taken in the near term to assure sustainability.

APPENDIX A

FIELD NOTES AND SUMMARIES OF DISCUSSIONS

Lessons Learned as summarized by GB from discussion with four CDWs and the Development Coordinator. August 17,1995

1. Listen to the tribals' ambitions and see how they are trying to achieve them.
2. The development worker needs to live the life of the community to understand them. If they come up with a plan, they will make it work.
3. The community has good ideas. i.e. ayurvedic medicines such as leaf plasters for fractures.
4. The tribal people have improved their standard of living very little on their own. They need an outsider to lead them.
5. Development is slow--They have been taught how to feed their kids better and the government has provided supplementary food but the kids are still malnourished.
6. Government programs such as providing food to anganwadas are necessary and with them literacy must be included.
7. If there are problems in getting a response from government offices, go to a higher level officer or sometimes take a morcha (protest demonstration) to the office.
8. If we can solve their problems, they will listen to us.

LESSONS LEARNED FROM 5 CHWS--SRI CHANDER

A. RELATED TO IMPLEMENTATION

1. "If we try, we will get success".
2. It is important to teach mothers what ORT can do (i.e. prevent death from diarrheal dehydration) and what it cannot do (i.e. stop diarrhea).
3. A rapid KPC survey, if done properly, provides a more accurate measure of child survival coverage than service records/statistics.
4. PRA (Participatory Rural Appraisal) is a very useful exercise to overcome our blindspots regarding the real needs and survival strategy of people in our target villages.
5. Use local tribal dialect to communicate more effectively with mothers regarding health behavior change.

6. Antenatal care services for pregnant women have significantly improved pregnancy outcomes (i.e. less spontaneous abortions, less stillbirths, and less neonatal deaths).
7. Importance of collecting information for immediate action.
8. Women's power is increased by organizing women into mahila mandals.
9. Tetanus toxoid vaccinations have effectively reduced maternal deaths.

B. RELATED TO SUSTAINABILITY

1. IGAs are good incentives to facilitate mahila mandals to continue functioning.
2. As the project phases out/scales down mobile health teams, it is important to promote health treatment-seeking behavior of mothers.
3. Need to invest more and more on VHWs, so that they can gradually take over some of the tasks of CHWs.

Lessons learned as summarized by Penny Altmann from discussions with VDWs and CHWs

Project staff members in this group have learned that education toward behavior change is a slow and often tedious process. They are committed to "not giving up," and understand that they must repeat messages regularly over a course of time. They have learned that vulnerability can facilitate education and report that a woman whose child is ill or has died is "ready to listen." If this mother finds that practicing suggested behaviors improves the health of her child or leads to successful delivery, she becomes a strong supporter of the program and an avid spokesperson.

Messages must be presented in the listener's language. Presenting the information is not enough to assure understanding or acceptance. People are more likely to grasp new information if they are encouraged to participate in the discussion. Presenters need to find out what methods best transmit the message. Visual messages (like "splash" cards) are most effective. When people understand the message, they get "more personal" with the community worker, and they ask when she is coming back.

Pool resources and reinforce the work of counterparts. CHWs and VDWs can increase their impact if each knows and supports what the other is doing. Use community organizations to spread information, educate and organize. Mahila mandals are the primary groups spreading health education, but they need a larger audience. Include more community leaders, especially the village head, in activities. Get the community to identify problems and consider solutions.

Communicate with government health assistants and support their work in the project. Promotion of one group by the other increases possible success and builds trust in both.

The children of villagers who migrate are at high risk. Target these families for income generating activities.

Comments:

The group identified their successful health interventions as

Immunization

CDD

Vitamin A

Prenatal Care

Nutrition and breastfeeding education

(Villager learned nutrition messages, but feel that the government should provide more food.)

Project workers say an activity is successful, even when there is little evidence of practice - family planning is an example.

They also believed that WV scaled down, the government would, because they were obligated to take up the slack. The VDW thought they needed more training in dealing with the government/

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SARA ANDERSON LESSONS LEARNED/SUCCESS STORIES FROM CHWS

17 August 1995

- o Received agriculture training at the agriculture college because of the project. Now capable of handling agricultural program on my own.
- o Had difficulty communicating with the women at first in 1992-93...but according to the recent survey, women have more information now.
- o In one hamlet, had a lot of ideas of things to do, but the people said that they just wanted a well

IMPACT, ~~OPINION~~ OBSERVATIONS, OWNERSHIP, ADVICE and ASSESSMENT OF

PERSONS WITHIN THE COMMUNITIES WHERE ICSP IS WORKING

SR NO	Persons interviewed	What they see as WV/ICSP's most important present activity	What they suggest should continue	What they feel they can take over or be responsible for	Advice on areas which should be worked at	Assessment of what they see as their future role/association with ICSP/WV	Remarks of evaluator
01.	Mahila Mandal	<ul style="list-style-type: none"> workup for improvement of health of children and pregnant mothers increasing knowledge of immunization, nutrition and health care promoting kitchen gardens Afforestation Immunization 	<ul style="list-style-type: none"> ✓ ✓ ✓ ✓ ✓ 	<ul style="list-style-type: none"> organise meetings ✓ ✓ ✓ (if given plants) 	<ul style="list-style-type: none"> more income generation programmes water resource creation 	<ul style="list-style-type: none"> will continue the work of informing other mothers but want WV to keep enhancing their capability. 	<ul style="list-style-type: none"> the Mahila Mandal are in existence and fairly effective. Efforts however need to be made to widen its base and get more members.
02.	Farmers Club (former members of a farmers club that had recently closed down ^{during} elections) problem)	<ul style="list-style-type: none"> Health programmes Agriculture development Afforestation Water resource creation 	<ul style="list-style-type: none"> ✓ ✓ ✓ ✓ 	<ul style="list-style-type: none"> water - ✓ ✓ (if given plants) Water resource creation for agriculture 	<ul style="list-style-type: none"> more irrigation water sources to be created. Introduction of high yielding varieties 	<ul style="list-style-type: none"> will continue to be associated with WV/ICSP 	<ul style="list-style-type: none"> the membership base of the farmers club needs to be increased. Simultaneously the mandate has to be widened to include other community community related development activities
03.	Villagers in general in the communities	<ul style="list-style-type: none"> Health related activities for mothers and child Water resource creation Agriculture development Afforestation Nutrition 	<ul style="list-style-type: none"> ✓ ✓ ✓ ✓ ✓ 	<ul style="list-style-type: none"> - - ✓ ✓ ✓ 	<ul style="list-style-type: none"> water resource creation and income generation programmes. 	<ul style="list-style-type: none"> look forward to closer association and participation in WV programmes. 	<ul style="list-style-type: none"> more community members need to be involved in both the Mahila Mandal and the farmers club. The better option would be to create

SR NO	Persons interviewed	What they see as WV/ICSP's most important present activity	What they suggest should continue	What they feel they can take over or be responsible for	Advice or areas which should be worked at	Assessment of what they see as their future role/association with ICSP/WV	Remarks of Evaluator
04	Others: • Teachers	<ul style="list-style-type: none"> • Mother and child health care • Vaccinations • Agriculture development • Health awareness • Water resource creation 	<ul style="list-style-type: none"> ✓ ✓ ✓ ✓ ✓ 	<ul style="list-style-type: none"> - - - ✓ - 	<ul style="list-style-type: none"> • income generation programmes • Water resource for agriculture • Education 	<ul style="list-style-type: none"> • Will definitely associate themselves in Education programmes and awareness programmes on health and health related issues 	<ul style="list-style-type: none"> • Others in the Community should also be accessed for involvement in WV/ICSP activities
05	Farmers club ^{members} - Subi, Pratapur	<ul style="list-style-type: none"> • Immunization • Saving schemes • H₂O potable + irrigation • Loans for IGA. • Health camps. • Farming education 	<ul style="list-style-type: none"> ✓* ✓ ✓* ✓* ✓ ✓* 	None of these might be able to get help from govt schemes	<ul style="list-style-type: none"> • Alcohol is a major health problem in the villages. • Income generation schemes need to be expanded. 	<ul style="list-style-type: none"> • Farmers clubs have not irregularly - though benefits have come to those who participate. Not all do better. • Main association will probably in using WV staff to get gov. benefits • WV role in village is somewhat restricted to a few active members of groups. 	<ul style="list-style-type: none"> • Some community mobilization has been done - but it is a difficult task. Factionalism has disrupted the work of FCs at times. A mix of people participate but it will be necessary to guard against working only with the most progressive farmers and to make diligent effort to reach the poorest.

Persons Interviewed	Important Activities	To continue	To take over	Areas to work at	Future association	Remarks.
Sarpanch from Kharekat, a Zilla Parishad member	<ul style="list-style-type: none"> ◦ Immunizations ◦ Referral to hosp. for serious cases ◦ Hand pumps ◦ Agricultural inputs 					

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PERSONS OUTSIDE OF THE COMMUNITIES WHERE ICSP IS WORKING -

SR No	Department/persons interviewed	What they see as WV's most important present activity	What they suggest should continue	What they feel they can take over or be responsible for	Advice on areas which should be worked at	Assessment of what they see as their future role/association with ICSP/WV	REMARKS of Evaluator
01	Forestry Department	<ul style="list-style-type: none"> involvement in afforestation promotion of fuel efficient 'Choodas' (Cooking Stoves) farmers nurseries mobilising peoples interest in afforestation 	<ul style="list-style-type: none"> ✓ ✓ ✓ ✓ 	<ul style="list-style-type: none"> - ✓ ✓ - 	<ul style="list-style-type: none"> They want WV/ICSP to help create a 100 hectare forest in their target village and they are willing to bear all the costs involved including protection, plants and labour costs for planting. 	<ul style="list-style-type: none"> They will continue to actively support WV in all areas of present association. 	<ul style="list-style-type: none"> The project has very good rapport and relationship with the Forestry department
02	Member of Parliament	<ul style="list-style-type: none"> Water resource creation organising people Health related activities Zeal for service 	<ul style="list-style-type: none"> ✓ ✓ ✓ ✓ 	<ul style="list-style-type: none"> ✓ - ✓ (partially) - 	<ul style="list-style-type: none"> water resource creation Development activities to increase 	<ul style="list-style-type: none"> will continue and strengthen 	<ul style="list-style-type: none"> The MP was well aware of the impact of the project though he wasn't familiar with all its activities. He however main mention of the 'missionary zeal' of the staff which succeeded while others failed
03	Panchayat Samiti Leadership	<ul style="list-style-type: none"> organising communities into action groups Organising women Creating linkages 	<ul style="list-style-type: none"> ✓ ✓ ✓ 	<ul style="list-style-type: none"> - ✓ - 	<ul style="list-style-type: none"> womens education Creating water resources 	<ul style="list-style-type: none"> will continue and strengthen. 	<ul style="list-style-type: none"> The Panchayat Samiti has very close relations with the project. While talking...

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SR No	Department/persons interviewed	What they see as WU's most important present activity	What they suggest should continue	What they feel they can take over responsibility for	Advice on areas which should be worked at	Assessment of what they see as their future role/association with ICSP/WU	Remarks of the evaluator
04	Press	<ul style="list-style-type: none"> • Community organization • Child and Maternal health care interventions • Water resource creation • Agriculture • Afforestation • Health camps 	<ul style="list-style-type: none"> ✓ ✓ ✓ ✓ ✓ ✓ 	<ul style="list-style-type: none"> - - - - - • Highlighting peoples problems • pointing out areas of shortcomings 	<ul style="list-style-type: none"> • greater awareness of government programmes • Activating the people for action on issues where they are victims. • Get people to access more government programmes and not have to duplicate them. • get more rural people to read newspapers because the newspaper is a means for village awareness 	<ul style="list-style-type: none"> • Association with world vision will definitely continue to prosper 	<ul style="list-style-type: none"> • Several members of the press mentioned that it was the 'selfless', devoted team worked the ICSP staff that is responsible for the success of the project. • They shared about minute details of the project that they were aware of to prove that they had the project under close scrutiny.
05	Block Development Officer Mr. Vasave	<ul style="list-style-type: none"> • Immunization • Potable Water • Irrigation Water • Training farmers in use of inputs • Health Education • Animal Husbandry 	<ul style="list-style-type: none"> ✓ * ✓ * ✓ ✓ ✓ * ✓ <p style="text-align: right;">* Priority</p>	<p>might be able to pay VHVs. will continue to supply subsidized beams buffalo and agricultural inputs and wells</p>	<p>AIDS is a problem - Need testing facility and education Requests additional food from WU for some remote villages</p>	<p>Very open to collaboration with WU. Appreciates the facilitative role VDU's play in accessing government program for villages</p>	<p>Excellent rapport has been established here. WU has a powerful ally in the BDO.</p>

	Important Activities	To continue	Can take over	Advice	Future association	Remarks	
65. Chinchpada Christian Hospital Dr. Larry Jacob Mr. Jagdish Solanki Dr. Shadrack	Health camps. Antenatal care - Development work	✓ ✓ ✓		<ul style="list-style-type: none"> • Perhaps some immunization in nearby communities • Referral center for serious illness and complicated deliveries 	<ul style="list-style-type: none"> • Maintain the good working relationship. 	<ul style="list-style-type: none"> • Health camps have built trust in the community for the hospital increasing their patient count. They see this as a very good strategy 	<ul style="list-style-type: none"> • Markedly improved relationships with the hosp. as compared to 3 yrs. ago. Also the hospital seems better kept and busier.

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Community Leaders Not Connected to the CSP Date 17/8/95

Interviewer S. T. Blunt Village Khe Kda

Interviewee _____ Position Village (No Interviewee)

1. How long has WV worked in your village? → 3 years.
2. How does WV work with your organization or community? What kind of activities does it do in cooperation with you?
 - Old sexual Interventions.
 - Farmers club was earlier making but party politics it is not functioning.
 - Women's club → Functioning. Yes.
3. Have you participated in or contributed to the work of the CSP? In what way?

Yes.

4. Of all the work WV does in your community, what do you consider to be most important?

5. As the project develops and changes, what must be continued? What new activities should be added?

6. What project activities which have been done by WV could be taken over by your organization or community? Are there things you have already taken over?

Notes Information Received from Village

Impression: VSA need to gear up (trained)
for Community organizing, which would benefit
people in future.

→ ... Development Activities

- a) FARMERS Club: Not found in the village.
No.
- b) Yes.
- c) Yes → for Handpump repair.
- d) No. → Needs improvement.
- e) Yes → loans for s. milking animals.
- f) Yes.
- g) Yes → ~~for~~ Inform women.
- h) Yes → partly.
- i) No.
- j) Yes → Do not uses modern method / technique of car.
- k) Not conducted.

Community Leaders Not Connected to the CSP Date 17/8/95

Interviewer S. J. Zeldin Village Doripoda

Interviewee Village Position Leader

1. How long has WV worked in your village? 3 years
2. How does WV work with your organization or community? What kind of activities does it do in cooperation with you?

Immunisation, A NT Care, Health Education,
Womens club, Preschool, etc.

3. Have you participated in or contributed to the work of the CSP? In what way?

→ Asking women/pregnant mothers to go for
Immunisation (Child Survival Program).
→ Co-operative with C.I.W.S.

4. Of all the work WV does in your community, what do you consider to be most important?

→ Work among women & children. (Health aspect)
→ Education to mothers & children.

5. As the project develops and changes, what must be continued? What new activities should be added?

→ Education to children should be continued.

6. What project activities which have been done by WV could be taken over by your organization or community? Are there things you have already taken over?

→ No, Community not ready to take over.
Lack of knowledge and back of leaders!

Mahila Mandal and Farmers Club Leaders

Date 17 AUG 1995

Interviewer S. J. SHETTY & SARA ANDERSON

Village KITEKDA

Interviewee GROUP Position

1. How long has WV worked in your village?

3 YEARS

2. WV does many things in the Nawapur area. In your opinion what is the most important thing WV does in your village?

IMMUNIZATION "FOR THE LIFE OF THE CHILD"

3. When was your MM/FC organized in this village? How long have you been active in the group?

2 YEARS

4. Since you have been with the group, what are the most important things the group has accomplished?

HEALTH CAMPS
PLANTING SEEDS
BUFFALOS
VEGETABLE GARDENS

5. What are some things which your community can do now since WV has helped you that you were unable to do before? Which of these do you think you can continue to do without WV help?

NO ANSWER

6. What are the things that you think are most important for WV to continue to do here? IMMUNIZATIONS

WHAT THEY WANT MORE:

- SCHEMES (GOVT.) SO THEY CAN GET MORE
- SEWING MACHINE & SEWING CLASSES
- PLANTING OF FRUIT TREES
- BRIDGE ACROSS RIVER SO CHILDREN CAN GET TO THE SCHOOLS

Go through the check lists.

G) HAVE BUFFALOS & ~~DE FRUIT~~ FOR PLANTING

A) YES, GO THROUGH MEETINGS

B) ? HAVE HAD LITERACY CLASS (FIRST ONE, BUT NOW NO TEACHER) THEY WANT MORE.

C) YES

D) YES

E) YES, KNOWLEDGE THEY GET THEY SPREAD TO OTHERS IN VILLAGES

F) NM

Mahila Mandal and Farmers Club Leaders

Date 17 AUG 1995

Interviewer ST. SHETTI & SARA ANDERSON

Village

DORAPADA

Interviewee GROUP Position _____

1. How long has WV worked in your village?

3 YEARS

2. WV does many things in the Nawapur area. In your opinion what is the most important thing WV does in your village?

THINGS FOR THE CHILD → IMMUNIZATION & GROWTH MONITORING

3. When was your MM/FC organized in this village? How long have you been active in the group?

• 3 YEARS • SLOWLY BUILDING MEMBERSHIP. 40-45 ATTEND MEETINGS EACH MONTH

4. Since you have been with the group, what are the most important

4. Since you have been with the group, what are the most important things the group has accomplished?

ENCOURAGE WOMEN FOR ANT-CARE & POST NATAL-CARE

5. What are some things which your community can do now since WV has helped you that you were unable to do before? Which of these do you think you can continue to do without WV help?

a) CHILD SURVIVAL

b) WOULD GO TO THE GOVT. SUB-CENTERS FOR IMMUNIZATION NOW

6. What are the things that you think are most important for WV to continue to do here?

IMMUNIZATION & CARE FOR PREGNANT WOMEN

b) YES

i) PLANTED 60 GUAVA PLANTS

Go through the check lists.

j) HELP WITH HEALTH CAMPS & IMMUNIZATIONS

a) YES

f) NO

b) ?

g) NOT YET → BUT THEY ARE GOING

TO MAKE LEAF PLATE & BOLL

c) YES

IN MARKETPLACE IN NAWAPUR

d) YES

APPENDIX B

KPC SURVEY QUESTIONNAIRE

PVO/COUNTRY _____ CLUSTER _____ HOUSEHOLD _____
ID NO. _____

PVO CHILD SURVIVAL RAPID KNOWLEDGE,
PRACTICE & COVERAGE (KPC) QUESTIONNAIRE

Integrated Child Survival Project
(A project of World Vision of India)
AUGUST 1995

All questions are to be addressed to the mother with a child under two (less than 24 months of age)

=====

Interview date ___/___/95 Reschedule interview ___/___/95

Interviewer name _____

Supervisor name and signature _____

=====

1. Name and age of the mother

Name _____ Age (years) _____

2. Name and age of the child less than 2 years of age

Name _____

Date of birth _____ Age in months _____

Village _____ Hamlet _____

Mother's Education/Occupation

3. What is your educational level?
- 1. none.....[]
 - 2. primary does not read[]
 - 3. primary reads.....[]
 - 4. secondary and higher.....[]
 - 5. literacy class.....[]
4. Do you work away from home?
- 1. yes.....[]
 - 2. no[]
5. Do you do any "income generating work"?
- (multiple answers possible; record all answers)
- 1. nothing..... []
 - 2. seasonal work..... []
 - 3. harvesting, fruit picker..... []
 - 4. selling agricultural products..... []
 - 5. selling foods, dairy products..... []
 - 6. servant/household services..... []
 - 7. shop keeper, street vendor..... []
 - 8. salaried worker..... []
 - 9. other (specify)..... []
6. Who takes care of (name of child) while you are away from home?
- a. mother takes child with her..... []
 - b. husband..... []
 - c. older children []
 - d. relatives []
 - e. neighbors/friends []
 - f. maid []
 - g. Balwadi/Anganwadi..... []

Breast feeding/Nutrition

7. Are you breastfeeding (name of child)?
- 1. yes.....[] go to 9
 - 2. no.....[]
8. Have you ever breastfed (name of child)?
- 1. yes.....[]
 - 2. no.....[] go to 10
9. After the delivery, when did you breast-feed (name of child) for the first time ?
- 1. during the first hour after delivery.....[]
 - 2. from 1 to 8 hours after delivery.....[]
 - 3. more than 8 hours after delivery.....[]
 - 4. do not remember.....[]

10. a. Are you giving (name of child) water ?
1. yes.....[]
 2. no.....[]
 3. doesn't know.....[]
- b. Are you giving (name of child) cow milk, goat milk, buffaloes milk, bottle milk ?
1. yes.....[]
 2. no.....[]
 3. doesn't know.....[]
- c. Are you giving (name of child) semisolid foods such as gruels, porridge or semolina? (gathu, dasli, khichadi, roka)
1. yes.....[]
 2. no.....[]
 3. doesn't know.....[]
- d. Are you giving (name of child) fruits juice ?
1. yes.....[]
 2. no.....[]
 3. doesn't know.....[]
- e. Are you giving (name of child) carrot, squash, mango , papaya or bhopala ?
1. yes.....[]
 2. no.....[]
 3. doesn't know.....[]
- f. Are you giving (name of child) dark green leafy vegetables, such as spinach ?
1. yes.....[]
 2. no.....[]
 3. doesn't know.....[]
- g. Are you giving (name of child) lentils, peanuts, or beans?
1. yes.....[]
 2. no.....[]
- h. Are you giving (name of child) meat or fish ?
1. yes.....[]
 2. no.....[]
- i. Are you giving (name of child) eggs ?
1. yes.....[]
 2. no.....[]
- j. Are you adding dark green leafy vegetables, such as spinach, to (name of child)'s food?
1. yes.....[]
 2. no.....[]

k. Are you adding jaggery or sugar to (name of child)'s meals?

- 1. yes.....[]
- 2. no.....[]

l. Are you adding iodized salt (local brand name) to (name of child)'s meals?

- 1. yes.....[]
- 2. no.....[]

m. Are you adding oil to (name of child)'s meals?

- 1. yes.....[]
- 2. no.....[]

Health workers believe that it is very important to breastfeed during the first two years of the baby's life.

11. What can a mother do in the baby's first four months of life to keep on breastfeeding ?

(multiple answers possible; record all answers)

- a. doesn't know.....[]
- b. breastfeed as soon as possible after delivery (don't discard colostrum).....[]
- c. care of breasts, nipples.....[]
- d. frequent sucking to stimulate production.....[]
- e. exclusive breastfeeding during the first four months.....[]
- f. avoid bottle feeding of baby.....[]
- g. relactation (if had to stop, mother can resume breastfeeding again).....[]
- h. other (specify).....[]

12. When should a mother start adding foods to breastfeeding ?

- a. start adding between 4-6 months of age.....[]
- b. start adding earlier than 4 months of age.....[]
- c. start adding later than 6 months of age.....[]
- d. doesn't know.....[]

13. What should those additional foods to breastfeeding be ?

(multiple answers possible; record all answers)

- a. doesn't know.....[]
- b. add oil to food.....[]
- c. give yellow fruits in Vitamin A[]
- d. give spinach (iron)[]
- e. other (specify).....[]

14. Which vitamin helps you prevent "night blindness"?

- 1. Vitamin A[]
- 2. doesn't know or other.....[]

15. Which foods contain vitamin A to prevent " night blindness"?
- doesn't know or other.....[]
 - green leafy vegetables.....[]
 - yellow type fruits.....[]
 - meat/fish.....[]
 - breast milk.....[]
 - egg yolks.....[]

Diarrheal Diseases

16. Has (name of child) had diarrhea during the last two weeks?
- yes.....[]
 - no.....[] go to 23
 - doesn't know.....[] go to 23
17. During (name of child)'s diarrhea did you breast-feed (read the choices to the mother).....
- more than usual ?.....[]
 - same as usual?.....[]
 - less than usual?.....[]
 - stopped completely?.....[]
 - child not breastfed.....[]
18. During (name of child)'s diarrhea, did you continue to provide (name of child) with solid/semisolid foods..... (read the choices to the mother).....
- more than usual ?.....[]
 - same as usual?.....[]
 - less than usual?.....[]
 - stopped completely?.....[]
 - exclusively breastfeeding.....[]
19. During (name of child)'s diarrhea, did you provide (name of child) with fluids other than breast-milk..... (read the choices to the mother).....
- more than usual ?.....[]
 - same as usual?.....[]
 - less than usual?.....[]
 - stopped completely?.....[]
 - exclusively breastfeeding.....[]
20. When (name of child) had diarrhea,, what treatments, if any, did you use ?
(multiple answers possible; record all answers)
- nothing.....[]
 - ORS sachet.....[]
 - sugar-salt solution.....[]
 - cereal based ORT.....[]
 - infusions or other fluids.....[]
 - anti-diarrhea medicine or antibiotics...[]
 - other (specify).....[]

21. When (name of child) had diarrhea, did you seek advice or treatment for the diarrhea?
1. yes.....[]
 2. no.....[] go to 23
22. From whom did you seek advice or treatment for the diarrhea of (name of child)?
- a. general hospital.....[]
 - b. health center/clinic/post.....[]
 - c. private clinic/doctor.....[]
 - d. pharmacy.....[]
 - e. village health worker/chw/vdw.....[]
 - f. traditional healer.....[]
 - g. traditional birth attendant.....[]
 - h. relatives & friends.....[]
 - i. other (specify).....[]
23. What signs/symptoms would cause you to seek advice or treatment for (name of the child)'s diarrhea?
(multiple answers possible; record all answers)
- a. doesn't know.....[]
 - b. vomiting.....[]
 - c. fever.....[]
 - d. dry mouth, sunken eyes, decreased urine output(dehydration).....[]
 - e. diarrhea of prolonged duration (at least 14 days).....[]
 - f. loss of appetite.....[]
 - h. weakness or tiredness.....[]
 - i. other (specify).....[]
24. What are important actions you should take if (name of child) has diarrhoea?
(multiple answers possible: record all answers)
- a. doesn't know..... []
 - b. initiate fluids rapidly.....[]
 - c. give the child more to drink than usual.....[]
 - d. proper mixing and administration of ORS.....[]
 - e. take child to the hospital/health centre.....[]
 - f. feed more after diarrhoea episode so that child can regain weight.....[]
 - g. withhold fluids.....[]
 - h. withhold foods.....[]
 - i. other (specify).....[]

25. Can you identify three main signs of dehydration?
- a. fever.....[]
 - b. vomiting.....[]
 - c. sunken eyes.....[]
 - d. pinched skin.....[]
 - e. depressed fontanelle (talus).....[]
 - f. dry mouth.....[]
 - g. loss of appetite.....[]
 - h. weakness.....[]

IMMUNISATION

26. Has (name of child) ever received any immunisations?
- 1. yes..... []
 - 2. no..... []
 - 3. doesn't remember..... []
27. At what age should (name of child) receive measles vaccine?
- 1. specify in months.....[___/___]
 - 2. doesn't know.....[]
28. Can you tell me the main reason why pregnant women need to be vaccinated with tetanus toxoid vaccine?
- 1. to protect both mother/newborn against tetanus.....[]
 - 2. to protect only the women against tetanus.....[]
 - 3. to protect only the newborn against tetanus.....[]
 - 4. doesn't know or other.....[]
29. How many tetanus toxoid injections does a pregnant woman need to protect the new born infant from tetanus?
- 1. one.....[]
 - 2. two.....[]
 - 3. more than two.....[]
 - 4. none.....[]
 - 5. doesn't know.....[]
30. Do you have an immunisation card for (name of child) ?
- 1. yes.....[] (must see card)
 - 2. lost it.....[] (go to 31)
 - 3. never had one.....[] (go to 31)
31. Look at the vaccination card and record the dates of all the immunisations and vitamin A capsules in the space below

	(dd/mm/yy)
BCG	_/_/_
OPV	_/_/_
	1st _/_/_
	2nd _/_/_
	3rd _/_/_

38. Do you want to have another child in the next two years?
1. yes.....[] go to 41
 2. no.....[]
 3. dosen't know.....[]
39. Have you or your husband had permanent family planning method ?
1. tubal ligation.....[]
 2. vasectomy.....[]
40. What is the main method you or your husband are using now to avoid/postpone getting pregnant ?
1. pill.....[]
 2. IUD.....[]
 3. condom.....[]
 4. abstinence.....[]
 5. others.....[]
41. When should a pregnant women first see a health professional (physicina, nurse, midwife)? (probe for months)
1. first trimester, 1-3 months.....[]
 2. middle of pregnancy, 4-6 months.....[]
 3. last trimester, 7-9 months.....[]
 4. no need to see health worker.....[]
 5. doesn't know.....[]
42. What foods are good for a pregnant woman to eat to prevant pregnancy anemia ?
1. doesn't know.....[]
 2. eggs, fish, meat.....[]
 3. leafy green vegetables, rich in iron.....[]
 4. others (specify).....[]
43. How much weight should a woman gain during pregnancy?
1. 10 to 12 kilos.....[]
 2. gain weight of baby.....[]
 3. doesn't know.....[]
 4. others (specify).....[]
44. When you were pregnant with (name of child) did you visit any health site (dispensary/health centre,aid post) for pregnancy/prenatal care ?
1. yes.....[]
 2. no.....[]

45. When you were pregnant with (name of child) was the amount of food you ate

(read the choices to the mother)

- 1. more than usual?.....[]
- 2. same as usual?.....[]
- 3. less than usual?.....[]

46. At the delivery of (name of child), who tied and cut the cord ?

- 1. yourself.....[]
- 2. family member.....[]
- 3. traditional birth attendant.....[]
- 4. health professional (physician, nurse).....[]
- 5. other (specify).....[]
- 6. doesn't know.....



Integrated Child Survival Project

A PROJECT OF WORLD VISION OF INDIA

(TN SOCIETIES REGN. NO. 63 OF 27 MARCH 1976)

PHONE & FAX : 02569 - 50390

MISSION COMPOUND, WAKIPADA, TALUKA NAVAPUR, DIST. DHULE - 425 418, MAHARASHTRA

DATE : NOVEMBER 15, 1995.
TO : ASSOCIATE DIRECTOR - WEST ZONE CC : B.M. (PUNE)
FROM : RAJU SURYAWANSHI FOR DEVSAGAYAM G. JEBARAJ.
SUBJECT : KPC SURVEY REPORTS/MFS. ~~Aug.~~ SEP. OCT. 95. *Suryawanshi*
1161111

Enclosed the following reports you will find.

1. KPC survey reports FY 95.
2. MFS ~~Aug.~~, Sep., Oct. 1995.

Thanks.

11. METHODOLOGY

A. The Questionnaire

The questionnaire which consists 46 questions was designed to collect information from mothers of children under 24 months of age. The questionnaire was based on a standardized survey format which A.I.D. requires of all PVO CS projects. The standardised survey instrument was developed along with the staff at JHU team.

The first two questions ask about the age of the respondent (mothers) and her youngest child under 24 months of age; questions 3-6 collect data regarding mothers literacy, employment and who cares for the child when the mother is away from home; questions 7-13 deal with breastfeeding and other feeding practices; questions 14-15 ask questions on Vitamin A; questions 16-25 refer to mothers response to diarrhoeal disease and management of the child with diarrhoea; questions 26-31 concern the immunisation status of the child; and finally questions 32-46 are about prenatal care, family planning and maternal nutrition.

B. Determination of Sample Size

Sample sizes were calculated with the following formula:

$$n = z^2 (pq) / d^2$$

where n = sample size; z = statistical certainty chosen; p = estimated prevalence/coverage rate/level to be investigated; q = 1 - p; and d = precision desired.

The value of p was defined by the coverage rate that requires the largest sample (p = .5). The value d depends on the precision or margin of error desired (in this case d = .1). The statistical certainty was chosen to be 95% (z = 1.96). Given the above values, the following sample size (n) was determined to be:

$$n = (1.96 \times 1.96) (.5 \times .5) / (.1 \times .1)$$

$$n = (3.84) (1.25) / .01$$

$$n = 96$$

It takes much time to randomly select an identified individual from the survey population and then perform this selection 96 times to identify a sample of n = 96. Time can be saved by doing a 30 cluster sample survey in which several individuals within each cluster selected to reach the required sample size. However, in order to compensate for the bias which enters the survey from interviewing persons in clusters, rather than as randomly selected individuals experience has shown that a minimum sample of 210 (7 per cluster) should be given the values of p, d and z above (Henderson et al., 1982). In general when using a 30 cluster sample survey, the sample size used should be approximately double the value n, when: $n = (z \times z) (pq) / (d \times d)$. In this case a sample size of 300 (10 per cluster) was selected so as to ensure that sub samples would be large enough to obtain useful management type information.

C. Selection of the sample

The sample consisted of 296 women with children 0-23 months of age in the three (kukna, mawchi and vasave) tribal communities in the selected target villages of the project in the Navapur taluka. On an average 10 women were selected in each of 30 randomly selected hamlets (cluster sites) following the process described in the EPI Coverage Survey training manual (WHO, Geneva, Oct. 1988).

Once the survey team reached the designated cluster site, the initial household surveyed within the cluster was selected by tossing a pen/bottle or a currency note and the direction from the initial household was randomly selected.

D. Training of supervisors and interviewers

The project staff were the interviewers and the supervisors. The training of supervisors and interviewers took place for three days August 9-11.

The first training day focussed on survey administration, methodology and understanding the questionnaire. Sessions on purpose and objectives of the survey, selection of the sample size, selection of the starting household and review of the customised questionnaire.

The second day of training concentrated on interviewing techniques, familiarization with the questionnaire through role play and the roles of the supervisor and interviewers.

The final day of training commenced with a field test of the survey questionnaire. Twenty villages were selected randomly by the project staff and two interviewers and supervisor interviewed two mothers of children 0-23 months old.

The three day training was conducted the ICSP Project Manager.

E. Conduct of the interviews

The survey was conducted from August 12 - 16. Thirty survey areas (hamlets) were randomly selected by the ICSP staff in consultation with JHU staff during the TOST workshop at Nepal.

The supervisors of each team were responsible for the selection of the starting household. The supervisors observed at least one complete interview by each surveyor each day. Each questionnaire was checked for completeness before the survey team left the survey area, so that in case of missing or contradictory information the mother could be visited again the same day.

On the last day of the survey the one member from the evaluation team went with the 7 teams as observers.

F. Method for Data Analysis

August 17 and 18 were allotted for manual tabulation. The ICSP Project Manager and the Evaluation team members supervised the hand tabulation.

Ten two-person teams made up of supervisors and interviewers were available for the hand tabulation. The hand tabulators sat around in the Development Coordinators room. The questionnaires were organised by cluster site and each set of questionnaires was circulated between each of the tabulators. The tabulators each recorded the responses to one question at a time going through each of the 296 questionnaires.

ACKNOWLEDGEMENTS

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3. Integrated Child Survival Project staff.
4. Supervisors and Interviewers.
5. The tribal community of Navapur.

SURVEY INTERVIEWERS AND SUPERVISORS

- | | |
|--------------------|----------------------|
| 1. Ramesh Valvi | 17. Phulwanthi Padvi |
| 2. Rupsingh Vasave | 18. Akka Gavit |
| 3. Arjun Gavit | 19. Kusum Gavit |
| 4. Dilip Gavit | 20. Premlatha Gavit |
| 5. Manohar Raisa | 21. Gangubai Vasave |
| 6. Manish Valvi | 22. Ramila Gavit |
| 7. Samuel Gavit | 23. Meena Gavit |
| 8. Ravidhas Kokani | 24. Bharathi Gavit |
| 9. Jatriya Vasave | 25. Sushila Gavit |
| 10. Suresh Gavit | 26. Chamula Valvi |
| 11. Jahagu Valvi | 27. Veena Valvi |
| 12. Balu Gavit | 28. Jaiwanthi |
| 13. Jeku Vasave | 29. Aruna Kuwar |
| 14. Sunitha Gavit | 30. Manorama Malge |
| 15. Yamuna Gavit | 31. Lalitha Chauhan |
| 16. Pramila Valvi | |

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APPENDIX

LISTING OF VILLAGES, HAMLETS BY CLUSTER NUMBER AND TEAM LOCATION ASSIGNMENTS

S.NO	CLUSTER #	VILLAGE	HAMLETS/ POPULATION
DAY 1			
01.	1	Amlan	Kokanifali /1012
02.	2	Ampada	Gauthan / 1067
03.	3	Bandarfali	Shalafali / 414
04.	4	Bedki	Holifali, Amblifali/203/116
05.	5	Bhavre	Kokanifali, Mawchifali/499/237
06.	6	Bilmanjira	Gauthanfali, Kilvanpada/433/409
07.	7	Chaukki	Mothifali, Vadfali/409/282
08.	9	Karanji Khurd	Monyafali, Sukafali, Tuljifali/238 /397/234
DAY 2			
09.	11	Kokarwada	Mothifali/299
10.	16	Wakipada	Wakipada/849
11.	17	Bhambarmal	Rastyafali, Polysylahafali/228/110
12.	18	Bokalzer	Gauthan, Ganglifali, Gatafali /356/ 41/222
13.	20	Borzer	Gauthan, Sadkifali, Tarpada 122/172 /111
14.	21	Devlipada	Mothifali/Veesfali/Khelfali
15.	22	Jamanpada	Jamanpada
16.	23	Kamod	Mothifali/Badfali/Dogalifali
DAY 3			
17.	24	Kelpada	Christifali/Sadkifali
18.	25	Morthowa	Mothogoan/Bedkiramfali
19.	26	Nangipada	Nangipada
20.	27	Pimpran	Shalafali/Kochanpada
21.	28	Raipur	Gauthan/Patilfali/Gulyhafali
22.	29	Tilasar	Motizira/Patilfali
23.	30	Varhardipada	Varhardipada
DAY 4			
24.	8	Dhanborda	Dhanborda
25.	10	Khekda	Gauthan/Ashramfali/Mandifali & Chamdiyafali
26.	12	Lakkodgot	Hrahafali/Ranglifali/ Junapatkifali/Gauthanfali
27.	13	Nagzari	Waglapada/Virahabordi
28.	14	Nagzari	Pandharfali/Ambraifali
29.	15	Suli	Patilfali/Wadfali
30.	19	Borpada	Amblifali/Dogalifali/Nilmao

**EOP KPC SURVEY RESULTS
(AUGUST 1995)**

NO.	INDICATORS	RESULT PERCENT P	RESULT NUMERATOR = N DENOMINATOR = D PERCENT = P
1.	<u>NUT : Initiation of Breast feeding</u> Percent of infants/children last 12 to 24 months) who were breastfed with first eight house after birth.	P =96.2%	N = 285 D = 296 P = 96%
2.	<u>NUT : Exclusive Breast feeding :</u> Percent of infants under four months, who are being given only breast milk.	P =41.5%	N = 17 D = 41 P = 41.5%
3.*	<u>NUT:Introduction of Foods -</u> Percent of infants between 5&8 months who are being given solid or semi solid food	P =95.8%	N = 46 D = 48 P = 95.8%
4.	<u>NUT : Persistence of Breastfeeding:</u> Percent of children between 20 and 24 months, who are still breastfeeding (and being given solid/semi-solid foods).	P =94.4%	N = 34 D = 36 P = 94.4%
b.	<u>CDD :Continued Breastfeeding :</u> Percent of infants/children with diarrhea in the past two weeks who were given the same amount or more breast milk.	P =87.6%	N = 85 D = 97 P = 87.6%
6.	<u>CDD :Continued Fluids :</u> Percent of infants/children (less than 24 months with diarrhea in the past two weeks who were given the same amount or more fluids other than breast milk.	P =89.6%	N = 87 D = 97 P = 89.6%
7.	<u>CDD :Continued Foods :</u> Percent of infants/children (less than 24 months with diarrhea in the past two weeks who were given the same amount or more food.	P =89.6%	N = 87 D = 97 P = 89.6%
8.	<u>CDD :ORT Usage :</u> Percent of infants/children (less than 24 months) with diarrhea in the past two weeks who were treated with ORT.	P =94.8%	N = 92 D = 97 P = 94.8%
9.	<u>MC : Maternal Card :</u> Percent of mother with a maternal card.	P =97.9%	N = 290 D = 296 P = 97.9%

NO.	INDICATORS	RESULT PERCENT P	RESULT NUMERATOR = N DENOMINATOR = D PERCENT = P
10.	<u>MC : Tetanus Toxoid Coverage :</u> (Card) Percent of mothers who received two doses of tetanus toxoid vaccine(card)	P =95.2%	N = 282 D = 296 P = 95.2%
11.	<u>MC : Antenatal Visits (card):</u> Percent of mothers who had at least three antenatal visit prior to the birth of the child (card + History)	P =94.2%	N = 279 D = 296 P = 94.2%
12.	<u>MC : Modern Contraceptive Usage :</u> Percent of mothers who desire no more children in the next two years, or are not sure, who are using a modern contraceptive method.	P =66.8%	N = 101 D = 151 P = 66.8%
13.	<u>VAC:</u> Percent of children 12-23 month who received appropriate doses of VAC semi-annually.	P =92.2%	N = 154 D = 167 P = 92.2%
14.	<u>VAC:</u> Percent of women 15-44 years months in the last 12 months who received a Vitamin A dose with in one month of delivery.	P =98% (recall only)	N = 147 D = 150 P = 98%
15. *	<u>EPI :</u> Percent of children 12-23 months who received BCG,OPV3,DPT3 & measles vaccine.	P =99.5%	N = 206 D = 207 P = 99.5%

SUMMARY OF THE FINDINGS
FINAL EVALUATION SURVEY
ICSP NAVAPUR

VARIABLES		FINDINGS	
		Final Evaluation (Aug. 95)	Midterm Evaluation
1.	Children 12-23 months fully immunised with six EPI vaccines before their first birthday	99.5%	34%
2.	Mothers of the infants immunised with TT2/TT2 +	95.2%	25%
3.	Children 12-59 months received VAC in the last six months	7352	3583
4.	Mothers practising breastfeeding to their infants	96.2%	NA
5.	Mothers practising weaning food to their infant/children between 4-6 months of age	95.8%	64%
6.	Competent in ORT	90.3%	52%
7.	Had diarrhoea in the last two weeks and treated with ORT	94.8%	52%
8.	Eligible couples practicing modern methods of contraception.	66.8%	NA

Appendix C1

HEALTH STANDARDS--THE IRREDUCIBLE MINIMUMS FOR AN ADP

IMMUNIZATION OBJECTIVES:

--% OF CHILDREN (12-23 MONTHS) WILL HAVE RECEIVED FULL IMMUNIZATION COVERAGE (CARD) BY AGE 12 MONTHS WITH BCG, DPT3, OPV3, AND MEASLES VACCINES;

--% OF MOTHERS (15-45 YEARS) WILL HAVE RECEIVED TWO DOSES OF TETANUS TOXOID VACCINE (CARD) BEFORE THE BIRTH OF HER YOUNGEST CHILD LESS THAN 24 MONTHS OF AGE;

VITAMIN A OBJECTIVES:

--% OF CHILDREN LESS THAN 12 MONTHS WOULD HAVE RECEIVED APPROPRIATE CARD-DOCUMENTED DOSES OF VITAMIN A AT EACH IMMUNIZATION CONTACT;

--% OF CHILDREN 12-71 MONTHS WOULD HAVE RECEIVED APPROPRIATE CARD-DOCUMENTED DOSES OF VITAMIN A TWICE A YEAR;

__% OF MOTHERS WHO DELIVERED IN THE LAST 12 MONTHS WOULD HAVE RECEIVED A CARD-DOCUMENTED VITAMIN A DOSE WITHIN TWO WEEKS OF DELIVERY;

NUTRITION OBJECTIVES

__% OF INFANTS LESS THAN FOUR MONTHS ARE BEING EXCLUSIVELY BREASTFED;

__% OF INFANTS BETWEEN FIVE AND NINE MONTHS, ARE BEING GIVEN SOLID AND SEMI-SOLID FOODS;

ORT/DIARRHEA CONTROL OBJECTIVES

__% OF INFANTS/CHILDREN LESS THAN 24 MONTHS OF AGE WITH DIARRHEA IN THE LAST TWO WEEKS WERE TREATED WITH ORT;

__% OF INFANTS/CHILDREN LESS THAN 24 MONTHS OF AGE WITH DIARRHEA IN THE LAST TWO WEEKS WERE GIVEN THE SAME AMOUNT OR MORE BREAST MILK;

___% OF INFANTS/CHILDREN LESS THAN 24 MONTHS OF AGE WITH
DIARRHEA IN THE LAST TWO WEEKS WERE GIVEN THE SAME AMOUNT OR
MORE FOOD;

___% OF INFANTS/CHILDREN LESS THAN 24 MONTHS OF AGE WITH
DIARRHEA IN THE LAST TWO WEEKS WERE GIVEN THE SAME OR MORE
FLUIDS OTHER THAN BREASTMILK.

PNEUMONIA CONTROL OBJECTIVES:

___% OF MOTHERS SOUGHT TREATMENT FOR THEIR INFANT/CHILD (LESS
THAN 24 MONTHS WITH COUGH AND RAPID BREATHING IN THE PAST
TWO WEEKS;

MATERNAL CARE OBJECTIVES:

___% OF BIRTHS ATTENDED BY A TRAINED HEALTH WORKER

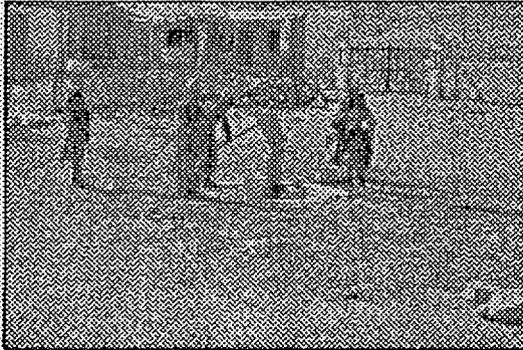
___% OF PREGNANT WOMEN RECEIVING AT LEAST TWO ANTENATAL VISITS
BY A TRAINED HEALTH WORKER

APPENDIX C 2

RECOMMENDATIONS FOR THE NEXT ADP PHASE—SRI CHANDER

1. CS OBJECTIVES:
 - (a) Short-list CS objectives to a list of “Irreducible Child Survival Minimums”:
 - (b) Convert all CS objectives to practice objectives.
2. With high CS coverage as revealed by the KPC survey, the project should begin to focus on assuring quality and monitoring and documenting impact. In this regard, the following are strongly recommended :
 - (a) a HMIS (Health Management Information System) Review;
 - (b) developing community-based disease and death surveillance for vaccine-preventable diseases to assess the effectiveness of a system for monitoring and evaluation of EPI activities;
 - (c) developing team approaches to improving quality of project training, supervision and service, including the development and field-testing of quality assurance instruments.
3. Use village-specific PRA data to facilitate village-level sustainability exercises with project partners.
4. Develop a communications strategy to pre-test and develop CS messages, materials and channels to effect sustained behavior change.
5. Explore creative ways to involve and train traditional practitioners (e.g. Bhagats) in CS delivery and disease prevention.
6. Revise job descriptions of the core team and CHWs to reflect their changing roles in the next phase ADP.
7. As the project transitions into the ADP mode, the project staff should reduce their operational roles and use creative alternative strategies for CS promotion and delivery:
 - (a) Facilitate mahila mandals to become Vitamin A depot holders and to take responsibility for semi-annual Vitamin A distribution and documentation in their respective villages.
 - (b) Train and supervise VHWs to take increasingly responsibility for the proposed community-based disease and death surveillance.
 - (c) Step up the already good referral linkages to the Chinchpada Hospital, Nawapur Hospital, and the government-run Primary Health Centers.
8. Improve project quality by introducing and field-testing:
 - (a) Immunization session supervisory checklist
 - (b) Sick Child Case Algorithm
 - (c) Missed Immunization Opportunity Survey

9. Explore with Panchayat Samithi ways to enlarge membership of the Farmers Clubs and mahila mandals through incentives like GAS and non-formal literacy classes.
10. Introduce cost-sharing by discussing with the BDO and the Farmers Clubs and mahila Mandals to absorb the costs of the VHWs' monthly honorariums.
11. Use the project as a field-based site for WV India's Western Zone, which will eventually oversee 20 ADPs in 4 states (Maharashtra, Gujarat, Karnataka, and Madhya Pradesh).
12. With the above-mentioned in mind, set aside budget for repairs of staff quarters.
13. Seriously consider new special initiatives:
 - (a) HIV/STDs/AIDS prevention and control
 - (b) Girl Child
 - (c) Reproductive Health
 - (d) Quality Assurance



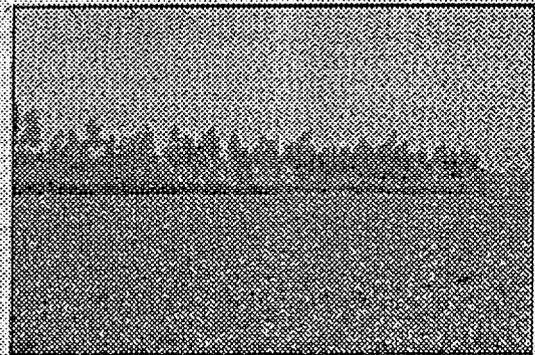
Now health & hygiene Abound.



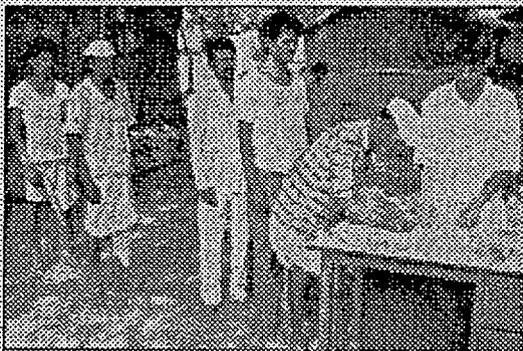
... Income and House to own.



Water of Life.



..... to fertility.



..... to literacy



Doctor's remedy tool

GEARING TOWARDS THE NEXT PHASE

(FOR PRIVATE CIRCULATION ONLY)

ST ANDIASO, PUNE 42.

Summary

At a time when the bulk of development funding is spent on crisis management, a small program is effectively helping to avert crisis by raising community health standards and expectations. Child Survival projects, which operate with community input at the community level, lower infant and child mortality, and empower communities in the process. The projects are low cost and results oriented. A program of regular assessment has found that they make a difference.

World Vision has implemented such a project in Navapur, Dhule Block, in India since 1990. A recent evaluation of the project as USAID funding for it ended, finds evidence of significant progress toward lowering infant mortality: increased immunization coverage; increased family planning; rising health and living standards; and progress in community organization and enterprise. By building capacity within the community through education and training, encouraging change in individual practice and expectation, and increasing interaction between the community and government and area institutions, the project has contributed to an increased pool of resources for health and development.

Over the course of project, the community has assumed more responsibility for funding its own needs, and the government has become more responsive to community needs. WV intends to continue supporting the community with reduced funds as an Area Development Project. As such, development priorities which have been addressed in the Child Survival project will increase in importance, and links with government and other organizations will continue to grow. Opportunities for cost recovery will expand. The project has already begun to serve as a training center for other community projects. Using the model developed in the Child Survival Program, successful strategies will be shared and replicated throughout the area World Vision serves.

The people of Navapur are, for the most part, still poor, but in partnership with World Vision, local government, area health facilities and area organizations, they are little by little moving towards self sufficiency. Parents want to have their children immunized; mothers know how to treat diarrhea; pregnant women understand the importance of prenatal checkups; villagers are not afraid to go to the health center. They know how to use and repair hand pumps and they know the value of clean water for health and agriculture. They are organizing literacy groups and savings societies. They want more schooling for their children. They know more about what they can have, and they want more. They see more opportunities and they are using them. These people deserve our support. Investments in programs like these generate dividends for everyone. A little help can go a long way.

“She saw that my baby was healthy;
then she started asking questions relating to the upbringing of her child.”

How do you make statistics breathe? How do you make them sweat?

In the Northwestern corner of India's Maharashtra State, people have been working to change their future. We have the figures that document their progress; we can show you the charts. But how do we document pride and enthusiasm; how demonstrate commitment, growth and increased capacity; how transmit excitement? Does it matter anyway? What is our stake in this future?

Being poor is defined by Karenji villagers as eating one meal a day

There have always been poor people. Children have always died. In that world we identify as "developing," communities have historically lived without enough food, without health care, with few amenities, and they have survived. In fact, their populations have grown. Why should we share our own resources? Why should we intervene?

26% of the villagers have been identified by their neighbors as very poor. Another 20% are defined as poor (two meals a day).

As technology, transportation and communication shrink the planet, we are aware more and more that we share the situation of our neighbors whether we want to or not. As the gap between rich and poor grows, population increases, and resources dwindle, the tension mounts. Ultimately we are faced with crises we cannot ignore, crises that are ugly and insoluble, crises that cost us far more than cooperative programs.

In some villages poverty means eating a meal every other day.

On the other hand, there are programs in effect in the world which help communities improve their lives and avert crisis - programs that work. After a decade of implementation of such programs, there is evidence that community-based initiatives can stimulate change for the better. There is evidence, for example that reducing child mortality reduces population growth. With increased faith in their ability to affect their own future, families can entertain plans for the future. With confidence that their children will live to maturity, they can choose how many to have.

The project initiated by World Vision in 1989 in Navapur is this kind of community-based program. In 1990, WV, with support from a USAID Child Survival Grant, initiated a project to improve the health and educational status of the children in tribal communities in villages surrounding Navapur Block, at the border of Maharashtra and Gujarat states. The Indian government had identified the communities in Navapur Block as among the neediest in India. Public health officials were eager to have a partner who could help in identifying and addressing their needs. World Vision's experience among poor communities, and its presence in the area through its sponsorship of children's hostels gave the organization an advantage in introducing a project which could effect positive change in these communities.

Subject to recurrent drought and crop failure, the Navapur block has rain only through the summer months. In August, Navapur is impressively beautiful country - softly green and rolling. Ten months of the year, though, the fields are brown from lack of water. Residents migrate to cities for work during the dry season, disrupting the community, interrupting the flow of available services, and fragmenting their children's education. In 1989, sixty percent of children under five of the 12,000 Mavchi, Vasavi and Kokna tribal families in the area were malnourished. Of 1,000 babies born alive, 124 would die before their first birthday primarily from neonatal tetanus, diarrheal diseases, measles and pneumonia. The lives of children under five were compromised by these diseases as well, and their effects were often exacerbated by vitamin deficiency.

World Vision based the Navapur project on principles established under the Child Survival Initiative: the use of low cost, effective, culturally appropriate strategies which include immunization, exclusive breastfeeding, appropriate introduction of complementary foods, birth spacing and appropriate care of acute childhood illnesses (fever, cough, diarrhea and malaria). Child Survival projects are predicated on a grassroots approach which includes the community in assessing needs, identifying personnel and implementing decisions, encouraging community participation and ultimately community ownership of the project. Project progress is assessed using indicators and tools developed for the Child Survival Program and field tested in functioning projects.

A rapid baseline survey, carried out at project start, determines health knowledge and practices of the population; needs are identified and objectives are based on findings from the survey and discussions with the community. An implementation plan for achieving the objectives is developed and reviewed by a panel of specialists with international health experience, and recommendations from the panel are integrated into the project's action plan. Over the years of implementation, detailed project reports track progress and expenditures. These reports are regularly reviewed by the funding agency (USAID/BHR/PVC) and there is regular communication between project and organization headquarters, and the USAID project officer. The Johns Hopkins PVO Child Survival Support Program offers technical assistance as needed and provides opportunities for information sharing and learning.

SUMMARY OF PROJECT CHILD SURVIVAL TARGETS AND ACHIEVEMENTS

OBJECTIVES	1991	END OF PROJECT TARGET	END OF PROJECT ACHIEVEMENT
IMMUNIZATION			
% of children 12-23 months, fully immunized by age 12 months with DPT3, OPV3, BCG, and measles vaccine	31%	85%(card)	96.7% (card) (592 children)
% of women 15-45 years who delivered in the last 12 months and were immunized by two doses of Tetanus Toxoid	3.3%	85%(card)	95.2%(card) (514 women)
ORT			
% of households with children 0-59 months with at least one member of the household competent in ORT use	0%	90%	95.2% (3,821 women trained)
% of children 0-23 months, with diarrhea in the last two weeks, who were given ORT	NA	90%	94.8%
NUTRITION + VITAMIN A			
% of mothers with children 0-23 months who know correct weaning and feeding practices	9%	85%	96.2% (1,090 mothers)
% of children 0-11 months given appropriate doses of vitamin A with their immunization	NA	90%	80.2% (592 children)
% of children 12-71 months given appropriate doses of vitamin A once every six months	NA	90%	99.9% 12-59 months (3,529 children)
MATERNAL CARE			
% of women, 15-45 years, who delivered in the last 12 months, and had at least two antenatal checkups by a trained person	NA	85%	94.2% (398 women -2 prenatal, 1 postnatal checkup)

"I'm learning to stand on my own feet."

The WV Integrated Child Survival Project at Navapur (ICSP) started out working in 15 villages. Over the course of three years 39 villages were added to the service area. About 9,700 families live in these village with an estimated population of 48,000. Staff was recruited from among the villagers and community development was targeted as the key to successful mobilization of the population. In September, 1995, when USAID funding ended, the Navapur program was phased into an Area Development Project, part of World Vision's new organizational structure. Area Development projects are organized to reflect regional needs and resources, and to take advantage of economies of scale, and a variety of funding. They integrate health and development strategies and allow flexibility of project design at reduced funding levels.

**"We realized that we needed to live what we were teaching,
and now we are better off because we do."**

Staff of today's Navapur project are visibly excited by the progress they have made in the community and by the skills they have acquired over the last five years. The Evaluation team visiting at the end of the original term of the project found staff eager to share their triumphs. Community health workers and community development workers glowed with enthusiasm. Villagers proudly received project workers and evaluators in their homes, and school children gathered to sing local songs to the visitors. Among their favorites were songs about health practices community health workers had made up and taught them.

"We saw the change in life in Bilmanjara. We wanted our village to change too!"

Many staff members have married while working at ICSP, and others have been recruited by their spouses. Couples serve as community resources and role models, and they are able to reinforce each other's work. Men understand and help spread health messages, and women encourage other women in the acquisition of development skills. Villagers look to them as facilitators in health and community activities, and in community organizations, which are themselves taking greater initiatives in health and development mobilization. One young couple, commenting on their experience in the project, articulated the change in their lives as a result "We realized that we needed to live what we were teaching, and now we are better off because we do"

DEVELOPMENT COMPONENT TARGETS AND ACCOMPLISHMENTS 1995

DEVELOPMENT OUTPUT	1995 TARGET	19 95 ACHIEVEMENT
HEALTH CAMPS ORGANIZED	10	10
GIRLS TRAINED IN VOCATIONAL SKILLS	10	8
ADULT LITERACY CLASSES INITIATED	10	18
HEALTH EDUCATION FILMS SHOWN	10	10
WOMEN'S GROUP MEMBERS VISITING MODEL DEVELOPMENT PROJECTS	150	120
DISTRICT LEVEL VETERINARY CAMPS	1	1
VILLAGE LEVEL VETERINARY CAMPS	10	7
BUFFALOES PROCURED FROM GOVERNMENT	50	78
ANIMALS VACCINATED SEMI-ANNUALLY (BUFFALOES, COWS, GOATS, POULTRY)	Not applicable	17,423
DAIRY COOPERATIVES INITIATED	1	1
FARMERS FACILITATED WITH TRAINING/EXPOSURE VISITS TO INITIATE KITCHEN GARDENS AND NEW FARMING TECHNIQUES	1,000	888
NEW COMPOST PITS DUG	400	834
FARMERS TRAINED IN PLANTING FRUIT TREES AND FOREST TREE SAPLINGS	400	400
NEW HAND PUMPS INSTALLED	15	26
HAND PUMP MAINTENANCE TRAINING SESSIONS	Not applicable	13
HAND PUMPS REPAIRED	Not applicable	13
RECURRING SAVINGS DEPOSIT ACCOUNTS OPENED BY TRIBAL FAMILIES	300	232

Survey results and evaluations demonstrate high levels of achievement in areas of maternal and child health and development. Staff members report that villages close to those working with the project have asked to be “adopted” into the program. In an area where mothers locked their doors against health workers offering immunization, 96% of children 12 -23 months are now fully immunized with DPT3 (diphtheria/pertussis/tetanus), OPV3 (polio), BCG(tuberculosis), and measles vaccines. Villagers are helping the project organize health camps and are using hospital services when they are needed. Project workers have attended training workshops in diverse subjects such as as general health, handpump maintenance, communication skills, appropriate technology and cold chain maintenance; and villagers have, at their own expense, visited development sites to see what others are doing. The prevailing sentiment in the community today is “if they can do it, we can do it!”

“We think of ICSP as our organization!”

Local government officials, health center and hospital personnel, and local press support for the project has grown steadily with increased cooperation and coordination of activities. The head of the district council, daughter of the local member of parliament, calls the Navapur project “our organization,” and personally responds to requests from project personnel. Government officials ask for assistance in setting up other “Navapur Model” projects, and the District Health Officer, in his plans for a fully staffed and equipped family planning center in Navapur, is considering assigning its technical oversight to the WV project. Health camps have been jointly organized by the project and the local hospital. Hosted by the village women’s clubs, these camps strengthen the project, build goodwill for the hospital, and accustom villagers to using such health services and paying for them.

“Our children are immunized. Previously the children were given no immunizations; now we know even about booster doses.”

The project has recently been the site of a training workshop in Participatory Rural Assessment, a collection of interactive exercises in which development workers learn about the communities with whom they work. These exercises help project personnel to appreciate and respect community knowledge and skills, understand community survival strategies and resources, and identify community priorities. In the future Navapur will serve as a training site for community workers from Area Development Projects. As an ADP, the Navapur project is increasing its emphasis on achievable community priorities in development and micro enterprise, technical training and education, while maintaining the level of health services achieved in the Child Survival Project.

“Diarrhea had reduced; even if there is diarrhea, we know what to do.”

TRAINING CONDUCTED IN 1995

TOPIC	PARTICIPANTS	DURATION	RESOURCE
General health	Nurse	5 days	District Health Office, Dhule
Handpump Repair & Maintenance	Village Development Workers (VDWs)	5 days	AFPRO, Ahmednagar
Goal Accounting	Account Officer/Accountant	3 days	World Vision/India
Leaf Plate Making	All Staff	1 day	Local Businessman
Income Generation	VDWs, Community Health Workers (CHWs)	1 day	ICSP Team
Communication Skills	VDWs, CHWs	1 day	ICSP Team
Better Animal Care	Community	3 days	Government/ICSP
Buffalo Rearing	Community	1 day	ICSP Team
Training of Survey Trainers	Project Manager	7 days	PVO CSSP/USAID
Management & Development	Accounts Officer, Project Manager	5 days	World Vision/India
Exposure Trip	Community	1 day	BAIF/Ralegoan Sid
Participatory Rural Appraisal	All Staff	5 days	World Vision/India
Appropriate Technology	VDWs, Account Officer	5 days	Ryan Foundation
Sun System	Account Officer	5 days	World Vision/India
Cold Chain Maintenance	Public Health Assistant	½ day	District Health Office, Dhule

“We want to gain knowledge and know what is happening in the world.”

Reviewers experienced in the workings of international assistance programs have identified indicators which can serve to predict sustainability for project activities when donor funding ends. Sustainability is defined as the maintenance of individual, community, NGO, health system, and private sector partnership capacity to continue services necessary to achieve locally established targets with minimum external input. These include community ownership of the program, confidence in project workers, and willingness to contribute to the support of personnel and services with labor, land, supplies and money, and willingness to pay for services and supplies.

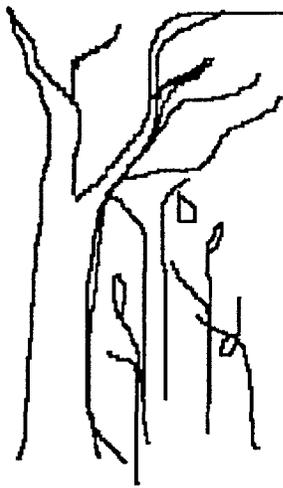
“We have planted many trees in our village, and also vegetable gardens which help us very much.”

Continuing training for community health and development workers, coordination and partnership with local and government agencies in providing and administering services, and communication of project goals and accomplishments in the community support the persistence of progress. Projects which respond to multiple community needs and develop activities in education, water, and agriculture have increased potentials for sustaining accomplishments. It is clear, however, that institutionalizing these accomplishments is a long term goal that is not achieved overnight - that is, in only a few years. Community desire to maintain activities, and community participation in the process are key to continuing the activities as outside funding is reduced.

“70% of the farmers have stopped selling cow dung to the businessmen and have started to use it in their own fields.”

The ADP structure will enable the project to continue as WV provides less direct financial support and the project develops other financial options. Activities which were begun by WV staff will be taken over by community organizations, by the local hospitals and health services, and by the government. Income generating activities like the successful dairy coop established in the last three years, will be enlarged and replicated. Women's groups, already active in immunization and health education activities, and farmer's clubs will be encouraged to take more responsibility for motivating health practices and for stimulating cost recovery plans and organizing financial support of project services. Partnerships already in place are being strengthened so that the balance of responsibility slowly shifts to the local resource.

The Navapur project with its dedicated staff, supporting network, and enthusiastic community support has made impressive progress over its first five years. As an Area Development project it can maintain and enlarge these achievements, multiplying its success by serving as example and teacher for other projects, continuing to build its own resources and those of other Indian communities as well.



Ampada village became part of the Navapur ICSP in 1990. The project provided buffaloes to a small group of poor families selected by the Women's Group, with the agreement that the buffalo loans be paid back. The following is excerpted from an interview with a buffalo holding family which appeared in the project publication, *Winds of Change*.

Occupation before getting the buffalo?

Very poor, could hardly afford a full meal...

Cost of the buffalo?

6700 Rupees.

Paid back?

5500 Rupees.

How much milk do you get each day?

When we bought the buffalo she used to give eight liters a day. She calved three months ago and now gives seven liters a day.

What do you do with the milk?

We drop the milk in the Dairy at Gujarat, but have always kept ½ liter of milk in the house.

How do you think you have benefitted?

I have bought a Kinetic Spark Scooter, and I drop milk for others as well and get paid for doing that. This is an added income. We have repaired the house. I bought a silver neckchain for my wife, and I save 10 Rupees a month, and my son saves 30 Rupees a month.

I used to drink, but now I don't have time because I am responsible for dropping milk at the dairy for myself and for others as well.

Over the course of this project, 300,000 saplings were planted

WORLD VISION RELIEF & DEVELOPMENT
India PIPELINE September 30, 1995

INDIA 0105

	Budget		Expenditures			
	Year to-date Jun/95		Grant to-date		Funds Remaining	
	AID	WV	AID	WV	AID	WV
I. DIRECT COSTS						
Personnel	115,602	0	124,075	1,396	(8,473)	(1,396)
Training	0	0	7,010	0	(7,010)	0
Travel	40,700	0	55,267	1,056	(14,567)	(1,056)
Supplies	34,430	18,277	17,877	99,325	16,553	(81,048)
Occupancy	0	0	9,093	440	(9,093)	(440)
Rep/Maint	0	0	7,022	61,485	(7,022)	(61,485)
Communications	0	0	15,700	0	(15,700)	0
Prof Fees	63,510	0	39,066	0	24,444	0
Other	41,231	0	8,017	4,512	33,214	(4,512)
Capital Expense	94,400	139,810	2,743	27,128	91,657	112,682
MSC/ see below	0	0		0	0	0
TOTAL - DIRECT COSTS	389,873	158,087	285,870	195,342	104,003	(37,255)
II. INDIRECT COSTS	59,094	3,655	56,626	33,643	2,468	(29,988)
A. Headquarters - 20% of direct costs less Equipment & GIK & GIK transport						
B. Allocation of Field Country Administrative and Program Support Costs (see schedule)		104,071		36,100	0	67,971
SUBTOTAL - INDIRECT COSTS	59,094	107,726	56,626	69,743	2,468	37,983
GRAND TOTAL	448,967	265,813	342,496	265,085	106,471	728
						107,199