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Pragati
Child Survival Project

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

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

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ACRONYMS

ADP	Area Development Program
AFP	Acute Flaccid Paralysis
ANC	Antenatal Clinic
ANM	Auxiliary Nurse Midwife
AWW	Anganwadi Worker
BCC	Behavior Change Communication
BRICS	Ballia Rural Integrated Child Survival Project
CDO	Community Development Officer
CDPO	Child Development Project Officer (ICDS)
CEDPA	Center for Development and Population Activities
CMO	Chief Medical Officer
CSSA	Child Survival Sustainability Assessment
CSP	Child Survival Project
CSTS+	Child Survival Technical Support (Plus) Project
DIP	Detailed Implementation Plan
DPT	Diphtheria, Pertussis, Tetanus vaccine
DPO	District Program Officer (ICDS)
EPI	Expanded Program on Immunization
FGD	Focus Group Discussion
GOI	Government of India
GSS	Gramin Swasthya Sevikas
HWPA	Health Worker Performance Assessment
ICDS	Integrated Child Development Scheme
IDI	In-Depth Interviews
IFA	Iron Folic Acid tablets
KPC	Knowledge, Practice, Coverage
LHV	Lady Health Visitors (Supervisors of ANMs)
LQAS	Lot Quality Assurance Sampling
PME	Performance Monitoring and Evaluation
MTE	Mid-Term Evaluation
MOH	Ministry of Health
MS	Mukhya Sevikas (Supervisors of AWWs)
MSH	Management Sciences for Health
NFHS	National and Family Health Survey
NGO	Non-Governmental Organization
OPV	Oral Polio Vaccine
PHC	Primary Health Center
PVO	Private Voluntary Organization
RH	Reproductive Health
RMP	Registered Medical Practitioner
SHG	Self Help Group
SIFPSA	State Innovations in Family Planning Services Agency
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
TOT	Training of Trainers
UP	Uttar Pradesh
VLDP	Virtual Leadership Development Program
WHO	World Health Organization
WV	World Vision

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A. Executive Summary

Pragati Child Survival Project (CSP) is a four-year cooperative agreement between USAID/Washington and World Vision US, in the Child Survival and Health Grants Program's Expanded Impact category, for the period FY 2004-07. Pragati will reach approximately 1.13 million children under the age of five and 1,609,280 married women of reproductive age, living in over 5000 villages in Ballia, Lalitpur and Moradabad districts of Uttar Pradesh state in India. Pragati takes to scale methods and tools developed and introduced in the Ballia Rural Integrated Child Survival (BRICS) Project, which ended in September 2001.

The project takes a focused set of Child Survival (CS) and Family Planning (FP) interventions to scale in the three districts. These interventions, with their proportionate levels of effort, are: Immunization (40%), Family Planning (30%), Maternal and Infant Nutrition (20%) and Vitamin A Supplementation (10%).

Under a new initiative for CS grant projects, 30% of Pragati's funds were provided from USAID's Population & Reproductive Health Flexible Fund (Flex Fund). Consequently, Flex Fund indicators were added to the results framework, and a baseline survey was conducted for married women of reproductive age.

Rather than providing direct service delivery, Pragati CSP seeks to:

- Improve the technical and service delivery capacity of its partners, and
- Build up demand and utilization of these services in communities.

Key partners include the Integrated Child Development Scheme (ICDS) and the Ministry of Health, both under the Government of India, as well as local NGOs. The grassroots workforce of the project is composed of Anganwadi Workers (AWWs) under ICDS, numbering approximately 4400 in the three districts.

In the first year of the project, four offices were established; staff was recruited; and all assessments were completed. In addition to routine quantitative surveys (KPC and Health Worker Performance) and qualitative studies (including Focus-Group Discussions and In-Depth Interviews), a survey of Married Women of Reproductive Age (MWRA) was carried out, as well as NGO and Community Competence assessments.

In the field, extensive networks are being developed. The profiling of communities has been completed. Relations have been established with various partners, and local NGOs have been identified and brought into the process. Manuals for training and supervision of the AWWs were designed, and training has been conducted at three levels. Approximately 750 AWWs and supervisors have been trained to date.

A participatory review was undertaken at the end of the first year of the project, in accordance with USAID guidelines. The review team assessed first-year achievements, visited the field to interview field staff, health workers and district officials, and drew up a list of recommendations for the coming year.

The review team's recommendations have been fully accepted by Pragati CSO staff: from October 2004, the project will fast track its implementation, giving priority to the introduction of registers, and will intentionally build partnerships at all levels.

B. Program Overview

As an acronym, PRAGATI stands for "Protecting and Advancing Gains". In Hindi, *pragati* suggests "acceleration" or "a gain in momentum". Pragati Child Survival Project is a four-year cooperative agreement (FY 2004-2007) between USAID/Washington and World Vision US. It was awarded under the Expanded Impact category of the Child Survival and Health Grants Program. This project will be implemented in Ballia, Lalitpur and Moradabad districts in Uttar Pradesh (UP). Pragati brings to scale the strategies, methods and tools developed and tested in the Ballia Integrated Rural Child Survival (BRICS) project, active FY 1998-2002.

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

Project Location and Demography

Uttar Pradesh State, the most populous of the country's 29 states, is located on the Ganges plain in northern India. With a population of 166 million, the state is divided into 70 districts in four regions, each having distinct dialect, culture and tradition. The three project districts are diverse and widely separated:

Ballia district is located in the eastern (Purvanchal) region, close to the border with Bihar state. The predominantly agrarian economy benefits from fertile alluvial soil and abundant water supply. However, an estimated 60% of the population is landless.

Moradabad has a predominantly Muslim population (70%). Only 24.7% of the population is literate. Moradabad district is in the western part of UP, close to Delhi. A majority of the population is employed in the brass industry, for which this district is renowned. Moradabad is one of the four districts in UP that have been a particular challenge to the country's polio eradication campaign, with a high proportion of families refusing OPV immunization and continued transmission of wild poliovirus.

Lalitpur district is one of the 7 districts in the southwestern (Bundelkhand) region of UP, and is located close to the border with Madya Pradesh state. The district still has extensive forests. Most people work on their own small farms and supplement their income by working in stone quarries. Urban migration is minimal.

Results Framework

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

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

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

The proportionate level of effort allocated to each Pragati intervention is as follows:

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

Methods and Strategies

Key partners of the project include: 1. the Ministry of Health (MOH) in Uttar Pradesh; 2. the Integrated Child Development Scheme (ICDS), and 3. Local NGOs.

The Ministry of Health operates health centers at block and village level, providing basic health services for a majority of the population in each district.

The ICDS has grassroots workers, known as Anganwadi Workers, who are responsible for educating and linking people to the government health system. The AWWs are key counterparts for Pragati CSP.

Local NGOs are situated in each of the districts, and will assist in coordinating and supporting AWWs, and strengthening linkages at community level.

Strategies employed by Pragati CSP include:

1. Performance assessment and improvement for AWWs and ANMs, identifying areas of competency critical for quality service delivery, and assess proficiency levels of service providers in these areas.

2. Ensured early registration of all pregnant women. This is crucial to ensure the provision of all services in a timely manner.

3. Targeted and timed behavior change communication for families. As opposed to group health education, this involves communicating "sets" of behaviors related to the project's intervention areas, to mothers and other Married Women of Reproductive Age, as well as decision-makers in their families, at appropriate times, and tracking changes in behavior within these groups.

4. Improved block and village level planning and use of data. This involves taking data back to those from whom it was collected and process the data to optimize its use at each level and create an enabling environment for the AWW to function effectively.

3. Phased coverage of blocks in each district, and of villages within each block.

C. Progress During FY 2004

Program Management

The Pragati CSP main office was relocated from Ballia to Lucknow, the capital of Uttar Pradesh, in April 2004. More efficient access to the three widely separated project districts, and proximity to the UP Health and ICDS offices, were the main reasons for this relocation. The project's seven-person Coordination Team is based in Lucknow. This team includes the project Manager, M&E Officer, Capacity-Building/Documentation Officer, Technical Officer, Finance Officer, ACOLES Officer and Family Planning Coordinator.

All three District Teams are fully staffed, and their offices have been established and equipped. Each team is led by a Project Officer, and includes a Technical Assistant, Accountant and Driver, as well as 3-5 Field Coordinators (3 for Lalitpur, and 5 each for Ballia and Moradabad). These teams have completed their initial technical training, and are working together effectively. Each team holds regular meetings, along with other joint activities intended to strengthen leadership and teamwork skills.

The three Project Officers and members of the Coordination Team meet once a month in Lucknow to review progress and address management issues. This time is also used to discuss key leadership-related topics, in conjunction with Pragati staff participation in the MSH Virtual Leadership Development Program (VDLP), which began in September and will continue through December 2004.

Baseline assessments have been completed in all three districts, including: KPC surveys, Health Worker Performance assessments, NGO Capacity assessments, Community Capacity assessments, and AWW assessments.

Detailed Implementation Plan (DIP)

The DIP was developed through a series of meetings, initially with World Vision and CSP staff, and then with key stakeholders at the district and state levels, facilitated by an external consultant. A first draft of the DIP was developed at a workshop held in Delhi, with the participation of Pragati CSP staff and partners (including state and district health and ICDS officials as well as family planning specialists from CATALYST/India), and support from consultant Dr. Marc Debay.

The draft DIP was presented to the USAID mission in March 2004, and submitted to USAID/Washington in late April. After extensive review and further revisions, the DIP was presented at the CSGHP Mini-University, held at Johns Hopkins University in June 2004. USAID approved the DIP at that time, with the understanding that a survey of Married Women of Reproductive Age would be carried out as planned, with results to be included in this report – see Annex (iv).

Sustainability Assessment

Concurrent with other steps in preparing the DIP, Pragati staff and partners at district and state level also developed a joint sustainability plan based on the Child Survival Sustainability Assessment (CSSA) framework. An essential process of dialogue and consensus building was initiated with key stakeholders in all three districts, and culminated in a four-day workshop held in Lucknow, with representation from each district, last February. Eric Sarriot of the CSTS+ project supported this process with invaluable technical assistance by e-mail during initial stages, through direct facilitation of the workshop, and subsequent follow-up.

At the outset, Pragati staff introduced other stakeholders to the CSSA framework and conducted visioning exercises in each of the three project districts. On the basis of these discussions, the team decided to divide CSSA Dimension I, separating the measurement of Health Status from Health Services. This was done "to account for the fact that health status can change without change in health services during or after the project."[1] During the sustainability workshop, a common vision was adopted, and elements of the four dimensions were identified and prioritized. Workshop participants felt it was necessary to consult more broadly with communities in each district before finalizing and adopting a project-wide sustainability framework. Pragati staff and partners also agreed that the sustainability framework should be more closely linked to the Pragati results framework.

The Sustainability Workshop produced the following outputs:

- A common, project-wide vision was articulated.
- Elements were identified and prioritized for each dimension.
- A project-wide sustainability framework was developed in draft form.

Sustainability assessment activities since the workshop include:

- Local NGO Capacity assessments (quantitative, through guided self-assessment)
- Community Competence assessments (qualitative, with scoring)
- AWW Capacity assessments (qualitative)

These assessments are described elsewhere in the report.

The key benefit from introducing the CSSA framework, with TA provided by CSTS+, is that the framework provides a common platform for all partners, and helps to focus their attention on measurable results and a commonly desired future. At the outset of an ambitious undertaking, it has helped a diverse group of partners "start on the same page".

The necessary groundwork for Sustainability Assessment consumed more time and effort than anticipated. These activities had a significant opportunity cost, competing to some extent with other steps crucial for DIP development, capacity building and early stages of implementation. Project staff had to give urgent priority to implementation of field activities in all three districts, while working on leadership and team building. In these circumstances, further refinement of the sustainability framework was postponed. Remaining steps, which will be completed in FY 2005, include:

1. Developing indicators for each dimension of the framework;
2. Reviewing each of the elements prior to the MTE, with assessment of progress.

Monitoring and Evaluation

Baseline Surveys:

An intensive series of surveys and qualitative studies were designed, and carried out in all three districts, during the first quarter of FY 2004, in preparation for the DIP. Separate sampling frames were used for each district, and thus separate surveys were conducted in each district. Data processing and analysis were done centrally in Ballia. Reports of these surveys were submitted with the DIP in April 2004. These studies are summarized in the table below:

#	Subjects	Survey Method	Districts Covered	Sample Size
1	Mothers of children 0-11 months	Two-stage 30 cluster	Ballia, Lalitpur and Moradabad	900 (300 in each district)
2	Mothers of children 12-24 months	Two-stage 30 cluster	Ballia, Lalitpur and Moradabad	900 (300 in each district)
3	Married women of reproductive age (15-49 years)	Two-stage 30 cluster	Ballia, Lalitpur	600 (200 in each district)
4	Health worker performance assessment	Stratified random sample (2 strata)	Ballia, Lalitpur and Moradabad	90 (30 in each district)
5	Private medical practitioners (RMPs), Traditional Birth attendants (TBAs), mothers-in-law and married men	Qualitative study	Ballia, Lalitpur and Moradabad	60 FGDs (5 groups x 4 categories x 3 districts)

Married Women of Reproductive Age (MWRA) Survey:

A separate report on the MWRA survey, summarizing methodology and findings, is included with this document, in Annex IV. This responds to the stipulation from USAID/CSHGP at the Pragati CSP DIP Review, during the Mini-University held at Johns Hopkins in June of this year. Approval of the project's DIP was granted with the understanding that the MWRA survey would be completed before the end of FY 2004, and that findings would be reported with the FAR.

Additional Qualitative Assessments:

Baseline qualitative studies required for the sustainability framework were carried out by members of the project team responsible for capacity development.

AWW assessments were carried out *"to assess their knowledge attitude towards their work, to identify constraints and assess their work load"*.

Two focus group discussions were held in each of the three districts on the following themes: (1) Knowledge of work, (2) Perceived competencies, (3) Supervision and support, (4) Perception of effectiveness, (5) Motivation and (6) Community participation.

Community competence assessments were carried out *"to assess the competence to provide a enabling environment for the AWW and ANM".*

Three focus group discussions were held in each of the three districts. Groups separately comprised of men, women and youth were brought together to discuss the following issues: (1) Participation in development, (2) Leadership, (3) Access to and utilization of information and (4) Community organization. These assessments used methodology adapted from the ranking system and focus group guidelines developed by World Vision for its Transformational Development Indicators.

NGO Assessments were held *"to make appropriate plans to build the capacity of the NGOs to sustain the gains made in health".*

A guided self-assessment tool was used to assess four NGOs in Ballia and two in Lalitpur with respect to the following capacities: (1) Organizational Governance and Leadership, (2) HR Management, (3) External Relations, (4) Finance, Management and Administration, (5) Financial Viability/Resource Mobilization and (6) Implementation Capacity.

Registers:

Tools developed, tested and used in Ballia District between 1997 and 2001, under the BRICS Project, have been adapted and further refined. Training in their use was conducted in three tiers, for field workers and their supervisors. Details are in the table below:

#	Tool	User	Purpose
1	Pregnancy register	AWW	Early registration and tracking of pregnant woman to convey the BCC messages and follow up
2	Infant register	AWW	Early registration and tracking of infants and to convey the BCC messages to mother
3	Eligible couples register	AWW	Registration of eligible couples to convey BCC regarding FP and for follow up
4	Monthly progress report	AWW	Consolidation of all the registers and to know the progress in work
5	AWW registers supervisory checklist	Mukhiya Sevikas/ Pragati staff	To check the quality and completeness of the registers and MPR
6	Monitoring tool for training programs	Pragati staff	To monitor the arrangements and quality of the training program
7	Consolidated training report	Trainers/ Facilitator	To report the daily activities during the training program

Capacity Development

Training:

Three levels of training were conducted in each of the three districts:

Key Facilitators	Total Number Trained	Duration
Master TOT for External Trainers and Project Officers of Pragati CSP	10	6 days
Lead TOT for Mukhya Sevika/Lady Health Visitors	84	6 days
Training for AWWs	710	5 days

The training of master-trainers was held in Lucknow, where the coordination office is located, followed by the training of lead-trainers held in each of the three districts. AWWs received training in their respective blocks. During each session, a pre-test and post-test were conducted to assess their increased knowledge level.

Materials Development:

The following materials were developed for purposes of training, monitoring and supervision:

- A manual for training and supervision of child health, for use by the MS and LHV in training AWWs.
- Registers for tracking the progress of pregnant women and infants, as well as eligible couples.
- Supervisory checklists to assist the Mukhya Sevikas in monitoring and supporting the work of AWWs.
- Counseling plan for pregnant women, infants and eligible couples for use by the AWW.
- Monthly progress reports for the AWWs.

Family Planning Interventions

Thirty percent of the project's budget and level of effort is committed to support for delivery of family planning services to all MWRAs. This component of the project is funded by the USAID Flexible Fund. In addition, Flex Fund arranged for the provision of technical assistance through CATALYST/India, including full-time secondment of a Family Planning Coordinator, who is helping to develop the capacity of other Pragati staff, as well as counterparts, in each district.

The major achievements of this collaboration have been:

a. Design and implementation of a 30-cluster survey for MWRAs;
b. Development of a Family Planning section for the AWW Training Manual;
c. Completing the Training of Master Trainers, and mentoring subsequent training;
d. Assistance in developing the operations research protocol related to FP; and
e. Supervision and support of field staff and partners during initial implementation.

As noted above, a report on the MWRA survey, with details on methodology and findings, is included here, in Annex IV. This responds to the stipulation from USAID/CSHGP at the Pragati CSP DIP Review, during the Mini-University held at Johns Hopkins in June of this year. Approval of the project's DIP was granted with the understanding that the MWRA survey would be completed before the end of FY 2004, and that findings would be reported with the FAR.

Operations Research Protocols

A workshop was held in August 2004 to develop protocols for the three Operations Research (OR) topics identified in the DIP. These include:

1. Expanding contraceptive choices (through introduction of natural FP methods);
2. Evidence-based advocacy for improved immunization coverage; and
3. Sentinel surveillance for fertility and mortality.

Participants included key staff of Pragati CSP and WV India, working under the sound technical guidance of consultant Dr. Marc Debay. The team began its work with discussions and field visits in Ballia District, and then continued in Lucknow. They were joined there by Dr. Bulbul Sood, Country Director for CATALYST/India, who participated in discussions on the protocol related to family planning. The protocols include reviews of relevant literature, specific research questions, indicators and timelines for research activities.

A draft of the family planning-related protocol was reviewed by Virginia Lamprecht of USAID Flex Fund and Rebecka Lundgren of Georgetown University, who both provided invaluable comments leading to further revision. Current (and nearly final) draft protocols are included with this report in Annexes VI-VIII. Their phased implementation will begin in October 2004, consistent with the timelines mentioned above.

Field Operations

During the first year of the project, training of ICDS workers at all levels has been the primary focus of field operations. In addition, development of profiles and networking at block level has been undertaken on a wide scale in all three districts.

Ballia: A total of 54 persons, including Mukhiya Sevikas (MS) and Lady Health Visitors (LHV), were trained in three batches as lead trainers, and 433 AWWs were trained in 21 batches, introducing them to the project's technical interventions. Training was held in each of the blocks, for periods of 6 and 5 days respectively.

In the process of implementing project activities, good rapport has been developed with district and block-level health and ICDS officials.

Lalitpur: A total of 24 persons, including Mukhya Sevikas (MS) and Lady Health Visitors (LHV), were trained in two batches as lead trainers, and 139 AWWs were trained in 6 batches, introducing them to the project's technical interventions. Training was held in each of the blocks, for periods of 6 and 5 days respectively.

Regular monthly meetings with district and block-level health and ICDS officials are being held to strengthen linkages.

Moradabad: A total of 16 persons, including Mukhya Sevikas (MS) and Lady Health Visitors (LHV), were trained in one batch as lead trainers, and 138 AWWs were trained in 5 batches, introducing them to the project's technical interventions. Training was held in each of the blocks, for periods of 6 and 5 days respectively.

Good rapport has been established with district and block-level health and ICDS officials.

Challenges and Constraints

A project of this scale and magnitude has had its share of challenges in its first year:

The scale of operations in three widely separated districts: This is both the purpose of the project as well as a challenge. The three districts are located 6-12 hours by rail, east, south and west from in Lucknow. The project's Coordination Team is traveling most of the time, and the schedule they have maintained during the first year has often been exhausting. The work of field staff in each district has also been very intensive.

The workload of AWWs, and their motivation: Various sectoral agencies and programs want to take advantage of the AWWs' presence at the grassroots. They are asked to take responsibility for a wide range of activities, from leprosy control to NFE for girls who have dropped out of school. These expectations, combined with a lack of supportive supervision, contribute to generally low levels of motivation. However, AWWs in Pragati districts have begun to see the project's value in helping to simplify and streamline some key tasks, making a real difference in the communities they serve.

Maintenance of supplies, and prevention of stockouts at health centers: In the past, a lack of timely and accurate reporting upward from peripheral facilities has led to frequent and prolonged stockouts. Much of the project's effort toward building a simplified and workable, yet complete MIS from the AWW upward, will be directed towards reducing stockouts. The project is also conducting focused advocacy at block, district and state levels to help ensure the uninterrupted supply of essential commodities.

Differences in the pace of work among the districts: Various factors affect the pace of work in each district, and coordination has been – and will continue to be – a challenge. Monthly meetings with key staff and partners in each district, as well as regular meetings of the Project Officers and Coordination Team in Lucknow, can help to minimize these differences and mitigate their effects on the progress of implementation.

D. FAR Methodology

The Terms of Reference prescribe a review strategy that fulfills the criteria established by the USAID/CSHGP annual review guidelines. The review methodology included the following:

- Presentations from the Pragati Team;
- Review of documents and reports;
- Field visits in each of the districts;
- Brainstorming on proposed strategies; and
- Conclusions and synthesize the findings.

Data Collection and Analysis: The team leader was responsible for overall methodology and design of the data collection techniques, guiding analysis of the data, and providing an assessment of project implementation based on this data. Data collection methods included:

- A review of project documents and records;
- Field visits and observation;
- Focus group discussions and key-informant interviews with stakeholders, including:

    3 Interviews were held with MOH officials
    3 Interviews with ICDS officials
    1 Focus group discussion with the Master Trainers.
    3 Focus group discussions with LHVs and Mukhiya Sevikas (Lead Trainers)
    6 Focus group discussions with Anganwadi Workers

E. Findings and Recommendations of the FAR Team

#	Key Findings	Recommendations	Response of Pragati CSP Staff
1	Baseline surveys and detailed planning, plus the initial phases of training have taken up a large proportion of the staff's time. Implementation of field activities, and particularly the identification and registration of beneficiaries, counseling and linking them to service providers, has only just begun.	**Re-focus the project's vision, developing and testing** a **strategic partnership model for rapid scale-up** of key child survival and reproductive health services to achieve increased coverage and improved outcomes.	**Agreed:** The focus of the coming year will be to demonstrate steadily increasing coverage.
2	Trust and coordination among Health Department and ICDS officials and workers are seen to be lacking or inadequate at all levels.	**Develop and implement an intentional plan for partnership, team building, networking and evidence-based advocacy** at state, district, block, sub-center and community levels.	**Agreed:** Steps being taken to address this issue include: - Joint supervisory visits by Health Department, ICDS & Pragati staff. - Joint development of supervisory checklists. - Monthly meetings at sector, block and district levels, in which partners will discuss issues and resolve any problems.
3	The major field level activity (apart from profiling and rapport building) has been the trainings	**Fast track the process of implementation –** do not wait until all workers are trained in a block before commencing activities.	**Agreed:** Implementation is scheduled to begin right after the FAR, coordinated with the household survey dates set by ICDS.
4	The AWWs have been trained in the use of registers for pregnant women and infants.	**Push for the trained Anganwadi Workers (AWWs) to quickly introduce community registers,** in order to track and refer each new cohort of pregnant women and newborns for service.	**Agreed:** AWWs have been trained in the use of these registers, and their routine use began in late September, in accordance with the ICDS work schedule.

5	Health Department and ICDS officials have expressed strong desire for joint supervisory visits to improve coordination, and thus raise coverage.	**Jointly develop and implement a supervisory plan and schedule** for AWWs and ANMs, using appropriate supervisory tools.	**Agreed:** A field supervision protocol has been developed for all levels of staff, and its implementation has begun.
6	There is a disproportionately large amount of effort being given to FP interventions by project staff. These add-on interventions could greatly increase the workload of the AWWs as well, because of the large numbers of MWRAs	Finalize with ICDS and MOH **the appropriate role and level of effort for the AWW in family planning.**	**Agreed:** A key decision was recently taken in this regard: AWWs are to provide FP counseling and referral services only for mothers of infants. These mothers are numerous, so targets may still be ambitious, and will be reviewed in the MTE.
7	The project is technically demanding. It is imperative that technical backstopping and day-to-day management of the project be handled by two people, rather than one.	**Appoint a CSP Manager to run the day-to-day operations of the project**- this will allow Dr Beulah to focus more on technical backstopping of the project and on scaling up to other World Vision ADPs.	**Agreed:** This process has been initiated jointly with the HR department. Dr. Beulah will continue to provide technical and supervisory support after a manager is recruited. This is expected to take several months.
8	The three project districts are vast in terms of geography and population. Monitoring may not be effective with current staff structure, given limited numbers of Field Coordinators in particular.	**Increase the number of Field Coordinators (FC) in each district so that one FC covers one block** to fast track and scale-up activities, thereby increasing coverage.	**Agreed:** The budgeted number of FCs does seem impractical, considering the area to be covered, and the deliverables. However, it is not realistic to assign one FC per block, for two reasons: (1) the project budget will not support this, and, (2) finding staff of good caliber, willing to live and work in Pragati districts, will be a challenge. The current number can be doubled, and vacant positions for field coordinators thus created will be filled over the next three months.

Other Findings of the FAR Team

Training:

One of the major activities of the year was training, conducted in three phases. The outcomes of this training, as reported by key counterparts, follow:

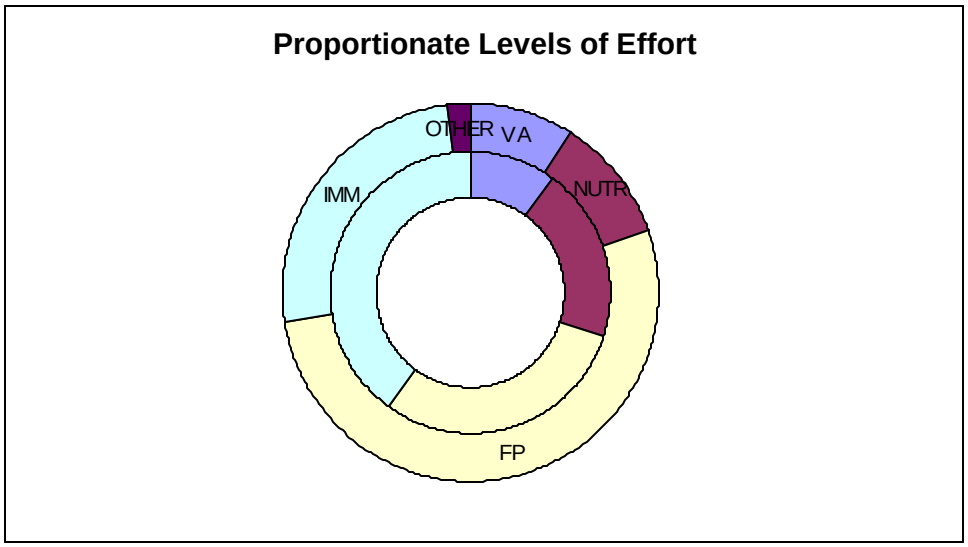
Training given by Pragati CSP provided correct and appropriate information needed for effective functioning of the Anganwadi worker. They received information beyond their own departments training and has improved their counseling skills also. The time schedule and all other logistic arrangements were appreciated. Some of the AWWs in Lalitpur felt the need to reduce the time of training, and suggested a increase in the training duration by one more day for lack of proper commutation reasons. The need for better support and coordination between the AWW and the ANM was expressed. The family planning related activities increases their workload and the need for increase in remuneration was expressed as a concern. A handbook for the AWW with all information was requested, and this is being developed by the project. Above all, they were motivated by the fact that they are part of the process in reducing child mortality rates

The Mukhya Sevikas were encouraged by the opportunity they had to be a trainer and it was a first time experience for some of them to conduct training for the first time. It has improved their relationship with each other.

The health officials also insisted on concentrating the ANM's in terms of capacity building. It was also expressed to appoint ANM's at all sub centers and motivate the ANM's to go to the sub-centers. There was a felt need to have joint meetings and supervision with the Health and ICDS officials.

Analysis of AWW Workload and Training

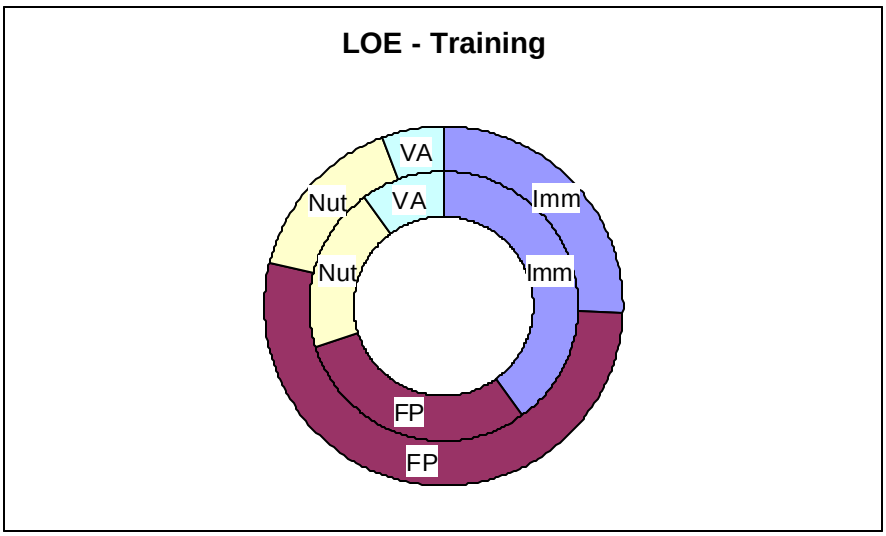
(1) The distribution of the AWW workload was reviewed and it was found that about 50% of her efforts go towards FP activities, mostly owing to the huge numbers of MWRAs. The inner circle in the graph below represents the proposed levels of effort and the outer one, the actual levels currently encountered in the field:



The chart above is the outcome of an apportioning exercise conducted by the FAR team in considering the AWWs' workload:

Visit timing	Number of visits/year/ intervention	Number of Beneficiaries	Nutrition	Family Planning	Immunization	Safe Motherhood (and others)
Pregnancy visit 1	0.5	40	20		20	
Pregnancy visit 2	0.5	40		20		20
Pregnancy visit 3	0.5	40	20			
Pregnancy visit 4	0.5	40	20		20	
Infant visit 1	1	36			36	
Infant visit 2	1	36	36			
Infant visit 3	0.5	36	18		18	
Accompany infant for immunization	5	36			180	
Eligible couples (numbers)	4	136		544		
Door-to-door for VAS	2	50				
THR/VA (take-home ration days)	1	32				
TOTAL		1072	114	564	274	20
Percent of total (%)		100	10.63	52.61	25.56	1.87

It was therefore decided, in consultation with CATALYST/India and ICDS, that AWWs will give priority to FP counseling, supplies and referral for mothers of children 0-11 months of age. This would still amount to a considerable number of beneficiaries per AWW, with potential for increasing CPR. In the block where OR1 is being implemented, the AWW would target all mothers of children less than 23 months of age, still permitting the addition of LAM/SDM there. Meanwhile, training will continue as planned, with a majority of the time allocated to FP topics, since this is a new technical area for the AWWs.



Phased Coverage for FY 2005

Given progress to date, and recommendations of the FAR team to accelerate implementation of project activities, the following targets have been set for FY 2005:

Ballia's coverage with CS/FP interventions provided through AWWs in the coming year will reach 100 % in 10 blocks, and 50 % in the remaining 7 blocks, out of the district's 17 blocks.

Lalitpur's coverage will reach 100 % in 3 out of the district's 6 blocks..

Moradabad's coverage will reach 100 % in 6 out of the district's 14 blocks.

Full coverage in all blocks of the three districts should be reached in the first half of FY 2006, as projected in the Detailed Implementation Plan (page 57).

Annex I

Pragati Child Survival Project

USAID COOPERATIVE AGREEMENT # GHS – A–00-03–00018–00

FIRST ANNUAL REVIEW
Terms of Reference

Key Objective

To conduct the first annual program review of the Pragati CSP and make recommendations on future strategies, activities and capacity building needs within the project

Purpose

The purpose of the First Annual Review (FAR) is to take stock of the accomplishments of the project in its first year of operation, identify constraints, critically review the proposed strategies for implementation in the light of the constraints, and provide recommendations on future directions.

Specific Objectives:

1. To review the accomplishments and constraints of the project from the start to the end of the first year comparing these with the deliverables put forth in the DIP
2. To identify factors which have contributed to the achievement of the progress and factors that have impeded progress.
3. To identify any substantial changes required from the approved agreement and DIP which would require a modification to the cooperative agreement and make recommendations if any are found.
4. To identify areas for technical assistance, if any.
5. Respond to the issues raised, if any, at the DIP submission.
6. To review program management system and discuss any factors that have positively or negatively impacted the overall management of the program since inception.
7. Communicate key review findings, conclusions and recommendations of the review to clients, and document them in the form of a Third Annual Review Report, which should include but is not limited to the following:
8. Summary and Recommendation including review methods, site visited, dates of fieldwork.
9. To make over-all recommendations for the strategy for the continuation of the project activities beyond FY 2002.

Evaluation Methodology

The Terms of Reference proposes a review strategy that fulfills the criteria established by the USAID Child Survival Annual Review/Third Annual Review Guidelines. The review methodology included the following:

- Presentations from the Pragati Team;
- Review of documents and reports;
- Interviews and discussions with grassroots workers and district level officials;
- Brainstorming on proposed strategies; and
- Conclusions and synthesize the findings.

Data Collection and Analysis: The review team leader was responsible for overall methodology and design of the data collection techniques, facilitating the analysis of the data, and providing an assessment of the quality of project implementation based on this data. The data collection technique included:

- An internal review based on information available with the project
- Field visits/observation
- Focus group discussion; and key informant interviews with stakeholders
- Review of project documents
- Others as required by the review team

FAR Team

Review Team Leader: Dr Sri Chander, Technical Advisor, Asia Pacific Region, World Vision will facilitate the review activities in a participatory manner and ensure that the review process is conducted according to USAID standards.

Team Composition

Team Leader:	Dr Sri Chander, Tech Advisor, WV APRO
Members:	Dr. Amita Jain, Deputy Director, IEC, ICDS III Project, Lucknow Dr. Ravi Anand, Senior Advisor RH , CEDPA/CATALYST Mr. K A Jayakumar, Operations Manager, PEI, WV India Mr. Ronald John, Manager, ADP Ballia, WV India* Mr. Moses Palmer, Manager, ADP Aparajita, WV India*
Coordinators:	Dr. Beulah Jayakumar, National CS Coordinator, WV India Mr. Ashwini Charles, Finance Officer, Pragati Ms Rajini Thambudorai, Research Officer, Pragati Ms Anjali Datta, Program Coordinator, FP, CEDPA/CATALYST Mr. Jeshurun Rajan, Capacity Development Officer, Pragati

Dr Vijay Edward, Director Health, WV India
Mr. Bradley Thompson, Pgm Quality Manager, Health, WV India

Documentation: Ms Anjali Datta, Program Coordinator, FP, CEDPA/CATALYST
Mr. Jeshurun Rajan, Capacity Development Officer, Pragati

Proposed Review Schedule

September 13
Meeting with the entire team, review reports, develop tools, share expectations and desired outcomes from the FAR, and develop a review strategy with the team.
Venue: Hotel Park Inn, Lucknow

September 13, Evening

Leave for the project districts

For Ballia: Dr. Ravi Anand
Mr. Samsonraj
Mr. Ashwini

For Lalitpur Dr. Beulah Jayakumar
Mr. Jeshurun Rajan
Ms. Anjali Datta
Ms. Thabitha

For Moradabad: Dr. Sri Chander
Ms. Rajini Thambudorai
Mr. Shibu Philipose

September 14 &15

Meet with ICDS workers and officials, health officials and Pragati team members; conduct interviews and focus group discussions, in the three project districts

September 16

Regroup, synthesize findings, make recommendations, and write the FAR report
Venue: Hotel Park Inn, Lucknow

September 17

Debrief participants, other invitees on findings and recommendations
Venue: Hotel Park Inn, Lucknow.

Expected Outcomes

A. The first annual report, written in accordance with USAID guidelines

B. List of recommendations on future strategies for Pragati

A draft review report will be completed and presented at the conclusion of the FAR. Following the visit, the Pragati team will edit and refine the draft document into its final form, sending it across to all participants for review. It will be the responsibility of the Project Manager to forward the final draft to the National Office Health dept, and thence to the regional office (Dr. Sri Chander) and the WVUS office (Lyndon Brown/David Grosz) for final inputs, and submission at USAID's CSHGP, the deadline for which is 31st October 2004.

Field Visit Teams to the Districts

For Ballia:	Dr. Ravi Anand Mr. Samsonraj Mr. Ashwini
For Lalitpur	Dr. Beulah Jayakumar Mr. Jeshurun Sunil Rajan Ms. Anjali Datta Ms. Thabitha
For Moradabad:	Dr. Sri Chander Ms. Rajini Thambudorai Mr. Shibu Philipose

Annex II

WORK PLAN FY 05

Pragati Child Survival Project - WV India
Work Plan for FY 05

(The numbers in each box represents the number of times the activity is to be done)

Activity	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
State level/Coordination team												
Liaison with FW for vaccines and FP material	1		1		1	1	1		1		1	
Design training package for ANMs	1											
Design handbook for AWW	1											
Design second edition of AWW manual	1											
Training for Field Coordinators	1					1					1	
Training for Accountants	1											
Backstopping visits to districts - M&E	2	2	2	3	3	2	3	3	3	3	3	2
Backstopping visits to districts - Cap Dev	3	3	2	2	3	2	3	3	3	3	3	2
Backstopping visits to districts - Finance	2	2	2	2	2	2	2	2	2	2	2	2
Backstopping Visits to Districts - FP Cood.	2	2	2	3	3	3	3	3	3	3	3	2
Backstopping visits to districts - Manager	2	2	2	2	2	2	2	2	2	2	2	2
LTOTs – LHVs and MS												
Training of Promoters	1											
Train and conduct LQAS for performance improvement							1					
Meetings with ICDS	1	1	1	1	1	1	1	1	1	1	1	
Meetings with FW	1		1		1		1		1		1	
Meetings with Local Mission	1			1			1			1		
Meetings at National Office - WV	1			1				1			1	
Regional exposure visits			1				1					
Training programs for key staff	1	1	1	1		1						
MID TERM EVALUATION												1

District Level												
Project Officer												
· District level meeting	1	1	1	1	1	1	1	1	1	1	1	1
· Block level meeting	2	2	2	2	2	2	2	2	2	2	2	2
· Staff program meeting	4	4	4	4	4	4	4	4	4	4	4	2
· Joint visit with NGO director (AWW/ANM)	2	2	2	2	2	2	2	2	2	2	2	2
· Joint visit with DPO/CDPO (AWW)	2	2	2	2	2	2	2	2	2	2	2	2
· Joint visit of ANM with MOIC	1	1	1	1	1	1	1	1	1	1	1	1
· Joint visit of ANM with field coordinator	4	4	4	4	4	4	4	4	4	4	4	3
. Monthly MS Aww meeting	3	3	3	3	3	3	3	3	3	3	3	2
. Community meetings	2	2	2	2	2	2	2	2	2	2	2	1
· Visit ANM on immunization day	1	1	1	1	1	1	1	1	1	1	1	1
· Visit AWW	1	1	1	1	1	1	1	1	1	1	1	1
· Joint visit of AWW with NGO promoter	1	1	1	1	1	1	1	1	1	1	1	1
Technical Assistant												
. Supervision of Immunization schedule with/without LHV	8	8	8	8	8	8	8	8	8	8	8	6
. Support AWW in counseling (4/day)	10	10	10	10	10	10	10	10	10	10	10	6
. Monthly meeting of AWW	4	4	4	4	4	4	4	4	4	4	4	2
. Refresher training for promoter	2	2	2	2	2	2	2	2	2	2	2	1
Accountant												
Field Visits - NGO offices	2	2	2	2	2	2	2	2	2	2	2	2
KPC & FP surveys											1	
Block level												
Field Coordinator												
· Counseling – joint supervision with Promoter	8	8	8	8	8	8	8	8	8	8	8	8
· Register – joint supervision with promoter	8	8	8	8	8	8	8	8	8	8	8	8
· Community Meetings (AWW & promoter)	2	2	2	2	2	2	2	2	2	2	2	2
· Block meetings (PHC)	2	2	2	2	2	2	2	2	2	2	2	2
· Joint supervision with MS (Counseling)	2	2	2	2	2	2	2	2	2	2	2	2
· AWW-monthly meetings	5	5	5	5	5	5	5	5	5	5	5	5
· ANM AWW meeting at the sub center level	2	2	2	2	2	2	2	2	2	2	2	2

NGO Promoter												
· Support and supervise AWW in Counseling & Registers	40	40	40	40	40	40	40	40	40	40	40	40
· AWW & Community Meetings	2	2	2	2	2	2	2	2	2	2	2	2
· ANM-AWW – Immunization schedule monitoring	8	8	8	8	8	8	8	8	8	8	8	8
· Monthly AWW meetings	5	5	5	5	5	5	5	5	5	5	5	5
· Joint supervision with Mukya sevika	8	8	8	8	8	8	8	8	8	8	8	8
· Joint Visits with the Project Officers	2	2	2	2	2	2	2	2	2	2	2	2
. Block level meeting	1	1	1	1	1	1	1	1	1	1	1	1
Village level												
AWW												
. House hold survey	1						1					
. Vitamin A round		1						1				
. Home visits	40	40	40	40	40	40	40	40	40	40	40	40
. Mahila Mandal meeting	1	1	1	1	1	1	1	1	1	1	1	1
. Monthly meeting with MS	1	1	1	1	1	1	1	1	1	1	1	1
Timeline for Operations Research												
OR1: Expanding Contraceptive Choices												
SDM/LAM training of AWWs												
Field test of Job aids/data collection tools												
Revision of OR1 tools and protocol												
Implementation of phase 1												
Interim and final analysis of phase 1												
OR2: Evidence Based Advocacy for Immunization												
AWW begin implementation of new registers												
Pragati staff visit other projects doing advocacy												
Field test 2 or 3 templates												

Finalizing tools, ready for implementation in Ballia ADP												
Implementation: monthly meetings with community groups												
OR 3: District Sentinel Surveillance System												
Enter, clean-up and initial analysis of BRICS data												
Final analysis and report writing of BRICS data												
Finalize changes in Pragati registers (workshop)												
Refresher training? In these blocks												
Begin sentinel surveillance in three blocks												

Annex III

Staff Capacity Development Plan FY 2005

Pragati Child Survival Project

#	Training Event	Participants	Duration	Organized By
1	Sun System Financial Training	Accountants from three districts, plus Finance Officer	5 days	In house
2	EPI Info & Data Management	Research Officer and M & E officer	5 days	IIHMR – Indian Institute of Health Management and Research
3	Technical Training on Pragati's interventions	New Field Coordinators and Technical Assistants	5 days	In house
4	M & E Workshop on RCH	M & E Officer	20 days	Mahidol University and University of North Carolina, Bangkok
5	Enhancing Competence for Trainers	Capacity Development Officer	5 days	IIHMR – Indian Institute of Health Management and Research
6	Virtual Leadership Development Program	All Key Staff of Pragati	12 weeks	Management Sciences for Health, through the Internet
7	Grant Fund Training	Finance Officer – Lucknow	6 days	World Vision US, in Manila
8	Leadership Training	Project Officers of 3 Districts.	4 days	In house
9	Leadership Training	Field Coordinators and Technical Assistants	4 days	In house
10	Lot Quality Assurance Sampling	All Key Staff of Pragati	6 days	In house
11	KPC Surveys and Data Management	All Key Staff of Pragati	2 weeks	In house
12	SEED-SCALE Training	Capacity Development Officer and Research Officer	6 days	Future Generations Uttaranchal, India
13	Cross visits to other projects	All key staff of Pragati	4 Days	In country

14	Planning & Management of Reproductive Health Programs	All Project Officers	6 days	IIHMR – Indian Institute of Health Management and Research
15	Operations Research and Evaluation of Health Care Programs	Research Officer and M&E Officer	6 days	IIHMR – Indian Institute of Health Management and Research
16	Project Planning, Implementation, Monitoring and Evaluation	All Key Staff of Pragati.	6 days	IIHMR – Indian Institute of Health Management and Research

Annex IV

WORLD VISION, Inc

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

BASELINE
QUANTITATIVE SURVEY

OF

Married Women of Reproductive Age

Conducted In Pragati Districts
(Ballia & Lalitpur)

June 2004

Written by: Clement T Dayal, M&E Officer, Pragati CSP

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ACKNOWLEDGEMENTS

The Pragati Child Survival Project records its deep appreciation for the guidance and support provided by CEDPA and TNS Mode for conducting the survey in Ballia and Lalitpur districts of Uttar Pradesh.

Virginia Lamprecht of SDI/PRH in USAID Washington provided invaluable support in designing and field-testing the questionnaire. Many thanks to her.

The support provided by World Vision senior management and the Pragati team in the districts was invaluable for the completion of this survey in time. Our heartfelt thanks to all of them.

Above all, we are grateful to the Married Women of Reproductive Age without whom the survey could not have been conducted.

Child Survival Project Team June 2004
Lucknow

LIST OF ABBREVIATIONS

ADP	Area Development Program
ANM	Auxiliary Nurse Midwife
AWW	Anganwadi Worker
BCC	Behavior Change Communication
BRICS	Ballia Rural Integrated Child Survival Project
CMO	Chief Medical Officer
CPR	Contraceptive Prevalence Rate
GOI	Government of India
KPC	Knowledge, Practice, Coverage
LAM	Lactational Amenorrhea Method
ICDS	Integrated Child Development Scheme
IUD	Intra Uterine Devices
MOH	Ministry of Health
MCM	Modern Contraceptive Method
MWRA	Married Women of Reproductive Age
PHC	Primary Health Center
PVO	Private Voluntary Organization
SDM	Standard Days Method
UP	Uttar Pradesh
USAID	United States Agency for International Development
WHO	World Health Organization
WV	World Vision

EXECUTIVE SUMMARY

The Pragati Child Survival Project is a USAID funded Child Survival project implemented by World Vision of India from October 2003 to September 2007. Its focus is to scale up a "wellness" package of child health interventions in Ballia, Lalitpur and Moradabad districts – Immunization, Family Planning, Nutrition in Pregnancy and Infancy and Vitamin A supplementation.

The survey on Family Planning was done among MWRA (Married Women of Reproductive Age – 15 to 49 yrs) in the districts of Ballia and Lalitpur. This was done as Flex Fund contributes 30% of the projects grant from USAID and the previous KPC covered only Mothers with children aged 0 – 23 months. CATALYST India (CEDPA) provides Technical Assistance in regard to family planning for Pragati. The survey was outsourced to TNS mode an international research agency. The interview schedule was prepared and modified to suit the Indian context by Flex Fund.

46.3% of MWRA in Ballia and 34% in Lalitpur report being new users of MCM. The CPR among MWRA who are not pregnant or unsure is 30.1% in Ballia and 35.9% in Lalitpur. 32.4% of MWRA in Ballia and 41.2% in Lalitpur started using a MCM in the past 12 months and are still using it

Practice of LAM as a MCM is nil in Ballia and Lalitpur, while postpartum initiation of FP is as low as 8.6% in Ballia and 7.4% in Lalitpur. Adequate child spacing is 53.5% in Ballia and 60% in Lalitpur.

The unmet need among MWRA who are not pregnant, not sterilized and do not want a child is 50.7% in Ballia and as high as 71.3% in Lalitpur though the CPR of Lalitpur is higher than Ballia

47.1% of the MWRA in Ballia and 38.9% in Lalitpur have discussed FP with their spouse in the past 12 months.

% FP clients who receive adequate counseling are just 8.5% in Ballia and even lower at 2.1% in Lalitpur. 62.9% of the MWRA in Ballia live within 5 km of Family Planning service delivery point while its just 34.3% in Lalitpur. 18% of MWRA in Ballia and 11.7% in Lalitpur have discussed Family Planning with a health worker.

Summary of Results

Key End Result (Strategic Objective): Increased Use of FP and Improved FP/RH Practices					
Core Results Level Indicators [1, 2]	**How to Calculate the Indicator**		**All**	**Ballia**	**Lalitpur**
New Acceptors **R2: % of WRA (15-49) who report being a 'new user' of a modern method3 of family planning** *Note: This indicator is related to the actual core indicator: "Number of WRA (15-49) who report being a 'new user' of a modern method of family planning (per time interval)." The core indicator is typically collected through service statistics, not through population-based surveys.*	Number of women 15-49 who report being a 'new user' (Q 605 = 2 (never used a method prior to current method)) AND who report using a modern method (Q 602 = A – L)	X 100			
	Number of women 15-49 who report using a modern method (Q 602 = A – L)	N	70	38	32
		D	176	82	94
		Indicator (%)	39.8	46.3	34.0
Contraceptive Prevalence **R3: % of women married or in union 15-49 years who are not pregnant or are unsure, who are using a modern family planning method[2, 3]**	Number of women 15-49 married or in union (Q 1001 = 1 (currently married) or 2 (living with a man)) **AND** who are not pregnant (Q503=2) or unsure if they are pregnant (Q 503 = 8) **AND** who are using a modern method of family planning (Q 602 = A – L)	X 100			
	Total number of women 15-49 married or in union (Q 1001 = 1 (currently married) or 2 (living with a man)) **AND** who are not pregnant (Q503=2) or unsure if they are pregnant (Q 503 = 8)	N	176	82	94
		D	534	272	262
		Indicator (%)	33.0	30.1	35.9

Key End Result (Strategic Objective): Increased use of FP and improved FP/RH practices					
Optional Result Level Indicators[4]	How to Calculate the Indicator		**All**	**Ballia**	**Lalit pur**
Continuation R4: % of WRA who started using a method of family planning in the past 12 months who are still using the method	Number of women 15-49 (or their partner) currently using a method (Q 601 = 1 (yes)) AND who started using that method within the past 12 months and are continuing to use it: (date of interview minus the date of starting to use current method (Q 603) is ≤ 12 months) Number of women 15-49 who (or their partner) started using a method within the past 12 months: (date of starting current method (Q 603) minus Date of Interview is ≤ 12 months) PLUS the number of women (or their partner) who stated using a method of family planning within the past 12 months and discontinued (Q 606 = 1 (yes))	X 100 N D Indicator (%)	 55 156 35.3	 34 105 32.4	 21 51 41.2
LAM Use R5: % of mothers with infants less than 6 months who report using LAM *Note: Using Questions 909-914, you may check to see if the criteria for LAM are being met by those who report using LAM (Q 602 = K). In addition, you may determine the percentage of women who meet the criteria of LAM but may not be aware that they are at low risk of becoming pregnant ('passive LAM use').*	Number of women 15-49 who have a child < 6 months. (Q 909 = 1 (yes)) AND who report using LAM (Q 602 = K) Total number of women 15-49 who have a child < 6 months (Q 909 = 1 (yes)) *The criteria for LAM use have been met if:* *If the child is less than 6 months (Q 909 = 1 (yes)) AND* *The woman is still breastfeeding (Q 911 = 1) AND* *The baby is only being fed breastmilk and nothing else* *(Q 912, 913 both = 2 (no) AND* *The mother has not returned to menses (Q 914 = 4)*	X 100 N D Indicator (%)	 0 81 0.0	 0 32 0.0	 0 49 0.0
Post-partum Initiation of FP R6: % of postpartum mothers who report initiating use of a modern method of FP within 6 weeks after birth	Number of women with children < 12 mos. (Q 902 = 1(yes)) AND who started to use a method of FP within 6 weeks of birth (Q 908 = 1 (6 weeks or earlier)) Number of women with children < 12 mos. (Q 902 = 1(yes))	X 100 N D Indicator	 11 139 7.9	 5 58 8.6	 6 81 7.4

N – Numerator **D – Denominator**

Key End Result (Strategic Objective): Increased use of FP and improved FP/RH practices				
<u>Optional</u> Result Level Indicators[4]	**How to Calculate the Indicator**	**All**	**Ballia**	**Lalitpur**
Adequate Child Spacing R7: % WRA who have a child < 12 months who report that the youngest child was born at least 24 months after the previous surviving child *Note: Programs being implemented for five years or longer may also elect to consider birth intervals of 36 months*	Number of women 15-49 who have at least two biological children < 5 years (Q 204 = 2 or 3) AND the youngest child was born at least 24 months after the next youngest child: (date of birth of second youngest child) (Q 207) minus the date of birth of youngest child) ≥ 24 months) --- Total number of women15-49 who have at least two biological child < 5 years (Q 203 = 1 or 2 or 3) X 100 N D Indicator (%)	 108 191 56.5	 54 101 53.5	 54 90 60.0
Condom Use with Non-Regular Partner R8: % of women who report that they or their partner used a condom during last intercourse with non-regular partner	Number of sexually active women 15-49 (Q 1002 date of last intercourse < 12 months since date of interview) AND Who report that they or their partner used a condom during last intercourse (Q 1004 = 1 (yes)) AND Last intercourse was with non-regular partner (Q 1003 = 3 or 4 or 5 or 6 (other friend, casual acquaintance, relative, other)) --- Number of sexually active women 15-49 (Q 1002 date of last intercourse < 12 months since date of interview) AND Who report having a non-regular partner (Q 1003 = 3 or 4 or 5 or 6 (other friend, casual acquaintance, relative, other)) X 100	Not possible to calculate		

Key End Result (Strategic Objective): Increased use of FP and improved FP/RH practices				
<u>Optional</u> Result Level Indicators[4]	**How to Calculate the Indicator**	**All**	**Ballia**	**Lalit pur**
Unmet Need for Family Planning R9: % of WRA (15-49) currently married or in union who are fecund (not pregnant and not sterilized) who desire to have no more or postpone childbearing, but who are not currently using a method of family planning	Number of women 15-49 married or in union (Q 1001 = 1 (currently married) or 2 (living with a man)) AND Who are not pregnant (Q 503 = 2 (no)) AND Who are not sterilized (Q 501 = 2) AND Do not want any more children at all (Q 504 = 2 (no) or 8 (unsure)) OR do not want any more children for at least two more years (505 = 2 (more than two years) or 8 (unsure)) AND Who are NOT using a method of family planning (Q 601 = 2 (no)) Total number of women 15-49 married or in union (Q 1001 = 1 (currently married) or 2 (living with a man)) AND Who are not pregnant (Q 503 = 2 (no)) AND Who are not sterilized (Q 501 = 2) AND Do not want any more children at all (Q 504 = 2 (no) or 8 (unsure)) OR do not want any more children for at least two more years (505 = 2 (more than two years) or 8 (unsure))	X 100 N D Indicator (%)	 158 265 59.6	 76 150 50.7	 82 115 71.3

Intermediate Result 1 [2,11]**:** Increased **knowledge and interest** in FP services through NGO/PVO involvement				
Core Indicator Intermediate Results Level[5]	**How to Calculate the Indicator**		**All**	**Ballia**	**Caliper**
Discussion of FP with Spouse/ Partner IR1.1 **% of sexually active respondents who report discussing FP issues with their spouse or (cohabitating) sexual partner in the past 12 months.**[2]	Number of sexually active women 15-49 (Q 1002: date of last intercourse < 12 months since date of interview) AND who have a husband or a cohabitating partner (Q 1001 = 1 or 2 (yes)) who report discussing family planning in the past 12 months with their spouse or regular partner (Q 802 = A) --- Number of sexually active women 15-49 (Q 1002: date of last intercourse < 12 months since date of interview) AND who have a spouse or regular partner (Q 1001 = 1 (spouse) or 2 (co-cohabitating partner))	X 100 N D Indicator (%)	 246 574 42.9	 131 278 47.1	 115 296 38.9
Optional Indicators Intermediate Results Level	**How to Calculate the Indicator**		**All**	**Ballia**	**Lalitpur**
FP Message Recall IR1.2 % of WRA (or other target group) who recall hearing or seeing a specific FP-related message being promoted by the program (message recall)	Number of women 15-49 who report having seen or heard a message about family planning (Q 807 = 1 for one or more of the media sources: radio, newspaper, television, or fair) --- Number of women 15-49 who are interviewed	X 100 N D Indicator (%)	 248 600 41.3	 148 300 49.3	 100 300 33.3

Intermediate Result 2:
Improved **quality** of FP service delivery in facilities and in the community

Core Indicator Intermediate Results Level	How to Calculate the Indicator							
	IF CURRENT METHOD, Q701 =					**All**	**Ballia**	**Lalitpur**
	Female Sterilization (A)	**Hormonal Methods (C-F)**	**Male Sterilization (B)**	**Barrier or Education-based (G-L)**				
Adequate Counselling IR2.1 **% of FP clients who receive adequate counselling** *Note: This indicator is related to the core indicator of the same name. Adequate Counseling' is typically assessed through direct observation or exit interviews, not through population-based surveys. The Flexible Fund is field-testing questions relating to this indicator.* ****To determine the numerator: calculate the numbers for each column, then add the column totals*** *The numerator of this indicator is based upon combining 'correct' answers as appropriate for each method (see Qs 701 – 708). See skip patterns for each method. For example, to meet all relevant criteria relating to 'adequate counseling' for pill use, the responses to the following questions must all be 1 (yes): Q 704, Q 706, Q 707, 708. To meet all the relevant criteria for 'adequate counseling' for LAM, only a 'yes' response for Q 708 is necessary.*	Number of women 15-49 who were sterilized (Q 701 = A) **AND** were told that they would not have more children (Q 702 = 1 (yes)) **AND** who were told at the time of the procedure about potential problems (Q 704 = 1 (yes)) **AND** who were told what to do if she experienced side effects Q 706 = 1 (yes)) **AND** who was told when to return for follow-up (Q 707 = 1 (yes)) **AND** who was told about other methods (Q 708 = 1 (yes))	Number of women 15-49 who are current users of the pill, IUD, injectables, or implants (Q 701 = C-F) **AND** who were told at the time they received the method about side effects (Q 704=1 (yes)) **AND** who were told what to do if she experienced side effects (Q 706 = 1 (yes)) **AND** who was told when to return for follow-up (Q 707 = 1 (yes)) **AND** who was told about other methods (Q 708 = 1 (yes))	Number of women 15-49 whose partner is sterilized (Q 701 = B) **AND** whose partner was told that he would not be able to have any (more) children (Q 703 = 1 (yes))	Number of women 15-49 who are current users of the condoms, diaphragm foam/jelly, LAM, or SDM (Q701=G-L) **AND** who was told about other methods (Q 708 = 1 (yes))	X 100 N D Indicator (%)	 9 176 5.1	 7 82 8.5	 2 94 2.1
	Number of women 15-49 (or their partners) who are current users of family planning methods (Q 701 = A – L)							

Intermediate Result 3: Increased FP **access** in communities				
Core Indicator **Intermediate Results Level**	**How to Calculate the Indicator**	**All**	**Ballia**	**Lalitpur**
Proximity to Family Planning Service Delivery Point[6] IR3.1 **% of population [of WRA] that lives within 5 km of a family planning service delivery point (SDP), [among women who know where to obtain a method]** *Note: This core indicator is typically collected by program staff, and not through population-based surveys. The Flexible Fund is field-testing questions relating to this indicator. Phrases in brackets have been added to the indicators for population-based surveys.*	Number of women 15-49 who are interviewed AND who live within 5 km of a family planning service delivery point (Q 402 = 1) AND who know where to obtain a family planning method (Q 402 NE Z) X 100 Number of women 15-49 who are interviewed AND who know where to obtain a family planning method (Q 402 NE Z)	N D Indicator (%)	262 544 48.2	166 264 62.9	96 280 34.3

Intermediate Result 3: Increased FP **access** in communities					
Core Indicator **Intermediate Results Level**	**How to Calculate the Indicator**		**All**	**Ballia**	**Lalitpu**
Discussion of **Family Planning with Health Worker** IR3.2 **% of respondents of reproductive age who report discussing family planning with a health or family planning worker or promoter in the past 12 months**[2]	Number of women 15-49 who have discussed family planning within the past 12 months with a health worker (Q 804 = 1) OR (Q 806 = 1) X 100 Number of women 15-49 who are interviewed	N D Indicator (%)	89 600 14.8	54 300 18.0	35 300 11.7
Optional Indicator **Intermediate Results Level**	**How to Calculate the Indicator**		**All**	**Balli**	**Lalitpur**
Travel Time to Family Planning Service Delivery Point R3.3 % of women 15-49 who report that the travel time to nearest SDP[6] is within 2 hours (geographical access)	Number of women 15-49 who live within 2 hours of a family planning service delivery point (Q 403 = 1 or 2 (two hours or less)) X 100 Number of women 15-49 who are interviewed	N D Indicator (%)	513 600 85.5	250 300 83.3	263 300 87.7

BACKGROUND

Project Overview

The Pragati project is implemented through a cooperative agreement between USAID Washington and World Vision United States, under the Expanded Impact category of USAID's Child Survival and Health Grants Program, from October 2003 to September 2007.

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

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

The strategies employed by Pragati would be:

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

Project Location And Demography

Uttar Pradesh State, the most populous of the country's 29 states, is located north in India's fertile Gangetic plain. Its population of 166 million[2] is spread over 70 districts. These 70 districts are grouped into 4 regions, each with a distinct dialect, culture and traditions. The proposed project districts are located in three regions of the state – Ballia district is located in the Eastern region, Moradabad in the Western region and Lalitpur in the Southern region.

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

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

Survey Methods

Sampling Design

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

Sample Size Calculations

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

In each cluster, 10 MWRA aged between 15 – 49 years were sampled. A total of 600 MWRA i.e. 300 from each district were sampled.

Protocols For Household Selection & Interview

In each cluster, one tola (hamlet, with about 50 households) was randomly selected.
In the selected tola, a direction was randomly selected from a central location.
In the selected direction, the houses were counted and the first household was randomly selected from them.

Subsequently, the household, which is nearest to the first, was selected and so on.
This protocol was followed as listing or door numbers of houses were unavailable.

Only one interview was conducted in one household. If there were two or more MWRA, one of them was selected randomly.

Survey Tools

The questionnaires were prepared by Flex Fund and modified to suit the Indian context. They also provided the indicators. The tools were designed in English and translated into Hindi script. Field-testing was done for comprehension and flow and changes made accordingly.

The following were the topics covered:

Questionnaire:

1. Respondents Background
2. Reproduction and Child spacing
3. Knowledge and Ever use of contraception
4. Access to Family Planning
5. Desire for future Children

6. Current use of Family Planning
7. Quality of counseling for current users
8. Diffusion of Family Planning messages
9. Postpartum family planning
10. Sexual activity
11. HIV/AIDS

Discussion of Results

Core Flex Fund indicators

46.3% of MWRA in Ballia and 34% in Lalitpur report being new users of MCM. The CPR among MWRA who are not pregnant or unsure is 30.1% in Ballia and 35.9% in Lalitpur. 32.4% of MWRA in Ballia and 41.2% in Lalitpur started using a MCM in the past 12 months and are still using it

Practice of LAM as a MCM is nil in Ballia and Lalitpur, while postpartum initiation of FP is as low as 8.6% in Ballia and 7.4% in Lalitpur. Adequate child spacing is 53.5% in Ballia and 60% in Lalitpur.

The unmet need among MWRA who are not pregnant, not sterilized and do not want a child is 50.7% in Ballia and as high as 71.3% in Lalitpur though the CPR of Lalitpur is higher than Ballia

47.1% of the MWRA in Ballia and 38.9% in Lalitpur have discussed FP with their spouse in the past 12 months.

% FP clients who receive adequate counseling are just 8.5% in Ballia and even lower at 2.1% in Lalitpur. 62.9% of the MWRA in Ballia live within 5 km of Family Planning service delivery point while its just 34.3% in Lalitpur. 18% of MWRA in Ballia and 11.7% in Lalitpur have discussed Family Planning with a health worker.

A maximum of 26% of the MWRA in Ballia belong to the age group of 25-29 yrs while in Lalitpur a maximum of 25% of the MWRA belong to the age group of 20-24 yrs. 48.3% of the MWRA in Ballia have attended school while it is only 31% in Lalitpur. Low level of education can be a reason for early marriage in Lalitpur.

In Ballia 24.7% of the MWRA have 3 children and is closely followed by 18.6% of them having 4 children while in Lalitpur 17.7% have 2 children.

77% of the MWRA in Ballia know that there is a fertility period in a woman's menstrual cycle and out of them only 4.3% know it right while 80.7% of MWRA in Lalitpur know of the fertile period but only .4% know it right.

62.9% of the MWRA in Ballia and just 34.3% in Lalitpur live within 5 kms or less from a Family Planning service delivery point.

Female sterilization is the most common method of FP followed both in Ballia and Lalitpur with 21.7% and 34% respectively.

46.7% of the MWRA in Ballia and 39.7% in Lalitpur have ever discussed FP with another person in the past 12 months and out of them 38.6% of them in Ballia and 97.5% in Lalitpur have discussed it with their husbands.

Only 14.7% of the MWRA in Ballia and 8% in Lalitpur have been visited by a Health worker in the past 12 months. Out of them 22.5% have discussed Fp in Ballia and 14.7% in Lalitpur.

Annex I: Survey Tool

USAID OFFICE OF POPULATION AND REPRODUCTIVE HEALTH
FLEXIBLE FUND FAMILY PLANNING SURVEY
WOMAN'S QUESTIONNIARE

REVISED VERSION MARCH 11, 2004 FOR WORLD VISION INDIA

Changes agreed upon on February 29, March 10, and March 11 Incorporated in this draft (in blue ink)

IDENTIFICATION

PLACE NAME_____

CLUSTER NUMBER.....

HOUSEHOLD NUMBER.....

RECORD NUMBER .....

REGION.....
…

URBAN/RURAL (URBAN = 1, RURAL =2).....

NAME OF HEAD OF HOUSEHOLD_____

NAME OF WOMAN_____

INTERVIEWER VISITS

	1	2	FINAL VISIT
DATE			DAY
INTERVIEWER'S NAME			MONTH
NEXT VISIT: DATE			YEAR
TIME			
RESULT CODE			

RESULT CODES:
1= COMPLETED
2 = NOT AT HOME
3 = POSTPONED
4 = REFUSED
5 = PARTLY COMPLETED
6 = INCAPACITATED

SUPERVISOR	FIELD EDITOR	OFFICE EDITOR	KEYED BY
NAME_	NAME		
DATE	DATE		

SECTION 1: RESPONDENTS BACKGROUND

INTRODUCTION AND INFORMED CONSENT

Hello. My name is _____ and I am working with (NAME OF ORGANIZATION). We are conducting a survey about the health of women and children. We would very much appreciate your participation in this survey. I would like to ask you about your health and family life. This information will help the government Ministry of Health and other organizations to plan local health services. This survey will take about ___ to ___ minutes to complete. Whatever information you provide to (NAME OF ORGANIZATION) will remain confidential. We will not pass on your name or the information you provide to any other parties. We will contact you again only if we have a question (or questions) that need(s) to be clarified.

Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. However, we hope that you will participate in this survey since your views are important.

At this time, do you want to ask me anything about the survey?

May I begin the interview now?

Signature of interviewer:_____ Date:_____
(day, month, year)

CIRCLE ONE:

RESPONDENT DOES NOT AGREE TO INTERVIEW……1 → END; DO NOT INTERVIEW WOMAN

RESPONDENT AGREES TO INTERVIEW……2 → BEGIN INTERVIEW

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
101	**RECORD THE TIME**	**HOUR**……..+-------+ MINUTES……+-------+	
102	**How old were you at your last birthday?** ~~**COMPARE AND CORRECT 102 AND 103 IF INCONSISTENT**~~	**AGE IN COMPLETED YEARS**……..+-------+	
103	**Have you ever attended school?**	**YES**……..1 **NO**……..2	→ **107**
104	**What is the highest level of school you attended: primary, secondary, or higher?**	**PRIMARY**……...1 **SECONDARY**……2 **HIGHER**……..3	
105	**What is the highest grade or year you completed at that level?**	**GRADE**…….....+-------+	
106	**CHECK 104: HIGHEST LEVEL OF SCHOOL:** **PRIMARY (CODE 1)** ☐⇩	**SECONDARY OR HIGHER (CODE 2)** ☐⇨	→ **108**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
107	Now I would like to you to read this sentence to me. SHOW CARD TO RESPONDENT IF RESPONDENT CANNOT READ WHOLE SENTENCE, PROBE: Can you read any part of the sentence to me? NOTE: EACH CARD SHOULD HAVE FOUR SMIPLE SENTENCES (FOR EXAMPLE, “PARENTS LOVE THEIR CHILDREN”, “THE CHILD IS READING A BOOK”, ETC)	**CANNOT READ AT ALL……1** **ABLE TO READ ONLY PARTS……2** **ABLE TO READ WHOLE SENTENCES……3** **NO CARD WITH REQUIRED LANGUAGE……4** **BLIND/VISUALLY IMPAIRED……..5**	

PROCEED TO NEXT SECTION→

SECTION 2: REPRODUCTION AND CHILD SPACING

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
201	**Now I would like to ask about all the births you have had during your life. Have you ever given birth?**	**YES……..1** **NO……2**	→ 208
202	**How many children have you given birth to? Include any children born alive, including those who cried or showed signs of life but did not survive.**	**TOTAL NUMBER OF CHILDREN EVER BORN ALIVE……** +-------+	
203	**How many children living in this household are under five years of age?**	**NONE……..0** **ONE CHILD…….** **.....1** **TWO CHILDREN……..2** **THREE OR MORE……..3**	→ 208
204	**How many of those children are your biological children?**	**NONE……0** **ONE CHILD…….. 1** **TWO CHILDREN……2** **THREE OR MORE……3**	→ 208
205	**What is the sex and date of birth of your youngest child?**	**YOUNGEST CHILD** **SEX** **MALE……..1** **FEMALE……2** **DATE OF BIRTH** **DAY** i__i__i **MONTH** i__i__i **YEAR** i__i__i__i__i	
206	**CHECK 204: NUMBER OF BIOLOGICAL CHILDREN:** **TWO OR MORE (CODE 2)** ☐ ⇩ **ONE (CODE 1)** ☐ ⇨		→ 208
207	**What is the sex and date of birth of your second youngest child?**	**SECOND YOUNGEST CHILD** **SEX** **MALE……..1** **FEMALE……2** **DATE OF BIRTH** **DAY** i__i__i **MONTH** i__i__i **YEAR** i__i__i__i__i	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
208	From one menstrual period to the next, are there certain days when a woman is more likely to become pregnant if she has sexual relations?	YES……1 NO…… 2 DON'T KNOW……..8	 → 210 → 210
209	Is this time just before her period, during her period, right after her period has ended, or halfway between her two periods?	JUST BEFORE HER PERIDD BEGINS……..1 DURING HER PERIOD……...2 RIGHT AFTER HER PERIOD HAS ENDED……..3 HALFWAY BETWEEN TWO PERIODS……4 OTHER ……..5 (SPECIFY) DON'T KNOW……8	
210	In the past 12 months, have you experienced a miscarriage or a pregnancy termination?	YES……..1 NO……2 DON'T KNOW/ REFUSED……8	

PROCEED TO NEXT SECTION→

SECTION 3: KNOWLEDGE AND EVER USE OF CONTRACEPTION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP

Now I would like to talk about family planning—the various ways or methods that a couple can use to delay or avoid a pregnancy.

ASK THE QUESTION 301 (FIRST COLUMN):

Which ways have you heard about?

FOR EACH METHOD LISTED MENTIONED SPONTANEOUSLY, CIRCLE "1" (YES) IN THE COLUMN 301 TO INDICATE THAT WOMAN HAS HEARD OF METHOD. THEN PROCEED DOWN THE LIST OF METHODS, READING THE NAME AND DESCRIPTION OF EACH METHOD NOT MENTIONED SPONTANEOUSLY. CIRCLE CODE "1" IN COLUMN 301 IF THE METHOD IS RECOGNIZED, AND CODE "2" IF NOT RECOGNIZED.

THEN, FOR EACH METHOD WITH CODE "1" IN COLUMN 301, ASK **BOTH** QUESTIONS 302 AND 303 "DO YOU KNOW OF A PLACE YOU COULD OBTAIN (METHOD)?" AND "HAVE YOU EVER USED (METHOD)?" FOR BOTH THESE QUESTIONS, CODE "1" IF THE ANSWER IS "YES" AND CODE "2" IF THE ANSWER IS "NO".

	METHOD	301	302	303
	Which ways have you heard about? PROBE: Have you heard of (METHOD)?		Do you know where to obtain (METHOD)?	Have you ever used (METHOD)?
A	FEMALE STERILIZATION Women can have an operation to avoid having any more children	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2
B	MALE STERILIZATION Men can have an operation to avoid having any more children	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2
C	PILL Women can take a pill every day to avoid becoming pregnant	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2
D	IUD Women can have a loop or coil placed inside them by a doctor or nurse	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2
E	INJECTABLES Women can have an injection by a health provider which stops them from becoming pregnant for one or more months	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2
F	IMPLANTS Women can have several small rods placed in their upper arm by a doctor or nurse which can prevent pregnancy for one or more years	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2

	METHOD	301	302	303
	Which ways have you heard about? PROBE: Have you heard of (METHOD)?		Do you know where to obtain (METHOD)?	Have you ever used (METHOD)?
G	CONDOM Men can put a rubber sheath on their penis before sexual intercourse	YES……1 → NO……..2	YES……1 NO……..2	YES……1 NO……..2
H	FEMALE CONDOM Women can place a sheath in their vagina before sexual intercourse	YES……1 → NO……..2	YES……1 NO……..2	YES……1 NO……..2
I	DIAPHRAGM Women can place a thin flexible disk in their vagina before intercourse	YES……1 → NO……..2	YES……1 NO……..2	YES……1 NO……..2
J	FOAM OR JELLY Women can place a suppository, jelly, or cream in their vagina before intercourse	YES……1 → NO……..2	YES……1 NO……..2	YES……1 NO……..2
K	LACTATIONAL AMENORRHEA (LAM) Up to 6 months after childbirth, a woman can use a method that requires that she breastfeeds frequently, day and night, and that her menstrual period has not returned	YES……1 → NO……..2	YES……1 NO……..2	YES……1 NO……..2
L	STANDARD DAYS METHOD A woman who is sexually active abstains (or uses a condom) on days 8 through day 19 each menstrual cycle	YES……1 → NO……..2	YES……1 NO……..2	YES……1 NO……..2
M	RHYTHM OR PERIODIC ABSTINENCE Every month that a woman is sexually active can avoid pregnancy by not having sexual intercourse on the days of the month she is most likely to get pregnant	YES……1 → NO……..2	YES……1 NO……..2	YES……1 NO……..2
N	WITHDRAWAL Men can be careful and pull out before climax	YES……1 → NO……..2	YES……1 NO……..2	YES……1 NO……..2
O	EMERGENCY CONTRACEPTION Women can take pills up to three days after sexual intercourse to avoid becoming pregnant	YES……1 → NO……..2	YES……1 NO……..2	YES……1 NO……..2
P	Have you heard of any other ways or methods that women or men can use to avoid pregnancy?	YES……1 → …… (SPECIFY) NO……..2	YES……1 NO……..2	YES……1 NO……..2

PROCEED TO NEXT SECTION→

SECTION 4: ACCESS TO FAMILY PLANNING

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
401	Now I would like to ask you about family planning services in your community. Do you know of a place where you could obtain a method of family planning? IF NO, CIRCLE "Z" [DON'T KNOW] IF YES, ASK, "Where is that?" [1] PROBE: "Are there any other places where you could obtain a method?" RECORD ALL MENTIONED. IF A SOURCE IS A HOSPITAL, HEALTH CENTER, OR CLINIC, WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE)	PUBLIC SECTOR: GOVT. HOSPITAL……A GOVT. HEALTH CENTER……..B FAMILY PLANNING CLINIC……..C MOBILE CLINIC…….. D FIELDWORKER…….. E OTHER PUBLIC……..……..F PRIVATE MEDICAL SECTOR: PRIVATE HOSP./CLINIC……G PHARMACY…….. H PRIVATE DOCTOR…….I MOBILE CLINIC……..J FIELDWORKER……..K OTHER PRIVATE MEDICAL…….L OTHER SOURCE: SHOP……...M CHURCH…….... N FRIEND/RELATIVE……O DON'T KNOW……Z	→ 501
402	How far away from your home is the place you can obtain a method of family planning: 5 kms or less or more than 5 kms?	5 KMS OR LESS ……1 MORE THAN 5 KMS……..2 DON'T KNOW…….. 8	
403	How long does it take you to get to the place where you can obtain a method of family planning?	LESS THAN 1 HOUR…….. 1 1 HOUR UP TO TWO HOURS…….2 2 HOURS UP TO 4 HOURS…….3 MORE THAN 4 HOURS……4	

PROCEED TO NEXT SECTION→

SECTION 5: DESIRE FOR FUTURE CHILDREN

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
501	CHECK QUESTION 303A: WOMAN NOT STERILIZED ☐ ⇩ (CODE 2)	WOMAN STERILIZED ☐ ⇨ (CODE 1)	→ 602
502	CHECK QUESTION 303B: MAN NOT STERILIZED ☐ ⇩ (CODE 2)	MAN STERILIZED ☐ ⇨ (CODE 1)	→ 602
503	Are you currently pregnant?	YES……1 NO……2 UNSURE ……8	→ 801
504	Do you want to have a/another child?	YES……1 NO……2 DON'T KNOW……8	→ 601 → 601
505	When do you want to have your next child?	WITHIN 2 YEARS ……1 MORE THAN 2 YEARS FROM NOW……2 UNSURE WHEN…… 8	

PROCEED TO NEXT SECTION→

SECTION 6: CURRENT USE OF FAMILY PLANNING

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
601	Are you currently doing something or using any method to delay or avoid getting pregnant?	YES……..1 NO…….. 2	→ 606
602	Which method are you (or your husband/ partner) using? CHECK RESPONSE PROVIDED IN 602 AGAINST 303: EVER USE OF METHOD. IF A METHOD IS CURRENTLY USED, THAT METHOD SHOULD ALSO BE CODED AS 'EVER USED' IN 303. IF WOMAN IS STERILIZED, CIRCLE A. IF MAN IS STERILIZED, CIRCLE B. IF MORE THAN ONE METHOD IS MENTIONED, FOLLOW SKIP INSTRUCTION FOR HIGHEST METHOD ON LIST	FEMALE STERILIZATION……A MALE STERILIZATION……B PILL……..C IUD……D INJECTABLES……E IMPLANTS……F CONDOM……G FEMALE CONDOM……H DIAPHRAGM……I FOAM/JELLY……J LACTATIONAL AMEN. METHOD……K STANDARD DAYS METHOD……L PERIODIC ABSTINENCE (OTHER THAN STANDARD DAYS)……M WITHDRAWAL……..……N OTHER……X (SPECIFY)	
603	For how long have you (or your husband/partner) been using (CURRENT METHOD) now without stopping? PROBE: In what month and year did you start using (CURRENT METHOD) continuously? IF STERILIZED, ASK: In what month and year was the sterilization performed?	MONTH……☐☐ YEAR……☐☐☐☐ DON'T KNOW……Z	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
604	Where did you obtain (CURRENT METHOD) when you started using it? IF THE WOMAN OR HER HUSBAND/PARTNER WAS STERILIZED, ASK: Where were you (your partner) sterilized? IF THE WOMAN IS USING LAM OR THE STANDARD DAYS METHOD, ASK: Where did you learn to use your method?	PUBLIC SECTOR: GOVT. HOSPITAL…….A GOVT. HEALTH CENTER……..B FAMILY PLANNING CLINIC……..C MOBILE CLINIC…….. D FIELDWORKER…….. E OTHER PUBLIC……..……..F _____ (SPECIFY) PRIVATE MEDICAL SECTOR: PRIVATE HOSP./CLINIC……G PHARMACY…….. H PRIVATE DOCTOR…….I MOBILE CLINIC……..J FIELDWORK ER……..K OTHER PRIVATE MEDICAL…….L _____ (SPECIFY) OTHER SOURCE: SHOP……....M CHURCH…….... N FRIEND/RELATIVE……O OTHER _____ X (SPECIFY) DON'T KNOW…….……Z	
605	Before using (CURRENT METHOD), did you ever use another method of family planning?	YES……..1 NO…….. 2	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
606	CHECK 501: NOT PREGNANT OR UNSURE ☐ ⇩ (CODE 2)	PREGNANT ☐ ⇨ (CODE 1)	→ 801
607	You have indicated that you are not using a method of family planning. Can you please tell me the reason you are not using a method? RECORD ALL MENTIONED	NOT MARRIED……A FERTILITY-RELATED REASONS NOT HAVING SEX……B INFREQUENT SEX ……C MENOPAUSAL/HYSTERECTOMY…D SUBFECUND/INFECUND……E POSTPARTUM AMENORRHEIC.....F BREASTFEEDING……G FATALISTIC…...……H OPPOSED TO USE RESPONDENT OPPOSED……I HUSBAND/PARTNER OPPOSED…. J OTHERS OPPOSED……K RELIGIOUS PROHIBITION……L LACK OF KNOWLEDGE KNOWS NO METHOD……M KNOWS NO SOURCE……N METHOD-RELATED REASONS HEALTH CONCERNS……..O FEAR OF SIDE EFFECTS… …… P LACK OF ACCESS/TOO FAR……Q COSTS TOO MUCH……R INCONVENIENT TO USE……S INTERFERES WITH BODY'S NORMAL PROCESSES…… ……T OTHER_____X (SPECIFY)_____ _____	

PROCEED TO NEXT SECTION→

SECTION 7: QUALITY OF COUNSELING FOR CURRENT USERS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
701	CHECK 602 (CURRENT METHOD). CIRCLE METHOD CODE. IF MORE THAN ONE METHOD USED, CIRCLE CODE FOR HIGHEST ON LIST IF NO METHOD CURRENTLY USED, CIRCLE Z	FEMALE STERILIZATION……A MALE STERILIZATION……B PILL……C IUD……D INJECTABLES……E IMPLANTS……F CONDOM……G FEMALE CONDOM……H DIAPHRAGM……I FOAM/JELLY……J LACTATIONAL AMEN. METHOD……K STANDARD DAYS METHOD……L PERIODIC ABSTINENCE (OTHER THAN STANDARD DAYS)……M WITHDRAWAL……N OTHER……X (SPECIFY) NO METHOD……Z	→ 702 → 703 → 704 → 704 → 704 → 704 → 708 → 708 → 708 → 708 → 708 → 708 → 801 → 801 → 801 → 801
702	Before your sterilization, were you told that you would not have any (more) children because of your operation?	YES……..1 NO……2	→ 704 → 704
703	Before the sterilization operation, was your husband (or partner) told that he would not be able to have any (more) children because of the operation?	YES……..1 NO……2 DON'T KNOW……3	→ 801 → 801 → 801
704	At the time you first started to use (CURRENT METHOD), were you told about side effects or problems you might have with the method? IF STERILIZED, ASK: At the time you were sterilized, were you told about side effects or problems you might have with the operation?	YES……..1 NO……2	→ 706
705	Did a health or family planning worker ever tell you about side effects or problems you might have with the method?	YES……..1 NO……2	
706	Were you told what to do if you experienced side effects or problems?	YES……..1 NO……2	
707	Were you told when you should return for follow-up (or when someone should be back to see you?)	YES……..1 NO……2	

708	When you obtained (CURRENT METHOD) from (SOURCE OF METHOD) were you told about other methods of family planning that you could use? IF USING LAM OR STANDARD DAYS METHOD, ASK: "When you first learned (METHOD) were you told about other methods of family planning that you could use?"	YES……..1 NO……2	→ 801
709	Did a health or family planning worker ever tell you about other methods of family planning that you could use?	YES……..1 NO……2	

SECTION 8: DIFFUSION OF FAMILY PLANNING MESSAGES

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
801	In the past 12 months, have you discussed family planning with your husband or partner, friends, neighbors, or relatives?	YES……1 NO……..2	→ 803
802	With whom? Anyone else? RECORD ALL PERSONS MENTIONED	HUSBAND/PARTNER……A MOTHER……..B FATHER…… C SISTER(S)……D BROTHER(S)…… E DAUGHTHER……..F SON…… G MOTHER-IN-LAW……H FRIENDS/NEIGHBORS……I OTHER……..J	
803	In the past 12 months, have you discussed the number of children that you want with your husband or partner?	YES……1 NO……..2 DOES NOT HAVE HUSAND/PART….3	
804	In the past 12 months, were you visited by a community health worker or promoter who talked to you about family planning?	YES……1 NO……..2	
805	In the past 12 months, have you visited a health facility for care for yourself (or your child?)	YES……1 NO……..2	→ 807
806	Did any staff member at the health facility speak to you about family planning methods?	YES……1 NO……..2	
807	In the past month, have you seen or heard any messages about family planning from the following? RADIO ..... NEWSPAPER..... TELEVISION..... HEALTH FAIR..……	**YES** **NO** 1 2 1 2 1 2 1 2	

PROCEED TO THE NEXT SECTION→

SECTION 9: POSTPARTUM FAMILY PLANNING

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
901	CHECK 204: DOES WOMAN HAVE A LIVING (BIOLOGICAL) CHILD? YES (CODE 1) ☐ ⇩	NO (CODE 2) ☐ ⇨	→ 1001
902	CHECK 205: AGE OF YOUNGEST LIVING CHILD: LESS THAN 12 MONTHS: ☐ ⇩ (CODE 1)	12 MONTHS OR OLDER: ☐ ⇨ (CODE 2)	→ 1001
903	Now I would like to ask a few questions about the time while you were pregnant with your youngest child. Did you see anyone for prenatal care while you were pregnant with (NAME)? IF YES, Whom did you see? Anyone else? PROBE FOR THE TYPE OF PERSON AND CIRCLE ALL PERSONS MENTIONED.	HEALTH PROFESSIONAL DOCTOR……A NURSE/MIDWIFE……B AUXILIARY NURSE……C OTHER PERSON TRADITIONAL BIRTH ATTENDANT……D COMMUNITY HEALTH WORKER…..E OTHER_____ F (SPECIFY) NO ONE…… Z	→ 905
904	During your prenatal check, were you counseled on the following?	YES / NO	
	Breastfeeding?	1 / 2	
	Lactational Amenorrhea Method?	1 / 2	
	Family planning?	1 / 2	
905	After the birth of (NAME) did anyone check on your health?	HEALTH PROFESSIONAL DOCTOR……A NURSE/MIDWIFE……B AUXILIARY NURSE……C OTHER PERSON TRADITIONAL BIRTH ATTENDANT……D COMMUNITY HEALTH WORKER...E OTHER_____ F	

		(SPECIFY) NO ONE…… Z	→ 907
NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
906	During your postpartum check, were you counseled on the following? Breastfeeding? Lactational Amenorrhea Method? Family planning?	YES NO 1 2 1 2 1 2	
907	After (NAME) was born, did you start to use a method of family planning?	YES……..1 NO……2	→ 909
908	Did you start to use the method within the first 6 weeks of after the first 6 weeks following (NAME's) birth?	6 WEEKS OR EARLIER……1 7 WEEKS OR LATER……2 DON'T KNOW……8	
909	CHECK AGE OF YOUNGEST CHILD (SEE 205) CHILD LESS THAN 6 MONTHS ☐ ⇩ YES (CODE 1)	CHILD 6 MONTHS OR MORE ☐ ⇨ NO (CODE 2)	→ 1001
910	Did you ever breastfeed (NAME?)	YES……..1 NO……2	→ 1001
911	Are you still breastfeeding (NAME?)	YES……..1 NO……2	→ 1001
912	Did (NAME) receive any liquids yesterday during the day or at night besides breastmilk?	YES……..1 NO……2	→ 1001
913	Did (NAME) eat solid, semi-solid or soft foods yesterday during the day or at night?	YES……..1 NO……2	→ 1001
914	When did your last menstrual period start? DO NOT COUNT BLEEDING WITHIN THE FIRST 6 WEEKS POSTPARTUM _____	DAYS AGO…… …1_ ☐☐ WEEKS AGO ……..2 ☐☐ MONTHS AGO……..3 ☐☐ BEFORE BIRTH OF (NAME)...4 HAS HAD HYSTERECTOMY..6	

PROCEED TO NEXT SECTION→

SECTION 10: SEXUAL ACTIVITY

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
100 1	When was the last time you had sexual intercourse? ~~RECORD 'YEARS AGO' ONLY IF LAST INTERCOURSE WAS ONE OR MORE YEARS AGO. IF 12 MONTHS OR MORE, RECORD ANSWER IN YEARS~~ RECORD NUMBER OF DAYS AGO IF LAST INTERCOURSE WAS WITHIN 1-6 DAYS AGO; RECORD IN WEEKS IF LAST INTERCOURSE WAS FROM 7 DAYS UP TO 27 DAYS AGO; RECORD IN MONTHS IF LAST INTERCOURSE WAS FROM 4 WEEKS UP UNTIL 12 MONTHS AGO; RECORD IN YEARS IF LAST INTERCOURSE WAS 12 MONTHS AGO OR LONGER AGO.	DAYS AGO……1 ☐☐ (1-6) WEEKS AGO……2 ☐☐ (1-3) MONTHS AGO……3 ☐☐ (1-11) YEARS AGO……4 ☐☐	

PROCEED TO NEXT SECTION→

SECTION 11: HIV/AIDS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1101	Have you ever heard of an illness called AIDS *(or the local term for AIDS)*?	YES ..... 1 NO 2	 → END
1102	Is there anything a person can do to avoid getting AIDS or the virus that causes AIDS?	YES ..... 1 NO ..... 2 DON'T KNOW 8	 → 1104 → 1104
1103	What can a person do? Anything else? RECORD ALL MENTIONED.	ABSTAIN FROM SEX .....A USE CONDOMS .....B LIMIT SEX TO ONE PARTNER/STAY FAITHFUL TO ONE PARTNER....C LIMIT NUMBER OF SEXUAL PARTNERS .....D AVOID SEX WITH PROSTITUTES ..... E AVOID SEX WITH PERSONS WHO HAVE MANY PARTNERS ..... F AVOID SEX WITH PERSONS WHO INJECT DRUGS INTRAVENOUSLY ..G AVOID CONTACT WITH CONTAMINATED BODY FLUIDS (BLOOD, SECRETIONS, ETC.) . . . . H AVOID UNNECESSARY INJECTIONS/ INJECTIONS BY TRADITIONAL HEALERS AND NON HEALTH PROFESSIONALS……..…I AVOID GETTING TATOOS ……. . . . .J AVOID SHARING RAZORS, BLADES ..K FOR MEN, AVOID HAVING SEX WITH OTHER MEN..... L AVOID KISSING .....M AVOID MOSQUITO BITES .....N	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
		SEEK PROTECTION FROM TRADITIONAL HEALER ..... Q OTHER ..... X DON'T KNOW ..... Z	
1104	Can the virus that causes AIDS be transmitted from a mother to a child? During pregnancy? During delivery? During breastfeeding?	YES NO DK DURING PREGNANCY ..... 1 2 8 DURING DELIVERY ..... 1 2 8 DURING BREASTFEEDING 1 2 8	
1105	If a mother is infected with the AIDS virus, is there any way to avoid transmission to the baby?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
1106	Can a person who has AIDS be cured?	YES ..... 1 NO ..... 2 DON'T KNOW 8	

Annex V

Technical Assistance – Sustainability Assessment

Pragati and its partners at the district and state level jointly developed ad sustainability plan for themselves, adapting the CSSA framework developed by the CSTS+ Project. This iterative process of dialogue and consensus building was facilitated by CSTS+ staff, both by e mail and through the state level workshop held for all partners in Lucknow in February 2004.

Pragati oriented its partners to the CSSA and conducted visioning exercises in each of the three project districts prior to their workshop. Based on these discussions, the team decided to divide the first dimension (health services) into two dimensions: health status and health services. This was done "to account for the fact that health status can change without change in health services during or after the project."[3] During the sustainability workshop, a vision was adopted, and the elements of the four dimensions were identified and prioritized. Participants at the workshop decided to consult more thoroughly with the communities before adopting the project-wide sustainability framework. The project and partners also decided to link the project's results framework and the sustainability framework, and are continuing to work toward accomplishing that.

Outputs of the State Level Sustainability Workshop:

- Project-wide vision
- Elements identified and prioritized
- Project-wide sustainability framework

Subsequent activities done in FY05

- Local NGO capacity assessments (guided self assessment – quantitative)
- Community Competence assessments (qualitative, with scoring)
- AWW capacity assessments (qualitative)

(these assessments are described elsewhere in the report)

The key merit of using this framework and the TA is that it provided a common platform for all partners. Right at the start of an ambitious project, its partners could all start from the same page. Add-on activities related to the Sustainability Assessment consumed more time and effort than anticipated. The project needed to jump start and fast track the implementation of field activities and also build leadership and teamwork in the districts. Therefore, the further refinement of the elements of the framework and building of indices have since taken a backseat.

Steps in FY05:

- Build indices for each dimension of the framework
- Revisit the elements before MTE and assess progress in each of them.

Technical Assistance – Family Planning

In addition to funding the Family Planning component of the project, the USAID Flexible Fund arranged for ongoing technical assistance to be provided by CATALYST/India.

The following activities were completed in FY 2004, with support from CATALYST:

1. Design and conduct of baseline population based 30-cluster survey of Married Women of Reproductive Age, in Ballia and Lalitpur districts. This was done separately, as the baseline KPC surveys had already been completed by the time the TA was built into the project.

2. A full time FP Coordinator has been appointed by CATALYST, seconded to the project, functioning from the project's Lucknow office.

3. CATALYST staff took part in the development of the DIP and in the project MIS.

4. The *Manual for training and supervision for Child Health* was prepared jointly with CATALYST. The latter undertook the design and material in the FP module of the manual as well as all FP related checklists and tools.

5. CATALYST staff took part in conducting the Master Training and backstopped/mentored Lead training and the field level trainings in the districts.

6. The FP coordinator, along with other coordination team staff, regularly visits the districts as a technical backstop.

7. CATALYST staff participated with the project in developing the protocols for the first OR topic which has to do with SDM/LAM.

8. CATALYST staff developed the training module for SDM/LAM for training the AWWs of the intervention areas of OR1.

Annex VI

PRAGATI Operations Research Protocol # 1

- Draft # 4, August 20, 2004 -

Expanding Contraceptive Choice

Table of contents:

1 Significance

Contraceptive prevalence in Uttar Pradesh remains low at 25% and with an unmet need of 25%.[4] In Ballia district, contraceptive prevalence is even lower at 12% and the unmet need reaches 50%.[5] Although access to family planning services is the main causes for this situation, the quality of services also plays an important role in the adoption and continuation of contraception by eligible couples (reference?).

Among the various dimensions of the quality of family planning services, contraceptive choice remains limited in Uttar Pradesh. While in principle five methods are offered in public health services, in practice only oral contraceptives pills (OCPs), female sterilization and condoms are used in approximately equal proportion (about 30% each).[6] Intra-uterine devices (IUDs) and male sterilization are not consistently available in primary health centers and rarely so in sub health centers. These two methods remains poorly accepted.

At the community level, community health workers such as the Anganwadi Workers (AWWs) of the ICDS and the Community-based Distributors (CBDs) of the SIFPSA project can provide OCPs and condoms and refer clients to health services to obtain IUDs and male and female sterilization where available. As the MOH is considering introducing the Standard Days Method (SDM),[7] the Lactational Amenorrhea Method (LAM) and Emergency Contraception as modern contraceptive methods offered in MOH's and NGO's health services, AWWs and CBDs can assume a role in counseling clients about these two methods and providing support and follow up to those who choose to use them.

A series of studies have been conducted in India that shows the acceptability of SDM at the community level. CASP Plan documented the provision of SDM in Sangam Vihar, a poor urban neighborhood of a primarily migrant population of about 25000 in New Delhi.[8] About 8500 potential users of SDM[9] where identified through a census of women of 13-49 years of age in union. Among these, a total of 225 (2.6%) women accepted SDM and were followed for 12 months (who were these acceptors? how were they offered the method? by whom? informed choice?). Interviews of providers and clients were conducted at beginning and end of the study. About half of the acceptors continued the method for at least 12 months and most of them were willing to continue doing so. Overall, the study demonstrated that SDM was well accepted by providers and clients and that it can be effectively taught to community health workers and result in improvement in client-provider interaction. The study also showed that SDM was accepted by new

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[4] CHECK NUMBERS--NFHS-II, 1998. For comparison, the contraceptive prevalence is 60% and the unmet need is 13% in Maharashtra State.

[5] CHECK NUMBERS--PRAGATI baseline Family Planning survey, World Vision 2004.

[6] Get contraceptive mix for UP (NFHS) and for Ballia (PRAGATI FP survey).

[7] See CEDPA Newsletter No. XXX, 2004 (page xx).

[8] Feasibility of incorporating Standard Days Method of Family Planning in the Indian Family Planning Programme. CEDPA, New Delhi, July 2004.

[9] 2000 condoms users, 500 natural FP methods users, and 6000 non-users of any FP methods.

users, suggesting a potential for meeting at least part of the unmet need in that population. However, the study also showed that some providers and some clients wanted 100% effective methods and lacked trust in the SDM effectiveness. A more detailed summary of this study and the key lessons learned for the design and implementation of this study is provided in Annex (TO BE DONE).

CARE conducted a study in rural villages in Sitapur, UP, which showed WHAT? REFERENCE?.

CEDPA/CATALYST is also beginning a study with the public sector and another NGO in Jharkand to assess at the impact of integrating the SDM into FP programs on provider behavior, method mix, and contraceptive prevalence. PROVIDE SUMMARY OF KEY RESEARCH QUESTIONS AND METHODOLOGICAL APPROACHES IN ANNEX.

One review of the feasibility and potential benefits of LAM in Uttar Pradeh[10] concluded that LAM should be systematically introduced among other post-partum contraceptive methods. No community-based study of LAM in Uttar Pradesh or India was identified (CHECK).

To date, there is no documented experience of the introduction of LAM and SDM in community-based child health programs, in which community health workers have a multitude of other tasks to conduct beside family planning. In addition, there are no fully developed guidelines and tools for the implementation of these methods in this context. As the PRAGATI project is scaling up a well-established package of community-based child survival and family planning interventions, it provides the opportunity to assess the feasibility and potential benefits of the provision of SDM and LAM by AWWs and develop the appropriate tools for doing so.

One concern regarding the introduction of new methods in health services is that providers might lead clients into using them[11] and therefore fail to comply with the principle of informed contraceptive choice that characterizes quality family planning services.[12] This concern applies to the introduction of LAM and SDM at the community level and into child health programs.

2 Purpose

This study will document the introduction of SDM and LAM within community-based child health programs in Ballia using locally adapted implementation tools, and will assess both their acceptability and the resulting change in overall contraceptive prevalence and method mix.

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[10] The Lactational Amenorrhoea Method (LAM) for Birth Spacing in Uttar Pradesh, India. Caleb, Leila E.; Townsend, John W. Population Council, Operations Research and Technical Assistance Project, 1996.

[11] EVIDENCE FOR THIS?

[12] The US Government Tiahrt Amendment forbids? any individual or organization providers of family planning to use any form of coercion for any kind methods.

3 Objective

To demonstrate the benefits of introducing SDM and LAM within community-based child health programs in terms of quality of care (informed choice), user satisfaction and contraceptive prevalence.

4 Research Questions

1. How can SDM and LAM be provided within a community-based child health program in addition to existing contraceptive methods?
2. Does the provision of SDM and LAM in addition to existing contraceptive methods at the community level affect the quality of family planning services in terms of informed choice?
3. Does the provision of SDM and LAM in addition to existing methods at the community level increase the overall contraceptive prevalence?

5 Specific aims

This study will address the three research questions above by ensuring that:

1. A set of tools is demonstrated as effectively used by AWWs for the provision of:

   Specific Aim 1: SDM services

   Specific Aim 2: LAM services

2. The following hypotheses are tested:

   Specific Aim 3: The provision of SDM and LAM in addition to existing contraceptive methods at the community level does not affect informed choice.

   Specific Aim 4: The provision of SDM and LAM in addition to existing contraceptive methods at the community level increases the overall contraceptive prevalence.

6 Study population

The study will be conducted in the block of Garwar (population 112,000) in Ballia District. Garwar is chosen as a block that does not receive the kind of support provided to Beruarbari block by the WV ADP, which is accessible to the researcher team, and where the cooperation with the ICDS CDPO has been good in the past. In Garwar, the ICDS currently supports 112 AWWs who will provide family planning services in addition to the other child health interventions scaled up under the PRAGATI project: immunization, maternal and infant nutrition and vitamin A supplementation. In July 2004, these AWWs received a 5-day training course on all these interventions (see Annex 1) that included two days of training on family planning (see Annex 2 and 3).[13]

7 Intervention

Garwar block will be divided into an intervention and a control area. All the AWWs and their supervisors will receive one additional day of training on informed choice and counseling skills. This is to ensure that these aspects of the services provided by the AWWs are well defined and comparable in the intervention and the control areas. The short duration of the training ensures that the additional content related to counseling, informed choice and SDM and LAM can be included in the 5-day course that the PRAGATI project provides to the AWWs. In the intervention area, this additional training day also include specific SDM and LAM information, tools and skills. After the training, the supervisors will reinforce these skills by including LAM and SDM in their routine activities during the entire duration of the study.

As the intervention consists in training and supervision of AWWs, the intervention and control areas will be defined by randomly assigning the supervisors and all their supervisees (AWWs) in one of two groups. Given the relatively small number of supervisors in Garwa (8 total), the comparability of the two areas will be checked against a few characteristics of the supervisors and the AWWs (qualifications, performance, gender) and of the population that they serve (urban/rural residence; access to health and AWWs services; community organization).

Note:
--discuss specific content of the additional training
--discuss source, availability, quality and cost of the necklace

8 Indicators

The key indicators used for each Specific Aim follow:

Specific Aim 1:

[13] The main topics and their time allocation of this training is: immunization (3.5 hours); nutrition (2.5 hours); vitamin A (1 hour); safe motherhood (1.5 hour); family planning (12 hours; see appendix). – CHECK THIS

- Tools for the provision of SDM within community-based child health programs relevant and adequate
- % supervisors who know the key information needed for the provision of SDM services (key information and acceptable threshold TO BE SPECIFIED)
- % providers who know the key information needed for the provision of SDM services (key information and acceptable threshold TO BE SPECIFIED)
- % providers who can demonstrate appropriate SDM skills (appropriate SDM skills and acceptable threshold TO BE SPECIFIED)

Specific Aim 2:
- Tools for the provision of LAM within community-based child health programs are relevant and adequate
- % supervisors who know the key information needed for the provision of LAM services (key information and acceptable threshold TO BE SPECIFIED)
- % providers who know the key information needed for the provision of LAM services (key information and acceptable threshold TO BE SPECIFIED)
- % providers who can demonstrate appropriate LAM skills (appropriate SDM skills and acceptable threshold TO BE SPECIFIED)

Specific Aim 3:
- % providers who can demonstrate appropriate family planning counseling skills (appropriate counseling skills and acceptable threshold TO BE SPECIFIED)[14]
- % providers who can demonstrate appropriate family planning counseling skills related to informed choice (appropriate counseling skills related to informed choice and acceptable threshold TO BE SPECIFIED)

Specific Aim 4:
- contraceptive prevalence rate among women of reproductive age
- contraceptive prevalence rate among mothers of children under 1 (for LAM)

9 Sample size

Specific Aims 1 and 2 imply the definition of the key information and skills needed for effective provision of SDM or LAM services and of a threshold for the proposed indicators above which the set of tools can be considered effective. The minimum number of supervisors and providers to be assessed to determine that this threshold is achieved can be calculated using the LQAS method. This number could be up to 19 if a threshold of 80%, a confidence of 95% and a power 80% are found acceptable.— CHECK

Specific Aims 3 and 4 imply a statistical test of the significance of the difference found in the proposed indicators in the intervention and the control areas. For Specific Aim 3, assuming that one indicator is 80% in one area and 60% in the other, a level of

[14] Appropriate counseling skills will be further specified in terms of the extent to which the providers (1) presents all the available methods; (2) provides detailed information on the selected method; (3) provides information on side effects; and (4) tells when to visit again.

confidence of 95% and a power of 80%, the size of the sample of providers should be at least 64 in each area (there are about 112 AWWs in Garwa! Is this number likely to increase or decrease in the course of the study?). For Specific Aim 4, assuming an increase in CPR from 12% (average in Ballia--CHECK) to 30% in the control area and to 40% in the intervention area (is this realistic within 18 months?), a level of confidence of 95% and a power of 80%, the size of the sample of eligible couples should be at least 280 in each area (intervention and control). A similar number of mothers of a child of at least 6 months of age would be required to detect a similar difference in the post-partum contraceptive prevalence.

TO BE DEVELOPED AFTER OVERALL AGREEMENT ON OTHER ASPECTS OF STUDY DESIGN.

10 Data collection

For Specific Aims 1 and 2, an external expert review will be conducted to assess the relevance and soundness of the set of tools that was implemented, and the provider data will be collected through interviews and standardized observations of their practices.

For Specific Aim 3, provider data will be collected through interviews and observations conducted on a routine basis during supervision visits or through the use of mystery clients. Client data will be collected through exit interviews.

For Specific Aim 4, contraceptive prevalence rates will calculated in the control and intervention sites using data from the regular information system implemented by the AWWs and ICDS: family planning registers, infant registers, and monthly progress reports.--still need to look again at the FP register and determine the feasibility and validity of using them for estimating contraceptive prevalence. Otherwise, look at what can be done during the household survey done every six months by the AWWs, or consider household sample survey. Consider household surveys of women of reproductive age and of mothers of children under 1 (for LAM).

11 Dissemination of findings

TO BE DETERMINED:
Data analysis and interpretation workshop
Research finding dissemination workshop
Study report publication and dissemination
Presentation in conference (which? when?)
Publication in scientific journals (which?)

12 Roles and responsibilities

TO BE DETERMINED:
WV India
Rajini

Beulah
Bradley

WV APRO
Chander

WV US
Lyndon
Consultant

CEDPA/CATALYST

Others?

13 Timeframe

The timeline of the study is in Annex 5. COMMENT.

Notes:
--The OR 1 timeline still considers a phase 1 for the OR study as defined in this protocol and a phase 2 to mainstream SDM/LAM in all PRAGATI areas. CHECK if this is realistic or whether this study should be limited to phase 1 under PRAGATI.

Annex 1 : Overall Training Plan for Anganwadi Workers

Total Days: Five

Session	Duration	Facilitator
Day One		
Welcome, Introductions Introduce Training package	1 hour	
Pretests	½ hour	
Module 2: Overview of Pragati Project	1 hour	
Module 3: Why Child Survival	½ hour	
Module 4: Immunization	3 ½ hours	
TOTAL HOURS: 6 ½		
Day Two		
Recap, questions	½ hour	
Module 5: Basic Facts about Nutrition	½ hour	
Module 6: Infant Nutrition	2 hours	
Module 7: Vitamin A	1 hour	
Module 8: Safe Mother hood	2 hours	
TOTAL HOURS: 6 ½		
Day Three		
Recap, questions	½ hour	
Module 9: Family Planning	6 hours	
TOTAL HOURS: 6 ½		
Day Four		
Recap, questions	½ hour	
Module 9: Family Planning (contd)	6 hours	
TOTAL HOURS: 6 ½		
Day Five		
Recap, questions	½ hour	
Module 10: Mobilizing Communities for Change	1 hour	
Post Tests	½ hour	
Description of Roles of AWW	1 hour	
Discussion on Registers and Counseling plan	2 ½ hours	
Discussion on Monthly Progress Report	1 hour	
TOTAL HOURS: 6 ½		

Annex 2 : Family Planning Module

Total time: 12 hours

Role of AWWs in Family Planning Related Work of Pragati Project

1. Explain advantages of birth spacing for at least 3 to 5 years
2. Explain advantages of limited family size
3. Explain the various FP methods and ask couple to choose the best one for them
4. Distribution of condoms and OC pills
5. Refer for Copper-T, male sterilization and female sterilization services
6. Follow up of all family planning clients
7. Give suggestions to women regarding emergency contraception

Teaching Objectives

At the end of the Family Planning module, the Anganwadi Workers will be able to:

1. Tell the advantages of birth spacing for at least 3 to 5 years
2. Tell the advantages of limited family size
3. List the various family planning methods
4. Help clients to choose from various family planning methods
5. Explain how conception takes place
6. Explain the various natural family planning methods
7. Explain and discuss condoms, Copper T, OC pills, and male and female sterilization
8. Distribute condoms and OC pills and refer clients for Copper T, male and female sterilization
9. Give suggestions for emergency contraception
10. Counsel clients regarding family planning

List of sessions

1.	Meaning and advantages of family planning	1 hour
2.	Methods of family planning and its choosing a method	1 hour
3.	How the contraception takes place	30 Min
4.	Natural methods of family planning	30 Min
5.	Full information regarding condom and discussion	1 hour, 30 Min
6.	Full information regarding OC pills and discussion	1 hour, 30 Min
7.	Full information regarding Copper T and discussion	1 hour
8.	Full information regarding male and female sterilization	2 hours, 30 Min
9.	Emergency contraception	30 Min
10.	Counseling for Family Planning	2 hours

Training Materials

- Flipcharts
- Marker pen
- Samples of Condom, OC tablets & Copper T
- Chart of male and female reproductive parts
- Guideline for teaching

Annex 3 : Family Planning Session Plans

Session - 1

Meaning and Advantages of Family Planning

Time: 1 Hour

Sl. No.	Subject of Session	Training Method	Time
1	Meaning of family planning	Discussion	10 Min
2	Advantages of family planning	Group work and discussion	45 Min
3	Debriefing		5 Min

Session – 2

Methods of Family Planning and its Selection

Time: 1 Hour

Sl. No.	Subject of Session	Training Method	Time
1	List of methods for family planning	Brainstorming and discussion	10 Min
2	Principles of family planning	Discussion	15 Min
3	Choosing of family planning method by client	Presentation and discussion	30 Min
4	Debriefing		5 Min

Session – 3

How Does Conception Takes Place

Time: 30 Min

Sl. No.	Subject of Session	Training Method	Time
1	How does conception takes place	Presentation	25 Min
2	Debriefing		5 Min

Session – 4

Natural Methods of Family Planning

Time: 30 Min

Sl. No.	Subject of Session	Training Method	Time
1	List of natural family planning methods and information on family planning	Brainstorming and discussion	10 Min
2	Debriefing		5 Min

Session – 5

Full Information of Condom

Time: 1 Hour 30 Min

Sl. No.	Subject of Session	Training Method	Time
1	Full information of condom	Brainstorming, discussion, presentation	1 Hour
2	Demonstration of condom	Practice in small group	25 Min
3	Debriefing		5 Min

Session – 6

Full Information of OC Pills

Time: 1 Hour 30 Min

Sl. No.	Subject of Session	Training Method	Time
1	Full information of OC pills	Brainstorming, discussion, presentation	1Hour
2	Demonstration of OC pills	Practice in small group	25 Min
3	Debriefing		5 Min

Session – 7

Full Information of Copper T

Time: 1 Hour

Sl. No.	Subject of Session	Training Method	Time
1	Full information of copper T	Brainstorming, discussion, presentation	30 Min
2	Demonstration of copper T	Practice in small group	25 Min
3	Debriefing		5 Min

Session – 8

Full Information of Male and Female Sterilization

Time: 2 Hours, 30 Min

Sl. No.	Subject of Session	Training Method	Time
1	Full information on male sterilization and suggestion	Brainstorming, discussion, presentation	1 Hour, 15 Min
2	Full information on female sterilization and suggestion	Brainstorming, discussion, presentation	1 Hour, 10 Min
3	Debriefing		5 Min

Session – 9

Emergency Contraception

Time: 30 Min

Sl. No.	Subject of Session	Training Method	Time
1	Essential information oo emergency contraception	Brainstorming, discussion, presentation	25 Min
2	Debriefing		5 Min

Session – 10

Counseling for Family Planning

Time: 2 Hours

Sl. No.	Subject of Session	Training Method	Time
1	What are the counseling for family planning?	Brainstorming, discussion, presentation	25 Min
2	While giving counseling, things to be kept in mind	Ask question as if you are client	15 Min
3	Step of counseling	Presentation and discussion	15 Min
4	Example of giving counseling	Story - “Lila Devi met Gita”	15 Min
5	Practice of family planning counceling session	Role Play	45 Min
6	Debriefing	Question-Answers	5 Min

Annex 4 : Sample Observation Checklist

Check List 1.1 – Counseling on condom

Check if the AWW does the following	Results of the counseling				
Welcomes the client with respect					
Checks the knowledge of the client on condom					
Clears all the misconception regarding condom					
Briefs the details of condom					
Explains how the condom works					
Explains the Benefits of condom					
Explains the shortcomings (limitations)					
Shows the condom and explains the use of it					
Makes sure that the client has understood "how to use condom"					
Explains about the maintenance of condom					
Gives her condom					
Asks if the client has got any other doubt and clarifies them					
Tells her when she will visit her again.					

Check List 1.2 – Follow up of condom client

Check if the AWW does the following	Results of the counseling				
Welcomes the client with respect					
Asks the client the following questions					
1. Whether she and her husband are happy with the method					
2. How are the couple using the condom					
3. Whether they have any problem in using the condom.					
Tells the client the following things					
1. Right way of using the method (if the client has forgot something)					
2. If they have any kind of problem like allergy, then they can use another brand or any other method					
3. If her husband says no to condom use or if the couple are not happy with the method then they can use any other method.					
4. If the client is happy with condom then give more packets.					
Asks if the client has got any other doubt and clarifies them					
Tells her when she will visit her again.					

Annex 5 : Study Timeline

See spreadsheet.

Note: The Excel spreadsheet still includes the timelines of the three PRAGATI OR studies for planning and coordination purposes.

Annex VII

PRAGATI Operations Research Protocol # 2

- Draft # 3, September 12, 2004 -

Evidence-based advocacy for immunization

Table of contents:

1. Significance

World Vision is a child-focused organization that seeks to promote the holistic development of the child through its Area Development Programs (ADP). Two of the Transformational Development Indicators that WV Partnership is introducing to monitor and evaluate ADPs world wide are related to child health: childhood immunization and nutritional status.

Ensuring access to quality child health services is therefore a priority for all ADPs. Rather than the direct provision of health services, however, ADPs can focus on strengthening the local health services that will continue providing services after the ADP ends. One important element of the quality and sustainability of health services is their accountability to the community that they serve. This can be achieved at least partially through the use of health information by the community and health workers.

In Uttar Pradesh and most other areas where WV supports ADPs, the information system of the health services and the Integrated Child and Development Scheme (ICDS) do not include any feedback to the community. As result, health data collected at the

community level feeds health information systems but are rarely accessed and used by those who most need to understand and interpret them – the local community.

There is a need for clear and effective procedures and tools to make health information available to communities so that they can understand and use it for decisions-making and advocacy purposes. This research can best begin with a focus on childhood immunization data and services because the related data and roles and responsibilities of health services are well defined. This study can best begin in a well-established ADP to better define the role that a ADPs can play to support this process, and the best way to integrate immunization and other health activities in their programs.

2. Purpose

This study will develop simple procedures and tools to support communities in the use of community-based health information for decision-making and advocacy. It will assess the effectiveness of these tools on improving community competence in advocacy and the feasibility of their introduction in WVIND ADPs.

3. Objective

To develop procedures and tools that WVIND ADPs can introduce in their communities to help them use the information in childhood immunization services for health advocacy.

4. Research questions

1. How can community-based HIS be used to improve community competence in evidence-based advocacy?
2. Does evidence-based advocacy improve accountability of health workers?
3. Does evidence-based advocacy increase immunization coverage?

5. Specific aims

This study will address the three research questions above by ensuring that:

Specific Aim 1: A set of procedures and tools using community-based HIS on immunization is demonstrated as effectively used for evidence-based advocacy by community members in WVIND ADPs.

and by testing the following hypotheses:

Specific Aim 2: The effective use of a defined set of procedures and tools for evidence-based advocacy increases health worker accountability.

Specific Aim 3: The effective use of a defined set of procedures and tools for evidence-based advocacy increases immunization coverage.

6. Study population

The study will be conducted in the 24 sponsorship villages in the Beruarbari block of ADP Ballia, which represent a total population of about 75,000, 30 CMS (?), 70 community groups (?), 50 AWWs, 8 to 10 ANMs and 8 supervisors. The choice of this ADP for the development and test of the set of procedures and tools is justified by the existence of already well- established Community Groups such as Self-Help Groups, MMs, and Village Development Committees, which have gained experience in child health and survival under the BRICS project. It is otherwise appropriate to choose these better organized communities since the objective of the study is to develop procedures and tools that WVIND ADPs can use.

7. Intervention

The study will be implemented in two phases: Phase 1 for the development and test of the procedures and tools and Phase 2 for the implementation of the procedures and tools in selected ADPs.

During Phase 1, the PRAGATI staff will first conduct a series of participatory meetings with ANMs, AWWs and community members to develop the set of procedures and tools to provide feedback to the community on the immunization services. This work is contingent on the experience of the newly trained AWWs and on the availability of immunization data for about three months. It will therefore only be completed by the end of the third quarter of year 2005. In the meantime, the PRAGATI staff will further define the main concept and conceptual framework of the study through a literature review and field visits to projects that have researched and implemented similar topics. Operational definitions will be defined for evidence-based advocacy, community competence, community decision-making, and health worker accountability.

When satisfactory procedures and tools are available, 12 sponsorship villages will be selected and the AWWs/ANMs in this area will be trained on how to communicate immunization data in a simple, easy to understand and pictorial form. Simultaneous meetings will be held with community members including AWWs/ANMs, MS, CMS, core group members and CDCs. The ANMs and AWWs in the intervention area will then use these tools for a period of at least 12 months, at the end of which their adequacy and effectiveness will be evaluated. Appropriate revision of the procedures and tools will be made on the basis of this evaluation.

During Phase 2, the revised procedures and tools will be introduced into selected ADPS (7?). After discussion, awareness raising activities and negotiations, the PRAGATI staff will train the appropriate ADP staff (WHICH? CDC?), who will then train and monitor the ANMs and AWWs as part of their routine activities. The use of the tools by the ANMs and AWWs, the change in accountability of health worker and the change in immunization coverage will be assessed in each participating ADP at the end of Phase 2.

8. Indicators

Specific Aim 1

Indicator 1.1:	A set of procedures and tools for evidence-based advocacy for immunization by community members in WVIND ADPs is available, relevant and adequate.
Indicator 1.2:	# of ANMs in the intervention areas who can explain the purpose and demonstrate the use of the tools above
Indicator 1.3:	# of AWWs in the intervention areas who can explain the purpose and demonstrate the use of the tools above
Indicator 1.4:	# of community meetings in the intervention areas during which the tools above were used

Specific Aim 2

Indicator 2.1:	INCREASED HEALTH WORKER ACCOUNTABILITY IN INTERVENTION AREA [find indicators]

Specific Aim 3

Indicator 3.1:	INCREASED IMMUNIZATION COVERAGE IN INTERVENTION AREA [find increase in which indicators can realistically be measured]

9. Data collection

Indicator 1.1:	Expert external review
Indicator 1.2:	In-depth interview and observation of ANMs in the intervention area
Indicator 1.3:	In-depth interview and observation of AWWs in the intervention area
Indicator 1.4:	Report from ANMs in the intervention area
Indicator 2.1:	Qualitative assessment of ANMs and other health workers in intervention [and control areas?]
Indicator 3.1:	Immunization reports from ANMs in intervention [and control areas?]

10. Timeframe

Phase 1 will last about 18 months, including a maximum of 6 months of formative research to develop the procedures and tools and for training the ANM and AWW, and at least 12 months of implementation of the procedures and tools.

Phase 2 will last about 15 months, including a maximum of 3 months to train the ADP staff and the ANMs and AWWs, and at least 12 months of implementation.

Annex VIII

PRAGATI Operations Research Protocol # 3

- Draft # 3, September 12, 2004 -

District Sentinel Surveillance System for mortality, fertility, and other health indicators

Table of contents

11. Significance

The PRAGATI project will scale up a series of community-based methods and tools that include the use of pregnancy and infant registers by AWWs. These registers support the routine home visits of the AWWs during which they provide various timed and targeted counseling and health services. The AWWs collect data in these registers and report selected indicators on a monthly basis to the ANMs in their areas, who themselves report aggregate data to the health services.

Although these aggregate data are potentially very useful for program monitoring and decision-making, their usefulness and actual use at the ANM and high levels of the health system are not known and suspected to be relatively low. Among reasons for the assumed low use of these data probably are their unknown and unsatisfactory completeness, timeliness and quality. Also, the efforts and resources needed to ensure satisfactory quality and use of data is may be too high to be available in all blocks of all districts.

This study will assess the usefulness and use of the data reported by the AWW at the ANM and higher levels of the health system. Given the socioeconomic and health systems differences in the three PRAGATI districts, assessments will be conducted in

each project district (Ballia, Lalitpur and Moradabad). Given the need to have relatively large population basis to calculate certain indicators such as fertility and mortality, assessments will be made at the block level. Given the relatively high level of efforts and skills needed to ensure the quality and use of this type of data, assessments will be done in only one block per district.

12. Purpose

The purpose of this study is to determine the feasibility and usefulness of establishing sentinel health surveillance system at the block level using the information system operated by the AWWs.

13. Objective

The objective of this study is to develop the methods and tools for measuring reliable mortality, fertility and other child health indicators using data routinely collected by the AWWs in their pregnancy and infant tracking registers.

14. Research questions

4. How reliable are the aggregate measures of mortality, fertility and other program indicators obtained from data routinely collected by the AWWS?
5. How useful are these aggregate measures in terms of decision-making at the ANM and higher levels of the health services?
6. If the quality of data warrants it, what are the rates and trends in the indicators available in these sentinel surveillance systems in the three project districts?

15. Specific aims

The specific aims of each phase of this study are:

Phase 1:

(1) To determine the completeness, quality and usefulness of the aggregate data collected during the BRICS project.

If the quality of the data warrant is,

(2) To determine the mortality, fertility and other program indicators rates and trends during the BRICS project

(3) To develop and test methods and tools to obtain reliable and useful mortality, fertility and other program indicators using the data routinely collected by the AWWs

Phase 2:

(4) To determine the completeness, quality and usefulness of the data collected in three block chosen as sentinel surveillance sites.

If the quality of the data warrant is,

(5) To determine the mortality, fertility and other program indicators rates and trends in one sentinel surveillance site in each PRAGATI project district.

(6) To make detailed recommendations on the feasibility and approaches to using data routinely collected by AWWs as a sentinel surveillance system at the district level.

16. Study population

The first phase of the study will assess the completeness and quality of the data collected by community health workers during the BRICS project and later. The assessment will be done in the former "Direct Impact" area, the Beruarbari block, and in selected other blocks of Ballia District in which the BRICS project was scaled up during the last 18 months of the project.

The Beruarbari block represents a total population of about 150,000. It is where the World Vision ADP is located and is covered by 8 Community Development Officers and one Program Coordinator. The other blocks in the Ballia district where covered by various NGOs. The child survival activities were conducted by GSS in Beruarbari and by AWWs in the other blocks--check.

During the second phase of the study, one sentinel surveillance site will be selected in each PRAGATI district. Buerarbari and one block in Lalitpur will be selected because the presence of an ADP may provide additional support to the establishment and monitoring of the surveillance system. One additional block will be selected in Moradabad.

17. Activities

Phase 1:

A retrospective review of the Monthly Progress Reports (MPR) from Beruarbari shows that all monthly reports for the period January 2001 to ??? 2003 (CHECK) are available at the ADP office. Similarly, the reports from three NGOs involved in seven? blocks under the BRICS project seem to be available for FY02.

Given the completeness of these monthly reports for these various areas and periods, the PRAGATI staff will enter most of the data included in these reports in a data base and analyze the completeness and quality of the related indicators at the block level. Statistical analyses will then be combined with the analysis of the usefulness of these indicators with the relevant decision-makers. If the quality of the data warrants it, analysis of the variation in completeness and quality across blocks and rates and trends for various indicators will be calculated. On the basis of the finding of these analyses,

specific recommendations will be made on the register and monthly reports of the AWWs and on the establishment of related sentinel surveillance system at the district level.

Phase 2:

The second phase of the study will consist in pilot-testing the system recommended after Phase 1 in one block of each project district. This sentinel surveillance system will involve reporting fertility, mortality and selected other health indicators otherwise already collected by the AWWs in the pregnancy and infant tracking registers adopted by ICDS.

During the second phase of this study, specific features of the system might be tested so that further recommendations can be made at the end of the project. One such feature of the system is to list pregnant women by the month of their Expected Date of Delivery and newborns by their date of birth. This procedure allows the AWW to quickly look at all the women who are at the same stage of their pregnancy or all infants of the same monthly cohort and easily know which women are due for delivery during the current month or which infants are due for which visits or which immunization. The feasibility and benefits of investigating causes of infant and child deaths may also be assessed in the Beruarbari block.

Phase 2 will also be used to build the capacity at the block and district level for managing, analyzing and disseminating the information obtained from the sentinel surveillance systems. DEVELOP?

18. Timeframe

The first phase of the study, the review of the available data from BRICS, will be completed in December 2004. In August and September, all data from the supervisor reports will be entered and preliminary analyses of completeness and quality will be conducted. In October and December, more advanced analyses including calculation of rates and trends and interpretation of the value of the available indicators in terms of programmatic decision-making will be completed. The AWWS register and reports will then be reviewed on the basis of the finding from these analyses.

Early in the second quarter of FY05, the finding of this retrospective analysis of the BRICS data will be complemented with that of the data from the field test of the PRAGATI registers and monthly reports. Potential revisions of these tools will then be presented during a HIS workshop with the government and other partners during which the final format of the tools will be adopted. Potential addition and modifications to these tools for the purpose of the sentinel surveillance system will be discussed at that time. The selection of the three sentinel sites and the training of the AWWs and supervisors in these blocks will follow this workshop and the adoption of the final tools.

The second phase, if the recommendations from Phase 1 warrant it, will be implemented throughout the remaining of the project, with the expectation that measurement of trends will be feasible and well established by the end of the project. The PRAGATI staff will conduct quarterly visits to the sentinel surveillance sites to address any implementation issues as they arise and to conduct analyses of the data of the previous quarter. Interim

analyses of the data from the three sentinel surveillance sites will be conducted in the third quarter of FY06 and the final analyses in FY07.

Annex 1: Monthly Progress Reports indicators to analyze in Phase 1

S.No.	Indicator	Target	Achievement
1	No.of children for BCG0/OPV0		
2	No. of children for DPT1/OPV1		
3	No. of children for DPT2/OPV2		
4	No. of children for DPT13OPV3		
5	No. of children for measles		
6	No. of children for Vitamin A		
7	No. of pregnant women for TT1		
8	No.of pregnant women for TT2		
9	No. of BCC sessions held		
10	No. of BCC sessions attended		
11	No. of register supervision done		
12	No. of EPI supervision done		
13	No. of ANC sessions supervised		
14	No. of wall paintings done		
15	No. of family visits done by GSS		
16	No. of children registered in this month		
17	Total no.of children registered		
18	No. of pregnant women registered in this month		
19	Total no. of pregnant women registered		
20	No. of birth deliveries in this month/live births		
21	How many of the above were conducted by a trained dai		
22	No. of DD kits sold in this month		
23	No. of pregnant women referred to hospital		
24	No.of sick children referred to hospital		
25	No. of ORS packets distributed		
27	No. of deaths of children registered in this month		
28	No. of deaths of women registered in this month		
26	No.of new clients registered for family planning	**New Clients**	**Total**
	a)Condoms		
	b)Copper T		
	c)Male Sterilisation		
	d)Female Sterilisation		

Catchment population?

The Target estimations are made in different ways in different areas and depend on the population figures available. Typically, the BCG and the Measles targets are the total of pregnant women with a due data that month in the Pregnancy register. The target for DPT 1 to 3 is typically different because frequent stock outs and dropout lead the AWW to include the infants who missed their immunization in the target for the current month.

Annex 2: Block and year covered by the PRAGATI sentinel surveillance system

	Block	2002	2003	2004	2005	2006	2007
Ballia							
1	Beruarbari						
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
Lalitpur							
1	ADP block						
2							
3							
4							
5							
6							
Moradabad							
1	To be determined						
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							