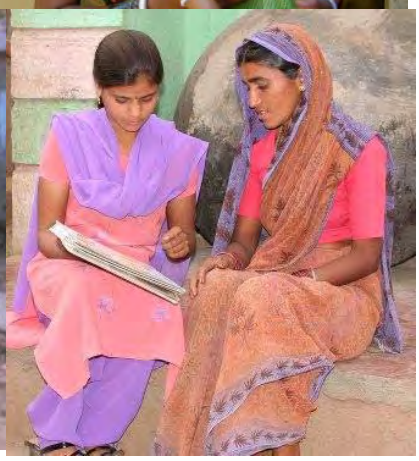
USAID

MGIMS

CLICS (Community Led Initiatives for Child Survival)

Final Report



Endline Study for Community Led Initiatives for Child Survival (CLICS)

ORG Centre for Social Research
(A Division of ACNielsen ORG MARG Pvt. Ltd.)

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LIST OF ACRONYMS

AAY	Antyodaya Anna Yojana
AIDS	Acquired Immunodeficiency Syndrome
AKF	Aga Khan Foundation
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwives
ARI	Acute Respiratory Infection
AWC	Anganwadi Center
AWW	Anganwadi Worker
BSD	Bal Suraksha Diwas
CBO	Community Based Organization
CLICS	Community Led Initiatives for Child Survival
DCM	Department of Community medicine
DDK	Disposable Delivery Kit
FGD	Focused Group Discussion
HIV	Human Immunodeficiency Virus
ICDS	Integrated Child Development Scheme
IEC	Information, Education and Communication
IFA	Iron and Folic Acid
IMNCI	Integrated Management of Childhood Illnesses
IUD	Intrauterine Device
KVM	Kisan Vikas Manch
LHV	Lady Health Visitor
MGIMS	Mahatma Gandhi Institute of Medical Sciences
MO	Medical Officer
NFHS	National family Health Survey
ORS	Oral Rehydration Salt
PHC	Primary Health Center
RTI	Reproductive Tract Infections
SC	Sub Center
SHG	Self Help Group
STI	Sexually Transmitted Infections
VCC	Village Coordination Committee
VHW	Village Health Worker
OCP	Oral Contraceptive Pills

FACTSHEET – I

Rapid Catch Indicators for Endline Survey

Indicators	Numerator	Denominator	Indicator	CI at 95%
% children (0-35 m) underweight (-2 SD from the median weight-for-age)	375	912	41.1%	38-44.4%
% children age 0-23 months who were born at least 24 months after the previous surviving child	261	343	76.1%	71.6-80.6%
% children (0-23 m) whose births were attended by trained provider	643	685	93.9%	91.8-95.4%
% mothers of children age 0-11 months who received at least two tetanus toxoid injections before the birth of their youngest child	352	376	93.4%	91.7-96.5%
% children (0-5 m) exclusively breastfed in the last 24 hours	83	132	62.9%	54.5-71.2%
% children (6-9 m) given breast milk and complementary foods in the last 24 hours	146	149	98.0%	95.7-100%
% children (12-23 m) fully vaccinated (against the six vaccine-preventable diseases) before their first birthday	323	337	95.8%	93.6-98%
% of children age 12-23 months who received a measles vaccine	325	337	96.4%	94.4-98.4%
% children age 0-23 months who slept under an insecticide-treated bed net the previous night (in malaria-risk areas only)	142	685	20.7%	17.7-23.7%
% mothers with children (0-35 m) who cite at least two known ways of reducing the risk of HIV infection	541	912	59.3%	56.1-62.5%
% mothers of children (0-35 m) who report that they wash their hands with soap/ ash:				
a) before food preparation	420	912	46.1%	42.9-49.3%
b) before feeding children	522	912	57.2%	54-60.4%
c) after defecation	899	912	98.6%	97.8-99.4%
d) after washing child after defecation	887	912	97.3%	96.2-98.4%
% mothers of children (0-23 m) who know at least 2 signs of childhood illness that indicate the need for treatment	681	685	99.4%	98.8-100%
% sick children (0-35 m) with cough and/or difficult/ rapid breathing during the past two weeks who received:				
a) increased fluids (after first 6 months)	67	141	32.2%	28.7-35.7%
b) continued feeding among those who were breastfeeding	169	172	98.3%	96.3-100%

FACTSHEET – II

LFA Indicators for the CLICS Programme

S.No.	Technical Intervention	Indicators	Baseline	Midline	End Term
1	Newborn Care	% of mothers of children (0-11) aware of care of the newborn			
		a) Hypothermia prevention (at least one method)	84.2%	88.2%	100%
		b) Low birth weight management (at least one method)	93.9%	91.8%	99.1%
		c) Initiation of breast feeding (Less than one hour)	0.6%	40.0%	68.7%
		d) Recognition of danger signs (at least three signs)	11.3%	30.0%	99.7%
		% of village health workers aware of four elements of care of the newborn (CLICS Doot)			100.0%
2	Safe Motherhood	% of mothers of children (0-11 months) Who receive minimum ANC package (At least 3 antenatal checkups by a trained provider, 2 tetanus toxide injections and 100 IFA tablets) during last pregnancy)	11.6%	10.9%	31.4%
		% of children (0-23 months) whose births were attended by trained provider	82.2%	97.0%	93.9%
		% of sick children (0-35 months) with cough and/or difficult/rapid breathing during the past two weeks who received			
		a) Increased Fluids (After first 6 months)	1.3%	0.5%	32.2%
		b) Continued feeding among those who were breast feeding	50.0%	82.1%	98.3%
		% of sick children (0-35 months) with watery or loose motion during the past two weeks who received			
		a) Increased Fluids (After first 6 months)	1.4%	66.3%	73.3%
		b) Continued feeding among those who were breast feeding	40.5%	89.5%	93.2%
3	Breastfeeding and Nutrition	% of children (0-5 months) breastfed within 1 hour of birth	0.9%	80.0%	65.2%
		% of children (0-5 months) exclusively breastfed in the last 24 hours	80.1%	85.1%	62.9%
		% of children (6-9 months) given breast milk and complimentary foods in the last 24 hours	72.0%	65.1%	97.9%
		% of children (0-35months) weighed in the last month	50.1%	79.8%	80.5%
		% of children (0-35 months) underweight (-2 SD from the median weight for age)	43.2%	44.3%	41.1%
		% of children (12-35 months) received a dose of vitamin A in the last 6 months	53.6%	60.1%	53.5%
		% of children (12-35 months) received iron and folic tablets in the last 14 days	6.0%	2.5%	20.1%
		% of mothers of children (6-35) months who can name 2 iron rich foods	22.3%	24.4%	89%
4	Early Childhood Development	% of children (0-5 months) weighed within 24 hours of birth	73.5%	85.8%	84.1%
		% of adolescent girls attended a Health Education/ Family Life Education Session	2.1%	21.0%	38.5%
		% of adolescent girls (16-19 years) aware of at least 2 ways of delaying pregnancy	26.2%	41.0%	36.0%
		% of adolescent girls (16-19 years) who cite at least two known ways of reducing the risk of HIV infections	24.9%	71.0%	66.2%
		% husband aware of at least 3 danger signs of pregnancy	13.2%	18.0%	42.2%

S.No.	Technical Intervention	Indicators	Baseline	Midline	End Term
5	ARI and Diarrhea	% mothers of children (0-23 months) who know at least 2 signs of childhood illness that indicate the need for treatment	30.5%	55.4%	99.4%
		% of mothers of children (0-35 months) who know at least 2 signs of childhood illness that indicate the need for treatment	29.5%	55.4%	99.9%
		% of mothers of children (0-35 months) who report that they wash hands with soap/ash			
		a) Before food preparation	9.1%	36.0%	46.1%
		b) Before feeding children	14.0%	40.6%	57.2%
		c) after defecation	87.6%	94.2%	98.6%
		d) after washing child after defecation	0.0%	83.8%	97.3%
		% of children (0-35 months) suffering from diarrhea during the last two weeks, who received home available fluid/ORS	6.8%	39.4%	67.9%
		% of children (0-35 months) presenting at clinics, advised to give fluids for child	0.0%	14.7%	35.0%
6	Immunization	% of children (12-23 months) fully vaccinated against the six vaccine-preventable diseases) before their first birthday	62.4%	69.8%	95.8%
7	RTI/STI and HIV/AIDS	% females (15-44 years) who sought treatment for RTI/STI from a skilled provider in the last three months	49.7%	51.0%	49.7%
		% of females (15-44 years) with RTI/STI in the last three months whose partner was also treated	4.3%	9.0%	16.5%
		% of mothers with children (0-35 months) who cite at least two known ways of reducing the risk of HIV infection	9.2%	56.8%	59.3%
		% of fathers with children (0-35months) who cite at least two known ways of reducing the risk of HIV infection	64.6%	86.0%	72.2%
8	Birth Spacing	% of children (0-35 months) born at least 36 months after the previous surviving child	29.3%	58.0%	38.5%
9	Safe Deliveries	Institutional Births	64.3%	84.0%	84.4%
		Home Deliveries by trained attendants		75.0%	60.4%
10		Neonatal Mortality	37.0	–	21.5
11		Infant Mortality Rate	–	–	29.5
12		Crude Birth Rate	–	–	16.6
13		Prevalence of low birth weight babies	29.4%	–	27.7%

Chapter 1
Introduction and Background of the Study

1.1 Introduction to Mother and Child Health: An India and Maharashtra Perspective

Despite health improvements over the last thirty years, lives continue to be lost to early childhood diseases, inadequate newborn care and childbirth-related causes. It is estimated that in India more than two million children die every year from preventable infections. Apart from this India also faces the challenge of having high rates of maternal deaths, mainly owing to poor access to health facilities and trained birth attendants.

As per the NFHS-3 estimates only 31% of the deliveries in rural India are institution based and only a little over 39% are assisted by trained health personnel. A similar trend is evident in the immunization against the six preventable diseases. According to the NFHS-3 findings, in rural India only 38.6% of the children in the age group of 12-23 are fully immunized and only 24% receive ORS when suffering from diarrhoea. Children in India continue to lose their life to vaccine-preventable diseases such as measles, which remains as one of the biggest killer.

With only 21.5% of the children under three years in rural India being breast fed within the first hour of birth and only 48.3% of children in the age group 0-5 months exclusively breast fed, malnutrition is more common in India than in Sub-Saharan Africa and it is believed that one in every three malnourished children in the world lives in India. Malnutrition in children is not affected by food intake alone; it is also influenced by access to health services, quality of care for the child and pregnant mother as well as good hygiene practices.

An estimated 400,000 children under five years of age die each year due to diarrhea. Several million more suffer from multiple episodes of diarrhea and still others fall ill on account of Hepatitis A, intestinal worms and eye and skin infections caused by poor hygiene and unsafe drinking water. Despite best efforts, diarrhea remains the major cause of death amongst children, after respiratory-tract infections. Unhygienic practices and unsafe drinking water are some of its main causes. Even though over the years India has been able to establish a network of health facilities, these have largely been found to be inadequate and overburdened to provide curative assistance to the entire population especially those residing in the rural areas. It has also been found that cultural and traditional practices have created

inertia among individuals to accept modern methods of medicine and change their behaviors to adopt new practices.

Maharashtra though is one of the better performing states in terms of the health indicators when compared to India as a whole. This can be attributed to a better per capita income and improved education profile of women in the state in comparison to the other states of the country. As per the NFHS-3 survey, the vaccination coverage in rural Maharashtra was found to be 50%, considerably higher than the all India average of 38.6%. It has though been seen that there has been an overall decline in the immunization levels, which according to NFHS-2 was close to 77% in the rural areas. It performs better in terms of other health indicators as well, such as access of pregnant women to at least three antenatal check-ups (65.5%), births assisted by trained health service providers (56.5%), children in rural areas and under three years breast fed within one hour of birth (53%) and children in the age group 0-5 months exclusively breast fed (55.1%). Thus, Maharashtra has a lower incidence of infant mortality and maternal deaths and enjoys a relatively better status of health indicators.

The CLICS program focuses on Wardha district of Vidharb region in Maharashtra. Vidharba is known to be one of the poorest regions of the state and is characterized by low rainfalls and regular droughts. The region also brought to fore the regional disparity of health indicators that exists in Maharashtra. It was found that the region had high incidence of childhood deaths due to diarrhea and poor awareness on hygiene and care of low-birth weight babies. It was estimated that in the project area, neonatal deaths caused 70% of infant deaths and only 1% (Base line) of the babies were breastfed within the first hour of their birth. Thus, even though Maharashtra as a state was performing better in terms of the health indicators when compared to the nation as whole, yet there existed regional disparities, which needed to be addressed within the state. The CLICS program targeted its interventions in Wardha district, which was one of the regions that lagged behind in terms of health indicators at the time of its inception.

1.2 Background of the Programme

The foundation for the Community Led Initiatives for Child Survival (CLICS) programme was laid by a pilot intervention (Partnering for Child Survival Programme) implemented in Wardha district of Maharashtra with a reach to 40,000 people. The project implemented till 2003 by the Department of Community Medicine (DCM) in collaboration with Aga Khan Foundation (AKF) India provided results that encouraged AKF and DCM to launch a similar programme with the support of USAID with a wider coverage and greater intensity. The programme, re-named as **'**Community Led Initiatives for Child Survival,' was scaled up to more than double the reach of the pilot phase to impact a population of over 88,000 across 67 villages in three sectors of Anji, Gaul and Talegaon in Wardha district. It was estimated that over a period of 5 years, starting from the year 2003, the programme would have around 32,000 direct beneficiaries comprising of children under the age of three, women in the reproductive age group and adolescent girls.

Objectives of the Programme

The key objectives of the CLICS programme were to:

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

1.2.1 Key Activities and Approach

The program aimed at building the capacity of the community to develop, manage, and ultimately achieve ownership of the village based child survival and health services. To achieve this program goal, a mix of social mobilizing, social franchising, community ownership and cross cutting issue based strategies was implemented in the project area.

Social Mobilizing

Social mobilization was identified as one of the pillars for the success and sustainability of the project. The main reasons for keeping social mobilization at the forefront of project implementation were:

- Firstly, the programme wanted to ensure that the community members were involved in both identifying their problems and developing a solution for the same.
- Secondly, it was felt important that the community was aware of their rights so that they could demand the same from the government.

Social Mobilization, under the project, started with rapport building exercises and culminated with the formation of a network of village level groups. Community was mobilized in the form of female SHG groups, Kissan Vikas Manch (A male farmers group) and Kishori Panchayats (An adolescent girls group). Representatives from these community based organisations and the Gram Panchayats along with village level health workers then formed a village representative body known as the Village Coordination Committee (VCC). This committee became the nodal unit for all health related interventions in the village.

Social Franchising

A demand driven, social franchising model was developed for the implementation of the programme. The model envisaged DCM as the franchiser and aimed to build the capacity of 67 different Village Coordination Committees (VCC) as the franchisees to produce an integrated package of affordable and high quality child survival and supportive health services-the social product.

The responsibilities of the VCC as a franchisee were to:

- Function as a decision-making body to select and manage child survival activities in the villages

- Conduct a community health needs assessment
- Engage in participatory program planning
- Implement and manage health care service delivery in the villages
- Generate the *Gram Swasthya Kosh* (revolving health fund)
- Select and depute a female Village Health Worker (CLICS Doot)
- Develop and maintain referral linkages with both public and private health care providers in the area
- Ensure quality of health care services provided to the community

DCM/MGIMS acted as a technical partner and monitoring agency and performed the following roles and duties as the franchiser:

- Facilitate health needs assessment
- Supervise quality assurance measures
- Provide trainings for basic health management

Community Ownership

Community ownership was considered as one of the most important success indicator for the project. The programme aimed at not just community participation in the programme but also intended at adequate community control and ownership over the processes that generated health. CLICS was thus designed to have an inbuilt mechanism to ensure that the VCCs achieved "ownership" of the partnerships developed and the processes that CLICS had helped it to establish and provide affordable high quality child survival services.

It was planned that once a village achieves community ownership, CLICS would design an exit strategy that would reduce the intensive inputs provided by DCM/MGIMS while ensuring sustenance of selected activities and health gains.

Cross cutting Strategies

CLICS ensured that certain cross cutting strategies were implemented to ensure smooth functioning of the project. These cross cutting strategies included:

- Capacity Building
- Quality Assurance
- Networking
- Dissemination
- Management Information System

1.2.2 Coverage Area and Target Group

CLICS programme was implemented in 67 villages of Wardha District of Maharashtra. The project served a total population of 88,128 residents in three sectors: Anji, Gaul, and Talegaon. It is estimated that the program had 32,962 direct beneficiaries comprising children under the age of three, women of reproductive age and adolescent girls. The details of the coverage area and the estimated size of the beneficiaries have been listed in the table given below:

Table 1.1: Coverage area and estimated size of the population covered under CLICS programme

Beneficiaries Description	Project Areas			
	Anji	Gaul	Talegaon	Total
Villages (under project area)	***23***	***21***	***23***	***67***
Population (under project area)	***31482***	***18700***	***37946***	***88128***
Total Households (under project area)	***7317***	***4429***	***8699***	***20445***
Beneficiaries: children (0-3 years)	1839	1039	2189	5067
Beneficiaries: women of reproductive age (15-44 years)	7524	4206	8955	20685
Beneficiaries: adolescent girls(12-19years)	2516	1492	3202	7210
Total beneficiaries	**11879**	**6737**	**14346**	**32962**

Chapter 2

Objectives of the Study and Methodology

The CLICS programme was initiated in the year 2003 and was proposed to be implemented for 5 years till 2008. As the project is nearing its end, an end line study was commissioned by the Aga Khan Foundation (AKF) India to assess the overall performance of the project and the achievement of the objectives.

2.1. Objectives of the Study

The objectives of the study were to:

- Assess the progress made towards achieving the set goals and objectives as per the DIP among the children less than three years, women in reproductive age (15-44 years) and adolescent girls aged 12-19 years in comparison to baseline and mid-term levels.
- Assess the improvement in knowledge, attitude, behavior and practices of community on key programme interventions in comparison to baseline and mid term levels.
- Assess the knowledge, attitude, behavior and practices of health service providers (both public and private) in the programme area on key program interventions.

2.2. USAID's Rapid Catch Indicators for Monitoring and Evaluation

The end line evaluation of the CLICS programme uses the Rapid Catch indicators for evaluating the project. Rapid Catch is a USAID recommended guideline, which provides a quick and accurate way to assess projects on child survival by drawing a relatively small sample from the beneficiary population.

The *Rapid CATCH* comprises a small set of questions from the KPC_{2000+} modules and is intended to provide a snapshot of the target population in terms of child health. There are nine technical intervention areas that comprise the Child Survival monitoring framework. These have been listed below:

1. Immunization
2. Nutrition and Micronutrients
3. Breastfeeding Promotion
4. Control of Diarrheal Disease
5. Pneumonia Case Management
6. Control of Malaria
7. Maternal and Newborn Care

8. Child Spacing
9. STI/HIV/AIDS Prevention

However, the survey's scope has been further expanded to include non-IMCI issues such as child spacing, maternal and newborn care, HIV/AIDS, and hand washing. The thirteen indicators used to evaluate child survival projects under the rapid catch are as under:

Priority Child Health Indicators

Sentinel Measure of Child Health and Well-being

1. *% of children age 0–23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)*

Prevention of Illness/Death

2. *% of children age 0–23 months who were born at least 24 months after the previous surviving child*
3. *% of children age 0–23 months whose births were attended by skilled health personnel*
4. *% of mothers with children age 0–23 months who received at least two tetanus toxoid injections before the birth of their youngest child*
5. *% of children age 0–5 months who were exclusively breastfed during the last 24 hours*
6. *% of children age 6–9 months who received breast milk and complementary foods during the last 24 hours*
7. *% of children age 12–23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday*
8. *% of children age 12–23 months who received a measles vaccine*
9. *% of children age 0–23 months who slept under an insecticide-treated net (in malaria risk areas) the previous night*
10. *% of mothers with children age 0–23 months who cite at least two known ways of reducing the risk of HIV infection*
11. *% of mothers with children age 0–23 months who report that they wash their hands with soap/ash before food preparation, before feeding children, after defection, and after attending to a child who has defecated*

Management/Treatment of Illness

12. *% of mothers of children age 0–23 months who know at least two signs of childhood illness that indicate the need for treatment*
13. *% of sick children age 0–23 months who received increased fluids and continued feeding during an illness in the past two weeks*

2.3. Research Design

2.3.1 Sampling Design and Size

The end line survey included collection of both quantitative and qualitative data in the project area. The sample for the quantitative survey was drawn from the following types of project beneficiaries:

- Mothers of children aged less than 36 months
- Adolescent girls (unmarried girls aged 12-19 years)
- Fathers of children aged less than 36 months

The objective of the quantitative survey was to assess the knowledge, attitudes and behavior of the target groups about safe motherhood, child survival and related issues. The interviews among the above categories of respondents were carried out by interviewers trained in administering a structured questionnaire specifically designed for each of the groups.

The quantitative data collected from the survey was complimented by the qualitative data which focused on collecting information on the attitudes, knowledge and practices of the community in general on issues pertaining to child survival and maternal health. The qualitative survey also helped in assessing the knowledge of health service providers and collect information on sensitive issues to the community, which may otherwise be difficult to collect from individual questionnaires. Focus Group Discussions (FGDs) and in-depth interviews were used to collect the qualitative information in an organized and analytical way.

Sample size

The EPI 30 cluster sampling method was used to carry out the study. WHO and UNICEF have developed the EPI 30-cluster sample method to assess the immunization coverage at a national level in a cost-effective and rapid way. This method was evolved to satisfy the needs of the study. In each of the identified sectors viz, Anji, Talegaon and Gaul 30 clusters were identified to carry out the qualitative survey. From each of these 30 clusters, 10 respondents were selected through systematic random sampling for each respondent category. Thus, for each respondent category, a sample size of 300 respondents per sector was selected. A total of 900 respondents were selected in the project area for each respondent category. A total of 3600 respondents were selected for the quantitative survey for the study.

Sample Selection

Selection of Clusters – In each sector, 30 clusters were selected from all project villages. The villages in each sector were arranged in descending order and cumulative populations were calculated. The sampling interval was calculated by dividing the cumulative population of all the villages in the sector by 30. A random number was then generated between 0 and the sampling interval, and using systematic sampling, 30 clusters were selected across the villages in the sector. Thus, in a larger village there was a possibility of selecting more than one cluster while some of the smaller villages were not selected. Similarly, in each of the three sectors, 30 clusters were selected, thus yielding a total of 90 clusters.

Selection of Respondents – At the village level, sampling frames were prepared separately for each of the four respondent categories. A complete listing of the households in a selected cluster was carried out to give an updated sampling frame in a cluster to select the target respondents. In a selected cluster, first the boundaries were identified by physical verification, followed by listing of all the households. The listing schedule was used to gather information about each household which included the details of household members. This detail helped in developing separate sampling frames for all four respondent categories.

10 respondents of each category were selected from the sampling frames in each cluster using the systematic random sampling technique for administering the questionnaires. In case the sampling frame did not have the requisite number of respondents or in case adequate numbers of respondents were unavailable due to any reason, the remaining respondents were then selected from the next cluster.

Thus, the sample for the quantitative survey was as follows:

Table 2.1: Size of the sample proposed for the quantitative survey

Target Respondent	Per Sector			Total for 3 sectors
	No. of Clusters	No. per cluster	Total	
Women with children aged less than 36 months (Women's Schedule)	30	10	300	**900**
Women with children aged less than 36 months (Child Health Schedule)	30	10	300	**900**
Fathers of children aged less than 36 months (Fathers Schedule)	30	10	300	**900**
Adolescent girls - unmarried girls aged 12-19 years (Adolescent Girls Schedule)	30	10	300	**900**
Total	**120**	**40**	**1200**	**3600**

The actual sample covered by the quantitative survey team is as under:

Table 2.2: Total sample achieved for quantitative survey

Target Respondent (Research Tool)	Sector			Total sample achieved
	Anji	Talegaon	Gaul	
Household Information (Household Schedule)	5448	6373	3695	**15516**
Women with children aged less than 36 months (Women's Schedule)	303	317	302	**921**
Women with children aged less than 36 months (Child Health Schedule)	304	320	298	**922**
Fathers of children aged less than 36 months (Fathers Schedule)	303	317	302	**931**
Adolescent girls - unmarried girls aged 12-19 years (Adolescent Girls Schedule)	299	317	313	**929**

As can be observed from the table 2.2, in some sections more than the proposed sample has been covered during the survey. This has happened as it was observed in the field that a large number of respondents were unavailable due to various reasons. Though revisits were planned, it was considered prudent to cover additional samples from cluster where additional respondents were available.

Focus Group Discussions - FGDs were carried out with different CBOs formed under the project to gather information on Knowledge, attitude and practices relating to child survival and reproductive health. A total of 40 such FGDs were carried out with the following CBOs:

- VCC members and other opinion leaders (including the CLICS Doots)
- Women SHG members
- Members of the *Kisan Vikas Manch*
- Members of *Kishori Panchayats.*

Each FGD had 8-10 participants and was coordinated by a moderator and an observer using a flexible discussion guideline. An attempt was made to ensure that members from more than one group in the same FGD type could participated in the discussions to make them more representative and unbiased. The villages for the FGDs were selected randomly.

In-depth interviews - In-depth interview were conducted with the Private Health Service Providers, Medical Officers and Panchayat Samiti representatives to ascertain their knowledge, attitude and practice regarding child and maternal health issues. A total of 10 Rural Medical Practitioners (RMPs), 3 Medical Officers and 8 Panchayat Samiti representatives were selected for administering the in-depth-interviews.

Facility Assessments – Facility survey was carried out to access the facilities available at the Primary Health Centres (PHCs) and the Sub-centers (SCs). Apart from these, in-depth interviews were carried out with the Medical Officers and Auxiliary Nurse Midwifes

(ANMs). From each sector, 1 PHC, 2 SCs and 5 AWCs were selected randomly to carry out the facility survey and in-depth interviews.

The sample size of the qualitative survey and the details of the actual coverage achieved is as under:

Table 2.3: Total sample planned and achieved for qualitative survey

	Sample per Sector	Total Sample	Sample Achieved
FGDs with VCC and Opinion Leaders	3-4	10	10
FGDs with women SHG members	3-4	10	10
FGDs with members of KVMs	3-4	10	10
FGDs with members of Kishori Panchayats	3-4	10	10
IDI with Private Health Providers	3-4	10	10
Facility Assessments and SSIs with providers at Public Health Facilities	1 PHCs, 2 SCs and 5 AWCs	3 PHCs, 6 SCs and 15 AWCs	3 PHCs, 5 SCs and 15 AWCs
SSI with 3-4 Zilla/block representatives	–	4	5
IDIs with CLICS Doot	–	–	51

2.4 Implementation of the Study

The study was coordinated by a Senior Manager, who was guided by an Advisor having extensive understanding of research issues related to the health sector. The Senior Manager, acting as the Project Coordinator was instrumental in carrying out the pre-testing and finalization of schedules, training of the investigators, regular monitoring of the field and compilation of the draft report.

The questionnaire was pre-tested with DCM and based on the findings of the pre-test, the questionnaires were suitably modified and training was planned for the field investigators. Four-day training was designed to guide the field investigators in administering the field schedules. The training, organized in the last week of May 2008, comprised of two components viz. training of the listing team and the training of the main survey team. Training was attended by representative from DCM, who provided valuable insights on the programme. Care was taken to ensure that all field investigators were fluent in Marathi and comfortable in working at Wardha.

Six listing teams, comprising of 4 investigators and 1 supervisor were engaged in carrying out a detailed listing of households in the project area and drawing the sample frame for each respondent category in a cluster. The composition of the field teams was made to ensure that at least 3 out of the 4 field investigators and either the supervisors or the Field executive were females. This was done to ensure a level of comfort for the female respondents.

The listing team initiated its work 3 days before the main survey team. This was to ensure that there was enough number of clusters in which listing was complete and sample frames for different respondent categories were developed to carry out the main field exercise. The main field work was initiated by the end of the first week of June 2008 and was completed

by the end of the month of June. Regular reports were collected from the field to monitor the progress made by the study.

The analysis plan and the data entry programmes were developed simultaneously along with the field work. The scrutiny of the questionnaires was carried out at Nagpur office of ORGCSR, whereas the data entry and analysis was carried out in Delhi. The analysis was carried out by using the SPSS 15 version and the data entry programme was developed with CSPro.

2.5 Field Issues and Limitations

The field team encountered a number of issues and field level challenges during the completion of the study. The major issues have been listed below:

- The survey period coincided with onset of monsoon in the region; this limited the availability of respondents for the quantitative data collection as well as mobilizing CBO members for focus group discussions.
- The period also coincided with a local tradition, in which married women traditionally go to their maternal homes for a considerable period. This significantly affected the availability of female respondents to the field survey team.
- Owing to the onset of monsoons and the local tradition, a large number of identified respondents were not available for interviews. Thus, revisits to these villages were carried out to ensure that adequate sample size was achieved.
- The cluster size in Gaul sector was found to be very small. Thus, the sample frames generated from these clusters were not able to provide with adequate number of male respondents even after revisits as a large number of respondents identified during the listing process were unavailable for interviews.

2.6 Profile of Households Visited

As mentioned earlier, complete household listing was conducted in all the households in the 90 selected clusters for identification of the target respondents for the Endline survey. A total of 18,959 households were visited across the three sectors. Of all the households visited, the interviews were completed in 15,516 households as some of the households were found to be locked or did not have a suitable respondent.

Table 2.4: Profile of the household

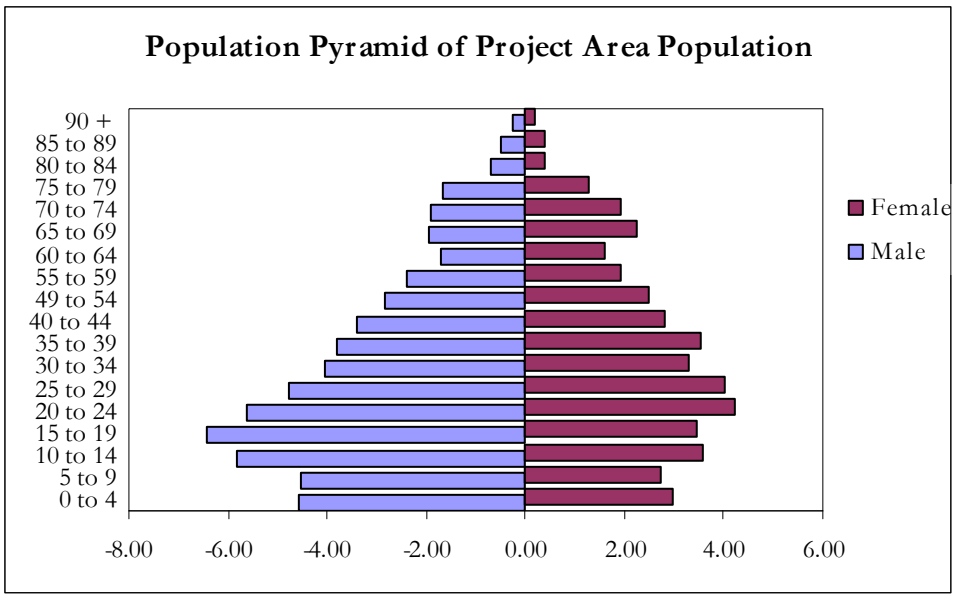
Population Characteristic	Anji	Talegaon	Gaul
Number of Households	5448 (35.1%)	6373 (41.1%)	3695 (23.8%)
Total population covered	23692 (35.3%)	28046 (41.8%)	15411 (23%)
Religion of the households			
Hindu	4697 (86.2%)	5451 (85.5%)	3123 (84.5%)
Muslim	114 (2.1%)	124 (1.9%)	31 (0.8%)
Christian	6 (0.1%)	9 (0.1%)	1 (0.01%)
Buddhist	615 (11.3%)	747 (11.7%)	537 (14.5%)
Sikh	8 (0.1%)	12 (0.2%)	1 (0.01%)
Others	8 (0.1%)	30 (0.5%)	2 (0.1%)
Caste			
SC	901 (16.5%)	973 (15.3%)	708 (19.2%)
ST	724 (13.3%)	677 (10.6%)	652 (17.6%)
VJ	32 (0.6%)	21 (0.3%)	16 (0.4%)
NT	680 (12.5%)	453 (7.1%)	521 (14.1%)
OBC	2,642 (48.5%)	3,830 (60.1%)	1,670 (45.2%)
Open	280 (5.1%)	295 (4.6%)	102 (2.6%)
Others	189 (3.5%)	124 (1.9%)	26 (0.7%)
Yearly Family Income			
Mean Income	25,215	29,307	31,766
Type of Ration Card			
Antodya	140	221	137
BPL	1,202	1,349	1,285
Others	2,557	2,995	1,484

More than 85% of the households visited for the Endline survey followed Hinduism while 1.7% were Muslims. About 12% of the households also followed Buddhism. The proportions were similar across the sectors.

About 52% of the households belonged to OBC category and this proportion was highest in Talegaon at 60%. About 16 % of the households across the three sectors were SCs while 13% were STs.

The figure below shows the population pyramid for the households visited during the survey. It was found that the total population in the households surveyed equaled 67,149 of which 51.98% were males and 48.01% were females. As is evident from the shape of the pyramid, the largest proportion of the population for men was concentrated in the 10-24 year age group whereas for females it was concentrated in 20-29 year age group.

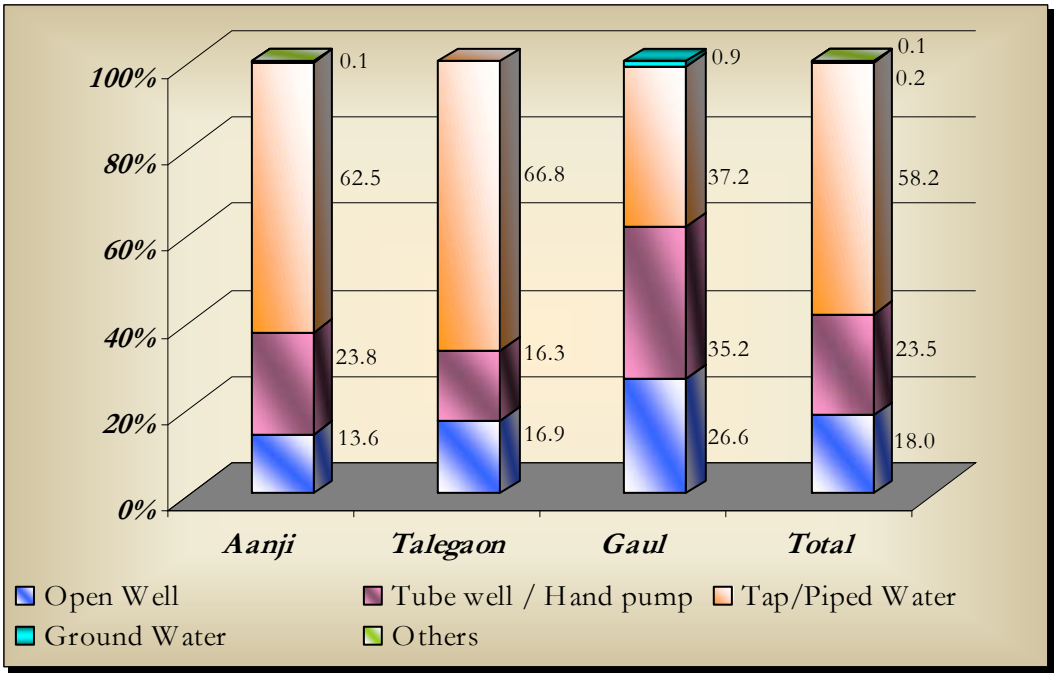
Figure 2.1: Population Pyramid



The mean annual household income was reported to be Rs 28,450 across the three sectors. It was reported to be highest in Gaul (Rs 31,766) followed by Talegaon (Rs 29,307). It was lowest for Anji at Rs 25,215 per annum. It was interesting to note that 24.2% of the households reported that they had got health insurance in the last year. Overall, 73.3% of the respondents reported that they had a ration card. The proportion was highest in Gaul at 78.6% and 71.6% in Anji and Talegaon. Among those who reported to possess a ration card, 33.7% had a BPL card. This proportion was highest in Gaul at 44.2% and lowest in Talegaon at 29.6%.

The main source of drinking water across the households visited for the Endline survey was Tap/Piped water in 58.2% of the households. This proportion was highest in Talegaon at 66.8% followed by 62.5% in Anji. It was lowest in Gaul at 37.2%. About 23.5% of the household across the three sectors reported that their main source of drinking water is Tubewell/Handpump and 18% reported that their main source of drinking water was an open well.

Figure 2.2: Source of drinking water



Base: All households covered under the listing study

All households were also asked if they used any method to purify the water used for drinking. About 97% of the households reported that they used a water purification method.

Table: 2.5: Use of water purification method in project area

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Purification method used	5,292	97.1	6,193	97.2	3,562	96.4	15,047	97.0
No. purification method used	151	2.8	172	2.7	132	3.6	455	2.9
No Response	5	0.1	8	0.1	1	0.0	14	0.1
Total	5,448	100.0	6,373	100.0	3,695	100.0	15,516	100.0

Base: All households covered under the listing survey

Filtering (95.1%) emerged as the most common method of purifying drinking water. Jeevan Drop, with 2.7%, emerged as the distant second method of purifying drinking water in the area.

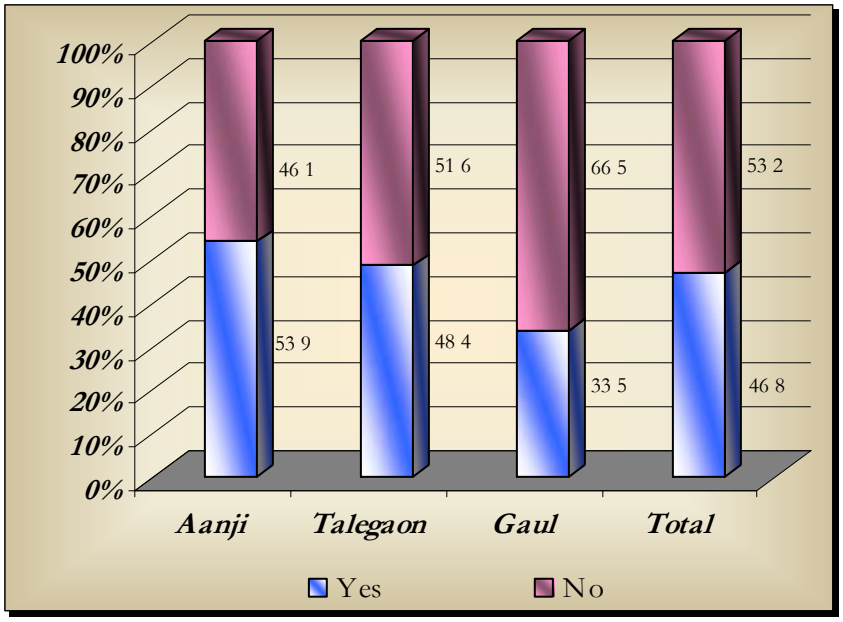
Table 2.6: Type of water purification method used in households

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Boiling	34	0.6	65	1.0	27	0.8	126	0.8
Filtering	4,924	93.0	5,948	96.0	3,442	96.6	14,314	95.1
Chlorine	23	0.4	36	0.6	25	0.7	84	0.6
Jeevan Drop	255	4.8	112	1.8	57	1.6	424	2.8
Others	56	1.1	32	0.5	11	0.3	99	0.7
Total	5,292	100.0	6,193	100.0	3,562	100.0	15,047	100.0

Base: All households that used a method of water purification

A sanitary latrine was available in 46.8% of the households across three sectors. The proportion was highest in Anji at 53.9% and lowest in Gaul at 33.5%.

Figure 2.3: Availability of sanitary latrines



Base: All households covered under the listing study

Among the households which have a sanitary latrine, 91% reported that it was used regularly, whereas only 9.1% of the respondents reported otherwise.

Table 2.7: Usage of sanitary latrine

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Regular Usage	2,780	94.6	2,774	90.0	1,044	84.3	6,598	90.9
Not used regularly	158	5.4	308	10.0	194	15.7	660	9.1
Total	2,938	100.0	3,082	100.0	1,238	100.0	7,258	100.0

Base: All households that reported to have a sanitary latrine

The details of the household members were also collected in each of the households visited. The mean number of household members was observed to be 4.4 across the three sectors. On an average, there were 1.1 married women in the age group of 15-44 years in a house. Further, it was observed that the mean number of adolescent girls in each household was 1.3.

Table: 2.8 Mean numbers of household members

	Anji	Talegaon	Gaul	Total
Total household members	4.4	4.4	4.2	4.4
Married women in the age group of 15-44 years	1.1	1.1	1.0	1.1
Adolescent girls (12-19 years)	1.3	1.3	1.4	1.3

Base: All Households

2.7 Key Health Indicators

The CLICS programme aimed at insuring high quality and affordable child survival health services for rural families. In view of this the programme team aimed at implementing interventions to reduce the neonatal mortality and prevalence of low birth weight babies.

The project created a strong community base to ensure that interventions aiming at increasing awareness and bringing about changes in the traditional practices were implemented with the best possible impact on the target group.

It has been observed that the project has been able to reduce the infant mortality rate to 29.54 deaths per 1,000. The neonatal mortality has been reduced from 37.0 deaths per 1,000 to 21.48 deaths per 1,000 as shown in the endline survey. This can be attributed to the increase in institutional births and awareness on improved nutrition among the expectant mothers and the new born babies. Apart from this increase in accessing neonatal care services and postnatal care has had its impact on the health of the mother and the new born child. The crude birth rate in the area was found to be 16.63 births per 1,000 in the endline survey. This too has significantly reduced when compared to the overall scenario in Maharashtra.

The prevalence of low birth weight babies has declined from 29.4% at the time of baseline to 27.68% in the endline survey. It was though envisaged that the project interventions would lead to a decline in the low birth weight babies by 20%. The programme has been able to reduce this to a certain extent but has fallen short of reducing it by the planned margin.

Chapter 3
Knowledge and Practices on Child Health

The CLICS programme was incepted mainly with an intention to improve the child health scenario by initiating a community led programme emphasizing on child survival and related health issues. It is a known fact that a large number of infant deaths are caused due to curable diseases and infections. Apart from these, basic nutritional deficiencies, slow growth and development of the child, make the child more susceptible to regular bouts of illness.

In an attempt to improve child health scenario, the CLICS programme initially aimed at organizing the community into groups so as to develop a platform for interaction with the target population. It was at a later stage that community health issues were brought to the forefront.

In order to improve the child health, an overall effort was made to improve the knowledge on various childhood related diseases, identifying symptoms of childhood illness, and affecting a change in the immunization, and feeding practices.

3.1 Newborn Health and Care

Care of the new born baby is considered to be one of the most critical components of its development. It has been found that in India, traditions play an important role in determining the newborn care practices, which often are detrimental to the health of the newborn child. These practices make the child vulnerable to various childhood related illnesses.

3.1.1 Awareness of Danger Signs of Illness in Newborn Children

Increasing the awareness about danger signs among parents was therefore considered as one of the most important components of the strategy to reduce mortality among newborn babies. It was envisaged that this would help by ensuring that medical assistance is obtained at the earliest in case of an illness, thereby reducing the chances of mortality.

It has been found that more than 99% of the female respondents having a child aged 0-11 months were aware about at least three symptoms of danger signs for the new born children. It has been reported that all respondents in Anji and Talegaon sectors were aware of at least three danger signs of childhood illness whereas in Gaul only one of the respondents was not aware of at least three danger signs among the newborn babies.

Table: 3.1: Knowledge among mothers about the danger signs for newborn

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Aware of less than three symptoms	0	0.0	0	0.0	1	0.9	1	0.3
Aware of three symptoms	0	0.0	0	0.0	2	1.8	2	0.6
Aware of more than three symptoms	114	100.0	125	100.0	106	97.2	345	99.1
Total	114	100.0	125	100.0	109	100.0	348	100.0

Base: All women with a child aged 0-11

Difficulty in breathing, unconsciousness/lethagy shown by the baby and convulsions were identified as danger signs by more than 97% of the respondents. Over 93% of the respondents felt that severe malnourishment and low body temperature were danger signs for new born babies. Apart from these, fever and pus draining from the umbillus were identified as danger signs by more than 93% of the respondents.

3.1.2 Management of Illnesses in Newborn Children

Illness among the newborns can be managed through a number of immediate actions. All women with a child aged 0-11 months were asked about ways to prevent hypothermia. It was found that 100% of the respondents were able to identify at least one mode of preventing hypothermia among the newborn children.

Table 3.2: Knowledge among women with children aged 0-11 months of at least one method of Hypothermia prevention

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Knows one method	0	0.0	0	0.0	1	0.9	1	0.3
Knows two methods	2	1.8	0	0.0	2	1.8	4	1.1
Knows more than two methods	112	98.2	125	100.0	106	97.2	343	98.6
Total	114	100.0	125	100.0	109	100.0	348	100.0

Base: All women with children aged 0-11 months

The respondents, when asked about their immediate action on identifying any of the danger signs in a newborn, were of the view that the child should be taken to a health service provider for assistance. Private practitioners emerged as an option in most of the cases, with over 84% of the respondents mentioning them. PHCs/District Hospital was mentioned as the source of medical attention by 43.7% of the respondents followed by MGIMS (Medical College), which was mentioned by 33.0% of respondents as the source of medical assistance in such cases. CLICS Doot was mentioned by 10.8% of the respondents as the source of medical help in case a new born showed danger signs.

Table 3.3: Action taken if new born child shows any danger sign of illness, as reported by women with children aged 0-35 months

	Total	
	N	%
Visit to ANM/Sub Centre	39	4.2
Visit to PHC/Rural Hospital/District Hospital	403	43.7
Visit Medical College	304	33.0
Visits a Private Practitioner	778	84.4
Visit a CLICS Doot	100	10.8
Any Other	112	12.1

Base: All women with children aged 0-36 months
Multiple response question, totals may not add to 100%

3.1.3 Breast Feeding and Nutrition

It is a well known fact that breast milk is the best source of nutrition for a new born baby. It has though been found that owing to a large number of cultural and social factors breast milk is often not provided to a child immediately after birth and in some cases accompanied with other food items such as honey, water etc. Both theses practices are ideally not recommended. The survey aimed at assessing the awareness, attitude and practices in this regard among the beneficiaries of the project.

Women respondents were asked about when they had initiated breastfeeding to their child. It was reported by 65.2% of the women with a child aged 0-5 months that they had initiated breast feeding within an hour of child birth. This was highest in Anji where 71.1% of the respondents reported that they had initiated breast feeding within an hour of child birth and lowest in Talegaon among the three sectors.

Table 3.4: Practice of breast feeding among children after birth

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Breast feeding initiated within 1 hr of Delivery	27	71.1	27	58.7	32	66.7	86	65.2
Breast feeding initiated after 1 hr of birth	11	28.9	19	41.3	16	33.3	46	34.8
Total	38	100.0	46	100.0	48	100.0	132	100.0

Base: All women with a child aged 0-5 months

The respondents were further asked if mother's first milk was discarded and not given to the child. It was reported by 84.2% of the women that they had not discarded the first milk. Only 14.6% of the women reported that the first milk was discarded and not fed to the child after birth. Among the three sectors it was found that the practice of discarding the mother's first milk was least prevalent in Anji (12.2%) and was highest in Gaul (17.4%).

Table 3.5: Practicing of discarding first breast milk

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
First breast milk was discarded	37	12.2	46	14.4	52	17.4	135	14.6
First breast milk was not discarded	263	86.5	271	84.7	242	81.2	776	84.2
Don't know	3	1.0	1	0.3	1	0.3	5	0.5
Don't remember	1	0.3	2	0.6	3	1.0	6	0.7
Total	304	100.0	320	100.0	298	100.0	922	100.0

Base: Women having children in the aged 0-36 months

The survey also enquired if children in the age group 0-5 months were exclusively breastfed in the last 24 hours. It was found that a total of 62.9% of the children in age group of 0-5 months were exclusively breastfed, whereas 37.1% had received other food items in the last 24 hours. Among the three sectors Anji (71.1%) had the highest whereas Gaul had the lowest percentage (58.3%) of children in the age group 0-5 months who were exclusively breast fed in the last 24 hours.

Table 3.6: Exclusive breastfeeding reported among children 0-5 months in the last 24 hours

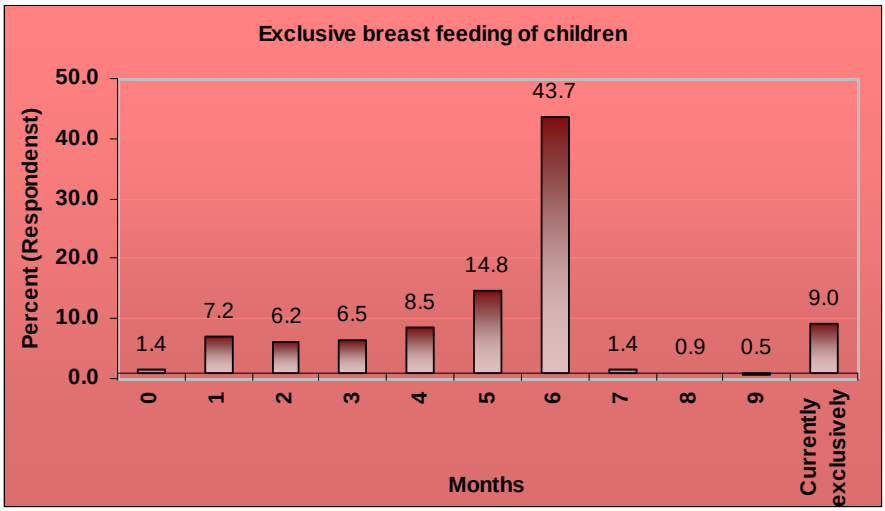
	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%

Exclusively breastfed	27	71.1	28	60.9	28	58.3	83	62.9
Not exclusively breastfed	11	28.9	18	39.1	20	41.7	49	37.1
Total	38	100.0	46	100.0	48	100.0	132	100.0

Base: Women having a child aged 0-5 months

The respondents were further asked about the number of months that their youngest child was exclusively breast fed. It was found that about 29% of the respondents reported that their child was exclusively breast fed for less than 5 months. 58.5% of the respondents reported that their child was breast fed for 5-6 months whereas about 2.8% of the respondents reported that the child was exclusively breastfed for more than 6 months.

Figure 3.1: How many months was the child exclusively breastfed



Base: Women having a child aged 0-36 months

For children in the age group of 6-9 months, it was enquired if they had been provided with complimentary feeding in the last 24 hours. It has been found that 98% of the children in the age group had been provided with complementary source of nutrition. No major variation in the proportion was observed across the sectors, as findings from all sectors reflect that over 95% of the children in the age group 6-9 months were receiving complimentary food items.

Table 3.7: Complimentary feeding among children 6-9 months in the last 24 hours

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Breastfed and complimentary foods in the last 24 hours	55	98.2	48	100.0	43	95.6	146	98.0
No complimentary feeding	1	1.8	0	0.0	2	4.4	3	2.0
Total	56	100.0	48	100.0	45	100.0	149	100.0

Base: Women having a child aged 6-9 months

The respondents were further enquired about the time the child was first given bath. It has been found that 12.5 % of the respondents reported that the baby was given a bath on the day of its birth, 11.4% reported that the child was given a bath on first or second day after birth, whereas a large majority, about 31.7 % and 34.3% of the total respondents reported that the baby was given a bath between the third to fifth day and after more than fifth day respectively.

Table 3.8: When was the child first bathed (0-36 months)

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
0-2 days	85	28.0	98	30.6	130	43.6	313	33.9
3-5 days	100	32.9	103	32.2	89	29.9	292	31.7
more then 5 days	119	39.1	119	37.2	78	26.2	316	34.3
DK	0	0.0	0	0.0	1	0.3	1	0.1
Total	304	100.0	320	100.0	298	100.0	922	100.0

Base: All women with a child aged 0-36 months

The respondents were further enquired about the time when their child was wrapped with a cloth immediately after birth. It was reported by 76.5% of the respondents that their child was wrapped within an hour of its birth. Only 1.2% of the respondents reported that their child was not wrapped with a cloth immediately after its birth. It was found that in Gaul 80.5% respondents reported that the child was wrapped in a cloth within an hour of its birth, which was the highest among the three sectors.

Table 3.9: When was the baby first wrapped after birth (0-36 months)

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Up to 1 hour	241	79.3	224	70.0	240	80.5	705	76.5
After 1 hour	57	18.8	86	26.9	49	16.4	192	20.8
Not Wrapped	2	0.7	6	1.9	3	1.0	11	1.2
Don't Know/Can't Say	4	1.3	4	1.3	6	2.0	14	1.5
Total	304	100.0	320	100.0	298	100.0	922	100.0

Base: All women with a child aged 0-36 month

Overall, 53.5% of respondents having a child in the age group of 12-35 months reported that their child had received a dose of vitamin A in the last six months. It was found that among the three sectors, a higher proportion of children in Gaul (57.0%) had received a Vitamin A dose as compared to the other two sectors.

Table 3.10: Receipt of Vitamin A dosage by children aged 12-35 months

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Received Vitamin A	91	48.9	105	54.7	106	57.0	302	53.5
Did not Receive Vitamin A	67	36.0	69	35.9	63	33.9	199	35.3
Don't Know/Can't Say	28	15.1	18	9.4	17	9.1	63	11.2
Total	186	100.0	192	100.0	186	100.0	564	100.0

Base: Women with a child aged 12-35 months

The number of vitamin A doses received by children where assessed as per the recall of the women interviewed.

Table 3.11: Number of Vitamin A doses received by children

	Anji	Talegaon	Gaul	Total
Min	0	0	0	0
Max	4	5	6	6
Mean	1.6	1.8	1.8	1.8
Median	1.5	2.0	2.0	2.0

Base: Women with a child aged 12-35 months

It has been found that about 89.3% of women with a child in the age group 6-35 months were aware of at least two sources of iron in regular food. The awareness in Anji sector was

the highest among the three sectors with 92.1% of women with a child in the age group 6-35 months aware of at least two sources of iron as compared to 85.9% in Talegaon.

Figure 3.2: Awareness among women about Iron rich foods

Base: Women with a child aged 6-35 months

3.2 Child Health and Care

3.2.1 Awareness of Danger Signs of Childhood Illness

The survey enquired about the awareness among women with a child less than 3 years about the symptoms of childhood illness. It was found that 99.4% of the women who had a child in the age group 0-23 months were aware of at least two signs of childhood illness. It is observed that among the three sectors Talegaon has the highest percentage of women with a child in the age group of 0-23 months who were aware of more than two childhood illnesses. There is very little variation among the three sectors, as the difference in the indicator value for the three sectors is of less than 1% point.

Table 3.12: Awareness among mothers of two danger signs of childhood illness

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Aware of no danger signs	1	0.45	1	0.4	1	0.5	3	0.4
Aware of one danger sign	1	0.45	0	0.0	0	0.0	1	0.1
Aware of two danger signs	2	0.91	0	0.0	0	0.0	2	0.3
Aware of more than two danger signs	216	98.2	248	99.6	215	99.5	679	99.1
Total	220	100.0	249	100.0	216	100.0	685	100.0

Base: Women with a child aged 0-23 months

3.2.2 Management of Childhood Illness: ARI and Diarrhea

The respondents were asked if their youngest child had suffered from any of the illnesses in the last 14 days. It was found that cold and running nose were the most common ailments in children followed by fever, cough and diarrhea.

Table 3.13: Prevalence of childhood illness in last 2 weeks among children aged 0-36 months

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%

Fever	79	26.0	95	29.7	86	28.9	260	28.2
Cold/running nose	102	33.6	106	33.1	103	34.6	311	33.7
Cough	85	28.0	74	23.1	78	26.2	237	25.7
Diarrhoea	44	14.5	30	9.4	32	10.7	106	11.5
Dysentery	0	0.0	1	0.3	2	0.7	3	0.3
Any other problem	17	5.6	19	5.9	16	5.4	52	5.6

Base: Women with a child aged 0-36 months
Multiple Responses

Of the total children who suffered from diarrhea 86.7% of the respondents reported that they had availed treatment for the same.

Table 3.14: Children reported to have availed treatment for diarrhea

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Diarrhea was treated	37	84.1	26	86.2	29	90.6	92	86.7
Diarrhea not treated	7	15.9	4	13.8	3	9.4	14	13.3
Total	44	100.0	29	100.0	32	100.0	106	100.0

Base: Children aged 0-35 months who experienced Diarrhea in the last 2 weeks

Overall, 67.9% of the respondents who had diarrhea in the last two weeks had taken Oral Re-hydration Salt and Home Available Liquids. Among the sectors, 80.0% of respondents in Talegaon who took treatment for diarrhea had consumed ORS or HAF or both. This is also the highest percentage among the three sectors. It was found that 93.2% of the cases where the child was breastfeeding and suffering from diarrhea, breast feeding was continued.

Table 3.15 A: Children who received ORS/HAF during diarrhea

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Respondents who reported giving ORS/HAF/ORS & HAF	28	63.6	24	80.0	20	62.5	72	67.9
Respondents who did not give ORS/HAF/ORS & HAF	16	36.4	6	20.0	12	37.5	34	32.1
Total	44	100.0	30	100.0	32	100.0	106	100.0

Base: Children aged 0-35 months whose Diarrhea in the last 2 weeks was treated

Table 3.15 B: Status of breast feeding in children with diarrhea

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Continued feeding among those who were breast feeding	*28*	*96.6*	*20*	*90.9*	*21*	*91.3*	*69*	*93.2*
Total Children with diarrhea who were breast feeding	*29*	*100.0*	*22*	*100.0*	*23*	*100.0*	*74*	*100.0*

Base: Women who reported that their child suffered diarrhea and were breast feeding

The respondents who reported that their child had suffered from cough or difficulty in breathing were asked if they had increased their fluid intake in case the child was not breast feeding or continued feeding to those children who were breast feeding. It was found that in case of children who were being breastfed, 88.5% reported that breastfeeding was continued. In case of respondents who were not being breastfed, 32.2% reported that increased fluids were given to children who suffered from cough or difficulty in breathing.

Table 3.16 A: Status of breast feeding in children with cough/difficult or rapid breathing

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Continued feeding among those who were breast feeding	10	90.9	4	66.7	9	100.0	23	88.5

Stopped feeding among those who were breast feeding	1	9.1	2	33.3	0	0.0	3	11.5
Total	11	100.0	6	100.0	9	100.0	26	100.0

Base: Women who reported that their child suffered cough/difficult or rapid breathing and were breast feeding

Table 3.16 B: Status of increased fluid intake in children with cough/difficult or rapid breathing

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Increased fluid intake for children above 6 months	27	37.5	19	28.4	21	30.4	67	32.2
Increase not reported	45	62.5	48	71.6	48	69.6	141	67.8
Total	72	100.0	67	100.0	69	100.0	208	100.0

Base: Women who reported that their child suffered cough/difficult or rapid breathing and were more than 6 months old

In India, Malaria has been found to be another major cause of childhood and infant mortality. Though the project did not have an intervention to emphasise usage of mosquito nets, the current prevalence of usage of mosquito nets was calculated. It was found that 20.7% of the children in the age group of 0-23 months had slept under a mosquito net last night.

Table 3.17: Children who slept under a mosquito net

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Child slept under a mosquito net	41	18.6	55	22.1	46	21.3	142	20.7
Child did not sleep under mosquito net	90	40.9	84	33.7	81	37.5	255	37.2
Don't have a mosquito net	89	40.5	110	44.2	89	41.2	288	42.0
Total	220	100.0	249	100.0	216	100.0	685	100.0

Base: Women with a child aged 0-23months

The respondents whose child had experienced any illness in the past two weeks were further probed about the cost that was incurred in securing treatment for the child. It was found that 39.5% of the respondents had incurred less than 101 rupees for the treatment of illnesses and about 54.6% of the respondents reportedly spent 101 to 500 rupees in treatment of their ill child.

Table 3.18: Cost incurred on the treatment of children 0-36 months who were ill

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
<101	58	42.0	42	31.8	55	45.1	155	39.5
101-250	52	37.7	48	36.4	36	29.5	136	34.7
251-500	25	18.1	30	22.7	22	18.0	77	19.6
>500	3	2.2	12	9.1	9	7.4	24	6.1
Total	138	100.0	132	100.0	122	100.0	392	100.0

Base: Women with a child aged 0-36 months who were ill

Table 3.19: Cost incurred on the treatment of children 0-36 months who were ill

	Anji	Talegaon	Gaul	Total
Min	0	0	0	0
Max	810	5,975	8,500	8,500
Mean	159.7	273.8	265.2	231.0
Median	135.0	170.0	127.5	150.0

Base: Women with a Child aged 0-36 months who were ill

Lack of hygiene has been one of the major sources of infections and diseases among the children. It has been document that these infections cause a considerable amount of mortality among children, especially in the initial months of their life and in those who are malnourished and of low weight. The CLICS programme had initiated interventions to promote personal hygiene among the target population.

Women were asked about the personal hygiene practiced by them. It has been reported that 98.6% of the female respondents reported that they used soap/ash to wash hands after defecation and 97.3% reported that they used soap/ash after washing their child after defecation. It has been observed that Anji outscores all other sectors on the four areas where hygiene was tested among the women. There has been considerable amount of awareness that has been created as 46.1% of the respondents report that they wash their hands with soap/ash and water before preparation food whereas 57.2 reported to do so before feeding their child. The practice of washing hands after defecation and washing the child after defecation was found to be very high. In both cases over 97% of the respondents reported that they washed their hands with soap/ash and water.

Table 3.20: Women who report washing hands with soap or ash

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
After defecation	295	99.0	311	98.7	293	98.0	899	98.6
Before eating meals	177	59.4	184	58.4	167	55.9	528	57.9
Before cooking food	160	53.7	142	45.1	118	39.5	420	46.1
Before feeding children	187	62.8	170	54.0	165	55.2	522	57.2
After cleaning faces of body	294	98.7	302	95.9	291	97.3	887	97.3
Total respondents with children 0-35 months	300	100.0	317	100.0	295	100.0	912	100.0

Base: All women with a child aged 0-35 months

3.2.3 Immunization Practices

One of the major strategies used by the CLICS programme to reduce mortality among children was to ensure complete immunization of children before completing their first year of birth. Around 95.8% of the respondents have reported that their child in the age group of 12-23 months was completely immunized against the six diseases. Among the three sectors Anji has reported highest levels of immunization with 97.2% of the eligible respondents confirming the same. Talegaon reports the lowest level of immunization among the three sectors with 94.4% of the eligible respondents confirming the same.

The proportions changed when vaccination for prevention of measles was considered in isolation. It was observed that 96.4% of the respondents reported that their child was vaccinated to prevent measles. Gaul reported highest level of immunization for measles whereas Talegaon reported the lowest levels among the three sectors.

Table 3.21: Children who received complete vaccination against 6 preventable diseases

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Fully immunized	103	97.2	117	94.4	103	96.3	323	95.8
Not fully immunized	3	2.8	7	5.6	4	3.7	14	4.2
Total	106	100.0	124	100.0	107	100.0	337	100.0

Base: Children aged 12-23 months

Table 3.22: Children in the age group 12-23 months who received Measles vaccination

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Received Measles vaccine	103	97.2	117	94.4	105	98.1	325	96.4
Did not receive measles vaccine	3	2.8	7	5.6	2	1.9	12	3.6
Total	106	100.0	124	100.0	107	100.0	337	100.0

Base: Children aged 12-23 months

In the field while inquiring about the details immunization status, the field investigators verified the details first from the immunization card maintained by the health service provider, In case the card was unavailable or not legible, the information was confirmed from the parent of the child.

3.2.4 Anthropometric Details

About 41.1% of the children in the age group 0-35 months found to be underweight. The calculation was carried out by using EPI Nutrition, the software recommended in Rapid catch guidelines. Among all children whose weight was measured, the proportion that was below minus 2 standard deviations of the median weight for age were considered underweight.

Table 3.23: Underweight Prevalence

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Median weight for age less than -2SD	122	40.7	135	42.6	118	40.0	375	41.1
Median weight for age more than -2SD	178	59.3	182	57.4	177	60.0	537	58.9
Total respondents with children 0-35months	300	100.0	317	100.0	295	100.0	912	100.0
Median weight for age more than -3SD	31	10.3	39	12.3	37	12.5	107	11.7

Base: Children aged 0-35 months
Software used: EPI Nutrition

It has been found that about 41.1% of the children were underweight in the area and were malnourished.

3.2.5 Low Weight Management

Based on the recall of the mother, the birth weight of children who had been weighed within 7 days of their birth was recorded. It has been found that about 27.68% of the children weighed less than 2500 grams and were low weight babies. The prevalence of low birth weight babies was the highest in Anji with about 32% of the respondents reporting low birth weight of child whereas it was reported to be lowest in Gaul at about 22%.

Table 3.24: Children with low birth weight

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Birth Weight less than 2500 Grams	94	32.3	84	27.9	62	22.6	240	27.7
Birth Weight greater than or more than 2500 Grams	196	67.4	213	70.8	210	76.4	621	71.6
Do not remember	2	0.69	3	1.00	3	1.09	8	0.92
Total	291	100.0	301	100.0	275	100.0	867	100.0

Base: All women with a child 0-35 months whose child was weighed within 7 days of birth

Further, women with children in the age group 0-5 months were asked when the child was weight after its birth. Overall, 84.1% of the respondents reported that their child in the age group of 0-5 months had been weighed on the first day of their birth. This is an important indicator as weighing the child at the time of birth is an important factor to assess the development and growth of the child. Among the three sectors, it has been found that in Talegaon the largest percentage (87%) of eligible respondents have reported that their child was weighed within the first day of birth whereas it is the lowest in Anji (81.6%).

Table 3.25 A: Weight measurement of the baby after birth as reported by mothers for children 0-36 months

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
On day 1	256	84.2	264	82.5	212	71.1	732	79.4
On day 2	25	8.2	27	8.4	44	14.8	96	10.4
3-7th day	10	3.3	10	3.1	19	6.4	39	4.2
After 7th day	11	3.6	9	2.8	18	6.0	38	4.1
Never	2	0.7	10	3.1	5	1.7	17	1.8
Total	304	100.0	320	100.0	298	100.0	922	100.0

Base: Women with a child aged 0-36 months

Table 3.25 B: Weight measurement of the baby after birth as reported by mothers for children 0-5 months

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
On day 1	31	81.6	40	87.0	40	83.3	111	84.1
Weighed later than day 1	7	18.4	6	13.0	8	16.7	21	15.9
Total	38	100.0	46	100.0	48	100.0	132	100.0

Base: Women with a child aged 0-5 months

As a part of monitoring the growth of children, 80.5% of the total respondents with a child in the age group 0-36 months reported that their child was weighed in the last month. Among the sectors this was reported to be the highest in Gaul at 85.4% and lowest in Anji at 76.7%.

Table 3.26: Children in the age group 0-35 months reported to be weighed in the last month

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Weighed in last month	230	76.7	252	79.5	252	85.4	734	80.5
Not weighed in last month	70	23.3	65	20.5	43	14.6	178	19.5
Total	300	100.0	317	100.0	295	100.0	912	100.0

Base: Women with a child aged 0-35 months

The respondents were further probed about their knowledge of any low birth management technique. It was found that 99.1% of the respondents, women with a child in age group of 0-11 months, were found to be aware of at least one Low Birth Management Technique. In Anji 100% of the respondents were aware of at least one weight management technique, whereas in Talegaon 98.4% of the respondents were aware of at least one method of low birth management, which was also observed to be the lowest among the three sectors.

Table 3.27: Knowledge among women of at least one method of Low Birth Weight Management

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Aware of no method	0	0.0	2	1.6	1	0.9	3	0.9
Aware of one method	0	0.0	0	0.0	3	2.8	3	0.9
Aware of two methods	9	7.9	7	5.6	6	5.5	22	6.3
Aware of more than two methods	105	92.1	116	92.8	99	90.8	320	92.0
Total	114	100.0	125	100.0	109	100.0	348	100.0

Base: All women with children aged 0-11 months

Child Health: A Community Perspective

As a part of the qualitative data collection, discussion on child health issues were carried out with the community based organizations developed in the project. It was found that members of such groups were very well informed about the child health issues.

It was observed in the FGD carried out among the KVM members that most members were aware of the important newborn and child health issues. It was found that all members were aware that the child should be wrapped immediately after birth. They were of the view that the child should be bathed after 2-3days of birth. As far as their knowledge about breast feeding is concerned, they felt that the child should be exclusively breast fed for six months.

Similarly, from the FGDs carried out with the SHG members it emerged that majority of the members were aware of the major illnesses among children. They felt that the child should be kept warm and given breast milk immediately after its birth.

The group members were aware of the majority of the diseases for which immunization is done. As per the members the immunization rates in the village were very high as it was regularly being carried out on the Bal Suraksha Diwas organized every month in the villages. The members also informed that the CLICS Doot also helped in monitoring the weight and immunization of children regularly.

It was observed that there was good knowledge among the CBO members about child health. This is clearly evident in the high rates of immunization and the other child health practices reported in the survey. They can certainly play the role of change agents at the village level.

Chapter 4
Knowledge and Practices on Safe Motherhood

India is known to have a higher maternal mortality rate as compared to Bangladesh. It's ironic that India with a much more robust economy and modernized medical care system still fails to keep pace with a nation like Bangladesh, when it comes to providing safe motherhood.

The maternal mortality ratio in India is estimated to be 540 maternal deaths per 100,000 live births, rising to 619 in rural areas. The major causes of maternal death are excessive bleeding during childbirth (generally among home deliveries), obstructed and prolonged labor, infection, unsafe abortions, disorders related to high blood pressure and anemia. More than 47% of maternal deaths in rural India are attributed to excessive bleeding and anemia resulting from poor nutritional practices.

One of the major reasons for this dismal performance is believed to be the traditional preference given to home based deliveries as compared to institutional deliveries. In some parts of the country more than two thirds of the deliveries are carried out at home, most of them attended by relatives or traditional birth attendants. The magnitude of the problem increases when a comparison is made based on the rural-urban divide. Policy makers have suggested a three pronged approach to counter the problem

1. Ensuring availability of a Trained Birth Attendant at village level,
2. Universalized institutional delivery, and
3. Increasing emergency obstetric services at the PHCs and rural hospitals would help in improving the safe motherhood related indicators.

The CLICS programme also followed a similar approach, keeping in line with the national health policies and plans. It has also paid stress on increasing institutional deliveries and providing antenatal care and services to pregnant women in the project area through the village based health worker, Kiran Clinics and Bal Surksha Diwas.

4.1 Age at Marriage

The age at marriage for females in the project area was found to be in the range of 12-30 years with the mean and median age at marriage being 19.4 and 19 years respectively. It was found that age at marriage did not vary much among the three sectors. The median age for all the three sectors was reported to be 19 years whereas the mean age varied marginally among the three sectors. Similarly the age at first child was also analysed based on the recall

of the respondents, it was found that the mean age at first child in the project area was 20.87 years. It had a difference of over a year from the mean age at marriage.

Table 4.1: Age at marriage and first child

	Anji	Talegaon	Gaul	Total
Mean age at marriage	19.7	19.2	19.4	19.4
Mean age at first child	21.12	20.42	21.09	20.87

Base: All women with a child aged 0-35 months

4.2 Antenatal Care: Knowledge and Practices

In the project area, all women respondents having a child aged 0-35 months reported to have received at least one ANC. This in itself is a phenomenal achievement considering the Indian context, where access to antenatal care is limited in the rural areas. One of the contributing factors to such a high rate of availing antenatal services is the spousal support available to the respondents. Over 97% of the Men with a child aged 0-35 years were of the view that women should access antenatal services during their pregnancies.

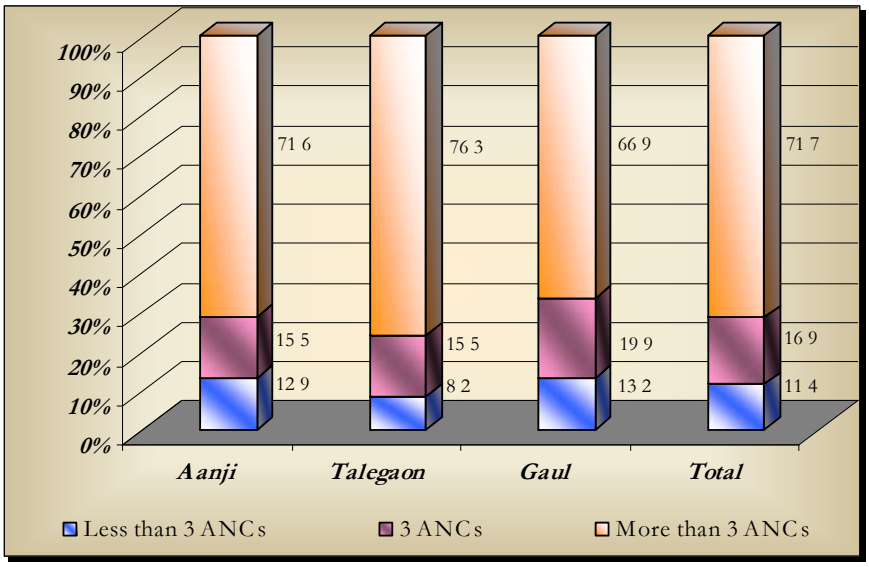
Table 4.2: Perception of men on availing Antenatal Checkups

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Should go for ANC	323	97.9	306	97.1	277	96.9	906	97.3
Should not go for ANC	5	1.5	9	2.9	9	3.1	23	2.5
Don't Know	2	0.6	0	0.0	0	0.0	2	0.2
Total	330	100.0	315	100.0	286	100.0	931	100.0

Base: All men with children aged 0-35 months

The respondents were further enquired about the number of antenatal check-ups availed by the mothers in last pregnancy. It is observed that 88.6% of the total respondents have received at least three mandatory antenatal check ups during the entire period of pregnancy.

Figure 4.1: Number of ANCs availed by women in the last pregnancy



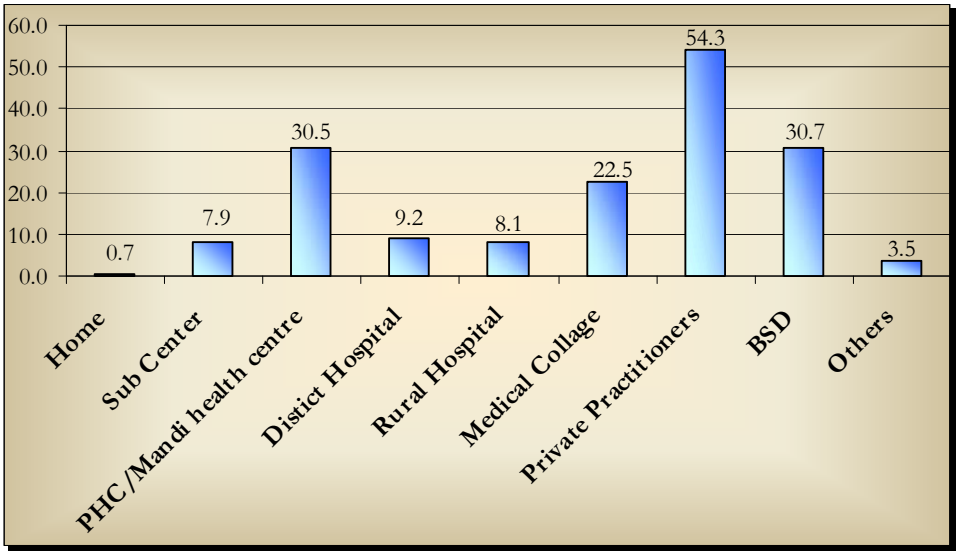
Base: All women with children aged 0-36 months

Among the sectors, Talegaon emerges with the best trends in antenatal care with over 90% of the females reporting to have received at least three antenatal check ups during the last pregnancy. Gaul with 86.8% of the respondents has the lowest proportion of respondents, among the three sectors, who report to have received at least 3 antenatal check–ups during the last pregnancy. This trend, in antenatal care is considerably higher than that existing in Maharashtra as a state. As per the NFHS-3 findings, only 65.5% of women in rural areas have reported to have received at least 3 antenatal check ups during their last pregnancy.

4.2.1 Medical Examinations and Check-ups

The figure below illustrates the place where the antenatal check up was availed by the respondents (Multiple responses to question asked were possible). It is observed that 54.3% of the respondents have reported to avail the antenatal services from private practitioners. Apart from the private practitioners, Bal Suraksha Diwas, PHCs and MGIMS (Medical College) have emerged as the other major sources of antenatal check ups to the respondents in the project area. .

Figure 4.2: Place of Antenatal Check-ups



Base: All women who received at least one antenatal check-up with a child aged 0-36 months

The following table illustrates the medical examinations that the respondents underwent in the antenatal check-ups. Abdominal examination, weight measurement, BP measurement and urine examination have emerged as the four most commonly reported examinations carried out during the ante-natal check-ups.

A relatively smaller proportion of the respondents, 71.6% and 77.9% respectively, reported that the service provider enquired about the delivery history of the respondents and carried out an internal examination during the course of the antenatal check-ups. HIV/AIDS testing of expectant mothers was the other major test carried out apart from the options already mentioned.

Table 4.3: Examinations reported to be carried out during the ANCs

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Inquiry about previous pregnancy/ delivery history	208	68.6	217	68.5	234	77.7	659	71.6
BP measurement	298	98.3	311	98.1	289	96.0	898	97.5
Weight measurement	299	98.7	317	100.0	298	99.0	914	99.2
Height measurement	261	86.1	249	78.5	262	87.0	772	83.8
Abdominal examination	297	98.0	314	99.1	299	99.3	910	98.8
Urine examination	295	97.4	306	96.5	290	96.3	891	96.7
Internal examination (PV)	223	73.6	262	82.6	232	77.1	717	77.9
Sonography	227	74.9	260	82.0	213	70.8	700	76.0
Blood test	276	91.1	292	92.1	258	85.7	826	89.7
Others	31	10.2	47	14.8	29	9.6	107	11.6

Base: All women with children aged 0-36 months and reported to have had at least one antenatal check-up in last pregnancy

All respondents were asked about the advice provided by the service provider during the antenatal check ups. It has been found that 97.7% of the respondents reported that they were advised to take appropriate diet and nutrition whereas 97.2% reported that they were also advised about breast feeding and newborn care.

Periodic check-ups during pregnancy and rest were the other two most common advises that were given by the health service providers during the antenatal check ups.

Table 4.4: Advice given to women during the antenatal check ups

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Advised on periodic check-ups	286	94.4	291	91.8	274	91.0	851	92.4
Advised on diet and nutrition	297	98.0	307	96.8	296	98.3	900	97.7
Advised rest	287	94.7	275	86.8	289	96.0	851	92.4
Advised on breast feeding and new born care	292	96.4	310	97.8	293	97.3	895	97.2
Advised on contraceptive use	203	67.0	256	80.8	256	85.0	715	77.6
Others	19	6.3	17	5.4	23	7.6	59	6.4
Total	303	100.0	317	100.0	301	100.0	921	100.0

Base: All women having a child aged 0-36 months who had antenatal check-ups

The respondents were asked to report any complications that they had in their last pregnancy. Anemia, reported by 23.3%, and swelling of ankles, reported by 22.6%, emerged as the most common complications during pregnancy among women. These were followed by high fever (11.2%) and hypertension (7.3%) as the most commonly reported complications during pregnancy.

Table 4.5: Complications experienced by women during their last pregnancy

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Convulsions	9	3.0	6	1.9	9	3.0	24	2.6
Abnormal presentation of the baby/breech/ hand prolapse	9	3.0	12	3.8	24	7.9	45	4.9
Hypertension/high blood pressure	24	7.9	21	6.6	22	7.3	67	7.3
Excessive bleeding	14	4.6	9	2.8	22	7.3	45	4.9
High fever	25	8.3	39	12.3	39	12.9	103	11.2
Swelling of ankles/feet	73	24.1	74	23.3	61	20.2	208	22.6
Anemia	63	20.8	73	23.0	79	26.2	215	23.3
Less fetal movements	19	6.3	20	6.3	22	7.3	61	6.6
Others	22	7.3	36	11.4	48	15.9	106	11.5
Total	303	100.0	317	100.0	301	100.0	921	100.0

Base: All women with a child aged 0-36 months
Multiple responses possible

Women with children in the age group of 0-23 month were further asked if they had received at least 2 tetanus toxide injections or a booster dose. It was observed that 94.12% of the respondents had received the prescribed dosage of tetanus toxide. Among the three sectors, Anji with 96.69% respondents reported the highest instance of receiving the prescribed tetanus toxide dosage.

Table 4.6: Women who reported to have received at least 2 TT injections or 1 booster dose (0-11 months)

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Women who received at least 2TT or 1 booster dose	117	95.9	120	93	115	92	352	93.6
Total	122	100	129	100	125	100	376	100

Base: All women with a child aged 0-11 months

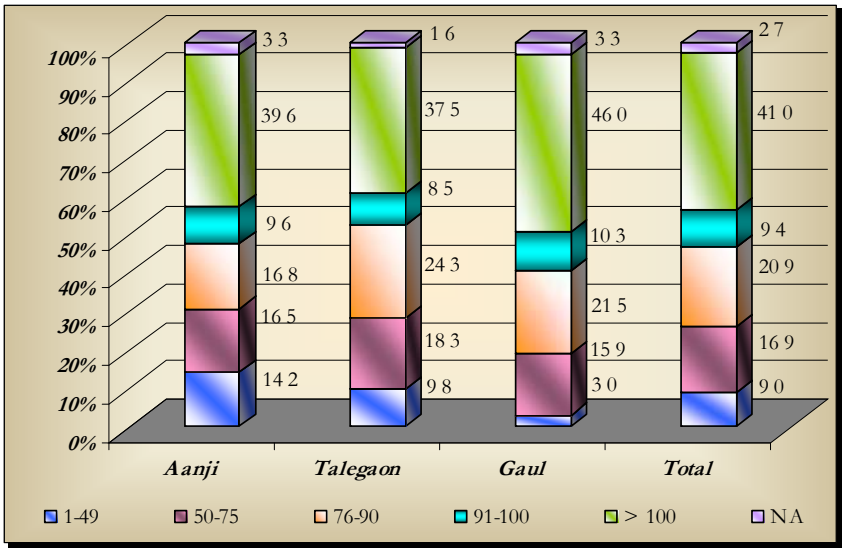
4.2.2 Supplementary Nutrition and Immunization of Pregnant Women

Considering the socio-cultural set up in rural areas, supplementary source of Iron and Folic Acid is considered as an important part of the antenatal care for pregnant women. It has been reported in the NFHS-3 survey that the incidence of anemia among pregnant women in the age group 15-49 is as high as 56% in Maharashtra, whereas the proportion of mothers who consumed IFA tablets for 90 days during their pregnancy in rural areas was 30.5%.

The CLICS programme aimed at ensuring improved access and increased consumption of IFA tablets among pregnant women in the project area. The figure below shows the proportion of respondents who reported to have received over 100 IFA tablets on the basis of recall by the respondents.

It is evident from the figure that over 41% of the respondents received more than 100 IFA tablets for their consumption in the project area. Among the three sectors, women in Gaul have reported to receive over 100 IFA tablets in a higher proportion as compared to the other two sectors.

Figure 4.3: Number of IFA tablets received by women (0-36 months)



Base: All women with a child aged 0-36 months
NA refers to those respondents who received IFA but could not recall the number

As observed in the following table, about 43.8% of the respondents who had infants between the age group of 0 to 11 months had received over 100 IFA tablets. This proportion was highest across sectors in Anji (49.2%).

Table 4.7: Number of IFA tablets received by women (0-11 months)

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
<50	20	16.7	10	7.9	3	2.5	33	9.0
50-74	14	11.7	18	14.2	24	20.3	56	15.3
75-89	1	0.8	5	3.9	2	1.7	8	2.2
90-100	26	21.7	49	38.6	33	28.0	108	29.6
100+	59	49.2	45	35.4	56	47.5	160	43.8

Total	120	100.0	127	100.0	118	100.0	365	100.0

Base: All women with a child aged 0-11 months
NA refers to those respondents who received IFA but could not recall the number

The following table presents that about 38.0% of the respondents who had infants between the age group of 12-23 months had received over 100 IFA tablets. This proportion was found to be the highest in Gaul among the three sectors.

Table 4.8: Number of IFA tablets received by women (12-23 months)

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
<50	11	10.8	14	13.2	5	5.0	30	9.7
50-74	20	19.6	19	17.9	15	15.0	54	17.5
75-89	0	0	2	1.9	4	4.0	6	1.9
90-100	34	33.3	32	30.2	35	35.0	101	32.8
100+	37	36.3	39	36.8	41	41.0	117	38.0
Total who received IFA	102	100.0	106	100.0	100	100.0	308	100.0

Base: All women with a child aged 12-23 months
NA refers to those respondents who received IFA but could not recall the number

As observed in the following table, about 45.3% of the respondents who had children between the age group of 23-36 months had received over 100 IFA tablets. This proportion was highest across sectors in Gaul (57.5%).

Table 4.9: Number of IFA tablets received by women (24-36 months)

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
<50	12	16.9	7	8.9	1	1.4	20	9.0
50-74	14	19.7	18	22.8	5	6.8	37	16.6
75-89	1	1.4	0	0.0	0	0.0	1	0.4
90-100	20	28.2	19	24.1	25	34.2	64	28.7
100+	24	33.8	35	44.3	42	57.5	101	45.3
Total who received IFA	71	100.0	79	100.0	73	100.0	223	100.0

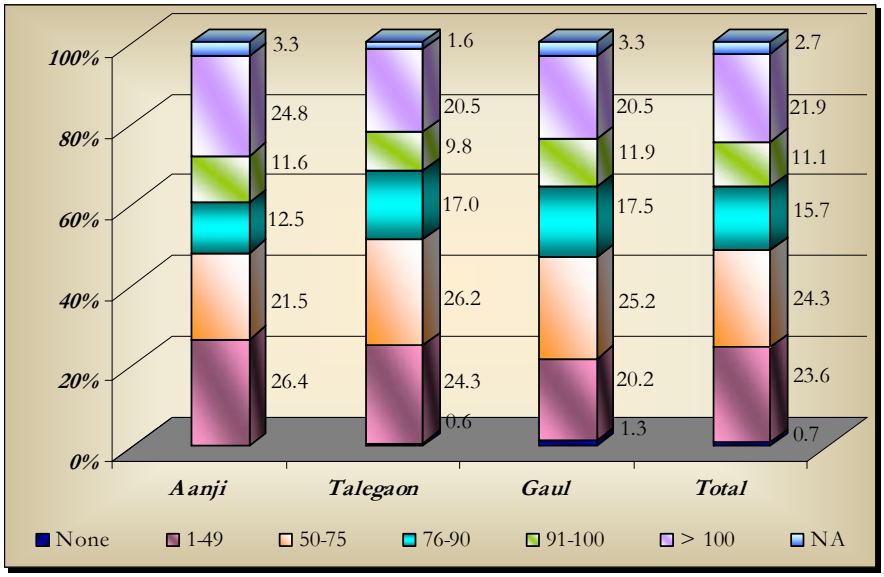
Base: All women with a child aged 24-36 months
NA refers to those respondents who received IFA but could not recall the number

It can be observed that 43.8 % of the women with a child in the age group 0-11 months reported that they had received more than 100 IFA tablets. It declined to 38.0% among respondents with children 12-23 months and further increased to 45.3% among respondents with children in the age group 24-35 months.

It has though been found that even though 41% of the women, with a child aged 0-35 months, in the project area report that they have received over 100 IFA tablets, only about 22% report that they actually consumed more than 100 IFA tablets.

The figure below illustrates the consumption pattern of IFA among women with children in the age group of 0- 35 months.

Figure 4.4: Consumption of IFA tablets as reported by women (0-35 months)



Base: All women with a child aged 0-36 months
NA refers to those respondents who received IFA but could not recall the number

The following table presents that about one fourth (25.5%) of the mothers of infants between the age group of 0-11 months had consumed over 100 IFA tablets. This proportion was highest across sectors in Anji (31.7%).

Table 4.10: Consumption of IFA tablets as reported by women (0-11 months)

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
<50	28	23.3	27	21.3	25	21.2	80	21.9
50-74	20	16.7	24	18.9	31	26.3	75	20.5
75-89	4	3.3	6	4.7	8	6.8	18	4.9
90-100	30	25.0	41	32.3	28	23.7	99	27.1
100+	38	31.7	29	22.8	26	22.0	93	25.5
Total	120	100.0	127	100.0	118	100.0	365	100.0

Base: All women with a child aged 0-11 months
NA refers to those respondents who received IFA but could not recall the number

The following table presents that about one fifth (20.5%) of the mothers of children between the age group of 12- 23 months had consumed over 100 IFA tablets. This proportion was highest across sectors in Anji (22.5%).

Table 4.11: Consumption of IFA tablets as reported by women (12-23 months)

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
<50	29	28.4	33	31.1	25	25.0	87	28.2
50-74	27	26.5	33	31.1	22	22.0	82	26.6
75-89	5	4.9	2	1.9	6	6.0	13	4.2
90-100	18	17.6	19	17.9	26	26.0	63	20.5
100+	23	22.5	19	17.9	21	21.0	63	20.5
Total	102	100.0	106	100.0	100	100.0	308	100.0

Base: All women with a child aged 12-23 months
NA refers to those respondents who received IFA but could not recall the number

The following table presents that about one fifth (20.6%) of the mothers of children between the age group of 23-35 months had consumed over 100 IFA tablets. This proportion was similar across sectors.

Table 4.12: Consumption of IFA tablets as reported by women (23-36 months)

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
<50	23	32.4	19	24.1	14	19.2	56	25.1
50-74	14	19.7	24	30.4	20	27.4	58	26.0
75-89	1	1.4	0	0	0	0	1	0.4
90-100	19	26.8	19	24.1	24	32.9	62	27.8
100+	14	19.7	17	21.5	15	20.5	46	20.6
Total	71	100.0	79	100.0	73	100.0	223	100.0

Base: All women with a child aged 23-36 months
NA refers to those respondents who received IFA but could not recall the number

As there was gap between the number of women respondents who reported that they had received more than 100 IFA tablets and those who had consumed more than 100 IFA tablets, the respondents who had not consumed all the IFA tablets that they had received were further probed for the reason of this practice. It was found that vomiting, gastric disorders and passing of black stools emerged as the most sighted reasons for discontinuation of the consumption of IFA tablets by women.

Thus, in the project area even after ensuring the availability of IFA tablets, actual utilization of IFA tablets has been limited by the misconceptions, myths and associated problem with its usage.

Table 4.13: Reasons reported by women for not consuming IFA tablets

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Passing black stools	7	5.8	18	10.8	26	14.9	51	11.0
Gastric disorders	7	5.8	30	18.0	24	13.7	61	13.2
Fear of large size of fetus	0	0.0	0	0.0	1	0.6	1	0.2
Opposition of mother in law	0	0.0	0	0.0	1	0.6	1	0.2
Vomiting	95	78.5	106	63.5	114	65.1	315	68.0
Don't felt like having	3	2.5	2	1.2	1	0.6	6	1.3
Uneasiness	3	2.5	4	2.4	7	4.0	14	3.0
Experienced stomach ache after having medicine	2	1.7	1	0.6	0	0.0	3	0.6
Indigestion	1	0.8	3	1.8	7	4.0	11	2.4
Could not digest the pills	2	1.7	4	2.4	5	2.9	11	2.4

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Child was delivered	2	1.7	5	3.0	6	3.4	13	2.8
Total	121	100.0	167	100.0	175	100.0	463	100.0

Base: All mothers of children aged 0-36 months who did not consume all IFA tablets received by them
(Multiple Response Question: % may not add to 100)

The table below gives us the proportion of women who received the minimum package of 3 antenatal check ups, atleast 2 TT injections or a booster dose and consumed 100 IFA tablets during their last pregnancy. It can be seen that Anji reports the highest percentage of mothers who have availed the minimum ANC package. In the project area 31.4% of the women have availed the minimum package.

Table 4.14: Mothers who received 3 ANC check-ups, atleast 2 TT injections and consumed at least 100 IFA tablets

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Percentage of mothers with child (0-11 months) who received 3 ANC check-ups, atleast 2 TT injections and consumed 100 or more IFA tablets	48	39.3	37	28.7	33	26.4	118	31.4
Others	74	60.7	92	71.3	92	73.6	258	68.6
Total	122	100.0	129	100.0	125	100.0	376	100.0

Base: All mothers of children aged 0-11 months

4.2.3 Knowledge of Danger Signs During Pregnancy

The incidence of high maternal mortality in India has been observed due to various complications that occur during the delivery of the child. The incidence is high as a majority of the deliveries in the rural areas still take place at homes, often conducted by untrained traditional birth attendants or relatives of the expectant mother.

It was found that when women with a child in the age group of 0-35 months were asked about their awareness of the danger signs during pregnancy, a total of 83.0% of the respondents felt that they were aware of the danger signs during delivery. Talegaon sector, with 86.8% of respondents, emerged as the sector with highest perceived knowledge of the danger signs during pregnancy whereas Gaul showed a relatively lower level of perceived awareness of the danger signs during delivery at 75.5%.

Table 4.15: Awareness among women of danger signs during pregnancy

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Aware of danger signs during pregnancy	262	86.5	275	86.8	228	75.7	765	83.1
Not aware of danger signs during pregnancy	33	10.9	36	11.4	39	13.0	108	11.7
Don't Know/Can't Say	8	2.6	6	1.9	34	11.3	48	5.2
Total	303	100.0	317	100.0	301	100.0	921	100.0

Base: All women with children aged 0-36 months

When queried about the danger signs during pregnancy, in response to an unprompted question, 73.1% of women with a child aged 0-35 months were able to spontaneously mention at least two danger signs during the delivery, which would require immediate medical care. When compared across sectors, 80.2% of the respondents in Anji were aware of two or more than two such symptoms, which was the highest among the three sectors.

Table 4.16: Awareness among women of danger signs during delivery

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Not aware	41	13.5	42	13.2	73	24.3	156	16.9
Aware of just one danger sign	19	6.3	27	8.5	46	15.3	92	10.0
Aware of two danger signs	61	20.1	63	19.9	65	21.6	189	20.5
Aware of more than two danger signs	182	60.1	185	58.4	117	38.9	484	52.6
Total	303	100.0	317	100.0	301	100.0	921	100.0

Base: All women with children aged 0-36 month

A similar question was asked to men with a child aged 0-35 months. It was observed that 41.6% of the men with a child aged 0-35 months were aware of at least three danger signs during pregnancies. However, this was the highest in Talegaon at 51.1% and lowest in Anji at 28.8% among the three sectors.

Table 4.17: Awareness among men of at least two danger signs during pregnancy

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Aware of at least 2 danger signs during pregnancy	95	28.8	161	51.1	131	45.8	387	41.6
Not aware of at least 2 danger signs during pregnancy	235	71.2	154	48.9	155	54.2	544	58.4
Total	330	100.0	315	100.0	286	100.0	931	100.0

Base: All men with children aged 0-36

4.3 Management of Complications During Pregnancies

4.3.1 Delivery Practices and Management

Unsafe delivery practices are one of the major reasons for maternal and infant mortality. It has been found that the chances of maternal and infant mortality are higher in home based deliveries, especially in the rural areas. In a response to a question asked to Men with a child aged 0-35 months, about 97.0% of the respondents expressed their desire to have institutional deliveries.

Table 4.18: Preferred place of delivery, as reported by Men

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Home	9	2.8	8	2.6	11	3.9	28	3.0
Hospital	318	97.2	303	97.4	271	96.1	892	97.0
Total	327	100.0	311	100.0	282	100.0	920	100.0

Base: All men having children aged 0-36 months
11 respondents have given no response to the question

Thus, one can infer that there exists a strong spousal support for institutional deliveries in the project area. The impact of this support is clearly evident as it was found that 85% of women with a child aged 0-23 months reported that their last deliveries were institutional. In comparison as per the NFHS 3 estimates, 56.5% of the deliveries in Maharashtra have been institutional deliveries.

It is further noticed that about 94.0% of the deliveries of women with a child aged 0-36 months were carried out by a trained health personnel. Together the two indicators augur well for the maternal and infant health.

Table 4.19: Place and person assisted the last delivery as reported by women

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Institution	270	88.8	275	85.9	233	78.2	778	84.4
At Home assisted by Doctor	7	2.3	6	1.9	2	0.7	15	1.6
At Home assisted by Nurse	4	1.3	6	1.9	3	1.0	13	1.4
At Home assisted by Trained Dai	13	4.3	6	1.9	40	13.4	59	6.4
At Home assisted by Untrained person	10	3.3	25	7.8	18	6.0	53	5.8
At Home assisted by Relative/Neighbor	0	0.0	2	0.6	2	0.7	4	0.4
Total	304	100	320	100	298	100	922	100

Base: All women with children aged 0-36 months

Over 98% of men with a child aged 0-35 months felt that they needed to be prepared in case a delivery was to happen in the near future in the family.

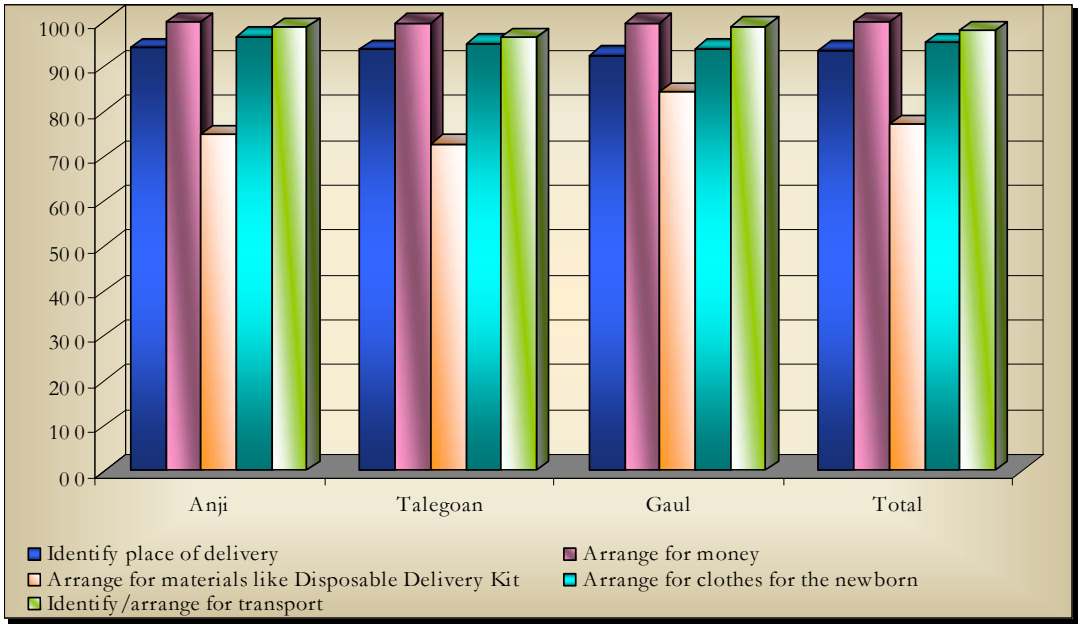
Table 4.20: Perception of Men on preparations before delivery

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Preparation is required	323	97.9	312	99.0	282	98.6	917	98.5
No preparation is required	6	1.8	3	1.0	4	1.4	13	1.4
Don't know/Cant Say	1	0.3	0	0.0	0	0.0	1	0.1
Total	330	100.0	315	100.0	286	100.0	931	100.0

Base: All men with children aged 0-35 months

Very high priority has been given to arranging money and transport before the delivery is scheduled. Almost 100% of the respondents felt that additional money should be arranged in case there was a delivery scheduled in the family. Disposable Delivery Kit (DDK) was given relatively lower priority as things required to be arranged prior to a delivery in the family. One of the reasons for such a pattern could be the high percentage of institutional deliveries that have been reported in the project area, thereby limiting the demand for DDK used mostly at home based deliveries.

Figure 4.5: Perceived preparation required before a delivery at home



Base: All men with children aged 0-35 months

4.4 Outcome of last pregnancy

Women interviewed during the survey were also enquired about the outcome of their last pregnancies. It was found that 98.3% of the women reported that their last pregnancies resulted in live births. About 1.3% reported that they had undergone induced abortions due to various reasons, whereas 0.4 % reported that they had spontaneous abortion when they had last conceived.

Table 4.21: Outcome of last pregnancy, as reported by women

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%

Live Birth	295	97.4	313	98.7	297	98.7	905	98.3
Spontaneous abortion	3	1.0	0	0.0	1	0.3	4	0.4
Induced abortion	5	1.7	4	1.3	3	1.0	12	1.3
Total	303	100.0	317	100.0	301	100.0	921	100.0

Base: All women with a child aged 0-36 months

4.5 Postnatal Care: Knowledge and Practices

Proper care of the new born baby and the mother in the 6-8 weeks that follow childbirth are considered to be crucial for the baby's and the mother's health; both physical and psychological. The immediate role of the postnatal services is to ensure that the mother gradually returns back to her pre pregnancy state and the growth of the new born baby is as per expectations.

It was found that the perception of the community was very receptive for postnatal check-ups. In response to a question asked to all Men with a child aged 0-35 months, over 97% of the respondents were of the view that women should avail postnatal check-ups.

Table 4.22: Perceptions of men on postnatal check-ups

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Should go for Postnatal check up	323	97.9	306	97.1	277	96.9	906	97.3
Should not go for Postnatal check up	5	1.5	9	2.9	9	3.1	23	2.5
Don't Know/Cant say	2	0.6	0	0.0	0	0.0	2	0.2
Total	330	100.0	315	100.0	286	100.0	931	100.0

Base: All women with children aged 0-36 months

Thus, women in the community have the spousal support for availing postnatal check-ups. The table below shows the sector wise details of the percentage of women who have availed postnatal care in the project area. Overall, 63.0% of the women having a child aged 0-36 months have reportedly availed postnatal check-ups. Though there is a considerable sector-wise variation. It is observed that over 70% of the respondents in Talegaon and Gaul avail postnatal care services whereas Anji lags behind considerably with only 47.5% of the respondents reportedly availing the postnatal services.

Table 4.23: Postnatal check-ups reportedly availed by women

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Availed Postnatal checkups	144	47.5	225	71.0	211	70.1	580	63.0
Did not avail postnatal checkups	159	52.5	92	29.0	90	29.9	341	37.0
Total	303	100.0	317	100.0	301	100.0	921	100.0

Base: All women with children aged 0-36 months

When the respondents who had availed postnatal care services where asked about the place where they had availed these services, it was found that a majority of the respondents had availed these services from either the government or private hospitals. About 10.0% of the respondents also reported that they had availed postnatal services from the MGIMS medical college in Wardha.

Only a small section of the group reported to have received these services within the village at their home (8.3%) or at the Bal Suraksha Diwas (7.6%).

Table 4.24: Place where postnatal services were availed by women

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
At Home	10	6.9	10	4.4	28	13.2	48	8.3
At Govt hospital	42	29.2	103	45.8	101	47.6	246	42.3
At Private hospital	79	54.9	92	40.9	68	32.1	239	41.1
At Bal Suraksha Diwas	7	4.9	12	5.3	25	11.8	44	7.6
Medical collage	11	7.6	24	10.7	23	10.8	58	10.0
Others	2	1.4	0	0.0	2	0.9	4	0.7
Total	144	100.0	225	100.0	212	100.0	581	100.0

Base: All women with children aged 0-36 months who received postnatal care
The question was multiple response question, thus Base value and total value will not be equal

4.6 Services of the Kiran Clinics

One of the major interventions in the project was to create a model of social franchise to ensure that good quality services could be provided to the community. The model was to ensure that the community members play an important role in securing quality health services for it. Kiran Clinics have emerged as a result of this model after an agreement between MGIMS and the VCC developed at the village level. This section aims at assessing the utility and the perception of the community members about the services provided at the Kiran clinics.

It was found that 54.6 % of the women interviewed were aware of the Kiran clinics. The awareness was found to be more in Gaul among the three sectors.

Table 4.25: Women who are aware of Kiran clinics

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Aware of Kiran clinics	174	57.4	145	45.7	184	60.9	503	54.6
Unaware of Kiran clinics	129	42.6	172	54.3	117	39.1	419	45.4
Total	303	100.0	317	100.0	301	100.0	921	100.0

Base: All women with children aged 0-36 months

The respondents who were aware about the Kiran clinics were further asked if they had used the services offered at the clinic. It was found that 81.3% of the respondents had utilized the services of the Kiran clinics. This was highest in the Talegaon sector in which 84.1% of the women who were aware of the Kiran clinics had utilized its services.

Table 4.26: Women who have utilized the services provided at the Kiran clinic

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Used the services of Kiran clinics	137	78.7	122	84.1	150	81.5	409	81.3
Not used the services	37	21.3	23	15.9	34	18.5	94	18.7
Total	174	100.0	145	100.0	184	100.0	503	100.0

Base: Women with children aged 0-36 months who have heard of HIV/AIDS

The respondents who had utilized the services offered by the Kiran clinics were asked about their levels of satisfaction from the services provided at the clinics. It was found that 95.6% of the respondents who had availed the services of clinics were satisfied with the services offered. It was found that respondents in Anji were the most satisfied by the services offered in the Kiran clinics.

Table 4.27: Perception of women about the services provided by the Kiran clinics

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Satisfied with the services provided	133	97.1	118	96.7	140	93.3	391	95.6
Not satisfied with the services	4	2.9	4	3.3	10	6.7	18	4.4
Total	137	100.0	122	100.0	150	100.0	409	100.0

Base: Women with a child aged 0-36 months and who visited Kiran clinics

The respondents who had reported that they were not satisfied with the services provided at the Kiran clinics were further probed about the reasons for dissatisfaction among them. It was found that 55.6% of the respondents felt that non availability of funds was the main reason for dissatisfaction whereas 22.2% reported that the timings of the centre were not suitable for them.

Table 4.28: Reasons of dissatisfaction from Kiran clinics as reported by women

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Timing not suitable	0	0.0	0	0.0	4	40.0	4	22.2
Rude behavior of health staff	0	0.0	0	0.0	2	20.0	2	11.1
Non Availability of drugs	3	75.0	3	75.0	4	40.0	10	55.6
High cost of the drug	0	0.0	1	25.0	1	10.0	2	11.1
Others	1	25.0	1	25.0	3	30.0	5	27.8
Total	4	100.0	4	100.0	10	100.0	18	100.0

Base: Women with a child aged 0-35 months and who were dissatisfied with the Kiran clinics

It is evident from the findings that the model has been successful in providing services that have been appreciated by the clients and can be successful in resolving the problem of accessibility to quality health services in rural areas within the village itself. Though to reach a final verdict various other factors also need to be assessed.

Safe Motherhood: A community perspective

During the FGDs with various groups safe motherhood was one of the major issues to be discussed. It was found that both women and adolescent girls felt that the girls should be married only after they had matured both physically and mentally. The age of marriage varied from group to group. The women from SHG groups felt that a girl should be married at an age between 18 to 23 years. This was significantly higher among the adolescent groups, where it was observed that the girls felt that the age of marriage should be 22 to 27 years. As per the members there was a gradual change in the age of marriage in the project area. The adolescent group members were of the view that currently it was very rare for a family to marry their girl child at an age less than 18 years.

It was observed that the members of the KVM groups were aware about the need for ante natal check-ups. It was found that there was good support among the males for ante natal check-ups, which is clearly reflected in the figures generate in the quantitative survey.

As per the SHG group members, majority of the deliveries were now institutional deliveries. They however also mentioned that some deliveries in the village still took place at homes. The awareness among the men and women on the preparation before a delivery was very high. Arrangement of transport and additional money emerged as the major preparations that were required for a delivery in a family.

Adolescent and women were found to be aware about the need for IFA consumption during the pregnancies. They were of the view that anemia in their community was very high. Thus emphasis on IFA consumption should be made. The women SHG group members felt that at least 100 to 200 IFA tablets should be consumed by a woman during her pregnancy. It was also observed that the community members were aware of the additional nutritional needs of a mother during pregnancy. The adolescent girls groups felt that the following precautions should be taken by a women during her pregnancy:

1. *A pregnant woman should take adequate rest and not lift heavy weights.*
2. *She should include green leafy vegetables and iron rich food items in her diet.*
3. *She should be immunized and go for regular check-ups*

It was found that both men and women were aware of the various danger signs among women during pregnancy. In the SHG group the major danger signs that emerged during discussions were

1. *Swelling in ankles and feet.*
2. *High blood pressure*
3. *Fever*
4. *Convulsions etc*

Chapter 5
Knowledge and Practices amongst Adolescents

The societal set-up in India has been such that openness on issues specially related to reproductive health are not often openly discussed. Thus, adolescents in India are found to be vulnerable to reproductive and other health risks. Poor nutrition and lack of information about proper diets further increase this risk and often lead misconceptions and myths among the youth.

Young women and men commonly have reproductive tract infections (RTIs) and sexually transmitted infections (STIs), but do not regularly seek treatment despite concerns about how these infections may affect their fertility. India also has one of the highest rates of early marriage and childbearing, and a very high rate of iron-deficiency anemia. The prevalence of early marriage in India as elsewhere poses serious health problems for girls, including a significant increase of maternal or infant mortality and morbidities during childbirth.

The adolescent girls are the future mothers. Thus, it is essential that they should be educated about reproductive and child health. With this view, the CLICS programme also involved the adolescent girls in the age group of 12-19 years in their program to ensure improvement child survival levels in the long term. The following section presents the findings about the knowledge and awareness of the adolescent girls on reproductive and health issues.

5.1 Menstrual Age

All the respondents were asked their age in completed years. About 56.3% of the respondents were in the age group of 12-15 years while 43.7% were in 16-19 years. A little less than 1% of the respondents were aged more than 18years. The proportions were more or less similar across the three sectors.

Table 5.1: Age profile of adolescents interviewed

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
12-15	169	56.5	183	57.7	172	54.6	524	56.3
16-19	130	43.4	134	42.3	141	45.3	405	43.7
Total	299	100.0	317	100.0	313	100.0	929	100.0

Base: All adolescent girls in the age group 12-19

The respondents were also asked if they had started menstruating. About four-fifth of the respondents (78.8%) reported that they had started menstruating (at the time of the survey). Among the sectors, the proportion was highest in Anji at 84.6% and lowest in Gaul (72.8%).

Table 5.2: Initiation of menstruation among adolescents interviewed

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%

Started menstruating	253	84.6	251	79.2	227	72.8	731	78.8
Had not started menstruating	46	15.4	66	20.8	85	27.2	197	21.2
Total	299	100.0	317	100.0	313	100.0	929	100.0

Base: All adolescent girls in the age group 12-19

The respondents who reported that they had started menstruating were asked the age at which they started the same. The results are presented in the table below. The mean age when the respondents reported that they started menstruating was observed to be 13.7 years and the median was 14 years. The mode age at which respondents started menstruating was observed to be 13 years.

Table 5.3: Age when menstruation started amongst adolescents interviewed

	Anji	Talegaon	Gaul	Total
Min	11	11	10	10
Max	17	19	17	19
Mean	13.5	13.6	14.0	13.7
Median	14	13	14	14
Mode	14.0	13.0	14.0	13.0

Base: All adolescent girls in the age group 12-19 who had started menstruating

The respondents who reported that they had started menstruating were asked if they were provided any information on the same. More than half (54.2%) of the respondents reported that they had received some information on menstruation before they started menstruating. The proportion was reported to be lowest in Anji at 44.3% and highest in Gaul at 59.9%.

Table 5.4: Adolescents who were briefed before initiation of menstruation

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Received information	112	44.3	148	59.0	136	59.9	396	54.2
Did not receive information	141	55.7	103	41.0	91	40.1	335	45.8
Total	253	100.0	251	100.0	227	100.0	731	100.0

Base: All adolescent girls in the age group 12-19 who started menstruating

Respondents who reported that they received information about menstruation etc before they started menstruating were asked who provided them with the information. The results are presented in the table below. The major source of information were reported as mothers in 55.6% of the cases followed by female friends in one third of the cases. In about 18.7% of the cases, the information was received by teachers and sisters of the respondents. About one fourth (22.7%) of the respondents reported that they had received this information from Kishori Panchayats. The proportion was similar across the sectors.

Table 5.5: Sources of information to adolescents on menstruation

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Mother	67	59.8	88	59.5	65	47.8	220	55.6
Sister	21	18.8	26	17.6	24	17.6	71	17.9
Girl friend	33	29.5	47	31.8	53	39.0	133	33.6
Teacher	16	14.3	25	16.9	33	24.3	74	18.7
Relatives	9	8.0	11	7.4	16	11.8	36	9.1
Books	3	2.7	2	1.4	5	3.7	10	2.5
CLICS Doots	11	9.8	15	10.1	10	7.4	36	9.1
Kishori Panchayat	25	22.3	33	22.3	32	23.5	90	22.7

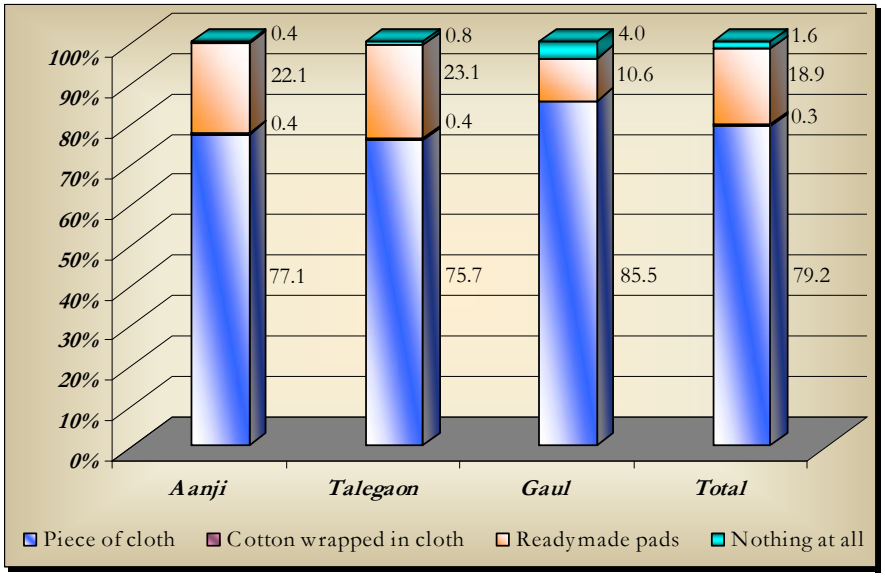
	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Other	26	23.2	24	16.2	16	11.8	66	16.7
Total	112	100.0	148	100.0	136	100.0	396	100.0

Base: All adolescent girls in the age group 12-19 who started menstruating and received information on the same
Multiple response question, Totals would not add to 100%

5.2 Menstrual Hygiene

The respondents who had started menstruating were asked questions regarding the practices during menstruation. Firstly they were asked what they used during their periods. About four fifth of the respondents (79.2%) reported that they used a piece of cloth. The proportion was highest in Gaul at 85.5% and lowest in Anji at 77.1%. About 18.9% of the respondents reported that they used readymade pads, and this proportion was highest in Anji at 22.1% and lowest in Gaul at 10.6%. Less than 2% respondents reported that they used nothing during their periods.

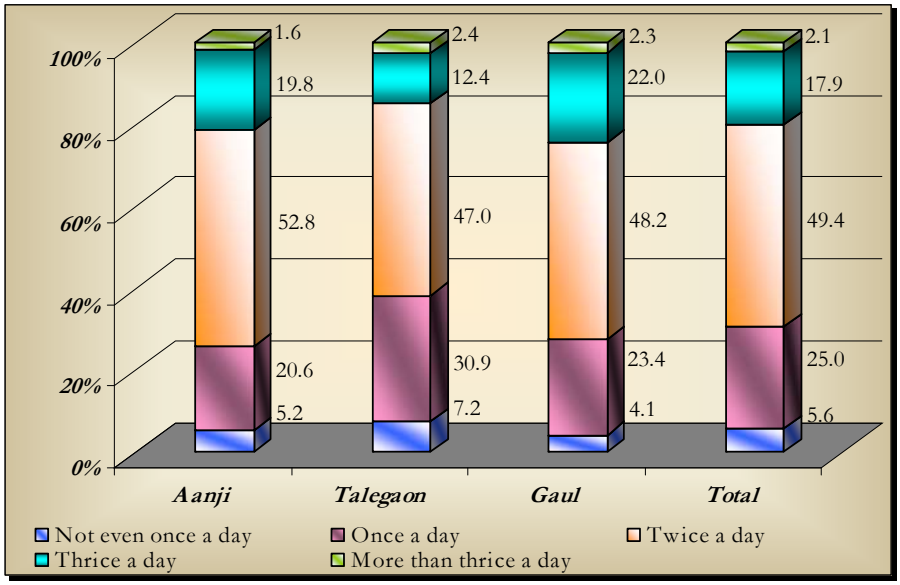
Figure 5.1: Practices during menstruation among adolescents



Base: All adolescent girls in the age group 12-19 who started menstruating

The respondents who reported using piece of cloth, cotton or readymade pads were asked how often they changed the same. About half (49.4%) of the respondents reported that they changed the same twice a day and 25.0% percent reported changing once a day. Nearly one fifth of the respondents reported changing the same more than twice a day. Further, there were 5.6% respondents who did not change the cloth, readymade pad or cotton even once a day.

Figure 5.2: Frequency of changing cloth/pads during menstruation as reported by adolescents



Base: All adolescent girls in the age group 12-19 who started menstruating and used something during periods

The respondents who used a piece of cloth, cotton or readymade made pads during the periods were also asked about the reusability of the same. About 42.7% of the respondents reported that they reused it while 53.1% reported that they destroyed it. However, 4.5% of the respondents reported that they throw it or dispose it. The proportions were similar across the sectors.

Table 5.6: Practice regarding reuse of cloth/pads used by adolescents during menstrual flow

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Reuse it	117	46.4	89	35.7	101	46.3	307	42.7
Throw the cloth /dispose the sanitary pad	12	4.8	15	6.0	5	2.3	32	4.5
Burn or bury cloth / sanitary pad	123	48.8	147	59.0	112	51.4	382	53.1
Total	252	100.0	249	100.0	218	100.0	719	100.0

Base: All adolescent girls in the age group 12-19 who started menstruating and used something during periods

Adolescents who reused the cloth or pads were asked about whether the cloth was washed. It was found that 96.7% of the respondents reported that they washed the cloth with water along with soap.

Table 5.7: Practice of washing cloth/pads used by adolescents during menstrual flow

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Plain water	3	2.6	1	1.1	1	1.0	5	1.6
Soap and water	111	94.9	86	96.6	100	99.0	297	96.7
Dettol / Savlon/ other antiseptics	3	2.6	4	4.5			7	2.3
Total	117	100.0	89	100.0	101	100.0	307	100.0

Base: All adolescent girls in the age group 12-19 who started menstruating and reused something during periods

They were further probed about the location where they dried the cloth. It was found that 78.2% of the responded dried the pads in sun before reusing whereas the remaining dried it elsewhere.

Table 5.8: Practice of drying cloth/pads used by adolescents during menstrual flow

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
In the sun	92	78.6	63	70.8	85	84.2	240	78.2
In the shade	27	23.1	26	29.2	17	16.8	70	22.8
Others (specify)	1	0.9					1	0.3
Total	117	100.0	89	100.0	101	100.0	307	100.0

Base: All adolescent girls in the age group 12-19 who started menstruating and washed cloth or pad during periods

5.3 Exposure to Family Life Education/Health Education

The CLICS programme also promotes family life education by conducting sessions in the Kishori Panchayats. All the respondents were asked if they had attended any such session in the past. About two-fifth of the respondents (38.7%) reported that they had attended such a session in the past. The proportion was highest in Gaul at 43.6% and lowest in Anji at 30.8%.

Table 5.9: Attended family life education

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Received family life education	92	30.8	131	41.3	136	43.6	359	38.7
Did not receive family life education	207	69.2	186	58.7	176	56.4	569	61.3
Total	299	100.0	317	100.0	312	100.0	928	100.0

Base: All adolescent girls in the age group 12-19

Knowledge and practices among adolescents

The discussions with the Kishori Panchayat members revealed that Anemia amongst the adolescent girls was one of the major problems in the community. The girls were found to be aware that anemia in them could lead to unclear vision, convulsions, general weakness etc.

Personal hygiene was also discussed with the members. It was found that all the girls were aware about the hygiene practices that were required during menstruation. The girls reported that majority of the girls were aware that usage of sanitary pads is the most hygienic practice during menstruation, but the most common practice in the community was to use cloth and cotton. These in most cases were reused after washing and changed three to four times in day.

The girls also informed that CLICS programme had contributed to better hygienic practices amongst them as, campaigns for awareness about hygienic practices had been carried out by both the project officials and the Kishori Panchayat members themselves.

Chapter 6
Child Spacing and Family Planning

It is a well known fact that most women would like to space the birth of their children, unfortunately though they are forced to depend on the traditional methods of birth spacing. These often fail as a large number of women are not able to effectively assess their safe periods, thereby leading to unwanted pregnancies.

Realising that a gap of 2-3 years in the birth of children significantly increases the chance of the survival of the child and good health of the mother, the CLICS programme has aimed at promoting family planning in the target area. Among the other community based distributed products, the CLICS Doots also promoted community based distribution of spacing aids.

This chapter aims at assessing the knowledge and the family planning practices of the target groups in the project area.

6.1 Knowledge and Awareness About Contraceptives

The women respondents were asked about their knowledge about the methods to prevent or delay pregnancy. The results are presented in the table below. All respondents were aware of at least one method of contraception. More than three-fourth (77.4%) of the respondents were aware of more than two methods of contraception. The proportion was highest in Talegaon at 83.6% and lowest in Anji at 67.0%. About 15.9% of the respondents were aware of two methods of contraception (Anji – 24.8%, Talegaon – 12.6%, Gaul – 10.6%). Only 6.6% of the respondents reported that they were aware of only one method of contraception.

Table 6.1: Awareness levels among women of methods to avoid or delay births

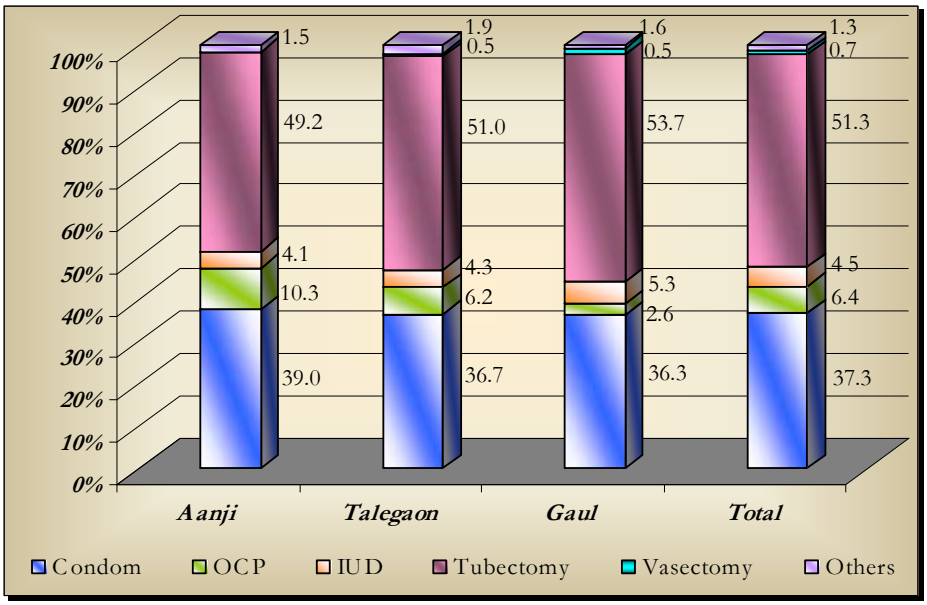
	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Aware of 1 method	25	8.3	12	3.8	24	7.9	61	6.6
Aware of 2 methods	75	24.8	40	12.6	31	10.6	146	15.9
Aware of more than 2 methods	203	67.0	265	83.6	246	81.5	714	77.4
Total	303	100.0	317	100.0	301	100.0	921	100.0

Base: Women with a child in the age group 0-36 months

The women respondents were then asked about the methods of avoiding or delaying pregnancies that they were aware of. It was found that women named spacing methods more often than the permanent methods of contraception. 88.5% of women mentioned condoms as a family planning method whereas 84.9% mentioned oral contraceptives.

Tubectomy was mentioned by 70% of the respondents whereas only 5.6% mentioned vasectomy as a method to space or avoid pregnancy.

Figure 6.1: Awareness among women about various contraceptive methods



Base: Women having child aged 0-23 months

The adolescent girls who were aged between 16-19 years were asked if they were aware of any methods of contraception. About 36.0% of the respondents reported that they were aware of two or more methods to delay or prevent pregnancy. Across the sectors, the proportion was highest in Gaul at 44.7% and lowest in Talegaon at 30.6%. About 17.8% of the respondents reported that they were aware about one method of contraception while 45.7% reported that they were aware of none.

Table 6.2: Awareness among adolescents about contraceptive methods

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Not Aware	71	54.6	59	44.0	55	39.0	185	45.7
Don't know/cant say	0	0.0	2	1.5	0	0.0	2	0.5
Aware of one method	17	13.1	32	23.9	23	16.3	72	17.8
Aware of two or more methods	42	32.3	41	30.6	63	44.7	146	36.0
Total	130	100.0	134	100.0	141	100.0	405	100.0

Base: All adolescent girls in the age group 16-19 years

6.2 Contraception Usage

The women interviewed in the Endline survey were also asked if they or their spouses were currently using any methods to prevent or delay pregnancy and the results are presented in the table below. About two-thirds of the respondents reported that they were currently using some family planning method. The proportion was reported to be highest in Talegaon at 66.2% and lowest in Gaul at 62.9%.

Table 6.3: Current usage of spacing and termination methods

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Currently using	195	64.4	210	66.2	189	62.8	594	64.5
Currently not using	108	35.6	107	33.8	112	37.2	327	35.5
Total	303	100.0	317	100.0	301	100.0	921	100.0

Base: Women with a child aged 0-36 months

The table below gives us the bifurcation of different modes of spacing and termination that are being used in the project area. Overall, 52% of the current users reported that they had opted for a permanent family planning method. Whereas, 48.2% of the current users were using a combination of condoms, OCPs and IUDs. The usage of condoms was reported to be the highest followed by OCPs among the modern spacing methods.

Table 6.4: Reported usage of different types of spacing and termination methods

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Condom	76	39.0	77	36.7	68	36.3	221	37.3
OCP	20	10.3	13	6.2	5	2.6	38	6.4
IUD	8	4.1	9	4.3	10	5.3	27	4.5
Tubectomy	96	49.2	107	51.0	102	53.7	305	51.3
Vasectomy	0	0.0	1	0.5	3	1.6	4	0.7
Others	3	1.5	4	1.9	1	0.5	8	1.3
Total	195	100.0	210	100.0	189	100.0	594	100.0

Base: Women having children aged 0-36 months and reportedly using spacing or termination method

6.3 Birth Spacing Practices

The details of the children born to the respondents were also collected from the mothers of children aged less than 23 months. Of the children aged less than 23 months who had an elder sibling, 76.1% had a gap of more than 24 months with the elder sibling. Thus it is observed that in more than 76% of the cases, a birth interval of at least two years was maintained. This proportion was observed to be highest in Talegaon at 80.8% across the sectors.

Table 6.5: Children born at least 24 months after the previous surviving child

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Child aged (0-23) and had elder sibling and gap of less than 24 months	23	23.7	24	19.2	35	28.9	82	23.9
Child aged (0-23) and had elder sibling and gap of 24 or more months	74	76.3	101	80.8	86	71.1	261	76.1
Total	97	100.0	125	100.0	121	100.0	343	100.0

Base: Women with children aged 0-23 months and having an elder sibling

Similarly, the details of the children born to the respondents with the youngest child in the age group 0-35 months were analysed. Of the children having an elder sibling, it was found that 38.3% had a gap of more than 36 months. Thus, it can be said that 38% of the children with an elder sibling had a gap of three years between them. The proportion was again found to be highest in Talegaon sector at 39.88 %.

Table 6.6: Children born at least 36 months after the previous surviving child

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Total number of respondents (0-35 months) who reported an elder sibling less than months older	85	60.71	98	60.12	107	64.07	290	61.70
Total number of respondents (0-35 months) who reported an elder sibling more than months older	55	39.29	65	39.88	60	35.93	180	38.30
Total	140	100.0	163	100.0	167	100.0	470	100.0

Base: Women with children aged 0-35 months and having an elder sibling

Chapter 7

Knowledge and Practices on RTI and HIV/AIDS

HIV/AIDS is fast emerging as one of the most formidable challenge for the health policy makers. It has been estimated that unlike our earlier believes, the HIV virus has spread considerably in the rural areas and among women and children.

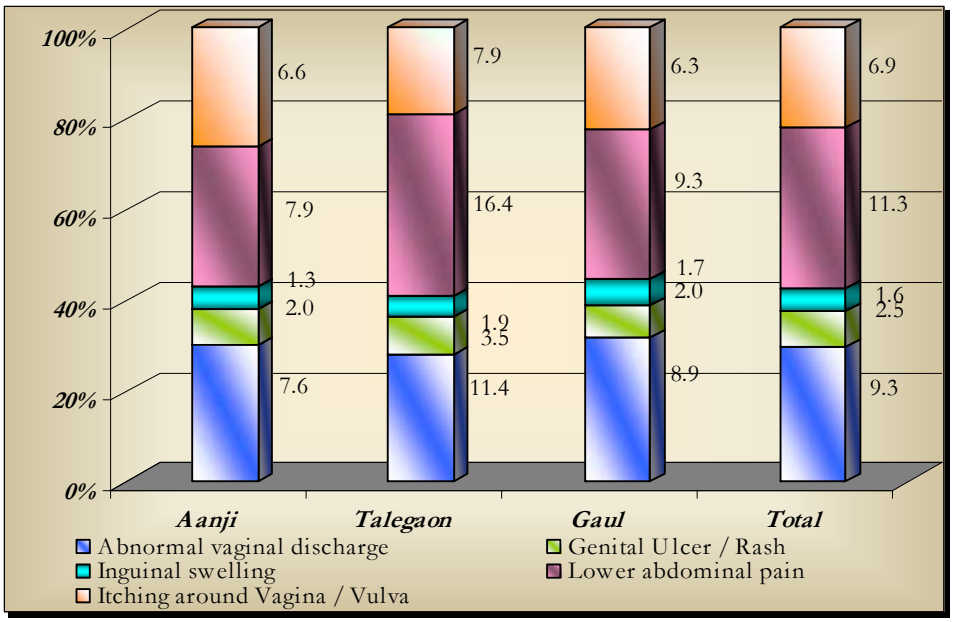
Similarly, the prevalence of reproductive Tract Infections too has been very high in the rural areas. This has been so as in most cases these infections in most cases go undetected. Even in cases where they are detected, treatment from a trained practitioner is very rarely sought. Apart from these issues, it has been observed that even when RTIs are treated, the spouse is often not treated for the same nor is any safe sex practice followed. Thus, the infection returns to the couple even after adequate treatment. Another context of looking at the prevalence of RTI in the Maharashtra is that apart from affecting the fertility of an individual RTIs also make him vulnerable to contracting HIV/AIDS relatively easily.

This chapter aims at assessing the knowledge and practices associated with RTIs and HIV/AIDS in the project area.

7.1 Incidence of RTIs and its Management

During the survey it was found that 11.3% of the women having a child in the age group of 0-36 months reported that they had suffered from lower abdominal pain and 9.3% reported abnormal vaginal discharge. These can be symptoms of RTIs, which if untreated can emerge as a severe problem. Talegaon among the three sectors shows a higher incidence of these symptoms among women of reproductive age.

Figure 7.1: Incidence of RTI's among women



Base: Mothers of children aged 0-36 months

It has been found that 21.2% of the women with a child 0-36 months reported that they had experienced a symptom of RTI. Among the three sectors, Talegaon had the highest proportion of the respondents who reported that they had suffered a symptom of RTIs, whereas Anji reported the lowest proportion.

Table 7.1: Women who reported at least one symptom of RTI

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Women who had at least one symptom of RTI	48	15.8	84	26.5	63	20.9	195	21.2
Total	303	100.0	317	100.0	301	100.0	921	100.0

Base All women with a child aged 0-36 months

Further those respondents who reported that they had suffered from a RTI symptom were asked if they had availed any treatment. It was found that 50.8% of the respondents who had suffered an RTI symptom had availed treatment from a skilled health service provider. Among the three sectors this behavior was found to be more in Anji and Talegaon where 54.2% and 54.8% of the respondents having symptoms of RTIs reportedly availed the services of a skilled health provider. This was considerably lower in Gaul where only 42.9% of the respondents with symptoms of RTIs availed the services of a skilled health service provider.

Table 7.2: Treatment of RTIs among women

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Availed treatment from skilled provider	26	54.2	44	52.4	27	42.9	97	49.7
Total	48	100.0	84	100.0	63	100.0	195	100.0

Base: Mothers of children aged 0-35months who report a symptom of STI

It was found that 16.2% of the women, who had availed any treatment for a symptom of RTI, reported that their spouse had also been treated by a skilled health provider for the symptoms of RTIs.

Table 7.3: Treatment of spouse from skilled provider

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Spouse availed treatment from skilled provider	3	11.54	7	15.91	6	22.22	16	16.49
Total	26	100.0	44	100.0	27	100.0	97	100.0

Base: Mothers of children aged 0-35months who report a symptom of STI

7.2 Awareness about HIV/AIDS

Among the male respondents, 7.3% of the respondents reported that they were not aware of HIV/AIDS and this proportion was highest in Gaul at 10.1%. The respondents, who reported that they have heard about HIV/AIDS, were asked about the methods of prevention of the same. 72.2% of the respondents were able to mention at least two ways of preventing HIV/AIDS. This proportion was highest in Anji at 78.8% and lowest in Gaul at 65.7%. About 5% of the respondents who had heard about HIV/AIDS were not able to mention any ways to prevent it.

Table 7.4: Men who were aware of at least ways of protection from HIV/AIDS

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Don't Know/ Cant Say	16	4.8	9	2.9	27	9.4	52	5.6
Aware of less than 2 modes of prevention	34	10.3	63	20.0	42	14.7	139	14.9
Aware of at least 2 modes of prevention	260	78.8	224	71.1	188	65.7	672	72.2
Total	310	93.9	296	94.0	257	89.9	863	92.7

Base: Men with children aged 0-35 months who have heard of HIV/AIDS

Men who were aware about HIV/AIDS were further probed about the modes of transmission of HIV/AIDS. It was found that 93.5% of the respondents felt that HIV/AIDS is transmitted through unprotect sex and 92.2% of the respondents were of the view that it could be transmitted through transfusion of infected blood.

It was observed that the knowledge about the transmission of HIV/AIDS from mother to child was relatively lower as compared to other modes among the respondents. It was though found that a significant number of respondents felt that HIV/AIDS could be transmitted through mosquito bites and shaking hands with HIV positive persons.

Table 7.5: Awareness among men on different modes of transmission if HIV/AIDS

	Anji	Talegaon	Gaul	Total

	N	%	N	%	N	%	N	%
Unsafe sex/ unprotected sex	289	93.2	289	97.6	229	89.1	807	93.5
Transfusion with infected blood/ blood products	278	89.7	286	96.6	232	90.3	796	92.2
From HIV positive pregnant mother to her baby	263	84.8	268	90.5	212	82.5	743	86.1
Use of unsterilized needle/ syringe	279	90.0	277	93.6	213	82.9	769	89.1
From breast milk of HIV positive mother to her baby	226	72.9	243	82.1	183	71.2	652	75.6
From mosquito bite	43	13.9	56	18.9	44	17.1	143	16.6
By shaking hands with HIV positive person	24	7.7	39	13.2	32	12.5	95	11.0
Others	23	7.4	17	5.7	51	19.8	91	10.5
Total	310	100.0	296	100.0	257	100.0	863	100.0

Base: Men who had heard of HIV/AIDS

Men who had reported that they were aware about HIV/AIDS were asked about the source of their information. It was found that 80.4% of the respondents had received information from TV/Film. Only 6.0% of the respondents reported that they had received information on HIV/AIDS from the CLICS Doot, whereas 7.3% reported that the community organizer of the CLICS programme had provided them with information on HIV/AIDS. It was found that about 60.7% of the men reported that doctors had provided them with the information on HIV/AIDS.

Table 7.6: Source of information about HIV/AIDS among male respondents

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Radio	84	27.1	94	31.8	114	44.4	292	33.8
TV/Film	256	82.6	265	89.5	173	67.3	694	80.4
Newspaper / Magazine / Journal	66	21.3	84	28.4	50	19.5	200	23.2
Debate / Seminar	34	11.0	35	11.8	31	12.1	100	11.6
Signboards / Poster	57	18.4	62	20.9	31	12.1	150	17.4
Relative / Friends / Wife	106	34.2	120	40.5	134	52.1	360	41.7
Doctor	175	56.5	174	58.8	175	68.1	524	60.7
ANM / LHV/ HW	3	1.0	4	1.4	1	0.4	8	0.9
Social Worker	29	9.4	11	3.7	8	3.1	48	5.6
Community Organizer (CLICS)	35	11.3	17	5.7	11	4.3	63	7.3
Self Help Group (SHG)	7	2.3	20	6.8	1	0.4	28	3.2
CLICS Doot	38	12.3	6	2.0	8	3.1	52	6.0
Informed in camp	8	2.6	18	6.1	12	4.7	38	4.4
Don't know/Don't remember	2	0.6	0	0.0	0	0.0	2	0.2
AIDS training	1	0.3	0	0.0	0	0.0	1	0.1
Writings on walls	1	0.3	2	0.7	1	0.4	4	0.5
Educational camps/School camps	3	1.0	3	1.0	6	2.3	12	1.4
Progarmme in a train compartment	0	0.0	1	0.3	0	0.0	1	0.1
Informed by a person with HIV/AIDS	0	0.0	1	0.3	2	0.8	3	0.3

Base: Men who had heard of HIV/AIDS

Overall, 8.9% of the women who were mothers of children aged 0-35 months reported that they were not aware of HIV/AIDS and this proportion was highest in Gaul (11.6%). The respondents, who reported that they have heard about HIV/AIDS, were asked about the methods of prevention and 59.3% of the respondents were able to mention at least two ways of preventing HIV/AIDS. This proportion was highest in Talegaon (66.7%) and lowest in Gaul at 50.2%.

Table 7.7: Awareness among women about the methods of preventing HIV/AIDS

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
At least one response	39	13.1	39	12.4	64	21.4	142	15.6
At least 2 response	110	36.9	98	31.1	86	28.8	294	32.2
More then 2 response	71	23.8	112	35.6	64	21.4	247	27.1
No response	78	26.2	66	21.0	85	28.4	229	25.1
Total	298	100.0	315	100.0	299	100.0	912	100.0

Base: Mothers of children aged 0-35 months

The women who had reported that they were aware of HIV/AIDS were further asked about the ways that HIV/AIDS could be transmitted. Over 91.9% of the respondents were of the view that HIV/AIDS could transmit through unprotected sex. This was also found to be the most recognized mode of transmission of HIV/AIDS among the respondents. It has also been found that there was a high level of awareness about transmission through blood transfusion (89.4%) and use of unsteralised needles (89.5%). The awareness about transmission of the HIV/AIDS from mother to child through breast feeding was found to be the lowest at 75.6%.

It was also found that about 16.3% of the respondents felt that HIV/AIDS could be transmitted through mosquito bite and about 8.0% felt that it could be transmitted by shaking hands. This indicates that though a majority of the women are aware of the different modes of transmission of HIV/AIDS, there are still a large number of women who still harbor myths about it.

Table 7.8: Awareness among women on different modes of transmission if HIV/AIDS

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Unsafe sex/ unprotected sex	254	91.4	282	95.6	236	88.4	772	91.9
Transfusion with infected blood/ blood products	240	86.3	275	93.2	236	88.4	751	89.4
From HIV positive pregnant mother to her baby	235	84.5	259	87.8	235	88.0	729	86.8
Use of unsterilized needle/ syringe	251	90.3	263	89.2	238	89.1	752	89.5
From breast milk of HIV positive mother to her baby	213	76.6	215	72.9	207	77.5	635	75.6
From mosquito bite	39	14.0	54	18.3	44	16.5	137	16.3
By shaking hands with HIV positive person	22	7.9	19	6.4	26	9.7	67	8.0
Others	2	0.7	4	1.4	6	2.2	12	1.4
Total	278	100.0	295	100.0	267	100.0	840	100.0

Base: Women who had heard of HIV/AIDS

Women who were aware of HIV/AIDS were further asked about their source of information. It was found that 77.7% of the respondents had come to know about HIV/AIDS from TV/films. This was followed by doctors (69.1%) and radio (35.0%).

About 21.6% of the women interviewed reported that they had been briefed about HIV/AIDS by the CLICS Doot.

Table 7.9: Source of information among women on HIV/AIDS

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Radio	71	25.8	120	41.2	99	37.6	290	35.0
TV/Film	221	80.4	240	82.5	183	69.6	644	77.7
Newspaper / Magazine / Journal	30	10.9	36	12.4	24	9.1	90	10.9
Debate / Seminar	21	7.6	25	8.6	15	5.7	61	7.4
Signboards / Poster	69	25.1	72	24.7	44	16.7	185	22.3
Relative / Friends / Husband	63	22.9	55	18.9	46	17.5	164	19.8
Doctor	190	69.1	200	68.7	183	69.6	573	69.1
ANM / LHV/ HW	34	12.4	32	11.0	51	19.4	117	14.1
Social Worker	11	4.0	10	3.4	11	4.2	32	3.9
Community Organizer (CLICS)	5	1.8	3	1.0	3	1.1	11	1.3
Self Help Group (SHG)	15	5.5	24	8.2	15	5.7	54	6.5
CLICS Doot	69	25.1	70	24.1	40	15.2	179	21.6
Others	39	14.2	39	13.4	36	13.7	114	13.8
Total	278	100.0	295	100.0	267	100.0	840	100.0

Base: Women who had heard of HIV/AIDS

Among the adolescent girls interviewed for the survey in the age group of 16-19 years, 13.6% reported that they were not aware of HIV/AIDS. The respondents, who reported that they have heard about HIV/AIDS, were asked about the methods of prevention and 66.2% of the respondents were able to mention at least two ways of preventing HIV/AIDS. This proportion was highest in Anji (70.8%) and lowest in Gaul at 61.7%. About 9.4% of the

respondents reported that although they had heard about HIV/AIDS, but were not aware about any prevention methods.

Table 7.10: Awareness among adolescents about methods of preventing HIV/AIDS

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Not heard of HIV/AIDS	20	15.4	15	11.2	20	14.2	55	13.6
Aware of less than two prevention modes	8	6.2	17	12.7	19	13.5	44	10.9
Aware of at least two prevention modes	92	70.8	89	66.4	87	61.7	268	66.2
Don't know/Cant say	10	7.7	13	9.7	15	10.6	38	9.4
Total	130	100.0	134	100.0	141	100.0	405	100.0

Base: Adolescents in the age group 16-19 years

The respondents who were aware about HIV/AIDS were further asked about the modes of transmission of the virus. It was found that 94.9% of the respondents felt that HIV/AIDS could be transmitted through infected blood transfusion whereas 93.7% of them reported that HIV/AIDS could spread through unsteralized needles. It was observed that transmission through unsafe sex was reported by 89.7% of the respondents, which is considerable less when compared to the responses received from women.

Table 7.11: Awareness among adolescents on different modes of transmission of HIV/AIDS

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Unsafe sex/ unprotected sex	99	90.0	111	93.3	104	86.0	314	89.7
Transfusion with infected blood/ blood products	106	96.4	116	97.5	110	90.9	332	94.9
From HIV positive pregnant mother to her baby	101	91.8	101	84.9	108	89.3	310	88.6
Use of unsterilized needle/ syringe	100	90.9	114	95.8	114	94.2	328	93.7
From breast milk of HIV positive mother to her baby	85	77.3	99	83.2	95	78.5	279	79.7
From mosquito bite	14	12.7	15	12.6	15	12.4	44	12.6
By shaking hands with HIV positive person	14	12.7	10	8.4	12	9.9	36	10.3
Others	3	2.7	4	3.4	4	3.3	11	3.1
Total	110	100.0	119	100.0	121	100.0	350	100.0

Base: Adolescents who had heard of HIV/AIDS

It was observed that a significant number of respondents reported that HIV/AIDS could be transmitted through mosquito bite and by shaking hands with an HIV/AIDS infected women. Thus, again it is observed that there are still myths associated with the transmission of HIV/AIDS, which need to be removed.

The adolescent respondents were also asked about their source of information on HIV/AIDS. It has been observed that though mass media medium of Radio and TV and film emerge as the highest reported source of information, their proportion is lower when compared to the responses among women and men. Instead, kishori panchayat and school teachers have emerged as one of the major sources of information.

Table 7.12: Source of information of HIV/AIDS for adolescents

	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Radio	42	38.2	27	22.7	41	33.9	110	31.4
TV/Film	85	77.3	90	75.6	59	48.8	234	66.9
Books/ Newspaper / Magazines	16	14.5	18	15.1	20	16.5	54	15.4
Debate / Seminar	10	9.1	5	4.2	5	4.1	20	5.7
Signboards / Poster	12	10.9	13	10.9	13	10.7	38	10.9
Friends / Parents / Relatives	17	15.5	48	40.3	36	29.8	101	28.9
Doctor	32	29.1	36	30.3	35	28.9	103	29.4
School/Teacher	67	60.9	74	62.2	84	69.4	225	64.3
Kishori Panchayat	30	27.3	46	38.7	46	38.0	122	34.9
Community Organizer (CLICS)	5	4.5	5	4.2	8	6.6	18	5.1
Self Help Group (SHG)	2	1.8	1	0.8	10	8.3	13	3.7
CLICS Doot	16	14.5	11	9.2	8	6.6	35	10.0
Others (specify	8	7.3	3	2.5	3	2.5	14	4.0
Don't remember/Can't say	0	0.0	0	0.0	2	1.7	2	0.6
Total	110	100.0	119	100.0	121	100.0	350	100.0

Base: Adolescents who had heard of HIV/AIDS

Chapter 8
Findings from Qualitative Discussions

The qualitative component of the study was carried out with the objective of exploring various social and cultural aspects that would influence the practices and behaviors related to child survival and maternal health. Apart from this the qualitative survey also aimed at developing an understanding of the attitudes and behaviors and the knowledge of health service providers associated with the CLICS programme.

Focus Group Discussion and in-depth Interviews were to collect qualitative information from the community. Checklists and structure interview schedules were developed to guide the qualitative data collection process. FGDs in the field were carried out among 8-10 people and the discussion was recorded by an observer sitting in the group. In-depth interviews with the Panchayat representatives, Anganwadi workers, Click Doots and the private practitioners were carried out by the qualitative data collection team, whereas the facility survey was carried out by the MGIMS team of qualified doctors.

This chapter aims at bringing to the fore the perception of various groups and individuals who have been associated with the CLICS programme and may play an important role in ensuring the sustainability of the project activities.

8.1 Qualitative Discussions with Community Based Organisations

8.1.1 Discussions with Members of the Kisan Vikas Manch

During the discussions it emerged that the farmers groups were formed with help of the Community Organizer and the CLICS Doot. The idea of forming a group was floated by them and individuals were organized to form a group. All the KVM's have a president, vice president and a secretary who were elected in consultation with group members. The KVM regularly meets every month to save money and for disbursal of loans. The group in its meetings discusses agriculture related issues such as irrigation and different varieties of improved seeds. Some of the members of the KVM have taken up loans and initiated income generation activities.

Environmental Sanitation

During the discussion the KVM members, it emerged that a large number of households still lacked toilets and defecation was still done in the open field. As per the KVMs this was a major problem. Non-availability of community toilets was a major problem, which was adversely affecting the village environment and creating major environmental issues. However, the members also mentioned some of their achievements; they felt that the drainage system in the village had improved with their efforts, they had also played an important role in ensuring tap water in the villages and had also along with Panchayat members ensured better cleanliness in the villages.

Role of husband in reproductive health

All KVM members agreed that Men had an important role to play in the reproductive health. The KVM members were of the view that it was the husband's responsibility to take their spouse for regular check ups during pregnancy. They should also ensure that timely medicines were provided and consumed and all arrangements for the delivery were made in advance. The KVM members felt that it was the husband's responsibility to inform the ANM or mid-wives about the delivery and arranging for conveyance and money for delivery. The KVM members were of the view that providing nutritional food to pregnant women was also the responsibility of the husband. The members also felt that the delivery should take place in a hospital.

Swollen feet, high blood pressure, nausea and convulsions were the common danger signs during pregnancies that emerged from the discussions. Most of the KVM members were aware of the postnatal care practices to be followed. The members were of the view that regular check-ups of both mother and child must be conducted after the birth. They also pointed out that the CLICS Doot played an important role in ensuring that these services were availed by mothers and often accompanied them to health facilities.

Preparation of delivery

From the various discussions with KVM members it emerged that most of the current deliveries were carried out in the health institutions. The respondents further reported that in case of any complication in delivery conducted at home the mother is immediately taken to a hospital after that for a check-up. From the discussions, it also emerged that money and a mode of transport were the two most important things to be done before a delivery. In some cases it was also mentioned that the ANM or a dai should also be informed about the delivery.

Newborn care

During the discussion the KVM members were assessed on their knowledge level for newborn care. Most of the KVM members reported that the child should be wrapped in warm and clean clothes immediately after the delivery. The child should be given bath after 3 days and regular massage should be done. The KVM members also reported of regular growth monitoring of the newborn and visit to primary health facilities in case the child suffers form diarrhea, pneumonia and neonatal jaundice.

Breast feeding

Most of the KVM members were of the view that breast feeding the child should be initiated within 1 hour of the delivery and exclusive breast feeding should continue for at least 4-6 months.

Family planning methods

From the discussions with the KVM members it emerged that they were aware of the family planning methods. The common family planning methods mentioned by the respondents were male sterilization, female sterilization, condoms, pills and copper T. As per the members, female sterilization was the most common method used in the villages. They were of the view that the *CLICS Doot* and campaigns on the Television were the main source of family planning methods. It emerged from the discussion that earlier a couple use to opt for sterilization after the birth of 3-4 children, but currently sterilization was carried out after 3 to 5 births only, but nowadays female sterilization is being after the birth of the second child.

CLICS Doot

Most of the KVM members reported that the *CLICS Doot* works in the village on health related issues and impart information to pregnant mothers. The *CLICS Doot* also accompanies them for regular visits to health facilities, insist on regular health check ups, get names of pregnant ladies registered and assists them in availing health card.

Role of VCC

During the discussion with the KVM members they were asked to state their perception on the role of the VCC. According to most of the members the VCC monitors the functioning of the SHG, KVM and Kishori Panchayat. The KVM members further were of the view that VCC is responsible for carrying out awareness campaigns in the village on health and nutrition of pregnant mothers, 0 to 3 years aged children and adolescent girls. The VCC coordinates with the gram Panchayat for cleanliness activities in the village and supervises the activities carried out by the *CLICS Doot.*

8.1.2 Kishori Panchayats

Kishori Panchayat according to its young members were formed under the CLICS programme mainly to develop a platform for the adolescent girls of the community to come and learn and share. The group comprised of girls of the age group of 12-19 years which comes together through regular meetings to share and impart information related to adolescent's health and nutrition. Apart from this representative of the Kishori Panchayat were members of the village coordination committee and contributed towards the overall health and well being of village.

"These girls are the mothers for tomorrow and giving information related to their health and nutrition, mother and child's health and nutrition will make them aware for the future. This will further help in reducing the infant and maternal mortality rate."

- Village Salod (Hirapur), Sector Talegaon

Age at marriage

In all the Kishori Panchayts it was found that the members were aware of the legal age of marriage for girls and that of boys. Most members felt that it was important for a girl to first

seek education and then marry. They were of the view that girls and boys are not physically and emotionally prepared to marry at an early age. They were of the view that in the current scenario only a few people would still get their daughters married at an early age. The girls were of the view that ideally marriage in cases of boys should be only after they are economically secure and in a position to support a family. They felt that girls should marry only after completing their education and reaching an age where they could support their family. Some of the Kishori Panchayat members were pursuing courses after completion of their 12 th standard to secure jobs.

Age of first pregnancy

The Kishori Panchayat members felt that the first pregnancy should be only after acquiring an age of 21 to 25 years. They felt that an early marriage would lead to long term health problems, which may even lead to the death of the infant or the mother.

Education of girls

In all Kishori Panchayats, members reported that there was a school till 12th class either within the village or in a nearby village. Education according to then was one of the most important tool for girls in becoming independent and gain self-confidence. Some of the members used to go to Wardha for pursuing courses of lab technician, pursue computer classes and beauty care courses. The members envisaged taking up jobs in future through education.

Anemia

The Kishori Panchayat members were aware of problem of anemia among adolescents. They reported anemia means convulsions, lower hemoglobin level, unclear vision etc. The members also reported that to cure anemia people should take nutritious food and iron tablets. The members reported some food items like peanuts, jaggery, green vegetables and fruit juices to be included in the diet of an anemic person. The members revealed that the adolescents in the village have less knowledge related to anemia. The Kishori Panchayat members also reported that the CLICS Doot goes door to door and provides iron tablets and information on anemia.

Personal and Menstrual hygiene

The Kishori Panchayat members were also asked to state their perception on personal hygiene. The members reported that taking bath daily using soap, cleaning of nails, keeping hair clean by regularly washing them and keeping the comb clean, wearing clean clothes and washing hands after defecation and before eating food are some common practices to be followed for personal hygiene. Also the members stated that taking care of cleanliness while cooking food, cooking vegetables after thoroughly washing them and drinking boiled water. The Panchayat members also reported that cleanliness prevents from diseases. The Kishori Panchayat members also reported that the CLICS programme has lead to a lot of changes in the village. They also stated that earlier adolescent girls were not aware of all the issues but with the help of the programme a lot of awareness campaigns have taken place.

It was observed that Kishori Panchayat members were aware about menstrual hygiene. The girls were aware that using sanitary pads was more hygienic but reported that majority of

girls used cloth during their menstrual flow. They reported that the cloth was changed at least three to four times in a day.

Most of the members reported that they had faced stomachache and backache during menstruation. The members also reported that majority of the respondents were not aware of the issues related to menstrual hygiene before the programme started in the village.

Antenatal care

The Kishori Panchayat members were also asked about the awareness regarding antenatal care. The members reported that pregnant ladies need to take a lot of care during pregnancy. They should not lift heavy weights and should not exert themselves much. The members were aware that pregnant mother's should get regular check ups done and visit the health facilities regularly. In most of the groups the members reported that pregnant women should take at least 100 IFA tablets and take nutritious food during their pregnancies. Most of the Kishori Panchayat members also accounted of arrangements to be made for delivery, like if planning a delivery at home than the ANM or mid-wife must be informed in advance. The Kishori Panchayat members were also aware of the danger signs. The most common danger signs that were mentioned were: high or low blood pressure, swelling in the feet and ankles, low hemoglobin, anemia and convulsions.

Natal care

The Kishori Panchayat members were asked about their perception regarding natal care also. According to the members the pregnant mothers should prefer delivery at health institutions as all services and facilities are available at the health institutions in case of complications in delivery. According to them deliveries in earlier days were mainly carried out at home, though this has considerably changed over the past few years. The members also reported that if the delivery is planned at home than all arrangements must be made well in advance.

Postnatal care

It was observed that Panchayat members were aware of the common practices to be followed after child's birth. The members reported that the child should be breast fed immediately after the delivery. They were also aware that a newborn baby should be exclusively breast fed for first six months. They felt that in their villages in some case this might not happen and the child may be given other food items after 4-5 months. The members were also aware of immunization, regular weighing of the child and monitoring of growth. The Kishori Panchayat members also felt that mothers should be provided with nutritious food during this period. The members further reported of protecting and taking necessary precautions to prevent the child from catching infections.

Breast feeding, weaning and supplementary feeding

During the discussion on breast feeding, weaning and supplementary feeding it was observed that most of the Kishori Panchayat members were aware about exclusive breast feeding for first 6 months and initiating with weaning foods only after 6 months. According to most of the Panchayat members, breast feeding should be continued for 2 years. The members were aware of different supplementary food like dal ka pani, khichhdi, suji halwa, vegetable and fruit juice, which can be provided as supplementary food to children.

CLICS doot

The Kishori Panchayat members were aware of CLICS Doot and its activities. The common activities reported by most of the members were distribution of iron tablets, imparting information related to health and nutrition of mother's and children aged between 0 to 3 years. The Kishori Panchayat members also accounted of conducting awareness campaigns on health issues of adolescents and also to make people aware of CLICS programme.

8.1.3 SHG groups for Women

SHGs have been formed in all the villages with about 15 to 20 members. In most of the villages are more than one SHG in a village and the groups meet to carry out thrift activities. The groups meet at least once every month and carry out their transactions. The SHG have office bearers who take the lead in organizing meeting and ensuring that the groups meet regularly. Though there are a large number of SHGs but these groups seldom meet together.

Age at marriage

When asked about the age at marriage, most of the SHG members reported that they are aware of the age at marriage specified by the government, 18 years for girls and 21 years for boys. According to the group members, in the current scenario girls in their villages are married only at an age above 18 years, whereas the age of marriage for boys is 25 to 28 years. It has though come out in some of the SHG discussions that in some communities, mainly tribal, girls and boys were married at a very young age. As per some of the group discussions this change has taken place in the recent years. The SHG members also reported an increase in the educational status of the villagers after the programme started in the village. The participants were of the view that girls should first be educated and then married. In all the groups it was raised by the group members that early marriage led to health problems at a later date and even death dues to early child bearing.

Antenatal care

The women in all the SHG groups were of the view that antenatal care has improved after the CLICS programme. In all group discussion the women felt that all pregnant women should

- Register themselves with a hospital for regular check-ups
- Have 100-200 IFA tablets
- Carry out regular tests

The women SHG members felt that blood tests, sonography, urine tests and blood pressure measurement should be regularly carried out.

The most common danger signs that were mentioned by the group members during the discussion were of swollen feet, high blood pressure, convulsions and excessive nausea during this period.

Natal care and danger signs

The SHG members also revealed that many women in the village are still getting deliveries done at home. The members though felt that it is better to get the delivery done in a hospital instead of getting it at home, as in a hospital doctors and nurses are always available for any help or assistance required. They were of the view that deliveries should though be carried out only by a trained attendant even if it was carried out at home. The SHG group members

felt that breast feeding should be initiated immediately after child birth and the first milk of the mother should especially be given to the child due to its nutritional value.

Postnatal care

As per the discussion with the SHG members, it was observed that most of the women were aware of the common practices to be followed after the child's birth. The members reported that the child should be breast fed immediately after the delivery and the child should be wrapped in warm, clean and soft cloth after delivery. In most of the discussion it emerged that that for first 6 months there should be exclusive breast feeding.

New born care, new born danger signs

The SHG members in most discussions felt that the new borne child should be kept warm and wrapped in a clean cloth. Diarrhea, pneumonia and jaundice were mentioned as the major danger signs. In some groups it emerged that low weight and malnourishment were also danger signs and must be treated carefully. The group members were of the view that if any of the danger signs were evident in a new born child then a medical service provider should be consulted immediately.

Breast feeding, weaning and supplementary feeding

The SHG members were asked about their perception on breast feeding and supplementary feeding also. In all the discussion it emerged that the child should be breast fed within the first hour after the delivery. Also the members reported that the child should be exclusively breast fed for the first 6 months after delivery. The SHG members revealed that earlier children were given honey or jaggery water, but now with an increase in the awareness the children are exclusively breast fed for 4-6 months.

Immunization

The SHG members reported that the children are given immunization at the Anganwadi centres. The common injections given to children were BCG, DPT and measles. Apart from this group members also mentioned that children should be provided with polio drops and Vitamin A doses along with the injections. It was informed that immunization of children was generally carried out on Bal Suraksha Diwas organized in the village.

Growth monitoring

As per the discussion with SHG members, most of them reported that the weight and height of the children are regularly monitored for monitored. It was informed that growth of the children was generally monitored on the Bal Suraksha Diwas by the CLICS Doot and the ANM.

Personal hygiene

The SHG members were asked to state their perception about personal hygiene. All the members agreed that personal hygiene was very important to ensure good health. The members reported that taking bath daily, cleaning of nails, brushing teeth daily, washing hands after defecation and before having food are the common practices that are followed. Use of soap or Ash was important after defecation. The group members informed that these practices are followed by most people in the villages. It emerged from the discussions in

some of the groups that boiling water or using chlorine drops and keeping our surroundings clean were also important to maintain good health

CLICS doot

All the SHG members in the discussions were aware of the CLICS Doot and the CLICS programme. They were generally happy with there work. According to the members the main role of the CLICS Doot was to provide information on health and nutrition of children aged 0 to 3 years, provide information on nutrition and antenatal care advice to pregnant ladies. In some of the groups it was mentioned that the CLICS Doot also imparted information on menstrual hygiene to adolescent girls and ensured that the children were immunized. The SHG members reported that CLICS Doot also imparts information on anti natal, natal and postnatal care among the community members.

Role of VCC

The SHG members were asked to report the role played by the VCC in the village. Most of the SHG members were aware of VCC and the common activities undertaken by the VCC reported by the SHG members were of information dissemination, carrying out on cleanliness drive in the villages and imparting information on RTIs and STIs to the adolescent girls.

Bal Suraksha Diwas (BSD)

The SHG members reported that Bal Suraksha Diwas takes place in the village every month. The common activities conducted during BSD were weight and height measurement of children and their immunization.

8.1.4 Village Coordination Committee (VCC)

The Village Coordination Committee (VCC) members comprises of members from Gram Panchayat, SHGs, Kishori Panchayat, Kisan Vikas Manch, Anganwadi workers, ANM and Sarpanch. The VCC members reported that VCC woks for various health related issues and others related issues such as cleanliness, environment and water supply in the village. The VCC meets on a regular basis, at least once a month to develop strategies and plans on health and related isses.

Linkage of VCC with other CBOs

As per the discussion with the VCC members on their linkage with other CBOs it emerged that in most cases, the VCCs work in coordination with the various CBOs existing in the village. The VCC members reported working with Kishori Panchayat on issues related to adolescent health, SHG groups on saving of the groups, optimum usage of money and help them in initiating an income generating activity. It also emerged that as VCC included members from all the forums, thus the linkage were also based the structure.

Improving health of villagers

VCCs were asked about their role in improving health of the villagers. It emerged that VCC in different villages had taken up different health related roles. Some of the VCCs had worked in close coordination with the Kishori Panchayats on adolescent health. Some had carried out cleanliness drives and others had helped in purchase of medicines.

Community based distribution system

It emerged from the discussions that contraceptive methods for both males and females were distributed through the system at very nominal cost as compared to the market price. It was observed that most of the VCC members were distributing iron tablets to pregnant ladies and adolescent girls. They also reported of giving '*Jeevan drops*' and ORS for children.

Supervision and monitoring of CLICS Doot

As per the VCC members, one of the major roles of the VCC was to monitor the role of the CLICS Doot. In all the groups it was found that the VCC members were satisfied with the performance of CLICS Doot. In some discussions, it emerged that the CLICS Doot was doing the best possible in the remuneration given by the project. To monitor the performance, it emerged that feedback from the community was taken about the quality of work done by her.

Achievements of VCC

The major achievements of the VCC that emerged from the discussions were as follows

- Development of *Gram Swasthya Kosh*
- Mobilising community under them on the health issue

Management of Village health fund

The gram swasthya kosh was managed by the VCC members. A fund was collected from the villagers to purchase low cost drugs, which were sold to the villagers at a cheaper rate. The revenue generated was reinvested for the purchase of medicines. The money collected was kept in the bank. The bank account was managed by three signatories.

Sustainability of activities

The VCC members felt that after the end of the programme, the programme activities would sustain. It emerged from one of the discussions that an attempt would be made to ensure that the Panchayats came forward to support VCC.

Linkage of VCC with other health care providers

Most of the VCC members reported working in coherence with ANM and doctors. Apart from this ANMs were also the members of the VCCs in each village and were suppose to be present during all its meetings.

8.2 Findings of the In-depth Interviews

8.2.1 In-depth Interviews with Anganwadi Workers

As a part of the survey, 15 Anaganwadi workers were randomly selected and interviewed to assess their knowledge and association with the CLICS programme.

Profile of the Anganwadi Worker:
It was found that the age of the Anganwadi workers interviewed varied from 27 to 54 years. Thirteen of them were resident of the village where they used to work. Their experience of working as an Anganwadi worker ranged from one to twelve years.

Association with the CLICS programme:
The Anganwadi workers interviewed were enquired if they had received any training under the CLICS programme. It was reported by eleven of the respondents they had participated in trainings provided by the programme whereas only four of the respondents reported otherwise. Nine of the respondents reported that they had received trainings on IMNCI, Newborn Care, ECCD, Malnutrition and RTI/STD whereas two of them reported to have received trainings only on IMNCI, Newborn Care and Malnutrition. All the respondents were satisfied with the quality of training provided to them by the CLICS programme and were of the view that the trainings provided to them were useful to them in their day to day work.

All the 15 respondents were of the view that there had been a change in the participation by parents in growth monitoring of children in their villages since the inception of the programme. Apart from that all the 15 respondents reported that the CLICS Doot used to provide support and help in carrying out their work in the village.

Participation in Village Level Activities:
Thirteen of the respondents reported that they participated in group activities in the villages. Six of the respondents reported that they were members of the Self Help Groups whereas five of them reported that they were members of the Gram Panchayat Committees, Mahila Mandals and VCC. The major roles played by them in these groups were reported to be that of mobilizing members for the meeting, maintaining the accounts and participate in the discussions.

Knowledge of the Respondents:
An attempt was made to assess the knowledge of the Anganwadi workers on various issues such as Nutrition, Safe motherhood, STI/RTI and HIV/AIDS.

Knowledge on Nutrition: All Anganwadi workers where enquired about the stages of life in which an individual required iron. It was reported by all 15 respondents that Adolescent girls and pregnant women required iron as it had special significance for them. Apart from this, thirteen respondents reported that children below the age 6 years and 10 respondents reported that lactating mothers require iron in their diet to maintain good health.

The respondents were further asked about the impact on adolescent girls due to lack of iron in their diet. It was found that most of the Anganwadi workers were able to enumerate at least three effects of lack of iron in adolescent girls. However, two of the respondents were not aware of any of the effects of lack of iron on the health of adolescent girls. Ten felt that iron deficiency could lead to Anemia among the adolescent girls whereas nine respondents reported that it may lead to weakness among the respondents.

The respondents were asked to enumerate food products that were rich in iron. It was found that eight of the respondents could identify two or more than two iron rich food items whereas six of them could identify one iron rich item and one of the respondents was not sure of any item that was rich in iron. Ten respondents reported green leafy vegetables as a source of iron, seven respondents reported jaggery and five respondents felt that eggs were rich in iron.

The respondents were asked about the stage of life when vitamin A had special significance. All except one respondent were aware of the impact of vitamin A deficiency. All other respondents were of the view that vitamin A was required by children who were less than six years. Four respondents also felt that vitamin A was required by adolescent girls whereas one respondent each felt that pregnant women and lactating females too required vitamin A rich food. The respondents were asked about the affect that vitamin A deficiency may cause among a child. It was reported by all respondents that vitamin A deficiency may cause night blindness among the children. Apart from this 4 respondents felt that it may cause diminution of vision and ulcers in the eyes of the child. The respondents were enquired about the food items that were rich in vitamin A. Fourteen of the respondents reported two or more food items that were rich in vitamin A. It was found that only one respondent was not aware of any item that was rich in vitamin A.

Knowledge of Reproductive Health: The respondents were asked about the age at which women should have her first child. It was found that responses ranged from 19 to 22 years. All respondents were able to enumerate at least two complications that were possible if a girl became pregnant before the age of 18 years.

The respondents were asked about their opinion on who was responsible to delay and avoid pregnancies. It was found that all respondents have reported that the wife and the husband were responsible for carrying delaying or avoiding pregnancies. In addition two respondents felt that ANMs were also responsible for avoiding or delaying of pregnancies among community members.

Knowledge of Safe Motherhood: All respondents were asked about the number of months at which women should get registered for antenatal check ups. The responses ranged from two to four months. It was observed that all but one respondent felt that women should register within three months of her pregnancy for antenatal check ups. The respondents were also asked about the minimum number of antenatal check ups that pregnant women should get. The responses of Anganwadi workers ranged from 3 to 9 check-ups.

The respondents were enquired about the examinations that should be done during an anti natal check up. All respondents were able to enumerate at least three examinations that should be carried out in an antenatal check up. Thirteen respondents felt that weight should be measured during an antenatal check up, whereas 12 of them reported that Blood

Pressure, Blood Test, Urine Test should be carried out during an antenatal check-up. One respondent each reported that HIV/AIDS test, Sonography and immunization should also be carried out during an Antenatal check up. The respondents were further probed about the advice that should be given during an antenatal check up. It was found that all respondents were able to enumerate at least three issues on which advice had to be given. All respondents were of the view that in an antenatal check up, women should be advised about their dietary needs. Ten respondents felt that women should be informed about the possible danger signs during pregnancy to women whereas eight of the respondents each felt that women should be briefed about preparation required for the delivery and given advise on breast care.

The respondents were asked about the danger signs during pregnancy. It was found that one respondent was not aware of the danger signs during pregnancy, whereas the fourteen other respondents could enumerate at least three danger signs each. It was also observed that all fourteen respondents listed swelling in ankles, anemia and less fetal movements as danger signs among pregnant women.

All respondents were of the view that all home deliveries should be conducted by a Trained Dai. Some of the respondents also felt that apart from a Trained Dai, home based deliveries could also be conducted by a qualified doctor or an ANM. The respondents were further enquired about the precautions that needed to be taken during a home delivery. All respondents could at least mention two precautions that should be taken during a home based delivery. It was reported by fourteen respondents each that the umbilical cord should be cut with a clean blade and the cord should be tied with a clean thread. Eleven respondents were of the view that only a trained person should conduct the delivery at home. Whereas another ten respondents felt that during a home based delivery, the room where the delivery is conducted should be well cleaned and ventilated.

The respondents were asked about the weight below which a baby would be considered as a low birth baby. Nine respondents were of the view that a baby less than 2.5 Kgs was underweight whereas six respondents felt that a baby with weight less than 2 Kgs could be considered as a low birth baby. The respondents were further probed about the reasons for low birth weight among babies. Except one, others were found to be aware of the reasons for low birth weight among babies. Thirteen respondents were able to enumerate at least three reasons for low birth weight among babies.

All the respondents were asked enumerate the common danger signs among newborn baby. It was found that twelve of the respondents could enumerate at least three danger signs among children whereas two of the respondents were able to enumerate only one danger sign among newborn babies. All respondents were of the view that the baby should immediately be taken to a doctor for treatment in case any of the danger signs was evident in a new born baby.

The respondents were then enquired about the possible ways of preventing the occurrence of Hypothermia in newborn babies. Three respondents were found to be unaware of the methods of preventing Hypothermia in babies whereas ten respondents were found to be aware of more than three ways of preventing Hypothermia among newborn children. The most common response, reported by twelve respondents, was that a child should be kept in warm clothes to prevent from hypothermia.

The respondents were enquired about the number of postnatal check ups that women should avail after delivery. It has been found that the responses of the Anganwadi workers ranged from two to eight postnatal check –ups. Further, the Anagnwadi workers were asked to enumerate the examinations that should be done in the postnatal check ups. It was found that apart from two respondents others were aware of at least two examinations that should be carried out in a postnatal check-up. Nine respondents felt that blood pressure should be measured during a postnatal check up whereas eight respondents each felt that the body temperature and abdominal examination should be done in a postnatal check up. Apart from this six respondents were of the view that the weight of the baby should be measured in a postnatal check-up.

The respondents were asked about the number of hours after birth that the baby should be breast fed. All respondents were of the view that breast feeding among the newborn should begin within half an hour after the birth. Thirteen of the respondents were of the view that in case the mother was ill, breastfeeding should be stopped and continued after the mother gets well. The respondents were further probed if breastfeeding should be stopped if the mother gets pregnant. It was found that twelve of the respondents felt that breast feeding should be continued whereas three of them felt that it should be stopped. All respondents were found to be of the view that a child in the age group of 0 to 6 months should not be given plain water. The respondents were probed about the number of times that a child in the age group of 6-8 months should be given a meal in a day. The responses to this question varied from 3 meals in a day to 5 meals that could be provided to the child.

RTI/STD and HIV/AIDS: All respondents except one were aware of a method through which HIV/AIDS could be prevented. Fourteen of the respondents were able to enumerate at least three methods through which HIV/AIDS could be prevented. All respondents except one were aware that HIV/AIDS could be transmitted from one person to another. It was found that fourteen respondents were aware of at least three modes of transmission of HIV/AIDS.

Service Delivery: The respondents were asked to enumerate the services provided by them to the community. The services listed are as under:

- Pre school education
- Immunization
- Health check-ups
- Referral of sick children
- Treatment of minor ailments
- Supplementary feeding
- Growth monitoring and promotion
- Nutrition and health

The Anganwadi workers reported that for delivery of these services they were mainly associated with the Panchayat functionaries, Anganwadi Supervisor, CLICS Doot and the ANM. The respondents also felt that the support provided by other functionaries was somewhat or completely satisfactory in most cases.

Distribution of Iron tablets: It was found that all respondents were engaged in distribution of iron tablets in their work area. It was reported that the iron tablets were generally provided to children under the age of 6 years, pregnant women and adolescent girls. The dosage recommended for children was of 30 pediatric tablets given to children over a period of 30 days whereas 90 adult tablets for adolescent girls and pregnant women over a period of 90 days.

8.2.2 In- depth Interviews of the CLICS Doot

A total of 51 CLICS Doots in the project area were interviewed. The details of the coverage are as under:

Table 8.1: CLICS Doots interviewed

	Anji	Talegaon	Gaul	Total
CLICS Doots Interviewed	17	21	13	51

An attempt was made top interview as many CLICS Doots as possible based on their availability during the survey. It was found that age of the CLICS Doots ranged from 24 years to 57 years and it was found that 58% of the respondents were of less than 35 years in age. The same number of the respondents was found to have 10th or less than that as their education qualification, whereas others had a higher education qualification. Their education ranged from 6th standard to a bachelors degree. This section aims at reflecting at the knowledge and the work done by the CLICS Doots in the area.

Association with the Programme

The CLICS Doots were asked if they were satisfied by the selection procedure adopted by the CLICS programme. It was found that all respondents irrespective of the sectors were satisfied by the selection procedure adopted under the programme. It was reported that 50% of the respondents had been associated with the programme for the last 4 years, whereas only two respondents had joined the programme within the last one year. This indicates that the programme has been able to retain the village level functionaries with it for longer duration. This augurs well for the programme as the resources invested in building their capacities and developing rapport at the village level have been used affectively. It has also insured that identity of the programme in the village has not shifted frequently and the selection procedures adopted by it have been effective.

All respondents have reported that they received trainings from the CLICS programme. All 51 respondents reported that they had been trained on IMNCI, Newborn Care, Malnutrition RTI/STD and record keeping. Two respondents, one from Anji and another from Talegaon sector reported that they had not been a part of the skill based training provided by the CLICS programme. Some of the respondents reported that they had received trainings on others issues as well from the CLICS programme. These included training on malaria, DOTS, basic nursing, and naturopathy.

It was found that all respondents were satisfied with the training provided to them on IMNCI, Newborn care and malnutrition. One respondent was found to be not completely satisfied with the quality of training provided on RTI/STD and skill based training. This

reflects that a large majority of the CLICS Doots were satisfied with the overall quality of the training. All respondents were of the view that the trainings were useful to them and utilized in their day to day work. It was however found that 10% of the respondents felt that their expectations from the skill based training provided by the CLICS programme were not fully met.

Linkages with other Stakeholder

The CLICS Doots were asked if they got help/support from ANM/AWW. It was found that all except one respondent from Gaul sector reported that they got support from the local ANM and AWW. All respondents were of the view that overall immunization the area has increased. All respondents reported that they had been contacted by the VCC about the CLICS programme activities, however two respondents from Talegaon sector felt that the VCC did not provide them with adequate support in carrying out their activities at the village level.

86% of the respondents felt that the activities carried out under the CLICS programme could be continued after the withdrawal of the DCM.

Practices at Work

All respondents were asked about the frequency of their household visits. It was found that 53% of the respondents made their household visits once in a week, 14% made their visits twice in every week, 22% reported that they made their visits once in a fortnight and 12% of the respondents reported that they made household visits once in a month.

All except one respondent from Talegaon sector reported that they promoted community based distribution systems. It was observed that 96% of the respondents were associated with community based distribution of Jeevan Drops and ORS, 88% were associated with distribution of IFA tablets, 76% reported that they were associated with the community based distribution of condoms, 49% were associated with community based distribution of sanitary pads and 25% reported that they were associated with community based distribution of nets for latrine pipes. Apart from this 58% of the respondents reported that they were associated with community based distribution items such as Phynol, first aid material and certain medicines such as Paracetamol and Septron.

Knowledge

The respondents were asked to enumerate the elements of newborn care. It was found that all respondents were able to enumerate at least four elements of newborn care. Similarly, it was found that all respondents were able to enumerate at least three complications that may occur among the newborn children. The levels of knowledge therefore among the CLICS Doot were found to be very good on the health of newborn babies.

Work Conditions

All respondents were asked if they were satisfied with the remuneration paid to them. It was reported 64% of the respondents that they were satisfied with remuneration given to them whereas the remaining 36% felt that the remuneration did not match the amount of work that was required. 76% felt that the VCC would be able to sustain the CLICS Doots activities after the CLICS programme is over whereas others felt that they would not be able to sustain their services after the end of the programme.

8.2.3 Registered Medical Practitioners (RMPs)

It has emerged from the discussions with about 10 RMPs, which were aware of the CLICS programme and have been regularly updated with information aides on common diseases. They feel that the major contribution of the CLICS programme has been in increasing awareness amongst the community members about health related issues, especially on sensitive issues such as antenatal, intra natal and postnatal care. The RMPS were also aware of the fact that certain routine tests were being carried out at much cheaper rates at the MGIMS medical college and were also aware about the health insurance scheme that was being offered to the community. Most of the RMPs were aware of the CLICS programme but felt that they could not directly associate with it due to paucity of time.

Some of the RMPs had been provided trainings by the CLICS programme on seasonal diseases, which were found to very interesting and helpful by the respondents. All the RMPS interviewed though were of the view that even prior to the CLICS programme they had the knowledge on health issues, but small trainings and access to information aides had helped them in building on it further.

8.2.4 Panchayat/Zila Parishad Members

It has emerged from the in-depth interviews carried out with the district and block level elected Panchayat representatives that none of the five interviewed representative was directly associated with the CLICS programme at any point of time. They had though heard about the programme from other acquaintances and were aware that the programme aimed at improving the health status of children in the age group of 0-3 years.

The Panchayat representatives were aware of the health programmes and the functioning of the ICDS programme, which provided supplementary nutrition to the children of 0-3 years through the Anaganwadi system. It emerged from the discussions that the PHCs and Panchayat Committee were related ideally, but in practice the Panchayat committee members are not called for the meetings. The number of births and deaths which took place in the PHC was reported in the Panchayat directly.

The Panchayat representatives were of the view that the role of Panchayats in ensuring better health services was being fulfilled through the various schemes that were implemented to provide nutritional support to the BPL families and through various awareness programmes being run through the Anganwadi and the health centers. The Panchayat representatives were unaware of the CLICS Doot, Kiran Clinic, the village health fund or the existence of the village health funds. They were though aware of the Bal Suraksha Diwas, where the Anganwadi worker and the ANM got together to weigh, measure the height and vaccinate children.

8.3 Facility Survey

8.3.1 Facility Survey PHC

The three PHCs in the project area at Anji, Talegaon and Gaul were covered in the facility survey. This section deals with findings of the PHC facility survey. The PHC facility survey was carried out by qualified MBBS doctors, provided by the MGIMS medical college.

Key Observations

Waiting Area

It was found that the clinic timings on all three PHC were displayed in the local language. The waiting are in all three PHCs was covered and had adequate seating and drinking water facilities for the patients.

Counseling and Examinations

Apart from the PHC at Gaul, it was found that there was adequate privacy for the clients in the counseling and examination room. All PHCs had screens and curtains for examination of patients. All three PHCs had electricity, running water and at least one toilet for the clients and outpatients. The toilets in all the PHC were clean and had adequate water available at the time of survey. Apart from the examination room of Gaul PHC, all other PHCs had clean examination rooms. The examination rooms at all the PHCs had an examination table, a BP instrument, a stethoscope, speculums and a source of light. However it was found that the PHC in Gaul did not have an anti-septic solution and gloves in the examination room, these were though present in the other two PHCs surveyed.

It was found that apart from the PHC in Talegaon, the IUD insertion room was not being exclusively used for IUD insertion. Further it was found that the IUD insertion room at the PHC in Gaul was not clean.

Operation Theatre (OT)

It was found that in all the PHC, the OTs had two operation tables adequate linen. Apart from the PHC in Gaul, the operation theatre of other PHCs had a functional Boyle's apparatus and an antiseptic solution. Pedestal lamps were being used as the source of light in the OTs of the PHCs in Anji and Talegaon, whereas in Gaul there was a shadow less lamp available as the source of light.

The OTs in all the three PHCs had a Pukka floor, washable walls and floor. It was found that apart from the OT at the PHC in Gaul, dust particles were present in the OTs of the other two PHCs. The OT in all the three PHCs had electricity connection and had a power back-up in case of a power failure. At the time of the facility survey, it was observed that there were no flies in all the OTs covered and the windows were closed to avoid any exposure to dust and other sources of infections.

It was found that apart from the PHC in Gaul, the other PHC centers had running water and a wash basin for hand washing. In all PHCs, the tap was not found to be elbow or foot operated. Ambu bag and Laryngoscope were not present in the OTs of any of the three

PHCs. Apart from that there was no oxygen cylinder with key and flow meters and suction machines available in OTs of the PHC in Gaul and Anji.

Stores, Supplies and Inventories

It was found that there was adequate space in the store rooms at all the three PHCs. A stock register was being maintained at each of the PHC. The store rooms were found to be clean and dry and protected from sun/rain and pests.

Lab Equipments

It was found that Apart from the PHC in Talegaon there was no trained person to carry out all the following tests in other PHCs:

- Hemoglobin,
- Urine (Albumin) and
- Urine (Sugar)

In Gaul none of these tests could be carried out, whereas in Anji only hemoglobin test could be done due to lack of trained staff.

The status of availability of the following functional lab equipments was checked. The results have been shown in the table below:

Table 8.2: Availability of lab equipment in PHCs

S.No.	Equipment	Name of the PHC		
		Anji	Talegaon	Gaul
1	Hemoglobinometer	√	√	×
2	Spirit Lamp	√	√	×
3	Test Tubes	√	√	×
4	Benedicts Reagent	√	√	×
5	RPR test Kits	×	√	×
6	Grams Stain	×	×	×
7	Crystal Water	×	√	×
8	Autoclave	√	×	×
9	Saffarin	×	×	×
10	Cider Wood Oil	×	√	×
11	Normal Saline	√	√	×
12	Microscope	√	√	×
13	Refrigerator	√	√	×

As is evident from the table, the PHC at Gaul has none of the lab equipments in functional state, whereas in the other PHCs in Anji and Talegaon, only selected lab equipments are functional.

Cold Chain Equipments

In the Facility survey, the team assessed the availability of functional. The findings have been documented in the table below:

Table 8.3: Availability of cold chain equipment in PHCs

S.No.	Equipment	Name of the PHC		
		Anji	Talegaon	Gaul
1	Functional ILR	√	√	√

2	Functional DF	√	×	√
3	Vaccine Carrier	√	√	√
4	Generator/Alternative Power	√	√	×
5	Baby Warmer	√	×	×

Availability of IEC Material

It was found that there was no audio-video equipment available in any of the PHCs. Wall Charts, booklets, pamphlets and flip books were available and displayed in all three PHCs.

Services provided by PHCs

The services provided by the three PHCs to its clients are as under:

Table 8.4: Services provided by the PHCs

S.No.	Equipment	Name of the PHC		
		Anji	Talegaon	Gaul
1	IUD Insertion	√	√	√
2	MTP/MR	×	×	×
3	Services for RTI/STD	√	√	√
4	Immunization	√	√	√
5	Natal Care	√	√	×
6	Basic Emergency Obstetric Care	×	×	×

Record Keeping

It was found that the four record registers viz. Eligible Couple Register, Service Delivery Register, Monthly Progress Report and stock register were available at all three PHCs. However it was found that these were being maintained only in PHCs at Anji and Talegaon.

Infection Control

The disposal items were being collected by attendants wearing gloves for protection. It was though found that the waste material was not separated in Talegaon and Gaul PHCs. In comparison the waste material was separated out in the PHC at Anji. The waste collected was reported burned in open air at the PHC in Anji. In comparison, the in Gaul the waste collected was simply dumped and in Talegaon it was dumped in some case and on other it was burned.

8.3.2 Discussions with the Medical Officers

As a part of the survey, the medical officers of three PHCs in the project area were interviewed. This section of the report reflects on the major findings of these interviews. The interviews were carried out by qualified doctors, which were provided by the MGIMS medical college Wardha.

Profile

The highest qualification of all the three doctors interviewed was MBBS and their age ranged from 23 to 52 years. Their experience as Medical Officers ranged from 24 years to 2 months.

Association of Medical Officers with the CLICS Programme

Apart from the Medical Officer of Talegaon PHC the other two Medical officers had not been associated with any training provided by the CLICS programme. The Medical officers of Gaul and Talegaon had heard about VCCs and reported that they had been contacted by the VCC members. However, the Medical Officer in Anji was not aware of the VCCs and reported that he had not been contacted by any of the representative of the same. This was understandable considering that, the medical officer had just joined the health department a couple of months back.

Child Survival Issues in Area

In Gaul it was reported that were no specific health issues related child survival. However, in Talegaon pneumonia, fever and Diarrhea were reported as the major child survival issues. Similarly, in Anji it was reported that malnutrition and infections were the major areas of concerns for child survival. It was felt by the medical officer in Anji that awareness through camps and Lady Health Worker could play an important role in reducing the incidence of Malnutrition in Anji. He also felt that the responsibility for tackling these major issues lie with the health department and NGOs. In contrast, the Medical officer of Talegaon felt that in his area a dual approach aiming at improving preventive and curative health was required to tackle the problems related to child survival. He also felt that parents were responsible for addressing these issue and attempts should be made to ensure that health education, sanitation and chlorination are promoted in his area.

The medical officers were of the view that Anemia, malnutrition and home deliveries were the major reasons for deaths among infants in the neonatal period. The medical officer at Gaul was also of the view that lack of health education, poor referral services and diagnostic services were also responsible for deaths in infants.

Maternal Health and Family Planning

The Medical Officers were of the view that lack of education, resources and poor transport facilities were the main reasons for home based deliveries in their region. In addition, the Medical Officer in Talegaon also attributed home base deliveries to the cultural pressure and social taboos in his region to the continuation of home based deliveries. The Medical officers were unanimous that health education/awareness, government schemes and good referral services could help in increasing the number of institutional deliveries. Poor IFA consumption, societal suppression, negligence of nutrition for females and worms were some of the reasons mentioned by the Medical officer for incidences of anemia among women.

Status of Health facilities

The medical officers were asked if the rural people were satisfied with the healthy facilities, it was reported by the Medical Officers of Talegaon and Anji that the people were not completely satisfied with the health facilities and demanded better infrastructure and supply. However, the Medical Officer in Gaul felt that rural people in his sector were happy with the health facilities available at the PHCs. The Medical Officers were asked about the improvement that could be made in the PHC facilities. It was reported in Talegaon and Anji that regular supply of drugs, trained staff and improved equipment would help in improving the health facilities at the PHCs, whereas in Gaul the Medical Officer stressed upon the need to introduce Naturotherapy for improving the health facilities.

Knowledge of family welfare services

All Medical Officers felt exclusive breast feeding should continue till six months after birth. They were of the view that keeping the child warm, immediate breast feeding, aseptic precaution and care of umbilical cord were essential neo-natal care for the new born.

The medical officers were asked if they would insert an IUD in women with certain characteristics. It was found that the responses varied among the medical officers. It was reported by the Medical Officer in Gaul and Talegaon that IUD would not be inserted in the following cases:

- If the age of the female was more than 35 years
- On the 25th day of the cycle
- To women who had delivered 3 days back
- Women with low backache and
- To women with Mennorrhagia

In comparison the Medical officer at Anji felt that an IUD could be inserted in the above cases.

When asked what would be done by the medical officers, if heavy menstrual flow id reported after IUD insertion, all medical officers reported that they would reassure the patient that it would soon subside. The Medical Officer at Gaul felt that antibiotics could also be referred to the patient. All medical Officers felt that there was no problem with the supply of contraceptives.

The Medical Officers felt that lack of hygiene was a major reason for transmission of STI/RTIs. It was also reported by the Medical Officer from Anji that lack of health education was a reason for transmission of RTIs and STIs. In Talegaon, the Medical Officer felt that sexual contact and shared needles were the modes of transmission of STIs/RTIs.

The Medical Officers were asked what they would do is if a 22 year old male patient complains of urethral discharge. The Medical officer in Talegaon was of the view that history of the patient and the examination of genitals would be done during the examination. The Medical Officers of Anji felt that the discharge would also be sent for culture and further investigation. Whereas that of Gaul felt that pathological tests would be carried out.

On confirmation of the discharge, it was reported by the MO at Talegaon that antibiotics would be initiated, whereas that of Gaul felt that Penicillin would be prescribed. The Mo at Anji felt that the decision would depend on results of investigations.

The MOs were asked about their course of treatment in case, a woman aged 27 years complains of excessive discharge from the vagina and the discharge is foul. It was reported by the MO in Gaul that the patient would referred to another health facility and would advise her to undergo sonography. The MOs at Anji reported that the patient would be asked to get a culture test done whereas the medical officer at Talegaon reported that the patient would be asked to get a PAP smear test, HIV test and VDRL done. When further asked about the course of treatment in case no gram negative diplococci are seen on grams staining. The MOs reported that they would prescribe antibiotics to the patient.

The MOs were asked about their course of treatment in case, a woman aged 35 years complains of discharge along with itching in vulva region and on her speculum examination, thick curdy discharge is seen, which adheres to the vaginal wall. The MOs were of the view that a PAP smear and a culture test would be carried out. The MOs were further probed about their diagnosis in case on wetmount examination, double walled refractive, oval shaped budding cells were seen. The MO's of Anji and Gaul were of the view that it was vaginal candidiasis whereas that of Talegaon felt that it was a case of Gonorrhea. On further probing about the course of treatment, the MO at only the Gaul PHC mentioned that the treatment would be provided to the patient's husband as well.

The MOs were of the view that if RTIs are left untreated they may spread to others through sexual contact and may cause further complications. They felt that immediate treatment, usage of condoms and being faithful to partners were the most important messages that have to be given on RTIs. All the MOs were aware of all the sexually transmitted diseases.
All the MOs were aware of HIV and the modes of its transmission. However it was found that none of the MOs were aware about the window period of HIV/AIDS. The MOs were of the view that in case the patient is HIV/AIDS positive, the patients would be counseled and referred.

Coordination with Others Sectors

It was reported that in Gaul, the PHC staff did not coordinate with any other departments, in Talegaon it was reported that the PHC staff coordinated with the ICDS, gram panchayat and the CLICS programme., whereas in Anji it was reported that the PHC staff coordinated on while having camps. The MOs felt that they did not face any problems in coordinating with the other departments but felt that these linkages should be further strengthened.

Highlights of the Facility Survey at PHC

- *All three PHCs could be identified easily as they had the name and timings displayed in local language.*
- *It has been found that the PHCs in all three sectors had adequate infrastructure in the form of waiting space for patients, examination halls, store rooms and OTs etc.*
- *Basis amenities such as drinking water and clean toilets were also found to be available.*
- *All PHCs were electrified and were found to have power back up in the OT.*
- *Availability of adequate manpower was found to be a major limitation in the PHCs. It has been found that trained manpower to carry out tests such as hemoglobin and urine were not available at two of three PHCs surveys.*
- *Availability of functional lab equipment was also a limitation. It has been found that the PHC in Gaul had no functional lab equipment.*
- *No PHC provides services such as Medical termination of pregnancies or emergency obstetric care.*
- *The OTs were well maintained and clean in all the three PHCs.*
- *Lack of emergency obstetric care at the PHC. None of the PHC reported that it provided emergency obstetric care*

8.3.3 Facility Survey of Sub Centers

A facility survey was carried out in 5 sub centers in the project area. The details of the coverage are under:

Table 8.5: Sub centers covered

S.No.	Details	Name of the PHC		
		Anji	Talegaon	Gaul
1	Sub-centers Covered	Dhotr Kasar and Selsura	Pavnar and Pepri Meghe	Andhori

The facility survey of sub centers was conducted by qualified MBBS doctors provided by MGIMS medical college.

It has been found that out of the five sub centers visited, those in Anji sector did not have the clinic timings displayed in local language outside the premises. It has been reported that all sub centers had shelters for the clients and all apart from one sub center in Anji had adequate seating space.

Apart from the two sub centers in Anji, drinking water was available in all other sub centers surveyed.

Counseling and Examination

The counseling and examination facilities available at sub centers were analysed by the surveyors. The details of the findings regarding privacy and cleanliness maintained at the center are as under

Table 8.6: Facilities available in the counseling and examination area

S.No.	Facilities	Name of the Sub Centers				
		Anji		Talegaon		Gaul
		Dhotr Kasar	Selsura	Pavnar	Pepri Meghe	Andhori
1	Is there adequate privacy	×	√	√	√	√
2	Availability of a Screen	×	√	√	×	×
3	Availability of Curtains	×	√	√	√	√
4	Availability of electricity	√	√	√	√	√
5	Availability of running water	√	√	×	√	√
6	Availability at least one toilet for clients	√	√	√	√	√

It is clear from the table given above that the sub center in Selsura has the best counseling and examination facilities, whereas its counter part in Dhotr Kasar has the poorest counseling and examination facilities when assessed purely on the basis privacy maintained for the clients while examining or counseling them.
It has been reported that all the sub center examination rooms were clean and had adequate water supply.

Equipment Available at the Examination Room

The sub centers were also assessed on the basis of the equipment available in the examination room. The table below illustrates the details of the findings.

Table 8.7: Equipment available in the examination rooms

S.No.	Facilities	Name of the Sub Centers				
		Anji		Talegaon		Gaul
		Dhotr Kasar	Selsura	Pavnar	Pepri Meghe	Andhori
1	Examination Table	√	√	√	√	√
2	BP instrument	√	√	√	√	√
3	Stethoscope	√	√	√	√	√
4	Speculums	√	√	√	√	√
5	Antiseptic Solution	×	√	√	√	√
6	Gloves	√	√	√	√	√
7	Source of Light	√	√	√	√	×

IUD Insertion Room

The team assessed the facilities in the IUD insertion rooms and found that in all sub centers the floor of the room was washable and apart from the sub center in Dhotr Kasar, the IUD insertion room was used specifically for IUD insertions only.

Lab Equipments Available

The team assessed the lab equipments available in the surveyed sub centers. The details of the findings are as under:

Table 8.8: Availability of lab equipment at the sub centre

S.No.	Facilities	Name of the Sub Centers				
		Anji		Talegaon		Gaul
		Dhotr Kasar	Selsura	Pavnar	Pepri Meghe	Andhori
1	Hemoglobinometer	×	√	√	√	×
2	Spirit Lamp	×	√	×	√	×
3	Test Tubes	×	×	×	√	×
4	Benedicts Reagent	×	×	×	√	×
5	RPR test Kits	×	×	×	√	×
6	Grams Stain	×	×	×	×	×
7	Crystal Water	×	×	√	×	×
8	Autoclave	×	×	√	√	×
9	Saffarin	×	×	×	×	×
10	Cider Wood Oil	×	×	×	×	×
11	Normal Saline	×	×	√	√	×
12	Microscope	×	×	×	×	×
13	Refrigerator	×	×	×	×	×

It is observed that the sub centers at Andhori and Dhotr Kasar do not have any lab equipments available. The sub center at Pepri Meghe has the best equipped lab facilities as compared to other sub centers surveyed.

It was found that in the sub centers in Selsura, Pavnar and Pepri Meghe sub centers, there was a trained person who could carry out the Hemoglobin, Urine Albumin and Urine Sugar tests. Whereas there were no trained personnel available in the other two sub centers who could carry out any of these tests.

Availability of IEC Material

The facility survey team assessed the availability and the display of IEC material in the sub centers. The IEC material observed included Wall Charts, Booklets, Pamphlets, Models and Flip Books. It was found that in the Andhori sub center there was no IEC material available, in contrast all the IEC material was available and displayed adequately at the sub center in Pepri Meghe. In the other three sub centers it was found that Wall Charts and Flip Books were available at all centers. Apart from Pavnar, these were displayed at adequate place by the in all other sub centers.

The sub center at Pepri Meghe also had a video aid, in comparison no other sub center had either a video or audio aid.

Services Offered

The facility survey team also assessed the number of services offered by the sub center to its clients. The details of the findings are as under:

Table 8.9: Services offered at the sub centers

S.No.	Facilities	Name of the Sub Centers				
		Anji		Talegaon		Gaul
		Dhotr Kasar	Selsura	Pavnar	Pepri Meghe	Andhori
1	IUD Insertion	×	√	√	√	√
2	MTP/MR	×	×	×	×	×
3	Services for RTI/STD	×	×	×	√	√
4	Immunization	√	√	√	√	√
5	Natal Care	×	√	√	√	√
6	Basic Emergency Obstetric Care	×	√	√	√	×

It is observed that the sub center at Pepri Meghe provided the highest number of health services. Immunization amongst the services was offered by all the sub centers; in contrast none of the sub centers offered the facility Medically Terminating Pregnancies. Dhotr Kasar in Anji emerged as a sub center that provided only Immunization services.

Record Keeping and Waste Management

It was found that all the sub centers had the Eligible Couple Register, Service Delivery Register, Monthly Progress Report and Stock Register and were maintained properly at all places except in Dhotr Kasar.

The waste was generally collected and dumped in all the sub centers. It was reported that in all sub centers apart from that in Andhori that the waste collected was separated before being dumped.

8.3.4 IDIs with Auxiliary Nurse Midwives and Lady Health Visitors

As a part of the facility assessment, an attempt was made to carry out in-depth discussions with the service providers at the government health facilities. These mainly comprised of the Auxiliary Nurse Midwives (ANMs) and the Lady Health Visitors (LHVs). The present

section of the report brings out the findings from the in depth interviews carried out with ANMs and the LHVs as a part of the survey.

Profile of the ANM and LHVs

It was found that the age of the ANMs and the LHVs ranged from 34 to 52 years. The ANMs and LHVs interviewed were found to be highly experienced in their work with number of years of experience varying from 10 to 25 years. All the respondents interviewed were found to be aware of the CLICS programme and reported that they were actively associated with the CLICS programme and its activities.

Interface with the CLICS Programme

All the eight respondents were of the view that the CLICS Doot in the villages have helped and supported carrying out their work. It was found that seven out of the eight ANMs/LHVs interviewed were aware of the Village Coordination Committees (VCC) formed under the CLICS programme and six out of the eight ANMs/LHVs reported that they had been contacted by the VCC members about the programme activities. All but one of the respondents reported that they had received trainings from the CLICS programme.

The ANMs/LHVs were asked if they felt that the BSDs were the same in terms of coverage of the services offered when compared with the days before the CLICS programme was implemented. Four respondents felt that there was a change in terms of the coverage of the services whereas three felt that it was the same and one of the respondents was not sure. Four of the respondents were of the view that there had been an increase in the participation of the beneficiaries in BSD after the implementation of the CLICS programme whereas three felt that the participation had remained the same as earlier and one of the respondents was not sure.

The respondents were asked if they felt that there was an increase in the immunization coverage in their work area. Six of the respondents felt that there was an increase in the immunization coverage whereas one respondent felt that the coverage was the same. One of the respondents was found to be undecided about the increase in the immunization coverage in the project area.

Participation in Group Activities in Village

It was reported by six of the respondents that they were members of a village level committee or group in the villages under their work area. Two respondents reported that they were members of VCC committee at the village level. Apart from the VCC, ANMs/LHVs reported that they were members of the Mahila Mandals, Self Help Groups, Health Committee under the NRHM, Nurses Association and Panchayat Arogya Samiti. When asked about the major activities carried out by the ANMs/LHVs in these groups, it was found that they ranged from organizing events such as Mahila Mela, health camps, donation camps and tree plantation. Apart from these events, it was also reported that ANMs/LHVs were responsible in these groups to register the new Births and Deaths in the group.

Knowledge:

An attempt was made to assess the knowledge of the ANMs/LHVs on various issues. It observation and findings of the same are as under:

Knowledge on Nutrition: The respondents were asked if they could name the stages in life when there is a special need for intake of iron. All the respondents felt that iron was a required by pregnant women and seven respondents were of the view that iron was required by lactating females. Six of the eight respondents were of the view that iron was required by adolescent girls and 5 felt that iron was required by children in the age group of 0-3 years.

The respondents were asked to reflect on what could happen if an adolescent girl did not receive required amount of iron. Seven of the respondents felt that the girl would feel weak and would not be able to carry out regular work whereas six of the respondents felt that the adolescent girl would also get Anemia. Four respondents each felt that the growth of the girl would get affected and she might encounter problems during her pregnancy. However there was one respondent who was not aware of what impact lack of iron may have on the adolescent girls.

All the respondents felt that Vitamin A was required by children in the age group of 0-3 years. Some of the respondents felt that vitamin A was also required by adults who had night blindness and by pregnant females.

All respondents were able to report at least two iron rich food items that should be included in the diet of individuals who required iron, whereas seven of the respondents could enlist at least two vitamin A rich food item.

Knowledge on Reproductive Health: All the respondents were asked the age at which a female should have her first child. It was found that the age reported by the respondents at which a female should have her first child varied from 19 to 21 years. It was found that all but one respondent felt that the onus of avoiding or delaying pregnancies lied with both wife and husband. It was reported that some of the respondents felt that parents and community also had a role to play in ensuring that pregnancies were delayed or avoided. It was found that all respondents were aware about Oral Contraceptive Pills, Condoms and IUDs as methods that could be used to avoid or delay pregnancy. Four respondents each have felt that pregnancies could be avoided or delayed by using female sterilization, male sterilization or by using the Rhythm method.

Knowledge about Safe Motherhood: All respondents were of the view that pregnant women should get themselves registered within 12 weeks of pregnancy. The respondents were enquired about the minimum number of antenatal check ups that a pregnant women should have during her complete pregnancy, the responses ranged from 5 to 12 check-ups. It was observed that 6 out of the eight respondents felt that a minimum of 5 check-ups are required during the complete pregnancy whereas one respondent each felt that a minimum of 12 and 6 check-ups were required during the course of pregnancy.

The respondents were enquired about the examinations that should be done during the antenatal check-ups. All respondents could enumerate at least four examinations that should be carries out during an antenatal checkup. All respondents were of the view that abdominal examination, weight and Blood Pressure should be measured during an antenatal check up.

Seven respondents felt that Blood test should be conducted, six felt that a urine test should be done and four felt that height of the client should also be measured. Two respondents also felt that Songraphy should be a part of the antenatal check-ups of pregnant women.

It was enquired from respondents as to what advice should be given to pregnant women about her diet. It has been found that all respondents reported that they would advise the pregnant women to increase the frequency of her dietary intake and increase the intake of green leafy vegetables and fruits.

All respondents were found to be aware of at least three danger signs during pregnancies. It was felt by most of the respondents that swelling of ankles, anemia, high blood pressure and high fever were the main danger signs during pregnancies.

All respondents were enquired about who would be the right person to conduct deliveries at home. All respondents were of the view that deliveries at home should only be carried out by trained birth attendants, or a Nurse or a doctor. All respondents felt that in cases of home delivery, the room for the delivery should be clean and well ventilated, a clean blade should be used o cut the cord, the umbilical cord should be tied with a clean thread, the hands of the person conducting the delivery should be clean and noting should applied on the cord stump. Apart from this two respondents felt that in case of a home delivery, there should be an alternative transport arrangement to shift the female to a hospital in case of an emergency.

Six out of the eight respondent felt that if the weight of the baby was less than 2.5 Kgs, the baby was underweight, whereas two of them felt that the baby could be termed underweight if its weight on birth was less than 2 Kgs. Lack of nutrition to mother and premature delivery emerged as the major reasons mentioned by the respondents for low birth weight. All respondents were able to list at least two ways of managing low weight babies. The most common methods suggested by the respondents were frequent feeding and keeping the baby close to the mother. All respondents also recommended that the low birth baby should immediately be taken to a skilled medical practitioner.

All respondents were found to be aware of at least three danger signs among the newborn baby. It was found that convulsions, hypothermia and low birth weight were reported the most as danger signs amongst the newborn babies. The respondents were enquired about the ways of managing Hypothermia in newborn children. All respondents felt that in hypothermia the child should be kept in warm clothes. Some of the respondents also felt that the child should be kept with the mother and should not be kept in front of fan or close to a wall.

The respondents were asked about the number of postnatal check-ups that a mother should get. The responses ranged from two to five postnatal check-ups. One of the respondents was of the view that number of postnatal check-ups should be based on the requirement of the baby for medical care. All respondents reported at least three examinations that should be carried out in a postnatal check up. Four respondents were of the view that weight of the baby, temperature, Examination of the vaginal discharge and the breast feeding of the newborn baby should be examined and discussed during the postnatal check-ups. Three respondents were of the view that the blood pressure, abdominal examination and internal

examination of the mother should be carried out as a part of the postnatal check ups. All the respondents were of the view that the mother during the postnatal check ups should be advised about the diet, breast feeding practices and personal hygiene. Some of the respondents were of the view that the mother should also be advised about managing low birth babies, family planning methods and taking care of the baby during the postnatal check ups.

All the respondents were of the view that the newborn baby should be breastfed within half hour of its birth. Five of the eight respondents were of the view that the mother should continue to feed the baby even when she is ill, whereas three of the respondents were of the view that the mother should stop breast feeding in case she was ill and continue it only after she recovers. The respondents were also enquired if the mother should stop breast feeding if she gets pregnant. It was found that four respondents were of the view that the mother should stop breast feeding in case she gets pregnant, whereas the other four felt that she should continue breast feeding even after getting pregnant. All the respondents were of the view that a child below the age of 6 months should not be given plain water other than breast milk. All the respondents felt that a child should not be fed milk by a bottle as there was a chance that the child may contract infections by its use. One of the respondents was also of the view that feeding from a bottle was not a good habit and thus should not be promoted among the children.

Knowledge of Child Health: All respondents were found to be aware of at least three danger signs among children. Seven of the eight respondents were of the view that Rapid or difficult breathing and high fever were the danger signs that indicated need for immediate medical attention to the child. Convulsions and lethargy were reported by five respondents as dangers signs among children, whereas dehydration was reported by three respondents as signs for need to medical help.

All respondents were asked to enumerate the signs of illness, which could be seen if the child had cough or difficulty in breathing and would indicated the need for taking the child to medical facility. All respondents were able to list at least three such signs. Chest indrawing, rapid breathing and a noisy chest emerged as the most common sign sited by the respondents.

Similarly, the respondents were asked to enumerate the signs of illness, which could be seen if the child had loose motions and that indicated the need for taking the child to medical facility. It was found that all respondents were of the view that if the child starts showing signs of dehydration and continues to have loose motions for a long time, then the child should immediately be taken to a medical facility.

Knowledge of RTI/STD and HIV/AIDS: It was found that all respondents were aware of at least two symptoms of RTI/STDs. All respondents were of the view that vaginal discharge and urethral discharge were the symptoms of RTI/STDs among males and females. Six respondents felt that genital rashes and three respondents were of the view that lower abdominal pains were also the symptoms of RTIs and STD among males and females.

Six respondents were of the view that condom usage and avoiding multiple partners could prevent RTIs/STDs. Further, maintaining menstrual hygiene and hygiene during delivery emerged as the other most frequently reported ways of avoiding RTIs/STD infections.

All respondents were found to be aware of ways to prevent HIV/AIDS. It was respondents apart from two were able to enumerate all four ways of preventing HIV/AIDS viz. avoiding multiple sexual partners, use of condoms, by using sterilized needles and blood transfusion of tested blood only. Use of condom was not reported as method of preventing HIV/AIDS by two respondents whereas the three other modes of prevention were quoted by all respondents. All respondents agreed that HIV/AIDS could be transmitted from one individual to another. All eight respondents reported that HIV/AIDS was transmitted through unsafe sex, transfusion of infected blood and through unsterilised needles. Only two respondents were aware of the possibility of transmission of HIV/AIDS from a mother to her child either through breast feeding or during giving birth.

Delivery of Services:

The ANMs reported that they were involved in delivering the following services to the community:

- Pre-school education
- Immunization Services
- Health check ups
- Referral of sick children
- Treatment of minor illnesses
- Supplementary feeding
- Growth monitoring
- Nutrition and health education.
- Blindness
- Leprosy
- Sanitation
- Water purification
- Family Planning

It was reported that the ANMs were completely dissatisfied or somewhat dissatisfied with the degree of involvement of the villages in the above mentioned activities. It was also reported by them that they were not satisfied with the support provided to them by various other functionaries in the villages to implement the said programmes.

All respondents were of the view that to increase the immunization rates it was important to create awareness among the population, whereas some of them also felt that supply of vaccines also needed to be regular to ensure better immunization rates, as three of the eight respondents reported difficulty in obtaining the supply of vaccines.

All respondents reported that they used disposable syringes. The ANMS were enquired about the major problems faced by them in carrying out their work, the major problems reported have been listed below:

- Lack of vehicle to cover interior villages.
- Less credibility with people from some of the villages/Resistance from villagers.
- Inadequate supply of products.
- Lack of support from Anganwadi Workers

- Excess work load

Highlights of the Facility Survey at Sub Centers

- *It has been found that out of the five sub centers visited, those in Anji sector did not have the clinic timings displayed in local language outside the premises.*
- *It has been reported that all sub centers had shelters for the clients and all apart from one sub center in Anji had adequate seating space.*
- *Apart from the two sub centers in Anji, drinking water was available in all other sub centers surveyed.*
- *The sub centers have adequate physical infrastructure in terms of toilets and examination rooms*
- *There was privacy maintained in the examination rooms of most of the sub centers.*
- *Poor availability of lab equipment.*

Chapter 9
Summary of Findings and Conclusion

The following chapter tries to summarize the findings of the Endline survey by comparison of the Rapid Catch Indicators with the Baseline and Midline surveys in an effort to evaluate the impact of the CLICS programme on the target population. The indicators for Baseline, Mid term and Endline assessments are presented in the following table.

Table 9.1: Rapid Catch Indicators – Comparison with Baseline and Mid-term surveys

Indicators	Baseline	Mid-Term	Endline
% children (0-35 m) underweight (-2 SD from the median weight-for-age)	43.2%*	44.3%	41.1%
% children age 0-23 months who were born at least 24 months after the previous surviving child	64.4%	68.0%	76.1%
% children (0-23 m) whose births were attended by trained provider	82.2%	97.0%	93.86%
% mothers of children age 0-11 months who received at least two tetanus toxoid injections before the birth of their youngest child	83.3%	-	93.4%
% children (0-5 m) exclusively breastfed in the last 24 hours	80.1%	85.1%	62.87%
% children (6-9 m) given breast milk and complementary foods in the last 24 hours	72.0%	65.1%	97.98%
% children (12-23 m) fully vaccinated (against the six vaccine-preventable diseases) before their first birthday	62.4%	69.8%	95.8%
% of children age 12-23 months who received a measles vaccine	67.1%	83.8%	96.4%
% children age 0-23 months who slept under an insecticide-treated bed net the previous night (in malaria-risk areas only)	NA	NA	20.7%
% mothers with children (0-35 m) who cite at least two known ways of reducing the risk of HIV infection	9.2%	56.8%	59.3%
% mothers of children (0-35 m) who report that they wash their hands with soap/ ash:			
a) before food preparation	9.1%	36.0%	46.1%
b) before feeding children	14.0%	40.6%	57.2%
c) after defecation	87.6%	94.2%	98.6%
d) after washing child after defecation	-	83.8%	97.3%
% mothers of children (0-23 m) who know at least 2 signs of childhood illness that indicate the need for treatment	30.5%	55.4%	99.41%
% sick children (0-35 m) with cough and/or difficult/ rapid breathing during the past two weeks who received:			
a) increased fluids (after first 6 months)	1.3%	0.7%	32.2%
b) continued feeding among those who were breastfeeding	50.0%	82.1%	98.3%

** NFHS II for Maharashtra* *#Received two TT injections or a booster*

In developing countries, malnutrition contributes to more than 50% of the under five mortality. The prevalence of underweight (low weight-for-age) is a reflection of both chronic (past) and acute (current) under-nutrition. At the start of the programme, the proportion of children aged 0-35 months underweight was taken as 43.3% from the NFHS 2 findings of Maharashtra. In the midterm survey, the proportion remained similar at 44.3%. However, in the Endline survey, the proportion decreased significantly to 41.1% indicating reduction of the under-nutrition in children.

A number of factors have contributed to the overall improvement in the status of child health. One of the factors that has contributed to the improvement of the overall child health is improvement in access to effective methods of child spacing. It is a well known fact that adequate availability of spacing techniques enables couples to space births and prevent unwanted pregnancies which has a direct bearing on mother & child health. Birth intervals of at least 24 months are associated with a lower risk of illness and death in children. The proportion of children aged 0-23 months who were born at least 24 months after the previous surviving child was 64.4% in the baseline survey and it increased marginally to 68.0% in the midterm. It was interesting to note that this proportion increased significantly to 76.1% in the endline survey. This clearly indicates that there has been an increase in adoption of birth spacing methods in the project area and a majority of the respondents have ensured a gap of at least two years between their children, thereby reducing the mortality rates among infants and the number of births every year.

The proportion of children aged 0-23 months whose birth was attended by trained providers (including TBAs) was 82.2% in the baseline survey. This proportion increased significantly to 97.0% in the midterm survey. The proportion was similar in the endline survey at 93.9% indicating that since the inception of the CLICS programme, higher proportion of births are attended by a skilled provider leading to lower number of deaths during delivery.

Another major intervention supported by the CLICS programme was to ensure protection against tetanus both to the new borne baby and the mother. It has been observed that the proportion of mothers of children aged 0-11 months who received at least two tetanus toxoid injections before the birth of their youngest child has increased significantly. In this case, the booster dose of tetanus if received was also included. It was found that the proportion of mothers who received protection against tetanus was 83.3% in the baseline survey and has increased significantly to 93.4% in the endline survey.

The current international standards related to breastfeeding and infant/child nutrition are exclusive breastfeeding of infants until about six months of age and appropriate complementary feeding from about six months of age. In order to assess this, the proportion of children aged 0-5 months who were exclusively breastfed in the last 24 hours was calculated. This proportion was 80.1% in the baseline survey and increased to 85.1% in the midterm survey. However, in the Endline survey, this decreased to 62.87%, which may be due to extremely hot conditions which prevailed during data collection in which mothers often give water etc in addition to breast milk to the infants. The proportion of children aged 6-9 months who were given breast milk and complimentary foods in the last 24 hours was 72.0% in the baseline and it increased significantly to 97.98% in the Endline survey.

The ultimate goal of immunization programs is to reduce the incidence of vaccine-preventable diseases in children. This is achieved through full immunization coverage against five diseases (poliomyelitis, diphtheria, pertussis, tetanus, and measles) by the end of the first year of life. The proportion of children aged 12-23 months who were fully vaccinated was observed to be 62.4% in the baseline and 69.8% in the midterm survey. This proportion significantly increased to 95.8% in the endline survey. Similar trend was observed in the proportion of children aged 12-23 months who received measles vaccine where it increased from 67.1% in the baseline to 96.4% in the endline survey.

In an attempt to assess the protection against malaria, the proportion of children who slept under a bednet the previous night was recorded. It has been observed that though the programme was not involved in promotion of use of bed nets, 20.7% children aged 0-23 months reportedly slept under a bednet the previous night.

It is also a known fact that sanitation and hygiene related ignorance leads to almost 50% of the infections among the children. The project aimed at increasing awareness about hygiene and increasing the practice of better hygiene among the target group. Maternal hand-washing behavior was assessed by the proportion of mothers of children aged 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated. The proportion of mothers who reported washing hands before preparing food increased from 9.1% in the baseline to 36.0% in the midterm and 46.1% in the endline survey. The proportion with regard to washing hands before feeding children also increased from 14.0% in the baseline to 40.6% in the midterm and 57.2% in the endline survey. The proportion with regard to washing hands after washing child who has defecated increased from 83.8% in the baseline to 97.3% in the endline survey. Similarly, the proportion of mother reporting that they wash their hands with soap/ash after defecation also increased from 87.6% in the baseline to 98.6% in the endline. This trend indicates a significant improvement in the hand washing practices of the mothers which would lead to improved child health.

Two focuses of the community Integrated Management of Childhood Illnesses (IMCI) strategy are 1) timely recognition of signs in children that indicate the need for treatment and 2) effective home management of child illnesses. To assess this, the proportion of children aged 0-35 months with cough and/or difficult/rapid breathing during past two weeks who received increased fluids and continued feeding was calculated. The proportion of children who received increased fluids during this condition increased from 1.3% in the baseline to 32.2% in the Endline survey. Similarly, the proportion of children in this condition in the last two weeks who received continued feeding increased from 50.0% to 98.3% in the Endline survey.

Widespread knowledge of ways to reduce the risk of HIV transmission is critical in thwarting the spread of HIV/AIDS. The proportion of mothers of children aged 0-35 months who were aware of at least two ways of reducing the risk of HIV/AIDS was only 9.2% in the baseline survey. The proportion increased significantly to 56.8% and 59.3% in the midterm and endline surveys to indicate that the awareness with respect to HIV/AIDS has increased significantly.

Overall, it is observed that almost all the indicators related to child survival which are captured under the Rapid Catch 2000 have increased significantly from the baseline survey. This indicates that the CLICS programme has been successful in achieving its objectives of increasing child survival and the achievements are truly commendable in all respects.

Annexure I

Community Led Initiatives for Child Survival Schedule Nu

Department of Community Medicine
MGIMS, Sewagram, Wardha

INTERVIEW SCHEDULE for HOUSEHOLD

(Schedule 1 of 5)

I. IDENTIFICATION

A. PHC_____

B. Name of the Cluster/ Village _____Cluster Number ☐
(As per list enclosed)

C. Name of the Household Head _____HH No. ☐

D. Name of the respondent _____

E. Name of Interviewer: _____ Signature: _____

F. Date of Interview: (DD/MM/YY) ☐☐☐

G. Result of Interview ☐

Completed =1
Postponed =3
Refused =5
Household absent = 2
No Competent Resp. Found in HH = 4
Partly completed = 6

H. Name of Supervisor:_____ Signature: _____

Introduction:

Namaskar. My name is …….. I come from CLICS program, MGIMS, Sewagram. We are studying health issues related to you and your children. This information will be used for evaluation of CLICS program. I would like to assure you that your name and the information given by you will remain confidential, and will be used research purpose. I shall be grateful if you could spare me 30-40 minutes of your time.

Respondent:

I have been explained the purpose of the study and I am ready to participate in the study.

_____

Signature/Thumb impression of Respondent

II. HOUSEHOLD INFORMATION

Please name all the people who are presently living in this household including any servant who lives here and anyone who is temporarily out, but usually lives here.

Table 1.1: Household Members

Sr. No.	Name of Household member	Relationship with head of household	Sex (Male=1, Female=2)	Age (in Completed years)	Education (Standard Passed)	Occupation (**Applicable for aged > 5 yrs**)	Sr. of Mother **or** Sr. No. of Husband*****
2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8
01							
02							
03							
04							
05							
06							
07							
08							
09							
10							
11							
12							
13							
14							
15							

INS: Write in chronological order incase of nuclear family. If joint family, write each family separately and chronologically.

Codes:

Q.2.3 *Head = 01* *Wife or Husband = 02* *Son or daughter = 03* *Son or D-in-law = 04*
Grand Children = 05 *Parents = 06* *Parents-in-law = 07* *Brother or sister = 08*
Brother-in-law/sister-in-law = 09 *Grand father/Grand mother=10* *Adopted/Foster = 11*
Not related = 12 *Other relatives= 13 (specify)*_____

Q. 2.7: *Unemployed = 1, Student/Education=2, Housework = 3, Service and Bussiness = 4, Skilled worker (Sutar and Mistry) = 5, Mill and Factory Laborer = 6, Farmer=7, Agri. Laborer =8, Unskilled worker (Any manual work other than mentioned above) = 9, Others =10(specify)*_____

Q 2.8: *Sr. of Mother to be recorded for children age under 5 years and Sr. No. of Husband to be recorded for currently married women age 15-44 years*

2.9 Total Family Income per Year (In Rupees) ☐

2.10 Do you have a Ration Card? (Yes=1, No=2) ☐

If 'Yes', then:

2.11 What type of Ration Card do you have? ☐
(Antyodayee=1, BPL=2, Other=3, Don't have=4)

2.12 Religion: (Hindu=1, Muslim=2, Christian=3, Buddhist=4, Sikh=5, Others=6) ☐

2.13 Caste category (SC=1, ST=2, VJ=3, NT=4, OBC=5, Open=6, Others=7) ☐

2.14 Have you had health insurance in the last year (Yes=1, No=2) ☐

Note: Q 2.15 to Q 2.18 to be filled from table 1.1

2.15 Total members in Household ☐

2.16 Total children below 3 years ☐

2.17 Total Number of married women in the age group 15-44 Yrs. ☐

2.18 Total No. of Adolescents girls (12-19 Yrs.) ☐

III. ENVIRONMENTAL SANITATION

3.1 What is the main source of drinking water in your family? ☐
Open Well=1, Tube well / Hand pump=2, Tap/Piped Water=3, Ground Water (Pond / Lake / River) =4, Others=5(Specify) _____

3.2 Do you use any water purification method? (Yes=1, No=2, No Response=3) ☐

If 'Yes', then: If 2 or 3 Then Skip to Ques Nu-3.4

3.3 Which method do you use for water purification? (Name the method) ☐
Boiling = 1, Filtering = 2, Chlorine = 3, "Jeevan Drop"=4,
Others= 5 (Specify) _____

3.4 Do you have sanitary latrine? (Yes=1, No=2) ☐

If 'Yes', then: If No Then Skip to Ques Nu-3.6

3.5 Do you use it regularly? (Yes=1, No=2) ☐

Check table 1.1: If there is no child less than 3 years, then go to Q. 4.1

In case of more than one child (< 3 yrs) ask Q. 3.6 for youngest child

3.6 Was the child slept under mosquito-net (*Macchardani*) in the previous night? ☐
(Yes=1, No=2, Don't have mosquito-net=3)

IV. BIRTH AND DEATH HISTORY

4.1 Since 1st May 2007, how many live births occurred in the household? ☐

If response is '**0**', then **Go to Q.4.8.**

4.2 Kindly give the following details for each woman who has given birth since, 1st May 2007.

Table 4.1 : Births

Name of mother	Date of birth **DD/MM/YY**	Sex of the child *(Male=1, Female=2)*	Whether surviving *(Yes=1, No=2)*	If not alive age at death *(months)*
4.3	4.4	4.5	4.6	4.7

4.8 Since 1st May 2007, has any child below 5 years of age died in the household? (Yes = 1, No = 2) ☐

If 'No', then Go to Q. 4.16

4.9 How many deaths? ☐

Kindly provide the following information about each of them?

Table 4.2 : Deaths of Children Age under 5 years

Name of deceased	Date of death	Sex of Deceased 1=Male 2=Female	Age at death (Months)	Place of death 1. Hospital 2. Home	Cause of death
4.10	4.11	4.12	4.13	4.14	4.15

(INS: Check if any death of child is reported in Table –4.1 It should also be reported in Table –4.2. If not reported probe and enter the information in Table –4.1 / Table – 4.2)

4.16 Did any married female died in age group of 15-44 during last five years **(May 2003 onwards)** in this household? (Yes = 1, No = 2) ☐

If response is 'No' then 'Thank and Terminate the Interview'

4.17 Was she died during pregnancy or during delivery or within 42 days of delivery? (Yes = 1, No=2) ☐

If '**No**' then '**Thank and Terminate the Interview**'

Kindly provide the following information.

Table 4.3 : Details of Maternal Death

Name of deceased	Date of death	Cause of Death	Age at death (Years)	Place of death (Hospital=1, Home=2)
4.18	4.19	4.20	4.21	4.22

Thank and Terminate the Interview

Community Led Initiatives for Child Survival **Schedule Nu**

Department of Community Medicine
MGIMS, Sewagram, Wardha

INTERVIEW SCHEDULE for WOMEN WITH CHILD IN AGE GROUP 0-3 YRS.
(Schedule 2 of 5)

IDENTIFICATION

A. PHC_____

B. Name of the Cluster/village _____Cluster Number ☐
(As per list enclosed)

C. Name of the respondent:-_____

D. Household Number: ☐

E. Responding women's Line Number from 2.1 of Household schedule: - ☐

F. Name of Interviewer: _____ Signature: _____

G. Date of Interview: (DD/MM/YY) ☐☐☐

H. Name of Supervisor:_____ Signature: _____

Introduction:

Namaskar. My name is …….. I come from CLICS program, MGIMS, Sewagram. We are studying health issues related to you and your children. This information will be used for evaluation of CLICS program. I would like to assure you that your name and the information given by you will remain confidential, and will be used research purpose. I shall be grateful if you could spare me 30-40 minutes of your time.

Respondent:

I have been explained the purpose of the study and I am ready to participate in the study.

_____

Signature/Thumb impression of Respondent

I. BACKGROUND CHARACTERISTICS

1.1 What is your current age? (Completed years) ☐

1.2 What was your age at the time of your marriage? (Completed years) ☐

1.3 Do you know, what is the legal age at marriage for boy and girl in India?

Boy ☐

Girl ☐

(If DK write 98 for Both)

1.4 How many pregnancies did you have so far? (Including current pregnancy) ☐

1.5 What was your age at the time of first pregnancy? (Years) ☐
(Don't Remember = 98)

1.6 How many live births did you have so far? Total ☐

Male ☐ Female ☐

1.7 What is the date of birth of your youngest surviving child? (Date of birth) ☐☐☐

1.8 What is the date of birth of your second youngest surviving child? ☐☐☐
If Only One surviving child leave write "11/11/11" else Date of birth)

II. SAFE MOTHERHOOD

2.1 What was the outcome of your last pregnancy?

Outcome	Place of delivery / abortion Hospital (private/public)= 1, Home= 2	Who attended the delivery / abortion?	In case of non-institutional delivery whether DDK was used? (Yes = 1, No = 2, DK = 3)
2.1	2.2	2.3	2.4

Q. 2.1 Outcome: *Live birth =1, Still birth =2, Spontaneous abortion =3, Induced abortion = 4*

Q. 2.3 Delivery attended by: *Doctor=1, Nurse=2, Trained Dai = 3, Untrained Dai = 4, Relative/ Neighbour=5,*

Others=6

*(Specify)*_____

III. ANTENATAL (Ask for the last pregnancy) i.e. Index Child

3.1 Did you receive any antenatal check-up during pregnancy? (Yes = 1, No = 2) ☐

3.2 How many months pregnant were you at the time of first antenatal check-up? ☐
(Record month of gestation)

3.3 During the whole pregnancy, how many times have you received antenatal check-ups? (No. of antenatal check-ups) ☐

3.4 From where you received these services? (Encircle all stated responses)
Home=1, Sub Center = 2, PHC/ Mandi health centre = 3, District Hospital=4,
Rural Hospital = 5, Medical College=6, Private Practitioners =7, BSD = 8,
Others = 9 (specify)_____

3.5 What examinations were conducted during the antenatal check-ups? Read out the Responses

Medical Check-up	Yes = 1, No = 2, Don't remember=3		
Inquiry about previous pregnancy/ delivery history	1	2	3
BP measurement	1	2	3
Weight measurement	1	2	3
Height measurement	1	2	3
Abdominal examination	1	2	3
Urine examination	1	2	3
Internal examination (PV)	1	2	3
Sonography	1	2	3
Blood test	1	2	3
Others (Specify)_____	1	2	3

3.6 During antenatal check-ups were you given following advices? Read out the Responses

Advice	Yes = 1, No = 2, Don't remember=3		
Advised on periodic check-ups	1	2	3
Advised on diet and nutrition	1	2	3
Advised rest	1	2	3
Advised on breast feeding the new born immediately after delivery	1	2	3
Advised on contraceptive use	1	2	3
Others (Specify)_____	1	2	3

3.7 During the pregnancy were you given or did you buy any iron folic acid (IFA) tablets or syrup? (Yes=1, No=2, Don't remember=3) ☐

If '**No**' or '**Don't remember**', then **Go to: Q. 3.10**

3.7.1 In which form you have received or purchased IFA tablets? ☐
(Strip=1, Packet=2, Loose=3, In more than one form=4)

3.7.2 How many strip(s) of IFA tablets you have received or purchased? ☐
(Number of Strips)

If '0', then Go to: Q.3.7.4

3.7.3 How many tablets were there in a strip? (Number of tablets) ☐

3.7.4 How many packet(s) of IFA tablets you have received or purchased? ☐
(Number of packets)

If '0', then Go to: Q.3.7.6

3.7.5 How many tablets were there in a packet? (Number of tablets) ☐

3.7.6 How many loose tablets you have received or purchased? (Number of tablets) ☐

3.8 During the whole pregnancy, how many IFA tablets were you received or purchased?
(Total no. of tablets received or purchased in all forms) ☐

3.9 During the whole pregnancy, out of ____ tablets received or purchased, how many IFA tablets did you consume? (Total no. of IFA tablets consumed) ☐

If response of **Q.3.9 is equal to the response of Q.3.8**, then **Go to: Q3.11**

3.10 What was the reason behind non-consumption of IFA tablets (difference between received/ purchased and consumed) during pregnancy? ☐
(Passing black stools=1, Gastric disorders=2, fear of large size of feotus =3, Opposition of mother-in-law=4, Others (specify)_____=5)

3.11 During this pregnancy, were you given an injection (TT) to prevent you and the baby from getting tetanus? (Yes=1, No=2, Don't remember=3) ☐

If **'No'** or '**DK'**, then **Go to: Q 3.14**

3.12 During this pregnancy, how many times did you get a tetanus (TT) injection?
(Verify from Card, if available) (No. of TT injections) ☐

If response is '**greater than 1'** then **Go to: Q 3.14**

Check Q.1.4: If response is '1', then **Go to: Q 3.14**

Check the birth spacing between two pregnancies **(Q.1.7 and Q.1.8)**: If '**birth spacing**' is **'greater than 35 months**', then **Go to: Q 3.14**

3.13 Was that a booster dose of TT? (Yes=1, No=2, DK = 3) ☐

3.14 Do you know about danger signs during pregnancy/delivery? (Yes=1, No=2, DK=3) ☐

If **'No'** or '**DK'**, then **Go to: Q. 3.16**

3.15 Enumerate the danger signs.
(Circle the Responses) against the spontaneous responses given by respondent)

Convulsions	**1.1.1.1.1.1.1 A**	1
Prolonged labor	B	2
Abnormal presentation of the baby/breech/ hand prolapse	C	3
Hypertension/high blood pressure	D	4
Excessive bleeding	E	5
High fever	F	6
Delayed separation of placenta	G	7
1.1.1.1.2 Swelling of ankles/feet	H	8
1.1.1.1.3 Anaemia	I	9
Less fetal movements	J	10
2.2 Early onset of delivery	K	11
Others (Specify)	L	12
Don't know/Can't say	Z	13

3.16 Did you have following complications during pregnancy? Read out Responses

Complications	(Yes=1, No=2, DK = 3)		
Convulsions	1	2	3
Abnormal presentation of the baby/breech/ hand prolapse	1	2	3
Hypertension/high blood pressure	1	2	3
Excessive bleeding	1	2	3
High fever	1	2	3
1.2.1.1.1 Swelling of ankles/feet	1	2	3
1.2.1.1.2 Anaemia	1	2	3
Less fetal movements	1	2	3
Others (Specify)_____	1	2	3
Don't know/Can't say	1	2	3

Note: If answer to above complications is "No" or "DK" then go to Q. 4.1

3.17 Whom did you consult first for treatment of complications during pregnancy?
(Please record responses in pathway)Ranking

A. ANM/LHV/HW ☐ B. Doctor at Govt. facility ☐

C. Doctor at Pvt. Clinic ☐ D. CLICS Doot ☐

☐

E. Village Coordination Committee ☐ F. Medical college

G. Kiran Clinic ☐ H. Others (Specify) _____ ☐

IV. INTRA NATAL CARE

4.1 Did you have following danger signs during delivery?
(Circle the responses) against the spontaneous responses given by respondent)

Danger signs	(Yes=1, No=2, DK = 3)		
Prolonged labor	1	2	3
Abnormal presentation of the baby/breech/ hand prolapse	1	2	3
Excessive bleeding	1	2	3
Delayed separation of placenta	1	2	3
2.3 Early onset of delivery	1	2	3
Others (Specify)_____	1	2	3
Don't know/Can't say	1	2	3

Note: If answer to above danger Signs is "No" or "DK" then go to Q. 5.1

4.2 Whom did you consult first for treatment of complications during delivery?
(Please record responses in pathway)Ranking

A. ANM/LHV/HW ☐ B. Doctor at Govt. facility ☐

C. Doctor at Pvt. Clinic ☐ D. CLICS Doot ☐

E. Village Coordination Committee ☐ F. Medical college ☐

G. Kiran Clinic ☐ H. Others (Specify) _____ ☐

4.3 How far is the health facility located from your place of residence? ☐
(Distance in KM with reference Q. 4.2)

4.4 What was the mode of transportation used for treatment on complications? ☐
(Walk =1, Auto Rickshaw =2, Motor Cycle=3, Trax/Tempo/Jeep=4, Bus=5, Train=6, Bicycle=7,
Bullock cart=8, Others=9 (Specify)_____, DR =10)

V. POSTNATAL CARE

5.1 Have you received any postnatal check-ups after delivery? (Yes=1, No=2, DK=3) ☐

If 'No', then Go to: Q. 6.1

5.2 How many times did you receive postnatal check-ups? (No. of postnatal check-ups)

In first 2 weeks ☐

During 3-6 weeks ☐

5.3 Who provided the postnatal services? (Encircle all stated responses)
ANM/LHV/HW=1, Doctor at Govt. facility=2, Doctor at Pvt. Clinic=3,
CLICS Doot=4, Others=5(Specify)_____

5.4 Where was/were postnatal services provided? (Encircle all stated responses)
At home=1, At govt. hospital=2, At private hospital=3, At BSD=4,
Medical college=4 Others=5 (specify)_____

VI. CONTRACEPTION

There are various ways or methods that a couple can use to delay or avoid pregnancy.

6.1 What are the methods of Family Planning, you know or have heard of?
(Encircle all stated responses)
Condom=1, OCP =2, IUD =3, Tubectomy=4, Vasectomy =5, Any other=6

*(specify)*_____

6.2 Are you or your husband currently using any spacing or termination method of family planning? *(Yes = 1, No = 2)* ☐

If 'No', then **Go to: Q. 7.1**

6.3 Which method are you or your husband currently using? (Encircle all stated responses)
Condom=1, OCP =2, IUD =3, Tubectomy=4 Vasectomy =5, Any other=6

*(specify)*_____

6.4 For how many months are you using this FP method? (Duration of use in month ☐

VII. RTI / STI AND HIV /AIDS

7.1 Do you have any of the following complaints in last 3 Months? Read out Responses

Complaint	Yes=1, No=2	
Abnormal vaginal discharge	1	2
Genital Ulcer / Rash	1	2
Inguinal swelling	1	2
Lower abdominal pain	1	2
Itching around Vagina / Vulva	1	2

(INS : If response is No in all above questions, then Go to 7.6)

7.2 Have you availed treatment for this problem? (Yes=1, No=2) ☐

If 'No', then Go to 7.6

7.3 Where did you seek treatment? (Record responses in pathway)Ranking

A. Private Doctor……..…. ☐ B. Govt. Hospital…….……... ☐

C. Medical college ……..… ☐ D. ANM / LHV / HW……. ☐

E. Medical shop……... ☐ F. Friends…… ☐

G. Self Treatment…….. ☐ G. Other (specify) _____ ☐

7.4 Was your spouse also given treatment? (Yes = 1. No = 2, DK = 3) ☐

7.5 Was your spouse counseled? (Yes = 1, No = 2, DK=3) ☐

AWARENESS ABOUT HIV/AIDS

7.6 Have you heard about HIV / AIDS? (Yes=1, No=2), If 2 then skip to 8.1 ☐

7.7 How is HIV/AIDS transmitted?Read out responses

1.3.	**Question**	Yes=1, No=2, DK=3		
1.3.	Unsafe sex/ unprotected sex	**1.3.1.**	**1.3.1.1.**	**1.3.1.1.**
02	Transfusion with infected blood/ blood products	1	2	3
03	From HIV positive pregnant mother to her baby	1	2	3
04	Use of unsterilized needle/ syringe	1	2	3
05	From breast milk of HIV positive mother to her baby	1	2	3
06	From mosquito bite	1	2	3
07	By shaking hands with HIV positive person	1	2	3
08	Others (specify) _____	1	2	3
98	Don't remember/ cannot say	1	2	3

(INS: If response is No / DK in all above questions, Go to 7.9)

7.8 What is the source of this information?
(Circle the responses) against the spontaneous responses given by respondent)

Radio	
TV/Film	1
Newspaper / Magazine / Journal	2
Debate / Seminar	3
Signboards / Poster	4
Relative / Friends / Husband	5

Doctor	6
ANM / LHV/ HW	7
Social Worker	8
Community Organizer (CLICS)	9
Self Help Group (SHG)	10
CLICS Doot	11
Others (specify)_____	12
Don't know/Don't remember	13

7.9 How can a person protect herself from getting infected with HIV / AIDS?
(Circle the Responses) against the spontaneous responses given by respondent)

01	Avoid sex with multiple sex partners	1
02	Use of condom during intercourse	2
03	Avoid sex with sex workers	3
04	Use of safe (HIV negative) blood	4
05	Use of Disposable / Sterile Needle / Syringe	5
06	Sexual relation with a mutually faithful partner	6
07	Other (specify) _____	7
98	Don't know/Can't say	8

VIII. PERSONAL HYGIENE

8.1 Can you tell me; with what do you wash your hands on following occasions? Circle the Responses

Occasions when respondent washes hands	**With what do you wash your hands?** (With only water -without soap or ash =1, With ash and water= 2, With soap and water=3, Don't wash hands=4)			
After defecation	1	2	3	4
Before eating meals	1	2	3	4
Before cooking food	1	2	3	4
Before feeding children	1	2	3	4
After cleaning faces of baby	1	2	3	4

IX. KIRAN CLINIC

(Note: to be asked only in the villages where Kiran Clinic exist)

9.1 Are you aware of Kiran Clinic in your village: (Yes=1, No=2) ☐

If" NO" Thanks and terminate the Interview

9.2 Have you/your family member utilized the services of the Kiran clinic? ☐
(Yes=1, No=2)

If" NO" Thanks and terminate the Interview

9.3 Are you /your family member satisfied with the services of the clinic? ☐
(Yes=1, No=2)

If" Yes" Thanks and terminate the Interview

9.4 What are the reasons for non satisfaction
(Circle the Responses) against the spontaneous responses given by respondent)

1. Timing not suitable ☐ 2. Rude behaviour of health staff ☐
3. Non Availability of drugs ☐ 4. High cost of the drug ☐
5. Any Other (Specify) ☐ ----------

Thank and Terminate the Interview

Community Led Initiatives for Child Survival Schedule Nu

Department of Community Medicine
MGIMS, Sewagram, Wardha

INTERVIEW SCHEDULE for CHILD HEALTH

(Schedule 3 of 5)

(Respondent: Mothers of children age under 3 years)

IDENTIFICATION

A. PHC_____

B. Name of the cluster /village _____ Cluster Number ☐
(As per list enclosed)

C. Household Number: ☐

D. Name of Mother _____

E. Line number of Mother in Q 2.1 from Household schedule ☐

F. Name of the child _____

G. Line number of child in Q 2.1 from Household schedule ☐

H. Date of birth: DD/MM/YY ☐☐☐

I. Sex: (Male=1, Female=2)

J. Name of Interviewer: _____ Signature: _____

K. Date of Interview: (DD/MM/YY) ☐☐☐

L. Name of Supervisor:_____ Signature: _____

I. BIRTH HISTORY

1.1 Where did the delivery take place? *(Home=1, Institution=2)* ☐

If 'Institutional delivery', then **Go To Q 1.3**

1.2 Who conducted the delivery? ☐
(Doctor=1, Nurse=2, Trained Dai=3, Untrained person=4, Relative/Neighbour=5)

1.3 When was the baby weighed after birth? ☐
(On day 1=1, On day 2=2, 3-7th day =3, After 7th day=4, Never=5)

If the answer is '4 or 5' then, **Go To Q 1.5**

1.4 What was the birth weight of the baby? *(in grams)* ☐☐☐☐

1.5 When was the baby given bath after birth? *(Mention the day)* ☐

1.6 When the baby was wrapped-up after birth? ☐

(Up to 1 hour=1, After1 hour=2, Not wrapped=3)

1.7 When did you start breast feeding the child? ☐
(Within ½ hour=1, ½ -1 hour=2, After1 hours and within 3 three hours=3, 3-6 hours=4, 7-24 hours=5, After 24 hours=6, No breastfeeding …8)

1.8 Whether the first breast milk was discarded? *(Yes=1, No=2, DK=3, Don't remember* ☐

1.9 Was the child given Plain water/Sugar water/Honey water/Janam Ghutty before initi breast feeding? *(Yes=1, No=2, DK=3, No response=4)* ☐

1.10 Are you currently Breastfeeding? *(Yes = 1, No = 2)* ☐

If 'Yes', **Go To Q 1.12**

1.11 For how many months have you breastfed the child, since birth? (Months) ☐

1.12 Whether any of the following was given to the child during last 24 hours Read out Responses

Item	Yes = 1, No = 2, DK		
a) Plain water	1	2	3
b) Formula or milk other than breast milk	1	2	3
c) Other liquids	1	2	3
d) Sugar/honey water	1	2	3
e) Powdered milk	1	2	3
f) Anything else (Specify)	1	2	3

1.13 Upto how many months was the child given exclusively breast milk? ☐
(Exclusively breast feeding means, child was given only breast milk without any liquid supplement like water, sugar/jaggery water, and diluted cow's milk) (Currently exclusively breast feeding=97)

1.14 At what age of the child, did you start giving complementary food? ☐
(In Months) (If not yet started = 96)

1.15 Can you tell the names of iron rich foods items?
(Circle the responses) against the spontaneous responses given by respondent)

	Iron rich food items	spontaneous response
1	Green leafy vegetables	1
2	'*Khajoor*'	2
3	Groundnut and jagary	3
4	'*Ahaliv*'	4
5	*Bit root*	5
6	Drumstick,	6
7	Chicken/mutton/egg/fish	7
8	Apple	8
9	Others (specify)_____	9

1.16 Immunization **(For children between 12-23 months)**
Do you have immunization card of _____? *(Yes = 1, No = 2)* ☐

If yes, please show me the card.
(Check the card as well as verify by asking the mother and Circle the Responses)Yes-1,No-2

Vaccine	Copy from Card		From mother's recall	
BCG*	**1**	**2**	**1**	**2**
Polio 1	**1**	**2**	**1**	**2**
DPT 1	**1**	**2**	**1**	**2**
Polio 2	**1**	**2**	**1**	**2**
DPT 2	**1**	**2**	**1**	**2**
Polio 3	**1**	**2**	**1**	**2**
DPT 3	**1**	**2**	**1**	**2**
Measles	**1**	**2**	**1**	**2**

*** Confirm by scar. Depending on scar, enter in respective column of mother's recall.**

1.17 How many doses of Vitamin A have your child received? *(No. of doses)* ☐

1.18 Has the child been given Vitamin A dose in last 6 Months? *(Yes=1, No=2, DK=3)* ☐

1.19 Has the child been given Iron tablets during last two weeks? *(Yes = 1, No=2, DK=3)* ☐

If 'No' or 'DK', then **Go To Q 1.21**

1.20 How many tablets of Iron the child received? *(No. of tablets)* ☐

1.21 Has the child been given Iron syrup in the last two weeks? *(Yes = 1, No=2, DK=3)* ☐

II. ANTHROPOMETRIC MEASUREMENT

2.1 Whether the child was weighed during last 30 days in BSD or Anganwadi? ☐
(Yes=1, No=2)

2.2 Length / Height *(Cm.)* ☐☐☐ *Cm.*

2.3 Weight *(gms.)* ☐☐☐☐☐ gms.

III. MORBIDITY PROFILE

3.1 Ask the mother for any of the following morbidities her child experienced in the last two weeks?

3.1	3.2			3.3		3.4	3.5		3.6		3.7		3.8			
Morbidity (In last 2 weeks)	**Whether experienced** *(Yes=1, No=2, DK=3)*			**Whether treated** ***(Yes =1, No=2)***		**Treatment Provider** *(use code)*	**Does treatment provider advised to give fluids to the child** *(Yes =1, No = 2)*		**Continued feeding observed** *(Yes =1, No=2)*		**Increased intake of fluids** *(Ye =1, No=2)*		**Was the child given:** *Only ORS=1, Only HAF= 2, ORS and HAF = 3, Nothing=4*			
A. Fever (In last 2 weeks)	1	2	3	1	2		1	2	1	2	1	2				
B. Cold/running nose (In last 2 weeks)	1	2	3	1	2		1	2	1	2	1	2	1	2	3	4
C. Cough and difficulties in breathing (In last 2 weeks)	1	2	3	1	2		1	2	1	2	1	2	1	2	3	4
D. Diarrhoea (> 3 loose stools per day) (In last 2 weeks)	1	2	3	1	2		1	2	1	2	1	2	1	2	3	4
E. Dysentery (Blood in stool) (in last 2 weeks)	1	2	3	1	2		1	2	1	2	1	2	1	2	3	4
F. Any other problem within last 2 weeks. (specify) _____ _____	1	2	3	1	2		1	2	1	2	1	2				

CODES: *3.4* ***Treatment Provider:*** *Nurse=1 ,Govt. Doctor=2, Private qualified Doctor (Degree holder)=3,CLICS Doots=4, Kiran Clinic=5, Home remedy=6 Quakes =7,*

If index child had not experience any morbidity (**'No' to Q. 3.2**) in last 2 weeks, then **Go to Q. 4.1**

3.9 Please give details of expenditure.

Was the child hospitalized? (Yes=1, No=2)		What was the Direct cost (in Rs.) (Fees+Drugs+Admission charges if any)	What was Indirect cost (in Rs.) (Travel+loss of wages)	Total cost (In Rs.) (2+3+ cost of home remedy/medicines)
(1)		(2)	(3)	(4)
1	2			

3.10 What was/were the source(s) of meeting the medical expenditure?
(Encircle all stated responses)
Earned and spent=1, Savings=2, Borrowing from money lender=3, Borrowing from SHG=4,
Borrowed from neighbors=5, Liquidation of assets=6,
*Others=7(specify)*_____

IV. KNOWLEDGE REGARDING DANGER SIGNS

4.1 What are the signs and symptoms which can be dangerous in a newborn baby? Read out Responses

Danger sign	*Yes=1, No=2, DK=3*		
Poor sucking	1	2	3
Lethargy/unconscious	1	2	3
Convulsions	1	2	3
Low body temperature	1	2	3
Severe malnutrition	1	2	3
Rapid/difficult breathing /pneumonia	1	2	3
Pus draining from umbilicus	1	2	3
Fever	1	2	3
More than 10 pustules or 1 big boil	1	2	3
Grunting	1	2	3
Any other thing (specify) _____ _____	1	2	3

4.2 What are the signs and symptoms in children aged 1-35 months, which can be dangerous and that indicate the need for treatment? Read out Responses

Danger sign	*Yes=1, No=2, DK=3*		
Poor sucking/ difficulty in feeding	1	2	3
Lethargy/unconscious	1	2	3
Convulsions	1	2	3
Vomits every thing	1	2	3
Severe malnutrition	1	2	3

Rapid/difficult breathing /pneumonia	1	2	3
Pus draining from ear	1	2	3
Fever	1	2	3
3 or more than 3 loose (watery) stools per day	1	2	3
Any other thing (specify) _____ _____	1	2	3

4.3 What should be done if the newborn/child is having any of the above symptoms? (Circle the spontaneous responses given by respondent)

Response	Tick mark
Visit to ANM/Sub centre	*1*
Visit to PHC/Rural Hospital/district hospital	2
Visit to medical college	3
Visit to private practitioners	4
Visit to CLICS Doot	5
Any other (specify) _____ _____	6

4.4 What can be done to prevent hypothermia? Read out Responses

Response	*Yes=1, No=2, DK=3*		
Put the child in warm clothes	1	2	3
Cover the child especially head and feet	1	2	3
Do not put the baby in front of fan	1	2	3
Put baby in skin to skin contact with mother	1	2	3
Any other (specify) _____ _____	1	2	3

4.5 What can be done to manage the low birth weight baby? Read out Responses

Response	*Yes=1, No=2, DK=3*		
Immediate consultancy with health provider	1	2	3
Not allowing many persons to touch the baby	1	2	3
Protect baby from cold (keep baby warm)	1	2	3
Keep baby with mother	1	2	3
Ensure sun light, fresh air in the room	1	2	3
Any other (specify) _____ _____	1	2	3

Thank and Terminate the Interview

Community Led Initiatives for Child Survival Schedule Nu

Department of Community Medicine
MGIMS, Sewagram, Wardha

INTERVIEW SCHEDULE for HUSBAND

(Schedule 4 of 5)

IDENTIFICATION:

A. PHC_____

B. Name of the cluster/village _____ Cluster Number ☐
(As per list enclosed)

C. Name of the respondent _____

D. Household Number: ☐

E. Respondent's line of Q 2.1 of Household schedule ☐

F. Name of Interviewer: _____ Signature: _____

G. Date of Interview: (DD/MM/YY) ☐☐☐

H. Name of Supervisor:_____ Signature: _____

Introduction:

Namaskar. My name is …….. I come from CLICS program, MGIMS, Sewagram. We are studying health issues related to you and your children. This information will be used for evaluation of CLICS program. I would like to assure you that your name and the information given by you will remain confidential, and will be used research purpose. I shall be grateful if you could spare me 30-40 minutes of your time.

Respondent:

I have been explained the purpose of the study and I am ready to participate in the study.

_____

Signature/Thumb impression of Respondent

I. REPRODUCTIVE HEALTH

1.1 What is your current age? *(In completed years)* ☐☐

1.2 In your opinion, who is responsible for determination of sex of a child (in womb)? ☐
Husband=1, Wife=2, Both Wife and Husband=3, Others=7 (Specify) _____
Don't know=8

II. SAFE MOTHERHOOD

2.1 Now let us talk about your understanding of pregnancy and care of the mother and unborn child during pregnancy.
During pregnancy, should the woman go for antenatal checkup? ☐
(Yes=1, No=2, Don't know=3)

If '**No**' or '**Don't know**', then **Go to: Q. 2.6**

2.2 At how many months of pregnancy should the woman go for antenatal checkup for the first time? *Number of months pregnant* ☐

2.3 In her entire pregnancy of nine months, at least how many times do you think should she go for ante-natal checkup? *Number of times* ☐

☐

2.4 How many times did you accompany your wife for antenatal checkup?

2.5 Where should a mother deliver her baby? *(Home=1 Hospital=2)* ☐

2.6 Are there any kind of preparations that the family members should make, when a child is due? (Yes=1, No=2, Don't know=3) ☐

If '**No**' or '**Don't know**', then **Go to: Q. 2.8**

2.7 What kind of preparations should they make? (**Probe for each preparation listed in table)**

1.3.1.1.1.1.6 Preparations	*1.3.1.1.1.1.6.1 Whether to be made* Yes=1	No=2	DK=3
1.3.1.1.1.1.7 Identify place of delivery	1	2	3
1.3.1.1.1.1.8 Arrange for money	**1**	**2**	**3**
1.3.1.1.1.1.9 Arrange for materials like Disposable Delivery Kit	**1**	**2**	**3**

1.3.1.1.1.1.10 Arrange for clothes for the newborn	**1**	**2**	**3**
1.3.1.1.1.1.11 Identify/arrange for transport	**1**	**2**	**3**

2.8 There are a few danger signs during pregnancy/delivery, which pose an immediate risk of death to the mother or the baby. On the occurrence of which danger signs should a pregnant woman be taken immediately to a health facility?
(Circle the Responses) against the spontaneous responses given by respondent)

Convulsions	**1.3.1.1.1.1.12 A**	1
Prolonged labor	B	2
Abnormal presentation of the baby/breech/ hand prolapse	C	3
Hypertension/high blood pressure	D	4
Excessive bleeding	E	5
High fever	F	6
Delayed separation of placenta	G	7
1.3.1.1.2 Swelling of ankles/feet	H	8
1.3.1.1.3 Anaemia	I	9
Less fetal movements	J	10
2.4 Early onset of delivery	K	11
Others (Specify)	L	12
Don't know/Can't say	Z	13

III. KNOWLEDGE REGARDING DANGER SIGNS

3.1 What are the signs and symptoms which can be dangerous in a newborn baby?Read out Responsese

Danger sign	*Yes=1, No=2, DK=3*		
Poor sucking	1	2	3
Lethargy/unconscious	1	2	3
Convulsions	1	2	3
Low body temperature	1	2	3
Severe malnutrition	1	2	3
Rapid/difficult breathing /pneumonia	1	2	3

Pus draining from umbilicus	1	2	3
Fever	1	2	3
More than 10 pustules or 1 big boil	1	2	3
Grunting	1	2	3
Any other thing (specify) _____	1	2	3

3.2 What are the signs and symptoms in children aged 1-35 months, which can be dangerous and that indicate the need for treatment? Read out Responsese

Danger sign	*Yes=1, No=2, DK=3*		
Poor sucking/ difficulty in feeding	1	2	3
Lethargy/unconscious	1	2	3
Convulsions	1	2	3
Vomits every thing	1	2	3
Severe malnutrition	1	2	3
Rapid/difficult breathing /pneumonia	1	2	3
Pus draining from ear	1	2	3
Fever	1	2	3
3 or more than 3 loose (watery) stools per day	1	2	3
Any other thing (specify)	1	2	3

IV. SAFE MOTHERHOOD – POSTNATAL CARE

4.1 Do you think a mother needs a postnatal checkup after the birth of her baby? ☐
(Yes=1, No=2, Don't know=3)
If '**No**' or '**Don't know**', then **Go to: Q. 5.1**

4.2 How soon after the birth should she get the first checkup?
(PROBE: How many days after birth should she get her first checkup?)
Number of days after birth ☐

4.3 How many times should she get such a checkup done within one and half months of delivery? *Number of times* ☐

V. BREASTFEEDING and NUTRITION

5.1 How soon after birth should she first start breastfeeding her child?

IF RESPONDENT FEELS THAT BREASTFEEDING SHOULD BE STARTED ON FIRST DAY OF BIRTH, RECORD NUMBER OF HOURS AFTER BIRTH _____ HOURS

OR

IF RESPONDENT SAYS BREASTFEEDING SHOULD BE INITIATED AFTER FIRST DAY, RECORD NUMBER OF DAYS AFTER BIRTH _____ DAYS

5.2 Upto how many months should the child be given exclusively breast milk? ☐
(Exclusively breast feeding means, child was given only breast milk without any liquid supplement like water, sugar/juggry water, and highly diluted cow milk)

5.3 In your opinion, do you think plain water should be given to a child below 6 months? ☐
(Yes=1, No=2, Don't know=3)

VI. RTI/STD and HIV/ AIDS

6.1 Now I would like to ask you about some health problems that you yourself may have. During the past three months, have you had _____ (READ OUT EACH HEALTH PROBLEM LISTED IN TABLE)?

1.4.1.1.1.1.1 Health Problem	**Present in last 3 months** (Yes=1, No=2)	
Urethral discharge	1	2
Genital rash or ulcer	1	2
Swelling on the thighs and/or groin	1	2
Scrotal swelling	1	2
Others (specify)_____	1	2

IF NONE OF THE PROBLEMS PRESENT IN LAST 3 MONTHS – GO TO 6.7

6.2 Have you sought anyone for advice or treatment? ☐
(Yes=1, No=2)
If '**No**', then **Go to: Q. 6.7**

6.3 Where did you seek treatment? (Record responses in pathway)Ranking

A. Allopathic Doctor…….. ☐ B. Ayurvedic Doctor……. ☐
C. ANM / LHV / HW……. ☐ D. Medical shop…… ☐
E. Friends…… ☐ F. Self Treatment…….. ☐
G. Other (specify) _____ ☐

6.4 Did you complete the entire course of treatment? ☐
(Yes=1, No=2)

6.5 Did the _____ (**MENTION RESPONSE TO 6.3**) advice you to use a condom? *(Yes=1, No=2)* ☐

If '**No**', then **Go to: Q. 6.7**

6.6 Did/Do you use condom? *(Yes=1, No=2)* ☐

6.7 Have you heard of an illness called HIV/AIDS? *(Yes=1, No=2)If NO then END THE INTERVIEW* ☐

6.8 How is HIV/AIDS transmitted?

1.4.	**Question**	Yes=1, No=2, DK=3		
1.4.	Unsafe sex/ unprotected sex	**1.4.1.1**	**1.4.1.1**	**1.4.1.1**
02	Transfusion with infected blood/ blood products	1	2	3
03	From HIV positive pregnant mother to her baby	1	2	3
04	Use of unsterilized needle/ syringe	1	2	3
05	From breast milk of HIV positive mother to her baby	1	2	3
06	From mosquito bite	1	2	3
07	By shaking hands with HIV positive person	1	2	3
08	Others (specify) _____	1	2	3
98	Don't remember/ cannot say	1	2	3

6.9 How can a person protect herself from getting infected with HIV / AIDS?
(Circle the Responses) against the spontaneous responses given by respondent)

01	Avoid sex with multiple sex partners	1
02	Use of condom during intercourse	2
03	Avoid sex with sex workers	3
04	Use of safe (HIV negative) blood	4
05	Use of Disposable / Sterile Needle / Syringe	5
06	Sexual relation with a mutually faithful partner	6
07	Other (specify) _____	7
98	Don't know/Can't say	8

6.10 From whom/where did you hear of this illness?
(Circle the Responses) against the spontaneous responses given by respondent)

Radio	1
TV/Film	2
Newspaper / Magazine / Journal	3
Debate / Seminar	4
Signboards / Poster	5
Relative / Friends / Wife	6
Doctor	7
ANM / LHV/ HW	8
Social Worker	9
Community Organizer (CLICS)	10
Self Help Group (SHG)	11

CLICS Doot	12
Others (specify)_____	13
Don't know/Don't remember	14

THANK and TERMINATE

Community Led Initiatives for Child Survival Schedule Nu

Department of Community Medicine
MGIMS, Sewagram, Wardha

INTERVIEW SCHEDULE for UNMARRIED ADOLESCENT GIRLS (12-19 years)

(Schedule 5 of 5)

IDENTIFICATION

A. PHC_____

B. Name of the cluster/village _____ Cluster Number ☐
(As per list enclosed)

C. Name of the respondent:-_____

D. Household Number: ☐

E. Respondent's line Number from 2.1 of Household schedule: - ☐

F. Name of Interviewer: _____ Signature: _____

G. Date of Interview: (DD/MM/YY) ☐☐ ☐☐ ☐☐

H. Name of Supervisor:_____ Signature: _____

Introduction:

Namaskar. My name is …….. I come from CLICS program, MGIMS, Sewagram. We are studying health issues related to you and your children. This information will be used for evaluation of CLICS program. I would like to assure you that your name and the information given by you will remain confidential, and will be used research purpose. I shall be grateful if you could spare me 30-40 minutes of your time.

Respondent:

I have been explained the purpose of the study and I am ready to participate in the study.

_____

Signature/Thumb impression of Respondent

I. BACKGROUND INFORMATION

1.1 What is your current age? *(in Completed Years)* ☐

1.2 Are you currently studying: *(Yes = 1, No = 2)* ☐

1.3 Till which class have you studied? *(Standard Passed)* ☐

II. MENSTRUAL HYGIENE AND PRACTICES

2.1 Have you started menstruating? *(Yes = 1, No = 2)* ☐

If '**No**' then, **Go To Q 3.1**

2.2 At what age you started menstruating? *(in completed years)* ☐☐

2.3 Did you receive any information regarding menstruation, before you experience? ☐
(Yes = 1, No = 2)

If '**No**' then, **Go To Q 2.5**

2.4 From whom did you come to know about it?
(Circle the Responses) against the spontaneous responses given by respondent)

01	Mother	1	05	Relatives	5
02	Sister	2	06	Books	6
03	Girl friend	3	07	CLICS Doots	7
04	Teacher	4	08	Kishori Panchayat	8
09	Other (Specify) _____				9

2.5 What do you use during menstruation? ☐

Piece of cloth = 1, Cotton wrapped in cloth = 2, Readymade pads = 3, Nothing at all = 4

2.6 How often do you change the cloth or pad on a given day? ☐
Not even once a day=1, Once a day=2, Twice a day=3, Thrice a day=4, More than thrice a day=5

2.7 After use, what do you do with the cloth or pad? (Encircle in given response)

Reuse it	**1.4.1**	1.4.1.1.1.1.8
Throw the cloth /dispose the sanitary pad	2	**GO TO Q 3.1**
Burn or bury cloth / sanitary pad	3	

2.8 With what do you wash the cloth before using it again? (Encircle in given response)

Plain water	**1.4.1**	**1.4.1.1.1.1.10**
Soap and water	2	
Dettol / Savlon/ other antiseptics	3	
No washing	4	**GO TO Q 3.1**

2.9 Where do you dry the cloth after washing? (Encircle in given response)

In the sun	**1.4.1**
In the shade	2
Others (specify)	3

III. REPRODUCTIVE HEALTH

3.1 Awareness about legal age at marriage

1) What is the legal age of marriage for boys in India? ☐☐

2) What is the legal age of marriage for girls in India? ☐☐

3.2 What is the earliest age that a girl is capable of becoming pregnant? ☐☐
(Enter age in years, or when she starts menstruation= 88, Don't know= 99)

3.3 Do you know any methods by which a gap can be kept between the births of two child ☐
(Yes = 1, No = 2)

If '**No**' then, **Go To Q 3.5**

3.4 What are those methods?

1. Oral pills ☐ 2. IUDs ☐ 3. Condoms ☐
4. Natural methods ☐ 5. Other (Specify) ☐ _____

3.5 Have you heard of HIV / AIDS? *(Yes =1, No = 2) If NO then skip to3.9* ☐

3.6 How is HIV/AIDS transmitted? Read out Responses

1.4.	**Question**	Yes=1, No=2, DK=3		
1.4.	Unsafe sex/ unprotected sex	**1.4.1.1**	**1.4.1.1**	**1.4.1.1**
02	Transfusion with infected blood/ blood products	1	2	3
03	From HIV positive pregnant mother to her baby	1	2	3
04	Use of unsterilized needle/ syringe	1	2	3
05	From breast milk of HIV positive mother to her baby	1	2	3
06	From mosquito bite	1	2	3
07	By shaking hands with HIV positive person	1	2	3
08	Others (specify) _____	1	2	3
98	Don't remember/ cannot say	1	2	3

3.7 Can you tell me how HIV/AIDS can be prevented?
(Circle the Responses) against the spontaneous responses given by respondent)

01	Avoid sex with multiple sex partners	1
02	Use of condom during intercourse	1
03	Avoid sex with sex workers	1
04	Use of safe (HIV negative) blood	1
05	Use of Disposable / Sterile Needle / Syringe	1
06	Sexual relation with a mutually faithful partner	1
07	Other (specify) _____	1
98	Don't know/Can't say	1

3.8 From where did you get the information on HIV/AIDS?
(Circle the Responses) against the spontaneous responses given by respondent)

Radio	1	School/Teacher	8
TV/Film	2	Kishori Panchayat	9
Books/ Newspaper / Magazines	3	Community Organizer (CLICS)	10
Debate / Seminar	4	Self Help Group (SHG)	11
Signboards / Poster	5	CLICS Doot	12
Friends / Parents / Relatives	6	Others (specify)_____	13
Doctor	7	Don't remember/Can't say	14

3.9 Did you attend any health education/family life education session(s) in the village or in the school? (Yes=1, No=2) ☐

If '**No**' then, **Thank and terminate the interview**

3.10 Who was the informant? (Circle the Responses)

1. Class teacher ☐ 2. CLICS Doot ☐ 3. ANM ☐

4. Kishori Panchayat ☐ 5. CLICS functionaries (MO/CO/APO) ☐

6. Other (Specify) _____ ☐

THANK and TERMINATE

Annexure II

Guidelines for qualitative survey

Objectives:

The objectives of end line qualitative survey is to explore the perception of members of community based organizations for village based program interventions and its effectiveness.

Methodology:

A qualitative survey (Focus Group Discussions, FGDs) will be undertaken. FGDs will be conducted with the members of community based organizations (CBOs) like women's self help groups (SHG), members of *Kishori Panchayat* (KP), members of *Kisan Viaks Manch* (KVM) and Village Coordination Committee (VCC) members in selected villages (Table I). An attempt will be made to cover respondents from different socio-economic strata of target respondents. In order to ensure the variety and richness of information not more than two CBOs will be selected from each selected village. The selection of village may be undertaken in consultation with the program staff or sector staff.

The respondents will be purposively selected from each of the separate group of participants who are willing to participate and talk freely. An informed consent will be obtained from the respondents. A trained facilitator and recorder (social work background) will facilitate the FGDs in local language *Marathi* using pre-decided broad guidelines for discussion. The FGDs will be undertaken in neutral locations in the village where all participants are willing to come. The recorders will undertake cassette recording of the entire discussion/ or take notes of the discussion.

Table I: No of FGDs to be undertaken with SHG, KP, KVM and VCC in each sector

PHC area	No of FGDs with women' SHG	No of FGDs with KP members	No of FGDs with KVM members	No of FGDs with VCC members
Talegaon	4	4	4	4
Anji	4	4	4	4
Gaul	2	2	2	2
Total	**10**	**10**	**10**	**10**

A) Issues to be discussed with the members of women's self help group

1) Age at marriage
2) Antenatal care, Natal care, Postnatal care
3) Danger signs during pregnancy
4) Newborn care, newborn danger signs
5) Breast feeding, weaning, supplementary feeding
6) Immunization
7) Growth monitoring
8) Personal hygiene
9) Kiran Clinic (If applicable)
10) CLICS doot
11) Role of Village Coordination Committee
12) *Bal Suraksha Diwas* (BSD)

B) Issues to be discussed with *Kishori Panchayat* members

1) Age at marriage
2) Age first pregnancy
3) Education of girls
4) Anemia among adolescent girls
5) Personal hygiene
6) Menstrual hygiene
7) Antenatal care, Natal care, Postnatal care
8) Breastfeeding
9) Danger signs during pregnancy and newborn period
10) Kiran Clinic (If applicable)
11) CLICS doot
12) Role of Village Coordination Committee

C) Issues to be discussed with the members of *Kisan Vikas Manch*

1) Environmental sanitation
2) Role of husband in reproductive health, Antenatal care, Natal care, Postnatal care
3) Preparation for delivery including emergency transport
4) Newborn care
5) Breastfeeding
6) Family planning methods
7) CLICS doot
8) Kiran Clinic (If applicable)
9) Role of Village Coordination Committee

D) Issues to be discussed with the VCC members

1) Linkage of VCC with other CBOs (SHG, KP, KVM and Gram-panchayat)
2) Role of VCC in improving health of villagers
3) Duties of VCC as a franchisee
4) Community based distribution system
5) Supervision and monitoring of CLICS doot
6) Achievements of VCC
7) Health rights
8) Management of Kiran Clinic (If applicable)
9) Management of Village health fund (*Gram Swasthya Kosh*)
10) Sustainability of activities
11) Linkage of VCC with other health care providers
12) Sources of health information for villagers
13) Health care seeking behavior (any change)

General guidelines for conducting Focus Group Discussion (FGD)

1) Identify key persons having similar socio-economic background
2) Fix date time and place in consultation with the participants

3) Make comfortable arrangement for sitting preferably circular
4) The maximum number of participants for FGD should restricted to 10
5) Obtain informed consent from all the participants
6) Welcome the participants and follow local protocol
7) Create informal atmosphere. Use ice breaking techniques
8) Introduce yourself and inform the purpose of discussion
9) Initiate discussion. Talk less and Listen more.
10) Encourage each participants to participate
11) Be ready for adverse comments/events
12) Discourage the dominating participants who talk excess
13) Maintain harmony
14) Never pass comments or make gestures that would hurt the feelings of the participants
15) Give equal respect to all responses. Don't be judgmental
16) Ensure that discussion flows on right tract
17) Maintain informal atmosphere throughout discussion
18) Summarize the discussion points in end to ensure your understanding of the discussion
19) Maximum FGD time should be 90 minutes
20) Express thanks to all the participants for spending their valuable time with you