FINAL VERSION - COPY

Aga Khan Foundation USA

Child Survival Program- India
Final Evaluation

Community-Led Initiatives for Child Survival (CLICS)
Wardha District, Maharashtra State, India

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Table of Contents

ANNEXES

1. Figures
2. Tables
3. List of VCC Activities and Characteristics included in the IMI
4. Results Highlight
5. CLICS 15 Key Behaviors
6. Special Areas of Training
7. Delhi Presentation
8. List of Publications and Presentations Related to the Project
9. Project Management Evaluation
    a. Planning
    b. Supervision of Project Staff
    c. Human Resources Management
    d. Financial Management
    e. Logistics
    f. Information Management
    g. Technical and Administrative Support
    h. Management Lessons Learned
    i. Strengthening the Grantee Organization
10. Logical Framework Analysis
11. Workplan Table
12. Rapid Catch Indicators for Endline Survey
13. Final KPC Report
14. Evaluation Team Members and their Titles
15. Evaluation Assessment Methodology
16. List of Persons Interviewed and Contacted
17. Project Data Form

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A. List of Acronyms and Terms

AKF, India	Aga Khan Foundation, India
AKF USA	Aga Khan Foundation U.S.A.
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
APO	Assistant Program Officer
ARI	Acute Respiratory Infection
ASHA	Accredited Social Health Activist
AWC	Anganwadi Center
AWW	Anganwadi Worker
BCC	Behavior Change Communication
BPL	Below Poverty Line
BPCR	Birth Preparedness and Complication Readiness
BSD	*Bal Surksha Divas*
CBO	Community-Based Organization
CBHS	Community Based Health Information System
CCSP	Chitral Child Survival Program
CHC	Community Health Center
CHW	Community Health Worker
CIMNCI	Community Integrated Management of Neonatal and Childhood Illness
CLICS	Community-led Initiatives for Child Survival
CO	Community Organizer
CQI	Continuous Quality Improvement
CRC	Community Resource Center
CSSA	Child Survival Sustainability Assessment
CSTS	Child Survival Technical Support Group
DCM	Department of Community Medicine
DDK	Disposable Delivery Kit
DHAP	District Health Action Plan
DHS	District Health Supervisor
DIP	Detailed Implementation Plan
ECD	Early Childhood Development
EmOC	Emergency Obstetric Care
ES	Endline Survey
FGD	Focus Group Discussion
FLE	Family Life Education
GoI	Government of India
GoM	Government of Maharashtra
GP	*Gram Panchayat*
GR	Government Resolution
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HSS	Health Systems Strengthening
ICDS	Integrated Child Development Services
IFA	Iron Folic Acid
IMCFSC	Integrated Model of Communication for Social Change
IMCI	Integrated Management of Childhood Illnesses

IMI	Institutional Maturity Index
IMNCI	Integrated Management of Newborn and Child Illnesses
IMR	Infant Mortality Rate
IPC	Interpersonal Communication
ISA	Institutional Strengths Assessment
KP	*Kishori Panchayat* (Adolescent Girls' Forum)
KPC	Knowledge, Practices and Coverage
KVM	*Kisan Vikas Manch* (Farmers' Development Forum)
LBW	Low Birth Weight
LHV	Lady Health Visitor
LFA	Log Frame Analysis
LoE	Level of Effort
LOGFID	Logical Framework for Institutional Development
LQAS	Lot Quality Assurance Sampling
MCH	Maternal and Child Health
MCHN	Maternal Child Health and Nutrition
MGIMS	Mahatma Gandhi Institute of Medical Sciences
MIS	Management Information System
MMR	Maternal Mortality Rate
MO	Medical Officer
MoH	Ministry of Health
MoHFW	Ministry of Health & Family Welfare, India
MTE	Mid-Term Evaluation
MTR	Mid-Term Review
NCE	No Cost Extension
NFHS III	National Family Health Survey (2005-06)
NMR	Neonatal Mortality Rate
NGO	Non-Governmental Organization
NRHM	National Rural Health Mission
OCAT	Organization Capacity Assessment Tool
OCP	Oral Contraceptive Pills
OR	Operation Research
ORS	Oral Rehydration Solution
PHC	Primary Health Center
PLA	Participatory Learning for Action
PNC	Post Natal Care
PRI	Panchayati Raj Institution
QA	Quality Assurance
RH	Reproductive Health
RTI	Reproductive Tract Infection
SC	Sector Coordinator
SD	Standard Deviation
SF	Social Franchise
SFA	Social Franchise Agreement
SHG	Self Help Group
STD	Sexuality Transmitted Disease
TNA	Training Needs Assessment
TST	Technical Support Team

TT	Tetanus Toxoid
USAID	United States Agency for International Development
VCC	Village Coordination Committee
VHAI	Voluntary Health Association of India
VHNSC	Village Health, Nutrition and Sanitation Committee
VHW	Village Health Worker

B. Executive Summary

The Community-Led Initiatives for Child Survival (CLICS) Project was implemented in the eastern Maharashtra district of Wardha and reached a population of approximately 90,000 in 67 villages. The **goal** of the project was to bring about sustainable improvement in the health status and well being of the children under the age of three and women of reproductive age (15-44 years).

CLICS had four **objectives**:
1) Provide affordable, high quality health care through effective partnerships at the village level;
2) Build the capacity of coalitions of local partners to sustain child survival activities and health gains;
3) Refine and test a social franchising model for the delivery of child survival interventions; and
4) Document, disseminate and share key program lessons and results to facilitate adaptation, replication and policy advocacy.

CLICS was implemented by the Department of Community Medicine (DCM) of the **Mahatma Gandhi Institute of Medical Sciences** (MGIMS), a highly respected health institution with a strong commitment to and long experience in community-based programming.

In accordance with the recommendations of the Mid-Term Evaluation (MTE), the **technical interventions** were reduced from nine and focused on maternal and newborn care (60% of the Level of Effort and resources), breastfeeding, nutrition, acute respiratory infection (ARI), and diarrhea, each at 10%. Other than this modification, AKF USA and MGIMS implemented the CLICS Project in accordance with the Detailed Implementation Plan (DIP) and the work plan.

The achievements of CLICS in terms of improved health status **outcomes** were impressive.

- Complete ANC increased from 11.6% in the baseline to 25% in endline;
- Delivery in health facility increased from 72.8% to >90%;
- >36 month interval between births increased from 29.3% to 49%;
- Low Birth Weights reduced from 29.4% to 25%:
- Breast feeding within 1 hour of birth increased from <1% to 68%;
- Mothers knowing three newborn danger signs increased from 11.3% to 95%;
- Low Birth Weight births decreased from 29.4% to 25%
- Initiation of breastfeeding within one hour increased from 21% to 68%;
- Children 12 – 23 months who are fully immunized increased from 62.4% to 98%;
- Vitamin A coverage of children 12-35 months old increased from 53.6% to 98%;
- Use of ORS from increased 6.8% to 60%; and
- Malnourished children minus three standard deviation (SD) decreased from 22% to 11.6%.

In addition, there is evidence that CLICS was able to have an **impact** on the infant and neonatal mortality rates. Between mid-2007 and mid-2008, the CLICS population-based information system showed a more than 20 percent decrease in these indicators.

Utilizing an innovative approach of **social franchising**, CLICS was highly effective in mobilizing communities. A significant component of this effort involved establishing and strengthening Community Based Organizations (CBOs), including the Village Coordination Committees (VCCs),

Self-Help Groups (SHGs), Kishori Panchayats or Adolescent Girls' Forum (KPs), and the Kisan Vikas Manch or Farmers' Development Forum (KVMs). The **organizational capacity** of these entities was developed which helped the project reach its objectives and outcomes and increased the chances of sustainability. Most CBO development and capacity building was accomplished during the first half of the project and was noted in the MTE report. The CBOs served as fora for health education and health promotion activities. CLICS developed an Institutional Maturity Index (IMI) that enabled the project to track the organizational capacity and effectiveness of the local organizations.

The project provided over 108 person years of **training** for community members ranging from community leaders to the village members. The community mobilization aspect of CLICS was particularly strong and establishes a basis for sustainability.

Considerable discussion during the final evaluation was devoted to comparing CLICS with components of the **National Rural Health Mission** (NRHM). While the goals are similar (i.e., to strengthen community organizations, utilize village-level workers, generate local funds, develop village health plans, improve quality of services, conduct monthly community child health days, build local capacity, and promote community-level monitoring) the **processes** used by MGIMS are very different from those used by the MoH. Specifically, the processes of how the local committees are mobilized, community workers are selected and trained, quality is maintained, child health days are focused on changing behaviors, and the community-based information system is utilized are very different between MGIMS and the MoH. MGIMS maintains its rural training area for its medical and nursing students in selected villages.

The CLICS approach and results are highly likely to be **sustained** in the villages (about one-third) in which the MGIMS training activities take place. There is less confidence that program effectiveness will continue at a high level in the remaining communities. In terms of growing the CLICS model, AKF USA has been granted a **no-cost extension** that will allow MGIMS to introduce the community-based model to several other medical schools which, in turn, will expose the next generation of medical practitioners to community mobilization to improve health outcomes.

Table 1: Summary of Impact Model Element for Project

Inputs	Activities	Outputs	Outcome	Objectives
Objective 1: Provide affordable, high quality health care through effective partnerships at the village level				
Training of AWW, PHC, SC, ANM, PHC MO, GP members, and CBOs	CLICS program orientation IMNCI and ANC training Organizational development and team building	108/person days training 8,318 people trained	Community mobilization skills developed CBO ownership of program developed	Build the capacity of coalitions of partners
BCC training materials BEHAVE framework	Formative research Doer non-doer study Training of CBOs and program staff on BCC BEHAVE workshop	Key child survival interventions identified BCC strategy developed	-% of husbands aware of at least 3 pregnancy danger signs increased from 13.2% to 42.2%. -% mothers of <1s knowing at least 3 newborn danger signs increased from 11.3% to 94.2%. -% mothers of <3s knowing at least 2 signs of childhood illness requiring treatment increased from 29.5% to 98.5%.	Determine key child survival interventions and develop BCC strategy
Guidelines for BSD IMNCI modules	BSD IMNCI modules development Training on IMCNI	1 BSD held per month in each village Household IMNCI adapted for the Indian context	-% of children12 -23 months immunized increased from 62.4% to 98% -% of mothers of <1s receiving ANC package increased from 11.6% to 58.9%.	Implement Child Survival Activities
CHC Supply of equipment for CHC Costing and Drug Policy	Operationalizing the CHC Social marketing training Social marketing of ORS, Jeevan Drop, OCP, IFA, Condoms, Nets, and Sanitary Pads	19 CHCs functioning 62 VCCs engaged in social marketing	100% increased access to services at village level at affordable cost within the intervention area	Provide community access to services and health related products
Training on quality assurance Check lists for different levels of facilities of Public Health system for BSD, CHCs, and health facility center PLA tools	Health Needs Assessment using PLA Village Health Planning Quality assessment and monitoring	Health Needs Assessment completed in all 64 VCCs 64 Village Health Plans prepared Quality assurance completed as per QA plan	-Implementation of village health plan by VCC -Monthly BSD organized Quality assurance in practice	Plan and provide affordable high quality health care to the target population

Inputs	Activities	Outputs	Outcome	Objectives
Objective 2: Build the capacity of coalitions of local partners to sustain child survival activities and health gains				
PLA tools and materials	Training in sustainability planning Sustainability plan development Workshops at village level with VCC, GP, ICDS, and PHC	Sustainability plans developed by 64 VCCs	96% VCC achieved reasonable level maturity (IMI more than 60%)	Develop a plan for sustaining child survival and health gains
Community-based community monitoring system	Training on community based monitoring of health care Development of data collection tools Costing study of CHC	Community based monitoring system in place Cost recovery of CHC	100% of villages using CBHIS data for decision making	Institutionalize Monitoring and Finance systems
Objective 3: Refine and test a social franchising model for the delivery of child survival interventions				
Social Franchise Framework and Agreement	Implementation of SF framework Advocacy of SF model at village and partner level	Finalized SF agreement SFA signed by all 64 VCCs	100% of VCCs signed SFA	Define and refine a social franchise model Test the feasibility of the 'Social Franchise Model'
Guidelines for Formation of VCCs Training of CBOs	Resolution from GP Village Meetings Constitution of CBOs Establishment of linkages between CBOs and PHC, ICDS, NGOs	Total 266 SHGs, 64 KPs, 75 KVMs, and 64 VCCs constituted	415 CBOs continuing to function effectively	Develop effective partnerships at village level
Objective 4: Document, disseminate and share key program lessons and results to facilitate adaptation, replication and policy advocacy				
Software to develop a website Training in documentation and dissemination Training in information and data base management for the website	Identification and documentation of salient areas/components of CLICS CLICS website development	Documents: Process documentation of all stages of the program Synergy of CLICS with NRHM Dissemination workshops/meetings	CLICS model envisaged in DHAP of 2 districts of MCH VCC guidelines adopted by DHS 2 Evidence Reviews by VISTAAR	Document key lessons and program results Disseminate and share lessons for replication

C. Assessment of Results and Impact of the Project

1. Results: Technical Approach

The partnership between the Aga Khan Foundation (AKF) and the Department of Community Medicine (DCM) of the Mahatma Gandhi Institute of Medical Sciences (MGIMS) has resulted in a successful community-based Maternal and Child Health (MCH) intervention. As the AKF and USAID-funded Community-Led Initiatives for Child Survival reaches the end of its five-year life, this report reviews the project's achievements and lessons learned. CLICS employed a double-pronged strategy of **awareness building and behavior change** built on a strong foundation of **community mobilization and organization**. The final evaluation report also poses the question on how the CLICS' strategy can be replicated elsewhere in India so that a larger number of the population can benefit from improved health status.

By launching community health clinics and encouraging the formation of village CBOs, CLICS was able to establish a close working relationship with project villages. With a high degree of **community ownership,** the project built the capacity of the local partners to identify and address health needs. CLICS has strengthened its operations since the Mid-Term Review (MTR) and has achieved significant progress in terms of both community involvement and improved health indicators.

The goal and objectives of CLICS have remained constant since it began in 2003.

Goal

Sustainable improvement in the health status and well being of children under the age of three and women of reproductive age (15-44 years).

Objectives

- 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; and
- Document, disseminate and share key program lessons and results to facilitate adaptation, replication and policy advocacy.

The CLICS program continues a relationship between AKF and the DCM of MGIMS that goes back to the mid-1990s when they collaborated on an effort "Partnering for Child Survival" in Talegaon sector of Wardha District in Eastern Maharashtra. Now, a dozen years later, the two organizations have joined forces to work in 67 villages in three sectors (Anji, Gaul, and Talegaon) surrounding Wardha city where MGIMS maintains its rural training area for its medical and nursing students. While AKF is responsible for the management of the Child Survival Grant, DCM has implemented the program that reached over 90,000 people (see **Table 2** below).

Table 2: Project Beneficiaries

	Anji	Gaul	Talegaon	Total
Villages (under project area)	23	21	23	67
Population (under project area)	31,443	20,272	38,719	90,434
Total Households (under project area)	6,896	4,906	9,025	20,827
Beneficiaries: children (0-3 years)	1,497	864	1,867	4,228
Beneficiaries: women of reproductive age (15-44 years)*	5,611	3,035	6,111	14,757
Beneficiaries: adolescent girls*	2,711	1,492	3,202	7,405
Total beneficiaries	**9,819**	**5,391**	**11,180**	**26,390**

Source: CLICS MIS, June 2008

Level of Effort – Based on the fact that between two-thirds to three-quarters of the infants dying in Maharashtra and the project area occur during the first month of life, maximum attention on reducing neonatal mortality is required. The MTR expressed concern that the initial design of CLICS included nine different programming areas. One of the major recommendations of the MTR was for CLICS to focus its time and resources on interventions that would reduce neonatal mortality rates. As a result, MGIMS cut the number of areas of focus and combined safe motherhood with newborn care and nutrition with breastfeeding and dropped HIV/AIDS, Sexually Transmitted Infections, birth spacing, Early Childhood Development, and immunization. The **reconfigured and streamlined** package of program activities is concentrated in only five areas:

Maternal and Newborn Care	60%
Breastfeeding	10%
Nutrition	10%
Acute Respiratory Infection (ARI)	10%
Diarrhea	10%

This set of interventions is considerably more appropriate and has improved the project's overall operation by allowing it to concentrate its energies more efficiently and effectively. With the present configuration, CLICS is promoting services that resemble what is found in Community Integrated Management of Neonatal and Childhood Illness (**CIMNCI**).

Strategy – The basic strategy of CLICS during the last two years has been to build the awareness of the target communities to improve the outcome of pregnancies and survival of newborns, while increasing their capacity to manage and achieve "ownership" of the village-based infant and child health services. DCM has employed the principle of "**social franchising**" to change communities' health behaviors and generate demand for health care, especially for the youngest and most vulnerable members of the village. The medical facilities served as the "franchisers" responsible for mobilizing the communities while entering into a contractual agreement with coordinating committees in the individual villages, the "franchisees." DCM built the capacity of the communities and formed VCCs and other CBOs that participate in developing, managing, and sustaining a package of quality and affordable maternal, newborn, and child health interventions that significantly improve the health status of the community, the "social product."

CLICS is a **complex and multi-faceted** program. **Figure 1 -** CLICS Stages of Development (see **Annex 1**) describes the four stages of CLICS implementation:

- *CLICS Doot*: The Village Health Worker is an essential component of the CLICS program. Each member of this cadre of committed, hard working women serves approximately 1,000 people (ranging from less than 500 in small villages to over 1,800 in larger ones). At present, there are 89 CLICS *Doots* serving in the 67 program villages. Among the important features of these community workers is the rigorous selection process, which involves a camp at the Sewagram Ashram where five finalists from each village compete in reading, public speaking, communication, and group interaction. The candidate with the highest score is chosen with the second ranked woman being an alternative in case the selected CLICS *Doot* migrates or becomes inactive. The CLICS *Doot* must be a woman between the age of 35 and 45 with children, who has completed at least the 7th standard, is interested in social work, and has the consent of her family to participate in the program. She receives Rs.300 (slightly more than US$7) per month from the VCC.

- *Community-Based Organizations* - CBOs have been an important part of the CLICS program from the very beginning. The three CBOs found in CLICS villages are SHGs, KVMs, and KPs. The number of CBOs by sector as of July 2008 is provided in **Table 3**.

Table 3: Number of CBOs (by Sector)

CBO	Anji	Gaul	Talegaon	Total
Self-Help Groups	85	70	121	276
Kishori Panchayats	20	21	23	64
Kisan Vikas Manch	27	22	26	75

The SHGs and KVMs have income generating (savings and micro-finance) aspects that serve as an incentive for attendance at monthly meetings. There is no need to encourage the adolescent girls to come to the KP gatherings since they are full of energy and participate with enthusiasm. During the period October 2007 and March 2008, approximately three-quarters of the members attended CBO meetings. These gatherings provide opportunities to deliver health awareness messages and discuss health-related topics.

- *Village Coordinating Committees* - The 67 villages have 64 VCCs because a few small, nearby communities have been combined. Social franchising agreements have been signed between MGIMS and all existing VCCs. The VCCs have a maximum membership of 25, with an average of 21 in the program villages. Membership includes one representative from each SHG, two from the KVM, two from the KP, two from the *gram panchayat* (GP), four co-opted influential leaders, and four ex-officio members: the Anganwadi Worker(s) or AWW(s), Auxiliary Nurse Midwife (ANM), Gram Sevak and Community Organizer (CO).

As a separate part of the final evaluation, the interface between the health and non-health interventions (e.g., life skills for adolescent girls, enhancing of farmers' capacity, and women's savings group and microfinance) was explored. The objective of the exercise was to assess whether and how non-health activities affected health outcomes and how they might impact the

replication and/or scaling-up of the CLICS strategy. A summary of these findings are included in Section E.

Table 4 (below) presents results of the CLICS Project. It provides the baseline, mid-term, and final evaluation results of some of the more important and revealing project indicators. For the mid-term segment of the project, data from the CLICS survey is also included for comparative and supportive purposes. Similarly, data from the population-based CLICS MIS is provided along with the final KPC. Its limitation is that the latter does not include any knowledge or awareness indicators. Project targets, established at the beginning of the project before the completion of DIP, are given to indicate what the project hoped to achieve[1]. Finally, the Table includes data for Maharashtra from the National Family Health Survey (NFHS) III (2005-2006), disaggregated for the rural population where available. For those indicators for which rural NFHS III data is not available (i.e, birth interval, LBW and nutritional status), it should be noted that urban centers like Mumbai significantly skew stateside results.

[1] A few of the project targets were revised after the MTR to reflect realistic expectations more appropriately.

Table 4: Summary M&E Table

Objective	Indicators	Baseline Estimate	Final Estimate	Final Target	Explanation or Reference
Improve maternal health	% of mothers of <1s receiving **ANC** package (at least 3 visits, 2 TT, consumed 100 IFA tablets)	11.6%	58.9%*	50%	Achieved
Improved maternal health and awareness	% of husbands aware of at least **3 pregnancy danger signs**	13.2%	42.2%**	70%	Overly ambitious/unrealistic target
Improved maternal and newborn health	% mother of <1s **delivered in health facility**	72.8%	90.7%*	75%	Achieved
Improved maternal and newborn health	% children <3s with at least **36 months interval** after previous surviving child	29.3%	49%**	60%	FP not an explicit component of the project
Improved maternal nutrition and health care	% of children born **Low Birth Weight**	29.4%	25%**	24%	Discussion on p.18
Improve breastfeeding practices	% mothers of <1s initiating **breastfeeding within 1 hour**: - knowledge/awareness - practice	0.6% 0.9%	68%** 67.9%**	80% 60%	Did not reach the awareness target but exceeded practice target
Improved newborn care and awareness	% mothers of <1s knowing at least **3 newborn danger signs**	11.3%	94.2%*	50%	Far exceeded target
Improved child health	% of children (12-23 months) **fully immunized**	62.4%	98%*	90%	Achieved
Improved child health	% of children (12-35 months) received **Vitamin A** dose in last 6 months	53.6%	98*	80%	Achieved
Improved child health and awareness	% mothers of <3s knowing at least **2 signs of childhood illness** requiring treatment	29.5%	98.5%**	80%	Achieved
Improved child health	% of <3s suffering from diarrhea in last 2 weeks who received **ORS/HAF**	6.8%	62.2%*	70%	Didn't quite reach target
Improved child nutrition	% of <3s -3 SD from the median **weight for age**	22%	11.6%*	NA	

* CLICS MIS (June 2008)

** ORG KPC (2008)

The individual indicators require some explanation to clarify what has or has not been achieved.

ANC coverage – This is a composite indicator that sets a high standard. A woman has to have received all three services fully to be counted as having completed satisfactory antenatal care. The Knowledge, Practice and Coverage (KPC) figure is considerably lower than the MIS data, possibly because of the way the question was asked, especially regarding the consumption of iron tablets. If consumption is reduced to 90 tablets, the ORG figure increases to almost 50%. Achieving almost 60% coverage according to CLICS MIS is excellent and exceeds the project target.

Husbands' knowledge of pregnancy danger signs – CLICS made considerable improvement over the baseline and mid-term in this indicator, however, it did not quite reach the project target which, in retrospect, was a little overly ambitious.

Delivery in Health Facility – The increase in this indicator is remarkable. There has been a sea change in institutional delivery during the program. As mentioned earlier, this rapid change required a modification of the DIP. The fact that the CLICS project area is close to the urban area of Wardha where MGIMS has three hospitals facilitated this unusually fast behavior modification.

36-Month Interval – The project target for this indicator was slightly high.

Low Birth Weight – The CLICS MIS only records birth weights in 100 gram intervals. If the figure of births below 2500 grams or 2.5 kgs is calculated, only 14.5% of the births are LBW. If it is 2,400 grams and below, the figure rises precipitously, almost triples, to 40.4%. If the difference is split, the prevalence is close to the figure reported in the final KPC. The FE team suggests that CLICS work with the three hospitals in Wardha in which approximately 50% of all births take place and install **digital weighing scales**. In addition, CLICS should modify its MIS so that the weight in grams can be entered to four decimal places or kilograms to three decimal points. In this way all births of 2,499 grams and below should be labeled LBW while 2,500 and above are classified as normal.

Recommendation: CLICS MIS should be modified to allow for four figures to track LBW indicator.

Initiation of Breastfeeding within one hour – CLICS surpassed the project target. Discussions with villagers suggest this represents a real success for the project since prior to CLICS, as demonstrated by the extremely low baseline figures, early initiation of breastfeeding was not the norm and colostrum was traditionally and routinely discarded as being bad milk.

Newborn Danger Signs, Immunization ands Vitamin A – All three of these indicators are above the project targets. **Postpartum vitamin A supplementation** should be added and included in the PNC package of services. This intervention is not part of the government policies and protocols, but international evidence strongly supports its distribution to postpartum mothers.

Recommendation: CLICS should initiate postpartum vitamin A supplementation as part of its PNC package and advocate for a change in national practices/policies.

ORS Usage – CLICS achieved good progress in this important indicator. Usage of ORS was facilitated by the fact that ORS is routinely available in the village through the **community-based distribution** system started by CLICS and maintained by VCCs and CLICS *Doots*.

Hand Washing – The program has brought about significant progress in awareness and practice in this area. More work is required to increase awareness about the importance of washing hands prior to food preparation and child feeding in which cases project targets were not achieved.

Nutritional Status – While the prevalence of -2 SD malnutrition has remained almost constant (48.1% in January 2007 and 48.8% in June 2008), important nutritional improvements have been made. The percentage of under-threes in the severely malnourished **-3 SD**, category has been reduced by half. It is the graduation of the most malnourished children that have swelled the ranks of the moderately malnourished. Communities are aware there is still a problem and express their concern and intention to improve the nutritional status of this group in the future.

MIS data shows a dramatic reduction in **severe malnutrition** in the under-three population between January 2007 and the present. At the beginning of the period, 17.8% of the targeted age group was severely malnourished and the rate remained constant through most of 2007. Prevalence began to drop in October and reached a low (9.8%) in February 2008. If February 2007 is compared to February 2008, there is a 39% decrease. Between January 2007 and June 2008, the decrease is 35%. As indicated in **Table 5 (Trends: Percent children age 0 – 35 months underweight)** in **Annex 2**, Gaul Sector registered the best performance—a drop in the prevalence of severe malnutrition from 32.2% to 13.6%, a decrease of 58% within 18 months. Of particular note is the precipitous drop between January and February 2008. Discussions with CLICS team and community members do not reveal any obvious reason for this dramatic reduction. CLICS should continue to monitor to determine whether this is a permanent improvement or a temporary phenomenon. **Figure 2 – Malnutrition Status** (**Annex 1**) graphically presents the data provided in **Table 5**, showing how the proportion of -3 SD children dropped in the three sectors.

Another way of tracking nutritional status is by **nutritional grade** with levels III and IV being considered severe malnutrition. This relates to the growth chart (i.e., under the bottom line) and is how villagers monitor the status of their under-threes. It is easy for them to relate to and comprehend. In this case, the numbers are considerably lower but evidence of improvement can also be found. Between June 2007 and June 2008, the rates in grade III and IV went from 2.1% to 0.8%, a decrease of 62%.

One factor that helps to explain the significant improvement in nutritional status is the **increased participation** in the CLICS nutrition program. The number and percentage of under-threes being weighed on a monthly basis increased between mid-2005 and present. Participation rates increased from mid-70% level to mid-80% level. This indicates a general increase in awareness that good nutritional status is essential for the healthy development of young children. CLICS' focus and success in monitoring and improving under-three nutritional status serves as an example for the rest of India and the Integrated Child Development Services (ICDS) program that historically has been unable reduce the prevalence of malnutrition in the vulnerable under three age group.

Anemia Prevalence Reduction – With such a high prevalence of anemia among the vulnerable sector of the Indian population, CLICS placed special attention on this intervention. It made a special point of ensuring that **ANC cases** not only receive but **consume** 100 or more Iron-Folic Acid (IFA) tablets during the prenatal period. One of the common activities of the KP members is to deliver IFA tablet daily to a pregnant neighbor and ensure consumption.

CLICS also carried out two Operation Research (OR) studies involving iron supplementation. In one OR, more than 250 participating **adolescent girls** demonstrated a 26% reduction (from 73.8% to 54.6%) in the prevalence of anemia in a four-month period (between March and July 2008). Another four-month study demonstrated an 18% reduction in anemia through iron supplementation among 0-36 month old children.

Neonatal and Infant Mortality – Child Survival grantees are not required or encouraged to report on impact indicators such as mortality reductions. Usually the numbers are small and MIS systems unreliable. In the CLICS case, however, the population-based MIS was strong and numbers were large enough to allow the final evaluation team to explore both neonatal and infant mortality during the last several years of the project. The results are encouraging and suggest that progress has been made.

Significant reductions have been realized in the reduction of infant and neonatal mortality rates. First there is the **Infant Mortality Rate (IMR)**. As **Table 6** below shows, for the full years between July 2006 and June 2007 and July 2007 and June 2008, there is a reduction from 49.3/1000 live births to 37.8 (a drop of 23%). In the **Neonatal Mortality Rate (NMR)**, the reduction is 21%, from 38.5/1,000 live births from mid-2006 to mid-2007 to 30.4 from mid-2007 to mid-2008. Although this decrease has a confidence interval of 95% with power of 80%, it is not statistically significant. It should continue to be monitored to see if this reduction can be sustained and even reduce further.

Table 6: Infant and Neonatal Mortality

Year	# Births	Infant Mortality		Neonatal Mortality		% of neonatal deaths
		# deaths	rate	# deaths	rate	
7/2006-6/2007	1,583	78	49.3	61	38.5	78.2
7/2007-6/2008	1,481	56	37.8	45	30.4	80.4
% reduction			23.3		21.0	

Confidence interval (CI) 95% with power of 80%

Although CLICS does verbal autopsies on every infant death, there has been no analysis of the causes. MGIMS should undertake such a study. Since approximately half of the births take place at three hospitals in Wardha and nine out of 10 births occur in health institutions, delivery procedures at these facilities should be reviewed to determine if improvements can be made to further reduce preventable neonatal and infant deaths. Project staff mentioned that **preventable deaths** (e.g., hypothermia, asphyxia, and sepsis) have been reported. These can and should be eliminated. With neonatal mortality comprising approximately 80% of under-one deaths, reducing neonatal mortality becomes the only viable means of reducing the IMR.

Recommendation: MGIMS undertake a study of neonatal deaths, determine the most common preventable causes, and strengthen the capacities of the hospital staff to dramatically reduce and eventually eliminate them.

Interestingly, the **number of births increases** during the second half of the year as do mortality rates. This may be due to the wedding season which takes place in the spring with more first births taking place later in the year. A study of this phenomenon may be useful so that communities can prepare themselves better and prevent some of the infant/neonatal deaths.

DIP Achievements

Other than modifying the intervention package, the CLICS program has remained consistent with its DIP and work plan. The project was delayed and inconvenienced in the first several years of the project when AKF was unable to provide the technical support, specifically in BCC and MIS. Later, an agency was identified by AKF to provide support on MIS. In the second half of the project, the DCM Project Director received training on the Behave Framework and implemented the approach upon being trained.

MGIMS has done an excellent job implementing this sophisticated and highly evolved project. CLICS devoted considerable time and energy to establishing the program in the 67 villages (conducting Participatory Learning for Action (PLA) exercises, forming and orienting VCCs and CBOs) during the first several years of the project. It emphasized the organization and empowerment of the target communities, developing a strong foundation upon which to build a quality and sustainable health program. During the last half, CLICS concentrated more on improving health indicators.

As mentioned in the MTR, the one revision in the original CLICS design was the dropping of maternity huts and supply/use of Disposable Delivery Kits (DDKs) since delivery practices in the project area changed quickly. As indicated in **Table 4** (pg 17), nine out of 10 births now take place in health facilities. Also, as mentioned, CLICS refocused its efforts from nine technical areas, as specified in the DIP, to five to help achieve more significant outcomes and impacts. Project performance indicates that such improvements have indeed been realized.

Principal Findings – The evaluation team is impressed with the progress made in its MIS since the MTR and CLICS MIS that has been developed is of high quality. Although it is overburdened with too many indicators, it is well designed to give project managers the information they require to determine the effectiveness of the program and to identify areas where additional attention is required.

There are two areas in which CLICS has monitored progress: capacity and competence of VCCs and CBOs and outcomes of health awareness building and behavior change activities.

Organizational Capacity – CLICS understood the importance of and is committed to developing and empowering local organizations. It realizes that project objectives cannot be achieved or sustained without the active participation of the community in all aspects of the program, from planning to implementation to management to monitoring. The project invested significant time to

build the capacity of the individual VCCs and CBOs in participating villages. To determine if the project is succeeding in building the leadership and management in program villages, it identified the need to develop tools to give feedback to the community as well as program management on the capacity of local groups to manage their activities. The result is two different tools that provide the necessary information and have been introduced and proven helpful: one for the VCCs - the Institutional Maturity Index (IMI); the other for the CBOs - the Logical Framework for Institutional Development (LOGFID).[2]

IMI: The IMI was developed in a participatory manner to measure and monitor the leadership and management capacities of the VCCs. It examines various activities vital for sustaining and achieving ownership of the CLICS program. Development of the IMI involved discussions and input from different CBOs and other stakeholders such as GP members, staff of the Primary Health Center (PHC) and the ICDS scheme, other NGO partners, and faculty of the DCM.

The IMI uses both qualitative and quantitative indicators. It is employed as a self-assessment tool to determine the capability of the village organization to develop a sustainability plan, identifying how child survival interventions will be managed and sustained in the village. The IMI instrument is administered in a participatory manner with all VCC members discussing overall achievements of the program to date with the aid of a web diagram (a PLA tool).

To determine the effectiveness of a village committee to deliver decentralized health care, 29 VCC activities and characteristics are included in the IMI. VCCs are scored yes or no on each of the 29 points depending on whether they successfully completed or achieved that particular indicator. Their score is then calculated in terms of a percentage – a perfect score being completion of all 29 activities. The communities are awarded stars based on their scores – one star for scores under 20%, two stars between 21% and 40%, three stars between 41% and 60%, four stars between 61% and 80%, and the top score of five stars for communities above 81% (See **Annex 3 for the VCC criteria included in the IMI**).

All VCCs applied the IMI twice during 2007 – once in the spring (April or May) and again in the fall (November or December). As expected, scores were lower in the first phase than in the second phase. **Table 7** shows how communities scored in the two phases.

Table 7: Comparison of IMI Scores between 1st and 2nd Phases

IMI Score	1st Phase (Apr-May 2007)	2nd Phase (Nov-Dec 2007)
* (1-20%)	0	0
** (21-40%)	3	0
*** (41-60%)	32	3
**** (61-80%)	29	35
***** (81-100%)	0	26

The VCCs made significant strides in development in the period between the two reviews. The aspects that proved to be the most difficult for the VCCs included linkages with private health care

[2] A number of capacity building instruments exist, including OCAT (Organizational Capacity Assessment Tool) as developed by PACT and ISA (Institutional Strengths Assessment), used by the Child Survival Technical Support (CSTS) Project).

providers, *gram sabha* attendance, and the development of a plan to retain village health workers. This feedback identifies what is required of VCCs to properly prepare to assume responsibility for the child survival program in their communities.

It is recommended that the IMI or a similar instrument would be very helpful for **NRHM** to focus attention on the process of community capacity building. It will help ensure that this vitally important component is given proper attention. This will be discussed at greater length below in the section on sustainability and replication.

LOGFID: MGIMS developed this tool for CLICS to guide the growth and development of CBOs at the village level. It provides a means to plan and monitor the progress of the various CBOs launched under CLICS.

The different indicators included in the IMI become objectives to be attained over various stages of growth in the LOGFID. By using the LOGFID, the program staff and community members can plan how and when they will achieve the various objectives or indicators. It provides a time-frame and systematic means to reach organizational maturity. In other words, it presents a road map for the CBO development process.

The development of the various organizations is broken into **stages** customized for each CBO. For example, for a SHG, Stage 1 is the formation of the group; Stage 2 is the selection of the group's formal leaders, the framing of its rules and regulations, and the development of a record keeping system; Stage 3 consists of opening a bank account, making members aware of the CLICS program, and raising health awareness; Stage 4 is addressing the credit needs of the members; and Stage 5 is ensuring member participation and nomination of representatives to the VCC. The VCC LOGFID is considerably more complex with 15 Stages. The LOGFID for each organization gives the objective of each Stage, the activities required to achieve that objective and the amount of time that should be allocated or needed to accomplish it.

This tool is a great help to a community and the respective CBO during the formation process. These types of guidelines will facilitate the replication process and will be a valuable instrument in the package that will be developed and made available in the Community Resource Center (CRC), the development of which will be the focus of AKF's and MGIMS's proposed NCE which is discussed below.

Program Performance – Once the community has been effectively mobilized and organized, CLICS focused on improving the health status of the target population. At the MTR, the project's MIS was weak and it was difficult to accurately and confidently assess the progress in the achievement of health objectives. Now, the project's MIS together with a final KPC Survey provided the evaluation team with a good sense of what has been achieved in relation to maternal and newborn health awareness and practices. In general it presents a positive picture and demonstrates what a quality community-based project like CLICS can accomplish in a relatively short span of time. Please see **Annex 4: Results Highlight**, for a discussion on innovative approaches.

2. Results: Cross-Cutting Approaches

This section includes eight different components: community mobilization, behavior change communications, capacity building, health system strengthening, policy and advocacy, contribution to scaling up, equity, and sustainability.

a. Community Mobilization

The design of the CLICS program is predicated on a **strong community foundation.** The MGIMS management understands that with the community's involvement, anything is possible. Conversely, they appreciate that without genuine community ownership and participation, little can either be achieved or sustained. Therefore, the focus of the first half of CLICS was devoted to establishing the strong foundation at the community level in the 67 CLICS villages. As such, considerable attention was focused on this aspect in the MTR, and this iteration will update what has been achieved or issues that have arisen during the past two years.

The formation of the **CBOs** was paramount. The health awareness building and behavior change strategy underlying CLICS was dependent of the group formation as a means of delivering their health messages. As seen in **Table 8** below, most of CLICS group formation was completed by the time the MTR was carried out. Only 12 SHGs and four KVMs were established in the last two years. No KPs were added.

Table 8: Increase in Number of Community-Based Organizations

CBO	Anji		Gaul		Talegaon		Total	
	MT	Final	MT	Final	MT	Final	MT	Final
SHGs	76	85	65	70	122	121	263	276
KVMs	24	27	22	22	25	26	71	75
KPs	20	20	21	21	23	23	64	64

The VCCs have been operating effectively during the second half of the CLICS project. The one remaining VCC, which had not signed the Social Franchise Agreement by the MTR, completed the process. The final evaluation team noted that there were only two **signatories** on the agreement, the VCC and MGIMS, with the *sarpanch* (head of the GP or village council) as a witness to the agreement. The FE team suggests that it might have assisted program implementation and increased partner involvement if the *sarpanch*, the ANM, and the AWW, even though they are included in the VCCs, signed the agreement and understood their respective roles and responsibilities vis-à-vis the VCC and the community.

The MTR recommended that **community health rights** be developed based on promises the government has made over the years and that neighboring VCCs join forces in association for the purpose of making demands on the health system based on these rights. The health rights developed by CLICS included:

- All children receive complete immunization;
- All children have growth monitored each month;
- All children have access to supplementary nutrition through the Anganwadi Center;
- All pregnant women get complete antenatal check-up;

- Female child has the right to be born; and
- Every villager receive timely treatment.

A **federation** of VCCs was considered inappropriate since it is seen as a semi-official body and should not confront an official entity such as the health department. However, the CBOs could play such a role and a KVM federation was formed and is functioning in Anji Sector. Its primary function is economic and it remains to be seen whether it will play an advocacy role.

The effectiveness and value of the ***Kiran*** **(Community Health) Clinics** was reviewed. Twenty-one Clinics were established and one in a village in Gaul Sector has been closed due to lack of patients. On average, 12-15 patients visit the clinic and the majority of them are older. The primary source of medical attention continues to be private practitioners. Despite low utilization, there still seems to be support for the Kiran Clinics. A **cost-benefit analysis** of Kiran Clinics pointed out that from a patient's perspective there is no doubt that the village facility provides the most reasonable choice. The cost comparison in terms of doctor's fee, cost of drugs, transport, and lost wages is strongly in favor of the Kiran Clinic (approximately Rs.64 at the Kiran Clinic versus Rs.390 for treatment outside the village. This amounts to a savings of almost Rs.350 (more than US$8).

Interviews and discussion groups pointed not only to a high level of demand for the services initiated by CLICS, but more importantly, to a significant degree of ownership. The latter will ensure that the activities started under CLICS are likely to continue after the end of the program. Although the COs will not be driving the effort, the VCCs and CBOs (especially the SHGs and KPs) are expected to continue to place a high priority on reinforcing the awareness and practice of the basic maternal and child health measures that were stressed during CLICS. The villages included in the DCM/MGIMS rural training site are more likely to suffer no decrease in results since there will be regular contact with the faculty and medical students.

The **COs** and **Assistant Program Officers** (APOs) play vital roles in the community mobilization process. It is not just CLICS; but virtually every NGO-managed project operating a community-based program has someone with expertise in community development, mobilization, and/or organization. Therefore, any program trying to replicate a CLICS-like program must consider how this essential function is provided.

NRHM: It should be noted that the NRHM as currently structured does not include such a person. The program has sanctioned a second ANM at the sub-center level and a person to manage the program at the district level. If the NRHM is to succeed it should: a) add a social worker/ community organizer at the sub-center level or b) out-source the **community mobilization responsibility** to experienced and qualified NGOs. Both options raise concerns, because the MoH might be reluctant to appoint a non-health person at the grassroots level or new and ineffective NGOs might be formed to take advantage of the funding made available. Yet there are checks and balances that could be applied if the government is truly interested and committed to making a community-based program effective.

There is a need to focus on how the CLICS program is similar to the NRHM as well as how it differs. **Figure 3 – Comparison: CLICS vs. NRHM** (see **Annex 1**) shows the similarities in form, with both sharing common elements (the "what"). While it is important to recognize the

similarities, it is vitally important that the processes (the "how") utilized and underlying the effectiveness of the strategy also be identified. It requires **deconstruction** of the effective operation and identifying and analyzing the "ingredients of success." What made the approach successful in the first place and what must be done to replicate the process so that similar results can be achieved? This topic is explored in greater depth in the section on Scaling Up below.

b. Communication for Behavior Change

CLICS considered its BCC strategy crucial to achieving its objectives of **creating awareness** of preventive health practices to promote safe motherhood and child **health behaviors** and utilization of services. It was critical for effective community mobilization to improve access, availability, and equity of health services.

A well articulated BCC **strategy** has been developed in the project, based on Integrated Model of Communication for Social Change (IMCFSC) that involves community dialogue and collective action to engineer a social change in the community through ownership of information and decision making for action at the community level.

There has been a significant impact of BCC on the critical behaviors in the households in the project villages. The most important visible change is in the environment of villages. There was an increased **commitment** and enthusiasm among the **community members** with a positive attitude towards child survival and safe motherhood issues and project activities. More importantly, the CBOs and VCCs have consistently sustained active interest in the program.

There was a significant change in the key indicators in the Endline Survey (ES) conducted in June-July 2008 (**Table 4**, pg 17). A few examples of improved behaviors include: breastfeeding of newborns within the first hour after delivery, fully immunized children, institutional deliveries, hand washing practices, and birth intervals.

The **process of BCC strategy** development and implementation was completed in-house in four steps:

1. Conducting formative research and undertaking a dialogue with the community to identify facilitating factors and barriers to child survival and effective channels for communication of messages;
2. Designing and producing an integrated package of communication material and activities to facilitate change;
3. Developing skills of the program staff and partners; and
4. Using multiple channels of communications to disseminate the behavior change messages in the community.

A doer and non-doer survey was also undertaken to identify key behaviors and factors that influence them.

Key behaviors were identified and prioritized in a workshop facilitated by an external expert followed by an in-house workshop of the program staff. Twenty key behaviors were listed to begin with, that have been subsequently narrowed to 15. Using the BEHAVE Framework, a matrix of

decisions, responses, and indicators has been developed. The program staff has identified the target groups, the right behavior to promote, key factors to be addressed, channel or media for communication, activities to promote such behaviors, and indictors to measure change.

To date CLICS has addressed 15 behaviors (outlined in **Annex 5**). For each behavior, **messages** have been developed. The messages are clear and simple, and appropriately address the targeted behavior. The messages were tested in the villages prior to development of the communication material.

A variety of communication **materials** have been locally developed, including posters (printed and hand written), flip charts, and models. Some of the materials were procured from the District Health Office and the state health department.

Mass media activities at the village level were the major strength of the behavior change efforts in the CLICS program. These included *Bal Suraksha Diwas* (Child Survival Days), *Suraksha Aichi aani Balachi Mohim* (Safe Mother and Child Campaign), *Mulgi Wachawa Mohim* (Save the Female Child Movement) and Parenting Workshops. The first two activities were organized on a monthly basis in each village by the VCC with support of the COs, CLICS Doot, ANMs and AWWs of the respective areas/villages. The role of the VCC in organizing these activities was commendable. The members of the VCC commanded respect from the village women. Role plays and skits, performed by the VCCs, SHGs and KPs, were very popular and well attended.

The following communication channels have been used in the program:

- **Interpersonal communication** has been effectively used by the CLICS *Doot* and COs at individual and household levels to communicate key messages. The FE team observed that the members of VCCs, KPs, project ANMs, and AWWs are actively involved in IPC. However, the participation of ANMs belonging to the public health system was limited.
- **Group level communication** activities were effectively organized for CBOs by COs and program coordinators through regular meetings. VCCs have played an effective role in the BCC activities by conducting group meetings with the women (SHGs and KPs) which were very effective in communicating messages on safe motherhood and child survival practices and interventions. KPs and VCCs have regularly organized orientation workshops for school teachers and upper class students for family life education to facilitate group interaction.
- **Mass media** activities at the village level were the major strength of the behavior change efforts. These included *Bal Suraksha Diwas* (Child Survival Days), *Suraksha Aichi aani Balachi Mohim* (Safe Mother and Child Campaign), *Mulgi Wachawa Mohim* (Save the Female Child Movement), and Parenting Workshops. The first two activities were organized on a monthly basis in each village by a VCC with support of COs, CLICS *Doot*, ANMs, and AWWs of respective areas/villages. The role of the VCC in organizing these activities was commendable. Members of VCCs commanded respect from the village women. Role plays and skits, performed by VCCs, SHGs, and KPs, were very popular and well attended.

c. Capacity Building Approach

Capacity building was one of the core strategies of the project to achieve its goals and objectives. CLICS has invested a tremendous amount of time, effort, and resources in building the capacities

of DCM and a wide range of partners, including community members, health personnel in the public health system, and private practitioners.

CLICS trainings are based on a **Training Needs Assessment** (TNA) conducted as the project was launched. The assessment determined the capacity building needs at the program, facility, community, and household levels. Separate needs assessments were carried out for all the different personnel involved in the CLICS project, including the Program Coordinators, the MIS Program Officer, the Documentation and Communications Program Officer, Project MOs, and ANMs, COs, AWWs, and VCC members. A training plan was developed based on the TNA and areas of training were identified (see **Annex 6**). CLICS has developed curricula, training materials, and teaching aids for all the components in their capacity building activities. The training approach is often on-the-job, highly participatory, practical, and field oriented.

The training load in the Project was immense, especially at the community level. It included 1,298 members of 64 VCCs, 4,329 members of 276 SHGs, 1,197 members of 75 KVMs, and 1,089 members of KPs. In addition, members of GPs were also trained. **Tables 9 and 10 (**in **Annex 2)** show the category-wise numbers of personnel and average person days of human resource capacity development and training. In total CLICS provided more than 28,000 person days (over 108 person years) of training.

Multi-day Training - The project provided **multi-day training** for specific target groups. ANMs, MOs, and Lady Health Visitors (LHVs) from the PHC staff received eight days of training on Integrated Management of Newborn and Child Illnesses (IMNCI) and two days on Quality Assurance (QA). CLICS conducted a six-day training session in Early Childhood Development (ECD) and a two-day training in QA for AWWs. CLICS staff (including the APOs, COs, ANMs, and MIS Assistants) were trained extensively in the principal project interventions (i.e., PLA, breastfeeding, complementary feeding, IMNCI, rational injection use, village health fund, and CHC record keeping). CLICS trained KVM members through Master Trainers in a three-day residential session at an agricultural institution on innovations in farming, livestock rearing, organic farming and vermiculture, and a popular course on motor winding which has led to employment for several community members. CLICS also conducted a three-day training session for school teachers on Family Life Education (FLE) to create awareness and education among adolescent girls.

CLICS conducted a series of trainings for the CLICS *Doots*. The initial five-day foundation training focused on introduction to and conceptual understanding of the CLICS program, their roles and responsibilities, the terms used in the program, communication skills, and the household register. The second training (three days) covered general anatomy, physiology of human body, and safe motherhood. Newborn care (three days) was covered in the third training. The fourth training was on IMNCI and lasted five days. CLICS *Doot* post-training evaluations have been conducted and half scored over 60%. Re-trainings were organized for those who scored less than 60%.

Short Trainings - A significant portion of CLICS training is done in **short trainings**, lasting anywhere from three hours to a day. It is designed this way because most people cannot absorb too much at one sitting. Experience shows that retention and behavior change is more likely to happen

if small doses of knowledge or skills are introduced at one time. Moreover, many trainees cannot devote three or four days to continuous training. This is particularly true for PHC staff, but also for village members (including members of VCCs, GPs, SHGs, and KVMs); their work in the field, at home, or at school limits the time they can allocate for health and nutrition activities. The GP training is typical of the way that CLICS conducts its community-based training. On a fixed day each month, the *sarpanch* and a GP member attends a session at the sector level. During this meeting (which is never more than three hours long), three topics (related to health and development issues) are discussed, with no subject lasting more than 30 minutes. The sessions encourage participation. When the *panchayat* members return to their village, they are responsible for passing on what they learned to the other members of the group.

Continuous Training - **On-going/refresher training** has been a hallmark of CLICS. The CLICS staff receives monthly training at their regular meetings. The members of CBOs, private practitioners, *Doots*, and TBAs, participate in a one-day training each month. The MOs, ANMs, and AWWs also receive one-day training each month during the BSDs. The VCC members are trained at the sector level each quarter, at the annual review meeting at the village level, and during a sector-level workshop each year.

External Training: In addition to the CLICS training, some staff members attended **external trainings**. Three project ANMs and six COs attended a two-week course on BCC at the Institute of Health Management at Pachod. Three APOs and three COs participated in a two-week course on ECD outside Mumbai. An APO, five COs and two project ANMs attended a training in nutrition given at the National Institute of Nutrition. Two MIS assistants completed a short course on health data management and statistical software conducted by Vellore Medical College in Tamil Nadu. Two APOs and a CO attended a week-long training of the national SHG Federation in Hyderabad. Ninety-five AWWs were trained in ECD (five days plus one day follow-up) by Gram Mangal in Thane. The KVM master trainers were trained at a local agricultural center and had an exposure visit to a nearby district.

Exposure Visits – **Study tours** have been organized for VCC members eager to initiate Community Health Clinics in their villages. These VCC members are taken for exposure visits to Padegaon village where they were able to see the clinic functioning, interact with villagers, and committee members responsible for the management of the clinic. CLICS organized a study tour for a contingent of 64, mostly VCC members, to several community projects elsewhere in Maharashtra.

Special Areas of Training were conducted in select areas. See **Annex 6** for a complete list.

Impact of Capacity Building Approach - Although no formal assessment of the effectiveness and impact of CLICS capacity building activities has been undertaken, evidence in the form of results demonstrates improvements in the competencies and skills at different levels, ranging from the DCM to the village level.

- *At the DCM Level* - CLICS has resulted in strengthening of the capacity of MGIMS/ DCM in terms of resources, development of **faculty and program staff**, new skills and training capacity. CLICS has proved to be a great learning opportunity for the DCM and Program Staff. It has

created an enabling environment in the department and offered opportunities for the faculty and staff to think creatively and innovatively. According to them, there has been personal growth, team work, and a rich sharing of ideas and information. Faculty at both senior and junior levels have learned new skills in the area of project planning and management, operational research, quality assurance, MIS, monitoring and evaluation, documentation, and communication. CLICS has also enhanced their training capacity in various areas, including community mobilization, BCC, information management, district- and village-level planning, and the training of trainers. The project implementation experience gained by the faculty will pay rich dividends in improving undergraduate medical education and training by using actual data on community health, health systems operations, and community behavior.

CLICS has strengthened the MGIMS **rural training site** by expanding the area and population coverage, enhancing resource availability, improving the database of households, and providing training and research opportunities. As a result, students have had and will continue to have quality practical and hands-on opportunities to gain experience in project implementation and research.

- *At the Community Level* – The greatest impact of CLICS training was evident at the **community level**. Training of CBOs was organized at a large scale.

The impact of CLICS training on **VCC** operations was easily discernable. They developed organization skills and changed the health situation in their villages. VCC members developed new skills in health needs assessment and planning, social mapping, conflict resolution, community-based monitoring and analysis, and communication and mobilization of the community and resources. Women have been empowered to make decisions and negotiate. CLICS training and participation in CLICS activities have raised the level of status of women in the community.

Training of **KP** members has tremendously changed the levels of concerns and knowledge of the adolescent girls, especially relating to reproductive health issues, education, and future career planning. KPs have become the voice of the adolescent girls in the project village.

SHG trainings have led to more effective operations through better planning and income generation. Linking them to VCCs has proven synergistic. **KVM**s have engineered male participation in social issues usually seen as female domains, including health and nutrition of women and children and social issues, such early marriage, alcoholism, and women's empowerment.

- *Health System Performance* - Training of **public health personnel and AWWs** have made an impact on the performance of the MCH services in their respective areas. This is supported by the significant improvement in health and nutrition indicators (**Table 4**, pg 17). Improved performance has been demonstrated in growth monitoring, immunization, ANC, and counseling of malnourished children as well as in functions, such as program monitoring, record keeping, and community mobilization. At the same time, there has been an increased concern for quality of services, especially through the use of quality checklists. Changed attitudes of AWWs and involvement of community women have led to improved services and performance.

Sustainability of Training – The chances of **sustaining** the capacity building at the community level are good. CLICS was implemented in the Field Practice Area of the MGIMS where it is held in high regard by the community. DCM will continue its presence in the area and remain active in approximately half of the CLICS villages which will allow it to reinforce and refresh what was taught during CLICS. Community empowerment and participation is high and the VCCs are now mature enough to sustain themselves. All partners at the community level have a high level of commitment and plans are in place to continue.

d. Health Systems Strengthening (HSS)

There are three components of the CLICS program that have contributed to HSS – the MIS development and application, quality assurance, and work with private practitioners.

a) **MIS** – CLICS MIS has evolved over time with an emphasis on information equity aiming at sharing information at community and other levels in the program for utilization in monitoring, decision making, and action. The program faced **initial failures** related to MIS software package developed by a professional agency, though the routine data collection was in place for monitoring of various program activities and generating reports at the sector and central program levels. The MIS software was tried in the field but did not succeed due to the programmer's lack of familiarity with field operations resulting in frequent errors and breakdowns.

An alternate MIS was developed in-house, based on the use of MS Excel spreadsheets for data management and SPSS statistical package for analysis of data. Macros have been created in MS Excel and SPSS syntaxes through which reports are generated for the monitoring indicators. To ensure data quality, Guidelines have been developed for data management and program indicators to ensure uniformity and avoid variations in data definition and analysis. The MIS Assistants, who are responsible for data handling at the sector and central levels, have been trained in manual generation of monitoring indicators. Presently, the MIS Assistants generate most of the monitoring indicators at sector level and present them during the monthly program staff meetings at central office where each performance indicator is discussed.

As the MIS Framework shows in **Figure 4** (**Annex 1**), there are two distinct components of the CLICS MIS, namely, 1) Program MIS and 2) Community-Based Monitoring.

1) Program MIS

There are three levels of the program MIS – Village, Sector, and Program. The information flow is from village to the program level, from bottom to top with a feedback loop. Initially there were 57 **indicators** (in the LFA) for which information was collected. Now the number has been reduced to 21 'key' indicators (15 for maternal health and six for child health and nutrition). Some of these are no longer relevant or worth tracking (e.g., home deliveries, all the different levels of IFA consumption, use of DDK) since the health situation in the community has changed since the MIS was first developed. It is suggested that it could be further reduced to focus attention on the most important program components (e.g., LBW, -3SD malnourished children, delivery at health facility, ANC, and births/deaths).

Recommendation: CLICS should reduce the number of indicators monitored at the village level to the most revealing in terms of improving outcomes and achieving objectives.

- Data Management and Monitoring – A CLICS *Doot* collects the data at the village level. She maintains a **household register** and MCH service register and **collects information** through household visits and during *Bal Suraksha Divas.* Data collection is regular and appears complete in all the project villages. The records are well-maintained with the help of the AWW and CO and are regularly updated. Based on the village records, a monthly Progress Report is generated by the CO and ANM for the village and the sector. The CLICS *Doot* shares her information with the VCC of her village which uses it for community-based monitoring and decision making regarding malnutrition, childhood illnesses, immunization, ANC, and other services.

At the sector level, the information from all the villages is **compiled and analyzed** on the selected 21 indicators. Data from each village is entered in the Excel-based data entry package and reports are generated using SPSS. The reports are regularly shared with all the ANMs, AWWs, and CLICS *Doots* in a monthly meeting at the sector levels. The analysis of reports is presented by the CO, performance is reviewed and gaps/problems are identified. Based on the information, decisions are made to address and resolve the problems identified. The feedback system is strong and follow-up action is taken by the APO and Sector Coordinator.

The report is sent to the Central Program Office along with the data from each sector, and **program-level indicators** are generated every month. The MIS Program Officer is responsible for the collation and analysis of information at the program level.

- Data Quality: The data quality is good. To ensure uniformity and reduce errors, Guidelines have been prepared that define each indicator, process of data entry, and analysis at each level of the program. At the village level, the MIS staff and Sector Coordinators continuously **validate** the information. The CO checks the records of the CLICS *Doot* and assists them in correcting the information they have collected. The sector team conducts a verification exercise for births, deaths, and ANC registration in all three sectors. Regular on-site training in data collection and processing is conducted in the field to ensure that information collected is accurate and complete.

The final evaluation team identified several MIS-related **issues**: the information burden is high on the staff at all the levels; as mentioned earlier, there are too many indicators and even with the reduced numbers, some information is redundant and duplicated; little effort has been made to integrate the CLICS MIS with the parallel Government Health and Family Welfare Department information system. At the same time, information was regularly analyzed and used for performance review and identifying gaps, and ANMs from the health system frequently utilize CLICS data in their reports.

2) Community-Based Monitoring

Community-Based Monitoring is a unique component of CLICS and a major contributor to its principle of **information equity**, which is graphically presented in **Figure 4 (**see **Annex 1)**. The VCC has assumed the role of monitoring maternal and child health activities at the village level. A

format for Community-Based Monitoring has been developed for the use by VCCs and information support is provided by the CLICS *Doot* as well as the village AWW.

The VCC tracks the status of malnutrition, immunization, ANC, the need for Emergency Obstetric Care (EmOC), and transportation to health facilities and other services. This information is shared at VCC meetings and decisions are taken on any action required.

The final evaluation team's interaction with VCC members was heartening. The VCC members felt **empowered and motivated** to mobilize the local *Panchayat*, CBOs ,and community to take action on behalf of the village residents. Availability of health information on each family, child, and pregnant woman in the village enables them to identify priorities, establish plans, and implement the program effectively. They wanted, needed, and used the data.

a. QUALITY ASSURANCE – The CLICS project aimed at providing appropriate, accessible, and affordable **high quality care** to the community members. It was envisaged that the Quality Assurance system would be village-based and generate information about standards for health care and performance, and help to achieve and maintain them. The VCCs, Cos, health workers, and AWWs collect the quality-related data for inputs, processes, and outputs.

- Quality Assessment: An initial quality **assessment** was undertaken in program villages for PHC, sub-centres, AWCs, BSD*s*, and Private Practitioner clinics between June and October 2005. The following service areas were identified for quality assurance and concerns identified.

Table 11: Summary of Quality Assessment Findings

Service Areas	Levels	Quality Problems
ANC	Sub-centre and village level	Poor coverage, late registration, lack of weighing of mothers, no urine and Hb examination, no proper medical and obstetric examination, lack of counseling
Immunization	Sub-centre and village level	Low coverage, improper technique of immunization, poor logistics and supply, irregular immunization sessions
Growth Monitoring	Anganwadi Centre	Poor performance and lack of role clarity of AWW, irregular and inadequate growth monitoring of children, poor maintenance of growth charts, method of weighing of children not proper, weighing machine inaccurate, lack of supply of vaccine, supplementary food and other materials, grossly inadequate counseling of mothers of severely malnourished, lack of referral, low competency and skills of AWW, lack of coordination with ANM and village community
Out-patient Care	PHC	Poor supervisory and monitoring skills, lack newborn care services, ORS, RTI/STD, low institutional deliveries.
	Private Clinics	Out-patient services unsatisfactory, irrational prescribing and treatment, lack of involvement in health programs

- Quality Improvement Approach: CLICS adopted an approach similar to **Continuous Quality Improvement** (CQI). The main emphasis was on improved process management of various maternal and child health, newborn care and nutrition services.

There were no explicit written **quality standards** on inputs, processes, outputs, and performance. However, these were implicit in LFA-based CLICS indicators, which were also driven by the

national health policy indicators. The Guidelines for standardizing processes was developed for VCCs, CHCs, and BSD*s* on the maintenance and analysis of records and other key processes.

The **major approaches** to quality assurance included:

- *Checklists for Self Assessment and Supervision* - These included **checklists** for BSD*s*, CHCs, and Out-Patient Clinics at PHCs. In addition, an IMI checklist was developed and is being used to determine the organizational capacity of VCCs.
- *Capacity Building and Training* - A series of technical training in IMNCI, ANC, immunization, ARI, diarrhea, nutrition, and growth monitoring have been organized for health and AWWs at all levels and for the project staff (CLICS *Doots*, COs, and APOs). These **short trainings** are on-going and serve as refresher trainings. In addition, training in BCC, QA, MIS, and record keeping have been conducted to improve counseling, monitoring, and record keeping. Training for VCCs, SHGs, and *KPs* are regularly conducted on organizational development and the management of BSD*s* and CHCs, health needs assessment, community-based monitoring, and specially developed formats.
- *Monitoring* - **Monitoring** of BSD*s* and CHCs is regularly done during the sessions using checklists, mainly on inputs and processes. During the initial project period, the project staff was doing a lot of the monitoring. Now the VCCs are entrusted to monitor these activities at the village level. A **scoring system** for BSD*s* and CHCs has been developed. This exercise is undertaken every month and the scores are shared with the ANM, AWW, community members, and the staff.
- *Sharing Information and Identifying Problems and Solutions* - Regular sector-level meetings are held and the village-level information is shared with staff and CLICS *Doots*. Using the problem identification/problem solving approach, gaps and problems are identified and solutions developed which are then implemented.

The results of this QA work include improved access and availability of services through the organization of BSD*s* every month in all 67 project villages and CHCs. Medical care for common illnesses is available at an affordable cost. Quality scores of BSD*s* and CHCs have continued to be high (consistently between 70-80% over the past year). As has been demonstrated, all key program outcome indicators (exclusive breastfeeding, immunization coverage of children, ANC, and reduction of malnutrition) have improved. Moreover, there has been a substantial decline in key health impact indicators, namely infant, and neonatal mortality.

b. PRIVATE PRACTITIONERS - Private Practitioners are a **major provider of health care** in India, particularly of out-patient care. They were partners in the CLICS project which has engaged in building their capacities and developing and refining their technical skills. An initial training needs assessment was undertaken and training in technical interventions and quality assurance were identified as key areas requiring capacity for private practitioners. After an initial orientation to CLICS, IMNCI training was conducted to ensure appropriate care of newborns and infants. They were also trained in quality assurance and use of quality checklists for clinics. These checklists are displayed in their clinics.

The final evaluation team conducted a **focus group discussion** (FGD) with a group of private practitioners to discuss their current and future role in CLICS. All of them were non-allopathic

practitioners and belonged to Indian system of medicine, namely, Ayurveda and Homeopathy. On average, each private practitioner was given training for over 33 days. They found their training useful in helping to improve their technical skills in newborn and infant health care and raised their standing in the community. They appreciated CLICS interventions and were willing to continue with CLICS services and play a role in providing services as envisaged.

Although CLICS has done well in supporting and supervising activities at the community level, the question remains about how well program activities will be carried out as the DCM withdraws. In addition to ownership exhibited by the community as mentioned above, there is also support for and strengthening of capacities of the PHC and sub-center staff. They feel and demonstrate a closer association with the community and the monthly BSDs have been institutionalized, providing the ANMs a forum to provide promotive, preventive, and curative MCH services.

e. Policy and Advocacy

GIMS has done an admirable job linking with policy-level officials and participating in national and state fora to discuss community-based MCNH programming and disseminate the lessons learned from CLICS. The prestige of MGIMS gives it credibility and respect, so communities tend to listen more carefully to what is said, giving more weight to research findings.

The director of the DCM sits on a number of state, national, and even international committees. The secretariat of the state chapter of the Voluntary Health Associate of India (VHAI) is located at MGIMS. Few organizations are as well placed to influence and advocate for a change in the way health programs and the health system operates. Nonetheless, since the institute has no control or direct influence on how the public health system functions, it is limited in what it is able to do.

As the NCE has been approved, CLICS and the MGIMS are in a better position to influence community MCNH policy and service delivery at the district, state, and national levels. The CRC will serve as a mechanism to provide those interested and committed to improving health status at the grassroots level with the vast knowledge and experience that CLICS and MGIMS has accumulated during the five-year project.

In addition, MGIMS is an active member of the USAID-funded efforts, VISTAAR, and MCH Star. Through these mechanisms, the institute will be able to influence and disseminate what it has learned from CLICS. At the same time, it is expected that CLICS approaches and strategy can be replicated in the rural training site of several other medical schools, thereby strengthening them and exposing more faculties and students to the CLICS approach.

f. Contribution to Scale/Scaling Up

CLICS and NRHM share common goals and objective. As illustrated in **Figure 3**, CLICS and NRHM share common components. Both envision a community-based program with the village playing an active role, relying heavily on a Village Health Worker.

However, CLICS did not fully succeed in integrating the CLICS approach with the NRHM. The VCCs and Village Health, Nutrition and Sanitation Committees (VHNSCs) have been merged in

project villages and public health and ICDS personnel have been trained in various aspects of the program, but in the end CLICS and MGIMS has little control over how the new government program is implemented and managed.

While the form of the NRHM and CLICS might appear and sound similar on paper, if one deconstructs CLICS and analyzes the processes by which it achieved its success, a number of challenges for NRHM are apparent. By using such techniques as Forced Field Analysis or Risk Analysis, it is possible to identify where and how CLICS and NRHM differ. For each of the seven common aspects described in **Figure 3** (**Annex 1**), there are processes necessary to make that component successful. Three examples are provided below:

- **Village Committee Formation** – CLICS has demonstrated how important the village committee is in effectively managing program implementation. Without good community leadership, the program will not succeed. How the committee is formed is a crucial first step. In CLICS the Cos invest considerable time building the trust and confidence of the community. It can take as much as 18 months or even 2 years to complete this task. In contrast, in the NRHM a Government Resolution (GR) is issued with instructions but no guidance. This formation by circular was tried in the Community Health Worker (CHW) Program in the 1970s and failed.
- **Composition of the Village Committee –** CLICS has been successful with VCCs in which the *sarpanch* is an ex-officio member. In the NRHM, the GR instructs the headman that a VHNSC should be formed by *gram sevak* with the *sarpanch* as its president with the AWW as the secretary. They are given a week or two to complete the task. There is no guidance on how to go about this crucial task. In addition, there is no mention of how the new committee will be oriented and no form of PLA, which proved so critical to the effective mobilization and ownership-building process in CLICS, is carried out. One problem related to this new structure has already arisen when an AWW in one of the CLICS villages has claimed the Rs.10,000 "untied grant" to the VHNSC to improve her *anganwadi* center rather than discuss in the committee how the funds would be used to support village health efforts. If this happens in a CLICS village, it does auger well for non-project communities.
- **Capacity Building** - A third element in the process is training. How the community health worker is trained largely determines how effective she will be. CLICS was able to achieve good results by spreading the awareness and skills building over time. One intervention is introduced at a time in a three- to four-day session and followed by a month or so during which the village worker is able to practice the newly gained knowledge and skills. This process is repeated over approximately a year until all the information and skills have been transferred. And the process never ends – with refresher and new skills training taking place on a monthly basis. Experience in other community based projects employing village health workers shows that this is the most effective way to train such low-level workers. This contrasts with the typical public training which is for a month or more at a time. First of all, they are unable to spend such a considerable block of time away from their families and work. Secondly, they are unable to absorb so much information and material at one time. While the NRHM has yet to outline its training content or approach in detail, mention has been made of a 30-day training for the ASHA or village health worker. It is hoped that CLICS and MGIMS will be able to influence how the training can most effectively be accomplished through the CRC which has been proposed under the NCE.

There is hope that CLICS can influence the way the NRHM is implemented in Wardha District, Maharashtra, and in India. The district health administration has already adopted the VCC Process Manual for the newly created VHNSC under NRHM and made it available to all *panchayats* in the district. In addition, the CLICS staff is assisting in the training of government health officials and functionaries and building their capacity through the development of the district health plan, village health planning, and community-based monitoring. It should be noted that District officials endorsed the idea of replicating the CLICS approach in **two additional blocks** (PHCs) in Wardha District. The request was forwarded to the Department of Health in Mumbai over a year ago without any approval yet received.

Figure 5 – Process/Management Requirements at Various Levels for Community-Based Health Programming (in **Annex 1)** describes elements necessary for the effective implementation of a community-based health program. This was part of the final briefing conducted with USAID and about 70 interested and involved representatives from both the public and private sectors in New Delhi. A significant portion of the presentation (**Annex 7**) and discussion that followed, addressed the problem of successfully scaling-up the CLICS approach. While the form of the NRHM and CLICS may be similar, there must be an awareness that success in implementing the model lies in the process (slide #13 on "ingredients of success") identifies the importance of such Participatory Action for Learning and community-based information systems. Genuine community mobilization and empowerment is required for CLICS to function effectively and that is the biggest challenge to those implementing the NRHM.

AFK and DCM applied for and were granted a no-cost extension. The major focus of this nine-month effort will be to replicate the CLICS approach in the DCM in several other medical schools in India. This will result in additional medical faculties and students being exposed to the best practices and lessons learned during the implementation of CLICS and help spread the approach.

g. Equity

As mentioned in the course of this evaluation, the CLICS program is population based. This means that every member of the village in included in the effort and receives its benefits. The concept of "**information equity**" was introduced. Thus, every person in the village was included in the MIS or village health records and, as such, received the full package of MCH services. In addition, every villager was encouraged to attend the monthly BSD clinics. In fact, those typically least likely to participate, the economically and socially marginalized, were the object of special attention and encouraged to participate so that coverage rates in immunization and nutrition interventions were optimized. In other word, CLICS was committed to achieving it objectives and, therefore, was interested in achieving universal coverage

Approximately 20% of the project population are tribal (*adivasi*) – this is more than double the proportion in Maharashtra. In addition, most of the target population is classified as Below the Poverty Line (**BPL**). The final evaluation team was unable to find anyone in the CLICS villages who was not benefiting from or enrolled in project activities. Not everyone was a member of a CBO, like an SHG, KVM or KP, but everyone was eligible and no one was discriminated against.

It was also noted during village visits by the final review team that the CLICS program has had a positive impact on intra-community relations. For example, in one village that was equally split between tribal and non-tribal people, members of the two groups work closer together since the program began. They collaborated on the VCC and in the CBOs and served each other in the various project interventions. They said that they even participated in the other group's funerals.

h. Sustainability

CLICS has been successfully implemented with demonstrable results, achieving most of its goals and objectives. The project has made strides towards achieving sustainability. Community mobilization and capacity building, especially among the women, adolescent girls, and the CBOs, are the moving forces behind the move toward sustaining CLICS. The project successfully utilized the **Child Survival Sustainability Assessment** (CSSA) framework which is based on three key dimensions of sustainability: i) assessment of health and health services (minimum package of services); ii) organizational capacity and viability (transformation of VCCs from franchisee to ownership); and iii) community competence and ecological conditions (enabling environment, community norms; and modified behavior).

As described in the MIS section, the **IMI** has enabled the VCCs to monitor and build their management and leadership capacities. Twenty-six (40.6%) of the VCCs have achieved a Five Star status, while another 35 (54.7%) have attained Four Star status on the IMI sustainability scores. Initially the scoring was done by the project staff along with VCC members, while in the second phase of assessment the scoring was done by the VCC members themselves. The average first phase IMI score was 58 (out of 100) and this increased to 77 six months later. The monitoring process itself was part of the capacity building exercise by increasing the VCCs' understanding of what makes a strong organization. The maturation process continues.

In-depth interaction with VCC members by the final evaluation team was very encouraging. Most of the VCCs were very upbeat. They were aware of and committed to the franchisee agreement. Almost all VCCs have developed their **sustainability plans**. They were willing to continue with CLICS interventions, especially supporting the CLICS *Doot's* salary. A number of VCCs have agreed to provide the village health worker Rs.75-100 per month as a base pay and then pay them Rs.1 per household visited as part of the health effort.

Interaction with the village community revealed that the program was highly acceptable and very popular. The community mobilization activities have succeeded in creating an **enabling environment** in the villages. Capacity building of CBOs and VCCs has lead to empowerment and an increase in confidence. Communities now know they have the capability to identify and solve their health problems. The VCCs have matured and taken up the coordination role effectively at the village level in articulating needs of the local people, planning and implementation of package of services, and monitoring information.

Gram Swasthya Kosh (Village Health Fund), a **revolving fund** created and managed by VCC in each village, will play an important role in sustaining CLICS activities. The revolving fund has grown in size. In addition, some of the village *panchayats* have agreed to provide a portion of their budget for MCH and nutrition efforts to VCCs on reimbursement basis. Further, the health

insurance provided to the SGH and households by MGIMS is expected to have long lasting implications for sustainability. Low premium and the MGIMS core values have attracted the village community to obtain health insurance and the coverage has gone up significantly.

CLICS has succeeded in **mobilizing support** of *Panchayati Raj* System, ICDS, and the health system. This is critical to ensure continuity of CLICS interventions after the withdrawal of the CLICS program, DCM, and program staff. As mentioned earlier, NRHM has a great degree of synergy with CLICS goals, VHNSC interventions, and program structure. Under NRHM, VHNSCs are constituted in each village, by the Health Department. Most VCCs have merged with the newly formed committees and almost all VCC members are members of VHNSC.

The presence of **DCM** in the project area will be a crucial factor in sustaining CBOs and VCCs on the long-term. DCM has its field practice and demonstration area where CLICS was implemented. Approximately half of the CLICS villages will be included in their field-based training site and medical students, interns, and postgraduates in community medicine together with DCM faculty will continue to be involved there, although with significantly less intensity. For example, sector meetings will take place quarterly rather than monthly. DCM is also using the same area for operations and dissertation research and intervention studies. Therefore, there would an indirect continuity of the DCM in the program area and some support should continue to be available.

In this new phase, it might be worthwhile to consider the formation of Sub-Center **Management Committees** and PHC Management Committees. The former would consist of several members from each village who would meet regularly (monthly) with the sub-center staff to work together to improve the local health situation and ensure services are as effective as possible. The PHC Management Committee would be made up of two representatives (possibly the head and secretary) from each Sub-Center Management Committee who gather (on a quarterly basis) to team with the PHC team to strengthen its services and links with the community.

Recommendation: Select one PHC and form/orient PHC and Sub-Center Management Committees to link health personnel and the communities more closely together with the objective of improving the quality of health services.

One issue that will be raised whenever replication is mentioned is the **costs** involved. In CLICS there is a need to focus on how much it would cost to train the village committees, the village workers, establish and train the CBOs, carry out BCC, provide the supporting materials, etc. The impression of CLICS now is a highly intensive, high cost operation. Much of that is related to the start-up and development aspect. It would be helpful if CLICS were to work with a consultant to calculate what the cost of replicating and operating such a community-based program would be and include this information in the CRC so that anyone considering replicating the CLICS approach would have a better sense of the resources required. It should be noted that a costing study was included in the NCE and will be carried out prior to the close of the project.

Recommendation: CLICS should calculate the cost of replicating and operating a CLICS program to assist other who might be interested in replicating the approach.

In conclusion, the CLICS has reached a reasonable level of sustainability. Much depends on

continued technical support of DCM-MGIMS, synergy, and partnership with ICDS and Public Health System, and on-going monitoring support.

D. Mission Collaboration

CLICS/MGIMS and USAID/New Delhi have a close working relationship. To begin with, the officer responsible for MCNH interventions and programming at the mission is a graduate of MGIMS and maintains a close attachment to the institution. The mission has taken considerable interest in CLICS and a member of the health staff participated in both the mid-term as well as final evaluations. In addition, USAID/New Delhi has included MGIMS in several of its VISTAAR panels (on Community-Based Interventions that Improve Newborn Health Outcomes and the Role of Village Health Committees in Improving Health and Nutrition Outcomes). The mission has also arranged for a group of policy and program staff to join the CLICS final evaluation team's presentation in New Delhi to discuss project findings as well as its relevance to other community-based MCH efforts in the country. The mission has been very supportive of AKF's NCE, expecting this 9-month extension will be useful in further disseminating documentation of what CLICS has accomplished and lessons learned about how to implement MCH interventions effectively at the community level.

E. Contextual Factors that Influenced Results

MGIMS strives to meet Mahatma Gandhi's definition of *swaraj* (self rule). Established in 1969, it is the first rural medical college in India and is a multi-disciplinary health institution. MGIMS' mission is to provide accessible and affordable health care primarily to under privileged rural communities. MGIMS' strategy is to (a) train doctors to serve in rural areas, (b) evolve the health care delivery system consonant to the needs of the community, and (c) empower community and village workers for primary health care. Medical interns are required to serve in villages situated within the proximity of MGIMS as a part of their training at the end of their undergraduate medical education. This rural training, combined with the use of the MGIMS hospitals, creates a strong link between the Institute and the surrounding communities. MGIMS has gained the respect and trust of communities in Wardha district because of its strong rural orientation and commitment. As a result, it has become a well-known institution, whose initiatives are well-received and considered credible within the rural communities. These attributes have provided an easy entrée into the communities targeted by CLICS, which overlap with those served by MGIMS medical students, and played a significant role in making the community mobilization efforts effective.

Methodology - A participatory evaluation methodology was employed to qualitatively understand the effect of the non-health interventions on CLICS. The methodology included the following:

- Literature review of CLICS/DCM publications.
- Field visits to 11 villages selected on the basis of the IMI score of the VCCs. Proportionate numbers were selected from high, moderate, and low performance brackets. The villages Panwar, Anjie, Babulgaon, Talegaon, and Padegaon were selected from the high performing VCC villages. Warud, Bhidi, Salu Kate, and Inzapur were selected as average performing villages and Dhotra and Pipri were the low performing villages. Four villages from Anji, two from Gaul and five from Talegaon sectors were selected for field visits.

- Individual/group meetings with the community members and representatives of the CBOs including SHGs, KPs, KVMs, VCCs and GPs.
- Meetings with non-members and families not directly benefiting from CLICS.
- Meetings with the faculty associated with CLICS and the President of Kasturba Health Society.
- Meetings with relevant government officials at the district level to understand external perceptions of the project.

The data collected through focus group discussions or semi-structured interviews were triangulated with the CLICS project team.

Non-health sector interventions that interface with CLICS - **Access to credit and group savings:** Access to credit is an urgent need in the CLICS project area, which is situated in Vidharba, Maharashtra's most underdeveloped region. This region's economy is primarily based on agriculture, which is becoming increasingly unviable because of drought, exploitation of farmers by money lenders, lack of technical know-how among farmers, and low yields. This has resulted in a large number of farmer suicides in the region. In fact Vidharba has experienced the largest number of suicides among farmers in India in the past two years.

In this context, access to credit becomes very important and the lure of easy credit motivates women to join the SHGs. Each SHG member contributes an agreed amount to a group savings account each month and members can access funds from this account as a loan. Participation in the SHGs facilitates women's access to credit at reasonable interest rates (average of 2-3% per month or 24% per year) without harassment or insult by money lenders. This is a major incentive for women as they are able to use this credit. In the CLICS area, a large number of families are highly dependent on money lenders who charge steep interest rates (5% per month or 60% per year).

SHG members primarily take loans that range between Rs. 2500 - 5000. These loans are used to purchase agricultural inputs during the planting season, to fund weddings, funerals, home repairs, initiate small businesses and petty trading, and medical emergencies (such as accidents, caesarean deliveries, planned surgeries). Only 20% of loans are used for health purposes. The SHG group lending has also helped to pay for the education expenses of member's children. All the SHG members who have accessed loans have been able to repay the amount with the requisite interest payments and members have a strong sense of responsibility to repay their loans on time.

In addition to facilitating access to credit and serving as a platform for health education, participation in the SHG empowers women at various levels. Women from several SHGs have taken a stand on various issues, such as illicit sales of liquor in their village representing their interests at the village assembly or village panchayat. In essence, the SHGs have given women a voice and a platform to represent themselves.

Use of SHG resources by members

In Insapur village (Telegaon Sector) a self help groups has been operating efficiently for many years. The group has been saving and lending credit to the members continually. The group accumulated a reasonable amount of capital and interest from its savings and lending activities. In 2006, the group decided to distribute equally the available resources of the group to each member and restart savings again. Each member got about Rs.6000 (US$42) as her share. The money was used for:

- Payment to electricity connection for new house

- Purchase of seeds for agriculture
- Purchase of gold
- Buying a TV/sewing machine
- Supporting their husbands to buy an auto rickshaw or hand cart for selling eggs.
- Two members used it for general expenses/health/education
- Lend money on interest to other women of the village

The groups restarted savings and currently has accumulated more than Rs.30,000 for credit facilities. However, distribution of their capital has reduced their lending capability.

Increasing farmer's access to information: The KVMs are a mechanism to get men more involved in their family's health and well-being by engaging them in health issues. However, given the prevalence and importance of agricultural activity in Wardha district, CLICS trained Master Trainers in relevant agricultural topics so that these trainers could participate in the KVM meetings and share information with the farmers that was immediately relevant to them. These trainers shared information with the farmers on organic farming, seed selection, horticulture, multi-cropping, and other relevant issues. During these meetings, the Master Trainers also discussed health issues. In the beginning, the attendance at the KVM meetings was very low; however, once Master Trainers started sharing information on agricultural know-how, attendance increased. As the men saw value in these meetings, this helped to get them more engaged in health issues.

The KVM group became further energized when CLICS started sharing information and helping farmers access the government farmers' relief package announced in response to the high level of farmer suicides in the region. The relief package provides small and marginalized farmers loan waivers and subsidies on agricultural equipment, such as bullock carts and buffalos.

In Anji sector, the KVM initiatives are even stronger because of effective Master Trainers and the existence of a federation of KVMs. The leaders of the KVM federations stated that the exposure visits to other KVMs organized by CLICS motivated them to build a collective of KVMs. In addition to benefiting from the agricultural technical assistance and improved access to the relief packages, the KVMs have also contributed to health initiatives in their community.

One of the KVMs in Anji purchased a tempo[3] to transport agricultural commodities to the market. They also devised a plan whereby the vehicle would be available for medical emergencies within the village. They posted the numbers of the KVM members responsible for the vehicle at different times at the Kiran Clinic so that they would be reachable during emergencies. Another KVM in Anji has a vision of starting a bus service for the girl students of their village to help transport them to Wardha because the public transportation system is unsafe and inconvenient.

The interviews and focus group discussions with the CLICS beneficiaries emphasized the importance of including activities and information on income-generation, access to credit, education, and agricultural know-how. Without these non-health initiatives, it would be difficult to engage the communities to the extent that CLICS has been able to.

Education initiatives through KPs: The KPs are the most dynamic group among all the CBOs in CLICS. This is because the membership consists of young, energetic girls between the ages of 13 –

[3] Tempo: a three wheel vehicle used for transporting goods.

17 who are keen on doing something for the betterment of their communities. Membership in the KP - which is a very selective process - is an opportunity for them to learn and influence members of their community on issues of maternal and child health. However, because of their drive, enthusiasm and energy, these girls have expanded their scope of focus to other issues including hygiene, water, sanitation, literacy, and girl's rights. The girls in this group get reinforcement and energy from each other and in some ways it is equivalent to a sorority.

In village Padegaon, the KP has adopted girls, who are out of school due to economic reasons, to educate them through informal classes so that they do not fall behind and are able to rejoin formal schooling in the future. Similarly, another KP has taken on a literacy campaign whereby they adopt a person in their community (e.g., mother, father, neighbor) who cannot read or write and teach them basic literacy skills.

Effect of CLICS implementation on DCM operations - Mr. Dhiru Bhai, President of the Kasturba Health Society expressed the benefits of CLICS to DCM. He recognizes the importance and effectiveness of the CLICS approach and also points to the transformation of the relationship between MGIMS and the community as a result of CLICS, "earlier as curative health care center and now as a development friend." DCM faculty members have also used the lessons from CLICS as the basis of dissertations and published papers in national and international journals, thereby raising the profile of the organization.

Another contextual factor is the launching of NRHM. This was not envisioned when CLICS designed and began in 2003. When NRHM was first described and launched, it was thought to be a positive opportunity and a program that CLICS could contribute to and assist in implementing, at least in Wardha District and maybe even Maharashtra. As the new program was rolled out and implementation began, it raised concerns about overshadowing and even threatening what CLICS has developed and that achieved such good results. It now seems apparent that there is little chance that CLICS can have a significant impact on the national program – it is just too large and rigid to be influenced by any outside forces.

F. Conclusions and Recommendations

AKF and local partner DCM MGIMS has **successfully implemented** CLICS and the yielded **impressive results** in consonance with the project DIP. The project has demonstrated the technical and operational feasibility of community mobilization and ownership in effective implementation of Child Survival interventions. Not only did it improve the access and availability of maternal and child health services, there was also an improvement in the health status of children and reduction in neonatal and infant mortality. In addition, the project engineered important non-health gains by building CBOs and mobilizing communities to create an enabling environment, especially for women and adolescent girls, which will result in long term dividends in health and development.

Based on the findings of the CLICS review, the final evaluation team submits the following recommendations:

1. The CLICS design, findings and processes should be **documented and shared** with the potential stakeholders, namely, donors, public health system and health ministries, international and national agencies, NGOs, and advocacy groups.

2. The AKF and DCM MGIMS should develop a well articulated **dissemination strategy** to share experiences of CLICS in states and at national level. This may include multi-level workshops, participation in conferences, and full development of website (i.e., with links to all the materials, publications and even dissertations produced by the DCM from the CLICS program).
3. CLICS has very rich repository of data and should be used developing new hypothesis, undertake **analysis** to test them and **publish** research papers in reputed journals and other publications for the benefit of the policy research groups, stakeholders and implementing agencies. Two possibilities that were identified during the final evaluation involve neonatal mortality and post-partum vitamin A supplementation.
4. CLICS and NRHM share a common objective and many common elements. Based on CLICS evidence and lessons learned, MGIMS should continue its **policy and advocacy work** to improve NRHM implementation to promote the reduction in neonatal and infant mortality through community-based monitoring and technical interventions for newborn care.
5. The possibility of replicating the CLICS approach in rural training sites of several **medical schools** and public health institutions in NRHM states should be explored. It would be helpful to work with the Association of Medical Colleges with its 174 members to influence the Departments of Community Medicine. This is included as a major activity under the recently granted no-cost extension.
6. The Final Evaluation Team supports enthusiastically the No Cost Extension of the project so that it can complete its agenda of documentation and dissemination, finalize training modules and packages, capacity building of key stakeholders, and develop a **Community Resource Center** at DCM, MGIMS. The CRC would also serve as a "Learning Center" where interested parties can visit to see the CLICS program in action. This experiential learning will help them conceptualize the community approach and the essential processes employed to achieve results.
7. It is hoped that the CLICS experience will help inform and improve the scaling up of the NRHM. The DCM/MGIMS has a responsibility to continue to inform and raise awareness of health authorities from the district to state and national levels that process factors (or "ingredients of success" such as community mobilization and community MIS) must be taken into consideration if significant results/impacts on maternal and child health indicators are to be achieved.

AKF India and USA plan to apply the most relevant best practices and lessons learned from CLICS to its projects within India and internationally. In India, it has been integrating lessons learned from CLICS in its ongoing projects in Gujarat and new projects in the states of Bihar and Uttar Pradesh. AKF,USA has identified possibilities of adopting best practices of CLICS in the Chitral Child Survival Program (CCSP) in Pakistan, which began in October 2008. Although the scope and context of CCSP is quite different from CLICS, there are several lessons and best practices that can be applied to the new program. For example, CLICS' experience with the PLA tools and process and the CBHIS is one to keep in mind as the CCSP community mobilization strategy is developed around Birth Preparedness and Complication Readiness (BPCR). The CLICS PLA process and CBHIS was instrumental in engaging communities and ensuring their buy-in and participation in health activities in their villages. CCSP may adapt some of the PLA tools used by CLICS for use in the community mobilization process. The CCSP community mobilization strategy may also include an element of CBHIS to ensure a feedback to the community so that they

are informed of progress on planned health activities and to ensure that they are treated as equal partners in bringing about improved health outcomes for mothers and newborns (the primary target group for CCSP). Another CLICS lesson learned that will be applied to CCSP is to link health activities with other more pertinent issues affecting the community. For example, CLICS used the KVMs and farmers' education as an avenue to get men involved in their family's health issues. Similarly, SHGs included discussions on credit and savings in addition to discussions on health. The "non-health hooks" are an important element that will be included in the CCSP community mobilization strategy to get the larger community involved and activated around BPCR.

CLICS has established a website (http://clics.org.in/index.asp) to facilitate the dissemination of best practices, lessons learned, and results to the broader development community. In addition, AKF India organized a session at the National Institute of Health and Family Welfare in New Delhi to share the results of the CLICS final evaluation, which was attended by over 70 members of the international development community and USAID. As a part of the No-Cost Extension, CLICS is developing a Community Resource Center, a location where those responsible for the state-level operations of the NRHM can study the work of CLICS and select those measures that have relevance. The CRC is a venue in which health professionals from other districts will learn more about CLICS through exposure visits, lectures, group activities and interactive sessions. The CRC is also a site for training health professionals interested in replicating the CLICS model. Specifically, training and replication activities undertaken in the CRC will address: (a) the formation of the Village Coordinating Committee (VCC); (b) capacity building and supervision of health workers; and (c) village-based approaches to financing the delivery of essential care. All are relevant topics in the NRHM. CLICS will also maintain a library of training materials and other tools that can be used as reference for the successful implementation of the NRHM at the CRC.

The HQ Backstop will continue to participate in the CORE Group meetings and the Global Health Council and share CLICS best practices and lessons learned with the broader development community as opportunities arise.

Annex 1: Figures (additional annex)

Figure 1: CLICS Stages of Development

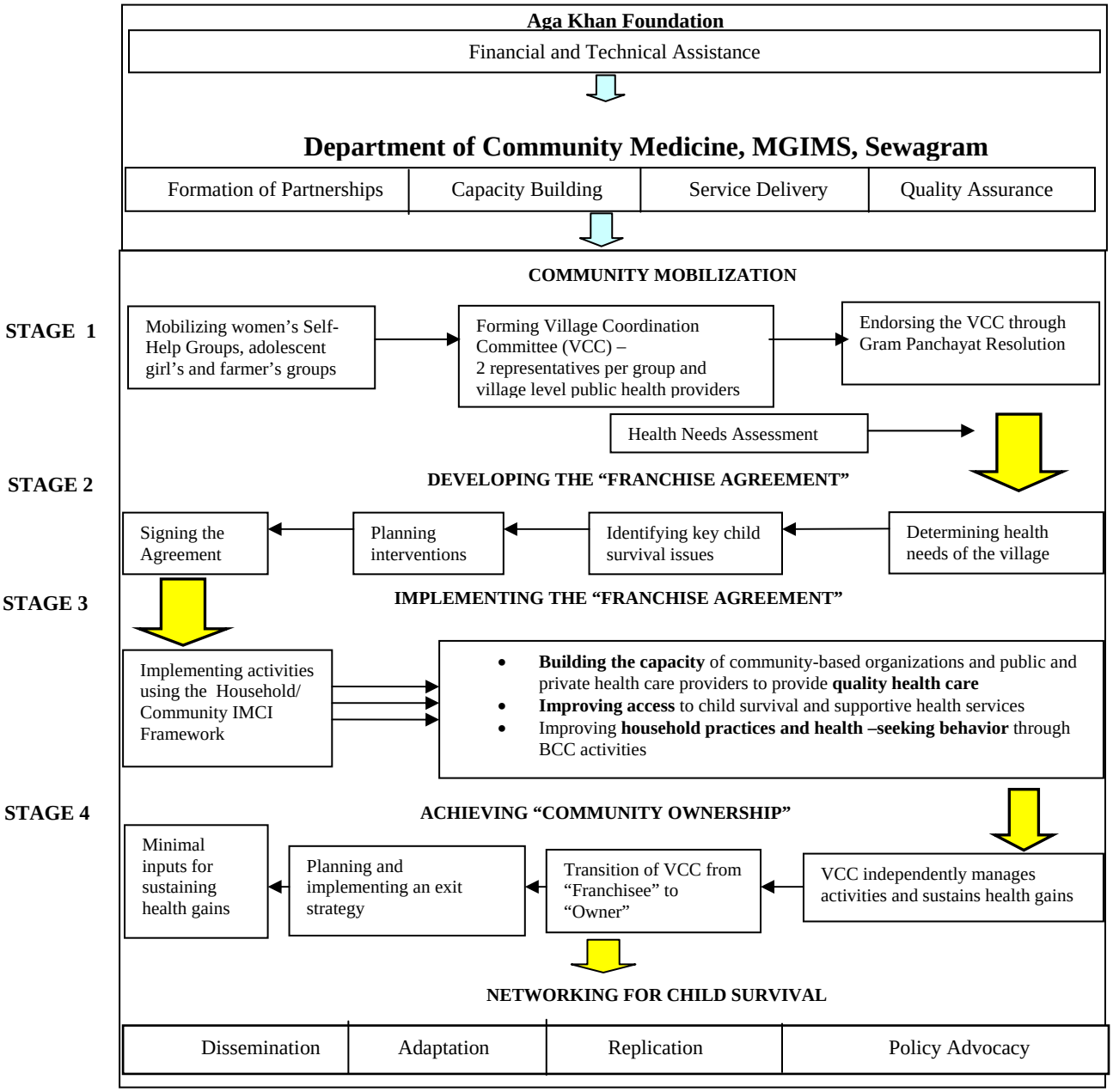

Figure 2: Malnutrition Status

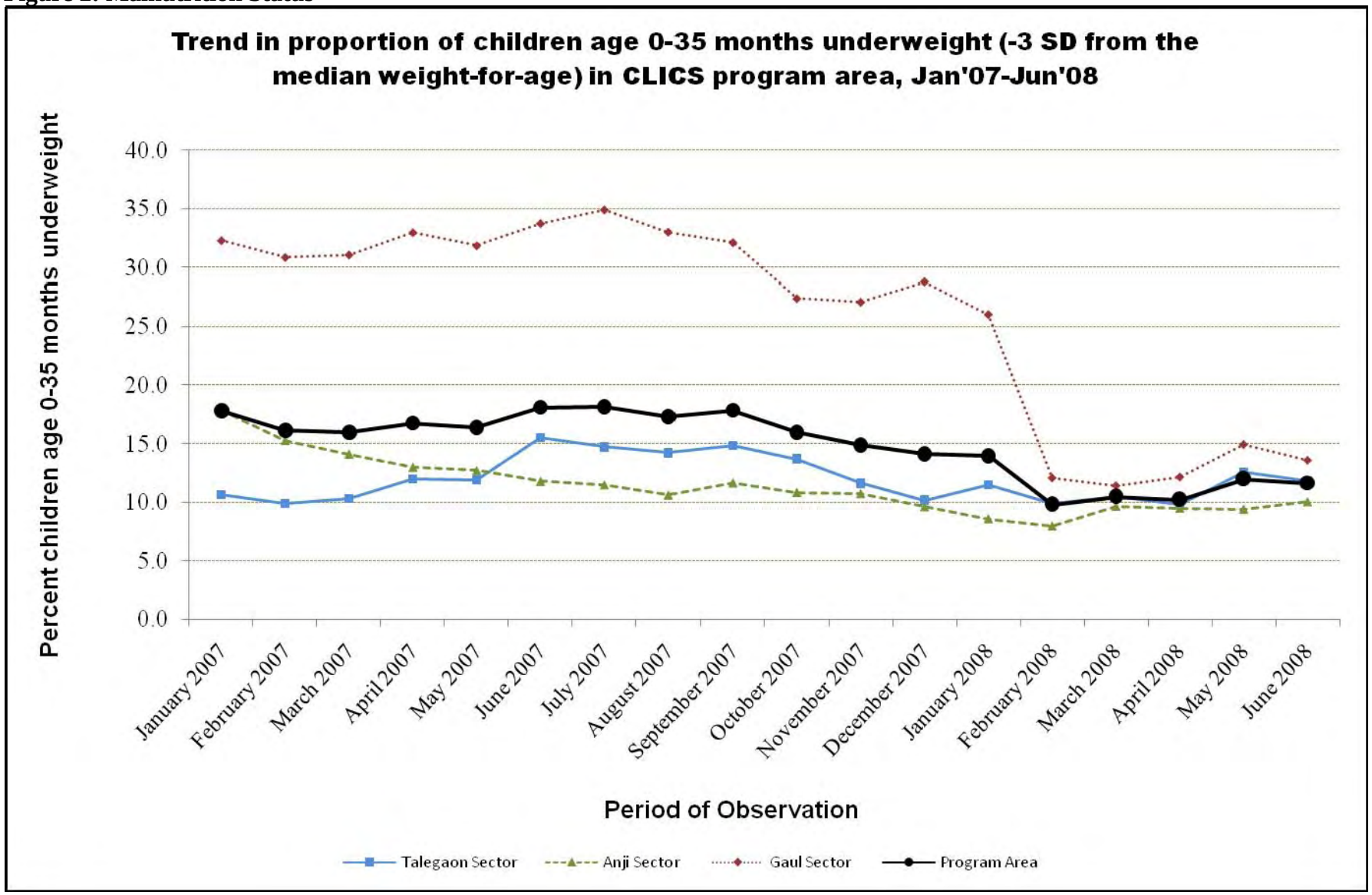

Figure 3: Comparison: CLICS vs. NRHM

Figure 4: Community-based Monitoring

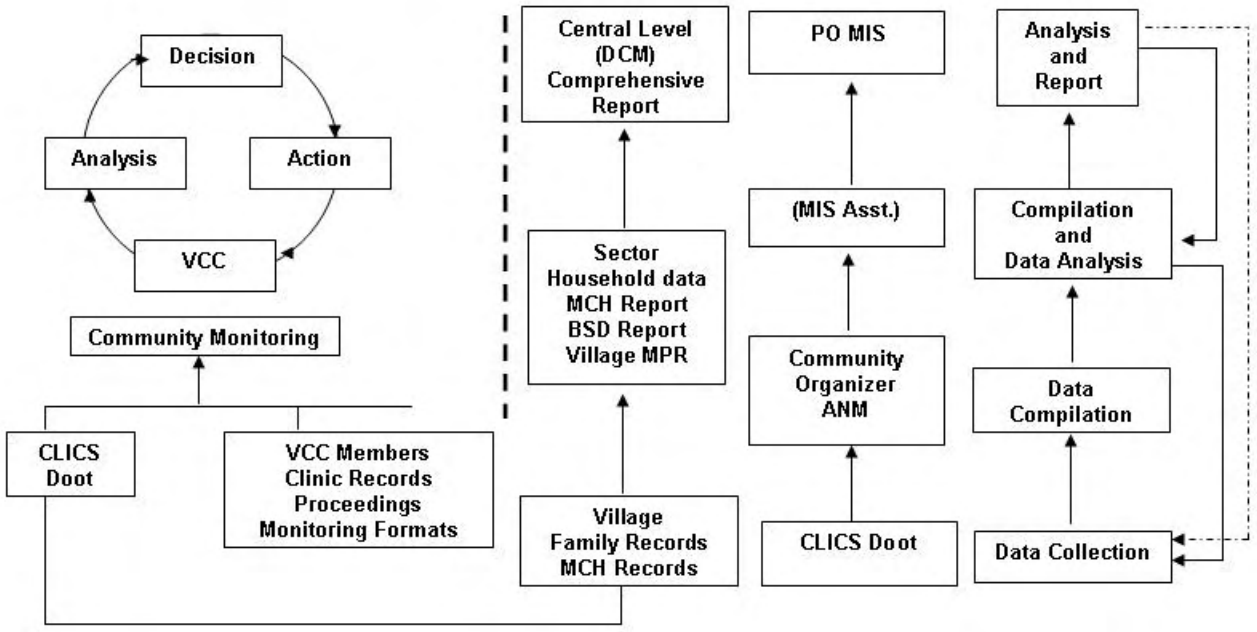

Figure 5: Process/Management Requirements at Various Levels for Community-Based Health Programming

Level	Community	Staffing/Structure	MIS	Finance	Training	BCC
National	Policy to support decentralization and flexible program planning	Policy support for social mobilization and necessary human resources	Monitoring progress of national indicators Advocacy	Release and transfer of budget and funds	Development of training curricula, materials and guidelines	Develop core BCC strategies and messages Develop materials
State	Adapt guidelines	Community mobilization support unit	Review of progress and feedback	Facilitate disbursement of program funds	Adaptation of training curricula and materials	Adapt and develop BCC strategy and messages
District	Orient and educate personnel to use guidelines	District Supervisor for Mobilization (Social Worker or community organizer)	Consolidation of CBM data and reports Monitoring and feedback	Appropriate allocation and timely release of funds	Training of trainers Monitoring of training quality	Identify targeted behavior and key strategies/messages Training of trainers
Block	Adapt and implementation guidelines	Community mobilizer or social worker (in place of 2nd ANM??)	Analysis and use of CBM data for decision making	Facilitate timely flow of funds to village committee and sub-centers	Training of community workers and CBOs	Planning, training and logistic support
Village	PLA, Implementation and Ownership	Village Health Worker/ASHA	Community-based monitoring and use of data	Access to allocated program funds Self finance/cost recovery/ insurance	On-going rather long duration initial training Regular re-enforcement	Message delivery and regular re-enforcement Inter-personal & Use of CBOs

Annex 2: Tables (additional annex)

Table 5

Trends: Percent children age 0-35 months underweight (-3 SD from the median weight-for age) in the CLICS

Period	Program Area			Anji Sector			Gaul Sector			Talegaon Sector		
	Nr	Dr	Indi.^{r}	Nr	Dr	Indi.^{r}	Nr	Dr	Indi.^{r}	Nr	Dr	Indi.^{r}
January 2007	425	2390	17.8	164	920	17.8	156	484	32.2	105	986	10.6
February 2007	401	2488	16.1	142	930	15.3	154	500	30.8	105	1058	9.9
March 2007	405	2540	15.9	135	957	14.1	160	516	31.0	110	1067	10.3
April 2007	432	2582	16.7	118	909	13.0	178	541	32.9	136	1132	12.0
May 2007	421	2570	16.4	118	929	12.7	172	541	31.8	131	1100	11.9
June 2007	487	2695	18.1	109	925	11.8	192	570	33.7	186	1200	15.5
July 2007	498	2744	18.1	107	932	11.5	215	617	34.8	176	1195	14.7
August 2007	473	2738	17.3	97	914	10.6	205	622	33.0	171	1202	14.2
September 2007	496	2783	17.8	108	927	11.7	209	652	32.1	179	1204	14.9
October 2007	437	2738	16.0	101	931	10.8	177	647	27.4	159	1160	13.7
November 2007	441	2966	14.9	113	1053	10.7	185	684	27.0	143	1229	11.6
December 2007	432	3063	14.1	105	1091	9.6	195	678	28.8	132	1294	10.2
January 2008	441	3161	14.0	91	1058	8.6	194	746	26.0	156	1357	11.5
February 2008	305	3113	9.8	82	1027	8.0	89	737	12.1	134	1349	9.9
March 2008	338	3228	10.5	96	993	9.7	90	789	11.4	152	1446	10.5
April 2008	340	3318	10.2	98	1032	9.5	90	741	12.1	152	1545	9.8
May 2008	401	3348	12.0	110	1170	9.4	111	744	14.9	180	1434	12.6
June 2008	388	3334	11.6	109	1086	10.0	103	759	13.6	176	1489	11.8

Table 9: Types of Training and Broad Contents for Various Categories of Personnel

Category	Content Areas Of Training
CLICS Program staff (PC, PO, Sec. Coordinator, APO, MIS Assistant & Office Assistant)	Key child survival issues, health management, BCC, MIS, Documentation & Dissemination (as per requirement of their job)
Technical support team	Research, documentation, QA, MIS and BCC
MO	Technical interventions, use of MIS, QA, IPC and training skills
Private practitioners	Technical interventions
ANM	Technical interventions, use of MIS, QA, IPC and training skills
Community Organizer	Community mobilization BCC (for all CS interventions), financial management, Technical interventions, use of MIS, documentation and QA
AWW	Technical interventions (GMP, immunization), ECD
CLICS Doot	All Technical Interventions (focus on NBC & SM), QA, reporting & use of MIS
TBA	Safe delivery, PNC, new born care, reporting & use of MIS
VCC members	Leadership & village level program management, financial management, QA, health needs analysis & use of MIS
Members of CBOs – SHG, KVM	Leadership & group management, financial management, QA, MIS, IGP related skill development (as per need of the group)

Table 10: Human Resource Capacity Building – Category and Average Person days of Training

CLICS Staff			CBOs and Others		
Category of Trainees	**Numbers**	**Average Training Days /person**	**Category of Trainees**	**Numbers**	**Average Training Days /Person**
Program Director	1	**23**	Private Practitioners	17	33.2
Program Coordinator	1	**33**	AWW/PHC Staff	172	26.8
TST members	7	**34.5**	Trained Birth Attendant	85	13.5
Asst Program Coordinators	2	**20.5**	KVMs	1197	26.75
Program Officers	2	**15.5**	VCCs	1298	30.1
Administrative Officer	1	**3**	SHGs	4329	35.9
Medical Officer	3	**6**	KPs	1089	32.3
Assistant Program Officer	3	**86.3**			
ANM	3	**128.6**			
MIS Assistant	4	**52.5**			
Community Organizers	15	**73.5**			
CLICS *Doots*	89	**41.13**			

Annex 3: List of VCC Activities and Characteristics included in the IMI (additional annex)

1. Development of VCC rules and regulations and election of office holders
2. Development of vision and mission statement and conducted health needs assessment
3. Development of village health plan and formation of sub-committees
4. Recognition of VCC by *gram panchayat*
5. Development of community-based distribution system
6. Development of village health fund
7. Regularity and coverage of *Bal Suraksha Diwas*
8. Linkage with ICDS and PHC/sub-center
9. Development of plan for community-based health insurance
10. Development of plan for emergency transportation
11. Initiation of community health clinic
12. Provision for marginalized/malnourished children
13. Submission of quarterly report to *gram panchayat*
14. Presentation of VCC activities at least two *gram sabha* a year
15. Development of community-based monitoring system
16. Supervision and monitoring of village health worker
17. Development of a conflict resolution plan
18. Linkage with private health care providers
19. Linkage with other agencies and NGOs
20. Development of village health worker retention plan
21. Organization of regular health promotion programs
22. Existence of cost recovery mechanism
23. Development of a sustainability plan

Annex 4: Results Highlight
(required annex)
INNOVATIVE IDEAS

1) Social Franchising

To address the issue of how to develop and implement decentralized health care at the village level, the DCM/MGIMS introduced the social franchising approach. The Department is the "franchiser" which mobilized the villages and enters into a contractual agreement with representative coordinating committees (the VCCs) which are the "franchisees." The contract or Memorandum of Understanding spells out how capacity is built, developed, managed, and sustained so that a package of high-quality affordable maternal and child health services that address priority health problems (the "social product"). The implementing group in the DCM builds capacity of the self-managing VCC by utilizing PLA tools which allow the local population to assess village health needs and, based on their findings, develop a village health plan. Subcommittees of the VCC are then given the responsibility to implement the plan.

To implement and sustain the village health plan, resources are required. The Village Health Fund (*Gram Swasthya Kosh*), collected from community contributions based on a fixed amount per family, provides the financial means. At least 75% of the households of the village must contribute to the fund if the program is to move forward. The Village Health Fund is designed to operate as a revolving fund and the core principle is generated by charging a one-time membership fee. The VCC uses a seasonal calendar to plan collections to augment the VHF so families are approached when they have resources (e.g., harvest time).

Based on the community health needs assessment, a Community Health Clinic (*Kiran* Clinic) is formed in villages without a Primary Health Center or in easy access to one. These clinics provide primary health care at the community level and overcome problems of access, both economic as well as geographic. The clinics are operated by the community members themselves. A portion of the VHF is used to purchase drugs and establish a revolving drug fund and a community pharmacy. Villagers can purchase medicines on a "no profit-no loss" basis, making it easier to access affordable drugs as and when required. The fund is replenished through user fees, annual membership fees and/or a health tax collected from all the village residents. VCCs also encourage in-kind contributions from community members. This local financing is designed to facilitate financial sustainability of the community-based PHC operation.

Within three years of the beginning of the CLICS program, Social Franchising agreements were signed with all VCCs participating in the CLICS program and all of them created a VHF. Mobilizing the individual communities and having them complete the local health assessments and plans required considerable program effort and time. Twenty CHCs were formed and all but one continued to function.

The Institutional Maturity Index (IMI) assessments indicate that the VCCs have improved their capacity to take complete village ownership. When the original scores were measured in April-May 2007, it was 58% and all 64 VCC were below 80%. As of the end of December 2007 some eight months later, 26 (41%) of the VCCs scored over 80%, meaning that these communities were able to manage health activities on their own with little or no need of support from outside.

2) ***Kishori Panchayats***

CLICS placed a lot of attention on the establishment and support of Community-Based Organizations (CBOs). In addition to the VCCs, SHGs, and KVMs, one of the most innovative and effective has been the Kishori Panchayat (KP), Adolescent Girls Forum.

Seventy KPs have been established in the 67 villages participating in the CLICS program. Approximately 15 to 20 girls are selected and belong to each of KP chapter. They are between the ages of 13 and 17. While most of the girls aspire to be in the local KP, there is only room for a limited number. Members are chosen on the basis of a competition - only the most mature, eloquent and talented are accepted. They are expected to have a commitment to health, serve the community, perform well in school academic performance and elocution. So the KP members are seen as leaders among their peers.

At the monthly KP meetings, usually led by the CLICS Community Organizer or the CLICS *Doot* from the village, different topics are discussed. Often the subject focuses on adolescent health and gender issues. The KP members make a concerted effort to reach out to the contemporary non-KP females in the community, passing on the new in formation they have learned through a more informal network. The efforts mobilize the adolescent population in the village. In addition to the KP meetings and activities, there are periodic *Kishori Malwas* (Adolescent Girls Fair) where all teenage girls from the community or KP embers from nearby villages gather to discuss adolescent health-related topics, perform dramas, hold nutritious food cooking demonstrations, etc.

Health-related skits are frequently produced and performed by the KPs. A typical topic might be protesting gender preference. It is a common practice in India to determine the gender of the fetus and abort it if it is female. Male children are highly desired for cultural and financial reasons. As ca result, approximately nine females are being born for every 10 males in many parts of India. The audience is informed about the importance of *Mulgi Wachawa Mohim* or Save the Female Child Campaign and that aborting female fetuses was outlawed by the Indian government over a decade ago.

Each KP nominates two or three members to the VCC in their village and is responsible for raising the adolescent health and related issues in the VCC, suggesting activities and getting their KP incorporated in the overall plans of the VCC.

The adolescent girls are energetic and idealistic and serve as a powerful resource for CLICS and the community as they strive to reduce infant and newborn mortality. One of the activities to which KP members in many of the CLICS villages are committed to in

most communities is compliance among the pregnant women in the daily consumption of **iron/folate tablets.** This is a vital part of ante-natal care to reduce the prevalence of premature deliveries and low birth weight infants. Individual members of the KP take responsibility for one pregnant woman living close to their house so that it is easy for them to provide the tablet each day and watch it being consumed.

Another demand made by the KP in the CLICS communities is for **sanitary napkins** to be made available at the village level. Menstrual hygiene is a topic of training is their monthly forum meeting and they want some shop or facility in the village to stock the pads so that they can be purchased. Other health education topics include first aid.

When asked what they are going to do after completion of their education, the girls are full of ambitions and dreams. They want to be doctors, nurses, engineers and all of them want to improve the health of their village. They are brimming with confidence and the support they receive from their fellow-KP members empowers and encourages them.

The Chief Executive Officer (CEO) of Wardha District (the highest development authority) was so impressed by the KPs in the CLICS program that she has mandated that the more than 900 villages of the district should establish KPs patterned after what the DCM has done in its 67 communities. This is a ringing endorsement for this creative way to ensure that the future mothers of the community are knowledgeable about good health practices for themselves and the children they will one day produce.

Annex 5: CLICS 15 Key Behaviors
(additional annex)

1. Mother initiates and continues *Exclusive Breastfeeding* (EBF) immediately after birth until six months of age.
2. Mother initiates appropriate *complementary feeding* at six months and continues breastfeeding.
3. Mother *washes hands* after defecation (self as well as baby), before cooking food and before feeding the baby.
4. Mother takes proper care of child with *ARI*, recognizes danger signs and seeks appropriate medical help if needed.
5. Mother takes proper care of child with *diarrhea*, initiates ORS, recognizes danger signs and seeks appropriate medical help if needed.
6. Pregnant mother seeks minimum five *ANC* visits of which one is before 12 weeks, consumes 100 IFA tabs and 2 TT injections. She is able to recognize complications during pregnancy and seek appropriate medical help.
7. Mother recognizes and takes appropriate care to manage a *LBW* baby.
8. Mother recalls the danger signs in *newborn* and seeks appropriate medical help.
9. Mother has ability to recognize *hypothermia* and ensures the baby is kept warm.
10. Mother *prepares for birth* and plans (place, money, identify referral, transport in case of emergency).
11. Women between 15-44 years ensure proper *menstrual hygiene.*
12. Mothers delay first pregnancy and keeps *birth interval* of 36 months.
13. Parents participate in growth monitoring and seek appropriate care in case of *malnutrition.*
14. Mother ensures child's primary *immunization* by the age of one year including first dose of *Vitamin-A.*
15. Mother receives five *PNC* visits out of which four should be in first 28 days, is able to recognize complications, and takes adequate diet and rest.

Annex 6: Special Areas of Training
(additional annex)

Areas	Participants
Integrated Management of Childhood Illness (Master Trainers Training) (2)	Program Staff and Faculty of DCM, Pediatrics, District Health System Personnel
Integrated Management of Childhood Illness (4)	Medical Offices, LHVs, ANMs of the Public Health System, APOs, COs, CLICS *Doots*
Appreciative Inquiry	TST Members and Project Staff
Quality Assurance (4)	Program Staff, PHC Staff (MO, Health Assistants, LHV, ANM), Private Practitioners, AWW
Behavior Change Communication	COs, ANMs, PO (at IHMP)
Workshop on Behavior Change Communication	DCM and CLICS Staff (MGIMS)
BEHAVE Framework Training	DCM and CLICS Staff (MGIMS)
Behavior Change Communication Training	MO, ANM, APO, CO
Early Childhood Development	CO, APO, AWW, ANM
Management Information System	Program Staff, CO, APO, MIS PO and Assistant
Documentation and Communication	Program Staff, CO, APO
Family Life Education	Program Staff and School Teachers

CLICS Final Evaluation

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8 August 2008
NIHFW
New Delhi

USAID
FROM THE AMERICAN PEOPLE

Community Led Initiatives in Child Survival (CLICS) program is implemented by the Department of Community Medicine at Mahatma Gandhi Institute of Medical Sciences (MGIMS) and managed and co-funded by the Aga Khan Foundation (AKF). CLICS is made possible by the generous support of the American people through the United States Agency for International Development (USAID)

Presentation Outline

- Methodology
- Findings – Results
- Findings – Process
- Comparison – CLICS & NRHM
- Where Do We Go from Here?

Methodology

- Document Review
- Data Review
- Key Informant Interviews
- Focus Group Discussions
- Field Visits

Package of Interventions

Maternal and Newborn Care	60%
Breastfeeding	10%
Nutrition	10%
ARI	10%
Diarrhea	10%

(CIMNCI)

I. Maternal Health

Indicator	Baseline (2004)	Midterm (2006)		Final/Endline (2008)		Revised Target	NFHS III (MH)
		KPC (MODE)	CLICS Survey	KPC (ORG)	CLICS MIS (Jun'08)		
% mother of <1s received minimum **ANC** package (at least three visits, 2 TT, consumed 100 IFA tablets)	11.6%	10.9%	8.4%	32.1%	58.9%	50%	NA
% husbands aware of at least **3 pregnancy danger signs**	13.2%	18%	NA	42.2%	NA	50%	NA
% mother of <1s **delivered in health facility**	64.3%	NA	84.4%	85.1%	90.7%	75%	50.5% (rural)
% children <3s with at least **36 months interval** after previous surviving child	29.3%	NA	39%	49%	NA	60%	41.1%

II. Infant/Child Health

Indicator	Baseline (2004)	Midterm (2006)		Final/Endline (2008)		Revised Target	NFHS III (MH)
		KPC (MODE)	CLICS Survey	KPC (ORG)	CLICS MIS (Jun'08)		
% of children born **Low Birth Weight**	29.4%	NA	26.6%	25.0%	14.5-40.4%	24%	22.1%
% mothers of <1s initiating **breastfeeding within 1 hour:** - knowledge/awareness - practice	0.6% 0.9%	NA 61.8%	NA 80.1%	68.0% 67.9%	NA 89.7%	80% 60%	NA 53.0% (rural)
% mothers of <1s knowing at least **3 newborn danger signs**	11.3%	8.2%	NA	99.7%	94.2%*	50%	NA
% of children (12-23 months) **fully immunized**	62.4%	91.7%	75.6%#	96.5% ##	98%	90%	49.8% (rural)
% of children (12-35 months) received **Vitamin A** dose in last 6 months	53.6%	80.5%	NA	83.5%	98%**	80%	29.9% (rural)

* CLICS Annual Survey, January 2008

** % of children (12-23 months) receiving 1st dose of Vitamin A

\# with card; ## without card

II. Infant/Child Health

Indicator	Baseline (2004)	Midterm (2006)		Final/Endline (2008)		Revised Target	NFHS III (MH)
		KPC (MODE)	CLICS Survey	KPC (ORG)	CLICS MIS (Jun'08)		
% mothers of <3s knowing at least **2 signs of childhood illness** requiring treatment	29.5%	55.4%	NA	98.5%	NA	70%	NA
% of <3s suffering from diarrhea in last 2 weeks who received **ORS/HAF**	6.8%	14.5%	NA	59.7%	62.2%*	70%	37.5% (rural)
% of mothers of <3s who report **washing hands** with soap/ash:							
- before food preparation	9.1%	36%	12.7%	46%	36.8%*	50%	NA
- before feeding children	14%	40.6%	16.8%	57.3%	44.4%*	60%	NA
- after defecation	87.6%	94.2%	90.1%	98.6%	97.7%*	100%	NA
- after washing child after defecation	NA	83.8%	NA	97.2%	95.6%*	90%	NA
% of <3s -3 SD from the median **weight for age**	22%	23.2%	NA	10.7%	11.6%	NA	19.1%

* CLICS Annual Survey, January 2008

Mortality Reduction

Year	# Births	Infant Mortality		Neonatal Mortality		% of neonatal deaths
		# deaths	rate	# deaths	rate	
7/2006-6/2007	1,583	78	49.3	61	38.5	78.2
7/2007-6/2008	1,481	56	37.8	45	30.4	80.4
% reduction			23.3		21.0	

Confidence interval (CI) 95% with power of 80%

Findings - PROCESS

- Community-based needs assessment and planning
- Community ownership/mobilization
- Social Workers
- Community-based organizations
- Institutional Maturity Index & LOGFID

Findings – PROCESS 2

- Capacity building/training
- Awareness raising and behavior change
- Community-based MIS
- Community Health Rights
- Safety Net

Recommendations

- Document and share CLICS design, findings and results
- Develop a dissemination strategy
- Analyze data, improve interventions and publish findings
- Continue policy and advocacy efforts to influence implementation of NRHM
- Explore possibility of replicating CLICS in DCM in several medical schools
- Utilize NCE period to fully develop the CRC/ “Learning Center” to give others opportunity to conceptualize community mobilization process

Comparison – CLICS vs. NRHM

NRHM		CLICS
Village health, nutrition & sanitation committee	⟷	Village Coordination Committee
ASHA	⟷	CLICS Doot
Untied Fund	⟷	Village Health Fund
Quality Monitoring	⟷	Quality Assurance Program
Village Health, Nutrition & Sanitation Day	⟷	Bal Suraksha Diwas
Community based monitoring	⟷	Community monitoring by VCC
Capacity building	⟷	Capacity building of PRIs, VCCs, Health functionaries

How CLICS Did It ("Ingredients of Success")

- **Committee** – PLA (with social worker support) & purposeful selection of leadership; link with CBOs
- **VHW** – rigorous selection
- **Fund** – internally generated & revolving drug fund
- **QA** – use checklists and improve as required
- **Health day** – complete coverage with CBO assistance and stress awareness raising/behavior change
- **Monitoring** – key indicators, CBMIS based on population-based data, and organizational capacity
- **Training** – Short sessions spread-out over year, constant reinforcement and supportive supervision

Matrix – Process/Management Requirements at Various Levels for Community-Based Health Programming

Level	Community	Staffing/Structure	MIS	Finance	Training	BCC
National	Policy to support decentralization and flexible program planning	Policy support for social mobilization and necessary human resources	Monitoring progress of national indicators Advocacy	Release and transfer of budget and funds	Development of training curricula, materials and guidelines	Develop core BCC strategies and messages Develop materials
State	Adapt guidelines	Community mobilization support unit	Review of progress and feedback	Facilitate disbursement of program funds	Adaptation of training curricula and materials	Adapt and develop BCC strategy and messages
District	Orient and educate personnel to use guidelines	District Supervisor for Mobilization (Social Worker or community organizer)	Consolidation of CBM data and reports Monitoring and feedback	Appropriate allocation and timely release of funds	Training of trainers Monitoring of training quality	Identify targeted behavior and key strategies/messages Training of trainers
Block	Adapt and implementation guidelines	Community mobilizer or social worker (in place of 2nd ANM??)	Analysis and use of CBM data for decision making	Facilitate timely flow of funds to village committee and sub-centers	Training of community workers and CBOs	Planning, training and logistic support
Village	PLA, Implementation and Ownership	Village Health Worker/ASHA	Community-based monitoring and use of data	Access to allocated program funds Self finance/cost recovery/ insurance	On-going rather long duration initial training Regular re-enforcement	Message delivery and regular re-enforcement Inter-personal & Use of CBOs

WHERE DO WE GO FROM HERE?

Annex 8: List of Publications and Presentations Related to the Project
(required annex)

Published:

1. Dongre AR, Deshmukh PR, Garg BS. The effect of community based health education intervention on management of menstrual hygiene among rural Indian adolescent girls.
   World Health & Population
   URL: http://www.longwoods.com/product.php?productid=19303&cat=469&page=1

2. Dongre AR, Deshmukh PR, Garg BS: Perceptions and health care seeking about newborn danger signs among mothers of rural Wardha.
   Indian J Paediatrics 2008;75:325-329

3. Dongre AR, Deshmukh PR, Garg BS: Perceived responsibilities of Anganwadi Workers and malnutrition in rural Wardha.
   Online J Health Allied Scs. 2008;7(1):3.
   URL: http://www.ojhas.org/issue25/2008-1-3.htm

4. Sinha N, Deshmukh PR, Garg BS. Epidemiological correlates of nutritional anemia among children (6-35 months) in rural Wardha, Central India.
   Indian J Med Sci 2008;62:45-54.
   Available from URL: http://www.indianjmedsci.org/text.asp?2008/62/2/45/39366

5. Ganguly E, Deshmukh PR, Garg BS. Quality assessment of private practitioners in rural Wardha, Maharashtra.
   Indian J Community Med 2008;33:35-7.
   Available from: http://www.ijcm.org.in/text.asp?2008/33/1/35/39241

6. Dongre AR, Deshmukh PR, Boratne AV, Thaware P, Garg BS. An approach to hygiene education among rural Indian school going children.
   Online J Health Allied Scs. 2007;4:2
   URL: http://www.ojhas.org/issue24/2007-4-2.htm

7. Deshmukh PR, Dongre AR, Gupta SS, Garg BS: Newly introduced WHO growth standards: implications in large scale demographic surveys and child health programs.
   Indian J Paediatrics 2007;74:987-990
   URL: http://www.ijppediatricsindia.org/text.asp?2007/74/11/987/37248

8. Dongre AR, Deshmukh PR, Garg BS: A comparison of HIV/AIDS awareness between self-help-group leaders and other women in the villages of Primary Health Centre, Anji.
   J Communicable Diseases 2007; 39(2):101-104

9. Dongre AR, Deshmukh PR, Garg BS: Impact of school health education program on personal hygiene and related morbidities in a tribal school of Wardha.
   Indian Journal of Community Medicine 2006 April-June; 31(2):81-82

10. Dongre AR, Deshmukh PR, Garg BS: Effect of socially marketed faucets fitted to earthen vessels and/or sodium hypochlorite solution on diarrhea prevention at household level.

Online J Health Allied Scs. 2008;7(2):1.

Accepted:

11. Dongre AR, Deshmukh PR, Garg BS: A community based approach to improve health care seeking for newborn danger signs in rural Wardha, India.
    (Accepted by Indian Journal of Pediatrics)

12. Sinha N, Deshmukh PR, Garg BS: Performance of WHO Color Scale and palmar pallor for screening of anemia among children.
    (Accepted by Indian Journal of Medical Research)

Submitted:

13. Dongre AR, Deshmukh PR, Garg BS: Qualitative appraisal of Supplementary Nutrition through ICDS in rural Wardha.
    (Submitted to Journal of Health Studies)

14. Dongre AR, Deshmukh PR, Garg BS: An approach to monitor and initiate community led actions for Antenatal care in rural India.
    (Submitted to Indian Journal of Medical Research)

15. Dongre AR, Deshmukh PR, Garg BS: Process documentation of 'Health Education Interventions' for school children and adolescent girls in rural India.
    (Submitted to Education for Health)

16. Dongre AR, Deshmukh PR, Garg BS: Participatory methods in Gender mainstreaming- an experience from rural India
    (Submitted to PLA Notes)

17. Deshmukh PR, Dongre AR, Sinha N, Garg BS: Acute childhood morbidities and their epidemiological correlates in rural Wardha.
    (Submitted to Indian Journal of Pediatrics)

Posters:

1. Assessment of Village Coordination Committee (VCC) in decentralized health care delivery in rural area: Introduction of Institutional Maturity Index (IMI)
2. CLICS Doot: A front line health worker at the village level under the CLICS Program
3. Financial Management in the VCC under CLICS
4. Social Franchise Model for Community Ownership
5. Bal Suraksha Diwas (BSD): Synergy with Village Health and Nutritional Day (VHND)
6. CLICS Program Overview
7. Household and Community IMNCI
8. Synergy in Community Action Cycle: VCC under CLICS Program and VHNSC committee under NRHM
9. Development of a system of community monitoring of health services at village level
10. Development of a system of Community Monitoring of Health
11. Kishori Panchayat (KP) (Adoloscent Girls Forum)

Other documents:

- 5 Semi-annual and 4 Annual Reports
- Documentation Plan
- Communication Strategy
- Behavior Change Communication strategy and BCC plan
- Drug Costing Policy
- Operating Cost of Kiran Clinic
- Training Needs Assessment (TNA) and Training Plan
- Quality Assurance Plan
- Formative Research
- LOGFID and Institutional Maturity Index
- IMNCI module for CLICS doot
- Marathi Newsletter *Samvedna* 57th edition (12th from CLICS)
- Case Studies from CLICS program
- Documentary Film on CLICS Program

Completed Operational Research:

- A study to find out reasons for partial / non immunization
- Morbidity profile of under three years children
- Assessment of Health Care Quality in PHCs attached to MGIMS
- Health Profile of Women and Children in rural Wardha
- Role of Parenting Workshop in improving KABP regarding MCH care
- Role of Preschool Education on Psychosocial Development of Children

Ongoing Operational Research:

- To assess effectiveness of VCC in decentralized health care delivery
- An epidemiological study of neonatal morbidity in rural Wardha
- Cost Benefit analysis of Kiran Clinics under CLICS program
- Development of Community - Based Health Management Information System

Completed activities:

- Formation and functioning of Village Co-ordination Committee (VCC)
- A qualitative enquiry into the functioning & growth of the Kishori Panchayats as an integral part of CLICS
  Community Ownership of Health through Social Franchising: The CLICS Programme (Process Documentation of all 4 stages of CLICS Program)

In Process:

- Best Practices in CLICS Program and Synergy of CLICS Program with NRHM
- Capacity Building of Village Coordination Committee under CLICS program

Annex 9
(required annex)
Program Management Evaluation

As described in the Final Evaluation, the CLICS program has been well managed. Program, financial and personnel records are well maintained, easily retrieved, and available. There is a high level of transparency. The project staff remains highly committed and morale is good despite extremely long work hours and the impending close of the project. They have satisfaction from being in what is viewed as a successful project at a well known and respected medical/health institution. The positive results, in both health indicators and community empowerment, make them confident and give them a strong sense of satisfaction.

a. Planning

Every aspect of the CLICS program is planned and has been from the development of the original proposal to the individual village sustainability plan. What distinguishes CLICS planning efforts is its **all-inclusive, participatory** nature, from the grassroots to the faculty and administrative staff at MGIMS. Planning is done on an annual as well as monthly basis. Moreover, plans are developed at the project and sector levels.

As the CLICS staff's experience and confidence grew at all levels, their planning improved. One thing that distinguishes CLICS planning, particularly at the community level, is its use of data. They learned the value of collecting and using local data/information during the early PLA exercises and continued to use and refine what they had learned. The VCCs are constantly and consistently **using the data** they collect to help them determine what they should do. For example, Gaul Sector decided to place a higher priority on malnutrition reduction when it was noted that prevalence was particularly high. The results were particularly impressive and were described in the Results Section of the report. Rates of severe malnutrition (-3 SD) were reduced by more than half in little more than a year.

Several respondents mentioned concerns with the **DIP process**. One suggested that it was too rigid. CLICS deviated from the DIP when there was an outbreak of chikungunya. MGIMS and the CLICS staff assisted the project communities respond to the epidemic. Even though not consistent with the DIP and its workplan, CLICS support was highly valued and it brought the project and the villages closer together. If the DIP had been followed too closely, it would have had a negative impact on relations with the communities and on the project.

Another view regarding the DIP was that while the process was helpful in providing the project with a blueprint, it consumed **too much time**. It should be reduced to six months. This should be possible by streamlining the process and efficient use of all the modern means of communication.

It has been observed that the CLICS village- and sector-level plans have not been merged or integrated with the NRHM district plans. Under the new government program the district is charged with developing a plan that reflects the health needs at the grassroots. It provided an opportunity for CLICS but there is no evidence that CLICS influenced the plan of Wardha District.

b. Supervision of Project Staff

Supervision of CLICS staff is taken seriously. It is described as **comprehensive** with accountability found at all levels. The staff monthly meeting is at MGIMS and the sector meetings are very important in the CLICS supervision strategy. In addition, field visits by the supervisors give an opportunity for supportive supervision, building capacity at the same time that the quality of the employee's work is being monitored. One approach to improve staff performance and provide personal supervision is to assign a Technical Staff Team (TST) member (usually a faculty member) to a particular field staff person to allow for mentoring and professional development.

It was mentioned that **direct feedback** to the staff on their performance could be improved and made more frequent. This used to be done during the annual employee performance review or appraisal, but, as is mentioned below, this practice is no longer used at MGIMS.

Supervision **checklists** are employed for several components of the CLICS program: Kiran Clinics, the BSDs, and to measure the maturity of the VCC (i.e., the IMI). As mentioned in the discussion of quality assurance in the evaluation report, these checklists are not directly tied to standards and could be upgraded through the development of such.

c. Human Resources and Staff Management

The most significant change since the MTR is the discontinuation of the **annual personnel performance appraisal** or review. This is now done in group settings where there is no direct feedback on performance to staff members and no opportunity to discuss short- and long-term personal and career goals. Several employees expressed the view that the old system would be preferred as it was more personal and done specifically. The reason given for dropping this exercise is the time required and the many demands of the project. It was simply a matter of not having sufficient time.

Other than faculty members, staff work on one-year **contracts**. Although there are no performance reviews, staff performance is monitored and if a person's work is judged to be unsatisfactory, they are given contracts for a shorter period, anywhere from one to six months. It is a form of probation. If their performance does not improve, they are either asked to resign or their contract is not extended. All staff, regardless of position or performance, receive a 9% annual salary increment. No one seemed to be concerned that that was below the current inflation rate.

There have been significant staff turnover and position **vacancies** during the course of CLICS. For example, the position of Project Coordinator was vacant for a year. As mentioned in the MTR, the Project Officer for BCC was not filled for three years. In addition, the MIS Officer left the project after less than two years. This did not seem to negatively impact the project although it was one of the factors that contributed to under spending of the project budget.

The staff is confident of their abilities, qualifications and employability. They believe they are better qualified now after having had the experience of working in CLICS and after CLICS they will be employed in another MGIMS project or, if necessary find a good position elsewhere since having worked at MGIMS will give them good standing.

d. Financial Management

The accounts were reviewed and found to be in order. There is a high degree of transparency in all CLICS financial matters.

The only financial concern has been the under spending. One of the reasons for this situation was the inability to fill several of the positions during the first half of the project. The budget **surplus** at the MTR has remained much the same during the latter half of CLICS. This means that the project has spent very close to what was budgeted. The NCE has been approved and the unspent resources are likely to be constructively utilized.

e. Logistics

As mentioned in the MTR, there is very little procurement and logistics involved in the CLICS project. There was an expectation that CLICS would equip six (out of 18 in the three sectors) sub-centers with some basic equipment to allow them to become delivery sites. They expect to spend IRS 10,000 (US$280) for equipment (e.g., delivery table) and supplies. They are still awaiting government approval to proceed with this activity.

f. Information Management

Out of all the aspects of CLICS, MIS is the component that has shown the greatest improvement in the period since the MTR. The lack of data at that time resulted in much frustration and many hours of discussion and review. The Program Officer for MIS has done an outstanding job developing an **effective** and relatively **user-friendly** MIS. CLICS had to learn how to develop an appropriate MIS the hard way. The consultant hired during the first half of CLICS was not familiar enough with program operations to develop an effective program. More recently, CLICS decided to forgo the development of a special program and resort to Excel and SPSS. It is now possible to get good population-based data derived from the data collected at the village and family level with the push of a few commands and filters.

It was noted that the MIS is based on a cumbersome register system maintained by the CLICS *Doots* at the community level. As good as it is, there is serious **doubt whether it can be sustained** once the CLICS project comes to an end. It may be possible in the villages which MGIMS selects to continue operations as part of it rural training site, but elsewhere, it is unlikely to be continued despite the community's interest and desire to know what is going on in its households. Even if it cannot be sustained in most of the CLICS villages, it is hoped that another organization (e.g., the Voluntary Health Association of India or VHAI, the secretariat for Maharashtra being located at DCM) would adopt it and share it with members. This would preclude the need for other groups to spend scarce resources to reinvent the wheel and develop a similar system.

CLICS also introduced a new data collection technique, Lot Quality Assurance Sampling (**LQAS**), to evaluate project activities and provide supervisors with performance data. This method allowed managers to identify communities where performance was lagging.

g. Technical and Administrative Support

MGIMS mentioned that they experienced difficulties with both AKF, India and USA. In both cases the problem involved gaps in project technical support and administrative backstopping. In Washington, the post of Program Officer, Health was **vacant** for much of the first three years. When the post was filled, the person was new and just getting to know the agency and the project when they departed and someone else filled the slot temporarily.

The situation was not much better in New Delhi. The Program Officer who was there when CLICS started left for an AKF international position not long after the project was launched. Long-term and constant support was not available until just before the MTR. MGIMS has been able to operate with minimal support and has done an admirable job despite uneven and inconsistent support from AKF.

An additional problem was the inability of AKF to recruit and provide the technical assistance support that was mentioned in the proposal and DIP. For example, CLICS never had the planned technical adviser. Fortunately, this did not significantly affect the project since the DCM was able to provide qualified support from within the institute. One impact that it had on CLICS was in reducing expenses and was one of the reasons underlying the under expenditure of project fund that is discussed in sub-section **d** above.

h. Management Lessons Learned

There are a few management lessons that were learned during the course of CLICS. One was that a consultant that is unfamiliar with the program aspect is unable to design an MIS system. This resulted in CLICS having to develop the system internally and it has functioned effectively and satisfied project needs.

Another lesson is that the community is not only able to monitor its own health status but is eager to do so. In addition, the VCCs have demonstrated an ability to monitor and pay

CLICS doots. Paying the CLICS doots through the VCCs has been found to be important to make them accountable to the community. It also increases the possibility that the VCC will contribute to the support of the CLICS doots after project funding ends, thus helping in the sustainability of the project activity. They can provide incentives and disincentives to the CLICS doots depending on their performance.

i. Strengthening the Grantee Organization

MGIMS goes to great length to build staff capacities. The **outside training** and meeting/conference attendance since the MTR is found in the following table. The amount of training indicates that the staff members are given every opportunity to build professional capacities. In addition, it is a way for information on the CLICS approach and results to be disseminated.

Staff Training and Conferences, Outside MGIMS (since MTR)

Training/workshop	Participants	Dates	Place
ISMS conference	Mr. M S Bharambe Dr. P.R.Deshmukh	28 November to 3 December 2006	ISMS Conference, PSG Institute of Medical Sciences and Research
Financial Management workshop	Mr. Bharambe	11-12 October 2006	Jamia Hamdard
Partners meeting at USAID,	Dr. Chetna Maliye Dr. Savinder Kaur	27 October 2007	USAID, New Delhi
Training workshop on Digital photography	Mr. Dinesh Gudadhe	12-15 December 2007	Social Communication Service center, Secunderabad
IAPSM & IPHA Conference	Dr. B.S.Garg Dr.P.R. Deshmukh Dr. Savinder Kaur Mr. Bahulekar Dr. Shib S Datta Dr. Abhijit Boratne	29-30 December 2006	DMI of Medical Sciences, Sawangi Wardha
IAPSM Conference , AIIMS	Dr. B.S. Garg Dr. Chetna Maliye Dr. Savinder Kaur Dr. A V Boratne Dr. Priti Thaware	22-24 February 2007	AIIMS, New Delhi
Training for Doctors-STIs (Including HIV) Certificate course	Dr.Priti Thaware	24 Febuary-04 March 2007	IASSTD & AIDS Chennai
Naturopathy & related issues	CLICS Doots Mr. Bahulekar Mr. Bhusari Mrs. Aswini Timande (PHN)	21-30 March 2007	Manibahi Desai Management Training Centre, Nature Cure Ashram, Uruli kanchan, Pune

Training/workshop	Participants	Dates	Place
	Mrs.Walke (ANM)		
LAQS training	CLICS Staff	23 March 2007	Dr. S. N. School of Public Health MGIMS, Sewagram
Dissemination Workshop for WHO funded 'Qualitative study on delivery and neonatal care practices in rural areas of Rajasthan'	Dr. S S Gupta	21-22 June 2007	ARTH Project, , Rajasthan
Application of Qualitative methods of data collection in Population Research	Dr. P R Deshmukh Dr A R Dongre	18-29 June 2007	IIPS, Mumbai
The Network: TUFH 2007 International Conference	Dr. B S Garg	15-20 September 2007	Human Resources for Health: Recruitment, Education and Retention
Training and Exposure visit to ARTH Project	Mr. N A Jaiswal Mr. M D Rathod Mr. J V More Mr. R P Khurpade Mr. S H Belurlkar Mr. S L Sute	21-27 August 2007	ARTH Project, Rajasthan
First meeting of the technical experts to review interventions in the area of Community Health Planning and Monitoring	Dr. S S Gupta	29-30 August 2007	RCH Campus, Namkon,
Scaling up FP/MNCH Best Practices in the Near East technical meeting	Mr. M S Bharambe Dr. Chetna Maliye Dr. Savinder Kaur	3-8 September 2007	USAID , New Delhi
The Network: TUFH 2007 International Conference	Dr. B S Garg	15-20 September 2007	Human Resources for Health: Recruitment, Education and Retention
Evidence review meeting on Community-Based Newborn Care	Dr. P R Deshmukh	26-27 September 2007	VISTAAR Project, New Delhi
Micro Enterprises Development Training Program	Ms. Hema Kshirsagar	28-30 September 2007	Development Alternatives Group Orchha, Madhya Pradesh
Monitoring and Evaluation Technical Advisory Group Meeting	Mr. M S Bharambe	9 October 2007	VISTAAR Project at New Delhi

Training/workshop	Participants	Dates	Place
Joint Annual State Conference of IAPSM and IPHA Maharashtra Chapter	Dr. B S Garg Dr. P R Deshmukh Mr. M S Bharambe Dr. Preeti Thaware Dr. Sushma Katkuri	29-30 December 2007	SBH Govt. Medical College, Dhule
Evaluation of National Health Programs	Dr. S S Datta	22 January 2008	Pre-conference workshop 35th annual national conference of IAPSM JIPMER, Puducherry
Qualitative Research Methods in Health	Dr. A V Boratne Dr. Preeti Thaware	22 January 2008	35th annual national conference of IAPSM JIPMER, Puducherry
35th annual national conference of IAPSM	Dr. Sanam Anwar Dr. Chetna Maliye Dr. S S Datta Dr. A V Boratne Dr. Preeti Thaware	23-25 January 2008	JIPMER, Puducherry
9th SEA Regional Scientific meeting	Dr. B S Garg Dr. P R Deskmukh Dr. A R Dongre	9-12 February 2008	International Epidemiological Association, Dhaka
4th resource group meeting on MCH	Dr. B S Garg	15 February 2008	New Delhi
First meeting on Child Health by MOHFW	Dr. B S Garg	1 March 2008	NIHFW, New Delhi
Investigation of Public Health Emergencies of International Concern	Dr. S S Datta Dr. Preeti Thaware	6 March 2008	Pre-conference workshop 52nd annual national conference of IPHA (by WHO and NICD) at Maulana Azad Medical College, New Delhi
52nd annual national conference of IPHA	Dr. B S Garg Dr. S S Datta Dr. Preeti Thaware	7-9 March 2008	Maulana Azad Medical College, New Delhi
Meeting of MNCHN consortium	Dr. S S Gupta	14 March 2008	VISTAR Project at New Delhi
Consultation meeting on “use of legal provision for reduction of maternal mortality and morbidity” by Vishva Yuvak Kendra	Dr. S S Gupta	15-16 March 2008	Human Rights Law Network
3rd Annual Forum of MCH Community	Dr. B S Garg Dr. S S Gupta Dr. S S Datta	17-18 March 2008	Solution Exchange (UNICEF, UNFPA and WHO India), Udaipur
35th Annual International Conference on Global	Dr. B.S. Garg	27-31 May 2008	Washington DC

Training/workshop	Participants	Dates	Place
Health, Community Health			
Annual International Public Health Summer Institute	Dr. P.R. Deshmukh	6 July-2 August 2008	Institute of Alabama , Birmingham, USA

One experience that was not included in the list of outside trainings was the **study tour** to three projects in Ahmednagar District in Central Maharashtra, including the community-based Comprehensive Rural Health Project (CRHP) in Jamkhed. Three staff members accompanied 59 VCC members and two COs. In addition to building capacities, these visits increased staff confidence.

AKF USA is capable and familiar with what is required to implement a successful Child Survival grant. However, during the CLICS program, the AKF USA office had problems associated with oversight of the activities in the field due to vacancy of the Health Program Officer in the headquarter which contributed to underspending of the budget. Despite this concern, AKF USA did participate with the CORE group and provided support through other staff members. Nonetheless, it is suggested that the Washington office could benefit from some of the CORE workshops and short courses to build capacity is specialized areas.

Annex 10: Logical Framework Analysis (required annex)

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%	89.0%
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%	–	28.6%

Annex 11: Work plan Table (required annex)

Objectives/Activities	Objective Met	Activity Status
Objective 1 To provide affordable high quality health care through effective partnerships at the village level		
Proportion of villages with VCC	Yes	All 67 villages have VCC
Proportion of VCCs with Franchise Agreement	Yes	All 64 VCC have signed Franchise Agreement
Quality Assurance and affordability	Yes	Completed
1.1 Develop effective partnerships		
Mobilize communities	Yes	Completed
Orient Community Based Organisations	Yes	Completed
Orient Health Providers (Public, Private, ICDS Functionaries, NGOs)	Yes	Completed
Form VCCs	Yes	Total 64 VCC formed in 67 village
Orient VCCs	Yes	Completed
Gram Panchayat Resolutions	Yes	Completed (all 64 VCC)
Conduct health needs assessment	Yes	Completed
Plan child survival interventions	Yes	Completed
Develop Franchise Agreement	Yes	Completed
1.2 Plan and provide affordable high quality care		
Develop QA Plan	Yes	Completed
Build Capacity in QA	Yes	Completed
Staff	Yes	Completed
Health Care Provider (HCP)	Yes	Completed
ICDS Functionaries	Yes	Completed
VCC	Yes	Completed
Operationalise QA system	Yes	Completed
Village Level	Yes	Completed
Facility Level	Yes	Completed
Objective 2 Build the capacity of coalition of local partners to sustain child survival activities and health gains		
% Improvement in capacities (task specific) of Program staff & Partners	Yes	All staff and partners trained about child survival activities
% VCCs with sustainability plan	Yes	All 64 VCC
2.1 Build the capacity of coalitions of partners		
Conduct Appreciative Inquiries, Org. Capacity Assessment for DCM	Yes	Completed
Conduct Training Needs Assessment for Staff, Providers and VCC	Yes	Completed
Develop Training Plan (task-specific)	Yes	Completed
Identify and train core trainers	Yes	Completed
Conduct training (task-specific) on…		
Community Mobilisation & PRA	Yes	Completed
Technical Interventions	Yes	Completed
Behaviour Change Communication	Yes	Completed
Management Information System	Yes	Completed
Quality Assurance	Yes	Completed
Documentation	Yes	Completed
Continuing Education (Refreshers)	Yes	Ongoing
2.2 Determine Child Survival interventions & develop BCC strategy		
Conduct baseline assessments	Yes	Completed
Survey	Yes	All conducted

Facility Assessment	Yes	Completed
Planning workshop for DIP	Yes	Completed
Develop Detailed Implementation Plan	Yes	Completed
Conduct Formative Research	Yes	Completed
Develop BCC Plan	Yes	Completed
Develop BCC tools & materials	Yes	Developed
2.3 Implement Child Survival Activities		
Generate Village Health Fund	Yes	All 64 VCC generated VHF
Select VHWs	Yes	Completed (Total 89 CLICS Doot)
Initiate intervention specific activities		
Home		
VHW Home Visits	Yes	Achieved
Trained Birth Attendant (TBA)	Yes	TBAs promote newborn care and safe motherhood
Community		
CBO meetings	Yes	Completed
Bal Suraksha Divas	Yes	Completed in all project villages
Parenting Workshops	Yes	Completed
Campaigns		
Suraksha Aichi aani Balachi (Safe Motherhood and Child Survival Campaign)	Yes	Organised in all project villages
Mulgi Wachawa Mohim (Save the Female Child campaign)	Yes	Organised in all project villages
Facility		
Community Health Clinics	Yes	20 Clinics established
Sub-centre labor rooms	Yes	To be completed during NCE
Anganwadi center	Yes	Completed
2.4 Provide community access to services and health related products		
Identify Social product required for franchises	Yes	Completed
Promoting Awareness for Health Rights in VCC & in Health Care Providers	Yes	Completed
Determine pricing policy for social products (Services & Commodities- drugs, contraceptives & ORS etc.) and distribution points (VHW & CHC)	Yes	Drug costing policy developed
Monitor utilisation of products and cost recovery	Yes	Tools developed and documented for the Kiran Clinics
2.5 Develop system for sustaining child survival activities & health gains		
Adapt & refine LOGFID for VCC	Yes	Completed
Assess institutional maturity of VCCs	Yes	IMI for VCC assessed twice
Develop and initiate sustainability plan	Yes	All 64 VCC implementing sustainability plan
Express 'ownership' intent	Yes	Dialogue completed
Second Agreement (Establishing VCC "ownership")	No	VCC under CLICS merged with VHNSC under NRHM
2.6 Institutionalise Monitoring and Financial Systems		
MIS	Yes	Completed
Financial reports	Yes	All reported
Narrative	Yes	5 semi-annual and 4 annual reports
Audits	Yes	Up-to-date

Objective 3 Refine & test social franchise model for delivery of child survival interventions		
% of VCCs with instituted annual reviews	Yes	All 64 VCC
% difference between CLICS and GOI facilities	Yes	Documented through operational research
3.1 Refine & define the social franchise model		
Institute review systems at VCC level	Yes	Completed
Program Steering Committee meetings	Yes	All held (Total 6)
Program Advisory Committee meetings	Yes	Total 7 held
3.2 Test feasibility of social franchise model		
Conduct pre-post project assessments		
Baseline	Yes	Completed
Mid-term	Yes	Completed
End-term	Yes	Completed
Annual Reviews	Yes	Completed
Operations Research for comparison of GoI facilities	Yes	Completed
Objective 4 Document, disseminate & share key program lessons & results to facilitate adaptation, replication & policy advocacy		
Communication strategy developed	Yes	Completed
# of workshops/meetings participated and papers presented	Yes	More than 100 workshop/meeting attended and > 50 papers presented
4.1 Document key programme lessons & results		
Develop documentation plan	Yes	Plan was documented but still few project activities require documentation like- VCC, CLICS doot & Parenting Workshop
4.2 Disseminate & share lessons		
Develop Dissemination strategy	Yes	Dissemination strategy developed
Develop communication products	Yes	Posters, Documentary Film, Modules developed
Newsletter/ Samvedna	Yes	12 Published so far from CLICS
Project Briefs	Yes	2 Published
Child Survival Website	Yes	Developed http://clics.org.in
Voices, lessons learned and others	Yes	10 voices and lesson learnt documented
Organise information sharing workshops/meetings	Yes	Organized both at national and local level
Organise advocacy workshops/meetings	Yes	One advocacy meet at New Delhi
Participate in conferences & network meetings	Yes	Continuing at state, national and even at international fora
Operations Research		
Plan Operations Research	Yes	8 dissertation completed including 17 other operational research (10 published, 2 accepted)
Implement Operations Research	Yes	Completed

Annex 12: Rapid Catch Indicators for Endline Survey (required annex)

FACTSHEET - I

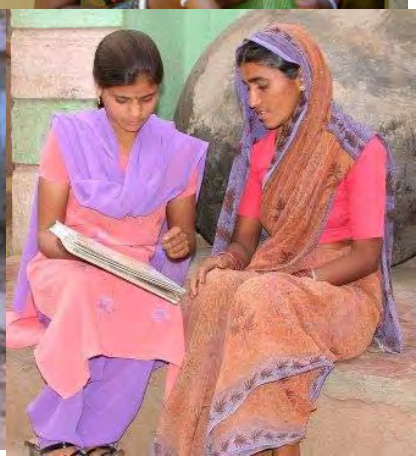
Indicators	Numerator	Denominator	Indicator	CI at 95%
% children (0-35 m) underweight (-2 SD from the median weight-for-age)	375	912	41.1%	38-44.4%
% children age 0-23 months who were born at least 24 months after the previous surviving child	261	343	76.1%	71.6-80.6%
% children (0-23 m) whose births were 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%

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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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

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%
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% 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%
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% 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%
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		% 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%
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		% of children (0-35 months) presenting at clinics, advised to give fluids for child	0.0%	14.7%	35.0%
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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%
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		% 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%
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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

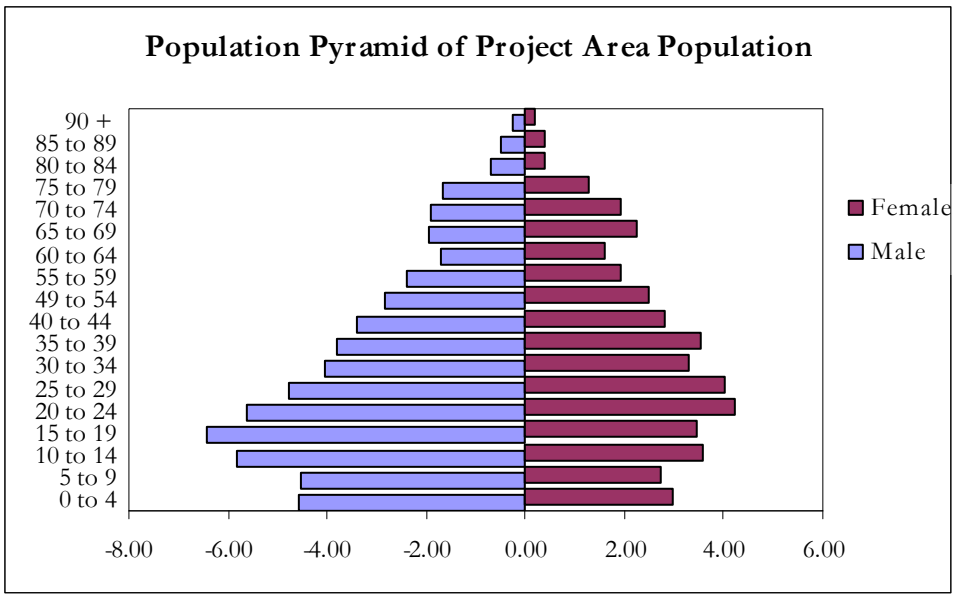
Population Characteristic	Anji	Talegaon	Gaul
Number of Households	5448 (35.1%)	6373 (41.1%)	3695 (23.8%)
Total population covered	23692 (35.3%)	28046 (41.8%)	15411 (23%)
Religion of the households			
Hindu	4697 (86.2%)	5451 (85.5%)	3123 (84.5%)
Muslim	114 (2.1%)	124 (1.9%)	31 (0.8%)
Christian	6 (0.1%)	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.

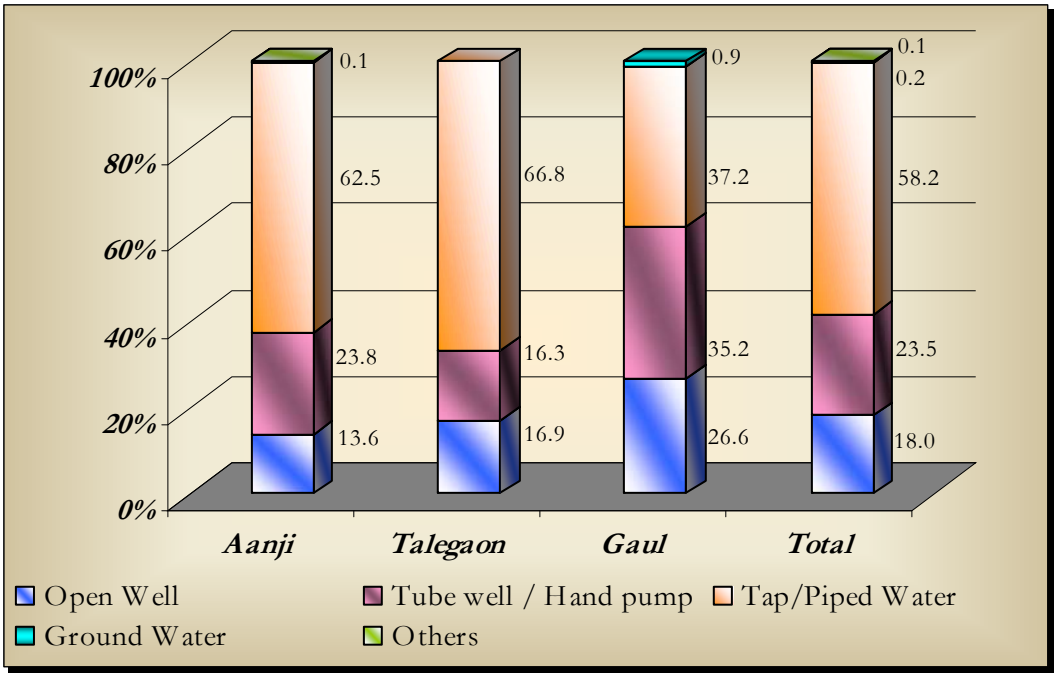
Figure 2.1: Population Pyramid



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.

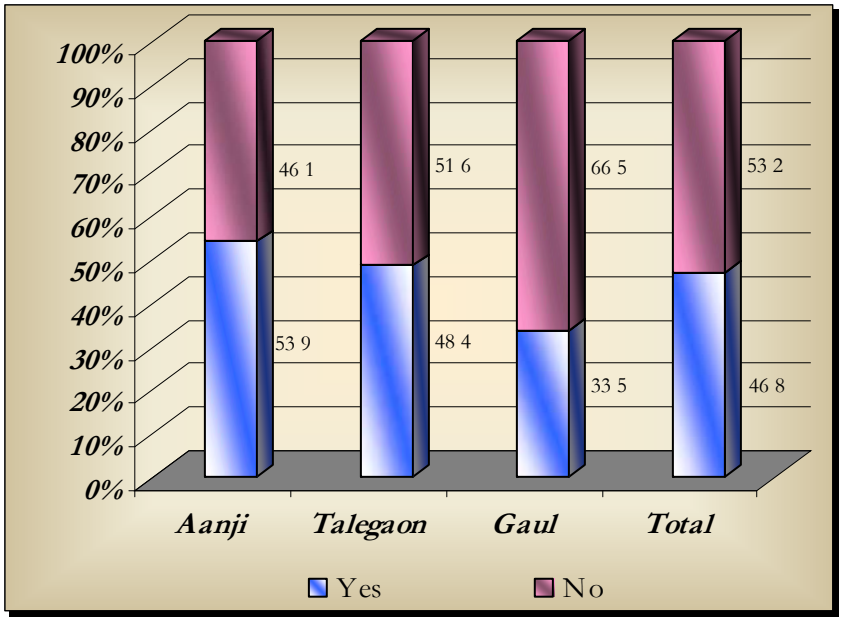
Table 2.6: Type of water purification method used in households

	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

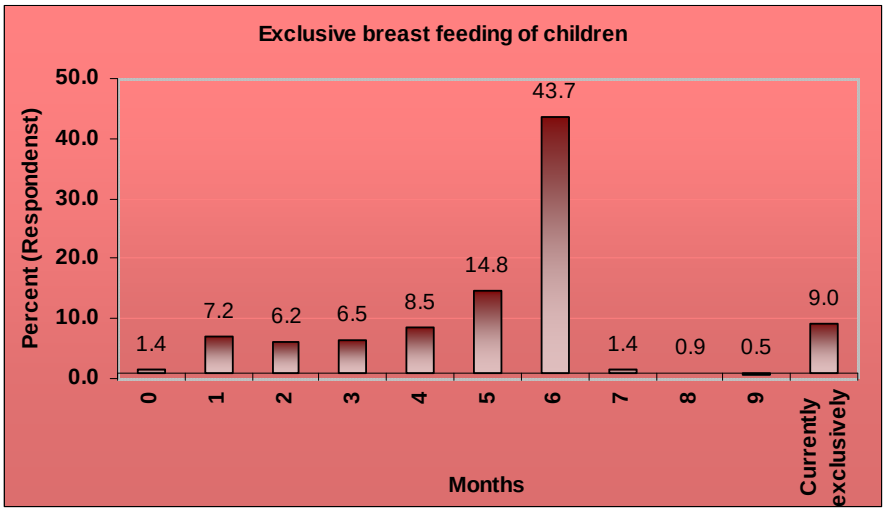
	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%

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.

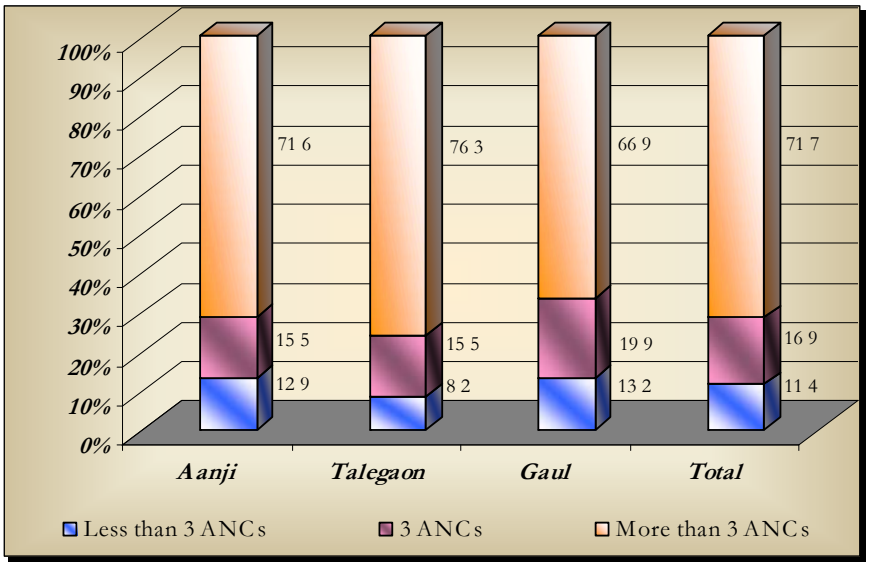
Table 4.2: Perception of men on availing Antenatal Checkups

	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



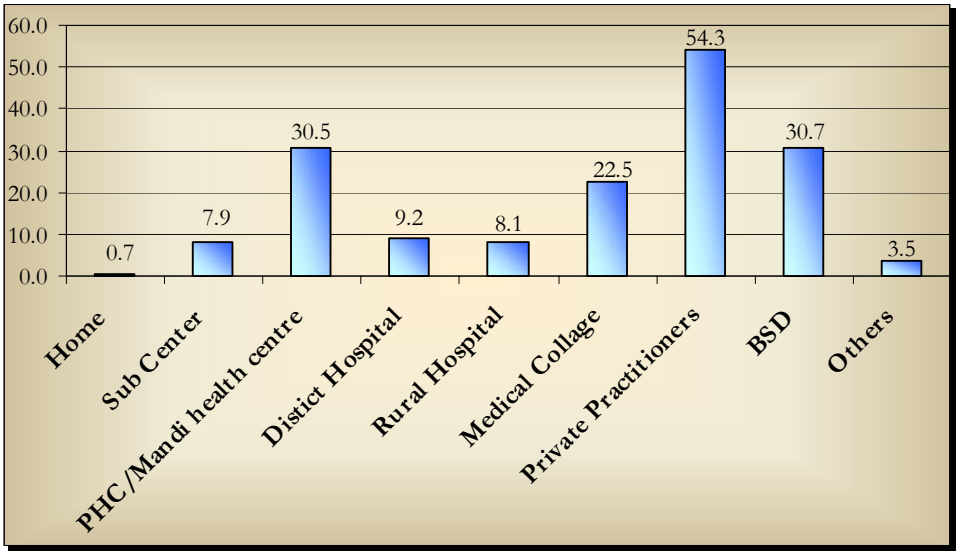
Base: All women with children aged 0-36 months

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

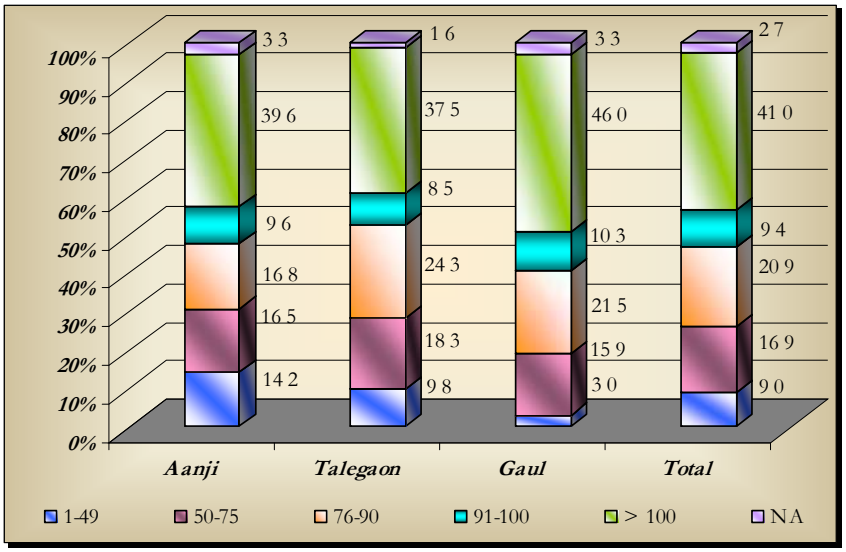
4.2.2 Supplementary Nutrition and Immunization of Pregnant Women

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

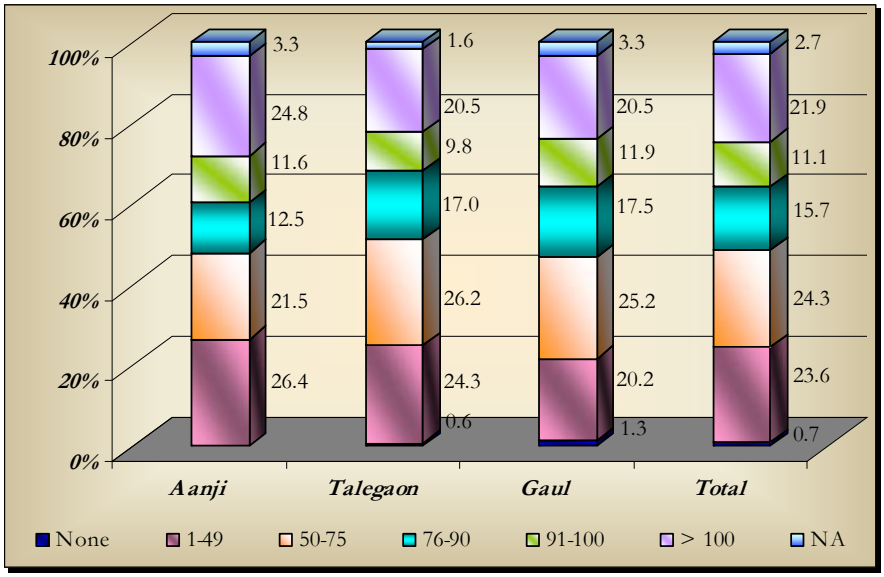
Base: All women with a child aged 24-36 months
NA refers to those respondents who received IFA but could not recall the number

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.

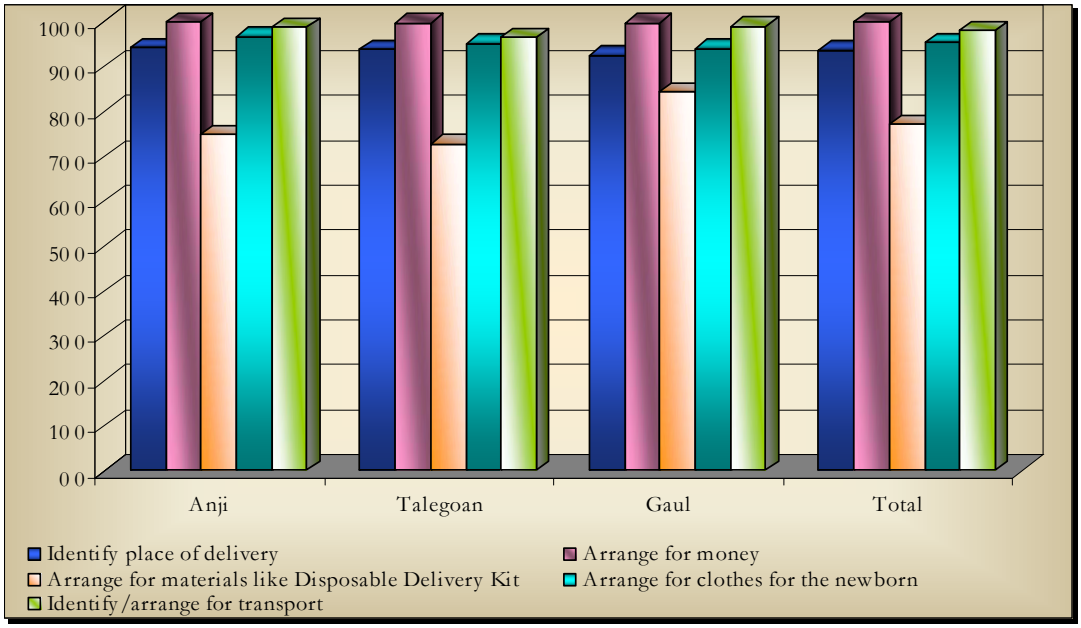
Table 4.20: Perception of Men on preparations before delivery

	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

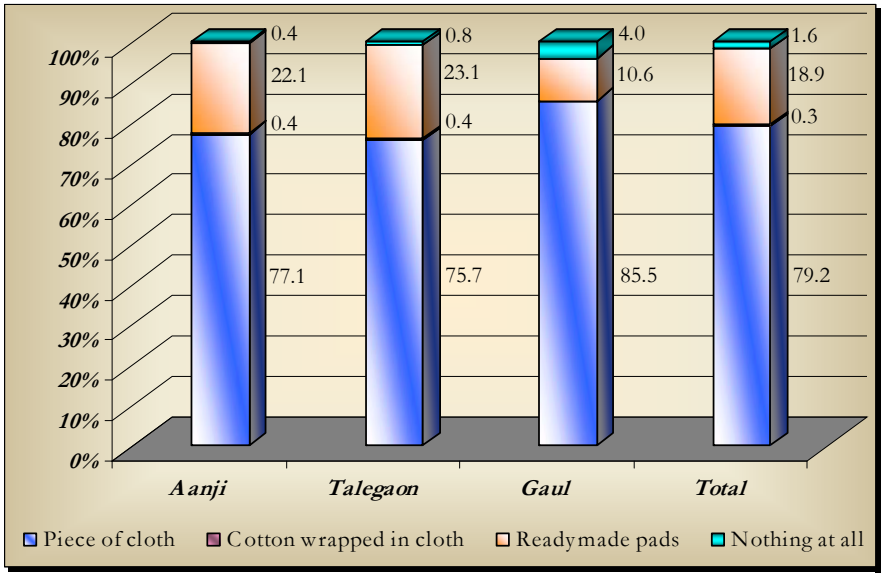
	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Other	26	23.2	24	16.2	16	11.8	66	16.7
Total	112	100.0	148	100.0	136	100.0	396	100.0

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.

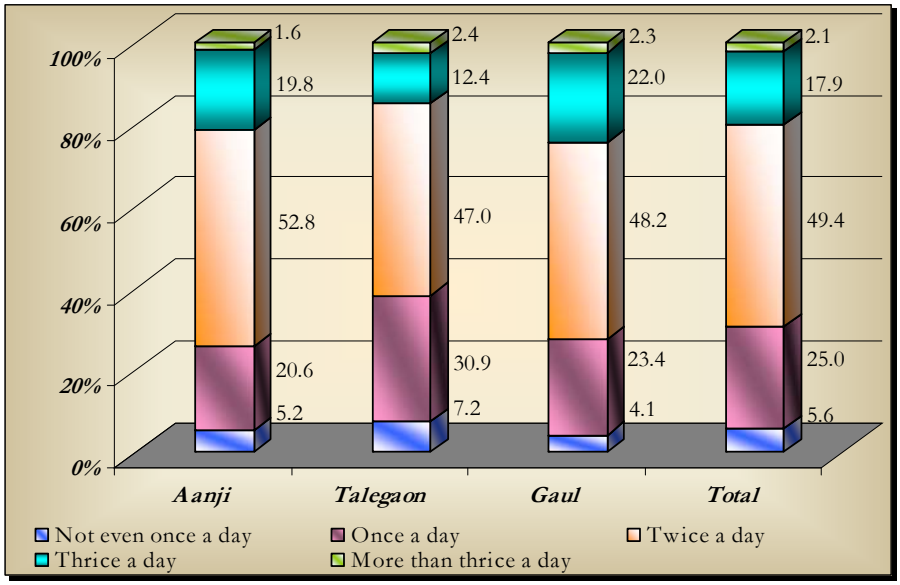
Figure 5.1: Practices during menstruation among adolescents



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

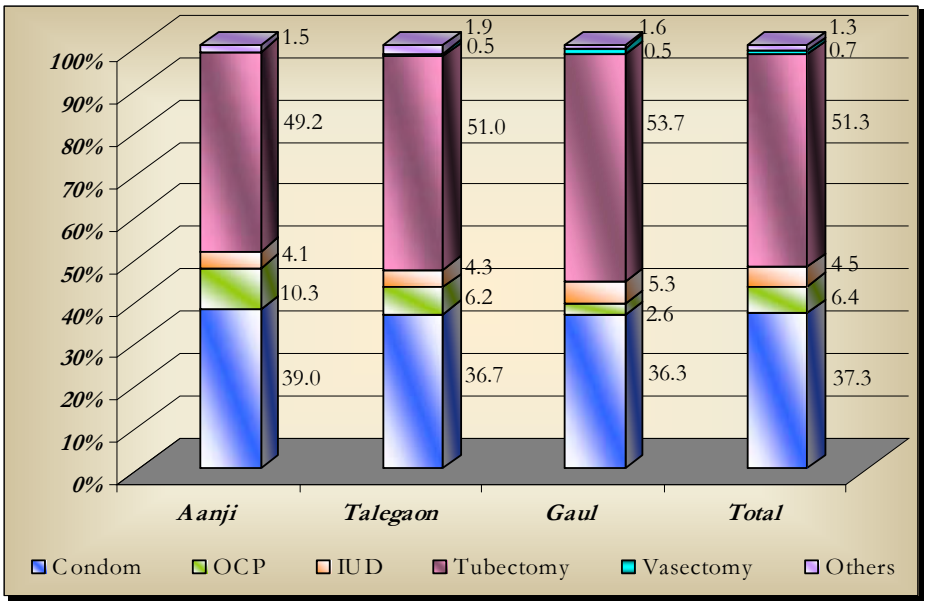
	Anji		Talegaon		Gaul		Total	
	N	%	N	%	N	%	N	%
Aware of 1 method	25	8.3	12	3.8	24	7.9	61	6.6
Aware of 2 methods	75	24.8	40	12.6	31	10.6	146	15.9
Aware of more than 2 methods	203	67.0	265	83.6	246	81.5	714	77.4
Total	303	100.0	317	100.0	301	100.0	921	100.0

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.

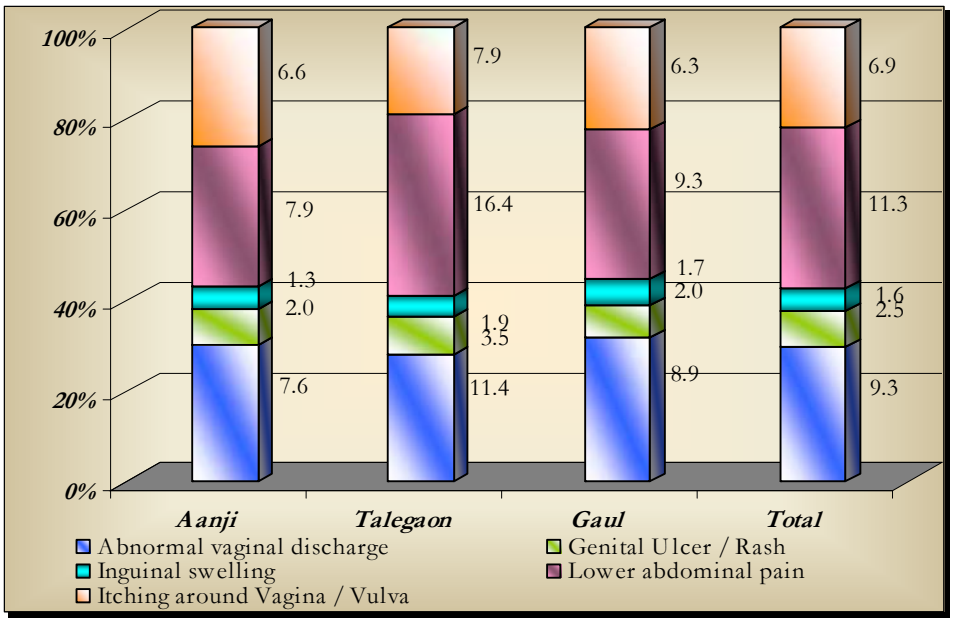
Similarly, the prevalence of reproductive Tract Infections too has been very high in the rural areas. This has been so as in most cases these infections in most cases go undetected. Even in cases where they are detected, treatment from a trained practitioner is very rarely sought. Apart from these issues, 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

Annex 14: Evaluation Team Members and their Titles (required annex)

David F. Pyle, Ph.D., Team Leader

Dr. S.D. Gupta, Ph.D., Indian Institute of Health Management Research

Yogesh Kumar, Director, Samarthan, Bhopal

Rachna Nangalia, Program Officer, Health, AKF USA

Seema Pahariya, Senior Program Officer, Health, AKF, India

Annex 15: Evaluation Assessment Methodology (required annex)

The methodology utilized by the Final Evaluation Team consisted of the following elements.

- Briefings – At the outset of the evaluation, the Project Director gave a PowerPoint presentation that was an overview of the CLICS Project – its objectives, progress/achievements, explanation of social franchising and discussion of constraints/barriers. This was followed by reviews of the findings of the final KPC survey, the project's MIS approach and a financial analysis of project expenditures versus budget.

- Sector Visits - The next three days were devoted to visiting the three sectors. At each site the sector project team made a PowerPoint presentation giving the evaluation team an overview of sector activities.

- Meetings with CBOs – The evaluation team had the opportunity to meet with a number of CBOs (VCCs, SHGs, KPs, KVMs) when visiting project sites.

- Discussions with Partners – The evaluation team were able to interview groups that are integral parts of CLICS – members of the *gram panchayats*, AWWs and *mukhya sevika*, ANMs, MPWs and MO from health staff, Assistant DHO, member (head of health committee) of the *Zilla Parishad* (elected district council) as well as the Chief Executive Officer. In addition, a primary health center and sub-center were visited.

- Interviews with Project Staff – The evaluation team spoke with CLICS staff (including Project Director, APOs, COs, MIS Assistants, MOs, ANMs and Master Trainers) about project activities and management issues.

- Observe Project Activities – A range of CLICS activities were attended, including *Bal Suriksha Diwas*, CHCs, *Kiran* Clinics.

- Review of Documents & Reports – The evaluation team had access to and reviewed a large volume of documents and reports (including the mid-term survey) on the CLICS Project (see attached list).

- Feedback – The evaluation team presented its findings and recommendations to the CLICS team, AKF, India and USAID/India which provided an opportunity for feedback and discussion.

Annex 16: List of Persons Interviewed and Contacted (required annex)

Name	Organization	Position
CLICS Central Office		
Dr. S. Chabbra	MGIMS	Dean
Dr. Narang	MGIMS	Secreatry
Dr. B S Garg	MGIMS/CLICS	Program Director
Dr. Subodh S Gupta	MGIMS/CLICS	TST Member
Mr. P.V. Bahulekar	MGIMS/CLICS	TST Member
Mr. Madhukar S Bharambe	MGIMS/CLICS	TST Member
Dr. Shib Sekhar Datta	CLICS	Asst. Program Coordinator
Dr. Abhijit Boratne	CLICS	Asst. Program Coordinator
Dr. Himanshu Dongre	Gaul Sector	Medical Officer, CLICS
Mr. Manoj Chaudhary	CLICS	Program Officer (MIS)
Mr. Sachin Nasare	CLICS	MIS Assistant
Mr. S G Bhagat	CLICS	Finance & Adm. Officer
Ms. Mamata Raut	CLICS	Office Assistant
New Delhi		
Dr. Rajeev Tandon	USAID	Chief, MNCUH
Dr. Devki Nandan	Director	National Institute of Health & Family Welfare
CLICS Sector Staff		
Dr. Chetna Maliye	Gaul Sector	Sector Coordinator
Dr. Sanam Anwar	Talegaon Sector	Sector Coordinator
Dr. Amol Dongre	Anji Sector	Sector Coordinator
Ms. Alka Kakde	Talegaon Sector	Asst. Program Officer
Mr. Vinod Yenurkar	Gaul Sector	Asst. Program Officer
Mr. Nitin Jaiswal	Anji Sector	Asst. Program Officer
Ms. Seema Mokaddam	Talegaon Sector	MIS Assistant
Ms. Shabana Sheikh	Gaul Sector	MIS Assistant
Ms. Shubhangi Vaidya	Anji Sector	MIS Assistant
Ms. Sushma Sardar	Gaul Sector	Community Organizer
Mr. Manik Rathod	Gaul Sector	Community Organizer
Mr. Jai Prakash More	Gaul Sector	Community Organizer
Ms. Chanda Shende	Talegaon Sector	Community Organizer
Mr. Satish Hinge	Talegaon Sector	Community Organizer
Ms. Rajshree Jhamre	Talegaon Sector	Community Organizer
Ms. Sunita Chauhan	Talegaon Sector	Community Organizer
Ms. Nanda Dabhade	Anji Sector	Community Organizer
Village coordination Committee, Village Salod, Sector Talegaon		
Ms. Surekha Wandile	VCC	President
Ms. Najma Pathan	VCC/VHNSC	Vice President/Secretary
Ms. Ushatai Raghatate	VCC/GP	Secretary
Ms. Vandana Wandile	VCC/VHNSC	Member/President
Ms. Nalinitai Bhoyar	VCC/Ex Panchayat Samiti President	Member

Ms. Sumantai Ikhar	VCC	Member
Ms. Arunatai Wandile	VCC/GP	Member
Ms. Kusumbai Dhok	VCC	Member
Ms. Sulochana Sawarkar	VCC	Member
Ms. Pratibha Wagh	VCC	Member
Ms. Shalini Baitage	VCC	Member
Ms. Vishakha Danvir	VCC	Sub Center ANM
Mr. Namdevrao Borkar	VCC/KVM	Member
Ms. Gita Zade	CLICS	CLICS Doot
Ms. Rekha Virulkar	CLICS	CLICS Doot
Ms. Rekha Chaudhary	CLICS	CLICS Doot
Ms. Chaaya Wandile	CLICS	CLICS Doot
Ms. Vandana Wagh	CLICS	CLICS Doot

Mahatma Fule Village Coordination Committee, Village Pavnoor, Anji Sector

Mr. Rameshrao Karankar	Gram Panchayat/VCC	Sarpanch
Ms. Vandana Karankar	VCC/SHG	President
Mr. Prakash Siraskar	VCC/KVM	Secretary
Ms. Jyoti Agawane	ICDS/VCC	AWW
Mr. Anuj Joge	VCC	Gram Sewak
Ms. Mala Chaudhary	VCC/SHG	Member
Ms. Kavishawari Kondalkar	VCC/SHG	Member
Ms. Durga Khandalkar	VCC/SHG	Member
Ms. Alka Meshram	VCC/SHG	Member
Ms. Swapna Mokalkar	VCC/KP	Member
Mr. Madhavrao Karankar	VCC/KVM	Member
Mr. Vijay Rajurkar	VCC	Member
Ms. Arun Kadoo	VCC	Member
Mr. Shriram Umake	VCC	Member
Mr. Laxmanrao Kondalkar	VCC	Member
Mr. Diliprao Kukde	VCC	Member
Mr. Madhukar Rambole	VCC	Member

KVM Federation Sector, Anji

Mr. Naresh Chandra Gomase	President KVM Fed	Anji KVM
Mr. Vilas Dabhale	Vice President KVM Fed	Anji KVM
Mr. Sanjay Khobragade	Vice Secretary KVM Fed	Pulai KVM
Mr. Mangesh Date	Treasurer KVM Fed	Pandharkawda KVM
Mr. Khushalrao Yede	KVM Federation	Ganeshpur KVM
Mr. Gunvantrao Balvir	KVM Federation	Dhulwa KVM
Mr. Damodar Lidbe	KVM Federation	Satoda KVM
Mr. Chanardas Pethkar	KVM Federation	Dorli KVM
Mr. Kiran Dhopate	KVM Federation	Ganeshpur KVM
Mr. Ambadas Dhopate	KVM Federation	Pawnar KVM
Mr. Punjabrao Rokde	KVM Federation	Warud KVM
Mr. Dharmapal Taksande	KVM Federation	Mahakal KVM
Mr. Abhay Bohre	KVM Federation	Majra KVM
Mr. Praksh Siraskar	KVM Federation	Pavnoor KVM
Mr. Gajanan Talhan	KVM Federation	Anji KVM
Mr. Nivrutti Mhasne	KVM Federation	Narsula KVM
Mr. Prakash Khobragade	KVM Federation	Karla KVM

Mr. Haribhau Abmatkar	KVM Federation	Anji KVM
Mr. Santosh Mahajan	KVM Federation	Anji KVM
Mr. Sunil Kumbhre	KVM Federation	Mandwa KVM
Mr. Ashish Kove	KVM Federation	Alodi KVM

Private Practitioners, Anji Sector

Dr. Arvind Wanjari	Anji
Dr. K O Waghmare	Anji
Dr. Jayant Gandole	Anji
Dr. Sharad Bangde	Anji
Dr. Vinod Bele	Anji
Dr. Ashok Hivre	Pawnar
Dr. Vandana Vaidya	Pawnar
Dr. Dilip Vaidya	Pawnar

PHC Staff, PHC Anji

Dr. Ramavtar Goyal	Medical Officer
Mr. D M Sahare	Health Assistant
Mr. V N Wandile	Health Assistant
Ms. N A Tatekar	ANM
Ms. N S Porate	ANM
Ms. M J Bobde	ANM
Ms. O P Zade	ANM
Ms. Rekha Morehswar Mankar	CHV (NRHM addl. ANM)

Kishori Panchayat Members, Gaul Sector

Ms. Kanchan Bhagat	Bhidi	President
Ms. Meena Bonde	Gaul	President
Ms. Priya Deshmukh	Babhulgaon	President
Ms. Mangala Wadekar	Kolhapur (R)	President
Ms. Shubhangi Patil	Wabgaon	President
Ms. Chaitali Chilurkar	Gaul	Secretary
Ms. Sunita Bhiskar	Watkheda	Secretary
Ms. Kalyani Bhagat	Bhidi	Member
Ms. Anju Walke	Bhidi	Member
Ms. Chaitali Thakre	Bhidi	Member
Ms. Rupali Yedme	Husnapur	Member
Ms. Mamta Nalhe	Husnapur	Member
Ms. Rupali Raut	Husnapur	Member
Ms. Shubhangi Turak	Kolona (C)	Member
Ms. Alka Sontakke	Kolona (C)	Member
Ms. Jaishree Sontakke	Kolona (C)	Member
Ms. Suchita Turak	Kolona (C)	Member
Ms. Sarika Chaware	Kolona (C)	Member
Ms. Manisha Dahare	Babhulgaon	Member
Ms. Anita Mahajan	Babhulgaon	Member
Ms. Deepali Masram	Babhulgaon	Member
Ms. Vaishali Bahadure	Babhulgaon	Member
Ms. Saroj Betankar	Wabgaon	Secretary
Ms. Priyanka Wankhede	Wabgaon	Member
Ms. Rupali Paratpure	Wabgaon	Member

Ms. Namrata Balbhudhe	Ganeshpur	Member
Ms. Kalyani Raut	Ganeshpur	Member
Ms. Sheetal Bhong	Gaul	Member
Ms. Anita Karbuke	Andori	Member

VCC Members, Gaul Sector

Ms. Savita Jambhule	Bhidi	President
Ms. Chandrakala Waghmare	Babhulgaon	President
Ms. Pramila Chore	Wabgaon	President
Ms. Savita Bhise	Kharda	President
Ms. Sulochana Nanhe	Bopapur	President
Ms. Sunanda Bhonde	Mominpur	President
Ms. Triveni Waghmare	Gaul	President
Ms. Jyoti Dable	Andori	President
Ms. Meera Dhale	Kolona (C)	President
Mr. Madan Ingole	Singarwadi	President
Ms. Kalpana Masram	Watkheda	President
Ms. Archana Tajne	Bhidi	Secretary
Ms. Sangeeta Patil	Wabgaon	Secretary
Mr. Prakash Karadbhaje	Kharda	Secretary
Ms. Aruna Badoble	Watkheda	Secretary
Ms. Veenatai Bobde	Kolona (C)	Secretary
Mr. Suresh Galad	Gangapur	Secretary
Ms. Suman Meghe	Andori	Member/GP Member
Ms. Lata Kadoo	Kolona (C)	Member/GP Sarpanch
Ms. Shalini Bhagat	Bhidi	Member
Ms. Sharda Khadse	Bhidi	Member
Ms. Meera Devghare	Bhidi	Member
Ms. Maya Deshmukh	Babhulgaon	Member
Ms. Sumantai Lonkar	Babhulgaon	Member
Ms. Chhabubai Tadas	Babhulgaon	Member
Ms. Chandabai Tahakre	Babhulgaon	Member
Ms. Sheela Betal	Kolhapur (R)	Member
Ms. Mina Lungse	Kolhapur (R)	Member
Ms. Kanta Dabhekar	Kolhapur (R)	Member
Ms. Panchafula Marathe	Kolhapur (R)	Member
Mr. Mangesh Thote	Wabgaon	Member
Ms. Pramila Darne	Wabgaon	Member
Ms. Vanita Paratpure	Wabgaon	Member
Ms. Prabhatai Wavre	Wabgaon	Member
Ms. Sunita Mangesh Thote	Wabgaon	Member
Ms. Nilima Bhende	Kharda	Member
Ms. Kamal Darodkar	Kharda	Member
Mr. Laxman Nanhe	Bopapur	Member
Ms. Durga Virulkar	Mominpur	Member
Mr. Sishir Raut	Husnapur	Member
Mr. Gulabrao Yemde	Husnapur	Member
Ms. Lata Chillurkar	Gaul	Member
Ms. Venutai Bawankar	Gangapur	Member
Ms. Shakuntala Debre	Andori	Member
Ms. Vandana Gadekar	Watkheda	Member
Ms. Manda Yengde	Watkheda	Member
Ms. Vanita Raut	Watkheda	Member

Ms. Sunanda Jagtap	Singarwadi	Member

SHG Members, Bhidi Village, Sector Gaul

Ms. Pratibha Jadhav	Ms. Suman Lonkar
Ms. Sharda Khadse	Ms. Chhabu Tadas
Ms. Sangeeta Kadukar	Ms. Chandraprabha Waghmare
Ms. Sarla Barfade	Ms. Sumi Waghmare
Ms. Archana Bhagat	Ms. Baby Chauhan
Ms. Meena Darne	Ms. Kamla Karpate
Ms. Vandana Barfade	Ms. Pramila Satpute
Ms. Surekha Bhoyar	Ms. Babybai Bire
Ms. Madhuri Bakal	Ms. Vaishali Khadse
Ms. Savita Jambhulkar	Ms. Sarita Bhagat
Ms. Prabhatai Kolhe	Ms. Savita Bhagat
Ms. Dwarkabai Dahekar	Ms. Jyotsna Dongre
Ms. Lilabai Chauke	Ms. Shalini Bhagat
Ms. Asmita Dahake	Ms. Archana Tajne
Ms. Mandabai Bhoyar	Ms. Archana Bhagat
Ms. Vaishali Zade	Ms. Surekha Bhoyar
Ms. Sunita Zade	Ms. Madhuri Bakal
Ms. Varsha Chaudhary	Ms. Shobha Dighade
Ms. Chanda Thakre	

CLICS Doots, Talegaon Sector

Ms. Sindhu Manikrao Thombre	Talegaon
Ms. Shobha Vinod Borikar	Talegaon
Ms. Nanda Bhagwan Mahakalkar	Talegaon
Ms. Kalpana Kuhite	Talegaon
Ms. Indira Khode	Ekurli
Ms. Kalpana Ashok Hinge	Dhotra (K)
Ms. Varsha Ankush Bawne	Sonegaon
Smt. Sunita Suresh Nagrale	Jaulgaon
Ms. Jyotsna Munjewar	Ashtha
Ms. Shubhangi Thakre	Bhugaon
Ms. Geeta Santosh Zade	Salod
Ms. Rekha Chintaman Virulkar	Salod
Ms. Rekha Murlidhar Chaudhary	Salod
Ms. Chaaya Ganesh Wandile	Salod
Ms. Vandna Narayanrao Wagh	Salod
Ms. Ratnamala Mohan Pawar	Salod (Indira Nagar)
Ms. Alka Narendra Satone	Padegaon
Ms. Baby Dhnyaneshwar Mendule	Padegaon
Ms. Chaaya Sharad Naranje	Dhotra (R)
Ms. Lata Pramod Dongre	Selsura
Ms. Prabha Ramesh Kamnale	Paloti
Ms. Jayashri Santosh Moharle	Jamtha
Ms. Aruna Diwakar Barahate	Inzapur
Ms. Sangita Sontakke	Wadad

Wardha District Functionaries

Ms. Gunjan Kinnu	Chief Executive Officer
Dr. Dhakte	ADHO

Dr. Madhuri Dighekar	MO I/C, PHC Talegaon
Dr. Kolhatkar	MO, PHC Talegaon
Dr. R A Goel	MO I/C, PHC Anji
Dr. Ganesh Bansod	MO, PHC Gaul
Ms. M D Sangole	ANM, Gaul PHC
Ms. Vidhya Bhoyar	ICDS Supervisor, Waifad PHC
Ms. Madhuri Gambhir	ICDS Supervisor, Anji PHC
Mr. S Maraskolhe	SA, ICDS
Ms. J M Sonune	ICDS Supervisor, Talegaon PHC
Ms. M Tadas	ICDS Supervisor, Anji PHC
Ms. Rekha Marotkar	ICDS Supervisor, Talegaon PHC
Ms. Anita Bhoyar	ICDS Supervisor, Madni
Ms. Rekha Mankar	LHV, Anji PHC
Mr. Kokate	HA, Anji PHC

VCC, Kolhapur (Rao), Sector Gaul

Ms. Shobha Nagrale	VCC President
Mr. Suresh Lungse	VCC Secretary
Ms. Vandana Betankar	AWW
Ms. Chanda Betankar	CLICS Doot
Ms. Shila Betal	VCC Member
Ms. Kanta Dabhekar	VCC Member
Ms. Meena Lungse	VCC Member
Ms. Panchafula Marathe	VCC Member
Ms. Mangala Wadekar	KP President
Ms. Saroj Betal	KP Secretary
Ms. Komal Betal	KP Member
Ms. Monika Betal	KP Member

VCC, Mahakal, Sector Anji

Ms. Prajwala Dhawne	President
Ms. Ranjana Gadge	Secretary
Ms. Sr. Raut	ANM
Ms. Kalpana Nehare	ANM (NRHM)
Ms. Nirmala Kinkar	AWW
Ms. Ranjana Dhawne	CLICS Doot
Ms. Sunanda Dhawne	Member
Ms. Ranjana Kamble	Member
Ms. Vaijayanti Taksande	Member
Ms. Vimal Raut	Member
Ms. Dhobi Girkar	Member
Ms. Kanta Dhawne	Member
Ms. Jyoti Ghughe	Member
Mr. Dharmapal Taksande	Member/KVM

Child Survival and Health Grants Program Project Summary

Dec-01-2008

Aga Khan Foundation
(India)

General Project Information:

Cooperative Agreement Number:	**GHS-A-00-03-00015-00**
Project Grant Cycle:	**19**
Project Dates:	**(9/30/2003 - 6/30/2009)**
Project Type:	**Standard**
AKF Headquarters Technical Backstop:	**Rachna Nangalia**
Field Program Manager:	**Seema Pahariya**
Midterm Evaluator:	**David Pyle**
Final Evaluator:	
USAID Mission Contact:	**Rajiv Tandon**

Field Program Manager Information:

Name: **Seema Pahariya**
Address:

Phone:
Fax:
E-mail: seema.pahariya@akdn.org

Funding Information:

USAID Funding:(US $): $1,386,480 **PVO match:(US $)** $648,201

Project Information:

Description:

The goal of the Community Led Initiatives for Child Survival (CLICS) is "sustainable improvement in the health status and well being of children under the age of three and women of reproductive age (15-44 years)".
Intervention areas include newborn care, safe motherhood, breast feeding and nutrition, management of acute respiratory infections, early childhood development, immunizations, STI HIV AIDS, and birth spacing.

The implementation strategy for these interventions is characterized by; mobilizing the community to form Village Coordination Committees; developing with each VCC a "social franchise agreement; implementing the franchise agreement through the VCC; and achieving "community ownership.

Location:

67 villages in Wardha District, Maharashtra State, India

Project Partners	Partner Type	Subgrant Amount
Mahatma Gandhi Institute of Medical Sciences	Subgrantee	$1,476,218.00
Subgrant Total		$1,476,218.00

General Strategies Planned:

Advocacy on Health Policy
Strengthen Decentralized Health System

M&E Assessment Strategies:

KPC Survey
Health Facility Assessment
Participatory Learning in Action
Lot Quality Assurance Sampling
Appreciative Inquiry-based Strategy
Participatory Evaluation Techniques (for mid-term or final evaluation)

Behavior Change & Communication (BCC) Strategies:

Mass Media
Interpersonal Communication
Peer Communication
Support Groups

Groups targeted for Capacity Building:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
US HQ (CS unit) Field Office HQ CS Project Team	(None Selected)	Private Providers	Dist. Health System Health Facility Staff Other National Ministry	Health CBOs Other CBOs CHWs

Interventions/Program Components:

(IMCI Integration)
(CHW Training)
(HF Training)

Nutrition (10 %)

(IMCI Integration)
(CHW Training)
(HF Training)
- Comp. Feed. from 6 mos.
- Cont. BF up to 24 mos.
- Growth Monitoring
- Maternal Nutrition

(IMCI Integration)
(CHW Training)
(HF Training)
(IMCI Integration)
(CHW Training)
(HF Training)

Pneumonia Case Management (10 %)

(IMCI Integration)
(CHW Training)
(HF Training)
- Pneum. Case Mngmnt.
- Case Mngmnt. Counseling
- Recognition of Pneumonia Danger Signs
- Community based treatment with antibiotics

Control of Diarrheal Diseases (10 %)

(IMCI Integration)
(CHW Training)
(HF Training)
- Water/Sanitation
- Hand Washing
- ORS/Home Fluids
- Feeding/Breastfeeding
- Care Seeking
- Case Mngmnt./Counseling

(IMCI Integration)
(CHW Training)
(HF Training)

Maternal & Newborn Care (60 %)

(IMCI Integration)
(CHW Training)
(HF Training)
- Emerg. Obstet. Care
- Recog. of Danger signs
- Newborn Care
- Post partum Care
- Delay 1st preg Child Spacing
- Integr. with Iron & Folate
- Normal Delivery Care
- Birth Plans
- STI Treat. with Antenat. Visit
- Emergency Transport

(IMCI Integration)
(CHW Training)
(HF Training)

Breastfeeding (10 %)

(IMCI Integration)
(CHW Training)
(HF Training)
- Promote Excl. BF to 6 Months
- Intro. or promotion of LAM

(IMCI Integration)
(CHW Training)
(HF Training)
(IMCI Integration)
(CHW Training)
(HF Training)
(IMCI Integration)
(CHW Training)
(HF Training)

Target Beneficiaries:

Infants < 12 months:	
Children 12-23 months:	
Children 24-59 months:	
Children 0-59 Months	
Women 15-49 years:	
Population of Target Area:	88,128

Rapid Catch Indicators:

	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	375	912	41.1%	5.2
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	261	343	76.1%	10.3
Percentage of children age 0-23 months whose births were attended by skilled health personnel	643	685	93.9%	7.5
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	352	376	93.6%	10.1
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	83	132	62.9%	15.8
Percentage of infants age 6-9 months receiving breastmilk and complementary foods	146	149	98.0%	16.1
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	323	337	95.8%	10.7
Percentage of children age 12-23 months who received a measles vaccine	325	337	96.4%	10.7
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	142	685	20.7%	4.6
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	681	685	99.4%	7.5
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	0	0	0.0%	0.0
Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	541	912	59.3%	5.9
Percentage of mothers of				

children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	0	0	0.0%	0.0

Comments for Rapid Catch Indicators

Notes & Comments

1. Under-weight children indicator has been analyzed as per CDC/WHO 1978 reference using EPI Info package. Baseline finding for under-weight children has been re-calculated using the CDC/WHO 1978 reference for comparison with the mid-term survey finding. Accordingly, the % children age (0-35) months who are under-weight (- 2SD from the median weight) was 42.3% at baseline/DIP), 44.3% at mid-term, and 41.1% at end-term of the program.
2. Data for some of the above indicators is available for the 0-35 months of children, because the program targets children under-3 years (in alignment with the government policy). These indicators are: under-weight children; sick children; HIV/AIDS and hand-washing.
3. Data for Maternal TT has been collected for 0-11 months children instead of 0-23 months.
4. Sick child indicator findings for the end-term are:
% 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): Numerator: 67 Denominator: 141 Percent: 32.2% CI: 28.7 - 35.7%
b) continued feeding among those who were breastfeeding: Numerator: 169 Denominator: 172 Percent: 98.3% CI: 96.3 - 100%
5) Handwashing indicator findings for the end-term are:
% mothers of children (0 - 35 m) who report that they wash their hands with soap/ash:
a) before food preparation: Numerator: 420 Denominator: 912 Percent: 46.1% CI: 42.9 - 49.3%
b) before feeding children: Numerator: 522 Denominator: 912 Percent: 57.2% CI: 54 - 60.4%
c) after defecation: Numerator: 899 Denominator: 912 Percent: 97.3% CI: 96.2 - 98.4%
d) after washing child after defecation: Numerator: 887 Denominator: 912 Percent: 97.3% CI: 96.2 - 98.4%